STANDARD OPERATING PROCEDURES OF HIV TESTING & COUNSELING SERVICES IN PRIVATE CLINICS

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Acknowledgments

This Standard Operating Procedure (SOP) manual was adapted for the Private Clinics from the HIV Counseling and Testing for MSM Project SOP Manual, developed by Dr. Kathleen Casey Regional Adviser, Testing, Counseling and Behavioral Interventions, FHI360; Ms. Aramsri Sriburi, Senior Laboratory Specialist, FHI360 and Mr. Greg Carl, Thai Red Cross AIDS Research Centre (TRC-ARC). Contributions to this version have been provided by Dr. Sairat Noknoy, Miss. Kittiphan Sirisup, Dr. Ajay Pratap Singh of the Health Services Unit, PSI Thailand Foundation, and Mr. Greg Carl, Consultant.

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Introduction to private clinic HTC Services

Private Community Clinic HTC 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 HTC. The services provided through the Private Community Clinic HTC services include:

- Clinical management of sexually transmitted infections
- Voluntary counseling and testing (HTC) services
- Essential package of care (EPC) to people living with HIV (PHIV)
- Referral for other services

Rationale of the community and mobile services

Voluntary counseling and testing (HTC) 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-HTC services should also reach clients who have recently learned that they are positive.

Private Community Clinic Site Commitment and Accountability

To ensure Private Community Clinic site commitment and accountability, it is important that:

1. Private Community Clinic HTC service staff holds monthly meetings to review site functioning and take necessary measures whenever indicated.
2. Quality assurance team from PST will conduct site assessments on at least three visits. New sites or sites requiring additional support will be monitored as needed. The TRC-ARC Laboratory Specialist will coordinate with the quality assurance team regularly and be responsible for overall quality assurance.
3. The Private Community Clinic HTC staff will have primary responsibility for all dealings with Private Community Clinic HTC 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 Private Community Clinic 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 Private Community Clinic HTC 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 “Consent for the Release of Information” form by the client and provided along with a copy of the signed “Consent for the Release of 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 clinic 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 HTC 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.

Note: This SOP manual covers the HIV counseling and testing component of Private Community Clinic HTC services. It is recommended to revise this manual every year to include new developments in the field.

SOP 300: Standardize Service Provisions at private clinics

HIV Counseling

1. The clinic must provide standardized counseling procedures.
2. Conduct standardized counselor training for all Private Community Clinic HTC counselors, including ongoing in-service training and guest lectures/ talks for counselors.
3. PSI Thailand Foundation will conduct regular supervision sessions/ stress management workshops for HTC counselors to prevent counselor burnout.
4. PSI Thailand Foundation and the clinic must 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. The counselors own attitudes, values and personal experiences should not influence the discussion, nor should the counselor instructs or advise the client what to do. Counselors must allow the client to find solutions to problems and strategies for personal behavior change on their own through facilitated discussion. Clients will have a greater success at changing behaviors and will become more self-reliant in the future if they make their own decisions.

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. Only qualified and trained counselors provide HIV counseling in Private Community Clinics.

Counselors must protect confidentiality and counseling must be conducted in private where others cannot overhear the conversation between counselor and the client. Counselors in the Private Community Clinic are required to participate in a training workshop on voluntary counseling and testing for men who have sex with men and transgender clients before providing services.

7. Each Private Community Clinic:

- Offers the health check-up package, which includes an HIV test, to clients from the target population 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.
- Counselor conduct and supervision:
  - Successfully complete a training course in voluntary counseling and testing for men who have sex with men and transgender clients by an expert in this field and arranged by PSI Thailand Foundation.
  - follows the counseling protocols as shown in this chapter, and maintains medical records which are included in the Annex;
  - Meet 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 pre-HIV test information sessions on basic information on HIV and transmission risks, etc. as the need arises;
    - After providing the pre-HIV test information session, the counselor must meet with each client individually to conduct clinic risk assessments.
  - 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 Private Community Clinic HTC Services will follow the same-day testing protocol algorithm that has been recommended by the MOPH Thailand
2. PSI Thailand Foundation will procure the rapid HIV, test kits for use by the Private Community Clinic HTC centers.

3. Private Community Clinic HTC staff performs the test according to this SOP. The Thai Red Cross AIDS Research Centre (TRC-ARC) and Thailand-United States Collaboration (TUC) will arrange training for the staff on testing procedures. in coordination with PSI Thailand Foundation.
4. All HIV positive patients will be referred to HIV treatment and care services. E.g. referral to services providing secondary care and/or case management provided by community service organizations.
5. A system for both internal and external quality assurance for the tests and the testing procedures will be in place. The project TRC-ARC Laboratory Specialist will be responsible to collect information from the reference laboratory and provide feedback to the implementing agencies (IAs).

SOP 301: Group Pre-test Information

It is recognized that in many settings the demand for HTC is high and resources are limited. Often clients are kept waiting in busy waiting rooms for long periods of time whereas 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
   - **Never** provide results of the HIV testing in the group (NEVER).
   - If couples seek services, then refer to SOP 306.

SOP 302: Individual Pre-HIV Test Counseling

It is the part of HTC counseling, which is done to prepare the client for testing. It is called pre-HIV 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 with this clinic. 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 service 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."
   - HTC process outline – sessions, duration, testing procedures.

     i.e. "Our services are for people who are interested in our health check-up package. We will talk for 20 to 30 minutes. If you decide to join the health check-up program, you will be asked to provide your health history, given a physical examination, and undergo a blood test, including a test for HIV. You can receive the results of the HIV test in approximately 20 to 60 minutes. We will make another appointment with you to provide you with the other test results. It will take 20 to 60 minutes to discuss the test results with you."

     - If in case a client has difficulty in providing personal information, such as name, surname and / or personal identification number, the counselor can provide additional information about service procedures and about anonymous testing to put the client at ease. However in the meantime, it is necessary to explain the disadvantages of not providing this information. For example, the client will not be able to access the benefits of National Universal Health Insurance scheme. And, if the scheme does not have the client's name in the system it will be difficult to access treatment drugs free of charge.
   - 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. The counselor must provide information about behaviors that will place the client at risk, provide information on how to reduce the risk and then ask the client in which behaviors he/she engages.

   The counselor should provide reasons to the client for discussing sensitive issues. 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 health problems, including non-infectious and infectious diseases, including HIV. Sometimes, you may be worrying unnecessarily about

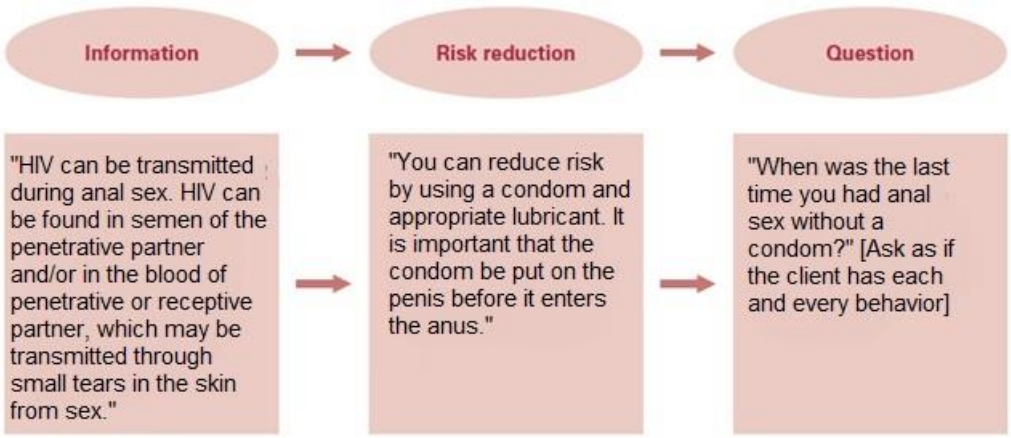
health issues.

- Ensure you know how to keep yourself and partners safe in the future – different practices have different risks.
- Make appropriate treatment and care suggestions. For example, if you have an abnormal blood test result, we can quickly and accurately make a treatment plan together."

"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.

Steps in a detailed risk assessment



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 cannot 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.

HCT in Drug addicts and Alcoholics:

Counsellors should ascertain that the client is sober is not under influence of Drugs or Alcohol

Since both will make the client unable to comprehend the counselling.

-ask the patient about Time, Place and Person

If counsellor feels that client is unfit for the session then

-Clients should be told the reason

-tell the client that these situations can cause depression

The counsellor can get the client to come back later on the same day or when the client feels better, make sure the client knows that test result of Anti-HIV will not be given until the client is sober.

Pre-HIV Test Counseling and Post Exposure Prophylaxis (PEP)

If a client may have been exposed to HIV with in the last 72 hours, the client should be informed about Post -Exposure Prophylaxis (PEP). PEP is antiretroviral drug treatment that is started immediately after someone is exposed to HIV. The aim is to get the drugs inside the body as quick as possible to fight the virus allow a person's immune system a chance to provide protection against the virus and to prevent HIV from becoming established in someone's body. In order for Post exposure prophylaxis PEP to have a chance of working the medication drugs needs to be taken as soon as possible, definitely within 72 hours, after possible exposure to HIV. Left any longer and it is thought that the effectiveness of the treatment is severely diminished.

Post exposure prophylaxis (PEP) usually consists of a month long (28-day) course of two or three different types of the antiretroviral drugs that are also prescribed as treatment for people with HIV. The antiretroviral regimen used in PEP requires close compliance and can have unpleasant side effects including malaise, fatigue, diarrhea, headache, nausea and vomiting. Some of these side effects can be quite severe and it is estimated that 1 in 5 people give up the treatment before completion.

PEP can also slow down the development of antibodies, potentially causing false negatives on a later HIV test. Counselors should advise clients who received PEP to get anti-HIV test at the completion of PEP course and at 3-6 months after that at 6 months post-exposure as well as the standard 3-month test. NAT testing should only be considered 2 weeks after the course of PEP is completed.

If the client needs to access PEP, refer the client to the Anonymous Clinic or Men's Health Clinic of the Thai Red Cross AIDS Research Centre.

Contact Chanwit Pakam, Tel. 084-148-2699.

Counselors in the community mobile service should discuss the following with clients with recent exposure:

- The client's risk behavior
- PEP needs to be started as soon as possible, but no later than 72 hours of risk or exposure.
- A baseline Anti-HIV test is required before PEP can be prescribed. (PEP will have no benefit if already infected with HIV).
- NAT testing is not recommended at this time because test results will be determined only after PEP is started.
- Anti-HIV and NAT testing are not recommended while taking PEP
- The importance of taking the proper amount of medication at the appropriate time.
- Practicing safer behaviors while taking PEP
- Support and staff contact information if the client experiences side effects from PEP.
- When to retest for HIV (see above)

PEP is not a cure for HIV and is not guaranteed to prevent HIV from taking hold once the virus has entered the body. Condoms and appropriate lubricant for sex remain the most efficient way of staying safe from HIV.

SOP 303: Individual Post Test Counseling

Posttest 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 24 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 counseling 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

c. NOT in groups (even if negative) 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 counseling. If the client has not received a same day test result (and has come to the clinic for other health check-up results) also discuss if there have been risks since the test was taken.
4. Advise the client with "window period" exposure of the need to practice 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 and can transmit the infection to others or may be re-infected through unprotected sex, 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 behavior 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 (infection or transmission to others) can be prevented. Review the client's 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 Private 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 **Annex II.**

8. Provide brief information about:
   a. The clinic and community service organizations can provide follow-up and some support needed by the client. For example, providing referral to secondary treatment services, accessing anti-retroviral medication, or accessing universal health benefits, among others.
   b. Provide contact numbers of community service organizations or hotline telephone numbers that the client may call if in need of assistance.
   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 (first 48 hours)
   a. Planning to reduce risk of HIV and STI re-infection and transmission to others
   b. Address issues related to readiness to disclosure (who, what, when and why) infection. The counselor will assist the client in assessing the advantages and disadvantages of the disclosure. It is important to remember that disclosure of blood status is dependent on the readiness of the client. See violence questions in the section 5 of the pre-HIV test counseling form in Annex 1).
   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 (the counselor may invite the client to come back to receive the remaining test results from the health check-up package).
10. Offer all clients testing positive an appointment for Essential Package of Care services.
11. If these are available the same day, this is best.
12. Some clients may not be ready and may need some time before this step, but an appointment date should always be given.
13. 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.
14. After providing referral to treatment services, the counselor must continually monitor whether the client has accessed secondary treatment services (according to their health insurance benefits).
15. Remember to ask if the client has any further questions.
16. Ask clients to write future questions down that arise between visits.
17. Provide referrals as required (Use the referral form in Annex 1)

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. Actively listen to and empathize with 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 by appointment to provide other Health Check-up Package test results.

In the package, the counselor will monitor how the client is coping with the positive status (preferably within 48 hour); or how they are managing to maintain the negative status. Follow-up sessions are supportive sessions where client's concerns are dealt with.

It is likely that Private Community Clinics will not be able to provide continuous counseling services for a long period (possibly only 4 to 6 follow-up sessions). Therefore, the client should be referred to secondary treatment hospitals or to civil society organizations, which are able to provide continuous support. In referring clients to other specialized or community services, a referral form along with the consent for release of information form must be used.

SOP 304: Counseling on the First Follow-Up Visit

The Counselor will:

1. Review the information recorded in the clients file before meeting with the client.
2. Answer the client's questions
3. Assess impact of the diagnosis or other issues:

   HIV-negative test result

   - assess client comfort with communicating with the counselor
   - assess client understanding of the test results received from the clinic and the client's risk of HIV infection
   - provide information about risk and HIV risk reduction, sexual health and safer sexual behaviors
   - Assist the client in identifying obstacles to behavior change and in developing a plan for behavior change.

