



Ministry of Health

Jamaica

Guidelines for HIV Case-based Surveillance

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Operational Manual for HIV Case-based Surveillance

**Ministry of Health
Jamaica**

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Glossary of Terms

AIDS	Acquired Immune Deficiency Syndrome
ANC	Antenatal Clinic
ART	Antiretroviral Therapy
ARV	Antiretroviral
BCC	Behaviour Change Communication
CARICOM	Caribbean Community
CI	Contact Investigator
CIMT	Caribbean Indicators and Measurement Tools
CRIS	Country Response Information System
ERTU	Epidemiology Research and Training Unit
GFATM	Global Fund to fight AIDS, Tuberculosis and Malaria
GoJ	Government of Jamaica
HATS	HIV/AIDS Tracking System
HFLE	Health and Family Life Education
HIV	Human Immunodeficiency Virus
HMIS	Health Management Information System
IBRD	International Bank for Reconstruction and Development
ILO	International Labour Organisation
IT	Information Technology
JN+	Jamaica Network of Seropositives
KABP	Knowledge, Attitudes, Behaviour and Practices
M&E	Monitoring & Evaluation
MEASURE Evaluation	Monitoring and Evaluation to Assess and Use Results
MESST	Monitoring and Evaluation Systems Strengthening Tool
MERG	Monitoring and Evaluation Reference Group
MCSR	Monthly Clinic Summary Report
MICS	Multiple Cluster Indicator Survey
MSM	Men who have Sex with Men
MTCT	Mother to Child Transmission
NERHA	North East Regional Health Authority
NHP	National HIV/STI Programme
NPHL	National Public Health Laboratory
NSP	National Strategic Plan
NGO	Non-Government Organization
PAHO	Pan American Health Organization
PLACE	Priority for Local AIDS Control Efforts
PLHIV	People Living With HIV
PMTCT	Prevention of Mother to Child Transmission
RHAs	Regional Health Authorities
SERHA	South East Regional Health Authority
SRHA	Southern Regional Health Authority
STI	Sexually Transmitted Infections
SW	Sex Worker
UNAIDS	Joint United Nations Programme on HIV and AIDS
UNGASS	United Nations General Assembly Special Session on HIV
USAID	United States Agency for International Development
VCT	Voluntary Counseling and Testing
WHO	World Health Organization
WRHA	Western Regional Health Authority

Foreword

Jamaica bears the distinction of having one of the oldest Case Based Reporting systems for HIV in the Caribbean. The National HIV Surveillance System has evolved from a paper based reporting and management system at all levels to a web-based computerized system at the national level that allows for efficient management and analysis of the data.

Information from the surveillance system documents the impact of interventions taken as part of the national HIV response. This surveillance system has allowed the Ministry of Health to track the trends in the HIV epidemic and from analysis of the data captured, we have seen the cases of AIDS reported in Jamaica peak in 1996 and decline steadily since the introduction of antiretrovirals in 2004. The HIV surveillance system also documents the successes of the programme to prevent mother to child transmission of HIV with a reduced number of infants with HIV/AIDS reported since 2005 and an even more striking reduction in the number of AIDS deaths reported in children since 2002. While currently, the majority of HIV/AIDS cases are reported among men, closer analyses of the cases reported since 1982 show an increasing proportion of reported cases among women over the 28-year period. These data also point to where future action is most urgently needed.

The HIV Case Based Surveillance manual is a resource guide for ALL members of the surveillance team, including nurses, physicians, contact investigators, hospital, parish and regional surveillance officers, the national surveillance officers, and all other stakeholders in the national HIV response. It is the result of collaboration between the US Centers for Disease Control and Prevention (CDC), the National HIV/STI Programme and the Surveillance Unit of the Ministry of Health.

The purpose of this manual is to provide useful instruction on how to report newly diagnosed cases of HIV/AIDS, advanced HIV, AIDS and AIDS Deaths, and also to provide updates on cases that were previously reported. It was written to be applicable to all settings in which HIV testing is carried out and lays out the principles of HIV case-based reporting and describes in detail the Jamaican forms for this activity.

We hope it will lead to more complete, timely and improved quality reporting of HIV/AIDS Cases and Deaths and guide planning and decision-making in all settings in which HIV testing occurs.

Overview of HIV Case-Based Reporting

a. Definition and objectives of Case-Based Surveillance

The HIV surveillance system collects information that is used to evaluate and expand the efficiency and appropriateness of programmes aimed at early detection of new HIV infections, preventing the spread of HIV, and treating the HIV infected. HIV case based surveillance (HCBS) is an important element in the monitoring and evaluation of any health system's response to the HIV epidemic. Through HCBS, each person with a HIV infection is reported using a single case report form containing information that pertains only to that person. This type of data collection usually occurs at health care facilities and other public and private entities and is forwarded to the parish, regional and national level for data compilation, entry and aggregation for reports.

A functioning surveillance system will support the following objectives:

- ♦ Provide in-depth information about individuals diagnosed with HIV
- ♦ Decrease the need for special population surveys
- ♦ Assist in monitoring the incidence and prevalence of HIV infections including AIDS, and HIV-related morbidity and mortality in the population
- ♦ Identify changes in trends of HIV transmission and identify populations at risk
- ♦ Guide targeted prevention interventions and evaluate their effectiveness
- ♦ More accurately determine the need for care and treatment
- ♦ Provide denominator data to evaluate reach of programmes
- ♦ Provide demographic, clinical and behavioural information on persons diagnosed with HIV
- ♦ Identify areas needed for further research/surveillance such as behavioural surveillance
- ♦ Serve as a platform for drug resistance and incidence surveillance
- ♦ Monitor completeness of surveillance forms and inform training and updates for staff

Surveillance case definitions for HIV infection and reportable events

HIV disease is classified as a class 1 (highest priority) disease in Jamaica. This means suspicion and/ or confirmation of HIV disease must be reported on a *Class 1 Reporting Form – Individual Notification (Appendix 3)* to the parish health department and/or the Epidemiology Unit at the MOH within 24 hours. There are different stages of HIV Disease as captured in Table 1.

Table 1: Different Stages of HIV disease

HIV infection (all clinical stages)	All persons newly diagnosed with HIV, regardless of clinical stage or immunologic status
Advanced HIV infection*	WHO clinical stages 3 ¹ or CD4 count <350
AIDS² case*	Clinical stage 4 ³ or CD4 count <200.
AIDS Death or AIDS related-death	Deaths of individuals with AIDS or AIDS related-death.

* Corresponding CD4 % for children as in Box 2

The World Health Organization has defined HIV infection for adults and children 18 months and older and for children younger than 18 months. These definitions have been adapted as standard definition in Jamaica. Cases diagnosed with advanced HIV infection (including AIDS) not previously reported should be reported according to the standard case definition (Box 1).

¹ WHO Case Definitions of HIV for Surveillance and Revised Clinical Staging and Immunological Classification of HIV-related Disease in Adults and Children - 2006

² AIDS in adults and children is defined as; clinical diagnosis (presumptive or definitive) of any stage 4 condition (defined in Appendix 2) with confirmed HIV infection: OR immunological diagnosis in adults and children with confirmed HIV infection and >5 years of age; first-ever documented CD4 count less than 200 per mm³ or %CD4+ <15: OR among children with confirmed HIV infection aged 12–35 months first ever documented %CD4 <20: OR among children with confirmed HIV infection and less than 12 months of age first ever documented %CD4 <25.

³ WHO Case Definitions of HIV for Surveillance and Revised Clinical Staging and Immunological Classification of HIV-related Disease in Adults and Children – 2006

Box 1. Case definition for HIV infection (WHO⁴)

Adults and children 18 months or older

HIV infection is diagnosed based on:

positive HIV antibody testing (rapid or laboratory-based enzyme immunoassay). This is confirmed by a second and a third HIV antibody test (rapid or laboratory-based enzyme immunoassay) relying on different antigens or on different operating characteristics;

and/or;

positive virological test for HIV or its components (HIV-RNA or HIV-DNA or ultrasensitive HIV p24 antigen) confirmed by a second virological test obtained from a separate determination.

