
***resource handbook for msm cbos towards
developing a sexual health programme***

Naz Foundation International

*providing technical, financial and institutional support to men who have sex with men
sexual health interventions, groups and networks in south asia*

Naz Foundation International
Palingswick House, 241 King Street
London W6 9LP, UK
tel: +44 20 8563 0191
fax: +44 20 8741 9841
email: london@nfi.net
website: www.nfi.net

Regional Liaison Office
Naz Foundation International
9 Gulzar Colony
New Berry Lane
Lucknow 226 001, India
tel: +91 (0) 522 2205781/2205782
fax: +91 (0) 522 2205783
email: lucknow@nfi.net

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PROJECT MANAGEMENT SYSTEMS

Project Management Systems

Documentation

For effective management of a Project, appropriate documentation is essential. Such documentation includes:

- * work plans and targets
- * financial reports, expenditure statements, petty cash books, etc.
- * monitoring records
- * surveys and qualitative records
- * work reports
- * progress reports

Such documentation enables the Management of the project to

- * ensure effective management is taking place
- * what progress the Project is making in regard to its Goal and Objectives
- * maintain office procedures and policies
- * ensure financial probity and management of funds
- * produce the required reports for the evaluation of the CBO's work
- * produce the required reports for the donor and for the Board of Management

The systems that produce the required documentation should all be in place as a part of a Project's initiation and implementation.

GUIDELINES ON DOCUMENTATION

(SACS model)

A. Planning - related documentation

During the monthly meetings, the Project Managers and Directors develop monthly plans. This plan needs to be discussed with the field staff and office staff. Plans are to be made so that the project achieves the objectives set out for the month successfully. These plans should be readily available for review. The information that needs to be available in the monthly plan of individuals is as follows:

- * Targets of the project to be covered - area
- * The BCC activities to be undertaken.
- * The condoms to be distributed.
- * Day-wise travel plan which details the areas to be covered.

B. Daily reporting

* In tune with the monthly plan, the Movement Register has to be filled by each member of the team who goes on the field for project implementation. The details carried in the movement register should include

- * Date
- * Name of the staff member
- * Areas covered
- * Time-in and time-out
- * Signature of the staff member

In the field, the staff member is expected to carry a Fieldwork diary, in which he takes running notes of the day's activities. The objective of having this book is to ensure that no information is lost to the project because of forgetfulness. This can be a small slip-pad, which can be retained by the field staff and returned to the project office on completion of the pad.

- * Once the staff member comes back from the field, the details of the day's work should be recorded systematically in the Fieldwork notes. The objective of the fieldwork notes is to record systematically what is done by the project in the field'. This is the primary documentation of the project. This can be maintained in a 200- pages long register and kept in the project office itself. The details that this notes should carry are:
 - * Date
 - * Area covered
 - * Detailed narrative of activities undertaken- covering STD, BCC, Condom and enabling environment related issues.
 - * A brief summary of the day's activities in terms of
 - * No. of beneficiaries met- split of first and repeat contact
 - * No. of one-one/ group sessions
 - * STD cases referred
 - * Condoms distributed
 - * Local travel expenses of the day
 - * Field expenses for the day

C. Internal review of the activities

The project activities should be reviewed once a week in a staff meeting, held preferably on Saturdays to assess the progress of the project against the plans. Difficulties and challenges faced may also be raised in this meeting. A Meeting Minutes Book has to be maintained. The objective of this document is to record the progress of the project each week, the difficulties faced by the staff and the decisions taken. The details to be contained in this document are as follows:

- * Date
- * Names of staff attending the meeting
- * Issues discussed in the meeting
- * Decisions taken in the meeting
- * Signature of the staff members who attended the meeting. The signature is the proof of consent of the person concerned on the issues recorded.

Only weekly staff meeting details is to be entered in this book.

D. Compilation of technical information at the project level

At the project level, the information needs to be compiled component-wise. This objective of this is to trace the progress of the intervention on the 4 components of STD, BCC, condom and enabling environment. The documentation for each of these components needs to be done in such a way that the details are available client-wise. These documents would trace the progress of the relation between the project and the beneficiaries.

This is a secondary level documentation where the basic input is the information from the field work notes. The documents that could be maintained are:

STD registers

STD register would be maintained at the project. It would carry the STDrelated details of a client from the initiation of the project to the current date in the same place in the register. The details that this register needs to carry are:

- * Date
- * Name of the client
- * STD referral no
- * Referred to
- * STDs diagnosed
- * Case history
- * Drugs prescribed
- * The quality of 'care' as perceived by the PSH
- * Cost incurred on STD treatment (including the travel cost)
- * Completion of full course of treatment

- * Partner notification
- * Repeat incidence of STD
- * Cumulative no. of STD cases treated by the project till date.

Condom registers

The condom register would be maintained at the Project level. It will carry details of condoms distributed by the outreach staff directly to the PSH and using different channels. The details of issue of condoms to the field staff will not be recorded here. The objective of this register is to track the distribution of condoms by the staff. The details to be carried are-

- * Date
- * Name of individual/point of stocking in community (community based / paan shops etc.)
- * Place
- * No. of condoms distributed through outlets, ORWs directly to beneficiaries, peers, ESH, SHSP and any other source separately.
- * Total no. of condoms distributed during the month.
- * Cumulative no. of condoms distributed till date.

BCC register

This would be a summary of sessions done with each beneficiary, specifying the type of session- e.g., one-one, one-group etc. This is to trace the interactions that the project has had with each of the beneficiaries. The register should carry the following details:

- * Categorization of the 'contact' as first or repeat contact.
- * Total no. of contacts over the month
- * Total no. of contacts with over the project period- cumulative.
- * Total no. of one-one and one-group sessions held by the project for the month.
- * Cumulative no. of one-one and one-group sessions held by the project.

Enabling environment register

This would be the summary of

1. Advocacy meetings, activities undertaken with ESH, SHSPs or others affecting /affected by the project in order to smoothen the functioning of the project.
2. Non-sexual health services delivered to the PSH/ESH/SHSP through the linkages developed by the project.

The objective of this document is to compile activities undertaken by the project to create an enabling environment for the beneficiaries. The details to be included in this register are:

- * Date
- * Name of the project
- * Name of the organisation (linkage)
- * Brief description of activities undertaken

E. Register of stocks

The project holds stocks of various items that need to be recorded. The items whose stocks need to be maintained are as follows:

- * Condoms

The objective for keeping the stock of condoms is to ensure that there is sufficient supply of condoms in the project at any point in time. The details to be included are:

- * Date
- * Particulars
- * Purchases
- * Issues
- * Closing balance

- * BCC materials
The objective of keeping the stock of BCC materials is to keep track of the types of materials being used and the quantities of stock available at any point in time. The details to be included are:
 - * Date
 - * Particulars-types of materials
 - * Purchases
 - * Issues
 - * Closing balance

- * Medicines
Some projects are procuring medicines for distribution. The objective of keeping stock is to ensure that there are sufficient stocks available. The details to be included are:
 - * Date
 - * Particulars
 - * Purchases
 - * Issues
 - * Closing balance

- * Assets
The objective of this is to keep track of the assets, physically numbered. The details to be included are:
 - * Date
 - * Item description
 - * Bill no.
 - * Cost of the asset
 - * Asset ID no.

- * Stationery
The stock of both printed and official stationery could be maintained if felt necessary.

F. Administrative

The Attendance Register needs to be maintained regularly.

Monitoring and evaluation

Monitoring systems should be kept as simple as possible. The indicators that have been selected for an MSM sexual health intervention give you guidelines as to what information is required.

All services and require to be monitored. Monitoring is both quantitative and qualitative.

Quantitative monitoring

For quantitative monitoring the Project measures the OUPUTS in terms of numbers. For example:

- * quantity of condoms distributed
- * numbers attending the drop-in (where new users are distinguished from regular users)
- * numbers accessing the clinic

The Monitoring Forms in this Manual have been used successfully by other MSM CBOs and could be adapted to the needs of the new MSM CBO.

Qualitative monitoring

Such monitoring enables a Project to see the results of its quantitative work. It measures the impact of its services and what changes are occurring due to the Projects work. Such monitoring is usually conducted through feed-back processes from the beneficiaries of the Project and involve regular

- * focus group discussions
- * one-on-one interviews
- * surveys of attitudes, beliefs, needs, issues, behaviour change
- * quality assurance surveys
- * impact assessments

For example:

Single group time series analysis

A single group time series includes a group (cohort) of individuals, who are subject to assessment both before and during and/or after an intervention in order to establish what impact the intervention has had.

Cross-sectional time series analysis

Same as the Single group time series, but involves sequential samples over time with different groups

FINANCIAL MANAGEMENT SYSTEMS

Financial Management Systems

The budget approved by a donor or by the Board of Management, is your baseline for managing the Project's finances. As you carry out project activities, you should use the budget to help in decision-making about expenditures and to monitor progress in relation to costs.

Comparing actual costs during the project to the costs shown in the approved budget is extremely important. Accurate financial records helps you to know if your spending is on track and can indicate when and where problems are likely to occur. A funding agency will also require you to submit periodic financial reports that account for the funds spent.

Keep track of every expenditure

Get a receipt for each expenditure. Where a receipt cannot be obtained for very small items, make sure that a note (self-written receipt) is kept. Keep any cancelled cheques, copies of bills, employee time sheets and other documentation related to expenditures.

Categorise each expenditure

Your budget will have approved categories of costs (line items). Funds for each expenditure will be taken from one of these approved categories. You may wish to number every receipt and write on it the budget category to be billed. Some project managers keep a separate file or envelop for each cost category and place all receipts to be billed to the category in the appropriate one.

Categories can also be coded. Thus electricity can be coded A4 (A = Administration, 4 is the line under which electricity budget is enumerated).

Keep accounting up to date

You need to ensure that accounting is kept up to date by keeping track of what you are spending (whether you are underspending or overspending both in general and by cost category, in order to make good decisions on expenditures. Accounting is not a difficult or a lengthy task if it is well organised and done regularly. Each month, add up the project's expenditures by cost category, and see how they compare to the budgeted amounts. This way, you will have a better idea of when you are likely to run out funds for particular costs that are essential to successful completion of activities.

A. Accounting Method

Projects should manage the Grant Funds using a double entry cash accounting system and use standard accounting practices as prescribed by the Institute of Chartered Accountants of India for non-profit making organisations.

All figures in the Financial Reports should be the year - to - date expenditures of actual cash. No adjustments should be made for any accruals and/or prepayments, or provision for payments.

B. Financial Records

In order to provide for accurate, current and complete disclosure, the source and applicability of the funds should be recorded and supported by source documents. The following has been recommended by APSACS as the books of accounts that need to be maintained by the organisation:

- * vouchers
- * two column cash book
- * ledger

i. VOUCHERS

Vouchers are the first step towards building up of the accounts records. It is an evidence of payments made, irrespective of the amount, vouchers are to be made. For payments above Rs.500/- it should be affixed by a one-rupee revenue stamp.

Standard Vouchers should be used

Cash Receipt Voucher

Cash Payment Voucher

Bank Receipt Voucher

Bank Payment Voucher

The essentials of a good voucher are:

- * Project name - in order to identify that the voucher belongs to a particular project, the project name needs to be stamped/marked on the voucher.
- * Voucher number - the voucher should be numbered and these voucher numbers should be pre-printed. The voucher book should be officially issued to the person responsible for preparation of vouchers. Any vouchers wrongly written should be marked CANCELLED across the face of the voucher and left in the book itself. Hence, either the vouchers would have been used and taken into the cash book or be left as cancelled or accounted for as balance remaining. This is a good practice in accounting and can be introduced over a period of time.
- * Date and the serial number of the voucher used.
- * Classification - The cost categories and lines items are clearly specified in the proposal. On the basis of the nature of expenses, it is certified that the expenses is correctly classified into the various line items as appearing in the proposal.
- * Narration - there should be a detailed narration in support of the classification showing the description of the transactions.
- * Amount - it is verified that the amount on the voucher is equal to the amount reflected by the supporting documents, or matches any adjustments effected (e.g. advance payments adjusted)
- * Supporting documents - these are in the form of original bills, which are the real proof transaction based on which payment is effected. The classification of the expenses is based on the nature of expense reflected by these documents and the amount on the voucher should be the amount reflected by these documents.
- * Signature of the person preparing the voucher.
- * Signature of the person authorizing payment (To verify with the delegation of powers of each member authorized within the organization to approve payments).
- * Signature of the person receiving payment.
- * Defacing of vouchers and supporting documents by a PAID stamp, subsequent to payment to avoid duplication of payments, and providing reference numbers of vouchers and cheque number if relevant.

All major payments should be made by cheques. The payment by cash is restricted to minor purchases and where it becomes inevitable, to pay cash.

For any payment exceeding Rs. 500/- the receiver's signature is obtained on a revenue stamp affixed to the voucher. If receipt is sent by the recipient then revenue stamp needs to be affixed on the voucher and defaced by a double line across the stamp.

It should be ensured that the vouchers are not overwritten. In cases where it is necessary to correct the figures, the figures originally written should be scored out and the new figures entered. The person preparing the vouchers as well as authorizing payment should then initial the corrections made.

Supporting documents are also not to be overwritten and if a major correction is to be effected, it should be seen that a fresh document has been obtained along with cancelled documents presented earlier on the document and be ratified by the appropriate authority.

Thus, the Thumb Rule is "No voucher can be passed for payment without supporting documents".

ii. CASH BOOK

The Cash Book is the primary book of entry after a voucher is prepared for a particular transaction. The cashbook is meant to record all transaction in which cash/bank receipts and payments are involved. The organization should be encouraged to maintain double column cash book wherein one column records cash transactions and the other column records bank transactions and is in accordance with widely accepted accounting principles.

All voucher entries should be recorded. The cashbook should contain the date of the transaction, voucher number, ledger folio number, classification and narration of expenditure/receipt and the amount. Since it is a record through which control can be kept over cash & bank balances, the cash book should be closed on a daily basis, or after closing of transactions for a period.

If the books of account are maintained on the computer then the computer should be password protected and backups of the cashbook should be done daily. Access to accounting records both on paper and on computer should be restricted to few members of staff.

iii. BANK BOOK

The Organisation must possess a separate project bank account for Grant Funds and ensure that all such funds are remitted into that account. All transactions related to that bank account will require two signatories from authorised persons of the Organisation and all withdrawals must be made by cheque. All transactions relating to this account is to be entered on a daily basis in the Bankbook or in the bank column of a double column cashbook.

iv. LEDGER

The ledger records all aspects of a transaction. It is a record of final entry which contains classified recording of accounts of all types, unlike a cash book which records only those transactions which involves cash or bank. All entries to the ledger are routed from the cash book/bank book.

