National Guidelines for HIV Testing Services (HTS) & Psycho-Social Support (PSS)

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National AIDS and STI Control Program

Ministry of Health

Republic of Liberia`

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ACRONYMS

AIDS	Acquired Immune Deficiency Syndrome
AGYW	Adolescent Girls and Young Women
NIAID	National Institute of Allergy and Infectious Dis.
ANC	Antenatal Care
ART	Antiretroviral Therapy
ARV	Antiretroviral (Drug)
CD4	Cluster of Differentiation 4
CBO	Community-Based Organisation
CHA	Community Health Assistant
CHT	County Health Team
CHSD	Community Health Services Department
CHW	Community Health Worker
CHP	Community Health Promoter
CHPPS	Community Health Promoter Peer Supervisor
CHSWT	County Health and Social Welfare Team
CMS	Central Medical Store
CSW	Commercial Sex Worker
DNA	Deoxyribonucleic Acid
ELISA	Enzyme-Linked Immunosorbent Assays
EMTCT	Elimination of Mother to Child Transmission
EPHS	Essential Packages of Health Services
EPSS	Essential Packages of Social Services EQA External Quality Assurance eLMIS Electronic Logistics Management Information System
FBO	Faith-Based Organisation
FP	Family Planning
GFATM	Global Fund for AIDS, TB and Malaria
HCT	HIV Counselling and Testing
HIV	Human Immunodeficiency Virus HIVST HIV Self-Testing
HTS	HIV Testing Services
IDP	Internally Displaced Person
IEC	Information, Education, Communication
IRIS	Immune Reconstitution Inflammatory Syndrome
IMAI	Integrated Management of Adulthood Illnesses
IMCI	Integrated Management of Childhood
LDHS	Liberia Demographic Health Survey
M&E	Monitoring and Evaluation
MARP	Most At Risk Populations
MoH	Ministry of Health
MSM	Men Who Have Sex With Men
NACP	National AIDS & STI Control Program
NDS	National Drug Service
NGO	Non-Government Organisation
NRL	National Reference Laboratory
OI	Opportunistic Infection
OVC	Orphans and Vulnerable Children
PA	Physician Assistant
PCR	Polymerase Chain Reaction
PEP	Post-Exposure Prophylaxis
PITC	Provider Initiated Testing and Counselling
PLWHA	People Living with HIV/ AIDS
PLHIV	People Living with HIV
PMTCT	Prevention of Mother to Child Transmission
PWID	People Who Inject Drugs
POC	Point-of-Care
PSS	Psycho-Social Support
QA	Quality Assurance
QC	Quality Control
SOPs	Standard Operating Procedures
STI	Sexually Transmitted Infections
TB	Tuberculosis
TG	Transgender
TOP	Targeted Outreach Program
TTI	Transfusion Transmissible Infections
UNAIDS	United Nations Program on HIV and AIDS
USAID	United States Agency for International Development
VCT	Voluntary Counselling and Testing
WHO	World Health Organisation
YPLWHIV	Young People Living with HIV

FOREWORD

The Government of Liberia has declared HIV and AIDS as a major Public Health priority and has put in place policies, infrastructures and programmes to control the epidemic and mitigate its adverse effects. The global impact of HIV and AIDS is immense; tens of millions of lives have been touched by the pandemic. As the disease has affected men, women and children of all ages, a multi-sectorial response is being implemented under the auspices of the National AIDS Commission, which is proposed to be chaired by the President of Liberia.

Government's efforts in the fight against HIV and AIDS are complemented both at home and abroad by many partners including the United Nations, numerous donors, NGOs, Civil Society and the private sector. One major achievement in this partnership is the development of the HIV Counselling Testing (HCT) and Psycho-Social Support (PSS) Guidelines.

These Guidelines on HCT and PSS have been prepared to maintain the momentum of scaling-up and to outline national standards that must be adhered to by all institutions, organizations and individuals in the provision of high-quality counselling and testing services in Liberia. The higher goal of counselling is prevention of HIV infection by promoting behaviour change and provision of psychosocial support for people infected or affected by HIV. This has been taken into consideration during the development of the guidelines.

The revised Guidelines for HIV Counselling and Testing and Psycho-Social Support are the result of the commitment to improving and expanding the national HIV programme effectively. The goal of this document is to provide an updated guideline reflecting national standards for HCT in a wider sense and to ensure coherence with other policies, standards and legislation.

It is our hope that the guideline will provide adequate guidance for the users – the front-line health care providers and contribute towards improvement in the quality of life for those infected and affected by HIV. We look forward to a continued partnership with you as we join forces in the fight against HIV and AIDS.

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SECTION 1: INTRODUCTION ON HIV

1.1 The Virus

AIDS (Acquired Immune Deficiency Syndrome) is caused by a virus, HIV (Human Immunodeficiency Virus) which was first discovered in 1983. The first case of HIV was identified in Liberia in 1986.

HIV belongs to a group of viruses called retroviruses. There are two main strains of HIV; HIV-1 and HIV-2. HIV has numerous varieties and has been shown to mutate, or change, within an individual during the progression of infection. Both HIV-1 and HIV-2 have the same modes of transmission and are associated with similar opportunistic infections, and both lead to AIDS.

1.2 HIV Transmission

Among adults, HIV is spread most commonly during unprotected sexual intercourse with an infected partner. During intercourse, the virus can enter the body through the mucosal linings of the vagina, vulva, penis, rectum, or, rarely, via the mouth and possibly the upper gastrointestinal tract after oral sex. The likelihood of transmission is increased by factors that may damage these linings, especially other sexually transmitted diseases that cause ulcers and inflammation. Research suggests that immune cells, which live in the mucosal surfaces such as macrophages and dendritic cells, may begin the infection process after sexual exposure by binding to and carrying the virus from the site of infection to the lymph nodes where other immune system cells become infected.

HIV can also be transmitted by contact with infected blood, by the sharing of contaminated needles or syringes among intravenous (IV) drug users, after occupational exposure among health workers and by contaminated blood transfusions.

HIV positive women can transmit HIV to their babies during pregnancy, at birth, and through breastfeeding. Without intervention up to 40% of untreated pregnant women infected with HIV will transmit the infection to their babies. The risk of mother-to-child transmission is higher when the mother is co-infected with certain STIs, namely syphilis. Approximately 50% of these children will die before the age of two if they do not receive antiretroviral treatment.

1.3 Life Cycle of HIV Infection

HIV begins its infection of a susceptible host by binding to the CD4 receptor on the host cell. CD4 is present on the surface of many lymphocytes, which are a critical part of the body's immune system. Following fusion of the virus with the host cell, HIV enters the cell. The genetic material of the virus, which is RNA, is released and undergoes reverse transcription into DNA facilitated by the reverse transcriptase.

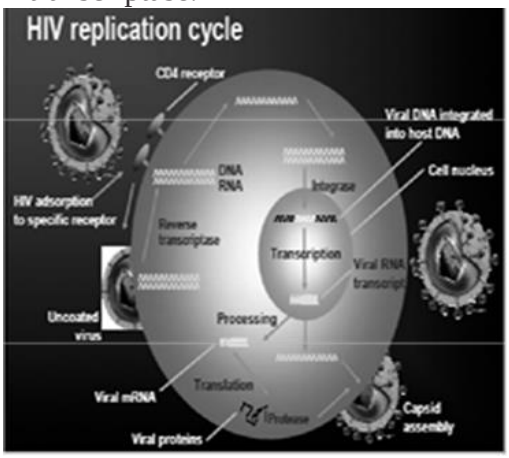

Figure 1: HIV Life Cycle

Once the genetic material of HIV has been changed into DNA, this viral DNA enters the host nucleus where it can be integrated into the genetic material of the cell. Once this happens, the cell can either become activated or can remain inactive. Activation of the host cells results in the transcription of viral DNA into messenger RNA, which is translated into viral proteins. The new viral RNA forms the genetic material of the next generation of viruses. The viral RNA and viral proteins assemble at the cell membrane into a new virus. Amongst the viral proteins is HIV protease, which is required to process other HIV proteins into their functional forms. Protease inhibitors, one of the most potent types of ARV medications, act by blocking this critical maturation step. Following assembly at the cell surface, the virus

then buds forth from the cell and is released to infect another cell.

Those CD4 cells that remain inactive act as a reservoir for HIV. The virus can persist within the cell for many years in a latent form. Because latent virus is not actively replicating, it cannot be targeted by antiretroviral drugs. Persistence of virus in latently infected cells is the major barrier to eradication or cure of HIV. For this reason, patients must remain on anti-retroviral therapy (ART) for life.

Unless the HIV cycle is interrupted by treatment, the viral infection spreads throughout the body and results in the destruction of the body's immune system.

HIV Testing Service is considered an important entry point to HIV prevention, care, treatment and support in Liberia, and the National Strategic Framework for HIV 2015-2020 highlights the need to strengthen testing interventions to increase the number of individuals who know their HIV status and are able to access antiretroviral therapy (ART). These guidelines bring together existing and new evidence-based guidance and recommendations for delivering high-impact HIV testing services, including linkage to HIV prevention and treatment, in diverse settings and populations.

SECTION 2: OBJECTIVES AND GUIDING PRINCIPLES OF HIV TESTING SERVICES (HTS)

2.1 Aims of HTS

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

2.2 Elements of a Good HTS Program:

- **Demand creation:** Create an enabling environment that promotes equal and universal access to safe, effective and good quality HIV testing services;
- **Counselling and message:** Encourage individuals, couples, families and communities to test for HIV in the interests of their own health;
- **HIV testing among Key Populations (KP):** Encourage Key Populations and marginalized groups to test and seek treatment in the interest of their own health;
- **Reaching social networks:** Social networks of key populations and adolescent girls and young women (AGYW) should be offered HIV testing through their organization as part of a comprehensive package of care and prevention. Lay providers such as Community Health Assistants (CHA) and Community Health Promoters CHP) who are trained and supervised can independently conduct safe and effective HIV screening testing using rapid diagnostic tests (RDTs) in their community locations.
- **Duo HIV/ syphilis rapid diagnostic tests:** Integrate syphilis and HIV testing at the ANCs for more efficient diagnosis of HIV and syphilis among pregnant women and increased prevention of mother-to-child transmission of HIV and syphilis.
- **Program Integration:** Facilitate and promote integration of HTS with malnutrition and TB clinics, family planning (FP), STI, Immunization and AGYW programs.
- **Retesting time points:** In high HIV burden settings, retesting is advised for the following category of persons;
    - Pregnant women with an unknown or HIV-negative status during late pregnancy (third trimester) and in post-partum care.
    - Sexually active individuals in high HIV burdened settings.
    - People who have ongoing HIV-related high risks in all settings, for example -
        - Key populations, including men who have sex with men (MSM), female sex workers (FSW), transgender people (TG), people in prison, people who inject drugs (PWID).
        - Epidemic specific risk groups such as men and adolescent girls and young women and people with a known HIV-positive partner.

2.3 WHO-Recommended Differentiated HTS Delivery Approaches

1. Facility-based HIV testing services should be considered and routinely provided in all service delivery points within a health facility (Multi-point testing)
2. Community-based Outreach HIV testing services should be used among key populations and high HIV burden settings. Scaling up screening testing in communities by lay service providers (CHA&CHP) and referral for confirmation at health facility.
3. HIV self-testing (HIVST) is recommended for underserved population such as KPs, AGYW and men

4. Index testing and social network referral-based approaches: These are very important strategies in identifying new HIV cases:

    a. Where feasible and acceptable to the client, provider-assisted referral should be prioritized, as it is highly effective and provides the opportunity to offer comprehensive prevention interventions to partners who are HIV-negative but remain vulnerable to HIV acquisition.

    b. Patient referral, in which a trained provider encourages the client to disclose their HIV status to their partner(s), and then refer them for HTS. The client should assist the provider on the approach, time and place to contact their partners. The choice of persons who do not want their partners to be contacted or need time to do so should be respected and supported in their decision. The details on partner notification options are described on table 1 below:

Method of partner notification	**Definition**
Client Referral	"Tell your partner about your positive HIV diagnosis and encourage him or her to come to the health facility for an HIV test"
Dual Referral	"If you are not confident informing your partner about your HIV status, just convince him/ her to come to the facility for any reason you will give. Without disclosing your HIV status, we will use our expertise to work with both of you from scratch and offer HIV testing and counselling"
Contract Referral	"We will give you some time to tell you partner about your HIV positive diagnosis and encourage him or her to come to the health facility for an HIV test. If we don't see him/her within the agreed period, we will support you reaching out to your partner using the contact details you provide"
Provider Referral	"Since you have indicated that you are not confident to reach out to your partner, I will use my expertise to reach out him/ her immediately so that should benefit from HIV testing"

    c. Family Index Testing: HTS should be extended to all sexual contacts and biological children of HIV positive clients. These contacts include; spouses, other sexual partners, injection drug partners, and biological children of less than 15 year of age. Care should be exercised to ensure the process is informative, non-coercive and confidential to avoid irrational exposure of one's sexual contacts. Adverse events such as intimate partner violence such as physical violence, sexual and emotional or other adverse events should be reported to HTS Supervisors and documented to inform refining protection of beneficiaries and program improvement

    d. Risk network referral approach: The probability of HIV index cases bringing HIV cases through their social networks is high. HIV positive people are told to bring anyone they socialize with in any way to benefit from HIV testing services.

5. Duo HIV/ syphilis rapid tests are recommended for testing pregnant women in antenatal care settings, to enable rapid progress toward the elimination of mother-to-child transmission of HIV and syphilis.

231 Individuals or Couples Wanting to Know Their Status

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

232 HTS May Also be Offered in the Following Circumstances:

1. Post-Exposure Prophylaxis (PEP): This is providing ARVs within 72hrs to people with accidental exposure to a potentially HIV positive source, such as in accidental prick from a high-risk source or a rape event (See Liberia HIV Treatment Guidelines). PEP must be preceded by pre-test counselling and HIV testing.
2. Research and other screening purposes: HIV testing for research purposes, includes –
    a. Sero-sentinel survey with anonymous antenatal screening (for determination of PMTCT needs and national HIV prevalence through Liberia demographic and health survey.
3. Domestic violence and rape: In the case of domestic violence and rape, provide pre-test counselling and HTS, and give PEP as quick as possible, within 72hrs.
4. HIV screening of blood and blood products, and organ donation (see box 3 for summary of required information)

Box 1: Summary of principles r elated to HIV and blood do nation

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

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

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

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

SECTION 3: SERVICE DELIVERY FOR HIV TESTING SERVICES

3.1 Types of HIV Testing Services

HIV testing services encompasses both the Client-initiated and Provider-initiated approaches to delivering the service.

3.1.1 Voluntary Counselling and Testing

VCT involves individuals actively seeking HIV counselling and testing. VCT usually emphasizes individual risk assessment and management by counsellors, addressing issues such as the desirability and implications of taking an HIV test and the development of individual risk reduction strategies. VCT is conducted in a wide variety of settings including health facilities, stand-alone facilities outside health institutions, through mobile services, in community-based settings and even in people's homes.

3.1.2 Provider-Initiated Testing and Counselling (PITC)

PITC refers to HIV testing and counselling which is recommended by health care providers to persons attending health care facilities as a standard component of medical care. The major purpose of such counselling and testing is to enable specific clinical decisions to be made and/ or specific medical services to be offered that would not be possible without knowledge of the person's HIV status.

PITC is not mandatory, however adequate information about the benefits of HIV testing, timely HIV diagnosis and early initiation of treatment if tested HIV positive should be provided even if the person opts out. This strategy will be used as part of the standard of care for all patients with tuberculosis, sexually transmitted infections (STIs), malnourished children, those with HIV related diseases and for women attending antenatal care.

All Providers of HIV testing and counselling services must be trained through a programme certified by the NACP – MoH, whether lay or clinical

3.2 Minimum Requirement for Service Delivery

There are some key features required for facilities providing HTS and psychosocial counselling and support whatever the setting (stand alone, integrated or private). These include:

A private space dedicated to HIV counselling, ideally one room per counsellor on duty
Viable and quality-assured HIV test kits
Glove sand all other medical supplies including those required for universal precautions
Puncture proof/ metal containers for disposal of sharp objects
Nationally agreed patient records and reporting registers
Clear referral system, especially for onward confirmation, HIV care and treatment, STIs, family planning
System for receiving and filing results
Condoms
National Guidelines on HTS & PSS
Use of Standard Operating Procedures
Internal and external quality systems.

3.3 Procurement of Test Kits

All HTS test kits shall be procured centrally, or in close collaboration with NACP (MOH). The NACP is responsible for processing requests for test kits with the National Drug Service (NDS) and afterwards monitor the distribution to sites by the central medical stores (CMS). A minimum buffer stock of 50% of total rapid test kit (RTK) allocation at each delivery period should always be maintained. Requests should be made well in advance to avoid stock outs. Warehousing regulations on storage capacity and temperature should be maintained to ensure quality of the kits.

SECTION 4: CORE ETHICAL PRINCIPLES AND APPROACHES

4.1 Counselling Basics and Guiding Principles

HIV testing shall be guided by the WHO 5C's:

- Consent
- Confidentiality
- Counselling
- Correct test result
- Connection to care, treatment and support

Counselling in the context of HIV is a dialogue between a client and a care provider aimed at enabling the client to cope with stress and make personal decision related to HIV:

- Help clients cope with emotions and changes they may face when they learn of their infection with HIV
- Help clients avoid infection or re-infection with another strain of HIV.
- Help clients cope better in any potential socio-economic crisis
- Help clients who are living with HIV to make choices and decisions that will prolong their lives and improve their quality of living.

