Practical Strategy 3:

Case Management

Photo by: Robbie Flick

Monitoring adherence and offering continued support to ensure patient retention

In order to achieve UNAIDS final 90-90-90 goal, 90% of people on HIV treatment must be retained in care and adherent to their medication. This strategy introduces various methods of case management with a focus on supporting adherence and retention, including monitoring patient appointments, providing targeted counselling about adherence issues, referring patients to other support or medical services as needed and supporting patients with home and facility-based follow up.

Developed by:

Tingathe Program

Baylor College of Medicine Children's Foundation Malawi

Contact details:

Address: Private Bag B-397, Lilongwe 3, Malawi

Phone: +265 (0)175 1047

Email: info@tingathe.org

Web: www.tingathe.org

This publication is made possible by the generous support of the American people through the United States Agency for International Development (USAID). The contents are the responsibility of Baylor College of Medicine Children's Foundation Malawi and do not necessarily reflect the views of USAID or the United States Government.

TABLE OF CONTENTS

SOP SUMMARY

Section 1: Pre-implementation and Training

Section 2: Implementation of Case Management Activities

Incorporation of Case Management Strategies into the Health Facility's Monthly Plans and Strategy
Flowchart of Case Management Activities
Encouraging and Monitoring Adherence to HIV Treatment at the ART Clinic
Viral Load Monitoring
Using the Appointment Register and Client Tracing Tools
Defaulter Tracing Activities
Additional Support for HIV-infected Children and their Caregivers (CBC Program Overview)

Section 3: Supervision, Monitoring and Evaluation

TOOLS AND FORMS

Appointment Register Workshop Package: This training is designed for those using the Appointment Register and corresponding Monthly Report. The workshop tools include an agenda, PowerPoint presentation, a M&E practice handout, and an exam.

Patient Referral Tools: Some health facilities receive support from multiple implementing partners, support groups and organizations who work together to provide patient care and support services. The goal of the Referral Organization Information Form is to create a comprehensive directory for each health facility by obtaining information from each organization and group about their activities and services in order to collaborate and facilitate referrals. After collecting information about each of the health facility's supporting organizations, the information can be combined in an easy to reference binder or poster, such as the Referral Organization Summary. The Referral Tracking Tool is the last step in the process. This tool allows facilities the ability to track patient referrals to see if the referral was successful.

Appointment Register Tools: This register is intended for use by health facilities that do not already have a way to monitor and track patient appointments. With the system outlined, CHWs can monitor appointments and track tracing efforts for patients who have missed appointments.

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.

CBC Program Package: This procedure outlines the tools used for the CBC program, a community health worker-based routine follow up system for HIV-infected children to improve clinical outcomes including retention and adherence to care. The tools include: a **CBC MasterCard** and **Locator Form** designed for CHWs to help keep track of important information and dates regarding their patient's care; a **CBC Register** designed to keep track of all registered patients and their follow up; a **CBC Follow Up Schedule** designed to provide guidance to CHWs as they conduct home-visits and help their patient access services; and a **CBC Follow Up Summary** designed for CHWs to keep track of the home-visits done to their patients.

Health Talk Procedure and Topics: Health talks are 20-30 minute long patient education sessions, usually presented by a CHW while a group of patients is waiting for their appointments, to provide education for patients on issues relevant to health.

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: **Units 6-12**.

FEATURED CASE STUDIES

Case Study 1: Tingathe Disability Directory – A Case Study of the use of the Referral Organization Information Form and Summary
Case Study 2: Monitoring Viral Loads
Case Study 3: Adherence Questionnaire
Case Study 4: Partnering with Existing Community Health Workers to Assist with Patient Follow Up
Case Study 5: CBC Program Overview

ACRONYMS

ACF	Active Case Finding
ART	Antiretroviral Treatment
CHW	Community Health Worker
CPT	Cotrimoxazole Preventive Therapy
HTC	HIV Testing and Counselling
MC	MasterCard
M&E	Monitoring and Evaluation
MOH	Ministry of Health
SOP	Standard Operating Procedure
STI	Sexually Transmitted Infections Clinic
TB	Tuberculosis
WHO	World Health Organization

PURPOSE:

In order to achieve UNAIDS final 90-90-90 goal, 90% of people on HIV treatment have suppressed viral loads, patients' adherence needs to be carefully monitored. This strategy introduces various methods of case management including monitoring patient appointments, providing targeted counselling about adherence issues, referring patients to other support or medical services as needed and supporting patients with home and facility-based follow up. The procedure is separated into three sections:

Section 1: Pre-implementation and Training

Section 2: Implementation of Case Management Strategies

A. *Incorporation of Case Management Activities into the Health Facility's Monthly Plans and Strategies*
B. *Flowchart of Case Management Activities*
C. *Encouraging and Monitoring Adherence to HIV Treatment at the ART Clinic*
D. *Viral Load Monitoring*
E. *Using the Appointment Register and Client Tracing Tools*
F. *Defaulter Tracing Activities*
G. *Additional Support System for HIV-infected Children and their Caregivers*

Section 3: Supervision, Monitoring and Evaluation

SCOPE:

Case management activities target patients that are enrolled in HIV care services.

RESPONSIBILITIES:

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

Sections 2 and 3 are intended for use by the community health worker team.

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 implement/scale up case management activities to monitor and promote patient adherence and retention in care.
2. Organize a workshop with the health facility and invite all relevant personnel (in-charge, department heads, etc). This workshop should take place at the facility and take approximately 1 hour. The workshop should take a participatory approach to discuss the following key items:
    a. Description of case management and its importance
    b. Case management goals for the facility
    c. The current state of case management activities and any gaps in service
    d. Which case management activities the facility would like to implement. It is recommended that these activities happen in combination with the active case finding, the Linkage to Care strategies.
    e. Techniques for monitoring and evaluation of case management activities
    f. Training dates and persons to be invited
3. Organize the training(s) and invite appropriate staff.
    a. It is recommended that CHWs are trained using the full **Community Health Worker Training Curriculum** and SSs attend an additional workshop which teaches basic leadership skills as well as their supervision responsibilities.
    b. After community health workers complete their training, a training should be organized with CHWs and all relevant health facility staff (i.e. HIV clinic in-charge, etc) from each site invited to be trained on how case management activities will be implemented at each site. During this time, the following should be accomplished:
        i. Development of a clear plan of action to implement adherence and monitoring strategies. This could include flow charts, departmental SOPs, rosters/rotas, etc.

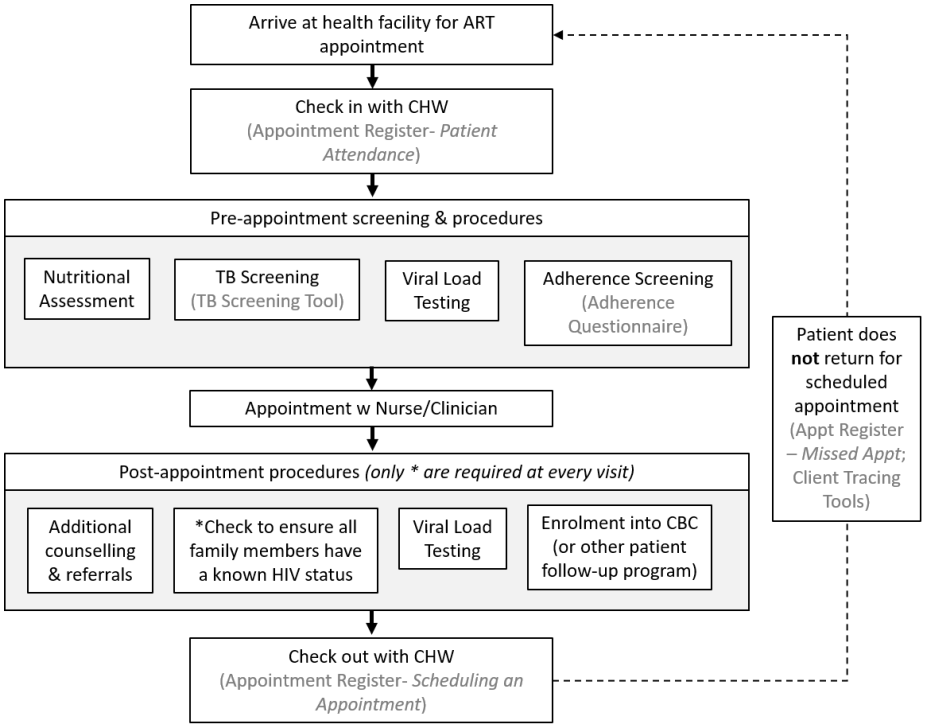
ii. Training on how to use any tools associated with case management activities using the **Missed Appointment Training Package** and any other relevant materials.
iii. A list of roles and responsibilities for each person. It is recommended that a focal person is assigned for each of the following key activities:
    1. Appointment Register
    2. Defaulter Tracing
    3. CBC Program
iv. Method of supervision, monitoring and evaluation

Section 2: Implementation of Case Management Activities

A. Incorporation of Case Management Activities into the Health Facility's Monthly Plans and Strategies

1. Prepare the health facility for the Adherence and Monitoring activities.
    a. Develop a list of all HIV organizations and support groups in your area using the **Patient Referral Tools**.
        i. Include specialized clinics or organizations that support common illnesses associated with HIV (e.g. disabilities, tuberculosis, stand-alone testing centers, etc).
        ii. Combine completed forms into a detailed directory that can be kept at the site (see Case Study 1). Once completed, this document should be updated annually.
        iii. Work with the organizations to form referral systems that allow for quick follow up and tracking of patients.
    b. Inventory all specialized patient education and counselling materials available at the facility.
        i. Ensure patient tools/posters can be easily accessed.
        ii. Determine the best storage location and use for facility-based counselling tools including **flipcharts, videos and counselling cards**.
    c. Compile a list of nearby health facilities that offer ART/HIV services to facilitate transfers between facilities. If possible, a referral system between facilities should be organized so that transfers can be tracked.
    d. Link with existing community-based volunteers and leaders to assist with tracing and follow ups.
2. Incorporate the following into the health facility's Monthly Plans and Strategy:
    a. Encourage outside referrals to HIV support groups and other related organizations when appropriate
    b. Use facility-based tools to communicate important messages and/or counsel patients during waiting times, one-on-one encounters and in group settings.
        i. Develop a roster for delivering health talks. It is recommended that multiple health talks are planned for each day in every department so as not to miss any patients. Reference the **Health Talk Procedure and Topics**.
        ii. Plan group pre-ART counselling sessions weekly for patients and their family members to learn more about their treatment and seek family-HTC services (e.g. every Friday afternoon).
    c. Develop rapport with patients and encourage them to seek out a CHW if they have any questions or concerns about their HIV services.
    d. Plan phone calls and home visits to follow up patients that have extra needs.

B. Flowchart of Case Management Activities



C. Encouraging and Monitoring Adherence to HIV Treatment at the ART Clinic

1. Once a patient arrives for an appointment, s/he should check in with the CHW in charge of the **Appointment Register**. The CHW will confirm his/her appointment in the Patient Attendance section.
2. Once check-in is complete, patients should see a CHW to complete screening and pre-appointment procedures. CHWs responsibilities include:
    a. Determining if any special tests need to be conducted or results need to be given (e.g. viral load testing, DNA-PCR, sputum/GeneXpert, etc)
    b. Tuberculosis screening
    c. Checking the patient's nutritional status
    d. Adherence screening and pill count (reference Case Study 2)
    e. Provision of special counselling, if needed
    f. Answering any questions the patient may have
3. When necessary, CHWs should advocate for a patient during the patient's appointment with the clinician/nurse. For example, the CHW can help bring attention to issues observed during pre-appointment procedures that the patient may not feel comfortable sharing him/herself.
4. After seeing the nurse/clinician, patients should see a CHW to complete post-appointment procedures. CHWs responsibilities include:
    a. Confirming that the patient understands the clinician/nurse's instructions and any change to their medication
    b. Ensuring all family members of the patient have a known HIV status. If any family member has an unknown HIV status, organize either home or facility-based HTC.
    c. Performing any tests ordered by the clinician
    d. Providing additional counselling and/or referrals, if needed
5. The patient should then check-out with the CHW in charge of the Appointment Register. The CHW will record the patient's next appointment and ensure it is clearly written and properly communicated to the patient.

D. Viral Load (VL) Monitoring by Community Health Workers

Viral load monitoring is an important component of monitoring patient case management and monitoring patient adherence to ART. The procedure below describes the roles and responsibilities of the CHW team in a situation where there are existing tools and procedures for monitoring viral load in place.

1. At each clinic visit, screen patient records to check for those that need a viral load drawn. If a viral load is needed:
    a. Remind the clinician/nurse
    b. Escort the patient to the area where viral loads are drawn
    c. Counsel the patient on the importance of viral load tests and the recommended schedule
2. Assist with the drawing viral loads (if qualified) and sample management. Report any issues with sample transport and results to/from the laboratory.
3. Routinely check viral load documentation to ensure:
    a. Accurate and complete records are being made
    b. Results are being recorded and elevated viral loads flagged for follow up
    c. Test results are returned in a timely manner from the laboratory
4. Help communicate viral load results to patients
5. If a patient is identified as having an elevated viral load, it is the responsibility of the CHW to:
    a. Notify the clinician/nurse
    b. Notify the patient that they need to return to the health facility for their test results
    c. Refer the patient for enhanced adherence counselling
    d. Provide and document enhanced adherence counselling given
    e. Ensure a repeat VL is done once enhanced counselling is completed
6. Educate all patients on the importance of viral loads, the recommended schedule for viral load draws and they can maintain a high viral load through one-on-one counselling and/or health talks.

