

Operating

Guidelines for

HIV & AIDS Core Team

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Department of Health

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ACRONYMS

AIDS	Acquired Immune Deficiency Syndrome
ALT	Alanine Transaminase
AST	Aspartate Transaminase
ART	Antiretroviral Therapy
ARV	Antiretrovirals
AO	Administrative Order
BUN	Blood Urea Nitrogen
CBC	Complete Blood Count
CSF	Cerebrospinal Fluid
DSWD	Department of Social Welfare and Development
ER	Emergency Room
FBS	Fasting Blood Sugar
HACT	HIV and AIDS Core Team
HCT	HIV Counseling and Testing
HCW	Health Care Worker
HEPO	Health Education and Promotion Office
HIV	Human Immunodeficiency Virus
HIV Ab	HIV Antibody
ICC	Infection Control Committee
IHBSS	Integrated Behavioral and Serologic Surveillance
IPT	Isoniazid Preventive Therapy

MAC	Mycobacterium avium complex
MARP	Most at-risk population
NASPCP	National AIDS/STD Prevention and Control Program
NGO	Non Government Organization
OPD	Out-Patient Department
PCP	Pneumocystis jiroveci Pneumonia (formerly Pneumocystis carinii pneumonia)
PE	Physical examination
PEM	Post Exposure Management
PICT	Provider-Initiated Counseling and Testing
PLHIV	People Living with HIV
PMTCT	Prevention of Mother to Child Transmission
PPD	Purified Protein Derivative
RPR	Rapid Plasma Reagin
SACCL	STD/AIDS Cooperative Central Laboratory
STI	Sexually Transmitted Infections
TCS	Treatment, Care and Support

DEFINITION OF TERMS

Acquired Immune Deficiency Syndrome (AIDS): condition in a person infected with HIV characterized by significant depression of the immune system and presence of clinical signs and symptoms of opportunistic infections and malignancies.

Antiretroviral therapy: combination of drugs that blocks different steps in the process of HIV multiplication inside the CD4 T-cell.

CD4 T-cell: subset of lymphocytes that plays a central role in the immune system.

HIV and AIDS Core Team (HACT): a team of doctor, nurses, medical technologist, social worker, dentist, and other health care personnel in charge of HIV and AIDS management in the hospital.

Human Immunodeficiency Virus (HIV): the name of the virus that causes AIDS.

HIV antibody (HIV Ab): substance produced by the body in response to the entry of the HIV into the body; it is not effective in neutralizing the virus.

HIV antibody test: usually refers to the laboratory test to detect the presence or absence of HIV antibody. This antibody indicates whether an individual has been exposed to the virus.

HIV counseling: a confidential communication between a client and a care provider aimed at enabling the client to cope with stress and take personal decisions relating to HIV and AIDS. The counseling process includes the evaluation of personal risk of HIV transmission, the facilitation of preventive behavior and evaluation of coping mechanisms when the client is confronted with a positive result; among others.

HIV education: a process of providing information to increase knowledge and educate and motivate behavior change; it is not usually confidential and conducted in small or large groups of people.

Mycobacterium avium complex (MAC): an opportunistic infection caused by Mycobacterium avium and Mycobacterium

intracellulare and is usually found among HIV infected individuals with CD4 T-cell count below 100 cells/cumm.

Pneumocystis carinii pneumonia (PCP): a severe infection of the lungs, usually appears when CD4 T-cell falls below 200 cells/cumm.

Pre-test counseling: a counseling process that helps to prepare the client for the HIV test. It also explains the implications of knowing that one is or is not infected with HIV, and facilitates discussion about ways to cope with knowing one's HIV status.

Post-test counseling: a counseling process conducted by a health worker to help the client understand and cope with the HIV test result. Whenever possible, it is recommended that the counselor who provided pre-test counseling also provides post-test counseling.

RA 8504: Philippine AIDS Prevention and Control Act of 1998.

Risky behaviors: activities known to increase a person's chance of acquiring HIV infection (e.g., having unprotected sex, multiple sex partners, and injecting illicit drugs).

Treatment hub: A hospital facility with an established HACT providing prevention, treatment, care, and support services to PLHIV, including but not limited to HIV counseling and testing, clinical management, and patient monitoring. ARVs can only be accessed through these facilities.

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For the past two years, there is a noticeable increase in the number of new cases of HIV. From January 1984 to January 2013, the Philippine HIV and AIDS Registry recorded a total of 12,082 HIV antibody seropositive cases. In 2000 until 2004, one new infection was registered every three days. In 2007, the average was one new case registered every day; the average in 2012 stands at nine (9) new infections reported per day.

While preventing the transmission of HIV is an important component of the country's response, the Philippines has also undertaken programs to provide treatment, care and support services to people living with HIV (PLHIV).

Prior to the passage of RA 8504, or the Philippine AIDS Prevention and Control Act of 1998, the Department of Health (DOH) issued Administrative Order (AO) No. 18 series of 1995 which standardized the clinical management of HIV and AIDS by mandating DOH-retained tertiary hospitals to establish an HIV and AIDS Core Team (HACT).

With the passage of RA 8504, the establishment of HACT was expanded to cover all local government and private hospitals. RA 8504, which also prescribes penalties for persons or institutions found guilty of violating the law's provisions, mandated the HACT of each hospital to oversee the implementation of policies and guidelines on all matters pertaining to HIV and AIDS in the healthcare setting.

This necessitated the need to develop comprehensive and standardized guidelines on the treatment and clinical management of PLHIV, as well as on preventing the risk of transmission in a hospital setting. In 2009, the guidelines were assessed to determine how it could be further improved and make the HACTs more effective in carrying out their mandates. The assessment, which would be published independently, yielded valuable insights and recommendations from people and organizations who directly work with the PLHIV. A workshop was then conducted to revise the guidelines, taking into consideration the results of the HACT assessment and inputs from the HACTs, civil society organizations, and PLHIV.

Although the guidelines are strictly for the management of PLHIV in a hospital setting, this revised manual reflects the actual practices and situations in local areas, particularly the meaningful engagement of non-government organizations and PLHIV to partner with the HACTs.

The guidelines may be adapted according to local situations and conditions. It is hoped that this manual would be useful not just for the HACTs, but also for PLHIV and NGOs in understanding and doing HIV and AIDS treatment, care, and support activities.

OBJECTIVES

1. To assist the hospitals in strengthening the capability of the HIV and AIDS Core Team;
2. To define the minimum expected HIV services in hospitals, including HCT and PMTCT;
3. To define roles and responsibilities of the HACT and its individual member.

Specific Objectives:

- a. To provide guidance to HACT on setting up systems on providing the following services: HIV counseling and testing, PMTCT, ARV, etc.
- b. To establish linkages with NGOs and other treatment hubs for access of other services and more advanced clinical management of PLHIV.
- c. To provide continuing health education in the workplace among hospital employees, in coordination with the Health Education and Promotion Office (HEPO).

SCOPE AND LIMITATION

On the basis of the above-mentioned objectives, these guidelines shall prescribe the minimum services that a functional HACT must be able to perform/deliver.

These guidelines will not provide detailed discussions on the provision of specific services to patients/clients. It is highly recommended to use these guidelines in consonance with other existing guidelines and manuals covering more specific aspects of TCS such as the following:

- Post Exposure Management (PEM) for HIV, Hepatitis B and C in Health Settings
- Palliative Care Manual for People Living with HIV
- AO 2010 - 0028: Policies and Guidelines in the Conduct of Human Immunodeficiency Virus (HIV) Counseling and Testing in Community and Health Facility Settings

- Guideline on the Integrated Management of Pediatric HIV and AIDS
- AO 2009 - 0006: Guidelines on Antiretroviral Therapy (ART) among Adults and Adolescents with Human Immunodeficiency Virus (HIV) Infection
- AO 2009 - 0016: Policies and Guidelines on the Prevention of Mother to Child Transmission of Human Immunodeficiency Virus (HIV)

The HIV and AIDS Core Team (HACT) will be the primary group tasked to provide treatment, care, and support services to PLHIV, as well as to implement policies and guidelines on matters relating to HIV and AIDS in a hospital setting. Depending on the organizational structure/specialty of the hospital, the Infection Control Committee (ICC) may also function as the HACT.

