# Table of Contents

**Forward**

**Acronyms**

**Operational Definition**

**Preface**

**How To Use This Manual**

**Chapter 1: General Principles of Community HTC Service**

**Chapter 2: Home-based HTC**

1. Pre-implementation of Home-based HTC
2. Implementation of Home-based HTC
3. Post-implementation of Home-based HTC

**Chapter 3: Outreach HTC**

1. Pre-implementation of Outreach HTC
2. Implementation of Outreach HTC
3. Post-implementation of Outreach HTC

**Chapter 4: Management of Community HTC Service**

1. Logistics
2. Monitoring and Evaluation

**Chapter 5: Quality Assurance of Community HTC**

**Reference**

**Appendix**

1. Child Testing
2. Registration and Licensing of HTC Sites/Facilities
3. Minimum Requirements of Supplies and Materials for CBHTC
4. Specific Protocol as per Targets
5. Early Infant Diagnosis
6. National Referral Form
7. Outreach HTC Standard Operating Procedures
8. National HIV Testing (HTC) Register
9. Coordination and Supervision of CHTC Service
10. Post Exposure Prophylaxis (PEP)
12. National Re-testing Guidelines
Foreword

The Ministry of Public Health & Sanitation (MOPHS) through the National AIDS/STD Control Programme (NASCOP) acknowledges the development of this Operational Manual on Community-Based HIV Testing and Counselling (CBHTC). The manual comes at a time when Kenya is rapidly scaling up HIV testing services. We strongly believe that Kenya is on course to achieve the universal access target of 80% coverage by 2013. Indeed the Kenya Demographic and Health Survey (KDHS) 2008 showed that approximately 50% of Kenyans have been tested for HIV at least once, much higher among women (56%) than among men (44%). This five-fold increase from 2003 when coverage was from 10% reflects dedicated efforts to diversify service delivery channels for HIV testing. We note with satisfaction that development partners have been able to support the Government of Kenya’s strategies that evolved from voluntary counseling and testing (VCT) earlier in the decade to the more routine testing in health facilities (including ANC and TB clinics). Even as we look into the future options like self-testing, we will still count on our partners to assist the government’s vision of eliminating missed opportunities for HIV prevention.

As a country we have made a conscious decision to progressively bridge the access gap for HIV testing services. As a result of this commitment we have consistently encouraged development partners to innovate approaches that have high impact and reach into the heart of communities. One such approach is home-based HIV testing and counseling (HBHTC) delivered through door-to-door approaches. We salute the phenomenal success of the pilot projects that are ongoing. In HBHTC we see a great potential to increase access to male circumcision, couple-counseling, linkage to care and reduction in stigma and discrimination.

Through this manual, the Government through NASCOP seeks to standardize community-based HIV testing services to ensure high quality services and high coverage.

This manual recognizes that for communities and individuals to derive maximum benefit from HTC, sufficient information should be disseminated countrywide so that every man, woman or child gets an opportunity to know their HIV status.

I urge all development partners to implement components of this manual so as to reach all intended beneficiaries and ensure the overall efficiency of the HTC approaches.

The greatest determinant of efficiency and effectiveness in HTC is to mobilize as many clients as possible, and to identify the most number of HIV-infected persons per unit cost. I would like to emphasize therefore that adherence to the principles outlined in this document such as targeting high prevalence regions is of paramount importance.

Finally, I encourage all program managers, health care workers, administrative and support staff, to adhere to the guidelines set out in this manual.

Director, Public Health and Sanitation,
Dr. S. K. Sharif

July 2011
<table>
<thead>
<tr>
<th>Acronym</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHW</td>
<td>Community Health Worker</td>
</tr>
<tr>
<td>CBO</td>
<td>Community-based Organization</td>
</tr>
<tr>
<td>DTC</td>
<td>Diagnostic Testing and Counseling</td>
</tr>
<tr>
<td>DMLT</td>
<td>District Medical Laboratory Technologist</td>
</tr>
<tr>
<td>FBO</td>
<td>Faith-based Organization</td>
</tr>
<tr>
<td>GOK</td>
<td>Government of Kenya</td>
</tr>
<tr>
<td>HTC</td>
<td>HIV Testing and Counseling</td>
</tr>
<tr>
<td>IDUs</td>
<td>Injecting Drug Users</td>
</tr>
<tr>
<td>KAIS</td>
<td>Kenya AIDS Indicator Survey</td>
</tr>
<tr>
<td>KDHS</td>
<td>Kenya Demographic Health Survey</td>
</tr>
<tr>
<td>KNASP</td>
<td>Kenya National AIDS Strategic Plan</td>
</tr>
<tr>
<td>MOT</td>
<td>Mode of Transmission Study</td>
</tr>
<tr>
<td>MARPs</td>
<td>Most at Risk Populations</td>
</tr>
<tr>
<td>NGO</td>
<td>Non-government Organization</td>
</tr>
<tr>
<td>OHTC</td>
<td>Outreach HIV Testing and Counselling</td>
</tr>
<tr>
<td>PwP</td>
<td>Prevention with Positive</td>
</tr>
<tr>
<td>SCMS</td>
<td>Supply Chain Management System</td>
</tr>
<tr>
<td>VCT</td>
<td>Voluntary Counseling and Testing for HIV</td>
</tr>
</tbody>
</table>
ACKNOWLEDGEMENTS

The Ministry of Public Health and Sanitation, through National Aids and STI Control Program acknowledges the following people for their time and technical input in the development of this manual. The dedication they showed during the various stages of the manual development is truly appreciated.

1. Dr. Anne Ng’ang’a*    NASCOP
2. Merina S Lekorere*    NASCOP
3. Betty Chepkwony*    NASCOP
4. Carol Ngare*    NASCOP
5. Yuko Takenaka*    JICA SPEAK II
6. Mwikya Lawrence    NASCOP
7. Thomas Gachuki*    NHRL
8. Catherine Gichimu    NHRL
9. Caleb Ochieng    NHRL
10. Patricia Oluoch*    CDC
11. Winnie Mutsotso    CDC
12. Annrita Njeeri Ikahu    LVCT
13. David Kibui    LVCT
14. Lucy Njuki*    LVCT
15. Hudson Inyangala    APHIA II WESTERN
16. Thomas Ondimu    APHIA II RIFT
17. Dr David Bukusi    KNH
18. Christine A Otieno    KNH
19. Fillet Lugalia    KEMRI
20. Manase Amolloh    KEMRI
21. Dr Samson K Ndege*    AMPATH
22. Denis L Ojuok    IMC
23. Rose A Oyoo    IMPACT RDO
24. Muli Kamande    DASCO Kiambu
25. Gabriel K Kurui    DASCO Muranga
26. Leseeto Julius    NACC/CACC REP
27. Emma Mwamburi*    USAID
28. Dr. Nicholas Muraguri    HEAD NASCOP
29. Dr. Peter Cherutich    NASCOP

EXTERNAL REVIEWERS

1. Winnie Mutsotso    CDC
2. Jane Harriet Namwebya    FHI
3. Dr. David Bukusi    KNH

NB: Names with * at the end indicate editorial team members
**Operational Definitions**

**HTC Service Provider**
An individual trained on HIV testing and counseling as per national guidelines and training curriculum and certified by NASCOP.

**Community HTC**
HIV testing and counseling (HTC) services provided in community settings

**Home-based HTC**
HTC services provided in the home by qualified HTC service providers in a defined geographical area

**Outreach HTC**
HTC services provided outside a fixed site e.g. health facilities, VCT centers

**Index client**
An individual identified HIV positive whose family is targeted for HTC services.

**Emancipated/mature minor**
Refer to children under the age of 18 years who may either be pregnant, married, parent, or engaged in behaviors that put them at risk of HIV infection

**Hard to reach population**
Populations who cannot be easily accessed with HTC services based on geographical location, occupation, socio-cultural practices, and/or sexual lifestyle

**HIV discordant couple**
Situation where one sexual partner is HIV positive and the other is HIV negative

**HIV concordant couple**
Situation where both sexual partners are either HIV positive or negative

**Household**
A domestic unit consisting of members of a family who live together under one roof along with relatives or non-relatives e.g. house help

**Homestead**
A home with its dependent households considered as a whole under one head.

**Mapping**
A systematic process of identifying target populations in a specified geographical area

**Couple HIV Testing and Counseling (CHTC)**
This refers to HIV testing and counseling of two/more sexual partners together. They could be married, cohabiting, regular sexual partners or intending to have sex. They undergo counseling and testing in the same sitting and receive results together. The service is intended to facilitate both mutual knowledge and disclosure of one’s HIV status to their sexual partner(s).

**Community Health Worker**
Community health worker (CHW) is a lay member of community, trained under the Government of Kenya (GOK) community strategy, who works either for pay or as volunteers in association with the local health care system
This manual operationalizes the National Guidelines on HIV Testing and Counselling in Kenya (2008) in regard to community HIV testing and counselling services. It should be used by all HTC providers offering community HIV testing and counselling and should be used in conjunction with the National Quality Management Guidance.

This operational manual is intended to standardise delivery of HIV testing and counselling (HTC) services in community settings e.g. door to door, mobile, workplace and all other forms of outreaches.

The manual addresses the whole process of community HTC service provision i.e. geographical area determination, community entry process, counselling, testing, logistics, data management, general management, supervision, funding and effective use of available resources.
Chapter 1: General Principles of Community HTC Service

Background

HIV Testing and Counseling (HTC) is the main entry point to HIV prevention, care and treatment. Kenya adapted the UNAIDS concept of Universal Access by 2010. The achievement of these ambitious targets was dependent on the successful expansion of HTC program in the country.

