CHAPTER THREE: HIV CASE FINDING

3.1. HIV Testing Services

HIV testing services refer to the full range of services that should be provided with HIV testing, including counselling (pre-test information and post-test counselling); linkage to appropriate HIV prevention, treatment, care and other clinical services and the delivery of accurate results.

HIV testing services (HTS) should be provided to eligible clients who are at high risk of HIV infection. HTS need to focus on high-risk individuals who remain undiagnosed need to be tested and linking them to treatment and care services as early as possible. People who are HIV-negative but with an ongoing risk also need to be re-tested and provided appropriate prevention package of services.

As we move closer to epidemic control, case finding will become more and more difficult hence HIV testing services should utilize HIV risk screening tools for both adults and children, enhanced index case testing response for recent infections, etc.

Goals of HIV testing services

- Identify people living with HIV by providing high-quality testing services for individuals, couples and families,
- Effectively link individuals and their families to HIV treatment, care and support and to HIV prevention services, based on their status,
- Support the scale-up of high-impact interventions to reduce HIV transmission and HIV related morbidity and mortality.

HTS service quality should not be compromised, hence standard operating procedures (SoPs), protocols, and other necessary job aides must be followed and regularly monitored.

Targeted HIV Testing Service

Targeted HTS is a process whereby individuals who are at risk of acquiring of HIV infection are tested for HIV if found eligible based on HIV risk screening tool. The focus of targeted testing is towards identifying of new HIV positive cases and proper utilization of HRST is important to implement targeted testing and achieve the first 95 of the UNAIDS goals.

3.1.1. Core Principles

Effective and efficient HTS service delivery models and approaches should focus on:

1. Reaching the largest number of individuals with HIV who remain undiagnosed with higher HIV risk

2. Increasing acceptability, equity and demand to reach those left behind, including key populations.

3. Prioritizing approaches that are most cost effective and efficient

4. Achieving national program targets (95-95-95)

5. Ensure linkage to treatment for individuals who are diagnosed HIV positive and providing appropriately tailored prevention for those who test HIV negative

3.1.2. Guiding Principles for HIV counseling and testing

HTS should always be voluntary. Protecting and maintaining client confidentiality is important, especially when offering ICT. An enabling environment that removes barriers such as stigma, discrimination, IPV is important for increasing access to and uptake of HTS. Therefore, the WHO guiding principles (also called 5Cs) should be applied in all HTS sites.

Consent: People receiving HIV counseling and testing must give informed verbal consent to be tested and counseled. Written consent is not required. They should be informed of the process for HIV counseling and testing and their right to decline testing. In Ethiopia, for pediatric age group (less than 15 years of age), the parents or guardian need to consent verbally. Mature minors (13-15 years old who are married, pregnant, commercial sex workers, street children, heads of families, or who are sexually active) can give verbal consent by themselves.

Unconscious or patient who is not in status of providing self-consent, should not be tested for HIV unless the clinician determines it is necessary to establish diagnosis and make treatment decisions. Consent of kin should be obtained during counseling.

- Confidentiality: HTS are confidential, meaning that what the HIV counseling and testing provider and the person discuss will not be disclosed to anyone else without the expressed consent of the person being tested. Counselors should raise, among other issues, whom else the person may wish to inform and how they would like this to be done. Shared confidentiality with partner or family members and trusted others and with health care providers is often highly beneficial.

- Counseling: HIV counseling and testing services must be accompanied by appropriate and standardized pre-test information and post-test counseling.

- Correct: HIV counseling and testing providers should strive to provide standardized testing services to reach to correct diagnosis.

- Connection: Connections to prevention, care and treatment services should include the provision of effective referral to appropriate follow-up services as indicated, including long-term prevention care and treatment services.

Client's Rights for HTS

Clients' rights during testing and counseling. Clients have the right to:

- Confidentiality
- Privacy
- Refuse testing
- Be treated with respect and
- Asking information or question.

3.2. Demand creation for HTS

Demand creation and mobilization strategies include activities intended to directly improve an individual's knowledge, attitudes, motivations, and intentions to test and to inform the decision to obtain HIV testing services.

Good practice approaches for demand creation

Demand creation to increase HIV testing service uptake and engage those in greatest need of services is a valuable tool for mitigating stigma, discrimination and IPV. Priorities may need to be set among demand creation approaches, depending on the setting, target population, available resources, and geographic area with high burden of HIV as part of a strategy to reach PLHIV who do not know their status and have high risk to HIV infection.

Many demand creation strategies have been assessed for how they affect HIV testing uptake and the proportion of people living with HIV diagnosed, including the following:

1. Evidence-informed platforms for delivering demand creation include:

- Peer-led demand creation interventions for KPPs
- Digital platforms, such as short-prerecorded videos encouraging testing at health facility waiting areas

2. Approaches that have showed evidence of increasing demand for HTS include:

• Advertising specific attributes of HIV testing services: on Radio, TV, social media, print and electronic media.

• Brief key messages and counselling by providers

• Messages during couples counselling that encourage testing,

• Messages related to risk reduction, to encourage testing among high-risk individuals,

• Motivational messages: through PLHIVs, religious leaders, (it could be speech at gatherings, written, picture or graphic message),

3.3. HIV Testing Service Provision Settings

HIV testing and counseling services can be provided in two major settings:

3.3.1. Facility Setting

Currently, the HIV testing and counseling services in health facilities are:

1. Client initiated HIV counseling and testing (VCT)

2. Provider initiated HIV testing and counseling (PITC), which is provided by opt-out approach using HIV risk screening tool at all clinical service delivery points except during first ANC testing.

3. Mandatory HIV testing

Mandatory HIV testing can only be performed for specific reasons with individuals or groups when requested by the court. HIV is a blood-borne pathogen readily spread by blood transfusion or tissue/organ transplantation: therefore, it is mandatory to test blood or tissue for HIV before transfusion, transplantation or grafting. Mandatory screening of donated blood/ organ/tissue is required prior to all procedures involving transfer of body fluids or body parts, such as artificial insemination, corneal grafts, and organ transplant. Donors should be specifically informed about HIV testing of donated blood, organ or tissue and link those with HIV positive test results to posttest counselling, care, and treatment services.

Mandatory HIV testing is required:

- HIV testing that will be done by the court order
- Testing of blood after donation, and
- Testing of organs before organ transplant

3.3.2. Community Setting

Refers to HTS offered in the community, outside of a health facility. It can be delivered in many ways and in different settings and venues. These include HTS at fixed locations in the community, mobile outreach in hotspots and community sites such as bars, youth centers, workplaces, and home based. It can also be delivered either alone or in combination with testing and screening for other infectious diseases such as TB, hepatitis and STIs.

As for any HTS, linkage to appropriate services after community-based testing is critical. While providing HTS services in the community, providers should use nationally approved protocols as appropriate.

Workplace HTS:

HTS in the workplace is an effective strategy for reaching high risk individuals such as mining, the transport and logistics sector, mega projects, large farming areas, the military and other uniformed services.

