

May 2009

**Three Interlinked
Patient Monitoring Systems
for HIV care/ART, MCH/PMTCT
(including malaria prevention during pregnancy),
and TB/HIV: Standardized
Minimum Data Set and
Illustrative Tools**



**World Health
Organization**



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HIV/AIDS
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Table of Contents

1. Figure summarizing flow of data in illustrative inter-linked MCH/ PMTCT and HIV care/ART patient monitoring systems
2. Illustrative maternal card (with HIV elements integrated)
3. HIV elements to integrate into ANC register
4. HIV care/ART card
5. Pre-ART register
6. ART register
7. Labour record (with HIV elements integrated)
8. Partograph¹
9. Postpartum record¹ (with HIV elements integrated)
10. HIV elements to integrate into labour and delivery register
11. HIV elements to integrate into child care card
12. HIV-exposed infant register
13. Cross-sectional quarterly (or monthly) report
14. ART cohort report
15. Figure summarizing flow of data in TB/HIV patient monitoring system
16. Register of TB suspects
17. TB lab register²
18. TB treatment card²
19. District TB register²
20. Quarterly TB case registration report²
21. Quarterly TB treatment outcomes report²

¹ Modified from form in WHO IMPAC PCPNC

² http://www.who.int/dots/_and_t_forms/en/index.html for updated TB card and TB registers

This publication - *Three interlinked patient monitoring systems for HIV Care/ART, MCH/PMTCT and TB/HIV: Standardized minimum data set and illustrative tools* - is based on the original HIV care/ART system that was initially drafted in 2004 and published in 2006 as the *Patient monitoring guidelines for HIV care and ART*.

The 2006 *Patient monitoring guidelines for HIV care and ART* outline a minimum data set and accompanying generic tools for data collection and reporting. More than 29 countries now use an adaptation of this generic system to support their HIV service provision and to provide important programme indicators, with increasing availability of core indicators from a routine, harmonized national system. But experience using the system with expanding treatment cohorts, increasing acceptance of the need to fully integrate PMTCT interventions with MCH service provision, and the need to more fully support and monitor the provision of INH prophylaxis, TB status screening, and TB-ART co-treatment within HIV services have led to collaborative efforts to produce a second version of the HIV care/ART patient monitoring system with an expanded minimum data set and integrated tools.

The 3 interlinked patient monitoring systems build and improve on the original 2006 patient monitoring tools by supporting integrated service provision, follow up of mother-infant pair and monitoring of key TB-related and paediatric variables. The MCH minimum data set includes all routine core maternal and infant variables plus key HIV-related variables. The generic ART cohort report has been simplified and the cross-sectional quarterly report is now integrated to collect not only HIV indicators, but also key PMTCT, MCH and TB/HIV indicators. The generic tools are illustrative, for country adaptation.

The following table lists some of the indicators measured by the system.

Indicators
HIV care¹
Percentage of adults and children enrolled in HIV care and eligible for Cotrimoxazole prophylaxis(CTX) and currently receiving CTX prophylaxis.(UA)
ART
Percentage of people with advanced HIV infection receiving ART (Core , UNGASS ²)
Percentage of patients initiating ART at the site during a selected time period who are taking an appropriate first line regimen 12 months later. (Core, EWI a3)
Percentage of adults and children with HIV known to be on treatment 12 months after initiation of ART (Core , UNGASS)
Drug Resistance Early Warning³
Percentage of patients initiating ART at the site during a selected time period who are initially prescribed, or who initially pick up from the pharmacy, an appropriate first-line ART regimen (EWI a1)
Percentage of patients initiating ART at the site in a selected time period who are lost to follow-up during the 12 months after starting ART (EWI 2)
Reproductive Health⁴
Proportion of women attended, at least once during their pregnancy, by skilled health personnel for reasons related to pregnancy (Indicator 4)
Percentage of liveborn babies who weigh less than 2500g (Indicator 9)
Prevalence of HIV infection in pregnant women (Indicator 16)
Prevention of Mother to Child Transmission⁵
Percentage of pregnant women who were tested for HIV and received their results (Core Indicator , UA)
Percentage of HIV-infected pregnant women who were assessed for ART eligibility through either clinical staging or CD4 testing (Core Indicator)
Percentage of HIV-infected pregnant women who received antiretrovirals to reduce the risk of mother-to-child transmission (Core Indicator , UNGASS , UA)
Percentage of infants born to HIV-infected pregnant women started on CTX prophylaxis within two months of birth (Core Indicator, UA)
Percentage of infants born to HIV-infected women who received an HIV test within 12 months (Core Indicator, UA)
Percentage of HIV-exposed infants who are exclusively breastfeeding, replacement feeding or mixed feeding at 3 months (Core Indicator)
Percent infected infants born to HIV-infected women (Core Indicator, UNGASS, UA)
Malaria During Pregnancy⁶
Percentage of pregnancy women attending antenatal care who receive a first dose of intermittent preventive treatment (IPT1) under direct observation
Percentage of pregnancy women attending antenatal care who receive a second dose of intermittent preventive treatment (IPT2) under direct observation
TB/HIV⁷
Percentage of HIV-positive patients who were screened for TB in HIV care or treatment settings (Indicator B 1.1)
Percentage of HIV-positive patients who received TB treatment (Indicator B.1.2.1)
Percentage of estimated HIV-positive incident TB cases that received treatment for TB and HIV (Indicator B.1.2.2, UNGASS)
Percentage of new HIV- positive patients starting IPT during the reporting period (Indicator B.2.1)
Proportion of TB patients with known HIV status (Indicator C.1.1)
Proportion of all registered TB patients who had documented HIV status recorded who are HIV-positive (Indicator C.1.2.1)
Case-detection rate of TB patients with documented HIV-positive status (Indicator C.1.2.2)
Proportion of HIV-positive TB patients who receive CPT (Indicator C.3.1)
Proportion of HIV-positive TB patients enrolled in HIV care services during TB treatment (Indicator C.4.1)
Proportion of HIV-positive registered TB patients given ART during TB treatment (Indicator C.5.1)

¹ World Health Organization (WHO) *A Guide on Indicators for Monitoring and Reporting on the Health Sector Response to HIV/AIDS*. WHO 2009. (<http://www.who.int/hiv/data/tool2009/en/>)

² UNAIDS. *Guidelines on Construction of Core Indicators: 2008 Reporting*. Geneva, UNAIDS, 2007. (http://data.unaids.org/pub/Report/2007/jc1318_core_indicators_manual_en.pdf)

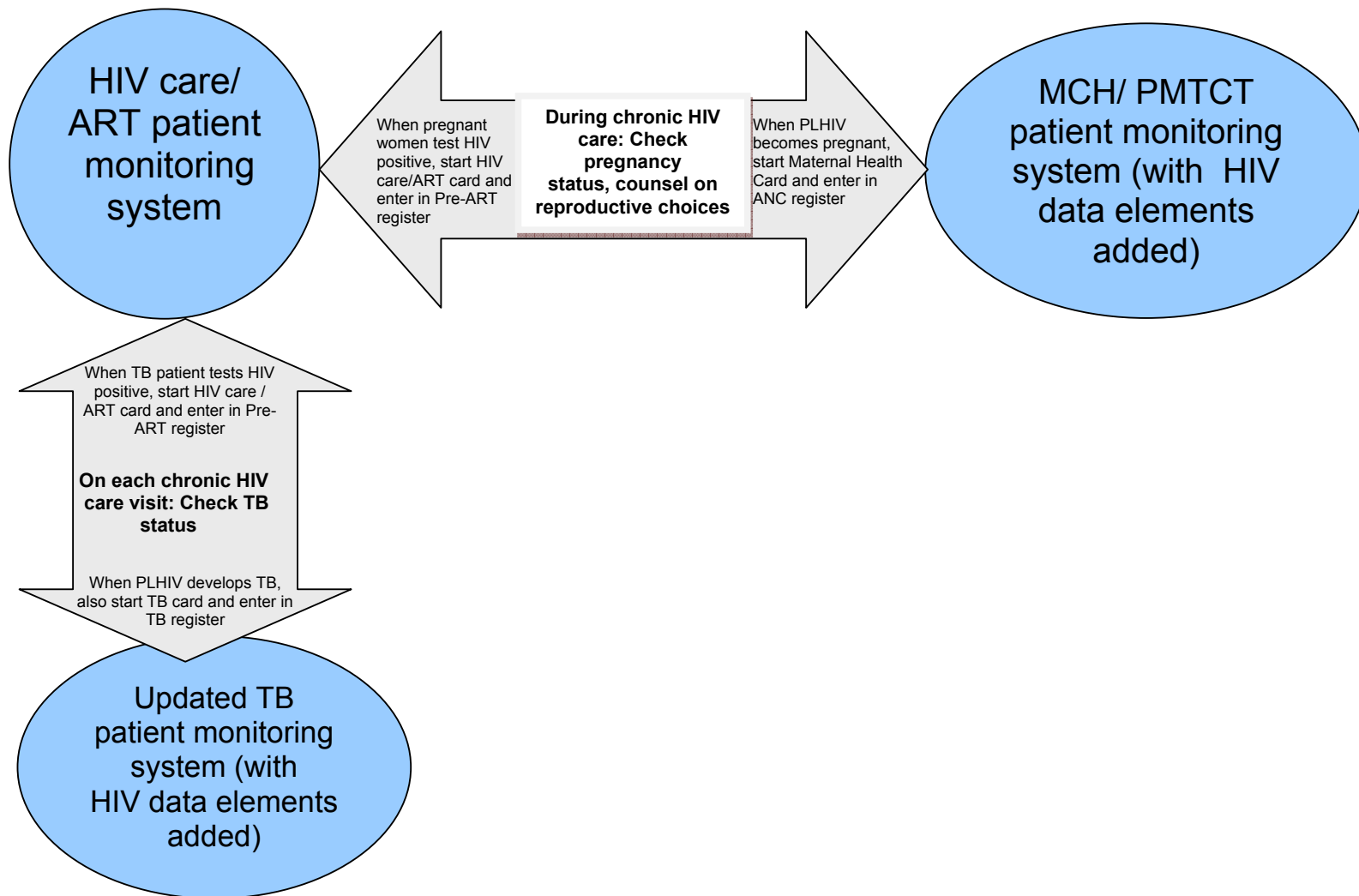
³ World Health Organization (WHO). *HIV Drug Resistance Early Warning Indicators (HIVDR-EWI): WHO-Recommended Set of Indicators for HIV Drug Resistance Prevention in Antiretroviral Treatment Sites*. Geneva, WHO,2008. (http://www.who.int/hiv/topics/drugresistance/hiv_dr_early_warning_indicators.pdf)

⁴ World Health Organization (WHO). *Reproductive Health Indicators: Guidelines for their generation, interpretation and analysis for global monitoring*. Geneva, WHO, 2006. (http://www.who.int/reproductive-health/publications/rh_indicators/index.html)

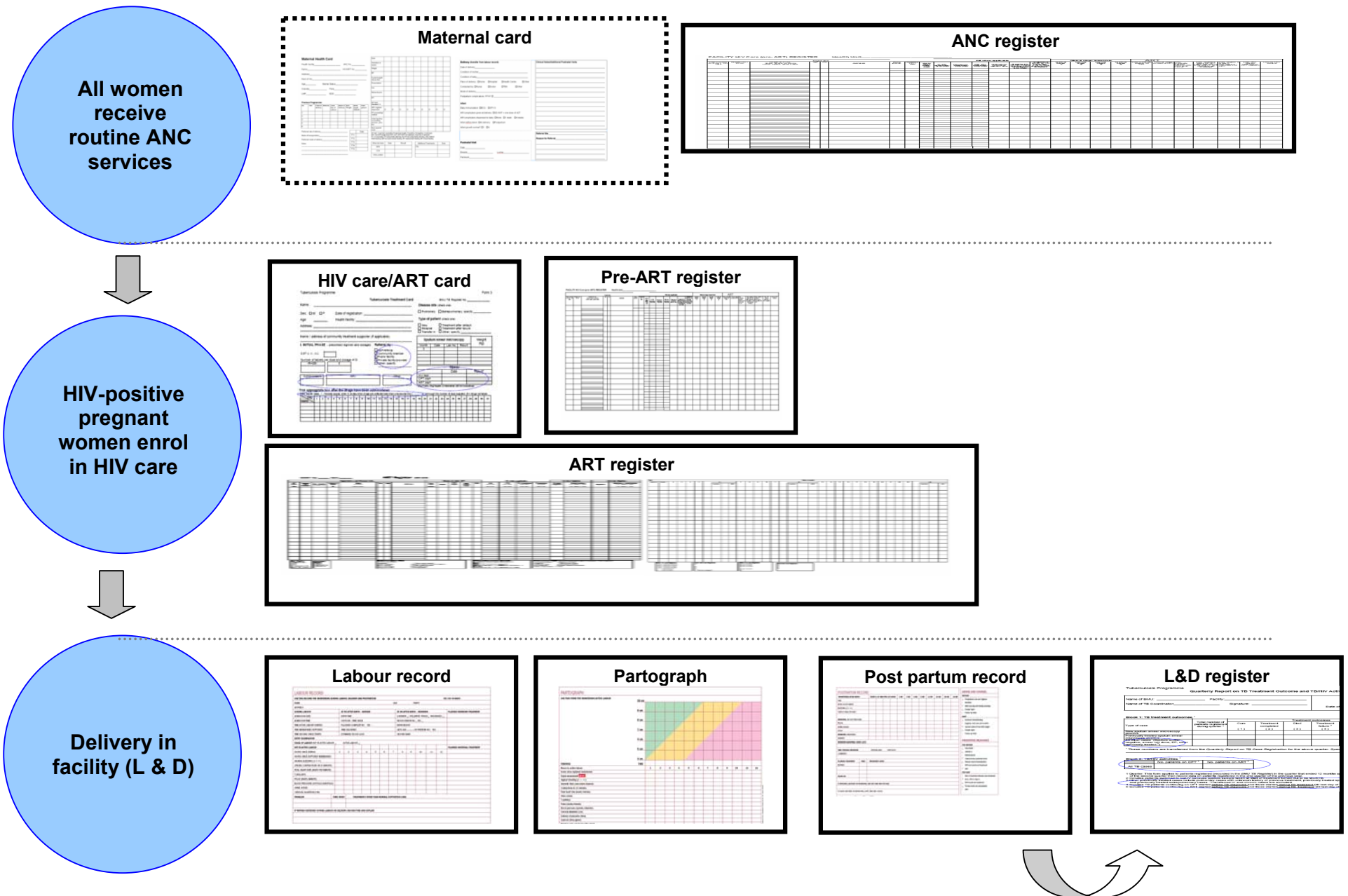
⁵ World Health Organization (WHO). *Guidelines to Monitoring and Evaluating National Programmes for the Prevention of Mother-to-Child Transmission*. Geneva, WHO, 2009.

⁶ World Health Organization (WHO). *Malaria in pregnancy: Guidelines for measuring key monitoring and evaluation indicators*. Geneva, WHO, 2007. (http://www.rbm.who.int/partnership/wg/wg_pregnancy/docs/MIPMEFramework.pdf)

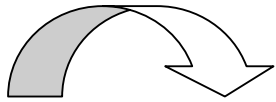
⁷ World Health Organization (WHO). *A guide to monitoring and evaluation for collaborative TB/HIV activities*. Geneva, WHO, 2009.



1. Figure summarizing flow of integrated PMTCT and HIV care/ART patient monitoring systems



1. Figure summarizing flow of integrated PMTCT and HIV care/ART patient monitoring systems



**Postpartum/
Infant follow-up**

**Exposed infant
receives own
HIV care/ART
card and also
followed in
mother's HIV
care/ART card.
Mother's pre-
ART/ART
register entries
linked to infant
follow-up in
HIV-exposed
infant register**

Child health card

HIV care/ART card

Pre-ART register

ART register

HIV-exposed infant register

Legend:

.....	Patient held
————	Facility held

2. Illustrative maternal card (with HIV elements integrated)

Illustrative Maternal Health Card

ANC No. _____	Date enrolled in HIV care _____	Unique HIV care/ART No. _____
---------------	---------------------------------	-------------------------------

Health facility _____

Name _____ Age _____

Address: _____ District: _____ Village _____

Marital Status _____

Gravida _____ Para _____

LMP _____ EDD _____

Contact person/next of kin _____

Preferred site of delivery _____
Mode of transportation _____
Notes _____

History of previous pregnancy and outcome of current pregnancy									
No.	Year	Place of delivery	Gestational age at delivery/abor-tion	History of prolonged labour (Y/N)	Mode of delivery	Birth weight	Sex	Birth outcome: Alive/Stillbirth Fresh/macerated	Serious obstetric complications
1									
2									
3									

2. Illustrative maternal card (with HIV elements integrated)

Antenatal (ANC) → Delivery (circle date) → Postpartum (PP)

		1 st visit	2 nd visit	3 rd visit	4 th visit	5 th visit	6 th visit	7 th visit	8 th visit	9 th visit	10 th visit
Date (dd/mm/yy) of visit, current pregnancy											
Gestation in weeks (ANC)/Weeks postpartum											
Weight											
Blood Pressure											
Fundal ht (ANC)											
Fetal Presentation (ANC)											
Uterus firm (PP)											
WHO clinical stage	ART Eligible? <input type="checkbox"/>										
CD4 (record Sent; result, result given to mother)											
Infant feeding: Counselling (Y/N)											
FP: Counselling ; PP write method or No FP											
ARV adherence counselling (Y/N)											
ARV adherence (Good, Fair, Poor)											
Hgb (record result)											
Blood group and RH (record result)											
Syphilis test result (Positive, Negative, Unknown)											
Syphilis treatment given/No. doses given (IM PCN 1 st , 2 nd or 3 rd)											
Urine protein											
HIV test result (Positive, Negative, Known positive, Unknown)											
Iron folate dispensed (Y/N) and No. dispensed		/	/	/	/	/	/	/	/	/	/
Malaria IPT (1 st , 2 nd , 3 rd dose)											
ARVs dispensed mother (AZT, Sd- NVP, AZT+ 3TC; or ART)											
Next appointment (dd/mm/yy)											

	Date
TT1	
TT2	
TT3	
TT4	
TT5	

Additional interventions	Date
ITN	
CTX started	
INH prophylaxis/ TB Rx started	
Mebendazole	
Vit A (Units)	

2. Illustrative maternal card (with HIV elements integrated)

Labour and Delivery (transfer from labour record)

Infant feeding intention: EBF RF MF

Date of delivery _____

Place of delivery: Home Hospital Health Centre Other _____

Conducted by: Nurse/Midwife Doctor TBA Other

Condition of mother _____

Condition of baby _____

Mode of delivery (indication if operative delivery) _____

Postpartum complications: PPH? _____

ARV given during delivery: Sd- NVP AZT+3TC ART None

ARV tail (AZT 300 mg +3TC 150 mg twice daily x 7 days) dispensed:

Postpartum- mother- outpatient visit

Problem with breast feeding _____

Perineum _____ Lochia _____

Breasts _____

Infant feeding practice: EBF RF MF

Infant

Birth weight _____ Sex: Female Male

Baby Immunization: BCG OPV 0

Vitamin K: Yes No

ARV prophylaxis:

Given at delivery: Sd-NVP AZT first dose

AZT dispensed to baby: None 1 week 4 weeks

Clinical Notes/Additional Postnatal Visits

Referral site _____

Reason for referral _____

2. Illustrative maternal card (with HIV elements integrated)

Instructions for completing the proposed maternal card elements

Recommend that this maternal health card not be surrendered at the end of the postpartum period. Recommend that it be attached to the child health card.

