Hand Book For Recording and Reporting System for STIs and HIV in Bhutan

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ACRONYMS

AIDS	Acquired Immune Deficiency Syndrome
ANC	Antenatal care
ART	Antiretroviral treatment
ARV	Antiretroviral
BHU	Basic health unit
DHO	District health officer
DMO	District medical officer
GFATM	Global Fund to Fight AIDS, TB and Malaria
HA	Health assistant
HISC	Health Information Service Center
HIV	Human Immunodeficiency Virus
IDU	Injecting drug-users
IPD	In-patient department
MARP	Most at risk population
M&E	Monitoring and evaluation
MSM	Men having sex with men
NACP	National AIDS Control Program
NGO	Non-governmental organization
OPD	Out-patient department
STI	Sexually transmitted Infections
SW	Sex workers
T&C	Testing and Counseling
TB	Tuberculosis
UNAIDS	Joint United Nations Programme on HIV/AIDS
VCT	Voluntary Counselling and Testing
WHO	World Health Organization

1 Background

The expanding access to Testing and Counseling (T&C) services plays a pivotal role in the scale up of prevention and care services [1]. The knowledge of HIV status is the condition for access to the national antiretroviral treatment (ART) programmes and T&C is the cornerstone to answering the need in care and treatment. In parallel, most of the clients coming to learn their HIV status will be tested negative and counseling is a unique opportunity to strengthen information and behaviour change. For the clients tested positive, counseling focuses on positive prevention and in particular on the prevention among the family (spouse and children).

In view of the need to enlarge the access to T&C, a new policy for T&C has been developed at global level in 2004 [2]. In addition to the situation where the clients come to learn their HIV status (client-initiated), this policy recommends situations where the offer of T&C should be initiated by the medical staff (provider-initiated) with respect of the underpinning principles of T&C, the '3Cs':

- **Confidential**,
- Be accompanied by **counseling**,
- Only be conducted with informed **consent**.

The '3Cs' principles have been endorsed in Bhutan and need to be strictly applied when prescribing an HIV testing for diagnosis. [3]

Four types of HIV testing can be distinguished:

1 " Voluntary Counseling and Testing, client-initiated,

2 Diagnostic HIV testing whenever a person shows signs or symptoms consistent with HIV/AIDS. This includes HIV testing of all tuberculosis patients as part of the routine management.

3 Routine offer of HIV testing by health care providers for all patients

- Assessed for Sexually Transmitted Infections (STI),

1 Increasing Access to HIV Testing and Counseling. Report of a WHO Consultation, 19-21 November 2002, Geneva, Switzerland. http://www.who.int/hiv/pub/vct/pub36/en/index.html

2 UNAIDS/WHO Policy Statement on HIV Testing. July 2004. http://www.who.int/hiv/pub/vct/statement/en/index.html

3 Guidelines for Voluntary Counselling and Testing. Ministry of Health. Royal Government of Bhutan.

- In the context of pregnancy for Prevention of Mother to Child Transmission (PMTCT),

4 Mandatory HIV screening, only for blood donors and prior to all procedures involving transfer of bodily fluids or body parts “.

Medical doctors, health assistants and nurses in charge, and not only the counsellors, have to propose an HIV test to those patients. Provider-initiated T&C does not mean that the health-care providers have to refer those patients to the counsellors but that T&C is part of their medical duties and responsibilities. In so, health-care providers have to propose the test, explain why it is important to verify HIV status and gave minimum information on HIV (this is a limited pre-test counselling). As they prescribe the test, they have to give back the result and additional information (post-test counselling) with the support of counsellor if necessary. They have to ensure that all patients tested HIV positive are referred to HIV counselling and care services and ensure that the confidentiality is maintained.

2 Objectives of T&C monitoring

As part of the expansion of HIV T&C services, an appropriate recording and reporting system is needed at all health levels: health-facility, Dzongkhag and national levels.

The monitoring of T&C services has 3 main objectives:

1 To measure the access to and coverage of T&C services, in general and for different sub-groups of population,
2 To document the quality of T&C services with pre and post-test counselling and informed consent,
3 To report each new case of HIV infection (HIV case reporting).

For the 1st objective, aggregated information on the number of clients pre-test counselled, tested (and their results) and post-test counselled should be reported on a quarterly basis to document the progress in access to T&C. In addition to the total number of clients accessing T&C, it has become more crucial to document the different sub-groups of population offered T&C (and

their HIV status) in line with the new policy of T&C[4] and the target population identified in the National Strategic Plan.

- Target populations: sex workers (SW) and their clients, injecting drug users (IDU), men who have sex with men (MSM), youths, uniformed personnel, mobile and migrant workers, prisoners, tourism industry staff,
- STI patients,
- TB patients,
- Pregnant women.

A special attention is also required to document the access of men and women by age-groups, in so to identify youths as a target group.

For the 2nd objective, it is important to record and report if the pre-test and post-test counsellings were performed and document the informed consent of the clients/patients.

For the 3rd objective, all new HIV case have to be reported with individual information. It is an important component of the surveillance of the HIV epidemic in Bhutan. Health providers have to ensure that all new HIV cases have been reported and that they have been reporting only once to avoid doubling reporting (e.g. new HIV test for confirmation in a person already know to be HIV positive and already reported). With the access to ART, an assessment and report of the clinical staging at time of HIV diagnosis is desirable. Special attention should also be paid to the familial status of the new HIV clients to document the access to T&C and HIV status of the spouse and children, to strengthen positive prevention.

3 Principles and data-flow

5 forms will support VCT monitoring; their use is explained in the following figure and table.

- For data-recording at facility level:
    - A VCT client's form,
    - A VCT register,

4 National Strategic Plan for the Prevention and Control of STIs and HIV and AIDS. Royal Government of Bhutan. 2008.

- A HIV lab register,

- For data-reporting and flow of data through the District Health Office to the NACP
  - A VCT quarterly report at facility level and compilation form for DHO,
  - A new HIV reporting form at facility level and compilation form for DHO.

Figure: Flow of data for VCT monitoring

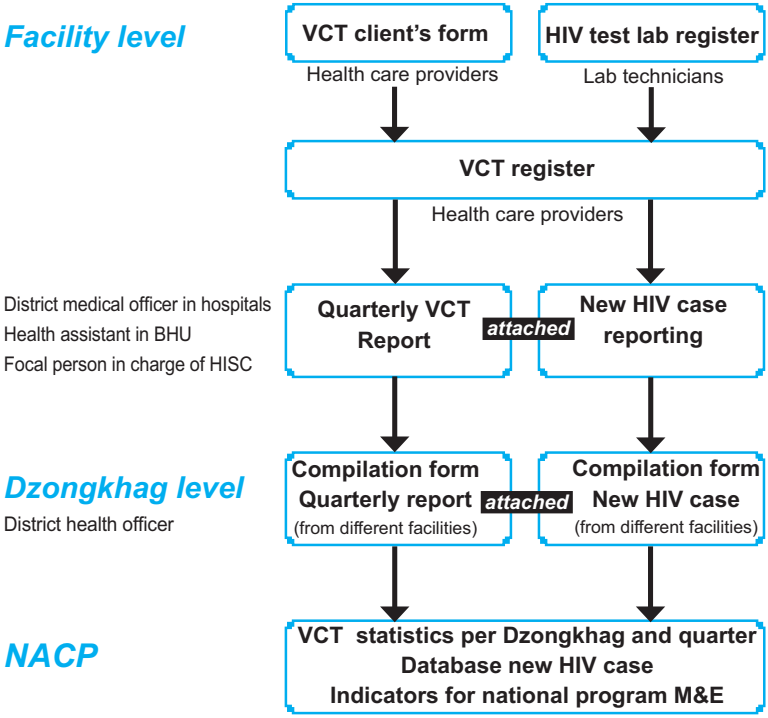


Table: Supporting forms for data recording, data reporting and data flow for VCT monitoring

