Operational Guideline for VCCT Centers in Vanuatu (2012 - 2016)

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<th>Full Form</th>
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<tr>
<td>AIDS</td>
<td>Acquired Immunodeficiency Syndrome</td>
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<tr>
<td>AHD</td>
<td>Adolescent Health Department</td>
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<tr>
<td>ANC</td>
<td>Ante Natal Clinic</td>
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<tr>
<td>ART</td>
<td>Antiretroviral Treatment</td>
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<tr>
<td>ARV</td>
<td>Anti-Retroviral</td>
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<tr>
<td>BCC</td>
<td>Behaviour Change Communication</td>
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<tr>
<td>CBO</td>
<td>Community-Based Organization</td>
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<tr>
<td>CD4</td>
<td>Cluster of Differentiation 4</td>
</tr>
<tr>
<td>CHC</td>
<td>Community Health Centre</td>
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<tr>
<td>CRIS</td>
<td>Country Response Information System</td>
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<tr>
<td>CSO</td>
<td>Civil Society Organization</td>
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<tr>
<td>CTX</td>
<td>Co-trimoxazole</td>
</tr>
<tr>
<td>DMLT</td>
<td>Diploma in Medical Laboratory Technology</td>
</tr>
<tr>
<td>DNA</td>
<td>Deoxyribonucleic Acid</td>
</tr>
<tr>
<td>DOTS</td>
<td>Directly Observed Treatment Short-course</td>
</tr>
<tr>
<td>EDD</td>
<td>Expected Date of Delivery</td>
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<tr>
<td>EQAS</td>
<td>External Quality Assessment Scheme</td>
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<tr>
<td>FBO</td>
<td>Faith-Based Organization</td>
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<tr>
<td>HIV</td>
<td>Human Immunodeficiency Virus</td>
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<tr>
<td>IATA</td>
<td>International Air Transport Association</td>
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<tr>
<td>I/C</td>
<td>In-Charge</td>
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<tr>
<td>ID</td>
<td>Identification</td>
</tr>
<tr>
<td>IDU</td>
<td>Injecting Drug User</td>
</tr>
<tr>
<td>IEC</td>
<td>Information, Education and Communication</td>
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<tr>
<td>LT</td>
<td>Laboratory Technician</td>
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<tr>
<td>IPD</td>
<td>In-Patient Department</td>
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<tr>
<td>MLT</td>
<td>Medical Laboratory Technology</td>
</tr>
<tr>
<td>MM</td>
<td>Mucous Membrane</td>
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<tr>
<td>MO</td>
<td>Medical Officer</td>
</tr>
<tr>
<td>MSM</td>
<td>Men who have Sex with Men</td>
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<tr>
<td>MTP</td>
<td>Medical Termination of Pregnancy</td>
</tr>
<tr>
<td>NAC</td>
<td>National AIDS Committee</td>
</tr>
<tr>
<td>NGO</td>
<td>Non-Governmental Organization</td>
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<tr>
<td>NPH</td>
<td>Northern Provincial Hospital</td>
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<tr>
<td>NRL</td>
<td>National Reference Laboratory</td>
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<tr>
<td>NTCP</td>
<td>National Tuberculosis Control Programme</td>
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<tr>
<td>NVP</td>
<td>Nevirapine</td>
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<tr>
<td>OI</td>
<td>Opportunistic Infection</td>
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<tr>
<td>OPD</td>
<td>Out-Patients Department</td>
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<tr>
<td>OPIC</td>
<td>Other Potentially Infectious or Contaminated</td>
</tr>
<tr>
<td>PAC</td>
<td>Provincial AIDS Committee</td>
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<tr>
<td>PCR</td>
<td>Polymerase Chain Reaction</td>
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<tr>
<td>PEP</td>
<td>Post-Exposure Prophylaxis</td>
</tr>
<tr>
<td>PIN</td>
<td>Patient Identification Number</td>
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<tr>
<td>PICTs</td>
<td>Pacific Island Countries</td>
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<tr>
<td>PI</td>
<td>Percutaneous Injuries</td>
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<tr>
<td>PLWHA</td>
<td>Positive Living With HIV/AIDS</td>
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<tr>
<td>PMTCT</td>
<td>Prevention of Mother-To-Child Transmission</td>
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<tr>
<td>PPTCT</td>
<td>Prevention of Parent-To-Child Transmission</td>
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<tr>
<td>PRL</td>
<td>Provincial Reference Laboratory</td>
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<tr>
<td>QC</td>
<td>Quality Control</td>
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<tr>
<td>RH</td>
<td>Reproductive Health</td>
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<tr>
<td>RNA</td>
<td>Ribonucleic Acid</td>
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<tr>
<td>RTI</td>
<td>Reproductive Tract Infection</td>
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<tr>
<td>STI</td>
<td>Sexually Transmitted Infection</td>
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<tr>
<td>Sl.No.</td>
<td>Serial number</td>
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<tr>
<td>SOP</td>
<td>Standard Operating Procedure</td>
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<tr>
<td>TB</td>
<td>Tuberculosis</td>
</tr>
<tr>
<td>TG</td>
<td>Transgender</td>
</tr>
<tr>
<td>TI</td>
<td>Targeted Intervention</td>
</tr>
<tr>
<td>TV</td>
<td>Television</td>
</tr>
<tr>
<td>UN</td>
<td>United Nations</td>
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<tr>
<td>UNICEF</td>
<td>United Nation’s Children Fund</td>
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<tr>
<td>UPS</td>
<td>Uninterrupted Power Supply</td>
</tr>
<tr>
<td>USP</td>
<td>Universal Safety Precautions</td>
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<tr>
<td>VCC</td>
<td>Vanuatu Culture Centre</td>
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<tr>
<td>VCCT</td>
<td>Voluntary Counseling and Confidential Testing</td>
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<tr>
<td>VCH</td>
<td>Vila Central Hospital</td>
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<tr>
<td>VFHA</td>
<td>Vanuatu Family Health Association</td>
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<td>VSO</td>
<td>Voluntary Service Overseas</td>
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<td>WHO</td>
<td>World Health Organization</td>
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<td>WSB</td>
<td>Wan Smol Bag</td>
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<td>WV</td>
<td>World Vision</td>
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Acknowledgement

The publication of the National Guidelines for Voluntary Counseling and Confidential Testing in Vanuatu is the result of determined efforts from many individuals and organizations that developed, edited, reviewed, and provided support for the production of this document.

Specific acknowledgements go to the VSO Vanuatu Program Office, WHO Vanuatu Country Office, UNICEF Suva Office and SPC Suva Office for the technical and financial support provided during the guidelines review process.

Special thanks go to Dr. Bernard Fabre-Teste, WHO-CLO (Vanuatu) and Dr. Ider Dungerdorj, PMTCT Specialist UNICEF (Suva) for their invaluable insight during the formative stages of the guidelines development process, and the Acting National HIV/STI coordinator Ms. Janet Jack for all coordination and logistics support.

All members who were present in the different consultation meetings/workshops to develop this guideline contributed significant time and efforts to planning, and reviewing the substantive contents outlined in this policy document. The MoH recognizes their individual and collective efforts in making these guidelines a reality.

Members who were present in the different consultation meetings/workshops were

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Ms. Gertrude Wafula, Mr. Julius Ssenabulya, Ms. Hellen Nabbanja, Mr. Julius Inzira, Dr. Jimmy Ong, Dr. Sutapa Basu, Ms. Annie Gude, Dr. Rupert Gude, Mr. Eric Odero, Ms. Lucy Atkinson, Ms. Maria Rosalia Conception.

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In particular, the MoH acknowledges the contributions of Dr. Falguni Basu, VCCT Strengthening Advisor (VSO Volunteer) for his tireless efforts in drafting the first draft of the document, collating the comments received, and editing the final document.

There are also many other persons who have contributed to this document in one way or another, but who may not have been mentioned here. To everyone, we say a big ‘Thank You!’

Len TARIVONDA
Director of Public Health
Foreword

Mr. Mark P Bebe
Director General
Ministry of Health

The HIV counseling and testing services, started in the year 2003 and has been scaled up in the recent years. Today, there are 25 counseling and Testing Centers and few are coming up which are located at all provinces of the country. Voluntary Counseling and Confidential Testing Centers (VCCTs) and facilities providing Prevention of Mother-to-Child Transmission of HIV/AIDS (PMTCT) services are now remodeled along with Sexually Transmitted Infection’s (STI’s) syndromic management and/or presumptive treatment as a hub to deliver integrated services to all clients.

Though counseling and testing services have been implemented in Vanuatu for the past seven years, but very few people in the country are aware of their HIV status. For this reason, Provider-Initiated Testing and Counseling will not only strengthen the prevention and control of HIV/AIDS but also lead to clear benefits to the health outcome of people living with HIV/AIDS.

The new VCCT operational guidelines aim to ensure uniformity in counseling and testing services across the country. The guidelines are a guide on various administrative, financial and operational issues to all concerned so that the highest quality of services are offered to clients who visit VCCTs. The minimum physical infrastructure, equipment as well communication aids required in a VCCT is detailed. The training protocol for various categories of staff as well as the duties of different staff members in an VCCT are also described.

I appeal to all Organizations and Government departments, who are implementing VCCT Programmes to use these guidelines as a basis to deliver, harmonize and regulated VCCT services to the people of Vanuatu.

I ensure these guidelines will help all concern in delivering high quality counseling and testing services throughout the country and also in achieving the ambitious targets we have set for ourselves.

(Mark P BEBE)

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1: VOLUNTARY COUNSELING AND CONFIDENTIAL TESTING SERVICES

1.1: Introduction:
An individual who is infected with the human immunodeficiency virus (HIV) will not develop the acquired immunodeficiency syndrome (AIDS) immediately. The immune system of the individual will wage a consistent and prolonged war with the virus, right from the day of infection, delaying the onset of AIDS by many years. The time lag between infection and manifestation of signs and symptoms of AIDS is approximately 5-7 years. It is important that an individual who is HIV-infected is aware of his/her status as otherwise he/she could unknowingly transmit the virus to others. The only way to diagnose the presence of HIV and get timely treatment is through a simple blood test.

Amongst all the PICTs, Papua New Guinea has highest HIV prevalence. An estimated 34,100 people were living with HIV in 2009. HIV prevalence was found to be the highest in the country's Highlands and Southern regions, at 1.02% and 1.17%, with lower but increasing prevalence in Momase and New Guinea Islands, at 0.63% and 0.61%. Approximately 3,200 people in Papua New Guinea were newly infected with HIV in 2009 and, that same year, some 1,300 people died of AIDS. The risk factors that contribute to HIV infection in Papua New Guinea have not changed. As another PICT; Vanuatu has almost same type of risk factors, though it is still considered as low prevalence country.

In Kiribati HIV was first diagnosed in 1991. To December 2009, 52 cases of HIV had been reported in Kiribati, including 23 aids-related deaths. Thirty-three of the diagnosed HIV cases were male and nineteen were female, and many of the early HIV infections in Kiribati occurred among seafarers and their wives. Internationally, seafarers are considered to be an at risk group for HIV due to their mobility and to long periods of separation from home and family which has been associated with the buying of sex. Like Kiribati, Vanuatu also has lots of seafarers and seasonal workers mainly overseas fruit pickers.

Situation in another PICT Solomon Islands is; although HIV and AIDS infection rates are low, but have the ingredients for an epidemic: poverty, the prevalence of sexually transmitted infections and limited counseling and testing services same as like Vanuatu.

In Vanuatu 1st HIV positive case detected in the year 2002. Since then total 5 cases detected out of which 4 adult (2 male & 2 female) and 1 child. AIDS related death in Vanuatu is 2 till now and 3 is living with the virus.

