

STANDARD OPERATING PROCEDURES FOR HIV COUNSELING AND TESTING

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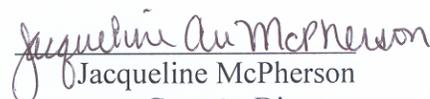
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FOREWORD

This HIV Counseling and Testing Standard Operating Procedures Manual (SOP) has been developed by Family Health International (FHI)/Nepal for use by its implementing agencies for delivering high quality HIV counseling and testing services. This SOP is aligned with the National Guidelines for Voluntary HIV/AIDS Counseling and Testing, 2007 developed by National Center for AIDS and STD Control.

HIV counseling and testing is a critical component of the national HIV response. It is a process of giving professional counseling before and after an HIV test. This process helps people prepare for and understand test results. Those who test negative can learn ways to prevent infection and those who test positive can learn to live healthier lives and prevent transmission to others. HIV testing serves as an entry point for continuum of care services for people living with HIV and AIDS.

FHI/Nepal would like to express its sincere appreciation to all contributors to this manual. We hope that this SOP will be useful to ensure high quality HIV counseling and testing services in Nepal.



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Acronyms

CT	Counseling and Testing
EPC	Essential Package of Care
EQA	External Quality Assessment
FHI	Family Health International
HIV	Human Immunodeficiency Virus
IHS	Integrated Health Service
MARP	Most at Risk Population
PEP	Post Exposure Prophylaxis
PLHA	People living with HIV/AIDS
SOP	Standard Operating Procedure
STI	Sexually Transmitted Infections

■ ■ Introduction

Standard Operating Procedures (SOP) have been developed to improve the overall quality of Counseling and Testing (CT) services provided in the Integrated Health Service (IHS) centers, which are supported by Family Health International (FHI)/Nepal under the ASHA project. CT services are integrated with STI services to the Most at Risk Population (MARP) and Essential Package of Care (EPC) services to People living with HIV/AIDS (PLHA). These SOPs adhere to the national HIV testing guidelines and are subjected to modification according to changes adopted in the guidelines. Basic principles of the CT services provided in the IHS centers are as follow:

Client-centered counseling

The CT centers' client-centered counseling tailors to the behavior, circumstances and special needs of the client. During counseling, the counselor takes into account a client's emotional reactions, interpersonal situations, specific risk behaviors, and readiness to change his/her behavior. The content of the counseling depends on the client's level of knowledge and his/her specific concerns about HIV/AIDS. The counseling focuses on personal risk assessment and developing a personalized action plan. Counselors also help to identify other problems and make appropriate referrals based upon the client's needs.

Opt-out approach

Each center offers HIV testing on an opt-out basis to all clients visiting the STI clinic. The client is informed of his/her right to refuse an HIV test that is routinely recommended and provided to each client.

Standard protocol of counseling

Counseling in the CT centers follows the standard protocols and records are maintained according to the SOP. All counselors also abide to the ethical standards of counseling. Depending on the need, nature and wish of the clients, individual, group or couple counseling is offered, and sessions usually last about 40 minutes to one and half hours.

Confidentiality

All the information collected is kept confidential and is not shared with anyone without the consent of the client. All staff of the IHS centers handling records and those who may deal with the clients' personal files must sign an oath of confidentiality. Breaching the oath may result in official as well as other action against the staff member.

Quality HIV testing

Internal and external measures of quality control are in place to provide valid and authentic test results. All centers provide same day results, using standard and approved test kits. The centers keep test kits in optimum storing conditions as recommended by the manufacturer. Trained and qualified laboratory personnel carry out HIV testing following the standard algorithm, and the results provided are based on a series of the tests.

CT 1: Group Pre-test Information

Given that the demand for CT is high and resources are limited, the clients' waiting time can be utilized for pre-test counseling, in order to reduce the amount of individual counseling time. The information of pre-test counseling could be provided in a group setting while issues specific to the client could be later discussed on an individual level.

The Counselor will:

1. Obtain informed consent for group pre-test.
2. Ensure adequate privacy.
3. Restrict group size to no more than 10 individuals.
4. Ensure similarity (when possible) of group members in terms of age and gender.
5. Arrange separate session for minors (accompanied by the guardians).
6. Never provide results of the HIV testing in the group.
7. Provide the following in group information sessions:
 - Information on confidentiality and privacy of the clients.
 - Basic information about HIV, HIV transmission and HIV risk reduction.
 - Demonstration and discussion about condom use.
 - The benefits and potential issues related to testing.
 - The testing procedures and how results are provided.
 - General information about reproductive health.
8. Only discuss the issues suggested above.
9. Utilize videos or trained peer educator/volunteer to provide general information in settings with limited counselor availability.

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Signature

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■ CT 2: Individual Pre-HIV Test Counseling

As a part of CT counseling, pre-test counseling prepares the client before testing for HIV.

The Counselor will:

1. Check code numbers on ALL forms against the client's code.
 2. Introduce and orient the client.
 - Name, designation, and role.
i.e. *"My name is I am a counselor at this center. My role is to discuss issues pertaining to HIV and AIDS and any other concerns that you may have."*
 - Confidentiality, including discussion of sensitive issues and anonymity.
i.e. *"Whatever we discuss will remain within this center and is confidential. Any information about you in relationship to HIV is kept in your file, with only your code number on the outside. These files will be kept confidential and used only in the provision of medical care and counseling for your benefit."*
 - CT process outline - sessions, duration, testing procedures.
i.e. *"Our services are for people who voluntarily come to this center. We will talk to you for 20 to 30 minutes, and if you decide to be tested, you will need to wait approximately 20 to 60 minutes for the results. You will also need another 20 to 60 minutes to discuss the results."*
 - Record taking by the counselor.
i.e. *"At the end of the session I will take down a few notes on our discussion for record-keeping purposes."* Discuss measures that will be taken to keep confidentiality.
 3. Provide basic information about HIV and transmission, briefly discussing the key methods of infection and also how one cannot contract HIV. If this was already completed during group pre-test counseling, review with the client some of the main points discussed during the session.
 4. Conduct clinical risk assessment, combined with risk education. Give the following explanation for discussing sensitive issues.
"I need to discuss some things today that perhaps normally we wouldn't discuss with others. I need to discuss these things in order to be able to:
 - *Give you realistic feedback about your risk of being infected - you may be worrying unnecessarily.*
 - *Ensure you know how to keep yourself and partner(s) safe in the future - different practices have different risks.*
 - *See if you have other potential health problems that this test will not identify - maybe we will need to consider other types of tests.*
 - *Make appropriate treatment and care suggestions. If you test HIV positive it would be important for us to know when you most likely contracted HIV or any other infections as this may determine the type of care you should receive.*

As you can see these are some good reasons for us to talk openly about these things even though it may not be comfortable."
- Then proceed with the clinical risk assessment.
- Provide information about the risk behaviors related to the transmission of HIV.
 - Assess the client's individual risk, when the risk occurred, and whether this date falls within the three-month window period.
 - Provide feedback to clients on their risk. Avoid saying whether they are at a very high or low risk. Explain to them in terms of having significant risks or appearing to have limited risks.
 - Remind clients that the only way they know if they are infected is by having an HIV test.

5. Discuss prevention related issues such as condom use, including condom demonstration and safe injecting information. Offer to explore and solve constraints to risk reduction. Such exploration may include:
 - Previous risk reduction attempts.
 - Details of successful attempts.
 - Details of failed attempts/obstacles. *For example: "What has been the most difficult part of reducing your HIV risk?"*
 - Assess condom use skills and condom demonstration.
 - Re-visit risk triggers for high risk behavior.
 - Engage in structured problem solving exercises with the client to resolve difficulties in engaging in transmission risk reduction strategies, and develop a personal risk reduction plan with the client.

6. Discuss testing, such as basic information about the test and how the results are provided. Some main points to include are:
 - HIV testing procedure and possible test results.
 - Meaning of positive or negative results.
 - Advantages and disadvantages of having an HIV test.
 - Advantages of being able to look after one's health by seeking treatment.
 - Implications of results to the client, his/her partner, and family.
 - The window period:

When HIV infects a person, their body recognizes that HIV is a virus and the immune system will begin to develop antibodies to try to kill the HIV and protect the person. The antibody test checks for these antibodies in the blood. Since it can take up to 12 weeks after infection with HIV for these antibodies to develop, an HIV test cannot guarantee a person's negative HIV status if they have had any risk for HIV in the past 12 weeks before the test. Thus this time period of 12 weeks is called the "window period".

7. Discuss how the client may react to possible negative or positive results.
 - Try to find out any history related to anxiety-sleeplessness, depression, loss of interest in life, etc.
 - Find out any history of substance abuse or use of drugs and medication.
 - If necessary, refer to the "Suicide Risk Assessment Matrix" (Annex 2).
 - Discuss disclosure, the possible consequences and effects if the result is positive.

8. Obtain informed consent to undergo HIV testing. This may be facilitated by asking the client to sign after reading the informed consent form (Annex 1).

For illiterate clients, read the form and then ask them to put their sign or a thumb mark (be sensitive to use it).

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■ CT 3: Individual Post-Test Counseling

Post-test counseling aims to prepare the client to receive the results of the test. Given the client's state of anxiety and stress, appropriate counseling should be provided prior to revealing the test results.

The Counselor will:

1. Understand the Results.
 - **Negative Test Result** - A test result is negative when the first screening test or the tie-breaker test in the serial algorithm shows a non-reactive result. A negative test result means that the person is either not infected with HIV, or so recently infected that the test could not detect the HIV antibodies (window period).
 - **Positive Test Result**- A test result is positive when both first screening and second confirmatory tests or the tie-breaker test show a reactive result in the serial algorithm. A positive test result means that HIV antibodies have been detected, and the person is infected with HIV and can transmit HIV to others.
2. Provide Result
 - **Key Principles**
 - a. The result giving session should address the following areas:
 - Dealing with emotional reactions
 - Re-visiting risk reduction plans
 - Repeat counseling sessions
 - b. Provide the result in person on an individual basis:
 - **Not** on the phone
 - **Not** in the mail
 - **Not** to other people - staff, friends, or family
 - **Not** in groups, even if it is negative
 - c. Check the details of the client's medical record with test results and make sure the results are in the correct medical record.
 - d. Check the details of the client's medical record with the client and make sure the results are given to the correct client.
 - **Providing HIV Negative Test Results**
 - a. After seating the client and confirming that they are ready for the results, simply explain that the result is HIV negative.
 - b. Explain that the test has shown that the client is not infected. However, explain that if a risk occurred within the last 12 weeks before the test was taken, there is still a chance that they may be infected and this has not shown up in the test result.
 - c. Check for any "window period" exposure that the client may not have disclosed at the time of pre-test counseling.
 - d. Advise the client with "window period" exposure of the need to practice safer sex until a further test has been conducted. Stress the importance of safe sex, emphasizing that people may be highly infectious when they first come into contact with HIV, even though the first test may have indicated that they are not infected.
 - e. Inform the client who has had "window period" exposure that they will require a further re-test and based on the last risk behavior, provide a date for re-testing.
 - f. Review the common means of how HIV infection is transmitted and how transmission can be prevented. Review the client's decisions about a personal risk reduction plan.

- g. Offer the client a copy of the HIV test result, it is client's choice to write his /her name on the it.

- **Providing HIV Positive Test Results**

- a. After seating the client and confirming that they are ready for the results, simply explain that the result is HIV positive. The results should be given promptly and then allow time for the news to sink in. The counselor should help the client to regain a sense of control by helping them to:
 - Express freely their anxiety and fears.
 - Feel more secure by maintaining a calm presence.
 - Explore exactly what it is that seems overwhelming.
 - Break down the problems into manageable aspects and set priorities.
 - Develop an action plan for coping.
- b. The steps to follow are:
 - Be aware of non-verbal communications when calling the client to the counseling room from the waiting room.
 - Check client details.
 - Be direct e.g. *"I need to tell you that your result has come back positive. The HIV antibodies have been detected in your blood, which means you are infected with the virus."*
 - Provide some silence and time for the client to absorb the news.
 - Make a gentle enquiry *"I'm wondering what you're thinking or feeling right now..."*
 - Encourage ventilation of emotion (normalize).
 - Check the client's ability to cope emotionally, assess for possible self-harm (suicide) or of the client's threatening harm to others. Continue discussion started during the pre-test counseling. Refer to the "Suicide Risk Assessment Matrix" (Annex 2).
 - Provide brief information about:
 - Follow-up and support available.
 - Contact number of the IHS center, hotline telephone number if available in the area.
 - In case of emergency, the nearest hospital.
 - A back-up to verbal information about diagnosis with written information such as IEC materials.
 - Assist the client with concrete planning.
 - Planning to reduce HIV transmission to others.
 - Address issues related to disclosure (who, what, when and why). See *"Suggested questions to use to assess for potential disclosure-related violence"*.
 - Leaving the clinic e.g. consider how will a distressed client get home?
 - Planning for the next 48 hours. This should include a follow-up counseling visit.
 - Offer all clients testing positive an appointment for EPC services.
 - Provide these services if they are available on the same day.
 - Some clients may not be ready and may need some time before this step, but an appointment date should always be given.
 - It is extremely important to emphasize that there are things that the client can do to live a longer, healthier and normal life, such as getting regular check-ups by a provider with knowledge in HIV. There are preventative medicines that can extend life and in most parts of the country ART is available, which can treat, although not cure HIV.
 - Remember to ask if the client has any further questions.
 - Ask the clients to write future questions down that arise between visits.

- Provide referrals as required .
- Offer the client a copy of the HIV test result. It is the client's choice whether to write or not write his /her name on the test result.

c. Be aware of the possible emotional responses to positive results.

- **Crying** - If the client breaks down and starts crying, it is important to let them cry. Give them space to ventilate these feelings. Offering them tissues is a way of telling them that it is okay to cry. Comment on the process, *'This must be difficult for you, would you like to talk about it? Would you like to tell me what is making you cry?'*
- **Anger** - The client might start swearing or exhibit outbursts of anger. Do not panic, stay calm and give the client space to express their feelings. Acknowledge that their feelings are normal and let them talk about what it is making them angry.
- **No response** - this could be due to shock, denial or helplessness. Check that the client understands the result, and be on the alert for suicidal thoughts.
- **Denial** - this could be verbal or non-verbal. The counselor should acknowledge the client's difficulty in accepting the information. Let them talk about their feelings.

The most important thing to remember in dealing with feelings is to allow free expression of feelings. Listen to the concerns and fears of the client.

3. Devise coping strategies

- The counselor should encourage the client to ask questions and also be prepared to answer any questions honestly and with as much detail as possible. The counselor should be honest if he/she does not know some of the answers.
- At some point an HIV positive client will need information on a variety of issues including health, rest, exercise, diet, safe sex, and infection control in the home and other social gatherings. The counselor should carefully assess how much information to provide.
- The counselor should offer follow-up counseling sessions. In these sessions, the counselor should focus on how the client is coping with the positive status (preferably within 48 hours) or how they are managing to maintain the negative status. Infant feeding options are also discussed. Follow-up sessions should be supportive and deal with the client's main concerns.

