



Republic of Kenya
Ministry of Medical Services
Ministry of Public Health and Sanitation

**National AIDS/STD
Control Programmes**

HMIS for HIV/AIDS

**REFERENCE MATERIALS
(PROCEDURE MANUAL)**

(NASCOP)

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HIV TESTING AND COUNSELLING

NOTE: THESE INSTRUCTION ARE STILL UNDER DISCUSSION AND MAY CHANGE (16-03-11)

How to use the cover page of this register

Note: Locate sample on *annex 2 page 1* in this document

The following information should be captured on the hard cover.

Variables	Instruction	Note
Service Delivery Point	Enter where HIV testing service is provided e.g. OPD, Pediatric ward, STI Clinic, VCT Center etc. except TB clinic and PMTCT related sites (ANC, Maternity Ward)	
SDP Number	Enter number at SDP e.g. Room 1	
Facility Name	Enter facility name.	
Master Facility List Code	Enter the facility code as derived from the Master Facility List (MFL). It should be 5 digits e.g. 13023 (Kenyatta National Hospital)	
District Name	Enter district name.	
Province	Enter province name	
County	Enter county name.	
Date	Enter starting date of this register usage, then enter date when this register fills up: dd/mm/yy	

How to use this register

This register is designed for service providers to record their daily practice of HIV testing and counseling (HTC) services using rapid HIV test kits. The register captures necessary information on HTC related variables. This information will be used to monitor and evaluate HTC service program at all levels. It is also useful for self and facility evaluation.

This register can be used in two ways as follows depending on what works well for each facility

- per service delivery point e.g. particular counseling room
- per service provider (individual HTC provider)

NB: Serialization of the register

Using SDP and number create unique code of the register in your facility. In the high volume sites, to add volume of the registers should be considered. For example, the register for MFL code 12345, OPD, Room 1, volume 1 will be 12345-OPD-1. This unique code is going to be used for DBS collection for quality control.

How to record your services in this register

Definition of the variables and instructions are as follows.

Variable		Instructions	Note
Serial Number	a	Enter serial number.	Serialization annually.
Date	b	Enter date offering/seeking HTC service: dd/mm/yy	
Client Name	c	Write all clients' name unless if client declines.	
Age	d	Enter actual age years.	

Variable		Instructions	Note
Sex	e	Enter M for male or F for female.	
Strategy	f	<p>Enter the HTC strategy which you are using as explained below:</p> <p>Enter one of the following strategies.</p> <p>HP: Regular HTC services for patients in the health facility (PITC)</p> <p>NP: HTC services for non-patients e.g. family members, relatives, and friends etc in the health facility</p> <p>VI: Static HTC services in integrated VCT sites.</p> <p>VS: Static HTC services in stand alone VCT sites.</p> <p>HB: Home-based HTC services e.g. door to door and index clients</p> <p>MO: Mobile and all other outreach HTC services e.g. in market places, schools, churches as well as workplaces.</p> <p>O: Others (specify)</p>	
Tested before?	g	<p>Enter an applicable abbreviation.</p> <p>Y: Client has ever tested before.</p> <p>N: Client has never tested.</p>	
If yes, the result	h	<p>Enter an applicable abbreviation if response in Column g is Y</p> <p>N: Negative</p> <p>P: Positive</p> <p>DN: Client did not receive the test results though previously tested.</p> <p>NA: Not applicable</p> <p>Therefore, s/he does not know her/his HIV status.</p>	
When last tested	i	Enter months e.g. a month ago, 2 months ago. If 2 years ago, write "24 months ago".	Record any justification in the remarks.
Marital Status	j	<p>Enter an applicable abbreviation.</p> <p>S: Single</p> <p>MM: Married Monogamy</p> <p>MP: Married Polygamy</p> <p>D: Divorce /Separated</p> <p>W: Widow//Widower</p>	Regardless the age e.g. under 18years, actual marital status should be captured.
MARPs (Most At Risk Populations)	k	<p>Enter as applicable as described below.</p> <p>NA: Not applicable=not MARPs</p> <p>F: Fisherperson</p> <p>T: Truck driver</p> <p>S: Sex worker</p> <p>M: Men who have sex with men (MSM)</p> <p>P: Prisoner</p> <p>I: IDUs (intravenous drug users)</p> <p>O: Others</p>	Please note that the above mentioned categories are the MARPs so far articulated in the Kenya National AIDS Strategic Plan (KNASP) 2008-2013.
Disability	l	<p>Enter an applicable abbreviation.</p> <p>NA: Not applicable=not disabled</p> <p>D: Deaf</p> <p>B: Blind</p> <p>M: Mental</p> <p>P: Physically challenged</p> <p>O: Other (specify)</p>	Indicate all that apply in cases of multiple disabilities.
Consent	m	Enter appropriately as either.	The client can confirm consent verbally as per the
		Y: Client has given consent to take a HIV test today.	

Variable		Instructions	Note
		N: Client declines to take a HIV test today.	HTC policy guidelines.
Client tested as	n	Enter appropriately as; I: Individual C: Couple includes polygamous	Couple means either two or more partners who report they want to be tested as a couple.
HIV Test-1	o	Kit Name: Write the name of the first HIV rapid test kit which you have used. Lot No: Write lot number of the test kit. If the lot number changes in the middle of the page, skip one row and write new lot number within one row. Expiry Date: Write expiry date of the test kit. Test Result: Write either of the following initial; N: Negative (non-reactive) P: Positive (Reactive) I: Invalid In case of invalid results, the same test should be done again. The repeat test results should be captured on the following row.	The national algorithm for HIV testing is serial. First test should be Determine; second test should be SD Bioline; tie breaker should be Uni-gold as per circular dated 23-Sep-09 by MOH.
HIV-Test-2	p	Kit Name: Write the name of the first HIV rapid test kit which you have used. Lot No: Write lot number of the test kit. If the lot number changes in the middle of the page, skip one row and write new lot number within one row. Expiry Date: Write expiry date of the test kit. Test Result: Write either of the following initial; N: Negative (non-reactive) P: Positive (Reactive) I: Invalid In case of invalid results, the same test should be done again. The repeat test results should be captured on the following row.	
HIV-Test 3	q	Kit Name: Write the name of the first HIV rapid test kit which you have used. Lot No: Write lot number of the test kit. If the lot number changes in the middle of the page, skip one row and write new lot number within one row. Expiry Date: Write expiry date of the test kit. Test Result: Write either of the following initial; N: Negative (non-reactive) P: Positive (Reactive) I: Invalid In case of invalid results, the same test should be	

Variable		Instructions	Note
		done again. The repeat test results should be captured the following row.	
Final Result	r	Write FINAL test result of the day. Write either of the following initial; N : Negative (non-reactive) P : Positive (Reactive) ID : Indeterminate	
Final Result Given?	s	Enter the applicable abbreviation. Y : Yes, the client was given and received the HIV test result. N : No, the client was either NOT given or did NOT receive the HIV result for any reasons.	You may indicate on the column for remarks why the client was not given or declined to receive the HIV results
Couple Discordant	t	Enter appropriately as; Y : Yes, N : No NA : Not applicable	This should be consistent with the column "Client tested as".
Quality Control DBS Collected?	u	DBS sample was collected. Y : Yes, N : No.	Every 20 th clients of the HTC service provider.
DBS Result	v	Enter the DBS result (feedback) from HIV reference lab (if it is received). P : Positive N : Negative R : Rejected	This will be filled later after the feedback from the Reference Lab which could be after a month. Indicate date when this feedback is received on this same column or at the remarks column
TB Screening	w	Enter the result of TB screening tool. S : TB suspect N : Not suspect ND : Not done T : On TB treatment	NASCOP and DLTLD (TB) will be circulating a simple TB screening sheet ie tool of few questions which would help the HTC providers know if client is a TB suspect or not hence refer appropriately. This is due to the high TB burden amongst the HIV positive clients.
Refer to	x	Record any referral services that the client has been referred to including for the negative clients	Remember referral is for all positives and negatives unless clients decline.
HTC provider	y	Sign of the HTC service provider. Write name of provider	
Remarks	z	Write anything which you think would help clarify any unique details about a client further to any one analyzing or interested in the data.	

PREVENTION OF MOTHER TO CHILD TRANSMISSION

1. ANTENATAL REGISTER – (FOR VISIT-BASED VERSION ONLY)

Note: Locate sample on *annex 2 page 2-3* in this document

INTRODUCTION

The Antenatal register is used for recording information concerning a woman's pregnancy at the initial and periodic follow-up visits at which health education for pregnant women is provided and checks on any danger signs and symptoms are done. At each visit, the health care provider fills out the data collected on the antenatal card and updates the appropriate records in the antenatal register. Each line in the register represents a unique visit by an expected mother – a new row is created for every visit a woman makes to the facility.

PURPOSE: It serves as a summary of key events or services provided to the woman during her pregnancy.

These services include promotional and preventive, nutritional support, and detection and treatment of any complications.

WHEN COMPLETED: The antenatal register is first completed upon contact with the patient at her initial visit to the clinic (booking day) and a new row is opened on every subsequent visit to the clinic.

WHO COMPLETES: Nurses or other staff assigned the responsibility.

WHERE PLACED IN THE FACILITY: The antenatal register is located in the room where the antenatal clinic takes place.

DESCRIPTION OF COLUMNS

COLUMN LABEL	COLU MN	COLUMN DESCRIPTION
Date of visit	(a)	Enter the date when the client visits the health facility either as a new client or a re-visit in the format DD/MM/YY
Antenatal Clinic Number	(b)	Enter Antenatal clinic number which has been given to the client for this pregnancy at her first antenatal visit. Fill-out the Antenatal Clinic Number in the format YYYY-MM-NNNN. Where YYYY is the year, MM is the month and NNNN is the sequential visit order number for this client. For example, a client who makes the initial visit in February 2009 and is the 8 th client of the month should be given the number: 2009-02-0008.
First Visit	(c)	Enter Y for yes if this is the first visit during this pregnancy else enter the visit number in column (d).
Number of Visits	(d)	Indicate the client's visit number by indicating, 2, 3 For second, third visit etc.

COLUMN LABEL	COLU MN	COLUMN DESCRIPTION
Names	(e)	Enter the client's full names in the order first name, middle and surname.
Village/Estate	(f)	Enter the name of the village or estate where the patient is currently staying.
Age	(g)	Enter the client's age in completed years as at last birthday on the first visit Note: Do not update this field on subsequent visit should the client's age change but just use the age at first visit.
Marital Status	(h)	Enter one of the options in the cell (1-Married, 2-Widowed, 3-Single, 4-Divorced, 5-Separated
Parity	(i)	Format X+Y: First part (X): Enter the number of previous deliveries that occurred at a gestation beyond 24 weeks (6 months) regardless of outcome. Second part(Y): enter the number of terminations or miscarriages that have occurred at a gestation less than 24 weeks prior to this pregnancy.
Gravidae	(j)	Enter the number of pregnancies that the woman has had including the current pregnancy. For example in her third pregnancy, a woman is said to be gravida three (3) regardless of outcome of the previous pregnancies.
Date of last normal menstruation (LMP)	(k)	Record the date of the last menstrual period in the format DD/MM/YY.
Estimated Date of Delivery (EDD)	(l)	Record the Estimated Date of Delivery in the format DD/MM/YY
Gestation in weeks	(m)	Record the duration of pregnancy expressed in weeks. This should be updated on each visit.
Weight (kg)	(n)	Indicate the actual weight of the client on this visit, expressed in kilograms
Blood Pressure	(o)	Record the blood pressure reading
Counselled on...	(p)	1= Birth Plan 2= Danger signs 3 = FP 4 = HIV 5= Supplemental feeding 6=Breast Care, 7=Infant feeding and 8= ITN

COLUMN LABEL	COL UMN	COLUMN DESCRIPTION
Laboratory	Haemoglobin	(q) Record the haemoglobin level
	RPR	(r) This is the routine test for syphilis/VDRL that is carried out for pregnant women. Record whether the results are Positive or Negative. If tests were not done on this visit, write ND for "Not Done"
	HIV Status	Initial (s) Record HIV status for this visit. Enter 'P' for Positive, 'N' for Negative 'U' for Unknown and 'KP' for Known Positive results at first ANC visit in this pregnant Note: Do not record "KP" on subsequent visits if the positive status was known during or after the 1 st ANC Visit.

	Repeat	(t)	This test refers only to those women who were tested during the first trimester and their tests were negative. It is recommended that such women are tested again in the last trimester or in maternity. Note: Women who were not tested earlier in the pregnancy but tested in the third trimester should be recorded under column (s) and not (t).
ART Eligibility	WHO Staging	(u)	If the client has been assessed for ART eligibility using WHO staging, record the stage under this column using the notation: 1, 2, 3 or 4.
	CD4 Test	(v)	If the client has been assessed for ART eligibility using CD4, record Y to indicate that the sample has been taken on this visit and N if not. When the results are ready, enter CD4 value against the visit (subsequent) the patient has made. There is no need to go and update the visit on which the blood was drawn. Note: For the purpose of reporting data on the indicator on assessment for eligibility, please count all the "Y"s even before the results have been known as long as the reporting date is due.
Start ART		(w)	Depending on the results from (u) and (v), if the patient is commenced on therapy, enter the date the patient was started on treatment within the ANC setting. Note: Patients already on therapy prior to this pregnancy should not be included.
Prophylaxis	Cotrimoxazole	(x)	Write Y if Cotrimoxazole has been given or N if not given. This is recorded for HIV positive mothers who are commenced on Cotrimoxazole. If the woman is not eligible, record NA for "Not Applicable"
	NVP	(y)	According to protocol, NVP is issued to the mother upon HIV positive results to go and take at onset of labour in case this takes place outside a health facility. Note: If a woman returns to deliver in the facility, do not count this Nevirapine again even if she is given another dose in the event of loss of the first issue.
	AZT	(z)	This is the AZT given to the mother during pregnancy to take ante partum.
	HAART	(aa)	Enter P if the mother is on HAART for prophylaxis and T if on HAART for treatment. Where <ul style="list-style-type: none"> - P (prophylaxis) includes all those women started on HAART not for their own health by for purposes of PMTCT and; - T (treatment) covers all the women started on HAART during pregnancy after assessing them and declared eligible for ART and those who entered into ANC already on ART
	NVP for the baby	(ab)	Enter Y if NVP Drugs have been dispensed to the mother for the baby or N, if not given

COLUMN LABEL	COLUMN	COLUMN DESCRIPTION
Screened for TB	(ac)	Enter the following: NO Signs = if no signs TB from previous assessment. TB Suspected = if a patient is clinically or radiologically suspected to have TB but not confirmed through laboratory tests. TB Rx = if patient is already on treatment
Screened for Cervical Cancer	(ad)	If the patient has been assessed for Cervical Cancer, enter the methods of assessment used (Pap Smear or VIA)
Other Conditions	(ae)	Using the code below, enter the condition observed on this visit: 1=Hypertension 2=Diabetes 3=Epilepsy 4=Malaria in Pregnancy 5=STIs/RTI 6=Others (Specify)
Treatment	Deworming	(af) Indicate YES if Deworming medication has been given and NO if not given
	IPT1-3	(ag) Intermittent Presumptive Treatment first, second or third dose. Write the dose which has been given or NO if not given. If the woman is not eligible, record NA for "Not Applicable"
	TT Dose	(ah) This refers to the Tetanus Toxoid Vaccine given to the woman during the visit. Record the number of doses given.
	Iron	(ai) Write YES if Iron supplementation has been given or NO if not given.
	Folic Acid	(aj) Write YES if Folic Acid has been given or NO if not given.
Received ITN	(ak)	Indicate Y if received an ITN on this visit or N if not.
Additional Treatment	(al)	Indicate if treatment for listed conditions has been provided by indicating the appropriate code for the treatment: 1=Hypertension 2=Diabetes; 3=Epilepsy 4=Malaria in Pregnancy 5=STIs/RTI 6=Others Specify)
	Counselled as a couple?	(am) Record Y if the woman was counselled on HIV testing together with the spouse, else enter N
Partner HIV Counselling & Testing	Partner Test Result	(an) Indicate HIV test result for the partner, P for Positive or N if Negative U for unknown or KP for known positive results.
Referred to	(ao)	Write the next level to which the client has been referred
Remarks	(ap)	Any other comments that will be beneficial to the client and service

2. MATERNITY REGISTER

Note: Locate sample on *annex 2 page 4-5* in this document

INTRODUCTION

The Maternity register is an institutional based document. All information on deliveries at the facility is recorded in this register.

PURPOSE: The Maternity Register provides information on the following:

- Delivery process and outcome
- Laboratory tests
- HIV prophylaxis to mother and baby and partner involvement

WHEN COMPLETED: At the time the woman is admitted to the labour ward until discharge

WHO COMPLETES: Nurses in the labour ward

WHERE PLACED IN THE FACILITY: In the labour ward. Each facility should ensure that the register is updated promptly before mothers are discharged.

DESCRIPTION OF COLUMNS

Column Label	Column ID	Column Description
Admission Number	(a)	Enter the unique identification number given to the mother on admission to maternity in the format 'yyyy-mm-xxxx'. Initialise every month e.g 2009-07-0001 for the first client in July 2009. Only women with full term pregnancy are enrolled here for delivery
Date of Admission	(b)	Write the date when the patient is admitted in the format 'dd/mm/yyyy'
No. of ANC Visits	(c)	Record the number of antenatal visits the client made to the clinic, prior to admission, as indicated on the ANC card.
Full Names	(d)	Enter the client's full names in this cell.
Village/Estate	(e)	Enter the name of the village/estate where the client resides.
Age	(f)	Enter the client's age in completed years as at last birthday
Marital status	(g)	Enter one of the options in the cell (1-Married, 2-Widowed, 3-Single, 4-Divorced, 5-Separated
Parity	(h)	Enter the number of previous pregnancies the client has had prior to this one.
Gravidae	(i)	Enter the number of pregnancies that the woman has had including the current pregnancy. For example in her third pregnancy, a woman is said to be gravida three (3).
LMP	(j)	Record the date of the last menstrual period in the format dd/mm/yy
EDD	(k)	Record the Estimated Date of Delivery in the format dd/mm/yy
Diagnosis	(l)	Write the final diagnosis made by the clinician. If the patient suffers from more than 1 condition,

Column Label		Column ID	Column Description
			record all diagnosis in this column.
Delivery	Duration of labour	(m)	Record the time count from onset of labour to actual delivery
	Date of Delivery	(n)	Record the date the mother delivers in the format dd/mm/yy.
	Time of Delivery	(o)	Indicate the time the delivery took
	Gestation at Birth (wks)	(p)	Record the duration of pregnancy expressed in weeks at birth
	Mode of delivery	(q)	Indicate the birth form, e.g normal spontaneous or caesarean delivery Use codes as in form 711 key: 1=normal delivery 2= CS 3= breech 4= assisted vaginal delivery
	Placenta	(r)	Write Y for "Yes" if placenta is complete and N for "No" if not complete.
	Blood loss <i>(in mls)</i>	(s)	Indicate the amount of blood loss during delivery in millilitres (mls)
	Condition after Delivery <i>(Alive/Dead)</i>	(t)	Write the condition of the mother after delivery
	Other delivery complications	(u)	Write down any complications related to delivery
Baby	Sex	(v)	Enter the sex of the baby M for Male or F for Female
	Birth Weight <i>(in grams)</i>	(w)	Enter the weight of the baby in grams
	Live Birth, FSB, MSB	(x)	Enter LB for Live Birth, FSB for Fresh Still Birth and MSB for Macerated Still Birth
	APGAR Score	(y)	See APGAR score table at the bottom of these instructions
RPR/VDRL Results		(P/N)	Indicate RPR/VDRL test result, P for Positive or N if Negative.
HIV Status	ANC	(P/N/KP/U)	(aa) Record HIV status from the last ANC visit. This can be copied from the card. Enter 'P' for Positive, 'N' for Negative 'U' for Unknown and 'KP' for known positive at 1 st ANC visit.
	Maternity	(P/N/KP/U)	(ab) Enter 'P' for Positive, 'N' for Negative 'U' for Unknown. Note 1: Only results for tests done in the maternity should be recorded here. Note 2: If column (aa) result is negative but column (ab) is positive, this is a repeat test for a woman who was tested early in the pregnancy.
ARV Prophylaxis	ANC Regimen	(drug codes)	(ac) If the patient received prophylaxis to reduce HIV transmission during pregnancy enter the following applicable drug code: NVP = (if dispensed with NVP during ANC) AZT = (if started on AZT at 14 weeks or thereafter) T = For women on HAART for their treatment P = For women started on full HAART for PMTCT purpose only

Column Label		Column ID	Column Description
	(drug codes)	(ad)	<p>Use the drug code listed under below</p> <p>PM1=AZT 300mg BD (from week 14 to Delivery); then NVP 200mg stat + AZT 600mg stat (or 300mg BD) + 3TC 150mg BD during labour; then 1 tab of AZT/3TC 300mg/150mg BD for ONE week post-partum</p> <p>PM2=NVP 200mg stat + AZT 600mg stat (or 300mg BD) + 3TC 150mg BD during labour; then 1 tab of AZT/3TC 300mg/150mg BD for one week post-partum (for Women coming for first time when in Labour)</p> <p>PM3=PMTCT HAART: AZT + 3TC + NVP</p> <p>PM4=PMTCT HAART: AZT + 3TC + EFV</p> <p>PM5=PMTCT HAART: AZT + 3TC + LPV/r</p> <p>PM6=PMTCT HAART: TDF + 3TC + NVP</p> <p>PM7=PMTCT HAART: TDF + 3TC + LPV/r [For use by Pregnant women with less than 2 years NVP exposure and who never received the 3TC tail]</p> <p>PM8=Nevirapine (NVP) Single Dose (SD) 200mg stat</p>
	NVP to baby	(ae)	Enter Y for Yes and N for No to indicate if baby was given NVP for prophylaxis. Only NVP given in maternity should be recorded. Do not therefore transfer contents of column (ab) in the ANC register to this column register
	Cotrimoxazole to the mother	(af)	Write YES if Cotrimoxazole has been given or NO if not given
	Vitamin A supplementation	(ag)	Indicate YES if vitamin A has been given to the mother and NO if it has not been given
Partner Involvement	Tested for HIV	(ah)	Enter Y for "Yes" if the partner to the client has tested for HIV in the maternity
	Test Result	(ai)	Record the partner's results as follows: 'P' for Positive, 'N' for Negative 'U' for Unknown and KP for known positive
Delivery Conducted by	(Enter Name)	(aj)	Indicate the name of the person who conducted the delivery
	Birth Notification Number	(ak)	Indicate the serial number from the birth notification sheet
Date of Discharge	(dd/mm/yy)	(al)	Indicate the date when the mother is discharged
Status of the baby at discharge	(Dead/Alive)	(am)	Enter D for dead or A for alive.
Comments		(an)	Any other remarks that may be beneficial to the mother, child or facility

3. POSTNATAL REGISTER

Note: Locate sample on *annex 2 page 6-7* in this document

INTRODUCTION

The postnatal register is used to record information concerning a woman's health immediately following delivery. The postnatal period lasts for a period of 6 weeks following delivery.

PURPOSE: It serves as a tool for recording information and services provided to the client in the postnatal period including: support to the woman to return to the pre-pregnant state, assessing and identifying danger signs, education to the woman on own care and care of the infant. A number of services provided are recorded here including HIV testing, infant feeding options, family planning and ARV prophylaxis etc.

WHEN COMPLETED: The postnatal register is first completed upon contact with the patient at her initial visit to the clinic following delivery and every time the patient makes a postnatal follow-up visit.

WHO COMPLETES: Nurses or other staff assigned the responsibility.

WHERE PLACED IN THE FACILITY: The postnatal register is located in the room where the postnatal clinic takes place.

DESCRIPTION OF COLUMNS

	Column Label	ID	Column Description
Registration Information	Date of Visit	(a)	Enter the date the mother reports to the health facility after delivery in the format dd/mm/yy
	PNC Register Number	(b)	This number is serially allocated to the mothers upon the initial (planned) visit. PNC number will be generated once and the format is YYYY-MM_xxxx
	Admission Number	(c)	Enter the unique identification number given to the mother on admission to maternity. Use the maternity admission number. Leave blank if delivery did not take place in this facility.
	Full Names	(d)	Enter the client's full names in this cell.
	Village/Estate	(e)	Enter the name of the village/estate where the client resides.
	Age	(f)	Enter the client's age in completed years as at last birthday
Maternity History	Date of Delivery	(g)	Record the date the mother delivered in the format dd/mm/yy.
	Place of Delivery	(h)	Indicate where the delivery occurred. For example home, clinic, on the road etc.. Home (any residence not necessarily your own, clinic, on the way to clinic, other---specify).
	Mode of Delivery	(i)	Enter the method of delivery e.g SVD, C/S.
State of Baby		(j)	Indicate the status of the baby using the APGAR score table
Vital Signs	Temperature	(k)	Record the temperature reading - actual reading of the thermometer.

Column Label		ID	Column Description
Postnatal Examinations	Pulse	(l)	Record the pulse of the mother on this visit.
	Blood Pressure	(m)	Record the blood pressure readings
	Parlor	(n)	Indicate 'YES' if it has been performed, NO if it has not been performed, 'NA if delivery occurred more than 6 weeks prior to the visit.. Use key provided 1= mild 2= moderate 3= severe
	Breast	(o)	Record the state of the breast. Use key provided 1=normal 2= crapped nipple 3=engorged 4=mastitis
	Uterus	(p)	Record the state of the uterus.
	PPH	(q)	Record if there is PPH or not
	C-Section Site	(r)	Record using the key provided 1, Bleeding 2, Normal 3, Infected.
	Lochial	(s)	Record using the key provided 1, Normal 2, Foul smelling Excessive
	Episiotomy	(t)	Record using the key given 1, Repaired 2, Gaping 3, infected ; 4, Healed
	Prior Known Status	(P/N/U)	(u) Record the HIV status of client P for positive and N for Negative and U for unknown
HIV Status	Tested (<=72 hrs)	(P/N/ND /NA)	(v) If the client was tested for HIV within 72 hours of delivery, enter P for Positive result, N for Negative, ND if the patient was eligible for the test but it was not done and NA for those in whom this test was not applicable.
	Tested (>72 hrs)	(P/N/ND /NA)	(w) If the client was tested for HIV after 72 hours of delivery, enter P for Positive result, N for Negative, ND if the patient was eligible for the test but it was not done and NA for those in whom this test was not applying.
	ARVs to baby	(Y/N)	(z) Enter Y for Yes and N for No to indicate if baby was given NVP for prophylaxis
Prophylaxis	CTX to baby	(Y/N)	(y) Enter Y for Yes if the child was dispensed with cotrimoxazole during this visit else enter N for No
	CTX to mother	(Y/N)	(z) Enter Y if mother was issued with CTX
	Couple counselled?	(Y/N)	(aa) If the mother was counselled for HIV together with the partner, record Y if not record N
Male involvements in HIV	Partner Tested in PNC	(Y/N)	(ab) If the partner was tested for HIV during PNC, enter Y
	Results	(P/N/U)	(ac) Record the test results as follows:

Column Label			ID	Column Description
				P for positive, N for negative, U for unknown and KP for known positive results before this visit

Column Label		Col ID	Column Description	
Screened for Cervical Cancer	(PAP /VIA)	(ad)	If the patient has been assessed for Cervical Cancer, enter the methods of assessment used (Pap Smear or VIA)	
Provided with modern FP method	(Method Code)	(ae)	Enter the following codes for the method provided: C = condoms ECP = emergency contraceptive pills dispensed OC = oral contraceptive pills INJ = Injectable IMP = implant IUD = intrauterine device LAM = Lactational Amenorrhea Method D = diaphragm/cervical cap FA = fertility awareness method/periodic abstinence TL = tubal ligation/female sterilization V = vasectomy (partner's)	
Treatment	Multi-vitamin	(Y/N)	(af)	If multivitamins are dispensed, enter Y or N if not
	Haematinics	(Y/N)	(ag)	If haematinics are dispensed, enter Y or N if not
Referred		(ah)	Enter destination name to which the client has been referred.	
Remarks		(ai)	Any critical (additional) information should be recorded here.	

HIV-EXPOSED INFANT FOLLOW-UP

1. HIV EXPOSED INFANT FOLLOW-UP CARD

Note: Locate sample on *annex 2 page 8-11* in this document

INTRODUCTION

The card has four (4) parts: the front page (which summarises patients details, key events before and after enrolment); replicated details from the child health cards (where similar details as on the mother/child's booklet are recorded); routine care and assessment (covering growth monitoring, prophylaxis and treatment) and assessments for child development and TB infection.

PURPOSE: To serve as a detailed record of care for HIV exposed infants and facilitate follow up of the child until discontinuation – arising from testing HIV positive, confirmed negative, death, or dropping out for any reason than the foregoing. In busy facilities where it may be cumbersome to complete both this card and the HEI register in real-time, the card can serve as a consecutive source for completing the register. Since this is facility-based record (not taken by patient), it provides for a valuable source for patient follow-up and records review.

WHEN COMPLETED: The card is opened immediately a patient registers into HIV exposed infant care and continuously updated on each contact. Some details covering historical events (such as date of birth, mother's prophylactic history, etc.) may be updated once while some information may require to be updated over the initial entries (e.g. partner's HIV status, history of TB contact and address) or creating a new entry (on each follow-up visit for variables such as weight, height, feeding method). Clinical notes may be completed depending on the circumstance – if additional information is required to be documented that may not be part of the information in the forms.

Note: This card is closed upon the child testing HIV positive and in such an event, the CCC card is opened and procedures for enrolling into care are commenced.

WHO COMPLETES: At first visit, depending on the set up of the facility, internal referral structures and staffing levels, a Doctor, Clinical Officer, Nurse, Health records officer or data clerk fills this form and on subsequent visits filled by a doctor, clinical officer or nurse.