Children younger than 18 months:

HIV infection is diagnosed based on:

positive virological test for HIV or its components (HIV-RNA or HIV-DNA or ultrasensitive HIV p24 antigen) confirmed by second virological test obtained from separate determination taken more than four weeks after birth. HIV antibody testing is not recommended for confirmatory HIV infection until 18 months of age

Advanced HIV infection is diagnosed based on clinical and/or immunological (CD4) criteria among people with confirmed HIV infection. In the preceding Box 2 outlines both the clinical and immunological criteria for diagnosing advanced HIV.

⁴ Ibid

Box 2. Criteria for diagnosis of advanced HIV (including AIDS⁵) for reporting - 2006

Clinical criteria for diagnosis of advanced HIV disease in adults and children with confirmed HIV infection:

Presumptive or definitive diagnosis of any stage 3 or stage 4 condition⁶.
and/or;

Immunological criteria for diagnosing advanced HIV in adults and children five years or older with confirmed HIV infection:

CD4 count less than 350 per mm³ of blood in an HIV-infected adult or child.

and/or;

Immunological criteria for diagnosing advanced HIV in a child younger than five years of age with confirmed HIV infection:

%CD4+ <30 among those younger than 12 months;

%CD4+ <25 among those aged 12–35 months;

%CD4+ <20 among those aged 36–59 months.

Indications for HIV testing⁷

In an effort to scale up HIV testing, the following categories of persons **should** be tested for HIV:

- a. All persons (especially adolescents, young women and young men) admitted to any private or public hospitals who have not had a HIV test done in the last three months or results of any test done are not known
- b. All pregnant females at first presentation to care and repeated in 3rd trimester (or as clinically indicated)
- c. All persons seeking care for a STI who have not had an HIV test in the last three months or results of any test done are not known

⁵ AIDS in adults and children is defined as; clinical diagnosis (presumptive or definitive) of any stage 4 condition (defined in Appendix 2) with confirmed HIV infection: OR immunological diagnosis in adults and children with confirmed HIV infection and >5 years of age; first-ever documented CD4 count less than 200 per mm³ or %CD4+ <15: OR among children with confirmed HIV infection aged 12–35 months first ever documented %CD4 <20: OR among children with confirmed HIV infection and less than 12 months of age first ever documented %CD4 <25.

⁶ See Appendix 2 for disease conditions associated with the different stages of HIV/AIDS

⁷ Ministry of Health, Jamaica field counseling and testing guidelines

- d. All persons who seek preventative or curative health care who request an HIV test
- e. All persons with signs and/or symptoms of HIV infection
- f. All persons with a history of risky sexual behaviour
- g. All persons diagnosed with tuberculosis
- h. All infants and young children of HIV infected mothers

All testing should be done in accordance with the Ministry of Health's counselling and testing guidelines. People who test HIV negative should also be supported and receive counselling on how to reduce exposure to HIV.⁸

Note: Jamaica supports the ten principles on HIV/AIDS and the world of work suggested by the International Labour Organisation (ILO). These principles include **no screening for the purposes of exclusion from employment or work processes**⁹, confidentiality, and continuation of employment relationship, prevention, care and support.

Diagnosis of an HIV infection

HIV infection is diagnosed primarily on laboratory criteria. Probable cases may have an AIDS-defining condition (See Appendix 2) but HIV at any immunological stage in an adult or child requires confirmation of HIV infection by the best age-appropriate test.

Generating a Class 1 Reporting Form – Individual Notification

All suspected and confirmed HIV cases must be reported using the *Class 1 Reporting Form – Individual Notification (Appendix 3)* including all babies born to HIV positive mothers. The notification should be done even if the individual is asymptomatic. All persons who are found to be presumptively positive after rapid testing (see figure 1) must be reported on a *Class 1 Reporting Form – Individual Notification*. Submitting a *Class 1 Reporting Form – Individual Notification* to the health department and/or the Ministry of Health will allow for follow-up of individuals who have not yet received a confirmatory HIV test.

⁸ Voluntary Counselling and Testing for HIV, Reference Manual. Jamaica

⁹ National HIV/AIDS Policy, Jamaica.

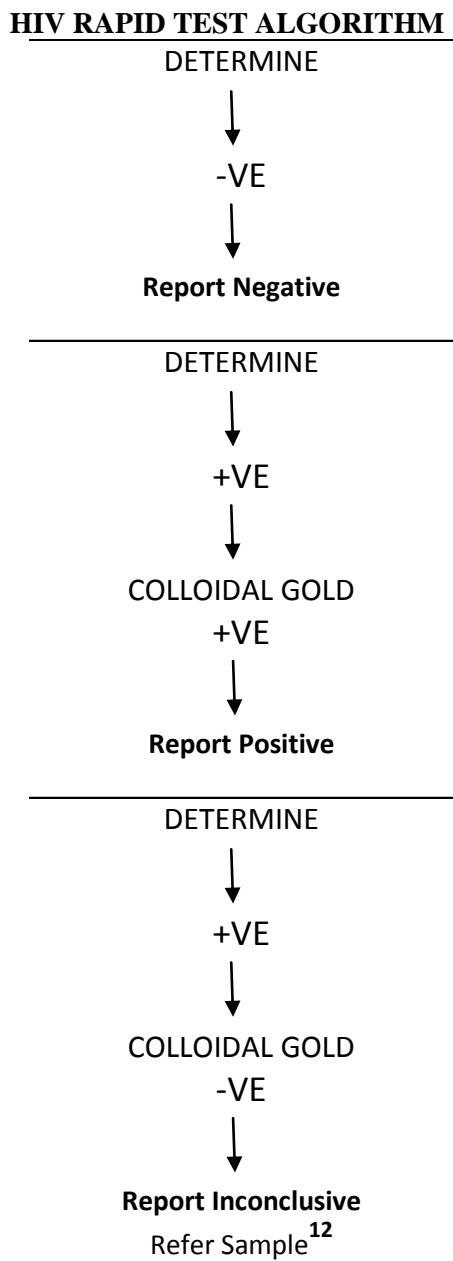
Generating a HIV/AIDS Confidential Reporting Form

A *HIV/AIDS Confidential Reporting Form (Appendix 1)* must be filled out when/for:

- A person is confirmed with HIV infection, regardless of clinical status
- A person previously diagnosed and reported with HIV clinical stage 1 or 2 who progresses to advanced HIV infection or AIDS¹⁰
- An HIV patient regardless of clinical status who now has a CD4 count <350 cells/mm³ (consider CD4 percentage in children <5 years)
- A HIV patient commences ART
- A HIV – infected person dies, regardless if the cause is AIDS related or not
- Pregnant HIV positive women even if previously notified in non pregnant state

¹⁰ Advanced HIV infection – stage 3; CD4 count <350 cells/mm³ or stage 4; CD4 count <200 cells/mm³

Figure 1: HIV algorithm for field rapid testing in Jamaica¹¹



¹¹ Ministry of Health. Approved by Michelle Hamilton, National Laboratory Service Edition 1 June 2012

