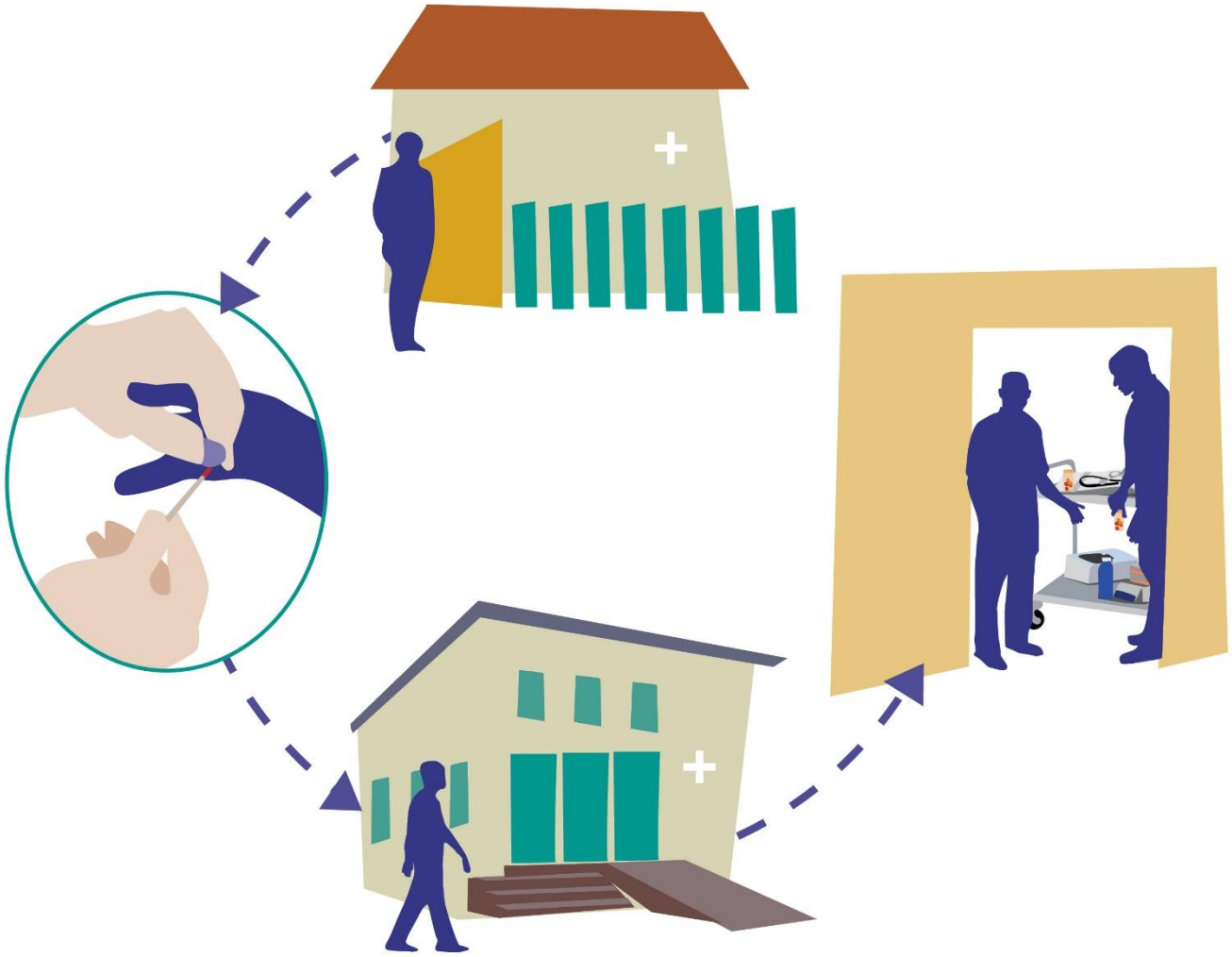

Linking HIV Testing and Counselling in Kenya

Standard Operating Procedures

July 2017

TR-17-190

USAID FROM THE AMERICAN PEOPLE

PEPFAR

MEASURE Evaluation PIMA

Linking HIV Testing and Counselling Standard Operating Procedures

July 2017

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ABBREVIATIONS

ART	antiretroviral treatment
CCC	comprehensive care centre
HTC	HIV testing and counselling
HTS	HIV testing services
LTC	linkage to care
PCR	polymerase chain reaction
PMTCT	prevention of mother-to-child transmission
SMS	short message service

EXECUTIVE SUMMARY

Background

In Kenya, HIV prevalence among adults ages 15–64 years decreased from a peak of 10.5 percent in 1995–1996 to 5.6 percent in 2012, and HIV prevalence among children ages 18 months to 14 years was estimated to be 0.9 percent in 2012 (KAIS, 2012). Between 2007 and 2013, new HIV infections in adults have decreased by only 7.5 percent, from 95,000 per year to 88,620 per year (NACC, 2013). How to significantly reduce new infections and promptly identify those who are HIV-positive and link them to HIV services, while scaling up treatment and care, is a major concern. Targeted HIV testing and counselling strategies have increased the detection rate of people with HIV, and those who test positive for the virus must have effective linkages from testing points to available care, with vigorous follow-up to ensure enrolment and retention in services.

The process of referral and linkage in Kenya varies among counties, with different tools, different investments, and markedly different methods for ensuring successful linkage. Linkage to care (LTC) practices depend on the implementing partners supporting HIV treatment programs within counties and the importance that the partners attach to this process as a performance indicator. Some factors recognized as barriers to effective linkage are stigma and discrimination against those with HIV, clients' lack of knowledge of the importance of access to services, lack of standard procedures for referring and linking clients, poor health system infrastructure, and lack of awareness by health workers of the need for longitudinal follow-up to ensure linkage to services.

Methods

MEASURE Evaluation PIMA conducted a baseline survey with the objective of mapping referral and linkage practices to identify the challenges associated with and barriers to effective systems in 18 health facilities in the following counties: Homabay, Kakamega, Machakos, Migori, Muranga, Nakuru, Nairobi, and Siaya. We selected these counties through a multistage sampling process. Data for the study drew primarily from desk studies of literature and reports. Quantitative data came from primary sources through a data extraction form, and qualitative data were collected through focus group discussions and key informant interviews using an interview guide. Process maps were drawn for observed practices. Triangulation of all data sources ensured accuracy. Graphs and charts summarized quantitative data, and qualitative data were transcribed and later analysed using the dominant themes.

Findings

Organization of the referral and linkage system for HIV services. All health facilities visited had some of form of referral and linkage system implemented for the wider health facility, including referrals for HIV services to ensure that all those identified as HIV-positive are linked to care and treatment services.