FACE OF THE CARD

DATA ELEMENTS	INSTRUCTIONS
Name of Facility	Enter in full the name of the facility where the service is being provided. If the child has been transferred from another facility and there is sufficient information to treat it as a transfer, record your facility here and in the referral section, to the right of the label “transfer-in”, enter the name of the source facility.
Facility Code	Facility codes are generated from the master facility list (MFL). If you are not sure what code has been allocated to your facility, contact the district records office for assistance.
District	Enter district name in full
Province	Enter province
Cohort by month and year of birth	This is the month and year the baby was born. It is generated from the variable “date of birth”. It is generated by a hyphenated combination the first three letters of the month and year thus MMM-YYYY. <i>For example, a child born in April 2010 will belong to the cohort APR-2010.</i>

DATA ELEMENTS	INSTRUCTIONS
	This information is for two main reasons: Firstly, to allow health worker allocate patients to the same group (birth/year) and secondly, to make possible for generating indicators that are demanded when children reach a specific age. <i>For Example: "Number of children on EBF at 6 months"</i>
HEI Number	The structure of this number is MMMMM- YYYY-NNNN. Where: MMMM is the master facility list (MFL) YYYY is the year of registration NNNN is the patient serial counter within each facility in that year.
Name	Write the names of the baby in this order: first, middle and last name.
Sex	Check the box to the right of either male or female. For this data element, the provider should ask the guardian for the child's sex.
Date of Birth	If delivery was done from a health facility, get the date of birth from prior documents issued in the facility. Due to the small units of measure required by some indicators, it's important that the correct date of birth is obtained. An example of these indicators include: <i>Number of Infants initiated on CTX</i> .
Birth Wt (kg)	Copy the weight from the birth documentation of the baby. at birth. In cases where there is no documentation of weight at birth, there needs to be a provision for documentation of weight at first contact or visit
Date of Enrolment	This is the same date on the HEI register and should be in the format dd/mm/yyyy. Enrolment onto the HEI follow-up programme constitutes provision of the following services: A) Identification of having been born to a confirmed HIV positive mother B) Opening the HEI follow-up card.
Age at Enrolment	The age at enrolment should be written in weeks – rounded to the next near week, e.g. 1 day old should be documented as 1 week. Calculating the age in weeks can be done by physically by counting the number of days from a calendar, then round them off to a full week.
Source of Referral	Referral can be done at two levels: For patients already enrolled on the HIV-exposed infant follow-up programme or and those recently identified to be born from HIV positive mothers and referred for enrolment on the follow-up programme. Already on the Programme: This is a child who meets the criteria of already being on the programme from another facility and is transferred in to this facility with acceptable records. Under this block, check the box to the left of the label "Other" and write the TI for Transfer-in followed by the sending facility, in the space to the right of the label. New on the Programme: This is a child who has just been identified to be born for an HIV positive mother either in the OPD, paediatric ward, MCH/PMTCT department, the CCC, maternity or any other source that acts upon the information about the infant's mother's HIV positive status. Select referral source by checking the box.
ARV Prophylaxis	Check the appropriate box for following responses for prophylaxis: 1= <u>Sd NVP only</u> : This is recorded if a child only received a single-dose of Nevirapine at birth or early postnatal. This can be verified at registration with information from the child health card. 2= <u>Sd NVP+AZT+3TC</u> . – The child should have taken single dose NVP at delivery and AZT/3TC for a prescribed duration after delivery 3= <u>NVP for 6 weeks (Mother on HAART or Not BF)</u> . – 4 = <u>NVP during BF period</u> : This should be recorded upon cessation of breast feeding against NVP dispensed for the period. 5= <u>None</u> – if the child did not receive any prophylaxis 6 = Other, specify by writing in the cell
History of TB	Information will be obtained from the guardian on the existence of a TB patient

DATA ELEMENTS	INSTRUCTIONS
Contact in Household	<p>in the household with whom this child may have come into contact with.</p> <p>Note: Health workers should be trained well on how to solicit for this information. Once satisfied with the response, a tick is appropriately made against “Yes” or “No” and process the patient for TB screening and/or prophylaxis. Once screening has been done column (i) of the “Growth, Nutrition and Development” section of this card is updated on the next visit.</p>
Name of mother	Write the names of the mother in this order: first, middle and last name.
Mother Alive	<p>This can be updated as follows:</p> <p><u>Upon registration:</u> If the child’s mother is dead or alive</p> <p><u>After registration:</u> If death of the mother takes place after the child has been enrolled on the programme. It is recommended that a pencil is used instead of indelible ink.</p>
Mother received drugs for PMTCT	<p>This is historical information about ARV prophylaxis a mother took during pregnancy and intra-partum. If it is reported that the mother took ARVs for prevention of mother-to-child transmission of HIV, one of the following will apply:</p> <p><u>SdNVP only:</u> If mother received only a single-dose Nevirapine as prophylaxis.</p> <p><u>Interrupted HAART:</u> If highly active regimen for MTCT prophylaxis was provided. This may be in the following combinations: AZT + 3TC + (NNRTI/PI/NRTI) and provided prior to, during pregnancy and for a variable duration postpartum.</p> <p><u>AZT+NVP+3TC:</u> The mother received AZT during pregnancy or AZT/3TC+NVP intrapartum</p> <p><u>HAART:</u> The mother was taking ARVs for her own health during the course of pregnancy.</p> <p><u>None:</u> If the mother did not take any prophylaxis.</p> <p><u>Other:</u> Specify type of prophylaxis the mother received.</p>
Mother on HAART at enrolment of infant.	Select “Yes” if the mother was on HAART during pregnancy and is still receiving treatment or if she started treatment after delivery. If the mother is alive and was on HAART during pregnancy and a “No” is selected, confirm the earlier response on prophylaxis or determine the reasons treatment interruption
HAART Regimen and CCC number	If the answer on HAART is “Yes”, enter the drug combination in full and the CCC number.
Mode of Delivery	Update this question from the mother’s maternal health card
Place of Delivery	<p>Information can either be obtained directly from the maternal health card or verbally from the mother or guardian.</p> <p><u>Home deliveries:</u> cover all deliveries taking place outside a health facility regardless of who attended to that delivery.</p>
Immunisation History	<p>Depending on the age of the child at enrolment, this information can be entered retrospectively from the child health card and updated on subsequent visits when the event occurs.</p> <p>Note: This is not a substitute to the child health card; both cards should be updated upon provision of service.</p>
Laboratory Information	<p><u>DNA PCR Test:</u> Data elements collected under PCR test; for both the 1st test and confirmatory test at 9 months, include the following: date of test; outcome of results, DBS sample code and the date the results were picked by parent or guardian:</p> <ul style="list-style-type: none"> • <u>Date of test:</u> This should be the date the sample was drawn from the patient and not the actual date the laboratory did the test. This applies to either the initial and repeat tests, regardless of whether it is an initial PCR test or a confirmatory test after the first antibody test. • <u>Test Results:</u> Possible answers include; positive (POS) or negative (NEG).

DATA ELEMENTS	INSTRUCTIONS
	<ul style="list-style-type: none"> DBS Code: Use the existing syntax for coding DBS samples. The syntax is as follows: Facility Code-Entry-Point code-Year-Serialised Sample Number
Patient Locator	<p>There are two spaces provided for two addresses; This is meant to take care of changes in the patient's address during the course of being on the programme. If this address is current but not permanent, check on current and leave permanent empty. However, if the current address is the permanent address, check both and the record the owner (supporter, health provider or parent) of the address then proceed to completing the other section as follows:</p> <ul style="list-style-type: none"> Name: This is not the name of the child but the owner of the address that is being provided. In urban areas record the house or plot number (Hse/plot); the street name, the district, location, division, telephone number and the landmark. In rural areas record the name of the chief and village, the district, location, division, telephone number and the landmark. <p>Note: For the telephone number, indicator the owner if different from the owner of the address. As for the landmark, select fixed structures that do not often change with time.</p>

GROWTH MONITORY CHARTS

These charts are a replication from the existing under-five booklet for purposes of keeping a record at the facility on the growth of the child. For visits made for immunisation, this card will be update simultaneously of the child health booklet. For visits made outside the EPI schedule, information can be update from the child health card.

Note: For this section of the card to remain up to date, health providers should encourage care-givers to always carry the child health booklet.

GROWTH, NUTRITION AND DEVELOPMENT MONITORING

Column ID	Column Label	Completing Instructions
Visit Date	(a)	The first visit should be the same date as the enrolment date. Enter it in the format dd/mm/yyyy.
Age	(b)	Update this data element at each visit. Enter the age in weeks
Weight	(c)	Update weight (in kgs) at every visit.
Height	(d)	Update height / length (cm) at every visit
Infant Feeding	(e)	Use the codes and bottom of the page to update infant feeding method. EBF = Exclusive Breastfeeding ERF = Exclusive Replacement Feeding MF = Mixed Feeding
Medication Given	(f) (g) (h)	For NVP and CTX, if the drug is given, enter the information in this order <i>Dose/Days</i> . For MV check against the visit if multivitamins have been dispensed Note: Entering dosage and days will assist provider to evaluate adherence on follow-up visits
TB Assessment Outcome	(i)	Enter the following: NO Signs = If no signs of TB from previous assessment. TB Suspected = If a patient is clinically or radiologically suspected to have TB but not confirmed through laboratory tests. TB Rx = If patient is already on treatment followed by the TB treatment number.

		IHN if the child has been dispensed with INH Note: Refer to the TB codes at the bottom of the page in reference.
Growth Milestone?	(j)	Using the reference table at the bottom of the page, assess, grade and record whether the child is meeting the expectations for that age by “Y” for “Yes” if achieving milestone, “N” for “No” if not improving and retrogressed if the child ratings are getting worse
Date of Next Appointment	(k)	Enter the date the patient is expected to make a scheduled visit to the facility in the format (dd/mm/yy)

CLINICAL NOTES

This part of the card is meant to enable health workers to enter any important information about this visit that may not be recorded anywhere on the card.

2. HIV-EXPOSED INFANT REGISTER

Note: Locate sample on *annex 2 page 12-13* in this document

INTRODUCTION

The information collected on this register can be grouped thus: Demographic and enrolment details; ARV prophylactic history; infant feeding practices, HIV testing and patient outcomes. The successful application of this register requires that the individual cards from the patient are also well maintained.

PURPOSE: This register is a line listing of children born in the same month, documenting service provided at each age of the child. This enables health worker to quickly identify gaps in service provision and which is not easy if individual patient files were to be reviewed. The information contained in this register provides a building block for summarising data needed to compute routine indicators.

Note1: Each page or a set of pages is a group of HIV exposed infants who were born in the same month and year. Use the format MMM-YYYY to denote the month and year the infant on this page(s) were born. For example, a page with children born in January 2010, the cohort will be entered in the top left corner as "JAN-2010.

WHEN COMPLETED: Depending on the conditions prevailing on the ground, one or both of the two options may apply: updating the register simultaneously with HEI follow-up Card or updating the register consecutively from the cards and at the end of the sessions. Transferred children should be entered on receipt and allocated to the month in which they were born and update older events retrospectively.

Note 1: Because of retrospective data updating, totals at the bottom of the page should only be completed once that cohort has matured to 12 months – the time at which we are expected to report data elements: HV02-24 to HV02-40 & HV03-01 and HV03-02.

Note 2: The point in note 1 therefore implies that every month, you need to report on a cohort that will have matured to 12 months at the end of the reporting month. For example, to compile a report for March 2011, turn to the page labelled (leftmost corner) MAR-2010, because all the children in that cohort will have completed 12 months by the end of March 2011. Do the page summaries up to 12 months and transfer to the aggregation form.

WHO COMPLETES: A trained records officer can update the register from the card. A nurse/clinician can update this register simultaneously with the HEI card.

COLUMN LABEL	COLUMN ID	COMPLETING INSTRUCTIONS
Serial No.	(a)	This is a sequential counter from 1 to n where n is the last patient in that birth/month. This number should be reset to 1 for each group (birth/cohort). It assists in quickly counting the number of children enrolled on the programme in each month.
Date of Enrolment	(b)	This is the same date on the HEI card and should be in the format dd/mm/yyyy. Enrolment onto the HEI follow-up programme constitutes provision of the following services: A) Identification of having born to a confirmed HIV positive mother B) Opening the HEI follow-up card.
HEI ID	(c)	Copy number from the HEI Card.
Infant's Name	(d)	Copy name from the HEI Card

COLUMN LABEL	COLUMN ID	COMPLETING INSTRUCTIONS
Date of Birth/Age	(e)	Copy date from the HEI Card and record the age at enrolment.
Sex	(f)	Copy entry from the HEI Card
Entry Point	(g)	<p>Use the information from the HEI Card under the label “source of referral” and use the corresponding code for the source as given below For example, if paediatric ward is checked on the card, in the register, write “2” using the code below:</p> <p>1=OPD 2=Paediatric Ward 3=MCH/PMTCT 4=CCC 5=Maternity 6. Others (Specify) If the child was transferred to this facility whilst on the programme, record “Transfer-in” in the register</p>
ARVs Received (0-6 weeks)	(h)	<p>Copy this information from the HEI card Enter the following coded responses for prophylaxis:</p> <p>1= <u>Sd NVP only</u>: This is recorded if a child only received a single-dose of Nevirapine at birth or early postnatal. This can be verified at registration with information from the child health card.</p> <p>2= <u>NVP+(AZT+3TC for 7 days)</u>. – The child should have taken single dose NVP at delivery and AZT/3TC for a duration of 7 days after delivery</p> <p>3= <u>NVP for 6 weeks</u> (Mother on HAART or Not BF). – This NVP to a baby whose mother is either on full ART or not breastfeeding the child.</p> <p>4= <u>None</u> – if the child did not receive any prophylaxis</p> <p>5. Other, specify by writing in the cell</p>
Mother's/Guardian's Name; Telephone	(i)	<p>The information here may the same as the one on the card – mother's name. If the mother is no longer active in presiding over the follow-up of the child, instead the name of the guardian should be recorded.</p> <p>The most recent telephone number on the patient locator section of the card should be copied to this register.</p>
Facility Enrolled & CCC number	(j)	<p>If the patient's mother is on ARV therapy, copy the CCC number from the mother's CCC card and write the name of the facility the child's mother is receiving care from.</p> <p>Note: If the details entered here are that of a guardian, in the bottom row enter N/A for “Not Applicable”.</p>
PMTCT ARVs - Mother	(k)	<p>Enter the following codes:</p> <p>1=SdNVP only: If mother received only a single-dose Nevirapine as prophylaxis.</p> <p>2=Interrupted HAART: If highly active regimen for MTCT prophylaxis was provided. This may be in the following combinations: AZT + 3TC + (NNRTI/PI/NRTI) and provided prior to, during pregnancy and for a variable duration postpartum.</p> <p>3=AZT+NVP+3TC: The mother received AZT during pregnancy or AZT/3TC+NVP intrapartum</p> <p>4=HAART: The mother was taking ARVs for her own health during the course of pregnancy.</p> <p>5=None: The mother did not take any prophylaxis.</p>

COLUMN LABEL	COLUMN ID	COMPLETING INSTRUCTIONS	
		6. Other: Specify type of prophylaxis the mother received.	
1st DNA PCR Test	Age at test (in weeks)	(l)	The age is given in weeks. It is calculated by taking the difference between date of birth and the date the blood is drawn (i.e. date of test) and the difference expressed in weeks.
	Test Type	(m)	<u>Initial:</u> This is first DNA sample drawn for testing <u>Repeat PCR for Rejections:</u> This is done in the event that initial test is unsatisfactory and rejected
	Sample/Test /Results dates	(n) (o) (p)	<u>Date Sample Taken:</u> This should be the date the sample was drawn from the patient (date of test) and not the actual date the laboratory did the test. This applies to either the initial and repeat tests, regardless of whether it is an initial PCR test or a confirmatory test after the first antibody test. This information is taken from the HEI card <u>Date Results Return from Laboratory:</u> This is a date on which the facility that originated the sample receives the results. This should not be confused with the date results have been recorded onto the local documents. This information is taken from the Laboratory Results records <u>Date Results are collected by parent/Guardian:</u> This is the date the caregiver is given the results of the child. Note: In the event of a repeat test , the corresponding cell for " Initial test " should be shaded or simply put X
	Test Result	(q)	Enter for positive (POS) or negative (NEG). Note: If the test result is positive, write "POS" in the final outcome column, and close this record.
	0 to 6 months	(r), (t), (v), (w)	The codes below are the possible responses for this age range: EBF for Exclusive Breastfeeding ERF for Exclusive Replacement Feeding MF for Mixed Feeding
Feeding Method	7 to 18 months	(z), (ab), (ad), (af)	After 6 months of birth, the programme is interested in knowing whether the child is breastfeeding or not. The codes are therefore : BF for currently breastfeeding No BF if the child has been weaned.
	NVP /CTX	(s), (u), (w), (y), (aa), (ae), (ag)	<u>Nevirapine</u> This information should be copied from the HEI card. In the upper cell of these columns, on each of the designated visit, write "Y" for "Yes" if NVP is issued on this visit. If the NVP has not be issued enter "N" for "No" but do not leave blank to denote that NVP was not issued. <u>Cotrimoxazole</u> This information should be copied from the HEI card. In the upper cell of these columns, on each of the visit, write "Y" for "Yes" if CTX is issued on this visit. If CTX has not be dispensed enter "N" for "No" but do not leave blank to denote that CTX was not issued.
1 st Antibody Test	Date of test	(ah)	See instruction for "Date Sample Taken" under 1 st DNA PCR
	Test Result	(ai)	Record POS for HIV positive results, NEG for negative result. Indeterminate results should not be recorded but wait until repeat test have been done and conclusive results obtained.

COLUMN LABEL		COLUMN ID	COMPLETING INSTRUCTIONS
Confirmatory PCR Test <i>(If AB Test at 9 months is Positive)</i>		(aj) (ak) (al) (am) (an) (ao)	If these columns are populated (test results for 1 st antibody test = positive), use instructions provided under the 1 st DNA PCR test. Note 1: This block of columns may remain blank if the 1 st antibody test results are negative. Note 2: The age of the child at test is recorded in months and not weeks Note 2: If the test result is positive, write "POS" in the final outcome column, and close this record.
2 nd Antibody Test	Date of test	(ap)	See instructions for 1 st antibody test
	Test Result	(aq)	See instructions for 1 st antibody test
HIV Status at 18 months		(ar)	Record the test result when the child was exited from the programme for any reason. However only confirmed test results should be entered here. POS if confirmed positive NEG if confirmed negative NK if the HIV status at exit is not known probably due to early exit before taking a confirmatory test. <u>Note:</u> The programme exit age is 18 months.
Final PMTCT Drugs given to Baby		(as)	Enter the following coded responses for prophylaxis: 1= <u>Sd NVP only</u> : This is recorded if a child only received a single-dose of Nevirapine at birth or early postnatal. This can be verified at registration with information from the child health card. 2= <u>NVP+(AZT+3TC for 7 days)</u> . – The child should have taken single dose NVP at delivery and AZT/3TC for a duration of 7 days after delivery 3= <u>NVP for 6 weeks</u> (Mother on HAART or Not BF). – This NVP to a baby whose mother is either on full ART or not breastfeeding the child. 4 = <u>NVP during BF period</u> : This should be recorded upon cessation of breast feeding against NVP dispensed for the period. 5= <u>None</u> – if the child did not receive any prophylaxis 6. Other, specify by writing in the cell
Outcome at Exit		(at))	Record the following possible outcomes: 1=Discharged 2=Referred to the CCC 3=Transferred Out 4= Lost to Follow-up 5= Dead Note: If the child has been confirmed HIV positive and referred for comprehensive care. Once "referred" is recorded, update the CCC number in column (au).
CCC Number		(au)	This column is only completed if column (at) has a "Referred" entry.

CARE AND TREATMENT

1. HIV CARE/ART CARD

Note: Locate sample on *annex 2 page 14-17* in this document

INTRODUCTION

The card has three parts: the face (which summarises key events, before and after enrolment into care); the encounter pages (where information about each visit is recorded; and the education and counselling page.

PURPOSE: To serve as a detailed record of clinical diagnosis and treatment. Any member of the clinical team who sees the patient needs to be able to know key clinical details and what education and support the patient has been given on the previous visits, in order to know what to do on this visit. This card can also serve as a transfer document and basis of continuity of care. This is done by photocopying or scanning a copy in order to send it together with other transfer documents.

WHEN COMPLETED: The card is opened immediately a patient registers for chronic HIV care including ART and continuously updated on each visit. The card therefore should be kept at the facility. Initial visit details cover demographics, patient's source and ART history. The remaining sections of the card can then be updated on subsequent visits by clinician.

Note: Do not open this card for patients who are yet not confirmed HIV positive. This includes those on PEP and HIV exposed infants; instead, a different card is opened for HIV exposed infants and is only transferred onto this card upon a confirmed HIV positive result.

WHO COMPLETES: At first visit, depending on the set up of the CCC and staffing levels, a Doctor, Clinical Officer, Nurse, Health records officer or data clerk fills this form and on subsequent visits filled by a doctor, clinical officer or nurse.

Note: This card should be part of the detailed patient file kept at the facility. It is not meant to restrict the provider only to the details on this card as such more pages (freeform or structured) for detailed information on treatment of acute problems may be required.

DESCRIPTION OF DATA LABELS

(i) FACE OF THE CARD

DATUM	INSTRUCTIONS
Facility Name	Write the name of the health facility enrolling the patient into HIV care
Patients Clinic Number	This is not the same as the unique ID. It is a link number to other services received in this facility. These numbers are usually allocated from the OPD registry.
Patients Name	Write patient's three names starting with the first name (Given name) followed by the middle name and last name (surname)
Unique Patient Number	Enter a unique identifier allocated to the patient once enrolled into HIV care. This number will be transferred from this to the Pre-ART register in column (c) and takes the format: Facility # from the Master Facility List (MFL) - Patient Serial Number Where; The first five digits represent the health facility number (e.g. 11740 for Port Reitz District Hospital as allocated by MFL).

DATUM	INSTRUCTIONS
	<p>The last six digits represent a sequential number generated at the CCC by the officer responsible for registration of ART patients e.g. health records officer, nurse or data clerk.(e.g. 000001 for the first patient into HIV care in this facility.</p> <p>In this example, the resultant unique number would be written as 11740-000001.</p> <p>Note: This nomenclature replaces the system that has been in use since 2006, which was province code + district code + patient serial counter.</p>
Date of Birth Age	<p>Date should be in the format dd/mm/yyyy. If patient does not know the day but only knows the month and the year the day shall be set to 15th of that month.</p> <p>If the patient only knows the year but does not know both the day and the month, Enter June for the month and 15th for the day.</p> <p>Ensure that all date cells are entered. Record the age of the patient as at her or his last birth day.</p> <p>Note:</p> <p>This data is very important especially for non-routine analysis like register review for in-depth analysis. As such do not use categories such Female Adult or Male Child, because that is what you need for reporting routinely. This data is transferred to column (d) of the Pre-ART Register.</p>
Sex	<p>Write M for male or F for female.</p> <p>Note: Sex here means the biological make up of a patient. This data element is transferred to column (e) under Pre-ART Register and column (e) of ART register.</p>
Postal Address	This is PO BOX # address or Private Bag (include postal code.)
Telephone Contact	Enter the telephone number for the patient. This can be a fixed line or mobile (cell). If the number belongs to the patient write “own” against the number else write the owner of the number.
District / Location/ Sub location/ Nearest Health Centre landmark	<p>Write down the name of the district where the patient is currently residing. The location and sub-location.</p> <p>Enter the landmark details (landmarks differ depending on different geographical area) e.g</p> <ul style="list-style-type: none"> -In urban area settings; state the Estate name, Phase number/court name, and, house number. -In a rural area, state the nearest feature e.g school, Health centre, church, or any other nearby physical feature. <p>This information is useful in patient follow up.</p>
Marital Status	<p>Tick whichever applies, in the box provided to the right of each category (Married Monogamous, Married Polygamous, Divorced, Widowed, cohabiting or Single).</p> <p>NB: For children, leave all categories unchecked. Single should only be selected for patients who have never been married (this should include those who may be currently engaged).</p>
Treatment Supporter(s)	<p>Treatment Supporter is someone who lives with or near the patient, and helps them with their treatment. (During preparations for ARV therapy, a health worker may help the patient choose the Treatment Supporter.)</p> <p>Write down the name of treatment supporter and his/her address the postal address and telephone number – and indicate the owner of the number. Indicate the relationship of the supporter to the patient. Incase the treatment supporter changes over time, update with the details of the new one.</p>
Entry Point	<p>Enter the following:</p> <p>PMTCT (ANC, Maternity and Post Natal clinic)</p> <p>VCT</p> <p>TB Clinic</p> <p>OPD</p> <p>IPD-Adult</p>

DATUM	INSTRUCTIONS
	<p>IPD-Pediatric MCH-child(mother is captured under PMTCT), Other, for all others - write the source in full (e.g. STI)</p>
Transfer-In	<p>Enter the date this patient was received and enrolled into CCC at your health facility. Record the name of referring facility, the district in which it is and the date this patient started ART incase he/she is already on ARVs.</p> <p>Note: <u>Transfer-ins</u>, are those patients who have already been enrolled into chronic HIV care or they have commenced ARVs from other CCCs. All TI patients should produce a referral document before they are accepted for continuity of HIV care. If no referral document is produced, the receiving facility should reinitiate the patient.</p> <p>For patients who transfer in with documents and are already on ARVs, remember to extract the date they started treatment and record it on the card.</p> <p>Note: The labels "Date Started ART" and "Date Started on 1st Line Regimen" will contain the same date value if the patient is a TI.</p>
ART History	<p>This is for patients ever on ARVs either for any purpose. For patients who report having used ARVs before, write down their drug history by listing down the purpose, (eg PEP, PMTCT or ART if the patient cannot provide documentation) individual drugs or combinations and for each and the date the drug was last taken.</p> <p>Note: This information is better extracted from the transfer documents. Verbal reports from patients will be in most instances inaccurate.</p>
Date Patient Confirmed HIV+ Where? Test was Done	<p>Write the date the patients HIV status was confirmed positive (+ve). Copy this date from the transfer documents or Lab test result slip. Date should be written in the format dd/mm/yyyy in the space provided.</p> <p>Indicate place/department, where this test was done.</p>
Date Enrolled in HIV Care Clinic	Record date patient is newly enrolled into chronic HIV care. This is not the same as the date patient was put on ARVs This date should be in the format dd/mm/yyyy. If patient is a transfer in, get this date from the referral documents
WHO Stage	This is WHO Stage at time of enrolment into chronic HIV care. It should not be confused with stage at commencement of ART. This is found on the ARV therapy section of this card and on the ART register col (i).
Known Drug Allergies	In the space provided the clinician will write any known allergies to drugs in this patient. The information can be from the verbal report by the patient or past medical history if patient has been using this facility before then.

(ii) HIV STATUS OF FAMILY MEMBERS

This section is meant to link the index (owner of this card) to other members of the nuclear family for purposes early HIV diagnosis, disclosure and strengthening the network of support. This information should be given freely by the index as coercing may infringe on privacy of some family members, who may have chosen not to receive care in this facility for a reason.

DATUM	INSTRUCTIONS
No.	<p>List order of the family member. For example the first member in the list will be "1" and their four listed members, the number for the last member will be "4".</p> <p>Note: In large families, family members should be limited to the spouse and the four youngest children in the house.</p>

Name of Members	Enter the name of the family as provided by the index.
Age	For children younger than one year, please enter the age in weeks expressed as a fraction of 52 thus “34/52” other record in years as at the last birthday.
Relation	This is the relationship between this index and the listed individual. If the listed person is a son, “son” will be recorded. Note: You may need to probe on relationships such as “son” and “daughter” so as to separate them from nephew and nieces. They latter category may be freely switched for the former in some family settings.
HIV Status	Ask if the patient know about this family member having tested for HIV. If the patient does not know, enter “DK” for “don’t know”. Where a patient knows about the family member having tested for HIV ask for the results and record either “P” for positive or “N” for negative”. Note: In the event that the index knows about a family member having been tested but does not know the results on this visit: <ul style="list-style-type: none"> If the test was done in this facility and a record exists, the health worker may need to update from the other person’s record. If the index can provide the information on subsequent visits, leave this column blank until the information has been provided.
In Care?	For those members with known HIV positive status, ask the index if those patients are receiving any care for the CCC.
CCC Number	This information can be obtained from the index if one has access to the other patient’s record. Otherwise, this information should be obtained by the health worker. Note: It may not be feasible to obtain this number if the listed family member receives care from another facility.

(iii) ARV THERAPY

DATUM	INSTRUCTIONS
Date Medically Eligible Reason for Eligibility	Write the date a patient was declared medically eligible for ARVs. This date should be in the format dd/mm/yyyy. For a patient whose eligibility is through clinical staging only, tick clinical in the box on the left and the write the WHO stage below it as: (1,2,3 or 4). For a patient whose eligibility is through CD4, tick CD4 in the box on the left and write the CD4 count or percentage (%) in the lower cell. For a patient whose eligibility is both through clinical and CD4, tick both the clinical and CD4 boxes and indicate WHO stage and CD4 count or percent (%) appropriately.
Date Start ART 1 st Line Regimen	<u>Date of Start 1st Line:</u> Enter the date the patient was started/commenced on first line regimen. Date should be written in the format dd/mm/yyyy
Cohort	Record the month and year in which this patient was commenced on ART. For example a patient enrolled in January of 2010 will belong to the cohort denoted “JAN2010”. Please abbreviate the month to three letters as shown in the example. This is the same entry made in the first row of the ART register. SEE instructions on how to complete the ART register. Note: This information is used to update the ART register for patients transferring in with records from other facilities. Each of the transfers-ins must be allocated to the appropriate cohort in the receiving facility.
Regimen	<u>1st Line regimen:</u> In the space to the right of the label “Regimen”, enter the drug combinations. Unlike in the ART Register where the drug combination codes (eg AF1A) are used, on this card, the actual drug combination should be written, (e.g –

DATUM	INSTRUCTIONS
	AZT+3TC+NVP)
Weight (kg)	Indicate weight of patient in Kgs at commencement of ART. This must be rounded off to one decimal place e.g 40.534kgs = 40.5 Kgs
Height (cm)	Write the height in children, the measure is in centimeters
WHO Clinical Stage	This stage is not necessarily the same as the stage recorded at time a patient is declared medically eligible. However, if the date of commencement of ART and date medically eligible are the same, then two will be same. It is also possible that they can be the same if the patients WHO stage has not changed since declared medically eligible.
Date Substitute Within 1 st Line Regimen	Below the label (date), enter the date when the substitution was done. Dates should be in the format dd/mm/yyyy
New Regimen (1 st Line)	Below the label (new regimen), enter the drug combination of the new regimen, (e.g AZT+3TC+NVP
Reason(s) for Substitution	<p>Enter the code indicating why substitution occurred. Codes for reasons of substitution are located at the bottom of the card and on codes description page on the third page of the card. The codes are 1 thru 7.</p> <p>Note:</p> <p>Pregnancy: A woman in her first trimester may have her drug substituted/stopped to safeguard the pregnancy.</p> <p>Risks of Pregnancy: Depending on the condition of the pregnant woman, she may develop a condition that might put the pregnancy at risk if continued on the drugs. The clinician may then substitute/stop the drug.</p>
Date Switched to 2 nd Line Regimen	This is the date a patient is moved from the first line to a 2 nd line regimen. The date format of dd/mm/yyyy applies.
New 2 nd Line Regime	Write the drug combination for the 2 nd line regimen eg AZT(300)-ddI(125)-LPV/r
Reason for Switch	Enter the code indicating why n switch occurred. Codes for switch reasons are located on the lower part of the card. The codes are 8 thru 10.
Substitute within 2 nd Line regimen	Below the label (date), enter the date when the substitution was done. Dates should be in the format dd/mm/yyyy.
New Regimen	Below the label 'New Regimen' enter the drug combination of the new regimen, (e.g AZT(300)-ddI(200)-LPV/r
Reason for Substitution	Enter the code indicating why substitution occurred. Codes for reasons of substitution are located on the lower part of the card. The codes are 1 thru 7. The reasons are the same for substitution within the first line regimen, therefore use the same code numbers provided in the box " Why SUBSTITUTE or SWITCH codes ".
Date Patient Transferred out	Below label (Date), enter the date when the patient was transferred out. Dates should be in the format dd/mm/yyyy.
To Where	Below label (Where?), enter the name of facility/institution and district the patient is being transferred to.
Date Patient Died	For DEATH, enter the date the patient died. For clients that die outside an institution, this information is obtained by follow-up if possible, or reports from treatment supporter, relatives, and friends.

