Islamic Republic of Afghanistan

Ministry of Public Health

National HIV Testing and Counseling Guideline

National HIV/AIDS Control Program (NACP)

Kabul, Afghanistan

24 September 2008
Preface by H. E. the Minister of Public Health

Afghanistan is a low HIV prevalence country and it is our wish and hope to continue this and prevent further transmission of HIV. The costs and consequences of HIV and AIDS in our population will be great, if we do not save this chance to prevent its further transmission to more and more of our citizens. There is only one time to keep HIV prevalence low and that is now, before prevalence increases. As HIV increases its prevalence, it means there are more people who can transmit it to others, more people who need treatment, and more people who need to be taught how to prevent transmitting it to others.

Like many diseases, HIV keeps its share of stigma. This stigma however blocks our efforts to prevent HIV transmission, as people living with HIV or most at risk of HIV are kept from accessing information, services, care, and support. This information needed to prevent HIV is simple and includes clear procedures for safe injecting practices, safe blood, and safer sexual practices. Who among us does not prefer that our medical practitioners use clean safe needles which are not contaminated by use with another person who may have one or other blood borne virus? Blood borne viruses are transmitted through unsafe, unprotected sexual activity, contaminated injections, and unsafe blood transfusions.

These guidelines for HIV testing and counselling are an important document for both medical workers and citizens. Our national HIV response is a multisectorial one, and together we need to build an enabling environment to increase access to HIV prevention and services. This approach to universal access presents clearly how the Ministry of Public Health will provide comprehensive HIV prevention, treatment, care and support services to help citizens not face HIV infection or transmit HIV to others. This important document will help us all to keep HIV prevalence low in Afghanistan.

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Minister of Public Health  
Islamic Republic of Afghanistan  
7 October 2008
Acknowledgements

This guideline presents the national approach for HIV testing and counselling as an entry point for universal access to HIV Prevention, Treatment, Care, and Support. We follow the principle that personal knowledge of HIV status is the gateway to further prevention and access to HIV treatment, care, and support services in Afghanistan. HIV prevention includes safety of blood transfusion and medical procedures, condom use, injecting drug use harm reduction and HIV client and provider initiated testing as an integral component of TB, IDU, STI, and ANC services. Universal access includes entry into HIV care, treatment and support services including Cotrimoxazole (CTX) prevention, opportunistic infections care, and antiretroviral therapy.

The sections on HIV rapid testing have been adapted by the MOPH for the Afghanistan program on HIV rapid testing from a draft regional guide on the use of rapid HIV tests prepared by Dr Corine Bronke, Dr Gabriele Riedner and Ms Joumana Hermez of the AIDS and Sexually Transmitted Diseases (ASD) unit of the Eastern Mediterranean Regional Office (EMRO) of the World Health Organisation (WHO) in April 2008. The protocol has benefited from review and comments by Ms. Anita Sands, WHO, Geneva. In addition, the able assistance of Dr. Thomas Kesteman, Laboratory Program Officer, and Dr. Florence Huber, HIV Advisor, Aide Medical International (AMI), Afghanistan is deeply appreciated.

This protocol for universal access to HIV prevention, treatment, care, and support for Afghanistan should be considered by all providers of HIV testing services operating under the Ministry of Public Health, Afghanistan, including HIV diagnostics for targeted interventions, TB/HIV, ANC, as well as blood screening by Central Blood Bank, BPHS, EPHS and private providers, and for HIV surveillance.

This protocol is also to be considered for the HIV program of the Afghan National Army.

The MOPH has related guidelines, including guidelines for HIV care and treatment, STI case management, TB/HIV collaborative activities, harm reduction, blood safety, PMTCT, and infection control. There is also a national HIV training manual to be used in connection with these guidelines.

Any question and concerns should be addressed to the Provincial Health Department or the National AIDS Control Program, Dr. Saifurrehman, Director, on email saifurrehman.dr@gmail.com
List of Abbreviations

AIDS  Acquired Immunodeficiency Syndrome
ANC  Ante Natal Care
ART  Anti Retroviral Therapy
BPHS  Basic Package of Health Services (rural based primary health care)
DOTS  Directly Observed Treatment Short Course
EIA  Enzyme Immunoassays
EPHS  Essential Package of Hospital Services
HIV  Human Immunodeficiency Virus
IDU  Injecting Drug Users
MSM  Male to male sex or Men having Sex with Males
NGO  Non-government Organization
NTP  National TB Program
PLHA  People or Persons Living with HIV and AIDS
PMTCT  Prevention of Mother to Child Transmission
PPV  Positive Predictive Value
STI  Sexually Transmitted Infection
TB  Tuberculosis
VCT  Voluntary Counseling and Testing
Wb  Western blot
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1. Background: HIV Situation and HIV Prevention in Afghanistan

01. HIV related Stigma and Discrimination

1. HIV-related stigma and discrimination undermine Afghanistan’s responses to the epidemic, because they prevent people from accessing information and important HIV prevention and treatment services. The take-up of HIV counseling and testing services, for example, is low. Discrimination against people living with HIV affects their access to information and knowledge, employment, housing, insurance, social services, education, health, and inheritance rights for women and men. Strong prejudice against people living with HIV has been found in health services. Furthermore, those groups that are most at risk of HIV infection are already discriminated against, marginalized, and in some countries criminalized. (AIDS 2008). Reducing and overcoming stigma is the greatest challenge for universal access to HIV prevention, treatment, care and services. This protocol points out the ways and means which can help increase access.

02. HIV among Most at Risk Populations

2. HIV is transmitted most efficiently through shared injecting equipment and unprotected sexual activity, therefore, HIV prevention programs are most effective when focused on most at risk groups. Available data shows that almost all injecting drug users (IDUs) share needles and/or syringes with multiple and concurrent users. Sexual behaviors of IDU are often risky, condom use is rare and sex with female sex workers (SWs) and male to male sex (MSM) occurs either for money or drugs. The surveyed number of IDUs (462 persons) in Kabul city (Todd, 2007) showed 3 percent prevalence of HIV. The study also showed that IDUs are engaged in high-risk behaviors such as receptive and distributive sharing of needles; have high prevalence of Hepatitis C (36 percent), engage in unprotected sexual activity including with women and more so with men (55 percent), predominantly minors; and reported an urgent need for treatment.

3. IDUs among prisoners were tested for HIV in Herat in 2008 by the MOPH found that over 10% of the 114 IDUs tested were HIV positive. Prisons that do not provide harm reduction access to clean needles and syringes or OST will find that IDUs in the prison will increase HIV and HCV infection through sharing of contaminated equipment and male to male sex.

4. The presence of SWs in urban areas, whose services are used by injecting drug users or those who have sex with injecting drug users points to an intersection of drug users and sex work that has serious implications for further spread of HIV mainly to the clients and sexual partners of the IDUs and SWs.
Figure 1. HIV Prevalence Surveys, Afghanistan, 2008 (JHU, 2008)

<table>
<thead>
<tr>
<th></th>
<th>Injecting Drug Users</th>
<th>Prisoners</th>
<th>Sex Workers</th>
<th>Male to Male sex</th>
</tr>
</thead>
<tbody>
<tr>
<td>HIV Prevalence</td>
<td>3.0%</td>
<td>11%</td>
<td>0.18%</td>
<td>No estimates</td>
</tr>
<tr>
<td>Risks</td>
<td>Shared syringes</td>
<td>Behavioral data unknown (shared injecting equipment, unprotected sex)</td>
<td>Ever used condom 51.5%</td>
<td>No estimates</td>
</tr>
<tr>
<td>Estimated Size</td>
<td>1465 (3 cities)</td>
<td>12,000 (MOJ)</td>
<td>1150 (3 cities)</td>
<td>No estimates</td>
</tr>
</tbody>
</table>

03. Blood Safety

5. Available data, based on blood screening throughout Afghanistan from 1989 to 2008, shows a rate of 100 per 100,000 HIV positive donations from a total of almost 500,000 donations. In addition, blood donations are also screened for other blood borne Disease including Hepatitis B (HBV), Hepatitis C (HCV) and Syphilis. Prevalence rates of these infections are higher even than HIV. There is strong evidence for need to strengthen blood safety practices by medical providers as well as by consumers.

Figure 2. Blood Borne Virus Screening 1989-2008, MOPH, Afghanistan

<table>
<thead>
<tr>
<th>Year</th>
<th>Tests</th>
<th>HIV</th>
<th>HBV</th>
<th>HCV</th>
<th>Syphilis</th>
</tr>
</thead>
<tbody>
<tr>
<td>1989 to 2004</td>
<td>216057</td>
<td>74</td>
<td>7982</td>
<td>989</td>
<td>412</td>
</tr>
<tr>
<td>2005</td>
<td>30287</td>
<td>74</td>
<td>779</td>
<td>579</td>
<td>87</td>
</tr>
<tr>
<td>2006</td>
<td>120639</td>
<td>133</td>
<td>2810</td>
<td>791</td>
<td>308</td>
</tr>
<tr>
<td>2007</td>
<td>72134</td>
<td>154</td>
<td>1926</td>
<td>512</td>
<td>169</td>
</tr>
<tr>
<td>2008</td>
<td>40153</td>
<td>69</td>
<td>184</td>
<td>36</td>
<td>3</td>
</tr>
<tr>
<td>Total</td>
<td>479210</td>
<td>504</td>
<td>13681</td>
<td>2907</td>
<td>979</td>
</tr>
</tbody>
</table>

04. Awareness Raising, Sensitization, and Prevention Education

6. Stigma and discrimination is the result of ignorance and fear, which can be overcome by effective awareness, or sensitization, education. Community leaders, especially religious leaders, are essential toward creating and raising awareness of universal access to HIV services in Afghanistan. Medical providers are often not well informed of
universal precautions and HIV prevention and can easily strengthen stigma of persons living with HIV. With patients presenting with TB and STI diagnosis, or infected blood donations, more and more health care workers will want to be well informed about HIV in order to provide quality care and treatment, as well as offer good prevention education. Prevention education includes knowledge of HIV transmission, blood safety and infection control, and prevention methods, including condoms and safe, sterile injecting equipment.

2. GENERAL PRINCIPLES OF HIV TESTING and COUNSELLING

01 Ethical HIV testing and counseling practices

7. Universal access to HIV testing and counseling services require active laws and policies that guard against discrimination on the basis of HIV status, risk behavior, and gender. Good laws and policies enhance privacy, autonomy and gender equality, which in turn strengthen client confidence in service provision. All HIV testing and counseling services including ethical disclosure and partner notification and counseling should be done in accordance with the HIV service code of ethics (HIV Services Code, 2007).

Figure 3. HIV Service Code of Ethics

| All persons seeking HIV prevention, treatment, care, and support services should be treated with respect and have their well-being and security safeguarded. |
| All persons will be assured of voluntary and confidential access to the information, diagnosis, and testing they need to protect themselves against HIV infection. |
| No one may disclose the HIV status of any individual except the person him or herself. This includes laboratory reports to other medical professionals. |
| People living with HIV and AIDS will have the same rights as all other citizens, and will not be discriminated against or stigmatized on the basis of their HIV status, gender, socioeconomic status, or HIV-risk behaviors. |
| HIV prevention, treatment, care, and support practices will follow evidence-based, international best practices in the context of Afghanistan’s religious and cultural values. |

02 Links with communities and other health services

8. Community preparedness and participation are integral aspects of HIV testing and counseling services to promote the rights of people living with HIV and to provide information about available services for HIV prevention, treatment, care and support. Persons living with HIV or AIDS and others from affected communities should be involved in the formulation, implementation, and monitoring of such services.
9. HIV testing and counseling services require mutual referral systems for patients, especially for TB, but also for anti-retroviral treatment (ART), cotrimoxazole prevention, OI and STI care, harm reduction, drug treatment, counseling, and mental health services.

03 HIV counseling

10. HIV counseling is a confidential dialogue between a client and a care provider aimed at enabling the client to understand HIV as it relates to him or her, to cope with any stress, and to take personal decisions relating to HIV, such as prevention or adherence. The counseling process includes increasing understanding the HIV transmission, recognition of the medical or clinical conditions related to HIV, teaching of prevention behavior, use of clean needles and syringes, and condoms as appropriate, and teaching of how to cope with and seek care for an HIV positive result.

11. HIV counseling includes pre-test, post-test, and supportive counseling for prevention and care.

   Pre-test counseling:
   Health care provider or counselor offers why HIV testing is important for their medical care or if client-initiated, the opportunity to explore and analyze their situation as it relates to HIV. Pre test counseling will help the client make an informed, voluntary, confidential decision to be testing.