Health facility	Record the name of the facility.
ANC No.	Record the woman's ANC card number .
Name	Record full name of the woman.
Date enrolled in HIV care	Record the date the mother is enrolled in HIV care (dd/mm/yy).
Unique HIV care/ART No.	Record the HIV/ART number if mother is enrolled in HIV care
Address	Record the address of the mother: the district and village name and number (adapt to local context).
Age	Record age in years.
Marital status	Record marital status of the woman: Married, Single, Widow, Divorced.
Gravida	Record number of all pregnancies .
Para	Record number of births (includes still births).
LMP	Record the date (dd/mm/yy) of the last menstrual period.
EDD	Record expected date (dd/mm/yy) of delivery.
Contact person/next of kin	Record the name and phone number of contact person.

Previous pregnancies - suggest also filling out with outcome of current pregnancy (circle current)

Record history of previous pregnancies according to birth order (start with the first pregnancy). Also record outcome of current pregnancy and circle.

- Record year of pregnancy.
- Record place of delivery if pregnancy ended with delivery, record place care was received if pregnancy ended with abortion.
- Record the gestational age in weeks at delivery or at time of abortion.
- Record 'Y' if labour was prolonged(>24hr for 1st pregnancy and >12hrs after the 2nd pregnancy) and 'N' if not.
- Record mode of delivery and the indication if operative delivery : SVD, Assisted vaginal delivery or operative delivery
- Record birth weight in grams.
- Record birth outcome as **Alive** or **Still Birth**. And if still birth **Fresh** or **Macerated**: (**A** or **SB**, **F** or **M**).
- Record any serious life threatening obstetric complications during the pregnancy, delivery, or postpartum period.

Preferred site of delivery	Record the woman's preferred site of delivery for current pregnancy : Health facility, Home.
Mode of transportation	Record the woman's mode of transport to the facility if chooses to give birth at health facility.
TT Dates	Record the actual date (dd/mm/yy) TT immunization administered.

2. Illustrative maternal card (with HIV elements integrated)

Antenatal (ANC) - Delivery- Postpartum (PP) follow-up	
Date	Record the dates (dd/mm/yy) the woman comes to the facility (including for ANC, delivery, and postpartum care). Indicate the date of delivery by circling it.
Gestation in weeks/Weeks postpartum	Record the gestational age in weeks under the corresponding date (to be filled only for pregnant woman), and number of weeks postpartum from delivery.
Weight	Record the weight of the mother under the corresponding date.
Blood Pressure	Record blood pressure of the mother under the corresponding date.
Fundal height (ANC)	Record fundal height in centimeters under the corresponding date (during antenatal care).
Presentation (ANC)	Record fetal presentation: Head, Transverse, Breech.
Uterus firm (PP)	Record Yes if the uterus is firm or No if it is not firm (during postpartum care)
WHO clinical stage	For HIV-positive woman: Record 1, 2, 3 or 4.
CD4	For HIV-positive woman: Record Sent on the date the sample was taken/sent, the CD4 count result when it is available, and Given on the day the result is given to the mother.
ART eligible?	Tick '√' on the box if mother is eligible for ART.
Infant feeding counselling	Record if counselling was done on this visit: Yes or No.
FP: Counselling/Method	ANC: record C if FP counselling was done; postpartum, record method if using- if not, record No FP.
ARV adherence counselling	Record (Y/N) if ARV adherence counselling is done.
ART adherence	If the woman is on ART, record Good if self report is ≤ 3 doses missed /month, Fair if 4-8 doses, or Poor ≥ 9 doses.
Haemoglobin	Record the haemoglobin result in gm/dl.
Blood group and RH	Record result as A [±] , B [±] , AB [±] , O [±] .
Syphilis test result	Record test result: Positive , Negative , Unknown . If available, note RPR titre (e.g. 1:8).
Syphilis treatment	Record if done (Y/N): If yes, note treatment given/dose (e.g. "IM PCN/1", IM PCN/2", etc.).
Urine protein	Record result.
HIV test	Record: Positive, Negative, or Known- HIV-positive (if documented to be positive from a previous test), Unknown (if woman declines testing). If the woman originally declines testing and subsequently accepts to be tested, this result can be replaced.
Iron folate dispensed	Record if iron folate dispensed: Y/N.
Malarial IPT	Record the dose of malaria Intermittent Preventive Therapy (IPT) - 1 st , 2 nd or 3 rd .
ARV regimen dispensed	Record the ARV regimen dispensed (for ART or ARV prophylaxis): AZT, for AZT alone, Sd-NVP, for single dose nevirapine, AZT+3TC, for AZT and 3TC (if dispensed postpartum), or the specific ART regimen.
Next appointment	Record the date for next appointment in the format dd/mm/yy.

Additional interventions	
ITN	Record the date Insecticide Treated Net was provided or woman referred to obtain the net.

2. Illustrative maternal card (with HIV elements integrated)

CTX started	Record date (dd/mm/yy) cotrimoxazole prophylaxis initiated (for HIV-positive woman).
INH prophylaxis/TB Rx started	Record the date (dd/mm/yy) INH prophylaxis or TB Rx is initiated. Circle which one the date refers to. If TB Rx, also record the TB No..
Mebendazole	Record date dispensed.
Vitamin A	Record date dispensed and number of units dispensed.
Other: insert	
Other: insert	

Labour and Delivery	
Infant feeding intention	At delivery: Record EBF if at delivery the woman says she intends to exclusively breast feed, or RF she says she will replacement feed.
Date of delivery	Record the date (dd/mm/yy) of delivery.
Place of delivery	Tick '✓' the appropriate box.
Conducted by	Tick '✓' the appropriate box.
Condition of mother	Record condition of mother at discharge (free text).
Condition of baby	Record condition of baby at discharge: Alive, Dead, or Still birth.
Mode of delivery	Record the mode of delivery and the indication if operative delivery.
Postpartum complication	Tick '✓' if mother had postpartum haemorrhage (PPH), record any other complications.
ARV given during delivery	Tick '✓' the appropriate boxes.
Postpartum - outpatient visit	
Problem with breast feeding	Record problem raised by the mother with breast feeding (free text).
Breasts	Record condition of breasts on corresponding date.
Nipple and areola	Record condition of nipple and areola on corresponding date.
Lochia	Record lochia.
Perineum	Record perineum status.
Infant feeding practice	Postpartum: Record EBF if exclusive breastfeeding, RF if replacement feeding, MF if mixed feeding.
Infant	
Birth weight _____	Record the infant's weight in kg. obtained within 24 hours of birth.
Baby immunization	Tick '✓' the appropriate box for the immunization the baby received.
ARV prophylaxis given at delivery	Tick '✓' the box(es) if baby received sd-NVP and first does of AZT.
ARV prophylaxis dispensed	Tick '✓' the appropriate box.
<p>Record any clinical notes in the clinical notes section. Record the name of the referral site, if appropriate and the reason for referral. The maternal card information can be extracted from the ANC and labour and delivery registers. At maternity ward, it should be filled at discharge of the mother.</p>	

3. Integrated ANC register

Column	Instructions
Admission date	Write in date of enrollment in the ANC (dd/mm/yy).
ANC number	Record the ANC number.
ANC visit number	Circle the appropriate ANC visit number (1, 2, 3, 4+).
Name	Record full name of the women.
Age	Record age in years.
Last menstrual period (LMP)	Record the date of the last menstrual period (dd/mm/yy).
Estimated due date (EDD)	Record expected date of delivery (dd/mm/yy).
Tetanus toxoid dose (TT)	Circle the appropriate number for tetanus toxoid dose (1,2, 3, 4, 5).
Intermittent Preventive Therapy (IPT)	Check the appropriate column (1st, 2nd, 3rd) for the dose of IPT given.
Iron supplementation	Check if iron supplementation for \geq 3months.
Syphilis test result	Record test result: Positive , Negative , Unknown .
HIV status at admission	Check Positive , Negative if HIV status confirmed with documentation upon admission, or Unknown .
HIV tested	Write in date mother HIV tested (dd/mm/yy).
HIV test result	Check Positive or Negative in the appropriate column. Check the "result given" column when the result has been received by the mother.
Partner tested	Check Positive , Negative , Unknown (if partner declines to be tested or did not come for testing) in the appropriate column.

3. Integrated ANC register

ART eligibility assessment	<p>Record date assessed for ART eligibility. If referral out for eligibility assessment, record REFER in this column. Cross check ANC registers with Pre-ART and ART register (in integrated setting); need to use referral form for information sharing across sites in non-integrated settings. Regardless of setting, eligibility assessment results should come back to ANC register so that it can serve as sole source of data for Indicator No.4.</p> <p>Fill in WHO clinical stage and CD4 count. Fill in date CD4 sent above the line and the value, once it is available, below the line. If eligibility assessed more than once and clinical stage or CD4 count changes, replace old values with new values.</p> <p>Circle the value that renders the patient eligible for ART. If patient progresses clinically or immunologically, cross out previous value and replace.</p> <p>Check the “result given” column if mother receives CD4 results.</p>
ARV prophylaxis or ART	Check Sd-NVP for single-dose NVP only; AZT for AZT; and ART for ART.
Enrolled in HIV care	Write in date enrolled in HIV care or ART (dd/mm/yy) and unique HIV care/ART ID No..

4. Facility-based HIV care /ART card

HIV CARE/ART CARD

Status at enrolment: HIV-exposed infant (assign unique ID only once confirmed HIV+) TB Rx Preg Postpartum Other _____

Unique No.

District _____ Health unit _____ District clinician/team _____

Name _____ Pt clinic No. _____

Sex: M F Age _____ DOB _____ Marital status _____

Address _____

Telephone (whose): _____

Treatment supporter/med pick-up if ill: _____

Address _____

Telephone (whose): _____

Home-based care provided by: _____

Family status				
Names of family members and partners	Age	HIV P/N	HIV care Y/N	Unique no.

Exposed infant follow-up						
Exposed infant (Name/No.)	DOB	Infant feeding practice at 3 mos.	CTX started by 2 mos	HIV test Type/Result	Final status	(if confirm +) Unique ID

HIV care	
	Date
Confirmed HIV+ test	/ /
HIV 1 2 Ab/virologic test Where _____	
HIV enrolled	/ /
Medically eligible for ART	/ /
	<input type="checkbox"/> HIV care transfer in from _____ Clinical stage _____ CD4 _____ <input type="checkbox"/> Presumptive clinical diagnosis of severe HIV infection in infant
Drug allergies	Relevant medical conditions

Prior ARVs			
Y(√)	Prior ART	Date	
	None		
	PMTCT only	/ /	Where _____ ARVs _____
	Earlier ARV not transfer in	/ /	Where _____ ARVs _____

ART Care		COHORT: -----/----- month/year
Date		
	/ / / ART transfer in from _____ ARVs _____	
	/ / / Start ART 1st-line initial regimen _____	
	At start ART: Wt _____ Cl. Stage _____ CD4 _____ Preg _____	
	Substitute within 1st-line	
	/ / / New regimen _____ Why _____	
	/ / / New regimen _____ Why _____	
	Switch to 2nd-line (or substitute within 2nd-line)	
	/ / / New regimen _____ Why _____	
	/ / / New regimen _____ Why _____	

ART treatment interruptions -- STOP or missed drug pick-up							
Stop or Lost (circle)	Stop Lost	Stop Lost	Stop Lost	Stop Lost	Stop Lost	Stop Lost	Stop Lost
Date	/ /	/ /	/ /	/ /	/ /	/ /	/ /
Why							
Date if restart							

Status		
	Date	
Dead	/ /	
Transfer out	/ /	Where _____
Lost to follow-up (drop)	/ /	

4. Facility-based HIV care /ART card

Unique No.

HIV CARE/ART CARD

Name _____

Date <small>Check if scheduled. Write in alternate pick-up if ill</small>	Follow-up date	Duration in months since first starting ART/ since starting current regimen	Wt <small>Ht at first visit If child record +/- oedema</small>	Pregnancy/RH-FP choices <small>If child record MUAC Write age in mos. if ≤59 mos</small>	TB status <small>(If TB Rx, record month/year started and TB reg No.)</small>	Potential SIDE EFFECTS	New OI, Other PROBLEMS <small>If child, include nutritional problems</small>	WHO clinical stage	Cotrim-oxazole		INH <small>No. pills dispensed</small>	Other meds dispensed (including nutritional supplements)	ARV drugs (incl. prophylaxis)		Investigations		Refer or consult or link/provide (including nutritional support and infant feeding) <small>If hospitalized, No. of days</small>	HIV Transmission prevention for key population (Check) <input type="checkbox"/> Discordant couple <input type="checkbox"/> MSM <input type="checkbox"/> IDU <input type="checkbox"/> SW <input type="checkbox"/> clients of SW
									<small>Adhere/ Why</small>	<small>Dose/ Days</small>			<small>Regimen/ Dose/ No. days dispensed</small>	<small>CD4 If < 5, record CD4%</small>	<small>Hgb, RPR, CXR, TB sputums, Infant Ab/HIV virologic test, other</small>			
<input type="checkbox"/>																		
<input type="checkbox"/>																		
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4. Facility-based HIV care /ART card

Codes for TB status (check on each visit):
No signs = no signs or symptoms of TB
Suspect = TB refer or sputums sent (Record sputum sent & results in lab column; record referral in Refer col)
Not done (ND) = not assessed for whatever reason
TB Rx = currently on TB treatment. Record month/year started and TB reg No.
 (Record INH in INH col. and TB treatment regimen in Other meds col)

Nutritional support and infant feeding:
 Therapeutic Feeding
 Infant Feeding Counselling (if <2 yrs)
 Nutrition Counselling only (if > 2yrs)
 Food Support
 Infant Feeding Practice on infant cards: **Exclusive Breast Feeding; Replacement Feeding; Mixed Feeding**

Codes for pregnancy/RH-FP choices
P: pregnant. List EDD and ANCNo.. If referred for PMTCT, note in last column.
AB: recent induced abortion. Note when.
MC: recent miscarriage. Note when.
Wants P: wants to become pregnant now or considering; not using FP
Has FP: already using condoms/other FP. Note method(s).
Wants FP: note method(s) provided or referred for. Record referral in last column.
Unable P: thinks she cannot get pregnant
No sex: not sexually active now

Codes for potential side effects or other problems:
 Nausea Rash Headache
 Diarrhoea Anaemia Jaundice
 Fatigue ABdominal pain FAT changes
 BN burning/numb/tingling
CNS: dizzy, anxiety, nightmare, depression

Codes for new OI or other problems:
 Zoster Thrush—oral/vaginal
COUGH* DB difficult breathing
FEVER DEmentia/Enceph
 Weight loss* Pneumonia
 UD urethral discharge
 PID pelvic inflammatory disease
 Ulcers—mouth or other ____
GUD genital ulcer disease
IRIS Immune reconstitution inflammatory syndrome
 Severe Complicated Malnutrition
 Severe Uncomplicated Malnutrition
 Poor Weight Gain
 Symptoms with * are suggestive of TB

HIV-exposed infant final status at 18 months:
DEAD if dead (write in date of death if known)
P if positive **N** if negative and no longer breast feeding
N/BF if negative and still breast feeding
U if status unknown

Why SUBSTITUTE or SWITCH codes:
 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)
Reasons for SWITCH to 2nd-line regimen only:
 8 Clinical treatment failure
 9 Immunologic failure
 10 Virologic failure

Why STOP codes:
 1 Toxicity/side effects
 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
 10 Other (specify)
 11 Excluded HIV infection in infant

Codes for CTX/ART adherence:

Adherence	%	Missed doses per month	
		1x daily dosing	2x daily dosing
G (good)	≥ 95%	<2 doses	≤ 3 doses
F (fair)	85-94%	2-4 doses	4-8 doses
P (poor)	< 85%	≥ 5 doses	≥ 9 doses

Codes for why poor/ fair adherence:
 1 Toxicity/side effects
 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
 10 Inability to pay
 11 Alcohol
 12 Depression
 13 Pill burden
 14 Other (specify)

Codes for HIV prevention interventions for key population :
CC- couple counselling
RR- targeted risk reduction
C- Condom promotion/provision
NSP- Needle and syringe programmes
NSP code is checked for all with access to NSP or have access to sterile injection equipment.
OST- Opioid Substitution Therapy
OST is checked for Opioid substitution therapy or other drug dependence treatment.

Codes for FP methods:

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)	UND = undecided

4. Facility-based HIV care/ ART card

Follow-up education, support and preparation for ARV therapy [to be revised]				
	Date/comments	Date/comments	Date/comments	Date/comments
Educate on basics, prevention, disclosure	Basic HIV and TB 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			
	Child's blood test			
Pro- gression, Rx	Progression of disease			
	Available treatment/prophylaxis			
	CTX, INH prophylaxis			
	Malaria prevention, IPT, ITN			
	Follow-up appointments, clinical team			
ART preparation, initiation, support, monitor, Rx	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			
	ARV support group			
	How to contact clinic			
Home-based care, support	Symptom management/palliative care at home			
	Caregiver booklet			
	Home-based care -- specify			
	Support groups			
	Community support			

4. Facility-based HIV care/ ART card

How to fill out the HIV care/ART card⁸.

There are 3 parts: the summary page, encounter pages, and record of education and counselling.

1. The summary (or "face") page, including the address, sex, other family members, the summary of the patient's HIV care, etc.

- **HIV care/ART card:** Record the number of the HIV care/ART patient card; i.e. 1st, 2nd, 3rd, etc.
- Record **age** at enrollment and **birth date** if possible.
- **Patient numbers:**
 - ❖ **HIV care or ART unique ID number:** This number will be assigned according to the system chosen by your national programme and issued at enrolment into care. In either case, the unique number for every HIV care and ART patient allows the National HIV care and ART Programme to identify and track patients as they move through different facilities and prevents duplication of patient counts. A transferring patient will, therefore, keep this number wherever they go.
 - ❖ The **patient clinic number** field is for other patient ID numbers that an individual may have from having received services at this facility.
 - ❖ HIV-exposed infants do not receive a unique number until confirmed HIV-positive. Record the HIV exposed infant registration number in the patient clinic number filed.

Some items are recorded at first visit but should be updated with any changes: marital status, address, telephone number, treatment supporter information, home-based care provider information, family information and drug allergies.

- **Treatment supporter/med pick-up information.** Fill in as many details about the treatment supporter as possible. Write the person's name and relationship to the patient in parentheses after the name. Write out the address even if it is the same as the patient's, as this information may change and need to be updated.

If the patient has named the treatment supporter as the person who could pick up medications, then circle treatment supporter on the HIV care/ART card.

If the patient is receiving home-based care, fill in the name of the organization providing this care and any contact or identifying information about the organization.

- **Family members and partners:** Record name, age, HIV status (P/N), enrolled in HIV care (Yes or No) and unique ID number (No.) for those also in care.
- **HIV-exposed infant follow-up:** On the mother's card, the boxes are filled in for each infant she gives birth to; on the exposed infant's card, the boxes provide a summary of what should also be recorded in the appropriate columns on the encounter page.
 - ❖ **Exposed infant (Name/No.):** fill in the name of the exposed infant, and an HIV-exposed infant number (not unique ID No. which will be assigned when confirmed HIV+) if available
 - ❖ **DOB:** fill in the infant's date of birth
 - ❖ **Infant feeding practice at 3 mos.:** fill in infant feeding practice at 3 months as **Exclusive Breast Feeding; Replacement Feeding; Mixed Feeding**
 - ❖ **CTX started by 2 mos:** place a check mark (√) in this column if infant was started on cotrimoxazole by 2 months of age
 - ❖ **HIV test type/results:** **AB** (antibody) or **HIV virologic test/ Positive** or **Negative**
 - ❖ **Final status:** Write in the final status of the infant at 18 months of age, if not sooner for dead or positive. Codes for final status are:

⁸ For more detailed descriptions of how to fill in each data element, refer to the *HIV care and ART Patient Monitoring Participant Training Manual*⁸.

