Practical Strategy 1:

ACTIVE CASE FINDING IN HEALTH FACILITIES

Photo by: Robbie Flick

Active case finding (ACF) is a set of activities that can be implemented to facilitate identification of HIV-infected patients with an ***explicit focus on routine HIV testing in health facilities or provider-initiated testing and counselling (PITC)***. As countries work to fulfill the first of the UNAIDS' ambitious 90-90-90 goals (90% of all people living with HIV knowing their HIV status; 90% of people with diagnosed HIV on antiretroviral treatment (ART); 90% of people on ART with viral suppression)[1], focusing efforts on activities to strategically increase and facilitate HIV testing within health facilities has become critical.

[1] UNAIDS. 90-90-90 An ambitious treatment target to help end the AIDS epidemic. Joint United Nations Programme on HIV/AIDS (UNAIDS); 2014.

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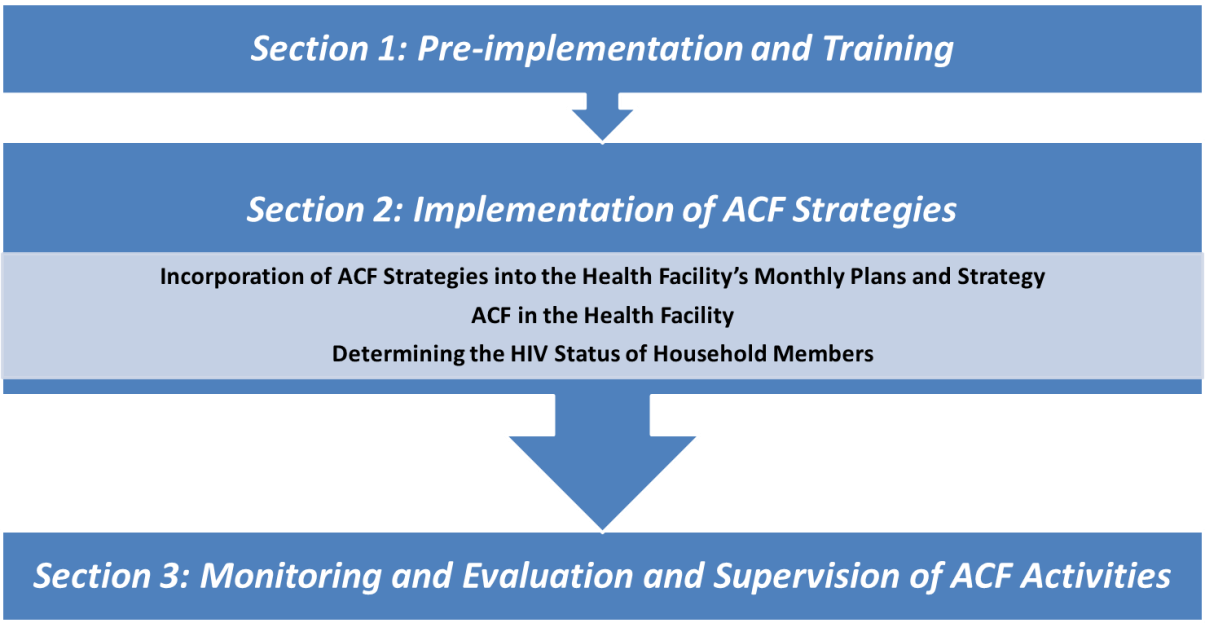
SOP SUMMARY



TOOLS AND FORMS

Active Case Finding Site Assessment Tool: The tool is designed to be used during the pre-implementation workshop to help health facilities understand their current ACF activities, their gaps in providing those services, and how featured tools can help to supplement their existing strategy.

Active Case Finding Workshop Package: This package is designed to teach health care workers to implement active case finding strategies into their facility with a focus on provider-initiated testing and counselling (PITC) using the PITC Register and corresponding PITC Monthly Report. The package consists of an agenda, a presentation, a brief SOP on how to implement PITC, a handout of exercises to practice filling the register and monthly report, the PITC Plan of Action (POA) tool (see **Case Study 1**) and an exam.

Health Talk Procedure and Topics: Health talks are 20 to 30 minute long patient education sessions, usually presented by a CHW or HSA while a group of patients is waiting to see a clinician or nurse. A health talk can be a great opportunity to educate patients on the benefits of HIV testing, discuss the HIV services available at the facility and dispel any common myths and misconceptions about HIV testing. An example health talk and tips can be seen in the **PITC Health Talk Case Study**.

PITC Register and Monthly Report: These tools were designed to be used in in-patient wards which do not keep a record of every patient's HIV status, although they can be adapted for use in any department. There are two versions of the PITC Register, one for **adults** and one for **pediatrics**. Used with the PITC Monthly Report, a reporting tool for collecting data on key indicators, a program can easily track testing activities within their facility. For an example of how this is used in our program, refer to the **Active Case Finding Case Study 6**.

Client Tracing Tools: These tools are designed to support the CHW organize and report on client tracing efforts, regardless on the reason for tracing. In the case of ACF strategies, CHWs can use them to manage patients that requested home-based testing for untested household members. The Client Tracing Form provides a document to record the client's locator information, tracing attempts and final tracing outcome. The CHW Client Tracing List helps the CHW manage and track all his/her client's that require tracing and their current tracing status.

HIV Diagnostic Assistant (HDA) Training: This curriculum is designed to provide HDAs the knowledge to implement and support key HIV services, including provider-initiated testing and counselling (PITC) and linkage to HIV care and treatment.

Community Health Worker Training Curriculum: This curriculum is designed to provide CHWs the knowledge needed to perform any activity in this toolkit. It is recommended that all CHWs receive the full training. If it is not possible, it is recommended to specifically look at: **Unit 2:** Overview of HIV Prevention, **Unit 3:** HIV Signs and Symptoms, and **Unit 4:** HIV Diagnosis.

FEATURED CASE STUDIES

Case Study 1: PITC Plan of Action Tool Example
Case Study 2: Example of Schedule/Rota of CHW ACF Responsibilities
Case Study 3: PITC Health Talk
Case Study 4: PITC in an In-Patient Ward Setting – The Sticker Method
Case Study 5: Household HTC
Case Study 6: In-Patient PITC and Reporting

ACRONYMS

ACF	Active Case Finding
ART	Antiretroviral Treatment
CBO	Community-Based Organization
FBO	Faith-Based Organization
HCW	Health Care Worker
HTC	HIV Testing and Counselling
M&E	Monitoring and Evaluation
MOH	Ministry of Health
PITC	Provider-Initiated Testing and Counselling
POA	Plan of Action (as referred to PITC POA Tool)
SOC	Standard of Care
SOP	Standard Operating Procedure
STI	Sexually Transmitted Infections Clinic

PURPOSE:

Active case finding (ACF) is a set of activities that can be implemented to facilitate identification of HIV-infected patients with an explicit focus on routine HIV testing in health facilities or provider-initiated testing and counselling (PITC). As countries work to fulfill the first of the UNAIDS' ambitious 90-90-90 goals (90% of all people living with HIV knowing their HIV status; 90% of people with diagnosed HIV on antiretroviral treatment (ART); 90% of people on ART with viral suppression)[i], focusing efforts on activities to strategically increase and facilitate HIV testing within health facilities has become critical. This procedure describes how active case finding activities including screening and PITC activities can be implemented. The procedure is separated into three sections:

Section 1: Pre-implementation and Training
Section 2: Implementation of ACF Activities
Section 3: Supervision, Monitoring and Evaluation

SCOPE:

Active case finding activities can be initiated in any department at the health facility and target all clients, including children and adults.

Although this SOP's scope is on facility-based activities, when appropriate, active case finding can also take place outside the health facility at HIV support groups, community gatherings and/or patients' homes.

RESPONSIBILITIES:

Section 1 of the SOP is intended for use by the trainer/organizer of ACF activities.

Sections 2 and 3 are intended for use by all health facility personnel. Referrals for case finding can be taken from any health facility employee, referring CBO, FBO and/or HIV support group.

PROCEDURE:

Section 1: Pre-implementation and Training

1. Inform Ministry of Health officials and other relevant district and facility personnel that your facility is planning to scale up active case finding activities. Special communication should be made to the logistics department at the Department of HIV/AIDS to facilitate resource mobilization (i.e. test kits, spirits, cotton wool, etc).
2. Organize an *Active Case Finding (ACF) planning workshop* with the health facility and invite all relevant personnel (in-charge, department heads, etc). This workshop should take place at the facility and will take approximately two hours. During the workshop, the following activities should take place and key points should be decided upon:
    a. Define active case finding and describe its importance
    b. Outline HIV testing and case identification goals for the facility. Goals could include:
        i. Coverage of assessing HIV statuses in a certain department (i.e. number of patients with an ascertained status/total number of inpatient enrollments)
        ii. Number of HIV tests done overall at site or by department (e.g. increase monthly testing rate by 100 tests/month)
        iii. Number of HIV tests done by each HTC provider
    c. Fill the **Active Case Finding Site Assessment Tool**. Use this tool to help the facility describe:
        i. Existing ACF activities already taking place

ii. Gaps and challenges in current ACF activities
iii. How to use CHWs and other facility resources to scale up ACF activities

d. Decide which ACF activities the facility would like to implement and in which departments. In cases of limited resources, ACF activities should be focused in departments which have patients at highest risk of HIV including: tuberculosis, STI, inpatient wards, nutritional programs, ART clinic, etc as well as those departments at highest risk of poor outcome if HIV diagnoses are missed, e.g. ANC and maternity.
e. Discuss desired key indicators to measure and identify monitoring and evaluation plan.
f. Nominate a supervisor or focal person to oversee ACF activities
g. Decide on training dates and persons to be invited

3. Organize the *ACF Workshop* and invite appropriate staff including HDAs, CHWs and MOH representatives from HTC and ART departments.
   a. It is recommended that CHWs are trained using the full **Tingathe CHW Training** and HDAs trained using the **Tingathe HDA Training** before the start of the ACF Training.
   b. Using the **Active Case Finding Workshop Package**, accomplish the following objectives:
      i. Discuss what ACF is, the facility's goals for ACF and the strategies which will be scaled up to reach those goals. Use the completed Active Case Finding Assessment Tool to help guide discussion.
      ii. Review units 2 through 4 in the **Tingathe CHW Training**
      iii. Build ACF strategies into existing departmental procedures and make them a standard of care (e.g. all patients should be screened/tested before discharging) using the **PITC Plan of Action Tool** (reference Case Study 1).
      iv. Introduce, practice and test practical knowledge of M&E tools
      v. Train supervisor/focal person using Section 3 of this SOP
      vi. Discuss how HIV-infected patients identified through ACF strategies will be linked to HIV services. It is recommended that ACF activities happen in combination with the Linkage to Care, Case Management and Defaulter Tracing strategies.
      vii. When the training is finished, the following products should be completed:
         1. Clear plan of action to implement ACF strategies and knowledge to use corresponding tools. This could include flow charts, departmental SOPs, rosters/rotas, registers, etc.
         2. List of roles and responsibilities for each person, including a responsible focal representative from both the MOH staff and the CHW team.
         3. Clear plan for supervision, monitoring and evaluation.

Section 2: Implementation of ACF Strategies

Incorporation of ACF Strategies into the Health Facility's Monthly Plans and Strategy

1. A schedule which assigns CHWs to perform ACF at various locations within the health facility daily (reference Case Study 2).
   a. ACF should be implemented in all departments within the health facility.
   b. If possible, ACF should be incorporated into the standard of care (SOC) package provided in each department.
2. To maximize the yield of ACF:
   a. Seek out newly admitted patients in all departments
   b. Target the busiest times of the day (usually morning)

   c. Schedule **Health Talks** in different departments to discuss with clients the importance of HIV testing early and often (reference Case Study 3). Consider having multiple health talks throughout the day to ensure patients do not miss important information.
   d. Work with health facility staff and mentors to ensure PITC is implemented in all departments (reference Case Study 4).
   e. Ensure the facility has identified a strategy to ensure ACF activities continue to take place during nights, weekends and holidays
3. Link with community HIV support groups to be sure all family members of patients living with HIV know their HIV status

ACF in the Health Facility

This strategy can be applied to any department in a health facility. For departments that do not regularly track HIV testing, the PITC Register Tools and corresponding PITC Monthly Report can be used (reference Case Study 6)**.**

1. When doing active case finding, CHWs first check the HIV status of all patients using official health facility records (i.e. patient chart, health passport book, etc). If a health facility record is not available, the CHW should assume the patient has an unknown HIV status.
   a. If the patient is HIV-infected or exposed: continue to Step 3.
   b. If the patient has an unknown HIV status:
      i Discuss the importance of HIV testing
      ii Use the opt-out HIV testing technique to offer him/her an HIV test. If the patient:
         1. Accepts to be tested, escort him/her to receive an HIV test. After the patient has received the test results, continue to Step 3.
         2. Opts out, emphasize the importance of HIV testing. Continue to Step 3.
   c. If a recently negative HIV test:
      If the patient is very ill or has signs and symptoms of HIV-infection consider offering a retest even if an HIV test was recently done. If not, use the *National HTC Guidelines* to determine if the patient is at high or low risk for HIV infection and if a retest is recommended.
      i If a retest is recommended, follow the steps above for patients with an 'unknown HIV status.'
      ii If a retest is not recommended, continue to Step 3.
2. After the HIV status of the patient has been assessed, write the HIV status on the appropriate department and/or patient records.
3. Confirm that the patient has accessed all HIV services available to them according to their HIV status. If a patient has not received a service, refer him/her appropriately.
   a. If HIV-infected and enrolled in HIV care:
      i Confirm their enrollment in HIV services and adherence to their treatment plan
      ii Discuss HIV prevention strategies
   b. If HIV-exposed infant:
      i Confirm the mother-infant pair is enrolled in HIV care
      ii Check that the mother has been adherent to her ART and clinic appointments.
      iii Check the child's passport for DNA PCR results, rapid test results (depending on age), clinic visits, and Bactrim prophylaxis
      iv Reinforce counseling on infant feeding, good adherence for the mother's ART, and good adherence to appointments
   c. If HIV-infected and *not* enrolled in HIV care:

i Discuss HIV care programs available and their benefits
ii Ask about what barriers they are facing that are preventing them from starting HIV treatment
iii Escort/refer the patient to access HIV treatment services

d. If HIV-uninfected:
i Discuss HIV prevention strategies
ii Reinforce the importance and time of retesting according to their risk level

4. Ask the patient if they have any additional questions.
5. Thank the patient for their time and continue with their normal appointment.

Determining the HIV Status of Household Members

The following household HIV testing steps can be implemented for all patients or just HIV-infected patients based on the resources available at your health facility.

1. Ask the patient the following questions to determine the HIV status of others in their household:
   a. Who do you live with?
   b. Do you have a partner? Do you have more than one partner?
   c. Has your partner(s) been tested?
   d. Do you have children?
   e. Have ALL of your children been tested?
   f. Are there any other members of your household who have not been tested?
2. If there are others in their household members who have **not** been tested for HIV, ask them if those individuals would prefer to be tested at their homes or at the health facility.
   a. If testing is preferred at the health center, explain the following:
      i when and where they can go to be tested during their next visit
      ii other HIV services offered including treatment and assistance with disclosure
   b. If testing is preferred at their home and home testing is an option:
      i Fill a **Locator Form**
      ii Determine the best time/date for a visit
      iii Reference the **Home-Based Visit SOP** for further details (reference Case Study 5)
      iv Note: tools can be found in the Client Tracing section

Section 3: Monitoring and Evaluation and Supervision of ACF Activities

1. Supervise departments regularly to ensure:
   a. ACF strategies are being implemented as discussed in the training
   b. HIV status is properly documented for every patient in department registers/records
   c. PITC POAs are being followed
2. Collect testing and ACF data regularly to evaluate PITC coverage and yield of testing.
   a. This can be done using the **PITC Registers for Inpatient Wards** and the **PITC Monthly Report**.
   b. Examples of basic indicators may include:
      i. Percentage of patients attending the department who are offered an HIV test
      ii. Number of HIV tests done
      iii. Number of HIV-infected patients identified (both through HIV testing and identification of known positives, not enrolled in HIV care)
      iv. Number of family members tested per index patient
3. Compare ACF data to:
   a. Facility HTC records to ensure accurate records and quality testing

b. Linkage to care data to ensure HIV-infected patients identified are enrolled in HIV services

4. Hold regular meetings for each department's focal person to discuss best practices and edit PITC POAs and ACF strategies accordingly.
5. Share data and best practices regularly between departments and facilities.
6. Liaise regularly with HIV support groups and other HIV organizations for continued dialogue of testing household members of people living with HIV

[i] UNAIDS. 90-90-90 An ambitious treatment target to help end the AIDS epidemic. Joint United Nations Programme on HIV/AIDS (UNAIDS); 2014.

Case Study 1: PITC Plan of Action (POA) Tool

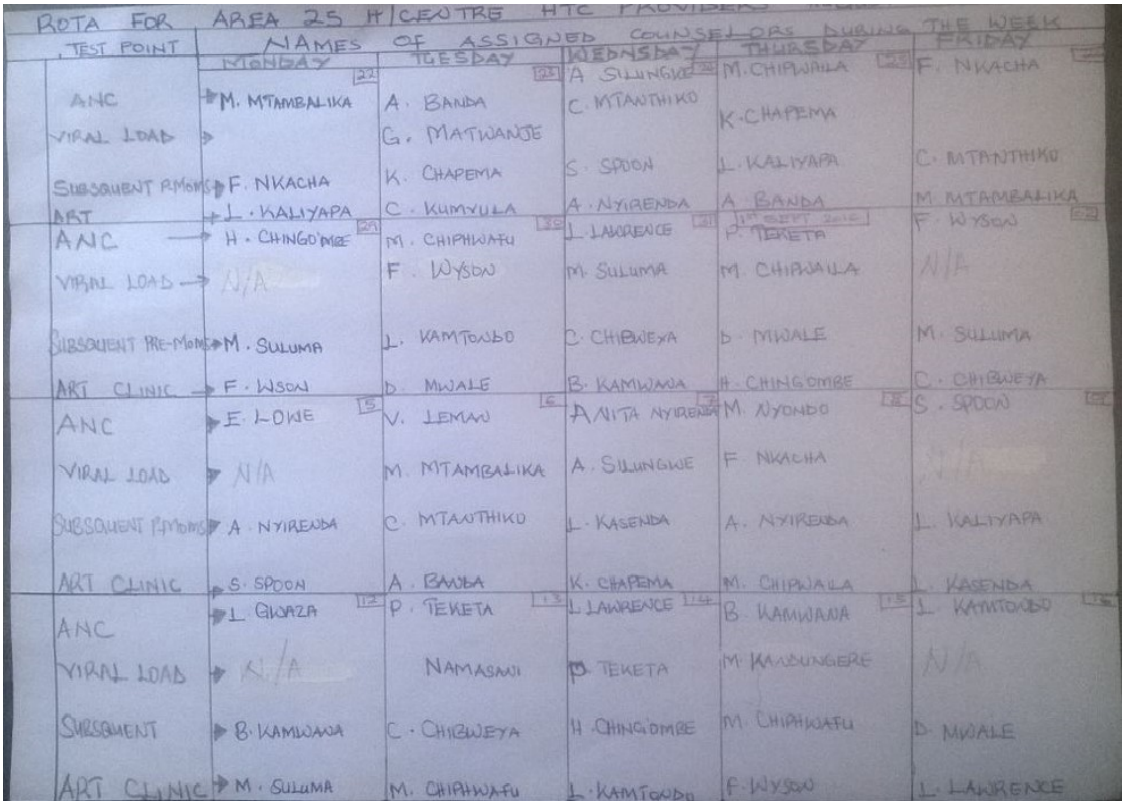
This tool is designed to be used during ACF training to assist departments to incorporate PITC activities into their standard of care procedures.

The tool guides participants to work through the following ten activities:

1. On which department do you want to focus this PITC POA?
2. Describe the current status of PITC in your department.
3. Choose a leader/focal person to be responsible for your plan of action.
4. Choose a responsible contact person from your department.
5. Develop a testing roster.
6. Make a standard operating procedure and/or flowchart to describe patient flow.
7. List the tools needed to accomplish your plan of action.
8. Develop goals and reporting methods.
9. List other ideas that you may be able to implement at a later date.
10. Make a reporting plan to track your progress.

Case Study 2: Example of Schedule/Rota of CHW ACF Responsibilities

This example of a testing rota outlines which HTC provider is responsible for the various test points around the health facility (ANC, viral load, subsequent testing rooms and ART clinic) on different days of the week. A rota such as this helps hold people accountable and ensure all key testing areas are covered.



TEST POINT	MONDAY	TUESDAY	WEDNSDAY	THURSDAY	FRIDAY
ANC	M. MTAMBALIKA	A. BANDA	A SULUNGWE	M. CHIPWAILA	F. NKACHA
VIRAL LOAD		G. MATWANJE	C. MTANTHIKO	K. CHAPEMA	
SUBSEQUENT PMTCT	F. NKACHA	K. CHAPEMA	S. SPOON	L. KALIYAPA	C. MTANTHIKO
ART	L. KALIYAPA	C. KUMYULA	A. NYIRENDA	A BANDA	M. MTAMBALIKA
ANC	H. CHINGO'MBE	M. CHIPHWAFU	L. LAWRENCE	P. TEKETA	F. WYSON
VIRAL LOAD	N/A	F. WYSON	M. SULUMA	M. CHIPWAILA	N/A
SUBSEQUENT PRE-MONC	M. SULUMA	L. KAMTONDO	C. CHIBWEYA	D. MWALE	M. SULUMA
ART CLINIC	F. WSON	D. MWALE	B. KAMWANA	H. CHINGOMBE	C. CHIBWEYA
ANC	E. LOWE	V. LEMAN	ANITA NYIRENDA	M. NYONDO	S. SPOON
VIRAL LOAD	N/A	M. MTAMBALIKA	A. SULUNGWE	F. NKACHA	N/A
SUBSEQUENT PMTCT	A. NYIRENDA	C. MTANTHIKO	L. KASENDA	A. NYIRENDA	L. KALIYAPA
ART CLINIC	S. SPOON	A. BANDA	K. CHAPEMA	M. CHIPWAILA	L. KASENDA
ANC	L. GWAZA	P. TEKETA	L. LAWRENCE	B. KAMWANA	L. KAMTONDO
VIRAL LOAD	N/A	NAMASANI	D. TEKETA	M. KAUSUNGERE	N/A
SUBSEQUENT	B. KAMWANA	C. CHIBWEYA	H. CHINGOMBE	M. CHIPHWAFU	D. MWALE
ART CLINIC	M. SULUMA	M. CHIPHWAFU	L. KAMTONDO	F. WYSON	L. LAWRENCE

Case Study 3: PITC Health Talk

Health talks are 20 to 30 minute long patient education sessions, usually presented by a CHW or HSA while a group of patients is waiting to see a clinician or nurse. A health talk can be a great opportunity to educate patients on the benefits of HIV testing, discuss the HIV services available at the facility and dispel any common myths and misconceptions about HIV testing. This case study outlines guidelines for presenting a health talk and includes a sample script.