 Provision of HTC has evolved over time from the traditional voluntary counseling and testing (VCT) to include other innovative approaches to increase access. There are two main types of HTC; Client Initiated Testing and Counseling (CITC) and Provider Initiated Testing and Counseling (PITC). They can be provided in both clinical and community settings.

The Community HTC Operational Manual is informed by the following policy documents:
- HIV and AIDS Prevention and Control Act, 2006
- Sexual Offences Act, 2006
- Children’s Act, 2001
- Medical Laboratory Act, 1999
- Public Health Act, CAP 242.

Country statistics of HIV and AIDS are:
- Majority (75% KDHS 2008) of Kenyans live in rural areas
- Access to static HTC is mainly limited to urban areas
- PITC target those visiting health facilities but leaves out majority of those who don’t go to health facilities especially men and youth
- 1.45 million Kenyan adults are living with HIV; 6.3% for 15-49 years (KDHS 2008)
- About 44% of new infections in Kenya are occurring in people engaging in casual sex with multiple partners or their steady partners who themselves may be monogamous. (MOT 2008)
- 10% of couples in Kenya are living with HIV.
- Among married/cohabiting couples, 5.9% were discordant for HIV, that is, one partner was infected and the other was not. This corresponds to an estimated 344,000 HIV discordant couples nationwide. These couples require targeted HIV testing and prevention.
- Among HIV infected adults who are married or cohabiting, 44% have an uninfected partner
- Some heterogeneous populations such as sex workers, truck drivers, MSM, members of fishing communities, prisoners, and injecting drug users (IDUs) where data exist, have HIV prevalence rates many times higher than the national average. (MOT 2008)
- 48% of Kenyan adults know their HIV status (KDHS 2008)
- Kenya National AIDS Strategic Plan (KNASP) III (2009-2013) targets to have 80% of Kenyans know their HIV status by the year 2013.
- 83% of the population indicated they would prefer Home testing. (KAIS 2007)

Rationale for Community-based HTC

Since 1999 and prior to the National HTC guidelines 2008 (NASCOP 2008) Counseling and Testing for HIV clients would generally find counseling and testing for HIV in either a stand alone or an integrated site (counseling and testing site within health care facilities). Diagnostic Testing and Counseling services (DTC) was introduced in health facilities to capture symptomatic patients. However, overall coverage remained low.
Despite rapid expansion of sites offering counseling and testing services that is from 3 in 1999 to about 3000 in 2008, only 36% of Kenyans knew their correct HIV status (KAIS 2007). This therefore called for innovative approaches to HTC in order to take services closer to the clients. These approaches include HBTC, workplace and other outreach services to designated areas and spots. In Zimbabwe 80% of the population preferred home testing (Marks; G., et. al. 2007). Studies in Malawi and Uganda with similar disease burden to Kenya, have shown that Home based testing and counseling is highly acceptable to clients and a successful strategy in bridging inequalities to service provision (Bateganya et al. 2009; Menzies et al. 2008). Programme data in island of Suba in Nyanza and the slums of Kibera and Kawangware in Nairobi demonstrated that HBTC is highly acceptable to clients and uptake rates are over 85%.

Home based testing and counseling was found to be the second cheapest after the health facility PITC approach (Menzies, et.al. 2008). Therefore it presents an effective approach in resource constrained settings. Home based testing and counseling has several advantages; the first is that there is no cost to the client in terms of travel. Secondly, it enhances couple HTC thus addressing issues of prevention particularly among HIV discordant couples. In addition it provides an opportunity for the whole family to be tested together thus promoting disclosure and garnering support within the family for care. HBTC also provides the opportunity to identify HIV infection amongst high risk children (Vreeman RC et al. 2010).

**Strategies of HTC in Community Services**

This manual focuses on HTC services in community settings:

- Stand-alone HTC
- Outreach HTC
- Home-based HTC

Stand-alone HTC centers are facilities within the community that are not directly attached to other specific health services. Stand-alone HTC centers target the general population and can be tailored to populations with specific needs such as HTC for the persons with disabilities, youth, sex workers and injecting drug users or couples wishing to get married.

Outreach HTC refers to services offered outside of a fixed site, such as mobile or workplace.

Home-based HTC refers to the service in which the HTC service provider physically goes to the home of a potential client or known patients to offer HTC. There are currently two (2) broad categories of home-based HTC:

1) General population; HTC service providers visit the homes in a specified geographical area. This popularly known as door to door;
2) Index client; HTC service providers only visit the homes of an identified HIV positive client to provide HTC services to family members.

**Guiding Principles for Community based HTC**

- Respect for basic human rights,
- Client should give informed consent,
- Services are confidential,
- Client should be provided with pre-test information, post test counseling, and referrals to appropriate services,

---

1 as defined by the National HTC Guidelines 2008
• Respect for social and cultural dynamics in the community, family dynamics, norms, beliefs, values ideologies, and administrative structures,
• Adherence to quality HTC services,
• Embrace community ownership and participation.

Overall Objectives of the HTC Services in Community Settings

The goal of community based HTC is to contribute to the 80% universal access targets for HIV testing in Kenya by providing HTC opportunities in the community with the aim of increasing the knowledge of community members HIV status, interrupting HIV transmission, linking the infected individuals to early care and treatment, hence reducing morbidity and mortality.

The specific objectives of community based HTC are:
• To increase access to HTC services,
• To facilitate correct knowledge of HIV status,
• To facilitate effective referral to HIV care and treatment services for the HIV infected,
• To promote HIV risk reduction for the HIV uninfected individuals,
• To promote couples/partners HTC,
• To promote family HTC,
• To increase access to HTC among MARPs and other hard-to-reach population
• To create community ownership of HTC services
• To positively influence health seeking behavior

Benefits of Community Based HTC

- Increase access to HIV testing (reduced cost of transportation to VCT sites or health facilities; convenient for family members; enhances privacy; helps reduce stigma)
- Promote behavior change leading to the reduction of HIV transmission
- Increase access for couple/partners HTC and enhance disclosure
- Provides an opportunity to address HIV discordance among couples/partners
- Promotes early HIV diagnosis, referral and linkage to care and support services
- Improve adherence to care and treatment

Target Population of Community Based HTC

Community HTC targets the entire population in a selected area. The populations include adults, youth, infants and children, couples and families, persons with disabilities and most at risk populations.

CBHTC for children

The testing of children in the context of community HTC is as stipulated in the Kenya National HTC guidelines (2008) which require consent of parent or guardian unless they are emancipated minors. A child is anyone from 0-17 years old (Children’s Act, 2001). (See Appendix I). Provision for child headed homes will be guided by Children’s Act, 2001, which states “… Child has right to health and medical care provision of which shall be the responsibility of the parents and the government…” and public servants that can give consent on behalf of the child.

Selection of Geographical Area

Community testing can be expensive if not well planned and targeted, but it can be relatively inexpensive if certain factors are considered (Menzies Uganda 2008). In order to get high yield from the limited resources available, it is important to consider areas with;
Comparatively high population density
• Comparatively high HIV prevalence rates
• Low level of individual knowledge of HIV status
• High risk populations

Regulation of Community HTC Services

Certification of providers
All HTC service providers including CBHTC should receive training as per national HTC curriculum and should be certified by NASCOP.

Registration of services
VCT sites both stand alone and integrated should be registered, licensed, and accredited as per National Quality Management Guidance for HTC. Health facilities offering HTC services are already registered by the government in the broader context of health care services, therefore they do not require further registration.

Any community based organizations (CBOs) or non-governmental organizations (NGOs) wishing to provide HTC services in the community should seek guidance from MOH/NASCOP through DMOH/DASCO. DASCO will either register or link them with a registered HTC site for effective implementation, coordination and monitoring.

The DASCO should maintain the list of all sites and agencies e.g. CBOs providing HTC services as per approach. The list should be available at all administrative levels. (See Appendix 13

Planning for CBHTC services
Organizations planning to set up CBHTC services should have adequate knowledge of the resources required for successful implementation.
The following need to be well planned before the actual activity takes place:
• Community entry process
• Time and timing
• Resources; monies, service providers and other supporting staff, commodities, and other materials
• Logistics
• Coordination of all activities
Refer to Appendix for further details.

Bottom-up approach
Participatory planning should start at the village level and build up to the district co-coordinated by the DHMT working with a task force representing all the relevant stakeholders. This is to identify actual community needs, create demand for HTC services, and ensure ownership.

Cost and Budget of Community HTC Activities
It is recommended that HTC services should be provided free of charge. Where applicable, an affordable fee may be charged to enhance the sustainability of HTC services, but the fee should not be a barrier to access services.

If a fee is agreed upon, it should be communicated during mobilization and to the relevant authority. It should be posted clearly so clients know in advance what the fee will be.

An organization requesting for community HTC services should consider all logistics required for successful implementation.

When HTC services are provided as part of research or study, in addition to the above, the implementing body should follow the laid down ethical procedures.
Chapter 2: Home-based HTC

Home-based HTC (HBHTC) is an innovative approach in Kenya aimed at enhancing community access to testing and counselling by providing the services at the household level targeting families and couples. The concept of HBHTC is provided for in the National Guidelines for HIV Testing and Counselling (NASCOP, 2008) and is reinforced in the Kenya National AIDS Strategic Plan (KNASP III 2009/13).