4. Facility-based HIV care/ ART card

- **DEAD** if dead (write in date of death if known);
 - **P** if positive (record the infant's unique No. in the family box once it is assigned)
 - **N** if negative and no longer breast feeding
 - **N/BF** if negative and still breast feeding; or
 - **U** if status unknown
- ❖ **(If confirmed HIV+) Unique ID:** Once infant has been confirmed HIV+, assign and record his/her unique ID No.
- **HIV care**
- ❖ **Confirmed HIV+ test:** Record the date the patient was documented HIV+; circle whether type HIV 1 or HIV 2. If the patient is less than 18 months old, circle whether it is an antibody test (Ab) or PCR (virological test). Record where the patient was tested and confirmed HIV+.
 - ❖ **HIV enrolled:** Record the date the patient first enrolls in HIV care at your facility. This applies to both new and transfer patients. If the patient transferred in from another facility before starting ART (pre-ART), check the box and record the name of the transferring facility.

An HIV-exposed infant the infant is given his/her own HIV care/ART card immediately after birth to track CTX provision, HIV testing, etc. The card will be continued if the infant is confirmed positive and closed if the infant is confirmed negative or dead. The infant's card should be kept with the mother's card. The day the infant is confirmed positive, s/he is then formally enrolled in HIV care; given a unique number; and entered in the pre-ART register as an independent patient.

- ❖ **Eligible for ART:** Record the date the patient is medically eligible for ART. Write the clinical stage and CD4 if applicable. If infant is \leq 18 months and a **presumptive clinical diagnosis of severe HIV infection** is made, check this box.
- **Drug allergies:** record drug, type of reaction and date of any allergy and update as needed.
- **Relevant medical conditions:** record any relevant medical conditions as necessary.
- **Status at enrolment:** tick the appropriate box(es) for the patient's status at enrolment in HIV care. Leave blank if none apply.

Summary of ART (right half of summary page).

- **Prior ART:** Tick whether the patient has prior ART experience in the **Y** column. If the patient has no prior ART experience, tick **None**. Tick the **PMTCT only** column for women who took or are on ARV prophylaxis in pregnancy, or an infant born to such women. Record the start date of ARV prophylaxis, the location where it was administered and the drugs for the woman on her own card, or for an HIV-exposed infant on his/her own card.

- **ART care**

- ❖ Tick **earlier ARV not transfer in** if the patient has taken ART before, but is not a transfer in with records i.e. bought ART on his/her own.

As the patient progresses through care, the ARV therapy sequential summary box (the right side of the summary page) needs to be filled in. Fill in the important dates for each step or change in the sequence: **Start ART** first-line → **Substitute** drug (still on ART first-line) → **Switch** to second-line regimen.

- ❖ If **transferred in** from elsewhere on ART, write date of transfer, the location from which the patient transferred in, and the ARV drugs the patient is on (also put the start month/year in the **COHORT** box). Fill in the ART summary from records transferred with the patient.
- ❖ Write **date start ART 1st-line regimen** started; also record the start month/year in the **COHORT** box (to identify ART start-up group) and what the first-line regimen is. Also record the patient's weight, clinical stage, CD4 count and pregnancy status (**PREGnant** or **Post Partum** if delivered within the last 42 days) at the start of ART. For children, you may also add height.

4. Facility-based HIV care/ ART card

- ❖ If a decision is made to **substitute regimens within 1st-line** (due to toxicity) or **switch to second-line** (because of treatment failure), the date of the substitution or switch should be filled in, as well the new regimen. The reason for the regimen change should be recorded using one of the why codes from the list at the bottom of the encounter page.
- **ART Treatment interruptions -- STOP or missed drug pick-up**
 - ❖ **Stop ART or Lost:** If a patient stops ART or is temporarily lost (missed drug pick-up, not just clinical appointment), circle *Stop* or *Lost*, record the date and the reason code for why stopped from the list at the bottom of the encounter page.
 - ❖ If ART is restarted, record the **date of Restart**.
- **Status**
 - ❖ Record date **dead or transfer out:** If the patient dies, the date of death should be recorded before the file is closed. If the patient transfers to another facility, the date of the transfer should be noted, as well as the name of the facility to which the patient is transferring. An effort should be made to send a copy of the patient's record with them. If a patient started on ART is **lost to follow-up** or **dropped** (not seen for 3 months since last missed appointment), record the date.

2. The encounter pages. On these pages, for each visit, one row is filled out.

Each row on the encounter page is to be used for a separate visit (the first row is filled out on the first visit). Photocopied blank encounter pages can be stapled to the original HIV care/ART card when the first one is full.

The following should be checked and recorded at each visit:

- **Date of this encounter with the patient.** If this is a scheduled visit, check the box. If the treatment supporter comes to collect the drugs, you still fill this in as an encounter by writing the date. (In this case the entire row is a non-visit client service, and the name of the treatment supporter or other support person can be entered across the whole row. You want to capture this person's name and contact information especially if it is different/changed from the person identified in the top left section of the summary/face page of the card.)
- **Date for the next follow-up appointment.** Record the date the patient is to return for monitoring, re-supply, or any other reason. In addition, this date should be written down for the patient to take with him or her (on the hand-held patient card or other tool), as well as in a facility appointment book to facilitate follow-up.
- **Duration in months since first starting ART/since starting current regimen.** Write in the number of months the patient has been on ART. If the patient has been on ART for less than one month, record 1 week, 2 weeks or 3 weeks as appropriate. When ART is first started, write "0" in this column. If a patient changes regimens, write a backslash "/" and thereafter, record the number of weeks or months the patient has been on the new regimen (beginning with "0"), while continuing to update the number of months the patient has been on ART in total before the backslash.
- **Patient's weight** in kilograms (kg) and **oedema** (+ or -) if the patient is a child (≤ 59 months).
- **For woman of childbearing age, ask at each visit if the woman:**
 - o *is pregnant now?* If the patient is pregnant, record as 'P', write the estimated delivery date (EDD) in the format dd/mm/yy and **ANC No.** . If referred for PMTCT, note in last column.
 - o *has recent induced abortion.* Record '**AB**' and note when (dd/mm/yy)
 - o *has recent miscarriage.* Record '**MC**' and note when (dd/mm/yy)
 - o *wants to become pregnant now or considering; not using FP.* Record as '**Wants P**'
 - o *already using condoms/other FP.* Record as '**Has FP**' and note method(s)
 - o *wants family planning,* record as '**Wants FP**'; note method(s) provided or referred for. Record referral in the last column.
 - o *thinks she cannot get pregnant,* record as '**Unable P**'
 - o *not sexually active now,* record as '**No sex**'

Checking the pregnancy status of women of childbearing age at each visit is essential for several reasons including: to avoid use of efavirenz (EFV) during the first trimester of pregnancy; and to provide linkages with, or direct provision of, PMTCT interventions. If the patient is pregnant, it is crucial to refer her to PMTCT services, either at your own facility or elsewhere, and record this in this column by writing "**PMTCT**". If the woman is given a special **PMTCT or ANC number**, recorded this here.

Often, there is a return to sexuality in patients on ART as they feel better, and it is important to again discuss safer sex, condom use, dual protection, and plans for childbearing. For all adolescent or adult patients, ask about family planning at each visit. If the patient is on family planning, record the method(s) using the codes below.

4. Facility-based HIV care/ ART card

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)	UND = undecided

For children, use this column to record age in months and Mid Upper Arm Circumference (MUAC).

- **TB status.** Check and record TB status at each visit, using the codes at the bottom of the encounter page. It is important to check and capture the TB status of patients at each HIV care visit. Five to 15% of HIV patients not on ART will develop TB disease each year.⁹ It is therefore essential to check for signs and symptoms of TB, to send sputums, or refer patients promptly for investigation when TB is suspected, and to make sure that these results are used, treatment started promptly, and the doctor consulted on TB-ART co-treatment decisions. Sputum samples that are sent and sputum results should be captured in the *Investigations* column. TB treatment drugs will be recorded in the *Other meds dispensed* column, and INH prophylaxis will be recorded in the *INH* column (see below).

If the patient's TB status is **TB Rx**, also record the TB registration No. and start month/year in the column.

- **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.
- **New opportunistic infection(s) (OI) or other problems.** These can be related to HIV, ART, or be problems of unknown cause. Use the codes at the bottom of the encounter page or write the whole word. If other, write in the diagnosis or new sign or symptom.

If the patient is a child (≤ 59 months), record any nutritional problems in this column using the codes below:

- Severe complicate malnutrition (**SCM**)
- Severe uncomplicated malnutrition (**SUM**)
- Poor weight gain (**PWG**)
- **Clinical stage (1, 2, 3 or 4) of the patient on the day of the encounter.** Refer to chapter 3 of *Chronic HIV Care with ARV Therapy and Prevention* for clinical staging of adolescents and adults, and Chapter 12 for paediatric clinical staging guidelines. Newly revised clinical staging guidelines allow patients on ART to go up or down in clinical stage. Record the clinical stage of ART patients with a 'T' before 1, 2, 3 or 4.¹⁰
- **Adherence and record dispensing of cotrimoxazole.** For cotrimoxazole prophylaxis, record the numeric percentage, or describe adherence as **Good** ($\geq 95\%$ or < 2 doses missed per month), **Fair** (85-94% or 2-4 doses missed per month), or **Poor** ($< 85\%$ or ≥ 5 doses missed per month) based on once-daily dosing. Write this in the Adhere column. Record in the Dose/Days column the number of doses and days dispensed that visit.

Note that dispensing of cotrimoxazole for *treatment* should be recorded in the 'Other meds dispensed' column.

- **INH:** Record INH pills dispensed for TB Preventive Therapy (TBPT).
- **Other meds dispensed (including nutritional supplements):** If the patient is taking medicine other than ARVs, INH, or cotrimoxazole prophylaxis, list the names, doses, and frequency in the *Other meds dispensed* column. This will include the patient's TB treatment regimen. Note the TB regimen. Note start month/year in TB status column on first HIV care/ARV visit after commencing TB therapy.

If the patient is taking any nutritional supplements, capture that in this column.

⁹ World Health Organization. *Guidelines for implementing collaborative TB and HIV programme activities*. Geneva, WHO, 2003 (WHO/CDS/TB/2003.319 and WHO/HIV/2003.01).

¹⁰ World Health Organization. *Antiretroviral therapy for HI infection in adults and adolescents in resource-limited settings: towards universal access- recommendations for a public health approach*. Geneva, WHO, 2006 revision.

4. Facility-based HIV care/ ART card

- **ARV drugs dispensed and Adherence.** In the *Adhere/Why* column, record the numeric percentage, or describe adherence as **Good** ($\geq 95\%$ or ≤ 3 doses missed per month), **Fair** (85-94% or 4-8 doses missed per month), or **Poor** ($< 85\%$ or ≥ 9 doses missed per month) based on twice-daily dosing. For once-daily dosing, use the percentages described above for cotrimoxazole adherence. Use the codes at the bottom of the encounter page to record the most important reason for non-adherence in patients with fair or poor adherence.

Write the full regimen (not the code) and number of doses (quantity of drug(s) prescribed) and for how many days given at this visit in the *Regimen/Dose/No. Days dispensed* column.

If there is a treatment interruption, (ART is stopped or patient is temporarily lost (missed and drug pick-up) record this on the summary page and write 'STOP' or 'LOST' in the ARV drugs column.

In cases where female patients are concurrently receiving ARVs for PMTCT and HIV care (pre-ART), the ARV drugs dispensed should be recorded in the ARV drugs column with "PMTCT" in parentheses.

- **Investigations**
 - ❖ **New CD4 count/percentage:** First write 'Sent' when specimen collected and sent to lab (which may be at another site). Note when the sample was sent, then fill in results when available. If the patient is a child (≤ 59 months) record the CD4% value.
 - ❖ **Hgb, RPR, CXR, TB sputums, Infant Ab/HIV virologic test, other:** Record tests done and results for other investigations
- **Any referrals or consults needed:** 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.

If the patient is being given **nutritional support**, capture this in the referral column using the codes:

- **Therapeutic Feeding** =
 - **Infant Feeding Counselling** (if < 2 yrs) =
 - **Nutrition Counselling only** (if > 2 yrs) =
 - **Food Support** =
 - **Infant feeding practice** in last 24 hours (if < 2 yrs) = **Exclusive Breast Feeding; Replacement Feeding; Mixed Feeding**
- **HIV transmission prevention for key populations: Check the key population box(s) as relevant.**
If patient is provided intervention(s), capture this in column using the codes:
 - **CC-** couple counselling
 - **RR-** targeted risk reduction
 - **C-** Condom promotion/provision
 - **NSP-** Needle and syringe programmes: *NSP code is checked for all with access to NSP or have access to sterile injection equipment.*
 - **OST-** Opioid Substitution Therapy: *OST is checked for Opioid substitution therapy or other drug dependence treatment.*

3. Summary of education and counselling (on back of encounter page)

Follow-up education, support and preparation for ARV therapy page (back side) - COMPLETE AS APPROPRIATE AT EACH FOLLOW-UP VISIT

The back of the HIV care/ART card lets the team keep track of the status of the patient's education, support and counselling. If the patient is a child, the contents of this page may be modified to include only child-relevant information, i.e. remove adult-specific information such as partner disclosure and family planning, and add nutrition support, malaria prevention and other relevant components of the PMTCT package.

4. Facility-based HIV care/ ART card

It is important that you remember to review care and to complete appropriate items with the patient on the back side of the HIV care/ART card at each visit. If there is a counsellor/educator in your clinic, he or she may do much of this. You should also do this with your patients as time permits.

You will not be able to cover every item on every visit. You need to prioritize with each patient the most important points to cover in each visit, based on the patient's clinical and ART history, time available, patient's ability to absorb information, health status, etc.

Example: Education, prevention, post-test counselling, disclosure, family/living situation, reproductive choices, and PMTCT might be covered in an early visit and noted on the card. The other rows would be blank. On the next visit, the remaining items would be covered, and then a determination would be made with the clinical team to assess readiness for ART.

Your notes should be legible so that other team members can understand them. If there is not enough room on the card, attach a separate sheet.

Keep your notes up-to-date. Fill them in while the patient is with you. These are not long notes! You can also write additional information in the patient's exercise book used as a clinical record if he or she has one. However, this is not preserved at the clinic as an ongoing record.

There are three "Date/Comments" columns provided on the card. When you have used all the columns, start a new card and attach it (or a photocopy) to the previous card.

5. Pre-ART register

Registration							Fill when applicable			Clinical stage (check)				PMTCT				ART	
Date enrolled in chronic HIV care	Unique ID No.	Patient clinic ID No.	NAME IN FULL Upper space: surname Lower space: given name	Sex	Age	Status at enrolment (record TI if transfer in)	CTX Start Month/year	INH Start Month/year	TB Rx Start Month/year and TB reg No.	1	2	3	4	For each pregnancy, record EDD, ANC No. and HIV-exposed infant No.				Date medically eligible for ART	Date ART started (transfer to ART register)
														Preg 1	Preg 2	Preg 3	Preg 4		

5. Pre-ART register

Instructions for filling in the pre-ART register

Using the patient HIV care/ART card, enter the following data into the pre-ART register as it becomes available:

First entry into the pre-ART register only

- Facility name
- Date enrolled in chronic HIV care (sequential)
- Unique ID number
- Clinic card number
- Patient name, sex, age, and address
- Status at enrolment (**Pregnant**; **Post Partum**; **TB Rx**; **Other**). If pre-ART transfer in patient, write **TI**.

First entry and update when data change:

- CTX prophylaxis -- record the month/year started
- INH prophylaxis - record month/year started at or during enrolment
- TB treatment – record month/year started and TB registration number if on TB treatment at enrolment or thereafter
- Clinical stage -- check the appropriate clinical stage as the patient's stage changes
- Date: medically eligible for ART
- ART start date.

For each pregnancy during the HIV care/ART follow up:

- EDD - record estimated due date or actual delivery date if postpartum
- ANC No. -- record the woman's ANC number
- HIV-exposed infant No. - record the exposed infant's registration or record number if available.

Quarterly follow-up status. For each quarter, record:

- Last CD4 - last CD4 count/% available in the quarter in top row
- TB status completed at last visit -- **Yes** if TB status was completed at last visit in the quarter, and **No** if otherwise in bottom row
- → -- an arrow indicating the patient did not have a visit scheduled during that quarter
- LOST - not seen during the quarter, but was scheduled for a visit (missed appointment)
- TO - transferred out to another facility, record to where
- DEAD -- record date of death.

6. ART register

Year Write in month															
Write in month															
Month 0	Month 1	2	3	4	5	6				7	8	9	10	11	12
									CD4 <i>No./%</i>						

Adult 1st-line regimens:
 1a = d4T-3TC-NVP
 1b = d4T-3TC-EFV
 1c = AZT-3TC-NVP
 1d = AZT-3TC-EFV
 1e = ...
 1f = ...

Child 1st-line regimens:
 4a = d4T-3TC-NVP
 4b = d4T-3TC-EFV
 4c = AZT-3TC-NVP
 4d = AZT-3TC-EFV
 4e = ...
 4f = ...

Adult 2nd-line regimens:
 2a(250) = ABC-ddl(250)-LPV/r
 2a(400) = ABC-ddl(400)-LPV/r
 2b(250) = ABC-ddl(250)-SQV/r
 2b(400) = ABC-ddl(400)-SQV/r
 2c(250) = TDF-ddl(250)-LPV/r
 2c(400) = TDF-ddl(400)-LPV/r
 2d(250) = TDF-ddl(250)-SQV/r
 2d(400) = TDF-ddl(400)-SQV/r
 2e = ...
 2f = ...

Child 2nd-line regimens:
 5a = ABC-ddl-LPV/r
 5b = ABC-ddl-NFV
 5c = ABC-ddl-SQV/r
 5d = ...
 5e = ...

Follow-up status at end of each month:
 On treatment (current regimen abbreviation)
 DEAD
 STOPped ART (continued on other care)
 LOST (missed drug pick-up)
 DROP (lost to follow-up), not seen 3 months from last missed appointment
 RESTART
 Transferred Out (TO) - if TO, transferred out to where TB status at last visit during the month: Yes or No

6. ART register

Write in months																			
			13	14	15	16	17	18				19	20	21	22	23	24		
		CD4 <i>No./%</i>										CD4 <i>No./%</i>							CD4 <i>No./%</i>

If follow-up status is "STOP", then add reasons (and weeks of interruption if later restarted):

1 Toxicity/side effects 2 Pregnancy 3 Treatment failure 4 Poor adherence 5 Illness, hospitalization 6 Drugs out of stock	7 Patient lack finances 8 Other patient decision 9 Planned treatment interruption 10 Other 11 Excluded HIV infection in infant
---	---

6. ART register

Instructions for filling in the ART register

Once the patient has started on ART, a subset of the information from the HIV care/ART card is entered into the **ART register**.

A patient is put in a cohort based on the year and month he or she started ART, regardless of where the ART was started. Each page of the ART register should only be used for recording/updating information on patients in the same cohort, one row per patient.

