

Module 10

Part 1 - Condom Distribution

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Condom Distribution



10.1 WHAT ARE THE TOOLS USED FOR DATA COLLECTION?

The data collection tools used in condom distribution are shown below. They are classified as follows:

Primary Tools

Primary data sources are essential to routine monitoring within the HIS and are prerequisite to the calculation of indicators. They form the basis of the guidance and training within this manual and are described in detail in the Illustrated Guides at the end of the module.

Secondary Tools

Secondary data sources have important functions within the HIS but are not directly used in the calculation of indicators. They play vital roles informing clinical decision-making and promoting service quality and performance. They are described in information boxes in the supporting text.



> Data collection and monitoring tools

Condom Distribution

Primary Tools
1. Community Health Worker records
2. OPD / STI Clinic records
3. Family Planning Register
4. HIV/AIDS Report



10.2 WHO IS RESPONSIBLE FOR COLLECTING THE DATA?

Responsibility for collecting and reporting condom distribution data should be designated to staff in each dispensing location (see below). Each staff member should understand how to keep an accurate log of the number of condoms distributed and should take responsibility for maintaining complete and accurate records.

At the end of each week, the HIV/AIDS supervisor should coordinate the collection of data from all reporting sections. This person should ensure that submissions are received from all locations, and entered in full and on time into the HIV/AIDS Report.



10.3 WHAT DATA SHOULD BE COLLECTED AND HOW?

A record of the number of condoms issued each day should be kept in each dispensing location. The number and types of location will vary according to programme design in each country, but in most operations this will include OPDs, community health departments, family planning clinics, and HCT and PMTCT sites.

The number of condoms distributed should be recorded in a separate counterbook, with the exception of family planning clinics where the number of pieces distributed and the type of user are recorded within the Family Planning Register (see Module 9: Reproductive Health).



10.4 HOW AND WHEN SHOULD THE DATA BE REPORTED?

At the end of each week, each dispensary should report the number of condoms distributed in the corresponding table in the HIV/AIDS Report.

The dates of the reporting weeks are shown in the Reporting Calendar. It is important that all staff are aware of these dates, and that copies the calendar are distributed to all locations.

10.4.1 Weekly Report

The HIV/AIDS supervisor is responsible for ensuring complete and timely submission of information from each dispensary. Photocopies of the form may be required to assist each dispensary to make an individual report prior to aggregation into the weekly total.

10.4.2 Monthly Report

At the end of each week the paper-based report forms can be directly entered into the computer. The database will then automatically combine these into a monthly report composed of 4 or 5 weekly reports, depending on the reporting calendar. More information on data management and is given in Part 3 of the manual.

An Illustrated Guide to the HIV/AIDS Report, and an explanation of how the information should be reported from daily sources, is given at the end of the module.



10.5 HOW SHOULD THE DATA BE INTERPRETED AND USED?

The indicator for condom distribution is shown below. It is classified according to the five core objectives of the HIS given in Part 1 of this manual. A summary of each indicator, including formulae, units of expression, and the corresponding standard (where available) is given in the Standard and Indicator Guide that accompanies this manual.



> Indicator Summary

Condom Distribution

Objective	Indicator	Source
3. Evaluate the effectiveness of interventions and service coverage	Condom Distribution Rate	UNHCR/UNICEF/UNFPA

Module 10

Part 2 - HIV Counselling and Testing (HCT)

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HIV Counselling and Testing (HCT)



10.6 WHAT ARE THE TOOLS USED FOR DATA COLLECTION?

The data collection tools used in the HCT are shown below. They are classified as follows:

Primary Tools

Primary data sources are essential to routine monitoring within the HIS and are prerequisite to the calculation of indicators. They form the basis of the guidance and training within this manual and are described in detail in the Illustrated Guides at the end of the module.

Secondary Tools

Secondary data sources have important functions within the HIS, but are not directly used to calculate indicators. They play vital roles informing clinical decision-making and promoting service quality and performance. They are described in information boxes in the supporting text.



> Data collection and monitoring tools

HIV Counselling and Testing

Primary Tools
1. HCT Client Register
2. HCT Results Register
3. HIV/AIDS Report
Secondary Tools
1. Informed Consent Form
2. Client Intake Form
3. Repeat Visit Form
4. HCT card



10.7 WHO IS RESPONSIBLE FOR COLLECTING THE DATA?

The task of recording each counselling and testing session is the responsibility of the individual HCT counsellor. Each must understand how to properly code and record information in the HCT Registers. The information system operates on the basis of shared confidentiality, whereby counsellors have shared access to a central set of registers in each HCT clinic (see Country Considerations Box). Each counsellor should be familiar with this principle of confidentiality, and access client information on a strictly 'need to know' basis.

At the end of each week, the HCT supervisor should coordinate the completion of the HIV/AIDS Report and ensure that all HCT sites have made their submission in full and on time. The HCT supervisor should monitor the upkeep of the registers and ensure the completeness of record entries each day.



10.8 WHAT DATA SHOULD BE COLLECTED AND HOW?

HIV counselling and testing should always be voluntary and confidential. All health information recorded in HCT should protect the confidentiality of the client and prevent his or her identity from being linked with HIV test results. The specific measures taken by the host government and/or health partner to protect individual confidentiality and prevent non-consensual disclosure of HIV status should be explicit and well defined.

Careful record management is a prerequisite for confidentiality. To adequately protect the confidentiality of HCT clients, all counselling and testing results in the HIS are coded to prevent identifying attributes (such as name and address) from being linked to HIV status in the same information source.

To achieve this, each counsellor should record HCT information in two registers:

1. Client Register
2. Results Register

All HCT Registers should be stored out of public view when not in use, ideally in separate locations that are secured with a lock and key. All HCT staff should be given appropriate training in how to apply these rules of procedure (refer to Country Considerations Box: Confidentiality).

10.8.1 Client Register

A Client Register is used to record basic information on each individual who attends the HCT clinic. All clients should be registered, regardless of the decision to proceed with a test. The information is not in itself confidential but, as it is the origin of the association between the identity of the client and the confidential code number, access to the register should be restricted at all times. New visits should be assigned a unique HCT code number, using Ministry of Health or health agency protocols for ciphering information. Revisits should use the same number that was allocated during the previous counselling session(s).

