December 01, 2008

Administrative Order
No. __________

**SUBJECT:** **Guidelines in the Conduct of HIV Counseling and Testing at All Levels of Health Care.**

## I. Introduction and Rationale

The HIV antibody testing plays an important role in the prevention and control of epidemic in any given country. Its usage includes diagnosis and treatment, surveillance purposes to monitor progress of infection among populations identified to be exposed to the virus, and ensuring safety to blood supplies.

As HIV is a still a highly stigmatized infection, utmost confidentiality should be observed. Complementing HIV testing with counseling is a proven effective intervention enabling individual to know their HIV status, deal with it, and change behaviours towards safer sex practices. HIV Counseling and testing (HCT) facilities should provide continuum services from prevention, treatment and care. Counseling and HIV testing provides people the opportunities to assess their vulnerabilities and know how to protect themselves in the future. It also facilitates access to treatment available in the country.

HIV counseling and testing is fundamental in the protection of public health. It equips individual with right information, approaches on lifestyle modification, improved health-seeking behavior, and risk reduction strategies such that he or she may protect his or herself, significant others and the community as a whole from the undermining effects of HIV and AIDS.

In 2006, Family Health International with assistance from USAID conducted Rapid Appraisal and Review on HCT in the country. While the findings showed promising areas for HCT upscale, gaps were identified including strategies formulation, issues on blood safety, social marketing, quality standards, monitoring and evaluation systems, etc.

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## II. Scope and Limitations

This guideline is intended for health program coordinators and STI and HIV service providers in HIV clinics and/or testing laboratories, whether STI and HIV are a free-standing service or integrated into other health programs including, but not limited to Maternal, Child Health and Nutrition, Family Planning, and Reproductive Health, and in all facilities/settings where HIV testing is conducted whether for diagnostic *(in and outpatient care, community-based interventions and outreach programmes)*, surveillance and blood safety purposes.

## III. Objectives

1. To provide guidelines for HCT implementation at all levels of health care
2. To ensure that HIV-infected persons and those who have risk to HIV will have access to HIV counseling and antibody testing
3. To establish a key entry point to the continuum of prevention, treatment, and care of HIV and AIDS

## IV. Definition of Terms

1. **Client-initiated HIV testing and counselling (CICT) -** involves individuals actively seeking HIV testing and counselling in a facility that offers HIV counselling and testing services. Individual risk assessment and management by counsellors, addressing issues such as the desirability and implications of taking an HIV test and the development of individual risk reduction strategies are done by the trained counsellor. This can be conducted in a wide variety of settings including health facilities, stand-alone facilities outside health institutions and through mobile services.
2. **Provider – Initiated Counseling and Testing (PICT) –** refers to HIV testing and counselling which is recommended by clinicians and other trained health care providers to patients/clients attending health care facilities as a standard component of medical care. This is done to enable 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.
3. **Voluntary HIV Counseling and Testing (VCT)–** refers to either CICT or PICT as both strategies entails the voluntary nature of HIV testing with the client/patient right to decline.
4. **Mandatory HIV screening –** refers to the non-voluntary and compulsory nature of HIV screening among blood units and blood products for transfusion, for procedures involving transfer of bodily fluids or body parts, such as corneal grafts and organ transplant as described in the RA 8504. Mandatory testing of individuals on public

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health grounds are punishable under the said law.

5. **Integrated HIV Behavioural and Serologic Surveillance** (IHBSS) – the systematic collection, analysis and interpretation of health data pertaining to HIV and AIDS being conducted by the National Epidemiology Center (NEC) in collaboration with the local government units (LGU) and other partner agencies which serves as a warning system on increase in HIV seroprevalence, identify risk practices and help policy-makers to arrive informed decision.
6. **Pre-Donation Counseling** – A process in blood donor selection wherein donors are informed about health conditions or risk behavior that would make them unsuitable to donate blood. The counseling offers the donor an opportunity to self-exclude or self-defer and to avail of confidential unit exclusion. The donor's informed consent to blood donation and to the blood testing (for TTIs) is obtained during the counseling.
7. **Positive Community** – refers to support groups/organizations comprised of People Living with HIV actively involved in prevention and/or care and support programmes.
8. **Special Studies** – HIV prevalence surveys among special populations being conducted by other organizations such as academe for the purpose of research and /or research based intervention programmes.
9. **RA 8504 –** otherwise known as the Philippine National AIDS Prevention and Control Act of 1998. An act promulgating policies and prescribing measures for the prevention and Control of HIV and AIDS in the country, instituting a nationwide HIV AIDS information and educational program, establishing a comprehensive HIV and AIDS monitoring system, strengthening the Philippine National AIDS Council, and for other purposes.
10. **Legal Guardian – c/o Doc Susan**
11. **List of Acronyms:**

