



MINISTRY OF HEALTH

**NATIONAL HIV TESTING SERVICES POLICY
AND IMPLEMENTATION GUIDELINES
UGANDA**



5TH EDITION

JUNE 2022



Ministry of Health

National HIV Testing Services Policy and Implementation Guidelines

Uganda

June 2022

5th Edition



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The Ministry of Health welcomes feedback and comments from both users and experts in HIV Testing Services (HTS).

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Abbreviations

ACP	AIDS Control Programme
AGYW	Adolescent Girls and Young Women
ADPs	AIDS Development Partners
AHPC	Allied Health Professional Council
AIDS	Acquired immune deficiency syndrome
ANC	Antenatal Clinic
APN	Assisted Partner Notification
ART	Antiretroviral therapy
ARV	Antiretroviral
CAO	Chief Administrative Officer
CBD	Community-based Distributor
CDC	Centre of Disease Control and Prevention
CDO	Community Development Officer
CHAI	Clinton Health Access Initiative
CHO	City Health Officer
CHWs	Community Health Workers
CITC	Client Initiated Testing and Counselling
CLFs	Community Linkage Facilitator
CME	Continuous Medical Education
CPD	Continuous Professional Development
CPHL	Central Public Health Laboratory
CQI	Continuous Quality Improvement
CSOs	Civil Society Organisations
CSR	Corporate Social Responsibility
DCDO	District Community Development Officer
DIC	Drop-in Centre
DBS	Dry Blood Spot Sample
DGHS	Director General – Health Services
DHO	District health Officer
DMO	Division Medical Officer
DNA	Deoxyribonucleic Acid
DPO	Disability People's Organisations
DREAMS	Determined, Resilient, Empowered, AIDS-free, Mentored and Safe Initiative
DTS	Dry Tube Specimens
EBIs	Evidence-based behavioural Interventions
EID	Early Infant Diagnosis
ELISA	Enzyme-linked immune-sorbent assay
EQA	External Quality Assessment
FCPSUs	Family and Child Protective Services Unit
FP	Family planning
GBV	Gender-Based Violence
GoU	Government of Uganda
HBHCT	Home Based HIV Counselling and Testing
HC	Health Centre
HCT	HIV counselling and testing
HEIs	HIV Exposed Infants
HIV	Human Immunodeficiency Virus

HIVRT	HIV Rapid Tester(s)
HIVST	HIV Self-Testing
HMIS	Health Management Information System
HR	Human Resource
HRH	Human Resources for Health
HLR	HIV Reference Laboratory
HSSIP	Health Sector Strategic & Investment Plan
HSHASP	Health Sector HIV & AIDS Strategic Plan
HTS	HIV Testing Services
ICC	Independent Certification Committee
ICF	Intensified Case Finding
ICT	Index Client Testing
IDPs	Internally displaced persons
IDPCs	Internally displaced people's camps
IEC	Information Education and Communication
IFU	Instructions for use
IGAs	Income generating activities
ILO	International Labour Organisation
IPs	Implementing Partners
IPC	Interpersonal Communication
IPV	Intimate Partner Violence
IQC	Internal Quality Control
IVD	In-vitro Diagnostic Medical Device
JMS	Joint Medical Stores
KPs	Key Populations
LC	Local Council
LF	Linkage Facilitator
LIMS	Laboratory Information Management System
LQAS	Lot Quality Assurance Sampling
MBCP	Mother Baby Care Point
M&E	Monitoring and Evaluation
MEL	Monitoring, Evaluation and Learning
MoEST	Ministry of Education, Sports and Technology
MoH	Ministry of Health
MSM	Men who have Sex with Men
NGO	Non-governmental organization
NHRL	National HIV Reference Laboratory
NHSP	National HIV and AIDS Strategic Plan, 2016-2020
NHTSC	National HIV Testing Services Committee
NMS	National Medical Stores
NQIT	National Quality Improvement Teams
OI	Opportunistic Infection
OTC	Over-the-Counter
OVC	Orphans and Vulnerable Children
PCR	Polymerase Chain Reaction
PEP	Post Exposure Prophylaxis
PFP	Private for Profit
PITC	Provider Initiated Testing and Counselling

PLHIV	People Living with HIV
PMO	Principal Medical Officer
PMS	Post-Market Surveillance
PMTCT	Prevention of Mother to Child Transmission of HIV
PNFP	Private not For Profit
POCTs	Point of Contact Tester(s)
PPs	Priority Populations
PPE	Personal Protective Equipment
PPP	Public-Private Partnership
PrEP	Pre-exposure prophylaxis
PTC	Post-Test Clubs
PWDs	Persons with Disabilities
PWUIDs	People who use and inject drugs
QA	Quality Assurance
QAD	Quality Assurance Department
QC	Quality Control
QI	Quality Improvement
QIT	Quality Improvement Teams
QPPU	Quantification Planning and Procurement unit
RCT	Routine HIV Counselling and Testing
RDT	Rapid Diagnostic Test
RHT	Rapid HIV Antibody Test
RTRI	Rapid Test for Recent Infection
SBCC	Social Behavioural Change and Communication
SGBV	Sexual Gender-Based violence
SMC	Safe Male Circumcision
SNS	Social Network-based Strategy
SOPs	Standard Operating Procedures
SRH	Sexual Reproductive Health
STD	Sexually Transmitted Disease
STIs	Sexually Transmitted Infections
SW	Sex Worker
TB	Tuberculosis
ToT	Training of Trainers
TWG	Technical Working Group
UAC	Uganda AIDS Commission
UCA	Uganda Counselling Association
UCE	Uganda Certificate of Education
UDHS	Uganda Demographic Health Survey
UHPC	Uganda HIV Prevention and Control Act, 2014
UN	United Nations
UNAIDS	The Joint United Nations Programme on HIV and AIDS
UNBS	Uganda National Bureau of Standards
UNHCR	United Nations High Commission for Refugees
UPHIA	The Uganda Population-based HIV Impact Assessment
USAID	United States Agency for International Development
UVRI	Uganda Virus Research Institute
VAC	Violence against children

VCT
VMMC
WHO
YAPs

Voluntary HIV Counselling and Testing
Voluntary Medical Male Circumcision
World Health Organization
Young People and Adolescent Peer Supporters

Foreword

The Government of Uganda (GoU) has made the fight against HIV and AIDS one of its top priorities. The strategies aimed at responding to the HIV and AIDS epidemic, are an integral part of the Health Sector Development Plan 2016-2020, National HIV and AIDS Strategic Plan (NHSP 2015/16-2019/20) and the National Health Policy (NHP II). HIV Testing Services are offered within a legal and human rights framework ensuring quality counselling, confidentiality, informed consent, giving of correct results and connecting those tested to further care and prevention. MoH acknowledges the need to continuously adopt new approaches in response to the changing epidemic. This enables the country to appropriately focus the response to target priority areas and population groups; hence the need for periodic HTS policy reviews to incorporate new evidence-informed approaches.

HIV Testing in Uganda began in 1990 with Voluntary Counselling and Testing (VCT) as the main mode of delivery. The country developed the first VCT policy in 2002 with an aim of scaling up VCT. The review of the 2005 policy introduced Routine HIV testing and counselling and Home-Based HIV Testing and Counselling (HBHCT) to complement VCT. The second review in 2010 separated the HIV Counselling and Testing (HCT) implementation guidelines from the HCT policy and aimed at increasing coverage for HCT services to achieve universal access.

The changes made in the second review resulted in significant achievements. The number of facilities providing HCT services increased to 3,565 in 2014; including all public and private hospitals and HC IVs. There has been a progressive increase in the number of individuals tested since 2011 from 5,524,327 individuals to 9,564,992 in 2014 with nearly two thirds of these being women, and about 10% being children under the age of 15 years. About 1,727,465 were pregnant women during Antenatal Care (ANC) visits. Over the last three years the percentage of women and men aged 15 -49 years who received an HIV test in the past 12 months and know their results has ranged from 42% to 51.4%^{1,2}. While this may be explained by the increase in the population, it still shows that there are many missed opportunities for HTS

The drive to end the HIV epidemic and meet the new nationally adopted global 90-90-90 targets towards elimination of HIV by 2030 as enshrined in the National HIV/AIDS Strategic Plan 2016-2020, underpins the review of the HTS policy and guidelines.

The review of the 2016 HTS policy is therefore aimed at galvanising efforts to achieve the first and second 95s of the UNAIDS fast-track 95*95*95 targets for Uganda. This shall be done through: improving efficiency and cost-effectiveness; addressing quality issues to ensure correct test results and scale up connection to prevention, care and treatment; enhancing HTS approaches and models to reach out to priority populations; strengthening quality assurance for HTS; adoption of new testing kits; streamlining strategic behavioural change communication; promotion of public and private partnerships; further integration of HTS into general health care and, strengthening coordination, monitoring and evaluation. The HTS policy and Implementation guidelines are aligned to the 2015 World Health Organization Consolidated HTS guidelines and the Uganda HIV Prevention and Control Act, 2014.

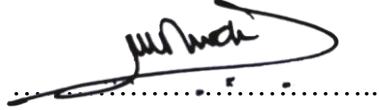
This document provides guidance on how HTS should be planned, delivered/ implemented, monitored and evaluated. Therefore, the document serves as a useful resource for policy-makers and planners, AIDS Development Partners (ADPs), HTS implementers, academicians, researchers and service providers.

¹Lot Quality Assurance Sampling (LQAS) 2012/14

² MOH 2011, Uganda AIDS Indicator Survey 2010/2011

The policy review process was participatory and included establishment of a Technical Working Group (TWG) to spearhead the process; a rapid performance appraisal of the 2016 Policy and Stakeholder consultations.

It's my conviction therefore that this policy is based on cutting-age evidence, vast experiences in planning and delivering HIV testing services and addresses diverse community HIV Testing needs.

A handwritten signature in black ink, appearing to read "Henry Mwebasa". It is written in a cursive style with a large, sweeping flourish at the end.

Dr. Henry Mwebasa
Director General Health Services

Acknowledgements

This document was developed through the contributions and expertise of a number of people and Institutions.

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Special gratitude is extended to the Members of the National HIV Testing Services Committee (NHTSC) for providing backstopping support to the review process.

It is my sincere hope that this HTS Policy and implementation guidelines will provide the necessary guidance for the provision of accessible, equitable, quality, human-rights sensitive and high impact HTS in order to fast-track the National HIV and AIDS Strategic Plan target of identifying 95 percent of HIV infected Ugandans and linking them to HIV care and support services by 2026.

Sincerely

.....
Dr Joshua Musinguzi
Programme Manager, STD/ACP

1.0 Introduction

1.1. General Overview

This 5th Edition replaces the 2016 National HIV Testing Services Policy and Implementation Guidelines. This has been aligned to the current HTS program priorities, practices based on novel evidence, global guidance and the WHO Consolidated Guidelines on HIV Testing Services 2019 guidelines.

Definition of HTS; The term HIV testing services (HTS) embraces the full range of services that should be provided together with HIV testing. These include brief pre-test information and post-test counselling; linkage to appropriate HIV prevention, care and treatment services and other clinical and support services; and coordination with laboratory services to support quality assurance (Adapted from WHO Consolidated Guidelines on HIV Testing Services 2019). In Uganda, this is aligned to the human rights approach which encompasses use of the essential 5Cs; Consent, Confidentiality, Counselling, Correct test results and Connection (linkage to appropriate services).

In summary, this policy will adopt HTS optimization strategies that include new recommendations on the following areas; risk-based testing, index client testing, scale up of HIV self-testing (HIVST), social network-based HIV testing approaches and HIV surveillance (including recency infection surveillance). The 2022 HTS policy and implementation guidelines integrate both the policy statements and implementation guidelines.

1.2. Situational Analysis of HIV and AIDS in Uganda

By the end of 2020, 80.9% of adults 15 years and above living with HIV in Uganda were aware of their HIV status. Of these 96.1% of those aware of their HIV status were receiving life-long antiretroviral therapy while 92.2% of those on ART were virally suppressed³. New HIV infections declined by 60% from 94,000 in 2010 to 38,000 in 2020 while AIDS-related deaths declined by 61% (34,000) from 56,000 in 2010 to 22,000 in 2020⁴. Amongst young people aged 15-24 years there was a 53% reduction in the number of new HIV infections from 29,000 in 2010 to 14,000 in 2020⁴. This was attributed to scale up of high impact and cost-effective interventions, such as targeted HIV testing approaches, strengthening linkage to care and optimization of ART services and scale up of viral load coverage. Despite this progress in reduction of the unmet need above, there are still disparities in HIV case identification among men, adolescents and children.

The HIV incidence has also declined over the years, among children 0–14 years from approximately 23,000 in 2010 to approximately 5,300 in 2020. Of all new HIV infections occurring in 2020 among young people aged 15-24yrs, 79% of these new infections were among young women. As much as there was a significant reduction in AIDS related deaths from 2010 to 2020, females aged 15 years and above are still more disproportionately affected, contributing to an estimated 9,100 AIDS related deaths in 2020⁴.

The two main modes of transmission are heterosexual intercourse and mother-to-child. There are several risk factors and key drivers that continue to fuel the HIV epidemic and play a crucial role in its spread. The key issues include multiple concurrent sexual partners, inconsistent condom use, transactional sex, cross generational sex, early sexual debut, sexually transmitted infections (STIs), discordance, non-disclosure and lack of male

³Preliminary results of the 2020 Uganda Population HIV Impact Assessment (UPHIA)

⁴2021 Factsheet – Facts on HIV and AIDS in Uganda 2021 <https://uac.go.ug/media/attachments/2021/09/13/final-2021-hiv-aids-factsheet.pdf>

circumcision (include reference). Other drivers include negative socio-cultural norms and values, income inequality and poverty, gender inequality, punitive laws, stigma, discrimination and inequity

1.3. HIV Testing Services in Uganda

HTS in Uganda began in 1990 with Voluntary Counselling and Testing (VCT) as the main approach to delivery. The country developed the first VCT policy in 2000, with an aim of expanding coverage of HIV testing. The first policy review done in 2005 introduced Provider Initiated HIV Testing and Counselling (PITC) and Home-Based HIV counselling and Testing (HBHCT) to complement VCT which further led to increase in the number of testing health facilities from 554 in 2007 to 1,215 in 2009⁵. During this period, emphasis was put on expansion of entry points, scale up of HCT to children, use of Lay Providers and testing in the community.

The second review in 2010 separated the HCT implementation guidelines from the HCT policy and aimed at increasing coverage for HCT services to achieve universal access. This review also led to the introduction of HTS into new programs particularly Voluntary Medical Male Circumcision (VMMC), Most at Risk Populations (MARPs), special groups and quality improvement (QI).

In 2016, the key focus was to align existing policy guidelines to the WHO 2015 HTS guidelines, the national HIV/AIDS strategic plan and regularize HTS related legal issues arising out of the HIV prevention and management act 2014. During the same period, Uganda adapted the 90-90-90-strategy and streamlined testing for children and adolescents.

In 2018, the country developed an addendum to provide guidance for implementation of index testing (APN) and HIV Self-Testing (HIVST).

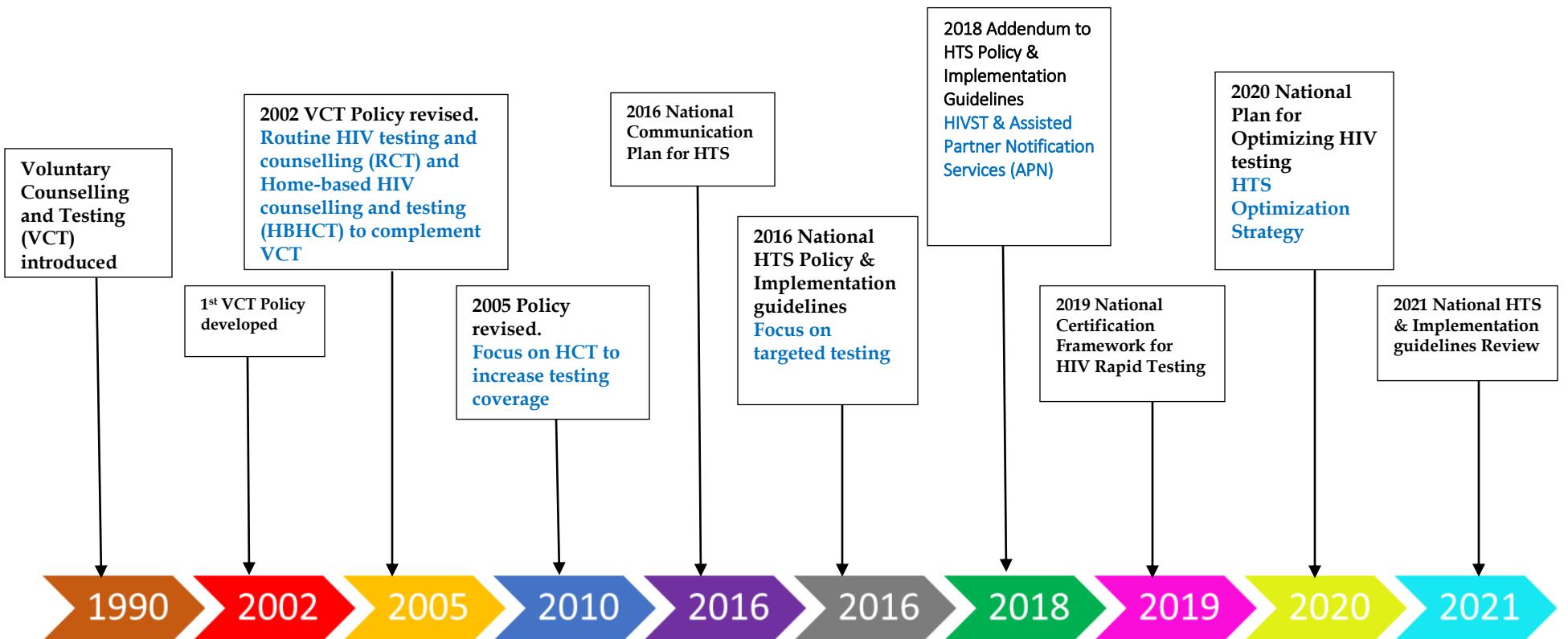
In 2020, Uganda moved to optimize HIV testing with adoption of risk-based testing including screening for HIV test eligibility, prioritizing testing of HIV exposed individuals [index testing with assisted partner notification (APN)] and scaling up HIV self-testing (HIVST) to reach hard-to-reach high-risk individuals.

HIV testing remains a cornerstone for HIV epidemic control and is critical to the attainment of the 95-95-95 targets by 2030. With progressively fewer individuals remaining undiagnosed, identifying new HIV positives is challenging, leading to a steadily declining yield hence the National HTS positivity which has remained at approximately 3% over the past years⁶. Identifying the remaining undiagnosed HIV-infected individuals requires new innovative approaches to be directed to geographic areas and sub-populations considered to be at elevated risk of HIV infection. The evolution of HTS in Uganda is as shown in figure 1 below.

⁵Uganda Bureau of Statistics (UBOS) 2012. Uganda Demographic and Health Survey 2011

⁶National Plan for Optimizing HIV Testing Services in Uganda 2020/21 – 2022/23

Figure 1: Evolution of HIV Testing Services in Uganda (1990 – 2021)



1.4. Rationale for Policy Review

According to the UPHIA 2020 assessment, Uganda had made progress in the HIV response with 80.9% of individuals living with HIV knowing their status. Although the prevalence of HIV among adults aged 15-49yrs had reflected a decrease from 6.0% in 2016/17 to 5.5% in the 2020 survey, urban areas demonstrated a higher prevalence in comparison to rural areas 7.1% vs 5.2%³. Analytics of HIV prevalence by age revealed that the highest prevalence of 11.1% was in the 45-49 year age group in men and among women, the highest prevalence of 13.6% was in the 50-54 year age group³. In addition to disparities that existed across population categories, gender and age groups, geographical variances were also existent. The magnitude of the HIV prevalence across certain regions was found to be considerably higher in comparison to the national estimate of 5.5% from the highest estimates of 8.1% in Central 1 region (greater Masaka), 7.6% in Mid-North, 6.3% in South Western, 6.2% in Central 2 (Greater Mubende, Luwero and Mukono) region, 6.0% in Kampala and 5.5% in Mid-western regions³. To bridge the gap on HIV case identification among these sub populations – this policy will provide guidance on strategies to address the unmet HTS needs towards attainment of HIV epidemic control.

In addition, program data shows limited access to HTS among Orphaned and Vulnerable Children (OVC), People with Disabilities (PWDs), and Key populations {Sex Workers (SWs), Men who have Sex with Men (MSM), truck drivers, the fisher folk, uniformed services personnel, prisoners}, and other emerging high-risk groups (alcoholics and drug addicts, *boda boda* cyclists, music artists, health workers, plantation workers).

The HTS program is still affected by existing health system gaps which include suboptimal risk screening, weak community-facility linkages of newly diagnosed clients, low staffing, inaccurate reporting, missed testing opportunities, limited IEC materials, and inconsistent supply of essential HIV testing commodities compounded by decline in the number of undiagnosed HIV-infected individuals which requires new innovative approaches that target high-risk populations at their preferred locations⁷.

Against this backdrop, there is need to re-orient and strengthen community and facility HTS delivery approaches; strengthen public-private partnerships; increase uptake of HTS in PPs; strengthen health system bottlenecks (coordination, M&E, Human resources, supply chain management); social behavioral change communication (SBCC) and strengthen linkages to care and prevention.

Additionally, a review of the current HTS Policy and implementation guidelines is warranted to;

- Align current practice to current National and Global guidance
- The Policy will provide the required guidance on what needs to be done to achieve the triple 95 goals in all risk groups
- Align the 2021 HTS policy and implementation guidelines with the revised 2019 WHO Consolidated Guidelines on HIV Testing Services 2019 and the National HTS Optimization Plan 2020/21 -2022/23
- Optimize HTS to appropriately and more efficiently target the undiagnosed HIV+ individuals especially men, adolescents and children

1.5. Policy Framework

This document is based on, supports and operational principles in National, Regional and International strategic and policy instruments as outlined in Annex 1.

⁷Boeke CE, et al. Assessing linkage to and retention in care among patients in Uganda and identifying opportunities for health systems strengthening: a descriptive study; BMC Infect Dis. 2018; 18(1): 138.

This policy provides a framework for establishing systems that ensure that rights of persons in Uganda to access non-discriminatory HTS services are realized.

This policy and guidelines will operate within the scope of the national and international policies; in alignment with national plans and in harmony with other MOH implementation guidelines. They will be used in conjunction with other operational guidelines for SBCC, HTS training and delivery, M&E and quality assurance (QA) standards.

1.6. Target Audience

This policy and guidelines target different stakeholders including: HTS service providers, policy makers, HTS programmers and planners, AIDS development partners and donors, programme and health facility managers and in-charges, district and facility HTS coordinators/supervisors and focal persons, academicians, People Living with HIV (PLHIV) and HIV advocates, researchers and beneficiaries of HIV Testing Services.

1.7. Process of Policy Review

This policy was developed through a highly consultative process which began with formation and commissioning of the HTS Policy Technical Working Group (TWG). The TWG had specific terms of reference (TORs) which ensured close coordination with the Consulting team. A desk review of high- impact evidence and good practices in HTS programming, appraisal of the 2016 HTS policy through a rapid assessment, and consultations with research and academic institutions in Uganda were carried out to generate recommendations to inform the 2022 policy. Policy writing workshops were conducted where the TWG and technical stakeholders reviewed the various chapters of this document. Input was sought through Consultative meetings with the Ugandan parliament Committee for Health; other line Ministries and departments; Uganda Counselling Association (UCA); Civil Society Organizations (CSOs), HTS Implementing Partners; and Special Interest and vulnerable groups [adolescents and youth, People with Disabilities (PWDs), uniformed officers and other KPs] and Development partners.

The draft was reviewed by a team of technical Peer reviewers who also provided input and finally the TWG and National HIV Testing Services Committee (NCTC) reviewed and refined the final draft before presentation to MoH Health Policy Advisory Committee (HPAC) and Senior Management for approval.

1.8. Guiding Principles and Values

It is the mandate of the Ministry of Health to deliver quality, affordable and non-discriminatory healthcare to all citizens of Uganda. The HTS Policy and implementation Guidelines derive their validity from and conform to relevant items of National legislations and core ethical principles. The circumstances and conditions under which people undergo HIV testing must be anchored in an approach which protects their rights. The HTS policy therefore upholds the basic human rights of individuals and families as enshrined in the various legislations and implementation principles.

In addition, HTS in Uganda shall conform to the UNAIDS Reference Group on HIV and Human Rights statement that supports policy directions that are focused on greater impact and greater speed in order to “end the AIDS epidemic as a public health threat by 2030.” The statement recognizes that effective interventions need to respond to epidemiological context and to the barriers to accessing HIV testing, prevention services, and sustained treatment.

The guiding principles for this HTS policy and guidelines are;

Protection of Human Rights: HIV counselling and testing must be ethical, based on human rights and conducted within a supportive environment.

Right to dignity:

- **Privacy and Confidentiality:** All information concerning a client, including information relating to his or her health status, treatment or stay in a health establishment is confidential. No one shall be subjected to arbitrary or unlawful interference with his or her privacy. Clients' information shall only be disclosed if the client consents, ordered by the court of law and or if necessary for the advancement of the client's care and treatment.
- **Personal responsibility to preventing HIV Infection:** All people in Uganda have a responsibility to protect themselves and others from HIV infection, to know their status and to seek appropriate prevention, care, treatment and support.

Right to Access: Access covers aspects of availability, convenience, quality, affordability and acceptability of HTS to all those who need the service. All essential commodities and information for HTS, should be made available, affordable and accessible and be of the required and approved quality.

Promoting equality for priority populations: The vulnerable position of women, girls, children, key populations and persons living with disabilities, with respect to HIV and AIDS and its social impact is recognized and addressed.

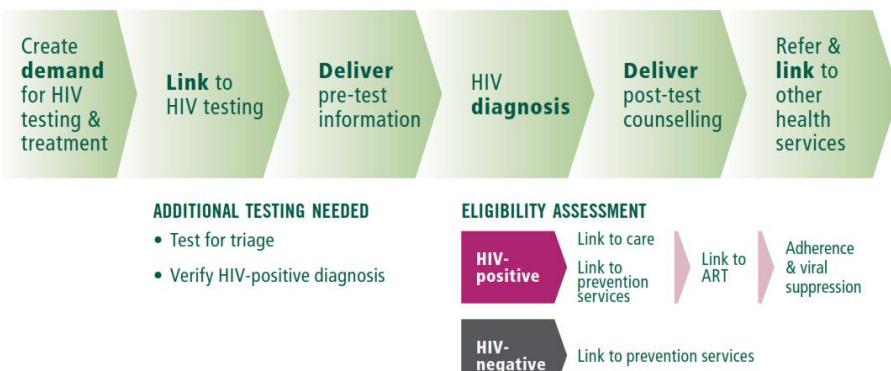
Promoting HTS in the best interests of Children: Respect for the best interests of the child dictates that children's rights and needs must be at the forefront of all interventions for HIV prevention, treatment and support

Conformity to the Core Principles of HTS: WHO recommends that HTS should be offered in consideration of Confidentiality, Consent, Counselling, Correct test results and Connection to care, treatment and support

1.9. Goal

The overarching aim of this guidance is to prioritize identification of HIV infected persons currently not reached with HTS and appropriately link them to care, treatment and prevention services. This shall be achieved through implementing the HTS continuum of linkage to care and prevention as prescribed by WHO (**figure 2**).

Figure 2: Continuum of Linkage to care and Prevention



Adopted from WHO consolidated guidelines on HTS, 2015

The guidelines are written in line with the five broad but inter-linked thematic areas namely; Priority Populations, Ethical-legal issues, Social behavioural Change Communication, Service delivery and Health Systems.

Under each thematic area, policy statements are highlighted and below each policy statement, guidance for implementation is provided. The guidelines also provide guidance for disseminating, implementing, monitoring and evaluating the results of the policy.

2.0 Purpose and Objectives of the HTS Policy and Guidelines

2.1 Purpose

The purpose of the revised HTS policy and guidelines is to provide a framework to regulate the planning, implementation, monitoring and evaluation (M&E) of high-quality HTS.

2.2 Objectives

- I. To guide provision of high quality and non-discriminatory HTS to all persons in Uganda.
- II. To provide a framework for aligning HTS interventions with current Global and National recommendations.
- III. To strengthen health systems for delivery of integrated and targeted HTS in facility and community settings towards increased access, coverage and utilization.
- IV. To provide guidance for Monitoring, Evaluation and surveillance for HIV testing services.

3.0 Key, Priority and Vulnerable Populations

There are still significant gaps for HTS among Key populations, priority populations and vulnerable populations in Uganda due to access challenges, stigma, legal, social and political environments. This revised policy is intended to support interventions that will allow increased access and utilization of HTS among Key Populations (KPs), Priority Populations (PPs) and Vulnerable Populations (VPs)⁶.

HTS programs should be designed to ensure that KPs, PPs VPs that have equitable access to testing and linkage to prevention, care and treatment services.

Policy Objective: To ensure that the specific needs and concerns of Key, Priority and Vulnerable populations are addressed during HTS.

3.1 Key Populations (KPs)

Population Category	Barriers to access HTS	Key Strategies for HTS
Key Populations These are people who due to their behaviour are at an increased risk of HIV infection irrespective of epidemic type or local context. These include: MSM, Sex workers, People who inject/ use drugs (PWUID), Transgender Persons, people in prisons and other closed settings	-stigma and discrimination -lack of confidentiality -Coercion -Fear of repercussions -lack of appropriate health services, resources and supplies -unfriendly, legal, social and political environments -negative attitudes from health providers -disclosure	-HIVST -Index Client Testing/APN -Social Network Strategy (SNS) -Peer-led and snow ball approaches -Services during flexible opening hours, walk-ins or same-day appointments -Mobile outreaches -Moonlight clinics -PITC -Drop-in Centre (DICs)

3.2 Priority populations (PPs)

Population Category	Barriers to access HTS	Key Strategies for HTS
<p>Priority Populations</p> <p>These still have high HIV burden and risk. They also have contextual factors that increase their vulnerability to HIV. Therefore, there is need to design contextual specific interventions to reach them with HTS.</p> <p>These include:</p> <ul style="list-style-type: none"> -Fisher folk, -Long distance truck drivers, -uniformed forces, -Boda boda riders, -Plantation and other migrant workers, -refugees and internally displaced persons (IDPs) -Plantation, Migrant workers and Miners. 	<ul style="list-style-type: none"> -Fatalistic attitude -peer pressure influence leading to low self-efficacy -stigma and discrimination -lack of appropriate health services (distance and time) -lack of HTS information -Migration, mobility -poor health seeking behaviours -Myths, misconceptions and beliefs - long waiting time at the facility -Lack of time to seek for HTS services since most of the day time they are working -disclosure -Abuse of Alcohol and other drugs 	<ul style="list-style-type: none"> -HIVST -Index Client Testing/APN -SNS -Services during flexible opening hours, walk-ins or same-day appointments -integrated Mobile outreaches -Moonlight clinics -DICs -Social media (interactive digital SMSs in different languages) -radio spots and jingles in different languages -Workplace testing -edutainment -PITC -social mobilization approaches (peer education and community radios) -Peer-led approach -Home based testing

***Uniformed Forces – Barriers to access HTS:** Health services in operation areas – at war

***Refuges and IDPs – Barriers to access HTS:** misconceptions, language barrier, social issues e.g., culture shocks, lack of IEC materials, lack of responsive services in internally displaced persons camps (IDPCs)

Key strategies for HTS in refugees & IDPs: identify and work with a translator(s) for different language(s) within the refugee community, translated IEC materials (brochures, posters, and print media)

***Plantation, migrant workers and miners – Barriers to access HTS:** Language barriers to access health services, fear of negative consequences including job loss; limited knowledge on health rights

3.3 Vulnerable Populations (VPs)

Population Category	Barriers to access HTS	Key Strategies for HTS
<p>Vulnerable Populations</p> <p>These populations continue to suffer high burden of HIV and limited access to HTS due to a number of biological, social, cultural and economic factors. To be able to reach them effectively with HTS there is need to design contextual specific strategies and approaches which suit their circumstances.</p>	<ul style="list-style-type: none"> -Stigma and discrimination -fear of the consequences of HTS for instance IPV -Disclosure -poor health seeking behavior -misconceptions and assumptions that a negative HIV status of a woman means that the male is also negative -Economic limitations (time off work, transport costs) 	<ul style="list-style-type: none"> -Index client testing/APN -HIVST -SNS -social mobilization and communication approaches (peer education and community radios) -E-health to provide messages on HTS -Mobile outreaches -IPC (couple counselling) -Radio spots and jingles -enhance targeted couple and sexual partner HTS information and setting up testing points in ANC, PNC, HIV care treatment points, HBHTS, religious premarital preparations and couple

<p>These include:</p> <ul style="list-style-type: none"> -Couples and Sexual partners, -Infants and children below 18 months, -Children 18 mths - < 10 years -Adolescents -Youth -Persons with Disabilities (PWDs) -Other high-risk Men -Health Workers 	<ul style="list-style-type: none"> -low self-efficacy for women -Lack of private space at facilities 	<ul style="list-style-type: none"> testing campaigns -the privacy and autonomy of the couple and sexual partners should be respected during HTS process. -assessment of IPV potential -refer to programs that address GBV. -informed and referred to join support groups including discordant couples where applicable -peer-led approaches -work-place and home-based testing
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***Infants and Children below 18 mths – Barriers to HTS:** parents/caretakers and providers' negligence, self-denial, non-disclosure, embarrassment, feeling too shy to go to a treatment center and financial constraints; relationship dynamics and female-directed emotional IPV; low levels of awareness among adults on the importance of testing their infants; access to the facility; lack of knowledge and confidence in PMTCT

Key strategies for HTS – infants and children below 18mths: encouraging all pregnant women to attend ANC and ensure that they are tested for HIV. If they have never been tested, they should be tested during delivery; health facilities in cooperation with CHWs, should establish an escort system to treatment facilities; prioritize collaborations with NGOs and CBOs in identifying and linking HIV-positive infants and children to care and treatment; HIV positive pregnant and breastfeeding women should be enrolled at the MBCPs where EIDs will be done through virological DNA/PCR; All breast-feeding mothers should be tested every 3 mths until cessation of breastfeeding; HEIs should be proactively identified from the different entry points including OPD, IPD, YCCs and PNC clinics; Identification of HEIs should be done through checking PMTCT codes on maternal passports and child health cards; In the absence of PMTCT codes on maternal passports and child health cards, an HIV antibody rapid test of the mother should be done to ascertain the HIV exposure status of the infant.