DATUM	INSTRUCTIONS
ART Treatment Interruptions	<p>Note: Once this information has been recorded, this card is closed and no further entries are made to the document.</p> <p><u>Date of interruption</u> Indicate the date in the format (dd/mm/yyyy)</p> <p><u>Reason for interruption</u> Write in the reasons for treatment interruption. These are Lost to follow up or Stop. A box for the reasons at the bottom of the card and explained below:</p> <p>STOP: If a patient has stopped ARVs, indicate "STOP"</p> <p><u>LOST to follow-up:</u> Indicate lost to follow-up if a patient is declared lost to follow-up. Different facilities may institute different dispensing schedules. For example, some facilities may ask patients to report for drug pickup several days before the patients drugs actually run out because any miss-out for drugs creates a bad resistance. A patient should not be declared lost to follow up if they do not come on the appointment date but still have drugs from the previous supply. However, a patient is declared lost to follow-up(3/12) if they have run out of drugs and have not come back to pick up the next supply and 3 months attempts by CCC staff to trace patient have failed. Enter LOST TO FOLLOW-UP</p> <p><u>Date Restarted ART after STOP or LOST to follow-up</u> If patient restarts, indicate the date of restart (dd/mm/yyyy). Conditions for restart are determined by the clinician and reasons don't have to be reported on this card but may be written on the freehand patient file inserts.</p>

(iv) INSIDE OF THE CARD - *Individual Visitation Details - Initial and Follow-up Visits*

DATUM	ROW ID	INSTRUCTIONS
Visit details	Date	(a) In this row, write down the date of this visit in the format dd/mm/yyyy starting with the initial in the first visit.
	Type	(b) If this is a scheduled visit (from an earlier appointment – row (ae)), tick in the box provided in the right corner of the cell. To the left of the box write "SF" for self is the patient came to the facility and "TS" for treatment supporter, in the event that the patient is ill and someone else has to pick the drugs for him or her. If TS is entered, the row for this visit will be blank except row (w) if the drugs have been dispensed. If the person that has picked the drugs is different from the support on the face of the card, use the blank spaces (outside row w) to write the name of details of the supporter. Note: The first visit has no tick box as this is an initial visit which may not arise from an earlier appointment.
Duration Since ART/Current Regimen	(c)	Write the number of months the patient has been on ART. This is the difference in months between "Date Start 1 st Line" on the face of the card and the "date of <i>this</i> visit" in row (a). If the patient has been on ART for less than one month, record in weeks appropriately as: 1 week, 2 weeks or 3 weeks. If this is the visit on which ART is started, write "0" in the row against that visit.
	(d)	If a patient changes regimens, write a backslash "/" and thereafter, record the number of weeks or months the patient has been on the new

DATUM	ROW ID	INSTRUCTIONS
		<p>regimen (beginning with “0”).</p> <p>Enter short codes for the drugs as follows:</p> <p>ADULT ART First-Line Regimens</p> <p>AF1A = AZT + 3TC + NVP (Zidovudine + Lamivudine + Nevirapine)</p> <p>AF1B = AZT + 3TC + EFV (Zidovudine + Lamivudine + Efavirenz)</p> <p>AF2A = TDF + 3TC + NVP (Tenofovir + Lamivudine + Nevirapine)</p> <p>AF2B = TDF + 3TC + EFV (Tenofovir + Lamivudine + Efavirenz)</p> <p>AF3A = d4T + 3TC + NVP (Stavudine + Lamivudine + Nevirapine)</p> <p>AF3B = d4T + 3TC + EFV (Stavudine + Lamivudine + Efavirenz)</p> <p>PAEDIATRIC ART First-Line Regimens</p> <p>CF1A = AZT + 3TC + NVP (Paed Patients on Zidovudine + Lamivudine + Nevirapine)</p> <p>CF1B = AZT + 3TC + EFV (Paed Patients on Zidovudine + Lamivudine + Efavirenz)</p> <p>CF1C = AZT + 3TC + LPV/r (Paed Patients on Zidovudine + Lamivudine + Lopinavir/Ritonavir)</p> <p>CF2A = ABC + 3TC + NVP (Paed Patients on Abacavir + Lamivudine + Nevirapine)</p> <p>CF2B = ABC + 3TC + EFV (Paed Patients on Abacavir + Lamivudine + Efavirenz)</p> <p>CF2C = ABC + 3TC + AZT (Paed Patients on Abacavir + Lamivudine + Zidovudine)</p> <p>CF2D = ABC + 3TC + LPV/r (Paed Patients on Abacavir + Lamivudine + Lopinavir/Ritonavir)</p> <p>CF3A = d4T + 3TC + NVP (Paed Patients on Stavudine + Lamivudine + Nevirapine)</p> <p>CF3B = d4T + 3TC + EFV (Paed Patients on Stavudine + Lamivudine + Efavirenz)</p> <p>ADULT ART Second-Line Regimens:</p> <p>AS1A = AZT + 3TC + LPV/r (Zidovudine + Lamivudine + Lopinavir/Ritonavir)</p> <p>AS1B = AZT + ddI + LPV/r (Zidovudine + Didanosine + Lopinavir/Ritonavir)</p> <p>AS1C = AZT + 3TC + ABC (Zidovudine + Lamivudine + Abacavir)</p> <p>AS2A = TDF + 3TC + LPV/r (Tenofovir + Lamivudine + Lopinavir/Ritonavir)</p> <p>AS2B = TDF + 3TC + ABC (Tenofovir + Lamivudine + Abacavir)</p> <p>AS2C = TDF + 3TC + AZT (Tenofovir + Lamivudine + Zidovudine)</p> <p>AS2D = TDF + ABC + LPV/r (Tenofovir + Abacavir + Lopinavir/Ritonavir)</p> <p>AS2E = TDF + AZT + LPV/r (Tenofovir + Zidovudine + Lopinavir/Ritonavir)</p> <p>AS3A = ABC + ddI + LPV/r (Abacavir + Didanosine + Lopinavir/Ritonavir)</p> <p>AS4A = d4T + 3TC + LPV/r (Stavudine + Lamivudine + Lopinavir/Ritonavir)</p> <p>AS4B = d4T + 3TC + ABC (Stavudine + Lamivudine + Abacavir)</p> <p>Pediatric ART Second-Line Regimens</p> <p>CS1A = AZT + 3TC + LPV/r (Paed Patients on Zidovudine + Lamivudine + Lopinavir/Ritonavir as 2nd Line)</p> <p>CS1B = AZT+ABC+LPV/r (Paed Patients on Zidovudine+ Abacavir</p>

DATUM	ROW ID	INSTRUCTIONS
		<p>+ Lopinavir/Ritonavir)</p> <p>CS1C = AZT+ddI+LPV/r (Paed Patients on Zidovudine + Didanosine + Lopinavir/Ritonavir)</p> <p>CS2A = ABC+3TC+LPV/r (Paed Patients on Abacavir + Lamivudine + Lopinavir/Ritonavir)</p> <p>CS2B = ABC+ddI + LPV/r (Paed Patients on Abacavir + Didanosine + Lopinavir/Ritonavir)</p> <p>CS3A = d4T+3TC+LPV/r (Paed Patients on Stavudine + Lamivudine + Lopinavir/Ritonavir)</p> <p>CS3B = d4T+ABC+LPV/r (Paed Patients on Stavudine + Abacavir + Lopinavir/Ritonavir)</p>
Weight (Kgs)/Blood Pressure	(e)	Enter weight of patient at this visit. The figure should be rounded off to one decimal place. Compare this weight with the weight at start of ART. After the slash record the blood pressure on this visit.
Height (cm) in children	(f)	On each visit record and write here the height in centimetres
BMI	(g)	Record the BMI for this visit.
Pregnancy Status	(h) (i)	<p>If the patient is pregnant, enter the antenatal care (ANC) number in this row and the EDD in row (i). If referred for PMTCT use (ac) to record "PMTCT" as the referral destination.</p> <p>In the case of a reported recent <i>induced abortion</i>, record AB in row (h) and the date of the abortion in row (i).</p> <p>If a miscarriage is reported, write MC in row (h) and the date of miscarriage in row (i).</p> <p>If patient is not pregnant, leave both row (h) and (i) blank.</p>
Family Planning Status	(j) (k)	<p>If a client is not pregnant or client is male, and is on family planning enter FP, in row(j) and in (k) record the (FP) method using the codes below which can also be located on the third page of the card:</p> <p>C = condoms</p> <p>ECP = emergency contraceptive pills dispensed</p> <p>OC = oral contraceptive pills</p> <p>INJ = Injectable</p> <p>IMP = implant</p> <p>IUD = intrauterine device</p> <p>LAM = Lactational Amenorrhea Method</p> <p>D = diaphragm/cervical cap</p> <p>FA = fertility awareness method/periodic abstinence</p> <p>TL = tubal ligation/female sterilization</p> <p>V = vasectomy (partner's)</p> <p>UND = undecided</p> <p>Note: If client is using two methods, both should be written down.</p> <p>On the other hand, if a patient is not pregnant and is not on family planning enter NOFP in (j) and record the reason for not being on FP in (k). Possible reasons for not being on FP are coded below:</p> <p>WP = Wants to get pregnant</p> <p>UP = Thinks can't get pregnant</p> <p>NSex = Not sexually active now</p> <p>If the patient has not been of FP but wants FP, enter WFP for "wants FP" and assess for unmet need. If a method is provided on this visit, record the method by entering method codes provided.</p>
TB Status	(l) (m)	Enter the following:

DATUM	ROW ID	INSTRUCTIONS														
		<p>NO Signs = In (l) if no signs TB from previous assessment.</p> <p>TB Suspected = In (l) if a patient is clinically or radiologically suspected to have TB but not confirmed through laboratory tests.</p> <p>TB Rx = In (l) if patient is already on treatment followed by the TB treatment number and in (m) record the TB treatment start month.</p> <p>ND = If screening was not done</p> <p>Note: Refer to the TB codes on the inside page of the CCC card. If patient's sputum is sent for testing on this visit record in (aa) and if patient is referred for further investigation record in the referral row (ac). If TB drugs are dispensed, they should be recorded under other medicines in row(s)</p>														
Potential Side Effects	(n)	<p>Potential side effects. Record the potential side effects using the abbreviations in the list at the bottom of the encounter page, or write out the whole word. "Potential" is used because it is sometimes unclear whether a new sign or symptom is a side effect or another problem. If other, write in symptoms or signs.</p> <p>Nausea Rash Headache Diarrhoea Anaemia Jaundice Fatigue ABdominal pain FAT changes BN burning/numb/tingling CNS: dizzy, anxiety, nightmare, depression</p>														
New opportunistic infections and other problems	(o)	<p>Write the word or highlighted letter for the code of the opportunistic infection. These problems can be related to HIV, ART, or problems of unknown cause.</p> <p>The coding for OIs is on the third page of this card.</p> <p>In children record any nutritional problems using the codes as follows: SCM=Severe complicated malnutrition SUM= Severe uncomplicated malnutrition PWG=Poor weight gain</p> <p>Note: This is a proposed list; clinicians can enter any other OIs not listed here.</p>														
Clinical Stage	(p)	<p>Refer to the most recent local guidelines on "HIV Care and ARV Therapy and Prevention" for the appropriate staging. Since the new guidelines allow shifting patients up and down the stage even while on therapy, the stage entered for the patients will be differentiated thus: For a patient not yet on ART, just enter 1, 2, 3, 4 appropriately. For patients on therapy the stage is prefixed with "T" to signify that patient is on treatment. Examples: T1, ...T4.</p>														
Cotrimoxazole adherence and Dispensing	(q) (r)	<p>If patient is on cotrimoxazole, after assessing for adherence, write the actual adherence percentage or 'G' for Good, 'F' for Fair, and 'P' for "Poor" adherence. This is recorded in row (q) using the guide below</p> <table border="1"> <thead> <tr> <th rowspan="2">Adherence</th> <th rowspan="2">%</th> <th colspan="2">Missed doses per month</th> </tr> <tr> <th>1 x daily dosing</th> <th>2 x daily dosing</th> </tr> </thead> <tbody> <tr> <td>G(good)</td> <td>≥ 95%</td> <td><2 doses</td> <td>≤ 3 doses</td> </tr> <tr> <td>F(fair)</td> <td>85-94%</td> <td>2-4 doses</td> <td>4-8 doses</td> </tr> </tbody> </table>	Adherence	%	Missed doses per month		1 x daily dosing	2 x daily dosing	G(good)	≥ 95%	<2 doses	≤ 3 doses	F(fair)	85-94%	2-4 doses	4-8 doses
Adherence	%	Missed doses per month														
		1 x daily dosing	2 x daily dosing													
G(good)	≥ 95%	<2 doses	≤ 3 doses													
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DATUM	ROW ID	INSTRUCTIONS																		
		<table border="1" style="margin-left: auto; margin-right: auto;"> <tr> <td style="text-align: center;">P(poor)</td> <td style="text-align: center;">< 85%</td> <td style="text-align: center;">≥ 5 doses</td> <td style="text-align: center;">≥ 9 doses</td> </tr> </table> <p>In (r) record the number of doses of CTX dispensed on this visit. The entries should be in this format: doses/days. Note: On CTX given for prophylaxis should be recorded here. If CTX is given for treatment, record it under “other medicines dispensed” in row (t)</p>	P(poor)	< 85%	≥ 5 doses	≥ 9 doses														
P(poor)	< 85%	≥ 5 doses	≥ 9 doses																	
IHN	(s)	Record INH pills dispensed for TB Preventive Therapy (PBPT)																		
Other medicines dispensed (incl. nutritional supplements)	(t)	Enter the generic name, dose and frequency for any drugs or any other medication dispensed during this visit. ARV, CTX for prophylaxis and INH should not be included here. If (l) = TB Rx, TB drugs should be included here if dispensed on this visit																		
ARV drugs Adherence/ Dispensed	(u) (v) (w)	<p>For adherence (u), use the instructions for CTX row(q). To complete row(v) if adherence is either poor or fair the following codes are used:</p> <table border="0" style="width: 100%; text-align: center;"> <tr> <td style="width: 50%;">1 Toxicity/side effects</td> <td style="width: 50%;">10 Inability to pay</td> </tr> <tr> <td>2 Share with others</td> <td>11 Alcohol</td> </tr> <tr> <td>3 Forgot</td> <td>12 Depression</td> </tr> <tr> <td>4 Felt better</td> <td>13 Pill burden</td> </tr> <tr> <td>5 Too ill</td> <td>14 Other (specify)</td> </tr> <tr> <td>6 Stigma, disclosure or privacy issues</td> <td></td> </tr> <tr> <td>7 Drug stock out—dispensary</td> <td></td> </tr> <tr> <td>8 Patient lost/ran out of pills</td> <td></td> </tr> <tr> <td>9 Delivery/travel problems</td> <td></td> </tr> </table> <p>In row (w), in this order (regimen/dosage/days) write the regimen (in short codes as in row (d)), number of doses (quantity of drug(s) prescribed) and how many days the drugs will cover.</p> <p>If the drugs are concurrently provided under PMTCT, write “PMTCT” against the drugs.</p>	1 Toxicity/side effects	10 Inability to pay	2 Share with others	11 Alcohol	3 Forgot	12 Depression	4 Felt better	13 Pill burden	5 Too ill	14 Other (specify)	6 Stigma, disclosure or privacy issues		7 Drug stock out—dispensary		8 Patient lost/ran out of pills		9 Delivery/travel problems	
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Laboratory Tests Done (CD4, HB, ALT and others)	(x) (y) (z) (aa) (ab)	<p>Enter the results of the tests done CD4 count or percentage, HB, ALT.</p> <p>Note: The type of test and its results must be appropriately recorded in the correct cells and against the date of clinic visit on which they were done and not against the date the patient comes to pick up the results. For tests not ordered on this visit, leave the appropriate cells blank.</p>																		
Referred To Hospitalized	(ac)	<p>A patient can be referred for other specialized services such as dental, PMCT or gynecology, Record this point appropriately.</p> <p>If hospitalized there is a need to update the row on the number of days the patient spent in hospital. The hospitalization period is between two appointments. This therefore can only be done on subsequent visits and recorded in the square braces [].</p> <p>Note if patient must be referred, or if you need to consult with the clinician. If the patient has been hospitalized, enter the number of hospital days in square brackets.</p> <p>If the patient is being given nutritional support, capture this in the referral column using the codes:</p> <p>TF = Therapeutic Feeding (if <2yrs) IFC = Infant Feeding Counselling (if <2yrs) FS = Food Support</p>																		

DATUM	ROW ID	INSTRUCTIONS							
		EBF, ERF, MF = Infant Feeding Practices							
At Risk Population	(ad)	<p>Next to the label “Positive Prevention” write over the grayed text by inserting the appropriate category of at risk population or positive prevention. The codes are:</p> <table border="1"> <tr> <td>At Risk Population</td> </tr> <tr> <td>DC= Discordant Couple; MSM; IDU; SW; cSW= Clients to SW</td> </tr> <tr> <td>Service</td> </tr> <tr> <td>CC- couple counselling</td> </tr> <tr> <td>RR- targeted risk reduction</td> </tr> <tr> <td>C- Condom promotion/provision</td> </tr> <tr> <td>NSP- Needle and syringe programmes</td> </tr> </table>	At Risk Population	DC = Discordant Couple; MSM ; IDU ; SW ; cSW = Clients to SW	Service	CC - couple counselling	RR - targeted risk reduction	C - Condom promotion/provision	NSP - Needle and syringe programmes
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Service									
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RR - targeted risk reduction									
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NSP - Needle and syringe programmes									
Next Appointment date	(ad)	<p>Enter the date when the patient is scheduled for the next visit. Date should be in the format dd/mm/yyyy</p>							
Clinicians initials	(ae)	On each visit, the clinician who attends to the patient should write his/her initials for that date in the space (cell) provided.							

(IV) LAST PAGE OF THE CARD - *Follow-up education, support and preparation for ARV therapy page*

The back of the HIV care/ART card lets the team keep track of the status of the patient’s education, support and counseling services offered.

Note: It is recommended that this page is not bound together with the preceding pages of the card. This is so to enable local teams edit the information on the page to make it relevant to a category of patients. For example, if the card is being used on a child, some of the current information may need adjustment/or replaced.

2. PRE ART REGISTER

Note: Locate sample on *annex 2 page 18-19* in this document

INTRODUCTION

The Pre-ART Register is an institution-kept document where all patients enrolling in HIV care are entered. This includes patients identified within the facility and those that are transferred in (TI) from other health units or institutions before starting therapy. While on this register, patients undergo clinical and/or laboratory assessments to determine their eligibility for ART.

WHEN COMPLETED: At the time of consultation starting with the initial visit. It is however not completed on every visit while a patient is in Pre ART: it is updated as events take place eg becoming eligible or commencing on prophylaxis. Quarterly follow-ups are completed at the last visit of the quarter.

Note 1: Quarters in this register refer to the duration a patient or a group of them have spent in care grouped in intervals of three (3 month) and not the calendar quarters. For example, for patients who start therapy in:

- January, the 1st quarter in the first year will be (Jan, Feb, Mar); 2nd quarter (Apr, May, Jun), etc
- February, the 1st quarter in the first year will be (Feb, Mar, Apr); 2nd quarter (May, Jun, July), etc
- March , the 1st quarter in the first year will be (Mar, Apr, May); 2nd quarter (Jun, July, Aug), etc

Note 2: For note 1 above to work, you must open a new page at the beginning of each month to be able to patients in monthly groups.

WHO COMPLETES: The nurses in the clinic or the health records officer or data clerk assigned the responsibility of updating CCC patient records at the facility. These responsibilities may vary, depending on the size of the facility and staffing levels.

LOCATION: Each health institution should evaluate its patient flow to determine the best location of the register(s) to ensure data accuracy and completeness. Ideally, this register should be located in the place where other patient records for HIV care are kept.

DESCRIPTION OF COLUMNS

LABEL	COLUMN ID	INSTRUCTIONS
Serial No.	<i>Blank</i>	<p>This number will run from 1 thru n. Let us assume that a facility starts offering HIV care services on January 1, 2005 and its first patient reports to the clinic on the same day, this patient will be allocated serial number '1' the next '2', etc.</p> <p>When one register fills up just continue on the next number in the new register. For example if the last patient in a register is 410, the first patient in the new register will take up 411. If you are opening a new register and you already have a known number of patients ever enrolled in care from this facility, again, just pick the next available number.</p> <p>Note: This column assists in quickly counting the number of patients ever enrolled in care: X time to Date (e.g. Year to Date).</p>
Date Start Chronic HIV	(a)	This is date the patient is enrolled into care. The date should be entered in the format dd/mm/yyyy.

LABEL	COLUMN ID	INSTRUCTIONS
care		<p>Note: This is not the date the patient was referred to the CC clinic. For patients transferred from another facility and not yet on ART, put (TI) after the UPN in column (b) of this register, record the date he/she enrolled for HIV/Care/at the referring facility. In circumstances such as this, the date will not be in sequence with the other dates on the same page.</p>
Unique Patient Number	(b)	<p>See description of this data element under the “CCC card”. If the patient has been transferred to this facility while in pre-ART (before commencing ART), write “(TI)” for Transfer-in after the number. The nomenclature for the UPN is:</p> <p>Facility # from the Master Facility List (MFL) - Patient Serial Number</p> <p>Where;</p> <ul style="list-style-type: none"> • The first five digits represent the health facility number (e.g. 11740 for Port Reitz District Hospital as allocated by MFL). • The last five digits represent a sequential number generated at the CCC by the officer responsible for registration of HIV care patients e.g. health records officer, nurse or data clerk (e.g. 00001 for the first patient into HIV care in this facility). <p>In this example, the resultant unique number would be written as 11740-00001.</p> <p>Note: This nomenclature replaces the system that has been in use since 2006, which was province code + district code + patient serial counter.</p>
Patients Name	(c)	Enter first name in the upper cell followed by the last two names, where available. First name is the given name, the other two being the middle and surnames.
Date of Birth/Age	(d)	<p><u>Use upper row to record date of birth.</u> If patient does not know the day but only knows the month and the year, the day shall be set to 15th of that month. If the patient only knows the year but does not know both the day and the month, enter June for the month and 15th for the day.</p> <p><u>Use lower row to record the age at enrolment</u></p> <p>Date should be in the format dd/mm/yyyy and ensure that all date cells are entered.</p> <p>Note: This column is very important especially for non-routine analysis such in-depth register reviews As such do not use categories such Female Adult or Male Child, because you need actual age for reporting routinely.</p>
Sex	(e)	Write M for male or F for female.
Entry Point	(f)	<p>Enter one of the following:</p> <ul style="list-style-type: none"> • PMTCT (ANC, Maternity and Post Natal clinic) • VCT • TB Clinic • OPD • IPD-Adult • IPD-Pediatric

LABEL		COLUMN ID	INSTRUCTIONS
			<ul style="list-style-type: none"> • MCH-child (<i>mother is captured under PMTCT</i>) • Other, for all others - write the source in full (e.g. STI) or TI for transfer-ins
Status at Enrollment	TB	Status (g)	<p>Enter the following:</p> <p>NO Signs = If no signs TB from previous assessment.</p> <p>TB Present = If a patient sputum test results is positive.</p> <p>TB Rx = If patient is already on treatment</p> <p>ND = TB screening not done</p>
		Start month/year – upper rows (h)	This column is updated for patients on TB treatment. Enter the month and year the patient was started on TB treatment in the upper row of column (h)
	Pregnancy	TB Reg No. – bottom rows (h)	<p>Note: Only patients on active treatment should have this column updated else record "NA" for not applicable.</p> <p>If the upper cell of column (h) is filled, record the TB registration number of the patient.</p>
PMTCT and Pregnancy #		Status (i)	<p>For pregnancy status at enrolment enter</p> <p>PREG=Pregnant;</p> <p>PP=Post Partum.</p> <p>NA= For Males</p> <p>NP = If woman of reproductive age and it is confirmed that she is not pregnant at enrolment</p> <p>If currently pregnant update column (l) and subsequently column (m) for this pregnancy. This will be pregnancy 1 while in care. The other two pregnancies should then be those taking place whilst in care.</p>
		(j)	Record the date the patient was put on Cotrimoxazole in this column in the format mm/yy.
	INH Start (month/year)	(k)	<p>Record the date the patient was put on INH prophylaxis. Enter the start date in the format mm/yy.</p> <p>Note: Update the information appropriately should need arise.</p>
			<p>A patient may fall pregnant more than once before commencement on ART. For each of pregnancy record, antenatal care number (ANC#), expected date of delivery (EDD) and when the child is born enter the HIV exposed infant number.</p> <p>Note 1: This column refers only to current pregnancies whilst in care. The first pregnancy may refer to a pregnancy before enrollment in care but before delivery or a pregnancy taking place whilst in care.</p> <p>Note 2: Only pregnancies taking place before starting ART but while in care should be recorded.</p>
		(ANC #) – upper rows, cols (l), (n), (p)	This number should be entered in the upper cell of columns (l), (n) and (p). It is obtained from the antenatal booklet of the mother for the current pregnancy.
		(EDD #) – lower rows, cols (l), (n), (p)	Copy this date from the client-held ANC records to the lower rows for columns (l), (n), and (p).
	Birth Type – upper rows, cols (m), (o), (q)		<p>This column is only updated after delivery. Entries for these cells are LB for Live Birth and SB for Still Born.</p> <p>Note: If these are twin births, enter</p> <ul style="list-style-type: none"> • (LB/LB) if both are alive • (LB/SB) if one was alive while the other was a still birth.

LABEL	COLUMN ID	INSTRUCTIONS
	HEI# – lower rows, cols (m), (o), (q)	This column is only updated after delivery and is dependent on birth type. Enter the HIV Exposed Infant Register number in here. The number of HEI #s should correspond to LBs in the upper cells.
Date medically eligible for ARVs	(r)	Enter date when the patient was declared eligible for commencement on ART. For details on assessment for eligibility; please refer to the ART Treatment Guidelines for Kenya. The date should be entered in the format - dd/mm/yyyy. Note: For TIs who are already eligible but have not yet been commenced on therapy, copy the date eligible from the transfer documents.
Date ART started	(s)	Enter the date the patient was started/commenced on ART. This is the same date that is transferred to the ART register in column (c). The date should be in the format dd/mm/yyyy.
Quarterly Follow up Status	(t) to (bc)	Information entered in these columns is inclusive of events taking place during the first visit. These include the CD4 values, WHO stage, cotrimoxazole and TB screening as long as long as they have not been updated by the end of the quarter.
	CD4/WHO Stage – upper/lower rows, cols (t), (w), (z), (ac), (af), (ai), (al), (ao), (ar) (au), (ax), (ba)	For CD4 and WHO stage, the columns should be updated with the most recent events for that quarter, if more than one visit was made during the quarter. Please use pencil in case you need to update this information within the quarter. <ul style="list-style-type: none"> For CD4 enter counts for adults and percentage (rounded to 1 decimal point) for infants. For WHO stage, enter the stage using this notation: I, II, III or IV Note: For TIs, the clinical stage history should be copied from the transfer documents where available.
	CTX/TB Status – upper/lower rows, cols (u), (x), (aa), (ad), (ag), (aj), (am), (ap), (as) (av), (ay), (bb)	If cotrimoxazole was dispensed, make a check mark (✓) in the upper row to indicate the patient was issued with CTX prophylaxis. NB: CTX for treatment should not be recorded here. TB Status should be assessed on every visit for all patients in care before starting therapy. Enter the TB status completed at the most recent visit in the quarter (past three months). <p>NO Signs = If no signs TB from previous assessment. TB Suspected = If a patient is clinically or radiologically suspected to have TB but not confirmed through laboratory tests. TB Rx = If patient is started or already on treatment. ND = If screening was not done.</p>
	Patient Status – cols (v), (y), (ab), (ae), (ah), (ak), (an), (aq), (at) (aw), (az), (bc)	When CD4/WHO stage and CTX/TB status are not completed in a given quarter, the following codes may apply under programme status: LOST: - Had a scheduled appointment during the last applicable month during the quarter but missed the appointment. TO: - A TO is a patient who has been transferred to another facility. NOAPP: - If patient did not have an appointment scheduled during the quarter in question DEAD: A patient reported to have died. Death of a patient can be made known to the CCC staff by either a treatment

LABEL	COLUMN ID	INSTRUCTIONS
		<p>supporter, relative, CHW etc.</p> <p>Note: Once death has occurred, close the record.</p>

3. ART MONTHLY REGISTER

Note: Locate sample on *annex 2 page 20-21* in this document

INTRODUCTION

The ART register is an event-based document. Initially this register designed to initially track patients up to 24 months post ART initiation; this version has been designed to assist in recycling patient details up to 48 months (written in the lower row). Except for month (0), all visitation months have additional months in increments of 24 months and printed in light print. This is to enable users to write in pen which cycle is applicable (25-48 months). On the second page, the register provides space on the top left corner where the cohort is recorded. The cohort period is obtained from the Care Card (ARV Therapy).

Note: Once users have gotten accustomed to recycling patients through columns (ab) to (bo), subsequent editions may be freeform - where visit months will not be pre-inserted. Users will therefore have the freedom to fill in months 1 to months "n". Where "n" is the visit month for which there is no patient left on a given cohort.

PURPOSE:

- Provides record of patient outcome.
- It provides a track record of patients from initiation to monthly visits.
- It serves as a source of information on patient drug mix.
- It also serves as a data source for reporting and aggregation.

WHEN COMPLETED: It is completed on each patient visit. For example, patients who start ART from January 1st to 31st are entered on a page (or pages) and January is written under month zero. For patients starting ART in February, a new page is used and February is written under month zero. Data clerks will have to start a new register-page each month. This facilitates analyzing cohort outcomes at month 6, 12 and 24. Transfer-ins, whose ART start date is within that month, must be included in the ART register after a double line in the middle of the register. At the end of each month data clerks should leave enough space to accommodate future Transfer-in (TIs) patients. This is so, to facilitate retrospective entry of transfer-ins who will come to the facility after the month of their ART start date.

WHO COMPLETES: The Health Records officer, nurse in the CCC or the data clerk are assigned the responsibility of updating ART patient records at the facility. Update of this register would rely on the patient card.

LOCATION: Each Health Institution should evaluate its patient flow to determine the best location of the register(s) to ensure data accuracy and completeness. Ideally this register should be located in the place where other patient's records for ART are kept. For purposes of updating the register each facility should ensure that records for patients seen on that day are kept separately. These records at the end of the day should be used to update the ART register.