Targeted mobile outreach

Targeted mobile outreach focuses on high-risk populations to avail HTS as mobile outreach in areas of low coverage and poor accessibility. HTS services can also be provided to high-risk populations such as widows, divorced and homebased female sex workers.

Home-based HTS:

HTS using ICT approach can be offered in the home has the potential to reach undiagnosed partners of index cases and eligible biological children. It can effectively reach undiagnosed individuals if offered at timings outside of work hours.

3.4. Approaches of HTS

A strategic mix of different HIV testing approaches are needed for an effective and efficient national HTS program depending on the epidemiology and resources available. Differentiated HIV testing service delivery approaches are recommended to address the needs of a variety of population groups, contexts, and epidemic settings.

The following HTS approaches are recommended to reach the 2030 global target to end HIV/AIDS epidemic control:

- Client Initiated: Voluntary Counseling and Testing (VCT)
- Provider Initiated Testing and Counseling (PITC)
- Index Case Testing
- Social Network based HIV testing (SNS)
- HIV self-testing (HIVST)

The implementation of the VCT, PITC approaches will use the respective protocols. However, if couples would like to get HTS together, couple counseling and testing (CHCT) protocol will be used. Each protocol has different components having tasks and scripts.

3.4.1. Voluntary Counseling and Testing (VCT)

VCT is initiated by clients seeking to know their HIV status. VCT is the oldest approach of testing that gives client an opportunity to confidentially explore his/her HIV risks to learn his/her HIV test result. The VCT intervention is "client-focused" to the extent that you focus on the client's unique issues and circumstances related to HIV risk. The intervention is based on a risk reduction model designed to reduce, not necessarily eliminate risk.

3.4.2. Provider Initiated Testing and Counseling (PITC)

This refers to HIV testing, and counselling recommended by a provider during a visit to a health care facility. The health care provider should use HIV risk screening tool to determine whether the client is eligible for the HIV testing

or not. A brief counselling or pretest information should always accompany testing even for diagnostic purposes and patients should never be forced to undergo testing against their will. Clients presenting with symptoms or signs of illness possibly attributable to HIV; it is a basic responsibility of health care providers to recommend HIV testing and counselling as part of routine clinical management.

PITC is an "Opt-out" approach. With the "opt-out" approach, individuals may specifically decline the HIV test having received pre-test information, without affecting their care. If a client declines HIV testing service, a provider should try to understand the reasons for the refusal. If a client is convinced, HTS can be provided. But if not, the client will be advised to reconsider his decision and return to get HTS at another time.

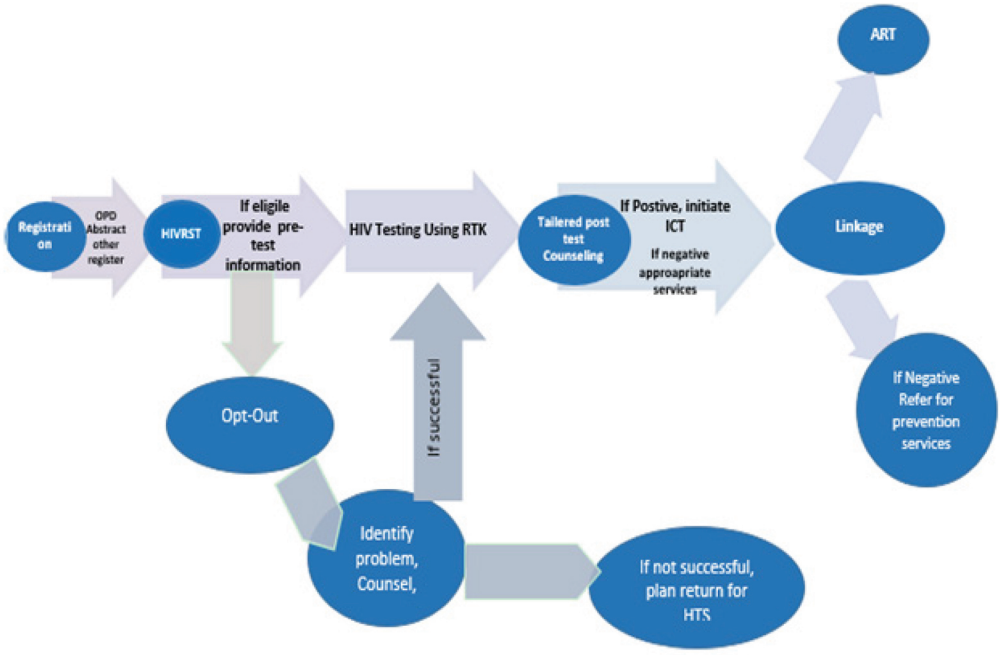


Figure 3.1. PITC Flow Chart

3.4.2.1. Use of HIV Risk Screening Tool (HRST) to Enhance PITC

HIV risk screening tool enables service providers to identify high risk clients. It gives opportunity for targeted HIV testing. HIV risk screening tool is a tool, having a set of questions, used to identify clients with specific risks for HIV. HRST helps to determine a client's HIV risk and whether the client is eligible for HIV testing or not based on the below category:

- Client's HIV status (is the client a known HIV positive case or not?)
- HIV risk behavior (practicing unprotected sex, having concurrent multiple sexual partners, etc.)
- Clinical symptoms or signs of HIV
- Occupational risk

Benefits of Using HIV Risk Screening Tool

HRST reduces over testing, improves case finding and subsequently increase yield. Risk screening tools have been utilized in different countries to identify clients who need to be tested and maximize HIV case detection and increase efficient utilization of limited resources including RTKs. In our setup, risk screening tool can be applied at all service delivery points with the exception for the first ANC/labor/post-partum visit. (Refer annexed 3a and b)

3.4.2.2. Eligible clients for HIV Testing and counseling while providing PITC includes:

- All pregnant at first ANC visit, laboring, and postpartum women with unknown HIV status.
- Partners of HIV positive pregnant/ postpartum women
- Sexual partners of index cases and all under 19 children of PLHIV; biological siblings and biological parents.
- Female sex workers with unknown HIV status.
- All TB patients and presumptive TB cases with unknown HIV status
- All patients with Sexually transmitted infections (STIs) and their partners
- Children orphaned by AIDS.
- Patients with clinical signs or symptoms of HIV/AIDS visiting health facilities (Annex 6a, 6b and 6c).

3.4.3. Index Case Testing

An index case is defined as an individual who is HIV positive. When counsellors identify index cases whose sexual partners or eligible biological children are not tested for HIV, they should immediately provide partner services including notification and contact tracing.

To improve case-finding, countries need to use

a mix of innovative testing strategies to identify positive individuals. Index case testing is one of the most important case finding approaches to identify HIV positive individuals.

ICT is a high yield, targeted testing approach for identifying and linking new HIV infected individuals to treatment services. This approach needs to be optimally utilized for case detection and to break HIV transmission cycle.

Some of the PLHIV might have not yet disclosed their HIV status to their partners while others have partners with ongoing risk. Clients' concerns should be addressed to improve disclosure and testing service uptake among index partners and HIV exposed biological children. If there is/are children who are not biological children of the index case but is/are exposed to HIV, HTS will be provided though this approach is not part of ICT.

