

STANDARD OPERATING PROCEDURES OF VOLUNTARY COUNSELING AND TESTING (VCT) SERVICES IN COMMUNITY AND MOBILE SERVICES

In July 2011, FHI became FHI 360.



FHI 360 is a nonprofit human development organization dedicated to improving lives in lasting ways by advancing integrated, locally driven solutions. Our staff includes experts in health, education, nutrition, environment, economic development, civil society, gender, youth, research and technology – creating a unique mix of capabilities to address today's interrelated development challenges. FHI 360 serves more than 60 countries, all 50 U.S. states and all U.S. territories.

Visit us at www.fhi360.org.



**STANDARD OPERATING PROCEDURES
OF VOLUNTARY COUNSELING AND
TESTING (VCT) SERVICES IN COMMUNITY
AND MOBILE SERVICES**

USAID supported community sites Thailand 2011

USAID, 2011

Any part of this document may be freely reproduced with the appropriate acknowledgement.



Acknowledgments

This Standard Operating Procedure (SOP) manual was developed by Dr Kathleen Casey Regional Adviser, Testing, Counseling and Behavioral Interventions; Ms. Aramsri Sriburi, Senior Laboratory Specialist and Mr. Greg Carl, Consultant with contribution from Mr. Siroat Jittjang, Senior Technical Officer, Men Sexual Health and Ms. Lalida Ketgudee, Program officer and Mrs. Aranya Ngawong, translator.

Table of Contents

Introduction to C-M VCT	1
SOP 301: Group Pre-test Information	5
SOP 302: Individual Pre-HIV Test Counseling	6
SOP 303: Individual Post Test Counseling	8
SOP 304: Counseling on the First Follow-Up Visit	12
SOP 305: Partner Disclosure Counseling	13
SOP 306: Counseling Couples in VCT	15
SOP 307: Counseling and Testing after Sexual Assault	16
SOP 308: Laboratory Safety and Universal Precautions	18
SOP 309: Venous Blood Collection Procedure	21
SOP 310: Management of Post-Exposure Prophylaxis (PEP)	22
SOP 311: HIV Rapid Test Procedures	24
SOP 312: Laboratory Quality Assurance, Quality Control and External Quality Assessment	30
SOP 313: Waste Disposal	32
SOP 314: Space and Supplies for VCT Centers	34
SOP 315: Staffing for VCT Services	36
SOP 316: Code of Ethics	37
SOP 317: Recording and Reporting	40
SOP 318: Retention and Disposal of Medical and Study Records	41
SOP 319: Protocol for Managing Requests to Conduct Research	42
SOP 320: Subpoenas, Summons and Arrest on Premises	43
Annex 1: Service Related Forms	46
Annex 2: Checklist for VCT Service Evaluation	53
Annex 3: Commitment to Confidentiality and Quality Care	54

Introduction to C-M VCT

Community based and mobile VCT services aim to increase access to testing and counseling among men who have sex with men and transgender (MSM & Transgender) in Thailand. These service delivery points are referred to as Community VCT and Mobile (C-M VCT) Centers. The services provided through the C-M VCT Centers include:

- ❖ Clinical management of sexually transmitted infections
- ❖ Voluntary counseling and testing (VCT) services
- ❖ Essential package of care (EPC) to people living with HIV/AIDS (PLHA)
- ❖ Referral for other services

Rationale of the community and mobile services

Voluntary counseling and testing (VCT) allows individuals to learn their HIV status. After learning of their status, activities for positive life changes can be initiated involving physical, emotional and social health. Making good decisions and providing support early can greatly enhance the future life of PLHA. Post-VCT services should also reach clients who have recently learned that they are positive.

C-M VCT Site Commitment and Accountability

To ensure C-M VCT site commitment and accountability, it is important that:

1. C-M VCT staff holds monthly meetings to review site functioning and take necessary measures whenever indicated.
2. Quality assurance team from the Technical Unit of FHI Thailand (may include an FHI external consultant also) will conduct site assessments on at least three visits. New sites or sites requiring additional support will be monitored as needed. The FHI Laboratory Specialist will coordinate with the quality assurance team regularly and be responsible for overall quality assurance.
3. The C-M VCT staff will have primary responsibility for all dealings with C-M VCT clients, including test quality control, counseling and adherence to confidentiality rules. Responsibility includes handling client complaints, ensuring the maintenance and security of client files, and ensuring that procedures or protocols are adhered to.

Standards for General Service Provision

In order to maintain high quality of services, the C-M VCT site management will make sure that:

1. A client is attended to immediately. No client is made to wait unattended for a long time.
2. Approximate time for all procedures is written in Thai and displayed at the place where everybody can see.
3. Each site has a client flow management plan. A system of giving fixed appointment for coming clinic days should be in place and clients should be entertained on the date and time of their appointment.
4. Procedures and protocols developed for the C-M VCT centers are strictly followed.
5. HIV/STI test results are shown to the client in person only and are not provided over the phone. Results should only be provided to the client and someone with client's written consent only after they sign a "Release of Confidential Information" form.

6. Copy of the test results required for medical or referral purposes are provided only after signing "Release of Confidential Information" form by the client and provided along with a copy of the signed "Release of Confidential Information" form.
7. Condoms and demonstration models (dildos) for condom demonstrations are available on-site at all times. Sufficient models for condom demonstrations and group practice should be available.
8. Confidentiality protocols are strictly followed. All C-M VCT staff are required to sign an "Oath of Confidentiality" and the appropriate Code of Ethics standard operating procedure (SOP) should be read, signed and followed. These are to be filed with the IA Manager.
9. Written consent is obtained from the guardian if a minor is brought for testing.
10. Ensure that every client is given a VCT card with client file and/or code number.
11. Counseling must be conducted in private, where the conversation between clients and counselors cannot be overheard or seen by others

Standardize Service Provisions at C-M VCT Centers

HIV Counseling

1. Provide standardized counseling procedures.
2. Conduct standardized counselor training for all C-M VCT counselors, including ongoing in-service training and guest lectures/ talks for counselors.
3. Conduct regular supervision sessions/ stress management workshops for VCT counselors to prevent counselor burnout.
4. Introduce a counseling quality assurance system to monitor performance of counselors on a regular basis.

HIV Counseling: A Brief Overview

1. Counseling is communication.

Counseling is communication, both verbal and nonverbal, made in response to and in the presence of feelings. It is the work of supporting someone in making decisions when their willingness or ability to act is affected by their feelings. Effective counseling can help a client to explore, express, understand, and accept feelings so that s/he can make decisions.

2. Counseling is not education.

Counseling is different from education, although education can be a component of counseling. Good counseling does not equal good information giving. Good counseling is "client-centered", it is tailored to the behaviors, circumstances, and special needs of the person being served.

3. Counseling is not solving the problem or giving advice.

Counseling is not solving the client's problem for him/her or giving advice, it is facilitating problem solving. In the counseling process, the counselor avoids taking on the client's problem or telling the client how to solve the problem or what decision or action to take. Instead, the counselor brings a set of skills to the interaction that can enable the client to reach a better understanding of the problem, deal with her/his related feelings and concerns, and assume responsibility for evaluating alternatives and making choices.

4. HIV prevention counseling is different than ongoing counseling.

The HIV prevention counseling intervention is focused on an immediate presenting problem related to HIV. Referrals are made for problems falling outside the scope of the clinic services or the expertise of the counselor.

5. HIV prevention counseling is client-centered.

HIV prevention counseling is a client-centered exchange designed to support individuals in making behavior changes that will reduce their risk of acquiring or transmitting HIV.

Client centered counseling:

- ❖ is tailored to the behavior, circumstances and special needs of a person;
- ❖ focuses on personal risk assessment and development of a personalized action plan;
- ❖ takes into account client's emotional reactions, interpersonal situations, specific risk behaviors and client's readiness to change his/her behavior;
- ❖ content depends on the client's level of knowledge and his/her specific concerns about HIV/AIDS;
- ❖ develops individualized risk-reduction plan for each client;
- ❖ identifies the general problem; and
- ❖ makes a referral based upon the client's needs.

6. Counseling in C-M VCT Center is provided by a qualified and trained counselor only.

Counseling must be conducted in private where the conversation between counselor and the client cannot be overheard by others.

7. Each C-M VCT Center:

- ❖ Offers testing to all clients on an opt-out basis. In an opt-out approach, an HIV test is routinely recommended and provided to each client, and the client is informed of his or her right to refuse (to opt-out) the test.
- ❖ Ensures that the Counselor:
 - ◆ follows the counseling protocols as shown in this chapter, and maintains medical records which are included in the appendix;
 - ◆ meets with each client for a minimum of 20-30 minutes during a pre-test counseling session, and 20-60 minutes during a post-test counseling. Pre-test counseling and post-test counseling sessions are separated by testing time to generate test results. Rapid testing may need up to 60 minutes;
 - ◆ conducts couple/group information sessions as the need arises;
 - ◆ abides by all ethical standards in counseling;
 - ◆ becomes empathic and very professional while dealing with clients; and
 - ◆ appears presentable and professional.

HIV Testing

1. The USAID supported C-M VCT Centers will follow the same-day testing protocol algorithm that has been recommended by the MOPH Thailand
2. The CDC TUC will procure the rapid HIV, test kits for use by the C-M VCT centers.
3. C-M VCT staff performs the test according to this SOP. CDC TUC will arrange training for the staff on testing procedures.
4. All HIV positive patients will be referred to HIV treatment and care services.
5. A system for both internal and external quality assurance for the tests and the testing procedures will be in place. The project FHI Laboratory Specialist will be responsible to collect information from the reference laboratory and provide feedback to the implementing agencies (IAs).

Note: This SOP manual covers the HIV counseling and testing component of C-M VCT. It is recommended to revise this manual every year to include new developments in the field.

SOP 301: Group Pre-test Information

It is recognized that in many settings the demand for VCT is high and resources are limited. Often clients are kept waiting in busy waiting rooms for long periods of time where as this time could be utilized to reduce the amount of individual counseling time required. The information components of pre-test counseling could be provided in a group setting whilst issues specific to the individual could be discussed on an individual level.

The Counselor will:

- a. Provide the following in group information sessions:
 - ❖ Information on confidentiality and privacy of the clients;
 - ❖ Basic information about HIV;
 - ❖ Basic information about 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; and
 - ❖ General information about reproductive health
- b. A trained peer educator/volunteer can provide basic general information in settings with limited counselor availability and this individual must use the provided Group Pre-test information session flip chart.
- c. Always do the following:
 - ❖ Always obtain informed consent for group pre-test;
 - ❖ Ensure adequate privacy;
 - ❖ Restrict group size to not more than 10 individuals;
 - ❖ Only discuss the issues suggested above; and
 - ❖ Do not provide results of the HIV testing in the group (NEVER).

