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Standard Operating Procedure for Conducting a General Clinic

1. Purpose

The standard operating procedures embedded in this document is meant to guide the implementers in the process of delivering the services and to provide standardized and simplified guidance to TASO service providers to ensure quality of care and treatment to clients

2. Scope

This SOP is intended for all service providers offering quality services to all HIV positive clients registered in TASO and the affected family members. This involves PMTCT, Adolescent and ART clinics.

3. Prerequisites

- The nature and purpose of the clinic.
- Ensure the appointment lists in printed and files retrieved a day before the clinic.
- Prepare for a health talk.
- Ensure data collection tools and Human Resource is available.
- Ensure monitoring tools i.e. weighing scales, Height, MUAC tapes etc are available.

4. Responsibilities

The Medical, Psychosocial and M & E teams will be responsible for ensuring that all the guidelines are followed before, during and after the clinic.

5. Procedure

A. Front Desk

- Issue FIFO cards with the number in ascending order of arrival.

B. Triage

- Register patients at triage and collect user fees.
- Identify stable and very ill clients.
- Take monitoring parameters of a patient i.e. weight, height, MUAC etc
- Send very ill patients to rest room or referral to hospital.
- Conduct a Health talk at waiting area/shed.
- Administer the Intensified Case Finding Form for TB screening to identify the TB suspects and send them to the TB Corner to management.
- Sort files according the client services required or triage team recommendation.

C. File Allocation

Files distributed by expert clients and filing clerks as per triage recommendation to the clinicians and/or counselors.

D. Service Provision



- i. Medical Services
 - Review the Patients medical history.
 - Conduct clinical assessment for any opportunistic infection, IRIS, and side effects.
 - Conduct a laboratory investigation where necessary.
 - Prescribe treatment and or drug refills to the patient.
 - Provide the next review date.
 - Send patient to pharmacy for prescribed treatment.
 - Pharmacy team dispenses drugs prescribed by medical team (clerking team).
 - Educate the patient on how to take the medicine prescribed.
- ii. Psychosocial services
 - Review the Patients file.
 - Create rapport with a patient
 - Identify the Patient's concerns.
 - Conduct counseling session
 - Incase a client has a serious psychosocial issues, refer accordingly.
 - Refer the client for medical services where needed.

6. References

- i. TASO Counseling guidelines.
- ii. National Counseling guidelines
- iii. Patient Charter
- iv. Uganda clinical guidelines
- v. TASO Medical guidelines
- vi. TASO clinic flow chart.

7. Definitions

A TASO clinic is where TASO registered patients and their family members' access comprehensive medical and psychosocial Services.

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Standard Operating Procedure for Monitoring of clients in care

1. Purpose

The SOP provides an agreed list of essential minimum standard HIV care and ART patient monitoring data elements and their definitions. A patient monitoring system is the backbone of clinical care, treatment and prevention by the clinical team caring for groups of patients.

The benefits are

- To enable effective clinical management of clients.
- To ensure that eligible clients are promptly started on ART.
- To ensure clients appropriately stay on 1st line ART regimen for as long as possible
- To save patient future ART options
- To generate data used for program monitoring and management, reporting and planning

Monitoring of Pre ART patients will enable determination of eligibility as per the national treatment guidelines.

2. Scope

All clients in care

3. Prerequisites

- Access to laboratory services
- Job aids
- Data collection tools.

4. Responsibilities

PERSONNEL	REPONSIBILITY
Clinicians	Carry out clinical assessments Request for laboratory tests Provide clinical care
Nurses	Provide nursing care Conduct clinical assessments Administer medicines
Pharmacy Technicians	Assess and document adverse drug events

Laboratory Technicians	Conduct laboratory tests
Counselors	Offer expert psychosocial support

5. Procedure

Pre-ART Patient monitoring.