Although the facilities recognized the need to transmit information between the referring and the receiving points, they lacked effective feedback mechanisms to confirm linkage. Respondents proposed that linkages be verified using the unique client identifier, which indicates whether the client has enrolled in antiretroviral treatment (ART) services at the receiving facility.

Process mapping of LTC practices. The study mapped referral and linkage processes at each health facility. Four models emerged as the most common, with varied outcomes:

Model 1. This model uses a referral form at testing points to refer HIV-positive clients for services, including ART. Clients are escorted to the receiving site if it is in the same facility. If referred externally, the client takes a copy of the referral form, and the same information is relayed by the peer counsellor at the referring facility to another peer counsellor at the receiving facility, with the date that the client is expected to appear. Linkage is expected to happen within two weeks of the date of testing. If linkage does not occur, the client is tracked using phone details or the details of the client's physical location that are collected through the locator form, until the client is successfully linked or declared lost to follow-up, after three months. Linkage is confirmed by recording the client's unique identifier from enrolment at the ART clinic in the linkage register. A functional county referral directory indicates the contact person and phone number for the health facility within each county to which most external referrals are made. This model has an average 97 percent successful linkage rate in three months of testing.

Model 2. In this model, HIV-positive clients are identified at the various testing points and given a referral form by the HIV testing and counselling (HTC) counsellors, who also collect physical location details in a locator form. The client is then transferred to a special cadre of staff who serve as "linkage officers." These linkage officers help the client navigate the referral pathway. If the client chooses to enrol on-site, the linkage officer escorts him or her to the receiving point, where the client is enrolled in ART services and receives a unique identifier. If the client enrols externally, he or she is given the referral form with referral details, including the health facility they are being referred to, and the linkage officer at the referring facility communicates these details to the linkage officer at the receiving facility by phone. Linkage is expected to occur within a week. If linkage does not occur within this period, a peer counsellor or educator follows up with the client, either by phone or through physical visits to the residential address, until the client is either linked successfully or declared lost to follow-up, after three months. The linkage register is structured to enable longitudinal follow-up with scheduled tracking activities for those not linked to care. Successful linkage is confirmed by registering a client's unique identifier in the linkage register, indicating enrolment in ART services. The rate of successful referral and linkage within three months has improved from 17 percent to more than 75 percent over a period of six months since this model was implemented.

Model 3. In this model, HTC counsellors conduct HTC at various points within the health facility and escort all clients identified as HIV-positive to the comprehensive care centre (CCC) at the health facility. All clients are initially enrolled in the CCC. Clients are offered additional counselling, samples are collected for baseline investigation, cotrimoxazole preventive therapy is prescribed or issued, and the follow-up appointment is scheduled to occur after two weeks. The second visit includes a discussion of further treatment options and the client's preferences for site of access to care and treatment services. If the client elects to enrol onsite, the enrolment number is communicated to the HTC counsellor as a successful linkage, and standard of care services are offered with ongoing preparation for ART. If the client elects to access ART services elsewhere, a transfer letter is issued to the client with details of the HTC test and baseline investigations. For clients linking externally, the community health extension worker is followed up with, to ensure arrival at the referral health facility. This model has an average 80-percent successful linkage rate within three months of testing.

Model 4. Clients who are identified as HIV-positive, at various HIV testing points in the hospital, are handed over to linkage or tracking officers who escort them to the linkage desk at the CCC, where they

enrol in the linkage register. The clients then receive a basic package of services, including a nutritional assessment, psychosocial counselling, and Prevention with Positives.[1] Blood samples are drawn for baseline investigations. Repeat appointments are scheduled at two weeks, during which a preference of site for access to services is established. Those who wish to continue with treatment outside the primary facility receive transfer letters detailing results of the HTC and baseline investigations. Linkage at the external facility is confirmed through follow-up phone calls to the client. Linkage or tracking officers also refer clients and link them with other services they may require, such as reproductive health services, prevention of mother-to-child transmission, and tuberculosis and HIV co-treatment. This model had an average 94 percent successful linkage rate within three months of testing over a period of seven months.

Use of referral and linkage tools and guidelines. None of the six counties included in the survey had clearly defined guidelines, protocols, or tools to enable standard referral and linkage practices. Instead, the existing practice had grown out of the need to solve a persistent problem with HIV care and treatment services. The linkage process was known only to those who were directly involved in it. All the services increasingly used improvised registers, referral forms, and other documentation to capture essential information.

Monitoring and evaluation of the referral and linkage process. Routine reports were regularly prepared and submitted according to the reporting needs of partners. However, there were no standard tools for reporting to various agencies. The reporting process was driven primarily by the donor-funded partners supporting HIV services.

Recommendations

Based on the results of the baseline survey, MEASURE Evaluation PIMA recommends the following to improve referral and linkage practices in Kenya:

- Standardize the process of referrals and linkages with guidelines, protocols, and tools.
- Streamline communication between the source facility and the receiving facility for confirmation of referrals.
- Establish reporting standards.
- Use all available resources for effective referral and linkage processes.

[1]Prevention with Positives is a suite of interventions designed under the U.S. President's Emergency Plan for AIDS Relief to decrease rates of HIV transmission and increase quality of life for people living with HIV. https://www.pepfar.gov/documents/organization/93123.pdf

INTRODUCTION

Background

Failure to initiate timely HIV care after diagnosis is common (Mugglin, et al., 2012). CD4 cell criteria indicate that longer delays in linkage to HIV care are associated with greater likelihood of progression to AIDS. (Morse, 2005). In addition, people with undiagnosed HIV and HIV-positive people who are not in care pose a greater risk for ongoing HIV transmission (Hoots, et al., 2015). The Ministry of Health in Kenya recommends that 90 percent of all adults and adolescents identified as HIV-positive through HIV testing and counselling (HTC) be enrolled in HIV care as soon as possible, preferably on the day they test positive (NASCOP, 2016). In the 2012 Kenya AIDS Indicator Survey, almost half (46.9 percent) of the HIV-positive adults and adolescents surveyed were aware of their HIV status, and 79.4 percent of all those known to be HIV-positive self-reported LTC within three months.

According to the National AIDS and STI Control Programme (NASCOP), improving LTC is the most critical challenge facing an HIV response that seeks to achieve the "three ones"[2] and "90-90-90" strategies[3] (NASCOP, 2016). Confronting this challenge has become even more urgent with the robust scale-up of HIV testing services (HTS), including both static and mobile testing facilities, as part of the drive to improve the awareness of HIV status in the general population. In a study conducted in Atlanta, GA, USA, on the treatment of people recently diagnosed as HIV-positive, linkage rates from 2001–2003 varied in duration between those receiving passive referrals and those receiving active referrals (i.e., facilitated by a case manager) (Gardner, et al., 2005). In the study, only 60 percent of the HIV-positive people were confirmed as linked to care within six months of the date of diagnosis for passive referrals, compared to 78 percent for active referrals. When evaluated at the end of the 12 months of follow-up, only 49 percent of the passive referral group visited the clinic twice in the 12-month period, compared to 64 percent of the active referral group (adjusted relative ratio=1.41, p=0.006) (Gardner, et al., 2005).

