



THE UNITED REPUBLIC OF TANZANIA

MINISTRY OF HEALTH, COMMUNITY DEVELOPMENT,  
GENDER, ELDERLY AND CHILDREN

# NATIONAL COMPREHENSIVE GUIDELINES ON HIV TESTING SERVICES



NATIONAL AIDS CONTROL PROGRAMME



January 2019



## **NATIONAL COMPREHENSIVE GUIDELINES ON HIV TESTING SERVICES**

Ministry of Health, Community Development Gender Elderly and Children  
National AIDS Control Programme (NACP)

P.O. Box 743,

**40478 DODOMA.**

Website: [www.nacp.go.tz](http://www.nacp.go.tz)

Email: [info@nacp.go.tz](mailto:info@nacp.go.tz)

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The Permanent Secretary,  
Ministry of Health, Community Development, Gender, Elderly and Children,  
P.O. Box 743,  
**40478 DODOMA**

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## ABBREVIATIONS AND ACRONYMS

<b>AIDS</b>	Acquired Immune Deficiency Syndrome
<b>ANC</b>	Antenatal Clinic
<b>ART</b>	Anti-Retroviral Therapy
<b>AYWG</b>	Adolescents, Young Women and Girls
<b>CDC</b>	Centres for Disease Control and Prevention
<b>CICT</b>	Client-initiated Counselling and Testing
<b>CTC</b>	Care and Treatment Clinic
<b>DNA</b>	Deoxyribonucleic Acid
<b>ELISA</b>	Enzyme-Linked Immunosorbent Assay
<b>EMTCT</b>	Elimination of Mother-to-Child Transmission
<b>EQA</b>	External Quality Assessment
<b>EPI</b>	Expanded Programme on Immunisation
<b>HBV</b>	Hepatitis B Virus
<b>HCV</b>	Hepatitis C Virus
<b>HIV</b>	Human Immunodeficiency Virus
<b>HIVST</b>	HIV Self-testing
<b>HTS</b>	HIV Testing Services
<b>IPT</b>	Isoniazid Preventive Treatment
<b>MAT</b>	Methadone Assisted Therapy
<b>MCH</b>	Maternal and Child Health
<b>M&amp;E</b>	Monitoring and Evaluation
<b>MOHCDGEC</b>	Ministry of Health, Community Development, Gender, Elderly and Children
<b>MSM</b>	Men who have Sex with Men
<b>NACP</b>	National AIDS Control Programme
<b>NHL-QATC</b>	National Health Laboratory Quality Assurance Training Center
<b>NGO</b>	Non-Governmental Organization
<b>OST</b>	Opioid Substitution Therapy
<b>PCR</b>	Polymerase Chain Reaction
<b>PEP</b>	Post-Exposure Prophylaxis
<b>PHC</b>	Primary Health Care

<b>PITC</b>	Provider-Initiated Testing and Counselling
<b>PMTCT</b>	Prevention of Mother-To-Child Transmission
<b>PPV</b>	Positive Predictive Value
<b>PrEP</b>	Pre-Exposure Prophylaxis
<b>PT</b>	Proficiency Testing
<b>PWID</b>	People Who Inject Drugs
<b>PWUD</b>	People Who Use Drugs
<b>QA</b>	Quality Assurance
<b>QC</b>	Quality Control
<b>RDT</b>	Rapid Diagnostic Test
<b>RMNCH</b>	Reproductive Maternal Newborn and Child Health
<b>RNA</b>	Ribonucleic Acid
<b>SBCC</b>	Social and Behaviour Change Communication
<b>SRH</b>	Sexual and Reproductive Health
<b>SOP</b>	Standard Operating Procedure
<b>STI</b>	Sexually Transmitted Infection
<b>TB</b>	Tuberculosis
<b>UN</b>	United Nations
<b>UNAIDS</b>	Joint United Nations Programme on HIV/AIDS
<b>UNDP</b>	United Nations Development Programme
<b>UNFPA</b>	United Nations Population Fund
<b>UNICEF</b>	United Nations Children’s Fund
<b>USAID</b>	United States Agency for International Development
<b>VCT</b>	Voluntary Counselling and Testing
<b>VMMC</b>	Voluntary Medical Male Circumcision
<b>WHO</b>	World Health Organization

## FOREWORD

The Ministry of Health Community Development Gender Elderly and Children recognizes HIV testing services as a critical entry point to HIV care, treatment, support and prevention services. It is expected that when people know their HIV status, they will make an informed choice on HIV prevention or if positive, access other services. In the country, HIV testing service has been available since 1989 and is used primarily for screening blood supplies, and for diagnosis of HIV and AIDS.

These guidelines provide a framework for effective action to facilitate access to safe and ethical testing services for different population groups. The implementation of the a comprehensive approach, known as HIV Testing Services (HTS) is cardinal as an effective package of services that diminishes the impact of the HIV epidemic in our country. All forms of HTS adhere to the 5Cs: Confidentiality, Counselling, Consent, Correct results and Connection, or linkage to care, with all based within a human right context. In addition to the 5Cs, however, the MOHCDGEC emphasizes the use of a variety of approaches to HTS that will reduce the number of missed opportunities. These include Provider-Initiated Testing and Counselling testing, Couple counselling and testing, Index testing, and infant and children counselling and testing in alignment to the revised WHO guidelines. Furthermore, these guidelines accentuate on the continual provision of integrated HTS service at all levels of the public and private health service delivery system.

The HTS Providers, managers and other stakeholders at all levels are required to make extensive use of these guidelines. They are also urged to provide to the MOHCDGEC any feedback that might be useful for the implementation of future editions of the guidelines.



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**Dr. Zainab A. S. Chaula**

**PERMANENT SECRETARY (HEALTH)**

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**Prof. Muhammad Bakari Kambi**  
**Chief Medical Officer**

## DEFINITION OF TERMS

**Accreditation** is a procedure by which an authoritative body gives formal recognition that an organization/individual is competent to carry out specific task<sup>1</sup>

**Certification** refers to the action or process of providing an individual or institution with an official document attesting to a status or level of achievement.

**Early infant diagnosis** is the testing of infants to determine their HIV status, given that HIV can be acquired in utero (during pregnancy), per partum (during delivery), or postpartum (after delivery through breastfeeding), or via parenteral exposure.

**External quality assessment scheme** is an inter-laboratory comparison to determine if the HIV testing service can provide correct test results and diagnosis.

**External quality assessment** is the monitoring of performance through direct observation and supervision or inter-laboratory comparisons by participating in an external quality assessment scheme (sometimes known as proficiency testing).

**HIV self-Testing (HIVST)** is a process in which an individual collects his or her specimen (Oral fluid or blood) and then performs a test and interprets the test result often in private. Both reactive and non-reactive test results must be followed by additional HIV testing services

**HIV Testing Services (HTS)** comprise a full range of services that a client is offered together with HIV testing. These include counselling (pre and post testing); linkage to appropriate HIV prevention, care and treatment and support; and coordination with laboratory services to support quality assurance and delivery of correct results.

**High and low volume sites** refer to testing sites that perform 25 HIV tests in a day and less than 25 HIV tests in a day, respectively.

**Index testing** refer to a focused HIV Testing Service approach in which the sexual partners, partners of drug users and family members (including children) of people diagnosed with HIV are offered HIV testing services. It is also referred to as index-case or index patient HIV testing.

**Internal Quality Control** is the process or mechanism to detect, reduce and correct deficiencies in a laboratory internal analytical process prior to release of patient results, in order to improve the quality of the results reported. The appearance of a control line for HIV Rapid Diagnostic Test is an example of a passed internal QC.

**Invalid HIV test result** is a test result obtained from a device that does not have a control line.

**Key and Vulnerable Populations (KVPs)** are groups of people who, due to specific high-risk behaviour, are at increased risk of contracting HIV, irrespective of the epidemic type or local context. In Tanzania, KVPs include: 1) men who have sex with men, 2) people who inject drugs, 3) sex workers 4) people in prison and other closed settings.

<sup>1</sup> Modified from ISO/IEC17000(refer to POTC guideline)

**Men who have sex with men** refer to all men who engage in sexual and/or romantic relations with other men.

**Non-reactive result** refers to an HIV antibody or HIV antigen/antibody test result that does not show a reaction to indicate the presence of HIV antibodies and/or antigen.

**Pre-test information** is a dialogue during which accurate information is provided by a trained HIV Testing Service provider or health worker before an HIV test is performed.

**Proficiency testing** is the testing of unknown samples sent to a testing point or laboratory by an approved program. It is used to verify the accuracy and reliability of the testing point or laboratory.

**Quality assurance** is any systematic process of determining whether a product or service meets a specified requirement (appearance of a control line for HIV RDTs is an example of a passed internal QC.)

**Quality control** is an assessment of product compliance with stated requirements.

**Quality improvement** is an approach to the study and improvement of the processes of providing health care services to meet client needs.

**Quality management system** is a systematic process-oriented approach to meet quality objectives.

**Reactive result** refers to an HIV antibody or HIV antigen/antibody test result that shows a reaction to indicate the presence of HIV-1/2 antibodies or p24 antigen.

**Repeat testing** refers to a 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.

**Retesting** refers to certain situations where individuals should be tested after a defined period of time for example in the case of inconclusive test results, for HIV-negative individuals with recent or on-going risk of exposure, and HIV-positive individuals before they are enrolled in care and initiate treatment.

**Rapid diagnostic test (RDT)** refers to in-vitro diagnostics of immunochromatographic or immune filtration formats for the detection of HIV-1/2 antibodies and/or HIV p24 antigen.

**Sensitivity** denotes the probability that an HIV assay/algorithm will correctly identify all specimens that contain HIV-1/2 antibodies and/or HIV p24 antigen.

**Specificity** denotes the probability of the assay/algorithm to correctly detect specimens that do not contain HIV-1/2 antibodies and/or HIV-1 p24 antigen.

**Sero-discordant couple** refers to a couple with conflicting (different) HIV test results, where one partner is HIV-positive and the other is HIV-negative.

**Task sharing** is the rational redistribution of tasks and expanded scope of work among different cadres of health-care providers, such as trained workers.

**Testing strategy** is a testing approach used to meet a specific need, such as for blood safety, surveillance and/or diagnosis.

**Testing algorithm** is the combination and sequence of specific assays or tests used in a given HIV testing strategy as approved by the MOHCDGEC.

**Window period** is the period between HIV-infection and the detection of HIV-1/2 antibodies using a serological test.

**People who inject drugs** refer to people who inject psychotropic (or psychoactive) substances for non-medical purposes.

**People who use drugs** include people who use psychotropic substances through any route of administration, including intravenous, oral, inhalation, transmucosal (sublingual, rectal, intranasal) or transdermal.

**Sex workers** include female and male individuals who receive money or goods in exchange for sexual services (usually as the main source of income).

**Vulnerable populations (VPs)** include adolescents and young women, orphans, street children, people with disabilities, migrant and mobile workers.

## EXECUTIVE SUMMARY

The Tanzania HIV Impact Survey (THIS) conducted in 2016-17, revealed that the prevalence of HIV among adults aged 15 to 49 years is 4.7 percent. The HIV prevalence was higher among adult females (6.2 percent) than males (3.1 percent). According to these results, there are approximately 1.4 million people living with HIV (PLHIV) in Tanzania and only 61% of them know their HIV positive status. This depicts an HIV positive identification gap of approximately 29% for Tanzania to attain the Joint United Nations Programme on HIV/AIDS (UNAIDS) first of the 90-90-90 target, whereby 90% of PLHIVs must be identified and linked to HIV services by 2020.

These HTS guidelines were developed to provide guidance on strengthening HIV testing approaches that will enhance uptake, equitable access and coverage of HTS. The guidelines contain several new recommendations aimed to improve on the previous practices in Tanzania. These include:

1. Giving more attention to key populations and vulnerable groups: Special efforts should be made to ensure that key populations and vulnerable persons have access to HIV testing services, and these services will be provided without discrimination or stigma.
2. Index client testing: HTS Providers will ask people diagnosed with HIV about their sexual partners, drug injecting partners and biological children, and with consent of the HIV positive client, these partners and children will be offered voluntary HIV testing.
3. Task Sharing: Engaging other medical and non-medical cadres in the health sector on HIV Testing Services.
4. Testing for verification: Persons who test HIV positive should be re-tested prior to ART initiation to rule out misdiagnosis.
5. “Window period” re-testing: For most people who test non-reactive or negative, there is no need for additional re-testing to rule out being in the window period. However, those persons who test non-reactive but report recent exposure or recent risk of getting infected with HIV, should be told to return for re-testing in 4 weeks.
6. Quality assurance and Improvement for HIV testing: This has been re-emphasized in this guideline as a key strategy to ensure quality HTS and correct HIV diagnosis for each individual accessing these services.
7. Inconclusive results: Persons who test reactive on the first test and non-reactive on the second test are considered to have inconclusive results and should be tested again on same setting/day using the approved national testing algorithm. If the repeat tests remain different, this is called inconclusive and these persons should return for repeat testing after 14 days.
8. Correct recording and timely submission of data: This is an essential component of a strong HTS programme. Health facilities that provide HTS should ensure that HIV test results are recorded accurately and data submitted on time.
9. Service Delivery Models for differentiated HIV services: These models aim to reach different population groups with appropriate HTS.
10. HIV Self-Testing: These guidelines mention about the prospect of adopting HIV Self-testing interventions as a tool to identify PLHIV.



## CHAPTER ONE: INTRODUCTION

### 1.1 Background

The HIV epidemic in Tanzania, since the first reported case in 1983, continues to represent a major disease burden. The country has a generalized stable epidemic with estimated 4.7 % of adult population to be living with HIV in 2017<sup>2</sup>. However, the burden of the epidemic varies considerably between different geographical regions, sex and population groups. HIV prevalence is higher in sub-groups such as people who inject drugs (PWID) (16-51%)<sup>3</sup>, men who have sex with men (MSM) (22-42%)<sup>4</sup>, and mobile populations and sex workers (14-35%)<sup>5</sup>. Women are disproportionately more affected, with an HIV prevalence of 6.2% versus 3.1% among men<sup>2</sup>.

HIV testing is a critical entry point to HIV prevention, care, treatment and support services. The Tanzania HIV Impact Survey (THIS) conducted in 2016-17, revealed that only 61% of People Living with HIV know their HIV positive status<sup>2</sup>. This depicts a big gap on HIV diagnosis of approximately 29% in order for Tanzania to attain the UNAIDS 90-90-90 targets by 2020, which translate as 90 per cent of PLHIV know their HIV status, 90 per cent of these testing HIV positive have been enrolled into and access antiretroviral treatment and 90 per cent of those taking ARVs have sustainable viral suppression i.e. a viral load more than 1000 copies/millilitre. Similarly, the country has a goal of 90% of PLHIV to be aware of their HIV positive status by 2020 as outlined in the Health Sector Strategic Plan IV.

### 1.2 Evolution of HTS in Tanzania

HIV Testing Services were initiated in Tanzania in 1989 as Voluntary Counselling and Testing (VCT) and are now commonly known as Client Initiated Testing and Counselling (CICT). The National Guidelines for VCT were developed in 2005<sup>6</sup>. Following the introduction of ARV in 2004, additional/new HIV testing approaches were instituted, and the HIV testing guidelines were revised in 2013.

### 1.3 Challenges in HTS in the Context of the UNAIDS “90 -90 -90” Strategy

The following challenges are foreseen in the implementation of HTS in the context of the UNAIDS “90-90-90” Strategy. People’s knowledge of their HIV status through HIV testing services (HTS) is crucial to the success of the HIV response. However, the following challenges will need to be addressed for the success of the programme:

- Low access of HTS for different population groups, different age and sexual groups and in different geographical areas

2 Preliminary Summary Findings: Tanzania HIV Impact Survey 2016-17

3 The United Republic of Tanzania, Ministry of Health and Social Welfare; national aids control programme and Muhimbili university of Health and allied sciences, Dar es salaam. Integrated Bio-Behavioral Survey Among People Who Inject Drugs in Dar es Salaam. April 16, 2014

4 Leshabari et. A; Prevalence of the Human Immunodeficiency Virus, other sexually transmitted infections, and health-related perceptions, reflections, experiences and practices among men having sex with men in Dar es Salaam,2013

5 National AIDS Control Programme; A study of Female Sex Workers in seven Regions: Dar es Salaam, Iringa, Mbeya, Mwanza, Shinyanga, Tabora and Mara. A Report published in 2014 (ISBN 978-9987-650-83-5)

6 National Guidelines for Voluntary Counselling and Testing, 2005

- Late or delayed linkage to prevention, care, treatment and support.
- Missed opportunities for increasing HTS coverage through integration with other services.
- Suboptimal quality of HIV testing services.

#### **1.4 Justification for the Revised Guidelines**

Tanzania has adopted UNAIDS' 90–90–90 strategy, which calls for 90% of all people living with HIV to be diagnosed, 90% of people living with HIV who are diagnosed to receive ART and 90% of those on ART to have a suppressed viral load by 2020. As the main entry point for the HIV continuum of care is through HIV testing it is of concern that only 52% of PLHIV have been diagnosed, there is therefore urgency for increased availability of HTS services. Revising the HTS guidelines in line with global guidance and renewing emphasis on quality, efficiency, yield and linkages is a prerequisite for the country to attain stated targets. A variety of HTS modalities should be utilised to reach targeted populations in different settings. This policy guideline provides a framework for all HTS modalities that should be implemented in the country.

#### **1.5 Goal and Objectives of the HTS Guidelines**

The primary goal of the updated HTS guideline is to provide consolidated guidance for a national HIV approaches to HIV testing services.

##### *Specific Objectives*

1. Provide comprehensive evidence-based policy guidance for the delivery of HTS, using a mix of approaches appropriate to the Tanzanian context.
2. Provide guidance to ensure the delivery of accurate test results and strengthen quality assurance for HTS.
3. Define HTS package for key and vulnerable populations who are societal marginalized and culturally stigmatized.
4. Offer guidance on scaling up targeted community-based approaches and services delivered by HTS trained health care providers.
5. Provide guidance for strengthening referral and linkages to prevention, care and treatment and other post-test services.
6. Outline data collection, reporting mechanisms and utilization.
7. Describe the responsibilities of various players in HTS guidelines implementation and monitoring

#### **1.6 Target Audience**

This document is intended for use by several institutions and individuals, including the following:

- i) HIV and HTS policy makers and HTS service providers at national, regional, district and community levels;
- ii) Health facility management teams in public or private health facilities;

- iii) HTS providers including laboratory managers and laboratory focal persons for HIV testing and quality services and their supervisors in all settings (facility and community based) and their respective organisations;
- iv) HIV focal persons in all Ministries, private sector, academia and implementers of work place based interventions.
- v) Ministerial departments/units directly involved in HIV and AIDS prevention, care, treatment and support services in different sectors.
- vi) Development partners and donors, particularly their support in the dissemination and roll-out of these guidelines in collaboration with their implementing partners;

### 1.7 The Development of the HTS Guidelines

The HTS guidelines were developed through a consultative process led by the MOHCDGEC. Field visits (review of progress reports, in-depth interviews and observation) provided evidence on existing HTS best practices in the country. The drafting of the guidelines was also informed by the Health Sector HIV/AIDS Strategic Plan IV<sup>7</sup>, the Differentiated Service Delivery Models Initiative<sup>8</sup>, the National Care and Treatment Guidelines<sup>9</sup>, the KVP Guidelines<sup>10</sup>, other key Government policy documents and the 2015 World Health Organization HIV Testing Services guidelines.<sup>[11,12;13]</sup> HTS guidelines from selected neighbouring countries available online were also very informative.<sup>[14,15;16;17, 18]</sup>

7 URT, Health Sector HIV/AIDS Strategic Plan IV, 2017

8 URT, PEPFAR, I-TECH -Mapping HIV Service delivery Models in TANZANIA, 2016.

9 URT, MOHCDGEC, NACP, National Guidelines For The Management of HIV and AIDS Sixth Edition, 2017

10 URT, MOHCDGEC, NACP, National Guidelines for Comprehensive Package of HIV Interventions for *Key Populations*.

11 Tanzania Third National Multi-sectoral Strategic Framework for HIV and AIDS (NMSF III) 2013/14-2017/18

12 URT- MOHCDGEC, Task Sharing Policy Guidelines for Health Sector Services in Tanzania, January 2016

13 URT- MOHCDGEC, NACP, National Guidelines for Community Based HIV and AIDS Services.

14 Ministry of Health, Kenya. NASCOP; Guidelines for HIV Testing Services in Kenya. Nairobi: 2015.

15 Uganda. Ministry of Health. 2003. Uganda national policy guidelines for HIV voluntary counseling and testing. Kampala: Ministry of Health.

16 Ministry of Health Malawi, HIV Testing Services Guidelines, 2016

17 Republic of South Africa, Health Department; National HIV Testing Services: Policy 2016

18 URT, MOHCDGEG National HIV rapid tester's certification framework 2017

## CHAPTER TWO: CORE PRINCIPLES OF HIV TESTING SERVICES

### *Preamble*

HIV testing services shall be conducted with the client in mind and in the client's best interests, in line with national and international standards for health care service delivery and human rights principles. HTS shall respond to the needs and risks of clients or patients. In view of that, all HTS shall adhere to five C core principles of HTS namely: Counselling, Consent, Confidentiality, Correct results and Connection.

### **2.1 Counselling**

Appropriate and effective counselling is an important catalyst for encouraging behaviour change by an individual who after learning her/his HIV status, is supported to seek referral to other HIV prevention, treatment, care and support services.