¹² Sample is referred to the National Public Health Lab for confirmation

Sources of HIV/AIDS Confidential Reporting Form

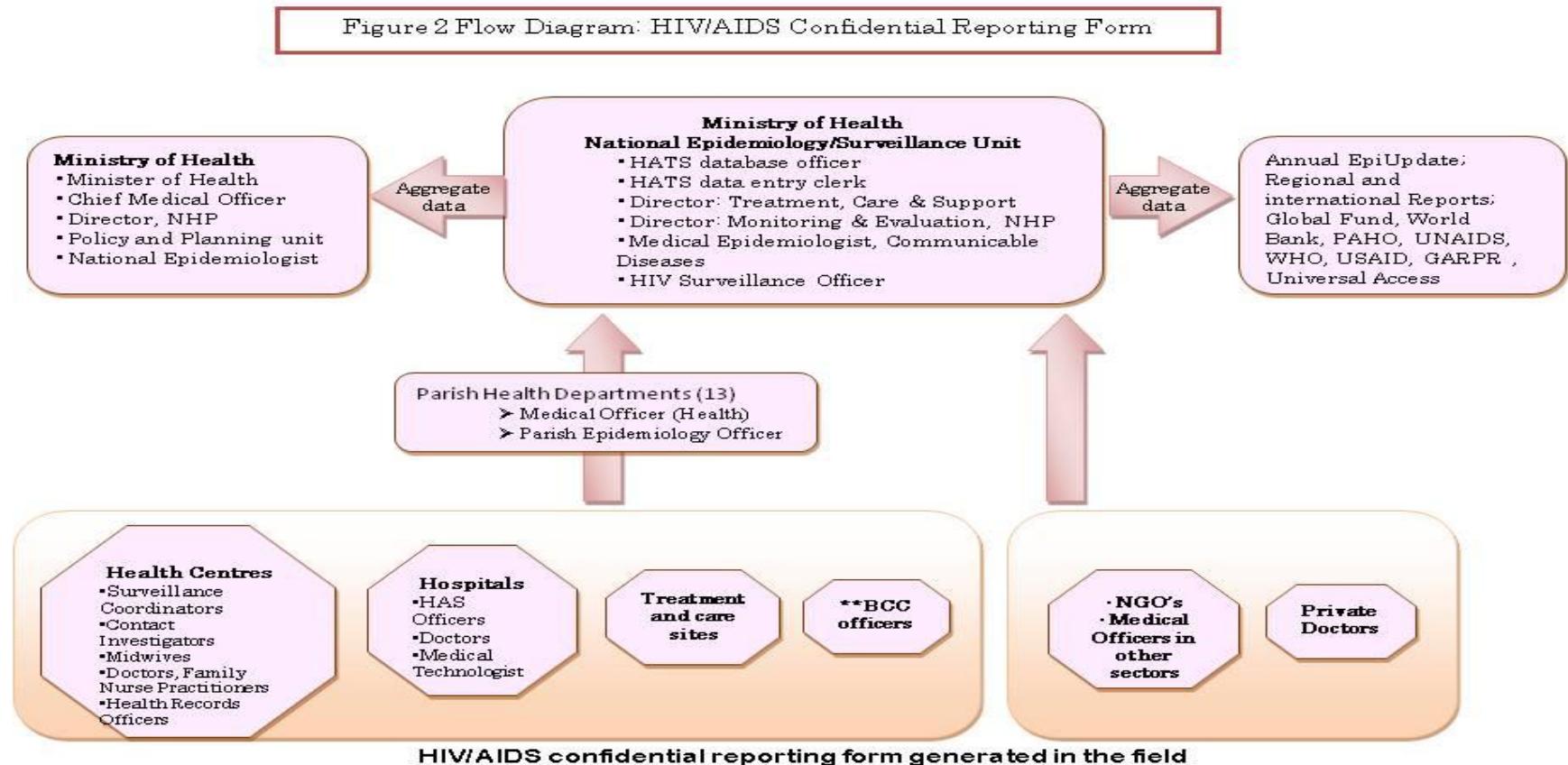
Public, private and non-governmental agencies that provide diagnostic and treatment services submit case reports to the national HIV surveillance system. Treatment, care and support sites are located at public health centres and hospitals throughout the country. Many of these facilities have Contact Investigators who complete a significant proportion of the case report forms in addition to those done by physicians and Public Health Nurses. The National Public Health Laboratory and private labs provide private physicians with blank case report forms for completion along with any confirmed HIV positive result for their patients. Other private, public and non-governmental agencies mostly submit line listing of the HIV positive individuals that they encounter. Some submit reporting forms directly to the NHP while others refer the patient to a treatment and care site where the case report form is completed. Figure 2 highlights the main sources of the completed *HIV/AIDS Confidential Reporting Form* and the expected route to the Ministry of Health through the National HIV/AIDS Programme.

Surveillance Officers can assist more directly with the reporting process and improve the completeness of case reporting by working closely with programmes and non-governmental entities that provide care to persons with HIV infection. In doing so they ensure that reports, through active or passive surveillance methods, are ultimately submitted to the Ministry of Health.

Current sources of HIV case based reports in Jamaica include:

- Hospitals (Public and Private)
- Public Health Centres
- ANC/ PMTCT programme
- Targeted community outreach programmes
- The Jamaica Defence Force
- The Jamaica Constabulary Force
- Non-Governmental Organizations
- Private physicians or Private clinics
- Insurance Companies
- Ministry of Labour and Social Security

Figure 2 Flow Diagram: HIV/AIDS Confidential Reporting Form



Roles and Responsibilities in HIV Case-based Surveillance

Table 2: Roles and Responsibilities for programmes and key personnel involved in HIV surveillance

Head of Department/ Unit/Section	Responsible persons	Responsibilities
SMO, NHP	1. Director, Monitoring and Evaluation	<ul style="list-style-type: none"> • Provide ongoing oversight of data entry and the management of the HIV surveillance database • Maintain a complete and accurate HIV surveillance database which is secure and has limited access by authorized personnel • Prepare annual Epidemic Updates that describe trends in HIV infection, Advanced HIV and AIDS cases and deaths • Triangulate HCBR data with data from other sources from the HIV response to inform and evaluate the national response and training
	2. National HIV Surveillance Officer	<ul style="list-style-type: none"> • Solicit, receive, review and file <i>HIV/AIDS Confidential Reporting Forms</i> on a timely basis • Ensure case reports are filled out completely, accurately and clearly • Conduct periodic docket review to generate HIV cases from medical records • Ensure that <i>HIV/AIDS Confidential Reporting Forms</i> are entered in the HATS database • Facilitate follow-up of investigations on cases of epidemiologic importance
	3. HATS Database Officer & Clerk	<ul style="list-style-type: none"> • Perform validation and verification of data entry forms with documentation of findings • Perform duplication checks on data entry forms • Perform data entry activities in prescribed databases including highly confidential information • Maintain filing system for data entry forms
	4. Director, Treatment, Care and	<ul style="list-style-type: none"> • Develop and implement an integrated model of HIV/STI treatment and prevention • Support and monitor the expansion of PMTCT • Facilitate and conduct training of health care

	Support	<p>workers in treatment and care of persons with HIV/STI</p> <ul style="list-style-type: none"> • Ensure the HIV/STI Treatment Information Programme is strengthened and reporting of indicators is timely and efficient
	5. Contact Investigators	<ul style="list-style-type: none"> • Notify ALL HIV positive cases on suspicion • Complete <i>HIV/AIDS Confidential Reporting Forms</i> of all confirmed HIV/AIDS cases (new and updates) received • Confirm with Clinical care physician that cases meet the case definitions and clinical staging is accurate. • Submit <i>HIV/AIDS Confidential Reporting Forms</i> to the Medical Officer of Health and the Epidemiology unit/MOH • Conduct partner notification and management of sexual contacts • Locate HIV exposed children who default from clinic to ensure that confirmation of HIV status is achieved for all HIV exposed children
	6. Behaviour Change Communication Officer	<ul style="list-style-type: none"> • Support outreach testing and counselling efforts across all regions • Ensure ALL HIV positive cases are notified and <i>Class 1 Reporting Form – Individual Notification forms</i> are completed and submitted to MO(H) • Coordinate and provide technical assistance to MO(H) and all related personnel
	7. Public/ Private Physician	<ul style="list-style-type: none"> • Notify ALL HIV positive cases on suspicion using <i>Class 1 Reporting Form – Individual Notification</i> • Complete <i>HIV/AIDS Confidential Reporting Forms</i> (initial and update) and send to the Medical Officer of Health or the Epidemiology unit/MOH • Ensure that cases have been referred to the contact tracing services • Evaluate each case report to determine if it meets the HIV case definition and assess clinical staging and monitor treatment of confirmed HIV positive patients
National Epidemiologist	1. Medical Epidemiologist	<ul style="list-style-type: none"> • Analyze, interpret and disseminate HIV surveillance data at national, regional and