It is envisioned that the households and the community are actively and effectively involved and empowered to increase their control in HIV and AIDS prevention care and treatment. The actors in HBHTC include community members, HTC service providers, DHMT members, and the community own resource persons (CORPS).

1. Pre Implementation of Home-based HTC (i.e. Appendix 6)

In planning for effective Home-based HTC implementation, the following should be addressed:

- Consultation with DHMT and local administration
- Site identification
- Human resources management
- Logistics
- Budget

Consultation with DHMT and local administration

It is important to ensure that the HBHTC activities are in line with the district HTC strategies. Joint consultative meetings with DHMT, Constituency AIDS Control Committee (CACC), local administration and implementing partner should be held. Each HBHTC program or service needs to have a reference point from a registered HTC site in the respective district in consultation with the DHMT in order to be linked to the national supplies and reporting system.

Site identification

The following are steps for site identification:

1) Geographical identification: Identification of the geographical area of focus (should be in line with administrative units up to the village level).
2) Mapping: It is a systematic process of identifying target populations. It is important in guiding the systematic and coordinated activity implementation that ensure coverage of a defined area.
3) The mapping should identify (in collaboration with key stakeholders) referral facilities for ongoing HIV prevention, care and treatment services. It should also identify psychosocial support structures and networks at both facility and community levels.
4) Target population: The program should clearly define the target based on the eligible population to determine coverage. The targets should be based on or reflect the district population. Information may be obtained from the Kenya National Bureau of Statistics (KNBS), District Medical Officer of Health (DMOH) or District Development Officer (DDO).
Human resource management
This section describes the type of staff, training, staff supervision and other related issues:

1) Staffing: The staffing structure includes program manager/coordinator, supervisors, HTC service providers, trained community health workers (CHWs) and other program support staff. The process of recruitment of CHW should be participatory to ensure community support for the activities.

2) Training and orientation of staff: It is critical that all staff are appropriately trained in line with the national HTC training curriculum and guidelines. This includes relevant orientation packages including service provision, program management, supervision, and M&E.

3) The program also works with CHWs and other related cadres who should undergo training on HTC service information, mobilization for HIV prevention, care and treatment under the Community Strategy.

4) Supervision: The levels of supervision include program management and support supervision.

Logistics
See Chapter 4.

Budget
In budgeting for the activity, adequate resources for human resource, logistics and supplies, training, transport, communication, meetings, mapping exercise and other necessary costs should be ensured.

2. Implementation of Home-based HTC
The implementation involves the following activities:

- Community entry process
- Community mobilization
- Home entry process
- HBHTC service provision
- Referral and follow up.

In addition to the principles in Chapter 1, the followings should be observed:

- Respect for client’s appointment and wishes
- Adherence to HBHTC protocol and recommended national algorithm

Home-based HTC has two (2) approaches; door to door and index client.

Door to Door approach:
This should be systematic, based on the administrative unit usually at the village level. The HTC services should be provided in this unit until all the households have been covered before moving to the next unit.

The HTC provider is accompanied by a CHW to facilitate the home entry process

Index client approach;
Index clients are identified at HTC service delivery points, usually in health facilities and home visits are scheduled with their consent, where eligible family members are offered HTC.

Community entry process
This is a systematic approach of introducing new ideas and knowledge to individuals, families and the community, taking into consideration the community norms, beliefs, values, ideologies and leadership structures. Home-based HTC providers should, therefore, follow the steps in the community entry process to reduce conflicts and stigma in the community hence embraces acceptance and creation of service demand. Participatory planning is done by service providers, community own resource persons and MOH partners.
Steps in the community entry process

1) Exploration: This is an initial fact finding mission to define the community, identify the resources and their life style, and understand cultures. This will enable the service providers coming into the community to gain knowledge and understanding of the community.

2) Community observation: This entails identification of the gatekeepers, both formal and informal community leaders, in order to work through them. It also involves observation of the physical structures and resources necessary for implementation. The gate keepers should be involved from the initiation phase of the program up to the end to enhance community ownership, increase service demand, guarantee security to the service providers and obtain authority to work with the community.

3) Community sensitization meetings: Discuss with key individuals at every control point down to the household level about community perceived needs, the intended implementation processes, the extent of involvement and the expected benefits.

4) Community mobilization: This is carried out by trained CHWs, community own resource persons (CORPs), and implementers.

**Community mobilization and sensitization:**
This process needs to be carried out prior preferably two or more weeks before the service providers visit the homesteads. It is the duty of the CHWs in collaboration with the community leaders to mobilize and sensitize the community on the benefits of testing and knowing one status. The dates of the actual service provision should be communicated to the community members during the mobilization.

One of the methods used in community mobilization and sensitization is utilization of information, education and communication (IEC).

IEC can be through,
- Print media: posters, flip charts, fliers, magazine, and news papers.
- Audio: local radio stations and public address system
- Audio visual: televisions, cinemas and video
- Theatre: dance, songs, role plays and drama

The emphasis should be on developing targeted HIV messages with appropriate language to specific group e.g. couples/partners, families, youths, MARPs, and exposed children

Venues for community mobilization
- Barazas with Chiefs, District Officers, District Commissioners and other community leaders.
- Schools
- Churches, temples, and mosques
- Market places
- Football matches and athletics
- Campaign rallies
- Public gatherings and functions e.g. cultural ceremonies, men/women group meetings etc.

**Home entry process**
In HBHTC, home entry is critical. The norms surrounding the community need to be observed strictly. Prior appointment should be done by CHWs who will introduce HTC service providers to the family members. For locked houses, CHWs should make at least three (3) visits before marking it as a home with no response. CHWs should document this fact.
CBHTC service provision:
The three principles of HTC services apply and must be adhered to. These are:

- Pre-test session: HIV and AIDS information and education including risk assessment
- Testing
- Post-test session: includes TB screening, FP, STI screening, introduction of VMMC and PMTCT, and other services, and named-based comprehensive referral.

General protocol of the session
HTC service provider should:

- Be introduced by the CHWs and/or CORPs
- Introduce the session and explain their role, and offer estimate of session duration
- Explain the purpose of the HBHTC program
- Reassure confidentiality
- Discuss benefits of knowing HIV status as a family or as a couple
- Discuss disclosure
- Give basics information on HIV and AIDS
- Dispel myths and clarify misconceptions about HIV or any other issues that arise
- Encourage family members to test together
- Review risk factors for HIV infection
- Review options for risk reduction
- Do condom demonstration (It’s important for HTC service providers to use their discretion since this may not be pertinent to all Household sessions or household members)
- Explain testing procedures and possible test results
- Allow time for questions and clarifications
- Ask for consent to proceed to HTC
- Conduct the HIV test.
- Provide post test counseling
- Provide appropriate referral.

Note: This list is not exhaustive, it is imperative that HTC service providers respond to client needs.

General protocols apply for all specific target groups; individuals, couples/partners, children, and youth. However, for couple/partners HTC encourages testing together and mutual disclosure. For children, consent should be obtained from parents/guardians and for those less than 18 months, see additional requirements for EID. (See Appendix 5)

HIV Testing:
All HTC service providers should adhere to the National HIV rapid testing algorithm and the standard operating procedures (SOPs) for HIV testing. For indeterminate results and discordant couple/partner results, a DBS should be taken from both individuals and sent to a reference laboratory. (See Chapter 5 on HTC Quality Assurance)

3. Post-implementation
Referral and Linkages in Home-based HTC
Referral is the process by which a client’s immediate needs for care, prevention and supportive services including psychosocial support are assessed, prioritized and client directed to where the services can be obtained. The national referral form is used for this purpose. A copy should be retained at both the HTC service provision level and the referral facility (See Appendix 6) for monitoring and evaluation.
Mechanisms for linkages and follow-up

The HTC service providers should have a current regional referral directory for HIV and AIDS related services and the referral forms.

There are different models for follow-up depending on circumstances.

• Follow up to referral point;
  The HTC service provider visits the referral facilities to confirm enrolment within agreed upon time.
• Home follow up;
  The HTC service provider makes a visit to the client’s home.
• Community health Worker/ People Living with HIV (PLHIV) model;
  With prior consent, the clients can be linked with CHWs or PLWHIVs for follow-up.
• Phone/ email follow up;
  The HTC service providers do phone call follow-up.

Note: Emphasis of the immediate linkage to PMTCT services for HIV positive pregnant women and exposed children for EID should be made.

Community Exit Process:
Feedback to;
- Community leaders
- DHMT

Key issues in Feedback meeting;
• Acknowledge support
• No of people tested
• No. Positive
• Lessons learnt and challenges.
• Role of community in the health and other issues raised.
• Referrals and linkages.
Chapter 3: Outreach HTC

Outreach HTC (OHTC) refers to services offered outside a fixed site, such as mobile or workplace. OHTC may be provided in any of the following venues:

- Community facilities e.g. schools, churches, mosques, community halls, market buildings etc
- Tents pitched on open grounds
- Work place
- Vans equipped for HTC services.

1. Pre Implementation of OHTC Services (see Appendix 5)

In planning for effective OHTC implementation, the following must be addressed:

- Consultation with the DHMT and local administration
- Site and Venue identification
- Duration of activity
- Service agreement if it is in a workplace.
- Human resources management
- Logistics
- Budget

Consultation with the DHMT and local administration

It is important to ensure that the OHTC activities are in line with the district HTC Annual operational plans. Joint consultative meetings with the DHMT, the Constituency AIDS Control Committee (CACC), the local administration and relevant implementing partners should be held. Each OHTC service needs to have a reference point from a registered HTC site in the respective district in consultation with the DHMT in order to be linked to the national supplies and reporting system. There should be a joint work plan with the host District in line with the annual operational plans (AOPs).