SOP 302: Individual Pre-HIV Test Counseling

It is the part of VCT counseling, which is done to prepare the client for testing. It is called pre-test counseling as it is done before testing for HIV.

The Counselor will:

1. Cross-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 centre. 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 centre and is confidential. Any information that we get from you in relationship to HIV is kept in your file, with only your code number on the outside. These files will be kept separately and used only in the provision of medical care and counseling for your benefit."*
 - ❖ VCT process outline – sessions, duration, testing procedures.
i.e. *"Our services are for people who come to this centre voluntarily. We will talk for 20 to 30 minutes. If you decide to be tested, you will need to wait approximately 20 to 60 minutes for the results. You will need a further 15 to 60 minutes to discuss the results after that."*
 - ❖ Record taking by 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 you will take to keep confidentiality.
3. Provide basic information about HIV and transmission discussing briefly the key methods of infection and also briefly how you cannot contract HIV.
4. Conduct clinical risk assessment. Combine risk education and assessment of risk. 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 partners 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 offered."

"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 clinical risk assessment. Provide information first followed by assessment of 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 they are very high or low risk. Talk to them in terms of having significant risks or appearing to have limited risks. Remind clients that the only way they can know if they are infected is by having an HIV test.

5. Discuss prevention related issues - condom use, including condom demonstration and safe injecting information. Exploration and problem solving of constraints to risk reduction should be offered. Such exploration may include:
 - ❖ Risk reduction attempts [previous]
 - ❖ Details of successful attempts
 - ❖ Details of failed attempts/obstacles

For e.g. "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 with the client to resolve difficulties in engaging in transmission risk reduction strategies, and develop a personal risk reduction plan for the client.
6. Discuss testing: provide basic information about the test and how results are provided. Some points to discuss here include:
 - ❖ Explain HIV testing procedure and possible test results
 - ❖ Discuss meaning of positive, negative and indeterminate results
 - ❖ Discuss advantages and disadvantages of having an HIV test
 - ❖ Advantages include being able to look after your health by seeking treatment
 - ❖ Discuss implications of results to self, partner and family
 - ❖ Explain about the window period

When HIV infects a person's body, their body realizes HIV is a virus that should not be in the body. The immune system in the body will begin to develop antibodies to try to kill the HIV and protect the person. The test used to check for HIV looks for these antibodies in the blood, and is called an antibody test.

It can take up to 12 weeks after infection with HIV for these antibodies to develop. This means that an HIV test can not guarantee a person's HIV status as negative if they have had any risk for HIV in the 12 weeks immediately before the test. This time period of 12 weeks before the test is called the "window period".

7. Obtain informed consent to undergo HIV testing and note on counseling record form.

SOP 303: Individual Post Test Counseling

Post test counseling is carried out to prepare the client to receive the results of the test. No test result should be given without appropriate counseling. At this stage clients are in a state of anxiety and stress, and proper care should be taken.

The Counselor will:

1. Understand Results

- a. Negative Test Result – A negative test result is given if the first screening test or the tie-breaker test in the serial algorithm shows non-reactive result. A negative test means that the person is either (1) not infected with HIV, or (2) so recently infected that the test could not detect the HIV antibodies (window period).
- b. Positive Test Result- A positive test result is given if both first screening and second confirmatory tests or the tie-breaker test show reactive result in the serial algorithm. A positive test means that the person is infected with HIV, that the HIV antibodies have been detected and that the person can transmit HIV to others.
- c. Indeterminate/Inconclusive Test Results- In the national serial testing algorithm there is no provision for indeterminate test result. All reactive with the first screening test are tested with the second confirmatory test and if both give different result, then the third tie-breaker test is used. The result of the tie-breaker test is taken as final. An indeterminate/inconclusive test result may either represent:
 - ❖ A biologic false positive test result, or
 - ❖ A truly positive test from a recent infection in which antibodies have not yet fully developed.

Clients must take the same risk reduction precautions as persons testing HIV positive until the indeterminate finding is resolved.

Need for repeat test:

A repeat test is recommended 6 weeks for pregnant women, and 12 weeks for others after the date of the inconclusive test result (or sooner if desired by the client; however the result may not be accurate before 6 weeks).

2. Provide Results:

Key Principles

- a. The result giving session addresses following main areas:
 - i. Giving test results, which includes dealing with emotional reactions and re-visiting risk reduction plans
 - ii. Repeat counselling sessions
- b. Show 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 negative)

- c. Check the details of client medical record with test results – make sure the results are in the correct medical record.
- d. Check the details of client medical record with the client – make sure you are giving the results to the correct client.

Providing HIV Negative Test Results

1. After seating the client and confirming that they are ready for their results simply explain the result is HIV negative.
2. Explain that the test has shown that the client is not infected however explain that if a risk occurred within the last three month period before the test was taken it will mean that there is still a chance that they may be infected and that this has not yet shown up in the test result that they have received today.
3. Check for any window period exposure that the client may not have disclosed at the time of pre-test counselling. If the client has not received a same day test result also discuss if their have been risks since the test was taken.
4. Advise the client with “window period” exposure of the need to practise safer sex throughout the life until a further test has been conducted. Advise them of the importance of this, 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.
5. Inform the client who has had “window period” exposure that they require a further re-test and based on the last risk behaviour advise them when to present for that re-test (give a date for re-testing).
6. Review the common means of how HIV infection is transmitted and how transmission can be prevented. Review the clients decisions about a personal risk reduction plan.

Providing HIV Positive Test Results

After seating the client and confirming that they are ready for their results simply explain 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:

- ❖ Freely express their anxiety and fears.
- ❖ Feel more secure by being warm and maintaining a calm presence.
- ❖ Explore exactly what it is that seems overwhelming.
- ❖ Break down the problems into manageable aspects and set priorities.
- ❖ Help client to develop an action plan for coping.

The steps to follow are:

1. Be aware of non-verbal communications when calling client to the counseling room from the waiting room.
2. Check client details.
3. Be direct e.g. *“I need to tell you that your result has come back positive and that means the HIV virus has been detected in your blood, which means you are infected with the virus”*
4. Provide some silence and time for the client to absorb the news.
5. Make a gentle enquiry *“I’m wondering what you’re thinking or feeling right now...”*
6. Encourage ventilation of emotion (normalize).
7. Check the client’s ability to cope emotionally, assess for possible self-harm (suicide) or of the client threatening harm to others. Refer to the “Detailed suicide/harm to others schedule” in the appendix.

8. Provide brief information about:
 - a. Follow-up and support available
 - b. Provide contact number of the C-M VCT center, hotline telephone number if available in the area
 - c. In case of emergency go to the nearest hospital
 - d. Provide a back-up to verbal information about diagnosis with written information. E.g. IEC materials.
9. Assist client with concrete planning
 - a. Planning to reduce HIV transmission to others
 - b. Address issues related to disclosure (who, what, when and why). See violence questions in the box that follows.
 - c. Leaving the clinic e.g. consider how will a distressed client get home?
 - d. Planning for the next 48 hours. This should include a follow up counseling visit.
10. Offer all clients testing positive an appointment for Essential Package of Care services.
 - a. If these are available the same day, this is best.
 - b. Some clients may not be ready and may need some time before this step, but an appointment date should always be given.
 - c. It is extremely important to emphasize that there are things that the client can do to live a longer, healthier and normal life. Getting regular check-ups by a provider with knowledge in HIV is one of them. 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.
11. Remember to ask if the client has any further questions.
12. Ask clients to write future questions down that arise between visits.
13. Provide referrals as required (Use the referral form)

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. Be on the alert for suicidal thoughts.

Denial – this could be verbal or non-verbal. Counseling should acknowledge client's difficulty in accepting the information. Let them talk about their feelings.

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

Coping strategies

Encourage the client to ask questions!

Be prepared to answer any questions honestly and with as much detail as is required. Don't be embarrassed to say you don't know some of the answers.

At some point an HIV positive client will need information on the following aspects:

- ❖ Information on treatment and care
- ❖ Health, rest, exercise, diet (lifestyle)
- ❖ Safe sex
- ❖ Infection control in the home and other social gatherings

You will need to carefully judge how much information to give.

Offer follow-up counseling sessions. In these sessions, the counselor is focusing on how the client is coping with the positive status (preferably within 48 hour); or how they are managing to maintain the negative status. Infant feeding options are also discussed. Follow-up sessions are supportive sessions where client's concerns are dealt with.

SOP 304: Counselling on the First Follow-Up Visit

The Counselor will:

1. Answer questions
2. Assess impact of the diagnosis
 - ❖ relationships
 - ❖ occupational
 - ❖ sexual health
 - ❖ assess client comfort with communicating with clinical care providers
 - ❖ partner disclosure issues including assessment for potential for violence related to disclosure (see appendix)
 - ❖ other social issues
 - ❖ sleep
 - ❖ diet
3. Engage the client in collaborative problem solving.
4. Conduct a suicide/harm to others risk assessment.
5. Further assist client in resolving issues and difficulties with disclosure of status to sexual partners or members of family or support network.
6. Assist with referral for assistance for services that your center cannot provide.
7. Workplace – client may find it hard to go to work when newly diagnosed. Assist them in making a plan around this issue.
8. Follow-up on success and difficulties with the client's personal risk reduction plan.
9. Ask about initial visit for Essential Package of Care 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 outcome and further follow-up plans.
10. Assist client in making decisions regarding treatment and gaining a referral.
11. Review the client's personal coping strategies and support needs. Refer for ongoing counseling where needed.
12. Refer using referral protocol described herein and use the consent form for referral.

How many times after VCT should we see VCT clients ?

Number of Sessions

- ❖ Clients attending VCT are expected to attend at least one pre-test counseling session, receive their test results and attend one or two post-test counseling sessions.
- ❖ Some clients will require additional counseling sessions.
- ❖ Although clients that have been seen at the VCT sites 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, no client seeking treatment will be refused.

SOP 305: Partner Disclosure Counseling

The Counselor will:

Offer all clients at risk or diagnosed with HIV support in disclosure to partners. The following support options should be routinely offered to all clients.

Why do we need to encourage disclosure?

1. Support broader access to treatment and care
2. Major transmission risk reduction strategy for HIV and STI
 - ❖ Primary transmission
 - ❖ Re-infection
 - ❖ The transmissibility of treatment resistance
3. We need to explain to clients that we encourage partner disclosure for the following reasons:
 - ❖ People can have STI/HIV for a long time without significant symptoms and not know and therefore pass to others (partners, children, blood donation).
 - ❖ The person who is in the window period (has a recent high risk) for HIV, HBV or HCV may actually be highly infectious but testing fails to provide a confirmed result.
 - ❖ If the partner does not know they are at risk, they may not suspect they are at risk. Therefore, they will not think to get tested and not receive 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 (see below) even when both individuals are infected and undergoing treatment.