The Client Register records identifying information and facts regarding marital status, number of children, and the reason for visit.





> Country Considerations

What measures are taken to protect individual confidentiality?

All medical records should be managed in accordance with appropriate standards of confidentiality. This is particularly true for HIV-related information, where confidentiality helps to obtain a client's trust and demonstrates sensitivity and respect toward the basic rights of the individual. This helps to avoid stigmatisation and discrimination and to enhance adherence to care.

Information shared during HIV counselling must not be shared with others. The HIV test result must only be reported to the client, unless the client states the desire to share the test result with a family member, partner or close friend.*

The HCT and PMTCT registers in the HIS are designed to protect client confidentiality by preventing identifying attributes from being linked with HIV test results. Results are coded in a separate register, in which data fields such as name and address have been removed. The host government and/or health partner policy towards the coding of information, and assigning unique HCT and PMTCT identifiers, should be followed at all times.

Principle of shared confidentiality

The health information system operates under a principle of shared confidentiality, whereby counsellors enter results into a common set of registers on a "need to know" basis. Only counsellors and health care providers with a direct role in the management of clients should update individual HCT and PMTCT records.

In a refugee setting, where high staff turn-over requires records to be accessible in the event of counsellor separation / repatriation, shared confidentiality enables the continuum of care can be preserved at all times.

Shared confidentiality is also the basis on which persons living with HIV/AIDS access other care and support services in the camp (such as nutritional support, outpatient services, and home-based care). Unique HCT and PMTCT coding, which are decipherable to health providers in those locations, permits identification of eligible individuals and provision of services.

* This form of shared confidentiality is appropriate and often very beneficial, but must be done with the consent on the client. In rare circumstances, confidentiality may be breached where there is a clear indication that a third party may be harmed by the actions of the patient, but this must following appropriate procedural guidance and occur only in exceptional circumstances.

10.8.2 Results Register

The Results Register contains the outcomes of each counselling and testing session. Information in the register is anonymous and recorded against coded age and sex information only. As for the HCT Client Register, it is vital that this kept private and access to client records restricted to individual HCT counsellors.

The design of the Results register is determined by the national testing algorithm for HCT in each country. The register should adequately reflect the types of test and the procedures for use as defined in the MoH guideline (refer to Country Considerations Box: HIV Testing Algorithm). The Results Register is also used to document the provision of pre-test counselling, indicate results of screening and confirmatory tests that were conducted, and to confirm the receipt of post-test counselling.

The HCT Client and HCT Results Registers collect summarised information to facilitate the routine monitoring of the HCT programme. Detailed pre-test and post-test questionnaire information, and a record of informed consent, should be maintained separately (see Secondary Tools Box).

> Postponement of testing

Postponement of testing may occur after pre-test counselling, for example to allow a client to discuss the decision more fully with family or partners and thereby offer an opportunity to engage them in the process. The decision not to be tested during the same visit must be recorded in the register. If the client subsequently chooses to return for a test, this should be documented as a new entry.

> Postponement of post-test counselling

Clients should receive post-test counselling immediately after the test is conducted. The decision not to be post-test counselled during the same visit must be recorded in the register. If the client chooses to return for a test result at a later date, this should be documented outside the Results register.

> HIV Status

HIV status should be classified based on the results of rapid testing, and recorded as HIV positive (P), HIV negative (N), or HIV indeterminate (I). The procedure for reporting results will depend on the national testing algorithm. For serial testing:

- If the screening test is negative do not complete the confirmatory or tiebreaker tests. Client status is classified as negative (N).
- If screening and confirmatory tests are positive, do not complete the tiebreaker test. Client status is classified as positive (P).
- If screening and confirmatory tests are discordant, this is termed an indeterminate event. Client HIV status will be determined by the result of a tiebreaker test.

If blood samples are required to be sent to referral laboratories for a tiebreaker test, HIV status should be left blank pending the definitive result. Depending on the time interval between sending the sample and receiving the tie breaker result, the number of HIV positive cases may or may not correspond with the HIV tests conducted in the same reporting period. If a tiebreaker test is

unavailable, HIV status is classified as indeterminate (I). The client should be counselled to return for a repeat test after 14 days to obtain a definitive result.

> **Couple Counselling**

If HCT clients attend as a couple, each should be recorded as a separate entry in the register and allocated a unique HCT code. Each entry should log the respective partner code and an indication of whether the result was shared to allow appropriate linking of data within the two registers.

This guidance is different to that in PMTCT, where one code is used for both the woman and her partner. More information on the measures that should be taken to protect confidentiality during couple counselling are given later in the module (see Part 3: PMTCT).

> **HIV Care and Support**

A minimum preventive care package should be offered to all persons identified as being HIV-positive, regardless of stage of HIV disease or eligibility for anti-retroviral therapy (ART). In country settings where elements of the package are not yet available, implementation should be prioritised as an essential component of the HCT service.

The Register should record the date on which each service is provided. A date should not be recorded unless all criteria within the intervention have been met.

• **Home-based care visit**

Enter date on which a visit was conducted by a trained counsellor to assess care and support needs in the home. This should include safe drinking water provision, particularly looking at issues of household access and means of safe water storage. The provision of soap should be also be considered part of a preventive care package, according to country-specific guidelines.

• **TB referral**

A referral system that links HIV counselling, testing, and care services with TB diagnostic and treatment centers is essential to ensure that persons with suspected TB are referred for diagnosis and treatment of active TB. Enter a date to certify that the HIV-infected client has been screened for active TB (for case definition criteria see Module 3: Morbidity).

• **Follow-up Counselling**

Counselling HIV-infected persons to refrain from high-risk behaviors offers an opportunity to reduce transmission of HIV to others. Similarly, counselling and testing of family members and other contacts of HIV-infected persons offers an opportunity to identify additional

> Secondary Tools

The HCT / PMTCT Client and Results Registers contain summarised information that facilitate the routine monitoring of outcomes each month. They do not replace the need to maintain records of informed consent and pre-test and post-test questionnaire information at the time of each visit.