Guidelines for Presenting a Health Talk

1. Arrive at the clinic waiting area early and be prepared to give the health talk once the waiting area has a large number of patients.
2. Greet the audience.
3. Introduce yourself as health facility personnel.
4. Explain the topic you will be presenting.
5. Give the Health Talk. Remember the following tips when presenting:
    - Be confident and know the material well
    - Be loud and move around while speaking
    - Engage your audience and encourage participation and questions
    - If someone asks a question you don't know the answer to, tell them you don't know but you will find out
6. Hold a question and answer session at the end to clarify any points and to check for audience understanding.

Example Script for a PITC Health Talk:

Key Talking Points

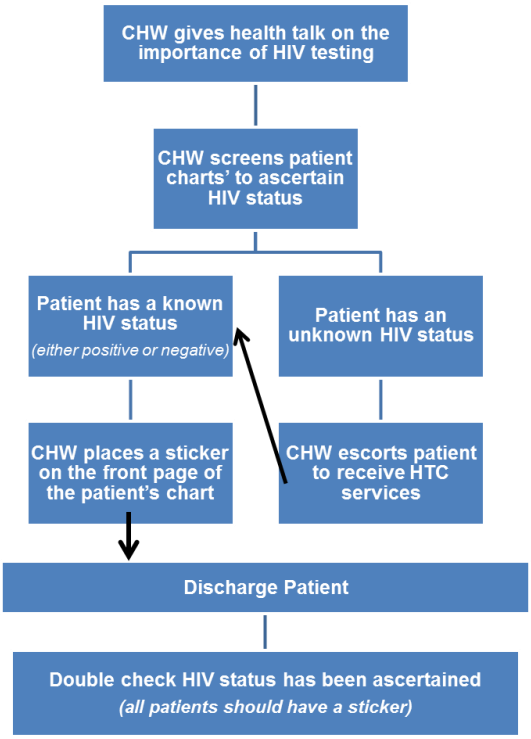
1. Why should you get an HIV test when you visit the health facility?
    - Entry point to care and allows clinician/nurse to diagnose properly
    - Start HIV treatment as soon as possible to allow you to live a long and healthy life
    - Protect your loved ones from contracting HIV
2. If you are not offered an HIV test, you should ask for one
    - Empower patients that their health is their responsibility and getting an HIV test can help them plan for a healthy life
2. Patients have a right to confidentiality – this is a priority for counselors.
    - If patients suspect someone has breached confidentiality, it should be reported
4. HIV services offered in the facility
    - HIV treatment (ARVs)
    - Partner testing and counselling
    - Child and Adolescent services, teen clubs, etc.
    - Disclosure services
    - Support groups

Activities

- Drama display to show the process of PITC
- Have audience give reason why people do not get tested and correct any misconceptions
- Explain where HTC is done within the health facility
- Have someone who is living with HIV give a testimonial on when/how they decided to be tested
- Ensure that there is a procedure in place such that any patients who choose to be tested immediately after the talk can do so.

Case Study 4: PITC in an Inpatient Ward Setting

For many large and busy health facilities, it can be hard to ensure that all inpatients are offered an HIV test before being discharged. Baylor supported the pediatric ward at Kamuzu Central Hospital in Lilongwe, Malawi to implement a unique system to ensure all pediatric inpatients were tested for HIV. CHWs within the facility screened the department at various times throughout the day by checking each child's HIV status on their patient chart and/or asking guardians about the child's status. If the patient had a known HIV status (positive OR negative), a green sticker was put on the chart indicating that screening had taken place. If not, the patient was escorted to HTC as indicated by the flow chart.



To ensure all staff participated in the process, counselors provided a report on PITC coverage in the weekly staff morning report. This presentation included a report on the percentage of patients with an ascertained status (i.e. number of patients with an ascertained status/total number of inpatient enrollments) in addition to the number of HIV positive patients found that week. Reporting on their progress, including both successes and failures, motivated the inpatient HTC team to work harder and improve their coverage. After implementing, the percentage of patients discharged with a known HIV status increased to almost 100% every week.

Case Study 5: Household HTC

Home-based testing has shown to be an acceptable and effective method of identifying HIV-infected patients. However, without proper planning, it can become a time-consuming, low yield activity. To maximize your yield, consider the following points when planning and implementing home-based HTC:

- **Time and Day:** patients and their household members may not be home during traditional working hours. Instead try Friday afternoons or Saturdays for testing.
- **Seasonal calendars:** try to focus home-based testing efforts during less busy seasons, for example: school summer holidays, before/after planting and harvesting seasons, etc.
- **Confirm the appointment:** it is best to confirm the appointment time with the patient before leaving the health facility
- **Combining with other community activities or home visits:** if a CHW is going into the community for any reason, try to plan for him/her to also do home-based HTC in the area as well
- **Distance patients live from the health facility:** if the catchment area of your health facility covers a large area, it may not be feasible to conduct home visits to patients living at a far distance
- **Yield compared to other ACF activities:** it is important that health facilities evaluate each of their ACF activities in terms of yield versus the time and effort taken. High yield, low effort activities should always be prioritized.

Case Study 6: Inpatient PITC and Reporting

Taking the time to develop a system which allows a program to analyze data and understand how different variables contribute to the large-scale goals is an important aspect of project implementation. The Tingathe Program has CHWs report monthly on key activities at site, including active case finding (PITC) and linkage to care. The Ministry of Health inpatient admissions register does not have a dedicated space to record HIV status, making it difficult to determine which and if patients were being tested for HIV. After identifying this gap in care, the PITC Register was developed to help ensure each patient's HIV status is ascertained before he or she is discharged. Working hand-in-hand with the nurses and clinicians in the inpatient ward, CHWs gave health talks, screened patients and provided HTC services daily to inpatients using the MOH register to record all the admissions and the PITC Register to record HIV status.

At the end of the month, CHWs compiled data from the MOH and PITC inpatient registers to enter into the Monthly Report. The process of completing the report allowed CHWs to see the big picture in their daily activities and helped them to see their progress and any shortfalls they had in reaching their goals. The site mentors used a Data Quality Checklist to verify the CHW's data entry and ensure all calculations were correct on the Monthly Report. They then took a picture of corrected Monthly Report to send via WhatsApp to the M&E team at the head office. This double check system saved the M&E clerks time cleaning and correcting data, leaving them more time to enter and analyze it instead. This combination of MOH and program tools has allowed the Tingathe Program's health facilities to demonstrate their success in supporting the ACF and linkage activities in their respective facilities.

Photo courtesy of Robbie Flick

The tool is designed to be used during the pre-implementation workshop to help health facilities understand their current ACF activities, their gaps in providing those services, and how featured tools can help to supplement their existing strategy. Facility staff, especially those involved with HTC and ART activities, should work together to complete the assessment and be encouraged to discuss the strengths and weaknesses in their current system.

During the Active Case Finding Training, the assessment can be used to guide discussions, provide specific examples of areas that need improvement and help form specific facility-level goals.

Instructions: Please complete the following assessment as a team and bring back to the active case finding training.

Provider Initiated Testing and Counselling (PITC) in your Facility

1. Describe what PITC means at your facility. (e.g. patient only is tested if clinician orders it, all patients are offered an HIV test, testing only happens if counselor is present, etc.)

_____

_____

_____

2. Fill the table below based on how PITC is being practiced in each of the departments. Remember, the definition of PITC we are using is ascertaining HIV status (offering opt-out testing) for *all* patients seeking services in these departments.

Department	Practicing PITC? (Yes, No or Some)	Who does testing?	When does testing NOT happen?	If testing is NOT happening, write reasons why.	Suggestions for Improvement
EXAMPLE: Antenatal Clinic	*Some*	*HTC counselor mostly, nurses supplement*	*Holidays*	*Nurses don't test because are too busy with other duties and HTC counselors are not around*	*Ensure at least one HTC counselor is available on holidays to do testing and assist nurses*
Antenatal Clinic					
Maternity					
TB Ward					

Dept	PITC?	Who does testing?	When testing NOT happening	Reason for NOT testing	Suggestions for Improvements
TB Office					
Adult In-Patient Ward /Short Stay					
Pediatric In-Patient Ward/Short Stay					
NRU					
OTP					
STI					

3. Fill the table below based on how HIV status records are kept in the following departments. If HIV status is not being recorded in a department, suggest a method to start keeping records of HIV status (e.g. PITC register, adding an extra column in an existing register to write HIV status, etc.)

Department	**Is there an HTC register specifically used for this department?**	**Is HIV Status Recorded in the…**			**Suggestions for Improvement**
		Department Register? *(Yes or No)*	**Patient Chart?** *(Yes or No)*	**Patient Health Passport Book?** *(Yes or No)*	
Antenatal Clinic					
Maternity					
Tuberculosis Ward					
Tuberculosis Office					
Adult In-Patient Ward/Short Stay					
Pediatric In-Patient Ward/Short Stay					
Nutrition Program					
Out-patient					
Sexually Transmitted Disease (STI)					
Other department *(specify)*					

Active Case Finding

4. Do you practice any of the following active case finding strategies in your facility?

Activity	**Do Activity?** (Yes or No)	**Comments/Suggestions for Improvement**
Test partners of known HIV-infected patients		
Ensure children of HIV-infected mothers have received an HIV test		
Refer patients from out-patient department with signs and symptoms of HIV for HIV testing		
Follow up DNA PCR positive test results received for exposed infants		
Retest pregnant women in the maternity ward		
Provide HTC as part of the standard of care in HIV high risk departments (e.g. TB, in-patient, nutritional programs, STI ward, ART department, etc)		

5. Are there any other active case finding strategies not listed above you use to identify HIV-infected children and adults? If so, please describe them below.

_____

Resources in Your Facility

6. List any special organizations, partners and/or staff members that you have at your facility that could assist with active case finding.
   - _____
   - _____
   - _____
   - _____
7. How could these other resources help your facility reach their active case finding and PITC goals?

_____

Making a Work Plan to Scale-Up Active Case Finding

8. Health facility supervisors will be required to make a work plan which outlines the roles and responsibilities of HCWs to scale-up active case finding. Please brainstorm where the HCWs can help to fill gaps, facilitate PITC and implement other active case finding strategies. Write some suggestions and key gaps/challenges below.

_____

_____

This package contains the instructions for use of the tools within the Active Case Finding Training Package. The documents within this package should be adapted based upon the planned activities to be implemented and the group attending the workshop. Each of the tools within this package is described below.

Agenda: A suggested agenda and timeframe for conducting the training.

Training PowerPoint & Facilitator's Guide: This PowerPoint presentation outlines key points of the training and acts as a visual reference for workshop participants. Key sections include: Review of ACF Activities (using the ACF Site Assessment Tool); review of PITC testing alogrithms; description and practice using PITC register and monthly report; Making a PITC POA; and M&E Overview. Comments, key discussion points and instructions are embedded throughout the presentation in the notes section to aid the facilitator in leading.

PITC Register Brief SOP: A two-page, quick-reference version of the PITC Register and Monthly Report SOP that can be used for training and on-site reference.

M&E Example Hand Out: This form is for use by the participants in order to practice filling and using the monitoring and evaluation tools associated with the PITC Register. The Training PowerPoint has a prompt for the exercise so that participants can practice their new skills immediately after learning about them.

PITC Plan of Action (POA) Tool: This tool is designed to be used during ACF training to assist departments to incorporate PITC activities into their standard of care procedures. An example of how this can be used can be seen in **PITC POA Case Study**.

Exam: This exam can be used to test CHW/HDA ability to use the Linkage Register, Tracing Tools and Monthly Report.

AGENDA

Activity	Time	Handouts Needed	Facilitator
Participants Arrive	8:00	Agenda	
Welcome and Introductions	8:00-8:15	PowerPoint presentation for reference	
Review of Active Case Finding	8:15-9:00	Completed ACF Assessment Tool*	
Review of PITC Testing Algorithms	9:00-9:30		
PITC Register	9:30-10:30	PITC Register, PITC Brief SOP	
Tea	**10:30-10:45**		
PITC Register – Exercise #1	10:30-11:15	M&E Example Handout	
PITC Monthly Report & Exercise #2	11:15-12:30	PITC Monthly Report	
Lunch	**12:30-1:30**		
PITC Exam	1:30-2:00	Exam	
PITC Plan of Action & Exercise #3	2:00-3:00	Plan of Action Tool	
Challenges and Solutions to Implementing ACF Strategies	3:00-4:00		
M&E Review	4:00-4:20		
Distribution of Site Supplies	4:20-4:30		
Closing Remarks & Tea	**4:30**		

***Note:** ACF Assessment Tool should have been completed after the initial ACF workshop at the health facility.

Active Case Finding Training

TINGATHE TOOLKIT

Objectives

- Discuss general ACF strategies and procedures
- Review definition and importance of PITC as a key component of ACF
- Discuss PITC coverage and challenges in PITC in wards/nutrition programs
- Discuss standard procedure for ACF activities
- Present algorithms for PITC in <12mo, 12-24mo, >24mo
- Present and practice PITC Register & PITC section of Monthly Report
- Test understanding of PITC tools
- Discuss implementation of PITC activities into your facility and work through the PITC Plan of Action Tool
- Receive site supplies

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What does Active Case Finding look like in your facility?

TINGATHE TOOLKIT

Instructions:

1. Using the ACF assessment tool – review what people are doing in their facilities in terms of ACF.
2. Encourage discussion and reflection on successes and challenges still faced.
3. Use the discussion to frame the training that all tools and strategies should be adapted to fit into their setting and fit the health facility's needs.

Examples of ACF Strategies:

- Screening health passport books/patient records to ensure everyone has had an HIV test
- Screening health passport books to identify those that are HIV-infected, but not enrolled in HIV services
- Encouraging HIV testing of family members of people living with HIV
- Routine HIV testing in high-risk departments (ANC, TB, inpatient, etc)

Facility-based HIV testing approaches

- **PITC:** routine provision of HIV testing to anyone accessing services at a health facility
- **VCT:** the client voluntarily makes a decision to learn his or her HIV status and seeks HIV testing at a site providing the service
- This workshop will focus on PITC – especially PITC in inpatient wards and nutrition program.

TINGATHE TOOLKIT

Note:

- Before displaying the definition of PITC – ask participants how they define PITC in their facilities. Note the difference in responses and use the next few slides to clarify any misconceptions and misunderstandings

Provider-Initiated Testing and Counseling (PITC): Key Points

- PITC means routinely offering HIV testing at the health facility
- PITC does not require an order from a clinician or nurse (a HTS provider can counsel patients and conduct HIV testing)
- PITC is NOT mandatory. Patients should be counseled about HIV testing and informed that they can decline testing. Patients should give verbal consent that they agree to HIV testing.

TINGATHE TOOLKIT

MoH recommends PITC

" Ascertain HIV status for all patients attending health services (ANC, maternity, TB, STI, U1/U5, adult and pediatric wards)"

- Especially focus on departments where patients are at higher risk of having HIV – ANC/Maternity, inpatient wards, TB, nutrition program (NRU, OTP, SFP), STI

2016 Clinical Management of HIV in children and adults. Malawi Ministry of Health.

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Why is PITC recommended?

- PITC is more likely to identify HIV-positive patients ("high yield"):
  - Patients admitted to the hospital or nutrition program are sick and therefore have a higher chance of being HIV infected.
- PITC is practical:
  - The patient is already at the health facility
  - There is no additional cost to families (transport/ time)
  - For those who test HIV+, there is a direct linkage to ART services at the facility

TINGATHE TOOLKIT

Note – can discuss although PITC may be an effective approach, in order to the most out of it, the patient must also be linked to care.

Evidence for PITC

- Impact of PITC in paediatric wards of KCH, Lilongwe:
  - After increasing PITC on paediatric wards (over 95% of all paediatric admissions tested), ART initiations in children increased by three-fold.
  - **Conclusion:** A focus on pediatric PITC led to improved HIV case identification and more children starting life-saving ART.

Weigel R, Kamthunzi P, Mwansambo C, Phiri S, Kazembe P. Effect of provider-initiated testing and counselling and integration of ART services on access to HIV diagnosis and treatment for children in Lilongwe, Malawi: a prepost comparison. BMC Pediatr 9(80): doi:10.1186/1471-2431-9-80.

TINGATHE TOOLKIT

Why focus on PITC?

- PITC training, quality improvement activities, and introduction of HDAs have improved PITC services, but there is still room for improvement.
- We are working to improve PITC coverage (Coverage means the % of patients who are tested or have HIV status ascertained)
- At Baylor-supported sites in SEZ in Q3 2016, the PITC coverage was:
  - Inpatient wards: 65-70%
  - NRU: 90%
  - SFP/OTP: 80%

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PITC Coverage Target

90% of all admissions/registrations to Pediatric Ward, Adult Ward, Nutrition Departments (NRU, OTP, SFP) have HIV status ascertained

–Tested or known status documented

UNAIDS 90-90-90

90% of people living with HIV know their HIV status

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Facilitator Note:

- This is a good point to discuss program-level goals and targets. Note that short-term, individual site goals will be developed later on.
- Discuss how the PITC goal fits into the bigger picture of supporting UNAIDS first '90 goal'

PITC TESTING ALGORITHMS

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When to test/ re-test

"Offer HIV testing to all patients attending health facilities for any reason, if:

- never tested
- tested negative more than 3 months ago (follow risk assessment guidelines)
- claims to have been tested any time in the past, but without documentation (being on ART counts as documented evidence)"

Source: Malawi Integrated HIV Clinical Guidelines, 2016.

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This is the difference between testing protocols for VCT and PITC –

For VCT, we use risk assessment guidelines only to tell if someone needs to be tested. You assess HIV risk factors and decide if a client needs testing.

For PITC, if a patient is sick in a health facility, we want to test the client if s/he has not been tested in the previous 3 months. (If the patient is very high risk – ie, known HIV exposure, occupational or rape – the client should be re-tested after 1 month per risk assessment guidelines.)

Re-testing after previous HIV-negative

Patient does not need to be re-tested if:

– Most recent test was less than 3 months ago
(or 1 mo ago if high risk exposure by risk assessment)

AND

– Test result is documented

*But you should re-test if the child is very sick or signs that child may be HIV-positive.

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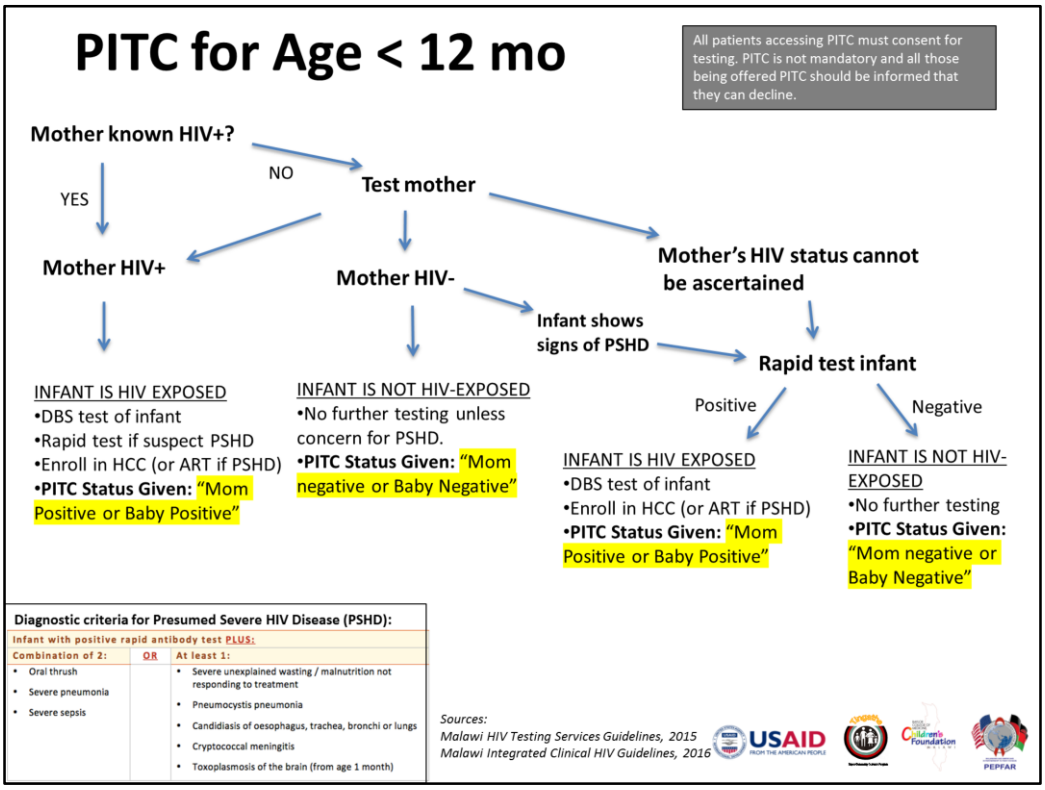
Note:
- Remind participants that HIV-infected children progress to AIDS much faster than adults, so it is important to retest children if they are very sick and shows signs/symptoms of HIV infection
- Can use this time to review CHW Training material – Unit 3: HIV Signs and Symptoms



Explanation of algorithms:

- These algorithms come from *2016 Clinical Management of HIV in children and adults. Malawi Ministry of Health.*
- Divided them into <12mo, 12-24mo and >24mo to make them easier to use.
- These algorithms are useful to make sure we all are doing things in the standard, recommended way. However, there may be exceptions – if a clinician is worried about a patient and wants to test/re-test them, this should be done, even if it is not in the algorithm.

Presumed Severe HIV Disease (PSHD)

Infant with positive rapid antibody test PLUS:		
Combination of 2:	**OR**	**At least 1:**
• Oral thrush • Severe pneumonia • Severe sepsis		• Severe unexplained wasting / malnutrition not responding to treatment • Pneumocystis pneumonia • Candidiasis of oesophagus, trachea, bronchi or lungs • Cryptococcal meningitis • Toxoplasmosis of the brain (from age 1 month)

2016 Clinical Management of HIV in children and adults. Malawi Ministry of Health.

PITC for Age 12-24 mo

All patients accessing PITC must consent for testing. PITC is not mandatory and all those being offered PITC should be informed that they can decline.