- Every newly registered client is clinically assessed, WHO staged and baseline laboratory tests done on the day of registration.
- Adherence in care is monitored and supported
- Promote positive living for all Pre ART patients to delay ART commencement and maintain positive health.
- At every visit, assess the presence/absence of opportunistic in
- CD4 monitoring is done 6 monthly to determine eligibility for ART as part of the eligibility criteria set out

ART Monitoring

1. Clinical monitoring

- Clinical ART monitoring shall be done every time the client interfaces with a staff either at the facility clinic, at the CDDP, FDDP or at home.
- Routine monitoring shall be done at 2 weeks after initiation, monthly for the next two months and every two/three months thereafter. This routine monitoring shall focus on; adherence, weight, height (children), mid-upper arm circumference, TB screening and signs and symptoms of opportunistic infections.
- Community ART Support Agents/CASAs (expert clients) shall follow up clients who have not turned up for their ARV drug refills in the community and will support their peers to cope with adherence challenges.
- Six (6) monthly reviews shall be conducted at the sites/points where the clients receive their ARV refills. A team comprising of at least a Clinician/Nurse, a Counselor and a Laboratory staff shall together conduct the 6 monthly reviews.
 - These reviews will include; clinical assessment that will focus on WHO staging, functional status, presence/absence of opportunistic infections, presence/absence of adverse drug effects, anthropometric measurements like weight, height (for children) and pregnancy testing for females in reproductive age.
 - All the findings at the 6 months reviews will be used at the time of case conference to make judgment of progress of the patient on ART. Decisions should be made at case conference whether to switch, substitute or stop certain clients or the client should continue with treatment as before.

Laboratory monitoring

Lab test for diagnosis and monitoring	Baseline(entry into care)	Initiation of 1 st or 2 nd regimen	Every six months	
HIV diagnostic testing	✓			
Hb	✓			✓
Cd4% or absolute CD4 count	For all patients ✓		For pre ART patients ✓	
Viral Load (VL)		At 6 months after ART initiation and then annually. If viral load is not routinely available, CD4 count should be done 6 monthly to monitor response on ART.		

Lab test for diagnosis and monitoring	Baseline(entry into care)	Initiation of 1 st or 2 nd regimen	Every six months	
Urinalysis	✓		✓	✓
WBC and differential				✓
				✓

2. Immunological monitoring

Carry out CD4 test every after six months. Successful HAART leads to increase of 90-150 or more CD4 cells from the baseline CD4 value.

Risk of disease progression is significantly reduced if the CD4 cell count can be maintained above 200 cells/mm

3. Virological monitoring

This is the gold standard for patient ART monitoring. Quantification of HIV RNA in plasma is the basis of ARV efficacy monitoring.



The ultimate goal of combination ARV is undetectable VL (400 copies/ml for detection standard or 50 copies/ml for detection ultra-sensitive)

Due to limited resources, VL monitoring in TASO will only be done when indicated (however where resources allow, each ART patient will receive a VL once in 2 years).

4. Psychosocial monitoring

- Psychosocial review that will include assessment for adherence, behavior change and positive living strategies.
- Carry out adherence monitoring on every visit. This is done through adherence counseling at CDDPs, home and TASO centers. The ultimate goal is to maintain >95% adherence. Clients with <95% need to be reviewed for non adherence and address this accordingly.
- Assess adherence through:
 - 3 days's recall
 - Pill count

6. **References**

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Standard Operating Procedure for Tracing Lost-to-Follow-up (LTFU) Clients

1. Purpose

The goal of the following SOP is to provide a nationally accepted mechanism to improve rates of linkage to and retention in HIV care. It is meant to define a series of *minimum* procedures which are both efficient and sustainable to link clients to care and retain those already in care (both Pre ART and ART care).

2. Scope

Clients testing HIV positive at HCT
 Clients in care that have missed their appointments

3. Prerequisites

Triplicate referral form
 Updated appointment book
 Client records/file
 Airtime

4. Responsibilities

Linkage facilitator/Nurse/M&E officer/Records clerk /Counselor/Expert clients

M&E:

- M&E Officer generates list of clients that missed appointments 3 days ago on a daily basis
- Records clerk retrieves files for all clients on the list generated by M&E

Linkage facilitator

- Makes telephone calls to the clients or treatment supporter
- Coordinates all the follow up activities.
- Compiles reports of patient tracking activities and ensures update of information in the various databases

Nurse/Counselor

- Makes home visits to clients not responding after the visit by linkage facilitator