Though Vanuatu is still low HIV prevalence country but in terms of other STI it is one of the high prevalence countries in the pacific. In 2008 second generation surveillance shows amongst ANC attendees 25% have Chlamydia and its still increasing. It is proven fact that those who have other STIs they 10% more prone to get HIV.

These figures can be the just tip of ice berg. We may have to face the underneath danger if we cannot roll out quality counseling and testing services throughout the country.

HIV counseling and testing services were started in Vanuatu in the year 2003. There are now 26 VCCTs and 2 are coming up, 4 of them are operated by NGOs and rest of them is in government setup. Still today, very few people in the country are aware of their HIV status. The challenge before us is to make all people in the country aware of their status so that they adopt healthy lifestyles and prevent the transmission of HIV to others, and access life-saving care and treatment. Thus, counseling and testing services are an important component of prevention and control of HIV/AIDS in the country.
HIV counseling and testing services are a key entry point to prevention of HIV infection, and to treatment and care of people who are infected with HIV. When availing counseling and testing services, people can access accurate information about HIV prevention and care, and undergo an HIV test in a supportive and confidential environment. People who are found HIV-negative are supported with information and counseling to reduce risks and remain HIV-negative. People who are found HIV-positive are provided psychosocial support and linked to treatment and care.

In general, VCT offers a holistic approach and addresses HIV in the broader context of people's lives, including the context of poverty and its relationship with risky practices.\textsuperscript{ii,iii, iv}

1.2: Aims and Objectives of VCCT:
The aims of VCCT are quite achievable. However, to be successful, a sensitive, trusting and respectful relationship between the counselor and the client\textsuperscript{1} needs to be formed. Further, a structured approach is necessary to ensure that the client has adequate information for problem solving and decision-making during pre- and post-test counseling.

Voluntary counseling and confidential testing (VCCT) is a dialogue between a counselor and a client to achieve the following:\textsuperscript{1}

- To provide the client with information on the HIV test, its benefits and the risks involved. The aim is to have the informed consent of the client before the test, and to help the client gain a better understanding of the test results.
- To provide the client with background information on HIV/AIDS infection, modes of transmission, preventive methods, treatment and care. To assess the risk of HIV infection in the client.
- To encourage and maintain a safe behaviour to avoid future infection and/or to prevent the further spread of HIV (e.g. through safe sex and changing drug injecting practices).
- To help the client to handle possible emotional reactions related to the HIV test results (e.g. grief, anger, fear and denial).
- To discuss courses of action adapted to each client, his family needs and circumstances.

1.3: What is a VCCT Centre?
A voluntary counseling and confidential testing centre is a place where a person is counseled and tested for HIV, on his own free will or as advised by a medical service provider. The main functions of a VCCT include:

- Early detection of HIV.
- Provision of basic information on modes of transmission and prevention of HIV/AIDS.
- Promoting behavioral change and reducing vulnerability.
- Link people with other HIV prevention, care and treatment services.
- STI management services.

Ideally, a health facility should have one VCCT for all groups of people. Accordingly, a VCCT can be located in the OPD, IPD and PMTCT clinic of a hospital or a maternity home where the majority of clients who access counseling and testing services are pregnant women. The justification for PMTCT centre is the need for providing prophylaxis to prevent the transmission of HIV from infected pregnant women to their infants. Similarly, a VCCT could be located in a tuberculosis (TB) microscopy centre or in a TB sanatorium. As TB is the commonest co-infection in people who are infected with HIV, availability of HIV counseling and testing can help clients to have their status diagnosed for accessing early treatment.

\textsuperscript{1} Those people are coming to VCCT for counseling and testing, it’s not necessary that they are sick, that’s why we are not calling them patient and we are not using the word people because it’s too broad.
1.4: Who needs to be tested in a VCCT?
It is the mandate of a VCCT to counsel and test everyone in the general population. There are subpopulations that are more vulnerable or practice high-risk behaviour. These subpopulations include sex workers and their clients, men who have sex with men (MSM), transgender, injecting drug users (IDUs), migrant workers, young peoples. Partners and children of people, who are prone to risky behaviour, should be encouraged to come for testing. HIV prevalence levels are typically higher among these subpopulations than in the general population. The personnel at VCCTs need to make concerted efforts to identify at-risk/vulnerable populations and ensure access for them to HIV counseling and testing services. Medical service providers also counsel clients who have a history of risky behaviour or have signs and symptoms suggestive of HIV/AIDS for counseling and testing to a VCCT.

1.5: Where can a VCCT be located?
A VCCT may be located in health facilities owned by the government, in the private/not-for-profit/NGO sector, in public sector organizations/other government departments such as the Municipality, Police Force, Armed Force and Correctional Centers etc. In the health facility, the VCCT should be well coordinated with all departments in the hospital as well as organizations in the local community like family planning clinics or youth centers. As the HIV test is a relatively low-cost test and since the risk perception is generally low, travelling a long distance to get tested could be a strong disincentive. Therefore, it is important to ensure that facilities for counseling and testing be located as close to the people as possible. VCCTs should ideally be located such that they provide maximum access to at-risk/vulnerable populations. However, a VCCT can be located in facilities that serve specific categories of people such as pregnant women and young people,

Some of the locations for setting up a VCCT are as follows:

**Government health sector**
A VCCT can be set up in any government health facility such as
- Country’s main referral hospital;
- Provincial hospital;
- Health centre, or
- TB department of a hospital.

**Private/not-for-profit sector**
VCCT can be set up in the private/not-for-profit sector in a facility which meets any of the criteria given below:
- Youth drop in centers;
- Family health centers and Clinics which are dealing with sexually transmitted infections (STIs);
- Clinics managed by faith based organizations.

**Public sector/other government departments**
VCCT can be set up by public sector organizations/other government departments. Some suggested locations are:
- Health facilities run by Municipal Council;
- Correctional Centers with a large number of inmates;
- Health facilities run by Police Organizations/Armed Forces;
- Health facilities run by public sector organizations catering to large volumes of migrant workers;
- University campuses.
1.6: What are the different type of VCCTs?

Broadly, VCCT can be classified into two types:¹

1. Fixed-facility VCCT
2. Outreach VCCT

**Fixed-facility VCCT**

Fixed-facility VCCTs are those that are located within an existing health-care facility/hospital/centre. A fixed-facility VCCT can be of two types:

1. **“Stand-alone” VCCT** having a full-time counselor and laboratory technician who undertake HIV counseling and testing. Such facilities should exist in main referral hospital, provincial hospitals and NGO clinics.

2. **“Facility-integrated” VCCT** which does not have full-time staff and provides HIV counseling and testing as a service along with other services. Existing staff such as the midwife/registered nurse are expected to undertake HIV counseling and testing. Such VCCTs will usually be established in facilities that do not have a very large client load and where it would be uneconomical to establish a stand-alone VCCT. Typically, such facilities are health centers. Such VCCTs will be supported by the National HIV/STI unit to the extent of:
   - Supply of rapid HIV testing kits;
   - Training of existing staff and professional supervision;
   - Quality assurance;
   - Supply of protective kits and prophylactic drugs for post-exposure prophylaxis (PEP) for staff;
   - Supply of information, education and communication (IEC) material required for a VCCT such as booklets, posters, flyers etc.

**Outreach VCCT**

It is often seen that high-risk/vulnerable populations are less likely to access fixed-facility VCCTs due to several impediments, the most important ones being distance and timing. Outreach VCCTs can be one way of taking a package of health services into the community.

A outreach VCCT consisting of a team of paramedical health-care providers (a health educator/midwife/registered nurse/counselor and LT) can set up a temporary clinic with flexible working hours in hard-to-reach areas, where services are provided ranging from regular health check-up, syndromic treatment for STIs and other minor ailments, antenatal care, immunization, as well as HIV counseling and testing services. Outreach VCCTs can thus cater to a larger audience and be a more effective preventive intervention by ensuring the reach of services.

An outreach VCCT may consist with a room to conduct a general examination and counseling, and a space for the collection and processing of blood samples, etc. hired or borrowed from local school/chiefs Nakamal or even within a Van, if the facility has one.

1.7: Characteristics’ of good VCCT session:

Client satisfaction and consequent positive changes in behaviour are the two major outcomes that can be expected from a successful VCCT session. A good VCCT session can have the following characteristics:¹⁶

- **Confidentiality:** Trust is one of the most important factors in the relationship between a counselor and a client.

¹ Irrespective of types of VCCT, the service is free in Vanuatu
**Time**: Time is necessary for the development of understanding and trust, both of which are indispensable.

**Non-Judgmental**: Counselor should be non-judgmental to the people irrespective of their lifestyle, sexual preferences, and socio economic, ethnic or religious background

**Accessibility**: VCCT services must be easily accessible. They must be based in health or other premises that are easy to get to in terms of physical accessibility and easy to use.

**Consistency and accuracy**: Any information provided through counseling and HIV voluntary testing should be consistent. The counselor therefore needs to have a clear understanding of the facts concerning HIV tests, infection and disease, and maintain close and confidential links with the other health workers who provide care to the client.

**Sensitivity and tact**: Although it is essential to raise issues related to sexuality and drug use, especially during pre-test sessions, such discussions should be sensitive to the client's concerns.

### 1.8: Human resources for a VCCT

The VCCT requires a team of skilled persons consisting of the manager/site facilitator, counselor and LT. An outreach worker would be necessary in high-prevalence areas.

Functions of VCCT team members:

1. **VCCT focal person**
   The VCCT focal person is responsible for the overall functioning of the VCCT. The administrative head of the facility where the VCCT is located must identify and nominate a person amongst staffs as manager/site facilitator of the VCCT.

   The VCCT focal person will have the following responsibilities:

   **Referrals and linkages**
   - Maintain effective coordination with the Provincial HIV committee RH and TB programmes as well as with the AHD programme, and visit key persons in the facilities run by these programmes once in a fortnight so as to strengthen linkages and minimise loss of clients during referrals.

   **Supply and logistics**
   - Report to the provincial HIV/STI focal person on the adequacy of stocks of condoms, medicine for STI syndromic managements, gloves, arrangement of PEP kit as and when required basis, disposable syringes and necessary items for sample collection, IEC materials etc. are available in the facility.

   **Monitoring**
   - Maintain HIV counseling & testing and STI management records and registers *(Appendix 3)*, and prepare quarterly reports *(Appendix 5)* which are to be sent to the national unit through provincial focal persons.

2. **Counselor**

   Ideally the VCCT focal person and counselor should be different person but due to lack of human resource same person can handle both the responsibility especially in health center setup. MoH will amend the job description to include counseling and testing job description of the nurses those who are trained in counseling and testing. And those nurses will only be transferred in such a health facility where there is a VCCT center.

   The duties of the counselor are as follows:

   **Preventive and health education**
   - Ensure that each client is provided pre-test information/counseling, post-test counseling and follow-up counseling in a friendly atmosphere.
Be available in the VCCT as per the specified timings.

Ensure that strict confidentiality is maintained.

Ensure that all IEC materials such as posters, etc. are displayed prominently in the VCCT.

Ensure that communication aids in the form of flip books and condom demonstration models, fliers, etc. are available in the VCCT.

**Psychosocial support**

- Provide psychological support when client discloses status and agrees disclosure of his/her medical records to help HIV-positive clients cope with HIV/AIDS and its consequences.

- Ensure that the extended family of the HIV-positive client is sensitized on how to deal with infected and affected members of the family.

- Conduct weekly/monthly visits after obtaining consents, to the homes of HIV-positive clients facing severe crisis.

**Sample collection and HIV testing**

- Collection of HIV and other STI for testing and where there is no LT is positioned, HIV rapid testing also, after getting required training from VCH/NPH lab.

- Referral of sample for confirmatory test as described in IATA packaging.