The ART register includes the following:

<p><i>Left page for the cohort starting ART within this month:</i></p> <ul style="list-style-type: none"> - Date start ART - Unique ID number, ANC number, patient clinic number - Patient name, sex and age (or date of birth) - Weight, clinical stage and CD4 (if available) at start of ART - INH prophylactic therapy - start month and year - CTX prophylaxis - start month and year - TB treatment - month and year started and TB registration No. - Switch to second-line/substitutions - Reasons for regimen change - ARV regimen: <ul style="list-style-type: none"> o 1st-line regimen: original, substitution with reason and date o 2nd-line regimen: original, switch/substitution with reason and date - For each pregnancy record EDD, ANC no. and HIV-exposed infant No. 	<p><i>Right page:</i></p> <p>Month 0 to 24 - record each month:</p> <ul style="list-style-type: none"> - Current ARV regimen or - Stop - Lost-missed drug pick-up - Drop or Lost to follow-up (LTF) - not seen for 3 months after last missed appointment - Restart, Dead, or Transfer Out - TB status completed (Y/N) <p>At 6, 12, 18 and 24 months:</p> <ul style="list-style-type: none"> - CD4 (if available); if infant CD4% and +/- severe
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7. Labour record

Labour record

USE THIS RECORD FOR MONITORING DURING LABOUR, DELIVERY AND POSTPARTUM													RECORD NUMBER
NAME				AGE			PARITY						
ADDRESS													
DURING LABOUR			AT OR AFTER BIRTH - MOTHER					AT OR AFTER BIRTH – NEWBORN					PLANNED NEWBORN TREATMENT
ADMISSION DATE			BIRTH TIME					LIVEBIRTH <input type="checkbox"/> STILLBIRTH: FRESH <input type="checkbox"/> MACERATED <input type="checkbox"/>					
ADMISSION TIME			OXYTOCIN – TIME GIVEN					RESUSCITATION NO <input type="checkbox"/> YES <input type="checkbox"/>					
TIME ACTIVE LABOUR STARTED			PLACENTA COMPLETE NO <input type="checkbox"/> YES <input type="checkbox"/>					BIRTH WEIGHT:					
TIME MEMBRANES RUPTURED			TIME DELIVERED					GEST. AGE _____ OR PRETERM NO <input type="checkbox"/> YES <input type="checkbox"/>					
			ESTIMATED BLOOD LOSS					SECOND BABY					
TIME SECOND STAGE STARTS			AZT 300MG+3TC 150MG 2X DAILY X 7 DAYS FIRST DOSE TAKEN <input type="checkbox"/> DISPENSED <input type="checkbox"/>					INFANT FEEDING COUNSELLING Y/N INFANT FEEDING PRACTICE EBF <input type="checkbox"/> RF <input type="checkbox"/> MF <input type="checkbox"/>					
ENTRY EXAMINATION													
STAGE OF LABOUR: NOT IN ACTIVE LABOUR <input type="checkbox"/> ACTIVE LABOUR <input type="checkbox"/>													
NOT IN ACTIVE LABOUR													PLANNED MATERNAL TREATMENT
HOURS SINCE ARRIVAL	1	2	3	4	5	6	7	8	9	10	11	12	
HOURS SINCE RUPTURED MEMBRANES													
VAGINAL BLEEDING (0 + ++)													
STRONG CONTRACTIONS IN 10 MINUTES													
FETAL HEART RATE (BEATS PERMINUTE)													
T (AXILLARY)													
PULSE (BEATS/MINUTE)													
BLOOD PRESSURE (SYSTOLIC/DIASTOLIC)													
URINE VOIDED													
CERVICAL DILATATION (CM)													
PLANNED ARV DRUG AND DOSE*													
ARV TIME**													
PROBLEM			TIME ONSET					TREATMENTS OTHER THAN NORMAL SUPPORTIVE CARE					
IF MOTHER REFERRED DURING LABOUR OR DELIVERY, RECORD TIME AND EXPLAIN.													
*ASK IF THE MOTHER HAS TAKEN AZT 600 MG OR SD-NVP AT ONSET OF LABOUR AT HOME, AND RECORD.													
**DURING LABOUR ADMINISTER ONLY 3TC AND ART EVERY 12 HOURS; RECORD TIME DRUG TO BE ADMINISTERED ABOVE THE LINE AND TIME ACTUALLY ADMINISTERED BELOW THE LINE.													

7. Labour record

ARV prophylaxis elements to be inserted into facility labour record

Instructions for completing ARV information in facility labour record

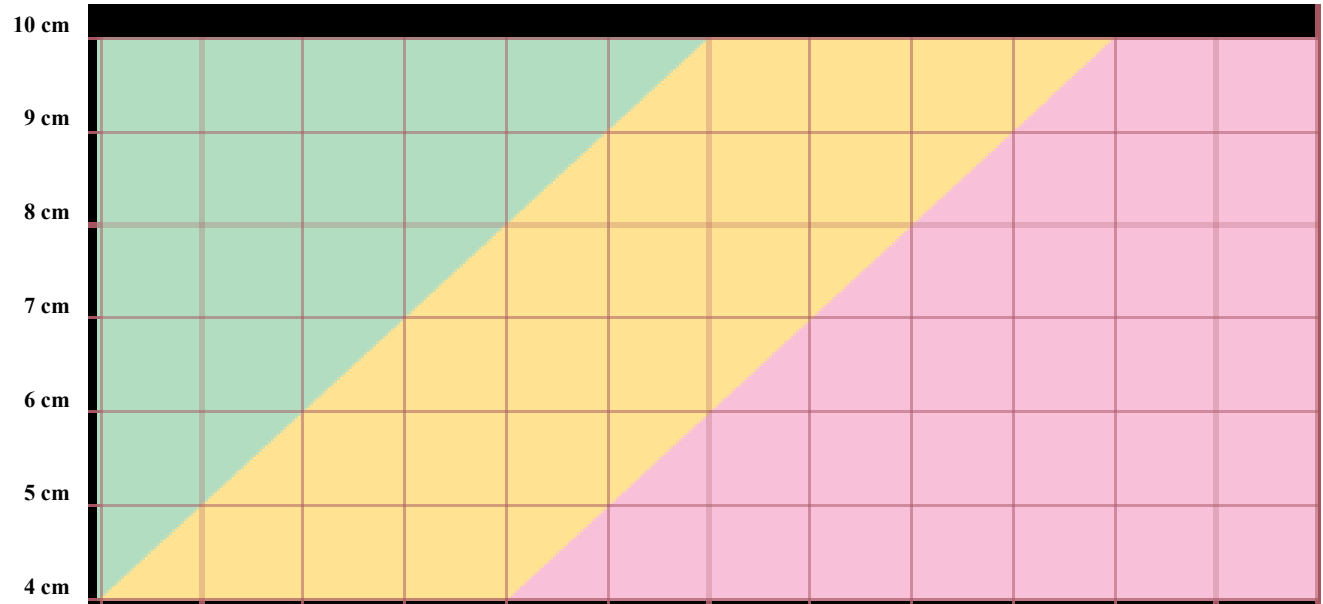
Planned ARV Drug and Dose	Record the name and dose of the ARV drug on the treatment plan to be administered during labour.
ARV Time	Record time the ARV drug will be administered (hh:mm) above the line. Record the actual time the ARV drug is administered during labour (hh:mm) below the line. Note that ARVs may be given every 12-24 hours
Infant feeding counselling	Record whether or not infant feeding counselling is done: Y/N .
Infant feeding practice	Tick '√' the corresponding box: EBF <input type="checkbox"/> if the woman exclusively breast feeds right away postpartum, RF <input type="checkbox"/> if the woman replacement feeds right away postpartum, MF <input type="checkbox"/> if the woman mix feeds right away postpartum.
Prophylaxis tail	Tick '√' the corresponding box if AZT 300mg + 3TC 150 mg twice daily is dispensed and/or first dose is given.

8. Partograph

Partograph

USE THIS FORM FOR
MONITORING ACTIVE LABOUR

Cervical Dilatation



FINDINGS	TIME											
HOURS IN ACTIVE LABOUR	1	2	3	4	5	6	7	8	9	10	11	12
HOURS SINCE RUPTURED MEMBRANES												
RAPID ASSESSMENT												
VAGINAL BLEEDING (0 + ++)												
AMNIOTIC FLUID (MECONIUM STAINED)												
CONTRACTIONS IN 10 MINUTES												
FETAL HEART RATE (BEATS/MINUTE)												
URINE VOIDED												
T (AXILLARY)												
PULSE (BEATS/MINUTE)												
BLOOD PRESSURE (SYSTOLIC/DIASTOLIC)												
CERVICAL DILATATION (CM)												
DELIVERY OF PLACENTA (TIME)												
OXYTOCIN (TIME/GIVEN)												
PROBLEM-NOTE ONSET/DESCRIBE BELOW												

9. Postpartum record

Postpartum record

											ADVISE AND COUNSEL		
Monitoring after birth	1 hour (if complications every 5-15 min)				2 hr	3 hr	4 hr	8 hr	12 hr	16 hr	20 hr	24 hr	MOTHER
Time												<input type="checkbox"/> Postpartum care and hygiene	
Rapid assessment												<input type="checkbox"/> Nutrition	
Bleeding (0 + ++)												<input type="checkbox"/> Birth spacing and family planning	
Uterus hard/round?												<input type="checkbox"/> Danger signs	
Maternal: Blood pressure												<input type="checkbox"/> Follow-up visits	
Pulse												<input type="checkbox"/> ARV adherence (mother and baby)	
Urine voided												BABY	
Vulva												<input type="checkbox"/> Infant feeding	
Newborn: breathing												<input type="checkbox"/> Hygiene, cord care and warmth	
Warmth												<input type="checkbox"/> Special advice if low birth weight	
												<input type="checkbox"/> Danger signs	
												<input type="checkbox"/> HIV testing	
												<input type="checkbox"/> CTX prophylaxis	
												<input type="checkbox"/> Follow-up visits	
Newborn abnormal signs (list)											PREVENTIVE MEASURES		
Feeding observed: Feeding well <input type="checkbox"/> difficulty <input type="checkbox"/>											For mother		
Initial feeding practice: EBF <input type="checkbox"/> RF <input type="checkbox"/> MF <input type="checkbox"/>											<input type="checkbox"/> Iron folate		
Comments											<input type="checkbox"/> Vitamin A		
											<input type="checkbox"/> Mebendazol		
Planned Treatment	Time	Treatment given									<input type="checkbox"/> Sulphadoxine-pyrimethamine		
Mother											<input type="checkbox"/> Tetanus toxoide immunization		
											<input type="checkbox"/> RPR test result and treatment		
											<input type="checkbox"/> ARV		
Newborn											For Baby		
											<input type="checkbox"/> Risk of bacterial infection and treatment		
If referred (mother or newborn), record time and explain:											<input type="checkbox"/> BCG, OPV -0, Hep-0		
											<input type="checkbox"/> RPR <input type="checkbox"/> Positive <input type="checkbox"/> Rx		
If death (mother or newborn), date, time and cause:											<input type="checkbox"/> TB test result and prophylaxis		
											<input type="checkbox"/> ARV prophylaxis		

9. Postpartum record

Instructions for completing HIV-related information in facility postpartum record

Initial feeding practice	Check EBF <input type="checkbox"/> or RF <input type="checkbox"/> or MF <input type="checkbox"/>
Record any HIV-related treatment planned, the time it was actually given, and what was actually given for both mother and baby.	

10. Labour and delivery register

Column	Instructions
Name	Record full name of the women.
Age	Record age in years.
ANC number	Record the ANC number.
Date of delivery	Record the date of delivery in dd/mm/yy format.
Mode of delivery	Record the appropriate number (1. Spontaneous Vaginal Delivery, 2. Assisted vaginal delivery 3. Caesarian section. (indicate if multiple pregnancy, ,and record the mode of delivery as 11, 12).
Obstetrics complications	Record "Y" if there are obstetric complications and "N" if no.
Maternal outcome	Record the maternal outcome as appropriate (1. Stable 2. Referred 3. Died).
Newborn outcome	Record newborn sex (M, F), weight in grams (<2,500 or > 2500) and outcome (1. Term, 2. Preterm and 3. Stillbirth) (indicate if multiple pregnancy, and record the outcome as MF, > 2500 (2X) and 11 ...).
HIV status at admission	Check Positive , Negative or Unknown in the appropriate column.
Previous HIV test date	Write in date HIV tested (dd/mm/yy) if test was done prior to arrival at L & D.
Maternity HIV test result	Check Positive , Negative or Unknown (if woman declines testing) in the appropriate column.
ARV woman took during pregnancy	Write in: AZT ; ART ; or None if none.
Weeks woman took ARV during pregnancy	Write in ≤4 if duration was less than or equal to 4 weeks; write in >4 if duration was greater than 4 weeks.
ARV women took in labour	Write in: NVP if single-dose NVP AZT+NVP+3TC if AZT plus single-dose NVP, 3TC for prophylaxis AZT+3TC if AZT plus 3TC without NVP AZT if AZT only ART if ART None if none.
Infant received NVP	Check if received, if none, write None .
ARV infant discharged with	Check AZT+1 if received 1 week of AZT, AZT+4 if received AZT for 4 weeks in the appropriate column; Write None if did not receive ARV prophylaxis.

10. Labour and delivery register

Infant feeding [practice]	Check the appropriate column EBF if exclusive breastfeeding; RF if replacement feeding; write MF if mixed feeding for infant feeding practice at birth.
Intended family planning method chosen	Write in Y or N .
Referred to HIV care/ ART	Write in: Refer if referred at delivery or discharge or Already in care if the woman was already in HIV care when she arrived for delivery.

11. Child card

Proposed HIV elements to be added to existing child health cards

Date and time of birth	Date: / / Time _____		
Maternal HIV status (<i>circle</i>)	<input type="checkbox"/> P	<input type="checkbox"/> N	<input type="checkbox"/> U
During pregnancy, mother took (<i>check</i>): <input type="checkbox"/> AZT <input type="checkbox"/> ART <input type="checkbox"/> None			
Duration of AZT or ART : <input type="checkbox"/> ≤ 4 wks. <input type="checkbox"/> > 4 wks.			
<input type="checkbox"/> Infant feeding counselling or support at delivery		Newborn feeding practice (<i>circle</i>) EBF RF MF	
Maternal Syphilis status (<i>check</i>)	<input type="checkbox"/> P <input type="checkbox"/> N <input type="checkbox"/> U	<input type="checkbox"/> IM PCN <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> 1 st dose <input type="checkbox"/> 2 nd dose <input type="checkbox"/> 3 rd dose	
During labour, mother took <input type="checkbox"/> AZT <input type="checkbox"/> AZT+ 3TC <input type="checkbox"/> Sd- NVP <input type="checkbox"/> ART <input type="checkbox"/> None			
Postpartum, mother took <input type="checkbox"/> AZT/3TC <input type="checkbox"/> ART <input type="checkbox"/> None			

ARV prophylaxis to newborn	
SD-NVP given	Date: / /
First dose AZT given	Date: / /
AZT dispensed (<i>Tick</i>)	<input type="checkbox"/> None <input type="checkbox"/> 1 week <input type="checkbox"/> 4 weeks
Adherence (<i>Tick</i>)	<input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor

11. Child card

Infant follow-up						
Date	Age in weeks or months	Infant feeding		HIV test		CTX given (√) <i>(start at 4 - 6 weeks, stop when confirmed negative)</i>
		Counselling Support (√)	Practice EBF, RF, MF	Ab or PCR DBS sent? (√)	Result P/ N /U Test result received? (√)	
/ /		<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	
/ /		<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	
/ /		<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	
/ /		<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	
/ /		<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	
/ /		<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	
Infant confirmed HIV-infected? Y <input type="checkbox"/> N <input type="checkbox"/>			Date infant enrolled in HIV care/ART _____			
			Unique HIV care/ART No.: _____			
Action(s) needed _____						

11. Child card

Instructions for Completing HIV Information on Child Health Card

Maternal HIV status	Circle P if HIV-positive, N if HIV-negative, U if HIV status is unknown because mother is not present, (e.g. infant is an orphan), or mother's status is not known for another reason (declined testing, etc.).
Maternal syphilis status	Check " P " if syphilis test positive, " N " if syphilis test negative, " U " if syphilis test status is unknown because mother is not present, (e.g. infant is an orphan) or mother's status is not known for another reason (declined testing, etc.).
Syphilis treatment mother took during pregnancy	Tick " Y " if IM penicillin given and " N " if no treatment for syphilis, and No. doses received (i.e., 1 st , 2 nd , 3 rd doses).
Date and time of birth	Record date (dd/mm/yy).
Newborn feeding practice	Circle the method of infant feeding the woman practised at the child's birth. EBF (exclusive breastfeeding) RF (replacement feeding) MF (mixed feeding, breast milk and other fluids).
Infant feeding counselling or support	Tick '√' the box if infant feeding, counseling or support was provided to the mother at delivery.
ARVs mother took during pregnancy	Tick '√' the box AZT , ART or None .
Duration ARVs taken during pregnancy	If the woman took ARVs during pregnancy, Tick '√' if ARVs were taken ≤ 4 weeks or >4 weeks.
ARVs mother took during labour	Tick '√' AZT , AZT+ 3TC , Sd- NVP , ART , if taken or None .
ARVs mother took postpartum	Tick '√' AZT/3TC or ART if taken, or None .

ARV prophylaxis to newborn

SD-NVP given	Tick '√' if NVP given.
Date SD-NVP given	Record date (dd/mm/yy).
First dose AZT given	Tick '√' if the first dose of AZT given.
Date first dose AZT given	Record date (dd/mm/yy).
AZT dispensed	Tick '√' 1 week or 4 weeks if AZT dispensed, tick '√' none if none.
Number of weeks AZT dispensed	If AZT was given, circle if given for 1 week or 4 weeks .
Adherence	Assess adherence at 6th week immunization visit or earlier. Record Good if self report is ≤ 3 doses missed.

11. Child card

	/month, Fair if 4-8 doses, or Poor \geq 9 doses or to be determined nationally
--	--

Infant Follow-Up

Record date (dd/mm/yy) and age of child (write "weeks" or "months") for each of the following:

Infant feeding, counselling and support	Tick '√' if the mother received infant feeding counselling and support.
Infant feeding practice	Write in the type of infant feeding the woman is practising. EBF (exclusive breastfeeding), RF (replacement feeding), MF (mixed feeding, breast milk and other fluids). Exclusive breastfeeding is applicable only until infant is 6 months of age.
HIV test	Write in the type of test: Ab (antibody HIV test) or PCR . Check DBS (PCR using dried blood spot) if the dry blood spot has been sent.
HIV test result	Write in the HIV test result: Positive , Negative or Unknown .
CTX	Tick '√' if the infant was provided cotrimoxazole (CTX). CTX should be started at 4 - 6 weeks, and stopped when the infant is confirmed negative.
Infant confirmed infected?	Circle Y (yes) or N (no) - this should correspond to the final status decision at 18 months.
Date infant enrolled in HIV care/ART	If infant confirmed HIV-infected, record date (dd/mm/yy) enrolled in HIV care/ART and given unique HIV care/ART number (note that infant will already have an HIV care/ART card appended to mother's card if she is alive, but not enrolled or given unique number until HIV infection confirmed).
Unique HIV care/ART No.:	Write in the infant's unique HIV care/ART No..
Action(s) needed	Write in any action needed and recommended (regarding nutrition, adherence, etc.).

