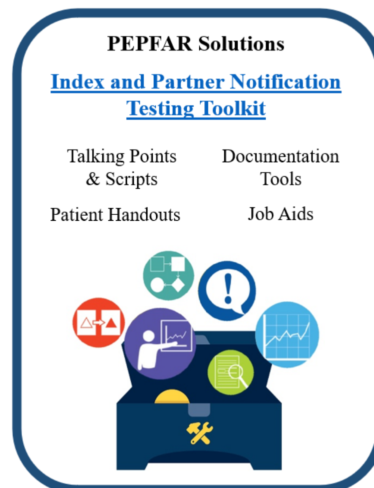
Standing Operating Procedure

Monitoring Coverage of Index Testing for Biological Children and Siblings of PLHIV newly diagnosed, initiated or already on ART

1. **Background:** Identification of children and adolescents living with HIV (C/ALHIV) is a key priority of PEPFAR to ensure timely diagnosis and requires increased focus, targeted interventions and close monitoring to track coverage. Index testing has proven to be an effective modality to identify C/ALHIV who would otherwise not be quickly linked to life-saving antiretroviral treatment (ART). This standard operating procedure (SOP) is focused on monitoring coverage of index testing for biological children of people living with HIV (PLHIV) on ART as well as siblings of C/ALHIV.

   Perinatally-infected children can be identified through a biological parent (often through a mother living with HIV, or if deceased or unknown status, through their father living with HIV) or a sibling who has HIV. Therefore, all PLHIV *newly diagnosed, initiated or already on ART* should be offered index testing to identify their biological children <19 years of age who are eligible for HIV testing services. Additionally, biological siblings of C/ALHIV *newly diagnosed, initiated or already on ART* should also be identified through index testing and promptly referred for HIV testing services.



   All biological children of adults living with HIV (including female sex workers) and siblings of C/ALHIV should be tested at least once and re-tested if there is a newly identified risk (e.g. sexual activity, abuse and HIV-exposed infants (HEI) without a documented final outcome). If adolescents test negative and have ongoing risk, providers should discuss HIV prevention services (including PrEP, VMMC and family planning) and refer or offer services to at-risk adolescents as indicated. While most programs have been scaling up index testing, a clear, systematic way to conduct and monitor indexing of biological children of PLHIV and siblings of C/ALHIV *newly diagnosed, initiated or already on ART* does not exist.

   For the purpose of this SOP, "biological children" refers to all live children and adolescents <19 years of age. It is also assumes that all PEPFAR-supported clinical, orphans and vulnerable (OVC), key populations (KP), and community implementing partners utilize appropriate index testing policies, algorithms, and tools as approved by their host country governments, including guidance on confidentiality, screening for intimate partner and family violence, disclosure of HIV status, age of consent and parental consent for HIV testing and disclosure guidance during the index testing process. No family should feel required to have their children tested, instead the dialogue should facilitate questions and refusal or deferral.

Finally, while this SOP is not focused on index testing of partners of PLHIV *newly diagnosed, initiated or already on ART* and parents of C/ALHIV *newly diagnosed, initiated or already on ART*, it is important to remember that these populations of at-risk adults should also be supported through completion of testing and linkage to either prevention or treatment services. It's important to note that non-disclosure of HIV status to partners can impact pediatric uptake of prevention and treatment interventions.[1] Additional partner notification tools and guidance may be found at the following PEPFAR site:
https://www.pepfarsolutions.org/tools-2/2018/4/11/index-and-partner-notification-testing-toolkit

2. **Objective:** This SOP aims to ensure that clinical partners, in close coordination with OVC, KP and community partners, ensure that all biological children of PLHIV and biological siblings of C/ALHIV currently on ART know their HIV status. Additionally, it aims to address, on an ongoing basis as routine standard of care and monitoring, indexing of biological children of newly diagnosed/initiated PLHIV and biological siblings of newly diagnosed/initiated C/ALHV to ascertain their HIV status as well.

The goals of this document are to:

a. Identify all of the biological children <19 years of age of all PLHIV *newly diagnosed, initiated or already on ART*,
b. Identify all of the biological siblings <19 years of age of all C/ALHIV *newly diagnosed, initiated or already on ART*, and
c. Offer testing to all of those biological children and siblings who have not previously been tested for HIV or who require re-testing based on HIV risk assessment.

The SOP outlines the process for:

1. Reviewing the backlog of PLHIV and C/ALHIV already on ART and not yet indexed,
2. Ensuring that newly diagnosed and initiated PLHIV and A/CLHIV are indexed
3. Ensuring at-risk children and adolescents are tested in a timely manner (within 2 weeks) either through community or facility-based testing platforms, and
4. Monitoring and documenting 100% coverage of index testing for biological children of PLHIV and biological siblings of C/ALHIV *newly diagnosed, initiated or already on ART*. Ensure documentation for not reaching 100% coverage (e.g. lack of consent).

The SOP is intended to be used in tandem with the Maximizing coverage of index testing for biological children of mothers living with HIV: Standard Operating Procedure (SOP) " (see cover sheet):

1. Health facility staff and clinical partners at ART sites in close coordination and collaboration with OVC and community partners.
2. Drop-in centers or other service delivery points that KP partners support where parents who are KP receive HIV services. KP partners should work closely with clinical and OVC partners to facilitate testing for at-risk children of KP in a safe, confidential, non-stigmatizing manner to avoid inadvertent disclosure of KP status of parents.