Providing a menu of options for Client Disclosure

1. Self disclosure by client
2. Client brings to clinic partner/family and self discloses with counselor present
3. Client brings to clinic partner/family and counselor discloses in presence of client
4. Client authorizes counselor to disclose in the absence of the client
5. Client discloses to a key trusted family or community member who discloses to partner
6. 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” for disclosure should be signed by the client even in cases where the client is to be present.

Assessing for disclosure-related consequences

Counselors should seek information about whether disclosure to partners or families is likely to result in violence being perpetrated on the client.

A protocol follows that assists the counselor in clarifying 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 result in a risk to you or your children's safety?"



The client should make the decision to disclose based on a realistic appraisal of the threat.

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

Provision of after hours emergency service

- ❖ VCT service center do not provide after hour service.
- ❖ 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 need arises.

Repeat HIV counseling sessions

Issues to be addressed in additional counseling session may include the following:

- ❖ How the client is coping
- ❖ Success in risk reduction
- ❖ Status of disclosure to partners
- ❖ Reinforcement of healthy living
- ❖ Access to EPC services
- ❖ Access to support services and
- ❖ Further discussion of other issues such as family planning, STI prevention and treatment, condom use etc.

SOP 306: Counseling Couples in VCT

The Counselor will:

Counsel couple together, when clients come as couple BUT

1. Before beginning, the counselor should assure that each individual had given his/her consent for counseling and testing and that each individual is aware that he/she is expected to disclose the test results to the partner.
2. The counselor should meet with each person individually to ascertain if there are any issues between the partners e.g. history of violence that may make disclosure difficult or if there is any coercion with regard to testing.
3. Pre-test counseling may be conducted with the two people together or individually. **Risk assessment must be done separately**, in order to accurately assess risk.
4. The counselor first provides test results individually. The counselor then assists a member of the couple to share the test results with his/her partner.
5. After the disclosure of the test results, post-test counseling may proceed with both partners present.
6. Individuals who are reluctant to disclose their test results to their partners will be counseled and encouraged to disclose them with the assistance of the counselor.
7. The counselor must be aware; however, that he/she may not disclose an individual test result without the client's permission.

SOP 307: Counseling and Testing after Sexual Assault

The Counselor and other VCT service provider will:

Consider the following:

It is essential that clients are provided medical/forensic consultations. According to the law of Nepal, medico-legal examination and forensic evidence can be collected by a registered doctor of government hospitals only. Testing should not be the first priority! Support, health service and forensics (with consent) come first. Arrange the referral accordingly if client comes directly to C-M VCT center.

Additional points to be considered:

a. Key differences from VCT perspective

Sexual assault survivors

- ❖ May be highly emotional and distressed
- ❖ May be non-communicative and in shock

There are also additional risk factors for HIV infection to consider

- ❖ Tissue trauma may facilitate infection
- ❖ Co-infection with STIs
- ❖ Lack of self esteem post-assault may mean less commitment to safer behaviors
- ❖ Increased suicide risk
- ❖ Stigma and silence

b. Key counseling tasks

- ❖ Provide emotional support with emphasis on securing personal safety
- ❖ Support the client through the process of an immediate medical review (HIV/STI prophylaxis and any forensic and legal investigation)
- ❖ Baseline testing should only occur after pre-test counseling. HIV testing is not one of the urgent forensic investigations.
- ❖ The client can decline baseline HIV testing.
- ❖ Post-exposure prophylaxis (PEP) for non-occupational exposure should be started as soon as possible, preferably within 2 hours of exposure. HIV testing needs to be done urgently, of course after counseling and consent.

c. Not all sexual assault survivors disclose assault

- ❖ Clients may present with undisclosed assaults. It may be appropriate to check to see if clients who present for VCT have had coerced or non-consensual sex.
- ❖ Male survivors often will not report or even acknowledge to themselves that they have been assaulted
- ❖ Children may be extremely fearful and find it difficult to articulate what has happened

d. 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 misuse
- ❖ Acute stress reactions, somatization (early)

- ❖ Later common clinical presentations include post-traumatic stress, change in eating habits, anxiety disorders, and major depression.
- ❖ Many sexual assault survivors become “worried wells”- frequent testers

e. Psychosocial and welfare support is required

- ❖ Client may fear for ongoing personal safety and may require alternative housing if assessed as an ongoing risk.
- ❖ Treatment may incur cost.
- ❖ Referral and ongoing support is often required.
- ❖ Suicide risk assessment should be conducted over several visits (baseline and follow-up tests).
- ❖ Family counseling with client agreement may be helpful – only with written client consent (complete the “Release of Information” form).

f. Counselors need to protect client’s confidentiality

- ❖ It is extremely important that client privacy (confidentiality) is protected. A client’s sero-status is considered confidential and must be protected at all times.
- ❖ Counseling must be conducted in private, where the conversation between clients and counselors cannot be overheard.
- ❖ All recorded forms, even though identified only with a client code number, must be kept under lock and key, at all times, when not in use.
- ❖ Counselors and their supervisors will protect the privacy of the clients by not referring to the clients by 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.

g. Other aspects to be considered are

- ❖ Referral to a domestic violence service and women’s shelter.
- ❖ Child welfare agency referral.
- ❖ Third party disclosure WITH CLIENT CONSENT to a trusted family member, religious leader or community member who will assist with disclosure. Counselor facilitated disclosure with the client or without the client followed by family counseling.
- ❖ Counselors must be responsive to client’s emotions during the counseling session. This is not an educational session.

SOP 308: Laboratory Safety and Universal Precautions

The control of potential biological hazards in the clinical laboratory is provided by the use of standard work practices, commonly referred to as Universal Precautions. Prevention of contact by any person, with potentially infectious body fluids, secretions or tissues is considered universal precautions.

Principles of safety at the work place are:

1. Create a barrier between health care worker (HCW) and infection not between HCW and client
2. Observe safety precautions
3. Precautions in every step/procedure
4. Education to all health care workers

Space management:

1. Laboratory space should be sufficient to minimize crowding, which may contribute to laboratory accidents.
2. Laboratory surfaces, counters, and floors should be made of impervious materials to facilitate disinfection.
3. Eating, drinking, and smoking are not permitted in the laboratory. Direct and indirect hand-to-face contact should be avoided.
4. Facilities for hand washing must be provided in each laboratory area.
5. Only authorized personnel are allowed in the laboratory. During blood collection the door should be closed and a sign placed on the door stating "Do not enter". Casual visitors should not be admitted. Children are not to be admitted unless they are being tested (no testing of infants under 18 months of age unless prescribed by ART physician). Non-laboratory personnel are closely supervised and taught to use appropriate protective measures to ensure that they do not cause a hazard to themselves or to the laboratory staff.

Hand Washing:

1. Frequent hand washing is an important safety precaution, which should be practiced after direct contact with patients and laboratory specimens.
2. Immediately after accidental skin contact with blood, body fluids or tissues, hands or other skin areas should be thoroughly washed with soap and water. If contact occurs through breaks in gloves, the gloves should be immediately removed and hands thoroughly washed.
3. Hands should be washed before eating, drinking, smoking, applying makeup, changing contact lenses and before and after using the lavatory facilities. Hands should be washed at the completion of work and before leaving the laboratory. Hands should be washed before all other activities, which entail hand contact with mucous membranes, eyes and breaks in the skin.

Gloves:

1. All phlebotomists must wear gloves while procuring specimens.
2. Gloves should be changed between each patient. If gloves become grossly contaminated hand should be washed after removal.
3. All laboratory personnel who come in contact with blood and body fluids must wear gloves. It is encouraged to wash hand before putting on a fresh pair of gloves and after it is removed.

Laboratory coats, and shoes:

1. All laboratory personnel are to wear either a long-sleeved white laboratory coat, which is buttoned closed, or a blue long-sleeved gown, which is tied at the back. These garments are to be worn at all times while at the workstation or at times when the possibility of blood or body fluids may be splashed on the worker.
2. Laboratory coats /gowns must be changed immediately if grossly contaminated with blood or body fluids.
3. If the risk of splashing could occur in the work area the blue gown should be worn which is fluid resistant. If one's personal clothing becomes contaminated the article of clothing should be removed and washed.
4. Laboratory coat/gowns are not to be worn outside the laboratory. The only time a laboratory coat is allowed outside the laboratory is for phlebotomy or other technical procedures. All personnel protective equipment must be removed prior to leaving the work area.
5. Open toed shoes should be discouraged to protect from accidental injuries, e.g. drop injuries.

Masks and Goggles:

Masks and goggles are to be worn by laboratory workers while opening tubes of blood or body fluids. When opening tubes of such specimens there is a risk of splatter or aerosolization. To reduce this risk a gauze pad should be placed over the top of the tube while removing the stopper. Eyeglasses do not provide adequate splash protection. Goggles or face shields if available should be worn over eyeglasses.

Specimen Handling:

All blood or body fluid specimens requiring centrifugation must be spun with covered lid. This is to eliminate any aerosol that may be produced if a tube breaks in the centrifuge. Pouring of a specimen from a tube to a cup or other container is a process that can create an aerosol. To eliminate this potential danger, all specimen transfer should be done with a transfer pipette. Mouth pipetting is forbidden. Mechanical pipetting devices should be used when manipulating liquids.

Any open wound should be covered with proper bandaging to prevent the contact of the blood or blood products with the open wound surface.

Exits and aisles:

1. Must not be obstructed in any way. No equipment, chairs, supplies or trash are permitted in exit routes or areas.
2. Doors to the laboratory should be kept closed, but exit doors must not be blocked, bolted or obstructed in any way to block exit.

Good housekeeping:

1. Rags and/or flammable solvents should be disposed of in self-closing metal containers.
2. Do not hang clothing on or near radiators, steam pipes, heating instruments or open flames.
3. Do not allow trash to accumulate in any area. Trash should be disposed of daily.
4. Festive decorations will be limited to designs on glass outside of lab work areas. Hanging decorations and wax candles are prohibited. Decorations on lights and instruments are prohibited.

Glassware:

1. Do not use broken or chipped glassware. Discard it in specially marked "Broken Glass" containers and reorder. Use plastic bottle for this purpose.
2. Do not leave pipettes sticking out of bottles, flasks, or beakers.
3. Do not attempt to forcibly remove glass tubing inside stoppers. If they are stuck, cut them out.
4. Glass blowing and other artistic endeavors are prohibited.
5. Decontaminate glass exposed to specimens that may be contaminated with a variety of pathogens.
6. Dispose of broken or discarded pieces of glass in a specially marked separate container. Do not pick up broken glass with bare hands - use some mechanical aid to pick up broken glass. Disposal of broken glass along with paper and trash is a hazard to the custodial staff.
7. Hot glass - heated containers should not be handled with bare hand.