Rapid test on both mother and child

Child +, any status of mother

CHILD IS HIV+
- Start ART
- Do confirmatory DNA-PCR
- PITC Status Given: New Positive

Mother +, Child -

CHILD IS HIV-EXPOSED
- Ensure child on CPT
- Ensure child in HCC
- Ensure mother on ART
- PITC Status Given: New Negative

Mother -, Child - *OR* Mother unknown, Child -

CHILD IS HIV-
- No further testing
- PITC Status Given: New Negative

Notes:
- If mother is known HIV+, test child only.
- If child is known HIV+, no need for testing, record Known Positive (ART or Kn+, depending on ART status).
- If mother and/or child are known HIV+, ensure they are on ART.

TINGATHE TOOLKIT

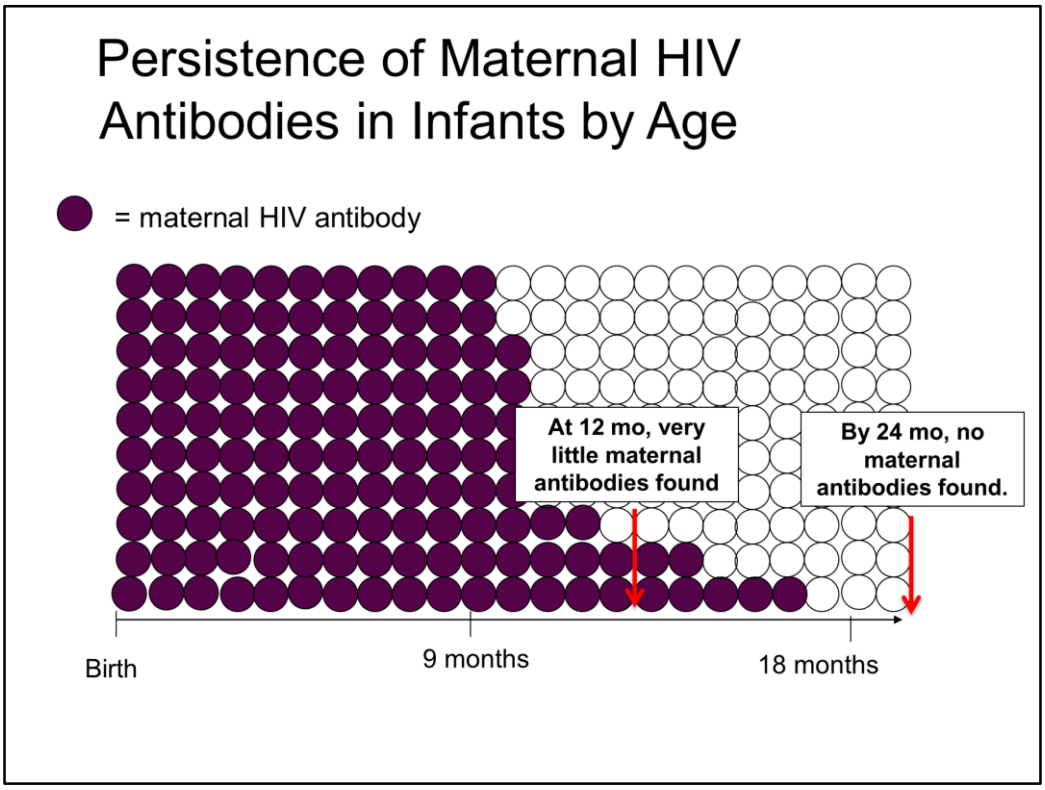
Sources:
Malawi HIV Testing Services Guidelines, 2015
Malawi Integrated Clinical HIV Guidelines, 2016

Confirmatory testing in <24 months of age

NEW IN 2016 GUIDELINES:

- All children under 24 months with positive initial test should get a confirmatory DNA-PCR.
  - The initial test is DNA-PCR if <12mo.
  - The initial test is rapid test if ≥12mo.
  - Confirmatory DNA-PCR can be collected on the day of starting ART.
- Do not wait for confirmatory DNA-PCR results to start ART.

2016 Clinical Management of HIV in children and adults. Malawi Ministry of Health.



Explanation: This figure shows that after 12mo very few children still have maternal Ab (the purple circles). So, rapid test is an appropriate test. But just to be sure that a positive rapid test is due to HIV infection in children 12-24mo (and not maternal antibody), a confirmatory DNA-PCR is done.

PITC for Age > 24 mo

All patients accessing PITC must consent for testing. PITC is not mandatory and all those being offered PITC should be informed that they can decline.

Rapid test

Test positive → HIV POSITIVE
- Start on ART
- PITC Status Given: New Positive

Test negative → HIV NEGATIVE
- PITC Status Given: New Negative

Tests discordant by 2 counselors → RESULT IS INCONCLUSIVE
- Repeat test in 4 weeks
- PITC Status Given: New Inconclusive

Note:
- If the child is still breastfeeding, mother should also be tested to determine exposure status.

Sources:
Malawi HIV Testing Services Guidelines, 2015
Malawi Integrated Clinical HIV Guidelines, 2016

TINGATHE TOOLKIT

PITC REGISTER

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Note:

- At this time, all participants should have a copy of the Brief PITC SOP, PITC Registers (adult and pediatric) and the PITC monthly report.

Introduction to PITC Register

- The PITC Register allows us to collect accurate information on PITC coverage and outcomes.
- This register will be used on:
  - Adult wards
  - Pediatric wards
  - NRU
- There are 2 versions of the PITC Register: Paediatric (for paediatric inpatient wards and NRU) and Adult (for adult inpatient wards).
- Only facilities with inpatient services will use the PITC Register.

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Note: Even if some staff do not work at sites where they have inpatient or will use the PITC Register, it is still good they learn about it. The way of approaching PITC in outpatient programs is the same, but just will not use the register.

PITC Register Procedure

1. Enter all new admissions/registrations into the PITC register each day, one patient per line. Only enter the names of the patients admitted to the ward. Do not enter the name of the patient's mother into the PITC register, even if she is tested on the ward. **(All persons tested should be entered in the HTC register per usual protocol.)**
2. Complete patient status based on PITC flowchart and testing algorithms described.

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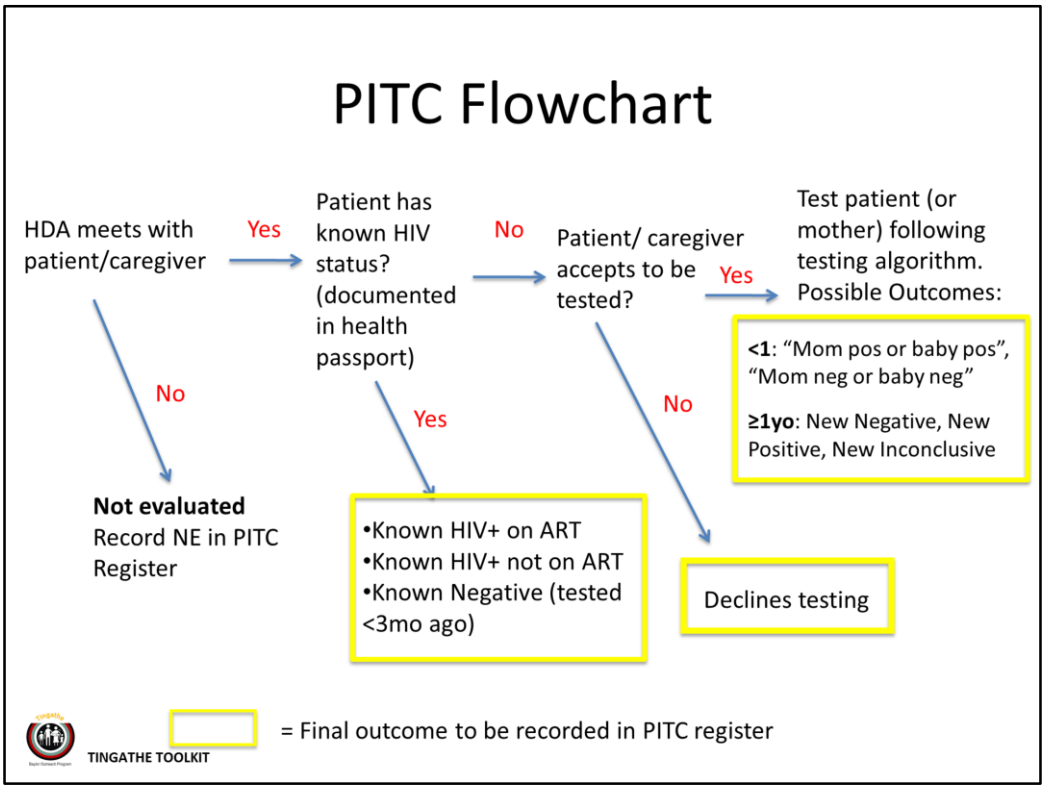
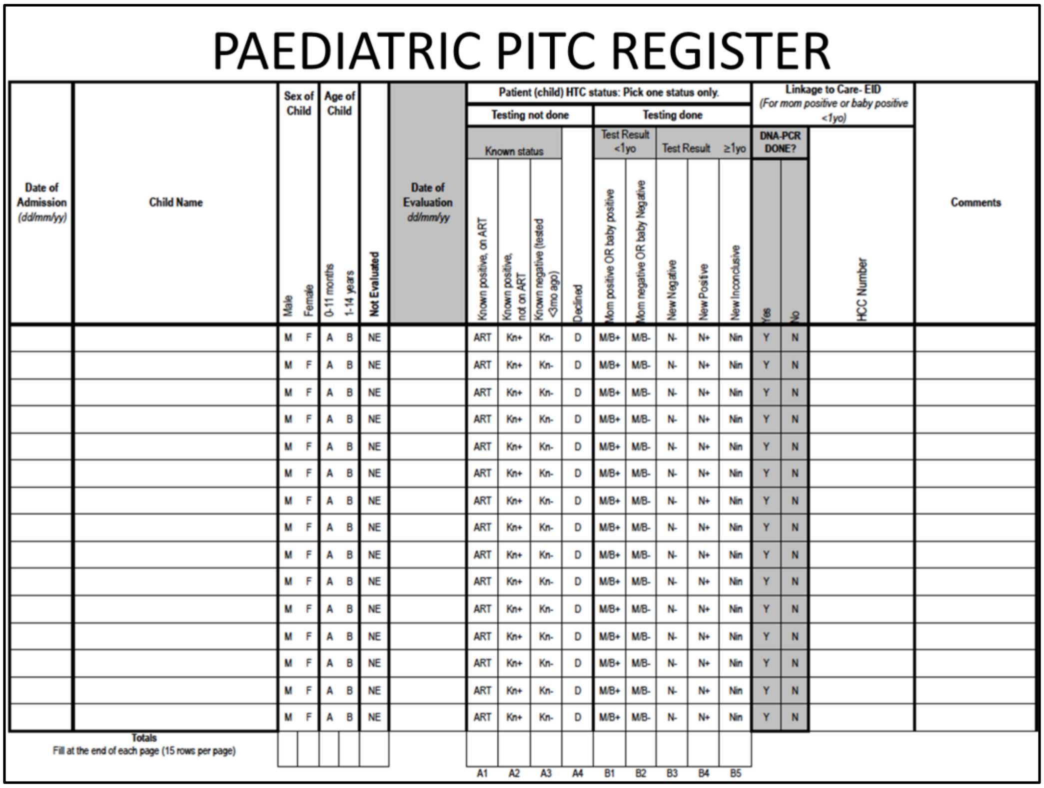


Explanation:

- HDA may not meet with and evaluated patient/caregiver on inpatient ward for many reasons: a very short admission, patient died before counseling, patient frequently off ward at Xray/surgery and could not be found, or HDA busy & didn't get to patient. We want >90% of patients to be evaluated by HTS providers.
- Testing outcome for <1yo: We will ideally test the mother with rapid test to determine if they baby is HIV exposed. If the mother is not available, we will test the baby (as discussed in algorithm).
- Thus, possible outcomes for <1yo are "mother or baby rapid test positive" or "mother or baby rapid test negative". For >1yo, the child should be tested & the result will be Pos/Neg or Inconclusive.



PAEDIATRIC PITC REGISTER

Date of Admission *(dd/mm/yy)*	Child Name	Sex of Child		Age of Child			Date of Evaluation *dd/mm/yy*	Patient (child) HTC status: Pick one status only.									Linkage to Care- EID *(For mom positive or baby positive <1yo)*			Comments
								Testing not done				Testing done								
								Known status				Test Result <1yo		Test Result ≥1yo			DNA-PCR DONE?			
		Male	Female	0-11 months	1-14 years	**Not Evaluated**		Known positive, on ART	Known positive, not on ART	Known negative (tested <3mo ago)	Declined	Mom positive OR baby positive	Mom negative OR baby Negative	New Negative	New Positive	New Inconclusive	Yes	No	HCC Number	
		M	F	A	B	NE		ART	Kn+	Kn-	D	M/B+	M/B-	N-	N+	Nin	Y	N		
		M	F	A	B	NE		ART	Kn+	Kn-	D	M/B+	M/B-	N-	N+	Nin	Y	N		
		M	F	A	B	NE		ART	Kn+	Kn-	D	M/B+	M/B-	N-	N+	Nin	Y	N		
		M	F	A	B	NE		ART	Kn+	Kn-	D	M/B+	M/B-	N-	N+	Nin	Y	N		
		M	F	A	B	NE		ART	Kn+	Kn-	D	M/B+	M/B-	N-	N+	Nin	Y	N		
		M	F	A	B	NE		ART	Kn+	Kn-	D	M/B+	M/B-	N-	N+	Nin	Y	N		
		M	F	A	B	NE		ART	Kn+	Kn-	D	M/B+	M/B-	N-	N+	Nin	Y	N		
		M	F	A	B	NE		ART	Kn+	Kn-	D	M/B+	M/B-	N-	N+	Nin	Y	N		
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		M	F	A	B	NE		ART	Kn+	Kn-	D	M/B+	M/B-	N-	N+	Nin	Y	N		
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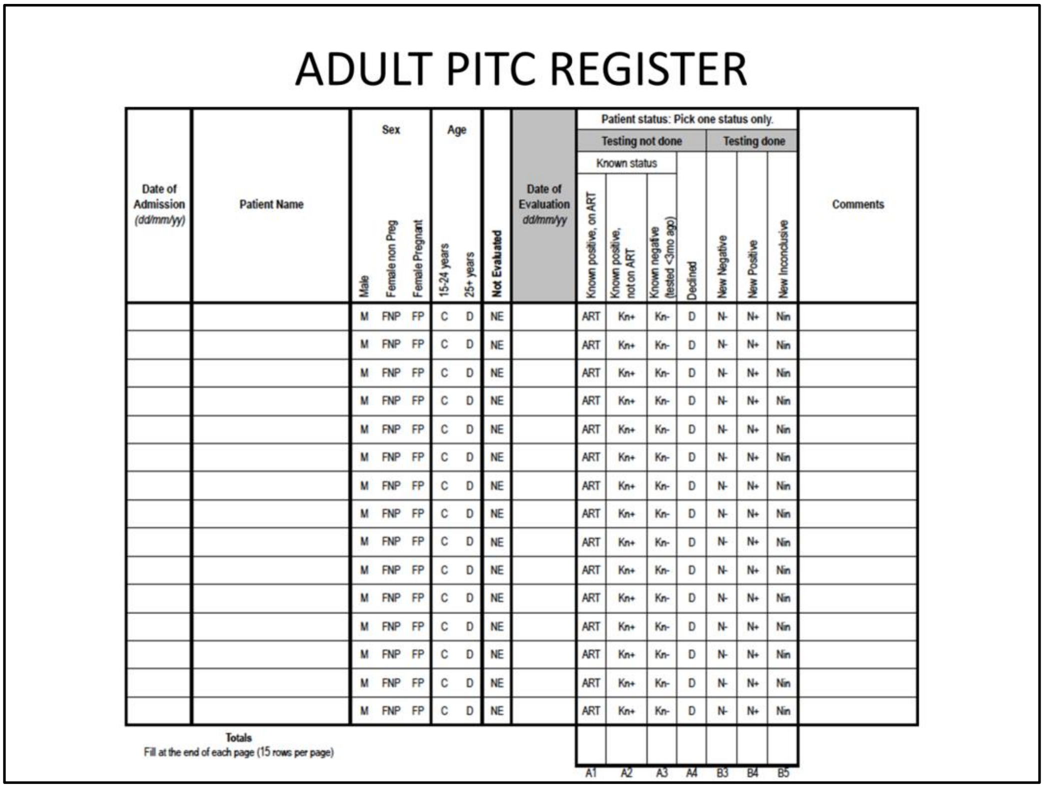
		M	F	A	B	NE		ART	Kn+	Kn-	D	M/B+	M/B-	N-	N+	Nin	Y	N		
Totals Fill at the end of each page (15 rows per page)																				
								A1	A2	A3	A4	B1	B2	B3	B4	B5				

Explanation:

- This is a picture of the pediatric PITC Register. All participants should have hard copies to reference and make notes on.
- We will use this register in many case examples later – so you'll get practice using it. I'll briefly walk you through the different sections of the register
- Any questions?



ADULT PITC REGISTER

Date of Admission *(dd/mm/yy)*	Patient Name	Sex			Age		Not Evaluated	Date of Evaluation *dd/mm/yy*	Patient status: Pick one status only.							Comments
									Testing not done				Testing done			
									Known status							
		Male	Female non Preg	Female Pregnant	15-24 years	25+ years			Known positive, on ART	Known positive, not on ART	Known negative (tested <3mo ago)	Declined	New Negative	New Positive	New Inconclusive	
		M	FNP	FP	C	D	NE		ART	Kn+	Kn-	D	N-	N+	Nin	
		M	FNP	FP	C	D	NE		ART	Kn+	Kn-	D	N-	N+	Nin	
		M	FNP	FP	C	D	NE		ART	Kn+	Kn-	D	N-	N+	Nin	
		M	FNP	FP	C	D	NE		ART	Kn+	Kn-	D	N-	N+	Nin	
		M	FNP	FP	C	D	NE		ART	Kn+	Kn-	D	N-	N+	Nin	
		M	FNP	FP	C	D	NE		ART	Kn+	Kn-	D	N-	N+	Nin	
		M	FNP	FP	C	D	NE		ART	Kn+	Kn-	D	N-	N+	Nin	
		M	FNP	FP	C	D	NE		ART	Kn+	Kn-	D	N-	N+	Nin	
		M	FNP	FP	C	D	NE		ART	Kn+	Kn-	D	N-	N+	Nin	
		M	FNP	FP	C	D	NE		ART	Kn+	Kn-	D	N-	N+	Nin	
		M	FNP	FP	C	D	NE		ART	Kn+	Kn-	D	N-	N+	Nin	
		M	FNP	FP	C	D	NE		ART	Kn+	Kn-	D	N-	N+	Nin	
		M	FNP	FP	C	D	NE		ART	Kn+	Kn-	D	N-	N+	Nin	
		M	FNP	FP	C	D	NE		ART	Kn+	Kn-	D	N-	N+	Nin	
		M	FNP	FP	C	D	NE		ART	Kn+	Kn-	D	N-	N+	Nin	
Totals Fill at the end of each page (15 rows per page)																
									A1	A2	A3	A4	B3	B4	B5	

Explanation:

- This is a picture of the pediatric PITC Register. All participants should have hard copies to reference and make notes on. We will use this register in many case examples later – so you'll get practice using it.
- The main differences from the pediatric register are: Sex (FP and FNP), Age categories, <1yo outcomes & section on linking to EID not included in adult register because not relevant
- Any questions?

Exercise #1

You, a HDA, determine the HIV status of patients in a pediatric inpatient ward. See the following description of the cases 1-6 to determine your next steps. For all cases, answer:

- What would you do? (test/don't test, who to test)
- Document outcome in Paediatric PITC Register

Instructions:

- Participants can work in pairs or individually to complete the exercise on the **M&E Example Handout**.
- Walk through each case together. Pause after each description of the case to let participants think about, then answer "what test would you do?"
- Once completed, review all responses together. Clarify any questions.

Case #1

- Patient A.B. is a 7mo old female admitted to the hospital for diarrhea. The child has never been admitted before, is otherwise healthy per the mother and has good nutritional status with W/H~0 and MUAC 13.5.
- What testing do you do?
  - Test mother
- Mother is HIV-negative. What do you do?
  - Nothing more
- Complete the PITC Register for this patient.

Explanation: When completing PITC Register, enter Date of Admission as yesterday (these were new patients admitted yesterday evening) & Date of Evaluation as today.

PITC Register: Outcome – M/B-

Case #2

- Patient A.C. is a 7mo old male admitted to the hospital for diarrhea. The child has never been admitted before, is otherwise healthy and has good nutritional status with W/H~0 and MUAC 13.5.
- What do you do next?
- The mother died when the child was 2mo old and the child is being raised by the grandmother. The grandmother does not think the mother had HIV – the mother died in a car accident.
- What testing do you do?
  - Rapid test on the child
- If the rapid test is positive, what do you do?
  - Child is HIV exposed.
    - You ensure child is enrolled in HCC and DBS is done (HCC number is 0001).
  - Clinician to evaluate if child meets criteria for PSHD/ needs ART.
    - In this case, child does not meet criteria for PSHD and doesn't need ART.
- Complete the PITC Register for this patient.

PITC Register Outcome: M/B+; complete section on "Linkage to Care-EID"

Case #3

- Patient A.D. is a 5 year old boy admitted for malaria. He is otherwise healthy. He was last admitted to the hospital 1 year ago for diarrhea.
- When you look at the health passport book, you see HTC documented from the admission 1 year ago & HIV status was negative.
- What testing do you do?
  - Re-test since child is sick (admitted to hospital) and test was >3mo ago.
- Test result is negative. Complete the PITC Register for this patient.

PITC Outcome= N-

Case #4

- Patient A.E. is a 18 mo old girl admitted to the ward for pneumonia. She has never been admitted to the hospital before. She is still breastfeeding. Mother tested HIV- at the time of delivery.
- What testing do you do?
  - Test child
  - Test mother
- Mother is positive, child negative. What do you do?
  - Refer mother for ART (high priority!), child for HCC.
- Complete the PITC Register for this patient.