Counselling should always precede and follow testing, particularly with VCT clients and must be conducted by an appropriately trained, mentored, and supervised counsellor or health provider. Counselling in any situation should be based upon mutual respect, and, the client needs to feel reassured that they are in a safe space to receive, understand and process issues in relation to coping with HIV. Please, follow the guide in Box 4 below:

Box 2: Key components of HIV counselling

Counselling includes:

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

Counselling does not include:

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

Counselling must take place in a private and confidential area where the session can be free from interruptions and distractions (phones should be turned off, =Do Not enter/ Counselling in Progress' sign is placed on the door; seating is comfortable and arranged to make clients feel at ease. Ensure there is water and tissues available in the room. Where counselling takes place outside (under a tree, in a compound, etc.) make sure the seating is comfortable, your client can see you without any obstruction and that there is privacy for the conversation.

4.2 Informed Consent

HIV testing must be voluntary and free of coercion. All HTS clients should be provided adequate information and given the choice of opting out if they are not willing to take the test. Except for unlinked anonymous testing (under approval of the MoH), The *HIV Law* (section 18.21) states that? it is unlawful for any person to perform an HIV test except:

i. With the voluntary informed consent of the person to be tested; or

ii. Where the person to be tested is aged or minor and is, in the opinion of the person providing the pre-testing formation, incapable of understanding the meaning and consequences of an HIV test,

iii. Where the person to be tested has a disability which, in the opinion of the person providing the pre-test information, renders the person incapable of understanding the meaning and consequences of an HIV test, with the voluntary informed consent to be sought from these persons in order in which they are listed:
    a. A legal guardian of the person; or
    b. A partner of the person; or
    c. A parent of the person; or
    d. A child aged 18 years or more of the person."

Informed consent and information about testing should be available in formats that are accessible to people with disabilities and in child-friendly versions.

- For VCT clients, informed consent should be verbal or written.
- For PITC patients, informed consent should be verbal and documented in the patient's file/health passport by the health-care provider.

In order to make an informed decision about testing, clients should be given information about:

- Assuring confidentiality
- HIV acquisition and transmission
- HIV risks and risk reduction
- Importance of early HIV diagnosis
- The HIV testing process
- The meaning and implications of a negative result
- The window period
- The meaning and implications of a positive result and information on referral
- Disclosure
- Positive living with a positive result

The health-care provider must ensure that a person with a disability, or one who has difficulty communicating, must fully understand the concept of informed consent prior to any HIV testing. Where possible, an appropriately trained provider and/or support person (family or friend) of the individual's own choice should be used to facilitate communication. An agreement to take the test must be in verbal and/ or written format using the prescribed informed consent form for minor.

Patients should also be made aware of relevant laws in jurisdictions that mandate the disclosure of HIV status to sexual and/ or drug injecting partners.

4.2.1 Illiteracy or Inability to Write

Where the client cannot write or has a disability that hinders his or her ability to write; the content of a consent form can be explained to him/her, and an indication of a consent obtained by the use of a right-hand thumbprint.

4.2.2 Mandatory Testing

Mandatory HIV testing is not supported by the Law of Liberia (Section 18.21 (2)) except in the following cases:

- A person has attempted to infect another person with HIV, as in the case of a known PLHIV using a sharp object with his/ her blood or body fluid on another person.
- A person convicted of rape".

4.3 Confidentiality and Privacy

All clients must be assured of the confidentiality of their test results:

- The results of the client should be documented in the client's file and HTS testing ledger and may be communicated to other members of the health-care team involved in the management of the client, with the client's consent.
- Disclosure to sexual partners should be encouraged; however, the decision to disclose should be taken by the person undergoing the test.
- The Liberia HIV law forbids disclosure of a person's HIV test results without the written or verbal consents of the individual, except in the following circumstances:
    a. The person who underwent the test
    b. The parent(s) / guardian(s) of a tested minor of an under aged child
    c. The parent(s) / guardian(s) in the case of a mentally disabled person or orphan
    d. A court of competent jurisdiction that has requested the test result."

4.3.1 Shared Confidentiality

Shared confidentiality is when information about the patient or client is disclosed to another person (who could be a family member, health provider, friend or relative) directly involved in the care of the client, with the client's expressed informed consent.

In most cases, sharing information about HIV status with the partner, family, trusted friends, community members and medical staff may benefit the client and their families and should be encouraged where appropriate. However, the counsellor should always take note of the following points:

Sharing HIV status should always be with the informed consent, which can be written or verbal.

a. Disclosure by service providers should be limited only to those who contribute directly to the continuity of the client's care.
b. HIV status should never be shared with the client's employer unless the client specifically requests this action.
c. Discussion about sharing confidentiality should explore (investigate the why not) the barriers faced by the client in disclosing. Where the client is in an abusive relationship, he/she should not be pressurized to disclose to an abusive partner and should be referred to appropriate service providers for support.
d. Revelation of an individual's HIV status to their sexual partner should only take place with informed consent from the client or where the following circumstances take place (*HIV Law*, sub-section 18.24 – emphasis added):

    i. ? they are requested by the person living with HIV to do so; **or**

    ii. Where **all** the following circumstances exist:

        a. In the opinion of the health care provider, there is significant risk of transmission of HIV by the person infected with HIV to the sexual partner; and
        a. Counselling of the person living with HIV has failed to achieve a change in behaviour necessary to reduce sufficiently the risk of HIV transmission to the sexual partner such that this is no longer significant; and
        b. The health care provider gives the person living with HIV advance notice for a period that is reasonable in the circumstances; and
        c. In the opinion of the health care provider the person living with HIV is not at risk of serious harm because of any notification to the sexual partner; **or**

    iii. Where the following circumstances exist:

        a. The person infected with HIV is dead or unconscious or otherwise unable to give consent to the notification; or

b. Unlikely to regain consciousness or the ability to give consent and
c. In the opinion of the health care provider, there is or was a significant risk of transmission of HIV by the person infected with HIV to the sexual partner."

In any such circumstance, the provider should seek advice from senior colleagues about un authorized disclosure of HIV status (preferably a provider covered by a professional body or association that provides a code of conduct).

4.3.2 Methods of Redress for Breaches in Confidentiality by Service Providers and Workers

Whilst established professional organizations issue codes of conduct for their professionals (e.g. the Medical, Nursing and Midwifery Council of Liberia), Health facilities should ensure the codes of conduct developed by the NACP for HTS providers are adhered to. Publicity should be given on how to redress situations where patient's confidentiality has been broken. Consideration should be given to the appointment of an independent ombudsman or patient advocate to whom breaches of HIV counselling and testing protocols and codes of conduct can be reported.

4.4 Avoiding Stigma and Discrimination in the Health Facility

HTS standard practice demands that all service providers treat clients and patients decently, with respect and without discrimination based on HIV status or risk behaviors, and to help patients address potential negative social consequences as result of HIV testing. Involvement of PLHIV, members of at- risk populations and their advocates in training sessions for health care providers issues is strongly recommended.

SECTION 5: PRE-TEST INFORMATION

PITC is an integrated part of each clinician's role and should not be considered an additional task. Clients may be referred to a trained HIV Counsellor for in-depth post-test counselling or on-going support.

Verbal communication is normally adequate for the purpose of obtaining informed consent. Jurisdictions that require consent to be given in writing are encouraged to review the policy. In case of decision to decline the HIV test, this should be noted in the medical record so that, at subsequent visits to the health facility, a discussion of HIV counselling and testing can be re-initiated.

Within health facilities during VCT, pre-test information can be provided in the form of individual information sessions or in group health information talks. A group education session should always be followed by shorter individual counselling sessions. Women who are pregnant and children will need additional information – refer to the *National PMTCT* and *Pediatrics Guidelines* for details on this.

Informed consent should always be given individually and in private (see section below on informed consent).

5.1 Pre-Test Counselling for VCT

Pre-test counselling in VCT would prepare the clients to:

- Access their own risk of contracting HIV
- Understand the benefits of HIV testing
- Be aware of the range of options and services available to them, including post –test support and ongoing psychosocial support
- Make an informed decision about having an HIV test
- Start thinking about coping with a positive HIV test result
- Develop a risk reduction plan.

5.1.1 Group Information Pre-test Session

A group information session should include the following key components beneficial to the client, and used as appropriate to the circumstances:

- Discussion on confidentiality and shared confidentiality.
- Information about HIV acquisition and transmission.
- Information about effective HIV prevention measures, including consistent and correct use of condoms, partner reduction and other options.
- Emphasis on the importance and advantages of early HIV testing to facilitate diagnosis, positive living, and healthy lifestyle.
- Information about the HIV testing process.
- Outline next steps following negative, preliminary positive, invalid or indeterminate test
- results Discussion on the option not to take the test if this is raised by the client.
- Offer an opportunity to test later should the client decline the test.
- The importance of TB symptomatic screening during pre- and post-test counselling.
- Referral to HIV and AIDS related services for those who test positive, such as care, treatment and support services, nutrition, TB screening, STI screening, viral load monitoring and OI management.
- Clients should be reassured that Antiretroviral drugs (ARVs) are free of charge.

5.1.2 Pre-Test Individual Counselling Session

The individual counselling session should include the following components:

- Assessment to determine whether the information provided in the group session has been absorbed and supplement information and fill knowledge gaps.
- Opportunity to respond to unanswered questions and attempt to clarify any misunderstandings.
- Discussion of specific issues for the individual and assessment of individual risk, including determining whether there is a history of domestic violence and the window period should the client test HIV negative.
- Discussion of prevention strategies including delayed sexual debut, abstinence and regular use of condoms.
- Discussion on the way forward and management options in the case of a positive result including
- TB screening, clinical staging, pre- Antiretroviral Therapy (ART) management and healthy lifestyles.
- Discussion on partner involvement and referral for testing.
- Discussion of the option to refuse testing if this is raised by the client.
- Obtain written or verbal informed consent for HIV testing.

Information sessions and IEC materials in the local language or easily understood English should be available to take home for all clients considering taking the HIV test.

All patients undergoing HIV testing must give their informed consent (oral or written) before the test is taken - see previous Section 4.2 for details.

5.1.3 Pre-Test Couple / Partners Counselling Session

The couple/partners counselling session should include the following components in addition to those in individual counselling session:

- Making decisions together/single about how to deal with HIV in the family?
- Discordance is common than positive concordant
- Assurance that treatment is available
- Knowing one`s status makes it easier to get better healthcare and protect family
- Discuss with the couple if they would like to receive the HIV test results together
- Help the Couple make decision about mutual disclosure together
- Couple discusses HIV risk issues and concerns together
- Couple participates equally and support each other
- Explain possible results
    - Singles: (-) negative, (+) Positive
    - Couple: Both tests (-) mean both do not have HIV (concordant negative).
    - Couple: Both tests (+) mean both have HIV (concordant positive).
    - Couple: One test (+), one test (-) means one has HIV and one does not (discordant).

SECTION 6: HIV TESTING

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

6.1 HIV Tests

There are several ways to establishing HIV infection. These are mentioned below. However, HIV testing in Liberia is mainly carried out by antibody detecting techniques. Children below 18 months are mainly tested with nuclei acid test (PCR) to avoid confusion with lingering antibodies from mother to child. For convenience and public health benefit, this period can be extended to 24months. Algorithms (sequence of HIV rapid antibody tests are followed to ensure HIV test results issued to a client are valid (see algorithms below):

6.1.1 Simple or Rapid Tests

Rapid tests are recommended for HIV Testing services. They are simple to perform, even in clinics and settings without specialized laboratory equipment, and are as accurate as ELISA tests when Standard Operation Procedures (SOPs) are followed. A sample of blood (via finger prick or intravenously) is taken from the patient/ client, and the result is ready within 20 minutes.

An essential requirement of all HIV testing is accuracy of the test result. The rapid test kits evaluated and approved for use in Liberia are those recommended and prequalified by the World Health Organisation (WHO), and include: Determine, SD Bioline, Unigold, HIV/Syphilis duo and OraQuick for HIV self-testing (See below). Additional rapid test kits may be evaluated in future and approved for use in Liberia.

6.1.2 Polymerase Chain Reaction (PCR) Tests

PCR tests are nuclei acid-based test that are used to detect the presence of RNA fragments of HIV. Others tests that can also show direct viral presence include p24 antigen test, and viral culture. They are useful where rapid anti-body tests are unreliable, such as babies below 18 months and people who have been on ART, and in survey where HIV prevalence rate is being determine as in Liberia Demographic Health survey or in sentinel survey.

6.1.3 Enzyme -Linked Immuno-Sorbent Assay (ELISA)

ELISA tests are used in facilities where there are adequate laboratory facilities, personnel and infrastructures. It is not in use in Liberia.

6.1.4 Importance of differentiating HIV-1 and HIV-2 infection

It is essential to determine the type of HIV infection (HIV-1, HIV-2, or HIV-1 / HIV-2 co-infection) for each patient. This information should be recorded clearly in the patient record and testing ledgers as they are essential for data purposes

6.2 HIV Testing Algorithms in Liberia

There are three testing algorithms based on availability of a DNA PCR laboratory:

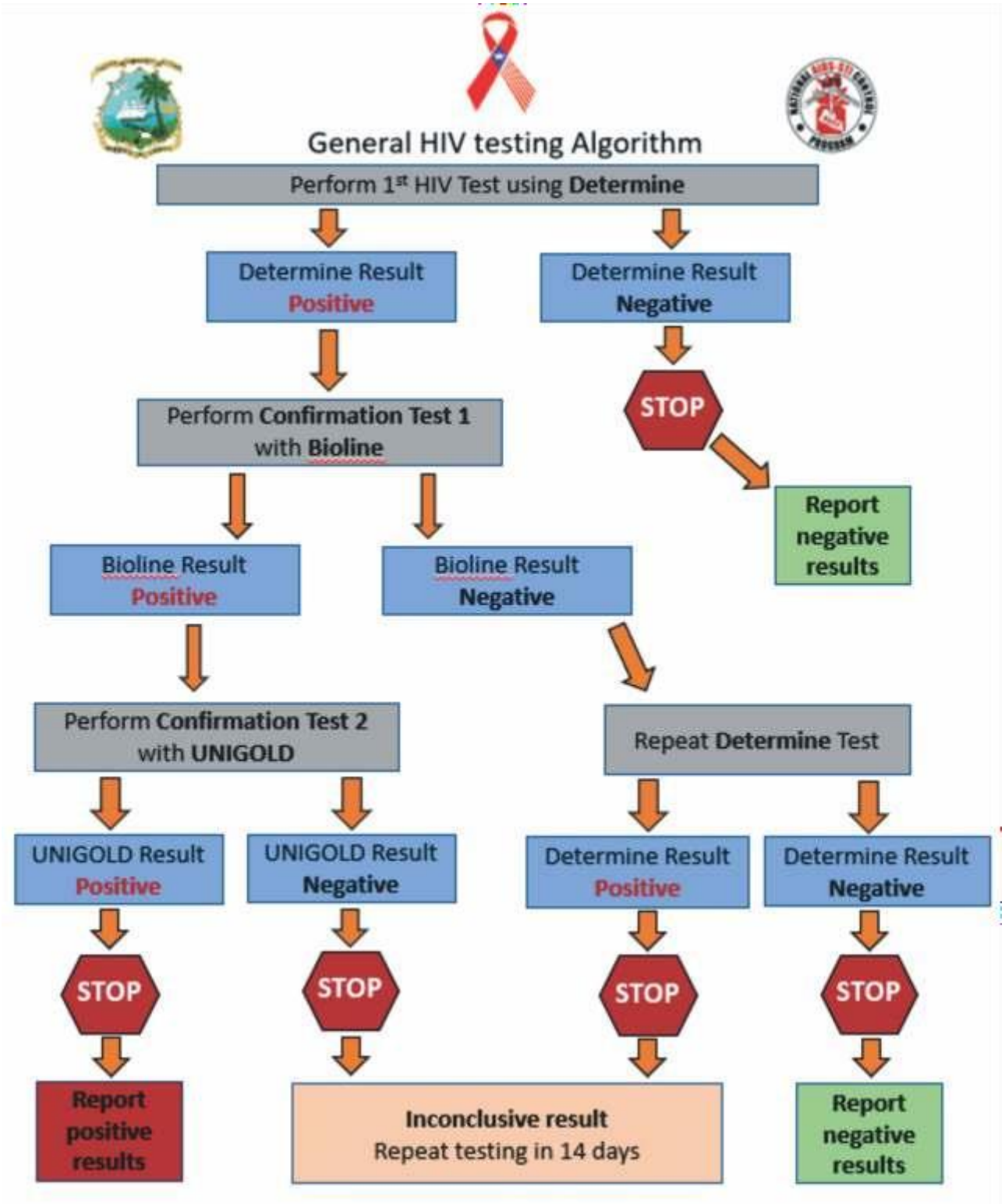

Figure 2: Algorithm for HIV diagnosis in adults and children >24 months of age (or three months after cessation of breastfeeding)