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

1. The needle of the disposable syringe should be disposed to a closed puncture-proof container. These items should be incinerated or burnt.
2. For disposable gloves, the gloves should be disposed to infectious leak-proof container. These gloves should also be burnt or incinerated.
3. Non-degradable wastes to be buried.
4. The burning, incinerating and burring place should be away from the premises of the clinic site.
5. Personnel transferring such waste should wear utility gloves.

Centrifuge:

1. Do not operate centrifuge unless the covers are closed. Keep hair, neckties, hair ribbons or other frilly or dangling items out of the way.
2. Do not centrifuge uncovered tubes or specimens (blood, urine, sputum) or flammable liquids. (Contaminated items can produce aerosols, flammables become bombs, etc.). Use caps.

Autoclaves:

1. Personnel must not operate autoclaves until they have been checked out in the proper operation by an authorized supervisor.
2. Do not open until both temperature and pressure is back to normal.
3. Be sure intake steam valve is off before opening.
4. Use insulated gloves when putting items into or removing items from the autoclave. The sides and door will still be hot in addition to the material being autoclaved. NOTE: Steam may permeate insulated gloves.
5. Loosen caps of any containers to allow equalization of pressures inside containers. This prevents explosions, boil-over and implosions.
6. Cellulose nitrate tubes may explode.
7. Refer any questions regarding proper preparation of items for sterilization directly to your senior. They will find the answer to you.

SOP 309: Venous blood collection procedure

Before collecting blood, the technician will label the tube in which the blood will be taken. The label should contain **client ID number and date of specimen collection**. The phlebotomist must verify and confirm the identity of the patients by checking client's ID number and by asking client to say their name

Procedure: Venous blood should be obtained by venupuncture of the median cubital vein.

1. Describe the procedure briefly to patient and inform him/her that there would be some pain due to needle prick
2. Ask the patient to sit on a chair and to place his/her forearm on the table or arm rest of phlebotomy chair
3. Identify the position of the median cubital vein in the medial aspect of the forearm just below and lateral to the elbow joint
4. Assemble the needed equipment
5. Tie the arm with the tourniquet above the elbow joint and ask the patient to fist his/her hand.
6. After locating the site, put the gloves on.
7. Clean the puncture site with 70% alcohol cotton ball or alcohol swab, working in concentric circles from the inside out. The process will be repeated if the arm is especially dirty.
8. The area will be allowed to air dry for 30-60 seconds or wiped with a sterile, dry gauze pad.
9. Re-palpate the vein, if necessary, to reassure location, depth and direction, this time with a gloved hand and after alcohol has been applied to the fingers.
10. Stabilize the vein by holding the vein between the index finger and thumb.
11. Enter the needle with bevel side up, directly above the vein and in the same direction.
12. Entry will be smooth, quick and at approximately a 15-degree angle relative to the skin.
13. Draw required amount of blood.
14. Release the tourniquet and ask the patient to release his/her fist hand.
15. Take out the needle and apply pressure on the punctured site with sterile cotton gauze and ask the patient to bend his/her forearm over the arm and apply a band-aid on the punctured site if necessary.
16. Discard the needle into sharp disposal container
17. Transfer blood to the tube. If EDTA blood is used, mix blood well by inversion at least 10 minutes
18. Records client information in registration book

SOP 310: Management of Post-Exposure Prophylaxis (PEP)

Introduction

Even when following universal precautions and safety procedures accident may happen. Most common accident to HCW is the percutaneous needle prick. Sometimes exposure of blood, semen, amniotic fluid and other blood-mixed body fluids to mucous membranes may happen. PEP flow chart should be displayed on the wall in all areas of the C-M VCT where exposure-prone procedures are likely to happen. The flow chart should contain all relevant contact names and numbers including after hours contact numbers.

The transmission of HIV infection through occupational exposure is rare. The risk of infection via percutaneous exposure is estimated to be approximately 0.3%. Risk after a mucous membrane exposure is 0.09%. Other common infections transmitted through such exposure include Hepatitis B and C.

What to do?

- ❖ Immediately wash the exposed part with soap and water.
- ❖ Do not squeeze the part and do not apply antiseptic, as it increases the area of trauma and may attract CD4 cells to the site of exposure.
- ❖ Immediately report to the focal person at your site.
- ❖ Follow the flow chart for HIV post-exposure prophylaxis (see annex).

Counseling following Accidental Exposure to Blood (AEB)

Counseling for prevention of transmission (safer sex, no blood donation etc.) whilst waiting for the follow-up serology, should be provided to the health worker. Counseling should be brief so that PEP can be started as soon as possible, preferably within 2 hours. Counseling can be continued even after the administration of the drug for PEP of HIV. The health worker may have anxieties about telling his/her sexual partner about the AEB and recommendations to use safer sex until the follow-up test result is known. The health care worker may wish to involve his/her partner in the counseling. Although PEP is highly effective and the risk of transmission post exposure is low, long term counseling and support services, possibly including treatment for HIV disease, must be in place for health workers who acquire HIV despite PEP.

Occupational exposure to Hepatitis B virus

Hepatitis B PEP is currently not available, so pre-exposure prophylaxis is recommended. It is mandatory for all laboratory technicians and those on the risk of exposure to get the three doses of Hepatitis B vaccine, please follow the agreement with FHI.

Hepatitis C post-exposure management

There are currently no medicines available for post-exposure prophylaxis for Hepatitis C virus (HCV). For HCV post-exposure management, the HCV status of the source and the exposed person should be determined. Follow-up HCV testing should be performed to determine infection at a later stage. No transmission in health care worker has been documented from intact or non-intact skin exposures to blood. Refer the case to the HIV clinician for the final decision as soon as possible.

Evaluation

Evaluation of post-exposure prophylaxis with respect to acceptability, adherence and tolerance to the PEP regimen is required. Thus it is important that doctors and health care workers caring for the exposed HCW keep careful record of this data.

Incident should be immediately reported to the focal person for that site, so that necessary steps as mentioned in the flow chart can be taken as soon as possible and PEP started as earliest as possible, preferably within 2 hours.

Exposure Report

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

1. If an occupational exposure occurs, the circumstances and post-exposure management should be recorded.
2. Relevant information includes date and time of exposure.
3. Details of the procedure being performed, including where and how the exposure occurred. If the exposure was related to a sharp device, the type of device and how and when in the course of handling the device the exposure occurred.
4. Details of the exposure, including the type and amount of fluid or material and the severity of the exposure (e.g., for a percutaneous exposure, depth of injury and whether fluid was injected; or for a skin or mucous-membrane exposure, the estimated volume of material and duration of contact and the condition of the skin (e.g., chapped, abraded or intact).
5. Action taken – first aid provided.
6. Details about the exposure source (i.e., whether the source material contained HIV or other blood-borne pathogen), and if the source is an HIV-infected person, the stage of disease, history of anti-retroviral therapy, and viral load, if known.
7. Refer all clients to your local government hospital or recognized ART prescribed service. Each VCT service will be advised of their local referral options for management of occupational exposure.

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 the lack of transmission of HIV from this incident.

SOP 311: HIV Rapid Test Procedures

Instruction for HIV testing by Determine HIV 1/2 test kit

Principle: The Determine HIV 1/2 is an Immunochromatographic test for qualitative detection of antibodies to HIV and HIV 2 sample is added to sample pad. As the sample migrates through the conjugate pad, it reconstitutes and mixes with selenium colloid-antigen conjugate. This mixture continues and migrate through the solid phase to immobilized recombinant antigens and synthetic peptides at the patient window site.

If antibodies to HIV-1 and/or HIV-2 are absent, antigen-selenium colloid flows past the patient window, and no red line is formed at patient window site.

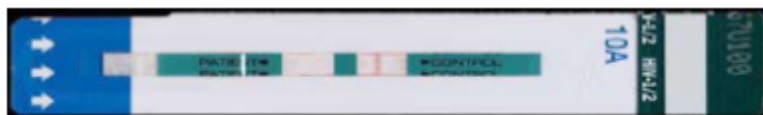
Materials and equipment

1. Determine HIV 1/2 test kit
2. Micropipette
3. Timer

Procedure

1. Check the expiry date and recommended storage temperature of the kit on the kit box./ Do not use expired kits or kits stored at non recommended temperature.
2. Bring desired number of Determine HIV 1/2 test kit to room temperature
3. Label client ID on test kit
4. Remove the protective kit cover from each test
5. Using a micro pipette, apply 50 µl of whole blood, serum or plasma to the sample pad marked by the arrow symbol
6. For whole blood sample, drop chase buffer one drop after apply the sample
7. Wait a minimum of 15 minutes (up to 60 minutes) and read the result and Record results
8. Interpretation of test result

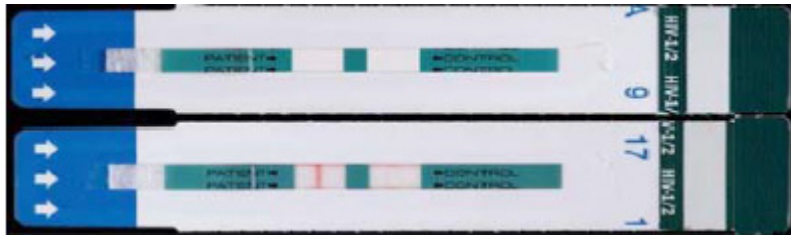
Non reactive (One Bar): One red bar appears in the control window of the strip (labeled 'Control') and no red bar appears in the patient window of the strip (labeled 'Patient').



Reactive (Two bars): Red bars appear in both the control window (labeled 'control') and the patient window (labeled 'Patient') of the strip. Any visible red color in the patient window should be interpreted as reactive.



Invalid (No Bar): If there is no bar in the control window of the strip and even if a red bar appear in the patient window of the strip, the result is invalid and should be repeated.