		<ul style="list-style-type: none"> international levels • Critically assess the performance of the surveillance programme through on-going evaluation of surveillance activity
	2. Medical Officers of Health	<ul style="list-style-type: none"> • Establish and maintain control mechanisms to prevent and control communicable and non-communicable diseases • Monitor disease trends and patterns within Parishes • Submit ALL <i>HIV/AIDS Confidential Reporting Forms</i> to the Epidemiology unit/MOH
	3. Hospital Active Surveillance Nurses	<ul style="list-style-type: none"> • Identify all HIV/AIDS cases (alive and dead) that have been admitted on the wards and suspected and confirmed cases that attend the Accident and Emergency department • Complete <i>Class 1 Reporting Form – Individual Notification</i> and submit to Health department
	4. Regional/ Surveillance Officers	<ul style="list-style-type: none"> • Coordinate the collection of <i>HIV/AIDS Confidential Reporting Forms</i> and <i>Class 1 Reporting Form – Individual Notification</i> from all providers (CIs, HAS, private physicians and others) in the parish • Ensure all <i>HIV/AIDS Confidential Reporting Forms</i> and <i>Class 1 Reporting Form – Individual Notification</i> are filled out completely, accurately and clearly • Submit all <i>HIV/AIDS Confidential Reporting Forms</i> and <i>Class 1 Reporting Form – Individual Notification</i> received to Epidemiology Unit, as soon thereafter received • Provide feedback about confirmed cases, where possible, to providers
	5. Midwives	<ul style="list-style-type: none"> • Notify and complete <i>HIV/AIDS Confidential Reporting Forms</i> of HIV positive cases in pregnant women • Refer cases to the nearest high risk clinic • Ensure that post-partum mothers are referred to and arrive at a treatment site
	6. Paediatricians	<ul style="list-style-type: none"> • Notify and complete <i>HIV/AIDS Confidential Reporting Forms</i> of exposed children • Ensure that confirmation of HIV status is achieved for all HIV exposed children

Instructions for completing HIV/AIDS Confidential Reporting Form

Health care providers should notify all HIV/AIDS cases to their Health Department or the Epidemiology Unit within 24 hours of diagnosis, including a physician's diagnosis based upon history and symptoms. Reports should be made regardless of the patient's nationality or whether a previous provider may have reported the HIV/AIDS case to the Health Department or the Epidemiology Unit.

Completed *HIV/AIDS Confidential Reporting Forms* and *Class 1 Reporting Form – Individual Notification* should be delivered to Medical Officer of Health at the Health Department or to the attention of Senior Medical Officer (SMO) of the National Surveillance Unit, MOH. ***It is prohibited for patients to deliver case reports.***

In order to maintain the confidentiality of HIV/AIDS surveillance data and to protect the privacy of HIV-infected persons, fax or email reporting is prohibited.

Note: The National HIV/AIDS Programme (NHP) encourages providers to explain to their patients that strict procedures are in effect to protect the confidentiality and security of all information collected on the HIV/AIDS Case Report Form. The NHP does not transmit names, Taxpayer Registration Numbers, or other information that could be used to identify an individual to any governmental or non-governmental agency, business, or individual. All data is reported in the aggregate, in summary tables, charts, and graphs. Nonetheless, some patients may not wish to provide their TRN. In this circumstance, the NHP encourages providers to complete the case report form to the best of their ability, providing the patient's name, date of birth, and other identifying information requested on the form. This will assist NHP in maintaining accurate, unduplicated records, an essential element of our quality assurance procedures.

As much as possible avoid leaving blanks. Insert NA for not applicable or – if unknown to assist in assessment of completeness of report.

Definition of variable designators

1. **Required:** Variables that are required to meet the case definitions of HIV or AIDS, to identify and track cases, and to do meaningful statistical analysis.
2. **Recommended:** Information that is useful for analysis but not essential for core surveillance.
3. **Required where applicable/ Required when available:** Information that should be ascertained if readily available or applicable. Please follow the guidelines below to complete the form.
 - **TRN- Tax Registration Number (Required when available)**
When available, enter the patient's full Taxpayer Registration Number. This information will be used to identify possible duplicate case records and will not be used for other purposes.

- **Clinic site (Required)**

Enter the name, of the reporting facility or provider from which the *HIV/AIDS Confidential Reporting Form* is being generated or where the patient is being treated as a newly diagnosed HIV positive person, advanced HIV or with AIDS, accordingly.

- **Medical record Number (Required)**

Enter any health record number that is assigned to the patient's medical record located at the clinic site.

- **Transfer:** This field describes the patients transfer status by noting if the patient transferred to current site from another treatment site (public, private, or overseas), and if the patient is already on treatment.

¹²**Select; (Required)**

- **Trace**

- Request for patient to be interviewed by a Contact Investigator; please note that it is **strongly recommended** that all newly diagnosed HIV positive and AIDS patients be referred to a Contact Investigator. Health care providers are encouraged to fully explain the importance of this to each patient.

- **Do not trace**

- Contact Investigator is not being requested by this health care provider to interview this patient (this could be because contact tracing may have already been done as with case report updates with no new partners). Health care providers who select this option automatically assume responsibility of contact tracing for the patient.

- **Contact partners only**

- Request that the patient should not be contacted, only the partners as per declared on the case report forms.

- **Update**

- Applies to any newly acquired information that is applicable to the case report and differs from a previous case report submission. Information such as change in address, new contacts, pregnancy, change in clinical status, death, etc.

- **Copy sent to CI**

- Indicates that a copy of the *HIV/AIDS Confidential Reporting Forms* has been forwarded to a Contact Investigator.

1. **Patient Name (Required)**

Enter the patient's last name, first name, and middle name. If available, write in any other names, a.k.a., aliases, maiden name, or prior legal names.

¹² This section is usually applicable to patients who are being reported from the private sector. All patients treated in public institutions are automatically provided with contact tracing services as a part of a comprehensive M&E programme.

Sex (current) (Required)

This field denotes the patient's biological sex at the time of diagnosis primarily male (M), female (F). (*Current sex may vary from the patient's sex at birth, for example, where a patient has had sexual reassignment surgery*)

2. Address (Required)

This field should be completed to reflect the patient's current residence. If at the time of diagnosis, the patient was incarcerated in correctional facilities or was a ward of the state, this should also be indicated.

- Tel. – A telephone number which the patient gives as most likely to be reached.

3. D.O.B – Date of Birth (Required)

Enter the patient's day, month, and year of birth in the *dd/mm/yyyy* format

Occupation (Recommended): This field should be completed to reflect the area in which the person has (1) formal or technical career or skill training or (2) the area in which the person is most often employed.

Employed (Recommended): This should be checked if the person is currently engaged in part- or full-time employment or is self employed.

Marital Status (Recommended): This field should be completed to reflect whether the patient is legally married, common law, visiting union or single

4. Highest level of Education (Recommended)

This field should be completed to reflect the highest level of education attained by the patient: No formal schooling, basic, primary/all-age, secondary/high school, tertiary, skills training, (other)

5. Number of children under 15 years of age (Recommended)

State the number of children under 15 years old that have been born to the patient

6. Ever Deported from a foreign country (Required)

Obtain whether the patient has ever been deported from a country

7. Next of Kin (NOK) (Recommended)

Usually describes a person's closest living relative, by blood or marriage. The person should be considered to be a personal confidant and can be substituted by friends or acquaintances whom they consider to be so.

- Name - Enter the person's first name and last name
- Relation to the patient - friend, mother, brother, etc.
- Address - Place of permanent residence of the NOK

7b. Mother's name (Required)

First, last and maiden name, where applicable.

Sections 8, 9 and 10 will yield data on how the patient may have acquired their infection. Select each depending on the specific information acquired from the patient or that which is clearly stated in the medical record. Select Unknown for those which motivation interviewing and other suitable information gathering techniques fail to yield an answer. Risk factors should not only be selected if individual has had primary exposure, but if there has been secondary exposure via sexual contact with an individual who has said risk factor.

8. Sexual practice (Required)

- **Heterosexual** – sexual attraction and activity only with persons of the opposite gender
- **Homosexual** – sexual attraction and activity primarily with persons of the same gender
- **Bisexual** – active/occasional sexual contact with persons of both genders
- **Not known** – sexual practice could not be determined.