A description of the most commonly used forms is given below. The design and composition of these forms varies, and should be guided by National HIV/AIDS Programme guidelines.

Informed Consent Form

This form should be signed after the client has received HIV testing pre-test counselling and before blood is taken for the purpose of HIV testing. This is a formal process designed to protect client interests and ensure HIV testing is not carried out improperly. If the client is unable to write an imprint should be made and the counsellor should sign to witness that they have given consent.

The consent form should be available in the preferred language of the client and kept in the medical record.

Client Intake Form*

This form is only used for initial visits (data from return visits are recorded on the Return Visit Form) and should record detailed client information related to both pre- and post-test sessions.

The pre-test questionnaire should collect information that help the counsellor assess the client's risk and counselling needs. The recorded content will vary according to the objectives of the session: from the simple offer to opt out of HIV testing to discussion about HIV and its transmission, assessment of risk, the test procedure and the implications of the results, risk reduction planning and identifying available support.

The post-test questionnaire should contain fields to ensure that relevant post-test information has been given to the client regarding their particular HIV test result. It should document the discussion of support needs and prevention of HIV transmission and may include further information to make an assessment of the person's understanding, explore the meaning and implications of the result, formulate safer behavioural strategies, identify emotional support, and provide follow up and referral as necessary.

After counselling, the forms should be stored in a confidential location at the HCT site.

Client Return Visit Form*

This form collects information about the client for each return visit. It should contain fields to ensure relevant discussions take place around reducing risk behaviours. A new Return Visit Form should be filled out for each return visit. After counselling, the forms should be stored in a confidential location at the HCT site.

* In some settings, these case-based forms may be used for higher data entry and analysis that is independent of the routine monitoring requirements of the HIS. Forms should be designed and standardised accordingly, and should be collected, stored and analysed under separate guidelines.



> Country Considerations

What is the HIV testing algorithm of the host government?

Choosing the most appropriate screening tests and the combination of tests for confirmation is essential to ensure an accurate diagnosis of HIV. It is important that the rapid tests and testing algorithms chosen for use in HIV testing and counselling have been thoroughly evaluated on samples from the geographical region where they are to be used.

The selection process is a responsibility of national governments and is predominantly performed by health ministries and national AIDS control programmes. The decision should be made following country-level technical assessments and an evaluation of other relevant factors, such as cost, current and continued availability, shelf-life and storage requirements.

Monitoring requirements should be adapted according to the national algorithm and data recording sources modified to reflect national guidance. Written directions on issues related to principles of use, quality assurance, and laboratory safety should also be made available to all health partner staff.

HIV-infected persons and refer them to appropriate care and prevention services. Enter a date on which follow-up counselling to both the client and members of the family was offered.

• SFP referral

Enter date on which referral to feeding centre for nutrition counselling was made. This visit should include guidance on how to use available foods and to maintain/increase food intake. Depending on the criteria defined in the nutrition protocol, HIV infected persons may also be eligible for supplementary feeding and/or other micronutrient supplementation and should be enrolled accordingly (see Module 8: Nutrition).

• OPD referral

Enter date of referral to OPD for medical history and examination, to assess co-morbidity and/or presence of other opportunistic infection.

Future modifications to the information system should be planned, as new areas for monitoring and implementing HIV preventive care programmes open in each country. For example, cotrimoxazole prophylaxis, insecticide treated bednet distribution and anti-retroviral therapy (ART) (see Illustrated Guide at end of module).

An Illustrated Guide to the HCT Registers, and an explanation of the information that should be recorded in each column heading, is shown at the end of the module.



10.9 HOW AND WHEN SHOULD THE DATA BE REPORTED?

At the end of each week the HCT Results Register should be used to compile the HCT table within the HIV/AIDS Report.

The dates of the reporting weeks are shown in the Reporting Calendar. It is important that all staff are aware of these dates, and that copies the calendar are distributed to all HCT clinics.

10.9.1 Weekly Report

The HIV/AIDS supervisor is responsible for ensuring complete and timely submission of the weekly report from each HCT site. The number of clients pre-test counselled, tested, tested positive and post-test counselled should be retrieved from the registers, and disaggregated by age (<18, ≥18), sex and status (refugee or national). Note that the number of reported HIV positive tests should not include clients with HIV indeterminate status or those who are awaiting tiebreaker test results.

If there is more than one HCT site in the camp, the information from each unit should be combined to create one weekly report for the entire camp. Photocopies of the weekly form may be required to assist units compile their individual reports prior to aggregation into the camp totals.

10.9.2 Monthly Report

At the end of each week the paper-based report forms can be directly entered into the computer. The database will then automatically combine these into a monthly report composed of 4 or 5 weekly reports, depending on the reporting calendar. More information on data management and is given in Part 3 of the manual.

An Illustrated Guide to the HIV/AIDS Report, and an explanation of how the information should be reported from daily sources, is given at the end of the module.



10.10 HOW SHOULD THE DATA BE INTERPRETED AND USED?

The indicators for HCT are shown below. Each is classified according to the five core objectives of the HIS given in Part 1 of this manual. A summary of each indicator, including formulae, units of expression, and the corresponding standard (where available) is given in the Standard and Indicator Guide that accompanies this manual.

It is essential that staff are familiar with how these indicators are calculated, and understand how they should be applied in public health practice. A group exercise on how to calculate and interpret the indicators, using sample data, is given on the CD-ROM which accompanies this manual.



> Indicator Summary

HIV Counselling and Testing (HCT)

Objective	Indicator	Source
2. Monitor trends in health status and continually address healthcare priorities	Prevalence of HIV	UNHCR
3. Evaluate the effectiveness of interventions and service coverage	HCT Uptake	UNHCR
	Proportional HCT service use by nationals	HIS
5. Evaluate the quality of health interventions	Proportion who received post-test counselling and result	UNHCR



> Illustrated Guide to HCT Client Register

A								B		
Serial No.	HCT No.	Name	Age	Sex	Status (Ref / Nat)	Address	Date of visit	Prev. Test (Y / N)	Referred from: *	Next appt. date

A REGISTRATION:

Serial No.:

> Enter sequence number in register

HCT No:

> Enter unique identifying number

Name:

> Print name of client

Age:

> Fill age (in years)

Sex:

> Enter Male (M) / Female (M)

Status:

> Classify as Refugee (Ref) / National (Nat)

Address:

> Print Camp Address (Refugee) / Nearest Village (National)

Date of visit:

> Enter date (dd/mm/yy)

Prev. test:

> Enter Yes (Y) or No (N) to indicate whether client has had previous test.