Different implementers in Kenya have employed varying strategies to improve referral and linkage processes, including the use of mobile phone technology for follow-up to determine whether clients have been successfully linked to care. In some settings, service providers have escorted clients from HTC service points to areas where they can be quickly enrolled in and initiate appropriate therapy. The process has lacked standardization, and there is varied understanding of its practice, the use of tools, and the collection of data for evaluation of the outcomes attained. There is, therefore, a need to address LTC, starting with the definition of a clear referral framework and followed by the strengthening of referral and linkages through the training of healthcare workers to standardize its practice and the instituting of regular data collection to evaluate the processes and outcomes.

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[2] The Kenya AIDS Strategic Framework defines the three ones strategy as "geographical, population, and intervention prioritisation, feasibility, and sustainability for impact" (http://nacc.or.ke/kenya-aids-strategic-framework-kasf/).

[3] The Joint United Nations Programme on HIV/AIDS defines the 90-90-90 strategy as follows: by 2020, 90 percent of all those with HIV will have been diagnosed, 90 percent of those diagnosed will be on antiretroviral therapy (ART), and 90 percent of those on ART will be virally suppressed (http://www.unaids.org/en/resources/documents/2017/90-90-90).

Table 1 provides standard operational definitions for the terms used in the referral and linkage process.

Table 1. Operational definitions

Term	Definition
Referral	The process by which a client's needs are assessed and prioritized—The client is sent to an appropriate service or level of care where his or her health needs can be comprehensively managed.
Linkage	The process of engaging newly diagnosed HIV-positive clients in primary HIV care—Successful linkage is defined as LTC within two weeks of diagnosis.
Enrolment number	A client is registered in a health facility for follow-up with a unique client number for future reference and documentation.
Follow-up	The client has scheduled HIV care appointments with his or her healthcare provider.
Missed visit	The client failed to attend the next scheduled appointment.
Lost to follow-up	The client has not attended his or her first HIV clinic after having an HIV test in the past six months.
Client-initiated testing and counselling	The client is seeking and initiating the HTC service, either in the community or at a health facility, of his or her own volition.
Provider-initiated testing and counselling	A service provider offers HIV testing to clients within a health facility, regardless of the reason for the visit. It is offered with an "opt out" option for the client.
Home-based testing and counselling	The HTS provider goes to the home of a potential client and initiates HTS.
HTS	The client is offered a full range of services together with HIV testing: counselling (pretesting and posttesting); linkage to appropriate HIV prevention, care, and treatment services and other clinical support services; and coordination with laboratory services to support quality assurance and delivery of correct results.
Intra-facility referral and linkage	The client is referred for care within the testing facility departments (e.g., referred from the HTS room to facility CCC).
Inter-facility referral and linkage	The client is referred outside the testing facility for follow-up.

Objectives of the Standard Operating Procedures

The primary objective of establishing standard operating procedures for referral and linkage to HIV services is to enable the establishment of a harmonized and coordinated evidence-informed system for timely referral and linkage from HIV testing service points to enrolment in care within a period of two weeks.

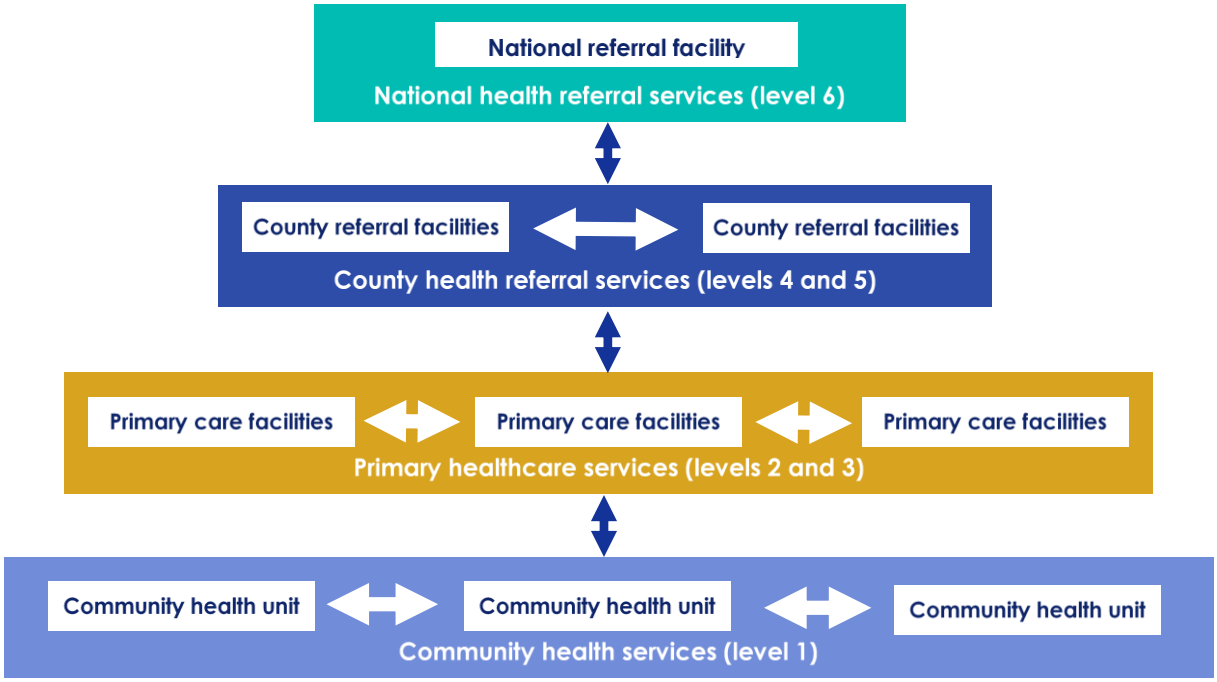
Justification

An effective HIV response calls for strengthening the link between identification of those with HIV and initiation of care. Strengthening this link is key to increasing uptake of care and treatment services, with the long-term goal of ensuring that 90 percent of all those identified as HIV-positive are enrolled in care and that appropriate clinical evaluation, baseline investigations, and initiation of treatment occur within a reasonable timeframe. Linking more of those who test positive for HIV to care will complement current efforts to scale up HTS for the segment of the population who are unaware of their HIV status and will expand access to HIV prevention, care, and treatment services.