3. **Laboratory technician**

The LT should hold a Diploma in Medical Laboratory Technology (DMLT) from an institution which is approved by the government. The services of existing LTs who do not hold a DMLT may be continued if they have done a Certificate Course in MLT and have experience of working in the VCCT.

Each "stand-alone" VCCT will have at least one LT. In VCCTs with a very large client load such as in VCH/NPH, etc. an additional LT may be appointed on a case-to-case basis after a thorough review by a committee constituted for this purpose with the experts from the field of counseling and testing as members. The LT reports to the VCCT focal person.

The LT has the following duties:

- Undertake HIV and other STI testing according to standard laboratory procedure.

- Keep the facility neat and clean at all times.

- Ensure that adequate stock of consumables and rapid HIV diagnostic kits are available in the VCCT.

- Keep a record of HIV test results (Appendix 4) as well as a stock of rapid test kits and consumables.

- Ensure the maintenance of all laboratory equipment.

- Scrupulously follow internal and external quality assurance procedures.

- Follow universal safety precautions and strictly adhere to hospital waste management guidelines.

4. **Outreach workers**

Outreach workers are recommended only in VCCTs which are located in high-populated areas and in remote areas also. Outreach workers should be educated at least till the secondary level with reasonable writing and speaking skills, and should be from the community of people who are infected with or affected by HIV/AIDS. A person affected with HIV/AIDS may be the spouse or the son/daughter of a person infected with HIV/AIDS. It is desirable that outreach workers are women. Aid post nurses and MGH mobile team can do the outreach work and if necessary arises outreach workers can be appointed on a contractual basis either directly by the VCCT or through NGOs.

The duties of the outreach worker are as follows:

- Mobilize pregnant women for prevention of parent-to-child transmission (PPTCT) services by visiting the homes of pregnant women and liaise with key functionaries such as the registered nurse/midwife.
Follow up HIV-positive pregnant women so as to ensure institutional delivery and antiretroviral (ARV) prophylaxis to both the mother and the baby. This will include regular monthly home visits from the second trimester onwards and weekly visits in the last month of pregnancy. Consent has to be obtained before carrying out home visits.

Follow up the mother-baby pair till 18 months after delivery imparting knowledge on immunization, infant-feeding options as well HIV testing for the baby.

Make home visits as per the schedule to ensure that the babies are brought for testing to the VCCT at the age of 6 weeks, 6 months, 12 months and 18 months.

Identify a family member whom the HIV-positive woman can confide in and who will be a source of support and strength for her.

Ensure that the HIV-positive mother and the baby are linked with the nearest ART centre.

### Schedule of home visits for an outreach worker

<table>
<thead>
<tr>
<th>Pre delivery</th>
<th>Up to 8 months</th>
<th>Monthly home visits to motivate the pregnant woman for institutional delivery. Also give nutritional counseling, identify family member for support and give infant-feeding counseling.</th>
</tr>
</thead>
<tbody>
<tr>
<td>9th month</td>
<td></td>
<td>Weekly home visits to ensure institutional delivery</td>
</tr>
</tbody>
</table>

**Delivery**

- **During and immediate after Labor**
  - Be with pregnant woman at the time of labor and ensure that prophylactic NVP is provided to the HIV positive mother and infant. Also give counseling on infant-feeding options with emphasis on exclusive breastfeeding from one hour after delivery till the infant is 6 months old.

**Post delivery**

- **Second day after delivery**
  - Home visit to counsel on infant-feeding options with emphasis on exclusive breastfeeding till the infant is six months old.

- **Day 44 after delivery**
  - Home visit to ensure that the baby is brought for medical checkup and follow up, including PCR test as per pediatric ART guidelines at 45 days and CTX prophylaxis.

- **6 months**
  - Home visit to ensure that the baby is brought for medical checkup and follow up, including PCR test as per pediatric ART guidelines at six months and CTX prophylaxis.

- **12 months**
  - Home visit to ensure HIV antibody testing for the baby at 12 months.

- **18 months**
  - Home visit to ensure HIV antibody testing for the baby at 18 months.

**1.9: Demand generation in a VCCT**

The services delivered in a VCCT should be publicized so as to generate adequate demand. This should be jointly undertaken by PACs, NGOs, CBOs and networks of people living with HIV/AIDS (PLWHA).

Large and small media IEC interventions to promote VCCT services include:

- Publicizing VCCT services through public service announcements spots on radio and TV and through promotional SMS by all mobile phone operator;
- Developing products specifically designed for target audiences, including pamphlets, videos, hoardings and brochures;
- Conducting advocacy workshops for journalists on HIV/AIDS and HIV testing and counseling in particular;
- Use traditional healer to understand and recognize the symptoms of STI and get referral of STI cases from them;
- Conducting interviews with administrators, those in-charge of the VCCT or counselors on
radio/TV/print media to explain the process of counseling and testing, and to remove fears and misconceptions related to an VCCT in the public mind;

- Promoting the rapid HIV test and immediate availability of test results as well as confidentiality of test results.

- National HIV unit will negotiate with police, crisis centers, prison/correctional services at the national level to start VCCT services at their premises according to their need i.e. Facility Integrated or Outreach. Or to link them up with the existing services.

Within a facility that hosts a VCCT, sign-boards and posters should be placed at prominent locations to publicize the VCCT services. Referral slips for referring clients to the VCCT can strengthen service. Directions should be placed across the facility to help clients easily locate the VCCT. At the VCCT a sign-board should be displayed which has the words “Voluntary Counseling and Confidential Testing Center” in bold letters in the local language. The sign-board should also contain other information such as working hours, name of staff, etc. Use of the “Red Ribbon” logo will help illiterate clients to locate the VCCT.
2: HIV COUNSELING

2.1: What is HIV counseling?
HIV/AIDS counseling/education is a confidential dialogue between a client and a counselor aimed at providing information on HIV/AIDS and education about behaviour change in the client. It is also aimed at enabling the client to take a decision regarding HIV testing and to understand the implications of the test results.

2.2: The steps in HIV counseling are:

HIV pre-test counseling/information:
This involves provision of basic information on HIV/AIDS and risk assessment to direct walk-in/referred clients.
HIV counseling helps a person make informed choices. In addition, a decision to be tested should be an informed decision. Informed consent implies awareness of the possible implications of a test result, including an awareness of the window period3.

The aim of pre-test counseling is to:
1. Assist the client to understand their risk behaviour, and if s/he has been exposed to HIV.
2. Assess the client’s understanding of HIV/AIDS (including the modes of transmission).
3. Assess the client's previous experiences in crisis management.
4. Provide information about the advantages and process of testing.
5. Discuss testing as a positive step towards behaviour change and the improvement of the quality of life.

Ensure in pre-test counseling that:
1. Existing worries and concerns regarding HIV/AIDS have been identified.
2. Knowledge about HIV/AIDS, and in particular its modes of transmission, has been explored.
3. Myths, misconception and misinformation related to HIV/AIDS have been clarified.
4. Emotional coping mechanisms and the availability of social support has been assessed.
5. Implications of knowing whether one is infected have been explained.
6. Ways of coping with a positive HIV test result have been discussed.
7. Risks of violent behaviour in case of positive result have been assessed.
8. Discussion on safe sexual practices has been carried out.
9. Discussions on relationships, especially the benefits of sharing personal information between the person and his/her loved ones, have been carried out.
10. Confidentiality and informed consent for the HIV test has been discussed informed consent form signed and pre-test form filled (Appendix Ia)

HIV post-test counseling:
Here the client is helped to understand and cope with the HIV test result. The post-test counseling session should begin by trying to put the client at ease. The room must be quiet, and private without any fear of being disturbed. The counselor should then tell the client the test result in a clear and direct manner. The result (either positive or negative) should be discussed while being sensitive to the client's feelings. Providing further information might be necessary, although, in case of a positive diagnosis, the client may be in shock, and may not fully take in all the information offered. However, in

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3 See article 3.2 at page 14 for the definition of Window Period.
some circumstances, this might be the only chance to counsel him and asking to repeat the information, or writing down some basic facts, will be helpful. It is important for the client to have time to reflect on the result and to understand the next course of action. Ideally, couple and/or family counseling should be started when appropriate and further follow-up counseling arranged. A form to keep track of a post-test counseling visit should be filled (Appendix Ib).

1. In case of a negative test result, the counselor reiterates basic information on HIV and assists the client to adopt behaviour that reduces the risk of getting infected with HIV in the future.
2. In case the client is in the possible window period, a repeat test is recommended.
3. All HIV positive clients and HIV negative clients with suspected tuberculosis are referred to the nearest TB microscopy centre for TB testing.
4. In case of a positive test result, the counselor assists the client to understand the implications of the positive test result and helps in coping with the test result. The counselor also ensures access to treatment and care, and supports disclosure of the HIV status to the spouse. If needed suicide risk assessment can be done at this stage, because some client got violent and think of suicide as last measure (Appendix Ic).

Follow-up counseling:
In follow-up counseling there is a re-emphasis on adoption of safe behaviors to prevent transmission of HIV infection to others. Follow-up counseling also includes contact tracing, establishing linkages and referrals to services for care and support including ART, nutrition, home-based care, psychological and legal support.

Bereavement counseling:
Many families and friends lack social support during the illness of a PLWHA, and after his/her death. Bereavement counseling should be available already before the death of a loved one and continue as long as there is need. Some people may accept the death in a short time, but for others it can take even years. Often the survivors blame themselves for not having done enough to ease the life of the ill person. Bereavement counseling should:
1. Give people an opportunity to discuss the events that lead to the death, about the death itself, and about the possible rituals after the death.
2. Reassure people that feelings of disbelief, denial, sadness, pain and anger are normal.
3. Provide people with an opportunity to express those feelings and other concerns.
4. Enable family members and friends to accept the loss and start to look towards the future.

At any stage of counseling, if counselor thinks that the client needs more expert opinion regarding counseling or treatment, s/he can refer the client at next level of settings. For referring the clients counselor should fill the referral form and get signature of client on release of information form (Appendix Id & Ie).

2.3: What are the settings in which counseling may be offered to clients?
Counseling and testing services may be offered to clients who are referred by medical providers or to clients who come to a VCCT of their own volition. The two settings in which counseling and testing can be offered to clients are as follows:

1. Provider-initiated counseling and testing
A clinician may offer HIV counseling and testing services to clients under his care. There are few other varieties of clients who are offered provider-initiated counseling and testing:
Clients who present at a health facility with symptoms suggestive of HIV infection. Examples include clients with pneumonia, TB or persistent diarrhea.

Clients attending the health facility with conditions that could be associated with HIV such as STI/RTI.

Settings with large client numbers such as pregnant women who register at ANCs. These also include pregnant women who directly come in labor without any antenatal check-up. Or in mobile testing facility after community mobilization and sensitization.

In blood donation programme, HIV testing is mandatory.

In such cases, the client is given basic information on HIV, educated about testing for HIV, and provided the clinical and prevention benefits of testing and also informed about the potential risks such as discrimination. The client is also informed about their right to refuse testing and that declining an HIV test will not affect their access to services that do not depend upon knowledge of the HIV status. Clients are also informed about the follow-up services that will be provided, and thereafter they are routinely offered testing. Pregnant women are given additional information on nutrition, hygiene, the importance of an institutional delivery and HIV testing so as to avoid HIV transmission from mother to child, and thereafter routinely offered testing. The counselor will ask each client, "Do you wish to test for HIV or not?" The client can "opt out" or choose not to test for HIV. If a client does not "opt out" then he/she is tested for HIV. Written consent has to be obtained before testing except for mandatory one. HIV testing is followed by regular post-test counseling. Follow-up counseling is provided for those are in the possible window period.