Expert client

- Follow up clients after unsuccessful phone calls

5. Procedure for clinic with Electronic Appointment System

1. Every day, print out the list of patients who had an appointment 3 days ago. If you have entered all patients who did come on that day (and entered a new appointment date for them), then this list will contain only those patients who did not come. Save and print the list.
2. Retrieve the files of the patients who are on this list
3. Check if they actually didn't come back. If they did come for a visit according to the file, then it means that the visit wasn't entered. Enter the visit in the database and put the file back
4. If the patient file indicates that the patient died or that (s)he has been transferred out, then that information has not been entered in the database
 - a) Enter or update the information (include the date of the event, even if it is only an approximate date) in the database
 - b) Put the file back
5. For all remaining files, the person did not come back so they need to be contacted at least 4 times (twice telephonically) within a space of at least 3 weeks , the third contact should be a home visit which may include an linkage facilitator referral, a home visit by CHWs. The last visit is by a counselor or nurse.
6. The first call should be done immediately after file review, second call is made 2 weeks after the first successful call.
7. If the second phone call is unsuccessful (patient does not return for 2 weeks), an expert client (CASA/ Mentor mother) or VHT should be contacted to do a home visit.
8. If a person doesn't have a phone or cannot be reached contact a CASA/CHW/Linkage facilitator for a home visit immediately.
9. If the patient does not turn up 1 month after the home visit by the lay service provider, the counselor or nurse will then conduct a home visit to establish the circumstances hindering his/her response
10. If the patient does not appear within 1 month after this home visit, this will mark 4 unsuccessful attempts to encourage the patient to link to care (initial test, follow up call, repeat follow up call or follow up visit) and no further attempts will be made. Such client will then be declared as lost to follow-up and the file closed.



Procedure for clinic with manual appointment system

1. Every day, the data clerk, or designated staff person, goes to the appointment page of last 3 days. All patients who have not been ticked off should be followed up
2. Retrieve the file of the patient to see if (s)he came. If the patient did come and was not ticked, tick off the patient in the "Attend?" box. Return the file in the shelf/cabinet.
3. If the patient did not come, try to follow up the patient telephonically. In the column "CALL", write the date you called the person.
4. If you are unable to reach the patient, call the treatment supporter whose details are on the patient file.
5. If the person doesn't have a phone or cannot be reached:
6. Contact a linkage facilitator to do home visit. Write down the date you referred to linkage facilitator for home visit.
7. If the patient comes back later on, write in the column "Date Patient came back" the date the patient returned. If the patient transferred out or died, record this in the appointment book and patient file.

8. If the patient does not come back 2 weeks after the phone call, contact the expert client/linkage facilitator to do a home visit.
9. If there is no response for 3 months, the patient is lost to follow up and no further attempts will be made to follow up. The file will be closed.

6. *References*

- National HIV Treatment Guidelines
- MOHSW Swaziland

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Standard Operating Procedure for Facility ART delivery Model

1. Purpose

This SOP will guide the implementation of the Facility ART Delivery Model. This involves delivery of ARV drugs to the clients under close monitoring by the clinicians at TASO facilities until a time when the client is stable on treatment to be referred for community-based ART delivery.

An assessment will be done after 6 months to determine eligibility for transfer to the community model.

2. Scope

This SOP will apply to all clients that fulfill these criteria.

1. Less than 6 months on ART
2. Less than 6 months on current regimen if there is a change in regimen
3. Viral load of less than 1000 copies/ μ l for plasma or 5000copies/ μ l for DBS
4. If viral load testing is not available, consider CD4 less than 350 cells/ μ l
5. No active TB or other stage iii/iv opportunistic infection
6. Pregnant and lactating women
7. Less than 15 years old.
8. Documented poor treatment adherence (and appointment keeping)

3. Prerequisites

- a. Weighing scales, stethoscopes, BP machines, thermometers, desk flip charts for WHO staging/ ARV Drug dosing Charts fixed on the walls.
- b. Laboratory equipments & reagents for common Opportunistic infections
- c. Drugs; for OIs, ARVs, co-trimoxazole for prophylaxis
- d. Data collection tools (ART refill forms, Medical forms,HIV/ART Cards)
- e. MoH registers like Pre-ART and ART registers, Exposed infants registers.
- f. National HIV Treatment Guidelines, National ART Policy