***Children 18mths – <10years – Barriers to HTS:** failure to grant parental permission/consent; unaccompanied minors; abandonment; maltreatment; suboptimal logistics; fear of the unknown; lack of information on HTS for HTS consenting

Key strategies for HTS: Integration of HTS into child health programs i.e., YCCs, Nutrition clinics, PNCs, IPD, OPD, TB clinics and OVC programs; develop clear HIV testing policies and guidance regarding consent and guardianship in children; provide legal authority to caregivers who are not parents or legal guardians to give proxy consent for medical care of a child; health facilities in cooperation with CHWs, should establish an escort system to treatment facilities; expand the role of designated HCWs (in-charge or department head) to provide consent for the child if no parent or legal guardian is available; HEIs should be proactively identified from the different HTS entry points including OPD, IPD, YCCs, nutrition, TB, OVC program and PNC clinics

***Adolescents – Barriers to HTS:** Lack of information on HTS; low risk perception on HTS transmission and prevention; low self-efficacy; peer influence; dependency on the caretakers; lack of adolescent responsive services; lack of flexible hours for HTS; lack of disclosure

Key strategies for HTS: services should be offered at the convenience of adolescents i.e., flexible hours, walk-ins or same-day appointments; offering HTS as part of comprehensive adolescent friendly services at adolescent corners; health provider should provide age-appropriate messaging and counselling to assist adolescents access HTS; health facilities in cooperation with CHWs, should establish an escort system to treatment facilities; integrate adolescents HTS at different entry points including OPD, IPD, YCCs, nutrition clinic, TB clinic, OVC program, sexual reproductive health and PNC clinics

***Youth – Barriers to HTS:** Low risk perception; peer influence; lack of time to visit health facilities (in school and involved in IGAs); poor health seeking behavior; lack of youth friendly services at facilities; fear of positive HIV status; accessibility of HTS, location and unsuitable working hours

Key strategies for HTS: Establishment of youth friendly services at health facilities; flexible hour services (after 5pm, weekends etc.); DSD HIV testing services; development of initiatives to counter stigma at community level;

integrated outreaches sports events e.g. workplace testing; inter-personal counselling; assessment of IPV potential; DICs

***Persons with Disabilities (PWDs) – Barriers for HTS:** Communication barriers i.e., sign language interpreters; physical inaccessibility; lack of targeted information

Key strategies for HTS: Implementation of disability-inclusive HTS (infrastructure, information, proximity, etc.); formation of support groups for PWDs; outreach and home-based interventions to mitigate accessibility barriers; targeted outreaches; orientation of service providers to be disability-sensitive; training of service providers in sign language, assessing capacity of the PWDs to consent to HTS and receive results, and providing appropriate referrals; work with disability peoples organizations (DPOs) to mainstream HTS within their organizations so as to increase access and coverage of HTS amongst PWDs

***Other high-risk Men – Barriers for HTS:** Fear of the unknown; Difficulties in HIV status disclosure; Fear of HIV life-long treatment; perception that health facilities are “female” spaces; direct costs and the opportunity costs of accessing services; poor health seeking behavior; lack of trust of HWs from local health centers to keep HIV test results confidential; busy work schedules; patriarchal (masculinity/social construction) societal norms

Key strategies for HTS: Spousal influence; expert clients and peers to encourage them to test (male champions); PITC for males at different entry points e.g., SMC clinics, IPD, OPD and Reproductive health clinics; Flexible hour testing; Targeting men at different events e.g., sporting events; work with religious organizations to create demand for HTS and psychosocial support to men and their couples; multi-disease screening for example coupling screening for other elements such as Hepatitis B, syphilis and HIV

***Health workers – Barriers for HTS:** Personal and professional shame; Fear of losing clients/ customers; Fear of damaging future career prospects; confidentiality and privacy concerns

Key strategies for HTS: providing of appropriate PPE and access to PEP

4.0 Ethical-legal Issues in HTS

This section aligns issues of ethics and legal provisions that should guide HTS implementation as guided by the *HIV Prevention and Control Act 2014*⁸. These include human rights, non-discriminatory and stigma-free service provision of HTS. It provides guidance on provision of high quality and non-discriminatory HTS to all persons in Uganda based on the 5Cs (Consent, Counselling, Confidentiality, Correct results and Connection to prevention, care, treatment and support services) as recommended by WHO.

HTS programming and implementation shall take into consideration provision of the national and regional legal frameworks as well as human rights-based approach as laid down in international and national human rights instruments.

Policy Objective:

To ensure that HTS is provided in a respectful, non-discriminatory and ethical manner reflecting professional integrity of the provider and respecting the human rights of the person receiving the service.

Policy Statements:

- a) All persons shall have the right to access quality HTS irrespective of age, race, religion, gender, ethnicity, disability, socio-economic and political status.
- b) All persons shall consent to HTS. In situations where consent cannot be obtained from the client, the next of kin, guardian/parent or other authorised persons shall provide consent on behalf of the client.
- c) Clear and accurate information, education and communication shall be provided to all persons seeking HTS through pre and post-test counselling to enable one make appropriate decisions related to HIV testing.
- d) Confidentiality shall be maintained in the process of providing HTS. Client information can only be shared with the CONSENT of and in the best interest of the client.
- e) Disclosure of a client's HIV status shall follow the standard guidelines
- f) HTS providers MUST ensure that the test results provided to the client are correct
- g) All persons accessing HIV counselling and testing shall have the right to be linked to appropriate health services

4.1 Human Rights

All persons shall have the right to access quality HTS irrespective of age, race, religion, gender, ethnicity, disability, socio-economic and political status.

HTS providers shall ensure that testing services respect human rights of clients irrespective of their age, race, religion, ethnicity, sex/gender, disability, socio-economic and political status. HTS services in Uganda will be accessible and non-discriminatory to all persons.

Access to HTS

Access and utilization of HTS shall be designed to minimize barriers and address the unique needs and interests of all persons in the different population groups. All persons will have the right to information, education and communication on HTS in a manner that suites their respective special needs.

Non-discriminatory and Stigma-free HTS

⁸The HIV and AIDS Prevention and Control Act 2014 <http://library.health.go.ug/publications/hivaids/hiv-and-aids-prevention-and-control-act-2014>

HTS shall be made accessible to all persons in Uganda irrespective of race, age, religious or political affiliation, ethnicity, disability, gender, economic or social status, or sexual orientation.

HTS providers shall ensure no stigma and discrimination during delivery of HIV testing services. Service providers should ensure privacy and protection of clients from discrimination due to perceived or confirmed HIV status. Persons who test HIV positive shall not be discriminated against directly or indirectly on the basis of their HIV status. For instance, HIV testing shall NOT be required at the time of recruitment, as a condition for employment or for insurance purposes unless authorized by a legal body or justified as part of ethical or professional standards.

HTS providers shall put in place initiatives to enforce protection of persons living with HIV. HTS providers should treat clients with dignity, respect and should observe the principles of equity, client participation, and respect for autonomy. HTS providers should ensure that PLHIV are meaningfully involved in all HTS activities, including mobilization, behavioural change education and communication, HTS provision, linkage facilitation, documentation, care and support, follow-up, Monitoring, Evaluation, and research. Community and home-based HTS shall address stigma and discrimination so as to promote care and support of persons infected and affected by HIV following an HIV diagnosis.

4.2 Guiding principles for HTS

This section guides the provision of quality HTS.

Consent	<ul style="list-style-type: none">• All persons ≥12 years can consent to HTS on their own. For children less than 12 years of age, HIV testing shall be done with the knowledge and consent of parents/guardians.• Mandatory testing should not be implemented• Written consent shall be obtained for HIV testing• For HIVST, verbal consent shall be sufficient
Confidentiality	<ul style="list-style-type: none">• All providers should ensure privacy during HTS provision.• All information discussed with clients should not be disclosed to another person without the client's consent.• Confidentiality in the context of HIVST should be maintained around the distribution of HIV self-test kits, testing and shared HIV self-test result.• Shared confidentiality shall be acceptable if it's in the best interest of the client.
Counseling	<ul style="list-style-type: none">• All persons accessing HTS should be provided with quality counseling before and after testing as per HTS protocol.• Quality counselling should be non-judgmental and client centered
Correct results	<ul style="list-style-type: none">• HTS providers should adhere to the national testing algorithm and must follow the SOPs for HIV testing to ensure that clients receive correct HIV test results.
Connection/ linkage to care	<ul style="list-style-type: none">• Providers should link HTS clients to appropriate HIV prevention, treatment, care and support services.• Linkage should be done within 7 days (within the same facility) and within 14 days if referred to another facility or from community

For details on guiding principles for HTS and disclosure, see section 6.6 under the HIV Testing Services protocol

5.0 Social Behaviour Change Communication (SBCC) for HTS

Social Behaviour Change Communication (SBCC) is a process where communication is used to influence peoples' knowledge, attitudes skills and practices (behaviour). SBCC is conducted at individual, interpersonal and community levels. It involves providing information to empower individuals and communities to make desirable health decisions and practices⁹.

SBCC is integral in the successful implementation of HTS. SBCC supports identification of HTS uptake, influences risk perception and risk reduction behaviours. SBCC process includes, situation analysis, design, pre-test, implementation and monitoring and evaluation and learning.

Primary and secondary audience segmentation for HTS will be selected and profiled in order to understand their specific needs (knowledge, attitudes, social norms, and practices), so as to address barriers for HTS.

Policy Objective: To guide design, implementation, monitoring and evaluation (M&E) of SBCC interventions for HTS based on the Comprehensive HIV Communication Strategy and the Health Sector Development Plan

Policy statements

1. SBCC interventions shall be integrated into the HTS programs for implementation and sustainability at all levels
2. SBCC interventions shall be evidence-based and consider the specific characteristics of each audience such as, age and gender location, socio – economic status, education, religion and culture.
3. Different target audiences shall be involved at all levels of SBCC intervention development for HTS
4. SBCC interventions shall aim at empowering the community with knowledge and skills to seek and utilize HTS.
5. SBCC shall utilize a mix of approaches and channels in order to reach the targeted audiences for HTS

5.2 SBCC Integration in the HTS Cascade

SBCC interventions shall be integrated into HTS programs for implementation and sustainability at all levels

HTS providers should integrate SBCC at all levels of the HTS cascade in order to address the barriers to the desired behaviours. The HTS cascade includes community mobilisation, health education, pre-test counselling, testing, post-test counselling and Linkage into care, treatment, prevention and support services. This will ensure continuity and consistency of the messaging to the client and therefore give opportunity to the client to obtain as much information as possible to facilitate behaviour change. At every stage of the testing process, the following key messages should be reinforced;

HTS Cascade	Relevant Messages to be emphasized	Responsible Human Resource
Community mobilisation	<ul style="list-style-type: none">• Benefits of HIV testing• Available testing facilities• Referral for testing• Behaviour change• HIV prevention• Information on HIVST.	Community mobilisers

⁹National Communication Plan for HIV Testing Services 2016 <https://www.health.go.ug/cause/national-communication-plan-for-hiv-testing-services/>

HTS Cascade	Relevant Messages to be emphasized	Responsible Human Resource
During Health Education and Information giving	<ul style="list-style-type: none"> • Benefits of HIV testing • Available testing options (HIVST, index testing), modes of transmission • Available services • Referral for testing 	Health worker
During Pre-test Counselling	<p>Pre-test counselling can be done in a group or as an individual.</p> <ul style="list-style-type: none"> • Provide information on benefits of testing, modes of transmission, confidentiality and risk assessment • A brief procedure of testing, possible results, Services available in the event of an HIV diagnosis, including ART. • Obtain consent 	Counsellor/Lay provider
During testing	<ul style="list-style-type: none"> • Process and duration for HIV testing 	HIV Rapid Tester
During Post-test Counselling	<p>Post-test counselling shall be provided to individuals, couples, and care givers in a private setting. Post-test counselling should not be provided in groups.</p> <ul style="list-style-type: none"> • Give test results • Agree on a risk reduction plan • Counsel on disclosure and encourage partner testing • Provide information on care, treatment, prevention and support services as appropriate. • Elicit for sexual partners if eligible for APN. <p>Refer to section 6.6 HIV Testing Services for details on Post-test counselling.</p>	Counsellor / Lay Provider
Linkage into Prevention, Care, Treatment and support services	<ul style="list-style-type: none"> • Importance of linkage • Available referral points • Follow up. 	Counsellor Lay Provider Linkage Facilitator

Information, education and communication on HTS should be focused so as to reach all target audiences with appropriate information based on their special needs.

5.3 Communication and Mobilisation for HTS

SBCC interventions shall be evidence-based so as to target the right population category, age and gender

Mobilization approaches should be tailored to the needs and contexts of different population groups in different places. Targeted mobilization and integration for HTS should be encouraged.

Different communication approaches should be used for identifying different target audiences for HTS to address social norms, attitudes, clarify myths and misconceptions.

Mass media should be limited to general HIV education and creation of a conducive environment for adoption of risk reduction behaviour.

SBCC messaging and material development should follow the standard process of situation analysis, design, testing and production.

Target audiences should be consulted and involved during messaging and material development.

Implementers should be as innovative as possible in designing and implementing SBCC interventions without violating the established Standards and Ethics.

Relevant stakeholders within the SBCC arena should review SBCC materials and tools to ensure that they cater for local contexts and target audiences. HTS Implementers should submit SBCC materials and tools to the national technical working group for review and approval by the health promotion and Education Division of MOH before implementation.

All HTS and related IEC should be designed to address the unique needs of target audiences. Ensure availability and utilization of SBCC materials for HTS to different end users and institutions

All approved SBCC materials and tools should be made available through a digital repository at MOH with specific guidelines for use and reproduction. This will allow for wide sharing and preservation of key SBCC materials and tools.

All programs that implement HTS as part of their service package should integrate SBCC according to the Comprehensive HIV Communication Plan 2021-2026⁹.

HTS Implementers should regularly obtain updated SBCC tools and guidelines from the Ministry of Health, Division of Health Education and Promotion.

MOH should continue to provide technical leadership and guidance for SBCC interventions and will address any emerging issues that require policy direction.

5.4 Demand Creation

Demand Creation interventions shall empower the community with knowledge and skills to take appropriate action to seek and utilize HTS.

Demand creation to increase HTS uptake and engage those in greatest need of services, is a valuable tool for mitigating stigma and discrimination. Target populations shall be involved in the planning and implementation of demand creation interventions. The following categories inductively summarize demand-creation strategies:

- IPC such as health education, counselling, satisfied user groups, testimonies
- Community dialogue meetings
- Social mobilization campaigns (community radios and drives)
- Satisfied users/ expert clients/ YAPS/ peers and champions.
- Media (print, electronic, digital platforms, social media and apps)
- Edutainment

5.5 Tracking and reporting SBCC interventions for HTS

All HTS SBCC interventions shall have an M&E framework to track the contribution of SBCC activities in the achievement of the policy objective

MoH shall develop specific indicators for measuring the progress and results of SBCC interventions. HTS programs implementing SBCC activities should report progress and results as per the National HTS SBCC indicators.

For sustained and effective SBCC interventions, implementers should innovate, learn, document, track and share results. SBCC interventions should be guided by the MOH Comprehensive HIV Communication Plan 2021-2026⁹.

6.0 Delivery of HIV Testing Services

Implementation of HTS in Uganda shall follow a strategic mix of approaches and models targeted towards improving program efficiency, impact and shall be risk based. HTS should be provided in both community and health facility settings and should employ both Client initiated (Voluntary) and Provider Initiated HIV Counseling and testing approaches. Individuals diagnosed with HIV should be immediately linked to care, treatment and support services while those who test negative shall receive appropriate prevention services

Delivery of HTS should be guided by the 5Cs i.e., Counseling, Consent, Confidentiality, Correct results and Connection to care.

Policy Objective:

To standardize delivery of high quality, risk based and population specific HTS at facility and community settings.

Policy Statements:

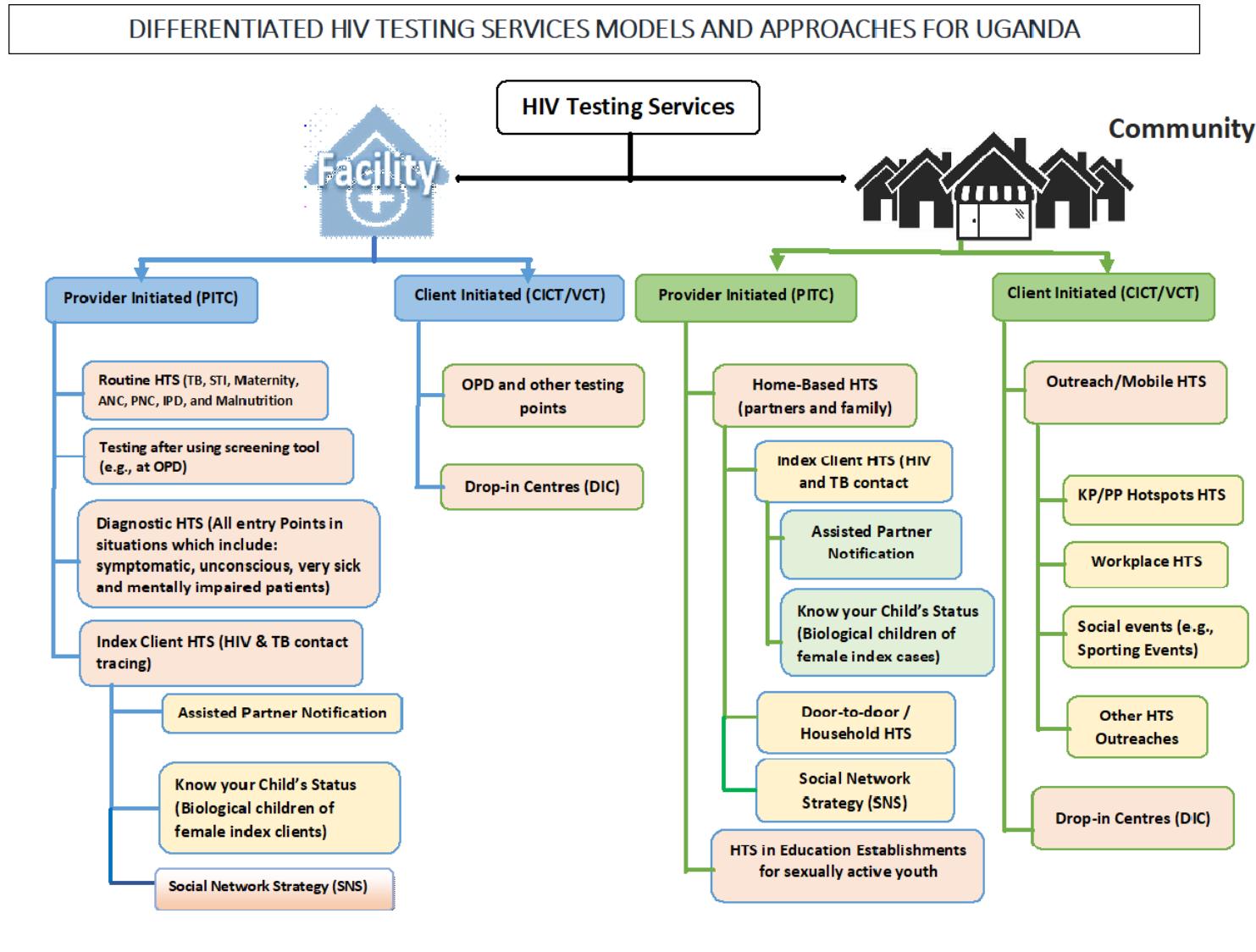
- a) A mix of facility and community-based approaches shall be used to provide HTS
- b) Facility based HTS shall be provided at various service points as part of routine service delivery.
- c) HTS in community settings shall be offered following a targeted approach especially for KPs, VPs and PPs who are less likely to attend facility-based HTS.
- d) HTS activities shall be incorporated in all health-related plans and programs and therefore be an integral component of all routine health care services
- e) Client initiated HIV Counselling and Testing (CICT) shall be provided on a client's request.
- f) PITC shall be provided by a health worker as part of routine preventive services, clinical management and care.
- g) HIVST is a screening test and shall be offered to eligible clients as an option for HIV testing.
- h) Mandatory and Diagnostic HIV testing shall be considered under special circumstances.
- i) HTS providers shall adhere to the nationally approved HTS protocol for adults and children as per the various approaches and models.
- j) All HTS delivery approaches and models shall adhere to the principles of Consent, Confidentiality, Counselling, Correct Test Results and Connection to prevention, treatment, care and support services
- k) The National recommended HTS algorithm shall be used to guide the performance of HIV tests using either rapid or DNA PCR tests in both public and private sites.
- l) MOH shall ensure periodic evaluations of HIV test kits and test algorithms
- m) Repeat testing shall be conducted in specified circumstances to rule out laboratory or transcription errors and sero-conversion.
- n) HIV re-testing shall be conducted based on the client's level of recent exposure and or ongoing risk of exposure.
- o) All individuals newly and previously diagnosed with HIV shall be re-tested for verification before ART initiation.

6.1 Differentiated Service Delivery (DSD) Models for HIV Testing Services

The differentiation is highly targeted to provide client centered models of testing at community and facility levels as recommended in the National Plan for Optimizing HIV testing services in Uganda 2020/21-2022/23^{10, 11}.

The figure below provides a diagrammatic flow of HTS models and approaches in Uganda. HIVST shall be provided as an additional testing option across all testing models. Reporting for HTS shall be synchronized and aligned to these models to track efficiency of each.

Figure 3: Differentiated HIV Testing Services Models and Approaches for Uganda

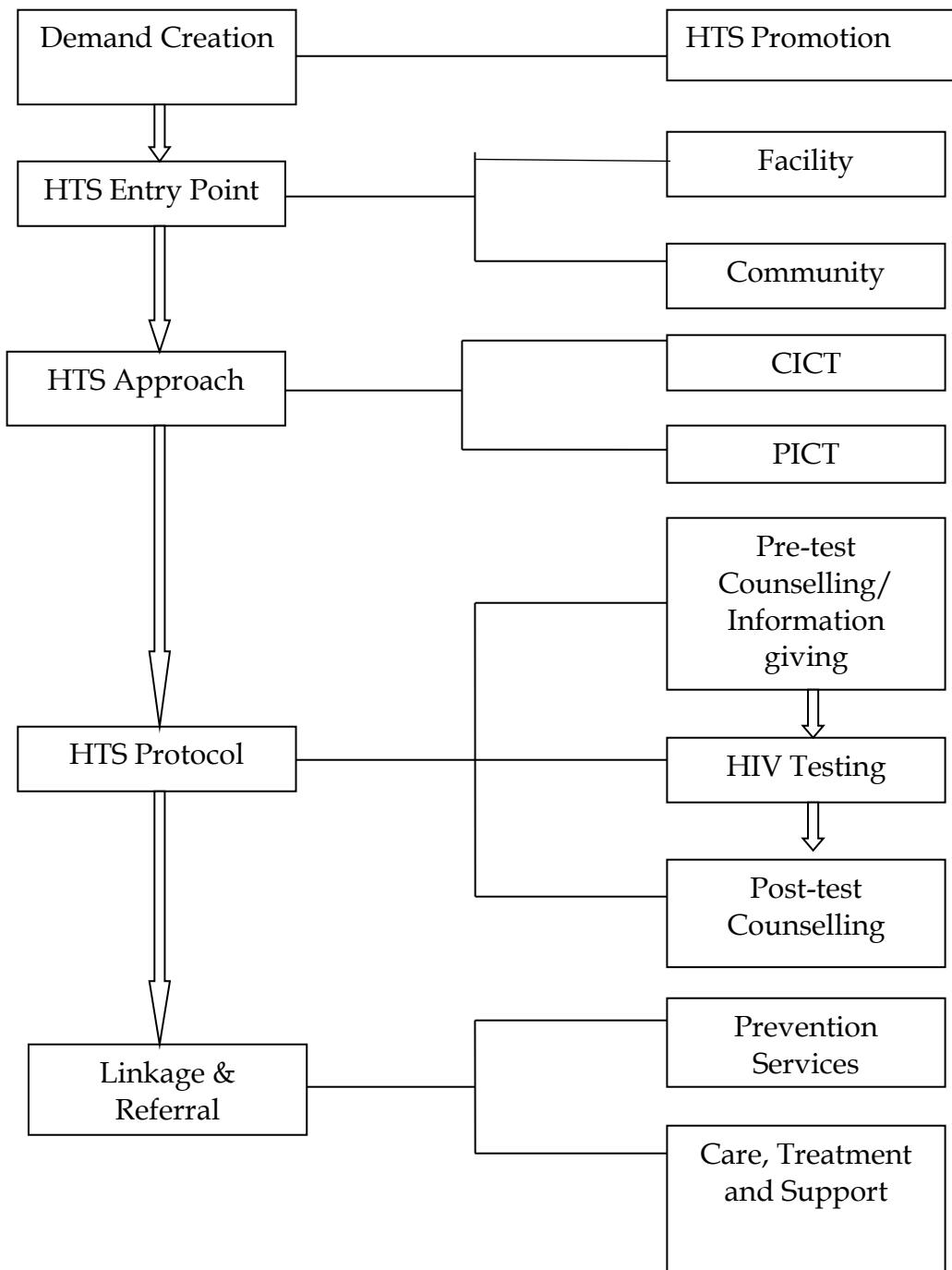


¹⁰ Implementation guide for Differentiated Service Delivery Models of HIV and TB Services in Uganda 2020
https://www.differentiateservicedelivery.org/Portals/0/adam/Content/FXBRYsohBEGGGiGnnnli3A/File/Uganda_HIV_TB_DSD.pdf

¹¹Differentiated Service Delivery for HIV: A decision framework for HIV Testing Services – Mobilizing, testing, linking
<https://www.differentiateservicedelivery.org/Portals/0/adam/Content/DCwLmrNFcUuLU4jWitw4-Q/File/DSD%20for%20HIV-%20A%20decision%20framework%20for%20HIV%20testing%20services.pdf>

In Uganda, the HTS cascade shall follow the steps depicted in figure 4 below.

Figure 4: The HTS Process



6.2 HTS Eligibility Screening

To optimize HTS, the program shall utilize the eligibility screening tools at both facility and community settings.

The following clients shall be screened for eligibility before HIV testing: adults and children in OPD, community, clients seeking SMC/VMCC, In-patients due to trauma and partners of pregnant and breast-feeding women. The following clients may not require screening before testing and these include; Presumed/Diagnosed TB clients, malnourished individuals, In-patients, clients with concurrent STIs, pregnant and breastfeeding women, sexual offenders and survivors, blood donors, body tissue and organ donors.

Paediatric & adolescent and adult screening tools have been developed, validated and shall be utilised for HTS eligibility screening. (Appendix A).

6.2.1 HTS at Health Facilities

Within the decentralized health system, HTS shall be offered up to HC II level. At HC IIs, HTS should be offered under supervision of higher-level health facilities. Both PITC and CICT shall be provided in health facilities by either the conventional HIV testing using the national algorithm or HIVST. [Refer to Appendix C for Uganda health strategic plan human resource health delivery (Uganda one health strategic plan 2018-2022)^{12]}

Client Initiated Testing and Counselling (CICT)

In this approach, individuals and couples willingly seek HTS either from the health facility or a preferred community setting and follow the approved HTS protocol. CICT should be offered to individuals or couples after risk screening.

Provider Initiated Counselling and Testing (PITC)

PITC should be conducted in either a health facility or community setting and is initiated by a health worker.

In this approach, health workers should screen for eligibility as a standard of care to clients. Adequate information should be provided to clients about the benefits of testing to enable them make an informed decision.

Service delivery points for PITC include MCH, adult and paediatric in-patient wards, TB clinics, nutrition units, family planning clinics, STI clinics, OPD and clinics managing survivors of sexual abuse. *See section 6.2 for details on integration of HTS.* PITC shall include diagnostic testing as well as routine testing.

Diagnostic testing: This shall be carried out on individuals as deemed necessary by the attending health care team with the purpose of better patient management. Such situations may include symptomatic, unconscious, very sick and mentally impaired patients. Through PITC, the patient or attendant should be given an opportunity to know his/her status to promote adherence; prevent further transmission and enhance psychosocial support for the patient.

¹²Uganda One Health Strategic Plan 2018-2022 <https://www.health.go.ug/cause/uganda-one-health-strategic-plan-2018-2022/>

Routine HIV testing: This shall be carried out for individuals likely to pose a risk of HIV infection to others. The following individuals shall be offered routine testing in reference to the Uganda HIV prevention and Control Act 2014⁸:

- Pregnant and breastfeeding women
- Partners of pregnant and breastfeeding women
- Donors of blood, body tissue and organs.
- Sexual offenders and survivors

6.2.2 HTS at Community Settings

HTS in communities will aim to serve populations that would otherwise not attend facility-based HTS. Services should be offered in homes, social gatherings, education establishments, DICs, safe spaces and at workplaces by either the conventional HIV testing using the national algorithm or HIVST.

Programs offering HTS at community level shall ensure that follow-up and linkage to prevention, care, treatment and other support services follow respective protocols.

HTS in community settings shall aim at offering an integrated package of primary health care services, including STI screening and management, child health services and other health promotion interventions. Recording and reporting community HTS will utilise MOH HMIS tools.

HTS at community level should be offered in various ways as listed below:

Outreach HIV testing services

Outreach HTS can be offered by higher to lower-level health facilities or to communities through planned and regular visits to the outreach sites or through community camping where outreach sites are inaccessible.

Note: HTS outreaches for general populations as well as during public campaigns are discouraged.

Home Based HIV Counselling and Testing (HBHCT)

HBHCT shall follow two main models:

- i. Door-to-door testing for all consenting individuals, couples or families in a specified geographic area.
- ii. Index client Contact tracing and testing that is offered to households with a consenting PLHIV or an active or presumptive TB patient (index client).

Door-to-door testing may be implemented ONLY in high HIV prevalence settings or communities for key populations such as, hotspots for Sex workers, Men who have sex with Men, or through the snow-ball approach.

HBHCT should be arranged in collaboration with existing health facilities and community support groups to ensure on-going care for persons who are offered HTS.

HBHCT should offer the benefits of supported disclosure and adherence to ART and other medications.

HTS at the work place

Workplace HTS conveniently provides HIV testing to individuals at their place of work. These are usually individuals whose work schedules do not permit them to leave their workplaces in search of health care. Workplace testing should be implemented with high levels of uptake and linkage to care and prevention services, particularly in

high burden settings. Providers, should ensure confidentiality, and non-coercion and effective linkage to prevention, care, treatment and support services.

Employers in Uganda should mainstream the provision of HTS to employees and their families in the work place as an integral component of staff welfare.

HIV testing services at work places should be offered within the workplace in collaboration with health facilities that provide care treatment and prevention services.

HTS in Educational Institutions

HIV testing services in educational establishments should address sexually active youth in the context of sexual health education and behaviour change interventions.

Provision of HTS in education institutions in Uganda should be done according to the National School Health Policy. HTS at the educational institutions should be implemented with high levels of uptake and linkage to care and prevention services

Mobile HTS

HTS is offered by mobile teams at hotspots for KPs and PPs.

Drop-In Centres (DICs)

Drop-in Centres (DICs) are service delivery points targeting special sub-populations (KPs, PPs and VPs), who would otherwise fail to access health services including HTS. These can be established by CBOs or MOH together with its partners. Members of the general population should not be denied services at these sites

The objectives of DICs are to promote and improve the quality of life through building capacity and skills empowerment, creating an enabling environment, establishing linkages with existing health services, NGOs, CBOs and other welfare and development programs and protecting and promoting the rights of the KPs, PPs and VPs. For KPs, PPs and VPs, a growing number of CBOs are utilising DICs to provide HTS.

6.2.3 Index Client testing

Index testing involves tracing contacts of index HIV infected clients and offering them testing services¹³. Examples of these approaches include Assisted Partner notification (APN) and index client testing for biological children/ Know Your Child Status (KYCS).

6.2.3.1 Assisted Partner Notification

APN is part of a comprehensive array of services offered to persons infected with HIV or STDs and their partners¹³. The critical function of APN is partner notification, a process through which HIV-positive index clients are interviewed to elicit information about their sexual partners, who can then be confidentially notified of their possible exposure or potential risk, and offered HTS. Index clients should be encouraged to notify past partners, in

¹³Addendum to the HIV Testing Services Policy & Implementation guidelines: HIV Self-Testing & Assisted Partner Notification Services 2018 <https://www.health.go.ug/cause/addendum-to-the-hiv-testing-services-policy-implementation-guidelines/>

addition to current partners, and engage them in testing services¹³. APN is voluntary, confidential, client-centred, and free, for both the index client and his/her partner(s).

Assisted Partner Notification Service Goals

The overall goal of APN is to prevent HIV transmission through partner notification, testing of contacts and linkage to appropriate treatment and prevention services¹³.

In particular, APN presents an opportunity for service providers to:

- Provide infected persons with support to confidentially inform their partners of the possibility of exposure to HIV, and
- Link infected persons and their partners to appropriate care, treatment, prevention and social support services.

Assisted Partner Notification Services Objectives

Provision of APN has both short-and long-term objectives¹³.