**BHFS** – Bureau of Health Facilties and Services
**BSF** – Blood Service Facilities
**IDO** – Infectious Diseases Office
**IHBSS** – Integrated HIV Behavioural and Serologic Surveillance System
**CHD** – Center for Health Development
**LGU** – Local Government Unit
**NASPCP** – National HIV AIDS/STI Prevention and Control Program
**NEC** – National Epidemiology Center
**NGO** – Non – Government Organizations
**NVBSP** – National Voluntary Blood Services Program
**PNAC –** Philippine National AIDS Council
**PBCC** – Philippine Blood Coordinating Council
**SLH** – San Lazaro Hospital



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**SACCL** – STD/AIDS Central Cooperative Laboratory
**STI** – Sexually Transmitted Infection
**SHC** – Social Hygiene Clinics
**TTI** – Transfusion – Transmissible Infections
**VCT** – Voluntary Confidential Counseling and Testing
**PICT** – Provider – Initiated Counseling and Testing

## VI. Policy Statements

1. This guideline emphasizes synergy of medical ethics and clinical, public health and human rights objectives.
   A. Human – Immunodeficiency Virus (HIV) testing shall be conducted in an informed and voluntary manner as people need to seek and receive HIV prevention, treatment, care and support services; to prevent the transmission of HIV and to be protected from HIV-related stigma, discrimination and violence;
   B. Children's rights to participate in decisions affecting their lives shall be promoted;
   C. Treatment and prevention outcomes shall be improved;
   D. Rights to autonomy, privacy and confidentiality shall be promoted and observed.
   E. Roles and responsibilities of key partners in ensuring access to HIV related testing, counselling and related interventions shall be defined and elaborated.
   F. Greater involvement of PLHIV and AIDS (GIPA) is promoted and upheld.
2. To ensure sound implementation of this guideline, a collaborative approach among HIV stakeholders is essential:
   A. Proper coordination between NASPCP, NEC, NVBSP, BHFS and DoH-designated Treatment Hubs
   B. Optimal participation and consultation with NGOs, community representatives, public and private facilities, and development partners

## VII. Implementing Guidelines

### 1. General Policies on VCT:

A. VCT Services *(See Annex I)* shall be provided in a space with privacy and confidentiality.
B. Pre-test counseling can be conducted in individual or group settings.
C. Clients should be encouraged to bring confidantes during post-test counseling sessions.

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D. It is highly recommended that the same counselor shall provide the pre and post test counseling and provision of follow-up counseling sessions with the client in a secured setting.
E. Pre and post - test counseling of minors shall depend on the maturity of the child where responsible parents or legal guardian maybe involved.
F. Ensure that the client understands information printed on the consent form.
G. The counselor should give necessary and correct information and not give advice to the client. The clients make decisions for themselves.
H. Always encourage follow-up.
I. Always have a network of referral for appropriate services.
J. All trained HCT counselors should have basic knowledge on voluntary blood donation.

**2. General Policies on PICT**

A. The basic conditions of confidentiality, consent and counseling shall be followed.
B. Pre-test counseling may be provided thru basic information giving to help the patient decide whether to accept HIV testing *(See Annex II)*.
C. Patients with signs and symptoms that are consistent with HIV-related disease or AIDS shall be offered Diagnostic HIV Testing.
D. HIV testing shall be offered and done to all children borne to HIV infected mothers (or with possible exposure to MTCT) as consented by parent or legal guardian.
E. HIV testing should be offered to all the following:
    1. Clients assessed in an STI clinic or elsewhere for an STI
    2. Pregnant women with one or more of the following HIV risks:
        i. *multiple sex partner*
        ii. *injecting drug user*
        iii. *history of STI including diagnosis of Syphilis*
        iv. *those with husbands or partners with multiple sex partners or IDU practices*
    3. People in prostitution and those involved in unprotected multiple sexual relationships, males engaging in sex with other males, and injecting drug users seen in clinical and community based health and outreach services settings.
    4. Diagnosed TB patients following Title AO 2008-0022
F. Post-test counseling services shall be provided to all clients tested by trained personnel *(See Annex III)*.