COMPOSITION

As a multidisciplinary group, the HACT shall be composed of, but not limited to, doctors, nurses, and allied medical professionals. At the minimum, the HACT should have physicians, nurses, medical technologists, psychiatrists/psychologists, pharmacists, nutritionists, and medical social workers. Other health care workers (HCW) and allied staff may be tapped as the need arises (e.g., a Human Resource office may be tapped to assist in the orientation of new employees and staff).

Team leaders and members should have received specified trainings on HIV and AIDS, including HIV clinical management, counseling, stigma and discrimination, gender sensitivity, and orientation on RA 8504.

For the criteria for the selection of HACT leader and members, refer to Administrative Order (AO) No. 9 s. 1997.

FUNCTIONS AND DUTIES OF HACT LEADERS AND MEMBERS

Team leader/physician

- Coordinates with the Hospital Infection Control Committee in the strict implementation of prevention and infection control measures within the hospital
- In-charge of the medical management of the patient/client
- Ensures follow-up of patient/client and referral to other specialties, NGOs, or treatment hubs as necessary
- Conducts trainings and research
- Ensures that HACT members are updated on all issuances (Administrative Orders, Executive Orders) pertaining to HIV and AIDS
- Submits report of HIV infection/AIDS to the National AIDS Registry

- Provides pre- and post-test counseling
- Encourages active participation of NGOs and PLHIV support groups in the treatment, care, and support of PLHIV
- Spearheads the establishment of mechanisms/policies for HIV and AIDS within the hospital setting
- Ensures turn-over of responsibilities in case a member or the leader resigns, or is re-assigned
- In-charge of handling grievance and receiving feedback (e.g., complaints from patient/client, family members, significant others, other section(s)/department(s) within the hospital, etc.)
- Acts as resource person/facilitator in training activities related to HIV

Team members:

Dentist

- Coordinates with ICC in the strict implementation of prevention and infection control measures within the dental clinic
- In-charge of the oral care and management of the patient
- Disseminates oral health information and counseling
- Ensures follow-up of dental patients
- Facilitates referral to specialists when necessary
- Conducts training and research related to dental field

Nurse

- In-charge of the nursing management of client
- Coordinates client referrals within the hospital
- Promotes health education activities in the hospital
- Conducts training and research activities for nurses and auxiliaries
- Ensures implementation of infection control guidelines
- Provides pre- and post-test counseling

Medical Social Worker

- In-charge of evaluating the social welfare needs of the patient/client during admission or OPD visits
- Provides psychosocial support services, including counseling to HIV-positive clients, their families, and significant others
- Coordinates and establishes linkages with government agencies and NGOs for other support services
- Identifies existing resources for efficient networking
- Assists in providing alternative source of income or livelihood

- Provides continuing psychosocial support
- Coordinates with the DSWD on matters concerning minors without parents or legal guardians, or for any services as the need arises
- Provides health education
- Conducts home visits/follow-ups
- Conducts training and research related to social work activities
- Provides pre- and post-test counseling

Medical Technologist

- Ensures that pre-test counseling is provided with a written informed consent
- Performs appropriate laboratory procedures according to set technical standards
- Ensures proper laboratory waste disposal
- Implements guidelines on laboratory safety and preparations
- Ensures that test results are reviewed and duly signed by the laboratory chief before releasing to HACT physician
- Ensures smooth referral to NRL-SACCL as the need arises

Pharmacist

- Dispenses the appropriate dosage and quantity of ARV and/or other needed medicines, as prescribed by the HACT or the attending physician
- Reinforces clear instructions on how to take ARVs and the importance of strict compliance
- Monitors client for any adverse reaction and report this to the HACT or the attending physician
- Monitors and manages the stock level of ARVs, if available, and ensure uninterrupted supply of the same

Nutritionist

- Educates client on the need for proper nutrition and healthy living
- Prepares dietary guidelines for client upon discharge

Psychiatrist/psychologist

- Assesses the mental and emotional well-being of the patient/client
- Evaluates the psychosocial needs of the patient/client during admission or OPD visits
- Provides periodic counseling to patient/client and/or their families as appropriate

The number of health care workers (HCW) that will be directly or indirectly involved in patient care would vary depending on the nature of the case and the type of hospital. More complicated cases would likely require the participation of health professionals from various sections/departments in the hospital. Exposure of medical students, interns, and student nurses in training/teaching hospitals on HIV and AIDS are important to ensure the sustained availability of skilled HCWs in this area. Strict confidentiality must be observed at all times.

It is the responsibility of the hospital to ensure that policies and/or mechanisms are in place to prevent a breach in confidentiality.

CONDUCT OF HCW, INTERNS, TRAINEES, AND OTHER STAFF IN CONTACT WITH THE PATIENT/CLIENT

- All HCWs and staff who are directly involved in patient care must handle information responsibly and must act with utmost professionalism.
- Access to patient/client and medical chart shall be limited to people involved in the direct care of the patient with proper orientation.
- The attending physician must explain to the patient/client the hospital procedures, policies, and activities relevant to his or her care and the type of hospital personnel and trainees that would be involved in his or her case and would have access to the medical records with assurance of strict protection of confidentiality.
- Training officers are tasked to provide orientation and conduct information dissemination focused on issues of confidentiality based on RA 8504 for HCWs, interns, clerks, and other trainees (from medical, nursing, laboratory, pharmacy).
- Prior to referral to another physician, a written informed consent must be obtained from the patient/client.
- Any procedure/intervention to be done must be thoroughly explained to the patient/client and a written informed consent must be obtained.
- A code for HIV and AIDS diagnosis must be used during ward rounds, endorsements, etc. especially in areas where other patients and watchers can overhear the case discussions.

HANDLING AND SAFEKEEPING OF MEDICAL RECORDS

- In ordering an HIV screening for the patient/client, use "HCT" as a code for HIV counseling and testing.
- Medical chart information will include the name of the patient/client, laboratory test results, and complete diagnosis. Code for HIV and AIDS diagnosis must be used in filing records.
- Medical record staff should be oriented on the issue of confidentiality as stated in RA 8504. Medical record clerks must handle the information on patients/clients responsibly.
- All types of medical certificates should include the patient/client's complete diagnosis. The patient/client must be informed of this policy prior to the issuance of certificate. This certificate must be properly endorsed to the concerned agency/office. The receiving agency/office must have proper orientation regarding issue of confidentiality based on RA 8504 and must handle the endorsed information responsibly.
- A written informed waiver of confidentiality or consent for the release of information must be obtained from patients/clients asking for medical certificates and abstracts. Patients/clients should also be informed that the released records should not be used for any purposes other than what it is requested for (e.g. processing of medical claims from private and/or public insurance services, etc.).
- Records may be kept separately, with only a selected group of persons able to access the files to ensure confidentiality. In cases where records of patients/clients are not kept separately, codes may be used.