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Date

CT 4: Partner Disclosure Counseling

The counselor should offer to all clients at risk or diagnosed with HIV, support in disclosure to partners.

The Counselor will:

1. Encourage disclosure in order to:

- Support broader access to treatment and care.
- Promote major transmission risk reduction for HIV and STI.
- Reduce the risks of non-disclosure.
 - People can unknowingly have STI/HIV for a long time without showing any significant symptoms and can pass it on to others (partners, children, strangers via blood donations).
 - The person who is in the “window period” and has a recent high risk for HIV, HBV or HCV may actually be highly infectious but testing will not always provide a confirmed result.
 - If the partner does not know or suspect they are at risk, they will not think about getting tested and thus not receive appropriate treatment.
 - If only one person is treated for an STI, that person may become “re-infected” by their untreated partner.
 - People with HIV can experience re-infection with different strains even when both individuals are infected and undergoing treatment.

2. Routinely offer to all clients the following support options for disclosure.

- Self disclosure by client.
- Client brings to clinic partner/family and self discloses with the counselor present.
- Client brings to clinic partner/family and the counselor discloses in presence of the client.
- Client authorizes the counselor to disclose in the absence of the client.
- Client discloses to a key trusted family or community member who discloses to the partner.
- Client hands out referral cards to sexual contacts.

Counselors should discuss with the client about the advantages and disadvantages of **each and offer assistance** such as disclosure rehearsal. Counselors must clarify what can and cannot be reported to partners during disclosure sessions. A “Release of Information” form (Annex 1) for disclosure should be signed by the client even in cases where the client is to be present.

3. Assess for disclosure-related consequences.

Counselors should seek information about whether disclosure to partners or families could likely result in violence against the client. The following protocol assists the counselor in assessing the threat of violence.

Suggested questions to use to assess for potential disclosure-related violence

"There are some routine questions that I ask all of my clients because some are in relationships where they are afraid their partners may hurt them.

What response would you anticipate from your partner if your test comes back HIV positive?"



If the client indicates that they are fearful or concerned then proceed as follows:

"Have you ever felt afraid of your partner?"

"Has your partner ever:

- *Pushed, grabbed, slapped, choked or kicked you?*
- *Threatened to hurt you, your children or someone close to you?*
- *Stalked, followed or monitored your movements?*
- *Threatened to throw you out of the house for any reason*



If they respond affirmatively to any of these points add:

"Based on what you have told me, do you think telling your partner your result will lead to a risk to you or your children's safety?"



Individuals can be offered a range of options if there is a clear indication of violence.

- 4. Provide explanation of after hours emergency services.
 - CT service centers do not provide after hour services.
 - Clients should be informed about the referral services available related to psychological and psychiatric services.
 - Clients should be encouraged to seek such services in case any need arises.

Note: Refer National Guidelines on VCT counseling, 2007 for further information on partner disclosure.

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■ CT 5: Counseling on the First Follow-Up Visit

The Counselor will:

1. Answer questions.
2. Assess the impact of the diagnosis on:
 - relationships
 - occupation
 - sexual health
 - health care worker/patient interaction
 - partner disclosure issues including assessment for potential for violence related to disclosure
 - sleep and diet
3. Engage the client in collaborative problem solving.
4. Conduct a suicide/harm to others risk assessment.
5. Assist the client in resolving issues and difficulties with disclosing their status to sexual partners, members of family, or support network.
6. Provide referrals for assistance for services that the center cannot provide.
7. Assist the client to plan around going to work, given their new diagnosis.
8. Follow-up on the successes and difficulties with the client's personal risk reduction plan.
9. Inquire about the initial visit for EPC Services. If they have not yet seen the doctor for this, assist in scheduling an appointment. If they have had the first visit, ask about the outcome and further follow-up plans.
10. Assist the client in making decisions regarding treatment and obtaining appropriate referrals.
11. Review the client's personal coping strategies and support needs. Refer the client for ongoing counseling where needed.
12. Use the referral protocol described herein and the consent form for referral.
13. Although clients that have been seen at the CT centers are eligible to return for as many sessions as needed, counselors should be aware that these services are not intended to provide ongoing counseling or psychotherapy. However, clients seeking further treatment are not to be refused.

Repeat HIV counseling sessions

1. Issues to address in additional counseling sessions may include:
 - Client's coping
 - Success in risk reduction
 - Status of disclosure to partners
 - Reinforcement of healthy living
 - Access to EPC services
 - Access to support services
 - Discussion of other issues such as family planning, STI prevention and treatment, condom use, etc.

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■ ■ CT 6: Counseling Couples in CT

The Counselor will:

1. Assure that each person has given his/her consent for counseling and testing and is aware that he/she is expected to disclose the test results to the partner.
2. Meet with each person individually to determine if there are any issues between the partners such as a history of violence that may make disclosure difficult or the use of coercion with regards to testing.
3. Conduct pre-test counseling either with the couple together or individually. **Risk assessment must be done separately**, in order to accurately assess risk.
4. First provide test results individually, and then assist a member of the couple to share the test results with his/her partner.
5. Counsel, encourage, and assist individuals who are reluctant to disclose their test results to their partners.
6. Disclose an individual test result only with the client's permission.
7. After the disclosure of the test results, proceed with post-test counseling with both partners present.

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■ CT 7: Counseling and Testing after Sexual Assault

It is essential that clients are provided medical and forensic consultations. According to Nepali law, medico-legal examination and forensic evidence can only be collected by a registered doctor of government hospitals. Support, health services, and forensics (with consent) should come prior to testing. The counselor should arrange the referral accordingly if the client comes directly to the IHS center.

The Counselor will consider:

1. Key differences from a CT perspective

- Sexual assault survivors may be highly emotional, distressed, non-communicative or in shock.
- Sexual assault survivors face additional risk factors for HIV infection such as:
 - Tissue trauma which may facilitate infection.
 - Co-infection with other STI.
 - Lack of self esteem since post-assault may mean less commitment to safer behaviors.
 - Increased suicide risk.
 - Stigma and silence.

2. Key counseling tasks

- Provide emotional support with an emphasis on securing personal safety.
- Support the client through the process of an immediate medical review (HIV/STI prophylaxis and any forensic/legal investigation).
- Conduct baseline testing only after pre-test counseling. Results should be provided with appropriate post-test counseling.
- Ensure that the client knows s/he can decline baseline HIV testing.
- Start post-exposure prophylaxis (PEP) for non-occupational exposure as soon as possible, preferably within 2 hours of exposure. PEP can be discontinued if assaulted person turns out HIV positive.

3. Not all sexual assault survivors will disclose assault

- It may be appropriate to check to see if clients who come for CT have had coerced or non-consensual sex.
- Male survivors often will not report the assault or even acknowledge to themselves that they have been assaulted.
- Children may be extremely fearful and find it difficult to articulate what has happened.
- Under-aged girls may present with STI symptoms.

4. Key psychological issues for the client

There is a high correlation between sexual assault and:

- Increased suicide attempts (greater than the general population).
- Increased substance abuse.
- Acute stress reactions, somatization (early).
- Later common clinical symptoms such as post-traumatic stress, change in eating habits, anxiety disorders, and major depression.

5. Provision of psychosocial and welfare support

- Client may fear for personal safety and require alternative housing if assessed that there is an ongoing risk in his/her current residency.
- Suicide risk assessments should be conducted over several visits (baseline and follow-up tests).
- Family counseling with the client's consent may be helpful.

6. The need to protect the client's confidentiality

- It is extremely important to protect the client's privacy, including his/her sero-status.
- Conduct counseling in private, where the conversations between clients and counselors cannot be overheard.
- When not in use, always securely lock up all recorded forms, even though they are identified only with a client code number.
- Counselors and their supervisors will protect the privacy of the client by not referring to the client's name.
- A client's confidentiality will also be protected in conversation between counselors and other project staff. Breaches in confidentiality may be grounds for dismissal of counselors and other staff.

7. Other aspects

- Referral to a legal service, child welfare agency, or women's shelter should be considered if necessary.
- Third party disclosure with client consent to a trusted family member, religious leader or community member, who will assist with disclosure might be an option..
- Counselors should be responsive to the client's emotions during the counseling session. This is not an educational session.

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■ CT 8: Counseling and HIV testing of Children

The Counselor will consider:

1. Conditions for Counseling and Testing for Children

It is strongly recommended by the national guidelines on pediatric HIV and AIDS that the following minimum conditions are in place before offering children counseling and testing:

- Age-appropriate pre- and post-test counseling.
- Availability of child-friendly, quality care services including the provision of medicines for opportunistic infections.
- Availability of continued support including sustained counseling.
- Availability of NGO or social welfare services to guarantee the care and support of children through the age of 18, who do not have a family support network.
- Awareness raising and advocacy on HIV and AIDS in the communities where the children come from, if they are still residing with their parents.

2. Informed Consent

- The health care worker shares information with the client and parents/guardians of the child in order for them to provide an informed consent to the testing procedure.
- This process is a dialogue between the health care provider and the person seeking care, and assists the person to make the most informed decision. The dialogue may not end after a single consultation.
- Any decision made must be 'owned', understood, and undertaken by that person.
- The provision of information and support should ensure that the person can appropriately deal with the outcome, such as avoiding becoming infected or infecting others or commencing treatment.
- Informed consent is closely connected with the process of counseling. Any consent provided in response to an inducement or as a result of coercion or policy of mandatory testing, is not informed, and thus, does not represent a freely made decision 'owned' by the person.

3. Competence of Parents or Guardians

- Parents or guardians have the right to make medical decisions on behalf of children who are not capable of making these decisions themselves.
- The Convention on the Rights of the Child (CRC) however, implicitly acknowledges the evolving capacity of adolescents less than 18 years to make their own decisions, including a competency to consent to medical treatment.

4. The Best Interests of Children

- Article 3 of the CRC states that "In all actions concerning children, whether undertaken by public or private social welfare institutions, courts of law, administrative authorities or legislative bodies, the best interests of the child shall be a primary consideration."
- Since children ages 10-14 years are cognitively mature enough to understand the process of informed consent, it is reasonable to conclude that they can determine their best interests.

5. Confidentiality

- Ensure that all necessary steps are followed according to the written protocols of CT, standard operating procedures for testing and counseling, and informed consent.
- Adopt identification numbers, identify methods to deliver results, deal with non attendance of results, and support and disclosure to parents/guardians as part of maintaining confidentiality.

6. Privacy

- Privacy means control by a person over the manner in which their health information is collected, used, stored, and transmitted.

- Privacy related to health information encompasses the client's access to health records, authority to obtain copies and request corrections, as well as specification of when an individual's authorization is required for disclosure of protected health information.
- Consider development of written protocols on circumstances of disclosure, written authorization of the parents/guardians or adolescents, and counselor training on maintaining privacy.

7. Parental and Community Support

- Parental and community support are required for the development and sustainability of adolescent CT programs.
- Stigma and discrimination surrounding HIV vary in different communities and can impact the amount of community and parental support for CT services for adolescents and children.

8. Special Consideration for Orphans

- Based on the issues discussed above, it is important for policy makers and service providers to consider if children or adolescents infected with HIV are orphans.

9. Testing a child below 18 months of age:

No child under the age of 18 months can be tested in FHI sites, unless it is requested by the HIV clinician. Sites should develop a referral directory with the names of these practitioners. HIV testing may be necessary even before the age of 18 months, however see notes below for HIV-exposed children between 9 to 18 months.

- If a child between 9 to 18 months tests HIV negative by rapid tests and has not been breastfed in the past 3 months, **s/he is HIV negative.**
 - In most cases, breastfeeding should be discouraged at this age.
 - Proper feeding counseling for parents/guardians is necessary.
 - Cotrimoxazole prophylaxis should continue in all infants exposed at birth until 12 months of age.
- If a child between 9 to 18 months tests HIV negative by rapid tests and has been breastfed in the past 3 months,
 - Encourage breastfeeding cessation and discuss the window period with retesting in 3 months after last possible exposure.
 - Proper feeding counseling for parents/guardians is necessary.
 - Cotrimoxazole prophylaxis should continue in all infants exposed at birth until 12 months of age.
- If a child between 9 to 18 months tests HIV positive by rapid tests, s/he may or may not be HIV infected.
 - This could simply be the mother's antibodies or it may mean that the child is infected.
 - The child should continue on Cotrimoxazole prophylaxis until at least 18 months of age.
 - The family should receive counseling on feeding issues.
 - Child should regularly followed up by clinician.

10. Disclosure: Talking to Children about HIV

Disclosure about HIV/AIDS is a process that requires repeated, continuous, and attentive conversations with children. Conversations will change and evolve as children progress through different developmental stages, and as circumstances change and new treatments are available. Children who are well informed about all aspects of HIV/AIDS will ultimately contribute to the strength of families and communities who are facing the epidemic. Youth who have experienced open and honest information will mature into adults who are equipped both to manage and prevent HIV/AIDS.

The effort to keep HIV a secret can be exhausting and ultimately difficult to sustain. While parents may find it easier to cope by not talking about the illness to the child, hiding the truth can make the child feel anxious, guilty or upset. Secrecy impedes a child's ability to come to terms with his/her fears or anxieties and may impede older children's ability to be safe in sexual relationships. Counseling and testing services can help parents decide whether to disclose to a child about their own or family

member's HIV status and how to do it. Counselors assist parents to consider the maturity and health of the child, especially very young children for instance, who may not understand the issues of stigma and discrimination surrounding HIV/AIDS.

- **When informing a child:**

- Be direct and use language and concepts appropriate for their age.
- Ask them what they think and understand about HIV/AIDS.
- Use words, pictures and drawings to explain about HIV.
- Ask them if they have any questions they would like to ask.
- Ask them to draw a picture about it. This may help them understand what they are thinking and their reactions. This is also good for them to express their feelings with the family so they can feel supported.

- **How to tell a child**

While each family will have different needs and questions, it may be helpful to begin the conversation by addressing the four domains listed below. By gradually reviewing and expanding upon each set of questions, families will be more likely to consider disclosure.

- a. The child:**

- Is the child symptomatic? Taking medication?
- How old is the child? How verbal is s/he?
- Is the child living with a sick parent or sick family members?
- Does the child ask questions about HIV?
- Does the child appear distressed, anxious, or worried?
- Is the child sexually active and at risk of contracting or spreading HIV?

- b. The parent/adult caregiver(s):**

- Has the parent/caregiver been tested for HIV?
- Is the parent/caregiver infected? Symptomatic? Taking medication?
- If the adult is ill, is s/he in need of help from children in the household?
- Is the infected adult an important attachment figure for the child?

- c. The family/household:**

- Are there any adults in the household infected with HIV? Who is aware?
- Are there any other children in the household infected with HIV? Who is aware?
- How many family members are taking HIV-related medication?
- Is the family unit cohesive, or characterized by separations and/or conflicts?