DESCRIPTION OF COLUMNS

DATUM	COLUMN ID	DESCRIPTION
Serial Counter	(a)	This serial number is different in usage from the one found on the Pre-ART Register. This number will reset to counter 1 at the beginning of each month both for patients who start ART at that facility and those who transfer in. For example if 30 patients commence on ART in the facility within the month of January 2010the serial counter will run

DATUM	COLUMN ID	DESCRIPTION
		<p>from 1 to 30 and start 1 again in February. The Health Records officer or nurse in the CCC or the data clerk responsible for updating ART patient records at the facility serially allocates this number as he/she records patients in the register.</p> <p>If whilst in February a facility receives 2 Trans-in, the serial counter for TIs below the double line in the register would be 1 and 2.</p> <p>Note: You should not update the column even when you have trans-outs. You need the original listing to assist you quickly ascertain how many patients were original in this cohort.</p>
ART Start date	(b)	<p>Date should be in the format dd/mm/yyyy. Copy this date from column (v) of the Pre-ART register.</p>
Unique Patient Number	(c)	<p>Same as col (b) of the Pre ART Register in the format: and takes the format:</p> <p>Facility # from the Master Facility List (MFL) - Patient Serial Number. Where;</p> <ul style="list-style-type: none"> The first five digits represent the health facility number (e.g. 11740 for Port Reitz District Hospital as allocated by MFL). The last five digits represent a sequential number generated at the CCC by the officer responsible for registration of ART patients e.g. health records officer, nurse or data clerk.(e.g. 00001 for the first patient into HIV care in this facility). <p>In this example, the resultant unique number would be written as 11740-00001.</p> <p>Note 1: Unique numbers for patients starting ART will not be sequential in this register as patients will be commencing ART in random order and not necessary the order in which they enrolled into HIV care.</p> <p>Note 2: Patients transferred from another facility whilst in care or on ART, retain their original number from source.</p>
Patients Name	(d)	Same as col (c) of the Pre ART Register
Sex	(e)	Same as col (e) of the Pre ART Register.
Date of Birth Age	(f)	Remember to update the age of the patient as per the date of birth at the time of analysis.
Address	(g)	In the top cell, enter the physical address and the bottom, enter the telephone number of the patient, the name of the nearest landmark e.g school, church/mosque, residential area etc
Reason for Eligibility	(h)	<p>For a patient whose eligibility is through clinical staging only, enter clinical in the upper cell and the WHO stage in the lower cell.</p> <p>For a patient whose eligibility is through CD4, enter CD4 in the upper cell with the CD4 count or percentage (%) in the lower cell.</p> <p>For a patient whose eligibility is both through clinical and CD4, enter WHO stage in the upper cell and CD4 count or percent (%) in the lower cell</p> <p>For a transfer in enter TI in the upper cell and the eligibility criterion in the lower cell. This criterion can be copied from the transfer documents or copy of Care Card where supplied</p>
WHO Clinical Stage	(i)	This is the stage at commencement of ART. (The information can be taken from the patient card).
CD4 Value	(j)	Enter the value of the CD4 count or percentage (%) for children.

DATUM	COLUMN ID	DESCRIPTION
or %		
Height for Child (cms)	(k)	Record the height of child - measured in centimetres
Weight in Kgs	(l)	Indicate weight of patient in kgs at commencement of ART. This must be rounded off to one decimal place. This is the same weight recorded on the CCC patient card under the heading ART therapy
CTX Prophylaxis Start month/year	(m)	Date should be in the format mm/yyyy. Record the month and year the patient was put on Cotrimoxazole
INH start month/year	(n)	This column is completed in conjunction with column (o); if the patient is not INH. The data format is mm/yyyy
TB Treatment Start month/year TB Reg No.	(o)	Enter the TB start month in the format mm/yyyy in the upper cell, and enter TB registration number in the lower cell..
PMTCT Pregnancies (1-3) Whilst on ART	(p) thru (r)	Enter the EDD in the upper cell if the client is pregnant and the ANC number in the lower cell.
Original Regimen	(s)	<p>Enter the first line drug combination codes a patient is put on, at commencement of ART. The standard drug regimen coding for 1st line is as follows:</p> <p>ADULT ART First-Line Regimens</p> <p>AF1A = AZT + 3TC + NVP (Zidovudine + Lamivudine + Nevirapine) AF1B = AZT + 3TC + EFV (Zidovudine + Lamivudine + Efavirenz) AF2A = TDF + 3TC + NVP (Tenofovir + Lamivudine + Nevirapine) AF2B = TDF + 3TC + EFV (Tenofovir + Lamivudine + Efavirenz) AF3A = d4T + 3TC + NVP (Stavudine + Lamivudine + Nevirapine) AF3B = d4T + 3TC + EFV (Stavudine + Lamivudine + Efavirenz)</p> <p>PAEDIATRIC ART First-Line Regimens</p> <p>CF1A = AZT + 3TC + NVP (Paed Patients on Zidovudine + Lamivudine + Nevirapine) CF1B = AZT + 3TC + EFV (Paed Patients on Zidovudine + Lamivudine + Efavirenz) CF1C = AZT + 3TC + LPV/r (Paed Patients on Zidovudine + Lamivudine + Lopinavir/Ritonavir) CF2A = ABC + 3TC + NVP (Paed Patients on Abacavir + Lamivudine + Nevirapine) CF2B = ABC + 3TC + EFV (Paed Patients on Abacavir + Lamivudine + Efavirenz) CF2C = ABC + 3TC + AZT (Paed Patients on Abacavir + Lamivudine + Zidovudine) CF2D = ABC + 3TC + LPV/r (Paed Patients on Abacavir + Lamivudine + Lopinavir/Ritonavir) CF3A = d4T + 3TC + NVP (Paed Patients on Stavudine + Lamivudine + Nevirapine) CF3B = d4T + 3TC + EFV (Paed Patients on Stavudine + Lamivudine + Efavirenz)</p>
(1st and 2nd Substitution while on 1st	(t)	Enter the drug combination codes of first substitution in the upper cell and at the second substitution in the lower cell.

DATUM	COLUMN ID	DESCRIPTION
line		Note: The code in (s) above will also apply here.
Date (of substitution)	(u)	Enter the date of first substitution in the upper cell and that of the second substitution in the lower cell in the format (dd/mm/yyyy).
Reasons for substitution	(v)	Enter the reason(s) for the substitution in column (t). For the first substitution enter the reason in the upper cell and that of the second substitution in the lower cell. The possible reason(s) and codes are found below the register.
2nd Line Regimen Regime, Reason(s) for switch	(w)	<p>In this cell, enter the drug combination the patient has been switched to from the 1st Line and the reason(s) in the lower cell. Reasons for switching to the second line are coded from 8 to 10 at the bottom of the register.</p> <p>The second line regimens and the codes are as follows:</p> <p>ADULT ART Second-Line Regimens:</p> <p>AS1A = AZT + 3TC + LPV/r (Zidovudine + Lamivudine + Lopinavir/Ritonavir) AS1B = AZT + ddI + LPV/r (Zidovudine + Didanosine + Lopinavir/Ritonavir) AS1C = AZT + 3TC + ABC (Zidovudine + Lamivudine + Abacavir) AS2A = TDF + 3TC + LPV/r (Tenofovir + Lamivudine + Lopinavir/Ritonavir) AS2B = TDF + 3TC + ABC (Tenofovir + Lamivudine + Abacavir) AS2C = TDF + 3TC + AZT (Tenofovir + Lamivudine + Zidovudine) AS2D = TDF + ABC + LPV/r (Tenofovir + Abacavir + Lopinavir/Ritonavir) AS2E = TDF + AZT + LPV/r (Tenofovir + Zidovudine + Lopinavir/Ritonavir) AS3A = ABC + ddI + LPV/r (Abacavir + Didanosine + Lopinavir/Ritonavir) AS4A = d4T + 3TC + LPV/r (Stavudine + Lamivudine + Lopinavir/Ritonavir) AS4B = d4T + 3TC + ABC (Stavudine + Lamivudine + Abacavir)</p> <p>Pediatric ART Second-Line Regimens</p> <p>CS1A = AZT + 3TC + LPV/r (Paed Patients on Zidovudine + Lamivudine + Lopinavir/Ritonavir as 2nd Line) CS1B = AZT+ABC+LPV/r (Paed Patients on Zidovudine+ Abacavir + Lopinavir/Ritonavir) CS1C = AZT+ddI+LPV/r (Paed Patients on Zidovudine + Didanosine + Lopinavir/Ritonavir) CS2A = ABC+3TC+LPV/r (Paed Patients on Abacavir + Lamivudine + Lopinavir/Ritonavir) CS2B = ABC+ddI + LPV/r (Paed Patients on Abacavir + Didanosine + Lopinavir/Ritonavir) CS3A = d4T+3TC+LPV/r (Paed Patients on Stavudine + Lamivudine + Lopinavir/Ritonavir) CS3B = d4T+ABC+LPV/r (Paed Patients on Stavudine + Abacavir + Lopinavir/Ritonavir)</p> <p>Note: For any additional combinations, code them appropriately and write in the space provided at the end of the instructions page. Make sure that once a code has been introduced, it has to be used consistently throughout the register.</p>
2nd line regimen (1st and 2nd substitutions)	(x)	<p>Enter the drug combination codes of first substitution in the upper cell and that of the second substitution in the lower cell.</p> <p>Note: The codes in column (v) or the addition second line drugs will apply.</p>

DATUM	COLUMN ID	DESCRIPTION
Date (of 2nd Line Substitutions)	(y)	Enter the date of first substitution in the upper cell and that of the second substitution in the lower cell in the format (dd/mm/yyyy).
Reasons for Substitution	(z)	Enter the reason(s) for the substitution done in column (x) Enter the reasons for the first substitution in the upper cell and that of the second substitution in the lower cell.
Month 0 (zero)	(aa)	Enter the cohort month inside the box labeled Month 0" which indicates the month when the patient commenced ART. For example, for patients who start ART between March 1st to 31st their initial month (March) is recorded inside the box labelled month 0 (zero). April then is recorded inside the box labelled month 1 and so on.
Monthly Visitations	(ab thru ag) (ak thru ap) (at thru ay) (bc thru bh)	IMPORTANT: Column from (ab) to (bk) can be reused for patients from 25 months to 48. The upper cells are use for entering data from months 1 to 24, and the lower cells from months 25 to 48 months Enter the drug combination code (eg AF1A) the patient is on for those patients that picked their drugs for that month. This indicates that the patient is alive and on the ART programme for that respective month. (The codes for the drug regimens are located at the bottom of this register). Conversely, enter one of the following outcomes: STOP – Stopped ART DEAD LOST if missed appointment for that month TO for Transfer Out. Note 1: For the patient whose status is “DEAD” block the remaining part of the columns for this patient’s row. Note 2: These columns MUST be updated at the month-end. In situations where a patient was given a prescription that goes beyond one month, please record the drug code in the month(s) that are covered by the drug issue
Assessments at intervals of six months till 48 months	(ah thru aj) (aq thru as) (az thru bb) (bi thru bk)	Data for these cells are recorded at 6 monthly intervals (till 48 months) after starting ART. Patients are assessed for CD4 viral load, weight and TB Status at 6 monthly interval Enter CD4 count or the percentage in columns (ah), (aq), (az) and (bi); Weight in columns (ai), (ar), (aa) and (bj) and; TB Status in columns (aj), (as), (bb) and (bk) using the coding below: <ul style="list-style-type: none"> • 1-No signs and symptoms • 2-TB suspect • 3-On TB treatment • 4-TB screening not done This data should be transferred from CCC card. Note: Ensure that columns are not switched when entering/reading data as these columns are all numeric and such a mistake can easily occur especially at the time of transferring data to the cohort summary form for analysis.

Note: For any additional combinations, code them appropriately and write in the space provided. Make sure that once a code has been introduced, it has to be used consistently throughout the register.

Other ADULT ART Regimens (<i>List any other regimens in these extra lines</i>)			
Codes		Combinations	Description
AO1A	=	ABC + 3TC + NVP	(Abacavir + Lamivudine + Nevirapine)
AO1B	=	ABC + 3TC + EFV	(Abacavir + Lamivudine + Efavirenz)
AO1C	=	ABC + 3TC + LPV/r	(Abacavir + Lamivudine + Lopinavir/Ritonavir)
	=		
	=		

Other PAEDIATRIC ART Regimens (<i>List any other regimens in these extra lines</i>)			
Codes		Combinations	Description
CO1A	=	AZT + ddI + NVP	Paed Patients on Zidovudine + Didanosine + Nevirapine
CO1B	=	AZT + ddI + EFV	Paed Patients on Zidovudine + Didanosine + Efavirenz
	=		
	=		

Cohort Analysis Timing				
ART Start Month	Cohort Analysis Month at ...			
	6 months	12 months	24 months	
January	<i>July</i>	<i>January [Year After]</i>	<i>January [2yrs Later]</i>	
February	<i>August</i>	<i>February</i> "	<i>February</i> "	
March	<i>September</i>	<i>March</i> "	<i>March</i> "	
April	<i>October</i>	<i>April</i> "	<i>April</i> "	
May	<i>November</i>	<i>May</i> "	<i>May</i> "	
June	<i>December</i>	<i>June</i> "	<i>June</i> "	
July	<i>January [Year After]</i>	<i>July</i> "	<i>July</i> "	
August	<i>February</i> "	<i>August</i> "	<i>August</i> "	
September	<i>March</i> "	<i>September</i> "	<i>September</i> "	
October	<i>April</i> "	<i>October</i> "	<i>October</i> "	
November	<i>May</i> "	<i>November</i> "	<i>November</i> "	
December	<i>June</i> "	<i>December</i> "	<i>December</i> "	

4. CARE AND TREATMENT ACTIVITY SHEET

Note: Locate sample on annex 2 page 27 in this document

This activity sheet covers the following aspects of care and treatment service delivery: enrolment in care, attendance whilst in care, cotrimoxazole prophylaxis, enrolment on ART, collecting ARV drugs on follow up visits and screening for cervical cancer and Tuberculosis.

Note: It is not a replacement for existing service registers or other detailed patient client line listings.

PURPOSE: This is a summary of selected programme indicators that demand immediate entry upon provision of a service. Unlike tally sheets that are difficult to audit, an activity sheet has a date and patient identifier against whom the service was provided, hence provides a basis for checking data completeness and consistency with other tools such as registers or cards. This activity sheet is also an appointment register

WHEN COMPLETED: Depending on the average number of patients each given facility sees per day, pages should be pre-dated upon opening a new book. On each given clinic day patients given appointments for future dates will be transferred to the appropriate pre-dated pages and only the CCC number will be recorded.

When that day is due:

- Some of the patients with appointments will report on this (appointment) date.

EXPECTED ACTION: Locate their CCC numbers, depending on the services offered, update details for columns (b) onwards. After that, place a check mark in column (aj) against each patient to show that this is a scheduled visit.

- Some patients will miss this day because they may have come a few day(s) earlier, plan to come on a later date or any other reasons.

EXPECTED ACTION: When such patients report to the facility, separate them from those with appointments by drawing a dark line (below the last patient with an appointment); enter them below this line and place a check mark in column (aj) against each patient to show that this is an unscheduled visit. Before then you would have closed out the cell for ‘visit type’ to show that the patient missed the appointment and column (aj) will be left empty.

NOTE 1: Depending on the volume of patients, several pages for each day may be used, if this happens, when starting a new sheet, repeat the date at right top of each sheet.

NOTE 2: Only in rare situations should we expect many patients “enrolled in care” to be placed above the dark line as most such patients come on unscheduled visits

WHO COMPLETES: This is completed by the service provider or a data clerk at the end of each day but before filing back the CCC cards. If completed by the clinician, data are recorded immediately the service is provided. However, this may not be possible for busy facilities and in this case; the data clerk will use the CCC cards from the day’s interactions to complete the day’s activities.

FORM IDENTIFIERS

Note: If more than one sheet is used, all fields for this section should be replicated on all pages.

DATA ELEMENT	INSTRUCTIONS
Day/Month/Year	Enter the pre-determined date for this page. This is the date of all scheduled appointments and those who would visit on this day but did not have an appointment

VISIT IDENTIFIERS

DATA ELEMENT	INSTRUCTIONS
Visit Type	<p>“Visit type” should not be confused with “patient type” for continuation of care or ART. This column is the type of visit in this month. If this visit is the first during the month, it is a new visit in this month and “N” should be written in this column. If during the same month a patient makes a subsequent visit, this is a “repeat” visit for that month and “R” should be entered against this visit.</p> <p>Example: If a patient is enrolled in care on January 1 and given an appointment for January 23. The following may apply on these visits:</p> <ul style="list-style-type: none"> • Jan 1 (enrol in care (f) to (j), started CTX (b) to (e), Screened for TB(ad) to (ag)) and N will enter as new visit this month; • Jan 23 (revisit in care (k) to (o), started on ART (q) to (u). On this visit, “R” will be entered for repeat to indicate that this patient has been to the facility earlier in this month. <p>Note 1: Type of visit” is meant to assist in:</p> <ul style="list-style-type: none"> (i) providing de-duplicated counts for patients on CTX, revisit in care and screening for TB. However, when summarising entries for “enrolment in care”, “starting ART” and “continuing on therapy”, this column is ignored as these are unique and autonomous events. (ii) counting unique patient contacts such as number of patients in care this month
CCC number (Column ‘a’)	<p>For patients already enrolled in care, this number is copied from the card. For patients enrolling in care on this visit:</p> <ul style="list-style-type: none"> • Complete the Pre-ART register first, from which the CCC number will be serially generated • Complete the CCC card and provide preliminary services <p>Note: Do not proceed with ticking which services have been provided before completing the CCC number. This is just as bad as not having provided a service because the record will not be included in the totals counts.</p>

SERVICES PROVIDED

Important: For services with the following desegregations: (<1), Male (<15), Female (>15) care must be taken when ticking for services provided. If the child is below 12 months, tick against “<1” and against “male (<15)” or “female (<15)” depending on the sex of the infant. This is so because when counting totals for that service, the under 1 category is also counted in the “<15”.

Data Element	Column ID	Instructions																																					
Cotrimoxazole	(b) thru (e)	<p>Under the appropriate cell, tick if the patient has been dispensed with CTX prophylaxis on this visit. The following patients should not be included:</p> <ul style="list-style-type: none"> • Patients on the HEI follow-up programme - who have not yet been confirmed positive • Patients with drugs at home (not dispensed on this visit) • HIV positive patients who are dispensed with CTX for treatment of an illness. <p>Note 1: For each patient with a tick in (b) thru (e), write the number of months the drugs (CTX) will cover before the patient requires a refill.</p> <p>Note 2: Since CTX prophylaxis is dispensed to the following type of patients: new in care, already in care, starting ART or continuing on ART, a tick on CTX is only authentic if a matching age/sex cell for the patient is checked under: in care (new/follow-up), on therapy or both.</p>																																					
Enrolment in Care	(f) thru (j)	<p>Enrolment constitutes all the processes that lead to the opening of the CCC card (MoH 257) and allocating the CCC number. Against the CCC number, sex and age group, provide a tick mark if the patient has been enrolled on therapy this visit.</p> <p>For example, the first patient on 1st January 2010 (aged 14 years and male), with CCC number 65400-0005, if enrolled in care on this visit will attract a check mark “✓” in row # 1 column (g), as shown below:</p> <table border="1"> <thead> <tr> <th rowspan="2">CCC Number</th> <th colspan="4">Cotrimoxazole</th> <th colspan="4">Enrollment in Care</th> </tr> <tr> <th>On CTX – Male (<15)</th> <th>On CTX – Male (15+)</th> <th>On CTX – Female (<15)</th> <th>On CTX – Female (15+)</th> <th>Enrolled in Care – <15</th> <th>Enrolled in Care – Male (<15)</th> <th>Enrolled in Care – Female (<15)</th> <th>Enrolled in Care – Male (15+)</th> </tr> </thead> <tbody> <tr> <td>(a)</td> <td>(b)</td> <td>(c)</td> <td>(d)</td> <td>(e)</td> <td>(f)</td> <td>(g)</td> <td>(h)</td> <td>(i)</td> <td>(j)</td> </tr> <tr> <td>64500-0005</td> <td></td> <td></td> <td></td> <td></td> <td></td> <td>✓</td> <td></td> <td></td> <td></td> </tr> </tbody> </table>	CCC Number	Cotrimoxazole				Enrollment in Care				On CTX – Male (<15)	On CTX – Male (15+)	On CTX – Female (<15)	On CTX – Female (15+)	Enrolled in Care – <15	Enrolled in Care – Male (<15)	Enrolled in Care – Female (<15)	Enrolled in Care – Male (15+)	(a)	(b)	(c)	(d)	(e)	(f)	(g)	(h)	(i)	(j)	64500-0005						✓			
CCC Number	Cotrimoxazole				Enrollment in Care																																		
	On CTX – Male (<15)	On CTX – Male (15+)	On CTX – Female (<15)	On CTX – Female (15+)	Enrolled in Care – <15	Enrolled in Care – Male (<15)	Enrolled in Care – Female (<15)	Enrolled in Care – Male (15+)																															
(a)	(b)	(c)	(d)	(e)	(f)	(g)	(h)	(i)	(j)																														
64500-0005						✓																																	
In Care Revisits	(k) thru (o)	<p>These are patients making subsequent visits after enrolment in care. The following patients qualify as revisits in care:</p> <ul style="list-style-type: none"> • All patients who were not enrolled in care during this month regardless of whether they are on therapy or not. • Patients discharged from the in-patient wards as long as in care on discharge. <p>The following patients should not be counted:</p> <ul style="list-style-type: none"> • Patients referred for other HIV care services. Such patients should be counted under the receiving departments. For 																																					

Data Element	Column ID	Instructions
		<p>example, a patient referred for admission from the CCC should not be counted under the CCC but under the in-patient ward at discharge.</p> <ul style="list-style-type: none"> • Patients receiving services such as TB/HIV and PMTCT, if the service on that specific visit is for TB or PMTCT respectively. • Children on early infant HIV diagnosis follow up programme, who have not yet been confirmed positive. <p>Note: Only patients with “N” new visit this month under “Visit type” should be totalled for this service.</p>
Number of months CTX is dispensed	(p ₁)	<p>This column is used in conjunction with columns (b) thru (e). For every patient with a tick in columns (b) thru (e), indicate the number of months the drugs dispensed on this visit will cover. In column (p₁), write 0, 1, 2 or 3. Where:</p> <ul style="list-style-type: none"> ➢ 0 = no CTX dispensed in this visit and columns (b) to (e) will be blank (no tick) ➢ 1 = CTX dispensed in this visit will cover only one month and one of the columns (b) to (e) will have been ticked. ➢ 2 = CTX dispensed in this visit will cover two months and one of the columns (b) to (e) will have been ticked. ➢ 3 = CTX dispensed in this visit will cover three months and one of the columns (b) to (e) will have been ticked. <p>Note: This column, in conjunction with (b) to (e) is meant to assist in estimating the number of patients receiving CTX. So please carefully read the instructions for transferring this information to the tally sheet.</p>
Number of months before next (HIV) care appointment	(p ₂)	<p>This column is used in conjunction with columns (f) to (j) and (k) to (o) to estimate the number of patients currently in care. For every patient with a tick in these columns, indicate the number of months before the patient is expected to make a scheduled visit. In column (p₂), write 1, 2, 3 etc. Where:</p> <ul style="list-style-type: none"> ➢ 1 = Patient is expected to come back in one month and one of the columns (f) to (o) will have been ticked. ➢ 2 = Patient is expected to come back in two months and one of the columns (f) to (o) will have been ticked. ➢ 3 = Patient is expected to come back in three months and one of the columns (f) to (o) will have been ticked. ➢ etc <p>Note: Carefully read the instructions for transferring this information to the tally sheet</p>
Starting Therapy	(q) thru (u) (v) to (w)	Starting therapy means the patient has been commenced on the therapy. Commencement on therapy is determined by the clinician's issuance of a prescription for the patient to go and pick the drugs from the pharmacy; it has nothing to do with whether that patient reached the pharmacy or not. As long as that prescription has not been revoked, the patient should be ticked as started on therapy.
Continuation	(x) thru	Continuing on therapy includes all patients who made a visit to the

Data Element	Column ID	Instructions
on Therapy	(ab)	<p>facility under the following circumstances:</p> <ul style="list-style-type: none"> • Periodic refill (even if they still have a few days' supply from the previous period as long as they have been dispensed with drugs on this visit. • Restarted after treatment interruption (Lost, STOP) <p>Patients who should be excluded from these counts include patients who still have drugs at home but make a visit to the facility for the following reasons:</p> <ul style="list-style-type: none"> • Clinical assessment (but not dispensed with drugs). Such patients will still be ticked under the appropriate age.sex column under "In care Revisits" • Short-term supply (for travellers or visitors to the area) as long as the supply is shorter than one month. • Visits for review after the first two weeks of commencing therapy (but within the same calendar month). This should not be counted even if the patient is dispensed with drugs because they will have already been counted under "Starting Therapy" in the same month.
Drug month dispensed	(ac)	<p>Column (ac) is meant to capture the number of additional months covered by this visit.</p> <ul style="list-style-type: none"> • Example 1: A female patient (on therapy) aged 32 who makes a follow-up visit and is dispensed with three months' supply of drugs, besides column (o), will attract a tick under column (ab) to show that drugs have been dispensed for this month and a "3" will be written in column (ac) to show that the patient has given drugs for 3 months. • Example 2: For a male patient (on therapy) aged 14 making a revisit and is dispensed with 2 months of supply on this visit, a tick will be placed in column (l) as a revisit and (y) for having received drugs on this visit then a "2" will be written in column (ac) to indicate that two months' supply were dispensed. • Example 3: For an infant (on therapy) who makes a repeat visit to the facility and is given a month's supply of drugs, a tick will be placed under column (k) as a revisit in care and in (x) for having received drugs. A one (1) will be written in column (ac) to indicate that one month of drugs was dispensed – meaning the patient is expected next month. • Example 4: Conversely, a patient (on therapy) who makes a follow-up visit to the facility but not dispensed with drugs for ANY reason, (x) thru (ac) will be blank, even if the patient still has drugs at home – because those drugs would already have been counted. However, ticks will have been appropriately placed in columns (k) to (o) to show attendance. If CTX was issued a tick will equally have been appropriately made. <p>Note: For all the patients dispensed with more than one month supply (column (ac)), these additional months are tallied on the "Care and Treatment Tally Sheet". See separate instructions for completing this tally sheet.</p>

Data Element	Column ID	Instructions
Screening while in Care	(ad) thru (ag) (ah)	Note: Screening for cervical cancer (ah) should be ticked only for women who are aged (18+) in column (ai).
Patient Type (Females 18+)	(ai)	All women making a clinical visit, regardless of whether they are in care or on ART, should be ticked, as long as they are aged (18+)
Appointment Management	(aj)	Provide a tick for all patients who made a visit on this day. For patients who missed the appointment, this will be left blank and "Visit Type" will be crossed out.

CONTACT TOTALS

Data Element	Instructions
Total for this Page	<p>Every page should have its own totals. This is done by counting all the ticks in the column and writing down the totals in the corresponding cells.</p> <p>For example, 10 ticks for "enrolled in care (<1) will be totalled right below the label "HV03-08", the row "total this page".</p> <p>Note: Count all ticks for "Enrolment in Care", Starting ART" and Continuation on Therapy" For "In Care Revisits" and "Screening", count only those patients with N in visit type.</p>
Total for this month	On the last page of the month, total all the page totals from sheets in this month, in the row "total this month"

5. CARE AND TREATMENT TALLY SHEET

Note: Locate sample on *annex 2 page 28* in this document

INTRODUCTION

This tally sheet is a collation companion to the care and treatment activity sheet and covers “continuation on therapy”.

PURPOSE: It is used for counting patients who received drugs this month and those who received drugs, in the previous months and those drugs cover the reporting month. Each tally sheet or a set of them should cover only one month. It means that events from different months cannot be mixed on the same tally sheet.

WHEN COMPLETED: At the end of every month, a new tally sheet is opened and the year and month are written in the spaces provided.

Note: All activity sheets for the month should be tallied onto one tally sheet.

WHO COMPLETES: This tally sheet should be completed by a designated health worker or clerk who manages health records for HIV Care.

DESCRIPTION OF COLUMNS

(i) IDENTIFIERS

Note: If more than one sheet is used, all fields for this section should be replicated on all pages.

Data Element	Instructions
Month	Enter the month for the tallying will be done. Write month in words.
Year	Enter the year in full. For example 2010

(ii) DATA ELEMENTS

Information for completing the C&T tally sheet is obtained from the C&T activity sheet using the columns indicated as “Source”, in the description table below:

DATA ELEMENT DESCRIPTORS			INSTRUCTIONS FOR TALLYING FROM C&T ACTIVITY SHEET
DATA LABEL	CODE	SOURCE	
On CTX - Current M(<15)	HV03-03	(b) with (p ₁)	<p><u>From this (reporting) month's activity sheet (eg Mar 2010):</u> For male patients, aged <15 years: From column (b), copy the “total this month” and transfer to the tally sheet under the label “Subtotal from this month.”</p> <p><u>From previous (last) month's activity sheet (eg Feb 2010):</u> Count and tally all male patients aged <15 years, who were dispensed CTX during the visit (with a corresponding ‘2’ or ‘3+’ in column (p₁)). This indicates that the patient was dispensed CTX enough to cover the reporting month.</p> <p><u>From activity register, 2 months ago (Jan 2010):</u> Count and tally all male patients aged <15 years, who were dispensed CTX during the visit (with a</p>

			corresponding ‘3+’ in column (p ₁)). This indicates that the patient was dispensed CTX enough to cover the reporting month.
On CTX - Current F(<15)	HV03-04	(c) with (p ₁)	See examples for HV03-03 and HV03-04
On CTX - Current M(15+)	HV03-05	(d) with (p ₁)	See examples for HV03-03 and HV03-04
On CTX - Current F(15+)	HV03-06	(e) with (p ₁)	See examples for HV03-03 and HV03-04

In Care - Current (<1)	HV03-14	(f) or (k) and (p ₂)	<p><u>From this (reporting) month's activity sheet (eg Mar 2010):</u></p> <p>For patients, aged <1 year:</p> <ul style="list-style-type: none"> • From column (f), copy the “total this month” and transfer to the tally sheet under the label “Subtotal from this month – new”. • From column (k), copy the “total this month” and transfer to the tally sheet under the label “Subtotal from this month – revisit”. <p><u>From previous (last) month's activity sheet (eg Feb 2010):</u></p> <p>Count and tally all patients aged <1 year, who made visits in care (f) or (k) with a corresponding ‘2’ or ‘3+’ in column (p₂) to show that their appointments are not yet due and therefore are still in care.</p> <p><u>From activity register, 2 months ago (Jan 2010):</u></p> <p>Count and tally all patients aged <1 year, who made visits in care (f) or (k), with a corresponding ‘3+’ in column (p₂), to show that their appointments are not yet due and therefore are still in care.</p>
In Care - Current M(<15)	HV03-15	(g) or (l) and (p ₂)	<p><u>From this (reporting) month's activity sheet (eg Mar 2010):</u></p> <p>For male patients, aged <15 years:</p> <ul style="list-style-type: none"> • From column (g), copy the “total this month” and transfer to the tally sheet under the label “Subtotal from this month – new”. • From column (l), copy the “total this month” and transfer to the tally sheet under the label “Subtotal from this month – revisit”. <p><u>From previous (last) month's activity sheet (eg Feb 2010):</u></p> <p>Count and tally all male patients aged <15 years, who made visits in care (g) or (l) (with a corresponding ‘2’ or ‘3+’ in column (p₂)) to show that their appointments are not yet due and therefore are still in care.</p> <p><u>From activity register, 2 months ago (Jan 2010):</u></p> <p>Count and tally all patients aged <15 years, who made visits in care (g) or (l), with a corresponding</p>

			'3+' in column (p ₂), to show that their appointments are not yet due and therefore are still in care.
In Care - Current F(<15)	HV03-16	(h) or (m) and (p ₂)	See examples for HV03-14 and HV03-15
In Care - Current M(15+)	HV03-17	(i) or (n) and (p ₂)	See examples for HV03-14 and HV03-15
In Care - Current F(15+)	HV03-18	(j) or (o) and (p ₂)	See examples for HV03-14 and HV03-15
On ART - Revisit (<1)	HV03-28	(x) and (ac)	<p><u>From this (reporting) month's activity sheet (eg Mar 2010):</u> Count all patients aged <1 year with a check mark in (x), who are revisits while on ART. Transfer the total for this month to the column labelled "Total this month" under HV03-28</p> <p><u>From previous (last) month's activity sheet (Feb 2010):</u> Count and tally all patients aged <1 year, who are revisits while on ART (with a '2' or '3+' in column (ac) to show that they picked drugs last month that cover this reporting month.</p> <p><u>From activity register, 2 months ago (Jan 2010):</u> Count and tally all patients aged <1 year, who are revisits while on ART (with a '3+' in column (ac) to show that they picked drugs two months ago that cover this reporting month.</p>
On ART - Revisit M(<15)	HV03-29	(y) and (ac)	<p><u>From this month's activity register (eg Mar 2010):</u> Count all male patients aged <15 years with a check mark in (y), who are revisits while on ART. Transfer the total for this month to the column labelled "Total this month" under HV03-29</p> <p><u>From last month's activity register (Feb 2010):</u> Count and tally all male patients aged <15 years, who are revisits while on ART (with a '2' or '3+' in column (ac) to show that they picked drugs last month that cover this reporting month.</p> <p><u>From activity register, 2 months ago (Jan 2010):</u> Count and tally all male patients aged <15 years, who are revisits while on ART (with a '3+' in column (ac) to show that they picked drugs two months ago that cover this reporting month.</p>
On ART - Revisit F(<15)	HV03-30	(z) and (ac)	See examples for HV03-28 and HV03-29
On ART - Revisit M(15+)	HV03-31	(aa) and (ac)	See examples for HV03-28 and HV03-29
On ART - Revisit F(15+)	HV03-32	(ab) and (ac)	See examples for HV03-28 and HV03-29

Note: The recommended sequence is:

- Transfer the totals from the current month for all data elements (HV03-03 to HIV03-06), (HV03-14 to HV03-17) (HV03-28 to HV03-32) to the tally sheet column label "subtotal from this month"
- Tally from last month
- Tally from two months ago
- Then add the subtotals (three for CTX and ART and four for Care) before transferring to the facility report

6. NUTRITION/HIV REGISTER

Note: Locate sample on *annex 2 page 22* in this document

INTRODUCTION

The Nutrition register is used for recording information concerning clients who make initial visits and follow up visits to the nutrition clinic where nutrition services are provided. At every visit, the nutritionist should record the client details into the nutrition register

PURPOSE: It serves as a record of key events or services provided to the clients on ARVs or on Care or for children exposed to HIV.