12. HIV-exposed infant register

"HIV-Exposed" infant Registers

EDD Date of delivery (dd/mm/yy)	HIV-exposed infant registration No.	Mother's unique HIV care/ART No.	Name	Duration ARVs during pregnancy	Infant ARV prophylaxis	Infant feeding practice within last 24 hours at DPT3 visit	Age in wks./mos. started CTX	Test/Retest					Date enrolled in HIV care, unique No.	Final Status (Dead Positive N N/BF Unknown)
								Date dd/mm/yy	Age in wks/mos.	Ab or PCR	Result (P or N)	Result given		

Codes for ARV during pregnancy
 None
 AZT<4
 AZT>4
 ART<4

Codes for infant ARV prophylaxis
 None
 AZT+1
 AZT+4
 Sd-NVP

Codes for Infant feeding practice
 EBF
 RF
 MF

12. HIV-exposed infant register

Instructions for completing the HIV-exposed infant register elements

Column	Instructions
Date of delivery	Write in date of delivery (dd/mm/yy).
HIV-exposed infant registration No.	Write in HIV-exposed infant registration number as relevant (this is different from the unique ID No. given upon confirmation of HIV-positive status and enrolment into care and treatment -- see column No.13).
Mother's unique HIV care/ART No.	Write in mother's unique HIV care/ART No. if she is enrolled in HIV care or ART.
Name of the infant	Write first and last name.
Duration of ARVs during pregnancy	Write in: None for none taken. AZT≤4 for ≤ 4weeks of AZT AZT>4 for more than 4 weeks of AZT; ART≤4 for 4 or less weeks of ART ART>4 for more that 4 weeks of ART.
Infant ARV prophylaxis	Write in: None for none taken AZT+1 for Sd-NVP plus 1 week of AZT AZT+4 for Sd-NVP plus 4 weeks of AZT Sd-NVP for single-dose NVP alone.
Infant feeding practice within 24 hours at last time seen at 3 months	Write in: EBF if exclusive breastfeeding RF if replacement feeding MF if mixed feeding For infant feeding practice reported within last 24 hours at last time seen at or around 3 months (DPT3 visit). Provider should ask "what/how did you feed your baby in the last 24 hours?".
Age started CTX	Write age in weeks or months when cotrimoxazole prophylaxis initiated, specify "wks." or "mos."
Test/Retest (information regarding 1st test above the line, information regarding 2nd test below the line)	
Date	Write in date HIV tested (dd/mm/yy).
Age in weeks/months	Write in age at test in weeks or months, specify "wks." or "mos.".
Ab or PCR	Write in Ab if antibody test; PCR if PCR test.
Results P/N	Write in P for positive result; N for negative result.
Result given	Check the "result given" column when the result has been received.
Date enrolled in HIV care, unique No.	If confirmed positive, write date enrolled in HIV care (dd/mm/yy) in the upper cell, and unique HIV care/ART ID number in the lower cell. Transfer patient to pre-ART register.
Final status	Write in the final status at 18 months, if not sooner for dead or positive: Dead if dead P if positive N if negative and no longer breast feeding N/BF if negative and still breast feeding; or U if status unknown. If dead, write in date of death if known.

Reporting period:	Year:
MOH or Project or Grantee:	Facility:
Location:	Country:

1. Pre-ART - new and cumulative number of persons enrolled in HIV care				
	Cumulative number of persons ever enrolled in HIV care at this facility at end of the previous reporting period	New persons enrolled in HIV care at this facility during the reporting period	Cumulative number of persons ever enrolled in HIV care at this facility at end of the current reporting period	Percentage (%)
Males (>14 years)	a.	b.	c.	c/o x 100
Females (>14 years)	d.	e.	f.	f/o x 100
Boys (0-14 years)	g.	h.	i.	i/o x 100
Girls (0-14 years)	j.	k.	l.	l/o x 100
Total	m.	n.	o.	
Subset of those newly enrolled in HIV care				
Pregnant		p.		
Started INH prophylaxis during the reporting period		q.		
Already enrolled in HIV care who transferred in from another facility during the reporting period		r.		
Subset of those cumulatively enrolled in HIV care				
Total number of persons who are enrolled and eligible for ART but have not been started on ART				s

2. Pre-ART - seen for HIV care during the reporting period		
Pre-ART persons seen for HIV care during the reporting period (total)	a.	
Subset of those seen during the reporting period		Percentage (%)
TB status assessed at last visit	b.	b/a x 100
TB treatment started during the reporting period	c.	c/a x 100

3. ART - new and cumulative number of persons started on ART				
	Cumulative number of persons ever started on ART at this facility at the end of the previous reporting period	New persons started on ART at this facility during the reporting period	Cumulative number of persons ever started on ART at this facility at end of the current reporting period	Percentage (%)
Males (>14 years)	a.	b.	c.	c/r x 100
Females (>14 years)	d.	e.	f.	f/r x 100
Children (5-14 years)	g.	h.	i.	i/r x 100
Children (1-4 years)	j.	k.	l.	l/r x 100
Children (< 1 year)	m.	n.	o.	o/r x 100
Total	p	q.	r.	100

4. ART - current on ART - based on age at start ART				
ARV regimen at end of reporting period	Male	Female	Total	Percentage (%)
On 1st-line ARV regimen				
Adults (>14 years)	a.	b.	c.	c/ag x 100
Children (5-14 years)	d.	e.	f.	f/ag x 100
Children (1-4 years)	g.	h.	i.	i/ag x 100
Children (< 1 year)	j.	k.	l.	l/ag x 100
Total Adults and children on 1st-line regimens	m.	n.	o.	o/ag x 100
Percentage (%)	m/ag x 100	n/ag X 100	o/ag x 100	
On 2nd-line ARV regimen				
Adults (>14 years)	p.	q.	r.	r/ag x 100
Children (5-14 years)	s.	t.	u.	u/ag x 100
Children (1-4 years)	v.	w.	x.	x/ag x 100
Children (< 1 year)	y.	z.	aa.	aa/ag x 100
Total Adults and children on 2nd-line regimens	ab	ac	ad	ad/ag x 100
Percentage (%)	ab/ag x 100	ac/ag x 100	ad/ag x 100	
Adults and children on 1st & 2nd-line regimens (Total current on ART)	ae	af	ag	100
Percentage (%)	ae/ag x 100	af/ag X 100	100	
Subset of those current on ART				
TB status assessed at last visit during the reporting period			ah	ah/ag x 100
TB treatment started during the reporting period			ai	ai/ag x 100

5. Antenatal care		
	Total	Percentage(%)
New ANC clients during reporting period	a.	
Known HIV-positive at arrival during reporting period	b.	$b/a \times 100$
HIV tested and received results during reporting period	c.	$c/a \times 100$
HIV tested positive and received results during reporting period	d.	$d/a \times 100$
Total known status (b+c)	e.	$e/a \times 100$
Total HIV-positive pregnant women (b+d)	f.	$f/a \times 100$
Total assessed for ART eligibility by CD4 or clinical staging	g.	$g/f \times 100$
Total received maternal ARV prophylaxis or ART during the reporting period (latest)*	h.	$h/f \times 100$
Received Sd-NVP only during the reporting period*	i.	$i/f \times 100$
Received AZT during the reporting period*	j.	$j/f \times 100$
Received ART during the reporting period*	k.	$k/f \times 100$
Received IPT1 (malaria) during the reporting period	l.	$l/a \times 100$
Received IPT2 (malaria) during the reporting period	m.	$m/a \times 100$
Received four or more ANC visits	o.	$o/a \times 100$
Received Hb test	p.	$p/a \times 100$
Total women screened for syphilis at least once at any visit	q.	$q/a \times 100$
Total women positive for syphilis test	r.	$r/a \times 100$
Received iron supplements (for at least three months)	s.	$s/a \times 100$

* Facilities will report on ARVs received at ANC in settings with low rates of facility delivery, **OR** L & D in settings with high rates of facility delivery.

6. Labour and delivery		
	Total	Percentage(%)
Delivered in the facility	a.	
Normal vaginal delivery	b.	b/a x 100
Assisted vaginal delivery	c.	c/a x 100
Delivered by Caesarean section	d.	d/a x 100
Delivery outcome - live baby	e.	e/a x 100
Delivery outcome - still birth	f.	f/a x 100
Of live births, newborn birth weight ≥2,500gms.	g.	g/e x 100
Of live birth newborn birth weight < 2,500 gms.	h.	h/e x 100
Arrived at the facility due to labour and delivery complications	i.	
Complications managed/referred from the facility	j.	
Known HIV-positive at arrival during reporting period	K.	k/a x 100
Pregnant women seen in L & D with unknown HIV status who were HIV tested and received results during reporting period	l.	l/a x 100
HIV tested positive and received results in L & D during reporting period	m.	m/a x 100
Total HIV-positive pregnant women (k+m)	n.	n/a x 100
Total received maternal ARV prophylaxis or ART during the reporting period (latest)*	o.	o/n x 100
Received Sd-NVP only during the reporting period*	p.	p/n x 100
Received AZT during the reporting period*	q.	q/n x 100
Received ART during the reporting period*	r.	r/n x 100
Received Active Management of Third Stage of Labor *	s.	s/a x 100
Newborns with complications managed/referred from the facility	t.	

7. HIV-exposed infants		
	Total	Percentage(%)
Total HIV-Exposed Infants turned 12 months of age in the reporting period	a	
Total received HIV test by 12 months	b	b/a x 100
Received HIV virological test by 2 months	c	c/a x 100
Of those HIV virological test at 2 months those positive		
Received initial virological test between 3-12 months	d	d/a x 100
Received rapid HIV antibody test before 12 months	e	e/a x 100
Total HIV-Exposed Infant received DPT3	f	f/a x 100
Total feeding practices assessed at DPT3	g	g/a x 100
Was exclusively breastfed at DPT3	h	h/f x 100
Was replacement fed at DPT3	i	i/f x 100
Was mixed fed at DPT3	j	j/f x 100
Total HIV-Exposed Infants turned 2 months in the reporting period	k	
Started on CTX by 2 months	l	l/k x 100
Total HIV-Exposed Infants turned 18 months in the reporting period	m	

HIV positive	n	$n/m \times 100$
HIV negative and breast feeding	o	$o/m \times 100$
HIV negative and no longer breast feeding	p	$p/m \times 100$

Instructions for tabulating the quarterly (or monthly) cross-sectional report

At the end of the quarter (or month), some of the information in the registers will be tallied and recorded on the **cross-sectional report**. This report provides some of the required indicators for the national programme or donors, such as:

- New and cumulative number of persons enrolled in HIV care
- Number enrolled and eligible but not yet started on ART
- New and cumulative number of persons on ART.

The cross sectional report captures the values for these indicators at one point in time - the end of the reporting period, either the month or the quarter depending on the country's system.

Using two people -- one to read out the register data and the other to record and tally them -- may facilitate the counts needed disaggregated by sex, age and pregnancy status in Tables 1, 2 and 4.

Table 1. HIV care (non-ART and ART)—new and cumulative number of persons enrolled.

Column 2 of table 1: **Cumulative number of persons ever enrolled in HIV care at this facility at end of the previous reporting period.** Go back to last reporting period's report to find this information. Transfer the data from table 1, column 4, cells "c-o", into column 2 of this month's report (cells "a-m" of this report).

Column 3: **New persons enrolled in HIV care at this facility during the reporting period.** Go to the pre-ART register and look at the first column *Date enrolled in chronic HIV care*. Count the number of patients who enrolled in HIV care during the reporting period, from the first to the last day. You should count every patient, even if they have died, been lost to follow-up or transferred out. If they already started on ART, they should still be counted as newly enrolled in HIV care at this facility during the reporting period.

You should both count the total, then tally the patients into the age/sex/pregnancy categories (using an enlarged version of the cross-sectional report form or similar tally tool), making sure that each person is only in one category.

The pre-ART register includes the age, sex and pregnancy status of the patient, so you have all the information needed to do this tally. Remember that you only tally those who enrolled in the reporting period - either the quarter or the month. The cumulative at the end of the previous reporting period can be obtained from last reporting period's report.

Column 4: **Cumulative number of persons ever enrolled in HIV care at this facility at the end of the current reporting period.** Add the numbers in cells across the rows as follows:

- Add cells "a" and "b" and write the total in cell "c"
- Add cells "d" and "e" and write the total in cell "f"
- Add cells "g" and "h" and write the total in cell "i"

Add cells "j" and "k" and write the total in cell "l"
Add cells "m" and "n" and write total in cell "o".

Last quarter you vertically added up cells "a" to "j"- this total is "m"- this gives you the total cumulative number of persons ever enrolled as of end of the previous reporting period.

This reporting period you vertically add up the new patients in cells "b" to "k"—this gives the total new persons in the current reporting period, "n".

If you add this reporting period's cumulative ever enrolled totals vertically, from "c" to "l", you get "o", the current cumulative number of persons ever enrolled in HIV care at your facility to date.

You can check your work by making sure that if you add "m" and "n" (going across the row), that you also get the same total "o".

Total number of pregnant females newly enrolled in HIV care at this facility during the reporting period (cell "p")

Go to the pre-ART register and look at the first column *Date enrolled in chronic HIV care*. Count the number of pregnant females who enrolled in HIV care during the reporting period, from the first to the last day.

Total number of newly enrolled patients in HIV care who started INH prophylaxis at this facility during the reporting period (cell "q")

Go to the pre-ART register and look at columns *Date enrolled in chronic HIV care and INH start month/year*. Of those patients newly enrolled in HIV care, count those who started on INH prophylaxis during the reporting period.

Number of persons already enrolled for HIV care who transferred in from another facility during the reporting period. (Cell "r").

Look through the pre-ART register pages for the reporting period. Patients who have transferred in will have "TI" (for "transfer in") in the margin to the left of their date of enrollment in chronic care (which is their date of enrollment in chronic care at your clinic). Count the number of patients who have these "TI" entries during the previous reporting period. Enter the total into cell "q" on the form.

Total number of persons who are enrolled and medically eligible for ART but have not been started on ART (cell "s")

This information comes from the pre-ART register. Do not count those that have started on ART, or those who have died, transferred out or been lost to follow-up before starting ART. Tally those who are eligible and have not started, regardless of whether or not they are ready for ART. In places with a rationed amount of ART, "r" is also known as the "waiting list".

Cell "r" is an updated total based on those patients who become newly eligible, and those who are no longer eligible because they started ART, or are no longer seen during the reporting period. Unlike the rest of Table 1, column 4, it is not a cumulative total of patients who become newly eligible for ART during the previous reporting period. Without the help of a tallying tool, it is necessary to page through the entire pre-ART register to tally current enrolled and eligible but not yet started on ART because people are moving into and out of this status all the time.

With a simple tallying tool such as the one provided below, you can simply update any patients who become newly eligible for ART during the new reporting period by tallying them in the left column (these will be additions to previous quarter's total), as well as those patients who have since started

ART, died, been lost to follow-up or transferred out in the previous quarter (these will be subtractions from the total). By keeping this simple tool next to the pre-ART register, and updating it when relevant, it will be possible to add newly eligible (5 in the example below) and subtract those who are no longer eligible (1 in the example below) to the previous reporting period's total (X in the example below) to come up with a new total (X+4 in the example below) without going through the entire pre-ART register every reporting period.

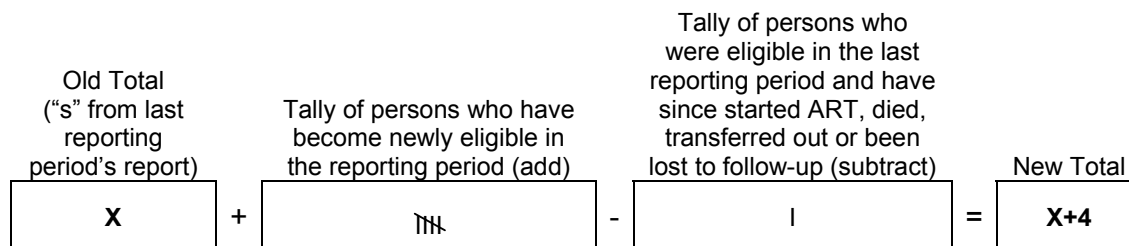


Table 2. Pre-ART -seen for HIV care during the reporting period (Cell "a")

Go to the pre-ART register and look at the quarterly follow up status column. Count all patients seen during the reporting period, excluding those who started ART in the last quarter.

Pre-ART with TB status assessed during the last visit in the reporting period

Go to the pre-ART register and look at the quarterly follow-up status column. Count all patients with TB status assessed at the last visit during the reporting period, excluding those who started ART in the last quarter.

Pre-ART with TB treatment started during the reporting period

Go to the pre-ART register and look at columns for *quarterly follow up status and TB RX start month/year*. Count those who started on TB RX during the reporting period, including newly enrolled patients in the reporting period already on TB Rx.

Table 3. ART care—new and cumulative number of persons started

This table is designed to report information on patients who started on ART at a facility. Please note that those patients who are on ART and were enrolled in the programme at another facility, i.e. the transfer-in patients below the line in each cohort in the ART register, should *not* be included in the “Cumulative number of persons ever started on ART at this facility” because **they have already been counted in the programme at the other facility**.

As in Table 1, counting patients starting on ART needs to be tallied broken down into categories (disaggregated): sex and age.

Column 2: **Cumulative number of persons ever started on ART at this facility at the end of the previous reporting period.** Go back to last reporting period's report and transfer this information (from column 4, cells “c”- “o”), into column 2, cells “a”- “m” of this report. Do not recount.

Column 3: **New persons started on ART at this facility during the reporting period.** This information can be found in the ART register.

The ART register is organized by month—everyone on a large double page (two A3 sheets, with one row per patient) was started in the same month. If more than 20 patients are started in a month, or the country decides to adapt an ART register that covers more than two years, there will be more than one

double page for that month. Go to the ART register and count the number of patients who started ART during the previous reporting period. Do this for cohorts who started ART during all months of the reporting period if the reporting period is longer than a month.

You should count the total (cell “q”), then tally the number of persons in each category (using an enlarged version of the cross-sectional report form or some other tally sheet), making sure that each person is in **only** one category:

- Male > 14 years (cell “b”)
- Female > 14 years (cell “e”)
- Children (5-14 years) (cell “h”)
- Children (1- 4 years) (cell “k”)
- Children (< 1 year) (cell “n”)

Check your math again, making sure the numbers in cells “b”- “n” equal the value in cell “q”.

Column 4: **Cumulative number of persons ever started on ART at this facility at the end of the current reporting period.** Add the numbers in cells *across* the rows as follows:

Add cells “a” and “b” and write the total in cell “c”
Add cells “d” and “e” and write the total in cell “f”
Add cells “g” and “h” and write the total in cell “i”
Add cells “j” and “k” and write the total in cell “l”
Add cells “m” and “n” and write the total in cell “o”

Last quarter you vertically added up cells “a” to “m”—this total is “p”. This gives you the total cumulative number of persons ever started on ART as of the end of the previous reporting period.

This reporting period, you vertically add up the new patients in cells “b” to “n”. This gives the total new persons during the reporting period, “q”.

If you add this reporting period's cumulative ever started on ART totals vertically, from “c” to “o”, you get “r”, the current cumulative number of persons ever started on ART at your facility to date.

You can check your work by making sure that if you add “p” and “q” (going across the row), that you also get the same total “r”.

Table 4. ARV regimen at end of the reporting period (Total current on ART)

This table includes information about the number of persons on 1st-line and 2nd-line (and higher) ART regimens at the **end** of the reporting period, and is sorted by age groups (adults > 14 years and children 5-14, 1-4 and <1) and sex. This information is found in the ART register. Tally the regimen codes listed in the column for the **last month** (end) of the reporting period. This will be the third month of the quarter if reporting is quarterly.