B VISIT DETAILS:

Referred from:

> Enter source of referral using legend given on each page

Next Appt date:

> Enter date of next scheduled appointment (dd/mm/yy)

> Illustrated Guide to HCT Results Register

A						B								C			
						TEST RESULTS											
Serial No.	HCT No.	Counsellor code	Age	Sex	Status (Ref / Nat)	Date of visit	Prev. test (Y / N)	Pre-test counselled	Tested	Screening test*	Confirmatory test*	Tie-breaker**	HIV Status**	Post test counselled	Partner HCT Code (if tested)	Referred to: †	Next appt. date

A REGISTRATION:

Serial No.:
> Enter sequence number in register

HCT No.:
> Enter unique client identifying code

Counsellor Code:
> Enter unique counsellor identifying code

Age:
> Fill age (in years)

Sex:
> Enter Male (M) / Female (M)

Status:
> Classify as Refugee (Ref) / National (Nat)

Date of visit:
> Enter date (dd/mm/yy)

Prev. test:
> Enter Yes (Y) or No (N) to indicate whether client has had previous test.

NOTES
HCT Client code and Counsellor codes should be ciphered according to Ministry of Health and/or agency guidelines.
Previous test means at any time in any location, including country of origin.

B TEST RESULTS:

For Pre-test counselled / Tested / Post-test counselled:
> Enter Yes (Y) or No (N) to indicate presence or absence of the event. Leave blank if not indicated.

For Screening / Confirmatory / Tiebreaker tests:
> Enter Positive (P) / Negative (N) to indicate result of the test

HIV Status:
> Enter Positive (P) / Negative (N) / Indeterminate (I) to classify status of client

Partner HCT code:
> Enter unique identifying code for partner, if client attended as a couple

C FOLLOW-UP CARE:

Referred to:
> Enter destination of referral using legend given on each page

Next Appt date:
> Enter date of next scheduled appointment (dd/mm/yy)

Module 10

Part 3 - PMTCT (Antenatal)

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PMTCT (Antenatal)



10.11 WHAT ARE THE TOOLS USED FOR DATA COLLECTION?

The data collection tools used to monitor counselling and testing in PMTCT are shown below. They are classified as follows:

Primary Tools

Primary data sources are essential to routine monitoring within the HIS and are prerequisite to the calculation of indicators. They form the basis of the guidance and training within this manual, and are described in detail in the Illustrated Guides at the end of the module.

Secondary Tools

Secondary data sources have important functions within the HIS but are not directly used in the calculation of indicators. They play vital roles informing clinical decision-making and promoting service quality and performance. They are described in information boxes in the supporting text.



> Data collection and monitoring tools

PMTCT (Antenatal)

Primary Tools
1. PMTCT Client Register
2. PMTCT Results Register
3. HIV/AIDS Report

Secondary Tools
1. Informed Consent Form
2. Client Intake Form
3. Repeat Visit Form
4. Antenatal card



10.12 WHO IS RESPONSIBLE FOR COLLECTING THE DATA?

The task of recording each counselling and testing session is the responsibility of the individual PMTCT counsellor. Each must understand how to properly code and record information in the PMTCT Registers. The information system operates on the basis of shared confidentiality, whereby counsellors have shared access to a central set of registers in each PMTCT clinic (see Country Considerations Box). Each counsellor should be familiar with this principle of confidentiality, and access client information on a strictly 'need to know' basis.

At the end of each week, the PMTCT supervisor should coordinate the completion of the HIV/AIDS Report and ensure that all PMTCT sites have made their submission in full and on time. The HCT supervisor should monitor the upkeep of the registers, and ensure the completeness of record entries each day.



10.13 WHAT DATA SHOULD BE COLLECTED AND HOW?

HIV counselling and testing should always be voluntary and confidential. All health information recorded in PMTCT should protect the confidentiality of the client and prevent his or her identity from being linked with HIV test results. The specific measures taken by the host government and/or health partner to protect individual confidentiality, and prevent non-consensual disclosure of HIV status, should be explicit and well defined.

The procedures for monitoring counselling and testing in PMTCT share many similarities with HCT and are described under the guidelines in Part 2 of this module. The key differences in data collection between the two programmes are described below.

10.13.1 Couple Counselling and Testing

Male involvement and support is critical to the success of any PMTCT programme. Disclosure of HIV status between couples can increase adherence to anti-retroviral (ARV) regimes in PMTCT and couple counselling should therefore be promoted as a means of facilitating communication, advocating behaviour change and decreasing HIV transmission.

As in HCT, a unique code should be assigned to each PMTCT client. New codes should be created following Ministry of Health or health agency guidelines. Repeat visits should use the same identifier at each counselling and testing session. For couples who are counselled together

in PMTCT, the male partner should be recorded in the same register entry and under the same PMTCT code as the female client (see Illustrated Guide to PMTCT Client and Results Registers). This differs to HCT, where each client in a couple counselling session should be entered in a separate row and assigned an individual code number.

Despite the system of shared coding in PMTCT, no disclosure of status between partners should occur without prior consent. Couples who come together for counselling and testing in PMTCT must receive their results separately in the first instance and then together in the same centre visit. This strategy is designed to ensure an individual is not coerced into sharing a result. It also assists the client to plan for how the shared disclosure is managed. The same principle of confidentiality and informed disclosure applies to couples in HCT.

If the partner is not counselled and tested in PMTCT (e.g. not present in the camp at the time of the visit, chooses not to be tested, or if the mother is widowed or separated) then this reason should be written in the partner field. If either partner decides to go for more HIV counselling and testing outside of the PMTCT programme, s/he should be enrolled into the HCT programme registers and assigned new HCT code numbers.

