The CBC program is a child-based case management program that uses community health workers to offer home and health facility based support to HIV-infected children and their families to encourage initiation and retention in HIV care programs and services. This program package includes the SOP for the program as well as detailed instructions for how to use the corresponding tools.

SECTION 1: OVERVIEW OF CBC PROGRAM
SECTION 2: CBC STANDARD OPERATING PROCEDURE
SECTION 3: CBC MASTERCARD
SECTION 4: CBC REGISTER
SECTION 5: CBC FOLLOW UP SCHEDULE
SECTION 6: CBC FOLLOW UP SUMMARY
APPENDIX: CBC MasterCard, CBC Register; CBC Follow Up Schedule

Note that these tools were originally designed prior to the time of universal ART eligibility and should be adapted to reflect current guidelines.

SECTION 1: OVERVIEW OF CBC PROGRAM

This flowchart provides a brief overview of the program's activities and key goals. Detailed instructions can be found in the Case Management SOP and in the instructions for the corresponding forms below.

Patient Enrolled	• All HIV-infected children are enrolled into the program
Assignment of CHW	• A CHW is assigned to each patient. This CHW is responsible for all home and facility-based follow up of the patient.
Patient Follow Up at the Facility	• CHW follows the patient at the facility and provides: targeted counselling for disclosure and adherence; reminders for important HIV, CD4 and/or viral load tests; and support and information resource for caregivers
Patient Follow Up at Home	• Scheduled monthly follow up to assess adherence and provide support • Defaulter tracing and adherence counselling
Patient Discharged	• Patient is discharged when s/he reaches one of the following outcomes: lost to follow up, moved, transferred out, died or refused HIV treatment

SECTION 2: CBC STANDARD OPERATING PROCEDURE

The SOP for the CBC program is divided into xx parts. This procedure is intended for use by community health workers (CHWs) and their Site Supervisor (SS).

A. Enrollment into the CBC Program

1. When an eligible child is identified, first ask the caregiver if s/he is currently enrolled in the Child-Based Care (CBC) Program. Eligible patients include all HIV-infected children under the age of 18 years.
2. Escort the patient and their caregiver to a private area for recruitment.
3. Ask if the child has been fully disclosed. In cases where the child has not been fully disclosed, ensure language is adapted so as to prevent accidental disclosure.
4. Explain the Child Based Care (CBC) Program. Outline these key points about the program:
    a. Role of a CHW in the CBC Program including: facility (and home-based) adherence monitoring, targeted counselling and support
    b. How having CBC Program can help both the caregiver and child deal with issues surrounding HIV and understanding what HIV is, the importance of ART and adherence, the disclosure process for children and any other questions the caregiver/patient may have
2. Ask the caregiver if s/he has any additional questions. After answering these, gain consent from the caregiver to enroll the child into the program.
    a. If the patient does not agree to enrollment into the program, continue to Step 3.
    b. If the patient agrees, then:

   i. Open a **CBC MasterCard** and fill the '*Patient Guardian Details at Enrolment*' and *'Child Details at Enrolment'* sections. For patients already on ART, fill the '*ART Information*' and information about their HIV test onto the '*Labs*' section.
   ii. Fill the **Locator Form** on the back of the CBC MasterCard. This must be done on the first encounter so that the patient can be traced.
   iii. Assign the patient a CBC ID number. Record the number on the patient's personal health records (e.g. health passport book). To ensure confidentiality of the patient, the CBC ID number should not be written on the part of the record that can be easily seen by others (e.g. do not write on the outside cover of a health passport book).
3. Assist patients to enroll in appropriate HIV services if they have not already.
4. Refer the patient to any support groups or child/adolescent programs offered at the facility.
5. Thank the patient for their time and let them know where they can find a CHW at the health facility should they have any questions.
6. At the end of each day, the SS:
   a. Fills the CBC register with the information from the patient MasterCard
   b. Assigns a CHW to each new patient. These assignments are usually based upon the location of the patient's home.
   c. Informs CHWs of their new patients and gives them their corresponding MasterCards

B. <u>Patient Monitoring and Follow Up by the CHW</u>

1. Use the patient's MasterCard and/or your personal diary to keep track of the patient's scheduled HIV clinic appointments and any important notes.
   a. Take special note of any labs (i.e. viral loads and/or confirmatory HIV tests) that need to be taken or results that need to be given on the MasterCard.
   b. CHWs should keep all their patient MasterCards in a single binder.
2. Ensure you are present during all the patient's HIV clinic appointments to provide counselling, assistance with disclosure and advocating if necessary.
3. Conduct regular phone or home-based follow ups according to the schedule on the **Follow Up Visits** page of the patient's MasterCard.
   a. Additional visits may be required in situations where the patient misses a scheduled appointment or needs additional counselling and support.
   b. Use the **Home Based Visit SOP** when conducting home visits.
4. Update the patient's MasterCard and Register entry regularly.
5. To ensure proper CBC patient follow up and record keeping, the Site Supervisor should:
   a. Cross check MasterCards and register entries to ensure each patient has a MasterCard and an entry
   b. Double check completed sections in the CBC register for accuracy
   c. Plan regular meetings to get information from MasterCards to update the CBC Register
   d. Conduct scheduled and unscheduled supervision visits with CHWs
      i. Supervision visits can be done to assess CHW's performance and patient satisfaction with the program
      ii. Record home-based patient supervision visits on the patient's MasterCard

C. <u>Outcomes and Discharge from the CBC Program</u>

1. Once an outcome has been reached, update the following documents:
   a. The *'Outcome'* section of the patient's MasterCard
   b. Entry in the CBC Register
2. If the patient is still alive, offer any further assistance and/or referrals, if necessary.
3. Inform the SS of the discharge.
4. Place the patient MasterCard in the discharge binder.