4. Responsibilities

Medical Doctor
Clinical Officer



Nurse
Counsellor
Pharmacy technicians
Nurse Dispenser
Laboratory technicians
M&E officer
Filing Clerk

5. Procedure

- a) Retrieve files for all clients on the appointment list a day before the clinic
- b) Register the patient at the front desk and give them a card with a number in ascending order of arrival.(Except for clients that need urgent attention)
- c) Conduct health talk
- d) Conduct group counseling/education of 12-15 people.
- e) Carry out triage (Medical triage by Nurse/Clinician, Counseling triage by the patient's Counselor)
- f) Conduct individual counseling session where appropriate
- g) Conduct clinical assessment for any opportunistic infections, IRIS and side/adverse effects of ARVs
- h) Conduct laboratory investigations where appropriate
- i) Provide treatment for OIs and manage side effects if any
- j) Provide ARV drug refills if there is no reason for stopping treatment (prescribed by the Clinician and dispensed by the Pharmacy staff)
- k) Educate the patient about how to take the different medications prescribed
- l) Provide an appointment for the next refill date/follow up
- m) If eligible for transitioning to community ART delivery, refer the patient to the convenient CDDP.
- n) Pharmacy staff with the patient's identification, drug regimen and name of CDDP in order to input information into the pharmacy information management system

6. References

- National Treatment Guidelines
- National ART Policy
- Uganda Clinical Guidelines
- IMAI

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Standard Operating Procedure for Community- Based ART Delivery Model

1. Purpose

This is the delivery of ARV drug refills at the most convenient designated place chosen by the patients within their communities known as a Community Drug Distribution Point (CDDP). This should be at least 5 km away from an accredited ART centre.

The patients are referred to the CDDPs upon determination of eligibility for community ART delivery. Clients at the CDDP are served in the morning.

Each CDDP will consist of minimum of 30 clients and a maximum of 45 clients.

Every 6 months, a comprehensive review will be conducted on all the clients in a particular CDDP by the medical team.

At any point, a client that is deemed unstable/uneligible for receipt of ART in the community will be referred back to the facility for closer monitoring until stable enough to be re-sent to the community arm of ART delivery.

2. Scope

The client that qualifies to be served in the Community ART delivery model need to meet the following criteria.

9. More than 6 months on ART
10. More than 6 months on current regimen if there is change in regimen.
11. Viral load greater than 1000copies/ μ l (plasma) or 5000copies/ μ l (DBS)
12. If viral load testing is not available, consider CD4 more than 350 cells/ μ l
13. No active TB or other WHO stage III/IV opportunistic infection
14. Not a pregnant or lactating woman
15. Above 15 years old
16. Well documented treatment adherence (and appointment keeping)

3. Prerequisites

- a) Weighing scales, MUAC tapes,
- b) HCG strips, haemocues
- c) Drugs; ARVs, Co-trimoxazole
- d) Condoms
- e) Data collection tools (ART refill forms, medical summary forms, HIV/ART Cards, ICF forms)
- f) Blood sample collection tubes and other sample collection containers
- g) Means of transport

- h) Receipt books

4. *Responsibilities*

Identify the personnel that have a primary role in the SOP and describe how their responsibilities relate to this SOP. If necessary, include contact information.



Counselor	Conduct routine refills Offer counseling (Individual and group) Conduct health talk
CASA	Mobilise the clients to attend CDDP Conduct health talk Follow up clients that have missed appointment Assist to collect user fees Conduct client registration Conduct anthropometric measurements Do TB screening using ICF
Laboratory Technician	Draw/collect samples for testing at 6 monthly review
Nurse/Clinician	Conduct clinical monitoring of clients at 6 monthly reviews.
Pharmacy technician	Generate and update dispensing list for the CDDPs Pre pack drugs Issue drugs to the counselors Ensure accountability of drugs issued for CDDPs and receive any un-issued drugs