- d. The community:**

- Is testing and treatment generally available in the community?
- Are there people in the community who are open about their own HIV status?
- Does the child know anyone in the community who is open about his/her HIV status?
- How strong is the stigma surrounding HIV in the community? Are there risks to the family such as isolation or discrimination if inadvertent disclosure occurs?
- Are there resources within the community for children such as a youth group, and/or trusted adults that they can talk to?

11. Readiness for Disclosure

Parents and caregivers who have decided to discuss HIV with their children will often ask providers if their child is ready for disclosure. One effective way to assess a child's readiness for disclosure is through individual counseling sessions with the child. Parents and counselors can look for clues that suggest a child is seeking more information. Another method is to observe the child in a group counseling session with other children in similar circumstances.

The following are some examples of language that parents and providers may use as they adjust their comments to a child's questions and developmental level.

● **To a 4 or 5-year-old:**

- "The blood in your body has a germ (or virus) in it that can make you sick—that's why you need to take medicine."
- "It is important to take your medicine every day so that your body will stay strong."
- "A virus is something that gets inside your body, into your blood, and can make you sick. Like a cold. A cold is a virus. The HIV virus is in your blood (...and in Mommy's/Daddy's)."

● **To a school-aged child:**

- "You were born with the HIV virus because it passed from Mommy's blood to yours when you were in her tummy."
- "Having HIV does not mean that anything is wrong with who you are. It is a virus in your blood. There are all different kinds of viruses that people can have."
- "HIV is the name of the virus in your blood. AIDS is the name of the illness that happens if HIV is not treated. You take medicine to treat the HIV virus so that you will not get sick."
- "Having HIV is something private and something that you can decide about telling others. You don't have to tell other people if you don't want to. On the other hand, it is OK to tell other people who may need to know (e.g., teacher, nurse, etc. if parents/caregiver approves). HIV is nothing to be ashamed of."

● **To an adolescent:**

- "You have the HIV virus. A virus is something that gets inside your body and your blood, and makes you sick. It does not necessarily mean that you are going to get very sick. You have the power to control the virus by taking your medication every day."
- "Knowing about HIV and having it in your blood, gives you a special responsibility not to pass the virus to other people. You can prevent getting the virus again, or giving it to others by...(Explain based on teen's current risk situation and sexual maturity)."
- "Having HIV does not mean that you cannot live a full life with loving, sexual relationships. It does mean that you need to plan carefully about your future with others so that you make good decisions about your safety and the welfare of others."
- "Lots of teens with HIV around the world have found that having the virus gives them a special kind of strength, to educate others about HIV, prevent the spread of the virus, and change people's misunderstandings and prejudices. You may decide that you want to use your HIV status to make a positive difference in other people's lives."

In all HIV disclosure conversations, no matter what age the child/teen is, it is helpful to let them know that they can always ask more questions, and adults will try their best to provide answers.

Prepared by: FHI/Nepal

Date adopted: August 2007

Reviewed by:

Name/Grade

Signature

Date

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■ CT 9: Suicide Assessment and Management

Suicide risk in HIV

There are two periods when people with HIV are more likely to attempt suicide. The first is when the person is initially diagnosed and s/he attempts suicide as an impulsive response to the emotional turmoil. The second period occurs late in the course of the disease when the complications of AIDS develop, capacity to earn income declines, and people feel they are a burden to family members or their work. During this late stage of the disease, people experience adjustment issues, impairment to their thinking, and other complications related to changes in their brain's chemistry. Counselors should be alert to suicidal intentions at all times.

The Counselor will:

1. During Pre-test Counseling

- Determine who may have suicidal intentions as early as possible in the HIV testing process.
Take note of the client's history of predisposed risk factors such as substance abuse, existing psychological disorders, or other life threatening illnesses such as chronic hepatitis.
- Ask the client that if they were to receive a confirmed positive result whether they could disclose their status to others and whether significant others (partners, relative or friends) would be supportive.
- Ask the client how they would react if they received a HIV positive result. If the client responds indicating that they would commit suicide, it is important that counselors make enquiries as to whether clients have, under other circumstances attempted suicide.
- Remind clients who make such statements in anticipation of a HIV positive result that there is a chance that their result will be negative. However, if the result is positive, there is support available to them.

2. In providing indeterminate results

- Remind clients who are provided an indeterminate result that they are not HIV positive.
- Assess the client's coping strategies and directly raise the issue of whether the client intends to self harm, or attempt suicide while waiting for further testing.
- Ask clients, who have either indicated that they are at risk of suicide or exhibit a history of predisposed risk factors, if they feel hopeless and might commit suicide.

3. In providing confirmed positive results

- Conduct suicide risk assessments with all HIV positive clients regardless of whether they indicated suicide risk during pre-test counseling.
- Gently question the client who first indicated during pre-test counseling that they would harm themselves if they received a positive result, whether they still had suicidal intentions. The counselor could say something like:

"During pre-test counseling you told me that you would kill yourself if you received a positive result....I am wondering if you still consider that this is what you will do."

- Determine why some clients may deny suicidal thoughts, after having indicated that they would commit suicide during pre-test counseling. Clients who cannot articulate why they would not attempt suicide may still be at risk.
- Determine if clients, who did not indicate during pre-test counseling that they would attempt suicide, might have changed their minds upon learning their diagnosis. This may be introduced in the following way:

"Sometimes when I have given positive results to people, they have indicated that they feel that their life is over, or they want to harm themselves or even end their lives. I am wondering how you are feeling right now. I wonder if you feel like this now or fear that you may feel like this in the near future."

4. Assess suicide risk throughout the illness

Counselors should routinely conduct psychosocial assessments of their clients throughout the course of their illness. Since clients confront stigma, discrimination in the family, relationship breakdowns, loss of income, and other social problems related to their illness, such an assessment should alert counselors to predisposed risk factors for suicide. Explicit suicide risk assessment should form part of a routine psychosocial assessment. Counselors could introduce this as part of the follow-up routine by asking the following questions:

"Many people I see feel that the problems they face in living with HIV are overwhelming, and that they cannot cope. Some even say that their life is not worth living and that they want end their lives.....I am wondering if you ever feel this way?"

- Documenting the assessment process

For medico-legal reasons the counselor must retain records that can demonstrate the client was assessed using standard clinical operating procedures.

- Determining the level of risk

For medico-legal reasons it is important for the counselor to determine the level of risk against a standard indices or assessment protocol. Use the suicide risk assessment matrix to determine the level of suicide risk.(Annex 2)

5. Manage suicide risk

After determining the client's level of risk, it is important to provide feedback and try to engage the client to develop an action plan. This plan will depend on the client's level of suicide risk.

Key Interventions for Low Risk Clients

- **Provide feedback.** Express concerns that suicidal thoughts may come and go and that the client may have a resurgence of suicidal impulses.
- **Ask the client to nominate one person** (family, partner or friend) that they could disclose their suicidal thinking to. The counselor could offer to meet with the client and the nominated person. Remind clients that they do not need to explain their HIV status if they do not want to. They simply could to tell the nominated person that they have been very stressed out and as a result have had suicidal thoughts.
- **Ensure the individual has immediate 24 hour access to suitable clinical care** (e.g. crisis team, extended hours team, general practitioner, hospital, telephone support). Give the individual a list of contact numbers and provide explicit contingency plans if one or more of the contacts is unavailable.
- **Remove all means of committing suicide** (e.g. guns, pills, chemicals, car keys, knives, rope, or other weapons). If the individual requires medication, ensure s/he only has access to a very small amount. Encourage the client to ask a family member or friend to supervise.
- **Encourage the client to identify and monitor their individual warning signs** for resurgence of suicidal intentions.
- **The suicidal contract - try to delay the individual's suicidal impulses.** For example, make a "contract" with the individual in which s/he promises not to attempt suicide within an arranged (short) period of time. Also, provide other options for the individual if s/he is on the verge of attempting suicide such as suggesting the individual to call someone reliable for help (e.g. counselor, a trusted family member or friend, a doctor, or a crisis hotline).
- **Restore hope.** Encourage the view that all problems can be managed if not solved. Identify, explore, and validate the client's ability to cope with past crises or difficulties.

Key Interventions for Medium to High Risk Clients

The level of involvement and response in supporting a client will largely depend on the counselor's professional background, the availability of other mental health services, and mental health legislation. The following interventions are only intended to be a guide to responding to a high risk client.

- Counselors should always **provide feedback to the client** when they feel that the client is significantly at risk of suicide. Counselors should encourage the client to find reasons to continue living.
- Counselors should inform the client that they would like to refer him/her for a **further assessment by a specially trained mental health professional**. The counselor should always work to try to gain the client's consent since it is best for them to voluntarily seek admission to mental health services or hospital for supervision.
- If the individual seems to be at a high risk of self-harm, but will not accept help, it may be necessary to consult a psychiatrist or general practitioner about **involuntary admission to hospital under mental health or public health legislation**. Counselors should also be fully aware of local mental health policies and legislation.
- Where there are no suitable options for in-patient supervision, counselors should contact family members and seek their supervision and support.
- The issue of confidentiality will be overridden to some extent in situations when the counselor believes the individual is acutely suicidal. Confidentiality about HIV status may be preserved, however a counselor who has a client at a high risk of suicide must inform others of the suicide risk.

Prepared by: FHI

Date adopted: August 2007

Reviewed by:

Name/Grade

Signature

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■ CT 10: Laboratory Safety and Universal Precautions

Universal precautions are standard work practices that aim to control the potential biological hazards in the clinical laboratory and to prevent contact by any person with potentially infectious body fluids, secretions or tissues. Health care workers (HCW) should be educated on and observe these safety precautions in every step and procedures in the laboratory. They should aim to create a barrier between them and the infection but not between them and the client.

1. Space management:

- Minimize crowding in laboratory space to reduce accidents.
- Construct laboratory surfaces, counters, and floors with impervious materials to facilitate disinfection.
- Do not permit eating, drinking, and smoking in the laboratory. Avoid direct and indirect hand-to-face contact.
- Provide facilities for hand washing in each laboratory area.
- Allow only authorized personnel to enter into the laboratory. During blood collection, close the door and place a sign on the door stating "Do not enter."
- Do not admit children unless they are being tested (no testing of infants under the age of 18 months unless prescribed by an ART physician).
- Closely supervise non-laboratory personnel and teach them to use appropriate protective measures to ensure that they do not cause a hazard to themselves or to the laboratory staff.

2. Hand Washing:

- Practice frequent hand washing after direct contact with patients and laboratory specimens.
- Wash hands and other skin areas thoroughly with soap and water immediately after accidental skin contact with blood, body fluids or tissues. If contact occurs through breaks in the gloves, immediately remove the gloves and wash hands thoroughly.
- Wash hands before eating, drinking, smoking, applying makeup, changing contact lenses and before and after using lavatory facilities. Wash hands also after completing work and before leaving the laboratory.
- Wash hands before all other activities, which entail hand contact with mucous membranes, eyes, or breaks in the skin.

3. Gloves:

- All phlebotomists must wear gloves while procuring specimens.
- Change gloves between each patient. If gloves become grossly contaminated, wash hands after removing gloves.
- All laboratory personnel who come in contact with blood and body fluids must wear gloves.
- Wash hands before putting on and after removing gloves.

4. Laboratory coats, gowns and shoes:

- Wear a long-sleeved white *laboratory coat, which is buttoned closed*. HCW must wear these garments at all times while at the workstation or when blood or body fluids may be splashed on the worker.
- Immediately change laboratory coats and gowns if grossly contaminated with blood or body fluids.
- Remove and wash personal clothing if it becomes contaminated.
- Do not wear laboratory coat outside the laboratory. The only time a laboratory coat is allowed outside the laboratory is for phlebotomy or other technical procedures. Remove all personnel protective equipment prior to leaving the work area.
- Discourage open-toed shoes to prevent accidental injuries, e.g. drop injuries.

5. Masks and Goggles:

- Laboratory workers should wear masks and goggles while opening tubes of blood or body fluids, due to the risk of splatter or aerosolization. To reduce this risk, place a gauze pad over the top of the tube while removing the stopper.
- Since eyeglasses do not provide adequate splash protection, wear goggles or face shields if available over eyeglasses.
- Masks should only be worn while doing the specific procedures.

6. Specimen Handling:

- All blood or body fluid specimens requiring centrifugation must be spun with a covered lid. This prevents any aerosol that may be produced if a tube breaks in the centrifuge.
- Since pouring a specimen from a tube into a cup or other container can create aerosol, transfer all specimen with a transfer pipette. **Mouth pipetting is forbidden.**
- Use mechanical pipetting devices when manipulating liquids.
- Cover any open wound with proper bandaging to prevent contact with blood or blood products.

7. Exits and aisles:

- Do not obstruct exit routes or areas with equipment, chairs, supplies or trash.
- Do not place wheelchair or stretched patients in areas that obstruct aisles or exit routes.
- Keep laboratory doors closed, but do not block or bolt exit doors.

8. Good housekeeping:

- Dispose rags and/or flammable solvents in self-closing metal containers.
- Do not hang clothing on or near radiators, steam pipes, heating instruments or open flames.
- Do not allow trash to accumulate in any area. Dispose trash daily.
- Limit festive decorations to only glass outside of laboratory work areas. Prohibit wall hangings, candles, or decorations on lights and instruments.

9. Glassware:

- Do not use broken or chipped glassware.
- Do not pick up broken glass with bare hands - use some mechanical aid to pick up broken glass. Discard it in specially marked "Broken Glass" containers. Do not dispose broken glass along with paper and trash since it is hazardous to the custodial staff.
- Do not leave pipettes sticking out of bottles, flasks, or beakers.
- Do not attempt to forcibly remove glass tubing inside stoppers. If they are stuck, cut them out.
- Prohibit glass blowing and other artistic endeavors.
- Decontaminate glass exposed to specimens that may contain a variety of pathogens.
- Do not handle hot glass or heated containers with bare hands.

10. Disposable single use items (e.g. disposable syringes and gloves):

- Destroy the needle of the disposable syringe with an electric needle destroyer. Dispose the syringe in a closed puncture-proof container. Burn or incinerate these items.
- Wash disposable gloves with sodium hypochlorite solution and dispose them in a leak-proof container. Burn or incinerate the gloves.
- Bury non-degradable wastes.
- Burn, incinerate, and burrow disposable items away from the premises of the clinic site.
- Wear utility gloves when transferring such waste.

11. Centrifuge:

- Do not operate centrifuge unless the covers are closed. Keep hair, neckties, hair ribbons or other dangling items **out of the way**.
- Do not centrifuge uncovered tubes or specimens (blood, urine, sputum) or flammable liquids. Contaminated items can produce aerosols or flammables can become bombs. Always use caps to cover tubes or specimens.