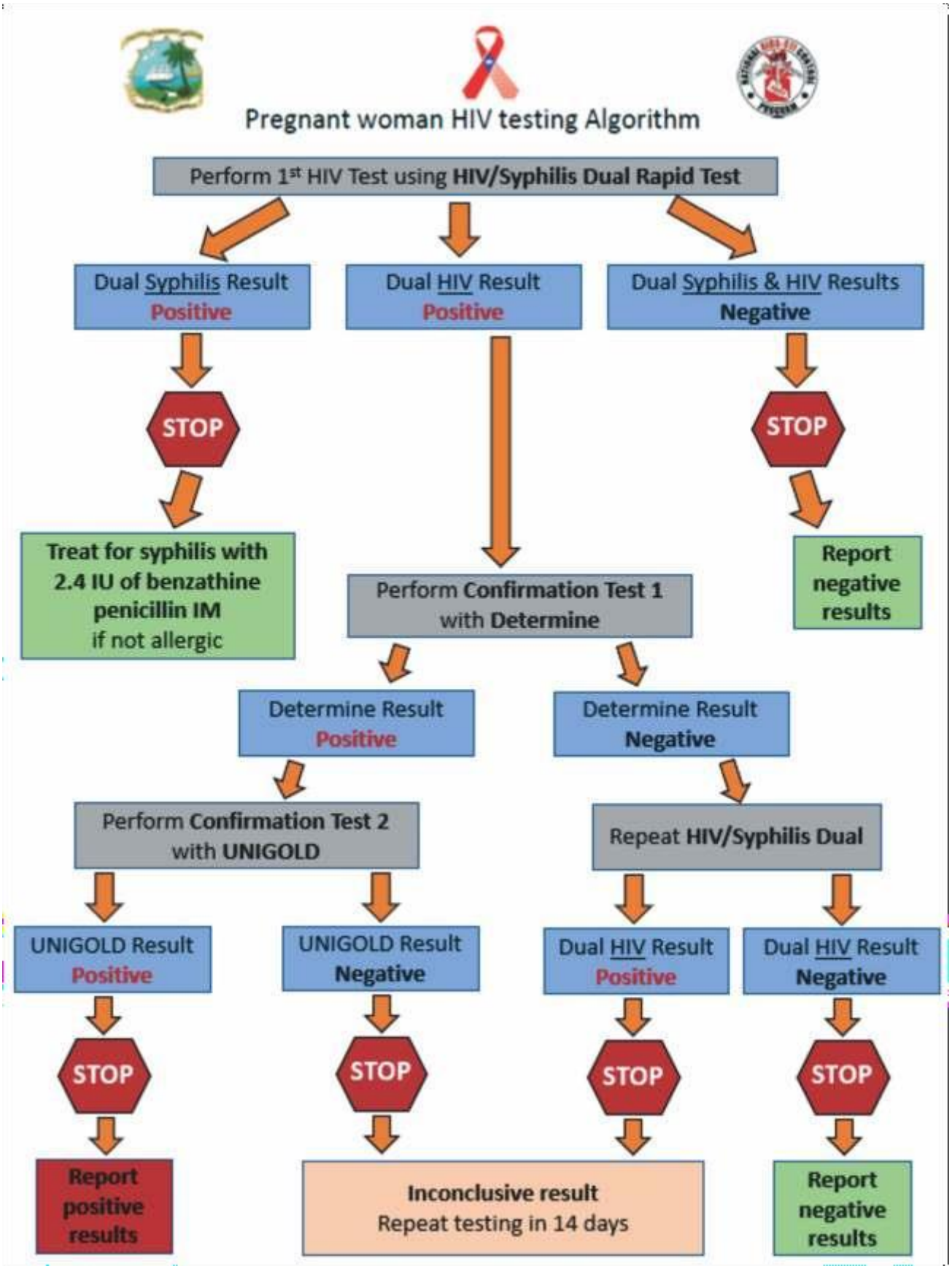

Figure 3: Algorithm for HIV diagnosis in pregnant women and male partners

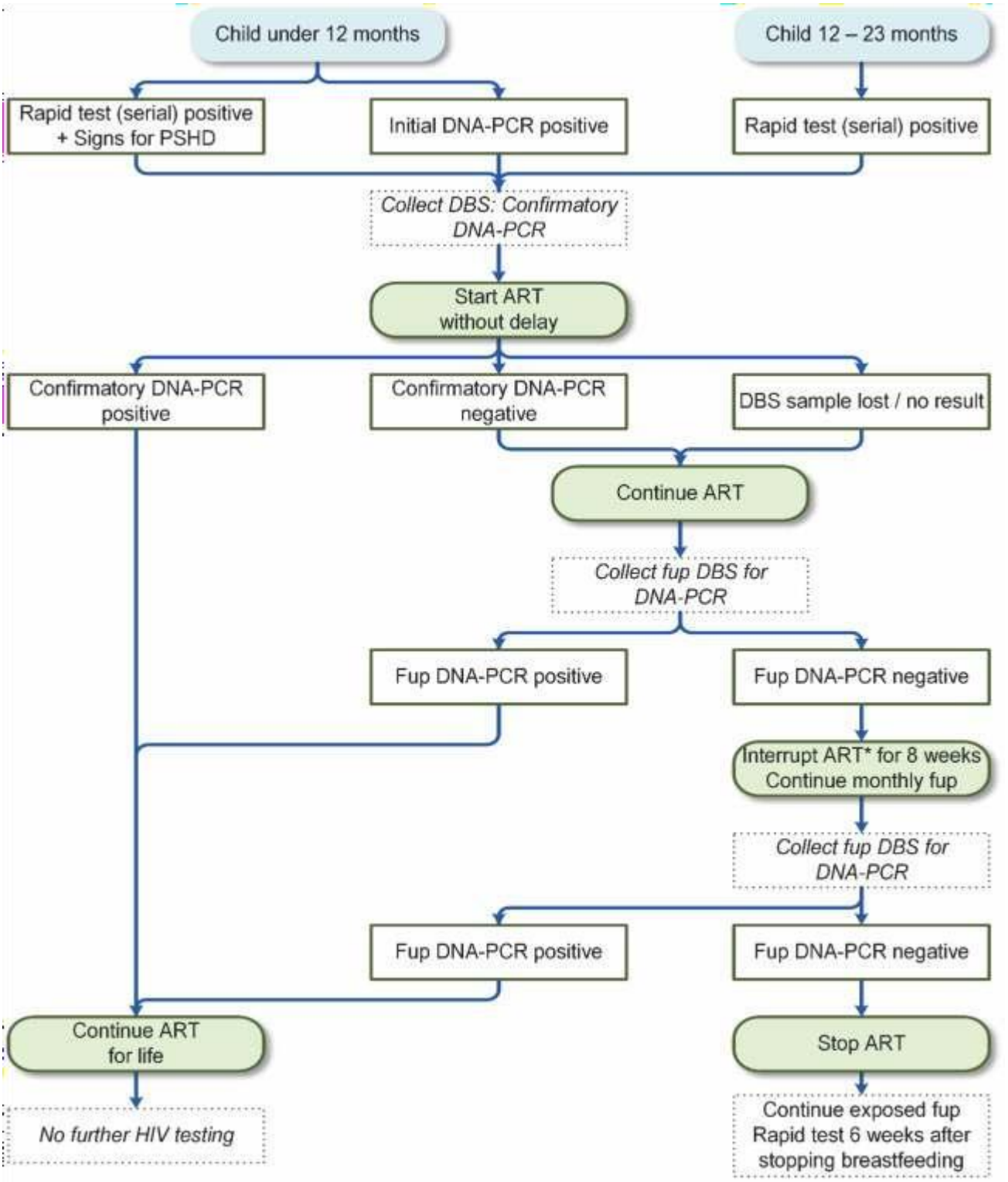

Figure 4: Algorithm for HIV diagnosis in children less than 24 months of age

6.3 Testing Standards (QC and QA)

To ensure quality control (QC) and quality assurance (QA) in ongoing internal HTS processes in all facilities, there will be regular onsite NACP supportive supervision of the HTS personnel and HIV testing procedures using pretested supervision checklist. 5% of known positives and 10% of known negatives will be retested by another HTS provider within the facility (internal QA).

For external QA, each HTS counsellor will be subjected to proficiency testing once per year. A qualified laboratory personnel or supervisor will conduct the assessment using previously characterized sample and the results will be documented in a personal proficiency log. Secondly, there will be a procedure for ascertaining every new batch of test kits using the previously characterized sample:

- Blinded rechecking: 5-10% of all blood samples used for HIV testing will be collected by random sampling and sent to a designated national reference laboratory (NRL) for re-testing.
- All facilities with consistently unreliable QA test results need to receive additional technical supervision and support.

6.4 Infection Prevention and Control

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

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

Components of standard precautions:

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

SECTION 7: POST TEST COUNSELLING

Provide post-test counselling to all recipients of an HIV test, as follows:

7.1 Delivering HIV Test Results

HIV test results should be given in person by health care providers or by trained lay personnel (preferably by the same health care provider who initiated HTS), although this may not always be possible. NEVER give results in a group setting. It may be given to a care giver in the case of a patient who is a minor.

- Ensure post-test counselling is delivered in a manner **private** and acceptable to the patient
- Don't withhold test results.

Post-test counselling prepares the client to:

- Understand and accept their HIV test result
- Review their risk reduction plan
- Review ongoing post-test support and ongoing psychosocial support with counsellor
- support Encourage disclosure of test results to partner

7.2 Post-Test Counselling for Individuals with an HIV Negative Result

HIV-negative clients should be offered a comprehensive post-test counselling on a prevention package. This includes an explanation of the test result, including information about the window period for the appearance of HIV-antibodies and a recommendation to re-test in case of a recent exposure. The window period should be explained taking into consideration the individuals' personal risk-assessment.

The health care provider and the patient should jointly assess whether the client needs referral to more extensive post-test counselling session or additional prevention support or PEP (e.g. in cases of rape or occupational exposure) through community -based services.

Box 3: Basic prevention package for persons diagnosed HIV -negative

- Information about prevention services and re-testing when confirmation is required
- Promotion and provision of male and female condoms and guidance on their correct use
- Needle and syringe access and other harm reduction interventions for injecting drug users
- Post-exposure prophylaxis (PEP), where indicated.
- Pre-exposure prophylaxis (PrEP), where indicated and available.

7.3 Post-Test Counselling for Individuals with an Indeterminate Result

An invalid or indeterminate result (no definitive diagnosis, HIV-Ve or HIV+ Ve) can be caused by improper use of test kit or test kit malfunction. Repeat the test with a new POC test kit. If an invalid or indeterminate result persists a second time, submit a sample for laboratory testing and report the malfunction to the County health team and the NACP.

- Explain that the client's HIV status cannot be determined and that this does not mean the individual is positive, but it does not also confirm that he/she is negative. Individuals who have indeterminate status should be considered as potentially HIV-positive.
- Assess that the client has fully understood that an invalid or indeterminate result should not be regarded as a positive or negative result. To determine that a client remembers what was discussed during the pre-test session about invalid and indeterminate results, ask the client what they remember.

- Reinforce that until the test is repeated with another POC test kit or confirmed by a standard laboratory test method, the client should not make any assumptions about what his HIV status might be.
- Reinforce transmission information, placing this prevention effort in the context that his HIV status will be unknown until a confirmatory test result is available.
- Emphasize the need to engage in safe behaviors and to return for further testing. The importance of clear results must be underscored due to acute HIV infection's characteristic period of high viral load and potentially greater infectivity as compared with the chronic phase of the infection.
- Emphasize importance of follow up.
- If the result of the second test is also invalid or indeterminate submit a venous sample for standard testing.
- If repeated tests are invalid, report the occurrence to the manufacturer.
- Document the process in the client record.

7.4 Post-Test Counselling for Individuals with an HIV Positive Result

HIV-positive clients must be given their test results and post-test counselled about their HIV status only after the second confirmatory test is also positive (following the HTS Algorithm).

The focus of post-test counselling for people with HIV-positive test results is psychosocial support to cope with the emotional impact of the test result, facilitate access to care, treatment and prevention services, prevention of transmission and re-infection and disclosure to sexual and injecting partners.

The counsellor should refrain from labelling patients' feelings for them, e.g. avoid saying, "You must be upset," or "This is difficult for you." Patients should first be supported to define the meaning of the results for themselves and identify their own thoughts, reactions, feelings, and emotions. The counsellor can then supportively reflect and normalize the individuals' experiences.

As appropriate, the counsellor may remind the patient of his/ her resources and strengths, identified earlier in the session. At the same time, the counsellor should help the couple recognize the potential need for additional support from others. Please refer to Table 1 for an outline of the counsellor's tasks.

Table 1: Outline of HIV Counsellors' tasks in post-test counselling with a positive result

Task	Counsellor's Objective
Invite the patient to express their feelings and concerns.	Understand how receiving a positive result impacts the individual. Provide patient with an opportunity to identify and voice emotions and reactions.
Validate and normalize the patient's feelings and acknowledge the challenges of dealing with a positive result.	Provide genuine empathy and offer support and understanding.
Ask how the patient can best seek support	Focus the patient on generating ideas about how they can be supported.
Recall the individual's strengths. Convey optimism that they will be able to cope and adjust to living with HIV.	Help the patient to recognize and build on his or her skills and resources, as an individual and as a member of the community or a family.
Address the individual's immediate concerns.	Determine if there are critical issues that must be addressed for the individual to listen, focus, and participate in the remainder of the session.
Discuss the issue of HIV testing of children if appropriate	Because children may have become HIV infected through their mothers, encourage the couple to bring their children for HIV testing. If the children are HIV-positive, they can get the care and treatment they need.

In addition, health care providers should provide the following information:

- Describe follow-up services that are available in the health facility and in the community, with special attention to the available treatment, PMTCT and care and support services
- Provide information on how to prevent transmission of HIV, including provision of male and female condoms and guidance on their use
- Provide information on other relevant preventive health measures such as good nutrition, use of co-trimoxazole and, in malarious areas, insecticide-treated bed nets
- Discuss possible disclosure of the result, when and how this may happen and to whom
- Encourage and offer referral for counselling and testing of partners and children
- Assess the risk of violence or suicide and discuss possible steps to ensure the physical safety of patients (See section 10)
- Arrange a specific date and time for follow-up visits or referrals for on-going counselling, care, treatment and support, and other services as appropriate (e.g. tuberculosis screening and treatment, prophylaxis for opportunistic infections, STI treatment, family planning, antenatal care, opioid substitution therapy, and access to sterile needles and syringes). Follow-up with phone calls when there is a no-show at scheduled appointments.

7.5 Post-Test Counselling for HIV-Positive Pregnant Women

Post-test counselling for pregnant women who test HIV-positive should address the following additional issues (refer to *Guidelines for the PMTCT* for further details):

- Childbirth plans
- Use of antiretroviral drugs for the patient's own health, and to prevent mother-to-child transmission
- Adherence to antiretroviral drugs for the mother and child to prevent mother-to-child transmission
- Adequate maternal nutrition, including iron and folic acid
- Infant feeding options and support to carry out the mother's infant feeding choice
- HIV testing for the infant and the follow-up that will be necessary
- Partner testing.

NOTE: Where the duo HIV/ syphilis rapid test is used, post-test counselling must also include the disclosure of syphilis test results. Women who test positive for syphilis should be counselled on the risks of mother-to-child transmission; should be encouraged to bring their male partners for testing; and should be treated immediately with 2.4 IU of benzathine penicillin-G intramuscularly unless allergic to prevent adverse outcomes in their child.

7.6 Post-Test Counselling for Couples

Delivering results to a couple can be a difficult situation for some counsellors, and excellent communication and conflict resolution skills are required.

Follow the pre-counselling agreed means of disclosure. There are three types of situations in delivering HIV results to couples: where both results are negative, or where a positive result is concordant or discordant.

7.6.1 Concordant Negative Results

Providing the couple with concordant negative results in a clear and straightforward manner,

- State clearly and simply that both tests results are negative, indicating that each partner is not infected. If available, show the test results or test strips to the couple.

- Explore the couple‘s reaction to their results - allow the partners to express their own feelings and emotions about the test results they have received.
- Discuss results in the context of any recent risks outside of their relationship. Counsellors should note the possibility that a recent exposure outside of the relationship may indicate a need for a re-test, because a recent exposure may not have been detected by the HIV test. The counsellor can say, “There is a very small chance that this test did not detect HIV if you were infected very recently. If you are concerned about a recent exposure to HIV, such as from another partner, you should get another test in about twelve weeks.”

  The most important message to convey is that the couple’s test results do not reflect the HIV status of any other partners, past or present.

- Ensure the couple has an accurate understanding of the outcome of the test results, their meaning and implication.
- Discus risk reduction with the couple
- Provide needed referrals for services such as STIs, family planning, care during pregnancy, or support.

7.6.2 Concordant Positive Results

The counsellor is responsible for providing the test results in a straightforward, clear, and succinct manner. Provide the couple with a summary of both of their test results by saying, *“Your results are the same.”* followed by, *“Your test results are HIV-positive, which indicates that both of you are infected with HIV”* This approach reaffirms that the partners have sought to learn their HIV status as a couple and that they will be coping with their shared test results together.

After issuing the results, the counsellor should:

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

7.6.3 Discordant Results

This applies to couples and means that one partner is HIV-positive and the other is HIV-negative. The HIV negative partner remains at high risk of becoming infected through future exposures. Research shows that expedient initiation to ART is beneficial regardless of HIV stage or CD4 count – once an individual is suppressing their viral levels (usually after 6 months if treatment adherence is good), this reduces the risk of transmission to their partner[1].

- Ensure the couple understand the following implications:
  - The HIV negative partner is at very high risk of infection and could be infected if the couple does not adopt safer sexual behaviors.

