HIV/AIDS-VCT

National Guidelines for Voluntary HIV/AIDS Counseling and Testing

Ministry of Health
National Center for AIDS and STD Control
Teku, Kathmandu, Nepal
July 2003

The publication of this National Guidelines for Voluntary HIV/AIDS Counseling and Testing is made possible through funding provided by the United States Agency for International Development (USAID) and technical assistance by Family Health International-Nepal.

NATIONAL GUIDELINES FOR VOLUNTARY HIV/AIDS COUNSELING AND TESTING

Ministry of Health
National Center for AIDS and STD Control
Teku, Kathmandu, Nepal
July 2003

Acknowledgement

The National HIV/AIDS Strategy (2002-2006) emphasizes Voluntary Counseling and Testing (VCT) as an important component as well as a pivotal entry point for comprehensive HIV/AIDS prevention, care support and treatment services. It also recommends the development of national VCT guidelines to standardize the procedure of counseling and HIV testing in the country. The effort in this direction was being made for some months. A National Working Group was constituted to prepare draft VCT guidelines, which was followed by a series of workshops for improvment and editing throw sharing the knowledge, skills and experience with the contribution of many national and international experts.

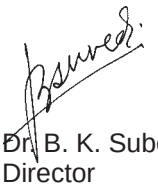
It is heartening to bring out the long awaited National Voluntary HIV/AIDS and Testing Guidelines. I sincerely hope this National Guidelines for Voluntary HIV/AIDS Counseling and Testing will be useful and serve the long felt need of the country beside being useful to different counseling service providers.

We all know that an endeavor of this kind draws upon the contribution and goodwill of many persons. The National Center for AIDS and STD Control would like to express sincere appreciation of the important contributions of all people both national and international who have participated at various stages of the development process of the National Guidelines for Voluntary HIV/AIDS Counseling and Testing.

The National Center for AIDS and STD Control would like to extend gratitude to Dr. Laxmi Raj Pathak, Director General of Department of Health Services, for his inspiring role in the development of these Guidelines. The National Center for AIDS and STD Control would also like to express its appreciation of the supports of Family Health International (FHI) and United States Agency for International Development (USAID).

We express special thanks to Mr. P. M. Jesse Brandt, Technical Advisor, USAID, Dr. Joan Mcneil, Senior Technical Officer, Care and Support, FHI Regional Office, Bangkok, Thailand and Dr. Jesper Svendsen, Senior Technical Officer, Care and Support, FHI, Nepal for their technical guidance and all the members of the National Working Group for their active contribution and inputs.

I feel it is my duty to thank my colleagues Dr. Shyam Sundar Mishra, former Director of NCASC, Dr. Sarala Malla, Director of National Public Health Laboratory, Dr. Dhruba Prasad Singh, Dr. Digvijay Rana, Dr. Sushmita Bhandari, Dr. Pulkit Choudhary, Mrs. Usha Bhatta and Mr. Rajan Bhattarai of the National Center for AIDS and STD Control, who have made substantial contribution in bringing out this present version of the National Voluntary Counseling, Testing and Referral Guidelines.



Dr. B. K. Subedi
Director
National Center for AIDS and STD Control

Preface

Prevention of HIV/AIDS is a priority for His Majesty's Government of Nepal. Even though the prevalence appears to be low in the general population, major efforts will be required to prevent the epidemic from spreading from high risk groups such as migrant workers, transport workers, intravenous drug users, sex workers and their clients, into the general population.

Voluntary Counseling and Testing VCT was used initially to support people diagnosed with HIV/AIDS in the clinical setting, but has developed over years to become a main entrance point to wider prevention, care, prophylaxis and treatment of HIV related illness, psycho-emotional and legal support for people tested positive and negative.

The Ministry of Health, National Center for AIDS and STD Control, recognizes the need and importance of VCT for prevention and care interventions, and plans to establish and expand Voluntary Counseling, Testing and Referral services in prioritized areas of the country in a phased manner. National guidelines for VCT are needed to regulate HIV counseling and testing services and to standardize the protocols and procedures of VCT all over the country, in public and private settings. Besides, the demand for VCT is growing in many parts of the country, especially among vulnerable populations, eg., injecting drug users, sex workers and their clients, migrant workers and men who have sex with men. The reduced cost of their and increased availability of Antiretroviral (ARV) drugs, relatively cheap and simple methods to reduce mother to child transmission, and simple and cheaper HIV testing methods has made VCT more feasible.

Many people in Nepal do not know whether they are infected or not. Learning one's sero-status assisted with counseling can be a powerful prevention and care strategy. High quality testing and counseling services help people make informed decisions about whether or not to take an HIV test, and prepare them in advance for a possible positive result. VCT assists people with HIV/AIDS to prevent transmission of HIV to others. VCT helps people living with HIV/AIDS and their families to reduce emotional stress, deal with problems, make important decisions and live positively with their situation. Counseling can play an important role in referring people requiring various HIV/AIDS services to relevant organizations and institutions. For non- infected people with risk of HIV infection, VCT assists in making changes in their lifestyle so as to reduce risk and remain HIV negative.

Nepal's National HIV/AIDS Strategy 2002 emphasizes the need to establish voluntary testing and counseling centers in the public and private sectors and to build the capacity of counselors and other services to deliver comprehensive prevention, care and support services.

The establishment of VCT centers is a major priority because VCT is an entry point to:

- Early access to medical care (including ARV therapy, treatment of opportunistic infections (OI), preventive therapy for tuberculosis and other OI and sexually transmitted infections).
- Reducing mother to child transmission.
- Emotional care (individual, couple and family).
- Referral to social support and peer support.
- Improved coping and planning for the future (orphan care and will making).
- Normalization of HIV/AIDS in society (reduction of stigma and discrimination).
- Family planning and contraceptive services.

The Ministry of Health, the National Center for AIDS and STD Control sincerely hopes that decision makers planning new services, care and support service providers and counseling staff will use these guidelines:

- as an ongoing resource to deliver high quality VCT and referral services to the people.
- to apply their newly acquired skills in their workplace and in communities.
- to continue to build the capacity of other service providers in order to prevent further transmission of HIV.
- to provide care and support to people living with HIV/AIDS.

This Guideline document is based on the current best international practice and has been adapted to suit the local Nepalese context. The Guideline will be reviewed and updated in the context of any future change in the national or legal policies regarding HIV/AIDS in Nepal. Any comments and suggestions for improvement of future editions will be highly appreciated.

List of Acronyms

AIDS	Acquired Immune Deficiency Syndrome
ARV	Antiretroviral
BCG	Bacillus Calmete Gurine
CBO	Community Based Organization
DPT	Diphtheria, Pertusis and Tetanus
ELISA	Enzyme Linked Immunoserbent Assays
FHI	Family Health International
FP	Family planning
FSW	Female Sex Workers
HIV	Human Immune Deficiency Virus
IDUs	Intravenous Drug Users
MoH	Ministry of Health
MSM	Men Having Sex with Men
NCASC	National Center for AIDS and STD Control
NGO	Non Governmental Organizations
NHTC	National Health Training Center
OPV	Oral Polio Vaccine
OI	Opportunistic Infections
PLWHA	People Living with HIV/AIDS
PMTCT	Prevention of Mother to Child Transmission
QA	Quality Assurance
STI	Sexually Transmitted Infections
SW	Sex Workers
TUTH	Tribhuwan University Teaching Hospital
TB	Tuberculosis
UMN	United Mission to Nepal
UNAIDS	United Nations Joint Program on HIV/AIDS
UNDP	United Nations Development Program
USAID	United States Agency for International Development
VCT	Voluntary HIV/AIDS Counseling, Testing and Referral
WHO	World Health Organization

Table of Contents

1. Background

In Nepal, the first case of AIDS was reported in 1988. The national HIV sentinel surveillance system has provided data that indicate there were around 60,018 people living with HIV/AIDS and 2958 AIDS related deaths by 2002. It is estimated that HIV prevalence is around 0.5 percent in the general adult population.

Behavioral data shows a high potential for an increased spread of HIV from high-risk groups to the general population.

Current information on the HIV epidemic

- Predominant mode of transmission is through sexual contact, mainly heterosexual.
- Highest rates of HIV infections identified in IDUs (up to 70 %).
- Data indicate that risk behaviors are widespread among FSWs, their clients, IDUs, labor migrants and youth.
- Limited information about homosexual/bisexual men.
- There is evidence of an explosive increase in the number of infections since 1996.
- Increasing levels of STIs reported.
- Most people living with HIV/AIDS do not know they are infected and many of them may be engaging in unsafe sexual practices. Stigma and discrimination make it difficult for people living with HIV/AIDS and for high-risk groups to practice safe sex, undergo testing, and if they know they are infected, from seeking treatment and care.

It is believed, that in the absence of effective interventions, even a low growth scenario, would make AIDS the leading cause of death in the 15-49 year old population over the coming years.

A generalized epidemic in the population would be a vicious circle. The impact of HIV/AIDS would increase poverty and vulnerability to HIV/AIDS. This vulnerability would lead to more infections and higher impact. In addition to the negative impact on socioeconomic development and the loss of productive life, the burden of disease would put further stress on the health sector and local communities.

2. Introduction

Voluntary HIV/AIDS counseling, testing and referral (VCT) is a major strategy in HIV/AIDS prevention and care.

Nepal's National HIV/AIDS Strategy 2002 emphasizes the need to "establish a non-discriminatory, accessible, voluntary, confidential HIV testing system with pre-and post-test counseling and urges the MoH "to develop a policy and quality framework for government and private institutions including NGOs" as a basis for expansion of services over the coming years.

This document presents His Majesty's Government of Nepal's Guidelines for Voluntary HIV/AIDS Counseling and Testing. The Guidelines are based on the recommendations of the Technical Working Group on VCT established by the National Center for AIDS and STD Control (NCASC), MoH.

VCT services are an important part of an expanded National HIV/AIDS Prevention and Care Strategy in Nepal because they:

- Contribute significantly to the prevention of HIV transmission by helping HIV infected persons to change risk behavior.
- Ensure that persons at increased risk of HIV receive quality prevention counseling to reduce their risk of acquiring HIV infection.
- Ensure that persons who are offered or receive HIV testing are provided with information about ways in which HIV is transmitted and can be prevented and about the meaning of the HIV test results.
- Ensure that HIV infected persons have early knowledge of their HIV status and increase their access to appropriate medical, prevention, psychological and social services.
- Facilitate links with other services such as prevention and treatment of STIs, prevention and treatment of tuberculosis and other OIs, and prevention of mother to child transmission (PMTCT).
- Play an important part in support of psychosocial services offered as part of outreach, home and community care programs as well as institutional and hospice care.

For communities, VCT can increase acceptance and normalization of HIV, decrease stigma and discrimination against people living with HIV/AIDS, if many people get VCT, talk together and act on their knowledge.

3. Policy for HIV Testing and Counseling

Testing for HIV for public health purposes may be done in the following circumstances:

- Surveillance by the NCASC's Surveillance Program or partners authorized to do so (unlinked and anonymous testing for epidemiological purposes without informed consent). (Refer to instructions from the NCASC not included)
- Diagnostic purposes (within institutional settings).
- As part of screening blood donations. (Refer to special instructions from the Ministry of Health not included)
- VCT services.
- Research.
- Mandatory testing[1] for HIV is not allowed in Nepal.
- Compulsory testing[2] for HIV is prohibited, unless required by law. e.g. recruits to army/police
- All testing for HIV should be voluntary and confidential.
- All anonymous unlinked testing conducted for research or surveillance purposes must be in accordance with Nepal Health Research Council approvals.
- All public and private institutions, Non-Government organizations (NGOs) and Community Based Organizations (CBOs) which conduct HIV tests must adhere to the Policy and Guidelines for VCT.
- All public and private institutions, NGOs and CBOs must provide adequate pre-test, post-test counseling and accurate results.
- HIV test for diagnosis and for VCT must use whole blood, plasma or serum. Tests based on urine and oral fluids are not allowed for VCT.
- Provision of rapid HIV tests to the general public through pharmacies and other consumer outlets for use, such as 'home test kits 'or' self testing kits is not allowed.

How can VCT prevent HIV?

- Learning one's test result helps people change behavior.
- Anyone having unprotected sex with someone whose HIV status is unknown is at risk.
- You cannot tell if someone has HIV unless they are tested.
- Premarital VCT protects young families.

---

1 Mandatory testing refers to testing that is conducted without any option for refusal.

2 Compulsory testing refers to testing which is required in order to access a particular benefit or service (e.g. visa, employment, medical care, armed forces, police, etc.) but where the individual has the option of rejecting the service or benefit and thus avoiding the test. (Please refer to Appendix 1: Disadvantages of mandatory HIV testing.)

Some companies may market rapid HIV tests as 'home test kits' or 'self testing kits' to the public through pharmacies and other consumer outlets. **The use and availability of home test kits is not allowed for several reasons including:**

- All VCT services are required to adhere to minimum standards of performance and training.
- All public and private, HIV/AIDS testing and counseling services must report quarterly to the NCASC and Regional Health Services Directorate. (Appendix 17).

Diagnostic testing in public and private health care facilities

- HIV testing for diagnostic purposes should only be carried out where confirmation of the patient's HIV status **would clearly benefit the patient in terms of determining the best course of treatment and with informed consent**. Routine testing of a person for HIV infection for the purpose of protecting a health care worker from infection is not allowed/prohibited regardless of consent. Instead, it is recommended to establish procedures universal precautions, occupational exposure prophylaxis.
- Pre-test counseling should be provided as part of informed consent, the patient should be informed of the result of testing only with post-test counseling.
- In general, children should only be tested with the permission of their parents or their legal guardians and provided with appropriate counseling. (see later)
- Test results must be kept confidential.
- No relative of the patient should be notified of the test or of the result, unless the patient has given permission.

Voluntary counseling and testing services

Whether in the public or private sector VCT service must follow the standards set down in these Guidelines.

- All testing must be accompanied by pre-and post- test counseling with informed consent. The client should be informed of the result of testing only with post-test counseling.
- Test results must be kept confidential.
- Testing procedures must follow the protocols defined in these Guidelines or as amended by the NCASC.
- Counseling and laboratory staff must be qualified according to NCASC and NPHL standards.

4. National Guidelines for Counseling, Testing and Referral

A. Purpose of the Guidelines

These Guidelines were developed for policy makers and service providers in settings that offer both public and private HIV VCT and referral.

The Guidelines are intended to be used to develop and provide VCT services and protocols for service delivery in clinical settings (such as STI clinics, private physicians' offices) and non-traditional settings (e.g., free-standing, community-based or outreach settings). which can be important places to provide access to VCT to persons at increased STI/HIV risk. Examples of HIV counseling, testing and referral settings are shown in Figure 1 below.

The NCASC acknowledges VCT providers' need for flexibility in implementing the Guidelines, given their particular client base, setting, HIV prevalence level and available resources.

The NCASC will ensure that these Guidelines are followed through the setting of standards, quality assurance, and mechanisms for reporting, monitoring and evaluation.

Figure 1: Examples of VCT Settings

- Freestanding services
- Outreach programs and health services for vulnerable groups: IDUs, migrants/ refugees, men who have sex with men (MSM), street children
- Hospital services
- Part of the continuum of care/home care.
- NGO
- Integrated into general medical services as part of specialist care: STI, antenatal clinics, family planning clinics, tuberculosis
- Correctional facilities
- Drug prevention and treatment programs
- Private sector settings
- Workplace clinics
- Where/when legally required such as: pre-employment, pre-travel, pre-marital
- Youth and school health services

B. Aims of the Guidelines

- To strengthen and support the expansion and extension of HIV VCT services in the public and private sectors.
- To make quality HIV testing services more accessible and available to HIV infected persons, persons at increased risk of infection and the population as a whole.
- To emphasize the need to provide information regarding the result of the HIV test to all clients.
- To encourage/enforce the availability of anonymous as well as confidential HIV testing and counseling.
- To ensure that HIV testing is informed, voluntary and consent is recorded.
- To ensure the use of a prevention counseling approach aimed at personal risk reduction for HIV infected persons, persons at increased risk of infections and the population as a whole.

To help in assessing appropriate care and services such as Sexually Transmitted Infections (STI), treatment, Prevention of Mother to Child Transmission (PMTCT), ARV and OI treatment.

