National HIV Self-testing Guidance

UNAIDS

2023

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List of **Abbreviations**

HIV	Human Immuno-defiency Virus
ART	Anti-retro viral therapy
AIDS	Acquired Immunodeficiency Syndrome
HST	HIV Self-testing
FDA	Food and Drug Administration
NAP	National AIDS Program
OTC	Over the Counter
NSP	National Strategic Plan
CSOs	Civil Society Organizations
LMIC	Low-and middle-income countries
MSM	Men Who Have Sex With Men
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNDP	United Nations Development Programme
UNODC	United Nations Office on Drugs and Crime
WHO	World Health Organisation
PLWHIV	People Living With HIV
PWUD	People Who Use Drugs
MoHP	The Ministry of Health and Population
SOPs	Standard operating procedures
VCT	Voluntary counselling and testing

Background

The prevalence of HIV among the general population remains low in Egypt. That is supported by data from HIV testing services (HTS) provided to pregnant women (In 2020, 368,674 pregnant women accessed HIV Testing services (HTS) and only 76 pregnant women tested HIV positive). However, Egypt continued to observe an increasing trend of HIV new infection. The incidence rate has increased by five folds between 2010 and 2019. In 2019, men had the highest HIV new infections compared to women. There was a rapid increase in the estimated number of adults and children living with HIV in the country during the period 2015 and 2020. UNAIDS estimated around 30,000 People Living with HIV by end of 2021 in Egypt according to Spectrum model estimates. According to the programmatic data people who inject drugs (PWID) and other men who engage in sex with men (MSM) are at higher risk of HIV infection than other population groups.

Egypt's commitment to controlling the HIV epidemic has been demonstrated. The ongoing efforts confirm Egypt's commitment to the international declarations. The HIV response has witnessed important milestones in the last decade.

The political commitment was translated into the updated HIV strategy with its ambitious targets, and the growing efforts to align with the recent global directions. In addition, the Ministry of Health and population took many steps to mainstream and integrate HIV as part of sustainability efforts. MoHP is working closely with the UN Joint Team to introduce a comprehensive package for harm reduction as well as expanding needle and syringe program, introducing OAT program and piloting self-testing, this may open new opportunities for KPs to join the available services especially with the geographical expansion and inclusion of new CSOs and communities to the HIV response. One of the big efforts is the national initiative to reach pregnant women with HIV testing and establishing safe pathway for women living with and affected with HIV.

Testing and counselling are the key entry point to all preventive and curative services of HIV and related harm reduction including partner notification and disclosure. Testing is the entry point to achieve the cascade and:

- Ensure that 95% of people living with HIV know their virus status
- Ensure that 95% of people diagnosed with HIV are receiving ART
- Ensure that 95% people diagnosed with HIV on treatment achieve viral load suppression.

Although, one of the strategic objectives is to Enhance HIV Testing Strategy and Policies, the programmatic data on HIV testing and surveillance continue to indicate that MSMs utilization of HIV testing is very low compared to the last population size estimate of 64000 that was conducted 2014.

In principle, the core prevention package should ideally include behavioral interventions, condom distribution, and the provision of voluntary counseling and testing. However, not all of the key population will be reached with an integrated package of these services.

Self-testing could add a new approach to support scaling up testing with potential to be high impact, low cost, confidential, and empowering for users. Reluctance to test has been associated with fear of results, and stigma and discrimination often hinder utilization of HIV services. Not only does testing at home ensure privacy, but it is more convenient for those who may struggle to find time to go to a clinic to receive testing. The oral HST kits have made HST more attractive to individuals who do not wish to have blood drawn and the short time period (\30 min) that testing and reading results takes is another attractive feature for users.

The first over-the-counter HIV test kits were approved by the US FDA in 1996. Finally, in 2012, the FDA approved the Ora Quick In-Home HIV Test as the first over-the-counter (OTC) rapid HIV self-test.

Introduction to the Guidance

Purpose and Scope of the Guidance

This document aims to develop a simple practical operating guidance for the national HIV self-testing piloting module and standard operating procedures.
The document will add core and process indicators to to ensure the mainstreaming of the piloting and ensure standard quality.

This document will be used by any facility that is willing to introduce self-testing as one of the testing modules especially for MSMs. It is applicable for outreach, drop-in center and standalone VCT centres.

Methodology

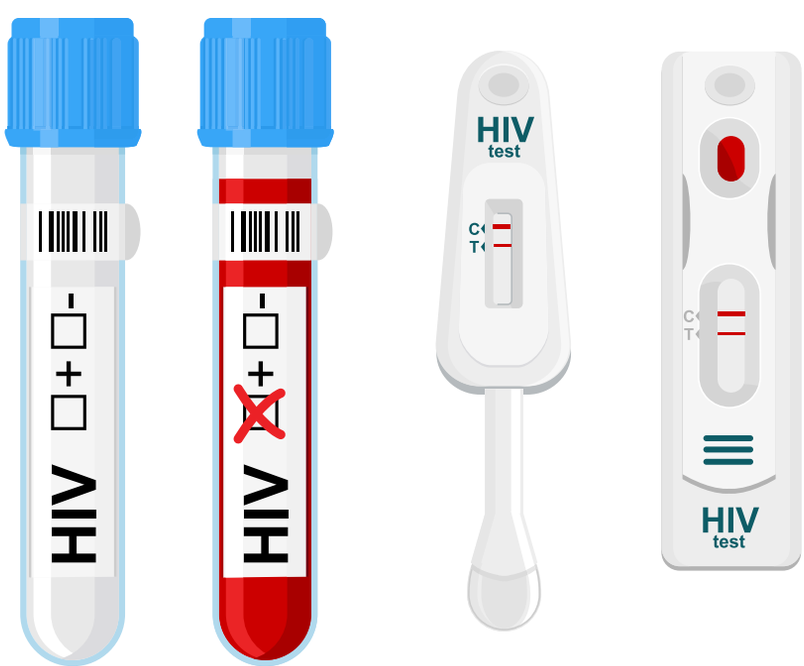
To ensure reflection of National needs regarding the HIV testing approaches and the potential to enrol HIV self-testing as one of the testing modalities, individualized and group discussions were conducted with concerned stakeholders. Group discussions were conducted with people living with HIV (PLHIV), key populations (KPs) from MSM groups (among whom the HIV self-testing is expected to be enrolled) and HIV service providers to promote discussions, sharing ideas/experiences and eliciting shared needs.