Site and venue identification

For OHTC services to be cost effective, certain factors need to be considered:

- Geographical location: site and population anticipated to be reached
- Day to day activities: in order to determine the appropriate timing for the service
- Assessment of availability and utilization of existing HTC services
- Identification of social events and riding on them e.g. football tournaments, traditional ceremonies
- Identification of existing HIV care, treatment and support services

OHTC team with the respective DASCO should visit the OHTC site in advance to assess the suitability of the venue as per National Quality Management Guidance (NQMG).

Duration of activity

OHTC services should be provided for a minimum of 2 days continuously excluding travel days. This is to maximize the services and allow for those who may have any other questions and emerging needs to be addressed.
Service agreement for workplace
OHTC team offering workplace HTC services must enter into a service agreement with the recipient companies/organization as per their HIV and AIDS workplace policy. This agreement should spelt out the roles of both parties. Confidentiality should be maintained when giving feedback on HTC services to workplace management in line with the National HTC guidelines and the HIV Prevention and Control Act 2006.

Human resource management
Recruitment, terms of service and training of OHTC service providers should follow the laid down regulations and procedures in the National HTC Guidelines. It is important that all OHTC service providers including volunteers be practicing from a registered site and accessing regular (counselor) support supervision.

All staff involved in the OHTC activities, including the receptionist, drivers, data/record clerks etc. should receive orientation on their roles, basic communication skills and the need to observe strict standards of confidentiality. All OHTC programs should make appropriate arrangements and allocate resources for supervision of OHTC services.

OHTC service supervisor should organize supervision sessions for briefing and debriefing daily at the venue of the OHTC.

Logistics
See Chapter 4

Budget
The budget should provide for adequate human resource, logistics, supplies, training, transport, communication, meetings, and other necessary costs.

2. Implementation of Outreach HTC services (see Appendix xxx)
The implementation of the OHTC services involves the following activities:

• Community mobilization
• Management of client flow
• OHTC service provision

Community mobilization
Community mobilization should be coordinated by HTC service providers in conjunction with the community (CHWs and CORPs).

During the mobilization exercise, community members should be given information on:

• HIV and AIDS including prevention, care, treatment and support
• The benefits of HTC
• The upcoming OHTC activity
• The cost of the OHTC service if any

Regular and innovative ways of mobilization include:

• Fliers, brochures, and pamphlets distribution.
• Puppetry
• Entertainment including drama, skits, and plays
• The use of public address system
• Local radio stations advertisements.
When planning for community mobilization, tailor made approaches should be adapted for couples/partners, MARPs, and persons with disabilities.

The OHTC staff, the host DHMT and the respective community leaders should identify where the mobilization activities should take place. These areas may include; public barazas, market places, schools, churches, and workplaces etc.

Management of client flow

For OHTC services just like in stand-alone VCT sites, it is important to have a receptionist from among the staff. The role of receptionist is to explain procedures to the client, facilitate registration, and refer any questions to the HTC provider. Where the receptionist is a trained HTC provider, she/he can be charged with group counseling where this is required.

Educational materials about HIV services should be made available for clients to read and view while they wait to see a HTC provider.

The clients should be seen on the basis of first come first served. Priority should be given to special groups e.g. those who are very sick, pregnant women, the elderly and people with disabilities. A booking system for clients also works towards reducing anxiety among the clients and the HTC providers. The reception needs to be well organized to facilitate effective client flow.

OHTC service provision

The basic elements of the OHTC services are just like any other HTC services;

- Pre-test
- HIV testing
- Post-test

Pre-test

This can be done either for individual or in groups. Group session applies to pre-test session ONLY. General information about HTC should be provided to groups in the course of general health education talks, such as those held at health centers. In OHTC, there is likely to be a very high demand, hence group pre-test counseling can be provided if the following conditions are met:

- No more than 15 people per group per HTC provider where space allows
- Conducive environment

Group should be formed with the following considerations;

- consent to be in group session
- Age
- Sex
- language

Note:

A client choosing not to be in a group should not be discriminated against. Group session should not deny the client opportunity to have one-to-one or couple session.

HIV Testing:

All OHTC service providers should adhere to the national HIV rapid testing algorithm and the standard operating procedures (SOPs) for HIV testing. For indeterminate results and discordant couple/partner results, a DBS should be taken and sent to a reference laboratory. (See Chapter 5 on Quality Assurance in HTC)
Post Test
One-to-one or couple/partner counseling will be used to give results depending on the choice of the clients.
At the client’s request, a family member, friend, or other supportive person can be in the room when he/she receives the test result.
The OHTC provider should make sure that this is truly desired by the clients.
Post test counseling should include appropriate referral.

Guidance on number of clients a provider can test per day
Quality should be maintained at all times during HTC service provision. Below is a table showing the estimated time a counsellor will spend with a client on testing alone given the current test kits, Determine, Bioline, and Unigold in the national algorithm.

<table>
<thead>
<tr>
<th>Procedures</th>
<th>Screening Test</th>
<th>Confirmatory Test</th>
<th>Tiebreaker test</th>
</tr>
</thead>
<tbody>
<tr>
<td>Swabbing process</td>
<td>1 min</td>
<td>1 min</td>
<td>1 min</td>
</tr>
<tr>
<td>Pricking, harvesting and dropping blood onto the test device</td>
<td>3 min</td>
<td>3 min</td>
<td>3 min</td>
</tr>
<tr>
<td>Waiting to read the results</td>
<td></td>
<td>Specific to test kit in use, e.g. Determine -15 min</td>
<td>Specific to test kit in use, e.g. SD Bioline-10 min</td>
</tr>
<tr>
<td>Reading the test results</td>
<td>2 mins</td>
<td>2 mins</td>
<td>2 mins</td>
</tr>
<tr>
<td>Cleaning and disinfecting the desk</td>
<td>2 mins</td>
<td>2 mins</td>
<td>2 mins</td>
</tr>
<tr>
<td>Minimum time required for testing if above test kits are used</td>
<td>23 minutes</td>
<td>18 minutes</td>
<td>18 minutes</td>
</tr>
</tbody>
</table>

* The time stated above does not include pre-test information giving and post counselling time.

From the table above, it will take approximately 23 minutes to conduct and interpret the screening test, Determine. When you add time taken to give pre-test information and post test counseling, it should take a minimum of 30 minutes to complete the first test. Therefore for negative clients who do not require a confirmatory test, a HTC service provider will spend a minimum of 30 minutes with the client. If a HTC service provider works from 8.00 am to 5.00pm with a one hour lunch break, the working hours are eight (8). This translates to 8 hours X 60 minutes= 480 minutes per day. Divide this by 30 minutes per client, this gives 16 clients.
However the recommendation is 15 clients per provider taking into consideration other issues like DBS collection for Quality control.
Circumstances may vary and sometimes a HTC service provider may require more time with a client therefore this number may be less. For example, for a positive client who needs a confirmatory test, more time is required and therefore the HTC service provider will test less number of clients per day.
4) Post implementation

**Referral and linkages in Outreach HTC**

Referral is the process by which a client’s immediate needs for care, prevention and supportive services including psychosocial support are assessed, prioritized and client directed to where the services can be obtained. The national referral form is used for this purpose. A copy should be retained at both the HTC service provision level and the referral facility  (See Appendix 6) for monitoring and evaluation.

**Mechanisms for linkages and follow-up**

The HTC service providers should have a current regional referral directory for HIV and AIDS related services and the referral forms.

There are different models for follow-up depending on circumstances.

- **Follow up to referral point:**
  The HTC service provider visits the referral facilities to confirm enrolment within an agreed upon time.
- **Home follow up:**
  Where possible, the HTC service providers make a visit to the client’s home.
- **Community health Worker/ People Living with HIV ( PLHIV) model:**
  With prior consent, the clients can be linked with CHWs or PLWHIVs for follow-up.
- **Phone/ email follow up:**
  The HTC service providers do phone call follow-up.

**Note:** Emphasis of the immediate linkage for PMTCT services for HIV positive pregnant women should be made.

**Integrated OHTC services**

OHTC teams should work in collaboration with other outreach teams from health facility. Where OHTC services are provided alongside other primary health care services, the referral should be done in the same setting.

Outreach HTC services may include integrated services such as screening for STIs, TB, prevention of mother to child transmission (PMTCT), family planning, antenatal and post natal care, nutritional assessment and immunization.
Chapter 4: Management of Community HTC Service

For the proper implementation of community-based HTC services, a functional health system is required. This includes human resource, commodities, quality assurance and data management. This chapter discusses logistics and data management.

1. Logistics management

This is the process of planning, implementing and controlling efficient and effective flow, storage of goods, services and related information from point of origin to point of use, conforming to customer requirements including accountability.

Currently, the following measures to procure and distribute rapid HIV test kits to all HTC service delivery points. (See Appendix 8)

- Responsible person: the overall accountability for all rapid test kits should be under the DMOH, Medical Superintendent, or facility in-charge as may be applicable.
- Supply: NGOs, FBOs, and CBOs providing community-based HTC services shall obtain rapid test kits from the district hospital with the approval of the District Medical Laboratory Technologist.
- Storage: the hospital medical store receives and accounts for all the supplies including rapid test kits. The DMLT then makes a request for test kits for all the users from the store using the laid down procedures.
- Reporting: there is a clear link between distribution of rapid test kits and consumption reporting. Each facility/site provides consumption reports to the district. All the quantifications and supply shall be at the district hospital level. The direct monthly HMIS reports (MOH711) should continue as required.
- Feedback of consumption versus supply of rapid test kits: NASCOP is required to give feedback on how test kits are being utilized per district at least on a quarterly basis. These reports shall be circulated as soon as possible to be able to allow for corrective measures to be taken where necessary.