5. What is VCT ?

A. Goals of Voluntary HIV/AIDS Counseling and Testing

The goals of VCT is to ensure that HIV-infected persons and persons at increased risk for HIV:

- Have access to HIV testing to promote early knowledge of their HIV status.
- Receive high-quality HIV prevention counseling to reduce their risk for transmitting or acquiring HIV, and have access to appropriate medical, preventive and psychosocial support services.
- Ensure that all persons either recommended or receiving HIV testing are provided information regarding transmission, prevention, and the meaning of HIV test results.

Counseling and testing will take place in a number of settings and situations as the HIV/AIDS prevention and care programs expand: (1) in free-standing VCT services, (2) integrated into general health services, (3) integrated with specialist health care services such as Tuberculosis (TB), STI, family planning (FP) and Prevention of Mother to Child Transmission (PMTCT), (4) in services for special groups such as young people, sex workers, IDUs, family and community counseling, private sector, associated with blood transfusion services and as HIV testing and counseling attached to research projects.

B. HIV/AIDS counseling definition

HIV counseling definition:

An interaction in which the counselor offers another person the time, attention and respect necessary to explore, discover, clarify ways of living more resourcefully.

Counseling is an **issue-centered** and **goal-oriented** interaction. Counseling is DIALOGING and helping to provide options for decision-making and BEHAVIOUR CHANGE. Good counseling helps another person to be AUTONOMOUS, meaning able to explore options, make decisions, and take responsibility for his or her own actions.

In 1994, WHO defined counseling as follows:

A confidential dialogue between a person and a care provider aimed at enabling the person to cope with stress and make personal decisions related to HIV/AIDS.

The counseling process includes an evaluation of personal risk of HIV transmission and facilitation of preventive behaviors and appropriate referrals for care and support services.

The essential elements of VCT services are:

- Determining the clients knowledge
- Providing information
- Conducting a personalized risk assessment
- Developing a personalized risk reduction plan
- Demonstrating appropriate condom use
- Counseling about test results
- Counseling about making the decision to take the test
- Assessing the client's capacity and ability to cope
- Counseling on how to inform partners of results and how to refer partners for testing
- Providing psychological and emotional support and referrals, as appropriate
- Also see figure 2, pg. 20

C. Who may benefit from VCT ?

- Clients with sexual exposure to an HIV infected person
- Clients with exposure to an HIV infected person through sharing of needles
- Clients who perceive themselves to be at risk of HIV infection through past or present practices or potential exposure
- Clients who have clinical symptoms suggesting HIV infection (according to WHO/CDC case definition)
- Clients who have medical diagnoses suggesting increased risk of HIV infection (e.g. STI or blood borne infection)
- Clients exposed to unsafe blood supplies or contaminated equipment
- Couples planning to marry and/or have children
- Couples planning to commence a sexual relationship
- Sexual partners of HIV infected persons
- Pregnant women.

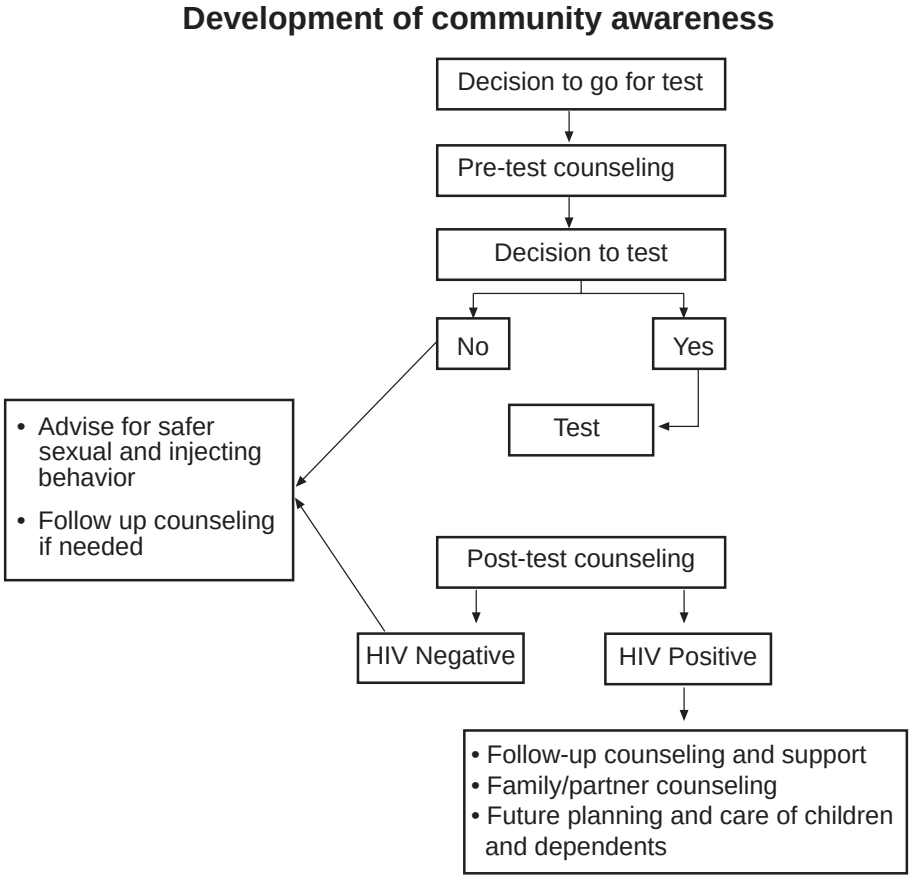
D. The VCT process

The following is an overview of the counseling process.

The VCT process starts with raising awareness in high-risk communities how the testing is beneficial for HIV prevention and access to appropriate care and support. Without adequate community understanding, acceptance of VCT will be poor and utilization of services low.

The process include between one and three pre-test sessions and at least one post-test session and follow up counseling, which can be adapted to the needs of the client(s), whether an individual, a couple, a family or children. Counseling content may vary considerably according to the target group: sex workers, IDUs, MSM, young people or counseling associated with TB therapy or interventions to PMTCT.

Figure 2. The VCT Process



E. Where should VCT services be provided?

VCT services are best offered at integrated or freestanding sites. (Figure 1/page 5). Each site should have at least the following:

- An appropriate private room for counseling
- A room for HIV testing
- A comfortable and discrete waiting area
- Appropriate equipment, test kits and supplies for testing
- A trained counselor
- A health worker/laboratory worker certified in HIV testing
- Appropriate record keeping, monitoring and evaluation systems
- Health education materials, condom supplies and a penis model

6. Principles for Effective Voluntary HIV/AIDS Counseling and Testing

Effective HIV testing, counseling and referral services are based on the following principles:

- Strict maintenance of confidentiality for all persons.
- Everyone is recommended to take an HIV test, and should be informed of how HIV is transmitted, the importance of obtaining test results, and the meaning of HIV test results.
- Informed consent before HIV testing.
- An option of anonymous HIV testing.
- Risk assessment to encourage clients to identify, understand and acknowledge his or her personal risk of acquiring HIV.
- Prevention counseling to reduce risk behaviors.
- Provision of HIV results timely and confidentially.
- Provision of referral:

  Clients may require referral for appropriate medical, prevention, psychological and social services (such as, STI treatment, family planinng nutrition, legal advice, PMTCT, TB).
- Each counseling service should have complete knowledge of referral resources including availability, accessibility and eligibility criteria for services.
- Ensure high quality services: Providers should develop and implement written protocols for VCT and written quality assurance and evaluation procedures. Appropriate to the client's culture, language, sex, sexual orientation, age, and developmental level.
- These factors could affect how the client seeks, accepts, and understands HIV services. Providers should consider these factors when designing and providing HIV services to increase the likelihood of return for test results and acceptance of counseling and referral services.
- Establishment of a referral network (Chapter 9).
- Responsive to client and community needs and priorities.

  Providers should work to remove barriers to accessing services and tailor services to individual and community needs. To ensure that clients find services accessible and acceptable, services can be offered in nontraditional settings (i.e., community-based or outreach settings); hours of operation can be expanded or altered; unnecessary delays can be eliminated, test results can be obtained more easily (e.g., with rapid same day testing), and less painful specimen collection can be used (e.g., finger-stick blood). Measures to improve uptake also include

specific sessions for different groups, a welcoming environment, respect for privacy, incentives and value added services for vulnerable groups. For example, baths, cosmetics, coffee/tea, drop in centers.

- Provision of condoms, access to clean injection equipment.

A. Community awareness and demand creation for VCT services

How to increase uptake to VCT ?

Partnerships with NGOs, CBOs, PLWA groups and target groups to increase **community awareness and create demand for VCT and referral services.**

The success of VCT services depends heavily on partnerships with target groups and among the various organizations working in a community to ensure community support, public awareness and high quality, comprehensive medical support services. Providing only VCT without appropriate linkages, referrals and associated prevention and care services undermines the potential impact of VCT services for both HIV prevention and HIV care and impact mitigation.

The main objectives of VCT communication and awareness raising activities are to:

- Promote awareness among target populations of the availability of high quality VCT services;
- Encourage the target population to use VCT services;
- Promote understanding of VCT and its benefits among the target population, including information on referral services such as clinical, treatments of STI, family planning, PLWHA support groups and possibilities for economic support;
- Encourage local leaders, public and private health providers and policy-makers to endorse the use of VCT center; and
- Reduce stigma and discrimination.

Demand creation for VCT and mobilization of target groups can be done through:

- Recruitment and training of doctors and nurses from hospitals and private clinics (STI, TB);
- Recruitment and training of local NGOs which conduct HIV prevention activities in the community;
- Specially trained peer volunteers will ensure that potential clients understand the meaning of their decision to:

- Obtain VCT
- Assess their risk
- Adopt positive behavior changes.
- Become aware of care and support services within their locality.
- Peer volunteers may accompany clients to the VCT site and referral services.

B. Ethical Context

Why is VCT voluntary ?

For the individual, being diagnosed as having, recognizing the possibility of, or suspecting the existence of HIV infection or AIDS all has profound emotional, social, behavioral and medical consequences. The type of personal and social adjustment required in the context of HIV infection often has implications for family life, for sexual and social relations, for work and education, for spiritual needs, for legal status and for human rights. Adjustment to HIV infection involves a lifelong process that makes new and changing demands on individuals, their families and the communities in which they live.

Although there are many benefits to knowing one's HIV status, testing may have negative consequences in communities where HIV-infected persons are stigmatized.

Trust is one of the most important factors in the relationship between counselor and client. It enhances that relationship and improves the chances that the individual will act on the information provided to the benefit of society.

Given the possibility of stigma and discrimination, ostracism and personal persecution that an individual diagnosed with HIV may face, it is all the more important that the following ethical and legal concerns are observed.

C. Informed consent

VCT is voluntary

In other words, clients who ask for or decide to take an HIV test need to provide informed consent to ensure that all persons being tested have voluntarily and freely agreed to being tested. (See, Informed Consent Form - Appendix 12)

Obtaining informed consent involves educating, disclosing advantages and disadvantages of testing for HIV, listening, answering questions and seeking permission to proceed through each step of counseling and testing. Informed consent cannot be implied or presumed. Informed consent can be verbal but written consent is recommended.

To obtain informed consent for testing for HIV:

- The client must be found competent by the counselor.
- The client must understand the purposes, risks, harms and benefits of being tested, as well as those of not being tested.
- The client's consent must be voluntary.

If the person is not found competent, his or her legal guardian must consent voluntarily.

Although most clients are likely to consent to testing for HIV, some may refuse. Their reason for refusal may be explored and resolved through supportive counseling. Ultimately, a person's refusal to be tested should be respected.

There are many reasons that may motivate a client to refuse being tested for HIV, including:

- False or inaccurate information.
- Insufficient psychological or emotional preparation.
- Lack of social support.
- Fear of breach of confidentiality.
- Fear of testing procedures.
- Fear of losing employment, housing, insurance or other economic support.
- Fear of losing friends, partners or child.
- Past or current history of physical or sexual abuse, or both personal and cultural values or beliefs.

D. Consent for testing infants, children and youth

In Nepal the legal age of consent is 18 years. Anyone 18 years or older requesting VCT is deemed able to give full, informed consent. Generally, for children and minors without the legal capacity to consent, voluntary informed consent from parents or legal guardian is required.

When children are brought to the VCT center by their parents, the counselor determines the reasons

for testing. VCT services are provided only if there is a clear potential benefit to the child and the counselor determines that there is no potential for neglect or abuse of a sero-positive child.

Under the following circumstances, HIV testing may be of benefit to minors:

- Children (14 years and below) with clinical indicators of HIV/AIDS.
- Children at increased risk of HIV infection (e.g. street children who engage in sex work and/or injecting drug use).
- Children who have been sexually abused.

In these circumstances, the counselor or clinician will need to explore with the individual and/or their parent/guardian:

- Whether it is in the best interest of the child to be tested for HIV.
- Whether the child and/or parent/guardian would benefit from counseling.
- Who will consent for the child.
- Whether the child will be informed of the result, when, and how.

Definition:

Confidentiality exists when personal information about clients, whether obtained directly or indirectly is not revealed without the client's permission. This information includes biographical details that may permit the client to be identified and the HIV test result disclosed**.**

For young people 14 to 17 years, VCT may be provided without parental consent on a case-by-case basis, if the counselor determines that the young person has sufficient maturity to understand the testing procedures and results. Alternatively, preventive counseling without testing should be offered.

Children below 14 years may be given preventive counseling if requested, but should not be tested unless this is done for medical reasons. The counselor determines, whether the VCT services have potential benefit for the child and this is clearly explained to the child.

Each case in the above categories will need to be assessed by the individual health professional or counselor and a decision reached on the basis of what is ultimately in the best interest of the child.

E. Confidentiality

Why is VCT confidential ?

Great harm may result from a breach of a client's trust. Many people are afraid to seek HIV services because they fear stigma and discrimination from their families and community.

Counselors offer confidentiality because:

- Confidentiality encourages a relationship where clients can reveal to the counselor information and feelings normally kept to themselves, some of which are often taboo.
- Confidentiality helps clients admit that they have been involved in associated high-risk behaviors (unprotected sex, using drug and alcohol).
- Confidentiality permits clients to remain in control and reveal their HIV sero-status to selected individuals, especially sexual partners and family members.
- Confidentiality should be applied in all activities of the VCT site. All members of the staff at the site should be trained in and incouraged to maintain confidentiality. The client can be helped to accept the guarantee of confidentiality by the continued emphasis that it is given by all members of the staff.

Who is responsible to maintain confidentiality?

All professional and support staff should understand and respect the confidentiality of information obtained during testing for HIV and counseling.

The client should be informed of how information about his or her serologic test results is recorded and stored and how staff maintains confidentiality or anonymity.

Any disclosure of confidential information, no matter how inconsequential it may seem, whether it occurs in public settings, over the telephone, on an answering machine, by mail, fax or email, requires the client's consent.

The test results should be given to the client in person and privately at a prearranged time to ensure confidentiality and adequate support. A client's preference whether he or she should have family members or confidents present should also be respected.

Types of confidentiality:

- **Pediatric confidentiality**

  No one except the child's parents, other guardians and the physician has a need to know the child's status regarding HIV infection. The family has no obligation to inform school authorities. If the family chooses to inform school authorities, the child's right to privacy must be assured.

- **Shared confidentiality**

  Shared confidentiality is encouraged. Shared confidentiality refers to confidentiality that is shared with others. These "others" might include family members, loved ones, caregivers and trusted friends. This shared confidentiality is at the discretion of the client being tested.

- **Option of anonymous HIV testing**

  Anonymous testing (i.e., consented voluntary testing conducted without a client's identifying information being linked to testing or medical records, including the request for testing or test results) has been used widely and effectively to the benefit of public health.

Confidential procedures

VCT sites, especially those located within hospitals and health centers, should ensure that clients requesting VCT services are not readily identified by the public or by other patients. Confidentiality in VCT services involves using code numbers and managing the waiting room and client flow procedures in such a way so as to maintain confidentiality.

F. Human rights principles relevant to VCT

The following recognized human rights principles must be observed in VCT:

- **The right to non-discrimination, equal protection and equality before the law:**

  Discrimination by staff will deny clients' access to VCT and thereby miss the opportunity for behavioral change and support as well as protect the public's health.

- **The right to marry and have children:**

  Mandatory premarital testing is discouraged. Similarly, coerced abortions and sterilization of HIV-infected women violates their right to have children.

- **The right to the highest attainable standard of physical and mental health:**

  Quality VCT can contribute to the physical and mental health of those who wish to know their HIV status. VCT is an entry point for access to supportive medical care and collaboration between client and provider.

- **The right to informed consent before a medical procedure:**

  It is a standard of medical practice that there should be informed consent before any medical procedure. The risks and benefits of the procedure should be explained to the client or patient to facilitate the process of informed consent. HIV testing is a medical procedure.