Discussions were conducted either virtually (via Zoom or Microsoft Teams) or in person according to the interviewees' availability and considering the tight time dedicated for the process. Individual and group discussions started by brief introduction of the purpose of the interview and the National intention to adopt a new HIV testing modality in Egypt to enhance the testing services trying to address the first 95% gap as well as and the important contributory role of the country dialogue. Given the vulnerability of PLHIV and KPs and the importance of maintaining confidentiality to help them feel at ease and contribute to the discussions, the consultant did not record the discussions with KPs and PLHIV. The topics discussed were tailored to each entity/person *(see **annex 1** for the discussion guide).*

Desk Review

To better understand the self-testing as one of the recommended HIV testing modalities and as a crucial pillar to develop the guidance, guidelines were reviewed including the below set of guidelines.

- ***GUIDELINES ON HIV SELF-TESTING AND PARTNER NOTIFICATIONS:*** SUPPLEMENT TO CONSOLIDATED GUIDELINES ON HIV TESTING SERVICES – *2016, WHO*
- ***HIV SELF-TESTING STRATEGIC FRAMEWORK:*** A GUIDE FOR PLANNING, INTRODUCING AND SCALING UP – *2018, WHO*
- ***Egypt National HIV Strategic Plan 2021-2025,*** *National AIDS Program*
- ***GLOBAL AIDS STRATEGY 2021-2026,*** END INEQUALITIES – *UNAIDS*
- ***Report of HIV Program Review in Egypt*** *June 2021 – National AIDS Program*
- ***List Of HIV Diagnostic Test Kits and equipments*** classified according to the Global Fund Quality Assurance Policy – *2022, Global Fund*



Desk review Findings

Egypt remains a low HIV prevalence country with evidence of a concentrated epidemic among people who inject drugs and men who have sex with men in Cairo and Alexandria (BioBSS 2010). Nonetheless, Egypt has undergone many events since then which prompt for updating the evidence base in addition to revising the situation and gap analysis that essentially informs the national strategic framework.

The National AIDS Program (NAP), following the Ministry of Health and Population (MoHP), established in 1987, coordinates the national efforts to control HIV and AIDS, through working with a wide range of stakeholders. This technical review of the HIV/AIDS National Strategic Plan (NSP) is endorsed by the NAP and envisions mobilizing the technical expertise and inherited knowledge from all national stakeholders through a transparent consultative process.

Trend of Modes of Transmission among Key Population:

Mode of transmission data has been captured using a surveillance questionnaire (case reporting). The data reflects what newly diagnosed PLHIV disclose about themselves has given the multiple-choice options on the survey during the counselling session with NAP focal points.

Programmatic data is useful to understand the level of HIV prevalence among the key populations. Interpretation of HIV-reported cases from these populations should be made carefully, however, as it does not provide systematic screening with multiple sources of bias. The table 3 below summarizes data about mode of transmission (MOT) for some of the PLHIV as registered by the national program as part of the surveillance system data.

Table 1: Trends of Modes of Transmission among Key Population

	2020		**2019**		**2018**		**Average**
	PLHIV	% of known MOT	PLHIV	% of known MOT	PLHIV	% of known MOT	% of total 3 years
PWID	725	75.2%	911	69.1%	835	62.6%	69%
MSM	175	18.2%	212	16.1%	462	34.6%	23%
Prisoners	64	6.6%	193	14.6%	33	2.5%	2.5%
FSW	0	0.0%	3	0.2%	4	0.3%	0.2%
Known MOT total	964		1,319		1,334		3,617

As shown in the figure, the pattern in Egypt has changed through the years.

**Report of HIV Program Review in Egypt June 2021.docx.pdf Page 12*

Closing the HIV testing gap and diagnosing 90% of all people with HIV by 2020 is critical to the success of the global HIV response. HIV self-testing (HIVST) is one innovation that has the potential to reach those who may not otherwise test, as it offers a discreet, convenient and empowering way to test. Therefore, HIV Self-testing (HIVST) can be offered as an additional approach that complements and creates demand for existing HIV testing services.

HIV testing services have been scaled up considerably worldwide. Between 2010 and 2014 more than 600 million people received HIV testing services in 122 low- and middle-income countries (LMIC). In 2016 WHO recommended HIVST as a safe, accurate and effective way to reach people who may not test otherwise, including people from key populations, men and young people.

Globally, HTS uptake and coverage for men continues to be lower than for women. Nearly 70% of adult HIV tests reported in 76 low- and middle-income countries in 2014 were conducted for women. Global reporting suggests this is because HIV testing has been successfully integrated into reproductive health services, including antenatal care, but not consistently into other relevant clinic settings. Also, male partner testing is not widely implemented or, where offered, taken up. As reported in recent systematic reviews, assisted HIV partner notification services, HIVST, male-focused interventions and outreach such as mobile or home-based HIV testing are particularly promising, having increased uptake of HTS among men in several settings.

For example, in many African countries, interest in HIVST was consistently high. In Zimbabwe, a cross-sectional study among 289 adults found 80% would self-test, and nearly 90% would self-test if the cost was low Men who have sex with men in the United States, particularly those with casual partners and who do not use condoms, reported that they were interested in using HIVST as a form of harm reduction by screening potential sex partners.

Focus Groups and Interviews

The interviews and the focus group discussions targets gathering inputs from: Beneficiaries (People Living with HIV in addition into key populations from MSM), stakeholders health care providers, Civil Society Organizations (CSOs).

The questionnaire form and the focus groups guidance are attached.

Findings of the focus group discussions:

1. Previous Experience for HIV Testing

The previous experience of HIV testing was a very crucial question to tackle the experience with its challenges and opportunities, the contribution of KPs and MSM add a lot to elaborate more on this point based upon their real experience and the stakeholders experience was also very productive to enrich the findings considering either their administrative/managerial or their direct contact with the beneficiaries.