E. Using the Appointment Register and Client Tracing Tools

This section is intended for use by health facilities that do not already have a way to monitor and track patient appointments. With the system outlined, CHWs can monitor appointments and track tracing efforts for those that have missed appointments. A full procedure can be found in **Appointment Register Tools** and **Client Tracing Tools**.

1. A CHW should be present to check in and check out patients using the **Appointment Register** during each ART clinic day.
    a. During check-in, the CHW records the patient's attendance at their appointment in the register.
    b. During check out, the patient's next appointment is recorded in the register.
2. The Appointment Register is checked at regular intervals to ensure that all patients have attended their appointment.
3. For patients that have not returned to the health facility in more than two weeks following their scheduled appointment, a CHW is assigned to perform client tracing.
    a. The CHW uses the **Client Tracing Form** to record tracing efforts and the **Client Tracing List** to record his/her list of clients.
    b. Once client tracing is complete, the CHW records the tracing outcome in the Appointment Register. If the patient intends to return, a new appointment is recorded.

F. Defaulter Tracing Activities

While defaulters should be identified through the appointment register system, the following defaulter tracing activities will provide extra attention to those who have defaulted from care.

Definitions for defaulters may vary by facility and/or country. Definitions and the degree to which each category of 'defaulter' is followed up should be clearly defined before any defaulter tracing programs are implemented. In this situation, a defaulter is defined as a client who has missed a scheduled ART refill appointment by more than 2 months. The following are the steps of defaulter tracing.

1. Each quarter, the ART clinic and CHWs should complete an audit of patient records to determine the patients who have defaulted from care.
2. Clients who have defaulted should be documented on the **Defaulter Tracing List**, to document clients and the assigned CHW.
3. Similar to the missed appointment tracing process, a CHW should be assigned to tracing, complete a Client Tracing Form, and add the patient to the CHW's Client Tracing List (see Case Study 4).
4. When a patient returns to care after a missed appointment, s/he should be provided with extended adherence counselling at the health facility.
5. Adherence counselling should be provided to the patient at every visit for the next three months. This adherence counselling can be done at the home or health facility, depending on availability of resources.

G. Additional Support System for HIV-infected Children and their Caregivers

This section briefly outlines a program which provides community health-worker based case management for HIV-infected children and youth to improve outcomes. A full procedure can be found in the **CBC Program Package** (Case Study 5).

1. All consenting, eligible children should be enrolled in the CBC Program as soon as they enroll in HIV services at the facility. Eligibility requirements include being less than 18 years old and HIV-infected.
2. Each child is assigned a CHW to provide regular follow up and monitoring.
3. The CHW provides support and additional counselling to the child during all facility visits. The CHW also conducts home visits at regular intervals to monitor the child's adherence.

Section 3: Monitoring and Evaluation and Supervision of Adherence and Monitoring Activities

1. Supervise departments regularly to ensure:
    a. The health talk roster is being followed
    b. All counselling and referral materials are up to date and readily available
    c. Patients with missed appointments are being assigned a CHW and traced
    d. Missed appointment and defaulter tracing is being done and properly recorded
2. Collect adherence and retention data regularly. Sample indicators may include:
    a. Nutritional status of patients
    b. Number of viral loads done
    c. Number of viral loads taken and/or number of results given to patients
    d. Number of DNA PCR test results given to patients
    e. Number of patients screened for tuberculosis
3. Hold regular meetings with each department's focal person to discuss best practices and edit case management strategies accordingly.
4. Share data and best practices regularly between departments and facilities.
5. Liaise regularly with HIV support groups and other HIV organizations to update their contact details and discuss referral practices.

Case Study 1:
Tingathe Disability Directory—A Case Study of the use of the Patient Referral Tools

SPECIAL OLYMPICS MALAWI

Sports Council Building, Blantyre

Postal Address: P.O. Box 452, Blantyre
Email: somalawidirector@gmail.com

National Director
Felix John Izeke Chisowa
0999 321 885

Institutional Status: International NGO

Disabilities Targeted: All

Background
In Malawi, the organisation started in 1999. The international office is located in Washington D.C., USA.

Activities
- Sports training to people with intellectual disabilities
- Family health focus to caregivers of those with disabilities
- Health screening
- Health promotion

Equipment
- Sports equipment
- Hearing aids
- Wheelchairs

Referral
For more information, contact the regional coordinator in your area.

Region	Director	Phone
South	Mrs. L Magagula	0998 083 206
Central	Mr. R January	0999 462 653
North	Mr. L Lungu	0999 989 317

An excerpt from the Disability Directory. Each age of the directory includes information on the organization's location, key activities and how to provide a referral

Many of the children living with HIV cared for by Tingathe struggle with an array of impairments, activity limitations, and challenges to daily living that can be broadly defined as disabilities. Care and treatment for these disabilities have not been considered a standard package of HIV care, primarily due to lack of awareness of what services are available.

In order to address this challenge Tingathe, in partnership with the Ministry of Gender, Children, Disability and Social Welfare, worked to update, expand, and improve the existing *2005 Directory of Disability Services and Organizations of Malawi*. Using the Referral Organization Information Form, information was collected from disability organizations, schools and specialty clinics across the country. The final product contains over 70 institutional entries, with further contact details for local officers and offices, along with all educational resource centres and specialty schools. The Directory also includes a special "Tools and Resources" section to assist care-givers and physicians to screen children for disabilities.

Case Study 2:
Monitoring Viral Loads

To ensure viral load suppression, it is important to draw patients' viral loads at the recommended intervals. CHWs can help streamline this process by:

- Screening patients during triage to see if they are at a recommended viral load time
- Informing the clinician that a patient is ready for a routine viral load
- Escorting patients to and from the area where viral loads are being drawn
- Giving expert counselling on what a viral load test is, what the results mean and the schedule for them to be drawn
- Encouraging patients to remind their clinician/ nurse when it is time for a scheduled viral load
- Drawing viral loads
- Giving enhanced adherence counselling at home and at the facility for patients with a high viral load

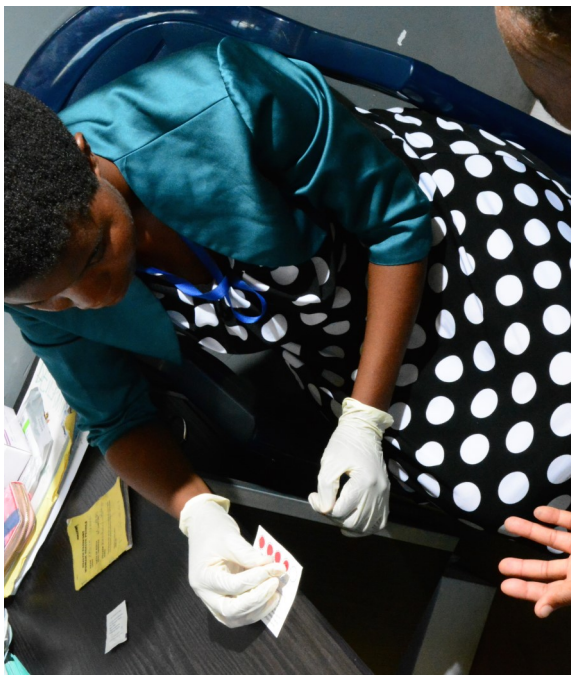


Photo courtesy of Louis Hugo

Case Study 3: Adherence Questionnaire

A key responsibility of a CHW is to provide support for patients and encourage them to remain adherent and in care. One way to do that is to assess a patient's adherence at every visit. This simple questionnaire can assist CHWs to assess their patient's adherence in a supportive way.

- Have you had any problems with your ART and other medication? If yes, what problems have you had?
- Tell me about the last time you missed a dose of your medication. What happened?
- Can you show me how you take/give the medication? -- Check dose and frequency.
- For children patients only: Who is responsible for giving ART and other medications to the child? Who gives the medicine if the primary caregiver is away?

Case Study 4: Partnering with Existing CHWs to Assist with Client Tracing

Patient home-based tracing can be difficult especially in catchment areas that cover an extensive area or where travel to communities is challenging. Tingathe faced a similar issue and decided to partner with existing HSAs at the health facility to help them. HSAs are the ministry of Health's community health provider cadre of and they work exclusively within their communities for the majority of the working week. After providing them with an abbreviated one-day training on HIV basics, the importance of adherence and how to conduct a home visit, HSAs were able to assist with patient tracing and follow up. Additionally, since HSAs were already recognized within their communities for targeting an array of health issues, HIV stigma and confidentiality were less of an issue for them than CHWs who were known for HIV-related activities only.

Photo courtesy of Chris Cox

Case Study 5: CBC Program Overview

This flowchart provides a brief overview of the program's activities and key goals. Detailed instructions can be found in the CBC Program Package.

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

This package contains the instructions for use of the tools within the Appointment Register Workshop 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 workshop.

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: Objectives and Importance of tracking client appointments; Using the Appointment Register and Client Tracing Tools; Using the Defaulter Tracing List; Reporting on Missed Appointments; and Implementation of Tools into your Facility. Comments, key discussion points and instructions are embedded throughout the presentation in the notes section to aid the facilitator in leading.

Appointment Register & Defaulter List Brief SOP: A two-page, quick-reference version that combines the procedures for the Appointment Register, Defaulter Tracing List and Client Tracing 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 Appointment Register. The Training PowerPoint has prompts for exercises #1 and #2 so that participants can practice their new skills immediately after learning about them.

Implementation Worksheet: This worksheet is designed to help health facilities adapt and implement the procedures and tools from this workshop into their own facility.

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

AGENDA

Activity	Time	Handouts Needed	Facilitator
Participants Arrive	8:00		
Welcome and Introductions	8:00-8:15	Handout of printed PPT	
Appointment Register SOP and Tools	8:15-8:45	Appt Reg Brief SOP	
Client Tracing SOP and Tools	8:45-9:30	Client Tracing Tools (Client Tracing Form,	
Exercise 1 – Using the Appointment Register and Client Tracing Tools	9:30-10:30	Copy of Appt Reg, M&E Example Handout	
Tea	**10:30-10:45**		
Appointment Register Monthly Report	10:45-11:20	Appt Reg Monthly Report	
Exercise 2 – Completing the Monthly Report	11:20-12:05		
Defaulter Tracing	12:05-12:30	Defaulter Tracing Worksheet	
Lunch	**12:30-1:30**		
M&E Review & Exam	1:30-2:45	Exam	
Implementing the Appointment Register into Your Facility	2:45-3:45		
Distribution of Site Supplies	3:45-4:00		
Closing Remarks & Tea	**4:00**		

Appointment Register and Defaulter Tracing

TINGATHE TOOLKIT

Objectives

- Define a missed appointment and defaulting from care
- Discuss the importance of missed appointment tracing
- Present the Appointment Register and review Client Tracing
- Present the Defaulter Worksheet
- Discuss cases and practice using Register and Client Tracing tools

Definitions

- Missed appointment:
  - Not coming on the scheduled appointment date for ART refill
  - For this program, a client should be traced by a CHW if s/he misses the scheduled appointment date by > 2 weeks.
- Defaulting from care:
  - Per MOH, defaulter is defined as a client who has missed a scheduled ART refill appointment by more than 2 months.

TINGATHE TOOLKIT

Note: Ministry of Health (MOH) definitions should be edited based on implementing country.

Part I.
Missed Appointments

Tracing for missed appointments

- Attending ART appointments as scheduled is important because if clients don't get ART, they will have poor ART adherence and risk drug resistance/treatment failure.
  - If a client misses an appointment by a day or two, s/he may have a buffer stock of ART and be able to maintain good adherence.
  - If a client misses an appointment by more than 2 weeks, s/he most likely has run out of ART and has poor adherence.
    - When you see a client who has come late for an appointment, ask them about adherence and provide education and counseling.

TINGATHE TOOLKIT

Note:

- This is a good opportunity to refresh CHWs knowledge of the 'Adherence Questionnaire' learned during their training.
- Discuss how CHWs can approach patients with poor adherence in a supportive way.

Tracing for Missed Appointments

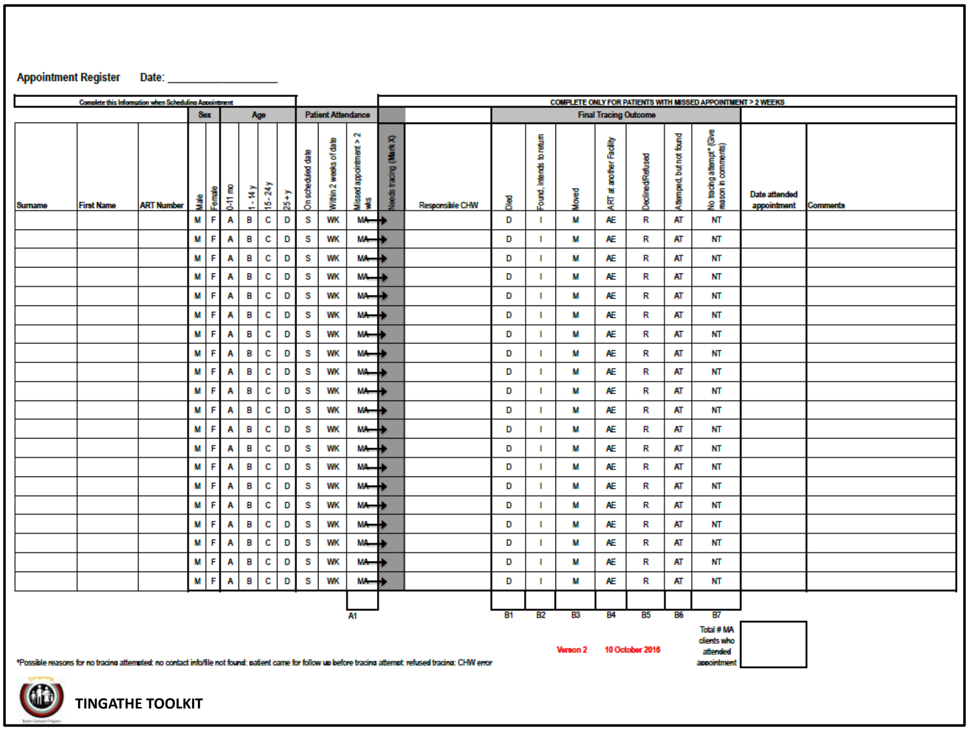
- The process of tracing for missed appointments is similar to Client Tracing for linkage to care.
- If a client misses a scheduled ART appointment for ≥ 2 weeks, a CHW should be assigned to trace the client.