- **Protecting Human Rights within a VCT site:**

  In addition to the strict observance of pre-and post-test counseling, confidentiality and informed consent, protecting the human rights of VCT clients can be promoted through the adoption of an "Ethical Code of Conduct" for all those involved with VCT services. Such a code of conduct could include a commitment to: competence, consent, confidentiality, and respect for people's rights, professional conduct, and integrity towards their clients.

  Refer to Appendix 2 and 3: Code of Conduct and Code of Ethics and Practice.

7. Guidelines for Pre-test and Post-test Counseling

A. Counseling in VCT

Counseling should be viewed as a means to initiate prevention and ensure access to continuing care. The decision to be tested should always be made by the client himself/herself. More than one pretest counseling session may be required for clients who refuse testing or are unprepared for testing.

The purpose of counseling is to ensure that HIV-infected persons and persons at increased risk of HIV:

- Have access to HIV testing to promote early knowledge of their HIV status.
- Receive high-quality HIV prevention counseling to reduce their risk of transmitting or acquiring HIV and have access to appropriate medical, preventive and psychosocial support services.
- Promote early knowledge of HIV status through HIV testing and ensure that all persons receive information regarding transmission, prevention, and the meaning of HIV test results.
- Help the clients cope with the emotions and challenges they face when they:
    - are worried about being infected with HIV.
    - have found out that they are infected with HIV.
    - are affected by AIDS in their family or among their friend.
    - are living with HIV and can make choices and decisions that will prolong their lives and improve their quality of life.

VCT consists of pre-test, post-test and follow up counseling/support. Counseling should be adapted to the needs of the client.

Approaches to counseling may include:

- Face to face individual counseling sessions
- Couple counseling
- Group sessions

Counseling consists of:

1.) Information

Regardless of whether an HIV test is done or not; HIV infection, risk-producing activities and specific ways in which the person can avoid or reduce risk should always be discussed.

In providing information about HIV, providers should use educational materials such as brochures and videotapes or refer the patient to other sources of information. NCASC, NGO's and AIDS service organizations can supply material for distribution.

2.) HIV prevention counseling to the individual

HIV prevention counseling involves talking to the counselor at least two times: before and after the HIV test.

Ad a) Information

- Individual pre-test decision counseling should be provided to all those requesting VCT.
- General information about VCT can be provided to groups in the form of health education talks.

The following areas should be discussed in a group pre- test session:

- Basic facts about HIV infection and AIDS
- Meaning of an HIV test, including the window period
- Reasons why the client is requesting VCT
- HIV testing procedures at the site, including whether or not written results will be given

Ad b) HIV prevention counseling

In the pre-test session, counseling should be centered on three main topics: first, the personal history and risk of being or having been exposed to HIV, secondly, the client's understanding of HIV/AIDS and previous experience in dealing with crisis situations; and thirdly, the client is asked to describe previous risk reduction steps attempted.

In the second session, the post-test session, which occurs when HIV test results are provided, the counselor discusses the test results, asks and helps the client identify and commit to additional behavioral steps and provides appropriate referrals.

To the client knowledge of HIV status can mean power, but only if this knowledge is acted upon and produces a change in attitude and in behavior.

Figure 2: Overview of the main components of counseling:

- Determining the clients knowledge
- Giving accurate information
- Conducting personalized risk assessment
- Developing a personalized risk reduction plan
- Demonstrating appropriate condom use
- Explaining the test and obtaining informed consent
- Discussing implications of the result
- Assessing coping ability/strategies
- Giving results
- Providing psychological and emotional support and referral as appropriate

Counseling also includes:

- Establishing a helping relationship with the client
- Having conversations that have a purpose
- Listening attentively to clients
- Helping clients tell their story
- Giving clients correct and appropriate information
- Helping clients make informed decisions
- Helping clients recognize and build on their strengths
- Helping clients develop a positive attitude towards life

Counseling does not include:

- Giving advice
- Making decisions on behalf of clients
- Judging clients
- Interrogating clients
- Blaming clients
- Preaching or lecturing to clients
- Making promises that cannot be kept
- Imposing own beliefs on clients
- Arguing with clients

B. Pre-test Counseling

There are generally **5 steps of pre-test counseling**

Step 1: ***Establish good contact and trust with the client, describe the roles and responsibilities of patient and counselor and establish consensus with the patient as to the objectives of the session.***

The patient should be helped to feel comfortable with the clinic procedures, understand the role of the counselor, and be clear about the content and purpose of the session. If the patient is clear about the expectations and the process, the counselor has reduced the patient's anxiety and increased the patient's ability to focus on the session. This clear delineation of the session serves to model for the patient a rational and responsible approach to addressing the challenging issues of behavior change.

The counselor should make the client feel confident that the counselor will be able to understand the patient's risk behavior and express trust in the patient's ability to initiate a risk reduction process.

Step 2: *Engage the patient in an exploration of his/her HIV risk behavior. The purpose is to focus the patient's attention on his/her risk behavior, increase his/her level of concern regarding these behaviors, and enhance the patient's self perception of risk. The goal is also to facilitate the patient's understanding of issues and circumstances that contribute to his/her risk behavior.*

Risk assessment is the portion of the discussion that encourages the client to identify, understand, and acknowledge his or her personal risk behavior and circumstances that put him/her at increased risk of acquiring HIV.

The session includes an exploration of previous attempts to reduce risk and identification of successes and challenges in previous risk reduction. This in-depth exploration of risk behaviors allows the counselor to help clients consider ways to reduce their personal risk and commit to a single, explicit step to reduce risk.

1. Assessment of Risk

Personal risk assessment (profile):

- Frequency and type of sexual behavior and specific sexual practices; in particular, high risk practices, such as vaginal and anal intercourse without using condoms, unprotected sexual relations with sex workers, and drug injecting.
- Being part of a group with known high HIV prevalence or with known high-risk lifestyles, e.g., injecting drug users, male and female sex workers and their clients, prisoners and MSM.
- History of blood transfusion, organ transplant, or administration of blood or body products.
- Exposure to possibly non-sterile invasive procedures, such as tattooing and scarification.
- Explore the who, what, where, when, how of the most recent exposure.
- Assess communication about HIV/STI with partners.
- Identify circumstances that contribute to risk behavior.
- Identify vulnerabilities and triggers to the risk behavior/pattern.
- Assess client's patterns of risk behavior (e.g., happening regularly or occasionally, due to an unusual incident.

Step 3: ***To identify patient's constructive risk reduction attempts, explore barriers toward behavior change, and provide understanding and support regarding these issues.***

The counselor should explore any changes initiated by the patient to reduce his/her HIV risk(s). This provides the counselor with an essential opportunity to **support** and **reinforce** the patient. The counselor should elicit obstacles encountered by the patient in considering or attempting behavior change. The counselor should gently and sensitively discuss the challenges the patient has encountered or perceived. It is important to acknowledge that behavior change is a complex, difficult, and challenging process. The counselor should get an idea of the patient's strengths and difficulties in initiating and sustaining behavior change.

Step 4: ***To summarize and characterize the patient's risk behavior by identifying his/her pattern of risk behavior and noting specific vulnerabilities and triggers to risk behavior.***

The purpose of this component of the session is to enable the patient to gain an understanding of the complexity of factors that influence his/her risk behavior. This summary provides the patient with an organized overview of his/her story. This component of the session provides the foundation on which the risk reduction plans will be developed.

Assess risk by asking simple, open-ended questions such as:

- To enable you and me to understand your risk of HIV infection better, may I ask you some specific questions ?
- Has your partner, or anyone who has had sex or used drugs with your partner, been found to have HIV infection or AIDS?
- When was the last time you had sex with a woman? With a man?
- What kinds of sexual activities do you have?
- How and when do you use condoms?
- Do you have sex when you are using drugs or alcohol?
- Have any of your partners had problems with alcohol or drugs ?
- When was the last time you injected drugs?
- Have you ever-injected drugs when you were under the influence of drugs or alcohol ?
- Has someone ever injected them for you?
- When was the last time you shared needles, "cookers" (syringes) or other drug-injecting equipment ?
- Have you ever had a sexually transmitted infections (STI)? Hepatitis?
- Have you ever had surgery or a blood transfusion?

Step 5: ***To explore the person's ability to cope with a diagnosis and the changes that may need to be made in response to it.***

2. Assessment of psychosocial factors and knowledge:

- Basic HIV prevention
- Client's intentions after learning test results
- Client's readiness to learn his/her sero-status
- Exploration of what the client mi ght do if the test is positive, and the possible ways of coping with a positive HIV result
- The client's reproductive intentions, and the role of family planning
- Exploration of potential emotional and social support from family and friends
- Condom use, including condom demonstration
- Any special needs discussed by the client

This initial assessment should make it possible to discuss and assess the client's understanding of: (a) the meaning and potential consequences of a positive or negative result; and (b) how change in behavior can reduce the risk of infection or transmission to others.

3. Assess the person's risk of HIV infection

When should a person who tests negative for HIV antibodies have a subsequent test ?

The diagnosis of HIV infection is usually made on the basis of the detection of antibodies to HIV.

The interval following infection and before the appearance of HIV antibodies is known as the serologic "window period." After being infected with HIV, most adults and youth will produce HIV antibodies within 3 months of infection. This should be communicated to a person during pre-test counseling to assist in test decision-making. This message should be repeated during post test counseling for clients who test negative. People may prefer to be tested at 3 months, or later, or both, after the most recent risk event.

To determine the window period, help identify the most recent risk event (i.e., potential exposure to HIV) and plan the appropriate time of testing. If a patient is believed to be in the window period, discuss risk reduction to prevent exposure to HIV while he or she is waiting to be tested.

Clients with exposure to ongoing risk practice may also benefit from referral to other HIV prevention and support services because their current risk practices might be reinforced by repeated negative HIV tests or they might view HIV testing as “protective”.

Counselors should consider the following factors related to individual client needs when recommending the timing and frequency for follow up testing:

- Timing of the last potential exposure
- Probability of HIV infection given type of exposure
- Presence or likelihood of ongoing risk behavior
- Likelihood of returning for follow up VCT
- Client anxiety
- Provider and client relationship

4. Provide information

5. Discuss record-keeping

Inform the patient that test results and information will be added to his or her record and will be available to other health professionals on a need-to-know basis. If the patient objects, anonymous testing should be discussed. Refer to sample Client Intake Record in Appendix 11.

6. Discuss the implications of testing

- Take time to examine and discuss the issues raised by testing so that the client has the opportunity to weigh the advantages and disadvantages of being tested and prepare for the potential consequences of a positive or negative test result. Testing should be carried out only when the patient considers the advantages to be greater than the disadvantages.
- Discuss the confidentiality of test results in relation to office or clinic procedures, communication of results to other health care officials, partner notification and reporting requirements.
- Evaluate the patient’s capacity to cope with a positive test result.

7. Determine the timing of testing and the post-test visit

Arrange a post-test appointment (if same day results are not available, with the use of rapid tests).

8. Obtain and record informed consent

Encourage the person to ask any additional questions to clarify doubts or fears or to seek information. Informed consent may be verbal. An example of a written informed consent form is given in Appendix 12.

Once an informed consent is expressed, it should be recorded in the patient's chart.

9. Provide support and follow-up

Test results, whether positive or negative, must be given only in person, in a face-to-face interview. Informing patients of their test result by telephone is unacceptable, even when it is negative. It places the provider at risk of liability, should disclosure to someone other than the patient inadvertently occur. Communicating test results face-to-face permits better appreciation of the patient's reaction and enables robust counseling.

C. Post-test Counseling

When simple/rapid tests are used, HIV test results may be available shortly after the blood draw or later on the same day. At other laboratories, clients may often have to wait for up to two weeks for their test result.

Whatever the result, post-test counseling should always be given. Post-test counseling involves working with the patient to understand the test result, address psychological reactions to it, promote behavior changes and assess the need for follow-up and care.

Immediate plans, intentions and actions should be reviewed and follow-up plans discussed.

1. Communicate the test result

The patient should be informed of the test result in a direct manner at the beginning of the post-test session. It is likely that he or she has been anxious about the test result and is both eager to learn it and apprehensive.

2. Assess the person's understanding of the test result

HIV testing can have three possible outcomes:

(i) a negative result;

(ii) a positive result; and

(iii) an indeterminate result.

For interpretation of assay results, see section on HIV testing. (See page 41)

(1) Negative result

Goal: To provide clear and accurate HIV negative test results with an emphasis on the need for the patient to initiate risk reduction in order to remain negative.

HIV-negative patients may express relief, surprise or disbelief, or sometimes feel invincibility or guilt.

The patient may believe the test result is an indication that he/she has, thus far, made the "right choices." Counseling should be directed at helping the patient to change behavior to avoid or reduce future exposure to HIV.

It is often helpful for the counselor to underscore the fact that the negative test result does not indicate that the patient's sex/needle-sharing partner(s) are not infected.

There is a slight possibility that a recent risk behavior (especially in the last month) may have resulted in the patient becoming infected without the infection being indicated in this test result (window period). If there is not a significant risk in the previous 3 months, then no additional test is indicated unless the patient has a later exposure to HIV. If there is a very recent and significant risk exposure, there is a small chance that the patient could have been infected by that exposure.

The counselor should remember that the risk of infection from a single exposure, when the partner is known to be infected, is relatively small (<1 – 8%). The counselor should avoid technical discussions of this information and recommend, when necessary, a specific time for possible retest linked to a specific previous date of exposure.

- Negotiate a specific, concrete **risk reduction plan** (see next section).
- Condom education, demonstration and distribution.
- Negotiate for partner to go to VCT.

(2) Positive result

Goal: To provide the patient with positive test with an emphasis on the need to initiate a risk reduction plan in order to avoid transmission of HIV and the need for positive living and access to medical and social support.

Clients diagnosed as having HIV infection or disease should be told as soon as possible. The client should be given time to absorb the news. After a period of preliminary adjustment, the client should be given a clear, factual explanation of what this news means. The counselor should be clear with the patient that the information provided by the patient in the beginning of the session, particularly the risk assessment, may help influence the patient and counselor's understanding of the results.

This is not a time for speculation about prognosis or estimates of time left to live, but for acknowledging the shock of the diagnosis and for offering and providing support. It is also a time for encouraging hope - hope that achievable solutions can be found to the resulting personal and practical problems. The counselor should stress that HIV infection is not AIDS.

- Every infected person should be encouraged to live a normal social and economic life.
- All HIV $^{+}$ clients should be counseled about "living positively with HIV" which includes maintaining a positive attitude, avoiding additional exposure to the virus and other STIs, maintaining weight by eating a balanced diet, regular exercise, maintain good hygiene, avoiding diarrhea, seeking early medical assistance in case of symptoms of infectious diseases, joining PLWHA organizations and other social support groups.
- Where resources are available, it may also be justifiable to talk about possible treatments for some symptoms of HIV infection and about the efficacy of new antiviral drugs.
- Discussion of the personal, family and social implications including who, if anybody, to tell.
- Dealing with immediate emotional reactions.
- Checking about immediate support available and adequacy of the support mechanism
- Arrange follow-up care and support, which may include the possibility of ongoing counseling, counseling of other family members and partners, social support and legal advice.
- Emphasize the importance of medical follow-up, referral when appropriate, and health promotion and stress-reduction in general (screening for STI, preventive therapy for TB).
- Family planning counseling and education: Information on family planning, its role for both HIV+ and HIV- clients, and how to access services should be included in VCT counseling sessions. The risks of pregnancy should be clearly explained, and the client made aware of risks to herself and to the unborn child if a pregnancy is carried to term.

- Develop a personalized **risk reduction plan**, including prevention of HIV transmission to partners, who may be uninfected or untested, and use of safer sex and/or injecting practices.
- Refer also to Appendix 4: Guidelines on prevention of further sexual transmission of HIV and Appendix 5: Guidelines for sexual partners of known HIV infected persons.
- Identify options and resources.
- Important: practical information for people with HIV infection must be provided.

  Refer to Appendix 6: Practical information for people with HIV infection.

3 Indeterminate result

Goal: To provide the patient with an indeterminate test results in a manner that incorporates the patient's risk into the understanding of the result and reinforces the need for the patient to return for result of additional conclusive testing.

Where the result is indeterminate and either the results of further testing are being awaited or further testing is not possible, it is not possible to say with any degree of assurance that the person is HIV infected.