Outcome	Description	Additional Information Required at time of Outcome
Lost	Patient could not be traced at home or at the health facility after 3 tracing attempts	Reason why patient was lost
Transferred Out	Patient received an official transfer letter from the HIV clinic to seek care at another health facility	Name of facility s/he is transferring to
Moved	The patient moved without receiving an official transfer from the HIV clinic	Location of place s/he is moving
Died	Death of the patient	Reason for death

Refused	Patient refused HIV treatment	Details or reasons for refusal
Other	Any other reason not listed above	Explain in details

SECTION 3: CBC MASTERCARD

A. Child/Guardian Details at Enrolment

This section should be filled completely at the time of the patient's enrollment into the CBC program. For all sections that do not apply to the patient or for which there is no response, please mark X.

Heading	Description	Response Options
Tingathe CBC Patient Number	Unique ID assigned to all patients. Should be assigned the day of registration.	
Registration Date	The date that the patient is enrolled into the CBC program	DD/MM/YY
MOH HCC Number	A unique ID assigned by the Ministry of Health for patients on pre-ART/enrolled in HIV Care Clinic (HCC)	
MOH ART Number	A unique ID assigned by the Ministry of Health for patients that have started ART	
Tingathe PMTCT Patient number	A unique ID assigned by the Tingathe Program for women enrolled in the PMTCT program.	
Permission to do home visit	Permission for the CHW to conduct home-based visits. Ask this question on the day of enrollment. If not, follow up will be done at the health facility only.	Yes = Patient agrees for home-based follow up No= patient does not agree to home-based follow up
CHW assigned	The first name and surname of the CHW assigned to the patient. CHW is responsible for all tracking and follow up.	
First home visit date	The first date of a home-visit done by the CHW. Should only be filled if patient has given permission for home-based follow up.	DD/MM/YY
Child first name	First name of the patient	
Child surname	Surname of the patient	
DOB	Date of birth of the patient. If the exact day/month cannot be remembered, write 01/06/YYYY.	DD/MM/YY
Sex	Gender of the patient	M= male; F= female
Address	Physical location of the patient's current home. Give as much detail as the space allows, should include at least the village name. Should be updated if patient moves.	
Phone	Mobile telephone number of patient. If possible, try the phone number to make sure it is correct while the patient is still with you.	10 digit number
Guardian Name	Name of the guardian/caregiver of the patient	
Relation	The relationship between the guardian and the patient (e.g. father, aunt, etc)	
Second guardian name	Name of an additional guardian/caregiver of the patient. Note: it is important for all children to have two caregivers.	
Relation	The relationship between the second guardian and the patient (e.g. father, aunt, etc)	
Followed up at home?	Mark 'Yes' if patient: 1) is able to be followed up at their home, **and** 2) patient consents to home-based follow up	Yes = patient fulfills both requirements; No = patient does not fulfill both requirements
Name of clinic	The name of the health facility that the patient is receiving HIV care and treatment services from.	
First clinic date	The date of the patient's first clinic appointment following initial enrollment into HIV services. Make a note in the comment section if this date was prior to enrollment into the CBC program	DD/MM/YY
All children at home HIV tested?	Have all the children (those aged <16 yo) in the patient's household have a known HIV status at the patient's time of enrollment in the CBC program	Y= yes all child household members have known HIV status (i.e. been tested for HIV) N= no, there are still children in the patient's household that have an unknown HIV status

Mother status	The HIV status of the patient's biological mother	Alive No ART= parent is HIV-infected but not enrolled in HIV care/started ART Alive ART = parent is alive and currently enrolled in HIV care/started ART Died = parent is dead Unk NA = parent has an unknown HIV status Neg = parent has a known negative status within the past 3 months
Father status	The HIV status of the patient's biological father	

B. Child Details at Enrolment

This section should be filled completely at the time of the patient's enrollment into the CBC program. For all sections that do not apply to the patient or for which there is no response, please mark X.

Heading	Description	Response Options
WHO Stage at Registration	The clinical stage of the patient at the time of the patient's registration into the CBC program. Must be done by a clinician/nurse using WHO Staging Guidelines.	1= Stage 1; 2= Stage 2; 3= Stage 3; 4= Stage 4
Staging Dx	Disease of condition for which a patient was assigned their WHO stage	
On ART at registration	Is the patient taking ART at the time of his/her registration into the CBC program	Y = yes the patient was taking ART at the time of enrollment N = no the patient was not taking ART at the time of enrollment
Disclosure done at registration	The patient's disclosure status (i.e. knowledge of his/her HIV status) at the time s/he was registered into the CBC program	N= no, the patient has had no disclosure Partial = the patient has been partially disclosed to Full = the patient has been fully disclosed to
TB status at registration	The tuberculosis status of the patient at the time of their registration	Never treated = Never had a TB diagnosis/treatment Last 2 years = Has had TB within the last two years Curr= currently diagnosed/taking treatment for TB
PMTCT hx Mom	The mother's PMTCT history or the ART regimen, if any, she took during pregnancy/breastfeeding. Verify that the mother was and/or currently is taking ART before filling. To be filled only if the patient was enrolled into CBC from the PMTCT Program.	
PMTCT hx Infant	Infant's history of PMTCT treatment. To be filled only if the patient was enrolled into CBC from the PMTCT Program.	None = child never received NVP NVPx6wks = patient received NVP for the full 6 weeks as recommended Other = specify other treatment or time that child received NVP

C. ART Information

This should be filled at that time of enrollment. If a child has not started ART at the time of enrollment, assist him/her to start as soon as possible.