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G. Explicit referral mechanisms shall be made in place by facilities for post-test counseling services emphasizing prevention, for all those being tested, and to medical and psychosocial support, for those testing positive.

**3. General Policies on HIV Testing**

A. HIV testing shall only be done with signed informed consent of the patient or the legal guardian of minors. For blood donors, informed consent shall be incorporated in the consent to donate blood.
B. HIV antibody testing should only be carried out by an HIV Proficient Medical Technologist/Physician duly licensed by NRL - SACCL.
C. Confirmatory tests for HIV reactive blood units and patients shall be done at RITM-NRL and NRL-SACCL, respectively *(See Annex IV).*
D. If HIV testing is not available within the HCT facility, the clients' blood specimen shall be referred to the nearest DOH – recognized VCT facility for HIV antibody screening or to any DOH – accredited HIV testing laboratories with duly accomplished referral form.
E. HIV test results should be sent back to the referring center or released only to the counselors and not to the clients directly otherwise it will defeat the purpose of post-HIV test counseling.
F. All serum reactive for HIV antibody test should be sent to SACCL for confirmatory testing.

**4. HIV Testing in Other Scenarios**

A. IHBSS protocol shall be presented to and approved by the HIV Technical Advisory Group (TAG) prior to its conduct.
B. Special studies should be approved by the ethical review board of institutions and use HIVdiagnostic kits registered at BFAD or evaluated by the NRL. *(Annex III).*
C. Staff in BSF should understand that they are placing the blood supply at risk when they provide HIV test results. When free tests are offered, high risk individuals will seek to donate blood in order to gain access to testing. This places the blood supply at risk as many high risk individuals have engaged in recent transmission risk activities and may be within the window period for detection of HIV antibodies. Pre - donation counseling must be strengthened to ensure that potential blood donors with high risk behaviour will be referred to VCT.

## VIII. Recommended HCT Models at Different Levels of Care

1. Rural Health Units/Basic Emergency Obstetric and Newborn Care Facilties

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A. PICT maybe conducted provided its requirements are complied. Clients then should be referred to the nearest facility with CICT capacity.

2. Social Hygiene Clinics and Provincial Hospitals
   A. Both PICT and CICT should be available at this level of health care.
   B. HIV testing is strongly encouraged to be done at the same site.
3. DoH - Accredited Level IV Hospitals
   A. PICT shall be done in both in and out-patient departments.
   B. All walk-in clients and those who tested positive in PICT services shall be referred to the HIV and AIDS Core Team of the hospital.
4. DOH - Accredited Commercial HIV Testing Laboratories (free-standing and hospital-based)
   A. All walk-in clients requesting for HIV testing shall be provided with pre and post test counseling by the HIV proficient medical technologist in the laboratory.
5. DoH – Accredited OFW Clinics –
   A. There shall be mandatory pre and post - test education provision to all clients seen in this facility. Post-test counselling should be provided to those with HIV positive results
   B. These facilities shall have a clear and well-defined referral mechanism to DoH – recognized VCT facilities with CICT capacity.
6. Mobile VCCT services
   A. Outreach activities for very specific target population not otherwise accessing health services of RHU/SHC can be done by NGOs and private institutions in coordination with the Local Health Department.
   B. Organizers for mobile VCCT should coordinate/establish networking with the NRL-SACCL for scheduling of release of results of confirmatory test in cases where Western blot testing is necessary.
7. Blood Service Facility

a. During pre-donation counseling, donors with identified high risk behaviour shall be referred to VCCT.

**IX. Financing**

A. DoH Hospitals shall allot for procurement of HIV rapid test kits for HCT services as forecasted by the HACT Chairperson.
B. Cost-recovery for rapid test kits and/or counseling fees in DOH – recognized HCT facilities are not discouraged. However, these shall be minimal and socialized.
C. The NCDPC shall augment the HIV test kits of DoH – recognized HCT facilities using IDO funds.