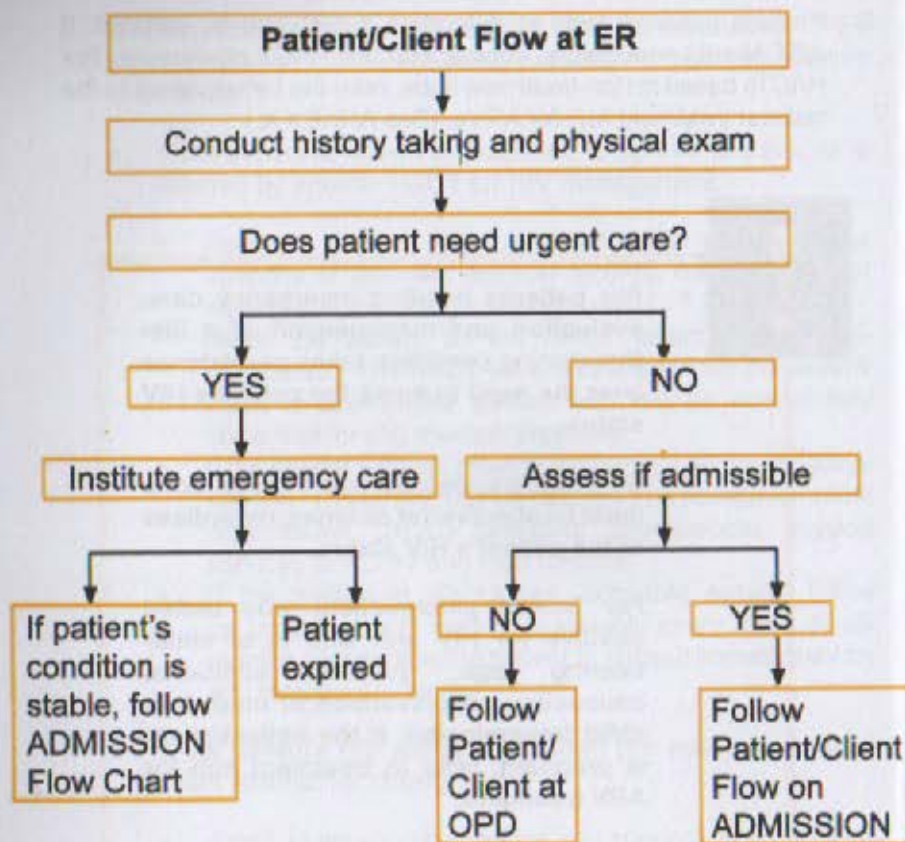
Strict confidentiality must be observed at all times. The confidentiality clause applies to all hospital personnel dealing with PLHIV and/or handling the patient/client's medical records, as well as to other agencies, both private and government, where medical records of the patient/client may be transmitted (e.g., insurance companies, Philhealth). As per RA 8504 Sec.33, violation of the confidentiality clause is punishable by six months to four years imprisonment. Administrative sanctions, which may include fines and revocation of licenses, may also be meted to individuals found violating the confidentiality clause.

1. Get the patient's history and conduct physical examination (PE). Strict adherence to standard safety precautions must be observed at all times.
 - a. If the patient is known or disclosed to be HIV positive, or is referred by another HACT for HIV management:
 - Secure a copy of most recent HIV test results. In the absence of pertinent medical records, the patient/client would have to undergo testing anew.
 - Refer the patient to the HACT chairperson or co-chairperson. The HACT will evaluate and refer the patient/client to appropriate person who will be immediately consulted for any medical problems.
 - If the patient expires, provide the family with psychosocial support. The family may be referred to a non-government organization (NGO) providing psychosocial support services to PLHIV and their families.
 - If the patient is discharged, schedule regular follow up treatment and testing, preferably every three or six months. Encourage the patient to consult immediately for any medical problems.
 - b. If the patient's HIV status is unknown (for walk-in or patient/client referred for testing):
 - Admit to appropriate service and conduct initial work-up and treatment. Identify the patient's risk factors and check for AIDS-defining conditions.
 - If the patient has no risk factors and AIDS-defining conditions, manage the illness accordingly.
 - If the patient has risk factors and/or AIDS-defining conditions, refer to HACT for counseling and testing. Other health care workers (HCW) who are trained to provide pre-test counseling may also be tapped.
 - If patient is negative for HIV, manage the illness accordingly. Provide post-test counseling and encourage the patient to retake the test after three months, if needed.
 - If the patient is positive, proceed with the medical management of the illness. Provide post-test counseling and psychosocial support.

2. Perform baseline tests to determine if ART can be initiated. If ART should commence, consult with the HACT pharmacist. For HACTs based in non-treatment hubs, refer the patient/client to the nearest treatment hub for ARVs. (See ANNEX A.)



- **For patients needing emergency care, evaluation and management of a life-threatening condition takes precedence over the need to know the patient's HIV status.**
- **Strict adherence to standard precautions must be observed at all times, regardless of the patient's HIV status.**
- **For female patient/client who tested positive for HIV and who is of child-bearing age, provide additional counseling on prevention of mother to child transmission. If the patient/client is pregnant, refer to treatment hub for ARV treatment.**
- **For infants born to HIV-infected pregnant women who have not received ARV drugs during pregnancy and labor, a referral must be done to the nearest treatment hub to access ARV drugs for the newborn as prophylaxis. This should be started immediately after delivery or within 12 hours after delivery.**



The approach to management of patients with HIV and AIDS in the hospital setting is no different from what is required for other diseases. Components of good practices such as professionalism, respect for patient's rights to privacy and confidentiality, non discriminatory actions, and ensuring access to optimum care and adherence to universal precautions must be observed at all times regardless of the type of illness.

HIV SCREENING

Health facilities represent a key point of contact among PLHIV who are in need of HIV prevention, treatment, care and support. Patients/clients consulting at the out-patient clinic or emergency room may not know or may not reveal their HIV antibody status. OPD/ER clerks, nurses, interns, or attending physicians may collect general data of patient. The attending physician must take patient history and perform thorough physical examination.

HIV screening is a three-part process starting with pre-test counseling, followed by HIV testing, and then post-test counseling. The patient/client should be informed of all the processes involved and it should be done if and only if the patient/client voluntarily agrees and a written informed consent for HIV testing is obtained. Pre- and post-test counseling should be done in a private and quiet place with only the counselor and the patient/client, unless the patient/client requests for the presence of a companion during the session.

For minors and critically ill patients/clients, an informed consent/dissent may be obtained from legal guardians. All guidelines specified here would then apply to the signatory. In cases where it is not possible to obtain the consent of the parent or legal guardian (e.g., if the patient/client is a street child and not under the custody of the Department of Social Welfare and Development), the HACT, through the medical social worker, should immediately consult with the local social welfare office and discuss appropriate measures to be undertaken for the best interest of the child/patient.

I. PRE-TEST COUNSELING

Counseling prior to HIV testing is important to prepare the patient/client for the possibility of a positive diagnosis.

1. All patients/clients must undergo pre-test counseling before HIV antibody testing.
2. The procedure for HIV testing must be thoroughly discussed with the patient/client during pre-test counseling.
3. Pre-test counseling may be done by a health care worker (HCW) who is not a member of the HACT, provided that he or she is properly trained on HIV counseling and testing.
4. In case the pre-test counseling will be done by an HCW who is not a member of the HACT, the patient/client should be informed that he or she will eventually be referred to the HACT.
5. Further assessment must be conducted by the attending physician, or the HACT together with the attending physician, if possible.
6. Counseling must be conducted in private unless the patient/client would request for the presence of spouse, relative, or companion during the session.
7. If the patient/client is a minor, use age-appropriate language and counseling methods.
8. In case the patient/client opted not to proceed with the testing, a waiver may be obtained.

Since knowledge of one's HIV status is critical to accessing HIV treatment, care and support in a timely manner, diagnosis of HIV infection must be facilitated. Hence, HCWs are encouraged to conduct provider-initiated counseling and testing (PICT) when one or more of the following initial clues is/are present:

1. Patient/Client or his/her sexual partner has one or more of the following **risk factors**:
 - multiple sexual partners
 - unprotected sex with a person who has multiple sexual partner
 - history or recent diagnosis with sexually transmitted infections (STI)
 - history of intravenous drug use for recreation purposes
 - unprotected sex with an HIV positive person
2. Patient/Client with clinical conditions suggestive of HIV infection in the absence of other causes of immune deficiency (AIDS-related illnesses)

3. Children below 15 years old born to HIV positive mothers, whether or not they have clinical conditions suggestive of HIV infection in the absence of other causes of immune deficiency

HCWs practicing PICT should still be guided by the principle of **Three (3) Cs** in HIV Testing:

1. Informed Consent
2. Counseling
3. Confidentiality

At the minimum, the following should be emphasized to patients/clients who will undergo PICT:

1. the reason why HIV testing and counselling is recommended
2. the clinical and prevention benefits as well as potential risks of testing
3. the follow-up services that will be offered in case of either HIV-negative or HIV-positive result
4. the fact that test result will be treated with confidentiality
5. the right to refuse or to 'opt out' of a systematic offer of testing
6. that declining an HIV test will not affect the patient's access to services that do not depend upon knowledge of HIV status
7. in the event of a positive test result, encouragement of disclosure to other persons who may be at risk of exposure to HIV
8. an opportunity to ask questions

II. HIV TESTING

1. A written informed consent must be obtained prior to HIV testing.
2. Request for HIV testing must be written on the chart using a code name for the test.
3. Request form must be filled up. The name of the test must be coded.
4. All hospital personnel with whom the patient/client may interact for the conduct of the testing (social worker, laboratory personnel, billing, and cashier personnel) should act professionally and responsibly to ensure confidentiality of the test.