Heading	Description	Response Options
WHO Stage at Initiation	The patient's WHO status at initiation of ART.	1= Stage 1; 2= Stage 2; 3= Stage 3; 4= Stage 4
Staging Dx	Disease or condition for which a patient is assigned a WHO stage when s/he is starting ART	
ART Start Date	The date that the patient start ART. Note: upon ART initiation, the patient's ART numbers should be written on the top of the MasterCard	DD/MM/YY

Initial Tingathe ART Regimen	The first ART regimen prescribed to the patient since their initiation into the CBC program	
Reason for Start	The reason the patient was recommended to start ART	
ART medication changed to	The ART regimen that the patient was switched to. This should be updated at any time the patient's ART regimen has been changed	
Date changed	The date that the patient switched ART regimen	DD/MM/YY
Reason for change	The reason that he ART regimen of the patient was changed	
TB meds started date	If at any time during the patient's time in the program, s/he starts tuberculosis (TB) treatment, the date of TB treatment initiation	DD/MM/YY

D. Labs

This section will be filled in the following circumstances:

- For all patients with a known HIV-infection at enrollment: fill the initial HIV test, test number, test date and age
- For all patients: record viral load tests done on the patient at any time point throughout their time in the program

Heading	Description	Response Options
Initial HIV test	The patient's first HIV test type (circle one)	Rapid = HIV rapid test; PCR = DNA PCR HIV test
Test Number	Unique ID of the initial HIV test	
Test date	Date of the initial HIV test	DD/MM/YY
Age	Age of the patient (in months if less than 24 months, in years if >24 months) when their initial HIV test was done	
Rapid HIV test from 12 mo test Date	The date of the rapid HIV test done for HIV-infected infants at age 12 months	DD/MM/YY
Result	Result of the 12 month rapid HIV test	NEG = negative test result; POS= positive test result; NA = not applicable (i.e. child is older than 12 mo at time of enrollment)
Rapid HIV test from 24 mo test date	The date of the rapid HIV test done for HIV-infected infants at age 24 months	
Result	Result of the 24 month rapid HIV test	NEG = negative test result; POS= positive test result; NA = not applicable (i.e. child is older than 24 mo at time of enrollment)
Type of test	This section should be filled for any test done during the patient's being enrolled in the CBC program	
Test date	Date of the test (from above)	DD/MM/YY
Result	Result of the test (from above)	

E. Final Outcome

All parts of this section should be filled at the time of the patient's outcome. The patient's outcome also marks their exit from the CBC Program and s/he should be officially discharged.

Heading	Description	Response Options
Final Outcome	Date and reason for final outcome	Lost; Transferred out; Moved; Died; Refused; Discharged Negative; Other
# CHW visits	Total number of CHW visits done to the patient's household during the patient's time in the program	
# Super visits	Total number of supervision visits done to the patient's household during the patient's time in the program	
All children at home tested	At the time of the outcome, do all children within the patient's household have a known HIV status	Y= Yes, all children have a known status N = No, there are still children left that do not have a known HIV status NA = Not applicable because there

		are no other children in the household
Disclosure done?	The patient's disclosure status (i.e. knowledge of his/her HIV status) at the time of the patient's outcome	N= no, the patient has had no disclosure Partial = the patient has been partially disclosed to Full = the patient has been fully disclosed to

F. Locator Form

1. Fill this form during the patient's enrollment into the CBC program.
    a. It is important to fill this at the first encounter as fully as possible to ensure follow up can be done.
    b. Try to build rapport with the patient before filling the locator form. This encourages accurate and detailed information.
    c. When possible, have a CHW who is familiar with the area the patient is living complete the map section of the form.
2. Write as much detail as the patient is comfortable giving.
3. Remember to do the following before completing the form:
    a. Repeat back the instructions you have written to get to the patient's house
    b. Try the phone number of the patient if the mobile phone is with the patient
    c. Ensure map and/or directions are written clearly

G. Goals for CBC Patients

This section is a checklist for CHWs to ensure all important tasks for the patient have been completed. This section is not mandatory and can be filled by anytime by the CHW. This checklist should be adapted based upon the needs of the patient being followed.

H. Comments

Write any comments or notes about the patient, the follow up visits conducted and any other important notes.

I. Supervision Dates

This section should be filled by the Site Supervisor (SS), Program Manager (PM) and/or monitoring and evaluation clerk (ME) every time s/he conducts a supervision visit to the patient. Indicate:

1. The date the visit was conducted (DD/MM/YY)
2. Signature initials of the person doing the supervision visit
3. Circle the type of supervision visit (SS, PM or ME)

SECTION 4: CBC REGISTER

The CBC Register is the primary source of all patient data and should be the source of information for all program reports. For that reason, it is important that it be regularly updated and accurate.

- All HIV-infected children in the facility should be enrolled in the register, regardless if they give consent to be followed by a CHW
- New patients should be entered into the register the same day as being identified
- Patient data should be updated on a regular basis by the Site Supervisor
- Sections within the register are separated based on the HIV-status and Follow up status of the patient

A. For all Enrolled Children

Heading	Description	Response Options
Tingathe Patient Registration Number	A unique ID assigned by the Tingathe Program for women enrolled in the PMTCT program.	
Reg Date	Date patient was enrolled/registered into the CBC program	
Name	First and surname of patient	
DOB	Date of birth of the patient. If the exact day/month cannot be remembered, write 01/06/YYYY.	DD/MM/YY
Male or Fem	Gender of the patient	M= male; F= female
Exp or Infected at Registration	HIV status at enrollment/registration into the program	Exposed; Infected
Place of	Village name (be as specific as possible) and patient's phone	