A critical function of ICT is partner elicitation, a process through which index patients are interviewed to elicit information about their sexual partners, counseled and assisted on disclosure and continuously supported to bring their partner for HIV testing. Partner services are voluntary, based on the decision of the index patient, and are provided confidentially in a patient-centered framework. The role of the service providers will be providing counseling about the risk of HIV transmission and importance of disclosure, assisting on disclosure, educating on the benefits of early treatment and better outcome.

Principles of ICT

- Client centered and focused
- Confidential
- Voluntary and non-coercive
- Non-judgmental
- Culturally, linguistically, appropriate
- Accessible and available to all
- Comprehensive and integrative

Approaches of ICT Services

1. Client Referral - Index clients tell partners about infection and encourage him or her to come to testing center for testing. A trained health care provider encourages the index clients to disclose his /her status to his/her partners. In this approach, the index client takes responsibility for encouraging partner(s) to seek HTS. This is often notified verbally by the index client.

2. Contract referral: The index client enters a "contract" with the health care provider whereby he or she agrees to disclose their HIV status to all partner(s) and or to refer them for HTS within two weeks.

If partner(s) do not access HTS within this period, health care providers contact the partner(s) directly to notify them that they may have been exposed to HIV without any disclosure of the index client after getting permission from the index client. Health care providers offer

voluntary HTS to partner(s) and other family members as appropriate while maintaining the confidentiality of the index client.

3. Dual Referral - Index clients and service provider will notify his/her partner together. The provider offers voluntary HIV testing to the index client and partner(s) for the potential exposure to HIV and encourage them to seek HIV testing together without any disclosure of the index client HIV status.

4. Provider Referral (Optional) - Health care provider will call or send text message to his/her partner of potential exposure of HIV without disclosing the index client name and HIV status to visit HIV testing sites without telling them the client's name (this will be done anonymously). In this approach, the index client has no role and involvement in the process.

Steps of Index Case Testing

Step 1: Introduce the concept of index testing during pretest session or PMTCT/ART visit

Step 2: Offer index testing as a voluntary service to all clients testing HIV-positive

Step 3: If client accepts participation, obtain consent to inquire about their partner(s) and biologic child (ren)

Step 4: Obtain a list of partners in last 12 months and biological children < 19 with unknown HIV status.

Step 5: Conduct an intimate partner violence (IPV) risk assessment for each named partner.

- Has [partner's name] ever hit, kicked, slapped, or otherwise physically hurt you?
- Has [partner's name] ever threatened to hurt you?
- Has [partner's name] ever forced you to do something sexually that made you feel uncomfortable?

Step 6: Determine the preferred method of partner notification or child testing for each named partner/child. Offer HIVST if a client prefers HIVST and provide necessary support including provision of HIVST kit.

Step 7: Contact all named partners in addition biological children less than 19 years old biological children and provide conventional HIV testing at the health facility and community level.

Step 8: Record outcomes of ICT

Step 9: Provide appropriate services for children and partner(s) based on HIV status.

Step 10: Follow-up with client to assess for any adverse events associated with index testing

N.B: IPV screening MUST be administered to all sexual contact of the index client. From the three asked questions, if the answer is "yes" to one of the questions, ICT service should not be initiated to avoid adverse outcomes.

Adverse Event Monitoring and Reporting System

Adverse Event is defined in the context of ICT, as an incident that results in harm to the client as a result of their participation in index testing services.

Site level adverse event monitoring, response and reporting system forms need to be available at the facility or community testing sites for service providers to document and monitor consent, IPV, and frequency of adverse events. Actively monitor reasons for refusing index testing services, prevalence of IPV and other adverse events (e.g., confidentiality breaches, stigmatization, coercive tactics, etc.) for improvement.

Service providers should routinely ask index clients if they experienced any adverse events following participation in index testing services.

NB: Unintended negative outcome as result of HIV status disclosure could still occur in the future and, as such, follow up should occur while all contacts are being traced. All reports of adverse events should be properly documented. They should also be informed of their ability to make a complaint if these rights are violated. This can be done through posters in waiting/examination rooms, patient handouts, and other educational materials. Index clients should be provided multiple pathways for issuing concerns or complaints regarding index testing services. These include suggestion boxes within health facilities and community testing sites.

Phone Counseling for Index Case Testing

Index case testing is not a onetime activity. It requires follow up counseling, relationship and trust building between the client and the provider. To this effect, ongoing in person counseling has been the main stay used by ICT counselors. However, due to changes in service delivery following the COVID-19, providing in person counseling has been challenged and several clients are being put on multi month dispensing (MMD). Virtual Phone counseling is counseling strategy to use in the context of COVID-19 where clients prefer to stay away from sites. Phone counseling integrated to ICT helps to reach and counsel index cases who are on MMD but have contacts not yet tested/ not elicited, newly diagnosed but have not yet disclosed and required follow up counseling. It is a tool to support sites to provide phone-based counseling to elicit contacts of index clients ensuring communication privacy, support indexes virtually to select contact referral approaches, and provide exposure notification mechanisms for partners with testing options including the HIV self-test.

Index Case Testing (ICT) minimum standards

Index testing should be client-centered and focused on the needs and safety of the index client and his or her partner(s) and children. Further, sites offering index testing services must ensure appropriate systems are in place for testing service providers to identify and respond to clients who disclose their fear or experience with Intimate Partner Violence (IPV) from partner(s).

The minimum standards for a site to provide safe and ethical ICT services are:

- Providers trained on HTS including index testing procedures, IPV screening, adverse event monitoring, 5Cs, and ethics.

- Adherence to 5C's (consent, confidentiality, counseling, correct test results, and connection to prevention/treatment)
- IPV risk assessment and provision of first line response, including safety check and referrals to clinical and non-clinical services (if not provided on site)
- Secure environment to store patient information, and
- A site level adverse event monitoring and reporting system.

3.4.4. Social Network Strategy (SNS)

Social network strategy (SNS) is a case-finding strategy that uses social network connections to locate individuals engaging sexual partner/s and it can also be applied for FSWs, drug injecting partners and social contacts of key population members with HIV and of those who are HIV-negative and at ongoing risk.

SNS has been used to find new HIV cases among key populations who have difficulty in accessing HIV testing services. It has also been used to find previously diagnosed individuals who were out of care, and who may then be linked to ART for the first time or re-engaged in ART services. SNS is a peer-driven HIV testing approach by addressing people's confidentiality concerns and broadening the reach to social contacts, social network-based HIV testing approaches can improve the acceptability of partner services among key populations and so reach more people who may not otherwise test for HIV.

The underlying assumption of SNS is that people in the same social network share similar risk behaviors that predispose them for HIV. This is not limited to current behaviors but includes past behaviors. The overall approach is to enlist HIV-positive and high-risk HIV-negative persons to recruit individuals from their social, sexual, and drug injecting networks for HIV testing services. Once recruited and tested, network members become recruiters and refer members of their networks for testing. This process continues, creating chains of recruitment that can penetrate hidden networks.