In case of a reactive result in the screening test, blood sample should be sent to San Lazaro Hospital – SACCL for confirmatory testing.

III. POST-TEST COUNSELING

1. All patients/clients who underwent testing must receive post-test counseling regardless of the result.
2. As much as possible, post-test counseling must be conducted by the HCW who conducted the pre-test counseling.

If result is Negative

- Explain to the patient/client the meaning of a negative result including the possibility of window period.
- Re-emphasize behaviors that will prevent HIV infection in the future.

If result is Positive

- Explain to the patient/client the meaning of a positive result.
- Provide adequate medical information about HIV and AIDS.
- Identify other medical and social support needed by the patient/client.
- Re-emphasize behaviors that will prevent HIV transmission to other people.
- Inform the patient/clinic of the availability of ARVs, if applicable, and other treatments
- Inform the patient of the availability of referrals for his/her other needs
- Refer the patient/client to the HACT.
- For pregnant women, counsel on the precautions that should be taken during pregnancy, infant feeding and other PMTCT services including referral to treatment hub for the use of ARV to prevent transmission of HIV to the baby. (Refer to DOH AO 2009-0016 for policies and guidelines on PMTCT.)



- The HACT will be the primary team tasked to provide or coordinate for optimum medical care to PLHIV, whether symptomatic or asymptomatic.
- The following guidelines do not include specific recommendations for the prevention and treatment of opportunistic infections and other HIV-associated complications and antiretroviral therapy. Refer to appropriate guidelines for the detailed procedures.

1. COMPLETE HISTORY AND PHYSICAL EXAMINATION

Complete history and physical examination among PLHIV should include baseline neurologic and mental status examination and evaluation of risky behaviors.

2. EVALUATION OF IMMUNE STATUS

Immune status of PLHIV is assessed by requesting for CD4 T-cell count or % CD4 for children less than 6 years old.

Clinical conditions and WBC count are also important parameters to assess the immune status:

- Clinical condition: Some infections and malignancies are frequently observed when the CD4 cell count drops to a certain level.
- WBC: Leukopenia and/or absolute lymphopenia may suggest low CD4 T-cell count.

Immunological and clinical evaluation of PLHIV will help in the assessment for the need to start ART and in the diagnosis of HIV-related infections that are usually present at certain CD4 level.

Note: In facilities where CD4 T-cell count is not available, refer patient/client to hospitals or laboratories with the required facilities.

3. SCREENING FOR CO-MORBIDITY (INFECTIONS, MALIGNANCY)

The following laboratory tests may be requested where resources are available:

- CBC
- Chest X-ray
- Sputum AFB smear, GeneXpert
- Urinalysis
- Fecalalysis
- Liver function tests
- BUN, creatinine
- RPR
- Hepatitis B Virus screening test
- Toxoplasma serology
- Pap smear for women every six months

In addition, the following approaches are important for symptomatic patients :

- specific work-ups depend on initial impression
- subspecialty referral for further evaluation and management as needed
- other laboratory tests where resources are available:
 - » blood – culture for bacteria, mycobacteria, and fungus; serum cryptococcal antigen detection
 - » sputum – gram stain, AFB , bacterial, mycobacterial, and fungal culture
 - » urine – bacterial and mycobacterial culture
 - » induced sputum (use 3% saline solution) or endotracheal aspirate or bronchial washing – PCP stain
 - » stool – bacterial and mycobacterial culture, modified AFB smear for cryptosporidium
 - » CSF – quantity/quality, gram stain, AFB stain, India ink stain, cryptococcal detection, bacterial, mycobacterial and fungal culture

4. EVALUATION FOR NEED OF PROPHYLAXIS

The need for prophylaxis in the following condition must be evaluated and then the recommended prophylaxis started once indicated:

Tuberculosis

Isoniazid Prevention Therapy (IPT) is the recommended prophylaxis for tuberculosis. (Please refer to AO No. 2008-0022 or the Policies and Guidelines on the Collaborative Approach of TB and HIV Prevention and Control.)

Pneumocystis carinii Pneumonia (PCP)

Criteria for starting prophylaxis for PCP:

- CD4+T cell count <200 cells/cumm OR
- Presence of AIDS-defining conditions

Cotrimoxazole is recommended for PCP prophylaxis.

Cotrimoxazole prophylaxis is also universally indicated for all infants born to HIV infected mothers starting at 4-6 weeks from birth UNTIL HIV infection is excluded, the risk of HIV transmission has ceased, and for those confirmed HIV infected infants at 12 months of age if they are classified in WHO clinical stage 1 with CD4% >25%.

MAC

Criteria for starting prophylaxis for MAC:

- CD4 T-cell <50 cells/cumm
- Clinical condition such as marked wasting, alopecia, skin discoloration

Azithromycin is recommended for MAC prophylaxis at 1200 mg per os., once a week. The alternative is Clarithromycin 500 mg per os., twice a day.

5. TREATMENT OF OPPORTUNISTIC INFECTIONS AND OTHER CO-MORBIDITY

Refer to Clinical Management of HIV Infection in the Philippines and/ or refer the patient/client to the nearest treatment hub for complicated cases.

6. INITIATION FOR ANTIRETROVIRAL THERAPY (ART)

Refer to DOH-AO 2009-006 and the Guideline on the Management of Pediatric HIV and AIDS on how to start antiretroviral therapy and what ARV regimen to be used.

All patients/clients on ART should be provided with adherence counseling prior to and during treatment.

The following laboratory tests are requested before initiating ART:

- Complete Blood Count
- Chest X-ray, sputum Acid Fast Bacilli (AFB) and sputum culture to rule out active tuberculosis
- Pregnancy test for females of reproductive age
- Baseline urinalysis, fasting blood sugar, liver function tests, creatinine, and lipid profile when indicated

For HACTs based on non-treatment hubs, refer eligible patient/client to the nearest treatment hub for ARV supplies.

FOR CONSULTATION AND MANAGEMENT

Referrals should be done after consulting and asking for the written informed consent of the patient/client.

Referring physician should have prior oral communication regarding the patient/client to the receiving physician or HACT.

The attending physician should properly endorse the patient/client to the receiving physician or HACT with proper referral letter including clinical summary, other important laboratory test results, and the reason for the referral.

Both the referring physician and the receiving physician or HACT must safeguard the confidentiality of the medical records and files.

FOR DIAGNOSTIC PROCEDURE

Written informed consent must be obtained prior to referral for diagnostic procedure. It must be explained that it is often necessary to disclose the status of the patient/client to the physician performing the procedure or the diagnostic laboratory staff through the request form, for proper evaluation of the findings or if the treatment or care carries the risk of transmission.

For certain diagnostic procedures, blood samples and/or specimens may be sent through couriers. Laboratory technicians must ensure that guidelines for proper packing and transporting blood samples and/or specimens are observed.



- For referrals, it is not mandatory for attending physicians to accompany patients/clients to the receiving hospital provided that the above guidelines are observed. However, attending physicians may accompany their patients/clients as the need arises.
- It is not the obligation of the receiving hospital to shoulder the transportation and other miscellaneous expenses that may be incurred by the patient/client.

SUPPORT COUNSELING

- PLHIV must receive psychosocial support from professionals on a regular basis while admitted at the hospital or during OPD visits, as appropriate.
- All patients/clients must be encouraged to disclose HIV status to trusted member/s of the family/community/social circle to establish early social support.
- Patient/client's family must also be provided counseling or support services as appropriate.
- Patient must be informed of care and support services provided by groups from the positive community for his/her best interest.
- A protocol must be established on when and how support groups or NGOs can approach a newly diagnosed patient/client. Any referral to support group needs consent from the patient/client.

SOCIAL SUPPORT SYSTEM

- The HACT must evaluate the psychosocial and social welfare need of the patient/client during admission or OPD visits.
- Upon consultation with the patient/client and/or family, appropriate social support groups must be identified.
- The patient and/or family may then be referred to this support group while patient/client is still confined or upon discharge.
- It is recommended that HACT provides a platform/ space/room for PLHIV interaction and support system.

