GOVERNMENT OF KHYBER PAKHTUNKHWA
HEALTH DEPARTMENT

To

1. All Divisional Commissioners in Khyber Pakhtunkhwa,
2. The Director General, Health Services Khyber Pakhtunkhwa,
3. The Chief Executive Health Care Commission
4. All Deputy Commissioners in Khyber Pakhtunkhwa.
5. All District Health Officers in Khyber Pakhtunkhwa,
6. All Medical Superintendents in Khyber Pakhtunkhwa,
7. All Hospital/Medical Directors of MTIs in Khyber Pakhtunkhwa.

Subject: - **Testing Policy for Covid-19**

I am directed to refer to the subject noted above and to enclose herewith a copy of testing policy for covid-19 using Ag-RDT (4 Pages) for information and strict implementation in letter and spirit.

(SYED QAISAR ALI SHAH)
Section Officer (General)

ENDST: OF EVEN NO. & DATE

Copy forwarded for information to the:

1. PS to Minister for Health, Khyber Pakhtunkhwa.
2. PS to Secretary Health Department, Khyber Pakhtunkhwa.
3. PA to Special Secretary (E&A), Health Department.
4. PA to Additional Secretary (E&A), Health Department.

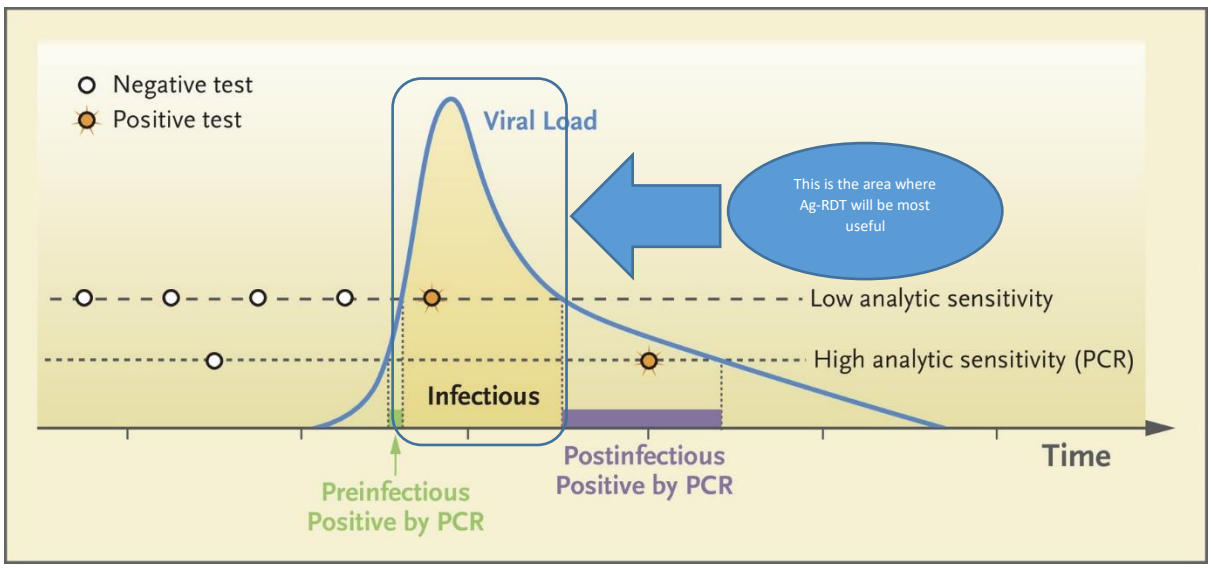
Section Officer (General)

Testing policy for COVID-19

In accordance with the National Policy Previously, the Government of Khyber Pakhtunkhwa's policy on COVID-19 testing was majorly focused around PCR testing and it is still considered as the gold standard. Now with the increasing acceptance of Ag-RDT in the global response against COVID-19 the government has decided to introduce it into the testing policy.

The Ag-RDT is a Point of Care (POC) test and in any infectious disease a test with rapid turnover time and ease of use adds to early diagnosis, management and control of transmission. They have a rapid turnaround time, which is critical to the identification of SARS-CoV-2 infection and rapid implementation of infection prevention and control strategies. These tests can augment other testing strategies, especially in settings where RT-PCR testing capacity is limited or testing results are delayed due to long sample transportation and laboratory turnaround times.

The sensitivity of the Ag-RDT is highly dependent on the viral load of the virus and the performance is highest when the sample is collected from 2 days before the onset of symptoms (pre-symptomatic) and 5 days after the onset of symptoms (symptomatic). A negative Ag-RDT does not exclude covid-19 infection in a clinical setting, up to 20-40% of the time and should be reconfirmed by PCR in case there is no alternate diagnosis or when the patient is suspected clinically.



https://www.nejm.org/doi/full/10.1056/NEJMp2025631

Where to use Ag-RDT?

A: Health care facilities

All the health care facilities especially on priority those where the turnover of patients is high (THQs, DHQs and Teaching Hospitals) and quick decisions are required, will be provided with the Ag-RDT kits and all those patients who are presenting with symptoms compatible with COVID-19, Influenza Like Illness (ILI) or Severe Acute Respiratory Illness (SARI) will be tested by Ag-RDT initially. If the test is positive in appropriate setting (pre-test probability is high) it will be considered positive and NO confirmation will be required and contrary to this if a test is reported negative in a patient with high pre-test probability (high risk group) the test will be re confirmed by PCR in all symptomatic and 20% of the asymptomatic contacts.