[1] Recent research findings (NIAID, 2019[1]) have shown that ART can prevent the sexual transmission of HIV among sero-discordant couples. This suggests that there is a need for the accelerated scale up or ART for everyone infected with HIV, irrespective of disease state and that earlier initiation on ART is better WHO ``test and treat`` policy.

- The couple needs to develop a risk reduction plan to protect the HIV-negative partner and enhance the wellbeing of the positive.
- Discordant results do not necessarily mean that someone has been unfaithful in the relationship – often the infected partner was infected before meeting their current partner.

7.7 Referral to Other HIV Clinical Services

Post-test HIV services for clients who test positive includes:

a) Palliative and psychosocial support

b) Prevention of Mother to Child Transmission of HIV (PMTCT) services for pregnant women.

c) Anti-retroviral services (ART) for treatment and associated laboratory investigations where necessary (This is limited now with adoption of test and treat.

d) TB screening (symptoms screening- cough, fever, weight loss, night sweats) Send all PLHIV with any of these signs for further TB evaluation.

e) Those with Stage III-IV HIV, or when available CD4 < 200, should refer for serum CrAG test and TB-LAM tests.

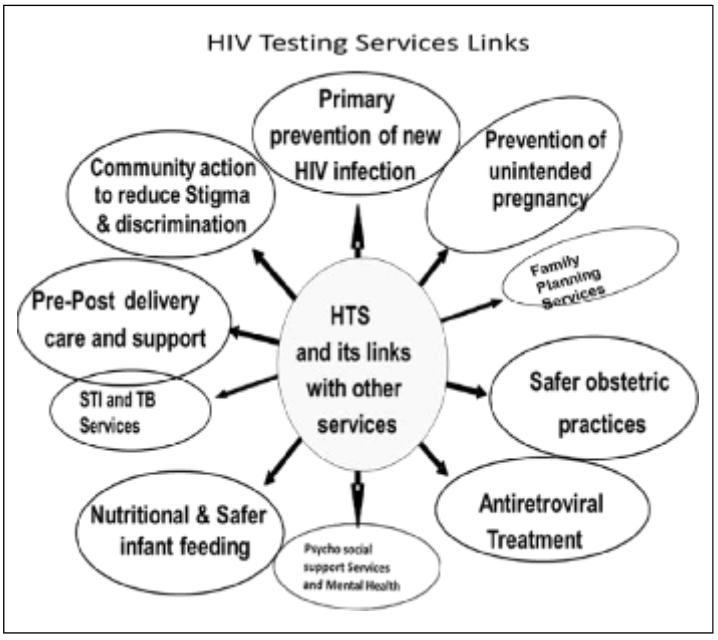

Figure 5: HIV testing services links

7.8 Frequency of Testing

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

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

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

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

SECTION 8: COUNSELLING AND TESTING IN SPECIAL POPULATIONS

8.1 Pregnant Women

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

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

8.2 Adolescents

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

8.3 Children

831 Identifying Which Children to Test

HIV disease progresses more rapidly in children than in adults, hence they may be the first to be identified as HIV-positive in the family.

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

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

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

1. Current pneumonia
2. Ever had ear discharge
3. Low weight for age
4. Losing weight / unsatisfactory weight gain
5. Floppy, weak or tired
6. Unable to sit up by 6 months
7. Unable to stand up by 12 months
8. Unable to say one word by 15 months
9. Ribs showing
10. Fast breathing
11. Persistent diarrhoea in the past 3 months
12. Enlarged lymph glands in 2 or more sites
13. Oral thrush (white sores in mouth)
14. Parotid enlargement.
15. Enlarged liver with no evidence of Malaria and/or any other cause of liver enlargement

832 Consenting Minors

Children 14 years or more may give consent for HIV testing. A child married, pregnant, a commercial sex worker, street teenager, family head or with known history of sexual intercourse is regarded as *mature (or emancipated) minor* and can consent for HIV testing.

HIV testing for children below 14 years of age who are not included in the *mature minor* category can only be performed with the knowledge and consent of their parents or guardians.

Exceptions to this include:

- Children below 14 years of age presenting with convincing signs or symptoms of HIV, and the parents or guardians are refusing to consent to a test. The Department of Social Welfare at Ministry of gender and children protection may be contacted to facilitate testing. Every effort should be made to explain to the parents or guardians the necessity and benefit of knowing the child's HIV status.
- Children who have been sexually abused and put at risk of HIV infection shall receive supportive counselling and be encouraged to take a test. Parents or guardians should be asked for their consent prior to testing.

833 Right to Defer Request for Testing of a Minor

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

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

834 Disclosure for Minors

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

8.4 Unconscious Patients.

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

- Non-consensual HIV testing of patients who are too unwell should be undertaken only in a situation where there is doubt about the diagnosis or if there is evidence of chronic dementia or ***where results of a HIV test will change the management of the patient***.[2] Consent is required from a legal guardian, partner, parent for a minor, and adult child of the patient. Gaining consent does not imply sharing of HIV test results to the person giving consent.
- Treatment should be initiated for any suspected opportunistic infection where there is evidence of immunosuppression and a diagnosis of HIV is strongly suspected. When the patient has sufficiently recovered to give consent, counselling and testing should be performed as per protocol.

[2] Note that the HIV Law does not address this issue fully, but a health care provider can argue that, as long as confidentiality is maintained, they were acting in the best interests of the patient.

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

8.5 Health -Care Providers and Workers Exposed to HIV

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

8.6 Survivors of Sexual Assault

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

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

8.7 Most At-Risk Populations (MARPs)

MARPS are populations with increased behavioral risk to HIV infection, and includes FSWs, MSMs, TGs, PWIDs,[3] etc. Due to societal stigma and discrimination on these populations, easy access to health care and HIV testing is often challenging. Integration of HTS in MARP-friendly programs, STI clinics and anti-drug dependence initiatives have shown increased HIV testing and access to ART services for these population, thereby mitigating community transmission.

8.7.1 Female S ex Workers (FSWs) and Their Clients

Among men who reported paying for sex, only half reported using a condom during their last transactional sex, exposing the extent of risky behaviour (Liberia Demographic Health Survey, LDHS, 2007). More research is required to understand the extent and complexities of transactional sex in Liberia in order to develop appropriate strategies to increase access to HTC for female Sex Workers (CSWs) and their clients.

[3] 2018 Liberia IBBS Report show HIV prevalence of 37.9% among men who have sex with men (MSM); 27.6% Transgender people (TG); 16.7% among female sex workers (FSWs); and 14.4% among people who inject drugs (PWIDs)

872 Men Who Have Sex with Men (MSM) and Drug Users

The vulnerability of men who have sex with men is heightened not only by social stigma but also by the legislation denying Men who have sex with men (MSM) to freely express their sexuality.

There is little known or reported about intravenous drug use in Liberia as the form of drug use directly responsible for high risk of transmission of HIV.

873 Convict ed Sexual Offenders

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

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

Strict requirements apply to confidentiality of the results - disclosure to the victim of sexual assault is sanctioned under Section 18.24, i. of the *HIV Law* if,? in the opinion of the health care provider, there is a significant risk of transmission of HIV by the person living with HIV to the sexual partner".

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

874 Prisoners [4]

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

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

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

For female prisoners - on admission to a detention facility:

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

875 Individuals with Mental Health Problems

The welfare of people who are mentally unwell should be the primary concern of the counsellor when HTS is requested. The counsellor reserves the right to refuse testing, if he or she determines that the

[4] The National Health and Social Welfare Policy and Plan (2011 – 2021) prioritizes provision of the Essential Packages of Health Services (EPHS) and Essential Packages of Social Services (EPSS) to vulnerable groups, including prisoners

patient is not competent to make decisions about testing. In such a case a referral should be made to a mental health clinician for appropriate assessment. HTS, however, can be provided in the company of a legal guardian in deserving cases.

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

8.7.6 Refugees

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

8.7.7 People with Mental & Physical Disabilities

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

SECTION 9: ON-GOING COUNSELLING AND SUPPORT FOR HIV-POSITIVE INDIVIDUALS

This section provides some tools and guidance on how to support people living with HIV in managing their diagnosis and learning to live positively with their HIV status. It is an extension of post-test counselling to helping the client cope with positive living.

9.1 Main Objectives of Counselling and Support

The main objectives of counselling in the context of supporting a person living with HIV are:

- To assist the client to cope with their HIV status;
- To promote adherence in ART preparation and for those who are considered eligible to commence therapy;
- To educate the client in preventing transmission of HIV to others;
- To minimize the risk of additional exposure to or re-infection by and onwards transmission of HIV.

Ongoing counselling and preparation for life-long therapy should be reinforced at every opportunity by all members of the Care and Treatment Program. Adherence counselling is essential for clients on ART and in preparation even if a patient is not yet eligible for ART.

9.2 Essential Features of Counselling and Support Services

Box 4: Components of basic prevention, care and support services for PLHIV

Basic prevention services for persons diagnosed HIV-positive:

- Individual post-test counselling by a trained provider that includes information about and referral to prevention, care and treatment services, as required.
- Support for disclosure to partner and couples counselling.
- Encourage HIV counselling and testing for partners and children.
- Safer sex and risk reduction counselling with promotion and provision of male and female condoms.
- Needle and syringe access and other harm reduction interventions for injecting drug users.
- Interventions to prevent mother-to-child transmission for pregnant women, including antiretroviral prophylaxis
- Reproductive health services, family planning counselling and access to contraceptive methods.

Basic care and support services for persons diagnosed HIV-positive:

- Education, psychosocial and peer support for management of HIV.
- Periodic clinical assessment, viral load and CD4 testing.
- Management and treatment of common opportunistic infections.
- Co-trimoxazole prophylaxis.
- Tuberculosis screening and treatment when indicated; preventive therapy when appropriate.
- Malaria prevention and treatment, where appropriate.
- STI case management and treatment.
- Palliative care and symptom management.
- Advice and support on other prevention interventions, such as safe drinking
- water. Nutrition advice.
- Infant feeding counselling.
- Antiretroviral treatment, where available.
- Refer to (or provide contacts for) support group for peer support.

The counsellor should gently transition the session away from addressing the individuals' feelings and emotions associated with dealing with HIV infection toward the clinical care, treatment, and preventive services required to manage HIV infection. Counsellors should emphasize that there are many preventive therapies that can enhance the quality of the individuals' life, and that of their partner and family. The goal is to motivate and empower clients to seek needed care and treatment services and to advocate for their own health. To do this, the counsellor should provide information at the client's level of understanding to educate them about the essentials of HIV care and treatment. The aim is for the client to fully understand and value the importance of accessing appropriate care.

Table 2: Counsellors objectives and tasks during a counselling session

Task	Counsellor's Objective
1. Discuss positive living.	1. Encourage the client to focus on their ability to enhance their health and well-being.
2. Address the need for preventive health care. Encourage immediate visit to the HIV clinic.	2. Encourage an immediate follow-up medical visit.
3. Encourage the client to access appropriate care and treatment services.	3. Motivate the client to obtain the essential clinical care for their HIV infection.
4. Provide needed referrals to the HIV clinic and Other services, including support groups. Identify and problem-solve obstacles.	4. Link the client to care and services, especially support groups.
5. Address spiritual or religious needs.	5. To ensure the client can find ways to accept living with HIV and ART within the context of their spiritual or religious needs.

9.3 Support with Disclosure

All patients should be counselled and strongly encouraged to disclose their HIV status to a friend or relative prior to initiating ART.

9.3.1 Disclosure Benefits and Basics

Potential benefits of disclosure to the HIV-infected person:

- May build a network of social and emotional support—may reduce sense of isolation and anxiety
- May enhance opportunities for the HIV-infected person to receive support in obtaining proper medical care and treatment
- Assists HIV-infected individuals in taking medication properly by:
  - Allowing the individual to take medication openly
  - Allowing the individual to acknowledge their own HIV status
  - Allowing the individual to identify and receive support during treatment.

Potential benefits of disclosure to sex partners:

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

Potential benefits of disclosure to family and community:

- Helps infected individuals, couples, and families prepare for the future

- Allows an opportunity to address children's fears and
- anxieties Provides a role model to friends, family, and community
- Allows health care providers to perform and/ or refer the patient to the care needed.

Box 5: Tools f or the counsellor in supporting adult patients with disclosure

Discussing disclosure to people and partners is an issue that must be approached with sensitivity. The counsellor can support the individual in disclosure by helping them to:

- Identify the person most likely to be supportive and understanding to disclose to first.
- Find a private and quiet place and time for the discussion.
- Request that the discussion be kept confidential.
- Mentally frame the issues to be addressed beforehand.
- Develop a script of what to say and how and when to say it.
- Anticipate both supportive and non-supportive responses and how they may feel to the couple.
- Imagine possible counter-responses.
- Focus on and share feelings. Avoid blame when disclosing to a partner.
- Be clear and specific about what support is needed and what would be helpful.
- When finished, review the experience. Revise the approach as necessary for disclosure to the next person.
- When deciding which sex partners to disclose to, prioritize those who may have been exposed to HIV (if the HIV-positive person feels it is safe to disclose to that person).
- Once couples and individuals decide to disclose and agree of whom to disclose, practicing the disclosure is a useful way to develop strategies to make the process easier.

Benefits of disclosing parental H IV status to children:

Not knowing can be stressful for children. Children, especially older children, can be highly perceptive and often know something is wrong even if the parent has not disclosed. Parents can relieve the stress of uncertainty as well as communicate trust and openness by talking about their status. It is best for children to learn about their parents' HIV status from the parents themselves and disclosure opens communication between parents and children, therefore allowing the parents to address the children's fears and misperceptions. In addition to the benefits for children, disclosure lowers parents' stress - parents who have shared their HIV status with their children tend to experience less depression than those who do not.

Considerations for disclosing to children include:

- The decision to tell a child that a parent or parents are HIV-infected should be individualized to the child's age, maturity, family dynamics, social circumstances, and health status of the parent.
- How a child reacts to learning that a parent (or parents) has HIV usually depends on the relationship the parent has with the child.
- Young children should receive simple explanations about what to expect with their parent's HIV status. The focus should be on the immediate future and addressing fears and misperceptions.
- Older children have a better capacity to cope with their parent's status and to understand the implications of being HIV-positive.
- It is possible that in some cases, disclosure may initially cause stress and tension. Parents should anticipate that their children might need time to adjust to and accept their parents' HIV status.
- If a parent discloses his or her HIV status but requires the children to keep it a secret from others, it can be stressful and burdensome to the children.
- Parents should consider disclosing their status to other adults who are close to their children. This creates a support network of adults who can help the children cope with and process their feelings.

- Parents who are experiencing intense feelings of anger or severe depression about their HIV infection may want to wait to disclose to their children until after they have learned to cope with their status.
- HIV-affected children and families need ongoing support beyond disclosure for coping with HIV and planning.

9.3.2 The Special Situation of Adolescents

Supporting an HIV-positive adolescent with disclosure:

Adolescents who are HIV-positive should be aware of their HIV status and should be fully informed the consequences of their status in order to appreciate its impact on many aspects of their health, including sexual behaviour and treatment decisions.

Situations where a young person or adolescent is diagnosed without their carer's knowledge will raise issues. The provider will often face a dilemma about when and how the parents or guardians should be informed. The problem is worse when the child does not want to disclose to parents/ guardians but would like to benefit from ART. In view of the complicated nature of ART and the need for family support to maintain good adherence, it is recommended that:

- Be supportive and non-judgmental.
- Every effort should be made by the counsellor to discuss with the adolescent the need to involve the parents/ guardians.
- Additional counselling time should be given to the adolescent to allow for deep understanding of the implications of ART.

  Identification of a friend or relative as a treatment buddy is established, preferably before ART is initiated.

Supporting disclosure to an adolescent:

Disclosing a child's or adolescent's HIV status needs to be done sensitively and in a comfortable, safe environment. Counsellors can support parents and carers in planning the disclosure using the following steps:

1. Preparation
   - Why disclose now?
   - What do you want to communicate to your child?
   - What will be the most difficult questions for you to answer when your child knows their HIV status?
   - How will this information affect the relationship between us?
   - Acknowledge the difficulty of disclosure and affirm motivation to begin process
2. Education
   - How to explain HIV transmission to a child
   - Anticipate questions and responses from child
   - Post disclosure expectations
3. Planning
   - When and where?
   - Who will be there?
   - What will you say?
   - Plans after disclosure
4. Follow-up
   - School and family functioning Monitor medical treatment
   - adherence

- Disclosure to peers and others
- Support groups/ Counselling
- Continue to reinforce the positives

Supporting an HIV-positive adolescent:

Dealing with the needs of adolescents in this difficult time of transition from childhood to adulthood is a complex and there is little research on how best to support them, but programmatic experience has developed some experiential approaches that have been successful (see Table 3).