Instruction for HIV testing by DoubleCheck™Ultra HIV 1/2 test kit

Principle: The DoubleCheck™Ultra HIV 1/2 kit is an Immunochromatographic qualitative test for the detection of antibodies. Recombinant proteins representing the immunodominant regions of the envelope and gag proteins of HIV 1 and the gp 36 molecule of HIV 2 are immobilized at the test regions of nitrocellulose strip and an antibody binding reagent dispensed at Control region of strip. HIV 1 and HIV 2 proteins, linked to colloidal gold are impregnated on the gold pad, placed between the sample and the nitrocellulose strip. The assay is initiated by applying the sample to sample port of the cassette. The subsequent addition of two groups of wash reagent facilitates the flow of the specimen into the cassette and onto the test strip. If antibodies specific to HIV and/or HIV 2 proteins are present in the sample, they will react with the colloidal gold conjugate particles. The antibody HIV protein-colloidal gold complexes move along the nitrocellulose membrane to immobilize HIV- 1 and HIV-2 antigens located at the Test region of assay cassette and if positive will form a pink/red band. Visualization of the control line generated when the IgG colloidal gold complex is bound by anti Ig G antibody bound to nitro-cellulose in the control region

Materials and equipment

- ❖ DoubleCheck™Ultra HIV 1/2
- ❖ Micropipette
- ❖ Timer

Procedure

1. Check the expiry date and recommended storage temperature of the kit on the kit box. Do not use expired kits or kits stored at non recommended temperature.
2. Bring desired number of Double Check Gold Ultra HIV 1/2 test kit to room temperature
3. Remove the protective kit cover from each test and label with the appropriate patient/client identification.
4. Using a micro pipette, apply 25 µl of whole blood to the sample well of the device
5. Add 2 drops (approximate 70 ul) of assay diluents and start the timer
6. Allow the reaction occur, the purple color move across the result window in the centre of the test device
7. Read the result after 15 minutes incubation. Do not read the result after 25 minutes
8. Interpretation of Test Results

Non reactive (One Bar)

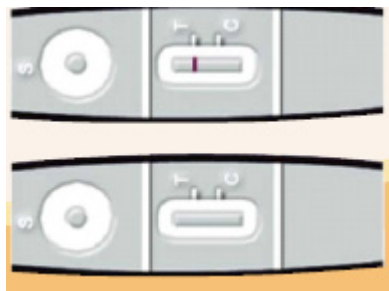
One red bar appears in the control region of the device (labeled 'Control') and no red bar (T) of the result window

**Reactive** (Two bars)

a) The presence of two color lines ("T" and "C") in the result window indicates a reactive result for HIV-1/2

**Invalid** (No Bar)

If there is no control line appears in result window of device, even though the a red bar appears in the Test region of the device (T), the result is considered as invalid and should be repeated with new device.



Instruction for HIV testing by SD HIV 1/2 test kit

Principle: The SD BIOLINE HIV 1/2 3.0 kit is an Immunochromatographic qualitative test for the detection of antibodies to all isotypes (IgG, IgM, IgA) specific to HIV-1 including subtype-O and HIV-2 simultaneously in human serum, plasma or whole blood. The test kit contains membrane strip, which is precoated with recombinant HIV-1 capture antigen (gp41, p24) on test line 1 region and with recombinant HIV-2 capture antigen (gp36) on test line 2 region respectively. The recombinant HIV-1/2 antigen (gp41, p24 and gp36)-colloid gold conjugate and the sample move along the membrane chromatographically to the test region (T) and forms a visible line as the antigen-antibody-antigen gold particle complex forms with high degree of sensitivity and specificity. The Test line and control line in the result window have been clearly label: "1" for test line 1 and "2" for test line 2 and "C" for Control line. Both test line and control lines in the result window are not visible before applying any sample. The Control line is used for procedural control and should always appear if the test procedure is performed correctly.

Materials and equipment

1. SD HIV 1/2 test kit
2. Micropipette
3. Timer

Procedure

1. Check the expiry date and recommended storage temperature of the kit on the kit box. Do not use expired kits or kits stored at non recommended temperature.
2. Bring desired number of SD bioline HIV 1/2 3.0 test kit to room temperature
3. Remove the protective kit cover from each test and label with the appropriate patient/client identification.
4. Using a micro pipette, apply 10 ul for serum/plasma or 20 µl of whole blood to the sample well of the device labeled "S"
5. Add 4 drops (approximate 120 ul) of assay diluents and start the timer
6. Allow the reaction occur, the purple color move across the result window in the centre of the test device
7. Read the result within 5-20 minutes incubation. Do not read the result after 20 minutes
8. Interpretation of test result

Non reactive

The presence of one color line (Control line "C") in the result window



Reactive The presence of control line at control window ("C") and strong red line at marked 1 in T region ("T") in the result window indicates a reactive for HIV 1



The presence of control line at control window ("C") and strong red line at marked 2 in T region ("T") in the result window indicates a reactive for HIV 2

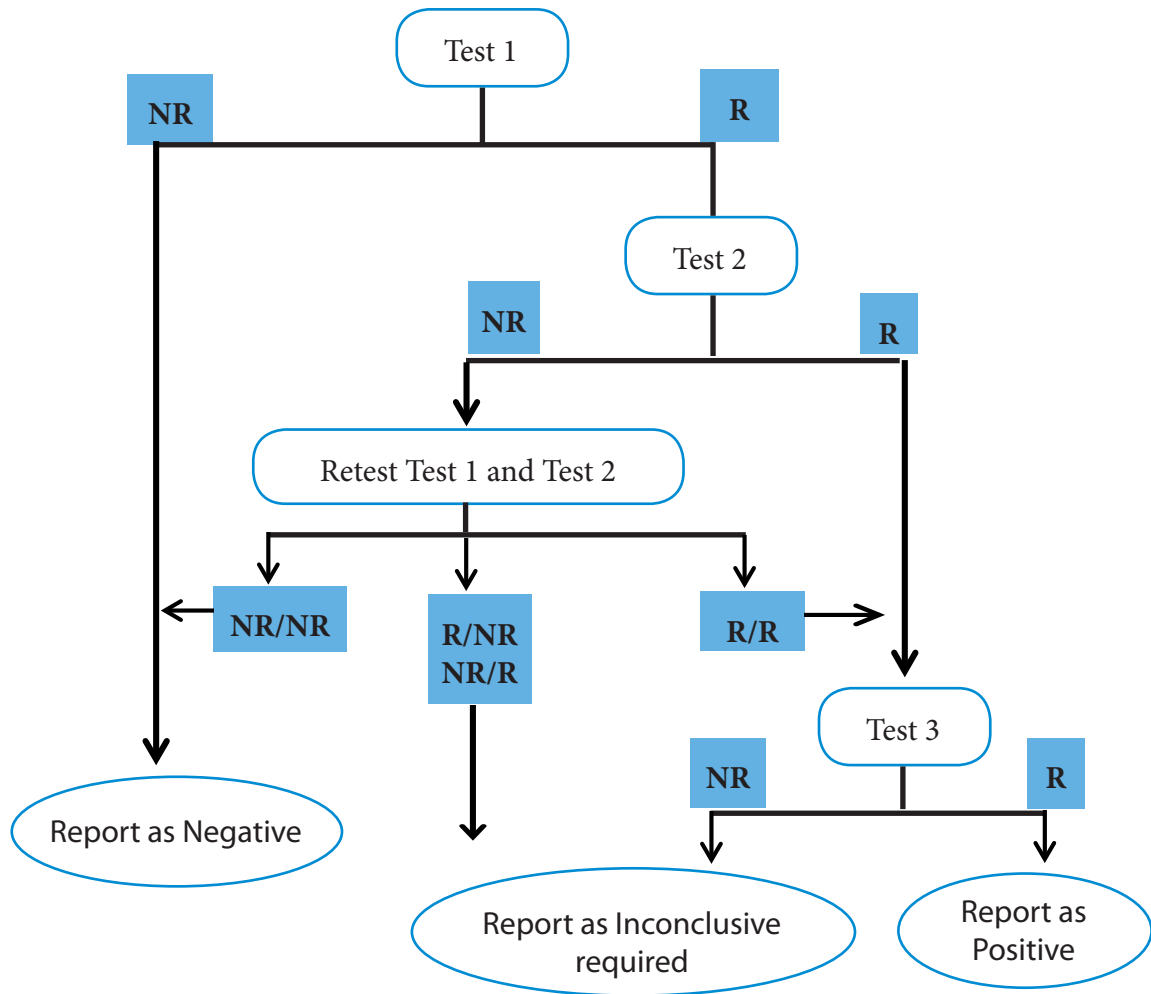


Invalid If there is no control line appears in result window of device, even though the a red bar appears in the result window of the device (T), the result is considered as invalid and should be repeated with new device.



National HIV testing algorithm

SOP 311: HIV Rapid Test Procedures



Note:

Test 1 = Determine HIV 1/2,
 Test 2 = DoubleCheck Gold HIV 1/2,
 Test 3 = SD Bioline HIV 1/2
 R = Reactive, NR = None Reactive

SOP 312: Laboratory Quality Assurance, Quality Control and External Quality Assessment (EQA)

Quality Assurance (QA): QA is the total process that guarantees that the final result reported by a laboratory is as accurate as possible. This involves inspecting specimens, reviewing transcriptional measures, using most reliable assays and verifying final reports.

Quality Control (QC): QC encompasses measures taken to monitor the quality of the test itself. Quality control ensures that the test is working correctly and the tester can report accurate test results with confidence.

There are 2 levels of QC for HIV rapid testing:

- ❖ Testing of samples with known results to verify if the procedure is working properly: This should be done at least once a month for each test kit.
- ❖ Interpreting the presence or absence of control bands/lines within the device itself: If the control band appears within the device the test is considered as valid and if the control band does not appear the test result is not considered valid and should not be reported to the client.

If problems or errors occur, corrective actions must be taken before giving results to patients. External Quality Assessment (EQA): EQA is the objective assessment of a test site's operations and performance by an external agency or personnel.

There are three main EQA methods:

- ❖ Proficiency testing (PT) – Proficiency panel may be used during on-site visits.
- ❖ On-site evaluation, which is sometimes referred to as on-site monitoring visits or audits.
- ❖ Rechecking or retesting of specimens.

Proficiency testing

The most common method for external quality assessment of laboratory's performance is proficiency testing. The national reference laboratory or other recognized reference laboratory should send to a participating laboratory a proficiency panel of approximately eight specimens to identify as HIV positive and HIV negative. This panel should have HIV positive and negative specimens representative of the HIV strains prevalent in the country.

Retesting at reference laboratory

Current policy in the FHI-supported laboratories in Thailand for external quality assessment is to send all (100%) positive and 10% of the negative serum or dried blood spot samples to the reference laboratory for retesting. These samples have already undergone testing at the FHI-supported lab using the existing serial testing algorithm. The reference laboratory will perform the HIV testing and forward the reports back to the FHI participating lab. Once reports are available they are cross-checked with the lab report at the participating VCT site and entered in the external quality assessment register.

1. All FHI-supported sites while sending the samples provide the list of the copy of the samples sent with the test result with code to the Reference lab (FHI laboratory, DARL).
2. Reference lab sends a copy of the results to the IA with copy to the Lab Specialist.