The Thumb Rule here is "All entries in the cash book should have a corresponding entry in the Ledger".

The ledger shows all necessary data at a single place since all the entries relating to transactions of a particular account are recorded in it and separate folios are maintained to record transactions of one type. Hence, if information is required on a particular head during a period, the ledger should be so maintained that it can be obtained by balancing the ledger accounts. The ledger is generally closed on a monthly basis.

The ledger is the record based on which the various statements or reports are prepared.

C. Contribution in kind

Valuation of in-kind contribution will be based on applicable cost principle

- * Value of services should be consistent with those paid for similar work.
- * Value of assets must be at fair market value.
- * Service of professionals at normal fees of such persons.
- * Volunteer services must be documented .
- * Basis for determining the value of personal services, material, equipment must be documented.
- * There must be verifiable records.

- * Should not be included as a contribution for any other funded program or paid for by another assistance agreement.
- * Cost must be necessary and reasonable.
- * Costs are provided for the approved budget.

There should be a basis for valuing the items/services; this should be shown on the voucher too. An Acknowledgement form needs to be attached to the Receipt voucher for item/services. According for contribution in kind could be passed through the cashbook, as no journal is being maintained. Contra entry for receipt and payment of the contribution for a particular programme. These entries can be posted to respective ledger heads in the usual manner.

Name of organisation Address			Cash Receipt Voucher	
			No: _____	
			Date: _____	
Received from				
S. No	Description	Account Head	Amount	
			Rs	Ps
Cash/Cheque/DD No.		Date	TOTAL	
(Amount in words) Rupees				
Prepared by		Approved by	Received by	

Name of organisation Address			Cash Payment Voucher			
			No: _____			
			Date: _____			
Paid to						
S. No	Description	Account Head	Bill		Amount	
			No	Date	Rs	Ps
					TOTAL	
(Amount in words) Rupees						
Prepared by			Approved by		Received by	

Name of organisation Address			Bank Receipt Voucher No: _____ Date: _____	
Received from				
S. No	Description	Account Head	Amount	
			Rs	Ps
Cash/Cheque/DD No.		Date	TOTAL	
(Amount in words) Rupees				
Prepared by		Approved by	Received by	

Name of organisation Address			Bank Payment Voucher No: _____ Date: _____			
Bank Name & A/C No						
Paid to						
S. No	Description	Account Head	Bill		Amount:	
			No	Date	Rs	Ps
Cheque/DD No.		Date	TOTAL			
(Amount in words) Rupees						
Prepared by		Approved by	Received by			

MODEL EXPENDITURE CODES

LINE ITEM	CODE	LINE ITEM	CODE
MANAGEMENT STAFFING	S	OFFICE EXPENSES	A
Director	S1	accommodation	A1
Administrator	S2	telephone/fax	A2
Admin Assist/Bookkeeper	S3	electricity	A3
Office Assistant	S4	water/gas	A4
Cleaner	S5	stationary	A5
PROGRAMME STAFF	PS	postage	A6
Programme Coordinator	PS1	office canteen	A7
Field workers	PS2	print/photocopy	A8
Peer Educators	PS3	subscriptions	A9
CENTRE STAFF	CS	insurance	A10
Counsellor	CS1	audit	A11
STD Specialist	CS2		
PROGRAMME EXPENSES	P	BCC EXPENSES	B1
Field supplies	P1	education materials	B1
field travel costs	P2	condom purchases	B2
DROP-IN CENTRE EXPENSES	D	CLINIC EXPENSES	M
education groups supplies	D1	clinic supplies	M1
vocational group supplies	D2	EQUIPMENT	E
Social Grps supplies	D3	Equipment	E1

PRODUCING A SUMMARY EXPENDITURE STATEMENT

LINE ITEM	CODES
Equipment	E1
Admin staffing	S1 to S5
Revenue	A1 to A11
Programme staff	PS1 to PS3 + CS1 + CS2
Field services	P1 + P2
Centre services	D1 + D2 + D3
Clinic services	M1
BCC	B1 + B2

PRODUCING PROJECT PROGRESS REPORTS

Reporting Systems

Project Meetings

1. Site Buddies
 - i. Site Buddies Meeting - daily with their Field Worker

 - ii. Monthly Site Buddies Meeting at Office with Field Coordinator and Project Coordinator

2. Field Workers
 - i. Weekly Field Workers Meeting - with Field Coordinator
 - discuss issues
 - assess work
 - develop work schedule for following week

3. Office
 - i. Bi-weekly Office Meeting - with Project Coordinator
 - include: Administrator
 - Field Coordinator
 - Office Assistant

 - discusses issues
 - assess work

4. Staff
 - i. Monthly Staff Meeting - with Project Coordinator- ALL STAFF
 - discuss issues
 - assess work
 - develop monthly work plan

5. Technical Advisory Group
 - Meets every three months to assess Services and Delivery
 - Provides technical advice, support and specific help

6. Board Meetings
 - 1st year: monthly meetings with reports from Project Coordinator
 - 2nd year: bi-monthly meetings
 - 3rd year: every 3 months

Reports

1. SITE BUDDIES REPORTS

Field workers meet with their site buddies once a week to hear comments and issue about sites

Issues:

condom usage

STD levels

social issues

new people

STD treatment compliance

mastan/police

This report is site specific

Field worker produces a weekly summary of this discussion and present to Field Coordinator

Report timetable: each Monday

Field Coordinator reads and files under

SITE NAME: Site Buddies Reports

Timetable: Tuesday

Every month: Field Coordinator produces a Site Buddy Monthly Summary Report of these weekly reports with attached issues & any recommendations.

This report is given to the Project Coordinator to read, who will then authorise any actions to be taken.

This report is then translated into English and filed under SITE NAME: SITE BUDDIES REPORTS

Report timetable: end of first week following reporting month

2. FIELD WORKER REPORTS

- a. Daily Report
Site Specific

report timetable: the following day of site visit

- b. These reports are kept till the end of the calendar month
- c. At end of calendar month - 1st day of month - till last day of month
DAILY SITE REPORTS passed to Field Coordinator

Field Coordinator will then make a MONTHLY SUMMARY REPORT

which includes QUANTITATIVE DATA
 QUALITATIVE INFORMATION

with recommendations, issues and actions

Report timetable: the end of the first week following reporting month

- d. This montly summary report is passed to Project Coordinator who will read and produce an action report to be attached to this SUMMARY REPORT

- e. After Project Coordinator has read this report, it is passed to Administrator for translation and filed as MONTHLY REPORT
3. SOCIAL GROUP REPORTS
 - a. Group facilitator writes report following group meeting
 - i. numbers attending
 - ii. issues discussed
 - iii. conclusions/recommendations
 - b. Report given to Project Coordinator to read, after which it is translated and filed under: SOCIAL MEETING REPORTS
 4. OFFICE AND DROP-IN CENTRE REPORTS
 - a. Administrator will produce monthly expenditure statements including Petty Cash Report for Project Coordinator
 - b. Will produce monthly office reports for
 - a. letters received/from who/what
 - b. phone calls received/from whom/what
 - c. STD patients: how many/from what site/problems
 - d. Social group reports/how many attend/what issues discussed
 - e. classes/attendance recordsreport timetable: end of the 1st week following reporting month
 5. CLINIC REPORTS
 - a. Administrator will compile CLINIC SESSIONAL REPORTS
Will collect referral cards from doctor following each session and produce a summary
SITE
NUMBER OF CLIENTS
STDS
OTHER HEALTH ISSUES

SESSIONAL STD SERVICE REPORT
 - b. MONTHLY STD SERVICE REPORT: SITE SPECIFIC SUMMARY

report timetable: end of the 1st week following reporting month
 6. PROJECT REPORTS
Project Coordinator will produce monthly PROJECT PROGRESS REPORT
includes Office Report
Expenditure Report
Field Report
Clinic report

report timetable: end of 2nd week following reporting month

HEALTH SERVICE CLINIC

- a. STD Services
registration book

date: client name/reference no.

client gives referral card to Doctor.
Doctor makes notes on referral card

All cards are given to Administrator after session

Administrator makes STD DAILY REPORT

After one month a MONTHLY STD AND HEALTH REPORT is produced

Contains:

number of clients from each site

STDs

issues

It is hoped that clients will be tested and given free prescriptions.

Perhaps a sliding scale of payments can be developed.

- b. Other health issues
These will also be noted on referral cards

All part of the HEALTH REPORT

However, clients are expected to pay for any necessary treatment/prescriptions

ADVICE HOTLINE

- a. Field Workers and Site Buddies distribute phone cards
- b. Reception/advisor monitors calls
- c. advice/referral given over telephone

Administrator monitors records for advice calls

Produces a WEEKLY HOTLINE REPORT

- a. information on caller
- b. from where
- c. what issues
- d. referrals made

DROP-IN

- a. drop-in sessions from Monday - Friday
- b. Monitoring record kept
- c. Daily report produced from the records by receptionist
- d. Administrator produces WEEKLY DROP-IN REPORT
 - a. number of people coming to drop-in
 - b. issues raised

ADVICE/COUNSELLING SESSIONS

- a. individual advice sessions offered
- b. use of clinic room during morning drop-in sessions
- c. daily monitoring report produced
- d. Administrator produces weekly monitoring report.

Reporting on progress

A donor will require regular reports from the CBO during Project implementation. The frequency of these reports can vary from monthly to quarterly to every 6 months.

Whenever a report is made on Project progress, it should be remembered that achievements must be compared to the objectives and workplan. In this way, it is easily seen which activities are progressing according to schedule and where work is falling behind. This comparison focuses attention both on achievements and on areas where there are problems that need to be addressed.

Model of SACS Monthly Progress Report

Name of Partner Organization

Location

Period of Reporting

Report prepared on

Number of sites

COMPONENT 1 : STD CARE/CLINIC

Particulars	Numbers	
	Current Month	Cumulative
Numbers of referrals		
Numbers of attending clinic		
STD cases confirmed after referral		
Cases referred but no confirmed as STD		
Patirnts provided medicine from Project		
Patients completed total course of Treatment		
Cases of reinfection		
Total cost incurred by project		
<i>Doctor</i>		
<i>Medicine</i>		
Number of Cases followed up		

COMMENTS

- * What were the targets and activities for this period?
- * What were the achievements and activities
- * What resources were used
- * What problems encountered
- * What solutions
- * What lessons learned
- * What plans for next period

COMPONENT 2: CONDOM PROGRAMME

Particulars	Numbers	
	Current Month	Cumulative
Condoms procured		
Source of Procurement		
Total Distributed		
Total from Field Teams		
Total through drop-in		

COMMENTS

- * What were the targets and activities for this period?
- * What were the achievements and activities
- * What resources were used
- * What problems encountered
- * What solutions
- * What lessons learned
- * What plans for next period

COMPONENT 3: BCC

Particulars	Numbers	
	Current Month	Cumulative

PSHs outreached by Field Teams

First Contact

Repeat Contacts

Sessions

Education Groups in Drop-in

PSHs participated in education groups

Materials used for BCC

Other modes of BCC undertaken

Brief write up on BCC sessions

COMMENTS

- * What were the targets and activities for this period?
- * What were the achievements and activities
- * What resources were used
- * What problems encountered
- * What solutions
- * What lessons learned
- * What plans for next period

COMPONENT 4: ENABLING ENVIRONMENT/NON-SEXUAL HEALTH NEEDS

Particulars	Numbers	
	Current Month	Cumulative
PSHs utilising drop-in		
First use		
Repeat use		
Social Group Meetings		
Total Number of users		
Literacy classes		
Total Number of users		
Vocational Classes		
Total Number of users		

COMMENTS

- * What were the targets and activities for this period?
- * What were the achievements and activities
- * What resources were used
- * What problems encountered
- * What solutions
- * What lessons learned
- * What plans for next period

ADMINISTRATIVE ISSUES

Comments on any issues, developments, problems arising, solutions.

Signed:

Honorary Director

Project Manager

Name of organisation	MONTHLY REPORT - continued	
Month	Total	
	<i>Total</i>	<i>New</i>
3. Clinic		
Referrals from the field		
Total number of patients		
Total no of STD cases treated		
4. Sexual Behaviour		
Total number of reported sex acts		
Number involved		
Anal sex with condom		
without condom		
vaginal sex with condom		
without condom		
Oral sex		
Thigh sex		
COMMENTS		

A model for a 6 month progress report

SIX MONTH PROGRESS REPORT

PROJECT: MALE HIV/AIDS PREVENTION PROJECT

IMPLEMENTING ORGANISATION:

COORDINATING OFFICER:

REPORTING REPORT:

DATE OF REPORT:

1. EXPECTED RESULTS

1.1 Output 1

Organisational development and capacity building of..... towards implementing and managing an MSM sexual health programme in..... and programme management established.

- 1.1 accommodation secured, furnished and equipped for Project office and drop-in centre
- 1.2 Management and programme staff recruited and trained
- 1.3 Monitoring and evaluation systems implemented
- 1.4 Management systems implemented
- 1.5 Financial management system implemented.
- 1.6 All services implemented and new services developed as and when services gaps are identified
- 1.7 appropriate technical assistance identified and accessed

Targets

- * All staff recruited and trained by end of 1st quarter, 1st year
- * Project office and drop-in centre operational by end of 1st quarter, 1st year
- * All management and monitoring systems in place by end of 1st quarter, 1st year
- * All services implemented by end of 1st quarter, 1st year

Write in details under each of the specified outputs. Add any additional work done after 1.7. Make sure you note the targets to be achieved.

1.2 Output 2

Sexual health promotion services implemented and managed for MSM in.....