The counselor should then advise the person to present again after one month (for repeat testing)

Prevention and support while waiting for an indeterminate result. The period of uncertainty following an indeterminate test results may be three months or longer after the last instance of potentially high-risk exposure or the previous test for HIV infection. It is, therefore, important for counselors to emphasize essential prevention messages regarding sexual and drug use activity, body fluid and tissue donation, and breast-feeding. The person will need to undertake the precautions recommended for HIV positive persons until further tests give a definite answer.

Just as importantly, however, the uncertainties associated with this period may lead to acute and severe psychosocial difficulties and the counselor must be prepared to assess and manage such issues.

While serologic status is being confirmed, providers should be available for support and they should identify HIV/AIDS service organizations and resources in their region.

D. Discuss Risk-reduction Strategies

The risk reduction plan is a fundamental component of counseling. The counselor should assist the patient in identifying a behavior that corresponds to his/her risk and that he/she wants to change. It is essential that the plan match the patient's skills and abilities with his/her motivation to change a specific behavior. The counselor should challenge the patient to go beyond what he/she has previously attempted in terms of risk reduction. The plan must be **specific** in that it describes the who, what, where, when and how of the risk reduction process. It must be **concrete** in that it details the successive actions required of the patient to implement and complete the risk reduction plan. Finally, it must be phased in a stepwise fashion so that it is directed at a single aspect of the risk behavior or one particular factor/issue that contributes to that risk behavior, at a time.

There is only a low risk of HIV transmission associated with activities that deposit blood, semen or vaginal fluid on intact skin or in a condom.

Exposure to HIV can be avoided by abstinence, monogamy of uninfected sexual partners and refusing to share equipment for injecting drugs. If these options are not realistic, risk- and harm-reduction strategies should be explored periodically, as behavior of all clients may change over time.

The counselor should avoid supporting risk reduction plans that involve unreasonable or radical changes in the patient's life. Global risk reduction messages such as "always wear condoms," "remain monogamous," or "abstain from sex" do not meet the criteria for an appropriate risk reduction plan. The counselor should ensure that the patient agrees with the plan and is committed to its implementation.

Condom education, demonstration, and distribution should be part of every post-test counseling session, and all clients, both HIV+ and HIV-, should be given condoms during the post-test session. The dual protection against HIV and against unwanted pregnancies should be emphasized. However, clients who refuse condoms should not be coerced to receive them.

Condoms should be used consistently by monogamous partners until both have established that they are not infected with HIV or have other STIs.

Repeated unprotected exposure to HIV should be avoided. If both partners are HIV-positive, the couple may reduce the risk of transmission of different types of HIV and other infections between them by practising safe sex. If one partner is HIV-positive, the couple should minimize unprotected sexual activity.

Counsel patients to make choices that will reduce their risk of acquiring HIV and other blood-borne infections; for example, adopting safer injecting practices or switching to safer modes of drug use such as smoking or methadone therapy.

Strategies for Risk Reduction Planning During Post Test Counseling

Global Risk Reduction steps which are unlikely to be effective in changing behavior	Specific risk-reduction steps which are likely to be more effective in changing behaviur
Always use condoms	• Buy a condom tomorrow and try it on. • Carry a condom next time you go out. • Starting today, put condoms beside the bed. • Starting tonight, request your partner/s to use a condom or tell them you will not have (vaginal/anal) sex.
Have fewer or less risky partners	• Stop having sex with specific partners who are having unproctected sex with other people. • Break up with specific partners before getting together with someone new.
Have safer sex	• Talk honestly about your HIV status with specific partners and ask about his/her HIV status. • Next time you are out with friends and may have sex, avoid getting “high” on drugs or alcohol. • Only kiss, pet, practice foreplay or manual stimulation of other forms of non penetrative sex etc., with specific partners. • Tomorrow, ask specific partners if he/she has had a recent HIV test and has been tested for other sexually transmitted diseases.
Stop injecting drugs	• Contact a drug treatment center and make an appointment. • Obtain clean equipment tomorrow so you can use it next time. • Make sure each time you “use” it is with clean equipment, and do not share your equipment (needles/syringes/water cotton, spoons etc).

1. Reducing other risk

Contaminated instruments and trauma to skin: Any skin-piercing instrument that is contaminated with someone else's blood can transmit HIV. Activities such as tattooing, ear and body piercing, acupuncture and scarification are considered to be risk producing when equipment is not sterilized.

Occupational exposure: Transmission of HIV through occupational exposure (particularly in health care settings) is rare in Nepal The greatest and most common risk has been associated with injuries from needles; the risk of infection as a result of injury from a needle used on an HIV-positive person does not exceed 0.3%. Needles should never be recapped and should be disposed of promptly in rigid prescribed containers. Universal precautions should be observed.

2. Partner notification and beneficial disclosure

People living with HIV/AIDS should be assisted by counselors to disclose their HIV sero-status to their families, husbands/wives and/or the public at large. This can bring about both positive and negative effects.

The advantages, disadvantages and degree of disclosure desired should be explored in depth and the counselor should address the HIV-positive client's feelings of guilt or anxiety about exposing and possibly infecting others.

The client should determine who will inform the client's partners (the client alone or the client with the assistance of the provider) and what information should be given to them.

If the provider notifies the partner, the client's identity should not be disclosed.

UNAIDS and WHO encourage **"beneficial disclosure".**

Beneficial disclosure:

- is voluntary.
- respects the autonomy and dignity of the affected individual(s).
- maintains confidentiality as appropriate.
- leads to beneficial results for that individual and for his/her partner/s and family.
- leads to greater openness in the community about HIV/AIDS.
- meets the ethical imperatives of situations where there is need to prevent onward transmission of HIV.

Strategies for encouraging “beneficial disclosure” by the client:

- Promote counseling and testing of partners together so that both are informed at the same time of their HIV status.
- Encourage couples to share information about their HIV status with each other.
- Encourage people with HIV infection to inform their partners of their HIV status and to use barrier methods to protect each other from infection and re-infection.
- Promote education, information and communication to change people’s attitudes in respect of disclosures of their HIV status to those who have critical reasons to know.
- Encourage openness about HIV/AIDS in order to reduce stigma and discrimination.

Active referral

Clients, both HIV+ and HIV-, should be referred for medical, social, legal, spiritual and psychological support if the counselor determines that these services would be helpful.

(See section on referral)

E. VCT Services for Particular Needs

1. Couple counseling and VCT

Couple counseling should be encouraged, not only for those planning to get married, but also for those already in a relationship who wish to make informed decisions about having children, selection of family planning methods and generally for those who want to work on their relationships and plan their future. Couples should not be forced into being counseled together but should be given opportunity to make informed decisions about it. Confidentiality is very important and couples should be informed about what it involves as well as its limits.

The counselor should attentively listen to the couple as they relate the reason why they have come for the test. The couple should be given equal opportunities to talk and ask questions, counselor should be non-judgmental, and respectful in the way they respond to the couple. Couples should be given the relevant and accurate facts about HIV/AIDS to help them make informed decisions.

They should be helped to explore the implications of their test results on their relationship, marriage, childbearing, family planning and sex life. Couples should be given an opportunity for individual sessions (i.e., pretest counseling with risk assessment) as some may find it threatening to explore

their current or past sexually risky behavior in the presence of their partner. Couples should also explore together the practicability of any changes in their sexual practice like abstinence, condom use or non-penetrative sex.

Sharing results

Couples who come together for VCT should be given their results together, unless they express a preference to receive the results separately. A client's status should not be disclosed to his/her partner without his/her consent. Counselors should ensure that both members of the couple have come voluntarily. If the counselor is concerned that one member of the couple has been coerced, the counselor should encourage the couple to return when they are both ready for VCT. Couples should be encouraged and supported to take the responsibility of discussing the implications of the results on their relationship.

Referral

Couples, both HIV+ and HIV-, should be referred for medical, social, legal, spiritual and psychological support if the counselor determines that these services would be helpful. Information about PMTCT programs should be provided when appropriate.

Discordant couples

Counseling procedures: The counselor should not take sides and should be respectful and understanding if conflicts or arguments arise between the couple during the session. There is need to discuss window period and need for re-testing especially of the HIV negative partner. Several supportive counseling sessions may be needed.

Disclosure

There is a need to be patient and understanding to the partner who is HIV positive and is reluctant to disclose to the partner at first. Most people, if supported and helped to explore the costs and benefits of disclosure to their partner, usually disclose in the end.

Prevention of further transmission

The counseling session should include discussion of the role of consistent condom use in preventing HIV transmission to the uninfected member of the couple.

2. Testing during pregnancy and for the prevention of mother to child transmission of HIV

To be able to make informed decisions about safe infant feeding and access to antiretroviral (ARV) therapy, a pregnant women needs to know and understand her HIV status. Infants who acquire HIV infection from their mothers do so during pregnancy, during labor and delivery and after birth through breastfeeding. The risk of infection is now thought to be 5–10 percent during pregnancy, 10–20 percent during labor and delivery and 10–20 percent during breast feeding.

It is, therefore, important that even in settings where ARV interventions are not available for pregnant women, but where women have access to VCT, that women are counseled about locally appropriate replacement feeding options.

Although pregnant women will require the same information as other people in pre- and post-test counseling sessions, the following subjects must be discussed:

Disclosure

Sharing results with the baby's father/her partner and close family members requires sensitive counseling as interventions to reduce mother to child transmission may involve decisions to change infant feeding methods and taking ARVs, which will make it difficult to conceal a seropositive status. **Sharing results during pregnancy should be encouraged only if the woman has adequate emotional support and is not at risk of harm or social ostracism/exclusion through disclosure**.

Reinforcing safer sex messages to all women and their partners

It is important to use this opportunity to reinforce safe sex messages. A woman who becomes infected with HIV during pregnancy or during breastfeeding is at increased risk of transmitting HIV to her baby due to the high viral load associated with acute infection

Promotion of couple counseling and testing

If women are tested alone, or their partners refuse to be involved in the VCT process, or if they feel unable to disclose their status to their sexual partner, it is difficult for women to take full advantage of the benefits of VCT. They will have difficulties in making decisions about using safer sex practices, planning for their and their families' future, accessing care and support, and making infant feeding choices. Testing a woman individually should be the exception (at the woman's request) and not the rule.

3. Vulnerable groups

Although vulnerable groups in Nepal will require the same information as other people, there are special considerations and challenges for VCT services. Some of these are outlined below.

Group	Special considerations	Challenges for VCT service
Youth	• Experimenting and sexually active • High risk behaviors often associated with drugs and alcohol • Peer pressure • Vulnerable period (dependent on others) • Unemployment • Broken families • Homeless street children	• Disclosure (to parent, guardian, family, partners). Although there are benefits of disclosure youth may be reluctant to disclose to parents and may be unsupported • Consent (legal and ethical considerations). When is it legal/ acceptable to be tested without parents consent? • Adequate support for vulnerable youth (orphans, street kids, children-headed households). Many children may not have adequate social and emotional support from families/communities • Lack of support groups/services available for youth • Need to make VCT available outside formal health settings • Collaboration with Peer Educators. Young women, in particular, are vulnerable and may face difficulties when they insist on condom use or make changes in sexual behavior following VCT. VCT is often of no benefit in such cases. Sex and gender awareness in schools and in association with VCT needs to be considered

Group	Special considerations	Challenges for VCT service
Female Sex workers	• Pressure to have unprotected sex • No access to female condoms • Discrimination i.e., when carrying condoms • Difficult to reach preventive services • Low awareness of safe sex • Often have undiagnosed STIs • Regarded as socially unacceptable, immoral • FSWs often subject to police harassment (although prostitution is not illegal)	• Target clients of FSW (including uniformed services) • Important to avoid blame and stigma • Need to offer comprehensive STI, condoms and family planning services • Access to services - inconvenient locations and opening hours. • Ongoing support for HIV positive FSW should be ensured • Different strategies are needed to address different needs of FSWs (students, housewives, bar girls) • FSWs may have multiple risk factors (drug and alcohol use, mental health, coercive unprotected sex)

Group	Special considerations	Challenges for VCT service
IDUs	• Very high risk • Needle sharing behaviours • Stigma • Often sex workers • High risk of hepatitis B and C • Illegality of possession of drugs (drug use not illegal) • Punitive rather than prevention approach to IDU • Mandatory testing before medical and psychosocial treatment or entry into prison.	• Counseling on clean sterilized needles • On decreased sharing of needles • Oral substitution • Safe sex • Support groups • Peer counselors • Hepatitis B and C counseling • Rehabilitation/treatment counseling • Partner counseling • Limited availability of care and support services for IDUs with HIV

Group	Special considerations	Challenges for VCT service
MSM	• Anal sex is particularly risky • Many bisexual • Often stigmatized	• Counseling on high risk behaviour • Safe sex practices for MSM • Support groups • Group counseling • Peer support

Group	Special considerations	Challenges for VCT service
Migrants (Internal and external)	• Poor social support • Difficult to provide continuity of care • Low awareness of HIV/AIDS • Higher risk due to contact with casual partners and spouse and exposure	• Increase awareness of risk • Consider pre-departure, destination, border counseling • Promote support groups • Family counseling, prior to or when returning from place of employment • Emphasis on STI counseling

Other vulnerable groups in Nepal

STI clients, trekking porters, transport workers, prisoners, trekkers.

4. Counseling without testing

According to the national policy, HIV testing for diagnostic purposes should only be carried out where confirmation of the patient's HIV status **would clearly benefit the patient in terms of determining the best course of treatment and with informed consent**. Routine testing of a person for HIV infection for the perceived purpose of protecting a health care worker from infection is impermissible regardless of consent. (Ref. universal precautions, occupational exposure prophylaxis).

A definitive clinical diagnosis of HIV/AIDS (without testing) can be done based on standardized criteria (AIDS case definition, World Health Organization, Center for Disease Control). The Ministry of Health has developed a definition adapted to Nepal, and this should be utilized more by medical professionals.

In areas where testing is unavailable or where clinical diagnosis is preferred, counseling services should be developed for people with symptomatic HIV and their families, and those seeking HIV prevention counseling (such as counseling about safe sex in family planning clinics).

The counselor (health provider) should:

- Review knowledge of HIV, including transmission and prevention.
- Conduct a personal risk assessment with the client.
- Discuss the possibility of an HIV-related diagnosis combining risk profile, symptoms and clinical state.
- Review the client's understanding of HIV/AIDS.
- Discuss personal risk reduction.
- Discuss personal and family implications if infected.
- Discuss strategies/options for referral and testing and/or further care and support.
- Discuss condom use and other risk reducing strategies and demonstrate condoms and other risk reducing measures (proper handling of syringes and needle exchange).

F. Qualifications of counselors for VCT

Counselors for VCT will be selected and recruited amongst health graduates including those in the fields of social work, psychology, nursing/paramedical, and amongst laboratory technicians (for sites where the technician will undertake a dual role).

Counselors may be recruited from the public, private or non-government sectors. Selection criteria should also include personal attributes conducive to HIV counseling including: capacity to be non judgmental; understanding; patient; comfortable speaking explicitly about "taboo topics" including explicit sexual practices, drug use, and sex work; comfortable demonstrating and discussing condom use; empathic; warm; and mature.

All recruited staff will be required to undergo a VCT counseling skills training program of no less than 12 days duration, as approved by the NCASC.

G. Quality assurance for counseling services

All VCT sites and counseling services must ensure that the counseling provided to clients is of high quality. The following strategies should be applied at all VCT sites to maintain quality assurance:

- Foundation training, refresher training and training updates for counseling staff.
- Regular formalized supervision and support for counseling staff (by a psychologist or social worker). Supervision may include case presentations, observation of counseling sessions (with client consent), taped counseling sessions (with client consent) and application of quality assurance tools (checklists and reflection forms).
- Peer support between counselors as required.

  Feedback from clients on their levels of satisfaction (for example, by using client exit interviews).

  Note: NCASC is in the process of developing specific tools and methods to assess the quality of VCT counseling services, such as client exit interviews to assess client satisfaction, counselor self-assessment tools, outline of supervisory sessions. These tools, when available generally, should be used on a regular basis to assess and monitor the quality of counseling provided to VCT clients. (See also section on Record Keeping and Monitoring and Evaluation).

  The VCT center coordinator shall be responsible for quality assurance of VCT services.

8. Guidelines for HIV Testing

A. HIV test assays

The diagnosis of HIV has traditionally been made by detecting antibodies against HIV. A wide range of different HIV antibody tests are available including ELISA tests based on different principles and many newer simple and rapid HIV tests.

In most industrialized countries, current diagnostic testing procedures use an enzyme linked immunosorbent assays (ELISA) to screen a specimen, and if it is reactive, the result is confirmed by testing the specimen with a Western Blot.