Residence/Phone	number	
Reason Enrolled	Reason patient is enrolled in the CBC program	VCT- Tingathe: patient tested HIV+ by a Tingathe CHW; DEF: defaulter referral; ADH: adherence referral; INFECTED other: infected child that was not tested by a Tingathe CHW and is not a DEF or ADH; PMTCT Program: patient referred from the PMTCT program (i.e. had a positive HIV test before 24 months); Other: any other reason not listed above, should be clarified in the comments section
Is this patient followed up at home?	If patient is able and has consented to home-based visits/follow ups by a CHW Note: ALL patients should have a CHW assigned, but not all of them may be followed to the home (for example if they live too far).	Yes: patient is able and has consented to home-based follow up; No: patient is not able to be followed and/or did not consent to home-based follow up
CHW assigned and first visit date	CHW assigned to the patient (assignment should be done by the SS)	
Name of clinic and registration date	Name of the clinic that the patient is going to Date that the patient FIRST came to clinic. If this is a DEF or ADH referral please enter the first date they came for clinic after the CHW starts following them.	
Other children need testing? Date tested	If children in the patient's household have an unknown HIV status at the time of the patient's registration Date of testing should be filled on the date all children have been tested/have a known HIV status	

B. For Infected Children Only

Heading	Description	Response Options
HIV test Place and Date	Place or health facility where the patient was first diagnosed with HIV and the date of the test	Date: DD/MM/YY
Was this test done by Tingathe?	Indicate if the HIV test that diagnosed the patient with HIV was done by a Tingathe CHW or not. Circle one.	Yes= the test was done by a Tingathe CHW; No= the test was not done by a Tingathe CHW
Viral Load Dates and Results	The date(s) and result(s) of any viral load tests done. Fill in one date and one result for each test.	
ART Start Date and MOH ART Number	Date of ART initiation (dd/mm/yyyy) and the Ministry of Health assigned unique ART id number	
Name of ART regimen	The name of the ART regimen that the child has started. This can be updated at anytime.	2P (standard first line, pediatric ART); Alt 1st line = alternative first line regimen; 2nd line = second line regimen; other (specify) = a non-mentioned regimen

C. For Exposed Infants Not in PMTCT Prgrm Only

This section is to be filled for infants that are not enrolled in the PMTCT program (i.e. their mother was not identified through and enrolled in the Tingathe PMTCT Program during pregnancy). See the PMTCT and EID strategy section for more details about the PMTCT program.

Heading	Description	Response Options
EID Number	Early Infant Diagnosis (EID) Number – a unique ID assigned by the Tingathe program in the EID Registration Book that tracks exposed infants	
PCR Date	Date of the infant's first DNA-PCR HIV test. Note there is space for	DD/MM/YYYY

	two separate tests.	
Result	Result of the DNA-PCR HIV test. Note there is space for two separate tests.	Circle either + (positive) or – (negative)
Date Result Given	The date the result of the DNA-PCR HIV test was communicated to the parent/guardian of the exposed infant. Note there is space for two separate tests.	DD/MM/YYYY
Final Dx Date	The date of the final HIV diagnosis of the infant – after all necessary confirmatory tests have been completed.	DD/MM/YYYY
Final Dx	The final HIV diagnosis of the infant following the completion of all necessary confirmatory testing.	Infected = infant is confirmed HIV-infected; Not-infected= infant is confirmed HIV-negative; Unknown = the child was LTFU or had an unknown HIV diagnosis at the time of discharge from the CBC program

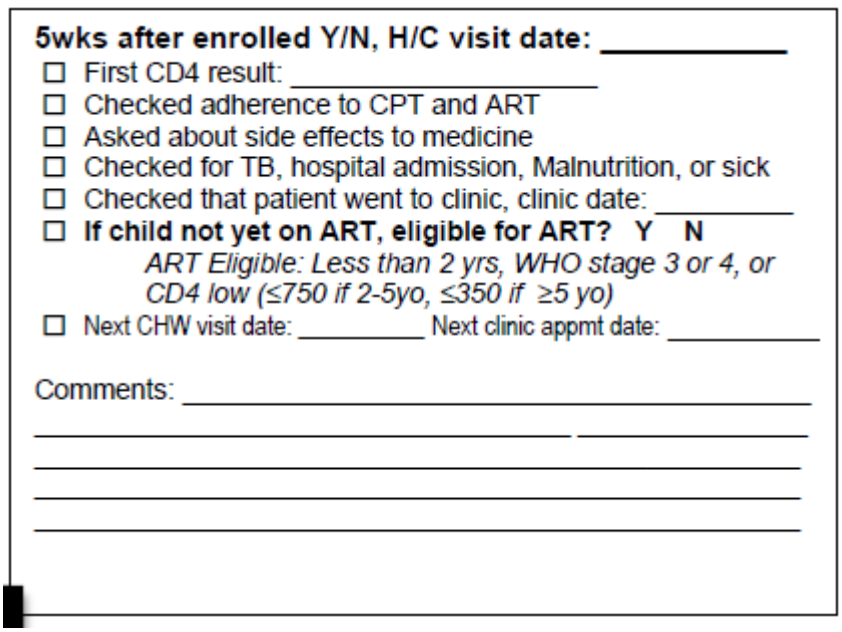
D. For All Enrolled Children

Heading	Description	Response Options
Clinic Visits and Home Visits.	Complete the first 'yr' section with the year that the child was enrolled in the CBC program. For all clinic visits that the child attended in that year, write the day(s) in the corresponding month box. Continue for all subsequent years until time of discharge. Follow the same procedure for all home visits conducted by their CHW.	
Discharge date	The date the child was discharged from the CBC program	DD/MM/YYYY
Discharge reason	The reason that the child was discharged from the program. Choose only one. Further descriptions of discharge reasons can be seen in ***Part C*** of ***SECTION 2: CBC Program Standard Operating Procedure***	Lost; Died; Transfer out/Moved; Discharged Negative; Doesn't want to be Followed; Other (explain in comment section)
# of CHW Visits	Total number of times the CHW visited the child and his/her home during their enrollment in the CBC program. Can be calculated by counting the number of home visits in the 'Clinic Visits and Home Visits' section of the register.	
Supervision Dates by Site Supervisor and Program Coordinators	Indicate the date(s) that the Site Supervisor and/or Program Coordinator did supervisions during a home visit.	DD/MM/YYYY
Comments	Any other comments or details corresponding to the enrolled child	