Form	Objective	Place of use	Type of information	Responsible person	Flow of data
VCT client's form	To record individual information for all clients and patients proposed an HIV test (and not only those accepting HIV test)	Facility level in all services proposing VCT: reproductive health (RH), TB, Out-patient Dept (OPD), In-patient Dept (IPD)	1form per client -Nominative Individual information regarding reason for testing, risk assessment and services delivered (pre and post tests, test) Signed informed consent	Health care providers (doctors, health assistants, nurses) proposing VCT should systematically complete the form, even if the person refuse the test	The form is kept in the Health facility. Information is transferred into VCT register
VCT register	To record all clients and patients proposed an HIV test (not only those accepting)	Facility level in all services proposing VCT In a hospital, each service might have 1 register (e.g RH, TB, OPD, IPD…)	1 row per client - Anonymous Limited individual information transferred from the VCT client's form	Health care providers proposing VCT should maintain the VCT register	The register is kept in each hospital department or in the BHU Statistics for quarterly report will be compiled from the VCT register
HIV lab register	To record each HIV testing performed	Facility laboratory	1 row per client – Anonymous Type of HIV test and results	Lab technician	Kept in the lab

VCT quarterly report	To report statistics on T&C (aggregated information)	Facility level	Number of pre and post test, test and positive results In total, per gender, age group, disease and target group	Focal person in HISC Head of Community Health Unit in Referral hospital District medical officer in hospital Responsible Health assistant in BHU	Completed using the VCT register (and not the lab register) In a hospital, statistics from the various VCT registers have to be compiled in a single quarterly report To be sent to the DHO
HIV case register	To create a data base for all HIV infected cohort in Bhutan	Facility level (hospitals)	Minimum information as given in table no. 1	Focal person/DMO at the health center.	Report to the Head of the National Care & Treatment Unit of NACP.
HAART form	To report statistics on ART	Facility level	Number on ART, number on HIV/TB co infection.	Focal person/DMO at the health center.	Report to the Head of the National Care & Treatment Unit of NACP.
New HIV case reporting	To report all new HIV cases diagnosed during VCT	Facility level	Line listing with 1 row per new HIV+ cases Individual information - anonymous	Focal person in HISC Head of Community Health Unit in Referral hospital District medical officer in hospital Responsible Health assistant in BHU	Form on the back of the VCT quarterly report To be sent to the DHO

4 Confidentiality and anonymity: registration number and patient's code

Stigma and discrimination continue to stop people from having an HIV test. To overcome this obstacle in accessing T&C services, the confidentiality of T&C should be strictly respected. As part of the confidentiality it is important to limit as much as possible the transfer and report of nominative information. Registers are highly sensitive as it contains information for the full group of persons and should be anonymous. New HIV case reporting is an anonymous system.

The **registration number** refers to the system used at facility level and allocated to all patients (not only VCT). This number will be reported in the VCT client's form and used thereafter in the VCT and lab registers. **No name will be recorded in the VCT and lab registers.** Patient tracking will be possible only through the registration number.

For a new HIV positive case, **a patient's code** will be allocated. The patient's code will be allocated only by the reference laboratory which confirmed HIV (for the time-being only in Thimphu). In so, in case rapid tests are positive, the local lab technician will send a sample to the reference laboratory for confirmation by Elisa as usual. If the sample is confirmed positive, the reference laboratory will allocate a patient's code and inform the local lab technician. The patient's code together with the registration number will be used in the anonymous new HIV case reporting. The patient's code consists of:

- 2 digits for identification of the reference laboratory
- 2 digits for serial numbering of cases confirmed during the year
- 6 digits for the day/month/year of confirmation.

For example TP-11-02/08/08 means 11th case confirmed in Thimphu reference laboratory on 2nd August 2008.

The patient's code will be used thereafter for reference to specific HIV counselling and care services.

5 Who should record and report?

Any public or private (NGO) services offering HIV testing should use the formats for recording and reporting. It includes:

- The VCT in Health Information Service Centers (HISC),
- The regional and district hospitals and their different departments offering HIV testing,
- The basic health units where HIV testing is available,
- The military services providing HIV testing,
- Any other organisation providing HIV testing.

6 Which information to record?

6.1 VCT client's form and VCT register

The purpose is to record key individual information for all patients and clients proposed HIV test as well as the counselling services offered (pre and post-test counsellings and informed consent).

The VCT client's form is nominative as kept in the patient's file but the VCT register is anonymous recording only the registration number to track back the person.

The information to record in the VCT client's form is as follows:

- **Date**: refers to the date the HIV test was proposed (pre-test counselling)
- *Client's identification:*
    - **Name**
    - **Registration number**, it is the routine registration system used in the facility for all patients, it is not specific to VCT
    - **sex** (M/F)
    - **date of birth or age** (years, months for babies)
    - **Dzongkhag and Geog of residence**, it is not necessary to record the address already in the patient's file
- *Family situation*
    - **Current marital status**. Codes of this variable are:

1. single,
2. married/partner,
3. divorced/separated,
4. widowed,
5. not applicable (i.e. for children)

- **Occupation** (free text as it is difficult to standardise the occupation)

- *Medical and risk assessment:* the purpose is to "capture" the main (not all) information on the type of patients and target population offered VCT. This information is a key element to monitor the progress and will be analysed in the quarterly report.
  - **Reason for T&C**
    1. Voluntary/self referred,
    2. STI patient
    3. TB patient
    4. HIV/AIDS related symptoms
    5. Pregnancy/ANC
    6. Operation/surgery
    7. Blood donor screening
    8. Contact tracing
    9. Other (specify) to capture reason for T&C which are less frequent such as confirmation of a positive HIV test, new test after a window period etc.
  - **Risk assessment**:
    1. Sex worker
    2. Injecting drug user
    3. Men who have sex with men
    4. Client of sex worker
    5. Mother HIV infected (for babies and children)
    6. History of blood transfusion or organ transplant
    7. Partner of person living with HIV/AIDS
    8. Uniformed personnel
    9. Mobile and migrant workers
    10. Prisoner

11. Tourism industry
12. Multiple partners/unprotected sex
13. Partner with high risk behaviour
14. History of being rape victim
15. Low/no risk
16. Other (specify)

Note: Risk assessment might lead to multiple choice. Try to report only 1 code corresponding to the main risk.

- *Services offered for VCT*
  - **Pre-test counselling**
  - **Patient consent to HIV test: <u>if the patient consent for HIV test, he (she) should sign the informed consent at the end of the VCT client's form; you cannot prescribe or perform an HIV test if the consent is not signed.</u>**
  - **Date of HIV testing**
  - **HIV result** (positive/negative/indeterminate) if done
  - **Date of post-test counseling** (date the result is given back to the client with counseling)
  - **Disclosure to partner**
  - **Partner status**
- *Follow-up*
  - **Referral to**, services where the patient or client was referred. It is particularly important to ensure referral to specific HIV counselling and care services if the person was tested HIV positive.

This information is standardised and part of it need to be reported in the VCT register and, for HIV positive cases, in the new HIV case reporting.