   HIV-positive test result

   - assess client comfort with communicating with the counselor
   - assess client understanding of the test results received from the clinic
   - assess and discuss the client's ability to cope t present and ways to reduce stress
   - assess tendencies for self-harm (especially suicide) or to harm others
   - Provide information about general health care strategies – plenty of rest, appropriate diet and exercise, as well as information on sexual health and safer sexual behavior.
   - Assess relationships with others – partners, family, friends, and co-workers.
   - partner (husband/wife/boyfriend/girlfriend/casual partners) disclosure issues including assessment for potential for violence related (see section 5 of the pre-test form in Annex 1)
   - life planning and problem solving on issues such as work and finances, among others
4. Engage the client in collaborative problem solving.
5. Conduct a suicide/harm to others risk assessment.
6. Further assist client in resolving issues and difficulties with disclosure of status to sexual partners or members of family or support network.
7. Assist with referral for assistance to appropriate services, e.g. secondary treatment services or to community service organizations
8. Workplace – client may find it hard to go to work when newly diagnosed. Assist them in making a plan around this issue.
9. Follow-up on success and difficulties with the client's personal risk reduction plan.
10. Investigate whether the client has already accessed secondary treatment services. If the client has not yet attended follow-up/secondary services, the counselor should encourage the client to do so and schedule an appointment to see a doctor in the secondary treatment service. If the client has already attended secondary services, provide positive reinforcement. Then investigate the results of the visit and any follow-up plans or appointments.
11. Assist client in making decisions regarding treatment and gaining a referral.
12. Review the client's personal coping strategies and support needs. Refer for ongoing counseling where needed.
13. Refer using referral protocol described herein and use the consent form for referral.

How many times after HTC should we see HTC clients?

Number of Sessions

- Clients attending HTC 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 HTC clinics 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 the following benefits of partner disclosure to clients:
   - 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

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?"

↓

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, chocked or kicked you?"*
- *"Threatened to hurt you or someone close to you?"*
- *"Stalked. followed or monitored vour movements?"*

↓

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 your 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 hour emergency service

- HTC 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.

Follow-up HIV counseling sessions

Issues to be addresses in additional counseling sessions 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 HTC

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. Counseling services will be conducted according to the standards outlined above. Group pre–test group information may be conducted with the two people together or pre-HIV test counseling may be conducted individually. **Risk assessment must be done separately**, in order to accurately assess risk.

3. 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.

4. After knowing their individual test results, 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.

5. Individuals who are reluctant to disclose their test results, the counselor should help them assess the advantages and disadvantages of disclosure. The counselor may then suggest the different options for counselor assisted disclosure and then allow the client to decide on the best strategy.

6. The counselor asks each person to provide consent for the disclosure of their test results to the other.

7. After the disclosure of the test results, post-test counseling may proceed with both partners present.

8. The counselor must be aware; however, that he/she may absolutely not disclose an individual test result without the client's permission.

SOP 307: Counseling and Testing after Sexual Assault

The Counselor and other HTC service provider will:

Work in cases where patients have been sexually abused requires the cooperation of a multidisciplinary nature. To help patients receive the physical, psychological and social are they need, requires assistance from professionals from diverse professions, i.e. doctors, nurses, psychiatrists / counselors, social workers and legal officers, such as the police and lawyers. Thus, the service provider requires a special expertise and has a clear system of operation to reduce the potential impact on the abused client.

Procedures for clinics under this project are to immediately refer clients to hospital secondary treatment services so that the client may be provided medical/forensic consultations. According to the law of Thailand, medico-legal examination and forensic evidence can be collected by a registered doctor of government hospitals only. It is collaboration between many professionals. HIV testing should not be the first priority! Support, health service and forensics (with consent) are more urgent and must come first. If a client attending Private Community Clinic HTC services is a victim, clinic staff should immediately refer the client to the OPD, ER/IPD departments of a secondary treatment hospital and/or to a hospital nearby, regardless of the client's health benefits.

From the start of the project, Private Community Clinics may refer clients to the Thai Red Cross AIDS Research Center for post exposure prophylaxis (PEP). Contact Chanwit Pakam, tel. 084-148-2699. Or, if the client wants to prosecute perpetrators of this violence, the clinics may contact the Police General Hospital. Contact Sexual Assault Unit (operating 24/7).

* Note: From a search for more information about services available in local hospitals and the Police General Hospital, the One Stop Crisis Centers (OSCC), in hospitals under the auspices of the Ministry of Public Health may be another option. Call the following numbers for additional information: 02-5901628, 02-5901629, 02-5901639, 02-5901641.

Additional points to be considered:

a. Key differences from HTC perspective

Sexual assault survivors

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

In such cases, counselors should be closely involved in providing care and support and in providing relieve to psychological stress by allowing the client to speak their thoughts feelings and express their concerns and not to ask questions out of curiosity. This includes not interrogating the client about the incident. (This is the duty of the police). Counselors should expediently refer the client to secondary services to secondary treatment services for examination and treatment of physical injuries.

There are also additional risk factors for HIV infection to consider among patients who were sexually abused:

- Tissue trauma may facilitate infection
- Co-infection with STIs
- Lack of self-esteem post-assault may mean less commitment to safer behaviors

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 HTC 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 tendency for self-harm (suicide) greater than the general population
- Changing lifestyle behaviors, such as turning to alcohol or increased substance misuse

If the client attends the clinic, continuous follow-up should be conducted on the following issues:

- Changes in behavior or personality. For example, turn to alcohol addiction. Withdrawn or paranoid behavior, isolates themselves, or do not talk to the others, among others.
- Signs of acute stress, such as somatization, and clinical presentations include post-traumatic stress, sleeplessness, and change in eating habits, anxiety disorders, and major depression.
- Thoughts of self-harm (suicide).
- In many cases, those who were sexually HIV repeatedly. Often fear that they have been infected with HIV and wish to be tested repeatedly.

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 less than 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 aeroselization. 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. Do not decorate the room by any hanging decorations or place candles in the laboratory. No decorations should be placed on or near lamps or other equipment. Mirror frames outside the laboratory may be decorated as an exception.

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. Theses 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.

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 and surname.

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

1. Describe the procedure briefly to client and inform him/her that there would be some pain due to needle prick
2. Ask the client 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 sterile 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 fisted 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 bandage 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. The clinic lab tester records client information in registration book

Collection and Destruction of Hazard-free Wastes, Infectious Wastes, and Sharp Wastes

See SOP 313: Waste Disposal

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 PRIVATE CLINIC HTC where exposure-prone procedures are likely to happen. The flow chart should contain all relevant contact names and numbers including afterhours 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. (Clinic Manager and Doctor at the 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.

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 HTC 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 311.1: 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 migrates 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

- Determine HIV 1/2 test kit
- 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 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 appears in the patient window of the strip, the result is invalid and should be repeated.

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

Principle: The DoubleCheckGold™ Ultra HIV 1/2 kit is an Immunochromatographic qualitative test for the detection of antibodies. Recombinant proteins representing the immune dominant regions of the envelop anf-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, paced 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 or red. 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

- DoubleCheckGold™ Ultra HIV 1/2 test kit
- Micropipette
- Timer

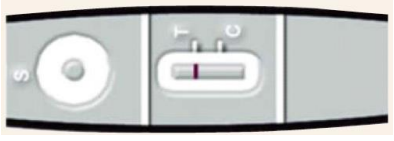
Procedure

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 DoubleCheckGold™ Ultra HIV ½ 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 µl) of assay diluents and start the timer
6. Allow the reaction occur, the purple color move across the result window in the center 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): 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 SD Bioline HIV 1/2 test kit

Principle: Core™ HIV 1&2 utilizes the principle of immunochromatography, a unique two site immunoassay on a membrane. A mixture of highly purified recombinant antigen of gp 41, recombinant p24 combined with subtype O specific synthetic peptide, representing HIV-1 and recombinant gp 36 representing HIV-2 are coated on the membrane in the test region and anti- rabbit antiserum in the control region. As the test sample flows through the membrane assembly within the test device, the colored HIV 1/2 specific recombinant antigen colloidal gold conjugate complexes with HIV antibodies in the sample. This complex moves further on the membrane to the test region where it is immobilized by the HIV 1/2 specific recombinant antigens coated on the membrane leading to formation of a colored band which confirms a positive test result. Absence of this colored band in the test region indicated a negative test result. The unreached conjugate and unbound complex, if any, along with rabbit IgG gold conjugate move further on the membrane and are subsequently immobilized by the goat anti-rabbit antibodies coated on the membrane at the control region, forming a colored band. This control band serves to validate the test results.

Materials and equipment

- Core™ HIV 1/2 test kit
- Micropipettes
- Centrifuge
- Timer

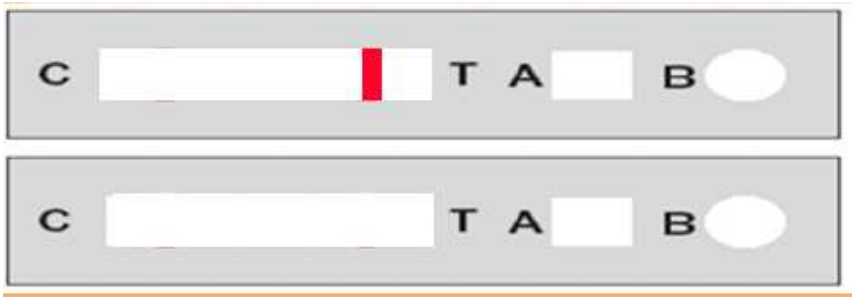
Procedure

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 Core™ HIV 1/2 sealed pouches to room temperature (20-30° C)
3. Tighten the cap of sample running buffer bottle clockwise to pierce the dropper bottle nozzle. The pin situated inside the buffer bottle cap will break through seals the opening of the dropper vial.
4. Tear open the sealed pouches and retrieve the appropriate number of test device as required. Label the test devices appropriately. Once opened the devices must be used immediately.
5. The addition of the specimen and buffer must be done at the center of the sample/reagent addition ports holding the sample micropipette/ dropper bottles in a vertical position. Ensure the drops are free falling. Use a new micropipette for each specimen to avoid cross contamination.
6. Using a micropipette, apply 50 µl of serum/plasma to the sample port “A”.
7. Dispense five drops of the sample running buffer into reagent port “B”.
8. Between 15-30 minutes after addition of buffer, read the results as below.
9. Negative results must be confirmed only at the end of 30 minutes although, depending on the concentration of antibodies to HIV in the specimen, positive results may start appearing as early as 2 minutes.

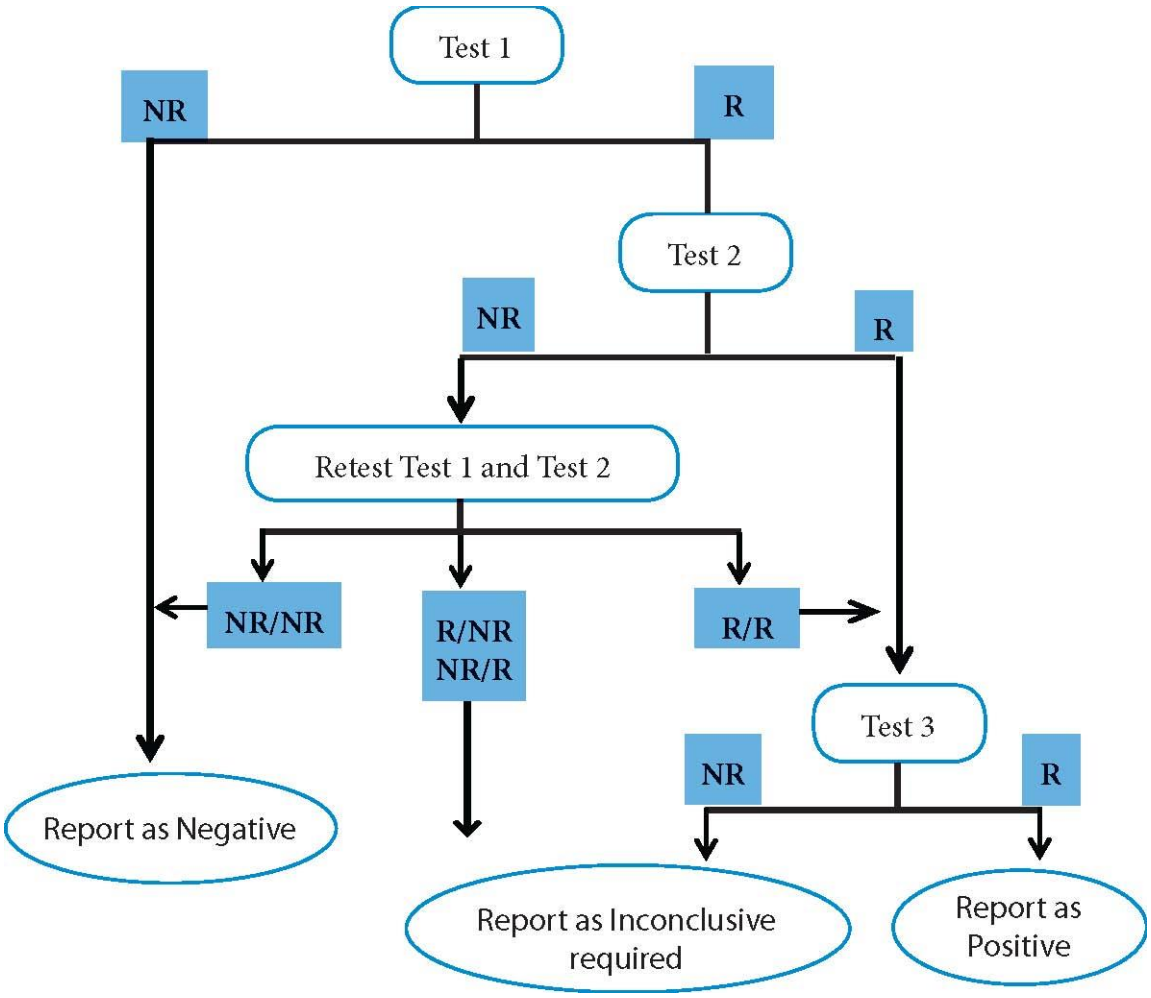
Non-reactive (One Bar) If HIV-1 and/or HIV-2 antibodies are absent, only one colored band at the Control (C) would appear.