12. Autoclaves:

- Operate autoclaves only after they have been checked out by an authorized supervisor.
- Do not open autoclaves until both temperature and pressure are back to normal.
- Use insulated gloves when putting items into or removing items from the autoclave. The sides, door, and material being autoclaved will still be hot. **NOTE:** Steam may permeate insulated gloves.
- Loosen caps of any containers to allow equalization of pressure inside containers. This prevents explosions, boil-over, or implosions.
- Cellulose nitrate tubes may explode.

Refer any questions regarding proper preparation of these items for sterilization directly to your supervisor.

Prepared by: FHI

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Reviewed by:

Name/Grade

Signature

Date

■ CT 11: Management of Occupational Exposure

This SOP deals with the post exposure prophylaxis of HIV related to the occupational exposure of the health personnel working in the facilities supported by FHI. Universal precautions for infection control are must for all IA.

Any injury with the infected instrument or any exposure to the bodily fluid with possible HIV infections during the care of the client or handling waste material is considered as an occupational exposure.

All the staff of the IHS should be made aware of the management of such exposure using the flow chart provided at Annex of this SOP.

It is mandatory to keep the flow chart in laboratory and STI clinic with proper orientation to the staff.

IA should make the provision for providing pre exposure prophylaxis of Hepatitis B through the vaccination of the concerned staff (laboratory staff, clinic staff and those involved with the disposal of sharp and infected materials).

PEP is provided to staff members when infection control measures fail and staff are considered to be at high risk of infection with HIV. The most common injury is a needle stick injury.

The injured staff

1. Should not panic.
2. Should wash the site with running water and mild soap.
3. Should not squeeze the wound.
4. Should not apply any antiseptic and spirit to the wound.
5. Immediately inform the in charge of the clinic.
6. Follow the instructions provided by the doctor/clinician and the clinic in charge as stated below.

The Clinic In charge:

1. Arrange for the HIV testing of the source person and injured staff following the standard procedure of the HIV counseling and testing.
2. Ask the doctor/ clinician for the risk assessment. Arrange for PEP drugs according to the instruction of the clinician preferably within 2 hours
3. Provide all doses of PEP drugs kept in the starter pack (five or three days pack) to the injured staff .
4. Call focal person at FHI country office, send the occupational exposure form filled by the doctor/clinician and get the supply of total 28 days pack of the PEP drugs
5. Refill the starter pack, keep for the future use. Provide remaining doses to the injured staff to complete the course of 28 days.

The Doctor or Clinician will:

1. Do the risk assessment following the flow chart at Annex
2. Prescribe PEP drugs if indicated (if the source has the positive status and the injured staff has the negative status)
3. Fill up the occupational exposure form (see annex) and provide to the clinic in charge

The counselor will:

Do the counseling of the source and injured person following the standard HIV counseling and testing SOP

- Counseling session can be shortened to meet the goal to start PEP earliest as possible (preferably within 2 hours)
- Provide counseling for prevention of transmission (safer sex, no blood donation, etc)..
- Continue counseling even after the administration of the drug for PEP of HIV, since the health care worker may have anxieties about telling his/her sexual partner about the accidental exposure. Offer to provide counseling with partner.

- While PEP is highly effective and the risk of transmission post exposure is low, the HCW may still acquire HIV. Be prepared to provide long term counseling and support services, including treatment for HIV.

Drugs for PEP for HIV should be available in the clinic at all times and checked for shelf life and expiry dates on a regular basis. These include:

1. Zidovudine (AZT) 300 mg; and
2. Lamivudine (3TC) 150 mg; and
3. Indinavir 400 mg or Lopinavir/Ritonavir (200/50mg)

Note: Zidovudine 300 mg and Lamivudine 150 mg may also be provided as a combination tablet. Each site should keep a stock of the PEP drugs following the instructions of FHI CO.

Exposure Report

All the data below must be collected with respect for the HCW's confidentiality and that of the source patient.

- Record of the circumstances of occupational exposure and post-exposure management. Include relevant information such as date and time of exposure.
- Details of the procedure being performed, including where and how the exposure occurred. If the exposure involved a sharp object, include details of the object, and how and when in the course of handling the object the exposure occurred.
- Details of the type and amount of fluid/material involved and the severity of the exposure. For a percutaneous exposure, record the depth of injury and whether fluid was injected. For a skin or mucous-membrane exposure, record the estimated volume of material, duration of contact, and the condition of the skin (e.g., chapped, abraded or intact).
- Details of action taken, such as first aid provided.
- Details about the exposure source, including whether the source material contained HIV or other blood-borne pathogen. If the source is an HIV-infected person record the stage of disease, history of anti-retroviral therapy, and viral load, if known.
- Details about counseling, post-exposure management including drug choices, and follow-up procedures which are outlined in the EPC SOP on PEP.

Follow up tests

- Follow up HIV tests are recommended at 6 weeks, 3 months and 6 months after exposure.
- Negative results at 6 months verify that HIV was not transmitted from this incident.

Prepared by: FHI

Date adopted: August 2007

Reviewed by:

Name/Grade

Signature

Date

■ CT 12: Waste Disposal

Safe disposal of bio-hazardous wastes minimizes occupational and environmental risk.

1. General considerations

- Ensure proper disposal of all contaminated laboratory waste.
- Decontaminate all contaminated waste in the laboratory and the clinic before disposal, including specimens of body fluids, broken glassware, and containers of contaminated needles.
- Place decontaminated materials in a strong, leak-proof container prior to transporting them outside the laboratory.
- Burn used syringes and other solid waste in an incinerator.
- Destroy used needles with the needle destroyer.

2. Collection

There are different types of containers for collecting various types of wastes generated in the clinic and laboratory settings. The three main types of wastes are:

- **Hazard free wastes** – These are papers, plastic covers of syringes and other uninfected materials. Recommended color for the container is **blue**.
- **Infected wastes** – These are either liquid or solid. Other than sharps, collect infected wastes in a leak and puncture-proof container with a secured lid. Collect liquid wastes in a container with enough 0.5% Sodium Hypochlorite solution, so when the liquid waste is added, the concentration of the solution remains approximately the same. Collect solid waste, such as dressing materials or swabs separate from liquid waste. Recommended color for the container is **red**.
- **Sharp wastes** - These are mainly needles. Destroy needles with the needle destroyer. Keep syringes and other sharp wastes in a puncture-proof container with a small hole on the top. This allows personnel to put syringes into the container, but prevents syringes from coming out. Recommended color for the container is **yellow**.

3. Disposal

- **Liquid Waste:** Continuously feed the effluent from clinical analyzers into the sink or sewer. Always wear goggles when pouring this waste down the drain to reduce the risk of splashing.
- **Solid Waste:** Burn solid waste preferably in an incinerator. Prior autoclaving is not necessary.
- **Sharps:** Do not bend, break, or recap needles. Place needles in needle destroyer immediately after use. Never stick fingers into sharps container. Bury sharp instruments deep into the ground.

4. Disinfection/Decontamination

- Absorb spilled material with gauze pads or paper towels and discard in a red biohazard trash bucket. Disinfect the spill site with fresh 0.5% Sodium Hypochlorite solution. Wear gloves during the entire process.
- Decontaminate working counters at the start of each shift or after each spill. Daily decontaminate surface of analyzers using manufacturer's recommendations.
- Carry out service and maintenance activities according to universal precautions.
- Decontaminate instruments repaired by service personnel with 0.5% freshly (daily) made 0.5% Sodium Hypochlorite solution. Decontaminate instruments or components before they are returned to the vendors.

5. Incineration

- Incinerate all combustible wastes with an incinerator that can be designed and made locally.

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Name/Grade

Signature

Date

■ CT 13: HIV Testing Procedures

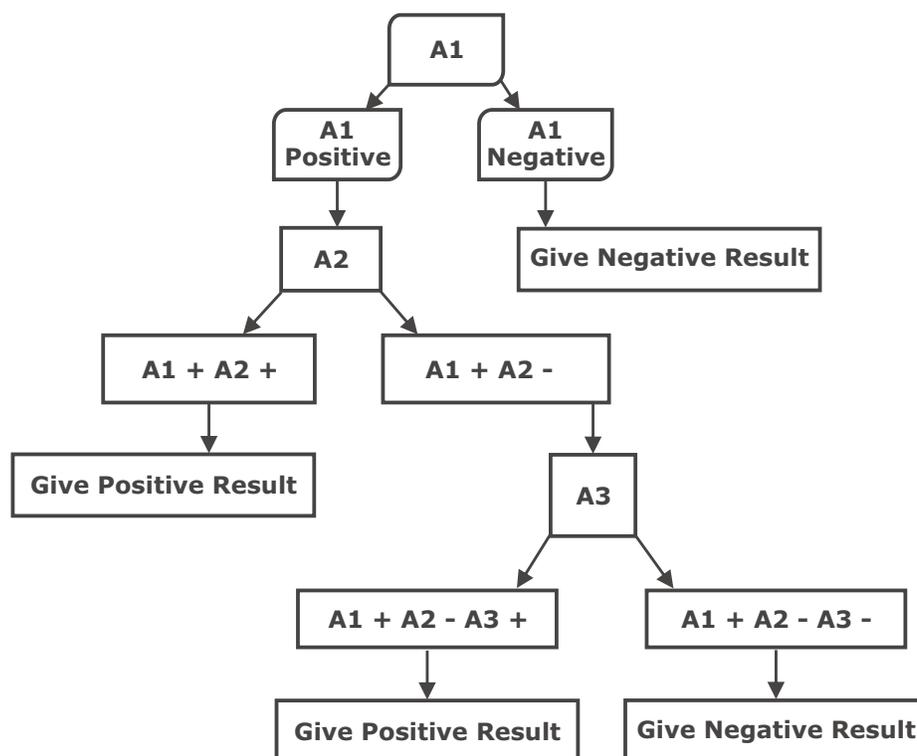
The reasons for using HIV rapid tests kits in ASHA sites are as follow:

- The client experiences significant delays and anxiety while waiting for Enzyme-Linked ImmunoSorbent Assay (ELISA) tests results.
- A high percentage of ELISA clients do not return for the test results.
- It is more economical to run rapid tests in "low test number" settings. There is no need to wait for "batch process tests" as for ELISA testing.
- HIV rapid tests are as reliable as ELISA tests and have been widely used for a number of years.
- HIV rapid tests are simple, utilize minimal equipment, and do not require sophisticated laboratory training.
- Worldwide experience shows that the use of HIV rapid tests, with same-day counseling, is cost-effective, efficient, reliable, and acceptable to CT clients.

The Laboratory Technician will:

1. Verify that the client has a lab request form with the client code number and the client is ready for a blood draw.
2. Receive and check the lab request form for the client ID number.
3. Explain to the client how the blood will be drawn and let them see their code affixed to the test sample.
4. Withdraw blood according to the following principles:
 - **Employ universal precautions**, since blood and body fluids from all patients are potentially infectious. Use adequate barrier techniques to prevent contact with skin or mucous membranes. **Be careful at all times!**
 - **Wear gloves** during phlebotomy; change when contaminated and between each patient.
 - **Wear buttoned lab coats, gowns or aprons** during phlebotomy; change when contaminated. Do not wear this garment in other areas such as the cafeteria, lecture halls, or home.
 - **Wash hands** when visibly contaminated and after completing blood draws.
 - **Handle sharps with caution.** Do not recap, bend or break needles. Each patient room should have a sharps container. Dispose of the sharps immediately and use caution when placing sharps in containers.
 - **Accurately label all specimens** with client code number, date, and technician initials.
 - **If an incident occurs** such as a needle stick, complete an exposure report and have the supervisor sign and follow-up with post-exposure protocols.

Serial HIV Testing Algorithm (National Guidelines for Voluntary HIV/AIDS Counseling and Testing, NCASC, 2007)



5. Use Determine as the first screening test, UniGold as the second confirmatory test and Capillus or SD Bioline as the third tie-breaker test. Characteristics of the rapid test kits are tabulated below:

Rapid Test Kit	Sensitivity Percent	Specificity Percent	Antigen	Principle of Testing
Determine HIV-1/2*, Abbott Laboratories, USA	100 (95.5-100.0)	99.4 (96.7-100.00)	rGP41, sGP41, rGP120, sGP36	Immunochromatography (Lateral flow)
Capillus HIV- 1/2*, Trinity Biotech, USA	100 (95.5-100.0)	100.0 (97.9 -100.00)	rGP41, rGP120, sGP36	Latex agglutination
UniGold HIV*, Trinity Biotech, USA	100 (95.5-100.0)	100.0 (97.9 -100.00)	rGP41, rGP120, sGP36	Immunochromatography (Lateral flow)
SD Bioline HIV ½ 3.0**, Standard Diagnostics, Korea	100 (95.5-100.0)	99.3 (97.6 - 99.9)	HIV1 (rGP41, rP24), HIV2 (rGP36)	Immunochromatography (Lateral flow)

Source: *WHO 2002. HIV Assays: Operational Characteristics Report 12: Simple/Rapid Tests
 **WHO 2004. HIV Assays: Operational Characteristics Report 14: Simple/Rapid Tests

6. Inform the client that the test results will be given in one hour and escort the client back to the counseling room.
7. Refer to "Rapid HIV Testing Procedure Manual for FHI-Supported VCT Clinics" for detailed laboratory testing procedure.

For Syphilis screening, please refer to STI-SOP.

Prepared by: FHI

Date adopted: August 2007

Reviewed by:

Name/Grade

Signature

Date

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■ CT 14: Laboratory Quality Assurance, Quality Control and External Quality Assessment (EQA)

The laboratory technician will be responsible for internal and external quality assurance of the laboratory tests carried out in the IHS laboratory. The laboratory technician should have proper training on rapid HIV testing.

1. For quality assurance:

- Check the expiry date of the test kit. Use the test kit before the expiry date.
- Store the test kits at the temperature specified by the manufacturer. If the test kits require cold chain regularly monitor the temperature of the refrigerator compartments.
- Place the procedural flow chart for testing in a visible area and strictly follow the instructions while conducting the tests.
- Use the correct amount of reagents as specified by the manufacturer. Reagents for one-test kit should not be used for another.
- Test the kits without built-in control bands, with the specific control everyday before carrying out the actual testing, eg, Capillus.
- Assess the presence or absence of the built-in control band in a test kit. If the control band appears within the device, the test is considered valid but if the control band does not appear, the test result is invalid and should not be reported.
- Interpret the result of each test kit properly.
- Carefully follow the entire algorithm before declaring the final test result.
- Record the result with the correct identifier code.
- Appropriately maintain records and the forms.

2. For external quality assessment:

- Collect the 10% of the total samples tested to send to reference laboratory for retesting.
- Every tenth sample should be selected for retesting at reference laboratory.
- Strictly follow the laboratory safety measures and universal precautions.
- Store all specimens as specified in the guideline related to the sample storage. Usually serum samples are stored at a temperature of -20°C. Follow the specific guideline for DBS samples.
- Properly label all the samples with code numbers.
- Send the specimen using proper format to the reference laboratory for retesting.
- Compare the result from the reference laboratory with the result obtained using RTK at the site and report to the laboratory specialist of the ASHA project.