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

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

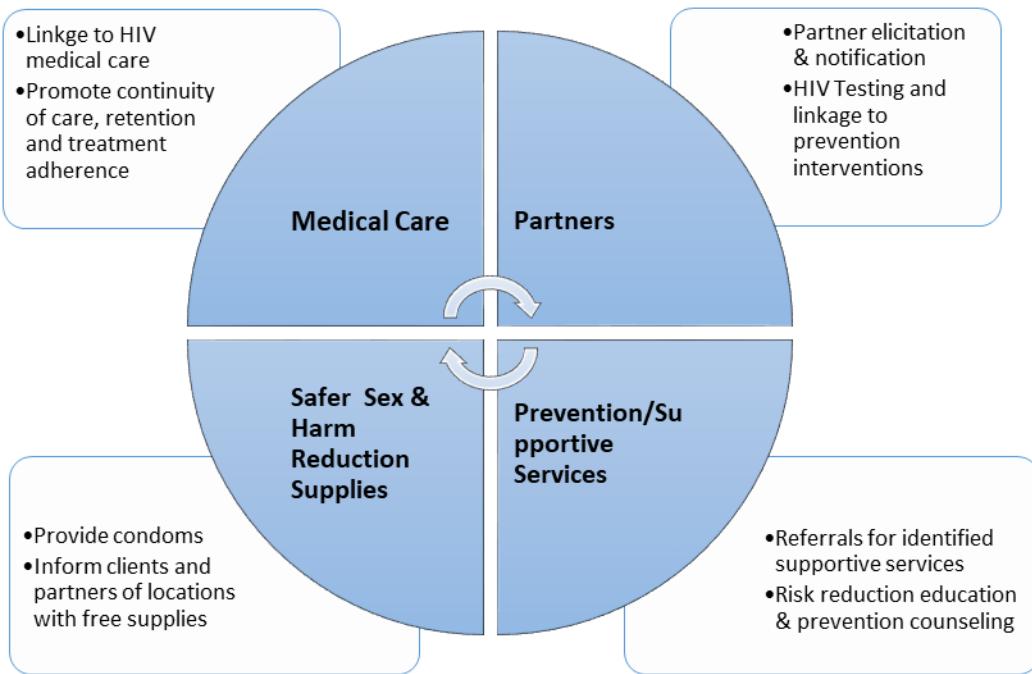
The **long-term** objectives are to:

- Decrease the rate of HIV transmission to reduce disease incidence
- Decrease risky sexual behaviors
- Increase the proportion of HIV infected individuals who are aware of their status
- Increase the proportion of partners of PLHIV who are notified, tested, linked to prevention, care and treatment

Components of Assisted Partner Notification Services

APN includes, partner elicitation and notification, counselling and testing for HIV linkage to HIV care, treatment prevention and other services as shown in the figure below¹³:

Figure 5: Components of Assisted Partner Notification Services



Benefits of APN

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

Table 1: Summary of the benefits of APN¹³

Partners of Index clients	<ul style="list-style-type: none"> • Maximizes effective linkage to care, treatment, prevention and other support services to reduce the risk for transmission to others • Maximizes the proportion of partners who are notified of their exposure to HIV/STDs • Maximizes early linkage of partners to testing, care, prevention and other support services • Reduces further transmission through early diagnosis, treatment and provision of prevention services
Community	

Target Populations for APN

The target populations for APN are individuals aged 15 years and above with high likelihood to transmit HIV to their partner(s)¹³.

These include:

- All persons newly diagnosed with HIV including those on ART for less than 6 months
- PLHIV on ART with an identified risk (e.g., new sexual partner(s), PWID sharing contact(s), or STI

diagnosis.)

- On ART but non- virally suppressed
- Adolescents living with HIV below 15 years of age sexually active and meet any of the above criteria

Principles of APN

These include: voluntary and non-coercive; free; non-judgemental; confidential; client centred and focused; comprehensive and integrative; culturally and linguistically appropriate; and available and accessible to all clients¹³.

Table 2: Principles of APN

Voluntary and non-coercive	<ul style="list-style-type: none">▪ APN is never coercive or mandatory and always relies on the willing participation of HIV-infected persons and their partners. Providers should encourage patient participation in APN by fostering rapport and an atmosphere of trust and mutual respect. All service recipients should be informed of the benefits and risks that may result from participating in APN.
Confidential	<ul style="list-style-type: none">▪ All information (both print and electronic) regarding index clients and their partners should be kept strictly confidential and not accessible or disclosed to anyone other than those who are authorized to have access (APN providers and their supervisors). Strict adherence to confidentiality should be followed during attempts to contact the patient, initial interview, notification of partners and subsequent contacts and re-interviews.▪ During attempts to locate and schedule an interview with a patient, the APN provider should not disclose to anyone other than the patient the reason for locating the patient. The HIV status or any other potential HIV-identifying information is discussed with only the patient and authorized public health staff.
Client-centered and focused	<ul style="list-style-type: none">▪ All communication with patients should be centered on the needs of the patient rather than the needs or priorities of the APN staff. The APN process should be tailored to the behaviors, circumstances, and specific needs of each patient.
Comprehensive and Integrative	<ul style="list-style-type: none">▪ APN staff should be a part and parcel of health services that are integrated to the greatest extent possible for persons with HIV infection or other STDs and their partners.
Available and accessible to all clients	<ul style="list-style-type: none">▪ APN staff should be available for persons who test HIV positive. All individuals who test positive should be informed of the option of obtaining APN without disclosing their identity or having their HIV test result disclosed. If the patient decides to participate in APN, the HIV counseling and testing provider trained on APN can provide APN at a place and time convenient to the patient. Partners of a person with HIV are notified of their HIV risk and are informed of anonymous and confidential testing options.

Partner Notification Methods

There are four notable partner notification methods as described below: provider referral, client referral, contract referral and dual referral methods¹³.

1. **Provider Referral** = The HTS provider shall contact the partner(s) of an index client, and provide HTS.
2. **Client Referral** = The index client informs and discusses with their partner(s) about the need to test for HIV.
3. **Contract Referral** = The index client and HTS provider shall work together to notify the index client's partner(s). The index client shall be given 14 days to inform and discuss with their partner(s) the need to test for HIV. If after 14 days the index client has not yet informed his/her partner(s) the HTS provider shall contact the partner(s) and provide HTS
4. **Dual Referral** = The HTS provider shall sit with the index client and their partner(s) and discuss the need for partner(s) testing.

APN Implementation Process

The following steps shall be involved in the delivery of APN services¹³:

Step 1: Index client Identification

The target populations for APN shall include:

- All persons newly diagnosed with HIV including those on ART for less than 6 months,
- PLHIV on ART with an identified risk (e.g., new sexual partner(s), PWID sharing contact(s), or recent STI diagnosis.)
- On ART but non- virally suppressed
- Adolescents living with HIV 15 years and above of age who are sexually active and meet any of the above criteria.

Step 2: Index Client Interview and Elicitation

This will encompass;

- Use the talking points to introduce APN services to the index client.
- Identify and address immediate concerns.
- Reassure the client about confidentiality.
- Obtain informed consent from the index client.
- Ask the index client to enlist the partner(s)/contact(s) and screen for IPV
- Support the index client to choose the most appropriate option for partner notification approach
- Document in the APN register

Step 3: Partner Notification

Following the initial Index client interview and partner elicitation process, the HTS/APN focal person and Index client shall develop a partner notification plan. In the absence of any history or concern for domestic violence, the APN focal person shall work with the index client to identify the best method of notifying the partner(s) and ensuring their linkage to HIV testing. If there is any concern for domestic violence or if the index client requests the APN focal person to notify their partner(s), the APN focal person shall make it clear that they will **NOT** disclose details of the index client's **name** or any hint on how they learned that the partner(s) may have been exposed to HIV.

a) Index client Notification

The APN focal person will arrange to re-interview the index client in 14 days after their initial interview. This follow-up shall be done either in-person when the patient returns for a clinic visit, or via telephone if in-person follow-up cannot be arranged in a timely manner. The APN focal person shall confirm that he/she is speaking to the patient and that the index client is in a place where he/she can speak privately before discussing any issues related to HIV by telephone.

The APN focal person will interview/ask if the index client has notified each partner identified in the notification plan, if the partner(s) tested for HIV, and the results of that test are known to the index client, the APN focal person will request the testing location of the partner(s) to follow up with the testing Health Facility. If the index client is unable to notify/choose not to notify their partner(s) the APN focal person will inform the index client that they will notify partner(s) of potential HIV exposure.

Always Remember:

- Behaviour change is a process that occurs in steps over time.
- Patients are in different stages of readiness to change at any given time.
- Movement is spiral, not linear.
- There are NO standard messages.
- Each patient has unique circumstances.
- Counselling strategy used needs to MATCH the patient's readiness for change.
- Relapse can occur at any time and is a normal part of the process of change.
- A patient can be in different stages for different target behaviours.

- Patients need different approaches that match their stage of change.
- Approaches that move ahead of the patient's readiness result in increased patient resistance and are not helpful for the patient.

b) Assisted/Provider Notification

The APN focal person shall initially attempt to contact partner(s) via telephone. When talking to partner(s), the APN focal person will first confirm the identity of the person to whom he/she is speaking. The APN focal person will inform the partner that he or she is calling from the Health Facility about an important health issue and ask if the partner is in a place where they can speak privately. If they are, the APN focal person will inform the partner that they may have been exposed to HIV infection, advise them that they need to be tested for HIV, and offer to help them arrange for an HIV test at the most convenient Health Facility for the partner (Appendix D).

- Partner(s) should not be coerced to meet with the APN focal person or visit the health care facility. They should be assured that meeting with the APN focal person is voluntary and for their own good.
- Field visits/ outreaches are critical components of the APN Initiative. Partners' responses may be unpredictable, and the APN focal person should always be aware of their surroundings. Situations in which personal safety is a concern should be discussed with a supervisor.

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

Step 4: Partner Counseled and Referred to or Linked to Care Services:

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

Step 5: Case Closure

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

- Index Client located, interviewed, and at least one partner elicited and interviewed
- Index Client located, interviewed, and partner(s) located, but declined to meet and/or be interviewed
- Index Client located and declined APN
- Index Client living/residing in another district or country
- All attempts to identify or locate partner(s) have been unsuccessful
- Other specified reason should be noted

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

HF In-Charges, HTS/APN focal persons and District HTS focal persons should meet monthly to jointly review/discuss case closures and any other investigation related issues. All APN data shall be retained within a confidential space for at least one year following case closure for data clarification and reference.

All APN data containing identifying information, and APN tracking documents should be stored in a secure place to maintain the confidentiality of index clients and partner(s) information.

Adverse Events / Challenges in APN

During APN implementation, adverse events /challenges may arise and therefore APN staff should follow appropriate national implementation guidelines and protocols to mitigate them.

The common adverse events or challenges include: index clients' acceptability of APN services, the potential for patient abuse or harm resulting from partner notification, and the potential negative effects on relationships between patients and their partners including physical, social, economic and emotional harm¹³.

All APN providers shall be trained on the how to access and mitigate adverse events and challenges that impact implementation of APN services. Such training shall cover among others;

- Maximizing acceptability of APN among patients and to minimize the negative effects resulting from notifying partners of their risk.
- Risks associated with home/field visits and how to assess the safety of each situation.
- Following appropriate safety policies and guidelines regarding field or home visits and should emphasize safety as a priority
- Keeping supervisors and/or colleagues aware of their field visit appointments and locations.
- Counseling and communication skills

6.2.3.2 Index client testing for biological children/Know Your Child's HIV Status (KYCS)

HIV positive clients and or TB patients in care should be mobilized to bring their biological children and other household members for HIV testing¹⁴. This also applies to HIV exposed infants whose mothers' access postnatal care (PNC), young child clinics (YCCs), family planning (FP) and/or gynaecological services e.g., STI or cervical cancer screening.

When conducting partner services, it is also important to offer HIV testing services to the biological children (2-19 years) of the HIV-positive client, when their HIV status is unknown. In all settings biological children of a parent with HIV should be routinely offered HTS and, if found to have HIV or to be at high risk for infection through breastfeeding, should be linked to services for treatment or prevention.

¹⁴Consolidated Guidelines on HIV Testing Services, 2019: Geneva: World Health Organization; 2020
<https://www.who.int/publications/i/item/978-92-4-155058-1>

6.2.4 Social Network Testing Strategy (SNS)

Social Network Testing Strategy (SNS) shall be offered as an HIV testing approach for KPs and other high-risk individuals as part of a comprehensive package of care and prevention.

Social Network: “a set of individuals linked by one or more specific types of relationships”- Wasserman 1999.

Social network strategy (SNS) is a case-finding strategy that uses social network connections to locate individuals at high risk for HIV. SNS can be particularly useful in finding KPs and other high-risk individuals¹⁴.

SNS addresses some of the challenges in scaling up HIV partner services among KPs and other high-risk individuals, particularly issues of confidentiality¹⁴. By addressing confidentiality concerns, SNS broadens the reach of partner services to include both HIV-positive and HIV-negative members of KPs and other high-risk individuals, their partners, social contacts and networks and other persons who are at risk of HIV but have no easy access to HTS.

Underlying assumption – People in the same social network share/have similar risk behaviours for HIV

The overall SNS strategy is aimed at enlisting HIV positive and high-risk HIV negative persons (recruiters) who identify individuals from their social networks for HTS.

SNS shall be implemented using the following appropriate tools:

- Standard Operating Procedures (SOPs),
- facility register and
- periodic reporting template

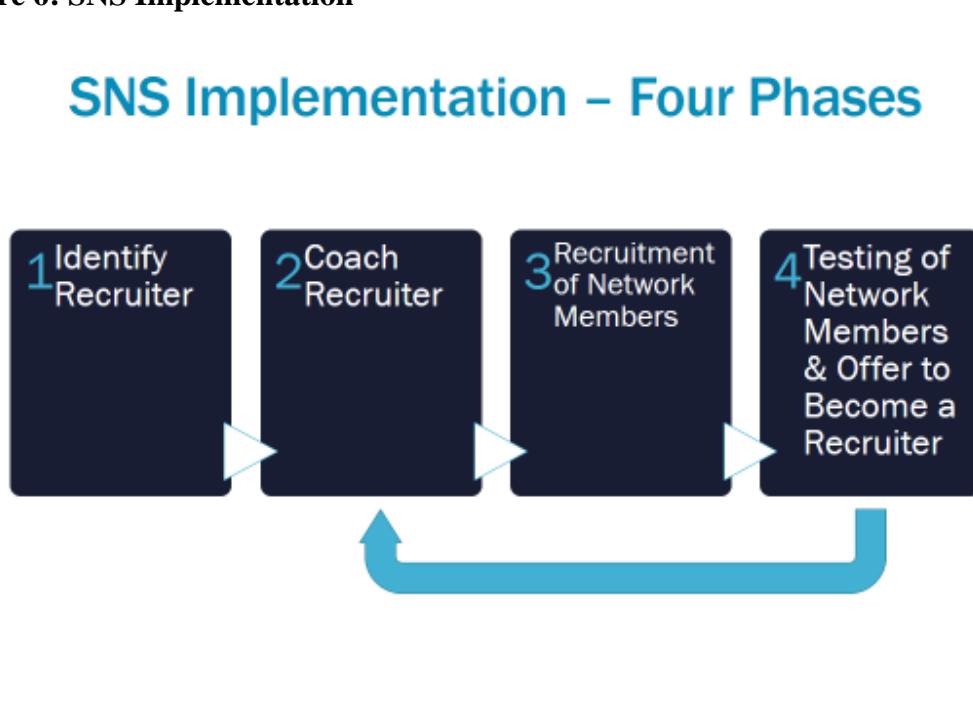
SNS processes shall involve training of health workers, identification of facility based focal persons, identification of eligible high-risk clients including KPs and other high-risk individuals, conducting risk assessment for each social contact, develop appropriate notification plan(s) for the social contact (time, method, means of contact) to ensure he/she receives an HIV test.

Note:

- i) Social contacts being tested should be linked to appropriate preventive, care, treatment and support services and
- ii) All named social contacts will be subjected to the HTS screening tool

SNS shall be implemented following four phases as illustrated in figure 6 below.

Figure 6: SNS Implementation



Integrating SNS into HTS shall help identify undiagnosed PLHIV, and link them to ART and other support services. SNS is an effective HIV case finding strategy for KPs and other high-risk individuals

Programmatic evidence shows that SNS results in higher HIV positivity in comparison to conventional HTS approaches, suggesting its potential for identifying additional PLHIV.

6.3 Accreditation of Health facilities to offer index client testing services

Policy statements:

- a) Index Client Testing (ICT) services shall be provided with adherence to minimum standards in order to meet expectations of the consumers and community.
- b) All health facilities offering Index Client Testing /APN will be assessed annually and accredited to ensure adherence to minimum index testing standards
- c) Only sites that meet the accreditation requirements shall be permitted to provide Index Client Testing (ICT) services

Index Client testing (ICT) services should meet the HTS ethical principles of the 5Cs which include consent, confidentiality, counselling, correct test results and connection to HIV

prevention, care, treatment and support services. Health facilities (sites) offering ICT services should ensure that appropriate systems are in place for testing, identification and responding to clients who disclose and fear or experience IPV from (a) named partner(s)¹⁵.

There should be mechanisms in place to monitor and address adverse events arising from the provision of ICT services.

The assessment shall be conducted using the minimum standards checklist provided by OGAC as it meets all the essential elements for quality ICT. The tool consists of 5 sections however, section one (1) which consists of 33 checklist scores shall be the minimum for accreditation.

Approach

Accreditation for Index Testing (AIT) shall be led by MOH with support from DPs and IPs working closely with District Health Teams (DHTs).

Each facility will be assessed by a team of a minimum of three persons including MOH/DHT representative, IP representative and CSO/KP representative or equivalent.

Preparing health facilities for accreditation

Facilities shall prepare for ICT assessment prior to the team's arrival. This shall ensure that relevant documents, tools and SOPs relating to ICT are retrieved, in place and also the responsible Health workers are available.

Assessment for Accreditation

A team shall assess a maximum of two health facilities in a day to allow adequate time for providing feedback and report writing

Data management and sharing plan

Each facility shall have a copy of the assessment tool indicating performance and remedial plans where necessary. A copy of the assessment tool shall be entered into the national dash board.

MOH or a delegated agency shall be a repository for data. Data should be used to inform further planning for ICT scale up, assessments, accreditation and quality improvement.

MOH should share data with various stakeholders implementing ICT.

The Post Assessment period

Facilities that meet the set standards (**score 33/33**) shall be recommended for accreditation. Reassessment will be done after 12 months to evaluate adherence to minimum standards. Quarterly support supervision/mentorships will be conducted to support facilities to maintain standard delivery of ICT services.

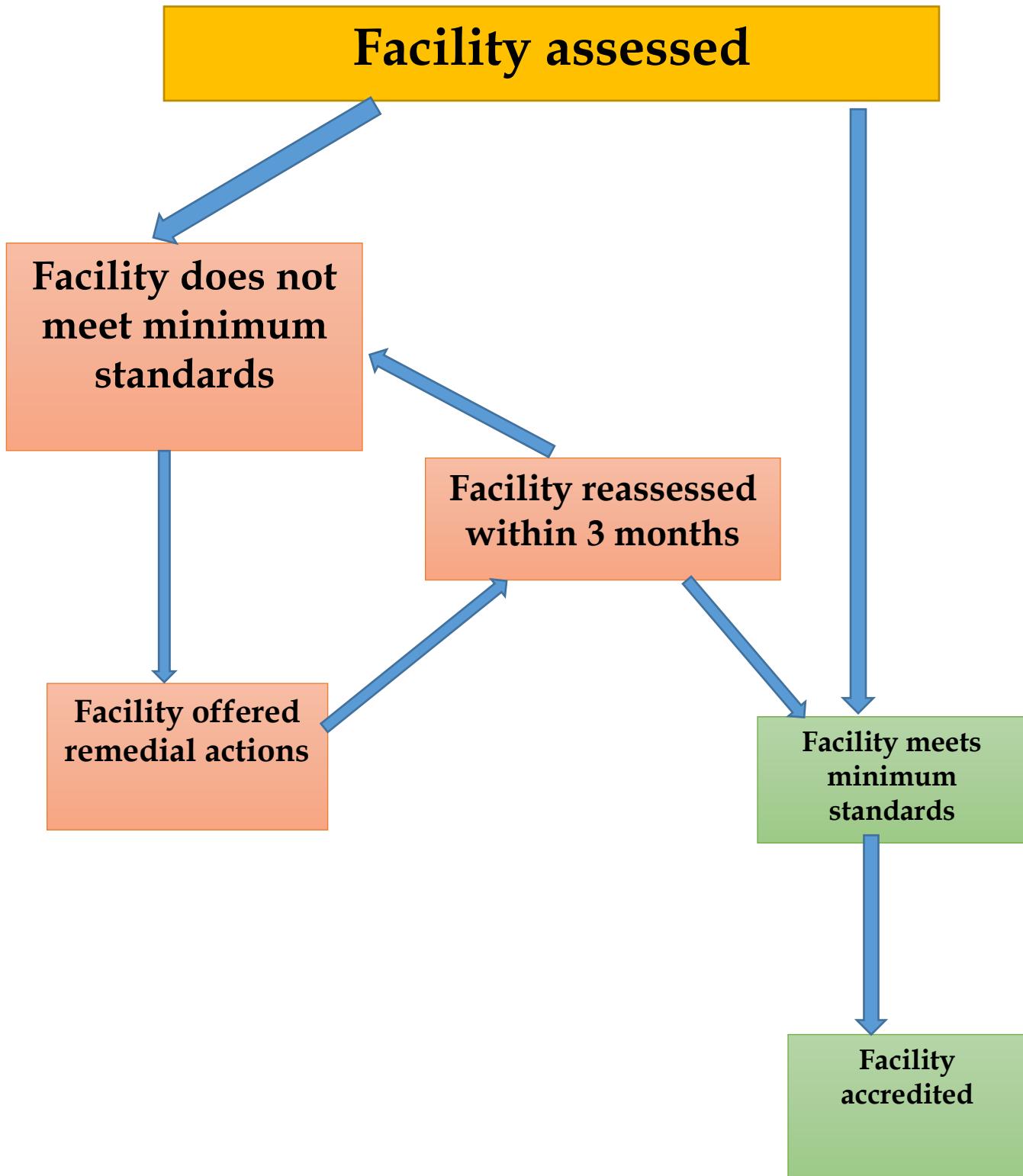
Facilities that fail to meet minimum standards shall be provided with an improvement plan/ remedial action as shown in figure 7 below¹⁵. These facilities shall have up to 3 months to meet

¹⁵National Certification Framework for HIV Rapid Testing

<https://www.uvri.go.ug/sites/default/files/files/Certification%20Framework%20HIV%20Rapid%20%283%29.pdf>

the required minimum standards upon which they will be reassessed, however reassessment can be conducted even when the stipulated 3 months have not elapsed¹⁵.

Figure 7: Index Client Testing Services Accreditation



6.4 HIV self-testing (HIVST)

HIV self-testing (HIVST) is a process in which a person collects his or her own specimen (oral fluid or blood) and then performs a test and interprets the result, often in a private setting, either alone or with someone he or she trusts^{13, 16, 17}. Prior to offering HIVST, clients shall be screened for eligibility according to the HTS screening protocol. HIVST is a test for triage and is not sufficient to make an HIV-positive diagnosis. Therefore, a reactive (positive) self-test result should be confirmed using the validated national testing algorithm by a trained HTS provider. HIVST results shall be reported and documented accordingly¹³.

POLICY STATEMENT

- a) HIV self-testing shall be offered as an additional approach to HIV testing services in Uganda.
- b) These implementation considerations are based on the oral-fluid and blood-based HIVST kits.
- c) Persons aged 2 years and above shall be considered for HIVST depending on eligibility
- d) HIV self-testing is a screening test and is not sufficient to make an HIV-positive diagnosis. Therefore, a reactive (positive) self-test result should be confirmed using the validated national testing algorithm

This section provides guidance on

1. Implementation and scale-up of HIVST in the most ethical, effective, acceptable and evidence-based manner.
2. Integration of HIVST into the existing community and facility-based HTS approaches.

Benefits of HIVST

HIVST has a number of benefits which are summarized as follows¹³:

- Promotes access to and creates demand for HIV testing among those unreached by existing services.
- Convenient and discrete
- Increases patient autonomy
- Assures confidentiality
- Empowers individuals
- Reduces the work load of a health provider
- Promotes self-care

¹⁶Uganda National Self-Care guidelines for Sexual and Reproductive Health and rights, 2020

¹⁷WHO Consolidated guideline on self-care interventions for health: sexual and reproductive health and rights. Geneva: World Health Organization; 2019

<https://apps.who.int/iris/bitstream/handle/10665/325480/9789241550550-eng.pdf>

Guiding Principles for Implementation of HIVST

The following five guiding principles should be followed while delivering HIVST services¹³:

i. Consent

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

ii. Confidentiality

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

iii. Counselling

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

iv. Correct results

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

v. Connection to care

All clients seeking HIVST should be referred and linked to HIV post-test services based on outcome of the test and other support services. Those with HIV negative HIVST results should be supported and/or linked to relevant HIV prevention services. Individuals whose HIVST results are reactive should be advised to go for confirmatory HIV diagnosis at the nearest health facility. If found to be HIV positive should be linked to HIV treatment services. Information on linkage including a helpline for any additional support may be provided on the separate referral card. A catalogue or directory of health facilities/services can be displayed at every HIVST kit distribution point.

Approaches to HIVST

HIVST will be provided through two main approaches¹³:

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

Directly assisted self-testing

A trained provider (a health worker, caregiver, distributor or peer) supervises/assists an individual in performing the HIVST. This involves an in-person demonstration before or during HIVST, on how to perform the self-test and interpret results¹³. This is in addition to the manufacturer-supplied instructions for use and other materials.

Process

- Explain the procedure of conducting HIVST & interpret results to the user.
- Demonstrate how to perform the self-test and how to interpret results.
- Provide additional information using leaflets and/or instructional video(s).

- Confirm understanding of the procedure by the user.
- Answer any questions raised by the user
- Issue the HIVST kits
- Provide appointment card including information on linkage to HIV prevention services and further testing for diagnosis among those with a reactive self-test.
- Provide a toll-free line, contact details for any other support information that the client may require.

Unassisted Self-Testing

Individuals are given HIVST kits and they conduct the test and interpret results without any supervision or assistance from a trained provider (health provider, distributor or peer)¹³. However, general information on how to conduct the test should be made available to the user with additional manufacturer's instructions, telephone hot line, instructional videos, leaflets, social media and other internet-based links.

Process

- The individual uses information about the kit provided by a trained provider (health provider, distributor or peer), guidance from the manufacturer-provided instructions to conduct HIVST and interprets results.
- Individual may seek or obtain additional information such as instructional videos through social media, toll free line or any other internet-based platforms from a service provider.
- The service provider should provide additional information on linkage to HIV prevention services and further testing for individuals who may have a reactive self-test.

Target Populations for HIVST

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

- Children 2 -14 years (Care-giver assisted screening)
- Adolescents 15-19 years
- Individuals 20-34 years
- Individuals 50 years and above
- Men including partners of Pregnant women and lactating mothers
- Key Populations and Priority Populations
- General population (through the Private Sector)

HIVST Delivery Models /Distribution Channels

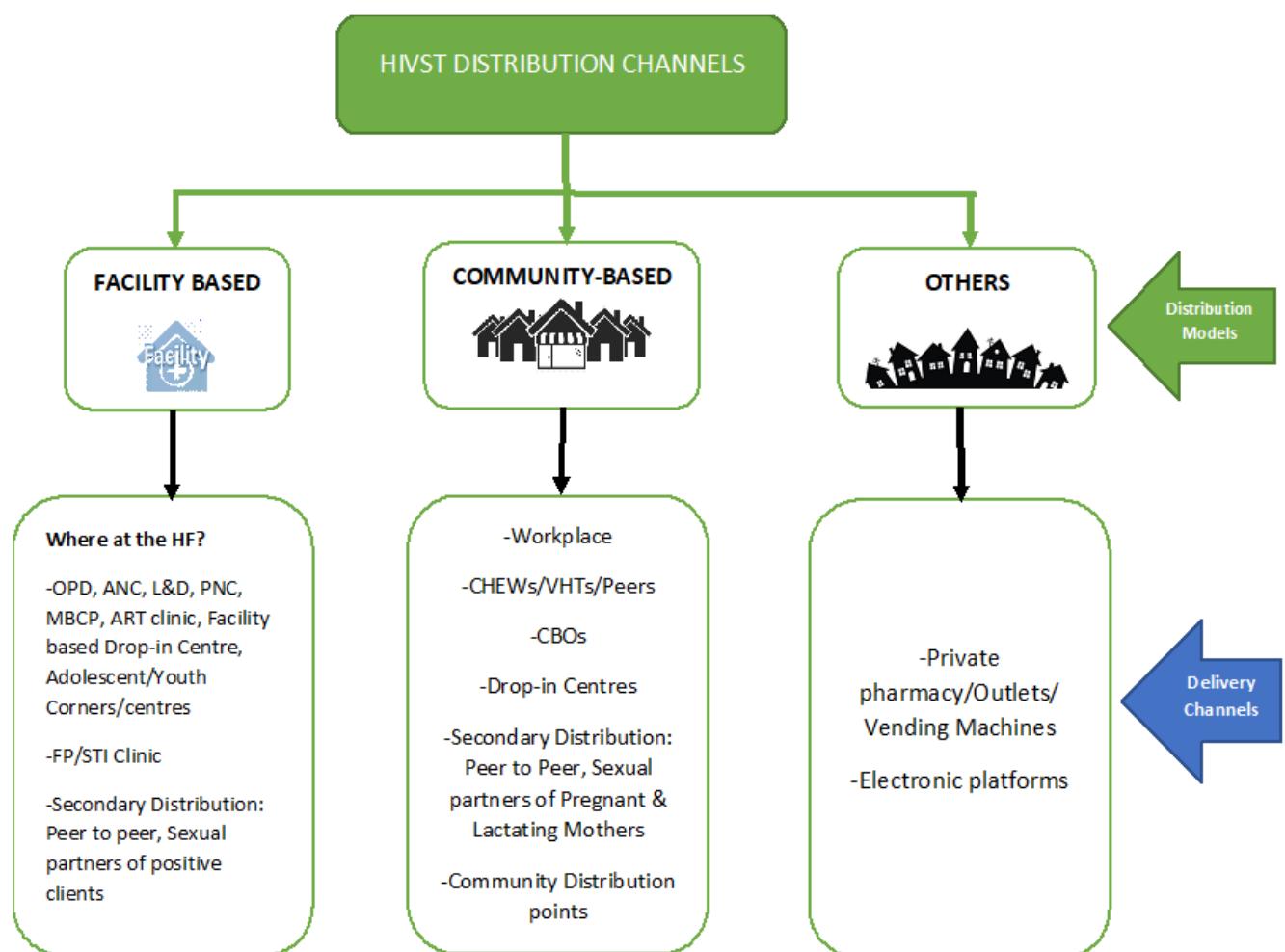
HIVST will be implemented through different delivery models/distribution channels targeting different populations in the public and private sectors. Figure 8 shows the distribution channels that will be used to implement HIVST. Additional channels may be adopted/adapted based on evidence.

HIVST kits can either be distributed via primary or secondary modes both at the facility or community

HIVST kits shall be distributed to primary recipients for self-use while in secondary distribution, the primary client takes the kit to another recipient.

In secondary distribution mode, a primary client will take the HIVST kit to their partner(s) or social contacts along with instructional materials on how to conduct HIVST and interpretation of the self-test results. Additional informational for linkage will also be provided.

Figure 8: HIVST Distribution Channels



6.4.1 Facility Based Delivery Models

HIVST kits will be distributed at all entry points within the health facility where the target population can be identified. Individuals will be offered HIVST on an opt-out basis.

Individuals opting for HIVST within the health facility are at liberty to conduct the test using either assisted or unassisted approaches. HIVST points will include private spaces or rooms that are well lit, with good ventilation, quiet and free from interruptions.

During the HIVST process, a service provider shall remain within reach for the client to seek additional support. Clients opting to test outside the health facility shall be provided with the HIVST kit and additional support information.

6.4.2 Community Based Delivery Models

a) Peer-to-Peer Delivery Model

In this model, Peer Leaders of targeted populations will be identified and trained on HIVST and basic HIV counselling. The Peer leaders shall be given kits and data collection tools on a weekly basis. These peer leaders will be attached to a health facility or a DIC for supervision by a qualified health worker and will be required to report back to the facility on a weekly basis.

b) Work Place based Model

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

c) Community based distributor (CBD) delivery Model

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

6.4.3 Other delivery Models

a) Pharmacy based delivery model

In this model, private pharmacies will be outlets to provide over-the-counter (OTC) sales of HIVST kits that are approved for use in the country. The general population will purchase kits and test either assisted or unassisted. Manufacturer instructions on how to use the kit are a prerequisite for all kits being sold. Community members shall be informed about the availability of HIVST kits on sale at private pharmacies. In addition, vending machines may also be used.

b) Electronic models (Internet-based delivery model /Mobile applications)

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

c) Secondary Distribution Channel

Secondary distribution of HIVST kits may occur both at health facility or community level. In this model, a client such as a sex worker or pregnant and lactating mother will take the HIVST kit to their partner(s) or social contact network along with instructional materials on how to conduct HIVST and interpretation of the self-test results. Additional information for linkage will also be provided.

Clients who receive HIVST kits should be encouraged to share HIV test results whether reactive or not with the providers where the kit was distributed from.

Partners of pregnant and lactating mothers that are absent should be sent an HIVST kit through their partner after IPV assessment.

Misuse and Adverse events associated with HIVST

Misuse and adverse events associated with HIVST should be assessed pre-and post-distribution¹³:

- Assess harm and adverse events associated with HIVST pre- and post-distribution.
- Individuals who disclose any form of violence by an intimate partner or social contact should be offered immediate support. Health care providers should offer first line support when clients disclose violence.
- There should be a system (framework) in place to report and document adverse events experienced during the provision of HIVST services. Providers experiencing adverse events should equally be offered first line support.
- Do not provide HIVST kits for secondary distribution to clients experiencing IPV
- Partners of individuals experiencing IPV should be offered alternative testing services.
- These events should be appropriately reported and documented using the standardised HMIS tools.
- HIVST is NOT suitable for users who are taking Anti-Retroviral Treatment
- Document and record all adverse events in the standardized HMIS tools

6.5 Strategies for promoting HTS accessibility

HIV testing services shall be delivered using strategies that promote access and utilization to ensure effectiveness and efficiency

HTS programming strategies and practices can be adapted to expand HTS and make it more accessible, efficient and cost effective. These strategies include:

- Integration of HTS into other health services
- Decentralization of HTS to primary health-care facilities and outside the traditional health care system to the community settings.
- Task sharing of HTS responsibilities to increase the role of trained lay providers

6.6 Integration of HTS

HIV testing services shall be provided at various service points within the health facility and community as part of routine service delivery.

HIV testing services shall be incorporated in all health plans and programs and therefore be an integral component of routine health care services

Integration involves provision of HTS within other health programs for sustainability, minimizing missed opportunities hence reducing HIV-related stigma and discrimination, improving utilization of services and enhancing convenience for clients¹⁸

HTS should continue to be integrated into the health services delivery systems in a manner that facilitates access and increases impact. Integration of HTS programming results in effectiveness and efficiency in service delivery: Integration of HTS with other health services will lead to its increased accessibility.

The primary purpose of integration is to make HTS more convenient for people coming to health facilities largely for other reasons other than HTS. This will increase HIV testing uptake. For the health system, integration may reduce duplication of services and improve coordination.