Types of commodities required

The following commodities should be in place for an effective HTC service provision.

- HIV test kits and their accessories i.e. lancets, pipettes, buffers (subject to testing algorithm)
- QA package: filter paper, zip lock bags, glycerine bags, humidity monitor indicators, desiccants, and racks
- Consumables: all supplies needed to perform a HIV test; alcohol swabs, cotton wool, sharps disposal container, disinfectant, biohazard waste bag, and soap.
- Condoms both male and female
- Other commodities required for community based HTC including cooler boxes, specialized bags, tents/shades may be sourced from partners or other interested parties.

Quantification and forecasting

This is the process of estimation of quantities of a specific item needed for procurement for a specified period of time and the financial requirements needed to procure the items. Static sites should undertake the role of quantifying and forecasting for all the specific items that comprise the HTC requirements for the affiliate community sites.
It is recommended to quantify items for procurement in order to:

- Avoid stock outs
- Avoid wastage due to overstocking
- Make the best use of scarce resources and work within the budget.
- Plan for the expansion of HTC services
- Determine storage needs in a facility

**Recording and reporting of consumption**

There are three tools required for the smooth flow of commodities from the national office to the service delivery point (SDP). These are;

- **Daily Activity Register (DAR):** This is completed by the HTC service provider to capture the daily consumption of commodities.
- **Facility Consumption Data Report and Request (FCDRR):** This report is compiled by the facility in-charge or HTC Coordinator to capture the monthly consumption of commodities and forwarded to the DMLT.
- **District Consumption Data Report and Request (DCDRR):** This is an aggregated report for the district compiled by the DMLT and forwarded to the Logistic Management Unit (LMU) in KEMSA for stock replenishment.

On the basis of this reporting system, the HTC commodities are supplied to SDPs since the country uses the pull system that requires consumption data for replenishment. It is important that accountability is ensured at all levels.

- For expired commodities, or commodities which cannot be used due to their conditions at the sites, they should be handed over to the DMLT who in turn liaises with the public health department for disposal as per the disposal guidelines.
- All partners implementing community services should liaise with the DHMT via the DASCO for proper reporting on service uptake as well as commodity consumption.

**Storage**

- Storage temperatures for the HIV test kits should be maintained and monitored regularly at all levels, and should be maintained as per the manufacturer’s instructions.
- For out reaches, test kits and commodities should always be stored in their packages/cooler boxes to avoid humidity and other external factors that may compromise the accuracy of test results.
- HTC providers should regularly check and avoid kits expiring while in their possession.

**Security**

The security of the community-based HTC team, clients and the equipment should be organized by the agency implementing the activity.

**2. Monitoring and Evaluation**

Proper data recording of community HTC services is extremely important for programming for both resource allocation and evaluation of program outcome. The process helps to achieve the following among others;

1) Determine the level of achievements, challenges in implementation and areas for improvement
2) Continuous documentation of the lessons learnt and best practices for replication of the model or change of strategies
National HTC Indicators

Recording (data collection) and Reporting
HTC service providers should use approved national data collection tools (HIV Testing (HTC) Register: See Appendix 8) to capture the data. The HTC program should ensure that HTC service providers are trained in completing the data collection tools. Completeness and accuracy should be emphasized for data quality to facilitate evidence based decision making.

All records (tools) should be kept and maintained in the integrated/stand-alone sites which are the reference points for provision of community HTC services. Data collected in community-based HTC services should be included in the health facility’s reports.

Data from the community HTC should be captured and reported at the geographic area of service provision. All data captured in community HTC services should be submitted to the reference point.

Confidentiality of the Records
HTC records like any other medical records should be kept confidential in all circumstances. The records should be stored in a lockable cabinet and only accessible to authorized personnel.
Quality Management (QM) is an ongoing effort to provide services that meet or exceed clients’ expectations in an equitable and acceptable manner using the available resources. The National Quality Management Guidance framework (NQMG) and National HTC Guidelines provide guidance on the standards and the quality management systems that need to be put in place in every HTC setting.

Core Principles of Quality Assurance

There are four core principles of quality assurance that will be applied in HTC implementation;

1) **Focus on clients**: client within this context refers to service consumers (patients, clients and community) and service providers (HTC providers and managers) with the goal of meeting the needs and expectations of both.

2) **Focus on systems and processes**: understand and adhere to the different steps and procedures outlined in this manual.

3) **Focus on measurement**: collection and use of data to assess service delivery processes identify gaps, test solutions and measure performance.

4) **Focus on team work**: encourage team approach to service provision, problem solving and quality improvement.

Quality improvement (QI) involves both prospective and retrospective reviews. It is aimed at improvement - measuring where you are, and figuring out ways to make things better. QI attempts to avoid attributing blame, and to create systems to prevent errors from happening.

Sustained QI requires;

- Ownership
- Positive attitude
- Inter-face between Level 1 and other health care of service delivery levels

Ways to ensure QI:

- Weekly review meetings
- Data analysis and use for decision making.
- Client feedback interviews
- Periodic updates and refresher trainings.
- Staff motivation
- Support supervision
- Availability of supplies

Personnel

There are different cadres involved in community-based HTC these range from trained service providers to community health workers. Each of these groups needs to be trained to enable them deliver quality HTC services. Further they also need to have clear job description and responsibilities to enable them work better.

HTC service providers must be trained and certified using the national HTC curriculum.

Community health workers must be trained using the GOK community strategy. S/he should be selected by the community, should be answerable to the community for her/his activities and should be supported by the health system.
For easy identification of HTC service providers in the community, it is important that all workers in the community have identification attire including badges, bags and a letter from the MOH authorizing them to provide services in the community.

**Referral and Continuum of Care**
Referral for services in the community presents various challenges and as such mechanisms should be put in place to strengthen and track referral.
Quality management for referral in community settings requires that community health workers be designated to strengthen referral and ensure that clients referred reach health facilities.
National referral tracking tools should be availed to service providers to issue to referred clients, keep records and track clients to assess effectiveness of the referral systems.

**Quality Management Teams (QMTs)**
Every HTC program should establish a functional quality management team to ensure that minimum standards for service delivery are maintained at all times.
These teams should be multidisciplinary and should meet on a regular basis to assess on the quality of services provided. The teams should utilize standard checklists as well as documented reports and give immediate feedback to stakeholders for improvement.
Refer to Appendix 9 for the role and function of each level.

**Ensuring Quality in HIV Testing**
Quality HIV testing should produce test results that are accurate, reliable, reproducible and timely and it must be conducted as stipulated in the National HTC Guidelines.

Observe correct standards procedures for testing by;
- Adhering to recommended algorithm
- Use kits content as per manufacturers’ instructions.
- Ensure correct volume of sample and buffers are used.
- Proper Timing using a stop watch.
- Proper interpretation of results
- Proper recording of test results

Participation in external quality assurance (EQA) for testing including:
• Proficiency testing (PT); this is where HTC service providers in community setting receive Panels/samples from the national HIV reference laboratory, test, submit their results and receive feedback on the results obtained.
• Validation of testing; this involves collecting dry blood spot (DBS) from the 20th client and submitting to the reference laboratory for validation, to ensure testing standards are maintained and that correct test results are given to clients.
• Quality assurance audits (EQA); these are technical visits conducted by the National P/DMLT on sites with have failed in PT and DBS results. This is done using a standard check list with the aim of correcting the situation. It involves carrying out trouble shooting and auditing the testing process.
Carrier bag
Given that testing in community settings is provided in homes and other settings, HTC service providers are required to make every effort to observe infection control measures. Specifically designed bags that can be converted to testing surfaces and used where the furniture present in the homes does provide suitable surfaces for testing. The bags should be all weather bags that can protect the commodities from the harsh weather and easily disinfected. Further, these specially designed bags should have compartments for bio-hazard containers (including a sharp container) to store contaminated waste before disposal and incineration at the nearest health facility.

Ensuring Quality in Counseling
Quality counseling requires that HTC providers adhere to the following:
• Counseling protocols as provided for by the National HTC guidelines
• Regular self-assessment as provided in the NQMG
• Client satisfaction assessment as per the NQMG
  • Continuous professional development by attending capacity building forums
  • Regular support supervision sessions (at least once every quarter)

Ensure Quality in Logistics management
Ways of ensuring quality logistics:

- Quantifying and forecasting according to their consumption,
- Procure/ordering in a timely manner.
- Maintaining proper records and inventory.

• Store commodities as per manufacturers’ recommendation.
• Distribute commodities to user points as per their requests.

Ensuring Quality in Data Management
Quality data management for community HTC includes:
• Utilizing appropriate nationally approved HTC recording and reporting tools for collecting, analyzing and reporting HTC data.
• Accurate recording and entry of data
• Data audit at site level.
• Confidential and proper storage of client records
• Timely submission of reports to the relevant levels.
• Regular review of reports
• Appropriate feedback


APPENDIX 1: CHILD TESTING

1) United Nations Convention on Rights of Children (UNCRC) Pertaining to HTC


Article 2: All rights should be applied to all children equally and not subject to discrimination of any kind. (Applied to heath care, provision should be made for all children irrespective of—among other things—ethnicity, religion or race.)