PITC outcome= N- (is HIV-exposed and needs PMTCT services, but outcome of today's test is N-).
Could make note in the comment – "mother new HIV+ -- referred for ART (mother) and HCC (child)"

Important points:
*There are 2 entries in the HTC Register: for the test of mother & the test of child.
*Only the child is entered in the PITC Register because she is the patient.
*If Linkage has already been discussed, should mention that Mother should be entered in the Linkage Register.

Case #5

- Patient A.F. is a 12 year old boy admitted to the ward. The caregiver says the child's HIV status is unknown. There is no record of testing in his health passport book.
- What testing do you do?

  Rapid test
- After testing HIV+, you find out from the caregiver that the boy is actually known to be HIV-positive and on ART (but not yet disclosed).
- Complete the PITC Register for this patient.

PITC Outcome: ART (Known positive, on ART)

This happens frequently in adults – maybe because they are nervous to disclose their status or they want to be tested again to see if it really gives a positive result. If they already knew their status (even if you re-test them), they can be recorded as Known positive.

Case #6

- Patient A.G. is a 6mo old girl admitted to the ward with malaria. She is a known HIV exposed infant (mother is HIV+ on ART). She had neg DBS at 6wks and is followed in HCC.
  - What testing do you do?
    - No testing needed unless child shows signs of PSHD
  - Complete the PITC Register for this patient.

PITC Outcome: M/B+

Note: Even though the child's last test result was negative (DBS), the mother is HIV+. For <1yo, we record based on primarily based on mother's status, so HIV-exposed infants are recorded as M/B+.

Get into groups. Check your PITC register with those in your group. Do you see any differences?

Date of Admission (dd/mm/yy)	Child Name	Sex of Child		Age of Child		Not Evaluated	Date of Evaluation dd/mm/yy	Patient (child) HTC status: Pick one status only.									Linkage to Care- EID (For mom positive or baby positive <1yo)			Comments
								Testing not done				Testing done								
								Known status				Test Result <1yo		Test Result ≥1yo			DNA-PCR DONE?		HCC Number	
		Male	Female	0-11 months	1-14 years			Known positive, on ART	Known positive, not on ART	Known negative (tested <3mo ago)	Declined	Mom positive OR baby positive	Mom negative OR baby Negative	New Negative	New Positive	New Inconclusive	Yes	No		
14/10/16	A. B.	M	F	A	B	NE	14/10/16	ART	Kn+	Kn-	D	M/B+	M/B-	N-	N+	Nin	Y	N		
14/10/16	A. C.	M	F	A	B	NE	14/10/16	ART	Kn+	Kn-	D	M/B+	M/B-	N-	N+	Nin	Y	N	0001	
14/10/16	A. D.	M	F	A	B	NE	14/10/16	ART	Kn+	Kn-	D	M/B+	M/B-	N-	N+	Nin	Y	N		
14/10/16	A. E.	M	F	A	B	NE	14/10/16	ART	Kn+	Kn-	D	M/B+	M/B-	N-	N+	Nin	Y	N		Mother new HIV+, referred child for HCC
14/10/16	A. F.	M	F	A	B	NE	14/10/16	ART	Kn+	Kn-	D	M/B+	M/B-	N-	N+	Nin	Y	N		
14/10/16	A. G.	M	F	A	B	NE	14/10/16	ART	Kn+	Kn-	D	M/B+	M/B-	N-	N+	Nin	Y	N		

Instructions:

- Have participants get into different groups than those that they were in during Exercise 1.
- Check their complete PITC registers with others. Note differences.
- Walk through each example again together, clarifying any mistakes.

PITC MONTHLY REPORT

PITC Reporting Procedure

1. It is the responsibility of HDA focal person to fill the PITC Monthly Report.

2. Fill the report at the end of each month and complete before the end of the first week of the following month (e.g. the monthly report for June should be completed by the first week July).

3. Fill in the first row of the form with:
   - Site (health facility name)
   - District

4. Reporting Month (e.g. a June reporting month covers all PITC done from June 1st -30th)

5. When the monthly report is completed, the HDA focal person completing the report should sign and date. The site supervisor should perform a quality check (check the report data against the PITC register data), then sign and date.

6. When report is completed, signed and checked for quality, it should be submitted to the M&E team.

TINGATHE TOOLKIT

TINGATHE SITE MONTHLY REPORT: PITC Section

SECTION 1. For Inpatient wards; use the Tingathe PITC Register

Indicator	Description	Data Location	Site Result	M&E Check
		PITC- NRU		
NR. 1	# Admissions	NRU Register		
NR. 2	# Evaluated	PITC Register (Sum of A1 to B5)		
NR. 3	# Known positive	PITC Register (Box A1+A2)		
NR. 4	# Known negative	PITC Register (Box A3)		
NR. 5	# Refused testing	PITC Register (Box A4)		
NR. 6	# < 1 Mom HIV+ or Baby HIV+	PITC Register (Box B1)		
NR. 7	# < 1 Mom HIV- or Baby HIV-	PITC Register (Box B2)		
NR. 8	# New negative	PITC Register (Box B3)		
NR. 9	# New positive	PITC Register (Box B4)		
NR. 10	# Inconclusive	PITC Register (Box B5)		
Comments:				
		PITC – Inpatient/Short Stay Paeds		
SP. 1	# Admissions	Ward Admissions Register		
SP. 2	# Evaluated	PITC Register (Sum of A1 to B5)		
SP. 3	# Known positive	PITC Register (Box A1+A2)		
SP. 4	# Known negative	PITC Register (Box A3)		
SP. 5	# Refused testing	PITC Register (Box A4)		
SP. 6	# < 1 Mom HIV+ or Baby HIV+	PITC Register (Box B1)		
SP. 7	# < 1 Mom HIV- or Baby HIV-	PITC Register (Box B2)		
SP. 8	# New negative	PITC Register (Box B3)		
SP. 9	# New positive	PITC Register (Box B4)		
SP. 10	# Inconclusive	PITC Register (Box B5)		
Comments:				
	PITC – In Patient/Short Stay Adult		**Male**	**Female**
SA. 1	# Admissions	Ward Admissions Register		
SA. 2	# Evaluated	PITC Register (Sum of A1 to B5)		
SA. 3	# Known positive	PITC Register (Box A1+A2)		
SA. 4	# Known negative	PITC Register (Box A3)		
SA. 5	# Refused testing	PITC Register (Box A4)		
SA. 6	# New negative	PITC Register (Box B3)		
SA. 7	# New positive	PITC Register (Box B4)		
SA. 8	# Inconclusive	PITC Register (Box B5)		
Comments:				

SECTION 2. For Outpatient Department; use department registers

	Description	Data Location	Site Result		
		PITC –OTP			
OP 1	# Registrations in OTP	OTP Dept Register			
OP 2	# HIV Status Ascertained	OTP Dept Register			
OP 3	# HIV Positive (New or Known)	OTP Dept Register			
		PITC –SFP			
SP 1	# Registrations in SFP	SFP Dept Register			
SP 2	# HIV Status Ascertained	SFP Dept Register			
SP 3	# HIV Positive (New or Known)	SFP Dept Register			
		PITC –STI			
ST	# Registrations in STI	STI Dept Register			
ST	# HIV Status Ascertained	STI Dept Register			
ST	# HIV Positive (New or Known)	STI Dept Register			
Comments:					

Explanation:

This is a picture of the Site Monthly Report (they should have hard copies to look at). There are two sections:

Section 1: Inpatient wards using PITC Registers

Section 2: Outpatient departments that <u>do not</u> use PITC registers

- For NRU, Inpatient Paeds and Inpatient Adult, the source is the PITC Register. The column totals in the PITC register should be used to get these numbers – we will practice this.
- For OTP/SFP/STI, you will get the data from the Departmental Registers. When you go to your sites, you should look for the OTP, SFP and STI registers at your sites to make sure they are being used and HIV status is being documented in these registers.

PITC Reporting Procedure – Section 1

1. Ensure that the PITC registers for each ward have their totals summed at the bottom of each page.

2. Enter the PITC Register data requested in the 'Description' column into the corresponding 'Site Result' column.
   - The first row in each section is **# Admissions**. This should be obtained from the total number of patients recorded in the ward/in-patient admission register during the monthly reporting period.
   - The row for **Evaluated** is the Sum of boxes A1 through B5

     # Evaluated = A1+A2+A3+A4+B1+B2+B3+B4+B5

Date of Admission (dd/mm/yy)	Child Name	Sex of Child		Age of Child		Not Evaluated	Date of Evaluation dd/mm/yy	Patient (child) HTC status: Pick one status only.									Linkage to Care- EID (For mom positive or baby positive <1yo)			Comments
								Testing not done				Testing done								
								Known status				Test Result <1yo		Test Result ≥1yo			DNA-PCR DONE?			
		Male	Female	0-11 months	1-14 years			Known positive, on ART	Known positive, not on ART	Known negative (tested <3mo ago)	Declined	Mom positive OR baby positive	Mom negative OR baby Negative	New Negative	New Positive	New Inconclusive	Yes	No	HCC Number	
		M	F	A	B	NE		ART	Kn+	Kn-	D	M/B+	M/B-	N-	N+	Nin	Y	N		
	Totals Fill at the end of each page (15 rows per page)											5								
								A1	A2	A3	A4	B1	B2	B3	B4	B5				

SECTION 1. For Inpatient wards; use the Tingathe PITC Register

Indicator	Description	Data Location	Site Result	M&E Check
		PITC- NRU		
NR. 1	# Admissions	NRU Register		
NR. 2	# Evaluated	PITC Register [Sum of A1 to B5]		
NR. 3	# Known positive	PITC Register (Box A1+A2)		
NR. 4	# Known negative	PITC Register (Box A3)		
NR. 5	# Refused testing	PITC Register (Box A4)		
NR. 6	# <1 Mom HIV+ or Baby HIV+	PITC Register (Box B1)	5	
NR. 7	# <1 Mom HIV- or Baby HIV-	PITC Register (Box B2)		
NR. 8	# New negative	PITC Register (Box B3)		
NR. 9	# New positive	PITC Register (Box B4)		
NR. 10	# Inconclusive	PITC Register (Box B5)		

Instructions:

1. Walk through an example of how to calculate column totals.
2. Demonstrate how data is transferred from the PITC register onto the monthly report.
3. Review how # admissions and #evaluated calculations are made.

Exercise #2: Reports

1. Complete the column totals for this page in the Paediatric PITC Register

2. Complete the "PITC – Inpatient/Short Stay Paeds" section of the Tingathe Site Monthly Report

TINGATHE TOOLKIT

Instructions:
1. Have participants complete column totals on their own.
2. Once finished, have them get into small groups to

PITC PLAN OF ACTION (POA)

TINGATHE TOOLKIT

Poster activity? Or sharing ball?

What are some ideas you have for implementing PITC in your facility?

Consider the following:

- Are you practicing PITC in all of the key departments?
  - If not, what can you do to ensure it happens?
- If you are practicing PITC, do you believe your testing 100% of patients?
  - If not, what can you do to improve the number of people tested?
- Are you keeping records of all persons tested in each department?
  - If not, what can you do to ensure proper records are being kept?

TINGATHE TOOLKIT

Instructions:

1. Ask participants to describe different ideas they have for implementing PITC strategies in their sites, including the incorporating PITC register into some departments. This should be a free brainstorm session.
2. Can list all suggestions on a flip chart paper.
3. This discussion should help segue into developing a POA for a specific department.

Exercise #3: Making a POA

1. **To understand how to make a PITC POA.**
2. **To develop a POA for one (or more) or your facility departments struggling with PITC.**

POAs should include:

- Responsible contact person
- Testing Roster
- Procedure of Flow Chart for flow of patients
- List of tools needed
- Goals and Progress Reports
- Other ideas for improvement
- Reporting Plan

TINGATHE TOOLKIT

- Discuss each point of the POA as participants follow along with hand out.
- Let sites decide which department they'd like to make a POA for.
- Go through the example (ANC) on the next few slides
- Break out into groups by site (for large site groups, can split up into two groups and give each group a different department. One coordinator/in-charge should be with each group).
    - Each group should nominate a writer.
    - Give each group a piece of flipchart paper and markers to write their flowcharts/SOPs on.
    - Remind groups to NOT do #7 Reporting Plan, until the next break out session.

EXAMPLE – ANC

- Current status:
  - PITC is usually offered to all women by the nurse in-charge at ANC
- Person Responsible for Implementing POA:
  - HTC Coordinator and Nurse in-charge of ANC department
- Responsible Person:
  - Nurse in-charge of ANC department
- Testing Roster:
  - ANC happens Tues and Thurs morning from 8-12
  - There is a counselor always present for Tues testing, but OTP also happens on Thursday morning and the counselor is sometimes too busy to test both ANC and OTP
  - HDAs can FILL THE GAP – and take over ANC testing on Thursdays, so the other counselor can take over OTP testing

TINGATHE TOOLKIT

EXAMPLE – ANC

- Flowchart/Procedure:
  1. HTC Counselor makes a short health talk at all ANC about the importance of PITC, PMTCT and explains that testing is now a routine part of care
  2. Counselor takes women in groups of three (who are not already diagnosed with HIV) and escorts them to the HTC testing room.
  3. Counselor provides HTC to the first group, goes back to report results to the clerk who fills the register and gets another group.
  4. All HIV-infected women identified will be referred to ART care.

TINGATHE TOOLKIT

EXAMPLE – ANC

- Flowchart/Procedure:
  1. Counselor will help screen women during all ANC appointments (first appointment, and subsequent appointments) to ensure all women are being offered a test
  2. ANC and HTC counselor will meet monthly to discuss the flow and progress of the plan

TINGATHE TOOLKIT

EXAMPLE – ANC

- List of Tools Needed:
  - ANC Register
  - PITC Health Talk
- Goals and Progress
  - Make a meeting with the ANC nurse, review POA and see if feasible within the next week
  - Make a PITC health talk for the HDA
  - Finalize testing roster and health talk roster

TINGATHE TOOLKIT

EXAMPLE – ANC

- Other Ideas
  - Provide a patient escort who can offer in-depth pre-ART counseling and support to newly diagnosed mothers
  - Have a monthly meeting with ART nurse in-charge and counselors to review collected data and improve practices
- Reporting
  - An HDA is responsible to go check the ANC register weekly to ensure HIV status is recorded appropriately

TINGATHE TOOLKIT

Exercise #4: Challenges and Solutions to Implementing ACF Strategies

- Each site will have different challenges when implementing ACF strategies
- We want to go over some possible challenges you will face and some potential solutions to prepare you

- Use other facility's suggestions to help improve your own
- Continue to make note of challenges and solutions so that you can share them at our follow up meetings

TINGATHE TOOLKIT

Instructions:

1. Hang 5-6 flipchart papers up. Each sheet should be split into three sections: Challenge, HDA, Supervisor
2. Ask each group for ONE challenge in implementing PITC and write it at the top of each sheet.
3. Give participants 5 minutes to discuss/brainstorm solutions to each challenge.
4. Go around the room and ask for ONE solution per group and write it on the sheet below the challenge. If it is something the HDA can do or supervisor.

Examples of Challenges and Solutions:

<u>Challenges:</u>

*getting HCW buy in - could be due to lack of knowledge or attitudes
*overworked staff
*seen as not part of core duties of HCW
*HDA not always recognized as HCWs
*need coordinated system to make sure all get tested

<u>Solutions:</u>

*PITC sensitization with all staff/team-approach
*HDAs focus on PITC – better coverage with a dedicate cadre
*integrate HDAs into departments – relationship-building
*QI teams to identify areas of weakness and test system improvements)

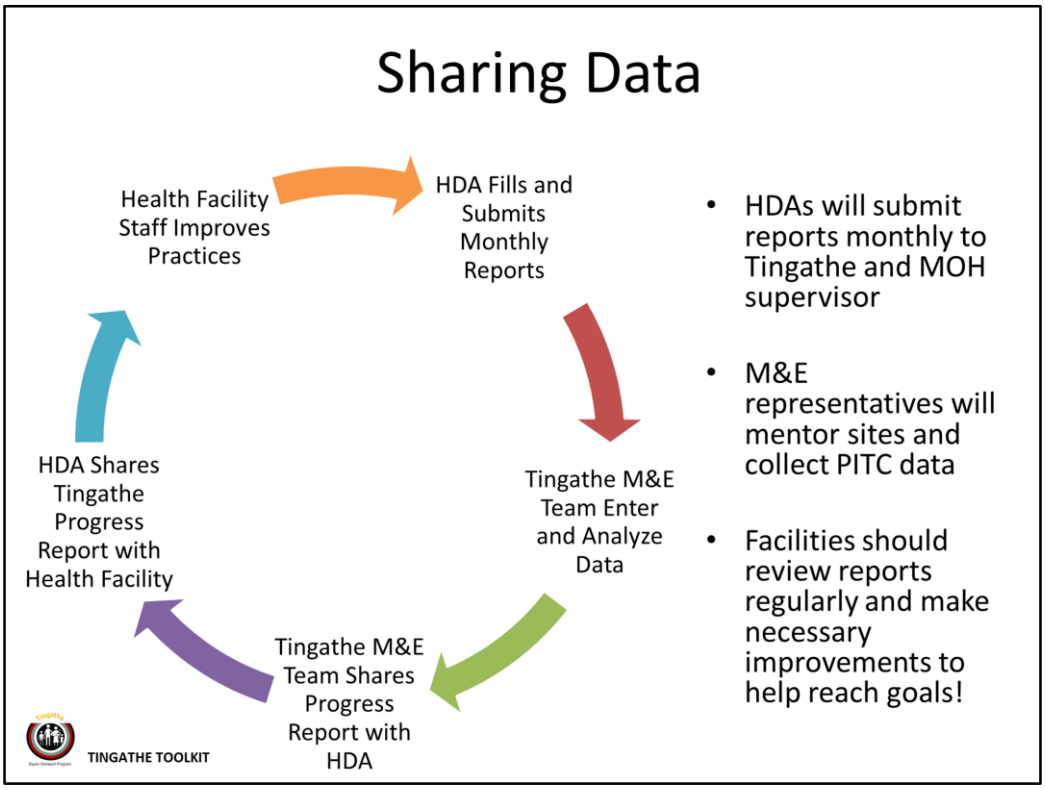
M&E REVIEW

TINGATHE TOOLKIT

Importance of M&E

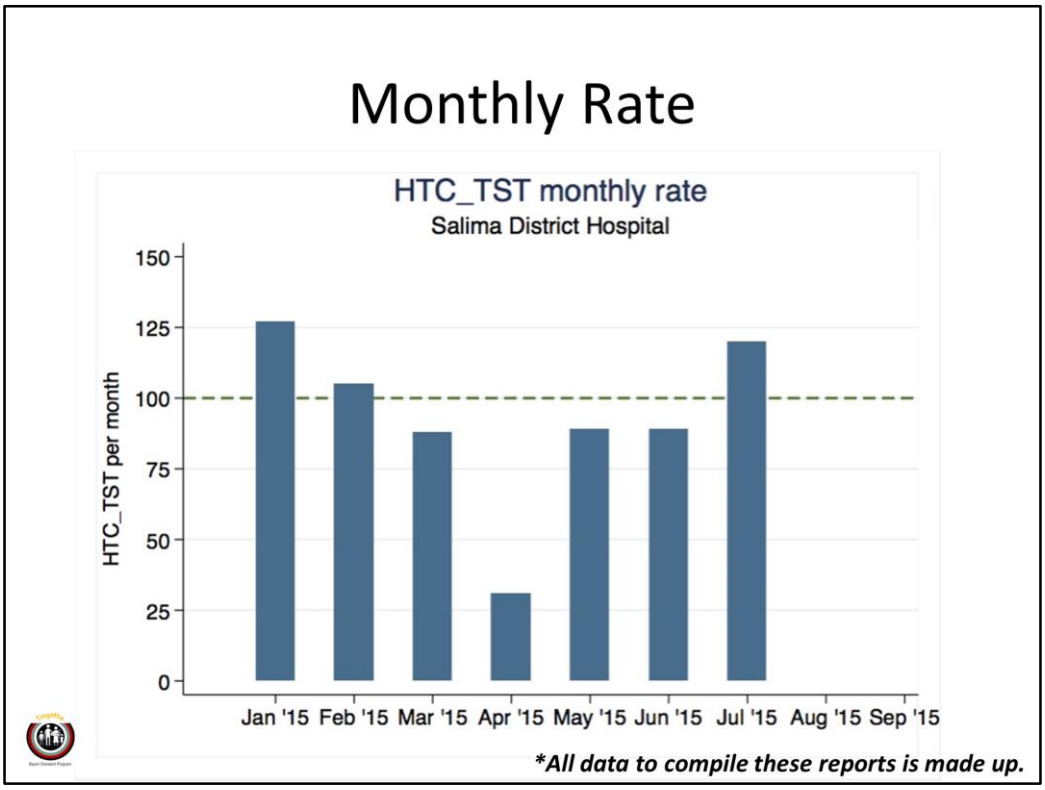
- Need to ***MEASURE*** our progress and see the impact HDAs are having on your health facility.
- This information can help guide the program and *best practices* for PITC and linkage.
- By properly recording data, you will be able to show everyone that HDAs are **successfully** filling gaps in the health facility and working with all team members to accomplish the facility's goals for improving PITC and increasing identification and linkage of HIV-infected children!

TINGATHE TOOLKIT



Explanation:

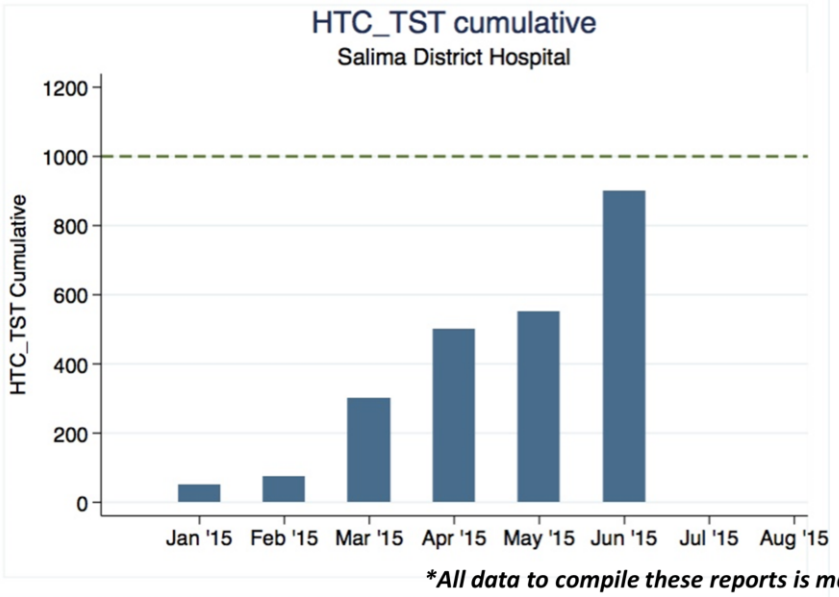
- The next few slides give examples of what the progress reports for the Tingathe M&E team will look like. These should be shared with all HDAs at the facility and MOH staff to see testing progress over time.