However, studies have shown that the latest generation of ELISAs and rapid tests are as reliable for confirmation as Western Blots. In addition, compared with Western Blots, ELISAs and rapid tests are less expensive, do not require as high a level of technical expertise to perform and interpret, and produce fewer indeterminate results.

Therefore, UNAIDS and WHO recommend alternative testing strategies using combinations of ELISAs or rapid tests to confirm initial positive tests (UNAIDS 1997).

• ELISA testing

ELISAs are best performed at a regional or national laboratory since they require well-trained and skilled laboratory technicians, technologically advanced equipment (incubators, washers, and spectrophotometers) that requires maintenance, and a constant source of electricity. ELISAs are most efficient for laboratories that process a large number of specimens (100 or more) daily. Because of test design, they are not suitable or cost-effective to run on a small number of specimens. Because laboratories often batch specimens and run them at one time, the time before results are available may be from days to 2 or 3 weeks after collection.

ELISAs may have limited application in rural settings where the laboratory infrastructure and equipment may be insufficient.

• Simple/rapid tests

Interest in the development of HIV antibody tests that provide same-day results and do not require reagents or equipment not contained in the kit led to the currently available HIV rapid tests.

Rapid tests are useful for VCT sites and small laboratories that routinely perform fewer than 100 HIV tests per day, for VCT sites and laboratories without electricity or equipment, and for geographic areas with limited laboratory infrastructure.

- They allow single tests to be performed at a time.
- They give quick results (< 20 m.).
- As they are easy to use they can be carried out by staff with no formal laboratory training (health staff).
- They may be stored at room temperature.
- Their diagnostic performance is comparable with traditional ELISAs currently in widespread use.

A rapid test is particularly appropriate also for confidential testing among hard-to-reach populations (e.g., IDUs, FSWs) or geographically remote populations.

In these populations, opportunities for provision of results may be limited after the initial encounter (most often the case). Therefore, testing (screening and confirmatory) must be performed on site on the same day as specimen collection.

If HIV test results are to be returned to the person tested, a confirmatory test is required (using a rapid test).

Rapid tests generally cost between US Dollars 1-3, a slightly higher cost per test than an ELISA.

However, rapid tests may be more cost-effective than ELISAs if the additional costs of conducting an ELISA are considered (e.g., equipment, laboratory infrastructure, technician training).

As the simple/rapid tests are easy to perform and interpret, there is less chance of error when compared with the technically more difficult ELISA tests giving overall more accurate results. In addition, most rapid tests include an internal quality control.

Rapid tests are useful in settings where ELISAs are not feasible or practical and in geographic areas with limited laboratory infrastructure. Rapid tests may be appropriate for hard-to-reach populations (e.g., IDUs, FSWs) or geographically remote populations (migrants), for whom HIV test results may need to be provided on site on the same day as specimen collection.

B. Which test should be used ?

The Ministry of Health regularly update a list of HIV test selected, tested and approved for use in VCT in Nepal. All VCT sites must use tests kits endorsed by the Ministry of Health or tested by WHO.

WHO comparative evaluation of HIV test kits can be found at the following web sites:
http://www.who.int/pht/blood_safety/hivtable1.html and
http://www.who.int/phy/blood_saftey/hivtable2.html and
http://www.who.int/pht/blood_safety/hivkits.html.

C. Specimens used in HIV testing

Recommended HIV test for diagnosis and for VCT: Use whole blood, plasma or serum. Tests based on urine and oral fluids are not allowed for VCT.

Some companies may market rapid HIV tests as 'home test kits' or 'self testing kits' to the public through pharmacies and other consumer outlets. **The use and availability of home test kits is not allowed for** several reasons:

Current regulations require that pre and post test counseling must accompany all HIV testing and this cannot be done at home. High illiteracy levels in many communities may lead to incorrect test administration and results. Some individuals may not understand the test and may misinterpret the results.

Until these and other issues are resolved, it is recommended **that rapid test kits are not made available to the public.**

Tests kits recommended by the Public Health Laboratory, MoH

Rapid Tests:

Capillus/Trinity Biotech	Ireland
Determine/Abbott	USA
Tridot	India
Serodia	Japan
Unigold/Trinity Biotech	Ireland

ELISA:

Generic Biologic Corporation	Korea
Human	Germany
Bio Tech	Italy
Dade Behring	Germany

Western Blot
Genelab

D. Collecting, processing, and storing blood specimens

Whole Blood, Serum, and Plasma

Blood needed for an HIV test can be collected either by venipuncture (whole blood, serum, plasma) or by finger stick (whole blood).

a) Processing Blood Collected by Venipuncture

To collect blood by venipuncture, follow local clinical or laboratory procedures.

b) Collecting Blood by Finger Stick

Blood collected by finger stick or ear-lobe stick can be used to perform a rapid test. The specimen is placed directly on the rapid test apparatus.

Blood collected by finger stick or ear-lobe stick can also be used to make a dried blood spot on filter paper. Dried blood spots allow for:

i. Storage at high temperatures for up to 2 years.
ii. Easy transport, for example by mail to a central laboratory.
iii. The central laboratory can perform a confirmatory tests (ELISA or Western Blot) based on the dried blood.
iv. The central laboratory can perform quality assurance of the local laboratory based on the dried blood. For procedures for finger prick and filter paper (see Appendix 9).

E. HIV test algorithms for Nepal

After assessing the current situation in the country regarding the technical and logistic problems of ELISA machines and kits, **the use of two or more rapid tests based on different test principles (antigen) is recommended as the minimum standard HIV test algorithm to be followed at all levels of health care delivery system (hospitals, health centers, clinics, etc.) in government, private and NGO settings.**

Rapid tests to detect antibodies to HIV can enable providers to supply definitive negative and positive results to patients at the time of testing. Rapid testing can increase the number of people undergoing HIV testing to know their results. Most people receiving rapid HIV test results can receive counseling and learn their HIV status in a single visit. Rapid testing may also assist in facilitating the diagnosis of HIV infection, improving HIV testing capabilities in facilities without access to laboratories, and facilitating post exposure prophylaxis in health workers following occupational exposure to blood and body fluids.

Rapid tests have important implications for HIV counseling procedures and will allow the involvement of health providers in HIV testing after adequate training.

F. National standard HIV testing strategy

All HIV testing should consist of an initial screening test and then retest with another test, when the first test result is positive in order to confirm the result. Those testing negative by the second test (but positive by the first test) shall be subjected to a third test (a tie breaker. A third different rapid test (or an ELISA) can be utilized).

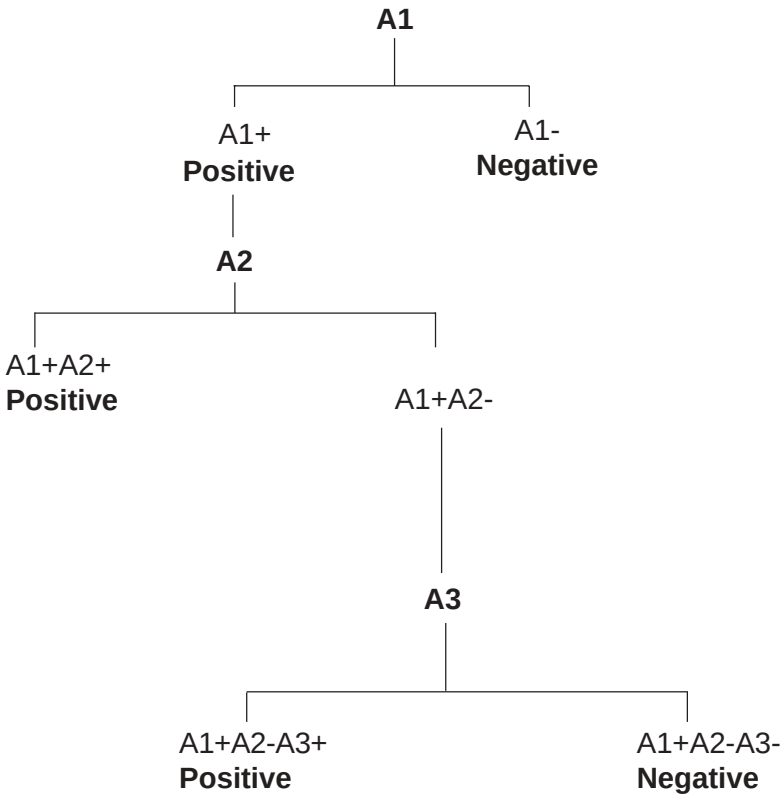
The first test (screening test) should be highly sensitive to provide reliable detection of antibodies in a specimen. The second test (confirmatory test) should be highly specific to confirm that the specimen truly contains antibodies specific to HIV. (Refer to Appendix 10 for information on sensitivity and specificity of rapid test.

Minimum standard:

The use of two or three rapid tests based on different test principles (antigen) is the minimum standard HIV test algorithm to be followed at all levels of health care, delivery system (hospitals, health centers, clinics etc.) in government, private, and NGO settings.

1. Strategy 1

Interpretation of HIV test results (Test Algorithm) A refers to **Assay (HIV test)**. Negative/Positive indicate whether report should be negative or positive. See explanation on next page.



Strategy 1 (Venous blood sample)

For testing facilities, where tie-breaker tests are not available, it is recommended that a new specimen of blood is collected on filter paper. The dried blood spot is then mailed to a regional or central laboratory, where a tiebreaker test is performed (ELISA).

1. All serum/plasma is first tested with one rapid assay, which is **highly sensitive (A1).**
2. Serum that is non-reactive on the first test is considered HIV antibody **negative (A1-).**
3. Any serum found reactive on the first assay is retested with a second **highly specific** rapid assay based on a different antigen and/or different test principle.
4. Serum that is reactive on both tests is considered HIV antibody **positive (A1+ A2+)**.
5. Any serum that is reactive on the first test but non-reactive on the second test should be retested with a third different rapid test/ tiebreaker test **or** ELISA at a central laboratory.

If the result is reactive then it should be considered HIV antibody **positive (A1+.A2-A3+).** The reactive result at the first test was probably a laboratory error.

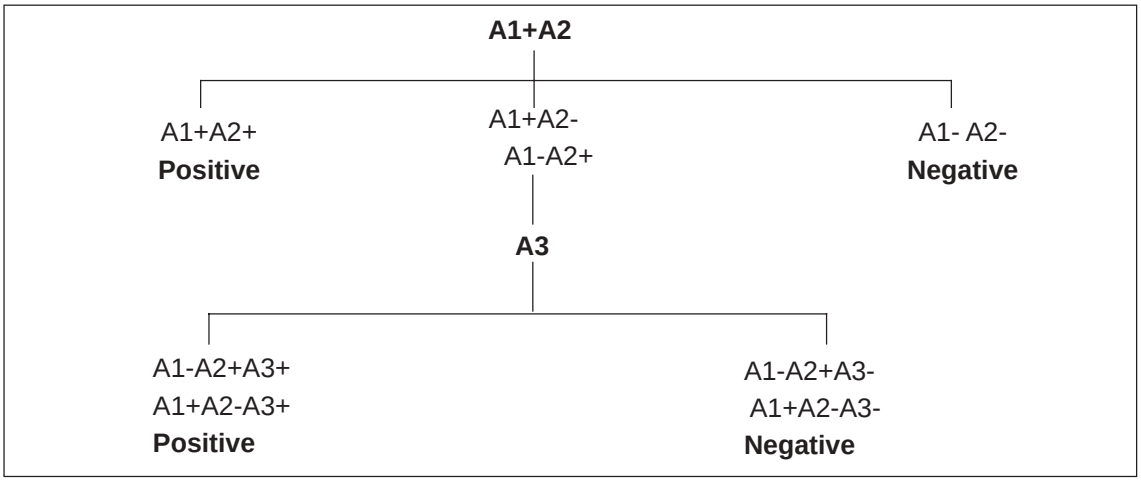
Any serum that is non reactive on the third test must be reported as **negative (A1+ A2-A3-)**.

The tiebreaker test kits will be needed in a limited number of cases (1 %).

Therefore, for economic reasons, some testing facilities will not have a tiebreaker test available.

2. Strategy 2

Rapid testing on whole blood directly from the subject. (Finger prick, earlobe prick) **A** refers to Assay (HIV test). (A1, A2, A3)



Evidence and experience indicate that clients and counselors have high levels of satisfaction with a VCT service that provide on site same hour/day results. For difficult to reach populations such as sex workers, their clients, drug users and migrants, this service is also important.

Strategy 2 offers same hour test results without the need for the client to return. (And a high drop out rate).

1. All blood collected by finger prick or ear lobe prick is directly applied to the 2 different tests at the same time.
2. Blood is also applied to filter paper for a) quality control at a regional or central laboratory and b) a third tiebreaker test (ELISA).
3. Blood that is reactive on both tests are considered **positive (A1+A2+)**. Blood that is non reactive on both tests are reported as **negative (A1- A2-)**.
4. Blood that is reactive on one test but non-reactive on the other test **(A1+ A2-)** or **(A1- A2+)** should be retested with a third different rapid test (or ELISA). If the result is reactive then it should be considered HIV antibody **positive (A1+A2-A3+) (A1- A2+ A3+).**
5. Any serum that is non-reactive on the third test must be reported as **negative (A1+ A2-A3-) (A1- A2+ A3-).**

The advantage of this procedure compared to strategy 1 is an easy client flow through the VCT center avoiding the need to obtain another sample if found positive in initial test in strategy 1. Drawing another sample could also lead others at the testing site to suspect that the individual is HIV+ potentially leading to stigma and jeopardizing the clients confidentiality and, thereby, the trust in the service.

Positive test result

An HIV test should be considered positive only after screening and confirmatory tests are reactive. A confirmed positive test result indicates that a person has been infected with HIV. False-positive results when both screening and confirmatory tests are reactive are rare. However, the possibility of a mislabeled sample or laboratory error must be considered, especially for a client with no identifiable risk for HIV infection.

Negative test result

Because a negative test result likely indicates absence of HIV infection (i.e., high negative predictive value), a negative test need not be repeated in clients with no new exposure in settings with low HIV prevalence.

For clients with a recent history of known or possible exposure to HIV who are tested before they could develop detectable antibodies, the possibility of HIV infection cannot be excluded without follow-up testing. It usually takes at least 3 months, for antibodies to develop, so the client should be advised to return for testing after this period (window period).

A false negative result also should be considered in persons with a negative HIV-1 test that have clinical symptoms suggesting HIV-1 infection or AIDS.

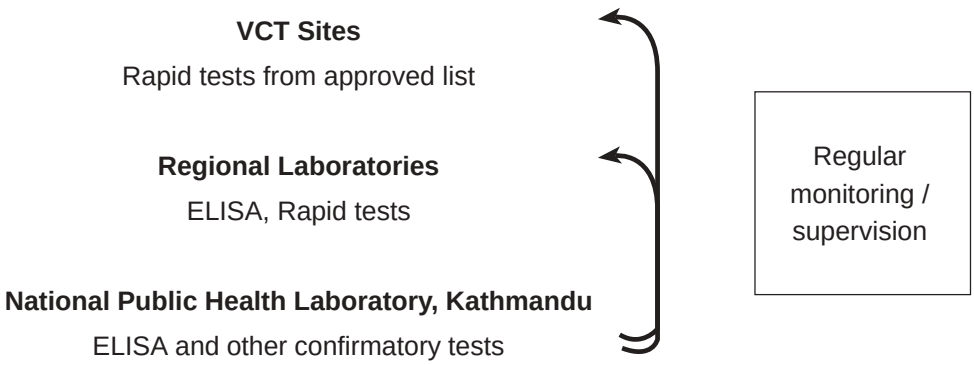
In rare instances additional testing for HIV-2 and HIV-1 group O infection might be appropriate for these persons.

G. Informing clients of test results

Because low rates of return for test results occur in many settings offering HIV VCT, where a third tiebreaker test is not available, providers should work to ensure that clients tested for HIV infection receive their test results, particularly HIV-infected clients who might benefit from earlier entry into care and initiation of antiretroviral therapy.

Reducing barriers to testing can maximize the number and proportion of persons tested for HIV who receive their test results in a timely manner. Strict confidentiality of the receipt of the HIV test and the HIV test result must be maintained, regardless of the method used. Because knowledge of HIV status is a critical HIV prevention strategy and essential for entry into care, providers should stress to clients the importance of returning to receive their test results and establish a plan for doing so with the client. Reminder systems might be useful.