Even if a patient substituted or switched regimens during the reporting period, you will still only count the regimen recorded in the last month of the reporting period. You will need to tally up the regimen codes by sex and age group from all of the ART register pages using the sex and age columns.

To facilitate adding up these results from multiple ART cohorts, you can enlarge the cross-sectional report form to use as a tally sheet.

After you have done the tallies, convert the tally to numbers. Then add up the totals across the rows and vertically.

The total number of adults and children on first-line and second-line regimens will equal the **Total current on ART** (cell "ag"). This is the numerator for the UNGASS and National Core 7 indicators, *percentage of people with advanced HIV infection receiving antiretroviral combination therapy*.

Current on ART with TB status assessed during the last visit in the reporting period

For those current on ART, count all patients with TB status assessed in the last visit during the reporting period.

Current on ART with TB treatment started during the reporting period

For those current on ART, go to the ART register and look at column *TB Rx start month/year*. Count those who started on TB Rx during the reporting period, including patients started on ART in the reporting period already on TB Rx.

Table 5. Antenatal care

This table is designed to report information about pregnant women who are enrolled in ANC at a facility. Please note that this report is for ALL pregnant women in ANC.

New ANC clients during reporting period (a)

Count all new clients enrolled in ANC during the reporting period.

Known HIV-positive at arrival during reporting period (b)

For those who enrolled in ANC during the reporting period, count all HIV-positive women at arrival.

HIV tested and received results during reporting period (c)

Count all pregnant women who were not known to be HIV-positive at enrolment to ANC, who were tested for HIV and received their result during the reporting period.

HIV tested positive and received results during reporting period (d)

Of pregnant women who were not known to be HIV-positive at enrolment in ANC and who were tested for HIV and received their results during the reporting period, count all those HIV-positive.

Total known status (e =) b+c

Count all those who were known to be HIV-positive at enrolment, and those who were tested for HIV and received their results in ANC during the reporting period.

Total HIV-positive pregnant women (f) = b+d

Count all those who were known to be HIV-positive at enrolment, and those who tested positive for HIV and received their results in ANC during the reporting period.

Total assessed for ART eligibility by CD4 or clinical staging

For those HIV-positive pregnant women in ANC, count all who have been assessed for ART eligibility during the reporting period.

Total who received maternal ARV prophylaxis or ART during the reporting period (latest)

For HIV-positive pregnant women in ANC, count all who received ARV prophylaxis or ART during the reporting period (h), and count those who:

- **Received Sd-NVP only during the reporting period (i)**
- **Received AZT during the reporting period (j)**
- **Received ART during the reporting period (k).**

For all pregnant women in ANC, count those who:

- **Received IPT1 (malaria) during the reporting period (l)**
- **Received IPT2 (malaria) during the reporting period (m)**
- **Received four or more ANC visits (o)**
- **Received Hb test (p)**
- **Total women screened for syphilis at least once at any visit (q)**
- **Total women positive for syphilis test (r)**
- **Received iron supplements for at least three months (s).**

Table 6. Labour and delivery

Delivered in the facility (a)

Count all mothers who delivered a newborn at the facility during the reporting period. Then count those delivered by::

- **Normal vaginal delivery (b)**
- **Assisted vaginal delivery (c)**
- **Caesarean section (d).**

For deliveries at the facility during the reporting period, count all with a delivery outcome:

- **live baby (e)**
- **still birth (f).**

Of the live deliveries at the facility during the reporting period, count all newborn with:

- **birth weight $\geq 2,500$ gm (g)**
- **birth weight $< 2,500$ gm (h).**

Arrived at the facility due to labor and delivery complications
Complications managed/referred from the facility

Known HIV-positive at arrival during reporting period (k)

For all mothers delivered at the facility in the reporting period, count all with a known HIV-positive result at arrival.

Pregnant women seen in L & D with unknown HIV status who were HIV tested and received results during reporting period

Count all pregnant women seen in L & D with unknown HIV status who were tested for HIV and received their result during the reporting period.

HIV tested positive and received results in L & D during reporting period

Of pregnant women who were seen in L & D with unknown HIV status, and who were tested for HIV and received their result during the reporting period count all of those who were HIV-positive.

Total HIV-positive pregnant women (k+m)

Count all women who were known to be HIV-positive at arrival at L & D, and those who tested positive for HIV and received their results in L & D during the reporting period.

Total received maternal ARV prophylaxis or ART during the reporting period (latest)

For HIV-positive pregnant women in L & D, count all who received ARV prophylaxis or ART during the reporting period () and count those who:

- Received Sd-NVP only during the reporting period
- Received AZT during the reporting period
- Received ART during the reporting period.

Received active management of third stage of labour

For all who delivered in the facility count those who received active management of third stage of labour.

Newborns with complications managed/referred from the facility**Table 7. HIV-exposed infants****Total HIV-Exposed Infants who turned 12 months of age in the reporting period**

Count all HIV-exposed infants who turned 12 months in the reporting period.

Total who received HIV test by 12 months

For HIV-exposed infants who turned 12 months in the reporting period, count all who received any HIV test. Then disaggregate this by those who:

- Received HIV Virological test by 2 months
- Received initial virological test between 3-12 months
- Received rapid HIV antibody test before 12 months.

Total HIV-Exposed Infant received DPT3

Count all HIV-exposed infants who received DPT3 during the reporting period.

Total feeding practice assessed at DPT3

For HIV-exposed infants who received DPT3 in the reporting period, count all whose feeding practice was assessed. In addition, or those with feeding practice assessed, count all who were:

- **Exclusively breastfed at DPT3**
- **Replacement fed at DPT3**
- **Mixed fed at DPT3.**

Total HIV-Exposed Infants who turned 2 months in the reporting period

Count all HIV-exposed infants who turned 2 months in the reporting period.

Started on CTX by 2 months

For HIV-exposed infants who turned 2 months in the reporting period count all who received CTX.

Total HIV- Exposed Infants who turned 18 months in the reporting period

Count all HIV- Exposed infants who turned 18 months in the reporting period

HIV Positive

For HIV-Exposed infants who turned 18 months count all who confirmed HIV positive

HIV negative and breast feeding

For HIV-Exposed infants who turned 18 months count all who are HIV negative and breast feeding

HIV negative and no longer breast feeding

For HIV-Exposed infants who turned 18 months count all who are HIV negative and no longer breast feeding

ART cohort report

	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 Jul 07	6 mo- Jan 08	12 mos. Jul 08	24 mos.- Jul 08	Cohort Aug 07	6 mos.- Feb 08	12 mos. Aug 08	24 mos.- Aug 08	Cohort Sep 07	6 mos.- Mar 08	12 mos.- Sep 08	24 mos.- Sep 08	Cohort Oct 07	6 mo- Apr 08	12 mos. Oct 08	24 mos.- Oct 08	Cohort Nov 07	6 mo-s. May 08	12 mos. Nov 08	24 mos.- Nov 08	Cohort Dec 07	6 mo-s. Jun 08	12 mos. Dec 08	24 mos.- Dec 08
G	Started on ART at 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 appropriate 1st-line regimen																								
I	On original non-appropriate 1st-line regimen																								
J	On alternate appropriate 1st-line regimen (Substituted)																								
K	On alternate non-appropriate 1st-line regimen (Substituted)																								
L	On 2nd-line regimen (Switched)																								
	Stopped																								
	Died																								
	Lost																								
	**Lost to Follow-up (DROP)																								
	Percent of cohort alive and on ART [(H + I + J + K + L) / N * 100]																								
	Total on appropriate 1st-line regimen (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 < 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	
	CD4 median or fraction ≥200 (of adults with available CD4 - optional)																								

ART cohort report

Instructions for tabulating the ART cohort report

On a monthly or quarterly basis, information from the ART register will be summarized on the **ART cohort analysis form** by the facility team for cohorts that have reached 6 or 12 months on ART, then for every year of completion of ART.

At 6 months, 12 months and then yearly the following indicators are tracked:

- Alive and on ART
- On original first-line
- Substituted to alternate first-line
- Switched to 2nd-line (or higher)
- Dead, Drop, Transfer Out, Stopped ART
- CD4 median or ≥ 200
- % children CD4% not severe.

These cohort data are verified and collected on an annual (or more frequent) visit by the district management team (see Roles and Responsibilities in the Operations Manual; Annual Patient Monitoring Review is described in a separate document). These reports are then collected by or sent to the district.

How to tally information on the cohort analysis report

Fill out the grey baseline data column for each ART cohort (start-up group) at the end of the month. The next column is for results at 6 months. In a new programme, you will not be reporting cohort results until at least 6 months into your scale-up work.

Note that baseline refers to the point in time when the patient starts ART -- **anything** that happens thereafter (transfer out, substitution or switch, stop, etc.) will be recorded in the 6-month column. This means that there are several cells that will not need to be filled out and remain blank, or have 0 values at baseline including transfer in, transfer out, substitute, switch, stop, dead and drop.

Fill in the number of persons started on ART in this clinic – original cohort (G). This is a simple tally of the number of patients in the ART register who started ART in that month at that facility. This number does not change, and can be carried over to the 6-, 12- and 24-month columns for that cohort. In the example shown below, in January your clinic started 13 patients on ART. The number of patients in the **original cohort** will not change. In the example below, **G** will also be 13 at 6, 12 and 24 months.

Count transfer in (TI) patients. 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 retroactively entered in the ART register under this line according to their ART start date. For example, in the ART register below, one patient transferred in during the month of March, but her start date was in January. She is therefore entered below the line of all patients who started ART in January at that facility. However, patient outcome data should not be entered retroactively on the second page (right-hand side) of the ART register, with the possible exception of at 6, 12, 24, etc. months. The first column that should have data recorded will be for the month in

ART cohort report

which the patient transferred to the facility. In the example below, the first entry is for March for the patient who transferred in during March. This will therefore be recorded in the 6-month column of the cohort analysis. You will also include this person as a transfer in at 12 and 24 months. This will enable you to see *when* the patient transferred into your facility and record this in the appropriate column in the cohort analysis form as a transfer in.

As described above, at baseline it is too early for anyone to transfer in or out. At 6 months and thereafter, count the number of patients below the line for each ART start-up group, and enter this number in the **Transfers In** row.

Count transfer out (TO) patients. Patients who transfer out of the facility will be noted by a **TO** in the monthly follow-up status cells on the right-hand side 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. For example, the second patient in the ART register shown below transferred out in June.

Calculate the net current cohort (N). Take the number of patients in the original cohort, add the transfers in and subtract the transfers out to get the net current cohort.

Count patients on original appropriate first line regimen(J): The original 1st-line regimen is recorded in its own column on the left-hand side of the ART register. This will be the baseline from which to compare subsequent 6-, 12- and 24- month reported regimens. At 6, 12 and 24 months, compare the reported regimen in the follow-up status cells to the original 1st-line regimen column, and record the number of patients who are still on the regimen noted in the original 1st-line regimen column. At baseline, most patients will have started ART on the original 1st-line regimen.

"Appropriate first line regimen" is a first line regimen included in national guidelines for first-line ART, or meeting WHO recommendations for first-line ART. For patients with a regimen code representing a standard first-line regimen, classify as "appropriate". For regimens with a code of "other", retrieve the ART card and classify the regimen as appropriate if it meets national or WHO criteria for a first-line regimen; otherwise classify as "not appropriate". (**Original non-appropriate 1st line regimen- I**)

Count patients on appropriate alternate 1st-line regimen (substituted) (J). Substitutions are noted in the substitutions column on the left-hand side of the ART register. They will also be recorded in the monthly follow-up status cells. Compare the regimens noted in the original 1st-line regimen column with the regimen recorded in the 6-, 12- or 24- month follow-up status cells, and count the number of patients who have since substituted 1st-line regimens. For patients with a regimen code representing a standard first-line regimen, classify as "appropriate". For regimens with a code of "other", retrieve the ART card and classify the regimen as appropriate if it meets national or WHO criteria for a first-line regimen; otherwise classify as "not appropriate". (**Substitute/Alternate non-appropriate 1st line regimen-K**)

Count patients on a 2nd-line regimen (switched) (L). Similar to substitutions, switches are noted in the switches column on the left-hand side of the ART register, as well as in the monthly follow-up status cells.

Count patients who stopped, died or dropped. Count the number of patients who have recorded STOP, DEAD, or DROP in the monthly follow-up status cells during the previous 6-, 12- or 24- month reporting periods. At baseline, there will be no patients in these cell.

ART cohort report

For those patients recorded as **dropped** and who missed their last appointment after the 9th month of initiating ART, to verify if they haven't been seen ≥ 90 days, go back to the HIV care/ART card and verify. This is important as the exact day of the missed appointment is not recorded in the ART register and knowing this relevant to calculate HIVDR EWI.

Count patients who were lost. Count the number of patients who have recorded LOST in the monthly follow-up status cells at 6, 12 or 24 months. At baseline, there will be no patients in these cells. These patients are counted to ensure completeness in counting; however, they are not analysed subsequently.

Calculate the per cent of the cohort alive and on ART $[(H+I+J+K+L)/N*100]$. This is a simple calculation using the data you have just collected in the rows above. At baseline, this percentage will always be 100.

Calculate the CD4 count proportion < 100 [of those with available CD4 count at baseline]. CD4 counts are optional for facilities where CD4 counts are available. In many clinics, patients are started without a baseline CD4.

Calculate the fraction of children <5 years old with CD4 % $< 15\%$ [of those with available CD4 count at baseline].

Calculate the CD4 count median or proportion ≥ 200 [of those with available CD4 count] (optional). CD4 counts are optional for facilities where CD4 counts are available. In many clinics, patients are started without a baseline CD4.

Alternatively, because the median value of numerous values can be cumbersome to calculate manually, if there are many CD4 counts available, the proportion of CD4 counts ≥ 200 can be calculated. The numerator is the number of patients with CD4 equal to or greater than 200 at the relevant time period. The denominator is the number of patients with available CD4 counts during that same time period.

NB: If proportions are used, it is important to show both the denominator and the numerator in order for district coordinators to be able to aggregate these data later on.

In the cohort analysis report, you will be recording the most recent patient outcome that occurred over the last 6, 12 or 24 months. Transfer in and dead patients will always be counted across columns (cumulative). However, transfer out patients may return, in which case they will stop being counted as transfers out once they do return (the most recent outcome). They will just remain in the original cohort and be included in the net current cohort. The same applies for patients who DROP, STOP, or change regimens. They will be counted as such until a more recent event occurs. For example, a patient who is dropped at month 4 will be recorded as such in the month 6 column. If, by month 8 s/he returns, she will be recorded as RESTART (with regimen code), and will be counted in row H, I, J, K or L and no longer as a DROP. Similarly, for regimen changes, you will record only the most recent change. For example, when reporting 12-month outcomes for a cohort, if a patient substitutes from 1a to 1b at Month 7, then switches from 1b to 2a at Month 8, you will record this as a *switch* to second-line regimen, and NOT as a substitution so you do not count this patient twice.

14. ART cohort report

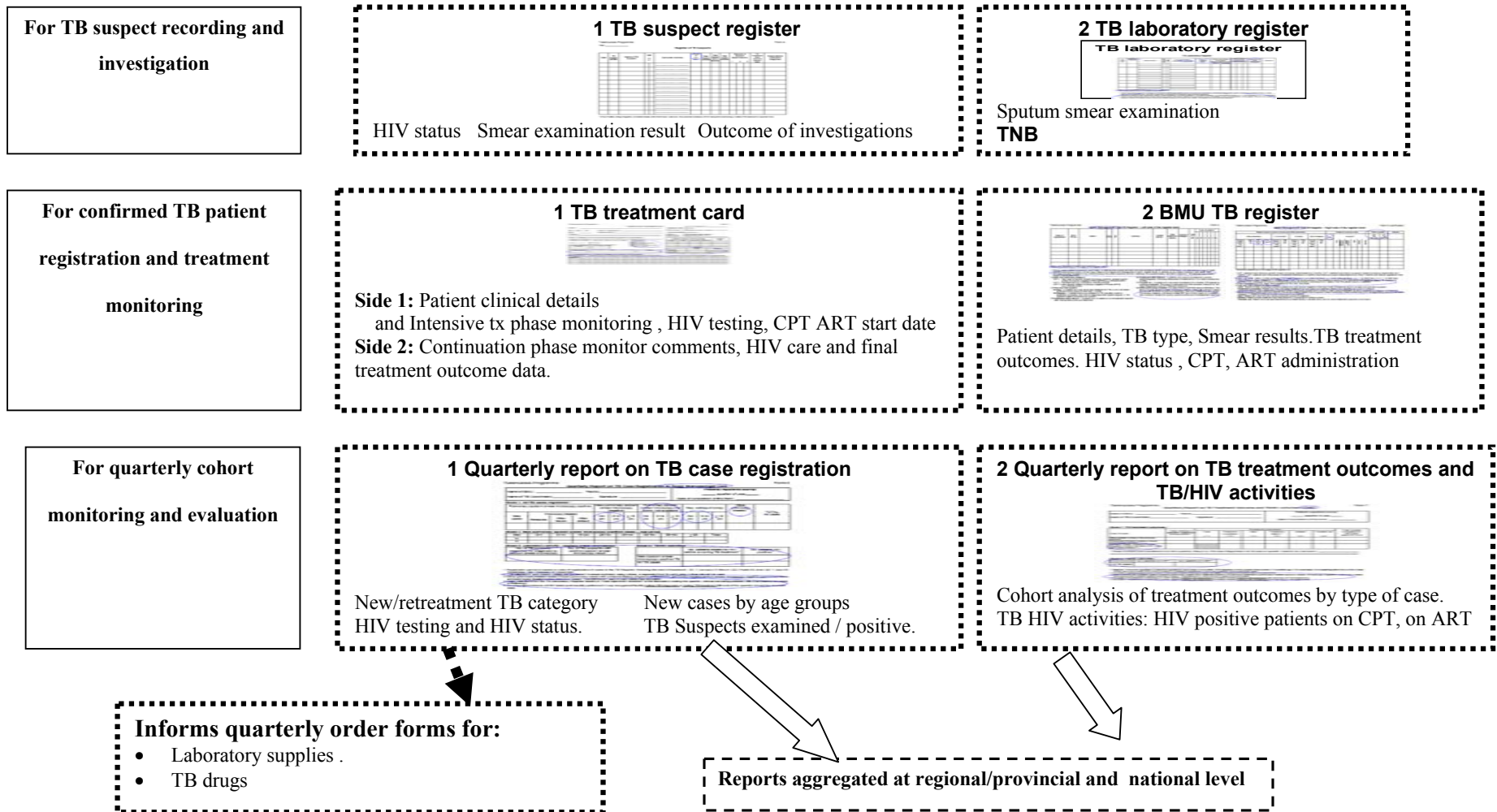
Baseline data of cohort starting ART in January, 2007

6-month outcome data of cohort starting ART in January, 2007

Baseline data of cohort starting ART in February, 2007

	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 07	6 m July 07	12 mo-Jan08	24 mo-Jan09	Cohort Feb07	6 mo-Aug 08						
G	Started on ART at this clinic - original cohort	13	13										
TI	Transfers in Add +	X	1			X							
TO	Transfers out Subtract -	X	1			X							
N	Net current cohort	13	13										
H	On original appropriate 1st-line regimen	13	8										
I	On original non-appropriate 1st-line regimen		1										
J	On alternate appropriate 1st-line regimen (Substituted)												
K	On alternate non-appropriate 1st-line regimen (Substituted)												
L	On 2nd-line regimen (Switched)		1										
	Stopped		1										
	Died		1										
	Lost		0										
	Lost to Follow-up (DROP)		1										
	Per cent of cohort alive and on ART [(H + I + J) / N * 100]	100%	77%										
	Fraction with CD4% <15% (of children <5 with available CD4 - optional)												
	Fraction with CD4<100(of adults with available CD4 at baseline)												
	CD4 median or proportion ≥ 200 [of those with available CD4] (optional)	50	NA										

15. Figure summarizing flow of data in TB/HIV patient monitoring system



16. TB suspects register

Year _____

Date	TB Suspect Number	Name of TB Suspect	Age		Complete Address	Result of HIV test *	Date sputum collected	Date sputum sent to laboratory	Date results received	Results of Sputum Examinations			TB Treatment Card Opened (record date)	Observations/ Clinician's Diagnosis
			M	F						1	2	3		

* (Pos) Positive; (Neg) Negative; (I) Indeterminate; (ND) Not Done/unknown. Documented evidence of HIV test performed during or before TB treatment is reported here.