Therefore, all HTS providers shall ensure that:

- All HTS include accurate and sufficient pre and post-test counselling sessions.
- The Pre-test counselling is provided in a one-on-one or group setting, but all clients or patients should have the opportunity to ask questions in a private setting.
- HIV testing must be followed by appropriate and high quality post-test counselling based on the HIV test results. It should address the unique needs and risks of the HTS clients or patients.

### *When HTS is declined*

When a client or patient refuses to give consent for HTS, the HTS provider shall:

- The client shall not be denied access to other health services.
- Record the decision to decline in the HTS register so that a discussion of HTS can be re-initiated at subsequent visits to the health facility.

### *Counselling Couples*

When counselling couples for HTS, the providers shall encourage both partners to:

- Be counselled and receive their test results together.
- Keep each other's test result private and confidential.
- Discuss HIV risk concerns together and support one another.

### **2.2 Consent**

All clients or patients receiving HTS must be provided with sufficient information about HIV testing and counselling so that they may give their explicit and voluntary informed consent to receive these services. The information should generally include:

- Benefits and implications of knowing one's HIV status and/or the reasons for recommending HTS.
- HTS process and procedures.
- Recognition of the client's right to withdraw consent at any time.
- Availability of follow-up treatment, care and support, and prevention services.
- Importance of disclosure, index and social network testing and availability of couples HTS.

### *Age of Consent*

The current guidance on the age of consent and procedures to have an HIV test is in accordance with the Tanzania HIV and AIDS Prevention and Control Act (2008)<sup>19</sup> and its regulations that are under discussion for policy revision. The Act states that:

- Individuals above 18 years of age and those below 18 years but married, pregnant, sexually active, or otherwise believed to be at risk for HIV infection, may give consent to access HTS.
- A young person below 18 years of age who does not meet the criteria mentioned in the preceding sentence should receive HTS after receiving consent from their parent or legal guardian.
- All children or youth who receive HTS shall be supported to disclose their results to their parents/guardians.
- For persons with auditory, visual or mental impairment and those who cannot write, a thumb print should be obtained and be regarded as informed consent.

### *When Consent is not necessary*

Consent shall not be required in the following specific situations:

- When HIV testing is ordered by the court of law.
- For human organs and tissue donations.
- For sexual offenders.
- Medical Practitioners may conduct HIV testing for patients without their consent if the person is unconscious and unable to give consent and they reasonably believe that the HIV test is clinically necessary or otherwise in the best interest of the patient.

## **2.3 Confidentiality**

HIV Testing Services are confidential. The HTS provider shall not share any information discussed with the client(s) or patient(s) with another person, unless the client(s) or patient(s) give consent. Therefore:

<sup>19</sup> The HIV and AIDS (Counselling, the Use of ARVs and Disclosure) Regulations, 2010

- HTS providers must remain committed to preserving confidentiality on the test results and any personal information, for example, information concerning their sexual behaviour and the use of illegal drugs, and
- Avoid practices that can inadvertently reveal test results to others in the waiting room or in the health facility.
- Health facility management should ensure that all HTS providers receive training regarding the confidentiality of medical records.

### *Confidentiality among Couples/Sexual partners*

With regards to HTS for couples and people in a sexual relationship, both partners should be encouraged to keep one another's HIV test results confidential until they decide together to disclose their results to another person/s i.e. shared confidentiality between the HTS providers and both partners.

### *Confidential Record Keeping*

Confidentiality in HTS maintains the same underlying principles as confidentiality of other medical information and records. It is meant to protect the dignity of clients and patients. Health facility management and HTS providers shall ensure that: -

- All personnel with access to clients' or patients' medical records shall be trained in procedures to maintain confidentiality.
- Clients' and patients' records shall be stored in lockable cabinets or rooms.
- Only staff with a direct role in the client's or patient's management, or specific data management staff shall have access to these medical records.

### *Correct test results*

All HTS providers should adhere to the national HIV testing algorithm and ensure provision of high-quality testing services and correct diagnosis as outlined in Chapters Six and Seven. Misdiagnosis of HIV status or presentation of HIV false positive results has been reported to be occurring in some resource-limited settings, there is therefore need to provide the client with correct test results.

## **2.5 Connection to services**

The expansion of HTS must be supported by effective and efficient linkage to HIV prevention, care, treatment and support services. It is the responsibility of all health facility

managers, HTS programmes and HTS providers to ensure that HTS clients and patients are connected with appropriate follow-up services.



## Chapter 2: Key messages

All forms of HIV testing should observe human rights and dignity and adhere to the WHO's "5 Cs", namely:

**Consent:** People receiving HTS must give informed consent to HIV testing.

**Confidentiality:** HTS providers must ensure that test results and discussions between provider and client are not disclosed to a third party without the consent of the person/s being tested.

**Counselling:** All HTS must include accurate and sufficient pre and post-test counselling sessions.

**Correctness:** Providers of HTS should strive to provide high-quality testing services. Quality Assurance mechanisms should ensure that people receive a correct diagnosis

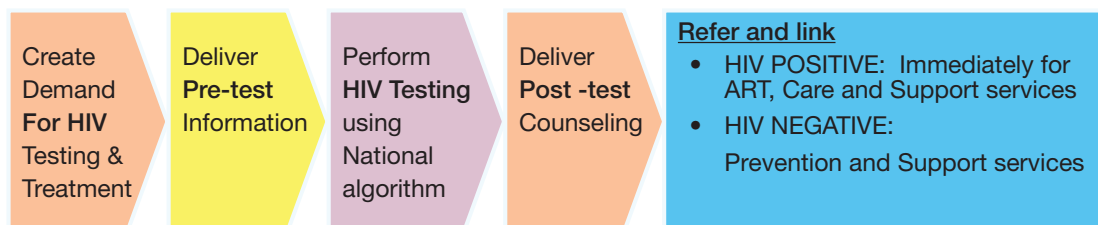
**Connection:** In the context of "test and treat" HTS providers should ensure they provide immediate linkage to treatment, care and support services.

## CHAPTER THREE: HIV TESTING SERVICES (HTS) PACKAGE

### Preamble

When a client/patient receives an HIV diagnosis it empowers them to make an informed decision about HIV prevention, treatment, care and support services. The HTS package recommended in Tanzania includes demand creation, pre-test information, HIV testing, post-test counselling, and successful linkages to prevention, treatment, care and support services for both HIV positive and HIV negative individuals (Figure. 3.1).

Figure 3.1: HIV Testing Service Package



### 3.1 Promotion of HIV Testing Services

Promotional activities focus on informing communities/individuals about the availability and benefits of HTS as well as sensitising, mobilizing and creating demand for HTS for communities/individuals. These activities aim at increasing support and utilisation of HTS, changing norms and reducing stigma. The information provided should be accurate and relevant to the target population, culturally sensitive, and should reflect current evidence and technological advances. The MOHCDGEC, Regional Medical Officers (RMOs) and District Medical Officers (DMOs) shall be consulted to provide support for the development of promotional materials and activities.

Some of the common examples of promotional activities include:

- Conducting Mass and Social Media campaigns,
- Development and distribution of information, education and communication (IEC) materials, and targeted community mobilization,
- Posting signboards with information and messages on benefits of knowing your HIV Status
- Provision of HTS as Combination Prevention interventions services package.

#### Mass and Social Media

Mass and social media are used to communicate messages about HIV testing and related services to an entire population or to specific segments of the population. Therefore;

- Health Management and HTS providers may select the following channels for mass and social media:



- Billboards, television, radio, newspapers, road shows, and folk media
- Applications such as WhatsApp, Face Book and Twitter.
- The MOHCDGEC shall approve HTS related mass and social media messages.

### *Information, Education and Communication (IEC) Materials*

High quality IEC materials are important elements of promotional activities for HTS. Effective IEC can be achieved through: -

- Increasing awareness and creating demand for HTS and related services both at health facility and community levels.
- Ensuring the availability of printed and/or electronic materials addressing all elements of the HTS package at all HTS sites.
- Providing materials in Kiswahili and English with culturally appropriate illustrations and graphics.
- Short video clips can be shown at the health facility and public places.

### *Advocacy, Sensitization and Mobilization*

HTS providers shall:

- Engage community leaders, community HTS providers such as trained Community Health Workers (CHW), Peer support groups and PLHIVs to provide information for the promotion of HTS at public community functions or during interpersonal communication with individuals, couples, and family members.
- Ensure that the information and messages shared with communities are accurate, culturally sensitive and consistent.
- Collaborate with CHWs and PLHIVs who are effective in providing messages and reaching specific populations.

### *Signboards*

All facilities and sites providing HTS shall have signboards clearly marked that HTS are offered with no fee. The signboard shall indicate the days and time when the services are offered. Within the facilities, each HTS delivery point shall also be marked, e.g. on the door, indicating that HTS are offered at that respective point.

### **Combination Prevention Interventions**

Another approach for providing information about HTS is through periodic campaigns. In order for these campaigns to be most effective the organizers must:

- Have prior planning sessions with national/regional or districts officials to ensure availability of adequate testing resources for the demand created.
- Ensure that the campaigns target specific populations or groups of people that may be at an elevated or continued risk of contracting HIV.
- Continuously monitor the campaign theme to ensure that it remains relevant throughout the duration of the campaign.

### **3.2 Creating an Enabling Environment**

All HTS providers should be aware of critical enablers, i.e. elements outside the health sector that facilitate the provision of effective and safe HIV Testing Services. Critical enablers are key to the success of health sector HIV interventions. Examples of such elements are: -

- **Preventing violence:** HTS providers shall set conducive environment that will protect safety and privacy of clients/patients. This will ultimately help to minimize violence from family members, employers and the larger population in relation to their HIV status.
- **Flexibility for testing time:** HTS should be provided during all hours that health facilities provide other services including weekends and public holidays.

### **3.3 Pre-Test Sessions**

Once a client(s) or patient(s) has/have completed registration they shall receive basic pre-test information that will help them to understand the reasons for testing, HTS processes and procedures, and the possible test results they may receive.

Pre-test information/counselling shall be provided to individuals, couples, families, or groups. Couples shall be encouraged to receive pre and post-test counselling together.

When group pre-test information is provided, client(s) or patient(s) should still be given the opportunity for an individual pre-test session with an HTS provider to address any personal concerns or questions.

Ask if the Patient/Client is participating in the Vaccine Trail and its implication on the results

Additional counselling and condom demonstration should be conducted during the HIV test.

The sessions can be shortened through the use of multimedia channels as outlined in section 3.3.1.

### *Minimum standards for Pre-test Information for all populations*

The aim of the pre-test session is to offer or recommend HIV testing to a client or a group of clients. Therefore, the HTS provider shall provide clear and brief information including:

- Information on the different modes of HIV transmission
- The benefits of HIV testing
- The meaning of an HIV-positive and an HIV-negative test result
- Clear information on the services available in the case of an HIV-positive or negative test result.
- Assurance that the test result and any information shared by the client is confidential.
- Information on the Client's option to refuse to be tested and assurance that declining a test shall not affect the client's access to other services.
- Assessment of risk behaviours and appropriate counselling
- Discuss the importance of Index testing and Partner Notification Services
- Information on the risks associated with blood contact.
- Provide assurance to client participating in the HIV Vaccine Trail on vaccine induced sero-positivity.

### *Special considerations for pregnant or postpartum women*

Pre-test information or health education for pregnant women or women who may become pregnant should include:

- The benefits of early HIV diagnosis for mothers and infants.
- The potential risks of transmitting HIV to the infant
- Measures that should be taken to reduce mother-to-child transmission if a pregnant woman is diagnosed as HIV positive, including the immediate initiation of ART to benefit the mother and prevent HIV transmission to the infant.
- The importance of testing their sexual partner and adopting safer sexual practices.

### *Special considerations for couples or sexual partners*

Couples' counselling and partner testing promote mutual disclosure of HIV status and increase the adoption of prevention measures, especially in the case of discordant couples. HTS providers should ensure that pre-test information session for couples: -

- Is offered together. If they refuse, then they should be provided pre-test counselling individually.

- Focuses on current generalised risk assessment rather than concentrating on past sexual behaviour or risks.
- Includes an explanation that disclosure of HIV status to another person/third party is desirable but must be done with consent from both partners.

### **3.4 HIV Testing**

After the pre-test session, HIV testing shall be conducted according to the National HIV Testing Algorithm and Quality Assurance procedures outlined in chapters 6 and 7.

### **3.5 Post Test Counselling Session**

All individuals who received an HIV test should be offered quality post-test counselling when being given their HIV test results. Post-test counselling shall be client-centred and focus on the specific risks and needs of the client or patient, based on their HIV test results, stated risk behaviours, and prior knowledge about HIV/AIDS.

Post-test counselling may be delivered to individuals, couples or families, depending on what they agreed to, during pre-testing counselling. However, couples shall be encouraged to receive post-test counselling together, when possible, to encourage mutual disclosure and to support couples' communication.

#### *Post-test counselling for clients who test HIV-Negative*

Individuals whose HIV test results are negative should receive the following:

- An explanation of their test result.
- Information on HIV prevention.
- Demonstration on correct use of male and female condoms and an initial supply of the same.
- Information on the importance of knowing the HIV status of their sexual partner(s) and on the availability of partner and couples testing services.
- Screening for TB and referral for TB services as appropriate.
- Referral and linkage to relevant HIV prevention services such as VMMC, PEP, PrEP post-test clubs, STI services and OST clinics for PWIDs.
- Recommendation for retesting based on the client's level of exposure and/or ongoing risk of exposure as detailed in chapter Six, Table 6.1.
- Clients should be offered an opportunity to ask questions and receive correct information.

### *Special considerations for adolescents who test HIV negative*

Adolescents who test HIV negative need information and education about adapting safer lifestyles including: -

- Stop sexual behaviours that increase the risk of contracting HIV infection.
- Safer sex practices and a demonstration on correct and consistent use of both male and female condoms for the prevention of unwanted pregnancy, HIV and Sexual Transmitted Infections/ Reproductive Tract Infections (STIs/RTIs).
- Repeat HIV testing after 4 weeks if they have new sexual partner(s).
- Accessing HIV prevention services such as Voluntary Medical Male Circumcision (VMMC) and engaging in youth clubs.

### *Minimum standards for post-test counselling for individuals who test HIV positive*

Post-test counselling for individuals who test HIV positive should focus on the needs of the client and be delivered in a non-judgemental approach. The HTS provider should do the following:

- Explain the test results and provide counselling on how to cope with emotions arising from the result. Clients should be encouraged to ask questions.
- Discuss immediate concerns and help the client to decide who in their social network may be available to provide immediate support.
- Provide clear information on ART and its benefits.
- Assess and provide counselling on risky behaviours and other diseases.
- Provide linkage to care and treatment centres and support to facilitate enrolment on ART on the same-day.
- Where same day referral to a CTC is not feasible, arrange and ensure active follow-up and referral to a CTC.
- Inform the HIV positive clients that they will be retested to verify their HIV diagnosis prior to enrolling in care and/or starting ART.
- Provide information and demonstrate correct use of male or female condoms.
- Discuss the importance of disclosure of the HIV test result, its risks and benefits among couples and partners. Assess the risk of intimate partner violence and discuss possible steps to ensure safety of clients.
- Assess the risk of suicide, depression, and other mental health consequences following a diagnosis of HIV-infection.
- Discuss information about sexual contacts, injecting drug users and children and other family members, request for consent to contact these groups for HIV Testing Services.
- Screen for Tuberculosis (TB) using the national TB screening tool and refer suspects to TB programme services. For all TB suspects, encourage screening of all family members.

- Provide referrals to other services such as STI/RTIs, prophylaxis for opportunistic infections, family planning, cervical cancer screening, Gender Based Violence (GBV) and legal services as appropriate.
- Identify and refer clients who are also participating in HIV vaccine research back to research sites or to public hospitals that can perform Polymerase Chain Reaction (PCR) to rule out Vaccine Induced Sero-Positivity (VISP).

### *Post-test counselling for special populations*

In addition to the general post-test counselling messages for all individuals, the following specific groups require more specific messages and repeat post-test sessions.

### *Key populations*

All trained HTS providers in all regions targeted for KVP interventions should receive refresher training on the 2017 National Guidelines for KVPs. In addition to the minimum standards for post-test counselling process listed in section 3.6 above, HTS providers should provide:

- Intensified post-test counselling combined with linkage to, follow-up support by community based HTS provider and “peer” volunteers where available.
- Linkage to a peer counsellor who may help KVPs tested HIV-positive and lack social networks and/or a supportive family, to cope with the diagnosis and support enrolment in care and treatment.

### *Pregnant women*

Post-test counselling for HIV-positive pregnant women, in addition to the standard messages described above, should include the following:

- Access to HIV Prevention of Mother to Child Transmission services.
- Screening for TB, STIs, particularly for Syphilis and Cervical Cancer.
- Counselling on maternal nutrition, including the need to take iron, folic acid and malaria prophylaxis, increase the variety and quantity of meals, and reduce workload especially during the last three months of pregnancy.
- Childbirth plans: providers should encourage HIV-positive pregnant women to deliver in a health facility for their own safety as well as the safe birth of the newborn.
- HIV testing for the infant and needed follow-up for HIV-exposed infant.
- Counselling on safer infant feeding practices to reduce the risk of HIV transmission during the breastfeeding period:

- HTS providers should give correct and up to date information on the different infant feeding options with support to decide on their feeding choice.
- Where available, HIV positive mothers should be referred to an Infant and Young Child Feeding (IYCF) trained provider.

### *Couples/sexual partners*

Post-test counselling for couples/sexual partners requires enhanced counselling skills. Post-test counselling for sero-discordant couples may be especially challenging, as test results may be hard for the provider to explain and difficult for the couple to accept. These guidelines recommend that all HTS providers should receive additional training/refresher training using the National Couple Counselling training materials of 2017.

### *Post-test counselling for HIV-exposed infants and children.*

Informing children of their HIV diagnosis is complicated. The approach depends on the child's age and the counselling skills of the health-care provider. HTS providers should refer to National Training guides and appropriate guidelines for details on how to do this.

### *Young Children (less than 10 years old)*

- Disclosure of a young child's HIV status shall be handled in an age appropriate manner. It is a process that develops over time.
- Some young children may not understand that they are being tested for HIV, but if they are positive, they will need to be made to understand the importance of taking their medication and staying healthy.
- Some young children will understand that they are being tested for HIV, and HTC providers shall be prepared to facilitate disclosure to children, if applicable.
- For young children who are able to comprehend, the HTS provider may participate in the disclosure session, however, much of the information during the session should be provided by the parent or guardian.
- Providers may wish to disclose a child's results to the parent or guardian before disclosing them to the child. This allows parents or guardians time to process the test results, initiate discussion about follow-up care and treatment for the child, and decide the best time and method for disclosure to the child.
- When deciding how and when to safely disclose, HTS providers and parents/guardians shall consider the level of cognitive development and emotional maturity of the child, as well as the child's ability to handle difficult situations.

- HTS providers and parents/ guardians should introduce age-appropriate information regarding HIV as early as possible, be transparent and work on reducing potential HIV/AIDS related stigma.
- It is recommended that full disclosure of a child's HIV status takes place by the age of 10 years.

### *Adolescents (above 10 years and below 18 years)*

Adolescents are generally capable of understanding the HIV test and test results, and the HTS session will generally be directed at the older child and the parent(s) or guardian(s) if they are present during the session. Along with standard messages for all those diagnosed with HIV-infection, post-test counselling for adolescents whose test result is HIV-positive should include:

- Provider-assisted disclosure of the child's HIV test results to the parent or guardian may help facilitate access to care and treatment, and may open lines of communication between parents/guardians and their children.
- Adolescents are generally becoming (or are already) aware of their sexuality, and may have special counselling needs around HIV and relationships, sexuality, and risk reduction, in addition to care and treatment support.
- HTS providers shall also be aware of the differences in counselling and support needs for these adolescents who have been living with HIV since birth, and those that became infected in their youth.
- Educational messages and materials that address the prevention, care and treatment of HIV shall be developed specifically for older children.
- Since adolescents might not want to receive services in the same place with adults receiving HTS, "youth-friendly" HTS and providers shall be made available, and where feasible, expanded to meet the needs of older children.
- Linkage to HIV care and treatment, specific psychosocial and mental health services according to the situation in which infection happened and the developmental age of the individual.
- An opportunity to ask questions and discuss issues related to sexuality and the challenges they may encounter in relationships, marriage and childbearing.
- On-going counselling and in particular around the time of transition into adulthood.
- Referral for small group counselling and structured peer support groups.
- Information on their rights and responsibilities, especially their right to confidentiality.



### Vaccine Induced Sero-Positivity (VISP)

Vaccine-induced sero-positivity refers to a situation whereby serological tests detect vaccine induced antibodies to client(s) participating in HIV vaccine research. VISP is a major focus in the preventive HIV vaccine field because the most common tests for HIV infection rely on detecting antibodies to HIV, they may also detect antibodies induced by the HIV vaccine.

#### Box 3.1 Vaccine Induced Sero-Positivity (VISP)

The associated VISP can be addressed as follows:

Research institutions conducting HIV vaccine trials must always conduct testing for VISP to all study participants at the end of the study to prevent social harm, incorrect HIV diagnosis, and inaccurate reporting to health care facilities.