1. Where to test ?



The diagram shows the VCT sites as the first line testing and counseling site with rapid tests from the recommended list. Regional laboratories will be developed to undertake confirmation with ELISA or rapid tests. (Samples collcted on Filter paper)

The National HIV Reference Center, Kathmandu, is the third line testing center and responsible for quality assurance. (Samples collcted on Filter paper)

Adequate reporting mechanisms will be established by the Ministry of Health and national and regional laboratories will provide regular monitoring, supervision and evaluation according to set standards.

2. Who should be involved in HIV testing ?

Providing a rapid on the spot HIV test service depends on the test being carried out by staff based in the VCT site. It is not practical or efficient to have a laboratory technologist at each site.

In order to expand the availability and accessibility of VCT services, various health care staff (doctors, nurses, laboratory technicians and other qualified professional staff) could potentially become involved in HIV testing procedures using rapid assays. In order to qualify for testing personnel must undergo a standardized training course on the testing procedures approved by the Ministry of Health.

Currently, the minimal requirement for approval to perform HIV testing is basic training as a Laboratory Assistant/ Laboratory Technician.

The participation of other medical personnel and trained non-medical personnel in providing testing in VCT projects is currently being piloted and assessed by the Ministry of Health, The National Public Health Laboratory, Kathmandu, has developed a curriculum and training course for such staff.

H. Ensuring high quality testing

The Ministry of Health requires that laboratories at all levels (e.g., HIV laboratories in hospitals, blood transfusion services, and private HIV laboratories and VCT sites) participate in a national external quality assurance of their performance.

The Ministry of Health requires that laboratories at all levels (e.g., HIV laboratories in hospitals, blood transfusion services, and private HIV laboratories and VCT sites) participate in a national external quality assurance of their performance.

Having highly accurate HIV tests does not necessarily guarantee reliable laboratory results. Many processes take place from the time the specimen arrives in the laboratory until the results are recorded, during which time errors can occur. Therefore, the ongoing process of monitoring the laboratory system, both internally and externally, is essential.

Quality assurance is an ongoing process of monitoring a system for reliability and reproducibility of results. Monitoring includes corrective action when established criteria are not met.

The Ministry of Health has the responsibility to ensure quality for all HIV testing services in the public and private sector.

1. National Quality Assurance

The NCASC, MoH therefore requires that laboratories at all levels (e.g., HIV laboratories in hospitals, blood transfusion services, and private HIV laboratories and VCT sites) participate in a national external quality assurance of their performance. The National Public Health Laboratory, in collaboration with the national AIDS program, will monitor the effectiveness of the participating laboratories' quality assurance systems to identify any laboratory that might require further training or other required action.

The most common method for external quality assurance of a laboratory's performance is proficiency testing. The national HIV reference laboratory will send to all participating laboratories a proficiency panel of approximately six specimens to identify as HIV positive or HIV negative and report back on their local results.

The Ministry of Health will also require all private and public laboratories performing HIV test to participate in further quality control. Private and public laboratories will send 3 out of every 10 positive samples and one out of every 10 negative samples to a reference laboratory for quality assurance on quarterly basis. Either this will be a venous sample or a sample collected using a filter paper method.

Providers must assure the quality of testing by:

- Assessing the efficiency of the staff involved in terms of competence to do the testing as well as making the results ready on time.
- Maintaining the standards of universal precautions.
- Assessing record keeping procedures and procedures for maintaining confidentiality.
- Ensuring good networking with care and support organizations.

2. Laboratory Quality Assurance

Laboratories at all levels (national, regional, and local) that conduct HIV testing must have a functioning internal quality assurance program. Each laboratory conducting HIV testing should routinely monitor and assess the quality in the preanalytical, analytical, and postanalytical phases of the testing process.

Laboratory errors most often occur in the preanalytic (i.e., specimen collection, labeling, transporting, processing, and storing) and postanalytic steps of testing (i.e., results validation and reporting) rather than during the test itself.

9. Guidelines for Referral

Referral is a key component of comprehensive HIV prevention and care services because not all providers can address the variety of medical, prevention, and psychosocial and legal issues that influence a person's ability to initiate and sustain the long-term behavioral changes needed to reduce the risk of acquiring or transmitting HIV.

The goal of HIV referral is to ensure that HIV infected persons and *persons at increased risk for* have access to appropriate medical, prevention, psychosocial support services and faith-based services.

Referral is the process by which client needs are assessed and prioritized and clients are provided with assistance (e.g., appointments, transportation) in accessing services. Referral should also include follow-up efforts necessary to facilitate/ contact with care and support service providers.

Referral does not include ongoing long-term support or management of the referral or case management (for example a plan to address needs and obtain services).

Referral is a two way process.

For the client, voluntary HIV testing and counseling services are often the entry point to services. Knowledge of available support services is essential for successful referrals. It is, therefore, a key responsibility for the counselor at the VCT center to actively develop and maintain a network of referral services. When referral resources are not available locally providers should identify appropriate resources available in their communities and link clients with them.

Confidential referrals

Regardless of whether a code number or the actual name is given to the referral service, the same standards of confidentiality must be maintained. Clients should be given the opportunity to decline a referral if they do not wish their name and status to be disclosed.

A. Referral needs

Clients have various needs for referrals to other services. Typical needs are for treatment, prophylaxis of opportunistic infections, TB, STI and hepatitis, partner counseling, reproductive health services, mental health, social welfare and legal services.

Detection and treatment of other STIs: The VCT center should take an active role in the detection and treatment of other sexually transmitted infections and diseases. STI screening should be offered to all VCT clients.

Tuberculosis screening and referral: All HIV+ VCT clients should receive counseling and health education about the risks of TB. TB screening should be provided in the hospital outpatient department for HIV+ VCT clients who may have TB.

Family planning services: Basic family planning information should be incorporated into all VCT counseling sessions, both for HIV+ and HIV- clients. Especially for HIV+ women, the risks of mother-to-child transmission should be explained and the benefits of family planning also should be explained. VCT clients should be referred for family planning services at the health centers.

Treatment and preventive therapy for opportunistic infections: For example, cotrimozazole for lungs and stomach infection and the isoniazid for TB and ARV when available.

Networks of referral agencies and support services: The VCT center staff should actively work to develop a network of relevant services to ensure that VCT clients can receive on-going supportive services, e.g., the treatment of drug dependency, mental health services, religious institutions and legal assistance. Some VCT clients, especially those who are HIV+, may also benefit from on-going group or individual therapy, and other services, such as supportive counseling, nutritional education and food supplementation. A two way referral system with agencies providing these services should be encouraged between the VCT center and existing PLWA support groups in the VCT site catchment area.

B. Implementing and managing referral services

The following should be considered key elements in the development and delivery of referral services:

Assessing client referral needs

Planning the referral

Facilitating client access to referral services

Clients should be provided with information necessary to enable them to successfully access the referral service (e.g., contact name, eligibility requirements, location, hours of operation, telephone number).

Documenting referral and follow-up

Providers should assess and document whether the client received the recommended referral services.

C. Referral Resources

Providers of HIV prevention counseling and testing services should maintain accurate and current information regarding referral services.

A resource guide should be developed and maintained to assist staff in making appropriate referrals, for each service specifying, for example, opening hours, location, cost, range of services, etc.

D. Ensuring high-quality referral services

Providers of referral services should know and understand the service needs of their clients and be aware of available community resources.

Education and support of staff

Providers should ensure that staff receives adequate training and continuing education to develop and maintain knowledge, skills, abilities essential to implement and manage referrals.

Authority

Staff members providing referrals must have the authority necessary to accomplish a referral. Supervisors must ensure that staff members understand referral policy and protocol and have the necessary support to provide referrals. This requires the authority of one provider to refer to another (e.g., through memoranda of agreement) or to obtain client consent for release of medical or other personal information.

Provider coordination and collaboration

Providers should develop and maintain strong working relationships with other providers and agencies that may be able to provide needed services. Such coordination and collaboration promotes a shared understanding of the specific medical and psychosocial needs of target populations, current resources available to address these needs, and gaps in resources.

Memoranda of agreement are useful in outlining provider/agency relationships and delineating roles and responsibilities of collaborating providers in managing referrals.

10. Standards for Implementation of Services

Record Keeping

Record Keeping is an important part of VCT service delivery because:

- Records provide vital information in relation to service operation.
- Records are used to collate statistics, which help to determine if the service is meeting its clients needs and if the service is having an impact.
- Records assist in revealing gaps in service provision.
- Records can be revisited as required to strengthen service provision.
- Records may be required as legal documents.
- Records play a role in referral of clients.
- Records play an important role in quality assurance.

Supervisors and counselors should ensure availability of standard record keeping formats (refer to Annexes). Annexed forms can be adjusted for individual sites if additional information specific to a site is required. However, the standard information required should be retained. These records play a crucial role in assisting the Government in monitoring the nature of the HIV/AIDS epidemic in Nepal and tailoring programs to more adequately address emerging prevention and care priorities.

Client records must be confidential and stored in a secured area (e.g. locked drawers/ cabinets). At a minimum, recorded information should include:

- Client code
- Client demographics
- Reasons for seeking VCT
- Client risk behaviour or exposure
- Date of pre test counseling
- Laboratory result

- Date of Post Test Counseling and result notification
- Any referral and follow up provided

NCASC/MoH requires each site to keep ordered records of each client according to standards set by the Ministry. The MoH, NCASC will require all providers to report on a regular basis.

NCASC is in the process of developing the following specific procedures, instructions, tools and methods to assist VCT providers in implementation.

Record keeping formats for VCT include:

- Client Intake Form (an example is given in Appendix 11)
- Client Register Book
- Coding System**:** A standardized system of assigning codes to ensure clients confidentiality yet allowing for identification
- Reporting Form for NCASC and Regional Health Directorate (quarterly)
- Informed Consent Form
- HIV Test Request Form
- Referral Form (an example is given in Appendix 13)
- Quality Assurance Checklists (Counselors Self Evaluation Form, Site Checklist)
- Counselor QA Assessment forms, Forms for QA of Testing)

In addition, the following will soon be available:

- A national standard training curriculum, accompanying training manuals and training plans for counselors
- Counselors' checklists, counselors' pocket guide
- Curriculum and short course for health staff in HIV testing
- National standard operating procedures for counseling and testing for site level
- Confidentiality protocols
- Care and support referral protocols
- Monitoring and evaluation protocols

11. Notification of positive cases to the National Center for AIDS and STD Control Kathmandu and to the Director, Regional Health Services

HIV/AIDS is a notifiable infectious disease. All HIV testing sites are required to submit demographic data on all new HIV positive cases (that have not previously tested positive) to the NCASC, Kathmandu and to The Director, Regional Health Directorate. (See quarterly voluntary counseling and testing form and quartely report form of HIV positive antibody tests (Appendix 17-18).

The data to be collected should include (but is not limited to):

- Age
- Gender
- Marital Status
- Educational Level
- Province/Region
- Mode of HIV transmission, if known
- Reason for testing
- Symptomatic/asymptomatic
- ID code number
- Total number of tested individuals (+/-)

No identifying information will be required beyond case reporting of demographic information. The purpose of such case reporting is to monitor the trends of HIV infection and to assess the impact of prevention and control interventions over time in line with the mandate of the National HIV/AIDS Program.

12. Monitoring and Evaluation

Monitoring and evaluation are critical components for the successful implementation of VCT services. Well designed and conducted monitoring and evaluation of VCT will help to identify and correct potential problems on an ongoing basis and provide feedback in the process of planning, designing and implementing of programs.

Monitoring and evaluation activities should address:

- Service delivery - how well VCT is provided, for example, uptake and acceptability of VCT, quality and content of counseling, reliability of HIV testing strategy (including external quality control), uptake of interventions, stress and burnout among counselors/health care workers).
- Program effectiveness - the outcomes and long term impact that VCT may have on the populations receiving the service. For example, coping, safe sex practices, use of family planning methods/services, and morbidity and mortality.

Site supervisors or managers should accomplish the following:

- Ensure that VCT sites operate during hours suitable to their clientele and with minimal delay in providing services.
- Ensure adequate stocks of authorized materials and equipment are available on site (test kits, gloves, written materials, condoms etc.).
- Establish and monitor frequently systems to ensure that confidentiality is maintained for all VCT clients.
- Target VCT to persons who may engage in high risk behaviours.
- New counselors should be observed during counseling (with the client's consent) by a trained "clinical" supervisor, until proficiency is assured.
- Ensure that counseling is tailored to the individual or couple's needs, and involves clients in identifying their own risk behaviours.
- Ensure that there is regular quality control for counseling and testing.
- Ensure training and re-training of counselors and laboratory staff as required.
- Ensure appropriate written materials are available and distributed to clients.
- Ensure condoms are available and distributed as appropriate to clients.

Some Illustrative indicators:

Process indicators, service delivery/program output:

- Proportion of people in the community/vulnerable groups who know about the HIV VCT disaggregated by risk groups services.
- Number of people counseled and tested at the VCT site (per month).
- Proportion of people counseled and tested for who have returned to receive their test result.
- Proportion of people testing HIV positive who have been referred to appropriate care and support services.
- Proportion of people counseled and tested, who state that they intend to inform their partners.
- Proportion of people counseled and tested who have informed their partners (partner notification).

Effectiveness indicators:

- Changes in HIV/STI-related risk behaviors among HIV VCT clients and their partners.
- Changes in behavior among people stating that they know their sero status.
- Changes in STI trends in sub-populations reached by the program.
- Increased community support for people living with HIV/AIDS.

A series of tools has been developed by UNAIDS to monitor the quality and content of counseling services at the level of countries, VCT services, individual VCT sites, counselors and clients:

- Counselor's needs and satisfaction
- Tool for evaluation of counselor selection, training and support
- Tool for VCT site evaluation (logistic considerations and coverage)
- Counseling evaluation
- Tool for evaluation of counseling skills
- Tool for evaluation of counseling content. Pre-test, Post-test, counseling about HIV diagnosis
- Client satisfaction
- Tool for evaluation of client satisfaction
- Cost effectiveness
- Tool for estimating cost and evaluation of cost effectiveness of VCT

Appendices

Appendix 1

Disadvantages of mandatory HIV testing

- Mandatory testing without informed consent or counseling does not help people change their sexual behavior to reduce HIV transmission to others.
- Testing without counseling and follow up support can be devastating for those who test seropositive. It may lead to depression and irresponsible actions, including violence to self and others.
- Mandatory testing may lead to a false sense of security. For example, it is illogical to require mandatory testing of surgical patients to "protect" health care staff, as universal precautions should be applied to all patients. In addition, **patients who test seronegative may be in the window period**.
- Insisting on testing new employees or military recruits will not ensure that they are HIV free, as they may acquire HIV infection during their employment or military service. It would be better to use resources to offer care and support to those with HIV and provide comprehensive HIV prevention and education programs for employees.
- The need to provide evidence of a negative test result has led to anecdotal reports of health workers selling negative certificates to untested people.
- Mandatory testing in health care settings (such as antenatal clinics) may lead to mistrust by clients and discourage them from seeking health care.

Code of conduct

Purpose of code of conduct

1.To establish and maintain standards for counselors.

2.To inform and protect members of the public seeking and using VCT counseling services.

The Nature of Counseling

The overall aim is to provide an opportunity for the client/s to work towards living in a more satisfying and resourceful way.

The objectives of each counseling relationship depends on the client's needs. The client may be concerned with:

- developmental issues
- addressing and resolving specific problems
- making decisions
- coping with crises
- developing personal insight and knowledge
- working through feelings of conflict
- improving relationships with others

The counselor's role is to facilitate the client to work in ways which respect the client's values, personal resources and capacity for self-determination. In counseling, both the counselor and client explicitly agree to enter into a counseling relationship. What distinguishes counseling from the use of counseling skills is the users intentions. Counseling skills are used to enhance the performance of one's functional role, as line manager, nurse, tutor, social worker, personnel officer, voluntary worker, etc. The recipient will in turn perceive them in that role.

Code of ethics and practice

Counselors uphold the basic values of integrity, impartiality and respect and apply the principles of autonomy, beneficence, avoidance of harm, justice and fidelity to specific situations. They have a responsibility to the clients, to themselves, their colleagues, the profession, members of other caring professions, to the wider community and the law.