During post-test counseling for an HIV-positive pregnant woman, in addition to the regular post-test counseling procedure, the importance of institutional delivery and ARV prophylaxis to prevent mother-to-child transmission (PMTCT) of HIV is re-emphasized. Additionally, the HIV-positive pregnant woman is counseled on the options for infant feeding, importance of regular follow up, immunization of the baby, and HIV testing of the baby at 45 days, 6 months, 12 months and 18 months. With the help of the outreach worker, a family member is identified whom the HIV-positive woman can confide in and who will be a source of support and strength for her. Thereafter, counseling sessions are arranged for this family member too. It is recommended that 3-4 follow-up counseling sessions are arranged for the HIV-positive pregnant woman before the date of delivery to counsel her on the issues mentioned above.

2. Client-initiated counseling and testing or Direct walk-in clients

These are clients who present themselves at the VCCT of their own free will. The motivation to visit and avail of the VCCT services could be based on individual risk behaviour or information and advice received, for example, from a friend, sexual partner, or outreach worker/peer educator in an NGO, or from advertisements in the mass media. Here the client is counseled for HIV and then "opts in" or actively agrees to be tested for HIV. Written consent has to be obtained before testing. HIV testing is followed by regular post-test counseling. Follow-up counseling is provided for those are in the window period.
2.4: Client flow in a VCCT

1. PRE-TEST FLOW CHART

**CLIENT ENTERING HEALTH FACILITY FOLLOWING SIGN TO VCCT**

- YES
  - REFERRED BY HEALTH CARE PROVIDER
  - PRE-TEST INFORMATION GIVEN
    - INDIVIDUALLY
    - GROUP
  - INDIVIDUAL PRETEST COUNSELLING
  - NO
    - HEALTH PROVIDER CHECKS FOR REASONS FOR ACCESSING VCCT CENTRE.

- NO
  - YES
  - CLIENT OPTS FOR HIV TEST
    - OBTAIN INFORMED CONSENT
    - DRAW AT LEAST 9ML OF BLOOD SAMPLE.
    - LABORATORY PERFORM HIV RAPID DETERMINE TEST FOLLOWING THE NATIONAL HIV ALGORITHM.
    - LABORATORY WILL SEND SEALED REPORT TO THE COUNSELLOR.
2. POST TEST FLOW CHART

**FIRST HIV SCREENING**

- **DETERMINE TEST**

**DETERMINE HIV NEGATIVE TEST RESULT**
- Post-Test Counselling
- Explain HIV Behaviour Change
- Explain Window Period
- Refer from VCCT to any other service as needed

**CONFORMATION TEST FOR HIV**
- Sealed reports send to the clinician through health service provider or concerned laboratory

**HIV NEGATIVE**
- Counsel for HIV Negative Result
- Explain Behaviour Change
- Refer to any other services as needed

**HIV POSITIVE**
- Individual Post Test Counselling
- Offer Support, After Getting Consent
- Refer to named HIV doctor or core group
- Pregnant women refer to HIV doctor and provide PPTCT

**DETERMINE HIV POSITIVE RESULT**
- Advice client to come back for result
- Separate sample for serum or plasma and send to Vila Central Hospital Lab. Serology with request
- Follow IATA regulations when referring sample

**CONFORMATION TEST FOR HIV**
- VCH serology lab performs Unigold and INSTI rapid HIV test in parallel
- VCH lab sends negative and positive sample to Australia NRL for quality control
3: HIV TESTING AND QUALITY ASSURANCE

The most common and easiest way to diagnose HIV infection is based on the detection of antibodies to HIV which are generated in the blood of an HIV-infected person.

3.1: Rapid tests:

Rapid tests are the most popular method of diagnosing HIV infection. They are user-friendly and can provide quick results to the client. A variety of rapid tests are available and these employ different principles. MoH recommends the use of rapid HIV test kits in a VCCT, which provide results to the client within 30 minutes of the test. The rapid Determine test must be read after 15 minutes as a minimum and before a maximum time of one hour for full accuracy. The use of rapid test kits which detect >99.5% of all HIV-infected individuals and give false-positive results in <2% of all those who are tested is recommended for use in a VCCT. Testing will be done free of cost for all clients in all VCCT clinics and in all 'stand-alone' VCCTs supported by National HIV/STI unit.

A client who has a negative result in one test is declared to be HIV-negative. A client is declared to be HIV-positive when the same blood sample is tested two times using kits with different antigens/principles and the result of all three tests is positive and simultaneously got positive result from NRL. 9 ml of blood should be collected for QC and incase of reactive samples.

3.2: HIV testing and the window period:

The window period represents the period of time between initial infection with HIV and the time when HIV antibodies can be detected in the blood (6-12 weeks). A blood test performed during the window period may yield a negative test result for HIV antibodies. These cases may require further testing after 12 weeks.

3.3: Emergency testing:

For women with an unknown HIV status and in labor, the labor room nurses, resident doctors, or medical officer will provide basic information on HIV/AIDS and about HIV testing. Thereafter, a single HIV test will be offered to determine the HIV status of the pregnant woman and requirement for ARV prophylaxis to prevent mother-to-child transmission. If reactive a repeat sample will be tested at the next level of facility to confirm the HIV status.

A court⁴ may order for HIV counseling and testing in sexual assault and defilement cases.

3.4: HIV testing of blood samples received at the VCCT:

In some situations, the client may not be able to come to the VCCT and the blood sample is sent from the hospital ward or other department. In this case, the VCCT should ensure that the client has been adequately counseled by the VCCT counselor and the blood sample is received with a requisition slip with code number only. Post-test counseling will be provided by the VCCT counselor in the ward/department where the client is admitted.

3.5: Storage and transportation of kits and samples:

Rapid HIV diagnostic kits should be stored between 2 – 30 °C. Since the VCH laboratory will be keeping the buffer stock of the rapid kits it is advisable that walk-in cold rooms are established in the VCH laboratory. While transporting kits from the VCH laboratory to the VCCT, care should be taken to maintain

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⁴ Magistrate and Supreme Court
the temperature. Cold chain must be maintained with ice packs during transporting sample from VCCT for confirmatory test. Rules of transportation of samples by Air is regulated IATA. Necessary Packaging instructions are as follows:

**Packaging and labeling**

![Diagram of packaging and labeling]

**Primary receptacle packaging (Packaging Instruction # 602)**

- **Primary receptacle**
  - Seal
  - Leak proof or silt proof
  - Labeled
  - Wrap in cushioning material or separate to prevent breakage
  - Use absorbent, if needed

- **Secure screw caps**
  - Tape
  - Paraffin sealing tape
  - Manufactured locking closure
Secondary Packaging (Packaging Instruction # 602)

- Contains
  - Cushioned primary receptacle(s)
  - Absorbent, if liquid
- Leak proof or sift proof

Outer Packaging (Packaging Instruction # 602)

- Sturdy box
- Contains
  - Primary & Secondary packaging
  - Itemized list of contents
- Outer surface
  - Markings
  - Labels
  - Required paperwork

Total maximum quantity per shipment (Packaging Instruction # 602)

- Passenger & Cargo Aircraft – 50ml/50gm
- Cargo Aircraft only – 4L/4Kg

Markings & Labeling of shipment

- **UN 2814** is the UN ID number of infectious substance, affecting humans
- Responsible person: Name & Phone#
- From: Vol = 50 ml
- To: Infectious substance, affecting humans

*UN 2814 is the UN ID number of infectious substance, affecting humans*
Blood samples should be stored at around 4°C. Serology samples should stored and transport in normal room temperature (within 30°C), should reach laboratory within 6 hours of collection.

3.6: Diagnosis of HIV in the newborn:
HIV antibody tests cannot be used to diagnose HIV infection in the infant because of transmission of maternal antibodies via the placenta. Maternal antibodies may be present in the newborn for up to 18 months. Newborn infants may therefore test HIV antibody-positive even if they do not have HIV infection. Transmission of HIV to the baby is confirmed at 18 months of age by a positive HIV antibody test. HIV can be provisionally diagnosed in the newborn before this time-point by using a variety of non-antibody-based assays including DNA or RNA PCR. These tests are ideally done twice, the first one when the infant is six weeks old and the second one at six months of age or later, depending on whether the infant was breastfed or not.

A positive virological test results should be considered to reflect HIV infection, and the usual confirmatory algorithms followed. However, interpreting negative results is difficult. A six-week window period after the complete cessation of breastfeeding is advised before testing; only then can negative virological test results be assumed to reliably indicate HIV infection status. This applies to breastfeeding infants and children of all ages.

3.7: Quality assurance:
The VCCT staff will endeavor to maintain the highest standards of quality in the services they provide. They will be held personally accountable for any substandard delivery of services. All VCCTs should participate in an external quality assessment scheme (EQAS). Each VCCT will be assigned a “Provincial Reference Laboratory” (PRL). EQAS involves sending of "coded" samples from the reference laboratories to the VCCTs twice a year for testing. In addition, VCCTs should send samples, which will include 20% of all positive samples and 5% of all negative samples collected in the first week of every quarter, for cross-checking to the PRL once every quarter. The LT will ensure that these samples are sent to the PRL in the first week of January, April, July and October. High-quality HIV testing services can be maintained by:

- Use of test kits that have not expired
- Adherence to standard operating procedures (SOPs)
- Correct interpretation of results
- Availability of laboratory internal quality control
- Regular calibration, monitoring and maintenance of equipment
- Proper documentation.

5 Provincial hospital's laboratory can act as PRL
4: INFECTION CONTROL & PROTECTION OF STAFF

4.1: Universal safety precautions (USP):
Staff working in the blood collection room and laboratory should observe simple precautions while handling blood and blood products. These include:

- Using gloves when handling blood samples
- Using disposable needles and syringes for drawing blood
- Practicing routine hand-washing before and after any contact with blood samples
- Disposing of sharp instruments safely as per procedure, e.g. discard disposable syringes in a puncture-resistant container after disinfection with bleach solution. In areas where such work is undertaken a source of clean water should be maintained.

Universal Safety Precaution chart (Appendix 6) should be displayed on the wall of counseling room, blood collection area and laboratory.

4.2: Kits for Universal Safety Precaution:
Kits will be made available in all VCCTs, which will enable medical staff such as doctors, nurses and attendees, etc. to handle all the delivery irrespective of HIV status of the expectant mother without being exposed to the risk of accidental exposure to HIV. The kit will consist of the following:

- Plastic disposable gowns
- Disposable goggles for protection of the eyes Face mask Disposable shoe covers
- Two pairs of long gloves
- Theater shoes

4.3: Disinfection and sterilization:
The laboratory should adhere to disinfection and sterilization standards. All re-usable supplies and equipment should be disinfected by sterilization or washing with soap and bleach solution and steam autoclaved.

4.4: Waste management:
Disposable non-sharp items such as gloves, IV bottles, catheters, etc. have to be shredded, cut or mutilated. This ensures that they can’t recycle/reuse. They must be burnt in a proper location.

For sharp waste, WHO recommended encapsulation as the easiest method for the safe disposal of sharps. Sharps are collected in puncture-proof and leak proof containers, such as high-density polythene boxes, metallic drums, or barrels. When a container is three-quarter full, a material such as cement mortar, bituminous sand, plastic foam, or clay is poured in until the container is completely filled. After the medium has dried, the containers are sealed and disposed of in landfill sites.

4.5: Post-exposure prophylaxis (PEP):
Drugs for PEP should be made available to any staff member who is accidentally exposed to HIV in all facilities which have a VCCT as early as 2 hours and within 24 hours of the accidental exposure and not later than 72 hours. Prior to administration of PEP drugs, risk assessment for occupational exposure to HIV must be done (Appendix 2). The VCH should have an assigned PEP focal point/person. It is important to ensure that health-care staff are aware of the hospital PEP procedures and the name and contact information of the PEP focal point/person as well as the location where the PEP drugs are stored.
5: TRAINING OF STAFF

5.1: Induction training/orientation:
All counselors, LTs and any other staffs who are newly appointed to a VCCT need to undergo training/orientation at provincial hospital. This includes counselors and LTs who have been appointed on a full-time basis as well as other staff who have been assigned the duties of a counselor/LT in addition to their existing work.

