

MINISTRY OF HEALTH AIDS CONTROL PROGRAM

ADDENDUM TO THE HIV TESTING SERVICES POLICY & IMPLEMENTATION GUIDELINES

HIV SELF-TESTING & ASSISTED PARTNER NOTIFICATION SERVICES

NOVEMBER 2018



THE REPUBLIC OF UGANDA

MINISTRY OF HEALTH AIDS CONTROL PROGRAM

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Table Of Contents

ABBREVIATIONS		i
ACKNO	WLEDGEMENTS	ii
FOREWARD		iv
DEFINITION OF TERMS OR GLOSSARY		٧
10	SECTION A: HIV SELF-TESTING	1
1.1	Background	1
1.2	Justification for HIV-Self Testing	2
1,3	Overview of HIVST	2
1.3.1	Description of HIVST	2
1.3.2	Benefits of HIVST	2
1.4	Summary of Evidence for HIV Self-Testing	3
1.4.1	HIVST for Various Populations	3
1.4.2	Potential for Harm/Social harm	4
1.5	Rationale for the Policy and Implementation Guidelines on HIVST	5
1.6	Purpose and Objectives of Policy and Implementation Guidelines on HIVST	5
1.6.1	Purpose	5
1.6.2	Objectives	5
1.7	Target Audience for the policy & Implementation Guidelines on HIVST	5
1.8	Process of Review of Policy on HIVST and development of implementation Guidance on HIVST	6
1.9	Implementation Considerations for HIVST	
1.9.1	Guiding Principles for Implementation of HIVST	6
1.9.2	Target Population for HIVST	7
1.9.3	Access to HIVST Rapid Test Kits	7
1.9.4	Approaches to HIVST	8

1.9.5	HIVST Distribution Channels/Delivery Models		
1.9.6	Facility Based Delivery Models		
1.9.7	Community Based Delivery Models		
1.9.8	Other Delivery Models		
1.10	Commodities and Quality Assurance for HIVST		
1.10.1	Performing HIV Self-Testing		
1.10.2	Diagnostics for HIVST		
1.10.3	Specimens for HIV Self-Testing		
1.10.4	Handling specimens for HIVST		
1.10.5	The HIV Self-Testing Strategy	14	
1.10.6	Procedure for conducting HIVST and interpretation of results		
1.11	Quality Assurance and control for HIVST		
1.11.1	Components of quality assurance for HIVST	15	
1.12	HIVST Logistics and Supply Chain Management		
1.13	SOCIAL BEHAVIOUR CHANGE COMMUNICATION (SBCC) FOR HIVST		
1.13.1	SBCC in the Context of HIV Self-Testing	18	
1.13.2	Communication goal and Objectives for HIVST		
1.13.3	Audience for HIVST	18	
1.13.4	Key Messages for Users and Implementers of HIVST	19	
1.14	MONITORING AND EVALUATION FOR HIVST IMPLEMENTATION	22	
1.14.1	Rationale for HIVST M&E	22	
1.14.2	Monitoring HIVST implementation	22	
	REFERENCES FOR HIV SELF-TESTING		
2.0	SECTION B: ASSISTED PARTNER NOTIFICATION SERVICES		
2.1	Background	28	
2.2	Rationale for Assisted Partner Notification Services(APN)	28	

2.3	Development process for APN Guidelines	29
2.4	OVERVIEW OF ASSISTED PARTNER NOTIFICATION SERVICES (APN)	29
1.12	What is Assisted Partner Notification Services?	30
1.13	Assisted Partner Notification Services Goals:	30
1.14	Assisted Partner Notification Services Objectives:	30
1.15	Components of Assisted Partner Notification Services	31
1.16	Benefits of APN	31
1.17	Target Populations for APN	32
1.18	Principles of APN	33
1.19	Program and Operations Requirements of APN	34
1.20	Challenges of APN	35
3.0	ASSISTED PARTNER NOTIFICATION SERVICES IMPLEMENTATION PROCESS	36
3.1	Step 1: Index client Identification	36
3.2	Step 2: Index Client Interview and Elicitation	36
3.3	Step 3: Partner Notification	37
1.3.1.	Index client Notification	37
1.3.2.	Assisted/Provider Notification	38
3.4	Step 4: Partner Counselled and Referred to or Linked to Care Services:	38
3.5	Step 5: Case Closure	39
4.0	APN COORDINATION STRUCTURE & ROLES AND RESPONSIBILITIES	40
5.0	MONITORING AND EVALUATION FOR APN	45
5.1	Process, Quality and Outcome Monitoring	45
5.2	Data Collection and Reporting Protocol	46
5.3	Reporting Flow	46
6.0	APPENDICES	47
APPEND	IX A: CONSENT FORM FOR APN	
APPEND	IX B: FLOW CHART FOR APN SERVICES	

APPENDIX C: Talking Points for Introducing Assisted Partner Notification Services to Index Clients			
APPEND	APPENDIX D: APN REGISTER		
APPENDIX E: PHONE CALL SCRIPT FOR ASSISTED PARTNER NOTIFICATION SERVICES			
APPEND	APPENDIX F: FIELD VISIT SCRIPT FOR APN		
APPEND	APPENDIX G: EXAMPLE OF PATIENT LETTER		
APPENDIX H: PERFORMANCE INDICATORS FOR APN			
REFERENCES FOR APN			
3.0	SECTION C: ADDITIONAL GUIDANCE ON HIV TESTING SERVICES	57	
3.1	HIV TESTING SERVICES MODELS & APPROACHES	57	
3.3.1.	FACILITY-BASED HTS MODEL		
8.0	THE HIV TESTING ALGORITHM FOR PERSONS AGED 18 MONTHS AND ABOVE	59	

Abbreviations

AIDS: Acquired Immune Deficiency Syndrome
APN Assisted Partner Notification Services

ART: Antiretroviral Treatment

ANC: Ante Natal Care

CAO: Chief Administrative Officer

CDC: Centers for Disease Control and Prevention

CHEWs Community health extension Workers

DHO: District Health Officer

DHT/DHMT: District Health Team/District Health Management

Team

DIS: Disease Intervention Specialist

DLP: District Led Programming
EQA: External Quality Assurance

FTE: Full Time Equivalent

GoU: Government of Uganda

HC: Health Centre
HF: Health Facility

HIV: Human Immune-deficiency Virus

HIVST HIV Self-Testing

HMIS: Health Management Information System

HSDP: Health Sector Development Plan

HTS: HIV Testing & Counseling

IPs: Implementing Partners

IPV: Intimate Partner Violence

KPs Key Populations

MARPs: Most At Risk Persons

MoH: Ministry of Health

M&E: Monitoring and Evaluation

NASTAD: The National Alliance of State & Territorial AIDS

Directors

NGO: Non-Governmental Organization
NPS: National HIV Prevention Strategy

NSP: National HIV and AIDS Strategic Plan

PEPFAR: U.S. President's Emergency Plan for AIDS Relief

QI: Quality Improvement

TA: Technical Assistance

UBOS: Uganda Bureau of Statistics

VHT: Village Health Teams

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Foreward

inistry of Health has committed to the 90:90:90 global targets towards HIV epidemic control. To achieve the United Nations (UN) first global HIV target of identifying 90% of all people living with HIV, the World Health Organization (WHO) released the Consolidated guidelines on HIV testing services in 2015 to which a supplement issuing new recommendations and additional guidance on HIV Self-Testing and Assisted Partner Notification services was added in 2016 as a result of emerging evidence.

This addendum to the 2016 Uganda National HTS policy and implementation guidelines contains guidance on HIV Self-Testing (HIVST) and Assisted Partner Notification Services(APN). It is informed by the World Health Organization (WHO) 2016 HIV Self-Testing and Partner Notification supplement to the Consolidated Guidelines on HIV Testing Services, and evidence generated from HIVST pilot studies and APN pilot in Kiboga and Rakai districts in Uganda. The document was further informed by a study visit to the USA on APN and another to Zimbabwe on HIV self-Testina.

Dr. Henry Mwebesa

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Definition of Terms or Glossary

- Directly Assisted self-testing: An individual who is self-testing
 for HIV receives an in-person demonstration from a trained
 provider or peer before or during HIVST, with instructions
 on how to perform the self-test and how to interpret the
 self-test result. This assistance is provided in addition to
 the manufacturer-supplied instructions for use and other
 materials found inside HIVST kits.
- 2. **Unassisted Self-Testing**: individuals self-test for HIV using guidance from the manufacturer-provided instructions. As with all self-testing, users may be provided with links or contact details to access additional support, such as telephone hotlines or instructional videos. No in-person demonstration from a trained provider or peer is provided
- Harm or Social Harm: any intended or unintended cause of physical, economic, emotional or psychosocial injury or hurt from one person to another, a person to themselves, or an institution to a person, occurring before, during or after testing for HIV.
- 4. **Test for Triage**: an HIV testing approach whereby a trained provider or self-tester performs a single HIV rapid diagnostic test. Individuals with a reactive test result are encouraged by a trained provider, or by written or pictorial information, to link to a facility for further HIV testing to confirm their status, and if confirmed HIV-positive they are linked to treatment. Individuals with a non-reactive test result are linked to appropriate HIV prevention services and advised to retest if they tested within six weeks of possible HIV exposure or are at ongoing HIV risk

- 5. **Sexual partner:** Person with whom index client has had sex with in the last twelve months
- 6. Intimate Partner: A person with whom one has a close personal relationship that can be characterized by the following: Emotional connectedness, Regular contact, Ongoing physical contact and/or sexual behavior, Identity as a couple, Familiarity and knowledge about each other's lives
- 7. **Intimate Partner violence:** Physical violence, sexual violence, stalking and psychological aggression (including coercive acts) by a current or former intimate partner
- 8. **Index client:** An individual aged 15 years or above, newly diagnosed as HIV-positive or an HIV-positive individual who is enrolled in HIV treatment services with a risk identified.
- 9. **Partner Notification:** A voluntary process where counsellors or health care workers ask index clients to list all their sexual partners within the past year.

1.0 SECTION A: HIV SELF-TESTING

1.1 Background

Uganda has committed to the United Nations (UN) global target of 90:90:90 by 2020. Closing the HIV testing gap and identifying 90% of all people living with HIV by 2020 is critical to the success of the national HIV response. The country has an HIV prevalence of 6.3% with 1.3 million people living with HIV among whom 1,040,015 (80%) have been identified (1, 2).

Despite the annual increases in HIV tests and testing coverage (3), in many settings HTS is not sufficiently targeted to the right populations and locations. High risk sub populations such as men, partners of people with HIV, adolescents and young people in high HIV prevalence settings and key populations remain largely unreached.

Men: Globally, HTS uptake and coverage for men continues to be lower than for women(4). In Uganda, HTS uptake is disproportionately lower for men compared to women despite HIV prevalence being highest among men aged 45 to 49, at 14.0%(1). According to the UDHS 2016, 55% of women and 47% of men age 15-49 years had been tested in the 12-month period preceding the survey and had been told the results of the last test they took and among respondents aged 15-49 years, a larger proportion of men (27 percent) than women (15 percent) had never been tested for HIV. In the FY 2015/2016, HTS uptake was disproportionately lower among males with 58% of males living with HIV identified compared to 92% of females by Dec 2015(5). In addition, partner testing within antenatal care settings in Uganda remains low (31%) despite a conducive policy environment (6).

Adolescents: Adolescents, particularly girls, are also at significant risk of HIV infection. Risk is highest in sub-Saharan Africa, where nearly 90% of the world's HIV-positive adolescents (10–19 years

of age) are estimated to be residing (7). Despite the need for HIV testing among adolescents, coverage and uptake remains poor. According to the UDHS 2016, the likelihood of having ever had an HIV test and receiving the results of the last test was lowest in the 15-19 age group (54 percent of women and 44 percent of men)(8). In Uganda 39% of young people aged 15-24years had been tested for HIV in the 12-month period preceding the survey and had been told the results of the last test they took(8).