6.2 HIV case register (to be used for HIV care & treatment database)

The HIV case register will be used for creating data base for the HIV cohort in Bhutan. The minimum data required is as shown in the table below:

Table 1: HIV infected case register

Registration and Practice management		
Unique Patient ID	2 digits for identification of the reference laboratory, 2 digits for serial numbering of cases confirmed during the year & 6 digits for the day/month/year of confirmation.	
Patient Name	Text	
Patient Address	Text	
Visit date	DD/MM/YYYY	
Site of care (clinic,home,etc)		
Demographics		
Birth Date	DD/MM/YYYY	
Birth Place	Text	
Village/city	Text	
District	Text	
Sex	Coded	
Employment	Coded	Yes, no
Salary	Numeric: Nu/year	0 to 100000000
Education Level	Numeric: ordinal scale	I (primary), II (secondary)
III(high school), IV (college	and beyond)	
History		
HIV-related diagnoses	Coded: ICD-10	
Co morbid diagnoses	Coded: ICD-10	
Medications	Coded: NDC/EDL	
Alcohol Use	Coded	Use: yes, no; abuse: yes, no
Numeric: drinks/day	0 to >10	
Cigarette Use	Coded	Use: yes, no; abuse: yes, no
Numeric: Packs/day	0>10	
Risk category		
IDU	Coded	yes, no

CSW	Coded	yes, no
MSM	Coded	yes, no
WHO Class	Numeric: ordinal scale	I, II, III, or IV
Physical Examination		
Blood Pressure, systolic	Numeric: mm Hg	30 to >300
Blood Pressure, diastolic	Numeric: mm Hg	30 to >300
Heart Rate	Numeric: beats/minute	0 to >200
Weight	Numeric: Kg	0.5 to >300
Height	Numeric: Cm	0.5 to >400
BMI	Numeric:	
Laboratory: HIV Specific		
HIV antibody	Coded	Positive, Negative
CD4 cell count	Numeric: cells/mm^3	0 to >1,000
Laboratory: HIV Monitoring		
Alanine aminotransferase	Numeric: IU/L	0 to >1,000
Albumin, serum	Numeric: g/L	0-10
Hemoglobin, blood	Numeric: g/L	0-25
Leukocytes, blood	Numeric: cells/mm^3	0 to >100,000
Platelets, blood	Numeric: count/mm^3	0 to >1,000,000
Lymphocytes	Numeric: count/mm^3	0 to >10,000
Creatinine	Numeric L mg/dL	0.1 to >25
Imaging		
Chest x-ray findings	Coded: LOINC	From local data dictionary
EKG Findings	Coded: LOINC	From local dictionary
Treatment		
Date of HAART started	DD/MM/YYYY	2000 to present
Line of Regime started	Coded	1 or 2
Performance Scale	Numeric: Ordinal Scale	I (normal activity) II (bedridden<50%) III (bedridden>50%)

The information collected at the health centers will go into an electronic database and will be maintained at the National level. The health facilities will be required to report the data directly to the Head of National Care & Treatment Unit once the electronic data base is established.

6.3 New HIV case reporting

All new HIV positive cases need to be reported once, at time of first HIV+ testing and no more thereafter.

Box 1: WHO case-definition for HIV infection[5]

In adults and adolescents and children ≥ 18 months
▪ a positive HIV antibody testing (rapid or laboratory-based enzyme immunoassay) confirmed by a second HIV antibody test (rapid or laboratory-based enzyme immunoassay) relying on different antigens or different operating characteristics than the initial test. *And / or* ▪ a positive virologic test for HIV or its components (HIV-RNA or HIV-DNA or ultrasensitive HIV p24 antigen) confirmed by a second virologic test obtained from a separate determination
Children younger than 18 months
▪ a positive virologic test for HIV or its components (HIV-RNA or HIV-DNA or ultrasensitive HIV p24 antigen) confirmed by a second virologic test obtained from a separate determination taken more than four weeks after birth

The individual information to report come from the VCT client's form & HIV register and is completed with:

- **Patient's code** as allocated by the reference laboratory after confirmation by Elisa
- **Route of transmission** (1 code only)
    1. Injecting drug user
    2. Heterosexual
    3. Men who have sex with men
    4. Blood and blood products
    5. Mother to child transmission

5 WHO case definitions of HIV for surveillance and revised clinical staging and immunological classification of HIV-related disease in adults and children. Geneva, World Health Organization, 2006(www.who.int/entity/hiv/pub/guidelines/WHO%20HIV%20Staging.pdf, accessed 13 February 2007).

Box2: Hierarchical order to assess the potential route of transmission in adults and adolescents

1. Any history of IDU with sharing materials ⇨ record as IDU
2. if no, history of MSM relation without protection ⇨ record as MSM
3. if no, personal high risk of heterosexual transmission (sex worker and clients, multiple heterosexual partners and unprotected sex, partner of high risk person, partner of PLWHA, …) ⇨ record as heterosexual
4. if no, personal history of blood transfusion, needle stick injury ⇨ record as blood and blood products
5. if no ⇨ record as heterosexual.

- **HIV status of the partner**
- **Total number of children**
- **Number of HIV positive children**
- **Client clinical staging**
    1. Asymptomatic
    2. Advanced HIV infection (see box 3).
    3. AIDS (clinical stage 4 or CD4<200 in adults and adolescents)
    4. Not assessed, if it was not possible to conduct a clinical assessment of HIV/AIDS related symptoms.

Box 3 WHO case definition for advanced HIV disease

Clinical criteria for diagnosis of advanced HIV in adults and children with confirmed HIV infection
▪ Presumptive or definitive diagnosis of any one stage 3 or 4 condition
Immunological criteria for diagnosing advanced HIV disease in adults and children five years or older with confirmed HIV infection
▪ CD4 count less than 350 per mm^3 in an adult or child.
Immunological criteria for diagnosis in a child younger than five years with confirmed HIV infection
▪ %CD4 < 30 among those younger than 12 months of age, ▪ %CD4 < 25 among those aged 12-35 months, ▪ %CD4 < 20 among those aged 35-59 months.

- **CD4 cell count:** record the date of CD4 testing and results
- **Referred for** (free variable to inform the service the PLWHA have been referred for additional HIV counselling, care and treatment)

Note: The patient code will link to the HAART form.

7 How to complete the quarterly report?

All facilities offering VCT should sent the statistics of activity every quarter to the district. They should also verify that they have reported all new HIV positive clients tested during the month. The district medical officer is the main responsible in district hospitals while the responsible health assistant is in charge in BHU. District hospital should sent only 1 report compiling VCT statistics from the different departments/services.

After the identification of the reporting center (hospital, BHU, HISC, other), the monthly report is divided in 3 parts to report access to T&C and HIV testing results:

- Part 1: by gender and age-groups,
- Part 2: according to the reason of testing,
- Part 3: according to the risk assessment.

From the VCT register, the total number of clients pre-test counselled during the month (column ''pre-test counselling given' code yes), the number tested (column 'HIV testing done' code 'yes'), the number tested HIV positive (column 'HIV result', code 'positive'), the number of clients post-test counselled (column 'post test counselling given', code yes, whatever HIV test result) should be counted. The same information should be disaggregated by:

- Gender and age-groups by counting in columns 'sex' and 'age',
- Reason for Testing and Counselling by counting in column 'Reason for T&C', the number of clients whose code was 2. STI, 3.TB, 5. Pregnant women, 7. blood donors, 8. Contact tracing.
- Risk assessment by counting in column 'risk assessment', the number of clients whose code was 1.SW, 2.IDU, 3.MSM, 4. client of sex worker, 8. uniformed personnel, 9. Migrant and mobile workers.

A client might be counted twice in part 2 and 3 ; e.g. a sex worker presenting STI symptoms.

8 How to compile the statistics at different levels?

The District Health Office and the National AIDS Control Programme should compile the quarterly statistics, in total and per gender, age-group, MARP and medical reasons for testing.

The District Health Office will compile the statistics of the reporting facilities making the total for the district using the compilation form. The completeness of report will be calculated.

The NACP will compile the statistics from all districts for the total at national level. It will also maintain a database disaggregated per district and quarter in order to follow the trends and the progress in coverage of the different groups of population.

9 How to analyse the statistics?

Completeness of quarterly reports

The completeness is the number of reports received among the number of reports expected (=number of facilities providing T&C). This indicator should be calculated at district and national levels, to follow how complete is the information to interpret thereafter the statistics.

Quality of services

- **Pre-test counselling rate:** all patients tested should have a pre-test counselling. The number of clients pre-test counselled should be higher than the number of clients tested as some will refuse. Any number of clients pre-test counselled less than the number of client tested need immediate corrective action.
- **Acceptance of the test** It is possible to analyse this indicator only if the pre-test counselling is systematic for all clients and HIV test performed only with signed consent. The acceptance of the test is the percentage of clients pre-test counselled who accepted the test (number of clients tested / number of clients pre-tested * 100). **It is important to analyse this information at facility level** and take corrective actions in case this result is less than 90% (less than 90% of clients accepted to be tested

after the pre-test counseling). The acceptance of the test should be analysed per sub-groups (gender and age-groups, risk group, medical reason). Knowing which sub-group has the lowest acceptance rate will help to improve comprehensive pre-test counseling for those persons.