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## X. Training and Capacity – Building

A. The National Center for Disease Prevention and Control shall develop a Training and Implementers' Manual on HCT six (6) months after the publication of this A.O.
B. Training of Trainors shall be institutionalized in the Training Departments of the Center for Health Development with the guidance of Health Human Resource Development Bureau in coordination with the NASPCP.
C. PICT shall be integrated into the existing capability-programmes of the RHUs including but not limited to MCHN, FP, RH and TB.
D. The San Lazaro Hospital – HIV AIDS Department with NASPCP-IDO-NCDPC will be the technical coordinators for HCT trainings.

## XI. Role of Partners

**A. NCDPC**
**B. NCHP**
**C. HHRDB**
**D. BHFS**
**E. NEC**
**F. NVBSP**
**G. PNAC**
**H. CHD**
**I. Treatment Hubs**
**J. LGU**
**K. Positive Community**
**L. NGO**
**M. Multi-lateral Agencies**

## XII. Quality Control and Assurance

A. All HIV test kits in HCT facilities shall be BFAD – registered or evaluated by NRL-SACCL.
B. The NRL-SACCL shall utilize the existing QA Programme required by the Bureau of Health Facilties and Services to ensure laboratory quality in HCT facilities.
C. HCT laboratories shall strictly adhere to internal quality control and assurance set by NRL-SACCL.
D. Under this guideline, the minimum set standards for a VCT facility are the following:

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1. At least one staff who successfully completed the competency-based training organized by DoH – NCDPC or its recognized training organizations;
2. One HIV proficient medical technologist trained by NRL-SACCL or its recognized training organizations;
3. Clear referral networking to care and support groups and DoH – Accredited HIV testing laboratories when testing is not available in the facility;
4. Participated in the External Quality and Assurance (EQAS) Programme of NRL – SACCL in the last 2 years at most

## XIII. MONITORING AND EVALUATION

A. Monitoring and evaluation planning should utilize existing mechanisms and tools of program reporting from HCT facilities to CHD NASPCP Coordinators.
B. Regular evaluations of health care provider performance and patient satisfaction should be done to improve the effectiveness, acceptability and quality of HIV testing and counselling services.
C. NGO and CSO shall also be tapped in doing joint M and E activities to ensure service quality and acceptability, including the maintenance of high ethical standards and human rights norms.

## X. SEPARABILITY/REPEALING CLAUSE

A. In the event that any section, paragraph, sentence, clause of this order is declared invalid for whatever reasons, other provision shall not be affected thereby.
B. These guidelines shall repeal and supersede all administrative orders and previous issuances inconsistent thereof.
C. Any breach in confidentiality shall be apprehended accordingly as stipulated in the Republic Act 8504 otherwise known as Philippine HIV and AIDS Prevention and Control Act of 1998.

## XI. EFFECTIVITY

This will take effect after date of signing.