Monthly Rate

- Will get two, one of each to show you:
    - how many HIV tests are done every month
    - how many children are enrolled in HIV services every month
- Will have target line which shows the country's target for testing at your facility per month
- Can compare the numbers between months to decide what new activities should be added to reach the target

Cumulative

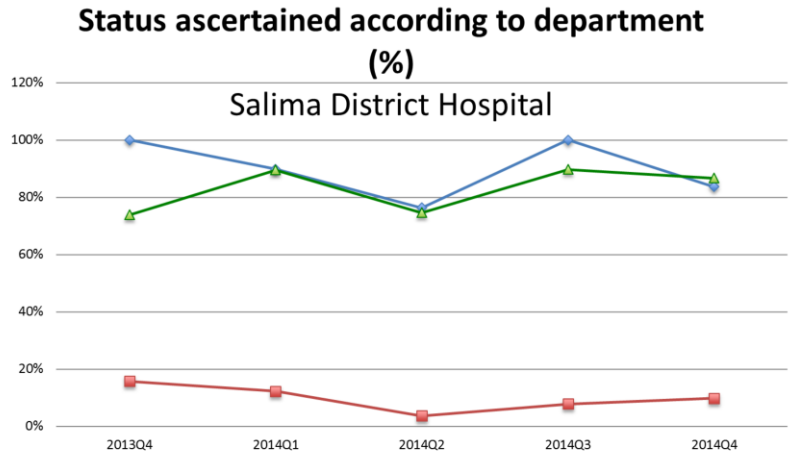


All data to compile these reports is made up.

Cumulative

- Will get two, one of each to show you:
  - how many cumulative HIV tests have been done at your site ever
  - how many cumulative child enrollments at your site ever
- Will have target line which shows the country's target for testing at your facility for the year
- Can see your progress toward the big target

PITC Status in Outpatient Depts.



TINGATHE TOOLKIT

ANC Maternity (retesting only) STI

All data to compile these reports is made up.

PITC Status

- Shows the percentage of patients that have been tested in all key departments
  - Number tested (status ascertained) / Total registered
- Can compare across months and departments
- Target for all departments is 100%

Performance Comparison

Zomba District—2015Q4 Indicator Overview

Site Name	HTC_TST Done 2015Q4	Percent of quarterly target	TX_NEW Done 2015Q4	Percent of quarterly target
Machinjiri Health Centre	495	177%	50	172%
City Clinic Zomba	358	139%	89	193%
Domasi Rural Hospital	408	128%	60	107%
Magomero Health Centre	436	115%	70	100%
Chilipa Health Centre	325	81%	75	127%
Lambulira Health Centre	400	89%	50	82%
Chingale Health Centre	375	78%	24	86%
Chamba Health Centre	324	67%	20	50%
Bimbi Health Centre	167	58%	40	71%
Likangala Health Centre	180	38%	39	55%
Chipini Health Centre	154	37%	40	56%
Makwapala Health Centre	85	26%	30	57%

TINGATHE TOOLKIT

All data to compile these reports is made up.

Performance Comparison

- Shows how close each site has gotten to their target
  - % = actual/target
  - All site targets are different
- Can compare your performance in HIV testing and child enrollments to other facilities in your district
- Can use it to ask and learn from other facilities their best practices and techniques
- Target for all facilities is 100%

Note: Comparing rates across health facilities within the same program can create a health competition, encouraging performance for all facilities.

Distribution of Site Supplies

Each health facility should have:

- PITC Register for each inpatient ward
  - x2 pediatric and x1 adult
- PITC Monthly Reports
  - x3 copies – x1 to submit to program; x1 to submit to MOH site staff; x1 to keep for records

TINGATHE TOOLKIT

Take Home Points

- PITC is an important way to identify HIV+ cases and link them to care.
  - Early diagnosis and treatment will improve the health of people living with HIV.
- The registers and PITC reports allow us to (1) evaluate our progress (2) share our successes and lessons with others.
- We can improve coverage & documentation of PITC in wards and nutrition program – but we need to work as a team and keep good records of what we are doing.

TINGATHE TOOLKIT

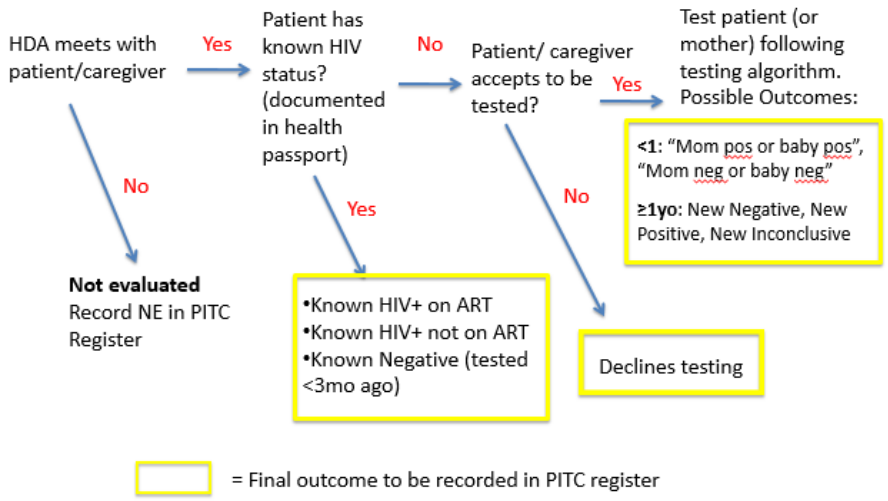
Purpose: This SOP explains the PITC process on inpatient wards and gives instructions on the use of the Adult In-Patient PITC Register and the Paediatric In-Patient PITC Register. The registers were designed for use by HIV Testing and Counseling (HTC) providers in in-patient wards that do not keep a clear record of every patient's HIV status.

Program Tools: Adult PITC Register (for use on adult wards; patients ≥15 years), Paediatric PITC Register (for use on paediatric wards and nutritional rehabilitation unit (NRU); patients <15 years).

Procedure:

1. Enter all new admissions/registrations into the PITC register each day, one patient per line. Only enter the names of the patients admitted to the ward. Do not enter the name of the patient's mother into the PITC register, even if she is tested on the ward. **(All persons tested should be entered in the HTC register per usual protocol.)**
2. Complete patient status based on PITC flowchart (Figure 1) and testing algorithms described below. The **PITC Flowchart** helps guide the HTC provider through all the steps needed to properly ascertain a patient's HIV status.

Figure 1. PITC Flowchart



3. If a patient does not receive any counseling/testing assessment from an HTC provider, the patient is recorded as Not Evaluated. These patients were entered into the PITC register on admission, but the HTC provider never evaluated and counseled the patient about PITC or offered a test. Evaluation date, patient status, and linkage columns are left blank.
   - Common reasons for this outcome in the inpatient setting include: busy ward with multiple new admissions, weekend admissions when there is no designated HTC provider, or difficulty accessing a patient who is receiving multiple ancillary services or critical care.
4. When the HTC provider evaluates a patient, s/he should first assess if the patient should be offered an HIV test or has a known HIV status by reviewing the patient's medical records (e.g. health passport book).

   The patient should be offered an HIV test if:
   - Never tested before
   - Tested negative more than 3 months ago (or test after 1 month if high risk exposure – follow HTS risk assessment guidelines)
   - Claims to have been tested any time in the past, but without documentation (being on ART counts as documented evidence). *[Source: Malawi Integrated Clinical HIV Guidelines, 2016]*

The patient should NOT be offered an HIV test if:

- *Known HIV+ on ART, Known HIV+ Not on ART, and Known HIV-:* These outcomes are used for patients who have a previous HIV status documented in the health passport book **and** do not need a repeat test.
  - If a patient tested HIV-negative more than 3 months ago, do **not** mark 'Known HIV-' as the patient's outcome. The patient should be offered an HIV test.
  - For known HIV+ patients, the HTC provider should assess whether the patient is enrolled in HIV care and on ART.

5. If the patient does not have known HIV status, the patient should be offered an HIV test. The HTC provider should counsel the patient on the importance of knowing his/her HIV status. HIV testing is not mandatory and patients have the right to decline HIV testing.

   Declined: This outcome is used if patient or caregiver (for patients under 13 yo) refuses HIV testing after appropriate counseling.

6. If the patient consents for testing, the HTC provider should follow the **PITC testing algorithms** (Figures 2-4) based on patient age (<12mo, 12-24mo, >24mo). Outcomes to be recorded in the PITC register are highlighted.

Figure 2. PITC Testing Algorithm for Patients < 12months

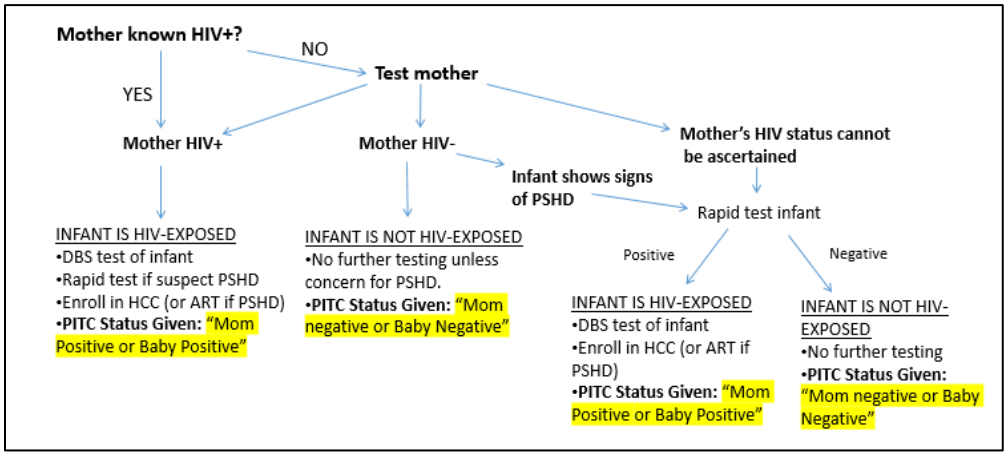


Figure 3. PITC Testing Algorithm for Patients 12 – 24 months

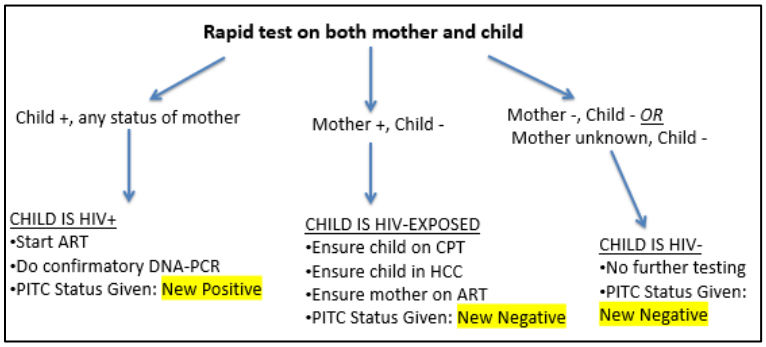
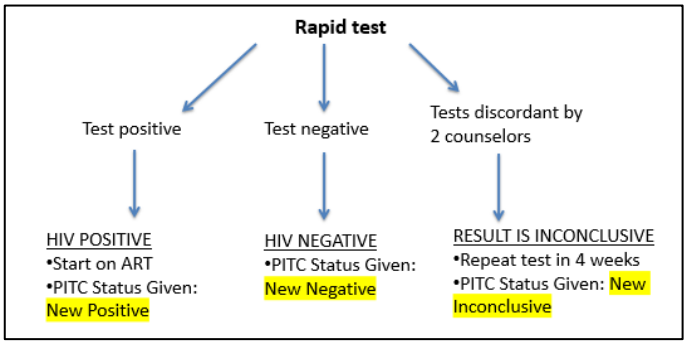


Figure 4. PITC Testing Algorithm for Patients > 24 months



Instructions: Distribute one copy of this hand out along with a blank sample of the register and monthly report form for reference to each participant. Participants will be prompted throughout the workshop to complete the exercises.

Exercise #1: You, a HDA, determine the HIV status of patients in a pediatric inpatient ward and enter them into the PITC register. See the following description of the cases to determine your next steps. For all questions in *italics* – the response will be given to you by the facilitator.

Case 1. Atupele Kambeze is a 7mo old female admitted to the hospital for diarrhea. The child has never been admitted before, is otherwise healthy per the mother and has good nutritional status with W/H~0 and MUAC 13.5.

- What testing do you do? _____
- *HIV Status of mother is:* _____
- What do you do? _____
- Complete the PITC Register for this patient.

Case 2. Alinafe Chionda is a 18 mo old girl admitted to the ward for pneumonia. She has never been admitted to the hospital before. She is still breastfeeding. Mother tested HIV- at the time of delivery.

- What testing do you do? _____
- *HIV status of mother:* _____ *HIV Status of Child:* _____
- What do you do? _____
- Complete the PITC Register for this patient.

Case 3. George Banda is a 7mo old male admitted to the hospital for diarrhea. The child has never been admitted before, is otherwise healthy and has good nutritional status with W/H~0 and MUAC 13.5.

- *What do you do next?* _____
- What testing do you do? _____
- If the rapid test is positive, what do you do?
  - Child is HIV exposed. You ensure child is enrolled in HCC and DBS is done (HCC number is 0001).
  - Clinician to evaluate if child meets criteria for PSHD/ needs ART. In this case, child does not meet criteria for PSHD and doesn't need ART.
- Complete the PITC Register for this patient.

Case 4. James Chikondi is a 5 year old boy admitted for malaria. He is otherwise healthy. He was last admitted to the hospital 1 year ago for diarrhea.

- When you look at the health passport book, you see HTC documented from the admission 1 year ago & HIV status was negative.
- What testing do you do? _____
- Test result is negative. Complete the PITC Register for this patient.

Case 5. Linly Tembo is a 6mo old girl admitted to the ward with malaria. She is a known HIV exposed infant (mother is HIV+ on ART). She had neg DBS at 6wks and is followed in HCC.

- What testing do you do? _____
- Complete the PITC Register for this patient.

Case 6. Peter Chileka is a 12 year old boy admitted to the ward. The caregiver says the child's HIV status is unknown. There is no record of testing in his health passport book.

- What testing do you do? _____
- After testing HIV+, you find out from the caregiver that the boy is actually known to be HIV-positive and on ART (but not yet disclosed).
- Complete the PITC Register for this patient.

1. **In which department do you want to scale up PITC activities?** _____

2. **Describe the current status of PITC in this department.** *Discuss what steps your facility is currently taking to implement PITC in this department. Describe who is currently doing the testing and where the gaps in providing PITC are.*

   _____
   _____
   _____
   _____

Developing a Plan of Action for Implementing PITC

3. **Choose a leader for your plan of action.** *This person will take the lead in implementing and monitoring the plan of action to ensure it is in place and working well. Write that person's name and title below.*

   - _____

4. **Choose a responsible contact person from that department.** *This person will be responsible for answering questions and monitoring the flow of PITC and record keeping within that department. Person should be familiar with department and work closely with HCWs and other HTC staff to ensure the PITC activity is working well. List two potential candidates for this position below.*
   - _____
   - _____

5. **Determine a Testing Roster.** *A testing roster ensures that there is always a HIV counselor and space available to perform PITC during all times the department is open. Consider night, weekend and holiday testing as well.*

	Mon	Tues	Wed	Thurs	Fri	Sat	Sun
Times Dept is Open							
Counselors Already Present							
Location of Testing							
Additional Counselors Needed?							
Notes							

6. **Make a Standard Operating Procedure and/or Flowchart.** *A standard operating procedure or flowchart outlines the steps needed to be taken to complete a task. Remember to include the following tasks within your procedure:*
   - *The role of each person in the department to ensure PITC is happening*
   - *How and who will screen patients to determine if they are eligible for PITC*
   - *Where will you test and how patients will get to and from the testing location*
   - *How and who will record the results of the test in the department register after it is finished*
   - *How a patient diagnosed with HIV will be referred for other HIV services*
   - *Who and when PITC promoting activities (i.e. health talks, etc) will be performed*
   - *How special situations will be handled (i.e. night, weekend and holiday testing, etc)*
   - *How and how often the Responsible Contact Person can follow up with PITC activities and ensure everything is being done correctly*

7. **List the Tools Needed to Accomplish PITC.** *Make a list of additional tools and reference materials you can use to assist you with PITC in this department. Be specific. Can include: registers, flip charts, pamphlets, posters, etc.*

   _____
   _____
   _____

8. **Goals and Progress Reports.** *It is important to set goals and make a plan to work toward them. The goal for all departments is to reach 100% of people being offered an HIV test, but this may take some time to reach for many departments. Make a few short-term, SMART goals for this department and outline steps on you will monitor progress.*

   Specific – defines who, what, when, where, how, why
   Measurable - describes how much/many and how you will know goal is accomplished
   Attainable – something that your team is both willing and able to achieve
   Realistic – goal should be something your team that can be achieved with available resources
   Timely – attach a specific date to complete

   List two PITC goals you would like to accomplish in this department in the next two months.

   1) _____
   2) _____

   How will you monitor these goals? Can include items such as: daily checks by responsible person, monthly meetings with HTC and department team members, etc.

   _____
   _____
   _____

9. **Other Ideas.** *You may have some ideas that are not SMART at the moment, but could be implemented later when your proposed PITC program is working and/or if more resources become available. List those ideas below.*

   _____
   _____
   _____

10. **Reporting Plan.** *Monitoring and evaluation are an important part of knowing how well your PITC Program is working within your facility. Develop a reporting plan below, considering the following questions.*

    - *Will you be able to collect all needed information from existing department registers? If not, how will you ensure all needed data can be recorded and collected (e.g. insert columns, introduce a PITC register, etc.).*

      _____
      _____

    - *How will data and progress be shared with other team members (e.g. posting data and progress toward goals in department office, monthly review meetings, etc.)?*

      _____
      _____

    - *What steps will you take to properly evaluate information and apply changes based on the performance (i.e. monthly meetings, etc)?*

      _____
      _____

Name: _____ **Date:** _____ **Final Score Practical:** ____ / _____

Instructions: This exam has two sections: PITC Register and PITC Monthly Report. Please complete all sections according to the *instructions in italics* given in each section. Complete all page summaries.

Section 1: Pediatric PITC Register

PITC Case 1: Patient B.A. is a 14 mo old girl admitted to the ward for pneumonia. She has never been admitted to the hospital before. She is still breastfeeding. Mother tested HIV negative at the time of delivery. You test the mother and her test result is positive. You then test the infant and get a positive test. Complete the PITC register for this patient.

PITC Case 2: Patient C.D. is a 6 year old girl admitted for malaria. She is otherwise healthy. She was last admitted to the hospital 1 year ago for diarrhea. When you look at the health passport book, you see HTC documented from the admission 1 year ago & HIV status was negative. You retest her because her last HIV test was more than 3 months ago. Test result is negative. Complete the PITC Register for this patient.

Date of Admission *(dd/mm/yy)*	Child Name	Sex of Child		Age of Child		Not Evaluated	Date of Evaluation *dd/mm/yy*	Patient (child) HTC status: Pick one status only.									Linkage to Care- EID *(For mom positive or baby positive <1yo)*		HCC Number	Comments
								Testing not done				Testing done								
								Known status				Test Result <1yo		Test Result ≥1yo			DNA-PCR DONE?			
		Male	Female	0-11 months	1-14 years			Known positive, on ART	Known positive, not on ART	Known negative (tested <3mo ago)	Declined	Mom positive OR baby positive	Mom negative OR baby Negative	New Negative	New Positive	New Inconclusive	Yes	No		
		M	F	A	B	NE		ART	Kn+	Kn-	D	M/B+	M/B-	N-	N+	Nin	Y	N		
		M	F	A	B	NE		ART	Kn+	Kn-	D	M/B+	M/B-	N-	N+	Nin	Y	N		
Totals Fill at the end of each page (15 rows per page)																				
								A1	A2	A3	A4	B1	B2	B3	B4	B5				

Section 2: Monthly Report

Instructions: *Use the registers to complete the Monthly Report. You will use the data from the PITC Register (PAGE 1). Leave M&E Check blank.*

PITC Monthly Report: USE REGISTER ON PAGE 3

Indicator	Description	Data Location	Site Result	M&E Check
		PITC- NRU		
NR. 1	# Admissions	NRU Register		
NR. 2	# Evaluated	PITC Register [Sum of A1 to B5]		
NR. 3	# Known positive	PITC Register (Box A1+A2)		
NR. 4	# Known negative	PITC Register (Box A3)		
NR. 5	# Refused testing	PITC Register (Box A4)		
NR. 6	# <1 Mom HIV+ or Baby HIV+	PITC Register (Box B1)		
NR. 7	# <1 Mom HIV- or Baby HIV-	PITC Register (Box B2)		
NR. 8	# New negative	PITC Register (Box B3)		
NR. 9	# New positive	PITC Register (Box B4)		
NR. 10	# Inconclusive	PITC Register (Box B5)		

Comments:

Health talks are designed for community health workers to sensitize and educate members of the community about issues that affect their health and the services offered at the facility within the scope of HIV/AIDS. Health talks are recommended to be about 20-30 minutes long and given in a common area of health facility before services are available and/or while patients are waiting to see a clinician or nurse. Health talks can also be performed within the community in support groups, during targeted community activities, and during HIV outreach activities.