- **Post-test counselling rate** All clients tested should have a post-test counselling. The percentage of clients tested (positive and negative) who had a post-test counseling need to be calculated (number of clients post-tested / number of clients tested*100). **It is important to analyse this information at facility level** and take corrective actions in case this result is less than 90%. It might signify that
    - the clients did not came back for results
    - or that the health facility is not providing post-test counselling and not giving back the results to the clients.

  It should be analysed per sub-groups (gender and age-groups, risk group, medical reason). Knowing which sub-group has the lowest post-test counselling rate will help to improve counselling for return for results.

HIV sero-prevalence

At all levels, the HIV sero-prevalence should be analysed (percentage of clients tested HIV positive: number of clients tested HIV+ / number of clients tested * 100). The HIV sero-prevalence should be analysed among all clients attending testing and per sub-groups: gender&age-groups, risk group, medical reason.

At facility level, this information will help in improving the services for the groups most affected by the epidemic. At district and national levels, this information is part of the surveillance of the HIV epidemic (which sub-groups are more affected by the HIV and what are the trends over time?) and will help for the planning of prevention and care services.

Age and sex distribution of clients tested

At all levels, it is important to know the age and sex distribution of clients coming for testing (number of clients tested in a specific sex&age sub-groups

/ total clients tested * 100). This information monitors the equitable access to T&C for the men and women and for the youths, to take corrective actions.

Distribution by target population and medical reason of clients tested
At national and district levels, the access to VCT for the target population and by medical reason should be analysed over time. It is important to analyse if the target populations are accessing VCT and if the access improves over time.

10 Training exercise: case studies

Following are 8 case studies of patients and clients proposed an HIV test in a district hospital.

Question 1: comment case study 1

- In what the service offered for HIV test has participated in the control of HIV and in prevention? Is there additional risk factors for HIV transmission that was not assessed?
- In case this lady is tested HIV positive during the next pregnancy, what is the medical responsibility of the gynaecologist?
- What should have been the T&C service offered and correct attitude of the medical staff?

Question 2: complete the VCT client's form and the VCT register for all 8 patients/clients

Question 3: complete the VCT quarterly report and new HIV case reporting for the period from 1/1/2008 to 31/3/2008 for the district hospital

Question 4: describe what should be analysed in the VCT quarterly report

Case study 1

Mrs A is pregnant. She is 20, housewife, married to a long distance truck driver. It is her first pregnancy. During her visit in ANC (20/1/2008) in the district hospital (registration number 100), the gynaecologist prescribed an HIV test without informing her and without giving information. She is HIV negative but no result was given back.

Case study 2

Mrs A is pregnant. She is 20, housewife, married to a long distance truck driver. It is her first pregnancy. During her visit in ANC (20/1/2008) in the district hospital (registration 101), the gynaecologist inform her about HIV, the risk of transmission to the baby and the importance to verify HIV status as the transmission to the baby can be prevented. She accepted and signed the consent. The result is negative. The gynaecologist informed her about the result and took time to ask her some questions regarding the husband. They are just married and both want more children and a healthy family. She is confident in her husband who is often travelling. However she asked for more information on HIV as she can talk to him and convince him to go for VCT. For this reason the gynaecologist referred her to the counsellor.

Case study 3

Mrs B is pregnant. She is 30, works as secretary and married to a teacher. They have already 2 children. During her visit in ANC (22/1/2008) in the district hospital (registration 102), the health assistant inform her about HIV, the risk of transmission to the baby and the importance to verify HIV status as the transmission to the baby can be prevented. During the discussion he did not identify risk factor for HIV. She accepted and signed the consent. The result is negative. The health assistant give her back the result and refer her to a group counselling.

Case study 4

Mr C is 22, single and shopkeeper. He came to the OPD (2/2/2008) in the district hospital (registration number 225) for an urethral discharge. After examination, the doctor discussed about the risk of HIV transmission and STI and refers him to the counselling for a full session. Mr C accepted the test and signed the consent. The result is positive (the reference lab allocated the patient's code TP-03-08). The doctor conducted a full post test counselling giving him the results and information on counselling support and care services for PLWHA and referred him to the HISC. He is asymptomatic and CD4 was not performed. During post test, Mr C talked about seldom visit to sex workers as well as some irregular partners with unprotected sex.

Case study 5

Mr D is 45, married and work as a farmer. He has 4 children. He was diagnosed with a pulmonary TB during a visit (10/2/2008) in the district hospital (registration 674). The TB nurse explain him that TB can be a disease associated to HIV and that it is highly recommended to check the HIV status. He accepted and signed the consent even if he does not report any risk factor. The result is negative and given back by the TB nurse who refer him to a group counselling.

Case study 6

Mr E is 35, married and business man travelling a lot. He has 2 children. He came to the OPD (15/2/2008) in the district hospital (registration 677) for a urethral discharge. He said to the doctor to have had a recent sex partner with no protection during a business trip. The doctor talked about the risk of HIV and he accepted and signed the consent for the test. The doctor referred him to the counsellor for a full pre-test counselling. The result is negative and given back by doctor. The doctor refer him to the counsellor for a full post test counselling and asked to attend his wife.

Case study 7

Ms F is 22, single and work as singer in a karaoke. She came spontaneously (18/2/2008) in the OPD (registration 254) in the district hospital and ask the doctor for VCT as she has heard about the risk of HIV and about the treatment for those positive. She is attended by the counsellor and during the pre-test she recognised having being occasionally engaged in sex with some clients supporting her. She accepted the test and signed the consent. The test is positive and given back by the counsellor (the reference lab allocated the patient's code TP-05-08). The counsellor supported her in the emotional choc and gave her confidence in the access to specific services. She referred her first to the doctor responsible for HIV in the district hospital then to the HISC. The doctor identified that she was at stage 3 and the CD4 count was at 290 on 28/2/2008.

Case study 8

Mr G is 38, married with 2 children and work as long distance truck driver. He is diagnosed with pulmonary TB on 14/3/2008 in the district hospital (registration 502). The TB nurse explain him that TB can be a disease associated to HIV and that it is highly recommended to check the HIV status. He accepted and signed the consent. The result is negative and given back by the nurse who referred him to the counsellor for individual post test counselling due to his profession.

Answers

Question 1: the correct VCT services and attitude of the gynaecologist is described in case-study 2

Question 2: the VCT register should be completed as follow

(To be completed according to the information collected in the VCT client's form – complete 1 row per client)

Serial number	Date (dd/mm/yy)	Registration number	Age	Sex (M/F)	Reason for VCT (code)*	Risk assessment (code)§	Pre-test counselling given (Y/N)	Signed consent for testing (Y/N)	HIV testing done (Y/N)	Post-test counselling given (Y/N)	HIV result (Pos/Neg/Indet.)	Remarks
1	20/1/08	100	20	F	5	16	N	N	Y	N	NEG	Husband truck driver
2	20/1/08	101	20	F	5	16	Y	Y	Y	Y	NEG	Husband truck driver
3	22/1/08	102	30	F	5	15	Y	Y	Y	Y	NEG	
4	2/2/08	225	22	M	2	4	Y	Y	Y	Y	POS	
5	10/2/08	674	45	M	3	15	Y	Y	Y	Y	NEG	
6	15/2/08	677	35	M	2	12	Y	Y	Y	Y	NEG	
7	18/2/08	254	22	F	1	1	Y	Y	Y	Y	POS	
8	14/3/08	502	38	M	3	9	Y	Y	Y	Y	NEG	

* **Reason for VCT:** 1=Voluntary/self-referred; 2=STI patient; 3=TB patient; 4=HIV/AIDS related symptoms; 5=Pregnancy/ANC; 6=Operation/surgery; 7=Blood donor screening; 8=contact tracing; 9=other

Risk assessment: 1=sex worker (SW); 2=injecting drug use (IDU); 3=men having sex with men (MSM); 4=client of SW; 5=mother HIV-infected; 6=history blood transfusion or organ transplant; 7=partner of person living with HIV (PLWH); 8=uniformed personnel; 9=mobile/migrant worker; 10=prisoner; 11=tourism industry; 12=multiple partners/unprotected sex; 13=partner with high risk behaviour; 14=history of being rape victim; 15=low/no risk; 16=other