10.13.2 Anti-retroviral Prophylaxis

A PMTCT client who tests HIV positive should receive comprehensive post-test counselling, including discussion of strategies to reduce the risk of HIV transmission to her unborn child and benefits of ARV prophylaxis. On the basis of informed consent, the sharing of the result and post-test decision making should involve the male partner.

The decision of an HIV infected woman to accept or decline ARV prophylaxis should be ascertained at the time of post-test counselling, and recorded in the register. This decision may change between the time of counselling and the time of delivery and is only to be interpreted as an intention to use. Actual receipt and use of ARV prophylaxis during labour and delivery should therefore be objectively established at the time of birth (see Part 4: PMTCT Labour, Delivery and Postnatal).

The specific ARV regime that is used in each country PMTCT programme will depend on the national policy of the MoH (see Country Considerations Box below). An Illustrated Guide to the PMTCT Registers, and an explanation of the information that should be recorded in each, is given at the end of the module.



10.14 HOW AND WHEN SHOULD THE DATA BE REPORTED?

At the end of each week the PMTCT Results Register should be used to compile the PMTCT tables in the HIV/AIDS Report. The dates of the reporting weeks are shown in the Reporting Calendar. It is important that all staff are aware of these dates, and that copies the calendar are distributed to all PMTCT units.

10.14.1 Weekly Report

The HIV/AIDS supervisor is responsible for ensuring complete and timely submission of the weekly report from each PMTCT site. The number of clients pre-test counselled, tested, tested positive and post-test counselled should be retrieved from the registers, and disaggregated by age (<18, ≥18), sex and status (refugee / national). Note that the number of HIV positive tests should not include clients with HIV indeterminate status or those who are awaiting tiebreaker test results.

If there is more than one PMTCT site in the camp, the information from each unit should be combined to create one weekly report for the entire camp. Photocopies of the weekly form may be required to assist units compile their individual reports prior to aggregation into the camp totals.

An Illustrated Guide to the HIV/AIDS Report, and an explanation of how the information should be reported from daily sources, is given at the end of the module.

10.14.2 Monthly Report

At the end of each week the paper-based report forms can be directly entered into the computer. The database will then automatically combine these into a monthly report composed of 4 or 5 weekly reports, depending on the reporting calendar. More information on data management and is given in Part 3 of the manual.



10.15 HOW SHOULD THE DATA BE INTERPRETED AND USED?

The indicators for PMTCT (Antenatal) are shown below. Each is classified according to the five core objectives of the HIS given in Part 1 of this manual. A summary of each indicator, including formulae, units of expression, and the corresponding standard (where available) is given in the Standard and Indicator Guide that accompanies this manual.

It is essential that staff are familiar with how these indicators are calculated, and understand how they should be applied in public health practice. A group exercise on how to calculate and interpret the indicators, using sample data, is given in the CD-ROM that accompanies this manual.



> Indicator Summary

PMTCT (Antenatal)

Objective	Indicator	Source
2. Monitor trends in health status and continually address healthcare priorities	Prevalence of HIV (PMTCT Clients)	UNHCR
	Prevalence of HIV (PMTCT Partners)	UNHCR
3. Evaluate the effectiveness of interventions and service coverage	PMTCT Coverage	UNHCR
	PMTCT Uptake	UNHCR
	Proportional PMTCT service use by nationals	HIS
5. Evaluate the quality of health care interventions	Proportion who received post-test counselling and result	UNHCR
	Proportion of partners who received post-test counselling and result	UNHCR

> Illustrated Guide to PMTCT Client Register

A								B					
Serial No.	PMTCT No.	Name	Age	Status (Ref / Nat)	Address	Date of visit	Prev. Test (Y / N)	Gravidity	Parity	No. of children	Gestational age	Type of counselling (Individual / Couple)	Next appt. date

A REGISTRATION:

Serial No.:

> Enter sequence number in register

PMTCT No.:

> Enter unique identifying number

Name:

> Print Name of expectant mother

Age:

> Fill age (in years)

Status:

> Classify as Refugee (Ref) / National (Nat)

Address:

> Print Camp Address (Refugee) / Nearest Village (National)

Date of visit:

> Enter date (dd/mm/yy)

Prev. test:

> Enter Yes (Y) or No (N) to indicate whether client has had previous test.

NOTES

Classification of reason for visit, physical and emotional state should be aligned with Ministry of Health and/or agency guidelines.

B VISIT DETAILS:

Gravidity:

> Number of pregnancy (see glossary)

Parity:

> Number of previous deliveries (see glossary)

No. of children:

> Number of surviving children

Gestational age:

> Gestational age in weeks (XX / 36)

Type of counselling:

> Enter individual or couple

Next Appt date:

> Enter date of next scheduled appointment (dd/mm/yy)

Module 10

Part 4 - PMTCT (Labour, Delivery and Postnatal)

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PMTCT (Labour, Delivery and Postnatal)



10.16 WHAT ARE THE TOOLS USED FOR DATA COLLECTION?

The data collection tools used to monitor counselling and testing in PMTCT are shown below. They are classified as follows:

Primary Tools

Primary data sources are essential to routine monitoring within the HIS and are prerequisite to the calculation of indicators. They form the basis of the guidance and training within this manual, and are described in detail in the Illustrated Guides at the end of the module.

Secondary Tools

Secondary data sources have important functions within the HIS but are not directly used in the calculation of indicators. They play vital roles informing clinical decision-making and promoting service quality and performance. They are described in information boxes in the supporting text.



> Data collection and monitoring tools

PMTCT (Labour, Delivery and Postnatal)

Primary Tools

1. PMTCT Labour, Delivery and Postnatal Register
2. PMTCT Referral Form
3. HIV/AIDS Report

Secondary Tools

1. Antenatal card



10.17 WHO IS RESPONSIBLE FOR COLLECTING THE DATA?

Recording of use of ARV prophylaxis during labour and delivery is the responsibility of the nursing staff on the maternity ward. Postnatal PMTCT data is recorded by the individual PMTCT counsellor. Staff in both locations must understand how to properly code and record information in a way that guarantees the confidentiality of the HIV infected mother (refer to Part 1 of this module).