HEALTH REFERRAL SYSTEMS FRAMEWORK IN KENYA

The Ministry of Health in Kenya established referral policy guidelines for the health sector that outline the relationships between the levels of healthcare service provision, thereby enabling a client to access different healthcare services from different places (Ministry of Health, 2014). As Figure 1 illustrates, the referral system interconnects the four tiers of the health system, clearly indicating the available capacity and type of service at each level.

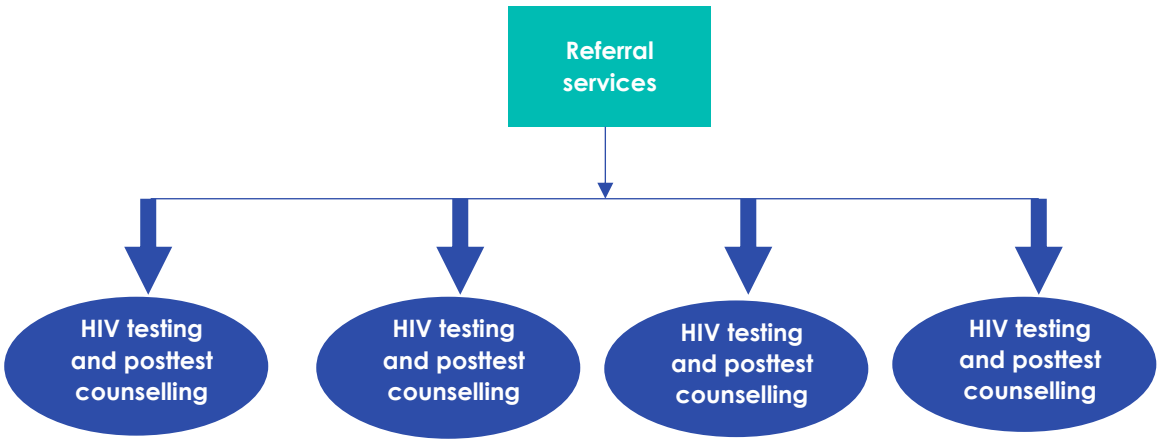
Figure 1. Referral and linkages among the levels of the healthcare system in Kenya



As shown in Figure 2, this framework enables four types of referrals:

- **Client movement.** A client seeks an appropriate level of care where his or her health needs, or the health needs of the next of kin, can be addressed in the most efficient and cost-effective way, given the choice of facilities available.
- **Expert movement.** Services that might not be available otherwise are offered to communities that need them, when they need them. Rather than moving clients to different levels of facilities, providers of special services come to the clients. Services can be provided in several ways, such as directly to clients, as outreach, as screening in a medical camp, or as surgeries in remote areas. Expert professionals move from higher levels to lower levels.
- **Specimen movement.** Laboratory specimens are moved to special facilities, usually for diagnostic purposes. Moving the specimen obviates the need to move the client in the health services system; refer to *National Guidelines for Laboratory Specimen Referral Networks* (Ministry of Health, 2012).
- **Client parameters movement.** Client information can be sent to appropriate levels of the health system for supportive diagnosis or management guidance. The scale-up of innovative information and communication technology in the health services, particularly in the context of e-health, will facilitate this form of referral.

Figure 2. Scope of referral services



Reasons for referral and linkage among health sectors are as follows:

- To seek expert opinion and report on the client's condition or specimen
- To procure additional or different services for the client
- To seek admission and management of the client
- To request the use of diagnostic and therapeutic tools
- To respond to mass incidents and disaster situations
- To send specimens for external quality assurance
- To address security issues
- To account for a lack of resources (financial, human, or material)
- To meet a client's request

REFERRAL AND LINKAGE FRAMEWORK FOR HIV SERVICES

Targeted HTC strategies have increased the identification rate of those who are HIV-positive, and effective linkage of these clients from testing points to care (along with vigorous follow-up to ensure enrolment and retention in services) is equally important. HIV programs must strengthen the existing HIV continuum of care pathway and ensure that increased access to HIV testing is accompanied by improved LTC if major progress toward universal access to antiretroviral treatment (ART) is to be attained.

Key Features of a Successful LTC Model

A successful LTC model has the following features:

- Standardizes the LTC process, by providing guidelines and tools that clearly outline the roles and responsibilities of the stakeholders, and can be adopted by all service providers
- Provides clear steps to be followed by the client when navigating the referral and LTC system, making every effort to facilitate the movement and make moving easy for the client, including steps such as escorting the client between testing and enrolment

- Informs the client clearly about the package of services to be offered to them at every step—at both referring and linking sites—with clear communication regarding expectations
- Ensures effective communication between service providers at various service points both to facilitate and provide feedback on the LTC process and enhance accountability
- Leverages all the resources available to ensure sustainability; one such strategy calls for community health extension workers to facilitate referrals outside the primary health facility, then follow up with clients in the community to ensure improved LTC and to trace defaulters
- Collects timely, complete, and accurate data from the LTC activities and uses those data to assess performance and improve the referral and linkage processes; supportive supervision and data review meetings should be undertaken regularly to further strengthen the LTC process