Key Populations (KPs): Key populations comprise approximately 36% of the 1.9 million new adult HIV infections that occur each year globally (9, 10). Although countries are increasingly including key populations in their national HTS guidelines, implementation remains limited, and coverage continues to be low in most settings (3). Poor coverage and low uptake of HTS among key populations is not only related to availability but also to acceptability of services. Low acceptability frequently reflects unfriendly services, fear of stigma, discrimination, and punitive laws and practices that criminalize behaviours and, thereby, discourage access to health services, including HTS (9). In Uganda, HTS uptake among KPs remains low.

1.2 Justification for HIV-Self Testing

The challenges with HTS require a new focus and approaches to reach people with undiagnosed HIV infection. HIV self-testing (HIVST) is one such innovative approach to delivering HTS. HIVST transcends barriers such as stigma, lack of time, mismatched timings and distance to health facilities or HTS centers. HIVST aims to make HIV testing more accessible to several under-served populations such as men, adolescents and youths, partners of HIV infected people, key populations including MSM and sex workers, and hence facilitates knowledge of HIV status.

1.3 Overview of HIVST

1.3.1 Description of HIVST

It is a process in which a person collects his or her own specimen (oral fluid or blood) and then performs a test and interprets the result, often in a private setting, either alone or with someone he or she trusts.

HIV self-testing is a screening test and is not sufficient to make an HIV-positive diagnosis. Therefore, a reactive (positive) self-test result should be confirmed using the validated national testing algorithm by trained HTS provider. A person testing negative is advised to re-test if the tested within six weeks of possible HIV exposure or are at ongoing HIV risk.

1.3.2 Benefits of HIVST

HIVST has a number of benefits which are summarized as follows:

- Promotes access to and creates demand for HIV testing among those unreached by existing services.
- Decentralize HIV Testing Services thus promoting access for HTS
- Convenient and discreet
- Increases patient autonomy
- Assures confidentiality
- Empowers individuals

1.4 Summary of Evidence for HIV Self-Testing

In 2017, studies in Uganda demonstrate that HIVST was feasible and acceptable through the peer networks of fishermen and female sex workers, and partners of pregnant (13,14,30).

Following this, Uganda committed to adapting HIVST as an approach for HTS.

1.4.1 HIVST for Various Populations

HIVST has proven to improve HTS uptake and is highly acceptable among various groups of users in diverse settings (11, 12), particularly: key populations & priority populations (13, 14), men (15, 16), young people (15, 17), the general population (15, 18) pregnant women (19) and their male partners (20, 21), and cohabiting couples (12).

Key populations & Priority populations

Acceptability and willingness to use HIVST is generally high among key populations(11, 20) despite concerns about the potential lack of support, possible social harm, the level of accuracy of test results, and the related costs which could hinder access(11, 22). In a recent study in Uganda among fishermen novel network-based distribution model of HIVST had high uptake among fishermen(14). In another cluster-randomized study among female sex workers in Uganda, HIVST increased rates of overall and repeat HIV testing compared to standard HIV testing and counseling services. The study also found that overall and repeat HIV testing was lower in the facility pick-up arm compared to personal provision arm(13).

General populations

A number of studies have consistently demonstrated high interest in HIVST in many African countries including Zimbabwe(23), Zambia(24), Kenya(25) and South Africa(26). Some of the motivators for HIVST identified in these studies include: low cost for HIVST(23), privacy and personal empowerment including access to HIVST kits at clinics or pharmacies(25), perception

that HIVST is a way to overcome barriers to existing HTS, such as lack of trust in health workers and the health system(26).

Couples and partners

Studies have shown a high level of acceptability and interest in using HIVST among couples and partners in Kenya(20), Malawi(21) and the United States(27). In Malawi, HIVST was seen as an enabling, innovative way to test with a partner, strenathen a relationship bond and address concerns about suspected infidelity(21). In Malawi, while the motivation to self-test as a couple among women was driven by long-term goals of health and "togetherness", men reported that they needed persuasion to self-test (perceived as beneficial) and viewed HIVST as more flexible and less intimidating than HTS at a facility (21, 28). HIVST also provided a way for couples to disclose a previously concealed HIV-positive status, alleviating internal conflict (28). Distribution of an HIVST kit to a partner was perceived to be both safe and acceptable in Malawi and Kenya (21, 29). In Uganda, HIVST was found to increase uptake of male partner and couples' HIV testing with male partner (30).

Young people (15–24 years of age)

Studies among young people report considerable interest in accessing HIVST. Specifically unassisted HIVST using an oral fluid was acceptable and empowering despite some concerns about accuracy and linkage to care among university students (31, 32).

1.4.2 Potential for Harm/Social harm

Available evidence suggests that there is no significant harm associated with HIVST with some studies reporting no cases of IPV, self-harm or suicide resulting from HIVST or other HIV testing in the community (15) and others showing harm which was not

directly related to HIVST(33). HIVST may not directly influence the risk of intimate partner violence (IPV), but that these risks largely depend on the setting, context and relationship dynamics of couples and partners. Such findings are consistent with those reported by systematic reviews assessing harm across all forms of HTS(34, 35).

While the overall results are encouraging, it is important to recognize the need to minimize the potential for harm in HIVST through provision of services within a human rights framework, adequate information provision, use of quality self-test kits, adequate community involvement in decision making, establishing context-specific approaches to implementing HIVST in ways that and the establishment of active monitoring and reporting systems.

1.5 Rationale for the Policy and Implementation Guidelines on HIVST

The 2016 National HTS policy provides for development of guidelines for delivery of HIVST upon availability of evidence. This 2017 addendum has been developed based on findings from in-country pilots on HIVST in different populations and provides recommendations and guidance on HIV self-testing (HIVST). HIVST will make HIV testing more accessible to several under-served populations such as men, adolescents and youths, partners of HIV infected people and key populations including MSM and sex workers. This will accelerate progress towards achievement of the first 90 in Uganda.

1.6 Purpose and Objectives of Policy and Implementation Guidelines on HIVST

1.6.1 Purpose

To supplement the existing 2016 National HTS policy and implementation guidelines and, provide alternative testing approaches aimed at improving access to testing especially for key and priority populations and people who may not otherwise test

1.6.2 Objectives

- Support the implementation and scale-up of HIVST in the most ethical, effective, acceptable and evidence-based manner.
- 2. Provide guidance on how HIVST services should be integrated into existing community-based and facility-based HTS approaches and tailored to specific sub-populations.

1.7 Target Audience for the policy & Implementation Guidelines on HIVST

This policy and guidelines target different stakeholders including: policy makers, HTS programmers and planners, AIDS development partners and donors, programme and health facility managers and in-charges, district and facility HTS coordinators/supervisors and focal persons, academicians, HTS providers including Lay testers and HIV activists, researchers and beneficiaries of HIV Testing Services.

1.8 Process of Review of Policy on HIVST and development of implementation Guidance on HIVST

A task team was constituted to review the 2016 HIVST policy and develop the HIVST implementation guidelines through a highly consultative process. The task team conducted a series of technical working group meetings at which draft zero of the implementation guidelines was developed. A writing workshop was conducted, a team of experts reviewed the draft zero and developed the first draft of the implementation guidelines. At a later writing workshop the HIVST implementation guidelines were further refined. A stakeholder meeting comprising of selected District Health Officers, regional referral hospital directors, members of the civil society, members of parliament, health workers, AID development Partners and Ministry of Health/AIDS Control Program team was held to seek input and gain consensus on the implementation guidelines.

1.9 Implementation Considerations for HIVST

POLICY STATEMENT

HIV self-testing shall be offered as an additional approach to HIV testing services in Uganda.

In Uganda, an oral-fluid based HIV RDT for self-testing has been validated and successfully piloted in adult populations. These implementation considerations will be based on the oral-fluid based HIV RDT for self-testing and guided by the following principles. However, the same principles will apply when evidence on blood-based HIV rapid diagnostic kits become available unless otherwise stated.

1.9.1 Guiding Principles for Implementation of HIVST

The following five guiding principles should be followed while delivering HIVST services: Consent, Confidentiality, Counselling, Correct results and Connection.

i. Consent

Clients for HIVST should be well informed and should voluntarily do the test without any form of coercion. For HIVST, verbal consent is sufficient.

ii. Confidentiality

HIVST enables people to screen themselves for HIV in the privacy of their preferred space, hence there is no fear of breach of confidentiality. In instances of HIVST, confidentiality should be maintained. Shared confidentiality and partner disclosure is encouraged.

iii. Counseling

Clients should utilize information provided in the test kit inserts, HTS providers, test kits dispensing points, phone helpline, and computer based applications such as live online two-way text, brochures and flyers, audio or video counseling services and YouTube videos.

iv. Correct results

Adequate and clear instructions with graphic illustrations on how to conduct self-testing should be provided with the test kits to ensure a person can ably follow the correct procedure to obtain accurate results. Specific quality assurance measures should be in place to ensure correct test result.

v. Connection

All clients seeking HIVST should be referred and linked to HIV post-test services based on outcome of the test and other support services. Those with HIV negative HIVST result should supported and/or linked to relevant HIV prevention services. Individuals whose HIV self-test results are reactive should be advised on further HIV testing for diagnosis at the nearest health facility and if found to be HIV positive should be linked to HIV treatment services. Information on linkage including a helpline for any

additional support may be provided on the separate referral card. A catalogue or directory of health facilities/services can be displayed at every HIVST kit distribution point.

1.9.2 Target Population for HIVST

The following population groups will be prioritized for HIVST in Uganda:

- Young people 18 years to 24 years
- Emancipated minors (17 <18 years) i.e. married, have a child.
- Men including partners of Pregnant women
- Key Populations
- Priority Populations

1.9.3 Access to HIVST Rapid Test Kits

HIVST kits will be availed for public health programs as well as for general public consumption through different channels. For programmatic utilization, HIVST will be distributed through the existing supply chain channels. At community level, HIVST kits will be delivered through existing community structures. The general public will access kits through other service delivery channels such as private pharmacies and vending machines.

1.9.4 Approaches to HIVST

HIV self-testing will be provided through two main approaches:

- 1) Directly Assisted Self-Testing
- 2) Unassisted Self-Testing

1.9.4.1 Directly Assisted self-testing

Performing of the HIV Self-Test should be supervised/assisted by a trained provider including a health worker, distributor or peer. This involves an in-person demonstration before or during HIVST, with instructions on how to perform the self-test and how to interpret the self-test result. This is in addition to the manufacturer-supplied instructions for use and other materials found inside HIVST kits.

Process

- Explain the procedure of conducting HIVST & interpret HIV self-test result to the user.
- Demonstrate how to perform the self-test and how to interpret the self-test result.
- Provide additional information using, leaflets and/or instructional video.
- Answer any questions raised by the user
- Issue the HIVST kits
- Provide appointment card including information on linkage for HIV prevention services and further testing for diagnosis among those with a reactive self-test.
- Provide a toll free line, contact details for any other support information that the client may require.

1.9.4.2 Unassisted Self-Testing

Individuals self-test for HIV using guidance from the manufacturer-provided instructions. Additional support through telephone hotlines or instructional videos should be made available via leaflets, social media and other internet based links. There is no in-person demonstration from a trained provider or peer is provided.

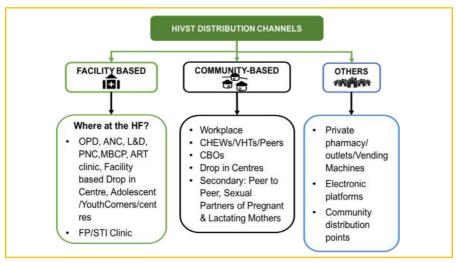
Process

- The individual uses guidance from the manufacturerprovided instructions to conduct HIVST and interprets results.
- Individual may seek or obtain additional information such as instructional videos through social media, toll free line or any other internet based platforms.
- Additional information on linkage for HIV prevention services and further testing for diagnosis among those with a reactive self-test should be provided on a separate referral and linkage card.

1.9.5 HIVST Distribution Channels/Delivery Models

HIVST will be implemented through different delivery models/ distribution channels targeting different populations in the public and private sectors. Figure 1 shows the distribution channels that will be used to implement HIVST in the country. Additional channels may be adopted/adapted based on evidence.