9. Risk History (Required). Date (dd/mm/yyyy) – date at which the risk assessment is being made.

Options – In the past year and ever (ever includes current use) – check both if applicable

- **Blood transfusion** – history of blood/blood products transfusions
- **Crack cocaine use** – history of or current use of crack or cocaine
- **Intravenous drug use** – injected drugs or steroids, during which equipment (such as needles, syringes, cotton, water) and blood were shared with others
- **Current STI** – currently being treated for any other sexually transmitted disease, apart from HIV
- **History of STI** – recent diagnosis of any sexually transmitted disease apart from HIV
- **Genital ulcers/sores** – has been diagnosed and/or treated for genital ulcers
- **Sex with CSW** – has engaged in sexual contact with an individual who requires payment in exchange
- **CSW** – gives sex in exchange for cash
- **Multiple partners** – has had/has more than one partner
- **Ever in prison** – history of being in jail or prison
- **Victim of sexual assault** – history of having been raped (vaginal or anal penetration)
- **Sex with known HIV +ve person** – has engaged in sexual contact with an individual who is known to have HIV

- **Transactional sex** – given sex in exchange for gifts

10. Clinical Status (Required). Date (dd/mm/yyyy) – date at which the clinical evaluation is being made

(Diagnosis should be confirmed by a physician)

- **Weight loss (10%)** – involuntary weight loss, i.e. patient has made no direct efforts to lose weight e.g., exercise or dieting
- **Cough (>4weeks)** – may be intermittent or persistent, productive or not
- **Fever (>1 month)** – on and off temperatures of 100.4 F (38 C) or more than is temporarily alleviated by antipyretics or other medications.
- **PCP** – current or past diagnosis of Pneumocystis Carinii Pneumonia
- **Recurrent Pneumonia** – repeated lower respiratory tract infections
- **Tuberculosis** – confirmed TB case
 - If yes: Pulmonary/Extra Pulmonary/Disseminated – circle the appropriate condition(s)
- **CNS involvement** – unexplained recent history of seizures, dementia, toxoplasmosis, CMV, Cryptococcus, encephalopathy
- **Severe bacterial infection** – an infection at any site of the body for which the patients had to be hospitalized for any period of time for treatment. **Candidiasis** – fungal Infection with Candida spp that can be oral (in the mouth), oesophageal (in the oesophagus or vaginal)
- **Generalized lymphadenopathy** – lymph nodes greater than 1cm in diameter that are found in two sites or more on the body. Common sites are head, neck, post or pre auricular, supraclavicular, axillary, epitroclear, and inguinal
- **Diarrhoea (> 1 month)** – three (3) or more watery stools in a 24 hr period
- **Chronic Herpes simplex** – reported history of recurrent genital ulcer, blisters or crusts
- **Shingles** – recent or current diagnosis of the skin infection caused by the chickenpox virus
- **Dermatitis** – unexplained rash to multiple parts of the body
- **Invasive cervical cancer** – history of or current cytology diagnosis cervical cancer that has spread beyond the cervix – stage 1a or greater
- **Kaposi's sarcoma(KS)** – HIV related Kaposi's sarcoma
- **Other** – any other illness or condition that may be considered an important sign of HIV infection or advanced HIV disease

11. Transmission category (Required)

- **Sexual**
 - likely to have resulted from sexual contact
- **Vertical**
 - history of a HIV positive mother and is diagnosed with HIV/AIDS as a child

- **IV drug use**
 - has shared needles with other IV drug users in the past
- **Haemophiliac**
 - diagnosed Haemophiliac that has been transfused repeatedly with blood/ blood products
- **Blood transfusion**
 - when this is the only risk factor that the person has or it has been confirmed that person received blood that was infected with the HIV virus

12. Complete; (Required when available)

The following section will give indications of the patient's immunological status and will assist in staging of the disease.

- **CD4 count**
 - value of last known CD4 count result
- **CD4/CD8 ratio**
 - value of last known CD4 count result/ value of the last known CD8 count result
- **Date of CD4 count**
 - date of last known CD4 count test
- **Viral load**
 - value of last known viral load test
- **Date of viral load**
 - date of last known viral load test.

13. Complete; (Required when available)

This gives an indication of ARV coverage in the HIV positive population that needs it and the timeliness of the initiation of ART

- **Is Pt on antiretroviral therapy (ART)? (Required)**
 - has patient been prescribed and is taking ARVs
- **Start date of ART: (Required where applicable)**
 - date that the recommended ARV regime was initiated by the patient.
- **ARV line** – choose 1st, 2nd, salvage or unknown regimes in accordance with the guidelines for ARV management (see appendix 4).

14. Current status of patient (Required)

- **HIV (no symptoms)**
 - positive test result for the HIV antibody, but individual displays no signs or symptoms of an immune-compromised state (clinical stage 1).
- **HIV minimal symptoms**
 - present with any sign or symptom associated with clinical stage 2
- **Advanced HIV (CD4 count 201-350)**
 - advanced HIV disease with a history of CD4 count that has fallen between 201 and 350

- **AIDS**
 - clinical stage 3 or 4
- **AIDS death**
 - person who has been diagnosed with HIV/AIDS who has died, irrespective of the cause of death, it should be reported.

16. Date of onset of symptoms (dd/mm/yyyy) (Required where applicable)

- Date that can be identified as the initial appearance of signs or symptoms.

17. Date diagnosed as Advanced HIV/AIDS (Required where applicable)

- use format dd/mm/yyyy – known date at which a clinician confirmed that patient has advanced HIV disease
- date of death – dd/mm/yyyy (*regardless of stated cause, all deaths of persons who are known to have HIV/AIDS must be reported*).
- cause of death – HIV and non-HIV related

18. Rapid Test– dd/mm/yyyy (Required)

- **Result** – positive or negative
- **Test type** – brand of rapid test used
- **Where tested** – select site at which the rapid test was done or specify
- **Confirmatory lab** – Laboratory at which the confirmatory test was processed
- **Confirmatory HIV test date** – dd/mm/yyyy

19. Blood transfusion (Required where applicable)

- Date at which blood transfusion was received – dd/mm/yyyy
- Hospital transfused – hospital where blood transfusion was administered

20. FOR PREGNANT WOMEN ONLY, PLEASE ENTER THE FOLLOWING INFORMATION

- Estimated gestational Age (in weeks) Expected date of delivery (dd/mm/yyyy)
- Clinic site (name of medical facility at which patient is receiving antenatal care) **Parish** (in which facility is located), **Clinic MRN#** (registration number on record at this site)
- Indicate Hospital to which patient has been referred to for high – risk antenatal care. Patient referred to: Victoria Jubilee Hospital (VJH), University Hospital of the West indies (UHWI), Spanish Town Hospital, Cornwall Regional Hospital, Mandeville Regional Hospital, St Ann's Bay Regional Hospital, Other (any other Obstetric high risk treatment and care site that the patient may have been referred to, including, private facilities):
Date of referral appointment – date of appointment received to attend High risk clinic

Pt Not referred – select if there is no record of being referred to a high risk clinic or if patient confirms that there was no referral given

Pt. Refused referral – referral offered and explained to patient and patient rejects offer.

- Enter the name of the person conducting the post-test counselling.

Done by: _____

Indicate date of post-test counselling: dd/mm/yyyy

Security of data¹³

Guiding Principles

The five guiding principles as defined by CDC and adapted here provide the foundation for all security considerations of HIV case reports.

Guiding Principle 1

HIV/AIDS surveillance information and data will be maintained in a physically secure environment.

Guiding Principle 2

Electronic HIV/AIDS surveillance data will be held in a technically secure environment, with the number of data repositories and individuals permitted access kept to a minimum. Operational security procedures will be implemented and documented to minimize the number of staff that have access to personal identifiers and to minimize the number of locations where personal identifiers are stored.

Guiding Principle 3

Individual surveillance staff members and persons authorized to access case-specific information will be responsible for protecting confidential HIV/AIDS surveillance information and data. They will also be responsible for protecting their own access information (username and password) which is never to be shared with other individuals.

Guiding Principle 4

Security breaches of HIV/AIDS surveillance information or data will be investigated thoroughly, and sanctions imposed as appropriate. Reference can also be made to section 4.5 of the Staff Orders for the Public Service of Jamaica.

Guiding Principle 5

Security practices and written policies will be made available to all staff and will be continuously reviewed, assessed, and as necessary, changed to improve the protection of confidential HIV/AIDS surveillance information and data.

¹³http://www.cdc.gov/hiv/topics/surveillance/resources/guidelines/pdf/Security_and_Confidentiality_v3.pdf

Ethical Considerations

People and groups at increased risk for HIV infection are vulnerable to a number of social, legal and physical harms. Because of this vulnerability and the *stigma* (mark of disgrace or shame) attached to the disease, the surveillance system needs to address a unique set of ethical issues. Infected persons in the general population and in high-risk groups have a legitimate fear of societal discrimination and the ways it may affect them.

Groups at increased risk may include:

- sex workers
- drug users
- prisoners
- mobile (or migrant) populations (such as persons who leave home for extended periods of time for work)
- men who have sex with men
- sex partners of high-risk persons, including those with known HIV infection.