6.6.1 Integration of HTS in other health services

Integration with Tuberculosis (TB) services

All HTS clients should be screened for TB symptoms during pre-test counseling.

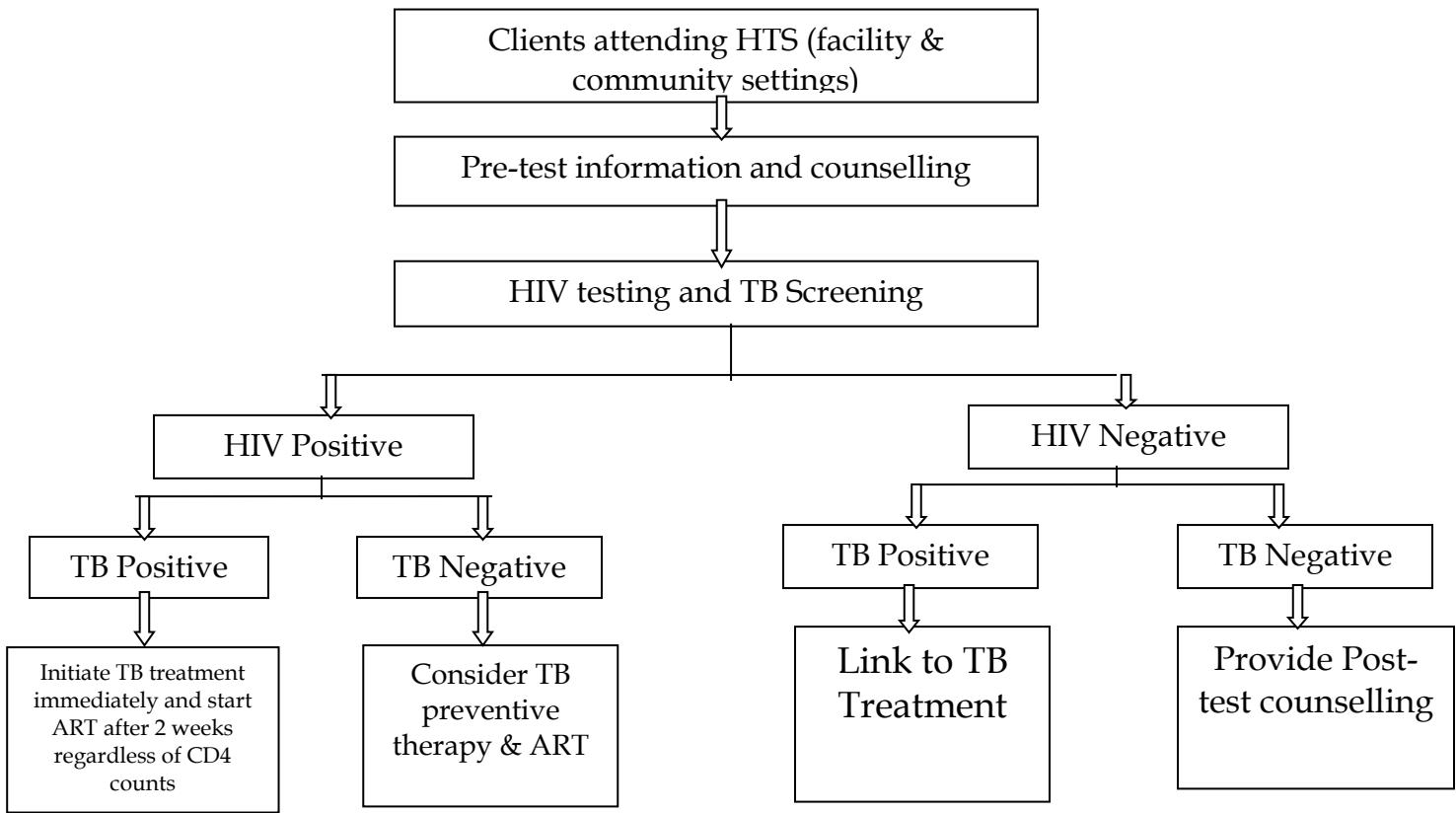
All patients with active or presumptive TB should be tested for HIV using the PITC approach.

Clients diagnosed with active/ presumptive TB and/or HIV should be immediately linked to appropriate care and treatment service points in accordance to the national policy and guidelines as shown in figure 9 below.

¹⁸National HIV Testing Services Policy and Implementation guidelines Uganda, 2016

<http://library.health.go.ug/sites/default/files/resources/UGANDA%20HTS%20POLICY%20AND%20IMPLEMENTATION%20GUIDELINES%202016%20%282%29.pdf>

Figure 9: HIV/TB testing and Screening Algorithm in HTS



Key approaches for TB/HTS integration should include the following:

- Active promotion of HTS among TB clients through the distribution of IFUs and health education talks.
- Health service providers should routinely offer HTS to all TB patients, their family members and other contacts as standard of care.
- On site HTS should be introduced at TB clinics and routine screening of all clients with presumptive and diagnosed TB should be done. Partners of known HIV-positive TB patients should be offered HTS with support for mutual disclosure.
- Clinical assessments for TB among HTS clients who test HIV positive should be conducted.
- Presumptive TB patients should be referred to the TB clinic for additional assessments.
- Health workers and community service providers should be trained on the integrated approach.
- Clients with presumptive and diagnosed TB should be encouraged to attend HTS sites with their partners and house hold members.

Specific considerations for cryptococcal and TB meningitis.

Among people living with HIV with TB meningitis or other forms of meningeal infection such as cryptococcal meningitis, earlier ART is associated with more severe adverse events and increased mortality with cryptococcal meningitis. For people living with HIV and TB meningitis, immediate ART is associated with more severe adverse events compared with initiating ART two months after the start of TB treatment¹⁹.

- ART should be delayed by 4–6 weeks of ART following initiation of treatment for cryptococcal meningitis¹⁹.
- ART should be delayed for at least four weeks (and initiated within eight weeks) after treatment for TB meningitis is initiated²⁰.

Immediate ART initiation is not recommended for adults, adolescents and children living with HIV who have cryptococcal meningitis because of the risk of increased mortality and should be deferred by 4–6 weeks from the initiation of antifungal treatment.

Integration with sexually transmitted Infections (STIs) services

STIs are recognized co-factors for HIV transmission and acquisition, and have been associated with increased risk of mother-to-child transmission of HIV.

HTS clients should be informed about STI services available on site and their importance. If STI services are not available on site, clients should be referred to the nearest facility or service point where STI treatment can be obtained.

It is recommended that STI screening be performed on the same blood sample as that used for HIV testing and results provided on the same day.

All clients diagnosed with STIs should be offered HTS. STI infections may indicate recent engagement in unprotected sex and thus a heightened risk of HIV acquisition.

People receiving STI treatment may also have primary HIV infection and therefore, a high HIV viral load. Diagnosing individuals with HIV/STI co-infection(s) is important both as a prevention strategy and to improve the quality of care for people with HIV.

On-site STI treatment should be offered immediately to any HTS client diagnosed with STI.

Integration with Family Planning (FP) services

Basic FP information should be incorporated into all HTS counselling sessions for both HIV-positive and HIV-negative clients. HTS information should also be offered at all FP settings.

¹⁹Guidelines for managing advanced HIV disease and rapid initiation of antiretroviral therapy. Geneva: World Health Organization; 2017. <https://www.who.int/publications/i/item/9789241550062>

²⁰Guidelines for treatment of drug-susceptible tuberculosis and patient care, 2017 update. Geneva: World Health Organization; 2017. <https://apps.who.int/iris/bitstream/handle/10665/255052/9789241550000-eng.pdf>

The risk of mother-to-child transmission and the benefits of FP should be clearly explained.

‘Dual protection,’ which is use of condoms for HIV and STI prevention and hormonal contraceptives for FP, should be emphasized during counselling sessions.

In the event that FP services are not available, clients should be counselled and referred for FP at the nearest FP service delivery point.

Integration with Maternal, Neonatal and Child Health (MNCH) services

All women and their partners should have access to HTS including information, before conception so that they make informed decisions about pregnancy and family planning.

PITC should be offered as part of the MNCH care package to all pregnant and breastfeeding women in accordance with the national PMTCT guidelines.

In the context of triple elimination of mother-to-child transmission of HIV, syphilis and hepatitis all pregnant and breastfeeding women should have access to integrated HIV and syphilis testing services.

HIV, syphilis, and hepatitis testing should be based on the national algorithm for pregnant and lactating women

Women and their partners seeking HTS, importance of eMTCT should be given.

In order to improve HIV diagnosis among HIV Exposed Infants (HEIs), EID will be integrated within Early Childhood Development (ECD) programs / activities.

In Young Child Clinics (YCC) and other points of care, all HIV exposed and suspected children must be offered HTS including their mothers. Those identified during immunization or other service points should be offered HTS.

All HIV-positive children identified in HTS should be checked to ascertain if they received all immunizations and if not, they should be referred for immunization.

Integration with Safe Male Circumcision (SMC) Services

All males accessing SMC should be offered HTS as an integral component of SMC, in accordance with the national guidelines

HTS Implementation during Public Health Emergencies

Amid public health emergencies for instance pandemics such as COVID-19, HTS implementation shall follow national guidance on Infection, Prevention and Control measures to minimize transmission of the pandemic.

HTS providers and their clients must adhere to the MOH Infection, Prevention and Control SOPs during service provision, to ensure continuity of services.

6.6.2 Decentralization of services

Decentralization refers to providing HTS in peripheral health facilities and community-based settings. Providing HTS in places closer to people's homes reduces transportation costs and waiting time experienced in health facilities hence increases uptake of HTS.

Decentralization of services, however, may not always be appropriate or acceptable to potential users. In some settings centralized HTS may provide greater anonymity than neighborhood HTS especially for KPs or others who are concerned about stigma and discrimination.

In all decentralized settings HTS will be provided following risk-based screening of all individuals.

For facility-based interventions, HTS should be provided up to the HC II and community levels. Where HTS is provided up to HC II and community, HTS implementers should ensure provision of quality of services through regular support supervision.

At community level, the context, needs, service gaps and overall costs and benefits should be weighed to decide where HTS should be decentralized.

6.6.3 Task sharing of HTS

Uganda continues to face shortages of trained health workers. **Task sharing** is the rational redistribution of tasks between cadres of health-care providers and is a pragmatic response to health workforce shortages.

Task sharing to trained Lay providers seeks to enable the existing workforce to provide HTS to more people; hence facilitating efforts to decentralize HTS.

Task sharing to community-based health workers may help address the needs of KPs, PPs and VPs. It aims at improving access, coverage and quality of HTS.

The following criteria should guide the selection of lay HTS providers:

- Should be trustworthy
- With ethical and professional conduct
- Knowledgeable about what they are doing
- Polite
- Proficient in dealing with sensitive issues
- Able to listen
- Basic required qualifications. (*See section 8.5 Human Resources for HTS under HTS health systems requirements*)

Lay providers shall be trained, mentored and supervised to perform their duties as per the accepted competency standards to ensure that they offer quality HTS. They should be trained using the standard training curriculum. (*See section 8.5 Human Resources for HTS under HTS health systems requirements*)

6.7 The HIV Testing Services Protocol

HTS service providers shall adhere to the nationally approved HTS protocol for adults and children as per the various approaches and models.

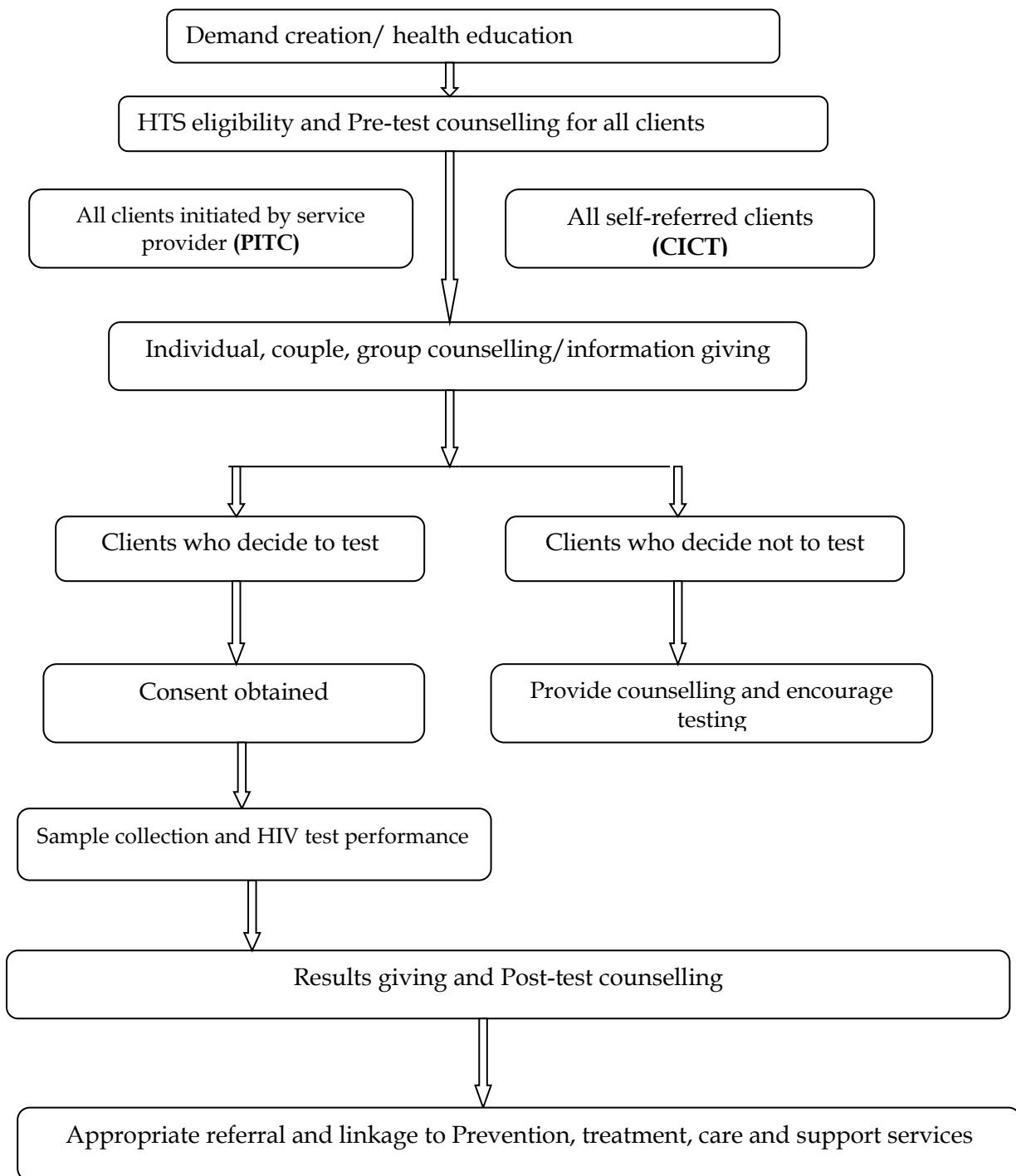
HTS providers shall adhere to the recommended counselling and testing procedures/protocols as detailed in each approach.

The HTS protocol describes the minimum steps that shall be followed in order to provide quality and effective HTS. For HTS to be complete, the following key steps must be undertaken:

- Demand creation/ health education
- HTS eligibility/Pre-test counseling/ information giving
- Testing for HIV
- Post-test Counseling
- Linkage into Prevention, Treatment, Care and support services

This is summarized in figure 10 below.

Figure 10: The HTS Protocol



6.8 Demand Creation

Demand creation refers to using communication approaches that influence attitude change, perceptions, and social norms to demand and utilise HTS. It is related to using media and other communication strategies to create interest in accessing and ultimately increasing use of HTS²¹.

Several tailored interventions and approaches shall empower communities to demand and utilize HTS. Demand creation approaches shall include; mass media, social media, interpersonal communication, community dialogues, edutainment and use of champions/ peer mobilisers/ satisfied users.

HTS implementers should involve target audiences in the planning and implementation of demand creation interventions to promote ownership and sustainability.

Demand Creation shall be used to:

- Motivate people to change their attitudes and perceptions and adopt positive HTS health seeking behaviors and sustain them.
- Address barriers to HTS utilization.
- Provide a supportive environment for HTS uptake at the household/family, community and health facility level.
- Motivate HIV positive clients to start ART on the same day and HIV negative clients to adopt risk reduction practices.
- Educate and inform secondary audiences about HTS to create an enabling environment for HTS uptake.

HTS implementers should use existing community structures and resources for mobilizing target populations. Such structures include:

- The Local Council system
- Champions/ peer mobilisers/ Satisfied users/ YAPS
- Informal groups including Village Savings and Loans Associations (VSLA)
- Cultural leaders
- Religious structures
- Formal structures like schools and health facilities

Eligibility screening and Pre-test counselling

Individuals will be subjected to eligibility screening using the standard screening tools prior to HIV testing (refer to Appendices A and B)

All persons accessing HTS shall be provided with quality counselling which will include pre-test information giving and consenting.

²¹What works for generating demand for HIV Testing Services. Geneva: World Health Organization; 2019.

<https://apps.who.int/iris/bitstream/handle/10665/329967/WHO-CDS-HIV-19.33-eng.pdf?sequence=1&isAllowed=true>

HTS clients shall be provided with pre-test information through individual, couple or group information sessions and through media such as posters, brochures, websites and short video clips shown in waiting rooms. When children and adolescents are receiving HTS, information should be presented in an age-appropriate way to ensure comprehension.

Intensive pre-test counseling is no longer strongly recommended and may create barriers to HIV testing services delivery. Individual risk assessment and individualized counseling during the pre-test information session is also kept at a minimum.

6.9 Counselling

Clear and accurate information, education and communication on HTS shall be provided to all persons through pre-test and post-test counselling to enable one to make appropriate decisions related to HIV testing.

Counselling is a core principle in the provision of HTS. Counselling is central in ensuring that HTS adheres to the human rights; is provided with utmost privacy and respect to ensure confidentiality; testing processes are monitored for quality to ensure correct test results are given and referral and linkage is done to ensure clients are linked to further care as per their HIV test results. This sub-section describes how counselling should be provided across the HTS continuum.

All persons accessing HTS shall be provided with quality counselling which will include non-judgemental, accessible and client centred pre- and post-test counselling.

Pre-test counselling:

Pre-test counselling can be conducted in a group or at an individual level. It encompasses

- Re-assurance about confidentiality
- Information pertaining to the modes of HIV transmission
- Benefits of testing for HIV
- Assessment for client risks
- Possible results and their implications
- A brief procedure of HIV testing process
- Importance of disclosure including mutual disclosure
- The potential for incorrect results if a person already on ART is tested
- Services available in the event of an HIV diagnosis, including ART.
- A brief description of prevention options and encouragement of partner testing for sexually active individuals
- An explanation of the informed consent form and possibility of opting out
- Such other relevant information as the counsellor may deem necessary

Post-test counselling:

Post-test counselling shall be provided to individuals, couples, and care givers in a private setting that promotes confidentiality with the aim of informing the client of their HIV results and enabling them to cope with the test outcome. HIV test results will determine the

counselling messages to be given to the client. Confidentiality and privacy should be observed during result giving. Post-test counselling should not be provided in groups.

For PITC, if the client is too ill or unconscious; the provider should wait until it is appropriate to give the results or consider giving the results to the next of kin.

When individual members of a couple receive pre-test counselling and testing separately, the service provider should reinforce the benefits of and support the disclosure of test results to the spouse or sexual partner.

a) Post-test counselling for HIV negative results;

It encompasses

- Preparation of client(s) and assess readiness to receive test results
- Assessing client's understanding of test outcome and its implications
- Importance of repeat testing where there is recent exposure.
- Additional support and linkage for those with significant ongoing risk to HIV infection. (SMC, PEP, PrEP, condoms, STI management, psychosocial support and risk reduction strategies)
- Importance of disclosure, partner notification, knowing sexual partner(s) status and availability of partner and couples testing services
- Opportunity for the client to ask questions and seek further clarification.

b) Post-test counselling for HIV positive results;

An HIV diagnosis is a life-changing event and before disclosing positive HIV test results, the provider should keep in mind the 5C's of HTS.

It encompasses

- Preparation of client(s) to receive collect test results
- Test results and their implications
- Discussing client's immediate concerns and helping him/her decide who in her or his social network may be available to provide immediate support
- Provision of clear information on ART and its benefits, reducing the risk of HIV transmission as well as where and how to obtain ARVs
- Making an active referral for a specific date and time
- Same-day enrolment and ART initiation
- Follow-up of clients who are unable to enrol in HIV care on the day of diagnosis
- Modes of transmission and preventive measures.
- Linkage to ART, prevention and support services.
- The importance of notifying significant others and sexual partner(s), risks and benefits of disclosure
- Information on HIV prevention, including information of reduced transmission risk

- when virally suppressed on ART, provide male/female condoms and lubricants and guidance on their use
- The importance of index testing (sexual partners, biological children and other family members of the client)
- Assess the risk of IPV and discuss possible steps to ensure client safety
- Assess for psychotic depression and the risk of self-harm and/or suicide as well as other mental health consequences of an HIV positive diagnosis
- Provide additional linkage to treatment and support services as deemed appropriate for instance TB, treatment for opportunistic infections, STI screening, contraception, ANC
- Such other information as the counsellor may deem necessary.
- Opportunity for the client to ask questions and seek further clarification.

c) ***Post-test counselling for HIV inconclusive results;***

It encompasses

- Preparation of client(s) to receive test results
- Test results and their implications
- Importance of repeat testing after 14 days
- Additional support and linkage to preventive services for those with significant ongoing risk to HIV infection.
- Importance of disclosure, knowing sexual partner(s) status and availability of partner and couples testing services

Opportunity for the client to ask questions and seek further clarification.

Counselling for HIV testing should be provided in accordance with approved and relevant HTS protocols. There should however be variation in the content and emphasis of the counselling sessions depending on the HTS approach.

Counselling for children should be age appropriate²².

- For children aged below 12 years: Counselling should be offered to the parent/guardian. The child should only attend the counselling session if the parent/guardian finds it appropriate for him/her to participate.
- For children aged 12 years and above: Individual counselling should be offered to the child unless the child prefers to have the parent/guardian to participate in the counselling session.

Special Considerations for HTS

HTS will be appropriately adjusted to cater for special situations such as: pregnant women and postpartum mothers, people with physical, mental and sensory disability, blood and other tissue donation, occupational and non-occupational exposure, unconscious patients, persons with temporary mental impairment as detailed in table 3 below;

²²Kranzer K, et al. Barriers to Provider-Initiated Testing and Counselling for Children in a High HIV prevalence setting: A mixed methods study. PLoS Med 2014; 11(5): e1001649.

Table 3: HTS in special Situations

Special Situation	Guidance
Pregnant women and Postpartum mothers	<p>Pre-test information or health education for women who are or may become pregnant or are postpartum should include:</p> <ul style="list-style-type: none"> • Potential risk of transmitting HIV to the infant • Reduction of mother-to-child transmission, including enrollment onto ART to prevent HIV transmission to the infant • Infant feeding practices to reduce HIV risk transmission • Benefits of early HIV diagnosis for mothers and infants • Benefits of partner testing. <p>Post-test counseling for pregnant and post-partum women who are diagnosed with an HIV infection should include the following, in addition to the standard messages described above for all people diagnosed with HIV infection:</p> <ul style="list-style-type: none"> • Childbirth plans to ensure they deliver under a qualified health worker • Initiate lifelong ART for their own health and PMTCT • Partner testing for support and involvement in the PMTCT interventions • Screening for TB and syphilis • Counseling on adequate maternal nutrition, including iron and folic acid • Infant feeding counseling to avert malnutrition and HIV transmission in their babies • Giving ARVs to their babies for PMTCT • HIV testing and follow up for the infant for early diagnosis and enrollment into care
Couples or partners who request to be tested together	<p>Pre-test: Couple counseling/partner testing promote mutual disclosure of HIV status and increases adoption of prevention measures, especially in the case of discordant couples. Pre-test counselling sessions should avoid history of past sexual behavior or risks, as this is may create tension for the couple. The person conducting a pre-test information session should make it clear that both testing and post-test counseling can be provided individually, and then the couple can be supported to disclose to each other.</p> <p>Post-test: Post-test counseling for sero-discordant couples may be challenging as these results may be difficult for the provider to explain and for the couple to accept. There may be need to engage a senior counselor and/or clinician in the disclosure process and also attach these couples to discordant couples' support groups. HTS providers should, as much as possible adhere to the protocol for discordance counseling.</p>
Key Populations	<p>Pre-test: KPs may encounter discrimination and stigmatization. All facilities should train health workers so that they can provide KP-friendly support and prevention services.</p> <p>Post-test: Intense post-test counseling combined with follow-up counseling by Peer Leaders will be availed to KPs. Those who test positive should be enrolled in HIV care and initiated on treatment immediately. Those who test negative should be supported to adopt risk reduction behaviors/practices.</p> <p>KPs who test HIV-positive may lack social networks and/or a supportive family to help them deal with their diagnosis. These people may need additional counseling as well as peer support services to cope with the diagnosis. A peer counselor may help this client cope with the diagnosis and support linkage to care and treatment by serving as a "Linkage Facilitator" "to assist them to find, choose and obtain a full range of services."</p>
Unconscious patients	<ul style="list-style-type: none"> • Consent should be obtained from the next of kin, guardian or authorized person • The service provider should offer adequate counselling and support to the authorized person. • If the next of kin asks the service provider to test the patient, he/she must exercise

Special Situation	Guidance
	discretion and in the best interest of the patient.
Adolescents	<p>Along with standard messages for all those diagnosed with an HIV infection, post-test counseling for adolescents with HIV should include:</p> <ul style="list-style-type: none"> • Tailored help with linkage to HIV care and treatment • Counseling, referral and linkage to specific psychosocial and mental health services tailored to both the situation in which infection happened and the developmental age of the individual • Information on adolescents' rights and responsibilities, especially their right to confidentiality and health care • An opportunity to ask questions and discuss issues related to sexuality and the challenges they may encounter in relationships, marriage and childbearing • Individualized planning on how, when and to whom to disclose HIV status and engage families and peers in providing support • Referral for small-group counseling and structured peer support groups, which may particularly benefit adolescents with HIV
Patients with mental illness	<ul style="list-style-type: none"> • Since patients with mental illnesses have cognitive impairment, consent should be obtained from the next of kin, guardian or an authorized person. • Patients/clients with temporary mental impairment, e.g., those who are under the influence of drugs or alcohol and unable to give informed consent, the service provider should not offer the test. HIV testing is not an emergency. However, where the service provider deems it necessary, he/she should make a decision to test for HIV at their discretion for the benefit of the patient.
Persons with hearing/speech disabilities	The health facility should provide for appropriate means of communication for sign language services through appropriate training of staff or collaboration and referral for sign language services.
Persons with visual disabilities or reading difficulties	HTS providers should be sensitive to and provide verbal explanations to clients with visual disability.
Post-exposure prophylaxis	<ul style="list-style-type: none"> • In case of occupational or non-occupational exposure, the source person shall be tested with or without consent. In the absence of the source person, the HTS provider shall consider the source as HIV positive and provide PEP • For the exposed person, HIV testing for PEP shall follow the HTS protocol
Blood and other tissue donors	HIV testing should be done as part of the donation process. Donors however shall be given an opportunity to know their results.

6.10 Confidentiality

Confidentiality shall be maintained in the process of providing HTS services. Confidentiality may only be broken with the CONSENT of and in the best interest of the individual.

HTS providers should ensure privacy when providing HTS services. This should include privacy of verbal communication, storage of HTS records and test results.

All information discussed with the client during the process of providing HTS should not be disclosed to anyone else without the CONSENT of the client.

While maintaining confidentiality, HTS service providers should support clients to disclose to their significant others. This is intended to promote HIV prevention and address issues of stigma and adherence to care/treatment and other prevention services.

Shared confidentiality may be acceptable where it is done in the best interest of the client to support clinical management. This may be intra-facility or inter-facility referral among service providers. In all cases, the client should be informed and he/she should consent to the need for shared confidentiality.

6.11 Correct Results

HTS Providers MUST ensure that the test results provided to clients are correct

HTS providers should provide high-quality testing services using the recommended HIV testing algorithm and adherence to the testing procedures. The following strategies should be adopted to ensure correct HIV test results:

- HIV testers should be trained and certified.
- Regularly receive technical support
- Availability and use the standard operating procedures (SOPs) and national algorithm for HIV rapid testing
- Routinely participate in the Quality Control (QC) and External Quality Assessment (EQA)
- Proper storage of HIV test kits should always be maintained.
- Ensure adequate stock levels for HIV testing supplies
- Routine monitoring of HIV testing supplies shelf life.

Dry Blood Spot (DBS) sample collection and dispatch for Deoxyribonucleic acid (DNA)/Polymerase Chain Reaction (PCR) for HIV testing should only be performed by trained laboratory staff and medical staff such as nurses/midwives or, clinical officers.

Inconclusive HIV test results or test results not yet confirmed

An HIV-inconclusive result means that the first reactive test results were not confirmed by additional testing using subsequent HIV assays. All clients with an HIV-inconclusive status should be encouraged to return after 14 days for additional testing to confirm their diagnosis (*Ref. Serial testing Algorithm*).

6.12 Consenting procedure for HTS

All persons shall consent to HTS. In situations where consent cannot be obtained from the client, the next of kin, guardian/parent or other authorised persons should provide consent on behalf of the client.

Informed consent is the voluntary agreement between a client and a service provider for the client to take HIV test. It arises from the client having received adequate information and education that enables the person to understand the benefits, need and implications of testing. In Uganda the legal age of consent is 18 years. For HTS, the age of consent shall be the age at which the individual is able to understand results, which is 12 years.

Consent for HIV testing shall be obtained and documented in the appropriate patient records and evidence indicated through signing or a thumbprint. This shall be done for both adults and children and will also include;

- Persons who are unable to make a decision such as the mentally disabled and the unconscious patients.
- Persons who are illiterate or unable to write or read
- Children below 12 years
- Persons participating in research as subjects

For purposes of preventing transmission, informed consent may not be required for the following categories of persons; -

- Pregnant women and breastfeeding mothers
- Spouses or partners of pregnant women/breastfeeding mothers
- Persons who have committed sexual offences
- Persons eligible for Post Exposure Prophylaxis
- Donors of blood, body tissue and organs

However, service providers MUST ensure that the individuals under this category understand the purpose of their testing.

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

Consent for HTS in Children

Persons aged 12 years and above shall consent to HTS and shall have a right to opt out of testing.

For adolescents aged 12 -17 years, approval of the parent or guardian shall not be a requirement for HIV testing. However, the provider shall encourage and support disclosure of test results by the adolescent to significant persons for support.

HIV testing for children less than 12 years of age shall be done with the knowledge and consent of parents or guardians and the testing must be done in the best interest of the child. For children without a parent or guardian, an authorized person, such as head of the institution, health centre, hospital, clinic or any other responsible person may consent for them.

Where a parent/guardian unreasonably withholds consent to HTS for a child; the Service Provider should use discretion to offer HTS ONLY if it is in the best interest of the child. Such situations may include: when a child is symptomatic or when the child's history is suggestive of HIV exposure.

Counselling for Disclosure of test results

HTS providers shall protect the client's privacy and guard against unlawful disclosure of clients' HIV status and being discriminated against, without compromising efforts for enhancing prevention, care, treatment and support services. Several approaches may be used to support client disclosure of HIV status as outlined below;

- ***Client self-disclosure:*** Service Providers empower the client to disclose by her/himself
- ***Provider-supported disclosure:*** Service providers support the disclosure process by the client to significant others. This gives the provider an opportunity to explain and give more information about HIV and AIDS. For couples and sexual partners, supported disclosure promotes dialogue, respect and mutual support
- ***Disclosure by a health worker to other health workers:*** This is when a clients' information is shared between providers involved in the clients' care. These disclosures should respect the basic client right to privacy and confidentiality of all medical information.

Disclosure of Test Results

Disclosure of a client's HIV status shall follow standard guidelines.

Disclosure of a client's HIV status should ONLY be done with the client's informed consent except in special circumstances such as defilement or rape. Health workers should emphasize to individuals about the necessity of informing their sexual partners if they are infected with an STI including HIV

Ethical and legal issues related to disclosure include;

Disclosure of a Client's test results to other persons.

The results of an HIV test may be disclosed to:

- Parent/guardian of a minor
- Parent/guardian of a person of unsound mind
- A legal administrator or guardian with written consent of the person tested
- A qualified /certified medical practitioner and counsellor of the individual, where the HIV status is clinically relevant
- Any other person with whom an HIV infected person is in close or continuous contact including a sexual partner if the nature of contact in the opinion of the medical practitioner or other qualified officer, poses a clear and present danger of HIV transmission to that person
- A person authorized by the HIV prevention and Control Act or any other law; or any other person as may be authorized by a court e.g., in the context of defilement or rape
- Any person exposed to blood or body fluids of a person tested.

Disclosure of HIV Status among Children and adolescents.

- Disclosure of an HIV positive status to a child should be done incrementally beginning at 5 years using age-appropriate language to accommodate their cognitive skills and emotional maturity in preparation for full disclosure by 12 years of age. This should be done upon the assessment by the provider and consent of the parent/guardian
- Disclosure to a child should be done by the parent or guardian with support from the health worker.
- In cases where a parent/guardian notices that the child is not ready for disclosure of the HIV positive status by 12 years, the health worker should provide on-going support to the process until the child is ready to be disclosed to.

- Though children 12 years and above shall consent for HTS on their own, the provider should encourage them to disclose their test results to significant persons.
- Children aged 12 years and above (Adolescents) should be given results after counselling. If the adolescent sought HIV testing alone, the provider should empower them to disclose their HIV status to caregivers and significant others to enhance their care.
- Disclosure should be made to the person with whom the child feels most comfortable.
- Children may be told the HIV status of their parents or guardians where applicable irrespective of the child's HIV status.

For all age categories mentioned above, on-going counselling and support should be provided by parents or guardians and the counsellor. Never should anyone lie to a child of any age about their HIV results.

Disclosure of HIV Status amongst Couples & sexual partner(s)

Service Providers should encourage disclosure of HIV status to sexual partner(s) or any other significant other for purposes of complimenting support and prevention.

HTS providers should discuss with recipients of care, opportunities for partner notification and where the client provides documented consent, the provider may notify the sexual partner.

During counselling, HTS providers should screen couples and partners for GBV/IPV risk using a standard screening tool. Where GBV/IPV risk is present, disclosure may be deferred to a later date; and follow up of the client should be done. These clients should be linked to other additional services for instance legal, violence mitigation and psychosocial support.