5.2: Ongoing/refresher training:
VCCT counselors, LTs and other staffs should undergo refresher training provided by National HIV/STI unit at least once in a year to upgrade their knowledge and skills.

5.3: Full-site sensitization:
All the staff in a facility which has a VCCT, including VCCT managers, nurses, administrative staff, pharmacists, X-ray technicians and nurse assistants need to be sensitized about specific issues related to HIV/AIDS such as the importance of HIV counseling, confidentiality, PEP, universal precautions and maintaining a respectful and non-discriminatory attitude towards VCCT clients. The person in-charge of the VCCT will be responsible for undertaking a full-site sensitization at least once a year. The National HIV/STI Unit will provide financial assistance for conducting the full-site sensitization.

National HIV/STI Unit will develop a VCCT training manual and conduct these training
6: SUPERVISION AND MONITORING

6.1: Supervisory protocol:
The supervisory mechanism in a VCCT will consist of the following:

- Provincial HIV/STI focal persons will lead the following process:
  - Review of quarterly reports from VCCT
  - Quarterly review meetings with counselors of VCCT at the provincial hospitals
  - Visits to VCCT by in charge of VCCT at the national level.

**Provincial HIV/STI focal person’s role in supervision and monitoring**

A Provincial HIV/STI focal person is provided in all the provinces to support and supervise VCCT services along with his/her other duties in the provinces. The duties and responsibilities related to the VCCT services of the focal person are as follows:

- Undertake on-site visits to a VCCT at least once a month to ensure quality VCCT services and provide technical support, administrative assistance.
- Take necessary steps to retain staff and reduce occupational stress.
- Conduct review meetings of all the VCCTs in the provinces on the 3rd day of every month and send reports to the National HIV/STI Unit.
- Grade all VCCTs based on criteria such as client uptake, HIV-TB coordination, coverage of HIV-positive pregnant women with NVP, etc. and
- Maintain a list of all VCCTs in the provinces as per grading.
- Collecting data, consolidate and send quarterly reports to Provincial Health Manager, M&E Officer at National HIV Unit as well as NAC.

**Quarterly review**
The quarterly reports which are being generated in a VCCT will be reviewed by the VCCT focal person/Site facilitator, Provincial HIV/STI focal person on each quarter. Ranking of VCCTs will be done and poorly performing VCCTs will be supervised closely.

**Half yearly review meetings at the Provincial Hospitals**

Twice in a year the in charge of VCCT at the national level will organize a review meeting of all the counselors of the VCCTs at the PAC. Performance of the VCCTs will be reviewed centre-wise and problems, bottlenecks faced by the counselors will be discussed.

**Visits by in charge of VCCT at the national level**
The in charge of VCCT/National HIV Coordinator at the national level will undertake frequent tours and visits to VCCTs in the state and closely supervise the functioning of poorly performing VCCTs. poorly performing VCCTs will be closely monitored and supervised by the officers.

6.2: Programme monitoring:

Programme monitoring is the ongoing assessment of routine activities and progress achieved. This facilitates early detection of warnings and taking corrective actions. Monitoring involves documenting all key aspects of services offered. The core indicators for monthly monitoring of VCCT services are as follows:

- Number of new VCCTs established (established means having administrative approval, staff appointed and trained, equipment installed and centre fully functional)

Number of persons pre-counseled
Number of persons tested for HIV
Number found positive among those tested
Number of persons post-counseled
Number of pregnant women provided counseling
Number of pregnant women tested for HIV
Number of pregnant women found positive among those tested
Number of deliveries of pregnant women found HIV-positive
Number of couple counseled and tested
Number of positive mother-baby pairs provided prophylactic treatment
Number of infants followed up after delivery at 6 weeks, 6 months, 12 months and 18 months
Number of infants samples sent for PCR testing
Number of HIV-positive persons on DOTS
Number of STI syndromic management provided
Number of partner notified
Number of partner treated for STI.
Number of referrals

For getting this information, different records in the form of registers are to be maintained and quarterly reports submitted.

The main registers to be maintained in a VCCT and the quarterly formats are as follows:

**PIN Register for General Clients and Pregnant Women (Appendix 3a)**
The purpose of this register is to have records for identifying the client visiting the VCCT. This is the first register where client details would be recorded when the client visits VCCT. Each client is registered as per a number called Patient Identification Number (PIN). This is a unique number assigned to each individual and helps identify the client and the centre where the client is tested. It records the contact details of the clients so that the follow-up is possible. This record is confidential and needs to be kept safely. The PIN number of a particular client assigned in this register continues in the rest of the register and the client details can be accessed as and when needed.

**VCCT Register for General Clients (Non-ANC Cases) (Appendix 3b)**
The purpose of the register is to collect in a single record all information relating to a client. Each client is registered as per PIN. This is a unique number assigned to each individual and helps identify the client and the centre where the client is tested. A brief history of the client is also maintained in the register. From this register the following information can be extracted for the monthly report:

- Number of new VCCTs established (established means having administrative approval, staff appointed and trained, equipment installed and centre fully functional)
- Number of persons pre-counseled
- Number of persons tested for HIV
- Number found positive among those tested
- Number of persons post-counseled
- Number of couple counseled and tested
- Number of STI syndromic management provided
- Number of partner notified
- Number of partner treated for STI.
- Number of referrals
VCCT Register for ANC Clients (Appendix 3c)
The purpose of the register is to collect in a single record all information relating to an ANC client. Each client is registered as per a number called PIN which is unique for VCCT with flag indicating ANC cases. This is a unique number assigned to each individual and helps identify the client and the centre where the client is tested. A brief history of the client is also maintained in the register. From this register the following information can be extracted for the monthly report:
- Number of pregnant women provided counseling
- Number of pregnant women tested for HIV
- Number of pregnant women found positive among those tested
- Number of deliveries of pregnant women found HIV-positive
- Number of couple counseled and tested
- Number of STI syndromic management provided
- Number of partner notified
- Number of partner treated for STI.
- Number of referrals

VCCT Post-natal Follow-up Register (Appendix 3d)
The purpose of this register is essentially Mother-baby follow-up. This register would provide information on critical follow-ups and status of babies with PCR testing and administration of treatments. The counseling including feeding practices for babies are recorded in this register. From this register the following information can be extracted for the monthly report:
- Number of mother-baby pairs provided prophylactic treatment
- Number of infants followed up after delivery at 6 weeks, 6 months, 12 months and 18 months
- Number of infants samples sent for PCR testing

VCCT HIV-TB Collaborative Activities Register (Appendix 3e)
The register records the details of HIV-TB collaborative activities. The following information would be available from this register.
- Number of HIV-positive persons on TB DOTS
- Number of referrals

Laboratory registers (Appendix 4)
This register provides information on the samples collected as well as the test results. The following information can be extracted for the monthly report from the laboratory register:
- HIV status of clients (positive, negative, indeterminate)

Monthly reports (Appendix 5)
Data for the monthly report is extracted from the above-mentioned registers and staff details. The monthly VCCT formats comprise information on:
- Monthly VCCT report on the number of clients counseled, tested, HIV status, NVP administration, and gender and age-wise distribution
- Monthly HIV-TB report on HIV-TB collaborative activities
- Details of referrals to and from various facilities
- Stock of drugs, equipment and consumables
- Critical staff position
6.3: Data flow:

Data flow from the facility to the district level to the national level is depicted in the following diagram:

Counselors and Laboratory Technicians fill in client information in their respective individual cards and registers

The information in a particular month is compiled in the monthly report for the VCCT based on the data in the registers

The information in the monthly report is verified and discussed by the VCCT manager with the staff for validity. The verified report is forwarded through provincial HIV officer to National unit by the 1st week of each quarter

The provincial HIV officer will check the information and uploads the information. (Feedback on data quality and rectification will be ensured by provincial HIV officer, once CRIS will be functional.)

Provincial staffs will provide a detailed feedback on the performance of the VCCT to National coordinator for using the data for preparing the report for donors and sharing with stakeholders

National unit will review the VCCT information and provide feedback to NAC and compiles a national report on the status of VCCT periodically for sharing
7: MOH ACCREDITATION REQUIREMENT FOR VCCT

All the VCCT sites in-country must be accredited by MoH, whether it operated by MoH or not for profit organizations. In a facility, the VCCT should be located in a place that is easily accessible and visible to the public. The VCCT should consist of a waiting room and a sound proof counseling room. For standalone VCCT site a separate blood collection and testing room is required.

Waiting area
1. Waiting area should be big enough to do group counseling; 15’ X 15’ in area can serve the purpose but if there is not enough space for this a small one should be there.
2. Informative posters on the wall and a space for take away IEC material like leaflets/pamphlets and male & female condom should be there.
3. TV and DVD player in a lockable cabinet preferably be available in a VCCT waiting area.
4. Communication aids such as flip charts on stand should be available
5. 15-20 chairs for waiting as well as for group counseling.

Counseling and blood sample collection room
The counseling and sample collection room should have a space of at least 10’ X 10’. Room should be an enclosed space, so that counseling sessions may be undertaken in an atmosphere of privacy. There will be at least one trained counselor, who can provide proper counseling service to the clients. The requirement for furniture and equipment for a counseling room in a VCCT are:

1. Desk and chair for the counselor
2. 2 chairs for clients and partner
3. Client examination table
4. Register books
5. Lockable filing cabinet for safe keeping of records
6. Medicine cabinet
7. Medicine for STI management
8. Sample collection kits for HIV and other STIs
9. Condoms and take away IEC materials
10. Charts and information materials on the walls
11. White board and white board markers for drawing
12. Condom demonstration models
13. Hand wash basin
14. Computer with printer and UPS

Blood testing room
Blood testing could be done either in the blood collection room or in the main laboratory of the facility. The equipments required for testing in a VCCT are:

1. Rapid test kit
2. Refrigerator
3. Centrifuge (Optional)
4. Needle destroyer
5. Precision pipette/plastic transfer pipette
7. Cabinet
8. Desk
9. Working bench
10. Record books

The consumables required for collection and testing of blood in a VCCT are:

1. Rapid HIV test kit
2. Precision pipette/plastic transfer pipette
3. Sterile needles and syringes/Vacutainer
4. Disposable gloves
5. Cotton swabs
6. Cleaning material such as spirit/antiseptic lotion
7. Bleach/hypochlorite solution

In order to provide PMTCT/PPTCT services to pregnant women who are HIV-positive, all VCCTs are required to have an infantometer as well as adequate stock of NVP tablets and syrup.
8: AMENDMENTS

This is a working document for the VCCT centers in Vanuatu. After certain time period this should amend with the changed situation in country/region/globally. At the same time it should not be amended too frequently to avoid confusion and extra financial burden. For this purpose five year should be the ideal time period for amendment.

Within this period it can be amended, if there is some certain unavoidable situation arises within the country/region/worldwide.

For amendment we need a group of people (VCCT guideline amendment committee) with wide background on HIV/AIDS. This group will sit together before end of the time period/in emergency manner to look at the document and make necessary changes or incorporate new things into it.

Suggested list of the first amendment committee is as follows:

1. Director Northern Health Care Group
2. Director Southern Health Care Group
3. National HIV/STI coordinator
4. National RH coordinator
5. HIV focal point Doctor of VCH
6. Laboratory Manager of VCH
7. Provincial HIV focal persons
8. Representative from NGOs, CBOs, FBOs, those are offering VCCT services
9. Representative from State Law Office
10. Representative from WHO
11. Representative from UNICEF

Unless there is an emergency situation arises this committee will sit together for the first time at the middle of year 2016 to amend the document and amended version will be effective from the year 2017.