The laboratory quality assurance will be strictly implemented and followed.

Prepared by: FHI

Date adopted: August 2007

Reviewed by:

Name/Grade

Signature

Date

■ CT 15: Suggested Space and Supplies for CT Centers

1. Counseling room

- The counseling room should have visual and auditory privacy and adequate lighting. The number of rooms depends on the number of counselors working.
- Counselors should lock the door during counseling. No one including IHS center staff should enter the room during counseling unless the client gives consent.
- The room should serve as counseling and office space for the counselor.
- Suggested non-consumable supplies for the counseling room include:
 - Armchairs
 - One desk with lockable cabinet
 - Fan or heater in each room, depending on the season
 - IEC stand
 - Waste basket

Note: Adjust sitting arrangements according to local customs. The client and counselor should feel comfortable during the whole counseling session.

2. Laboratory

- The laboratory should be a separate room to maintain the confidentiality of the client.
- The laboratory technician should lock the door during blood draw and testing.
- The laboratory should have a running water supply for hand washing.
- The room should serve as working and office space for the laboratory technician.
- Suggested non-consumable supplies for the laboratory include:
 - Working counter
 - Refrigerator with lock
 - Thermometer
 - Desk and chair
 - Place for elbow rest during blood draw
 - Sink with elbow taps
 - Lockable filing/desk cabinet
 - Sharps disposal container
 - Separate contaminated waste disposal facilities
 - Fan/heater
 - Waste baskets for different types of wastes: general, infected and sharp
 - Power back-up for refrigerator
 - Emergency battery light
 - Autoclave
 - Centrifuge
 - Micropipette

3. Registration room

- Conduct initial registration in this room.
- This room should be separate from the waiting area to maintain confidentiality of the client.
- Take optimum care to protect the identity the client.
- Suggested non-consumable supplies for the registration room include:
 - Desk and chair

- Lockable filing cabinet
- Waste basket (pedal)
- Telephone
- Fan/heater

4. Waiting area

- Display IEC materials and show videos in this area.
- The waiting area should be separate from the registration room.
- Suggested non-consumables supplies for the waiting area include:
 - Enough chairs for people waiting
 - Water filter with glasses
 - Television with DVD/VCD player (optional)
 - Open display of IEC materials
 - Waste basket (pedal)
 - Condom boxes

5. Administration

This office room is for the Program Manager. Suggested non-consumable supplies include:

- Desk and chair
- Computer with accessories
- Fax machine
- Telephone
- Photocopier
- Lockable filing cabinets
- Cupboard

6. Group Room

- Organize pre-test information sessions in this room.
- Utilize this room for support group meetings.
- Carpet the room and provide cushions

7. Restrooms/Toilets

- Make sure restrooms are clean and preferably separate for male and female.
- Make sure there is adequate lighting and running water supply.
- Supply restrooms with soap (preferably liquid) to wash hands.
- Place a condom supply box in the restroom

Prepared by: FHI

Date adopted: August 2007

Reviewed by:

Name/Grade

Signature

Date

■ CT 16: Staffing for CT Services

- 1. Program Manager:** This person supervises all the administrative and financial activities of the IHS center, including separate services like CT, unless otherwise mentioned in other SOPs.
- 2. Counselors:** Depending on the nature of the IHS, there are provisions of separate trained counselor or technical staff (HA/Staff Nurse) trained on counseling providing counseling. Non technical staff with training on HIV counseling can also provide counseling at IHS.
- 3. Laboratory Technician:** This person will be dedicated full-time to the IHS center. There will be one laboratory technician per site. If the demand increases, employ another laboratory technician.
- 4. Front Desk Staff:** In the absence of any designated front desk staff, one staff member will be responsible for performing the front desk duties during IHS center operating hours.
- 5. Support worker:** This person supports the activities of the entire IHS center.

Prepared by: FHI

Date adopted: August 2007

Reviewed by:

Name/Grade

Signature

Date

■ CT 17: Code of Ethics

General Principles

1. Competence

The staff should maintain and develop their competence and work within the limitations of their capabilities. They should:

- Refrain from claiming that they possess qualifications or expertise that they do not have;
- Recognize and acknowledge their limitations.
- Make appropriate referral to others with expertise that they do not have.

2. Consent

- **HIV Testing-** The staff should conduct HIV/AIDS testing only with the informed consent of the client provided either in writing or by a personal mark. The staff must read the points included on the form to illiterate clients. The staff must:
 - Ensure that clients adequately understand all of the issues involved in CT, including the anticipation of the consequences, before giving written informed consent to HIV testing.
 - Recognize the right of clients to withdraw their consent at any time, even after their blood has been taken for HIV testing.
 - Take steps to establish who has the legal right to give consent to HIV testing.
 - Recognize the rights of those because of age, learning disabilities, or mental illness may not be able to give a valid consent to HIV testing.
 - Refrain from making exaggerated claims about the effectiveness of CT in HIV prevention.
- **Consent and release of confidential information to third parties** – Clients must sign or mark the "Release of Information" form (Annex 1). The staff must read the contents of the form to illiterate clients.
- **Withdrawal of Consent** –When a client removes consent for "Release of Information" or "HIV testing," the staff should draw a line across the page and clearly write the date and "Consent Withdrawn." The staff should amend the record and notify the lab to discontinue further testing. In the case that information has been already released, the staff should ensure that no further information is provided to the other agency or individual from the date of the withdrawn consent.

3. Confidentiality – The staff must maintain adequate records of their counseling work and take careful steps to preserve the confidentiality of information acquired through the counseling process. The staff must:

- Strictly keep confidential the identity of clients utilizing the IHS center.
- Strictly keep confidential information obtained during all client encounters and share information with other health care providers only for the purpose of providing care with permission from the client.
- Strictly keep confidential all information that is in any way associated with research undertaken in the clinic.
- Obtain informed consent before patient data can be used for research purposes.
- Undergo orientation in confidentiality prior to any client encounter or accessing any patient information.
- Sign a "Commitment to Confidentiality and Quality Care" (Annex 4) oath signifying that they understand and agree to the project's policy of confidentiality as well as quality care.
- Not allow pictures to be taken of patients without their consent.

4. Respect for people's rights. The staff must recognize the fundamental rights, dignity and worth of all people. The staff must:

- Be aware of cultural differences and biases based on gender, race, ethnicity, caste, religion, sexual orientation, disability and socio-economic status.
- Recognize personal prejudices and try not to let these biases interfere in their work, or else refer the client to another staff member.

- Not participate in or condone any discriminatory practices based on these biases.

5. Personal Conduct – The staff must behave and act properly so as not to damage the interest of their clients or undermine the public's confidence in the center. The staff must:

- Not attempt to secure financial or other benefits other than what has been contractually agreed or awarded by salary.
- Not exploit any counseling relationship for the gratification of personal desires. Under no circumstances should any FHI or IA staff member or volunteer have a sexual or intimate relationship with past or current clients.
- Refrain from counseling when their physical or psychological condition is impaired either when ill or through the use of alcohol or drugs.
- Not have intimate sexual contact with partners or illicit drug use on premises.

6. Integrity - The staff must seek to promote integrity through honesty, fairness and respect for others.

Corrective/Disciplinary Measures

1. All personnel involved in FHI's IHS program will sign an oath of confidentiality and the relevant professional code of ethics for counselors, nurses, laboratory technicians, or medical practitioners. All other staff must agree and sign the general code of ethics described above. The site manager and staff members should retain a signed copy of this code of ethics.
2. Corrective measures will be taken upon breaching of this oath.
3. Serious or suspected breaches of this code of ethics, such as allegations of sexual misconduct of staff with clients, selling or use of drugs on premises, or charging fees for free services will be notified immediately and directly to the FHI Country Director. FHI and the IA will conduct a joint investigation and decide on corrective measures.
4. Further disciplinary actions will be put in place depending on the code of ethics to address issues related to the termination of services as an IHS center staff member, justification for termination, and the methods of termination.

Common Ethical Dilemmas

The staff should be aware that in their work they will face a number of ethical dilemmas relating to:

1. A client's dependence.
2. The disclosure of test results to partner/s or other third parties. Do not disclose without the client's consent.
3. The provision of services to minors.
4. The appropriateness of gifts received or offered. Counselor should decline gifts. Fruit or small food items may be accepted but similarly staff should not accept "services in kind".
5. Sexual approaches by or to clients.

Staff members or volunteers who confront these situations and are not clear how to act, should discuss the situation with their supervisor and/or relevant FHI Senior Program officer or Technical Officer.

Prepared by: FHI

Date adopted: August 2007

Reviewed by:

Name/Grade

Signature

Date

CT 18: Recording and Reporting

The Unified Patient Clinical Record System

- All IHS Centers operate under shared medical confidentiality principles. This should be clearly explained to all patients/clients.
- Shared medical confidentiality means that a patient's treating doctor and counselor will operate from a common record and share confidential information.
- The aim of shared medical confidentiality is to promote better support, care and prevention for individuals, families and communities affected by HIV/AIDS.
- Only the doctor, health care provider and counselor at the IHS who provide a direct service to the patient/client have the right to access the clinical record.
- External service providers are only provided information after the patient/client has signed a "Release of Information" form (Annex 1).

1. First Visit – When an individual arrives for his/her first visit at the IHS center, the staff should:

- Registered the client's name and give the client an ID code.
- Enter this code number on the client's file (all record forms) and provide the client the ID code on a CT/STI card for future visits to the IHS Center.
- **Ensure that only the client number** will appear on the cover of the file and all the necessary forms are placed inside the file.

2. Subsequent Visits – During the client's follow-up visits, the counselor/doctor should:

- Request the client's card.
- Retrieve the client's file from the lockable filing cabinet.
- Verify the client's name (shown on the CLIENT FILE) with the client to confirm that the correct client file has been pulled out from the files.
- Record the session on the counseling follow-up case notes, and appropriately file the client folder.

3. Filing – The counselor/health care provider should:

- File the client folders in the appropriate filing cabinet.
- Numerically file client folders.
- Ensure that the files are filed accurately and the client register is maintained on a daily basis. Files must always be accessible by authorized staff during clinic working hours.

4. Maintenance of files and disposal protocol

- Retain files as prescribed under standard rules and regulations.
- Dispose records only under prescribed health regulations.

5. Site Monitoring Data Collection and Reporting

- Collect data following the standard instructions.
- Report as per the agreement between FHI and the IA.

Prepared by: FHI

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Reviewed by:

Name/Grade

Signature

Date

■ CT 19: Retention and Disposal of Medical and Study Records

1. Clinical Records (medical, counseling, and laboratory records)

In Nepal, there are no explicit government guidelines regarding the possession, storage and disposal of clinical records. Usually, the service providers in clinics manage the clinical records. The implementing agencies will keep the medical records in their central files for a minimum of five years from the date of the client's last clinic attendance. While maintaining clinical records, ensure that:

- HIV/STI test results are provided to the client in person only and are not provided over the phone. Provide results to another person only after the client signs the "Release of Information" form.
- The copy of the test results required for medical or referral purposes must be provided with a copy of the "Release of Information" form signed by the client.
- Records are provided to the court if ordered officially (subpoenas). Please see below.
- Confidentiality protocols are strictly followed. All IHS staff are required to sign an "Oath of Confidentiality" as well as read, sign, and follow the appropriate Code of Ethics SOP. These are to be filed with the IA Manager.

2. Transferring records out from the central filing system

- Transfer records out if the client has not shown up for five years since the last recorded visit to the facility.
- Transfer records out if more than three months elapsed from the date of reported death.
- Store transferred records in a secure place for a maximum period of three years.
- Maintain confidentiality of the stored records.

3. Disposal of clinical records

- Dispose unclaimed records that have been stored for three years after being transferred from the central files.
- The IA should appoint a committee to supervise the destruction of the records.
- Committee members must sign and date a formal statement testifying the destruction of the records.
- Never recycle papers with medical records.

4. Study Records

Unless stated otherwise in national rules and regulations (not present to date), FHI's policies will be followed.

Prepared by: FHI

Date adopted: August 2007

Reviewed by:

Name/Grade

Signature

Date

■ CT 20: Summons, Subpoenas, and Arrest on Premises

1. Summons to attend court or legal proceedings

A summons is a court order that may require staff of implementing agencies to attend court or legal proceedings. Some summons, specifically in criminal offense, will be punitive if it is bypassed or not followed within the issued timeframe. Summons can also be issued to seek expert opinion on the reports or services provided by the implementing agencies; hence implementing agencies should comply with the court's orders.

Implementing agencies are advised to seek their own independent legal advice with regard to such summons. Implementing agency staff members are advised to immediately notify their site manager, who is required to immediately and directly inform the FHI Director.

If a patient is required to attend court, a medical practitioner should be immediately contacted to assess whether the patient is fit to attend.

2. Subpoenas

Subpoenas are issued by the court and are legally binding documents. Subpoenas can order implementing agencies to present to the court or authorities confidential client records. Implementing agency staff receiving such an order should immediately notify the site manager, who is required to immediately and directly inform the FHI Director.

3. Arrest on implementation agency premises

Implementing agency staff or clients may be arrested on the premises of implementing agencies. In these circumstances, the site manager must immediately be contacted. Implementing agencies are advised that lawful arrests should be accompanied by a warrant for arrest. However, as a health care provider, there may not be a situation of arrest for providing any service. Staff might be requested to come to provide an expert opinion on their services. In the case of such incidents, implementing site managers are required to immediately and inform the FHI Director.

Although the arrest of implementing agency staff for reasons of providing health services is highly unlikely, it is worthwhile to be aware of the rights to criminal justice under the judicial system of the Government of Nepal. The pertinent rights after arrest, while in police custody, during interrogation, during investigation, and while lodging a First Incident Report (FIR) are listed below for reference.

Rights to Criminal Justice (as per the Government of Nepal)

- If arrested, one has the right:
 - to know the reason of the arrest and ask for the warrant.
 - to be presented before the judicial authority within 24 hours of the arrest (excluding the time necessary for the journey).
 - if a woman, to be arrested by a female staff.
- While in the police custody, one has the right:
 - to get the letter of custody.
 - not to be handcuffed or physically restrained.
 - to meet with family or friends.
 - to consult with a lawyer.
 - not to be subjected to abuse or inhuman behavior while an inmate.
 - to complain about any abuse while an inmate.
 - to be examined by a medical practitioner.
 - if female, to be kept in a female cell.
 - if pregnant for more than 6 months, not to be subjected to custody until the child's delivery.

- While being interrogated, one has the right:
 - to have the interrogation conducted before a concerned authority (i.e. public attorney).
 - not to self-incriminate (compelled to speak against oneself).
 - to read by self or aloud by someone else before signing any document,
 - to sign the documents with one's own free consent

- During an investigation, one has the right:
 - to have one's body searched only in the presence of at least 2 witnesses and if possible, representative of local authorities.
 - if female, be searched by a female staff
 - if female, to be examined, as far as possible, by women medical practitioners while having a body check up during the investigation.