> ***Reluctance to test has been associated with fear of results, and stigma and discrimination often hinder utilization of HIV services.***

Conclusion of the findings:

- The importance to have standardized testing SOPs and mechanism in place, it seems that however there is a national testing algorithm, the implementation procedures vary from place to another.
- Lack of enough trained teams to perform HIV testing and provide the needed counseling messages either for positive or negative cases.
- Limited geographical coverage of facilities providing HIV testing
- Limited information where to go for HIV testing.
- Very limited no of CSOs that can provide HIV testing
- Still stigma and discrimination considered a great challenge that can hinder KPs from going to have HIV test.
- Some indicate that there was some problem in the referral and continuum of care after being tested HIV positive.
- Social media and animation movies can assist a lot to raise the awareness about the importance of HIV testing and maps of facilities providing those services.
- The needs of KPs are not the same, there is a need to tailor some services to address MSMs that differ from those provided to PWUD.

2. Potential use of HIV Self-test

The knowledge among the participants about HIV self-testing seems to be adequate and it was somehow surprising, MSM groups know some info about HIV self-testing even if some of the info was not right, the knowledge about this approach among health care providers was very low.

Also, the participants insights about the HIV self-testing, does this modality can work in Egypt, if so, what is the best way to adapt it according to the National context and their main fears and concerns regarding this matter.

Conclusion of the findings:

- Introducing HIV self-testing in Egypt becomes a must, especially with the priority national need to scale up testing services to address the first 95% gap.
- The notable current political commitment to accelerate the National HIV response is the best time to enroll HIV self-testing as a new testing modality.
- There is a general consensus that HIV self-testing can help to mitigate stigma and discrimination challenge which has a negative impact on the KPs turnover to benefit from testing services.
- There is also a general consensus that we should have HIV self-testing as a pilot initiative to allow proper monitoring and evaluation of the implementation results and hence easily rectify the mechanism to give the best outcomes.
- MSMs are the most suitable KP groups to start with this modality as recommended by all participants and which is in line with the international and WHO recommendations for HIV self-testing.
- There was a general fear from ensuring the quality of the process after performing the test whether the result is negative or positive, how to assure that no one will be lost to follow up and how we can make sure that the client has received all the needed right information.

- The proper monitoring and evaluation framework was a request from all participants to be able to measure the outcome of the experience and modify the performance if needed.
- There is a need to have a standardized operating procedures and flow of work to make the process clear for all the implementers.
- The HIV self-testing technique is very important to have kits that are tolerable and with a high sensitivity and specificity, all agree that relying on WHO pre-qualified kits is the best choice.

3. Distribution model of HIV Self-testing kits:

- The participants agree that HIV self-tests should be provided through trained CSOs staff for their clients from MSMs either who come to the drop-in centers or who are reached through the outreach teams.
- Some of the targeted population and healthcare workers suggested the distribution through private pharmacies. But they express their fear of loss of monitoring the process and mitigate Lost to follow ups.
- Few of the participants urge that the kits can be placed at ART centers and VCTs.
- PLWHIV recommend that the test should be free or at very low cost.
- It is very crucial that the HIV self-test kit include simple Arabic instructions that guide the beneficiary clearly about the testing technique and how to interpret the result as well as provide basic information about HIV modes of transmission and prevention and hotline services in addition to map of VCTs, NGOs and ART centers.

4. Challenges that may face the implementation

Healthcare workers and other decision makers broach the subject of the importance to have a proper media campaign and they preferred that it be launched on social media platforms. There for, the KPs know about the existing of such service.

5. Linkage to care

The contributors to these focus groups and interviews strongly agreed that the linkage to care and prevention services should be done through a hotline service

6. Characteristics of recommended test kits

The targeted patients showed that it would be an extra option, if the test kit could detect sexually transmitted disease (STIs) as syphilis and gonorrhea.

Operational Guidance for Pilot Implementation of HIV Self-testing in Egypt

Introduction

Self-testing pilot implementation in Egypt:

- The self-testing implementation for the piloting phase will be based on tailored model. The model will follow mixed methodology and approaches.
- This tailored method was agreed to adapt standard model to meet the national circumstances, especially the structural stigma challenges, lack of awareness on HIV test result interpretation, and the lack of clear self-referral pathway.
- The model will be guided and centered by peer driven approach.
- The model will combine the provider initiating approach (outreach and/ or drop in center or VCTs) and the individual demand approach (voluntary self-based request).
- The selected civil society organizations will take the main role on creating the community demand on self-testing, and will support and manage the awareness messages dissemination, result interpretation, and finally the referral system.
- It is very crucial that the HIV self-test kit include simple Arabic instructions that guide the beneficiary clearly about the testing technique and how to interpret the result as well as provide basic information about HIV modes of transmission and prevention and hotline services in addition to map of VCTs, NGOs and ART centers.

> ***“Self-testing could add a new approach to support scaling up testing with potential to be high impact, low cost, confidential, and empowering for users.”***

Demand creation

- CSOs will advocate and promote for the self-testing as an alternative model of the rapid testing. this will be provided mainly to whom will reached on spot and cannot confirm their willingness to be tested at the drop-in centers nor willing to visit the stand alone VCTs.
- The national AIDS program will also create channel for promoting the self-testing and referral to the CSOs through its hotline and VCTs.
- The service will target MSMs and their partners. Although other KPs as PWID and FSW can benefit from the services but still not the priority group.
- The client will be offered the choice to do the test by himself inside the drop-in center or to perform it at home. If he prefers to do the test by himself at home, there will be a potent mechanism to recall the client to ensure the proper understanding of the test result.
- The test kit has to include simplified description of the method of use, result interpretation, and disposal in Arabic// It is very crucial that the HIV self-test kit include simple Arabic instructions that guide the beneficiary clearly about the testing technique and how to interpret the result as well as provide basic information about HIV modes of transmission and prevention and hotline services in addition to map of VCTs, NGOs and ART centers.
- All clients will be provided by complete counselling session before receiving the testing kits.
- NAP and its partners are to create a demand creation and advocacy plan for the intervention.

