



ጤና ሚኒስቴር - ኢትዮጵያ
MINISTRY OF HEALTH-ETHIOPIA

Health Centre /Clinic/Hospital HIV Self Testing Register

Region

Zone/Subcity/Woreda

Health Facility Name

Begin Date

End Date



ጤና ሚኒስቴር - ኢትዮጵያ
MINISTRY OF HEALTH-ETHIOPIA

Instruction for Completing HIV Self testing Register

S.No	Data Elements	Instruction
1	S.No	Put consecutive serial numbers, that help in auditing if the number of sheets in the register is intact or not.
2	Client Name /UIN/ , UIN, Phone No. & Physical address	Write full name (Frist Name/Father Nam/Grandfather Name) of person who collected the HIV self-test kit for their contacts,UIN for unique identifier, Phone number of contact person on each box provided and write woreda/town, Kebele, House number/Establishment (Hotel, cafeteria, Bar,,,)for each address
3	Age and Sex (M/F)	Write the age and Sex of client who collected HIVST Kit
4	Marital Status	Write marital status with (code 1-4) 1.Never Married 2.Married 3.Separated/Divorced 4.Widowed
5	Target Population and Date DD/MM/YY/	Write Target population group with (code 1-9) 1. FSW 2. Partner of FSW 3. Partner of HIV positive index 4. Partner of PMTCT clients 5. Long distance truck drivers (LTD) and their assistant 6. Daily Laborer/mobile workers 7. Widowed/ divorced/ remarried 8. Vulnerable adolescents and youth clients (18- 24) years old) 9. Others, Write date client took HIVST kit Write specific date HIV self-test kit distributed either through secondary distribution or direct distribution for beneficiaries.
6	Pre-test information	Pretest Information & test procedure information on HIVST provided (Y,N): Write (Yes) if pretest information was provided with HIV self – test procedure detail information; write (No) if pretest information and test procedure not provided. HIVST kit provided with leaflet, information card and HIVST video (Y/N): Write (Yes) if HIV self-test kit provided with leaflet, information card and video and (No) of even 1 item not provided as they all are equally important.
7	HIVST kit distributed by (Write Code)	Write specific contact person through which HIV self-test kit distributed by code number 1-6 on the column. (Code: 1. Nurse counsellor 2. ART provider 3. AS/CMs 4. PNs/Pes 5. MSGs 6. Health extension workers(HEWs) 7. Other (specify)
8	Place of Kit Distribution	Write place of Kit distribution with the (code 1-3) based on site of distribution 1. Health Facility 2. Community 3. Othes
Kit Information		
9	Kit Name	Write Kit Name
10	Kit Batch No	Write Kit Batch No
11	Kit Expire Date	Write Kit Exp. Date
12	Tested Before (Y,N)	Write Y if the client was tested before and N if not tested
13	Prior HIV test result (P/N/I)	Write Previous HIV test result as P= for Positive, N= for Negative, I= for Inconclusive
14	Duration since last test (in mths)	Write how long it has been since the client was last tested in months
15	HIVST Implementation Modalities	Write the HIVST Implementation Modalities as 1. Assisted 2. Un assisted
HIVST Testing Status		
16	Provided with HIVST(Y/N)	Write Y if Provided with HIVST and N) if not,
17	Tested with HIVST (Y/N)	Write Y if Tested with HIVST and N if not,
18	HIVST Tested Reactive (Y/N)	Write Y if HIVST Tested Reactive and N if not,
19	HIVST Confirmed positive (Y/N)	Write Y if HIVST Confirmed positive and N if not.
20	Post-Test Counseling Status (Y/N)	Write Y if the client has received post-test counseling and N if not.
21	Proactive follow up conducted through:	Write codes through which proactive follow up was provided: 1.Self reported 2. Provider 3. Adherence Supporters/Case Mmanagers 4.Peer Navigators/peer educators 5.Mothers Support Group. 6. Health extension workers 7. Others
22	Date Linked to ART	Write the date client is linked to ART on the space provided
23	Date ART started	Write the date client started ART on the space provided
24	UAN of newly identified HIV positive	Write the UAN if client started ART on the space provided
25	Date new HIV Positive contact linked to Partner &Family Based ICT service	Write the date new HIV Positive contact linked to P&FB ICT service
26	If not linked to P&FB ICT (Code 1-3)	Write (Code 1-3) if not linked to P&FB ICT service: 1.Referred 2. Declined 3.Other
27	Disclosure Staus	Write Y if the client disclosed his/ her HIV status after enrollment to ICT services and N if not disclosed
PrEP services cascade for HIV Negative Sero Discordant Couples		
28	Assessed for PrEP (Y, N)	Write Y if the client assessed for PrEP services and N if not
29	PrEP eligibility (E, NE)	Write E if the client is eligible for PrEP services and N if not
30	Started Oral PrEP (Y,N)	Write Y if the client started oral PrEP and N if not
31	Date Started PrEP	Write the date client started PrEP on the space provided
32	Remark	Document all valuable information you think and not captured in the register or any additional information of the client