   Post test counseling:
   Health care providers help the tested clients and patients to understand HIV transmission, prevention, and other issues related to their medical condition, such as TB, being pregnant, having an STI, being a drug user.
   Post test counseling should be provided for all clients with positive and negative results.

   Supportive counseling, (follow up and referral):
   Health service providers’ assists the people living with HIV (PLWH) to cope with their situation, to adopt and maintain safe sexual behaviors and to adhere to the ART drug regimen (adherence counseling) and PLWH should aware about opportunistic infections and based on need should refer to the relevant health centers.

04 Client and Provider Initiated HIV testing and counseling

12. The purpose of this document is to provide guidance for the range of service providers operating at multiple health facilities in Afghanistan on HIV rapid testing. The target audience is professionals, both specialists and care providers, working in the field of HIV, whether in blood banks, for surveillance, and for TB (tuberculosis), ANC (antenatal care), harm reduction or other targeted interventions in BPHS and EPHS facilities, and the private sector.
13. Client-initiated approaches have been the primary model for providing HIV testing and counselling and have been applied in “Voluntary HIV Counselling and Testing” (VCT) services. Coverage of client-initiated HIV testing and counselling services is inadequate in both high-income and resource-constrained settings. WHO and UNAIDS strongly support the continued scale up of client-initiated HIV testing and counselling.

14. Provider-initiated HIV testing and counselling presents an opportunity to ensure that HIV is more systematically diagnosed in health care facilities in order to facilitate patient access to needed HIV prevention, treatment, care and support services.

**Figure 4. Client Initiated HIV Testing and Counseling**

**Client-initiated HIV testing and counseling** involves individuals actively seeking HIV testing and counseling at a facility that offers these services. Client-initiated HIV testing and counseling usually emphasizes individual risk assessment and management by counselors, addressing issues such as the desirability and implications of taking an HIV test and the development of individual risk reduction strategies. Client-initiated HIV testing and counseling is conducted in a wide variety of settings including health facilities, stand-alone facilities outside health institutions, through mobile services, in community-based settings and even in people’s homes. Informed consent should always be given individually, in private, in the presence of a health care provider. Patients should also be made aware of relevant laws in jurisdiction that mandate the disclosure of HIV status to sexual and/or drug injecting partners. Verbal communication is normally adequate for the purpose of obtaining informed consent.

**Figure 5. Provider initiated HIV Testing and Counseling**

**Provider-initiated HIV testing and counseling** refers to HIV testing and counseling which is recommended by health care providers to persons attending health care facilities as a standard component of medical care. The major purpose of such testing and counseling is to encourage more people to know their HIV status. In the case of persons presenting to health facilities with symptoms or signs of illness that could be attributable to HIV it enables specific clinical decisions to be made and/or specific medical services to be offered that would not be possible without knowledge of the person’s HIV status. In such cases it is a basic responsibility of health care providers to recommend HIV testing and counseling as part of the patient’s routine clinical management. Provider-initiated HIV testing and counseling is neither mandatory nor compulsory. Informed consent should always be given individually, in private, in the presence of a health care provider. Verbal communication is normally adequate for the purpose of obtaining informed consent is still a requirement for conducting the test. The individual has the right to accept or refuse to be tested. Provider initiated testing and counseling observes the requirement that HIV testing should always be accompanied by appropriate counseling. Mandatory or compulsory testing of individuals on public health grounds is plainly not ethical.
15. Provider-initiated HIV testing and counseling also aims to identify unrecognized or unsuspected HIV infection in persons attending health facilities, often in connection with STI, TB, injecting drug use, prison experience. Health care providers may therefore recommend HIV testing and counseling to patients in some settings even if they do not have obvious HIV-related symptoms or signs. Such patients may nevertheless have HIV and may benefit from knowing their HIV status in order to receive specific preventive and/or therapeutic services. In such circumstances, HIV testing and counseling is recommended by the health care provider as part of a package of services provided to all patients during all clinical interactions in the health facility. This includes recommending HIV testing and counseling to tuberculosis patients and persons suspected of having tuberculosis.

05 Pre-test information

When recommending HIV testing and counseling to patients of ANC, TB and STI services, the health care provider should at a minimum provide the patient with the following information to enable the patient to consent to the HIV test or to reject it:

**Figure 6. Minimum Information for Informed Consent**

When recommending HIV testing and counseling to a patient, the health care provider should at a minimum provide the patient with the following information:

1. The reasons why HIV testing and counseling is needed or being recommended.
2. The services that are available in the case of either an HIV-negative or an HIV-positive test result, including whether antiretroviral treatment is available.
3. The fact that the test result will be treated confidentially and will not be shared with anyone and that patients should be advised that information about their test may be conveyed to other than health care providers directly or on referral in order to assure quality of care, as in the case of TB suspects.
4. The fact that the patient has the right to decline the test.
5. The fact that declining an HIV test will not affect the patient's access to services that do not depend upon knowledge of HIV status.
6. An opportunity to ask the health care provider questions.

16. Pre test information for women who are or may become pregnant should include the risks of transmitting HIV to their infant, measures that can be taken to reduce mother to child transmission, and the benefits to infants and mothers of early diagnosis of HIV. HIV testing and counseling to children involve special considerations, as children cannot legally provide informed consent, and they have the right to be involved in all decisions affecting their lives, and every attempt should be made to explain to the child what is happening and to obtain his or her assent.

17. Declining an HIV test should not result in reduced quality or denial of services, coercive treatment or breach of confidentiality, nor should it affect a person’s access to health services that do not depend on knowledge of HIV status. Individuals declining the
test should be offered assistance to access either client-initiated or provider-initiated HIV testing and counseling in the future.

**06 Pre-test counseling**

*Figure 7. Minimum Information provided through pre-test counseling*

<table>
<thead>
<tr>
<th>Minimum information to be given to a client/patient in the context of client-initiated HIV testing and counseling and according to need in provider-initiated HIV testing and counseling:</th>
</tr>
</thead>
<tbody>
<tr>
<td>01. The reasons why HIV testing and counseling is needed or being recommended.</td>
</tr>
<tr>
<td>02. In some cases, explanation of the window period and joint decision on whether the test should take place immediately or deferred till later due to the window period, along with prevention risk reduction plans and supply of prevention material.</td>
</tr>
<tr>
<td>03. The services that are available in the case of either an HIV-negative or an HIV-positive test result, including whether antiretroviral treatment is available.</td>
</tr>
<tr>
<td>04. The fact that the test result will be treated confidentially and will not be shared with anyone and that patients should be advised that information about their test may be conveyed to other than heath care providers directly or on referral in order to assure quality of care, as in the case of TB suspects.</td>
</tr>
<tr>
<td>05. The fact that the patient has the right to decline the test.</td>
</tr>
<tr>
<td>06. The fact that declining an HIV test will not affect the patient's access to services that do not depend upon knowledge of HIV status.</td>
</tr>
<tr>
<td>07. In the event of an HIV-positive test result, discuss to whom the result may be disclosed, i.e. to family members or friends who may be potential care givers and supporters as well as sexual partners or injection partners. Assure the client that disclosure would happen only if he or she approves.</td>
</tr>
<tr>
<td>08. Basic advice on methods to prevent HIV transmission.</td>
</tr>
<tr>
<td>09. Provision of male and female condoms and guidance on their use.</td>
</tr>
<tr>
<td>10. An opportunity to ask the health care provider questions</td>
</tr>
</tbody>
</table>

**07 Post-test counseling**

18. Post-test counseling is an integral component of the HIV testing process. All individuals undergoing HIV testing must be counseled when their test results are given, regardless of the test result. Given that many inpatient and outpatient facilities are crowded, care should be taken to discuss results and follow-up care in a confidential manner with only the patient and counselor present. Results should be given to patients in person by health care providers or by trained lay personnel. Ideally, post-test counseling should be provided by the same health care provider who initiated HIV testing and counseling. Results should not be given in group settings. It is not acceptable practice for health care providers to recommend HIV testing and counseling to patients and to subsequently withhold or fail to convey test results. Although patients can refuse to receive or accept results of any test or investigation, health care providers should make
every reasonable attempt to ensure that patients receive and understand their test results in a confidential and sympathetic manner.

**Figure 7. Post-test Counseling for HIV-negative Persons**

<table>
<thead>
<tr>
<th>Counseling for individuals with HIV-negative test results should include the following minimum information:</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. An explanation of the test result, including information about the window period for the appearance of HIV-antibodies and a recommendation to re-test in case of a recent exposure.</td>
</tr>
<tr>
<td>2. Basic advice on methods to prevent HIV transmission.</td>
</tr>
<tr>
<td>3. Provision of male and female condoms and guidance on their proper use.</td>
</tr>
<tr>
<td>4. The health care provider and the patient should then jointly assess whether the patient needs referral to more extensive post-test counseling session or additional prevention, follow up and support, for example, through community-based services.</td>
</tr>
</tbody>
</table>

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

**Figure 8. Post-test Counseling for HIV-positive Persons**

<table>
<thead>
<tr>
<th>Health care providers should:</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Inform the patient of the result simply and clearly, and give the patient time to consider it.</td>
</tr>
<tr>
<td>2. Ensure that the patient understands the result.</td>
</tr>
<tr>
<td>3. Allow the patient to ask questions.</td>
</tr>
<tr>
<td>4. Help the patient to cope with emotions arising from the test result.</td>
</tr>
<tr>
<td>5. Discuss any immediate concerns and assist the patient to determine who in her/his social network may be available and acceptable to offer immediate support.</td>
</tr>
<tr>
<td>6. Describe follow-up services that are available in the health facility and in the community, with special attention to the available treatment, PMTCT and care and support services.</td>
</tr>
<tr>
<td>7. Refresh client information on how to prevent transmission of HIV, including provision of condom and guidance on their proper use.</td>
</tr>
<tr>
<td>8. Provide information on relevant health measures such as good nutrition, use of co-trimoxazole and, in malarious areas, insecticide-treated bed nets.</td>
</tr>
<tr>
<td>9. Discuss possible disclosure of the result to the individuals identified in the pretest counseling or identify new ones, when and how this may happen. Stress again that disclosure would only happen in the case of her/his approval.</td>
</tr>
<tr>
<td>10. Discuss prevention and risk reduction measures that can prevent transmitting the infection to others and that prevent further exposure of the client to other subtypes of the HIV virus.</td>
</tr>
</tbody>
</table>
11. Supply prevention material such as condoms and sterile injection equipment
12. Encourage and offer referral for testing and counseling of partners and children.
13. Assess the risk of violence or suicide and discuss possible steps to ensure the physical safety of patients, particularly women.
14. Arrange a specific date and time for follow-up visits or referrals for treatment, care, counseling, support and other services as appropriate (e.g. tuberculosis screening and treatment, prophylaxis for opportunistic infections, STI treatment, family planning, antenatal care, opioid substitution therapy, and access to sterile needles and syringes) (Harm Reduction Package).

20. HIV test results must be communicated with an explanation of the prevention, treatment, care and support services available to the patient. Program for other chronic illnesses and community-based HIV prevention, treatment, care and support services are especially important resources and it is important to establish and maintain collaborative mechanisms with them. At a minimum, referral should include providing the patient with information about whom to contact as well as where, when, and how to contact them. Patient referral works best if the health care provider makes contact in the presence of the patient and schedules an appointment, making note of the contact and the organization in the patient’s file. Staff within the referral network need to routinely inform each other of changes in personnel or processes which could impact upon the referral of patients.

21. How often patients are re-tested will depend on the continued risks taken by the patient, the availability of human and financial resources and HIV incidence in the setting. Re-testing every 6-12 months may be beneficial for individuals at higher risk of HIV exposure, sex workers and their clients, men who have sex with men, injecting drug users and sex partners of people living with HIV. Additional research is needed in diverse settings with varying HIV epidemiology to determine the optimum interval between HIV tests for specific populations. Risks of HIV transmission to the infant are very high if the mother HIV positive. HIV testing and counseling should generally be recommended to patients where doubt exists about the patient’s prior testing history or the accuracy or veracity of prior test results. It is important that regular HIV testing does not become a substitution for prevention behaviors. Health care providers should emphasize that people should sustain safer behavior.

3. HIV rapid tests

01 Characteristics of HIV rapid tests

22. HIV rapid tests are a proven alternative [4,5] for HIV testing, especially in resource-limited settings. They are fast (under 30 minutes hands-on time) and simple to perform. They may be performed with little or no laboratory equipment/consumables and are technically less demanding. It has been shown that rapid tests can have sensitivities and specificities of up to 100%, similar to the performance of EIA (EMRO, 2008).