END OF THE GUIDELINE
# Appendix 1a: Pre-test counseling form & informed consent form

## Pre HIV test counseling form

<table>
<thead>
<tr>
<th>Date: <strong>/</strong>/__</th>
<th>Site Name: ____________________________</th>
<th>Client Code: ___________________________</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>No names should be recorded on this form. In confidential testing, names and contact details are to be stored in a separate secure location</td>
</tr>
</tbody>
</table>

### 1. Number of previous HIV test:

<table>
<thead>
<tr>
<th>Last test date: <strong>/</strong>/__</th>
<th>Result: (circle one)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Positive</td>
</tr>
</tbody>
</table>

Last test was done within 3 months of exposure risk (circle) Yes / No

### 2. Individual risk assessment:

<table>
<thead>
<tr>
<th>Client has regular partner: 1 = YES, 2 = NO</th>
<th>Is any regular partner HIV-positive? 1 = YES, 2 = NO, 3 = Unknown</th>
</tr>
</thead>
<tbody>
<tr>
<td>HIV status of mother: 1 = Positive, 2 = Negative, 3 = Unknown</td>
<td></td>
</tr>
<tr>
<td>HIV status of father: 1 = Positive, 2 = Negative, 3 = Unknown</td>
<td></td>
</tr>
</tbody>
</table>

(tick in the appropriate box then circle respective yes or no)

<table>
<thead>
<tr>
<th>Client indicates history of STI</th>
<th>Treatment required: YES / NO</th>
</tr>
</thead>
<tbody>
<tr>
<td>Referral required: YES / NO</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Client’s partner has history of STI</th>
<th>Treatment required: YES / NO</th>
</tr>
</thead>
<tbody>
<tr>
<td>Referral required: YES / NO</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Client reports symptoms of TB</th>
<th>Treatment required: YES / NO</th>
</tr>
</thead>
<tbody>
<tr>
<td>Referral required: YES / NO</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Client’s partner has symptoms of TB</th>
<th>Treatment required: YES / NO</th>
</tr>
</thead>
<tbody>
<tr>
<td>Referral required: YES / NO</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Client is pregnant YES / NO (circle)</th>
<th>If YES, stage of pregnancy: (tick)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Partner is pregnant YES / NO (circle)</td>
<td>1st trimester</td>
</tr>
<tr>
<td></td>
<td>2nd trimester</td>
</tr>
<tr>
<td></td>
<td>3rd trimester</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Client uses condom regularly YES / NO (circle)</th>
<th>Partner uses condom regularly YES / NO (circle)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Family planning referral required: YES / NO (circle)</td>
<td></td>
</tr>
</tbody>
</table>

---

1 Regular partner could be husband or wife, boyfriend or girlfriend, or regular sex client seen over a period of time. There could be more than one partner.
### 3. Indicate nature and time of most recent potential exposure

<table>
<thead>
<tr>
<th>Sex with (Tick):</th>
<th>Opposite sex</th>
<th>Same sex</th>
<th>HIV positive person</th>
</tr>
</thead>
<tbody>
<tr>
<td>(tick in the respective box only when there is exposure risk)</td>
<td>Last time this risk occurred</td>
<td>Window period (tick only if within the window period)</td>
<td></td>
</tr>
<tr>
<td>Unprotected vaginal intercourse</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Unprotected anal intercourse</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Unprotected oral sex</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Blood products / Organ</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sharing injecting equipment for tattoo, scarification, piercing etc.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Accidental exposure in the workplace</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Forced sex</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Client requires repeat HIV test because of window-period exposure: **YES** / **NO** *(circle)*

If **YES**, date of repeat test: __ __/__ __/ __ __ __

### 4. Assessment of personal coping strategies:

**ASK** "How do you think you would cope if you test shows that you have HIV?"

(Circle yes or no in any of the boxes below that apply)

- Client has adequate personal support network including disclosure plan: **YES** / **NO**
- Client indicates potential risk of violence if status disclosed to partner(s): **YES** / **NO**
- Client indicates intent to harm another if test result is HIV positive: **YES** / **NO**
- Client indicates suicide intent if test result is HIV-positive
  - If yes, ask the following:
    - Client has prior history of self harm or suicide attempt: **YES** / **NO**

### 5. Orientation on condom use: *(tick in appropriate box)*

<table>
<thead>
<tr>
<th>Delivered verbally</th>
<th>Written leaflet given</th>
<th>Demonstration</th>
<th>Client practice</th>
</tr>
</thead>
</table>

### 6. Orientation on HIV prevention for injecting drug user *(tick in appropriate box)*

<table>
<thead>
<tr>
<th>Delivered verbally</th>
<th>Written leaflet given</th>
<th>Not applicable</th>
</tr>
</thead>
</table>

**Additional notes:**

**Consent from the client:** *(tick in the appropriate)*

- Yes. I hereby give my free and full consent for the testing procedure.
  - Any reason for saying **YES**
  - No. I do not wish to be tested.
  - Any reason for saying **NO**

Client’s signature ______________________ ___ Counselor’s signature ______________________ ___

Counselor’s name: ______________________ ___ Date: ______________________ ___

---

2 This does not refer to sex work but rather to exposure to blood-borne pathogens in the course of work (e.g., a needle stick injury or muco-cutaneous exposure sustained by a nurse, doctor, ambulance assistant, police officer, cleaner, etc.).
Appendix 1b: Post-test counseling form

**Post-HIV test counseling form**

<table>
<thead>
<tr>
<th>Date: <strong>/</strong>/___</th>
<th>Client test date: <strong>/</strong>/___</th>
</tr>
</thead>
</table>

| Site Name: ___________________________________ | Client Code: ______________________ |

1. **Result provided:** *(Please tick)*
   - [ ] Antibody–negative
   - [ ] Antibody–positive
   - [ ] Indeterminate

2. **For Negative result provision only:**
   - Checklist of counselor actions:
     - [ ] Provided and explained client result
     - [ ] Checked for window period and subsequent exposure
     - [ ] Advised client to retest  
       If YES, retest date: __/__/___
     - [ ] Provided risk reduction counseling
     - [ ] Made referral
     - [ ] If YES, obtained signed consent for release of information

   **Details of referral:**

3. **For Indeterminate result only:**
   - [ ] Explained the possibility that testing was done during the window period
   - [ ] Urged client to avoid unprotected intercourse or sharing of injecting equipment
   - [ ] Scheduled retesting at this centre in 12 weeks (4–6 weeks for pregnant clients)
   - [ ] Provided stress management and supportive counseling

4. **For Positive result provision only:**
   - Checklist of counselor actions:
     - [ ] Checked result before providing it to client
     - [ ] Assessed client’s readiness for results
     - [ ] Provided and explained the result
     - [ ] Provided brief information about follow-up and support
     - [ ] Assessed suicide risk *(follow suicidal risk assessment form)*
     - [ ] Discussed strategies for partner disclosure (to whom, what, when, and why;)
     - [ ] Checked to make sure the client can get home safely

   4.2: **Coping management plan:**
     - [ ] Helped client plan how to cope in the next 48 hours
     - [ ] Assessed suicide risk
     - [ ] Provided IEC material
     - [ ] Discussed transmission reduction strategies
     - [ ] Made referral
     - [ ] If YES, obtained signed consent for release of information

   **Details of referral:**

   **YES / NO (Please circle)**

   **YES / NO (Please circle)**
5. **Type of support required:** (tick in appropriate box)

<table>
<thead>
<tr>
<th>Support Type</th>
<th>Selection</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ongoing counseling support</td>
<td></td>
</tr>
<tr>
<td>Medical/Treatment support</td>
<td></td>
</tr>
<tr>
<td>Peer-group support/Positive-network support</td>
<td></td>
</tr>
<tr>
<td>Financial support</td>
<td></td>
</tr>
<tr>
<td>Specialized mental health support</td>
<td></td>
</tr>
<tr>
<td>Others (please specify)</td>
<td></td>
</tr>
<tr>
<td>Not required</td>
<td></td>
</tr>
</tbody>
</table>

6. **Orientation on condom use:** (tick in appropriate box)

- Delivered verbally  [ ]
- Written leaflet given  [ ]
- Demonstration  [ ]
- Client practice  [ ]

<table>
<thead>
<tr>
<th>Client uses condom regularly</th>
<th>Family planning referral required:</th>
</tr>
</thead>
<tbody>
<tr>
<td>YES / NO</td>
<td>YES / NO (circle)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Partner uses condom regularly</th>
<th>YES / NO (circle)</th>
</tr>
</thead>
</table>

7. **Orientation on HIV prevention for injecting drug user**

- Delivered verbally  [ ]
- Written leaflet given  [ ]
- Not applicable  [ ]

8. **Referral offered** *(write down name of organization)*

- Feedback from referral received  [ ]

9. **Date of follow-up counseling:** __ __/__ __/__ __ __ __

**Additional notes:**

---

Counselor’s signature: ________________________________
Counselor’s name: ___________________________ Date: ___________________________
Suicide risk assessment interview guide

Introduce this topic by using one of the following according to the circumstance of the client:

<table>
<thead>
<tr>
<th>During post-test counseling for HIV positive result with a client who indicated he or she would commit suicide if the result was positive</th>
<th>During post-test counseling for HIV positive result with a client who did not disclose suicide intent during pretest counseling</th>
<th>During the routine post-diagnosis follow up of an HIV positive client</th>
</tr>
</thead>
<tbody>
<tr>
<td>“I am concerned that during pretest counseling you said you would commit suicide if you received a positive result.... I am wondering if you still feel that way.”</td>
<td>“Often when people first learn that they have HIV they feel so overwhelmed that they want to end their lives or harm themselves. I am wondering if you feel that way now or feel you may feel that way after you leave my office today.”</td>
<td>“Often the pressures of living with HIV are so overwhelming that some people feel that their life is not worth living and they think of taking steps to end their life or hurt themselves in some way. I am wondering if you ever feel that way, and if you do, how often you think of this.”</td>
</tr>
</tbody>
</table>

Follow up questions to be asked:

Has your appetite for food changed?
For clients who have just received a positive test result, this question can be asked in terms of how they were over the last month before they received their test result.

If you are having sex, are you experiencing any difficulties?
For clients who have just received a positive test result, this question can be asked in terms of how they were over the last month before they received their test result.

How has your mood been lately? Describe how you have been feeling.
For clients who have just received a positive test result this question can be asked in terms of how they were over the last month before they received their test result.

Do your moods often change?
For clients who have just received a positive test result, this question can be asked in terms of how they were over the last month before they received their test result.

Do you have close friends and relationships with people? □YES □NO

How often do you think of suicide?
□ Occasionally □ More than once a day □ Constantly thinking about suicide
How long do the thoughts usually last?
☐ Very short  ☐ Sometimes for over an hour  ☐ All day

On a scale of 0 to 10, with “0” being the best you can feel and “10” the worst, how bleak are your thoughts? Which number on the scale would stand for those thoughts?

| 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |

Do you have a specific plan for how you would do it?  ☐ YES ☐ NO
How?
When?
Where?

Do you have the things you would need to do this?
Ask specifically about firearms, drugs, or pesticides (or whatever else the client indicated that he or she would use in the suicide plan).  ☐ YES ☐ NO

Have you made any preparations
(e.g., writing a note; giving away prized possessions)?  ☐ YES ☐ NO
What?

Have you ever attempted suicide in the past?  ☐ YES ☐ NO
How?
When?
Where?

Do you feel your family or friends are concerned and willing to help you with your situation?