These services include nutrition assessment, counselling, support and referral.

WHEN COMPLETED: The Nutrition register is first completed upon contact with the patient at their initial and subsequent visits to the nutrition clinic.

WHO COMPLETES: Nutritionists or other staff assigned the responsibility.

WHERE PLACED IN THE FACILITY: The nutrition register is located in the nutrition room.

COLUMN LABEL	COLUMN	COLUMN DESCRIPTION
Date	(a)	Fill in the date the patient receives Nutrition services. The date should be in the format: dd/mm/yyyy.
Client Unique No.	(b)	Copy the IP/OP No. that appears on the patient card.
Client Name	(c)	Record the patients Three Names
Revisit	(d)	Tick if a revisit or Leave blank if a new client
SeroStatus(P/N) P=1,N=2)	(e)	Write 1 if positive and 2 if Negative
Date of Birth	(f)	Indicate Date of birth of patient as dd/mm/yy
Age(yrs)	(g)	Indicate the age (this applies to adults only)
Gender	(h)	Write M for male and F for Female
Residence and Land Mark	(i)	Enter the name of the place the client stays(sub- /ocation/village) and include closest landmark e.g school, church, mosque)
Telephone Number	(j)	Fill in the clients phone no. or no.for next of kin.
Pregnant/Post partum(P/PP),P=1, PP+2	(k)	Record whether client is pregnant(P) or Post partum(PP)
Weight(Kg)	(l)	Fill in the weight of the client in kilograms rounded to two decimal places e.g 33.23 kgs
Height/Length(cm)	(m)	Write height /length in centimetres to 1 decimal place
Weight for Height(WFH) Z score(0-59mnths)	(n)	For children 0-59 months, write the standard deviation (SD). Refer to WHO Z Scores reference charts
BMI for Age(5-17 yrs)	(o)	For ages 5 – 17 years indicate BMI for age boys Z score or BMI Z scores for girls using WHO BMI for age Z score reference charts.
BMI for Age (Adults over 18 yrs)	(p)	Calculate and fill in the BMI for adults i.e (> 18 years) using this formula. Weight in Kgs /height in metre squared. Wt/Ht(m) ²
MUAC(cm)	(q)	For those you cannot BMI or SD record the MUAC in centimetres to 1 decimal point i.e (for pregnant women, disabled persons, very sick

COLUMN LABEL	COLUMN	COLUMN DESCRIPTION
		(patients.)
Hb(g/dl)	(r)	Fill in the haemoglobin level of the patient and the date it was done
On ARVs (Y/N) Y=1, N=2	(s)	Write Y if client is on ARVs and N if client not on ARVs
IYCF (Infant and Young Child Feeding)	(t)	Tick if client was counseled/received commodities on infant and young child feeding
SCNPs (Critical Nutrition Practices)	(u)	Tick if client counselled on critical nutrition practices
IYCN+CNP	(v)	Tick if client received both services
TF (Therapeutic feeding)	(w)	Tick if patient received therapeutic feeding support
SF(Supplementary feeding)	(x)	Tick if client received supplementary feeding support
MM(Multiple micronutrients)	(y)	Tick if client received multiple micronutrient support
EBF(Exclusive Breastfeeding upto 6mths)	(z)	Tick if client is exclusively breast feeding and within 6 months
ERF(Exclusive Replacement feeding upto 6mths)	(aa)	Tick if on replacement feeding and within 6 months
MF(Mixed Feeding)	(ab)	Tick if mixed feeding and within 6 months
TCA(dd/mm/yyyy)	(ac)	Indicate the return date for the visit
Remarks	(ad)	Write any other comments that will be beneficial to the client and the service.

7. THE ART COHORT SUMMARY SHEET

Note: Locate sample on *annex 2 page 29* in this document

INTRODUCTION

In order to assess programme success, data on treatment outcomes and retention for a group of patients are extracted from the ART register at intervals of 6, 12 and 24 months after commencing therapy.

NOTE 1: Care must be taken when transferring data from columns (*ah, ai, aq, ar, bi, and bj*). The chances of mistakenly switching the “CD4” columns (*ah, ag, bj*) with entries from “weight” columns (*ai*) (*ar*) and (*bj*) when collating are high.

These groups of patients are formed at commencement of therapy and referred to as “cohorts”. An ART cohort therefore is a group of patients who commenced on ART during the same month and year. They are called so, because at selected intervals, these patients will be evaluated on a number of parameters collectively to check for outcomes.

NOTE 2: In a paper-based system, ART cohorts cannot be analysed if the ART monthly register is not properly maintained.

Data for patients who have completed 6, 12 or 24 months on ART are extracted from columns (*aa*) to (*aj*), (*aa*) to (*as*) and (*aa*) to (*bk*) respectively. Depending on the age of the cohort, data are then transferred appropriately to the time block for (G, TI, TO, N, H, I and J)

PURPOSE: In order to assess programme success and early warning signs for HIV drug resistance.

WHEN COMPLETED: Every month for cohorts that have matured to 6, 12 and 24 months. If a facility has just started offering ART services, this facility may not be expected to report on cohorts in the first 6 months unless it has received many transfers.

WHO COMPLETES: The person responsible to fill the CCC cohort summary sheet would vary from one site to the other. At the health centre level, the In-charge completes this form, at the hospital level (sub-district, District, Provincial or National), either a medical records staff, nurse, or data clerk would complete it.

LOCATION: In a health center, the office of the health centre In-charge; in a hospital, where all other ART records are managed and kept; most preferably at the CCC. This form remains at the facility for health unit management while selected data elements are summarised onto the 711 for health system management and planning.

DESCRIPTION OF DATA ELEMENTS

Note: All references to column id for source of data, should default to the ART monthly register.

COLUMN	DATUM	INSTRUCTIONS
(G)	Started on ART in this clinic-original cohort	<p>This is a tally of the number of patients in the ART register who started ART in that month at that facility. This can be obtained by simply using the serial counter (Column ‘a’) of the ART register for those starting ARVs in that facility</p> <p>This number does not change, and can be carried over to the 6, 12 and 24 month columns for that cohort.</p> <p>Note: Excluded all transfer-in (usually at the bottom of the register, below a thick line).</p>

COLUMN	DATUM	INSTRUCTIONS
(TI)	Transfers in Add +	At the end of each month in the ART register, a line is drawn under all patients who have started ART at that facility during that month. Patients who subsequently transfer in who have previously started ART at another facility are serially retrospectively entered into the ART register under this line
(TO)	Transfers out Subtract-	Patients who transfer out of the facility will be noted by a TO in the monthly follow-up status cells of the ART register. Count the total number of TOs that have occurred during the previous 6, 12 or 24 months for each ART start-up group.
(N)	Net current cohort	Take the number of patients in the original cohort, add the Transfers In and subtract the Transfers Out to get the net current cohort.
(H)	On original 1 st line regimen	<p>These are patients who have not substituted to an alternative 1st line regimen. Data for this category of patients are extracted from column (s), complemented by column (t) & (w). If both cells (upper and lower) in column (t) are blank and column (w) is blank; this means that the patient has not substituted or switched to another drug from the one in column (s).</p> <p>To confirm that the patient is still on the Original 1st line drug, check whether:</p> <p style="padding-left: 20px;">The terminal column ((ag), (ap) or (bh)) has a drug combination code; and this code is similar to the one in column (s).</p> <p>APPROPRIATENESS [OPTIONAL]: To know if the regimen is appropriate, change against the drugs combination table. However, the order as outlined in the table may not be adequate in itself to determine the appropriateness; there is a need to have a clinician on the team to assist with this. For a example, a given combination may be considered first choice but may be contraindicated to some condition at the time of initiation.</p>
(I)	On alternate 1 st line regimen (substituted)	<p>These are patients who have substituted to an alternative 1st line regimen. Data for this category of patients are extracted from column (t) complemented by column (w). If one or both cells (upper and/or lower) in column (t) have an entry, this means that the patient has substituted at least once to another drug from the original regimen in column (p).</p> <p>To confirm that the patient is still on an alternative 1st line:</p> <ol style="list-style-type: none"> 1. Make sure the patient has not switched to 2nd line - column (w) is empty 2. The terminal column ((ag), (ap) or (bh)) has a drug combination code; and this code is same as the one in column (t) <p>APPROPRIATENESS?: See explanation for (H)</p>
(J)	On 2nd-line regimen (switched)	<p>These are patients who have been switched from the 1st line to the 2nd line or higher regimen. Data for this category of patients are extracted from column (w). If column (w) has an entry, this means that the patient has switched to the 2nd line regimen.</p> <p>To confirm that the patient is still on the 2nd Line Drug:</p> <p style="padding-left: 20px;">The terminal column ((ag), (ap) or (bh)) has a drug combination code; and this code is a second line drug</p>

COLUMN	DATUM	INSTRUCTIONS
	Stopped Died Lost to follow-up	<p>Data for these parameters are obtained from terminal columns ((ag), (ap) or (bh)). This is the status at the end of 6, 12 or 24 months. For each occurrence of stopped, died, or lost to follow up, proceed thus:</p> <p><u>Col (ag)</u>- For stopped, died or lost to follow up, include these entries to the 6 months cohort under stopped, died and lost to follow up respectively.</p> <p><u>Col (ap)</u>- For stopped, died or lost to follow up, include these entries to the 12 months cohort under stopped, died and lost to follow up respectively.</p> <p><u>Col (bh)</u>- For stopped, died or lost to follow up, include these entries to the 6 months cohort under stopped, died and lost to follow up respectively.</p>
	Percent of cohort alive and on ART [(H+I+JL) / N * 100]	This is a simple calculation using the data you have just collected in the rows above (Sum (H, I, J) divided by N) X 100
	CD4 values	<p>Data for this indicator may not be available in most of facilities as not all of them initiate patients based on CD4. To obtain the count or the percentage:</p> <p>COUNT: Run through column (j), count all non-blank cells for adults (by checking column (f) for age). From the entries, just counted, count those entries with values below 100. Fraction of CD4 counts < 100 will therefore be: # of counts for adults with entries below 100 <i>divided by</i> all available CD4 values for adults in this cohort.</p> <p>PERCENTAGE: Run through column (j), count all non-blank cells for children (by checking column (f) for age). From the entries, just counted, count those entries with values below 15. Fraction of CD4 percentages < 15 will therefore be: # of percentages for children with entries below 15 <i>divided by</i> all available CD4 values for children in this cohort.</p> <p>Note: It is important to show both denominator and numerator in order for district coordinators to be able to aggregate these data later on.</p>

VOLUNTARY MALE MEDICAL CIRCUMCISION

MINOR THEATRE REGISTER

Note: Locate sample on *annex 2 page 23-24* in this document

NOTE: [PRESENTED AS CIRCULATED WITH THE TOOLS IN 2010]

COLUMN LABEL	VARIABLE NAME	INSTRUCTIONS
A	Date	Enter the date when the client presents to theatre for surgery in the format dd/yy/mm
B	Theatre Register Number	Enter the number given to the client at the theatre, according to facility procedures
C	Client Number	Enter the client number as per facility procedures e.g. MC client number for client presenting for MC.
D	Referred by	<p>Enter the clinic from which the client was referred to the theatre. The options, as provided in the Client Form, are given below</p> <p>Self: Where client is an adult who reports for VMMC</p> <p>Parent / Guardian: Where client is a minor reporting for VMMC in the presence of a parent or guardian. Be sure to complete the appropriate consent / assent form for minors.</p> <p>HTC: For clients referred from VCT or other clinic where HIV testing and counseling is provided</p> <p>MCH: For those under 5 years old who are referred from the Maternal and Child Health clinic</p> <p>OPD: For those who are referred for MC from the Out Patient Department</p> <p>CHW: For clients who are referred by Community Health Workers for MC</p> <p>Other: For all others who present themselves for MC from other areas not stated above, be sure to write where client was referred from in the space provided.</p>
E	Client's Full Name	Enter the full name of the client
F	Age	Enter the client's age in years
G	Sex	Enter the sex of the client - M=Male, F= Female
H	HIV Status	Enter the client's HIV status as either U=Unknown, P=Positive or N=Negative (see note at bottom of page)
I	Diagnosis	Enter the clinician's diagnosis of the client. NOTE: Write N/A for clients presenting for MC for HIV prevention
J	Procedure	Enter the surgical procedure that the client underwent e.g. MC for Male Circumcision
K	Start Time	Record the time when the surgical procedure started in the 24 hour format

COLUMN LABEL	VARIABLE NAME	INSTRUCTIONS
L	End Time	Record the time when the surgical procedure ended in the 24 hour format
M	Procedure outcome	Indicate the outcome of the procedure
N	AE During Surgery? (Y/N)	Enter whether there was an Adverse Event DURING the surgery. N=Mild (Skip Column O); Y=Moderate or Severe (Complete Column O)
O	Severity of AE (M/S)	Enter the level of severity of the Adverse Event DURING surgery. M=moderate; S = Severe. Refer to the DURING CIRCUMCISION ADVERSE EVENT FORM FOR DEFINITIONS AND MANAGEMENT
P	Surgeon	Enter the full name of the clinician who conducted the surgical procedure
Q	Assistant	Enter the full name of the health care provider who assisted in conducting the surgical procedure
R	AE Post Surgery? (Y/N)	Enter whether there was an Adverse Event AFTER the surgery. N=Mild (Skip Column S); Y=Moderate or Severe (Complete Column S)
S	Severity of AE (M/S)	Enter the level of severity of the Adverse Event POST surgery. M=Moderate; S = Severe. Refer to the POST CIRCUMCISION ADVERSE EVENT FORM FOR DEFINITIONS AND MANAGEMENT
T	Amount Paid	Record the fee paid for the surgical procedure, if any. If no fee was charged, write FREE
U	Receipt Number	Record the receipt number corresponding to the fee paid for the operation procedure. If no fee was charged and there is no receipt, write N/A (not applicable).

POST-EXPOSURE PROPHYLAXIS

PEP REGISTER

Note: Locate sample on *annex 2 page 25-26* in this document

INTRODUCTION

This register covers information needs for the management of health workers who may be exposed to Human Immuno-Virus or Hepatitis B Virus during the course of their work, other workers, such as the police, people who may be sexually assaulted and exposed to HIV or any other person who may be exposed to HIV.

PURPOSE: This register is an extension of the existing register which was designed for health workers only.

This edition covers all other persons who come to the facility to post-exposure interventions at the facility.

WHEN COMPLETED: Depending on how the facility is organised, the first seven (7) columns can be completed upon the client getting into contact with the facility and the remaining columns can be updated as the service is offered or the intervention is provided.

WHO COMPLETES: Each facility can decide who completes the register, bearing in mind aspects such as the training of the staff member and confidentiality.

DESCRIPTION OF COLUMNS

COLUMN ID	COLUMN LABEL	COMPLETING INSTRUCTIONS
(a)	Serial Number	This is a counter of all the clients in the facility. The number is reset at the beginning of each year. For example, the first client in 2010 will take up number 0001, the next one 0002. If the register fills, the next available number is transferred to the newly opened register. However, at the end of the year, the numbering is closed and restarted in the new year.
(b)	Date	This is the date that the client reports the incident to your facility. Use the format dd/mm/yy.
(c)	Client ID	Record the ID number of the client by asking for the actual document.
(d)	Cellphone Number	Ask and write the mobile phone number for the client
(e)	Age in Years	For adults enter the age in completed years at last birthday while for infants use the notation x/52.
(f)	Sex	Enter M for Male and F for Female
(g)	Client Type	Enter the following codes for the type of client: <u>1 – Occupational</u> : If the client was exposed to the virus in the cause of his or her work. <u>2 – Sexual Assault</u> : If a client was exposed to the virus through sex. Exposure to the virus as a result broken condom for example but in consensual sex arrangement should be recorded under “3” but written the cell as “broken condom”. <u>3 – Other</u> : Do not write “other” in the register; rather fill in the actual type of exposure which will later be summarised as “other” at the bottom of the register.
(h)	Cadre	This applies to occupational exposure only. The following coding structure applies: 1=Doctor

COLUMN ID	COLUMN LABEL	COMPLETING INSTRUCTIONS
		<p>2=Clinical 3=Nurse 4=Student 5=Lab technologist 6=Cleaner 7=Waste handler 8=VCT counsellor 9=Other health worker (enter “9” and specify) 10=Non health worker (enter “10” and specify)</p>
(i)	Timing of Exposure	<p>Record the reported time and date when the exposure took place. This is very important information as it provides part of basis for evaluating whether the prophylaxis should be given or not. Note: Enter date in the format dd/mm/yy and time with an appropriate suffix (am or pm)</p>
(j)	Location of Exposure	<p>This information applies more to those exposed through occupational means. Use the codes below: 1=Medical ward 2=Surgical ward 3=Theatre 4=Maternity 5=Dental clinic 6=OP/MCH 7=Laundry 8=VCT 9 = Enter “9” and specify the location</p>
(k)	Nature of Exposure	<p>Record the nature of the exposure based using the following codes: 1=Needle stick 2=Cuts 3=Mucosal 4=Non-intact skin 5=Bite 6=Unprotected sex</p>
(l)	Severity of Exposure	<p>Based on the assessment, classify the exposure as: 1=Superficial 2=Deep</p>
(m)	Specimen Status	<p>Using the following codes, specify the HIV/HBV of the source patient or specimen: Use the top row, record the HIV status: 1=HIV negative 2=HIV positive 3=HIV status unknown In the bottom row, record the Hepatitis B status: 1=HBVsAG negative 2=HBVsAG positive 3=Vaccinated 4=unknown</p>
(n)	Risk of HIV	<p>Risk of HIV is classified as either HIGH or MEDIUM. High= if the source is confirmed HIV positive Medium= if the source status is unknown with exposure to synovial, pleural, peritoneal, and amniotic fluids on mucous membrane or non-intact skin.</p>
(o)	PEP History	<p>If the client has received PEP before, record the duration of PEP (in the upper row) and use the codes below to state which drug(s) the</p>

COLUMN ID	COLUMN LABEL	COMPLETING INSTRUCTIONS
		<p>client was put on for prophylaxis:</p> <p>PEP for Adults</p> <p>PA1A =AZT + 3TC (Adult PEP Option 1) PA1B =AZT + 3TC + LPV/r (Adult PEP Option 2) PA2A =d4T + 3TC (Adult PEP Option 3) PA2B =d4T + 3TC + LPV/r (Adult PEP Option 4)</p> <p>PEP for Children</p> <p>PC1A=AZT + 3TC (Paed PEP Option 1) PC1B=AZT + 3TC + LPV/r (Paed PEP Option 2) PC2A=d4T + 3TC (Paed PEP Option 3) PC2B=d4T + 3TC + LPV/r (Paed PEP Option 4)</p>
(p)	Baseline Status	<p>Record the HIV/HBV status of the patient before at pre prophylaxis assessment. Enter the following codes:</p> <p>Use the top row, record the HIV status:</p> <p>1=HIV negative 2=HIV positive 3=Deferred</p> <p>In the bottom row, record the Hepatitis B status:</p> <p>1=HBVsAG negative 2=HBVsAG positive 3=Vaccinated 4=unknown</p>
(q)	Timing of Current PEP	If PEP has been initiated, record the time and date prophylaxis has been commenced. Date format should be dd/mm/yy and time in 12 hour format with an appropriate qualifier (am/pm)
(r)	Current PEP Regimen	<p>If a patient has been commenced on prophylaxis, enter the drug combinations as:</p> <p>PEP for Adults</p> <p>PA1A = AZT + 3TC (Adult PEP Option 1) PA1B = AZT + 3TC + LPV/r (Adult PEP Option 2) PA2A = d4T + 3TC (Adult PEP Option 3) PA2B = d4T + 3TC + LPV/r (Adult PEP Option 4)</p> <p>PEP for Children</p> <p>PC1A=AZT + 3TC (Paed PEP Option 1) PC1B=AZT + 3TC + LPV/r (Paed PEP Option 2) PC2A=d4T + 3TC (Paed PEP Option 3) PC2B=d4T + 3TC + LPV/r (Paed PEP Option 4)</p>
(s)	Date PEP completed	After the patient has completed the prophylaxis, fill in the last date the patient took the last dose of the prophylaxis.
(t)	Reasons for not completing PEP	If PEP has not been offered, enter reason by selecting codes below:
(u) & (v)	HIV Status at 3 weeks, 3 months and 6 months	Record the follow-up HIV status at 3 weeks, 3 months and 6 months post-prophylaxis. 1=Negative 2=Positive 3=Deferred.
(w)	Remarks	Enter any special observation include indicating if client has been referred elsewhere for management.

FACILITY AGGREGATION FORM

Unlike other programmes, reporting on HIV/AIDS services through a routines system has been changing rapidly with changes in interventions and approaches. Just as it has strived to explain the contents each data collection tools, in this section, the manual attempts to explain in detail the summaries that finally get aggregated onto the facility form.

This section endeavours to explain in detail each data element, mainly focussing on collection and collation issues. There is no attempt made in this section to explain the use of these elements as most of them only become useful when used in conjunction with other data elements when computing indicators. This aspect has been left to another document – the indicators manual.

There are two classes of data for HIV/AIDS; cross-sectional and group interval data. Whereas cross-sectional data look at a snapshot of an event occurring to a group of people regardless of their attributes, group interval data are collected by first grouping people according to a given attribute, then data on specific events to this group are collected. Most of the data collected are cross-section except for HIV-Exposed Infants and some aspects of ART.

Note: The instructions that follow are narrative; for notational instructions, please turn to the appropriate programmes in Annex 1 of the Procedure Manual.

HIV TESTING AND COUNSELLING

All the data elements discussed under this section refer to all forms of counselling and testing other than that which takes place under PMTCT, in ante-partum or intra-partum settings. The PMTCT counselling and testing is discussed separately.

DATA ELEMENT (DE)	DE CODE	DE DESCRIPTION
1.1 TESTING		
First	HV01-01	<p>These are clients, who at the time of testing report that they have not had an HIV test before.</p> <p>Note: If clients came as couple, for this data element, they should be separated and counted appropriately, that is either both testing for the first time or only one of them doing so.</p>
Repeat	HV01-02	<p>All clients who had a HIV test before the current one is included here, regardless of the outcome of the test.</p> <p>Note: If clients came as couple, count them individually according to the timing of the test. Either both would be testing as repeats or only one of them doing so.</p>
Total Tested (HV01-01 plus HV01-02)	HV01-03	<p>This data element provides a total of all clients who took a HIV test during a given reporting period.</p> <p>Note: As long as clients are not mistakenly re-entered on a different line in the register, within the same month, this total should be a de-duplicated count of all clients who were tested.</p>
Couples	HV01-05	<p>This refers to those individuals who present together for a test and both of them take a test. In this case, “both” refers to:</p> <ul style="list-style-type: none">- A couple where both or all (in case of

DATA ELEMENT (DE)	DE CODE	DE DESCRIPTION
		<p>polygamous arrangements) take a test.</p> <ul style="list-style-type: none"> - A couple where one of them has known positive results and the other(s) is taking a test during this instance; in which case the couple qualifies for “testing as a couple”. <p>Note 1: If they just came as couple, counselled together and only one of them takes a test, while the other part has unknown status, they only qualify for “couple counselling” and not “couple testing”.</p>
Static [Health Facility]	HV01-06	Includes all the counselling and testing, regardless of the approach, which takes place in a fixed facility setting. Among others, “Static” includes the testing done in the VCT centre, TB clinic, OPD, IPD.
Outreach	HV01-07	Outreach includes all the counselling testing whereby the service provider leaves the station of work to go and provide HTC services to individuals at their homes or to groups of people in designated places.
1.2 POSITIVE TEST RESULTS		
Concordant Couples	HV01-08	This data element is a subset of HV01-05. These are persons who took a test as couples and both or all results are positive
Discordant Couples	HV01-09	<p>Like HV01-08, this data element is a subset of HV01-05. It is a count of clients who tested as couple and their results did not match.</p> <p>Note: In polygamous arrangements, discordance refers to unmatched test results between two or more partners in the relation.</p>
1.3 RECEIVING RESULTS		
Males - Below 15 years	HV01-10	Receiving results means that the client was made aware of the results of the test.
Females - Below 15 years	HV01-11	
Males - 15 to 24 years	HV01-12	
Female - 15 to 24 years	HV01-13	
Males - 25 years & older	HV01-14	
Female -25 years & older	HV01-15	
Total received results (Sum HV01-10 to HV15)	HV01-16	<p>Note 1: In the event that a test done and results are received in the following month, the client will not be counted as having received results unless they pick the results before the report is compiled</p> <p>Note 2: Additionally, results given in [this month] but belong to tests done [last month] cannot be included in [this month]’s report.</p>

PREVENTION OF MOTHER-TO-CHILD TRANSMISSION

DATA ELEMENT (DE)	DE CODE	DE DESCRIPTION
2.1 TESTING FOR HIV		
Antenatal	HV02-01	This is a count of women who take a first test at any time during ANC but before labour and delivery. It excludes repeat test during pregnant for those women who could have tested negative earlier in the pregnancy.
Labour and Delivery	HV02-02	This counts all women, who were not tested during pregnancy but undertake a test as result being pregnant, whilst in labour and delivery. It excludes all those who took a test earlier in the pregnancy, and for

DATA ELEMENT (DE)	DE CODE	DE DESCRIPTION
		reason, a repeat test is done in L&D.
Postnatal (within 72hrs)	HV02-03	This counts all women who get tested within 72 hours of delivery. Included are women, who after delivering at home or within the facility, choose to confirm her HIV status with the view of affording the baby prophylaxis before the 72 hour window elapses. It is also possible in the event that
Total Women Tested (PMTCT) (Sum HV02-01 to HV02-03)	HV02-04	This is a unique count of all women who were tested for the first time (from ANC to PNC) at any of the three stages.
2.2 HIV POSITIVE RESULTS		
Known positive status (at entry into ANC)	HV02-05	“Known positive status” refers to all those women, who at the time of making the first visit to the ANC have documented evidence of their positive status. As such these women are not required to take another test, either in ANC, L&D or PNC.
Antenatal	HV02-06	Counts all women who knew their HIV positive status at any time during the pregnancy. Note: It does not matter at what stage of the pregnancy or visit count or order, when the test was done. What matters is that the woman knew HIV positive status during antenatal.
Labour and Delivery	HV02-07	This is a count all those women who knew their HIV positive results during labour and delivery. The count includes women who could have taken the test during antenatal but only knew their HIV positive status during L&D.
Postnatal (within 72hrs)	HV02-08	This data element counts all the women whose HIV positive status is confirmed within 72 hours post-delivery. Note: The test does not necessarily need to have take place in a postnatal setting for the result to be counted.
Total Positive (PMTCT) (Sum HV02-05 to HV02-08)	HV02-09	This an aggregate count of women who knew of their HIV status before pregnancy or at any other time but before 72 hours after delivery
Total with known status (HV02-04 plus HV02-05)	HV02-10	This aggregate is a summary of all women who entered into the ANC already knowing that they were HIV positive and all those who knew that they were either positive or negative, any time during antenatal, labour and delivery or in postnatal (< 72 hours post-delivery).
2.3 PARTNER INVOLVEMENT		
Male partners tested - ANC	HV02-11	PMTCT interventions are likely to be more effective if both partners are involvement and provide support to each other. This data element attempts to measure the ultimate involvement (testing) of partners. It is a count of all male clients, who test in ANC in the company of their spouses. The count includes all males regardless of the woman's test results.
Discordant Couples	HV02-12	This is a count of couples (Man and Woman) whose HIV test results are different (one positive, the other negative). Note: In a polygamous relationship, one male client may be counted more than once. For example, if a man is married to two wives and both of them are negative while he is positive, this will generate two counts for discordant couples.
2.4 PROPHYLAXIS		

DATA ELEMENT (DE)	DE CODE	DE DESCRIPTION
Prophylaxis – NVP Only	HV02-13	This counts all women who were dispensed only single dose of NVP. If counted from ANC, this is a count of NVP upon testing positive and no AZT is started at 14 weeks. The majority of women counted under this data element are usually tested late in their pregnancy or in maternity
Prophylaxis – (AZT + SdNVP)	HV02-14	This data element includes the following categories of women. Those: <ol style="list-style-type: none"> 1. Dispensed sdNVP during ANC (to take at onset of labour) then started on AZT at 14 weeks gestation or thereafter. 2. Takes SdNVP (dispensed earlier in the pregnancy or L&D) in labour and takes AZT intrapartum 3. Combination of categories 1 & 2 above.
Prophylaxis – Interrupted HAART	HV02-15	This count of women who are started on full combination of HAART for the prevention of mother to child and not for their own health. The treatment is later discontinued when exposure of the baby to HIV is eliminated.
HAART (ART)	HV02-16	This should not be confused with HV02-15 above. This refers to women on therapy because they needed HAART for their own health. It includes those started in before this pregnancy and those assessed, found eligible and commenced on treatment.
Total PMTCT prophylaxis (Sum HV02-13 to HV02-16)	HV02-17	NOTE – I still feel HV02-13 to -16 are circular and should not be totalled.
2.5 ASSESSMENT FOR ART IN MCH		
Assessed for eligibility at 1st ANC - WHO Staging done	HV02-18	This is a count of all HIV positive women who were assessed for ART eligibility using WHO staging only. Note: To avoid multiple counting, only assessments done on the first ANC visit will be counted.
Assessed for eligibility at 1st ANC - CD4	HV02-19	This counts all women assessed through CD4. Women assessed through both WHO and CD4 are only counted under CD4.
Assessed for Eligibility in ANC (Sum HV02-18 to HV02-19)	HV02-20	This is a unique count of women who were assessed for ART eligibility either through WHO staging only or CD4/WHO
Started on ART during ANC	HV02-21	This is a count of all women started on therapy within the ANC setting. EXCLUDE all women who started on therapy from CCC even if this was done during pregnancy. Transfer and add this number to either HV03-22 or -24 depending on the age.