5. *Procedure*

- a) The Pharmacy technician prints out a dispensing list of clients on appointment consisting of details of clients at a particular CDDP from the SPIMS.
- b) Pre pack ARV drugs at least a day before the refill date of a particular CDDP by a pharmacy staff.
- c) Using the dispensing list, retrieve clients' files/cards from the records room at least one day before.
- d) Pharmacy staff issue ARV drugs to the counselors at the time of departure for the CDDP.
- e) Counselors cross-check the ARV drugs provided to him/her against the clients on the dispensing list. The cross checking includes individuals client's Name, drug regimen, sex, Septrin/dapsone uptake, Uptake of TB drugs or Fluconazole prophylaxis.
- f) Counselors travel to the CDDPs with the clients' files to aid proper and complete documentation.
- g) At the CDDP, counselor and CASA conduct a health talk on a topical subject.
- h) Register the clients.
- i) Collect user fees from the clients
- j) Counselor offers group and/or individual counseling.
- k) The counselor issues drugs to all the while recording the patient data in the forms.
- l) Counselor may follow up any clients that may have missed their appointment or assign the CASA to follow up.
- m) If it is a 6 monthly review date, the medical team travels with the counselors to conduct clinical and laboratory monitoring of the clients at the CDDP.
- n) Clients that are identified to be responding poorly are referred to Clinical Services supervisor to make further decisions regarding the care of the patient.

6. *References*

- National treatment guidelines
- National ART Policy
- Mozambique CAG Model
- TASO ART Program guidelines

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Standard Operating Procedure for Community Client Led ART Delivery

1. Purpose

The aim of CCLAD is to increase accessibility to, and efficiency of delivery of, ART through greater clients' involvement and task shifting so as to contribute to universal access to treatment, while maintain high quality of service delivery.

The objectives of CCLAD are:

- To increase sustainability of ART delivery
- To decongest facility clinics enable the trained staff to effectively support the novices on ART.
- To involve clients in their monitoring to maximize retention in care.

2. Scope

This model serves clients that meet the following criteria:

17. Documented willingness to receive drugs through this model
18. More than 3 years on ART
19. More than 6 months on current regimen
20. Viral load of less than 1000copies/ μ l (plasma) or 5000copies/ μ l (DBS)
21. If viral load testing is not available, consider CD4 more than 350 cells/ μ l
22. No active TB or other active opportunistic infection
23. Not on second line ART treatment
24. Not pregnant or lactating
25. Age of 15 years and above.
26. Well documented treatment adherence (and appointment keeping)
27. No co-existing chronic medical/surgical condition such hypertension, diabetes mellitus, malignancies etc

Assess clients using the Community ART eligibility form before they are started on this model of ART delivery.

3. Prerequisites

- Community ART Eligibility form
- CCLAD data collection form
- TB ICF forms
- Packaging materials
- Means of transport
- .

4. *Responsibilities*



Personnel	responsibilities
Counselor	<ul style="list-style-type: none"> Coordinate activities of CCLAD Delivers prepacked drugs to CCLAD leaders at CDDP site Review reports from CCLAD groups Update HIV care cards and register Receipt of user fees Coordinate follow up of lost patients in the groups
CASA	<ul style="list-style-type: none"> Collects reports from CCLAD group leaders and submits counselor in charge at the TASO centre Monitor activities of group under his/her mandate
CCLAD Group leader	<ul style="list-style-type: none"> Mobilise members of the group for user fee payment and drug collection Conduct group education Record client data variables on the cdata form Ensure accountability for drugs Provide feedback to Counsellor in charge on any challenges in the group Conduct TB screening Condom promotion

5. *Procedure*

- Pharmacy staff generate lists of clients in the groups to be served at least one week before the activity is due.
- Pre pack the drugs for each client and package for each separately with appropriate labeling
- Pharmacy staff issues the drugs (ARVs and Cotrimoxazole) and other commodities to the counselor in charge who verifies the correctness and acknowledges receipt.
- Counselor in charge of CCLAD group conducts briefing with CCLAD group leaders at CDDP to discuss emerging issues.
- Counselor receives user fees and issues receipts.
- Counselor issues drugs and other commodities to CCLAD group leaders who acknowledge receipt.
- CCLAD leaders conduct health talk as well as TB screening to the group members
- CCLAD leaders document information about the individuals in the group on the form and issue drugs whose receipt is acknowledged by the patients through signing or thumb-printing.
- The leaders follow up clients that have missed appointments
- Submit the forms and reports to CASA for submission to the counselor in charge.
- Counselor in charge transcribes the data collected into the appropriate patient monitoring tools (HIV care cards) before it is entered electronically into the databases.