23. Rapid tests are based on various immunodiagnostic principles [5]. Tests based on the immuno chromatographic principle (also known as lateral-flow format), on the particles
agglutination principle and on the immuno filtration principle have many benefits for resource-limited settings as most of them do not require refrigeration, they require fewer steps to perform and are relatively easy to interpret with good eye sight and appropriate lighting. Furthermore, most of them cost less than US$ 2 [5].

24. The main advantage of rapid HIV tests is the short time needed to perform testing and hence the possibility to obtain HIV test results within hours of specimen collection. This may result in higher rates of people receiving their test results [5] and subsequently, in higher rates of people entering into treatment and care programmes. As with other formats of HIV testing, informed consent must be obtained from the individual, and confidentiality of test results must be maintained. In addition, it is important to select reliable rapid tests from the wide range available on the market. **Careful selection of rapid tests that have certified quality by WHO, combined with selection of suitable testing strategies and algorithms, will achieve accuracy that can be proven to be at least as high as using a combination of EIA and WB [5].**

25. A summary of rapid HIV tests characteristics suggests:
   
   1. The reliability of HIV rapid tests is equivalent to that of EIA, provided that both tests are carried out properly, according to standard operating procedures.
   2. Training of personnel who perform HIV tests and quality assurance measures is extremely important.
   3. HIV rapid tests are affordable and can be more economical, especially for settings with low specimen throughput.
   4. HIV rapid tests are easier to use and require none or minimal equipment and reagents.
   5. Because HIV rapid tests are easier to use, they can be performed both by laboratory personnel and non-laboratory personnel (such as health workers, nurses, counsellors) with training.
   6. Rapid tests are suitable for performing smaller numbers of tests at one time.
   7. All types of tests require attention to training, supervision, and quality assurance.
   8. Rapid tests obviously have a particular importance to mobile testing services that target “hard-to-reach” populations.

**02 Types of HIV rapid tests**

**Figure 9. Types of HIV Rapid Tests**

*Agglutination device:*
- Used with serum or plasma.
- Require 10-60 minutes or more.
- Cross-linking between HIV antibody in serum / Plasma and HIV antigen-coated latex particles
  Leads to agglutination.
- Sometimes difficult and subjective to read-out,
  Reagents require refrigeration and costs are US$ 1-3 per test.
Flow-through device (immuno-filtration):
- Require 5 to 15 minutes.
- Involves several steps.
- HIV antigens are immobilised on a porous
  Membrane and capture HIV antibody in serum /
  Plasma (sometimes whole blood).
- Some reagents require refrigeration.
- Costs are US$ 1-3 per test.

Lateral-flow device (immuno-chromatographic):
- Potentially only one step because the
  Nitrocellulose strip incorporates both HIV antigens
  And signal reagent.
- Most require little or no additional reagents, no
  Refrigeration, and can be performed within 15 minutes.
- Used with serum / plasma, whole blood including
  Finger-stick specimens or oral fluids (currently with
  Less accuracy).
- Costs are less than US$ 1.50 per test.

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03 Operational Characteristics of Commercially Available HIV Rapid Tests

26. In addition to shelf life, need for refrigeration, cost, the following parameters indicate
the level of complexity of some HIV tests.
  • Use of micropipette (fix or adjustable) and thus need of disposable tips
  • Performance of tests on serum or plasma requires centrifuge (electric or manual).
    Allowing blood specimen to clot to obtain serum can be done, but needs
    additional time.
Other multi-step assay requiring additional reagents and specimen preparation or
additional equipment, such as LIA, EIA or WB, are not considered here.

27. To facilitate access to high quality test kits, WHO coordinated the Prequalification of
Diagnostics programme this programme provides objective assessments of commercially
available assays. The results of these studies are published in a series of reports,
describing operational characteristics, such as ease of use, sensitivities and specificities
[1,4]. Operational Characteristics Reports 9/10, 11, 12, 13, 14, and 15 are available
  “HIV Assays: Operational Characteristics (Phase 1): Report 16: Simple/Rapid Tests” will be
  published in the near future with updated information about characteristics of
  commercially available rapid tests.
28. HIV assays evaluated by WHO are analysed against a panel of well-characterised sera of diverse geographical origins, and in addition some have been analysed against whole blood, oral fluid and urine with matched serum / plasma specimens. Results obtained with the tests under evaluation are compared to a composite “gold standard” result, otherwise known as the reference result as determined by reference tests.

29. Assays that meet certain standards are made available for purchase at competitive prices through the United Nations Bulk Procurement Schemes (UN BPS). Current prices of tests are available for those eligible to procure using the WHO WebBuy catalogue. For additional assistance, please email <diagnostics@who.int>

**Figure 10. Websites for Rapid Test Evaluation Reports**


**Figure 11. Sources in Afghanistan for HIV Rapid Tests.**

- Local Pharmaceutical Suppliers in Kabul and elsewhere
- Creditable Suppliers via Internet such as Medecins sans Frontiers (MSF)

Inclusion of suppliers of HIV rapid tests does not constitute endorsement of the product. Information is provided for purposes of illustration.

**04 Selection of HIV rapid tests**

30. Some special considerations to keep in mind, when selecting tests for use in country are: use of a) performance characteristics, b) whole blood versus serum specimen type, c) specimen through-put at testing facility, d) need of refrigeration (and electricity), e) need for other equipment and consumables, f) capacity of staff and the g) guaranteed shelf-life upon delivery related to storage conditions of test kits.

**Figure 12. Factors for Selection and Purchase of HIV Rapid Tests**

<table>
<thead>
<tr>
<th>Factor</th>
</tr>
</thead>
</table>

NACP, MOPH
4. HIV testing strategies

01 General considerations

31. Diagnosis of HIV-seropositivity should not be determined based on the result of one test alone, regardless of assay format (EIA, rapid tests or WB. The positive predictive value (PPV) is not only determined by the sensitivity and specificity of an HIV test, but most importantly by the HIV prevalence in the population to be tested. Hence, HIV tests must be used in a defined sequence, known as an HIV testing strategy that takes HIV prevalence and purpose of testing (i.e. blood safety, surveillance, diagnosis) into consideration. The exact selection of tests combined with the selection of an appropriate testing strategy is known as a testing algorithm. The accuracy of testing algorithms using rapid tests has been proven to be at least as high as algorithms with an EIA and WB combination (EMRO, 2008). Each testing algorithm that is introduced in a specific testing setting must be assessed and validated at country level. Training of personnel who perform HIV rapid tests is extremely important for quality assurance of rapid testing.

32. As testing strategies differ according to the HIV prevalence level in the population, it is absolutely essential to estimate the prevalence of HIV in the population being tested. For example, the prevalence of HIV in members of high-risk groups, like injecting drug users may be much higher than the prevalence among women attending antenatal care or in asymptomatic clients of voluntary counseling and testing (VCT) services.

33. The purpose of HIV testing, besides the HIV prevalence, will influence testing strategies. For example, in order to avoid HIV transmission through contaminated blood and blood products, screening with a very sensitive test (as close to 100% possible) is recommended, assuming that all units of donated blood yielding reactive or indeterminate results are disposed of immediately. However, a minimum of two tests is required for testing undertaken as part of HIV surveillance, as the PPV value of using one test alone is too low.

34. The algorithm for assays (including rapid tests) in any combination requires that:
   01. all tests have a sensitivity of at least 99% and a specificity of at least 99%;
   02. the final PPV for any testing algorithm is at least 99%;
03. the 1st test has the highest sensitivity and is followed by a 2nd test with higher specificity;
04. all tests in one testing algorithm do not share the same false negative and false positive results;
05. all tests in one testing algorithm are based on different antigen preparations; and
06. one nationally validated testing algorithm.
02 Diagnostic testing strategy

35. **Diagnostic testing (3 step HIV rapid testing).** Individuals can only be diagnosed as HIV-positive after three serial rapid tests have been performed, which are all reactive (see Figure 12; [15,16]). This is because the PPV based on the results of two reactive tests will remain too low in a low prevalence population.

36. The third test should be performed at the initial testing site to take full advantage of rapid testing, but may not be, depending on local factors such as specimen through-put, experience of technicians, availability of third test kits (note expiry dates), as well as accessible referral test sites. If the third test is not performed at the initial testing site, extensive counseling (after the 2 reactive tests, when an HIV-positive result is likely) is required to motivate the individual to return for the confirmatory test result and to take the necessary precautions in his/her daily life.

37. A declaration of a positive HIV result should be delivered after 3 positive tests. The client should be counselled that any positivity is checked again as a usual procedures. In addition, WHO recommends to obtain a second blood specimen from individuals newly diagnosed with HIV in order to ensure no specimen mix-up has occurred.

*Figure 13. Diagnostic Testing Strategy - 3 different rapid tests*  
(adapted and modified from WHO draft global guide on HIV)
03 Blood transfusion and organ/tissue transplantation testing strategy

38. **Blood transfusion and organ/tissue transplantation (1 step HIV rapid testing).** For all blood transfusion and organ/tissue transplantation settings, one rapid test should be used with the highest possible sensitivity (i.e. as close to 100% as possible), and all units of donated blood yielding reactive or indeterminate results should be disposed of immediately [15]. Any donation that is non-reactive is safe for release in the absence of evidence of infection. If the blood screening unit has indicated to the donor before taking of blood, that it will deliver the result to the patient, then, when it informs the patient that the blood donation was not accepted, the patient should be referred to physician for proper care for blood borne virus (for HIV further testing). In figure 14 instead of patient, donor should be write.

**Figure 14. Blood transfusion and organ/tissue transplantation: one test only.**
04 Surveillance testing strategy

39. Surveillance (2 step HIV rapid testing). For surveillance purposes, it is recommended, irrespective of HIV prevalence, to use a strategy consisting of two serial performed assays [15,17,18]. Western blot is never recommended for this specific purpose. As shown in Figure 7, a non-reactive result after the first test should be considered as HIV-negative. A reactive result must be further tested with a second test. When the result is reactive again, it is considered HIV-positive and if it is non-reactive it is considered HIV-negative.

Figure 15. Surveillance (all prevalences): serial testing strategy with 2 different tests.

5. HIV testing as Entry Point to HIV Prevention, Care and Treatment in health facilities

01 Health facilities providing HIV testing

40. This strategy for HIV testing for Afghanistan should be considered by all providers of HIV testing services operating under the Ministry of Public Health, Afghanistan, including HIV diagnostics for targeted interventions, TBHIV, reproductive health and ANC, as well as blood screening by CBB (Central Blood Bank), BPHS (Basic Package of Health Services), EPHE (Essential Package of Hospital Services) and private providers, and for HIV surveillance. This strategy is also to be considered for the HIV program of the ANA (Afghan National Army).
41. The strategy emphasizes the use of HIV rapid tests because this method increases access and affordability, which is an important advantage over Enzyme-Immuno-Assays (EIA) and Western blot (WB). Rapid tests are especially suitable for resource-limited settings with low prevalence of HIV. They are accurate, quick, simple to perform and can be cost-saving. They may be performed with little laboratory equipment, few laboratory consumables, and are technically less demanding. A well-trained and competent health worker can perform HIV rapid testing.

42. Figure 4 presents locations in the Afghan health care system where rapid HIV testing for diagnostic, blood screening, and surveillance purposes could be applied. Facilities include VCT (voluntary counselling and testing centres) which will become HUBs (HIV urban bases), NGOs (non governmental organizations that provide targeted interventions and harm reduction, BHC (basic health centers), CHC (comprehensive health centers, DH (district hospital, PH (provincial hospital), and RH (regional hospital) among others.