Appointment Register

- The appointment register has multiple functions:
  - Lets us know when people are scheduled for appointments and when they miss them
  - Helps to even out patient load among the clinic days – make sure not to overfill a clinic
  - Documents tracing efforts for missed appointments
  - Can use data from Appointment Register for Monthly Report – lets us know how we are doing over time

TINGATHE TOOLKIT

Note:
Helps to even out patient load among the clinic days – make sure not to overfill a clinic: when printing the register, it can be designed so that only a certain number of pre-determined spots are available per day to schedule patients. By keeping track, and limiting the number of patients scheduled per clinic day, the clinic can ensure their human and time resources are able to properly accommodate all patients scheduled for that day.



Appointment Register Date: ___________________

Complete this Information when Scheduling Appointment												COMPLETE ONLY FOR PATIENTS WITH MISSED APPOINTMENT > 2 WEEKS										
			Sex		Age				Patient Attendance					Final Tracing Outcome								
Surname	First Name	ART Number	Male	Female	0-11 mo	1 - 14 y	15 - 24 y	25 + y	On scheduled date	Within 2 weeks of date	Missed appointment > 2 wks	Needs tracing (Mark X)	Responsible CHW	Died	Found, intends to return	Moved	ART at another Facility	Declined/Refused	Attemped, but not found	No tracing attempt* (Give reason in comments)	Date attended appointment	Comments
			M	F	A	B	C	D	S	WK	MA→			D	I	M	AE	R	AT	NT		
			M	F	A	B	C	D	S	WK	MA→			D	I	M	AE	R	AT	NT		
			M	F	A	B	C	D	S	WK	MA→			D	I	M	AE	R	AT	NT		
			M	F	A	B	C	D	S	WK	MA→			D	I	M	AE	R	AT	NT		
			M	F	A	B	C	D	S	WK	MA→			D	I	M	AE	R	AT	NT		
			M	F	A	B	C	D	S	WK	MA→			D	I	M	AE	R	AT	NT		
			M	F	A	B	C	D	S	WK	MA→			D	I	M	AE	R	AT	NT		
			M	F	A	B	C	D	S	WK	MA→			D	I	M	AE	R	AT	NT		
			M	F	A	B	C	D	S	WK	MA→			D	I	M	AE	R	AT	NT		
			M	F	A	B	C	D	S	WK	MA→			D	I	M	AE	R	AT	NT		
			M	F	A	B	C	D	S	WK	MA→			D	I	M	AE	R	AT	NT		
			M	F	A	B	C	D	S	WK	MA→			D	I	M	AE	R	AT	NT		
			M	F	A	B	C	D	S	WK	MA→			D	I	M	AE	R	AT	NT		
			M	F	A	B	C	D	S	WK	MA→			D	I	M	AE	R	AT	NT		
			M	F	A	B	C	D	S	WK	MA→			D	I	M	AE	R	AT	NT		
			M	F	A	B	C	D	S	WK	MA→			D	I	M	AE	R	AT	NT		
			M	F	A	B	C	D	S	WK	MA→			D	I	M	AE	R	AT	NT		
			M	F	A	B	C	D	S	WK	MA→			D	I	M	AE	R	AT	NT		
			M	F	A	B	C	D	S	WK	MA→			D	I	M	AE	R	AT	NT		
			M	F	A	B	C	D	S	WK	MA→			D	I	M	AE	R	AT	NT		
											A1			B1	B2	B3	B4	B5	B6	B7		

Total # MA clients who attended appointment ☐

Verson 2 10 October 2016

*Possible reasons for no tracing attempted: no contact info/file not found; patient came for follow up before tracing attempt; refused tracing; CHW error

TINGATHE TOOLKIT

- Explain the general layout of the appointment register (we will go through the procedure on the following slides)
- Explain that the appointment register should be labeled ahead of time like a calendar with pages for each date (decide how many pages per date based on clinic size). The first columns will be completed when the patient is being scheduled for an appointment (like in a calendar, fill in patient info on the day when they are being scheduled). The second part is only for people who miss appointment by >2 weeks.
- We will practice using this form with cases later.

Procedure for Appointment Register

1. All scheduled HIV clinic appointments (ART refills) should be entered in the appointment register.
   - Enter patient information (Name, ART number, age, sex) on the page for the scheduled follow up date.
2. During the clinic day, circle "S" in the Patient Attendance column for all patients who attend clinic on their scheduled date.
   - If the patient does not attend, the Patient Attendance column can be left blank on the date of the scheduled appointment.

Procedure for Appointment Register (2)

3. If a patient comes at a later date for their appointment, the Patient Attendance outcome should be updated on the patient entry for the date of the scheduled appointment.
   - If they are late but <2 weeks, circle "WK" for within two weeks of date
   - If they are late by >2 weeks, circle "MA" for missed appointment by more than two weeks.
4. Every Friday, the focal person for Client Tracing (CHW) should check the appointment register for 2 weeks prior. All clients who have not come to clinic for > 2 weeks should be marked "MA" and assigned to CHWs for client tracing.
   - Example: On the third Friday of October, a CHW should check the Appointment Register for the first week of October and mark everyone without a Patient Attendance outcome as MA and assign a CHW to trace each one.

Procedure for Appointment Register (3)

5. Client Tracing:

- The column for the name of the Responsible CHW should be completed at this time.
- The assigned CHW should add the client to his/her CHW Client List, use the Client Tracing Form, and document the tracing outcome in the appointment register.

Procedure for Appointment Register (4)

- Outcomes after missed appointment:
  1. Tracing Outcome: This is what happens when you try to trace the patient.
  2. Appointment Outcome: Did the client come back for an appointment?
     - If so, document the date when they returned for an appointment in the column "Date Attended Appointment" – this will be on the day of their originally scheduled appointment.

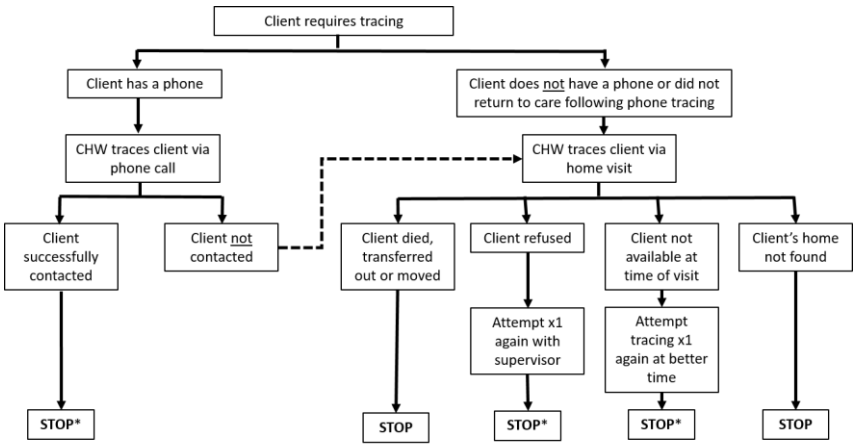
Review of tracing outcomes on the next slide

Review of Tracing Outcomes

Outcome	Outcome Description
Died	Client has died
Found, intends to return	Client is located and says s/he will return to care. Schedule a new appointment.
Moved	Client has changed address
ART at another facility	Client says s/he is receiving care at another facility. Document what facility in comments section.
Declined/Refused	Does not intend to return to care
Attempted, but not found	Tracing attempts exhausted but client has not been found
No tracing attempt	Client has not been traced. Provide reason in register comments

CLIENT TRACING TOOLS

Client Tracing after Missed Appointment



***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.*

TINGATHE TOOLKIT

Tracing Tools (1)

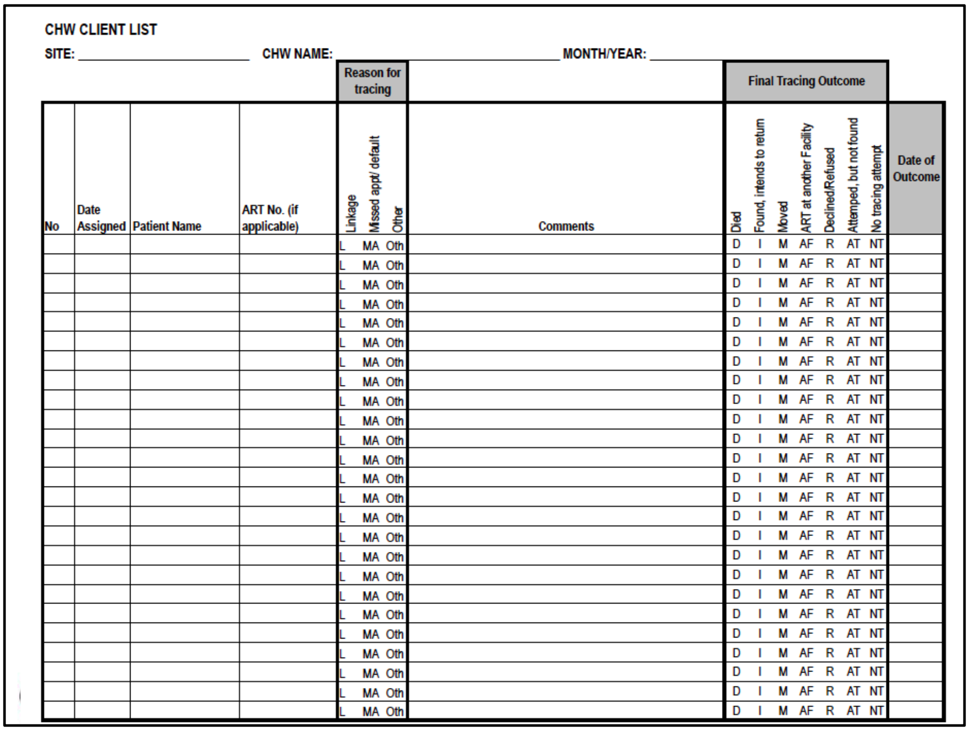
- The purpose of the tracing tools is to help the CHW keep track of their activities and thus better perform their duties
- There are 2 tools to support Client Tracing:
  - CHW Client List
  - Client Tracing Form
- Client Tracing tools will be used any time a client needs to be traced (phone or home visit) by a CHW
  - This may be for linkage to care, missed appointment, defaulting from care, or other reason (TB test results, VL or DNA-PCR results, etc)

Tracing Tools (2)

- CHW Client Tracing List
  - A list kept where the CHW can keep track of all the clients s/he is tracing (for linkage, missed appointment/defaulter, or any other reason).
  - Each CHW should have a Client Tracing List.
- Client Tracing Form
  - A form the CHW will use to document what tracing activities are done & the outcome.
  - The CHW should use one Client Tracing Form for each client.

Tracing Tools (3)

- Data for reports will be taken from the Registers, not the Tracing Tools.
- The Tracing Tools are there to help you do your job well!
- The supervisors will check each CHW's Tracing Tools to monitor tracing activities.



CHW CLIENT LIST

SITE: ______________________ **CHW NAME:** ____________________________ **MONTH/YEAR:** ____________

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

Review hard copy together. Answer questions.

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).....

TINGATH

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

Go through the different sections of the form, discuss how they can use and answer questions.

Cases

- Use Appointment Register, CHW Client List, and Client Tracing Form to record the activities and outcomes for the cases
- At the end, we will fill in the section on Appointments in the Site Monthly Report
- You should all start with the Appointment Register for the clinic day 17/10/16

Appointment Register Date: ____17/10/2016_____

Complete this Information when Scheduling Appointment														COMPLETE ONLY FOR PATIE					
			Sex		Age				Patient Attendance						Final Tracing Outc				
Surname	First Name	ART Number	Male	Female	0-11 mo	1 - 14 y	15 - 24 y	25 + y	On scheduled date	Within 2 weeks of date	Missed appointment > 2 wks	Needs tracing (Mark X)	Responsible CHW	Died	Found, intends to return	Moved	ART at another Facility	
A	A	1048	M	F	A	B	C	D	S	WK	MA	→		D	I	M	AE	
B	B	1201	M	F	A	B	C	D	S	WK	MA	→		D	I	M	AE	
C	C	1135	M	F	A	B	C	D	S	WK	MA	→		D	I	M	AE	
D	D	1824	M	F	A	B	C	D	S	WK	MA	→		D	I	M	AE	
E	E	1678	M	F	A	B	C	D	S	WK	MA	→		D	I	M	AE	
F	F	1902	M	F	A	B	C	D	S	WK	MA	→		D	I	M	AE	
G	G	1132	M	F	A	B	C	D	S	WK	MA	→		D	I	M	AE	
H	H	1428	M	F	A	B	C	D	S	WK	MA	→		D	I	M	AE	
I	I	1909	M	F	A	B	C	D	S	WK	MA	→		D	I	M	AE	
J	J	1768	M	F	A	B	C	D	S	WK	MA	→		D	I	M	AE	
K	K	1245	M	F	A	B	C	D	S	WK	MA	→		D	I	M	AE	
L	L	1689	M	F	A	B	C	D	S	WK	MA	→		D	I	M	AE	
M	M	1356	M	F	A	B	C	D	S	WK	MA	→		D	I	M	AE	
			M	F	A	B	C	D	S	WK	MA	→		D	I	M	AE	

TINGATHE TOOLKIT

State that these patients were all put on the schedule to be seen today for ART refills – some were last seen 1mo, 2mo or 3mo ago, but this was the follow up date to return given to them by the clinician at their last visit.