Help is available and people are willing to help
Help is available but not often, or the client indicates he doesn’t want to ask for it
Family or friends not willing to help or are hostile and express anger at the client

What would need to change in your life in order for you not to think of suicide?
(Knowing that HIV cannot be cured; do you need other things to change? Which other things?)
Appendix 1d: Referral form

Referral form

To the receiving referral agency:

This client has signed a form authorizing the release of confidential information. Please let us know about the outcome of this referral.

Detailed client notes and assessments are attached

If NO, they are available on request

Client code: _______________________ Date referral made: __ __/__ __/ __ __ __ __

Name and address of client (if required and client has agreed to release the information):

Referred to (specific contact person at referral agency): ________________________________

Address of referral agency / individual provider:

Telephone number:

Referral feedback to be sent to (referring counselor address and phone contact):

Type of assistance sought for the client:

- HIV medical assessment and treatment
- STI medical assessment and treatment
- TB assessment and treatment
- Family planning advice or contraception
- Antenatal or postpartum care (circle which)
- Psychological or psychiatric and spiritual assessment and treatment
- Drug/Alcohol counseling/treatment
- Food and nutrition
- Welfare assistance (housing, financial, schooling for children, etc.)
- Legal
- Others (specify):

Summary background information:

Detailed client notes and assessment are attached

If NO, they are available on request

_____________________________ Signature: __ __/ __ __/ __ __ __ __

Counselor's name: Date:
Appendix 1e: Release of information consent form

Consent for release of information

Client code:
Date of birth:
Client name (if release is agreed to): __________________________
Contact details (if release is agreed to): _____________________________________________

If client cannot read this form, please read all instructions to the client. No coercion is to be exerted. Let the client know that this agreement can be revoked at any time.

I, ______________________________________, consent to _________________________________'s
(Name of client)                                                       (Name of doctor/counselor)

Tick (✓) what you agree to. Cross (X) what you do not want to be provided.

- Releasing information to referral agency
- Releasing information to partner
- Releasing information to family member

(For release of information to referral agency: Tick (✓) what you agree to. Cross (X) what you do not want to be provided.)
I agree to the counselor/doctor’s providing the following information for the purposes of referral:

- My HIV test results
- My medical records
- My counseling information
- My financial information
- My contact details
- Other (specify)

This information is to be provided to: ……………………………………………………………………………..…
(Name of staff member of referral agency)
at the ……………………………………………………..………………………………………………………………
(Name of centre)
I understand that, where information is provided for referral purposes, I am consenting to that organization’s providing information back to my counselor about my referral.

(For release of information to referral agency: Tick (✓) what you agree to. Cross (X) what you do not want to be provided.)
I consent to the following:

- The counselor’s telling my partner/family in my presence
- The counselor’s being present while I disclose to my partner/family, and the counselor’s answering questions
- The counselor’s telling ______________________________________ (nominee’s name) so that he or she will tell my partner or family on my behalf.

Is there anything you do not want the counselor to disclose to partner/family/other? (Record here)

Date: __ __/ __ __/ __ __
(Signature of client)                        (Signature of doctor/counselor)
Appendix 2a: Risk assessment for occupational exposure to HIV

Is the source material blood, blood products, other potentially infectious material (OPIC) or an instrument contaminated with one of these substances?

Yes

What type of exposure has occurred?

Skin and mucus membrane integrity compromised

Determine volume of material

Small (Few drops)

Refer to Fact Sheet For MM

Large (Splash)

Refer to Fact Sheet For PI

Intact skin only

No PEP needed

Percutaneous exposure

Determine severity of exposure

Not severe (Solid needle, superficial)

No PEP needed

Severe (Large bore, deep injury, visible blood in device, needle in patient's artery/vein)

Refer to Fact Sheet For PI

No

No PEP needed

Determine volume of material

Small (Few drops)

Refer to Fact Sheet For MM

Large (Splash)

Refer to Fact Sheet For PI

Not severe (Solid needle, superficial)

No PEP needed

Severe (Large bore, deep injury, visible blood in device, needle in patient's artery/vein)

Refer to Fact Sheet For PI

3 Other potentially infectious materials or an instrument contaminated (OPIC) with one of these substances: semen or vaginal secretions, cerebrospinal fluid, synovial fluid, pleural fluid, pericardial fluid, amniotic fluid; tissues.
## Appendix 2b: PEP for percutaneous injuries (PI)

### HIV Post-Exposure Prophylaxis for Percutaneous Injuries (PI)

<table>
<thead>
<tr>
<th>Exposure</th>
<th>Source HIV + and low risk&lt;sup&gt;4&lt;/sup&gt;</th>
<th>Source HIV+ and high risk&lt;sup&gt;4&lt;/sup&gt;</th>
<th>HIV status of the source is unknown</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Not severe</strong></td>
<td>Zidovudine (AZT) 300mg BD+ Lamivudine (3TC) 150mg BD for 28 days&lt;sup&gt;5&lt;/sup&gt;</td>
<td>Zidovudine (AZT) 300mg BD+ Lamivudine (3TC) 150mg BD + Efavirenz (EFV) 600mg OD for 28 days&lt;sup&gt;5&lt;/sup&gt;</td>
<td>Usually none; consider Zidovudine (AZT) 300mg BD+ Lamivudine (3TC) 150mg BD for 28 days if source is high risk for HIV or HIV infection is most likely</td>
</tr>
<tr>
<td><strong>Severe</strong></td>
<td>Zidovudine (AZT) 300mg BD+ Lamivudine (3TC) 150mg BD + Efavirenz (EFV) 600mg OD for 28 days&lt;sup&gt;5&lt;/sup&gt;</td>
<td>Zidovudine (AZT) 300mg BD+ Lamivudine (3TC) 150mg BD + Efavirenz (EFV) 600mg OD for 28 days&lt;sup&gt;5&lt;/sup&gt;</td>
<td>Usually none; consider Zidovudine (AZT) 300mg BD+ Lamivudine (3TC) 150mg BD for 28 days if source is high risk for HIV or HIV infection is most likely</td>
</tr>
</tbody>
</table>

---

<sup>4</sup> Low risk: Asymptomatic HIV or viral load <1500 copies/ml. high risk: Symptomatic HIV, AIDS, acute seroconversion and high viral load.

<sup>5</sup> Concern for drug resistance: Initiate prophylaxis without delay and consult an expert.
### Appendix 2c: PEP for mucous membranes (MM) and non-intact skin exposures

**HIV Post-Exposure Prophylaxis for mucous Membranes (MM) and Non-Intact Skin Exposure**

<table>
<thead>
<tr>
<th>Exposure</th>
<th>Status of source</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Source HIV + and low risk</td>
<td>Source HIV+ and high risk</td>
<td>HIV status of the source is unknown</td>
</tr>
<tr>
<td>Small volume</td>
<td>Consider Zidovudine (AZT) 300mg BD+ Lamivudine (3TC) 150mg BD for 28 days</td>
<td>Zidovudine (AZT) 300mg BD+ Lamivudine (3TC) 150mg BD for 28 days</td>
<td>Usually none; consider Zidovudine (AZT) 300mg BD+ Lamivudine (3TC) 150mg BD for 28 days if source is high risk for HIV or HIV infection is most likely</td>
</tr>
<tr>
<td>Large volume</td>
<td>Zidovudine (AZT) 300mg BD+ Lamivudine (3TC) 150mg BD for 28 days</td>
<td>Zidovudine (AZT) 300mg BD+ Lamivudine (3TC) 150mg BD + Efavirenz (EFV) 600mg OD for 28 days</td>
<td>Usually none; consider Zidovudine (AZT) 300mg BD+ Lamivudine (3TC) 150mg BD for 28 days if source is high risk for HIV or HIV infection is most likely</td>
</tr>
</tbody>
</table>

---

6 Non-intact skin: Dermatitis, abrasion, wound.

7 Low risk: Asymptomatic HIV or viral load <1500 copies/ml. high risk: Symptomatic HIV,AIDS, acute seroconversion and high viral load.
### Appendix 3a: PIN Register for VCCT

**Patient Identity Number (PIN) for VCCT (general clients and pregnant women)**

<table>
<thead>
<tr>
<th>Sl. No.</th>
<th>PIN</th>
<th>Date</th>
<th>Name</th>
<th>Address</th>
<th>Province</th>
<th>Phone</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tr>
</tbody>
</table>

### Appendix 3b: VCCT Register for general clients

**VCCT Register for General Clients (excluding Pregnant Women)**

<table>
<thead>
<tr>
<th>S. No.</th>
<th>PIN</th>
<th>Date</th>
<th>Referred by</th>
<th>Mark of identification</th>
<th>Age</th>
<th>Sex</th>
<th>Education</th>
<th>Occupation</th>
<th>Marital status</th>
<th>Date of pre-test counseling</th>
<th>Type of risk behaviour</th>
<th>Consented for HIV test</th>
<th>Test report</th>
<th>Date of post test counseling and report handover</th>
<th>Follow-up due date (with partner)</th>
<th>Referred to</th>
<th>Spouse tested</th>
<th>PIN of spouse</th>
<th>Test report of spouse</th>
<th>Condom counseling and demonstration</th>
<th>Condom given</th>
<th>Confirmation of referral done</th>
<th>STI management</th>
<th>Partner treated</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tr>
</tbody>
</table>

**Code for column 10:** 1. Married, 2. Single, 3. Living with regular partner  
**Code for column 14 & 20:** 1. Positive, 2. Negative, 3. Not tested, 4. Indeterminate
### Appendix 3c: VCCT Register for ANC

**VCCT Register for Pregnant Women (ANC)**

<table>
<thead>
<tr>
<th>S. No.</th>
<th>PIN</th>
<th>Date</th>
<th>ANC registered/direct delivery</th>
<th>Referred by</th>
<th>Mark of identification</th>
<th>Age</th>
<th>Education</th>
<th>Marital status</th>
<th>Occupation</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Island:</th>
<th>Province:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Month of pregnancy at registration</th>
<th>Parity</th>
<th>EDD</th>
<th>Pre-test/group counseling done</th>
<th>Consented for HIV test</th>
<th>Test report</th>
<th>Date of post test counseling and report handover</th>
<th>STI treated</th>
<th>Referred to</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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<td></td>
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<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Spouse tested</th>
<th>PIN of spouse</th>
<th>Test report of spouse</th>
<th>Spouse treated for STI</th>
<th>Where is the delivery planned</th>
<th>In case outside – details of referral slip No.</th>
<th>Date referred to ART center for assessment</th>
<th>ART center registration No.</th>
<th>Assessment result (CD4 count)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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<td></td>
</tr>
</tbody>
</table>

**Code for column 4:** 1. ANC, 2. Delivery


**Code for column 9:** 1. Married, 2. Single, 3. Living with regular partner


**Code for column 16 & 22:** 1. Positive, 2. Negative, 3. Not tested, 4. Indeterminate

**Code for column 24:** 1. Same facility, 2. Other govt. facility, 3. Home delivery

Continued
**Appendix 3d: VCCT Register for post natal follow-up**

**VCCT Register for post natal follow-up**

<table>
<thead>
<tr>
<th>VCCT Code:</th>
<th>VCCT Name:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Island:</td>
<td>Province:</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>S. No.</th>
<th>PIN</th>
<th>Date of registration</th>
<th>NVP given to pregnant women</th>
<th>Date of delivery</th>
<th>PIN of baby</th>
<th>Sex of baby</th>
<th>NVP given to new born</th>
<th>Follow-up details</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Follow-up at 6 weeks (date of visit)</td>
</tr>
</tbody>
</table>

**Follow-up details**

<table>
<thead>
<tr>
<th>Date of sending sample for DNA/PCR</th>
<th>Result of DNA/PCR</th>
<th>Current feeding practice</th>
<th>Follow-up at 6 months</th>
<th>Follow-up at 12 months</th>
<th>Follow-up at 18 months</th>
<th>HIV test of baby at 18 months</th>
<th>Baby referred to ART center (Date)</th>
<th>ART center registration No. of baby</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
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<td></td>
<td></td>
</tr>
</tbody>
</table>