This strategy uses inclusion and exclusion criteria to identify the appropriate target/ recruitment process and enhances success of the SNS.

Inclusion criteria for recruiters/seeds include:

- HIV positive and/or high-risk negative
- Willing to refer network members to HTS
- Comfortable talking about HIV
- Knowledgeable about HTS and testing locations

Exclusion criteria for recruits include:

- Persons who might pose a risk for violence,
- Persons with significant mental illness who might interfere with appropriate participation,
- Known HIV positive cases,

There are four major phases to a social networks program. These phases are

1. Recruiter Enlistment: In this phase, HIV-positive or HIV-negative high-risk persons who are willing to recruit individuals at risk for HIV infection from their social, sexual, or drug-using networks are enlisted into the program. To identify recruiters, approach HIV positive clients and identify additional people through the existing HTS or ART/PMTCT services.

2. Engagement (Orientation, Interview, and Coaching): After recruiters are enlisted into the program, they are provided with an orientation session that explains the nature of the program and the social network techniques that might be used to approach their associates and discuss HIV testing with them.

3. Recruitment of Network Associates: Next, recruiters will refer individuals for testing who they have identified as being at risk for HIV infection. All individuals should be approached by the recruiter alone, without the provider).

4. HTS: The next phase involves providing HTS to the network associates identified through the social network strategy.

3.4.5. HIV Self Testing

HIV self-testing (HIVST) refers to a process in which a person collects his or her own specimen (oral fluid or blood) and then performs an HIV test and interprets the result, often in a private setting, either alone or with someone he or she trusts. HIV self-testing should be offered as an additional approach to HIV testing services. As with all approaches to HIV testing, HIVST should always be voluntary, not coercive, or mandatory.

Delivery of HIV Self Testing

HIVST can be delivered in two ways depending on the level and type of support provided.

Directly assisted HIVST refers to trained/ oriented providers, or peers giving individuals an in-person demonstration before or during HIVST on how to perform the test and interpret the test result.

Unassisted HIVST refers to when individuals self-test for HIV and only use an HIVST kit with manufacturer-provided instructions for use.

HIV Self -Testing, as a key strategy in the context of COVID-19, should be utilized optimally as additional testing strategy to reach clients undiagnosed otherwise and those who could not be reached timely because of MMD and COVID-19 situation.

Both directly assisted and unassisted HIVST may include additional support:

- Manufacturer's instructions and brochures.
- Brief in-person demonstration (one-on one) before testing.
- In-person assistance during procedure.
- Hotline contacts for HIVST information.
- Virtual support via telephone and text to track based on clients preference

Demand creation strategy of HIVST

To create awareness and increase uptake of HIVST, advocacy and communication strategies should aim to emphasize:

- Correct use of the self-test kits, and ensure correct interpretation of results and linkage for confirmatory testing,
- Demand creation should be tailored to high-risk target populations. It will be most successful when developed with communities in local setting.
- Demand creation will be conducted at health facility and community platforms. Clients should get adequate information to increase their knowledge and decision-making ability to test themselves

Methods of demand creation

Clear messages are needed to ensure that users understand what to do after a reactive self-test result, including where to go to access conventional HTS for confirmation of results, treatment, care, and other support. The messages can be delivered through:

- One to one (health care providers, health extension professionals, peer educators, volunteers).
- Print media (banners, poster, fliers)
- Audio visual
- Networks of people living with HIV
- Community-based organizations

NB: Providers and users should be aware that HIVST is not recommended for people with a known HIV status, as this may lead to an incorrect self-test result.

Standards and procedure

Directly Assisted HIVST: HIVST must be conducted using the nationally approved HIV rapid self-test kit(s). The kit(s) will include instructions in English and local language as well as pictorial diagrams to aid ease of use and correct interpretation of results. All service delivery points distributing HIV self-test kits should display instructions on HIVST procedures. In addition, all outlets should show those who will assist clients how to perform the test. The assistant will provide pretest information, demonstration, and interpretation of the result.

If the HIVST result is reactive, the assistant should link the self-tester to conventional HIV testing for confirmation, where the approved national HIV testing algorithm is utilized. And the assistant will also follow whether the confirmation test performed and whether the client is enrolled to ART if test result turns out to be positive.

For individuals with non-reactive self-test results, the assistant should advise the self-tester to retest in 3-6 months if the client has an ongoing risk to HIV infection.

Unassisted HIVST

Refers to when individuals self-test for HIV using a self-test kit using an instruction provided with the kit. Service providers/ trained peers who distribute HIVST kits should demonstrate the instructions on HIVST procedures. Users should be informed about links or contact details to access additional support, such as telephone hotlines or instructional videos.

The kit will include instructions in local languages and pictorial diagrams to aid simplicity of use and correct interpretation of result.

Quality assurance of HIVST

Guidance on ensuring the quality of HIV self-testing test kits and testing processes include:

- Monitor the quality of HIVST through integrating with the existing HTS QA program
- Include HIVST in mentoring and supportive supervision activities
- Ensure provision of HIVST instructions with pictorial illustrations in local language on how to conduct self-testing and obtain the correct results.
- All clients should be informed to follow manufactures instructions in the test kits insert.
- All clients must also be aware of correct practices to minimize biosafety risks the need to confirm any reactive test results as per the national HIV testing algorithm.
- The safety, quality, and performance of HIVST should be further verified upon delivery and before distribution to the clients.
- Adequate orientation and demonstration should be given to the clients to verify the presence of control line irrespective the result.

3.4.6. Recency Testing

Recent HIV infection is referred to as HIV infection acquired in the past 12 months. Recency testing distinguishes between recent (HIV infection acquired in the past 12 months) and long-term HIV infection. Recent HIV infections are presented with the following manifestations as high viral load, immature and weak immune response, continued high risk behavior, High probability of ongoing transmission (40%-60% of transmissions). Recency testing provides opportunity for interruption of transmission by contact tracing and it increase yield of HIV testing.

Probable recent infection case is a confirmed newly diagnosed HIV positive individual who tested positive for recent infection.

Confirmed recent infection is a confirmed newly diagnosed HIV positive individual who tested positive for recent infection and has high viral load.

Purposes of Recency Testing

The identification of newly infected individuals and the presence of recent infection will support the national HIV program to rapidly

respond to sub-populations and sites where high levels of HIV transmissions are detected. Following identification of cases, responding to individuals with probable recent infection or groups of HIV-infected persons with sexual partners and social networks is a critical step toward bringing the nation closer to the goal of no new infections.

Case reporting and HIV recency data should be used to guide an enhanced response at the health facility/site level and at the cluster/above site level. As the country is getting closer to epidemic control, it is recommend conducting recency testing for all newly diagnosed HIV cases.

A. Site Level Response

Healthcare providers are required to document all probable recent infections and risk factor information about the newly identified HIV positive cases to provide enhanced response and timely monitoring.