SECTION 5: CBC FOLLOW UP SCHEDULE

This form outlines the recommended times for patient follow up and corresponding counselling points and tasks to be done during that time. Each patient should have a follow up schedule attached to their MasterCard, so that the CHW can easily track important dates and events. Below is an example of how a CHW may use the form:

1. CHW should make a home visit 5 weeks after the patient has been enrolled. Circle either Y or N if the home visit was done.
2. Fill the date that the patient visited the health centre (H/C visit date). Make a note in the comments section if the patient did not attend their scheduled appointment.
3. While at the home, move through the checklist:
    a. Reference the patient's health passport book to see if they have received the results for their first CD4 test. If yes, write the result in the space provided and check the box. If a CD4 result was done, but no results are back yet, write a note


5wks after enrolled Y/N, H/C visit date: _____

☐ First CD4 result: _____
☐ Checked adherence to CPT and ART
☐ Asked about side effects to medicine
☐ Checked for TB, hospital admission, Malnutrition, or sick
☐ Checked that patient went to clinic, clinic date: _____
☐ **If child not yet on ART, eligible for ART? Y N**
ART Eligible: Less than 2 yrs, WHO stage 3 or 4, or CD4 low (≤750 if 2-5yo, ≤350 if ≥5 yo)
☐ Next CHW visit date: _____ Next clinic appmt date: _____

Comments: _____
_____
_____
_____
_____

in the comments and check the box. If no CD4 test was done, write N/A (not applicable) in the space provided and check the box.

b. Check the patient's adherence his/her CPT and ART by doing a pill count. Make a note of any issues. Remind the patient about the importance of adherence and check the box.
c. Ask about any side effects the patient is having due to their medication. Counsel and refer the patient as necessary, then check the box.
d. Screen the patient for tuberculosis and ask the caregiver about any other hospital admissions, malnutrition or sicknesses the child has had. Counsel and refer the patient as necessary, then check the box.
e. Check the patient's health passport book to ensure that s/he went to his/her last scheduled ART appointment. Write the date of their appointment in the space provided and check the box. If the patient did not attend the last scheduled appointment: provide adherence counselling, make a note in the comments, then check the box.
f. If the child was not on ART at the time of your last visit, reassess his/her status to see if s/he is now eligible. Circle either N or Y (no or yes), then check the box.
g. Communicate your next planned home visit with the patient and write the date in the space provided. Communicate the patient's next scheduled ART appointment with the patient and write the date in the space provided, then check the box.
h. Write any additional comments or notes in the comments section.

SECTION 6: CBC FOLLOW UP SUMMARY

This form was designed for CHWs to easily track their patient's follow up schedule.

Fill patient details at the top of the sheet. Write down the details of each follow up visit with the patient. Keep this form with the patient's CBC MasterCard for a quick reference.

Heading	Description	Response Options
Date	Date of follow up	DD/MM/YY
Home/clinic visit?	Indication of where the follow up visit was done, either at the patient's home or at the clinic/health facility	H= home-based follow up; C = health facility/clinic-based follow up
Went to clinic?	Patient's attendance at their last scheduled ART appointment	Y = yes, the patient attended; N = no the patient did not attend
Taking CPT?	Patient prescribed to be taking CPT	Y = yes the patient is prescribed to be taking CPT; N = no, the patient has not been prescribed to take CPT
Taking ART?	Patient prescribed to be taking ART	Y = yes the patient is prescribed to be taking ART; N = no, the patient has not been prescribed to take ART
Adherence good?	Patient's adherence to their medication (CPT and/or ART) good – 95% adherence or better according to a pill count	Y = yes the patient's adherence is >95%; N = no, the patient's adherence is <95%
Eligible for ART?	Patient's eligibility status for ART	Y = yes, the patient is eligible to start ART; N = no, the patient is not eligible to start ART
TB Screen done?	Indication that the CHW did the 5 question tuberculosis (TB) screening on the patient	Y = yes, screening was done; N= no, screening was not done
Problems	Any issues that the patient is having	TB = suspected active tuberculosis or currently on TB treatment; Admit = patient has been admitted to the hospital; Mal = patient is malnourished; Sick = patient is suffering from a sickness that has not been mentioned; Sx =symptoms
Comments	Any comments regarding the visit or patient's status	
CHW responsible	First and last name of CHW responsible for the follow up of the patient	
CHW visit scheduled date	The next planned home-based visit by the CHW	DD/MM/YY
Patient next clinic	The patient's next scheduled ART clinic appointment	DD/MM/YY

visit date		

An example of an entry is shown below:

Date *(dd/mm/yy)*	Home/ clinic visit? H/C	Went to clinic? Y/N	Taking CPT? Y/N	Taking ART? Y/N	Adherence good? Y/N	Eligible for ART? Y/N	TB screen done? Y/N	Problems *(circle all applicable)*
16/03/16	H	Y	Y	N	Y	N	Y	TB Admit Mal Sick Sx

Comments	CHW responsible	CHW next visit scheduled date	Patient next clinic visit date
Patient screened positive for TB – answered yes to poor weight gain and cough	John Doe	14/4/16	02/04/16