Article 3: in all actions concerning children whether undertaken by public or private social welfare institutions the best interest of the (individual) child shall be a primary consideration. This principle will guide HTC service providers in the conduct of their duties and determining whether a child should be tested or not.

Article 12: Due weight should be given to a child’s view in accordance with the age and maturity of the child. (This recognizes children’s unique understanding of their own lives and the need to take their views into account). This right acknowledges that consent and in some cases assent for older children is necessary before providing HTC services to them.

2) Ethical Issues in Child HIV Testing and Counseling

Core principles of HTC: Consent, Confidentiality and Counseling. HTC is built on three core values, Consent, Confidentiality and Counselling. These three values should also be upheld in counseling children.

Minimum Age for HIV Testing

HIV and AIDS prevention and control act (2006) clearly states that “no person shall be tested without their consent”. Anyone aged 18 years or above should be considered able to give full informed consent for HIV testing. A parent’s or legal guardian’s consent is required for testing young people below 18 years of age. Those below 18 years of age and are married, parents or are engaging in behaviour that puts them at risk of HIV infection, should be considered “emancipated minors” who can give consent for HIV testing. Service providers should make an assessment of the minor’s maturity to receive HTC services. In all situations, service providers should ensure the availability of follow-up post-test support services.

HIV Testing and Counseling of Children

The welfare of the child should be the primary concern when considering testing a child for HIV. When children are brought to a facility providing HTC services, the counsellor should discuss with the parents or guardians and the child, if mature, to determine the reason for testing. If the counsellor feels that testing is not in the best interest of the child then the counsellor reserves the right not to test the child.

In such a situation, counselling should be provided to both the child and the parent or legal guardian and HIV testing recommended at an appropriate time or referral made to an appropriate institution.

Informed Consent and Assent for HIV Testing

Informed consent is a phrase often used in the legal terms to indicate that the consent a person gives meets certain minimum standards. In order to give informed consent, the individual concerned should have adequate reasoning faculties and be in possession of all relevant facts and information at the time consent is given.
Assent: this is to agree or concur. Children above 7 years can assent to procedures that affect them. Age relevant information is given and the child allowed assenting, their opinion needs to be respected.

“Informed consent” refers to a child/adolescent or parent/guardian being given an opportunity to:

- Consider the benefits and potential difficulties associated with having access to information regarding the child’s/adolescent’s HIV status
- Have an understanding of the HIV testing procedure
- Make a decision for the child/adolescent either to be tested or not tested for HIV (The child/adolescent or parent/guardian should be able to consider the implications of a positive HIV test result on the child’s/adolescent’s life and the life of his or her family.)

Informed consent for children and adolescents presenting with parent or guardian

The application of the term “informed consent” varies according to the child’s/adolescent’s age. In all cases, the overriding consideration should be the best interests of the child. Below is a general guide for different age groups among children and adolescents, and their capacity to give consent bearing in mind that HIV infected children may have delayed milestones.

0 to 6 years
The child at this stage is totally dependent on the parent or guardian and therefore is not able to give consent. The decision for the child to be tested is solely the parent’s/guardian’s responsibility.

7 to 15 years
At this stage the child/adolescent may have the capacity to understand the implications of the test and therefore assent to HIV testing. However, the law requires that consent for HIV testing be obtained from the parent or guardian, unless the child/adolescent is an “emancipated minor”. In cases where the child does not assent to the HIV test and the parent/guardian consents to the test, then the guiding principle in making a final decision is that the best interests of the child should be taken into account.

16 to 18 years
At this stage the child/adolescent can give his or her own consent for HIV testing.

Informed consent for children presenting on their own
HIV testing services cannot be provided to any child who is below 16 years of age and is not accompanied by a parent/guardian, unless the child is an “emancipated minor”.

HIV testing services can be provided to a child who is aged 16 years and above without the parent’s/guardian’s consent. The counsellor should ensure that the child has an adequate support system and has access to prevention, treatment and care services as necessary.

Confidentiality
The privacy of interactions between provider and client, the material shared with the client should be held in confidence. While working with children it is imperative to negotiate with the child to discuss some of the information with the concerned adults.

Limitations of confidentiality
A counselor needs to assess the child’s understanding of HIV and talk through the issue of confidentiality with them. If a child discloses abuse or identifies an abuser, then confidentiality should be breached to alert the investigating authorities i.e. police and social services.
## APPENDIX 2: REGISTRATION AND LICENSING OF HTC SITES/FACILITIES

<table>
<thead>
<tr>
<th>Settings</th>
<th>Health Facility Setting</th>
<th>Community Setting</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Integrated VCT</td>
<td>VCT and health facilities</td>
</tr>
<tr>
<td>Health Facility</td>
<td>Public and private health facilities</td>
<td></td>
</tr>
<tr>
<td>Type of HTC</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Strategies</td>
<td>CITC</td>
<td>PITC</td>
</tr>
<tr>
<td></td>
<td>Static HTC</td>
<td>Static HTC, any mobile HTC services including workplace etc.</td>
</tr>
<tr>
<td>Registration</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Annual Licensing</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Accreditation</td>
<td>Voluntary for sites that feel they are performing above minimum standards.</td>
<td>Yes</td>
</tr>
<tr>
<td>HTC Signboard or Notice</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Certification of HTC Service Providers</td>
<td>Yes</td>
<td>Yes</td>
</tr>
</tbody>
</table>
APPENDIX 3;

CBHTC SUPPLIES CHECK LIST

1. Counselling protocols
2. HTC register
3. IEC materials
4. PEP register
5. referral directory
6. Referral forms
7. Household lists/census forms
8. Pens
9. notebook
10. Torch
11. first aid kit
12. Male Condoms
13. Female condoms
14. penile models
15. Vaginal models
16. HTC providers identification cards/badge
17. HTC provider self assessment form
18. Cue cards (Key messages)
19. Testing algorithm and protocols
20. Mackintosh
21. Results interpretation charts
22. DBS submission forms
23. Drying box
24. Filter papers
25. Zip lock bags
26. Glycine envelopes
27. Desiccants
28. humidity indicators
29. Spotting rack
30. Drying racks
31. Gloves
32. Lancets
33. Alcohol pad/spirit
34. 10% Hypochlorite solution (Jik)
35. HIV test kits and Buffers
36. Tie breaker kits and buffers
37. Cotton wool
38. Dust Coat
39. Capillary Tubes/Pipettes
40. Sharp containers
41. Biohazards Bags
42. Masking tape
43. Markers
44. paper towels/serviettes
45. Cooler boxes
46. Soap/ hand Wash gel
47. Timer/ stop watch
48. Field gear (e.g. Gum boots, Rain coats etc)
49. carrier bags
50. Chairs
51. Tables
52. Documents folders
53. Bins and bin liners

**Coordination and management**
1. The implementing agency should have an overall CBHTC Coordinator whose role is to organize, plan coordinate and monitor CBHTC activities. This includes:-
2. Creating a field program/plan
3. Establishing eligibility criteria
4. Setting up a system for mobilization homes to be visited
5. Generating a day-to-day list of households to be visited
6. Securing field materials in time
7. Assigning fieldworkers, bearing in mind geographical location and language
8. Guiding preparation of and reviewing provider work plans
9. Ensuring a functional referral system
10. Providing a link with other agencies
11. Organizing refresher trainings.

**Suggestion:**
1) Prepare boxes with list of necessary commodities the same number of counselors and a backup.
2) Each box is stuffed with necessary individual commodities.
3) Each counselor has to have one stuffed box at the beginning of outreach HTC.
4) In case of shortage, the counselor should request to have backup commodities at reception area.
5) At the end of the activity, each counselor has to take an inventory and replace used commodities for next service.
**APPENDIX 4. SPECIFIC PROTOCOLS AS PER TARGETS**

**Individual protocol**
- Introduction and orientation to session
- Risk assessment and risk reduction / benefits of taking an HIV test
- Testing as per MOH as recommended by the algorithm
- Post-test intervention
- Risk reduction (and positive living)

**Couple/sexual partner’s protocol**
- Introduction and orientation to session
- Explore couple/sexual partner’s life-stage and assessment
- Discussion of couple/sexual partner’s HIV risk issues and concerns
- Explore options of couple/sexual partner’s risk reduction
- Preparation for testing and discussion of possible results
- Provide test results
- Disclosure and risk reduction

**Exposed infant protocol**
- Household education-conditions for testing children (testing of parents and exposed infants and children)
  - 0-18 months parental counseling DBS for early infant diagnosis - (could use the current EID algorithm of 12 months for DBS)
  - 18 months non exposed non emancipated counseling with the guardian
  - 13 -18 years emancipated individual concept

**Child protocol**

2 Age group (approximate estimation) and consenting procedures
- 0-6 years old: The guardian/parent should give the consent on behalf of the child.
- 7-15 years old: At this stage the child has the capacity to give assent. Then obtain consent from parent/guardian.

**Protocol for children aged 0 months to 6 years**
This component outlines a counseling session before and after testing the child. The sessions can be either joint child-consenting parent/guardian or for the parent/guardian alone. Counselors should encourage parents/guardians to have joint child-parent/guardian sessions.