Figure 1: HIVST Distribution Channels



1.9.6 Facility Based Delivery Models

HIV Self- Test kits will be distributed at all entry points within the health facility where the target population can be identified. HIV self test kits will not be distributed at the In-patient departments.

Individuals within the target population seeking health services at the various entry points will be offered HIVST on an opt out basis i.e. opting out of HIVST for provider testing or opting out of provider testing for HIVST.

Individuals opting for HIVST within the health facility will conduct their own test at the HIVST point following an in-person and video demonstration on HIVST. HIVST points will include well lit private space or rooms as shown in the picture below. During the HIV Self testing process, a service provider shall remain within reach for the client to seek additional support. Clients opting to test away from the health facility should be provided with the HIV Self test kit and additional support information.

Facility based Drop in Centres or Specialized clinics for KPs & PPs (Truckers) will be used to provide HIVST.

An example of a cubicle for HIVST



A cubicle for HIVST at a health facility (Picture Courtesy of Zimbabwe MOH-)

1.9.7 Community Based Delivery Models

a) Peer-to-Peer Delivery Model

In this model, Peer Leaders of targeted population will be identified and trained on HIV self-testing and basic HIV counselling. The Peer leaders shall be given kits and data collection tools on a monthly basis. These peer leaders will be attached to a health facility or a Drop in Centre for supervision by a qualified health worker and will be required to report back to the facility on a monthly basis.

b) Work Place based Model

This is a model where HIVST is integrated within the workplace wellness and occupational initiatives. Health facilities shall map out workplaces within their respective catchment areas and extend HIVST Services. In this model, employees are provided with a variety of options for accessing HIVST kits, including through pharmacies, the Internet, mobile phone applications and dispensers in offices. Information on where and how employees can discretely access HIV prevention, treatment and care services is also provided.

c) Community based distributor (CBD) delivery Model

In this models, existing community Health Workers will be identified and trained on HIV self-testing and basic HIV counselling. They will be given HIV self-test kits and data collection tools and guided on their distribution and reporting mechanisms. Various demand creation mechanisms shall be put in place on HIVST.

1.9.8 Other Delivery Models

a) Pharmacy based delivery model

In this model, private pharmacies will be outlets to provide over the counter sales of HIV self-test kits that are recommended for use in the country. Individuals from the general population will buy the kits and unassisted HIVST done. Manufacturer instruction on how to use the kit are a pre-requisite for all kits being sold. The community members will be informed about the availability of the HIV self-test kits on sale at the private pharmacies. In addition, vending machines may also be used.

b) Internet based delivery model

This will involve use of internet and computer-based programmes/ applications to support self-testers. Information shall be disseminated on available electronic platforms for individuals to access services. The session/ programs offers step-by-step instructions on how to carry out this test, what to do following a reactive self-test result including descriptions of where and how to obtain a HIV self- testing kits, further testing, prevention, treatment and care. In case the person requires additional information, they can phone a toll free line. Hotline or send a given email. The ordering of the HIV self test kit shall be done online and delivered at a fee by authorized institutions/ organisations.

c) Secondary Distribution Channel

Secondary distribution of HIV self test kits may occur both at health facility or community level depending on where the HIVST kit is obtained from.

In this model, a client such as a sex worker or pregnant and lactating mother will take the HIV self-test kit to their partner/s along with instructional materials on how to conduct HIVST and interpretation of the self-test results such as leaflets and videos. Additional informational for linkage will also be provided.

For pregnant and lactating mothers, it's important that partners who receive HIV self-test kits are encouraged to share HIV test results whether reactive or not with the maternal & child health(MCH) providers where the kit was distributed from.

i. Distribution of HIV Self -Test Kits within MCH Settings

In an effort to promote partner testing, all partners of pregnant and lactating mothers that are absent will be sent the HIV self-test kit through their partner. This is called secondary distribution. In this distribution model, pregnant and lactating mothers will take the HIV self-test kit to their partner/s along with the HV self-testing instructional materials such as leaflets and videos providing guidance on how to conduct HIV Self-Testing and interpretation of the HIV self-test results. Its preferred that one HIV Self-Test kit will be distributed through an individual in this model. Therefore, pregnant and lactating mothers should have a health worker demonstration and where possible watch the HIVST demonstration video before receiving the HIV self-test kit for their partner.

For pregnant and lactating mothers, it's important that partners who receive HIV self-test kits are encouraged to share HIV test results whether reactive or not with the maternal & child health (MCH) providers where the kit was distributed from. Additional informational before and after distribution of the HIV self-test kits should be provided using the HTS job aid or consolidated quidelines for HIV Prevention, Care and treatment Desk Job aid.

1. 10 Commodities and Quality Assurance for HIVST

1.10.1 Performing HIV Self-Testing

HIV Self-Testing shall follow the "testing for triage strategy as recommended by WHO.

 All clients with reactive results will be supported to ensure referral and linkage to the health facility for additional testing following National HIV testing algorithm All clients with Negative results from HIVST should be advised to repeat the test as per the National recommendations for HIV re-testing.

1.10.2 Diagnostics for HIVST

All HIV self-testing should be performed in accordance with the assay manufacturer's instructions on the insert in the kit. In addition, procedures have been packaged with the kits to help Individuals minimize testing and reporting errors and improving the quality of the testing results. Guidance for additional testing and linkage to prevention services shall be provided to the client upon kit collection.

1.10.2.1 Performance characteristics of assays for HIV selftesting

In Uganda, the performance characteristics and conditions in table 1 shall be considered when selecting assays for HIVST in Uganda.

Table 1: Performance characteristics and conditions for selecting Assays for HIVST in Uganda

Criteria	Description
Prequalification	High-quality manufacturing standards, according to ISO 9001Should be WHO prequalified
Validation	Local and or International evaluation conducted
Time to result	Result with in not more than 20 minutes

Ease of use	 Should not require additional equipment to perform and interpret results Should not require technical training to perform the test Stable end-reading points
Affordability	Should be affordable for both public and private sector users
Packaging	 Single packing of complete set Pictorial instructions for use with any text-based instruction
Shelf Life	No less than 12months
Storage	Between 2-30 degrees

1.10.3 Specimens for HIV Self-Testing

These guidelines recommend two types of specimen.

- Oral transudate: This is the recommended specimen for use in HIV Self-Testing using oral-based HIVST kit.
- Whole blood: This will be used on blood based HIV self-test kits that shall be recommended by MOH upon successful evaluation.

1.10.4 Handling specimens for HIVST

Universal precautions should be observed during specimen handling. The kit package inserts should be followed to ensure that accurate test results are obtained.

1.10.5 The HIV Self-Testing Strategy

The HIVST strategy includes steps to follow during HIVST which includes performing the test, interpreting of results, next steps after interpreting results as shown Figure 2.

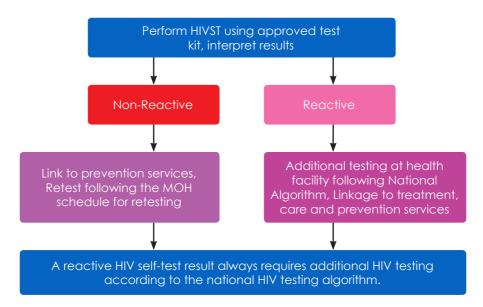


Figure 2: The HIV Self-Testing (HIVST) Strategy

1.10.6 Procedure for conducting HIVST and interpretation of results

Manufacturer's instructions for performing and interpreting an HIV self-test shall be followed. Additional information should be provided **through leaflets**, **jobs aids**, **and instructional videos**.

1.11 Quality Assurance and control for HIVST

Quality Assurance shall be an in-built component of the HTS cascade. All facility and community based HIVST should be provided as per the set standards. Internal Quality control and quality improvement activities should be integral components of quality assurance in HIVST.

Quality Assurance (QA) in the context of HIVST refers to adherence to the set standards; conducting quality control and Continuous quality improvement (CQI) to offer quality HIVST. Quality assurance should be achieved through training, mentorship, data quality assessment and implementation of process control mechanisms. Routinely collected HIVST data should be used to track performance, identify any gaps and use CQI approaches to improve performance.

1.11.1 Components of quality assurance for HIVST

Quality assurance for HIV self-testing will focus on quality assurance for the HIV self-testing process/procedure or service provision and the test product-HIV self-test kit.

1.11.1.1 Quality Assurance During HIV Self-Testing Process or Service Provision

The following must be considered and adhered to during the provision of HIVST services:

i) Capacity building and sensitization on HIVST

All HIVST service providers should be trained according to the HIVST training package for HIVST. Capacity building for HIVST will include trainings and mentorships using standard Ministry of health curriculum targeting all HIVST providers and including distributors. Training focus will include: how to conduct HIV self test, interpreting HIV self-test result, the tests and where to refer clients to for linkage for additional testing and further support, HIVST approaches, strategy & delivery models among others.

ii) Availability of testing aids, Instructions for Use (IFU) and Standard Operating Procedures (SOPs) at the outlet

Information on HIVST including but not limited to how to

conduct a HIV self-test and results interpretation should be readily available to all clients. All clients must also be aware of the need to confirm any reactive test results as per the national HIV testing algorithm.

iii) Infection, prevention and control

While the risk of HIV transmission through HIV self-tests has been demonstrated to be minimal, clients should be made aware of correct practices for disposal of the biohazard waste after performing the kits both at community and facility level to minimize biosafety risks. This information should consistently be provided prior to dispensing the kits as part of pretest information giving/education.

iv) Referral and linkages

Information on referral and linkage to HIV appropriate services should be made available to all clients. In the event of a reactive HIV self-test result, clients must be made aware of where testing for diagnosis can be conducted. A referral directory should be available for HIV additional testing and other services. HIV. Clients testing Negative of self-test should be advised on and linked to HIV prevention services of their choice.

1.11.1.2 Quality Assurance for HIV Self-Test Kits

i) WHO Prequalification

All self-test kits for national procurement and use MUST attain WHO pre-qualification

Registration by regulatory bodies

All HIVST test kits must be validated, certified and registered by relevant national regulatory authorities before being dispatched into the market

iii) Lot to lot validation

All procuring entities must ensure that any new lots of HIVST test kits coming into the country are evaluated to ensure that products delivered meet criteria for quality and performance. Only lots with satisfactory results should be distributed. Quality control should be performed on the test kits using the manufacture's controls

iv) Post-market surveillance

Post-market surveillance will be conducted periodically by the National drug authority in conjunction with MOH to assess the quality and performance of the test kits in use, in compliance with the set standards.

v) Adherence to standards and policies

HIVST shall be provided according to the provisions of this policy and guidelines. Therefore, HTS supervisors and managers should ensure that HIV self- testing providers adhere to the set standards.

1.12 HIVST Logistics and Supply Chain Management

Refer to 2016 National HTS Policy and implementation guidelines.

1.13 Social Behaviour Change Communication (SBCC) FOR HIVST

This section of the implementation guide introduces the role of SBCC in implementing HIV Self-Testing. It defines health communication activities, materials, tools and approaches that are needed to implement HIV Self-Testing in a simple and easy way.

1.13.1 SBCC in the Context of HIV Self-Testing

SBCC is the systematic application of interactive and evidence-based communication processes and strategies to equip and empower audiences with knowledge and skills to adopt and utilize HIV Self-Testing at the individual, community, and social levels.

1.13.2 Communication goal and Objectives for HIVST

The communication goal is to motivate audiences to accept and demand for HIV-Self Testing services.

The specific objectives of the communication include:

- 1. Increase HIV risk perception among audiences.
- 2. Address barriers and motivate audiences to demand and utilize HIVST services.
- 3. Provide a supportive environment for HIVST uptake at the family, community and facility levels.
- 4. Motivate HIV positive clients to start ART on the same day and HIV negative clients to adopt risk avoidance and reduction practices.