Box 6: Approaches in supporting adolescents and young people living with HIV

Health care provider requirements:

- Build capacity among trained counsellors with longer-term commitments for supporting adolescents
- Continuity of care-giver / counsellor is important
- Be there to support family and guardians support process and do not place them

Family-based approaches:

- Facilitatefamilyconferencestoaddresscriticalsituationsandcommunication; give support with disclosure and crises within the family
- Parents and other caregivers should be equipped with skills and understanding about HIV and care and treatment requirements

Forums for peer support:

- Separate groups for children & caregivers
- Outreach & role modelling by adults & young people living with HIV (YPLWHIV)
- Targeted interventions to address negative stigma (e.g. in schools)

Meeting caregiver needs:

- Counselling support for own disclosure, grief, and bereavement
- Support and referrals to meet basic needs
- Link to income-generating activities

HTS for children:

- Continuous counselling, counsellors trained in age-appropriate counselling
- Individual and joint sessions with parent and with child
- Hopeful consistent messaging(reinforced by all providers)
- Do not overwhelm with too much information

Addressing grief & bereavement:

- Continuous screening and counselling for children and caregivers
- Prioritized support for acute situations (for child or caregiver and household)
- Targeted activities to prepare for the death of a parent/caregiver (succession planning, will writing, memory boxes/ books, family trees)
- Contact throughout the death of a loved one (e.g. attend funeral, home visit)
- Referrals for ongoing support, such as income-generating activities, social welfare
- Engage young people in youth-center, youth-led approaches in planning, implementation & evaluation.

9.4 SUPPORTIN ACHIEVING POSITIVE LIVING

9.4.1 Nutrition

Children and adults with HIV have increased energy needs and should be counselled to ensure access to locally available and adequately nutritious diet. Symptoms of HIV or opportunistic infections (OI) that frequently result in poor appetite and malabsorption should be quickly managed as part of post-test care.

9.4.2 Reducing Risk of Other Infections

As people living with HIV have reduced immune capacity, clients should be advised on how to prevent exposure to common OIs. Immunization for children should be adhere to as per the national child vaccination schedule

9.4.3 TB

All PLHIV should be routinely screened for TB on initial presentation and during each subsequent visit (intensified TB case finding)., TB/HIV co-infected individuals are eligible for ART irrespective of CD4 and clinical stage. PLHIV screened TB negative should be placed on TB preventive therapy as soon as possible. Similarly, at the TB DOTS clinics, all TB patients should be screened for HIV.

9.4.4 Hygiene

Counsel the client to keep a good hygiene standard always to minimize the risk of OIs:

- Promote hand washing with soap and water
- Simple, accessible and affordable interventions to ensure safe household water and sanitation (i.e. management of human waste) reduce the risk of transmission of water-borne and other enteric pathogens.
- Household-based water treatment and storage of water in containers that reduce manual contact are recommended to reduce diarrheal disease (clients should be advised to ensure disposal of faeces in a toilet, latrine or, at a minimum, burial in the ground is recommended.)

9.4.5 Malaria Prevention

Infants, children under-5 and pregnant women with HIV who live in high malaria endemic areas should be provided with long-acting insecticide-treated bed nets (LITN) and/or residual spraying of their rooms and homes to reduce their exposure to malaria. Pregnant women with HIV who are already receiving cotrimoxazole prophylaxis do not require sulfadoxine-pyrimethamine (Fansidar)-based intermittent preventive therapy (IPT) for malaria. However, in areas of malaria transmission, pregnant women living with HIV who are not taking cotrimoxazole should be given at least three doses of intermittent preventive treatment (Fansidar) for malaria as part of their routine antenatal care.

9.4.6 Sexual Health and Family Planning (Sexual and Reproductive Health; SRH)

Integrate HIV testing and treatment services with SRH. Supporting PLHIV in achieving reproductive health has two main goals:

1. To help patients and their spouses/ partners better plan their families and avoid unintended pregnancies through contraceptive services.
2. To help HIV positive and discordant couples achieve the desire of pregnancy without infecting the mother, sex partners and the unborn child.

Benefits of SRH and HIV integration:

- One-stop shop service. HIV-infected patients who go to the regular family planning clinics may find that providers may not be familiar with the special needs of HIV-infected patients. Where a co-located service is not possible, referral linkage to family planning services should be strengthened and documented.

- Offering family planning services in the HIV clinic can also help overcome the stigma related to HIV and AIDS, which is one of the major constraints to accessing family planning services.
- Providing integrated services to clients with HIV requires that HIV Providers familiar with HIV, ART and how they affect the reproductive life of the PLHIV and vice-versa.

HIV counsellors will require specific training in family planning to be able to expertly advice and counsel couples and women who wish to consider conception. Whilst antiretroviral treatment reduces the risk of HIV transmission from mother to child, discordant couples have an increased risk of HIV transmission between partners.

Key points about counselling couples and individuals about reproductive health include:

- Sexual Health (not ill health) must be addressed
- Couples counselling is important and must address fertility desires and careful counselling on safe(r) conception (adherence to ART is vital)
- Simply saying =use a condom or =abstain is not useful.
- Follow international guidance on counselling couples about how to time unprotected intercourse in order to maximize the potential for conception once undetectable viral load has been achieved on treatment.

9.5 Support with Antiretroviral Therapy

9.5.1 Adherence to ART

Patients who are supported in their adherence efforts are much more likely to maintain undetectable viral levels. Explaining the link between viral suppression and clinical outcome allows patients to identify obstacles to successful adherence. It is important to avoid drug resistance, as second line and subsequent ART options are more expensive and have more side effects.

Box 7: Forms and consequences of poor ART adherence

Forms of poor adherence:

- Missing one dose of a given drug
- Missing multiple doses of one or more prescribed medications
- Missing whole days of treatment
- Not observing the intervals between doses
- Not observing the dietary instructions
- Not storing drugs appropriately
- Not attending regular and appointed clinic visitation

Consequences of poor adherence:

Incomplete viral suppression– increasing viral load

Continued destruction of the immune system - reduced CD4 cell counts

Disease progression

Emergence of resistant viral strains

Limited future treatment options

Higher costs to the individual and ARV programme

Box 8: Issues which impact adherence

Personal:

- Denial of diagnosis and internalized stigma Fear of external discrimination
- Inadequate understanding of HIV
- Communication difficulties, poor literacy or
- Unresolved grief reaction, guilt
- Lack of disclosure and lack of social support
- Alcohol and/or active drug use
- Depression and other psychiatric problems
- Dementia
- Difficult life conditions
- Food insecurity
- Economic instability

Environmental:

- Pill burden and side-effects Other health issues
- Income and food insecurity -underlying starvation
- Access to clinic appointments (opening hours of clinics)
- Lack of training of staff
- Patient-provider relationship
- Shift work; time off work to attend appointments
- Poor communication materials / s kills
- Difficult living conditions
- Transportation barriers

9.5.2 General Principles

Interaction needs to be an ongoing process ideally with the same clinicians that enables two-way exchanges between providers and patients based on a trusting relationship.

Ensure an intensive, individualized adherence intervention at ART initiation

Monitor and offer ongoing support of adherence. Be supportive and non-judgmental to encourage patient honesty.

Provide ongoing education to patients on their disease, including any new diagnoses, unexplained symptoms or opportunistic infections

Reassure on the transient nature of nausea and vomiting, if a patient experience these at treatment initiation

Address adverse events, interim illness, issues around stigma and

disclosure Treat depression and substance abuse

Identify food insecurity and actively address this through government support programmes

Ensure communication between clinic visits and between referral points

Ensure that interim management is available during holidays or other absences; discuss absences with patient

If there is sub-optimal adherence, provide extra support:

- Recommend more visits with more frequent adherence checks
- Enlist support of family/ friends/ partners/ support group members/ community adherence support workers
- Increase home visits if possible and will not have negative impact on client
- Use reminders and reinforce with adherence tools
- Actively address food security.

Box 9: Key counselling messages to be reinforced at each visit

i. ARVs are not a cure and there is currently no known cure - HIV may be suppressed (the virus level or load can be decreased) but is not eradicated from the body.

ii. The use of ARVs is associated with improved quality of life and health and long survival if adherence is good.

iii. ARVs should **not** be discontinued when an individual's clinical condition improves.

iv. ARVs should be taken daily **for life** to prevent development of resistance and treatment failure. The relationship between adherence and resistance should be well understood by the patient.

v. Regular attendance at the clinic and adherence to ARVs is essential to achieve good results – that means taking every pill as prescribed every day and not missing any doses.

vi. Disclosure to a trusted friend or relative improves adherence. Ideally a household member should accompany the patient to clinic appointments and help to support adherence to treatment on a daily basis. However, lack of disclosure will **not** be a reason on its own to delay ART initiation.

vii. ARVs can cause side effects in some individuals. Patients need to be informed of what side effects they may experience and be informed of what to do if they experience them. Developing side effects does not always mean that the medicines need to be changed (see section 16 of the *Integrated Guidelines* for list of common side effects for each ARV in the national regimen).

viii. Symptoms of Immune Reconstitution Inflammatory Syndrome (IRIS) or drug toxicities should be discussed (see *HIV treatment Guidelines*). The counsellor should be informed of the proposed regimen by the clinician prior to commencing adherence counselling so as to correctly inform the patient of likely side effects.

ix. ARVs interact with other medications. The patient should discuss non-prescribed drug intake (including traditional medicines) with the physician before taking any other medicines or prescriptions.

x. Patients should be shown samples of the drugs which they will be taking and asked to demonstrate which pills to take and when.

xi. HIV is disease affecting the whole family and patients should be encouraged to bring their partners and children in for testing.

xii. Practicing safer sex is important to prevent the re-infection of the patient and the new transmission of HIV to others. Condoms should be provided to all patients.

9.5.3 Strategies to Promote Adherence

Adherence is a dynamic process, and an individual's level of adherence will change over time and with different situations over time. Adherence is influenced by multiple factors and requires a combination of promotion strategies through an integrated, multi-disciplinary team effort. Good communication between counsellors, clinicians, pharmacists, social workers, other carers and the patient with his or her family and supporters is required.

9.5.4 Preparing Clients for ART

- Adherence counsellors (where possible, patient advocates, community health care providers, treatment supporters) need to:
  - Spend time with the patient and explain the disease, the goals of therapy and why the need for adherence that ensures virologic suppression as often as it is needed
  - Identify whether a patient can keep several appointments at the clinic, including adherence counselling sessions

- Identify that a patient can demonstrate good understanding of the implications of ART
- Consider monitoring of medications such as co-trimoxazole prior to ART initiation; this should, however, never delay ART
- Negotiate a treatment plan that the patient can understand and to which he/ she commits

- Explain to patients how to avoid adverse drug-drug interactions. Herbs and other over-the-counter preparations can lead to renal and liver toxicity, complicating the clinical picture of adverse events, and may have unknown drug interactions affecting antiretroviral drug levels. The patient should understand the possible consequences of unknown content and the danger of over-the-counter drugs and traditional medicines.

- Travel arrangements to and from the clinic: determine how much the patient will pay for transportation and if it is sustainable. Consider the option of a facility nearer to the patient's home if it offers ART.

- Direct and indirect costs: help the patient to consider costs of treatment such as laboratory investigations, travel, time away from work and to be realistic about their ability to afford treatment so that they can plan appropriately.

- Review home, work or school situation: identify what barriers there may be to adherence – e.g. Finding somewhere private to take ARVs, having access to water and food to accompany taking of ARVs, facilities for pill storage, and ability to make time to attend clinic appointments.

- Arrange home visit if available to be undertaken by the nominated community care giver, or trained home-based carer or other health care provider to facilitate:
  - Access to drug and alcohol counselling
  - Social welfare for grant access
  - Emergency relief for nutritional support
  - Support with disclosure (see section 9.3)

9.5.5 Assess Readiness

- ART should be initiated immediately following the `test and treat` policy. However, it should not be started without documentation of readiness by the adherence counsellor except in cases where immediate initiation is required in a life-threatening situation.
- Missed appointments for medicine pick-ups are a powerful predictor of poor adherence and should trigger immediate questions about issues that may affect attendance and adherence.
- Assess knowledge of HIV disease, medications and side effect
- Assess perceptions about seriousness of illness.
- Assess attitudes – positive belief and perceptions, self-efficacy and commitment to treatment.

9.5.6 Enhancing Adherence

Key to supporting good adherence is the development of an ***individualized*** treatment plan developed ***with*** the patient and tailored to his or her individual situation, needs and capabilities. Providing continuity of care and familiarity with the primary care provider can improve adherence by enabling the development of a trusting patient-provider relationship.

- Providing an intensive adherence intervention at ART initiation can improve adherence to ART. This should include a one-to-one, individualized session.

- Identify appropriate *pill cues* with each individual (e.g. put tablets next to toothbrush if you brush your teeth twice a day) or an alarm clock, watch or phone. Using multiple approaches to pill cues can be useful (for example, using alarms or SMS along with case management).

- Assess adherence at each clinic visit for patients on prophylaxis and ART.

- Consider using a =treatment buddy or even directly observed therapy for an agreed period.
- Ensure consistency in adherence messages by all carers and reinforce at each clinic visit.
- Keep an organized appointment record to enable identification of individuals who miss appointments. If a patient default from a clinic visit, every effort should be made to contact them.
- Consider using technologies such as telephone reminders
- Encourage attendance and participating in a support group. These should be ideally run by community members but might need to be supported by the clinic staff or adherence/therapeutic counsellors or social workers.
- Offer group education sessions for a patient who is on ART or enrolled to the care and treatment programme and is a useful time efficient approach.
- Identify and trace defaulters using clinic appointment books, Community Health Workers (CHA and CHP) and lay counsellors to help track and phone calls/ home visits. This needs to be bolstered with improved community care and support (possibly including use of *Patient Advocates* or *peer Treatment Partners)* –tracing LTFUs alone is not an adequate mechanism to promote adherence and avoid treatment failure.

9.5.7 Assessing Adherence

Adherence to ART and prophylaxis should be assessed and recorded at each visit. Individuals who are noted to have any issues with adherence (missing doses) need to be referred to a counsellor for more in-depth, one-to-one adherence counselling (see below). There is no gold standard way of measuring ART adherence, but tools to assess ART adherence include:

a. ***Recall of missed pills - self-report***: Take time in how you ask questions - do not use direct challenging questions (such as *"Do you forget to take your tablets?"*). Instead, demonstrate empathy and ask: *" Many people find it hard to remember to take every single dose—when was the last time you missed a dose?*?. You can also ask: ? *What things can make it hard for you to remember your tablets?*? A trusting and supportive patient-provider relationship is vital to enable the assessment of adherence.

b. ***Pill Counts***: This method requires the patient to return to an appointment with all remaining pills in each container - the health provider (ideally a pharmacist) then counts the number of pills remaining in the bottle or box. He or she then compares it to the number of pills that should be left if the patient took every dose since the last visit. Counting the pills is quick and easy, but it requires the health provider also to calculate the number of pills that should be left. This can be facilitated if the patient receives a defined and constant number of drugs each month.

   If done well, pill counting can help to reassure the provider that adherence is good or identify those patients that need extra support. However, if it is approached insensitively, it can promote a relationship of distrust between the patient and provider.

   A limitation to this is the phenomenon of *pill dumping*, where patient empty pills that they have not swallowed knowing that the remaining pills will be counted. To counter this, unannounced home visits can be conducted taking care not to breach confidentiality.

c. ***Clinical and biological markers***: The development of new OI after a period of good immunity, declining BMI, or rising viral load should alert the clinician to the possibility of poor adherence. Changing to a second line regimen will achieve nothing if the underlying cause of treatment failure is not addressed.

9.5.8 Adherence Counselling - Improving Poor Adherence

When patients are assessed as having any issues with their adherence, they should be referred to a counsellor for in-depth and individualized counselling. It is important that adequate time is provided for individuals requiring adherence support.

To develop an individualized plan for addressing adherence, the counsellor and patient need to assess and discuss:

- Patient's present health status
- Experience with ART and adherence
- Expected changes in physical well-being and biological markers with ART
- Importance of adherence
- Patient's living conditions
- Disclosure
- Patient's daily routine
- Understanding of patient's beliefs and attitudes.
- HIV disease, ART, preventive behaviour.

To develop an individualized treatment plan, the counsellor and patient need to:

- Identify potential barriers and ways to address them (see box 10, below)
- Discuss the treatment regimen
- Discuss proposed adherence strategy to enhance adherence that integrates treatment into patient's daily routine
- Agree a follow-up plan which may include home visits by a counsellor and/or a social worker.

Box 10: Addressing barriers to adherence

1. **Communication difficulties** (language, cultural differences, patient attitudes regarding treatment efficacy, lack of comprehension about treatment plan or regimen)
   - Discuss in an open and non-judgmental way Provide
   - patients with scientific basis for treatment Repeat and
   - paraphrase
   - Use counsellors who speak the same language and understand the cultural context of the patient
2. **Poor literacy**
   - Verbal repetition of adherence message, treatment plan and regimen
   - Use patient literacy materials
   - Use dummy pills for demonstration
   - Review information with patient
3. **Inadequate knowledge or awareness about HIV disease**
   - Provide patients with scientific information about HIV disease
   - Review information with patient
   - Use examples
4. **Inadequate understanding about effectiveness of medications**
   - Inform patient and bring change in attitudes and understanding of effectiveness of medications
5. **Lack of social support**
   - Establish contact with People Living with HIV/AIDS (PLWHA) support groups
   - Link with community health providers and home-based care services
   - Link with charitable institutions, Faith Based Organizations
6. **Discomfort with disclosure of HIV status**
   - Counselling patient to support disclosure
   - Identify other support persons like friends or peers if patient unable to disclose to the family
7. **Difficult life conditions** (lack of income, housing and food; lack of support for childcare)
   - Establish contact with PLWHA support groups
   - Link with community health workers and home-based care
   - services Link with charitable institutions, church programmes
8. **Alcohol and drug use**
   - Counselling—emphasize link between alcohol, ARV medications and liver damage
   - Family support
   - Peer group support programmes, church programmes
   - Medical consultation—de-addiction programmes
9. **Depression and other psychiatric problems**
   - Refer to mental health clinician for treatment

9.6 Other Types of Counselling[5]

9.6.1 Counselling Around Relationships

Counselling is not always restricted to individual clients. You may sometimes find yourself counselling groups, couples or families.