POST MORTEM CARE

- Persons who died of AIDS-related illness may be buried or cremated within 24 hours or embalmed by a DOH-licensed embalmer. Standard safety precautions must be observed.
- The embalmed cadaver is safe for public viewing.
- Family of the deceased may be referred to DSWD, NGOs or support groups for assistance in processing the required documents for burial.

Strict adherence to standard safety precautions cannot be emphasized enough, regardless of whatever disease or medical case health care providers are managing. A breach in the observance of standard safety precautions put both health care workers and patients at risk of getting infected with blood-borne diseases including HIV.

An HIV positive health care worker poses no threat, provided that he/she does not perform exposure-prone procedures and he/she strictly follows standard safety precautions. He/she may perform other procedures which do not pose a risk of transmission, where the hands and fingertips of the worker are visible and outside the patient's body at all times, or where sharp instruments are not required.

Standard precaution consists of five practices:

- Hand washing
- Use of protective barriers to prevent direct contact with body fluid
- Safe handling and disposal of sharps
- Safe decontamination of instruments and other contaminated equipment
- Safe disposal of waste contaminated with body fluids

I. HAND WASHING

- HIV cannot pass through intact skin but it is possible for infection to be acquired when blood is in contact with damaged skin. Hand washing with soap and water can remove microorganisms acquired on the hands by contact with body fluids or contaminated surfaces.
- Hands should be washed with running water. However, hand washing using a bowl of water and soap is still effective.
- If a reusable towel is used to dry the hands, wash it regularly.
- Hands should always be washed after contact with patients and after gloves are removed.
- Skin in contact with blood, body fluids, or body substances should be washed immediately with soap and water.
- Any exposed cuts and abrasions should be covered with waterproof dressing.
- A health care worker with exudative lesions or dermatitis which cannot be adequately covered should refrain from direct patient care which may involve exposure to blood, body fluids, or body substances. He or she should also refrain from handling

contaminated patient care equipment until the lesions or dermatitis resolve.

II. USE OF PROTECTIVE BARRIERS

Gloves

- Gloves are not necessary when contact is limited to patient skin and blood or body substance is not present.
- Gloves should be worn when contact with potentially infected substances or with contaminated surfaces or equipment is anticipated.
- Glove should be discarded into appropriate waste container after use.
- Gloves should be discarded immediately if torn or punctured during procedure.
- Gloves should be discarded after each patient contact. If this is not possible, certain kinds of gloves can be washed and/or sterilized before reuse.
- General purpose utility gloves, such as rubber household gloves, may be used for housekeeping activities involving anticipated contact with contaminated surfaces or items.
- Gloves should be worn when handling used instruments, whether visibly soiled or not. Sharp items must be handled with extreme care.

Fluid resistant gowns and aprons

- Gowns are indicated during procedures that are likely to soil clothing or when splashing of a potentially infectious substance is possible.

Masks and protective eye wear

- Masks should be worn if aerosolisation or splattering of the facial mucus membranes with blood or body substances is likely to occur

III. SAFE HANDLING AND DISPOSAL OF SHARPS

- Always dispose of your own sharps. Never pass used sharps from one person to another.
- During exposure-prone procedure, the risk of injury should be minimized by ensuring that the operator has the best possible visibility (e.g., by positioning the patient, using a good light source,

- and controlling bleeding).
- Protect fingers from injury during suturing by wearing gloves and using a gauze or cotton wool pad.
- Never bend or break disposable needles. Recapping of needles should be avoided, but if appropriate container for sharps is not always available, it is better to recap needles using single-hand technique or forceps than to allow them to remain uncapped. Precautions should be observed when recapping.
- Immediately after use, store needles and syringes in a rigid container until ready for decontamination.
- Locate sharp disposal containers close to the point of use (e.g., patient's room, medicine trolley, treatment room).
- Dispose of, and transport sharps in a puncture-resistant container (e.g., empty cans of milk formula, soft drinks, or fruit juices). Never place used sharps in other waste containers.
- Keep all sharps and sharps disposal containers out of reach of children.
- Prevent overflow by sending sharps disposal container for incineration when three-quarters full.

IV. SAFE DECONTAMINATION OF INSTRUMENTS AND OTHER CONTAMINATED EQUIPMENT

Selecting the method of decontamination

Level of risk	Items	Decontamination method
High	Instruments which penetrate the skin/body	Sterilization Single use of disposables
Moderate	Instruments which come into contact with mucus membranes or non-intact skin	Sterilization Boiling Chemical disinfection
Low	Equipment which comes in contact with intact skin	Thorough washing

Efficient cleaning with detergent and hot water removes a high proportion of any microorganisms present. All equipment should be dismantled for thorough cleansing.

Heavy duty gloves should be worn when cleaning instruments to reduce the risk of injury. If splashing of body fluid is likely, additional protective clothing should be worn (e.g., plastic aprons and protective spectacles).

Sterilization

All forms of sterilization will destroy HIV, Hepatitis B, and Hepatitis C viruses.

Recommended methods of sterilization

Steam under pressure (e.g., autoclave, pressure cooker) Required pressure: 15 psi (101 kPa)	
Temperature	Time
115 C	30 minutes
121 C	15 minutes
126 C	10 minutes
134 C	3 minutes

Dry heat (e.g., electric oven)	
Temperature	Time
160 C	120 minutes
170 C	60 minutes
180 C	30 minutes

Instruments that are unwrapped for sterilization quickly become contaminated with microorganisms upon removal from the autoclave. Consequently, these instruments should either be used immediately following sterilization or stored in clean, dry conditions and resterilized when required for an invasive procedure.

Disinfection

Disinfection will usually inactivate HIV. Two commonly used methods are boiling and chemical disinfection.

Boiling is an effective way to disinfect equipment if autoclaving facilities are not available. Equipment should be first cleaned then boiled for 20 minutes.

Chemical disinfection is used for heat sensitive equipment. Most disinfectants are effective against a limited range of microorganisms and vary in the rate at which they destroy microorganisms. Items

must be fully dismantled and immersed in the disinfectant. Care must be taken to thoroughly rinse the disinfected items with clean water so that they do not be recontaminated. Chemical disinfectants are unstable and chemical breakdown can occur. Hence, expiration date and proper storage must always be noted. They may also be corrosive and irritating to skin. Protective clothing may be required. Chemical disinfectant is not as reliable as boiling or sterilization. However, the following will inactivate HIV:

- 2% glutaraldehyde
- 70% ethyl and isopropyl alcohol

Cleaning

Detergent and cleaning water are adequate for routine environmental cleaning (e.g., floors, walls, toilets, beds, rubber draw sheets). Disinfectants are not necessary for routine cleaning.

Spillage of blood and other body fluids

Spills of blood and other body fluids must be immediately cleaned. The health care worker should wear gloves and do the following:

- Pour 1:10 bleach solution or bleach granules into the spill.
- Wipe the spill with disposable towel or old newspaper or old linen or a mop.
- Discard into leak-proof waste bag.
- Pour 1:100 bleach solution into the spill area.
- Wipe the area with disposable towel or old newspaper or old linen or a mop.
- Clean area with water and detergent.
- Discard gloves and used disposable towel or old newspaper or old linen into the waste bag.
- Wash hands.

*Mops may be reused after disinfection and should be handled as little as possible to avoid splashing. Use heavy duty gloves. Soak soiled mops in 1:10 bleach solution for at least 30 minutes. Wash with detergent and water. Soak again in 1:10 bleach solution for at least 30 minutes. Let it dry.

Soiled linens and clothes

- Should be handled as little as possible
- Fold wet portion towards dry portion.
- Place inside plastic bag or other leak proof container at the point of collection.
- Soak in 1:100 bleach solutions for 30 minutes before washing.
- Wash with water and detergent. If soiled linen is to be washed by hands, heavy duty gloves should be worn.

Eating and drinking utensils

- The combination of hot water and detergents used in hospital dishwaters is sufficient to decontaminate dishes, glasses, cups, and eating utensils.