- They should sensitize local government authorities and health care staff at all levels, particularly in regions with ongoing and planned HIV vaccine trials.
- HTS providers can minimize misinterpretation of VISP by obtaining a complete client history e.g. by asking if they are participating in an HIV vaccine trial.
- Clients should be asked if they have an HIV vaccine research identification card that shows one is/was a participant. If needed, referrals for PCR can either be done by referring clients back to the research site or to a public hospital capable of performing PCR.

### 3.6 Disclosure of HIV Status

Disclosure refers to when a person who has undergone an HIV test shares the test results with other individuals. It also refers to the process of an HTS provider sharing a client's or patient's HIV test results with the client or patient, or with a third party. Test results may be disclosed to the individuals receiving HTS alone and/or to couples or families who agree to receive their results together.

Maintaining privacy about HIV-positive test results is key to HTS, particular attention is needed to protect client/patient safety and privacy.

### 3.7 Linkage to Care, Treatment and Support Services

HTS providers have a crucial responsibility to ensure that all individuals with a confirmed reactive HIV test are immediately linked to care and treatment services for enrolment to ART and other support services. Therefore:

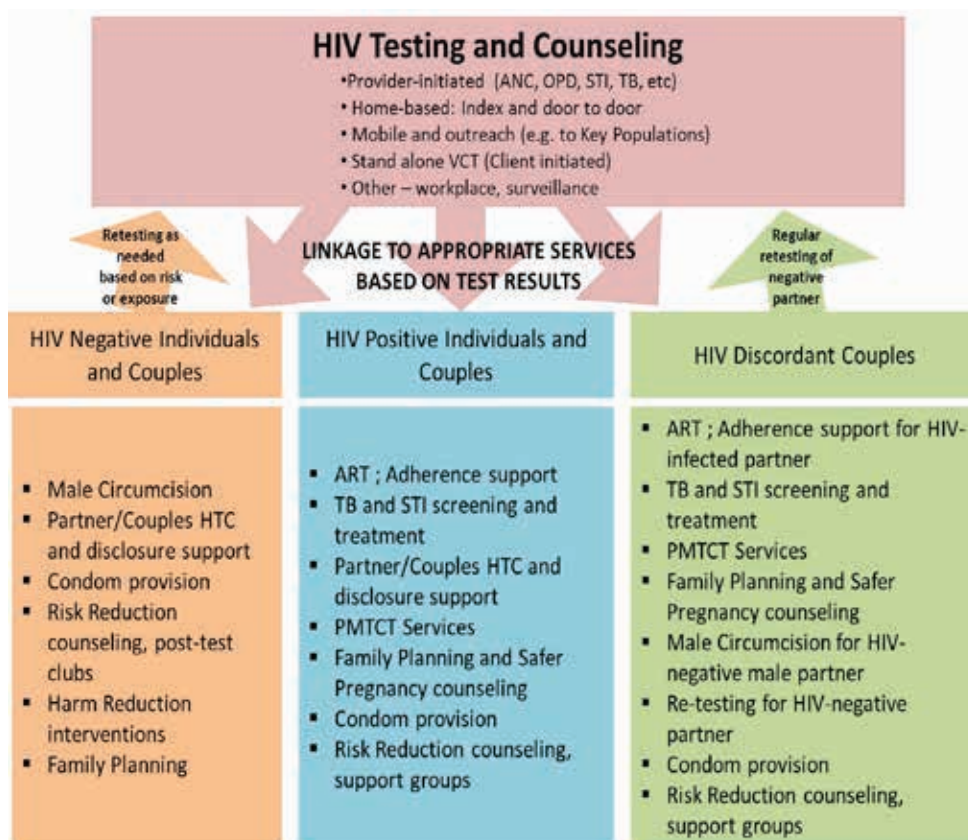
- Every HTS site should map and keep a directory of all HIV and AIDS support services in the catchment area. This should be done in collaboration with HTS, ART providers, social workers, community development and other extension workers in the catchment area (see Figure 3.1)
- HTS providers shall record referrals in the HIV testing register and fill the MOHCDGEC approved referral form in duplicate (One form to take to the CTC and a copy to be maintained at the testing site).

- Where feasible, HTS providers shall arrange for escort/or verify by phone that all referred individuals have been received at the CTC and enrolled into care and treatment
- ART providers shall re-test all the referred individuals to verify their HIV positive status before they enrol them at the CTC. They should fill the referral form and send feedback to the HTS provider.

**Strategies for Effective Referral and Linkage**

- Immediately refer or link all people who test HIV-positive to ART services.
- Refer all people who test positive in community settings to a health facility-based Care and Treatment services for verification of HIV test results and further assessment for care and treatment services.
- Link people who test HIV-negative with ongoing HIV risk to appropriate prevention services.

**Figure 3.2: HIV Post-test Linkages to Prevention, Care and Treatment Services**





## Chapter 3: Key points

- HTS should be prioritised for and promoted to those who are at high risk and have not been tested recently.
- All populations accessing HTS should receive Pre-test counselling and have the right to opt-out without denying other health services.
- It is ethical and professional responsibility of the person providing HIV test results to adhere to national guidelines to ensure correct test results.
- People who test HIV-negative will usually need health information about their HIV status, how to prevent HIV acquisition in the future and where and how to link to HIV prevention services, as appropriate.
- People who test HIV-positive should receive at least minimum package of Post-test counselling with appropriate information and linkages related to HIV care, treatment and support.
- HIV disclosure targeted for HIV prevention, care, treatment and support, is important for reducing stigma, discrimination, adherence to ART and lost to follow up.

## CHAPTER FOUR: HTS DELIVERY APPROACHES AND SETTINGS

### *Preamble*

The 2016 HIV Service Delivery Model Mapping Report revealed that there are many settings for providing HTS in Tanzania. These guidelines recommend prioritization of a mix of approaches and settings that will facilitate early HIV testing and diagnosis of many individuals, focusing on populations with the highest risk for HIV as well as underserved geographic areas. They also emphasize timely and effective linkage to prevention, care and treatment services. According to these guidelines, all newly diagnosed HIV positive individuals shall be re-tested and verified as HIV positive before they are enrolled into Antiretroviral Treatment. Those testing HIV negative shall be asked about their sexual behaviour to identify HIV, linked to HIV prevention services and provided with knowledge on when to re-test.

### **4.1 Approaches and Settings for HTS Delivery in Tanzania**

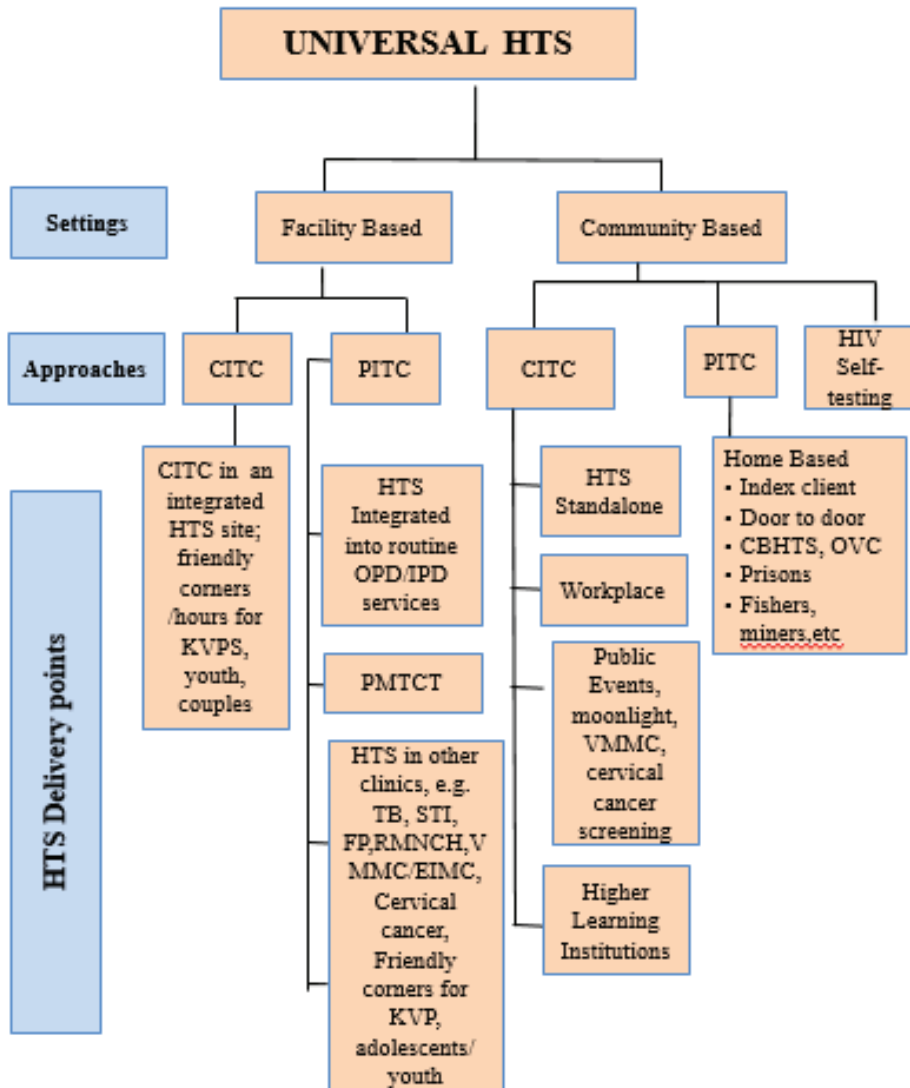
The main approaches for HTS are Provider-Initiated HIV Testing and Counselling (PITC) and Client-Initiated HIV Testing and Counselling (CITC) see Figure 4.1. HIV self-testing (HIVST) has been recommended by WHO as an additional approach for delivering HIV testing services. The introduction of HIVST will be based on the recommendations from the ongoing 2018 Implementation Science on HIVST. The HTS are delivered in two broad settings, namely community and facility based settings.

#### **4.1.1 Provider-Initiated HIV Testing and Counselling (PITC)**

PITC refers to situations in which a health care worker or HTS provider recommends and offers HTS to individuals, couples, families, or groups attending clinical services in health facilities as a standard component of medical care. PITC may also be recommended in non-facility settings i.e. in community settings.

- PITC providers shall give clients/patients basic pre-test information, in an individual, couple, family, or group setting. Testing may be done by the provider in the consultation/private room or in a designated side room by a designated HTS provider, or in the laboratory. Results shall be given to the patients/clients, along with appropriate post-test counselling and linkage to follow-up services.
- Given the high time demand in PITC settings, post-test counselling may be streamlined. It is recommended that these patients/clients be referred to a counsellor or support group for on-going counselling and support as needed.
- *Patients/clients who decline PITC shall still be provided with high quality medical care for their presenting illnesses.*
- PITC services shall be expanded and integrated in all facility and community health services provision points. Examples of these services are listed below.

Figure 4.1: The main HTS approaches and settings



**Reproductive Maternal, New-born, Child and Adolescent Health (RMNCAH)**

It is now the standard policy in Tanzania to offer routine PITC as part of RMNCAH care including Antenatal Clinics (ANC), Postnatal Care, Family Planning and couples’/partners health services

### *Child health services*

All children below the age of 18 months admitted as paediatric inpatients, with or without signs and symptoms of HIV infection, all HIV exposed children, and all children whose mothers' HIV status is not known shall be offered HIV testing with the consent of their parent(s) or guardians. PITC shall also be offered in outpatient departments to all children accessing various RCH services and specialized paediatric clinics.

### *Integrating HIV Testing with TB services*

In Tanzania, TB/HIV co-infection is estimated to be 37-39%. Intensified TB case finding in clinical and outreach settings will facilitate early detection of HIV-associated TB and linkage to treatment and appreciably contribute to the reduction of morbidity and mortality associated with TB. These guidelines emphasize that: -

- HTS providers shall integrate TB screening wherever HIV testing is carried out irrespective of their test result.
- Health providers in TB settings shall ensure that all patients/clients diagnosed with TB shall also receive HIV Testing Services (Index patients/partners).

### *Integrating HTS in STI services*

Service delivery points for Sexually Transmitted Infections (STIs) are one of the key entry points for HIV prevention, care, and treatment and support services. Therefore, all STI service providers should:

- Provide HTS to all patients diagnosed with STI.
- Routinely offer STIs and HIV testing services to all pregnant women attending ANC.

### *Voluntary Medical Male Circumcision (VMMC) services*

Voluntary medical male circumcision can reduce HIV acquisition in HIV negative males by 60%. The MoOHCDGEC has developed a strategy for providing VMMC services with HTS as one of the VMMC packages. All health Workers and HTS providers shall ensure that:

- All persons receiving VMMC shall be offered HTS. However, HTS shall not be a precondition to access VMMC services.
- Clients accessing HTS are informed about the benefits of (VMMC) for HIV prevention and referred to VMMC sites.

#### **4.1.2 Client-Initiated HIV Testing and Counselling (CITC)**

Client-initiated HIV Testing and Counselling previously referred to as Voluntary Counselling and Testing (VCT), is an approach in which client(s) voluntarily decide to learn their HIV status as an individual, couple or family. CITC offers many opportunities for more personalized risk assessment and client-centred behaviour change counselling.

In Tanzania, CITC services are offered within health care facilities as well as in the community as stand-alone sites, in outreach services, in homes or in workplaces.

### *Stand-alone CITC service delivery points*

- Stand-alone CITC sites provide services to the general population, or can be tailored to meet the needs of specific populations, such as persons with visual, auditory, and/or other disabilities, youth, or KVPs.
- HTS providers in stand-alone VCT sites shall also integrate other health services in order to maximize the benefits of these sites.
- Health managers should provide guidance on the planning and supervision of Mobile/outreach services in order to ensure HTS providers sustain high-quality HTS services, adhere to the 5Cs Core principles of HTS, infection control SOPs, and provide immediate linkages to CTC services.

### **4.1.3 Community Based HIV Testing Services (CBHTS)**

This refers to HTS offered to individuals, couples and families outside of health facilities. It is an important approach to reach those who test HIV for the first-time and people who seldom use clinical services.

Community based HTS can be provided in a variety of settings including: Home-Based HTS, stand-alone community HIV testing services; and HIV self-testing.

#### *Home-Based HTS (HBHTS)*

In the HBHTS approach, an HTS provider may visit a household or be requested by clients/patients to visit their home to offer HTS to individuals, couples, and families within the household setting. HBHTS includes aspects of both PITC and CITC. One of the advantages of this approach is that it builds upon the existing community health setting and facilitates linkages with other health services. However, HTS providers need to receive additional training for them to effectively offer HBHTS. There are two primary models for conducting home-based HTS in Tanzania: door-to-door and index-patient models.

#### *Door-to-door HBHTS model*

In this model, HTS providers aim to provide HTS in all homes within a specific, pre-defined geographic area. This model requires strong community linkages and advance preparation to ensure acceptance into the community and homes. The approach is best utilized in areas with a high population density, low numbers of people previously tested, or high HIV prevalence.

### **4.1.4 Index client testing and partner notification model**

- Index client HIV Testing is a focused HTS approach in which people diagnosed with HIV are encouraged and supported to have their sexual partner/s, children, other household and family members access HTS<sup>20</sup>. PWIDs should also be offered this service for their networks.

<sup>20</sup> World Health organization: Guidelines on HIV self-testing and partner notification: supplement to consolidated guidelines on HIV testing services; 2016

The following steps should be followed when implementing index client testing:

- HTS providers should counsel every client who test HIV positive on the importance of ensuring their partner/s children and family members are also tested.
- With consent, the index client's sexual partner/s and children may be referred for HTS using the following approaches:
  - Passive disclosure approach whereby the index client discloses their status to their sexual and/ or drug injecting partners by themselves (unassisted), and also suggests HTS to their partner(s)
  - Assisted voluntary disclosure approaches whereby with the client's consent, the HTS provider anonymously notifies their sexual and/or drug injecting partner(s) using three approaches:
    - i. HTS provider contacts the index client's partners directly and confidentially.
    - ii. The HIV-positive client enters into a **contractual approach** with the HTS provider and agrees to disclose their HIV status by themselves and refer their partner(s) for HTS within a specific time period e.g. one month. If the partner does not access HTS or contact the provider within that period, the provider will contact the partner(s) directly and offers voluntary HTS.
    - iii. HIV-positive client opts for community/home visit by the provider when they disclose their HIV status to their partner(s). The HTS provider then offers HTS to the sexual partner(s), children and other family members who agree to receive HTS. This is also referred to as *Dual approach*.

These guidelines emphasize enhanced use of this approach throughout the country as among the new innovations to rapidly increase the number of PLHIV diagnosed.

#### 4.1.5 HTS approaches for KVPs

Approaches and delivery of HTS for KVPs in health facilities shall aim at locating KVP services at friendly corners and friendly times to promote their confidentiality. In the community, efforts should be made to access them in their natural environments such as “moonlight services”.

Suggested HTS sites for reaching key populations include:

- Needle and Syringe Programme (NSP) sites;
- Methadone Assisted Therapy (MAT) sites;
- Home-based HTS sites;
- Mobile or outreach HTS at hotspots e.g. bars, guest houses or brothels;
- Other closed settings such as prisons;
- As much as possible, referrals and linkages for additional services should address the individual's medical, psychological, social, vocational and legal challenges.



## 4.2 Integrating Community –Based HTS

Health Managers and HTS providers should promote the integration of Community –Based HTS with other community health services as outlined in the 2015 NACP’s National guidelines for Community Based HIV and AIDS Services. Examples of services that can be integrated with Community –Based HTS include: -

- Home-based HIV care, TB screening and treatment, EPI and child growth monitoring and promotion programmes, Malaria screening, ANC services, family planning, cervical cancer, and non-communicable diseases screening.
- Health education services, health campaigns during national events such as the International Trade Fair - Saba Saba and the National Farmers’ Day Nane Nane, Village Health Day, World AIDS Day, Uhuru Torch Race sports tournaments e.t.c)

### *Personnel Conducting Home/Community Based HTS*

- Home/community based HTS providers must be certified by the MOHCDGEC.
- It is recommended that Home-based HTS Providers shall work in pairs and where possible the pairs should comprise a male and a female. It shall also be useful to have a community gatekeeper or mobilize to accompany the providers.
- Members of PLHIV Post-test clubs (PTCs) shall be oriented on how to effectively mobilize communities and on the 5 Cs core principles of HTS.
- There shall also be an experienced team leader or senior counsellor available on-site or in nearby facilities to provide professional backstopping to Home-based HTS providers.

### *Planning Home-Based HTS*

- HTS providers must carry all necessary HTS supplies with them, and adhere to the standards and quality assurance systems outlined in these guidelines and accompanying Standard Operations Procedures.
- Home-based HTS also require advance preparation and engagement with local leaders to gain access to the community and peoples’ homes.
- Providers should adhere to bio safety and waste precautions, appropriate lighting, allow tests to develop for the appropriate amount of time, ensure appropriate temperature for test kits and supplies, ensure confidentiality, and maintain high quality services.

## 4.3 HTS in Workplace Settings

HTS shall be offered in public and private sector work places as part of routine, comprehensive workplace HIV programmes in line with *HIV and AIDS (Prevention and Control) Act 2008*.

- Workplace HTS may be provided on-site through a workplace clinic or in coordination with a nearby HTS centre. HTS providers may visit the workplace and offer HTS, either in an office room, a mobile van, or in tents. HTS may also be introduced into a workplace on an ad hoc basis, for example during an annual family day or event.

- A workplace HIV Focal person may offer information about HTS and refer employees to a nearby HTS site to receive services.
- HTS providers shall provide sufficient information to employees to enable them make informed decisions about HTS, and access them voluntarily; that is, workers or their families shall not be forced to be tested by their employer.
- All personal data relating to an employee’s HIV status or other personal information shall not be disclosed to the employer unless the employee provides written consent to do so.
- Employers should promote continual education of employees in relation to HIV and AIDS preventive, care and treatment service as a method to minimize stigma and discrimination related to HIV and AIDS.
- Workplace HTS providers must adhere to MOHCDGEC SOPs for HTS, paying particular attention to waste disposal.

#### **4.4 Health Care providers and Risk of exposure to HIV**

All HTS management should incorporate the welfare of all staff involved in service delivery by ensuring that: -

- All HTS providers are oriented on the national post exposure prophylaxis (PEP) guidelines.
- All HTS sites are equipped with PEP equipment and supplies at all times. Where not available the staff shall be well informed of the next level to get them.
- Providers who are accidentally exposed to HIV through occupational exposure, shall report the exposure to the employer as per national PEP Guidelines 2014.

#### **4.5 HIV Self-Testing**

HIV self-testing (HIVST) has been recommended by WHO as an additional approach for delivering HIV testing services. The HIV self-testing (HIVST) approach is defined as the process whereby an individual collects their own specimen (blood or oral fluid), performs HIV testing using a HIV Rapid Diagnostic Test (RDT) and interprets the result themselves either assisted or unassisted. The HIVST does not provide a definitive diagnosis. A reactive (positive) result always requires further confirmatory testing from a trained HTS provider using the relevant validated national HIV testing algorithm. The WHO strongly recommends the introduction of HIV Self-Testing (HIVST) as one of the approaches for rapidly increasing the number of new testers. The process of adapting HIVST has commenced and operational studies that will better guide the adaptation of HIVST in the country are currently underway.

#### **4.6 Other HIV Testing Approaches**

Other HTS approaches include mandatory testing, testing of blood and tissue donations, and testing for the purposes of research or surveillance. These approaches are further described below:

### Mandatory HIV testing

According to the *HIV and AIDS [Prevention and Control Act] (2008)*, the following situations permit mandatory HIV testing:

1. Court order;
2. Donors of human organs and tissues;
3. Sexual offenders;
4. If a person is unconscious and has signs/symptoms of HIV/AIDS and is unable to give consent; and the medical practitioner reasonably believes that such a test is clinically necessary or desirable in the interest of that person.