Exercise #1

- It is 17/10/16 and you are managing the appointment register in ART clinic.
- As clients check in, you mark that they have appeared "on scheduled date".
- As clients finish seeing the clinician, you enter them in the appointment register on the date of the scheduled follow up appointment.
- Clients AA, CC, DD, EE, FF, GG, JJ, and MM have all come to clinic today. *Update the Appointment Register with Patient Attendance now.*

TINGATHE TOOLKIT

Participants should following along with their **M&E Example Handout**.

Exercise #1

- Each day, when you see that someone has come for ART refill but it is not their scheduled date, you note this in the appointment register.
- On 4/11, you review the Appointment Register for two weeks prior. On the 17/10 page, the following information has been added in the appointment register:
  - BB attended clinic on 19/10
  - HH attended clinic on 21/10
  - There is no patient attendance outcome circled for Patients II, KK, and LL.

Update your appointment register with this information.

TINGATHE TOOLKIT

- WK should be circled for BB and HH (date atteneded appointment does not need to be completed bc this is only for those who miss their appointment by >2 weeks)
- MA should be circled for patients II, KK and LL.

Exercise #1

- What do you do now?
  - Assign a CHW to trace patients II, KK and LL.
  - Note that KK and LL are children – can you tell if their parents are enrolled in ART too? Are they related?
  - Fill in the "Responsible CHW" column with the name of the CHW assigned for client tracing.

TINGATHE TOOLKIT

- CHWs should take note if any patients are related (child-parent or spouses) before assigning CHWs.
- If the patient is a child and their parents are also on ART, it may be helpful to see if their parents are also enrolled and if so, if they attended their last ART refill appointment to see if there are any trends in adherence. Note that during tracing of child patients, special counselling should be given.

Patient II

- You are the CHW assigned to trace Patient II. You pull her MasterCard and note that she is a 16 year old girl who was diagnosed HIV+ 3 months ago and has only been on ART for 2 months. There is a phone number and location information on the card. What do you do?
- Try to call (maintain confidentiality). In this case, you try to call but she is not reachable by phone, so you make a home visit.

Patient II

- You visit her home and find her there. She says she had exams at school so she couldn't come to her appointment – she borrowed some ART from her mother who is also a client at the clinic. She says she will come back to clinic on Nov 4th.

Update your CHW Client List and Client Tracing Form with this information. Complete the Final Tracing Outcome in the Appointment Register.

TINGATHE TOOLKIT

Client Tracing Form – should note the attempted call & the home visit.

Discuss issues of confidentiality on home visit, especially with a teen – If she is not home but her parents are there, how do you approach the situation?

Patient II

- On Nov 1, you see Patient II at clinic – she sees the clinician and gets an ART refill. You also conduct adherence counseling and enroll her in Teen Club.

Update the Appointment Register with Date Attended Appointment.

She is scheduled to return in 1 month and entered in the Appointment Register for the date of her future appointment.

Patient KK & LL

- Now you are the CHW assigned to trace patients KK and LL. You pull their MasterCards and note that they are from the same household (same phone number and locator information).
- Patient KK is a 6 month old girl and started ART at 3mo of age.
- Patient LL is a 8 year old boy and started ART 3 years ago.
- What do you do next?

Patient KK & LL

- You call the phone number. The mother says they have moved and are now getting ART at another health facility (though they didn't do an official transfer).

Complete the CHW Client List, Client Tracing Form, and Update the Appointment Register.

TINGATHE TOOLKIT

- If 2 clients in same household (family members), enter both as separate clients on the CHW Client list but can use one Client Tracing Form since you're tracing to the same phone number/household. Ensure you write both names on the Client Tracing Form. Make a note if tracing outcomes are different for each patient.
- Question: What is the tracing outcome for this client? Moved – but indicate in comments section that they are receiving ART at another health facility.

Appointment Register Monthly Report

- The Monthly Report should be completed by the 5th day of the following month (Example: Monthly Report for October should be submitted by November 5th).
- Two staff at the site should complete the report by recording data in the Site Result column, and signing their names on report.
- The Site Supervisor will also review the report for data quality, sign and date.
- Comments sections are to be used to explain any unusual or incomplete data.
- Appointment Register data is collected from the Tingathe Program Appointment Register.
- All missed appointment data is reported for the previous month. The Reporting Month is the month you are filling the monthly report, and the Outcome Reporting Month (ORM) is the month the data is from.

Appointment Register Monthly Report

1. Fill the top of the monthly report with the site name, district, reporting month and reporting year.
2. Collect the Appointment Register.
3. Count the total number of clients the appointment register by counting each name registered. Write this value in MA1 'Total number of clients registered'.
4. Tally and complete the total section at the bottom of each Appointment Register sheet for the reporting month.
5. Add the total boxes across each sheet (e.g. add the Box A total from page 1 to Box A total from page 2, etc).
6. Enter the calculation totals into the corresponding row on the Monthly Report in the 'Site Result' column.
7. Once all sections have been completed, sign and date the report, then give it to the site supervision for a data check.

Appointment Register Monthly Report

			Sex		Age				Patient Attendance					Final Tracing Outcome								
Surname	First Name	ART Number	Male	Female	0-11 mo	1 - 14 y	15 - 24 y	25 + y	On scheduled date	Within 2 weeks of date	Missed appointment > 2 wks	Needs tracing (Mark X)	Responsible CHW	Died	Found, intends to return	Moved	ART at another Facility	Declined/Refused	Attemped, but not found	No tracing attempt* (Give reason in comments)	Date attended appointment	Comments
											12			0	9	3	0	0	0	0		
											A1			B1	B2	B3	B4	B5	B6	B7		
																				Total # MA clients who attended appointment	8	

*Possible reasons for no tracing attempted: no contact info/file not found; patient came for follow up before tracing attempt; refused tracing; CHW error

Missed Appointments– Use Appointment Register (Report Data for Previous Month)

Instructions: The following data will be filled from the outcome reporting month (ORM) from the Appointment Register. Please see ta determine the ORM. After determining the ORM, write both the reporting month and the ORM below.

Reporting Month	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
ORM	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov

Reporting Month: _____ **Outcome Reporting Month (ORM):** _____

MA1	Total Number of Clients Registered	Appointment Register		100
MA1.1	Number of clients with a Missed appointment > 2 wks	Appointment Register (Box A1)		12
MA 2.0	Died	Appointment Register (Box B1)		0
MA 2.1	Found, intends to return	Appointment Register (Box B2)		9
MA 2.2	Moved	Appointment Register (Box B3)		3
MA 2.3	ART at another Facility	Appointment Register (Box B4)		0
MA 2.4	Declined/ Refused	Appointment Register (Box B5)		0
MA 2.5	Attempted, but not found	Appointment Register (Box B6)		0
MA 2.6	No Tracing Attempt	Appointment Register (Box B7)		0

Comments:

TINGATHE TOGETH

Exercise #2

- Get into small groups.
- You already have the Appointment Register page for 17/10/16.
- You will be given another completed Appointment Register page for 31/10/16.
- We will pretend that your site only had ART clinic 2 days in the month of October.
- Complete the appointment section of the Site Monthly Report for October using the Appointment Register data.

Part II.
Defaulter Tracing

TINGATHE TOOLKIT

Defaulter Tracing

- Review: What is a defaulter?
  - Client who misses scheduled ART appointment by >2 months.
- We will do a MasterCard audit each quarter to identify defaulters and trace them.
  - These are clients who may have been traced for missed appointments initially but slipped through the cracks.
  - This gives us valuable information on how many patients reach the point of defaulting & if tracing can help bring them back to care.

TINGATHE TOOLKIT

Note:
- Mastercards are patient records kept at the health facility. Patient ART details and records of each ART refill appointment are kept here.
- The goal of the Appointment Register is to prevent defaulters by tracing them before they become defaulters. Initially there may be many defaulters, but over time there become fewer (or none!).

Defaulter Audit Procedure

- Review all MasterCards each quarter.
- If a client has missed his/her scheduled appointment by >2 months, enter that client on the Defaulter Worksheet.
  - The format of the Defaulter Worksheet is very similar to the Appointment Register.
  - Assign a CHW to tracing & document tracing outcome.
  - CHW should add these clients to CHW Client List and use the Client Tracing Form like usual.

Defaulter Worksheet

Date of Audit: _____ Health Facility Name: _____

	Date of Last Scheduled ART Refill (>2 mo ago)	Surname	First Name	ART Number	Village	Phone Number	Sex		Age				CHW Assigned	Final Tracing Outcome							Date of Outcome	Comments
							Male	Female	0-11 mo	1 - 14 y	15 - 24 y	25 + y		Died	Found, intends to return	Moved	ART at another Facility	Declined/Refused	Attemped, but not found	No tracing attempt* (Give reason in comments)		
1							M	F	A	B	C	D		D	I	M	AE	R	AT	NT		

- Notice similarities to both the Appt Register and the Linkage Register
- Client tracing procedure and tools are the same

TINGATHE TOOLKIT

- Review hard copies of the worksheet
- Point out similarities in this sheet to other tools (Linkage Register & Appointment Register)
- Client tracing procedure and tools are the same
- **Discuss:** how would you treat clients that you have traced through defaulter tracing audit different than those that have a missed appointment? Is there additional follow up/counselling/support that they should be offered?
- During the first audit, it is recommended that there is support from the program and/or M&E team to conduct the audit so that it can be reviewed in a more timely setting.

Any questions about Defaulter Tracing??

Implementing Appointment Register Into Your Facility

Work within your site groups to complete the Appointment Register Implementation Worksheet.

Be prepared to present on possible challenges and solutions.

TINGATHE TOOLKIT

Instructions:

- Break participants into site groups (if multiple sites) or keep in one large group if all one site to discuss the questions
- Review the questions first to ensure understanding of the activity
- Give participants ~35 minutes to complete all questions
- Once done – ask each site to present on their expected challenges and possible solutions.

Take Home Points

- After we identify new HIV+ cases (PITC) and link them to ART, we want to be sure that they stay on ART with good adherence.
- We monitor missed appointments and defaulting from care in order to identify clients at high risk for poor ART adherence – these clients should get extra support and counseling from CHWs in a non-judgmental way.
- Use the Appointment Register, Defaulter Tracing Sheet and Client Tracing Tools to keep track of missed appointments and retention in care.

Appointment Register & Defaulter Tracing Brief SOP

PURPOSE: The purpose of the missed appointment/defaulter tracing program is to identify patients who have missed ART appointments and thus are at risk for poor outcomes. CHWs will be instrumental in tracking missed appointments and counseling patients on the importance of returning to care. This procedure is broken up into three sections:

ASSOCIATED TOOLS: Appointment Register (with Missed Appointment Tracing section), Defaulter Tracing List, Client Tracing Form, CHW Client Tracing List

DEFINITIONS:

- Missed appointment: For this program, a client should be traced by a CHW if s/he misses the scheduled appointment date by > 2 weeks.
- Defaulter: A defaulter is defined as a client who has missed a scheduled ART refill appointment by more than 2 months.
- Client tracing: Activities to locate the client and provide counseling/information, either phone calls or physical visits (at home or other meeting place)

PROCEDURE:

Section 1: Appointment Register and Tracking Missed Appointment

1. A community health worker (CHW) should be assigned each day of ART clinic to be responsible for completing the Appointment Register.
2. All scheduled HIV clinic appointments should be entered in the appointment register by the responsible CHW. Each date will have one or more designated pages in the appointment register and the client's information (i.e. name, ART number, age sex) should be entered on the page for the scheduled follow up date.
3. On the scheduled date of the appointment, the CHW should circle "S" in the Patient Attendance column for all patients who attended clinic on their scheduled appointment date.
    a. If a patient does not attend, the Patient Attendance column can be left blank on the date of the scheduled appointment.
    b. If a patient comes at a later date for their appointment, the Patient Attendance outcome should be updated on the patient entry for the date of the scheduled appointment. If they are late but <2 weeks, circle "WK" for within two weeks of date; if they are late by >2 weeks, circle "MA" for missed appointment by more than two weeks.
4. Every Friday, the focal person for Client Tracing (CHW) should check the appointment register for the previous week. All clients who have not come to clinic for > 2 weeks (circled MA) should be assigned to CHWs for client tracing.
5. The column for the name of the Responsible CHW should be completed at this time. After this time, the assigned CHW is responsible for tracing the client using the tracing protocol below, then documenting the tracing outcome in the appointment register.
6. The tracing outcome should be assigned by the next monthly reporting period or sooner if the tracing procedure has been fully exhausted. It is possible that this outcome could change in future, however the outcome in the appointment register is the outcome on that date when it is assigned by CHW.