Quality assurance is applied throughout the testing process at all testing sites. It is not a one time event. This is a continual process encompassing three phases and there are multiple activities associated with each phase of testing.

Quality assurance should be applied throughout three phases. They are:

1) Pre-Analytical Phase 2) Analytical Phase 3) Post-Analytical Phase

1. Pre-Analytical Phase: This phase encompasses the following components.

- ❖ Laboratory Staff: Laboratory staff should have had formal training on rapid HIV testing.
- ❖ Laboratory safety: Laboratory staff and all the concerned staff should follow the universal precautions and laboratory safety throughout the testing.
- ❖ Cold chain maintenance of the test kits and samples: All the test kits should be stored at 2-8 °C inside the refrigerator, if necessary. Samples for EQA should be stored at -20 °C for storage of more than a week.
- ❖ Specimen collection and labeling: Specimen collection should be done following universal precaution and safety. Collected specimen should be labeled with patient's code number.
- ❖ Number of specimens tested: Only manageable number of specimen should be tested each day.
- ❖ Expiry dates of test kits: The test kit to be used for testing should be within its expiry date. Kits having shorter expiry should be used first.
- ❖ Test kits stock: Test site should have stock of test kits for at least one month.

2. Analytical Phase: This phase encompasses the testing process itself. Some of the components are as follows:

- ❖ Written Procedure Manual: Test site should have written standard operating procedures for all tests to be performed at the laboratory. Procedure flow charts for the tests should be stuck on the wall of the laboratory at accessible and visible area.
- ❖ Laboratory staff should adhere to the standard operating procedures
- ❖ Correct use of reagents: Reagents for testing should be used in appropriate amount as described in manufacturer's package insert/ protocol. While performing tests, the reagents to be used for one test kit should not be used for another test kit.

3. Post-Analytical Phase: This phase encompasses all elements that occur after testing.

- ❖ Interpreting result properly and judiciously.
- ❖ Transcribing results: e.g. recording results on the correct identifier code.
- ❖ Entering data into the tracking system (computer or hard copy).
- ❖ Maintaining records in the forms and registers.
- ❖ Reviewing quality control.

The laboratory quality assurance will be strictly implemented and followed judiciously.

SOP 313: Waste Disposal

Introduction

Safety precautions are essential and should be followed at all points in the testing process from specimen collection to testing and disposal of bio-hazardous wastes, so as to minimize occupational and environmental risk.

General considerations

- a. Proper disposal of all contaminated laboratory waste is essential.
- b. All the contaminated waste in the laboratory and the clinic should be decontaminated before disposal; this includes specimens of body fluids, broken glassware, and containers of contaminated needles.
- c. Materials that are decontaminated or disposed of outside the laboratory should be placed in a strong leak-proof container prior to transporting them outside the laboratory.
- d. Burn used syringes and other solid waste in an incinerator.
- e. If it possible, use the needle destroyer for used syringe needles.

Collection

There should be different types of containers for the collections depending on types of wastes generated in the clinic and laboratory settings. Overall wastes generated can be categorized into three categories:

- ❖ **Hazard free wastes** are papers, plastic covers of syringes and other uninfected materials. Recommended color for the container is blue.
- ❖ **Infected wastes** other than sharps should be handled carefully and collected in a leak-proof and puncture-proof container with a secured lid. Recommended color for the container is red. Infected wastes may be liquid and solid. Liquid wastes are collected in a container with 0.5% Sodium Hypochlorite solution. There must be enough 0.5% solution in the container so that even when liquid waste is added, the concentration of the solution remains approximately the same. Infected dressing materials, swabs etc. are solid waste and collected separately from liquid wastes.
- ❖ **Sharp wastes** produced in our settings are mainly needles. Needles are not collected but destroyed by using the needle destroyer. Syringes and other sharp wastes generated in the facility can be kept in a puncture-proof, container with a small hole on the top which allows personnel to put the materials, mainly syringes, into the container, but it can not come out. Color code of the container is yellow.

Disposal

Liquid Waste: (a) The effluent from clinical analyzers can be continuously fed into the sink or sewer. (b) When this waste is poured carefully down the drain, goggles must be worn as there is a risk of splashing.

Solid Waste: Waste can be disposed of by burning, preferably in an incinerator. Prior autoclaving is not necessary.

Sharps: Caution must be used when handling needles, scalpels and other sharp objects. Needles should not be bent, broken or recapped. Needles must be placed in needle destroyer immediately after use; never stick fingers into sharps container. Sharp instruments are disposed of by burial deep into the ground.

Disinfection/Decontamination

- ❖ Spillage: cover spill material with gauze pads or paper towels, pour or spray disinfectant e.g 0.5% freshly (daily) made 0.5% Sodium Hypochlorite solution. over and around spilled materials. Wait for certain time, then collect the gauze pads or paper towels and discard in red biohazard trash bucket. Disinfect the spill site with disinfectant. Wear gloves during the entire process.
- ❖ Decontamination of working counters should be done at the start of each shift and for each spill. The surface of analyzers should be decontaminated daily using manufacturer's recommendations.
- ❖ Service and maintenance activities should be carried out under universal precautions. Outside service personnel should wear gloves and other appropriate barrier protection if potentially exposed to blood or body fluids. Instruments to be repaired by service personnel must be decontaminated with 0.5% freshly (daily) made 0.5% Sodium Hypochlorite solution. Instruments or components returned to vendors should be decontaminated before leaving the laboratory.

Incineration

All combustible wastes should be incinerated by using available incinerator, which can be designed and made locally.

SOP 314: Space and Supplies for VCT Centers

Counseling room

A sound proof, confidential room with adequate lighting is needed. The number of rooms depends on the number of counselors working.

1. There should be provision of locking the door during counseling. No one including C-M VCT center staff should enter the counseling room during counseling unless the client gives consent.
2. The room serves as counseling space as well as an office room for the counselor.
3. Suggested non-consumable supplies of the counseling room are as below:
 - ❖ Three armchairs
 - ❖ One desk with lockable cabinet
 - ❖ Fan or heater in each room, depending on season
 - ❖ IEC stand
 - ❖ Waste basket

Note: Sitting arrangements can be adjusted according to local customs; client and counselor should feel comfortable during the whole session of counseling.

Laboratory

1. Laboratory should be a separate room where confidentiality of the client can be maintained.
2. There should be the provision of locking the door during blood draw and testing.
3. Laboratory should have running water supply and provision of hand washing.
4. This room can serve as the office as well as working space for the laboratory technician.
5. Suggested non-consumable supplies of the laboratory are as below:
 - ❖ Working counter
 - ❖ Refrigerator with lock
 - ❖ Thermometer
 - ❖ Desk and chair
 - ❖ Place for elbow rest during blood draw
 - ❖ Sink with elbow taps
 - ❖ Lockable filing/desk cabinet
 - ❖ Needle destroyer
 - ❖ 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
 - ❖ Micropipette

Registration

- ❖ Initial registration is done in this room.
- ❖ It should be separate from waiting room or other peer activities to maintain confidentiality of the client.
- ❖ Optimum care should be done not to disclose the identity of one client to another.
- ❖ Suggested non-consumable supplies for the reception room are:
 - ◆ Desk and chair
 - ◆ Lockable filing cabinet
 - ◆ Office supplies

- ◆ Waste basket (pedal)
- ◆ Telephone
- ◆ Fan

Waiting area

1. This area serves as the waiting area for the people waiting for the VCT service.
2. It should be separate from registration and counseling area.
3. It is the area for IEC display and video shows.
4. There should be an effective display of the IEC materials.
5. A condom supply box can be kept in this room.
6. Suggested supplies of the non-consumables are:
 - ❖ Enough chairs for waiting people
 - ❖ Water filter with glasses
 - ❖ Television with DVD/VCD player (optional)
 - ❖ Open display for IEC materials
 - ❖ Waste basket (pedal)
 - ❖ Condom boxes

Administration

Basically this is the office room for program manager. Suggested non-consumable supplies are:

- ❖ Arm chair
- ❖ Working Desk
- ❖ Computer with accessories
- ❖ Fax Machine
- ❖ Telephone
- ❖ Photocopier
- ❖ Filing cabinets
- ❖ Cupboard

Group Room

- ❖ Group room to organize pre-test information session
- ❖ Room can be utilized for support group meeting
- ❖ Room should be carpeted and provided with cushions

Restrooms (Toilets)

- ❖ Should be clean and preferably separate for male and female
- ❖ Should have enough light and running water supply
- ❖ Should be supplied with soap (preferably liquid) to wash hand
- ❖ A condom supply box can be placed in the rest room

SOP 315: Staffing for VCT Services

1. **Manager:** This person is the administrative cum financial manger working in the C-M VCT center. One program manager can look after all the administrative and financial activities of whole C-M VCT center, not only for separate services like VCT, unless otherwise mentioned in other SOPs.
2. **Counselors:** During C-M VCT start-up phase, each site should have at least one counselor dedicated to the VCT services. Later, when demand increases there should be another counselor. It is ideal to have a counselor of each gender available.
3. **Laboratory Technician:** This individual will be trained in the serial rapid testing testing protocol. . There will be one at least one laboratory technician attending VCT open hours. Later, when demand increases there should be another laboratory technician.
4. **Front Desk Staff:** In absence of any designated front desk staff, one staff will be responsible for performing the front desk duties during C-MVCT center opening hours.

SOP 316: Code of Ethics

A. General Principles

1. Competence

Staff shall endeavor to maintain and develop their competence and work within the limitations of their expertise.

Specifically they should:

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

2. Consent

HIV testing

HIV testing should only be conducted with informed consent. Consent may be obtained verbally, however the counselor must tick the box on the HIV pre-test counselling form that indicates that verbal consent has been obtained to draw blood and conduct the test.

Counselors and lab staff are expected to ensure that clients have adequately understood all of the issues involved in VCT, including the anticipation of the consequences, before informed consent to HIV testing is given.

- ❖ 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 counseling and HIV testing.
- ❖ Recognize the rights of those whose position to give valid consent to HIV testing may be diminished because of age, learning disabilities or mental illness.
- ❖ Refrain from making exaggerated claims about the effectiveness of VCT in HIV prevention.

Consent and release of confidential information to third parties

Clients must sign or mark the Release of Information Form. The counselor must read the contents of the form to the client if they are illiterate.

Withdrawal of consent for release of information (Refer to release of information form)

Where a client removes consent for "release of information" a line should be drawn across the page and the words "Consent withdrawn" must be clearly written across the page and dated.

Once a client has withdrawn consent for release of information – no further information should be provided to the referral agency/or individual. If the agency requires an explanation simply provide the information to the agency that the client has withdrawn his/her for disclosure of information and that you are therefore not able to give further information.

