



**FEDERAL MINISTRY OF HEALTH  
NIGERIA**

**NATIONAL GUIDELINES  
FOR  
HIV COUNSELLING AND TESTING**

**NOVEMBER 2011**



## Heart to Heart

*...We listen, we care*

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## FOREWORD

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HIV and AIDS is one of the most challenging health problems of this era. Since the first case of AIDS was reported in Nigeria in 1986, the number of persons infected with the HIV has risen markedly. By the end of 2010 it was estimated that over 3.1 million in Nigeria were living with the virus, and about 1,512,720 would require antiretroviral therapy. Based on the 2007 NARHS Report, only 14.5% of Nigerians have ever been tested for HIV, a large proportion of Nigerians still do not know their HIV status.

HIV Counselling and Testing (HCT) is universally acknowledged as an entry point to HIV prevention, treatment and care services; also a vital component for the expansion of access to comprehensive care for PLWHAs.

The benefits of HCT are numerous. It is a strong weapon against stigma and discrimination; provides accurate information on HIV/AIDS prevention; offers psycho-social support for the infected and affected and links the infected to other care and support services.

The benefits of HCT are dependent on the quality of service provided. It is therefore imperative that all persons who provide HCT services operate within acceptable standards. This Guideline should guide the practice of HIV counselling and testing and provide the minimum acceptable standards for the provision of HCT services in Nigeria.

I recommend this Guideline to all stakeholders in the response to HIV and AIDS in Nigeria, particularly organizations and institutions involved in the provision of counselling and testing for HIV/AIDS in the country.



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## ACKNOWLEDGEMENT

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## EXECUTIVE SUMMARY

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HIV Counselling and Testing (HCT) is a gateway to various HIV prevention, treatment, care and support services including Prevention of Mother to Child Transmission (PMTCT) of HIV. HCT provides opportunity for people to learn about HIV and AIDS, know their sero-status, as well as accept and cope with the outcome of their test results. It provides psychosocial support to people living with HIV and AIDS (PLWHA) and people affected by AIDS (PABA). It also facilitates behavioral change and helps reduce stigma and discrimination in the community.

The effort of the government is geared towards universal access to prevention, treatment, care and support by the year 2015. The universal access target for HCT is to counsell and test at least 80% of sexually active population (approx. 80 million) by 2015.

The national HCT Guidelines offer clear and unambiguous guidance for service providers in the practice of HCT, it also provides the minimum requirements for setting up an HCT site. The importance of this document cannot be overemphasized as the HCT services are being scaled up to the Primary Health Care centres.

The document is the product of the unflinching efforts of experts and stakeholders in the fight against HIV/AIDS in the country. It offers a set of recommendations necessary for the provision of high quality HCT service delivery.

The National Guidelines on HIV Counselling and Testing (HCT) is a nine-section document. Each of these sections address technical issues related to service Delivery Models, Coordination and Operational Requirements, HIV Counselling, HIV Testing, Scaling up HIV Counselling and Testing services, Ethical and Legal Considerations, Logistics Management and Monitoring and Evaluation.



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## ACRONYMS

|         |   |
|---------|---|
| AIDS    | Acquired Immune Deficiency Syndrome             |
| ANC     | Antenatal Clinic                                |
| APIN    | AIDS Prevention Initiative in Nigeria           |
| ART     | Antiretroviral Therapy                          |
| ARV     | Antiretroviral Drugs                            |
| ATM     | AIDS, Tuberculosis and Malaria                  |
| CBCs    | Community Based Counsellors                     |
| CBO     | Community Based Organisation                    |
| CDC     | Centres for Disease Control and Prevention      |
| CiSHAN  | Civil Society on HIV/AIDS in Nigeria            |
| CRH     | Centre for the Rights to Health                 |
| CSP     | Community Support Project                       |
| CT      | Counselling and Testing                         |
| CHCT    | Couples HIV Counselling and Testing             |
| DFID    | Department for International Development (UK)   |
| DNA     | Deoxyribonucleic Acid                           |
| ELISA   | Enzyme-linked Immunosorbent Assay               |
| ENHANSE | Enabling HIV/AIDS and Social Sector Environment |
| FBOs    | Faith Based Organisations                       |
| FMOH    | Federal Ministry of Health                      |
| FP      | Family Planning                                 |
| GHAIN   | Global HIV/AIDS Initiative Nigeria              |
| HAART   | Highly Active Antiretroviral Therapy            |
| HAD     | HIV/AIDS Division                               |
| HCT     | HIV Counselling and Testing                     |
| HIV     | Human Immunodeficiency Virus                    |
| HMH     | Honourable Minister of Health                   |
| IDU     | Injection Drug Users                            |
| IEC     | Information, Education and Communication        |
| IHVN    | Institute of Human Virology, Nigeria            |
| ILO     | International Labour Organisation               |
| LACA    | Local Action Committee on AIDS                  |
| MARPs   | Most at Risk Populations                        |

## NATIONAL GUIDELINES FOR HIV COUNSELLING AND TESTING

|           |  |
|-----------|--|
| MCH       | Maternal and Child Health                                      |
| MSM       | Men who have Sex with Men                                      |
| NACA      | National Agency for the Control of AIDS                        |
| NAFDAC    | National Agency for Food and Drugs, Administration and Control |
| NASCP     | National AIDS/STDs Control Programme                           |
| NEPWHAN   | Network of People Living with HIV/AIDS in Nigeria              |
| NGOs      | Non-Governmental Organisations                                 |
| NHMIS     | National Health Management Information System                  |
| NNRIMS    | Nigeria National Response Information Management System        |
| NPHRL     | National Public Health Reference Laboratory                    |
| NTT / HCT | National Task Team / HIV Counselling and Testing               |
| Ois       | Opportunistic infections                                       |
| PATHS     | Partnership for Transforming Health Systems                    |
| PCR       | Polymerase Chain Reaction                                      |
| PEP       | Post Exposure Prophylaxis                                      |
| PHCC      | Primary Health Care Coordinator                                |
| PICT      | Provider Initiated Counselling and Testing                     |
| PLWHA     | People Living with HIV and AIDS                                |
| PMTCT     | Prevention of Mother to Child Transmission of HIV              |
| QA        | Quality Assurance  |
| SACA      | State Action Committee on AIDS                                 |
| SFH       | Society for Family Health                                      |
| ENR       | Enhancing Nigeria's Response to HIV and AIDS                   |
| SOP       | Standard Operating Procedure                                   |
| STIs      | Sexually Transmitted Infections                                |
| SWs       | Sex Workers  |
| SWAAN     | Society For Women Against AIDS In Nigeria                      |
| TB        | Tuberculosis   |
| TOT       | Training of Trainers   |
| TV        | Television   |
| UNFPA     | United Nations Population Fund                                 |
| USAID     | United States Agency for International Development             |
| VCR       | Video Cassette Recorder  |
| VCT       | Voluntary Counselling and Testing                              |
| WHO       | World Health Organisation                                      |



## Chapter 1:

# Introduction

**T**he impact of HIV and AIDS continues to be felt in Nigeria. The disease affects all populations, but worst affected are women, children and the youth. The first case of AIDS was reported in 1986, since then the epidemic has reached alarming proportions with HIV prevalence rate increasing from 1.8% in 1991 to 5.4% in 2001, dropped to 5.0% in 2003, 4.4% in 2005, slightly declined to 4.6% in 2008 and 4.1% in 2010. Currently, it is estimated that about 3.1 million Nigerians are living with the virus. The Government of Nigeria still remains committed to the prevention and control of HIV and AIDS. The National Action Committee on AIDS (NACA) has now become a full-fledged agency known as the National Agency for the Control of AIDS. While the National AIDS/STI Control Program (NASCP) has been re-organised into the HIV/AIDS Division of the Federal Ministry of Health with a National Task Force on AIDS, Tuberculosis and Malaria (ATM) reporting directly to the Honourable Minister of Health.

HCT is the entry point to prevention, treatment, care and support. It contributes to the reduction of stigma and discrimination. Currently access to knowledge of one's HIV status is mainly through multiple approaches within the HCT Models. A new concept being introduced is the Couples HIV Counselling and Testing (CHCT) which encourages partners to receive HCT services together and receive their results together.

Opportunities to counsel and test individuals for HIV are being missed, because despite the high rate of HIV prevalence there is low coverage and uptake of HCT. Thus there is a need to scale-up HCT services especially with availability of new opportunities for prevention, treatment, care and support.

So far implementation of HCT services has relied mainly on donor funding. With decreasing funding or policy changes, there is need to implement sustainability strategies.

The purpose of this document is to provide acceptable national standards for all organisations (Public and private) and individuals providing HCT services in Nigeria. Therefore, this National HCT Guideline must be the basis for the establishment and provision of HCT services in Nigeria.

## Chapter 2:

# Service Delivery Models

HCT is an entry point for prevention, treatment, care and support services, however, demand for and supply of this essential service has continued to be low due to:

- Stigma and discrimination,
- Low awareness and misconceptions
- Low coverage and poor access to HIV treatment, care and support services.

Thus demand creation for HCT service is still a considerable challenge. This is why the country is utilizing multiple approaches including the client-initiated counselling and testing and provider-initiated counselling and testing.

**The client-initiated approach** is the traditional Voluntary Counselling and Testing (VCT) in which an individual voluntarily seeks counselling and testing services. This approach will continue to be offered in all HCT settings.

**The provider-initiated counselling and testing (PICT) approach** allows the health care provider to recommend HCT routinely to clients/patients as a standard component of medical care in the facility.

Two strategies are commonly used in Provider-initiated approach:

- “Opt-out” – HIV test is routinely recommended and *provided to* each patient and the patient is informed of his/her right to refuse the test
- “Opt-in” – HIV test is recommended and *offered to* each patient and the patient explicitly consents to receive the HIV test.

Nigeria has adopted the Opt-out strategy to boost access to HCT within selected clinical settings. The Opt-out strategy is used as part of basic care for ante-natal clinic clients, all patients with tuberculosis (TB), sexually transmitted infections (STIs) and HIV-related diseases.

Universal human rights requirements for confidentiality, consent and counselling must be respected and upheld.

The following HCT service delivery models already in practice in the country incorporate both client-initiated and provider-initiated approaches:

1. Stand alone
2. Integrated Health Facility
3. Mobile/ Outreach

### **Stand Alone Model**

Stand alone services are provided in sites other than the health facilities. They are usually situated outside the health facilities. In some cases, these sites provide additional HIV and AIDS care and support services. Stand Alone provides client initiated HCT services to the general populace who voluntarily access it, for example, the sexually active male youths.

### **Integrated Health Facility Model**

Integrated services are provided within health facilities e.g. maternal and child health (MCH), STI, TB, FP and out-patient clinics as well as for in-patients. These provide both the client initiated and provider initiated HCT services.

### **Mobile/Outreach Model**

*Mobile/Outreach* HCT services are provided for special populations such as Hard to Reach (fishermen, nomads, women in purdah, people living in remote areas), Most at Risk Populations (MARPs) such as highly mobile populations, long distance truck drivers, MSM, IDU, SW, people whose work schedule makes it difficult for them to access services (factory shift workers), and those incarcerated (prisoners). This model provides both the client initiated and provider initiated HCT services.

### **Role of the Private Sector**

The private sector is a major HCT service provider, particularly for those who can afford to pay for services, have medical insurance or for employees/families provided with medical services. Companies, organizations, private hospitals, FBOs and NGOs, etc provide this service, utilising any or a combination of the models described above. However, linkage and referral to other care and support services needs to be institutionalised.

## CHAPTER 3:

# Coordination and Operational Requirements

The burden of disease in Nigeria attributable to HIV/AIDS, Malaria and Tuberculosis has a significant impact on the nation and human development. Addressing the three diseases is an integral aspect of Government Policy including the Millennium Goals.

A Ministerial Task Force chaired by the HMH has been formed on AIDS, Tuberculosis and Malaria (ATM TF) with the aim of prioritizing actions within the Federal Ministry of Health to strengthen coordination, program management, performance, information flows and alignment of existing HIV/AIDS, Tuberculosis and Malaria programmes. The task force (ATM –TF) is placed at the peak of the coordination and operational framework to improve FMOH oversight, program management, service delivery and performance within and across the disease components and to report on actions and results achieved.

The ATM TF is primarily serviced by technical working groups (TWG) for each of the three diseases which are responsible for reporting progress, actions and results on the three programmes and progress towards strengthening FMOH leadership, systems and capacity both within and across the three diseases. They also identify and support development of systems overall within the ministry

The national HIV/AIDS TWG is a component of the ATM TF particularly responsible for issues relating to HIV/AIDS control. The HIV/AIDS TWG responds promptly to all thematic areas of HIV/AIDS interventions that are health sector and non-health sector related.

The national task team on HCT (NTT-HCT) like other task teams on HIV/AIDS health sector response is responsible for the coordination of HCT services and provision of technical assistance to FMOH. The representation of NTT-HCT and other task teams for other thematic areas of HIV/AIDS work to determine and report to the HIV/AIDS TWG on priority actions to be taken to reduce transactional costs across projects and sub components among other responsibilities.