[1] See for example: Jasseron et al. 2011. Non-Disclosure of a Pregnant Woman's HIV Status to Her Partner is Associated with Non-Optimal Prevention of Mother-to-Child Transmission https://link.springer.com/article/10.1007/s10461-011-0084-y

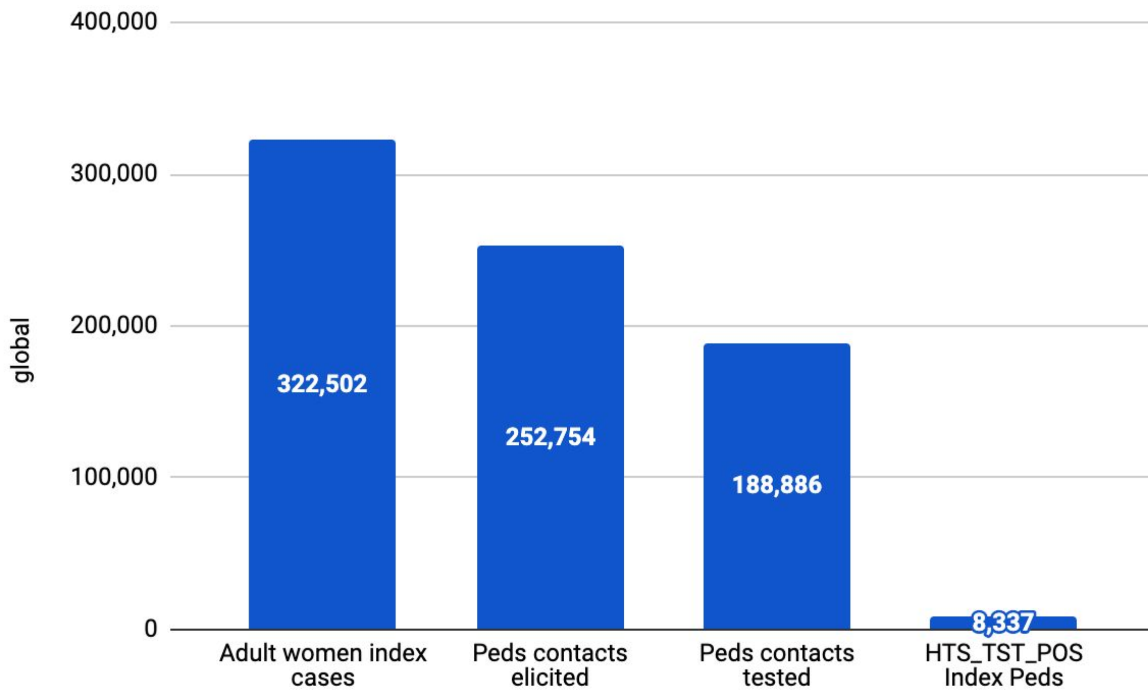
Outcome: All biological children of PLHIV and biological siblings of C/ALHIV *newly diagnosed, initiated or already on ART* are tested in a timely manner, ideally within 2 weeks from being identified through an index client, and those who test HIV-positive, linked to ART immediately or at a maximum within one week.

3. **Monitoring & Evaluation Indicators:** The indicators needed to complete this process include TX_CURR, TX_NEW and HTS_TST, HTS_TST_POS, and HTS_INDEX. TX_CURR will identify how many PLHIV and C/ALHIV are currently on ART.

Table 1: Indicators to determine index testing coverage for children and adolescents <19 years of age

Indicator	Description	Disaggregates
HTS_TST_POS	Number of individuals who were identified and tested positive and received their results HTS_TST Index modality)	<1 F/M, 1-4 F/M, 5-9 F/M, 10-14 F/M, 15-19 F/M, 20-24 F/M, 25-29 F/M, 30-34 F/M, 35-39 F/M, 40-44 F/M, 45-49 F/M, 50+ F/M, Unknown Age F/M
HTS_INDEX*	Number of individuals who were identified and tested using index testing services and received their results *(data from HTS_INDEX auto-populates to HTS_TST Index modality)	Number of index cases offered index testing services by age/sex, Number of index cases that accepted index testing services by age/sex, Number of contacts elicited and age/sex, Number of contacts tested by test result and age/sex, New positives, New negatives, known positives
TX_CURR	Number of adults and children currently receiving ART	<1 F/M, 1-4 F/M, 5-9 F/M, 10-14 F/M, 15-19 F/M, 20-24 F/M, 25-29 F/M, 30-34 F/M, 35-39 F/M, 40-44 F/M, 45- 49 F/M, 50+ F/M, Unknown Age F/M
TX_NEW	Number of adults and children newly enrolled on ART	1 F/M, 1-4 F/M, 5-9 F/M, 10-14 F/M, 15-19 F/M, 20-24 F/M, 25-29 F/M, 30-34 F/M, 35-39 F/M, 40-44 F/M, 45- 49 F/M, 50+ F/M, Unknown Age F/M