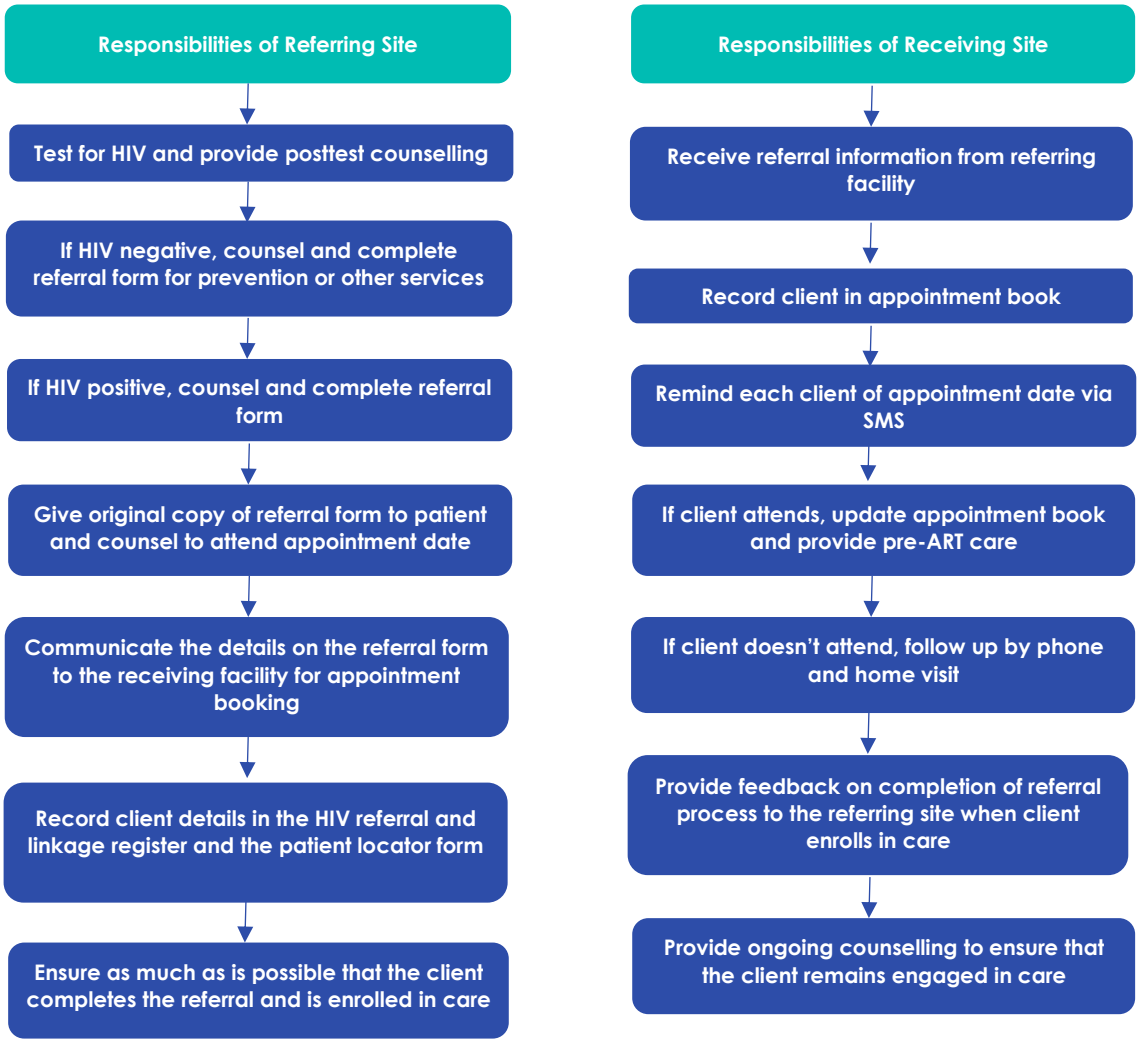
Roles and Responsibilities of Providers

Efficient LTC is best described as a seamless client-driven and provider-supported process that begins as early as when the client presents for pretest counselling and continues through posttest counselling to enrolment in care. The LTC process is supported by key players with different roles, as described in Table 2. However, institutions can realign roles and responsibilities as necessary to manage available resources. Figure 3 illustrates the responsibilities of referring and receiving sites.

Table 2. Roles and responsibilities of healthcare providers in HIV referral and linkage

Type of healthcare worker	Task	Service delivery point
HTC counsellors	• Offer pretest and posttest counselling • Initiate LTC process • Document clients' contacts to facilitate linkage	HTC room (voluntary counselling and testing, mobile site, home-based testing and counselling)
Community health workers	• Sensitize and mobilize all clients and the public to receive HTC • Link clients to community-based client support groups • Undertake home visits to follow up with clients • Other tasks as needed	Community/facility (all outpatient department clients, in-client)
Clinical staff	• Receive clients after screening • Enrol clients in care • Provide counselling • Provide continuation of care	Health facility/CCC
Expert clients/peer mentors/community health volunteers/ linkage coordinators/ community health extension workers	• Follow up with clients to facilitate linkage through phone calls and home visits • Provide ongoing HIV care and treatment counselling • Support clients in navigating HIV clinic clinical care processes • Provide defaulter tracing	Community
Facility administration	• Provide linkage resources, such as phone, airtime, and other resources as needed • Undertake monitoring and evaluation of referral and linkage processes	Health facility

Figure 3. Summary of responsibilities at different stages of the referral process



STEPS IN THE REFERRAL AND LINKAGE PROCESS

A person is considered successfully linked to HIV care and treatment and capable of moving to the subsequent step of clinical staging if he or she (1) undergoes proper HIV counselling and testing procedures; (2) tests positive for HIV; (3) is referred to HIV care and treatment services, complete with documentation on referral forms; and (4) is enrolled in pre-ART care with an enrolment number issued to the client within a defined period. These steps are described in more detail in the sections that follow.

Step 1: Counselling and Testing

Successful strategies for follow-up care begin with the implementation of strong routine screening procedures for HIV testing. The following basic information will help guide the design of routine screening for most healthcare practices.

For Clients in All Healthcare Settings

- HIV screening is recommended for clients in all healthcare settings, after the client is notified that testing will be performed unless the client declines (opt-out screening).
- Clients with varying risk profiles for acquiring HIV should be screened in accord with national guidelines.
- The standard HTC basic package should be provided with both pretest counselling and posttest counselling routinely offered to all clients in accord with the national guidelines.

Pretest Counselling

- Provide pretest counselling in accord with national HTS guidelines.
- Before testing, inform the client of the availability of a linkage process to HIV care and treatment services.
- Discuss the importance of follow-up care, retesting for HIV-negative clients, and CD4 count for HIV-positive clients to be done as soon as possible before any further deterioration in the client's immunity.

Posttest Counselling

- Provide posttest counselling in accord with national HTC guidelines.
- Review the importance of initiating HIV care, including baseline CD4, clinical assessment, and opportunistic infections prophylaxis as soon as possible.
- Discuss the client follow-up process to enable the client to provide informed consent.
- Discuss the details of follow-up with the client, such as the client's phone number, physical location, and next of kin.

Required Tools and Materials

- Counselling cue cards for pretest and posttest counselling
- Counselling job aids
- HTC register (and antenatal care register if in a prevention of mother-to-child transmission [PMTCT] setting)

For HIV-Exposed Infants

Confirmation of HIV in children under the age of 18 months should follow the nationally recommended guidelines for early infant diagnosis, using DNA polymerase chain reaction (PCR) or antibody testing. The results for DNA PCR may not be available immediately; however, all HIV-exposed infants should receive the standard-of-care services as soon as they are identified.