- 2.1 Sexual health promotion through on-site outreach programmes by trained field teams developed and implemented for MSM in a range of target sites.
- 2.2 Quality and content of interventions among MSM include:
 - on-site advice and information
 - condom distribution
 - on-site condom and STI/HIV/AIDS education
 - personal support and community-building
 - referrals to appropriate STI services
 - referrals to drop-in centre and social groups
- 2.3 Increased numbers of MSM accessing these services and information and modifying their sexual practices towards safer sex behaviours

Targets

- * condom usage increased by 70% from baseline by EOP
- * knowledge scores increased to 80% from baseline by EOP
- * (.....write in number) MSM reached by BCC and support by EOP

Achievements

* **Field Services**

No of sites:

Name sites

No of field teams:

No. of field officers:

No. of Site Buddies:

Comments

* **BCC materials distributed at field sites and centre activities**

Identify which materials and report quantities

Comments

* **Condom distribution**

a. public sites

b. centre activities

drop-in

clinic

social group meetings

special group meetings

Give quantities

Comments

* **Referrals to clinic from sites**

Comments

* **People contact through field work**

Total

New

Comments

* **BCC leaflets produced**

Comments

1.3 Output 3

Community building strategies developed and promoted among MSM intowards community mobilising for sustainable behaviour change

- 3.1 social support groups developed for MSM in drop-in centre
- 3.2 vocational classes developed from 2nd year of project including literacy, drama, arts and crafts, and dance
- 3.3 drop-in services providing psycho-sexual counselling, advice, information and support
- 3.4 other social activities developed as the project develops

Targets

- * 2 weekly social group meetings in drop-in centre by end of 1st quarter, 1st year
- * (insert number) drop-ins per week by end of 2nd quarter, 1st year
- * specialised support groups meeting once a week developed for
 - i. married MSM
 - ii. male sex workersby end of 2nd quarter, 1st year
- * literacy classes developed by end of 1st quarter, 2nd year

Achievements

* Drop-in centre visits

Total
New

No. for counselling
Issues

Comments

- * **Social group meetings**
 - social group meetings per week
 - total number of meetings
 - total participants
 - new participants
 - sexual health meetings

Comments

- * **Special meetings**
 - list all special groups with no of meetings and participants (total/new)

Comments

* Help-line

total number of calls
issues

Comments

- * **Vocational Classes**
 - List classes and number of participants

Comments

- * **Other social activities**
List all other activities and numbers participants

Comments

1.4 Output 4

Syndromic management of STIs provided on a regular basis

- 4.1 STI treatment, advice and counselling sessions provided once a week by STI specialist
implemented 1st quarter, 1st year
- 4.2 increased take up of STI services actively promoted
- 4.3 treatment compliance encourage through support by field teams
- 4.4 partner notification encouraged by field teams and social support
- 4.5 referrals made for HIV testing

Target

- * 80% of STI cases identified among contacted MSM referred and treated

Achievements

No. of clients attending clinic

Issues dealt with by clinic

- a. STIs
 - gonorrhoea
 - syphilis
 - other STIs
 - anal bleeding issues
- b. psychosexual counselling
- c. HIV counselling
- d. general health concerns

Give numbers

Comments

1.5 Other activities

- 1.5.1 Training programs
- 1.5.2 Meetings
- 1.5.3 Advocacy
- 1.5.4 Technical assistance
- 1.5.5 Collaboration with other partners

2. UNPLANNED ACHIEVEMENTS

3. PLANNED RESULTS NOT REACHED

4. FUNDS UTILIZED

4.1 EXPENDITURES DURING REPORTING PERIOD

ITEM	BUDGET	ACTUAL	VARIANCE
------	--------	--------	----------

4.1.1 Staffing
Administration Staffing

4.1.2 Programme Costs
Staffing
IEC materials/condoms
Clinic
Group Meetings

4.1.3 Administration

sub-total

TOTAL EXPENDITURES

4.2 INCOME

4.2.1 Primary Donor

4.2.2 others

TOTAL INCOME

4.3 BALANCE

Comments (ABOUT VARIANCE)

5. PLANNED RESULTS FOR NEXT PERIOD (give time period)

Quantify and qualify

5.1 Output 1

5.2 Output 2

maintaining field work activities

5.2.1 IEC materials distributed: leaflets

5.2.2 condom distribution: public sites
drop-in centre

5.2.3 people contacted: total
new

POLICIES AND PROCEDURES

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GOAL AND OBJECTIVE OF THE AGENCY

Goal

To address the lack of appropriate provisions of HIV/AIDS and sexual health services to meet the specific needs of marginalised and low income males who have sex with males through the development of appropriate outreach, prevention and treatment support services in

Objective

To develop and provide an appropriate and accessible sexual health promotion services and products and their use promoted amongst marginalised males who have sex with other males and who may be at risk from STI/HIV in....

ETHICAL STATEMENT

This Agency focuses on male to male sexualities and sexual health concerns. In its work the Agency will fully consider the implications of males who have sex with males, for themselves, for any male or female sexual partners such males may have, and for any clients of those males who do sex work.

In this work we will be guided by the following principles:

1. promoting the reproductive and sexual health of males who have sex with males by encouraging sexual responsibility and safer sexual practices
2. encouraging males who have sex with males to access STD treatment whenever necessary
3. respecting confidentiality in the relationship between males and their sexual partners and/or clients
4. promoting the protection of children and non-consenting adults from abusive sexual relationships
5. promoting the reproductive and sexual health of any female partners of males who have sex with males by encouraging greater sexual responsibility of their male partners
6. encouraging communication of sexual health information between sexual partners and promoting partner notification of STD/HIV infection, irrespective of the gender of the partner
7. working with female reproductive and sexual health services in order to facilitate appropriate access to infected female partners of males who have sex with males.

CONFIDENTIALITY POLICY

This policy applies to the Trustees, all staff, sessional workers, volunteers and service users. It relates to spoken, written and computerised information.

The agency recognises the importance of confidentiality for individuals, in particular their HIV Status and their sexuality. As such, confidentiality must be central to the work of the agency. Service users must be assured of confidentiality when they access our facilities/services. It is crucial that staff, volunteers, sessional workers and other service users recognise this.

Definitions

Confidentiality

Treating with confidence personal information about clients, whether obtained directly or indirectly or by inference. Such information includes name, address, biographical details, and other descriptions of the service user's life and circumstances which might result in the identification of the service user. (British Association of Counselling)

Confidential

Spoken, written, or given in confidence.

Entrusted with another's confidence or secret affairs. (Collins English Dictionary)

Breach of Confidentiality

A breach of these confidentiality guidelines is regarded very seriously. Service users may be suspended, volunteers may be asked to leave and staff will face disciplinary action which may lead to dismissal.

The agency believes that there is a need to keep information on service users, volunteers and staff in order for it to function effectively. However, the methods of obtaining, storing and using this information must be carefully assessed, particularly when information is to be given to an outside body, whether an individual or an organisation. The cooperation of all parties (those disclosing information, those handling it and those receiving it) is essential in this process, in particular express consent of service users should be obtained before recording any information. Information collected should be limited to the minimum necessary for the use required.

Confidential information must be securely locked away and not left lying around unattended on desks or within an open access area.

Records will be reviewed annually and all information which is no longer relevant will be removed. This redundant information will be destroyed.

Computers

Confidential information stored on computer must be password protected. Floppy discs containing confidential information must be securely locked away. Terminals should not be left unattended when confidential information is being displayed.

Files will be reviewed annually and any information no longer relevant will be deleted.

Post

All service users, agencies and organisations who send confidential information in to the workplace must be asked to mark their correspondence "Private and Confidential" and staff dealing with the post instructed not to open such correspondence.

Telephone Calls

Telephone calls in which the service user may be identified, or in which information relating to HIV status will be disclosed, should take place in private. If calls cannot take place within a private setting, provision must be made not to give out service user identifying information.

The volume on answer machines should be kept low when noting messages. Messages left for service users must use the worker's name only. Service users should be reminded, when leaving messages, to consider how much information to give message takers.

EQUAL OPPORTUNITIES

Statement of Intent

This Agency is fully committed to Equal Opportunities and Positive Action in the fields of volunteering, employment, training, social activities and service delivery that it provides generally to the individuals, groups, networks and communities it targets.

Positive action enables groups that are facing discrimination or who are under represented to develop their full potential and start to overcome possible past discrimination. This Agency will, where appropriate and practicable, take positive action to provide additional encouragement and assistance to particular groups facing discrimination or who are under represented.

This Agency fully recognises the forces in society which operate against kothis, women, the poor and vulnerable, disabled people and those of differing sexualities, to become actively involved in the organisation, in terms of the membership, clients and volunteers. It will seek to encourage such members to become part of the management structure and will ensure that access is fully available to all without regard to their HIV/AIDS status, gender, physical ability, sexuality, religious affiliation, caste. class, age, marital status political affiliation, nationality. or trade union activities,(provided these persuasions/organisations are themselves committed to equal opportunities and have accepted the objectives of the agency).

This Agency would apply these principles in it's recruitment and management of employees. It would ensure advertisements are placed in appropriate media; that advertisements state that it is an equal opportunities employer; that interview panels reflect as far as possible the disadvantaged sections of society whom it is trying to involve; and that the person(s) recruited have full access grievance and disciplinary procedures and (subject to funding) full economic and other contractual privileges afforded to Government Employees.

RECRUITMENT POLICY AND PROCEDURE

ACTION TO IMPLEMENT EMPLOYMENT POLICY

This Agency recognises that individual and institutional discriminatory practises has meant that some groups in society have not had equal access to fair employment practises. Wherever practicable and within the framework of the law it aims to achieve and maintain a workforce which broadly reflects the communities to whom services are provided.

Advertising

The Agency will endeavour to advertise any employment to as wide an audience as is practicable for the communities it is serving.

Recruitment Process

All posts for recruitment will have a person specification based on the job description. The person specification will state clearly the skills, experience and ability required to do the job and not contain any unnecessary qualification or requirement.

All applicants will receive a copy of the Naz Foundation International's Equal Opportunities Statement.

The Recruitment Policy and Procedures will be adhered to. The selection of recruitment panels, short listing and interviewing will be representative of the respective post and comply with the

philosophy of equal opportunities.

Recruitment Authority

- a. Where the position to be filled is a replacement post and within budget the authority to recruit is vested in the Executive Director.
- b. Where the position to be filled is a new post, but within budgets, the authority to recruit is vested in the Director and Board of Trustees subject to approval of a job description and person specification.
- c. Where the position to be filled is outside budget the authority to recruit is invested in the Board of Trustees.

Temporary Contracts

Temporary staff are defined as staff contracted to work for Agency but who are employed on a contract for six months or less. Temporary staff may be required to meet short-term operational needs and accordingly authority to recruit is vested in the Director and the appropriate Line Manager. Where the temporary post is outside budget the Director will report the appointment to the Board at it's next meeting.

Job Descriptions/Person Specification

Job descriptions and person specifications will be prepared jointly by the immediate supervisor and the Director.

Job descriptions must comprise an overall description of the post and list all the principle accountabilities of the job-holder. The job description should state to whom the job-holder is responsible and the grade of the post.

The person specification should be strictly related to the job description and should not be unnecessarily demanding or restrictive. The person specification should avoid unnecessary emphasis on formal qualifications and recognise that applicants may be qualified by appropriate experience.

Advertising

All permanent posts where practicable, will be advertised both internally and externally. External advertising could include an appropriate mass circulation newspaper or through networking and circulars within appropriate networks.

APPOINTMENTS

It is solely the responsibility of the Director to notify all candidates of the decision of the interview panel at the earliest opportunity and to provide any feedback to unsuccessful shortlisted applicants. Only the Director is authorised to make offers of employment and all contracts of employment must be signed by the Director.

All offers of employment will be subject to the receipt of satisfactory references one of which must normally be from the candidates current or most recent employer. Where the current or most recent employer is the agency a reference should also be obtained from an appropriate previous employer. Where the person being appointed is an Agency Volunteer an additional reference should be obtained from the appropriate staff person.

COMPLAINTS

All applicants should be made aware of the complaints procedure enabling any applicant who feels that s/he has been discriminated against to write to the Chair of the Panel within one month of the facts giving rise to the complaint and if not satisfied s/he should write to the Director, within 7 days of the Chair of the Panel's reply. Applicants are encouraged to make any complaints of discrimination as quickly as possible in order to provide the agency with an opportunity to redress the situation in the event of the complaint being upheld.

MONITORING

There will be regular monitoring of the existing workforce to establish the composition and hierarchy of the staff e.g. gender and sexuality.

Each recruitment will be monitored to assess its effectiveness in relation to the composition of applicants throughout the process.

POSITIVE ACTION

The Agency will, where appropriate and practicable, take positive action to provide additional encouragement and assistance to particular groups facing discrimination or who are under represented.

TRAINING

The Agency will encourage staff to question and examine their practices and attitudes and will seek to eliminate those which are discriminatory in effect be that directly or indirectly.

The Agency will arrange in house training for all staff, volunteers and management committee members on a variety of issues including Equal Opportunities. Where appropriate to skills development all staff will be encouraged to participate in external training courses/events.

EMPLOYEE RESPONSIBILITIES

Whilst the main responsibility for providing Equal Opportunity is on that of the employer, individual employees at all levels also have responsibilities.

Tackling discrimination requires a commitment by all

All job descriptions will include the responsibility of the employee to adhere and promote the Equal Opportunities Policy.

All person specifications will include the essential criteria of commitment and practical implementation of the equal opportunities policy.

Management job descriptions will state their responsibilities to oversee, adhere to and promote the policy.

This Agency commits itself to dealing with breaches of the equal opportunities policy as a potentially serious disciplinary offence.

GRIEVANCE

Any employee who feels that s/he has been discriminated against should raise the matter under the Grievance Procedure as stated in their Terms and Conditions of Employment.

THE AGENCY MANAGEMENT TEAM

The responsibility for monitoring the effectiveness of this policy will remain with the Management Team which shall be empowered to make further policy decisions to create greater opportunity for the under represented.

DISCIPLINARY PROCEDURES

The Disciplinary Procedure will be brought into use when an employee or volunteer is considered to have undertaken an action which contravenes the disciplinary rules. It is anticipated that in most cases of unsatisfactory performance and conduct, discussion at an early stage, counselling and training should resolve problems and make formal disciplinary action unnecessary. It should be noted that competency will be dealt with differently from misconduct in that it is intended that a significant amount of time and effort will be put into counselling a member of staff with a view to improving their performance prior to formal disciplinary action being considered.

The procedure helps to ensure that the standards set for handling disciplinary matters are adhered to and are applied to consistently. The procedure should not be seen as a means of imposing sanctions, but is designed to encourage and enable improvement in individual performance.

The disciplinary procedure will only be instigated where it is considered necessary and will not replace the usual supervisor/supervisee relationship between manager and a member of staff, where support, encouragement and realistic target setting and counselling should be applied in order to improve the performance of a member of staff.

These procedures apply to all staff employed by this Agency and can be commenced at any stage, depending on the severity of the disciplinary offence.

General Principles

Management has the responsibility to ensure that rules, regulations and reasonable standards of behaviour are observed. They have the responsibility to bring to the attention of their staff any matter which they consider is unacceptable behaviour so that the matter can be addressed at an early stage and not left until a "crisis" has occurred and the full disciplinary procedure instigated.

At each stage of the disciplinary process the employee has the right to be accompanied by a colleague.

Disciplinary action from Stage two onwards must be by a panel of managers and all appeals will be heard by a panel. These panels will comprise not less than two people who will not have been directly involved in previous decisions.

The employee has the right to appeal against a disciplinary decision at each stage of the process. The employee has the right to see all evidence and/or statements gathered by management during investigations relating to a disciplinary case and which may be presented to a disciplinary hearing.