Partners of known HIV positive TB patients shall also be offered HTS and additional support provided for mutual disclosure.

6.13 HIV Testing

Nationally recommended HTS algorithms shall be the standard for HIV testing.

HIV Testing shall be performed by a certified tester in accordance to the national HIV testing algorithm.

Diagnostics for HIV

All HIV testing should be performed in accordance with the assay manufacturer's instructions. SOPs and job aids that guide the performance of HIV testing should be developed in order to minimize errors during pre-analytical, analytical, and post-analytical testing stages.

Performance characteristics of assays

The following performance characteristics should be considered when selecting assays to validate as testing algorithms;

- First line assay should have the highest sensitivity ($\geq 99\%$ sensitivity)
- Second- and third-line assays should have the highest specificity and lowest invalid rates ($\geq 98\%$ specificity)
- All assays should have very low inter-reader variability

Specimens for HIV testing

Currently, the recommended specimens for use in HIV testing remain limited to whole blood, plasma, serum, oral transudate and dry blood spots. These specimens can either be drawn by using vene-puncture or finger prick. Other specimens may be used after NHRL validates them.

Whole blood: Whole blood freshly collected by either finger prick or vene-puncture. The specimen should be subjected to testing immediately.

Serum: Collect fresh whole blood in a container without an anticoagulant. Mix by whirling the container 4–5 times immediately. Let it stand for the clot to form. Extract the serum within 30 minutes of collection of the blood sample. The serum can be stored at 2–8 °C and used for testing within 5 days or as specified by the instructions for the assay to be used.

Plasma: Collect whole fresh blood in a container with a recommended anticoagulant such as ethylenediamine tetra-acetic acid (EDTA), heparin or citrate. Immediately mix it by whirling 8–10 times. Centrifuge for up to 10 minutes. After centrifugation, the plasma is separated above the blood cells. Extract the plasma within 6 hours of collection. The plasma can be stored at 2–8 °C. This can be used for HIV testing within 5 days or as specified by the manufacturer of the assay device.

Dried blood spot (DBS): Venous or capillary whole blood is applied to a filter paper by hanging drop or microcapillary technique and allowed to air dry. Whole blood is later eluted from the filter paper and used for HIV testing. The collected blood sample on the DBS can be stored at 4 °C for up to 3 months, at –20 °C for longer.

The use of specific assays with DBS should be validated by the manufacturer. When the manufacturer has not validated their assay for DBS, the use of DBS is considered “off-label”, or unauthorized for returning medical results.

Handling specimens

Universal precautions should be observed during specimen handling. SOPs should be followed to ensure that accurate test results are obtained. Guidelines for sample referral and transportation should be adhered to.

6.13.1 HIV Testing Algorithms

An algorithm is a combination and sequence of HIV tests that have been tested and approved by the national reference laboratory to standardise HIV testing for a given purpose.

HIV Testing Algorithm for testing persons aged 18 months and above in Uganda

HIV testing for programming in Uganda shall be conducted using rapid diagnostic antibody tests and/ or molecular tests following the approved National testing Algorithm

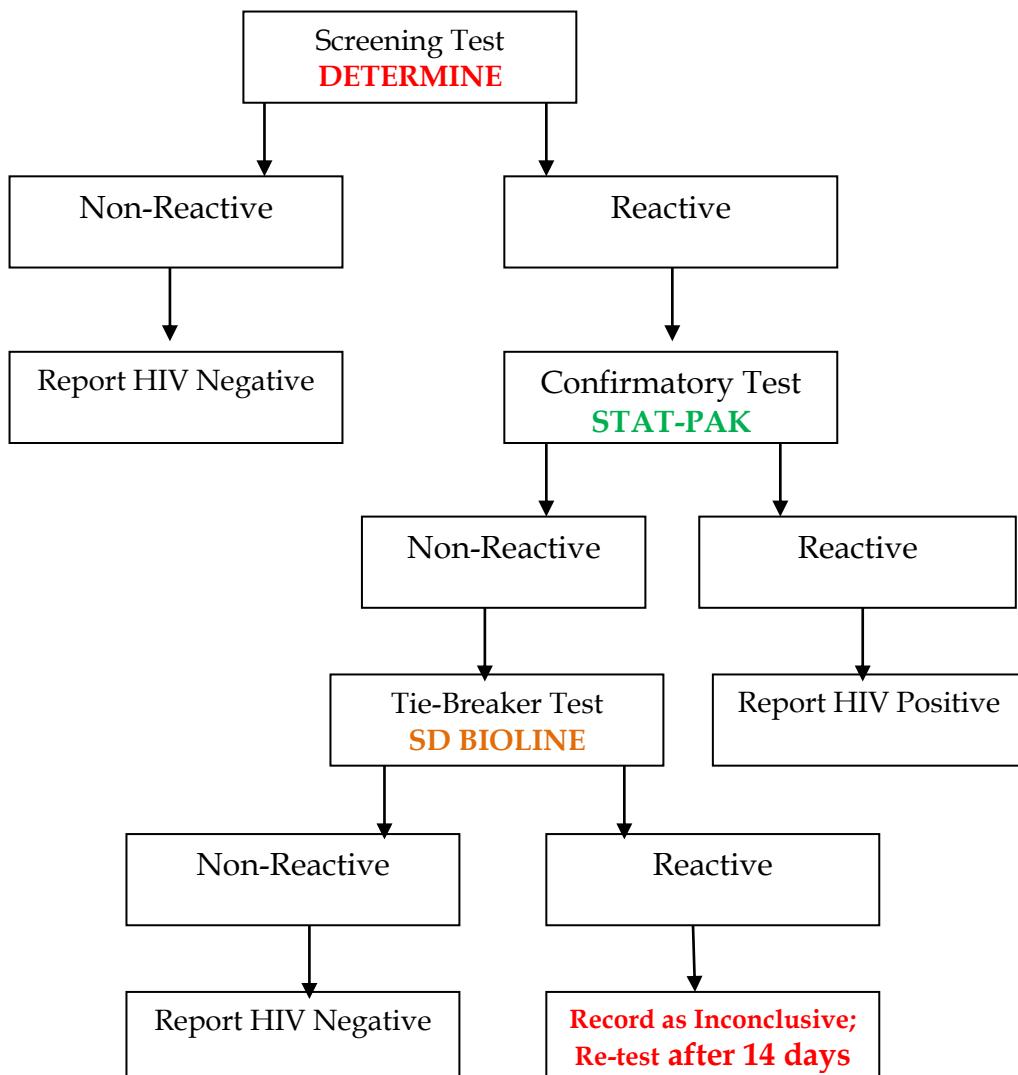
The Nationally approved Algorithm for HIV testing in Uganda is as follows:

- A. Screening test
- B. Confirmatory test
- C. Tie-Breaker

Note that in Uganda, the tie breaker will no longer be used to provide a definite HIV diagnosis to rule out negatives that are discrepant on screening and confirmation.

Individuals whose samples react with the tie breaker shall be retested after 14 days as per the WHO recommendation. Figure 11 below shows Uganda's serial testing Algorithm.

Figure 11: Serial HIV Testing Algorithm for testing persons above 18 months of age in Uganda, 2021



The HIV testing algorithm for persons aged 18 months of age and above recommends Determine as the *screening test*, Statpak as the *confirmatory test* and SD Bioline as the third test (*tie-breaker*). A reactive test on SD Bioline is reported as inconclusive.

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

Resolving a second HIV inconclusive Test Result

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

Retesting for Verification

The re-test for Verification shall be performed by a health worker (Tester), other than the one who performed the first test using a different blood sample drawn from the same Individual (client).

Retesting for Verification shall be performed at the point of ART Initiation. This may be performed at the Mother Baby Care Point (MBCP), HIV/ART clinic or laboratory.

The respective national HIV testing algorithm must be followed during retesting for verification (same algorithm in test event 1 and 2).

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

Resolving Discrepant results on retesting for Verification

For clients whose results are NEGATIVE on retest for verification, samples should be collected, labelled “**Discrepant**” and sent to the national HIV reference laboratory (UVRI) for testing. A result will be sent back as either POSITIVE or NEGATIVE.

Sample and result transportation will utilize the existing hub system.

Note: Before discrepant results are sent to national HIV reference laboratory (UVRI), rule out errors at facility level such improper handling of samples or testing kits and personnel incompetence.

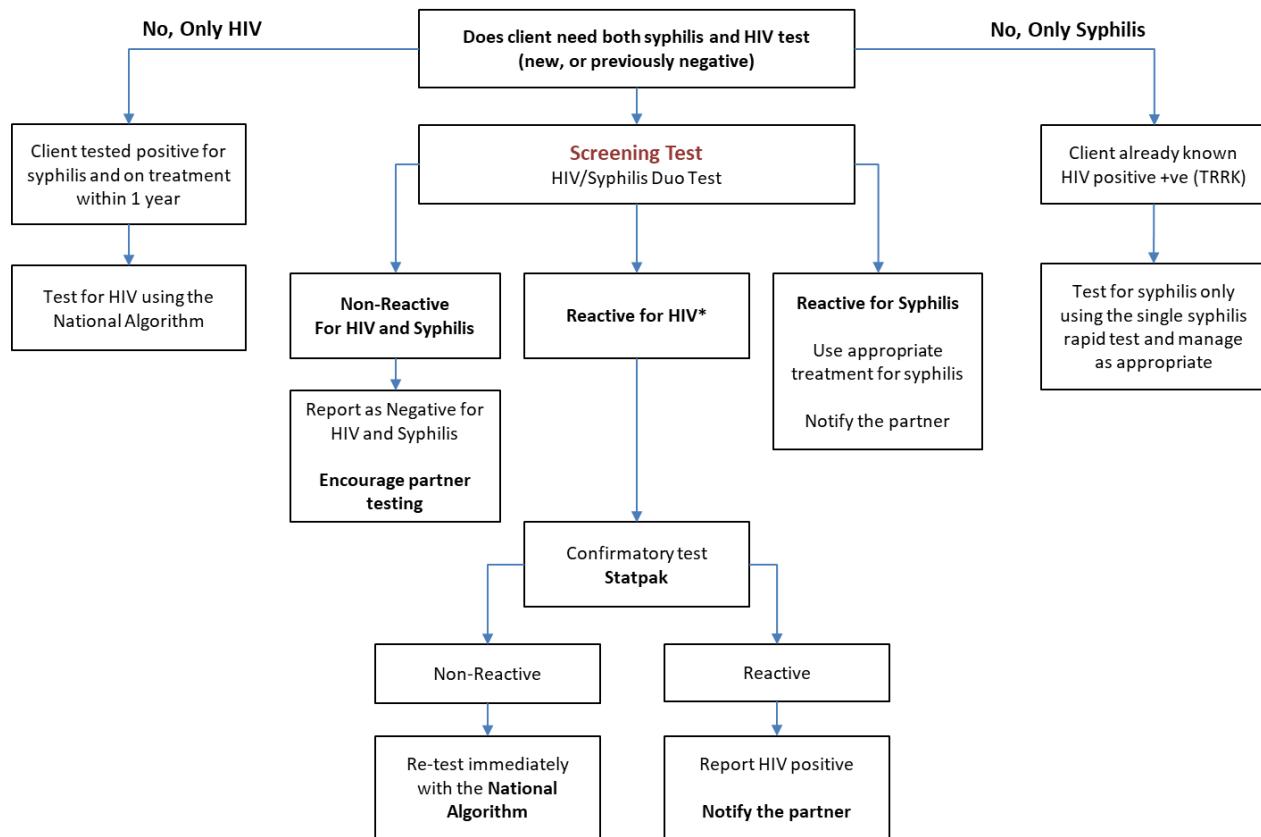
6.13.2 MCH HIV and Syphilis Testing Algorithm

Within MCH settings, the HIV /syphilis duo kit will be used as a *screening test* for both women and their partners. Statpak shall be used for HIV test *confirmation*. Women who are already known HIV positive will still need to test for Syphilis using the single rapid syphilis test (figure 12)

For samples that react on HIV syphilis duo but do not react on stat-pak the tester shall utilize the national HIV testing algorithm using determine as a screening test and following respective tests.

Index testing should be provided for those testing positive for HIV and/ or Syphilis.

Figure 12: HIV Testing Algorithm using the HIV-Syphilis Duo Kit in MCH Settings



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

6.13.3 HIV Testing Algorithm for Infants and Children below 18 Months of Age / Early Infant Diagnosis (EID) Cascade

In sub-Saharan Africa approximately half of perinatally infected and a quarter of infants infected through breastfeeding will die before their second birthday, compared to <5% infant mortality in HIV-exposed uninfected infants²³. The cascade of care required for optimally effective EID programs, essentially has two primary goals:

- (1) Correctly informing caregivers of infant infection status and
- (2) Linking all HIV-infected infants to care and ART.

Diagnosing HIV among infants is therefore prudent and should be done at 4-6 weeks or at the earliest opportunity thereafter. All infants diagnosed with HIV should be initiated on ART immediately to reduce morbidity and mortality.

A virological test (DNA/PCR) is recommended for determining HIV status in infants and children below 18 months of age. The sample for testing should be collected using dried blood spot (DBS) specimens²⁴.

HIV testing schedule for infants

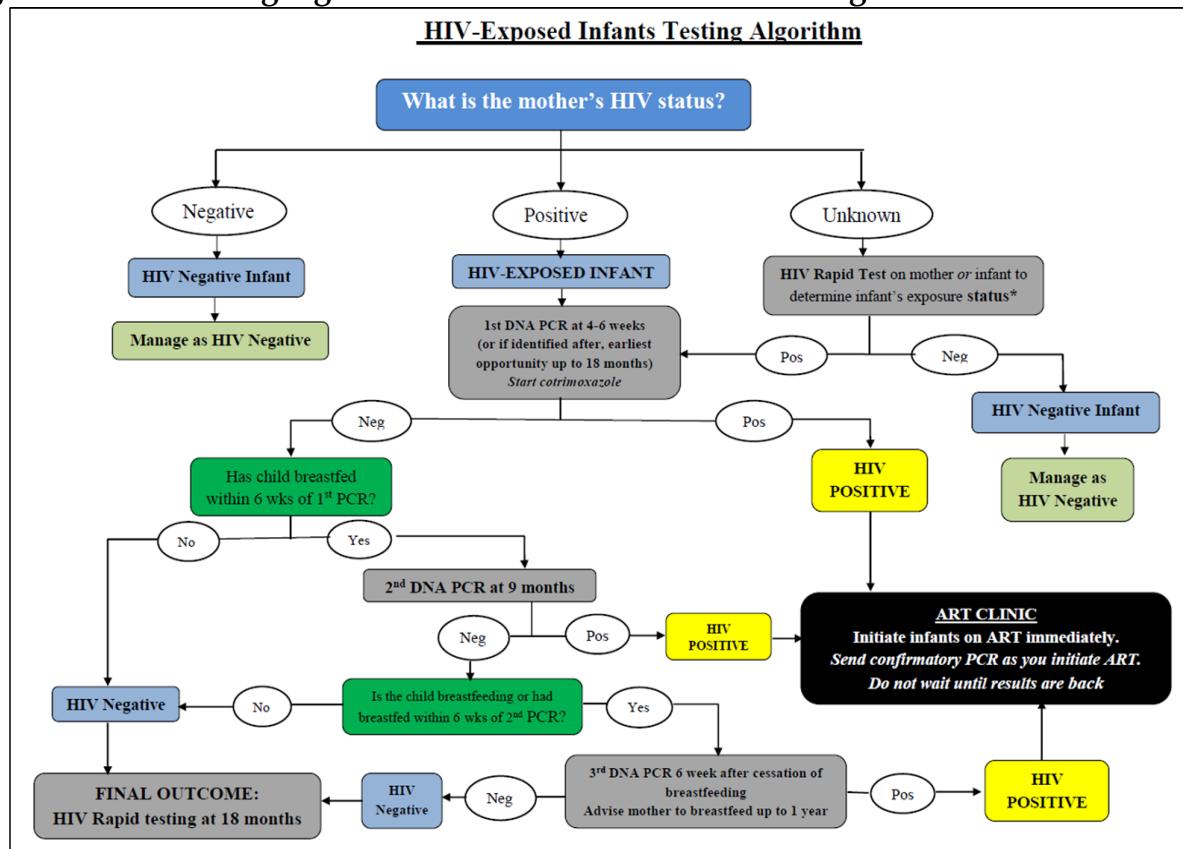
The 1st DNA/PCR test should be done at six weeks of age or the earliest opportunity thereafter. Another PCR test has been introduced to be conducted at 9 months of age as the second test for all infants irrespective of breastfeeding status²⁴. The 3rd PCR should be done 6 weeks after cessation of breastfeeding²⁴. Interpretation of the results and further testing are guided by the testing algorithm in Figure 13 below.

²³Davies M-A et al. Survival of HIV-1 vertically infected children. Curr Opin HIV AIDS 2016; 11(5): 455-464.

²⁴Consolidated guidelines for the prevention and treatment of HIV and AIDS in Uganda, 2020.

<https://differentiatedservicedelivery.org/Portals/0/adam/Content/HvpzRP5yUUSdpCe2m0KMdQ/File/Uganda%20HIV%20and%20AIDS%20Guidelines%202020%20June%2030th.pdf>

Figure 13: HIV testing algorithm for children <18 months of age



*If an infant with a negative previous PCR is symptomatic while still breastfeeding, take off a PCR sample at that point in time. If negative, another PCR sample must be taken according to the algorithm either 9 months or 6 weeks after breastfeeding.

*If mother's status cannot be ascertained, may use rapid test in babies to determine HIV exposure status. Should perform DNA PCR for baby who is symptomatic, malnourished or has TB as routine.

*If breastfeeding is stopped before 9 months then a final DNA PCR can be done at any point 6 weeks after cessation of breastfeeding.

A POSITIVE DNA/PCR test result indicates that the child is HIV-infected. All infants with a positive DNA/PCR test result should be initiated on ART and another blood sample should be collected on the day of ART initiation to confirm the positive DNA/PCR HIV test result²⁴. A NEGATIVE FIRST DNA/PCR test result means that the child is not infected but could become infected if they are still breastfeeding. Infants testing HIV negative on first DNA/PCR should be re-tested using DNA/PCR at 9 months of age irrespective of breastfeeding status and six weeks after cessation of breastfeeding. Infants with negative third DNA/PCR test should have a final rapid antibody test performed at 18 months using the national HIV testing algorithm²⁴.

Note: A rapid HIV antibody test can be used to establish if an infant is exposed to HIV before the age of 18 months. This can be done if the infant doesn't present at the health facility with the biological mother. A reactive HIV rapid antibody test will confirm **exposure** to HIV but not **HIV infection**. In that case, if the HIV test is reactive, a DNA PCR sample should be taken as explained above to establish if the infant is HIV infected or not²⁴.

There is need to pro-actively look for infants whose mothers never attended eMTCT services through the routine offer of PITC in child health services, immunization clinics, under-5 clinics,

malnutrition services, well-child services and services for hospitalized and all sick children, TB clinics, and services for orphans and vulnerable children and testing the family members of index clients to identify HIV-exposed infants.

Assessing a child (18mths - 14yrs) to be tested for HIV should be guided by the HTS eligibility screening tool for children and adolescents. However, in a high HIV prevalence setting like Uganda, **every child** who is admitted should be tested for HIV.

6.14 Re-Testing and Repeat Testing

- *Re-Testing shall be conducted in specified circumstances to rule out laboratory or transcription errors*
- *All individuals newly and previously diagnosed with HIV shall be re-tested before ART initiation.*
- *HIV repeat-testing shall be conducted based on a client's level of recent exposure and/or ongoing risk of exposure to rule in or rule out sero-conversion.*

6.14.1 Re-testing

All Newly Identified HIV positive patients, should be re-tested before initiating ART. This should be performed by a different tester using the approved national HIV testing algorithm at the ART initiation site/ care point.

Re-testing clients on ART

Retesting clients on ART is not recommended because most of these clients turn out with FALSE HIV NEGATIVE results

6.14.2 Repeat Testing

Repeat testing should be conducted in specified circumstances to rule out laboratory or transcription errors and either to rule in or rule out sero-conversion. This could be followed by supplemental testing where additional assay(s) not used in the first testing algorithm may be used on the same specimens to obtain more information about the HIV test result.

Repeat testing for individuals thought to be in the window period is needed ONLY for those who report specific recent risk²⁴. Table 4 below shows the categories of people to repeat test at specified time-points.

Table 4: Categories of HIV-negative persons to re-test at specified time points

Population category	When to re-test
Individuals exposed to HIV within four weeks before HIV testing	Four weeks after the 1 st test
Key populations	Depending on risk of exposure in the past 3 months
HIV-negative partners in discordant couples	Depending on risk of exposure in the past 3 months
Pregnant women	1 st trimester/1 st ANC visit, then in the 3 rd trimester/during labor or delivery
Breastfeeding women	Every three months until three months after cessation of breastfeeding
Confirmed and presumptive TB Patients	Four weeks after the 1 st test
TB, Hepatitis and STI patients	Four weeks after testing
PEP clients	At one month, three months and six months after completing the PEP course
PrEP	Depends on risk of exposure in the past 3 months
HIV-exposed infants (HEIs)	Nine months of age, six weeks after cessation of breastfeeding and at 18 months of age
Children who are still breastfeeding beyond 18 months of age	3 months after cessation of breastfeeding
INCONCLUSIVE results	14 days after the last test
VMMC clients (10-14 years)	Risk based
Children and adolescents (2-14years)	Risk based with exceptions explained earlier in these guidelines
Family planning clients	Risk based
Sexual offenders and survivors of SGBV	Four weeks after the 1 st test
Index testing-Sexual partners	Four weeks after the 1 st test
Blood, Tissue donors	Four weeks after the 1 st test
General Population	Once a year depending on risk of exposure for the duration in which they have not had an HIV test.>-3 months

7.0 Linkage to Prevention, Care, Treatment and Support Services

The second 95 in the UNAIDS fast-track targets of 95-95-95 by the year 2030 is ‘linkage of 95% of HIV positive individuals to treatment’. Without effective strategies that ensure linkage and enrolment in care, the effect of HTS in reducing HIV transmission, morbidity and mortality cannot be fully realized²⁴. It is therefore the mandate of the HTS program to ensure identification and linkage of HIV positive individuals to care, treatment, support and prevention services.

This section therefore provides guidance to HTS providers to ensure successful linkage of all HIV positive individuals identified. It emphasizes the critical role of Linkage Facilitators as well as strategies to track intra-facility, inter-facility and community - facility linkages.

Policy Objective: To guide HTS providers to implement effective referral and linkage mechanisms to achieve 95% linkage into care for all identified HIV positive individuals to achieve epidemic control

Policy Statements

- a) All persons accessing HIV counselling and testing shall have the right to be linked to appropriate health services
- b) Linkage shall be complete after enrolment and/ or access to appropriate HIV prevention, care, treatment and support services.
- c) All intra-facility linkages shall be on the same day and where not possible, should be effected within 7 days; while inter-facility and community linkages shall be effected within 14 days.
- d) Community and inter-/intra-facility networking and collaborations should be promoted for effective linkages of clients.
- e) All HTS points should have a regularly updated referral directory of community and institutional prevention, care and support services.
- f) HTS providers should link all HIV positive individuals to prevention, treatment, care and support.
- g) HTS providers should refer HIV Negative persons to appropriate HIV prevention services
- h) All HTS providers should designate personnel to work as Linkage Facilitators
- i) The success of linkage shall be measured by enrolment into care and not by intermediary process indicators such as the number of referral cards issued.
- j) HTS providers should put in place follow-up mechanisms for all linked and referred HIV positive individuals.
- k) All referrals and linkages should be documented using appropriate national data collection tools (HIV Comprehensive Referral and Linkage Form, Linkage and pre-ART register).

7.1 Community-Facility, Intra and Inter-facility linkages

Community and Inter-/intra-facility networking and collaborations shall be promoted for effective linkages of clients.

Linkage refers to an act of connecting an individual from one point of care to another. Intra-facility linkage refers to connecting a client from one point of care to another within the same

facility; while inter-facility linkage means connecting a client from a point of care in one facility to another facility.

HTS providers should address barriers to linkage in order to ease the process. Barriers may include;

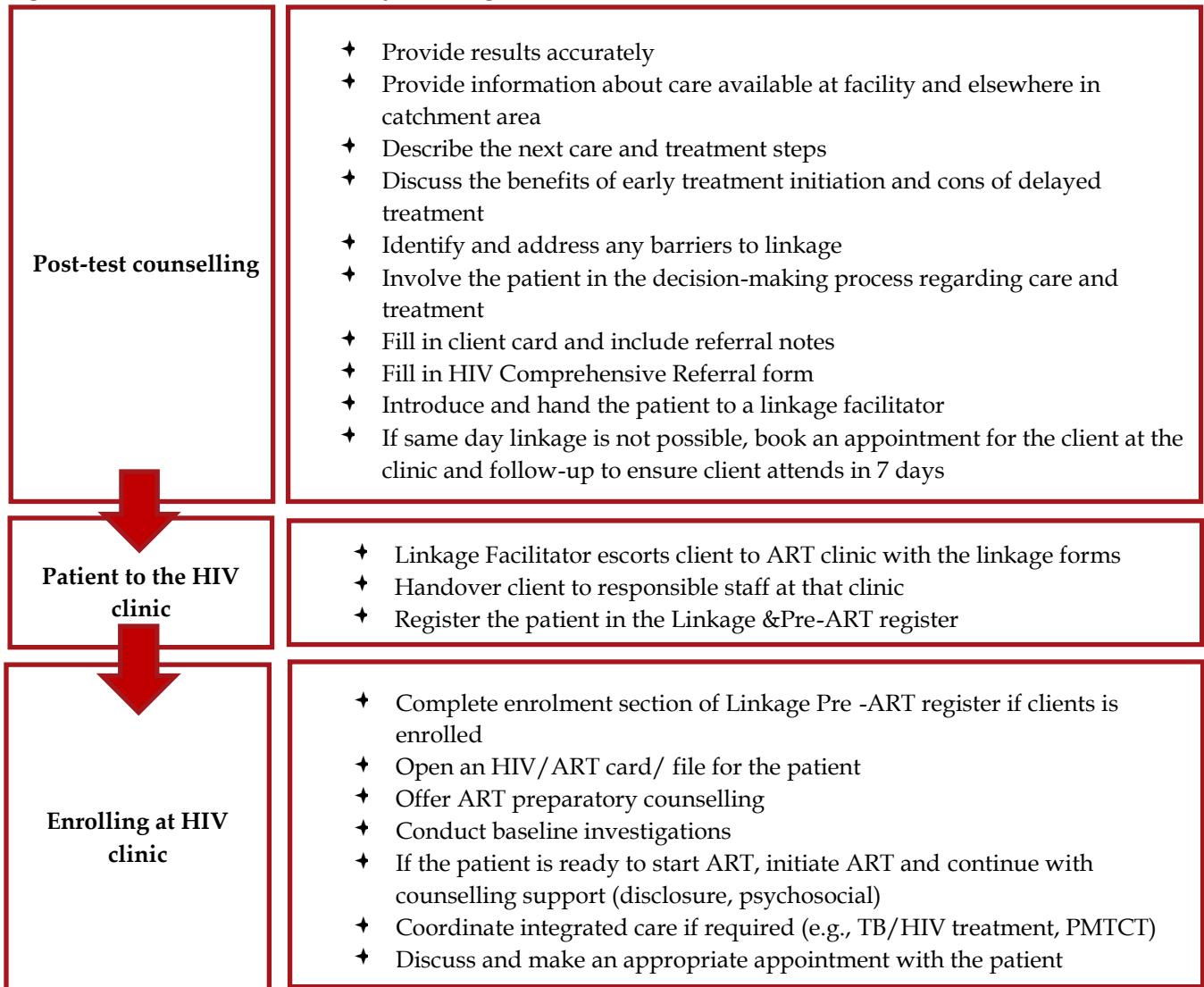
- Client factors such as feeling healthy, depression, lack of social or family support and fear of disclosure
- Social or cultural factors such as stigma and discrimination
- Structural or economic factors; including legal issues and lack of transportation, Health system barriers; such as poor referrals, stigmatizing or unfriendly services and long waiting times in facilities

7.1.1 Intra-facility linkage

Intra-facility linkage should be encouraged for facilities that are accredited to offer HIV treatment. However, clients should be given an opportunity to choose the most appropriate facility to receive care, treatment or prevention services from. All intra-facility linkages shall be on the same day and where not possible, should be effected within 7 days.

The process of linkage within the same health facility is described in Figure 14 below.

Figure 14: Intra Health Facility Linkages for HIV Positive individuals



7.1.2 Inter-facility linkage

Inter-facility linkage refers to connecting clients from one facility to another facility for HIV treatment, care, and support services. The referring facility should track (follow-up) all HIV-positive clients referred to other facilities and ensure they are enrolled in HIV care and treatment within 14 days, using the follow-up/tracking schedule described in **Table 5**.

Table 5: Schedule for follow-up/tracking inter-facility linkages for HIV positive individuals

Timeline	Action
Day 1 (referral day)	<ul style="list-style-type: none"> -A client diagnosed HIV positive and referred to the facility of choice. -Linkage facilitator documents clients' contacts. -Linkage facilitator obtains client's consent for home visiting. -Linkage facilitator introduces the client to community health worker.
Week 1	<ul style="list-style-type: none"> -Linkage facilitator calls a client or the contact in the health facility where the client was referred to. If client reached the new facility, document complete linkage. -If the client didn't reach the new facility by week 1, the community health worker (VHT) visits client's home to remind about the referral.
Week 2	<ul style="list-style-type: none"> -Linkage facilitator calls client or new facility to confirm if the VHT visit to client's home made any impact. If client reached the new facility, document complete linkage. -If the client didn't reach the new facility, the linkage facilitator visits client's home to discuss reasons for the client's failure to reach the referral point. -Linkage facilitator calls client or facility to confirm if client reached. If yes, document linkage as complete. If no, document as lost.

7.1.3 Community-Facility Linkage

Community-facility linkage refers to connecting a client in the community to a health facility for HIV, treatment, care, prevention, care and support services. HTS programs shall work with peer leaders, expert clients, YAPS, VHTs and CHWs to create demand for community HIV testing approaches, referral and follow up of all individuals for appropriate services. Linkage from community to facility shall be done within 14 days. The process of community-facility linkage is described in **Table 6**.

Table 6: Schedule for follow-up/tracking community-facility-community linkages for HIV positive individuals

Timeline	Action
Day 1 (referral day)	<p>A client is diagnosed HIV positive and referred to the preferred facility using the HIV Comprehensive referral form. A copy of the referral form is given to the CHW who documents the address and contact information into the follow-up register, schedules an appointment for facility visit and obtains client's consent for home visiting. The HIV Comprehensive referral form copy should be delivered to the facility where the client has been referred.</p>

Week 1	<ul style="list-style-type: none"> -The organization doing community testing should call the client or the contact in the health facility where the client was referred. If client reached the facility, document complete linkage. -The health facility linkage facilitator identifies referred clients who have come to the facility and documents those referrals as linked/complete. The facilitator notifies the CHW of all clients who have not yet been linked. -The CHW visits client's home to ascertain reasons for failure to reach the facility and makes a new appointment for facility visit. The CHW documents the outcome of the visit and notifies the health facility team.
Week 2	<ul style="list-style-type: none"> -The health facility linkage facilitator ascertains if the client was linked and notifies CHW of the pending clients -The CHW makes a final visit to client's home; discusses reasons for failure to reach the facility; makes a final appointment if the client is willing or documents outcome (refused, not ready, relocated, etc.). If the client has not yet decided to enrol in care, the CHW will continue to contact and encourage them to seek care. <i>A client is lost to linkage if he/she is not in care within 14 days of HIV diagnosis.</i>

This process should be replicated for clients identified in the facility and linked to community for other support services.

7.2 Referral Directory

All HTS points shall have a regularly updated referral directory of community and institutional prevention, care, treatment and support services

All HTS service points should have a regularly updated referral directory of existing community and institutional prevention, care treatment and support services within their catchment area¹⁸.

The referral directory should be district-specific and should show the scope and nature of services provided at various sites. The directory should be regularly updated in consultation with the DHO (District Health Officer) and implementing partners (IPs) within the district and should have provision for linkage to community structures, including CHWs.

Within the health facility, linkage meetings should be held to track and document linkage between different service points and ensure that clients who are not linked are tracked and brought into care.

Systems to monitor and evaluate the success of linkage approaches and identify areas for improvement should be established. Implementing and documenting Continuous Quality Improvement (CQI) should be done.

Appropriate information about services to which the client is referred for and linked to should be provided; mechanisms for documentation, feedback and monitoring should be established.

Table 7: Referral and Linkage Services Directory

Institution	Services Available
Health facility	HTS, PrEP, PEP, GBV/IPV response, condom programming, blood donation, STI management, YAPS interventions, Determined/Resilient/Empowered/AIDS-free/Mentored/Safe (DREAMS), Paediatric care, OVC services, TB/HIV care, OI management, psycho-social support, Family planning, PMTCT, ART and SMC
Civil Society Organisations (CSOs)	Psychosocial support, shelters, nutritional support, livelihood, income generating activities (IGAs), OVC services, life planning skills, education, GBV/VAC (Violence against Children), legal services, financial support
POLICE: Family and Child protection services units (FCPSUs)	Legal services, psychosocial support
Faith-based institutions	Psychosocial support, shelters, nutritional support, livelihood, income generating activities (IGAs), OVC services, life planning skills, education, GBV/VAC, financial support
District Development Community Officers, Community Development Officers, Para socials and the Local Council (LC) System	Psychosocial support, legal services
Tertiary administrations: Schools and tertiary institutions	Psychosocial support, nutritional support, life planning skills, education

Means of follow up shall include;

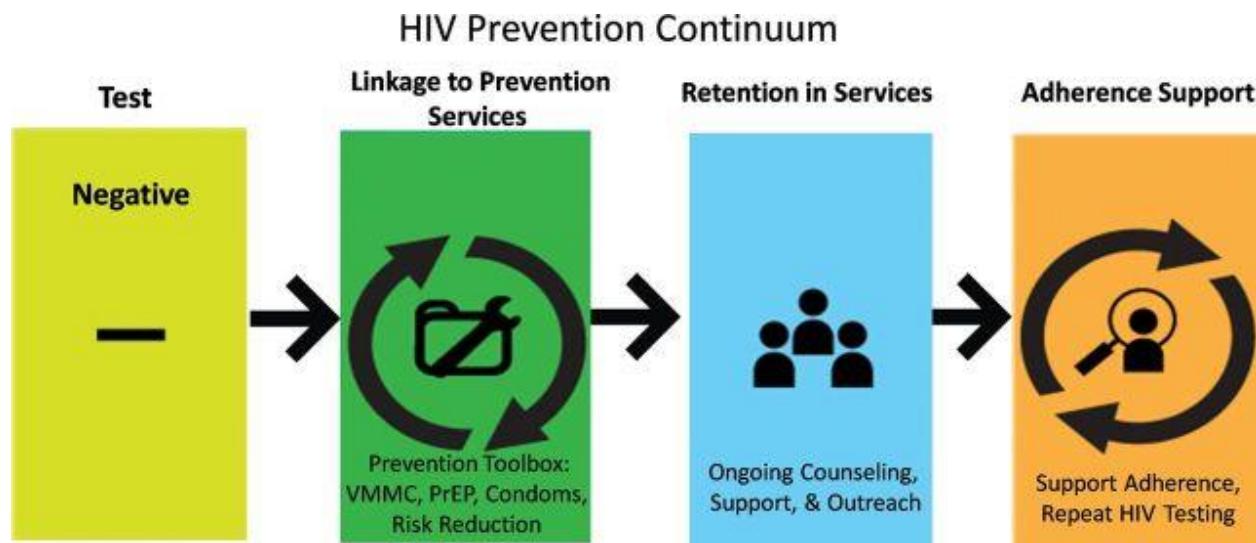
1. **Using phone calls:** call the facility where the client was linked
2. **Periodic physical check-ups of records:** crosscheck in the Linkage and Pre-ART register where the client was linked
3. **Client report back:** should be done by phone call or physical reporting. Encourage client to report back after reaching the facility referred to. Provide your facility contacts to the clients and the exact point to return to, in case they physically comeback.
4. **Physical home visits:** by both CHWs and Linkage Facilitators based at the facility.