When an HIV-exposed infant is identified, the following steps should be undertaken:

- Provide individual pretest counselling to the mother or any other caretaker who is available.
- Collect a sample of blood on the dried blood spot filter paper following the recommended guidelines for DNA PCR testing, label it appropriately, and complete the laboratory test requisition form.
- Enrol the infant immediately in HIV-exposed infant services and provide comprehensive care as specified in the following PMTCT guidelines:
    - History taking

    - Assessment of growth and development
    - Childhood immunization
    - Prophylaxis (cotrimoxazole, nevirapine, isoniazid preventive therapy)
    - Screening and treating for tuberculosis and other opportunistic infections
    - Counselling on infant and young child feeding practices
- Set the next appointment for the mother or guardian to bring back the HIV-exposed infant when the PCR results have been received at the point of service.
- If the HIV-exposed infant will be receiving the DNA PCR result and follow-up at the place of testing, **document the follow-up appointment in the appointment register.**
- If the HIV-exposed infant will be receiving the DNA PCR result and follow-up care and prophylaxis at a *different facility*, complete the referral form as with any other client. Follow Step 2: Referral for HIV Care, below.
- Ensure that the mother is linked to (or active in) HIV chronic care. If the mother is not in care, complete the **referral form** for HIV care. Screen the mother for tuberculosis.

Step 2: Referral for HIV Care

The Ministry of Health's ART guidelines recommend that each HIV care site have a focal person to oversee and ensure proper and timely organization of the referral process and follow-up of referred clients who delay or do not attend scheduled appointments. The referral steps are described as follows.

Establish the Need and Place for Referral

Clients identified as HIV-positive through HTS may require a referral for certain services:

- Voluntary medical male circumcision
- HIV prevention care and treatment services
- Family planning and other reproductive health services
- Nutritional assessment and support
- Social support services
- Other general medical services

The counsellor and the client work together to identify the need and the probable service point to which that client will be referred, taking the following factors into consideration:

- Client preference
- Distance to the service point
- Availability of expected service and expertise

If the facility has an HIV clinic, but the client wants to attend a different facility, or if there is no on-site HIV clinic, consult the referral directory and referral map to determine the nearest preferred facility that can support the client's needs.

Navigate the Referral System

After client identification, every effort should be made to enable the client to enrol in services at the earliest opportunity. This may be facilitated by enrolling the client at the point of testing, escorting the client from the testing point to HIV services, or transferring the client to another health worker (such as a

peer educator, community health worker, or community health volunteer) who can be held accountable for linkage. This health worker should engage in the following activities:

- Encourage the client to attend the HIV care and treatment site closest to his or her home that is acceptable to him or her:
    - If the receiving HIV care site is at the same location as the testing point, **the appointment should be set for the same day** if the client assents, and the referral should be made accordingly.
    - If the receiving HIV care site is not at the same location as the testing point, the **appointment date should be set within two weeks** of the HIV-positive test.
    - For those identified while receiving in-client care, all efforts should be made to ensure that enrolment at the CCC occurs after discharge, by escorting the client to the CCC.
- If the client has a condition requiring urgent attention (e.g., cryptococcal meningitis), ensure immediate linkage to the necessary care point for treatment of the condition.
- If the client has conditions other than HIV that ***require additional management,*** prioritize the referral according to the health condition most in need of additional management.
- Record the details in the HIV referral and linkage register to enable follow-up, ensuring completion of the referral.
- Record the client's details in a client locator form and obtain the necessary permission required for home visits.
- Give the client the original copy of the referral form to bring to the receiving facility as evidence of the referral for the required service.
- Emphasize to the client that the HIV care site will be expecting him or her on the appointment date and, ***if permission is granted,*** the healthcare provider can contact the client if the appointment is not kept.
- Provide additional informational and educational materials on the new diagnosis, if available. Also, refer the client for additional counselling, if needed.

Required Tools and Materials

- Referral form
- Information and education communication materials on supporting treatment
- Referral directory and referral map
- HTC referral pamphlet
- Counselling cue cards about referral
- HIV referral and linkage register

Step 3: Follow-Up of Referred Clients

The process of referral and linkage should be well coordinated and easy for the client to navigate. This process concludes with one of two outcomes: **linked to care** or **not linked to care**. The main objectives of the follow-up process, therefore, are to

- Offer additional psychological support depending on the outcomes of the HIV testing service
- Support the client in initiating timely enrolment in follow-up care through facilitated linkage

Follow-up of clients should be done at prearranged intervals (second week, fourth week, sixth week, and then monthly until the third month after the date of the test).

Follow-up procedures are as follows:

- All information on referrals made should be received by the respective HIV care facilities on the same day, if the testing point was at the same location, or within two days, if the testing point was at a different location (through phone calls or other means of communication using the county referral directory).
- Immediately write the client's name in the facility's appointment register with the date that he or she is expected to arrive at the HIV care site for linkage, if the referral is in the same facility.
- Remind referred clients by phone and follow up with those who do not come to enrol in care. Depending on the protocol followed by the health facility, the following actions should be undertaken:
    - Each day, review the appointment register to determine which clients are expected the following day.
    - One the day before the expected visit, contact each client to remind him or her of the appointment by
        - Sending a short message service (SMS) message using standard message text to all expected clients (and documenting that it was sent)
        - Calling the client if the healthcare worker recognizes that the client will need personal encouragement to come to care
        - Requesting that a community health worker, community health volunteer, or expert client visit the client in person ***if consent for a home visit has been obtained and if the client cannot be reached through the phone number given***
- If the HIV-positive client does not come as expected on the appointment date, follow up with the client.

Required Tools and Materials

- Facility appointment register
- Telephone, airtime, and standard SMS reminder message
- Call register

The healthcare worker responsible for follow-up should collect the information detailed in Table 3 in the designated HTS linkage register for every case of referral and linkage, to enable evaluation of the success of the process and identify gaps that need attention.

Table 3. Tools for referral client follow-up

Data	Rationale	Where tool is collected
Date tested	When the client was tested at the service delivery point	HTS linkage register
Client referred to	A link to show follow-up in referred department or facility	HTS linkage register
CCC number	Complete follow-up cascade	HTS linkage register/pre-ART register
Type of tracing	Establish follow-up efforts for those not linked to care on the same day	HTS linkage register /pre-ART register
Date enrolled	To estimate linkage turnaround time	HTS linkage register/pre-ART register

Step 4: Enrolment in HIV Care

Ultimately, all clients referred from the HTS point should be linked to and enrolled in HIV care and treatment services. Proof of enrolment in the form of a unique client enrolment number is required as confirmation of successful linkage. Enrolment should follow adequate counselling of the client with acceptance of the HIV test outcomes within a period of two weeks to three months after the test. The following steps should occur at enrolment:

- Enter client details into the **Pre-ART register.**
- Counsel the client on basic HIV information (usually done by the expert client, community health worker, community health volunteer, or peer educator).
- Give the client a personal appointment card with a clearly indicated HIV care number.
- Open a new HIV chronic care client file and enter the appropriate demographic data and physical location details.
- Obtain and confirm consent for a home visit by a community healthcare worker (and indicate it on the client file) as part of psychosocial assessment and preparation in readiness for ART initiation.
- Confirm the treatment supporter contact details and that the client understands the role of the treatment supporter (e.g., if the client does not come to care, the treatment supporter might be contacted).
- Once enrolled, the client's enrolment number should be communicated to the referring facility or testing point to ensure accountability for all referrals made.