- While lodging a FIR, one has the right:
 - to have a FIR registered in the manner that one requests
 - to be accompanied by one's family members or friends
 - to have the FIR read aloud by someone else before signing it.
 - to complain to higher authorities if the appropriate police station did not register the FIR

Prepared by: FHI

Date adopted: August 2007

Reviewed by:

Name/Grade

Signature

Date

स्वैच्छिक परामर्श तथा परीक्षण सहमति फाराम

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निम्न कुराहरूको विषयमा मैले जानकारी र परामर्श पाएको छु :

१. मानिसको रोग प्रतिरोधात्मक क्षमतामा असर पुऱ्याउने विषाणु (एचआईभी) र भिरिङ्गीको स्वभाव र संभावित संक्रमणको असर ।
२. एचआईभी र सिफिलिस परीक्षणको उद्देश्य र कस्तो हुन्छ भन्ने जानकारी ।
३. एचआईभी र सिफिलिस परीक्षणले मलाई के जानकारी दिन्छ र के कुराको जानकारी दिन सक्दैन ।
४. एचआईभी र सिफिलिसको परीक्षणपछि हुने फाइदा र जोखिमहरु र ती परीक्षणको परिणामबाट पाइने फाइदा र जोखिम ।
५. एचआईभीको परीक्षणको सिलसिलामा पोजिटिभ, नेगेटिभ टेष्ट रिजल्ट एवं भ्याली अवधिको अर्थ ।
६. आफू र आफ्ना साथीलाई संक्रमण हुनबाट कसरी बचाउने ।

परीक्षणका नतिजालाई गोप्य राखिने, यसको जानकारी मलाई मात्र दिने र मेरो लिखित सहमतिविना कसैलाई पनि यो जानकारी दिन नपाइने शर्तमा म एचआईभी र सिफिलिसको परीक्षण गराउन सहमत भएको छु ।

परीक्षणपछि म मेरो एचआईभी र सिफिलिसको परीक्षणको परिणाम विषयमा छलफल गर्न, एचआईभी र सिफिलिसको संक्रमण रोक्ने उपाय एवं एचआईभी र सिफिलिस भविष्यमा अरुलाई नसरोस् भन्ने विषयमा कुरा गर्न तयार छु ।

मलाई थाहा छ कि मेरो एचआईभी र सिफिलिसको परीक्षणको परिणामले र मैले यी परीक्षण गराए वा नगराएमा यो क्लिनिकको स्वास्थ्य हेरचाह सेवामा कुनै पनि नकारात्मक असर पर्ने छैन ।

मैले धेरै प्रश्नहरु सोध्ने अवसर पाएँ र यी प्रश्नका सबै उत्तरहरु चित्तबुभ्दो गरी पाएँ ।

म आफ्नो स्वविवेकले स्वेच्छापूर्वक मेरो एचआईभी र सिफिलिसको परीक्षण गर्ने स्वीकृति दिन्छु ।

सेवार्थीको हस्ताक्षर वा औंठाछाप	परामर्शदाताको नाम र सही	मिति
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नाबालक र मानसिक असन्तुलनका सेवार्थीको लागि : म,.....ले नाबालक/केटाकेटी/ब्यक्तिको नजिकको नातेदार/अभिभावकको नाताले उनीहरूको नमूना रगतमा एचआईभी र सिफिलिस परीक्षण गर्न अनुमति दिएको छु ।

अभिभावकको सही वा औंठाछाप	परामर्शदाताको सही	मिति
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परिक्षणको नतीजा प्रकशित गर्ने सहमति

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म.....निम्न जानकारी प्रकाशित गर्न.....लाई दिन
स्वीकृत दिन्छु

(सेवार्थीको नाम)

(चिकित्सक वा परामर्शदाताको नाम)

- ⑥ एचआईभी परीक्षण नतीजा
- ⑥ मेरो मेडिकल रिपोर्ट
- ⑥ परामर्श सम्बन्धी जानकारी
- ⑥ आर्थिक स्थितिको जानकारी
- ⑥ मेरो सम्पर्क ठेगाना
- ⑥ अन्य

यी जानकारी(केन्द्रको नाम) मा.....(कर्मचारीको नाम)
लाई दिने

मलाई थाहा छ कि यी जानकारीहरू उपचारमा सहयोगी हुने गरी दिइएको छ र यो जहाँ दिइएको छ त्यहाँबाट पनि मेरो उपचारको लागि मेरो परामर्शदातालाई फिर्ता दिइने छ ।

सही.....
सेवार्थीको हस्ताक्षर वा औंठाछाप

सही.....
(चिकित्सक वा परामर्शदाताको)

सही गरेको मिति.....

नाबालक र मानसिक असन्तुलनका सेवार्थीको लागि: म.....ले
नाबालक/केटाकेटी/व्यक्तिको नजीकको नातेदार/अभिभावकको नाताले नाबालक/केटाकेटी/व्यक्तिको

- एचआईभी परीक्षण नतीजा
- सेवार्थीको मेडिकल रिपोर्ट
- परामर्श सम्बन्धी जानकारी
- आर्थिक स्थितिको जानकारी
- सेवार्थीको सम्पर्क ठेगाना
- अन्य

जानकारी प्रकाशित गर्न.....लाई दिन स्वीकृत दिन्छु।
(चिकित्सक वा परामर्शदाताको नाम)

.....
अभिभावकको सही वा औंठाछाप

.....
परामर्शदाताको सही

.....
मिति

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Consent for Release of Information

I _____, consent to _____,
 (Name of client) (Name of doctor/counselor)

to provide the following information:

- | | | |
|--|---|---|
| <input type="checkbox"/> HIV test results | <input type="checkbox"/> my medical records | <input type="checkbox"/> counseling information |
| <input type="checkbox"/> financial information | <input type="checkbox"/> my contact details | <input type="checkbox"/> other (specify) |

This information is to be provided to:

.....
 (Name of staff member)
 at the

 (Name of center)

I understand that where information is provided for referral purposes, I am consenting to that organization providing information back to my counselor about my referral.

I understand that I can cancel this authority to give my confidential information at any time.

Signed: _____ Signed: _____
 (Signature of client) (Signature of doctor/counselor)

Date Signed: __/__/__

For minors and intellectually disabled: I, _____ the guardian/ nearest relative of the minor/child/person, give consent to release the information of the following about the minor/child/person.

- | | | |
|--|--|---|
| <input type="checkbox"/> HIV test results | <input type="checkbox"/> medical records | <input type="checkbox"/> counseling information |
| <input type="checkbox"/> financial information | <input type="checkbox"/> contact details | <input type="checkbox"/> other (specify) |

 Guardian signature

 Counselor Name & Signature

 Date

VCT FORM

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Date: _____ Return visit: 1 2 3 4 5 6 7 8 9 Target group

<p>PRETEST COUNSELING*</p> <p><input type="checkbox"/> Attended Group information</p> <p>1. Counseling</p> <p><input type="checkbox"/> Individual <input type="checkbox"/> Couple</p> <p>2. How did client learn about this service</p> <p><input type="checkbox"/> Referred PE/ORW <input type="checkbox"/> Sexual partner</p> <p><input type="checkbox"/> Injecting partner <input type="checkbox"/> Family/ Friends</p> <p><input type="checkbox"/> By other partner organization</p> <p><input type="checkbox"/> Others specify _____</p> <p>3. Reason for testing: Medical*</p> <p><input type="checkbox"/> STI <input type="checkbox"/> TB</p> <p><input type="checkbox"/> Pregnancy <input type="checkbox"/> High prevalence area (asymptomatic)</p> <p><input type="checkbox"/> Surgery <input type="checkbox"/> HIV/ AIDS symptoms</p> <p><input type="checkbox"/> None _____</p> <p>Other _____</p> <p>4. Has client had an HIV test before</p> <p><input type="checkbox"/> No</p> <p><input type="checkbox"/> Yes , negative <input type="checkbox"/> Yes, positive</p> <p><input type="checkbox"/> Yes but, don't know the result</p> <p>If Yes has partner been notified: <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>5. In case of Minor (Please indicate code 1=HIV Positive, 2=HIV Negative, 3=Unknown)</p> <p>HIV Status of Mother <input type="checkbox"/> HIV Status of Father <input type="checkbox"/></p> <p>6. Most recent potential exposure</p> <table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 40%;">Exposure (Only tick when there Exposure risk)*</th> <th style="width: 15%;">Last occasion when this risk occurred Date</th> <th style="width: 15%;">Window Period (only tick if within the window period)</th> </tr> </thead> <tbody> <tr><td>Needle stick <input type="checkbox"/></td><td></td><td></td></tr> <tr><td>Occupational exposure</td><td></td><td></td></tr> <tr><td>Rape History <input type="checkbox"/></td><td></td><td></td></tr> <tr><td>Sharing injecting equipment <input type="checkbox"/></td><td></td><td></td></tr> <tr><td>Blood products/organ <input type="checkbox"/></td><td></td><td></td></tr> <tr><td>Vaginal intercourse <input type="checkbox"/></td><td></td><td></td></tr> <tr><td>Oral sex <input type="checkbox"/></td><td></td><td></td></tr> <tr><td>Anal intercourse <input type="checkbox"/></td><td></td><td></td></tr> <tr><td>Tattoo, piercing <input type="checkbox"/></td><td></td><td></td></tr> <tr><td>Mother to Child transmission (if child) <input type="checkbox"/></td><td></td><td></td></tr> <tr><td>Sexual practice</td><td></td><td></td></tr> <tr><td><input type="checkbox"/> Heterosexual <input type="checkbox"/> Homosexual</td><td></td><td></td></tr> <tr><td><input type="checkbox"/> Both</td><td></td><td></td></tr> </tbody> </table> <p>7. Explained about window period</p> <p>No <input type="checkbox"/> Yes <input type="checkbox"/> if client do not agrees for testing next date _____</p>	Exposure (Only tick when there Exposure risk)*	Last occasion when this risk occurred Date	Window Period (only tick if within the window period)	Needle stick <input type="checkbox"/>			Occupational exposure			Rape History <input type="checkbox"/>			Sharing injecting equipment <input type="checkbox"/>			Blood products/organ <input type="checkbox"/>			Vaginal intercourse <input type="checkbox"/>			Oral sex <input type="checkbox"/>			Anal intercourse <input type="checkbox"/>			Tattoo, piercing <input type="checkbox"/>			Mother to Child transmission (if child) <input type="checkbox"/>			Sexual practice			<input type="checkbox"/> Heterosexual <input type="checkbox"/> Homosexual			<input type="checkbox"/> Both			<p>8. HIV status of person/partner exposed to*</p> <p><input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Unknown <input type="checkbox"/> N/A</p> <p>Partner's Code (if positive)(Govt.) _____</p> <p>9. Children history</p> <p><input type="checkbox"/> Number of children* _____</p> <p><input type="checkbox"/> No. of HIV positive* _____</p> <p>Children Code if positive* _____</p> <p>10. Condom use in last 12 months</p> <p><input type="checkbox"/> Never <input type="checkbox"/> Sometimes <input type="checkbox"/> Always <input type="checkbox"/> Not sexually active in last 12 months</p> <p>Other method of contraception: _____</p> <p>11. Client/Client's partner (please circle) is pregnant: <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If Yes stage of pregnancy: <input type="checkbox"/> 1-3 months</p> <p><input type="checkbox"/> 4-6 months <input type="checkbox"/> >6 months</p> <p>12. Client gives history and/or STI</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If yes Medication</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>13. Client's partner has history and/or STI</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If yes Medication</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>14. Orientation on condom use:</p> <p><input type="checkbox"/> Verbally <input type="checkbox"/> Written leaflet given</p> <p><input type="checkbox"/> Demonstration <input type="checkbox"/> Client practice</p> <p>15. Orientation on HIV prevention for IDU</p> <p><input type="checkbox"/> Verbally <input type="checkbox"/> Written leaflet</p> <p><input type="checkbox"/> Not applicable <input type="checkbox"/> Demonstration</p> <p>16. Assessment of personal coping strategies: Depression:</p> <p>H/O Drugs for Psychological Problems <input type="checkbox"/> yes <input type="checkbox"/> No</p> <p>Suicide intent if result is HIV positive</p> <p><input type="checkbox"/> yes <input type="checkbox"/> No</p> <p>History of self harm or suicide attempt</p> <p><input type="checkbox"/> yes <input type="checkbox"/> No</p> <p>Intent to harm another if test result is HIV positive</p> <p><input type="checkbox"/> yes <input type="checkbox"/> No</p> <p>Potential risk of violence if discloses to partner</p> <p><input type="checkbox"/> yes <input type="checkbox"/> No</p> <p>Adequate personal support network</p> <p><input type="checkbox"/> yes <input type="checkbox"/> No</p> <p>17. Client Agreed to for the HIV testing</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
Exposure (Only tick when there Exposure risk)*	Last occasion when this risk occurred Date	Window Period (only tick if within the window period)																																									
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_____ Counselor Name _____ Counselor Signature _____ Date

* Government reporting requirement

VCT FORM

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Date: _____ Return visit: 1 2 3 4 5 6 7 8 9 Target group

<p>POST TEST COUSLING*</p> <p>18. Result Provided (Please Tick)* <input type="checkbox"/> HIV antibody Positive <input type="checkbox"/> HIV antibody Negative</p> <p>19. Use only for HIV negative result provision: Certification of all counselor/doctor interventions in this session <input type="checkbox"/> Provided & explained client result</p> <p><input type="checkbox"/> Checked for window period and subsequent exposure</p> <p><input type="checkbox"/> Client advised to re-test: <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If YES, Re-test date: ___ / ___ / ___</p> <p><input type="checkbox"/> Provision of risk reduction counseling Referral <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If YES <input type="checkbox"/> Consent for release of information signed <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Details of referral: _____</p> <p>20. For use only for HIV positive result provision: <i>Certification of all counselor/doctor interventions in this session</i></p> <p><input type="checkbox"/> Checked result prior to provision to client <input type="checkbox"/> Assessed client's readiness for results <input type="checkbox"/> Provided & explained the result <input type="checkbox"/> Provided brief information about follow-up and support <input type="checkbox"/> Assessed client capacity to cope with result <input type="checkbox"/> Suicide risk assessment (Refer SOP-VCT) <input type="checkbox"/> Discussion on strategies for partner disclosure <input type="checkbox"/> Disclosure (who, what, when and why) (Refer SOP-VCT) <input type="checkbox"/> While leaving clinic checked the client can get home safely <input type="checkbox"/> Assisting client to plan how they will cope during the next 48 hours <input type="checkbox"/> Discussed transmission reduction strategies</p> <p><u>Referral</u> <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If YES <input type="checkbox"/> Consent for release of information signed <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Referred to Care and Support <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p>21. Status of the partner <input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Unknown <input type="checkbox"/> N/A Partner's Code (if positive) _____</p> <p>22. Condoms provided* <input type="checkbox"/> No <input type="checkbox"/> refused <input type="checkbox"/> not available Yes, how many : _____</p> <p>23. IEC <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>24. Referred to* : <input type="checkbox"/> STI services <input type="checkbox"/> HIV clinician/Hospital <input type="checkbox"/> EPC <input type="checkbox"/> PLHA group/ Support group <input type="checkbox"/> TB services <input type="checkbox"/> Reproductive Health <input type="checkbox"/> Home base Care <input type="checkbox"/> PMTCT service <input type="checkbox"/> Psychosocial counseling <input type="checkbox"/> Others (specify) _____ <input type="checkbox"/> Not referred</p> <p>25. Referral Offered (write name of organization): _____</p> <p>26. Date of ongoing counseling: ___ / ___ / ___</p> <p>27. Other relevant information: _____ _____ _____ _____ _____ _____ _____ _____ _____ _____</p>
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 Counselor Name Counselor Signature Date

* Government reporting requirement

Counselor interventions performed this visit

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(Please tick appropriate boxes)

I certify that the following activities were performed this counseling session.