    Example: If the scheduled appointment was in January and by reporting in the first week of March, the CHW tried but not able to trace the client by phone or home visit, then the outcome is "Attempted, but not found" and the CHW should enter the date in March.
7. The column results should be totaled for the designated columns in the Appointment Register.
8. If the client returns for their appointment >2 weeks, the CHW should update the appointment register with the date they attended their appointment.

Section 2: Defaulter Tracing

While defaulters should be identified through the appointment register system, the defaulter tracing program will provide extra attention to those who have defaulted from care. The following are the steps of defaulter tracking:

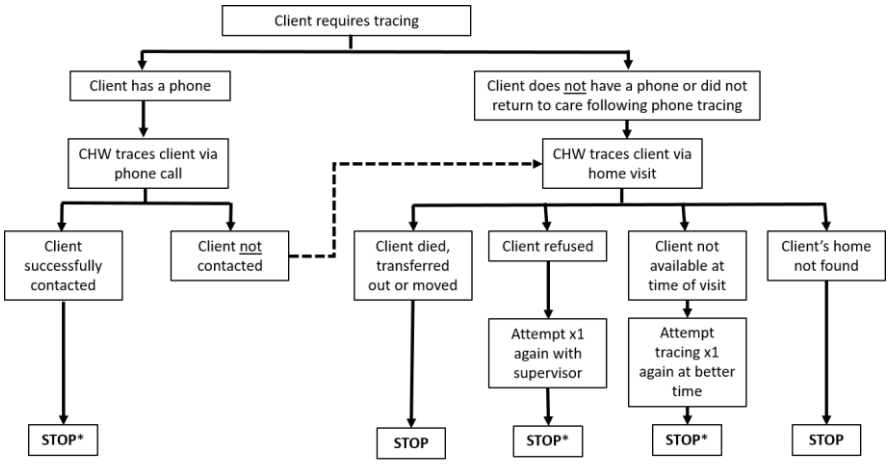
1. Each quarter, the ART clinic and Tingathe staff (clinical mentors and CHW with support of district M&E officer) should complete an audit of patient records to determine the patients who have defaulted from care. Patient records can be programme records or Ministry of Health records.
2. Clients who have defaulted should be documented on the Defaulter Tracing List, to document clients and the assigned CHW.
3. Similar to the missed appointment tracing process, the column for the name of the Responsible CHW should be completed at this time. After this time, the assigned CHW is responsible for tracing the client using the tracing protocol below, then documenting the tracing outcome on the Defaulter Tracing List.

4. The tracing outcome should be assigned by the next monthly reporting period or sooner if the tracing procedure has been fully exhausted. It is possible that this outcome could change in future, however the outcome on the Defaulter List is the outcome on that date when it is assigned by CHW.

   Example: If the defaulter was identified in January and by reporting in the first week of March, the CHW tried but not able to trace the client by phone or home visit, then the outcome is "Attempted, but not found" and the CHW should enter the date in March.
5. For all defaulters identified, additional counselling should be given by the CHW. During this counselling CHWs should work with the client to determine their barriers to adherence and reinforce the importance of good adherence and retention in care. Intensified counselling should repeated as often as necessary.
6. The column results should be totaled for the designated columns in the Defaulter Tracing List. Once complete, this list should be submitted directly to the M&E team for data entry.

Section 3: Client Tracing Procedure

Figure 1. *Summary of Tracing Protocol*



***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.*

1. Complete a **Client Tracing Form** to keep track of the tracing activity. Patient information is documented on the form. If client is an EID infant, then s/he should be prioritized for tracing.
2. CHW should follow the tracing procedure described in Figure 1. If phone number is available, the CHW may begin by trying to reach the client by phone. If client is successfully contacted but has not returned to care in two weeks, the CHW makes a home visit. If the client is not home but it is the correct house, the CHW should return one other time at a better time.
3. If the client does not have a phone, the CHW should proceed directly to a home visit.
4. Tracing attempts should be documented on the Client Tracing Form. While in use, the Client Tracing form is stored by the CHW in a binder.
5. Once a client has a final tracing outcome, the CHW should update the appropriate register (i.e. appointment register or defaulter tracing list) with the final outcome. Each Friday, the focal person for the register from where tracing was assigned will communicate with the CHWs responsible for tracing to see if any clients have a final tracing outcome. All clients must be given an outcome by the end of the following month (ie if they were registered in June, they should be given an outcome 'Attempted, but not found' or 'No Tracing Attempt' by the end of July).

Table 1. *Final Tracing Outcomes*

Outcome	Outcome Description
Died	Client has died
Found, intends to return	Client is located and claims they will return to care. Schedule a new appointment.
Moved	Client has changed address. This information can come from the patient first-hand (on the phone or in person) or by a neighbor (from home visit).
ART at another Facility	Client says they are receiving ART at another health facility. Document what facility in the comments section
Declined/Refused	Does not intend to return to care, for a variety of reasons.
Attempted, but not found	Tracing attempts exhausted but client has not been found
No tracing attempt	Client has not been traced. Provide reason in the register comments

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

EXERCISE #1

Part 1:

- It is 17/10/16 and you are managing the appointment register in ART clinic.
- As clients check in, you mark that they have appeared "on scheduled date".
- As clients finish seeing the clinician, you enter them in the appointment register on the date of the scheduled follow up appointment.
- Clients AA, CC, DD, EE, FF, GG, JJ, and MM have all come to clinic today. *Update the Appointment Register with Patient Attendance now.*

Part 2:

- Each day, when you see that someone has come for ART refill but it is not their scheduled date, you note this in the appointment register.
- On 4/11, you review the Appointment Register for two weeks prior. On the 17/10 page, the following information has been added in the appointment register:
  - BB attended clinic on 19/10
  - HH attended clinic on 21/10
  - There is no patient attendance outcome circled for Patients II, KK, and LL.
- *Update your appointment register with this information.*

Part 3:

- What do you do now?
  - _____
  - _____
  - _____

Part 4: Patient Tracing – *Use the Client Tracing Forms and Client Tracing Lists to Track all Patients*

Appointment Register **Date: ____17/10/2016_____**

Complete this information when Scheduling Appointment													COMPLETE ONLY FOR PATIENTS WITH MISSED APPOINTMENT > 2 WEEKS									
			Sex		Age				Patient Attendance						Final Tracing Outcome							
Surname	First Name	ART Number	Male	Female	0-11 mo	1 - 14 y	15 - 24 y	25 + y	On scheduled date	Within 2 weeks of date	Missed appointment > 2 wks	Needs tracing (Mark X)	Responsible CHW	Died	Found, intends to return	Moved	ART at another Facility	Declined/Refused	Attempted, but not found	No tracing attempt* (Give reason in comments)	Date attended appointment	Comments
A	A	1048	M	F	A	B	C	D	S	WK	MA→			D	I	M	AE	R	AT	NT		
B	B	1201	M	F	A	B	C	D	S	WK	MA→			D	I	M	AE	R	AT	NT		
C	C	1135	M	F	A	B	C	D	S	WK	MA→			D	I	M	AE	R	AT	NT		
D	D	1824	M	F	A	B	C	D	S	WK	MA→			D	I	M	AE	R	AT	NT		
E	E	1678	M	F	A	B	C	D	S	WK	MA→			D	I	M	AE	R	AT	NT		
F	F	1902	M	F	A	B	C	D	S	WK	MA→			D	I	M	AE	R	AT	NT		
G	G	1132	M	F	A	B	C	D	S	WK	MA→			D	I	M	AE	R	AT	NT		
H	H	1428	M	F	A	B	C	D	S	WK	MA→			D	I	M	AE	R	AT	NT		
I	I	1909	M	F	A	B	C	D	S	WK	MA→			D	I	M	AE	R	AT	NT		
J	J	1768	M	F	A	B	C	D	S	WK	MA→			D	I	M	AE	R	AT	NT		
K	K	1245	M	F	A	B	C	D	S	WK	MA→			D	I	M	AE	R	AT	NT		
L	L	1689	M	F	A	B	C	D	S	WK	MA→			D	I	M	AE	R	AT	NT		
M	M	1356	M	F	A	B	C	D	S	WK	MA→			D	I	M	AE	R	AT	NT		
			M	F	A	B	C	D	S	WK	MA→			D	I	M	AE	R	AT	NT		

EXERCISE #2

Use the register from Exercise #1 and the register below to complete the Appointment Register Monthly Report.

Implementation Guide

Instructions for Facilitation:

1. Review each of the questions with the participants using the Training PowerPoint and Facilitator's Guide.
2. Break participants up into groups. There should be one group representing each health facility and all members of a health facility should be in the same group.
3. Give each group a blank Implementation Guide.
4. Allow each group 20 minutes to discuss within their group how they plan to accomplish and work through each of the scenarios. Encourage discussion and brainstorming of possible challenges (and solutions!) they may face in implementation.
5. During the discussion, the facilitator should walk around to help provide guidance and answer questions.
6. After the designated amount of time, sites should share their challenges and solutions with others.
7. Encourage participants to look back on this tool during the first few weeks of implementation as a reminder of their plans and to modify it as necessary.

Site Name: _____

Assign Focal Persons:

	Responsibilities	Name	Phone Number
Appointment Register Focal Person	Ensuring the roster for completing the Appt Reg at each ART clinic day is followed; checking for MAs every Friday; assigning CHWs to trace; following up with tracing outcomes; completing the monthly report		
Defaulter Tracing Focal Person	Leading the defaulter audit; assigning CHWs to trace; following up with tracing outcomes; ensuring that the list is complete and returned to the M&E team for reporting		

Adapting the Appointment Register

- Is there already an appointment system in place? If yes, what systems/protocols can you adapt from this workshop to fill any gaps in monitoring and tracing patients with missed appointments?
- Determine a feasible number of patients to schedule each day – consider clinician/nurse load and other scheduled clinic days.
- How will you define a missed appointment – should it be greater or less than the recommended 2 weeks?

Implementing the Appointment Register

- What protocol will be used to ensure all patients appointments are entered into the appointment register and properly traced? Will you need a roster? Is there a certain place in the clinic for a CHW to sit to complete it?
- Is there already a procedure in place that records client location and contact details? If not, how will you reference those when doing client tracing?
- How will the focal person follow up with CHWs to get tracing outcomes – e.g. weekly group meeting, one-on-one follow up, etc?
- What challenges (and possible solutions) do you expect when implementing this procedure?

Defaulter Tracing

- How will you define a defaulter? Is there already a definition in place by the Ministry of Health?
- How often will you complete defaulter tracing? Should the number of tracing attempts be increased or reduced?
- Do you need support from any other program or ministry of health staff to compelte the audit?
- What records can you use to track defaulters? Is there location/contact details attached to those records?
- Do you have any special counselling already in place for defaulters/people with poor adherence?
- What challenges (and possible solutions) do you expect when implementing this procedure?

Client Tracing

- Are there any other teams/groups of people that can help with community tracing?
- How often will tracing happen? Does a roster need to be put in place to ensure there are enough CHWs at the facility while other CHWs perform tracing?
- How will you assign CHWs to patients – will you assign clients by region, distance from the clinic, distance from the CHWs home?
- Are there any additional supplies or resources that need to be procured in order for tracing to take place (e.g. airtime, bicycles, phones, etc.)?
- What challenges (and possible solutions) do you expect when implementing this procedure?

Community Health Worker
Exam - Practical

Name: _____ **Health Centre:** _____ **Date:** _____ **Final Score Practical:** ____ / ___

Instructions: This exam has three different sections: Appointment Register, Client Tracing Form, and Monthly Report. Please complete all sections according to the *instructions in italics* given in each section.

Section 1: Appointment Register

There are 6 patients in the Appointment Register scheduled to come today (September 25th) for ART refill. Complete the register according to the situation of each patient described below.

Patient 1: John Banda – he attended his appointment on the correct date.
Patient 2: Jane Madzi – She did not attend her appointment on her scheduled day. After two weeks, the Appointment Register focal person assigns you as her CHW for follow up. She does not have a cellphone. When you visit her at her home, she says she was away at a funeral and will return to clinic the on Oct. 15. She returns on Oct 15 as she said.
Patient 3: Mercy Phiri – She did not attend her appointment on the scheduled day. After two weeks, the Appointment Register focal person assigns you as her CHW for follow up. You call her phone, but it is a wrong number. You attempt to follow her at her home using the instructions she gave, but was not able to locate the home.
Patient 4: Gladys John – She attended her appointment 3 days after her scheduled appointment.
Patient 5: Obvious Dzidzi – He attended his appointment on the correct date.
Patient 6: Chimwemwe Smith – She did not attend her appointment on her scheduled day. After two weeks, the Appointment Register focal person assigns you as her CHW for follow up. She does not have a cellphone. When you follow her at her home, she says that she is stopping her ART because she is cured through prayer. You return once more with your supervisor and she still does not want to return to clinic.