6. *References*

- TASO CCLAD Operational guidelines
- National ART Treatment guidelines

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Standard Operating Procedure for Couple Counseling

1. Purpose

1. To empower couples to make an informed choice and take up the challenge of HIV prevention and improve the quality of life of HIV affected couples.
2. Strengthen the couples' relationship and promote mutual understanding
3. Develop and promote positive behavioral change adoption among the couple

2. Scope

This SOP is intended for use in counseling couples in marriage and steady relationships.

3. Prerequisites

- Ensure Privacy
- Obtain consent for CHCT
- Data collection tools

4. Responsibilities

The HIV counselor will be responsible for ensuring that all steps in this SOP are followed. The Psychosocial Coordinator will supervise the implementation of this SOP.

5. Procedure

Process of conducting couple counseling

- The HIV Counselor seeks consent from the couple to be counseled.
- The HIV Counselor will set ground rules to govern the counseling session.

A. Couple HIV Testing

In case a couple tests for HIV together, the test results to expect include;

- i. Concordant Negative - Explain
- ii. Concordant Positive - Explain
- iii. Discordant - Explain

B. Supporting couples with concordant Negative Test results

- i. Ensure that the couple has understood their results
- ii. Explore the couple's reaction to their results
- iii. Discuss results in the context of any recent risk outside their relationship

C. Risk reduction issues for concordant negative couples

- i. Review factors that pre-dispose couple to HIV infection and draw risk reduction plans.
- ii. Provide Condoms for those who wish to have
- iii. Address the risk associated with having multiple sexual partners
- iv. Encourage the couples to maintain their HIV negative status through use of condoms, being faithful to each other.
 - If the couple is testing for the first time, encourage them to come back for an HIV test after three months
 - Remind the couple that their results do not indicate the state of their other partners (past or present)
 - Discuss risk reduction by being faithful. Address obstacles to being faithful such as: Travel, Use of alcohol and other issues
- v. Discuss couple's specific HIV concerns or risks based on the information they provide
- vi. Explore skills required to reduce risks such as:
 - Open communication
 - Commitment to protect relationship from HIV
- vii. Encourage the couple to openly communicate with each other concerning sexual issues
- viii. Provide needed referrals for services such as those for STIs, family planning and care during pregnancy

D. Supporting couples with concordant Positive Test results

- i. Ask if the couple understood their results
- ii. Provide appropriate emotional support to the couple to help them acknowledge the challenges of dealing with positive results

E. Risk reduction issues for concordant positive couples

- i. Discuss the importance of being faithful
- ii. Emphasize the importance of safer sex and faithfulness
- iii. Discuss the issue of HIV testing of their children
- iv. Provide information on family planning
- v. Discuss PMTCT services available and how the couple can access them
- vi. Discuss aspects of Positive living and Basic Care Package
- vii. Emphasize the importance of positive living HIV prevention, care and support.
- viii. Discuss the Benefits of disclosure among concordant positive couples
- ix. Provide referrals for appropriate services

F. Supporting couples with Discordant HIV Test results

- i. Ensure the couple understands the results
- ii. Discuss the factors that led to discordance
- iii. Discuss risk reduction strategies
- iv. Discuss the positive living package and
- v. Refer the couple for further support and management.