8 Forms

- VCT client's form
- VCT Register
- Laboratory Register
- Quarterly VCT report – reporting form at facility level
- New HIV case reporting – reporting form at facility level
- HAART form (to be used at the ART providing centers)
- Quarterly VCT report – compilation form at DHO level
- New HIV case reporting – compilation form at DHO level

VOLUNTARY COUNSELING AND TESTING CLIENT FORM (To be stored in the health facility)

1. Name of the Health Service					
2. Type of the Health Centre	1.Regional Hospital	2. VCT	3.District Hospital	4.BHU	6.Others (specify)
Registration no.	3. Date	4. Name		5. Age	6. Sex. .....
7. Marital status	1. Single	2.Married/with partner	4. Divorced	4. Widowed	5.Not applicable
8. No. of children	.....	Dzongkhag of residence		Geog/Thromdue of residance	
9. Occupation.....	10. Education	1. Literate	2. Illiterate	3. Primary	4. Secondary 5. Tertiary

11. Reason for T&C	1. Voluntary/self referred 2. STI patient 3. TB patient 4. HIV/AIDS related symptoms	6. Pregnancy/ANC 6. Operation/Surgery 7. Blood donor screening 8. Contact tracing	9. Others (Specify)
12. Risk Assessment	1. Sex Workers 2. Injecting Drug use 3. MSM 4. Client of Sex worker 5. Mother HIV infected 6. History of blood transfusion or organ transplant	7. Partner of PLWHA 8. Uniformed personnel 9. Mobile migrant worker 10. Prisoner 11. Tourism Industry	12. Multiple partners/unprotected sex 13. Partner with high risk behaviour 14. History of being rape victim 15. Low/no risk 16. Others (specify)

13. Pre test counselling given	1. Yes 2. No	14. Consent for HIV test 1. Yes 2. No	If yes ask the patient to sign the consent statement below
16. Date of HIV test ——/——/——	18. HIV result 1. Positive 2. Negative 3. Indeterminate		17. Date of patient post test counselling ——/——/—— ☐ Not done
18. Disclosure to Partner 1. Done 2. Not done	19. Partner status		

Client's informed consent.

I have received information on HIV and HIV testing. I agree to be tested for HIV. I understand I will get back the result with additional counselling.

Signature of client .....

Name of Counsellor

VCT register

(to be completed according to the information collected in the VCT client's form – complete 1 row per client)

Serial number	Date (dd/mm/yy)	Registration number	Age	Sex (M/F)	Reason for T&C (code)*	Risk assessment (code)$	Pre-test couns. given (Y/N)	Signed consent for testing (Y/N)	HIV testing done (Y/N)	Post-test couns. given (Y/N)	HIV result (Pos/ Neg/ Indet.)	Remarks

*__Reason for T&C:__ 1=Voluntary/self-referred; 2=STI patient; 3=TB patient; 4=HIV/AIDS related symptoms; 5=Pregnancy/ANC; 6=Operation/surgery; 7=Blood donor screening; 8=contact tracing; 9=other

__$ Risk assessment:__ 1=sex worker (SW); 2=injecting drug use (IDU); 3=men having sex with men (MSM); 4=client of SW; 5=mother HIV-infected; 6=history blood transfusion or organ transplant; 7=partner of person living with HIV (PLWH); 8=uniformed personnel; 9=mobile/migrant worker; 10=prisoner; 11=tourism industry; 12=multiple partners/unprotected sex; 13=partner with high risk behaviour; 14=history of being rape victim; 15=low/no risk; 16=other

Counselling and Testing Laboratory Register

Name of Reporting person ***Name of District/Centre***

S.NL	Date of HIV test (dd/mm/yy)	registration number	Name of test and result*			Test result interpretation		Signature of Technician
			1st	2nd	3rd	Pos.	Neg.	

National AIDS Control Programme
Quarterly VCT Report- Reporting form at facility level

(to be completed in each health facility providing VCT and sent to the person in charge of HIV in the DHO)

Quarter/year: Name of reporting center:

Type of reporting center: ☐ VCT ☐ Regional hospital ☐ District hospital ☐ BHU ☐ Other (specify)

Dzongkhag: Geog:

PART 1: TOTAL ACTIVITY

	# CLIENTS PRE-TESTED	# CLIENTS HIV TESTED	#CLIENTS HIV POSITIVE*	% HIV POSITIVE (#HIV +/# tested X 100)	# CLIENTS POST-TESTED
TOTAL					

*Ensure that all HIV+ cases have been reported using the HIV reporting form on the back of the quarterly VCT report

PART 2: ACTIVITY AND RESULTS BY GENDER AND AGE GROUP

	# CLIENTS HIV TESTED			#CLIENTS HIV POSITIVE		
	Male	Female	Total	Male	Female	Total
0-29/365						
1/12-11/12						
1 – 4 yrs						
5-14 yrs						
15-24 yrs						
25- 49 yrs						
50 and above						
Total						

*29/365 means 29 days, 1/12 means one month & 11/12 means 11 months

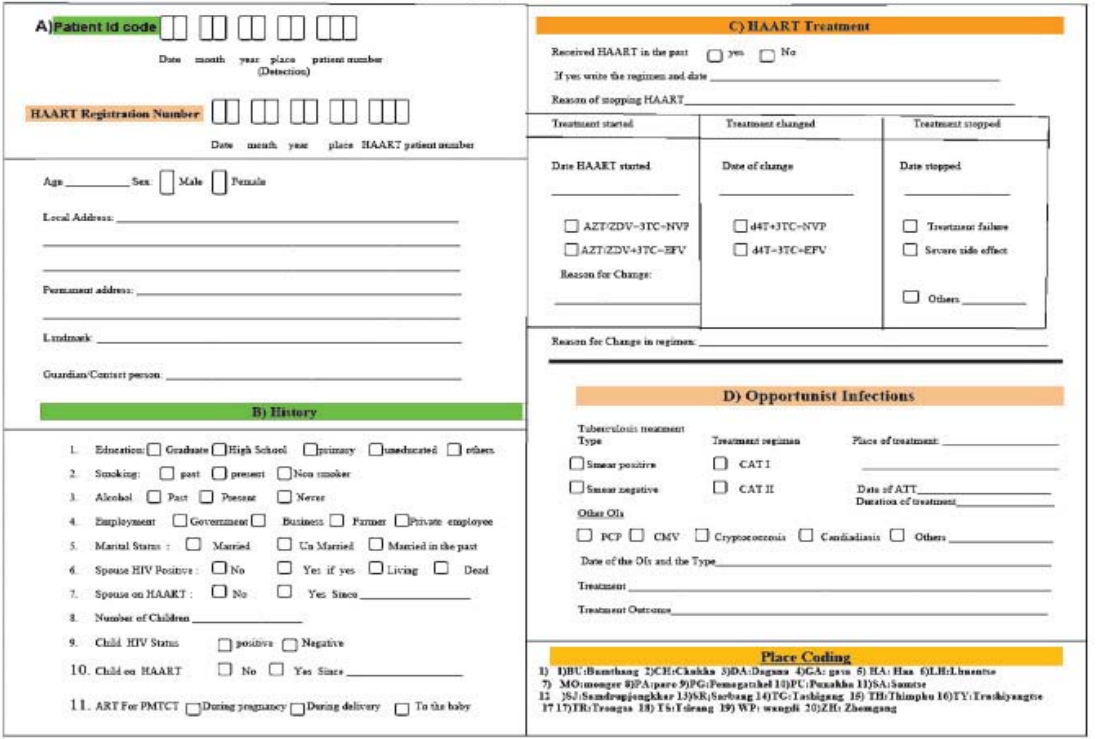
PART 3: DISTRIBUTION BY REASON FOR T&C

	# CLIENTS PRE-TESTED	# CLIENTS HIV TESTED	#CLIENTS HIV POSITIVE	% HIV POSITIVE # HIV+/# tested X 100	# CLIENTS POST-TESTED
STI patients					
TB patients					
Pregnant women					
Blood donors					
Contact tracing					