Appointment Register **Date:** 25/09/2016

Complete this Information when Scheduling Appointment												COMPLETE ONLY FOR PATIENTS WITH MISSED APPOINTMENT > 2 WEEKS									
			Sex		Age				Patient Attendance					Final Tracing Outcome								
Surname	First Name	ART Number	Male	Female	0-11 mo	1 - 14 y	15 - 24 y	25 + y	On scheduled date	Within 2 weeks of date	Missed appointment > 2 wks	Needs tracing (Mark X)	Responsible CHW	Died	Found, intends to return	Moved	ART at another Facility	Declined/Refused	Attemped, but not found	No tracing attempt* (Give reason in comments)	Date attended appointment	Comments
Banda	John	1301	M	F	A	B	C	D	S	WK	MA			D	I	M	AE	R	AT	NT		
Madzi	Jane	4325	M	F	A	B	C	D	S	WK	MA			D	I	M	AE	R	AT	NT		
Phiri	Merci	3927	M	F	A	B	C	D	S	WK	MA			D	I	M	AE	R	AT	NT		
John	Gladys	7302	M	F	A	B	C	D	S	WK	MA			D	I	M	AE	R	AT	NT		
Dzidzi	Obvious	9786	M	F	A	B	C	D	S	WK	MA			D	I	M	AE	R	AT	NT		
Smith	Chimwemwe	9917	M	F	A	B	C	D	S	WK	MA			D	I	M	AE	R	AT	NT		
											A1			B1	B2	B3	B4	B5	B6	B7		

Total # MA clients who attended

Section 2: Client Tracing Form

Patient 6: Chimwemwe Smith – She did not attend her appointment on her scheduled day. After two weeks, the Appointment Register focal person assigns you as her CHW for follow up. She does not have a cellphone. When you follow her at her home on 10/10/16, she says that she is stopping her ART because she is cured through prayer. You return once more with your supervisor on 15/10/16 and she still does not want to return to clinic.

1. *Fill the Client Tracing Form for this patient.*

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

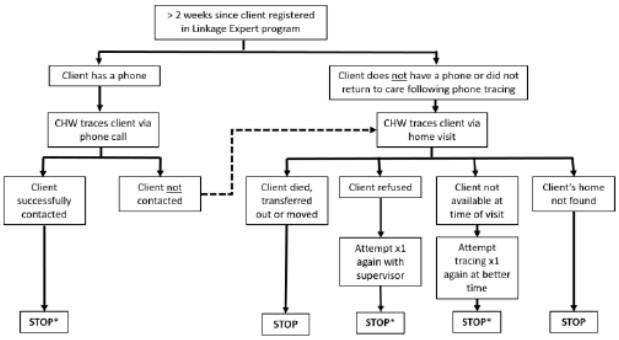
☐ Attempted, but not found

☐ 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.*

Section 3: Monthly Report

1. *Total the entries on the Appointment Register from the information you entered from Patients 1-6 in* ***Section 1 –Appointment Register****.*
2. *Use the entries to complete the Missed Appointment section of the Monthly Report. Note – the reporting month is October.*

Section 7. Appointment Register

Missed Appointments- Use Appointment Register (Report Data for Previous Month)

Instructions: The following data will be filled from the outcome reporting month (ORM) from the Appointment Register. Please see table below to determine the ORM. After determining the ORM, write both the reporting month and the ORM below.

Reporting Month	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
ORM	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov

Reporting Month: _____ **Outcome Reporting Month (ORM):** _____

MA1	Total Number of Clients Registered in ORM	Appointment Register			
MA1.1	Number of clients with a Missed appointment >2 wks	Appointment Register (Box A1)			
MA 2.0	Died	Appointment Register (Box B1)			
MA 2.1	Found, intends to return	Appointment Register (Box B2)			
MA 2.2	Moved	Appointment Register (Box B3)			
MA 2.3	ART at another Facility	Appointment Register (Box B4)			
MA 2.4	Declined/ Refused	Appointment Register (Box B5)			
MA 2.5	Attempted, but not found	Appointment Register (Box B6)			
MA 2.6	No Tracing Attempt	Appointment Register (Box B7)			

Most health facilities receive support from multiple partners, support groups and organizations who work together to provide patient care and support services. The goal of the **Referral Organization Information Form** is to create a comprehensive directory per site by obtaining information from each organization and group about their activities and services in order to collaborate and facilitate referrals. After obtaining information about each of the health facility's organizations, they can be combined in an easy to reference binder or poster, such as the **Referral Organization Summary**.

The **Referral Tracking Tool** is the last step in the process. This tool allows facilities the ability to track patient referrals to see if the referral was successful. This can provide valuable insight on how referral systems are working and patient barriers to attending referrals.

Referral Organization Information Form

(to be filled by organizations)

Name of Organization: _____

Status: □ Government □ NGO □ CBO/FBO □ School

□ Material or equipment supplier □ Other (specify): _____

Target Audience:
Describe the target audience for your program. (e.g. children below the age of 16, adults, all, HIV-infected individuals, etc.)

_____

Services Offered/Activities:
Describe your organization's main activities. Please try to keep the descriptions for your activities brief.

_____

_____

Cost for Services Offered? □ No □ Yes *(please attach document with price list)*

Outreach:
Tick below if you have an outreach program. If yes, please attach the location, dates, times, and services provided at your outreach center.
□ No, we do not have an outreach program. □ Yes, we do have an outreach program.

Contact Information:
Write N/A if not applicable. Cell number should only be filled if it is an official organization phone line.

Physical Address:			
Postal Address:			
Office Phone:		***Phone:***	
Fax:		***Cell:***	
Email:			
Website:			

Hours of Operation:
Please fill in your hours of operation for each day (e.g. 8am-4pm). If all of your services are offered on that day, please tick 'All', if not, tick 'Only' and specify which services are available on the lines provided.

	Monday	Tuesday	Wednesday	Thursday	Friday	Sat/Sun
Time						
Service Provided	□ All □ Only: _____ _____ _____	□ All □ Only: _____ _____ _____	□ All □ Only: _____ _____ _____	□ All □ Only: _____ _____ _____	□ All □ Only: _____ _____ _____	□ All □ Only: _____ _____ _____

Key Contact Personnel:
List the contact person for your organization below. Note that this person's name and title will be in the manual. Their personal email and phone information will NOT be listed in the manual, but will be used by Tingathe staff for further reference only.

Name			
Title			
Email		***Phone***	

Referral Organization Summary:

(compiled to be kept at the health facility for reference)

Organization Name	Key Activities	Contact Details *(name, phone number, email address)*	Location

Referral Tracking Tool

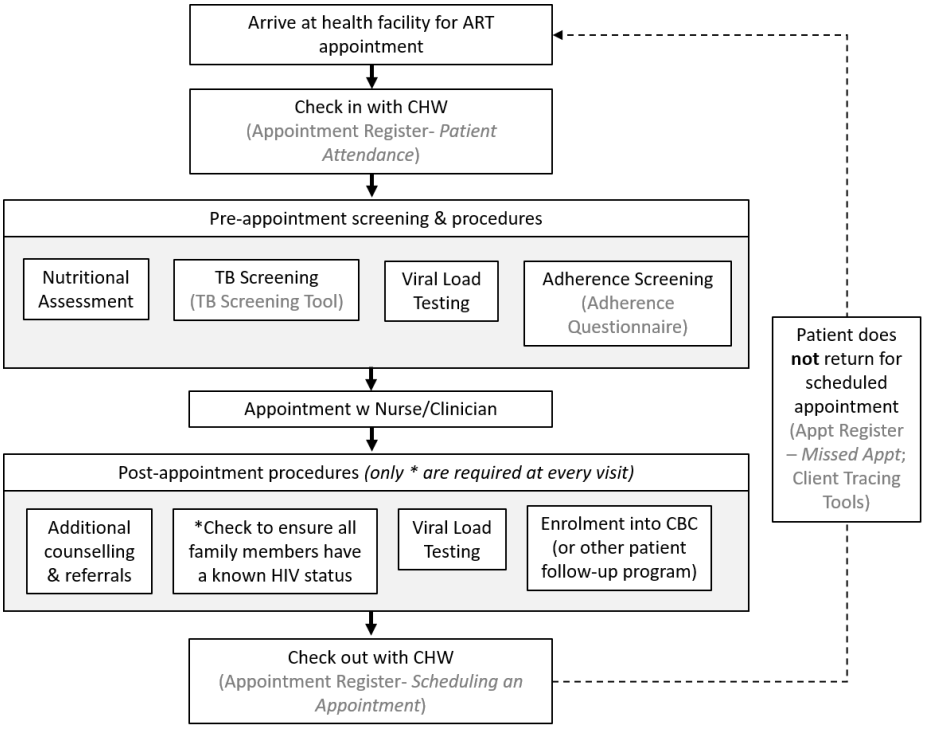
(kept at health facility for tracking purposes)

Site: _____ Month: _____

Date of Referral	Patient Name	Patient ART No.	Reason for Referral	Organization Referred To	Date of Follow-Up	Referral Successful?		Comments/ Outcome Details
						Yes	No	

This package of tools includes the Appointment Register, Appointment Register Monthly Report and Defaulter Tracing Form. These tools are designed to help CHWs trace and track patient appointments to ensure that they are retained in care and adherent to their ART. Instructions for using each of the tools is described below in the following sections.

SECTION 1: OVERVIEW OF THE CASE MANAGEMENT PROCESS AND CORRESPONDING TOOLS



SECTION 2: APPOINTMENT REGISTER

The purpose of the missed appointment/defaulter tracing program is to identify patients who have missed ART appointments and thus are at risk for poor outcomes. CHWs will be instrumental in tracking missed appointments and counseling patients on the importance of returning to care. This register is intended for use by health facilities that do not already have a way to monitor and track patient appointments.

Definitions:

Missed appointment: For this program, a client should be traced by a CHW if s/he misses the scheduled appointment date by > 2 weeks.
Client Tracing: Activities to locate the client and provide counseling/information, either phone calls or physical visits (at home or other meeting place)

Procedure:

1. All scheduled HIV clinic appointments should be entered in the appointment register. Each date will have one or more designated pages in the appointment register & the client's information should be entered on the page for the scheduled follow up date.
2. Complete the name, ART number, age, sex.
3. On the scheduled date of the appointment, the CHW should circle "S" in the Patient Attendance column for all patients who attended clinic on their scheduled appointment date.
4. If a patient does not attend, the Patient Attendance column can be left blank on the date of the scheduled appointment.
5. If a patient comes at a later date for their appointment, the Patient Attendance outcome should be updated on the patient entry for the date of the scheduled appointment. If they are late but <2 weeks, circle "WK" for within two weeks of date; if they are late by >2 weeks, circle "MA" for missed appointment by more than two weeks.
6. Every Friday, the focal person for Client Tracing (CHW) should check the appointment register for the previous week. All clients who have not come to clinic for > 2 weeks (circled MA) should be assigned to CHWs for client tracing.

7. The column for the name of the responsible for client tracing should be completed at this time in the 'Responsible CHW' column. Details of the client tracing procedure can be found in the '**Client Tracing Tools**' section.
8. The tracing outcome should be recorded by the next monthly reporting period or sooner if the tracing procedure has been fully exhausted. It is possible that this outcome could change in future, however the outcome in the appointment register is the outcome on that date when it is assigned by CHW.

   Example: If the scheduled appointment was in January and by reporting in the first week of March, the CHW tried but not able to trace the client by phone or home visit, then the outcome is "Attempted, but not found" and the CHW should enter the date in March.
9. The column results should be totaled for the designated columns in the Appointment Register.
10. If the client returns for their appointment >2 weeks, the CHW should update the appointment register with the date they attended their appointment.

Design of Register:
Each sheet of the appointment register is designed to be one day. Sheets can be bound together in a traditional register form or in a binder to allow for pages to be removed or added as needed. Alternatively, the dates can be pre-filled to ensure only a certain number of patients are entered for each clinic day. This promotes a better quality of care because clinic dates are not overbooked to ensure clinic staff can comfortably manage the number of patients.

The process works best when there is a CHW assigned to be responsible scheduling at every clinic day – checking in patients as they arrive for clinic and recording their next appointment before leaving. The register should be stored at the ART clinic.

Time to Complete	Heading	Description	Response Options
While scheduling their next ART refill appointment	**Name**	first name of the client	
	Surname	last name or family name of the client	
	ART Number	Unique ID given to a patient by the MOH when initiated on ART	
	Sex	the gender and/or current pregnancy state of the client	M = male; FNP = female non-pregnant; FP = pregnant female
	Age	Age of the client	A= aged 0 to 11 months; B= aged 1 to 14 years; C=aged 15 to 24 years; D = aged 25 years or more
On or within 2 weeks of the patient's scheduled appointment date	**Patient Attendance**	Indication that the patient attended their scheduled appointment	S = on scheduled date; WK = within two weeks of scheduled appointment date; MA = has not attended scheduled appointment within two weeks and needs tracing
Two weeks after scheduled appointment	**Needs Tracing**	Indication (with an X) that the patient has not attended their scheduled appointment within two weeks and requires tracing by a CHW	If tracing is required, fill this section with an 'X'
	Responsible CHW	The CHW appointed to trace the client	Write CHW first and last name
Following tracing attempt (all must be completed by end of reporting month)	**Final Tracing Outcome**	The final tracing outcome (i.e. outcome after one successful tracing attempt or two unsuccessful attempts)	D= died; I = Found through tracing and client has said they intend to return to clinic (fill date attended apt w rescheduled); M = moved; AE = client is now receiving ART at a different health facility; R = client has declined or refused to return to ART clinic; AT = tracing attempts were made, but the client could not be found/traced; NT = no tracing was attempted
On the date the patient	**Date Attended Appointment**	If the patient did not attend clinic within two weeks of their scheduled appointment, write the	DD/MM/YYYY

attended their rescheduled appointment		date of the date that they actually attended clinic (will usually be after tracing)	
	Comments	Any comments. Specific comments are required for those that indicated 'No Tracing Attempt'	

SECTION 3: APPOINTMENT REGISTER MONTHLY REPORT

This form is a reporting tool to help programs monitor and evaluate a health facility's progress toward Appointment Register goals. This tool is designed to be filled using data from the Appointment Register.