A subclass will be all the emergency surgeries where the time is crucial and delays in surgeries can't be afforded. This should not be used for any elective procedures/surgeries. Results of all the tests has to be uploaded in the IPMS as per details given below.

B: Field Teams

Ag-RDT will be introduced only in areas where transportation of samples for PCR testing is a challenge. The districts which are proposed for the first phase are Chitral(upper & lower) ,Torghar, South and North Waziristan, Kohistan Upper , Lower and Kolai Palas. In these districts at sentinel sites the mechanism will be as mentioned above while for the Field teams of RRT two types of people will be presented, one is the symptomatic patient calling at first hand and the second are the contacts who can be asymptomatic, pre-symptomatic or symptomatic, All the symptomatic can be tested by Ag-RDT while for the others if the facility of PCR testing is available it should be preferred and if not use Ag-RDT and counter check 20% of the negatives by PCR.

C: Outbreak response in congregate settings

The third use is in close congregate settings as an outbreak response for quick segregation where PCR confirmed cases are already reported. In such scenarios the test can be repeated on weekly interval for not to miss any person who can be infective.

These settings include health care facilities, teaching institutions, prisons, camps, factories, and any other place where the movement is otherwise controlled.

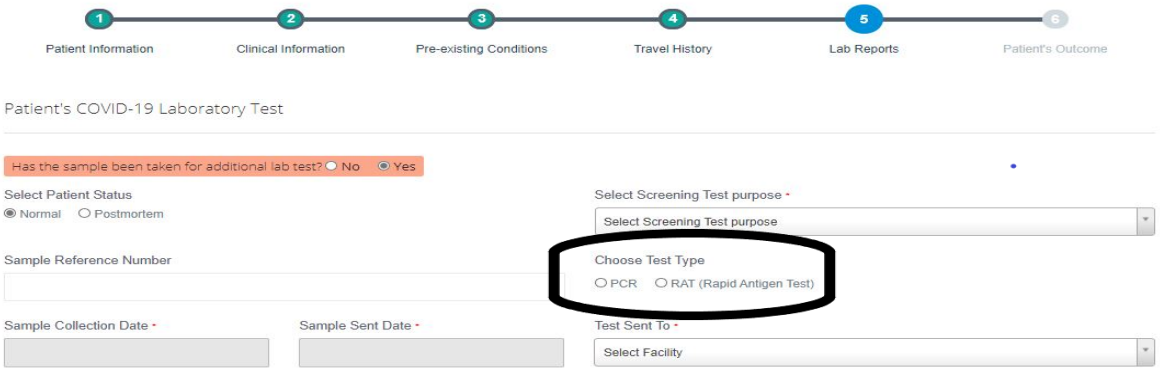
D. Border screening

Pak Afghan Borders where the turnover is very high and those who are symptomatic on screening needs quick testing on site for quick segregation should be tested by Ag-RDT. 20 % of the negatives of these symptomatic should be confirmed by PCR and these persons should be instructed to strictly follow the isolation recommendations or should be quarantined if desired.

Private labs outside hospital settings should not be allowed to perform Ag-RDT to avoid any data error and false misconception in the community due to in appropriate selection of the test. And all those private hospitals that are using Ag-RDT must not use it outside the approved indications and should be reporting on daily basis to the health department after getting approval from HCC.

Waste management: The used kits and disposables should be properly disposed of as per protocols of the infectious waste of COVID- 19.

DATA Capturing and Sharing: The data for Rapid Antigen Testing will be shared through IPMS from District/Health Facility. The option for selection of Test type has already been provided in IPMS in Lab Reporting section of the Patient's Profile.



The RRTs will submitt the data for Rapid Antigen Testing by selecting type to test as 'Antigen' at serial number 42 of the survey in the mobile application.

Rapid Response Team 2 Survey

39: High Risk Area *

Sentinel S..

40: Educational Sector *

Selected:-

- ○ Private
- ○ Public

41: Educational Institute Levels *

Primary

42: Type of test *

Selected:-

- ○ PCR
- ○ Antigen

43: Result of Antigen Test *

Selected:-

- ○ Positive
- ○ Negative
- ○ Inconclusive

Submit

Test	Sample	Test site	Period of positivity	Purpose	Whom to test	Advantages	Disadvantages
PCR (Individual)	Nasopharyngeal, nasal, oropharyngeal	Specialized laboratory	2 days before symptoms, 2 to 8 weeks after symptoms	Clinical diagnosis	Individuals suspected of COVID-19 or contact tracing	Highly sensitive. Very low false-positive rate	Expensive. Remains positive after recovery
PCR (Pooled)				Screening asymptomatic individuals (e.g pre-op, contact tracing)	Asymptomatic individuals at risk of transmitting	Reduces costs of testing	Less useful if prevalence is high. Cannot be used in patients with symptoms
Antibody	Blood	Laboratory or point of care	7 to 14 days after symptoms. Duration of positivity unknown	Clinical diagnosis, surveillance	For diagnosis late in the illness. Seroprevalence studies.	Cheap and accessible	Variable sensitivity and specificity. Late positivity. Does not inform about immunity or recovery
Antigen	Nasal or nasopharyngeal	Point of care	2 days before symptoms till 5 days after symptoms	Very early diagnosis	Rapid diagnosis in early disease	Rapid and can be deployed in the field	Negative needs to be confirmed by PCR. Low sensitivity after the initial few days