In addition, outcome of fruitful deliberations/ recommendations and actions from the HIV health sector partners' forum and other coordination platforms such as the public private partnership forum, NACA/NASCP forum, NASCP/SASCP forum and the procurement and supply management TWG are channelled to the HIV/AIDS TWG, which will eventually get to the ATM TF for further discussion, actions and decision/policy making.

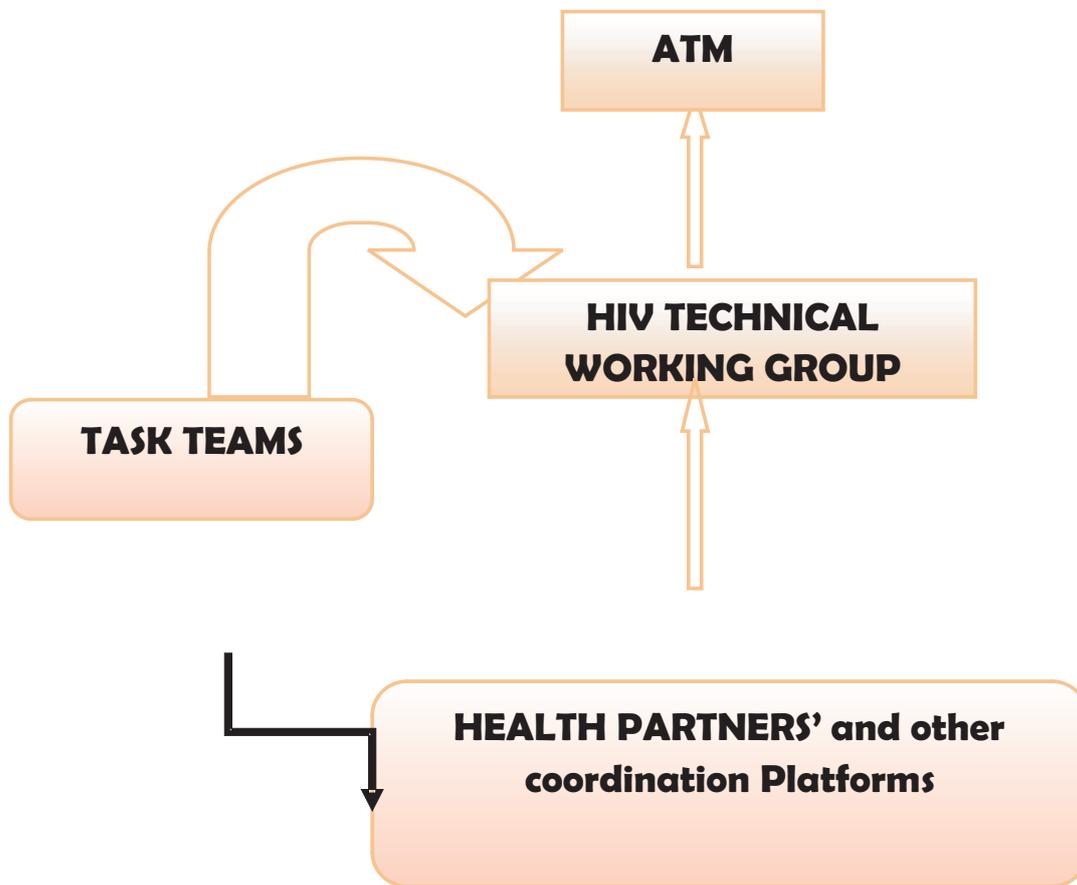
The Joint Annual Review (JAR) Coordination platform provides, in a joint and coordinated manner, a comprehensive account of stewardship by lead health sector response offices. The forum facilitates the development of service improvement plans and enables tracking of progress of the health sector strategic plan. The participants at the JAR include the officers from the IPs, Donors, NASCP, NACA, SASCPs, FASCP, CSOs, International NGOs, the academia and the Media. The forum is accountable to the HMH through the Director of Public Health at the FMOH for the national office and to Honourable Commissioners for health of respective states of the Federation.

The joint annual review meeting shall be held once in a year in a public forum during which heads of States and FCT AIDS and STI programmes as well as the heads of Components of NASCP render account of their stewardship for the year

The internal coordination in the HIV/AIDS Division (HAD) is also very important as this will ensure that the Division provides the lead for most of the coordinating bodies. To ensure that HAD is able to deliver on these coordinating activities, HAD shall institute five internal coordination (horizontal coordination) mechanisms as a means of institutionalizing its lead role in the coordination of the health sector response to HIV/AIDS in Nigeria. The internal mechanisms shall include the following:

- Weekly meeting of components to synchronize weekly activities of the Division and sharing of information (HCT unit is under Prevention component).
- Weekly management meeting by head of components and other Directors.
- Monthly technical and progress report by all components (report of HCT will part of Prevention component)
- HAD annual retreat.
- Harmonization of activities in HAD.

Figure: Accountability lines



**Coordination Roles for HCT Services:**

Effective coordination of the implementation of HCT services is vital and should take place at all levels of operation to ensure optimal use of limited resources.

**Role of FMOH**

The HAD shall:

- Provide the framework for the roles of all stakeholders and partners to achieve synergy in HCT service delivery at all levels
- Coordinate, monitor and evaluate HCT service delivery in the country
- Provide policy direction, national approaches to HCT service delivery, development and subsequent review of national HCT guidelines, Standard Operating Procedures (SOPs), protocols, training manuals and other documents on HCT
- Strengthen linkages between HCT services and other HIV/AIDS and health programmes
- Facilitate information exchange on HCT among stakeholders

## NATIONAL GUIDELINES FOR HIV COUNSELLING AND TESTING

- Provide technical assistance and capacity building to States to strengthen their roles
- Maintain a logistics management system for HCT within the logistics management system for HIV and AIDS.

The National Task Team on HCT (NTT-HCT)

The Federal Ministry of Health has constituted a national task team on HCT. The team leader for the task team shall be elected from among the membership. The membership comprises the Academia, Civil Society Representatives, Network of People Living with HIV/AIDS in Nigeria, CiSHAN, Development Partners and Technical Consultants.

The objective is to provide technical guidance and support for policy/guideline development and practices on HIV counselling and testing in Nigeria to the FMOH

### TERMS OF REFERENCE:

- i. Advise the honourable Minister of Health on all HCT issues
- ii. Advise government on HCT policy formulation
- iii. Support the FMOH in the coordination of HCT service delivery in the country
- iv. Assist government in the review of national guidelines, training manuals and other documents on HCT
- v. Advise on minimum standards for all forms of HCT services
- vi. Advise as well as assist government to develop scale-up plans for HCT services, support FMOH in the development and review of proposals and work plans for HCT
- vii. Provide technical assistance to FMOH in the periodic review of the national HCT monitoring and evaluation framework, in harmony with the Nigeria National Response and Information Management System (NNRIMS) and the National Health Management Information System (NHMIS)
- viii. Advise government on integration of HIV Counselling and Testing into the existing general guidance and counselling curricula of higher institutions.
- ix. Advise government on statutory requirements for HCT counsellors in relation to professional structures, cadres remunerations, and accreditation mechanisms
- x. Network with other national task teams on the HIV and AIDS
- xi. Assist in the supervision of HCT service delivery and training, and
- xii. Attend a meeting every quarter and any other meetings as might be convened by the HCT section of the national office.

**TENURE:** The tenure of elected team leaders (Chairman & Vice) shall be for 4 years in the first instance which shall be renewable.

**The Secretariat of the National Task Team shall reside in HIV and AIDS Division (HAD) (formally known as NASCP) of the Department of Public Health. HAD shall ensure adequate funding for effective functioning of the National Task Team.**

### State Level

The State Ministry of Health shall constitute a state task team for HCT. The membership will comprise the academia, developmental partners in HCT, State Health Management

Board, SACA, State Min. of Health , NGOs, FBOs, PLWHA state networks, and Health facility representatives (public and private) and technical consultants.

### **Role of State Ministry of Health**

#### **SMOH shall:**

- Provide the framework for the roles of all stakeholders and partners to achieve synergy in HCT service delivery in the state
- Coordinate, monitor and evaluate HCT service delivery in the state
- Provide oversight function on the HCT activities of all stakeholders and partners in the state
- Strengthen the capacity for implementation of HCT services within the state.
- Strengthen linkages between HCT services and other HIV/AIDS, TB and other health programmes within the state
- Facilitate information exchange on HCT among stakeholders
- Provide technical assistance and capacity building to LGAs to strengthen HCT implementation
- Ensure effective management of HCT commodities and logistics at the state level through the national logistics management systems

#### The State Task Team for HCT (STT-HCT) shall:

- Liaise with the NTT-HCT in the performance of their roles
- Support the State Ministry of Health (SMOH) in the coordination of HCT service delivery in the state
- Advise SMOH on the selection criteria for centres.
- Provide state government with information on HCT activities and service delivery in the state
- Assist state government in implementing national HCT guidelines, and ensuring compliance with other national HCT documents
- Advise state government in implementing the scale-up plans for HCT. Explore opportunities for technical assistance from relevant agencies in support of effective implementation of HCT services in the state
- Assist the SMOH in the development and review of proposals and workplans on HCT for the state
- Support the state government in the supervision, monitoring and evaluation of HCT activities and service delivery
- Network with the national and other State task teams on HIV and AIDS programme

***The Secretariat of the task team shall reside in the SMOH. SMOH shall ensure that adequate funding is made available for effective functioning of the task team.***

### Local Government Level

The Local government (LGA) shall establish HCT task teams. Members of the LGA task team shall be drawn from the community, LGA officials, NGOs, CBOs, FBOs, PLWHA Support Groups, LACA and Health facilities (public and private).

The LGA Task Team for HCT (LTT-HCT) shall:

- Support the coordination of HCT service delivery in the LGA
- Provide oversight function for HCT activities of all stakeholders and partners in the community
- Ensure adherence to standards of practice for HCT
- Explore opportunities for technical assistance from relevant agencies in support of effective implementation of HCT services in the LGA
- Advise LGA on the selection criteria for centres
- Advise LGA on implementing the national scale-up plans for HCT. Ensure participation in the development and review of proposals and work plans on HCT for the LGA.
- Support primary health care (PHC) and community-based implementation on effective and efficient supervision, monitoring and evaluation of HCT activities.

### Minimum Requirements for Service Delivery

#### I. Stand Alone facilities

##### a. Space and equipment

##### *i. Reception area:*

- Desk
- Chairs
- Filing cabinet/s
- IEC materials
- Record books
- Computer for data entry.
- Communication gadgets e.g. telephone.

##### *ii. Waiting area:*

- A comfortable sitting facility with a capacity for 5-20 people;
- Open display area for educational materials, including those that explain the HIV testing procedure; and audiovisual equipment.

- iii. Counselling room(s):** Both counselling and rapid HIV tests are conducted in them.
- Three (3) chairs and a table
  - A washable work surface
  - Sink with running water/wash hand basin and water.
  - Storage space for blood drawing equipment
  - Disposal containers for *sharps and non-sharps*.
  - Lockable cupboard, registers and other stationery
  - Ensure audio and visual privacy
- iv. Laboratory:** Areas for rapid HIV testing must be equipped according to standardised national laboratory guidelines for HIV rapid testing.
- A desk and chair
  - Acid-resistant surface work bench
  - Storage space for medical consumables
  - Lockable storage for test kits that do not need refrigeration
  - Refrigerator for test kits and/or reagents which must be stored according to manufacturers' specifications.
  - Standard disposal containers for contaminated waste
  - Sink with elbow taps and running water (both hot and cold).

*\*Note that most Stand Alone sites may not need a laboratory if they have counsellor-testers using rapid testing.*

- v. Toilets** – Male, female and staff toilets must be provided, be clean and have water.

### **b. Staffing**

Key staffing areas should be:

- Management
- Technical
- Ancillary

### **Management**

The manager ensures the provision of high quality HCT services. The responsibilities of this position include planning, coordination, supervision and support for staff.

### **Technical staff**

Counsellors:

Adequate number of trained counsellors must be provided on the basis of a minimum of 1 counsellor to 10 clients/day.

## **Personnel to perform rapid HIV testing:**

A Medical Laboratory Scientist/Technician/Assistant conducts HIV testing where possible. However, in order to support the expansion of HCT services in Nigeria, HCT counsellors and other health workers who have received the requisite training could be authorised to perform rapid HIV tests. Linkages should be established with Medical Laboratory scientists to provide quality assurance.

## **Data entry personnel:**

The site should designate personnel for accurate and up to date records of activities of the site. The data will be transmitted to the FMOH through the existing National Health Management Information System (NHMIS) and also meet the reporting needs of the Nigeria National Response Information Management System (NNRIMS).

## **Receptionist**

The role of the receptionist includes welcoming clients, registering them, explaining procedures, providing educational materials and entering data, where applicable.

## **Ancillary staff**

These include general service staff such as cleaners, security guards and drivers. They are responsible for the general upkeep and other duties at the site.

## **2. Integrated facilities**

### **a. Space and equipment requirements**

- Counselling rooms that will ensure privacy during counselling sessions
- Areas for rapid HIV testing must be equipped according to standardised national laboratory guidelines for HIV rapid testing

*Reception area* should be equipped with:

- Desk
- Chairs
- Filing cabinet/s
- IEC materials
- Record books
- Computer for data entry.
- Communication gadgets e.g. telephone.