- The Monthly Report should be completed by the 5th day of the following month (Example: Monthly Report for October should be submitted by November 5th).
- Two staff at the site should complete the report by recording data in the Site Result column, and signing their names on report.
- The Site Supervisor will also review the report for data quality, sign and date.
- Comments sections are to be used to explain any unusual or incomplete data.
- Appointment Register data is collected from the Tingathe Program Appointment Register.
- All missed appointment data is reported for the previous month. The Reporting Month is the month you are filling the monthly report, and the Outcome Reporting Month (ORM) is the month the data is from.

			Sex		Age				Patient Attendance					Final Tracing Outcome								
Surname	First Name	ART Number	Male	Female	0-11 mo	1 - 14 y	15 - 24 y	25 + y	On scheduled date	Within 2 weeks of date	Missed appointment > 2 wks	Needs tracing (Mark X)	Responsible CHW	Died	Found, intends to return	Moved	ART at another Facility	Declined/Refused	Attemped, but not found	No tracing attempt* (Give reason in comments)	Date attended appointment	Comments
											12			0	9	3	0	0	0	0		
											A1			B1	B2	B3	B4	B5	B6	B7		
																				Total # MA clients who attended appointment	8	

*Possible reasons for no tracing attempted: no contact info/file not found; patient came for follow up before tracing attempt; refused tracing; CHW error

Missed Appointments– Use Appointment Register (Report Data for Previous Month)

Instructions: The following data will be filled from the outcome reporting month (ORM) from the Appointment Register. Please see ta determine the ORM. After determining the ORM, write both the reporting month and the ORM below.

Reporting Month	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
ORM	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov

Reporting Month: _____ **Outcome Reporting Month (ORM):** _____

MA1	Total Number of Clients Registered	Appointment Register		100
MA1.1	Number of clients with a Missed appointment >2 wks	Appointment Register (Box A1)		12
MA 2.0	Died	Appointment Register (Box B1)		0
MA 2.1	Found, intends to return	Appointment Register (Box B2)		9
MA 2.2	Moved	Appointment Register (Box B3)		3
MA 2.3	ART at another Facility	Appointment Register (Box B4)		0
MA 2.4	Declined/ Refused	Appointment Register (Box B5)		0
MA 2.5	Attempted, but not found	Appointment Register (Box B6)		0
MA 2.6	No Tracing Attempt	Appointment Register (Box B7)		0

Comments:

1. Fill the top of the monthly report with the site name, district, reporting month and reporting year.
2. Collect the Appointment Register.
3. Count the total number of clients the appointment register by counting each name registered. Write this value in MA1 'Total number of clients registered'.
4. Tally and complete the total section at the bottom of each Appointment Register sheet for the reporting month.
5. Add the total boxes across each sheet (e.g. add the Box A total from page 1 to Box A total from page 2, etc).

6. Enter the calculation totals into the corresponding row on the Monthly Report in the 'Site Result' column.
7. Once all sections have been completed, sign and date the report, then give it to the site supervision for a data check.

SECTION 4: DEFAULTER TRACING SHEET

While defaulters should be identified through the appointment register system, the defaulter tracing program will provide extra attention to those who have defaulted from care.

Definitions:

Defaulter: A client who has missed a scheduled ART refill appointment by more than 2 months

Procedure:

1. Each quarter, the ART clinic and Tingathe staff (clinical mentors and CHW with support of district M&E officer) should complete an audit of patient records to determine those who have defaulted from care.
2. Clients who have defaulted should be documented on the Defaulter Tracing Sheet.
3. The defaulter tracing focal person should assign a CHW to each patient for tracing. Details of the client tracing procedure can be found in the '**Client Tracing Tools**' section.
4. Weekly, the defaulter tracing focal person should follow up with CHWs about their final tracing outcomes. Outcomes for all patients should be recorded by the next monthly reporting period or sooner if the tracing procedure has been fully exhausted.
5. Extensive adherence counselling is necessary for all traced patients. If the patient was traced via phone, CHWs should ensure the patient receives the counselling when they return to the health facility. If traced at home, counselling can be done there.

Design of Sheet:

Complete the top of the sheet with the date of the audit and the name of the health facility.

Time to Complete	Heading	Description	Response Options
At time of audit	**Date of Last Scheduled ART Refill (>2 mo ago)**		
	Name	first name of the client	
	Surname	last name or family name of the client	
	ART Number	Unique ID given to a patient by the MOH when initiated on ART	
	Village	Name of the patient's village	
	Phone Number	Phone number of patient	
	Sex	the gender and/or current pregnancy state of the client	M = male; FNP = female non-pregnant; FP = pregnant female
	Age	Age of the client	A= aged 0 to 11 months; B= aged 1 to 14 years; C=aged 15 to 24 years; D = aged 25 years or more
Immediately after audit by defaulter focal person	**Responsible CHW**	The CHW appointed to trace the client	Write CHW first and last name
At time of final outcome (follow up CHWs weekly for	**Final Tracing Outcome**	The final tracing outcome (i.e. outcome after one successful tracing attempt or two unsuccessful attempts)	D= died; I = Found through tracing and client has said they intend to return to clinic (fill date attended apt w rescheduled); M = moved; AE = client is now receiving ART at a different health facility; R = client has declined or refused to return to ART clinic; AT = tracing attempts were

outcomes, final completion by end of following month)			made, but the client could not be found/traced; NT = no tracing was attempted
	Date of Outcome	Date of the final tracing outcome. If '*Found, intends to return*', then the date that the patient returned to clinic	DD/MM/YYYY
	Comments	Any comments. Specific comments are required for those that indicated 'No Tracing Attempt'	

Appointment Register Date: ____________________

Complete this Information when Scheduling Appointment												COMPLETE ONLY FOR PATIENTS WITH MISSED APPOINTMENT > 2 WEEKS										
			Sex		Age				Patient Attendance					Final Tracing Outcome								
Surname	**First Name**	**ART Number**	Male	Female	0-11 mo	1 - 14 y	15 - 24 y	25 + y	On scheduled date	Within 2 weeks of date	Missed appointment > 2 wks	Needs tracing **(Mark X)**	Responsible CHW	Died	Found, intends to return	Moved	ART at another Facility	Declined/Refused	Attemped, but not found	No tracing attempt* (Give reason in comments)	**Date attended appointment**	**Comments**
			M	F	A	B	C	D	S	WK	MA→			D	I	M	AE	R	AT	NT		
			M	F	A	B	C	D	S	WK	MA→			D	I	M	AE	R	AT	NT		
			M	F	A	B	C	D	S	WK	MA→			D	I	M	AE	R	AT	NT		
			M	F	A	B	C	D	S	WK	MA→			D	I	M	AE	R	AT	NT		
			M	F	A	B	C	D	S	WK	MA→			D	I	M	AE	R	AT	NT		
			M	F	A	B	C	D	S	WK	MA→			D	I	M	AE	R	AT	NT		
			M	F	A	B	C	D	S	WK	MA→			D	I	M	AE	R	AT	NT		
			M	F	A	B	C	D	S	WK	MA→			D	I	M	AE	R	AT	NT		
			M	F	A	B	C	D	S	WK	MA→			D	I	M	AE	R	AT	NT		
			M	F	A	B	C	D	S	WK	MA→			D	I	M	AE	R	AT	NT		
			M	F	A	B	C	D	S	WK	MA→			D	I	M	AE	R	AT	NT		
			M	F	A	B	C	D	S	WK	MA→			D	I	M	AE	R	AT	NT		
			M	F	A	B	C	D	S	WK	MA→			D	I	M	AE	R	AT	NT		
			M	F	A	B	C	D	S	WK	MA→			D	I	M	AE	R	AT	NT		
			M	F	A	B	C	D	S	WK	MA→			D	I	M	AE	R	AT	NT		
			M	F	A	B	C	D	S	WK	MA→			D	I	M	AE	R	AT	NT		
			M	F	A	B	C	D	S	WK	MA→			D	I	M	AE	R	AT	NT		
			M	F	A	B	C	D	S	WK	MA→			D	I	M	AE	R	AT	NT		
			M	F	A	B	C	D	S	WK	MA→			D	I	M	AE	R	AT	NT		
			M	F	A	B	C	D	S	WK	MA→			D	I	M	AE	R	AT	NT		
											A1			B1	B2	B3	B4	B5	B6	B7		

*Possible reasons for no tracing attempted: no contact info/file not found; patient came for follow up before tracing attempt; refused tracing; CHW error

Total # MA clients who attended appointment ☐

TINGATHE TOOLKIT

Date of Audit: _____ **Health Facility Name:** _____

	Date of Last Scheduled ART Refill *(>2 mo ago)*	Surname	First Name	ART Number	Village	Phone Number	Sex		Age				Responsible CHW	Final Tracing Outcome							Date of Outcome *(if 'intends to return', write date of return)*	Comments
							Male	Female	0-11 mo	1 - 14 y	15 - 24 y	25 + y		Died	Found, intends to return	Moved	ART at another Facility	Declined/Refused	Attemped, but not found	No tracing attempt* (Give reason in comments)		
1							M	F	A	B	C	D		D	I	M	AE	R	AT	NT		
2							M	F	A	B	C	D		D	I	M	AE	R	AT	NT		
3							M	F	A	B	C	D		D	I	M	AE	R	AT	NT		
4							M	F	A	B	C	D		D	I	M	AE	R	AT	NT		
5							M	F	A	B	C	D		D	I	M	AE	R	AT	NT		
6							M	F	A	B	C	D		D	I	M	AE	R	AT	NT		
7							M	F	A	B	C	D		D	I	M	AE	R	AT	NT		
8							M	F	A	B	C	D		D	I	M	AE	R	AT	NT		
9							M	F	A	B	C	D		D	I	M	AE	R	AT	NT		
10							M	F	A	B	C	D		D	I	M	AE	R	AT	NT		
11							M	F	A	B	C	D		D	I	M	AE	R	AT	NT		
12							M	F	A	B	C	D		D	I	M	AE	R	AT	NT		
13							M	F	A	B	C	D		D	I	M	AE	R	AT	NT		
14							M	F	A	B	C	D		D	I	M	AE	R	AT	NT		
15							M	F	A	B	C	D		D	I	M	AE	R	AT	NT		
16							M	F	A	B	C	D		D	I	M	AE	R	AT	NT		
17							M	F	A	B	C	D		D	I	M	AE	R	AT	NT		
18							M	F	A	B	C	D		D	I	M	AE	R	AT	NT		
19							M	F	A	B	C	D		D	I	M	AE	R	AT	NT		
20							M	F	A	B	C	D		D	I	M	AE	R	AT	NT		
21							M	F	A	B	C	D		D	I	M	AE	R	AT	NT		
22							M	F	A	B	C	D		D	I	M	AE	R	AT	NT		
23							M	F	A	B	C	D		D	I	M	AE	R	AT	NT		
24							M	F	A	B	C	D		D	I	M	AE	R	AT	NT		
25							M	F	A	B	C	D		D	I	M	AE	R	AT	NT		
26							M	F	A	B	C	D		D	I	M	AE	R	AT	NT		
27							M	F	A	B	C	D		D	I	M	AE	R	AT	NT		
28							M	F	A	B	C	D		D	I	M	AE	R	AT	NT		
						Totals:																
							A1	A2	B1	B2	B3	B4		C1	C2	C3	C4	C5	C6	C7		

TINGATHE TOOLKIT: Defaulter Tracing Sheet

Tingathe Appointment Register Monthly Report

Site: _____ **District:** _____

Reporting Month: _____ **Reporting 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.

Appointment Register

Missed Appointments- Use Appointment Register (Report Data for Previous Month)

Instructions: The following data will be filled from the outcome reporting month (ORM) from the Appointment Register. Please see table below to determine the ORM. After determining the ORM, write both the reporting month and the ORM below.

Reporting Month	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
ORM	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov

Reporting Month: _____ **Outcome Reporting Month (ORM):** _____

	Description	Data Location	Accuracy check	Site Result	M&E Check
MA1	Total Number of Clients Registered in ORM	Appointment Register			
MA1.1	Number of clients with a Missed appointment >2 wks	Appointment Register (Box A1)			
MA 2.0	Died	Appointment Register (Box B1)			
MA 2.1	Found, intends to return	Appointment Register (Box B2)			
MA 2.2	Moved	Appointment Register (Box B3)			
MA 2.3	ART at another Facility	Appointment Register (Box B4)			
MA 2.4	Declined/ Refused	Appointment Register (Box B5)			
MA 2.5	Attempted, but not found	Appointment Register (Box B6)			
MA 2.6	No Tracing Attempt	Appointment Register (Box B7)			

Comments:

Report Completed by _____ **Date Submitted:** _ _/_ _ / _ _ _ _ **Signature:** _____

Quality Check Completed by _____ **Date Checked** _ _/_ _ / _ _ _ _ **Signature** _____

Entered by (for M&E only) _____ **Date Entered**_ _/_ _ / _ _ _ _ **Signature** _____

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.