V. SAFE DISPOSAL OF WASTE CONTAMINATED WITH BODY FLUIDS INFECTIOUS WASTE/PATHOLOGIC WASTE

- Heavy duty gloves should be used by anyone transporting waste to the site of disposal.
- Eye protection should be used when disposing liquid waste.
- Waste not contaminated with body fluids can be disposed of as a general waste.
- All infectious/pathologic waste should be placed in a leak-proof container.
- Biodegradable waste must be buried in a 7-feet deep pit at least 30 feet away from a water source. Non-biodegradable waste must be buried sealed in an impermeable container.
- For liquid waste (e.g., blood), pour down a drain connected to an adequately treated sewer or a pit latrine.

GENERAL POLICIES AND GUIDELINES FOR SAFE PRACTICE OF SURGICAL, OBSTETRIC, DENTAL, AND OTHER SIMILAR PROCEDURES

Risk classification	Type of exposure	Barriers required	Examples
High risk procedure	Contact with blood probable, splashing, uncontrolled bleeding likely	Gowns Fluid-resistant gown or apron Eye protection Mask	Major surgical procedures, oral surgery, oral prophylaxis, vaginal delivery, autopsy
Moderate risk procedure	Contact with blood probable, splashing unlikely	Gloves Aprons may be necessary to protect clothing	Venipuncture (arterial or venous), phlebotomy, insertion or removal of intravenous cannula, collection and transport of laboratory specimen, endoscopy, bronchoscopy, suctioning, care of large open wound, internal examination, lumbar puncture, grafting
Low risk procedure	Low risk of contact with small amount	Gloves helpful but not essential	Injections, skin testing, care of small and minor wounds.

*There is no need for a separate surgical/obstetrical unit, medical ward, nursery and dental clinic or to separate instruments for patients suspected or diagnosed with HIV infection if the objective is solely to prevent HIV transmission in the health care setting.

SPECIAL CONCERNS FOR SAFE PRACTICES AND PROCEDURES

Dental procedures

- Environmental surfaces predisposed to contamination with spatter of saliva or blood during treatment and which may not be disinfected with chemical solutions should be covered with materials like plastic wrap, aluminum foil, impervious backed paper, polyethylene sheets or plastic tubing. After each clinical procedure, the covering should be removed and changed with a new one.
- It is recommended that anti-retraction valves (one-way check valves) should be installed to prevent fluid aspiration and to reduce the risk of transfer of potentially infective materials. However, in the absence of anti-retraction valve, flush out air and waterlines of hand pieces by running/operating it for 20 – 30 seconds.
- Disposable instruments (e.g., prophylactic angle, prophylactic cups and brushes, tips for high speed evacuators, saliva ejectors, and air/water syringes) should be used once, and not to be intended to be cleaned, disinfected, or sterilized for reuse.
- Impressions must be cleaned from any debris, saliva, or blood with water and should be disinfected with an accepted disinfectant before being poured with cast stones or delivered to the dental laboratory.
- Prothodontic and orthodontic appliances should be disinfected with iodophore before insertion.

Handling of specimen

- All specimens should be treated as potentially infectious, and transported in leak proof containers with the request form protected from contamination. All personnel who transport specimens should know how to handle specimens safely and should have practical understanding of standard precaution.
- Laboratory/pathology procedures and practices
- All persons processing blood and body fluid specimens (e.g., removing tops from vacuum tubes) should wear gloves. Masks and protective eyewear should be worn if mucus membrane

- contact with blood or body fluids is anticipated. Gloves should be changed and hands washed after completion of specimen processing.
- For routine procedure, such as historic and pathologic studies or microbiologic culturing, a biological safety cabinet is not necessary. However, a biological safety (cabinet class II) should be used whenever procedures are conducted that have a high potential for generating droplets. These include activities such as blending, sonicating, and vigorous mixing.
- Mechanical pipetting devices should be limited to situations in which there is no alternative and the recommendations for preventing injuries with needles outlined under standard precautions should be followed.
- Laboratory work surfaces should be decontaminated with an appropriate chemical germicide after a spill of blood or other body fluids and when work activities are completed.
- Contaminated materials used in laboratory tests should be decontaminated before reprocessing or be placed in bags and disposed of in accordance with institutional policies for disposal of infective waste.
- Equipment that has been contaminated with blood or other body fluids should be decontaminated and cleaned before being repaired in the laboratory or transported to the manufacturer.
- All persons should wash their hands after completing laboratory activities and should remove protective clothing before leaving the laboratory.

Dialysis unit

- Patients suspected or diagnosed to have HIV infection that need either hemodialysis or peritoneal dialysis need not be isolated from other patients.

Handling of cadavers

- All dead bodies shall be considered potentially infected with HIV. Cadavers should be properly placed inside a non-permeable material such as plastic bag before autopsy, burial, or cremation.

For accidental exposure, refer to Post Exposure Management (PEM) for HIV, Hepatitis B and C in Health Setting for the detailed treatment protocol.

GENERAL APPROACHES

All Health Care Workers (HCWs) that were exposed to blood and other potentially infectious body fluids (semen, vaginal secretion, CSF, synovial, pleural, peritoneal, pericardial, amniotic fluid) or an instrument contaminated with one of these substances through percutaneous, mucosal or direct skin exposure through an abraded or open wound shall be evaluated for possible Post Exposure Prophylaxis (PEP).

All exposed HCWs should be given initial treatment/ first aid.

After percutaneous exposure

- Allow wound to bleed freely
- Do not squeeze or rub injury site
- Wash site immediately using soap or a mild solution that will not irritate skin
- If running water is not available, clean site with a gel, or hand cleaning solution
- After a splash of blood or body fluids onto unbroken skin
- Wash the area immediately with running water
- Do not use strong disinfectants such as alcohol-based products

After exposure of the eye

- Irrigate exposed eye immediately with water or normal saline
- Do not use soap or disinfectant in the eye

After exposure of the mouth

- Spit the fluid out immediately
- Rinse the mouth thoroughly, using water or normal saline, and spit out again. Repeat this process several times.

The decision to commence PEP shall be based on the specific treatment protocol for HIV, Hepatitis B, and Hepatitis C.

GENERAL GUIDELINES IN PROVIDING PEP FOR HIV

An exposed HCW must be evaluated as soon as possible, preferably during the first hour after the exposure. After counseling and obtaining informed consent, PEP should be initiated as soon as possible, preferably within the 1st hour after exposure, especially if the source is known to have HIV. PEP should not be offered beyond 72 hours after exposure.

Medication for the first three days consists of Zidovudine (AZT) and Lamivudine (3TC). This basic regimen may be initially given and expanded regimen may be given after further evaluation.

Treatment is administered for four weeks. It is important to emphasize the need to complete the treatment.

If the exposed HCW refuses baseline testing and PEP, have him/her sign a waiver.

Before commencing PEP treatment, all issues regarding PEP must be explained to the exposed HCW such as the risks involved, follow-up testing, and window period.

Consult the HACT chair of the nearest DOH-designated treatment hub if:

- PEP initiation is delayed for more than 72 hours
- HIV status of source is unknown
- Exposed person is pregnant or breastfeeding
- Source is known to have resistant HIV strain
- There is a toxicity issue in drug selection

Pre-test counseling

- Obtain the HCW's written informed consent for baseline testing.
- Extensive counseling and assistance must be provided to lessen the exposed HCW's anxiety.

Testing (baseline and follow-up)

- Baseline testing for HIV serology must be conducted to assess infection status at the time of exposure. Repeat testing at three months and six months.
- Perform the following basic tests: FBS, CBC, BUN, Creatinine, ALT, AST, and Urinalysis

Post Test Counseling

- All HCWs who underwent baseline testing must be given a post-test counseling regardless of the result.

Follow-up

- Exposed person should be encouraged to report any acute illnesses during the follow-up period.

GENERAL GUIDELINES IN PROVIDING PEP FOR HEPATITIS B

Step 1. After initial first aid treatment, determine if source of exposure and exposed health care worker is positive for Hepatitis B.