**Code for column 11:** 1. Positive, 2. Negative, 3. Not tested

**Code for column 12:** 1. Breast feeding, 2. Alternative feeding

**Code for column 13:** 1. Mother, 2. Baby, 3. Both

**Code for column 14:** 1. Mother, 2. Baby, 3. Both

**Code for column 15:** 1. Mother, 2. Baby, 3. Both

**Code for column 16:** 1. Positive, 2. Negative, 3. Not tested

---

**Appendix 3e: VCCT HIV-TB Activity**

**VCCT Register for HIV-TB collaborative activity**

<table>
<thead>
<tr>
<th>VCCT Code:</th>
<th>VCCT Name:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Island:</td>
<td>Province:</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>S. No.</th>
<th>PIN</th>
<th>HIV status</th>
<th>Date of referral to NTCP</th>
<th>Investigated under NTCP (Y/N)</th>
<th>Sputum positive TB (Y/N)</th>
<th>Extra-pulmonary TB (Y/N)</th>
<th>Put on DOTS (Date)</th>
<th>Referred from NTCP</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Code for column 10:** 1. Positive, 2. Negative, 3. Not tested
### Appendix 4: Laboratory registers

**VCCT Laboratory Register**

<table>
<thead>
<tr>
<th>S. No.</th>
<th>PIN</th>
<th>Date</th>
<th>Name of referring VCCT</th>
<th>Lab. Sample No.</th>
<th>HIV test results</th>
<th>Final test result given</th>
<th>Sample sent to NRL (code)</th>
<th>Result received from NRL</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Test 1</td>
<td>Test 2</td>
<td>Test 3</td>
<td></td>
</tr>
</tbody>
</table>
## Appendix 5: Quarterly reporting template

Sections A common for all VCCT Clients; Section B for all clients excluding Pregnant women; Section C for Pregnant women; Section D for HIV-TB collaboration for all VCCT clients

### Section A

**[All VCCT clients]**

#### IDENTIFICATION

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Name of the VCCT</td>
</tr>
<tr>
<td>2</td>
<td>Address</td>
</tr>
<tr>
<td>3</td>
<td>Reporting period</td>
</tr>
<tr>
<td>4</td>
<td>Name of the in-charge</td>
</tr>
<tr>
<td>5</td>
<td>Contact number</td>
</tr>
</tbody>
</table>

### Section B

**[All clients excluding pregnant women]**

#### Progress Made During the Quarter by the VCCT

(i) Details of client visit to VCCT and HIV test undertaken

<table>
<thead>
<tr>
<th></th>
<th>Client initiated</th>
<th>Provider initiated</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Male</td>
<td>Female</td>
<td>TG</td>
</tr>
<tr>
<td>1. Number of clients received pre-test counseling/information</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Number of clients tested for HIV</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Number of clients received post-test counseling</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Number of clients received HIV test results</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. Total number of clients diagnosed sero-positive (after three tests)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. Number of clients for follow-up counseling</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

(ii) Details of partner visit to VCCT and STI management provided

<p>| | | | | | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Number of partner received pre-test counseling/information</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Number of partner tested for HIV</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Number of partner received post-test counseling</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Number of partner received HIV test results</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. Total number of partner diagnosed sero-positive (after three tests)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. Number of partner for follow-up counseling</td>
<td></td>
<td></td>
<td></td>
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<td></td>
</tr>
</tbody>
</table>

(iii) Details of clients and partner visit to VCCT (Age wise distribution)

<table>
<thead>
<tr>
<th>Age group (Years)</th>
<th></th>
<th>15 – 19</th>
<th>20 – 24</th>
<th>25 – 29</th>
<th>30 – 34</th>
<th>≥ 35</th>
<th>Unknown</th>
</tr>
</thead>
<tbody>
<tr>
<td>≤ 14</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>15 – 19</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>20 – 24</td>
<td></td>
<td></td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>25 – 29</td>
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<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>30 – 34</td>
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<td></td>
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<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>≥ 35</td>
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</table>

Total

### Section C

**[Pregnant women]**

#### Details of clients visit to VCCT

<table>
<thead>
<tr>
<th>Age group (Years)</th>
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<th>15 – 19</th>
<th>20 – 24</th>
<th>25 – 29</th>
<th>30 – 34</th>
<th>≥ 35</th>
<th>Unknown</th>
</tr>
</thead>
<tbody>
<tr>
<td>≤ 14</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>15 – 19</td>
<td></td>
<td></td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>20 – 24</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>25 – 29</td>
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<td></td>
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<td></td>
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<tr>
<td>30 – 34</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>≥ 35</td>
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Total

### Section D

#### Details of client visit to VCCT and STI management provided

<table>
<thead>
<tr>
<th>Age group (Years)</th>
<th></th>
<th>15 – 19</th>
<th>20 – 24</th>
<th>25 – 29</th>
<th>30 – 34</th>
<th>≥ 35</th>
<th>Unknown</th>
</tr>
</thead>
<tbody>
<tr>
<td>≤ 14</td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>15 – 19</td>
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<tr>
<td>20 – 24</td>
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</tr>
<tr>
<td>25 – 29</td>
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<tr>
<td>30 – 34</td>
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<tr>
<td>≥ 35</td>
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</table>

#### Details of client visit to STI management provided

<table>
<thead>
<tr>
<th>Age group (Years)</th>
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<th>15 – 19</th>
<th>20 – 24</th>
<th>25 – 29</th>
<th>30 – 34</th>
<th>≥ 35</th>
<th>Unknown</th>
</tr>
</thead>
<tbody>
<tr>
<td>≤ 14</td>
<td></td>
<td></td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>15 – 19</td>
<td></td>
<td></td>
<td></td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>20 – 24</td>
<td></td>
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<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>25 – 29</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>30 – 34</td>
<td></td>
<td></td>
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<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>≥ 35</td>
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<td></td>
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<td></td>
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</tr>
</tbody>
</table>

Total

### Open Questions

- What is the significance of the reported data in the context of voluntary counseling and confidential testing centers in Vanuatu?
- How can this template be used to improve the effectiveness of these centers?
- What are the potential challenges in implementing this reporting template in different settings?
<table>
<thead>
<tr>
<th></th>
<th>Tested</th>
<th>Detected</th>
<th>Treated</th>
</tr>
</thead>
<tbody>
<tr>
<td>2. Chlamydia</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Syphilis</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Trichomonas</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. Hepatitis B</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

(v) Details of partner visit to VCCT for STI partner management

1. Gonorrhea
2. Chlamydia
3. Syphilis
4. Trichomonas
5. Hepatitis B

Total

(vi) Linkages and referrals

<table>
<thead>
<tr>
<th>Departments/Agencies</th>
<th>In referrals</th>
<th>Out referrals-Positive</th>
<th>Out referrals-Negative</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Male</td>
<td>Female</td>
<td>TG</td>
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<tr>
<td>Total</td>
<td></td>
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</tr>
</tbody>
</table>

Section C

[Only for pregnant women]

Progress Made During the Quarter by the VCCT

(i) Pregnancy and delivery

<table>
<thead>
<tr>
<th></th>
<th>During ANC</th>
<th>Directly in labour</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Number of new registrations</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Number of cases receiving pre-test counseling/information out of all ANC registered</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Number of cases tested for HIV</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Number of cases received HIV test results</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. Number of cases received post-test counseling</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. Number of cases diagnosed HIV-positive</td>
<td></td>
<td></td>
</tr>
<tr>
<td>7. Number of HIV-positive cases received HIV test result</td>
<td></td>
<td></td>
</tr>
<tr>
<td>8. Number of spouses/partners of HIV-positive women found HIV-positive</td>
<td></td>
<td></td>
</tr>
<tr>
<td>9. Number of spouses/partners of HIV-negative women found HIV-positive</td>
<td></td>
<td></td>
</tr>
<tr>
<td>10. Total number of deliveries this month</td>
<td></td>
<td></td>
</tr>
<tr>
<td>11. Total number of HIV-positive deliveries this month</td>
<td></td>
<td></td>
</tr>
<tr>
<td>12. Total number of live births to HIV-positive mothers</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
13. Total number of mother-baby pairs who received Nevirapine
14. Number of HIV-positive pregnant women receiving Nevirapine during the month
15. Number of babies of HIV-positive receiving NVP during the month
16. Number of HIV-positive women opting for exclusive breastfeeding
17. Number of HIV-positive women accepting MTP after counseling

(ii) Follow-up

<table>
<thead>
<tr>
<th>Description</th>
<th>This quarter</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Number of HIV-positive women coming for follow up at 6 weeks</td>
<td></td>
</tr>
<tr>
<td>2. Number of babies undergone HIV diagnostic testing (PCR)</td>
<td></td>
</tr>
<tr>
<td>3. Number of babies found positive</td>
<td></td>
</tr>
<tr>
<td>4. Number of mothers counseled for breastfeeding</td>
<td></td>
</tr>
<tr>
<td>5. Number of positive mothers counseled for family planning</td>
<td></td>
</tr>
<tr>
<td>6. Number of HIV-positive women coming for follow-up at 6 months</td>
<td></td>
</tr>
<tr>
<td>7. Number of babies of HIV-positive women undergone HIV diagnostic testing</td>
<td></td>
</tr>
<tr>
<td>8. Number of babies found positive at 6 months follow-up</td>
<td></td>
</tr>
<tr>
<td>9. Number of positive women coming for follow-up at 12 months</td>
<td></td>
</tr>
<tr>
<td>10. Number of babies of positive women coming for follow-up at 12 months</td>
<td></td>
</tr>
<tr>
<td>11. Number of positive women coming for follow-up at 18 months</td>
<td></td>
</tr>
<tr>
<td>12. Number of babies of positive women coming for follow-up at 18 months</td>
<td></td>
</tr>
<tr>
<td>13. Number of babies found HIV-positive at 18 months</td>
<td></td>
</tr>
<tr>
<td>14. Number of clients referred for CD4 testing</td>
<td></td>
</tr>
</tbody>
</table>

(iii) Linkages and referrals

<table>
<thead>
<tr>
<th>Departments/Agencies</th>
<th>In referrals</th>
<th>Out referrals-Positive</th>
<th>Out referrals-Negative</th>
</tr>
</thead>
</table>

Total

Section D

[HIV-TB collaboration for all clients]

Progress Made During the Quarter by the VCCT

(i) Referral of suspected TB cases from VCCT to NTCP

<table>
<thead>
<tr>
<th>Indicators</th>
<th>HIV-positive</th>
<th>HIV-negative</th>
</tr>
</thead>
<tbody>
<tr>
<td>a) No. of persons suspected to have TB referred to NTCP Unit</td>
<td></td>
<td></td>
</tr>
<tr>
<td>b) Of the referred TB suspects, No. diagnosed as having:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(i) Sputum positive TB</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(iii) Extra-pulmonary TB</td>
<td></td>
<td></td>
</tr>
<tr>
<td>c) Out of above (b), diagnosed TB patients, number receiving DOTS</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

(ii) Referral of diagnosed TB cases from NTCP to VCCT

| a) No. of NTCP registered TB patients referred for HIV testing            |              |              |
| b) Out of above (a), no. tested for HIV                                  |              |              |
| c) Out of above (b), no. detected to be HIV-positive                     |              |              |
Appendix 6: Universal Safety Precaution Chart
Bibliography


vi.  Tools for the HIV counseling for the Asia-Pacific, jointly developed by WHO, FHI and UNICEF.


viii.  Integrated Counseling and Testing Center guideline of India

ix.  VCT guidelines for Pakistan

x.  SPC Publication 2010
For more information please contact:

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