### **b. Staffing**

The following categories of personnel are recommended for HCT services

1. Trained Counsellors
2. Trained Counsellor Supervisors

### 3. Medical Laboratory Scientist

These staff provide both clinical and HCT services. The following additional staff may be required;

#### **Personnel to perform rapid HIV testing:**

It is desirable that Medical Laboratory Scientists conduct HIV testing. However, in order to support the expansion of HCT service in Nigeria, basic HCT counsellors and other health service providers who have received the requisite training should perform rapid HIV tests under supervision for quality assurance.

#### **Data Entry Personnel:**

Personnel should be designated to complete the HCT registers, document activities carried out in the centre as well as ensure data linkage to the M&E framework for Health sector HIV/AIDS response, NHMIS and NNRIMS through data forwarding to the appropriate authorities.

### 3. Mobile/Outreach Services

Outreach services are provided from both the integrated and stand alone facilities. Premises at which outreach services are provided should meet the required standards for quality HCT services in the country.

#### **Supplies for all Service Delivery Models**

The quantity of supplies depends on volume of work, number of clients expected and the adopted testing protocols. These supplies include:

- Forms and registers for recording activities within the centre
- HIV test kits
- Lancet, needles and syringes
- Supplies for universal precautions including gloves and other medical supplies.
- Puncture proof containers (for disposal of sharp objects)
- Soap
- Disinfectants

#### **Selection of Service Providers**

##### **Selection criteria for counsellors**

There are three categories of counsellors in Nigeria. These categories are:

##### **I. Counsellor supervisors**

Basic Requirements:

- a. A basic degree in health, social or behavioural science, education or theology OR

b. A diploma in health sciences, nursing, social work, education or theology

## 2. Basic HCT Counsellors

*Basic Requirements:*

SSCE/GCE Certificate or its equivalent.

## 3. Community-based HCT Counsellors

*Basic Requirements:*

Junior Secondary School certificate, First School Leaving Certificate, Community workers, and volunteers.

Regardless of background, candidates for training courses can be assessed based on the following criteria; educational background, level of interest, interpersonal skills, personal values, and demonstration of capacity to apply good counselling techniques and discretions.

### Selection criteria for personnel performing HIV rapid test

- Professional laboratory personnel
- Basic Counsellors trained to perform rapid tests

### Orientation and Training of Service Providers

- Health workers and others selected to provide HCT services must receive basic counselling and testing training for a minimum of 10 days
- All staff trained and serving as counsellors must also receive refresher training within 12-24 months to update knowledge and improve skills
- All counsellors must be trained using the national HCT guidelines and training manuals.
- Professional counselling supervision and mentoring will be organised by NTT-HCT, NASCP and partners to impart practical counselling skills.

### Certification of Counsellors

#### **Counsellor Supervisors:**

For certification, a counsellor supervisor should have:

- Basic HCT counsellor training
- Minimum of 5 years counselling experience
- Counsellor supervisors training

#### **Basic HCT Counsellors:**

For certification, basic HCT counsellors must undergo ALL of the following:

A. 10-day core training as follows:

- i. 5 -day counselling
- ii. 2 -day HIV testing theory
- iii. 2 -day supervised practical
- iv. 1 -day feed back

B. 3-month supervised service delivery and evaluation by a trained counsellor-tester supervisor

***Community-based Counsellors:***

The training of the community-based HCT counsellors will be in line with the national training manual. The duration of training shall not be less than 10 days.

**Personnel to conduct testing**

Adequate number of persons per site should be trained in conducting the simple, rapid tests recommended for HCT purposes. This is to ensure that all clients receive their results within one hour as a routine.

**Training of Ancillary staff**

All staff and volunteers who work in HCT sites, including the receptionists, drivers, data entry personnel, secretaries and cleaners should receive basic introductory training on HCT.

## Chapter 4:

# HIV Counselling

### **Definition of HIV counselling**

Counselling, in relation to HIV and AIDS, is a confidential dialogue between a person and a caregiver aimed at enabling the person cope with stress and make informed personal decisions relating to HIV and AIDS.

In all approaches for HIV and AIDS counselling in Nigeria, the 3 Cs ( pre and post test Counselling, Confidentiality and informed Consent) will be observed.

HIV Counselling involves the following steps:

### **Pre-test counselling**

#### ***Pre-test counselling prepares the client to:***

- Exploration-Sharing information
- Assess their own risk
- Understand the benefits of HIV testing
- Understanding – helping the client consider options
- Be aware of the range of options and services available to them, including post-test support and on-going psychosocial support
- Make an informed decision about having the test
- Cope with a positive and negative HIV test result
- Develop a risk-reduction plan

#### ***Major components of the pre-test counselling session include:***

- *Basic facts on HIV and AIDS*
- *Discussion of benefits and potential difficulties*
- *Explanation of HIV rapid test process and meaning of HIV test results*
- *Exploration of personal HIV risk behaviour and options for reducing risk including dual protection*
- *Assessment of clients' readiness for HIV testing*
- *Exploration of support systems and discussion of disclosure mechanism*
- *Obtaining informed consent for HIV testing.*

### **Post-test counselling**

Post-test counselling is provided for both HIV positive and HIV negative clients who have undergone HIV testing.

#### ***Post-test counselling prepares the client to:***

- Cope with the HIV test result
- Review their risk reduction plan
- Review available psychosocial support systems
- Discuss disclosure of test results and partner referral

#### ***Major components of the post-test counselling session***

- Provision of HIV test results highlighting window period for HIV negative clients
- Review of risk reduction plan including condom-use skills building
- Discussion of positive living, ongoing support and referral for such services as family planning, TB and STI screening and management
- Discussion of disclosure of test results
- Partner referral for HIV testing

#### **Follow-up counselling and referral for care and support**

- Follow-up counselling must be provided to both HIV negative and HIV positive clients.

### **Referral**

Referral is the process by which clients are assisted to access services that are not available at the HCT site. Clients should be referred for appropriate services such as treatment for opportunistic infections (OIs), STI and TB management, ART, PMTCT, family planning, nutrition and psychosocial support.

### **Adherence Counselling**

Adherence counselling is given to HIV clients who are positive and have already commenced antiretroviral therapy. This is to enable them adhere to treatment regimen. Treatment with antiretroviral drugs (ARV) succeeds only when patients adhere strictly to the prescribed treatment regimen. Poor adherence leads to treatment failure and development of drug resistance, a situation in which the virus is no longer controllable using particular ARV regimen.

## Counselling scenarios

### **Requesting Testing only:**

In the client-initiated approach, those who request HIV testing but decline counselling must have the benefits of counselling explained to them by the service provider. All HCT clients must always be counselled before they are tested.

### **Requesting counselling only:**

Sometimes clients may attend HCT services to learn about HIV but do not want to receive HIV testing. Others may decide after pre-test counselling that they do not want to be tested or that they want to go away and think about testing. The service provider should accept the decision of the client not to be tested and encourage the client to come back for further counselling, with or without being tested. The counsellor should view counselling without testing as being just as important as counselling with testing.

### **Pre-marital HCT services:**

Pre-marital HCT services should be encouraged in all sectors of society and must observe the 3Cs principles of HCT - Counselling, Confidentiality and Consent (informed and voluntary). It is recommended that the couple is seen together where possible. However, the individuals can be seen separately if they so desire, but should be encouraged to share their test results and be made aware of the potential implications of the results on marriage decisions.

### **Couple counselling:**

Couple counselling is recognized as an important and effective intervention in which the two clients are counselled and provided with HIV test results as a couple. This encourages the couple to start planning for their future and discuss a realistic risk reduction plan that they can implement together. In situations where the couple refuses to receive services together, they can be counselled and receive results separately and then encouraged to disclose results to each other.

In some cases, the results can be discordant, i.e. one partner is HIV positive while the other is HIV negative. The need for disclosure and mutual support in such a situation should be emphasised. It is crucial that the window period and need for *re-testing of the HIV negative partner after 3 months are discussed with the couple.*

*NOTE: The 3 Cs Principles - counselling, confidentiality and consent should be observed in all types of HIV Counselling and Testing*

### **Group information sessions:**

Group information sessions, with skilled facilitation, can be used prior to provision of both client-initiated and provider-initiated services. These sessions are aimed at providing

information rather than counselling. They can be utilised in settings such as ANC, TB, STI family planning clinics and mobile/outreach. The goal of the session is to discuss general information about HIV and AIDS including HCT specifically.

### **Prevention of Mother to Child Transmission of HIV (PMTCT):**

The FMOH has adopted the “opt-out approach” to be used in the provision of PMTCT services. By this approach, HCT is offered routinely as part of basic care for ANC. However, testing is still voluntary and a pregnant woman has a right to consent or refuse HIV testing should she choose to do so.

### **HIV and TB:**

TB is the most prominent opportunistic infection associated with HIV infection in Nigeria. It is estimated that on the average TB accounts for over 30% of HIV and AIDS-related mortality and over 50% of hospital visits by PLWHA. The high rate of TB among those with HIV provides an opportunity for identifying individuals with HIV among TB patients. HIV counselling and testing is offered routinely as part of basic care **for all TB patients and suspects**. However, the services must observe the 3Cs principles, where the patient has a right to consent or refuse HIV testing should she/he choose to do so (opt-out approach).

### **The Youth (18-24 yrs):**

The youth might be reluctant to have HCT or have difficulty accessing it where adults are also receiving the same services. The number and coverage of “youth-friendly” services offering HCT should therefore be increased. Specially trained youth counsellors and peer educators should work with this age group and offer flexible hours of service in these facilities. The youths should be strongly encouraged to abstain from sex through intensified and targeted IEC campaigns and materials. In addition to encouraging abstinence, condom use should be promoted as a backup strategy for when abstinence fails.

### **Children (below 18 yrs):**

*Children* infected with HIV may have delayed milestones, i.e. their level of maturity may not always match their chronological age. This has an impact on the conduct of counselling sessions and the stage at which the HIV status of the child is disclosed. Service providers should ensure that the parents or legal guardians are intimately involved with all issues pertaining to the child's illness including the disclosure process. Counsellors should explore reasons for parents or legal guardians wanting to know the child's HIV status and refer accordingly. It is important that children are not tested for the wrong reason such as parents wanting to know their own status indirectly through the child or as an excuse for legal guardians to abandon their responsibilities. Parents of HIV positive children should be counselled for HIV so that they develop better understanding of the child's circumstances and *emotional needs*.

Young people below 18 years of age, who are married, pregnant, parents or sexually active, may be considered “mature minors” and could be further considered to personally grant consent for HIV testing.

### **Counsellor self-care and support:**

“Burn-out” can be described as a physical, emotional, psychological and spiritual phenomenon, characterised by progressive loss of idealism, energy and purpose experienced by people working in helping professions. All counsellors need formal support, stress management and mentoring strategies to prevent or mitigate the effects of burnout.

### **Counselling support strategies include the following:**

- Ensuring that counsellors have clear roles and responsibilities
- Counsellors should receive periodic health screening, especially for TB.
- Counsellors who are HIV positive should be provided access to preventive service such as TB preventive therapy, medications to prevent OIs and ongoing medical and psychosocial support
- All counsellors are encouraged to go through the process of HCT so that they understand the process and are more empathetic when providing services. Measures must be taken to reduce the risk of occupational transmission of blood-borne diseases.
- It is advised that counsellors are periodically screened for hepatitis B and where negative should receive hepatitis B immunization.
- A more experienced counsellor must act as a mentor for a less experienced counsellor. The mentor must be readily available and accessible for support at all times
- Periodic counselling review meetings should be held at least once a month. During these meetings the counsellors can discuss challenging cases, share experiences and be updated on new developments in HIV and AIDS
- Counsellors should form groups in order to support and assist one another in an informal environment where both social and work-related activities will be discussed. This mutual support will help in minimising stress and burn-out
- Adherence counselling is the degree to which the client follows a treatment regimen, which has been designed through a consultative partnership between the clients and the health care worker/counsellor. It encourages the engagement and accurate participation of a client in the plan of care and provides opportunity for discussion about the various factors in the client life that will influence the ability to exactly follow the treatment. Adherence counselling is done at ART clinics usually by trained personnel.

## Chapter 5:

# QUALITY ASSURANCE SYSTEM FOR HCT SERVICES

Quality assurance is critical to the provision of high quality HCT services. It is a technique for monitoring and evaluating the quality of services provided at HCT sites based on set national standards, guidelines, policies and protocols. The goal is to ensure high quality service and to continuously improve the efficiency and reliability of services as well as improve on it by resolving inadequacies and concerns. It is therefore important as new services are set up in the scale-up process that efforts are intensified towards ensuring that the new and existing sites adhere to national standards for performance and in the training of personnel involved in service delivery. The national programme (HAD) will play a key role in developing and providing the requisite tools for this purpose. Quality assurance measures should be put in place for both counselling and testing components of HCT services. This will assist in addressing issues related to staff competency, client satisfaction and adherence to counselling and testing protocols among others.