- Built rapport and introduced your role to the client, explained about service and record keeping
- The confidentiality and privacy that you can offer the client
- Basic information about HIV and transmission
- Conducted clinical risk assessment and provided feedback on client risk
- Behaviour change counselling following ABC model and Condom/safe injecting education/demonstration
- Assessed client's readiness to learn sero status
- Exploration of what the client might do if the test was positive, and the possible ways of coping with a HIV-positive result. This may include a suicide risk assessment if indicated.
- Exploration of potential support from family and friends
- Basic information about the test and result provision procedure
- Informed consent to undergo HIV and syphilis test obtained

Other notes:

Counselor Name

Counselor Signature

Date

VCT Follow Up Care Counseling Form

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Client Session Number :

Date: _____

1. DATE OF INITIAL DIAGNOSIS:

2. Has the client visited EPC?

Yes date.....

No reason.....

Comments:

3. PSYCHOLOGICAL STATUS OF THE CLIENT:

Client self report on coping with the diagnosis (brief note):

Counselor assessment of suicide/harm to order:

Client assessed to be at risk of suicide Yes No

Client assessed to be risk to others Yes No

Lifestyle changes made. Yes No notes:

4. POSITIVE PREVENTION

4.1 Partner disclosure

Already disclosed Yes No

If not, partner disclosure plan:

Client self disclose

Client would like to disclose in presence of counselor

Counselor to disclose on behalf of client without the presence of the client. (Signed release of information must be completed by client).

Client will disclose to a trusted third party and request that individual to make disclosure on their behalf.

Comments:

Disclosure to others (other partners or family members)

Others disclosure plan:

Client self disclose

Client would like to disclose in presence of counselor

Counselor to disclose on behalf of client without the presence of the client. (Signed release of information must be completed by client).

Client will disclose to a trusted third party and request that individual to make disclosure on their behalf.

Comments:

4.2 TRANSMISSION RISK ASSESSMENT:

Current condom use:

- 1. Doesn't use condoms with any sexual partners
- 2. Condoms used with regular partner only
- 3. Condoms used with all partners EXCEPT regular partner
- 4. Condoms used with ALL partners

IDU behaviors:

- Sharing needles and equipment
- Using only New needles and equipments
- No longer taking drugs

Drug dependency assessment or management referral required Yes No

Comments:

4.3 CLIENT IS CURRENTLY BREASTFEEDING:

N/A 1 = Yes, 2 = No

If YES, complete part 4.4

4.4 FEEDING REGIMEN:

- 1= Exclusive breastfeeding
- 2 = Exclusive supplement
- 3 = Mixed feeding

5. REFERRAL AND SUPPORT

5.1 Referral made for EPC services :

1= Yes, 2= No

If Yes, complete part 5.2

5.2 Referral made to*:

6. ADDITIONAL NOTES:

Data entry by:

(Name of VCT staff)

* Government reporting requirement

गोप्यता र गुणस्तरीय हेरचाहको लागि प्रतिबद्धता

म,.....निम्न उपायबाट मेरो विरामीको गोप्यता संरक्षण गर्छु :

(नाम)

- औषधोपचारको सिलसिलामा वा अत्यावश्यक अवस्थामा बाहेक मैले मेरो विरामीको विषयमा, उनको अवस्था बारे कसैलाई पनि जानकारी दिन्न । मेरो विरामीको परीक्षणको जानकारी तोकिएका व्यक्ति वा मेरो विरामीसँग सहमति लिएर मात्र अरुसँग यसको चर्चा गर्ने ।
- मेरो विरामीको सहमति नलिइकन कसैसँग उनको परिवारका सदस्यहरूसँग समेत उनको एचआइभी परीक्षणको विषयमा जानकारी दिइने छैन र छलफल गरिने छैन ।
- विरामीको फाइल, फाराम आदिमा उनको नाम उल्लेख नगरी संकेत चिन्ह दिन सबैले देख्ने गरी विरामीको फाइल जहाँपायो त्यहीं नछोड्ने
- विरामीको व्यक्तिगत फाइल प्रयोग नभएको समयमा निश्चितरूपले ताला मारी राख्ने

म निम्न कुराको पालना गर्न प्रतिज्ञारत छु :

मेरो क्षमताले भ्याएसम्म विरामीलाई सर्वोत्तम सुविधा दिने छु

- निजको हेरचाह र सहयोग मेरो क्षमता र तालीमभन्दा बाहिरबाट हुनसक्दैन । मेरो पहुँचभन्दा बढी हेरचाह र सहयोग आवश्यक परेमा म विरामीलाई अरु कहा सिफारिस गर्नेछु ।
- जसले सहयोग र हेरचाहको लागि मद्दत माग्छ उसैलाई दिने छु
- जसलाई हेरचाह र सहयोगको आवश्यकता पर्छ म उसलाई अस्वीकार गर्दिन । उसलाई अनुगमन सेवा दिने र हेरचाह गर्ने छु ।
- म सुपरभाइजर रहेमा मेरो टोलीले गोप्यता कायम गर्न गरेको वचनवद्धतालाई पालना गर्न लगाउने छु ।

हेरचाह गर्ने व्यक्तिको हैसियतले मेरो निम्न अधिकार हुने छ :

- कामको लागि पन्जा, ब्लिच/क्लोरीन, आदि गुणस्तरीय प्रतिरोधात्मक वस्तु पाउने ।
- कामको सिलसिलामा एचआइभी सार्ने घटना भएमा राष्ट्रिय एचआइभी नीति अनुरूप रोकथामका लागि पी.इ.पी. पाउने ।
- कामको सिलसिलामा एचआइभी संक्रमण भएमा एआरटी पाउने ।
- हेरचाह गर्ने व्यक्तिको हैसियतले मैले आफ्नो सीप र क्षमता विकास गर्न आवश्यक तालीम पाउने ।
- म भन्दा माथिका अधिकारीबाट मैले र मेरो टोलीले रेखदेख र सहयोग पाउने ।

नाम र सही

मिति

Commitment to Confidentiality and Quality Care

I, _____, commit to protect the confidentiality of my clients by:
(name)

- Not discussing my client or anything about his/her condition or situation with anyone unless required for referral or receiving clinical second opinion. Information regarding my client will only be shared for a referral or to receive a clinical second opinion with approval from my client.
 - This includes not discussing my client's HIV status with anyone including family members of the client unless given clear approval from the client to speak openly about their HIV status with some or all of the client's family members.
- Using code numbers instead of names for client files or forms.
- Not leaving client files in public view.
- When not using the client file, ensuring it is kept in a locked cabinet.

I also commit to do the following:

- Provide quality services to my clients to the best of my ability.
- Not provide care and support which is beyond my ability or training. To refer clients when I am unable to provide the care and support they need.
- Only provide services to people who request them.
- Do not abandon or reject clients who need care, but to provide immediate follow-up services and care to clients who require it.
- If I am a supervisor, I will closely monitor the activities implemented by my team to ensure that this commitment to confidentiality is followed.

As a care provider, I have the right to:

- Have access to standard precautions materials such as gloves, bleach, or chlorine.
- Access post-exposure prophylaxis if exposed to HIV as per the national guidelines.
- Access ART in the event of becoming HIV infected while working with the project.
- Receive training to upgrade my skills and capacities as a service provider.
- Receive supportive supervision from my supervisors and to provide supportive supervision to my team.

Name

Date

Annex 2

SUICIDE RISK ASSESSMENT MATRIX –

Source: King, M. (1993) AIDS, HIV and Mental Health. University of Cambridge Press

Client Name/Code: _____ Date: ____/____/____ Counselor: _____

Details	Low Risk	Medium Risk	High Risk
1. Suicide Plan a. Details b. Availability c. Time d. Lethality or method Chance of intervention	<ul style="list-style-type: none"> Vague Not available, will have to get No specific time or in time Pills, slash wrists Others present most of the time 	<ul style="list-style-type: none"> Some specifics Available, has close by Within a few hours Drugs and alcohol, car wreck, carbon monoxide Others available if called upon 	<ul style="list-style-type: none"> Well thought out; knows when, where how Has in hand Immediately Gun, hanging, jumping No one nearby; isolated
2. Previous Suicide Attempts	None or one of low lethality	Multiple of low lethality or one of medium lethality, history of repeated threats	One of high lethality or multiple of moderate Several attempts over past weeks
Stress	No significant stress	Moderate reaction to loss and environmental changes	Severe reaction to loss or environmental changes Many recent social/personal crises
4. Symptoms a. Coping Behavior b. Depression	<ul style="list-style-type: none"> Occasional suicidal thoughts Daily activities continue as usual with little change Mild, feels slightly down 	<ul style="list-style-type: none"> More than one suicidal thought per day Some daily activities disrupted, disturbance in eating, sleeping, schoolwork Moderate, some moodiness, sadness, irritability, 	<ul style="list-style-type: none"> May resist help Constant suicidal thoughts Gross disturbances in daily functioning Disillusions, paranoid, lost touch with reality Overwhelmed with hopelessness, sadness and anger (verbal/physical) feelings of worthlessness Extreme mood changes
5. Resources	Help available, significant others concerned and willing to help	Family and friends available but unwilling to help consistently	Family and friends not willing or hostile, exhausted or injurious Significant self neglect
6. Communication aspects	Direct express of feelings and suicidal thoughts	Inter-personalized suicidal goal ("They'll be sorry -I'll show them")	Very indirect or non verbal expression of internalized suicidal goal (guilt, worthlessness)
7. Lifestyle	Stable relationships, personality and school performance	Recent acting-out behavior and substance abuse, acute suicidal behavior in stable personality	Suicidal behavior in unstable personality, emotional disturbance, repeated difficulty with peers, family and teachers
8. Medical Status	No significant medical problem	Health declining	Chronic debilitating illness. Significant weight loss

Instructions for completion

- Read your notes from the risk assessment and case history.
- Using either a fluorescent marker or colored pen, highlight the appropriate the response that best describe the client. Work from the top of the document.
- At the conclusion of marking all items you should be able to see which areas are marked most frequently. Use this as a visual guide to the client's level of risk.
- This tool is an evidence-based instrument derived from meta-analysis of risk factors and suicide outcomes. It is likely the client's level of risk may fall between two distinct levels (i.e. low-to moderate or moderate to high.)
- Interventions should consider the upper level of risk of the client, and the client's responses.
- The tool should also provide guidance to a case support management plan.

Annex 3: Checklist for CT Service Evaluation

Name of Implementing Agency:
Assessment team:

Name of IHSC:
Date:

SUMMARY SHEET

Sub-category	Scored	Max	Follow up actions recommended	Resources/support needed	Responsible person(s)	Expected completion date
1. Management and Administration						
2. General Clinic Operations Issues						
3. C&T Services						
Total						

Scoring Notes:

NA: Not applicable (0) No
(1) Yes, partially (2) Yes

Method Notes:

O= Observation
R= Records Review
SI= Staff Interview
MI = Management Interview

 Red flag: serious deficiency, FHI senior management should be notified

DETAILED CHECKLIST
I. PROGRAM MANAGEMENT FUNCTIONS

1. Management and Administration		Method	Score			Observations/rationale for score
1.	Do the manager, finance officer and others have minimum the qualifications as stated in their JD?	R/SI	NA	1	2	
2.	Has the Manager been trained on FHI minimum standards and do all staff members understand the FHI minimum standards?	SI	NA	1	2	
3.	Are all necessary staff (especially the counselor, lab technician, project manager and outreach worker) available at the IHC?	O	NA	0	1	2
4.	Are written job descriptions for each position available including PEs? Are staff members aware of their roles and responsibilities?	R	NA	0	1	2
5.	Are staff members recruited according to FHI/IA agreed recruitment practice? Is the manager able to explain this practice?	R/MI	NA	0	1	2
6.	Is there an Organogram with names of staff and clear lines of supervision available?	R	NA	0	1	2
7.	Do staff receive ongoing mentoring, encouragement, supportive supervision and training to fulfill their responsibilities? How is this conducted?	SI/MI	NA	0	1	2
8.	Have all staff read and signed a code of ethics? Is this document available to the review team?	R	NA	1	2	
9.	Have all staff signed the "Oath of Confidentiality"? Is this document available to the review team?	R	NA	0	1	2
10.	Is a standard FHI approved registration and filing system (including confidentiality) being maintained at all times?	R	NA	1	2	
11.	Is there a referral directory available and updated within the last 12 months?	R	NA	0	1	2
12.	Are clients accessing important referral services? Are there any recent examples?	R/MI	NA	0	1	2
13.	Have targets been set for key performance indicators (e.g. number of people receiving services)?	R	NA	0	1	2

1. Management and Administration	Method	Score			Observations/rationale for score
		NA	0	1	
14. Is performance against targets reviewed together with staff? How often and in what manner?	MI	NA	0	1	2
15. Did the number of CT clients served during the last month meet or exceed targets?	R	NA	0	1	2
16. Did the number of target groups reached with outreach/peer education during the last month meet or exceed targets?	R	NA	0	1	2
17. Are reports including service coverage indicators properly stored and readily available?	R	NA	0	1	2
18. Do managers provide onsite orientation to all referral services for counselors/clinicians who make referrals?	MI	NA	0	1	2
19. Have all medical and lab staff (and cleaner) had a Hepatitis B vaccination?	MI	NA	0	1	2
20. Do counselors and doctors participate in case reviews as part of clinical supervision and support? How is this carried out?	MI	NA	0	1	2
21. Is staff performance appraised annually? How is it conducted? Are the results on file?	R/MI	NA	0	1	2
22. Is the IHSC easily accessible (consider waiting time, opening hours, distance, security etc)?	O	NA	0	1	2
23. Are there separate rooms for: administration, waiting, doctor, laboratory, counselor, and training/recreation?	O	NA	0	1	2
24. Do service hours comply with stated opening hours and days?	O/SI/CI	NA	0	1	2
25. Do clients have a waiting area, accessible drinking water and toilet facilities?	O	NA	0	1	2
26. Does the IHSC have space for relaxation/recreation?	O	NA	0	1	2
27. Does the IHSC have branding materials appropriately displayed – front sign?	O	NA	0	1	2
28. Does the IHC have branding materials appropriately displayed – mood poster?	O	NA	0	1	2