Site level response includes:

- All newly diagnosed HIV positive individuals should be linked and start ART within the same day.
- ICT services should be provided for sexual partners and eligible biological children

B. Above-Site level response

Above site response is primarily based on the identification and analysis of clusters based on the CBS data. The type and level of public health response needed for each identified cluster is guided by the magnitude and the spread of transmission. Some clusters may require routine public health actions such as ICT Services and linkage to care and treatment services, while other clusters may require enhanced response activities (e.g. targeted demand creation and testing as well as strengthening partnership of relevant stakeholders).

3.5. Procedures of HTS delivery

During provision of testing service, providers should follow specific procedures as outlined below. While following the procedures, providers need to utilize the national guideline, protocol, cue-card, and job-aids.

a. Client registration

At service delivery points, clients will be registered using code numbers, names, MRN (Medical record number). Conduct HIV risk screening: If eligible based on the HRST, provide pre-test information

b. Pre-test information

Pre-test information should be provided by health care providers or counselors. Couples should be encouraged to receive results together. Pre-test information for PITC can be provided in the form of individual or group information sessions. The relevant information that should be provided includes but not limited to:

- Exposure to HIV infection and implications of undiagnosed HIV infection.
- The clinical and prevention benefits of

HIV testing individuals, sexual partners, and eligible biological children (less than 19 years).

- Benefits of early ART and the fact that people with HIV who achieve and maintain an undetectable viral load cannot transmit HIV sexually to their partners.
- The meaning of an HIV-positive diagnosis and of an HIV-negative diagnosis.
- The importance of disclosing known HIV status to the provider to minimize repeat testing of a known case. There is a possibility for false negative result if a person who is already on ART is tested for HIV using an antibody test.
- Verbal consent should be obtained before conducting HIV testing from:
  - Adult client including mature minors,
  - Guardian or next of kin if a client has an altered consciousness or a child under 15 years of age
- The confidentiality of the test result and any information shared by the client
- Discuss any concern or questions through availing more time for the client
- The client's right to refuse testing and that declining testing will not affect the client's access to HIV-related services or general medical care.

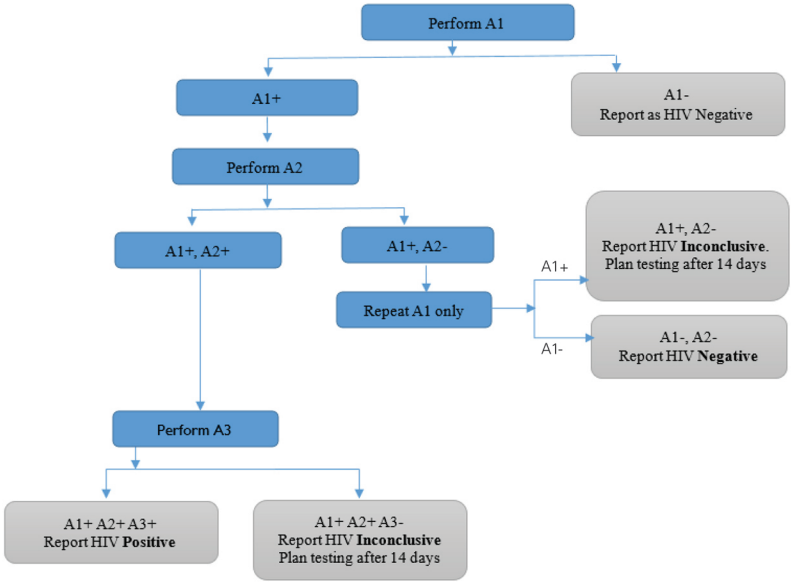
c. Offer HIV Testing:

- If a client accepts HIV testing when offered, proceed to HIV testing.
- If a client decline HIV testing, identify the problem and proceed to HIV testing if successful.
- If a client declines and the counseling is not successful, plan return for testing

d. Conduct HIV Testing

Ethiopia is implementing the low prevalence (<5%) testing strategy. Currently we are using serial algorithm (three test algorithms instead of tiebreaker). In a serial testing algorithm, the samples are tested by a first test. The results of the first test determine whether additional testing is required. To improve the acceptability, uptake and quality of service delivery for HTS in all settings, rapid diagnostic tests (RDTs) should be used. These testing strategies have been developed assuming that all HIV assays used have a sensitivity of at least 99% and a specificity of at least 98%, resulting in an overall positive predictive value of 99%. The HIV testing must be done using nationally accepted RDTs following national HIV testing strategy as shown below. Same day results should always be respected irrespective of the type of delivery approach.

Figure 3.2: Recommended HIV testing strategy for Ethiopia.



- All individuals are tested on Assay 1 (A1). Anyone with a non-reactive test result (A1-) is reported HIV negative.
- Individuals who are reactive on Assay 1 (A1+) should then be tested on a separate and distinct Assay 2 (A2).
- Individuals who are reactive on both Assay 1 and Assay 2 (A1+; A2+) should then be tested on a separate and distinct Assay 3 (A3).
  - Report HIV-positive if Assay 3 is reactive (A1+; A2+; A3+)
  - Report HIV-inconclusive if Assay 3 is non-reactive (A1+; A2+; A3-). The individual should be asked to return in 14 days for additional testing.
- Individuals who are reactive on Assay 1 but non-reactive on Assay 2 (A1+; A2-) should be repeated on Assay 1
  - If repeat Assay 1 is non-reactive (A1+; A2-; repeat A1–), the status should be reported as HIV negative;
  - If repeat Assay 1 is reactive (A1+; A2–; repeat A1+), the status should be reported as HIV-inconclusive, and the individual asked to return in 14 days for additional testing.

e. Providing HIV test results

Test results should be declared in person maintaining privacy (not by telephone, email, or letter). Sites should not provide written HIV negative test results to clients to avoid misuse of results. Clients with HIV positive results requesting or requiring referral to other facility should be referred to the appropriate institution with pertinent information.

f. Provide Post-test counseling

All clients undergoing HIV testing should be provided with post-test counseling in person as individual or couple. The messages and information included in post-test counselling and their intensity need to be tailored according to the test result. For those with negative results, this will further depend on whether they face ongoing HIV risk. Messages should always be clear and concise and client-centered, acceptable to the client and delivered in a safe, confidential, and non-judgmental manner. Post-test counseling should be provided by health care providers or counselors.

Post-test counseling service: HIV negative result

Using cue card, provide posttest counseling for HIV negative client as below:

- **Provide HIV test result in person:** Inform the meaning of HIV negative test result. Explain window period in case of recent exposure or ongoing risk and recommend repeat testing based on the client's level of recent exposure and/or ongoing risk.
- **Conduct risk reduction plan:** Clients who do have sex with a person with unknown status can protect themselves by using condoms correctly and consistently every time they have sex.
- **Identify support for risk reduction plan:** Identify a person to whom the client fills comfortable to disclose the risk reduction plan.
- **Provide information on HIV prevention interventions and how to access them:** Condoms, PrEP methods, and harm-reduction services for people who inject drugs
- **Address disclosure and partner referral:** This HIV test result only shows your current HIV status, and it cannot tell us about your sexual partner's HIV status

Posttest counseling services: HIV positive result

Using counseling support tools provide posttest counseling for HIV positive clients as below:

- Provide the HIV test result clearly and simply explain the meaning of test result in person. Focus on the client's level of understanding and acknowledge that the test result may be difficult to hear, however a provider needs to explain to the client and have confidence in client's ability to adjust and cope.
- Discuss immediate concerns and help the client to identify who could provide immediate support (individual or organizations in the community).