3. Confidentiality

Staff must maintain adequate records of their counseling work with clients and take all reasonable steps to preserve the confidentiality of information acquired through the counseling process. They should take steps to protect the identity of individuals, groups and others revealed through counseling.

1. The identity of clients utilizing the C-M VCT center will remain strictly confidential.
2. All information obtained during all client encounters will remain strictly confidential and be only discussed with other health care providers for the purpose of providing care with permission from the client.
3. All information that is in any way associated with research undertaken in the clinic will remain confidential.
4. Informed consent must be obtained before patient data can be used for research purposes.
5. All staff working at the C-M VCT center will undergo orientation in confidentiality prior to any client encounter or prior to accessing any patient information.
6. All staff will sign a "Commitment to confidentiality and quality care" oath signifying that they understand and agree to the project's policy of confidentiality as well as quality care. Clinic staff will photocopy or print copies of the following page for all staff to sign.
7. No pictures will be allowed without specific patient consent.

4. Respect for peoples' rights

Staff must recognize the fundamental rights, dignity and worth of all people.

Staff must:

- ❖ Be aware of cultural and role differences of gender, race, ethnicity, caste, religion, sexual orientation, disability and socio-economic status.
- ❖ Recognize personal prejudices and biases of the above human differences. Try to deal with them so that they do not compromise your non-judgmental qualities or else refer the client.
- ❖ Not participate in or condone any discriminatory practices based on the above human differences.

5. Personal conduct

Staff must conduct their activities in a way that does not damage the interest of their clients or undermine public confidence in their colleagues and the service.

Staff must:

- ❖ Not attempt to secure financial or other benefits other than that contractually agreed or awarded by salary.
- ❖ Not exploit any counseling relationship for the gratification of personal desires. No intimate relationship (sex, dating) should occur between a counselor and a past or current client.
- ❖ Refrain from counseling when their physical or psychological condition is impaired through the use of alcohol or drugs or when ill such that the counselor's professional judgment and abilities are impaired.
- ❖ No intimate sexual contacts with partners/or illicit drug use on premises.

6. Integrity

Staff must seek to promote integrity through honesty, fairness and respect for others.

B. Corrective/Disciplinary Measures

1. All personnel involved in the FHI C-M VCT program will sign an oath of confidentiality and the relevant professional code of ethics (counselors, nurse, laboratory technicians, medical practitioners are appended). All other staff must sign the general code of ethics described in the paragraphs above. A copy of this signed code of ethics can be signed and retained by the site manager. Individual staff members should retain a copy for reference to at any time as required.
2. Corrective measures shall be taken upon breach of this oath.
3. Breaches or suspected breaches of ethics that are of a serious nature such as allegations of sexual misconduct of staff with clients, drug use or selling on premises, staff charging fees for free services etc. should be notified immediately and directly to the FHI Country Director. FHI and the IA will conduct a joint investigation and jointly decide on corrective procedures.
4. In addition, further disciplinary actions can be put in place depending on the code of ethics that also addresses issues related to termination of services as C-M VCT center staff member, justification for termination, and the mechanisms of doing so.

C. Common Ethical Dilemmas

Staff should be aware that during their course they would face a number of ethical dilemmas, for example:

1. Issues of client's dependence.
2. Issues of disclosure of test results to partner/s or other third parties. Disclosure should not be done without client consent.
3. Issues of provision of services to minor.
4. Issues of appropriateness of gifts received or offered, etc. Counselor should decline gifts. Fruit or small food items may be accepted; similarly staff should not accept "services in kind".
5. Sexual approaches by or to clients.

Staff members who confront these situations should discuss the situation with their supervisor and/or relevant FHI Senior Program officer or Technical Officer.

Under no circumstances should any FHI or IA staff member or volunteer have sexual or intimate relationship with past or present clients.

Where staff or volunteers are not clear about how to act they should seek confidential advice from their supervisor and/or FHI Technical Advisor or Program Officer .

SOP 317: Recording and Reporting

The Client Clinical Record System

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

First Visit

The following steps will be taken when an individual arrives for his/her first visit at the C-M VCT center.

1. The client is registered by name and given a client ID code.
2. This client code number is entered on the client's file (all record forms) and provided to the client in a VCT/STI card for future visits to the C-M VCT Center.
3. **Only the client number** will appear on the cover of the file and all the necessary forms are placed inside the file.

Subsequent Visits

The following procedures are carried out during a client's follow-up visit to the C-M VCT center:

1. Upon arrival, the client's card is requested.
2. The counselor/doctor retrieves the client's file from the lockable filing cabinet.
3. The counselor verifies 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.
4. At the end of the session, the counselor/doctor records the session on the counseling follow-up case note and files the client folder appropriately.
5. The counselor enters data on the weekly data form.

Filing

The staff then files the client folders in the appropriate filing cabinet in a secure area. Client files are filed according to the numerical file number. The counselor/doctor is responsible for ensuring that the files are being filed accurately and the client register is being maintained on a daily basis. Files must always be accessible by authorized staff during clinic working hours.

Maintenance of files and disposal protocol

1. Files should be retained as prescribed under standard rules and regulations.
2. Disposal of records should only occur under prescribed health regulations.

Site Monitoring Data Collection and Reporting

1. Collection of data is done following the standard instructions
2. Reporting is done as per the agreement between USAID collaborating partners and the IA.

SOP 318: Retention and Disposal of Medical Records

Clinical Records (medical, counseling and laboratory records)

Retention of clinical records:

There are explicit government guidelines in Thailand regarding the possession, storage and disposal of clinical records. Usually the clinical records are managed by the service providers in hospitals, and this will be followed by the implementing agencies. The implementing agencies will store the medical records for a minimum of five years from the date of the last clinic attendance by the patient.

The following points will be followed strictly while retaining clinical records:

1. HIV test results are shown to the client in person only and are not provided over the phone. Results should only be provided to the client and someone with client's written consent only after they sign a "Release of Confidential Information" form.
2. Copy of the test results required for medical or referral purposes are provided only after signing "Release of Confidential Information" form by the client and provided along with a copy of the signed "Release of Confidential Information" form.
3. Confidentiality protocols are strictly followed. All C-M VCT staff are required to sign an "Oath of Confidentiality" and the appropriate Code of Ethics standard operating procedure (SOP) should be read, signed and followed. These are to be filed with the IA Manager.

Disposal of clinical records:

The clinical records will be maintained for a period of five years. The IA will appoint a committee to supervise the destruction of the records. Records are burnt and the committee members who witness the destruction of records all sign and date a formal statement testifying to the destruction of the records.

SOP 319: Protocol for managing requests to conduct research at community sites and or within VCT mobile services

Prior to a request being granted the individual or organization making the request, should submit their request in writing and submit a formal study proposal.

In order to protect human subjects all studies involving human subjects must pre-approved by the relevant behavioral and clinical research regularity bodies in Thailand, and according to USAID protocol.

Specifically the following cannot occur at the VCT site/service without prior approval in writing:

- ❖ Client interviews or interviews with staff related to client consultations
- ❖ Distribution of survey forms, or questionnaires
- ❖ Access to or review of client medical records or site data

If approval is granted in writing by the implementing agency individual staff or client informed consent must be obtained prior to data collection.

Protection of human subjects in research shall then be provided in accordance with the approved study design.

SOP 320: Subpoenas, Summons and Arrest on Premises

Summons to attend court or legal proceedings

Summons is a legal document. Staff of implementing agencies may be required to attend such proceedings by court order. Some summons, specifically in criminal offense, will be punitive if it is bypassed or if it not followed as per mentioned timeframe. Some times this kind of summons are 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. But implementing agency staff is advised to immediately notify their site manager. The site manager is to immediately and directly inform the FHI PROGRAM OFFICER.

Where an in-patient is required to attend court the medical practitioner should be immediately contacted in order that s/he can make an assessment as to whether the patient is fit to attend.

Subpoenas

Subpoenas are issued by the court and are legally binding documents. Subpoenas can order that implementing agencies present to the court or authorities confidential client records. Implementing agency staff receiving such an order should immediately contact the site manager. The site manager is required to immediately and directly inform the FHI Program Officer, VCT site management, and where relevant the management of government clinical facility.

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. But as a health care provider, there may not situation of arrest for providing any service. They might be asked to come for expert opinion on their services. Implementing site managers are required to immediately and inform the FHI Program Officer, VCT site management, and where relevant the management of government clinical facility.

Although 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 Government of Thailand

General rules governing arrest under the Criminal Code of Thailand:

The officer has to identify him or herself as a police officer, using reasonable means, such as showing a badge or official identification. The identifying information of the arresting officer should be written down and given to any companions you have who are not under arrest.

Excessive force cannot be used in making the arrest, and the accused cannot be restrained in a way that is excessive or intended only to humiliate them.

At the scene of the arrest the officer must also present a warrant for the arrest or announce the charges against the accused. If the circumstances allow, the officer must also tell the accused that:



-
- ❖ They can make a statement, but that the statement can in the future be used in evidence at a trial;
 - ❖ They have to right to call and have a lawyer present;
 - ❖ They may call a relative, friend or other party, and the police have a duty to let you use a telephone to do so.

The arresting officer has to take the accused to the police station immediately. However, the arresting officer must them with any medical emergencies the accused may have, even before taking them to the police station.

Once at the police station, an officer must explain all of the above information and rights to the accused, even if they were previously explained by the arresting officer. The accused must also be allowed to call a lawyer, friend or other person at state expense. It must be explained to them that you may have a lawyer present at any stage of the procedure. The accused must be helped with any medical problem you have.

Before the above rights have been explained to the accused, a confession given by the accused will probably not be admissible against them in later proceedings. Because the law relating to this issue is technical, a lawyer should be consulted before assuming the police cannot use statements given against the accused.

Except under a few circumstances, the police cannot keep the accused for more than 48 hours in the arrest phase.

If the police do not comply with any of the above rules the accused may have the right to prosecute the offending officer for any crime or misuse of authority they may have committed. The accused can also make a complaint to the police Commissioner General, which will trigger an inquest. There are several ways to do this, including an oral complaint to the offending officer's superior.

What if the police won't release the accused? Under Thai criminal law, a lawyer can file a petition with a judge, who will review the case and order the accused released if the grounds for detaining them are improper.



ANNEX

Annex 1: Service Related Forms

Pre HIV test counselling interview form

Site Name: _____ Name (optional): _____

Client code: - Laboratory no: - Date: __/__/__

1. No names should be recorded on this form. In situations of confidential testing, names and contact details are to be stored in a separate location.