#### 4.6.2 HIV testing of blood and tissue donors

According to the *National Blood Transfusion Practice/Policy Guidelines (2006)*, Health Managers, Health Care Workers and HTS providers shall ensure that:

- All blood for transfusion is screened for blood Transfusion Transmissible Infections (TTIs) including HIV, according to blood screening standard operating procedures (SOPs).
- General information about HIV and AIDS is provided including the fact that all donated blood is subjected to routine HIV testing.
- Donors can access their HIV test results at the blood donation sites, usually after TWO weeks.
- When the blood donors return for their HIV test results they should receive post-test counselling, including screening for TB.
- Those who test HIV positive should be referred to a Care and Treatment Centre for verification of HIV status before being enrolled on ART.
- Those who test HIV negative and who have low-risk of acquiring HIV, including HIV concordant negative couples, are encouraged to be regular blood donors.



## Chapter 4: Key points

The main Settings for HTS delivery are;

- Facility based
- Community (non-facility) based

The main approaches for providing HTS are

- Provider Initiated HIV testing and Counselling (PITC)
- Client Initiated HIV testing and Counselling (CITC)
- Community/Home Based HTS (a hybrid of CITC and PITC); Index testing have proved to be effective and efficient ways of identifying PLHIV
- HTS should be integrated with other services in both facility and community based settings.
- HIV Self-testing will be rolled out upon understanding field feasibility and community acceptability from the ongoing implementation study in few regions.

## CHAPTER FIVE: PRIORITY POPULATIONS

### *Preamble*

HIV Testing services should be made available to individuals, couples/partners, families and KVPs. It is a fundamental human right for all Tanzanians to know their HIV status. This chapter outlines key considerations for different populations.

### **5.1 Key and Vulnerable Populations**

Key and Vulnerable Populations are persons who engage in socially stigmatized behaviours including sex work, injecting drug use and male-to-male sexual relations. HIV may spread rapidly in these populations due to more frequent exposures in high risk behaviours such as unprotected anal and vaginal sex with partners of unknown HIV-status and the sharing of syringes and needles. The risk of HIV infection among these groups multiply because persons who engage in these behaviours often overlap (e.g. sex workers who inject drugs, men who have sex with men who engaging in commercial sex, a female injecting drug user engaging in receptive anal sex). In addition, since these populations are mostly hidden due to our cultural context, they are harder to reach, and less likely to have access to services, or to use services where they are available.

Therefore:

- Priority interventions and enabling environment should be in place to ensure that KVP receive HTS without stigma or discrimination.
- Community based HTS targeted for KVP is a recommended approach for reaching more KVPs.
- HCWs should receive training on provision of KVP-friendly services based on the current KVP guideline.
- Community based health care providers and peer educators should be used to sensitize and mobilize KVPs to seek HTS.

### **5.2 Infants and Children**

Mortality rates among infants infected with HIV who go untreated is very high in the first year of life. All babies and infants known to be HIV exposed should be tested for HIV at the age of 6 weeks. HTS for older children should be age-appropriate. Providers should make an assessment of level of maturity in a particular age. Approaches for delivering age-specific HTS for children are elaborated in Chapter Six.

### **5.3 Adolescents**

Health management officials and HTS providers should ensure adolescent-friendly services are strengthened and/or established either as adolescent-friendly corners or provided on special days and times.

Groups of adolescents who need special considerations are:

- Adolescents infected vertically who were not diagnosed in infancy.
- Adolescents acquiring HIV horizontally through early sex and injecting drugs.
- Adolescents from key populations.
- Vulnerable adolescents such as those living on the streets, orphans and adolescents in child-headed households.
- Girls in-school and out-of-school aged between 15 -19 years.

#### **5.4 HTS for Orphans and Vulnerable Children (OVC)**

Orphans and Vulnerable Children shall have access to health care services including HTS, and shall receive appropriate treatment, care and support, based on their HIV status. There are some unique situations that may need to be considered by HTS providers and guardians who serve OVCs, including:

- OVCs should not be forced to take an HIV test, but shall be supported to do so when it is in their best interest, i.e. for their own health and well-being.
- Health care providers shall discuss with parents/guardians on how to talk to OVCs in an age-appropriate manner about the risk of HIV infection and the benefits of treatment, care and support.
- In collaboration with social welfare and community development service providers, HTS providers shall address the risks and needs of children and youth living in the streets, and support them to develop risk reduction plans, and link them to appropriate follow-up services.

#### **5.5 Pregnant Women**

HIV testing in Ante-Natal Clinics (ANC) settings has considerable public health benefits in reducing and eventually eliminating the transmission of the HIV virus from mothers to their children. Currently HTS is offered in all ANCs as per National policies.

#### **5.6 Men**

Currently fewer men than women report ever testing for HIV. Men are more likely to start ART at later stages of HIV infection and thus experience higher morbidity and mortality after initiating treatment.

It is therefore recommended that Health managers and HTS providers: -

- Promote male involvement in health care services such ANC, PNC, FP, RCH.
- Integrate HTS with men-targeted services such as VMMC and other mobile, home-based, or workplace health services at all levels.
- Implement defined combination prevention interventions targeting men.

## 5.7 Couples and Partners

In order to facilitate disclosure, identify discordance, and prevent HIV transmission between couples/partners, HTS managers should strengthen the following: -

- Training/refresher training of HTS providers on Couples HTS delivery.
- Provision of Health information to raise awareness on the importance of HIV Testing services among individuals engaged in sexual relationships.
- Promotion of a conducive environment for Couple HTS such as allocating afternoon times for couple HTS, and/or using events such as Valentine's or Christmas months to offer couple HTS.
- Training/orientation of all HTS providers on how to screen clients for intimate partner violence and provide appropriate support and referral to follow-up services.
- Where the HTS provider has reason to believe that one partner may have been coerced to attend couples HTS or that there may be underlying partner violence; the provider should separate the couples and recommend individual HTS first.

### *Discordant couples*

There is a high risk of HIV transmission among HIV discordant couples. Health management and HTS providers shall emphasize follow-up counselling and linking of discordant couples with other supportive services including:

- Reproductive and Child Health Services including family planning and provision of contraceptives.
- Offering PrEP services to all HIV negative sero- discordant couples.
- Providing PMTCT services for HIV-infected pregnant women.
- Voluntary medical male circumcision for male partners.
- Demonstration of correct use of condoms and explanation of where to access condoms as needed.

## 5.8 Other Populations at Higher Risk of HIV Infection

In addition to key populations, there are other populations that may also be vulnerable to HIV infection or may have difficulty accessing equitable health care services, including HTS.

### *Populations in Closed Settings*

Prisoners and other persons in closed settings may either enter the prison with unknown HIV infection, or may acquire HIV infection through high-risk behaviours while in prison. It is recommended that Health management, HTS supervisors in collaboration with prisons health authorities: -

- Sensitize the Prison Department and jail wardens to ensure that they establish comprehensive HIV programmes including HIV prevention, HTS, care, treatment and support services in prisons.

- Offer PITC voluntarily to all prisoners at entry as part of medical screening and thereafter, as needed e.g. when a prisoner shows signs or symptoms of underlying HIV infection.
- Ensure that Post Exposure Prophylaxis (PEP) is provided following rape in prisons or work place HIV exposure according to the national PEP protocol.

### *Uniformed Forces*

Members of uniformed forces may be at a particularly high risk of getting HIV infection due to long periods of time spent away from their homes or spouses, at times in other countries. Therefore, military health authorities should:

- Establish and promote HTS in all health facilities providing services to uniformed personnel, their partners and children.
- Provide/solicit outreach and mobile HTS from public health facilities where stand-alone services are unavailable.
- Integrate Voluntary Medical Male Circumcision (VMMC) with HTS.
- Effectively link members of uniformed forces to appropriate care, treatment and support services after HIV testing.

### *Persons Abusing Alcohol and Other Drugs*

Persons who abuse alcohol or other drugs may participate in high HIV risk behaviour due to lowered inhibitions as a result of alcohol or drug use. Persons who are under the influence of alcohol or other drugs at the time they present for HTS shall be requested to return when they are sober.

### *Mobile populations and individuals employed in environments with high HIV risk.*

Long distance drivers, bus drivers, mine workers, fishermen, plantation workers, frequent travellers, road construction workers, taxi drivers, motorcycle and tricycle drivers may be at an increased risk of HIV infection due to engagement in risky behaviours and long periods of time spent away from home/family. Therefore: -

- Employers/self-employment unions should be capacitated with HTS promotion messages and knowledge on basic HIV prevention services in their institutions, including condom distribution.
- HTS providers should initiate/ strengthen interventions targeting these groups and should include their sexual partners.

### *Refugees, displaced persons and migrants*

Refugees, displaced persons and migrants may be vulnerable to HIV infection because they are separated from family members or loved ones. They may also have language barriers that

limit their ability to communicate with health care providers. Therefore:

- Health management shall ensure that refugees have access to comprehensive health care services, including HTS and follow-up HIV prevention, treatment, care and support services.
- HTS shall be provided through: health facilities, mobile/outreach or home-based approaches.
- Institutions serving these populations may need to train additional providers who speak the language of the particular population or hire interpreters/translators.

### *Survivors of sexual violence*

Sexual violence is linked to the risk of HIV infection. Therefore:

- Health facility managers and HTS providers shall provide urgent HTS to survivors of sexual violence including clinical evaluation, documentation, treatment and psychosocial counselling.
- The management of all health facilities should ensure that PEP is available and accessible at all times it is needed. Survivors should start PEP within 72 hours from the time of sexual assault as per national PEP guidelines
- HIV testing should include syphilis screening and treatment, pregnancy testing and emergency contraception where appropriate.
- In addition to PEP, sexually abused children should be referred to proper social welfare services, and to medical and legal aid support as necessary.
- If sexual violence is committed by a parent or a guardian against their children, it is recommended that the child should receive HIV test without the consent of their parents/guardians and be given age-appropriate counselling.

### *Persons with Disabilities (PWD)*

Persons with disabilities include anyone with physical, sensory (hearing, seeing) or mental limitations. PWDs are vulnerable to HIV infection not only because of their clinical condition, but also because they may not have equitable access to information, education and other public services due to communication, attitudinal and infrastructural barriers. These guidelines recommend the following:

- Health management and HTS providers shall make provisions to address barriers for PWDs to access HTS in a manner that meets their specific needs.
- HTS providers may be required to attend clients or patients in their homes or other appropriate settings.
- HTS service providers shall assess the client and their ability to comprehend the testing process, give informed consent and understand their test results.





## Chapter 5: Key points

- Key and Vulnerable population groups are among the priority target groups for HIV testing services in Tanzania. HTS should be friendly and accessible to encourage reach and uptake by KVPs.
- All pregnant women who test HIV negative at first Antenatal visit must be re-tested during the third trimester or during the time of delivery/post-delivery.
- Special efforts should be placed to reach infants with Early Infant Diagnosis services and Adolescents with HTS.
- HTS and health care providers need to be sensitive to the need for confidentiality, and adhere to non-stigmatizing and non-discrimination principles when providing HTS to priority populations.
- Male friendly services and strategies to reach them should be emphasized by HTS managers and providers at all levels

## CHAPTER SIX: HIV TESTING STRATEGIES FOR DIAGNOSIS

### *Preamble*

The MOHCDGEC uses Rapid Diagnostic Tests (RDTs) for scaling up HIV testing. RDTs are a critical tool as they can be used at any level of the health-care system, and a diagnosis can be made for many individuals on the same day. They can be performed by HTS trained health-care workers and laboratory professionals in various settings, irrespective of the infrastructure, as they do not require specialized equipment. However, ongoing monitoring of correct HIV test procedures and performance of HIV tests is required, especially when performed by non-laboratory personnel and in hot and humid areas.

### 6.1 Indications for HIV Testing

1. Knowledge of one's HIV status.
2. Diagnosis of HIV infection in all age groups.
3. Screening of donated blood and blood products for transfusion.
4. Surveillance of HIV prevalence in a given population.
5. Management of sexual assault cases.
6. Management of work-related exposure to HIV.

### 6.2 Testing Strategy for Diagnosis of HIV in Adults and Children Aged 18 Months or Older

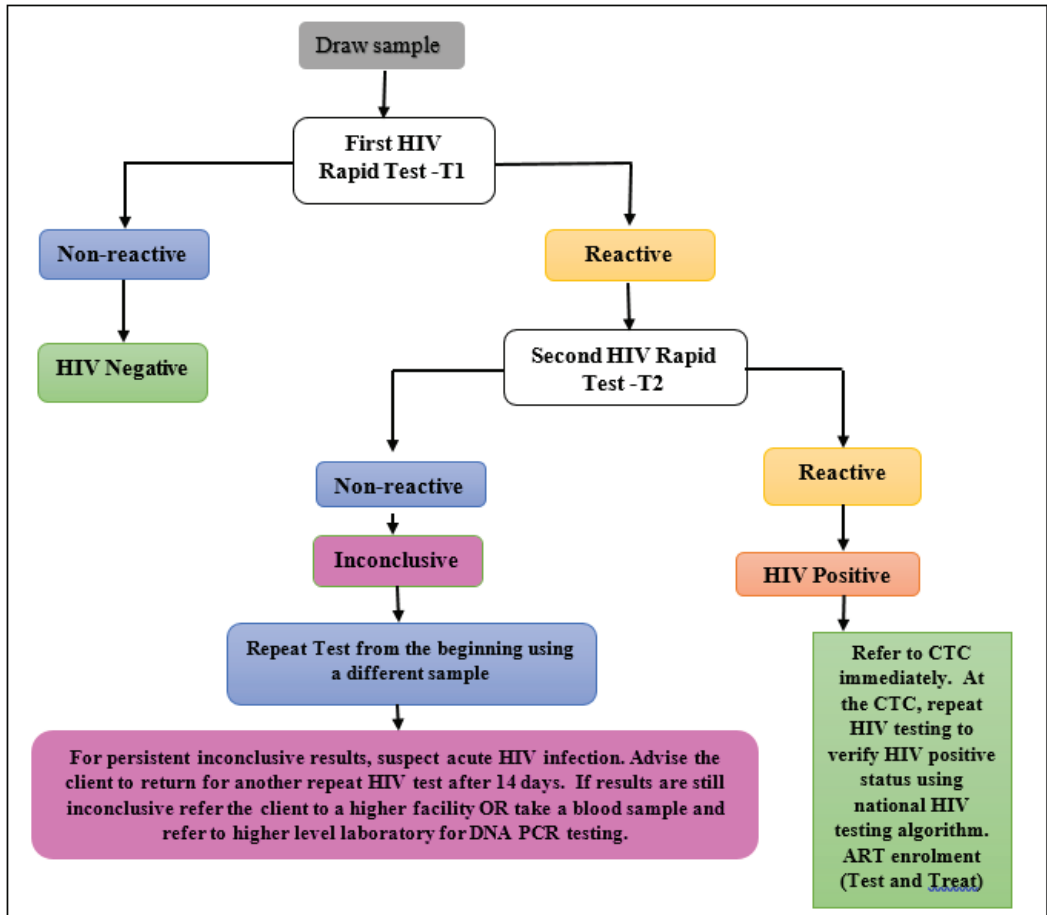
In adults and children 18 months or older, HIV diagnosis should be done by detecting antibodies to the HIV virus using rapid HIV tests. Rapid tests can be performed using whole blood, serum or plasma samples. In Tanzania, finger-prick whole blood samples are used for HIV rapid testing. The MOHCDGEC through the NHLQATC periodically reviews the different samples or tests to be used for HIV testing based on prevailing scientific evidence. These guidelines recommend a serial tests strategy using two approved samples. All qualified laboratory personnel or trained HTS providers involved in sample collection, testing and reporting results must adhere to this testing strategy.

The HIV serial (two) tests strategy shown in Figure 6.1 describes the following sequence of samples and number of tests to be performed: -

1. All samples should first be tested with **one Test (T1)**, and samples that are non-reactive should be reported HIV-negative.
2. **T1** should be the most sensitive HIV test available, taking into account diagnostic sensitivity, sero-conversion sensitivity and analytical sensitivity.
3. Samples that are reactive on the first-line test (**T1 positive**) should be tested with a separate and distinct second test (**T2**) comprised of a different antigen preparation to avoid false cross-reactivity with T1.
4. For samples that are reactive on the first-line test but non-reactive on the second-line test (T1 positive; T2 negative), testing should be repeated using the same sample with the same two tests.

5. When the two samples use finger-prick whole blood, a new sample should be taken for the repeat testing.
6. Samples that remain reactive on the first test but non-reactive on the second test (T1 positive; T2 negative) should be reported HIV-inconclusive and the patient or client should be asked to return for retesting in 14 days.
7. If after 14 days the test is still in determinant, it should be reported as inconclusive. Fresh venous blood samples should be collected or the client/patient should be referred to a higher level laboratory for PCR testing.

Figure 6.1: The sequence of blood tests in the Serial HIV testing strategy



*Note: For clients who are participants of experimental HIV vaccines trials collect venous blood sample and send to PCR Laboratories*

### *Diagnosis of HIV infection in breastfeeding children <18 months where the mother is known to be HIV positive*

If the mother is HIV positive, testing of the HIV exposed infant or child < 18 months should follow these steps for diagnosis of HIV infection:

- Take a blood sample and do DNA-PCR from 6 weeks of age; if positive, start ART immediately while waiting for second HIV DNA-PCR results.
- All children with HIV negative results should have a final rapid test at 18 months to confirm their status. Note: Final rapid test must be taken 3 months after complete cessation of breastfeeding.
- If the child is being breastfed by an HIV infected mother, a negative antibody test does not exclude an HIV infection. On-going exposure to HIV through breastfeeding continues to put the child at risk of acquiring an HIV infection.
- A single positive DNA-PCR test means that the infant is presumably infected and should be initiated on ART. A second DNA PCR sample should be taken immediately after receiving positive test results so as to confirm the first test result. NB: The second test should not delay ART initiation.
- For a child that was never breastfed: a single negative DNA PCR test after the age of 6 weeks excludes HIV infection.
- For a child that has completely stopped breastfeeding for more than 6 weeks prior to virologic DNA PCR testing, a negative DNA PCR test excludes HIV infection.
- Children between the age of 9 and 18 months or after cessation of breastfeeding should have a rapid HIV antibody test since maternal HIV antibodies started to diminish rapidly between 9-18 months of age (Figure6.2).

### **FOR HIGH RISK INFANTS**

A High risk child is one who is symptomatic, *fulfilling WHO stage 3 or 4 criteria* and a DNA PCR test is not available but HIV antibodies are present (rapid test is positive), a presumptive diagnosis should be made and ART started.

### *Diagnosis of HIV infection in Children <18 Months where the Mother's HIV Status is Unknown*

Testing of a mother is the best way to ascertain HIV exposure status of her infant. If the mother is HIV positive, testing of the infant should follow the steps for diagnosis of HIV infection in the HIV exposed infant or child < 18 months. If the mother is not available, test the child for HIV infection using both antibody test. If the test result is positive, use DNA-PCR to confirm the HIV infection.

### *Diagnosis of HIV Infection in Children <18 Months where the mother is not available*

Since the mother's HIV status is unknown, the HIV exposure status of the baby needs to be established. If the mother is not available, the guardian/ care taker should be counselled for HIV testing of the child. Steps for Diagnosis of HIV Infection in a child where mother is not available:

- i. Do rapid HIV antibody tests immediately the child is seen at the HF to determine HIV exposure.
- ii. If HIV antibody test result is positive and the child's age is <18 Months: do HIV DNA-PCR.
- iii. If HIV antibody test result is positive and the child' age is unknown: do DNA PCR immediately. If the result is negative, repeat DNA-PCR after 6 weeks to confirm.
- iv. If rapid HIV antibody test is positive and the child has stage Three or Four symptoms (Presumptive Diagnosis), do DNA PCR test and start ART immediately.
- v. If child is younger than 18 months and is symptomatic, HIV DNA PCR should be taken even if the rapid antibody test is negative.
- vi. All children with negative results should have a final rapid test at 18 months to confirm their status.

Note: HIV exposed children should be seen monthly for the first year of life and should be followed up as per recommendations for all children.

## **6.6 Managing and documenting HIV Test Results**

Key information should be collected for each HTS encounter in all approaches and settings. This data will allow the health provider to monitor service delivery in a standardised manner and allow for useful analysis of data. Correct completion of standard data collection tools should be done immediately after completing the test procedure for each individual/couple as a key best practice for quality performance monitoring of HTS service delivery. Using the above serial testing algorithm, the reporting of HIV diagnosis shall be as follows:

### **HIV negative results**

- All samples are first tested with sample T1 (screening test), and samples that are non-reactive are considered **HIV-negative** and reported as such.

### **HIV positive results**

- Any samples that are reactive on T1 shall be tested again using a different sample T2 (confirmatory test). For samples that are reactive on the first and the second sample (T1 and T2), the result should be reported as **HIV-positive** and the patient or client should receive post-test counselling and immediate referral for ART.

## HIV inconclusive results

If the first and the second samples (T1 and T2), test results are not the same (indeterminate results) the following should be done: -

- Repeat the full serial testing procedure (sample T1 and T2) immediately with a new sample and where feasible by a different HTS trained health worker.
- If the two tests remain indeterminate, this should be considered an **inconclusive** HIV result. The client or patient should be advised to return for re-testing after two weeks (14 days).
- If the client or patient still has inconclusive HIV test results after 14 days, blood sample should be collected using DBS and sent to the NHLQATC for further testing.
- If the facility cannot take a DBS sample; then client should be referred to a higher level health facility. A tracking plan must be made including his/her telephone number.