- Assess current health conditions and link to services as appropriate, e.g., TB, OI, STI, etc.
- Assess the risk of intimate partner violence (IPV) and discuss possible steps to ensure safety of clients, particularly women, who are diagnosed HIV-positive.
- Assess the risk of suicide, depression, and other mental health issues and discuss positive living.
- Reassure the client about maintaining confidentiality of the test result. Clients might be concerned about others knowing their HIV status, and they will need time to figure out who to disclose to and how to manage their situation. Also explain about the importance of shared confidentiality.
- Advise to use condom consistently and correctly all the time. Assess clients' knowledge on proper use of condoms and conduct condom demonstration. Inform clients about the importance of preventing transmission of HIV or other STI to their partners /or re-infection with different strains of HIV. The client may inform you that his/her partner(s) has already been tested. If the partner tested positive, note that protection from other strains of HIV and STI is important for both individuals. If the partner tested negative, provide counseling to the client to protect the negative partner.
- Provide disclosure support and do partner elicitation. Assisted partner notification and referral services are voluntary at the choice of the client and are provided confidentially in a client-centered framework
- Stress the importance of same day/early ART initiation including prophylaxis for OI if required. If a client is a pregnant woman, advise about the need for PMTCT service.
- Discuss if there are barriers to same day initiation, arrange a follow-up visit for clients who are unable to start ART.
- Retesting is required before ART initiation using the existing testing algorithm by the ART or PMTCT provider.
- Assess the need for any additional health care services including family planning and provide the service or refer.
- Encourage and provide time for the client to ask additional questions.
- Link clients from SDPs to ART clinic through accompanied referral for further counseling, confirmatory testing and subsequent services.

Disclosure Support

All clients, positive or negative, should be empowered to inform their sexual partner/s of their test result. When HIV-positive clients are reluctant or fearful to disclose their results, the counselor should provide additional counseling to help the client to disclose the test result and bring the partner for testing.

- Counselor should discuss the benefits and risks of disclosing HIV-positive status to partner(s) and support individuals and couples with disclosure.

- For couples, mutual disclosure has many benefits. People with HIV who can share their results with a trusted partner will often find it easier to cope with their diagnosis and to adhere to ART.

- If a client fails to disclose after two documented counseling sessions and the counselor feels that the partner is at risk of infection, he/she should consult the supervisor or health facility head for further action including revealing the result. This will help to share responsibility of handling a difficult case with the health care provider and will protect safety of providers.

- Disclosure and risk of intimate partner violence. Planning for disclosure should include steps to maximize client's safety. Counselling for index client who are considering voluntary or mutual disclosure of HIV-positive status should include discussion about the challenges of their situation, the potential risk of violence and ways to disclose more safely. Options when a client fear of violence or are experiencing violence include mediated, delayed disclosure. If there is risk of severe violence, advice not to disclose.

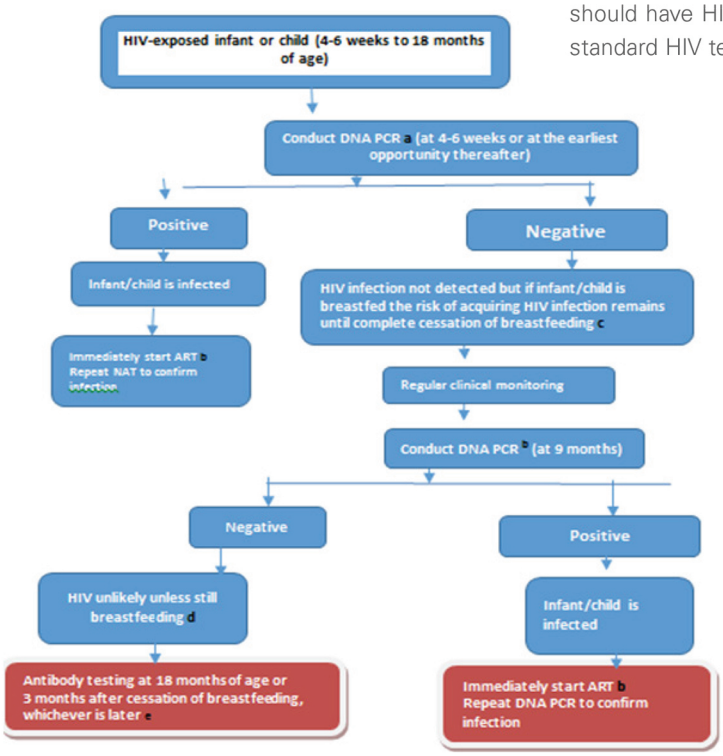
- Disclosing HIV status to children is a process. Counselors should be encouraged to answer children's questions truthfully from early age. Information should be given in a way a child can understand at a pace she/he can cope with according to their cognitive and emotional maturity. For details refer chapter six

3.6. HIV Testing in infants and children

Mortality is very high among untreated infants infected with HIV in the first year of life, making early HIV testing, prompt return of results and rapid initiation of treatment is essential. Definitive diagnosis at the end of the risk period of mother-to-child transmission (breast feeding period) should be ensured. For children 18 months of age and older (who are not being breastfed or who stopped breastfeeding for at least six weeks), standard HIV serological tests such as rapid diagnostic tests can be used to reliably determine HIV infection status.

Recommendations

- HIV testing and counseling should be offered to under five children visiting health facilities if eligible based on HIV risk screening tool.
- All HIV-exposed infants must have HIV virological testing at six weeks of age or at the earliest opportunity thereafter using conventional PCR testing.
- For infants with an initial positive virological test result, on the same day ART should be started and a second specimen needs to be collected to confirm the initial positive virological test result.
- Children 18 months of age or older with suspected HIV infection or HIV exposure should have HIV serological testing using a standard HIV testing algorithm.



Note:

- [a]Point-of-care DNA PCR can be used to diagnose HIV infection as well as to confirm positive results.

- [b]Start ART without delay. At the same time, retest to confirm infection. As maternal treatment is scaled up and MTCT transmission rates decrease, false-positive results are expected to increase: retesting after a first positive DNA PCR is hence important to avoid unnecessary treatment, particularly in settings with lower transmission rates. If the second test is negative, a third DNA PCR should be performed before interrupting ART.

- [c]For children who were never breastfed, additional testing following a negative DNA PCR at 4-6 weeks is included in this algorithm to account for potential false-negative DNA PCR results.

- [d]The risk of HIV transmission remains as long as breastfeeding continues. If the 9-month test is conducted earlier than 3 months after cessation of breastfeeding, infection acquired in the last days of breastfeeding may be missed. Retesting at 18 months or 3 months after cessation of breastfeeding (whichever is later) should be carried out for final assessment of HIV status.