7.3 Linking an HIV Negative Client to Preventive Services

Optimizing service delivery among HIV negative persons and linking and retaining them in effective prevention services is crucial. Once a person is engaged in prevention interventions, HIV testing services will continue to serve as part of prevention monitoring.

The HIV prevention continuum²⁵ in Figure 15 below, builds on HIV testing as its foundation followed by linkage of HIV Negative persons to prevention services and adoption of behaviour change to prevent HIV acquisition and transmission. The common desired endpoint of the prevention continuum is ensuring that individuals remain HIV Negative.

Figure 15: HIV Prevention Continuum



7.4 Good practices to increase linkage to HIV care

Uganda adopted the ‘test and treat’ strategy for all individuals testing HIV positive. Hence, same day linkage to HIV care and treatment should be prioritized. It is noted that some people may not be linked to care and treatment immediately due to social, psychological and clinical reasons. Often, people need time to accept the diagnosis and seek support from partners and families before being linked to care.

Strategies to improve linkage to care and treatment services

- Sensitize the community to reduce stigma and increase community-based support for treatment adherence and retention
- Improve service delivery, reporting and feedback mechanisms
- Reduce barriers to care, such as lengthy processes and unnecessary requirements for enrolment into care.
- Monitor linkage between HIV testing, treatment and prevention services.

²⁵McNairy ML et al. A Paradigm Shift: Focus on the HIV prevention continuum 2014; 59(Suppl 1): S12-S15.

Practices which may increase Linkage to ART Initiation

- **Integrated services** where HIV testing, prevention, treatment and care, TB and STI screening and other relevant services are provided together at a single facility or site
- Providing on-site or immediate CD4 testing with same-day results.
- Work with **trained lay providers** (peers, CHWs, Linkage Facilitators) to link and follow-up those that are lost.
- **Intensified post-test counseling** by both facility and community health workers
- Provision of **brief strengths-based case management** which emphasizes people's self-determination and strengths, is client-led and focuses on future outcomes, helps clients set and accomplish goals, establishes good working relationships among the clients, and the health worker and other sources of support in the community, and provides services outside of office settings
- Using communication technologies, such as **mobile phones and text messaging**, which may help with disclosure, adherence and retention particularly for adolescents and young people
- **Promoting partner testing** shall increase rates of HIV testing and linkage to care, as many HTS approaches that encourage male involvement
- **Partner notification** by the provider, with permission, is feasible in some settings; it identifies more HIV-positive people and promotes their early linkage to care
- **Decentralized** and community-based distribution of ART

7.5 Linkage Facilitators (LFs)

All HTS providers should designate personnel to work as Linkage Facilitators

LFs should be established in health service delivery to minimize lost to follow up and ensure effective linkage of clients into HIV services within and across programs. Currently, various HTS providers have institutionalised this cadre either as designated full time paid staff or volunteer personnel. This guidance provides a framework to effectively plan and efficiently manage volunteer lay providers, streamline and harmonize their roles, incentives and supervisory structures.

LFs should operate at two levels; at the health facility and within the communities. At facility level, LFs may include designated staff or Volunteers with a defined scope of work and supervised by the HTS focal person. These should include expert clients, YAPS, champions, and Mentor Couples at different care points. Key functions of facility-based LFs should include:

- Supporting health workers in service delivery e.g., registration and weight taking, client file retrieval etc.
- Linking HIV positive individuals to care and treatment both within and across facilities
- Peer to peer education and counselling
- Follow up of clients referred to other facilities
- Client follow up in the community
- Drug adherence counselling and monitoring
- Reporting

Facility LFs should be aged 25 years and above and be able to read and write at least in both English and a local language.

All resource persons working within the community and linking individuals to HIV services include VHTs, Expert Clients, Young Adolescent and Peer Supporters (YAPS), Mentor mothers, and Peer educators.

These may also be referred to as ‘Community Linkage Facilitators’ (CLFs) and will be selected at Parish level. They should coordinate with other CHEWs to minimise missed opportunities for HTS.

Parish VHT coordinators should be supported to take on the role of CLFs. Key functions of CLFs shall include:

- Mobilizing community members for services (outreach services and health education talks)
- Sensitizing the community on benefits of HTS and seeking care
- Linking clients to appropriate service providers –i.e., escort clients to service points
- Providing information to clients on different providers and services provided
- Keeping a record of clients to follow up in catchment area
- Keeping a record of other linkage facilitators in the catchment area
- Actively following up clients in the community
- Gathering client’s concerns and preferences and giving feedback to providers
- Preparing monthly reports

7.6 Monitoring Linkage

All linkages shall be monitored routinely to ensure that no HIV positive individual falls out of the cascade. The LF should verify successful linkages on a weekly basis by comparing the HTS Register with the Linkage and Pre-ART Register. All HIV positive individuals identified should be recorded in the Linkage and Pre-ART register for easy follow-up.

HIV comprehensive referral and Linkage Form shall be utilized by all HTS providers. HIV Comprehensive Referral and Linkage Form, Linkage and pre-ART register, and ART register should be used to track all linkages.

HTS providers should use data on linkage to identify challenges and apply QI principles to improve linkage to care.

8.0 HTS Health Systems requirements

In order to increase access, meet the 5Cs, and ensure quality, HTS should be offered within a functional health system: committed leadership and governance, qualified Human Resources for Health (HRH), clear financing mechanisms, infrastructure, a functional procurement and supply chain management system and a clear M&E plan.

Policy Objective: To provide guidance for a functional and sustainable health system that ensures quality and equitable HTS

Policy statement

- a) Governance and coordination of HTS under the multi-sectoral approach shall remain the responsibility of the Uganda AIDS Commission (UAC)
- b) Overall technical leadership for HTS shall be the mandate of MOH with delegated functions along the decentralized health system.
- c) HTS shall be offered under infrastructure which ensures privacy and confidentiality during counselling, physical accessibility for all, safety of the provider, client and community and appropriate storage of HTS supplies.
- d) MoH shall maintain a functional procurement and supply chain management system to ensure sustained delivery of HTS through forecasting, quantification, monitoring stocks, and timely ordering of adequate and quality HTS supplies at all levels
- e) It shall be the mandate of MoH to mobilize resources to finance and ensure universal access to quality HTS through provision of affordable services by both public and private health facilities.
- f) HTS shall be offered at designated and certified testing sites
- g) HTS shall be offered by trained and certified providers such as Lay Providers, counsellors, laboratory personnel, medical workers, data managers and logistics managers.
- h) Training of HTS providers shall be conducted by accredited HTS Training Institutions using MOH approved curricula
- i) HTS shall be conducted in line with the National M&E Framework for HIV/AIDS.
- j) The MoH shall ensure availability of a functional HIMS for HTS and all its implementers shall adhere to standardised mechanisms for data collection, storage, analysis, and reporting
- k) QA shall be an in-built component of the HTS cascade. All facilities will offer HTS as per the national set standards, implement QI and QC activities
- l) MOH shall guide HTS research to evaluate feasibility, acceptability, quality and effectiveness of interventions for evidence-based programming

8.1 Leadership and Governance of HTS

Governance and coordination of HTS under the multi-sectoral approach remains the responsibility of Uganda AIDS Commission (UAC)

Overall leadership and governance for HTS shall be the mandate of MOH with delegated functions along the decentralized health system.

Leadership and governance functions for HTS should be carried out along the entire cascade of the decentralized health service delivery system as mandated by the MoH. Organizations delegated to perform these functions will ensure that strategic policy frameworks exist and are combined with effective coordination, oversight, regulations, functional systems and accountability.

8.1.1 Coordination and oversight

Coordination and oversight for HTS implementation shall be done at National, district and service delivery levels.

At **national level**, this shall be carried out by UAC and AIDS Control Program (ACP) of the MoH. UAC will provide overall coordination of the multi-sectoral response to HIV/AIDS including provision of leadership for planning, implementation and monitoring of HTS by different stakeholders ACP shall coordinate technical assistance for implementation, M&E of HTS.

ACP will fulfil this mandate through a National HIV Testing Services Committee (NHTSC) comprising of representation from key HTS organisations and development partners who will advise on the technical aspects of the HTS program.

At **regional level**, directors of regional referral hospitals through delegated HTS focal persons shall oversee the coordination and implementation of quality HTS in the region.

At **District, City, Municipal and Division Levels**, responsible health officers/ directors through the HTS Focal Persons shall coordinate and ensure effective implementation, supervision and monitoring of HTS.

At health facility level, the In-charges through designated HTS Focal Persons shall coordinate and ensure effective implementation of HTS.

The roles and responsibilities of different stakeholders at all levels are described in *section 12.0* of this policy and guidelines.

8.1.2 Accountability

Accountability should focus on tracking how financial resources and other inputs for provision of HTS translate into service provision, uptake and impact on identifying PLHIV as per the triple 95 strategy. The accountability mechanisms should engage key stakeholders who finance HTS, the beneficiaries and HTS providers.

The following should be done for accountability at all levels;

- IPs and political leaders should be engaged to witness the delivery of HTS supplies.
- Annual financial audits for HTS resources should be conducted.
- Financial reports for HTS resources should be compiled quarterly. Funds spent on salaries and facilitation of HTS providers should be included in financial expenditures.

At National level, MoH should ensure that funds for procuring HTS supplies are well accounted for. MoH should ensure that mechanisms for procurement and management of HTS supplies have clear accounting procedures to track flow and utilization of resources.

At regional Level, directors of regional hospitals should put in place mechanisms for tracking the procurement and management of HTS supplies.

At District, city, municipal levels, the Chief Administrative Officers (CAO) and the DHOs should ensure availability of clear accounting procedures to track flow and utilization of HTS resources²⁶. HTS data and other relevant information to monitor and evaluate performance should be utilised. Districts should undertake bi-annual financial audits on all HTS related logistics.

At Health facility level, the health unit in-charge should be responsible for tracking performance around the actual uptake of services in relation to the resources availed to the health facility.

Use of HTS data capture tools, including the HTS register and HIV daily activity register for recording HIV tests should be used to track utilization of HIV test kits and compilation of monthly reports.

8.2 Infrastructure for HTS

HTS shall be offered under infrastructure that ensures privacy, confidentiality and physical accessibility.

This environment should ensure safety of providers, clients and community during HIV testing process and appropriate storage of HTS supplies and records.

Appropriate infrastructure is essential for delivery of accessible, quality and safe HTS. This includes availability of adequate physical space and a conducive environment for HIV counselling and testing and equipment to run HIV tests.

8.2.1 Physical accessibility

HTS providers should ensure physical accessibility to HTS to all persons by reorganising the facilities as per the accessibility standards²⁷. People affected by accessibility barriers include persons; who use wheelchairs, have limited walking/movement abilities, visual impairment, hearing impairment, intellectual disabilities, psychosocial disabilities, Elderly persons, pregnant women, and people with temporary disabilities²⁷. Accessibility modifications may include ramps, stairs, relocation of service points, and barrier-free entrances.

²⁶Guidelines for Governance and Management structures, Ministry of Health, 2013.

<http://library.health.go.ug/publications/governance/guidelines-governance-and-management-structures>

²⁷Accessibility Standards: A practical guide to create a barrier-free physical environment in Uganda.

<https://unapd.org/publication/view/accessibility-standards>

8.2.2 Counselling space

HTS should be provided in a clean, well-ventilated areas with sufficient lighting and adequate space for both the provider and client. The designated areas should be private to allow for confidential discussions and sitting space for both the counsellor and the client. At outreach sites, counselling may be conducted in an open space such as under the tree but confidentiality should be observed.

8.2.3 Testing space

At facility level, HIV testing should be conducted both in the laboratory and designated points within the facility. HIV testing should also be done in community settings such as homes, DICs, work places or any other outreach sites.

Any area designated for performing HIV tests should have adequate space to allow for all the testing materials/tools to be comfortably used to facilitate quality testing. Appropriate HTS Infection Prevention and Control (IPC) measures should be available and adhered to including safety SOPs, safety gears, disinfectants, waste segregation containers (HIVST waste however, should be disposed of with household waste).

8.2.4 Storage space for HTS supplies

Health facilities should designate proper storage space for HTS supplies. This should be in line with the manufacturer specifications and recommendations. In addition, health facilities should design and/or implement systems for management and distribution of HTS supplies within the facility to avoid stock-outs and expiry.

At the community level, HTS supplies shall be stored according to the instructions from the source

8.2.5 Records storage rooms

All sites offering HTS should store records including laboratory records in a designated secure place. This should ensure confidentiality of clients' records as well as easy retrieval.

8.3 HTS Logistics Supply Chain Management

MoH shall maintain a functional procurement and supply chain management system to ensure sustained delivery of HTS through forecasting, quantification, monitoring stocks, and timely ordering of adequate and quality HTS supplies.

An effective supply chain management system is critical for maintenance of adequate stocks of quality HIV testing supplies for sustained and un-interrupted service delivery. It guides the processes of monitoring stocks, forecasting, quantification and ordering and, ensures adequate levels of quality and essential HTS supplies.

8.3.1 Supplies, Stock management and Monitoring

MoH shall ensure HTS supplies availability at all HTS sites by utilizing the approved national warehousing and supplies management systems. MoH approved tools for stock management and HMIS records shall be used by HTS programs to track stock levels and consumption patterns of HTS supplies. Use of both electronic and paper-based tools such as stock cards are crucial in improving HTS delivery and ensuring adequate stock of HTS supplies.

8.3.2 Forecasting and Quantification

MoH shall ensure availability of quality and adequate stocks of essential HTS supplies at all levels. The MoH approved Logistics management systems at national and district levels shall be utilized and adhered to during monitoring of stocks, forecasting, quantification and requisitioning/ordering for HTS supplies at all levels.

The National Quantification Planning and Procurement unit (QPPU) together with Central Public Health Laboratories (CPHL) and the NCTC shall forecast, and quantify the national need in consultation with key national stake holders²⁸. Forecasting assumptions required for HTS supplies shall be reviewed from time to time to suit the prevailing country testing need.

HTS supplies should be availed through the approved National warehouses which shall distribute to facilities through the ‘last mile’ with the support of the district.

All facilities should use consumption data and stock at hand to forecast the need for HTS supplies. The forecast should factor in the expected volume of clients to be served at the facility.

Quantification of HTS supplies and assessment of operations of the laboratory credit line shall be conducted annually. Analysis of supply and consumption data for HTS supplies shall be conducted by MOH personnel at all levels, in collaboration with IPs.

When estimating the number of persons to be tested for HIV, the following should be considered:

- The projected increase in demand for HTS
- Planned HTS activities like VMMC
- Shelf life of the test kits available in the warehouse in relation to consumption rates
- The National testing algorithm at the time
- Facility based trainings, internal and external quality testing procedures.

8.3.3 Procurement and distribution

MoH shall define specifications and procure all HTS supplies. All HTS supplies should be purchased centrally through approved MoH Warehouses as stipulated in the supply chain

²⁸National Annual Quantification for Public Health Facilities in Uganda for FY 2018/19

<http://library.health.go.ug/publications/pharmaceuticals-and-drugs/national-annual-quantification-public-health-facilities>

rationalization of the time. Each warehouse should ensure that the supplies are stored and distributed to all facilities in accordance with the MOH SOPs.

8.3.4 Storage of HTS supplies at district and Facility

All HTS sites should be supported to have proper storage of HTS supplies as per the manufacturer's recommendations to ensure potency.

8.3.5 Training in logistics management

In order to ensure a functional logistics and supply chain system, all designated Stores personnel at the district and facility levels should be trained in logistics and stock management.

Key training content should include;

- Quantification, Stock taking and ordering of the required essential reagents and other supplies for HTS
- Collecting and using accurate consumption information,
- Storage, management and distribution of HTS supplies

8.4 Financing for HTS

It shall be the mandate of the MoH to mobilize resources to finance HTS and ensure universal access to affordable and quality HTS through public and private health facilities.

In order to guide and regulate the cost of HIV testing services, MoH will be responsible for mobilizing resources to support delivery of quality HTS. The MoH will work within the existing mechanisms such as budget allocations from government and support from development partners such as Global fund, PEPFAR to finance HTS. The AIDS Trust Fund when regularised shall be another source of financing for HTS and allocated HTS resources will be ring fenced and utilised for implementing planned activities.

MoH shall provide HTS supplies to accredited public and private not for profit health facilities. HTS should be equitably accessed to all clients at the accredited facilities.

In Private for-profit health facilities (PFPs) where a fee may be charged for HTS to enhance sustainability, it should be affordable.

Funding priorities for HTS should include;

- Human resource (HR),
- Supplies,
- Capacity building,
- Support supervision,
- Coordination,
- Research and
- Service delivery
- QA

On an annual basis the HTS programme should determine priorities for funding. These should inform resource allocation and resource mobilisation efforts.

8.5 Human Resources for HTS

- *HTS shall be offered by trained and certified providers such as laboratory personnel and Lay Providers.*
- *Training of HTS providers shall be conducted by accredited HTS Training Institutions using MOH approved curricula*

8.5.1 HTS service providers

All HTS providers should be trained using the nationally approved curricula for the different HTS models. An HTS provider must be competent and proficient in providing pre- and post-test information or counselling including HIV testing.

HTS sites should ensure that all HTS providers have sufficient knowledge, skills and attitudes to offer comprehensive HTS as per the different models available in the country. Lay Providers, who are appropriately trained and certified should provide these services under supervision of a qualified and competent HTS provider.

8.5.2 Use of Lay Providers

Task-sharing through the use of trained and well supervised Lay providers is highly recommended to increase access to and reduce missed opportunities for HTS. MOH shall standardize the training and supervision of Lay providers to ensure they deliver quality HTS. The Lay providers' scope of work in relation to HTS shall include:

- Demand creation
- Health Education
- Pre-test Counseling and information giving
- Conducting rapid HIV tests if trained and certified
- Post-test counseling
- Linkage to Prevention, care, treatment and support services
- Follow-up of clients including tracing those lost to follow-up

Lay providers should be engaged at community and health facility level where task sharing is applied to complement HTS

8.5.3 HTS Provider qualifications

HTS providers should possess a minimum education background of the Uganda Certificate of Education (UCE)/Ordinary level or its equivalent. This applies equally to those with or without a medical background.

8.5.4 Performing an HIV Test

HIV testing using the rapid test kits should be conducted by trained and certified providers. Other HIV tests including ELISA and virological tests should be performed by qualified Medical Laboratory personnel

8.5.5 Training in HIV counselling and testing

All HTS providers should undergo the foundational HTS training using standardized National HTS training curricula. This training shall take the duration of 10 working days in a classroom setting followed by a supervised field practicum.

All HTS training must be conducted by trainers certified by MOH.

All HTS providers MUST:

- Meet the minimum educational qualifications required to perform specific tasks
- Demonstrate knowledge of content of an MOH approved HTS curriculum
- Complete a period of supervised practice (as specified by the specific training curriculum) with endorsement by a supervisor, and
- Pass a final assessment

After earning the basic certificate to provide HTS, providers can then be oriented in the different models of providing HTS depending on their organizations or institution's mandate and settings.

HTS providers should regularly update their knowledge through refresher and in-service training. Health workers are required to earn 24 hours of Continuing Medical Education (CME) per year as per national guidelines. Non-medical HTS providers should participate in an equivalent number of hours of refresher training per year in order to be certified and hence ensure quality HTS services.

8.5.6 HIV Tester and Site Certification

Certification is the process by which an independent and authorized agency assesses the quality system of a facility/site and/or competency of a provider based on certain pre-defined standards¹⁵. Certification gives formal recognition that a facility/site or tester is authorized to carry out a specific task such as HIV rapid testing for diagnosing HIV infections¹⁵.

Policy statement

- a. HIV rapid testing shall be conducted in accredited sites by certified testers.
- b. MOH in collaboration with other certifying and licensing bodies shall establish and implement a certification and an accreditation system for sites and testers.
- c. HIV rapid testing sites and testers that meet the accreditation criteria shall be allowed to provide HTS. Sites and testers that do not meet the minimum standards for accreditation shall be supported to attain accreditation status before being permitted to provide HTS

Specific Objectives of Certification

1. Ensuring adherence to national standards of delivering HIV rapid testing

2. Ensure availability of competent personnel for HIV rapid testing
3. Ensure conformity of sites to national standards for quality results

Rationale of HIV Testing Certification

HIV Rapid tester (figure 16) and site certification (figure 17) shall be a key strategy to enhance the quality of HTS¹⁵.

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

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

Implementation and maintenance of HIV rapid testing site and tester certification program adds credibility to any testing site, provides the means to ensure and monitor adherence to quality standards and instills confidence in the results for patient care. This program provides an umbrella under which all aspects of quality HIV testing shall be gathered and continuously monitored.

Figure 16: Tester Certification Process

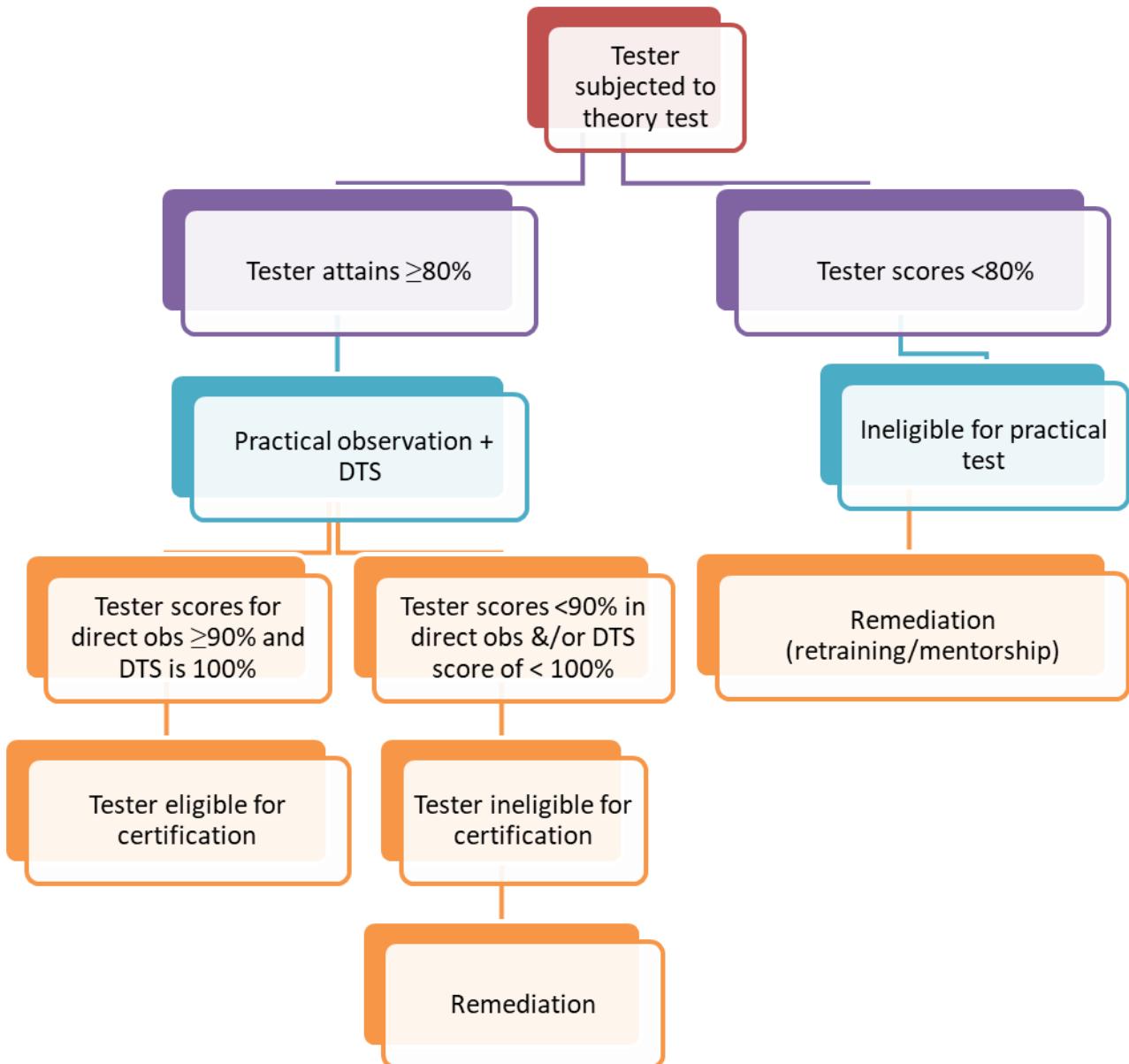
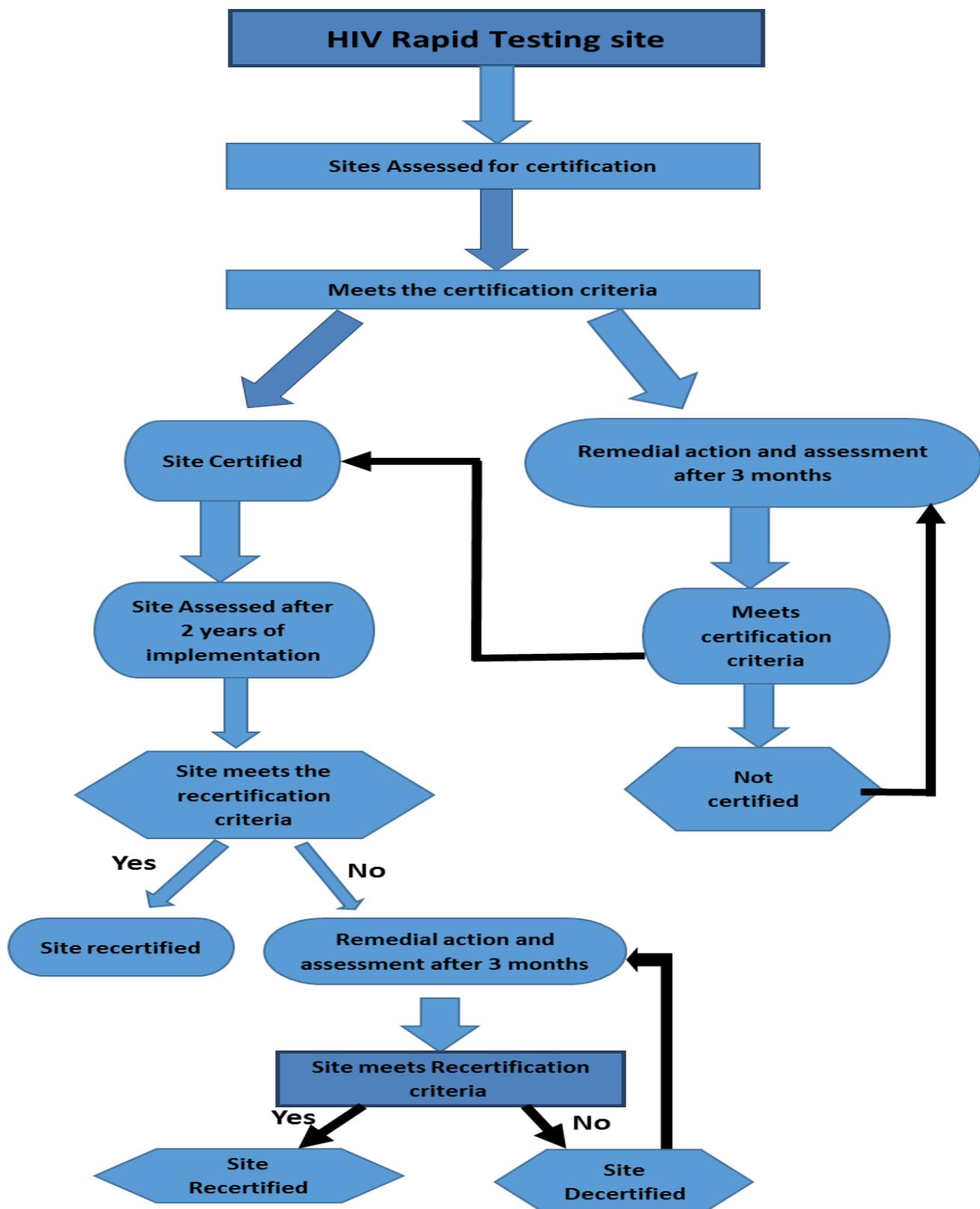


Figure 17: Site Certification Process



National Certification Committee (NCC)

This shall be a multi-sectorial committee with diverse membership to increase objectivity, minimize bias and address conflict of interest. It shall be comprised of technical personnel from the following institutions: UVRI, Allied Health Professional council (AHPC), CPHL, Uganda Medical Laboratory Technologist Association (UMLTA), ACP, Quality Assurance Department (QAD), Civil Society Organizations (CSOs), Ministry of Trade - National Bureau of standards (UNBS), Ministry of Education, testers, Academia, NDA, Private practitioners, Uganda Healthcare Federation, Uganda National Health Consumer Association (UNHCO) and PLHIV Networks. Members serving on this committee shall be assigned by the Director-General, Health Services (DGHS), MOH and will serve for a three-year term before new members are nominated. The recommending authority upon satisfactory performance may renew the three-year term for each member of the independent certification committee.

HIV Testing Certifying Body

National HIV Reference Laboratory (NHRL)/UVRI shall have the mandate from MOH to conduct quality assurance for HIV rapid testing in Uganda. UVRI shall be the Certifying Body for HIV rapid testing sites and testers. It shall work closely with the ACP and the QAD of MOH in fulfilling its role.

Implementation of HIV Testing Certification

Implementation of the HIV Testing Certification shall include a process of assessments/audits of the testers and testing sites, certification, decertification, recertification, monitoring and evaluation¹⁵.

Certification shall ensure maintenance of standards and reliability of results generated to support clinical and public health activities by the HIV Testing point (site) and HIV Rapid Tester (HIVRT).

Both HIVRT and Site certification shall be valid for a period of not more than two years

8.5.6.1 Tester Certification

Tester Certification should verify that the provider performing HIV testing is adequately trained, is authorized to do so and there is evidence of demonstrated competency¹⁵.

This shall encompass

- Training of all testers using the MOH approved curriculum.
- All testers should pass the post-training assessment of HIV rapid testing in both theory (with minimum of 80%) and practical (100%) to become eligible for an onsite evaluation
- All testers MUST pass an onsite evaluation of HIV rapid testing in both theory (with minimum of 80%) and practical (100%) to become eligible for certification

When the evaluations are completed, reports shall be submitted to the ICC for final decision in regards to HIVRT certification. Testers who passed the evaluation are eligible for certification.

Testers who fail to achieve the pass mark will be supported for a period of three months before re-assessment. HIV Rapid testing should be performed by this tester under supervision by a certified tester. They should be given three opportunities to be re-assessed within a period of two years and if this tester does not achieve the standard pass mark after the three consecutive evaluations, he/she shall not be permitted to perform HIV Rapid testing.

Suspension of tester certification

Suspension of testers may occur within the period of two years or when the certification expires. Suspension may occur in the following scenarios;

- If tester(s) does not participate in HIV rapid test PT panel for a period of two years
- Tester(s) participates but fails two consecutive HIV rapid test PT within the two years
- Tester(s) exhibits behavior(s) contrary to ethical code of conduct.

Recertification of Testers

Testers whose certification has been suspended can be re-certified upon completion of remedial action and passing the certification criteria. Figure 17 above describes the process of HIV rapid tester certification, de-certification and re-certification

8.5.6.2 Site Accreditation/Certification

To ensure provision of quality HTS, testing points within health facilities will be assessed for conformity to minimum standards and thereby be certified.

Site Certification entails verification of HIV Testing Points, testing procedures, validity of test results, competency of staff, and site conformity to a quality management system¹⁵.

This shall involve enrolment of sites onto the certification program and conducting national site audits by Auditors¹⁵. When National audits are completed, reports shall be submitted to the ICC for final decisions. Sites that are eligible for certification (scoring >90%) will be certified. Sites with scores <90% will be supported for three months before another National audit is conducted.

Decertification and recertification of testing sites

Testing sites may be decertified within the 2 years' or after expiry of the two years' certification period¹⁵.

Scenarios under which decertification may occur include:

- Closure of site(s) due to regulatory non-compliance
- Cessation of HIV testing at a particular site(s)

Recertification of testing sites

Sites that are suspended can be re-certified upon corrective action and passing the certification criteria.

Auditor Certification Process

Auditors for site certification shall be identified from experienced health practitioners who have undergone relevant site audit training¹⁵.

- Auditors shall be trained using an approved curriculum
- They will be subjected to practical and theory examinations
- To certify a trainee as an auditor, an average score of 80% in the theory exam and ≥90% in practical auditing skills must be attained. Certification shall expire after a period of two years.
- Recertification of auditors shall be after two years. An auditor should audit a minimum of 20 sites within a period of two years.