Reactive (Two bars): If HIV-1 and or HIV-2 antibodies are present; two colored bands appear at the Test (T), and Control (C) region.

Invalid (No Bar) The test is invalid if only the Test band and no Control band is visible at 30 minutes. Verify the test procedure and repeat the test with a new Core HIV 1& 2 device. The test is also invalid if the Control band is not visible at 30 minutes. Verify the test procedure and repeat the test with a new Core HIV 1& 2 device.



National HIV testing algorithm



Note:

Test 1 = Determine HIV 1/2

Test 2 = DoubleCheckGold™ Ultra HIV 1/2

Test 3 = SD Bioline HIV 1/2

R = Reactive,

NR = Non-Reactive

Inconclusive report should be followed up at 2 weeks and all three tests performed, if inconclusive Then they should be followed up at 1month and or 3 months, if at 3 months the test result remains Inconclusive then explain to the client about “False Positive”.

SOP 311.2: HIV Outsourced Lab Procedures

- Clinics unable to perform Rapid tests at the clinic will send the blood to an outsourced laboratory designated by PSI Thailand. The steps are as follows:
- Pretest counseling, at this stage counselor should about the next day result and fix an appointment for HIV lab result and posttest counseling. To reduce the waiting period anxiety it is preferable to fix the appointment by next day evening.
- Consent for Anti-HIV testing clinics can use the regular consent form of the clinic.
- Label the tube with UIC Red cap tubes for Clotted Blood.
- Blood drawing 3ml of blood should be drawn (minimal 2ml), to prevent hemolysis Tubes should be kept stationary for 5- 10 minutes and then refrigerate it in 4-8°C
- Note “Payment from PSI” on the laboratory order sheet. This is to prevent Lab invoicing clinics in place of PSI
- Contact Bangkok RIA on this number 02-106-6999 extension 0 for operator before 7:30 pm and notify operator about lab test and clinic name.
- Appoint the patient for a follow up on next day evening (normally if blood drawn in the evening collection of samples will be next morning and result in the evening)

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 TRC-ARC laboratory is to send all (100%) positive and 100% of the blood spot samples to the reference laboratory for retesting. These samples have already undergone testing at the community / mobile lab using the existing serial testing algorithm. The reference laboratory will perform the HIV testing (confirmation testing or NAT) and forward the reports back to the mobile clinic team for follow-up. Once reports are available they are cross-checked with the lab report at the participating HTC site and entered in the external quality assessment register.

1. All community and mobile 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 (Thai Red Cross AIDS Research Centre Laboratory).
2. Reference lab sends a copy of the results to the IA with copy to the Lab Specialist.
3. 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 ºC inside the refrigerator, if necessary. Samples for EQA should be stored at -20 ºC for storage of more than a week.
   - Specimen collection and labeling: Specimen collection should de 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 cannot 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 HTC Sites

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 PRIVATE CLINIC HTC 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
    - A folding table with lockable file box
    - Fan in each room
    - 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
    - Ice chest with appropriate number of “cool packs”
    - Thermometer
    - Place for elbow rest during blood draw
    - Sink with elbow taps (in near vicinity)
    - Lockable filing box
    - Needle destroyer
    - Separate contaminated waste disposal facilities
    - Fan
    - Waste baskets for different types of wastes: general, infected and sharp
    - Water flushing bottle
    - Micropipette

Registration and administration

1. Initial registration is done in this room.
2. It should be separate from waiting room or other peer activities to maintain confidentiality of the client.
3. Optimum care should be done not to disclose the identity of one client to another.
4. Suggested non-consumable supplies for the reception room are:
    - Desk and chair
    - Lockable filing cabinet
    - Office supplies
    - Waste basket (pedal)
    - Telephone
    - Fan

- Equipment for collection of basic health information: scales for weight and height and a blood pressure machine.

Waiting area

1. This area serves as the waiting area for the people waiting for the HTC service.
2. It should be separate from registration and counseling area.
3. It is the area for IEC materials to read and/or to conduct other activities, such as BMI (body mass index measurement).
4. A condom supply box can be kept in this room.

Restrooms (Toilets)

- Should be clean and preferably separate for male, female and transgender (if necessary)
- 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 HTC Service Center

Staffing of the HTC Service Center should consist of the following:

1. **Manager:** This person is the administrative cum financial manger working in the PRIVATE CLINIC HTC center. One program manager can look after all the administrative and financial activities of whole Private Community Clinic services, not only for separate services like HTC, unless otherwise mentioned in other SOPs.
2. **Counselors:** During Private Community Clinic HTC service start-up phase, each site should have at least one counselor dedicated to the HTC 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 protocol. . There will be one at least one laboratory technician attending HTC services. Later, when demand increases there should be another laboratory technician, if needed.
4. **Front Desk / Reception Staff**: In absence of any designated front desk staff, one staff will be responsible for performing the front desk duties during Private Community Clinic HTC service hours.
5. **Doctor**: The Clinic Doctor, if present and available, should provide the HIV test results to the client in the counseling room, where the counselor will also be present to provide post-test counseling.

SOP 316: Code of Ethics for Service Center Staff

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 counseling 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 HTC, 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 HTC 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 Private Community Clinic HTC services 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 in the Private Community Clinic HTC services 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 Private Community Clinic HTC 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 agency responsible. An investigation will be conducted to 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 Private Community Clinic HTC service 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 Senior Program officer or Technical Officer.

Under no circumstance should any staff member or volunteer have sexual or intimate relationships 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 Program Officer

D. Commitment to the Code of Ethics

I, _____ have read and understood this Code of Ethics and fully understand and agree to adhere to this code.

_____ Name

_____ Date

SOP 317: Recording and Reporting

The Client Clinical Record System

1. All PRIVATE CLINIC HTC 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 PRIVATE CLINIC HTC 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 PRIVATE CLINIC HTC center.

1. Upon arrival, the client's National ID card is requested.
2. The client is registered by name and given a client ID code. The client is registered by name and given a HN number for general services at the clinic and a special code ID (UIC) for HIV and STI counseling and testing services under the project. This code will be the link to the client's HIV / STI counseling and testing record, which will be kept in a separate locking file cabinet during the project period.
3. This client code number is entered on the client's file (all record forms) and provided to the client in a HTC/STI card for future visits to the PRIVATE CLINIC HTC Center.
4. **Only the client number** will appear on the cover of the file and all the necessary forms are placed inside the file.

Unique Identifier Code (UIC) should be issued to each client along with HN system of the Private community clinic. These code aides in keeping the client's confidentiality.
UIC have 9 digits:

First Thai alphabet of the name does not include Vowel.
First Thai alphabet of the surname does not include vowel.
Day of birth Monday = 1….. Sunday = 7.
Date of birth use two digits from 01 to 31
Month of birth use two digits January =01……. December = 12
Year of birth use last two digits of the Buddhist era e.g. 2535 = 35

NB: if the client feels uncomfortable or refuses for any column use 9 or 99 as the case maybe

Example of UIC:

Serial	First alphabet of name	First alphabet of surname	Day of birth	date		month		Buddhist era Year.	
1	ป	ส	1	1	9	0	3	3	3
2	ม	ม	7	0	4	1	2	3	1
3	จ	ม	9	9	9	9	9	3	6

1- Name ปริญ สุภารัตน์ born on Monday 19 January 2533

2- ชื่อมาริโอ้ เมาเร่อ (foreigner) born on Sunday 4th of December 2531.

For twins:

Use "พ" for the first one to register in place of first digit of the year
"น" for the twins registering later e.g. ขก51505พ2 for first ขก5150น2 for second.

Subsequent Visits

The following procedures are carried out during a client's follow-up visit to the PRIVATE CLINIC HTC center:

1 The counselor/doctor retrieves the client's file from the lockable filing cabinet.
2 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.
3 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.
4 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 or in a secured computerized filing system. 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.

- The client file should be organized in the following sections:
    - Visit date page
    - Pre-test & post-test counseling forms. Forms for the same visit should be together (latest visit on top)
    - Referral forms and consent for release of information forms should be attached to the pre-and post-test counseling forms of the same visit.
    - HIV & STI Lab forms at the back of the file.

  If the client has received a positive HIV test result and returns for counseling or other services before referral to medical follow-up or psychosocial care and support services, a follow-up counseling form should be used. Follow-up counseling forms should be placed, together with any referral and consent for release of information forms, on top of the Pre-test & post-test counseling forms (latest visit on top)

Forms

Pre-test counseling form

The pre-test counseling form is a medical-legal document on which a client's history of HIV testing, the assessment of client's risk of infection, and the assessment of personal coping strategies are recorded. The information collected on this document will then be used to determine whether the client should be invited back for re-testing and when re-testing should occur and what referral services may be recommended. This document also indicates the client's consent to have the HIV test.

A copy of this form maybe found in Annex 1

Post-test counseling form

The post-test counseling form is also a medical-legal document or checklist to record counselor or doctor service interventions. It is to ensure that the steps in post-HIV test provision are followed and to assess any medical, psychosocial, or other services that may be needed by the client.

A copy of this form may be found in Annex 1

Referral form

The referral form is needed when recommending a client attend a medical, psychosocial or other support service outside the clinical services offered by your clinic. In most situations, the standardized referral form from the Ministry of Public Health will be used. When these forms are unavailable or when referring a client to community-based psychosocial support services, the project Referral Form (See Annex 1) may be used.

For confidentiality purposes, the counselor should only note the client's code/file number on the referral form. One copy of the form should be kept in the HTC client file at the Private Community Clinic and another should be provided to the client to give to the referral service provider upon presentation to the service.

Referral forms are important. Do not assume that the client will remember the details of the service for which he/she is referred.

Consent for release of information form

The consent for release of information form is a medical-legal document for the protection of both the client and the counselor and clinic.

It is mandatory to obtain client consent for the release of any personal information (e.g. test results/HIV status, lab report, blood or tissue samples, contact information) to an outside service. The client must be made aware of the necessity of disclosure when referred to follow-up medical services and/or the benefits of disclosure when referring to psychosocial support services or the counselor is assisting in the disclosure of the clients HIV status to partners or family members. The CLIENT will decide what information may be disclosed and will sign a "consent for release of information form" One copy of the form should be kept in the HTC client file at the Private Community Clinic and another should be provided to the client to keep for his/her own records.

A copy of this form may be found in Annex 1.

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 and the funding recipients.

SOP 318: Referral to Follow-Up Testing and Other Medical Services

Potential referral needs to consider

Clients may have complex needs that affect their ability to adopt and sustain behaviors that will reduce their risk of infection, re-infection and/or acquiring other infections and transmitting infections to others. They may need referrals for medical evaluation, care, and treatment of opportunistic infections (OIs) and communicable diseases (e.g., TB, hepatitis, and STIs). Referrals may also be needed for clients who need:

- treatment of a drug or alcohol addiction;
- psychosocial support counseling: individual, relationship, or family counseling;
- social services: social health insurance; change in housing registration;
- peer educator support; or
- family planning services, among others

Assessing clients' referral needs

Counselors should identify the key factors that are likely to influence a client's ability to adopt or sustain behaviors that:

- reduce the risk of transmitting HIV or acquiring STIs;
- promote health; and
- Prevent disease progression.

The assessment should include an examination of the client's willingness and ability to accept and complete a referral. Service referrals that match the priority needs identified by the client himself or herself are most likely to be completed successfully. Counselors may refer a client to clinical or community support groups, depending on the client's needs and responsiveness to counseling.

Shared Confidentiality

In pre-test counseling, all clients should be informed that clinics under the auspices of the PSI Thailand Foundation maintain the same standards of work, first and foremost maintaining the confidentiality of a client's personal information, including blood test results, counseling record, and referral and follow-up records. This information will not be sent to others or distributed to any other party, unrelated to the project. The clinics will keep client information secure and confidential.

Disclosure will only occur in cases where clients have given their signed consent for release information to disclose specified information only. The disclosure must be of benefit to the client, for example, in the case of referral for treatment or the client would like to disclose blood test results to family members.

Referral for Clients Receiving Negative HIV Test Results

- Clients receiving negative test results will be informed of Nucleic Acid Amplification Testing (NAT) and the benefits for both treatment and prevention of knowing whether

they are in the acute stage of HIV infection. If the client would like to have the NAT test, he/she will be referred to the Thai Red Cross AIDS Research Centre. Before the referral takes place, the client should be informed that if the test result is positive for HIV, the client will be notified by telephone within 3-5 days. When the clients contact information is collected, it is recommended that the Consent for Release of Information form be used.

- If the client receives a test while still in the window period for HIV, HBV or HCV he will be informed of when he should re-test and that testing is available through various testing sites that offer these services.
- If the client receives a negative HIV test result but receives either a positive HBV, HCV test result, the client should be referred to a hospital in which they have access to universal health insurance benefits.

- If the service is the result of HIV-negative but there are indications for other diseases examined under the Health Check-up Package, caused by various diseases that have examined the health of the package, the service provider should offer treatment according to clinical and professional standards, or to refer the client to sites in which his/her universal health insurance benefit used.