1.13. 3 Audience for HIVST

All SBCC interventions will be targeted to reach specific HIV Self-Testing audiences including; leaders, service providers and the community. SBCC will consider the specific characteristics of each audience such as gender, age, location, socio-economic status, education and culture. The specific audiences include;

- Men
- Key Populations
- Priority Populations
- Couples and Partners
- Partners of PLHIV

- Sero-discordant Couples
- Young women and men
- Health workers
- Inter Personal Communication Agents: VHTs, peers, linkage facilitators, para social workers, and expert clients
- Leaders: Cultural, Political, Religious and Opinion

1.13.4 Barriers to HIVST Uptake

- Low HIV risk perception
- Limited Knowledge and skills on HIVST
- Inadequate information on HIVST
- Misconceptions and Myths about HIVST
- Doubts about accuracy of HIVST results
- Failure to interpret results
- Fear of distress following positive results
- Use of partner results
- Fear of Violence from peers, partners and others.
- Negative attitude of the service providers
- Limited resources/ inconsistent supply of HIVST kits and program roll out.
- Poor health seeking behavior and low HTS uptake

1.13.4 Key Messages for Users and Implementers of HIVST

Any HIV RDT for self-testing which is procured or used for HIVST should be approved by the relevant regulatory authority, or the results of an international regulatory review may be used.

Appropriate and clear instructions for the use of HIVST kits are critical to minimize errors and maximize the performance of HIV RDTs used for self-testing. Printed instructions – written and/or

pictorial – are essential to support correct use and interpretation. In-person demonstrations of how to use an HIVST kit, along with additional population-specific information, can be very useful, particularly for rural settings or where literacy and formal education levels are low.

Other support tools, such as telephone-based or Internet-based messaging services, which provide information on HIVST and answer questions about how to perform a self-test and interpret a self-test result, may also be appropriate and potentially improve performance for some populations.

Pre-test information and post-test counselling messages should be readily accessible and available – for instance, through package inserts or brochures, hotlines, text message services, in-person demonstrations, counselling delivered by trained providers, volunteers or peers, Internet- or computer-based programmes, or videos posted on the Internet.

Clear messages are needed to ensure that users understand that a reactive test result must be confirmed through further HIV testing by a trained tester. Additionally, messaging on what to do after a reactive self-test result is crucial, including where to go to access stigma-free HTS, HIV prevention, treatment and care and other support services. Messages and information on tuberculosis, STIs and viral hepatitis are also beneficial, since individuals with HIV are at high risk of co-infection.

A non-reactive self-test result does not usually require further HIV testing. However, clear messages are needed to ensure that users understand that a non-reactive test result does not always indicate an HIV-negative status. The accuracy of results can depend on possible errors in performing the self-test or interpreting the results, as well as the limitations of testing in the window period before HIV infection is detectable. As with all HIV testing, individuals with known or possible HIV exposure in the 6 to 12 weeks prior to testing should be advised to retest or

seek facility-based testing at an appropriate interval based on the client's risk and the type of test used.

Appropriate and clear messages should be provided to ensure that users understand that HIV self-test results should not be used to sero-sort or to justify HIV risk behaviour such as condomless sex following a negative self-test result. Since a negative self-test result does not always indicate that a person is HIV-negative, users should be encouraged to utilize existing HIV prevention options, such as condoms and PrEP, regardless of their self-test result.

As with any HIV testing, there is a need for information and tailored messaging on disclosure in order to mitigate the risk of social harm and help couples and families to cope with a reactive self-test result or sero-discordant self-test results. Individuals or couples who report Intimate Partner Violence (IPV) in their current relationship should be counselled to disclose or undergo couples testing only if the safety of both partners can be assured. Linkages to further testing, prevention, treatment and care, as well as services for domestic abuse and gender-based violence, should be offered as part of HIVST services, either during the counselling in directly assisted approaches or in the package inserts/ instructions in unassisted approaches

Educating the Community including Networks of People Living with HIV, key and Priority d populations, trained testers and health workers – **about HIVST is critical** in order to increase the uptake of HIV Self-Testing and minimize the risks of misuse. It is also important to communicate to providers that HIVST can serve to create demand for existing services and, thereby, enhance their role in delivering HTS. Information tools such as brochures, job aids and standard operating procedures can also be useful in increasing understanding and raising awareness, especially when combined with training and information giving sessions.

Integrating HIVST into comprehensive sexual health services is critical in settings where there is a rising incidence of STIs. Highrisk clients who have a non-reactive HIV self-test result should be provided with information on further HIV testing and treatment, as well as on other STIs and viral hepatitis, and are encouraged to access comprehensive sexual health services.

1.14 Monitoring And Evaluation For HIVST Implementation

Monitoring and Evaluation (M&E) of HIV self-testing implementation in the continuum of the HIV/AIDS response is critical for tracking performance towards attainment of the 90-90-90 targets. In order to track programmatic outcomes, monitoring and evaluation of HTS indicators will have to be adapted to include HIVST.

This provides guidance on indicators and their respective data sources for use by HIVST implementers to track performance HIVST services in Uganda.

Existing HMIS data tools will be revised to accommodate HIVST services and where necessary new tools will be developed to capture critical data required for reporting.

1.14.1 Rationale for HIVST M&E

Monitoring and Evaluation of HIVST will enable managers and other stakeholders to understand implementation processes, track uptake of HIVST services, and monitor correctness in used HIVST by users. Data derived from M&E will inform decisions for policy changes and programming.

1.14.2 Monitoring HIVST implementation

1.14.2.1 Recording for HIVST

Understanding how to capture and report HIVST data is a key step in monitoring its implementation.

Standard HTS data tools will be revised appropriately to include HIVST variables. As such, the MOH has already proposed addition of HIVST variables into the HIV Counselling and Testing register and the Daily activity register to capture HIVST data variables. Further HIV testing among individuals with a reactive self-test will be done using a blood based national HIV testing algorithm and recorded in the standard HTS register. Additional data tools for HIVST may be developed as and when evidence based need is realized.

1.14.2.2 HIVST Reporting tools and systems

The source documents for reporting HIVST will be the HTS register, Daily activity register and other tools that may be developed based on need. Indicators for HIVST of interest to the country are shown in table 2.

Table 2: Indicators to Monitor

	Nothing of	Number of A	/ 00 m 0 0 m 10 0	love	Donating
	indicator	Denominator	Means of Verification	, ,	Frequency
1. Proportion of health Input facilities offering	Inpu†	No. of HFs reporting HIVST	DHIS2	National	Monthly
HIVST		Total No. of HFs approved to offer HTS services			
2. No. of HIVST kits	Input		Warehouse	National	Bimonthly
issued to the public sector			data (NMS/ MAUL/JMS)		
3. No. of HIVST kits	Input		Warehouse	National	Bimonthly
issued to the private			data		
sector			(NMS?MAUL/ JMS)		
4. Proportion of HIVST	Process	Total number	DHIS2 and	Facility Level	Monthly
kits distributed to		Of HIVST Kits	Warehouse	(Sub-	
the public sector		individuals through	ב ס	District/HCIV	
		the public sector		/HCIII/HCII)	
		No. of HIVST kits			
		issued to the			
		public sector			

<u>n</u>	Indicator	Nature of indicator	Numerator/ Denominator	Data Source/ Means of Verification	Level	Reporting Frequency
5.	Proportion of HIVST test kits distributed/ sold to individuals through the private sector	Process	Total number of HIVST kits distributed/sold to individuals through the private sector No. of HIVST kits issued to the private sector private sector	DHIS2 and Warehouse Data	Facility Level (Sub- National/ District/HCIV /HCIII/HCII)	Monthly
9	Proportion of individuals who performed HIVST and shared their result with a provider	Output	No. of individuals who returned and shared their results with a provider No. of kits distributed	Probably introduce an Facility Level integrated (Sub-HIVST Register National/that captures District/HCIV number of /HCIII/HCII) HIVST kits distributed	Facility Level (Sub- National/ District/HCIV /HCIII/HCII)	Monthly
7.	Proportion of individuals with reactive HIVST result who test positive with the national algorithm	Output	No. of individuals confirmed HIV positive using national algorithm No. of individual who reported at the facility and received confirmatory test	Facility Le Integrated (Sub- HIVST Register National/ District/HC	Facility Level (Sub- National/ District/HCIV /HCIII/HCII)	Monthly

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2.0 SECTION B: ASSISTED PARTNER NOTIFICATION SERVICES

2.1 Background

Uganda has made significant progress in the fight against HIV/AIDS over the last two decades, however the country is vet to achieve the UNAIDS 90-90-90 targets. Of the estimated total population of People living with HIV (PLHIV), 78% have been identified (UPHIA 2016). As we move towards achieving epidemic control Uganda, the Ministry of Health (MoH) requires that investment is made in the right things, right places and time for maximum impact. This calls for investment in areas with high burden and high prevalence while actively targeting the key and priority populations. The UNAIDS 90-90-90 targets will only be achieved through intensive efforts around active and targeted HIV counseling and testing services (HTS), using innovative approaches to identify and link HIV+ individuals into care and treatment. The identification of the remaining HIV + individuals will progressively become harder as we move towards epidemic control. This requires additional facility and community investments to effectively and efficiently identify PLHIV and their HIV-positive sexual contacts/partners and link them into care.

Partner identification and testing, in addition to couple testing and counseling, needs to be offered as standard of care and as a core component of prevention services for PLHIV. This is because testing of partners of index HIV-positive clients through contact tracing and partner notification programs is emerging a viable strategy for increasing yield of HTS. Partner notification is included as an approach within WHO's guidelines on HIV testing Services (36). In regions with high prevalence partner notification with linked HTS is cost-effective relative to other modalities such as door-to-door home-based HTS (37)

2.2 Rationale for Assisted Partner Notification Services (APN)

Assisted Partner Notification Services(APN) is a longstanding cornerstone of public health efforts to control the spread of sexually transmitted infections (STD) and HIV. An increasing body of research suggests that successful partner elicitation, notification and testing improves the success of HIV care. Many high-income nations have APN programs specifically designed to increase partner testing. However, until recently, APN has not been a component of HIV prevention programs in sub-Saharan Africa, including Uganda. In most African countries, patients diagnosed with HIV are advised to notify their partners, but clinics do not offer assistance nor systematically follow-up with patients to ensure that their partners are notified. Despite the limited availability of APN in Africa, mounting evidence suggests that it is both feasible and highly effective in this setting (38). A randomized controlled trial undertaken in Malawi found that assisted partner notification approximately doubled the number of sexual partners of persons with HIV who were tested, and that assisted APN are cost-effective (39). In Cameroon, APN have been provided to over 10,000 persons with HIV, demonstrating very high levels of case-finding and successful linkage to care, and demonstrating that APN programs can be brought to scale in a resource limited environment (40). In Kenya, assisted APN increased case-finding and could therefore be implemented at population level to enhance linkage to care and initiation of antiretroviral therapy to decrease HIV transmission. Preliminary results from the pilot program evaluation of APN in Tanzania similarly suggest that APN are feasible, acceptable, and effective and could be integrated into facility-based HIV Testing Services (41).

Despite the gains made in improving and scaling up HIV/AIDS services in Uganda, the program still has challenges. Only an

estimated 71% of all PLHIV have been identified, with high loss to follow up. Despite the implementation of Provided Initiated HIV Testing & Counseling (PITC), targeted HTS outreaches and the use of linkage facilitators for linkage into care and treatment. As control efforts and surveillance improves, detecting the last few cases and halting their HIV transmission potential becomes even more difficult using the traditional HCT outreach and home-tohome campaigns. To use funds efficiently and effectively, HTS should prioritize those approaches that most effectively and efficiently identify HIV-infected persons and sero-discordant couples. This calls for more focused and targeted testing to improve the yield and for dedicated human resources to follow up and link the patients to services. This can be addressed through the introduction of APN intervention. APN prevents HIV transmission and progression via partner notification and the provision of screening and referrals for treatment for identified partners. Effective APN will improve case finding among the population exposed to HIV and is expected to generate higher positivity rates than the traditional outreaches.

2.3 Development process for APN Guidelines

The development of this guide was participatory- involving national experts in HTS and various stakeholders. A task team was constituted to undertake the coordination and secretarial role of the process. The team comprised of representatives from the MoH, CDC, IPS, DHT, and facility-level staffs that were in the demonstration project for APN in Uganda. A series of meetings and a workshop were held by the task team. During these events, drafts of the guide were developed in small-groups and reviewed through plenary presentations. Issues not agreed on in the small-group discussions were resolved during the plenary sessions by consensus.