[5] WHO (2005) Mental Health and HIV.

Counselling with individuals on their relationships with others:

Clients may discuss difficulties in their relationship with others or ask counsellors to see them together with their partner or another family member to help them sort out difficulties. This can cover a range of difficulties, some more complex than others. For example, conflict with a partner, disagreements with a treatment supporter, well-intentioned interference by family members. Below are guidelines in talking with the client (or with the client and another person):

- Be prepared to find out about both sides of the story, don't take sides
- Ask for the story, including circumstance (what was it about, who was/is involved, when did it start/ what started it, has this happened before, what did each person do or say, how did you feel now and then, how did you understand the other person's point of views, what has happened since and where are things now?)
- Look at options for dealing with the difficulty, including getting others to mediate; and
- Develop a specific plan (if the other person is not present, when, where and how to approach the other person).

Working with couples:

There may be moments when the counsellor needs to work together with a PLHIV and their partner. Here are some guidelines for you to keep in mind when dealing with them:

- Always remember to **protect and build the relationship of the couple**: Sticking to the principle that disclosure is best, but tactful, bearing in mind that this may do damage to the relationship and jeopardize this intimate support the client already has.
- **Create an environment of free expression** as far as possible: this may be helpful in some relationships but more destructive in others. Although we aim to foster trust, it is sometimes necessary to counsel the couple separately.
- **Try not to centralize yourself:** as the counsellor, part of your role is to facilitate communication between the couple. If they are already able to communicate with each other, you are present as a source of support and information. Enhance, don't undermine, the existing strengths of the relationship.
- **Active, open communication between the partners**: is each one *hearing* what the other is saying – both in their verbal and non-verbal communication? At times you may need to be a voice to amplify or clarify messages directed from one partner to the other.
- **Remain neutral**: it is not your role to take sides – by doing so you may lose trust, presence and hope over the counselling process. Be aware of a natural tendency to side with the same sex-partner as you or with clients who have situations that you relate to.
- **Make the couple aware of their strengths**: try to find, at least, one strength that exists in the relationship, or else focus on everyone's strengths. The couple would not be sitting together with you if they didn't care about each other and/or the relationship.

9.6.2 Counselling in Crisis

Clients who are distressed, in shock or are in an acutely difficult situation require *crisis counselling*. Not everyone responds to events in the same way, but many people experience the following as crises:

- Getting positive results (especially without proper pre-test counselling)
- Anticipated or actual lack of support or rejection by partner / family / friends / employer
- Life changes as a result of illness, e.g. job loss, being ejected from one's home, changes in financial situation
- Needing to change medication due to side-effects or resistance
- Beginning to show symptoms suggesting the onset of AIDS or deterioration in health status

- Death of someone close to them from AIDS.

Important elements of crisis counselling are:

- Assess the situation and deal with any urgent needs
- Ensure your clients' and your own safety
- Let clients express their emotions
- Identify your clients' most urgent problems
- Assist your clients to work out what to do about their most urgent problems (see box 11 below on problem solving)
- Help your clients identify sources of support that can help them out of their current difficulty or distress, e.g. family, friends, a shelter, child protection agency, other organizations
- Help clients to identify things they will do starting when they leave the session
- Plan follow-up counselling.

As you do the above, keep in mind these points:

- Remain calm and stable, convey confidence.
- Focus on reducing tension, but don't make light of the way a client perceives the problem (don't say ? cheer up, it's not as bad as you think").
- Repeat information and summarize frequently if a client seems to be too distressed to take in what is being said.
- Adapt what you do and say, taking account of how much a client is feeling helpless and lacking control and what a client can do or deciding at the moment.
- Don't agree to do anything for clients that they could do for themselves as this is disempowering.
- Aim to restore your clients' sense of competence and control over the situation as far as possible: let clients know that by doing something, however small, will begin to make them feel better, more in control and hopeful.

Sometimes in a crisis, clients express an intention to harm themselves. This may not always be an active intention to commit suicide but should be taken seriously (see next section).

Box 11: Guiding clients to adopt a problem -solving approach to urgent problems

This is a structured way to look at problems and can be used with a variety of problem situations. For example:

- Let clients explain the problem as they see it, including feelings and efforts/ intentions to deal with problem;
- Assist clients to break the problem into manageable bits;
- Identify areas where something can be done now, or which seem important, as opposed to those that could be left until later, or about which little can be done;
- Help clients to decide which problems to address first;
- Identify options for what can be done and look at how to deal with any obstacles;
- Focus on clients' strengths and previous ways of coping which can be used in this
- situation; Help clients identify and develop new ways of coping;
- Identify and help clients work out how to access sources of support (family, friends, church, other local resources);
- Help clients decide on realistic achievable plan; and
- Get clients to commit to carrying out first steps of plan within a certain time-period.

9.7 Dealing with Depression and Suicide

9.7.1 Dealing with Depression

PLHIV are often affected by depression. Use the features on Box 12 below to determine referrals, where possible a, to Mental Health Clinician.

Box 12: Signs and symptoms of depression:

- Depressed or sad mood
- Loss of interest of pleasure
- Loss of appetite and/or weight, or conversely, overeating and/or weight
- gain Fatigue or loss of energy
- Difficulty sleeping or oversleeping
- Difficulty concentrating, making decisions or remembering
- Irritability, restlessness, or feeling slowed down and lethargic
- Feelings of worthlessness or guilt
- Frequent thoughts of death, suicidal ideation, or suicide attempt.

9.7.2 Dealing with Suicide

PLHIV may be inclined to committing suicide. When a client with such threats is encountered, a counsellor should put aside personal beliefs and feelings about suicide and deal effectively with the situation, including referral to a more capable person to ensure safety of the client.

Box 13: Some facts about suicide

- Talking about suicide may be how the client expresses how anxious, sad and desperate they are feeling. It may not necessarily indicate a definite decision to commit suicide. However, talk of suicide should ***always*** be taken seriously and explored further. Do not dismiss it as manipulative or not serious.
- Asking about suicidal thoughts does not make it more likely that a person will commit suicide.

  If the counsellor raises the issue, the client may feel relief at being understood and this may reduce the risk of suicide.

  In the case of severe depression or shock, especially when the client seems to have limited or no support system, the counsellor should ask about whether the client has ever thought about harming himself.

9.7.3 Assessing Suicide

Health providers can assess the risk of suicide in order to decide how best to manage the situation:

- Consult with a colleague and if unsure, refer where possible.
- Keep a record of what you are told and observe how you manage the situation and reasons for what you do.
- Find out about the client's situation – consider:
  - What provoked the suicidal thoughts or intention?
  - Is there any specific crisis, e.g. financial crisis, marital strain?
  - Is there any genuine support that can be drawn from family members or friends?
  - What factors might help to prevent the client from carrying out an intention (e.g. religious beliefs, fear of dying, shame about suicide, concern about family)?
- Consider and ask about factors that suggest high risk, especially when you suspect suicidal thoughts even though the thoughts are not directly expressed:
  - Current suicidal thoughts or previous attempts
  - Pre-existing mental disorder or recent psychiatric admission
  - History of reported current alcohol or drug abuse
  - History of impulsive behaviour
  - Recent social disruption (e.g. bereavement, marital breakup, job loss)
  - Social isolation or rejection or lack of support.
- Check the client's mental state for any of the following characteristics:
  - Extreme depression, ideas of killing self or others, out of touch with reality, irrational beliefs about self or others (e.g. everyone is against me, I do not deserve to live (despite evidence that indicates otherwise, extreme anxiety or panic symptoms, very agitated, delirious.
- Assess how definite and clear the clients' plans are:
  - Abstract thoughts and vague plans (which may reflect the client's feelings rather than a definite intention to kill him- or herself); or
  - A definite plan which could really result in death and with the means to carry it out (e.g. has made a will, written a farewell note, has a stock of pills or gun available, has worked out when to carry out the plan).

9.7.4 Managing the Situation of Depression and Suicide Attempt

Follow general crisis counselling guidelines, especially to remain focused on the immediate medical problem.

- Where the client has a definite plan and means to carry it out, try to keep this client where he/ she is safe until you can decide to ensure his/ her longer-term safety.

- Where the client does not have a definite plan, try to develop workable alternatives with the client (including linking him/her with supports) and a plan for what to do in the short term (24 hours).
- If you judge your relationship with the client to be strong, consider making an agreement that, if the client starts to think about suicide again, he/ she will contact you before doing anything to harm him/herself. But do not rely *only* on an agreement of this kind – you must also have other reasons to believe the client will be safe.
- Arrange as a minimum to have contact with the client within the next 24 hours and a follow-up appointment as soon as possible after that.
- If you do not feel confident about the situation refer it if possible, to secondary level care for expert care (see section below, on referral).

9.8 Counselling People who are Dying and their Families [6]

9.8.1 Counselling in Palliative Care

Some of the counselling needs of a dying person are specific. The following advice for counsellors is particularly relevant for palliative care:

- Assess the patient's cultural beliefs and ensure that any religious or cultural observances can be met or explain any adaptations that may be required.
- Be aware of your own losses and feelings that could influence your counselling.
- Remember that people can grieve for =what might have been and in anticipation of losses, not only when such a loss as death occurs.
- Don't avoid using words like dying or death. Ask about needs, fears and worries about dying.
- Acknowledge that this is a difficult time, ask about other hard times in their lives and how they got through those times.
- Encourage those affected (including family members, children) to talk to each other and with the counsellor about the illness and to share feelings, such as guilt, relief, pain or anger. It is often helpful to hear from everyone in the family what worries them the most.
- Help the client and family members to identify people or organizations that can provide support, and refer to a clinician if appropriate, to advise the client on how to deal with distressing symptoms.
- Encourage the client to talk about what will happen to the family after his or her death.
  Find out if the client has discussed what will happen to his or her possessions with family members. Is there a will? Does the patient need assistance in making a will?
- Explore the patient's religious or cultural beliefs and help contact appropriate sources of spiritual support, e.g. church/mosque elders, traditional healers, etc.

9.8.2 What to do at the Time of Death

Some clinicians may find themselves present around the time of a death; these are some guidelines on counselling around that time for the family members and other bereaved persons:

- At the time of death, encourage the family members to stay with the deceased for as long as they need.
- Encourage the family to hold the patient's hands or to say goodbye in their own way.
- Do not refer to the deceased as "the body", but by his or her name.
- If the family was not present at the time of death, give as many details, with sensitive editing, as possible.

[6] Adapted from WHO (2005) *ibid*, and Palliative care and bereavement counselling (2001) South African AIDS Trust.

- Involve children and explain to them what is happening.
- Be comfortable with the expressions of feelings, e.g. crying, shouting, wailing at the time of death and later.
- Encourage repetition of the story of illness and death.
- Make sure a religious person is present if requested.
- Take time and go slowly.

9.8.3 What not to do at the Time of Death

- Do not tell family members what they should or should not do.
- Do not panic when strong emotions are expressed or when there is a lot of crying. Just listen and try to understand.
- Do not try to tell grieving family members how they feel – avoid saying things like? you must be feeling sad" – every experience is different.
- Do not talk about your own experience.
- Do not make a bereaved person feel you are in a hurry.
- Do not use phrases like "God only takes the best" or "time will heal" as the bereaved do not find them useful.
- Do not tell the bereaved person that they will "get over" this.
- Do not stop a grieving person from crying.

9.8.4 What to do During Bereavement

Some counsellors may find themselves continuing with their clients' counselling for family members or partners, or their clients may themselves be experiencing a loss. Guidance for counsellors in situations of bereavement includes:

- Listen rather than talk. Allow time for thought and silence.
- Encourage the use of rituals that help channel the grieving process, e.g. making memory boxes, arranging memorials, writing notes to children.
- Discourage a bereaved person from making big decisions whenever possible, e.g. change of job, home, town. Their emotional state can make it harder to make practical decisions.
- Encourage those affected to tell you about the person who has died.

SECTION 10: SUPERVISION AND SELF-CARE FOR COUNSELLORS

10.1 Counselling Supervision and Support

Counselling is a discipline that requires ongoing practice as well as monitoring of the use of such skills by a competent supervisor, to ensure counselling standards are preserved.

Box 14: Counselling support strategies

Ensure that counsellors have clear roles and responsibilities

All counsellors are encouraged to go through the process of HTS, this creates empathy with clients.

Knowledge of their own HIV status will also help counsellors access care and support

Counsellors are encouraged to form peer support systems in order to support and assist each other in an informal environment (see section below on *Group counselling*)

Supportive supervision – include county team supervision as part of the monitoring and evaluation process.

Periodically hold a counselling review meeting at least once a month to share lessons and experiences.

10.1.1 Group Supervision

Group supervision is a working alliance between a supervisor and several counsellors, in which each counsellor can regularly reflect on their work and, receive feedback from a supervisor and other colleagues. Group supervision should enable each counsellor to gain ethical competence, confidence and creativity.

Advantages of group supervision:

- There is richness in having access to, and seeing other people work
- For people working in isolated ways the group provides interaction with colleagues and a sense of belonging
- It allows fuller feedback and reflection of who you are as a counsellor
- If safe enough, it is the place where you can be authentic, take risks and disclose failure or vulnerability and be helped to do something about it
- It is possible to receive support and challenge at the same time
- You can rest as well as be active
- There is opportunity to learn to supervise others, and practice

Disadvantages of group supervision:

- It may feel highly dangerous to be authentic, which invites competition
- There is less time for individual presentation
- Different people will experience different emotions and ideas to the same stimulus
- Family patterns often surface in groups, e.g. rivalry
- Dynamics can get messy
- Issues of confidentiality can be difficult to maintain about the client, other counsellors and the agency.

10.2 Self-Care

Definitions of stress and burnout:

Stress is physical, mental, or emotional factor that causes bodily or mental tension. **stress** can be external (from the environment, psychological, or social situations) or internal (illness, or from a medical procedure). Too much stress interferes with work performance.

Burnout refers to a state of mental/physical exhaustion caused by excessive and prolonged stress. It is a gradual process by which a person, in response to prolonged stress and physical, mental, and emotional strain, detaches from work and other meaningful relationships. The result is lowered productivity, cynicism, confusion, and a feeling of being drained, or having nothing more to give.

Table 3: Symptoms of Burnout

Physical	Behavioural	Cognitive
Exhaustion • Lingering minor illness • Frequent headaches and backaches • Sleeplessness • Gastrointestinal disturbances • Chronic and vague physical pains • General malaise	• Quickly irritated or frustrated • Quickness to anger and/ or irritability • Prone to prejudice • Alcohol and/ or dr ug abuse • Marital or relationship problems • Rigidity (inflexibility) in problem solving • Impulsivity or acting out	• Exasperation: "I've had enough" or "I can't take this • anymore" • Ruminating (over-thinking a situation) • Emotional numbness, indifference, impoverishment • Emotional hypersensitivity • Over-identification with clients' situations • Pessimism, helplessness, hopelessness • Grief and sadness

10.2. 1 Stress Management

"Stress management" refers to efforts to control stress, and an understanding of. knowing when to relax, get more sleep, or implementing other stress management strategies to avoid a total burnout. Counsellors ought to:

- Take care of the single most important instrument: *themselves*
- Be aware of the causes of burnout
- Know how to recognize and remedy burnout
- Know how to prevent burnout

To recognize burnout in themselves, counsellors can ask the following questions:

- If I were "burning out". what signs do you think my clients would see first?
- Who would be the first person to notice that I wasn't burning out? . . . Me, my clients, my family, a friend, a colleague, or a supervisor?
- Have I ever noticed that someone I work with is burning out? What did I notice and how did I respond?

What can counsellors do to prevent burnout?

- Ensure that there is an opportunity for individual, peer, or group supervision or counselling for counsellors.
- Be associated with committed, concerned colleagues who can help identify risk of burnout
- Analyze the situation, and decide on corrective actions

- Draw support from a partner, work team, or the work environment.
- Engage in self-assessment
- Retain an attitude of hope
- Keep changing the way of working (e.g., alter the counselling style, get different supervision, take on new challenges)
- Learn to accept what one can and cannot control.

Box 15: Coping strategies for stress and burnout

Adopt a healthy lifestyle:

- Talk to others about their stress and asking for help when needed
- Try physical exercise and/ or recreation
- Avoid smoking
- Drink alcohol only in moderate quantities
- Adopt an adequate sleep routine
- Eat balanced and regular meals
- Get adequate rest.

Manage time; work more efficiently, rather than harder:

- Assess value and use of time
- Set goals and routines
- Manage and avoid distractions
- Choose priorities
- Learn to say "no"
- Plan projects or duties so they are done properly with adequate resources
- Do one thing at a time, and break down large tasks into manageable components

Develop boundaries between personal and professional lives:

- Avoid offering support to clients in your own time or meeting them when off duty
- Avoid work-oriented social networks
- Develop a decompression routine—a ritual that signals the workday is ending and the personal life is beginning.

Change the way one thinks:

- Avoid generalizing, focusing on unimportant details, jumping to conclusions, "making mountains out of molehills," and taking things too personally.