- If the client describes or shows symptoms of sexually transmitted infections other than HBV, HCV and Syphilis, the counselor should recommend that the client receive proper examination, testing, and treatment. The client should be informed that examination, testing and treatment for many infections is available at government and private hospitals and at the Thai Red Cross AIDS Research Centre. If the client wishes to receive STI services, the appropriate referral form and the Referral and Consent for Release of Information forms should be used.

- If the client wishes to gain needed knowledge and skills for behavior change. Counsellors can refer the client to the care of staff of community-based/civil society organizations for continuous care. The service provider should offer alternative choices to all clients.

Referral for Clients Receiving Positive HIV Test Results

- All newly diagnosed clients should be referred for medical consultation as soon as possible.
- If the client describes or shows symptoms of sexually transmitted infections the counselor should inform the client of the benefits of getting appropriate examination and treatment during his follow-up visit for CD4 testing. The same Referral and Consent for Release of Information forms can be used for this.
- All attempts are made to try to get the client to come in for follow-up testing within 48 hours after receiving their test result in order to reduce the risk of suicidal ideation or plan to harm oneself.
- Where possible, the counselor should provide an after-hours emergency contact phone number. This should not be your personal phone number but rather the contact number of an ”on-call staff”, the “hotline” crisis services, or even the local hospital accident and emergency department.

	1663 สายด่วนปรึกษาเอดส์ 1663 AIDS Hotline Counseling Call 1663. Everyday 10 a.m. to 7 p.m.

- All clients receiving a positive HIV test result, should be referred or secondary treatment. The clinic can make referral in three ways:
    1. Refer clients to secondary treatment hospitals affiliated with the clinic so that the client may receive basic services according to universal health benefits designated by NHSO, i.e. CD4 and viral load testing and ARV. The counselor should remind the client that these services are without charge, because the hospital will be reimbursed by the National Health Security Office.
    2. Refer clients to treatment services accepting personal health insurance. In the event that the client is unsure of his/her health benefits, the clinic staff should assist the client by searching the National Health Security Office website, http://www.nhso.go.th/peoplesearch to arrange the appropriate referral documents according to the client's insurance benefits.
    3. Refer the client to civil society organizations for continuous care, which may include transfer of housing registration & treatment benefits and assistance in accessing secondary treatment.
- Clients who have tested positive should be informed about available support services are available through HIV-positive individuals, networks or support groups, and that referral the counselor will refer the client to these services if and when he is ready to access them.

Referral and Consent for Release of Information forms

See Annex 1 for the forms.

SOP 319: 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, hard copy and electronic, 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, or to the end of the project, 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 Private Community Clinic HTC staff are required to sign an "Oath of Confidentiality" and the appropriate Code of Ethics standard operating procedure (SOP 316) 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 or to the end of the project. PSI will collect project client files and lab reports from providers on the termination of project.

SOP 320: Protocol for managing requests to conduct research at Private Community Clinics

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 protocols.

Specifically the following cannot occur at the HTC 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 321: 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. Sometimes 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 PSI 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 Program Officer, HTC 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 Program Officer, HTC 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.

SOP 322: Health Checkup for men who have sex with men and transgender

PRINCIPLE

WHO defines health checkup as a preventive measure which identifies risks of diseases and identify diseases that could benefit from early detection, before an illness occurs appropriate health checkup can identify the risk factors that can cause future illness or diseases. Risk factors modification will/should avert future disease.

Health checkup is an opportunity for the client to be informed about clinical promotion and preventive services, such as counseling for smoking cessation and vaccination. Interventions included in a health checkup should be based on evidence that there is more benefit than risk, when administering such intervention. Furthermore, health checkup provides services providers with an opportunity to build rapport with their clients. Which it can help alleviate clients' fears and anxieties?

Health checkup HAS 4 major components, which are

1. Screening of clients by history taking to assess risk factors from life style and family history, along with preliminary physical examination and necessary laboratory test. The list of test included for the client varies across different group of population.
2. Counseling for risk behavior modification as per the diagnosis
3. Vaccination as per the need
4. Treatment with medicine as per the need

The steps in health checkup package for men health clinic network include the following:

1. Explain the client about the health checkup package.
2. Screening of client's health risks is composed of two main components
   2.1 Metabolic disease screening
   2.2 Screening of risk factor particular to MSM group, which includes the risk assessment for sexually transmitted diseases, which performed along with pre-counselling for HIV testing services and request for client consent for services provision as well as HIV testing
3. Physical examination
4. Blood drawing
5. Reporting the client the result from the health checkup
6. Provide the client with information specific to their health risk behavior identify from the screening, through history taking, physical and laboratory test to help them modified the risk that could are modifiable.

STEP 1: Introduction

1. Service providers will introduce themselves and explain that health checkup services consist four parts.

✓ Introduction history taking, screening for risk factors and health problems
✓ Physical Examination
✓ Blood drawing for laboratory
✓ Explain the result and advice

The objective of Health checkup is to make clients aware of the risk factor with regard to health. If a risk is identified the team would provide support with knowledge and intervention to help modify the risks. If a disease is diagnosed, then treatment will be initiated.

2. Explain about the 20 items of the health checkup (use the brochure to explain)

STEP 2: Screening of risk factors of health checkup client

2.1 Metabolic disease screening using the NHSO screening form (appendix)

2.2 Screening of risk factors with regard to health issues found commonly in MSM, pretest counseling and consent for Anti-HIV testing (SOP 302)

STEP 3: Physical Examination

The physical examination in this health checkup package includes visual acuity, blood pressure measurement, heart rate and rhythm, height and body weight the detailed steps are as follows:

3.1 Visual acuity

The standard method to measure visual acuity is through Snellen chart (Naphaphorn Tananuwat, 2551)

3.1.1 Snellen Chart must be placed on a wall and the person tested must stand 20 feet or 6 meters away from the chart. The chart should have white background with black objects, and good illumination is necessary.

3.1.2 Test one eye at a time.

3.1.3 Start with naked eye (VA without correction)

3.1.4 Test with corrective glasses or contact lenses (VA with correction)

3.1.5 VA with pinhole is the third step, this helps to determine the depth of focus in persons with refractory errors. The standard pinhole diameter is 1.2mm; smaller diameter will cause light to be more concentrated causing blurred image. This makes pinhole test an important test for persons with refractory errors.

Method to test VA

1. The client stands at a distance of 6 meters or (= 20 feet) away from the Snellen chart. Start reading from the upper most line (the largest letters) then the second line till the last line he can read correctly. Note down the line, for example if the client can read till line 6/36 it means that the client can read from a distance of 6 meters, when a normal vision person can read from a distance of 36 meters. Or, 6/6 means that both can read from 6 meters that is normal vision.
2. If the client cannot read up to the 6/6 line, then the patient can put their glasses and ask the client to use pinhole, if the client could not read up to normal vision. An example of a note taking should be as below, for a client who could read only the upper most line with a naked eye, and extend to the second line when using glass the reading, whilst with a pinhole the client could read up to the last line VS sc 6/60 (sc= VA without correction)

VA cc 6/36 (cc= VA with correction)

VA c PH 6/6 (c PH = with pinhole)

3. If the person cannot read the top most line at 6 meters have the person move towards the chart by one meter at a time till it can be read. For example, if the client reads it at 5 meters distance, the reading is 5/60, or at 1 meter away it is 1/60.
4. For clients who cannot read at 1 meter, place two fingers at client's eye level and ask the client to read the number of fingers, starting from 3 feet away and get closer by one foot at a time till

the patient can read the fingers correctly. Note down the distance as FC …. Ft (FC = finger counting). For example, at 2 feet, the note taking is FC 2 ft, and at 1 foot FC = 1 ft.

5. Clients who are unable to perform finger counting should be tested by Hand Movement (HM), by waving the tester hand in front of the client face and ask them whether they can see the waving hand? For a positive answer write down HM, care should be taken to not hit the patient while waving.
6. If the clients are unable to see the waving hand, then shine a light from a torch and ask the client if they can see the light. If the client is able to correctly identify the light but cannot identify the direction, then write down Perception of light (PL). If the patient can identify both the light source and direction of the light source correctly the write down Projection of light (PJ)
7. Client who are unable to see the light at all write down as No light perception (no PL). However, the test should be performed with highest intensity light source before diagnosing as No PL.

RECORDING THE RESULT

The result can be recorded in many different ways. Usually, it is recorded as 6/6 metric system or 20/20 foot. Some places use the log system (Table 1) from normal vision to Blindness. (Metric system)
20/20, 20/40----------20/200, 19/200, 18/200---------- 1/200, or 6/6, 6/9----------6/60, 5/60----------1/60FC (counting finger)
HM (hand movement)
PJ (projection of light)
PL (perception of light)
No PL (no perception of light or total blindness)

Snellen acuity	
Feet	Meters
20/200	6/60
20/160	6/48
20/125	6/38
20/100	6/30
20/80	6/24
20/63	6/20
20/50	6/15
20/40	6/12
20/32	6/10
20/25	6/7.5
20/20	6/6
20/10	6/3

3.2 BLOOD PRESSURE MEASUREMENT

Preparation of client for blood pressure, heart rate and rhythm measurement

Preparation of patient is very important in blood pressure, heart rate and rhythm measurement. Improper preparation can cause inaccurate measurement results. Clients must avoid smoking tea and

coffee at least 30 minutes before measurement. In addition, clients should avoid hard physical exertions, foods and drinks, which have effects on blood pressure. The last step is to allow for rest of at least 5 minutes before blood pressure is measured.
(*National guidelines for Hypertension care Ministry of Public Health*)

Blood Pressure measurement

1. Five minutes rest and no smoking, tea or coffee for 30 minutes prior to blood pressure measurement
2. Always use standard and regularly calibrated equipment regardless of whether Mercury manometer or digital manometer is used. The cuff bladder must envelop 80% of the arm. The usual size is 12-13 cm x 35 cm.
3. Start by wrapping the cuff 2-3 cm above the arm fold keeping the center of bladder (usually there will be circular marking) on top of brachial artery.
4. Measure the Systolic Blood Pressure (SBP) by palpating the brachial artery and inflating the cuff till brachial artery is impalpable. Then, slowly release the air at the rate of 2-3 mm/second, until brachial artery is palpated; this is the SBP.
5. Place the stethoscope over the brachial artery and inflate the cuff to 20-30 mm above the SBP, then slowly release cuff pressure. The first sound (Korotkoff) is the Diastolic pressure.
6. Measure twice 1-2 minutes apart; if the difference is less than 5mmHg then take out the average of the two measurements. If the difference is more than 5mmHg then take the third measurement and take the average of the two nearest figures.
7. Measure the blood pressure of both arms in geriatric or diabetic clients. In clients who complain of postural dizziness, giddiness-standing blood pressure should also be measured. If the standing SBP is less than 20mmHg than sitting SBP, it means that client has orthostatic hypotension. The test for orthostatic hypotension is more sensitive when comparing between standing SBP and lying SBP.

Hypertension means blood pressure equal to or more than 140/90 mmHg, which could be either SBP or DBP that is elevated. The term— Isolated systolic hypertension is used for when SBP is 140 mmHg or more and the DBP remain below 90 mmHg.

Home based Self Blood Pressure Measurement

Home based blood pressure measurement is easy with the advent of digital manometer. Home based measurement helps in diagnosing and treatment blood pressure.

1. Measurement should be same as in the above stated steps
2. Proper training in equipment use should be provided
3. The value read from digital manometer is 5 mmHg lower in comparison to the measurement by mercurial manometer. To interpret whether there is hypertension the value used when measured by mercurial manometer 140/90 mmHg, whilst the value for home based monitoring with digital manometer is 135/85 mmHg.

3.3 Pulse rate and rhythm measurement

Pulse is the expansion and contraction of distal arteries, measured in the elbow (brachial artery), or

wrist (radial artery), which is measuring of the wave from the aortic contraction. The steps for pulse measurement are as following:

1. Turn the palm upward, place the three fingers: index finger, middle finger and ring finger at radial side on palmar surface side of wrist, while placing the thumb on the other side. Then press the fingers until you feel the pulse. The rate of the pulse can then be counted. .

Pulse measurement tells us the following

a. Pulse rate, reflecting the heart rate
b. Rhythm of the heart
c. Gap between two side of limb
d. Character of pulse, for example small pulse

When the pulse rhythm is regular, the examiner can count the pulse for 15 seconds and then multiply by 4 to get one-minute equivalent. The normal range is 60-100 beats/minute, with regular rhythm. If there is irregular rhythm or the pulse rate is higher or lower than normal range, the pulse must be counted for full one minute while auscultating the heart at the same time.

3.4 Body weight, Height measurement and Body Mass Index calculation

The standard equipment according to the NHSO guideline include the following

i. Using a mechanical balance equipment
ii. Able to weigh at 160kg
iii. The unit weigh should be in 100 grams
iv. Coupled with height scale, able to measure 80-200 cm

3.4.1 Record the weight in kilograms up to 2 decimal points for example 50 kg and 800 grams is equal to 50.80 kg.

3.4.2 Record the height in meters with 2 decimal points for example a height of 158 cm is equal to 1.58 meter.

3.4.3 Calculate the Body Mass Index (BMI) by the following formula

BMI=weight (kg) / meter

For example 99.79 kg and a height of 1.90 meter $99.79/1.90^2 = 27.64$

STEP4 Blood drawing and laboratory testing

Blood drawing

If the client has risk for metabolic diseases according to NHSO guidelines: age 35 years and above BMI, more than 25 kg/m^2, then he/she should be advised for 12 hour fasting, and get the full screening laboratory test for metabolic disease. The full screening laboratory test includes Total- Cholesterol, HDL-Cholesterol, LDL-Cholesterol, Triglyceride and Fasting Plasma Glucose.