Section 1: Planning for the Health Talk

1. Tingathe staff should communicate daily with patients, clinical staff, and community leaders and take note of any of the following:
    a. Health-related issues that patients, staff or community leaders don't understand or are misinformed about (e.g. medical services or medical knowledge)
    b. Complaints or concerns
    c. Gaps in their knowledge
2. The Site Supervisor should decide, along with the CHW team, the schedule and topics of health talks (see list of ***Health Talk Topics*** below). While choosing topics the following points should be considered:
    a. Any issues discovered above
    b. Where the health talk will be held
    c. The target audience
    d. The needs of the target audience
3. Choose a presentation form (drama, talk, discussion, etc) that may best convey the topic you are trying to teach and fits best with the current audience.
4. Compose a script or outline of what to say. Have SS/Asst. SS and/or other CHWs review and make comments as needed.
5. Confirm the time, date, and place of the health talk with the Site Supervisor.
6. Ensure that there is a procedure in place such that any patients who choose to be tested immediately after the talk can do so.

Section 2: Presenting the Health Talk/Drama

1. Arrive at the clinic waiting area early and be prepared to give the health talk while the waiting area has many patients.
2. Greet the audience.
3. Introduce yourself as health facility personnel.
4. Explain the topic you will be presenting.
5. Give the Health Talk. Remember the following tips when presenting:
    a. Be confident and know the material well
    b. Be loud and move around while speaking
    c. Engage your audience and encourage participation and questions
    d. If someone asks a question you don't know the answer to, tell them you don't know but you will find out
6. Hold a question and answer portion at the end to clarify any points and to check for audience understanding.

Section 3: Supervision of the Health Talk

1. On a regular basis, health talks should be observed by the Site Supervisor to ensure accurate and appropriate messages are being given to clients.
2. Following the health talk, the SS should give feedback to the CHW who presented the health talk. During the feedback session the SS should cover the following points:
    a. Appropriateness of content
    b. Accuracy of content
    c. Knowledge and presentation of material, especially when answering questions
    d. Presenting skills (projection of voice, speed, moving around while speaking, etc)
    e. Audience participation
    f. Generally what went well and what did not go well
3. Have an open discussion of how to improve that health talk and others in the future.
4. Discuss any issues brought up by participants that could be incorporated into the next health talk.

Section 4: Health Talk Topics

HIV Testing and Counseling (HTC)

Key Talking Points:

1. Importance of getting tested
    - a Start medication as soon as possible to stay healthy
    - b Keep spouse and children healthy by preventing spread of infection
2. Different methods of HTC
    - a Individual, group, family, with spouse
    - b At home or at health center
3. How and where they can be tested
    - a The procedure of HTC (first counsel and answer any questions, then tested and given results, further counseling)
    - b Different facilities and organizations that offer testing (heath facility, Tingathe, other organizations)
    - c Confidentiality
4. Future of living with or without the disease
    - a Testing others in the family
    - b Positive living
    - c Disclosure
    - d Support groups (PLWHAS, Mothers 2 Mothers, Tingathe, etc)
    - e Medication and ART

Activities:

- ✓ Have audience give reasons why people do not get tested and correct any misconceptions
- ✓ Do a drama which shows the whole process of HTC (person decides to get tested, goes to health facility to be tested, counselor performs HTC, person is positive—finds ways of living with HIV/AIDS)
- ✓ Show people where HTC is done within the health facility
- ✓ Ensure there is a procedure in place such that any patients who choose to be tested immediately after the talk can do so
- ✓ Have someone who is living with HIV give a testimonial on when/how they decided to be tested

Provider-Initiated Testing and Counselling (PITC)

Key Talking Points:

1. Why should you get an HIV test when you visit the health facility?
    - a Entry point to care and allows clinician/nurse to diagnose properly
    - b Start ART as soon as possible to allow you to live a long and healthy life
    - c Protect your loved ones from contracting HIV
2. If you are not offered an HIV test, you should ask for one
    - a Empower patients that their health is their responsibility and getting an HIV test can help them plan for a healthy life
3. Patients have a right to confidentiality - this a priority for counselors. If patients suspect someone has breached confidentiality, it should be reported
4. HIV services offered in the facility
    - a HCC and ART
    - b Partner testing and counselling
    - c Child and Adolescent services, teen clubs, etc
    - d Disclosure
    - e Support groups
    - f Linkage to Care and PMTCT programs through Tingathe (and other organizations)

Activities:

- ✓ Drama display to show the process of PITC
- ✓ Have audience give reason why people do not get tested and correct any misconceptions
- ✓ Explain where HTC is done within the health facility
- ✓ Have someone who is living with HIV give a testimonial on when/how they decided to be tested
- ✓ Ensure there is a procedure in place such that any patients who choose to be tested immediately after the talk can do so

Viral Load

Key Talking Points:

1. What is viral load and why do you do it?
    - a Blood test to measure the amount of HIV in your body
    - b More virus = faster destruction of immune system = more sick and higher risk of transmission
    - c Can be used to check for resistant viruses and to help monitor adherence
2. When and how will a viral load be taken?
    - a 6 months after starting ART and routinely every two years after that if adherence is good
    - b May ask for additional test to be done if clinician/nurse suspects that your medicine is not working
    - c Dried blood spot (DBS) done similarly to how infants are tested for HIV
3. What do I want my viral load to be?
    - a If you are adherent to your ART, your VL should be low – this is what you want!
    - b If your VL is high (or you are non-adherent) you are at risk for:
        - i Becoming more sick
        - ii Getting a resistant virus
4. Methods of staying adherent to ART

Activities:

- ✓ Use pictures on flipchart to describe what viral load is
- ✓ Use pumpkin poster on flipchart to describe resistance
- ✓ Allow patients to share the different methods they use to remember their ARTs
- ✓ Demonstration of how a DBS is taken

General HIV/AIDS Information

Key Points:

1. Definition
    - a What HIV is (virus which kills the "soldier cells" of the body, which causes the immune system to become weak)
    - b Difference between HIV and AIDS
2. Ways of transmission
    - a Sex, blood, childbearing
3. Prevention
    - a Condoms, abstinence, single partner
    - b PMTCT care (through Tingathe)
    - c Not sharing used needles, touching other people's blood, etc
    - d Getting tested early and knowing your status!!
    - e Ways HIV is <u>not</u> transmitted
4. Treatment
    - a ART
    - b CPT, IPT, etc
5. Relationship between HIV and:
    - a STIs: higher risk of contracting and transmitting STIs, so should always wear a condom during sex
    - b TB: people with HIV have a higher risk of getting sick from TB. If you have a cough, fever, night sweats or unplanned weight loss, you should tell the doctor

Activities:

- ✓ State different forms of transmission of HIV/AIDS and have the audience decide whether it is a myth or a fact, if wrong, correct the myth
- ✓ Do a demonstration of how to use a condom and pass them out after
- ✓ Show people where HTC is done within the health facility
- ✓ Have an option for any who want to be tested right after the talk a way to be tested immediately

Nutrition

Key Points:

1. What nutrition is and why it's important
    - a Getting the right amount of the right kind of foods every day
    - b Important to grow, stay healthy, prevent infections
2. Six Food Groups
    - a Vegetables, Fruits, Legumes and Nuts, Animal Foods, Fats, Staples
3. Eating a well balanced diet
    - a Try to eat foods from each of the food groups every day
    - b Be creative and try to use the food growing around you to fulfill your needs
4. Malnutrition
    - a Can be caused from various things: starvation, other infections (HIV, TB, etc), diarrhea, etc
    - b Effects of malnutrition: stunting, marasmus, and kwashiorkor

Activities:

- ✓ Give examples of different foods in each of the six food groups
- ✓ Make a poster of the six food groups and different examples of meals to hang in the health facility
- ✓ Have group plan out different kinds of meals which include all food groups (encourage them to be creative!!)
- ✓ State how each food can help you (e.g. proteins from meat help you build muscle and repairing body, fats from groundnut oil help your body absorb vitamins, fruits and vegetables provide vitamins to keep the body strong, etc)

Hygiene

Key Points:

1. Importance of good hygiene
    - a Staying healthy
    - b Preventing infection (TB, diarrhea, etc)
2. Practicing good hygiene
    - a Body Hygiene: bathing, washing and ironing clothes, brushing teeth
    - b Household Hygiene: good ventilation, clean kitchens and toilets, having a rubbish pit, hanging clothes on a drying rope, defecating only in the toilet, having a drying rack
    - c Food Hygiene: washing hands before preparing and eating food, wash vegetables and fruit before eating, left over foods should be reheated before heating, cook meat thoroughly, drink and cook with clean water
3. Teaching children good hygiene practices

Activities:

- ✓ Have audience list different ways they remain hygienic in their households
- ✓ Have someone from environmental section describe the benefits of open defecation free villages (Key goal of Malawi)
- ✓ Give different examples of ways to stay hygienic
- ✓ Do a demonstration of how to: make a hand washing station for their toilets, build a better toilet, make a drying rack for dishes, etc

Adherence

Key Points:

1. What adherence is
    - a Taking medicine EXACTLY as prescribed (only your medicine, every day)
    - b Done for all medication, not just ART
    - c Taking medication for as long as it's prescribed, not just until you feel better
    - d Storing medication properly
2. Benefits of good adherence
    - a Better health and a stronger immune system
    - b Lowers chance of transmission of HIV from mother to child or spouse
    - c Lowers the chance of developing a resistant virus; allows current medication to work for longer
3. Strategies for good adherence
    - a Keep a diary
    - b Take it at the same time as other family members who are taking ART
    - c Set a reminder on your phone
4. Results of poor adherence
    - a Sickness
    - b Increased risk of HIV transmission to child and/or spouse
    - c Resistance
    - d Treatment failure
5. Keeping clinic appointments

Activities:

- ✓ Demonstrate how to give certain types of medication to children
- ✓ Have people with good adherence to medication come and share their techniques for good adherence
- ✓ Comedy: Two friends are on ART but have different regimens (2A and 5A). One friend runs out of his mediation and goes to his friend to ask to take his. The other friend gives him his medication, although it is not the same. The friend, who is now taking the wrong medication, becomes very sick due to side effects. The two friends go to the clinic together and discover the risks of not taking medicine as prescribed.

Family Planning

Key Points:

1. Meaning of Family Planning
    - a Clarify that family planning means having the number of children you want when you want them
    - b Applies to people who want children and those that do not want children
    - c Women have a right to decide when/if they want to have children
2. Methods of FP
    - a Dual Method (condom + second form)
    - b IUD, Depo, condom, injection, LAM, sterilization
3. Advantages and disadvantages
    - a Of each FP method
    - b Highlight that it allows you to have the number of children you want, when you want them
    - c Dual method lowers chance of pregnancy and STI transmission
4. Places to access FB methods
5. Dispel myths

Activities:

- ✓ Demonstrate how to use a condom
- ✓ Distribute condoms
- ✓ Have multiple different women come in to discuss the advantages and disadvantages of their own personal birth control
- ✓ Demonstrate how family planning
- ✓ Give examples of how to make a family plan with the spouse and certain key points to cover
- ✓ Show where and who people should go in the health facility to access FB options
- ✓ Make a poster with the different types of contraceptive methods
- ✓ Have audience list anything they know about FP methods and correct any myths that come from it

PMTCT

Key Points:

1. Meaning of PMTCT
    a Preventing mother-to-child transmission of HIV
    b Can lower the chance from ~40% to less than 2% if follow all steps
2. Transmission (when and how)
    a Pregnancy, birth or breastfeeding
    b Long time frame and must be diligent until infant receives his/her final HIV status
3. Prevention and key interventions
    a Adherence to medication
    b Delivering at the health facility
    c Proper testing (DBS and rapid)
    d Breastfeeding techniques
    e Routine HIV testing during pregnancy and breastfeeding; expect a repeat test when at maternity if previously negative or unknown regardless of when previous test was done
4. Maternal factors involved with increased risk of MTCT
    a Poor adherence to medication
    b Poor hygiene and nutrition
    c HIV-Infection during that time
5. Support groups
    a Tingathe
    b Mothers to Mothers, etc

Activities:

- ✓ Make a poster of proper breastfeeding techniques
- ✓ Have groups brainstorm different ways they can be sure to deliver at the health facility
- ✓ Have group leaders (Tinagthe, Mothers to Mothers, etc) speak about how their programs can help assist women

STIs

Key Points:

1. STIs
    a Different types of STIs: Chlamydia, gonorrhea, syphilis, HPV, HIV, herpes, etc
2. Ways of contracting STIs
    a Through sex (oral, anal, or vaginal)
    b Other forms of transmission: rubbing infected part of the body on a non-infected part of the body,
3. Prevention & early screening
    a Use of condoms
    b Going with your partner to be tested and treated
4. Relationship between STIs and HIV/AIDS
    a Higher risk of contracting and transmitting STIs if have HIV
    b Symptoms can be worse
5. Signs & Symptoms of STIs
    a Vaginal itch, sores or bumps on genitals, pain when having sex, pain during urination, discharge
    b Complications: cervical cancer, infertility, chronic abdominal pain, pregnancy outside the womb, transmission to child, miscarriages, mental disorders
6. Treatment
    a Some have cures, but others do not (HPV and HIV)

Activities:

- ✓ Having audience list different types of STIs that they know
- ✓ Showing how and where people can be tested and treated for STIs in the health facility
- ✓ Demonstrate how to use a condom
- ✓ Give methods to discuss STIs with the doctor or the spouse
- ✓ Drama: A woman has signs and symptoms of an STI, but is too afraid to discuss it with her partner. Instead, she goes to the health facility alone and gets treated. A few weeks later, she is re-infected by her partner. She goes to the health facility again and is counseled on how to talk to her partner. She talks to her partner and they go together to get tested and treated for STIs.

This SOP gives instructions on the use of three tools: the Adult In-Patient PITC Register, the Paediatric In-Patient PITC Register, and the Monthly PITC Report for In-Patient Wards. The registers were designed for use by HIV Testing and Counseling (HTC) providers in in-patient wards, but can be adapted for use in any department that does not keep a clear record of every patient's HIV status.

There are two versions of the PITC Register: one **Adult PITC Register** (for use on adult wards; patients ≥15 years old) and one **Paediatric PITC Register** (for use on general paediatric wards and nutritional rehabilitation unit - NRU; patients <15 years old). The **PITC Monthly Report** is a form used to compile PITC data from all departments that the program has focused PITC efforts regardless of the method of record keeping. Using this data, coverage and yield of PITC by testing point can be calculated.

The procedure is separated into six sections:

SCOPE:
The PIT Register part of the procedure is designed for use on the in-patient, short stay and/or NRU wards of any health facility that does not keep a clear record of every patient's HIV status. The PITC Monthly Report can be used to collect data and measure PITC efforts in in patient wards (i.e. those that use the PITC register) and outpatient departments (i.e. departments that do not use the PITC register).

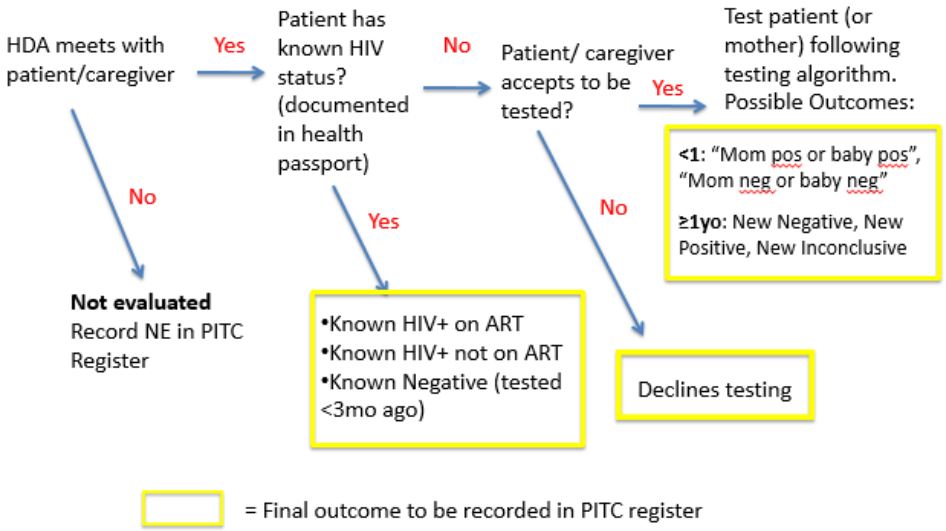
RESPONSIBILITIES:
This is intended for use by HTC providers. HTC should only be done by qualified HTC providers. When/if possible, Ministry of Health (MOH) staff should be trained to complete PITC registers to ensure continuity of documentation.

PROCEDURE:

SECTION 1: OVERVIEW OF THE PITC FLOWCHART AND PITC OUTCOMES

The **PITC Register Testing Flowchart** (Figure 1) helps guide the HTC provider through all the steps needed to properly ascertain a patient's HIV status.

Figure 1. PITC Register Testing Flowchart



All yellow boxes on the flowchart represent potential outcomes of PITC evaluation for patients who are admitted to the hospital. The instructions are written for use in the inpatient wards but can be adapted to other settings. If evaluated, **each patient should only have ONE of the following outcomes**:

Heading	Subheading	Outcome Option	Definition
Testing Not Done	Known Status	Known HIV+ on ART	*Patient has a known HIV+ diagnosis and is taking ART*
		Known HIV+ not on ART	*Patient has a known HIV+ diagnosis but is not taking ART*
		Known HIV-	*Patient had a documented HIV-negative test result within the last 3 months*
		Declined	*Patient refuses testing*
Testing Done	Test Result <1yo	Mom Positive or Baby Positive	*Patient's mother is HIV+ or if the mother's test cannot be ascertained and the patient has a positive rapid test result*
		Mom Negative or Baby Negative	*Patient's mother is HIV- or if the mother's test cannot be ascertained and the patient has a negative rapid test result*
	Test Result ≥1yo	New Negative	*Patient's rapid test result is negative*
		New Positive	*Patient's rapid test result is positive*
		New Inconclusive	*Patient's rapid test result is inconclusive*

Full description of PITC Flowchart:

1. If a patient does not receive any counseling/testing assessment from an HTC provider, the patient is recorded as Not Evaluated. These patients were entered into the PITC register on admission, but the HTC provider never evaluated and counseled the patient about PITC or offered a test. Evaluation date, patient status, and linkage columns are left blank.
    - Common reasons for this outcome in the inpatient setting include: busy ward with multiple new admissions, weekend admissions when there is no designated HTC provider, or difficulty accessing a patient who is receiving multiple ancillary services or critical care.
    - The goal is to minimize the number of patients who are not evaluated/tested.

2. When the HTC provider evaluates a patient, s/he should first assess if the patient should be offered an HIV test or has a known HIV status by reviewing the patient's medical records (e.g. health passport book).

    The patient should be offered an HIV test if:

    - Never tested before
    - Tested negative more than 3 months ago (or test after 1 month if high risk exposure – follow HTS risk assessment guidelines)
    - Claims to have been tested any time in the past, but without documentation (being on ART counts as documented evidence). *[Source: Malawi Integrated Clinical HIV Guidelines, 2016]*

    The patient should NOT be offered an HIV test if:

    - Known HIV+ on ART, Known HIV+ Not on ART, and Known HIV-: These outcomes are used for patients who have a previous HIV status documented in their health passport book **and** do not need a repeat test.
    - If a patient tested HIV-negative more than 3 months ago, do **not** mark 'Known HIV-' as the patient's outcome. The patient should be offered an HIV test.
    - For known HIV+ patients, the HTC provider should assess whether the patient is enrolled in HIV care and on ART.

3. If the patient does not have known HIV status, the patient should be offered an HIV test. The HTC provider should counsel the patient on the importance of knowing his/her HIV status. HIV testing is not mandatory and patients have the right to decline HIV testing.

    Declined: This outcome is used if patient or caregiver (for patients under 13 yo) refuses HIV testing after appropriate counseling.

4. If the patient consents for testing, the HTC provider should follow the **PITC testing algorithms** (Figures 2-4) based on patient age (<12mo, 12-24mo, >24mo).

Figure 2. PITC Testing Algorithm for Patients < 12months

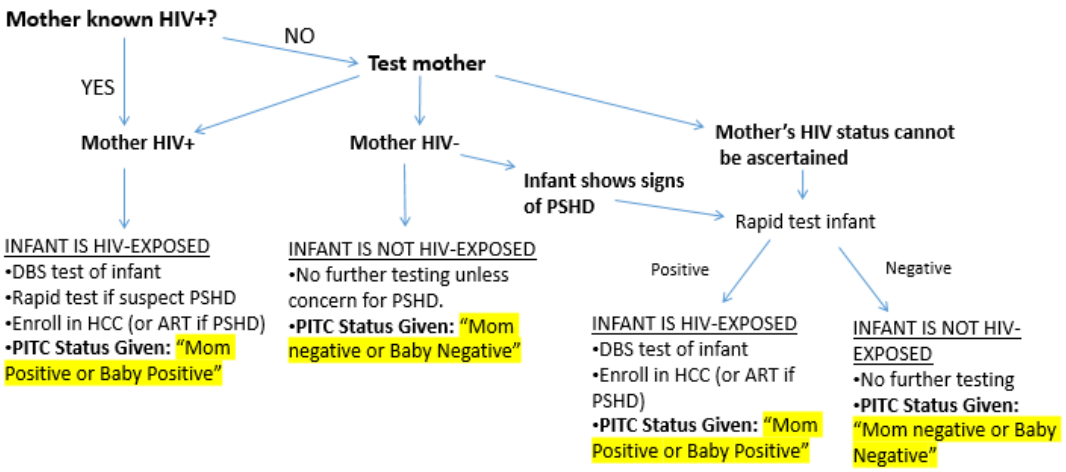


Figure 3. PITC Testing Algorithm for Patients 12 – 24 months

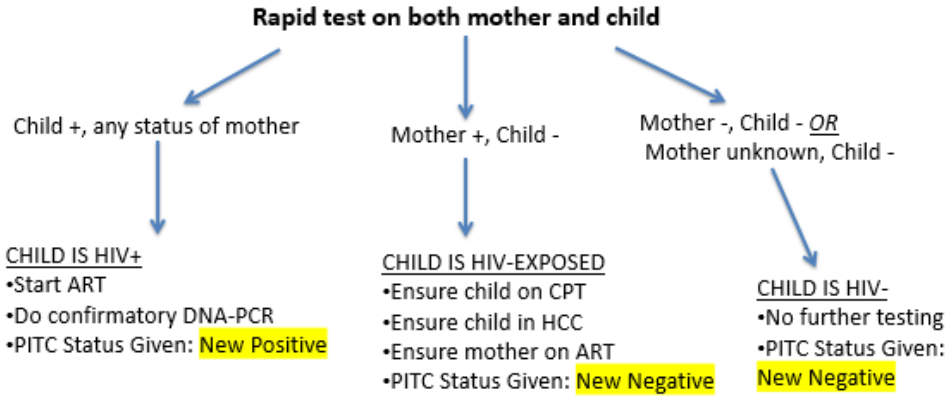
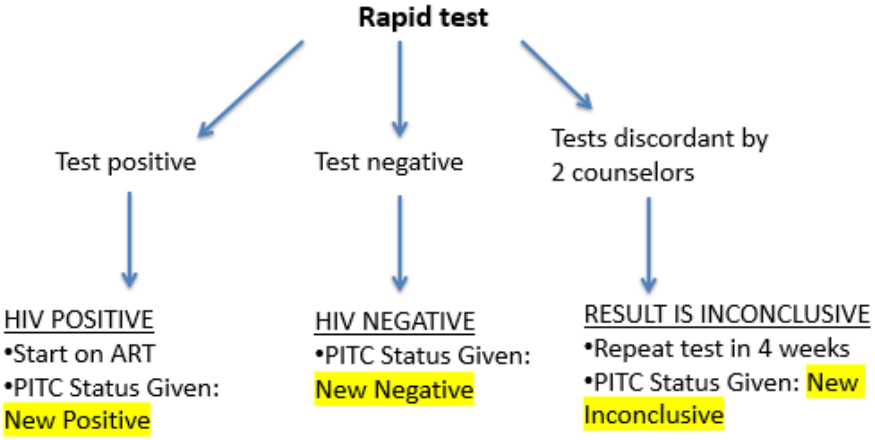


Figure 4. PITC Testing Algorithm for Patients > 24 months



5. The patient will have one of the following testing outcomes:
   - <12mo: Possible results include:
     - Mom Positive or Baby Positive (mother has a known or new positive HIV status; or if mother is not available, child's rapid test is positive)
     - Mom Negative or Baby Negative (mother tests HIV negative; if mother is not available, child's rapid test is negative)
   - ≥12mo: Possible results include – New HIV Positive, New HIV Negative, New HIV test Inconclusive
   - Special scenarios are discussed below [see Section 4. Special Paediatric PITC Cases]

6. Thus, for outcomes **Known status and Declined,** the patient is not tested during the inpatient admission. For **Testing Done** outcomes, either the patient or mother is tested during the inpatient admission (based on PITC algorithm).