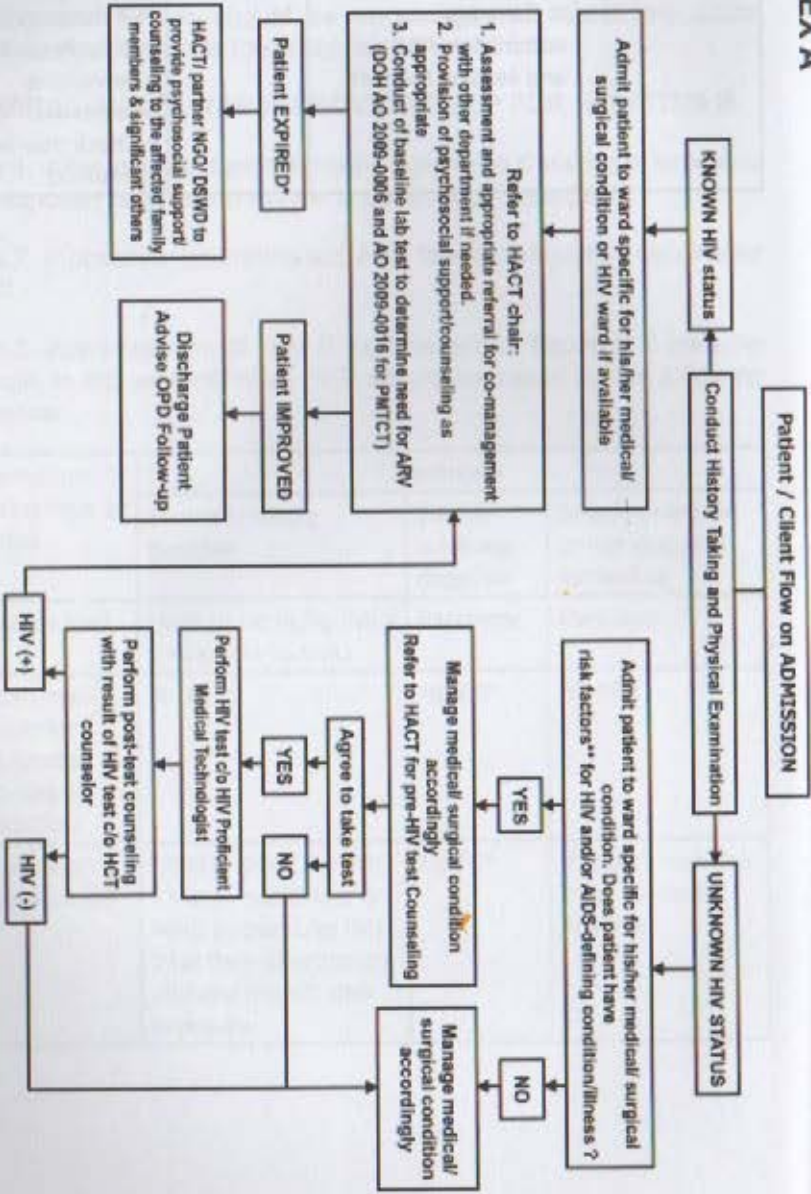
Step 2. If possible, determine anti-HBs titer of completely vaccinated HCW.

Step 3. Administration of Hep B vaccine and/or hepatitis B immune globulin to exposed HCW as PEP should be based on the following guideline:

Vaccination/ Ab response of worker	Treatment		
	Source is HBsAg positive	Source is HBsAg negative	Source unknown or not available for testing
Unvaccinated	HBIG (0.06mL/kg IM) x 1 + vaccine (0.5mL)	Vaccinate	Vaccinate
Vaccinated- responder (Adequate anti-HBs \geq 10mLU/mL)	No PEP	No PEP	No PEP
Vaccinated- nonresponder	HBIG (0.06mL/kg IM) x 1 and revaccinate or HBIG (0.06mL/kg IM) x 2 (at time of exposure and one month after exposure	No PEP	If known high risk treat as HBsAg positive

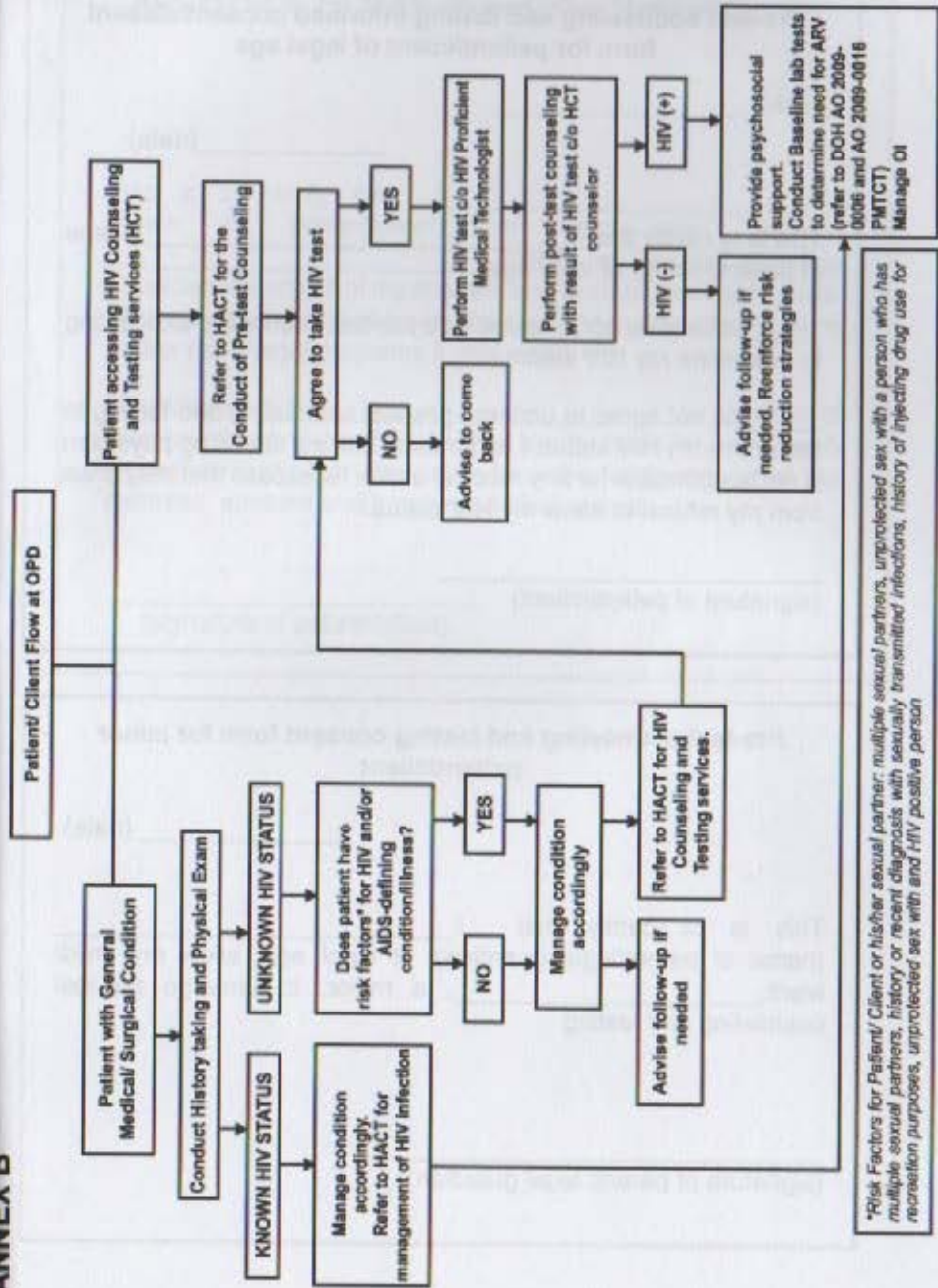
Vaccinated- Ab response unknown	Test exposed person for anti-HBs 1. If adequate, no PEP necessary 2. If inadequate, administer HBIG x 1 and vaccine booster	No treatment	Test exposed person for anti- HBs 1. If adequate, no PEP necessary 2. If inadequate, give vaccine booster and recheck titer in 1 -2 months
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ANNEX A



*Patient infected with HIV who expired may be buried or cremated within 24 hours, or embalmed by a DOH-licensed embalmer (RA 8534 197 sec. 52).
 **Risk Factors for Patient/Client or his/her sexual partner: multiple sex partners, unprotected sex with a person who has multiple sexual partners, history or recent diagnosis with sexually transmitted infections, history of injecting drug use for recreation purposes, unprotected sex with an HIV positive person.