Ethical Guidelines for Counselors

1. Counselors need to be aware of what their needs are, what they are getting from their work, and how their needs and behaviors influence their clients. It is essential the counselor's own needs not be met at the client's expense.
2. Counselors should have the training and experience necessary for the assessments they make and the interventions they attempt.
3. Counselors need to become aware of the boundaries of their competence, and they seek qualified supervision or refer clients to other professionals when they recognize that they have reached their limit with a given client. They should make themselves familiar with the resources in the community so that they can make appropriate referrals.
4. Although practitioners know the ethical standards of their professional organizations, they are also aware that they must exercise their own judgments in applying these principles to particular cases. They realize that many problems have no clear-cut answers, and they accept the responsibility of searching for appropriate solutions.
5. It is important for counselors to have some theoretical framework of behavior change to guide them in their practice.
6. Counselors need to recognize the importance of finding ways to update their knowledge and skills through various forms of continuing education.
7. Counselors should avoid any relationships with clients that are clearly a threat to therapy.
8. It is imperative that counselors be aware of their own values and attitudes, recognize the role that their belief system plays in their relationships with their clients, and avoid imposing their beliefs, either subtly or directly.

Guidelines on prevention of further sexual transmission of HIV

The following general guidelines are aimed at individuals or groups directly affected by an HIV positive result. Counselors can share them with the clients and their partners or give them as a hand-out for them to read and keep.

Recommendations to HIV infected persons

- Inform former and current sexual partners and/or injecting partners, about your HIV status and recommend that they visit a VCT center or health care provider for counseling and testing. If you are unable or unwilling to notify former and current sexual partners personally, request health workers or public health agencies to notify or help with notifying such partners.
- Inform potential sexual partners about your HIV status and either decide to avoid sexual intercourse, rigorously restricting sexual contact to accepted activities (e.g., hugging, caressing) that do not involve sharing of semen, vaginal and cervical secretions, or blood. Also discuss the precautions that need to be taken to minimize the risk of HIV transmission from sexual activity i.e., **the use of condoms.**
- If you both decide to engage in penetrative sexual intercourse, learn how to use condoms correctly, as consistent correct use will reduce the risk of HIV transmission.
- Strictly avoid sexual intercourse when you or your sexual partner has an infection or lesion in the genital, anal, or oral area and during menstruation.
- Avoid pregnancy. HIV infected women who are pregnant should know about the great health risk to their unborn children and the potential health hazard to themselves, and be provided with counseling services. HIV infected men should discuss the hazard of pregnancy with their partners.
- Do not share syringes, needles or other skin piercing instruments.
- Do not donate blood, plasma, body organs, or other tissues.
- HIV positive mothers are advised to continue to breast-feed, if no alternative exists.

Guidelines to sexual partners of known HIV infected persons

- Contact a health-care provider for counseling and evaluation (including serological testing). If the HIV test is negative and you are clinically healthy, and if the last unprotected sexual or needle-sharing exposure to your infected partner was six or more months ago, it can generally be assumed that you have not acquired HIV infection from the sex contact. If your last exposure was less than six months ago, or if you continue to have sexual intercourse without condom with your infected partner, *repeat tests will be necessary to determine whether infection has occurred.* If you were negative on initial serological testing, see the recommendations below.
- Be aware that avoiding sexual intercourse with an HIV infected person or rigorously restricting sexual contact to activities that do not involve sharing of semen, vaginal and cervical secretions, or blood (e.g., hugging, caressing) is the only way of eliminating the risk of acquiring HIV infection from that person. If this is not acceptable, use of a condom is an alternative. Although the precise effectiveness of condoms in preventing HIV infection is unknown, their correct and consistent use will significantly reduce the risk of transmission.
- Avoid all sexual intercourse when either you or your sexual partner has an infection or lesion in the genital, anal, or oral area and during menstruation.
- If you are pregnant, find out and seek counseling about HIV antibody testing. If you are tested and found to be sero-positive, find out and seek counseling about the significant health risk to your unborn child and the potential risk to yourself.
- Do not donate blood, plasma, semen, breast milk, body organs, or other tissues.

Practical information for people with HIV infection

- HIV infection is *not* the same as AIDS. People with AIDS have HIV infection, but only a proportion of those with HIV have AIDS.
- Sexual intercourse, whether heterosexual or homosexual, is the major route of transmission of HIV. The virus can be transmitted by any penetrative sexual act in which HIV infected semen, vaginal/cervical secretions, or blood is exchanged. HIV infection can be prevented. During each act of sexual intercourse, men should always use a condom, from start to finish. Women should make sure that their partners use a new condom for each act of sexual intercourse.
- Condoms, when carefully and consistently used, provide effective protection against HIV transmission. Latex condoms lubricated with a silicone or water-based lubricant are recommended. When additional lubrication is desired to reduce the risk of condom breakage, only water-based not oil-based, lubricants should be used. Animal membrane (e.g., lambskin) condoms are not believed to be as effective as latex condoms, as a barrier against HIV and are therefore not recommended.
- Non-barrier contraceptives such as intrauterine devices (IUDs) have no protective effect against HIV transmission. It is not clear whether oral and injectable contraceptives affect the risk of HIV transmission. Coordination between AIDS control and family planning services is clearly essential.
- Certain health conditions, especially other STIs may accelerate the progression of HIV infection to AIDS. Guidelines for avoiding STIs should be followed by people with HIV as well as by those without. This type of information must be clearly explained to the client and, with the explicit agreement of the client, his/her sex partner, if that person is known and accessible.
- It is not yet clear whether pregnancy accelerates the progression of HIV infection to AIDS. The uncertainties about this must be carefully explained to infected women of childbearing age. The risk of transmission to the fetus is 16-39%. If a woman has AIDS she is much more likely to have problems with the pregnancy. If HIV-infected women want to avoid pregnancy, advice about contraceptives should be given to them and to their sex partners. Access to safe and reliable contraceptive methods must be ensured.
- With regard to immunization, studies have demonstrated that the use of the following vaccines is safe in children suspected of being infected with HIV: BCG, DTP, OPV, TB, measles vaccine

and tetanus toxoid (all the standard vaccines recommended for children). However, BCG should not be used if a child has symptoms of any HIV related disease.

- Persons with HIV infection should never donate body fluids, such as blood, semen, and breast milk, or body organs.
- If blood from a person infected with HIV is spilt in the home or workplace, it should be cleaned up with an absorbent material (such as a cloth, rag, paper towel, or sawdust), while avoiding direct skin contact with it. The blood-soaked absorbent material should then be immediately burned or washed with a disinfectant (preferably sodium hypochlorite, or household bleach, diluted 1:10 with water) to clean up any excess blood. Household (rubber) gloves should be worn, if available, when cleaning up blood spills. If gloves are not available, another barrier such as a large wad of paper towels should be used to protect against direct skin contact with the blood. Hands should always be washed with soap and water after cleaning up blood or other body fluid.
- Clothes or cloths that are visibly contaminated with blood should be handled as little as possible. Household (rubber) gloves should be worn, if available, and the clothes or cloths placed and transported in leak-proof bags. Such items should be washed with detergent and hot water at minimum 71º C for 25 minutes, or if in colder water (with a detergent suitable for cold-water washing). Disposable sanitary towels and tampons, on which menstrual blood has been spilt, should be disposed of immediately after use. Bandages and other dressings soiled with HIV infected blood should be similarly disposed of. If they cannot be placed in tied plastic bags, they should be burned or buried. If cloth or material is used for menstrual blood, these should be wrapped in plastic or paper until laundered as other clothes.
- People with HIV infection must not share syringes, needles, or other skin-piercing instruments, e.g., in drug injection, as this adds the risk of transmission of HIV and other pathogens to the existing risk of such practices. People with HIV should avoid being tattooed or having any other invasive procedure unless sterilization of the instruments can be ensured before and after the procedure.
- People with HIV infection should not share toothbrushes, blade razors or other instruments that could become contaminated with blood (even though the risk of HIV transmission from these devices is extremely low).
- A person with HIV infection or disease usually seeks or requests information about treatment and possible cures. It is therefore important for counselors to receive regular and *reliable* updates as to the progress of research, together with information about the availability and effectiveness of specific drugs or therapies for HIV-related conditions. While there is as yet no cure for HIV infection or for AIDS, some therapies have been found to be effective in treating opportunistic infections arising from immunodeficiency.

- It is also important to recognize that many people may mistake expensive treatment or care for good treatment. Counselors should be aware of this and help patients make decisions on the advantages and disadvantages of different therapies and interventions.

- Counseling should also emphasize socially constructive behaviors and activities that do involve a risk of HIV transmission. Casual social contact, sharing crockery and cutlery, being in the same room, sharing swimming pools and lavatories do not pose a risk to anyone and help to maintain a feeling of social cohesion.
- Drug injectors who are unable to stop using drugs should be told where they could obtain sterile needles and syringes (if this is possible) or how to disinfect, with bleach, equipment used for injection. Some cities in Nepal have needle and syringe exchange programs. Drug use is always expensive, and some drug injectors may engage in prostitution to obtain the money they need for drugs. Combining drug use with prostitution is particularly dangerous for both the prostitute and the client. Special care is needed in counseling those thought to be doing this, in regularly providing condoms, and in encouraging them to insist on their use.
- Sex partners of drug injectors may be at risk of acquiring HIV infection and other diseases if sexual intercourse occurs without the use of condoms. Counseling and information should always be provided for the sex partners of drug injectors on how to avoid possible HIV infection by the adoption of safer sexual practices.
- Positive health behaviors need to be actively encouraged.

Basic counseling skills

- Active listening (nodding, reflecting)
- Encouraging (“yes, please continue...”)
- Recognizing (“that must be very difficult to accept...”)
- Acknowledging (“I understand this is not easy for you...”)
- Effective questioning, (“Please tell me exactly what you know...
- Empathizing (“I can see you’re feeling very anxious ... ”)
- Respecting (paying attention while the client talks)
- Paraphrasing (“So you’re saying that...”)
- Challenging (“Is this what you really want to do ... ”)
- Repeating (“You felt happy to have a girlfriend ... ”)
- Emphasizing (“Can I just emphasize the following points ... ”)
- Structuring (“There are three main issues we are facing ...)
- Summarizing (“To summarize then, these are the issues...”)

Counseling discussion is:

- Specific
- Focused
- Serving a purpose

Accordingly, counseling:

- Clarifies and addresses problems
- Provides information on alternative options and resources
- Enables selection of realistic alternatives
- Stimulates motivation and decision-making

Common features and requirements of counseling:

1. Time
2. Acceptance and respect
3. Accessibility
4. Consistency and accuracy
5. Honesty
6. Tactfulness
7. Confidentiality

Guidelines for finger prick blood sampling

- Ask the client to wash hands with warm water first.
- Ask the client to rub hands together if cold, to improve skin circulation.
- Sterilize site with an alcohol wipe.
- Use 2nd, 3rd or 4th finger, avoiding calloused finger-tips.
- The correct site for skin puncture is off-center on the finger-tip.
- Hold the client's finger firmly during puncture.
- Position finger below elbow level and gently massage the finger base until a blood drop forms.
- Touch capillary tube to the blood drop, ensuring air bubbles are not introduced.
- Collect enough blood.
- Apply your fingertip to other end of tube while transferring sample. (to form a vacuum).
- Allow blood drop to fall onto test pad of the test.

Blood collected by finger stick or ear-lobe stick can also be used to perform a rapid test or make a dried blood spot on filter paper (quality control and confirmatory ELISA), if needed

Preparing and storing a dried blood spot for an HIV test

Blood from a finger or ear lobe stick can be used to make dried blood spots.

Although finger stick is the most typical method, dried blood spots can also be obtained by using blood collected in a tube with an anticoagulant. Dried blood spots have the advantage of being easily transported, without the need for a cold chain.

1. Apply blood directly from a finger or a pipette onto special filter paper (Schleicher and Schuell Grade 903 Filter Paper or Whatman BFC 180 paper). It is supplied by the National Public Health Laboratory at Teku, Kathmandu.

   The paper may come with preprinted circles that will contain approximately 100-microL blood when completely filled.

   If the paper does not have preprinted circles, place blood on the paper so that it makes a circle with a 1.5 cm diameter. Allow the blood to soak through and fill the entire circle.

   Caution: If the blood does not saturate the filter paper, that paper should not be used.
2. Label the side of the filter paper with a code after the filter paper is saturated with blood (circle is filled).
3. Suspend filter paper strips containing the filled circles during the drying process to allow air to circulate around the paper. Stands for holding the strips are commercially available. However, strips may also be dried by placing them between two books (taping the edges of the strips to the books with sticky tape) on a table or a laboratory bench top so that the blood-containing part of the paper is not in contact with the surface of the table or laboratory bench top. Be sure not to get tape on the blood spot.
4. Let the blood spots air dry at room temperature for **at least 4 hours** (and for at least 24 hours in humid climates). Do not heat or stack blood spots, and do not allow them to touch other surfaces while they are drying.
5. After blood spots have been adequately dried, wrap the strip in one sheet of glassine paper or plastic to prevent carryover of specimen from one sheet to another.
6. Place the wrapped strips in a gas-impermeable bag with desiccant. Approximately 20 strips may be placed in each bag. Bags may be kept at room temperature for up to 30 days and then stored at 4^0C for up to 90 days. If the dried blood spots in their plastic bags are to be stored longer than 90 days, they should be maintained at -20^0C . Properly stored dried blood spots have been shown to be stable for at least 2 years. The bags should be placed in a sturdy envelope for shipment.

Sensitivity and specificity of some rapid tests

Sensitivity and specificity of approved rapid tests

Rapid Tests	Sensitivity	Specificity	Specimen
Capillus/Trinity Biotech	100	98.8	Serum/plasma/whole blood
Determine/Abbott	100	99.4	Serum/plasma/whole blood
Tridot/J Mitra & Co	99.6	99.7	Serum/plasma
Serodia/Fujirebio	100	100	Serum/plasma
Unigold/Trinity Biotech	100	100	Serum/plasma/whole blood

*WHO/UNAIDS 2002. HIV simple/rapid assays: Operational characteristics (phase 1)

National voluntary HIV/AIDS counseling and testing client intake record

Date: Name & Address of Institution (VCT Center)

Name: Permanent Address of Client District: VDC

Return Visit ? Yes:☐ No:☐ New Code ? Yes:☐ No:☐ Client Code: Partner Code:

1. Age: ☐ yrs
2. **Sex:** (Tick one)
1. ☐ Male
2. ☐ Female
3. ☐ **Occupation:** (Tick one)
1. ☐ None
2. ☐ Unskilled
3. ☐ Skilled
4. ☐ Professional
5. ☐ Student

Other Specify: ☐

4. ☐ Education: (Tick one)
1. ☐ None
2. ☐ Primary
3. ☐ Secondary
4. ☐ Post Secondary

5. Marital Status: (Tick one)
1. ☐ Unmarried
2. ☐ Steady partner, not living together
3. ☐ Steady partner, living together
4. ☐ Married, monogamous
5. ☐ Married, polygamous
6. ☐ Widowed
7. ☐ Separated/divorced

6. Client Counseled as:
(Tick one)
1. ☐ Individual
2. ☐ Couple
3. ☐ Group

7. Pregnancy Status:
(Tick one)
1. ☐ No
2. ☐ Yes
3. ☐ Don't know
4. ☐ N/A

8. Service Required:
(Tick one)
1. ☐ Information only
2. ☐ Counseling only
3. ☐ Full VCT service

9. **Why here today:** (Reasons)
(Tick all that apply)
1. ☐ Plan to get married
2. ☐ Plan to get pregnant
3. ☐ Plan for the future
4. ☐ Client risk behavior
5. ☐ Partner risk behavior
6. ☐ Feel unwell
7. ☐ Had blood transfusion
8. ☐ Pregnant
9. ☐ Reunion with spouse
10. ☐ Referred by other client
11. ☐ Referred by health worker
12. ☐ HIV positive child
13. ☐ Partner ill/died
14. ☐ New sexual partner
15. ☐ Tested elsewhere
16. ☐ After window period
17. ☐ Exchanged sex for money/favors
18. ☐ Intravenous drug use
19. ☐ Other-Please specify: ☐

10 How did client learn about this service:
(Tick all that apply)
1. ☐ Television
2. ☐ Radio
3. ☐ Newspaper
4. ☐ Poster/sign post
5. ☐ Pamphlets
6. ☐ Relative/friend
7. ☐ Sex partner/spouse
8. ☐ Another VCT client
9. ☐ Health facility/worker
10. ☐ Other-please specify

11 Member of Sex partners in last 12 months:
☐ Hetero ☐ Homo

12 Condom use in last 12 months:
(Tick one per partner)
Steady Partner:
0 ☐ Never
1 ☐ Sometimes
2 ☐ Always
9 ☐ Not sexually active in last 12 months

Non-steady Partner:
0 ☐ Never
1 ☐ Sometimes
2 ☐ Always
9 ☐ Not sexually active in last 12 months