7. The date of evaluation is the date that the HTC provider evaluated the HIV status of the patient and should be completed whether or not testing is done.

SECTION 2: INSTRUCTIONS FOR COMPLETING PITC REGISTERS

Instructions are generally the same for both the adult and paediatric registers. The instructions are written for use in inpatient wards, but can be adapted for other testing points.

1. Enter all new admissions/registrations into the PITC register each day. Fill in one patient per line. See Section 3 for details on how to fill in the information for each column heading.

   Notes:
   - All patients on the designated ward should be entered into the PITC Register. By entering all new admissions each day, the HTC provider can track which patients need evaluation for PITC, and the program can gather accurate data on PITC coverage.
   - Only enter the names of the patients admitted to the ward. Do not enter the name of the patient's mother into the PITC register, even if she is tested on the ward. **(All persons tested should be entered in the HTC register per usual protocol.)**

2. Using the PITC flowchart as a guide, circle the outcome of PITC counseling/testing. Only one outcome should be given per patient. Below are samples of the Paediatric PITC Register (Figure 5) and Adult PITC Register (Figure 6), and possible outcomes are highlighted.

Figure 5. Paediatric PITC Register

Date of Admission (dd/mm/yy)	Child Name	Sex of Child		Age of Child		Not Evaluated	Date of Evaluation dd/mm/yy	Patient (child) HTC status: Pick one status only.									Linkage to Care- EID (For mom positive or baby positive <1yo)			Comments
								Testing not done				Testing done								
								Known status				Test Result <1yo		Test Result ≥1yo			DNA-PCR DONE?			
		Male	Female	0-11 months	1-14 years			Known positive, on ART	Known positive, not on ART	Known negative (tested <3mo ago)	Declined	Mom positive OR baby positive	Mom negative OR baby Negative	New Negative	New Positive	New Inconclusive	Yes	No	HCC Number	
		M	F	A	B	NE		ART	Kn+	Kn-	D	M/B+	M/B-	N-	N+	Nin	Y	N		
		M	F	A	B	NE		ART	Kn+	Kn-	D	M/B+	M/B-	N-	N+	Nin	Y	N		
		M	F	A	B	NE		ART	Kn+	Kn-	D	M/B+	M/B-	N-	N+	Nin	Y	N		
		M	F	A	B	NE		ART	Kn+	Kn-	D	M/B+	M/B-	N-	N+	Nin	Y	N		

Figure 6. Adult PITC Register

Date of Admission (dd/mm/yy)	Patient Name	Sex			Age		Not Evaluated	Date of Evaluation dd/mm/yy	Patient status: Pick one status only.							Comments
									Testing not done				Testing done			
									Known status							
		Male	Female non Preg	Female Pregnant	15-24 years	25+ years			Known positive, on ART	Known positive, not on ART	Known negative (tested <3mo ago)	Declined	New Negative	New Positive	New Inconclusive	
		M	FNP	FP	C	D	NE		ART	Kn+	Kn-	D	N-	N+	Nin	
		M	FNP	FP	C	D	NE		ART	Kn+	Kn-	D	N-	N+	Nin	
		M	FNP	FP	C	D	NE		ART	Kn+	Kn-	D	N-	N+	Nin	
		M	FNP	FP	C	D	NE		ART	Kn+	Kn-	D	N-	N+	Nin	
		M	FNP	FP	C	D	NE		ART	Kn+	Kn-	D	N-	N+	Nin	

3. Provide appropriate counseling and referral for services based on the patient's outcome. Situations in which special counseling and referrals are needed include:
    a. If the patient has **a known positive status**:
        i. Assess whether the client is already on ART.
        ii. If the client is known positive but not on ART, refer case to ward clinician and counsel patient on the importance of enrolling in HIV care. (*Note:* All Known HIV+ clients should be on ART under Test and Treat guidelines.)
    b. If the patient **declines**:
        i. Counsel the patient on the importance of HIV testing.
        ii. Continue to follow up with the patient to encourage HTC until the patient is discharged.
    c. If the patient is **New Positive (≥1yo)** or **Mom Positive or Baby Positive (<1yo):**
        i. Refer case to ward clinician and counsel patient on the importance of enrolling in HIV care.
        ii. Enter all **New Positives** in the Linkage Register and facilitate linkage to care.
        iii. If the mother of a patient <12 mo is newly diagnosed positive, assess if mother is on ART. If not, refer mother for ART to start immediately and enroll child in HCC.

4. If there is a question about how to fill in a data field in the register, make notes in the **Comments** section and discuss the case with your supervisor.

5. All patients without an outcome completed before they are discharged from the hospital should be recorded as **Not evaluated.**

6. At the end of each page of the register, total the number of responses in each column and write the numbers in the "Totals" boxes at the bottom. These totals can be used to fill the **Monthly PITC In-Patient Report**.

SECTION 3. PITC REGISTER COLUMN HEADING DESCRIPTIONS

Note: There are slight differences in the adult and paediatric registers as labeled below.

Column Heading	Description	Response Options
Date of Admission	Date that the patient was admitted to the ward	DD/MM/YY
Patient Name	Patient's first and surname	First name then Surname
Sex (Sex of Child)	The gender and pregnancy status of the patient	Adult Register: M = Male; FNP = Non-pregnant female; FP = Pregnant female Child Register: M=Male; F=Female
Age (Age of Child)	Age of patient	Paediatric Register:

			A= 0-11 months; B= 1- 14 years Adult Register: C= 15-24 years; D= 25+ years
Not Evaluated		Patients that do not receive HTC testing/ assessment from an HTC provider.	NE= Not evaluated
Date of Evaluation		Date that patient was evaluated by the HTC provider to determine HIV status	DD/MM/YY
Patient HTC status: Testing not done	Known Status	Patient has a known HIV status and does not need a re-test. This means that the HTC provider has seen documentation of the patient's HIV status and s/he does not need to receive HTC services.	ART = Known positive, on ART: *patient has a known HIV+ diagnosis and is taking ART* Kn+ = Known positive, not on ART: *patient has a known HIV+ diagnosis but is not taking ART* Kn- = Known negative: *patient had a documented HIV-negative test result within the last 3 months*
	Declined	Patient has an unknown HIV status, has been offered HTC services, and denied/refused to receive them.	D = Declined

Paediatric Register

Column Heading	**Column Subheading**	**Description**	**Response Options**
Patient (child) status: Testing Done	Test Result: <1yo	The HIV status based on the testing of the patient and/or mother (use PITC algorithms to determine testing approach); for infant less than 1 year old.	M/B+ = Mom Positive or Baby Positive: *patient's mother is HIV+ or if the mother's test cannot be ascertained and the patient has a positive rapid test result* M/B- = Mom Negative or Baby Negative: *patient's mother is HIV- or if the mother's test cannot be ascertained and the patient has a negative rapid test result*
	≥1yo	The HIV test result based on the testing of the patient and/or mother (use PITC algorithms to determine testing approach); for child one year old (12 months) or older.	N- = New negative: *patient's rapid test result is negative* N+ = New positive: *patient's rapid test result is positive* Nin = New inconclusive: *patient's rapid test result is inconclusive* **Note:** Use N- for any child ≥1yo where rapid test is negative during the admission. Even if a child ≥1yo is HIV-exposed, the PITC Register outcome is based on the testing on that day.
Linkage to care- EID *For mom positive or baby positive <1yo*	DNA-PCR Done?	Was a sample taken from the patient for DNA-PCR? Cases that require DNA-PCR taken: ○ Mother of patient <12mo tests positive ○ Infant <12mo with a positive rapid test ○ Confirmatory test for patient 12-24mo with a positive rapid test	*Y = Yes: sample was taken for DNA-PCR* *N = No: sample was not taken for DNA-PCR*
	HCC Number	Record HCC number for newly exposed infant.	

SECTION 4. SPECIAL PAEDIATRIC PITC CASES

NOTE: Use **PITC testing algorithms** to clarify the testing recommendations based on patient age (<12mo, 12-24mo, >24mo).

Case	Testing	Outcome in Register
Infant <12mo on inpatient ward; unable to ascertain mother's status Example: 9mo admitted for diarrhea. Caregiver is grandmother; mother died during childbirth.	Rapid test of infant (to determine HIV exposure status)	If rapid test result is positive, PITC outcome is: Mom Positive or Baby Positive* If rapid test result is negative, PITC outcome is: Mom Negative or Baby Negative *Note: If rapid test result is positive, child needs DNA-PCR testing and evaluation by clinician to determine if meets criteria for PSHD.
Known exposed infant, <12mo Example: A 6 month old who is in the hospital with malaria, no signs of PSHD, and had a negative DBS done at 6 weeks of age. Mother is on ART and infant is enrolled in HCC.	No testing needed	Mom positive OR Baby Positive *Note: This is the one exception where the outcome is in the section "Patient Status: Testing done" even though no testing was done.
Known exposed infant, 12-24mo Example: A 16mo known HIV-exposed infant with previous negative DBS at 6 weeks of age and rapid test at 12mo of age. The child is admitted with malaria and no signs of PSHD. Mother is on ART and infant is enrolled in HCC.	Rapid test of child Note: Per national guidelines, all patients attending a health facility should be re-tested if tested negative more than 3 months ago. (Follow risk assessment guidelines and test after 1 month if history of high risk exposure.)	If rapid test negative, outcome is: New Negative If rapid test positive, outcome is: New Positive *Note: Although child is also HIV exposed, the outcome is based on the testing on that day. Thus, if the rapid test is negative, the outcome is New Negative, even though the child continues to be HIV exposed.

SECTION 5: OVERVIEW OF PITC MONTHLY REPORT

1. It is the responsibility of HDA focal person to fill the PITC Monthly Report.

2. Fill the report at the end of each month and complete before the end of the first week of the following month (e.g. the monthly report for June should be completed by the first week July).

3. Fill in the first row of the form with:
    a. Site (health facility name)
    b. District
    c. Reporting Month (e.g. a June reporting month covers all PITC done from June 1st -30th)

4. There are two sections of the Monthly Report. Complete them using Sections 6 and 7 of this SOP. Descriptions of each column's headings are provided in the table below.

5. When the monthly report is completed, the HDA focal person completing the report should sign and date. The site supervisor should perform a quality check (check the report data against the PITC register data), then sign and date.

6. When report is completed, signed and checked for quality, it should be submitted to the M&E team.

Descriptions of Column Headings

Column Heading	Description
Indicator	Indicator which corresponds with the data being collected
Description	Description of the data needed
Data Location	Location that the data can be found (i.e. register name, row, etc) and/or calculation that needs to be made
Site Result	Corresponding data filled by the HTC provider at the site
M&E Check	Confirmation of correct data entry by the HTC provider by the M&E team

SECTION 6: INSTRUCTIONS FOR FILLING MONTHLY PIC REPORT FOR INPATIENT WARDS

SPECIAL NOTES:

- This section of the Monthly Report uses data from Ministry of Health (MOH) registers from departments that use the PITC register because the existing department registers do not keep a clear record of every patient's HIV status.
- Programs should adapt this section of the monthly report depending on their own existing resources and needs.

Section 1 of the Monthly PITC Report for In-Patient Wards has three parts:

- PITC- NRU: PITC in the nutritional rehabilitation unit (NRU) ward for paediatric patients
- PITC-Inpatient/Short Stay Paeds: PITC in a short stay or in-patient paediatric ward
- PITC- Inpatient/Short Stay Adult: PITC in a short stay or in-patient adult ward

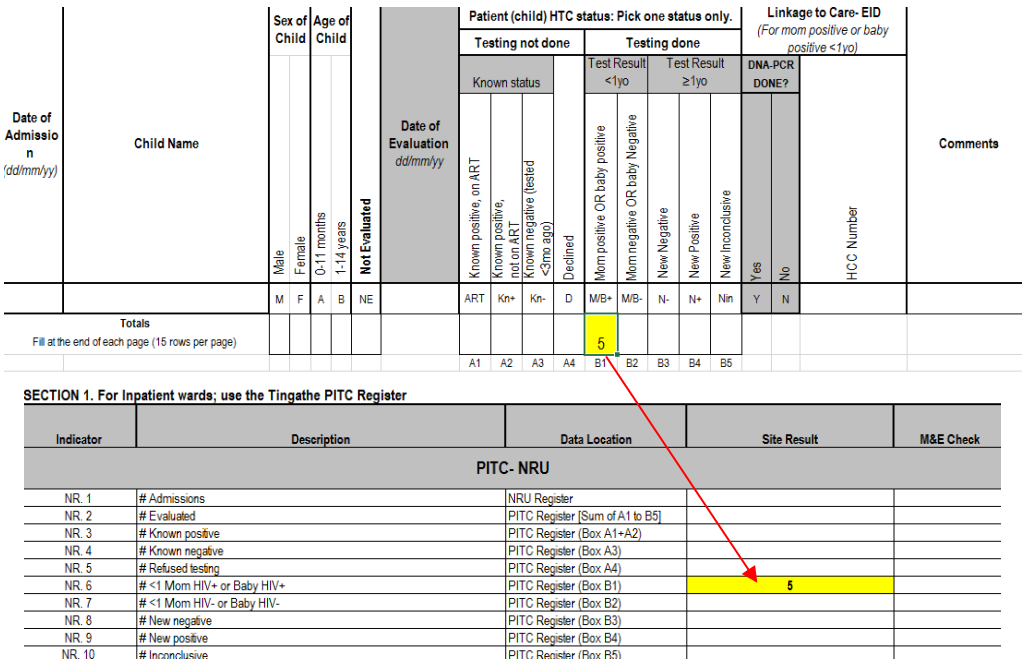
Notice how each department has a specific register (either **Adult** or **Paediatric PITC Register**) associated with it. One PITC register should be used for each ward.

1. Ensure that the PITC registers for each ward have their totals summed at the bottom of each page.

2. Enter the PITC Register data requested in the 'Description' column into the corresponding 'Site Result' column.
   a. The first row in each section is **# Admissions**. This should be obtained from the total number of patients recorded in the ward/in-patient admission register during the monthly reporting period.
   b. The row for **Evaluated** is the Sum of boxes A1 through B5
      # Evaluated = A1+A2+A3+A4+B1+B2+B3+B4+B5

   c. Most rows only require copying the column total onto the report (Figure 7).
   d. The row for the outcome 'Known Positive' requires addition of Boxes A1 and A2 to get the total number of Known Positives. (Example: 3 Known positives on ART [Box A1] + 1 Known positive not on ART [Box A2] = 4 Known Positives).

Figure 7. Example of data transfer from PITC Register to PITC Monthly Report



Date of Admission (dd/mm/yy)	Child Name	Sex of Child: Male	Sex of Child: Female	Age of Child: 0-11 months	Age of Child: 1-14 years	Not Evaluated	Date of Evaluation dd/mm/yy	Patient (child) HTC status: Pick one status only. Testing not done – Known status: Known positive, on ART	Known positive, not on ART	Known negative (tested <3mo ago)	Declined	Testing done – Test Result <1yo: Mom positive OR baby positive	Mom negative OR baby Negative	Test Result ≥1yo: New Negative	New Positive	New Inconclusive	Linkage to Care- EID (For mom positive or baby positive <1yo) DNA-PCR DONE?: Yes	No	HCC Number	Comments
		M	F	A	B	NE		ART	Kn+	Kn-	D	M/B+	M/B-	N-	N+	Nin	Y	N		
Totals Fill at the end of each page (15 rows per page)												5								
								A1	A2	A3	A4	B1	B2	B3	B4	B5				

SECTION 1. For Inpatient wards; use the Tingathe PITC Register

Indicator	Description	Data Location	Site Result	M&E Check
PITC- NRU				
NR. 1	# Admissions	NRU Register		
NR. 2	# Evaluated	PITC Register [Sum of A1 to B5]		
NR. 3	# Known positive	PITC Register (Box A1+A2)		
NR. 4	# Known negative	PITC Register (Box A3)		
NR. 5	# Refused testing	PITC Register (Box A4)		
NR. 6	# <1 Mom HIV+ or Baby HIV+	PITC Register (Box B1)	5	
NR. 7	# <1 Mom HIV- or Baby HIV-	PITC Register (Box B2)		
NR. 8	# New negative	PITC Register (Box B3)		
NR. 9	# New positive	PITC Register (Box B4)		
NR. 10	# Inconclusive	PITC Register (Box B5)		

SECTION 7: INSRUCTIONS FOR FILLING MONTHLY PITC REPORT FOR OUTPATIENT DEPARTMENTS

SPECIAL NOTES:

- This section of the Monthly Report uses data from Ministry of Health (MOH) registers from departments that track the HIV status of patients.
- Departments were included in this section because: 1) PITC data could not be abstracted from existing MOH quarterly reports, and 2) the department has 'high risk' clients and the program had focused PITC efforts there.
- Due to the variation in recording HIV status information for patients in each of the MOH registers, that data reported from departments that do not use the PITC Registers is more general than from those that do.
- Programs should adapt this section of the monthly report depending on their own existing resources and needs.

Section 2 of the Monthly PITC Report for Outpatient Departments has three parts.

- PITC – OTP: PITC in the outpatient therapeutic program (OTP) – a nutritional rehabilitation program
- PITC – SFP: PITC in the supplementary feeding program (SFP) - a nutritional rehabilitation program
- PITC – STI: PITC in the sexually transmitted infections department

Note that each department/program has a different way of recording HIV status in their register.

1. Collect registers from each of the departments. Check for completeness of the 'HIV Status' columns in each register. If columns are not completed appropriately, discuss with the head of that department.

2. Enter the PITC Register data requested in the 'Description' column into the corresponding 'Site Result' column.
    a. The first row in each section is **# Admissions**. This should be obtained from the total number of patients recorded in the register during the monthly reporting period.
    b. The second row in each section is **# HIV Status Ascertained**. This should be obtained by counting the number of patients that have any HIV status recorded, regardless of whether it was new or known.
    c. The third row in each section is # HIV Positive (new or known). This should be obtained by counting the number of patients that have a positive HIV status recorded, regardless of whether it was a new or known diagnosis.