### Quality Assurance for Counselling

Different approaches will be used for assessing and improving on services and these will include:

- ◆ Training of site personnel
- ◆ Availability of job aides
- ◆ Availability of HCT protocols and SOPs
- ◆ Availability of National Guidelines
- ◆ Privacy accorded to clients
- ◆ Counsellor self/peer assessment using the Counsellor reflection form (Annex 13)
- ◆ Client exit interviews to measure client satisfaction and improve quality of service delivery. Self administered forms should be completed by 10% of all clients or every 10<sup>th</sup> client. (Annex 12)
- ◆ Mentorship for newly trained counsellors
- ◆ Supportive counselling supervision to resolve concerns and prevent burnout of counsellors
- ◆ External supervision and supportive monitoring through the use of standardized checklist by the LGAs, State and National Officers

- ◆ Training and re-training including stress management skills

### Quality Assurance for HIV Testing

HIV testing is a critical component of HCT. It defines who is HIV-positive and HIV-negative, both of which can be of life changing outcomes.

Laboratory quality assurance (QA) is defined as planned and systematic activities to provide adequate confidence that requirements for quality will be met. It is therefore, important that each facility/organization performing HCT establishes and implements a QA programme to monitor and evaluate HCT services throughout the total process.

### Strategies for QA for testing

- 1. Adoption of the systems approach in laboratory QA** – this ensures that all components of the laboratory services are seen as important parts of a system and for “this system to be quality assured, each of the components must be quality assured”. This system monitors all parts of the testing system, detects and reduces errors, improves consistency between testing sites and helps curtail costs.
- 2. Adoption of the “Hub and Spoke Model” of HCT service sites** – this would ensure that testing sites at the PHC and other peripheral sites (spokes), are linked to state or secondary facility laboratory (the Hub). The hub laboratories would provide monitoring, supervision, general laboratory testing oversight, and external quality assessment to the peripheral testing sites (spokes).
- 3. Adoption of 4-EQA Processes**
  - a. On-site evaluation** – to be performed by the laboratory quality control officer of the hub laboratory using standard on-site evaluation tool.
  - b. Rechecking and Re-testing** – this would involve the testing of a minimum of 5-blinded samples (whole blood and serum), by the tester while the site supervisor watches, and a re-testing of the samples by the supervisor while the tester watches. The results are then compared and the supervisor provides immediate feedback.
  - c. Proficiency Testing** – this would involve the preparation of inactivated and well characterized serum samples and distribution peripheral testing sites for testing. This procedure would occur at least twice a year.
  - d. Certification and Re-certification** – this would involve evaluations of would be testers after training using written tests and practical hands-on tests.

**4. Adoption of Internal Quality Control Measures** – this would include stringent use of:

- a. Standard Operating Procedures (SOPs)
- b. Process Improvement
- c. Supplies and inventory management
- d. Safety

## Chapter 6

# HIV Testing

### Introduction

HIV testing in Nigeria is mainly carried out using antibody-detecting techniques, which include Enzyme-Linked Immunosorbent Assay (ELISA), simple and rapid tests. Testing is carried out in public and private health facilities including NGOs/FBOs at the following tiers of care:

- Tertiary health facilities (Teaching Hospitals, Federal Medical Centres and Research Institutes)
- Secondary Health facilities (General Hospitals and State Specialist Hospitals)
- Primary Health Clinics, Community Health Centres, NGO stand alone HCT Centres, Health Posts and Mobile Clinics

The indications for HIV testing include:

- Need to Know one's HIV status
- Screening of donated blood for transfusion and organ transplant.
- HIV Prevalence Surveillance in a given population
- Diagnosis of HIV infection in individuals
- Treatment monitoring
- Research

### Laboratory HIV tests

Persons who become infected with HIV produce HIV antibodies over a period of 3 months. Different types of tests are available for detection of these antibodies in adults and children over 18 months of age.

### Types of HIV Tests

#### (i) Rapid tests

Rapid tests are recommended for HCT services because they are fast, simple and accurate. It takes about 15-30 minutes to conduct, can be performed even in clinics without laboratories or specialised laboratory equipment and are as accurate as ELISA test when the manufacturer's instructions and SOPs are strictly followed.

Test is performed using a small sample of blood (taken from the client's fingertip), serum or plasma, and the result is ready within 15 minutes. Available rapid test kits are either cold or non cold chain dependent, but non cold chain dependent test kits are highly recommended, however refrigeration is advised for all rapid test kits in view of our wide range of temperatures in the country.

### **(ii) Simple tests**

Simple tests are similar to and usually based on same principle or method as ELISA but take longer time (30–35 minutes) to perform. Refrigeration is advised.

### **HIV testing of children less than 18 months old**

Babies less than 18 months tested with HIV antibody technique may test HIV positive due to the presence of antibodies passed from their mothers through the placenta (false positive) or breast milk. Antibodies from the mother can be present in the baby's blood for up to 18 months after birth. At the HCT sites, children less than 18 months requiring this test are referred to the laboratory.

***It is recommended that facilities without standby generators should make use of cold boxes and ice packs for storage of their kits that are cold-chain dependent.***

### **Recommended HIV test kits**

An essential requirement of all HIV testing is accuracy of the test result. The rapid test kits used in Nigeria are those that are approved for use by NAFDAC. These tests are further evaluated and recommended as part of National algorithm by HIV/AIDS Division of the Federal Ministry of Health. The list of recommended rapid test kits can be obtained from HAD.

### **Testing algorithms**

Strategies to be used for HIV testing are determined by the purpose of the test; there are three strategies (I, II and III) defined by WHO, based on different principles or methods known as testing algorithm.

### **Serial testing**

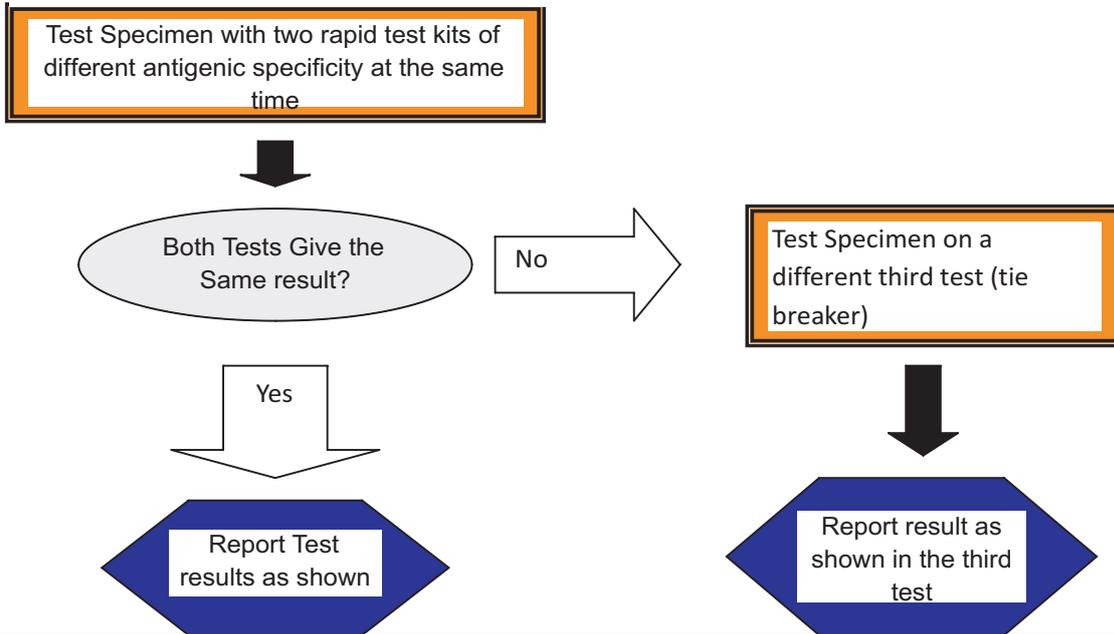
With 'serial testing' an initial blood sample is taken and tested using the more sensitive kit. If the result is negative, the result is given to the client as HIV negative. If the result is positive, the blood sample is tested using a second HIV rapid test kit based on different test principles. If the second test is also positive, the result is given to the client as HIV positive. However, if the second test is negative use a tie-breaker, and the results of the tie-breaker given to the client.

**Parallel testing**

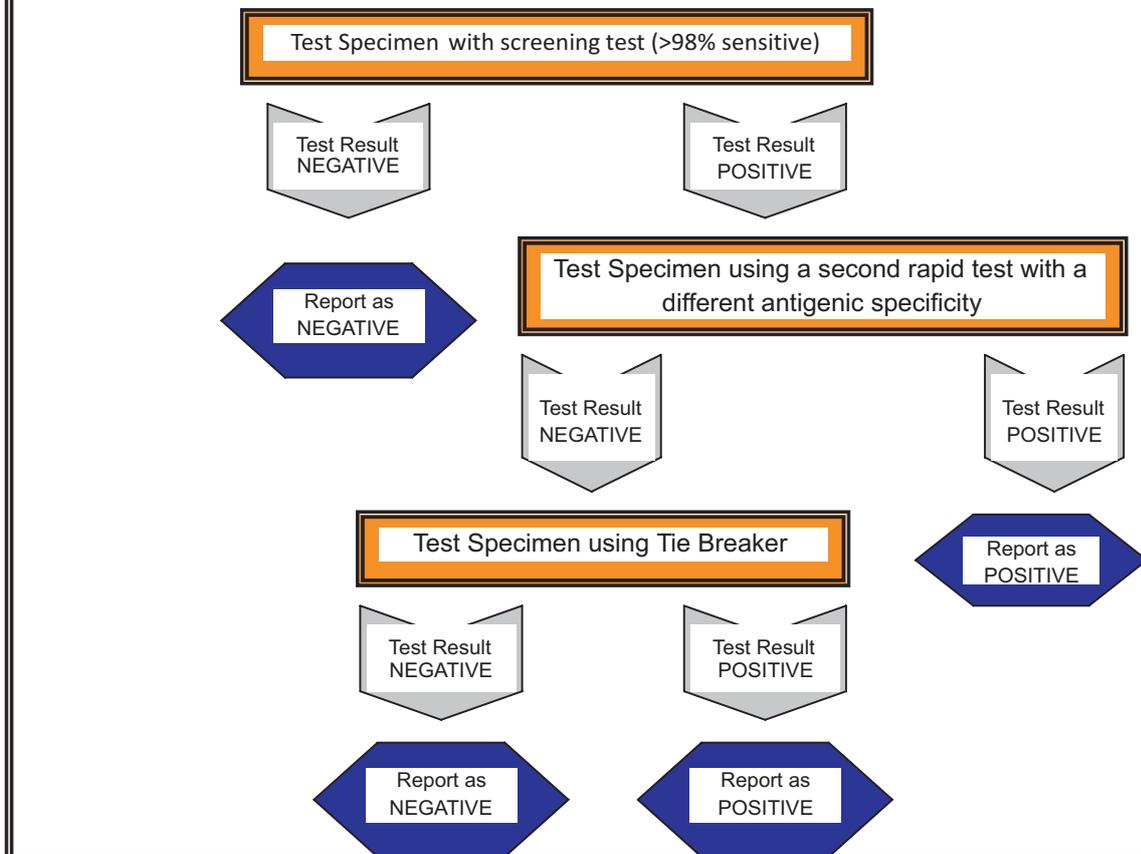
This testing strategy involves use of blood samples (plasma, serum and whole blood finger stick) with two HIV test kits based on different test principles simultaneously ('in parallel') and the results issued if both tests give the same result (concordant result). If one result is positive and the other negative (discordant results), the tests are repeated using the same test kits. If the results are still discordant, a recommended tie-breaker is used and the results of the tie-breaker given to the client. In cases where the tie-breaker is not available, the specimen/client is sent to a reference laboratory where the tie-breaker is available.

# NATIONAL GUIDELINES FOR HIV COUNSELLING AND TESTING

## Parallel Algorithm for Rapid HIV testing



## Serial Algorithm for Rapid HIV Testing



## National Testing Algorithm

**Nobody should be diagnosed to be “positive” based on only one HIV test.** The current national testing algorithm recommends the serial testing strategy as approved by the Federal Ministry of Health.

The use of specific test kits in the algorithm should be based on operational research to be determined by HAD. However, only rapid test kits on the NAFDAC approved list should be used.

HAD shall be responsible for disseminating information and monitoring compliance with the National Testing Algorithm. As such, all laboratories/facilities carrying out HIV test in the country should be mapped to ensure adequate monitoring and dissemination of information.

### RECOMMENDED SERIAL ALGORITHM TABLE

#### 1. Round 1 Phase 1 Algorithm

| Screening test(1 <sup>st</sup> Line) | Confirmation of positive (2 <sup>nd</sup> Line) | Tie-breaker |
|--------------------------------------|---|-------------|
| Determine                            | Unigold   | Statpak     |

#### 2. Round 2 Phase 1 Algorithm

| Screening test(1 <sup>st</sup> Line)   | Confirmation of positive (2 <sup>nd</sup> Line)                              | Tie-breaker             |
|--|--|-------------------------|
| SD Bioline<br>Dialab<br>Determine Combo<br>RetroscreenVikia<br>Vikia<br>HIV Quick Check<br>Oraquick<br>DPP | Retrocheck<br>Rapid Signal<br>Core Instant<br>Advanced Quality<br>HIV Status | Colloidal Gold<br>Insti |

**Note:**

1. *These kits in this algorithm (Round 2 Phase 1 Algorithm) are valid for only Whole Blood, Serum or Plasma.*
2. *Any of the test kits in the first line can be used for screening, any of the second line test kits can be used for confirmation while any kit in the tie breaker column can be used to resolve discordance.*

### **Window period**

The 'window period' is the period between exposure to HIV and when the body has produced enough antibodies to be detected with HIV antibody test. This period is usually within 3 months. This means that a client who has just been infected may test negative for the HIV antibody because the body has not produced enough antibodies for detection by the test. Such a client can still pass the virus to others. Clients who test negative but might have been exposed to HIV infection, including those with high-risk behaviour, should be encouraged to return for a repeat test in 3 months. If the test is still negative, the client should come back after 6 months for a repeat test.