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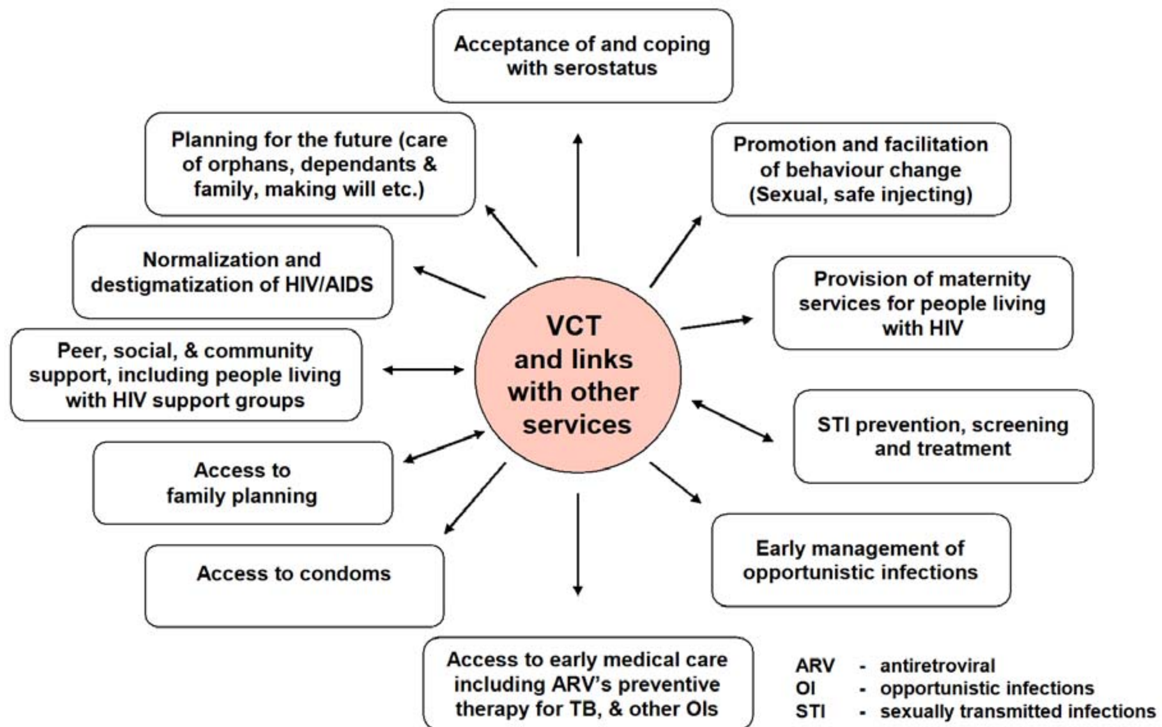
## Annex I. VCT linkage to continuum of HIV Prevention, Treatment and Care
*(adapted: VCT Trainor's Manual, WHO-SEARO, 2004)*

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**Annex II. Minimum Information Provided in PICT Settings** *(Guidance on Provider-Initiated HIV Testing and Counseling in Health Facilties, WHO – UNAIDS 2007)*

| Minimum information for informed consent |
|---|
| 1. The reasons why HIV testing and counselling is being recommended;<br>2. The clinical and prevention benefits of testing and the potential risks, such as discrimination, abandonment or violence;<br>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;<br>4. The fact that the test result will be treated confidentially and will not be shared with anyone other than heath care providers directly involved in providing services to the patient;<br>5. The fact that the patient has the right to decline the test and that testing will be performed unless the patient exercises that right;<br>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;<br>7. In the event of an HIV-positive test result, encouragement of disclosure to other persons who may be at risk of exposure to HIV;<br>8. An opportunity to ask the health care provider questions;<br>9. Patients should also be made aware of relevant laws in jurisdictions that mandate the disclosure of HIV status to sexual and/or drug injecting partners. |
| **Additional information for women who are or may become pregnant** |
| 1. The risks of transmitting HIV to the infant;<br>2. Measures that can be taken to reduce mother-to-child transmission, including antiretroviral prophylaxis and infant feeding counselling;<br>3. The benefits to infants of early diagnosis of HIV. |

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**Annex III. Post-test Counselling Services in both PICT and PICT** *(adapted from: Guidance on Provider-Initiated HIV Testing and Counseling in Health Facilties, WHO – UNAIDS 2007)*

| **Post-test counselling for HIV-negative persons** |
|---|
| Counselling for individuals with HIV-negative test results should include the following minimum information:<br>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;<br>2. Basic education on methods to prevent HIV transmission;<br>3. Provision of male and female condoms and guidance on their use;<br>4. The health care provider and the patient should then jointly assess whether the patient needs referral to more extensive post-test counselling session or additional prevention support, for example, through community -based services and VCT facilities with CICT capacity. |
| **Post-test counselling for HIV-positive persons** |
| The focus of post-test counselling 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. Health care providers should:<br>1. Inform the patient of the result simply and clearly, and give the patient time to consider it;<br>2. Ensure that the patient understands the result;<br>3. Allow the patient to ask questions;<br>4. Help the patient to cope with emotions arising from the test result;<br>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;<br>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;<br>7. Provide information on how to prevent transmission of HIV, including provision of male and female condoms and guidance on their use;<br>8. Provide information on other relevant preventive health measures such as good nutrition, use of co-trimoxazole and, in malarious areas, insecticide-treated bed nets;<br>9. Discuss possible disclosure of the result, when and how this may happen and to whom;<br>10. Encourage and offer referral for testing and counselling of partners and children;<br>11. Assess the risk of violence or suicide and discuss possible steps to ensure the physical safety of patients, particularly women;<br>12. Arrange for a specific date and time for follow-up visits or referrals for treatment, counseling, support and other services as appropriate (TB screening and treatment, antenatal care, access to sterile needles and syringes) |