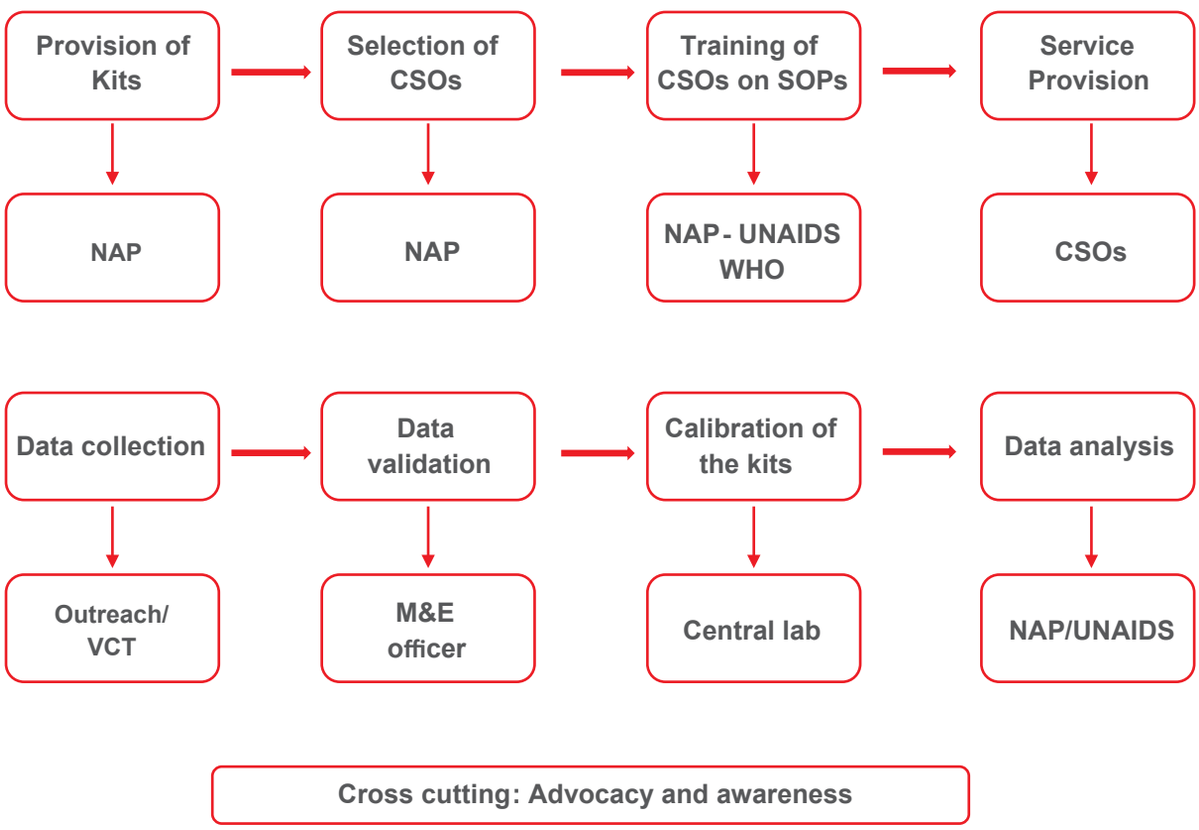
Site selection

- The piloting phase will be implemented in big cities that tend to dilute the stigma and has easy access to CSOs services without stigma or discrimination. In addition, the big cities are more appropriate to attract MSMs who are willing to declare their behavior and received health and additional services.
- The selected CSOs has to have a very good experience in working on HIV and AIDS service provision for at least 5 years and to ensure that they have enough excellent human resources who are capable of dealing with key population and highly professional on providing counselling.
- The selected CSOs must have drop-in center/s that provide HIV and AIDS services, services for key population, in addition to special services or support to key population.
- The CSOs must have a good referral mechanism with other related service. The referral to confirmatory testing, care and treatment system, and the referral to other harm reduction services if not available at the CSO facility

Client selection

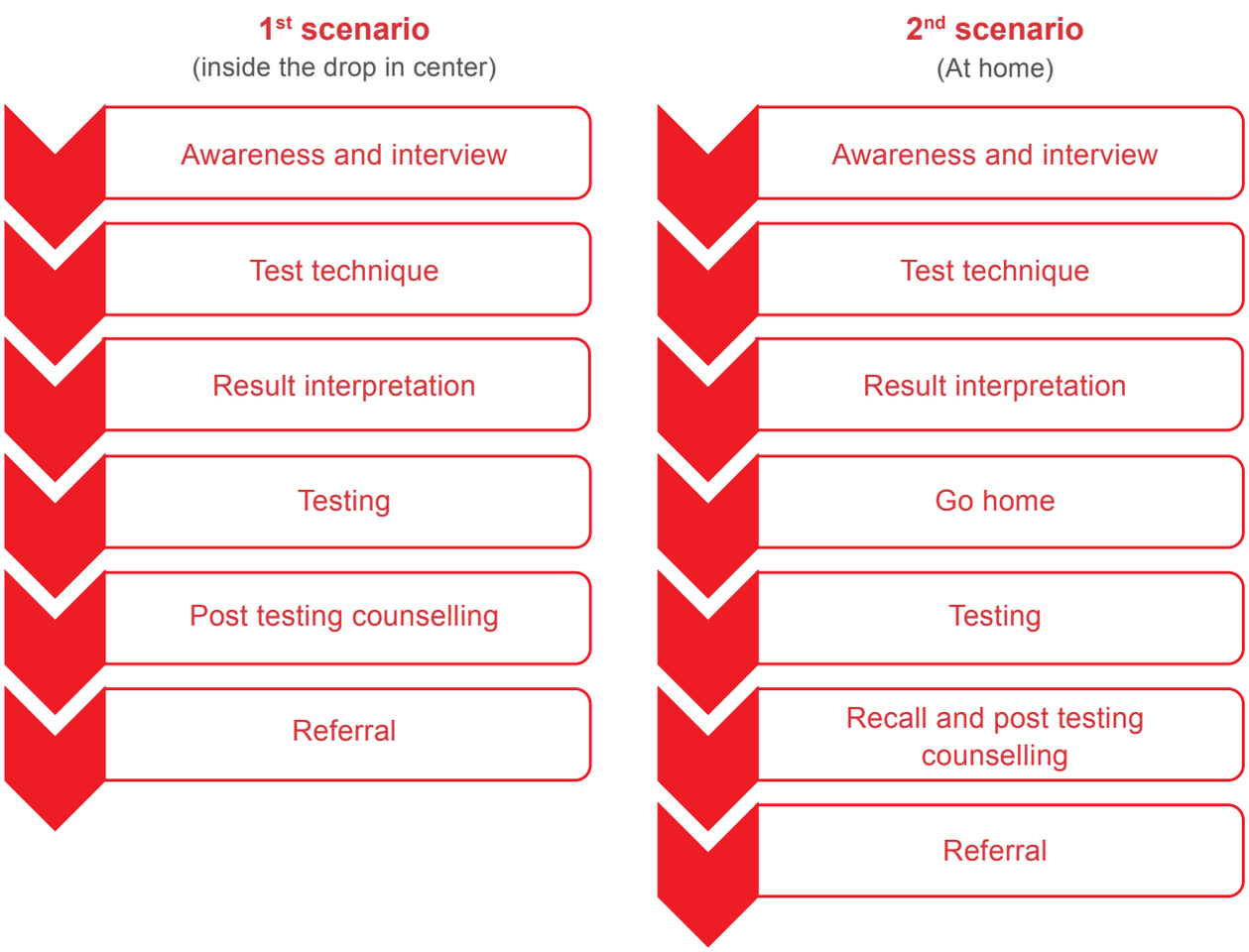
- MSMs are the main target group
- Age between 18-49 years.
- Fresh client will be prioritized.
- Not more than one test every six months.
- Good mental status.
- Good level of education is an asset. At least read and write properly.
- Agree to be offered counselling session.
- Agree to give feedback after self-testing.
- Other groups may be included but not more that 10% of the sample.