### **Maintenance of Laboratory Quality Management System**

#### **Quality assessment:**

- i. Quality control (QC)
- ii. External quality assurance (QA)
- iii. Documentation Process (Record Keeping)
- iv. Standard Operating Procedure (SOP)

#### **i) Quality Control**

Quality control (QC) is defined as the overall programme put in place to ensure that the results coming from the laboratories are reliable and accurate. **It should include the following:**

- Good laboratory practices with set standards of practice for performing HIV tests
- Systems for management of HIV test results
- Records on available test kits, batch numbers and expiry dates
- Periodic inclusion of previously characterised samples in order to identify problems with competency of the personnel performing the HIV tests and the test kits.

**N.B** - Medical laboratory scientists have a vital role to play in the supervision of personnel conducting HIV testing at all facilities.

#### **ii). External Quality Assurance (QA)**

External quality assurance is the overall programme of both internal and external quality control put in place to ensure that the results coming out from the laboratories are reliable. At least one or more QA methods will be used to externally assess the quality of HIV testing in Nigeria. This includes:

- **Training** (including refresher trainings), Supervision and certification of personnel to ensure continuing quality performance.
- **Blind re-checking:** 5-10% of all blood samples obtained and selected by systematic sampling must be sent to a designated National Reference Laboratory (NRL) for re-testing. Where number of clients is very high, this percentage can be reduced with guidance from the NRL. This QA method does not apply to centres that use only rapid

test kits, but must be adhered to by centres that use ELISA as a tie breaker or non-rapid test kit. Samples can also be exchanged between testing centres for comparison of results.

- **Proficiency testing:** All facilities providing HCT services should receive HIV proficiency sample panels from the NRL at least once a year in accordance with national and international guidelines. Also, each testing site should be provided with positive and negative controls to be run weekly.

***All facilities with consistently unreliable QA tests need to receive additional technical supervision and support.***

### **Laboratory Safety**

Standard Universal and strict laboratory safety precautions must be followed. In addition testing facilities are required to have on-hand; site-appropriate SOPs on laboratory safety precautions. These should be displayed conspicuously in corresponding key areas where the testing is performed. Precautions should include the following:

- Good laboratory practices
- Universal precaution
- Good record management
- Incident/Accident register
- Access to Post Exposure Prophylaxis (PEP)

### **Handling and disposal of contaminated items**

Sharps, such as lancets and needles, must be placed in a specially designed sharps disposal container. The sharps bin can be sealed when the container is three-quarter full. Used test kits and blood-contaminated materials should be placed in a separate biohazard bags. All containers should be decontaminated with 10% bleach before leaving the laboratory and subsequently by incineration or disposal according to standard health care waste management practices.

## Chapter 7

# Scaling Up HIV Counselling and Testing Services

The Federal Government of Nigeria has put in place the following strategies to increase access to HCT services and mitigate the impact of HIV and AIDS:

- a. Ensuring a conducive policy environment
- b. Capacity building
- c. Increasing demand for services
- d. Increasing access to services
- e. Referral and linkages
- f. Support Groups

### a. Ensuring a conducive policy environment

#### i) National HIV and AIDS Policy

The National HIV and AIDS Policy recognise that all Nigerians have a fundamental right to know their HIV status. It stipulates that HCT services be provided and made available and accessible to everyone.

#### ii) Multi-sectoral Co-ordination of HIV and AIDS Activities

NACA provides a multi-sectoral framework for the coordination, facilitation, mobilization of resources, support, monitoring of and decentralization of HCT services as part of the national multi-sectoral response to HIV and AIDS.

#### iii) Local Resource Mobilisation Efforts

Efforts should be made to mobilise local resources (private sector, individuals and communities) for HIV and AIDS impact mitigation at all levels of the society.

#### iv) Mainstreaming HIV and AIDS in all Sectors

All public and private sectors, including CSOs should be encouraged to mainstream HIV and AIDS into their programmes, including HCT services.

#### v) HCT as part of providing Basic Care

All health facilities in Nigeria should adopt HIV counselling and testing as part of

basic care for all patients who come in contact with their services (especially Antenatal Care, tuberculosis (TB), sexually transmitted infections (STIs), and other HIV related services). Informed consent written or verbal must be obtained during the normal process of counselling between the health care provider and the patient or client for the purpose of testing.

### **b. Capacity building**

#### **i) Training of counsellors**

In order to enhance the counselling capacity in all facilities providing HCT services, the following strategies should be put in place:

- Training community service providers, such as community-based counsellors (CBCs), to provide psychosocial support to the infected and affected.
- Incorporating HIV counselling and testing into pre-service training curricula of different cadres of health workers and other professionals to increase the number of service providers who can offer HIV counselling in their areas of work.
- Continuing education as part of in-service training to update capacity of existing cadres of service providers in HCT.

#### **ii) Training of personnel to conduct HIV testing**

In order to enhance the capacity of personnel to conduct HIV testing the following strategies are recommended:

- Training of basic counsellors to conduct HIV rapid testing
- Continuing education as part of in-service training to update knowledge and improve skills of existing cadres of health personnel in HIV testing.

### **c. Increasing demand for services**

#### **i) Community mobilization**

It is essential that communities are aware of the importance of HIV counselling and testing in the fight against HIV and AIDS. Consequently:

- Existing and new strategies on creating community awareness and mobilization should be intensified and implemented. These will ensure that the benefits of HIV counselling and testing are explained and people encouraged to access services
- Information should be disseminated through multi-media channels, to create awareness about HCT services being provided **in health facilities**
- Approaches for reaching those who are illiterate, visually impaired, or mentally and physically challenged should be explored and implemented at all times
- Branding of client-initiated service should continue in defined settings to promote uptake

### **ii) Male involvement**

In Nigeria, the role of males in the decision-making process is important, especially for married women. Therefore, male groups in different settings should be provided with information and targeted for HCT

### **iii) Reducing stigma and discrimination in the community**

- Public HIV testing should be encouraged, especially for opinion leaders and role models in the society in order to reduce stigma associated with HIV testing
- Political leaders should be encouraged to continue to publicly discuss HIV and AIDS issues as a means of de-stigmatising HIV as well as increasing public awareness of the importance of knowing one's status.
- The Meaningful Involvement of People with AIDS (MIPA) principle should be promoted as a means of stigma reduction and empowered PLWHA should be encouraged to participate in campaigns in order to continue to give a human face to the epidemic

### **(iv) Scaling-up of the Anti retroviral therapy (ART) Programme**

As part of the scale-up plans for ART, the country expanded its programme that ensures that Nigerians who are eligible have easy access to affordable medicines for their conditions. The scale-up of the ART programme demands continued scaling up of HCT services in the country as a means of identifying those who are eligible for ART.

## **d. Increasing access to services**

### **i) Involvement of various sectors in service provision**

Different sectors and organisations in the country should be involved in the provision of HCT services, in accordance with national policies and guidelines. This involvement will lead to improved access to services thereby ensuring that the different needs of the various segments of the society are met.

### **ii) Reducing waiting period for HIV test results**

Rapid HIV tests should be conducted in all facilities providing HCT services in Nigeria. The use of rapid tests ensures availability of test results on the same day. This will reduce the need for repeat visits for collection of results, and ensure timely implementation of prevention, treatment, care and support services.

### **iii) Provider Initiated “opt out” approach in HIV Counselling**

The “opt out” approach should be used especially in TB, ANC, STI, in-patients and out-patient clinics to improve coverage of HIV and AIDS prevention and treatment

programmes. This approach will reduce “missed opportunities”

### **iv) Targeting Special groups**

#### ***Most at-risk populations***

Most at-risk groups such as long distance transport workers, prisoners, alcoholics, sex workers (SWs), intravenous drug users (IDU), men having sex with men (MSM) and uniformed services personnel face challenges in accessing services. These groups should be specially targeted with information and education pertaining to HCT. In the case of SWs, it is essential to target their client communities at the same time to facilitate behaviour change. Education and mobilisation on the benefits of HIV counselling and testing, for the entire community, will enhance sex workers' capacity to negotiate for safer sex, primarily through condom use. Confined groups such as prisoners should be encouraged to know their HIV status without being coerced to take the HIV test. Condoms should also be provided to those who need them, even in prison settings.

#### ***Vulnerable groups***

Targeting vulnerable groups such as children, youth, women, and the physically and mentally challenged is crucial to increasing access to services. Females should be targeted due to their increased vulnerability to the epidemic, while integrated youth friendly services should be designed to meet the needs of the youths. HIV test should not be mandatory for anyone especially physically and mentally challenged persons.

### **iv) Integrating HCT into FP and Youth Friendly Services**

HCT services should be integrated into Family Planning (FP) services as a key HIV prevention strategy in order to increase access to HCT services. This will also increase awareness of healthy sexual behaviour, provide a channel for more targeted family planning and serve as an intervention strategy for PMTCT. HIV counselling should be incorporated into FP services so that testing or referral services can be provided.

FP counselling and services should be integrated into HCT services to holistically address clients' dual risk of HIV infection and unintended pregnancy. This will provide an opportunity to reach clients who may traditionally never access reproductive health services such as men and youth.

### **e. Referral and linkages**

A 2-way referral system with agencies providing prevention, treatment, care and support services is encouraged. HCT providers should actively work to ensure that they become part of existing networks and directories of relevant services. Where such networks and directories do not exist, the HCT site should work to develop such, to ensure that clients can receive on-going supportive services. In addition clients may be referred for legal

assistance, treatment of alcohol/drug dependency and mental ill-health.

### **f. Support Groups**

The importance of support groups cannot be over-emphasised as a useful component of HCT services because they can help improve the quality of service and increase utilisation.

#### **i) PLWHA Support groups**

HCT centres should facilitate the formation of support groups for PLWHA in all communities. These support groups should develop close links with HCT facilities and collaborate for the purpose of information sharing and cross referrals. PLWHA should be involved in the planning and implementation of HCT services and ensure good linkages with other support groups.

#### **ii) Post-test clubs**

These clubs should comprise clients who have undergone HCT and tested negative, the club should provide a forum to promote positive behaviours and messages as well as increase knowledge and demand for HCT. Post-test club formation should be actively promoted.

## Chapter 8

# Ethical and Legal Considerations

### a. HCT and Human Rights

Counsellors must recognize the fundamental right, dignity and worth of all people. Every Nigerian has the right to know his or her HIV status and all stakeholders must create the right conditions to ensure that this happens. The human rights principles most relevant to HCT, and which every service provider and client should be made aware of include:

- The right to information for making choices about one's health and well-being
- The right to education
- The right to privacy
- The right to non-discrimination, equal protection and equality before the law
- The right to marry and establish a family
- The right to the highest attainable standard of physical and mental health

In Nigeria, all health care workers are bound by ethical principles to do all that is necessary and available to provide the best possible care through the use of diagnostic tools and follow-up treatment. Therefore HIV test must be provided when requested or indicated in accordance with the 3Cs principle of counselling, confidentiality and consent. Treatment and follow-up must also be provided as necessary while referral should be made for other needed services. Counsellors should provide services to people irrespective of their age, sex, race, culture, religion, values or belief system.

### b. Ethical/Legal issues

#### 1) *Informed Consent*

The term “informed consent” refers to an intentional permission given by a client to a health care provider to proceed with the proposed HIV test procedures. The permission is based on an adequate understanding of the advantages, risks, potential consequences and implications of an HIV test result which could be negative or positive. The client should be able to consider the implications of a positive diagnosis on his/her personal and professional life. It must be noted that:

- HIV testing must be voluntary, with clients making an informed decision about accepting an HIV test

- The procedure should be explained to the client and informed consent obtained to ensure that testing is done without coercion
  - The choices of individuals must be *respected*; *clients have the right to refuse testing at any time even after the blood sample has been taken for the test*
  - When anonymous testing is carried out, clients are required to either put their signatures or fingerprints on an informed consent document or verbal consent.
- ii) Legal issues relating to informed consent:
- **Minimum age for testing**  
In Nigeria, anyone aged 18 years or above and requesting HCT should be considered able to give full informed consent. A parent's or legal guardian's consent is required before testing of children below the age of 18 years. Young people below 18 years of age, that are married, pregnant, parents or sexually active, may be considered “mature minors” and should be able to grant consent for HIV testing.  
Counsellors should make an independent assessment of the minor's maturity to undergo an HIV test and ensure the availability of follow-up post-test support services.
  - **Testing of children**  
Children require special consideration; their welfare must be the primary concern when considering testing for HIV. These considerations can best be protected by laws and policies which should specify the age and circumstances under which minors may consent or assent to HIV testing. When children are seen at facilities providing HCT services, counsellors should determine the reason for testing and reserve the right to refuse testing, if not in the best interest of the child.  
A good example is where parents bring a child for testing in order to find out their own HIV status.
  - **Testing of mentally challenged persons**  
The welfare of people who are mentally challenged should be the primary concern of the counsellor when HCT is requested. The counsellor reserves the right to refuse testing if he or she feels that the testing is not in the best interest of the client. HCT can be provided in the company of a legal guardian, in deserving cases. HCT services must not be provided to clients who cannot give informed consent for testing because they are under the influence of alcohol or illicit drugs. The service should be withheld until they have fully recovered.