G. Coping and mutual support issues for discordant couples

- i. Ensure that the couple has understood their results
- ii. Explore the couple's reaction to their results
- iii. Emphasize the importance of HIV prevention (including PMTCT and Family planning) in a discordant relationship
- iv. Discuss care and support strategies for the positive partner



- v. Encourage the Negative partner to provide appropriate support to the Positive partner
- vi. Encourage involvement in peer support groups
- vii. Discuss Risk Reduction
- viii. Discuss the possibility that the negative partner can get infected if no risk reduction plan is made and adhered to
- ix. Address risk reduction within the couple. Explore long-term measures to reduce the risk of HIV transmission to the Negative partner
- x. Emphasis the importance of condom use in discordance
- xi. Emphasis the importance of regular HIV testing for HIV-Negative partner
- xii. Address the need to test children (below 5 years) if the mother is HIV Positive
- xiii. Refer for appropriate support

6. *References*

- vii. TASO Counseling guidelines.
- viii. National Counseling guidelines
- ix. National HCT Guidelines
- x. National CHCT guidelines

7. *Definitions*

A couple is pair of individuals who have had or intend to have sexual relationship.

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Standard Operating Procedure for Counseling Children

1. Purpose

- A. To provide psychosocial support to children and their care givers
- B. To provide information and education about HIV and AIDS prevention, care and support to children and their caregivers
- C. To provide support that can enhance adherence to pediatric treatment
- D. To educate and sensitize caretakers and parents on the rights and also the responsibilities of children in a home and equipping them with skills in communicating with children.

2. Scope

This SOP is intended for counseling children 5 to 17years and care takers/parents of children 0-4years. Child counseling will require the counselor to understand and bear in mind the child's developmental age, experience and abilities of judgment regarding issues.

3. Prerequisites

- E. The nature and purpose for counseling children
- F. The goals of the child in relation to those of the counselor and the other people who matter in the child's life
- G. Consider the child's level of understanding and the age
- H. A suitable environment needs to be identified depending on the level of understanding.
- I. The counselor may use drawings. Storytelling, writing letters, pictures, play therapy and she or he observes the child, puppets etc but as the counselor uses all this he or she should bear in mind the ways in which children communicate that's through non verbal, verbal and play therapy.
- J. Need to adjust to the level of the child and respect the child's rights but at the same time bear in mind the child's character.

4. Responsibilities

The Child counselor will be responsible for ensuring that all steps in this SOP are followed and will need to adjust to the level of the child and should also respect the rights and at the same time bear in mind the child's character.

5. Procedure

- A. Select the appropriate media

- i. Before meeting the child, decide on most appropriate media, which will be based on gender, personal characteristics and type of emotional problems

B. Joining with the child

- ii. Have an initial counseling session with parents/caretakers without the child being present. This will enable the counselor to gather information about the child and the problems to help the counselor get a clue about what might be happening
- iii. The subsequent sessions should be generally for the child only with parents coming only when feedback is to be given.
 - Make the parents/children feel welcome and valued from the moment they arrive
 - Beware that children have their own unique and special personalities and needs
 - Help the child to clearly understand the nature of the child-counselor relationship to let the child know what to expect of a counselor
 - Negotiate ground rules to let the child know what may not be permissible and what may be

C. Invite the child to tell his/her story

- i. The counselor should invite the child tell his/her story through the use of play or suitable media according to the child's age, cognitive level and exposure as well as gender. The counselor should empower the child and provide effective therapy
- ii. The counselor should recognize if the child is disturbed and therefore should not hurry the process or interrogate but should invite the child to disclose what they wish
- iii. The counselor should guard against any of their behavior that can inhibit the child

D. Enabling the child to tell the story

- i. Give a chance to (Enable) the child to tell the story
- ii. Make use of appropriate child counseling skills
- iii. Re - evaluate the media and change
- iv. The counselor should deal with resistance and transference

E. Resolution of issues



- i. Through telling their story, the child may realize that this reduces their emotional pain and leads to a resolution of issues
- ii. The counselor may also need to help the child work through particular issues until they are no longer troublesome
- iii. The child will be enabled to relate to others more comfortably when issues are resolved

6. References

- xi. TASO Counseling guidelines.
- xii. National guidelines for Counseling children and Adolescents
- xiii. National Strategic Programme Plan of Interventions (NSPPI-2) for OVC.

7. Definitions

A child: An individual below the age of 18years.

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Standard Operating Procedure for Group Therapy

1. Purpose

To identify clients with similar psychosocial concerns to be addressed in a group setting so as to support individual clients to overcome the challenges of positive living.