Figure 1: Example of a pediatric index testing cascade



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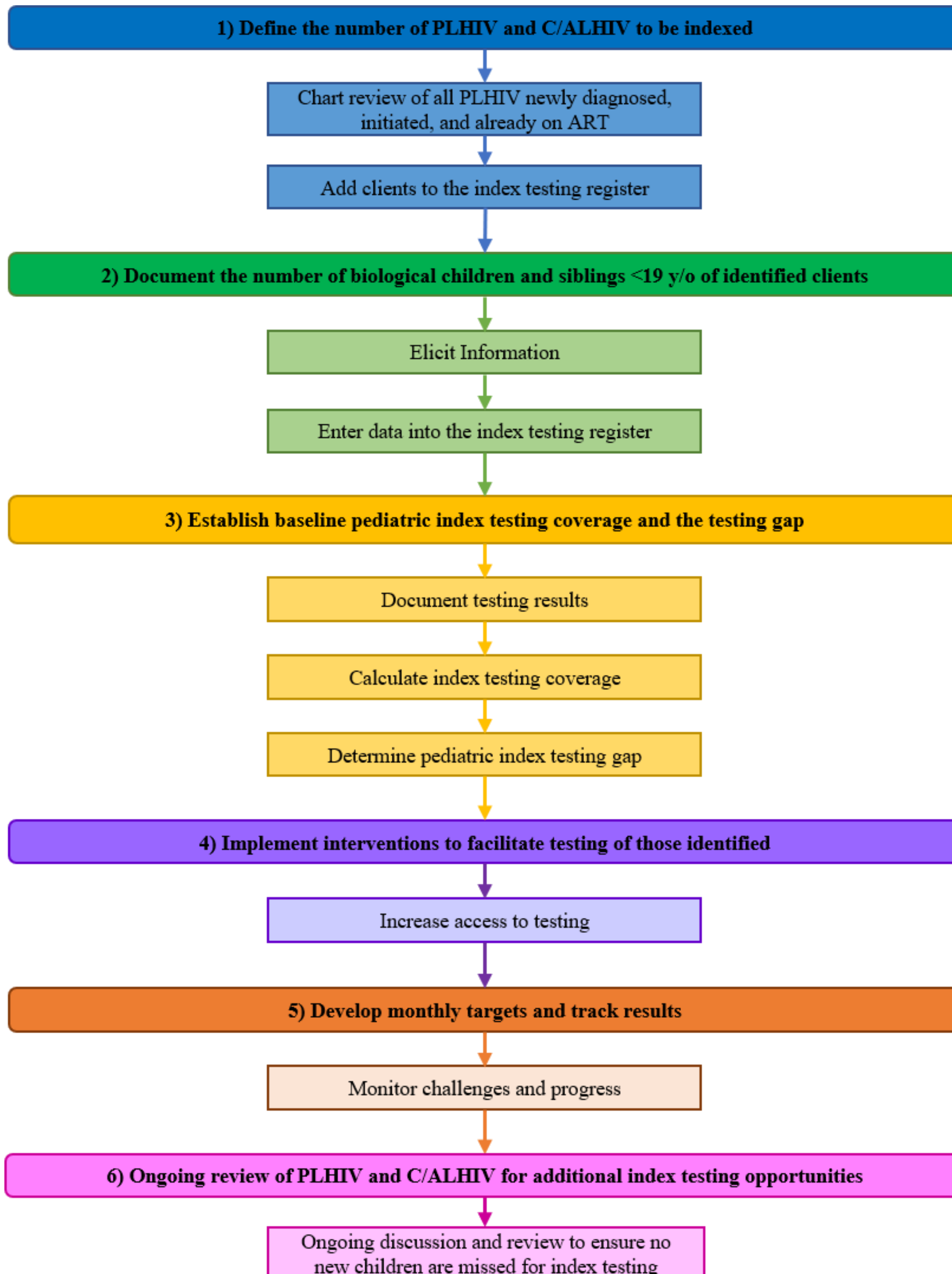
4. **Steps in process:**

Figure 2: Overview of the index testing coverage and monitoring process



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5. **Methodology**

<u>Step 1</u>: Define the number of PLHIV and C/ALHIV to be indexed

What: To determine how many biological children and siblings need to be tested, the first step is to delineate the number of PLHIV and C/ALHIV *newly identified, initiated and currently on ART* that have biological children and siblings respectively and therefore should be indexed.

- *For adults newly diagnosed, initiated or already on ART:* This number is a subset of TX_CURR plus the subset of HTS_TST_POS clients that were not effectively linked to ART. Identify all mothers living with HIV *newly identified, initiated and currently on ART* who have biological children, and fathers living with HIV *newly identified, initiated and currently on ART* who have biological children whose mother's serostatus is unknown or who are deceased. PLHIV who would be *excluded* are those who do not have biological children, and fathers living with HIV *newly identified, initiated and currently on ART* whose wives (or partners) with their children have tested HIV negative. <u>If any of this information is not available, the client's name should be added to the register to be indexed (example of the register in Annex)</u>.

- *For C/ALHIV newly diagnosed, initiated or already on ART:* All C/ALHIV *newly diagnosed, initiated and currently on ART* should have a family tree assessment that includes their biological parents and biological siblings. C/ALHIV whose parents are already on ART do not need to be indexed, as their siblings will be tested through indexing of their parents. Only siblings who share the same biological mother living with HIV (or whose mother is deceased or her status is unknown) should be evaluated for indexing. C/ALHIV who would be *excluded* are those who do not have any biological siblings or whose parents are receiving ART and have been or will be indexed. <u>If any of this information is not available, the client's name should be added to the register to be indexed (example of the register in Annex)</u>.

How: Perform a data review of all PLHIV and C/ALHIV who are *newly identified, initiated and currently on ART* (HTS_TST_POS, TX_NEW and TX_CURR).

- *For HTS_TST_POS clients (adults, adolescents and children living with HIV):*
  All newly identified HIV+ clients should be indexed and those to be entered into the register for testing of their children and siblings include those that are:
  1) Women living with HIV who have biological children < 19 years of age,
  2) Men living with HIVwhose wife or partner (the biological mother of his < 19 year old children) has an unknown HIV status
  3) HIV+ adolescents and children who have biological siblings whose mother's status is HIV+ (or unknown) *and* whose parents are not on ART

  <u>*If any of this information is not available, the client's name should be added to the register to be indexed (example of the register in Annex)</u>.