**Figure 16. HIV Rapid Testing in Afghanistan (common plan)**

<table>
<thead>
<tr>
<th>Facilities</th>
<th>Service</th>
<th>24/7 refrigeration</th>
<th>Diagnostic Testing (3 step for HIV, TB, ANC)</th>
<th>Blood Screening Testing (1-step)</th>
<th>Surveillance Testing (2 steps)</th>
</tr>
</thead>
<tbody>
<tr>
<td>VCT or HUB</td>
<td>HIV diagnosis</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>NGOs (harm reduction and other targeted interventions)</td>
<td>HIV diagnosis</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>BHC (not included in BPHS policy)</td>
<td></td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>CHC</td>
<td>HIV Testing and counselling</td>
<td>Yes (if 24/7 refrigeration, otherwise No)</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>DH</td>
<td>TB, ANC, HIV diagnosis, blood screening</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>PH/RH</td>
<td>TB, ANC, HIV diagnosis, blood screening</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Blood Bank</td>
<td>Blood</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Prisons</td>
<td>TB, HIV diagnosis</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>---------------</td>
<td>-------------------</td>
<td>----</td>
<td>-----</td>
<td>----</td>
<td>----</td>
</tr>
<tr>
<td>Sample Survey</td>
<td>Surveillance</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>Yes</td>
</tr>
</tbody>
</table>

**02 HIV Treatment, Care, and Support in Afghanistan**

43. Building on six VCT centers established in 2006 and 2007 in Kabul (2), Herat, Jalalabad, Mazari- Sharif, and Faizabad in Badakhshan, the MOPH has introduced integrated HIV rapid testing throughout BPHS and EPHS at CHC, DH, and other hospitals as well as with NGOs providing services to most at risk in communities and in prisons. Blood screening may be conducted by approved hospitals and other centers. The national HIV case registration center was established in 2008 at the Infectious Disease Hospital or Anteny Hospital in Kabul under the responsibility of Dr. Zubair Harooni. This HIV Urban Base (HUB) works with laboratory services provided by the Central Public Health Laboratory in Kabul and with NGOs or other established HIV services, such as VCT where present. With the implementation of the Global Fund Round 7 HIV project, HIV services will be contracted to NGO sub recipients in 8 provinces with HIV treatment in Kabul and Herat for the present.

44. There are seven entry points to HIV continuum of care for persons living with HIV (PLHA or PLHIV), all based on HIV rapid testing. Client-initiated rapid testing requires comprehensive pre-test counseling leading to informed consent. Provider-initiated rapid testing is prompted by clinical conditions which should be explained to the patient or client leading to informed consent. All HIV positive persons should be registered at the national HIV care center at the IDH or Antany Hospital in Kabul with Dr. Zubair Harooni, even when case management and treatment is conducted by another physician.

1. The seven entry points are
   1. Client initiated voluntary testing and counseling (VCT centers)
   2. Blood transfusion services with referral to VCT
   3. TB services
   4. STI services,
   5. ANC services and PMTCT, and
   7. IDU services

2. This protocol summarizes the recommended continuum of prevention and care from each entry point. Cotrimoxazole (CTX) should be part of HIV care and treatment provided by HIV care providers, as it requires long term follow up.
03 Entry 1: Client initiated voluntary HIV testing and counseling

45. Entry 1. Client initiated voluntary HIV testing and counseling. These are any persons who wish to know their HIV status for any reason. Persons may be government workers, students, military, police, or most at risk. They will consult a physician in a hospital or clinic or HIV voluntary testing and counseling center.

Figure 17: Flow chart for CITC

- Client
- Physician (clinic hospital, pharmacy, VCT center)
- Pre-test counseling!!!
  - Laboratory or on the spot for rapid test HIV
  - If positive*, the second and third tests should be performed for diagnosis
  - Post-test counseling, condoms
  - HIV Case registered at IDH

* following NACP algorithms

04 Entry 2: Blood transfusion services

46. Entry 2: Blood transfusion services (provider-initiated HIV testing and counselling). These are any persons who wish to donate blood. They will come for voluntary blood donation to a blood bank or hospital. All donated blood should be tested for HIV, HBV, HCV, and Syphilis.
Figure 18: Flow chart for HIV testing and referral to VCT in blood transfusion services

Donor → Blood bank. Ask donor if she/he wants to be told the result of blood screening,

Yes → Blood screening for HIV in blood bank by rapid test

No → Reactive to 1st test

Discard donated blood.
Refer to VCT service.
In VCT service: Apply HIV testing algorithms used for diagnostic testing

Non-reactive to 1st test
Use donated blood.
Provide minimal post-test counseling for negative results (as in PITC)

Reactive to 1st test
Discard donated blood

Non-reactive to 1st test
Use donated blood.
05 Entry 3: TB services

47. Entry 3. TB services (provider-initiated HIV testing and counseling) these are any persons who are TB positive. Their TB care provider will recommend HIV testing to improve patient care.

Figure 19: Flow chart for PITCT in TB services

* following NACP algorithms
06 Entry 4: STI services

48. Entry 4. STI services (provider-initiated HIV testing and counseling). These are any persons who are diagnosed by physician with any STI condition, such as Chlamydia, gonorrhea, syphilis, etc. The STI care provider will recommend HIV testing to improve patient care. (Note. STI providers should be aware some STIs have a very short incubation period (for example, gonorrhea) so patients may be in the window period and should be tested again after 1-2 months).

Figure 20: Flow chart for PITC in STI services

* following NACP algorithms
07 Entry 5: ANC services and PMTCT

49. Entry 5. ANC services and PMTCT (provider-initiated HIV testing and counseling). These are any pregnant women whose blood is screened. The pregnancy care provider will recommend HIV testing to improve pregnancy care.

*Figure 21: Flow chart for PITCT in ANC services*

- **Pregnant woman**
  - RH Physician in clinic and hospital will provide routine antenatal care and recommend blood screening to pregnant woman for better care. If woman consents to HIV test:
    - **Blood screening in Lab for HIV by rapid test**
      - Why in lab and not by trained providers?
        - If positive* )
          - If HIV positive on 3 tests, prevention counseling, condoms and refer to RH physician for care and PMTCT
            - RH physician will complete RH care + immediate referral to HIV care and joint follow up of woman by RH and HIV care teams
              - Refer to HIV care and treatment service for assessment and registration, care and treatment (immediate referral following HIV positive test result and HIV post-test counseling)
        - If negative*
          - Inform pregnant woman about HIV test result

* following NACP algorithms
08 Entry 6: Clinical Assessment

50. Entry 6. Clinical Assessment (provider-initiated HIV testing and counseling). These are any patients under care, who present clinical symptoms suggesting HIV infection (see WHO staging). The physician will recommend HIV testing to improve care.

*Figure 22: Flow chart for PITCT in IPD or OPD services*

* following NACP algorithms
09 Entry 7: IDU services in prisons and communities

51. Entry 7. IDU services in prisons and communities (provider-initiated HIV testing and counseling) These are any IDUs under harm reduction care, who present clinical symptoms suggesting HIV infection (see WHO staging). The physician will recommend HIV testing to improve care.

* Figure 23: Flow chart for PITCT in harm reduction services

10 Estimating quantities of HIV tests needed

52. The quantity of HIV rapid tests to have in stock should be based upon the expected demand at the health facility and the shelf life of the test. Demand for diagnostic HIV rapid test can be estimated on the number of patients or clients currently served for the following needs: a) harm reduction or other targeted intervention, b) TB positive patients, c) Pregnant women, or d) HIV status. The demand for blood screening can be added to the demand for HIV rapid test, as both services can use the same first test. The demand for surveillance is related to the number of persons to be tested in the sample.
Figure 24. Quantity of Tests to be stocked

<table>
<thead>
<tr>
<th>Facilities</th>
<th>First Test</th>
<th>Second Test</th>
<th>Third Test</th>
</tr>
</thead>
<tbody>
<tr>
<td>VCT and HIV Urban Base (HUB)</td>
<td>Per demand</td>
<td>5% of demand</td>
<td>3% of demand</td>
</tr>
<tr>
<td>NGOs (harm reduction and other targeted interventions)</td>
<td>Per demand</td>
<td>5% of demand or none if referred</td>
<td>3% of demand or none if referred</td>
</tr>
<tr>
<td>BHC</td>
<td>No</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>CHC</td>
<td>Per demand</td>
<td>5% of demand</td>
<td>3% of demand or none if referred</td>
</tr>
<tr>
<td>DH</td>
<td>Per demand</td>
<td>5% of demand</td>
<td>3% of demand</td>
</tr>
<tr>
<td>PH/RH</td>
<td>Per demand</td>
<td>5% of demand</td>
<td>3% of demand</td>
</tr>
<tr>
<td>Blood Bank</td>
<td>Per demand</td>
<td>None</td>
<td>None</td>
</tr>
<tr>
<td>Prisons</td>
<td>Per demand</td>
<td>5% of demand</td>
<td>3% of demand</td>
</tr>
<tr>
<td>Sample Survey</td>
<td>Per sample size</td>
<td>5% of sample size</td>
<td>None</td>
</tr>
</tbody>
</table>

53. The number of HIV positive tests that require a second test will be a percentage of the overall demand. If the expected demand is for 100 tests kits, then the need for the second test will be less, but should take into account the number of HIV positive results, false positives and repeats for invalid results. Stocking 5% of the quantity of the demand will give ample supply for the second test, for as long as Afghanistan is low prevalence. In higher prevalence groups, as prisons are, a bigger quantity of second and third lines tests should be considered.

54. The number of second HIV positive tests that require a third test will be a small percentage of the overall demand. If the expected demand is for 100 tests, and about 5 tests are stocked for the second test, about 3 tests can be expected to be needed for the third test not including false positives and repeats for invalid results. WHO does not recommend that the 3rd test be performed in outreach settings, but referred. However, in Afghanistan this needs to be balanced with the distance to the next referral level and the chance of patient compliance.

6. Quality Assurance for HIV Rapid Testing in Afghanistan

55. Staff should be given the tools needed to perform testing so that accurate and reliable test results are obtained. Direct support for the testing staff will include initial training for the testing and some method for periodic evaluation of each person. This periodic evaluation is conducted to ensure that all protocols, including SOPs, are being followed and that testing can still be performed accurately. Unlike other laboratory testing, HIV rapid tests will frequently be performed by individuals who do not have training in laboratory technology. Therefore, careful attention must be given to the training provided, especially for non-laboratory personnel. (Guidelines, WHO, 2005)
56. Training should include:
   01. How to perform the test, including all parts of the process – from specimen collection to the reading and interpretation, recording, and reporting of results. The appropriate use of external control materials must be included.
   02. A hands-on component, with all participants actually carrying out specimen collection and testing procedures.
   03. How the test is used in the program at the site
   04. The importance of the quality essentials
   05. The importance of biohazard safety procedures, including waste disposal.
   06. An assessment of ability to safely and accurately perform the testing.

57. Procurement and logistics. Availability of dependable and reliable test kits and supplies is essential. This requires a national plan for procurement and distribution, as well as careful management of supplies and reagents at the testing site, including:
   01. An inventory record for kits and supplies should be maintained. Each site should determine re-order levels for each item in the inventory based on workload and usage. This will allow for ordering in a timely manner, so that the testing site always has the necessary reagents and supplies and no interruption in testing will occur.
   02. On receipt of new supplies and reagents, the inventory record should be updated and all of the new material stored under the appropriate environmental conditions. Annex 3 provides examples of forms that can be used for inventory records.
   03. To avoid waste, sites should follow the concept of “first expired, first out”. Kits that expire earliest must be used before kits with a longer expiration date.

58. Quality control. Quality control procedures are essential to ensure that the testing process has been carried out properly and that the kit reagents are performing as intended. External quality assurance (EQA) can be accomplished by a careful on-site observation of the testing processes and procedures, carried out by a knowledgeable person or team. A checklist that allows for assessment of all parts of the quality system is an important tool for such an on-site visit. For the moment in Afghanistan, organizations responsible for HIV services are responsible for on-site observations.
   01. On-site monitoring should include all aspects of the quality system, including personnel competency and training, equipment policies, inventory control, quality control practices, records and documents, and facilities and safety.
   02. If other testing is performed at an HIV rapid testing site, an integrated approach to on-site visits should be taken to assess all aspects of testing practices.
   03. The site visit should include observation of testing with specimens of known reactivity (proficiency panels).
   04. When possible, direct observation of interaction with a client is useful. Other means of assessing performance of testing personnel could include exit interviews with clients and use of “mystery clients” (persons with known serostatus who present anonymously).
   05. A standard checklist must be used for all visits.
06. The on-site assessment should occur at least twice yearly in established sites, and at least quarterly for new sites or sites with new personnel. Frequency should be based on initial finds and need for corrective action.

07. The on-site visits should be instructional and provide a mentoring experience. The experience should not be punitive.

59. Process control refers to the activities and techniques that are carried out to ensure that the testing procedures are correctly performed, that the environment is suitable for reliable testing, and that the test kit works as expected to produce accurate and reliable results. Evaluation of HIV rapid test kits should be performed by the national reference laboratory, the Central Public Health Laboratory, Kabul or other appropriate body.