13. Used condom during last sex: (Tick one)
0 ☐ No
1 ☐ Yes
2 ☐ Yes, but condom broke
3 ☐ Not sexually active in last 12 months
4 ☐ Never had sex

14 If not tested, why not:
(Tick one)
1 ☐ Changed mind
2 ☐ Want to test later
3 ☐ Want to test with partner
4 ☐ No test kits available
5 ☐ Not satisfied with quality of the service
6 ☐ Declined to answer
9 ☐ N/A
88 ☐ Other - Please specify: ☐

15. Has client had an HIV test before? (Tick one)
1 ☐ No
2 ☐ Yes, negative
3 ☐ Yes, positive
4 ☐ Yes, do not know result

16 HIV Result today:
(Tick one per test)
Screening Test:
0 ☐ Negative
1 ☐ Positive
2 ☐ Inconclusive
9 ☐ Not done

Confirmatory Test
0 ☐ Negative
1 ☐ Positive
2 ☐ Inconclusive
9 ☐ Not done

Tie breaker:
0 ☐ Negative
1 ☐ Positive
9 ☐ Not done
1 ☐ Positive
9 ☐ Not done

17 Couple Discordant:
(Tick one)
0 ☐ No
1 ☐ Yes
9 ☐ N/A

18 Condoms given:
(Tick one)
0 ☐ No
1 Yes-How many:
2 ☐ Refused
3 ☐ None available

19 Referred to:
(Tick all that apply)
0 ☐ Not referred
1 ☐ HIV clinician
2 ☐ STI services
3 ☐ Inpatient services
4 ☐ TB services
5 ☐ PMTCT services
6 ☐ Family planning
7 ☐ Other outpatient services
8 ☐ Home based care
9 ☐ Post-test club
10 ☐ Ongoing counseling
11 ☐ Spiritual support
12 ☐ People living with AIDS groups
13 ☐ Legal services
14 ☐ Other-Please specify: ☐
20 ☐ **Other relevant information:**

Note: For code number, use district name first then of institute name (initials), VCT number and date of first contact for counseling eg. Kath/NCASC-200/29-6-2003

Initials of Counselor:

Signature and Date:

Informed consent form

Consent Form for HIV Testing

This is to state that I have been counseled about the HIV test to be conducted on me and have been explained about the implications of the test result. All details pertaining to HIV, its transmission, testing procedure, its limitations and interpretation of results have been explained to me in a manner that I can understand. I have been given the return date for my test results (if not same day service). I also understand that I am free to refuse the test and still get the help I need from this Center without being discriminated against.

I hereby give my consent for the test to be conducted in order for me to know my HIV status.

Signature of Client: _____

Date: _____

Counselor's Name and Signature: _____ Seal or Stamp of institution

Date:_____

Institution:_____

Address:_____

THIS DOCUMENT IS CONFIDENTIAL

Referral form

Name of Institution:

Address: Date:

VCT SERVICE REQUEST FOR REFERRAL
1. CODE NUMBER OF CLIENT
2. DATE OF FIRST ATTENDANCE TO THE VCT CENTER
3. REFERRAL DATE
4. REASON FOR REFERRAL (Please tick) a. Medical Services _____ b. Social Services _____ c. Legal Services _____ d. Orphan Services _____ e. Family planning Services _____ f. STI Services _____ g. Other support services (specify) _____
5. Referred to (Name of Institution)
6. Referred by Counselor (Name): 7. Organization: 8. Stamp

HIV laboratory request form

S.N.	Client's Code Number	Age	Sex	Client's permanet address/district	Initial/ Confirmatory/ Tie breaker	Result	Remarks

Name of Counselor: Signature:

Date:

Stamp: Name of Institution and Address:

Name of Laboratory Technician : Signature:

Date:

Stamp: Name of Institution and Address:

Note: For code number, use district name first then of institute name (initials), VCT number and date of first contact for counseling eg. Kath/NCASC-200/29-6-2003

Counselor reflection form

(For counselor/s and/or supervisor after sessions as a quality assurance measure)

Counselor Reflection Form

COUNSELOR CODE:	**CLIENT CODE:**		
	Yes	**No**	**N/A**
Did I conduct a client Centered session?	☐	☐	☐
Did I provide too much technical information?	☐	☐	☐
Did the client speak as much or more than I did?	☐	☐	☐
Did I perform a risk assessment?	☐	☐	☐
Did I attain a risk reduction plan?	☐	☐	☐
Did the client understand the meaning of the test results?	☐	☐	☐
Did I assess the availability of the client's social support?	☐	☐	☐
Did I discuss referral options with the client?	☐	☐	☐
Did I discuss disclosure of test results with the client?	☐	☐	☐
Did the client determine an immediate plan of action?	☐	☐	☐
Did I deal with the client's and my own emotional reactions?	☐	☐	☐

How could I have improved the session?_____

_____

_____

Date: _____

VCT client exit survey form

Date: _____/_____/_____

Type of visit: **Initial** ☐ **Follow up** ☐

If survey declined, reason for declination:_____

Type of session: **Individual** ☐ **Couple** ☐

Indicate your answer by circling the appropriate answer to the following statements:

		Yes=1	No=2
1.	Overall, the services I received at the VCT center were satisfactory.	1	2
2.	A staff member greeted me within 15 minutes of my arrival.	1	2
3.	I had a place to sit while I was waiting.	1	2
4.	The staff were helpful and supportive to me.	1	2
5.	I felt comfortable asking the Counselor questions.	1	2
6.	I felt the Counselor answered my questions fully.	1	2
7.	I felt comfortable as my blood samples were taken.	1	2
8.	The Counselor made me comfortable talking to him/her.	1	2
9.	The Counselor displayed good skills in his/her counseling session.	1	2
10.	I was given the information I needed about HIV/AIDS.	1	2
11.	I felt I learned something from the video playing in the waiting room (*if applicable*).	1	2
12.	The information given makes/made me feel confident to receive my results.	1	2
13.	I intend to tell others about this service.	1	2
14.	I intend to discuss the results of my test with my partner.	1	2
15.	I intend to change my behaviour as a result of this visit.	1	2

Additional Comments:

Form Filled by: Name:

Institution:

Date:

Appendix 17

Quarterly Voluntary Counseling and Testing Report Form

Name of Reporting Institution:_____ Reporting Period:_____

Address:_____

	Single Male	Single Female	Couple	Total	Remarks
A. Total Number					
Number of New Clients					
Number of Repeated Clients					
B. Total Number of HIV Testing					
Total HIV (-) Negative Result					
Total HIV (+) Positive Result					
Undecided/not tested					
C. Reasons for seeking counseling/testing					
• Unwell					
• worried					
• Partner high risk sexual behaviour					
• Referred by health worker					
• Reconfirm					
• Injecting drug use					
• New sexual Relationship					
• Going abroad					
• Plan to marry					
• Other					
• Other					
• Other					
D Age group					
<14 yrs					
14-24 yrs					
25-49 yrs					
50 + yrs					
E Marital Status of counseled new clients					
Married					
Unmarried					
Widow/Divoced					
Other					
F Total Number refd to get services					
Refd for - STI Services					
- Social/psychological					
Rehab./Care - Medical Services					
- Other					

Note: 1. Please send this report every quarter confidentially to National Center for AIDS and STD Control, Teku, Kathmandu.

2. For HIV positive cases please use another form; which is used to report HIV cases (Appendix 18)

Monthly Report Form of HIV Antibody Test

Appendix 18

Name of Reporting Institution:

Reported by: Reporting Period:

SN	Code No.	Reg. Date	Age	Sex	Occupation	District	Risk Group	Referred by	Lab	Type of Test	Result	Counseling	Remarks

Prepared by:
Date:

Stamp of Institution

Total Sample Tested (during this period):
Total HIV Positive Cases (during this period):

National working group on VCT

List of participants

1. Dr. Bal Krishna Suvedi, Director, National Center for AIDS and STD Control
2. Dr. S.S. Mishra, Former Director, National Center for AIDS and STD Control
3. Dr. D.V. Rana, Senior Medical Officer, National Center for AIDS and STD Control
4. Dr. Ram Charitra Shah, National Center for AIDS and STD Control
5. Dr. Malcolm Steinberg, Consultant, National Center for AIDS and STD Control
6. Dr Susmita Bhandari, National Center for AIDS and STD Control
7. Ms. Bina Pokhrel, National Center for AIDS and STD Control
8. Ms. Usha Bhatta, National Center for AIDS and STD Control
9. Ms. Saraswati Shrestha, National Center for AIDS and STD Control
10. Ms. Urmila Khadka, National Center for AIDS and STD Control
11. Mr. Nirmal Rizal, National Center for AIDS and STD Control
12. Mr. Purushotam Poudyal, Lab Technologist, NPHL
13. Dr. Baburam Marasani, NHTC
14. Dr. Piyush Rajendra, Teku Hospital
15. Mr. Batu Krishna Sharma, SACTS
16. Ms. Shanta Maya Gurung, HIV/AIDS Specialist, USAID
17. Dr. John Dickinson, Director HIVand AIDS Sakriya Unit, United Mission to Nepal
18. Ms. Bishnu Ghimire, United Mission to Nepal
19. Mr. Chunna Prasad Gyawali, United Mission to Nepal
20. Ms. Jamuna Sangraula, Supervisor, Tribhuvan University Teaching Hospital
21. Ms. Apsara Prasai, GWP
22. Mr. Sashank Sing Basnet, Blue Diamond Society
23. Mr. Umesh Pandey, Blue Diamond Society
24. Mr. Budhi Bal Ramtel, Counselor, International Nepal Fellowship
25. Mr. Bishwa Rai, AIDS Care Officer, International Nepal Fellowship
26. Mr. Anjan Amatya, Life saving and Life Giving Society
27. Dr. Bhoj Raj Pokhrel, Senior Resident Advisor, Policy Project
28. Ms. Kamala Moktan, Program Officer, Family Health International
29. Dr. John MacNeil, Senior Technical Officer, Family Health International, Regional Office, Bankok.
30. Dr. Jesper Svendsen, Senior Technical Officer, Family Health International, Nepal Office.
31. Mr. Bharat Mani Pant, Program Officer, Family Health International
32. Ms. Chandeshori Tamrakar, ADRA Nepal
33. Mr. Julian Archer, ADRA Nepal

शब्दावली/GLOSSARY

Acceptance and respect	स्वीकार र आदर
Access	पहुँच
Acknowledging	स्वीकार गर्नु
Active listening	सक्रिय सुनाई (ग्राहकको कुरालाई ध्यानपूर्वक र अर्थपूर्वक रुपमा सुन्दै बेला बेलामा उसलाई उत्प्रेरित गर्नु)
Affected	प्रभावित
Algorithms	चरणबद्ध रूपमा काम गर्ने
Anonymous	नचिनेको/गुमनाम
Antenatal clinics	पूर्व प्रसुति क्लिनिक
Antibodies	प्रतिरक्षात्मक वस्तु
Availability	उपलब्धता
Bandage	पट्टी (घाउ छोप्न प्रयोग गरिने)
Beneficial disclosure	उपयोगी भनाई/फाईदाजनक जानकारी
Bisexual	द्विलिङ्गि/स्त्री र पुरुष दुवैसंग यौन सम्बन्ध राख्ने व्यक्ति
Blood Transfusion	रक्त संचार
Challenging	चुनौतीपूर्ण कुरा गर्नु
Coerced	दण्ड/प्रताडना
Conceive	गर्भधारण
Confidential	गोपनीय/गोप्य
Confirmatory	सुनिश्चित
Consistency and accuracy	निरन्तरता र ठीक
Contaminated	फोहर/दुषित
Convey	कुनै कुरा पुऱ्याउनु/भन्नु
Couple Counselling	श्रीमान्/श्रीमती दुवैलाई गरिने परामर्श
Creasing	माया गर्नु र सुमसुम्याउनु
Deemed	कुनै विषयमा आफ्नो खास मत राख्नु
Delineation	प्रष्ट वा विस्तृत रुपमा विषय छुट्याउनु
Diagnostic	कुनै रोग पत्ता लगाउनु वा खुट्याउनु, निदान गर्नु
Disclosure	भन्नु, खुलासा गर्नं
Discordant couples	अमिल्दो जोडी (जस्तैः- एक जना HIV + अर्को HIV-)
Discrete	विभिन्न/अमिल्दो
Divulge	प्रकाश पार्नु

Effective questioning	प्रभावकारी रुपमा प्रश्न गर्नु
Eligibility	योग्यता पुगेको
Empathizing	सहानुभूति गर्नु
Emphasizing	बल/जोड दिनु
Encouraging	उत्प्रेरित गर्ने
Ensuring	सुनिश्चित
Epidemic	महामारी/विगविगि/रोग ब्यापक रूपमा देखिनु
Ethics	नीतिशास्त्र
Fidelity	इमान्दार/विश्वासिलो
Hazard	खतरा
Heterosexual	विपरित लिङ्गी (स्त्री र पुरुष वीच हुने यौन सम्बन्ध)
High risk communities	अति जोखिमपूर्ण समुदाय
High risk group	अति जोखिममा परेको समूह
Homosexual	समलिङ्गी
Honesty	इमान्दारिता
Hugging	अँगालो हाल्नु
Inconsequential	कुनै असर नदेखाउनु
Infected	संक्रमित
Informed consent	सुसूचित, अनुमति, पाएको मंजूरी
Informed decisions	सुसूचित निर्णय
Instruments	उपकरण/औजार
Invincibility	अजेय
Laundered	धोइएको
Legal advice	कानूनी सल्लाह
Mandatory testing	वाध्यात्मक परीक्षण
Men having sex with men (MSM)	समलिङ्गी (पुरुष र पुरुष बीच यौन सम्बन्ध राख्ने व्यक्तिहरू)
Minors	आश्रित व्यक्तिहरू, बच्चाहरू
Mitigation	साम्य पार्नु/नोक्सान घटाउनु/कम गर्नु
Morbidity	रोगको प्रकोपबाट मर्नु
Mortality	मृत्युदर
Mystery Client	अचम्मको/रहस्यमय ग्राहक
Non-penetrative sex	योनीमा लिङ्ग नपसाइकन गरिने यौन सम्पर्क
Nutrition	पोषणयुक्त
Operational	कार्यात्मक र काम सम्बन्धी
Para phrasing	वाक्यलाई पूनर्कथन गर्नु

Pediatric confidentiality	यदि बच्चाको रगत जाँच गर्दा एच. आई. भी. देखिएमा उसका बाबु आमा वा अभिभावक वाहेक अरूलाई सो वारे जानकारी गोप्य राख्नु
Penis	लिङ्ग
Phased	चरण/अवस्था
Plasma	रगतमा रहने रंगहिन झोल पदार्थ
Post-test counseling	परीक्षण पछि गरिने परामर्श
Pre- test counseling	परीक्षण भन्दा पहिले गरिने परामर्श
Prevention counseling	बचाउ परामर्श
Prophylaxis	बचावट/रोकथाम
Psychosocial	मनोसामाजिक
Recognizing	पहिचान गर्नु
Referral	रेफरल (सम्बन्धित ठाँउमा पठाउनु)
Repeating	दोहोऱ्याउनु
Respecting	आदर गर्नु
Rigorously	कठोरतापूर्वक
Robust	दरो/बलियो
Scarification	छालामा छेड्नु वा काटनु
Sero- Positive	रगत परीक्षण गर्दा एच. आई. भी. भेटिएको
Sexual intercourse	यौन क्रिडा/यौन सम्पर्क
Shared confidentiality	आफ्ना नजिकका नातेदार वा विश्वसनिय मित्रहरूसंग गोप्य कुराहरू खोल्नु
Specimen	नमूना
Statutory	कानूनी/ऐनले तोकेको
Sterilized	निर्मलीकरण
Stress	तनाव
Structuring	संरचना गर्नु
Summarizing	सारांश खिच्नु/संक्षेपीकरण
Surveillance	निगरानी
Taboo	सांस्कृतिक वा धार्मिक रूपमा प्रतिबन्धित व्यवहार ।
Tactfulness	बुद्धिमत्तापूर्ण
Tattooing	छालामा बुट्टा भर्ने काम
Trauma	आघात/चोटपटक
Vaginal and cervical secretions	योनी र पाठेघरको मुखबाट निस्कने श्राव
Voluntary counseling and testing	स्वेच्छिक परामर्श र परीक्षण
Voluntary	ऐच्छिक/स्वेच्छापूर्वक
Vulnerable group	जोखिममा पर्न सक्ने समूह

HIV/AIDS-VCT

Family Health
International