Flow of work



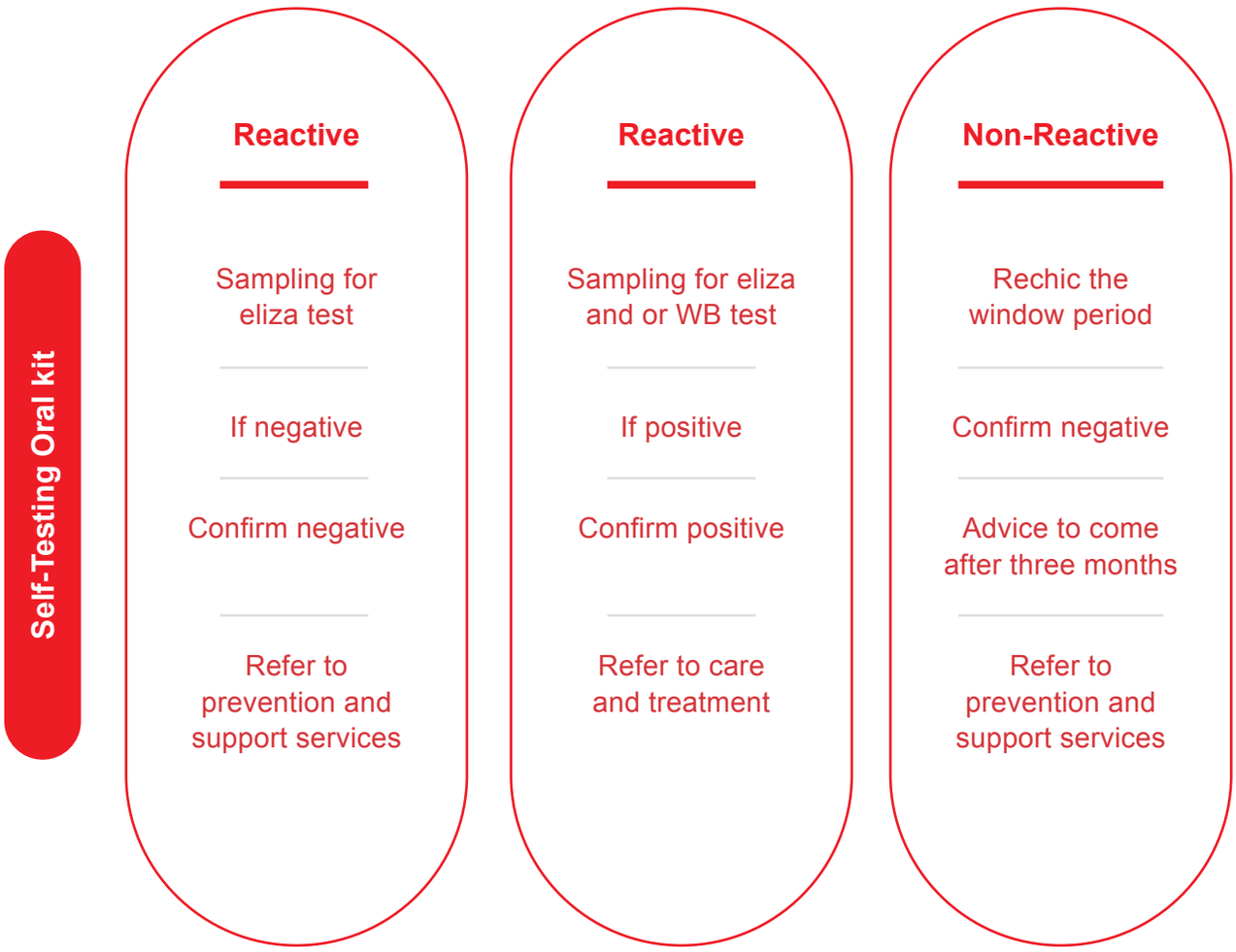
> ***Not only does testing at home ensure privacy, but it is more convenient for those who may struggle to find time to go to a clinic to receive testing.***

Flow chart of the Service Provision:

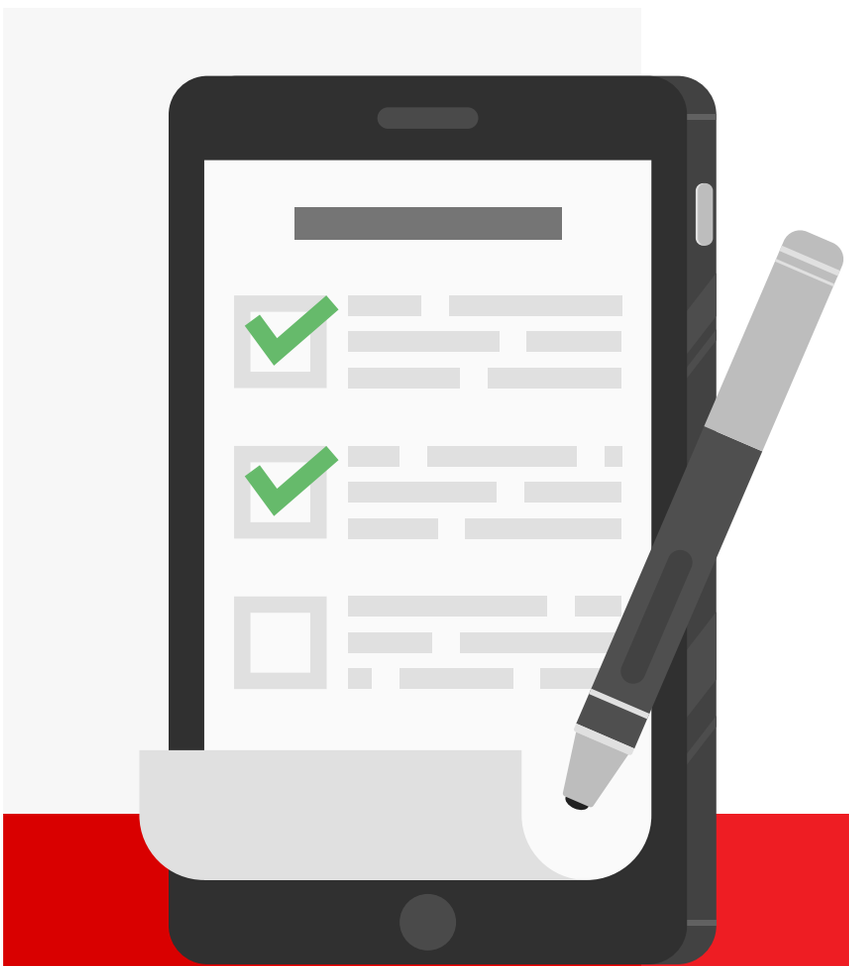


- The testing will be done by the client himself regardless he will perform it inside the facility or at home.
- Calibration of the results to be performed on regular base by repeating the test using other standard type of rapid test (to be defined by the lab authorities.

Self-Testing Algorithm



National Self-Testing Standard Operating Procedures



Standard Operating Procedure number 1

Name of the Procedure: Provision of HIV Self-testing kits.

Name of the Responsible for the Procedure procurement: National AIDS Program - United Nations Program for Development.

Objective of the Procedure:
Timely provision of the needed HIV self-testing kits ensuring the quality of the delivered tests and avoiding facing stock outs / over stocks.

Steps of the Procedure:

- For the launching of the pilot phase, the National AIDS Program requests from UNDP (as the principal recipient of the GF grant) the provision of the testing kits with a request mentioning the needed quantities of the kits based upon the targeted number of MSM who will benefit from the self-testing modality.
- The Program associate in the Global fund unit in UNDP issues the purchase order of the kits to the procurement unit to start the procurement process.
- UNDP ensures the quality of the procured kits through selection of WHO prequalified and accredited testing kits.
- UNDP share with the National AIDS Program the shipping documents that are received from the procurement unit to have the approval on shipping the kits with the included specifications and the available dates of expiries.
- Once the kits shipment is delivered in the airport, the National AIDS Program issues letter of acceptance to the received.
- The letter is sent to UNDP.
- UNDP share NAP acceptance letter with the Ministry of Foreign affairs to finalize the custom release of the shipment.
- Once the custom release of the shipment is finalized, UNDP sends an email to National AIDS Program to inform that the shipment is ready to be delivered and requests detailed address to where the kits will be delivered as well as NAP focal point who will coordinate the delivery process.
- The National AIDS Program receives the kits.
- The National AIDS Program distribute the quota kits to the NGOs

Standard Operating Procedure number 2

Name of the Procedure: Self-testing service promotion.

Name of the Responsible for the Procedure: Implementing civil society organization (outreach team and on-site counselor).

Objective of the Procedure: Advocate for the service.

Steps of the Procedure:

- The outreach team offers the service of HIV self-testing for selected client during the field outreach work and the peer awareness.
- The drop-in center counselor offers the service of HIV self-testing in the drop-in center.
- The service provider must ensure the full knowledge and understanding of the client the self-testing modality and technique.
- In case the client shows his interest to perform the self-testing, a full counseling course is provided by trained certified counselor.
- And provided with printed awareness material if available

Standard Operating Procedure number 3

Name of the Procedure: Self-testing service counseling.

Name of the Responsible for the Procedure: Implementing civil society organization (outreach team and on-site counselor).

Objective of the Procedure: Provide the proper counseling message for the beneficiary.

Steps of the Procedure:

- The counseling process should include detailed description of the testing technique whether blood based or oral based and the infection control measure related to the mechanism.
- The client decides the suitable time to pick up the testing kit
- The client decides either to make the test at home or inside the drop-in center.
- In case the test will be performed inside the drop-in center, the client is provided with the kits and related PPEs.
- A private room is secured for the client to perform the test without breaching his privacy.
- As a pilot phase, the counselor reviews the test result and the proper interpretation of the test.
- The client is provided with needed/requested referral services as applicable.
- In case the test is performed at home, the client is provided with the testing kit and the required PPEs.
- The client is requested to return with result, preferred through physical visit or can be via phone if physical visit is not applicable.

Standard Operating Procedure number 4

Name of the Procedure: Performing HIV self-testing.

Name of the Responsible for the Procedure:
- Implementing Civil society organization (outreach team and on-site counselor).
- The Client.

Objective of the Procedure:
Proper performing of the HIV self-testing with ensuring the quality assurance of the process.