ANNEX B



*Risk Factors for Patient/ Client or his/her sexual partner: multiple sexual partners, unprotected sex with a person who has multiple sexual partners, history or recent diagnosis with sexually transmitted infections, history of injecting drug use for recreation purposes, unprotected sex with and HIV positive person

Pre-test counseling and testing informed consent/dissent form for patient/client of legal age

_____ (date)

This is to certify that I, _____ (name of patient/client), of legal age:

_____ voluntarily agree to undergo pre-test counseling and testing to determine my HIV status.

_____ do not agree to undergo pre-test counseling and testing to determine my HIV status. I understand that my attending physician is not accountable for any medical and/or legal case that may arise from my refusal to know my HIV status.

(signature of patient/client)

Pre-test counseling and testing consent form for minor patient/client

_____ (date)

This is to certify that I, _____ (name of parent/legal guardian), of legal age, allow my child/ward, _____, a minor, to undergo pre-test counseling and testing.

(signature of parent/ legal guardian)

Request Form for Abstracts and other Medical Records

_____ (date)

This is to certify that I, _____ (name of patient/client), of legal age, request _____ (name of hospital/attending physician) for copies of my abstract and/or other medical records. The said documents will be used to facilitate my insurance claims and/or other legal purposes it may serve me.

I understand that _____ (name of hospital/attending physician) is not legally liable for any breach of confidentiality that may arise from the improper use of the released abstract and/or other medical records.

(signature of patient/client)

REFERRAL FORM TO HACT/TREATMENT HUB

_____ (date)

To: _____ From: _____

Respectfully referring to your institution

_____ (name/alias of patient/client)
_____ years old (age), _____ (sex)
from _____ (address)

- For:
- opinion management and treatment
 - HIV screening Hepatitis C screening
 - Hepatitis B screening

Other reasons for referrals:

Thank you very much.

(signature over printed name of referring person)

(organization/affiliation/hospital)

REFERRAL FORM TO NGO

_____ (date)

To: _____ From: _____

Respectfully referring to your institution

_____ (name/alias of patient/client), _____ years old
(age), _____ (sex) from _____ (address)

- For:
- psycho-social support
 - Other reasons for referrals:

Thank you very much.

(signature over printed name of referring person)

(organization/affiliation/hospital)

Palliative Care Manual for People Living with HIV. Field Test Version. Published by the Department of Health, Positive Action Foundation of the Philippines Inc., and World Health Organization. 2009

The manual provides a comprehensive guide in the provision of palliative care for PLHAs and their families. Palliative care is a process starting from the diagnosis of the illness until death, when the bereaved family is provided with psychosocial support to help them cope with the loss of a loved one. The book discusses the key elements of palliative care, which include physical care; nutrition, HIV and AIDS; food safety and good hygiene; emotional and spiritual care; positive community/support groups; and institutions with supportive and palliative care.

Post Exposure Management (PEM) for HIV, Hepatitis B and C in Healthcare Setting. Published by the Department of Health, Health Action Information Network, and World Health Organization. 2009

The guideline enumerates the protocols to be followed in providing post exposure prophylaxis for HIV and Hepatitis B and post exposure management for Hepatitis C for health care workers who have been accidentally exposed to potentially infectious blood or body fluids.

Clinical Management of HIV Infection in the Philippines. Published by the AIDS Society of the Philippines and the Philippine National AIDS Council. 2002.

The book is a comprehensive listing of treatment protocols for HIV infection, including management of symptomatic infection in adults, management of HIV infection in pregnant women, diagnosis and management of symptomatic infection for infants and children, and anti-retroviral treatment (ART) for adults, infants, and children.

Guideline on the Integrated Management of Pediatric HIV and AIDS. Published by the Department of Health, Crossing Borders, World Health Organization, and Unicef.

Since the diagnosis and clinical management of HIV infection among infants and children are relatively new fields in the country, the guideline provides a comprehensive protocol starting from counseling and testing, diagnosis, and management of HIV infections, including pediatric ART. The guideline also emphasizes the upholding of the principles of the Convention on the Rights of the Child.

Guidelines for Establishing and Operating an HIV Counseling and Testing Facility. Published by the Department of Health, Pacific Rim Innovation and Management Exponents Inc., and Unicef.

The manual discusses the different aspects of establishing and operating a counseling and testing facility, including the needed infrastructure, operational set up, costing, promotions and marketing, data management system, and quality assurance. The manual also standardizes the processes for counseling and testing.

Treatment Hub	Address	Contact Details	Point Person
LUZON			
San Lazaro Hospital	Quiricada St., Sta. Cruz, Manila	732-3125	HACT Leader
Research Institute for Tropical Medicine (RITM)	Department of Health Compound, FILINVEST Corporate City, Alabang Muntinlupa City	807-2628 loc 332	HACT Leader
Philippine General Hospital (PGH)	Taft Ave., Manila	554-8400 loc 3249	HACT Leader
Makati Medical Center	#2 Amorsolo St., Legaspi Village, Makati	888-8999 loc 2336	HACT Leader
The Medical City	Ortigas Ave., Pasig City	(632) 635-6789 local 6323 - Infection Control Office	HACT Leader
Ilocos Training and Regional Medical Center (ITRMC)	San Fernando City, La Union	(072) 6076413 loc 124	HACT Leader
Baguio General Hospital and Medical Center (BGHMC)	Gov. Pack Rd., Baguio City	(074) 442-4216 loc 381	HACT Leader
Bicol Regional Training and Teaching Hospital (BRTTH)	Legaspi City, Bicol	(052) 4830017	HACT Leader
Cagayan Valley Medical Center	Tuguegarao City, Cagayan Valley	(078) 304-1410	HACT Leader
Jose B. Lingad Memorial Medical Center	Brgy. San Dolores, San Fernando, Pampanga	(045) 961-3989 (Medicine Department)	HACT Leader

VISAYAS			
Vicente Sotto Sr. Memorial Medical Center (VSSMMC)	B. Rodriguez St., Cebu City	(032) 2539891 - 96	HACT Leader
Western Visayas Medical Center (WVMC)	Q. Abeto St., Mandurriao, Iloilo City	(033) 3212841	HACT Leader
Corazon Locsin Montelibano Memorial Regional Hospital (CLMMRH)	Dept. of Internal Medicine, 3rd Flr. OPD Bldg., CLMMRH, Lacson St., Bacolod City	((034) 709-0244	HACT Leader
Gov. Celestino Gallares Memorial Hospital	M. Parras St., Tagbilaran City	(038) 4114868	HACT Leader
MINDANAO			
Southern Philippines Medical Center (formerly Davao Medical Center)	JP Laurel St., Davao City	(082) 2272731 loc 4205	HACT Leader
Zamboanga City Medical Center	Ligaya Center for Healing, Zamboanga City Medical Center, Sta. Catalina, Zamboanga City	(062) 991-2934	HACT Leader

Guidance on Provider-Initiated HIV Testing and Counselling. May 2007. Published by the World Health Organization and UNAIDS. http://whqlibdoc.who.int/publications/2007/9789241595568_eng.pdf
Date accessed: March 9, 2010

Management of Opportunistic Infections and General Symptoms of HIV/AIDS Clinical Protocol for the WHO European Region. http://www.euro.who.int/document/sha/e90840_chapter_2.pdf. Date accessed: March 19, 2010

www.medterms.com

Post Exposure Management (PEM) for HIV, Hepatitis B and C in Health Settings. 2009. Published by the Department of Health, Health Action Information Network, and World Health Organization.

Walkowiak, Helena and Douglas Keene. Expanding the Role of Pharmacy Staff in Antiretroviral Therapy. Rational Pharmaceutical Management Plus (RPMPlus) Program, Management Sciences for Health, United States. http://pdf.usaid.gov/pdf_docs/PNADP036.pdf.
Date accessed: February 19, 2010

Administrative Orders Cited:

AO 18 series of 1995: Revised Guidelines in the Management of HIV/AIDS Patients in the Hospital

AO 2009-0016: Policies and Guidelines on the Prevention of Mother to Child Transmission (PMTCT) of Human Immunodeficiency Virus (HIV)

AO 2009 - 0006: Guidelines on Antiretroviral Therapy (ART) among Adults and Adolescents with Human Immunodeficiency Virus (HIV)

AO 2008-0022: Policies and Guidelines in the Collaborative Approach of TB and HIV Prevention and Control