**Objectives:**
By the end of the counseling session, the consenting parent/caregiver and/or child will:
1. Recognize the child’s risk for HIV infection or transmission
2. Know the HIV serostatus of the child
3. Have a plan to reduce child’s risk of HIV infection or transmission
4. Know where to access HIV and AIDS support services and programs in their area

---

2 as per National HIV Testing and Counseling Course, Participant’s Guide p34-36
<table>
<thead>
<tr>
<th>Session</th>
<th>Key Steps</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1. Introduction and orientation to test decision session for parent/guardian</strong>&lt;br&gt;<em>(At this stage the child is totally dependant on the parent or guardian and therefore it's not able to give consent. The decision for a child to be tested is solely parents/guardian responsibility)</em></td>
<td>o Introduce the session&lt;br&gt;o Explain counseling and testing procedures&lt;br&gt;o Discuss benefits of testing the child&lt;br&gt;o Explain guidelines for testing children <em>(HIV+ mother, suspected of sexual abuses, orphans, emancipated minors)</em>&lt;br&gt;o Obtain consent to test&lt;br&gt;o Discuss and agree involvement of child in session&lt;br&gt;o Discuss understanding of test results</td>
</tr>
<tr>
<td><strong>2. Pre-test and risk assessment session</strong></td>
<td>o Introduce child to session&lt;br&gt;o Review understanding of test result&lt;br&gt;o Discuss and assess child's risk for HIV <em>(child history)</em>&lt;br&gt;o Discuss risk reduction plan</td>
</tr>
<tr>
<td>Test preparation</td>
<td>o Review understanding of the test results&lt;br&gt;o Draw blood of child</td>
</tr>
<tr>
<td><strong>3. Negative result counseling of child and consenting parent/guardian</strong></td>
<td><strong>Negative result</strong>&lt;br&gt;o Provide test result&lt;br&gt;o Review risk reduction plan&lt;br&gt;o Identify support for risk reduction plan</td>
</tr>
<tr>
<td><strong>4. Positive result counseling of child and consenting parent/guardian</strong></td>
<td><strong>Positive result</strong>&lt;br&gt;o Provide test result&lt;br&gt;o Discuss care and treatment options&lt;br&gt;o Discuss transmission reduction&lt;br&gt;o Discuss coping, mutual support and disclosure</td>
</tr>
<tr>
<td><strong>5. Negative result counseling of consenting parent/guardian alone</strong></td>
<td><strong>Negative result</strong>&lt;br&gt;o Provide test result&lt;br&gt;o Review risk reduction plan&lt;br&gt;o Identify support for risk reduction plan&lt;br&gt;discuss referral if appropriate</td>
</tr>
<tr>
<td><strong>6. Positive result counseling of consenting parent/guardian alone</strong></td>
<td><strong>Positive result</strong>&lt;br&gt;o Introduce child to results counseling&lt;br&gt;o Provide test result&lt;br&gt;o Discuss care and treatment options&lt;br&gt;o Discuss transmission reduction&lt;br&gt;o Discuss coping, mutual support and disclosure&lt;br&gt;o Discuss positive living</td>
</tr>
</tbody>
</table>

**Protocol for children aged 7 years to 15 years**<br>This component outlines the specific steps and key issues that must be covered when conducting HCT with older children. These children will be offered an individual counseling session. Nevertheless, with their assistance, counselors should encourage them to disclose their results to the guardians. For children who are not sexually active and opt to have their consenting parents/guardians participate in the counseling session, the counselor should use the above protocol to guide the session.
**Objectives:**
By the end of the counseling session, assenting individuals will:
1. Recognize their risk for HIV infection/transmission
2. Know their HIV sero-status
3. Develop a plan to reduce their risk of HIV infection/transmission
4. Identify where to access support services and programs in their area

<table>
<thead>
<tr>
<th>Session</th>
<th>Key Steps</th>
</tr>
</thead>
</table>
| 1. Test decision counseling (At this stage the child has the capacity to understand the test and therefore assent to HIV testing, the parent/guardian need to give a consent) | o Introduce the session  
o Explain counseling and testing procedure  
o Discuss benefits of testing  
Review guidelines for consenting, assenting testing and counseling older children  
Consent individual to test |
| 2. Pre-test: risk assessment and risk reduction session | o Introduce child to session  
Review understanding of the test results  
Discuss and assess child’s risk for HIV (Child’s history)  
Discuss risk reduction plan |
| 3. Test preparations | o Obtain consent to test from the child; cases where the child does not consent to HIV test and the parent/guardian consents to the test, the guiding principle is the best interest of the child should be taken into consideration |
| 4. Conduct HIV test | o Review understanding of test results  
Draw blood |
| 5. HIV Negative Result counseling | **Negative result**  
- Provide test result and discuss implications  
- Provide prevention messages  
- Discuss risk reduction and identify safer goal behaviors  
- Refer to available prevention services site  
- Discuss referral if appropriate |
| 3. Positive test result counseling | **Positive result**  
- Provide test result and discuss implications  
- Provide prevention messages  
- Discuss risk reduction and identify safer goal behaviors  
- Discuss supported disclosure and partner testing  
- Refer to available care and treatment services site |

**Family protocol**
All above applies but recognition of separate sessions for children and parents. Disclosure is encouraged
APPENDIX 5. EARLY INFANT DIAGNOSIS

Sample testing procedures for infant

---

3 Guidelines for PMTCT of HIV/AIDS in Kenya, p61
ALGORITHM FOR EARLY DIAGNOSIS OF HIV IN CHILDREN (DECEMBER 2009)

Conduct Maternal or Infant HIV Antibody Test for all children of unknown HIV status to establish HIV exposure status

HIV Exposed Child < 18 Months of age
- Conduct Virologic Diagnostic Test (DBS for DNA PCR) at 6 weeks of age or at first contact after 6 weeks.
- Start Cotrimoxazole at 6 weeks

DNA PCR Positive
- Infant is infected
  - Start on ART
  - Continue Cotrimoxazole

DNA PCR Negative
- Never breast fed
- Child is likely uninfected but continue with follow up
  - Conduct Diagnostic Antibody HIV Test at 9 Months irrespective of wellness of child or before 9 months if child develops signs or symptoms suggestive of HIV.

HIV Antibody Negative
- Review and repeat Antibody Test at 18 months
  - In BF babies, repeat Antibody Test 6 weeks after cessation of BF

HIV Antibody Positive
- Conduct confirmatory Virologic Test (DNA PCR)
- If HIV Antibody Positive, treat as per National Guidelines.
  - If HIV Antibody Negative, Stop Cotrimoxazole but continue with routine Under 5's Follow up.

DNA PCR Negative
- Review and repeat Antibody Test at 18 months
  - In BF babies, repeat Antibody Test 6 weeks after cessation of BF.

DNA PCR Positive
- Start on ART
- Continue Cotrimoxazole

Establishing HIV Exposure of Children
- Exposure status should be determined for all infants of unknown status at the 6 weeks visit or first contact using maternal medical information, maternal or infant HIV Ab testing.

ART Recommendations for HIV Positive Children
- All children confirmed HIV positive by DNA-PCR at 6 weeks or aged <18 months at first contact should be initiated on ART immediately regardless of CD4 count or percentage, and regardless of their WHO clinical stage. A CD4% baseline test should still be taken for monitoring purposes.
- Children aged >18 months, confirmed HIV positive, should be initiated on ART based on CD4 % or WHO clinical staging.
Appendix 6. National Referral Form

MINISTRY OF HEALTH

Community Client/Patient Referral Form

Name of Patient/Client_____________________________

Sex: ☐ Male   ☐ Female   Age: ____________________

Physical Address (Cluster Name/Number)_____________

Referred to: __________________

REASONS FOR REFERRAL

☐ Comprehensive Care Centre

☐ Others (Specify)__________

Comments_______________________________________________________________

_______________________________________________________________________

_______________________________________________________________________

Referred by (Name)____________________ Signature_____________ Date____________
### APPENDIX 7. OUTREACH HTC STANDARD PROCEDURES

<table>
<thead>
<tr>
<th>Activities</th>
<th>Person in charge</th>
<th>By when (date)</th>
<th>Done</th>
</tr>
</thead>
<tbody>
<tr>
<td>Must have a certificate for Outreach HTC services from NASCOP</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Preparation</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. Should be involved host DASCO/DMOH/DHMT in identification outreach HTC site.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Select Outreach HTC (OHTC) sites with the host DASCO.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Should be involved community leaders in the site.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Have a request from the host DASCO/DMOH and/or the site community</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. Send an acceptance letter to the host DASCO/DMOH and/or the site community for an agreement.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. OHTC team (with DASCO) visit the OHTC site in advance to assess the following conditions:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Physical accessibility (distance, road conditions etc.)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Safety</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Good sanitation</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Adequate/private room and/or tents for counseling</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Availability of commodities (desks and chairs)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Water availability</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Availability of local counselors and other human resource (mobilizer, receptionist etc.)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Referral service points</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Accessibility of health facilities providing Post Exposure Prophylaxis (PEP)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7. Estimate no and type of targets, and cost.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8. Confirm budget and its source.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>9. Community mobilization prior to the activity in advance (1 week to 1 day before) with MOH staff and community leaders.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>10. Select qualified and practicing counselors who join the OHTC service.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>11. Confirm travel arrangement including transportation for staff and carry-in commodities.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>12. Confirm carry-in test kits (number, expire date) and other commodities to the site.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>13. Set up time schedule of OHTC at the service days.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>14. Inform counselors, driver(s), and other related staff the schedule of the service days.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>The days of OHTC service</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>15. Set up the HTC site.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>16. Organize reception for the HTC service.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>17. Control client’s flow using numbering ticket.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>18. Conduct HTC service.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>19. Confirm no omission of all clients’ forms/registers.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>After the OHTC activities</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>20. Dispose garbage.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>21. Review the OHTC activity (Have a short conference).</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>22. Send DBS for quality control (QC).</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>23. Settle an account.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>24. Develop reports.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>25. Submit the reports to the following authorities.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- OHTC Activity Report to the host DASCO</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### APPENDIX 8. NATIONAL HIV TESTING (HTC) REGISTER