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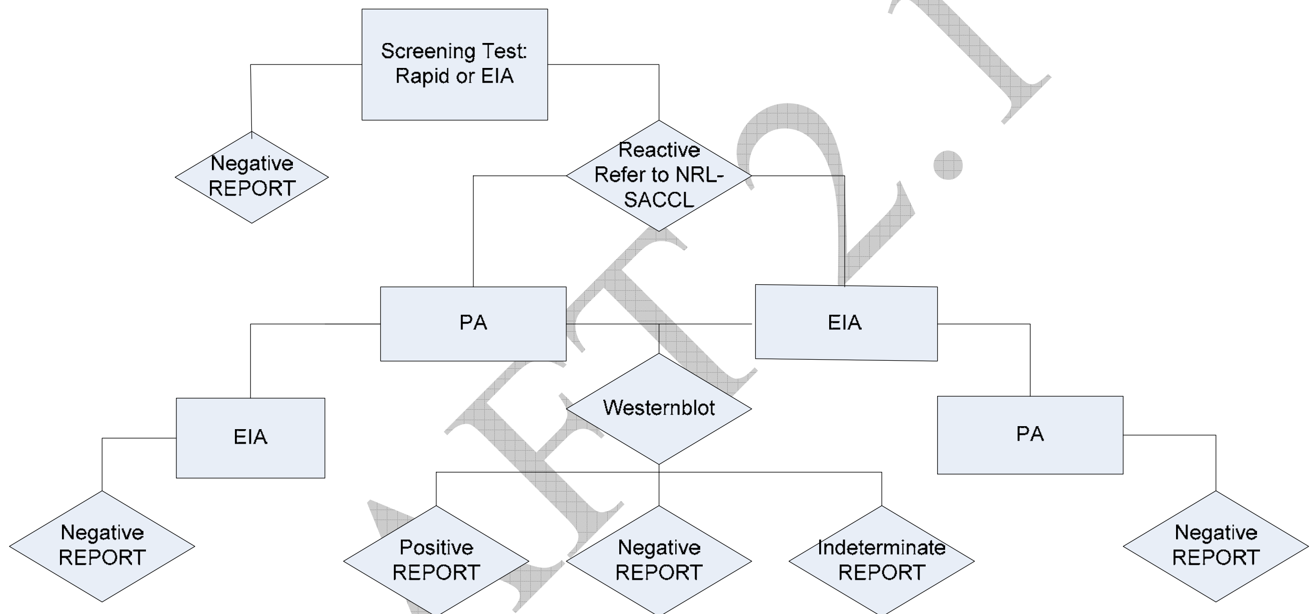
## Annex IV. Current HIV Diagnostic Testing Algorithm




a) Rapid HIV test kit with 99% specificity is used for the first screening process.
b) Samples that turn out to be non-reactive on the first screening test are considered “sero-negative” and the client is given a negative test report. No further testing is required
c) Samples that are sero-reactive after the first HIV screening test need to be retested using another HIV rapid test with different antigen and/or platform with sensitivity > 99%.
d) Samples found sero-reactive by all HIV screening test will be sent to the referral laboratory (SACCL) Western blot.
e) If the first and second serum yields an indeterminate result, the sample should be sent to SACCL – SLH for confirmation. If the result from the reference laboratory is also indeterminate, longer follow-up may be required (3,6 and 12 months). If the results remain indeterminate after 1 year,

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the person is considered to be HIV antibody negative. The client is given a negative test report.

f) Samples found 'sero-reactive' after the first HIV screening test but 'non reactive' in the subsequent HIV test (using different antigen / principles) are considered 'indeterminate'.
g) Indeterminate samples are declared 'non-reactive' for clients who have not been exposed to any risk of HIV infection. The client is given a negative test report.
h) Client should be advice to come back to the VCT unit after an estimated turn-around time.
i) The client is given HIV test report after conducting post-test counseling.

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