18. TB treatment card

BMU TB Register No. _____

Name: _____

Sex: M F Date of registration: _____

Age: _____ Health facility: _____

Address: _____

Name / address of community treatment supporter (if applicable)

I. INITIAL PHASE - prescribed regimen and dosages

CAT (I, II, III):

Number of tablets per dose and dosage of S:

(RHZE)	S
<input type="text"/>	<input type="text"/>

Cotrimoxazole	ARV	Other
<input type="text"/>	<input type="text"/>	<input type="text"/>

Referral by :

- Self-referral
- Community member
- Public facility
- Private facility/provider
- Other, specify _____

Disease site (check one)

- Pulmonary
- Extrapulmonary, specify _____

Type of patient (check one)

- New
- Relapse
- Transfer in
- Treatment after default
- Treatment after failure
- Other, specify _____

Sputum smear microscopy				Weight (kg)
Month	Date	Lab No.	Result	
0				

TB/HIV		
	Date	Result*
HIV test		
CPT start		
ART start		

* (Pos) Positive; (Neg) Negative; (I) Indeterminate; (ND) Not Done/unknown

Tick appropriate box after the drugs have been administered

Daily supply: enter . Periodic supply: enter X on day when drugs are collected and draw a horizontal line (—●—) through the number of days supplied. ∅ = drugs not taken

Day / Month	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31

18. TB treatment card

II. CONTINUATION PHASE

Number of tablets per dose

(RH)	(RHE)	Other

Daily supply: enter ✓ . Periodic supply, enter X on day when drugs are collected and draw a horizontal line (———●) through the number of days supplied. Ø = drugs not taken

Day Month	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	

X-ray (at start)
Date: _____
Results (-), (+), <i>ND</i>

HIV care
Pre ART Register No. _____
CD4 result _____
ART eligibility (<i>Y/N/Unknown</i>) _____
Date eligibility assessed _____
ART Register No. _____

Comments: _____

Treatment outcome
Date of decision _____
<input type="checkbox"/> Cure
<input type="checkbox"/> Treatment completed
<input type="checkbox"/> Died
<input type="checkbox"/> Treatment failure
<input type="checkbox"/> Default
<input type="checkbox"/> Transfer out

Name and address of contact person: _____

19. District TB register- left side of the register book

Date of registration	BMU TB No.	Name	Sex M/F	Age	Address	Health facility ¹	Date treatment started	Treatment category ²	Site P / EP	Type of patient ³						
										N	R	F	D	T	O	

Footnotes appearing on first page of the register only.

1 Facility where patient's treatment card is kept. In case several copies are kept, the most peripheral facility should be entered. Use standardized type of health facilities according to block 2 of the *Yearly Report on Programme Management in BMU*. Health facility is defined as any health institution with health-care providers formally engaged in any of the following TB control functions (DOTS): referring TB suspects/cases, laboratory diagnosis, TB treatment and patient support during treatment.

2 Enter the treatment category:

CAT I: New case of sputum smear microscopy positive, severe sputum smear microscopy negative PTB & EPTB e.g. 2(RHZE)/4(RH)

CAT II: Re-treatment e.g. 2(RHZE)S/1(RHZE)/5(RHE)

CAT III: New sputum smear microscopy negative PTB and EPTB e.g. 2(RHZE)/4(RH).

3 Tick only one column:

N = New – A patient who has never had treatment for TB or who has taken anti-tuberculosis drugs for less than 1 month.

R = Relapse – A patient previously treated for TB, declared cured or treatment completed, and who is diagnosed with bacteriological (+) TB (sputum smear microscopy or culture).

F = Treatment after failure – A patient who is started on a re-treatment regimen after having failed previous treatment.

D = Treatment after default – A patient who returns to treatment, positive bacteriologically, following interruption of treatment for 2 or more consecutive months.

T = Transfer in – A patient who has been transferred from another TB Register to continue treatment. This group is excluded from the *Quarterly Reports on TB Case Registration and on Treatment Outcome*.

O = Other previously treated – All cases that do not fit the above definitions. This group includes sputum smear microscopy positive cases with unknown history or unknown outcome of previous treatment, previously treated sputum smear microscopy negative, previously treated EP, and chronic case (i.e. a patient who is sputum smear microscopy positive at the end of re-treatment regimen).

19. District TB register- right side of the register book

Results of sputum smear microscopy and other examination										Treatment outcome & date						TB/HIV activities		Remarks	
Before treatment				2 or 3 months ¹		5 months		End of treatment		Date	Outcome ⁵						ART Y/N Start date	CPT Y/N Start date	
Sputum smear microscopy result ²	Date/ Lab. No.	HIV result ³ Date	X-ray Result ⁴	Sputum smear microscopy result ²	Date/ Lab. No.	Sputum smear microscopy result ²	Date/ Lab. No.	Sputum smear microscopy result ²	Date/ Lab. No.		Cure	Treatment Completed	Treatment Failure	Died	Default	Transfer			

Footnotes appearing on first page of the register only

1. CAT I patients have follow-up sputum smear microscopy examination at 2 months; CAT II patients have follow-up sputum smear microscopy examination at 3 months. CAT I patients with initial phase of treatment extended to 3 months have follow-up sputum examinations at 2 AND 3 months with results registered in the same box.
2. (ND): Not done; (NEG): 0 AFB/100 fields; (1-9): exact number if 1 to 9 AFB/100 fields; (+): 10-99 AFB/100 fields; (++) : 1-10 AFB/ field; (+++) : > 10 AFB/ field.
3. (Pos): Positive; (Neg): Negative; (I): Indeterminate; (ND): Not Done/unknown. Documented evidence of HIV test performed during or before TB treatment is reported here. Measures to improve confidentiality should accompany recording of HIV status in the TB patient record or registers.
4. (Pos): Suggestive of TB, (Neg): Not suggestive of TB; (ND): Not Done.
5. **Tick only one column for each patient:**
 - Cure:** Sputum smear microscopy positive patient who was sputum negative in the last month of treatment and on at least one previous occasion.
 - Treatment completed:** Patient who has completed treatment, but who does not meet the criteria to be classified as a cure or a failure.
 - Treatment failure:** New patient who is sputum smear microscopy positive at 5 months or later during treatment, or who is switched to Category IV treatment because sputum turned out to be MDRTB. Previously-treated patient who is sputum smear microscopy positive at the end of his re-treatment or who is switched to Category IV treatment because sputum turned out to be MDRTB.
 - Died:** Patient who dies from any cause during the course of treatment.
 - Default:** Patient whose treatment was interrupted for 2 consecutive months or more.
 - Transfer out:** Patient who has been transferred to a health facility in another BMU and for whom treatment outcome is not known.

20. Quarterly report on TB case registration

Name of BMU: _____ Facility: _____ Name of TB Coordinator: _____ Signature: _____	Patients registered during¹ _____ quarter of year _____ Date of completion of this form: _____
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Block 1: All TB cases registered²

Pulmonary sputum smear microscopy positive				New pulmonary sputum smear microscopy negative			Pulmonary sputum smear microscopy not done/not available			New extrapulmonary			Other previously treated ³	TOTAL All cases
New cases	Previously treated			0-4 yrs	5-14 yrs	≥ 15 yrs	0-4 yrs	5-14 yrs	≥ 15 yrs	0-4 yrs	5-14 yrs	≥ 15 yrs		
	Relapses	After failure	After default											

Block 2. New pulmonary sputum smear microscopy positive cases – Age group

Sex	0-4	5-14	15-24	25-34	35-44	45-54	55-64	≥ 65	Total
M									
F									

Block 3: Laboratory activity - sputum smear microscopy⁴

No. of TB suspects examined for diagnosis by sputum smear microscopy	No. of TB suspects with positive sputum smear microscopy result

Block 4: TB/HIV activities²

	No. patients tested for HIV before or during TB treatment ⁵	No. patients HIV-positive ⁵
New sputum smear microscopy positive TB		
All TB cases		

1 Registration period is based on date of registration of cases in the *TB Register*, following the start of treatment. Q1: 1 January–31 March; Q2: 1 April–30 June; Q3: 1 July–30 September; Q4: 1 October–31 December.

2 'Transferred in' and chronic cases are excluded. In areas routinely using culture, a separate form for unit using culture should be used.

3 Other previously treated cases include pulmonary cases with unknown history of previous treatment, previously treated sputum smear microscopy negative pulmonary cases and previously treated extrapulmonary cases. 'Transferred in' and chronic cases are excluded.

4 Data collected from the *TB Laboratory Register* based on "Date specimen received" in the laboratory during the quarter, without including patients with examination because of follow-up.

5 Documented evidence of HIV tests (and results) performed at any recognized facility before TB diagnosis or during TB treatment (till end of the quarter) should be reported here.

21. Quarterly report on treatment outcomes

Name of BMU: _____ Facility: _____ Name of TB Coordinator: _____ Signature: _____	Patients registered during ¹ _____ quarter of year _____ Date of completion of this form: _____
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Block 1: TB treatment outcomes ¹

Type of case	Total number of patients registered during quarter *	Treatment outcomes						Total number evaluated for outcomes: (sum of 1 to 6)
		Cure (1)	Treatment completed (2)	Died (3)	Treatment failure ² (4)	Default (5)	Transfer out (6)	
New sputum smear microscopy positive								
Previously treated sputum smear microscopy positive								
All other cases (Sputum smear negative, smear not done, EP, other previously treated ³)								

* These numbers are transferred from the *Quarterly Report on TB Case Registration* for the above quarter. Specify any exclusion. _____

Block 2: TB/HIV activities ¹

	No. patients on CPT ⁴	No. patients on ART ⁵
All TB cases		

1 Quarter: This form applies to patients registered (recorded in the *BMU TB Register*) in the quarter that ended 12 months ago. For example, if completing this form at the close of the second quarter, then record data on patients registered in the 2nd quarter of the previous year.

2 Includes patients switched to Cat. IV because sputum sample taken at start of treatment turned out to be MDRTB.

3 Other previously treated cases include pulmonary cases with unknown history of previous treatment, previously treated sputum smear microscopy negative pulmonary cases, and previously treated extrapulmonary cases. 'Transferred in' and chronic cases are excluded.

4 Includes TB patients continuing on CPT started before TB diagnosis and those started during TB treatment (till last day of TB treatment).

5 Includes TB patients continuing on ART started before TB diagnosis and those started during TB treatment (till last day of TB treatment).

Standard Variables, Periodicity and Coding for the Three Interlinked Patient Monitoring Systems for HIV Care/ART, MCH/PMTCT (including malaria during pregnancy), and TB/HIV

This table includes the agreed variables and their coding, and combines (and indicates where each is recorded) the variables on the:

- Facility-held patient HIV care/ART card or other form of patient record
- Pre-ART register
- ART register
- Maternal health card
- ANC register
- Labour record
- Postpartum record
- Labour and delivery register
- Child health card
- HIV-exposed infant register
- TB suspects register
- TB lab register
- TB treatment card
- BMU TB register

These are then used to produce the:

- Cross-sectional quarterly (or monthly) facility-based HIV care/ART report form
- ART cohort analysis report form
- Quarterly TB case registration report
- Quarterly TB treatment outcome report

Standard data variables for the three interlinked patient monitoring systems for HIV care/ART, MCH/PMTCT and TB/HIV and their coding

Variable name	Periodicity of collection and where recorded	Coding (full words, abbreviations or coding numbers may be used)	Notes
I. Demographic information			
Collected at baseline/enrolment (update if changed)			
1. Name	<i>Once</i> HIV care/ART card (summary & encounter pages): copy to pre-ART and ART registers Maternal health card, ANC register, labour record, L & D register and exposed infant register TB suspects and TB lab registers, TB treatment card, BMU TB register	Free text Last name First name	Write full name <i>2006: Last name and first name were put as separate variables (No. 1 & 2)</i>
2. Sex	<i>Once</i> HIV care/ART card (summary page): copy to pre-ART and ART registers Maternal health card L & D register TB suspects and TB lab registers, TB treatment card, BMU TB register	Write out or use abbreviation Female/Male	May include other in certain contexts
3. Date of birth	<i>Once</i> HIV care/ART card (summary page), maternal health card (date of delivery) child health card, exposed infant register Month and year of delivery of infants copied to mother's entry in the pre-ART and ART registers	dd/mm/yyyy	Record in as much detail as possible. May use age to calculate birth year or month.
4. Age	<i>Once at enrolment</i> HIV care/ART card (summary page and encounter page for < 59months) copy to pre-ART and ART (age at start of ART) registers Maternal health card, ANC register, labour record, L & D register, TB suspects and TB lab registers, TB treatment card, BMU TB register <i>Each visit</i> HIV care/ART card (summary page infant follow-up boxes, encounter page for infants ≤ 59 months), child health card (in weeks or months)	Years Age in months (if < 59 months)	Age at ART start is calculated from DOB or age at enrolment. <i>2006: Age at registration (No. 5)</i>
5. Marital status	<i>Update as needed</i> HIV care/ART card	Write out or use abbreviation Single	

Standard data variables for the three interlinked patient monitoring systems for HIV care/ART, MCH/PMTCT and TB/HIV and their coding

Variable name	Periodicity of collection and where recorded	Coding (full words, abbreviations or coding numbers may be used)	Notes
	(summary page) Maternal health card	Married Divorced/separated Widowed	
6. Unique (HIV care/ART) ID number	<i>Once</i> HIV care/ART card (summary and encounter pages): copy to pre-ART and ART registers, maternal health card, ANC register, child health card, exposed infant register (mother's and infant's if appropriate) and TB treatment card	Combination of a facility-level code plus unique patient number (see <i>Chapter 2</i>) Nationally determined	Issued when enrolling for HIV care and kept for life. This is referred to as pre-ART and ART register numbers on the TB treatment card. For HIV-exposed infants, only assign once confirmed HIV positive.
7. Patient clinic ID number	<i>Once</i> HIV care/ART card (summary page): copy to pre-ART and ART registers	[number]	Usually a pre-existing patient record or chart number.
8. Address	<i>Update as needed</i> HIV care/ART card (summary page): copy to pre-ART and ART registers Maternal health card, ANC register, labour record, TB suspects and TB lab registers, TB treatment card, BMU TB register	Free text Address of the patient or the treatment supporter. Record the name(if applicable the number) of district and village	This should be as detailed as possible to allow for patient follow-up. A simple map may be appended.
9. Telephone	<i>Update as needed</i> HIV care/ART card (summary page)	[number]	Phone number of patient or any contact. Specify whose phone number.
II. HIV care			
Collected at baseline/enrolment (update if changed)			
10. Date positive HIV test confirmed	<i>Once</i> HIV care/ART card (summary page), maternal health card, ANC register, child health card, exposed infant register, TB suspects register, TB treatment card	dd/mm/yyyy	Entry of date implies confirmation which should be a pre-requisite for enrolment. <i>2006: Positive HIV test confirmed, Yes or No (No. 11)</i>
11. HIV type	<i>Once</i> HIV care/ART card (summary page)	HIV-1 or HIV-2	This may be removed where HIV type determination is not feasible or a single subtype exists within a country.
12. Site where HIV test confirmed	<i>Once</i> HIV care/ART card (summary page)	Free text	

Standard data variables for the three interlinked patient monitoring systems for HIV care/ART, MCH/PMTCT and TB/HIV and their coding

Variable name	Periodicity of collection and where recorded	Coding (full words, abbreviations or coding numbers may be used)	Notes
13. Date enrolled in HIV care	Once HIV care/ART card (summary and encounter pages): copy to pre-ART register, maternal health card, ANC register, child health card, exposed infant register	dd/mm/yyyy	On the encounter page of the HIV care/ART card, this is the date of the first encounter (first row)
14. Status at enrolment	Once HIV care/ART card (summary page): copy to pre-ART register	Tick box on card Record code on pre-ART register Preg = pregnant at enrolment PP = postpartum (42 days post delivery) at enrolment TB Rx = on TB treatment at enrolment Sick = no TB but sick at enrolment Asx = no symptoms and not pregnant HIV-exp = HIV-exposed infant (assign Unique ID only once confirmed HIV +) Other = all others at enrolment (specify)	New data element -- replaces 'Care entry point' <i>2006: This replaced the entry points(No. 15)</i>
15. District	Once HIV care/ART card (summary page)	Free text	This is the district where facility currently providing HIV care is located.
16. Health unit/facility	Once HIV care/ART card (summary page), pre-ART and ART registers, maternal health card, TB treatment card, TB register	Free text	This is the facility name where the relevant service is provided. <i>2006: This was specific to health unit-facility where HIV care currently received(No. 17).</i>
17. District clinician/team	Once Update as needed HIV care/ART card (summary page)	Free text	Each clinical team requires a medical officer or doctor. If there is no doctor at the first-level facility, the responsible doctor or medical officer who is part of the clinical team should be listed here.
18. Name of treatment supporter	Update as needed HIV care/ART card (summary page) TB treatment card	Free text	To support patient adherence to care and treatment and assist patient for any care needs (e.g. pick up medications if ill, etc.).
19. Address of treatment supporter	Update as needed HIV care/ART card (summary page) TB treatment card	Free text	
20. Telephone (of treatment supporter)	Update as needed HIV care/ART card (summary page)	[number]	
21. Home based	Update as needed	Free text	Name of person or organization

Standard data variables for the three interlinked patient monitoring systems for HIV care/ART, MCH/PMTCT and TB/HIV and their coding

Variable name	Periodicity of collection and where recorded	Coding (full words, abbreviations or coding numbers may be used)	Notes
care provided by	HIV care/ART card (summary page)		
22. Name of child/partner/family member	<i>Update as needed</i> HIV care/ART card (summary page)	Free text	Indicate as many children/partners as necessary.
23. Child/partner/family member age at registration	<i>Update as needed</i> HIV care/ART card (summary page)	Years	
24. Child/partner/family member HIV status	<i>Update as needed</i> HIV care/ART card (summary page)	Positive, Negative, Unknown	
25. Child/partner/family member HIV care status	<i>Update as needed</i> HIV care/ART card (summary page)	Yes/No if in HIV care	If yes, record unique ID number.
26. Child/partner/family member unique ID number	<i>Update as needed</i> HIV care/ART card (summary page)	[number]	
27. Date (visit)	<i>Each visit</i> HIV care/ART card (encounter page): copy first encounter date to ART summary section of the card and to pre-ART register as date patient enrolled in HIV care (See No.5: 'date enrolled in HIV care') Maternal health card, Child health card Labour record (admission date to labour ward) TB suspects and TB lab registers, TB treatment card, BMU TB register	dd/mm/yyyy On maternal health card: record ANC for antenatal visits, PP for postpartum visits, and circle date of delivery	This date applies to all outpatient encounter data for that date. First visit is date patient enrolled in HIV care. Record name of person picking up ARVs in case patient is too sick to do so.
28. Visit type	<i>Each visit</i> HIV care/ART card (encounter page)	Tick box if scheduled Scheduled/unscheduled	
29. Next scheduled outpatient visit date (follow-up date)	<i>Each visit</i> HIV care/ART card (encounter page), maternal health card	dd/mm/yyyy	This may also be recorded in an appointment book and used for patient follow-up. It should also be entered in the patient's hand-held card.
30. Drug allergies	<i>When applicable</i> HIV care/ART card (summary page)	Free text Record drug, type of reaction and date	A designated section for this should be included in a visible spot on the HIV care/ART card.
31. Body weight	<i>Every visit</i> HIV care/ART card (encounter page and summary page at start of	Number in kg For infants at birth check if < or ≥2,500	2006: No. 40 & 69