Date of Admission *(dd/mm/yy)*	**Patient Name**	**Sex**			**Age**			**Date of Evaluation** *dd/mm/yy*	**Patient status: Pick one status only.**							**Comments**
									Testing not done				**Testing done**			
									Known status							
		Male	Female non Preg	Female Pregnant	15-24 years	25+ years	**Not Evaluated**		Known positive, on ART	Known positive, not on ART	Known negative (tested <3mo ago)	Declined	New Negative	New Positive	New Inconclusive	
		M	FNP	FP	C	D	NE		ART	Kn+	Kn-	D	N-	N+	Nin	
		M	FNP	FP	C	D	NE		ART	Kn+	Kn-	D	N-	N+	Nin	
		M	FNP	FP	C	D	NE		ART	Kn+	Kn-	D	N-	N+	Nin	
		M	FNP	FP	C	D	NE		ART	Kn+	Kn-	D	N-	N+	Nin	
		M	FNP	FP	C	D	NE		ART	Kn+	Kn-	D	N-	N+	Nin	
		M	FNP	FP	C	D	NE		ART	Kn+	Kn-	D	N-	N+	Nin	
		M	FNP	FP	C	D	NE		ART	Kn+	Kn-	D	N-	N+	Nin	
		M	FNP	FP	C	D	NE		ART	Kn+	Kn-	D	N-	N+	Nin	
		M	FNP	FP	C	D	NE		ART	Kn+	Kn-	D	N-	N+	Nin	
		M	FNP	FP	C	D	NE		ART	Kn+	Kn-	D	N-	N+	Nin	
		M	FNP	FP	C	D	NE		ART	Kn+	Kn-	D	N-	N+	Nin	
		M	FNP	FP	C	D	NE		ART	Kn+	Kn-	D	N-	N+	Nin	
		M	FNP	FP	C	D	NE		ART	Kn+	Kn-	D	N-	N+	Nin	
		M	FNP	FP	C	D	NE		ART	Kn+	Kn-	D	N-	N+	Nin	
		M	FNP	FP	C	D	NE		ART	Kn+	Kn-	D	N-	N+	Nin	
Totals Fill at the end of each page (15 rows per page)																
									A1	A2	A3	A4	B3	B4	B5	

Date of Admission *(dd/mm/yy)*	**Child Name**	**Sex of Child**		**Age of Child**			**Date of Evaluation** *dd/mm/yy*	**Patient (child) HTC status: Pick one status only.**									**Linkage to Care- EID** *(Exposed Infants)*			**Comments**
								Testing not done				**Testing done**								
								Known status				Test Result <1yo		Test Result ≥1yo			**DNA-PCR DONE?**			
		Male	Female	0-11 months	1-14 years	**Not Evaluated**		Known positive, on ART	Known positive, not on ART	Known negative (tested <3mo ago)	Declined	Mom positive OR baby positive	Mom negative OR baby Negative	New Negative	New Positive	New Inconclusive	Yes	No	HCC Number	
		M	F	A	B	NE		ART	Kn+	Kn-	D	M/B+	M/B-	N-	N+	Nin	Y	N		
		M	F	A	B	NE		ART	Kn+	Kn-	D	M/B+	M/B-	N-	N+	Nin	Y	N		
		M	F	A	B	NE		ART	Kn+	Kn-	D	M/B+	M/B-	N-	N+	Nin	Y	N		
		M	F	A	B	NE		ART	Kn+	Kn-	D	M/B+	M/B-	N-	N+	Nin	Y	N		
		M	F	A	B	NE		ART	Kn+	Kn-	D	M/B+	M/B-	N-	N+	Nin	Y	N		
		M	F	A	B	NE		ART	Kn+	Kn-	D	M/B+	M/B-	N-	N+	Nin	Y	N		
		M	F	A	B	NE		ART	Kn+	Kn-	D	M/B+	M/B-	N-	N+	Nin	Y	N		
		M	F	A	B	NE		ART	Kn+	Kn-	D	M/B+	M/B-	N-	N+	Nin	Y	N		
		M	F	A	B	NE		ART	Kn+	Kn-	D	M/B+	M/B-	N-	N+	Nin	Y	N		
		M	F	A	B	NE		ART	Kn+	Kn-	D	M/B+	M/B-	N-	N+	Nin	Y	N		
		M	F	A	B	NE		ART	Kn+	Kn-	D	M/B+	M/B-	N-	N+	Nin	Y	N		
		M	F	A	B	NE		ART	Kn+	Kn-	D	M/B+	M/B-	N-	N+	Nin	Y	N		
		M	F	A	B	NE		ART	Kn+	Kn-	D	M/B+	M/B-	N-	N+	Nin	Y	N		
		M	F	A	B	NE		ART	Kn+	Kn-	D	M/B+	M/B-	N-	N+	Nin	Y	N		
		M	F	A	B	NE		ART	Kn+	Kn-	D	M/B+	M/B-	N-	N+	Nin	Y	N		
Totals Fill at the end of each page (15 rows per page)																				
								A1	A2	A3	A4	B1	B2	B3	B4	B5				

Tingathe Site Monthly Report

Site: _____ **District** _____

Reporting Month: _____ **Year** _____

Instructions: Site supervisor must sign for data quality check before submitting. M&E must also verify and not accept reports as final until all data quality checks have been completed. Use comments sections to explain any unusual or incomplete data.

SECTION 1. For Inpatient wards: use the Tingathe PITC Register

Indicator	Description	Data Location	Site Result	M&E Check
		PITC- NRU		
NR. 1	# Admissions	NRU Register		
NR. 2	# Evaluated	PITC Register [Sum of A1 to B5]		
NR. 3	# Known positive	PITC Register (Box A1+A2)		
NR. 4	# Known negative	PITC Register (Box A3)		
NR. 5	# Refused testing	PITC Register (Box A4)		
NR. 6	# <1 Mom HIV+ or Baby HIV+	PITC Register (Box B1)		
NR. 7	# <1 Mom HIV- or Baby HIV-	PITC Register (Box B2)		
NR. 8	# New negative	PITC Register (Box B3)		
NR. 9	# New positive	PITC Register (Box B4)		
NR. 10	# Inconclusive	PITC Register (Box B5)		
Comments:				
		PITC – Inpatient/Short Stay Paeds		
SP. 1	# Admissions	Ward Admissions Register		
SP. 2	# Evaluated	PITC Register [Sum of A1 to B5]		
SP. 3	# Known positive	PITC Register (Box A1+A2)		
SP. 4	# Known negative	PITC Register (Box A3)		
SP. 5	# Refused testing	PITC Register (Box A4)		
SP. 6	# <1 Mom HIV+ or Baby HIV+	PITC Register (Box B1)		
SP. 7	# <1 Mom HIV- or Baby HIV-	PITC Register (Box B2)		
SP. 8	# New negative	PITC Register (Box B3)		
SP. 9	# New positive	PITC Register (Box B4)		
SP. 10	# Inconclusive	PITC Register (Box B5)		
Comments:				
		PITC – In Patient/Short Stay Adult		
SA. 1	# Admissions	Ward Admissions Register		
SA. 2	# Evaluated	PITC Register [Sum of A1 to B5]		
SA. 3	# Known positive	PITC Register (Box A1+A2)		
SA. 4	# Known negative	PITC Register (Box A3)		
SA. 5	# Refused testing	PITC Register (Box A4)		
SA. 6	# New negative	PITC Register (Box B3)		
SA. 7	# New positive	PITC Register (Box B4)		
SA. 8	# Inconclusive	PITC Register (Box B5)		
Comments:				

SECTION 2. For Outpatient Department: use department registers

	Description	Data Location	Site Result	
		PITC –OTP		
OP 1	# Registrations in OTP	OTP Dept Register		
OP 2	# HIV Status Ascertained	OTP Dept Register		
OP 3	# HIV Positive (New or Known)	OTP Dept Register		
		PITC –SFP		
SP 1	# Registrations in SFP	SFP Dept Register		
SP 2	# HIV Status Ascertained	SFP Dept Register		
SP 3	# HIV Positive (New or Known)	SFP Dept Register		
		PITC –STI		
ST	# Registrations in STI	STI Dept Register		
ST	# HIV Status Ascertained	STI Dept Register		
ST	# HIV Positive (New or Known)	STI Dept Register		
Comments:				

Client Tracing Tools: These tools are designed to support the CHW organize and report on client tracing efforts, regardless on the reason for tracing. The ***Client Tracing Form*** provides a document to record the client's locator information, tracing attempts and final tracing outcome. The ***CHW Client Tracing List*** helps the CHW manage and track all his/her client's that require tracing and their current tracing status. The ***Locator Form*** can be used in cases where there is not space or an opportunity to record a patient's locator details in an existing register/sheet. The ***Home-Based Visit SOP*** describes the process for conducting home-based tracing visits with confidentiality and respect.

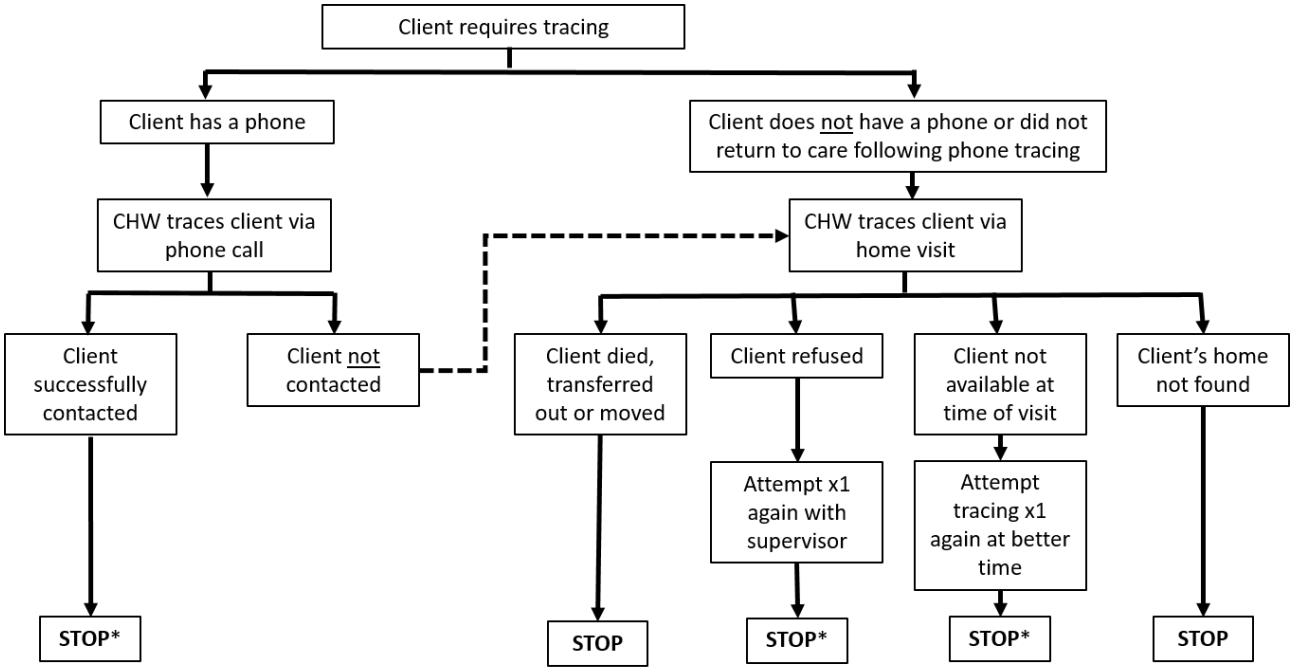
This set of tools is broken up into the following four sections:

Section 1: Client Tracing Form

A client may be traced for many reasons: missed appointment, defaulting, or linkage to care or to follow up VL or TB test results. For each assigned client for tracing, the CHW should follow the following procedure:

1. Complete a **Client Tracing Form** to keep track of the tracing activity. Clearly document client information on the form. If client is an EID infant, then s/he should be prioritized for tracing.
2. Follow the tracing procedure described in **Figure 1**. If phone number is available, begin by trying to reach the client by phone. If the client is successfully contacted but has not returned to care in two weeks, make a home visit. If the client is not home but it is the correct house, return one other time at a better time.
3. If the client does not have a phone, proceed directly to a home visit.
4. Tracing attempts should be documented on the Client Tracing Form. While in use, store the Client Tracing form in a binder.
5. Once a client has a final tracing outcome, update the appointment/linkage register with the final outcome. Then pair the completed Client Tracing Form with the client's MasterCard.

Figure 1. Client Tracing Flowchart



***Note:** CHW should stop tracing efforts at this time, but continue to follow the client. If the client does not return to care 2 weeks after tracing, the CHW may make another tracing attempt.*

Section 2: Client Tracing Lists

*The **CHW Client Tracing List** provides an overview of the CHW's assigned clients for Client Tracing. To use the CHW Client List, the CHW should follow following procedure:*

1. Tick the month of the encounter in the row of the client's name every time contact has been made with the client (at facility, on phone, or at home visit).
2. Monitor Client Lists – if it has been > 2 months since contact with an assigned client (sooner if an urgent issue), make an effort to connect with the client – at an upcoming appointment, by phone, or on home visit.
3. Maintain the Client Tracing Forms and Client Lists in binders/files.
4. The supervisor should review Client Tracing Forms and Client Lists for each CHW at least quarterly to ensure quality activity.

Section 3: Patient Locator Form

The Patient Locator Form can be used to record detailed locator information for a patient. It is designed for use in situations where there is not an existing place in client records for recording tracing information. For example, a client locator form can be filled for existing ART patient's requesting home-based HIV testing of their family members.

1. The CHW should fill the client locator form with the patient present in as much detail as possible. When possible, it is recommended to:
    a. Form some rapport with the patient to promote the patient to feel comfortable giving accurate details
    b. Have the form filled by a CHW who is familiar with the area that the patient is from and/or the person assigned to trace the patient
    c. Fill the form in as much detail as possible. If there is not enough space on the front of the form, the back can also be used
2. Complete the top of the form with the name of the CHW filling it and the date that it is filled. It is important that the CHW filling the form to make instructions as clear as possible because s/he may not be the one tracing the patient.
3. Ask for consent for both home and phone-based tracing.
4. Complete the 'Phone Follow Up' section with the client's phone number and any other details to ensure confidentiality/comfort to the client.
5. Complete the 'Home-Based Follow Up' section in addition the map.
6. If the client is comfortable, ask and complete the other questions on the form. This information can be used to trace the client if the written instructions and map are not enough.
7. Once completed the form should be stored with other patient records.
8. When conducting home-based tracing, the Locator Form should not be taken with the CHW to trace. Instead notes about the location should be copied onto another sheet or a picture of the form can be taken by the CHW on their phone for reference.
9. If needed, the Follow Up/Tracing section can be used to record notes and dates of tracing.

Section 4: Home-Based Visit Procedure

Home-based patient visits can be done for a number of reasons including defaulter tracing, testing of household members and/or general follow up for special cases/patients. This procedure outlines the general process for conducting a home visit and should be adapted to include details for conducting specific visits. It is intended for use by all CHWs assigned to patients who have agreed to home visits. Preparation for the home visit should be done at the health facility, while home visits are conducted at the patient's home.

*Agreement on home visits is usually decided at the time of enrolment into any program (Linkage, PMTCT, etc) with details written on the patient's entry in the register, MasterCard or **Locator Form**. However, the time/day of any visit should be adjusted to the preference of the patient, and they may change their decision at any time. It is important to always respect the preference of the patient.*

HOME VISIT BY A CHW

Part 1: Preparation

1. Visits should be conducted only by those who have proper training and consent from the head office.
2. Bring with you:
    a. The complete locator information and know where you're going
    b. Your ID badge, but you don't have to wear it (to maintain confidentiality and avoid attracting unnecessary attention)
    c. Notebook and pen
    d. Any counselling/testing tool needed for reference
    e. Charged cell phones (for security)

3. Ensure professional behavior and attire.
4. Remember that confidentiality is a PRIORITY.
5. No hand-outs or incentives should be given or received.
6. If going by bicycle or motorcycle, confirm that it is in working order and bring any necessary tools or safety equipment with you.

Part 2: Conducting the Home Visit

1. After arriving at the home, lock and store your bicycle/motorcycle in a secure area.
2. Ensure that you are speaking to the appropriate person before you disclose any information.
    a. If the person is not your patient, ask to speak with your patient as well.
3. If the home is in close proximity to another,, agree with the patient on a private area to speak.
    - ❖ When patient or caregiver is of the opposite sex, make sure you maintain appropriate distance.
    - ❖ If a young child is present, be careful to avoid accidental disclosure (avoid words like HIV or AIDS in their presence)
    - ❖ Try to involve yourself in their conversation or let them finish if the situation permits you to do so (rapport building).
4. Introduce yourself as a CHW (use ID badge if needed).
5. Ask about disclosure. If the patient has disclosed to their spouse and/or family, ask if anyone else would like to join the session.
6. Explain to the patient the reason for your visit and what will be happening.
7. Complete any necessary tasks. Tasks may include:
    a. Adherence counselling
    b. Pill count
    c. Assistance with disclosure
    d. HIV testing of household members
    e. Screening for signs of TB / need for IPT among patient and/or family members
8. Document your visit in the appropriate places, including the patient's health passport book (if available), being sure to include the following:
    - Date of the visit
    - Important information about the visit
    - Next clinic appointment
    - CHW name
9. Remind the patient of their next clinic visit.
10. Agree with the patient on a time and date for their next home visit (if appropriate).

Part 3: Post Visit Documentation

1. Upon returning to the health facility, record all information you have collected onto the proper forms (i.e. patient MasterCard, patient Locator Form, register, etc). Do this within 24 hours of the home visit.
    - ❖ Documentation should still be done, even if the patient was not found at home.
2. Let the Site Supervisor/Assistant SS know if there are any concerning issues about a patient.

<u>SUPERVISION OF HOME VISITS</u>

Supervised visits by the Site Supervisor should be conducted on a regular basis to ensure procedures are followed by all CHWs. These visits can be either planned or random spot-checks.

Part 1: Supervision of Visit

1. Prepare for the home visit by reviewing the patient's information you plan on visiting including: the number and frequency of visits, the reasons for visits, any difficult issues.
2. Travel to the site with the CHW, following steps 1-4 of the Conducting Home Visit Section.
3. Meet the patient/guardian. Have the CHW introduce you.
4. Observe the CHW as they perform a home visit.
    a. Observe if the CHW is:
        i. Maintaining confidentiality
        ii. Practicing active listening
        iii. Explaining things in detail in a way the patient can understand
        iv. Being patient and not getting frustrated
        v. Respecting the patient
    b. Confirm that the CHW completes the following tasks (if the situation is appropriate):
        i. Follows proper procedures for any scheduled activity (e.g. HTC, pill count, adherence counselling)

ii. Checks and records any important information in the health passport book

5. After the CHW finishes, check documentation in the health passport book and cross check it with information you brought with you.
6. Ask the patient if you can ask some follow-up questions without the CHW so you can know whether the patient is helped by the CHW and the Tingathe program at large.
    a. Do you think it is important to have a CHW come for home visits? Why or why not?
    b. How do you feel you have benefited from the Tingathe program?
    c. Have you had any issues – positive or negative – with your CHW?
7. Document your visit in the patient's passport book.
8. Leave the home and go back to the health facility.

Part 2: Follow-Up and Reporting on Supervision

1. Compare documentation found in the passport book with the information in the patient's record.
2. Give feedback to CHW in the presence of the SS/Asst. SS.
3. Give feedback to CHW once at the site. Discuss the following issues:
    a. Performance during home visit
    b. Documentation in the passport book and MasterCard
    c. Concerns for documentation
    d. If any, concerns for falsification
    e. Any other patient findings not found in patient records
    ❖ Concerns for falsification **must** be reported to the main office within 2 days.
4. Properly document the patients you supervised.

Appendix: Client Tracing Form, Client Tracing List, Client Locator Form

CLIENT TRACING FORM

TO BE FILLED IN BY THE CHW

Date client referred for tracing: _____ **CHW Responsible:** _____

Reason for tracing:

Linkage to care ☐ Positive DNA-PCR ☐ Positive Rapid Test ☐ Known +, not on ART

Patient HTC/PCR ID #:_____

EID Infant? ☐ YES ☐ NO

☐ Missed appointment ☐ Defaulter (missed appt ≥2mo)

Patient ART/HCC#:_____

EID Infant? ☐ YES ☐ NO

☐ Other Reason *(Please Specify):*

Name of Patient:_____**Age:**_____ **Sex:**_____
Guardian Name:_____

Phone number:_____

Physical address (Descriptive):_____

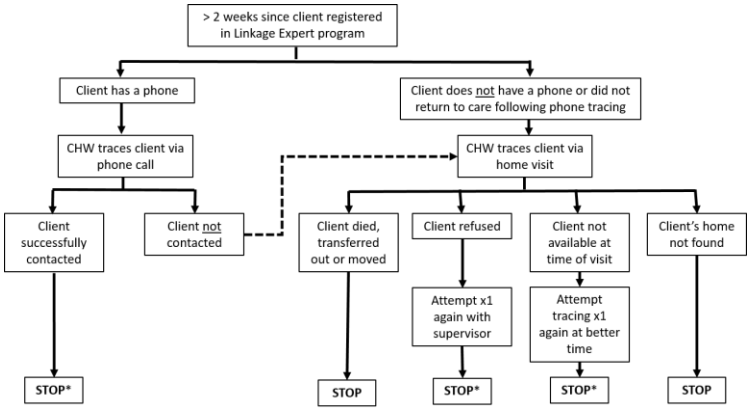
Tracing visits:

Date	Type of encounter	Notes
	☐Home ☐Phone	
	☐Home ☐Phone	
	☐Home ☐Phone	

Tracing Outcomes (Tick one box)- Update Linkage or Appointment Register with Outcome

☐ Died
☐ Found, intends to return: Date to Return (*dd/mm/yy*):_____ *(For ART patients, update appointment register with client's new appointment)*
☐ Declined/ refused
☐ Attempted, but not found
☐ Moved
☐ ART at another facility
☐ Other (please explain)……

Date of Tracing Outcome: _____ *Name of CHW:* _____



***Note:** CHW should stop tracing efforts at this time, but continue to follow the client. If the client does not return to care 2 weeks after tracing, the CHW may make another tracing attempt.*

CHW CLIENT TRACING LIST

SITE: ____________________ CHW NAME: ____________________ MONTH/YEAR: ________________

				Reason for tracing				Final Tracing Outcome							
No	Date Assigned	Patient Name	ART No. (if applicable)	Linkage	Missed appt/ default	Other	Comments	Died	Found, intends to return	Moved	ART at another Facility	Declined/Refused	Attemped, but not found	No tracing attempt	Date of Outcome
				L	MA	Oth		D	I	M	AF	R	AT	NT	
				L	MA	Oth		D	I	M	AF	R	AT	NT	
				L	MA	Oth		D	I	M	AF	R	AT	NT	
				L	MA	Oth		D	I	M	AF	R	AT	NT	
				L	MA	Oth		D	I	M	AF	R	AT	NT	
				L	MA	Oth		D	I	M	AF	R	AT	NT	
				L	MA	Oth		D	I	M	AF	R	AT	NT	
				L	MA	Oth		D	I	M	AF	R	AT	NT	
				L	MA	Oth		D	I	M	AF	R	AT	NT	
				L	MA	Oth		D	I	M	AF	R	AT	NT	
				L	MA	Oth		D	I	M	AF	R	AT	NT	
				L	MA	Oth		D	I	M	AF	R	AT	NT	
				L	MA	Oth		D	I	M	AF	R	AT	NT	
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				L	MA	Oth		D	I	M	AF	R	AT	NT	
				L	MA	Oth		D	I	M	AF	R	AT	NT	
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				L	MA	Oth		D	I	M	AF	R	AT	NT	
				L	MA	Oth		D	I	M	AF	R	AT	NT	
				L	MA	Oth		D	I	M	AF	R	AT	NT	
				L	MA	Oth		D	I	M	AF	R	AT	NT	
				L	MA	Oth		D	I	M	AF	R	AT	NT	

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

CONSENT:

CAN WE CONDUCT FOLLOW UPS AT YOUR HOME?: YES NO

CAN WE CONDUCT FOLLOW UPS BY CALLING YOUR MOBILE PHONE?: YES NO

PATIENT'S NAME:_____

PHONE FOLLOW UP

MOBILE PHONE NUMBER: _____

SPECIAL INSTRUCTIONS FOR PHONE CONTACT (E.G. HUSBAND'S PHONE, ALTERNATE NUMBER)

_____

_____

HOME BASED FOLLOW UP

VILLAGE NAME: _____

BEST DAY(S) FOR HOME VISITS: _____

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***)**

Comments:

_____

_____

_____

_____

_____

Follow Up:

Date	Follow Up Notes	Initials

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