PART 4: DISTRIBUTION BY RISK ASSESSMENT

GROUP	# CLIENTSPRE-TESTED	# CLIENTS HIV TESTED	#CLIENTS HIV POSITIVE	% HIV POSITIVE #HIV +/# tested X 100	# CLIENTS POST-TESTED
Sex workers					
Injecting drug users					
MSM					
Client of sex worker					
Uniformed personnel					
Mobile/migrant workers					

HAART Information card (HIC)



A) Patient Id code ☐☐ ☐☐ ☐☐ ☐☐ ☐☐☐

Date month year place patient number (Detection)

HAART Registration Number ☐☐ ☐☐ ☐☐ ☐☐ ☐☐☐

Date month year place HAART patient number

Age _____ Sex: ☐ Male ☐ Female

Local Address: _____

_____

_____

Permanent address: _____

_____

Landmark: _____

Guardian/Contact person: _____

B) History

1. Education: ☐ Graduate ☐ High School ☐ primary ☐ uneducated ☐ others
2. Smoking: ☐ past ☐ present ☐ Non smoker
3. Alcohol ☐ Past ☐ Present ☐ Never
4. Employment ☐ Government ☐ Business ☐ Farmer ☐ Private employee
5. Marital Status : ☐ Married ☐ Un Married ☐ Married in the past
6. Spouse HIV Positive : ☐ No ☐ Yes if yes ☐ Living ☐ Dead
7. Spouse on HAART : ☐ No ☐ Yes Since _____
8. Number of Children _____
9. Child HIV Status ☐ positive ☐ Negative
10. Child on HAART ☐ No ☐ Yes Since _____
11. ART For PMTCT ☐ During pregnancy ☐ During delivery ☐ To the baby

C) HAART Treatment

Received HAART in the past ☐ yes ☐ No

If yes, write the regimen and date _____

Reason of stopping HAART _____

Treatment started	Treatment changed	Treatment stopped
Date HAART started	Date of change	Date stopped
☐ AZT/ZDV+3TC+NVP ☐ AZT/ZDV+3TC+EFV Reason for Change:	☐ d4T+3TC+NVP ☐ d4T+3TC+EFV	☐ Treatment failure ☐ Severe side effect ☐ Others _____

Reason for Change in regimen: _____

D) Opportunist Infections

Tuberculosis treatment

Type: ☐ Smear positive ☐ Smear negative

Treatment regimen: ☐ CAT I ☐ CAT II

Place of treatment: _____

Date of ATT _____

Duration of treatment _____

Other OIs

☐ PCP ☐ CMV ☐ Cryptococcosis ☐ Candidiasis ☐ Others _____

Date of the OIs and the Type _____

Treatment _____

Treatment Outcome _____

Place Coding

1) 1)BU:Bumthang 2)CH:Chukha 3)DA:Dagana 4)GA: gasa 5) HA: Haa 6)LH:Lhuentse
7) MO:mongar 8)PA:paro 9)PG:Pemagatshel 10)PU:Punakha 11)SA:Samtse
12)SJ:Samdrupjongkhar 13)SK:Sarbang 14)TG:Tashigang 15) TH:Thimphu 16)TY:Trashiyangtse
17 17)TR:Trongsa 18) TS:Tsirang 19) WP: wangdi 20)ZH: Zhemgang

E) Referrals:

Sl	Place		Date	purpose	Remarks
	From	To			

Check List:

☐ Drug Adherence ☐ Condom Use ☐ Nutrition/Drug abuse

☐ Safe Sex

1)AZT/ZDV=Zidovudine(300mg) twice daily 2) 3TC=lamivudine(150mg) twice daily 3)NVP=nevirapine(200mg) once daily for 14 days and then twice daily 4)d4T=stavudine(30mg) twice daily 5) EFV=Efavirenz(600mg) once daily

Pediatric ARV drug Dosage:

1) AZT/ZDV: 240mg/m2 twice daily neonates: 2mg/kg 8hourly
2) 3TC: 4mg/kg twice daily neonates: 2mg/kg twice daily
3) d4T: <30kg 1mg/kg twice daily > 30kg 30mg twice daily
4) NVP: 5mg/kg once daily for 14 days and then 7mg/kg twice daily to continue.
5) EFV: > than 10kg/ > three years 15mg/kg Hs

EFV not to be used in children less than 3years or 10 kg body weight

NVP 2mg/kg in neonate size

General information

Three copies of the form are to be made
1)To be retained with the health centre
2) To be kept with the patient
3) send to the pharmacy Department JDWNRH, once on HAART.

Note: Changes in regimen are to be informed to the Programe or the Pharmacy Department JDWNRH

F) Follow up Details

	Date	weight	Clinical Stage	Hb	ALT/AST	CD4	OIs
1.							
2.							
3.							
4.							
5.							
6.							
7.							
8.							
9.							
10.							
11.							
12.							
13.							
14.							
15.							
16.							
17.							
18.							
19.							
20.							
21.							
22.							
23.							
24.							
25.							
26.							
27.							
28.							
29.							
30.							
31.							

When laboratory abnormalities appear, clinical judgment must be made before a change in the HAART regimen is considered

QUARTERLY NATIONAL HIV CASE REPORTING FORM – Reporting form at facility level

Reporting Quarter ..... **Name of Reporting Centre** .....

Please report each of the new HIV* case for each quarter. *(Each row is for a new case).* Reporting is to be done quarterly and not case-wise. Do not report again an old case already reported (e.g. re-testing for confirmation of an old case)

☐ VCT ☐ Regional Hospital ☐ District Hospital ☐ BHU ☐ Others (Specify)

Registration No.	Patient's code*	Age	Gender M/F	Dzongkhag	Gewog/ Thromde/Area	Occupation	Marital status	Date of HIV testing	Reason for TBCI	Risk assessment	Mode of transmission	Status of partner	No. of children	No. of children with HIV	Patient's clinical stage	Last CD4 (Date & Result)	Referral for

30

**The patient's code is allocated by the reference laboratory after confirmation by Elisa*

Dzongkhag Code:
1. Bumthang
2. Chukha
3. Dagana
4. Gasa
5. Haa
6. Lhuntse
7. Mongar
8. Paro
9. Pemagatshel
10. Punakha
11. Samtse
12. Sarpang
13. Thimphu
14. Trashigang
15. Trashiyangtse
16. Trongsa
17. Tsirang
18. Wangdue
19. Zhemgang
20. Others

Marital status:
1. Single
2. Married/with partner
3. Divorced
4. Widowed
5. Not applicable

Reason for TBCI:
1. Voluntary/self referral
2. STI patient
3. TB patient
4. HIV/AIDS related symptoms
5. Pregnancy/ANC
6. Opportunistic surgery
7. Blood donor screening
8. Contact tracing
9. Others (Specify)

Risk Assessment
1. Sex Workers
2. Injecting Drug use
3. MSM
4. Client of Sex worker
5. Mother HIV Infected
6. History of blood transfusion or organ transplant
7. Partner of PLHIV
8. Uniformed personnel
9. Mobile migrant worker
10. Prisoner
11. To whom Indirectly
12. Multiple partners/sex partners during
13. Partner with high risk behaviour
14. History of being rape victim
15. Low/no risk
16. Others (specify)

Mode of transmission:
1. Injecting drug use
2. Hetero-sex
3. Bi Sbl
4. Blood & blood products
5. Mother to child

Status of partner:
1. Positive
2. Negative
3. Unknown
4. Not applicable

Referral for:
1. ART
2. Admitted to hospital
3. Counselling
4. TB/Other screening
5. Care & support services
6. NGO Care Centre
7. ANC Maternity/PMTCT
8. CD 4 count

Clinical stage:
1. Asymptomatic
2. Advanced HIV infection
3. AIDS
4 Not assessed

National AIDS Control Programme
Quarterly VCT Report- Compilation form at DHO level

(to be completed in the DHO, compiling data from the reporting centers and sent to the NACP)

Quarter/year: Donor/drug:

Completeness of the district report

	VCT	District Hospital	BHU	Other services	Total	Completeness (B/Ax100
VCT reports expected					A	
VCT reports received					B	

PART 1: TOTAL ACTIVITY

	# CLIENTS PRE-TESTED	# CLIENTS HIV TESTED	#CLIENTS HIV POSITIVE*	% HIV POSITIVE (#HIV +/ # tested X 100)	# CLIENTS POST-TESTED
TOTAL					

*Ensure that all HIV+ cases have been reported using the HIV reporting form on the back of the quarterly VCT report

PART 2: ACTIVITY AND RESULTS BY GENDER AND AGE GROUP

	# CLIENTS HIV TESTED			#CLIENTS HIV POSITIVE		
	Male	Female	Total	Male	Female	Total
0-29/365						
1/12-11/12						
1 – 4 yrs						
5-14 yrs						
15-24 yrs						
25- 49 yrs						
50 and above						
Total						

*29/365 means 29 days, 1/12 means one month & 11/12 means 11 months.