Steps of the Procedure:
- After providing the client with the needed proper counseling message, the client decides the suitable time to pick up the testing kit.
- The client decides either to make the test at home or inside the drop-in center.
- In case the test will be performed inside the drop-in center, the client is provided with the kits and related PPEs.
- A private room has to be secured for the client to perform the test without breaching his privacy.
- As a pilot phase, the counselor reviews the test result and the proper interpretation of this result and ensure right client understanding of the result.
- The client is provided with needed/requested referral services as applicable.
- In case the test is performed at home, the client is provided with the testing kit and the required PPEs.
- The client is requested to return back with result, preferred through physical visit or can be via phone if physical visit is not applicable.
- There will be a verbal consent similar to that used currently.

Standard Operating Procedure number 5

Name of the Procedure: Data Reporting

Name of the Responsible for the Procedure: Implementing civil society organization and the National AIDS Program.

Objective of the Procedure: Timely reporting of the service data.

Data Quality Assurance:
- Data collection forms should be made simple with clear items, Data channels through which data will be transferred from the CSO to the National AIDS Program in addition to the feedback trying to include more than one data check point to ensure data validation.
- The software package which will be used for data keeping, retrieval and analysis will include checking fields whenever possible to ensure the quality of data entered.
- Necessary training for all personnel related to data reporting at the peripheral level who will share in filling out the data collection forms should be done first. Necessary on-the-job training will be carried out in the data generation sites.

Data management:
The National electronic health management information system shall be adapted to include the HIV self-testing reporting for easy data flow from each implementing CSO to the National AIDS Program centrally.

Data Collection
Standardized data collection forms have to be designed for each indicator that defines the data fields and ensures consistency of the collected information.

Data transmission
- Data transmission takes place from implementing CSO to the National AIDS. All data should be provided in electronic forms while hard copies forms should be kept at the primary source (implementing CSO) in a filing system for at least 4 years to ensure that they can be verified whenever requested.

Quarters run as follows: (January - March), (April - June) (July - September) (October - December)

Data from the primary source must be sent no later than:

- The 5th of the month following the quarter to the central level.

Key Monitoring & Evaluation Indicators

The below Profile data has to be collected for each client serviced (either through Outreach /VCT/Drop-in center forms /Survey)

- Unique ID (as per a uniform national coding system developed)
- Sex (male /female/other)
- Key population: IDU /MSM/FSW/other
- Age
- Contact number (if applicable)
- Service location (town /locality as applicable)
- Service location (city as applicable)
- Service province /Governorate
- Month and Year of data collected

This profile data will be kept at the registry inside the drop-in center and shall be available for any validation purposes.

1. Indicators to monitor the Utilization rate

Indicator 1: Quantity of kits utilized during the reporting period

Definition of indicator: The number of testing kits utilized during 1 month of implementation

Rational: To monitor the stock and validate the quantities of the kits used related to the number of clients.

What the indicator measures: It measures the utilization rate of the testing kits

Numerator: Number of testing kits utilized during reporting period.

Denominator: Total stock of testing kits at the implementing CSO during the reporting period

How to measure the indicator: The data is collected from the stock registry at the CSO as well as the client registration file.

Disaggregation: Disaggregated by type of key population, gender and age group

Measurement Frequency: Monthly, quarterly and annually

2. Indicators to monitor the quality of provided services

Indicator 1: Number of clients agree to have the HIV self-testing and provided by the kits

Definition of indicator: The number of clients who showed their interest to have the HIV self-testing whether in the drop-in center or at home (in this case only the number of clients who return with the result will be considered).

Rational: To assess the quality of counseling services.

What the indicator measures: It measures the acceptance and turnover rate of clients for the HIV self-testing modality

Numerator: Number of clients who showed interest to perform HIV self-testing whether in the drop-in center or at home.

Denominator: Total number of clients who received counseling services about self-testing

How to measure the indicator: The data is collected from counselor and client file registry at the implementing CSO.

Disaggregation: Disaggregated by type of key population, gender and age group

Measurement Frequency: Monthly, quarterly and annually

Indicator 2: Number of tests with a validated final confirmed result versus the preliminary results.

Definition of indicator: The number of tests which have the same confirmatory test result versus the preliminary test result (e.g.: No of tests rechecked and proven with the same result. (This will be done on regular base for at least 10% of the clients using systematic stratified random sampling)

Rational: To assess the specificity rate of used testing kits

What the indicator measures: It measures the accuracy rate of testing kits

Numerator: Number of tests which have positive/negative confirmatory results

Denominator: Total number of clients who received counseling services about self-testing

How to measure the indicator: The data is collected from counselor and client file registry at the implementing CSO.

Disaggregation: Disaggregated by type of key population, gender and age group

Measurement Frequency: Monthly, quarterly and annually.

Indicator 3: Number of testing services provided inside the drop in / at home testing.

Definition of indicator: The number of tests conducted based on the setting where the self-test is conducted whether inside the drop-in center or at home.

Rational: To assess which mechanism the clients are interested to help addressing and monitoring the process.

What the indicator measures: It measures the HIV self-testing provision modality.

Numerator: Number of tests performed at the drop-in center/number of tests performed at home.

Denominator: Total number of tests conducted.

How to measure the indicator: The data is collected from testing and client's registry at the drop-in center.

Disaggregation: Disaggregated by type of key population, gender and age group

Measurement Frequency: Monthly, quarterly and annually.

Indicator 4: Number of HIV positive / HIV negative results versus total number of tests conducted in the reporting period

Definition of indicator: The number of positive HIV test results in relation to the total number of tests conducted.

Rational: To measure the positivity rate of the HIV self-tests conducted.

What the indicator measures: It measures the positivity rate of the conducted HIV self-tests.

Numerator: Number of HIV tests with positive results.

Denominator: Total number of tests conducted.

How to measure the indicator: The data is collected from testing registry at the drop-in center.

Disaggregation: Disaggregated by type of key population, gender and age group

Measurement Frequency: Monthly, quarterly and annually.

Indicator 5: Number of clients referred to care/prevention services

Definition of indicator: The number of clients whom are referred to receive care or prevention/harm reduction services based on the HIV self-test result.

Rational: To assess the quality of linkage and continuum of care services.

What the indicator measures: It measures the linkage to care.

Numerator: Number of clients referred to receive services based on the testing result.