Stages of the Procedure

Depending on the nature of the alleged disciplinary offence, the disciplinary procedure can commence at any of the stages which is thought appropriate. The member of staff will be informed at which stage of the procedure they are being seen.

Stage One

Verbal Warning.

Any manager can give a verbal warning to a member of their staff. This must be made clearly so that the member of staff is aware that the formal procedure has been used.

No record of the warning will be kept on a personal file, but the manager must make a record of the reason for giving the verbal warning, the date it was given and the expected date by which improvement should be made. A copy of the note of the meeting will be given to the member of staff concerned. They will be informed for how long the verbal warning is in force by the manager,

and this period should not usually last longer than six months. There should then be a planned review of performance and if satisfactory, the employee informed the matter has ended.

If the performance has not improved, the manager will need to consider whether a further period of assessment is appropriate or whether progression to the next stage of the procedure is appropriate.

Stage Two

Written Warning

A meeting should be held by the manager accompanied by another member of the management team, with the member of staff concerned. The member of staff must be given notice of the meeting, with the reasons and given the opportunity of arranging that they be accompanied.

If deemed appropriate, a formal warning will be given to a member of staff by a manager and the reason for the warning given, the corrective action/improvement expected and the time by which this can be achieved. Evidence to support the reason for disciplinary action can be presented by the manager, but the member of staff and their representative must be allowed time to read and respond to any written material. This period should not need to exceed five working days. The manager must listen to any comments/mitigating circumstances offered by the member of staff and must take these into consideration when deciding on the action to take.

The issues raised, standards expected, time for improvement and review and the appeal process must be detailed in a letter, which will be copied to the personal file of the member of staff. The disciplinary panel will determine for how long a disciplinary decision letter will remain on the personal file of the member of staff concerned, but this should not normally exceed a period of twelve months. If further disciplinary action is required within the period of the disciplinary decision being in force, the letter on file will be taken into consideration. At the end of the disciplinary period, if there is no further cause for concern, the letter will be removed from the personal file at the request of the member of staff.

The employee wishing to appeal against the decision at this stage must do so in writing, addressed to the relevant Director, within five working days. The Director will appoint the Appeal Panel.

Stage Three

Final Written Warning

For more serious disciplinary matters, the procedure may commence at this stage. The member of staff concerned will be informed if this is so.

The member of staff whose performance has not improved following the first written warning may go to receive a final written warning indicating that further failure to improve performance could lead to dismissal.

Again a panel will meet with the member of staff. Areas of improvement required will be detailed, a time set for improvement or warning that cause for further disciplinary action may lead to dismissal, mitigating circumstances must be heard. A letter, including appeal rights, will be confirmation of the meeting.

Any appeal must be submitted in writing within five working days of receipt of the decision letter and will be addressed to the Director.

The Disciplinary Panel will determine for how long a disciplinary letter will remain on the personal file of the member of staff concerned, but this should not normally be for a period in excess of two years. If further disciplinary action is required within this period, the letter on file will be taken into consideration. At the end of the disciplinary period, if there has been no further cause for concern, the

letter will be removed from the personal file at the request of the member of staff.

There may be occasional exceptional circumstances where it is considered these periods need to be extended by the disciplinary panel. If this is the case, the reason(s) will be clearly explained to the member of staff concerned.

Stage Four

Dismissal

Action at this stage of the procedure cannot be undertaken without the knowledge and agreement of the Trustees and can only be carried out by the relevant Director or other manager nominated by him/her.

Summary dismissal can occur where there has been a particularly serious breach of the disciplinary rules.

This stage of the procedure will normally occur when earlier stages have not resulted in the required improvements, or can be commenced at this stage when a particularly serious offence has been committed.

Dismissal will be in confirmed writing, detailing the reasons for this and stating how to appeal against the decision. The appeal must be submitted in writing within five working days of receipt of the decision letter and will be addressed to the Chair of the Trustees.

Suspension

Suspension from duty does not form part of the disciplinary procedure, but may be used prior to any disciplinary action being taken. The reasons for this may be that it is desirable for an employee to be removed from their place of work whilst investigations are undertaken or in the case of misconduct which would make the working relationship between the member of staff and their manager, colleagues, service users or volunteers untenable.

In these circumstances, suspension will be for a very limited period.

Suspension of a member of staff must be with the prior knowledge and approval of the Director in conjunction with the Trustees.

Appeals

The appeal against any level of disciplinary decision will be to the Trustees.

Appeal requests will receive a response within five working days, setting a date for the appeal hearing, which will normally be within fifteen working days.

Appeals will be heard by members of the Board who have not been directly involved in the previous disciplinary decision and will be considered impartially.

Both the member of staff concerned and the managers who have made previous decisions can be asked to present information/answer questions.

The Appeal Panel can confirm or overturn the decision of an earlier disciplinary panel and the reasons will be given in writing. Once the decision is confirmed, there is no further level of appeal.

Disciplinary Rules

Whilst it is not possible to produce an exhaustive list of topics which cover all situations, the following provide guidance to the type of matter which could lead to disciplinary action, and the likely stage at which this action would commence.

MISCONDUCT

This level of misconduct generally relates to continued inadequate performance, but requires that considerable counselling has preceded any disciplinary action in order to try and improve performance.

- a) Persistent lateness/failure to arrive at work in time for duty.
- b) Unauthorized absence.
- c) Failure to notify when sick.
- d) Being in an unfit state for work either through alcohol/recreational drug use.
- e) Disregarding health and safety requirements.
- f) Smoking in non designated areas.
- g) Drinking alcohol/using recreational drugs during working hours.
- h) Misuse of the Agency's facilities/equipment
- i) Behaviour which is likely to bring the organisation into disrepute.

GROSS MISCONDUCT

- a) Physical or sexual abuse/harassment of a service user, volunteer or a member of staff.
- b) Verbal abuse/harassment of a service user, volunteer or a member of staff.
- c) Violation of the Agency's Equal Opportunities Policy.
- d) Breaching the Agency's Confidentiality Policy.
- e) Theft.
- f) Wilful damage to property.
- g) Buying or selling of recreational drugs or drug use on the premises.
- h) Having sex on the Agency's premises

GRIEVANCE PROCEDURE FOR STAFF

The Grievance Procedure is intended for staff to take up matters affecting them as individuals arising from their employment with the Agency.

The Agency wishes to resolve staff grievances in a speedy, fair and equitable manner in order to maintain good working relations. The object of the policy is to enable you to air your grievance, to discover the causes of your dissatisfaction and, wherever possible, to resolve them. It is hoped that many grievances will be resolved satisfactorily by informal discussion. If the matter is not resolved, you may wish to pursue the following procedure, the intention of which is to resolve the grievance at the earliest possible stage.

General Provisions

1. The procedure will not cover grievance relating to disciplinary decisions.
2. From stage two onwards, you will be entitled to be accompanied by a colleague.
3. At each stage notes will be made of the discussions held and a copy will be made available to you and your representative.

Stages of the Grievance Procedure

Stage 1: If you wish to discuss a grievance you should, in the first instance, raise the matter informally with the person concerned or your manager. If the matter concerns your manager, then you should refer to their manager at the first stage of this procedure.

It is suggested that you put the nature of your grievance in writing so that all concerned are clear about the nature and extent of your grievance and are aware that you are pursuing the formal procedure. You will receive a response within two working days.

Stage 2: If this response is not satisfactory, you can then request, in writing, a formal meeting with the Director to discuss the grievance. At this stage you are entitled to be accompanied by a colleague.

The meeting will take place within three working days of the written request being received. Following this meeting a full formal reply will be given within two working days. This will also detail the next stage of the procedure, if this needs to be pursued.

Stage 3: If the matter cannot be resolved at the senior management level, or you are not satisfied with the response given at stage 2, you can appeal to the Trustees. This should be in writing detailing the nature of your appeal and should be addressed to the Chair.

A meeting comprising representatives of the Committee (a minimum of two, but ideally three members) will be held within ten working days of receipt of your letter.

This is the final stage of the grievance procedure and the decision reached by the Trustees representatives will be final. Their decision will be put in writing within five working days of their meeting.

Notes

- a) If any line manager is not available in stages 1 and 2 then the grievance will be heard by his/her nominee.
- b) Only in exceptional circumstances may the time limits be extended, and in this case, you and your representative will be informed of the reason for this.
- c) The Director will be responsible for ensuring the procedure operates within the deadlines, that notes are taken and distributed, and that decision letters are produced in accordance with the deadlines.
- d) All documentation will be kept separate from your personal file, unless the decision affects your pay or conditions of service, in which case only the decision letter will be placed on your personal file.

COMPLAINTS POLICY

The Agency's Policy is that complaints enable the organisation to become more responsive to the needs and expectations of its service users. The Agency positively welcomes suggestions, comments and complaints as a means by which users can say what they think of the services that they are receiving.

The Agency would like to ensure that the complaints procedures are easy to use, not intimidating and produce both an effective and efficient response. Also that when something has gone wrong it should be openly acknowledged and dealt with as quickly as possible.

Scope of Procedure

This procedure covers the following types of complaint:

1. Complaints about services.
2. Complaints about a service user(s)
3. Complaints against a sessional worker or volunteer
4. Complaints against a member of staff.

Complaints about Services/Products

Informal complaints or suggestions for improvement may be dealt with in a number of ways:

1. A note may be put in the suggestion box.
2. The Director or a member of staff may be approached either personally or in writing.

If the complainant chooses to identify themselves in writing, then the matter will be responded to personally. All suggestions and complaints are referred to the staff team for information or discussion. Complaints about a specific incident will only be considered within one week of the incident occurring.

Complaints about a service user:

Stage 1

1. A meeting should be arranged between the two parties, facilitated by the Director/or a member of staff to attempt to solve the dispute. Minutes will be taken and signed by both parties and the facilitator at the end of the meeting.
2. This stage can be bypassed if there is a serious fear of harassment. If serious harassment is alleged, the service user accused may be suspended pending investigation. The service user making the complaint has the option of the complaint remaining confidential. However it must be recognised that keeping the source of the complaint confidential may restrict the worker's investigation and so make it difficult to take formal action.

Stage 2

3. If the complaint is not resolved at stage 1, the complainant will be asked to put the matter in writing and the Director will formally investigate the complaint. Interviews will be held with all witnesses and all views recorded in writing and may be made available to both parties.

Service users being interviewed are welcome to be accompanied by a friend.

This investigation must be conducted within two weeks of the complaint being received. If this is not possible the reasons must be explained to the complainant.

4. Having as far as possible established the facts, the Director may seek advice from the Board of Trustees.
5. The Director will then agree a decision with the Board and inform the service user(s) concerned whether a breach of the Conditions of Use has taken place and therefore the appropriate action taken. If a warning or ban is imposed, this will not be discussed with the other party, but they must be reassured that action has been taken in line with the policy.

Stage 3

6. If either service user is unhappy with the result of the investigation, an appeal may be made to the Board.
7. Records of any ban or warning will remain on file for 12 months. If further disciplinary action is required within this period, the letter on file will be taken into consideration. At the end of the period of 12 months, if there is no further cause for concern, the letter will be removed from the file by the Director.

Volunteer Services

Any complaint by a volunteer or about a user of volunteer services may be dealt with by the appropriate staff person instead of the Director as a delegated responsibility.

Complaints against Member of staff

1. Complaints against staff will be investigated by the Director unless the complaint is against the Director in which case it will be investigated by the Board.
2. The complaint must be made in writing, or made verbally to a member of staff who will write it down and then get it signed by the complainant. Immediately on receipt, the member of staff must be informed and provided with a copy of the complaint.
3. The Director will arrange an informal meeting of all parties to try and resolve the problem within two weeks or, if this is not possible, the complainant will be informed of the nature and cause of the delay. Minutes will be taken and signed by both parties stating whether the issue is resolved. The Director will take whatever action seems appropriate to avoid exacerbating the problem (which may involve suspension of staff or service user).
4. If an informal meeting does not resolve the issue, the Director will conduct a formal investigation, interviewing all witnesses and persons concerned, obtaining signed statements where possible. All persons interviewed may be accompanied by a friend providing they agree to abide by the confidentiality of the proceedings.
5. Having as far as possible established the facts, the Director may seek advice from the Board.
6. The Director will then make a decision and parties to the dispute will be informed of whether a breach of policy has occurred and the right of appeal to the Board. If the member of staff is found to have broken their terms of their employment, the Disciplinary Procedure will come into operation.

Complaints against Volunteers and Sessional Workers

Complaints against volunteers and sessional staff will follow the same guidelines as for complaints against staff with the following differences:

The informal meeting stage will be conducted by the delegated staff person responsible for volunteers and/or sessional workers

Complainants dissatisfied with the decision of the Director following a formal investigation should appeal in writing to the Board.

Confidentiality

Interviews relating to complaints are confidential to Management Staff. It is up to the complainant how much their statements are shared with the subject of the complaint. However, the degree to which a solution is possible will often depend on how much the issue may be discussed with the subject of the complaint. All discussions with other agencies will be anonymised, unless the agreement of the complainant has been received.

Appeals

Appeals against a decision made as the final stage of the Complaints Procedure should be addressed to the Board.

QUALITY ASSURANCE STATEMENT

The Agency will constantly strive to improve the quality of the services it is providing. To achieve this it will seek to ensure the following:

1. The Agency will be available for contact during our opening hours which are from 9.a.m. - 5.30.p.m.

Outside of these hours a message can be left on the answer phone. All calls will be responded to on the next working day.
2. All referrals for service provision will be responded to by telephone within 24 hours. If telephone access is not possible, contact will be made in writing within 3 working days.
3. The policies/procedures adopted by the Agency will be made available to all Service Users, Staff and Voluteers. They are available for inspection at Agency office.
4. All information which is disclosed to the Agency by Service Users, Volunteers, Staff and External Agencies will be treated in accordance with the Agency's Confidentiality Policy.
5. That issues in relation to equality as highlighted in the agency's Equal Opportunities Policy are integral to its working practices and all service provision.
6. In accordance with the Agency's Complaints Policy it has established a "Suggestion Box " for Service Users who have access to the Drop-In. For Service Users who may not be able/ wish to come to the Agency it will make available copies of it's Complaints Policy.
7. That all Staff/Volunteers have access to regular support, training and supervision sessions, either one to one and/or in a group setting.
8. That when the Agency is approached by individuals/organisations whose needs it cannot directly meet it will strive to refer them onto an appropriate agency.
9. That these Quality Initiatives will be regularly reviewed via Team Meetings, supervision and Service User Consultations which are integral to the way in which staff at the Agency works, and any amendments made accordingly.

QUALITY ASSURANCE SYSTEM

A key concept for service providers is the concept of Quality Assurance. This is the principle and the policy which derives from it to assure service users, donors and staff that the agency providing services will make every effort to ensure that its service delivery is of the highest quality and standards.