1. Management and Administration		Method	Score		Observations/rationale for score
29. Does the IHSC have branding materials appropriately displayed – photo album?	O		NA	0 1 2	
30. Does the IHSC have sufficient supply of condoms? Are they accessible?	O		NA	0 1 2	

II. TECHNICAL AND PROGRAMMATIC IMPLEMENTATION: SERVICE DELIVERY

2. General Clinic Operations Issues		Method	Score		Observations/rationale for score
1. Is there an accident register and FHI approved written procedure for management of occupational accidents available and visible by wall chart?	R		NA	0 1 2	
2. Does the clinic have separate rooms for: administration, waiting, doctor, laboratory, counselor and training?	O		NA	0 1 2	
3. Is PEP available? Does IHS manager, doctor and other supervisory staff know what steps to follow?	O/MI		NA	0 1 2	
4. Is visual and auditory privacy for clients maintained in the doctor's room, counselor's rooms and lab?	O		NA	0 1 2	
5. Do clients have a waiting area, accessible drinking water and toilet facilities?	O		NA	0 1 2	
6. Do bathrooms/toilets have soap and clean hand towels?	O		NA	0 1 2	
7. Does the clinic have adequate water and electricity supply?	O		NA	0 1 2	
8. Does the clinic have a backup power supply?	O		NA	0 1 2	
9. Is the clinic clean and well maintained?	O		NA	0 1 2	
10. Are there limited or no health and safety risks to clients or staff in clinic facilities? i.e. no electric wires exposed, water on floor, etc	O		NA	0 1 2	
11. Does each room (doctor, counselor, lab) ensure the auditory and visual privacy and comfort of patients wherever possible?	O		NA	0 1 2	
12. Are designated, experienced staff available throughout stated opening hours to provide a full range of agreed upon services?	O/SI/CI		NA	0 1 2	

2. General Clinic Operations Issues	Method	Score				Observations/rationale for score
		NA	0	1	2	
13. Does the IHS have and distribute materials related to promotion of services to the target groups?	O/SI	NA	0	1	2	
14. Is there an approved sharps disposal container available and in use?	O	NA		1	2	
15. Are condoms available in the counseling room?	O	NA	0	1	2	
16. Is there a dildo/artificial penis available in the counseling room?	O	NA	0	1	2	
17. Are appropriate IEC materials available in the waiting and counseling room (STI, HIV, IDU, CT, prevention & referral services)?	O	NA	0	1	2	
18. Do counselors have phone access at site?	O	NA	0	1	2	
19. Are gloves available in lab rooms?	O	NA	0	1	2	
20. Are lab coats and masks available to lab technicians and medical staff?	O	NA	0	1	2	
21. Is there a first aid box available to staff including simple methods for eye washing, covering of cuts and lesions etc?	O	NA	0	1	2	
22. Do policy and procedures exist for the short and long-term confidential and secure storage of clients' medical records to comply with requirements?	R	NA		1	2	
23. Infection Prevention Practices						
1. Is chlorine solution prepared at correct strength (0.5%)?	O	NA	0	1	2	
2. Do staff wear gloves, gown, shoes, mask, cap, and eye protection?	O	NA	0	1	2	
3. Were instruments cleaned with clean water and detergent?	O	NA	0	1	2	
4. Were instruments dried before autoclaving?	O	NA	0	1	2	
5. Were instruments sterilized by autoclave at 121°C at 106 KPa pressure for 30 minutes (for wrapped) or 20 minutes (unwrapped)?	O	NA		1	2	
6. Were sterile instruments stored in a clean, dry place and log book maintained?	O	NA	0	1	2	
7. Was liquid clinical waste disposed as per SOP?	O	NA	0	1	2	

2. General Clinic Operations Issues		Method	Score		Observations/rationale for score
8.	Are all units of the center including kitchen areas maintaining high standards of hygiene?	O	NA	0	1 2
9.	Do all clinical areas reflect high standards of bio-safety and universal precautions?	O	NA	0	1 2
10.	Are gloves used during waste handling?	O	NA	0	1 2
11.	Are sharps (syringes and needles) disposed in sharps container?	O	NA	0	1 2
12.	Do procedures exist for the safe disposal of waste (incineration and dumping) in accordance with FHI standards?	O	NA	0	1 2

II. TECHNICAL AND PROGRAMMATIC IMPLEMENTATION: CLINICAL PROCEDURES

3. C&T Services		Method	Score		Observations/rationale for score
I. Training					
a.	Lab technician trained on HIV testing using rapid test kits	SI	NA	0	1 2
b.	Counselor trained on CT / STI counseling / psychosocial assessment at FHI, or other FHI accredited organization	SI	NA	0	1 2
c.	Serious adverse events are reported to FHI senior management (including major allergic reaction, suicide/threats to others, arrest of clients, professional misconduct, etc.)	MI/R	NA	0	1 2
d.	Do written procedures SOPs/guidelines exist for all services? Are they accessible to all relevant staff? Have staff been trained on these procedures?	MI/SI	NA	0	1 2
II. Pre-test counseling					
a.	Build rapport & introduce role to client, explain about service & record-keeping	O	NA	0	1 2
b.	Ask about prior history of HIV testing	O	NA	0	1 2
c.	Informed written consent is provided free of coercion for HIV testing	O	NA	0	1 2
d.	Client given adequate time to understand the CT services and to have their questions answered in a manner that they can understand	O/CI	NA	0	1 2

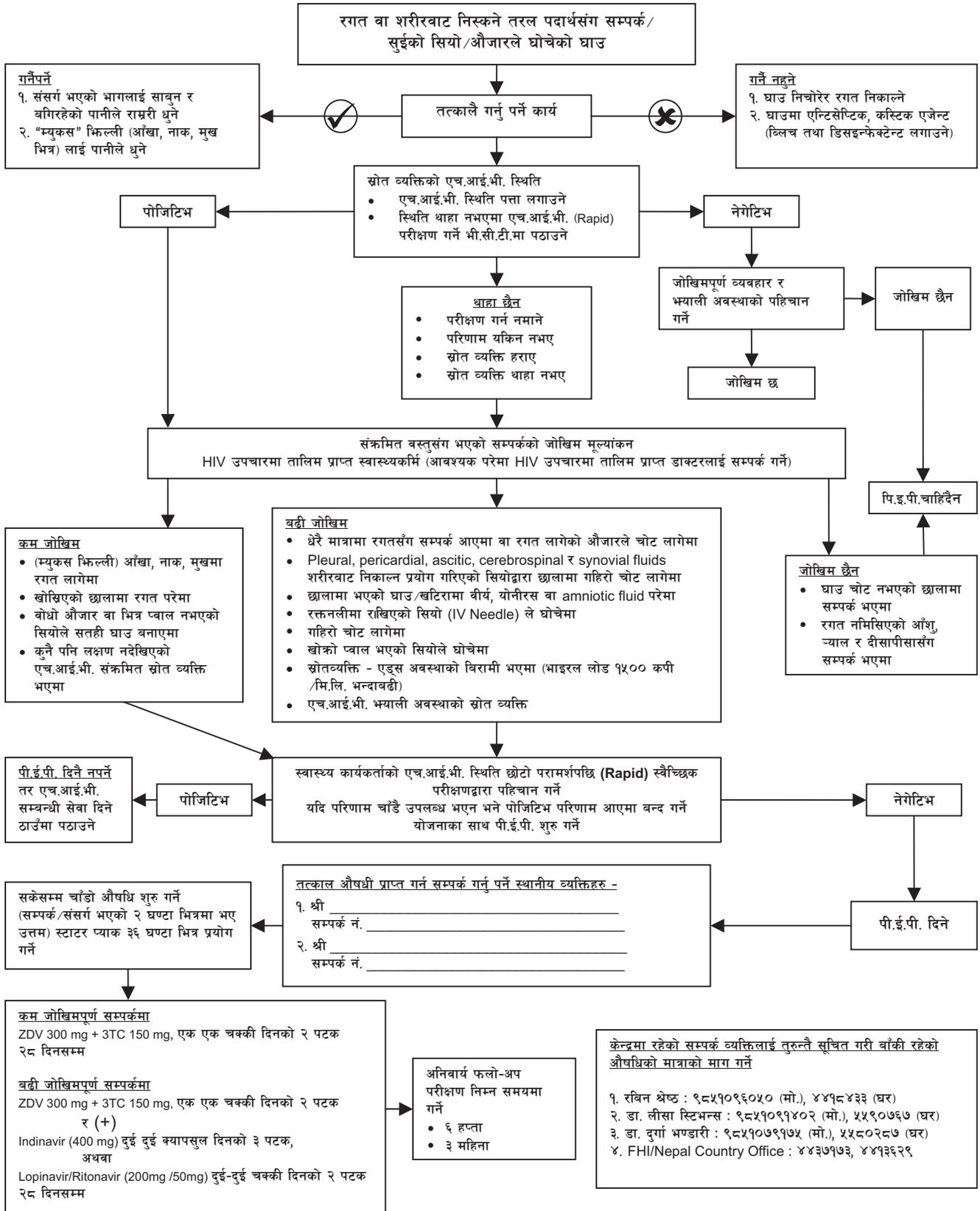
3. C&T Services	Method	Score		Observations/rationale for score
		0	1 2	
e. Explain confidentiality and privacy offered to client	O	NA	0 1 2	
f. Assess clients knowledge about HIV and provide basic information about HIV and transmission	O	NA	0 1 2	
g. Conduct clinical risk assessment & provide feedback on client risk	O	NA	0 1 2	
h. Ask client about symptoms of STI/treatment for STI	O	NA	0 1 2	
i. Ask client about her/partner pregnancy	O	NA	0 1 2	
j. Reinforce information about window period & provide client details of date for retesting	O	NA	0 1 2	
k. Behavior change counseling following ABC model & condom/safe injecting education/demonstration/rehearsal	O	NA	0 1 2	
l. Exploration of what client might do if test is positive, explain ways of coping & suicide risk assessment if indicated	O	NA	0 1 2	
m. Exploration of potential support from family & friends	O	NA	0 1 2	
n. Basic information about the test, blood collection & result provision procedure	O	NA	0 1 2	
o. Information provided for pregnant women and their partners (potential for HIV transmission, methods of PMTCT, etc)	O	NA	0 1 2	
p. Provide clients with condoms as appropriate	O	NA	0 1 2	
q. Specific prevention education for IDU	O	NA	0 1 2	
III. HIV Testing				
a. Use USFDA (or on USAID's waiver list) and FHI approved test kits (Determine, Unigold and Capillus)	O	NA	0 1 2	
b. Use test kits within expiry date and store according to the conditions specified by the manufacturer (also applies to transfer of kits to satellite sites).	O	NA	0 1 2	
c. Test kits are in sufficient supply for anticipated use	O	NA	0 1 2	
d. Before procedures are performed, answer clients' questions satisfactorily in a language they understand	O	NA	0 1 2	

3. C&T Services		Method	Score	Observations/rationale for score
e.	Staff wear gloves for blood collection	O	NA	1 2
f.	Swab bleed site prior to blood collection and offer a band aid after blood collection	O	NA	0 1 2
g.	Dispose syringes and needles, used test devices, micropipette tips and pipette according to FHI guidelines	O	NA	1 2
h.	Pack and transport test kits and samples according to SOP	O	NA	1 2
i.	Perform tests according to the SOP (within correct time)	O	NA	1 2
j.	Perform testing according to national and FHI testing algorithm (Determine ↑ Unigold ↑ Capillus/SD Bioline)	O	NA	1 2
k.	Correctly label HIV test result form (only ID and lab no.) and send to the counselor (confidential)	O	NA	1 2
l.	Complete national reporting forms according to national protocols	O	NA	0 1 2
m.	Lab testing is subject to internal and external quality assessment	O	NA	0 1 2
IV. Post-test counseling to requirements:				
<i>All types of results:</i>				
a.	All results are checked by counselor prior to provision to client	O	NA	0 1 2
	• Transfer test result form to client's file	O	NA	1 2
	• Give results simply and directly	O	NA	0 1 2
	• Check for understanding/discuss meaning of result	O	NA	0 1 2
	• Assess for type of support required (i.e. ongoing counseling, medical/treatment support, etc.)	O	NA	0 1 2
	• Discuss personal risk reduction strategy incorporating ABC	O	NA	0 1 2
	• Refer client for assessment of other medical conditions/vaccinations that may contribute to a false positive/negative result	O	NA	0 1 2

3. C&T Services	Method	Score			Observations/rationale for score
		NA	0	1	
<ul style="list-style-type: none"> Provide information for pregnant women/or partners (potential for HIV transmission, methods of PMTCT, referrals, etc) Provide clients with condoms as appropriate 	O	NA	0	1	2
<i>Negative result</i>					
a. Checked for window period and subsequent exposure	O	NA	0	1	2
<ul style="list-style-type: none"> Client advised to re-test if necessary Referral if necessary 	O	NA	0	1	2
<i>Indeterminate result</i>					
a. Explained possibility that testing performed during window period	O	NA	0	1	2
<ul style="list-style-type: none"> Refer to physician for investigation of other illness/indeterminate result Re-testing at this center in 12 weeks (6 wks if pregnant) Stress management and supportive counseling 	O	NA	0	1	2
<i>Positive result</i>					
a. Checked results and client details prior to provision	O	NA	0	1	2
<ul style="list-style-type: none"> Assess client's readiness for result Provide and explain result, check client understanding Provide brief information about follow-up and support Assess client capacity to cope with result Assess potential for harm to self/others Discuss strategies for partner disclosure Develop coping management plan Discuss follow up care and support and make referrals where necessary 	O	NA	0	1	2
<i>Follow-up care counseling</i>					
a. Engage client in discussion of priorities for support	O	NA	0	1	2

3. C&T Services		Method	Score			Observations/ rationale for score	
•	Assess mood of client including assessment of suicidal intentions	O	NA	0	1	2	
•	Assess client's capacity to adhere to risk reduction and partner disclosure	O	NA	0	1	2	
•	Engage where appropriate in active problem solving to resolve client psychosocial issues	O	NA	0	1	2	
•	Explore treatment & other adherence support	O	NA	0	1	2	
•	Assess client's potential for harm to self/others	O	NA	0	1	2	
V. Post-service delivery							
a.	All staff use standardized and FHI approved data collection forms (e.g., medical records, registers)	R/O	NA	0	1	2	
b.	All staff at all levels should appropriately use data collection forms, including correct and complete recording of activities according to donor requirements	R/O	NA	0	1	2	
c.	Off-site storage and destruction of clinical and medical records meets all local, regional and national requirements	R/SI/O	NA	0	1	2	
d.	Is there an adequate supply of all forms (list of forms in annex)?	O	NA	0	1	2	

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