### c. **Mandatory testing**

Mandatory HIV testing is not acceptable except in special circumstances e.g. rape. In such cases testing shall be accompanied by counselling. However, testing for the rape perpetrator can only be performed with a court order and the results disclosed to the magistrate or judge handling the case.

HCT sites must not be used for mandatory testing, such as for pre-employment, insurance, education or travel-related purposes. Clients requesting such services should be referred to the appropriate institutions such as Government laboratories but should receive counselling or group information.

### d. **Confidentiality**

Confidentiality is one of the guiding principles for provision of HCT services and must be guaranteed. It is important that counselling and testing centres adhere to policies that protect the confidentiality and privacy (visual and auditory) of clients. Those testing must be assured of the confidentiality of their records, the record keeping system and their test results.

- **Anonymity**

Anonymity is practised when only code numbers and/or pseudo-names of clients are used in facilities providing HIV Counselling and Testing. Service providers should clearly explain the procedure to all clients and still maintain the same standards of confidentiality.

- **Confidential Record Keeping**

All medical records, including those with HIV-related information, must be managed in accordance with appropriate standards of confidentiality. Only persons with a direct role in the management of the client should have access to these records.

- **Shared confidentiality**

Shared confidentiality is when information about the patient or client is disclosed to another person (who could be a family member, health worker, friend or relative) directly involved in the care of the client, with the client's express consent. Counsellors should explain the benefits of shared confidentiality to the client.

- **Written results**

All sites for HIV Counselling and Testing should not provide written HIV test results as this may compromise patient confidentiality and may lead to misuse of results. However, there are laid down procedures for referral and continuum of care for those who test HIV positive

**e. Ethical disclosure**

HIV test results should be disclosed only to the client in person. Disclosure of the results to anyone else should only be done with the client's consent. Disclosure of HIV status to children will depend on thorough assessment of the child's level of maturity. In situations where the child is assessed to be immature or unable to deal with the implications of a positive HIV test result, the counsellor can disclose to the parent or legal guardian.

**f. Partner notification**

All clients, both HIV positive and negative, should be encouraged to inform their sexual partners about their HIV test results. For HIV positive clients who are reluctant or fearful to disclose their results, the counsellor should offer additional, on-going counselling to help the client inform the partner. However on client's request, the counsellor may inform the sexual partners of the client about the HIV test results in the presence of the client,

**g. Issues relating to rape**

All persons who have been raped should be offered HCT. For those who are HIV negative, post-exposure prophylaxis (PEP) should be offered within 72 hours. If the client is HIV positive, management should follow the national ARV guidelines. Mandatory testing and counselling for the rape perpetrator can only be performed with a court order and the results disclosed to the magistrate or judge handling the case.

## Chapter 9

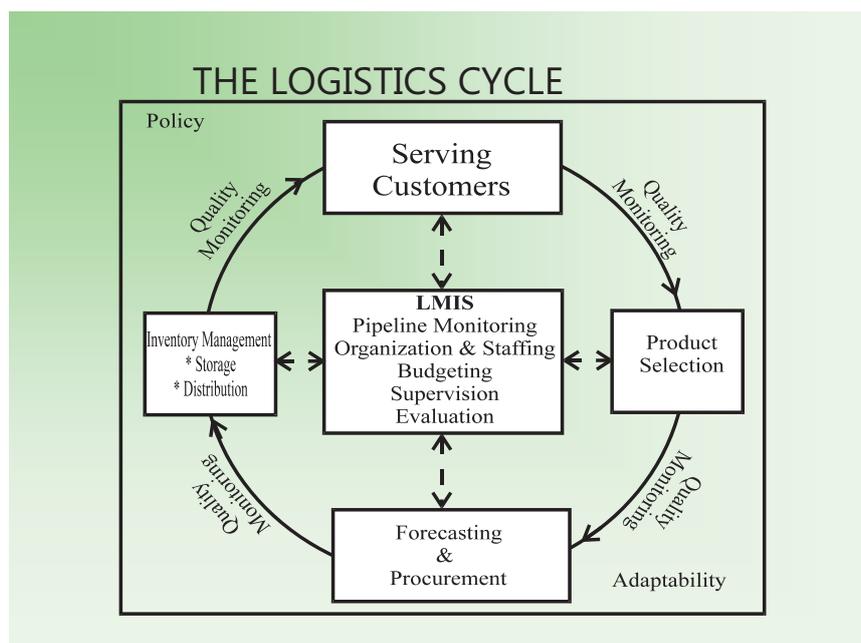
# Logistics Management

Logistics is the process of sourcing, warehousing, distribution and rational use of supplies. “Logistics” in this context refers to the process of ensuring that HCT commodities are available and ready for use by all who need them in a sustainable and reliable manner.

### a. Procurement and distribution procedures

Issues of logistics and supplies must take into account several factors, namely:

- Source(s) of funds for the implementation of the logistics programme
- Scope of the programme
- Effective forecasting
- Effective quantification
- Effective procurement
- Warehousing/Storage and distribution
- Rational use
- Monitoring and evaluation
- Feedback mechanism



To ensure non-interruption of supplies, it is important to establish procurement and distribution system for test kits and other consumables to be used in HCT facilities. HIV test kits selection and testing protocol will be in conformity with the prevailing national HIV testing algorithm. Forecasting, quantification, budgeting, financing, procurement and distribution of test kits should be evidence-based.

### **b. Procurement of test kits**

All test kits for the public sector should be procured centrally at the national level. However, where central/national procurement is not feasible, state government and other service providers must procure only test kits on the national testing algorithm as approved by the Federal Ministry of Health.

Rapid test kits that do not require refrigeration are more appropriate for use at HCT sites. Test kits with long shelf life should be used in remote areas and sites performing smaller numbers of tests.

### **c. Distribution of test kits**

The Federal Ministry of Health shall distribute test kits to public health sector facilities and shall maintain an emergency or buffer stock of rapid HIV test kits for distribution when needed. However, where central/national logistics is not feasible, states and other service providers must only distribute test kits on the national testing algorithm to all facilities within their area of jurisdiction.

### **d. Stock Management of tests kits**

It is highly recommended that rapid test kits (RTK) which can be stored at room temperature (25-28 degrees centigrade) be used at HCT sites. However where the climatic conditions make this unattainable, the test kits should be refrigerated or stored in an air conditioned room.

Cold chain dependent tests kits must not be stored or used at sites without reliable power supply.

Every facility providing HCT services should have a designated officer in charge of ensuring that test kits are stored properly and used before their expiry date.

Where available, test kits should be stored in household refrigerators but not in the freezer compartments. Where refrigeration is not possible, the manufacturer's storage instructions should be followed. An inventory system should be developed in accordance with national logistics guidelines to track usage and projection of needs. Storage facilities for test kits and other consumables should take into account special requirements of the test kits and capacities of the sites.

### **e. Recording and Reporting: Logistics Management Information System**

An effective logistics system is supported by timely logistics data that will enable HCT managers to account for and ensure adequate supplies of HIV test kits. The following information should be collected in this system:

**Stock on hand:** data on the usable quantities of stock held at the central and the facility level

**Rate of consumption/usage:** data on the quantities of products given to clients/patients during a particular period.

**Losses and adjustments:** Losses are the quantity of stock removed from the system for reasons such as expiration, damage, etc; adjustments are made when commodities are transferred from one service delivery point to another.

*Relevant forms to collect and report the above mentioned information items are included in the annex.*

## Chapter 10

# Monitoring and Evaluation

Monitoring and evaluation for HCT services should be in line with the National Health Management Information System (NHMIS) and should feed into the Nigeria National Response Information Management System (NNRIMS).

The HCT database would be used to monitor and evaluate HCT services at the sites, Local Government Area, State, and National levels. This data should be used to identify programme areas that need to be strengthened for effective and efficient programme implementation. Special studies may be required for specific issues but in general, the emphasis should be on using the HCT database for planning.

### a. Data Management

Handling of HCT records and data will require confidentiality and efficiency. This will give the clients a sense of security.

- i) **Data Collection System:** The national HCT data collection and analysis system developed by FMOH in collaboration with stakeholders should be in conformity with guidelines on HCT M&E.
- ii) **Data Collection Instruments:** The following instruments should be used to collect HCT data;
  - HCT facility registers (Annex 9)
  - HCT laboratory registers
  - HCT summary forms
- **Coding System:** A standardised system of assigning codes or reference numbers to clients for identification purposes should be developed and used within each institution
- **Record Keeping:** A filing system for HCT records should be developed and followed within each institution. All records must be kept confidential and stored in a secure room with lockable cabinets

- **Data Entry and Transfer:** At each HCT site, the data collection forms (see appendix) should be completed and forwarded to the LG, where the data are collated and in turn forwarded to the state Ministry of Health. At the state level, all HCT data should be collated, analysed and forwarded to the FMOH (HAD)
- **Data Analysis and Reporting:** Data collected should be analysed at the national level and findings should contribute to programme planning and implementation. It will also be analysed at NACA and fitted into the NNRIMS. The FMOH should design feedback mechanisms to ensure that each level of service, the management, partners and stakeholders are informed on a quarterly basis on service statistics of HCT services in the country.

### b. **Quality Assurance:**

Staff competency, client satisfaction and adherence to counselling and testing protocols should be assessed periodically. Quality assurance measures and examples of selected tools can be found in the annex.

A systematic plan for periodic external data quality checks to be conducted by HAD/FMOH and other stakeholders should be developed. These checks should include a review of site registers and reporting forms for completeness and accuracy.

### c. **Monitoring Activities**

The FMOH should develop and provide HCT M&E registers and summary forms for HCT sites. Guidelines and training materials for proper completion of the registers and forms should be made available. The FMOH in collaboration with partners and other stakeholders should support training on data collection and reporting.

### d. **Evaluation Activities**

Process and outcome evaluations should be periodically conducted to assess current programme success and inform future revisions of the National HCT guidelines and strategic plans.

### e. **One M&E Framework**

The global strategy for HIV and AIDS control now demands that there be **one** country level M&E system, **one** national coordinating body and **one** national strategic plan (the “three ones”). Accordingly, the HCT-MIS should feed into the multi-sectoral M&E framework (NNRIMS).

### f. **HIV Counselling and Testing Programme Reports**

- All facilities/sites should produce monthly, quarterly and annual reports of HCT activities
- National annual HCT reports should be produced by Federal Ministry of Health and

- feed back given to the facilities, stakeholders and partners
- The annual reports should be discussed in annual NTT review meetings where progress, challenges faced in service provision, “best practices” and the way forward should be identified.

**g. National HCT Indicators**

Indicators for the National HCT programme include those that measure Coverage, Quality of service, Quantum of Service provided and Outcome.

These are listed in the table below. Details on them can be found in the “Monitoring and Evaluation Framework for the Health Sector Response to HIV and AIDS in Nigeria”.