The nurse in-charge and PMTCT supervisor should monitor the upkeep of the registers in their respective sections, and ensure the completeness of record entries each day. At the end of each week, the PMTCT supervisor should coordinate the completion of the HIV/AIDS Report and ensure that all sites have made their submission in full and on time.



10.18 WHAT DATA SHOULD BE COLLECTED AND HOW?

Nursing staff should check the HIV status of all women admitted to the maternity unit, as indicated by the unique PMTCT code on the ANC card. All deliveries, regardless of HIV status, should be entered into the Delivery Register (see Module 9: Reproductive Health). In addition HIV positive (and HIV indeterminate) deliveries should be recorded in a PMTCT Referral Form, with details of maternal and infant anti-retroviral (ARV) prophylaxis use.

All staff involved in the collection and reporting of HIV-related health information should be given appropriate training in the application of guidance to protect the medical privacy and confidentiality of PMTCT clients (refer to Part 1 of this module).

10.18.1 Use of ARV Prophylaxis

This module sets out the monitoring requirements for the minimum single-dose ARV prophylaxis regime. This is used in most refugee settings, and recommends single-dose nevirapine to be provided to HIV infected mothers at 28 weeks gestation and swallowed at the onset of labour, and provided to newborns within 72 hours of birth. The specific regime should be aligned to the policies of the host government in each country (refer to Country Considerations Box: Anti-retroviral policy).

A summary of delivery outcome, receipt and use of maternal and infant ARV prophylaxis, and status of the newborn should be recorded in a PMTCT Referral Form. In the event of multiple pregnancy, more than one form should be filled. HIV infected mothers should be identified and referred to the maternity ward before the onset of labour. This permits nursing staff to objectively verify maternal ARV use, and adherence to the national protocol. If the onset of labour occurs before arrival, a witness statement by the mother (seconded, if possible, by other persons present

at the time) should be used to certify the use of ARV.

The PMTCT Referral Form should also document the status of the newborn and log the provision of infant ARV prophylaxis. This event should be certified by the member of staff responsible for administration.

10.18.2 Postnatal counselling and follow-up

After discharge from the maternity unit, the Referral Form should be used to refer the mother back to her individual counsellor in the PMTCT unit. Information contained within the form should be transferred into the PMTCT Labour, Delivery & Postnatal Register: including the date, mode and location of delivery, newborn condition, and the use of maternal and infant anti-retroviral prophylaxis (individually and as a pair). The register also enables prospective follow-up of the mother and infant in the postnatal phase. Infant feeding and family planning options should be discussed and the decision to accept indicated by entering a date in the corresponding column.



> Country Considerations

What is the policy for use of anti-retroviral prophylaxis in PMTCT?

Women may receive anti-retroviral (ARV) drugs during pregnancy as part of combination of regimens, of varying cost and complexity, that are used to treat their HIV infection or as prophylaxis to prevent HIV infection in infants.

In resource-constrained settings, the capacity exists to deliver only a minimal range of such ARV drugs for PMTCT. Even pregnant women who do not yet need, or have access to, ARV *treatment* the use of complex prophylaxis regimes is faced with numerous difficulties and constraints.

Single Dose Maternal and Infant ARV Prophylaxis

The HIS is designed to monitor implementation of the simplest recommended ARV prophylaxis regimen, which consists of single-dose nevirapine (NVP) for the mother at onset of labour and single-dose nevirapine for the infant within 72 hours.*

Although single-dose maternal and infant NVP is the simplest regimen to deliver, programmes should consider introducing more complex ARV regimens where possible. Such programme expansion will necessitate appropriate improvements and modifications to the HIS to enable these more complex ARV regimens to be delivered and monitored.

* The exact protocol adopted in each country should concur with National HIV/AIDS Programme and Ministry of Health Guidelines.

Home-based care plans should be developed and the date of the first home-based visit logged in the register. The mother/infant pair should remain within the PMTCT programme until infant HIV status is tested at 18 months. This long period of follow-up demands careful and organised data management within each unit. Women who are HIV indeterminate at the time of delivery, and who subsequently test negative, do not require further follow-up

The reason and date of exit should be recorded, according to the legend on each register page. Discharge refers to mothers who have remained in the programme until infant status has been determined aged 18 months.

An Illustrated Guide to the PMTCT Referral Form and the Labour, Delivery & Postnatal Register, plus an explanation of the information that should be recorded in each, is given at the end of the module.



10.19 HOW AND WHEN SHOULD THE DATA BE REPORTED?

At the end of each week the PMTCT Results Register should be used to compile the PMTCT section within the HIV/AIDS Report. The dates of the reporting weeks are shown in the Reporting Calendar. It is important that all staff are aware of these dates, and that copies the calendar are distributed to all PMTCT units.

10.19.1 Weekly Report

The HIV/AIDS supervisor is responsible for ensuring complete and timely submission of the weekly report from each PMTCT site. The number of HIV positive deliveries should be retrieved from the PMTCT Labour, Delivery, Postnatal register and disaggregated by age (<18, ≥18), location (home or health facility) and status (refugee or national). Postnatal options (for infant feeding, family planning and home-based care), the number of discharges, and the status of infants tested at 18 months should also be recorded at the end of each week, disaggregated by age (<18, ≥18) and status (refugee or national).

If there is more than one PMTCT site in the camp, the information from each unit should be combined to create one weekly report for the entire camp. Photocopies of the weekly form may be required to assist units compile their individual reports prior to aggregation into the camp totals.

An Illustrated Guide to the HIV/AIDS Report, and an explanation of how the information should be reported from daily sources, is given at the end of the module.

10.19.2 Monthly Report

At the end of each week the paper-based report forms can be directly entered into the computer. The database will then automatically combine these into a monthly report composed of 4 or 5 weekly reports, depending on the reporting calendar. More information on data management and is given in Part 3 of the manual.



10.20 HOW SHOULD THE DATA BE INTERPRETED AND USED?

The indicators for PMTCT (labour, delivery and postnatal) are shown below. Each is classified according the five core objectives of the HIS given in Part 1 of this manual. A summary of each indicator, including formulae, units of expression, and the corresponding standard (where available) is given in the Standard and Indicator Guide that accompanies this manual.