## 6.7 Retesting

Re-testing refers to additional testing of an individual after a defined period of time, using the same testing algorithm on a second sample.

## 6.8 Retesting to validate HIV-seropositive status prior to ART initiation

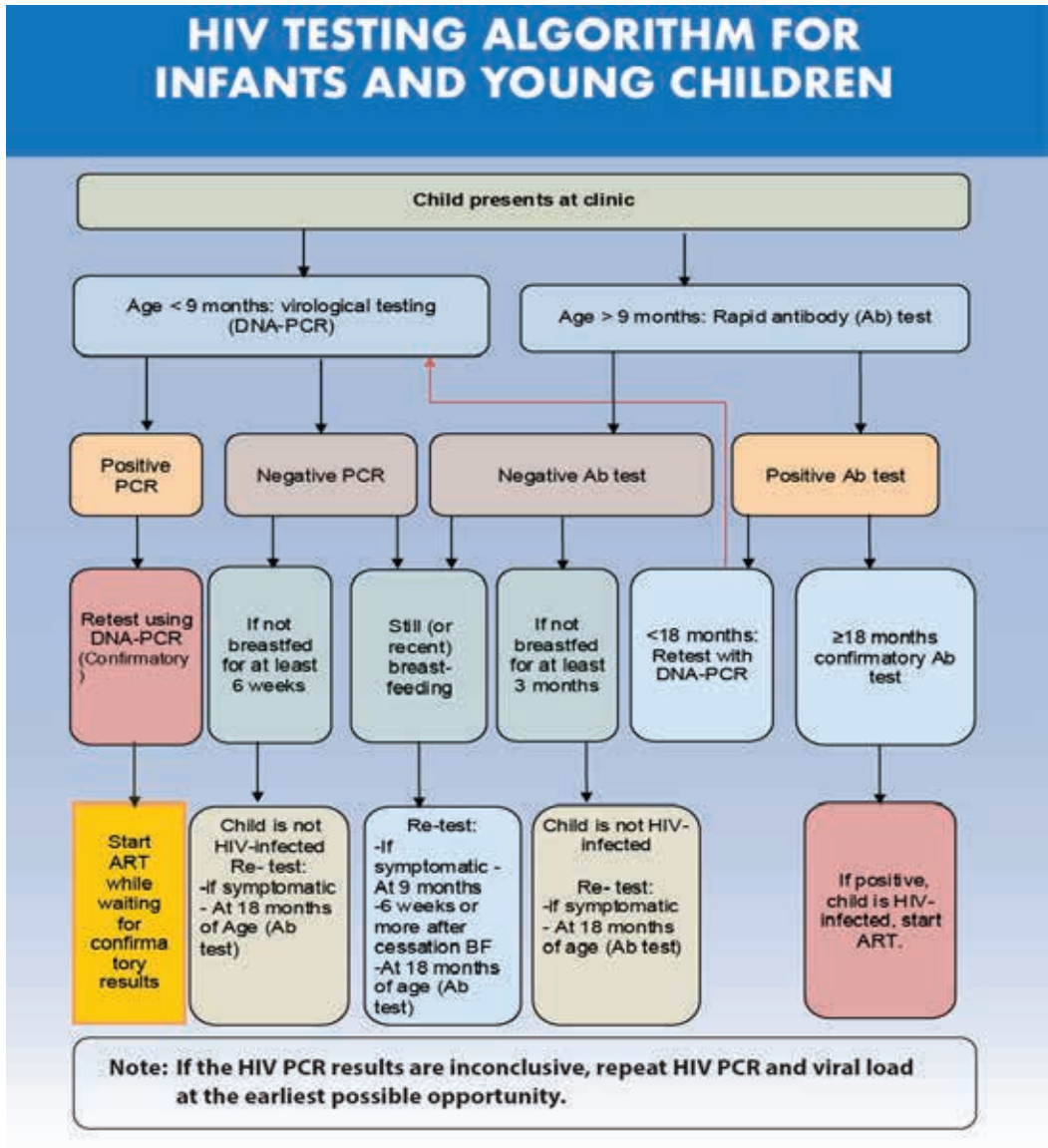
- To ensure that individuals are not needlessly placed on life-long ART (with potential side-effects, waste of resources, and the psychological impact of misdiagnosis), the **NEW RECOMMENDATION** stressed in these 2017 HTS guidelines is to retest every new individual diagnosed as HIV positive to verify their HIV status prior to enrolling in care and starting ART.
- Retesting according to this procedure aims to rule out possible technical or clerical errors, including sample mix-up through mislabelling and transcription errors, or errors from the test device.
- The retesting should be conducted by a different provider using the same testing algorithm. However, when there is only one health worker in the facility, s/he should be the one do the repeat test.
- Retesting should preferably be conducted at the site where the decision about ART initiation is made.
- If the HIV status is the same upon retesting, the individual's HIV-positive status should be considered as verified.
- If the test status is not the same upon retesting, the individual or their sample should be referred for additional testing at nearby higher level facility testing site.

**NOTE:** All the time the Health Care provider in the testing site and ART site should be accountable for Tracking and Linkage until the discrepancy is resolved.

**Critical Message to remember:**

Individuals undergoing HIV testing must be made aware of the risk of incorrect diagnosis if they do not disclose that they are on ART or had previously been on ART. ART may suppress antibody production and lead to “false –negative” results.

Figure 6.2: HIV testing Algorithm for Infants and young children



## 6.9 Infection Prevention & Control and Waste Management

The occupational safety and health procedures as outlined in the National Guidelines for Infection, Prevention and Control shall be adhered to by all HTS providers. The following actions are important: -

- Sharps shall be disposed of in designated sharps containers
- Used test kits and other contaminated waste shall be placed in separate closed containers according to National Waste Management Guidelines
- All medical wastes shall be properly incinerated, or disposed according to the National Waste Management and Infection Prevention and Control (IPC) Guidelines.
- HTS providers, community and laboratory staff involved in handling and disposing hazardous waste shall be adequately trained on biosafety and infection prevention and control procedures.
- Workplace managers shall provide Personal Protective Equipment (PPE) to HTS providers
- HTS providers must regard all blood and body fluids samples potentially infectious and shall take all standard precautions to protect themselves and their clients [HIV and AIDS (Prevention and Control) Act 2008]

**Table 6.1: Retesting Messages for individuals who test HIV Negative**

Scenario	When to repeat HIV test	When to do future HIV tests
<b>A GENERAL POPULATION</b>		
General Population who test HIV Negative with no ongoing risk.	No “window” period retesting	Re-test annually
<b>Inconclusive</b> (Indeterminate test results) HIV status	Immediately repeat HIV test following the national HIV testing algorithm OR repeat test by another tester or laboratory technician	If still in inconclusive retest in 2 weeks. If still inconclusive take the sample for PCR or refer the client to a higher level facility/ laboratory
Have a spouse or partner who is HIV Negative (discordant couples)	4 weeks	Every 3 months until the HIV positive partner has confirmed viral suppression i.e. Viral Load less than 1000 copies/millilitre. Thereafter re-testing every 6 months.
Individuals on PrEP	4 weeks	Every 3 months
Individuals on PEP	4 weeks	At 3 and 6 months, then annually



Have specific incident of HIV exposure past 3 months	4 weeks	With each new known exposure and if still negative, as for general population i.e. annually.
Have an ongoing risk of HIV infection (SW, IDU,MSM)	4 weeks	Annually
Has STIs/ RTIs	4 weeks	With each new STI, if still HIV Negative test annually
Survival of sexual violence or rape or experience occupational exposure	4weeks	As per PEP guidelines
Adolescents and young people	4 weeks	Annually if sexually active
<b>B: PMTCT SETTINGS</b>		
Pregnant women and partners counselled and tested during first ANC visit	Third trimester, or during labour/delivery	Six months after delivery, if still negative test annually and with each new pregnancy
Pregnant women who had specific sexual risk behaviour in past 3 months	<ul style="list-style-type: none"> <li>• 4 weeks then</li> <li>• Third trimester, or during labour/delivery</li> </ul>	Six months after delivery.If still negative test annually and with each new pregnancy
Breastfeeding women who were tested during pregnancy, labour/delivery	6 months after last test	If still negative test annually and with each new pregnancy
Breastfeeding women with unknown HIV status: test at first postnatal contact	6months;	If still negative test annually and with each new pregnancy
HIV Exposed infants	PCR test at 6 weeks after birth.	Conduct Rapid antibody testing at 18 months for confirmation of HIV status. Repeat testing six weeks after cessation of breast feeding.
*High risk HIV exposed infants	DNA –PCR at birth, then at 6 weeks of age;	6 weeks after cessation of breast feeding and a confirmatory antibody (Ab) at 18 months

## 6.10 HIV Recent Infection Surveillance

Recent HIV infection refers to persons newly infected with HIV approximately within the last one year. Recency testing distinguishes between recent and long-standing HIV infection by testing for an immunologic marker of disease progression among newly identified PLHIV. This marker is referred to as antibody avidity or the strength of binding between the HIV antibody and HIV protein, which increases over time. HIV recency testing improves HIV surveillance and enhance program activities such as PLHIV identification through Index testing, without altering routine HIV care. For these reasons, it is important to establish an HIV recent infection surveillance system in routine HIV testing services to detect, characterize, monitor and intervene on recent HIV infection among newly diagnosed cases.

Since this technology is new and without global recommended Recency Infection Testing Algorithm (RITA), MOHCDGEC will implement HIV Recency surveillance in few regions to generate evidence for country and global actions.



### Chapter 6: Key points

- Only HIV rapid test kits evaluated and approved by the MOHCDGEC should be used for HTS.
- A serial based approach is the current national HIV testing algorithm where a sample is tested with one HIV test; then if test results is HIV positive another fingerpick sample is tested with a second different HIV test. The tie-break test has been dropped for now.
- All individuals tested HIV positive at an HTS site must be referred to the CTC where a repeat HIV test will be done on a new sample before starting ART.
- All HIV exposed children must be identified and tested for HIV at 6 weeks. A DBS sample must be taken at the point of ART initiation for confirmation of HIV positive status using DNA-PCR but they should be initiated on ART while waiting for the confirmatory test results.
- All infants with unknown HIV exposure but presenting with Presumed Severe HIV Disease should be tested using HIV rapid tests. If the result is positive, the infant should be started on ART immediately and a HIV NAT should be performed immediately.
- Re-testing messages must be posted on the wall in all HTS sites.

## CHAPTER SEVEN: QUALITY ASSURANCE AND QUALITY IMPROVEMENT OF HTS

### *Preamble*

Quality Assurance (QA) and Quality Improvement (QI) are essential components of all HIV Testing Services. These measures help to ensure that HTS conform to set requirements and standards. HTS coordinators and health care providers must have a systematic and planned approach to monitor and assess the quality of HIV testing services on a continuous basis. They shall also seek to consistently modify programmes in a way that improves the effectiveness and quality of all HTS offered. More details on QA and QI can be found in the National Guidelines for Quality Improvement of HIV and AIDS services (2017) and National Laboratory Quality Assurance Framework (2016).

### **7.1 The Role of the NHLQATC in HTS**

The National Health Laboratory Quality Assurance and Training Centre (NHLQATC), has the mandate to plan and implement QA activities in order to monitor and improve the quality of HIV testing. These activities include; production of proficiency testing (PT) panels, promoting the use of standardized testing and QA register, HIV register (Rejesta ya upimaji wa VVU na uhakiki wa ubora), or implementing external quality assessment (EQA)/PT schemes, analysis of EQA data, and implementation of corrective actions.

The role of laboratory personnel at the health facilities.

- Ensure QA of HIV testing.
- Ensure that all testing SOPs are in place and adhered to.
- Ensure participation in EQA/PT schemes.
- Observe proficiency testing to ensure adherence to SOPs.
- Conduct training and mentorship for HTS providers on quality testing.
- Conduct supportive supervision to all HTS providers and testing sites.
- Perform QA audits and ensure corrective actions are done after PT.
- Ensure timely and accurate projection and accountability for HTS commodities (RDTs, DBS and PT panels).
- Ensure proper storage and management of testing commodities in accordance with the SOPs.
- Prepare reports on all HTS QA activities.

## 7.2 Quality Assurance for HIV Testing Services

Quality Assurance is defined as the overall systematic processes and procedures to ensure accurate and reliable HIV test results. Errors can occur at each step of the testing process therefore measures must be in place to assure the quality of HIV testing. Systems for IQC, EQA and Continuous Quality Improvement (CQI) must be in place at all HIV testing sites.

In order to ensure accuracy and reliability of HIV test results, health management and HTS providers must ensure that the following basic QA components are established and/or strengthened:

- All HTS providers conducting HIV testing should participate in HIV EQA schemes
- All persons performing HIV rapid tests must complete the national rapid test training, including a practical component and competency assessment, and awarded a certificate of competence. A copy of their certificate shall be made available at the HIV testing site.

The Health Laboratory Practitioner's Council (HLPC) shall provide licenses to all successful testers in accordance with the Health Laboratory Practitioners Act, 2007<sup>21</sup>

- SOPs and visual aids for HIV testing must be available onsite and adhered to by all HTS providers.
- There should be a continuous supply of appropriate HIV testing commodities.
- All persons performing HIV rapid testing must validate every new batch of test kit and document it in the national HIV register before using it for HIV testing.
- All persons performing HIV rapid testing must follow the HIV Testing Algorithm and document all HIV testing results in the National HIV register.
- HTS site supervisors, HTS focal persons, and/or authorised laboratory supervisors must conduct quarterly supervision. They must also conduct competence assessment of HIV testers, identify gaps and take corrective measures for quality improvement.
- HTS providers shall follow standard safety precautions as outlined in the respective SOPs on safety issues, including personal safety and waste management.
- The immediate supervising laboratory (i.e. the laboratory with the capacity to provide reference value or address challenges relating to HIV rapid testing) shall be responsible for QA backstopping and CQI.
- Site in-charges shall ensure that HTS providers at HIV testing sites record HIV testing data accurately and timely to ensure high quality data management.

## 7.3 Quality Control (QC)

- Quality control refers to processes and activities that ensure that testing procedures are performed correctly, that environmental conditions are suitable, and that the sample works correctly as expected. The QC process helps to detect, evaluate and correct errors before test results are reported. It is a multi-step process with checkpoints throughout the testing process.

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21 URT, MOH, Health Laboratory Practitioners Act ,2007

### *Internal Quality Control (IQC)*

- Each HIV testing site shall perform IQC using known HIV-positive and negative samples according to SOPs to ensure the production of accurate test results. If known positive and negative controls are supplied by the manufacturer, these shall be run according to the manufacturer's instructions and SOPs. HIV rapid testers shall make sure that the inbuilt control line in the test device is reactive before giving test results to a client/patient.
- Laboratory personnel shall provide IQC samples and it is recommended that HTS providers run controls:
- At the beginning of each day, for high-volume sites which are defined as HIV testing sites with 25 or more HIV tests performed in one day.
- Once a week, for low volume sites which are defined as HIV testing sites with less than 25 HIV tests performed in one day.
- Every time a new batch of HIV test kit is opened and recorded in the laboratory HIV register and when an HIV test kit is exposed to potentially damaging conditions such as extreme heat or sunlight.
- Every time when a new HIV tester starts working at a site.

### *External Quality Assessment (EQA)*

External quality assessment ensures that tests are performed accurately, results are reproducible, and errors are detected and corrected to avoid misclassification or incorrect diagnosis. The EQA process helps to evaluate testing competence and reliability of HIV testing procedures, assess performance of specific testing testers, establish the accuracy of reports of HIV status, and provide information for self-evaluation.

### *Proficiency Testing (PT)*

Participation of HIV testers in PT at least once in every year is one of the criteria to assess their competency. All HIV Testing sites shall receive their proficiency testing results through the NHLQATC within one month, and facilities that do not achieve level four of competency assessment shall continue to receive technical support from the laboratories at each level of the national laboratory system. The NHLQATC shall coordinate training on PT and register and provide PT panels to all HIV testing sites. All testers shall perform HIV testing on the PT samples on a rotational basis, and document the test results on a standard form. Testers shall return the PT results to NHLQATC within the allocated time. The NHLQATC shall crosscheck the results for accuracy. Any errors or mistakes shall be reported back to the site for corrective action. Any PT results received from the PT service provider **MUST** be reviewed and the reviewed records maintained at the testing site.

### *Supportive supervision, site assessment and observed practice*

- In regions and districts, HTS supervisors and/or staff from the referral laboratory supporting the site shall conduct regular (at least once every quarter) monitoring and assessment of each HTS site.
- All supervisors shall be trained on supportive supervision using the approved national curricular and they shall use a standard checklist.
- The national supervisory team comprising of members from the MOHCDGEC and laboratory regulatory authorities shall conduct supportive supervision including site assessments and observed practice at the regional level.
- Any recommended corrective actions from a site/supervisory visit shall be implemented before the next visit.

### *National HIV Testing Register (Rejesta ya upimaji VVU, Uhakiki ubora na matumizi ya vitendanishi)*

The HIV testing register is a critical tool for quality HTS services. It shall be used to ensure the following:

- Recording of specific HIV test results for each test performed.
- Monitoring of the batch number, type and number of HIV test kit used, date of test run, and name of the tester and QC results.
- Facilitate testers to address test kit problems, such as expired test kits or inconclusive results.

### *Therefore:*

- All testers shall fill in the HIV register immediately after conducting the HIV rapid test on a client or PT sample(s).
- Authorised laboratory officers, HTS focal persons and site supervisors shall review the HIV registers regularly for compliance.

## **7.4 Regulation on HIV Diagnostics**

The quality of HIV test kits must be assured before and after they are in the market. The WHO Pre-qualification of in vitro diagnostics promotes and facilitates access to safe, appropriate and affordable diagnostics of good quality. WHO reviews the quality, safety and performance of diagnostics that are available in the market in resource-limited settings; therefore:

- The MOHCDGEC has been using and shall continue to use WHO prequalified HIV rapid test kits.
- The NHLQATC shall continuously monitor the quality, safety and performance of HIV test kits used in the country.
- All rapid test kits utilized at testing sites must be subjected to both pre- and post-market surveillance. The NHLQATC shall conduct in-country lot verification testing both before and after distribution of test kits to testing sites to identify problems, if any.

## 7.5 Site Audit, Certification, Accreditation and De-certification

### Site Audit

- Regional and District Health Management Teams shall assess and certify all HIV testing sites based on national set standards prior to the provision of services to ensure the preparedness and credibility of the site to deliver quality HTS.
- A standard checklist (Stepwise Process for Improving the Quality of HIV Rapid Testing (SPI-RT) checklist shall be used to ensure that the testing site has the set standards in place. This is a prerequisite for certification by the MOHCDGEC. Site audits shall be done biannually.

### Site Accreditation

Sites that achieve a low score in one or more items in the checklist will be provided additional support by the facility management team to improve the score and staging of levels (levels 0 to 4). Only testing sites that have achieved Level 4 will be accredited by an independent site accrediting body appointed by the MOHCDGEC- Quality Assurance Department. Accreditation shall be valid for two years.

### Certification of HIV Rapid Testing Personnel

The Health Laboratory Practitioner’s Council (HLPC) shall provide a license and/or provisional license to all successful testers in accordance with the set criteria.

All providers performing HIV rapid testing shall be ethically responsible for taking part in QA measures by:

- Registering/retaining registration for a license to practice as per of HLPC Act 22, of 2007. The certifying board shall provide a unique registration number that will be valid for two calendar years.
- Participating in established EQA programs at least once in every two years.
- Attending refresher training related to HIV testing at least once a year.
- Demonstrating consistent competency in the HIV tests they perform.
- Performing quality, accurate and reliable testing, following testing and documentation SOPs and documenting HIV test results as per standardized HIV register and instructions (“ Rejesta ya matumizi na uhakiki ubora wa upimaji VVU”( 2017))
- Performing and documenting IQC.
- Performing at least one PT panel a year.
- Testers who are deemed not to perform well shall be given technical support through supportive supervision or mentoring training approved by MOHCDGEC as stated in relevant guidelines.
- Note More detailed information on certification can be obtained from the National HIV Rapid Tester’s Certification Framework<sup>22</sup>

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22 URT, MOHCDGEG National HIV rapid tester’s certification framework 2017

## **7.6 Quality Assurance for HIV Counselling**

The counselling component of HTS provides the client or patient with important information regarding HIV prevention, care, treatment and support. The basic conditions to ensure that high quality counselling services are being delivered are outlined in chapter three.

## **7.7 Quality Assurance for Logistics Management**

The MOHCDGEC has the overall responsibility for QA of logistics in terms of forecasting, procurement, distribution and supervision throughout the country. As the MOHCDGEC relies on accurate reporting and record keeping by facilities, the following shall be observed:

- Each HTS facility shall identify a person responsible for quality HTS logistics who will:
- Ensure accurate and timely procurement of HIV-supplies from MSD, appropriate storage of supplies and records keeping and reporting.
- Conduct realistic forecasting for HIV supplies (including test kits).
- Make timely procurement of supplies and maintain adequate stocks of unexpired supplies.
- Ensure proper storage of supplies and ensure timely delivery of HIV supplies to HTS facilities in right quantities and conditions.