10.3 Workplace policies

HCT facilities should be encouraged to develop workplace policies for a safe and healthy working environment. In particular;

- Ensure measures that reduce the risk of occupational transmission of blood-borne diseases (including vaccination against hepatitis B).
- PEP is available within 72 hours in cases of occupational exposure.
- Well ventilated counselling rooms
- Periodic medical screening for TB.
- Counsellors (and health workers) who are HIV-positive should be provided access to care and treatment, while ensuring their confidentiality.

SECTION 11: INCREASING ACCESS TO HIV COUNSELLING AND TESTING

11.1 Approaches to Increasing Demand

- **Advocacy** to increase political commitment and influence policies, strategies and programs;
  - For a positive attitude towards priority themes touching on access, quality and equity of health services,
  - To mobilize resources and services in the implementation of HIV programs.
- **Community mobilization and community to increase participation**
  - By community members, leaders, CHAs and CHPs
  - To rally members of a community to action.
- **Mass media communication** to convey messages
  - To the public-at-large: the press, the movies, radio, and television.
  - To youth especially both in-school and out-of-school,
  - To service providers, border officers, residents in the transport corridors, and adult mobile populations.
- **Male involvement to increase greater uptake of family member and strengthen support**
  - To male headed households and male domineering societies
  - To couple with strong marital relationship
- **Capacity building** to increase the community members' skills, knowledge and expertise
  - To individually and collectively mobilize a community's ability to identify and address its needs.
- **Peer education to increase knowledge and motivate to act**
  - For youth in-school, youth and out-of-school,
  - For CSWs, MSM, residents in the transport corridors and adult mobile population interventions

11.2 Increasing Access to Services

- Providing same day results.
- Link ART services to HIV testing services.
- Ensure quality counselling and on-going support through well-trained and supervised counsellors, lay counsellors.
- Raise the profile and recognition of HIV Counsellors within the multi-disciplinary health team
- Integrate PITC to all point-of-care health services, including in-patient, out-patient and emergency departments.
- Increase access to HTS for prisoners and other detainees.
- Target HTS for MARPs: long distance transport workers, internally displaced persons (IDPs), prisoners, alcoholics, CSWs, intravenous drug users (IDUs), men who have sex with men (MSMs) and uniformed service personnel face challenge in accessing services.
- Ensure services are youth-friendly with adequately trained personnel to increase access to young people.
- Explore new technologies, such as saliva HIV testing kits easing access to HIV testing will be considered – these offer great potential for increasing access to HTS as they can be done at home and offer possibilities for providing health care providers with self-testing strategies.
- Use Lay community services providers like CHAs and CHPs to perform screening test and refer
- Explore efficacy and efficiency of community and mobile HTS services in the context of Liberia.

11.3 Community HIV Testing and Screening

Community HIV Testing and Screening

- Community HIV screening occurs
  - In non-clinical settings, often combined with education and outreach events.
  - Innovative strategies may target MSM, FSW, PWID, TG and truck drivers and wider community with HIV tests in their hotspots, truck stops, rest stops, social events and homes.
  - Those who test positive in such outreach events are linked to an ART facility for confirmation, care and treatment
- `Community settings for testing may include:
  - Health fairs
  - Schools
  - Substance use disorder treatment programs
  - Correctional facilities
  - Employment centers and workplaces
  - Social services organizations
  - College campuses
  - Community and sport events
  - Churches
  - Places where people socialize, like bars
  - Community-based residential facilities
  - Hotspots

1131 Role of Community Health Assistants (CHA)/ Community Health Promoter (CHP) in Communities

1. **Community HIV testing:**
   a. **Home-based/ door-to-door testing:** CHP create awareness and conduct testing in the domain of their control areas for community members that opt-in for testing.
   b. **Educational institution testing:** This approach targets educational institutions to establish and/or strengthen school health clubs. These in turn create awareness and mobilize pupils and staffs for testing.
   c. **Targeted outreach programs (TOP) for the general population** (for example, men, young people especially AGYW Programs): Focused on events like sport, workplace, and other program that attracts population of interest e.g. beauty pageant for high risk general population: AGYW and their partners, men and young people of all age groups.
   d. **Targeted Outreach Program (TOP) for key populations:** Target events that attract Key Populations (KPs) for awareness and testing, like party celebration in ghettos, MSM events, entertainment centers, social clubs, and hideouts. This can be backed by field confirmation and assignment to a case manager to enhance entry into care and treatment. Also target most at risk population, including prisons.
   e. **HIV testing and multi-disease campaigns:** Integrate HIV testing with other community diseases and immunization campaigns.

f. **Community based geographic prioritization:** Focus available resources in communities, regions and counties with high HIV burden. This has been the case for Montserrado, Margibi and Grand Bassa Counties.

2. **Community and peer-led approaches for adherence:**
   a. **Family or community led case manager:** Friend or family member is chosen by the Client after test confirmation to provide sustained ART adherence support.
   b. **Peer-led case manager:** This uses HIV Peer who may not be a CHP to provide management support for adherence. This type of case managers can lead the client to support group meetings where a wider adherence support and intimate relationship can be built.
   c. **CHP/ CHA -led case manager:** CHP/ CHA who tested the client HIV positive may be selected by the client to provide ongoing adherence support to the client

1132 User Engagement

1. Involvement of people with HIV in all aspects of HIV testing and counselling services
   a. Is consistent with a rights-based approach,
   b. Acknowledges that people have a part to play in decisions that affect their lives.
   c. Supports people playing an effective part in such decisions which is vital for ensuring greater involvement.
2. HTS and Care and Treatment facility is advised to
   a. Coordinate or have access to a directory of facilities and services that provide support mechanisms for PLHIV.
   b. Facilitate and encourage Client attendance
3. Post-test support groups and clubs are often useful feature of HTS services.
   a. *Support Groups* for PLHIV are formed in communities. They develop close links with HTS facilities and make plans for cross-referrals. PLHIV are involved in the planning and implementing of HIV Testing services. They also ensure good linkages with post-test support groups.
   b. *Post-Test Clubs* comprise clients who have undergone HTS, regardless of their status. These clubs are a forum to promote positive behaviors and messages, as well as to increase knowledge and demand for HTS. Post-test club's formation is actively promoted.
4. Strategies to meaningfully engage PLHIV organizations, youth, women and members of the Community Health Development Committee (CHDC) should be included in projects and programmes related to the care and support of PLHIV.

SECTION 12: HIV SELF TESTING (HIVST)

121 1 Introduction

(HIVST) is a process whereby an individual collects his or her specimen, performs a test and interprets the results, often in a private setting either alone or with someone he or she trusts. HIVST can either be supervised or unsupervised. It is recommended by the World Health Organization to increase the proportion of adults and adolescents tested for HIV.

HIVST provides an opportunity to overcome traditional barriers to HIV testing. It is especially promising for hard-to-reach populations who have shown poor access into health facility for standard HTS services. Importantly, an *HIV self-test result does not constitute a confirmed diagnosis.* A certified HTS provider must confirm self-test results in accordance with the national HIV testing algorithm.

HIVST should not be given to clients who are: (1) under 18 years of age; (2) have previously tested HIV-positive; and (3) are currently taking ART or PrEP. Amongst eligible populations, HIVST may increase demand for HTS and expand the reach of the existing health system.

122 2 Basic Definition and HIVST Principle

The HIVST strategy is guided by the principles of routine HIV testing services {see section two (2)}.

End-User: The intended user of the HIVST kit.

Reactive results: It means that the test indicates that HIV antibodies are present in the blood or oral fluid sample. Anyone whose result is reactive to a rapid HIV test (including a self-test) must be followed by additional HIV testing services by a trained provider following the national HIV testing algorithm.

Non-reactive results: It means that the test indicates that HIV antibodies were not found in the blood or oral fluid sample. Anyone whose result is nonreactive to a rapid HIV test (including a self-test) does not need further testing but should be supported to re-test if they have had a recent potential HIV exposure or are at on-going HIV risk.

"Supervised" self-testing: The end-user receives support from a health worker or volunteer before or after individuals test themselves for HIV; may include a demonstration of how to use the test, pre- or post-test counselling and referrals to additional services.

"Unsupervised" self-testing refers to independent or open access to HIV self-testing; support may or may not be indirectly provided to the end-user, based on the end-user's initiative, such as leaflets, telephone calls or hotlines, referral information, support groups and HIV treatment, care and prevention services.

Primary distribution: Health care workers and other trained personnel directly distribute HIVST kits to the desired end-user. Primary distribution encompasses supervised self-testing.

Secondary distribution: Health care workers and other trained personnel distribute HIVST kits to an in-between individual who is instructed to deliver the HIVST kit to the desired end-user. Secondary distribution encompasses unsupervised self-testing.

123 3 Goals, Purpose, and Rationale

12.3.1 Goals

The overall goals for Liberia's HIVST Guidelines are as follows:

- Increase demand for HTS among hard-to-reach and underserved populations, including populations who do not frequent health facilities and individuals who refuse standard HTS.

- To enhance linkage to treatment for individuals testing HIV positive or linkage to prevention services for persons testing HIV negative.
- To catalyze and potentially increase of repeat testing in populations at high risk of HIV infection with an aim of normalizing HIV testing in these groups of people.

There are several HIVST tests, including oral- and blood-based test kits. Both show very high clinical sensitivity and specificity. Variations in test accuracy are largely due to errors committed by users (e.g. sample collection, conducting all steps accurately, interpreting results. Acceptable levels of accuracy can be promoted through frequent and high-quality HIVST demonstrations to end-users, along with easy to understand user instructions. Liberia will presently use oral HIV self-test kits, and the algorithm below:

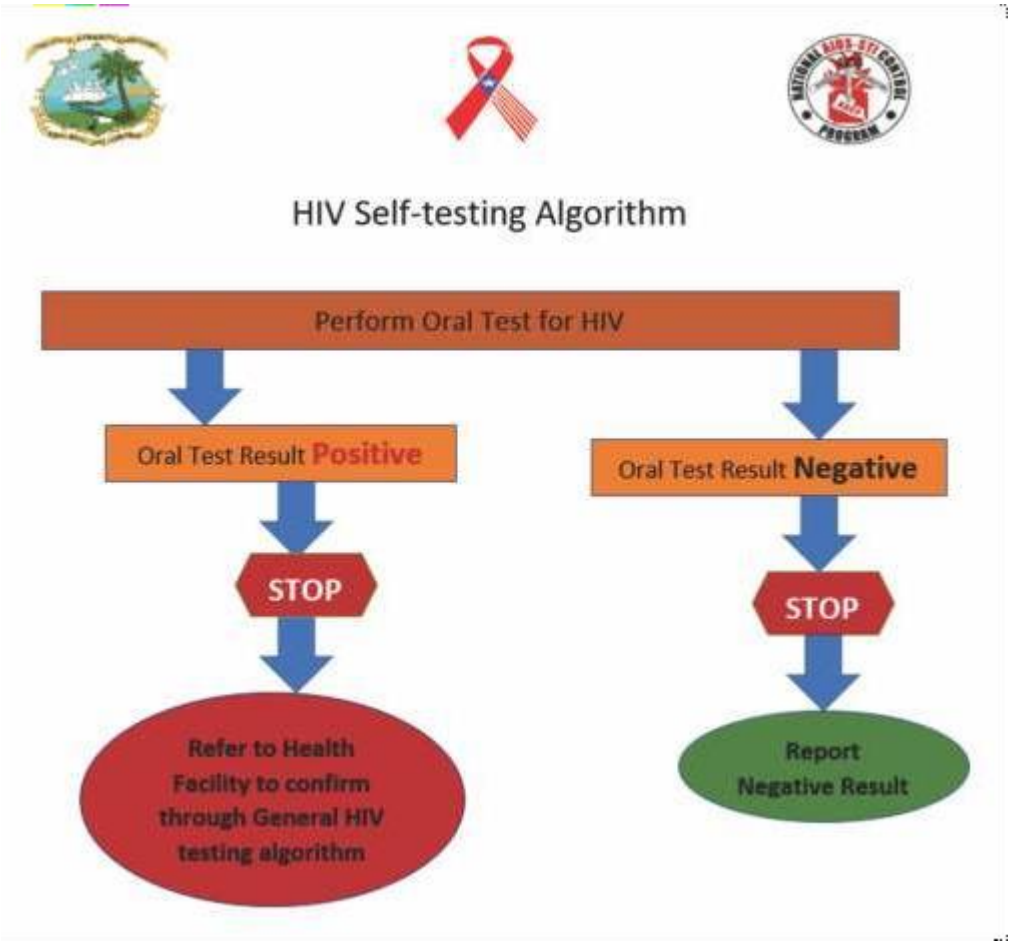

Figure 6: Algorithm for HIV self-testing

12.4 4 HIVST Delivery Approaches

HIVST delivery will utilize both facility- and community-based approaches.

12.4.1 Facility -Based Approaches

HIVST can be distributed at health facilities through both primary and secondary distribution strategies (see Table 4). Subsequent referrals and linkages to prevention, care, and treatment, services will be promoted at all sites offering HIVST, and referral and linkage information will be distributed alongside HIVST kits.

Table 4: Facility-based HIVST delivery approaches

Distribution model	Kits distributed to	Desired end-user	Distributor
Secondary distribution	Index clients (Pregnant and HIV-positive clients)	Sexual partners of index clients	HTS provider
Primary distribution	Clients who refuse standard PITC	Clients who refuse standard PITC	HTS provider

12.4.2 Facility -Based Secondary Distribution

Secondary distribution of HIVST screening kits may be considered for the sexual partners of high-risk clients identified at health facilities (also known as index testing). Index testing is a focused type of HTS in which sexual partners of people diagnosed with HIV are offered HTS. Standard index testing strategies will continue to be used, and HIVST screening kits may be added to the current index testing strategies to increase demand for HTS among the sexual partner.

Based on the decreased sensitivity and specificity of unsupervised HIVST, secondary distribution activities should *ensure high quality HIVST demonstrations and provide referrals for sexual partners who are unsure or unable to accurately complete the HIVST test.* HIVST screening kits should only be given to clients who are comfortable and willing to give a HIVST demonstration to their sexual partner.

Secondary distribution within facility settings may be prioritized in high-yield settings, namely, the following:

- Antenatal care (ANC)
- Maternity (labor and postnatal wards)
- All HIV-positive adults attending the health facility (HTS or ART clinics)

All patients/clients accessing secondary distribution for HIVST must consent for receiving the HIVST kit; index testing is neither mandatory nor compulsory, and those being offered should be informed of their right to decline.

Patients/clients who accept a HIVST screening kit to take home to their sexual partner should receive all of the following components:

- Pre/ post counselling about the HIVST screen with this guidance in the language of the client:
  - HIVST is a screening tool for HIV; it is not diagnostic.
  - Please deliver the kit to your partner and give them the same demonstration you are about to receive
  - Whether your partner uses the HIVST screening kit or not, they should return to the facility for standard testing and additional information regarding their health
- HIVST demonstration
- Answer questions regarding HIVST to ensure accurate understanding of the demonstration
- Confirm that clients are willing to give the same demonstration to their sexual partner
- Referral and linkage materials, including a standard Family Referral Slip (FRS)

12.4.3 Facility -Based Primary Distribution

Facility-based PITC provides an ideal opportunity for clients to access HTS. Clients may be asked by a provider to test for HIV based on their testing history and various risk factors. However, clients at risk of HIV infection may refuse PITC. This is especially true for traditionally underserved populations, such as men and adolescents and other key populations. Many of the concerns with standard PITC may be addressed through HIVST (privacy and confidentiality, long wait -times, concern about the quality of care, etc.).

To address this gap, primary distribution of HIVST screening kits may be considered for patients/ clients who are offered PITC but refused it for whatever reason. Patients/ clients who agree to PITC should always be referred to the standard HTS protocol.

Primary distribution to patients/clients may be prioritized in any setting where PITC coverage may be suboptimal, such as:

- Sexually Transmitted Infections (STI)
- Outpatient Department (OPD)

All patients/clients accessing primary distribution for HIVST within health facilities must consent for receiving the HIVST kit; testing is neither mandatory nor compulsory, and those being offered should be informed of their right to decline.

Patients/ clients who accept a HIVST screening kit should receive all the following components:

- Pre/ post counselling about the HIVST screen
    - HIVST is a screen for HIV
    - Whether you use the HIVST screening kit or not, you should return to the facility for standard testing and additional information regarding your health
- HIVST demonstration
- Answer questions regarding HIVST to ensure accurate understanding of the demonstration
- Referral and linkage materials, as appropriate.

12.4.4 Community-Based Approaches

HIVST can be distributed in communities through primary distribution strategies (see Table 2). Strategic and targeted community-based HIVST screening approaches are needed to ensure appropriately high yield with a specific focus on priority and high-prevalence geographical areas; or key and priority populations with higher risk behaviors or access challenges. Target groups include sex workers, men who have sex with men, prisoners and other people in closed settings, orphans and vulnerable children, young women aged 15 to 24 years, fisher folks, and estate workers. Community HIVST could also be used to target high-risk male populations who normally would neither access VCT or PITC.

Partners implementing community based HIVST screening should offer referrals and linkages to HIV testing, prevention, care, and treatment services alongside all HIVST distribution activities. Implementing partners should comply with the quality of HIV testing, supply chain, and reporting requirements noted in these guidelines. They should consult the MOH Department of HIV and AIDS for guidance before implementation.