2.4 Overview Of Assisted Partner Notification Services (APN)

- The purpose of this section is to provide an overview of APN.
 This section will define:
- APN, APN Goals and Objectives
- APN Components, Benefits, and Target Populations
- APN Principles, Program and Operations Requirements and Challenges

2.4.1 What is Assisted Partner Notification Services?

Assisted Partner Notification Services (APN) are part of a comprehensive array of services offered to persons infected with HIV or STDs and their partners. The critical function of APN is partner notification, a process through which HIV-positive index clients (i.e., infected persons who are candidates for APN) are interviewed to elicit information about their sexual partners, who can then be confidentially notified of their possible exposure or potential risk, and offered HIV testing services. Index clients should be encouraged to notify past partners, in addition to current partners, and engage them in testing services. APN are always voluntary, confidential, client-centered, and free, for both the index client and his/her partner(s).

2.4.2 Assisted Partner Notification Services **Goals**:

The overall goal of APN is to prevent HIV disease transmission and progression via partner notification and the provision of screening and referrals for treatment for identified partners. In particular, APN:

- Provide all infected persons with support to ensure that their partners are confidentially informed of their possible exposure to HIV, and
- Efficiently link infected persons and their partners to medical care, treatment, prevention interventions or other appropriate social support services in order to improve their health outcomes and reduce the risk for transmission to others.

2.4.3 Assisted Partner Notification Services **Objectives**:

Provision of APN has both short and long term objectives.

The **short-term** objectives are to:

- Elicit and notify persons exposed to HIV by explaining the importance of notifying partners and encourage disclosure of risk to partners
- Help elicited partners identify and reduce risks that contribute to HIV transmission or re-infection
- Link partners to testing, medical care and treatment
- Engage healthcare providers, community health centers, CBOs and other public health partners to participate in collaborative APN.

The **long-term** objectives are to:

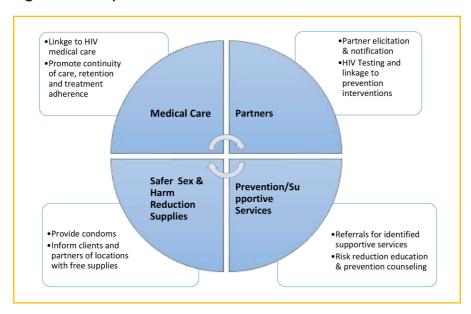
- Decrease the rate of HIV transmission to reduce disease incidence
- Decrease risky sexual behaviors
- Increase the proportion of HIV infected individuals who are aware of their status

 Increase the proportion of partners of those infected with HIV who are notified, tested, linked to prevention, and care and treatment

2.4.4 Components of Assisted Partner Notification Services

APN includes counseling and testing for HIV, partner elicitation & notification, linkage to medical care, provision of prevention counseling, and linkage to other care and prevention services e.g., reproductive health services, antenatal care, social support, etc.

Figure 1: Components of Assisted Partner Notification Services



2.4.5 Benefits of APN

In general, APN programs have several public health benefits such as decreased HIV transmission, reduced HIV incidence, increased access to care and treatment, and increased early identification and treatment of previously undiagnosed HIV infection, including HIV and TB co-infections. In addition, APN programs have several benefits to the index clients, their partners, and the community at large summarized in Table 1 below:

Table 1: Summary of the benefits of APN

Benefits to the index client	Maximize access to APN by providing all infected persons with support to ensure that the partners are confidentially informed of exposure
	Maximize effective linkage to medical care, treatment, prevention interventions, and other services to reduce the risk for transmission to others
Partner of Index client	Maximize the proportion of partners who are notified of their exposure to HIV/STDs
	Maximize early linkage of partners to testing, medical care, prevention interventions, and other services
Community	Reduce future rates of transmission by aiding in early diagnosis and treatment (or linkage to treatment, for those with HIV infection) and provision of prevention services to infected persons

2.4.6 Target Populations for APN

The target populations for APN are those with high likelihood to transmit HIV to their partner. These are outlined below:

- All persons with newly diagnosed HIV infection
- Previously known HIV positive persons with a risk identified (e.g., new sexual partner and/of drug sharing contact, recent diagnosis of an STD, etc.)
- Pre-ART
- On ART but non-suppressed

2.4.7 Principles of APN

The principles of APN are outlined in the table XX below. In general, APN are; voluntary, confidential, patient-centered, comprehensive and integrated and available to all individuals who test HIV positive.

Table 2: Over view of the principles of APN

APN is never coercive or mandatory and always relies on the willing participation of HIV-infected persons and their partners. Providers should encourage patient participation in APN by fostering rapport and an atmosphere of trust and mutual respect. All service recipients should be informed of the benefits and risks that may result from participating in APN. Appendix A.

Confidential All information (both print and electronic) regarding index clients and their partners should be kept strictly confidential and not accessible or disclosed to anyone other than those who are authorized to have access (APN providers and their supervisors). Strict adherence to confidentiality should be followed during attempts to contact the patient, initial interview, notification of partners and subsequent contacts and re-interviews. During attempts to locate and schedule an interview with a patient, the APN provider should not disclose to anyone other than the patient the reason for locating the patient. The HIV status or any other potential HIVidentifying information is discussed with only the patient and authorized public health staff. Patient-All communication with patients centered should be centered on the needs of the patient rather than the needs or priorities of the APN staff. All steAPN of the APN process should be tailored to the behaviors, circumstances, and

Comprehensive and Integrative

 APN staff should be are a part and parcel of health services that are integrated to the greatest extent possible for persons with HIV infection or other STDs and their partners.

specific needs of each patient.

Available to all Patients who Test HIV Positive

APN staff should be available for persons who test HIV positive. All individuals who test positive should be informed of the option of obtaining APN without disclosing their identity or having their HIV test result disclosed. If the patient decides to participate in APN, the HIV counseling and testing provider trained on APN can provide APN at a place and time convenient to the patient. Partners of a person with HIV are notified of their HIV risk and are informed of anonymous and confidential testing options.

2.4.8 Program and Operations Requirements of APN

To ensure quality APN that meet the required standards, Districts and Health Facilities providing APN should ensure the availability of the following core program and operations requirements:

Table 3: Program and Operations Requirements for APN

Policy and Procedures

- Abide by and adhere to Uganda HIV/ AIDS Strategic Plan, Policy Manuals, Procedures and Practice Standards for HIV Testing Services
- Develop a plan to ensure all cases are linked to appropriate care and treatment services by coordinating with District HIV service providers, and
- Comply with national, district and APN data collection and reporting requirements.

Staffing and Training

- Minimum of one APN focal person should be assigned at the district level to work with the DHT team to coordinate APN activities and ensure adequate planning for APN at the district
- Minimum of three staff should be assigned at facility level (2 HTS/APN focal persons and 1 clinic in-charge/ APN Supervisor) to offer, coordinate and supervise APN services in the health facility)
- All District and Health facility staff engaged in providing, supervising and coordinating APN should be trained in APN
 - Complete basic national HIV prevention and HIV Testing Services courses
 - Attend and successfully complete training offered by the MOH
 - Shadow an experienced APN staff to observe interviews and field work
 - Conduct field visit being observed by an experienced APN trainer / supervisor
 - Attend ongoing orientation and refresher trainings
 - Demonstrate knowledge and understanding of data collection tools.

Regular Review Meeting and Supportive Supervision	Conduct and actively participate in APN related regular review and supportive supervision meetings (weekly at a facility level; monthly at the district level and quarterly at the national level) and trainings supported by MOH and Partners
Resources	Transportation, mobile phones, telephone airtime, computer, standardized reporting tools and supplies

2.4.8 Challenges of APN

APN can be challenging for the APN staff who must discuss difficult topics that may be deeply personal. The APN staff needs to protect a patient's confidentiality, while following appropriate national guidelines and protocols. Challenges for APN include: Patients acceptability of the services, the potential for patient abuse or harm resulting from partner notification, and the potential negative effects on relationships between patients and their partners.

In order to mitigate such challenges, APN providers should:

- Be trained to maximize acceptability of APN among patients and to minimize the negative effects resulting from notifying partners of their risk.
- Be trained regarding risks associated with home/field visits and how to assess the safety of each situation.
- Follow appropriate safety policies and guidelines regarding field or home visits and should emphasize safety as a priority
- Keep supervisors and/or colleagues aware of their field visit appointments and locations.
- Be trained in counseling and communication skills

3.0 ASSISTED PARTNER NOTIFICATION SERVICES IMPLEMENTATION PROCESS

POLICY STATEMENT

Assisted Partner Notification Services shall be offered as an additional approach to HIV testing services in Uganda

The purpose of this section is to:

- Use health facility (HF) data to identify, engage, and/or reengage HIV positive individuals in care in order to improve health outcomes and reduce the risk of HIV transmission.
- Delineate how HFs will identify all newly HIV diagnosed and previously diagnosed HIV positive persons with a risk identified reported to/within HFs
- Utilize APN focal persons to interview, notify and test named partners and link to medical services.

Newly diagnosed and previously known HIV positive persons with a risk identified (e.g., new sexual partner and/of drug sharing contact, recent diagnosis of an STD, etc.) will be interviewed and offered comprehensive APN, inclusive of: linkage to medical care, referrals for identified supportive services, risk reduction counseling, and safer sex supplies. The HTS/APN focal person will interview index clients to elicit partners for the purpose of partner notification, offer all named and traceable partners immediate access to rapid HIV testing or make an active referral for HIV testing services, and if applicable, link them to medical care. In this document, newly diagnosed and peviously known HIV positive persons with a risk identified are referred to as **index clients**. Refer to Appendix B for a flow-chart of Partner Notification Services. The detailed steps involved in the delivery of APN are explained below:

3.1 Step 1: Index client Identification

Any patient tested for HIV by the HF who had a new diagnosis of HIV identified through routine and/or targeted HIV testing and/or previously known HIV positive person currently in care at the HF with an identified risk will be eligible for APN. Following a positive HIV test and/or the newly identified risk, the index client (IP) will be immediately linked to the HTS/APN focal person at the Health Facility to begin working with the index client. Health Facility staff will utilize the Client linkage form (Triplicate referral) to link index clients to the HTS/APN focal person.

3.2 Step 2: Index Client Interview and Elicitation

After identification of the Index client, the HTS/APN focal person will facilitate a risk reduction counseling session; identify and assess the patient's concerns and barriers to care and the patient's willingness to formulate a linkage to care (LTC) plan; provide condoms and safer sex supplies as necessary; and interview patient to elicit potentially HIV-exposed sexual partner (Appendix C). Partner elicitation is a critical function of APN and patients must be assured that confidentiality is at the forefront of all patient and partner intearctions with the HTS/APN focall staff and other HF staff. The APN focal person will enter the information obtained during the patient interview into the APN Register. The register collect data on index client demographics, reason for HIV testing, and contact information. It also collects identifying and locating information about potentially HIV-exposed sexual partners over the preceding 12 months (see Appendix D).

3.3 Step 3: Partner Notification

Following the initial Index client interview and partner elicitation process, the HTS/APN focal person and Index client will develop a partner notification plan. In the absence of any history or concern for domestic violence (42), the APN focal person will work with index client to define how the patient and/or APN focal person will notify the partner and ensure their partners' linkage to HIV testing. If there is any concern for domestic violence or if the index client requests the APN focal person to notify their partner, the APN focal person will make clear that they will **NOI** ever tell partners the index client's name or how they learned that the partner may have been exposed to HIV.

3.3.1 Index client Notification

Following the initial Index client interview, the APN focal person will arrange to re-interview index client 2 weeks after their initial interview. This follow-up will be done in-person when the patient returns for a clinic visit, or via telephone if in-person follow-up cannot be arranged in a timely manner. Prior to APN focal person discussing any issues related to HIV by telephone, APN focal person will confirm that he/she is speaking to the patient and that the index client is in a place where he/she can speak privately. The APN focal person will interview/ask if the index client has notified each partner identified in the notification plan, if the partner tested for HIV, and the results of that test are known to the index client, the APN focal person will request the testing location of the partner(s) to follow up with the testing HF. If the index client is unable to notify/choose not to notify their partner(s) the APN focal person will inform the index client that they will notify partner(s) of potential HIV exposure.