Required Tools and Materials

- Client appointment card
- Pre-ART register
- HIV chronic-care client file
- Facility appointment register
- Lab investigation forms for baseline tests

ESTABLISHING A LINKAGE DIRECTORY

The Kenyan healthcare system has six levels, ranging from low- or limited-capacity community-owned clinics to tertiary institutions that have the capacity to offer more complex health services. HIV services are similarly designed, with some facilities providing HTS only to identify those who are HIV-positive. These clients then must move to another health service to access ART and treatment for comorbidities. Thus, a list of all health services offered in a health jurisdiction is important to enable client movement from one service area to another to access the needed services.

Table 4 offers a sample format for a county referral and linkage directory that can be adopted for the various health systems.

Table 4. Example of a county referral and linkage directory

Name of health facility	Location details and address	HIV-related health services offered	Contact person	Contact phone number/e-mail address	Operating days and time	Service eligibility criteria

FOLLOW-UP ACTIVITIES

Step 1: Follow Up with Phone Calls

Call 1. The first phone call is made to the client on the same day the client is expected for his or her appointment (about two weeks after the HIV test), because it is assumed that within two weeks a client will have internalized the HTS outcome and will be composed enough to meaningfully participate in the linkage process. The client is offered additional counselling and psychosocial support. The outcomes of the call are recorded in the linkage register for follow-up purposes. The call is recorded in the linkage register as "linked" if the client is registered and "not linked" if the client requests more time to show up for the appointment or cannot be reached.

Call 2. The second phone call is made four weeks from the date of the test for clients who have not yet been linked to HIV care services. The aim is to determine whether the client has accepted the test results by this date and identify any additional counselling needs. If the client is ready, he or she should be assisted through the referral system to a health facility of his or her choice.

Call 3. The third call is made six weeks after the HIV test. This is a follow-up call that ends the biweekly follow-up period that was meant to link the client and to offer support to the client regarding his or her HIV outcomes. This call continues the psychological support of the client.

Calls 4–8. Additional calls are made monthly, preferably by the same person who performed the HIV test or the same person who has consistently followed up with the client from the beginning. This assumes that the client and the provider will already have established rapport, enabling discussion of issues hindering linkage. If needed, the client should be asked to return to the testing health facility or redirected accordingly for any outstanding counselling or medical needs identified through phone conversations. All outcomes of phone calls are documented in the linkage register.

Step 2: Follow Up with Home Visits

Home visits to a client's physical address may be considered part of client follow-up, but only in the following circumstances:

- A client has not been enrolled in HIV care and treatment services as agreed at the planning of the referral and linkage process
- A client cannot be reached through the phone number listed, but can be traced to the physical address indicated in the location details
- A client has given consent (written or verbal) permitting home visits as part of the follow-up process

The home visits should be conducted by trained community health workers, community health volunteers, peer educators, or any other service providers trained in appropriate client follow-up. The following are some objectives of such home visits:

- Identify any barriers to successful linkage
- Offer additional counselling based on identified needs
- Elicit a client's preferences for enrolment
- Offer any help that may be required to enable the linkage process

BARRIERS TO THE REFERRAL AND LINKAGE PROCESS

Barriers to the referral and linkage process may be client-driven or related to the provider or health system. As part of the planning process for referral and linkage at the initial encounters with the client, every effort should be made to identify these barriers so that solutions can enable seamless movement from one service area to another. Table 5 outlines some of the recognized barriers and possible interventions.

Table 5. Barriers to referral and linkage

Barrier	Possible intervention
Lack of understanding of the importance of enrolment in care	Offer additional counselling and ensure longitudinal follow-up with the client.
Fear of disclosure and possible stigmatization	Offer additional counselling and ensure longitudinal follow-up with the client to encourage the client to get a treatment supporter.
Poor reception and confusing organization of the referral system	The health system addresses this through quality improvement interventions. Explain clearly to the client how to navigate the referral system. Where necessary, a service provider may escort the client.
Long wait times at facilities	The health system addresses this through quality improvement interventions to shorten the wait times. Offer new clients priority at enrolment.
Distance to clinic or lack of transportation	Encourage the client to identify and enrol in the health facility and services that are closest to the client's residence.

MONITORING AND EVALUATION OF THE REFERRAL AND LINKAGE PROCESS

Referral and linkage data should be collected on a regular basis to assess the performance of the referral and linkage systems and provide evidence that actions have yielded improvements. Performance measurement mechanisms should be established at the different levels of the system (health facility, subcounty, county, and national) to enable implementation of these guidelines.

Table 6 lists the set of minimum indicators on which data should be collected periodically to monitor the referral and linkage systems.

Table 6. Indicators for referral and linkage

Indicator	Description
Total number of clients identified as HIV-positive at HTS	This indicator refers to the total number of clients who were identified as HIV-positive by a qualified service provider per HTS service point in the facility and in the community. This indicator should be disaggregated by gender, age, and service point for reporting purposes.
Percentage of HIV-positive clients referred for HIV services	This indicator refers to the percentage of clients who have been counselled on the need for enrolment in HIV services and have agreed on a plan for referral, out of the total who tested HIV-positive. This indicator should be disaggregated by age, gender, and service point.
Percentage linked internally	This indicator refers to the percentage of HIV-positive clients, out of the total referred, who opt to be enrolled in HIV services at the same health facility as the point of testing, within two weeks of the date of testing and who have an enrolment number recorded in the linkage register. This indicator should be disaggregated by age, gender, service point, and time from testing to enrolment.
Percentage linked externally	This indicator refers to the percentage of HIV-positive clients who opt to be enrolled in HIV services at another health facility other than the point of testing within two weeks of the date of testing, who have an enrolment number recorded in the linkage register. This indicator should be disaggregated by age, gender, service point, and time from testing to enrolment.
Percentage referred but not linked	This indicator refers to the percentage of HIV-positive clients who have agreed to a referral plan and been followed up with by phone calls or home visits, but have not enrolled in any HIV services for chronic care within two weeks of their date of testing—shown by the lack of enrolment numbers associated with their names in the linkage register. This indicator should be disaggregated by age, gender, service point, and time from testing to enrolment.