60. Central Public Health Laboratory, Kabul should develop a proper External Quality Control (EQC) system to test annually laboratories in which HIV tests are performed. This EQC should consist in providing laboratories sera or blood of known serostatus, including at least one negative and one positive sample. The laboratories should test the samples and provide feedback to the Central Public Health Laboratory with technique used, algorithm used and results of the tests. The Central Public Health Laboratory will then check that techniques and algorithm are consistent with national policy and that results are corrects.
7. Conclusions

61. Rapid tests are accurate, yet simple and quick to perform and can be more economical. They are less technically demanding and have no need for a laboratory set-up. They support expansion of HIV testing and counselling services and are highly beneficial in interventions such as PMTCT, diagnosis of symptomatic patients, and asymptomatic individuals attending TB, STI and other health care settings. With the introduction of rapid tests, feasibility of scaling-up HIV testing is useful in order to reach “hard-to-reach” populations. For prevalence settings involving most-at-risk/vulnerable populations, rapid tests offer the advantage of same-day result, post-test counselling and immediate referral to treatment, care and support.

62. In Afghanistan, the introduction of HIV rapid testing should be welcomed as these tests offer many advantages for the diverse settings in this region. In addition to above mentioned advantages (i.e. cost-saving, simplicity and rapidity), these tests are ideal in resource-limited settings and in populations with low HIV prevalence. A well-trained non-laboratory health worker can perform the tests without sophisticated laboratory equipment. In addition, these tests allow reading of individual test results, and are thus ideal for low turn-over of testing.
Annexes

Annex 1. References
Annex 2. HIV Rapid Tests
Annex 3. Stock Card
Annex 4. Rapid Test Logbook
Annex 5. Infection Prevention and Control
Annex 7. Standard Operating Procedures for HIV Care Centers, Afghanistan
Annex 1. References


Annex 2. HIV Rapid Tests

This present an overview of HIV rapid tests that have been evaluated by WHO in the HIV Assays Operational Characteristics Report series and are commercially available.

The names (and manufacturers) of the “Rapid Test” assays, evaluated by WHO are listed in the tables below, with the final sensitivities, final specificities and corresponding 95% Confidence Limits (CL) as reported in the HIV Assays Operational Characteristics Report series (see footnote 3 in main document).

Please note that this information is regularly updated and should be checked on http://www.who.int/diagnostics_laboratory/publications/evaluations/en/ and if possible on the WHO Web Buy catalogue (http://extranet.who.int/newwhowebbuy/home.asp).

The use of tests on plasma requires centrifuge. The use of tests on serum don’t require centrifuge, but use of this machine accelerates the process. Certain tests may require pipetting and chase buffer.

This form maybe used for planning purchase of HIV Rapid Tests after taking into account cost.

Figure 18. Form for Test Selection in Afghanistan

<table>
<thead>
<tr>
<th>Test</th>
<th>Shelf Life</th>
<th>Quantity</th>
</tr>
</thead>
<tbody>
<tr>
<td>Test 1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Test 2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Test 3</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

The following table shows tests that were selected from the list of HIV rapid tests provided by EMRO, WHO, April 2008. All test kits should be purchased on the basis of convenience of use, shelf life or expiry date, and cost. Inclusion in the list is in no way a recommendation for the brand or supplier mentioned. Other tests may be used in Afghanistan, as long as they are prequalified by WHO and that their use is consistent with WHO recommendations and, in particular, testing strategies.

- Sensitivity is the ability of the assay to detect correctly sera that contain antibody to HIV.
- Specificity is the ability of the assay to detect correctly sera that do not contain antibody.
Test kits selected for Test 1 must have higher sensitivity. Test kits selected for Test 2 must have higher specificity. Test kits selected for Test 3 should not be either of the ones selected for Test 1 and Test 2.

Please see further information on guidelines.

**Table 19. Selected Quality HIV Tests with Characteristics for Tests 1-2-3.**

This table has been made on basis of information available on September the 15th 2008. We recommend the reader to update this data regularly.
<table>
<thead>
<tr>
<th>Assay (manufacturer)</th>
<th>Sensitivity (%)</th>
<th>Specificity (%)</th>
<th>Refrigeration</th>
<th>Equipment required</th>
<th>Specimen</th>
<th>Conser-vation</th>
<th>Ease of performance (30)</th>
<th>Suitable for 1st first line</th>
<th>Suitable for 2nd line</th>
<th>Available in Kabul</th>
</tr>
</thead>
<tbody>
<tr>
<td>SD Bioline HIV 1/2 3.0 (Standard Diagnostics)</td>
<td>100.0</td>
<td>97.7-100.0</td>
<td>99.3 97.6-99.9</td>
<td>No</td>
<td>Micropipette (10-12 µl)</td>
<td>Serum/plasma/whole blood</td>
<td>18 months at 15-30°C</td>
<td>29</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>HIV (1+2) Antibody (Colloidal Gold) (KHB Shanghai Kehua Bioengineering Co.Ltd.)</td>
<td>100.0</td>
<td>97.7-100.0</td>
<td>100.0 98.8-100.0</td>
<td>No</td>
<td>Micropipette (40 µl)</td>
<td>Serum/plasma/whole blood</td>
<td>18 months at 2-30°C</td>
<td>29</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>GENEDIA® HIV 1/2 Rapid 3.0 (Green Cross Life Science Corp)</td>
<td>100.0</td>
<td>97.7-100.0</td>
<td>99.7 98.1-100.0</td>
<td>No</td>
<td>Micropipette (40 µl) for whole blood. Sahli pipette (20 µl) and centrifuge for serum/plasma</td>
<td>Serum/plasma/whole blood</td>
<td>18 months at 2-30°C</td>
<td>29</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>HIV ½ Stat-Pak (Chembio Diagnostics Systems)</td>
<td>97.5</td>
<td>93.6-99.3</td>
<td>100.0 98.8-100.0</td>
<td>No</td>
<td>-</td>
<td>Serum/plasma/whole blood</td>
<td>15 months at 8-30°C</td>
<td>30</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>Retrocheck HIV WB/Core HIV 1&amp;2 (Qualpro Diagnostics/Core Diagnostics)</td>
<td>100.0</td>
<td>98.8-100.0</td>
<td>99.12 97.7-99.8</td>
<td>No</td>
<td>-</td>
<td>Serum/plasma/whole blood</td>
<td>12 months at 2-30°C</td>
<td>29</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>DoubleCheckGold™ HIV 1&amp;2 WholeBlood (Organics Ltd)</td>
<td>100.0</td>
<td>98.8-100.0</td>
<td>99.34 98.1-99.9</td>
<td>No</td>
<td>Centrifuge, micropipette (10 µl)</td>
<td>Serum/plasma</td>
<td>18 months at 2-30°C</td>
<td>30</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Determine™ HIV-1/2 (Abbott Laboratories Dainabot Co. Ltd)</td>
<td>100.0</td>
<td>95.5-100.0</td>
<td>99.4 96.7-100.0</td>
<td>No</td>
<td>-</td>
<td>Serum/plasma/whole blood</td>
<td>18 months at 2-30°C</td>
<td>30</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>First Response™ HIV-1/HIV-2 WB (PMC Medical Pty.)</td>
<td>100.0</td>
<td>95.5-100.0</td>
<td>98.8 95.8-99.9</td>
<td>No</td>
<td>Micropipette (30 µl)</td>
<td>Serum/plasma/whole blood</td>
<td>28</td>
<td>Yes</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>ADVANCED QUALITY™ HIV Rapid Test (InTec Products)</td>
<td>99.68</td>
<td>98.2-99.8</td>
<td>99.78 98.8-100.0</td>
<td>No</td>
<td>Micropipette (5 µl)</td>
<td>Serum/plasma/whole blood</td>
<td>18 months at 2-30°C</td>
<td>28</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Uni-GoldTM HIV (Trinity Biotech plc)</td>
<td>100.0</td>
<td>95.5-100.0</td>
<td>100.0 97.9-100.0</td>
<td>No</td>
<td>-</td>
<td>Serum/plasma/whole blood</td>
<td>20 months at 2-27°C</td>
<td>30</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Genie II HIV-1/HIV-2</td>
<td>100.0</td>
<td>97.7-100.0</td>
<td>99.7 98.1-100.0</td>
<td>Yes</td>
<td>Fridge, micropipette (50µl)</td>
<td>Serum/plasma</td>
<td>15 months at 2-8°C</td>
<td>25</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>OraQuick HIV-1/2</td>
<td>98.1</td>
<td>94.5-99.6</td>
<td>100.0 98.8-100.0</td>
<td>No</td>
<td>-</td>
<td>Serum/plasma/whole blood</td>
<td>7 months at 2-8°C</td>
<td>90</td>
<td>No</td>
<td>Yes</td>
</tr>
</tbody>
</table>

Note: 3rd (third) test should not be any of the tests selected for Test 1 and Test 2
Annex 3. Stock Card

Item Name_________________________________ Unit________________________

Manufacturer _______________________

Kit Lot Number:_________________ Expiration Date:___________________

Stock Re-order Level___________________

<table>
<thead>
<tr>
<th>Date</th>
<th>Received From</th>
<th>Issued to</th>
<th>Quantity Received</th>
<th>Quantity Issued</th>
<th>Balance</th>
<th>Lot #</th>
<th>Signature</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tr>
</tbody>
</table>
Annex 4. HIV Rapid Test Logbook

Name of Unit _______________________

| Serial No. | Client or specimen ID | Age (yrs) | Gender | Date Tested | Test 1 Kit Name | Test 1 Lot Name | Test 1 Exp Date | Test 2 Kit Name | Test 2 Lot Name | Test 2 Exp Date | Test 3 Kit Name | Test 3 Lot Name | Test 3 Exp Date | Final Result | Operator Name |
|------------|----------------------|-----------|--------|-------------|-----------------|----------------|-----------------|-----------------|----------------|----------------|----------------|----------------|----------------|----------------|--------------|---------------|
| 1          |                      |           | M      | F           | R               | NR             | INV             | R               | NR             | INV             | R              | NR             | INV             | P N I         |               |
| 2          |                      |           |        |             |                 |                |                 |                 |                 |                 |                 |                 |                 |               |               |
| 3          |                      |           |        |             |                 |                |                 |                 |                 |                 |                 |                 |                 |               |               |

Note: INV (invalid) from internal control reading

PURPOSE: To provide a guide to the personnel to for the care of all patients and to protect personnel, patients and visitors. All patient blood and body fluids are considered potentially infectious, and standard precautions are indicated for all patients.

POLICY:
- Standard precautions shall be applied to all patients receiving care in health care facilities, regardless of their diagnosis or presumed infection status.
- The health care personnel after orientation shall be responsible for complying with the standard precautions.
- Personal protective equipment (PPE) and other supplies are provided to all health care personnel. Each health care worker shall know where the PPE and other supplies are kept in the department/unit/ward.
- The type of protective barrier(s) shall be appropriate for the procedure being performed and type of exposure anticipated.
- PPE available includes gloves, gowns or aprons, masks, eyewear, and resuscitation devices

STANDARD PRECAUTIONS

Apply to:
- Blood
- All body substances, secretions and excretions except sweat, regardless of whether or not they contain visible blood
- Non intact skin
- Mucous membranes

Standard precautions are designed to reduce the risk of transmission of microorganisms in healthcare facilities. Standard precautions involve the use of safe work practices and protective barriers.