## NATIONAL GUIDELINES FOR HIV COUNSELLING AND TESTING

### HIV Counselling and Testing (HCT) National indicators

| Programme Area                | Indicator Type | Indicator   | Periodicity of reporting | Source  |
|-------------------------------|----------------|---|--------------------------|---|
| HCT 1                         | Input          | <b>Core 1:</b> Existence of updated national policies, strategy, and guidelines for HCT programmes  | Biannually               | HAD documentation/<br>key informant interview |
| HCT 2                         | Input          | <b>Core 2:</b> Number & Percentage of Local Government Areas with at least one health facility providing HCT services in-line with national standards | Annually                 | HIV service delivery mapping/<br>HCT database |
| HCT 3                         | Input          | <b>Core 3:</b> Number and percentage of service outlets providing HCT according to National guidelines  | Biannually               | Health facility survey                        |
| HCT 4                         | Input          | <b>Core 4:</b> Number of personnel trained on HCT in accordance with national or international standards  | Annually                 | Health facility survey/<br>Programme reports  |
| HCT 5                         | Output         | <b>Core 5:</b> Number of clients who received counselling, received their test results and also received post test counselling (male and female)      | Biannually               | HCT register                                  |
| HCT 6                         | Outcome        | <b>Core 6:</b> Proportion of clients aged 15 – 49 years (male and female) who in the last 12 months had a HIV test and received their test results    | 3-4 yearly               | NARHS   |
| <b>HCT Service statistics</b> |                |   |                          |   |
| HCT 7                         | Output         | Number of clients who received pre-test counselling (male and female)   | semi-annually            | HCT register                                  |
| HCT 8                         | Output         | Number of clients who received HIV testing (male and female, source/care entry point, rural-urban)  | semi-annually            | HCT register                                  |
| HCT 9                         | Output         | Number of clients who test positive (male and female)   | semi-annually            | HCT Laboratory result register                |

## NATIONAL GUIDELINES FOR HIV COUNSELLING AND TESTING

| <b>Programme Area</b> | <b>Indicator Type</b> | <b>Indicator</b>  | <b>Periodicity of reporting</b> | <b>Source</b>     |
|-----------------------|-----------------------|---|---------------------------------|-------------------|
| HCT 10                | Output                | Number of DOTS clients who report for HIV counselling & testing (male & female) | Biannually                      | HCT register      |
| HCT 11                | Output                | Number of HCT clients referred for TB screening                                 | Biannually                      | Referral register |
| HCT 12                | Output                | Number of clients referred for ART  | Biannually                      | Referral register |
| HCT 14                | Output                | Number of clients referred for Care and Support services                        | Biannually                      | Referral register |

## References

- Federal Ministry of Health (2003): National Guidelines for HIV/AIDS Voluntary Counselling and Testing.
- Federal Ministry of Health (NASCP) HIV/AIDS: what it means for Nigeria Background, Projections, Impact, interventions and Policy (2002)
- Federal Ministry of Health (NASCP 2005); Technical Report: National HIV/Syphilis seroprevalence Sentinel Survey among Pregnant Women attending Antenatal Clinics in Nigeria
- FHI (2004) HIV Voluntary Counselling and Testing: A Reference Guide for Counsellors and Trainers
- FMOH/NASCP (2005 – 2007): National Health Sector Strategic Plan for HIV & AIDS in Nigeria
- FMOH (2008), National HIV/AIDS and Reproductive Health Survey 2007
- FMOH (2005): National Guideline on PMTCT
- FMOH, Nutrition Division: Guidelines on Infant and Young Child Feeding and HIV/AIDS in Nigeria. 2003
- HIVAIDS Care and Counselling (2003) A Training Curriculum for Health Care Professionals
- Kenya Ministry of Health (2001) National Guidelines for Voluntary Counselling and Testing
- The Ministry of Health, Zimbabwe (2005): Zimbabwe National Guidelines on HIV Testing and Counselling.
- UNAIDS (2004): Summary Consultative Meeting on HIV Counselling and Testing in the African Region
- UNAIDS (June 2004): UNAIDS/WHO Policy Statement on HIV Testing
- WHO (2003): Treating 3 million by 2005; Making it happen: The WHO Strategy.
- WHO (2003): Emergency scale-up of antiretroviral therapy in resource-limited setting: technical and operational recommendations to achieve 3 by 5

## Annex I



### HIV COUNSELING AND TESTING: CLIENT INTAKE FORM

|   |   |                             |
|---|---|-----------------------------|
| Client's Name _____                       | Age _____                                     | Date of visit _____         |
| Client's Code _____                       | Sex _____                                     | First time visit [No] [Yes] |
| State of Residence _____                  | LGA of Residence _____                        |                             |
| Marital status _____                      | No. of own children <5 years [ ] (if married) | No. of wives/co-wives [ ]   |
| Type of Counseling: [Individual] [Couple] |   |                             |

#### Pretest Counseling

MARK with "X" the [0] if answer is No, the [1] if answer is Yes

| Knowledge Assessment  |  | HIV Risk Assessment   |         |
|---|--|---|---------|
| Previously tested HIV negative  | [0] [1]                                    | Blood transfusion in last 3 months  | [0] [1] |
| Client pregnant (if yes, refer to PMTCT)  | [0] [1]                                    | Ever had sexual intercourse   | [0] [1] |
| Client informed about HIV transmission routes   | [0] [1]                                    | Unprotected sex with casual partner in last 3 months  | [0] [1] |
| Client informed about risk factors for HIV transmission   | [0] [1]                                    | Unprotected sex with regular partner in the last 3 months   | [0] [1] |
| Client informed on preventing HIV transmission methods  | [0] [1]                                    | STI in last 3 months  | [0] [1] |
| Client informed about possible test results   | [0] [1]                                    | More than 1 sex partner during last 3 months  | [0] [1] |
| Informed consent for HIV testing given  | [0] [1]                                    | (calculate the sum of the 6 answers above) <b>Risk score:</b>   |         |
| <b>Clinical TB screening</b>  |  | <b>Syndromic STI Screening</b>  |         |
| Coughing for > 3 weeks  | [0] [1]                                    | <i>Female:</i> Complaints of vaginal discharge or burning when urinating <input type="checkbox"/>             | [0] [1] |
| Weight loss of $\geq$ 3 kg in last 4 weeks  | [0] [1]                                    | <i>Female:</i> Complaints of lower abdominal pains with or without vaginal discharge <input type="checkbox"/> | [0] [1] |
| Lymphadenopathy (swelling of the lymph nodes)   | [0] [1]                                    | <i>Male:</i> Complaints of urethral discharge or burning when urinating <input type="checkbox"/>              | [0] [1] |
| Fever for > 2 weeks   | [0] [1]                                    | <i>Male:</i> Complaints of scrotal swelling and pain  | [0] [1] |
| Night sweats for > 2 weeks  | [0] [1]                                    | Complaints of genital sore(s) or swollen inguinal lymph nodes with or without pains <input type="checkbox"/>  | [0] [1] |
| (calculate the sum of the 5 answers above) <b>TB screening score:</b>   |  | (calculate the sum of the 3 answers above) <b>STI screening score:</b>  |         |
| <i>If score <math>\geq</math> 1, test for sputum AFB or refer to TB service</i>   |  | <i>If score <math>\geq</math> 1, follow syndromic STI management guidelines or refer</i>                      |         |
| <b>Post Test Counseling</b>   |  |   |         |
| <b>HIV test result</b>  | <b>negative</b> [ ]<br><b>positive</b> [ ] | Counseling done   | [0] [1] |
| HIV Request and Result form signed by tester  | [0] [1]                                    | Risk reduction plan developed   | [0] [1] |
| HIV Request and Result form filled with CT Intake Form  | [0] [1]                                    | Post test disclosure plan developed   | [0] [1] |
| Client received HIV test result   | [0] [1]                                    | Will bring partner(s) for HIV testing   | [0] [1] |
|   |  | Will bring own children <5 years for HIV testing  | [0] [1] |
| <b>If client tests HIV negative, and HIV Risk Assessment Score &gt;0 or there is evidence for a STI syndrome, recommend re-testing after 3 months</b> |  | Provided with information on FP and dual contraception  | [0] [1] |
|   |  | Client/Partner use FP methods (other than condom)   | [0] [1] |
|   |  | Client/Partner use condoms as (one) FP method   | [0] [1] |
|   |  | Correct condom use demonstrated   | [0] [1] |
| Client referred to other services   | [0] [1]                                    | Condoms provided to client  | [0] [1] |
| If [1] Specify:   |  |   |         |

Comments:

**Annex 2**



**Request and Result Form**

Facility Name: \_\_\_\_\_  
 \_\_\_\_\_  
 (DD/MM/YYYY)

Sample Collection Date: \_\_\_\_\_  
 \_\_\_\_\_  
 Date

Client Name: \_\_\_\_\_

Client No. \_\_\_\_\_

Sex (Tick): O M O F

Age: >2 (in years) .....  
 2 (in months) .....

**SEROLOGY REQUEST:**

|                                    |                                    |
|------------------------------------|------------------------------------|
| <b>Antibody Test</b>               | <b>Antigen Test (PCR)</b>          |
| Negative: <input type="checkbox"/> | Negative: <input type="checkbox"/> |
| Positive: <input type="checkbox"/> | Positive: <input type="checkbox"/> |
| <b>Lab no:</b>                     | <b>Test date:</b>                  |

Requested by: \_\_\_\_\_  
 \_\_\_\_\_  
 Name (in capital)

\_\_\_\_\_  
 \_\_\_\_\_  
 Signature Date DD/MM/YYYY)

Tested by: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 Name (in capital)  
 (DD/MM/YYYY)

\_\_\_\_\_  
 \_\_\_\_\_  
 Signature Date

Checked by: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 Name (in capital)  
 (DD/MM/YYYY)

\_\_\_\_\_  
 \_\_\_\_\_  
 Signature Date

### Annex 3



### CLIENT REFERRAL FORM

- Referring organizations: please fill out Part A and ask client to take it to the receiving organization.
- Please fill out one form per service needed.
- Receiving organization: please fill out Part B and either return it directly to the referring organization or ask the client to return it to the referring organization at next visit.

**Part A: Referral Slip: To be filled out by the organization making the referral (referring organization)**

|   |                                      |            |      |
|---|--------------------------------------|------------|------|
| Date:   | Client name:<br>Client phone number: | Age:       | Sex: |
| Referred from (unit/department):                            |                                      |            |      |
| Name of person referring client/designation                 |                                      |            |      |
| Name, Address & Phone number of referring organization:     |                                      |            |      |
| Referred to (unit/department):                              |                                      |            |      |
| Name of contact person:                                     |                                      |            |      |
| Name, Address & Phone number of the receiving organization: |                                      |            |      |
| Services needed/notes:                                      |                                      | Signature: |      |

**CLIENT REFERRAL FORM**

| <b>Part B: Services provided: To be filled out by the organization providing the service(s)</b>                 |  |  |   |   |
|---|--|--|---|---|
| <b>Name &amp; address of organization providing the service(s):</b>   |  |  |   |   |
| Date:   | Client name:   |  | Age:  | Sex:  |
| List services provided here   | Service completed as requested? Y/N  | Type of follow up needed   |   | Follow up date  |
|   |  |  |   |   |
|   |  |  |   |   |
| Additional comments:  |  |  |   |   |
| Signature of Service provider   |  |  |   |   |
| <b>Categories of services</b>   |  |  |   |   |
| 1. Adherence counseling and Treatment support<br>2. Antiretroviral therapy<br>3. Child care<br>4. Clinical care | 5. Education/ schooling<br>6. Family planning<br>7. Financial, material and microfinance support and services<br>8. Food support | 9. HIV counseling and testing<br>10. Home-based care<br>11. Legal support<br>12. Nutrition counseling<br>13. OB/GYN services | 14. PEP services<br>15. Pharmacy<br>16. PLHA support<br>17. PMTCT services<br>18. Prevention services ( including peer counseling and information services) | 19. Psychosocial support<br>20. Social services<br>21. Spiritual support<br>22. STI services<br>23. TB services<br>24. Oncology |

### Annex 4

#### REFERRAL REGISTER

| S/N   | Date  | Names  | Age  | Sex | REFERRAL |    | SERVICES         |                 |                |                          |
|---|---|--|--|-----|----------|----|------------------|-----------------|----------------|--------------------------|
|   |   |  |  |     | From     | To | Requested (CODE) | Provided Yes/No | Date Completed | Type of Follow up needed |
|   |   |  |  |     |          |    |                  |                 |                |                          |
|   |   |  |  |     |          |    |                  |                 |                |                          |
|   |   |  |  |     |          |    |                  |                 |                |                          |
|   |   |  |  |     |          |    |                  |                 |                |                          |
|   |   |  |  |     |          |    |                  |                 |                |                          |
|   |   |  |  |     |          |    |                  |                 |                |                          |
|   |   |  |  |     |          |    |                  |                 |                |                          |
|   |   |  |  |     |          |    |                  |                 |                |                          |
|   |   |  |  |     |          |    |                  |                 |                |                          |
|   |   |  |  |     |          |    |                  |                 |                |                          |
|   |   |  |  |     |          |    |                  |                 |                |                          |
|   |   |  |  |     |          |    |                  |                 |                |                          |
|   |   |  |  |     |          |    |                  |                 |                |                          |
|   |   |  |  |     |          |    |                  |                 |                |                          |
|   |   |  |  |     |          |    |                  |                 |                |                          |
|   |   |  |  |     |          |    |                  |                 |                |                          |
|   |   |  |  |     |          |    |                  |                 |                |                          |
|   |   |  |  |     |          |    |                  |                 |                |                          |
|   |   |  |  |     |          |    |                  |                 |                |                          |
| 1. Adherence Counselling and Treatment support<br>2. Antiretroviral therapy | 9. HIV Counselling and testing<br>10. Home-based care<br>11. Legal support<br>12. | 14. PEP services<br>15. Pharmacy<br>16. PLHA support<br>17. PMTCT services<br>18. Prevention | 19. Psychosocial support<br>20. Social services<br>21. Spiritual support<br>22. STI services<br>23. TB services<br>24. Others..... |     |          |    |                  |                 |                |                          |