APPENDIX

CBC Patient Mastercard:

Tingathe CBC Patient Number: _____ MOH HCC #: _____
Enrolment Date: _____ MOH ART #: _____
Tingathe PMTCT Number: _____

Permission to do home visit: yes no
CHW assigned: _____
First Home Visit Date: _____
# of days from enrollment to first visit _____
New CHW (and date): _____
New CHW (and date): _____

Child/Guardian Details at Enrolment:

Child First name:	Child Surname:	DOB:	Age:	Sex: M F
Address:		Patient Phone:		
Guardian Name and Phone:		Relation:		
Second Guardian Name and Phone:		Relation:		

Followed at home? N Y	Name of Clinic:	First Clinic Date:	All children at home HIV tested? N Y NA

Mother status: Alive No ART	Alive ART	Died	Unk NA	Neg	Father status:: Alive No ART	Alive ART	Died	Unk NA	Neg

Child Details at Enrolment:

WHO stage at enrolment: **1 2 3 4**	Staging Dx:	
On ART at enrolment: N Y	Disclosure done at enrolment: NO Partial Full	TB status at enrolment: Never Treated / Last 2yrs / Curr
PMTCT hx MOM: None / ART d4T/3TC/NVP / ART TDF/3TC/EFV / Other:		
PMTCT hx Infant: None / NVPx6wks / Other:		

ART Information:

WHO Stage at Initiation: **1 2 3 4**	Staging Dx:	ART Start Date: ****write MOH ART number on top**

Initial Tingathe ART Regimen: AZT/3TC/NVP / d4T/3TC/NVP / TDF/3TC/EFV / alt 1st line / 2nd line	Reason for start: Universal / PSHD / CD4 low / WHO3/4	
ART medication changed to:	Date changed:	Reason for change: / TB meds started date:

LABS:

Initial HIV test: RAPID PCR	Test Number (EID/HTC):	Test date:	Age:
Rapid **HIV test from 12mo** test Date:	Result: NEG POS NA	Rapid **HIV test from 24mo** test Date:	Result: NEG POS NA
Type of test: CD4 VL	Test Date:	Result (if CD4- put percentage and abs count):	
Type of test: CD4 VL	Test Date:	Result (if CD4- put percentage and abs count):	
Type of test: CD4 VL	Test Date:	Result (if CD4- put percentage and abs count):	
Type of test: CD4 VL	Test Date:	Result (if CD4- put percentage and abs count):	
Type of test: CD4 VL	Test Date:	Result (if CD4- put percentage and abs count):	
Type of test: CD4 VL	Test Date:	Result (if CD4- put percentage and abs count):	

Final Outcome Date: _____ (*please tick the appropriate box)*

☐ Lost: Details: _____
☐ Transferred Out ☐ Moved Location: _____
☐ Patient Died date: _____ Cause: _____
☐ Refused: Details: _____
☐ Discharged Negative ☐ Other (explain in comments)

# CHW visits:	# Super visits:	All children at home tested: N Y NA	Disclosure done: NO Partial Full

Name of Person Filling Form: _____ Date Locator Form Filled: ___/___/_____

MOTHER'S NAME:_____
VILLAGE NAME: _____
MOBILE PHONE NUMBER: _____
BEST DAY(S) FOR HOME VISITS: _____
CONSENT:
CAN WE CONDUCT FOLLOW UPS AT YOUR HOME?: YES NO
CAN WE CONDUCT FOLLOW UPS BY CALLING YOUR MOBILE PHONE?: YES NO
SPECIAL INSTRUCTIONS FOR CONDUCTING FOLLOW UPS:
_____
_____
_____

WRITTEN DIRECTIONS TO AND/OR LANDMARKS AROUND YOUR HOME_____
_____
_____
_____

ONLY ASK THE QUESTIONS BELOW IF PATIENT IS COMFORTABLE ANSWERING:
CHILD'S SCHOOL NAME: _____
NEIGHBOR'S NAME: _____
NAME OF YOUR CHURCH: _____
ALTERNATIVE CONTACT/CAREGIVER FOR PATIENT:
NAME: _____ RELATION: _____
PHONE: _____ VILLAGE NAME: _____

*****PLEASE DRAW A MAP TO THE HOUSE OR DESCRIBE HOW TO GET TO THE HOUSE (***IF PATIENT MOVES, PLEASE FILL OUT A NEW LOCATOR FORM AND ATTACH TO PATIENT MASTERCARD***)**

Goals for CBC patients:

- ☐ First clinic visit date: _____
- ☐ WHO staging done: 1 2 3 4, staging Dx: _____
- ☐ PMTCT history obtained and recorded in child details box
- ☐ HIV test dates and results recorded in child details box
- ☐ TB status and disclosure status recorded in child box
- ☐ **Two guardians trained and know why child is on CPT/ART**
- ☐ Caregivers understand **what resistance is**
- ☐ Family members tested and in care
- ☐ **If child already on or started ART:**
  ART start date, MOH #, ART regimen, and ART reason recorded in ART box
- ☐ **If child not yet on ART, eligible for ART? N Y**
  ART Eligible: Less than 2 yrs, WHO stage 3 or 4, or
  CD4 low (≤750 if 2-5yo, ≤350 if ≥5 yo)
- ☐ **If eligible, patient started on ART: ART start date** _____
- ☐ First CD4 obtained, test date: _____ result: _____
- ☐ Asked about side effects to medicine, and if need to change ART, change made
- ☐ Tb screening questions asked
- ☐ Disclosure process started

Comments:
_____
_____
_____
_____
_____
_____
_____

Supervision Dates:

Date: _____ Sig: _____ SS Co PM ME Date: _____ Sig: _____ SS Co PM ME
Date: _____ Sig: _____ SS Co PM ME Date: _____ Sig: _____ SS Co PM ME
Date: _____ Sig: _____ SS Co PM ME Date: _____ Sig: _____ SS Co PM ME

The CBC Register is a tool to keep track of all children enrolled in the program in once place for ease of monitoring by the Site Supervisor and for data collection by the program's monitoring and evaluation team.