Denominator: Total number of clients who perform HIV self-tests.

How to measure the indicator: The data is collected from services referral registry at the drop-in center.

Disaggregation: Disaggregated by type referral services - disaggregated by type of key population, gender and age group.

Measurement Frequency: Monthly, quarterly and annually.

Indicator 6: Client satisfaction survey

A client satisfaction survey will be conducted biannually to evaluate the quality of the provided service from the client perspective.

Quality assurance

- The process of re-alignment of existing system would demand specific actions at each level, for which general guidelines are provided here. Effective implementation of the self-testing would require data quality to be ensured not only in generation of data, but also in the consolidation, analysis and use of information. The data quality protocol therefore is defined by various stages (generation, analysis and use).
- Timely, correct and consistent data collection by NGOs: Every focal point team can assist the implementation of the quality of data collection and reporting. Additionally, backend management information system at each site, needs to be tuned in accordance with harmonized data requirements
- Avoidance of duplication (double counting) and ensuring harmonization using a unique coding system for key population that can be uniformly followed across the country by different entities.

Compilation of Data

At the CSO level: data has to be compiled on an ongoing/monthly basis to ensure easy data handling and transmission. These data are transmitted to the M&E officer in the NAP through the Technical officer for analysis and reporting.

At central level: The M&E unit is the structure responsible for the compilation of data from all centers. This section is in contact with the various monitoring programs in all areas and cooperates with the Technical Institution in the programmatic areas of implementing CSOs.

Steps of the Procedure

- The CSO should report separate monthly report about the self-testing implementation.
- Data is gathered and verified through outreach, receptionist and the counselor using the attached form.
- Data is verified and validated by M&E at the CSO and the NAP level.
- Data is analyzed and approved by M&E at the CSO and the NAP level.
- The monthly report must address the core indicators included in this guidance.
- Forms and raw data must be kept at the CSO at least for four years.

Data Quality Assurance

- Data collection forms should be made simple with clear items, Data channels through which data will be transferred from the CSO to the National AIDS Program in addition to the feedback trying to include more than one data check point to ensure data validation.
- The software package which will be used for data keeping, retrieval and analysis will include checking fields whenever possible to ensure the quality of data entered.
- Necessary training for all personnel related to data reporting at the peripheral level who will share in filling out the data collection forms should be done first. Necessary on-the-job training will be carried out in the data generation sites.

Annex 1

Data collection form

إستمارة بيانات اساسية

إسم المثقف:			التاريخ:	يوم		شهر		سنة			
المكان:			المركز:								
كود المستفيد	تاريخ الميلاد		اول حرف من اول 3 اسماء					كود الجمعية			
	يوم	شهر									
كود جديد	نعم	لا	كود قديم	نعم	لا	تاريخ اخر زيارة					
تحويل من الميدان			كود الشريك								

السن	< من 15 سنة	19-15 سنة	24-20 سنة	35-25 سنة	49-36 سنة	> من 50 سنة

الجنس	ذكر		أنثي	

	نعم	لا
يعمل		
طالب		

المهنة/الوظيفة:

التعليم

بدون تعليم		يقرأ ويكتب		إبتدائي	
ثانوي		جامعي		دراسات عليا	
إعدادي					

الحالة الإجتماعية

اعزب		متزوج		أكثر من زوجة	
أرمل		شريك مقيم		شريك غير مقيم	
مطلق					

هل حللت إيدز قبل كده | نعم | لا

النتيجة إيه | سلبي | إيجابي | لا أعلم

فين | إمتي

هل أجري الشريك تحليل الفيروس من قبل | نعم | لا

النتيجة إيه | سلبي | إيجابي | لا أعلم

فين | إمتي

هل تم توزيع واقيات | نعم مع الشرح | نعم | لا | رفض الزائر

تم عمل الفحص السريع | نعم | لا

هل حللت إيدز قبل كده | نعم | لا

تم عمل مشورة ما بعد الفحص | نعم | لا

نتيجة الفحص السريع | متفاعل | سلبي | غير محدد

نتيجة الفحص التاكيدي | إيجابي | سلبي | غير محدد | لم يتم

هل تلقي الزائر النتيجة | نعم | لا

هل ينوي إخبار الشريك | نعم | لا

Risk factor

ممارسة الجنس في الستة أشهر السابقة | نعم | | لا |

لو نعم | إستخدام الواقي في اخر التقاء جنسي | نعم | | لا |

نوع الشريك | ملازم | | غير ملازم |

زواج		بدون زواج		بمقابل		بدون مقابل		بمقابل	
ذكر	انثي	ذكر	انثي	ذكر	انثي	ذكر	انثي	ذكر	انثي

عدد الشركاء بصفة عامة | | عدد الشركاء اخر شهر | | عد الشركاء اخر اسبوع | |

إستخدام الواقي بصفة عامة | دائما | | احيانا | | نادرا | | نهائيا | |

طريقة ممارسة الجنس مع الإناث | شرجي | | مهبلي | | سطحي | |

طريقة ممارسة الجنس مع الذكور | مستقبل | | معطي | | سطحي | |

لم امارس الجنس نهائيا | نعم | | لا | |

استخدام الواقي الذكري في اخر التقاء جنسي مع الشريك الملازم | نعم | | نعم لكن انقطع الواقي | | لم يحدض | | لم يمارس الجنس ابدا | |

استخدام الواقي الذكري في الستة اشهر السابقة مع الشريك الملازم (علم واحدة) | لم يحدث | | احيانا | | دائما | |

استخدام الواقي الذكري في الستة اشهر السابقة مع الشركاء الاخرين (علم واحدة) | لم يحدث | | احيانا | | دائما | |

هل تم عمل احالة خلال 7 ايام من تاريخ تاكيد نتيجة التحليل	نعم	لا	لا ينطبق
هل تم عمل إحالة بعد 7 ايام			
تم التحويل الي (علم ما يتطبق)			
لم يتم التحويل			
طبيب متخصص في الايدز			
خدمات الامراض التناسلية			
خدمات رعاية السل			
خدمات نفسية			
خدمات قانونية			
المزيد من المشورة			

خدمات اخرى-حدد:.....

نعم ☐ لا ☐