Annex 7



HCT MONTHLY SUMMARY FORM

Reporting Period: Month \_\_\_\_\_ Year \_\_\_\_\_

State: \_\_\_\_\_ LGA: \_\_\_\_\_ Site name: \_\_\_\_\_

| Data elements<br><i>(All data elements exclude women attending ANC)</i>  | Age group<br>(years) | In-patients | Out-patients |         |            |         | Mobile | Total |
|--|----------------------|-------------|--------------|---------|------------|---------|--------|-------|
|  |                      |             | CT site      | TB site | Blood bank | FP site |        |       |
| No. of ind. tested HIV negative (male)   | <2                   |             |              |         |            |         |        |       |
|  | 2-14                 |             |              |         |            |         |        |       |
|  | 15-19                |             |              |         |            |         |        |       |
|  | 20-24                |             |              |         |            |         |        |       |
|  | 25+                  |             |              |         |            |         |        |       |
| No. of ind. tested HIV negative (female)   | <2                   |             |              |         |            |         |        |       |
|  | 2-14                 |             |              |         |            |         |        |       |
|  | 15-19                |             |              |         |            |         |        |       |
|  | 20-24                |             |              |         |            |         |        |       |
|  | 25+                  |             |              |         |            |         |        |       |
| <i>Subtotal A: No. of ind. tested HIV negative</i>   |                      |             |              |         |            |         |        |       |
| No. of ind. tested HIV positive (male)   | <2                   |             |              |         |            |         |        |       |
|  | 2-14                 |             |              |         |            |         |        |       |
|  | 15-19                |             |              |         |            |         |        |       |
|  | 20-24                |             |              |         |            |         |        |       |
|  | 25+                  |             |              |         |            |         |        |       |
| No. of ind. tested HIV positive (female)   | <2                   |             |              |         |            |         |        |       |
|  | 2-14                 |             |              |         |            |         |        |       |
|  | 15-19                |             |              |         |            |         |        |       |
|  | 20-24                |             |              |         |            |         |        |       |
|  | 25+                  |             |              |         |            |         |        |       |
| <i>Subtotal B: No. of ind. tested HIV positive</i>   |                      |             |              |         |            |         |        |       |
| <i>Total no. of ind. HIV tested (subtotal A + B)</i>   |                      |             |              |         |            |         |        |       |
| No. of ind. HIV counselled & test & result (male)  | <2                   |             |              |         |            |         |        |       |
|  | 2-14                 |             |              |         |            |         |        |       |
|  | 15-19                |             |              |         |            |         |        |       |
|  | 20-24                |             |              |         |            |         |        |       |
|  | 25+                  |             |              |         |            |         |        |       |
| No. of ind. HIV counselled & test & result (female)  | <2                   |             |              |         |            |         |        |       |
|  | 2-14                 |             |              |         |            |         |        |       |
|  | 15-19                |             |              |         |            |         |        |       |
|  | 20-24                |             |              |         |            |         |        |       |
|  | 25+                  |             |              |         |            |         |        |       |
| <i>Total no. of No. of ind. HIV counselled &amp; test &amp; result</i>   |                      |             |              |         |            |         |        |       |
| No. of STI clients tested HIV negative   |                      |             |              |         |            |         |        |       |
| No. of STI clients tested HIV positive   |                      |             |              |         |            |         |        |       |
| No. of TB patients tested HIV negative   |                      |             |              |         |            |         |        |       |
| No. of TB patients tested HIV positive   |                      |             |              |         |            |         |        |       |
| No. of HIV neg. clients clinically screened for TB score 0   |                      |             |              |         |            |         |        |       |
| No. of HIV pos. clients clinically screened for TB score 0   |                      |             |              |         |            |         |        |       |
| No. of HIV neg. clients clinically screened for TB score 1+  |                      |             |              |         |            |         |        |       |
| No. of HIV pos. clients clinically screened for TB score 1+  |                      |             |              |         |            |         |        |       |
| No. of external onsite monitoring visit(s) conducted by government official(s) in-charge during reporting period using standard check list |                      |             |              |         |            |         |        |       |
| No. of external onsite monitoring visit(s) conducted by TA/Consultants during reporting period using standard check list                   |                      |             |              |         |            |         |        |       |
| No. of counselor(s) of facility newly trained on HCT (excluding PMTCT) during reporting period   |                      |             |              |         |            |         |        |       |
| No. of counselor(s) of facility re-trained on HCT (excluding PMTCT) during reporting period  |                      |             |              |         |            |         |        |       |
| No. of trained counselors who provided HCT services (excluding PMTCT) at the facility during the reporting period                          |                      |             |              |         |            |         |        |       |

Completed by: Name \_\_\_\_\_ Designation: \_\_\_\_\_ Sign: \_\_\_\_\_ Date: \_\_\_\_\_

Annex 8

|  <b>DAILY HIV TEST WORKSHEET</b> |            |  |                   |                    |                  |              |                     |
|---|------------|--|-------------------|--------------------|------------------|--------------|---------------------|
| State:.....   |            | LGA.....   |                   |                    | Month/Year:..... |              |                     |
| Facility/Site Name.....   |            | Unit within facilities(TB, CT, BLD BK, FP, Lab and others specify):..... |                   |                    |                  |              |                     |
|   |            | TYPE OF TEST   |                   |                    |                  |              |                     |
|   |            | SCREENING TEST   | CONFIRMATORY TEST | TIE BREAKER        |                  |              |                     |
|   |            | Name of the test   |                   |                    |                  |              |                     |
|   |            | Lot number   |                   |                    |                  |              |                     |
|   |            | Expiry Date  |                   |                    |                  |              |                     |
| LAB No.   | CLIENT NO. | PURPOSE  | RESULT            | RESULT             | RESULT           | FINAL RESULT | Signature of Tester |
| S/N   |            | Control  |                   |                    |                  |              |                     |
|   |            | Control  |                   |                    |                  |              |                     |
| 1   |            |  |                   |                    |                  |              |                     |
| 2   |            |  |                   |                    |                  |              |                     |
| 3   |            |  |                   |                    |                  |              |                     |
| 4   |            |  |                   |                    |                  |              |                     |
| 5   |            |  |                   |                    |                  |              |                     |
| 6   |            |  |                   |                    |                  |              |                     |
| 7   |            |  |                   |                    |                  |              |                     |
| 8   |            |  |                   |                    |                  |              |                     |
| 9   |            |  |                   |                    |                  |              |                     |
| 10  |            |  |                   |                    |                  |              |                     |
| 11  |            |  |                   |                    |                  |              |                     |
| 12  |            |  |                   |                    |                  |              |                     |
| 13  |            |  |                   |                    |                  |              |                     |
| 14  |            |  |                   |                    |                  |              |                     |
| 15  |            |  |                   |                    |                  |              |                     |
|   |            | Total Used   |                   |                    |                  |              |                     |
|   |            | Losses/ Wastage  |                   |                    |                  |              |                     |
|   |            | Day Total  |                   |                    |                  |              |                     |
|   |            | Total Qty Used (All pages to date this month )                           |                   |                    |                  |              |                     |
| Daily Summary of Total Used Per Purpose   |            |  |                   |                    |                  |              |                     |
| HIV TEST  | HCT        | PMTCT  | TB                | CLINICAL DIAGNOSIS | DONOR SCREENING  | TOTAL        |                     |
| Screening Test  |            |  |                   |                    |                  |              |                     |
| Confirmatory Test   |            |  |                   |                    |                  |              |                     |
| Tie-Breaker   |            |  |                   |                    |                  |              |                     |

Supervisor's Name:.....

Designation:.....

Signature:.....

Date:....





## Annex II

### Combined Report-Requisition and Issue Form- HIV Test Kits

State: \_\_\_\_\_ LGA: \_\_\_\_\_ Facility Name: \_\_\_\_\_

Report Period: \_\_\_\_\_ Date Prepared \_\_\_\_\_ Stock Level Guideline: Maximum Stock Level: 3 Months  
 Month/Year Day/Month/Year Minimum Stock Level: 1 Month

| Serial No. | HIV TEST KITS     | No. Test Per KIT | Basic Unit | REPORT                                 |   |   |                           |  |                        |                   |                 |  |
|------------|-------------------|------------------|------------|--|---|---|---------------------------|--|------------------------|-------------------|-----------------|--|
|            |                   |                  |            | Beginning Balance for Reporting Period | Quantity Received during Reporting Period | Total Number of Test Used During Reporting Period | Losses/ Adjustments (+/-) | Quantity on Hand at the end of the Reporting Period (Physical Count) | Maximum Stock Quantity | Quantity to Order | Quantity Issued |  |
|            |                   |                  |            | A                                      | B   | C   | D                         | E = A + B - C +/- D  | F = C x 3              | G = F - E         | H               |  |
| 1.         | DETERMINE         |                  |            |  |   |   |                           |  |                        |                   |                 |  |
| 2.         | STAT PAK          |                  |            |  |   |   |                           |  |                        |                   |                 |  |
| 3.         | CAPILLUS          |                  |            |  |   |   |                           |  |                        |                   |                 |  |
| 4.         | GENIE II          |                  |            |  |   |   |                           |  |                        |                   |                 |  |
| 5.         | DOUBLE CHECK GOLD |                  |            |  |   |   |                           |  |                        |                   |                 |  |
| 6.         |                   |                  |            |  |   |   |                           |  |                        |                   |                 |  |
| 7.         |                   |                  |            |  |   |   |                           |  |                        |                   |                 |  |
| 8.         |                   |                  |            |  |   |   |                           |  |                        |                   |                 |  |
| 9.         |                   |                  |            |  |   |   |                           |  |                        |                   |                 |  |
| 10.        |                   |                  |            |  |   |   |                           |  |                        |                   |                 |  |
| 11.        |                   |                  |            |  |   |   |                           |  |                        |                   |                 |  |
| 12.        |                   |                  |            |  |   |   |                           |  |                        |                   |                 |  |
| 13.        |                   |                  |            |  |   |   |                           |  |                        |                   |                 |  |

Comments:

\_\_\_\_\_

\_\_\_\_\_

Prepared By: \_\_\_\_\_ Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Full Name

Approved By: \_\_\_\_\_ Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Full Name

Issued By: \_\_\_\_\_ Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Full Name

Received By: \_\_\_\_\_ Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Full Name

## Annex 12

### HIV Counselling And Testing Client Exit Survey Form

NAME OF ORGANIZATION \_\_\_\_\_

Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Type of visit \_\_\_\_\_

Initial \_\_\_\_\_

Follow  
up

If survey declined, reason for declination:  
\_\_\_\_\_  
\_\_\_\_\_

Type of counselling session \_\_\_\_\_

Individual \_\_\_\_\_

Group \_\_\_\_\_

Indicate your answer by circling the appropriate answer to the following statements

| S/NO |   | Yes=1 | No=2 |
|------|---|-------|------|
| 1.   | Overall, the services I received were satisfactory.   | 1     | 2    |
| 2.   | A staff member greeted me within 15 minutes of my arrival                                     | 1     | 2    |
| 3.   | I was offered a place to sit while I was waiting  | 1     | 2    |
| 4.   | The staff fully explained what to expect at the VCT site                                      | 1     | 2    |
| 5.   | The staffs were helpful and supportive to me.   | 1     | 2    |
| 6.   | I felt comfortable asking the Counsellor questions.   | 1     | 2    |
| 7.   | I felt the Counsellor answered my questions fully   | 1     | 2    |
| 8.   | I felt comfortable as my blood samples were taken   | 1     | 2    |
| 9.   | The Counsellor made me comfortable talking to him/her   | 1     | 2    |
| 10.  | The Counsellor displayed good skills in his/her counselling session                           | 1     | 2    |
| 11.  | I was given the necessary information I needed about HIV/AIDS.                                | 1     | 2    |
| 12.  | I felt I learned something from the video playing in the waiting room (if <i>Applicable</i> ) | 1     | 2    |
| 13.  | The information given makes/made me feel confident to receive my results.                     | 1     | 2    |
| 14.  | I intend to tell others about this service  | 1     | 2    |
| 15.  | I intend to discuss the results of my test with my partner.                                   | 1     | 2    |
| 16.  | I intend to come for all follow up visit (if <i>applicable</i> ).                             | 1     | 2    |

Any additional comments:  
\_\_\_\_\_

### Annex 13

HIV Counselling and Testing Counsellor Reflection Form

NAME OF ORGANIZATION

Counsellor Reflection Form

|  |  |
|--|--|
| <b>COUNSELOR CODE or NAME:</b>   | <b>CLIENT CODE:</b><br><i>(optional)</i>                                   |
| <b>Date:</b> _____   |  |
|  | <b>Yes      No      N/A</b>  |
| 1. Did I conduct a client centred session that responded to the client’s needs and concerns <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> |
| 2. Did I provide appropriate technical information <input type="checkbox"/>  | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> |
| 3. Did the client speak as much or more than I did <input type="checkbox"/>  | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> |
| 4. Did I perform a risk assessment <input type="checkbox"/>  | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> |
| 5. Did I work with the client to attain a risk reduction plan <input type="checkbox"/>                               | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> |
| 6. Did the client understand the meaning of the test results <input type="checkbox"/>                                | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> |
| 7. Did I assess and address the availability of the client’s social support <input type="checkbox"/>                 | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> |
| 8. Did I discuss relevant referral options with the client <input type="checkbox"/>                                  | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> |
| 9. Did I discuss disclosure of test results with the client <input type="checkbox"/>                                 | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> |
| 10. Did the client determine an immediate plan of action <input type="checkbox"/>                                    | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> |
| 11. Did I deal with the client’s and my own emotional reactions <input type="checkbox"/>                             | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> |
| 12. What did I do well <input type="checkbox"/> _____  |  |
| 13. What could I have improved upon _____  |  |
| 14. Professional Issues to follow up _____   |  |