For clients who without metabolic disease risk, non-fasting random test for glucose, Total Cholesterol and Triglyceride will be done. Recent studies shows that there is no significant difference between fasting and random values of Cholesterol, LDL and HDL, except for Triglyceride in which there is 20% difference between fasting and non-fasting blood test. However, when comparing between the pros and cons, non-fasting blood test is encouraged as it reduce the barrier in getting accessing the services. *(Oh and while you are here "Fasting may be unnecessary for Lipid testing. Best Test. November 2013)*

Preparation

1. Review the tests needed and prepare the equipment
2. Write down the identity details of the client on the test tube in a legible fashion.

2.1 Both name surname and UIC must be on the tubes.

2.2 Show the tubes to clients and let clients verify the accuracy of name, surname and UIC

3. Record name, surname and UIC on the lab request sheet, tick all the test ordered along with the name of the clinic date and time of the lab order.

Steps:

1. Verify the client's identity on the tubes and lab order sheet
2. Verify that correct test tubes are present in required quantity
3. Use tourniquet in the arm. The standard place of draw is the veins in the elbow folds, o not tourniquet for more than 1 minute
4. Clean the area with alcohol soaked cotton balls
5. Palpate the vein use the thumb to stretch the skin over the vein and slowly insert the needle at 15 degree angle to the vein, slowly draw approximately 8 cc of blood. Release the tourniquet
6. Use sterile cotton ball over the insertion point and slowly withdraw the needle, let the client use pressure to stop bleeding for 2-3 minutes, then use plaster to close the wound
7. Discard the needle into the sharp object container
8. Draw the blood into the tubes as per below
9. The draw order is as following

First order is the Red Tubes (clot blood) 4 cc: Cholesterol, TG, HBsAg, VDRL and Anti-HIV

Note: For clinics performing Rapid test, a separated general tube is needed to collect 2 cc bloods for Anti-HIV rapid test

Second order EDTA tube (Violet cap) for CBC 2 cc

Third order of draw tube Sodium fluoride (Grey Cap) for Blood Glucose 2 cc

10. Discard the syringe into the bin for infected material, close the tube with appropriate caps mix the content by inverting the tubes 10 times
11. Ensure all the tubes are fully sealed to prevent leaks.

Storage and transfer to Laboratory

1. Store the tubes in appropriate temperature while waiting for transfer to lab

1.1 the tubes can be stored for 6 hours in room temperature

1.2 For more than 6 hours storage place the tubes in a refrigerator at 2-8 degree Celsius for 6-20 hours. (do not freeze the samples)

2. Phone the laboratory
3. Send the tubes along with Lab order sheet
4. Plan and make a follow up appointment with client accordingly

Precautions in blood drawing and storage

- Use needle size 20-22
- Do not draw the blood while area of the draw is still wet with alcohol
- Do not tourniquet for long periods because coagulation factor will distort the result
- Do not forcefully pull the syringe plunger it will cause the cell wall to breakup
- Do not shake the tube; gently invert the tubes.

STEP 5 Reporting Results; Giving Advice and Counseling

Reporting result include interpretation of the result from history taking, physical exam and laboratory test.

Physical Examination

1. **Visual Acuity**

VA 6/36 means that the client can read from the distance of 6 meters when normal eyesight reads from 36 meters away. VA 6/6 means the client can read from 6 meters when normal eyesight can read from 6 meters, meaning that the client has normal eyesight.

Advise: abnormal eyesight have effect on visibility therefore clients with abnormal eyesight must be advised to be assessed with optician and consider corrective measures.

2. **Blood Pressure**

The interpretation of blood pressure result needs to be carefully performed, and a follow up visit is always needed. The schedule for follow up visit after the measurement is as following.

Table Schedule for a follow up appointment to re-assess the blood pressure

Blood pressure reading		Time span to follow up
SBP	DBP	
<120	<80	Follow up at 1 year
120-139	80-89	Follow up at 6 months
140-159	**90-99**	**Reexamine to confirm if hypertension is diagnosed within 2 months**
160-179	100-109	Follow up at 1 month
≥180	≥110	Assessment, provide proper management and referral immediately or 1 week (depending on client's clinical presentation)

Blood pressure measurement

High blood pressure means the client's blood pressure value is 140/90 mmHg, after being measured 3 times, correctly. The measurement must perform after 5 minutes of rest, without smoking, having tea or coffee, 30 minutes before the measurement, as well as having no other causes that could stimulate the blood pressure. *Client should be advised for a definite diagnosis. That is having blood pressures that reach the diagnostic criteria after a follow up evaluation. In addition to this, a home based blood pressure measurement for 4-7 days, twice a day (in the morning and before sleeping time) should be suggested. The average value from the record is performed by subtracting the readings in the 1st day. If the average is equal to or more than 135/85 mmHg a definite diagnosis of hypertension can be made*.

(For clients older than 85 years, the diagnosis is made with blood pressure of 145/85mmHg, or more).

Home based self-measurement is the real life measurement and it take out "white coat hypertension" out of the equation.

If the diagnosis of hypertension is made, a treatment is provided using the national guidelines.

Table for home based self-measurement record.

Day	**Date month year**	**Morning (SBP/DBP)**		**Evening (SBP/DBP)**	
		First reading	**Second reading**	**First reading**	**Second reading**
1*		...../.....	...../.....	...../.....	...../.....
2		...../.....	...../.....	...../.....	...../.....

3		...../.....	...../.....	...../.....	...../.....
4		...../.....	...../.....	...../.....	...../.....
5		...../.....	...../.....	...../.....	...../.....
6		...../.....	...../.....	...../.....	...../.....
7		...../.....	...../.....	...../.....	...../.....
Average		...../.....		...../.....	

*discount 1st day reading

Table Interpretation of blood pressure result for adult 18 years and above

Blood Pressure	Blood pressure at clinic and hospital		Home based self-measurement (mmHg)
	SBP mmHg	DBP mmHg)	
Optimal	120	80	Normal Blood pressure135/85
Normal	120-129	80-84	
High normal	130-139	85-89	
Mild hypertension	140-159	90-99	135-149/85-94
Moderate hypertension)	160-179	100-109	≥150/95
Severe hypertension	≥180	≥ 110	
SBP	≥140	< 90	

3. Pulse measurement

Pulse should be regular and the rate range 60-100 beats/minute. In athlete or people who regularly exercise, their pulse rate can be slower than 60 beat/minute. However, the pulse will be strong and the rhythm will be. Pulse rate can be faster when exercise or when having fever.

Advise: If the rhythm is irregular or the rate is slower or higher than the normal rate, refer the client to the physician for further workup and proper diagnosis.

4. Body Mass Index (BMI)

BMI value can be interpreted into 4 categories: underweight, normal weight, overweight or obese. However, the range for each category for the Asian population is different from International range.

classification	Asian Range	World Wide Range
underweight	<17.50	> 18.50
Normal weight	17.50-22.99	18.50-24.99
Over weight	23.00-27.99	25.00-29.99
obese	>28.00	> 30

Advise: counsel clients about weight control through life style modification: regular exercise and dietary control, according to NHSO metabolic disease guidelines.

LABORATORY RESULT

Guideline for MSM/TG who come to receive health checkup package in the project

In the initial process an NSHO screening form will be used to assess whether the client has high risk to develop diabetes. If it is found that the client has high risk for diabetes, an 8 hours fasting plasma

glucose should be suggested to the client. However, for other clients without high risk random plasma glucose can be applied.

Screening for diabetes:

An initial screening is performed using NHSO screening form, to assess whether the client has the following risk factors for diabetes.

1. Obese or body weight more than 20 percent of the normal range or BMI more than 25 kg/m^2
2. Family history of diabetes
3. Hypertension
4. History of Impaired Glucose tolerance (IGT) Impaired fasting glucose (IFG) glucose higher than 100-125 mg/dl
5. HDL level lower than 35mg/dl and or Triglyceride more than 250 mg/dl(fasting TG)

Note: *Person who have had delivered babies more than 4000 kg or had been diagnosed with gestational diabetes have positive risk for metabolic disease.*

For people with the risk factors mentioned as above, fasting plasma glucose (8 hours) should be performed, and those who are above 45 years of age, a fasting blood glucose test should be performed every 3 years. The interpretation of laboratory test for diabetes screening is as following.

Fasting Plasma Glucose (8 hour fasting)

<100 mg/dl normal

100-125 mg/dl abnormal fasting plasma glucose

≥ 126mg/dl fasting plasma glucose is high and should, provisional diagnosis of diabetes

2 hours post prandial blood sugar (2 hours after food testing)

<140 mg/dl Normal

>140 mg/dl High blood glucose

Random Plasma Glucose

< 200 mg/dl Normal

≥ 200 mg/dl high glucose level

Table: Laboratory test for Plasma Glucose level—Interpretation and management

Glucose level	Meaning	Advise
Random Plasma Glucose(RPG)		
< 200 mg/dl	Normal	
≥ 200 mg/dl	High level of Glucose	An 8 hours fasting glucose should be ordered to assess risk factors, and clinical presentation if the client have weight loss, polydipsia, polyuria, reaching the criteria for the diagnosis of diabetes
Fasting Plasma Glucose (FPG) 8 hours fasting		
<100 mg/dl	Normal	
100-125 mg/dl	impaired fasting glucose level	Positive risk of developing diabetes, advise for follow-up testing in 6 months
126 mg/dl	High blood glucose level	The client should have the FPG repeated, to confirm if the FPG is ≥126 mg/dl. When there is a result of≥ 126mg/dl twice, a diagnosis as diabetic can be made and consider the standard guideline for the treatment of diabetes, per NHSO recommendation.
2 hours post prandial Glucose(2 hours after meal)		
<140 mg/dl	Normal	After meal, blood glucose level usually people usually gets normal level of glucose within 2 hours, whilst diabetic needs more than 2 hours to get normal glucose level.
>140mg/dl	High glucose level	An advice for FPG for proper diagnosis should be provided, so the client can receive a definite diagnosis and further management.

LIPID PROFILE

Clinically for people above 35 years of age without metabolic disease risk only total Cholesterol should be tested. If the level is more than 240mg/dl then Total cholesterol, Triglyceride, HDL-C and LDL-C is tested.

Risks for dyslipidemia are as following

1. People with risk factors to develop atherosclerotic disease—hypertension, diabetes, obesity, smoking, having family history of stroke, ischemic heart disease and city dwellers.

2. Clients with atherosclerotic heart disease and stroke

These two groups, with risk factors and with atherosclerosis, should be advised for TC, TG and HDL
Advice: To reduce the barrier of client access to the services, the blood test for cholesterol and triglyceride will be collected as non-fasting blood. In general, cholesterol has approximately 2% variation between fasting and non-fasting, whilst triglyceride has a variation of 20%.
If clients have positive risk for metabolic disease according to NHSO guideline, then 12 hour fasting with testing of TC, TG, HDL add should be advised and get reimbursed from NHSO.

Lipid mg/dl	**Primary prevention undeveloped Atherosclerotic disease**		
	Ideal level	**Level when care is needed**	**Meaning**
Cholesterol	<200	200-239	**Moderate high**
		240-299	**High**
		>300	**Very high**
LDL	<130	130-159	**Moderate high**
		160-189	**High**
		>190	**Very high**
HDL	≥40	<35	**Low**
TG	< 150	200-399	**Moderate high**
		400-999	**High**
		>1000	**Very High**

Interpretation of non-fasting blood test for cholesterol and Triglyceride. Cholesterol: Non-fasting values have a variation of approximately 2% from fasting values. Therefore if any abnormality is found, life style modification should be recommend to the client.

Triglyceride: Non-fasting TG has a variation of 20%; hence

- If TG level remain below 150mg/dl with non-fasting blood test, the interpretation is that the client has normal TG value.
- For those with moderately high TG values, it is most probably that their TG level is normal. TG levels can increase due to food such as wheat product, alcohol consumption 6-8 hours before testing. ***The TG value that is very high after meal reflects that the client might have high risk to develop cardiovascular disease and insulin resistance***. If TG level is higher than 400mg/dl, the client should be advised to get a 12 hour fasting blood test for TG.

COMPLETE BLOOD COUNT (CBC)

The normal value in this table is used for male client receiving the test from the health checkup package for under the “men health network clinic”.

Normal reference vales in male	**Explanation(Thai)**	**Normal values and advices**
RBC concentration (Hematocrit: Hct / Normal = 40.7 - 50.3%)	Hematocrit concentration	-Low Hematocrit can be due to blood loss or anemia hematocrit lower than 39% is considered low -High hematocrit if found in dehydration, shock and in long term smokers
RBC Oxygen carrying capacity (Hemoglobin: Hb/ Normal = 13.7-17.2 gm/dL)	Oxygen carrying capacity (hemoglobin which carry the oxygen)	Anemia means Hemoglobin lower than 13 mg/dl in male Doctor will work up further to make a diagnosis and treatment
RBC size and quality:		
Mean Corpuscular Volume (MCV) (normal 80-98 FL)	Average size of the Red blood cell (RBC)	MCV lower than 80 FL is found in anemia High MCV level is found in Vit B12 and folate deficiency
Mean Corpuscular Hemoglobin (MCH) (27-31 pg)	Quantity of Hemoglobin in RBC	Measurement of Hemoglobin in cells
Mean Corpuscular Hemoglobin Concentration(MCHC)(32-36 g/dL)	Hemoglobin density	Measurement of hemoglobin density in RBC
Red Blood Cell Distribution Width(RDW)	Red blood cell distribution	>15% means RBC have 15% size difference
Red Blood Cell Count (RBC) (normal: 4.7-6.1 million cell/mcL)	RBC count	-Low RBC count is found in Anemia -High RBC count means high production of RBC
White Blood Cell Count (WBC) (normal= 4500-10,000 cell/mcL)	White blood cell count	WBC count lower than 4000 is low higher than 11000 is high
Platelet Count (PLT) (normal 140,000-400,000/uL)	Platelet count	Lower than 100,000 is abnormal

Sexually transmitted disease screening

Screening for HIV

Follow the procedure for HTC in this Manual

Screening for hepatitis B virus with HBsAg

HBsAg Positive

HBsAg positive means that the client have Hepatitis B virus, consult physician for further workup and assessment from hepatic enzymes etc. and refer the client to specialized unit for treatment if it is needed. Counseling for safe sex life-style, regularly and correct use of condom and lube, should be delivered.