HIV SELF TESTING REGISTER

Month _____ Year _____

Client Information						HIVST kit distribution Status					Previous HIV Test Status		HIVST Testing Status							Linkage to care & treatment						Disclosure Staus	HIV Prevention Services				Remark		
S.N	Client Name	Age	Marital Status	Target Population (1 - 9)	Pre-test information	Kit distributed by: (Write Code)	Place of Kit Distribution (1. Health Facility 2. Community 3. Othes)	Kit Information			Tested Before (Y,N)	Prior HIV test result (P/N/I)	Duration since last test (in mths)	HIVST Implementation Modalities		Provided with HIVST (Y/N)	Tested with HIVST (Y/N)	HIVST Tested Reactive (Y/N)	HIVST Confirmed positive (Y/N)	Post-Test Counseling Status		Proactive FU conducted for linkage through: _____ (write code)	Date Linked to ART	Date ART started	UAN of newly identified HIV positive	Date new HIV Positive Contact linked to P&FB ICT service	If not linked to P&FB ICT (Code 1-3)	Has the client disclosed his/ her HIV status after enrollment to ICT services? (Y, N,)	PrEP services cascade for HIV Negative Sero Discordant Couples				
	UIN	Sex (M/F)		Date DD/MM/YY/	HIVST kit provided with leaflet, information card and HIVST video (Y/N)			Kit Name	Batch No	Exp. Date				1. Assisted 2. Un assisted	Has the client received post-test counseling? (Y, N,)					Assessed for PrEP (Y, N)	PrEP eligibility (E, NE)								Started Oral PrEP (Y,N)	Date Started PrEP			
	Phone No. & Physical address																																
(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)	(12)	(13)	(14)	(15)	(16)	(17)	(18)	(19)	(20)	(21)	(22)	(23)	(24)	(25)	(26)	(27)	(28)	(29)	(30)	(31)	(32)		
																											Partners's Name:						
																											Partners's Name:						
																											Partners's Name:						
																											Partners's Name:						

Target population group (5)
1. FSW 2. Partner of FSW 3. Partner of HIV positive index 4. Partner of PMTCT clients
5. Long distance truck drivers (LDTD) and their assistant 6. Daily Laborer/mobile workers
7. Widowed/ divorced/ remarried 8. Vulnerable adolescents and youth clients (18- 24) years old
9. Others

Marital Status (Column 4)
1.Never Married 2.Married
3.Separated/Divorced
4.Widowed

Kit distributed by (Column 7):
1. Nurse counsellor 2. ART provider
3. AS/CMs 4. PNs/PEs
5. MSGs 6. HEWs
7. Other (specify)

Proactive FU linkage (Column 21) :
1.Self reported 2. Provider
3. AS/CMs 4.PNs/PEs
5.MSG. 6. HEWs 7. Others)

AF: If not linked to P&FB ICT (column 26)
1.Referred
2. Declined
3.Other