This Briefing Paper expounds on this and develops a model of such a Quality Assurance for NFI partner agencies.

1. Introduction

- 1.1 In accordance with its Mission Statement, Overall Objectives and Core Values, the agency will deliver quality services equally to all its service users and partner organisations. A quality service will ensure that everyone is satisfied with the service they receive. This applies to both the services we deliver to members of the public and other organisations as well as employee conditions of service.
- 1.2 Quality Assurance is the method employed to ensure that the agency delivers a quality service and comprises of a written system which ensures that every person doing a job knows exactly what to do and when to do it and that they are properly trained and supervised in doing their work
- 1.3 The assurance part of the phrase means that the agency services are consistently delivered to agreed standards and that everyone will have proof of their quality. The agency will constantly strive to improve the services it provides
- 1.4 A Quality Assurance System operates by developing standards for the agency's work which are consulted upon and agreed by staff, Board of Trustee members, partner organisations and service users. Each standard makes an unambiguous commitment about what the agency is going to do and, where possible, when we are going to do it.
- 1.5 The agency's standards have also derived from the following range of sources:
 - * Stakeholders policies and procedures
 - * Donors Performance Indicators
 - * Legislation and Legal Guidance.
 - * NFI recommendations

2. Quality Framework

The following criteria have been used to determine the effectiveness of the agency's services:

- * ACCESS - the ease with which service users can approach the service
- * ACCEPTABILITY - service delivered in a culturally and linguistically appropriate manner
- * NEEDS BASED - services relevant to service users' needs
- * NON-DISCRIMINATORY - all service users receive a quality service
- * EFFICIENCY - service provides value for money
- * ON TIME - service delivered within appropriate time scales

3. Quality Standards

3.1 In order to ensure that the agency's's overall objectives are delivered consistently the following set of core standards have been developed which apply to each persons work.

3.2 ACCESS

3.2.1 The agency is open 9.30 a.m. to 5.30 p.m. Monday to Friday except for public holidays. Certain services are open at times other than this and details are given to callers by the receptionist and on agency literature. Outside of these hours a message can be left on our answer phone. All calls will be responded to on the next working day

3.2.2 No charge is levied for individuals using our services.

3.2.3 Information will be available in the vernacular language about all services provided by then agency and how people can access them.

3.2.4 Staff will arrive on time for appointments.

3.2.5 Outreach work will be undertaken in the evenings and weekends as required.

3.3 ACCEPTABILITY

3.3.1 All our services will be delivered in a culturally and linguistically appropriate manner. Service users will be asked about their religious or cultural needs but where religious beliefs are in conflict with Equal Opportunities Policies, the latter will take precedence.

3.3.2 All new staff and volunteers will be given HIV and AIDS awareness training in particular how it affects members of our communities.

3.3.3 Thye agency has clear and explicit rules for staff and volunteers about respecting the confidentiality of service users who disclose information to them.

3.3.4 All new resources will be piloted first among the target group aimed at. Their comments will be taken into account in evaluating the usefulness and acceptability of the resource.

3.4 NEEDS BASED

3.4.1 Services will be accessed and reviewed following an assessment of the user's needs to be carried out in partnership with the service user within prescribed time-limits.

3.4.2 Service users, individually and in groups will be involved at all levels in the evaluation and review of service procedures through various forms of consultation.

3.5 NON - DISCRIMINATORY

3.5.1 The agency will ensure that services are provided in a non-discriminatory manner and that work practices are underpinned by the issues highlighted in our Equal Opportunities Policy.

This means that the agency will not discriminate in terms of class, gender identification, sexual identity, caste, religious affiliation, education, age, or place of origin.

- 3.5.2 The agency has a strategy for pursuing equality of opportunity in the community around HIV issues and in particular among our staff and volunteers.

3.6. EFFICIENCY

- 3.6.1 The agency will deliver services within budgets.

- 3.6.2 The agency's Business Plan sets out activities three to five years ahead to achieve specific outcomes.

- 3.6.3 All agency staff participate in the organisation's annual planning cycle and the Director develops service specific operational plans at the start of each cycle.

- 3.6.4 The Director will develop work plans for each employee which set out specific personal objectives at the start of each cycle.

- 3.6.5 All staff will work co-operatively to achieve the core standards regarding both internal and external relationships.

- 3.6.6 The Director (or delegated staff person) will provide regular supervision, support and advice in matters relating to the delivery of services to all staff either in a one to one or in a group setting. Work programmes will be drawn up for each member of staff and supervision will take place once per month.

- 3.6.7 All staff will have:

- * freedom from harassment and discrimination in the workplace
- * support from the Director during emergencies
- * clear information about their duties and the agency's requirements with regard to their performance and conduct
- * operational guidelines/procedures relating to their work and the opportunity to contribute to the monitoring, evaluation and review of those procedures
- * a formal appraisal system and acknowledgement for their achievements (once a year)
- * opportunities for training and development

- 3.6.8 The agency has a Complaint's Procedure for staff, volunteers and service users

3.7 ON-TIME and WITHIN SPECIFIC TIME SCALES

- 3.7. 1 All enquiries will be welcomed and responded to promptly as follows:

- * letters will be replied to within 10 days

- * the telephone will be answered within 8 rings and written responses within 6 days if appropriate
- * complaints and comments will be responded initially within 48 hours and the investigation completed within 28 days

4. Evidence Of Achievement

- 4.1 The Director will ensure that there exists a written operational policy on all the core standards identified.
- 4.2 All staff will be required to produce documented records of the services they provide in a pre-determined format which requires reference to the core standards.
- 4.3 The Director will be responsible for ensuring that the achievement of all quality standards are met through regular supervision, staff appraisals and other forms of monitoring and will take appropriate action where this is not the case.
- 4.4 A quarterly monitoring report will be produced for the Board of Trustees and Stakeholders which will include an assessment of progress made toward maintaining and improving the core quality standards or on new ones.
- 4.5 Qualitative reports will also be produced at least once per year..
- 4.6 Every two years all agency services will be comprehensively assessed and evaluated (preferably by an external organisation).
- 4.7 Specific programmes will be evaluated by independent research organisations e.g. NFI
- 4.8 All Training provide by ther agency will be evaluated in a methodical manner and the feedback from course participants taken into consideration when designing or re-designing courses.
- 4.9 All research activities will be undertaken by competent and professional organisations.

OFFICE RULES OF CONDUCT

- * There will be no discrimination based on Caste, Colour, Class, Religious Affiliation, Political Affiliation, Language, Region, Gender Identity and/or Sexual Identity, or Age.
- * Confidentiality will be respected at all times.
- * No staff or drop-in should speak to any form of media about the agency without the express permission of the Project Coordinator/Executive Director
- * Personal issues and inter-personal differences must not be brought into the office/drop-in space
- * All Staff/Drop-ins are requested to behave with basic courtesy and consideration towards each other.
- * Obscene behaviour in the office and drop-in will not be tolerated.
- * Sexual behaviours within the office/drop-in and surrounding areas are not acceptable.
- * Physical and verbal abuse, as well as sexual harassment is unacceptable.
- * Alcohol and/or illegal drugs are not allowed on the premises.
- * Neither can a person come to the Project office in an intoxicated manner, either from alcohol and/or drugs.
- * Please cooperate with the staff and abide by the rules.
- * Please recognise that the building may have other tenants. This means respecting them. So please ensure that the noise level is maintained appropriately.
- * No drop-ins are allowed into the staff rooms without express permission.
- * Any damage to furniture and equipment must be reimbursed.

Please remember that entry to the Project office/drop-in as well as into the street leading to the office, is a public space. Inappropriate behaviour could lead to a poor reflection on yourself, other MSM, and the Project and its work. We ask you to be considerate of this.

TERMS AND CONDITIONS OF EMPLOYMENT

A. Introduction

All staff based at the Agency will be employed based on the same standard terms and conditions.

B. New Employees

1. Hours of work

The normal working week for full time staff is 40 hours. Unless otherwise stipulated, full-time staff will work a schedule of:

9.00am - 6.00pm - inclusive of one hour's break (for lunch).

Exceptions to this are to be negotiated with the Line Manager.

Staff may be required to work outside these hours to attend meetings, for which time of lieu is granted.

Requests for alterations to these arrangements should be addressed to the Director (or in the case of the Director to the Board)

2. Pay

Salaries will be paid by cheque on the last banking day of each month.

2.1 Time off in Lieu

Overtime payments cannot be made but time off in lieu of overtime worked may be taken by arrangement with the Director (and in the case of the Director with the Board of Trustees). Such time off should be taken as soon as reasonably possible after the evening or day concerned, in consultation with the line manager. The 'lieu' time off must not be accumulated and no more than one day off 'in lieu' may be taken in any one week.

3. Probationary Period

All members of staff are appointed subject to completing a satisfactory probationary period of six months.

At the end of three months and six months, a review will take place, comprising an interview between the employee and the Director (in the case of the Director between the Director and the Board), of which a record will be made.

An employee who successfully completes the probationary period will receive a written confirmation of this.

At the end of the probationary period, or at any time throughout, the employee may be served by the Executive Director with a notice of dismissal or of extension of his/her probationary period (in the case of the Director this will be dealt with by the Board of Trustees). Employees have the right of appeal against these decisions via the Board of Trustees.

Any amendments to the above will be communicated in writing to the respective employee by the Executive Director.

C. Existing Employees

1. Holidays

Paid annual leave is as follows:

Any employee working 5 days a week will receive 20 days

Any employee working 4 days a week will receive 15 days

Any employee working 3 days a week will receive 10 days

Any employee working 1 day a week will receive 5 days

The leave year runs from 1st April to 31st March. Employees starting work mid-year will have an annual leave entitlement pro-rata.

Up to five days annual leave may be carried over into the next leave year.

Employees may not take pay in lieu of untaken annual leave

Annual leave must be agreed a minimum of one month in advance of the employee's manager, unless exceptional circumstances are agreed by the manager.

Employees are entitled to other Government holidays.

2. Sickness and sick pay

When an employee is unable to work due to sickness, he/she must inform his/her supervisor or the Director (in the Director's case, the Board) as soon as possible and in any case on the first day of absence, and keep the supervisor informed throughout the period of sickness.

If the absence is for up to seven days, the employee must complete a self-certification form.

If absent for eight days or more, the employee must produce a doctor's certificate.

An employee who has accumulated more than 10 days uncertificated sick leave in one year will have their salary deducted accordingly.

If the absence follows or precedes a Bank Holiday period, a period of annual leave, termination of employment or any other kind of absence, a doctor's certificate is required, regardless of the length of absence.

Employees are entitled to reasonable time off, with pay, to attend hospital. Dental and GP appointments are to be arranged in your time unless there are exceptional circumstances which do not permit this.

If an employee is absent due to sickness, their line manager will review on their return the reasons for their absence. Long term absence or frequent periods of short term absence will warrant a review of the situation by their line manager, to which the employee is entitled to make representations.

At the Agency's discretion an employee or an intending employee may be examined by a doctor nominated by the Board.

3. Entitlements

An employee is permitted entitlements in accordance with the following scale:

During the first year of service: 4 weeks on full pay and 4 weeks on half pay.

During the second year of service: 8 weeks on full pay and 8 weeks on half pay.

During the third year of service: 12 weeks on full pay and 12 weeks on half pay.

During the fourth and fifth years of service: 20 weeks on full pay and 20 weeks on half pay.

After completing five years of service: 26 weeks on full pay and 26 weeks on half pay.

Continuation of sick pay beyond the limits laid down may be made at the discretion of the Board of Trustees in cases regarded by them as exceptional or deserving of particularly compassionate treatment.

4. Maternity Leave

A woman who has been employed for at least one year, will be entitled to take up the post she left, for up to twenty nine weeks from the actual date of confinement provided she has informed the Agency of her intention to return to work at least three months before her expected date of confinement, inclusive of statutory maternity pay:

For the first twelve weeks of absence: full pay

For the next twelve weeks of absence: half pay

Up to five weeks unpaid leave.

Employees with responsibility for children, other dependents, partners or relatives are entitled to up to five days paid leave each year, subject to self-certification of the reasons for absence.

5. Other leave

Paternity leave of up to 3 days will be granted to employees with at least one year's service.

Adoptive parental leave for up to one week will be granted to employees with at least one year's service.

Requests for compassionate leave and leave without pay will be treated individually. Requests must be in writing and directed to the Director, who will decide; appeals against a decision are to be addressed to the Board whose decision will be final.

Employees are entitled to up to one day's paid; leave each year for taking examinations, moving house, marriage or emergency repairs.

6. Pensions

There is no contracting out certificate in force. If an employee has a personal pension plan, they are to advise the Agency so that relevant payments can be made and claimed.

7. Travelling And Other Expenses

Staff members are entitled to reasonable travel and out-of-pocket expenses necessarily incurred in carrying out duties directly related to their employment, according to an approved scale available from the Finance Worker.

D. Termination of Employment

Notice in writing will be given as follows:

One week, after up to four weeks continuous employment.

Except in the case of gross misconduct, the Agency will give at least one month's notice in writing to all members of staff of the termination of their employment.

One week for each year of continuous employment thereafter, up to a maximum of twelve weeks.

Employees are required to give one week's notice in writing up to four weeks employment and to give at least one month's notice in writing of their intention of leaving employment thereafter.

E. Disciplinary Procedure

Please refer to the Agency's Policy

F. Trade Union Membership

Where there is a recognised trade union, employees who are members will have the rights defined in any agreement in force between such a trade union and the employee.

Where there is a collective bargaining agreement, affecting pay settlements and other service conditions, changes agreed between the union and the employer will apply to members and non-members alike.

G. Membership of Outside Bodies

Any employee who wishes to serve as a member of any local government or Voluntary Organisation where there may be a potential conflict of interest or public body of any organisation not connected with the work of the Agency should first secure agreement from the Board of Trustees and the Director if such membership involves working during normal office hours.

H. Disclosure Of Information

The employee shall not at any time during his or her employment (except so far as is necessary and proper in the course of his or her employment or with the consent of the Director and/or the Board of Trustees) or afterwards, disclose to any person any information as to the practice and affairs of the Agency or of any organisation or individual with which it is dealing or as to any matters which may come to his or her knowledge by reason of his or her employment.

The Agency reserves the right to take legal action against any individual who infringes their condition of employment

No employee should discuss the Agency or any issue connected with Agency with any media unless cleared with the Director, and/or with the Board of Trustees.

I. Confidentiality

Definition: Treating with confidence personal information about another person, whether obtained directly or indirectly or by inference. Such information includes name, address, biographical details, and other descriptions of the person's life and circumstance which might result in the identification of the person and/or degrades the person.