I. HAND HYGIENE:
A. Hands shall be washed after touching blood, body substances, and contaminated items, whether or not gloves were worn
B. Hands shall be washed immediately after gloves are removed, between patient contacts, and when otherwise indicated to avoid transfer of microorganisms to other patients, personnel or environments
C. If necessary, hands shall be washed between tasks and procedures on the same patient to prevent cross-contamination of different body sites
D. Hand washing shall be performed using one of the following methods:
   1. Hand washing with clean water and plain soap: before and after regular procedures
   2. Hand washing with clean water and an antimicrobial soap: before and after procedures in critical care areas (e.g.; nursery, ICU), in the care of patients on
transmission-based precautions and other areas when indicated by the IPC Committee

3. Waterless antiseptic rub: if hands are not visible soiled, the waterless rub can be used before and after regular procedures, and before and after procedures in critical care areas (e.g.; nursery, ICU), in the care of patients on transmission-based precautions and other areas when indicated by the IPC Committee

E. Hands shall be dried after hand washing with clean paper towel, clean individual cloth towel or air-dried

F. Health care personnel shall cover cuts and abrasions on exposed skin with water-resistant occlusive dressing which shall be changed when necessary or when dressing becomes soiled

G. Hand lesions that cannot be covered shall have the conditions assessed by a medical practitioner. If necessary, health care personnel shall be temporarily re-assigned or released from duty according to the medical assessment

H. If hand lotions are to be used to protect hands from abrasion, non-oil based moisturizing lotions or creams shall be used. Compatibility between lotions and antiseptic products and the integrity of gloves shall be considered. Lotions and creams shall be dispensed by using squeeze tubes/bottles or pump packs

II. GLOVES:

A. Gloves shall be worn whenever exposure to blood and blood substances is planned or anticipated, in particular:
   1. During any procedure where direct contact with patient’s blood or body fluids, mucous membranes or non-intact skin is anticipated
   2. While suctioning a patient
   3. While handling items or surfaces that have come in contact with blood or body fluids
   4. While performing invasive procedures, venepuncture or finger stick

B. The selection of the type of glove shall be appropriate to the type and risk of the procedure and a suitable size for the user

C. Double gloving shall be used if sterile gloves are reused, the procedure involves coming in contact with large amounts of blood or other body fluids (e.g., c-sections, orthopedic, vaginal delivery), the procedure is longer than 30 minutes, or the local prevalence of HIV/AIDS is equal to or greater than 5%

D. Sterile gloves shall be worn if the procedure involves contact with sterile tissue. High level disinfected gloves are the only suitable alternative if sterile gloves are not available

E. Examination or procedure gloves shall be worn for all procedures that may involve direct skin or mucous membrane contact with blood or other body fluids or contaminated equipment

F. Examination or procedure gloves shall not be reused

G. Utility gloves or heavy duty gloves shall be worn for housekeeping activities, instrument cleaning and decontamination procedures, soiled linen handling and waste handling and disposal

H. Gloves shall be changed or discarded:
1. As soon as they are torn or punctured
2. After contact with an individual is provided and before care is provided to another
3. When performing separate procedures on the same patient and there is risk of transmitting infection from one to another part of the body
I. The use of gloves does not eliminate the need for hand washing

III. MASKS, EYEWEAR, FACE SHIELDS:
A. Masks shall be worn during procedures that are likely to generate droplets, splashes, or sprays of blood or body fluids
B. The type of masks selected shall be appropriate to the type and risk of the procedure
C. Masks shall completely cover nose and mouth of the health care personnel
D. Single-use masks shall be discarded once it has been worn and shall not be reused
E. If cloth masks are to be used, they shall be changed as soon as they get wet and shall not be reused until reprocessed
F. Non-disposable face shields shall be decontaminated and cleaned after use
G. Eyewear (goggles or face shields) shall be worn during procedures that are likely to generate droplets, splashes, or sprays of blood or body fluids
H. The type of eyewear selected shall be appropriate to the type and risk of the procedure
I. Protective eyewear that is reusable shall be decontaminated and cleaned after use

IV. GOWNS/APRONS:
A. Impervious gowns (clean, non-sterile gowns) shall be worn when there is potential for soiling clothing with blood and body fluids
B. Gown/apron selection shall be appropriate to the type and risk of procedures. If cloth gowns are to be used and blood and body fluid contact is anticipated, a plastic or rubber apron shall be worn underneath
C. Soiled gown/apron shall be removed as promptly as possible and hands washed to avoid cross contamination
D. Plastic or rubber aprons shall be decontaminated and washed after use
E. Re-usable gowns shall be washed after use

V. PATIENT PLACEMENT:
A. A shared room is appropriate for most patients. A private room shall be considered only when the patient’s hygiene is poor or in cases where blood and/or body fluids cannot be contained

VI. PATIENT CARE EQUIPMENT:
A. Used patient care equipment shall be handled in a manner that prevents contamination
B. Reusable patient care equipment shall be reprocessed before reuse with another patient
C. Single use items shall be discarded immediately after use
VII. RESUSCITATION EQUIPMENT:
A. Mouthpieces or other ventilation devices shall be available as alternatives for mouth to mouth resuscitation

VIII. SHARPS HANDLING, USE AND DISPOSAL:
A. Special care shall be taken to prevent injuries during procedures, when cleaning reusable sharp instruments and during disposal of used sharps
B. Health care facilities shall ensure adequate and accessible resources for disposable of sharps
C. Each health care personnel shall be responsible for the management and disposal of the sharps they use
D. “Hands-free” technique to pass or transfer sharps (scalpel, needles and sharp-tipped scissors) shall be used by establishing a Safe or Neutral Zone in the operative field (Keep hands behind needle or sharp at all times.)
E. Sharps shall be removed from the operational field immediately after use
F. Reusable sharps shall be placed immediately after use in a puncture proof container
G. Each disposable needle and syringes shall be used only once
H. Sterile needle and syringe units shall be opened in front of the client/patient
I. Needle and syringe shall not be disassembled after use
J. Needles shall not be recapped, bent or broken prior to disposal
K. If needles need to be recapped (e.g. blood gas draw), the one-handed recap method shall be used.
L. Needles and syringes and other disposable sharps shall be disposed of immediately after use into a sharps container.
M. Needles and syringes shall be decontaminated prior to disposal, especially if method of disposal is to a landfill. In this case, the sharps shall be decontaminated by flushing the assembled needle and syringe three times, using 0.5% chlorine solution, prior to placing in the sharps container.
N. Sharps containers shall be easily visible and within horizontal reach of the user but not within easy access of non-users (patients or visitors). They shall be readily available and conveniently located at point of use throughout the health care facility.
O. Sharps containers shall be closed and disposed when ¾ full
P. Sharps containers shall not be reused.
Q. Needles (used or unused) and other sharps shall never be disposed of into regular trash/waste receptacles

IX. LAB SPECIMEN:
A. Lab specimens shall be placed in a container that prevents leakage during collection, handling, processing, storage, transport, or shipping and shall be labeled with biohazard symbol. If outside contamination of the primary container occurs, it shall be placed within a second container

X. BLOOD SPILLS:
A. Spills of blood or other body fluids shall be removed and the area decontaminated and cleaned using 0.5% chlorine solution or other approved disinfectant. Utility gloves shall be worn during decontamination and cleaning.

XI. LINEN:
A. Soiled linen shall be handled as little as possible at point of use
B. Soiled linen shall be collected and transported in a leak proof container (e.g.; plastic bag, cart, bucket) to prevent contamination
C. Utility gloves and plastic apron shall be worn during soiled linen handling.
Annex 6. HIV Counseling

1. Aims of HIV Counseling
2. Voluntary
3. Informed consent
4. Confidentiality
5. Disclosure
6. Managing clients’ emotional responses
7. Definitions

1. Aims of HIV/AIDS counseling
HIV/AIDS diagnosis has many implications – psychological, social, physical, economical, and spiritual and others. Also HIV being a life threatening as well as lifelong illness, counseling is important. The main aims of counseling are:

01. To help the client make an informed choice
02. To explore the client’s knowledge on HIV/AIDS and provide correct information
03. To assess the client’s potential exposure to HIV
04. To explain the process of testing
05. To help clients prepare themselves for the test result and the issues that may arise after learning HIV status
06. To bring about behavior change in order to prevent further transmission
07. To deal with stigma and discrimination
08. To access the services for prevention, treatment and care

Counseling is essentially a confidential dialogue between an individual/couple and a counselor, aimed at enabling the individual to make personal decisions in the context of HIV/AIDS. The counseling process includes an evaluation of personal risk of HIV transmission and acceptance of preventive behavior. HIV counseling is a behavior change interaction aimed at HIV prevention.

Counseling promotes trust between the counselor and the client. The client is helped to identify and understand the implications of a negative or positive result. They are helped to think through the practical strategies for coping with the results of the HIV test. Post-test counseling further reinforces the understanding of all implications of a test result. Counseling also helps clients decide who they should share the test result with, and how to approach that aspect.

A Classic Counseling Package ensures that:

1. Knowledge of status is voluntary.
2. Pre-Test Counseling is offered either through one or more sessions with a trained counselor, after which the client may choose to test on the same or different day.
3. Informed Consent is obtained from the client by the service provider
4. HIV Test is performed using approved HIV test kits and testing protocols
5. Post Test Counseling [one or more sessions] that includes informing clients of their HIV test results takes place on the same or different day.

Source: UNFPA Programme Brief Number 5 on VCT. April 2002.
Key Principles of Voluntary Counseling and Testing

Critical to the provision of VCT services are the principles of voluntary attendance, informed consent and confidentiality and of high quality, reliable and affordable counseling services. The conditions of ‘3 Cs’ [Confidential, accompanied by Counseling, only conducted with informed Consent] continue to be underpinning principles for the conduct of HIV testing of individuals. These principles are defined below for operational clarity:

[a] Voluntary
 Seeking knowledge of HIV status is voluntary. The decision to pursue testing for HIV must be made by the client who seeks counseling and testing services. The voluntariness of testing is crucial both to comply with human rights principles and to ensure sustained public health benefits. The NACP Afghanistan will not support mandatory testing of individuals on public health grounds recognizing that voluntary testing is more likely to result in behavior change to avoid transmitting HIV to other individuals.

[b] Confidential
 Information shared during counseling must not be shared with others. The HIV test result must only be reported to the client unless the client states the desire to shared the test result with a family member, partner or close friend. Confidentiality is defined as the state of being ‘private’. Maintaining client’s privacy by restricting access to personal and confidential information, especially in respect to HIV test results, demonstrates sensitivity and respect towards the basic rights of the client. The physical environment in a VCT site must allow private discussion between client and counselor.

Keeping confidential any information provided by a client is crucial for promoting trust. It ensures that all people at risk of HIV infection feel at ease while seeking VCT services to determine their HIV status, and do not anticipate stigma and discrimination. While a breach of confidentiality may be unintentional, nevertheless, the effect of a breach of confidentiality can be serious and may have an immediate fall out in that the client begins to encounter stigma and discrimination. A deliberate breach of confidentiality is unethical and should possible lead to disciplinary action against the concerned staff. Examples of breach of confidentiality include: The use of protective gear such as gloves in hospitals only with people who are HIV positive, telephone conversations, written records or client files that are not kept under lock and key. Health care staff should adopt universal precautions with all patients irrespective of HIV status.

[c] Informed consent
 The client agrees to HIV testing through giving his/her informed consent. Informed consent is a deliberate and autonomous permission given by a client to health care provider to proceed with the proposed HIV test procedure. The permission is based on an

---

2 Mandatory screening of HIV and other blood borne viruses of all blood that is destined for transfusion or for manufacture of blood products will be supported.
adequate understanding of the advantages, risks, potential consequences and implications of an HIV test result, which could be both negative and positive. The permission is entirely the choice of the client and can never be implied or presumed.

The option to go through a screening test for HIV is explained to the client through a process of HIV pre-test counseling. Client-specific information about personal risk, details about HIV transmission, modalities for prevention, HIV testing procedures, their limitations and the interpretation, as well as systems and structures for psychosocial support are discussed. Informed consent to HIV testing should be obtained from the client prior to proceeding for HIV testing. Access to VCT services should be available to children and young people under the age of 18 years also. However, informed consent of parents/guardians is required prior to testing of minors for HIV.

<table>
<thead>
<tr>
<th>The minimum amount of information that patients require in order to be able to provide informed consent is the following:</th>
</tr>
</thead>
<tbody>
<tr>
<td>• the clinical benefit and the prevention benefits of testing</td>
</tr>
<tr>
<td>• the right to refuse</td>
</tr>
<tr>
<td>• the follow-up services that will be offered and</td>
</tr>
<tr>
<td>• in the event of a positive test result, the importance of anticipating the need to inform anyone at ongoing risk who would otherwise not suspect they were being exposed to HIV infection</td>
</tr>
</tbody>
</table>

*Source: UNAIDS/WHO Policy Statement on HIV Testing, June 2004*

**[d] Disclosure**

In the context of HIV, disclosure refers to the act of informing any individual or organization [such as health authority, an employer or an school] of the HIV sero-status of an infected person or it refers to the fact that such information has been transmitted, by any means, by the person or third party with or without the consent. Except in circumstances, when disclosure to another person is required by law or for ethical considerations, the person with HIV has the right to privacy, and also the right to exercise informed consent in all decisions about disclosure in respect of his/her status.

Beneficial disclosure of HIV status is voluntary, respects the autonomy and dignity of the affected individuals, maintains confidentiality as appropriate, leads to beneficial results for the individual, his/her sexual or drug injecting partners, and family, leads to greater openness in the community about HIV and meets ethical imperatives so as to maximize good for both the un-infected and infected. It also assists care providers in identification of health needs of PLHAs [people living with HIV and AIDS].