## **7.8 Quality Improvement Teams (QITs) for HTS**

Quality improvement teams shall be responsible for overseeing the implementation of QA strategies as stipulated in the Tanzania Quality Improvement Framework (2017). QI activities shall be implemented at all levels from national to community level.

At the health facility, HTS providers shall form an active HTS Work Improvement Team (WIT), whose role will be to address the needs of clients and HTS providers related to HTS in the facility and the community they are serving. Individual HTS providers are also responsible for the delivery of high quality HTS to clients and communities, according to defined standards.

The HTS WIT shall apply the QI Model to identify areas of HTS provision that are performing well and areas that need improvement.





## Chapter: Key points

All HTS sites shall participate in QA monitoring and evaluation. The national HTS quality indicators shall be collected regularly at all HTS sites and used to inform program staff of achievements and gaps in quality.

Health managers shall ensure that the following minimum standards are met:

- All new batches of HIV test kits are validated before use.
- All HIV tests are conducted according to the National HIV Testing Algorithm and SOPs.
- All HTS sites take part in regular EQA activities
- All HIV positive HTS clients are referred/escorted to care and treatment centres for verification of HIV status
- Client exit interviews are conducted periodically to monitor the quality of counselling

## CHAPTER EIGHT: HIV POST TEST CLUBS SERVICES

### *Preamble*

An HIV Post Test Club (HPTCT) is a group of people who have tested for HIV and know their HIV status. They form an organized group that enables them to come together to talk about challenges, solutions, experiences and/or roles that they have in common without being judged, blamed, stigmatized or isolated. The establishment of HPTCs is of paramount importance as more people become aware of HIV and AIDS and the benefits of knowing their HIV status. HPTCs provide benefits for those who test positive as well as those who test negative. HPTCTs, also known as support groups, offer a holistic approach that can address HIV in a broader context of peoples' lives and thus mitigate the impact of HIV.

### **8.1 Rationale for HIV Post Test Clubs**

HPTCs provide immediate connection from HIV testing point to other care, treatment and support services. HPTCs members also learn different strategies on how to cope with their HIV status. Experience sharing from each other is an added advantage for those who join HPTCs for the first time after knowing their HIV status. In Tanzania, different forms of support services have been established by different stakeholders. Implementation of the comprehensive package of interventions in these clubs or support groups is expected to contribute to the attainment of the global target of 90-90-90 by 2020<sup>23</sup>.

### **8.2 Establishment of HIV Post Test Clubs**

After post HIV testing counselling, service providers at HTS and CTCs shall mobilize and sensitize clients to form or join HPTCs. Service providers shall also support the formation of HPTCs by supporting the clubs with guidelines on how to run their meeting sessions, and linking the clubs with district authorities and other support groups to get more guidance and support on how to run a club

### **8.3 Types of HIV Post Test Clubs**

There are various types of HPTCs including the following:

#### *Health Facility-Based HPTCs*

- Facility-based HPTCs are often organized as part of the integrated HIV services offered by health facilities. These clubs are structured, scheduled and facilitated by a health service provider and they provide group members with a direct link to other services (e.g. counselling, psychosocial support, etc.). Service providers shall make sure that these clubs are established and guided.

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23 The UNAIDS 2016 – 2021 Strategy: On the Fast-Track to end AIDS.UNAID. Geneva

### *Institution-Based HPTCs*

Institution-based clubs are clubs that may be allied, but not directly associated with health facility directly.

- Most of them are organized through community-based organizations, Institution-based or Faith-based Clubs. Some of these organizations offer home-based, peer-facilitated clubs or off-site locations. Service providers need to first establish their existence and then link clients as necessary.

### *Professional HPTCs*

- These clubs are not officially affiliated with an institution or governmental agency. Their members belong to the same profession e.g. teachers, doctors, nurses, etc.
- They are organized by professionals who are HIV negative, who have had experience with HIV, or are living with HIV. Others are facilitated by a social worker or healthcare professional.
- They serve as a shelter for emotional support and interaction, encouraging members to actively exchange ideas, advocate for their rights and pursue professional development.

The HTS and other health care providers must establish their existence and link clients as necessary.

### *Community HPTCs*

These are clubs that are based at the community and usually meet at a community site/centre or a house. Most of them are organized by people who have tested HIV positive.

Individuals who test HIV negative or those who have had experience working with PLHIVs should also be encouraged to either join the PLHIV clubs or form their own.

These clubs often serve as an emotional and economic empowerment club; encouraging members to actively exchange ideas, advice and experiences.

HTS providers should:

- Support the establishment of community HPTCs in their catchment areas.
- Solicit and link to additional support from various extension workers including community development officers, social workers, community health workers, and CBOs that provide HIV and AIDS services.

### *Online HPTCs*

Online clubs are not very common in Tanzania but they serve an important function for PLHIVs who are either isolated by location or feel they can speak more freely and safely in an anonymous environment. Online clubs are useful for disseminating HIV-related information regardless of HIV status, offering valuable emotional and coping support, particularly in times of crisis.

- HTS providers should identify and map HPTCs in their catchment areas and link clients as necessary.

#### **8.4 Age categorization of HPTCs**

The needs of HPTCs may differ by age and this has to be taken into consideration in the formation of HIV post-test clubs. There are three main types of HPTCs for different age categories, each type with different needs.

##### *Paediatric clubs: Pre-school and low level class (0 to 9 years)*

After post-test counselling, the HTS provider should discuss with the parent or guardian about post-test clubs and solicit their consent if they agree to have their children enrolled in a HPTC. Paediatric members MUST get consent from their parent or guardian.

##### *Youth clubs: Early adolescence (10 to 14 years), adolescence (15 to 19 years) and young adulthood (20-24 years)*

- HTS providers shall seek parents' or guardians' consent for their adolescent child or youth adult's participation in an HPTC.
- They should ensure that members' psychosocial and training needs are tailored according to their respective age groups. Counsellors and facilitators providing services to adolescents and minors should receive additional training on issues relating to the establishment and operationalisation of youth clubs.

##### *Adult clubs: (25 years and above)*

HTS providers shall make sure that people 25 years of age and above can join adult clubs and service providers shall group adult members into two age groups:

- 25-49 years
- 50 years and above

##### *Pregnant and Lactating Mothers' Clubs*

These clubs are formed at ANC and PMTCT clinics. In some sites they are called Mother to Mother (M2M) clubs where mothers meet to share their concerns.

In order to sustain these clubs, the health and HTS providers shall:

- Assist in the formulation of clubs at the ANC/PMTCT clinics.
- Support members by providing psychosocial support and skills for partner disclosure counselling.
- Link mothers with community-based HIV services for continuity of care and adherence counselling including counselling on safer infant feeding practices.

## 8.5 HPTC Leadership

Health and HTS providers shall ensure that:

- All HPTCs have appropriate leadership comprising of a Chairperson and Secretary. Clubs may elect additional leaders based on their needs.
- Club leadership is selected through a process that is transparent and fair, as articulated in the Club's constitution.
- Council AIDS Control Coordinators (CHACCs), NGOs, CBOs and FBOs should assist during HPTC elections by serving as objective observers.

**IMPOTANT:** It is important to distinguish between HPTC activities and IGAs.

- There must be a clear distinction between club activities for HIV support and club activities for IGAs; if mixed up it usually jeopardizes HPTC activities.
- HIV and AIDS prevention shall be a permanent agenda of HPTC among other agendas even if they are engaging in IGAs.

## 8.6 Monitoring and Evaluation of HIV Post Test Clubs

Monitoring and evaluation of HPTC helps to assess operations, track progress and facilitate decision making for improving service. Monitoring provides constant feedback on the extent to which the clubs are achieving their goals. Every HPTC cluster level will monitor and evaluate the operations and activities of the cluster below it, from national down to ward level. Detailed information on monitoring of HTS is provided in chapter ten.



### Chapter 8: Key Points

- HIV Post Test Clubs are support groups for both HIV positive and HIV negative individuals.
- Involvement of HPTC members is essential to achieving a holistic understanding of and response to HIV.
- Members may be recruited at health facility points, in the community, or online after knowing their HIV status.
- Members shall be involved as much as possible in the planning, designing and delivery of services in the clubs.
- Clubs members' personal experiences have been extremely valuable in peer counselling and in the normalization of HIV and AIDS in communities.
- Monitoring and evaluation is an essential aspect of club operations to ensure a meaningful contribution to the HIV response.

## CHAPTER NINE: HUMAN RESOURCES FOR HIV TESTING SERVICES

### *Preamble*

Availability of well-trained HIV Testing Providers countrywide is critical for the provision of high-quality HTS. HIV testing providers are required to be compassionate, dedicated, caring individuals, as they have the very challenging and rewarding task of informing persons of their HIV status. Standardized HTS training should cover how to correctly conduct full HTS procedures, including collecting samples, performing RDTs following the national HIV testing algorithm, as well as record-keeping and reporting. HIV testing providers should also be oriented to these guidelines, up-to-date job aids, and SOPs. In addition, they should receive on-going supportive supervision, mentorship and refresher training from HTS supervisors and Health Management Teams (HMTs). This chapter describes the human resources component in the provision of quality HTS at different levels.

### **9.1 Basic Educational and Ethical Requirements for HTS Providers**

#### *Educational requirements*

HTS providers should have following educational qualifications:

- Secondary level education.
- Additional training or certification in health or related fields.
- Training and certification as an HTS provider based on the approved national HTS training curricula with both didactic and practical components.
- Passed a skill-based proficiency test in order to be certified as HTS providers.
- Certified by the Tanzania Health Laboratory Practitioner Council to perform HIV testing.

#### *Ethical Standards*

HTS providers shall adhere to professional and ethical codes of conduct in all HTS approaches and settings. A breach of these standards will result in disciplinary action as provided in *The HIV and AIDS (Prevention and Control) Act 2008*.<sup>24</sup>

### **9.2 Training of HTS providers**

MOHCDGEC through the NACP and Diagnostic Services section, are responsible for the development of the HTS curriculum and training packages. The training materials have been translated into Kiswahili so that their content is well understood by all HTS providers at all levels of the health care delivery system. There shall be two main types of training; namely basic training and ongoing refresher training.

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24 HIV and AIDS (Prevention and Control) Act 2008

### *Basic training*

This shall be provided to identified HTS providers prior to their engagement in HTS. The main types of basic trainings are: -

#### *Client Initiated HIV Testing and Counselling (CITC) Training*

HTS providers in an integrated or stand-alone CITC/VCT site, mobile/outreach, and home based, work-place, or health facility HTS settings shall receive CITC training according to the MOHCDGEC CITC training curriculum.

#### *Training on Provider-Initiated Testing and Counselling (PITC)*

PITC training shall be conducted for facility health care professionals to enable them provide HTS as part of routine medical care.

#### *HIV Rapid Testing Training*

HIV rapid testing training and certification shall be provided to all identified HTS providers to enable them perform HIV rapid testing. The training shall be provided as a module during the CITC/PITC counsellors' course to equip providers with the following:

- Skills to draw blood samples, conduct HIV rapid tests, and read, record and reporting of HIV rapid test results, according to the national HIV testing algorithm.
- Skills to conduct quality assurance for HIV testing.

**Note:** All trainees shall be certified and licensed as HIV testers by the Tanzania Health Laboratory Practitioner Council after they pass the competency test.

#### *Additional training considerations for some population groups*

Additional training curricula that supplements HTS provider skills are listed below. HTS providers can take these trainings in their entirety or as refresher trainings.

#### *HTS Training for Key and Vulnerable Populations (KVPs)*

Health care workers and HTS providers shall receive standardized pre-service and refresher training on providing HTS to KVPs. The 2017 guidelines for Key Populations shall be used for training/re-training HTS providers.

#### *HTS for Persons with Disabilities (PWD)*

The MOHCDGEC shall coordinate the orientation of some of the HTS providers in knowledge and skills to understand the use of sign and brail language and psychology of persons with disabilities.

### 9.3 Coordination and Harmonisation of HTS Training

In order to sustain the quality of HTS training and service provision, all training must be conducted on the basis of the HTS training curriculum approved by the MOHCDGEC. In addition to didactic training courses, practical, hands-on training with supportive supervision and mentorship shall be provided as a pre-requisite to licensing. The MOHCDGEC through NACP shall do the following:

- Maintain a team of master trainers to carry out all counsellor training using the approved national training curricula and training materials to ensure standardisation and quality. The counsellor master trainers must be qualified counsellors themselves and role models of counselling ethics.
- Develop and carry out periodic reviews of HTS training curriculum and materials to be used for the different courses.
- Provide a mechanism that will facilitate the identification and accreditation of institutions (zonal), NGOs and FBOs and empower them to provide HTS training.
- Maintain a roster of mentors for HTS providers and conduct regular site visits preferably every quarter. Teams should comprise of members from counselling, laboratory, quality improvement and health information units.
- In collaboration with the HLPC, the NACP shall also coordinate auditing of HTS Providers and sites outlined in chapter 7.

### 9.4 Comprehensive Supportive Supervision and Mentoring

Regular and appropriate comprehensive supportive supervision shall cover HTS, among other things, to ensure high quality service provision and mentorship to HTS providers.

#### *During supportive supervision, supervisors shall;*

- Identify issues/challenges
- Empower health workers to improve on their performance by enhancing skills, knowledge and abilities.
- Identify gaps that require further technical support.
- Facilitate the development of an action plan to address the identified problems.
- Follow up on the implementation of the previous action plan.

#### *During mentorship, mentors shall;*

- Mentor HTS providers according to the Manual of Comprehensive Supportive Supervision and Mentoring of the HIV and AIDS Services (2017 Edition).
- Assess mentees' performance and provide coaching as necessary;
- Support the application of theoretical learning to clinical /practical care;
- Prepare and agree on an action plan.



### 9.5 HTS Providers Professional Growth and Development

As with any profession, HTS providers shall have opportunities for professional growth and development to ensure an active and competent workforce. HTS managers and supervisors shall facilitate the participation of HTS providers in the attainment of additional knowledge and skills.

### 9.6 Occupational Health and Safety

All health management and HTS organizations have an obligation to care for their workers. HTS providers are at risk of occupational exposure to HIV through needle stick injuries and other workplace accidents. It is the responsibility of the management to do the following:

- Provide adequate training to all employees so that all HTS are conducted in accordance with SOPs, minimizing risk of needle pricks. In addition, there should be, adequate facilities for disposal of contaminated waste.
- Make PEP available to persons who experience occupational exposure to blood contaminated needles or other sharp instruments.
- Ensure all HTS delivery sites have a copy of the MOHCDGEC PEP guidelines.
- Provide appropriate infrastructure for HTS e.g. good ventilation, comfortable workstations with hand washing and sharps disposal facilities.

### 9.7 Task Sharing of HTS: Increasing the Scope of Trained Workers

Task sharing – the rational redistribution of tasks from “higher level” cadres of health-care providers to other cadres – is a pragmatic response to health workforce shortages. The MOHCDGEC Task Sharing Policy Guidelines for Health Sector Services in Tanzania (2016) indicate that Social Welfare Assistants (SWAs) and CHWs can be allowed to support health workers in the provision of HTS. For successful implementation of Task sharing in HTS;

- The MOHCDGEC shall develop/coordinate the development of the HTS training curriculum and training materials for non-medical cadres.
- Existing and new HTS Master Trainers shall receive abbreviated training on the non-medical HTS curriculum before they train non-medical cadres.
- Master Trainers must ensure that the training provided to non-medical HTS providers is practical to enable trainees undertake tasks such as provision of quality HTS, linkage to care, adherence counselling, post-test support and group management.
- The selection of non-medical HTS trainees shall ensure the selected trainees have a professional conduct, knowledge, and skills in dealing with sensitive issues, respect for confidentiality and an ability to listen.
- The MOHCDGEC (NACP) shall develop and distribute job aides and SOPs (preferably translated into Kiswahili).

- Regional and District providers and HTS Supervisors shall conduct on-going mentoring and supportive supervision.
- The NACP in collaboration with the National Laboratory Diagnostics section shall strengthen quality assurance systems at all levels of health service delivery, including EQA for the trained non-medical HTS providers.

### 9.8 Roles and Responsibility of the personnel providing HTS

The managerial and coordination roles and responsibilities at different levels are described in Chapter Twelve.



## Chapter 9: Key points

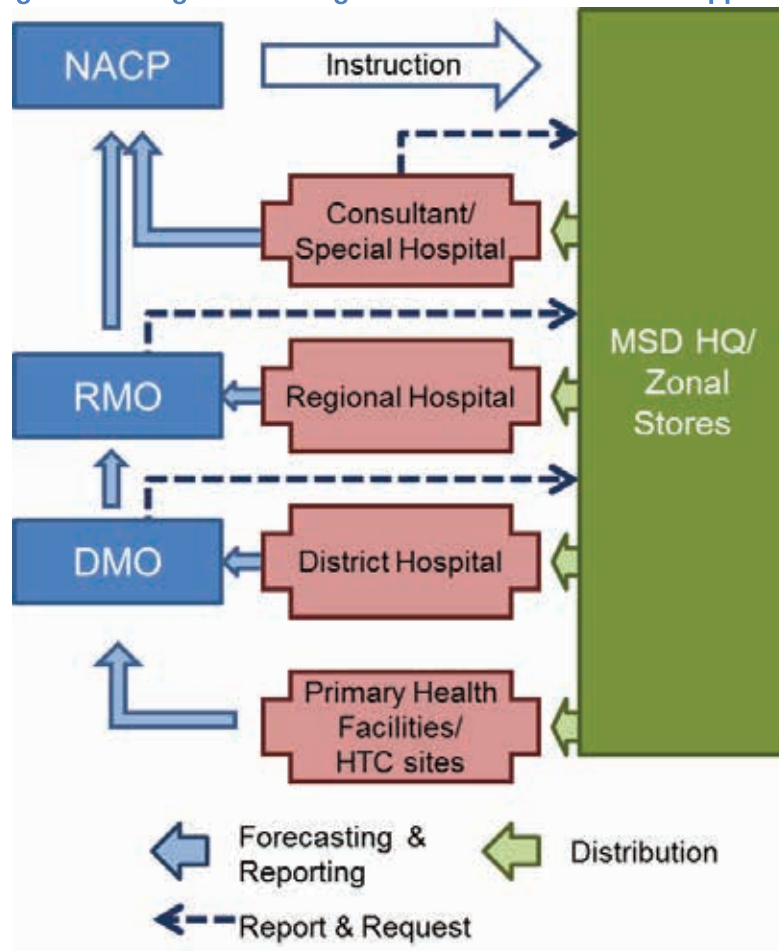
- All HTS training for health care workers as well as non-health care workers must be conducted using the national HTS training curricula.
- HTS providers must be certified by the Tanzania Health Laboratory Practitioner Council to perform HIV testing.
- Health Facility Management, HTS and laboratory supervisors should conduct on-going supportive supervision, mentorship and refresher training for HTS providers at least once a year.

## CHAPTER TEN: COMMODITY MANAGEMENT FOR HTS

### Preamble

The quality of services provided at HTS sites depends much on timely and accurate quantification, procurement, storage, distribution, and monitoring of essential HTS commodities and supplies, including those used for Infection Prevention and Control (IPC). Logistics management of HTS commodities requires all actors at MSD, MOHCDGEC, NACP, Specialized Hospitals, Regional Hospitals, District Hospitals, and Primary Health Facilities/ HTS sites, to effectively perform their roles and responsibilities to ensure the availability of the right products, in the right quantities and condition, at the right place and time, acquired at right cost.

Figure 10.1 Logistics Management Flowchart for HTS Supplies



## 10.1 Required HTS Supplies

Accurate record maintenance and reporting of the number of clients attended and specific services offered are among important factors that help to establish types and quantities of supplies needed at each HTS site. Generally, the commodities and supplies listed below should be sufficiently available during the provision of HIV rapid testing for all approaches and in all settings:

- HIV rapid test kits and accessories
- Lancets and capillary tubes if not included in the DBS or test kit
- Timer or stop watch for ensuring test kits are read within the recommended time frame
- Needles and syringes
- Other medical consumables, such as swabs, spirit, disinfectants, sodium hydrochloride
- Gloves and other supplies needed for universal precautions
- Sharps disposal containers / safety boxes
- Waste disposal (colour coded) containers and their liners
- Registers for record keeping
- Reporting forms (logbook)
- Condoms – both female and male
- Penile and pelvic models for demonstration of condom use

In addition to standard HTS supplies, the following supplies shall be used by HTS providers during home-based, outreach and mobile HTS services:

- Boxes for carrying test kits and ensuring that the temperatures do not exceed (2□-27□ C)
- Plastic sheets and testing surface such as a plastic cutting board
- Portable sharps disposal containers and biohazard waste containers
- Torches, umbrellas, rain coats, gum boots
- Hand washing equipment and water (Soap and/or hand sanitizer, paper towels)
- Backpack for carrying supplies
- Water bottle for storing drinking water
- Mobile phone for each home-based HTS team in case of an emergency
- Job aids and home-based HTS protocols

## 10.2 HIV Test Kits

All HIV test kits procured and used for HTS in Tanzania must be approved and registered by the MOHCDGEC through the Tanzania Food and Drug Authority (TFDA). Only HIV test kits approved by TFDA and included in the National HIV Testing Algorithm shall be used for HIV testing. Table 10.1 shows the currently recommended HIV Test kits, storage temperature requirements, maximum shelf-life and packaging

**Table 10.1: The Current Recommended HIV Test Kits**

S/N	Test
1	SD BIOLINE HIV I/2-3.0 (Rapid test kit)
2	Uni-Gold HIV Test

The MSD shall ensure newly received batches of HIV test kits are quality checked by the NHL-QATC before their distribution to sites. This requirement applies to all sites providing HTS in both public and private health facilities. Public facilities and approved private and faith based facilities may receive HIV rapid test kits from MOHCDGEC through MSD.