HIV EXPOSED INFANT FOLLOW-UP

The data elements in sections 2.7 to 2.9 are group interval. They are a retrospective report on events that would have occurred in a group of HIV-exposed infants at the time maturing to 12 months. Therefore, the data labels present below represent those children who would have matured to 12 months of age during the reporting month. For example, a report for April 2011 would be a report on children who were born April 2010.

DATA ELEMENT (DE)	DE CODE	DE DESCRIPTION
2.7 INFANT TESTING (INITIAL TESTS ONLY)		

DATA ELEMENT (DE)	DE CODE	DE DESCRIPTION
PCR (within 2 months)	HV02-24	This data element, counts all those HIV-exposed children (after turning 12 months) who were tested for HIV (using PCR) before they turned three (3) months.
PCR (from 3 to 8 months)	HV02-25	This data element, counts all those HIV-exposed children (after turning 12 months) who were not tested for HIV (using PCR) before they turned three (3) months but were tested (using PCR) before they turned nine (9) months.
Serology antibody test (from 9 to 12 months)	HV02-26	This data element, counts all those HIV-exposed children (after turning 12 months) who were not tested for HIV (using PCR) before they turned nine (9) months but were tested (AB test) before they turned 12 months.
PCR (from 9 to 12 months)	HV02-27	This data element, counts all those HIV-exposed children (after turning 12 months) who were <ul style="list-style-type: none"> • Not tested for HIV (using PCR) before they turned nine (9) months but • were tested (AB test) before they turned 12 months and • their test results were positive then • PCR test was done to confirm the test results
Total HEI Tested by 12 months (Sum HV02-24 to HV02-26)	HV02-28	This is a total sum of HIV-exposed children who after turning 12 months took a HIV test any time before they turned 12 months.
2.8 CONFIRMED INFANT TEST RESULTS		
Positive – (by 2 months) – PCR	HV02-29	This data element is a subset of HV02-24. It is a count of all HEI who were confirmed HIV positive within the first 2 months of birth
Positive – (3 – 8 months) – PCR	HV02-30	This data element is a subset of HV02-25. It is a count of all HEI who were confirmed HIV positive at any time from 3 to 8 months out of those tested between 3 and 8 months
Positive – (9 – 12months) – PCR	HV02-31	This data element is a subset of HV02-25. It is a count of all HEI who were confirmed HIV positive at any time from 3 to 8 months out of those tested between 3 and 8 months
Total Confirmed Positive (Sum HV02-29 to HV02-31)	HV02-32	This data element is a subset of (the sum of HV02-24, -25 & -27). It is a count of all HEI who were confirmed HIV positive by the time they turned 12 months.
2.9 INFANT FEEDING		
EBF (at 6 months)	HV02-33	This is a count of HEI who at 6 months were still exclusively breastfeeding. Note: Only includes those infants with uninterrupted EBF from birth to 6 months.
ERF (at 6 months)	HV02-34	This is a count of HEI who at 6 months were still exclusively replacement fed. Note: Only includes those infants with uninterrupted ERF from birth to 6 months.
MF (at 6 months)	HV02-35	This is a count of HEI who by 6 months had been introduced to other foods (outside the definition of EBF or ERF)
Total Exposed 6 months	HV02-36	Total number of HEI in the cohort at 6 months.
BF (12 months)	HV02-37	This is the number of infants who at 12 months were still breastfed
Not BF (12 months)	HV02-38	This is the number of infants who at 12 months had been weaned
Not Known	HV02-39	This is the number of infants who at 12 months had

DATA ELEMENT (DE)	DE CODE	DE DESCRIPTION
		missing information (for any reason) on breastfeeding status.
Total Exposed 12 months (Sum HV02-37 to HV02-39)	HV02-40	Total number of HEI in the cohort at 12 months.

CARE AND TREATMENT

DATA ELEMENT (DE)	DE CODE	DE DESCRIPTION	
3.1 COTRIMOXAZOLE PROPHYLAXIS			
HIV Exposed Infant (within 2 months)	HV03-01	This data element is a count (from the HEI register) of all infants who by the time they turned 2 months, were already started on cotrimoxazole as a prophylaxis.	
HIV Exposed Infant (Eligible for CTX at 2 months)	HV03-02	Count of all eligible HEI infants in the cohort (at 12 months). Note: This data element may be equal to HV02-40 if the eligibility criteria are all-inclusive.	
Male -Below 15 years	HV03-03	These are patients already confirmed HIV positive, enrolled in care regardless of whether they are on ART or not, and are receiving CTX for prophylaxis. This includes all those patients started this month and those from earlier months who are picked drugs this month. Note: This is just a proxy. In the absence standard prescription practice, it is possible to apply the concept in section 3.3.	
Female - Below 15 years	HV03-04		
Male - 15 years & older	HV03-05		
Female- 15 years & older	HV03-06		
Total on CTX (Sum HV03-03 to HV03-06)	HV03-07	Enrollment in care constitutes, but not limited to the following events: <ul style="list-style-type: none">• Presenting to the CCC clinic with confirmed HIV+ results• Being allocated the CCC number and having been seen by a member of the clinical team• Opening CCC card or similar documents.	
3.2 ENROLLING IN CARE			
Below 1 year	HV03-08	In some facilities, patients are made to pass through a records office/desk on the initial visit, where an appointment to see a clinician. If the patient does not see the clinician on this very visit, this visit does not constitute enrollment in care even if the CCC number has been allocated. SEE INSTRUCTION ON WHEN TO COMPLETE THE C&T ACTIVITY SHEET.	
Male -Below 15 years	HV03-09		
Female- Below 15 years	HV03-10		
Male 15 years & older	HV03-11		
Female -15 years & older	HV03-12		
Total Enrolled in Care (Sum HV03-09 to HV03-12)	HV03-13	These are unique counts of individuals who were enrolled in care this month in addition to those who made visits as revisits in care this month and the previous three (3) months. Note: Only first visit during the month are considered. SEE INSTRUCTION ON HOW TO COLLATE THESE DATA ON THE C&T ACTIVITY/TALLY SHEETS.	
3.3 CURRENT IN CARE			
Below 1 year	HV03-14		
Male -Below 15 years	HV03-15		
Female- Below 15 years	HV03-16	This is a count of data of individuals started on HAART for treatment disaggregated by the age at starting therapy and gender.	
Male 15 years & older	HV03-17		
Female -15 years & older	HV03-18		
Revisit in Care (Sum HV03-15 to HV03-18)	HV03-19		
3.4 STARTING ART			
Below 1 year	HV03-20		
Male -Below 15 years	HV03-21		
Female- Below 15 years	HV03-22		

DATA ELEMENT (DE)	DE CODE	DE DESCRIPTION
Male 15 years & older	HV03-23	
Female -15 years & older	HV03-24	
Total Starting ART (Sum HV03-21 to HV03-24)	HV03-25	Note: Patients started on HAART in the MCH setting should be included either in -22 or -24.
Pregnant	HV03-26	This is the total number of women started on ART in MCH (HV02-21) and those started in the CCC whilst pregnant. Note: Do not count women who fell pregnant while on therapy
TB Patient	HV03-27	This is the number of patients who had an active TB when they were started on ART.
3.3 CONTINUATION ON THERAPY		
3.3.1 REVISITS (FROM THE TALLY SHEET- THIS MONTH ONLY AND FROM LAST 2 MONTHS)		
Below 1 year	HV03-28	Patients continuing therapy are those patients: 1. Who started therapy before this month and 2. Visited the facility this month to pick drugs Or 1. Started therapy before this months 2. Collected drugs (in the last three months) enough to cover the reporting month
Male -Below 15 years	HV03-29	
Female- Below 15 years	HV03-30	
Male 15 years & older	HV03-31	
Female -15 years & older	HV03-32	
Total Revisit on ART (Sum HV03-29 to HV03-32)	HV03-33	
3.3.1 ON THERAPY		
Current on ART – (<1) (HIV03-20 plus HV03-28)	HV03-34	This is a summary count of patients who: 1. Started therapy this month or 2. Started therapy before this month but made a visit to collect drugs this month or 3. Started therapy before this month but did not make a visit to the facility during this month because had picked enough drugs (during earlier visits before this month) to cover the reporting month
Current on ART – Male (<15) (HIV03-21 plus HV03-29)	HV03-35	
Current on ART – Female (<15) (HIV03-22 plus HV03-30)	HV03-36	
Current on ART – Male (15+) (HIV03-23 plus HV03-31)	HV03-37	
Current on ART – Female (15+) (HIV03-24 plus HV03-32)	HV03-38	
Total Current on ART (Sum HV03-35 to HV03-38)	HV03-39	
3.4 CUMULATIVE EVER ON ART		
Male -Below 15 years	HV03-40	This is a “roll-on” count of people started on ART before this month plus those started during the reporting month. This procedure repeated every month to build cumulative figures
Female- Below 15 years	HV03-41	
Male- 15 years & older	HV03-42	
Female -15 years & older	HV03-43	
Total Ever on ART (Sum HV03-40 to HV03-43)	HV03-44	Note: Individual facilities should rehearse with the district office so that a thorough review of records is conducted to count and report once on these elements then thereafter just add data element HV03-20 to -24.
3.5 SURVIVAL AND RETENTION ON ART AT 12 MONTHS		
ART Net Cohort at 12 months	HV03-45	This information is obtained from the cohort summary form. Only that cohort that would have matured to 12 month in the reporting month should be reported on every month
On Original 1st Line at 12 months	HV03-46	
On alternative 1st Line at 12 months	HV03-47	
On 2nd Line (or higher) at 12 months	HV03-48	
On therapy at 12 months (Sum HV03-46 to HV03-48)	HV03-49	
3.6 SCREENING		

DATA ELEMENT (DE)	DE CODE	DE DESCRIPTION
TB - Male -Below 15 years	HV03-50	Please refer to the instruction on completing the C&T activity sheet
TB – Female- Below 15 years	HV03-51	
TB – Male- 15 years & older	HV03-52	
TB – Female- 15 years & older	HV03-53	
Total Screened for TB (Sum HV03-50 to HV03-53)	HV03-54	Please refer to the instruction on completing the C&T activity sheet
Screened for cervical cancer (females 18+)	HV03-55	
3.8 HIV CARE VISITS		
HIV Care visit – females (18+)	HV03-70	Please refer to the instruction on completing the C&T activity sheet
HIV-Care visit – scheduled	HV03-71	
HIV-Care visit – unscheduled	HV03-72	
HIV Care visits (Add HV03-71 and HV03-72)	HV03-73	

MEDICAL MALE CIRCUMCISION

DATA ELEMENT (DE)	DE CODE	DE DESCRIPTION
4.1 NUMBER CIRCUMCISED		
Below 15 years	HV04-01	
15-24 years	HV04-02	
25 years and older	HV04-03	
Total Circumcised (Sum HV04-01 to HV04-02)	HV04-06	<p>These are the males circumcised as part of the minimum package for HIV prevention program, disaggregated according to the three age groups. This information should be gathered from the page summaries of the Theatre Register.</p> <p>Note: Males who are circumcised for other reasons (as indicated in the diagnosis column of the Theatre Register) should not be counted under this indicator</p>
4.2 HIV STATUS (AT CIRCUMCISION)		
Positive	HV04-07	<p>This is the HIV status of VMMC clients, either tested at the facility before or as reported by the client. This information can be gathered from the page summaries in the Theatre Register or from the individual MC client form</p> <p>NOTE: Any client who self-reports as HIV negative should be recorded as Unknown</p>
Negative	HV04-08	
Unknown	HV04-09	
4.3 ADVERSE EVENTS (CIRCUMCISION)		
During -AE(s)- moderate	HV04-10	<p>Number of males circumcised who experienced at least one moderate or severe adverse event DURING surgery. This information can be gathered from the page summaries in the Theatre Register (or the completed during circumcision adverse event form).</p> <p>NOTE: As indicated in the adverse event form, only the adverse event with maximum severity is reported for each client who experiences any adverse event during circumcision.</p>
During- AE(s) – severe	HV04-11	
Total AE During (Sum HV04-10 & -11)	HV04-14	
Post -AE(s)- moderate	HV04-12	<p>Number of males circumcised who experienced at least one moderate or severe adverse event POST surgery. This information can be gathered from the page summaries in the Theatre Register (or the completed post circumcision adverse event form).</p> <p>NOTE: As indicated in the adverse event form, only the adverse event with maximum severity is reported for each client who experiences any adverse event post circumcision</p>
Post- AE(s) – severe	HV04-13	
Total AE Post (Sum HV04-12 & -13)	HV04-15	

POST-EXPOSURE PROPHYLAXIS for HIV

DATA ELEMENT (DE)	DE CODE	DE DESCRIPTION
5.1 TYPE OF EXPOSURE		
Occupational – male	HV05-01	This is a count of all clients who were exposed to HIV in the course of their work
Occupational – female	HV05-02	
Sexual assault – male	HV05-03	Count of all clients who were exposed to the virus through sex. Note: See instructions under PEP register
Sexual assault – female	HV05-04	
Other reasons - male	HV05-05	Count of all other exposures than occupational or sexual assault.
Other reasons - female	HV05-06	
Total Exposed (Sum HV05-01 to HV05-06)	HV05-07	Sum of all clients who sought PEP services disregarding gender, and type of exposure.
5.2 PROVIDED WITH PROPHYLAXIS		
Occupational – male	HV05-08	These are subsets of HV05-01 and -02. Count all clients who sought PEP services as a result of
Occupational – female	HV05-09	

DATA ELEMENT (DE)	DE CODE	DE DESCRIPTION
		occupational exposure to HIV and received the service.
Sexual assault – male	HV05-10	
Sexual assault – female	HV05-11	These are subsets of HV05-03 and -04. Count all clients who sought PEP services as a result of exposure to HIV through sexual assault and received the service.
Other reasons – male	HV05-12	
Other reasons – female	HV05-13	These are subsets of HV05-03 and -04. Count all clients who sought PEP services as a result of exposure to HIV through any other means other than sexual assault or occupational exposure and received the service
Total PEP (Sum HV05-08 to HV05-13)	HV05-14	Sum of all clients who sought PEP services disregarding gender, and type of exposure.

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ANNEXES

ANNEX 1: THE INDICATOR-DATASET MAPPING MATRIX

PREVENTION: HTC

HIV01-01: NUMBER OF INDIVIDUALS WHO RECEIVED TESTING COUNSELLING SERVICES FOR HIV AND RECEIVED THEIR TEST RESULTS.

Referees:	KNASP	WHO	PEPFAR	GFTAM		
Codes:	2.2.4	UA-A2	P11.1.D	HIV-P8B		
Required Data Elements (disaggregation)	Code	Data Source			Reported on	
		Register/ Sheet	Columns		Facility Form	MoH 711B
First	HV01-01	HIV Testing	<i>Count "date" in (b) w/ "N" in (g)</i>		✓	
Repeat	HV01-02	HIV Testing	<i>Count "date" in (b) w/ "Y" in (g)</i>		✓	
Total Tested	HV01-03		<i>Calculated = (HV01-01 plus HV01-02)</i>		✓	✓
Individual	HV01-04	HIV Testing	<i>Count "date" in (b) w/ "I" in (n)</i>		✓	
Couples	HV01-05	HIV Testing	<i>Count "date" in (b) w/ "C" in (n)</i>		✓	
Static	HV01-06	HIV Testing	<i>Count "date" in (b) w/ "HP", "NP", "VS" and VI in (f)</i>		✓	
Outreach	HV01-07	HIV Testing	<i>Count "date" in (b) w/ "HB", "MO" in (f)</i>		✓	
Positive	HV01-08	HIV Testing	<i>Count "date" in (b) w/ "P" in (r)</i>		✓	✓
Discordant Couples	HV01-09	HIV Testing	<i>Count "date" in (b) w/ "Y" in (t)</i>		✓	
Male (<15)	HV01-10	HIV Testing	<i>Count "date" in (b) w/ "M" in (e) & (d) <15 & "Y" in (s)</i>		✓	
Female (<15)	HV01-11	HIV Testing	<i>Count "date" in (b) w/ "F" in (e) & (d) <15 "Y" in (s)</i>		✓	
Male (15-24)	HV01-12	HIV Testing	<i>Count "date" in (b) w/ "M" in (e) & (d) =15-24 "Y" in (s)</i>		✓	
Female (15-24)	HV01-13	HIV Testing	<i>Count "date" in (b) w/ "F" in (e) & (d) =15-24 "Y" in (s)</i>		✓	
Male (25+)	HV01-14	HIV Testing	<i>Count "date" in (b) w/ "M" in (e) & (d) =25+ "Y" in (s)</i>		✓	
Female (25+)	HV01-15	HIV Testing	<i>Count "date" in (b) w/ "F" in (e) & (d) =25+ "Y" in (s)</i>		✓	
Total received results	HV01-16		<i>Calculated = (Sum HV01-10..HV15)</i>		✓	✓

PMTCT AND INFANT NUTRITION

HIV02-01: Number of pregnant women with known HIV status

Referees:	PEPFAR	UA
Codes:	P1.1.D	I#-5

Required Data Elements (disaggregation)	Code	Data Source		Reported on	
		Register/Sheet	Columns	Facility Form	MoH 711B
ANC – Tested	HV02-01	ANC	Count 'P'&'N' in (s)	✓	
L&D – Tested	HV02-02	L&D	Count 'P'&'N' in (ab)	✓	
PNC – Tested (<=72hrs)	HV02-03	PNC	Count 'P'&'N' in (v)	✓	
Total Tested	HV02-04	Calculated = (Sum HV02-01...HV02-03)		✓	✓
ANC – known positive status at entry	HV02-05	ANC	Count 'KP' in (s)	✓	✓
Positive – ANC	HV02-06	ANC	Count 'P' in (s)	✓	
Positive – L&D	HV02-07	L&D	Count 'P' in (ab)	✓	
Positive – PNC<72hrs	HV02-08	PNC	Count 'P' in (v)	✓	
Total Positive (PMTCT)	HV02-09	Calculated = Sum(HV02-05...HV02-08)		✓	✓
Total with Known Status	HV02-10	Calculated = (Sum HV02-04 plus HV02-05)		✓	✓
Total (1 st ANC visits, total deliveries, 1 st PNC visits)		Calculated from RH entries		✓	✓

HIV02-02: Percentage of pregnant women whose male partners were tested for HIV in the PMTCT setting.

Referees:
Codes:

Required Data Elements (disaggregation)	Code	Data Source		Reported on	
		Register/Shee t	Columns	Facility Form	MoH 711B
Male partners tested – ANC	HV02-11	ANC	Count 'P'&'N' in (an)	✓	✓
Discordant Couples	HV02-12	ANC	If (am)=Y & (an) =('P' or 'N') in (an) Compare with (s) or (t)	✓	✓

HIV02-03: Number of HIV positive pregnant women who received antiretroviral medicines to reduce the risk of mother-to-child transmission

Referees:	KNASP	PEPFAR
Codes:	2.3.1	P1.2.D

Required Data Elements (disaggregation)	Code	Data Source		Reported on	
		Register/ Sheet	Columns	Facility Form	MoH 711B
Prophylaxis – 1 drug (<i>NVP</i>)	HV02-13	ANC; L&D	<i>ANC=Count 'Y' in (y); LD= Count 'PM8' in (ad)</i>	✓	
Prophylaxis – 2 ARVs (<i>AZT(14wks+) +NVP</i>)	HV02-14	ANC; L&D	<i>Count 'Y' in (y) & (z); Count 'PM1' & 'PM2' in (ad)</i>	✓	
Interrupted HAART (3 ARVs)	HV02-15	ANC	<i>Count 'P' in (aa)</i>	✓	
HAART	HV02-16	ANC	<i>Count 'T' in (aa)</i>	✓	
Total Prophylaxis	HV02-17	<i>Sum(HV02-13...HV02-16)</i>		✓	✓

HIV02-04: Proportion of HIV positive women assessed for ART eligibility (by WHO staging or CD4) at 1st ANC.

Referees:	PEPFAR
Codes:	P1.4.D

Required Data Elements (disaggregation)	Code	Data Source		Reported on	
		Register/ Sheet	Columns	Facility Form	MoH 711B
Pregnant – ART eligibility – WHO	HV02-18	ANC	<i>If (v) is empty, in (u) count cells with entries (1,2,3 or 4)</i>	✓	
Pregnant – ART eligibility – CD4	HV02-19	ANC	<i>Count 'Y' in (v) and not the CD4 value</i>	✓	
Pregnant Assessed for ART Eligibility	HV02-20	<i>(HV02-18 plus HV02-19)</i>			
Pregnant – Start on ART	HV02-21	ANC	<i>"Date" count in (w) for the reporting month</i>		
Proxy: Total Positive (PMTCT)	HV02-09	<i>Comment: See HIV02-09 above</i>			

HIV02-05: Proportion of HIV infected women who received family planning services at 1st post-natal visits

Referees:	Local indicator
Codes:	

Required Data Elements (disaggregation)	Code	Data Source		Reported on	
		Register/Sheet	Columns	Facility Form	MoH 711B
PMTCT-Receive FP Method -PNC	HV02-22	PNC	<i>Unique Count of (ae)</i>	✓	✓
PMTCT- 1st PNC attendants	HV02-23	PNC	<i>Date count of (a) if (u) or (v) = "P"</i>	✓	

HIV02-06: Percentage of HIV-Exposed Infants initiated on CTX within two months of birth.

Referees:	PEPFAR
Codes:	C4.2.D

Required Data Elements (disaggregation)	Code	Data Source			Reported on	
		Register /Sheet	Columns		Facility Form	MoH 711B
CTX to baby within 2 months	HV03-01	HEI	<i>Count 'Y' in (s)</i>		✓	✓
HIV-exposed (eligible for CTX at 2 months)	HV03-02	HEI	<i>Cohort count of all children who received any service at 6 weeks</i>		✓	✓

HIV02-07: Percentage of infants born to HIV-positive women who received an HIV test within 12 months of birth.

Referees:	PEPFAR
Codes:	C4.1.D

Required Data Elements (disaggregation)	Code	Data Source		Reported on	
		Register/Sheet	Columns	Facility Form	MoH 711B
Tested by 2 months – PCR	HV02-24	HEI	<i>Age < 12 weeks in (l)</i>	✓	
Tested (3 - 8 months) - PCR	HV02-25	HEI	<i>Age 12-35 weeks in (l)</i>	✓	
Tested (9-12 months) - Serology	HV02-26	HEI	<i>Age 9-12 months in (ah)</i>	✓	
Tested (9 – 12 months) - PCR	HV02-27	HEI	<i>Age 9-12 months in (aj)</i>	✓	
Total Tested by 12 months	HV02-28	<i>Calculated = (Sum HV02-24, -25 & -26)</i>		✓	✓
Total Exposed 12 months	HV02-40	<i>Calculated = (Sum HV02-37..HV02-39)</i>		✓	✓

HIV02-08: Percentage of HIV-exposed children confirmed positive through a confirmatory test

Referees:	UNGASS	PEPFAR
Codes:	UNG-25	P1.7.N

Required Data Elements (disaggregation)	Code	Data Source		Reported on	
		Register/Sheet	Columns	Facility Form	MoH 711B
Confirmed Positive – (by 2 months) – PCR	HV02-29	HEI	<i>Age < 12 weeks in (l) & 'P' in (q)</i>	✓	
Confirmed Positive – (3 – 8 months) – PCR	HV02-30	HEI	<i>Age 12-35 weeks in (l) & 'P' in (q)</i>	✓	
Confirmed Positive – (9 – 12months) – PCR	HV02-31	HEI	<i>Age 9-12mths in (aj) & 'P' in (ao)</i>	✓	
Total Confirmed Positive	HV02-32	Calculated =(Sum HV02-29...HV02-31)		✓	✓
Denominators = HV24 thru HV28					

HIV02-09: Percentage of HIV exposed Infants by feeding type

Referees:	AOP	PEPFAR
Codes:	AOP-12	P1.6.D

Required Data Elements (disaggregation)	Code	Data Source		Reported on	
		Register /Sheet	Columns	Facility Form	MoH 711B
EBF (6 months)	HV02-33	HEI	<i>Count "EBF" in (x)</i>	✓	✓
ERF (6 months)	HV02-34	HEI	<i>Count "ERF" in (x)</i>	✓	✓
MF (6 months)	HV02-35	HEI	<i>Count "MF" in (x)</i>	✓	✓
BF (12 months)	HV02-37	HEI	<i>Count "BF" in (ab)</i>	✓	✓
Not BF (12 months)	HV02-38	HEI	<i>Count "No BF" in (ab)</i>	✓	✓
BF Not Stated (12 months)	HV02-38	HEI	<i>Count blanks in (ab)</i>		
Total Exposed 6 months (on follow up)	HV02-36	HEI	<i>Include all children with an entry from 6-12 months</i>	✓	✓
Total Exposed 12 months	HV02-40	Calculated = (Sum HV02-37...HV02-39)		✓	✓

HIV02-10: Percentage of infants born to HIV-infected women (HIV-exposed infants) receiving antiretroviral prophylaxis to reduce the risk for peripartum mother-to-child transmission

Referees:

Codes:

Required Data Elements (disaggregation)	Code	Data Source		Reported on	
		Register/Sheet	Columns	Facility Form	MoH 711B
Issued in ANC	HV02-41	ANC	Count "Y" in (ab)	✓	✓
Labour and Delivery	HV02-42	L&D	Count "Y" in (ae)	✓	✓
PNC (<72hrs)	HV02-43	PNC	Count "MF" in (z)	✓	✓
Total Infants Issued Prophylaxis	HV02-44	Calculated = (Sum HV02-41 to HV02-43)			
Annual estimate of HIV-exposed Infants		Population-based estimate			

HIV02-11: Percentage of infants born to HIV-infected women (HIV-exposed infants) who are breastfeeding provided with ARV drugs (either mother or infant) to reduce the risk of HIV transmission during the breastfeeding period

Referees:

Codes:

Required Data Elements (disaggregation)	Code	Data Source		Reported on	
		Register/Sheet	Columns	Facility Form	MoH 711B
Record reviews of infants (in the HEI Register) at 12 months started on ARVs whilst breastfed before they turned 12 months out all those that have reached 12 months of age (HV02-40)					

CARE AND TREATMENT

HIV03-01: PERCENTAGE OF PLHIV WHO KNOW THEIR STATUS AND ARE RECEIVING COTRIMOXAZOLE PROPHYLAXIS

Referees:	KNASP	PEPFAR	GFTAM
Codes:	1.3.1	C2.2.D	HIV-CS1

Required Data Elements (disaggregation)	Code	Data Source		Reported on	
		Register/Sheet	Columns (in activity sheet)	Facility Form	MoH 711B
On CTX – Male (<15)	HV03-03	C&T Activity Sheet	Monthly sum of (b)	✓	
On CTX – Male (15+)	HV03-04	C&T Activity Sheet	Monthly sum of (c)	✓	

On CTX – Female (<15)	HV03-05	C&T Activity Sheet	Monthly sum of (d)	✓	
On CTX – Female (15+)	HV03-06	C&T Activity Sheet	Monthly sum of (e)	✓	
Total on CTX	HV03-07	Calculated = (Sum HV03-03...HV03-06)		✓	✓

HIV03-02 NUMBER OF ADULTS AND CHILDREN WITH ADVANCED HIV INFECTION NEWLY ENROLLED ON ART

Referees:	AOP	PEPFAR
Codes	AOP-29	T1.1.D

Required Data Elements (disaggregation)	Code	Data Source		Reported on	
		Register/Sheet	Columns (<i>in activity sheet</i>)	Facility Form	MoH 711B
Start ART – (<1)	HV03-20	C&T Activity Sheet	Monthly sum of (q)	✓	
Start ART – Male (<15)	HV03-21	C&T Activity Sheet	Monthly sum of (r)	✓	
Start ART – Female (<15)	HV03-22	C&T Activity Sheet	Monthly sum of (s)	✓	
Start ART – Male (15+)	HV03-23	C&T Activity Sheet	Monthly sum of (t)	✓	
Start ART – Female (15+)	HV03-24	C&T Tally Sheet	Monthly sum of (u)	✓	
Total Start ART	HV03-25	Calculated = (Sum HV03-21...HV03-24)		✓	✓
Start ART – Pregnant	HV03-26	C&T Activity Sheet	Monthly sum of (v)		✓

HIV03-03: PERCENTAGE OF ADULTS AND CHILDREN WITH ADVANCED HIV INFECTION currently RECEIVING ARVs.