Spoken, written, or given in confidence. Entrusted with another's confidence or secret affairs.

As part of the work of the Agency, much personal information becomes available. All information about any individual will be treated confidentially, whether staff, volunteer or service user, unless an agreement has been given by the persons involved and the Agency.

Such information may include details about HIV serostatus, AIDS diagnosis, health, medical con-

dition and treatment, finances, living arrangements, drug use, employment, sexuality, and details about family and friends.

A breach of confidentiality is a serious disciplinary offence and will be treated as such according to the rules of the disciplinary procedures adhered to by the Agency.

J. Discrimination

The Agency considers that it is each individual's responsibility, whether staff or volunteer, to challenge any form of sexism, heterosexism, classism, casteism and religious discrimination within the organisation as well as without. Any such discrimination will not be tolerated by the Agency, and will be treated as a serious breach of the contract of employment. As such these will be treated according to the rules of disciplinary procedures adhered to by the Agency.

Acts which are not deliberately or intentionally offensive, but which nevertheless causes offence may constitute any of the above forms of discrimination.

K. Outside Engagements

Before agreeing to take part in meetings or seminars, give a talk or lecture or write an article during working hours for which a fee will be paid, the employee should seek authorisation from the appropriate line manager.

L. Changes In Terms And Conditions of Employment

The above terms and conditions of employment will be reviewed annually. Such a review will also include the job description of the employee and salary level agreed upon. This will be conducted by the Director, and the Board of Trustees in consultation and agreement with the staff member(s).

Any variation in the Terms and Conditions of Employment will be notified to you in writing within a month of the change occurring.

GUIDELINES FOR COUNSELLING

GUIDELINES FOR COUNSELLING

What is Counselling?

Counselling is:

- A relationship between two people
- In which information is shared
- Options are discussed
- A client is facilitated to find the best options for himself from the ones discussed.

A counselling relationship at a site or in the office can start with:

- Shaking hands and introducing yourself by telling your name

Example:

Hello, Namaste, Aslamalekum, I am

- Introduce your organisation and its work

Example:

I work for organisation called.....We mainly work on male sexual health etc.

- Give a complementary remark that makes the client feels nice about himself

Example:

*That is a nice shirt that you are wearing.....
I like the way you have your hair.....*

- Continue the conversation by posing open-ended questions

Example:

*How many times during a week do you come here?
How many tea stalls are there in this park?*

- Once the conversation starts, information can then be shared

Example:

Our organisation assists people who are tested positive for any sexually transmitted infection. We have a doctor who comes here every Saturday etc.

We have a drop in centre atand each Wednesday we have a social group where we all meet and discuss our problems. It is very nice and friendly etc.

- It is possible that the client may describe several problems that are on his mind

Example:

I have a burning sensation when I urinate and also each night I have a problem falling asleep. My

brother is forcing me to take up a job outside the city etc.

My body is aching all the time. I am harassed by the hotel people where I am staying. They think that I am a sex worker and they are very rude to me etc.

- Normally in any given situation counsellors have time constraints. Therefore, it is always good to prioritise the problems of the clients with mutual agreement with him.

Example:

So you were saying that you have a problem when you urinate and then you also said that you find it difficult to fall asleep at night time. You mentioned about your brother insisting that you take a job outside the city. In total we have three issues/problems that we have to resolve. We have 20 minutes today and we will try to talk about all the three but lets decide in what order we will address these three issues. If anything is left due to time constraint then we call discuss that on the follow up date. How do you feel about that?

- Once the problems are prioritised then take up the first issue with the client and start discussing the options with him.

Example:

So you said that you would want to discuss your sleeping problem first. What do you think may be causing this problem. Okay if it is the food you eat what kind of food do you feel creates more problems for you. Is it possible for you not to eat that food for one or two nights and see if it helps you in sleeping better or like you said that you will change the rice with a roti and see. Okay so change the rice with the roti and see if that helps.

- Normally a counselling session would follow the same format as above. However, one needs to remember the following during any counselling session:

ESSENTIALS OF COUNSELLING:

- Always introduce yourself to your client
- Be polite and complimentary to your client
- Enable the client to feel relaxed
- Assure the client of confidentiality
- Ask your client open-ended questions
- Share information with your client in precise, short and simple language
- Always be attentive towards your client
- Reassure the client of your support and provide sense of comfort through touch, if needed and if culturally appropriate
- Avoid using street language with your client
- Behave in a professional way i.e. being friendly does not necessarily mean that you replicate your client's behaviour
- Be punctual
- Maintain eye contact with your client
- Motivate the client to speak if he is hesitant to speak
- Provide emotional support to your client
- Have empathy and avoid sympathy towards your client
- Be positive in your attitude
- Do not interrupt your client when he is speaking, even if he is saying something incorrect
- Wait till the client has finished speaking and then politely, without commenting on inaccuracy of client's information, give out correct information
- Try to follow the client's posture i.e. sit down if your client is sitting etc.
- Use positive reinforcement during the counselling session
- Try to bring your client back to the relevant issue if he is distracted. This should be done in a polite way
- Your client is the most important thing to you and he should be aware of that by your attitude
- Share information with your client and stay away from advising him
- Facilitate the decision making process of the client. Do not impose your own decision upon the client

- Always make follow up appointment before the client leaves or you leave the site
- Wrap up each issue that has been resolved during the session
- Have good grasp over the subject matter of counselling i.e. if you are counselling on HIV/ AIDS prevention then you should know all about it before you start talking to a client
- If you feel that you do not have an answer for a question tell your client that you will find the answer and would let him know in next session or refer him to someone who may have the answer
- Always be non-judgmental while counselling
- Your body language should not be offensive or intimidating to the client
- Probe without getting inquisitive
- Be objectivite
- Do not promise anything that you cannot do for your client
- Recap for the client once he is finished telling the problem
- Try to have minimum physical barriers between yourself and your client
- Create an environment of trust for you client
- If the client is agitated try to calm him down before starting the session
- Do not use accusatory tone with your client
- Your voice should be clear but soft and gentle
- Do not force the client to say or do things that he may not want to do or admit

Importance of the essentials of counselling

We introduce ourselves to other person i.e. client in this case because:

- It is polite
- It shows the other person that we are respecting him
- It helps in building rapport with the person
- It helps in building trust with the person

When you compliment the other person on something he may be wearing or something that he may have done:

- It makes the other person feel good
- It helps in breaking barrier of shyness and reluctance in your client
- It shows the client that you care and are taking notice of him
- It creates a friendly and easy to talk environment

When you make your client feel relaxed:

- He finds it easy to talk and discuss the problem with you
- It gives him confidence in you and in self
- It motivates the client to give you information that otherwise he may hold back
- Sharing difficult experience becomes easy for your client

When you assure your client of confidentiality he:

- Feels confident
- Share experiences problems that they may not share in other situation
- Trust you with their secrets
- Refer their friends to you for counselling

When you ask your client open-ended questions it helps in:

- Free flow of information from the client
- Understanding the problem better because the information is detailed
- Building rapport with the client

When you share information with your client in short, precise and simple language it helps the client to:

- Understand better
- Remember the messages
- Repeat to his friends without losing much
- Ask questions without forgetting what you had said

When you are attentive towards your client your client feels:

- Important
- Comfortable
- Motivated
- Confident

When you are punctual you are:

- Setting up a good example for your client
- Creating trust in your client
- Creating confidence in your client
- Making your client feel good about himself
- Letting your client know that you are serious about your work

When you maintain eye contact with your client you:

- Show your client that you are listening to him
- Understand the problem of your client better
- Motivate your client to share all he needs to share

Empathy versus sympathy gives your client:

- Self confidence
- Assurance that you as counsellor have the strength to provide support if needed
- A positive message regarding your professionalism

If you have a positive attitude you:

- Pass it on to your client
- Facilitate your client effectively to find solution to his problems

If you interrupt your client while he is talking to you the client:

- Gets nervous and the flow of information stops
- Feels intimidated and loses confidence in himself
- May have problem in communicating with you in future

When you use positive reinforcement with your client during the counselling session:

- It helps in building up the confidence of the client
- The client starts feeling comfortable
- The client starts trusting you
- The client is willing to share more than he may have planned to

When you advise your client:

- It can effect his self confidence adversely
- It can intimidate your client
- It can effect the decision making power of the client negatively
- It can create a feeling of dependency in your client

When you make a follow up appointment with your client it:

- Conveys to the client that you are concerned about him
- Helps you in knowing whether client was able to resolve the problem
- Helps you in systematically recording all what you may have done to assist the client

When you know your subject matter you:

- Are confident
- Are able to share accurate information with your client and have good rapport with him

The Dos and Don't of counselling that you should always remember:

Do

- Always greet your client
- Be polite with your client
- Introduce yourself, your organisation, and its work
- Be precise and clear
- Always know your subject matter
- Be punctual and always keep appointments
- Make your client feel comfortable
- Ask open-ended questions
- Facilitate the decision making process of your client
- Share information
- Maintain eye contact with your client
- Recap the conversation for your client
- Make your client feel important
- Empathise

Don't

- Be judgmental
- Make promises that you cannot keep
- Impose your own solutions on your clients
- Show sympathy to your client
- Give advise to your client
- Provide incorrect information
- Interrupt your client while she/he is talking
- Intimidate your client through your body language
- Use negative reinforcement
- Think that you can control your client's behaviour

Exercise I:

Self reflection

You have just come out of a counselling session after counselling a client ask yourself the following questions:

When the client was talking where did he give the most information about his problem? Why did he give more information in that part of his conversation versus others?

When did your client feel most comfortable during the counselling session? Why do you think he felt comfortable?

Think of three things that you can do better in the next counselling session.

Exercise 2:

Tell a friend that you have a problem and needs his assistance. While he is going through the process of assisting you to resolve the problem make mental notes of the process he is following. As soon as the exercise is over take a pencil and paper nad put the process down step-wise. Use your own checklist of counselling skils and mark what was followed and what was not, and reflect how some missed steps effect you in describing your problem to you friend.

Exercise 3:

Testing yourself

Please mark the correct response

1. Counselling is most effective when you sympathise with your client.
 - a. Yes
 - b. No

2. Making notes on a piece of paper while listening to your client is good for the counsellor's memory and enables the client to know that you are listening to him.
 - a. Yes
 - b. No

3. If the client is giving incorrect information, the counsellor should immediately check if the client before he makes any more mistakes.
 - a. Yes
 - b. No

4. It is important that the client feels that he is listened to.
 - a. Yes
 - b. No

5. Mirroring means replicating the behaviour of your client in terms of his posture and positioning.
 - a. Yes
 - b. No

6. Having a table between yourself and your client gives the counselling set up a more professional look and your client will feel that he is in a proper counselling session.
 - a. Yes
 - b. No

7. Always greet your client before starting the session.
 - a. Yes
 - b. No

8. Do not look at your client while making conversation with him as that can be impolite.
 - a. Yes
 - b. No

9. Always let your client know that he is doing the wrong thing and would be considered a bad person by others if he continues with such behaviour.
- a. Yes
 - b. No
10. Tell your client what is wrong and right instead of sharing the correct information with him.
- a. Yes
 - b. No

written by Tahir Khilji for Naz Foundation International

Guidelines For Good Working Practise For Counsellors.

1. Do not give out your home and work number.
2. Negotiate time keeping with the service user. Always adhere to time decided by yourself and the service user. That is, do not be late for visits or stay longer than agreed. For example do not stay for three hours if you negotiated one hour. This is also to eliminate visits at ad hoc times.
3. On NO terms is the counsellor to accept gifts or money.
4. It is the service user's responsibility to identify the counsellor to whoever it is deemed appropriate. It is not the counsellor's role to explain him. The relationship between counsellor and service user must be defined at all times. For example it would be inappropriate if the service user treated the counsellor as a family member and if this happens, then the line manager must be informed immediately. A counsellor is providing a service via his agency. This must be communicated to the service user as directly and concisely as possible. This is very important as boundaries need to be established and adhered to at all times.
5. If the service user or counsellor cannot make an agreed time, then the counsellor must contact the service user and the line manager as soon as possible. The service user will also be expected to contact the counsellor's line manager if they cannot make an appointment.
6. On no account is the counsellor to give/borrow money to/from the service user.
7. The counsellor is NOT to sign any document(s) on behalf of the service user. This is not the counsellor's responsibility and must be adhered to at all times.
8. The counsellor is on NO account to disclose any information about the service user to anyone apart from their line manager
9. The counsellor is on NO account to spend a night with the service user.
10. On NO account is the counsellor to have sex with the service user or with their family member (s), or friends. If there is an attraction of any kind, then inform the line manager immediately.
11. On NO account is the counsellor to use illegal drugs immediately prior to and whilst with the service user. If the service user uses illegal drugs, then inform your line manager immediately.
12. The counsellor is NOT to use alcohol immediately prior to and whilst with the service user.
13. If any of these guidelines are broken by the counsellor, then disciplinary action may be taken which could result in a termination of contract.
14. If you encounter physical or verbal violence from a service user PLEASE WITHDRAW IMMEDIATELY and inform your line manager immediately.

Declaration for Confidentiality

I am working for, which is an HIV/AIDS and sexual health agency. The Agency works specifically in issues arising from male sexual behaviours.

I understand that in the course of my work for the Agency, I may have access to information about individuals which is of a highly personal and confidential nature. Such information may include details about sexual practice, sexualities, HIV status, AIDS diagnosis, health, medical condition, treatment, and details about family and friends.

I understand that this information is strictly confidential.

I agree not to disclose any information of a personal or confidential nature to any person or organisation not connected to the Agency, nor those within the Agency who are not authorised to receive such information.

In the event of a breach of confidentiality, I understand that disciplinary action may be taken against me.

Date:

Print Name:

Signature:

GUIDELINES FOR HIV COUNSELLING

Guidelines for HIV counselling

Introduction

The primary purpose of pre-test counselling is to provide the client with information about HIV transmission, prevention, and the personal and medical benefits of learning ones serostatus. The patient should be counselled using frank, non-judgmental language, in a private setting, in which the client is comfortable asking questions and discussing behaviours.

Post-test counselling provides the opportunity to clarify information and to further promote HIV risk reduction behaviour and good health practices. In addition, post-test counselling provides an opportunity to discuss the client's personal HIV prevention strategy. The benefits of obtaining HIV-related primary care can be explained, if the client tests positive. Moreover, the client can learn about the options to notify partners.

The following protocol outlines components of the pre- and post- test counselling sessions. Since this protocol draws heavily upon the expertise of experienced counsellors, many of the recommended approaches may be familiar to those who have been involved in HIV counselling. Practitioners should adapt this protocol to the individual client. Conducting an individual risk assessment in the pre-test session may be of limited use for clients who do not know or are not ready to discuss personal risk factors. On the other hand, individual risk assessment in pre-test counselling may help the client to clearly understand his or her risk and encourage the client to adopt risk-reducing behaviours.