### 10.3 Quantification

Quantification is the general term for the process of estimating the quantities of specific equipment, laboratory reagents, and consumable medical supplies required to serve customers in a health program for a given period of time.

Quantification for HIV test kits involves:

- I. Preparation  
This includes defining the scope and purpose and collecting required data directly from health facility reports or through HMIS or eLMIS.
- II. Forecasting  
This includes organizing and analysing data, selecting a forecasting method, building forecasting methods and calculating forecasted consumption for each product.
- III. Supply planning  
This includes but is not limited to organizing and analysing data, building supply planning assumptions and developing a supply plan.

#### *Roles and Responsibilities – Site level*

Forecasting for test kits and other supplies depends on accurate and timely reporting from all HTS sites.

- I. HTS sites shall report the requisite consumption data to the DMO. This information shall include the number of test kits used each month, quantities in stock and the number of test kits expired each month.
- II. HTS sites shall also note if there is a need for more kits in a particular month due to planned outreach HTS events, other mass HTS services, or increased capacity for providing HTS.
- III. HTS sites shall consider the lead period between ordering and delivery of supplies.
- IV. HTS sites shall observe the established maximum and minimum levels for inventory.

## 10.4 Procurement

All HIV tests and related commodities are procured centrally through NACP and received by MSD. Following the reporting procedures outlined above, sites will request test kits and other HTS supplies from the DMO and the DMO shall request supplies directly from MSD. Medical officers, and in-charges of regional and district hospitals shall order their own supplies.

## 10.5 Receiving, Storage & Distribution

At national level, HIV test kits are received and inspected centrally then distributed to MSD's eight zones and two sales points. MSD zonal stores and all facilities/sites providing HIV testing services shall keep an accurate inventory of their supplies and commodities. They should also ensure that HIV test kits and other commodities are stored properly and used before their expiry date by adhering to the First to Expire First Out (FEFO) rule during issuance. HIV tests and commodities must be stored as specified in the manufacturers recommended storage conditions inserted in the HIV test kits and SOPs.

At every facility where commodities are stored, a designated person shall ensure accurate and timely ordering of HIV testing supplies, appropriate storage including accurate stock rotation, record keeping and reporting. This person shall be accountable for maintaining quality HIV testing supplies and shall promptly report any problems with the management of commodities to the site supervisor or in-charge of the facility. MSD is responsible for the distribution of test kits and other supplies to all health facilities in accordance with the Integrated Logistic System (ILS) Protocol.

### *Roles and Responsibilities - National level*

The MOHCDGEC forecasts needs, allocates central funds, procures and supervises

MSD Central/zones receive the right supplies of the right quality in the right quantities and at the right time. They then store and distribute the same to the right place.

The **Hospital level** prepares orders, receives supplies of the right quality in the right quantities and at the right time and serves clients.

The **District level** reviews and approves orders from dispensaries and health centres, allocates local funds, receives right supplies of the right quality in the right quantities and at the right time and delivers the same to facilities/sites while storing in transit supplies.

The **Site level** prepares orders, receives right supplies of the right quality in the right quantities and at the right time and serves clients.

## 10.6 Monitoring & Evaluation of HTS Commodities

NACP shall conduct yearly audits of the commodity management systems for HIV test kits and other essential supplies. This will facilitate the determination of the effectiveness of the process and prevent mismanagement of HTS commodities and supplies.

Personnel at every level of the commodity management process for HTS commodities shall strive for high quality commodity management in order to avoid stock outs altogether. In the event that any HTS supplies including HIV rapid tests are out of stock at the HTS site, the DMO shall be informed in order to mobilize test kits or supplies from other sites in the area.

Personnel at every level of the commodity management process for HTS commodities shall strive for high quality commodity management in order to avoid stock outs altogether. In the event that any HTS supplies including HIV rapid tests are out of stock at the HTS site, the DMO shall be informed in order to mobilize test kits or supplies from other sites in the area.



## Chapter 10: Key Points

- Logistics management of HTS commodities the availability of the right products, in the right quantities and condition, at the right place and time, acquired at right cost is key to quality HTS.
- Only HIV test kits approved by TFDA and included in the National HIV Testing Algorithm shall be used for HIV testing.
- HTS providers must be trained/re-trained on accurate record maintenance and reporting of the number of clients attended, commodities and supplies.
- Every facility must have a designated person accountable for maintaining adequate and quality HIV testing supplies.
- The MSD shall ensure newly received batches of HIV test kits are quality checked by the NHL-QATC before their distribution to sites. The same principle applies in all HTS sites, that new batches are quality checked and recorded in the HIV register.

## CHAPTER ELEVEN: MONITORING AND EVALUATION

### *Preamble*

Monitoring and Evaluation (M&E) is an essential component of quality HIV testing and services. It provides reports on key indicators that allows programmers to track trends in HTS inputs, processes, outputs, outcomes and impacts which are useful for informed strategic planning.

**Monitoring** involves routine collection, analysis and reporting of data to assess progress against set targets. It aims to establish trends, patterns, adaptation of strategies so as to inform decisions for programme management.

**Evaluation** includes assessment of ongoing or completed projects, programmes or policies, their design, implementation and results. The aim of evaluating HTS is to determine the relevance and fulfilment of objectives, developmental efficiency, effectiveness, impact and sustainability.

The MOHCDGEC through NACP shall ensure that National HTS M&E tools are used at all HTS sites for data collection and reporting on key indicators. Data quality shall be assessed regularly and improvement plans developed as needed by supervisors as part of QA systems. It shall also conduct periodic reviews/evaluations to assess HTS outcomes and impacts more rigorously. These evaluations may provide key information on specific elements of HTS that are successful or where modifications need to be made.

### **11.1 HTS Data Sources**

HIV testing data are generated from various service points as follows:

- a) Clinical departments (e.g. OPD, IPD, theatre, dental clinic, eye clinic, TB/HIV clinic, laboratory, etc.) within hospitals, health centres and dispensaries,
- b) Gender Based Violence (GBV) Services,
- c) PEP Services,
- d) PMTCT: ANC, labour and delivery, postnatal, and family planning
- e) VMMC Services,
- f) Community Based HIV Services (CBHS),
- g) Standalone Voluntary Counselling and Testing (VCT) Centres,
- h) KVP Services,
- j) ART CTCs (may be stand alone or integrated)

### **11.2 Data Collection**

Client or patient information shall be collected during every HTS encounter in all approaches and settings using MOHCDGEC approved HTS data collection tools:

- National HTS registers to record initial testing and retesting for verification for collecting both demographic and HIV testing information



- HTS reporting tools to be used at designated periods (i.e. on monthly basis).
- Accurate recording on and completion of data collection tools shall be ensured. All HTS providers shall be trained on data variables and on the necessity of completing data collection tools for each client or patient before they leave the HTS room. However, collection of such information shall not interfere with the counselling process.
- HTS clients or patients shall be informed that information captured on the data collection tools is confidential.

### **11.3 Data Compilation**

These guidelines contain several new innovative approaches and settings for the provision of HTS which have necessitated a revision of data collection and reporting. Health Management teams and HTS supervisors must ensure that all HTS providers at all levels are trained/supervised and mentored on these changes. They should utilize the data they collect for planning purposes and identification of areas for improving service provision at their individual sites. The changes are elaborated in Table 11.1.

### **11.4 Data Reporting and Feedback**

At the end of every month, HTS sites shall aggregate data from the registers and enter this information into the standard monthly HTS reporting form as outlined below:

- Monthly reporting forms shall be sent to the DMO's Office, through DACCs by the 7th day of the month following the month of data collection.
- The DMO/DACC will receive, validate, and enter data into the District Health Information System (DHIS-2) for the data to be available to the RMO's Office and national level.
- The DMO's and RMO's offices as well as NACP will validate the data and send feedback to the lower level, as such, the district level shall provide feedback to the HTS site, regional level shall provide feedback to the district; and the national level shall provide feedback to the region.
- Annual reports will be developed and disseminated to all relevant stakeholders, including HTS sites.
- In addition to national level reports, all reporting levels should retain their copies and utilize them for planning purposes. Feedback on data collection, data quality, or trends in data outcomes shall be communicated back to HTS sites, districts and regions, as outlined in the data flow system in Figure 11.

### **11.5 Data Analysis and Interpretation**

HTS data are analysed regularly, on demand and on an annual basis to produce reports. The outputs in these reports, together with activity-specific reports are aligned with national HTS input, process, output and outcome indicators.

**Selection and Use of Indicators**

These revised guidelines have recommended multiple HTS approaches to maximize HTS coverage and uptake. Disaggregating service statistics by HIV diagnosis, by service delivery point and/or by population subgroups shall help when setting targets for HTS and linkages into care, treatment, and prevention and support services. Disaggregation of HTS data at national level is important to ensure that critical populations are accessing HTS. Such disaggregation's are exemplified in Box No. 11.1

**Table 11.1: HTS Data Compilation**

Testing and data compilation scenarios	Final report sent to NACP
<p><b><u>PITC data</u></b></p> <p>All clinical departments (as listed above) within all health facilities, GBV services, PEP &amp; PrEP services, Postnatal services, Family Planning services, VMMC services, ART clinics, Community HTS and KVPs services such as those provided to Adolescents Girls and Young women (AGYW), Sex Workers (SW), Males having Sex with other Males (MSM), Injecting Drug Users (IDU). All the testing data from all of these points, if within the same facility, will be combined as one report from each facility.</p>	<p><b><u>PITC through DHIS2</u></b></p> <p>Compile as one report for each facility</p>
<p>National HTS Register shall be used to record Retesting for verification at all ART initiating sites. Reports of retesting for verification shall be prepared separately and be included in a comprehensive monthly facility report for HTS.</p>	<p>Prepare data separately. Include the data in the monthly facility report for HTS.</p>
<p><b>Antenatal</b></p>	<p><b><u>MTUHA-6</u></b></p>
<p><b>Labour &amp; Delivery clinics</b></p>	<p><b><u>MTUHA-12</u></b></p>
<p>ANC and Labour clinics shall use HIV testing registers (both for initial testing and retesting for verification)</p>	<p>Testing data will be entered into DHIS2 through the PITC channel</p>
<p>Standalone <b>CITC</b> Clinics and Private Health Facilities shall use the national HIV testing registers for testing and retesting data, and compile report using monthly facility report for HTS.</p>	<p>Report into DHIS2 through the <b>CITC</b> channel</p>

HIV testing at the community shall be done using the HIV testing registers for initial testing and compile monthly summary HTS report	Report into DHIS through the <b>Community Based HIV Services (CBHS)</b> channel.
Retesting for verification registers shall only be used in the community if ARVs would be initiated by approved personnel at the community.	Prepare data separately. Include the data in the monthly facility report for HTS.

### HTS Global Indicators

Two indicators are adopted from WHO's recommendation for re-testing all newly diagnosed persons to verify the results before starting ART. These indicators shall read;

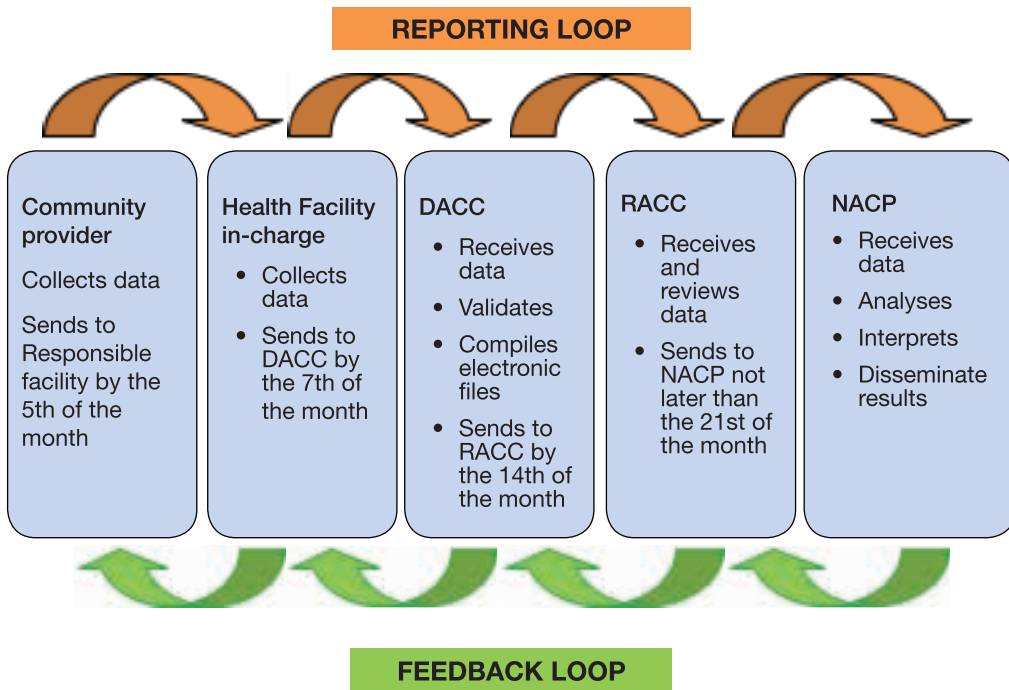
- **% of persons linked and re-tested (verified) HIV positive at care and treatment clinics**  
**Numerator:** *Number of person linked and re-tested positive (newly diagnosed)*  
**Denominator:** *Total number of newly diagnosed persons linked and re-tested*
- **% of persons linked and re-tested (verified) HIV negative at care and treatment clinics**  
**Numerator:** *Number of person linked and re-tested as HIV negative*  
**Denominator:** *Total number of persons linked and re-tested for HIV at CTC.*

#### Box 11.1 Categories for disaggregation of variables recommended by WHO

Below is an exemplified list of variables for disaggregating HTS data:

- **Age:** <1, 1–9, 10–14, 15–19, 20–24, 25–49, 50+
- **Sex:** male, female
- **Test result:** HIV-positive, HIV-negative, Inconclusive
- **Population:** pregnant or breastfeeding women, partners, key populations; sero-discordant couples, infants and children, adolescents, TB/STI clients/patients linkages.
- **Geographic area:** district, region, province, facility, community
- **Service delivery point:**
  - Facility-based, for example, ANC clinics, outpatient care, inpatient care, TB clinics, STI clinics, HTS clinics, integrated HTS
  - Community-based, for example, home-based, door-to-door, mobile outreach

Figure 11.1: M&E Data Flow and Information system for HTS in Tanzania



## 11.6 Data Use and Sharing

HTS reports shall be used for health planning, resource mobilization, documentation and scientific publications.

### HTS Sites

At HTS sites, providers shall use their data for:

- Guiding programme planning and implementation;
- Resource allocation to meet programme goals.
- Monitoring uptake of HTS services over time.
- Determine populations that utilize HTS services and map areas/populations not using these services.
- Monitoring and improvement of the quality of HIV testing services while also addressing any problem(s) identified.

## *Districts and Regions*

At district and regional levels, HTS managers shall utilize data for:

- Guiding programme planning and implementation;
- Resource allocation to meet programme goals.
- Determining sites that are successful and those that may need additional supportive supervision.
- Motivational support to sites that are performing well e.g. a letter of recognition or congratulatory letter. This could be done bi-annually.

## *MOHCDGEC- National HIV/HTS*

The NACP shall use HTS data for some of the following:

- Answering critical questions about Tanzania's HIV epidemic in a local, regional, national context.
- Determining geographic areas that shall be prioritized for HTS service delivery using different HTS approaches.
- Documentation and dissemination as outlined in sections 11.4.4 and 11.4.5

## **11.7 Documentation**

- The MOHCDGEC encourages continuous documentation of M&E best practices, lessons learned and publications of HTS data. Nonetheless, scientific publications in any format e.g. papers aimed for peer review journals, abstracts, conference proceedings, etc. that are based on national HTS data must seek the prior approval of the MOHCDGEC.
- Moreover, where appropriate, other national ethical approval entities such as the National Institute of Medical Research (NIMR) and independent academic ethical committees shall also be engaged.

## *Sharing of data summary reports*

Data summary reports and resulting information shall be shared with stakeholders at all levels as follows:

- DMOs shall share these reports with HTS sites, Local Government Authorities, District Commissioners, District Executive Directors and stakeholders in the district,
- RMOs shall share their reports with all districts within their region, the Regional Commissioner, the Regional Administrative Secretary and key stakeholders in the region,
- The NACP Programme Manager shall share reports with RMOs, TACAIDS, other ministries, implementing partners, development partners and other key national stakeholders,

## 11.8 Data Storage and Security

Both paper based and electronic data collected at HTS sites are confidential and therefore: -

- All HTS providers shall treat clients' records with the same level of protection as all other medical records.
- HIV testing registers shall be stored at HTS sites for as long as permitted both by facility and the MOHCDGEC agreed archiving standards.

## 11.9 HTS Target Setting

National targets shall be developed on the basis of contributions from regional and district levels. HTS sites shall also establish their targets, which shall contribute to district set targets. Relevant providers at all levels shall be trained to understand the set targets, so as to avoid possibilities of under or over-targeting at all levels.

### *Stakeholders' Support for M&E Roles*

The successful implementation of the HTS monitoring system requires the concerted efforts of different stakeholders at all levels of the health care delivery cascade i.e. national to community level.

### *National Level Support for M&E*

- The M&E section of NACP maintains a secure electronic system with overtly updated, summary-level data based on information received from site, district, and regional levels. NACP's M&E for HTS is centered on the following core activities:
- Maintain support to prevent tempering of micro-databases at all testing sites
- Analyze, interpret, provide feedback and disseminate HTS information to all stakeholders
- Guide supportive supervision for M&E activities at regional, district and HTS sites,
- Coordinate training of HTS providers on the importance of data collection, analysis and use,
- Routinely review national HTS M&E tools
- Ensure credibility of reported data through guided data quality assessments at all levels

### *HIV and AIDS Implementing Partners*

- Comply, develop and scale-up the national HTS M&E system
- Support regions, councils and health facilities on the analysis, dissemination and use of quality data

### *Regional and Council Level Support for M&E*

Slight variations may exist with regard to M&E roles and responsibilities of regional and council stakeholders. The shared roles and responsibilities of regional and council stakeholders include but are not limited to:

- Building the capacity of primary health facilities and standalone sites on the management (including recording and reporting and data quality reviews) of HIV testing data.
- Coordinate trainings of service providers at all testing points on HIV and AIDS HTS M&E system.
- Mobilize resources at those levels to strengthen the HTS M& E system.
- Disseminate HTS data at regional and council level, and
- Strengthening communication with national level regarding all HIV and AIDS M&E matters at regional and council level.

### *Health Facility level*

- Ensure availability and effective use of the recording and reporting tools for HIV and AIDS testing services,
- Ensure timely entry into DHIS2 of HTS reports and submission to the DMO's office,
- Report all challenges faced by the health facility in all HIV and AIDS HTS M&E systems to the DMO,
- Conduct and report on internal data quality assessments on a quarterly basis.

### **11.10 Monitoring and Evaluation of HIV Post Test Clubs**

Monitoring and evaluation of HPTCs helps to assess operations, track progress and facilitate decision making for improving service. Every HPTC Cluster level will establish their M&E plan reflecting the operational objectives and activities of the cluster below it, from national down to ward level.

### *National, Regional, and District Authorities*

- Conduct baseline study or use existing information as baseline reference,
- Involve all stakeholders based on the principles stated in Public Private Partnership (PPP) e.g. ensure ethical consideration to respect and protect the rights and welfare of all those involved in HPTC operations,
- Design a specific methodology to gather information about HPTC establishment and operationalisation that links specific goals and objectives to result pathways.

### Suggested Monitoring Indicators for HPTCs

HPTC indicators for monitoring and evaluation will include but not be limited to the following:

- Total number of HPTC members registered, by sex, age and marital status
- Number of new HPTC members registered in every quarter/year
- Number of functioning HPTCs at district, region and national
- Number of HPTC members linked to care and supportive services
- Number of HPTC engaging in IGAs
- Number of couples joining HPTCs each quarter/year
- % of members with known HIV status

### 11.11 Monitoring and Evaluation of essential HTS Commodities

Monitoring of HTS consumables at service delivery points enables the establishment of both efficiency and effectiveness in the acquisition, usage, and disposal of supplies and commodities.

Personnel at all testing points shall ensure high quality recording and reporting of commodities and supplies to avoid unrecorded expirations and stock-out altogether.

### Suggested Monitoring Indicators for HTS Essential Commodities

Suggested indicators for monitoring HTS essential commodities will include but not be limited to:

- % of testing sites that have experienced stock-out of HTS test kits
- % of testing sites that have experienced stock-out of condoms
- % of ordering facilities timely submitting logistics reports for HTS test kits
- % of health facilities implementing electronic logistics data management system.



## Chapter 11: Key points

- Monitoring and evaluation of HTS has expanded from measuring numbers, such as number of people tested, to measuring HTS effectiveness and outcomes.
- The global critical indicator is: *“Proportion of People Living With HIV Who Know Their Status”*.
- A new indicator has been added i.e. Proportion of people newly diagnosed HIV-positive who have been re-tested and verified as positive or inconclusive.
- In addition to routine programme monitoring special surveys shall be carried out for Key population-specific data.