Table 5: Community-based HIVST delivery approaches

Desired end-user	Distribution Location	Recommended Distributor
Men	Workplace (formal & informal)	Health workers or Peer educators (trained)
	Targeted CBD (settlements/ slums)	Trained lay distributors (community volunteers) & Link age nurse (HTS provider)
Young people	Targeted CBD (settlements/ slums)	Trained lay distributors (community volunteers) & Link age nurse (HTS provider)
	Peer based (tertiary institutions)	Trained Peer distributors
Key population	Peer based (hot spots)	Trained Peer distributors

All community based HIVST delivery approaches will utilize a primary distribution strategy. All distributors will receive a formal training in HIV pre/ post counselling, HIVST, completing a HIVST demonstration, interpreting HIVST results, and referring and/ or linking end-users to HIV testing, prevention, care, and treatment services.

All community members accessing HIVST must consent for receiving the HIVST kit; testing is neither mandatory nor compulsory, and those being offered should be informed of their right to decline.

Community members who accept a HIVST screening kit should receive the following components:

- Pre/ post counselling about the HIVST screen
  - HIVST is a screen for HIV
  - Whether you use the HIVST screening kit or not, you should return to the facility for standard testing and additional information regarding your health
- HIVST demonstration
- Answer questions regarding HIVST to ensure accurate understanding of the demonstration
- Referral and linkage materials, as appropriate.

Special consideration for female sex workers: Measures should be taken to prevent Sero-sorting among female sex workers. HIVST results should not encourage Sero-sorting or unprotected sex.

Box 16: Summary of Key Points

- HIVST should target populations otherwise not reached by standard HTS strategies.
- All HIVST distribution approaches must be accompanied with detailed HIVST demonstrations
- All HIVST distribution approaches must provide referral and linkage support to HIV testing, prevention, care, treatment, and other services.
- Community based HIVST distribution should be strategic and targeted, to ensure appropriately high yield.
- Partners implementing any CBHTS should comply with the quality of HIV testing, supply chain, and reporting requirements noted in these guidelines.

125 5 Operational Procedures for HIVST

12.5.1 Forms of Counselling in HIVST

1. Counselling the End-User (Primary Distribution)

   End-user counselling involves counselling of an individual intended to use the HIVST screening kit. Counselling will be done by trained personnel and include counselling on HIV testing and HIV and AIDS prevention, treatment, care, and support; a description of HIVST as a screening tool and HIVST demonstration; and referral and linkage support to HIV services.

2. Counselling the Index Client (Secondary Distribution)

   Index clients identified within health facilities may be given HIVST screening kits to take home to their sexual partners. Index clients who receive HIVST kits should receive similar counselling components as end-user counselling: counselling on HIV testing and HIV and AIDS prevention, treatment, care, and support; a description of HIVST as a screening tool and HIVST demonstration; and referral and linkage support to HIV services.

12.5.2 The General HIVST Protocol

The HIVST protocol involves two components:

1. Pre/ post-test counselling and demonstration
2. Referral and linkage to HIV services

12.5.3 3 Pre/ Post-Test Counselling

The pre-test counselling session provides basic information about HIV, HTS, and HIVST. Trained personnel will conduct all counselling activities. HIVST should be free of coercion. Clients/ sexual partners have the right to refuse to be tested. The right to refuse testing should be especially emphasized to index clients who are taking HIVST kits home to their sexual partners (secondary distribution). All individuals receiving a HIVST kit should be provided an opportunity to see a HIVST demonstration and ask questions. Clear and concise information should be provided about:

- Benefits of HIVST
- Who is eligible to undertake an HIVST?
  - Ineligible clients include those who are:
    - Ever tested HIV+
    - Currently taking ART
    - Currently taking PrEP
    - <18 years of age
    - Tested for HIV in the past month
    - Unwilling to receive standard HTS testing algorithm
- Test kit handling and storage before use
- Instructions on use
- Interpretation of results
- Referral and linkage to HIV services at a health facility
- Disposal of used kits
- Ethical and legal obligations regarding social harms (no coercion)

NOTE: Both instructions for use and demonstrational materials should be simple with pictorial aids and word instructions should be in simple English language. In addition, end users should be given information that individuals on PrEP and ART should NOT self-test but also about a enough extended

window period for those exposed to a high risk of contracting HIV. Thus, there is a need to limit the provision of HIV self-test kits in projects that are providing PrEP.

Special consideration for adolescents >1 8 years of age:

Adolescents >18 years of age are legally able to consent for HIV testing without the presence of a guardian. HIVST protocols will follow national HTS guidelines. Adolescents between 18 years of age and above should receive extensive counselling to ensure they fully understand the HIVST screening kit. Additional measures to ensure there is no coercion among this population.

Special consideration for high-burden settings:
In high burden settings, giving **pre-test information** is the preferred choice, rather than pre-test counselling. In this case, the trained personnel only give the individual relevant information on benefits and why he/she (or his/her partner) needs to be tested for HIV and a detailed HIVST kit demonstration

12.5.4 4 Confirmatory HIV Test

All patients who present with a positive HIV test after using a HIVST screening kit should complete standard national HTS algorithms for confirmatory.

12.5.5 Referral and Follow -Up

All HIVST trained personnel should have a directory of available HIV and AIDS services in the vicinity to which they will refer HIVST end-users. These referral points include community-based care and support groups as well as health facilities.

HIV self-testing is a screening test. All individuals, regardless of HIVST test result, should be advised to go for testing. They should also be referred for relevant support services. Individuals with a positive self-test result will follow the approved national HIV testing algorithm will be utilized to conduct the HIV test.

12.5.6 6 Quality Assurance for HIVST

Quality assurance is the maintenance of desired level of quality in a service especially by means of attention to every stage of the process of delivery. It also includes all systems for monitoring and evaluating the quality of HTS in accordance with national guidelines.

Components of QA:

1. **Counselling**
   - Providers will be trained by the NACP HTS team using a standardized package (to be developed by the NACP and her HTS Partners)
   - Ensure that counselling information is clearthat HIVST is a screening tool
   - If HIVST is reactive (positive), follow the national algorithm for confirmation; the same applies to negative results.
   - Job aids, SOPs and all instructions for use by the provider will be made available by the NACP.
   - Infection prevention and control
   - Referral and linkage
2. **Testing:**
   - Quality control
   - EQA
   - Supportive supervision
   - Quality improvement
3. **Test kits:** Test kits for HIV self- testing should comply with the following criteria to ensure quality products in the system:

- All products should be WHO prequalified
- The products should undergo an in-country laboratory verification including lot verification
- The product should undergo registration by the regulatory body
- Post – market surveillance processes should be conducted
- There should be ongoing evaluation for other HIVST kits including blood-based one (for future consideration)

Quality of kits:

- Currently, there is no QC for saliva-based test but small volume of DTS (dried tube specimen) for QC in a laboratory will be used. (Protocol for DTS preparation will need to be developed)
- QC will be done twice in a month and NACP will pick up test kits from testing sites where laboratory is not available
- The criteria for QC checks should be followed per national rapid HIV testing
- Laboratory will communicate back the results to the facilities through phone and the hard copy will be collected by NACP

Providers/ users:

- Specific training of the providers on HIVST will be conducted.
- All information about the HIVST will be made available through leaflets and will be in English
- Community Health Workers (CHWs) will be available to clients who need more help on how to use the HIVST
- There will be a quality assurance program which will be distributing the positive and negative test results to providers for interpretation as well as to the client. (Post-test assessment)

12.5.7 7 Disposal

A self-test diagnostic must remain as consumer oriented as possible; therefore, no biohazardous chemicals may be used. Oral fluid tests are easy to use, do not involve sharps disposal, and have low technical demands for specimen collection, which make these potentially attractive choices. However, information on disposal of the kits after use should be same as kits using blood samples and this should be provided.

Used test kits should be appropriately disposed using the following disposal locations:

- Pit latrines in the community
- At facility level incineration

12.7 7 HIVST Supply Chain System

Quantification and procurement:

- MOH coordinates the quantification, procurement planning, and procurement of HIV self-test kits, with an anticipated national funding from Global Fund
- The NACP coordinate the quantification based on assumptions generated from programmatic strategies. All NGOs must contact NACP before procurement of HIV self-test kits to minimize wastage that may arise from parallel procurement systems.
- NACP will be responsible for coordinating procurement-planning activities to ensure optimal utilization of resources allocated for HIV self-test kits at the national level.
- Test kits should have customized labelling: Government of Liberia; Not for sale

Product selection:

- Oral-quick
    - Shelf life 24 months
- Other HIVST kits (blood-based) will be explored as they become available in Liberia.

Warehousing:

- It is to be integrated with existing national supply chain system

Distribution:

- To be integrated with national program routine distribution of commodities based on prior planning with utilization and requisition reports from facilities.
- Emergency deliveries will be coordinated with implementing partners during scale-up phase
- Distribution plan will be based on targets

Inventory management:

- Health facility to have max 3 months of stock and minimum of 2 months of stock
- Central level to have max 12 months of stock and min of 6 months of stock

Commodity tracking and reporting:

- To integrate with existing commodity tracking and reporting tools
- Following tools to be used:
- Stock cards, Requisition and Issue Vouchers, Daily Activity Register, Stock Reports and eLMIS

SECTION 13: MONITORING, EVALUA TION AND REPORTING

13.1 Monitoring and Evaluation Objectives

The HTS database should be used to monitor and evaluate HIV testing services in each site, county and national levels. This information will be used to identify programme areas that need to be refined for more efficient and effective programme implementation. Special studies may be required for specific issues, but in general the emphasis should be on using the HTS database to maximize the utilization and quality of the services.

NACP will provide HTS facilities with registers and summary forms, aligned with the MoH monitoring and evaluation framework. The NACP shall ensure that providers are trained in the proper completion of the registers and forms.

Process and outcome evaluations will be periodically conducted to assess current programme success, and plan future revisions of the National HTS Guidelines and strategic plans.

- Best practices will be documented by all facilities.
- All facilities/ sites will produce monthly, quarterly and annual reports of HTS activities.
- National annual HTS report will be produced by the NACP, and feedback will be given to the HTS facilities.

13.2 The Monitoring and Evaluation Frame work

Data management for HTS services will be in line with the National Health Management Information System (NHMIS).

13.3 HCT Programme Indicators

Indicators for the National HTS Program (excluding TB and PMTCT indicators) include the following:

Geographic coverage indicators:

- Proportion of all the counties reporting HTS services (all models)
- Proportion of all the health care facilities per county reporting HTS services.
- Number of facilities providing other models of HTS provision per county.

Uptake of services:

- Number of clients receiving pre-test counselling
- Proportion of clients who accept testing after counselling
- Number of clients who test positive for HIV
- Proportion of clients referred to a care and treatment programme
- Proportion of clients who receive post-test counselling from among those who tested
- Proportion of people who have accessed HTS through provider initiated HTS
- Proportion of people who have accessed HTS through client initiated HTS
- Proportion of the total population that has tested and know their HIV status
- Number of HIVST kits distributed per facility and per community distribution channels
- Number of HIVST results reported to the providers
- Number of HIVST results confirmed in a health facility with the HTS national algorithm

Provision of services:

- Proportion of the total health providers trained in provider-initiated HTS.
- Proportion of the total health providers trained in provider initiated HTS per facility
- Proportion of contacts of index PLHIVs reached
- Proportion of contacts of index PLHIV tested for HIV
- Proportion of contacts of index PLHIV tested positive

13.4 Data Management

- **Data collection system:** The national HTS data collection and analysis system developed by NACP should be used by all facilities providing HTS services across the country.
- **Data Collection Instruments:** National HTS registers should be used at all facilities providing *HTS*. **Data Recording:** HTS record forms should be filled for all clients, before they leave the counselling room or immediately after.
- **Coding System:** A standardized system of assigning codes or reference numbers to clients for identification purposes should be developed and used within each institution. This will be facility specific.
- **Record Keeping:** A filing system for HTS records should be developed and followed within each institution. All records must be kept confidential and stored in a secure room with lockable cabinets.
- **Data entry and Transfer:** At each facility providing HTS services, the data collection form (the monthly report form obtainable from CHT) should be completed and forwarded to the CHT on a monthly basis. Data should be forwarded from the counties to the national level on a monthly basis.
- **Data Analysis and Reporting:** Data collected will be analyzed, and findings will contribute to the on-going review of HTS component of the National HIV and AIDS policy. The NACP will design feedback mechanisms to ensure that each level of service and management is informed on a quarterly basis regarding HTS services.

NACP and other stakeholders will conduct systematic periodic external data quality checks. These checks will include a review of facility register and reporting forms for completeness and accuracy, as well as to verify that previously submitted summary forms represent accurate tallies of the register information.

13.4.1 Coordination of HCT Services at National Level

In order to ensure optimal use of limited resources and maximum impact of HIV counselling and testing service delivery, coordination of service should take place at the national level. Key elements of HIV counselling and testing coordination will include the following:

a. The coordinator of HIV/ AIDS Counselling and the coordinator of Blood Safety at NACP comprise the HTS coordinating unit. These work with technical sub-committee on HCT and Blood Safety that meets on a quarterly basis. At county level, the unit works with the hospital/ facility focal persons for HTS.
b. Definition of standards and protocols for HIV testing, including approval of HIV test kits.
c. Facilitation of the overall implementation of the HTS services by partners and ensuring that the national guidelines are adhered to.
d. Advocacy for official recognition of counsellors, including salaries and benefits commensurate with other professional categories; establishment of section criteria; definition of different level of counsellors; accreditation mechanisms; training and supervision programmes, including development of standardized curricula.
e. Selection of common indicators for uniform monitoring and evaluation, which can be integrated into national health information system.
f. Compilation and dissemination of HTS service delivery reports, to all key stakeholders, including the implementing partners.
g. Preparation and subsequent distribution of common reporting forms for a centralized data collection and analysis system.
h. Standardization of records for post-test referrals and follow-up.

i. Establishment of linkages with other health, social and AIDS support services.
j. Advocacy for commitment by Government to provide resources and funds for community mobilization and support for HTS.
k. Definition of and subsequent implementation of methods for sharing lessons learnt and cross referrals with other HIV services through national AIDS services network.

ANNEX 1: KEY ELEMENTS AND CONSIDERATIONS FOR HCT SETTINGS

Stand alone services : Stand-alone HCT services are those situated outside Health facilities.	
Key Elements:	**Possible Challenges:**
• High level of public awareness required to stimulate demand, including community mobilization of appropriate messaging and social marketing strategies • Location in a busy and easily accessible area, where there will be a high concentration of clients • Staff dedicated to provide full HTS services • Strong linkages with providers of support services • Anonymous and confidential testing offered • Flexible hours of operation including evenings and weekends • Targets general public, especially those who would not normally visit health facilities e.g. men and youths • Nominal fee charged to clients who can afford to pay • Youth friendly activities should be incorporated to encourage access by young people.	• Sustainability as many are donor- funded and managed by NGOs without long-term plans for funding • Entails significant commitment in terms of time, resources, infrastructures and staff • Need to ensure good referral mechanism for follow-up care • High possibility of stigmatization • High likelihood of staff burnout as they have little relief from HIV and AIDS counselling • Clients who cannot afford to pay should not be denied services. • Fear among clients of unintentional disclosure by association with a dedicated • HIV service and stigma for attending nominated HTS site.

Integrated HTS services: Integrated services are provided within health facilities, including maternal and Child health (MCH) services, STI, TB, opportunistic infection (OI), in-patient and out-patient clinics.	
Key Elements:	**Possible Challenges:**
• Ideal for rapid scaling-up of HTS, as the basic infrastructure and health are already in place • Existing staff must receive training in the provision of HIV counselling and testing service. • Close links with other medical services already exist and facilitate clinical referral • It is important to hold regular meetings among different departments to ensure good liaison and cross referral. • Potentially less expensive, since existing facilities and staff are utilized. • Low stigmatization, as people could be attending the facility for other reasons.	• Staff must be given adequate space to provide HIV counselling and testing services. • Limited space can also affect privacy and expansion of services. • May exclude people who do not frequent formal health services; e.g. men and youths' inflexible hours may limit access to HTS services. • Translates into added responsibility for existing staff. shortage of staff due to transfers, and staff engagement in primary responsibilities

Out-reach HIV Testing Services: services offered through mobile teams of providers, aim to increase access for special populations such as people living in the remote rural areas, internally displaced populations, highly mobile populations, (e.g. long-distance truck drivers, fishermen) and vulnerable groups, e.g. prisoners, commercial sex workers. Services may be provided at premises such as Community halls, school halls, youth facilities and mobile structures such as vehicles can also be utilized for service provision.

Key Elements:

- Strong support system and referral mechanisms must be established at community level before initiating an out-reach HIV Testing service.
- Ideal for rapid scaling-up of HTS, as the basic infrastructure and health are already in place
- Existing staff must receive training in the provision of HIV counselling and testing service.
- Close links with other medical services already exists and facilitate clinical referral
- It is important to hold regular meetings among different departments to ensure good liaison and cross referral.
- Potentially less expensive, since existing facilities and staff are utilized.
- Low stigmatization, as people could be attending the facility for other reasons.

Possible Challenges:

- Staff must be given adequate space to provide HIV testing services.
- Limited space can also affect privacy and expansion of services.
- May exclude people who do not frequent formal health services; e.g. men and youths
- Inflexible hours may limit access to HIV
- Testing services.
- Translates into added responsibility for existing staff.
- Shortage of staff due to transfers, and staff engagement in primary responsibilities.

Private Sector: may be provided by companies or organizations that offer work-place HIV services or at private medical entities. The private sector caters for some important segments of the population including those who can afford to pay for services, have medical insurance, or are provided with medical services by their employers.

Key Elements:

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

Possible Challenges:

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