> Indicator Summary

PMTCT (Labour and Delivery)

Objective	Indicator	Source
2. Monitor trends in health status and continually address healthcare priorities	Proportion of HIV positive deliveries to nationals	HIS
	Proportion of mothers who swallowed ARV prophylaxis during delivery	UNHCR
3. Evaluate the effectiveness of interventions and service coverage	Proportion of newborns who were given ARV prophylaxis within 72 hours of birth	UNHCR
	Ratio of HIV positive live-births : mother-newborn pairs that ARV prophylaxis	UNHCR



> Indicator Summary

PMTCT (Postnatal)

Objective	Indicator	Source
5. Evaluate the quality of health care interventions	Proportion of HIV positive mothers who plan to exclusively breastfeed after delivery	UNHCR
	Proportion of HIV positive mothers who received at least one home-based counselling visit after delivery	UNHCR
	Proportion of HIV positive mothers who accepted a modern method of family planning after delivery	UNHCR

> Illustrated Guide to PMTCT Referral Form

All HIV positive (or HIV indeterminate) mothers should be registered in a PMTCT Referral Form immediately after delivery, and referred to a PMTCT Counsellor for postnatal counselling and follow-up.

Health Information System			
10.4/5 PMTCT Referral Form			
A <i>Section 1: Mother Information</i>			
<i>PMTCT No.</i>	<i>Gravidity</i>	<i>Status (Circle)</i> Refugee / National	
<i>Age</i>	<i>Parity</i>	<i>HIV Status (Circle)</i> Positive / Indeterminate	
Event	Date	Time	Remarks (<i>Circle</i>)
Admission to labour ward			
Onset of labour			Spontaneous / Induced
Swallowed ARV			
Membrane rupture			Spontaneous / Artificial
Delivery			<i>Mode of delivery:</i>
B <i>Section 2: Newborn Information (fill more than one form if multiple pregnancy)</i>			
<i>Sex (Circle)</i> Male / Female	<i>Weight (kg)</i>	<i>Head circumference (cm)</i>	
<i>Apgar Score</i>	<i>Length (cm)</i>	<i>Remarks</i>	
Event	Date	Time	Remarks
Given ARV			Within 72 hours? Yes / No
C <i>Section 3: Referral Information</i>			
<i>Referred to (counsellor / clinic):</i>		<i>Date:</i>	<i>Print Name:</i>

A MOTHER INFORMATION:

PMTCT No:

> Enter unique identifying number

Age:

> Fill age (in years)

Gravidity:

> Number of pregnancy (see glossary)

Parity:

> Number of previous deliveries (see glossary)

Status:

> Circle to indicate Refugee or National

HIV Status:

> Circle to classify HIV status as Positive (P) or Indeterminate (I)

This should be determined using PMTCT identifying code on antenatal card

In table, enter:

> Enter date (dd/mm) and Time (hh:mm) of:

- Admission to labour ward
- Onset of labour
- Swallowed ARV prophylaxis
- Rupture of membranes
- Delivery

Circle to indicate whether onset of labour was spontaneous or induced

Circle to indicate whether rupture of membranes was spontaneous or artificial

Enter remark indicating mode of delivery

B NEWBORN INFORMATION:

Sex:

> Enter Male (M) / Female (F)

Apgar Score:

> Enter number (1 - 10) (see Module 9)

Weight:

> Weight (kg)

Length:

> Length (cm)

Head circumference:

> Measurement (cm)

Remarks:

> Enter comment on physical state of newborn:
Good / Poor / Critical

In table, enter:

> Date (dd/mm) and Time (hh:mm) that:

- Newborn was given ARV prophylaxis

Circle to indicate whether this was less or more than 72 hours from the time of delivery.

NOTES

Apgar criteria and scoring chart should be clearly visible on wall of every maternity ward.

C REFERRAL DETAILS:

Referred to:

> Enter name of PMTCT counsellor and clinic to which mother is being referred

Date:

> Enter date of referral (dd/mm/yy)

Signature:

> Print name of staff member making the referral

> Illustrated Guide to PMTCT Labour, Delivery and Postnatal Register

A								B						
Serial No.	PMTCT No.	Counsellor code	Age	Status (Ref / Nat)	Gravidity	Parity	HIV Status*	LABOUR & DELIVERY						
								Date of delivery	Mode of delivery	Location of delivery	Newborn sex (M / F)	Anti-retroviral Use (enter date given)		Mother-Newborn pair (✓ or X)
											Mother	Newborn		

A REGISTRATION:

Serial No.:
> Enter sequence number in register

PMTCT No.:
> Enter unique client identifying code

Counsellor Code:
> Enter unique counsellor identifying code

Age:
> Fill Age (in years)

Status:
> Classify as Refugee (Ref) / National (Nat)

Gravidity:
> Number of pregnancy (see glossary)

Parity:
> Number of previous deliveries (see glossary)

HIV Status:
> Enter Positive (P) / Negative (N) / Indeterminate (I) to classify status of client

NOTES
All HIV positive deliveries should be entered into this register, using information within the PMTCT Referral form.
Mother and infant pairs should be followed until infant reaches 18 months of age, and HIV status has been determined.

B LABOUR AND DELIVERY:

Date of delivery:
> Enter date (dd/mm/yy)

Mode of delivery:
> Classify as Spontaneous Vaginal Delivery (SVD) / Vacuum Extraction (VE) / C-Section (CS)

Location:
> Specify Health facility (Name) / Birth before arrival / Home

Newborn sex:
> Enter Male (M) / Female (F)

Anti-retroviral (ARV) use:
> Enter date indicate if:

- Mother swallowed ARV
- Newborn given ARV

Co-trimoxazole use:
> Enter date mother and infant started prophylaxis

C						D	
POST-NATAL						Date of exit	Reason for exit
Co-trimoxazole use (enter date started)		Infant Feeding Options **	Accepted FP	Received HBC	Infant HIV Status at 18 months		
Mother	Infant						

1. Discharge
2. Death (neonate)
3. Death (< 1 year)
4. Death (> 1 year)
5. Default
6. Referral

C POSTNATAL:

Infant Feeding Options:
 > Select ONE feeding option only from legend on bottom of page:

- Exclusive breastfeeding
- Replacement feeding
- Other (specify)

Accepted FP:
 > Enter date on which mother accepted to start a modern family planning method (dd/mm/yy)

Home-based Care:
 > Enter date on which mother received first home-based care visit (dd/mm/yy)

Infant Status at 18 months:
 > Enter results of infant HIV testing aged 18 months; classify status as Positive (P) or Negative (N)

D EXIT DETAILS:

Date of exit:
 > Enter date (dd/mm/yy)

Reason for exit:
 > Enter reason for exit, using options provided in legend.