- *For TX_NEW and TX_CURR adults clients*:
  Perform a chart review of all PLHIV who are new and current on ART (TX_NEW and TX_CURR) to ascertain the following information:
  1) Does the client have biological children <19 years of age?

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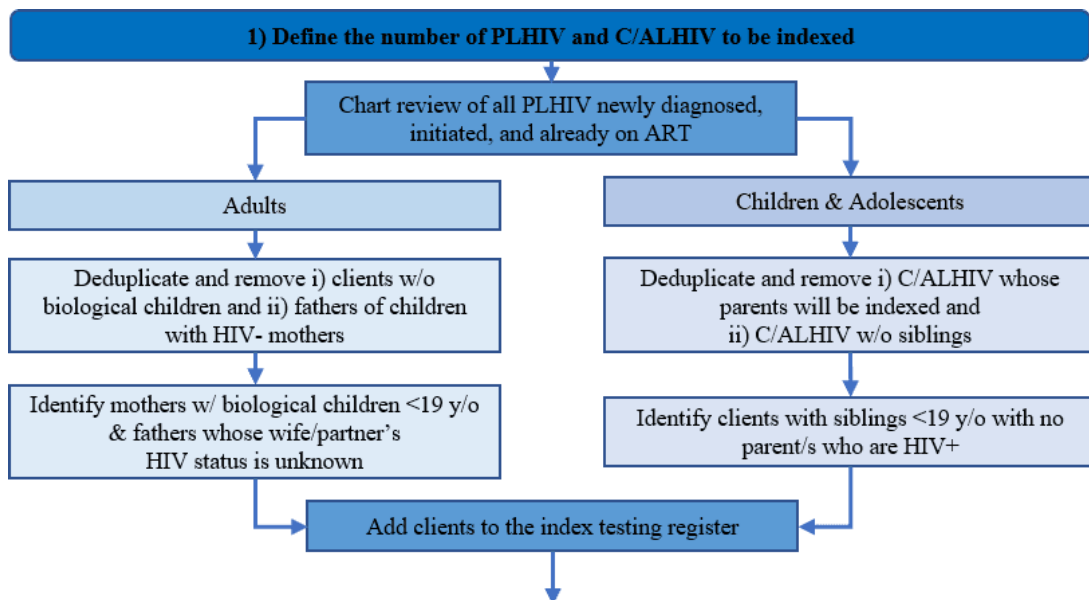
2) If yes and a man, do we know the HIV status of the biological mother of his children?
3) If yes, is the biological mother HIV negative?

Remove from the list those clients on ART who do not have biological children and those men whose wives or partners (and the mothers of their biological children) are HIV negative. The remaining PLHIV should be added to the index testing register for further follow up.
*Note that there will be a need to deduplicate those TX_NEW clients that were already identified through the HTS_TST_POS data review. Also, <u>if any of this information is not available, the client's name should be added to the register to be indexed (example of the register in Annex)</u>.

- *For TX_NEW and TX_CURR adolescent and child clients*:
  Perform a chart review of all C/ALHIV who are new and current on ART (TX_NEW and TX_CURR) to ascertain the following information:
  1) Does the child or adolescent have a parent who is *newly diagnosed, initiated or already on ART?*
  2) If yes, is the parent part of a cohort to which the IP has access (i.e. will the biological siblings be elicited through their parents, or will they be missed if not elicited through this C/ALHIV)?

  Deduplicate and remove the C/ALHIV from the list whose parents will be indexed and add only those C/ALHIV identified as having no parents *newly diagnosed, initiated or already on ART* or unknown status of the mother.
  *Note that there will be a need to deduplicate those TX_NEW clients that were already identified through the HTS_TST_POS data review. Also, <u>if any of this information is not available, the client's name should be added to the register to be indexed (example of the register in Annex)</u>.

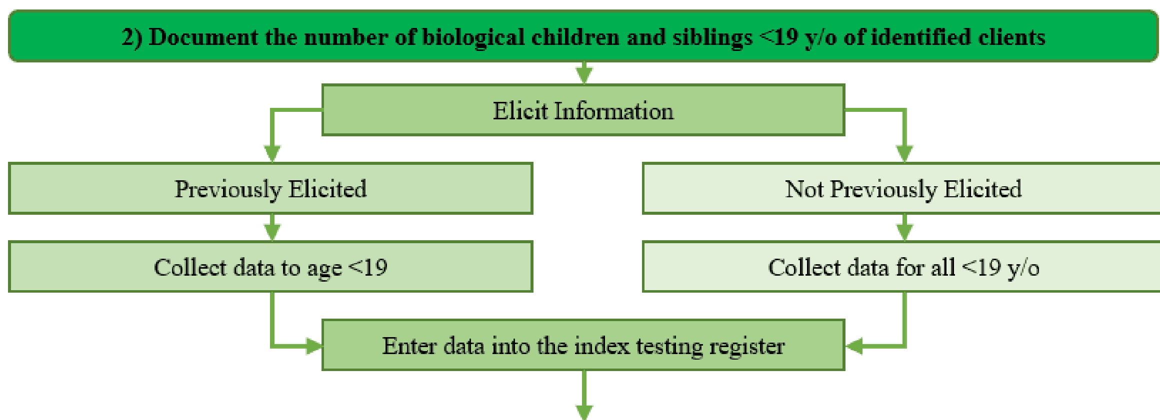


***Step 2*: Document the number of biological children and siblings <19 years of age of these identified clients**

What: The testing status of all biological children and siblings of all the above identified PLHIV and C/ALHIV should be reviewed and updated. This number serves as the denominator for the calculation of pediatric index testing coverage. One hundred percent pediatric index testing coverage is achieved when all of the below know their HIV status:

- All of the biological children of women living with HIV that are receiving HIV services
- All biological children of fathers living with HIV whose wives or partners (i.e. the mothers of their biological children) are deceased or have an unknown HIV status, and
- All of the biological siblings of C/ALHIV whose parents are not available for whatever reason (i.e. whose siblings will not be elicited elsewhere through a parent living with HIV)

How: Once the list of clients to be engaged for indexing is developed, use the active missed appointment tracking system currently in place to communicate with the designated ART clients and identify their biological children and siblings <19 years of age. This dialogue should also include a discussion of index testing (as per national guidelines' standards) and conveyance of these children and siblings for testing (if their status is not yet known), with particular emphasis on the WHO's 5C minimum standards, including consent, counseling, confidentiality, correct test results, and connection to HIV prevention. Be cognizant that, if antecedent indexing had been done to identify children <15 years of age, there is a need to elicit if there are children between the ages of 15-19 years of age who were not previously identified. All the data of biological children and siblings elicited should be added to the index testing register, including those who have already been HIV tested.



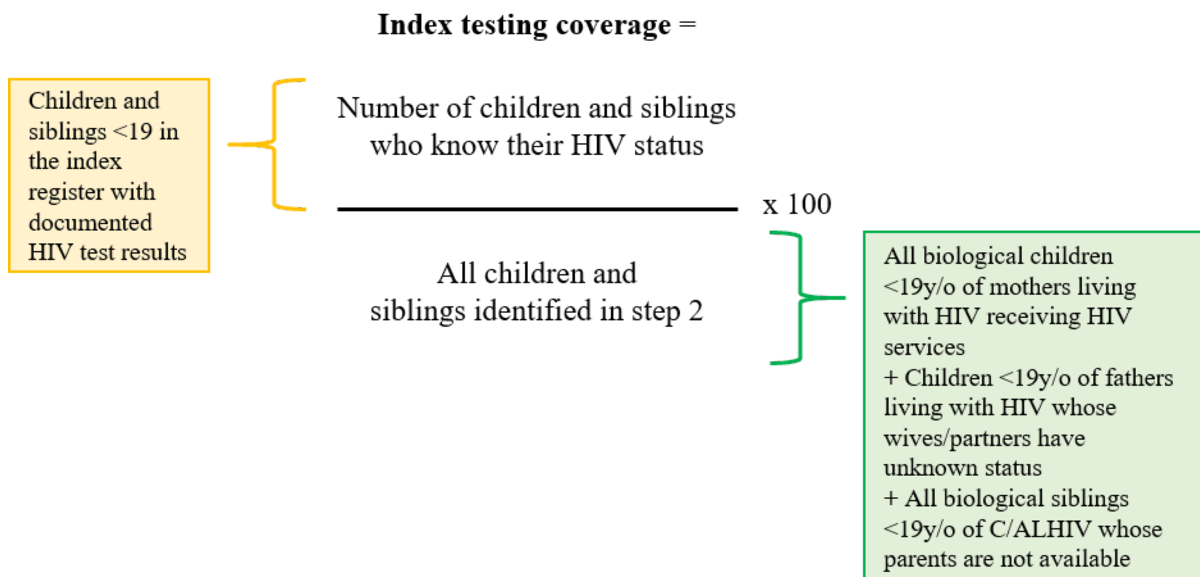
***Step 3*: Establish baseline pediatric index testing coverage and identify pediatric index testing gap**

What: Ascertain how many and what percentage of these now documented biological children and siblings already have a known status. Once this baseline known status is documented, then identify the index testing gap. The pediatric index testing gap is the number of biological children

and siblings who do not yet know their status and therefore should be linked to testing services after consent is obtained from them or their parent(s) or caregivers per national guidance.

How: Once all the children and siblings <19 have been entered into the index register, document the results of those who have already been tested. The children and siblings with known status will be included in the index testing coverage calculation. The index testing coverage is measured as follows:

Index testing coverage = number of children and siblings who know their HIV status x 100
all children and siblings identified in step 2



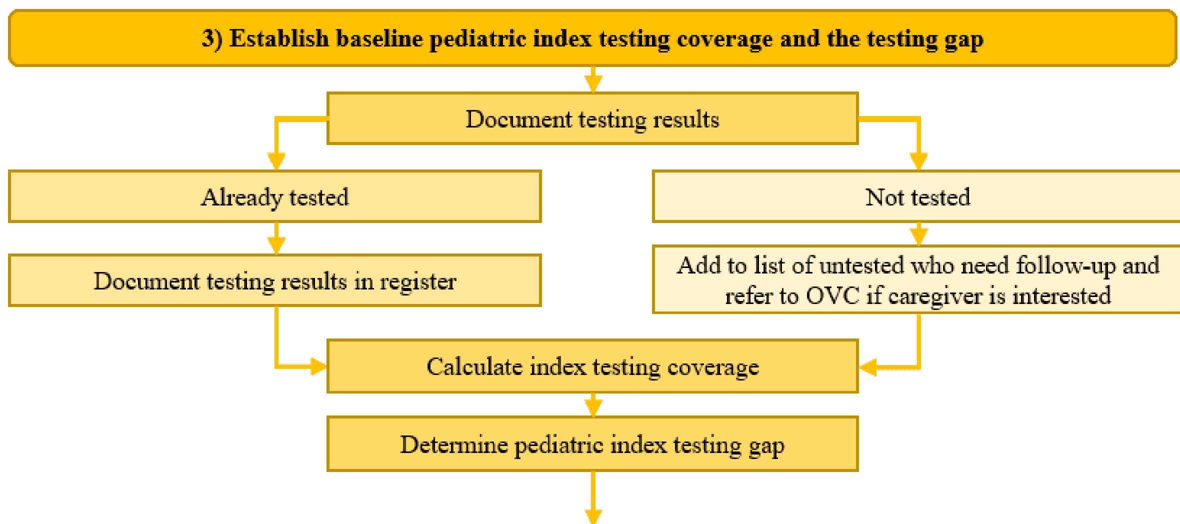
Index testing Gap:
Total # of biological children and siblings identified -- # of biological children and siblings with known HIV status