Asymptomatic and without hepatic inflammation client are carriers of HBV, it means that clients have the virus in their body and can spread it to others. Hence, use of condom during sexual contact is a must to prevent spreading and further infection with another strain of virus.

Counsel clients for regular follow up to check if there is hepatic inflammation and for those with hepatic inflammation a follow up and management with a specialist should be considered.

HBsAg Negative

HBsAg negative means that no HBV is found in the client. If the client has never been vaccinated for HBV, counseling for client to get anti-HBc antibodies testing is advised. A HBV vaccination should be considered if the client doesn't develop the immunity to HBV (Anti-HBc antibody test result is negative).

Venereal Disease Research Laboratory (VDRL) or Rapid Plasma Reagin (RPR)

These tests are screening test to test if there is antibody for T.Pallidium; however, the test is not specific to T Pallidum. The test result could be report as either Reactive (NR) or nonreactive (R)

Nonreactive (NR) no antibody was found

Reactive (R): weakly, 1:1, 1:2, 1:4, 1:8, 1:16, 1:32 or the report can be weakly reactive, moderately reactive and strongly reactive.

When the test result for VDRL (RPR) is reported as reactive, there should be a further confirmatory test with either TPHA or FTA-ABS, and then consider an appropriate treatment.

STEP 6 Behavioral and lifestyle modification with vaccination counseling

Vaccine prevents and protects from diseases and helps client to remain healthy, for MSM Tetanus vaccine and HBV vaccine should be recommended. In general tetanus should be booster every 10 years.

LIFE STYLE AND SEXUAL BEHAVIOR COUNSELING

All clients should receive counseling for attaining and maintaining good health, such as choosing healthy diet, exercising regularly, having work-life balance. .

Sexual preference is an individual right but safe sexual contact with condom use is a must.

Health Check Up list

1. Visual Acuity
2. Body weight and Height
3. BMI - Body Mass Index
4. Blood Pressure
5. Heart Rhythm
6. Heart Rate
7. Health Risks Screening for Metabolic Syndrome
   - Diabetes
   - Dyslipidemias
8. Lipid Profile
   - Total Cholesterol
   - Triglyceride
9. BS-Blood Sugar
10. RBC concentration (Hematocrit: Hct)
11. RBC Oxygen carrying capacity (Hemoglobin: Hb)
12. RBC size and quality:
    - Mean Corpuscular Volume (MCV)
    - Mean Corpuscular Hemoglobin (MCH)
    - Mean Corpuscular Hemoglobin Concentration(MCHC)
13. Red Blood Cell Count (RBC)
14. White Blood Cell Count (WBC)
15. Platelet Count (PLT)
16. Hepatitis B - HBsAg
17. VDRL
18. Anti-HIV
19. Healthy lifestyle tips
20. Sexual health tips

ANNEXES

ANNEX 1: Service Related Forms

Pre HIV test counseling interview form

Site Name: _____

Client code: ☐☐—☐☐☐ UIC: ☐☐☐☐☐☐☐☐☐☐

Date: _ _/ _ _/ _ _

1. No names should be recorded on this form. In 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*): ☐HIV-positive ☐ HIV-negative ☐ Indeterminate ☐ Cannot remember
	Last test was done within 3 months of exposure risk ☐
3. Individual risk assessment:	
Client has regular partner:[1]☐ 1 = YES, 2 = NO	**Is any regular partner HIV-positive?**☐ 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	
Indicate code and date of most recent potential exposure	
Sex with ☐ men ☐ women or ☐ both	

(Tick only when there is exposure risk)	**Last time this risk occurred**	**Window period (tick only if within the window period)**
Accidental workplace[2] exposure ☐		☐
Tattoo, scarification, piercing ☐		☐
Blood products / Organ transplant ☐		☐
Vaginal / Neo-vaginal intercourse ☐		☐
Oral sex ☐		☐
Anal intercourse ☐		☐

[1] Regular partner could be husband or wife, boyfriend or girlfriend, or regular sex client seen over a period of time. There could be more than one partner.

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

Sharing injecting equipment ☐		☐
Client requires repeat HIV test because of window-period exposure: **YES / NO (***circle*) If YES, date of repeat test: _ _/ _ _/ _ _		
Client risk was with a known HIV-positive person ☐		
Client is pregnant ☐ Client's partner is pregnant ☐	If **Yes**, stage of pregnancy: ☐ 1–3 months ☐ 4–6 months ☐ At least 7 months	
Client uses contraception regularly ☐ Client's partner uses contraception regularly ☐	Family planning referral required: ☐ YES ☐ NO	
Client uses non-injecting drugs or substances ☐ (Alcohol, ATS, Marijuana, inhalants, other)	If **Yes**, does the client use these before sex: ☐ YES ☐ NO	
Have you ever been forced to have sex without your consent? ☐	Referral required: ☐ YES ☐ NO	
Client indicates history of STI infection ☐ Client's partner has history of STI infection ☐	Treatment referral required: ☐ YES ☐ NO Treatment referral required: ☐ YES ☐ NO	
Client reports symptoms of TB ☐ Client's partner has symptoms of TB ☐	Treatment referral required: ☐ YES ☐ NO Treatment referral required: ☐ YES ☐ NO	

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

Write a 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 you 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 If yes, ask the following: Client has prior history of self-harm or suicide attempt	☐ Yes: ☐ Yes:
Client indicates intent to harm another if test result is HIV-positive	☐ Yes:
Client indicates potential risk of violence if status disclosed to partner	☐ Yes:
Client has adequate personal support network	☐ Yes:

6. Orientation on condom use:			
☐ Delivered orally	☐ Written leaflet given	☐ Demonstration	☐ Client practice
Number of condoms provided to the client:			

7. Orientation on HIV prevention for injecting drug user		
☐ Delivered orally	☐ Written leaflet given	☐ Not applicable

8. Orientation on the HIV testing process and the meaning of possible test results		
☐ Client has history of fainting during blood draws	☐ Client informed of the blood draw and HIV testing procedure	☐ Client informed of the meaning of possible test results

☐ Client consents to having the HIV test

Additional notes:

Counselor's signature: _____

Counselor's name: _____ **Date: _____**

Post HIV test counselling form

UIC: | | | | | | | | | |

Client code: | | | | | |

Place of testing: _____

Client test date: _ _/ _ _/ _ _

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 YES/NO *(Please circle)*

If YES ☐ Consent for release of information signed YES/NO *(Please circle)*

Details of referral:

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

☐ Discussed transmission reduction strategies

☐ Referral YES/NO If YES ☐ 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	

6. Condom Use:			
1. Verbally ☐	2.Written leaflet given ☐	3.Demonstration ☐	4. Client practice ☐
Number of condoms provided to the client:			
7. HIV prevention for injecting drug user			
1. Verbally ☐	2.Written leaflet given ☐	3.Not applicable ☐	

8.Referral offered (write name of organization):	**Feedback from referral received ☐**
9.Date of follow-up counselling: _ _/ _ _/ _ _	
Notes: _____ _____ _____ **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 panning 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 UIC 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: Other Important Counseling Forms

Suicide risk assessment interview guide

Introduce this topic by using one of the following according to the circumstance of the client:

During post-test counselling for positive HIV result with a client who indicated they would commit suicide if their result was positive	**During post-test counselling for positive HIV result who did not disclose suicide intent during pre-test counselling**	**During the routine post-diagnosis follow-up of a HIV positive client**
"I am concerned that during pre-test counselling that you said you commit suicide if you received a positive result…. I am wondering if you still feel that way"	*"Often when people first learn that they have HIV they feel so overwhelmed that want to end their lives or harm themselves. I am wondering if you feel that way now or feel you may feel that way after you leave my office today."*	*"Often the pressures of living with HIV are so overwhelming that some people feel that their life is not worth living and they think of taking steps to end their life or hurt themselves in some way. I am wondering if you ever feel that way, and if you do how often do you think of this."*

Follow-up questions to be asked:

How often do you think of suicide?

Occasional ❒ More than once a day ❒ constantly thinking about suicide ❒

Duration:- How long do the thoughts usually last?

Very short ❒ Sometimes for over an hour ❒ whole day ❒

On a scale of 1 to 10, how severe are your thoughts? If 10 were the worst thought you had ever had and zero was the best you can feel. What number?

……

0 1 2 3 4 5 6 7 8 9 10

Do you have a specific plan of how you would do it? **Yes ❒No ❒**

How?

When?

Where?

Do you have the things you would need to do this? **Yes ❒No ❒**

Ask specifically about firearms, drugs or pesticides (or whatever the client indicated that they would use in the suicide plan)

Have you made any preparations **Yes ❒No ❒**

(e.g., writing a note; giving away prized possessions)

What?

Have you ever attempted suicide in the past? **Yes ❒No ❒**

How?

When?

Where?

Do you feel your family or friends are concerned and willing to help with your situation?

Help is available and people are willing to help	❒
Help is available but not often or the client indicates he doesn't want to ask	❒
Family or friends not willing to help or are hostile and express anger at the client	❒

Do you have close friends and relationships with people? **Yes ❒No ❒**

How has your mood been lately? Describe how you have been feeling.

For clients who have just received a positive test result this question can be asked in terms of how they were over the last month before they received their test result.

Do your moods change frequently?

For clients who have just received a positive test result this question can be asked in terms of how they were over the last month before they received their test result.

Has your appetite for food changed?

For clients who have just received a positive test result this question can be asked in terms of how they were over the last month before they received their test result.

If you are having sex are you experiencing any difficulties?

For clients who have just received a positive test result this question can be asked in terms of how they were over the last month before they received their test result.

What would need to change in your life in order for you not to think of suicide? *I ask this knowing that HIV cannot be cured but what other things would need to be changed*

Case support planning: for positive health[3]

Client/Patient Number: **Today's Date: _ _ _/ _ _ _ _/_ _ _ _**

Date of original HIV diagnosis:

1. Medical follow-up

For newly diagnosed clients or clients new to your service.

Has the client seen a HIV doctor since they were originally diagnosed HIV positive?

❒ YES Date: ❒ NO, Reason?

When was the last time that you saw a HIV doctor? Date:

What has the doctor (or nurse) told you about your health? (Brief note)

Did they give you any medicine to take? Details

Are you experiencing any difficulties with taking the medication (correct dose, correct way, and correct time)?

---

2. Wellness – Medical review and general observations required. Liaise with treatment doctor in relationship to required tests or health screen.

Routine Laboratory Tests

- CD4 Count

---

[3] Adapted from Counselling Tool 4.6, Post-diagnosis follow-up counseling form, HIV Counselling Training Package, Family Health International, UNICEF EAPRO, WHO WPRO & SEARO, February 2010.

- Viral Load
- Resistance test
- Complete Blood Count (CBC)
- Chemistry Panel
- Toxoplasma IgG
- Blood Fats
- Blood Sugar
- Pap Smear
- Tuberculosis
- Urinalysis

- Tests for Sexually Transmitted Infections
    - Syphilis
    - Gonorrhoea
    - Chlamydia
    - Human Papilloma Virus (HPV)
    - Other
- Hepatitis tests
    - Hepatitis A
    - Hepatitis B
    - Hepatitis C

Vaccinations

- Human Papilloma Virus (HPV)
- Hepatitis
- Influenza
- Measles, Mumps and Rubella

General medical review/notes for follow-up

3. Brief psychological assessment

Over the last month (existing patients) or since patient diagnosis (newly diagnosed patients)

Has the client experienced any of the following?[4]

(tick the appropriate box):

- A persistent sad, anxious or "empty" mood
- Too little or too much sleep
- Reduced appetite and weight loss or increased appetite and weight gain
- Loss of interest or pleasure in activities once enjoyed
- Withdrawing from friends, relatives or others they are normally close too
- Agitation, restlessness or irritability

[4] If the client/patient experiences five or more of these symptoms for longer than two weeks or if the symptoms are severe enough to interfere with their daily routine. Conduct a more detailed assessment if you are a psychiatric nurse, psychiatric social worker or psychologist; if not refer to a doctor or a qualified mental health professional.

- Persistent physical symptoms that don't respond to treatment (possible indicator of health anxiety disorder)
- Difficulty concentrating, remembering, or making decisions
- Hallucinations (hearing voices or seeing things others cannot hear or see)
- Fatigue or loss of energy
- Feelings of guilt, hopelessness or worthlessness
- Thoughts of death or suicide (briefly note the thoughts)

4. Social and welfare

Does the client/patient experience difficulties with any of the following?

Accommodation	❒Yes	❒No	Details:
Finances	❒Yes	❒No	Details:
Obtaining food, medications	❒yes	❒No	Details:
Relationships (partner, family, and friends)	❒yes	❒No	Details:

5. Positive prevention

5.1 Partner disclosure

Already disclosed ❒Yes ❒No

Notes on outcome of any disclosures / reasons for non-disclosure:

Future disclosure plan

- Client/patient will self-disclose
- Client/patient would like to disclose in presence of counsellor
- Counsellor to disclose on behalf of client/patient without the presence of the client/patient (who must complete signed release of information)
- Client/patient wishes counsellor to disclose in his or her presence
- Client/patient will disclose to a trusted third party and request that individual to make disclosure on the client/patient's behalf.