Always Remember:

- o Behavior change is a process that occurs in steps over time.
- o Patients are in different stages of readiness to change at any given time.
- o Movement is spiral, not linear.
- o There are NO standard messages.
- o Each patient has unique circumstances.
- Counseling strategy used needs to MATCH the patient's readiness for change.
- o Relapse can occur at any time and is a normal part of the process of change.
- A patient can be in different stages for different target behaviors.
- o Patients need different approaches that match their stage of change.
- Approaches that move ahead of the patient's readiness result in increased patient resistance and are not helpful for the patient.

3.3.2 Assisted/Provider Notification

Following Index client interview, the APN focal person will attempt to contact partners. The APN focal person will initially attempt to contact partners via telephone. When talking to partners, the APN focal person will first confirm the identity of the person to whom he/she is speaking. The APN focal person will inform the partner that he or she is calling from the Health Facility about an important health issue and ask if the partner is in a place where they can speak privately. If they are, the APN focal person will inform the partner that they may have been exposed to

HIV infection, advise them that they need to be tested for HIV, and offer to help arrange them for an HIV test at the convenient most Health Facility for the partner (Appendix E). The APN focal person will **NOT** tell partners who gave them their name or answer any questions about when the partner may have

- Extreme care should be taken to ensure that partners do not feel coerced to meet with the DIS or visit the health care facility. They should be assured that meeting with the DIS is voluntary and that deciding not to meet or get tested will not impact any aspect of their life.
- Field visits or outreach are critical component of the APN Initiative.
 Partners' responses may be unpredictable, and the DIS should always be aware of their surroundings.
 Situations in which personal safety is a concern should be discussed with a supervisor.

been exposed or how. If APN focal person is unable to reach partners by telephone, he or she will make up-to three attempts to find them at their homes or at work. APN focal person may choose to leave a letter (Appendix G) at the partner's residence indicating a number to call the APN focal person to discuss their potential exposure. As with telephone calls, one-on-one contact with potentially exposed partners in the field will follow strict procedures to ensure confidentiality. The APN focal person should emphasize the critical importance of avoiding any breaches of confidentiality and will model ways to redirect partners to the importance of being tested, rather than answering questions about who may have exposed them to HIV.

3.4 Step 4: Partner Counselled and Referred to or Linked to Care Services:

If the partner is receptive to APN, the APN focal person will develop a plan that ensures an appointment for HIV testing and any additional services as identified. Based on the outcome of the HIV test, the APN focal person will interview the partner(s) to elicit potentially HIV-exposed sexual partners and the newly identified HIV positive partner becomes a case finding and an index client. Therefore, starting the APN cycle again. It is important to note that the partners may decline testing and other services at any time.

3.5 Step 5: Case Closure

To effectively monitor and assess the success of APN, the APN focal person should submit the proper documentation to the Health Facility in-Charge or Supervisor for entry and closeout of case outcomes in a timely manner. Documentation and data entry is critical to the APN process. Depending on case outcomes, additional data entry may be requested in other field record subsections based on the information gathered during the interview process. A case should be closed when one of the following conditions are met:

- Index Client located, interviewed, and at least one partner elicited and interviewed
- Index Client located, interviewed, and partners located, but refused to meet and be interviewed
- Index Client located and refused APN
- Index Client determined to live in another district or country
- All attempts to identify or locate partners have been unsuccessful

Other specified reason should be noted

All closures will be documented in the APN register. The HTS/APN focal person should review all cases. The Health Facility In-Charge and HTS/APN focal person should meet weekly, or at minimum bi-weekly, to discuss case status, workflow, and any potential complications/challenges.

HF in-Charge, HTS/APN focal person and the District HTS focal person should meet monthly to jointly review/discuss case closures and any other investigation related issues. To ensure that requests for data clarification can be sufficiently addressed, it is expected that all data is retained within a confidential space for at least one year following case closure.

All data, related documentation containing identifying information, and the APN tracking documents should be stored in secured place to maintain the confidentiality of index client and partner information.

4.0 APN COORDINATION STRUCTURE & ROLES AND RESPONSIBILITIES

The purpose of this section is to outline: The general structure and define the roles and responsibilities of different stakeholders who will be involved in the planning, coordination, supervision and provision of APN at all levels.

The Uganda national health care delivery system constitutes all institutions, structures and actors whose actions have the primary purpose of achieving and sustaining good health. The Ministry of Health (MoH) provides leadership for the health sector and takes a leading role and responsibility in the delivery of curative, preventive, promotive, palliative and rehabilitative services to the people of Uganda. The provision of health services in Uganda has been decentralized with districts and health subdistricts playing a key role in the delivery and management of health services at district and health sub-district levels. The incorporation of APN into existing institutions and structures was seen as an effective strategy to make use of existing resources while simultaneously addressing the HIV/AIDS epidemic

The implementation of APN requires the active involvement of different stakeholders at different levels of health system including the Ministry of Health, districts, development partners, and implementing partners. The MoH should ensure the functionality and coordination of these structures for the effective and sustainable implementation of APN. Creating buy-in for the programme is the most critical step in programme planning and implementation. Strong buy-in helps to ensure commitment and ownership from key stakeholders and team members. Ownership of the program by the MoH and Districts as well as support from the implementing partners (IPS) will guarantee that resources are allocated to the APN implementation.

through structured and regular communication. Regular scheduling of consultative discussion Stakeholders and team member involvement during implementation is best sustained constantly involved in the management of the programme. The key structures and roles and responsibilities of the different stakeholders who will be involved in the implementation sessions, providing regular updates, feedback and reports ensures that stakeholders are and coordination of APN program is are described below.

Table 4: Roles and Responsibilities for APN

Levels –National Key Roles and Responsibilities

The Ministry of Health

- Advocate for and support district level APN implementation
- The MoH through National AIDS control program will coordinate implementation of APN.
- Develop policy and technical guidance for scaling up the implementation
- Support monitoring and support supervision of APN under the decentralized nealth service delivery system
 - Developing a monitoring and evaluation framework integrated within the existing national Health management systems
- Support the development of costed district integrated annual health sector HIV/AIDS response workplans
- Mobilize additional resources to roll out the APN implementation including advocacy for the inclusion of other cadres like the HTS counsellors into the ministry of Public Service local government staffing norms.

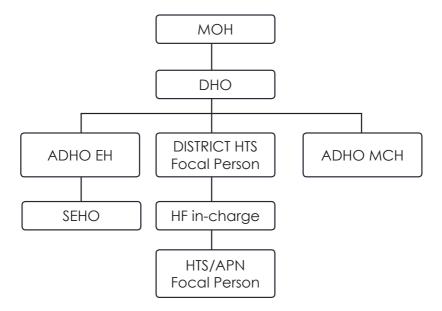
Levels –National	Ж	Levels –National Key Roles and Responsibilities
Development partners/	•	Work with MoH and implementing partners to provide resources for APN implementation
PEPFAR-CDC	•	Support Implementing Partners to realign program resources in support of the APN implementation.
	•	Provide technical support to MoH in the development of policies, implementation guidelines and strategic information systems for the APN program
	•	Support the development of costed district integrated annual health sector HIV/AIDS response workplans
Above-site implementing	•	Support national and district level program planning assessment to determine the feasibility of APN Implementation
partners (METS)	•	Support development of standard operating procedures, guidelines, and data management protocols to support the implementation of APN at all levels
	•	Support development of APN Training Manual and train staff at all levels on the implementation of APN.
	•	Support the administration, oversight, monitoring & evaluation of APN at all levels.
	•	Support documentation and dissemination of lessons learned.

Levels –National		Key Roles and Responsibilities
District-DHO	•	Provide oversight and supervisory leadership to the DHT and plan for the
		successful implementation of the APN pilot.
	•	Ensure APN is integrated within the district and health facility systems
	•	Conduct periodic review of facility APN workforce/workload alignment to ensure that APN staffing needs remain sufficient.
	•	Work with local leadership, CBOs, IPS to harness networks of community-
		level agents/duxilianes (i.e. vH1s, peer morners, linkage racilitators, etc.) to support APN
	•	Ensure adequate planning for resources to support district and facility-level HIV control activities including the APN programmatic activities
District HTS	•	Conduct data quality assessments and review APN facility reports to ensure
focal person or		that all HIV positive individuals are identified followed up and their partners
designee		traced.
	•	Work with the DHT to comprehensively conduct disease surveillance
		activities and monitor disease trends.
	•	Train HTS facility teams
	•	Track facility-level investigation progress and provide ongoing supportive supervision and guidance to HTS facility teams.
	•	Monitor coordination of clinic and field activities and increase HTS
		coverage.
	•	Monitor facility level HIV testing services (HTS) and community HTS outreach
		activities.
	•	Closely work with the District Health Team (District biostatistician, HMIS
		focal person and District HIV/AIDS focal person) to generate timely data/ information for makina informed decisions.

Levels –National	Key	Levels –National Key Roles and Responsibilities
Facility in- charge	•	Monitor and coordinate daily staff assignments, plan community activities for APN.
	•	Support HTS teams to locate, notify, and refer identified at-risk community members for appropriate medical evaluation, recommended treatment services and oversees workload distribution across the staff.
	•	Ensures timeliness and accuracy of HF APN data entry and conduct data review regularly with HTS staff to address any data consistency issues.
HTS teams	•	At health facility level, it is preferred that APN services are provided by technical /professional health workers. However, trained Lay Testers may
		support APN services with supervision from the technical/professional health workers.
	•	At the facility level the HTS team led by the HTS focal person will provide the following services:
		o Identify the HIV index cases/ STD clients,
		o Provide additional risk reduction counseling and engage the index client to elicit partner information,
		o Engage and agree with index case on partner notification strategy. Either for the self-referral (client notifies partner) or HTS assisted
		frame; DIS notifies partner if client fails to notify his/her partner) or HTS
		provider notification,

Levels –National	<u>×</u>	Levels –National Key Roles and Responsibilities
		o Document partner notification strategy to assist with monitoring and follow-through.
		o Ensure, document, and track referrals for treatment and other services.
		o Locate exposed partners using information provided by index case using the outlined policies and procedures.
		o Counsel partner(s) discussing possible exposure to disease while maintaining confidentiality of the index case.
		o Notify, counsel, and link persons identified or at risk of sexually transmitted disease (STD), including HIV to treatment and preventive
		services.
	•	Document and report to the health facility in-charge.
Implementing	•	Support implementation of APN in the district by:
Partners		o Providing logistical support including: air time, cellphones, transport, allowances,
		o Support coordination and APN trainings.
		o Support performance review meetings for APN and APN implementation.
	•	Work with above-site IPS to support TA for data management and reporting.
Community	•	Support health facility HTS teams to locate partners

Figure 2: APN Coordination Structure



5.0 MONITORING AND EVALUATION FOR APN

The purpose of this section is to provide guidance on monitoring and reporting of the APN Program. This section includes:

- Overview of Monitoring and evaluation of APN
- APN Logic Model
- Data Collection and Reporting Protocol
- Reporting, Procedures, Responsibilities and Timeline

To realize the maximum benefits from APN, there is a need for close monitoring and reporting of this public health strategy. The ultimate goal of APN is to increase the proportion of partners of those infected with HIV who are notified of their exposure, tested for HIV infection and linked to medical care and treatment as necessary. To determine if this public health strategy is yielding the expected outcomes, below are the short term objectives and the long term goals to keep at the forefront of all discussions during the planning, implementation, and evaluation stages of APN.

To effectively monitor and assess the success of APN, proper documentation and timely entry of case outcomes is critical. APN monitoring and reporting activities involve the collection of data that help answer important programmatic questions such as the following:

- How successful is the APN strategy at identifying and interviewing index clients?
- How successful is the APN strategy at notifying partners of their exposure to HIV?
- How successful is the APN strategy at testing and/or linking partners for HIV testing?
- How successful is the APN strategy at linking positive partners to medical care services?