PART 3: DISTRIBUTION BY REASON FOR T&C

	# CLIENTS PRE-TESTED	# CLIENTS HIV TESTED	#CLIENTS HIV POSITIVE	% HIV POSITIVE # HIV+/# tested X 100	# CLIENTS POST-TESTED
STI patients					
TB patients					
Pregnant women					
Blood donors					
Contact tracing					

PART 4: DISTRIBUTION BY RISK ASSESSMENT

GROUP	# CLIENTS PRE-TESTED	# CLIENTS HIV TESTED	#CLIENTS HIV POSITIVE	% HIV POSITIVE #HIV +/# tested X 100	# CLIENTS POST-TESTED
Sex workers					
Injecting drug users					
MSM					
Client of sex worker					
Uniformed personnel					
Mobile/migrant workers					

QUARTERLY NATIONAL HIV CASE REPORTING FORM – Compilation form at DHO level

Reporting Quarter _____ **Dzongkhag** _____

Please report each of the new HIV* case for each quarter. *(Each row is for a new case).* Reporting is to be done quarterly and not case-wise. Do not report again an old case already reported (e.g. re-testing for confirmation of an old case)

Registration No.	Patient's code*	Age	Gender M/F	Dzongkhag	Gewog/ Thromde/	Occupation	Marital status	Mode of HIV testing	Place of HIV testing	Reason for T&C	Mode of transmission	Risk assessment	Status of partner	Risk of delivering	Risk of delivering with HIV	Patient's clinical stage	Last CD4 (Date & Result)	Referral for

** The patient's code is allocated by the reference laboratory after confirmation by Elisa*

Dzongkhag, marital status, reason for T&C, mode of transmission, risk assessment, status of partner, clinical stage, referral for: use the same codes as in the Quarterly HIV case reporting form-Facility level

Table 2: Supporting forms for data recording, data reporting and data flow for PMTCT, STI and MSTF monitoring.

Form	Objective	Place of use	Type of information	Responsible person	Flow of data
PMTCT patient summary form	To record key medical information for HIV positive women during pregnancy up to 18 months after delivery, to support follow up and document the interventions received.	Facility level	▪ 1form per client –HIV positive pregnant woman ▪ Individual information on support follow up, during pregnancy up to 18 months.	Health care providers proposing PMTCT should maintain	▪ The form will be kept in each hospital, BHU ▪ Statistics for quarterly report will be compiled from the PMTCT register and this form.
Quarterly STI case reporting form	To report statistics on STIs	Facility level	Number of STI syndromic diagnosis- as per gender, age group Number of ANC syphilis screening	▪ Head of Community Health Unit in Referral hospital ▪ District medical officer in hospital Responsible Health assistant in BHU	The form is duly filled and sent to the District Health Office and a copy retained in the health facility.
Quarterly STI case reporting form- compilation form	To compile STI statistics from the various facilities	District Health Office	Completeness of STI quarterly reports (% of facilities reporting) Same statistics as in the STI quarterly report	District health Officer	▪ Sum of the statistics from the various facility STI quarterly reports ▪ To be sent to the NACP
MSTF quarterly report form	To report MSTF activities statistics	MSTF secretariat	Number of meetings, advocacy campaigns conducted.	MSTF secretariat	▪ The form is duly filled and sent to the District Health Office and a copy retained in the MSTF secretariat.
MSTF quarterly report form- compilation form	To compile MSTF activities statistics from the various Dzongkhags	District Health Officer	Completeness of MSTF quarterly reports (% of facilities reporting) Same statistics as in the MSTF quarterly report	District health Officer	▪ Sum of the statistics from the various MSTF quarterly reports ▪ To be sent to the NACP

5 FORMS

1 PMTCT Patent Summary Form

2 STI quarterly report form at the facility level

3 STI quarterly report- compilation form at the DHO level

4 MSTF quarterly report form at the facility level

5 MSTF quarterly report- compilation form at the DHO level

Prevention of mother-to-child transmission
Patient summary form

This form aims to capture the key medical information for HIV positive women during pregnancy up to 18 months after delivery, to support follow-up and document the interventions received. PMTCT program indicators will be calculated using this form. This form should be kept in the health facility and stored with respect of confidentiality.

A. Woman s' background

Patient's code: /_____/ Name:_____

Dzongkhag of residence: _____ Geog:_____

Age: _____ Occupation:_____

Marital status: ☐single ☐married/with partner ☐divorced ☐widowed

Education: ☐Literate ☐illiterate ☐primary ☐secondary ☐tertiary

B. HIV testing and family situation

Date of first HIV+ testing: /____/____/_____/

Was HIV+ status discovered ☐during this pregnancy? ☐before this pregnancy? (explain)

Mode of transmission: ☐Injecting drug use ☐Heterosexual ☐Blood/blood products

Partner HIV status: ☐positive ☐negative ☐unknown ☐no partner

Number of children:_____ specify sex, age and HIV status of the children

- child1:_____
- child2:_____
- child3: _____
- child4:_____

Woman's clinical stage: ☐stage1 ☐stage2 ☐stage3 ☐stage4 ☐not assessed

CD4 count: date/___/___/_____/ results/_____/ or ☐not assessed

C. Mother ARV treatment

C.1 Before delivery

Type of ARV regimen prescribed: ☐HAART (for women in need of treatment) ☐ARV prophylaxis (for prevention of MTCT only)

Date of start of ARV drugs/____/____/_____/Estimated gestational age at start: /_____/ weeks

ARV drugs and doses prescribed during pregnancy:

1._____

2._____

3._____

Was ARV regimen: ☐ yes (all drugs taken as prescribed, since 28 weeks without discontinuation)

C.2 At delivery

Date of delivery: /____/____/_____/ Number of babies born alive: /____/

Type of delivery (or end of pregnancy): ☐vaginal discharge ☐Unplanned C-section ☐planned caesarian section ☐spontaneous abortion

☐Voluntary abortion

ARV drugs and doses prescribed during delivery: Was ARV regimen completed: ☐ yes ☐ no

1._____

2._____

3._____

C.3 After delivery

ARV drugs, doses, duration prescribed after delivery: Was ARV regimen completed: ☐ yes ☐ no

1._____

2._____

3._____

D. Baby prophylaxis

ARV drugs, doses, duration prescribed to the baby: Was ARV regimen completed: ☐ yes ☐ no

1._____

2._____

Feeding choice: ☐exclusive breastfeeding if yes duration:_____
☐Replacement feeding ☐mixed feeding (not recommended)

Infant feeding counseling performed at birth: ☐yes ☐no, regularly after birth: ☐yes ☐no

Date of starting cotrimoxazole primary therapy in baby: /___/___/_____/ ☐not done

E. HIV testing in babies

E.1 PCR at 6 weeks ☐ done ☐not done
If done, date, place and result:_____

E.2 HIV anti-body testing

- Before 18 months: ☐done ☐not done, if done, date and result:_____
- At 18 months, date/___/___/_____/ Result: ☐positive ☐negative ☐indeterminate

If not done at 18 months, reason: ☐baby death, date of death: /___/___/_____/
☐mother/baby lost for follow-up, date of last visit/___/___/_____/
☐other reason, specify_____

Baby referred to:_____

STI reporting forms: instructions for use

Reporting centers

- All health services attending STI patients and pregnant women
  - o OPD and IPD departments for STI syndromic report
  - o Reproductive health/ANC department for report of syphilis screening among pregnant women

Information to report

▪ Number of STI syndromic cases per gender and age-groups

Case-definitions

Urethral discharge syndrome: Urethral discharge in men with or without dysuria.
Vaginal discharge syndrome: Abnormal vaginal discharge (indicated by amount, colour and odour) with or without lower abdominal pain or specific symptoms or specific risk factors.
Genital ulcer syndrome: Non vesicular ulcer on penis, scrotum, or rectum in men and on labia, vagina, or rectum in women, with or without inguinal adenopathy.
Lower abdominal pain in women: Symptoms of lower abdominal pain and pain during sexual intercourse with examination showing vaginal discharge, lower abdominal tenderness on palpation, or temperature >380 C.