5.2 Transmission risk reduction:

Use of condoms

- Doesn't use condoms with any sexual partners
- Condoms used with regular partner only

- Condoms used with all partners EXCEPT regular partner
- Condoms used with ALL partners

Does the client/patient indicate that s/he has difficulties with sexual functioning?

Yes ☐ No ☐

If yes (Indicate which)

☐ Arousal ☐ Difficulty maintaining erection ☐ Difficulties with ejaculation

Does the client/patient indicate that the above-mentioned problems make it difficult to use condoms? Yes ☐ No ☐

Does the client/patient indicate that s/he is using any sexual performance enhancing substance (e.g. sildenafil / Viagra®)?

Yes ☐ No ☐ ……..If yes, what?

Details of any treatment or referrals the client/patient has received or requires:

Has the client/patient used any non-prescribed drugs (including hormones and steroids) and/or alcohol in the last month?

Yes[5] ☐ No ☐

Has the client/patient been prescribed any hormones or steroids in the last month?

Yes ☐ No ☐

Sharing needles and equipment ❒Yes ❒No Details:

Drug dependency assessment or management referral required ❒Yes ❒No

(Refer to the International Classification of Diseases (ICD) website: http://www.who.int/classifications/icd/en/

Pregnancy

Client/patient is pregnant ❒Yes ❒No NA❒ Partner is pregnant ❒Yes ❒No

If Yes, stage of pregnancy

☐ 1-3 months ☐ 4-6 months ☐ More than 6 months

On ARV prophylaxis? ❒Yes ❒No NA❒

[5] If yes, please condGJuct the detailed “Drug and Alcohol Assessment” available in the Toolkit.

Client/patient's partner uses contraception regularly	❒Yes	❒No	NA❒
Family planning referral required:	❒Yes	❒No	
Pregnancies test referral required:	❒Yes	❒No	NA❒
Client/patient support plan (attached) has been completed	❒Yes	❒No	
Release of Information signed for referrals	❒Yes	❒No	NA❒

Additional counseling notes:

Counselor signature

Name of patient casework coordinator

Date:

Client/patient support plan

Key Issues	Considerations / support strategies

Drug and Alcohol Screening Tool (CAGE)

		Yes	No
1.	**Have you felt you ought to Cut down on your drinking or drug use?**	☐	☐
2.	**Have people Annoyed you by criticizing your drinking or drug use?**	☐	☐
3.	**Have you ever felt bad or Guilty about your drinking or drug use?**	☐	☐
4.	**Have you ever had a drink or used drugs first thing in the morning to steady your nerves or to get rid of a hangover ("Eye-Opener")?**	☐	☐

Yes to 1 or 2 questions = possible problem ***Yes to 3 or 4 questions = probable problem***

If CAGE-AID score is ≥ 1 Brief intervention provided ☐ ☐

CAGE = Cut down * Annoyed * Guilty * Eye-opener

Drug dependency (ICD-10 diagnostic guidelines)

A definite diagnosis of dependence syndrome is usually made only if three or more of the following were present together at some time during the previous year:

- evidence of tolerance, such that increased doses of the psychoactive substance are required to achieve effects originally produced by lower doses;
- physiological withdrawal state when substance use has ceased or has been reduced:
- strong desire or sense of compulsion to take the substance;
- difficulty controlling substance-taking behavior – onset, termination, or levels of use;
- progressive neglect of alternative pleasures or interests because of psychoactive substance use – increased amount of time necessary to obtain or take the substance or to recover from its effects; or
- Persistent substance use despite clear evidence of overtly harmful consequences – depressive mood states consequent to periods of heavy substance use or drug-related impairment of cognitive functioning.

Source: International Classification of Diseases (ICD) website: http://www.who.int/classifications/icd/en/

ANNEX 3 Guideline to dispose expired reagents and instruments

	Name	Position	Signature	Date
Prepared by				
Reviewed by				
Approved by				

Objective:

The document is to be used as a guideline for disposal of expired and or used Reagents and other medical instruments used in project “Same day result HCT in MSM at WCC “

Responsibilities:

1. It is the responsibility of each laboratory staff should read, understand and follow the guideline.
2. Project site managers should review and approve the disposal.

STEP NO.	STEPS	STAFF RESPONSIBLE:
1	All expired reagents and used medical instruments should be logged in a logbook.	Laboratory staff.
2	Details of the reagents e.g. Lot#, expiry date, manufacturer's name methods of disposal	Laboratory staff
3	For Used medical instruments reasons for disposal should be mentioned.	Laboratory staff
4	Prior approval from Project manager or site manager has been taken	Project manager or site manager
5	Disposal must be in accordance of the local legislation an	Laboratory staff
5.1	For contaminated used instruments and test samples should be disposed of as per the legislated containers. For example, needles in sharp instrument container.	

Name	Quantity disposed	Date in	Lot#	Expiry	Reason for disposal	Date of disposal	Approved by	Lab staff
Determine HIV 1//2 Abbot Lab								
Double check Gold ultra HIV 1/2 Alere Lab								
SD Bioline HIV 1/2 3.0 Standard Diagnostics								
Microtips								
Hand gloves/ Swabs/ cotton balls/needles/syringe								
EDTA Test tubes								
Vacutainer								
PPE								
IQC test samples/Samples								
Stop watch								
Miscellaneous								

ANNEX 4: Checklist for HTC services evaluation

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

- Direct observation, using the Quality Assurance / Quality Improvement Checklists
- Counseling records audit
- Client feedback on services (form and interview)

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

General Management, Administration and Operations QA/QI Checklist

Clinic Name:

Assessment team member: **Date:**

1.Training	Method	0,1,2	Observations/rationale for score
1.1. Written guidelines and/or procedures (SOPs) exist for clinical facility administration, management and general operations staff.	MI/SI		
1.2. They are accessible to administration, management and general operations staff.	MI/SI/O		
1.3. The administration, management and general operations staff have been trained on these procedures.	R/MI/SI		
2. Administration - staff			
2.1 Written job descriptions for each position are available. Staff members are aware of their roles and	R/O/SI		

responsibilities.			
2.2 Staff members are recruited according to FHI/IA agreed recruitment practice and the manager is able to explain this practice.	**R/MI**		
2.3 The manager has been trained on minimum standards and all staff members understand the minimum standards.	**MI/SI**		
2.4 Written procedures (SOPs)/Site Operations Guidelines exist for all services. SOPs have been provided to all relevant staff.	**MI/SI/O**		
2.5 All necessary staff members are available at the facility during the advertised hours of operation.	**R/SI/O**		
2.6 An organogram with names of all staff members and clear lines of supervision is available.	**R/MI**		
2.7 Staff performance is appraised annually and documented on file.	**R/MI/SI**		

2. Administration - staff			
2.8 Staff members receive ongoing mentoring, encouragement, supportive supervision and training to fulfill their responsibilities.	**SI/MI**		
2.9 All staff members signed the "Oath of Confidentiality" and the relevant code of ethics and these documents are available to the review team.	**R/O**		
2.10 All new staff members undergo a formal clinic orientation procedure.	**R/MI/SI**		
2.11 All health workers, IA staff, volunteers and cleaners had HBV serology checked and, if negative, were offered vaccination.	**R/MI/SI**		
2.12 Clinical staff members participate in case reviews as part of clinical supervision and support.	**MI/SI**		

3. Reporting, monitoring and evaluation			
3.1 Targets have been set for key performance indicators (e.g., number of people receiving services).	MI/R		
3.2 Data collection forms are available.	O/SI		
3.3 All data collected at each staff level is correct and complete.	O/R		
3.4 Project reporting requirements are fulfilled (timely, complete reporting).	R/SI		
3.5 Data on clinical outcomes is routinely collected and used to monitor the quality of service delivery	MI/SI		
3.6 Performance against targets is reviewed with staff members.	MI/SI		
3.7 Clinic manager can explain how data is used for day-to-day activity planning, management and advocacy.	R/MI		
3.8 The number of clients served during the last reporting period met or exceeded targets.	R/MI		
3.9 Reports including service coverage indicators are produced and readily available.	MI/0		
3.10 Serious adverse events are reported to management (including major allergic reactions, suicides, threats to others, arrests of clients, professional misconduct, etc.).	R/MI/SI		

3.11 Clinical records are maintained for the period required under the project.	R/MI		
3.12 Clinical records are disposed of in accordance with national and local laws.	R/MI		
4. General clinic operations issue			
4.1 The clinic is accessible (consider waiting time, opening hours, confidentiality, distance and travel time etc.).	CI		
4.2 Services provided to clients are offered on 100% voluntary basis.	O/CI		
4.3 There is a logical organization and flow of clients.	O		
4.4 There is a client comment box located in the waiting area.	O		
4.5 Clients are greeted within 15 minutes of arrival at the clinic.	O		
4.6 Clinic staff members are aware of how to respond to various legal issues that may arise, including staff/client arrests on the premises, issuing of a subpoena and requests from legal authorities to review client clinical records. This information is contained in site operating procedure guidelines.	CI		

5. General commodity management			
5.1 There is a commodity management system in place	O/MI/SI		
5.2 Commodities are stored securely, safely and in accordance with the manufacturer's requirements.	O/MI/SI		
5.3 Commodities are ordered sufficiently in advance to avoid stock-outs.	MI/SI		
5.4 The facility has sufficient supplies of condoms (a minimum of two months stock).	O/SI		
5.5 Appropriate IEC materials are available in the waiting and counseling room (e.g., STI, HIV, IDU, VCT, prevention & referral services).	O		
6. Staff and client safety and security			
6.1 Emergency procedure plans been developed and are available for bomb threats, fire, violence or death on premises.	R/O/SI	NA	
6.1 Staff members have completed first aid training (e.g., C.P.R. updated US CDC 2006).	R/SI	NA	
6.2 There is an accident register and written procedure for management of occupational accidents, which is available and visible. This contains CURRENT contact phone numbers.	O/SI	0	

6.3 There is a first aid box available to staff that includes simple supplies for eye washing, covering of cuts and lesions etc.	O/SI	1	
6.4 PEP is available. The facility manager, doctor and other supervisory staff members know what steps to follow. A nodal PEP officer is identified and trained.	O/MI/SI	2	
7. General clinic facilities			
7.1 The clinical/medical records are stored in a secure filing cabinet and only specifically designated clinical staff members have access to this.	O		
7.2 During hours of clinic operation, files are not left in areas where patients and non-authorized staff members can readily access these.	O		
7.3 Clients have access to toilet facilities.	R/MI		
7.4 All staff and client toilet facilities are equipped with soap, water and hand towels.	MI/SI		
7.5 Clients have a designated and suitable waiting area.	MI/SI		
7.6 Client seating in waiting area is a sufficient distance away from the registration desk to allow reasonable privacy during client registration.	O		
7.7 All clinic rooms, including the kitchen, are clean.	O		

7.8 Clinical waste disposal facilities comply with national and local guidelines.	R		
7.9 Clinical consultation rooms (counseling, medical and laboratory) offer visual and auditory privacy.	O		

Total possible score:

Score: 100

Scoring Notes:

Not applicable	NA
No	0
Yes, partially	1
Yes	2

Pre-Post HIV Test and Follow-up Counseling QA/QI Checklist

Facility Name: _____

Assessment team member: _____ **Date:** _____

1. Training		Method	Score				Observations/rationale for score
1.1	Written SOPs exist for the counselor.	MI/SI	NA	0	1	2	**a.**
1.2	These are accessible to the counselor.	MI/SI	NA	0	1	2	**b.**
1.3	The counselor has been trained on these procedures.	MI/SI/R	NA	0	1	2	**c.**
1.4	The counselor has received MOH training on HIV counseling.	MI/SI/R	NA	0	1	2	**d.**
2.	**Pre-test counseling- individual/couple**[6]	**Method**	**Score**				**Observations/rationale for score**
2.1	Counselor builds rapport, introduces role to client, and explains about service and record keeping.	O	NA	0	1	2	
2.2	Counselor explains confidentiality and privacy offered to client.	O	NA	0	1	2	
2.3	Counselor asks about prior history of HIV testing.	O	NA	0	1	2	
2.4	Counselor assesses client's knowledge about HIV/provides basic information about HIV and transmission.	O	NA	0	1	2	
2.5	Counselor asks client about symptoms of STI/treatment for STI.	O	NA	0	1	2	
2.6	Counselor asks client about symptoms of TB/treatment for TB.	O	NA	0	1	2	
2.7	Counselor conducts individual risk assessment and provides feedback on client risk.	O	NA	0	1	2	
2.8	Counselor determines the clients opportunity to access				1		

[6] Where Group pre-test information is provided use that checklist to evaluate the process.