Counsellors should have also read the handbook on Guidelines For Counselling as a precursor to this handbook.

Further the Agency should check thoroughly into what services are available in the city/town in which it is based. This includes any HIV testing service, government or private, and

- * *their quality, confidentiality, and appropriateness*
- * *whether these testing services anonymous or confidential*
- * *whether they discriminate against, and stigmatise, men who have sex with men, hijras and kothis*
- * *whether they have adequate and appropriate counselling services*
- * *what treatment services are available and their costs*
- * *what support services and self-help groups are available*

Other services should also be investigated included, drug and alcohol abuse treatment centres and psychiatric and psychotherapeutic treatment. Local legal and human rights services should also be accessed.

The Agency should have access to a range of appropriate referrals contact numbers available, and an appropriate healthy-living chart that outlines the dietary and medical needs of someone living with HIV.

The Agency should also be networked Positive Groups in the city, state and country. Advocacy work may also be required in terms of the needs of hijras, kothis, gay-identified men, and other men who have sex with men in relation to all these services.

Pre Test Counselling

I. Opening the Counselling Session

- A. The Counsellor should create an environment that is both friendly and supportive to the client. The relationship between Counsellor and Client is outlined in a previous section in this handbook.
- B. Explain to the client that the discussion will explore personal issues and risks, and that explicit language may be used.
- C. Explain that this discussion will be kept strictly confidential.
- D. Encourage the client to discuss knowledge of, and his concerns about HIV/AIDS; set a supportive, nonjudgmental atmosphere in which the client will feel comfortable.
- E. Ask the client about any history of HIV counselling and testing.
 1. If the client has never been tested, proceed with a discussion of HIV transmission and prevention.
 2. Explain that anonymous HIV testing is available and that you will explain the difference between anonymous and confidential counselling and testing.
 3. If the client has tested negative, and has an ongoing or identified risk, proceed with counselling to repeat HIV testing. If the test was within the past 6 months, and there is no identified risk since testing, offer the client the option of counselling and retesting if the client wishes.
 4. If the client has tested HIV positive, determine whether the client is receiving appropriate medical care and support services. If the client is not receiving care, then offer what is practicable and available in the current situation in your city. Ensure that the client can have access to support services and an appropriate self-help group.

II. HIV Transmission and Prevention

A. Provide Basic Information on HIV and AIDS

Ask what the client knows about HIV, the virus that causes AIDS. Explain that HIV causes acquired immune deficiency syndrome, most commonly known as AIDS. HIV infection causes a breakdown in the body's immune system. When the immune system is weakened, the body cannot fight off infections. The most serious consequence of HIV infection is AIDS. A person with AIDS gets illnesses which are little or no threat to someone with a healthy immune system. It can take as long as ten years, or perhaps longer, for a person with HIV infection to develop full-blown AIDS; it is still unknown whether all persons with HIV infection will eventually get AIDS. Most people who are infected with HIV do not appear ill and may be unaware of their infection. An asymptomatic infected person can unknowingly transmit HIV to others. HIV antibody testing is recommended because it is difficult to know if the patient was ever exposed to HIV. Knowing one's HIV status can help plan a health strategy for the client, even in a medically poor environment.

B. Transmission and Prevention Information

1. Explain that HIV is transmitted when an infected person engages in specific behaviours with an uninfected person. Anyone who is infected can infect other people by:

- having sexual intercourse (vaginal or anal) without a condom, or incorrectly using a condom;
 - having oral sex (vaginal or penile), particularly in the presence of genital or oral sores/lesions, bleeding gums, or menstrual blood;
 - sharing needles, works, cookers and other drug-injecting paraphernalia;
 - passing it on to babies during pregnancy, birth, and through breastfeeding.
2. Explain that having multiple sexual partners may increase the potential for exposure to HIV and other sexually transmitted diseases. However, exposure to one infected partner can also result in HIV infection.
 3. Explain that the risk of HIV infection through sexual intercourse can be reduced by using full-size latex condoms for anal and vaginal sexual intercourse. Explain the risks regarding oral sex and recommend condoms for this practice.

In addition, condoms can help prevent sexually transmitted diseases (STDs).

No barrier method, including condoms, can guarantee 100 percent protection as product failure or incorrect use may occur. Counselling regarding condom use must emphasise the need for consistency in use, proper application, and the need for the condom to remain intact. The latter may be facilitated through the use of a water-based lubricant. Such counselling should include a demonstration of condom use.

Condoms can deteriorate over time and under adverse conditions. Counsel clients to observe expiration dates, avoid extreme heat, and avoid exposing condoms to oil-based lubricants, which may cause deterioration of latex condoms that results in breakage. Advise clients that condoms should never be reused. Counsel male partners to hold on to the rim of the condom while withdrawing whether or not ejaculation occurred. This prevents the condom from slipping and semen or pre-ejaculatory fluid from spilling out.

4. Explain that the risk of HIV infection through injecting drugs can be eliminated by avoiding drug use. Risk can be reduced by not sharing or by properly cleaning shared needles, works, cookers or other drug paraphernalia. Do not reuse cotton or water. Drug-injecting equipment can be cleaned with bleach (flush needle and syringe two times with bleach, then with water). All injecting equipment must be cleaned before each use. Needle drug users (intravenous or skin-popping) should be advised that needles and syringes sold on the street as safe should be cleaned.

As with sexual contacts, the likelihood of being exposed to an HIV-infected needle-sharing partner increases with the number of partners. Since the HIV infection status of an individual cannot be determined by appearance, sharing needles or works with anyone is risky.

5. Explain that HIV infection cannot be spread by casual contact, including:
 - shaking hands;
 - eating or drinking from common utensils;
 - sneezing or coughing;
 - using public toilets;
 - being around an infected person.

While HIV has been isolated from tears, saliva and urine, there is no documentation of HIV transmission from any of these body fluids.

Dry kissing, except in the presence of open sores or lesions on the mouth, is considered safe. Deep kissing poses a small risk if sores, lesions, or blood are present in the mouth. It may be difficult or impossible to ascertain whether blood is present (e.g., toothbrushing almost always causes gums to bleed).

Counselling should emphasise that there is no evidence of transmission through casual contact..

III. *Discussing the HIV Test*

A. Explain to the client

that all sexually active or needle drug-using persons are encouraged to be tested for HIV. HIV antibody testing is the only way to tell if he or she is infected. In addition, there can be personal and medical benefits to knowing one's HIV antibody status.

B. Tell the client the benefits of being tested:

1. If the test result is negative and the client has not engaged in a high risk behaviour for more than six months, it means that the client is probably not infected with HIV. Discuss retesting, if appropriate.
2. If not infected, the client can take precautions to prevent infection by following basic risk reduction steps (repeat the ways in which infection occurs and can be prevented).
3. If the test result is positive, it means the client is infected with HIV. It is important to know this, so that the client can take steps to receive support, medical evaluation, access treatment (if locally available), and develop a healthy-living plan.

Advise partners of pregnant women, and parents of young children:

4. The children need special medical care which includes:
 - frequent checkups and a clinical evaluation to determine whether HIV infection is present;
 - special immunisations (e.g., inactivated polio vaccine), if HIV antibody positive or infected;
 - regular monitoring if infected and treatment as appropriate.

C. Review psychological and emotional consequences of receiving the test result

Inform the client that anxiety about the HIV test result is a common feeling. Assure the client that you will assist with identifying psychological and emotional support services if needed.

D. Review HIV Antibody Test and Procedure

1. Explain that the HIV antibody test is a blood test. It can show if the person is infected with HIV; it does not show if the person has AIDS. There is no blood test that tells if a person has AIDS.
2. Tell the client that it takes about three weeks to get test results back. Results are given at the post test session and are only given in person.

IV. *HIV Counselling and Testing Options*

A. Explain the difference between confidential and anonymous counselling and testing.

1. Confidential: Explain that the advantage of confidential counselling and testing done in a medical setting is that necessary medical care and services can be provided or arranged. HIV counselling and testing information, including the test result, is recorded in the patient's

medical record. Blood specimens and test results are identified to the laboratory only by a code number, not by name.

2. Anonymous: No personally identifying information is asked at any time. Records and blood specimens are identified by code numbers.

V. Discrimination

Advise the client to be careful of telling other people about having been tested for HIV. People have been discriminated against because of disclosure of HIV-related information. Discrimination may result in termination of employment, loss of housing, or have other negative consequences.

Post Test Counselling - Seronegative

I. Test Result

The patient should receive the HIV antibody test result in person.

- A. Begin post test counselling by providing the test result.
- B. Show the client the lab slip with the recorded test result.
- C. Give the client time to react to the test result and encourage the client to express feelings and concerns.
- D. Address the client's immediate concerns.

II. Meaning of Negative Test Result

A negative HIV test result almost always means that the patient is not infected. Explain that:

- A. If the client has not engaged in risk behaviour in the past six months, the client is most likely not infected with HIV either because he or she was not exposed to HIV, or the client was exposed to HIV but did not become infected.
- B. If the client has engaged in risk behaviour in the past six months, the client may be infected with HIV but may not yet have produced antibodies. People usually produce antibodies within 6-12 weeks after infection. Some people take longer (6 months or more) and a very small number of infected people may never produce antibodies to HIV. Discuss retesting for HIV antibodies, when appropriate, based upon the client's risk history.

Explain to a new mother that if she is infected but her result is negative, the baby may be infected but not yet have HIV antibodies. If the mother is retested and the result is positive, the baby should also be tested.

- C. Explain that a negative test result does not mean that the patient is immune to infection. Exposure to HIV always presents a risk for infection.

III. Risk Reduction

Help the client to understand the negative test result in relation to personal risk.

A. Sexual Risk Behaviour

If appropriate, offer to also give the client's partner(s) risk reduction counselling.

The sexual or drug use history of one's partner is often not reliably ascertained. Therefore, clients should be counselled to avoid sexual intercourse without a condom unless they are certain of their partner's behavioural risk history and HIV serostatus. The only way to be certain that neither partner is infected is if both partners are tested, are negative, and have not engaged in risk behaviour.

Talk about sexual behaviours that may put people at risk (if they are uncertain about their partner's risk history and HIV serostatus). Explain the issues of high risk and low risk.

1. anal intercourse without the male partner using full-size latex condoms;
2. vaginal intercourse without using full-size latex condoms;
3. oral-penile sex, particularly in the presence of genital or oral sores, lesions, or bleeding gums.
4. oral-vaginal sex, particularly in the presence of genital or oral sores, lesions, bleeding gums, or menstrual blood.

B. Drug Use Risk Behaviour

The discussion of needle drug use behaviour (intravenous and skin-popping) is appropriate when counselling patients who use drugs, or are suspected of using drugs.

1. Explain that not using drugs can greatly reduce the potential for acquiring HIV.
2. Although abstinence from all drugs should be strongly encouraged, all drug users should be made aware of the importance of:
 - not sharing needles, works, cookers and other drug-injecting paraphernalia;
 - cleaning all injecting equipment before each use (flush needle and syringe two times with bleach, then with water).
3. Encourage the client to enrol or stay in a drug treatment program.

C. Other Drug Use Behaviour

Explain that the use of any of the following substances may put the patient at risk because it makes it more difficult to practice safer sex:

- alcohol,
- marijuana,
- barbiturates/other sedatives (downers),
- amphetamines/other stimulants (uppers),
- hallucinogens,
- cocaine, crack,
- heroin.

Several factors implicate the emergence of cocaine use, both by injection and smoking, as a risk factor for HIV. Studies show that, compared to heroin, needle-sharing in cocaine injection is more strongly related to HIV infection, possibly due to more frequent injections in cocaine use. Those who smoke cocaine in the form of "crack" may also risk HIV infection due to unsafe sexual practices, including the exchange of sex for drugs. Crack users may also inject cocaine and/or heroin to counteract the extreme effects (highs and lows) of crack.

IV. Individual Prevention Strategy

- A. Help the client to develop a strategy to reduce personal risk of exposure to HIV.
- B. Help the client prepare to use the prevention strategy. Discuss any difficulties anticipated in carrying it out.
- C. Provide information about the proper use of condoms. Advise the patient never to reuse a

condom.

- D. If the last risk for HIV was within six months, encourage the client to be retested.
- E. Encourage the patient to discuss testing with sexual or needle-sharing partner(s) who are at risk for HIV. Explain the importance of partner(s) knowing their HIV serostatus. If both the patient and the partner are negative and without past or current risk, there is no risk of HIV transmission between them.

V. Providing Literature

Provide written information (if the client is literate) that describes the way HIV is transmitted and how to prevent HIV infection. Include materials on sexual risk reduction for all patients, drug use risk reduction when appropriate (i.e., handouts on cleaning needles and works), and information on HIV counselling and testing programmes.

Post Test Counselling - Seropositive

Learning of a positive HIV test result is extremely stressful. Be prepared to work with an anxious or distressed client. Providers in agency settings should be familiar with the agency's policy for getting immediate help for patients in crisis.

I. Test Result

The patient should receive the HIV antibody test result in person.

- A. Begin post test counselling by providing the test result.
- B. Show the client the lab slip with the recorded test result.
- C. Give the client time to react to the test result and encourage the patient to express feelings and concerns.
- D. Address the client's immediate concerns.

II. Helping the Patient Cope with the Test Result

- A. Set a supportive and encouraging tone.
- B. Be prepared to deal with the client's emotions which may include: disbelief, anxiety, anger, guilt, depression, apathy, and fear of death. If the patient becomes distressed:
 - stay with the client and respond to the situation; listen to the client's concerns;
 - help sort out the issues;
 - help identify coping mechanisms used in other crisis situations;
 - offer to assist the client in contacting crisis support services and provide a confidential place for the patient to use the telephone.
- C. Discuss the client's feelings about the test result and how the client anticipates handling this information during the next 48 hours and over time.
- D. Remind the client about support systems identified in the pre test session. Ask who the client can talk to about the test result, such as a family member, friend, or other person. If the client identifies someone, discuss how the client might tell that person and what the reaction might

be.

E. Provide the client with referrals for emotional support.

III. Meaning of Positive Test Result

The test showed that antibody to HIV was present.

A. A positive HIV test result means:

1. the client is infected with HIV and antibodies to the virus were produced;
2. the client has active virus and can infect others.

B. A positive test result does not mean the patient has AIDS.

IV. Medical Follow-Up

A. Explain the importance of getting into medical care as soon as possible.

1. Laboratory tests can tell how the immune system is functioning and show if HIV related infections or cancers are present.
2. Treatments are available that may slow the progression of HIV disease and prevent some infections.