Index Testing Gap =

[Total number of biological children and siblings <19y/o identified] — [Number of biological children and siblings <19y/o with known HIV status]

For those children and siblings who do not yet know their status, use the lost-to-follow up (LTFU) tracking system to trace these families. Once the family has been traced, the involved provider should obtain consent for testing (as per national guidelines) and if consent is obtained, ask if the family prefers testing in the community (either in their home or at a community testing site, if such services are available) or at the facility, and then arrange a date for testing accordingly. The provider should use whatever system is in place to identify that client as an index testing referral.

If no system is in place, a referral slip that notes that the client has been identified for testing through indexing is recommended as there have been issues in the past with referrals being turned away due to perceived low HIV risk. The date of the testing appointment should be noted in the index register to track if the client and their family do not attend. If there are OVC services available in the catchment area, it is essential that the clinical and OVC partner collaborate closely as the family may already be enrolled in the OVC program and the tracking and follow up can be apportioned with the OVC providers. See section 6 for more details on coordinating with OVC partners.



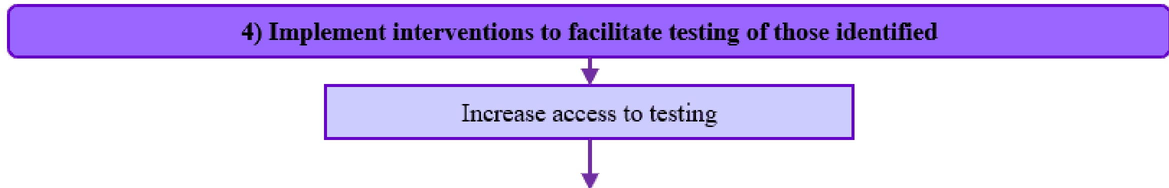
***Step 4*: Implement interventions to facilitate testing of those children identified**

What: A variety of different interventions can be employed to increase access to index testing for biological children and siblings of PLHIV and C/ALHIV on ART.

How: Once the list of biological children and siblings of PLHIV who have not yet been HIV tested is created, and the LTFU platform as well as OVC services are working to bring these children in, systems should be in place to facilitate access. As a reminder, all HIV testing should follow national testing recommendations and appropriate confidentiality, privacy, disclosure and linkage to treatment services must be available. It is also important to ensure a safe environment for all testing services and to screen for intimate partner or family violence in the home, especially for self-testing or caregiver assisted HIV oral screening in the home. Options for increasing access to index testing can include (but are not limited to):

1) *Facility-based testing*
2) *Bring your children to a "be tested day"*
3) *Provider facilitated home-based testing*
4) *Caregiver-facilitated home-based testing*
5) *Community-based testing*

A reminder that, as per HTS guidelines, any HIV self-testing or caregiver assisted oral screening must be repeated with a rapid test to ascertain HIV status. More information and specific details on these testing options can be found in the Annex.



***Step 5*: Develop monthly targets and track results**

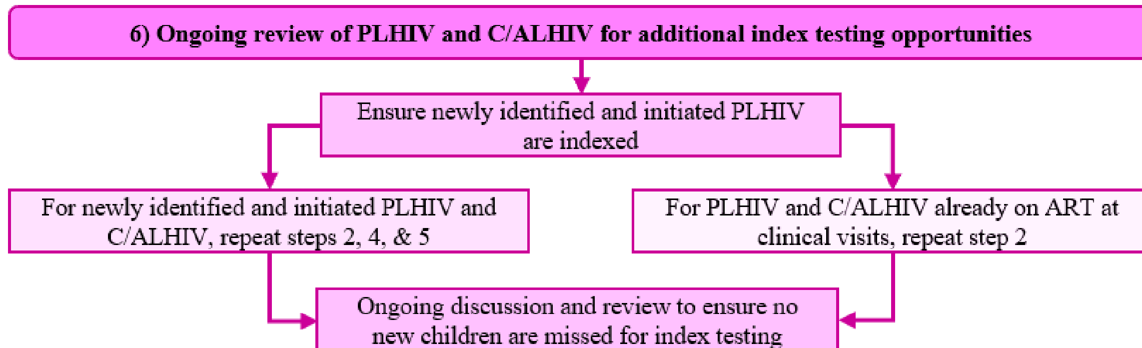
What: Monthly targets provide practical goals for providers and facilitate attainment of targets, especially for a surge activity. Review data weekly and monthly, and address barriers as they develop.