Certification of Evaluators

Evaluators for tester certification shall be identified from experienced health professionals who have undergone relevant tester Evaluation training. Recertification will be every two years based upon;

- Successful completion of 50 tester evaluations within two years.
- Passing evaluator competence assessment

Maintenance of site and tester certification

This shall be done using the following approaches;

- **Mentorship:** A national mentorship guide shall be used at the site by Quality officers, Trainers of testers, Auditors and Experienced Point of Care Testers (POCTs)
NB: Site(s) should be mentored at least quarterly and there should be mentorship reports
- **Support Supervision:** This shall be conducted quarterly using the national support supervision tool.
- **Continuous Education:** Testers shall undergo refresher training(s). They should participate in continuous professional development (CPD) in accordance with the national approved curricula.
- **Participation in HIV EQA:** All testers must participate and pass the national HIV proficiency-testing program at least once a year.
- **Competency Assessments:** The competency of the tester shall be assessed once every year during the two years of certification.

8.5.7 Qualification of HTS Trainers

HTS Trainers should have a minimum of a diploma in a health and/or other related fields. In addition, he/she should possess the following requirements:

- Strong background knowledge in HIV/AIDS Counseling skills
- Experience of not less than 6 months providing HTS
- Training of trainers (ToT) skills from a recognized institution.
- Be oriented in the use of standardized HIV counselor training courses approved by MOH.

HTS trainers should regularly update their knowledge and skills through personal reading, seminars, refresher training, conferences and further training so as to remain relevant.

8.5.8 HTS Provider Support Supervision and Mentorship

HTS supervisors should be professionally competent to provide personal and professional support during supervision meetings.

At **national level**, MOH shall conduct quarterly oversite supervisions and mentorships to ensure quality HTS. These shall be conducted by national trainers and mentors. HTS implementing programs should institutionalize support supervision activities. MoH shall develop standardised supervision guidelines, tools and checklists to guide supervisors to provide quality supervision of HTS providers.

At **district level**, support supervisions and mentorships as part of CQI should be conducted to ensure quality HTS.

At **facility level**, the team should implement remedial actions arising from support supervision and mentorship and ensure compliance to SOPs, standards and guidelines.

8.5.9 Composition of HTS Providers

The following persons shall offer HTS;

- Laboratory personnel
- Trained and certified Lay testers.

8.6 Quality Assurance and Control (QA & QC) for HTS

Quality Assurance (QA) shall be an in-built component of the HTS cascade. All facilities should offer HTS as per the set standards, implement QI activities and carry out Quality Control (QC) activities to ensure quality HTS

QA in the context of HTS refers to adherence to the HTS set standards; conducting QC and CQI to offer quality HTS. QA shall be achieved through training, mentorship, certification, DQA and implementation of process control mechanisms. Routinely collected HTS data should be used to track performance, identify gaps and utilize CQI approaches to improve performance.

8.6.1 Adherence to standards and policies

HTS shall be provided according to the provisions of this policy and guidelines. Therefore, HTS supervisors and managers should ensure that HTS providers adhere to the set standards such as protocols, approved algorithms and guidelines.

Non-compliance shall result in withdrawal of certification and hence, prohibition from providing HTS.

8.6.2 Quality Assurance for Laboratory reagents and test kits

a) WHO Prequalification

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

b) Registration by regulatory bodies

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

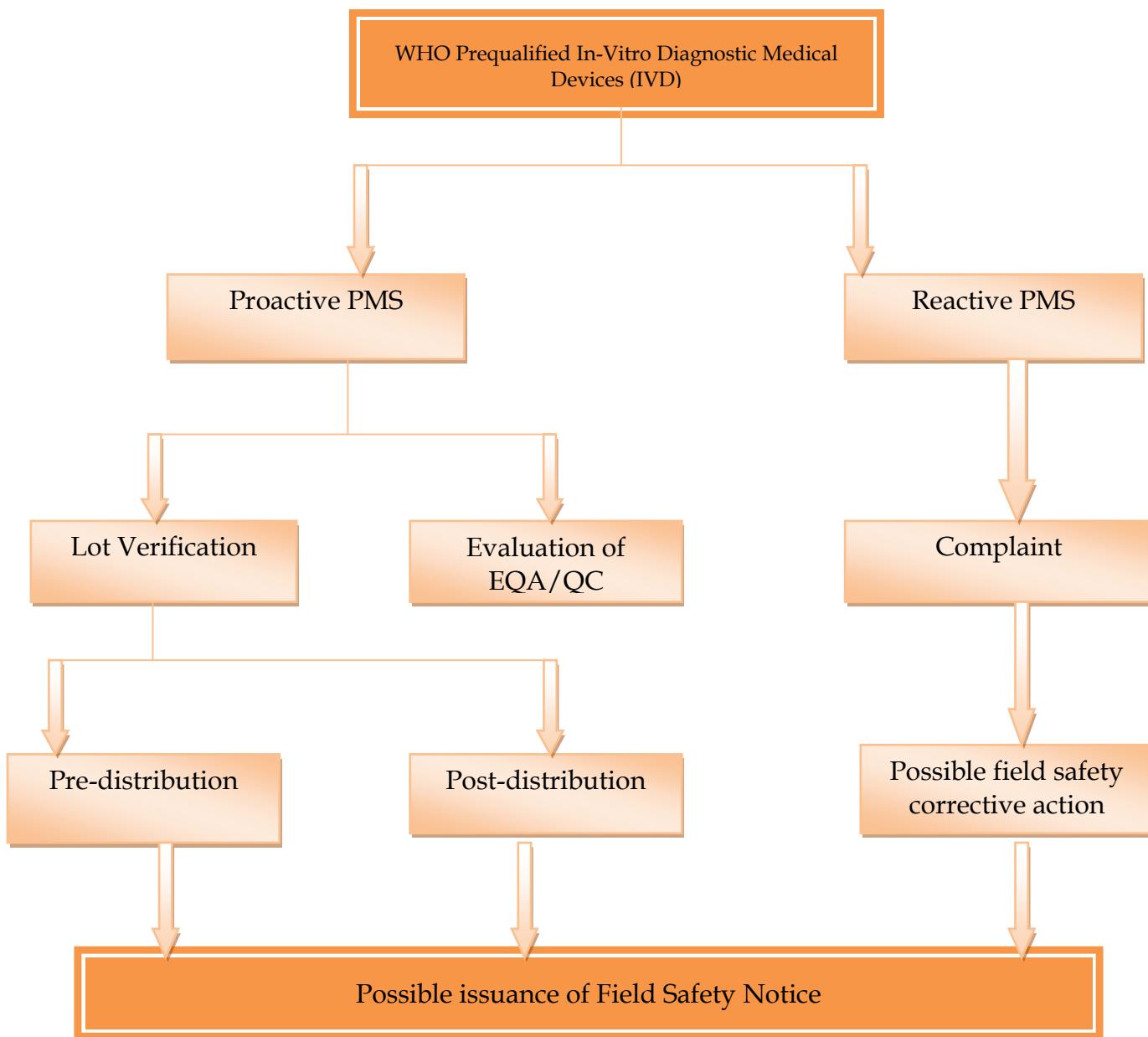
c) Lot to lot validation

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

Proactive post-market surveillance must be conducted through in-country lot/batch verification testing, before and after distribution of test kits to testing sites according to set National guidelines. This will be conducted periodically by the National drug authority in conjunction with MOH to assess the quality and performance of the test kits in use, in compliance with the set standards.

Reactive post-Market surveillance of all test kits must be conducted through reporting and evaluation of complaints, including reports of adverse events, and any required actions to correct the problem and prevent re-occurrence. The steps for post market surveillance are depicted in figure 18 below¹⁸.

Figure 18: Steps for post Market surveillance of WHO prequalified Diagnostic kits



MOH shall conduct evaluations of HIV test kits and laboratory reagents for potency every five years or earlier based on new scientific evidence.

All HIV test kits shall be validated prior to importation, on their arrival and during their use as per national standards.

HTS providers should ensure proper storage of all supplies at designated storage spaces. This should be in line with the manufacturer's specifications and recommendations.

8.6.3 Quality assurance for Recent infection testing

As part of laboratory QC, clients who consent for point of care testing for recency also consent to provide extra blood samples for shipment to Uganda Virus Research Institute (UVRI) for Viral Load testing and re-testing. Recent Infection Testing (RIT)^{29,30} combines results of recent infection assay and viral load for final interpretation of recency status. Specimens that test recent on RTRI with a viral load result $\geq 1,000$ copies/mL will be classified as a RIT recent infection while specimens that test recent on RTRI with a viral load result $< 1,000$ copies/mL will be classified as RIT Long term infection. Including the additional VL reduces misclassification of an infection as a recent infection when the infection is actually long term.

8.6.4 Quality assurance (QA) for Laboratory processes and procedures

All testers and testing points shall undergo certification before commencing testing. Testing sites and testers shall be audited and assessed bi-annually using the SPI-RT checklist. Certification shall be awarded to those that meet the criteria. Testers and sites that do not meet certification criteria shall be supported to bridge gaps identified during audit and assessment.

HTS SOPs should be available on site, displayed, read, understood, signed by users and adhered to.

Testing SOPs should provide detailed instructions on all aspects of testing including:

- Test requesting
- Environmental requirements
- Test performance
- A stepwise process for conducting the test
- QC instructions
- Test interpretation
- Reporting and recording results
- Appropriate use of the testing algorithm
- Storage
- Inventory information
- Internal and external quality assurance requirements.

Manufacturer instructions will be periodically reviewed for any new information on the test kits as deemed necessary. HIV testing and safety related SOPs should be reviewed at least annually.

²⁹Galiwango RM et al. Short Communication: Validation of the Asante HIV-1 Rapid Recency Assay for detection of Recent HIV-1 infections in Uganda. AIDS Res Hum Retroviruses 2021; 37(12): 893-896.

³⁰HIV Recency Testing in Uganda: Update 2020 https://ug.usembassy.gov/wp-content/uploads/sites/42/HIV-Recency-Testing-in-Uganda_Update_Dr-Emmy-Muramuzi_Ministry-of-Health_UCSF.pdf

QC specimens from a National Reference Laboratory (NRL) or Public Health Laboratory (PHL) accredited to perform the production of such materials should be used to evaluate quality of test kits and proficiency of the testers.

EQAs shall be conducted through proficiency testing, retesting a subset of specimens or all positives by another qualified tester, facility or laboratory.

8.7 External Quality Assessment (EQA)/Proficiency Testing (PT)

External Quality Assessment (EQA) is the objective assessment of a test site's operations and performance by external agency or personnel^{15,31}. Proficiency testing (PT) is **the evaluation of practitioner performance against pre-established criteria**. Proficiency testing schemes (PTS) are inter-laboratory comparisons that are organized regularly to assess the performance of analytical laboratories and the competence of the analytical personnel^{15, 31}.

In Proficiency Testing (PT), samples are prepared from HIV positive sera which are obtained commercially and HIV negative sera which are prepared in the laboratory. The performance of these samples is evaluated with the appropriate screening tests before they are dispatched to the HIV Rapid testers¹⁵.

Policy Statements:

- i. All HIV Rapid Testers shall participate in External Quality Assessments (EQA)/Proficiency Testing (PT) at least once every six months
- ii. Dry Tube Specimens (DTS) shall be utilised for HIV Rapid testing and EQA/PT
- iii. The National HIV Reference Laboratory shall be responsible for PT packaging, distribution and evaluation.

8.7.1 Proficiency Testing Process

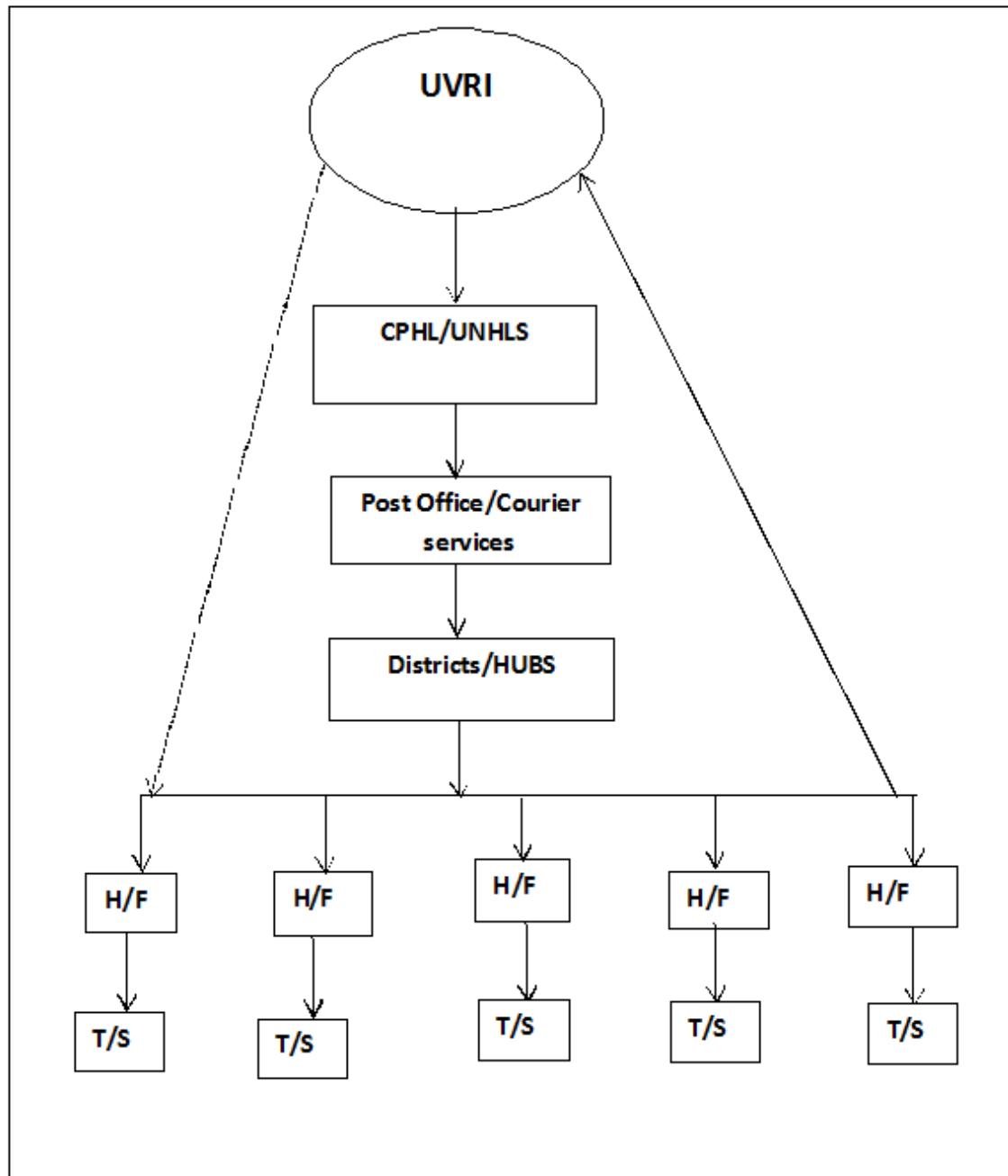
PT samples shall be sent out on a quarterly basis to all HIV Rapid Testers. Testers are expected to analyse these samples and send results to the National HRL within 30 days of dispatch. All results received will be processed at HRL and feedback given to the HIV Rapid testers with an identification code.

The PT process is depicted in figure 19 below.

³¹Guidelines for appropriate evaluations of HIV Testing Technologies in Africa

<https://www.afro.who.int/sites/default/files/2017-06/rpa%20HIV%20Test%20Evaluation%20Guidelines.pdf>

Figure 19: National Proficiency Testing Process



UVRI=Uganda Virus Research Institute; CPHL=Central Public Health Laboratories, UNHLS=Uganda National Health Laboratory service; HF= Health Facility; TS = Test Site (Point of Service)

Benefits of PT

- Evaluations of laboratory testing competence
- Assessing individual testing performance of laboratory STAFF
- Evaluation of reliability of a test procedure
- Establishing the degree of accuracy of test results in the specimen
- Provision of analytical information to participating laboratories for self-evaluation.

Application of Dry Tube specimen (DTS) in EQA/PT

DTS shall be the cornerstone of EQA/PT

Composition of DTS

DTS is composed of 20µL of plasma/serum mixed with 0.1% dye placed in a serum tube and left to dry in air overnight.

Procedure of DTS

The procedure for the delivery of DTS shall involve the packaging, distribution, testing and evaluation of testers' results

i. Packaging

Before distribution the panels shall be packaged in a parcel and addressed to the respective Hubs in the districts.

Each parcel contains identical packages destined to the individual (target) testing sites in a specific District, together with a checklist of the target sites.

The PT packages to the testing site consist of: A pre-packed panel (of 7 tubes & 7 pipettes), Paper work of the HRL Director's Bulletin, DTS Reconstitution procedure and the PT report form. This is accompanied with a pre-stamped General Post Office (GPO) envelope if delivery is via post office or a non-stamped envelope for the hub system delivery.

ii. Distribution

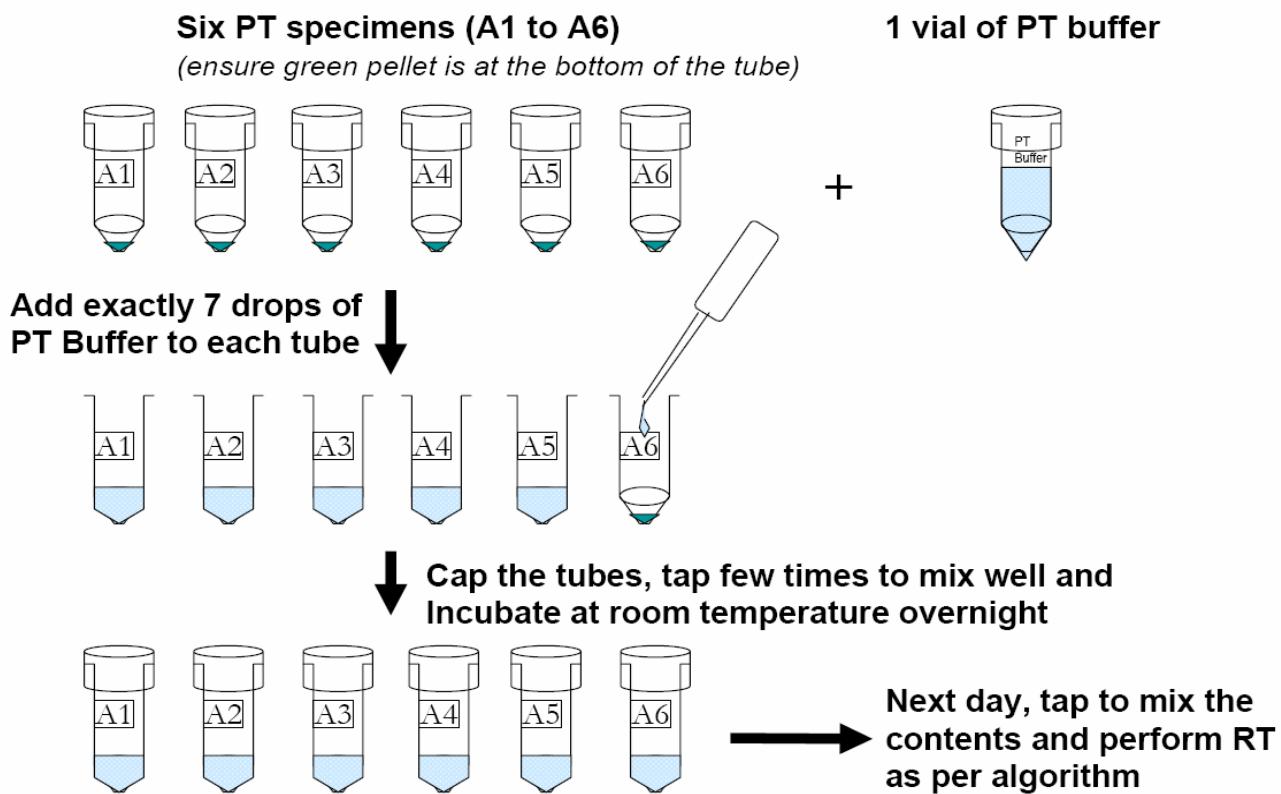
This shall be done on a Quarterly basis. All panels/packages destined to target testing sites in a particular district are packaged together in a parcel and delivered through either the post office or the hub system.

iii. Testing

On arrival at testing sites, the figure 21 below will provide guidance in reconstituting samples.

Figure 20: Reconstitution of DTS samples

DTS Testing Instructions



iv. Evaluation of PT results

It shall be the mandate of the HRL to evaluate PT performance of testers and providing feedback.

8.8 Evaluation of test kits and other laboratory reagents

MoH should conduct periodic evaluations and QA of HIV testing kits and reagents. Protocols for quality standards for reagents should be developed, printed and distributed regularly to all facilities performing HIV testing as per the manufacturer's specifications for HIV test kits or reagents in use.

The quality of HIV laboratory diagnosis should continuously be monitored. Poorly performing laboratories should be identified and supported through mentorship, training and corrective actions.

Modes of monitoring quality of laboratory diagnostics include:

- Internal controls
- Periodic site audits

- Tester competency assessments
- Periodic Proficiency testing
- Routine observation of lay testers by the laboratory supervisor

8.9 Commodities and Quality Assurance for HIVST

8.8.1 Performing HIVST

HIVST shall follow the “testing for triage” strategy as recommended by WHO.

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

8.9.2 Diagnostics for HIVST

All HIVST should be performed in accordance with the assay manufacturer’s instructions on the insert in the kit¹³. In addition, procedures have been packaged with the kits to help Individuals minimize testing and reporting errors and improving the quality of the test results. Guidance for additional testing and linkage to prevention services shall be provided to the client upon kit collection.

8.9.3 Performance characteristics of assays for HIVST

In Uganda, the performance characteristics and conditions in table 7 below shall be considered when selecting assays for HIVST in Uganda¹³.

Table 8: Performance characteristics and conditions for selecting Assays for HIVST in Uganda

Criteria	Description
Prequalification	<ul style="list-style-type: none"> • High-quality manufacturing standards, according to ISO 9001 • Should be WHO prequalified
Validation	<ul style="list-style-type: none"> • Local and /or international evaluation conducted
Time to result	<ul style="list-style-type: none"> • Result within not more than 20 minutes
Ease of use	<ul style="list-style-type: none"> • Should not require additional equipment to perform and interpret results • Should not require technical training to perform the test • Stable end-reading points
Affordability	<ul style="list-style-type: none"> • Should be affordable for both public and private sector users
Packaging	<ul style="list-style-type: none"> • Single packing of complete set • Pictorial instructions for use with any text-based instruction

Shelf Life	• Not less than 12 months
Storage	• Between 2-30 degrees Celsius.

8.9.4 Specimens for HIVST

These guidelines recommend two types of specimens.

Oral transudate: This is the recommended specimen for use in HIV testing using oral-based HIVST kit.

Whole blood: This is the recommended specimen for blood-based HIVST kits.

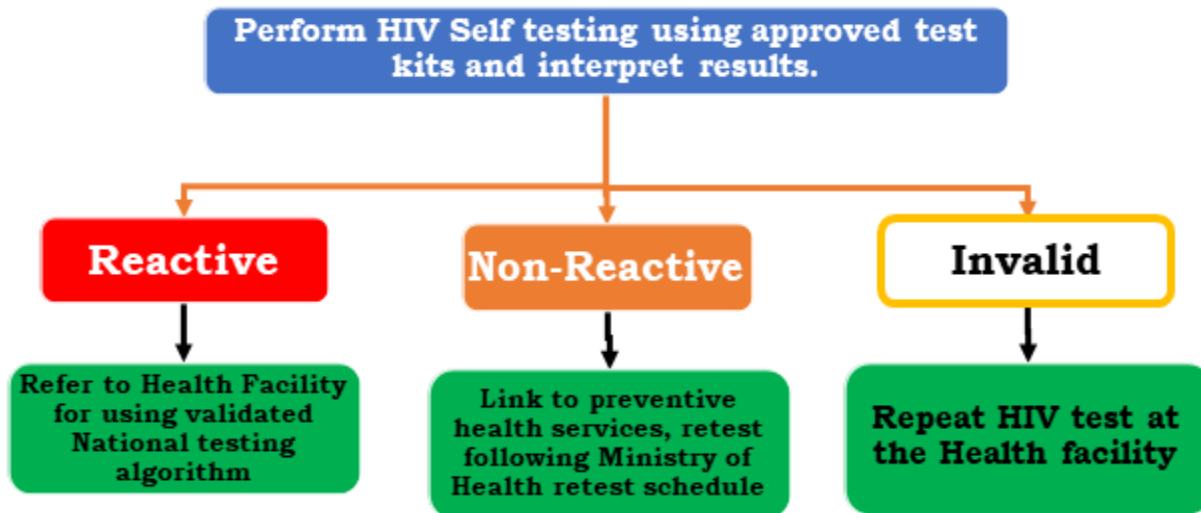
8.9.5 Sample collection and handling HIVST process

The instructions for use on the kit insert should be followed to ensure that adequate and appropriate sample is collected and used to guarantee accurate test results are obtained.

8.9.6 The HIV Self-Screening Algorithm

The HIVST strategy includes steps to follow during HIVST which includes performing the test, interpreting of results and next steps after interpreting results as shown in Figure 22 below¹³.

Figure 21: HIV Self-Screening Strategy



Procedure for conducting HIVST and interpretation of results

Manufacturer's instructions for performing and interpreting an HIVST shall be followed. Additional information should be provided through information for user, jobs aids, and instructional videos.

Components of Quality assurance for HIVST

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

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

a) Capacity building and sensitization on HIVST

All HIVST service providers should be trained according to the HIVST training package. Capacity building for HIVST will include trainings and mentorships using standard MoH curriculum targeting all HIVST providers.

b) Availability of testing aids, Instructions for Use (IFU) and Standard Operating Procedures (SOPs)

Information on the HIVST process should be readily available to all clients. All clients must also be aware of the need to confirm any reactive test results as per the national HIV testing algorithm.

c) Infection, Prevention and Control

Universal precautions should be observed during specimen handling. While the risk of HIV transmission through HIVST has been demonstrated to be minimal, clients should be made aware of correct practices for disposal of the biohazard waste after performing the kits both at

community and facility level to minimize biosafety risks. This information should consistently be provided prior to dispensing the kits as part of pre-test information giving/education.

d) Referral and linkages

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

8.10 Research

MOH shall guide HTS research to evaluate feasibility, acceptability, quality and effectiveness of interventions for evidence-based programming.

Research shall be an integral part of HTS implementation in Uganda. MOH shall collaborate with Research Institutions, implementing partners and individual researchers to conduct implementation science and surveillance-based research as well as population-based studies in HTS. HTS-related studies shall be done in consultation with MoH.

Operational research for innovative HTS models should be prioritised by HTS implementers. Findings from such studies shall be disseminated to all stakeholders to promote learning and adaptation. Research results shall be utilized to inform policy development, HTS programming and implementation.

All HTS research shall conform to the relevant legislation and ethical standards of practice set by appropriate research ethical committees and bodies of government at various levels.

8.10.1 HIV testing in Surveillance settings

HTS being the entry point for all HIV&AIDS related support, care and prevention services, will contribute to the HIV&AIDS surveillance function i.e. collection, analysis and interpretation and use of HIV/AIDS related data for public Health action.

HTS will therefore contribute to the following HIV&AIDS surveillance activities:

- HIV Recency Infection Surveillance
- HIV case-Based surveillance
- ANC Sentinel surveillance
- Periodic Surveys

The intersection between HTS and HIV/AIDS Surveillance will be done through collaboration, and integration in the following areas:

1. Data Collection, transmission, storage and reporting
2. Supplies,
3. Human Resource
4. Infrastructure
5. Public Health response

8.10.1.1 HIV Recent Infection Surveillance

All newly-diagnosed HIV cases by the national HIV testing algorithm and aged 15 years or older shall be tested for HIV recent infection and routinely monitored by demographic and risk characteristics^{29, 30}.

Justification

As Uganda moves closer towards reaching 95-95-95 goals and sustained epidemic control, it is important to have individual-level data to monitor trends in the actual number of newly-diagnosed individuals with HIV.

Information on the timing of HIV infection using tests for recent infection among newly-diagnosed persons provide important surveillance data on where and among whom recent transmission is occurring to guide the rapid public health response efforts.

These data will allow Uganda to better target HIV prevention programs to subpopulations and locations with a high burden of HIV, ongoing transmission and interrupt a chain of transmission.

Implementation guidance

HIV recent infection testing will be conducted at both health facility and community level. At the facility, recent infection testing will be done at the HTS testing points. At the community level, HIV recent infection testing will be integrated in the HTS outreach and other community HTS modalities.

All newly diagnosed HIV cases by the national HIV testing algorithm and aged 15 years and above shall be offered a test for HIV recent infection.

Eligible clients will be consented before testing for HIV recent infections. During the consenting process, clients will provide information on the purpose, risks, benefits, confidentiality and voluntary nature of participation. They will also be informed that their results shall not be returned.

In testing for HIV recent infections, a Point- of-Care Rapid Test for Recent Infection (RTRI) or any other approved Assay shall be used to test HIV recent infection. Whole blood, plasma or serum may be used in conducting the recent infection testing.

Data on recent infection testing shall be collected using the standard HTS tools. Collected data will be entered in EMR and uploaded to the central server hosted by CPHL. This data will be used for surveillance and public response only and NOT for diagnostic purposes.

9.0 Monitoring and Evaluation for HTS

Monitoring and evaluation (M&E) for HTS shall be conducted in line with the National Monitoring and Evaluation Framework for HIV/AIDS in the health sector.

Health Management Information system (HMIS) for HTS: MoH shall ensure review, availability and proper utilization of national HMIS tools for HTS. All HTS providers shall adhere to standardised mechanisms for HTS data collection, storage, analysis and reporting.

M&E for HTS shall be done in line with the National HIV and AIDS M&E framework for the health sector. Information generated shall be made available to responsible officers at national and sub-national levels to guide HTS planning, implementation and response.

9.1 Data collection for HTS

Program data for HTS shall be collected through the national HMIS. Data shall be collected at facility and community levels using the MoH approved HMIS tools including paper based and electronic tools.

9.2 Data collation and aggregation

a) Paper based tools

Collected facility and community HTS data shall be compiled and aggregated into the MoH approved HMIS Reports.

b) The Electronic Medical records (EMR)

The EMR shall be designed to enable data entry of HTS data from the primary tool (HTS client card) and auto-generation of required HTS reports.

9.3 HTS reporting

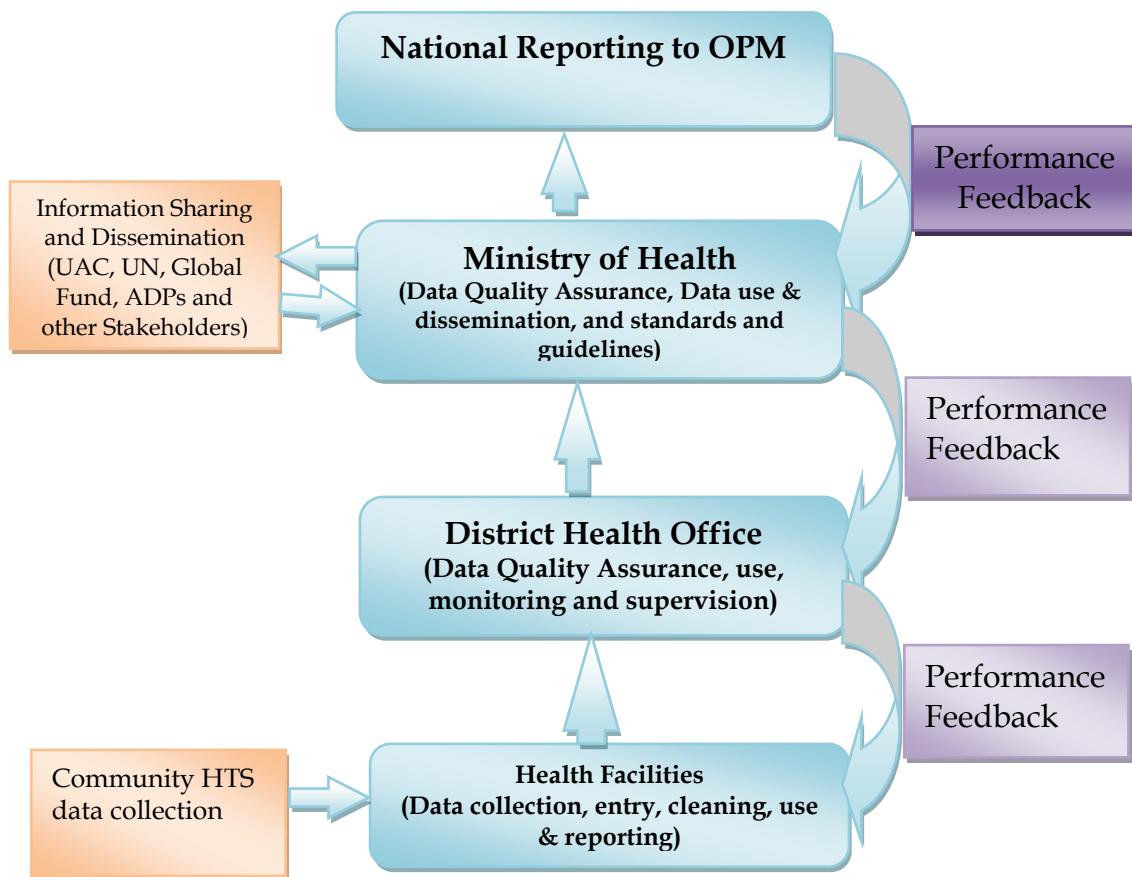
HTS reporting to the national level shall be done through HMIS reports as defined by MOH. The District Health Officer shall ensure that Health facilities submit timely and complete reports to the National Health data base (DHIS2).

9.4 HTS Information Sharing

The sharing of HTS information with stakeholders shall be done in line with the National MOH information sharing policy and other relevant guidelines.

The figure below shows the flow of data from the community/facility to National level.

Figure 22: HTS data flow chart



9.5 HTS Data Quality Assurance and improvement (DQAI)

Quality HTS data is required to inform provision of quality HTS.