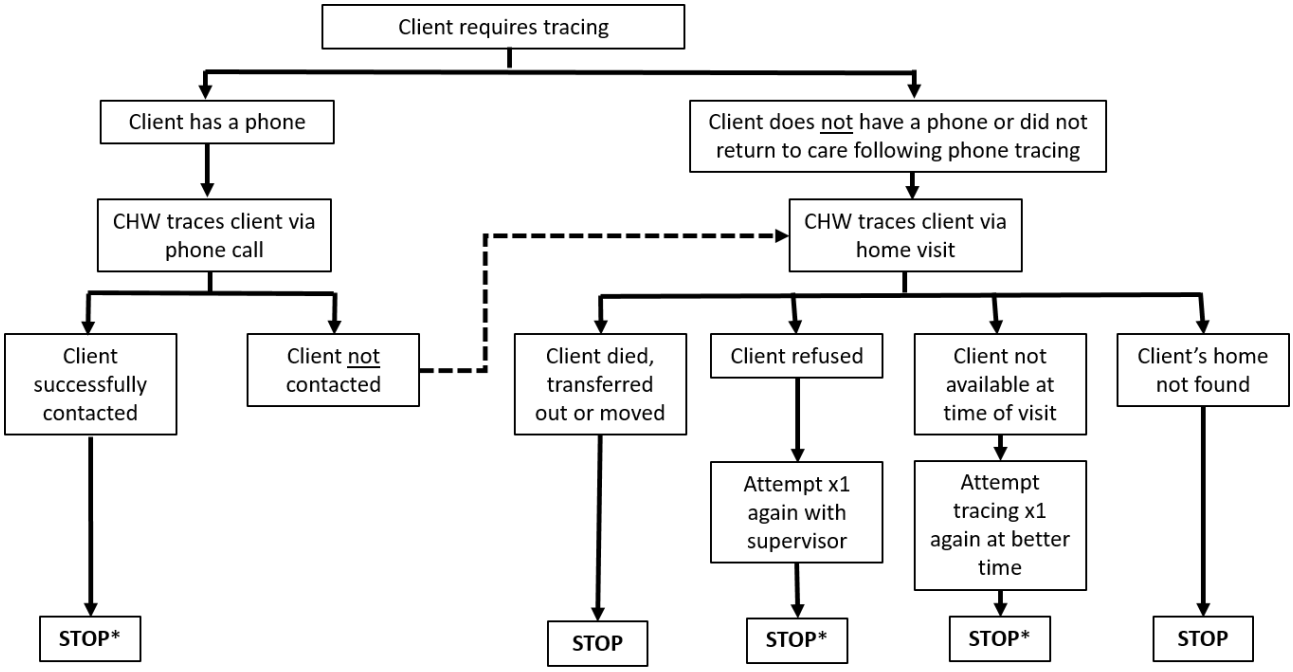
This set of tools is broken up into the following four sections:

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):_____

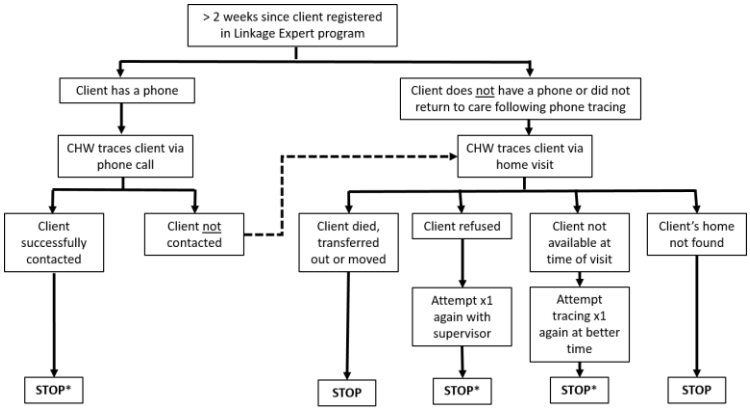
Tracing visits:

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:** ________________

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

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 **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

Section 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.

Section 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).

Section 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.

SUPERVISION OF HOME VISITS

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.

Section 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.

Section 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.

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

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

SECTION 1: OVERVIEW OF CBC PROGRAM

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

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

SECTION 2: CBC STANDARD OPERATING PROCEDURE

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

A. Enrollment into the CBC Program

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

i. Open a **CBC MasterCard** and fill the '*Patient Guardian Details at Enrolment*' and *'Child Details at Enrolment'* sections. For patients already on ART, fill the '*ART Information*' and information about their HIV test onto the '*Labs*' section.
ii. Fill the **Locator Form** on the back of the CBC MasterCard. This must be done on the first encounter so that the patient can be traced.
iii. Assign the patient a CBC ID number. Record the number on the patient's personal health records (e.g. health passport book). To ensure confidentiality of the patient, the CBC ID number should not be written on the part of the record that can be easily seen by others (e.g. do not write on the outside cover of a health passport book).

3. Assist patients to enroll in appropriate HIV services if they have not already.
4. Refer the patient to any support groups or child/adolescent programs offered at the facility.
5. Thank the patient for their time and let them know where they can find a CHW at the health facility should they have any questions.
6. At the end of each day, the SS:
    a. Fills the CBC register with the information from the patient MasterCard
    b. Assigns a CHW to each new patient. These assignments are usually based upon the location of the patient's home.
    c. Informs CHWs of their new patients and gives them their corresponding MasterCards

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

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

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

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

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

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

SECTION 3: CBC MASTERCARD

A. Child/Guardian Details at Enrolment

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

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

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

B. Child Details at Enrolment

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

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

C. ART Information

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

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

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

D. Labs

This section will be filled in the following circumstances:

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

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

E. Final Outcome

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

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

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

F. Locator Form

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

G. Goals for CBC Patients

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

H. Comments

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

I. Supervision Dates

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

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

SECTION 4: CBC REGISTER

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

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

A. For all Enrolled Children

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

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

B. For Infected Children Only

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

C. For Exposed Infants Not in PMTCT Prgrm Only

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

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

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

D. For All Enrolled Children

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

SECTION 5: CBC FOLLOW UP SCHEDULE

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

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

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

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

Comments: _____

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

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

SECTION 6: CBC FOLLOW UP SUMMARY

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

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

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

visit date		

An example of an entry is shown below:

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

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

APPENDIX

CBC Patient Mastercard:

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

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

Child/Guardian Details at Enrolment:

Child First name:	Child Surname:	DOB:	Age:	Sex: M F
Address:		Patient Phone:		
Guardian Name and Phone:		Relation:		
Second Guardian Name and Phone:		Relation:		
Followed at home? N Y	Name of Clinic:	First Clinic Date:	All children at home HIV tested? N Y NA	
Mother status: Alive No ART / Alive ART / Died / Unk NA / Neg		Father status:: Alive No ART / Alive ART / Died / Unk NA / Neg		

Child Details at Enrolment:

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

ART Information:

WHO Stage at Initiation: 1 2 3 4	Staging Dx:	ART Start Date: **write MOH ART number on top	
Initial Tingathe ART Regimen: AZT/3TC/NVP / d4T/3TC/NVP / TDF/3TC/EFV / alt 1st line / 2nd line		Reason for start: Universal / PSHD / CD4 low / WHO3/4	
ART medication changed to:	Date changed:	Reason for change:	TB meds started date:

LABS:

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

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

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

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

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

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

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

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

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

Goals for CBC patients:

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

Comments:
_____
_____
_____
_____
_____
_____
_____

Supervision Dates:

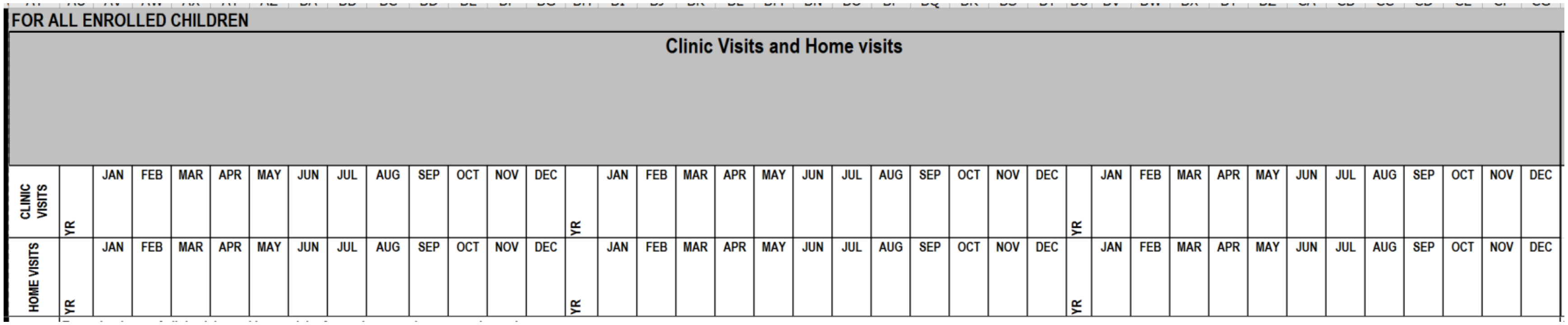
Date: _____ Sig: _____ SS Co PM ME Date: _____ Sig: _____ SS Co PM ME
Date: _____ Sig: _____ SS Co PM ME Date: _____ Sig: _____ SS Co PM ME
Date: _____ Sig: _____ SS Co PM ME Date: _____ Sig: _____ SS Co PM ME

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

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

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

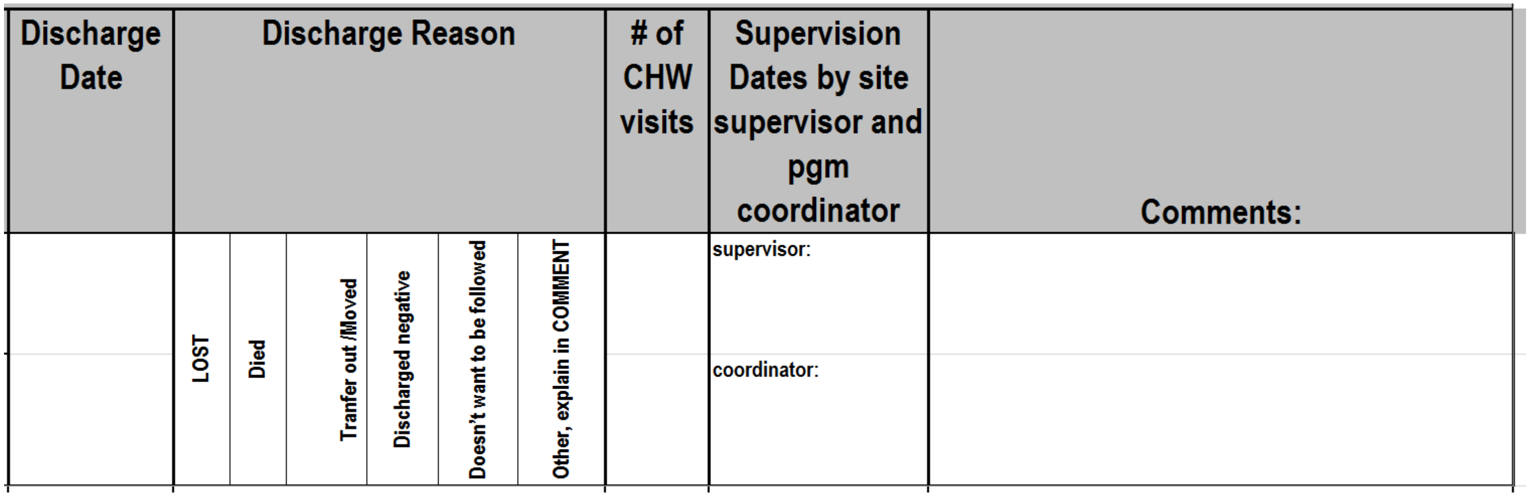
FOR INFECTED CHILDREN ONLY								FOR EXPOSED INFANTS NOT in PMTCT PGM ONLY								
HIV test Place and Date:	Was this test done by Tingathe ?	Viral Loadss. Dates and results			ART Start Date and MOH ART Number	Name of ART regimen		EID Number	PCR Date	Result		Date Result Given	Final Dx Date	Final Dx	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



FOR ALL ENROLLED CHILDREN

Clinic Visits and Home visits

CLINIC VISITS	YR	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	YR	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	YR	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC
HOME VISITS	YR	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	YR	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	YR	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC



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

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

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

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

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

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

Comments: _____

Already on ART or needs ART- follow up

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

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

Comments: _____

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

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

Comments: _____

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

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

Comments: _____

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

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

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

Comments: _____

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

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

Comments: _____

4mo after enrolled Y/N, H/C visit date: _____ ☐
Checked adherence to CPT

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

Comments: _____

Anytime Child needs ART go to ART follow up box

Already on ART or needs ART *(continued)*

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

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

Comments:_____

6mo after enrolled Y/N, H/C visit date: _____

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

Comments:_____

7mo after enrolled Y/N, H/C visit date: _____

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

Comments:_____

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

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

- ☐ Checked adherence to CPT
- ☐ Checked for TB, hospital admission, Malnutrition, or sick
- ☐ Checked that patient went to clinic, clinic date: _____
- ☐ Disclosure done? N Partial Full
- ☐ Next CHW visit date: _____ Next clinic appmt date: _____

Comments: _____

6mo after enrolled Y/N, H/C visit date: _____

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

Comments: _____

7mo after enrolled Y/N, H/C visit date: _____

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

Comments: _____

Anytime Child needs ART go to ART follow up box

Additional Visits During First 7months after enrolment:

Visit Date	Comments:

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

CBC Follow up Visits Summary Tingathe Patient ID#: __________________ Pt Name: _____________________ DOB: ___________ CHW: ________________

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

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