How: Implement the following measures for tracking progress:

1) Health facilities should review the number of PLHIV on ART and the index testing gap for biological children and siblings, and set monthly targets to reach 100% coverage, both retrospectively and prospectively.
2) These targets should be shared with all staff, including community and OVC partners that are actively involved in the families' care and can assure confidentiality of the families' information.
3) Monthly targets and performance should be reported and tracked, including reasons/challenges for not reaching 100% coverage.
4) Develop a plan to link with clinical support partners, OVC partners or Ministry of Health facilities in other geographic areas, as some clients may now be located in catchment areas outside the initial facility, to hand-off contacts to local facilities and partners for follow up and testing.

***Step 6*: Ongoing review of PLHIV and C/ALHIV for additional index testing opportunities**
What: Ensuring that newly identified and initiated PLHIV are indexed once the full cohort of PLHIV on ART is completed, as well as having ongoing discussions with PLHIV on ART if there are additional children that were not identified previously.

How: Repeat steps 2, 4 & 5 for newly identified and initiated PLHIV and C/ALHIV, and step 2 for PLHIV and C/ALHIV who are already on ART at clinical visits to ensure that no new children or children living elsewhere have been missed.



6. **Coordinating with Orphans and Vulnerable Children (OVC) Implementing Partners:** Clinical and OVC programs must work closely together to ensure robust, bi-directional referral systems are in place for all C/ALHIV and their caregivers/parents/families. Roles and responsibilities of each program (clinical and OVC) should be defined in mutually-agreed upon MOUs to ensure strong collaboration between OVC and clinical IPs at the HF level. These efforts are key to reach 100% coverage of index testing of biological children and for the identification of C/ALHIV previously undiagnosed.

   As emphasized in the COP20 guidance, OVC programs support HEI, to ensure they receive a documented final outcome at 18-months, and children with unknown HIV status to receive testing, as well as to ensure C/ALHIV and their caregivers living with HIV access ART.

   > COP20 Guidance
   >
   > "In order to ensure that 100% of biologic children of HIV infected mothers have a documented HIV test result, **clinical and OVC programs must formalize their partnership and work together as part of multidisciplinary teams.**"

   Therefore, it is expected that OVC programs are required to assess all identified HIV+ mothers, as they play a critical role (as family gatekeepers) in gaining access to biological children who may be C/ALHIV not yet diagnosed. Further details on the specific role OVC staff can play in identifying C/ALHIV in need of testing and linkage services can be found in the Maximizing coverage of index testing for biological children of mothers living with HIV: Standard Operating Procedure (SOP).

7. Ongoing routine use:

This SOP is applicable to children and adults newly identified, newly initiated and currently on ART and should be incorporated into routine program review to assist HIV programs in ensuring all biological children of PLHIV and biological siblings of C/ALHIV currently on ART know their status and are tested in a timely and efficient manner. This effort at first will take time to retrospectively review charts and ensure index testing coverage of 100%, but should become routine and eventually only needed for newly identified PLHIV. A routine schedule (i.e. quarterly) should be initiated to ensure no child or adolescent is missed. Every effort must be made to support timely diagnosis of all at-risk children; this SOP enables programs to routinely assess gaps in index testing from national to site level to ensure children are diagnosed and rapidly linked to life-saving ART.

Updated: June 24, 2020
Reviewed by: OGAC Pediatric and OVC Advisors, PEPFAR Pediatric and OVC Interagency subject matter experts (ISMEs), PEPFAR Pediatric and OVC Advisors from country teams, and implementing partners.
Contact: Anouk Amzel (aamzel@usaid.gov), Megan Gleason (mgleason@usaid.gov), Meena Srivastava (asrivastava@usaid.gov)

Annex: Tools & Other Resources

1. **Index Testing Registers or Tracking Tools:**
    a. Example from Ethiopia (pages 15 - 16) (https://drive.google.com/file/d/1SSF6iRmPKaTQCkbmKm4e2LTa-RuqIrhe/view?usp=sharing)
    b. Example from Lesotho (page 17) (https://drive.google.com/file/d/1O655IbMYmDXjYyORsuC6NZ4COP9bwkAY/view)

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ICT Linelisting Register Documentation Instruction

Sno.	Data Element	Description
1	S/NO.	Put consecutive serial numbers, that help in auditing if the number of sheets in the register is intact or not.
2	Date of enrollment	Write the date of enrollment to ART care
3	Name of the Index Case	Write the name of index case
4	MRN/UAN	Write the Medical Record Number and Unique ART number of index case
5	Address (Woreda/Kebele/House number) and telephone number/s of the index case	Write: the name of Woreda, Kebele, house number and telephone number/s of the Index Case.
6	Marital Status	Write the code for marital status of index cases at the time of registration in to ART:1 =Never married, 2=Married, 3= Separated, 4= Divorced and 5=Widowed of index case.
7	Age	Write the age of index case at the time of registration
8	Name of Contacts	Write the name of index contacts (if blank, contact not elicited). Leaving this column blank indicate that the information is snot elicited.
9	Age	Write the age of index contacts at the time of registration to HIV care need to be captured.
10	Sex (M/F)	Write the sex of index contacts M for male and F for Female
11	Relation to Index Case	Write the code for relation to index contact to index cases:1.Spouse partner 2.Child 3.Non-spouse 4.Parent of an index child
12	Address(R/Z or Sub City/W/ K)	Write the address:Woreda, Kebele and House number of the index contacts
13	Previous HIV Test Result	Previous HIV Test Result, leaving this column blank indicate no previous test result or not done.
14	Tested (write code)	Write the code for testing Y=Yes for tested for HIV N= No for not tested for HIV
15	Date HIV Tested	Write date tested for HIV
16	HIV Test Result	Write the code of HIV tested result for HIV test done R for reactive, NR for non reactive and I for indeterminate
17	HIV Positive status	Write the code for HIV Positive index contact status: 1. Enrolled to Care/ART, 2. Referred and linkage confirmed 3. Other Specify
18	MRN/UAN of the Positive Identified	Document the MRN and or UAN of the Positive Identified. Please put MRN or UAN before the number to make sure the number is recognized.
19	Remark	Put any information which is not captured in the previous columns.