## CHAPTER TWELVE: IMPLEMENTATION FRAMEWORK

### *Preamble*

Delivery of HTS in Tanzania relies on the participation and coordination of many authorities within the Government structure, from the national level to primary health facilities. Additionally, the role of Non-Governmental Organizations (NGOs), Private Health Facilities including faith-based organizations (FBOs) and Community-Based Organizations (CBOs) is critical to improving access to quality HTS for all Tanzanians. This chapter outlines the roles and responsibilities for HTS provision at different levels of implementation.

### **12.1 National Level**

The Tanzania Commission for AIDS (TACAIDS) provides overall coordination of the multi-sectorial response to HIV and AIDS in the country.

The MOHCDGEC, through the NACP, coordinates the implementation of technical aspects of HIV and AIDS prevention, care, treatment and support programmes, including HTS.

The President's Office Regional Authority and Local Government (PO-RALG), manages planning and implementation of the HIV and AIDS prevention, care, treatment and support programmes, including HTS.

The Medical Stores Department (MSD) is responsible for procurement, storage and distribution of HIV and AIDS commodities and supplies.

The National Health Laboratory and Quality Assurance Training Centre (NHL-QATC) is responsible for quality assurance and quality improvement of HIV testing.

The NACP convenes an HTS Technical Working Group (TWG) comprised of technical experts from MOHCDGEC, representatives from regional and district health authorities, bilateral and multilateral agencies, international and national NGOs, academia and other implementing partners, which meets regularly and provides technical support in the following key areas:

- Policy formulation and establishment of strategic plans regarding HTS.
- Appropriate dissemination and implementation of HTS policies.
- Advising on HTS roll out and scale up.
- Management of HTS commodities.
- Coordination, monitoring of HTS performance and assessment of the quality of service delivery.
- Capacity building for HTS service providers and systems.
- Improvement and management of national data collection and database.

- Operational and health systems research including identification of priority research agenda on HPTC services and facilitating their implementation.
- Development of best practices in HTS in collaboration with international and national partners and HPTC coordination and service delivery.
- Coordination of partners involved in HTS and HPTC services.
- Development and review of new IEC materials.
- Approval of IEC materials before production and dissemination.

*With regards to HPTC services:*

- The NACP shall promote HPTCs and coordinate all stakeholders involved in the provision of HPTC services to promote equity in geographical coverage.
- NACP shall also set targets and strategies to ensure establishment, monitoring and evaluation of HPTCs.

**12.2 Regional Level**

The Regional Medical Officer (RMO) is the overall overseer of all HIV and AIDS services in the region, the RMO works with the Regional Health Management Team (RHMT), receiving technical input from Regional AIDS Coordinator and Regional HTS Coordinator. The RMO carries out the following roles: -

- Dissemination and enforcement of MOHCDGEC policies, guidelines and standards including those related to promotion of HTS services.
- Coordination and supervision of HTS service performance.
- Capacity building, including initiation of staff deployment, training, and certification.
- Monitoring and evaluating of HTS.
- Facilitates reporting from district to national level and vice versa.
- Comprehensive supportive supervision and mentoring of HTS service providers and HPTC clusters.
- Laboratory support for quality assurance (QA) of HIV testing.
- Networking and coordination of stakeholders at the regional level
- Resource mobilization and accountability.
- Ensuring availability of HIV testing supplies and commodities throughout the region.
- Review of new IEC materials and forwarding them to NACP for approval before they are disseminated to the public. This includes materials related to the promotion of HPTC services.

### 12.3 District Level

The District Medical Officer (DMO) is the overall overseer of all HIV and AIDS services in the district, as such, they have the same roles listed for the RMO in Section 12.2 but at the level of the district. They are supported by the District AIDS Coordinators (DACs) and the District HTS focal persons. In addition, DMOs have the responsibility of ensuring that HIV and AIDS interventions are incorporated into the Comprehensive Council Health Plans (CCHPs).

### 12.4 Facility Level

The successful implementation of HTS relies on the implementation of quality HTS at primary health facility levels. The following roles are carried out by HTS providers under the accountability of the health facility in charge: -

- Provision of quality HTS to clients and patients as directed by the DMO;
- Putting in place quality assurance (QA) measures for HIV testing services including: -
- Abiding to national standards for HTS site set up.
- Conducting regular client exit interviews.
- Validating all new batches of HIV Rapid Test Kits (HRTK) before use.
- Conducting all HIV tests according to national HIV testing algorithm and SOPs.
- Recording clients' and testing data accurately, using nationally approved tools
- Taking part in regular EQA activities
- Managing HTS commodities following the principle of "first in first out" and ensuring timely reporting of stock outs.
- Managing safe disposal of medical waste generated at the HTS site.
- Linking clients and patients from HTS to appropriate follow-up services, as needed;
- Preparing accurate and timely reports for the health facility and district levels.
- Mobilizing communities on HTS, raising awareness, and providing HTS education and information material.
- Participating in relevant stakeholder forums and planning meetings.

#### *Roles and responsibilities of primary health facilities in relation to HPTCs*

Primary service providers in all facilities with VCT, CTC and PITC shall:

- Assist in mobilizing and sensitizing clients to join HPTC at the health facility or at community level.
- Provide space for HPTC meetings and for their activities.
- Link HPTC with available resources from private and public partners.
- Support HPTC with referrals to relevant level of service.
- Support HPTC to have Income Generating Activities (IGAs).
- Support counsellors to provide home based testing and counselling (HBTC).

Health Facility In-charges, Assistant Social Welfare Officers, and Ward Health Officers shall collaborate with district authorities to support the formation of Ward HPTC clusters and support the clusters to have a constitution and be registered as CBOs.

### **12.5 Roles and responsibilities of HTS providers at community level**

Successful implementation of an HTS relies on the provision of quality HTS at the outreach site/mobile and home based. HTS providers shall conduct the following activities at the HTS outreach site level under the accountability of the health facility in charge: -

- Provide HTS education and information, raise awareness and mobilize communities for HTS services.
- Provide quality HTS to clients and patients.
- Manage outreach site-level HTS logistics and commodities;
- Prepare accurate reports and ensure their timely submission to the health facility.
- Make referrals from the community to the nearby health facility.
- Manage safe disposal of medical waste generated at the community HTC sites.
- Participate in relevant stakeholders' forums and meetings including planning for HTS and provide community perspective of HTS.

### **12.6 HIV Testing and Counselling Focal persons**

The MOHCDGEC has instituted HTS focal persons at all levels to work closely with Regional/District AIDS Coordinators and Laboratory HIV focal persons. Their roles are outlined below.

#### ***Regional/District HTS focal persons***

- Ensure the availability of adequate commodities, supplies and personnel for HTS.
- Set up Regional/District capacity building programmes in consultation with RHMTs/CHMTs.
- Develop and coordinate the network of providers and hold quarterly meetings involving HTS stakeholders.
- In consultation with RHMTs/CHMTs, identify and recommend HTS supervisors for training.
- Provide feedback to the facility management and to the RHMT/CHMT on the performance of HTS.
- Compile and submit monthly and quarterly reports.
- Ensure HTS providers are trained according to the approved requirement and enrolled into proficiency testing programme and corrective measures taken whenever necessary.

### *Health Facility HTS Focal Person*

The HTS focal person at the health facility level shall support the facility manager to ensure the provision of quality HTS services. Therefore, they shall:

- Coordinate HTS in all testing units including community based HTS.
- Supervise all HTS providers.
- Ensure M&E tools are filled correctly and timely.
- Ensure availability of IEC materials related to HIV prevention, care, support and treatment.
- In regards to HIV post-test clubs, the HTS Focal persons shall:
  - Ensure a strong referral system to enable members get services needed.
  - Secure and maintain partnerships through networking.
  - Ensure all members' records are well documented.
  - Ensure meaningful involvement of HPTC members in their day to day activities through expert patients or peer educators.
  - Ensure external facilitators are outsourced to provide expert talks in different areas as per Club needs.
  - Ensure that HPTCs are linked well with district management and other existing community, health and social systems.



## **Chapter 12: Key points**

The delivery of sustainable and quality HIV testing services in Tanzania is anchored on the participation and coordination of many authorities at different levels: -

- The NACP is responsible for the overall coordination of the implementation, monitoring and evaluation of the 2017 HTS policy including writing and dissemination of reports and scientific publications.
- The National Health Reference Laboratory (NHRL) shall coordinate all issues relating to quality assurance and quality improvement in HIV testing including conducting post market surveillance of HIV rapid test kits.
- Regional and District Medical Officers shall oversee all HTS issues including coordination of activities of all NGOs, Private Health Facilities and Community-Based Organizations (CBOs) in their respective regions/districts.





**APPENDIX 2: REFERRAL FORM**

**FOMU YA RUFAA YA MTEJA**



RUFAA KUTOKA (Weka Tiki)

KITUO CHA AFYA  JAMII

**A. TAARIFA ZA MTEJA**

Tarehe ya Rufaa: \_\_\_\_\_ Jina la Kituo Anachokwenda: \_\_\_\_\_  
 Jina Kamili la Mteja: \_\_\_\_\_ Namba ya Upimaji (HTS No) \_\_\_\_\_  
 Tarehe ya Kuzaliwa: (dd/mm/yyyy) \_\_\_\_\_ **Jinsi** (ME/KE): \_\_\_\_\_  
 Kata Anayoishi: \_\_\_\_\_ Kijiji \_\_\_\_\_ Kitongoji/Mtaa \_\_\_\_\_  
 Jina la Mwenyekiti wa Kitongoji/Mtaa: \_\_\_\_\_ Namba ya Simu ya Mteja \_\_\_\_\_  
 Wilaya: \_\_\_\_\_ Mkoa: \_\_\_\_\_  
 Huduma Alizopewa \_\_\_\_\_  
 Taarifa za kipekee (Mfano; allergy): \_\_\_\_\_  
 Sababu ya Rufaa \_\_\_\_\_

**Kielelezo Cha Aina za Huduma**

*Nasaha na kupima, Kliniki ya Tiba na Matunzo (CTC), Kituo cha kutoa tiba za magonjwa nyemelezi, Kliniki ya kifua kikuu, Huduma za kuzuia maambukizi toka kwa mama kwenda kwa mtoto (PMTCT), Huduma ya afya ya uzazi na mtoto (RCH), Huduma ya Tohara (VMMC), Huduma za kuzuia ukatili wa kijinsia (GBV), Msaada wa kisheria, Vikundi vya kusaidiana, Huduma za watoto wanaoishi katika mazingira hatarishi na yatima (Ustawi/ wa jamii), Vituo vya wazee, Huduma Nyingine (taja)*

**B: TAARIFA ZA ANAYETOA RUFAA** (Mhudumu, Msimamizi, Afsa Mradi nk)

Jina la anayetoa Rufaa \_\_\_\_\_ Sahihi na Muhuri \_\_\_\_\_  
 Cheo Cha Mtoa Huduma \_\_\_\_\_  
 Jina la shirika/Kituo cha Kilichotoa rufaa \_\_\_\_\_  
 Namba ya simu ya Kituo/Mhudumu \_\_\_\_\_

*Tafadhali kata kipande hiki na Mpatie Mteja uliyempa Huduma, Baada ya Kupokea Rufaa*

**C: MREJESHO WA RUFAA**

Jina la Kituo alikopokelewa \_\_\_\_\_ Namba ya Upimaji (HTS) \_\_\_\_\_  
 Jina Kamili la mteja \_\_\_\_\_ **Jinsi** (ME/KE) \_\_\_\_\_  
 Namba ya Utambulisho (CTC Unique ID) \_\_\_\_\_  
 Tarehe ya Kuzaliwa (dd/mm/yyyy): \_\_\_\_\_  
 Maelezo ya Huduma iliyotolewa kwa Mteja \_\_\_\_\_  
 Tarehe ya Huduma (dd/mm/yyyy): \_\_\_\_\_ Jina la aliyetoa huduma \_\_\_\_\_  
 Cheo \_\_\_\_\_ Namba ya simu ya Kituo/Mhudumu \_\_\_\_\_ Sahihi na Muhuri \_\_\_\_\_







**APPENDIX 5: INDEX CLIENT ELICITATION AND OUTCOME FORM**

**INDEX CLIENT ELICITATION AND OUTCOME FORM**

Name of Provider: \_\_\_\_\_ Testing Point (Code A): \_\_\_\_\_ Date of Elicitation: \_\_\_\_\_

**Instructions:** This tool is used to document sexual partners, needling partners, and biological children or biological mother (for OVC) of index clients or biological father if the mother is deceased. Index testing is an approach whereby the HIV exposed partner/contacts of an index client are elicited and offered testing services.

**NB:** If there are suspicion of Gender Based Violence assess on-going risk of harm, explore alternative partner notification methods and refer to GBV services.

Index Client Name: _____	CTC ID Number: _____	Phone Number: _____
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No.	Date (dd/mm/yyyy)	Names of Index Contacts	Age	Sex (M/F)	Relationship to Index Client (Code B)	Primary Phone Number	Physical Address	HIV Status (Code C)	On Treatment (Y/N/NA)	GBV Screening (Y/N/NA) See Code D	Eligible for testing (Y/N)	Notification Method (Code E)	Contact Tested (Y/N/NA)	Final Test Results (POS/NEG/NA)	Linked to Care (Y/N/NA)	CTC ID Number	Comments
						Alternative Phone Number											
(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)	(12)	(13)	(14)	(15)	(16)	(17)	(18)
1.																	
2.																	
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**Code A: Testing Point**  
**TB** = TB Clinic (OPD)  
**STI** = STI Clinic  
**OPD** = Out Patient Department Clinics  
**IPD** = In Patient Department  
**LAB** = Laboratory  
**BT** = Blood Transfusion  
**CBHTS** = Community Based HIV Testing Services  
**VCT** = Voluntary Testing and Counselling  
**FP** = Family Planning  
**CTC** = Care and Treatment Clinic  
**VMMC** = Voluntary Medical Male Circumcision  
**OS** = Outreach Services  
**RCH** = Reproductive and Child Health Clinic  
**CcCAP** = Cervical Cancer Prevention  
**Others** = other testing points

**Code B: Relationship**  
**SP** = Sexual Partner  
**NP** = Needle Sharing Partner  
**BC** = Biological Child < 15 years  
**Sib** = Siblings < 15 years  
**BM** = Biological Mother  
**BF** = Biological Father (if mother is deceased)

**Code C: HIV Status**  
**NEG** = Negative  
**POS** = Positive  
**U** = Unknown  
**HEI** = HIV Exposed Infant

**Code D: GBV Screening**  
 1. Has [partner's name] ever emotionally or physically hurt you in your lifetime?  
 2. Has [partner's name] ever hit, kicked, slapped, or otherwise physically hurt you within the last year?  
 3. Has [partner's name] ever forced you to have sexual activities within the last year?  
 4. Are you afraid of any of the partners that you have mentioned above?  
 5. Do you have any complimentary information regarding the violence you have subjected to?

**Code E: Notification Method**  
**CR** = Client Referral  
**PR** = Provider Referral  
**CT** = Contact Referral  
**DU** = Dual Referral  
**NA** = Not Applicable for those who are not eligible for testing

## APPENDIX 6: HTS Service Delivery Models

Service Delivery Models are designed using the building blocks approach with four delivery components: (i) the types of services delivered; (ii) the location of service delivery; (iii) the provider of services; and (iv) the frequency of services. The four components are guided by the following key questions:

When is care provided?

Where is care provided?

Who is providing care?

What type of care or services are provided?








Differentiated models of HTS delivery should be designed and implemented as a direct response to specific challenges or barriers identified for clients and/or health care workers.

### Service Delivery Models (SDMs) for differentiated HTS

The Service Delivery Model for differentiated HTS is a client centred approach that simplifies and adapts HIV services for different population groups

Select examples of how HIV testing has been differentiated

Table 2: Components and building blocks for building an HIV testing service delivery model

	 MOBILIZING	 TESTING	 LINKING
 WHEN	Time of day and frequency	Time of day and frequency	Time period for linking and frequency of tracing
 WHERE	Location of mobilization activities	Health facility Non-health facility Community	Location of linkage activities
 WHO	Who does the mobilization?	Who does the HIV testing?	Who supports linkage to prevention? Who supports linkage to ART initiation?
 WHAT	For HIV testing alone or with other services	For HIV testing alone or with other services	Prevention: SMS/phone Community-based tracing  ART initiation: SMS/phone Community-based tracing

Source: Adapted from International AIDS Society (IAS). *Differentiated Service Delivery for HIV: A decision framework for HIV Testing Services*. July 2018

## APPENDIX 7: Differentiated HIV Testing Services in different populations

WHEN	WHERE	WHO	WHAT
<b>General Population</b>			
HTS should be available in all facilities during government defined opening hours. HTS should be available 24 hours (overnight and weekends) for facilities providing maternity and inpatient care.	Facility based testing: PITC should be offered at all entry points of the health facilities, including OPD, IPD (malnutrition and paediatric wards), CTC, TB, STI, and RCH/PMTCT. Facility and community based index client testing should be offered at all facilities. Targeted sub-population testing should be offered as community based outreach testing monthly at all facilities.	Expert clients should be trained to mobilise communities to access HTS. All cadres of existing health care workers should be eligible to be trained to perform HTS. Every facility must ensure that there is always a HCW on duty who has been trained to perform HTS.	Integrated screening approaches should be implemented in community testing strategies. This may include HIV testing, TB and STI screening, blood pressure and blood glucose checks, and nutrition assessments.
<b>Special considerations for children and adolescents</b>			
	Targeted outreach testing for schools and colleges, street children and orphanages should be included in monthly outreach planning.	Expert adolescent peers should be trained to mobilise adolescents for testing. All cadres of existing health care workers should be trained to prepare DBS samples for EID testing. All facilities should ensure there is always a HCW on duty that has been trained to provide HTS and prepare DBS samples for EID testing. Trained health care workers should perform HTS and EID DBS during mobile outreach activities.	Integrate EID DBS and HTS into outreach Health services e.g. EPI, TB, NCD and Family Planning services

Special considerations for pregnant and breastfeeding women		
	Re-testing of HIV negative pregnant and breastfeeding women should be integrated in facility and outreach EPI activities.	
Special considerations for key and vulnerable populations (KVPS)		
Key and vulnerable populations should be consulted to determine the most appropriate time to offer community or facility based HTS e.g. moonlight testing for female sex workers.	Districts should map the locations where specific KVP will access HTS. Targeted outreach testing from the facility serving the defined locations.	KVP peers should be trained to mobilise their communities to access HTS. KVPs should be offered an integrated package of services with HTS e.g. for female sex workers, HTS, Condom distribution, Family Planning, STI screening and treatment, GBV services, and Prevention services (PEP).
Linkage to care		
<ul style="list-style-type: none"> <li>All HIV positive clients identified at an HTS site should be guided (with their consent) to the CTC for enrolment into ART care. This should ideally be done by the HTS/Health care provider who has performed the test or by a community HTS provider.</li> <li>All HIV positive clients identified should be linked (with their consent), with a community health worker or community HTS provider. A referral form should be completed for anyone testing positive in the community and the respective client should be encouraged to attend the CTC at a facility of their choice.</li> <li>Any client who has tested HIV positive should be asked for their consent to be traced. Any client who has not been linked to care after one month should be traced. Tracing should initially be done by phone followed by a home visit.</li> </ul>		

## **APPENDIX 8: SOP for Index Client Testing and Partner Notification**

### INDEX CLIENTS TESTING AND PARTNER NOTIFICATION SERVICES PACKAGE

During pre-test information/counselling, providers should:

- Explain the importance of ensuring that all partners get tested for HIV.
- HIV-positive partners can start on HIV treatment to keep them healthy and reduce the risk of passing HIV to other sex partners and/or children.
- HIV-negative partners can access HIV prevention services to help them remain HIV-negative, including condoms, pre-exposure prophylaxis (PrEP), and male circumcision.
- Inform the index client that:
  - We are Offering Partner Testing Services to assist the client to contact their partners so that these partners can learn their HIV status.
  - The service is offered because disclosure of HIV status to partners can be difficult.
  - It is important to provide a list the names and contacts of their sexual partners and people they have shared needles with.
  - Names of any children who may need an HIV test should be provided to ensure they too are offered the necessary tests and/or services.

During post-test counselling: -

- Remind the client of the importance of partner testing using information from the section above.
- Inform the client that there are 4 options for contacting their partners: -
  1. Client to contact their partner(s) to let them know that they should be tested for HIV;
  2. The healthcare providers to contact the client's partners directly, without telling them the client's name (this will be done anonymously);
  3. Client to contact their partner within a certain time period, after which the provider will offer assistance if the partner has not been tested;
  4. The counsellor/provider to sit with the client and their partner(s) and support the client as they tell their partner(s) about their HIV infection.
- If the client chooses option (3), they will have 4 weeks to bring in or refer their partner(s) for HTS.
- If the partner does not come in for HTS after 4 weeks, then the provider will contact the index client for permission to contact their partner(s).

Inform the index client that:

- All information will be kept confidential; meaning that:
- Partners will NOT be told the index client's name or test results.
- The index client will NOT be told the HIV test results of their partner(s) or whether or not their partner(s) actually tested for HIV.
- Contacts will only be reached after receiving index client consent.
- HIV positive tested clients will continue to receive the same level of care at this health facility regardless of whether they choose to participate in partner notification services.
- The index client shall be given the opportunity to ask questions and give verbal consent to continue. Once the index client provides consent this should be documented in the remarks column of the HTS register as well as in the client HIV referral form. Contact tracing and documentation has been incorporated in the national CTC2 forms.