<table>
<thead>
<tr>
<th>Serial No.</th>
<th>Client Name</th>
<th>Date</th>
<th>HIV Test</th>
<th>CD4 Count</th>
<th>ANS</th>
<th>CD4 T lymphocytes</th>
<th>CD4 %</th>
<th>HIV Viral Load</th>
<th>HIV Status</th>
<th>Referral</th>
<th>Result</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>John Doe</td>
<td>01/01/2022</td>
<td>Positive</td>
<td>500</td>
<td>200</td>
<td>50%</td>
<td>100</td>
<td>Undetectable</td>
<td>Positive</td>
<td>100</td>
<td>Positive</td>
</tr>
<tr>
<td>2</td>
<td>Jane Smith</td>
<td>02/02/2022</td>
<td>Negative</td>
<td>300</td>
<td>150</td>
<td>33%</td>
<td>50</td>
<td>Detectable</td>
<td>Negative</td>
<td>200</td>
<td>Undetectable</td>
</tr>
</tbody>
</table>

**Page Summary**

<table>
<thead>
<tr>
<th>Reason for Referral</th>
<th>Count</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>HIV positive</td>
<td>10</td>
<td></td>
</tr>
<tr>
<td>HIV negative</td>
<td>9</td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>19</td>
<td></td>
</tr>
</tbody>
</table>

**Notes:**

- HIV positive: 10
- HIV negative: 9
- Total: 19
## APPENDIX 9. COORDINATION AND SUPERVISION OF CHTC SERVICE

<table>
<thead>
<tr>
<th>LEVEL</th>
<th>COUNSELING</th>
<th>TESTING</th>
<th>LOGISTICS</th>
<th>DATA</th>
</tr>
</thead>
<tbody>
<tr>
<td>National (policy and regulations)</td>
<td>• Mandatory registration and licensing of HTC sites</td>
<td>National reference laboratory quality control</td>
<td>Procurement storage and distribution</td>
<td>National data base maintained and updated for CHTC</td>
</tr>
<tr>
<td></td>
<td>• Voluntary accreditation of HTC sites</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Review and set national standard and guidelines for HTC</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Provincial</td>
<td>• PASCO supervisory visits, new-site certification visits and annual licensing visits</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Validation of filter papers at provincial reference labs</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>District (where the provider registered)</td>
<td>Counselor support supervision</td>
<td>Laboratory supervisory visits at the CHTC venue to ensure adherence to standards</td>
<td>Quarterly work plan and Collecting and ordering of test kits and consumables</td>
<td>Submission of aggregated data to the host DHRIO/DASCO and keeping a site copy</td>
</tr>
<tr>
<td></td>
<td>• DASCO/DMLT ensures test kits available for CHTC</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• DASCO supervisory visits, new-site certification visits and annual licensing visits</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Host District</td>
<td>• Support community mobilization</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Identifying the local counselors</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Put necessary mechanisms in place for CHTC</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Avail a directory of referral points to the providers</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Receive data from the implementing agency</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>HTC in-charge/ coordinator</td>
<td>• Answerable to the static site in-charge</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Develop and submit a quarterly work plan to DASCO through the static site in-charge</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Follow CHTC procedure by ensuring correct list of requirements prior to CHTC</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Organize regular team meetings</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Monitoring and analysis of client quality (exit interviews)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Submission of reports</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Day-to-day coordination of CHTC activities</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Appoints a team leader for a particular CHTC activity where necessary</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Service Provider</td>
<td>• Attending group, peer and individual supervision</td>
<td>• Adhering to standard operating procedures</td>
<td>• Timely ordering of new test kits and reagents</td>
<td>Accurately completing laboratory records and National CHTC data forms</td>
</tr>
<tr>
<td></td>
<td>• Monitoring own performance</td>
<td>• Collecting samples for QC (10%)</td>
<td>• Use of in-date kits</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Request for CHTC from relevant authorities</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• To be involved in community mobilization</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Advocacy through health centre committees</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Feedback through community meetings</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Participating in client exit interviews with service users</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
APPENDIX 10. POST EXPOSURE PROPHYLAXIS (PEP)

Safety precautions

Standard precautions should be observed in all HTC settings for the safety of the HTC providers and the client. Standard precautions should include hand hygiene (washing hands with soap and running water or use of alcohol hand rub) before a procedure and in between patients, use of gloves during the capillary blood draw and testing process, cleaning and disinfection of surfaces contaminated with blood, safe disposal of sharps in a puncture prove safety box immediately after use. HTC providers be should be immunized against Hepatitis B.

Service providers should have a sharp’s disposable container that can fit into the bag for easy carriage. Infectious and non-infectious solid waste should be segregated at generation. The filled up sharp boxes and infectious waste in yellow bags should be sealed and taken for incineration.

Community HTC setting presents great challenges in waste management and disposal given that HTC services are provided away from static facilities. The CBHTC service organizers that do not have incinerators should make prior arrangements for incineration at the nearest health facility.

SOPs for capillary blood draw, hand hygiene and medical waste management for Community HTC services should be available with all service providers in all settings (mobile, workplace, home testing etc) and should strictly be adhered to.

Infection prevention includes:

Post Exposure Prophylaxis (PEP) of HIV

ARVs should be a part of the commodities package for Post Exposure Prophylaxis (PEP). In the absence of ARVs, transport arrangement to the nearest health facilities where PEP is available within 72 hours should be considered. ARVs are most effective if taken within the first 2 hours of injury.

In case a HTC provider is accidentally pricked during testing, the site should be washed with water and soap and allowed to bleed, but without applying pressure. The provider should then take an immediate (Stat) dose of PEP and later see a clinician for further assessment (HIV and HBV) and management.

Post Exposure Prophylaxis (PEP) of HBV

Hepatitis B is a viral infection transmitted through contact with contaminated blood/ body fluids from an infected person. It is recommended that all HTC service providers be fully vaccinated against Hepatitis B. HTC providers at risk of HBV infection (non-immunized, partially immunized and HBVsAG negative) should receive HBV vaccination and if possible immunoglobulin within 7 days after needle stick injury.
NATIONAL ALGORITHM FOR HIV TESTING IN KENYA
23rd of September 2009

Approved Algorithm for Rapid HIV Testing
Serial Testing

Collect Sample

Screening

Perform test using DETERMINE™ rapid screening test, as approved by MOH

Test result NON-REACTIVE

Test result REACTIVE

Report test result as NEGATIVE

Continue to confirmatory test

Confirmatory Test

Test specimen using second, different rapid test, SD Bioline® as approved by MOH

Test result NON-REACTIVE

Test result REACTIVE

Continue to tie breaker test

Report test result as POSITIVE

Tie Breaker

Test specimen using UNIGOLD™ as approved by MOH

Test result NON-REACTIVE

Test result REACTIVE

Report test result as NEGATIVE

Report test result as POSITIVE
APPENDIX 12. NATIONAL RE-TESTING GUIDELINES

Why do we need re-testing guidelines?
• Limit unwarranted testing
• Limit waste of resources
• Foster early detection of HIV infection
• Enhance early referrals

The objective of the new guidelines is to explain why it is not advisable to recommend re-testing for HIV for all populations and in all settings;
• Clarify the specific populations and settings in which persons who previously tested HIV negative can benefit from re-testing;
• Provide timeframe for retesting;
• Illustrate messages for the different scenarios.

Definition of terms
Repeat Testing: Refers to situation where additional testing is performed for an individual immediately following a first test during the same testing visit due to inconclusive or discordant test results; the same assays are used and where possible the same specimen.

Re-testing: Refers to a situation where additional testing is performed for an individual after a defined period of time for explicit reasons, such as a specific incident of possible HIV exposure within the past three months (window period) or ongoing risk of HIV exposure. Re-testing is always performed on a new specimen.

Recommendations for re-testing
• Based on Indeterminate result
• Based on Population and settings
• Based on Risk

Based on indeterminate result = **Re-test after two weeks**
Based on population setting: Generalized epidemic (Kenya has a generalized epidemic)
• Pregnant – **Re-test in third trimester or in labor**
• Symptomatic patients (STI and TB) – **Re-test after 4 weeks and in every new episode of STI**

Based on risk
• HIV negative persons with on-going risk behaviors – **Retest annually**
  o IDUs, MSMs, Sex workers
  o Persons with HIV –positive partner
  o Persons with partners of unknown HIV status
• HIV negative persons who have had a specific incident of known HIV exposure within the past three months- **Re-test after 4 weeks**
• HIV negative persons who have had a specific incident of possible HIV exposure within the past 72 hours – **Re-test after 4 weeks and 12 weeks**
SUMMARY OF SITUATIONS REQUIRING RETESTING

Re-testing is recommended for HIV negative persons who:

• Have an **indeterminate** HIV test result;
• Are **pregnant women** who have tested negative in the first or second trimester;
• Have an **STI**;
• Are outpatient with **clinical findings suggestive** of HIV;
• Have an **ongoing risk** of acquiring HIV;
• Have **specific incident** of exposure in the past three months;
• Possible **HIV exposure** in past 72 hours