The register was originally printed on A3 paper and bound into a register with multiple entries per page. The version below shows only the register headings and a space/response options for one entry.

FOR ALL ENROLLED CHILDREN																												
	Tingathe Patient Registration #	Reg Date	Name	DOB	Male or Fem	Exp or Infected at Registration	Place of Residence/ Phone:	Reason Enrolled								Is this Patient followed up at home?	CHW Assigned and First Visit date	Name of Clinic and Clinic Registration Date	Other Children need testing? Date tested by										
								VCT-Tingathe	DEF	ADH	INFECTED other	EXPOSED other	PMTCT Program	Other															
1			First Name		Male	Exposed										YES	CHW:	Clinic	YES		NO		NA						
			Last Name		Fem	Infected										NO	Date:	Reg Date	Date										

FOR INFECTED CHILDREN ONLY								FOR EXPOSED INFANTS NOT in PMTCT PGM ONLY								
HIV test Place and Date:	Was this test done by Tingathe ?	Viral Loadss. Dates and results			ART Start Date and MOH ART Number	Name of ART regimen		EID Number	PCR Date	Result		Date Result Given	Final Dx Date	Final Dx		
Place	YES	Date	Date	Date	Date	2P	Alt 1st line		1	+	-			Infect	Not Infect	Unk
Date	NO	Result	Result	Result	ART Number	2nd line	Other (specify)		2	+	_					

FOR ALL ENROLLED CHILDREN

Clinic Visits and Home visits																																				
CLINIC VISITS	YR	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	YR	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	YR	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC
HOME VISITS	YR	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	YR	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	YR	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC

Discharge Date	Discharge Reason						# of CHW visits	Supervision Dates by site supervisor and pgm coordinator	Comments:
	LOST	Died	Tranfer out /Moved	Discharged negative	Doesn't want to be followed	Other, explain in COMMENT		supervisor: coordinator:	

Tingathe CBC Patient Mastercard-**Follow up visits** Tingathe Patient ID#: _____ Pt Name: _____ DOB: _____

1st wk after enrolled Y/N, H/C visit date: _____

- ☐ First clinic visit date: _____
- ☐ WHO staging done: 1 2 3 4
- ☐ WHO staging Dx: _____
- ☐ PMTCT history obtained and recorded in child details box
- ☐ HIV test dates and results recorded in child details box
- ☐ TB status and disclosure status recorded in child box
- ☐ Explained importance of CPT
- ☐ All children at home tested? N Y
- ☐ **If child already on ART:**
  ART start date, MOH #, ART regimen, and ART reason recorded in ART box
- ☐ **If child not yet on ART, eligible for ART? Y N**
  ART Eligible: Less than 2 yrs, WHO stage 3 or 4, or CD4 low (≤750 if 2-5yo, ≤350 if ≥5 yo)
- ☐ First CD4 obtained, test date: _____
- ☐ Next CHW visit date: _____ Next clinic appmt date: _____

5wks after enrolled Y/N, H/C visit date: _____

- ☐ First CD4 result: _____
- ☐ Checked adherence to CPT and ART
- ☐ Asked about side effects to medicine
- ☐ Checked for TB, hospital admission, Malnutrition, or sick
- ☐ Checked that patient went to clinic, clinic date: _____
- ☐ **If child not yet on ART, eligible for ART? Y N**
  ART Eligible: Less than 2 yrs, WHO stage 3 or 4, or CD4 low (≤750 if 2-5yo, ≤350 if ≥5 yo)
- ☐ Next CHW visit date: _____ Next clinic appmt date: _____

Comments: _____

Already on ART or needs ART- follow up

2mo after enrolled Y/N, H/C visit date: _____

- ☐ Pre-ART counseling done, two guardians identified
- ☐ Checked that patient started ART:
  ART start date: _____ MOH ART #: _____
  ART Regimen: _____Reason for ART: _____
  MAKE SURE you record this data in ART box
- ☐ Checked adherence to CPT and ART
- ☐ Asked about side effects to medicine
- ☐ Checked for TB, hospital admission, Malnutrition, or sick
- ☐ Checked that patient went to clinic, clinic date: _____
- ☐ All children at home tested? N Y
- ☐ Are both parents enrolled in care? N Y
- ☐ Nutritional counseling given
- ☐ Next CHW visit date: _____ Next clinic appmt date: _____

Comments: _____

3mo after enrolled Y/N, H/C visit date: _____

- ☐ Checked adherence to CPT and ART
- ☐ Asked about side effects to medicine
- ☐ Checked for TB, hospital admission, Malnutrition, or sick
- ☐ Checked that patient went to clinic, clinic date: _____
- ☐ All children at home tested? N Y
- ☐ Are both parents enrolled in care? N Y
- ☐ Disclosure done? N Partial Full
- ☐ Next CHW visit date: _____ Next clinic appmt date: _____

Comments: _____

4mo after enrolled Y/N, H/C visit date: _____

- ☐ Checked adherence to CPT and ART
- ☐ Asked about side effects to medicine
- ☐ Checked for TB, hospital admission, Malnutrition, or sick
- ☐ Checked that patient went to clinic, clinic date: _____
- ☐ Next CHW visit date: _____ Next clinic appmt date: _____