Figure 1. Minimum Information for Informed Consent

When recommending HIV testing and counseling to a patient, the health care provider should at a minimum provide the patient with the following information:
1. The reasons why HIV testing and counseling is needed or being recommended.
2. In some cases, explanation of the window period and joint decision on whether the test should take place immediately or deferred till later due to the window period, along with prevention risk reduction plans and supply of prevention material.
3. The services that are available in the case of either an HIV-negative or an HIV-positive test result, including whether antiretroviral treatment is available.
4. The fact that the test result will be treated confidentially and will not be shared with anyone and that patients should be advised that information about their test may be conveyed to other than health care providers directly or on referral in order to assure quality of care, as in the case of TB suspects.
5. The fact that the patient has the right to decline the test.
6. The fact that declining an HIV test will not affect the patient's access to services that do not depend upon knowledge of HIV status.
7. In the event of an HIV-positive test result, discuss to whom the result may be disclosed, i.e. to family members or friends who may be potential caregivers and supporters as well as sexual partners or injection partners. Assure the client that disclosure would happen only if he or she approves.
8. Basic advice on methods to prevent HIV transmission.
9. Provision of male and female condoms and guidance on their use.
10. An opportunity to ask the health care provider questions.

Critical to the provision of HIV testing and counseling services are the principles of voluntary attendance, informed consent and confidentiality and of high quality, reliable and affordable counseling services. The conditions of ‘3 Cs’ (Confidential, accompanied by Counseling, only conducted with informed Consent) continue to be underpinning principles for the conduct of HIV testing of individuals. These principles are defined below for operational clarity:

Figure 2. Post-test Counseling for HIV-negative Persons

Counseling for individuals with HIV-negative test results should include the following minimum information:
1. An explanation of the test result, including information about the window period for the appearance of HIV-antibodies and a recommendation to re-test in case of a recent exposure.
2. Basic advice on methods to prevent HIV transmission.
3. Provision of male and female condoms and guidance on their use.
4. The health care provider and the patient should then jointly assess whether the patient needs referral to more extensive post-test counseling session or additional prevention support, for example, through community-based services.

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

Figure 3. Post-test Counseling for HIV-positive Persons

<table>
<thead>
<tr>
<th>Health care providers should:</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Inform the patient of the result simply and clearly, and give the patient time to consider it.</td>
</tr>
<tr>
<td>2. Ensure that the patient understands the result.</td>
</tr>
<tr>
<td>3. Allow the patient to ask questions.</td>
</tr>
<tr>
<td>4. Help the patient to cope with emotions arising from the test result.</td>
</tr>
<tr>
<td>5. Discuss any immediate concerns and assist the patient to determine who in her/his social network may be available and acceptable to offer immediate support.</td>
</tr>
<tr>
<td>6. Describe follow-up services that are available in the health facility and in the community, with special attention to the available treatment, PMTCT and care and support services.</td>
</tr>
<tr>
<td>7. Refresh client information on how to prevent transmission of HIV, including provision of male and female condoms and guidance on their use.</td>
</tr>
<tr>
<td>8. Provide information on relevant health measures such as good nutrition, use of co-trimoxazole and, in malarious areas, insecticide-treated bed nets.</td>
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<tr>
<td>9. Discuss possible disclosure of the result to the individuals identified in the pretest counseling or identify new ones, when and how this may happen. Stress again that disclosure would only happen in the case of her/his approval.</td>
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<tr>
<td>10. Discuss prevention and risk reduction measures that can prevent transmitting the infection to others and that prevent further exposure of the client to other subtypes of the HIV virus.</td>
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<tr>
<td>11. Supply prevention material such as condoms and sterile injection equipment</td>
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<tr>
<td>12. Encourage and offer referral for testing and counseling of partners and children.</td>
</tr>
<tr>
<td>13. Assess the risk of violence or suicide and discuss possible steps to ensure the physical safety of patients, particularly women.</td>
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<tr>
<td>14. Arrange a specific date and time for follow-up visits or referrals for treatment, care, counseling, support and other services as appropriate (e.g. tuberculosis screening and treatment, prophylaxis for opportunistic infections, STI treatment, family planning, antenatal care, opioid substitution therapy, and access to sterile needles and syringes).</td>
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**Counseling** should be conducted with the objective of maximizing the health and well being of individuals. Counseling should include the following and be provided in a suitable environment.

01. **Listening and Exploring:** In this, the counselor establishes rapport, gains client’s trust, and defines roles, boundaries and needs of the client. Adequate time and attention should be provided to the client and the client should be encouraged to ask questions.
02. **Understanding**: In this, the counselor develops insight into client’s problem and deals with his intense feelings through positive regard, empathy, interpretation and probing. Be familiar with local terms that the client could use. Ensure the client understands information printed on the consent form.

03. **Problem solving**: In this, the counselor helps the client generate and evaluate possible solutions to problems, encourages him/her and gives feedback on results of client’s action. The goal is to empower the client to reach a stage of solving problems associated with his/her life-stresses. Do not give advise to the client but give relevant information.

04. **Termination**: In this, the counselor brings an end to the counseling process without leaving the client in an uncomfortable state. S/he achieves this by giving feedback, reviewing, summarizing and planning for follow-ups. Always encourage follow-up and encourage client to come back as soon as possible.

05. **Environment for HIV Counseling**
   - Space used for counseling sessions should provide privacy and the environment should be non-threatening and non-stigmatizing.
   - The same counselor should provide pre-test, post-test and follow up counseling to the client.
   - Check the source of referral—is it from within the hospital or health center, NGO, private practitioners, from TB, or any other source.

The option to be tested for HIV is explained to the client through a process of HIV pre-test counseling. Client-specific information about personal risk, details about HIV transmission, modalities for prevention, HIV testing procedures, their limitations and the interpretation, as well as systems and structures for psychosocial support are discussed. Legal implications and disclosure obligations are also discussed. Informed consent to HIV testing should be obtained from the client in writing, on a standardized consent form, prior to proceeding for HIV testing. Access to HIV testing and counseling services should be available to children and young people under the age of 18 years also. Consent of minors below age 18 should be sought from responsible adults, that is, parents and guardians.

Keeping confidential any information provided by a client is crucial for promoting trust. It ensures that all people at risk of HIV infection feel at ease while seeking HIV testing and counseling services to determine their HIV status, and do not anticipate stigma and discrimination. While a breach of confidentiality may be unintentional, nevertheless, the effect of a breach of confidentiality can be serious and may have an immediate fall out in that the client begins to encounter stigma and discrimination. A deliberate breach of confidentiality is unethical and should possible lead to disciplinary action against the concerned staff.

6. **Managing clients’ emotional responses**
01. **Crying:** If the client breaks down and starts crying, it is important to let him/her cry. Give him/her space to ventilate these feelings. Offering him/her tissues is a way of telling it is okay to cry. Comment on the process, ‘this must be difficult for you, would you like to talk about it? Would you like to tell me what is making you cry?’

02. **Anger:** The client might start swearing or exhibit outbursts of anger. Do not panic, stay calm and give the client space to express feelings. Acknowledge that these feelings are normal and let him/her talk about what it is making him/her angry.

03. **No response:** This could be due to shock or denial or helplessness. Check that the client understands that result. Be on the alert for suicidal thoughts.

04. **Denial:** This could be verbal or non verbal. Counselor should acknowledge client’s difficulty in accepting the information. Let them talk about their feelings.

7. **Definitions**

01. **Sensitivity:** Is the ability of the assay under evaluation to detect correctly sera that contain antibody to HIV (reference assays positive). Thus sensitivity is the number of true positive sera identified by the assay under evaluation as positive (a), divided by the number of sera identified by the reference assays as positive (a+c), expressed as a percentage.

02. **Specificity:** Is the ability of the assay under evaluation to detect correctly sera that do not contain antibody to HIV (reference assays negative). Thus specificity is the number of true negative sera identified by the assay under evaluation as negative (d), divided by the number of sera identified by the reference assays as negative (b+d), expressed as a percentage.

03. **Positive Predictive Value (PPV)** is the probability that when a test is reactive, it means truly that the specimen contains HIV antibodies; i.e. it is the probability that it is not a false positive. Negative Predictive Value (NPV) is the probability that when a test is negative, it means truly that the specimen does not contain HIV antibodies. PPV and NPV depend on the sensitivity and specificity of the assay and on the HIV prevalence in the tested population.

04. **False negative.** A false negative result reports that the sample is not HIV infected when in fact it is infected. Selecting test kits with high sensitivity reducing the likelihood of false negative tests. When assays are highly sensitive, the most common reason for a false negative HIV antibody test result is that the patient is recently infected with HIV and is currently in the window period. Therefore accurate HIV risk assessment during the period must be undertaken.

05. **False positive results.** A false positive test result is a reactive specimen which in reality does not contain HIV antibodies. Currently available HIV antibody tests are highly specific and false positive rates are low. All HIV testing
strategies require repeated HIV antibody assays to be undertaken in order to increase the PPV. A false positive on one assay is unlikely to also test positive on the second assay. Potential reasons for false positives include technical error, serological cross reactivity, repeat thawing and freezing of sample.

06. **Linked-anonymous testing.** The blood samples sent for HIV testing have an identifier on it, such as a PID number or name which links the sample to the individual client. To ensure maximum confidentiality for clients, samples sent for HIV testing should not be identified with a name bit with some other unique identifier such that laboratory scientists and other people with access to laboratory records will not be able to identify the client. Sometimes HIV test request forms will have sequential numbers printed on them whereby the laboratory gets copies of the request only with a number and the Center retains copies with the number and client information. No names or other identifiers from the client are recorded. The client receives a unique number, in no way linked to any medical records that matches the number places on the blood sample sent to the laboratory. The result from the laboratory for the specific number is reported back to the clinic/counseling site. The individual must come to the clinic/site with the correct number to be informed of the result. In this procedure, no record is kept of the clients who provided blood for the samples and there is no way to find the client if he or she does not return for the results.

07. **Qualifications for HIV testing.** The minimal requirement for approval to perform HIV testing is basic training on drawing a pin prick blood sample. In order to qualify for testing, staff should undergo a standardized training course on the testing procedures and these guidelines.
Annex 7. Standard Operating Procedures for HIV Care Centers, Afghanistan

1. Adhering to universal precautions
2. Blood collection site
3. Client Satisfaction Monitoring.
4. Client’s initial visit
5. Counseling rooms
6. Demand Generation for HIV testing and counseling Services
7. DIP (Digital Identifier of Patient) Number
8. IEC material
9. Linkages and Referral
10. Location, setup and basic infrastructure
11. Medical Officer’s room
13. Outreach activities
14. Post exposure prophylaxis [PEP]
15. Prevention Material
16. Registers to be maintained for HIV testing and counseling
17. Role and Responsibilities of HIV Counselor
18. Roles and Responsibility of Medical Officer
19. Staff Requirements
20. Standards of Care
21. Waiting Area

1. Adhering to universal precautions. Staff working in HIV should handle all biological specimens with precaution. The standard procedure for preventing occupational hazard is the implementation and adoption of universal precautions to minimize the exposure of health care staff to blood and body fluids of patients. Staff who handle client’s biological samples should adhere to the following:
   01. Maintain a source of clean water
   02. Practice routine hand washing before and after any contact with blood samples
   03. Safe handling and disposal of sharp instruments should be planned before beginning a procedure
   04. Use sterilized/disposable lancets, needles and syringes for drawing blood. Discard disposable all sharp material in a puncture resistant container after disinfection with bleach solutions

2. Blood collection site
   Blood samples should be taken in a safe and clean environment, such as the counseling room. Suggested equipment at blood collection sites:
   01. Rapid test kits (3 types)
   02. Cotton swabs
   03. Cleaning materials such as spirit/antiseptic lotion
   04. Bleach solution
05. Sharp containers
06. Gloves, laboratory coat/plastic apron
07. Sink and soap
08. Color coded disposal mechanisms and equipment during needle destroyer
09. PEP [Post exposure prophylaxis] Guidelines

3. Client Satisfaction Monitoring.
   - Periodic ‘Client Satisfaction Survey’ [suggested] Periodic evaluation of client satisfaction ensures that HIV testing and counseling services meet the client needs. These evaluations can provide important feedback for operations. The client satisfaction evaluations can be conducted over 1-2 weeks, four times a year. Evaluations should begin once a HIV testing and counseling health center has been operating for at least 3 months.

   - Periodic counselor and laboratory assistance satisfaction survey [suggested]
     To complement monitoring and evaluation NACP should undertake periodical assessment of functioning of laboratory technicians and counselors so as to improve operations and determine further training needs and development of services

   - Client suggestion box. Client voluntary suggestions may provide valuable feedback on the operations HIV testing and counseling and on improvements required. Suggestions should be regularly reviewed by the staff.