5.1 Process, Quality and Outcome Monitoring

APN monitoring and evaluation activities will focus on process, quality and outcome monitoring and evaluation activities. To get proper answers to the above programmatic questions, the following process, quality and outcome indicators in Appendix H will be monitored.

National level indicators:

- Total Number of partners tested & received results through APN
- Number of partners tested Positive through APN

5.2 Data Collection and Reporting Protocol

5.3 Reporting Flow

Data on selected indicators for APN will flow from the health facility level to district and then to the national level, and back to the lowest level for feedback and utilization. All stakeholders involved in the processes of APN implementation and coordination should be involved in reporting, monitoring and evaluation to ensure that standardized data collection and reporting occurs at different levels of the program implementation.

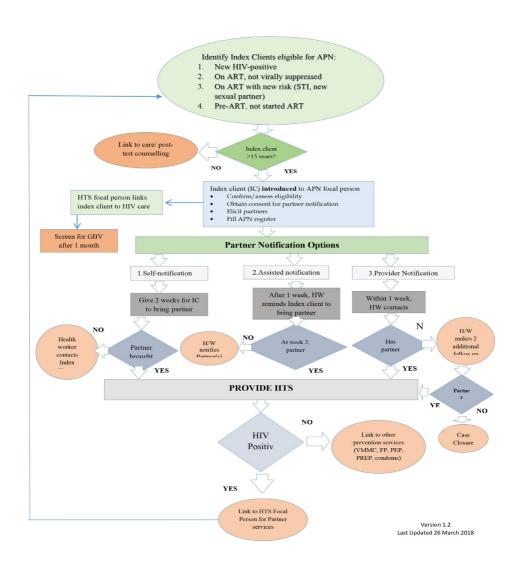
- APN reporting monitoring and evaluation process should take place at different levels and all efforts should be made to align reporting requirements, reporting frequencies and data flow with the existing data flow structure of the District.
- Supervisors and mentors at different levels of the APN strategy implementation should supervise the completion, collation, and submission of reports.

6.0 APPENDICES

APPENDIX A: CONSENT FORM FOR APN

Dear Sir/Madam my name is a health worker at health facility. I would like to invite you to
participate in a program for identified HIV-positive persons. We
will ask you for information about you and your sexual partners. Knowing yours and your partners' HIV status is important for you
and your partners' health. If you agree we will contact your
sexual partners for HIV testing. All the information shared with
us will be kept confidential and we will not reveal your identity
to any of your named sexual partners. Please ask any questions
you have about the program and I will do my best to answer
them.
Please sign below to indicate your consent to participate in this program.
Clients:
Name
Signature or thumb print
Health worker's:
Name
Signature or thumb print

APPENDIX B: FLOW CHART FOR APN SERVICES



APPENDIX C: Talking Points for Introducing Assisted Partner Notification Services to Index Clients

- 1. Explain the importance of ensuring that all partners get tested for HIV.
 - <u>HIV-positive partners</u> can start on HIV treatment to keep them healthy and reduce risk that they will pass HIV to other sexual partners and/or children.
 - <u>HIV-negative partners</u> can access HIV prevention services to help them remain HIV-negative, including condoms, pre-exposure prophylaxis (PrEP), and male circumcision.
- 2. Inform the index client that:
 - The clinic is offering Partner Notification Services to assist the client to contact their partners so that these partners can learn their HIV status.
 - The service is offered because we know disclosure of HIV status to partners can be difficult.
 - You will ask the client to list the names of all persons they
 have had sex with, including people they may have only
 had sex with one time. If there are also persons the client
 has shared needles with, you will also ask for their names.
 - You will also ask for the names any child(ren) who may need an HIV test.
- Inform the client that there are 3 options for contacting their partners using "Options for Notifying Your Partner about HIV" Job Aid:
 - Client can contact them to let them know they should be tested for HIV;

- Client can contact them within a certain time period, after which the provider will offer assistance if the partner hasn't been tested;
- The healthcare providers can contact the partners directly, without telling them the client's name (this will be done anonymously).
- 4. If the client chooses option (2), they will have 4 weeks to bring in or refer their partner for HTS.
 - If the partner does not come in for HTS after 4 weeks, then
 the provider will contact the index client for permission
 to contact the partner.
- 5. Inform the index client that all information will be kept confidential. This means that:
 - Partners will NOT be told the index client's name or test results.
 - The 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.
- 6. You will NOT contact the partner without first contacting them to get their permission.
- 7. They will continue to receive the same level of care at this health facility regardless of whether they choose to participate in partner notification services.
- 8. Answer any questions that the index client might have and obtain verbal consent to continue.
- 9. Use the **APN Register** to record contact information for the index client.

APPENDIX D: APN REGISTER

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APPENDIX E: PHONE CALL SCRIPT FOR ASSISTED PARTNER NOTIFICATION SERVICES

Good day. My name is (health worker at [Facility Name]	and I am a
Am I speaking with <u>partner's name</u> ?	
[IF NO]: Ispartner's name available?	!
[If partner is not available]: Thanks. I'll try back later.	
[If YES]: To confirm I am talking with the right person please tell me your age? [Confirm age provided is within range of age reported by index client]	•
[If age is not same]: I'd like to plan a time to meet you When is a convenient time you can come to the facility.	•
[If identify confirmed]: I have some important information. Are you in a private location/place? Is now a stotalk?	
[If NO]: When would it be a better time for me to cal	l Aons
[If YES]: I am a health worker and everything we ta private. I am calling because someone who cares a gave me your telephone contact so that I give you related information. Your life might have been exposit is therefore important that you get tested for HIV is so that you can learn your HIV status. HIV treatment charge and can prevent serious illness.	about you this health sed to HIV. ight away
We would prefer that you come to thefor discuss. HIV Testing Services are available Monday – Fig. 30 in the morning until 5:00 in the evening. Alternation and a health worker to your home for an HIV to option would you prefer?	riday from atively, we

When you come to	health facility, ask for
(say your names), I will	be available.
Please feel free to reach me on (sa contact) or my colleague (sa contact) at health facility ir	y names and telephone
[FACILITY TEST]: What day would you liktest?	ce to come in for an HIV
[HOME TEST]: What date and time we health worker to come to your home for	, ,
Thank the client for his or her time with y	you.

APPENDIX F: FIELD VISIT SCRIPT FOR APN

SAMPLE FIELD VISIT SCRIPT FOR APN

Field Visit at home or work

Good	day.	My	name	is		from
[Facilit	<u>y Name</u>	<u>;]</u>			_•	

I am looking for [partner's name]. Is he/she around?

[IF NOT]: Ok, thanks. Do you know when he/she will be back?

[Once the partner is in front of you]: Is there a private place that we can talk?

[Once you are in private area where others cannot overhear]: To confirm I am talking with the right person, can you tell me your age? [Confirm age provided is same or within range of age reported by index client]

[Once identity is confirmed]: My job to talk with people who have been exposed to HIV and other infections. Everything we talk about is private. I am here because someone who is concerned with your life informed me that you may have been exposed to HIV. It is important that you get tested for HIV right away so you can learn your status. HIV Treatment is free of charge and can prevent serious illness.

- **[For community HIV testing, preferred, if available]:** I can test you for HIV right now. Shall we get started?
- **[For escorted HIV testing, preferred]:** We can go together right now to [Name of health facility] for HIV testing. Shall we go?
- [For referral for HIV testing, last alternative]: I can refer you
 to [Name of health facility] for an HIV test as soon as you
 can go. When can you make time to come to the clinic?

Its important you get tested as soon as possible. HIV testing services are available Monday – Friday from 8:30 in the morning until 5:00 in the evening.

Additional message of confidentiality assurance

- Reassure the partner that you will not disclose their results to anyone and that you will not tell them who provided their contacts.
- In case the partner also tests positive, we shall request he/ she provide sexual contacts and help the partner start HIV treatment right away

Before leaving for a home or work visit:

- Review the record and memorize partner's information and precise objectives of the visit
- Store confidential information in a secure place
- Become familiar with the environment and anticipate obstacles

Locate the partner, confirm identity, seek private setting, then notify

Use Sample Field Visit Script below:

APPENDIX G: EXAMPLE OF PATIENT LETTER

Insert Date

Dear [Insert Patient Name],

I have been trying to contact you to provide some health information that is important for you to have. The nature of the information I have for you requires that it be delivered directly to you, rather than sent in a letter. At this point it is urgent that we speak as soon as possible.

When we connect, I would like to talk about any health needs you may have that are not being met. One of my roles as a Public Health Representative is to link people to the care they need.

Again, it is very important that I speak with you as soon as possible. Please call my office Monday through Friday, 8:30AM to 3:30PM at X.XXX.XXXX.XXXX [insert you may text me at that number if applicable]. If I am not here when you call, please tell the representative that answers the phone that you are responding to a letter from me and someone else will help you. If you call before 8:30AM, or after 3:30 PM please leave a message with the best method (e.g., phone call, text, face-to-face visit, etc.) and time to contact you back.

I look forward to speaking with you soon.

Best Regards,

Insert Worker Name

Health Facility Name

APPENDIX H: PERFORMANCE INDICATORS FOR APN

	Indicators					
1	Number of	eligible HIV positive individuals identified				
2	Number of	index clients interviewed				
3	Number of	partners elicited				
4	Number of	partners notified				
5	Number of	partners tested				
	HIV Status	Negative				
		Positive				
6	Number of HIV positive partners linked to HIV care/ART					
7	Number of	Partners already in HIV care				
8	Number of	index clients experienced GBV				

7.0 SECTION C: ADDITIONAL GUIDANCE ON HIV TESTING SERVICES

7.1 HIV TESTING SERVICES MODELS & APPROACHES

To improve access and efficiency of HTS, a mix of health facility and community-based models should be utilized. Under each of these two models, the two main approaches for HTS will included: Provider- initiated HIV testing and counseling (PITC) and Client-initiated testing and counseling (CITC). Refer to chapter 9 for more details on service delivery models for HTS.

7.3.1. FACILITY-BASED HTS MODEL

HTS approaches under the Facility-based model are further described below:

7.3.1.1 Provider-initiated HIV testing and counseling (PITC)

This is HIV testing and counselling offered by health care providers to persons attending health care facilities, as a standard component of medical care. It offers an opportunity to the client to opt in or opt out of the HIV testing. Under this approach, HTS should be initiated by the health worker as part of standard health care. It can also be offered within community settings when the health worker initiates the HTS process e.g. index testing.

Health workers should routinely offer HTS to the following categories of individuals:

 TB and presumptive, malnourished clients, STI, inpatients, Pregnant and breastfeeding women, Partners of pregnant and breastfeeding women, Donors of blood, body tissue and organs, clients for SMC/VMMC, Sexual offenders and survivors Within OPD settings, HIV testing should be guided by a Screening tool to determine eligibility for HIV testing using the adult and Paediatric & Adolescent Screening Tools. PITC will be offered as an 'opt-out' HTS service.

7.3.1.2. Diagnostic HIV Testing

This shall be carried out on individuals as deemed necessary by the attending health care team with the purpose of better patient management. Such situations may include symptomatic, unconscious, very sick and mentally impaired patients.

7.3.1.3. Index client HIV Testing

This involves tracing contacts of index HIV infected clients and offering them testing services. Examples of these approaches include: Assisted Partner notification (APN) services and know your child status campaigns.

7.3.1.4. Client-initiated testing and counseling (CITC)

CITC formerly known as voluntary counseling and testing is where individuals and couples seek HIV testing services on their own. These clients should receive HIV testing and counseling from any trained and certified HTS providers or designees who may be lay providers, counselors, laboratory personnel and medical workers at any entry point in the facility.

7.3.2. COMMUNITY BASED HTS MODEL

HIV testing services at communities will aim to serve especially most at risk populations (key vulnerable and priority populations) that otherwise would not attend facility based HTS. All community HIV testing services should ensure that all clients diagnosed with HIV are effectively linked to HIV prevention, treatment and support services.