Comments: _____

Child does NOT need ART (pre-ART)- follow up

2mo after enrolled Y/N, H/C visit date: _____

- ☐ Checked adherence to CPT
- ☐ Made sure caregiver understands importance of CPT
- ☐ Made sure caregiver understands what is CD4
- ☐ Checked for TB, hospital admission, Malnutrition, or sick
- ☐ Checked that patient went to clinic, clinic date: _____
- ☐ All children at home tested? N Y
- ☐ Are both parents enrolled in care? N Y
- ☐ Nutritional counseling given
- ☐ Next CHW visit date: _____ Next clinic appmt date: _____

Comments: _____

3mo after enrolled Y/N, H/C visit date: _____

- ☐ Checked adherence to CPT
- ☐ Made sure caregiver understands importance of CPT
- ☐ Made sure caregiver understands what is CD4
- ☐ Checked for TB, hospital admission, Malnutrition, or sick
- ☐ Checked that patient went to clinic, clinic date: _____
- ☐ All children at home tested? N Y
- ☐ Are both parents enrolled in care? N Y
- ☐ Disclosure done? N Partial Full
- ☐ Next CHW visit date: _____ Next clinic appmt date: _____

Comments: _____

4mo after enrolled Y/N, H/C visit date: _____ ☐

Checked adherence to CPT

- ☐ Checked for TB, hospital admission, Malnutrition, or sick
- ☐ Checked that patient went to clinic, clinic date: _____
- ☐ Next CHW visit date: _____ Next clinic appmt date: _____

Comments: _____

Anytime Child needs ART go to ART follow up box

Tingathe CBC Patient Mastercard-**Follow up visits** Tingathe Patient ID#: _____ Pt Name: _____ DOB: _____

Already on ART or needs ART *(continued)*

5mo after enrolled Y/N, H/C visit date: _____
- ☐ Checked adherence to CPT and ART
- ☐ Asked about side effects to medicine
- ☐ Checked for TB, hospital admission, Malnutrition, or sick
- ☐ Checked that patient went to clinic, clinic date: _____
- ☐ All children at home tested? N Y
- ☐ Are both parents enrolled in care? N Y
- ☐ Disclosure done? N Partial Full
- ☐ Next CHW visit date: _____ Next clinic appmt date: _____

Comments:_____

6mo after enrolled Y/N, H/C visit date: _____
- ☐ Checked adherence to CPT and ART
- ☐ Asked about side effects to medicine
- ☐ Checked for TB, hospital admission, Malnutrition, or sick
- ☐ Checked that patient went to clinic, clinic date: _____
- ☐ Next CHW visit date: _____ Next clinic appmt date: _____

Comments:_____

7mo after enrolled Y/N, H/C visit date: _____
- ☐ Checked adherence to CPT and ART
- ☐ Asked about side effects to medicine
- ☐ Checked for TB, hospital admission, Malnutrition, or sick
- ☐ Checked that patient went to clinic, clinic date: _____
- ☐ All children at home tested? N Y
- ☐ Are both parents enrolled in care? N Y
- ☐ Disclosure done? N Partial Full
- ☐ If good adherence consider every 3month home visit **must get approval from site sup and clinician**
- ☐ Next CHW visit date: _____ Next clinic appmt date: _____

Comments:_____

Child does NOT need ART (pre-ART) *(continued)*

5mo after enrolled Y/N, H/C visit date: _____
- ☐ Checked adherence to CPT
- ☐ Checked for TB, hospital admission, Malnutrition, or sick
- ☐ Checked that patient went to clinic, clinic date: _____
- ☐ Disclosure done? N Partial Full
- ☐ Next CHW visit date: _____ Next clinic appmt date: _____

Comments: _____

6mo after enrolled Y/N, H/C visit date: _____
- ☐ Checked adherence to CPT
- ☐ Checked for TB, hospital admission, Malnutrition, or sick
- ☐ Checked that patient went to clinic, clinic date: _____
- ☐ Remind patient to get CD4 at 6month clinic appointment
- ☐ Next CHW visit date: _____ Next clinic appmt date: _____

Comments: _____

7mo after enrolled Y/N, H/C visit date: _____
- ☐ CD4 date:_____ CD4 result: _____
- ☐ **Is child eligible for ART? Y N**
  Less than 2 yrs, WHO stage 3 or 4, or
  CD4 low (≤750 if 2-5yo, ≤350 if ≥5 yo)
- ☐ Checked for TB, hospital admission, Malnutrition, or sick
- ☐ All children at home tested? N Y
- ☐ Are both parents enrolled in care? N Y
- ☐ Disclosure done? N Partial Full
- ☐ If good adherence and **does NOT need ART** consider every 3month home visit **must get approval from site sup and clinician**
- ☐ Next CHW visit date: _____ Next clinic appmt date: _____

Comments: _____

Anytime Child needs ART go to ART follow up box

Additional Visits During First 7months after enrolment:

Visit Date	Comments:

Make sure pre-ART patients get CD4 every 6months and get their WHO stage re-assessed if they appear sick or get malnourished. Make sure ART is started as soon as they are eligible.

CBC Follow up Visits Summary Tingathe Patient ID#: _____ Pt Name: _____ DOB: _____ CHW: _____

Instructions: Fill patient details at the top of the sheet. Write down the details of each follow up visit with the patient. Keep this form with the patient's CBC MasterCard for a quick reference.

Date *(dd/mm/yy)*	Home/ clinic visit? H/C	Went to clinic? Y/N	Taking CPT? Y/N	Taking ART? Y/N	Adherence good? Y/N	Eligible for ART? Y/N	TB screen done? Y/N	Problems *(circle all applicable)*	Comments	CHW responsible	CHW next visit scheduled date	Patient next clinic visit date
								TB Admit Mal Sick Sx				
								TB Admit Mal Sick Sx				
								TB Admit Mal Sick Sx				
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