B. Explain that a medical evaluation includes:

1. medical and personal history;
2. physical examination;
3. tests of immune system functioning;
4. tests for other infections such as sexually transmitted diseases and tuberculosis.

C. Emphasise the importance of following good health care practices.

D. Stress that it is important to stay in a medical treatment program to get regular medical checks and information about new medical treatments.

E. Explain that a positive test result may mean that partners and children could be infected with HIV. If this is the client's first HIV test, the client should be encouraged to refer partners and children for HIV antibody testing and medical evaluations. Provide the client with medical and counselling referrals for partners and children.

F. If the client is pregnant or has recently delivered, inform her that:

1. all babies are born with their mother's antibodies; therefore, if the mother has antibodies to HIV, her baby will test HIV antibody positive at birth;
2. the mother's infection does not necessarily mean that the baby is infected with HIV; research studies suggest that approximately 30-50 percent of babies born to infected women are infected themselves;

3. if the baby is not infected, the baby should test negative by 18-24 months of age;
 4. if the baby is infected, it is possible that the baby will test positive at birth, test negative for a period of time, and then test positive again, after the production of the baby's own antibodies;
 5. it is important for the baby to receive regular medical care from a physician who is knowledgeable about HIV, and that the physician providing care to the baby be aware of the mother's infection so that the health status of the infant can be closely monitored;
 6. women who are breastfeeding, or planning to breastfeed, should discuss the risk of possible HIV transmission with a physician who is knowledgeable about HIV.
- G. Women who are considering future pregnancies should consult a physician who is knowledgeable about HIV to review reproductive options.

V. Transmission Reduction

Emphasise that although the client may not have any signs or symptoms of HIV infection, the client can transmit infection by:

- having sex without a condom, or incorrectly using a condom;
- sharing intravenous needles, works, and other drug paraphernalia;
- passing it to the baby during pregnancy, birth, and breastfeeding.

Stress that HIV is not spread through casual, household transmission. Discuss risk reduction strategies, based on a review of the client's sexual and/or drug use behaviours. Explain that the steps below may keep the client from getting other infections and from passing HIV infection on to others. Offer to explain the following risk reduction strategies to both the client and any partners.

A. Sexual Risk Reduction

1. HIV transmission can be prevented by not having vaginal, oral, or anal sex.
2. The risk of HIV transmission can be reduced during vaginal-, anal-, and oral-penile sex by preventing contact with body fluids (semen, blood, and vaginal secretions) through the male partner's use of full-size latex condoms every time they have sex. Condoms reduce but do not eliminate risk. Demonstrate how to properly use condoms. Advise the patient never to reuse a condom.
3. The risk of HIV transmission from partner to partner during oral sex (vaginal or penile) increases when oral or genital sores/lesions are present.
4. If appropriate, discuss birth control methods with the HIV positive woman. Provide information about the increased risk of infection (e.g., pelvic inflammatory disease) associated with using an IUD. Remind the client that some birth control devices, such as the contraceptive pill, offer no protection against the transmission of diseases, including HIV. The effectiveness of diaphragms or cervical caps as barriers to HIV has not been demonstrated.

B. Drug Use Risk Reduction

The discussion of needle drug use behaviour (intravenous and skin-popping) is appropriate when counselling patients who use drugs, or are suspected of using drugs. Explain that:

1. HIV transmission can be prevented by not sharing drug-injecting equipment.
2. Stress the importance of cleaning all injecting equipment before each use (flush needles and syringes two times with bleach, then with water).

Encourage the drug-using client to abstain from drug use and to enrol or stay in a drug treatment programme.

Explain to the patient that use of the following substances may put HIV negative partner(s) at risk, if the patient or partner is unable to adhere to safer sex behaviours:

- alcohol,
- marijuana,
- barbiturates/other sedatives (downers),
- amphetamines/other stimulants (uppers),
- hallucinogens,
- cocaine, crack,
- heroin.

Several factors implicate the emergence of cocaine use, both by injection and smoking, as a risk factor for HIV. Studies show that, compared to heroin, needle-sharing in cocaine injection is more strongly related to HIV infection, possibly due to more frequent injections in cocaine use. Those who smoke cocaine in the form of “crack” may also risk HIV infection due to unsafe sexual practices, including the exchange of sex for drugs. Crack users may also inject cocaine and/or heroin to counteract the extreme effects (highs and lows) of crack.

C. Additional Risk Reduction

Clients testing HIV positive should be advised:

1. not to donate blood or blood products, organs, tissue, breast milk, or sperm;
2. not to share toothbrushes, razors, or other items that could become contaminated with blood; this measure is recommended even though these items have not been shown to transmit HIV;
3. to clean and disinfect surfaces on which blood or other body fluids which may contain blood have spilled (a solution of 1/4 cup bleach to one gallon of water is effective).

D. Individual Risk Reduction Strategy

1. Discuss options and strategies to reduce the risk of HIV transmission to partners.
2. Discuss any difficulties the client anticipates in carrying out the risk reduction plan.
3. Offer to help practice how the client will handle difficult situations.

VI. Individual Follow-Up Plan

A. Medical and Support Services

1. Provide or refer the seropositive client for medical care.
2. Provide or refer the patient for needed support services, i.e. a local Positive Support Group.

3. Provide or refer the seropositive client who abuses alcohol or drugs to an alcohol or drug treatment programme.

Offer to assist the client with calling service providers; provide a confidential place for the client to use the telephone.

B. Partner Notification

The client who tests positive for HIV should be encouraged to directly notify partner(s).

1. Ask if the client discussed the risk of HIV exposure and testing with partner(s).
2. Encourage the client to directly notify partner(s) and help develop a notification plan. Offer to practice how the client might tell the partner(s).
3. If possible, offer to provide counselling and testing for the partner(s). Otherwise encourage the client to refer partner(s) for HIV counselling and testing. Give the client written information about HIV counselling and testing programs if he or she is literate.
4. Explain why it is important for partner(s) to know their HIV status:
 - if positive, referral for medical evaluation and treatment is available;
 - early treatment may slow down HIV disease and prevent the onset of some infections.

VII. Providing Literature

Provide written information that discusses HIV infection and describes the ways HIV is transmitted and how it can be prevented. Include materials on sexual risk reduction and drug use risk reduction when appropriate (i.e. handouts on cleaning needles and works). The client should be literate.

VIII. Discrimination

Advise the client to be careful of telling other people about having tested HIV positive. People have been discriminated against because of disclosure of HIV-related information. Discrimination may result in being denied health or life insurance, denied or terminated from employment, or denied housing.

adapted from the New York State Health Department AIDS Institute

SUMMARY

Before the test

A good counsellor should always discuss these things with a client:

1. All about HIV/AIDS and risks
2. Why you want the test
3. Why do you think you are at risk
4. What the testing procedure is
5. What a negative result means
6. What a positive result means
7. Who will you tell your result to
8. Developing a sexual health strategy

After the test

These issues should be covered after the test

1. What your test result means
2. What do you do with your test result
3. Safer sex and safer injecting
4. Support your health
5. Support systems for the client
6. Who does the client inform
7. Partner notification

TAKING THE TEST

The HIV anti-body test

(also known as the "AIDS" test)

THINKING OF HAVING A TEST?

There are lots of things to think about before deciding to have a test. This document looks at some of the problems you may be facing as well as giving information about what the test is, how to have a test, and what the result means.

Before making a decision, it is strongly recommended that you talk to an experienced counsellor about your particular situation. Everyone is different and everyone has a different set of questions to face. Discussing these questions with someone who understands how a test can affect you will give you much more confidence to make the right decision.

Ensure that you can have such a test with strict confidentiality. Check into the situation in your town or city.

HAVE YOU BEEN AT RISK?

HIV is the virus which can lead to AIDS. It can only be transmitted in a limited number of ways.

If someone is infected with HIV their blood, semen or vaginal fluid may carry enough HIV to infect other people. HIV can only be passed from an infected person to someone else if blood, semen or vaginal fluid passes into their blood stream. There are four ways in which this can happen:

1. Having penetrative sex (either vaginal or anal) without a condom. Using a condom can protect you and your sex partner from HIV.
2. Sharing needles or other injecting equipment.

If you're injecting you should always use new equipment every time.

Tattooists should always use sterilised equipment and fresh ink.

3. From mother to baby during pregnancy.
4. Through infected blood and blood products entering the bloodstream.

Giving oral sex (licking or sucking a man or woman's genitals) carries a small risk of HIV transmission.

WHAT DOES THE TEST MEAN?

Often the HIV anti-body test is called an AIDS test. But it is not a test for AIDS. AIDS is just a name for a collection of diseases which develop because the body's immune system breaks down. This is caused by a virus - HIV, the Human Immunodeficiency Virus. The test will tell you whether or not you have HIV, the virus which can cause AIDS. It will not tell you that you have AIDS.

If you do have HIV you may still be perfectly well. You may stay well for a long time.

The test is not for HIV itself, but for antibodies to the virus. When any virus enters your body, body tries to destroy it. One of the ways it does this is by making special killer substances called antibodies. For reasons not fully understood HIV antibodies do not destroy HIV.

When HIV enters someone's bloodstream, these antibodies may not appear straight away. In most people the antibodies appear six weeks after infection. It can take three months for antibodies to appear, and clinics will advise you to have your test at least three months after the time you could have become infected. Some people request a further test at six months as confirmation that infection has not occurred.

DECIDING WHETHER TO TEST

Knowing

Perhaps you want to get tested because you want to know for sure whether you have HIV or not. You may feel that knowing as much as possible about your life gives you more control. You might be confident that you are not infected but feel the need to be absolutely sure. Perhaps you are worried that you are HIV positive. This may be because of a particular reason or it may just be a general fear.

Not knowing your HIV status can be very stressful. You may feel that knowing the result, whether it is positive or negative, will help you make decisions about the direction of your life.

On the other hand, you might feel that not knowing is better. You may decide that a positive test result would be much harder to deal with than the worry of not knowing.

Living with HIV can be very difficult to come to terms with. If you are not ill you may stay well for many years. We don't know yet whether everyone with HIV will eventually develop AIDS. But living with the knowledge that you may get ill at any time can be challenging and hard.

This can be a very difficult choice to make. Whether or not you know your HIV status, you can help protect yourself and your partners by practising safer sex and safer drug use.

GOING FOR A TEST

Preparing for a test

An HIV test can have a huge impact on your life. Before deciding to have a test think carefully about your reasons for wanting one and how the different possible results will affect you.

There may be people you want to talk to and get support from. But think first about how your test result could affect them and your relationships with them.

Going for a test can be very stressful and traumatic. Taking someone with you can be very reassuring. Make sure you choose someone you feel you can trust with your test result.

Where to go

There are a growing number of private clinics which will conduct the test. Also there may be several government centres which will also conduct the test. Find out how good and reliable they are, how much they respect confidentiality, and whether they can conduct the test anonymously.

What to Expect

The test itself only requires a sample of your blood to be taken. This sample will be used for several separate tests to make sure the result is correct. The doctor may ask personal questions of you.

You may have to wait for up to three weeks for the result.

A NEGATIVE RESULT

A negative result can mean either that you do not have HIV or that you have not yet developed antibodies to HIV.

Remember that this is a test for antibodies to HIV. Antibodies may not appear until three months after infection.

But remember, a negative result today is no protection against HIV infection tonight.

A POSITIVE RESULT

However well you have prepared yourself, the most common reaction to a positive diagnosis is one of shock. This can take many forms, from feeling euphoric - "I knew anyway", to total despair. It can take time for the news to sink in, and longer for you to come to terms with what it means to you. Make sure that you have a supportive network and/or agency to help give guidance.

Dealing with the result

Accepting a positive diagnosis can be very difficult for you and those around you, even if you have talked it through beforehand. You will be faced with the dilemma of who else should know about your result. It's a good idea to allow yourself a lot of time in deciding who to tell. Think about whether others will pass on the information without asking you. This includes partners, family friends, and people at work. Remember there is no need to rush. In the meantime you will be able to talk about your result with a counsellor if you want to. Then, when you are ready, you can choose who else to tell.

One problem faced by a lot of people is that in telling family, partners and friends about their positive status they may also have to deal with questions about their sexual and/or drug taking behaviour. This can be very difficult. Talking this through with a professional counsellor can be very useful, whether or not you have the support of those close to you, but especially if you don't. This can be done in complete confidence and may help you deal with your situation in a way that is best for you as an individual. Seeking this help is not a sign of weakness or of being unable to cope. It is actually the first step towards coming to terms with your diagnosis.

What does a positive result mean?

A positive result tells you that you have HIV but does not tell you anything about the state of your health. People with HIV can experience a range of different conditions from well and healthy to life-threatening illness. It is impossible to predict the course of any individual's infection.

Looking after yourself

One of the most important things to think about is having good medical back-up.

Treatments

One of the potential benefits of knowing your status if you are HIV positive is that you can have your health monitored and take measures to look after yourself.

Keeping Healthy

There are other measures you can take to look after yourself if you are HIV positive, such as a healthy diet and taking exercise. Herpes, stress, poor diet, drugs, alcohol, smoking and poppers are some of the things believed to increase the risk of someone with HIV developing AIDS. It makes sense to avoid as many of these as possible, though stopping things like smoking and drinking at such a stressful time may be counter-productive if it makes you miserable.

Sex

Being HIV positive can change your feelings about sex, but does not mean you have to make drastic changes to your sex life. Safer sex will protect your partner from HIV, and will protect you from any sexually transmitted disease which might harm you. Safer sex is the same whether you are positive or negative.

Condoms, if used properly, are an effective barrier against HIV when used in anal and vaginal penetrative sex. Oral sex is very much safer than penetrative sex without a condom. If you want to be extra careful, use a condom.

Kissing, licking, body rubbing and mutual masturbation are safe but sex toys (e.g. vibrators or dildos) shouldn't be shared.

Rimming (oral-anal contact), whilst unlikely to transmit HIV, may be unwise for someone with HIV because of the risk from hepatitis, parasites or intestinal infections. A vaccine against hepatitis B is available which can be given to someone with HIV infection.

Whether to inform sexual partners of your HIV status can be a difficult question. If you have safer sex every time you may feel you don't need to tell people. Or you may feel more comfortable if you do.

It could be that you go off sex altogether at first. This is a common and normal reaction. However, if this becomes distressing it could mean that you need some help working through it.

Wives and children

If you are married, and you are tested positive, then you will need to have your wife, If you children are young, they too may need to be tested. Seek support from your counsellor as the best way to deal with this issue.

Risks to Children

Being cared for by someone with HIV poses no special risk of infection to a baby or child. HIV is not passed on in food prepared by someone with HIV. Any amount of kissing and cuddling is perfectly all right.

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YOUR NOTES

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