- [e]If breastfeeding extends beyond 18 months, the final diagnosis of HIV status can only be assessed at the end of breastfeeding. If breastfeeding ends before 18 months, the final diagnosis of HIV status with antibody testing can only be assessed at 18 months. Antibody testing should be undertaken at least 3 months after cessation of breastfeeding (to allow for development of HIV antibodies). For infants younger than 18 months of age **DNA PCR** should be performed to confirm infection. If the infant is older than 18 months, negative antibody testing confirms that the infant is uninfected; positive antibody testing confirms infant is infected.

- If a child tested negative for **DNA PCR** becomes symptomatic suggestive of HIV infection, do PCR test.

3.7. Retesting

Retesting refers to a situation where additional testing is performed for an individual after a defined period for explicit reasons. Retesting is always performed on a new specimen and may or may not use the same assays (tests) as the one at the initial test visit. There is a need to reduce unnecessary retesting among persons who have previously been tested and learnt their results. Most people do not require retesting to validate an HIV-negative result. However, it is important to accurately identify persons who do require retesting. Such persons include those whose initial test results were indeterminate, those who tested negative but are at ongoing risk for acquiring HIV (e.g., due to high-risk behaviors) and those who may be in the early stages of infection and have not yet developed a sufficient level of antibodies that can be detected by rapid antibody ('window period').

Retesting will be conducted for:

A. Individuals with ongoing risk

B. Before ART initiation

A. Retesting for individuals with ongoing risk

Retesting is recommended for persons who tested negative but have an ongoing risk:

1. Occupational exposure or sexually assaulted client who started post exposure prophylaxis (PEP): retest at 6 weeks, 3 months, and 6 months.

2. A pregnant during the third trimester, laboring, or postpartum period will be eligible for re-testing if:

- She has unknown or HIV-negative status and in sero-discordant relationships,
- Pregnant women whose partner has an updated but unsuppressed viral load result,
- She has ongoing HIV risk in late pregnancy (unprotected sex, STI, etc.).

3. People with STI, viral hepatitis, presumptive TB, clinical manifestations of HIV: retest at 6 weeks.

4. Female sex workers and PWID consider retesting every six months.

5. Have specific incidents of known HIV exposure at 6weeks.

6. Discordant couple: retest after 6-12month or even earlier based on risk of infection to a discordant partner such as HVL.

7. Individuals receiving PrEP every quarter

B. Retesting before initiation of ART

It is required that all HIV positive clients linked to care and treatment services need to be retested before treatment is initiated. Retesting aims to rule out possible technical or secretarial errors, including specimen mix-up through mislabeling and transcription errors, as well as random error either due to the provider or the test device.

Retesting a person diagnosed to be HIV positive to verify the diagnosis should include:

- Taking a new specimen for each newly and previously diagnosed individual, preferably conducted by a different provider using the current testing algorithm, prior to initiation of ART.
- Retesting is preferably conducted at a different site/unit, ideally the site where the decision about ART/PMTCT initiation will be made or another unit designated and monitored by the ART/PMTCT clinic.
- If the retesting result is negative (the previous test result is positive and the current test result is negative), different provider should repeat the test either using the same kit or different batch of test kit if available.

Retesting people on ART is not recommended. The effect of ART in suppressing viral replication may extend to suppression of the immune response and therefore reduction of antibody production. Once a person is started on ART, low antibody titers make it challenging to discern whether an individual is indeed HIV positive, and this will lead to potential risks of incorrect diagnosis (false negative result).

C. Retesting 14 days later after an HIV-inconclusive status: Perform retest using the same assay and different/new sample

Repeat testing

When the same specimen is tested again on the same assay when the initial result is reactive, or test results are discordant. The assay is repeated to rule out biological false reactivity. For assays that utilize capillary whole blood, another prick may be needed to collect adequate specimen volume, but it must be in the same testing event.

3.8. Quality assurance and Quality Improvement for HTS

Quality can be defined as accessible services that meet the need of clients and providers, in an equitable and acceptable manner, within the available resources and in line with national guidelines. While providing the HTS, quality of the service should address the major parameters of quality: safety, efficiency, effective (correct result) and provided with reasonable time. It should be easily accessible services that meet the need of clients and providers, should be conducted in line with national guidelines. To ensure the quality of HTS, all service providing sites should:

- Provide standardized conventional HTS procedures at all time
- Ensure all service providers undergo on the standardized HTS training.
- Conduct RTKs quality control for all newly received kits.
- Conduct regular mentoring and periodic supervision sessions to provide technical assistance to improve quality of HTS.
- Introduce HTS quality assurance system to monitor performance of service providers on a regular basis.
- Conduct proficiency testing every four months.

Quality assurance

Quality assurance (QA) for HIV counseling and testing refers to periodic assessments of factors that affect the quality of HIV testing. Issues that need to be addressed while conducting QA:

- Have the counselors/service provider received basic training packages approved by MOH?
- Is there enough physical space to provide that ensures privacy of the clients and point of care testing?
- Are basic supplies and provider support tools available to provide HTS?
- Is the service accessible and affordable to the clients?
- Are clients satisfied with the services?
- Are counseling and testing sessions conducted according to nationally approved protocols?

- The QA Should be conducted by well-trained program supervisors on regular basis to ensure HIV testing service qualities. The roles and responsibilities of the supervisors are:
  - To determine if counselors/service providers received standard trainings and refresher courses.
  - To monitor how well counselors/service providers follow the counseling and testing protocol.
  - To monitor whether clients feel that their confidentiality is protected and satisfied with the services they are provided.
  - To make sure that HIV test results are given in person during the post-test counseling session.

Supervision for quality assurance of HIV testing:

The supervisory visits for HIV testing standards and biosafety should assure that:

- The national testing protocol is consistently being followed.
- The laboratory operating procedures are being observed.
- Infection prevention practice is in place.
- Proficiency testing is in place including quality control testing in central laboratory.
- A standardized laboratory logbook is available and being used.
- Technical support for QA is in place.

Quality control (QC) is a procedure or set of procedures intended to ensure that a performed service adheres to a defined set of quality criteria or meets the requirements of the client. It is an important means of verifying for the test kit and the procedures used are performing according to the manufacturer's intended specifications.

Quality control of HIV testing

Only test kits validated by the Ethiopian Public Health Institute should be used by counseling and testing sites. Training and supervision of laboratory staff, accurate testing materials that are well stored and have not expired, and good maintenance of laboratory records are essential to ensure the quality HIV testing.

External quality assessment (EQA)

For EQA, proficiency testing samples (dried tube specimen), which was prepared by the higher laboratory tier, i.e., national reference laboratory (NRL), regional reference laboratory (RRL) or EQA centers must be done. This method evaluates individual's performance in testing procedure, results reporting, capabilities of laboratories and testing points on performing HIV rapid testing. Sites failing the proficiency tests need to receive additional technical supervision and support. In addition, onsite evaluation must be done at least twice a year.

Internal quality control (IQC)

For IQC, trained laboratory technicians in the facility should regularly perform the IQC to verify the quality before the test kits are being used by the testing units.