The sources for the data on the key performance indicators can be obtained from the following:

- Standard referral forms
- Standard referral and linkage register
- HTS register
- Client counter-referral forms

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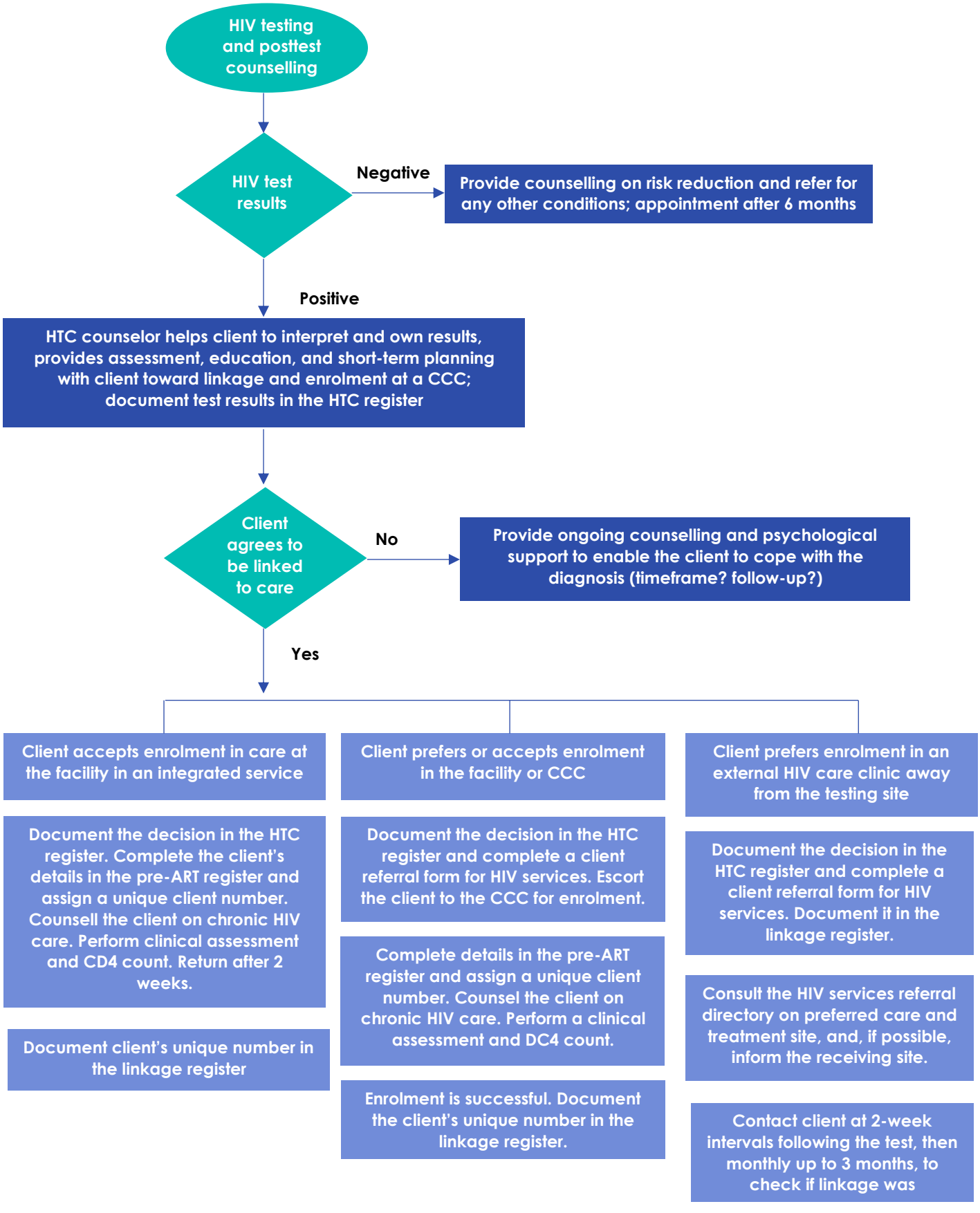
APPENDIX 1. LINKAGE FROM HIV TESTING TO HIV CARE



APPENDIX 2. CLIENT REFERRAL FORM

ANNEXES

Appendix One: Client Referral Form

Serial No: _____

Name _____ Client No. _____

DOB(dd/mm/yy) _____Age_____ Sex: □ Male □ Female

Physical Address _____

Mobile No _____ Pregnant □ Yes □ No □ N/A

Marital Status □ Single □ Married Monogamous □ Married Polygamous □ cohabiting □ Divorced/Separated □ Widow/Widower

Referred From (Facility / Organization & SDP)	Referred To (Facility / Organization & SDP)
MFL Code:	

Reason for Referral (Tick Appropriate service).		
□ HTC □ VMMC □ ANC / PMTCT □ Early Infant Diagnosis (EID)/HEI follow up □ Care and Treatment (ART, OI treatment, Prophylaxis, default on treatment, Adherence Counseling etc) □ TB	□ Family Planning □ STI □ Post Exposure prophylaxis (PEP) □ Nutrition Services □ Psycho-social Support (Including Support Groups) □ Home-based Care □ Drug and Substance Abuse Counseling Services	□ Behavior Change Communication Program □ Child Care Services (include OVCs) □ Social Welfare Services □ Legal Services □ Others ( )

Clinical Information			
Date Last Tested		HIV Test Result	□ N □ P □ Exposed □ Unknown
WHO Stage	□ I □ II □ III □ IV □ N/A □ ND	CD4 Count/CD4 %	□ N/A □ ND
Started on ART?	□ Yes □ No □ N/A	If on ART, Indicate Start Date:	
Current ART Regimen	□ Treatment:_____	□ ARV Prophylaxis:_____	
Other Diagnoses			
Other medication			

COMMENTS

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Referred By		**Received by**	
Name	_____	Name	_____
Designation	_____	Designation	_____
Mobile No.	_____	Signature	_____
Signature	_____	Date	_____
		MFL code of receiving facility_____	

APPENDIX 3. LINKAGE REGISTER

Many teams that provide HTS have developed custom linkage tools to address the challenge of linkage to care. The register below is an example of a linkage register used during the Family Testing Rapid Results Initiative held in 2014.

HTC REFERRAL AND LINKAGE BOOKLET

MONTH..... YEAR.....

S/No.	Date tested	Name of the client	Age **(d)**	Telephone number	Patient referred to:	Date patient prefers to be enrolled:	Handed over to: (Indicate Name and Cadre)	Type of tracing, Note the date of each attempt and outcome on a separate row **(j)**		Outcome **(k)**		Date Enrolled	CCC Number	Remarks
(a)	**(b)**	**(c)**	Sex **(e)**	**(f)**	**(g)**	**(h)**	**(i)**	Client called	Physical tracing	NC=No contact (**Tick Appropriately**)		**(l)**	**(m)**	**(n)**
										C	NC			
										C	NC			
										C	NC			
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