Index Case Testing (ICT) Line Listing Register

Information of the Index Case							Information of the Contacts (Spouse, Children, Parents of Index Child & Non-spouse Partner/s)					Service to the Contacts (Spouse, Cildren & Non-spouse Partner/s)						
													HIV Status					
S.No	Date of enrollement to ART	Name of the index case	MRN/UAN	Address (Woreda/Kebele/House number) and telephone number/s of the index case	Marital status (enter code)	Age	Name of contacts (if blank, contact not elicits)	Age	Sex (M/F)	Write code of relation to Index Case	Address: Woreda/Kebele/House Number	Previous HIV test result (R/NR)	Tested (Y/N)	Date HIV tested	Test result R/NR	Write code of HIV positives ART initiation status	MRN/ UAN of the HIV Positive Identified	Remark
(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)	(12)	(13)	(14)	(15)	(16)	(17)	(18)	(19)

6.Marital status
1. Never married
2. Married
3. Separated
4 Divorced
5. Widowed

11.Relation to index case
1.Spouse
2.Biologic child
3.Non-spouse partner
4.Parents of index child
5.other exposed, Specify

17.HIV Positives ARTinitiation status
1.Enrolled in care
2.Initiated ART
3.Referred to other HF& confirmed initiation of ART.
4. Declined to initiate ART

INDEX CLIENT REGISTER

Client Details													Prior HIV Test Status		HIV Testing Services Provided							
No.	Date enrolment	Date diagnosed	ART Unique Number	Name & Surname of Index Client	Sex of Index Client	Age of Index Client	Index client accepted index testing services	Index UIC	Name of Partner/Child First Name	Relationship to index	Age of Partner/Child	Sex of Partner/Child	Tested Before	Prior Test Result	Duration Since Last Test	Tested?	If no, Why?	Date partner/child tested?	Partner/ Child Test Result?	Linked to care & treatment?	Partner/Child's PRE/ART Number	Referral to prevention services
	(dd/mm/yyyy)	(dd/mm/yyyy)			[M/F]	DOB/Age	[Y/N]	[YYMMLNLSCNCS]	Surname	[1=Partner, 2=Child]		[M/F]	[Y/N]	[P/N/NA/U]	[months]	[Y/N]	1=KP+ 2=KP+ on ART 3=KN- 4=Declined	[dd/mm/yyyy]	[P/N/ND]	[Y/N/NA]		1=PrEP, 2=VMMC, 3=FP, 4=Other (specify)
(a)	(b)	(c)	(d)	(e)	(f)	(g)	(h)	(i)	(j)	(k)	(l)	(m)	(n)	(o)	(p)	(q)	(r)	(s)	(t)	(u)	(v)	(w)

2. Further information and details on interventions that can be employed to increase access to index testing for biological children and siblings of PLHIV and C/ALHIV on ART

1. *Facility-based testing:*
PLHIV can bring their children into the ART clinic for HIV testing at any time. Providing an appointment can improve uptake and follow through if this option is selected by the family. If a child or adolescent tests positive, they can be prepared and initiated straight away. Once the child is tested, the results should be added into the index testing register by the testing provider.
2. *Bring your children to a "be tested day*."
This activity is usually done on a weekend to increase access and reduce time away from school for school aged children. Index testing is the focus of this modality and PLHIV currently on ART are notified of the date and time and asked to bring their children and siblings in for testing on these days. Once the child is tested, the results should be added into the index testing register by the testing provider.
3. *Provider facilitated home-based testing*:
Community testing providers can come to the home of the family (by invitation of the index client or parent of C/ALHIV, ensuring consent of the parent and/or adolescent is obtained) to have their children or siblings tested. If any test positive, the child or adolescent should be escorted to the facility to initiate ART. If same day referral is not agreeable to the family, a date and time for escorting should be arranged to ensure linkages for ART initiation. All testing results should be added into the index testing register. Either the community testing provider comes to the facility and directly enters the data, or that providers share the index clients' names and those who were tested and their results to the facility testing provider to enter into the index register. Sharing of data between the community and facility providers should be (at a minimum) weekly.
4. *Caregiver-assisted home-based screening:*
If upon discussion, the indexed client prefers to screen at home, but by themselves, HIVST kits may be given to the index client (or parent/caregiver of the indexed child or adolescent) for testing at home. Careful assessment for intimate partner or family violence should especially be prioritized by the health care worker prior to providing the HIVST kits. If deemed safe, the provider should give careful instructions on how to use the test kits and interpret the results and how to follow up after the testing for post-test counseling. All testing should follow national guidelines and those who screen positive should have HIV testing performed,via one of the other modalities.
5. *Community-based testing*:
In some countries, there remain some targeted community-based testing locations (such as for PrEP or VMMC or other services that can be offered in the community). If the family prefers to go to one of these community testing sites, the date and time of the next testing date should be identified and the provider should arrange to escort the family to the testing site on that date. The clinical and OVC IPs should arr If any test positive, the child or adolescent should be escorted to the facility to initiate ART. If same day referral is not agreeable to the family, a date and time for escorting should be arranged to ensure linkages for ART initiation.

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3. Combined, detailed step-by-step methodology diagram

The following diagram summarizes the methodology section in one, easy-to-visualize infographic.