Referees:	KNASP	UNGASS	AOP	WHO	PEPFAR
Codes:	3.0.2	UNG-4	AOP-30	UA-G2	T1.2.D

Required Data Elements (disaggregation)	Code	Data Source		Reported on	
		Register/Sheet	Columns (from reporting forms)	Facility Form	MoH 711B
Current on ART – (<1)	HV03-34	Sum(HV03-20 plus HV03-28)		✓	
Current on – Male (<15)	HV03-35	Sum(HV03-21 plus HV03-29)		✓	
Current on – Female (<15)	HV03-36	Sum(HV03-22 plus HV03-30)		✓	
Current on – Male (15+)	HV03-37	Sum(HV03-23 plus HV03-31)		✓	
Current on – Female (15+)	HV03-38	Sum(HV03-24 plus HV03-32)		✓	
Total Current on ART	HV03-39	Calculated = (Sum HV03-35..HV03-38)		✓	✓

HIV03-04: NUMBER OF ADULTS AND CHILDREN WITH ADVANCED HIV INFECTION ever ENROLLED ON ART

Referees:	PEPFAR
Codes:	T1.4.D

Required Data Elements (disaggregation)	Code	Data Source		Reported on	
		Register/Sheet	Columns	Facility Form	MoH 711B
Ever Start ART – Male (<15)	HV03-40	Rolled monthly counts for HV03-20		✓	
Ever Start ART – Female (<15)	HV03-41	Rolled monthly counts for HV03-21		✓	
Ever Start ART – Male (15+)	HV03-42	Rolled monthly counts for HV03-22		✓	
Ever Start ART – Female (15+)	HV03-43	Rolled monthly counts for HV03-23		✓	
Total Ever on ART	HV03-44	Rolled monthly counts for HV03-24		✓	✓

HIV03-05: PERCENTAGE OF PLHIV KNOWN TO BE ALIVE AND ON ART TREATMENT 12 MONTHS AFTER INITIATION ON ANTIRETROVIRAL THERAPY

Referees:	KNASP	UNGASS	WHO	PEPFAR	GFTAM
Codes:	3.0.1	UNG-24	UA-G3a	T1.3.D	HIV-I3

Required Data Elements (disaggregation)	Code	Data Source		Reported on	
		Register/Sheet	Columns	Facility Form	MoH 711B
On Original 1st Line at 12 months	HV03-46	Cohort Summary Sheet		✓	
On alternative 1st Line at 12 months	HV03-47	Cohort Summary Sheet		✓	
On 2nd Line (or higher) at 12 months	HV03-48	Cohort Summary Sheet		✓	
On Therapy at 12 months	HV03-49	(Sum HV03-46...HV03-48)		✓	✓
ART Net Cohort at 12 months	HV03-34	Cohort Summary Sheet		✓	✓

HIV03-06: PROPORTION OF WOMEN RECEIVING CARE SCREENED FOR CERVICAL CANCER

Referees:	Local Indicator
Codes:	

Required Data Elements (disaggregation)	Code	Data Source		Reported on	
		Register/Sheet	Columns	Facility Form	MoH 711B
Screened for cervical cancer (females 15+)	HV03-55	C&T Activity Sheet	Monthly sum of (ah)	✓	✓
HIV clinical visit – Females (18+) proxy =	HV03-04	C&T Activity Sheet	Monthly sum of (ai)		

HIV03-07: PERCENTAGE OF HIV PATIENTS SCREENED FOR TB

Referees:	KNASP	WHO	PEPFAR	Other
Codes	3.3.3	UA-E3	C2.4.D	TB-HIV1

Required Data Elements (disaggregation)	Code	Data Source		Reported on	
		Register/Sheet	Columns (in activity sheet)	Facility Form	MoH 711B
TB - Male (<15)	HV03-50	C&T Activity Sheet	Monthly sum of (ad)	✓	
TB - Female (<15)	HV03-51	C&T Activity Sheet	Monthly sum of (ae)	✓	
TB - Male (15+)	HV03-52	C&T Activity Sheet	Monthly sum of (af)	✓	
TB - Female (15+)	HV03-53	C&T Activity Sheet	Monthly sum of (ag)	✓	
Total Screened for TB	HV03-54	Calculated = (Sum HV03-50..HV03-53)		✓	✓

HIV03-08: PERCENTAGE OF TB/HIV CO-INFECTED CLIENTS WHO ARE STARTED ON ARVs.

Referees:	KNASP	UNGASS	WHO
Codes:	3.3.1	UNG-6	UA-E1

Required Data Elements (disaggregation)	Code	Data Source		Reported on	
		Register/Sheet	Columns (<i>in activity sheet</i>)	Facility Form	MoH 711B
Start ART-TB Patient	HV03-27	C&T Activity Sheet	Monthly sum of (w)	✓	✓
TB Patient enrolled in Care	[unallocated]				

NUTRITION FOR PLHIV
HIV03-09: PERCENTAGE OF ELIGIBLE PLHIV (ADULTS AND CHILDREN) RECEIVING THERAPEUTIC OR SUPPLEMENTARY FOOD

Referees:	KNASP	PEPFAR
Codes:	3.4.1	C2.3.D

Required Data Elements (disaggregation)	Code	Data Source		Reported on	
		Register/Sheet	Columns	Facility Form	MoH 711B
Received Food (<15)	HV10-64	Nutr. HD		✓	
Received Food (15+)	HV10-65	Nutr. HD		✓	
Total Received Food	HV10-66	(Sum HV10-64...HV10-66)		✓	
Clinically malnourished (<15)	HV10-67	Nutr. HD		✓	
Clinically malnourished (15+)	HV10-68	Nutr. HD		✓	
Total clinically malnourished	HV10-69	(Sum HV10-67...HV10-68)		✓	

HIV03-10: PERCENTAGE OF ART CLIENTS WITH IMPROVED NUTRITION STATUS

Referees	Local
Code	indicator

Required Data Elements (disaggregation)	Code	Data Source		Reported on	
		Register/Sheet	Columns	Facility Form	MoH 711B
Improved nutrition status 0-59 mths	HV03-60	Nutr. HD		✓	
Improved nutrition status 5-17 yrs	HV03-61	Nutr. HD		✓	
Improved nutrition status 18+ yrs	HV03-62	Nutr. HD		✓	
Total improved nutrition status	HV03-63	(Sum HV03-60..HV03-62)		✓	✓
Initiated food Support, 6 months ago (0-59 mths)	HV03-56	Nutr. HD		✓	
Initiated food Support, 6 months ago (5-17 years)	HV03-57	Nutr. HD		✓	
Initiated food Support, 6 months ago (18+)	HV03-58			✓	
Total initiated food - 6 months ago	HV03-59	(Sum HV03-56..HV03-58)		✓	✓

MALE CIRCUMCISION

HIV04-01: NUMBER OF MALES CIRCUMCISED AS PART OF THE MINIMUM PACKAGE OF MC FOR HIV PREVENTION SERVICES

Referees:	KNASP	PEPFAR
Codes:	2.4.1	P5.1.D

Required Data Elements (disaggregation)	Code	Data Source		Reported on	
		Register/Sheet	Columns	Facility Form	MoH 711B
Circumcised – (< 1)	HV04-01	Minor Theatre	(k) & (l) w/ (f)	✓	
Circumcised – (1 to 14)	HV04-02	Minor Theatre	(k) & (l) w/ (f)	✓	
Circumcised – (15-19)	HV04-03	Minor Theatre	(k) & (l) w/ (f)	✓	
Circumcised – (20-25)	HV04-04	Minor Theatre	(k) & (l) w/ (f)	✓	
Circumcised – (above 25)	HV04-05	Minor Theatre	(k) & (l) w/ (f)	✓	
Total Circumcised	HV04-06	(Sum HV04-01...HV04-05)		✓	✓
Circumcised – (Positive)	HV04-07	Minor Theatre	(k) & (l) w/ (h)	✓	✓
Circumcised – (Negative)	HV04-08	Minor Theatre	(k) & (l) w/ (h)	✓	
Circumcised – (Unknown)	HV04-09	Minor Theatre	(k) & (l) w/ (h)	✓	

HIV04-02: NUMBER OF MC CLIENTS WHO EXPERIENCED ONE OR MORE MODERATE OR SEVERE ADVERSE EVENTS WITHIN THE REPORTING PERIOD

Referees:	PEPFAR
Codes:	P5.2.D

Required Data Elements (disaggregation)	Code	Data Source		Reported on	
		Register/Sheet	Columns	Facility Form	MoH 711B
During –AE(s)– moderate	HV04-10	Minor Theatre	(n) w/ (o)	✓	
During – AE(s) – severe	HV04-11	Minor Theatre	(n) w/ (o)	✓	
Post –AE(s)– moderate	HV04-12	Minor Theatre	(r) w/ (s)	✓	
Post– AE(s) – severe	HV04-13	Minor Theatre	(r) w/ (s)	✓	
Total– AE(s) – During	HV04-13	HV04-10 plus HV04-11		✓	✓
Total– AE(s) – Post	HV04-13	HV04-11 plus HV04-12		✓	✓

POST-EXPOSURE PROPHYLAXIS (PEP)

HIV05-01: PROPORTION OF PEOPLE (OTHER THAN IN PMTCT) REPORTED TO BE EXPOSED TO HIV WHO WAS PROVIDED WITH POST-EXPOSURE PROPHYLAXIS WITHIN 72 HOURS OF EXPOSURE.

Referees:	KNASP	PEPFAR
Codes	2.5.2	P6.1.D

Required Data Elements (disaggregation)	Code	Data Source		Reported on	
		Register/Sheet	Columns	Facility Form	MoH 711B
Exposed – Occupational – male	HV05-01	PEP	Sex (f); w/ (g)	✓	
Exposed – Occupational – female	HV05-02	PEP	Sex (f); w/ (g)	✓	
Exposed – Sexual assault – male	HV05-03	PEP	Sex (f); w/ (g)	✓	
Exposed – Sexual assault – female	HV05-04	PEP	Sex (f); w/ (g)	✓	
Exposed – Other reasons - male	HV05-05	PEP	Sex (f); w/ (g)	✓	
Exposed – Other reasons - female	HV05-06	PEP	Sex (f); w/ (g)	✓	
Total Exposed	HV05-07	(Sum HV05-01...HV05-06)		✓	✓
PEP – Occupational – male	HV05-08	PEP	Sex (f); w/ (g) & (q)	✓	
PEP – Occupational – female	HV05-09	PEP	Sex (f); w/ (g) & (q)	✓	
PEP - Sexual assault – male	HV05-10	PEP	Sex (f); w/ (g) & (q)	✓	
PEP - Sexual assault – female	HV05-11	PEP	Sex (f); w/ (g) & (q)	✓	

Required Data Elements (disaggregation)	Code	Data Source		Reported on	
		Register/Sheet	Columns	Facility Form	MoH 711B
PEP - Other reasons – male	HV05-12	PEP	Sex (f); w/ (g) & (q)	✓	
PEP - Other reasons – female	HV05-13	PEP	Sex (f); w/ (g) & (q)	✓	
Total PEP	HV05-14	(Sum HV05-08...HV05-13)		✓	✓

BLOOD SAFETY

HIV06-01: PERCENTAGE OF DONATED BLOOD UNITS SCREENED FOR TTIs IN A QUALITY ASSURED MANNER

Referees:	KNASP	UNGASS	AOP	PEPFAR	GFTAM
Codes:	2.6.1	UNG-3	AOP-32	P2.1.N	HIV-P17

Required Data Elements (disaggregation)	Code	Data Source		Reported on	
		Register/Sheet	Columns	Facility Form	MoH 711B
Blood units screened for TTIs	HV06-02			✓	✓
Screened in quality-assured manner	HV06-03	NBTS Network		✓	✓
Donated blood units	HV06-01			✓	✓

HIV06-02: NUMBER OF UNITS OF WHOLE BLOOD COLLECTED BY NBTS NETWORKS AND SCREENED FOR TTIs PER 1,000 POPULATION PER YEAR

Referees:	PEPFAR
Codes:	P2.2.D, P2.2.N

Required Data Elements (disaggregation)	Code	Data Source		Reported on	
		Register/Sheet	Columns	Facility Form	MoH 711B
Units of whole blood screened for TTIs	HV06-04	NBTS Network		✓	✓
Estimated target population					

HIV06-03: PERCENTAGE OF BLOOD UNITS SCREENED AND FOUND POSITIVE FOR HIV BY NBTS NETWORK

Referees:	PEPFAR
Codes	P2.4.N

Required Data Elements (disaggregation)	Code	Data Source		Reported on	
		Register/Sheet	Columns	Facility Form	MoH 711B
Blood units reactive to HIV	HV06-05	NBTS Network		✓	✓
Blood units screened for HIV	HV06-06			✓	✓

ABSTINENCE, BE FAITHFUL, AND CONSISTENCE CONDOM USE
HIV07-01: NUMBER OF THE TARGETED POPULATION REACHED WITH INDIVIDUAL AND/OR SMALL GROUP LEVEL PREVENTIVE INTERVENTIONS THAT ARE PRIMARILY FOCUSED ON ABSTINENCE AND/OR BEING FAITHFUL, AND ARE BASED ON EVIDENCE AND/OR MEET THE MINIMUM STANDARDS REQUIRED

Referees:	PEPFAR
Codes:	P8.2.D

Required Data Elements (disaggregation)	Code	Data Source		Reported on	
		Register/Sheet	Columns	Facility Form	MoH 711B
Reached with ABC – male(10-14)	HV07-01	Project/Programme Level Specific Tools		✓	
Reached with ABC – female(10-14)	HV07-02			✓	
Reached with ABC – male(15+)	HV07-03			✓	
Reached with ABC – female(15+)	HV07-04			✓	
Total Reached with ABC	HV07-05	(Sum HV07-02...HV07-04)		✓	✓

MOST-AT-RISK PERSONS

HIV08-01: NUMBER OF MARP REACHED WITH INDIVIDUAL AND/OR SMALL GROUP LEVEL INTERVENTIONS THAT ARE BASED ON EVIDENCE AND/OR MEET THE MINIMUM STANDARDS REQUIRED

Referees:	PEPFAR
Codes:	P8.3.D

Required Data Elements (disaggregation)	Code	Data Source		Reported on	
		Register/Sheet	Columns	Facility Form	MoH 711B
MARP-reached-CSW	HV08-01			✓	
MARP-reached-IDU	HV08-02			✓	
MARP-reached-MSM	HV08-03			✓	
MARP-reached-Other	HV08-04			✓	
Total MARPS-reached	HV08-05	Calculated = Sum HV08-01...HV08-04)		✓	✓

HIV08-02: NUMBER OF MARPS REACHED WITH INDIVIDUAL AND/OR SMALL GROUP LEVEL HIV/STI PACKAGE OF SERVICES AS PER NATIONAL GUIDELINES

Referees:	UNGASS	PEPFAR	GFTAM
Codes:	Partially #9	P8.3.D	P4b

Required Data Elements (disaggregation)	Code	Data Source		Reported on	
		Register/Sheet	Columns	Facility Form	MoH 711B
STI Service - CSW	HV08-06			✓	
STI Service - IDU	HV08-07			✓	
STI Service - MSM	HV08-08			✓	
STI Service - Other	HV08-09			✓	
Total MARPS-HIV/STI	HV08-10	(Sum HV08-06...HV08-09)		✓	✓

HIV08-03: NUMBER OF HIV POSITIVE MARPS PROVIDED WITH HIV CARE REFERRAL

Referees:

Codes:

Required Data Elements (disaggregation)	Code	Data Source		Reported on	
		Register/Sheet	Columns	Facility Form	MoH 711B
Tested – CSW	HV08-11	HIV Testing	Count "date" in (k) w/ "S" in (h)	✓	
Tested – IDU	HV08-12	HIV Testing	Count "date" in (k) w/ "I" in (h)	✓	
Tested – MSM	HV08-13	HIV Testing	Count "date" in (k) w/ "M" in (h)	✓	
Tested – other MARPs	HV08-14	HIV Testing	Count "date" in (k) w/ "F", "T", "O" in (h)	✓	
Total MARPs tested for HIV	HV08-15	(Sum HV08-11...HV08-14)		✓	✓
MARPs tested positive	HV08-16	HIV Testing	Count "date" in (k) w/ "P", in (o) & (h) <>"NA"	✓	✓
MARPs tested referred for care	HV08-17	HIV Testing	Count "date" in (k) w/ "P", in (o) & (h) <>"NA" & (o) is true	✓	✓

PREVENTION WITH POSITIVES (PwP)

HIV09-01: PERCENTAGE OF PLHIVs REACHED WITH A MINIMUM PACKAGE OF PREVENTION WITH PLHIV (PwP) INTERVENTIONS

Referees: PEPFAR
Codes: P7.1.D

Required Data Elements (disaggregation)	Code	Data Source		Reported on	
		Register/Sheet	Columns	Facility Form	MoH 711B
Disclosed HIV status to sexual partner	HV09-01	Project/Programme Level Specific Tools	✓	✓	
Partner received on-site HIV testing	HV09-02		✓	✓	
On-site screening for STIs/RTI	HV09-03		✓	✓	
Modern contraceptive methods	HV09-04		✓	✓	
Provided with condoms	HV09-05		✓	✓	

HOME & COMMUNITY-BASED HIV CARE/HCBC

HIV10-01: PERCENTAGE OF CLIENTS PROVIDED WITH HCBC SERVICES IN ACCORDANCE WITH THE NATIONAL GUIDELINES

Referees:	KNASP
Codes:	3.2.1

Required Data Elements (disaggregation)	Code	Data Source		Reported on	
		Register/Sheet	Columns	Facility Form	MoH 711B
HCBC Service – male(<15)	HV10-01	COPBAR thru NACC		✓	
HCBC Service – female(15+)	HV10-02			✓	
HCBC Service – male(<15)	HV10-03			✓	
HCBC Service – female(<15)	HV10-04			✓	
Total Provided HCBC	HV10-05	(Sum HV10-01...HV10-04)		✓	✓
HCBC – Clinical & BNC	HV10-08	COPBAR thru NACC		✓	
HCBC - Palliative care	HV10-09			✓	
HCBC - Life skills development	HV10-10			✓	
HCBC - Family care and support	HV10-11			✓	
HCBC - Food and nutrition support	HV10-12			✓	
HCBC - Prevention of HIV transmission	HV10-13			✓	
HCBC - Linkage coordination	HV10-14			✓	

HIV10-02: PERCENTAGE OF CLIENTS ENROLLED FOR HCBC

Referees:	
Codes:	

Required Data Elements (disaggregation)	Code	Data Source		Reported on	
		Register/ Sheet	Columns	Facility Form	MoH 711B
Referred for HCBC	HV10-06	COPBAR thru NACC		✓	✓
Newly registered for HCBC	HV10-07			✓	✓

HIV10-03 NUMBER OF OVC PROVIDED WITH HEALTH SERVICES

Referees:
Codes:

Required Data Elements (disaggregation)	Code	Data Source		Reported on	
		Register/Sheet	Columns	Facility Form	MoH 711B
OVC (<18 years) provided service	HV10-15	COPBAR thru NACC		✓	✓

HIV10-04 NUMBER OF HCBC COMMODITIES DISTRIBUTED

Referees:
Codes:

Required Data Elements (disaggregation)	Code	Data Source		Reported on	
		Register/Sheet	Columns	Facility Form	MoH 711B
HCBC Kits – CHW/CHEW	HV10-16	COPBAR thru NACC		✓	
HCBC Kits – Volunteer	HV10-17			✓	
HCBC Kits – Focal/Desk	HV10-18			✓	
BC Package – PLHV	HV10-19			✓	

HIV10-05: NUMBER OF DEATHS AT THE COMMUNITY LEVEL

Referees:
Codes:

Required Data Elements (disaggregation)	Code	Data Source		Reported on	
		Register/Sheet	Columns	Facility Form	MoH 711B
Death – community – male (<15)	HV10-20	COPBAR thru NACC		✓	
Death – community – female (<15)	HV10-21			✓	
Death – community – male (15+)	HV10-22			✓	
Death – community – female (15+)	HV10-23			✓	
Total Deaths Community	HV10-24		(Sum HV10-20...HV23)	✓	✓

HIV10-06: NUMBER OF ELIGIBLE CLIENTS WHO RECEIVED FOOD AND/OR NUTRITION SUPPORT.

Referees:	PEPFAR
Codes	C5.1.D

Required Data Elements (disaggregation)	Code	Data Source		Reported on	
		Register/Sheet	Columns	Facility Form	MoH 711B
Clinically malnourished (<15)	HV10-25	COPBAR thru NACC	✓		
Clinically malnourished (15+)	HV10-26		✓		
Total malnourished	HV10-27	(Sum HV10-25...HV10-26)	✓	✓	
Nutritional support (<15)	HV10-28		✓		
Nutritional support (15+)	HV10-29		✓		
Total Nutritional support	HV10-30	(Sum HV10-28...HV10-29)	✓	✓	
Received food/nutrition support (<18)	HV10-31	COPBAR thru NACC	✓		
Received food/nutrition support (18+)	HV10-32		✓		
Nutrition support - pregnant/lactating women	HV10-33		✓		

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ANNEX 2: DATA COLLECTION AND REPORTING TOOLS

PREVENTION: HTC

Serial No	Date	Client Name	Age	Sex	Strategy	Tested before?	If yes, the result	When last tested	Marital status	MARP's	Disability	Consent	Client tested as	HIV Test 1	HIV Test 2	HIV Test 3	Final Result	Final Result Given?	Couple Discordant	Quality Control	DBS Collected?	DBS Result	TB Screening	Refer to	HTC Provider (name and sign)	Remarks
														Kit Name	Kit Name	Kit Name										
Lot No.	Lot No.	Lot No.																								
Expiry / /	Expiry / /	Expiry / /																								
a	b	c	d	e	f	g	h	i	j	k	l	m	n	o	p	q	r	s	t	u	v	w	x	y	z	
							month ago							N: Negative P: Positive I: Invalid	N: Negative P: Positive I: Invalid	N: Negative P: Positive I: Invalid	P: Positive ID: Indeterminate									
<Page Summary>		Tested					<15	15-24	25-49	50+	Total	Test Kits Performance														
							Male											HIV Test 1	HIV Test 2	HIV Test 3						
							Female											N:	N:	N:						
							Total											P:	P:	P:						
							Positive	<15	15-24	25-49	50+	Total						I:	I:	I:						
							Male											Wastage:	Wastage:	Wastage:						
							Female											Total:	Total:	Total:						
							Total											Supervisor/In-charge:								
							Newly Tested (g)	<15	15-24	25-49	50+	Total						Date: _____ Signature: _____								
							Male																			
					Female																					
					Total																					

PREVENTION: PMTCT

Ministry of Health

Antenatal Care Register - MOH 405 - Reformatted for Procedure Manual

Page 1

No. New Clients (c): _____
No. Revisit Clients (d): _____
No. Completed 4th Antenatal Visit (d): _____
No. Clients with Hb < 7 g/dl (q): _____
No. Tested for Syphilis (r): _____
No. Syphilis positive (r): _____

No. Known HIV Positive at entry (s): _____
No. Tested for HIV (s): _____
No. Retested for HIV (t): _____
No. Tested HIV Positive(s) & (t): _____
Counselled as couple (am): _____
Male Partner Tested (an): _____

Assesed for ART Eligibility - WHO (u): _____
Assesed for ART Eligibility - CD4 (v): _____
Started on ART (w): _____

Screened for TB (ac): _____
Screened for Cervical Cancer (PAP) (ad): _____
Screened for Cervical Cancer (VIA) (ad): _____

Mother	NVP - (mother) (y): _____ NVP+AZT (y) & (z): _____
Baby	No. HAART for Treatment (aa): _____ NVP for baby (ab): _____
	No. given IPT1 (ag): _____ No. given IPT2+ (ag): _____ No. of received ITN (ak): _____

Codes for Col (p)	
1 = Birth Plan	5 = Supplemental Feeding
2 = Danger Signs	6 = Breast Care
3 = FP	7 = Infant Feeding
4 = HIV	8 = ITN

Codes for Col (ac)
NO Signs = No signs of TB
TB Suspected = TB Suspected
TB Rx = On TB Treatment

Codes for Col (ad)

Codes for Col (ae)&(al)

1 = Hypertension
2 = Diabetes 5 = STI/RTI
3 = Epilepsy 6 = Other (write in)
4 = Malaria in Pregnancy

Diagnosis Alive: Dead:
No. with APH: _____
No. with PPH: _____
No. with Eclampsia: _____
No. with Ruptured Uterus: _____
No. with Obstructed Labour: _____
No. with Sepsis: _____

No. Normal Deliveries (q): _____
No. Caesarean Sections (q): _____
No. Breech Delivery (q): _____
No. Assisted vaginal delivery (q): _____

Pre-Term babies (p):	_____
Under Weight Babies (w):	_____
Live Births (x):	_____
Still Births (x):	_____
No. of babies discharged alive (am):	_____
Neonatal Deaths (am):	_____
Maternal Deaths (t):	_____

No. Tested for HIV (ab): _____
No. retested for HIV (aa) & (ab): _____
No. Tested HIV Positive (ab): _____
No. HIV Positive Deliveries(aa)(ab): _____

Codes for Col (g)	
1	= Married
2	= Widowed
3	= Single
4	= Divorced
5	= Separated

Codes for Col (q)	
1	= Normal Delivery
2	= Caesarian Section
3	= Breech
4	= Assisted Vaginal
5	= Separated

Codes for Col (ac)&(ad) - See detailed descriptions prefixed to this register	
PM1 = AZT; NVP + AZT+ 3TC; AZT/3TC	PM5 = PMTCT HAART: AZT + 3TC + LPV/r
PM2 = NVP + AZT + 3TC; AZT/3TC	PM6 = PMTCT HAART: TDF + 3TC + NVP
PM3 = PMTCT HAART: AZT + 3TC + NVP	PM7 = PMTCT HAART: TDF + 3TC + LPV/r
PM4 = PMTCT HAART: AZT + 3TC + EFV	PM8 = Nevirapine (NVP) Single Dose (SD)

Codes for Col (ae) -
See detailed descriptions prefixed to this register

- Visit within 48 hours (a)(g)
- Visit after 48 hours (a)(g)

Total attendances (a)

No. Tested for HIV (<=72hrs) (v): _____
No. Tested for HIV (>72hrs) (w): _____
No. Tested HIV positive (<=72hrs) (v): _____
No. Tested HIV Positive(>72hrs) (w): _____
Counselled as a couple (aa): _____
Male Partner Tested (ab): _____

Screened for Cervical Cancer (PAP) (ad): _____
Screened for Cervical Cancer (VIA) (ad): _____
Received an FP Method (ae): _____

Codes for Col (i)

1	= Normal Delivery
2	= Caesarian Section
3	= Breech
4	= Assisted Vaginal
5	= Separated

Codes for Col (n)

Codes for Col (o)
1 = Normal
2 = Crappled Nipple
3 = Engorged
4 = Mastitis

Codes for Col (r)

1	= Bleeding
2	= Normal
3	= Infected

Codes for Col (s)

1 = Normal
2 = Foul Smelling
3 = ...

Codes for Col (t)

1	= Repaired
2	= Gaping
3	= Infected
4	= Healed

Codes for Col (ad)
PAP = Pap Smear Used
VIA = VIA Method Used

Codes for Col (ad)	
C	= Condoms
ECP	= Emergency contraceptive pills
OC	= Oral contraceptive pills
INJ	= Injectable
IMP	= Implant
IUD	= Intrauterine device
LAM	= Lactational Amenorrhea Method
D	= Diaphragm/cervical cap
FA	= Fertility awareness method/periodic abstinence
TL	= Tubal ligation/female sterilization
V	= Vasectomy (partner's)

CARE AND TREATMENT

HIV Exposed Infant (HEI) Follow-up Card

Name of Facility: _____ Facility Code: _____ District: _____ Province: _____
 Cohort by month and year of birth: MMM-YYYY

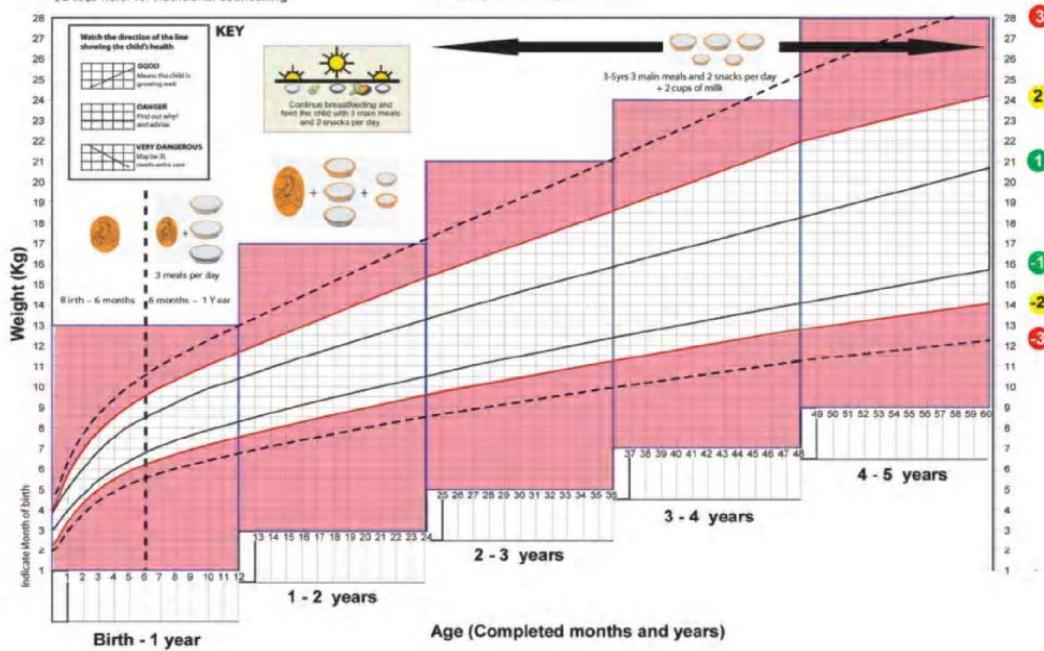
INFANT PROFILE					
HEI ID Number _____					
Name (First, Middle, Last): _____					
Sex:	M <input type="checkbox"/>	F <input type="checkbox"/>	Date of Birth:	/ /	Birth Wt(kg)
Date of Enrollment: _____ / _____ / _____					
Age at Enrollment _____					
Source of Referral	<input type="checkbox"/> Paediatric Ward	<input type="checkbox"/> OPD	<input type="checkbox"/> Maternity	<input type="checkbox"/> CCC	
	<input type="checkbox"/> MCH/PMTCT	<input type="checkbox"/> Other specify _____			
ARV Prophylaxis					
<input type="checkbox"/> Sd NVP only					
<input type="checkbox"/> Sd NVP+AZT+3TC					
<input type="checkbox"/> NVP for 6 weeks (mother on HAART or No BF)					
<input type="checkbox"/> NVP during breastfeeding	<input type="checkbox"/> None				
History of TB Contact in Household?			<input type="checkbox"/> Yes	<input type="checkbox"/> No	
If "Yes", screen for TB; and appropriately refer for INH prophylaxis					
PARENT PROFILE					
Name of Mother : _____					
Alive?	<input type="checkbox"/> Yes	<input type="checkbox"/> No			
Mother Received Drugs for PMTCT? <input type="checkbox"/> Yes <input type="checkbox"/> No					
If Yes, (Select Drug Combination)					
<input type="checkbox"/> Sd NVP Only	<input type="checkbox"/> AZT + NVP + 3TC				
<input type="checkbox"/> Interrupted HAART	<input type="checkbox"/> HAART	<input type="checkbox"/> None			
On ART at Enrolment of Infant? <input type="checkbox"/> Yes <input type="checkbox"/> No					
If "Yes" Enter Regimen: _____ & CCC: _____					
Mode of Delivery: <input type="checkbox"/> SVD <input type="checkbox"/> C-section					
Place of Delivery: <input type="checkbox"/> Facility <input type="checkbox"/> Home					

IMMUNISATION HISTORY					
BCG	<input type="checkbox"/>	OPV at Birth	<input type="checkbox"/>	OPV/Penta 1	<input type="checkbox"/>
OPV/Penta 2	<input type="checkbox"/>	OPV Penta 3	<input type="checkbox"/>	Measles 9 mths	<input type="checkbox"/>
Measles 6 mths <input type="checkbox"/> Other (Specify): _____					
LABORATORY INFORMATION					
Type of Test	Date of Test	Results	DBS Sample Code	Date Results Collected	
1 st PCR					
Repeat PCR (for rejections)					
1 st Antibody					
Confirmatory PCR					
Repeat PCR (for rejections)					
Final Antibody					
PATIENT LOCATOR					
Address 1	<input type="checkbox"/> C _____ nt	Permanent <input type="checkbox"/>	Address 2	<input type="checkbox"/> C _____ nt	Permanent <input type="checkbox"/>
<input type="checkbox"/> Parent	<input type="checkbox"/> Gu _____ lan	<input type="checkbox"/>	<input type="checkbox"/> Parent	<input type="checkbox"/> Gu _____ lan	<input type="checkbox"/>
Name: _____			Name: _____		
Telephone Number: _____			Telephone Number: _____		
District: _____			District: _____		
Division: _____			Division: _____		
Location: _____			Location: _____		
Estate/Village: _____			Estate/Village: _____		
Hse/Plot #: _____			Hse/Plot #: _____		
Sub/Cheif's Name: _____			Sub/Cheif's Name: _____		
Landmark: (e.g. School/Church/Mosque) _____			Landmark: (e.g. School/Church/Mosque) _____		

±3 Refer for further investigations
±2 to ±3 Refer for nutritional counselling

Weight-for-Age BOYS

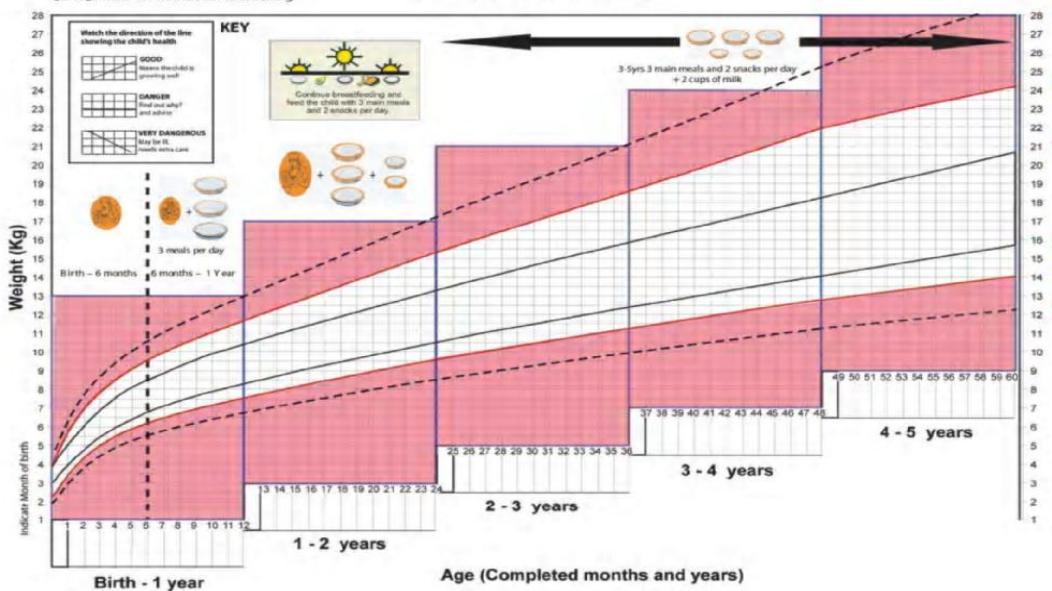
(See page 25 for special care)



±3 Refer for further investigations
±2 to ±3 Refer for nutritional counselling

Weight-for-Age GIRLS

(See page 25 for special care)



GROWTH, NUTRITION AND DEVELOPMENT MONITORING

Infant Feeding Codes
EBF= Exclusive Breastfeeding
ERF= Exclusive Replacement Feeding
MF = Mixed Feeding

TB Assessment Outcomes	
No signs	= No signs or symptoms of TB
Suspect	= TB referral or sputum sent
Confirmed	= Confirmed Sputum (+)
TB Rx	= currently on TB treatment. If recording for the first time or inserting new page in the file, record month/year started and TB reg No.