Record as Discharge / Death (neonate) / Death (< 1 year) / Death (> 1 year) / Default / Referral

NOTES
 HIV positive women and infants who are discharged from the PMTCT register should be referred to other appropriate programmes for follow-up care and support.

> Illustrated Guide to HIV/AIDS Report (FRONT)

Health Information System

Reporting Form

10.0 HIV/AIDS

A

Organisation: _____

Location: _____

Reporting period: _____

B

10.1 Condom Distribution

Number of condoms distributed	Condom type	
	Male	Female
OPD / STI Clinic		
Family Planning Clinic		
Community Health		
Other		

C

10.2 HIV Testing and Counselling (HCT)

Number of HCT clients	Refugee				National			
	< 18		≥ 18		< 18		≥ 18	
	M	F	M	F	M	F	M	F
Pre-test counselled								
Tested for HIV								
Tested positive for HIV								
Post-test counselled								

D

10.3 PMTCT (Antenatal)

Number of pregnant women	Refugee			National		
	< 18	≥ 18	Partner	< 18	≥ 18	Partner
Pre-test counselled						
Tested for HIV						
Tested positive for HIV						
Post-test counselled						
Who accepted to take ARV at 28 weeks						

XXXXX XXXXX_EN_ddmmyy

A HEADER:

Organisation:

Print name of health partner

Location:

Print name of Camp and Reporting Unit

Reporting period:

Enter number of week and month (e.g. Week 1 March)

NOTES

The dates of the reporting weeks are shown in the Reporting Calendar. It is important that all staff are aware of these dates, and that copies the calendar are distributed to all antenatal clinics.

The HIV/AIDS supervisor is responsible for coordinating the complete and timely submission of all sections contributing to the weekly report.

B CONDOM DISTRIBUTION:

Complete Table 10.1 using records from each condom dispensing location.

NOTES

The HIV/AIDS Supervisor should coordinate the timely and complete submission of condom distribution figures from each dispensing location.

For locations where primary HIS tools are not available (e.g. community health department) alternative counterbooks should be maintained.

C HCT:

Complete Table 10.2, using the HCT Results registers.

NOTES

If a client decides not to be tested or post-test counselled during the same visit, this must be recorded in the register.

The number of HIV positive tests does not include clients with HIV indeterminate status, or those who are awaiting tiebreaker test results.

The number of HIV positive tests does not include clients with HIV indeterminate status, or those who are awaiting tiebreaker test results.

D PMTCT:

Complete Table 10.3, using the PMTCT Results registers.

NOTES

If a client decides not to be tested or post-test counselled during the same visit, this must be recorded in the register.

The number of HIV positive tests does not include clients with HIV indeterminate status, or those who are awaiting tiebreaker test results.

The number of HIV positive tests does not include clients with HIV indeterminate status, or those who are awaiting tiebreaker test results.

> Illustrated Guide to HIV/AIDS Report (REVERSE)

E

10.4 PMTCT (Labour and Delivery)

HIV positive deliveries	Refugee				National	
	< 18		≥ 18		< 18	≥ 18
	Home	Health Facility	Home	Health Facility		
Live births						
Still births						
Abortions						
During which mother swallowed ARV						
After which newborn was given ARV < 72 hours						
No. of mother-newborn pairs that received ARV *						

* on time, according to national protocol

10.5 PMTCT (Postnatal)

Number of HIV positive women who:		Refugee			National		
		< 18	≥ 18	Total	< 18	≥ 18	Total
Choose to exclusively breastfeed							
Choose to replacement feed							
Received at least 1 HBC visit*							
Accepted modern family planning							
Number of mothers who started co-trimoxazole							
Number of infants who started co-trimoxazole							
Number of exits:	<i>discharge</i>						
	<i>death (neonatal)</i>						
	<i>death (< 1 year)</i>						
	<i>death (> 1 year)</i>						
	<i>default</i>						
	<i>referral</i>						
Infant HIV outcomes	HIV positive at 18 mnths						

* Home Based Care

E

PMTCT (LABOUR, DELIVERY & POSTNATAL):

Complete Table 10.4 and 10.5, using the PMTCT Labour, Delivery and Postnatal Care register

NOTES

Only HIV positive women should be entered.

Women who are HIV indeterminate at delivery, and are subsequently confirmed negative, should not be included in post-natal follow-up for PMTCT.

> Illustrated Guide to ART Report

Health Information System

Reporting Form

10.6 Anti-Retroviral Therapy (ART) Program

A

Organisation: _____
 Location: _____
 Reporting period: _____

B

	Refugee		National	
	< 18	≥ 18	< 18	≥ 18
	M	F	M	F
Cumulative number of patients on ART at beginning of period				
Number started on ART				
commenced new				
transfer in				
Number re-started ART after interruption of treatment				
Number of exits				
stopped ART				
transfer out				
lost to follow-up				
death				
unknown				
Cumulative number of patients on ART at end of period				

Number enrolled in HIV care and eligible for ART but NOT started ART by end of period

XXXXX XXXXX_EN_ddmmyy

A **HEADER:**

Organisation:

Print name of health partner

Location:

Print name of Camp and Reporting Unit

Reporting period:

Enter number of week and month (e.g. Week 1 March)

NOTES

The dates of the reporting weeks are shown in the Reporting Calendar. It is important that all staff are aware of these dates, and that copies the calendar are distributed to all antenatal clinics.

The HIV/AIDS supervisor is responsible for coordinating the complete and timely submission of all sections contributing to the weekly report.

B **ANTI-RETROVIRAL PROGRAMME:**

Complete table using ART registers to maintain the cumulative number of beneficiaries on receiving ART in each location.