	post-exposure prophylaxis (PEP) based on the date of the client's last risk behavior						
2.9	The counselor provides counseling on the use of PEP [Inform that the antiretrovirals must be taken within 72 of exposure to HIV; Importance of completing the 28-day regime; need to be tested after completing PEP and then 3-6 months thereafter.]						
2.10	Counselor provides information to pregnant women or their male partners (potential for HIV transmission, methods of PMTCT, etc.).	O	NA	0	1	2	
2.11	Counselor asks client about her/partner's possible pregnancy.	O	NA	0	1	2	
2.12	Counselor asks client about her/partner's contraception.	O	NA	0	1	2	
2.13	Counselor explores what client might do if test is positive, explains ways of coping, and undertakes a suicide risk assessment, if necessary.	O	NA	0	1	2	
2.14	Counselor explores potential for support from family and friends.	O	NA	0	1	2	
2.15	Counselor provides behavior change counseling and condom education/demonstration/rehearsal.	O	NA	0	1	2	
2.16	Counselor provides clients with condoms.	O	NA	0	1	2	
2.17	Counselor provides basic information about the test, blood collection and result provision procedure.	O	NA	0	1	2	
2.18	Client provides informed consent, free of coercion for HIV testing (written).	O	NA	0	1	2	
2.19	Client is given adequate time to understand the CT services and to have their questions answered in a manner that they can understand.	O	NA	0	1	2	
2.20	Client is provided with information related to partner	O	NA	0	1	2	

disclosure						
3. Pre-test counseling- group pre-test information only[7]	**Method**	**Score**				**Observations/rationale for score**
3.1 Counselor builds group rapport, introduces the role of the group to clients, and explains about service and record keeping.	O	NA	0	1	2	
3.2 Counselor explains confidentiality and privacy offered to/required of group members, and mentions the "anonymous question box system for questions". Counselor seeks group confidentiality consensus.	O	NA	0	1	2	
3.3 Counselor provides information about HIV, and transmission and prevention, and provides brochures.	O	NA	0	1	2	
3.4 Counselor provides information on STI transmission/treatment and importance of partner notification and treatment.	O	NA	0	1	2	
3.5 Counselor informs group members about referral for brief clinical risk assessment and discusses the rationale for risk assessment *(using the "4 reasons" covered in training)*.	O	NA	0	1	2	
3.6 Counselor provides information related to PMTCT (potential for HIV transmission, methods of PMTCT, and prevention of unplanned pregnancy etc.) - *in both male and female groups*.	O	NA	0	1	2	
3.7 Counselor provides behavior change counseling and condom education/demonstration/rehearsal.	O	NA	0	1	2	
3.8 Condoms offered to group members as appropriate.	O	NA	0	1	2	
3.9 Basic information about testing procedures and client flow is provided, including on the test, blood collection and individual result provision procedure.	O	NA	0	1	2	
3.10 Group members are provided information about HCT services and have their questions answered in a	O	NA	0	1	2	

[7] This checklist should be used for Group Pre-Information provision.

manner that they can understand.						
3.11 Referral to counselor/doctor/nurse for individual informed consent and brief individual risk assessment.	O	NA	0	1	2	

4. Post-test counseling requirements:	**Method**	**Score**				**Observations/rationale for score**
All types of results:						
4.1 All results are checked by counselor prior to provision to client.	O	NA	0	1	2	
4.2 Test result form is transferred to client's file.	O	NA	0	1	2	
4.3 Results given simply and directly to the client.	O	NA	0	1	2	
4.4 Checked for understanding/ meaning of result discussed.	O	NA	0	1	2	
4.5 Assessed for type of support required (e.g., ongoing counseling, medical/treatment support etc.).	O	NA	0	1	2	
4.6 Discussion of personal risk-reduction strategy.	O	NA	0	1	2	
4.7 Client is referred for assessment of other medical conditions/vaccinations that may contribute to a false positive/negative result.	O	NA	0	1	2	
4.8 Information is provided for pregnant women/or partners (potential for HIV transmission, methods of PMTCT, referrals, etc.).	O	NA	0	1	2	
4.9 Client is provided with condoms, as appropriate.	O	NA	0	1	2	
e. Negative result						

4. Post-test counseling requirements:	Method	Score				Observations/rationale for score
4.10 Checked for window period and subsequent exposure.	O	NA	0	1	2	
4.11 Client is advised to re-test if necessary (in a number of countries, it is practice to retest HIV-negative individuals after three months, especially if there is a doubt about the window period).	O	NA	0	1	2	
4.12 Referral if necessary.	O	NA	0	1	2	
f. Indeterminate result						
4.13 Possibility is explained that testing is performed during window period.	O	NA	0	1	2	
4.14 Client referred to physician for investigation of other illness/indeterminate result.	O	NA	0	1	2	
4.15 Re-testing at this center in 12 weeks (4-6 if pregnant).	O	NA	0	1	2	
4.16 Stress management and supportive counseling.	O	NA	0	1	2	
g. Positive result						
4.17 Counselor checks results and client details prior to provision.	O	NA	0	1	2	
4.18 Counselor assesses client's readiness for result.	O	NA	0	1	2	
4.19 Counselor provides and explains result, and checks client understands.	O	NA	0	1	2	
4.20 Counselor provides brief information about follow up and support.	O	NA	0	1	2	
4.21 Counselor assesses client capacity to cope with result.	O	NA	0	1	2	
4.22 Counselor assesses potential for harm to self/others.	O	NA	0	1	2	

4. Post-test counseling requirements:	Method	Score				Observations/rationale for score
4.23 Counselor discusses strategies for partner disclosure. Discussion on disclosure usually takes place during follow up counseling visit.	O	NA	0	1	2	
4.24 Counselor discusses coping management plan.	O	NA	0	1	2	
4.25 Counselor discusses follow up medical care/support and makes referrals where necessary.	O	NA	0	1	2	

5. Post-service delivery						
6.1 Counselor uses standardized approved medical records and registers.	R/O	NA	0	1	2	
6.2 Data collection forms are appropriately used by counselors, including correct and complete recording of activities according to local or national requirements.	R/O	NA	0	1	2	
6.3 There is an adequate supply of all counseling forms.	O	NA	0	1	2	
Maximum score:				**122**		
Total number of "NAs":						
Total number of NA points possible (total number of "NAs" x 2):						
Total points (count all points, excluding any items that are marked "NA"):						
Total Score (percentage, the total points / total points possible):				**/ 122**		

General HCT Laboratory QA/QI Checklist

Facility Name:

Assessment team memb

1. Training	Method	Score				Observation/rationale for score
1.1 **All** laboratory personnel have been adequately trained on tests presently being conducted.	R/SI	NA	0	1	2	
1.2 Laboratory personnel received refresher ("in service") training in the last 6-12 months.	R/SI	NA	0	1	2	
2. HIV laboratory	**Method**	**Score**				**Observation/rationale for score**
2.1 Copy of written job description for all staff working in the laboratory is available: a. Laboratory technician b. Laboratory support staff c. Laboratory attendant	R/MI	NA	0	1	2	
2.2 Copy of written SOP for blood collection available and accessible	O/SI	NA	0	1	2	
2.3 Copy of written SOP for HIV testing (including use of	O/SI	NA	0	1	2	

	rapid test, if being used) available and accessible.						
2.4	A written procedure for collection, storage and shipment of QC specimen is available and follows the SOP for such procedure.	O/R	NA	0	1	2	
2.5	Copy of written SOPs for expired kits and reagent disposal/destruction are available.	R/SI	NA	0	1	2	
2.6	Guidelines and protocol for immediate and long- term management and accidental inoculation/laboratory-related injuries are available.	R/SI	NA	0	1	2	
2.7	The laboratory follows HIV diagnosis strategy as recommended by national guidelines/ protocol:	MI/SI	NA	0	1	2	
2.8	Laboratory technicians wear lab coats and gloves during specimen collection, processing and testing.	O	NA	0	1	2	
2.9	Laboratory staff members use disposable needle and syringe for venepuncture.	O	NA	0	1	2	
2.10	Venepuncture site was cleaned with alcohol swab and the arm was placed on fixed surface for the procedure (table or arm rest of phlebotomy chair).	O	NA	0	1	2	
2.11	After completion of venepuncture, band aid/tape was used to stop bleeding.	O	NA	0	1	2	
2.12	Serum separation process is started 15-30 minute after venepuncture and the sample is not haemolysed.	O	NA	0	1	2	
2.13	The primary sample, subsequent testing device (centrifuge tube, slides, RPR card) and sample aliquots are labeled with the proper ID No.	O	NA	0	1	2	

2.14 The following equipment is available and in functioning condition with appropriate monitoring chart: a. Refrigerator with temperature monitoring chart b. Centrifuge c. RPR rotator d. Microscope with clean lens e. Micropipette f. Laboratory equipment repair/maintenance logbook	O	NA	0	1	2	
2.15 Kits and reagent for all the tests are available and are stored at the temperature recommended by the manufacturer.	O	NA	0	1	2	
2.16 All kits, reagents and devices used and in store are not expired (expired kits, if present, are stored in separately with clear marking of expired status).	O	NA	0	1	2	
2.17 Kits, reagents and devices for the next three months are in stock.	O/SI	NA	0	1	2	
2.18 HIV tests are performed as per the SOP and using appropriate internal controls as recommended in the SOP or as instructed by the manufacturer:	O	NA	0	1	2	
2.19 Kits are taken out of the refrigerator and brought to room temperature before use.	O	NA	0	1	2	
2.20 RPR rotator is used at 100/rpm for 8 minutes and the card is read.	O	NA	0	1	2	
2.21 HIV test results are read after recommended period and test failure, if any, is recorded.	O	NA	0	1	2	
2.22 All biological specimens remaining after the test are disposed as per SOP	O	NA	0	1	2	

2.23	Lab book containing all primary source data is available and stored appropriately.	O	NA	0	1	2	
2.24	Register book containing the daily test results with remarks, if necessary, is available.	O	NA	0	1	2	
2.25	Laboratory staff members complete, verify, and report data as per the national and program protocols.	O/R	NA	0	1	2	
2.26	Laboratory staff members keep a copy of the submitted report for future reference.	O/R/SI	NA	0	1	2	
2.27	Laboratory staff follows QA procedures	O	NA	0	1	2	
2.28	Laboratory staff participates in internal/external quality assurance programs.	MI	NA	0	1	2	
2.29	Laboratory staff members comply with the guidelines and time line of the quality assurance program.	R/MI	NA	0	1	2	
2.30	Needle destroyer is available and functional	O	NA	0	1	2	
2.31	Waste bin for infectious and non-infectious material is available	O	NA	0	1	2	
2.32	Contact details of laboratory experts are available for trouble shooting purposes.	O/SI	NA	0	1	2	

TOTAL SCORE:	/ 68			

General Clinic Infection Control QA/QI Checklist

Facility Name: **ame:**

Assessment team memb

1. Training for designated infection control personnel	Method	Score				Observations/rationale for score
1.1. Written SOPs exist for **all** infection control procedures.	O/MI/SI	NA	0	1	2	
1.2. They are accessible to clinical staff members with infection control responsibilities.	O/MI/SI	NA	0	1	2	
1.3. **All** infection control staff members are trained on these procedures.	O/MI/SI	NA	0	1	2	
1.4. **All** infection control staff members have been trained on their specific job description.	O/MI/SI	NA	0	1	2	
2. General clinic infection control	**Method**	**Score**				**Observations/rationale for score**
2.1 Functional hand washing facilities (including running water and disinfectant soap) are available at the site of examination.	O	NA	0	1	2	
2.2 Instruments are sterilized by autoclave at 121^0C at 106 KPa pressure for 30 minutes (for wrapped) or 20 minutes (unwrapped) or properly decontaminated, washed and boiled for 20 minutes if autoclave is not available.	O/SI	NA	0	1	2	
2.3 Sharps (syringe and needle) are disposed of in a sealed, non-punctured sharps container.	O	NA	0	1	2	

2.4 Sharps containers with contaminated sharps are stored safely (e.g., out of reach of children).	O/SI	NA	0	1	2	
2.5 Procedures exist for the safe disposal of waste (incineration and dumping), in accordance with local or national standards.	O/SI	NA	0	1	2	
2.6 Gloves are used during waste handling.	O	NA	0	1	2	
2.7 Waste is properly segregated and decontaminated prior to disposal.	O/SI	NA	0	1	2	
2.8 Clinical waste (liquid and solid) is disposed as per clinical guidelines.	O/SI	NA	0	1	2	
2.9 Chlorine solution is prepared at right strength (0.5%) and done so on a daily basis.	O/SI	NA	0	1	2	
2.10 Staff members have access to gloves, masks, gown, shoes, and eye protection, where required.	O	NA	0	1	2	
2.11 Gloves are worn by all clinical and cleaning staff members who are likely to be exposed to infectious materials.	O/SI	NA	0	1	2	
2.12 Instruments are cleaned with clean water and detergent.	O/SI	NA	0	1	2	
2.13 Instruments are dried before autoclaving.	O/SI	NA	0	1	2	
2.14 Sterile instruments are stored in a clean, dry place and a log book is maintained.	O/SI	NA	0	1	2	
2.15 **All** units of the center, including kitchen areas, maintain high standards of hygiene.	O	NA	0	1	2	
2.16 **All** clinical areas reflect national or local standards for bio-safety and universal precautions.	O	NA	0	1	2	

Maximum score:	**40**
Total number of “NAs”:	**2**
Total number of points possible (total number of “NAs” x 2):	**4**
Total points (count all points, excluding any items that are marked “NA”):	**36**
Total Score (percentage, the total points / total points possible):	**18 / 36**

Health Checkup QA/QI check list

Clinic Name:

Date:

Assessment member:

Score = 0,1,2, NA	Score	Remarks
1. Written guidelines / SOP exist for Health checkup/SOP-Guideline are accessible to operational staff		
2. Data collection forms, OPD card file folder, consent form are available		
3.Health checkup reporting card available		
4. serious adverse events are reported to management : in case the clinic treat Syphillis		
5. Standard Weighing machine with height scale present		
6.Standard Snellen chart with pinhole occluder present and 6 meters point for VA measurement is clearly marked		
7. Blood sample is collected and stored in the prescribed fashion		
8.clinic staff perform VA correctly, ask the client to close one eye each time reading, noted down the result and explain the result correctly		
9.clinic staffs knows how to perform blood pressure measurement correctly: asking the client to sit and rest for 5 minutes and interviewed if the client smoke 30 minutes before getting the measurement		
10.clinic staff palpate the pulse to check the pulse rhythm for at least 15 seconds		
11.clinic staff interprete the blood sugar result correctly		
Total score		

PSI Thailand Foundation

Unit A 2nd Floor, Q House Convent Building,

38 Convent Road, Silom Bangrak, Bangkok 10500

Tel: 66 (0) 2 2349225-29; Fax: 66 (0) 2 2349230

www.psi.org