Successful surveillance in marginalized populations depends on assuring the at-risk populations and communities of PLHIV that information about them will be held in strict confidence and used only for designated surveillance purposes. An effective surveillance system requires that at-risk populations and populations with known elevated incidence or prevalence of HIV are identified and accessible for:

- HIV testing
- ascertainment and monitoring of risk behaviors
- care, treatment, social and prevention services

The NHP undertakes this ethical responsibility in all aspects of work.

Monitoring and Evaluation

Periodic evaluation of the HIV surveillance system is necessary in order to maintain a responsive and relevant system capable of monitoring disease trends. Evaluations of the surveillance system should include recommendations for improving quality, efficiency and usefulness. The objective of the evaluation is to determine how well the surveillance system meets its purpose. Guidelines have been developed by CAREC to address methods used to evaluate a surveillance system.

Monitoring and evaluating your HIV surveillance system can help determine:

- the number and proportion of facilities reporting cases
- the facilities not reporting cases
- the time it takes facilities to report a case after the case has been identified
- the completeness of the variables included on the case report forms

Various attributes can be monitored in a surveillance system including accuracy, simplicity, acceptability, flexibility and completeness of data etc. The MOH has established monitoring principles that will **annually** evaluate the surveillance system data for the following:

- completeness of case reporting
- timeliness of case reporting
- validity (accuracy) of the data reported

The goal is to have all testing facilities in Jamaica meet or exceed the standards for HIV Surveillance set forth by CAREC (Table 6).

Table 3: HIV Surveillance Standards	
Data Quality Indicators	Standards
Completeness	<ul style="list-style-type: none"> • 85%
Timeliness	<ul style="list-style-type: none"> • 66% within 6 months of diagnosis in year 1 of HIV case surveillance system implementation • 85% within 1 year of diagnosis in year 2 and after
Validity	<ul style="list-style-type: none"> • 90%

To ensure the accuracy, completeness and timeliness of data collected for case reporting, the MOH will consider all the contributing factors including:

- legibility of the surveillance forms
- quality of training and supervision of persons who complete surveillance forms
- care exercised in data management

Completeness of HIV/AIDS Confidential Reporting Form

Completeness of a case based surveillance system measures the proportion of all true cases that are reported to the surveillance system. This definition of completeness should not be confused with measuring the completeness of information that is collected on a case report form. The Surveillance programme should strive to have reporting as complete as possible. As surveillance systems improve, completeness should increase.

Timeliness in obtaining the HIV/AIDS Confidential Reporting Form

Timeliness in obtaining the completed HIV/AIDS Confidential Reporting Form assists in accurate and complete reporting. The surveillance team should aim at ensuring that complete and

accurate HIV/AIDS Confidential Reporting Forms are submitted and meet the established standards for reporting as per Table 6.

Accuracy of the HIV/AIDS Confidential Reporting Form

Accuracy or validity measures the extent to which the information on the case report form matches information in the patient record at the health facility. Validity can be considered a measure of the ‘truth,’ assuming that the patient’s record at the healthcare facility is correct.

Appendix 1 - HIV/AIDS Confidential Reporting Form

HIV/AIDS CONFIDENTIAL REPORTING FORM

Send all reports to S.M.O, Surveillance Unit
2 King Street, Kingston
Ministry of Health,
Telephone: 967-1100/1/3/5, Fax # 967-1280
AIDS/STD Helpline Tel: 967-3830

FOR THE EPI – UNIT ONLY: ACCESS #

TRN: Clinic Site MEDICAL RECORD

TRANSFER: Yes No

Trace , Do not contact trace , Contact partners only , Update , Copy sent to CI

1. NAME: _____ Sex: M() F()
Last _____ First _____ Middle _____ Pet name _____

2. ADDRESS: _____ PARISH: _____ Tel: _____
2b. CHECK HERE IF HOMELESS

3. D.O.B.: dd/mm/yyyy AGE: _____ yrs. OCCUPATION: _____
weeks if infant employed unemployed MARITAL STATUS: _____

4. HIGHEST LEVEL OF EDUCATION (COMPLETED): _____

5. NUMBER OF CHILDREN UNDER 15 YEARS OF AGE: _____ 6. DEPORTED? Y() N() _____
Country _____

7. NEXT OF KIN: _____ Name _____ Relation _____ Address _____

7b. MOTHER'S NAME _____

8. Sexual contacts

(Surname)	First Name	Sex (m/f)	Relation	Address	Parish
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

9. SEXUAL PRACTICE of Patient: Heterosexual Homosexual Bisexual Not known

10. Risk History	Date: / /	In the past year	Ever	11. Clinical Status	Date: / /	Y() N()	Gen. Dermatitis	Y() N()
Blood transfusion	Y() N()	Y() N()		Weight loss (>10%)	Y() N()	Y() N()	Gen. Lymphadenopathy	Y() N()
Crack/Cocaine use	Y() N()	Y() N()		Cough (>4 weeks)	Y() N()	Y() N()	Diarrhoea (>1 month)	Y() N()
Intravenous drug use	Y() N()	Y() N()		Fever (> 1 month)	Y() N()	Y() N()	Kaposi's Sarcoma	Y() N()
Current STI	Y() N()	Y() N()		PCP	Y() N()	Y() N()	Shingles	Y() N()
History of STI	Y() N()	Y() N()		Recurrent Pneumonia	Y() N()	Y() N()	Tuberculosis:	Y() N()
Genital Ulcers/sores	Y() N()	Y() N()			Y() N()	Y() N()	Candidiasis -	Y() N()
Sex with CSW	Y() N()	Y() N()					If Yes: Pulmonary /	Y() N()
CSW	Y() N()	Y() N()					Extra Pulmonary /	Y() N()
Multiple Partners	Y() N()	Y() N()					Disseminated	Y() N()
Ever in Prison	Y() N()	Y() N()						
Victim of sexual assault	Y() N()	Y() N()						
Sex with known HIV +ve person	Y() N()	Y() N()						
Transactional sex	Y() N()	Y() N()						

12. TRANSMISSION CATEGORY: Sexual Vertical IV Drug Use Haemophiliac Blood Transfusion

13. CD4 COUNT _____ CD4/CD8 ratio _____ Date of CD4 count ____/____/____ Viral _____ Date of Viral load ____/____/____

14. IS PT ON ANTIRETROVIRAL TREATMENT (ARV)? Y() N() START DATE OF ARV: ____/____/____

14b. ARV Line: 1st line 2nd line Salvage therapy Unknown

Guidelines for HIV Case-based Surveillance, Jamaica

Page 2 HIV/AIDS CONFIDENTIAL REPORTING FORM

15. CURRENT STATUS OF PT: HIV (no symptoms) () HIV (minimal symptoms) () Advanced HIV (CD4 count 201 – 350) () AIDS () AIDS-related Death ()

16. DATE OF ONSET OF SYMPTOMS: ____/____/____

17. Date diagnosed as Advanced HIV/AIDS ____/____/____ Date of Death ____/____/____ Cause of Death _____

18. **Rapid Test:** Date: ____/____/____ Result: Pos Neg Test Type: _____

Where tested? Antenatal Clinic Private Antenatal STI Clinic Blood Bank Hospital Private doctor
Other Specify _____

Confirmatory HIV Test DATE: ____/____/____ Result: Pos Neg Test Type: _____ Lab: _____

19. Blood transfusion: ____/____/____ Hospital transfused: _____

20. FOR PREGNANT WOMEN ONLY, PLEASE ENTER THE FOLLOWING INFORMATION:

a. Estimated gestational Age: _____ weeks Estimated date of delivery: ____/____/____

b. Clinic site: _____ Parish _____ Clinic MRN #:_____

c. Patient referred to: VJH clinic () UHWI () Spanish Town () CRH () Mandeville () St Ann's Bay ()

Other: _____ Date of referral appointment: ____/____/____ Pt. Not referred () Pt. Refused referral: ()

d. Post test counselling done by: _____ (Enter name) Date of Post test counselling: ____/____/____

Definitions:

- ◆ **Transfer** -- Indicate if the patient transferred in from another treatment site or private physician.
- ◆ **Date (questions 10 & 11)** ---Date on which risk history of clinical status is being updated
- ◆ **Multiple partners** --- Persons who report having sex with more than one person within a year.
- ◆ **CSW** --- Commercial sex worker; exchange of sex for cash as a main source of income
- ◆ **Sexual Assault** --- Anal or vaginal intercourse without explicit consent; incident involved intimidation or threat or fear of violence
- ◆ **Transactional Sex** --- exchange of sex for food, goods or cash (but not as main source of income)
- ◆ **PCP** --- Pneumocystis Jiroveci Pneumonia
- ◆ **CNS involvement** --- Unexplained recent onset of seizures, dementia, toxoplasmosis, CMV, Cryptococcus, encephalopathy
- ◆ **Recurrent pneumonia** --- Two or more episodes within a 1-year period
- ◆ **Gen. lymphadenopathy** --- Two or more sites with enlarged lymph nodes
- ◆ **ARV Line**--Indicate HAART line patient is currently on/or last took - 1st, 2nd, or Salvage Therapy
- ◆ **Education**--No formal schooling, Basic, Primary/All Age, Secondary/High School, Tertiary, Skills training, Other (specify)
- ◆ **Marital Status** --legally married, common law, visiting union, single

PLEASE NOTE:

- Enter all dates in the format dd/mm/yyyy.
- Reporting physicians are advised to initiate interview of index case to identify sexual contacts and encourage partner notification.
- If all sexual partners have been investigated, please tick "Do not contact trace" on front of form.
- DO NOT SEND PATIENTS to the Ministry of Health, 2-4 King Street with confidential reporting forms.**
- If you have an "update" on the clinical condition or death of a patient please complete and send new HIV Confidential Reporting Form.
- Send report under confidential cover to the MO(H) at the Parish Health Department or S.M.O. at top of page 1 of this form.

PATIENT'S DOCTOR: _____ Address/hospital: _____ Tel: ____ - ____

SOURCE OF INFORMATION: _____ REPORTED BY: _____ Date reported: ____/____/____

Confidential patient counselling, information for providers, and automated information are available from AIDS/STD Helpline
Tel: 967-3830, 967-3764, 1-888-991-4444 Hours: 10:00 a.m. – 10:00 p.m. Monday through Friday

Web Page: www.nhpjamaica.org

Revised: June 2012

Appendix 2 – HIV/AIDS Defining Conditions

Table 1: WHO clinical staging of HIV/AIDS for adults and adolescents with confirmed HIV infection.

Clinical stage 1
<ul style="list-style-type: none"> ▪ Asymptomatic ▪ Persistent generalised lymphadenopathy
Clinical stage 2
<ul style="list-style-type: none"> ▪ Moderate unexplained weight loss (<10% of presumed or measured body weight)¹⁴ ▪ Recurrent respiratory tract infections (sinusitis, tonsillitis, bronchitis, otitis media, pharyngitis) ▪ Herpes zoster ▪ Angular cheilitis ▪ Recurrent oral ulceration ▪ Papular pruritic eruptions ▪ Seborrhoeic dermatitis ▪ Fungal nail infections
Clinical stage 3
<ul style="list-style-type: none"> ▪ Unexplained¹⁵ severe weight loss (>10% of presumed or measured body weight) ▪ Unexplained chronic diarrhoea for longer than one month ▪ Unexplained persistent fever (intermittent or constant for longer than one month) ▪ Persistent oral candidiasis ▪ Oral hairy leukoplakia ▪ Pulmonary tuberculosis ▪ Lymph node TB ▪ Severe bacterial infections (for example, pneumonia, empyema, pyomyositis, bone or joint infection, meningitis, bacteraemia) ▪ Acute necrotizing ulcerative stomatitis, gingivitis or periodontitis ▪ Unexplained anaemia ($<8 \text{ g/dL}$), neutropenia ($< 0.5 \times 10^9 /L$) and/or chronic thrombocytopenia ($< 50 \times 10^9 /L^3$)
Clinical stage 4
<ul style="list-style-type: none"> ▪ HIV wasting syndrome ▪ Pneumocystis pneumonia ▪ Recurrent severe bacterial pneumonia ▪ Chronic herpes simplex infection (orolabial, genital or anorectal of more than one month's duration or visceral at any site)

¹⁴ Assessment of body weight in pregnant woman must consider expected weight gain of pregnancy.

¹⁵ Unexplained refers to those cases in which the condition is not explained by other conditions.

- Oesophageal candidiasis (or candidiasis of trachea, bronchi or lungs)
- Extrapulmonary tuberculosis
- Kaposi's sarcoma
- Cytomegalovirus infection (retinitis or infection of other organs)
- Central nervous system toxoplasmosis
- HIV encephalopathy
- Extrapulmonary cryptococcosis including meningitis
- Disseminated non-tuberculous mycobacteria infection
- Progressive multifocal leukoencephalopathy
- Chronic cryptosporidiosis
- Chronic isosporiasis
- Disseminated mycosis (extrapulmonary histoplasmosis or coccidiomycosis)
- Recurrent septicaemia (including non-typhoidal *Salmonella*)
- Lymphoma (cerebral or B cell non-Hodgkin)
- Invasive cervical carcinoma
- Atypical disseminated leishmaniasis
- Symptomatic HIV-associated nephropathy or HIV-associated cardiomyopathy

Table 2: WHO clinical staging of HIV/AIDS for children with confirmed HIV infection

Clinical Stage 1
<ul style="list-style-type: none"> ▪ Asymptomatic ▪ Persistent generalised lymphadenopathy
Clinical Stage 2
<ul style="list-style-type: none"> ▪ Unexplained persistent hepatosplenomegaly ▪ Papular pruritic eruptions ▪ Extensive wart virus infection ▪ Extensive molluscum contagiosum ▪ Fungal nail infections ▪ Recurrent oral ulcerations ▪ Unexplained persistent Parotid enlargement ▪ Lineal gingival erythema ▪ Herpes zoster ▪ Recurrent or chronic upper respiratory tract infections (otitis media, otorrhoea, sinusitis, tonsillitis)
Clinical Stage 3
<ul style="list-style-type: none"> ▪ Moderate unexplained malnutrition not adequately responding to standard therapy ▪ Unexplained persistent diarrhoea (14 days or more) ▪ Unexplained persistent fever (above 37.5 intermittent or constant, for longer than one month) ▪ Persistent oral candidiasis (after first 6-8 weeks of life) ▪ Oral hairy leukoplakia ▪ Acute necrotizing ulcerative gingivitis/periodontitis

- Lymph node tuberculosis
- Pulmonary tuberculosis
- Severe recurrent bacterial pneumonia
- Symptomatic lymphoid interstitial pneumonitis
- Chronic HIV-associated lung disease including bronchiectasis
- Unexplained anaemia (< 8g/dl), neutropenia (<0.5x10⁹/L³) or chronic thrombocytopenia (< 50x10⁹/L³)

Clinical Stage 4

- Unexplained severe wasting, stunting or severe malnutrition not responding to standard therapy
- Pneumocystis pneumonia
- Recurrent severe bacterial infections (e.g. empyema, pyomyositis, bone or joint infection, meningitis, but excluding pneumonia)
- Chronic herpes simplex infection; (orolabial or cutaneous of more than one month's duration or visceral at any site)
- Extrapulmonary tuberculosis
- Kaposi's sarcoma
- Oesophageal candidiasis (or candidiasis of trachea, bronchi or lungs)
- Central nervous system toxoplasmosis (after one month of life)
- HIV encephalopathy
- Cytomegalovirus infection retinitis or CMV infection affecting another organ, with onset at age over one month.
- Extrapulmonary cryptococcosis (including meningitis)
- Disseminated endemic mycosis (extrapulmonary histoplasmosis, coccidiomycosis, penicilliosis)
- Chronic cryptosporidiosis
- Chronic isosporiasis
- Disseminated non-tuberculous mycobacteria infection
- Cerebral or B cell non-Hodgkin lymphoma
- Progressive multifocal leukoencephalopathy
- Symptomatic HIV-associated nephropathy or HIV-associated cardiomyopathy

Appendix 3 – Class 1 Reporting Form – Individual Notification

CLASS I REPORTING FORM - INDIVIDUAL NOTIFICATION (ON SUSPICION)