Age break down: 29/365 means 29 days, 1/12 means 1 month & 11/12 means 11 months.

▪ Syphilis screening among pregnant women

Source of information

- STI syndromic case report: OPD and IPD registers
- Syphilis screening among pregnant women: ANC registers

Frequency of report: quarterly

Responsible person to report

- At facility level: District Medical Officer in District Hospital, Health Assistant in charge in BHU
- At district level: District Health Officer

Flow of information

A single form has to be completed in each facility (compiling statistics from the different departments: OPD, IPD, ANC) at the end of the quarter and sent to the District Health Office.
The District Health Office will compile the statistics from the different facilities in a single form and calculate the completeness of the District STI report (number of STI reports expected compared to reports received). The DHO will send the District STI compilation form to the NACP.

Quarterly STI case reporting form – Reporting form at facility level

(to be completed in each health facility and sent to the person in charge of STI in the DHO)

Quarter/year: Name of reporting center:

Type of reporting center:

☐Regional hospital ☐District hospital ☐BHU ☐Other (specify)

Dzongkhag: Geog:

1. Syndromic STI diagnoses

	Males		Females		
Age group	Urethral discharge (UD)	Genital ulcer disease (GUD)	Vaginal discharge (VD)	Genital ulcer disease (GUD)	Lower abdominal pain (LAP/PID)
0-29/365					
1/12-11/12					
1 – 4 yrs					
5-14 yrs					
15-24 yrs					
25- 49 yrs					
50 &above					
Total					

Remarks:

Note: *29/365 means 29 days, 1/12 means 1 month & 11/12 means 11 months.*

2. ANC syphilis screening

Number of pregnant women with ANC first visit in the quarter

VDRL/RPR		TPHA*		Syphilis
Number of performed	Number of reactive	Number of performed	Number of positive	Number of pregnant women treated.

* Where the testing facility is available

Remarks:

Quarterly STI case report – Compilation form at DHO level

(to be completed in the DHO compiling data from the reporting centers and sent to the NACP)

Quarter/year: Dzongkhag:

Completeness of the district report:

	District hospital	BHU	Other services	TOTAL	Completeness (B/Ax100)
STI reports expected				A	
STI reports received				B	

1. Syndromic STI diagnoses

	Males		Females		
Age group	Urethral discharge (UD)	Genital ulcer disease (GUD)	Vaginal discharge (VD)	Genital ulcer disease (GUD)	Lower abdominal pain (LAP/PID)
0-29/365					
1/12-11/12					
1 – 4 yrs					
5-14 yrs					
15-24 yrs					
25- 49 yrs					
50 & above					
Total					

Remarks:

Note: *29/365 means 29 days, 1/12 means 1 month & 11/12 means 11 months.*

2. ANC syphilis screening

Number of pregnant women with ANC first visit in the quarter

VDRL/RPR		TPHA*		Syphilis
Number of performed	Number of reactive	Number of performed	Number of positive	Number of pregnant women treated.

* Where the test facility is available.

Remarks:

Instructions for use: Multi-Sectoral Task Force (MSTF) activity report

Organisations to report

- All organisations part of the MSTF (even if no activities were conducted during the quarter: zero-reporting)

Period of report

- Every quarter

Information to report: Activities conducted such as meetings, trainings, etc, during the quarter.

Each organisation will use the form to report activities conducted during the quarter. In so, each organisation will mention the target populations to be reached. **For each target population, each organisation will report the following activities conducted during the quarter:**

- Number of outreach services: outreach refers to going to the specific target population for one-to-one contact,
- Number of groups sensitisation: refers to meetings with a group of people from the target population to deliver information and promotion,
- Number of peer-counsellor involved: peer-counsellor refers specifically to the counsellors issued from the target population and in no case from the hierarchy. For example for school children, peer-counsellors are school children not the teachers.
- Target - number of persons from the target population to be reached during the quarter. Each organisation should have a working plan with targets regarding the number of person to reach. Report here how many person you expected to reach during the quarter of report,
- Coverage - number of persons from the target population effectively reached during the quarter. Report here the number of persons you effectively reached during the quarter of report and compare it to your target for the quarter
- Number of persons from the target population referred for VCT. This is the number of persons you individually promoted VCT and referred them to VCT. Do not count in this indicator, the persons attending a group sensitisation where VCT was promoted as it is not individual referral to VCT.
- Number of condoms distributed to the target population

Flow of information and responsible persons

The focal person in each organisation will send a quarterly report to the MSTF secretariat.
The MSTF coordinator will compile the activities from the different organisations in a single form and will calculate the completeness of the MSTF report (number of organisations to report compared to the number of reports received). The MSTF will send a report to the NACP.

Quarterly report of MSTF activities – Reporting form at organisation level

(To be completed by each organisation part of the district MSTF and sent to the MSTF secretariat office)

Quarter/year: Name of the organisation:

Dzongkhag: Contact person:

	Activities	Who are the participants/audience and how many reached?	Outcome
A	1. Meeting (s)		
	2. Training (s)		
	3. Advocacy campaign(s)		
B	1. Condom Distribution		
	Deachong boxes existing		Deachong boxes installed new
	2. Number of Condoms distributed (total)		
C	High priority of groups* reached (pls. mention the target population reached & note activities as mentioned in page no. 40 under information to report.) Number of outreach services. ☐ Number of groups sensitisation. ☐ Number of peer-counsellor involved. ☐ Target ☐ Coverage. ☐ Number of persons from the target population referred for VCT. ☐ Number of condoms distributed to the target population. ☐		

* Sex Workers, Clients of Sex workers, Injecting drug users, Men having sex with men, Youths in school, Youths out-of school, Uniformed personnel, Mobile/migrants workers, Prisoners, Tourism industry workers, and other population (Specify)

Quarterly report of MSTF activities – Compilation form at MSTF level

(To be completed by the district MSTF according to the information received by the different organisations and sent to the NACP)

Quarter/year: Dzongkhag: MSTF reporting person:

Number of organizations part of MSTF (A): Number of organizations reporting during the quarter (B): Completeness (B/A)x100):

	Activities	Who are the participants/audience and how many reached?	Out come
A	1. Meeting (s)		
	2. Training (s)		
	3. Advocacy campaign(s)		
B	1. Condom Distribution		
	Deachong boxes existing		Deachong boxes installed new
	2. Number of Condoms distributed (total)		
C	High priority of groups* reached (pls. mention the target population reached & main activities as mentioned in page no. 40 under information to report.) Number of outreach services. ☐ Number of groups sensitisation. ☐ Number of peer-counsellor involved. ☐ Target ☐ Coverage. ☐ Number of persons from the target population referred for VCT. ☐ Number of condoms distributed to the target population. ☐		

* Sex Workers, Clients of Sex workers, Injecting drug users, Men having sex with men, Youths in school, Youths out-of-school, Uniformed personnel, Mobile/migrants workers, Prisoners, Tourism industry workers, and other population (Specify)

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