HTS approaches under the Community-based model are further described below:

7.3.2.1. Provider-initiated HIV Testing and counseling (PITC)

In this approach, the index client is used to help identify subsequent clients for testing or through a snowball approach.

a. <u>Home-based HIV testing and counseling (HBHTC)</u>

Home-based HIV testing and counseling is where HTS is provided in a home setting through an index HIV client invitation or a door-to-door approach. Index-client HBHTC should be prioritized for household members of all HIV-positive individuals in care as well as confirmed and presumptive TB patients. Index testing may be provided through HBHTC.

b. Index Client Contact Testing or index case HIV testing

A focused approach to HIV testing in which the household and family members (including children) of people diagnosed with HIV are offered HIV testing services. HIV testing services should be offered to family embers/household members that are exposed to HIV through the index client. Other forms of index testing include: APN and Know your Child Status.

c. Snowball Approach

In this approach, the HTS team works with the index client to invite other members of the group for HTS. This approach is recommended for use among sex workers and men who have sex with men. It is a form of index client contact tracing.

7.3.2.2. Client initiated Counselling and testing (CITC)

a.HTS Outreach/Mobile:

This approach should target priority populations that otherwise have limited access to HTS services (see section on target populations below). Outreach HTS can include:

- Door-to-door HIV testing which should be implemented only in high HIV prevalence settings or communities with key populations such as the fisher folk or hotspots for sex workers.
- HTS integrated into health outreaches like immunization or VMMC.
- HTS outreaches in locations frequented by target populations like key population hotspots, sporting events or workplaces.

These outreaches could include moonlight testing and mobile clinics.

b. Workplace HTS

This approach gives opportunities to employees, their families, and communities to access HTS services in the workplace. Workplace HIV testing should be confidential, delivered in a safe environment and should not be abused. Disclosure of HIV sero-status is at the discretion of the employee.

- KP/PP Hotspot HTS
- Social Events HTS(E.g. Sports Events)
- Other HTS Outreaches

8.0 THE HIV TESTING ALGORITHM FOR PERSONS AGED 18 MONTHS AND ABOVE

The HIV testing algorithm for persons aged 18 months recommends Determine as the screening test, Statpak as the confirmatory test and SD Bioline as the third test. A reactive test on SD Bioline is reported as inconclusive

An inconclusive result on the national HIV testing algorithm does not deem SD Bioline an inferior test assay. This is a WHO recommendation for all HIV antibody tie breaker tests. Therefore, the Final HIV test result in the HTS client card, HTS register and the Daily Activity register can be recorded as: NEGATIVE, POSITIVE, INCONCLUSIVE.

Note: if the child is still breastfeeding at 18 months or above and the HIV test is negative, a final test should be done six weeks after the child stops breastfeeding.

8.1 Resolving inconclusive HIV Test Results following a first Inconclusive result

For clients whose results are Inconclusive after the recommended 14 days following a first inconclusive test result, a sample should be collected, labelled "2nd INC" and sent to the national reference laboratory (CPHL) for testing. A result will be sent back as either POSITIVE or NEGATIVE. Sample and result transportation will utilize the existing hub system.

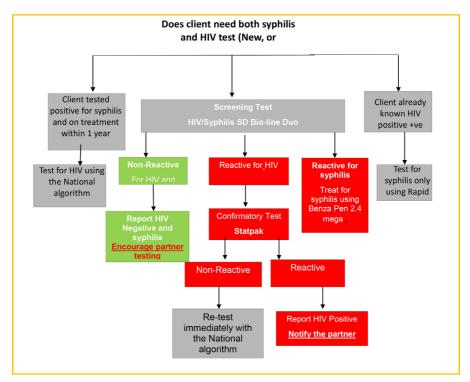
8.2 MCH HIV AND SYPHILIS TESTING ALGORITHM

There is Within MCH settings, the HIV /syphilis duo test will be used as screening with Stat-pak as confirmatory. Women who are already known HIV positive will still need to test for Syphilis using the single rapid syphilis tests.

need to take advantage of Duo kit for syphilis testing and treatment scale-up. For those where HIV status cannot be ascertained on the MCH algorithm, re-testing should be done by laboratory using the National adult HTS algorithm (i.e. Determine-Stat-pak,Bio-line). Very few mothers will require the tie breaker.

APN should be provided for those testing positive for HIV or Syphilis, and encourage Partner testing for negative.

Figure 4: HIV Testing Algorithm using the HIV-Syphilis Duo Kit in MCH Settings



Note: For clients that have tested positive for syphilis and been treated within one year, test for HIV using the National Algorithm. For known HIV positive mothers, test for syphilis using rapid syphilis test kits.

8.3 HIV TESTING ALGORITHM FOR INFANTS AND CHILDREN BELOW 18 MONTHS OF AGE

A virological test (DNA/PCR) is recommended for determining HIV status in infants and children below 18 months of age. The sample for testing should be collected using dried blood spot (DBS) specimens.

HIV Testing Schedule For Infants

The 1st DNA/PCR test should be done at 4-6 weeks of age or the earliest opportunity thereafter.

Another PCR test has been introduced to be done at 9 months of age as the second test for all infants irrespective of breast feeding status.

The 3rd PCR should be done 6 weeks after cessation of breastfeeding.

Infants with negative third DNA/PCR test should have a final rapid antibody test performed at 18 months using the national HIV testing algorithm.

RE-TESTING FOR HIV

2.5.1. Re-testing for verification

All HIV-positive individuals should be re-tested for HIV before enrolling in HIV care.

What is Re-testing for Verification?

All Individuals NEWLY diagnosed HIV positive according to the National HIV testing algorithm MUST be retested before ART

initiation. This test is called a retest for Verification.

Note:

- i. Re-testing for verification refers to the process of retesting all HIV Positive clients identified both within the facility and those referred from another facility or Community.
- ii. All Individuals in Pre-ART care should NOT be re-tested, unless upon discretion of the attending Clinician.
- iii. Clients on ART should NOT be Re-tested.

Who should perform the retest for Verification and where should the retesting take place?

- i. The re-test for Verification shall be performed by a health worker (Tester), other than the one who performed the first test using a different blood sample drawn from the same Individual (client).
- ii. It is preferred that retesting for Verification shall be performed at the point of ART Initiation. This may be performed at the Mother Baby Care Point (MBCP) or the HIV/ART clinic.
- iii. The national HIV testing algorithm must be followed during retesting for verification.

Note: A retest for verification is not performed to assess the competency of the first tester but it is a quality measure to ensure that a client who is enrolling in HIV Care is TRULY HIV positive.

How to Resolve Discrepant Results on Retest for Verification

For clients whose results are NEGATIVE on retest for verification, samples should be collected, labelled "Discrepant" and sent to the CPHL for testing. A result will be sent back as either POSITIVE or NEGATIVE. Sample and result transportation will utilize the existing hub system.

Note: Before discrepant results are sent to CPHL, rule out errors at facility level such improper handling of samples or testing kits and personnel incompetence.

2.5.2. Re-testing for HIV-positive Infants

All babies testing HIV-positive at the first or second DNA/PCR HIV testing should be re-tested for HIV. The DBS sample should be collected on the day the child is initiated on treatment.

2.5.3. Re-testing for HIV-Negative individuals

The following population categories should be re-tested for HIV as summarized in Table 2.

Table 2: Categories of HIV-Negative persons to re-test at specified time points

Population category	When to re-test (<u>individuals</u> initiating ART)				
ALL NEWLY IDENTIFIED HIV-positive patients or those	Before initiating ART. Re-testing should be performed by a different tester using the approved national HIV testing algorithm at the ART initiation site/care point				
mose	Do not retest clients previously enrolled into care on Pre-ART unless reasonably justifiable.				
Population category	When to re-test (individuals with previous negative test results)				
Individuals exposed to HIV within four weeks before HIV testing	Four weeks after the 1st test				
Key populations	Every 3 months				
HIV-negative partners in discordant couples	Every three months; if on PrEP, follow PrEP guidelines				

Population category	When to re-test (<u>individuals</u> initiating ART)
Pregnant women	1st trimester/1st ANC Visit, then in the 3rd trimester/during labor and delivery
Breastfeeding/lactating women	Every three months until three months after cessation of breastfeeding
Confirmed and presumptive TB patients, STI patients, HIV symptomatic patients testing negative	Four weeks after the 1st test
PEP clients	At one month, three months and six months after completing the PEP course
PrEP	As per the new guidelines
HIV-exposed infants(HEIs)	Six weeks upon cessation of breastfeeding and at 18 months of age
Children >18 months who are still breastfeeding	Six weeks upon cessation of breastfeeding
	14 days after the last test.
INCONCLUSIVE results	For clients whose results are Inconclusive after the recommended 14 days following a first inconclusive test result, a sample should be collected, labeled "2nd INC" and sent to the national laboratory (CPHL) for testing through the existing hub system.

HIV TESTING CERTIFICATION FRAMEWORK

Certification is the process by which an independent and authorized agency assesses the quality system of a facility/site and/or competency of a provider on the basis of certain predefined standards.

Certification gives formal recognition that a facility/site or tester is authorized to carry out a specific task such as HIV rapid testing for diagnosing HIV infections.

The Certification Framework for Uganda details the governance and coordination structure, roles and responsibilities of stakeholders, standards for HIV rapid testing, the process of auditing and assessing for compliance as well as monitoring and evaluation.

HIV Testing Certification Framework Goal:

To ensure that sites and testers accurately and reliably perform HIV rapid testing as per the set national standards.

Specific Objectives of Certification Framework include:

- Ensuring adherence to national standards of delivering HIV rapid testing
- 2. Ensure availability of competent personnel for HIV rapid testing
- 3. Ensure conformity of sites to national standards in order to ensure quality results

Why the HIV Testing Certification Framework?

The national HIV testing policy 2016 and national health laboratory strategic plan 2016-2020 provide for tester and site

certification as a key strategy to enhance the quality of HIV testing services.

As access to Rapid diagnostic and point of care technologies expand in low- and middle-income countries, need for simple, practical and low cost innovative approaches to ensure sustainable quality assurance practices that lead to accurate and reliable patient results and improved public health outcomes is real.

Despite many interventions to strengthen quality of HIV testing, gaps in quality assurance still exist including few and/ or inadequately trained staffs, unavailability of testing supplies, lack of post market surveillance practices, deviation from testing procedures, low participation and performance rates in proficiency testing programs and under-utilization of testing data for timely corrective actions. A national certification program for HIV rapid testing may prove to be not only a healthcare cost saving approach, but also an expansion of quality of care.

It also provides clinical governance to support health care providers involved in testing by creating an enabling environment for health-care providers to be accountable for providing the quality of HIV Rapid testing services and safeguarding high standards of care and excellence in clinical care.

Implementation and maintenance of HIV rapid testing site and tester certification program adds credibility to any testing site, provides the means to ensure and monitor adherence to quality standards and instill

confidence in the results for patient care. The national certification program for HIV testing sites and testers provides an umbrella under which all aspects of quality HIV testing shall be gathered and continuously monitored.

The HIV Testing Certifying Body

The Uganda Virus Research Institute (UVRI) is mandated by the Ministry of Health to conduct quality assurance for HIV rapid testing in Uganda. By virtue of this role, UVRI shall be the Certifying Body for

HIV rapid testing sites, auditors and testers. UVRI shall work closely with the AIDS Control Program and the Quality Assurance Department of MOH in fulfilling her role in the certification program.

Implementation of the HIV Testing Certification Framework

Certification will be done at regular intervals to ensure maintenance of standards and reliability of results generated to support clinical and public health activities by the HIV Testing point (referred to as site here) and provider.

Site Certification verifies that at a specific HIV Testing Point, testing procedures are in place and followed, results are technically valid, only competent staff performs testing, and confirms that the site conforms to a quality management system.

Tester Certification verifies that the provider performing HIV testing is adequately trained, is authorized to do so and there is evidence of demonstrated competency.

HIV Testing Certification Framework Implementation Plan: The implementation plan includes the process of assessments/audits of the testers and testing sites, certification, decertification, recertification.

For further reading, refer to the HIV Testing Certification Framework

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