Date of Report: _____ / _____ / _____ (DD/MM/YY)	NEW CASE / PREVIOUSLY REPORTED CASE (Circle One)
Diagnosis: _____	
Case Demographic Information	
Name (Including pet name): _____	Sex: _____ Age: _____ D.O.B _____ / _____ / _____ (dd/mm/yy)
Address: _____ Lot #: _____ Street: _____ (Include Landmark)	(Name) _____ Street Type: _____ (Drive, Road, Close etc)
Community: _____	Neighbouring Community/District: _____ Parish: _____
Workplace/School: _____	Occupation: _____
(H) Phone #: _____	(Wk) Phone #: _____
History of overseas travel in past 4-6 weeks? Y / N	
Specify area/country: _____	
Name of NOK/Parent: _____	Relationship to case: _____
Address of NOK/Parent: _____	Phone No.: _____
Clinical Information:	
Symptoms: _____	Hosp./Facility Name: _____
Date of onset: _____ / _____ / _____ (dd/mm/yy)	Date seen: _____ / _____ / _____ (dd/mm/yy)
Specimen Taken Y / N Type: _____	Medical Record # _____
Specimen Date: _____ / _____ / _____ (dd/mm/yy)	Case admitted to Hosp?: Y / N (Circle one)
Result (s): _____	Date of Admission: _____ / _____ / _____ (dd/mm/yy)
Ward: _____	If dead, Date of Death: _____ / _____ / _____ (dd/mm/yy)
Notifier Information	
Name of notifier: _____	Phone #: _____
Address: _____	Email: _____
Comments: _____	Received by MO(H) _____ / _____ / _____ (dd/mm/yy)
	Parish MO(H) Signature _____ / _____ / _____ (dd/mm/yy)
	Forwarded to R.S.O. _____ / _____ / _____ (dd/mm/yy)
	Forwarded to Surveillance Unit _____ / _____ / _____ (dd/mm/yy)
Ministry of Health, Surveillance Unit. September 2006	

Appendix 4 – National Antiretroviral Treatment Guidelines 2011



1. National Adult Antiretroviral Treatment Guidelines – 2011

Recommended First Line Regimen

Start antiretroviral therapy (ART) if CD4 count is equal to or less than 350 cells/ uL or patient is diagnosed with an AIDS defining illness, TB, Hepatitis B or HIV Associated Nephropathy (HIVAN).

Choose one from column A and one from column B.

Column A	Column B
Nucleoside Reverse Transcriptase Inhibitors, NRTI	Non-Nucleoside Reverse Transcriptase Inhibitors, NNRTI
Tenofovir + Emtricitabine* (one daily)	Efavirenz (one daily)
Zidovudine + Lamivudine (one twice daily)	Nevirapine (one twice daily)

* Preferred option for ARV naïve patients

Follow-up

- Do CD4 count at **three and six** months then once every **six** months.
- Do Viral Load at **six** months after commencing ARVs and then at **12-month** intervals.

Failure can only be assessed in patients who are >95% adherent to ARVs and is defined as:

- A confirmed viral load greater than 400 copies/ml in a patient on ART for more than 6 months and a previously undetectable viral load
- Falling CD4 Count of more than 30% decline in six months
- Clinical progression or development of new or recurrent Opportunistic Infections despite being compliant with medications for at least six months.

Always check adherence.

Recommended Second Line Regimen**Choose one from column A and one from column B.**

Column A	Column B
Nucleoside Reverse Transcriptase Inhibitors, NRTI	Protease Inhibitors, PI
Zidovudine + Lamivudine (one twice daily)	Lopinavir + Ritonavir (two twice daily)
Tenofovir + Emtricitabine (one daily)	Atazanavir (one daily) + Ritonavir (one daily)

2. National Paediatric Antiretroviral Treatment Guidelines – 2011**Recommended first-line regimen**

Option	Children < 10 years	Adolescents (10 – 19 yrs)
Preferred	Zidovudine + Lamivudine + Nevirapine*	Tenofovir + Emtricitabine + Efavirenz**
Alternative	Zidovudine + Lamivudine + Efavirenz**	Zidovudine + Lamivudine + Nevirapine*

Nevirapine should be used with caution in females with child bearing potential**Efavirenz can be used in children ≥ 3 years with appropriate dosages***Recommended second-line regimen**

Option	Children < 10 years	Adolescents (10 – 19 yrs)
Preferred	Didanosine + Abacavir + Lopinavir/ritonavir	Tenofovir + Emtricitabine + Zidovudine + Lopinavir/ritonavir
		Zidovudine + Lamivudine + Tenofovir + Lopinavir/ritonavir
Alternative		Tenofovir + Emtricitabine + Zidovudine + Indinavir/ritonavir
		Zidovudine + Lamivudine + Tenofovir + Indinavir/ritonavir

Recommended third-line regimen (salvage regimen) ***

Children < 10 years	Adolescents (10 – 19 yrs)
Tenofovir + Emtricitabine + Zidovudine + Darunavir/ritonavir	Didanosine + Zidovudine + Lamivudine (****) + Darunavir/ritonavir
Didanosine + Lamivudine + Zidovudine + Darunavir/ritonavir	Didanosine + Tenofovir + Emtricitabine + Darunavir/ritonavir
	Didanosine + Abacavir + Darunavir/ritonavir

*** should be guided by resistance testing if feasible

****consider continuing 3TC/FTC to reduce viral fitness

3. National Guidelines for the Prevention of Mother-to-Child Transmission of HIV – 2011

All pregnant HIV Positive women attending antenatal clinic should have a CD4 count upon presentation.

- Women with CD4 counts equal to or less than 350 cells/ uL are deemed to require antiretrovirals for their own health and should be commenced on triple therapy immediately regardless of gestational age.
- Women with CD4 counts above 350 cell/ uL should commence a triple therapy regimen from as early as 14 weeks gestation or as soon as possible when women present late in pregnancy, in labour or at delivery.

Recommended Regimens for Prevention of Mother-to-Child Transmission of HIV

CD4 COUNT	REGIMENT	DOSAGES
Equal to or less than 350 cells/uL	Zidovudine + Lamivudine (AZT + 3TC) plus Nevirapine (NVP)	AZT 300mg + 3TC 150mg, one tablet every twelve hours plus NVP 200 mg once daily for 14 days then 200 mg every 12 hours.
Equal to or above 350 cells/uL	Zidovudine + Lamivudine (AZT + 3TC) plus Lopinavir/ritonavir (LPV/r)	AZT 300mg + 3TC 150mg, one tablet every twelve hours plus LPV 200mg/r 50mg two tablets twice daily.

Antiretrovirals are to be continued during labour and delivery for all HIV positive women.

Post delivery, the following should ensue:

- If the preliminary CD4 count was equal to or less than 350 cells/ uL, continue all antiretrovirals. Ensure follow-up treatment and care.
- If the CD4 count was above 350 cells/ uL, discontinue all antiretroviral medication immediately postpartum for non-breastfeeding women. Ensure follow-up treatment and care.

For infants of all HIV Positive Mothers

- A single dose of Nevirapine 2mg/kg immediately at birth or within 24 hours.
- Zidovudine 4mg/kg po q 12hr for six weeks

Dosages for premature infants

- Nevirapine 2mg/kg single dose at birth or within 24 hours.
- EGA less than 34 weeks, begin Zidovudine 2mg/kg po q 12hr for 2 weeks then 3 mg/ kg po q 12h for 4 weeks

Appendix 5 – List of approved Treatment Sites in the Public Health Care System (2011)

South East Regional Health Authority (SERHA)

1. Comprehensive Health Centre
2. KPH
3. St. Jago Park
4. CHARES
5. Bustamante Children's' Hospital (Paeds)
6. UHWI Paediatric Clinic
7. National Chest Hospital
8. Princess Margaret Hospital
9. Maxfield Park Health Centre
10. Victoria Jubilee Hospital (Maternity)
11. Windward Road Health Centre
12. Spanish Town Hospital (Paeds)
13. Bellevue Hospital
14. Duhaney Park Health Centre

Western Regional Health Authority (WRHA)

15. Cornwall Regional Hospital
16. Montego Bay Type V
17. Savanna-la-mar Hospital

North East Regional Health Authority (NERHA)

18. St Ann's Bay Type 4
19. St. Ann's Bay Hospital
20. Port Antonia Hospital
21. Port Maria Hospital

Southern Regional Health Authority (SRHA)

22. Mandeville Type V
23. Mandeville Hospital
24. May Pen Hospital
25. Black River Health Centre