3.9. Linking People Diagnosed with HIV Infection

Linkage is defined as a process of actions and activities that support people testing for HIV and people diagnosed with HIV to engage with prevention, treatment, and care services as appropriate for their HIV status. For people with HIV, it refers to the period beginning with HIV diagnosis and ending with enrolment in care or treatment. It is critical for people living with HIV to enroll in care as early as possible. This enables timely initiation of ART as well as access to interventions to prevent the further transmission of HIV, prevent other infections and co-morbidities and thereby to minimize loss to follow-up.

Linkage to HIV treatment, prevention, care, support, and other relevant services is the primary responsibility of HIV testing services and the testers and providers delivering HIV testing services Multiple factors may hinder successful linkage to care, including distance from services, transport costs, long waiting times at the facility and, for those testing positive, stigma and disclosure-related concerns.

Linkage to HIV care should be improved through interventions that support people in the initial steps in the continuum of care. Such interventions may vary based on the local context, including: the health-care delivery systems, geography, and target population. A combination of interventions is needed to improve linkage to prevention, care, and treatment for specific groups at risk.

Post-test counselling messages remain key. They should be concise, addressing the needs of the client and focusing on supporting linkage to care. Post-test counselling messages need to be tailored to specific populations and their situations and whether their test results are HIV-positive, negative, inconclusive or they already know their status and need to engage, re-engage in care. Messages need to provide clients with the latest information, including:

- The personal health benefits of early ART initiation
- People living with HIV receiving ART who achieve and maintain Undetectable Viral Load result has minimum risk of transmission to their partners
- The benefits of voluntary provider-assisted referral for people living with HIV.

All people with HIV-positive diagnoses should be offered a package of support interventions that ensure timely linkage to care including ART initiation with in/outside the health facility, friendly and flexible services designed to suit specific population groups and digital platform. Providers should note that people who are HIV-negative but at ongoing risk also need to be linked to effective prevention services.

The following interventions have demonstrated benefit in improving timely linkage of PLHIV after an HIV diagnosis:

1. Efficient interventions to reduce time between diagnosis and engagement in care, including support for HIV disclosure, tracing and training staff.

2. Peer support and navigation approaches for linkage

3. Quality improvement approaches using data to improve linkage.

Good practices of linkage to care at site level

The recommended good practices to improve linkage of HIV positive person to care and treatment services after the person is found positive should be implemented at all sites.

A. Implement standardized service delivery system that will improve referral and linkage between HIV chronic care through:

- Prepare standard operating procedure (SOP) for inter- and intra- facility service outlets referral linkage system
- Strengthen referral system between health facility and community by using SOP.
- Establish site level support groups to improve escorting/accompanied referral and feedback practices for intra-facility referral.
- Establish facility and catchments area level regular referral linkage auditing system to ensure that all new HIV infected clients are linked to ART.
- Map and establish network between available, chronic care, and other support services in the area (linkage service directory).
- Preparing, avail and utilize service directory which can be availed in soft copy or other forms.
- Ensure that a referring and accepting health care facilities or sites are accountable for assurance of the client's referral is successful.
- Strengthen Post-test counseling in such a way that the client understands the benefits of ART; develop trust and confidence on the provider and reaches to informed decision on linkage.
- Promote health seeking behavior for service utilization
- Educate clients on benefits of early ART initiation and related care.
- Call or text to the client and remind him/her for linkage service.

B. Standardized documentation, reporting system and feedback practice through:

- Ensure the availability and sustainability of recording and reporting formats.
- Ensure a referral and linkage feedback mechanism in health facility.
- Ensure standardization of guidelines and training materials on referral and linkages issues.

C. Improve the engagement of Health Extension Workers (HEW), PLHIV in awareness creation activities:

- Support HEWs in their day-to-day information education and communication (IEC) / behavioral change communication (BCC) activities in relation to HIV.

- Establish and strengthen PLHIV associations and support groups to be involved in the facilitation of referral and linkage through escorting and other mechanisms.

D. Reduce stigma and discrimination through:

- Community involvement
- Identification and analysis of the root cause of stigma and discrimination.
- Development of IEC/BCC material and utilize media focusing on stigma and discrimination.
- Advocacy of gender inequality that predisposes to stigma and discrimination.
- Leadership role in community activities to address stigma and discrimination through contextual available values and norms of the community.
- Involvement of PLHIV to reduce stigma and discrimination and to be part of prevention and care services.

3.10. Ethical and Legal Recommendations for HIV Testing Service

- Knowingly transmitting HIV shall impose punitive legal measures.
- HTS shall be integrated into existing health and social welfare services and be available in all settings for KPP: government, non-governmental, private sector, workplace, and faith-based organizations.
- HTS shall be strengthened through effective networking, consultation, and collaboration among stakeholders.
- HTS shall be standardized nationwide and shall be supervised, supported, and regulated by appropriate government health authorities.
- Informed consent for testing shall be obtained in all cases unless it is a mandatory testing.
- Mandatory HTS should be permissible for the following conditions:

1. Screening purposes of blood and blood components for transfusion,

2. In cases of organ or tissue transplantation, and

3. Order of court.

- Adequate pre-test information needs to be given for ANC clients, TB and STI patients.
- All clients who are eligible for HTS based on HIV risk screening tool shall be offered pre-test information and post-test counseling.
- Test results, positive or negative, shall be declared to clients in person and must be provided with post-test counseling.
- HIV test results will not be provided in certificate form; however, referral will be offered to access prevention, care, and treatment services.

- Clients' confidentiality will always be maintained, however:
  - Results can be shared with other health care providers with those involved in clinical management of clients as part of shared confidentiality.
  - Clients can be referred for HIV services or other services while stating his/her HIV status if required or upon request.
  - Cases of altered state of consciousness and his/her partner or care giver are at risk of infection, based on the circumstances the endangered partner or care giver shall have the right to access the information regarding the sero-status of the index case.
- Couples shall be encouraged to be counseled, tested, and receive results together.
- Partner notification shall be encouraged in cases where one partner receives the results alone.
- In some special cases, such as child adoption, a counselor may refuse a testing request when this is not in the best interest of the child.
- Children who have been sexually abused and put at risk of HIV infection shall receive counseling, be encouraged to test for HIV and helped to access appropriate services.
- The result of HIV testing is the property of the child tested and shall not be disclosed to third parties unless clearly in the best interest of the child
- Youth-friendly counseling and testing services shall be made widely available for youth population based on HIV risk screening tool.
- People with physical disabilities and mental impairment require special care when providing counselling and testing services, particularly regarding communication shall accommodate the special needs of people with visual and hearing impairments by adopting appropriate medium of communication.
- Individuals under the immediate influence of alcohol or addictive drugs (substance use) shall not be offered HIV testing due to a mental inability to provide informed consent.
- For a mentally impaired individual requires the knowledge and consent of his/her guardian and should be for the benefit of the mentally impaired individual or patient.

Ethics in counseling

- All service providers shall abide by the rules, regulations and protocols contained in this document and other related national guidelines
- All service providers shall observe the ethical requirements of confidentiality, informed consent, proper counseling, anonymity and privacy.
- Shared confidentiality shall be promoted.