Development Milestones by Age	
Age Ranges	Milestones
4-6 Weeks	Social Smile
1-3 Months	Head Holding/ Control
2-3 Months	Turns towards the origin of sound
2-3 Months	Extends hand to grasp a toy
5-9 Months	Sitting
7-13 Months	Standing
12-18 Months	Walking
9-24 Months	Talking

CLINICAL NOTES

Cohort: Month/Year (MMM-YYYY)

HIV Exposed Infant Register MoH

Infant and Mother/Guardian Information												First DNA PCR Test at 6 weeks or First Contact							6 weeks		10 weeks	
Registration Information			Infant's information					Mother's information				First DNA PCR Test at 6 weeks or First Contact							6 weeks		10 weeks	
Serial No.	Date of enrollment	HEID	Infant's Name	DOB Age	Sex	Entry Point (code)	Infant ARVS Received 0-6wks (codes)	Mothers/Guardian's Name	Facility Enrolled	PMTCT ARVS Received (codes)	Age at Test (in weeks)	Initial	Date sample taken	Date results from PCR lab	Date guardian collected results	Test result (POS, NEG)	Feeding (Codes)	Given NVP Given CTX	Given NVP Given CTX	Given NVP Given CTX		
(a)	(b)	(c)	(d)	(e)	(f)	(g)	(h)	(i)	(j)	(k)	(l)	(m)	(n)	(o)	(p)	(q)	(r)	(s)	(t)	(u)		
											Initial										
											Repeat for Rejections										
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Entry Point (g)	
1=OPD	4=CCC
2=Paediatric ward	5=Maternity
3=MCH/PMTCT	6. Other (specify)

PMTCT ARVs-Infant (h)

1=sdNVP ONLY
2=NVP+ (AZT+3TC for 7 days)
3=NVP for 6 weeks (Mother on ART or ERF)
4=None
5=Other (specify)

PMTCT ARVs-Mother (k)	
1=SdNVP only	4=HAART
2=Interrupted HAART	5=None
3=AZT+NVP+3TC	6. Other (specify)

Feeding Method (r), (t), (v)
EBF = Exclusively Breastfed
ERF = Exclusive Replacement fed
MF = Mixed Fed

Feeding Method (z), (ab), (ad), (af)
BF = Baby still breastfed
No BF = Baby has been weaned

PMTCT ARVs-Infant (as)
1=sdNVP ONLY
2=NVP+ (AZT+3TC for 7 days)
3=NVP for 6 weeks (Mother on ART or ERF)
4=NVP during BF period
5=None
6=Other (specify)

HIV Exposed Infant Register MoH

INSTRUCTIONS AND PROCEDURES

REFERENCE MATERIALS

HIV/HMIS Annex 2 Page 13

3-Risk of pregnancy
4-Due to new TB
5-New drug available
6-Drug out of stock
7-Other reasons(specify)

9. Immunologic failure
10. Virologic failure

COMPREHENSIVE CARE CLINIC PATIENT CARD - INITIAL AND FOLLOW UP VISITS MOH257

Data Completion Codes for Selected Variables

Codes for potential side effects or other problems (n)	Codes for new OI or other problems: (o)	Why SUBSTITUTE or SWITCH codes (front page)	Codes for CTX/ART adherence (q) & (r)																				
Nausea Rash Headache Diarrhoea Anaemia Jaundice Fatigue ABdominal pain FAT changes BN burning/numb/tingling CNS : dizzy, anxiety, nightmare, depression	Zoster Thrush \pm oral/vaginal COUGH* DB difficult breathing FEVER* DE mentia/ Enceph Weight loss* Pneumonia UD urethral discharge PID pelvic inflammatory disease Ulcers \pm mouth or other ____ GUD genital ulcer disease IRIS Immune reconstitution inflammatory syndrome Severe Complicated Malnutrition Severe Uncomplicated Malnutrition	<p>1 Toxicity/side effects 2 Pregnancy 3 Risk of pregnancy 4 Due to new TB 5 New drug available 6 Drug out of stock 7 Other reason (specify)</p> <p>Reasons for SWITCH to 2nd-line regimen only:</p> <p>8 Clinical treatment failure 9 Immunologic failure 10 Virologic failure</p>	<table border="1"> <thead> <tr> <th colspan="4">Missed doses per month</th> </tr> <tr> <th>Adherence</th><th>%</th><th>1 x daily dosing</th><th>2 x daily dosing</th> </tr> </thead> <tbody> <tr> <td>G(good)</td><td>$\geq 95\%$</td><td><2 doses</td><td>≤ 3 doses</td> </tr> <tr> <td>F(fair)</td><td>85-94%</td><td>2-4 doses</td><td>4-8 doses</td> </tr> <tr> <td>P(poor)</td><td>< 85%</td><td>≥ 5 doses</td><td>≥ 9 doses</td> </tr> </tbody> </table>	Missed doses per month				Adherence	%	1 x daily dosing	2 x daily dosing	G(good)	$\geq 95\%$	<2 doses	≤ 3 doses	F(fair)	85-94%	2-4 doses	4-8 doses	P(poor)	< 85%	≥ 5 doses	≥ 9 doses
Missed doses per month																							
Adherence	%	1 x daily dosing	2 x daily dosing																				
G(good)	$\geq 95\%$	<2 doses	≤ 3 doses																				
F(fair)	85-94%	2-4 doses	4-8 doses																				
P(poor)	< 85%	≥ 5 doses	≥ 9 doses																				
Codes for HIV prevention interventions for key population		Why STOP codes (front page)	Codes for why poor/fair adherence (v)																				
At Risk Population DC= Discordant Couple; MSM; IDU; SW; cSW= Clients to SW		1 Toxicity/side effects 10 Other (specify)	1 Toxicity/side effects 10 Inability to pay																				
Service																							

CC- couple counselling RR- targeted risk reduction C- Condom promotion/provision NSP- Needle and syringe programmes	Poor Weight Gain Symptoms suggestive of TB	2 Pregnancy 3 Treatment failure 4 Poor adherence 5 Illness, hospitalization 6 Drugs out of stock 7 Patient lacks finances 8 Other patient decision 9 Planned Rx interruption	2 Share with others 3 Forgot 4 Felt better 5 Too ill 6 Stigma, disclosure or privacy issues 7 Drug stock out—dispensary 8 Patient lost/ran out of pills 9 Delivery/travel problems	11 Alcohol 12 Depression 13 Pill burden 14 Other (specify)
Referral/Nutritional Support (ac)				
TF = Therapeutic Feeding (if <2yrs)				
IFC = Infant Feeding Counselling (if <2yrs)				
FS = Food Support				
Infant Feeding Practice = EBF, ERF, MF				

Follow-up Education Support and Preparation for ARV Therapy

Follow-up Education Support and Preparation for ARV Therapy					
		Date/comments	Date/comments	Date/comments	Date/comments
Educate on basics, prevention, disclosure	Basic HIV education, transmission				
	Prevention: abstinence, safer sex, condoms				
	Prevention: household precautions, what is safe				
	Post-test counselling: implications of results				
	Positive living				
	Testing partners				
	Disclosure, to whom disclosed (list)				
	Family/living situation				
	Shared confidentiality				
	Reproductive choices, prevention of MTCT				
Progression, Rx	Child's blood test				
	Progression of disease				
	Available treatment/prophylaxis				
	CTX, INH prophylaxis				
	Malaria prevention, IPT, ITN				
ART preparation, initiation, support, monitor, Rx	Follow-up appointments, clinical team				
	ART -- educate on essentials (locally adapted)				
	Why complete adherence needed				
	Adherence preparation, indicate visits				
	Indicate when READY for ART: DATE/result clinical team discussion				
	Explain dose, when to take				
	What can occur, how to manage side effects				
	What to do if one forgets dose				
	What to do when travelling				
	Adherence plan (schedule, aids, explain diary)				
	Treatment supporter preparation				
	Which doses, why missed				
Caregiver support	ARV support group				
	How to contact clinic				
Caregiver support	Symptom management/palliative care at home				
	Caregiver booklet				

	Home-based care – specify				
	Support groups				
	Community support				

Number Enrolled in Care			
	<1	1-14	15+
Males			
Females			

Enrolment by Entry Point		OPD	MCH-Child	
PMTCT				
VCT		IPD-Adult	Other	
TB Clinic		IPD-Paediatric		

Column Codes	Enrolment by Entry Point (f)	
1	= PMTCT	5 = IPD-Adult
2	= VCT	6 = IPD-Pediatric
3	= TB Clinic	7 = MCH-child
4	= OPD	8 = Other

TB Status (g) and quarterly followups (u, x, aa, ...)	
NO Signs	= If no signs TB from previous assessment
TB Present	= If a patient sputum test results is positive
TB Rx	= If patient is already on treatment
ND	= TB screening not done

Pregnancy Status at Enrolment (i)	
PREG	= Still pregnant at enrollment
PP	= Postpartum

Program Status - quarterly followups (v, y, ab, ...)	
LOST	= Had an appointment during the quarter but absconded
TO	= Was transferred to another facility
NOApp	= Did not have an appointment during the quarter
DEAD	= Died during this quarter - <i>Close remaining quarters</i>

ADULT ART First-Line Regimens	
Codes	Combinations
AF1A	= AZT + 3TC + NVP
AF1B	= AZT + 3TC + EFV
AF2A	= TDF + 3TC + NVP
AF2B	= TDF + 3TC + EFV
AF3A	= d4T + 3TC + NVP
AF3B	= d4T + 3TC + EFV

ADULT ART Second-Line Regimens			
Codes	Combinations	Codes	Combinations
AS1A = AZT + 3TC + LPV/r		AS2D = TDF + ABC + LPV/r	
AS1B = AZT + ddI + LPV/r		AS2E = TDF + AZT + ABC	
AS1C = AZT + 3TC + ABC		AS3A = ABC + ddI + LPV/r	
AS2A = TDF + 3TC + LPV/r		AS4A = d4T + 3TC + LPV/r	
AS2B = TDF + 3TC + ABC		AS4B = d4T + 3TC + ABC	
AS2C = TDF + 3TC + AZT			

Other ADULT ART Regimens	
Codes	Combinations
AO1A	= ABC + 3TC + NVP
AO1B	= ABC + 3TC + EFV
AO1C	= ABC + 3TC + LPV/r
	=
	=
	=

PAEDIATRIC ART First-Line Regimens			
Codes	Combinations	Codes	Combinations
CF1A	= AZT + 3TC + NVP	CF2C	= ABC + 3TC + AZT
CF1B	= AZT + 3TC + EFV	CF2D	= ABC + 3TC + LPV/r
CF1C	= AZT + 3TC + LPV/r	CF3A	= d4T + 3TC + NVP
CF2A	= ABC + 3TC + NVP	CF3B	= d4T + 3TC + EFV
CF2B	= ABC + 3TC + EFV		

PAEDIATRIC ART Second-Line Regimens			
Codes	Combinations	Codes	Combinations
CS1A	= AZT + 3TC + LPV/r	CS2B	= ABC + ddI + LPV/r
CS1B	= AZT + ABC + LPV/r	CS3A	= d4T + 3TC + LPV/r
CS1C	= AZT + ddI + LPV/r	CS3B	= d4T + ABC + LPV/r
CS2A	= ABC + 3TC + LPV/r		

Other PAEDIATRIC ART	
Codes	Combinations
CO1A	= AZT + ddI + NVP
CO1B	= AZT + ddI + EFV
	=
	=
	=
	=

Reasons for SWITCH to 2nd Line (w)

8 = Clinical treatment fail	5 = New drug available
9 = Immunologic failure	6 = Drug out of stock
10 = Virologic failure	7 = Other reason (specify)

Reasons for Changing Drugs (Substitution) (v) & (z)

1	= Toxicity/side effects	5	= New drug available
2	= Pregnancy	6	= Drug out of stock
3	= Risk of pregnancy	7	= Other reason (specify)
4	= None	8	

Codes if Patient was not on therapy at end of month

(ab thru ag)	STOP	= Stopped ART
(ak thru ap)	DEAD	= Died this month - close record
(at thru ay)	LOST	= missed appointment for that month
(bc thru bh)	TO	= Transfer Out.

MINISTRY OF MEDICAL SERVICES
FACILITY DAILY ACTIVITY REGISTER FOR NUTRITION AND HIV/AIDS

Date dd/mm/yyyy	Client Unique No.	Client names	Background Information						Assessment						Nutrition Intervention						Follow up									
			Revisit Tick (✓)	Serostatus (P/N) . P = 1, N = 2	Date of Birth (dd-mm-yy)	Age (in Years)	Gender (M/F): M=1, F=2	Residence & Landmark	Telephone No	Pregnant/ Postpartum (P/PP): P=1, PP=2	Weight (kg)	Height/Length (cm)	Weight for Height (WFH) Z score (0-59 mths)	BMI for Age (5-17 yrs)	BMI (adults over 18 yrs)	MUAC (cm)	Hb (g/dl)	On ARVs (Y/N): Y = 1, N = 2	Infant and Young Child Feeding	Nutrition Counselling	Nutritional Support	Feeding Practice	dd/mm/yyyy	TCA (dd/mm/yyyy)	Remarks					
(a)	(b)	(c)	(d)	(e)	(f)	(g)	(h)	(i)	(j)	(k)	(l)	(m)	(n)	(o)	(p)	(q)	(r)	(s)	(t)	(u)	(v)	(w)	(x)	(y)	(z)	(aa)	(ab)	(ac)	(ad)	
Total			P: N:	M: F:	P: PP:													Y: N:												

Facility Daily Summary Sheet:

Total number of clients seen (a) N: P:
 No. of children (0-59 months with WFH <-2 Z score) (n) N: P:
 No. of children (5-17 yrs) with BMI-for-Age < -2 Z score (o) N: P:
 No. of adults (over 18yrs) with BMI < 18.5 (p) N: P:

No. of adults (over 18 yrs) with BMI >30 (p) N: P:
 No. of pregnant women with MUAC <22cm (q) N: P:
 No. of postpartum women with MUAC <22cm (q) N: P:

Number Receiving Nutrition Support	
Counselling(v) N: <input type="text"/>	P: <input type="text"/>
Therapeutic Feeding (w) N: <input type="text"/>	P: <input type="text"/>
Supplementary Feeding (x) N: <input type="text"/>	P: <input type="text"/>
Multiple Micronutrients (y) N: <input type="text"/>	P: <input type="text"/>

Infant and Young Child NutritionCounselling	
Prenatal (t) w/ (g) N: <input type="text"/>	P: <input type="text"/>
Postnatal (t) w/ (g) N: <input type="text"/>	P: <input type="text"/>

Infant Feeding Practices	
EBF (6 months) (z) N: <input type="text"/>	P: <input type="text"/>
ERF (aa) N: <input type="text"/>	P: <input type="text"/>
MF (ab) N: <input type="text"/>	P: <input type="text"/>

MALE CIRCUMCISION

Theatre Register

COLUMN KEY

Column	Description
H	U= Unknown, P=Tested/ Self-reported Positive, N= Tested Negative. NOTE: Client self-reporting as "Negative"= "Unknown"
I	Record N/A for MC procedures
N	N=Mild (Skip Column O), Y=Moderate or Severe AE (complete column O)
O	M=Moderate, S=Severe. NOTE: For MC procedures refer to appropriate MC AE Form
R	N=Mild (Skip Column O), Y=Moderate or Severe AE (complete column S)
S	M=Moderate, S=Severe. NOTE: For MC procedures refer to appropriate MC AE Form

Theatre Register

PAGE SUMMARIES FOR VMMC

Number of MC Clients Age <1: _____ Number of Clients with AE DURING MC: _____ Moderate: _____, Severe: _____
Number of MC Clients Age 1-14: _____ Number of Clients with AE POST MC: _____ Moderate: _____, Severe: _____
Number of MC Clients Age 15+ : _____ Total number of AEs: _____
Total number of MC Clients: _____

Removed Until Revised by the Programme

Removed Until Revised by the Programme

ACTIVITY SHEET: HIV - Care and Treatment

[MOH 366]

Day Month Year
 / /

This Page This Month

Total Scheduled Visits (HV03-71)
Total Unscheduled Visits (HV03-72)

HIV Care Monthly Tally Sheet

(from Care & Treatment Activity Sheet)

[MOH 728]

Year: _____

Month: _____

Data Element	DE Code	Source Column ID	Subtotal from this month	Tally from previous months' "Care and Treatment Activity Sheets"					
				From Previous month			From two months ago		
				(Tally 2s and 3s)		Subtotal	(Tally 3s or more only)		Subtotal
On CTX - Current M(<15)	HV03-03	(b) with (p ₁)		00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000			00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000		
On CTX - Current F(<15)	HV03-04	(c) with (p ₁)		00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000			00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000		
On CTX - Current M(15+)	HV03-05	(d) with (p ₁)		00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000			00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000		
On CTX - Current F(15+)	HV03-06	(e) with (p ₁)		00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000			00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000		
				New (f) to (j) (k) to (o)	Revisit				
In Care - Current (<1)	HV03-14	(f) or (k) and (p ₂)		00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000			00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000		
In Care - Current M(<15)	HV03-15	(g) or (l) and (p ₂)		00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000			00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000		
In Care - Current F(<15)	HV03-16	(h) or (m) and (p ₂)		00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000			00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000		
In Care - Current M(15+)	HV03-17	(i) or (n) and (p ₂)		00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000			00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000		
In Care - Current F(15+)	HV03-18	(j) or (o) and (p ₂)		00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000			00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000		
				Subtotal from this month					
On ART - Revisit (<1)	HV03-28	(w) and (ab)		00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000		00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000		Revisits - On ART	
				00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000		00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000			
On ART - Revisit M(<15)	HV03-29	(x) and (ab)		00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000		00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000			
On ART - Revisit F(<15)	HV03-30	(y) and (ab)		00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000		00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000			
On ART - Revisit M(15+)	HV03-31	(z) and (ab)		00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000		00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000			
On ART - Revisit F(15+)	HV03-32	(aa) and (ab)		00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000		00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000			

Note: For information on tallying, please refer to the detailed instructions released with this tally sheet.

MINISTRY OF HEALTH
Comprehensive Care Clinic Cohort Summary Sheet

Facility Name: _____		Type (e.g H/C, Hosp.): _____		District: _____		Province: _____		Year: _____																	
For cohort starting ART by month/year: at baseline then results at 6 months on ART, 12 months on ART, 24 months on ART		Cohort Jan	6 mo- Jul	12 mo- Jan	24 mo- Jan	Cohort Feb	6 mo- Aug	12 mo- Feb	24 mo- Feb	Cohort Mar	6 mo- Sep	12 mo- Mar	24 mo- Mar	Cohort Apr	6 mo- Oct	12 mo- Apr	24 mo- Apr	Cohort May	6 mo- Nov	12 mo- May	24 mo- May	Cohort Jun	6 mo- Dec	12 mo- Jun	24 mo- Jun
G	Started on ART in this clinic- original cohort																								
TI	Transfers in Add +	X				X				X					X			X				X			
TO	Transfers out Subtract -	X				X				X					X			X				X			
N	Net current cohort																								
H	On original 1st-line regimen																								
I	On alternate 1st-line regimen (Substituted)																								
J	On 2nd-line regimen (Switched)																								
Stopped																									
Died																									
Lost to follow-up (DROP)																									
Percent of cohort alive and on ART [(H + I + J) / N * 100]																									
Total Appropriate 1st Line (H+J)																									
Fraction CD4 < 100 (of adults with available CD4 at baseline)		X	X	X		X	X	X		X	X	X		X	X	X		X	X	X		X	X	X	
Child $\frac{1}{5}$	Fraction with CD4% < 15% (of children <5 with available CD4 at baseline)	X	X	X		X	X	X		X	X	X		X	X	X		X	X	X		X	X	X	
CD4 median or fraction =200 (of adults with available CD4 - optional)		X	X	X		X	X	X		X	X	X		X	X	X		X	X	X		X	X		

National AIDS & STI Control Programme
Comprehensive HIV/AIDS Facility Reporting Form – NASCOP

[MOH731]

District: _____ County: _____ Facility: _____ Month: _____ Year: _____ MFL Code: _____

1 HIV Counselling and Testing		Value	3 Care and Treatment	
1.1 Testing			3.1 On Cotrimoxazole Prophylaxis	
First	HV01-01		HIV Exposed Infant (within 2 months)	HV03-01
Repeat	HV01-02		HIV Exposed Infant (Eligible for CTX at 2 months)	HV03-02
Total Tested (HV01-01 plus HV01-02)	HV01-03		On CTX - Below 15 years	HV03-03 (M)
Couples	HV01-05		On CTX - 15 years & older	HV03-05 (M)
Static [Facility]	HV01-06		Total on CTX (Sum HV03-03 to HV03-06)	HV03-07
Outreach	HV01-07			
1.2 Receiving Results - (Couples only)			3.2 Enrolled in Care	
Cocordant Couples	HV01-08		Enrolled in Care - Below 1 year	HV03-08
Discordant Couples	HV01-09		Enrolled in Care - Below 15 years	HV03-09 (M)
1.3 Receiving Positive Results			Enrolled in Care - 15 years & older	HV03-11 (M)
Males - Below 15 years	HV01-10		Enrolled in Care - Total (Sum HV03-09 to HV03-12)	HV03-13
Females - Below 15 years	HV01-11			
Males - 15 to 24 years	HV01-12			
Female - 15 to 24 years	HV01-13			
Males - 25 years & older	HV01-14			
Female - 25 years & older	HV01-15			
Total receiving positive results (Sum HV01-10 to -15)	HV01-16			
2 Prevention of Mother-to-Child Transmission			3.3 Currently in Care - (from the tally sheet- this month only and from last 2 months)	
2.1 Testing for HIV			Currently in Care - Below 1 year	HV03-14
Antenatal	HV02-01		Currently in Care - Below 15 years	HV03-15 (M)
Labour and Delivery	HV02-02		Currently in Care - 15 years & older	HV03-17 (M)
Postnatal (within 72hrs)	HV02-03		Currently in Care - Total (Sum HV03-15 to HV03-18)	HV03-19
Total Tested (PMTCT) (Sum HV02-01 to HV02-03)	HV02-04			
2.2 HIV Positive Results			3.4 Starting ART	
Known positive status (at entry into ANC)	HV02-05		Starting ART - Below 1 year	HV03-20
Antenatal	HV02-06		Starting ART - Below 15 years	HV03-21 (M)
Labour and Delivery	HV02-07		Starting ART - 15 years & older	HV03-23 (M)
Postnatal (within 72hrs)	HV02-08		Starting ART - Total (Sum HV03-21 to HV03-24)	HV03-25
Total Positive (PMTCT) (Sum HV02-05 to HV02-08)	HV02-09		Starting - Pregnant	HV03-26
Total with known status (HV02-04 plus HV02-05)	HV02-10		Starting - TB Patient	HV03-27
2.3 Partner Involvement			3.5 Revisits on ART (from the tally sheet- this month only and from last 2 months)	
Male partners tested - (ANC/L&D)	HV02-11		Revisit on ART - Below 1 year	HV03-28
Discordant Couples	HV02-12		Revisit on ART - Below 15 years	HV03-29 (M)
2.4 Maternal Prophylaxis (at first contact only)			Revisit on ART - 15 years & older	HV03-31 (M)
Prophylaxis – NVP Only	HV02-13		Total Revisit on ART (Sum HV03-29 to HV03-32)	HV03-33
Prophylaxis – (AZT + SdNVP)	HV02-14			
Prophylaxis – Interrupted HAART	HV02-15			
HAART (ART)	HV02-16			
Total PMTCT prophylaxis (Sum HV02-13 to HV02-16)	HV02-17			
2.5 Assesment for ART Eligibility in MCH (at diagnosis)			3.6 Currently on ART [All] - (Add 3.4 and 3.5 e.g. HV03-34 = HV03-20 + HV03-28)	
Assessed for eligibility at 1st ANC - WHO Staging done	HV02-18		Currently on ART - Below 1 year	HV03-34
Assessed for eligibility at 1st ANC - CD4	HV02-19		Currently on ART - Below 15 years	HV03-35 (M)
Assesed for Eligibility in ANC (Sum HV02-18 to HV02-19)	HV02-20		Currently on ART - 15 years & older	HV03-37 (M)
Started on ART during ANC	HV02-21		Total Current on ART (Sum HV03-35 to HV03-38)	HV03-39
2.7 Infant Testing (Initial tests only)			3.7 Cumulative Ever on ART	
PCR (within 2 months)	HV02-24		Ever on ART - Below 15 years	HV03-40 (M)
PCR (from 3 to 8 months)	HV02-25		Ever on ART - 15 years & older	HV03-42 (M)
Serology antibody test (from 9 to 12 months)	HV02-26		Total Ever on ART (Sum HV03-40 to HV03-43)	HV03-44
PCR (from 9 to 12 months)	HV02-27			
Total HEI Tested by 12 months (Sum HV02-24 to HV02-26)	HV02-28			
2.8 Confirmed Infant Test Results			3.8 Survival and Retention on ART at 12 months	
Positive – (within 2 months) – PCR	HV02-29		ART Net Cohort at 12 months	HV03-45
Positive – (3 – 8 months) – PCR	HV02-30		On Original 1st Line at 12 months	HV03-46
Positive – (9 – 12months) – PCR	HV02-31		On alternative 1st Line at 12 months	HV03-47
Total Confirmed Positive (Sum HV02-29 to HV02-31)	HV02-32		On 2nd Line (or higher) at 12 months	HV03-48
			On therapy at 12 months (Sum HV03-46 to HV03-48)	HV03-49
2.9 Infant Feeding			3.9 Screening	
EBF (at 6 months)	HV02-33		Screened for TB - Below 15 years	HV03-50 (M)
ERF (at 6 months)	HV02-34		Screened for TB - 15 years & older	HV03-52 (M)
MF (at 6 months)	HV02-35		Total Screened for TB (Sum HV03-50 to -53)	HV03-54
Total Exposed 6 months	HV02-36		Screened for cervical cancer (F 18+)	HV03-55
BF (12 months)	HV02-37			
Not BF (12 months)	HV02-38			
Not Known	HV02-39			
Total Exposed 12 months (Sum HV02-37 to HV02-39)	HV02-40			
2.10 Infant ARV Prophylaxis (at first contact only)			3.10 Prevention with Positives	
Issued in ANC	HV02-41		Modern contraceptive methods	HV09-04
Labour and Delivery	HV02-42		Provided with condoms	HV09-05
PNC (<72hrs)	HV02-43			
5 Post-Exposure Prophylaxis			3.11 HIV Care Visits	
5.1 Type of Exposure			Females (18+)	HV03-70
Occupational	HV05-01 (M)	HV05-02 (F)	Scheduled	HV03-71
Sexual assault	HV05-03 (M)	HV05-04 (F)	Unscheduled	HV03-72
Other reasons	HV05-05 (M)	HV05-06 (F)	Total visits (HV03-71 & -72)	HV03-73
Total	HV05-07			
5.2 Provided with Prophylaxis			4 Voluntary Medical Male Circumcision	
Occupational	HV05-08 (M)		4.1 Number Circumcised	Value
Sexual assault	HV05-10 (M)		0-14	HV04-01
Other reasons	HV05-12 (M)		15-24	HV04-02
Total	HV05-14		25+	HV04-03
			Total (Sum HV04-01 to HV04-02)	HV04-06
6 Blood Safety			4.3 Adverse Events (Circumcision)	
Donated blood units			During -AE(s)- moderate	HV04-10
Blood units screened for TTIs			During- AE(s) – severe	HV04-11
Blood units reactive to HIV			Post-AE(s)- moderate	HV04-12
			Post- AE(s) – severe	HV04-13
			Total AE During (Sum HV04-10 & -11)	HV04-14
			Total AE Post (Sum HV04-12 & -13)	HV04-15

Prepared By: (Name) _____ **(Designation)** _____ **(Signed)** _____

Verified By: (Name) _____ **(Designation)** _____ **(Signed)** _____