4. Client’s initial visit At any point during a visit, the client may choose to consult a medical officer if he/she wishes.
   Step 1. Client follows signboards, enters site and is seated in the waiting area
   Step 2. Counselor calls client, enters client register, assigns DIP [Digit for Identification of Patient] and conducts pre-test counseling.

   Step 3. Decision to test for HIV
   01. Client does not consent: leaves
   02. Client agrees to undergo an HIV test and gives informed consent. Client is given HIV parallel rapid tests.
   03. If negative, client receives post-test counseling.
   04. If positive, client receives post test counseling, including follow up and referral.
   Step 4. Client may leave

5. Counseling rooms. These should be designed to make the atmosphere as relaxing as possible. Two separate rooms for counseling to be located near the waiting area and blood collection site. These rooms should offer privacy to create an appropriate counseling environment. Suggested materials in counseling rooms:
   - Chairs, desks with lockable drawers or filing cabinets
   - Registers and forms (TB referral, etc)
   - Counseling materials
     01. Counseling guidelines with checklist
02. Free condoms  
03. Pre and Post test counseling forms  
04. Informed consent form in Dari/Pashto  
05. Referral directory/referral cards  
06. Visual aids: Flip charts, posters for demonstration  
07. Model for condom demonstration on correct use

6. Demand Generation for HIV testing and counseling Services. Information about HIV testing and counseling services such as location and opening timings, should be made widely available to enhance access to the new service. This is critical and should be done through various channels including IEC and outreach initiatives, otherwise uptake of the service will be limited. The officer in charge will be responsible for planning the demand generation component of the service.

7. DIP (digital identifier of patient) Number. The client should be assigned a DIP number, and the name, address and DIP number of the client are kept with the counselor in the client register. Other records will show only the DIP number without the client’s name.

8. IEC material. At least one brochure in the local language on HIV testing and counseling services available, timing etc is suggested to be developed and copies shared at the various referral linkages sites suggested in the previous section. Information on the HIV testing and counseling health center can also be done through posters, pamphlets, flyers, advertisements on local TV channels, newspapers etc. The MOPH and local NGOs, CBOs would jointly undertake this. IEC material should be accompanied with prevention material, including condoms, sterile injection equipment and other harm reduction services.

   - **TB Referral.** In the event that a client has been coughing for at least three weeks (as revealed through counseling or medical history, the client should be referred to the most accessible TB screening point. A form is provided for this below.
   - **STI/dermatology clinics.** Sexually transmitted infections (STIs) and HIV epidemiologically are behaviorally linked. The presence of STIs, characterized by genital ulcers and discharge, enhances the chance of HIV infection manifold. STI clinics are established in Maiwand and other public sector hospitals in Kabul, as well as NGO clinics, such as Marie Stopes clinics, in the country. HIV counselors should have accurate information about STI clinics and strong referral linkages between STI clinics and HIV testing and counseling health centers would be useful to establish.
   - **NGOs working with most at risk and vulnerable populations.** In the event that a client wishes to know where they can obtain more information and support, they should be referred to local NGOs which provide HIV information and education in their programmes.
• **A referral directory** should be developed by the center to include the following information about other services including targeted at vulnerable populations such as:
  01. Name of the provider and agency
  02. Range of services provided
  03. Target populations
  04. Service areas
  05. Contact names, phone number, street addresses
  06. Hours of operation

• **A referral card** should be given to clients. The card contains ‘who refers’ and ‘whom’ indicating name of referral center, address and contact number. A record of referrals for each client and the outcome needs to be maintained. See below for TB referral form.

• **Post-test Service In/Drop-in center.** Some HIV testing and counseling clients may need on-going support from their counselors. These clients may be invited to join an on-site support service or referred to one offered by an accessible NGO. Services provided to members of drop-in centers may include:
  01. On-going counseling and group therapy
  02. Education through lectures and drama, music and dance on HIV and other topics that promote behavior change and positive living
  03. Nutrition counseling
  04. Medical treatment for minor ailments
  05. Recreation facilities such as screening a popular movie once a month
  06. Harm reduction and drug treatment services for IDUs

10. **Location, setup and basic infrastructure.** HIV testing and counseling services should be easy for clients to locate. It may have signboards and symbols for non-literate clients. It should be easily accessible to the clients and non-stigmatizing in terms of name that should be easy to understand in Dari/Pashtu. The center will provide a walk-in service and no appointment will be required. A basic set-up of a one-stop site for HIV testing and counseling includes about 5 rooms: a) separate waiting areas or reception rooms for male and females, b) counselor rooms for clients where HIV rapid tests are conducted and condoms are discussed and distributed, c) medical officer.

11. **Medical Officer’s room.** A medical officer may provide complete health checkup and other consultation to the clients besides HIV related services. This would be useful and also act as a motivation to visit the HIV testing and counseling center. Suggested materials in the medical officer’s room are thus suggested to also include for health check such as B.P instrument, weighing machine, besides condoms and others.

12. **Monthly client monitoring.** The officer in charge should submit monthly progress reports to the provincial HMIS with copies to NACP in the given formats.

   **Number of clients for pre-test counseling**
01. No. of voluntary clients for pretest counseling
02. No of referred clients from within hospitals
03. Total number of clients in pretest counseling per month

Number of clients consent to HIV testing
01. No. of voluntary clients consent to HIV testing
02. No of referred clients from the hospitals consent to testing

Post test counseling
01. No. of voluntary client pick up test result
02. Total number of clients who pick up test result

Follow up counseling
01. No of clients for follow up counseling [after post test counseling]

Referrals
01. Number of clients referred from and to TB
02. Number of clients referred from and to NGOs
03. Number of clients referred from and to STI clinics
04. Number of clients referred from and to hospitals
05. Number of clients who bought their partners for counseling

13. Outreach activities. Community outreach activities strongly influence HIV testing and counseling service utilization. Counselors and staff would give health talks to sensitize and inform hospital staff, schools, colleges, NGOs and outreach workers from different CBOs and others about HIV services. Outreach activities should also involve community workers and peer counselors for creating demand for HIV testing and counseling services. The counselors will also organize group-counseling sessions. Peer educators will be selected as appropriate for enhanced outreach activities. This initiative will also link with other MOPH advocacy initiatives with religious leaders, Ministry of education and others. Special IEC efforts will be made for reaching vulnerable population groups as well as women and adolescents/young people.

14. Post exposure prophylaxis [PEP]. It is important to ensure that all staff are aware of the PEP procedures, that PEP kits are available and that contact information of PEP focal point is known. Needle stick injuries are to be treated as medical emergencies.

In order to protect or reduce transmission of HIV through accidental needle stick injuries, the following practices are essential:

01. No recapping of needles
02. No bending/breaking of needles by hand
03. Use of puncture resistant containers
04. Use needle shredder/destroyer
05. Do not leave needles on trolleys or beds
06. Do not pass sharp instruments by hand
07. Wear gloves routinely and discard them after use with each client to prevent contact with infected blood
08. Wear laboratory coats routinely
09. Adhere to disinfection and sterilization standards
10. Re-usable supplies and equipment should be disinfected by sterilization or washing with soap and bleach solution

In case of exposure to HIV, the following measures should be taken immediately:
01. Do not put cut pricked finger in mouth
02. Wash injury with soap and water immediately
03. No evidence that use of antiseptic or expressing fluid by squeezing would further reduces HIV transmission, however, they are not contraindicated
04. Contact PEP focal point immediately

15. Prevention material includes condoms, sterile injection equipment and other harm reduction services. These should be provided during pre and post test counseling.

16. Registers to be maintained for HIV testing and counseling
01. Client register: Record of clients to be maintained by counselors [Serial no./name/age/sex/address/identification marks/PID]
02. Follow up and referral register: Record of counseling and referrals maintained by counselor [SL.No/PID/date of pretest/date of post test [assigned/actual]/HIV test result/date of follow up/referrals to/outcome of referrals/disclosure to/spouse counseling-testing/comments/signature of initiator
03. Condom register: Record of condoms distributed. Maintained by counselors [sl.no./date/purpose of use/no. received/no issued/balance/signature]
04. Test result register: Record of clients test results maintained by laboratory technicians [SL.No./PID/client consented for HIV test/HIV test results/Authorized signatory/result of test 1/other test result 2/other test result 3
05. HIV Diagnostic Kit stock register: Record of kits used for HIV testing maintained by in charge [Date / item/ receipt [quantity] /Issue/Balance/Signature/remarks [mfg.date, expiry date, batch/lot no. etc]

17. Role and Responsibilities of HIV Counselor. Professionally trained counselors will be employed to conduct HIV counseling. The counselors would have undergone training in HIV counseling. However, health professionals including those in mental health who have undergone training can provide counseling in cases where professional counselors are not available. The HIV counselor will be able to:
01. Assign PID number to clients.
02. Fill in counseling forms at the end of each session.
03. Maintain counseling records [forms] and clients counseling files and keep under lock and key.
04. Establish linkages and update the referral directory.
05. Establish linkages with HIV prevention and other support services in the community.
06. Maintain strict confidentiality of client information.
07. Maintain respectful and professional attitude towards clients.
08. Ensure that clients may return to the same counselor for HIV test results.
09. Keep up to date with the evolving needs of clients in terms of information and developments in HIV.
10. Participate in counseling supervision sessions and case discussions.

11. Be sensitive to the needs of the clients, especially women, young people and people from marginalized groups.

18. **Roles and Responsibility of Medical Officer.** The Medical Officer should be trained in the principles of HIV case management, in diagnosis of opportunistic infections and should understand the concept of HIV counseling. Medical officers should be sensitized in interacting with HIV positive people in a sensitive non-judgmental manner. The medical officer assigned will be able to:

01. Examine clients and refer clients to other health services if needed.
02. Provide basic information about HIV, symptoms, modes or transmission, treatment options.
03. Prescribe drugs for opportunistic infections, STIs others according to national drug policy.
04. Refer clients to an HIV counselor to explore risk behavior.
05. Address a client’s immediate questions and concerns in a sensitive manner.
06. Maintain respectful and professional attitude with clients.
07. Maintain strict confidentiality of client information.
08. Establish linkages with different institutions, NGOs.
09. Follow universal precautions.
10. Follow PEP guidelines and policies in Afghanistan.
11. Not be judgmental.
12. Not provide counseling unless specially trained.
13. Not routinely screen hospital patients for HIV infection.

19. **Staff Requirements.** Depending on resource availability and number of clients, the core staff would include:

01. Medical Officer
02. Two trained counselors, one male and one female, or ideally as per client load per counselor 8-10 counseling sessions per day also trained to conduct rapid tests.
03. Other optional staff could be:
04. Peer counselors from client groups
05. Support and cleaning staff
06. Dietician, receptionist, book keeper/accounting

20. **Standards of Care.** All staff, counselors, laboratory technicians and medical officers are accountable to the client and the public health system for the services provided. They need to meticulously document and file client information to ensure confidentiality and be responsible for the client’s well being by following standard guidelines and procedures.

01. Be sensitive and non-judgmental.
02. Hold regular meetings with other staff.
03. Network with NGOs, provincial health departments and administration to advocate for the HIV services.
04. Supervise administration and accounts.
05. Ensure adherence to guidelines in all aspects of HIV testing and counseling.
06. Assure maintenance of confidentiality of client information.
07. Assure completeness of counseling forms.
08. Conduct staff appraisals and feedback.
09. Facilitate professional supervision and networking of counselors.
10. Develop procedures for HIV testing and counseling operations.
11. Be present during specific hours.
12. Be responsive to client feedback and complaints.
13. Identify and develop networks with NGOs and social service organizations to facilitate referrals and care and support.
14. Establish system such as drop in centers to provide space for PLHIV to meet on regular basis.
15. Establish systems/mechanisms to ensure that program monitoring and evaluation of services is appropriately conducted.
16. Ensure sufficient supply of condoms.
17. Ensure that monthly data reports, progress and financial reports are prepared and submitted in a timely manner to the provincial HMIS with copies to NACP.

21. Waiting Area. The waiting area close to the counseling and blood collection sites should be well lit and have sufficient seating space for clients. The suggested materials in the waiting area:
   01. Books, posters and IEC material should be at hand including those on HIV, TB, Malaria, addictions, STI, family planning and antenatal care
   02. Information on HIV testing and counseling services pasted on the wall to orient waiting clients
   03. Condom box
   04. Client suggestion box [for feedback and complaints]
   05. Clean drinking water