HTS data quality shall be ensured through:

- Periodic Data Quality Assurance and Quality Improvements
- Support supervision
- Data review meetings
- Standardised MOH Approved tools

9.6 Desired Policy Outcomes

By 2026, the following are the desired outcomes of this policy and implementation guidelines;

- Quality and equitable HTS offered
- 95% of estimated HIV infected persons identified
- 95% of identified as HIV positive persons are linked into HIV care
- 95% of individuals identified as HIV negative are linked to prevention services

9.7 Policy Performance Indicators

The HTS program will track the following indicators, as aligned to the Health Sector HIV & AIDS Strategic Plan (HSHASP) 2018/19-2022/23³² and the health sector HIV and AIDS monitoring and evaluation plan 2018/19 – 2022/23³², as below:

Table 9: HTS Policy Performance Outcome, Process and Output Indicators

Level	Indicator	Frequency	Target	Source
Outcomes	Proportion of HIV-positive individuals who are aware of their HIV positive status	Monthly/ 5 years	95%	HMIS/ Survey/ spectrum
	Proportion of individuals who tested HIV positive	Monthly	4.0%	HMIS
	Proportion of key populations who tested for HIV and received their results	Annually	95%	Survey
	Proportion of individuals newly identified HIV positive through index client testing	Monthly	10%	HMIS
	Proportion of testers conducting HIV Rapid testing and are participating in HIV serology EQA, with 100% satisfactory passing	Quarterly	100%	UVRI EQA LIMS
	Proportion of approved HIV test kits that pass post market surveillance	Annually	100%	Post market surveillance reports
Processes	Proportion of individuals who tested and	Monthly	100%	HMIS

³²The Monitoring and Evaluation plan for the National HIV and AIDS Strategic Plan 2020/21-2024/25

https://uac.go.ug/index.php?option=com_content&view=article&id=23:hiv-prevention-1122&catid=8&Itemid=101

	received HIV Test results			
	Proportion of Individuals who were newly diagnosed with HIV	Monthly	3%	HMIS
	Proportion of newly diagnosed HIV positives and linked to HIV care	Monthly	95%	HMIS
	Proportion of individuals who were tested for HIV and received results as a couple	Monthly	N/A	HMIS
	Proportion of individuals who were tested for HIV and received results as a couple and whose results were discordant	Monthly	N/A	HMIS
	Proportion of individuals who performed HIVST and shared results with the provider.	Monthly	100%	HMIS
	Proportion of individuals who report HIV positive results following self-Testing and are retested using the National Algorithm	Monthly	100%	HMIS
	Proportion of pregnant and breastfeeding women who were tested HIV positive	Monthly	5%	HMIS
	Proportion of pregnant and breastfeeding women who were tested for HIV and received HIV positive results and were initiated	Monthly	95%	HMIS
	Proportion of eligible clients that accepted Index Client Testing services	Monthly	95%	HMIS
	Proportion of contacts elicited, notified and tested for HIV using Index testing services and received their results.	Monthly	95%	HMIS
	Proportion of newly identified HIV positives through Index testing services	Monthly	10%	HMIS
	Proportion of newly diagnosed HIV Positive individuals (15 years +) who were tested for recent infection	Monthly	100%	HMIS
	Proportion of newly diagnosed HIV Positive individuals who tested for Recent infection and have a documented recent result	Monthly	100%	HMIS
	Proportion of individuals who report social harm as a result of HTS	Monthly/5 years	100%	HMIS/ Survey
	Proportion of HIV Rapid testing sites participating in HIV serology PT/EQA	Quarterly	100%	UVRI EQA LIMS
	Proportion of HIV Rapid testers who are assessed and certified	Quarterly	100%	UVRI EQA LIMS
	Proportion of HIV Rapid testing sites assessed and certified	Quarterly	100%	UVRI EQA LIMS
Outputs	Number of HTS providers trained, mentored, coached	Quarterly	100%	Program Data
	Number of HTS sites certified	Annually	90%	Program Data
	Number of health facilities reporting adequate stock for HTS commodities	Quarterly	N/A	Program Data

INPUTS: The program will require the following inputs for the successful implementation of HTS activities and these include: HTS protocols and guidelines, human resource, financial resources/support and HIV commodities

10.0 Policy Implementation Framework

This section highlights the proposed framework for ensuring implementation of the policy guidelines to improve HIV testing services.

Table 10: Policy Implementation Framework

Level	Roles and Responsibilities
NATIONAL LEVEL UAC	<ul style="list-style-type: none"> Overall national coordination of multi-sectoral response to HIV and AIDS Leadership for planning, implementation and monitoring of HTS by different stake holders
NCTC	<p>Provision of oversight and technical support of the HTS cascade focusing on the following areas:</p> <ul style="list-style-type: none"> Policy and research laboratory services and supply chain QA M&E capacity building social mobilisation and communication
Ministry of Health	<ul style="list-style-type: none"> Coordination of technical aspects of implementation, monitoring and evaluation of HTS in Uganda Development and dissemination of a Priority Action plan for HTS Coordination of ADPs funding to support HTS priority areas Coordination of HTS partners Planning, policy formulation and setting standards Capacity building Ensure equitable distribution of HTS services across the country Adequate supplies and logistics management Research Developing a monitoring and evaluation framework integrated within the existing national Health management systems Provision of technical assistance to Support development of costed district integrated annual health sector HIV/AIDS response work plans Mobilize resources for HTS implementation including advocacy.
Development partners	<ul style="list-style-type: none"> Build local capacities for technical assistance in HTS programming Provide technical assistance to the HTS program i.e., planning, implementation, M&E and QA Finance HTS activities Provide support for HTS research Support Implementing Partners to realign HTS program resources in line with MOH priorities. Provide technical support to MoH in the development of policies,

	<p>implementation guidelines and strategic information systems</p> <ul style="list-style-type: none"> Support the development of costed district integrated annual health sector HIV/AIDS response work plans <p>Figure 24 below shows the coordination structure for HTS in Uganda</p>
Implementing partners	<ul style="list-style-type: none"> Provision of support to MOH to disseminate and distribute the HTS policy and implementation guidelines along the decentralized district health systems. Reinforce adherence to and use of the HTS policy and implementation guidelines during provision of HTS Build capacity of HTS providers through training, mentorship, and assessment for certification Support Implementation, monitoring and reporting for HTS <p>Support HTS sites participate in EQA for HIV testing.</p> <ul style="list-style-type: none"> Support HTS sites to utilize nationally approved data collection tools and conduct quarterly DQA Ensure sites receive adequate support supervision for HTS. Support development of SOPs, guidelines, and data management protocols to support the implementation of HTS at all levels
<u>Regional Level</u>	<p>At regional level, regional referral hospitals shall support HTS implementation by performing the following functions:</p> <ul style="list-style-type: none"> provide supervision for HTS implementation within districts and health facilities in the catchment area Coordinate and support HTS capacity building mechanisms (training, coaching, mentorship, CMEs) in the region Maintain quality assurance and ensure that facilities within the region adhere to HTS standards, policies and guidelines Coordinate different HTS implementing partners in the region Take lead in conducting HTS regional performance review and use of data for decision making Perform the health facility roles as described in facility section below
<u>District Level</u> District Health Officer	<p>The DHO through the district HTS Focal Person shall:</p> <ul style="list-style-type: none"> Profiling HTS partners in the district and developing a directory Coordination of HTS partners at district level Coordinating joint planning, implementation, monitoring and supervision of HTS activities within the district. Advocacy, communication and social mobilisation to implement district based HTS Conducting community assessments and identify priority areas and populations for HTS Conduct periodic review of facility HTS workforce/workload alignment to ensure that HTS staffing needs remain sufficient. Supervising HTS delivery at district level Managing HTS supplies and logistics Data management and reporting about HTS in the district QA of HTS ensures HTS is integrated within the district and health facility systems Ensure participation in HTS surveillance activities. Ensure facility teams are trained and mentored to provide quality HTS.

	<ul style="list-style-type: none"> • Ensure that the HIV testers and sites are assessed and certified. • Ensure that health facilities that provide index client testing services are assessed and accredited
Facility Level	<p>The health facility In-charge through a designated HTS Focal Person shall:</p> <ul style="list-style-type: none"> • Coordinate and ensure effective implementation of HTS at health facility and community level in line with national policies and standards. • Conduct support supervision, mentorship and coaching of HTS service providers both at community and facility • Coordinate supply chain management of HTS supplies at facility and community level. • Ensure effective referral and linkage for prevention, care and treatment services • Ensure data management including reporting • Promote demand creation for HTS including community mobilisation • Ensure internal quality controls and external quality assurance (QA) for HIV testing, and perform QA audits and Proficiency Testing corrective actions. • Ensure availability and correct use of HIV testing SOPs (testing algorithms adult and infant, EID dispatch books, HIV testing log book, waste management and safety precautions) <p>HTS providers shall:</p> <ul style="list-style-type: none"> • Provide quality HTS using national standards, protocols and guidelines <ul style="list-style-type: none"> - Conduct risk assessment and reduction counseling. - Conduct pre-test and post-test counseling - Perform HIV tests and give correct results. - Facilitate evidence based behavioral interventions (EBIs). - Provide and appropriately document referrals and linkages. • Utilize approved national tools for data and supplies management • Participate in HTS supportive supervision, and mentorships • Conduct continuous quality improvement for HTS • Create demand for HTS through health talks and other social mobilization approaches <p>All providers shall perform the above functions under the supervision of their respective unit heads/heads of department</p>

11.0 Policy Review Plan

The National HTS Policy shall be reviewed every 5 years. This is in alignment with the National HIV and AIDS Strategic Planning process.

12.0 Good Practices in HTS Programming

This policy and guidelines adopts good practices identified and documented globally, regionally and nationally to ensure effective HTS programming and delivery. These include initiatives and innovations that prove relevant, efficient, cost-effective, and sustainable and add value to the realization of the goals and objectives of this policy. Identified good practices include;

- Integration of HTS with other health services at all entry points
- Expansion/scale-up of HTS to public and private health facilities under the Public-Private Partnership (PPP) and the community programs
- Task sharing to trained and supervised lay providers, counselors, social and development workers, and teachers
- Targeting individuals and couples in most need of HTS classified as priority populations
- Target setting for the HTS program
- Using data to improve HTS programming.
- Use of peer-led HTS innovations for HTS delivery in adolescent/youth, PWDs and Key Populations
- Capacity strengthening for HTS providers through Pre-service training and in-service training, mentorships and Coaching, and peer and group supportive supervision

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²³Davies M-A et al. Survival of HIV-1 vertically infected children. Curr Opin HIV AIDS 2016; 11(5): 455-464.

²⁴Consolidated guidelines for the prevention and treatment of HIV and AIDS in Uganda, 2020. https://differentiatedservicedelivery.org/Portals/0/adam/Content/HvpzRP5yUUSdpCe2m0KMDQ/File/Uganda_Consolidated%20HIV%20and%20AIDS%20Guidelines%202020%20June%2030th.pdf

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²⁶Guidelines for Governance and Management structures, Ministry of Health, 2013. <http://library.health.go.ug/publications/governance/guidelines-governance-and-management-structures>

²⁷Accessibility Standards: A practical guide to create a barrier-free physical environment in Uganda. <https://unapd.org/publication/view/accessibility-standards>

²⁸National Annual Quantification for Public Health Facilities in Uganda for FY 2018/19 <http://library.health.go.ug/publications/pharmaceuticals-and-drugs/national-annual-quantification-public-health-facilities>

²⁹Galiwango RM et al. Short Communication: Validation of the Asante HIV-1 Rapid Recency Assay for detection of Recent HIV-1 infections in Uganda. AIDS Res Hum Retroviruses 2021; 37(12): 893-896.

³⁰HIV Recency Testing in Uganda: Update 2020 https://ug.usembassy.gov/wp-content/uploads/sites/42/HIV-Recency-Testing-in-Uganda_Update_Dr-Emmy-Muramuzi_Ministry-of-Health_UCSF.pdf

³¹Guidelines for appropriate evaluations of HIV Testing Technologies in Africa <https://www.afro.who.int/sites/default/files/2017-06/rpa%20HIV%20Test%20Evaluation%20Guidelines.pdf>

³²The Monitoring and Evaluation plan for the National HIV and AIDS Strategic Plan 2020/21-2024/25 https://uac.go.ug/index.php?option=com_content&view=article&id=23:hiv-prevention-1122&catid=8&Itemid=101

13.1 Annex 1: Policy Guidance for development of HTS Policy

These HTS implementation guidelines should operate within the scope of the national, regional and international polices; in alignment with national plans and harmony with other MOH implementing guidelines.

International guidelines

- WHO Consolidated Guidelines on HIV Prevention, Testing, Treatment, Service Delivery and Monitoring: Recommendations for a Public Health Approach, July 2021
- WHO Consolidated Guidelines on HIV Testing Services, 2019
- UNAIDS, 95*95*95 Fast Track Targets
- 65th UNGASS declaration to end the AIDS epidemic as a public health threat by 2030
- The Sustainable Development Goals

Regional Guidelines

- The East African HIV Prevention and Management Act 2012

National guidelines

- The Constitution of the Republic of Uganda (3rd revision, 15th February 2006)
- The Penal Code, ACP 120.
- National HTS Optimization Plan 2020/21 – 2022/23
- The Uganda HIV Prevention and Control Act (2014)
- The National Development Plan II (2016-2020)
- Minimum Initial Service Package (MISP) for Reproductive Health in Crisis Situations: A Distance Learning Module
- Implementation Guide for Differentiated Service Delivery Models of HIV and TB Services in Uganda March 2020
- The National HIV and AIDS Strategic Plan (2015/2016-2019/2020);
- The National HIV and AIDS Monitoring and Evaluation Plan (2015/2016-2019/2020)
- The National HIV and AIDS Indicator Handbook (2015/2016-2019/2020)
- The National HIV and AIDS Priority Action Plan (2015/2016-2017/18)
- Uganda Adolescent Sexual Health and Development Policy (2011)
- Ministerial Directive on Access to Health Services without Discrimination (2014)
- The Uganda Patient's Charter (2009)
- The National Integrated Antiretroviral Treatment and Care Guidelines for Adults and Children 2009
- Addendum to the National Treatment Guidelines, 2014
- The Home-based care policy guidelines
- Safe Male circumcision Policy, March 2010
- National Plan for Optimizing HIV Testing Services in Uganda (2020/21-2022/23)
- National HIV Testing Services Policy and Implementation Guidelines 2016, Uganda
- Ministry of Health -National Certification Framework for HIV Rapid Testing
- Addendum to the HIV Testing Services Policy & Implementation Guidelines: HIV Self-Testing & Assisted Partner Notification Services, November 2018

13.2 Annex 2: Glossary of terms

Accreditation of testing sites: this refers to ensuring that testing sites are supported and held to a standard of quality

Acute HIV Infection: Acute HIV infection is a highly infectious phase of disease that lasts approximately two months and is characterised by nonspecific clinical symptoms. Acute HIV infection contributes disproportionately to HIV transmission because it is associated with a high viral load. HIV infection may not be detected on antibody-based HIV tests only. Persons who are in the phase of acute HIV infection often have flu-like symptoms and may be core infectious than persons with chronic HIV infection.

Attendant: A person who cares for someone who is ill.

An active referral: is one in which the tester makes an appointment for the client or accompanies the client to the appointment and enrolment into HIV clinical care.

Client: An individual who seeks HIV counselling and/or HIV testing and/or support for HIV/AIDS and related conditions.

Client Initiated HIV testing and counselling: This is a type of HIV testing and counselling in which persons actively seek HTS, often at facilities that offer those services.

Couple counselling and testing: This is counselling provided to sexual partners or intending sexual partners to enable them take the test and receive results together.

Decentralization

Refers to the process of delegating or transferring significant authority and resources from the central ministry of health to other institutions or to field offices of the ministry at other levels of the health system (regional, district, health sub-district, primary health-care post and the community)

Discordant couple: Sexual partners with one testing HIV negative and the other testing HIV positive

Discordant test results: When one HIV test in an individual is reactive and another test using a different HIV test in the same individual, is non-reactive.

Disclosure: A process where a client shares his or her HIV test results with their partner(s), family, friends, community members or others for the purpose of obtaining their support. This is also done with the aim of actively preventing HIV transmission to sexual partners and/or unborn children.

Discrimination: Making an unjust distinction in dealing with people on the basis of their revealed or assumed HIV status, which results in them being denied opportunities, benefits, care or services

Drop-In Centre (DIC): are service delivery points targeting special sub-populations, who would otherwise fail to access health services including HTS.

Early Infant Diagnosis (EID): Testing of infants to determine their HIV sero-status, given that the infant can be infected in utero, peripartum or postpartum (breast feeding)

Ethylenediamine tetra-acetic acid (EDTA): This is a chemical that binds certain metal ions, such as calcium, magnesium, lead, and iron. It is used **in medicine to prevent blood samples from clotting**. EDTA is used extensively in the analysis of blood. It is also used in certain blood collection tubes used by medical laboratories. It is an anticoagulant for blood samples for CBC/FBCs, where the EDTA chelates the calcium present in the blood specimen, arresting the coagulation process and preserving blood cell morphology. Tubes containing EDTA are marked with lavender or pink tops.

External Quality Assessment (EQA): This is the objective assessment of a test site's operations and performance by an external agency or personnel

HIV testing algorithm: A combination and sequence of HIV test assays that have been agreed upon by a reference laboratory to represent HIV testing for a given purpose.

HIV Exposed Infant (HEI): Infants that are exposed to HIV either during pregnancy, delivery, and through breastfeeding or via maternal/parenteral exposure

Index Testing or index case HIV testing: A focused approach to HIV testing in which the household and family members (including children) of people diagnosed with HIV are offered HTS.

Indeterminate Results: HIV indeterminate status is the HIV status of an individual in whom the test results do not lead to a definitive status (where HIV negative or HIV positive).

Informed consent: A process by which a client voluntarily confirms his or her willingness to provide written or verbal consent to be tested for HIV or to provide information about his or her HIV status to a health care provider or researcher.

The agreement is obtained after the client has received information about the HIV test and understands the purpose of the procedure or after understanding the purpose of the exchange of the information as being in the best interest of his or her own health or that of the partner, or in the case of a pregnant woman, the foetus or the baby being breast fed.

Informed consent should be voluntary and conducted according to the legal and ethical requirements outlined in these guidelines.

Integration: Refers to the co-location and sharing of services and resources across different disease areas in the context of HIV, this may include the provision of HIV testing, prevention, treatment and care services alongside other health services, such as TB, STI, HBV and HCV services, antenatal care, contraceptive and other family planning services, and screening and care for other conditions, including non-communicable diseases.

Integrated service delivery: This is a service delivery approach that encourages and allows the health care provider to review the client as whole, assessing needs beyond the primary reason for the visit. This provides the basis for providing additional services or referring the client to receive services from another provider or facility. Its aim is to increase the efficiency of service delivery and reduce stigma associated with HIV/AIDS.

Internally Displaced Persons: People or groups of people who have been forced to leave their homes or places of habitual residence, in particular as a result, or in order to avoid the effects of armed conflict, situations of generalized violence, violation of human rights or natural-or human-made disasters, and who have not crossed an international border.

Key Populations: KPs are defined groups who, due to specific higher-risk behaviours, are at increased risk for HIV infection irrespective of the epidemic type or local context. KPs in Uganda as specified by the National HIV Prevention strategy are: SWs, Fisher Folk, Long distance Truck drivers, MSM, people in prisons and other closed settings, *boda-boda* men and the Uniformed Personnel.

Lay provider: Any person who performs functions related to health-care delivery and has been trained to deliver specific services but has received no formal professional or paraprofessional certificate or tertiary education degree to provide health-care delivery services.

Next of kin: Spouse or close blood relative

Non-reactive: Refers to an HIV antibody or HIV antigen/antibody test that does not show a reaction to indicate the presence of HIV antibody and/or antigen.

Outreach sites: This refers to sites where HTS services should be offered outside a health facility setting. This could be in smaller health facilities such as levels II and III and sites mentioned in the home based HTS models like workplaces, school establishments with a mechanism for ongoing support services for HTS clients.

Persons at high risk: These include heterosexual persons who have engaged in unprotected sex with someone of unknown or known HIV negative status, or have had sex with someone who has engaged in unprotected sex since their most recent HIV test.

Pre-test information: A dialogue and the provision of accurate information by a trained lay provider or health worker before an HIV test is performed

Primary HIV infection: acute HIV infection is also known as primary HIV infection or acute retroviral syndrome. It is the initial stage of HIV infection and it lasts until the body has created anti bodies against HIV that HIV tests detects.

Priority Populations: Populations with increased risks of HIV infection and transmission; yet have limited access to HTS. They include Key Populations, Vulnerable populations and populations with limited access.

Proficiency Testing: Proficiency testing is the evaluation of practitioner performance against pre-established criteria. Proficiency testing schemes (PTS) are inter-laboratory comparisons that are organized regularly to assess the performance of analytical laboratories and the competence of the analytical personnel.

Provider-initiated HIV testing and counselling: This is HIV testing and counselling offered by health care providers to persons attending health care facilities, as a standard component of medical care. It offers an opportunity to the client to opt in or opt out of the HIV test.

Quality Assurance (QA): Is a part of quality management focused on providing confidence that quality requirements should be fulfilled. Any arrangement that safeguards maintains or promotes the quality of HIV counselling and testing services according to defined national and international standards.

Quality control (QC): Is a material or mechanism which, when used with or as part of a test system (assay), monitors the analytical performance of that test system (assay). It may monitor the entire test system (assay) or only one aspect of it. Effective management and support to ensure that standard operating procedures stipulated at each service point are adhered to in order to ensure provision of quality HIV Testing services according to defined national and international standards.

Quality improvement (QI): Is a part of quality management focused on increasing the ability to fulfil quality requirements

Reactive: Refers to an HIV antibody or HIV antigen/antibody test, which shows a reaction to indicate the presence of HIV antibody and/or antigen

Refugees: People who are outside their country of nationality or habitual residence, and have a well-founded fear of persecution due to their race, religion, nationality membership of a particular social group or political opinion

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

Retesting: Refers to a situation where additional testing is performed for an individual after a defined period of time for explicit reasons, such as a specific incident of possible HIV exposure, such as unprotected sexual intercourse. Retesting is always performed on a new specimen and may or may not use the same tests as the one at the initial test visit.

Risk-based testing: Targeted HIV testing depending on an individual's risk of exposure

Shared confidentiality: refers to situations when client's medical information is shared among health workers for the purpose of providing the continuum of care to the client

Sensitivity: This is the probability that an HIV test correctly identifies all individuals who are infected with HIV.

Sero-conversion: Refers to a period from HIV infection to when sufficient quantity of HIV antibodies is produced by an individual to become detectable on a given HIV antibody and/or antigen test.

Specificity: This is the probability that an HIV test correctly identifies all individuals that are not infected with HIV.

Stigma: These are negative attitudes or perceptions of towards individuals who are known or perceived to be infected or affected by a condition such as HIV/AIDS.

Supply chain management: this refers to the process of ensuring uninterrupted supply and appropriate storage of test commodities.

Task sharing: This refers to the rational redistribution of tasks between cadres of health-care providers with longer training and other cadres with shorter training, such as trained lay health services providers.

Tester Certification: This is the procedure by which a third party gives written assurance that an individual performing point of care testing conforms to specified requirement within the laboratory and non-laboratory settings.

Trimester: Refers to three-month intervals of a woman's pregnancy. The first trimester is the period of pregnancy from the first day of the last menstrual period through completion of 14 weeks. The second trimester is the period between the 15th and 28th week and the third trimester the period of pregnancy from the beginning of the 29th through the 42nd completed week of gestation.

Voluntary HIV testing and counselling: A type of HIV testing and counselling model in which persons actively seek HIV Testing services out of their own initiative, often at facilities that offer these services.

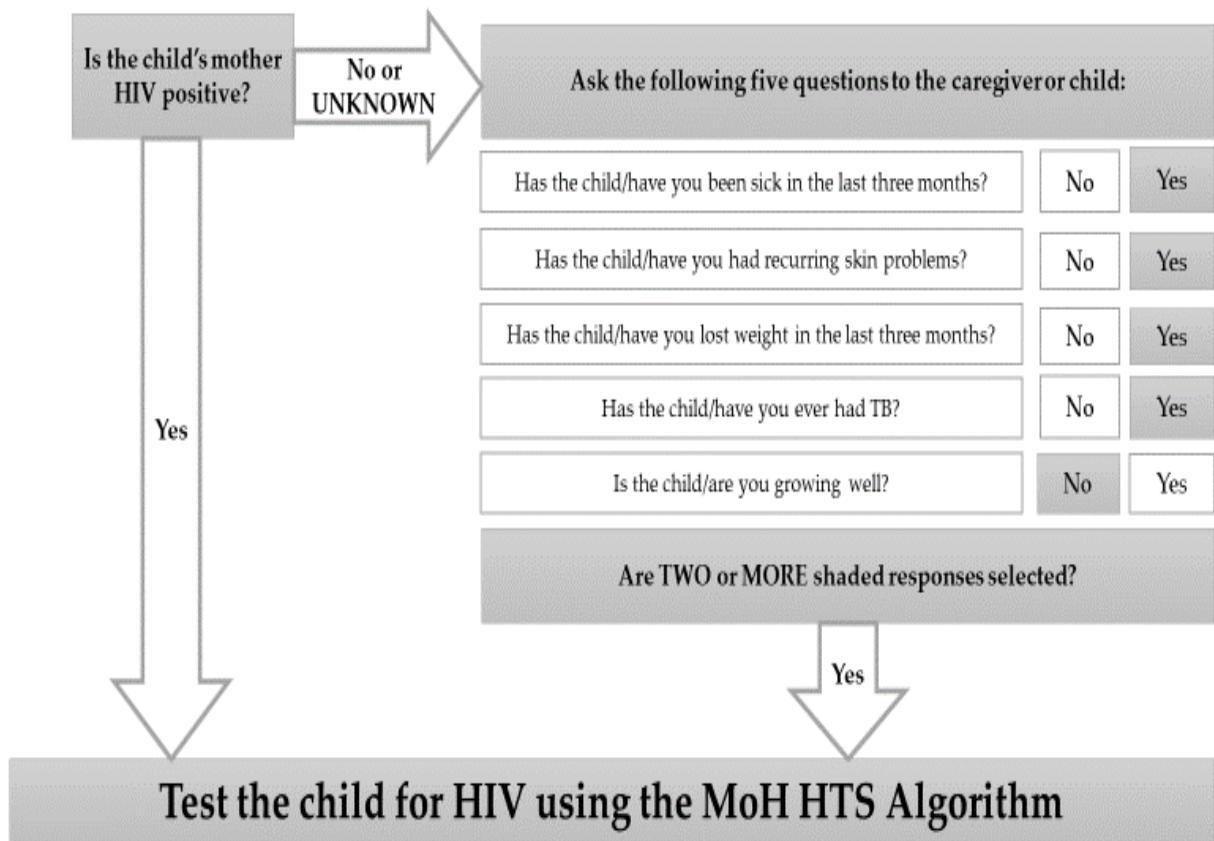
Vulnerable Populations: These are persons that are highly susceptible to or unable to protect themselves from significant harm or exploitation linked with HIV infection.

Window period: This refers to a period of time from when a person is suspected to have been infected with HIV to when HIV antibodies can be detected by a given HIV test assay. The window period varies from person to person and also depend on the HIV test assay used (1st, 2nd, 3rd and 4th generation tests assays). The mean time from exposure to development of antibodies is about one month. Most people should develop antibodies by 3-4 months.

14.0 Appendices

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APPENDIX A: Pediatric and Adolescent Eligibility Screening Tool for HIV Testing (18 months to 14 years)



Appendix B: HIV testing Screening Tool for adults (≥15 years)

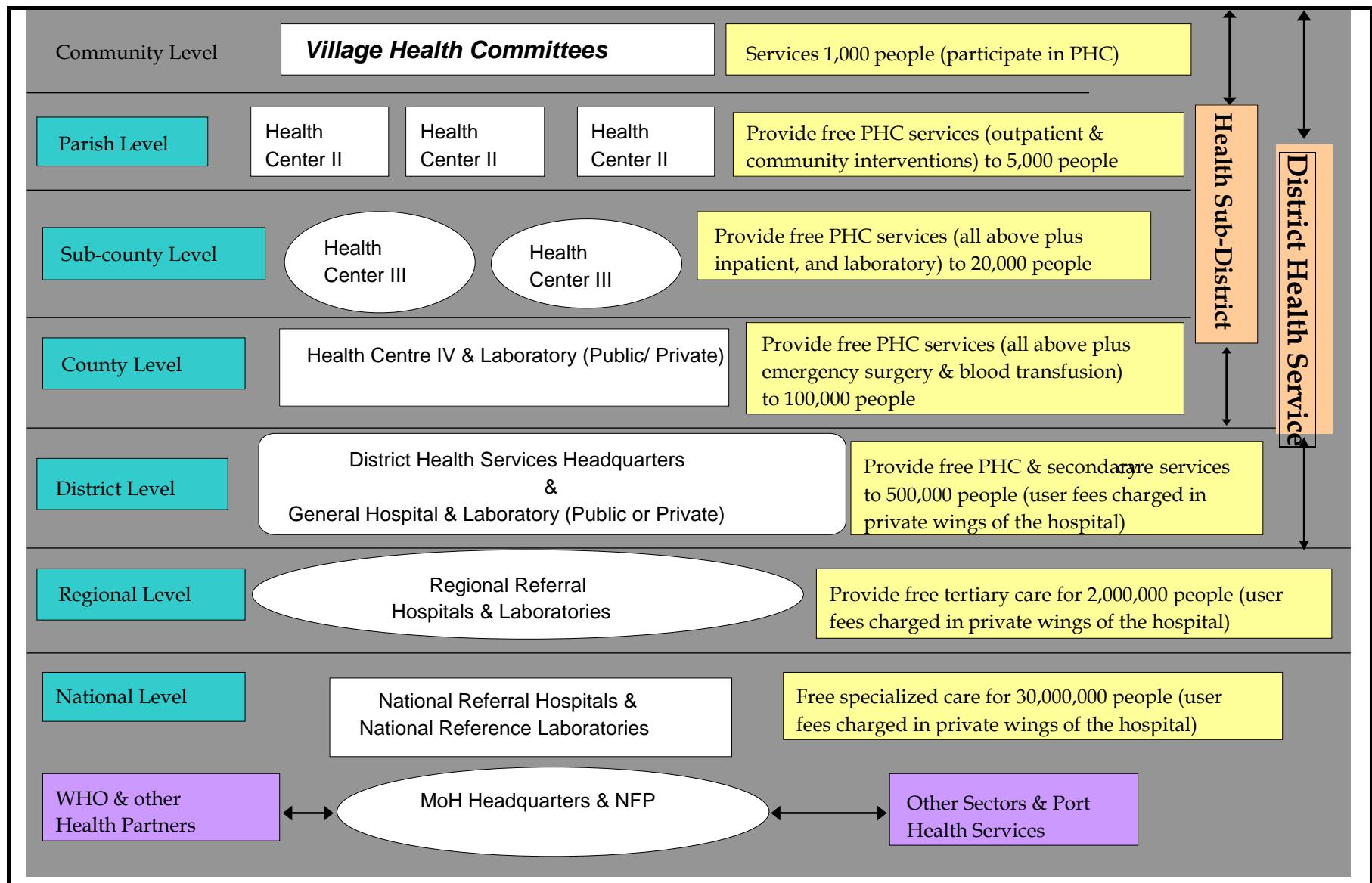
1	Does the client belong to ANY of these categories?		
1a	• Not tested for HIV in the last 12 months.	YES	NO
1b	• Has TB Disease or presumptive TB (2 weeks' history of Cough, night sweats, weight loss, fever)	YES	NO
1c	• Has symptoms of Sexually Transmitted Infection (blisters, sores, unusual urethral or vaginal discharge)	YES	NO
1d	• Newly diagnosed with Hepatitis B or C	YES	NO
1e	• Has experienced or caused Sexual violence (SGBV)	YES	NO
1f	• Has a reactive HIV self-test result	YES	NO
1g	• Has been identified through an Index client	YES	NO
1h	• Has been exposed to blood or body fluids from a Known HIV positive or unknown HIV status source	YES	NO
1i	• Has signs and symptoms of HIV disease and has not had an HIV test in the last 1 month.	YES	NO
For clients who have not tested for HIV in the last 3 months			
2	Have you had unprotected sex with partner(s) of unknown HIV status?	YES	NO
3	Have you had unprotected sex with an HIV positive partner? (includes discordance)	YES	NO
4	Have you shared injecting needles or piercing objects with anyone else?	YES	NO

NB: Always document screening eligibility in column 14 of the OPD register

If YES to any of the above, Client is ELIGIBLE for HIV testing

If "NO" to all the above, client NOT ELIGIBLE for HIV testing

APPENDIX C: UGANDA HEALTH STRATEGIC PLAN HUMAN RESOURCE HEALTH DELIVERY (Uganda one health strategic plan 2018-2022)



APPENDIX D: PHONE CALL SCRIPT FOR ASSISTED PARTNER NOTIFICATION SERVICES

Good day. My name is _____ and I am a health worker at
[Facility Name] _____.

Am I speaking with _____ partner's name _____?

[IF NO]: Is _____ partner's name _____ available?

[If partner is not available]: Thanks. I'll try back later.

[If YES]: To confirm I am talking with the right person, can you please tell me your age?
[Confirm age provided is same or within range of age reported by index client]

[If age is not same]: I'd like to plan a time to meet you in person. When is a convenient time you can come to the _____ facility?

[If identify confirmed]: I have some important information for you. Are you in a private location/place? Is now a good time to talk?

[If NO]: When would it be a better time for me to call you?

[If YES]: I am a health worker and everything we talk about is private. I am calling because someone who cares about you gave me your telephone contact so that I give you this health-related information. Your life might have been exposed to HIV. It is therefore important that you get tested for HIV right away so that you can learn your HIV status. HIV treatment is free of charge and can prevent serious illness.

We would prefer that you come to the _____ facility and discuss. HIV Testing Services are available Monday – Friday from 8:30 in the morning until 5:00 in the evening. **Alternatively**, we can send a health worker to your home for an HIV test. Which option would you prefer?

When you come to _____ health facility, ask for _____ (say your names), I will be available.

Please feel free to reach me on _____ (say your telephone contact) or my colleague _____ (say names and telephone contact) at _____ health facility in case I am not around.

[FACILITY TEST]: What day would you like to come in for an HIV test?

[HOME TEST]: What date and time would you prefer for the health worker to come to your home for an HIV test?

Thank the client for his or her time with you.

APPENDIX E: EXAMPLE OF PATIENT LETTER

Insert Date

Dear [Insert Patient Name],

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

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

Again, it is very important that I speak with you as soon as possible.

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

I look forward to speaking with you soon.

Best Regards,

Insert HTS Service Provider Name

Health Facility Name

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