2. Scope

HIV Counselors and expert clients to implement the SOP supervised by the psychosocial coordinator. This SOP is targeting the service providers offering psychotherapy services to clients with a similar challenge in a group.

3. Prerequisites

- A conducive environment
- Privacy
- Availability of an expert client that has gone through a similar challenge
- Purpose and Objectives for psychotherapy (Similar challenge).
- Tools to be used to capture group psychotherapy session
- *Group should be not more than 12 people.*

4. Responsibilities

The Psychosocial counselors

5. Procedure

A. Triage:

- Identify clients with a similar challenge
- Group them according to the challenge.
- Each group should comprise of 12 people.
- Identify expert client on challenge of discussion
- Each group should be facilitated by 2 counselors (1moderator, 1 rapportuer).
- Identify an expert client to co-facilitator and share their success story during the session to enhance modeling.

B. Working Stage

- Identify place with privacy
- Foster climate setting and sharing which will enhance healing.

c. Group therapy

- The key is confidentiality;
- Introduce the challenge to be discussed.
- Seek consent from clients for participation
- Facilitate discussion on challenge through active participation,
- Develop documented individual action plans.
- Schedule individual next appointments.

D. The closing stage

- Ask participants to share what each will do basing on lessons learnt from what was shared in the session.
- Participants who will have the desire to become peer support group members could be empowered to join existing peer support groups or to create one e.g. SLP, PMTCT, Couple counseling and many others. In case there is no such group, the counselor could complete a form to create a peer support group.



6. References

- i. TASO training manual

7. Definitions

- i. **Similar challenge:** It is a problem that many people are experiencing within a community.
- ii. **Group Therapy:** It is the model of counseling that involves bringing clients together with a similar problem.
- iii. **Expert client:** These are clients that have been in care for a longer time with a specific experience and willing to support others to corp.

**MONITORING AND EVALUATION
SECTION**

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Standard Operating Procedure for Data Storage and Retrieval

1. Purpose

The purpose of this document is to outline SOPs for storage and retrieval of (HIV) data.

2. Scope

The document is intended for persons responsible for storing and retrieving (HIV) records at all levels. These include but not limited to M&E specialists, M&E officer, Assistant M&E Officer IT specialists and Filing Clerks at Head Quarters and TASO Centers. These are TASO-MIS, Clients files, SPIMS data, OPENMRS data, HRMIS, Fleet Data, Projects data, self evaluation data, Navision financials, MS-Exchange/Outlook mail data, Staff welfare scheme data, user data on public, secretariat, accounts, support and home folders.

3. Prerequisites

- Disaster recovery committee at centre and TASO HQs.
- Electronic storage devices.
- Persons with technical competence.

4. Responsibilities

The M&E Officers and filing Clerks will be responsible for ensuring that all the guidelines are followed.

5. Procedure

E. Data Storage

- Receive and document reception of data to be stored in electronic or paper form.
- Sort the data pre defined order.
- File data according to the filing method in place.
- Electronic stored data should be kept under lockable safe on backup tapes, CDs etc.
- File should be given only to authorized individuals and recorded in a tracking book.
- Records room should be under key and lock.

F. Data retrieval

- Receive a request for file retrieval i.e. appointment list, file review form, File tracking book and data request form.
- Prioritize the data requests.
- Assign the staff to retrieve the data.
- Document

G. Security considerations for data storage and retrieval

- Electronic: Use of passwords and usernames, Backup(CDs, external hard disks);incorporate user trailing mechanism.
- Provide privileges to only authorized data user.
- Manual: Lockable, secured fire proof cabinets and rooms.
- Electronically; computers and databases.
- Password changes enforced every 14 days.

H. Determine Who has access to data

- Authorized users should be vetted and approved by the management
- Medical legal requirement
- Authorized researcher.
- Authorized technical teams

I. Determine the location where data will be stored

The location of storage for data will be in the server room and fire proof safe in cashiers office

File storage is dependent on availability of space and Quantity of data

6. References

- xiv. TASO Standard Operating Procedure (SOPs) Manual, 2012.