Additional identifying data (could be a client logo etc)

2. Number of previous HIV test:

Last test date/time: __/__/__	Result (check one): <input type="checkbox"/> HIV Positive <input type="checkbox"/> HIV Negative <input type="checkbox"/> Indeterminant <input type="checkbox"/> Cannot remember
	Last test was conducted within three months of exposure risk <input type="checkbox"/>

3. Individual risk assessment:

Client has regular partner ¹ : <input type="checkbox"/> 1=Yes, 2=No	Is any regular partner HIV positive: <input type="checkbox"/> 1= Yes 2= No 3= Unknown
--	--

In case of minor: HIV status of mother 1= HIV Positive, 2= HIV Negative 3= Unknown

HIV status of father 1= HIV Positive, 2= HIV Negative 3= Unknown

Please indicate code and date of most recent potential exposure.

Sex with men women or both

(only tick when there is exposure risk)	Last occasion when this risk occurred	Window period (only tick if within the window period):
Accidental Exposure in the workplace ² <input type="checkbox"/>		<input type="checkbox"/>
Tattoo, scarification, piercing <input type="checkbox"/>		<input type="checkbox"/>
Blood products/organ <input type="checkbox"/>		<input type="checkbox"/>
Vaginal intercourse (female) <input type="checkbox"/> or transgender (neo-vaginal)		<input type="checkbox"/>
Oral sex <input type="checkbox"/>		<input type="checkbox"/>
Anal intercourse <input type="checkbox"/>		<input type="checkbox"/>

¹ Regular partner could be husband/ wife, boyfriend or girlfriend or even regular sex client seen over a period of time. Partner may be more than one partner.

² This does not refer to sex work but rather exposure to blood borne pathogens in the course of work (e.g. a stick injury or muco-cutaneous exposure sustained by a nurse, doctor, ambulance assistant, police officer, cleaner, etc.).

Sharing injecting equipment <input type="checkbox"/>		<input type="checkbox"/>
Client requires repeat HIV test due to window period exposure:		
YES/ NO (please circle) If Yes, date for repeat test: __/__/__		
Client risk was with a known HIV positive person <input type="checkbox"/>		
Client is pregnant <input type="checkbox"/>	If Yes, stage of pregnancy:	
Client's partner is pregnant <input type="checkbox"/>	<input type="checkbox"/> 1- 3 months <input type="checkbox"/> 4 – 6 months <input type="checkbox"/> >7 months	
Client is using contraception regularly <input type="checkbox"/>	Family planning referral required: Yes <input type="checkbox"/> No <input type="checkbox"/>	
Client's partner is using contraception regularly <input type="checkbox"/>		
Have you ever been forced to have sex without your consent <input type="checkbox"/>	Referral required: Yes <input type="checkbox"/> No <input type="checkbox"/>	
Client indicates history and/ or STI infection <input type="checkbox"/>	Treatment referral required: Yes <input type="checkbox"/> No <input type="checkbox"/>	
Client's partner has history and/or STI infection <input type="checkbox"/>	Treatment referral required: Yes <input type="checkbox"/> No <input type="checkbox"/>	
Client reports symptoms of TB <input type="checkbox"/>	Treatment referral required: Yes <input type="checkbox"/> No <input type="checkbox"/>	
Client's partner has symptoms of TB <input type="checkbox"/>	Treatment referral required: Yes <input type="checkbox"/> No <input type="checkbox"/>	

4. Brief statement of self reported medical history of client.

Write brief note here regarding past significant or current illnesses that may affect diagnosis: (e.g. Hepatitis B or C)

5. Assessment of personal coping strategies:	
ASK "How do you think you would cope if your test shows that you have HIV?" Briefly note any changes? (Note client response and tick any of the boxes below that apply)	
Client indicates suicide intent if test result is HIV positive	<input type="checkbox"/> Yes
Client has prior history of self harm or suicide attempt	<input type="checkbox"/> Yes
Client indicates intent to harm another if test result is HIV positive	<input type="checkbox"/> Yes
Client indicates potential risk of violence if discloses to partner	<input type="checkbox"/> Yes
Client has adequate personal support network	<input type="checkbox"/> Yes

6. Orientation on Condom Use:1. Verbally 2. Written leaflet given 3. Demonstration 4. Client practice **Number of condoms provided to the client:****7. Orientation on HIV prevention for injecting drug or hormone users**1. Verbally 2. Written leaflet given 3. Not applicable **8. Discuss testing procedure and procedure for result provision** Check if client has had prior history of fainting or dizziness during blood collection Outline blood collection and testing procedure Discuss how results will be provided Client provides informed verbal consent to blood draw and HIV testing.**Additional Notes****Counselor signature:** _____**Counselor Name:** _____**Date:** _____

Post HIV test counselling form

Client code:

	-			
--	---	--	--	--

Laboratory no:

	-			
--	---	--	--	--

Client test date: __/__/__

Place of testing: _____

1. Result provided: *(Please tick)*

1. HIV antibody negative

2. HIV antibody positive

3. Indeterminate

2. Use only for HIV negative result provision:

Certification of all counsellor/doctor interventions this session:

Provided & explained client result

Checked for window period and subsequent exposure

Client advised to re-test:

YES/NO (Please circle)

If YES, Re-test date: __/__/__

Provision of risk reduction counselling

Referral

If YES Consent for release of information signed

Details of referral:

YES/NO (Please circle)

YES/NO (Please circle)

3. Indeterminate result only:

Explained the possibility that testing has been performed during the window period.

Avoid unprotected intercourse or sharing injecting equipment

Re testing at this centre in 12 weeks (4 to 6 weeks in case of pregnancy)

Stress management and supportive counselling

4. For use only for HIV positive result provision:

4.1 Certification of all counsellor/doctor interventions this session:

Checked result prior to provision to client

Assessed client's readiness for results

Provided & explained the result

Provided brief information about follow-up and support

Assessed client capacity to cope with result

Suicide risk assessment (follow suicidal risk assessment form)

Discussion on strategies for partner disclosure

- disclosure (who, what, when and why); use structured problem solving form.

- leaving clinic-checked the client can get home safely

-

4.2: Coping management plan:

Assisting client to plan how they will cope during the next 48 hours-

Assessed for suicide risk

Provided IEC material

<input type="checkbox"/> Discussed transmission reduction strategies <input type="checkbox"/> Referral YES/NO If YES <input type="checkbox"/> Consent for release of information signed YES/NO Details of referral: _____
--

5. Type of support required:	
1. Ongoing counselling support	Comments:
2. Medical/treatment support	Comments:
3. Peer group support/Positive network support	Comments:
4. Financial support	Comments:
5. Specialized mental health support	Comments:
6. Others	Comments:
7. Not required	<input type="checkbox"/>

6. Condom Use:			
1. Verbally <input type="checkbox"/>	2. Written leaflet given <input type="checkbox"/>	3. Demonstration <input type="checkbox"/>	4. Client practice <input type="checkbox"/>
Number of condoms provided to the client:			

7. HIV prevention for injecting drug user		
1. Verbally <input type="checkbox"/>	2. Written leaflet given <input type="checkbox"/>	3. Not applicable <input type="checkbox"/>

8. Referral offered (write name of organization):	Feedback from referral agency <input type="checkbox"/>
--	---

9. Date of follow-up counselling: __ / __ / __

Notes:						
<table style="width: 100%; border: none;"> <tr> <td style="width: 30%; border: none;">_____</td> <td style="width: 40%; border: none;">_____</td> <td style="width: 30%; border: none;">_____</td> </tr> <tr> <td style="border: none;">Counsellor Name</td> <td style="border: none;">Counsellor Signature</td> <td style="border: none;">Date</td> </tr> </table>	_____	_____	_____	Counsellor Name	Counsellor Signature	Date
_____	_____	_____				
Counsellor Name	Counsellor Signature	Date				

Referral form

To the receiving referral agency:

This client has signed a "release of information" for release of confidential information. Please provide information back to us about the outcome of this referral.

Detailed client notes and/or assessments are attached Yes No
If No, they are available on request Yes No

Client code:

Date referral made: __/__/__

Name and address of client (if required and client has agreed):

Referred to (specific contact person at referral agency):

Address of referral agency/ individual provider:

Telephone:

Referral feedback to be sent to (referring counselor address & phone contact):

Type of assistance sought for the client:

- HIV medical assessment and treatment
- STI medical assessment and treatment
- TB assessment and treatment
- Family planning advice or contraception
- Ante natal or post partum care (circle which)
- Psychological or psychiatric assessment and treatment
- Drug/alcohol counseling/treatment
- Welfare assistance (includes housing, financial, schooling for children, etc)
- Legal
- Others (specify):

Summary back ground information:

Detailed client notes and or assessment are attached Yes No
If No, they are available on request Yes No

Counselor Name:

Signature:

Date:

Consent for release of information

Client code:

Date of birth:

Client name if agreed for release: _____

Contact details (if client agrees): _____

Instruction for completion: If client is unable to read this form please read each instruction to the client. No coercion is to be exerted. Inform the client this can be revoked at any time.

_____, consent to _____,
(Name of client) (Name of doctor/counsellor)

Tick ✓ which you agree to. Cross X what you **do not** want to be provided.

- Referral release of information
- Release of information to partner
- Release of information to family member

For Referral Release Tick ✓ which you agree too. Cross X what you **do not** want to be provided.

I agree to the counsellor doctor providing the following information for the purposes of referral:

- HIV test results
- My medical records
- Counselling information
- Financial information
- My contact details
- Other (specify)

This information is to be provided to:.....
(Name of staff member of referral agency)

at the
(Name of centre)

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

For Partner disclosure release

I consent to the following:

- The counsellor telling my partner/family in my presence
- The counsellor being present whilst I disclose to my partner/family, and the counsellor answering questions.
- The counsellor telling my partner/family I am HIV positive, when I am not present.
- The counsellor telling _____ (nominee's a name) so that they will tell my partner or family on my behalf.

Anything you do not want the counsellor to disclose to partner/family/other? (Record here)

(Signature of client)

(Signature of doctor/counsellor)

Date Signed: __/__/__

Annex 2: Checklist for VCT Service Evaluation

VCT Service will be monitored in consultation with the service sites through:

- direct observation of
- counseling record audits

The findings from service monitoring will be used in the development of future trainings and/or person-to-person mentoring as appropriate

Annex 3: Commitment to Confidentiality and Quality

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, forms, etc.
- 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: gloves, bleach/chorine, etc.
- 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.
- To receive supportive supervision from my supervisors and to provide supportive supervision to my team.

Name

Date



FHI: The Science of Improving Lives
Family Health International
19th Floor, Sindhorn Building, Tower 3
130-132 Witthayu Road, Lumpini
Pathumwan, Bangkok 10330
Tel: +66 2 263 2300