Standard data variables for the three interlinked patient monitoring systems for HIV care/ART, MCH/PMTCT and TB/HIV and their coding

Variable name	Periodicity of collection and where recorded	Coding (full words, abbreviations or coding numbers may be used)	Notes
	ART): copy to ART register at start of ART Maternal health card L & D register <i>At each visit sputum sample taken</i> TB treatment card		
32. Oedema (for children)	<i>Every visit</i> HIV care/ART card (encounter page)	Oedema +/-	New data element
33. Height at enrolment	<i>Once</i> HIV care/ART card (encounter page)	Number in cm Record with weight, after '/' at first encounter	Revised data element -- replaces height in children <i>2006: No. 41 & 70</i>
34. Mid-upper arm circumference (MUAC) (for children)	<i>Every visit</i> HIV care/ART card (encounter page)	Number in cm	New data element
35. Functional status	<i>Every visit</i> HIV care/ART card (encounter page & summary page at start ART):	Working Ambulatory Bedridden	Working: able to perform usual work in or out of the house, harvest, go to school or, for children, normal activities or playing. Ambulatory: Ambulatory but not able to work or play. Able to perform activities of daily living. Bedridden: Not able to perform activities of daily living Functional status is independent of clinical staging and immunological status. <i>2006: No. 39 & No. 67</i>
36. TB status	<i>Each visit</i> HIV care/ART card (encounter page): copy INH prophylaxis and TB Rx start year onto pre-ART and ART registers Copy INH prophylaxis and TB Rx start dates onto maternal health card	No signs = no signs or symptoms suggesting TB Suspect = TB refer or sputums sent (record sputum sent, results (-, +, ++, or +++) and referral) TB Rx = currently on TB treatment (record month and year TB RX started and TB registration/card number. The TB drugs dispensed should be recorded in other medication dispensed) Not Done = not assessed or checked for whatever reason	Linked with TB treatment card, BMU TB register Codes have changed
37. INH	<i>When applicable</i>	Record INH prophylaxis start month and year and	

Standard data variables for the three interlinked patient monitoring systems for HIV care/ART, MCH/PMTCT and TB/HIV and their coding

Variable name	Periodicity of collection and where recorded	Coding (full words, abbreviations or coding numbers may be used)	Notes
prophylaxis	HIV care/ART card(encounter page) Copy to the Pre-ART and ART register	pills dispensed	
38. Pregnancy	<i>Each visit if applicable</i> HIV care/ART card (encounter page and summary page for status at enrolment and start ART): copy ANC number & EDD to pre-ART and ART registers Maternal health card	For all women of childbearing age P = pregnant and record estimated due date (EDD) and ANC number PMTCT = if woman referred to PMTCT/ANC services	Family planning should also be assessed in men and youths at each visit. <i>2006: No.73 & 74</i>
39. RH/Family planning assessment	<i>Each visit if applicable</i> HIV care/ART card	For all women in the reproductive age group record: P : pregnant. List EDD and ANCN.. AB : recent induced abortion. Note when. MC : recent miscarriage. Note when. Wants P : wants to become pregnant now or considering; not using FP Has FP : already using condoms/other FP. Note method(s). Wants FP : note method(s) provided or referred for. Record referral in last column. Unable P : thinks she cannot get pregnant No sex : not sexually active now Codes for FP methods: 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	

Standard data variables for the three interlinked patient monitoring systems for HIV care/ART, MCH/PMTCT and TB/HIV and their coding

Variable name	Periodicity of collection and where recorded	Coding (full words, abbreviations or coding numbers may be used)	Notes
		sterilization V = vasectomy (partner's) UND = undecided	
40. WHO clinical stage	<i>Every visit</i> HIV care/ART card (encounter page) Copy the stage on summary page when medically eligible and when ART started. Transfer date when change in clinical stage to pre-ART register as needed. for ART and at start ART): copy to ART register at start, 6,12 months and yearly thereafter Maternal health card, ANC register	1, 2, 3, or 4 if not on ART T1,T2,T3 or T4 if on ART Tick on pre-ART register	See Chapter 2. <i>2006: No.30, 38 & 68. The old one was specific to the WHO clinical stage when medically eligible and at start of ART.</i>
41. CD4 count or percentage	<i>When applicable</i> HIV care/ART card (encounter page & summary page for when eligible for ART): copy to ART register at start, 6,12 months and yearly thereafter Maternal health card, ANC register TB treatment card	Record date sent, "sent" and value: CD4 count (mm ³) or CD4 % in children < 5 years. Note CD4% severe +/- in children <5	Revised data element Country adaptation if in national guidelines CD4, where available, may be collected to track immunological progress of patient on treatment. CD4 severe threshold <25% - for infants ≤ 11months <20% - for children 12-35 months <15% - Children ≥ 3years <i>2006 :No.31. The old one was specific to the WHO clinical stage at start of ART. It also included TLC at the start of ART which is now moved to No. 47.</i>
42. Cotrimoxazole prophylaxis	<i>Each visit if applicable</i> HIV care/ART card (encounter page) copy CTX start year to pre-ART and ART registers Maternal health card, child health card TB treatment card, BMU TB register	Dose in mg Number of days Start year in registers	Revised data element <i>2006: No. 79 For all prophylaxis</i>
43. Adherence to cotrimoxazole	<i>Each visit if applicable</i> HIV care/ART card (encounter page)	Grading as for ART (see 84)	
44. Other medications	<i>Each visit if applicable</i>	Name, dose in mg and number of days	This includes nutritional supplements

Standard data variables for the three interlinked patient monitoring systems for HIV care/ART, MCH/PMTCT and TB/HIV and their coding

Variable name	Periodicity of collection and where recorded	Coding (full words, abbreviations or coding numbers may be used)	Notes
dispensed			
45. Reason for discontinuation of prophylaxis medication	<i>As applicable</i> HIV care/ART card (encounter page)	1 = completed therapy 2 = improved immune function (e.g. CD4 count >200 cells for 6 months) 3 = side-effects/toxicity 4 = stock out/drug supply disruption 5 = patient preference 6 = other, describe	Possible country adaptation
46. Potential medication side-effects	<i>Each visit if applicable</i> HIV care/ART card (encounter page)	Write in as applicable: Nausea Diarrhoea Fatigue Heachache BN burning/numb/tingling Rash Anemia ABdominal pain Jaundice FAT changes CNS (central nervous system): dizzy, anxiety, nightmare, depression Or write in others	Write the word or code, or check all that apply. These may be due to ARVs or other medications and have occurred at any time since the last visit. Laboratory values are recorded in another column. Alternative entry systems can be used. A simple system may be used by a nurse after training or a full doctor-based system. Substitute other recording systems for health workers with other training or more diagnostic resources.
47. Severity of side-effect(s)	HIV care/ART Card (encounter page)	No problem, mild, moderate, severe. Grade 1, 2, 3 or 4	Possible country adaptation
48. New opportunistic infections, other problems [symptoms and diagnoses] and nutritional problems (if child)	<i>Each visit if applicable</i> HIV care/ART card (encounter page)	Write in as applicable: Zoster Pneumonia DEmentia/Encephalitis Thrush – oral, vaginal FEVER COUGH DB difficult breathing IRIS Immune reconstitution inflammatory syndrome Weight Loss UD urethral discharge PID pelvic inflammatory disease GUD genital ulcer disease Ulcers – mouth and other_____	Example: IMAI2 codes for new OI or other Problems (or write in or use codes from potential side-effect list). Alternative entry systems can be used. A simple system may be used by a nurse after training or a full doctor-based system. In either case, a more detailed record of the illness and management plan would be kept in a patient-held or clinic-held record. This treatment card includes only an abbreviated summary. Change in codes

Standard data variables for the three interlinked patient monitoring systems for HIV care/ART, MCH/PMTCT and TB/HIV and their coding

Variable name	Periodicity of collection and where recorded	Coding (full words, abbreviations or coding numbers may be used)	Notes
		For children ≤ 59 months, record any nutritional problems: SCM severe complicated malnutrition SUM severe uncomplicated malnutrition PWG poor weight gain If symptom/sign (cough, fever, night sweats, weight loss, etc.) is suggestive of TB, note with “**”	
49. Investigations	<i>Each visit</i> HIV care/ART card (encounter page)	Record test name, “sent” and then value: Laboratory tests: Hemoglobin (g/dL) RPR TB sputum Chest X-ray other	In higher-resource settings, viral load tests may be carried out regularly. Adapt the patient monitoring system to include viral load test results.
50. Refer or consult or link provided (including nutritional support)	<i>Each visit</i> HIV care/ART card (encounter page and copy the infant feeding practice at 3 months on the summary page) Maternal health card, labour record, postpartum record	As applicable on HIV care/ART card: TB = refer, suspect TB PMTCT = refer to ANC/PMTCT services Nutritional support: Therapeutic Feeding Infant Feeding Counseling (if < 2 years) Nutrition Counseling Only (if > 2 years) Food Support Infant feeding practice = EBF, RF, MF [see No.207] Record Yes/No for infant feeding counselling in the maternal health card and labour record	Write in referral, reason and location. Change in codes
51. Number of hospital days	<i>When applicable</i> HIV care/ART card (encounter page)	Number of days	If patient was hospitalized for any reason, not just HIV-related.
III. ART			
52. Antiretroviral treatment prior to enrolment	<i>Once</i> HIV care/ART card (summary page)	Tick ‘√’ appropriate None = no prior ART Transfer in with records [already on ART] = currently being treated and transferred in with treatment records from within system Earlier ARV but not a transfer in = earlier ARV treatment but not transfer in with records; or client	

Standard data variables for the three interlinked patient monitoring systems for HIV care/ART, MCH/PMTCT and TB/HIV and their coding

Variable name	Periodicity of collection and where recorded	Coding (full words, abbreviations or coding numbers may be used)	Notes
		not able to provide treatment or referral information/ documentation PMTCT only = PMTCT only, record ARVs and start date for mother and infant, and location received	
53. Date eligibility assessed	Once Maternal health card, HIV care/ART card (summary page), TB treatment card	dd/mm/yyyy	WHO clinical staging should be done at every visit in care and treatment settings; CD4 and TLC according to national guidelines. Date eligibility assessed is derived from clinical staging, CD4 or TLC assessed during patient encounter visit(s) and recorded on the encounter page of the HIV care/ART card.
54. Date determined medically eligible to start ART	Once HIV care/ART card (summary & encounter pages): copy to pre-ART register Maternal health card	dd/mm/yyyy On maternal health card: check box if eligible for ART	Based on CD4, WHO clinical staging, TLC, weight, or other national guidelines.
55. Why medically eligible to start ARV therapy	Once HIV care/ART card (summary page): copy to ART register	Tick '√' appropriate Clinical only = clinical criteria only (not based on CD4 or TLC) CD4/% = CD4/% with or without clinical criteria TLC = clinical criteria plus TLC Presumptive clinical diagnosis of severe HIV infection in infant = same	Determination of ART eligibility requires clinical and/or laboratory values (if CD4 or TLC available).
56. Date determined medically eligible and ready to start ART (prepared for adherence)	Once HIV care/ART card (summary): copy to pre-ART register	dd/mm/yyyy	'Ready' means prepared for adherence as determined by country ARV programme criteria regarding required adherence preparation, clinical team meeting, and minimal essential patient education. More details are recorded in the follow-up education/support section of the HIV care/ART card.
57. Date transferred in from another treatment facility on ART	Once HIV care/ART card (Summary) Patients who transfer in pre-ART may get recorded as such in the pre-ART register by noting TI in margin of patient entry.	dd/mm/yyyy May be denoted as TI in margin by encounter date	Patient must have medical record/ documentation of Treatment from original clinic

Standard data variables for the three interlinked patient monitoring systems for HIV care/ART, MCH/PMTCT and TB/HIV and their coding

Variable name	Periodicity of collection and where recorded	Coding (full words, abbreviations or coding numbers may be used)	Notes
58. Location transferred from	Once HIV care/ART card (summary page)	Free text	Health unit (facility name) and district
59. ART started at original clinic	Once HIV care/ART card (summary page): copy to pre-ART and ART register (ART register only for Transfer In patients already on ART) TB treatment card, BMU TB register.	dd/mm/yyyy and ARV drugs TB/HIV Yes/No [ART started]	In HIV care/ART, for patients who have transferred in from another facility within the system or a private facility. If start date is not known, leave blank. In TB/HIV, start date for all patients
60. ART cohort (start-up group)	Once HIV care/ART card (summary page): copy to ART register	Month, year (e.g. Jan 08 or Jan 2008 = started therapy in January 2008)	Month and year originally started ART at qualified health facility. Cohorts are formed by month of starting ART, when patients are entered in the ART register. This is also the case for Transfer In patients.
61. First [original] ARV regimen at this facility	Once HIV care/ART card (summary page & encounter page): copy to ART register (left-side and right-side at end of month)	Write out full regimen on the HIV care/ART summary page, but use codes in the ART register Adult 1st-line regimens: 1a = d4T-3TC-NVP 1b = d4T-3TC-EFV 1c = ZDV-3TC-NVP 1d = ZDV-3TC-EFV Children 1st-line regimens: 4a = d4T-3TC-NVP 4b = d4T-3TC-EFV 4c = ZDV-3TC-NVP 4d = ZDV-3TC-EFV	ARV regimens listed here follow WHO recommendations. Adapt to country specific recommendations, leaving room for other regimens as needed and code accordingly.
62. Antiretroviral drug dispensed	Each time medication dispensed HIV care/ART card (encounter page) ART register Maternal health card (both maternal and infant ARVs in visits, L & D and infant sections), ANC register, labour record (in active labour and at or after birth sections), L & D register, child health card, exposed infant register	Record the drug(s)name (regimen code), dose and number of days dispensed Drug Name zidovudine lamivudine stavudine didanosine abacavir nevirapine efavirenz nelfinavir lopinavir/ritonavir saquinavir/ritonavir tenofovir others (specify) FDC: Note as relevant	Abbreviation ZDV or AZT (according to national guidelines) 3TC d4T ddl ABC NVP EFV NFV LPV/r SQV/r

Standard data variables for the three interlinked patient monitoring systems for HIV care/ART, MCH/PMTCT and TB/HIV and their coding

Variable name	Periodicity of collection and where recorded	Coding (full words, abbreviations or coding numbers may be used)	Notes
		If ARVs for prophylaxis, note ' PMTCT ' on HIV care/ART card Tick the appropriate box for the ARVs in the maternal health card.	TDF
63. ARV adherence assessment	<i>When applicable</i> HIV care/ART card (encounter page) Maternal health card, child health card	Good (≥95%) Fair (85–94%) Poor (≤84%)	Several systems can be used: % pills or doses taken (enter %), based on once- or twice-daily regimen, monthly pill or blister pack count; self-report based on 3, 7, etc. day recall; or other method. Assessment and recording of adherence based on national adaptation. A single recommendation does not exist.
64. Reason for missing ARV doses/adherence problems	<i>Each visit</i> HIV care/ART card (encounter page)	Codes for why poor/fair adherece: 1 = toxicity/side-effects 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 10 = inability to pay 11 = alcohol 12 = depression 13 = pill burden 14 = other	
65. Date of substitute ARVs within first-line regimen	<i>When applicable</i> HIV care/ART card (summary & encounter pages): copy to ART register (left-side and right-side at end of month)	Enter date of substitution(s) dd/mm/yyyy	Entering date means "yes" in paper system. <i>2006: No. 43 & No.46</i>
66. Reason for substitution within first-line regimen	<i>When applicable</i> HIV care/ART card (summary page): copy to ART register (left-side)	1 = toxicity/side-effects 2 = pregnancy 3 = risk of pregnancy 4 = newly diagnosed TB 5 = new drug available 6 = drug out of stock 7 = other reason: (specify)	<i>2006: No. 44 & No.48</i>
67. New ARV regimen after	<i>When applicable</i> HIV care/ART card	[see regimen codes in No.59]	<i>2006: No.45 & No. 47</i>

Standard data variables for the three interlinked patient monitoring systems for HIV care/ART, MCH/PMTCT and TB/HIV and their coding

Variable name	Periodicity of collection and where recorded	Coding (full words, abbreviations or coding numbers may be used)	Notes
substitution	(summary & encounter pages): copy to ART register (left-side and right-side at end of month)		
68. Date of switch to second-line ARV regimen	<i>When applicable</i> HIV care/ART card (summary & encounter pages): copy to ART register (left-side and right-side at end of month)	Enter date of switch(es) dd/mm/yyyy	Entering date means "yes" in paper system. 2006: No. 49 & 52
69. Reason for switch to second-line regimen or substitution within second-line regimen	<i>When applicable</i> HIV care/ART card (summary and encounter pages): copy to ART register (left-side)	1 = toxicity/side-effects 2 = pregnancy 3 = risk of pregnancy 4 = newly diagnosed TB 5 = new drug available 6 = drug out of stock 7 = other reason: (specify) 8 = clinical treatment failure 9 = immunologic failure 10 = virologic failure	Medical officer should also keep log with clinical summary and reasons for switch to second-line, who consulted.
70. New second-line ARV regimen after switch	<i>When applicable</i> HIV care/ART card (summary page): copy to ART register (left-side and right-side at end of month)	Write out full regimen on the HIV care/ART summary page, but use codes in the ART register Adult 2nd-line regimens 2a(250) = ABC-ddI(250)-LPV/r 2a(400) = ABC-ddI(400)-LPV/r 2b(250) = ABC-ddI(250)-SQV/r 2b(400) = ABC-ddI(400)-SQV/r 2c(250) = TDF-ddI(250)-LPV/r 2c(400) = TDF-ddI(400)-LPV/r 2d(250) = TDF-ddI(250)-SQV/r 2d(400) = TDF-ddI(400)-SQV/r For pts < 60 kg use 30 or 250 mg For pts ≥ 60 kg use 40 or 400 mg Child 2nd-line regimens 5a = ABC-ddI-LPV/r 5b = ABC-ddI-NFV 5c = ABC-ddI-SQV/r (for pts ≥ 25kg)	Switch refers to switch to a second-line or salvage regimen.
71. Months since first starting ART and on current ARV regimen	<i>Each visit</i> HIV care/ART card (encounter page)	Number of months starting with '0' for month starting ART	Record number of months from start of original regimen, indicate new regimen with "/" and note number of months since start of new regimen and start of original regimen. 2006: o. 66 the old one was only for months on current regimen.

Standard data variables for the three interlinked patient monitoring systems for HIV care/ART, MCH/PMTCT and TB/HIV and their coding

Variable name	Periodicity of collection and where recorded	Coding (full words, abbreviations or coding numbers may be used)	Notes
72. Date ART interrupted, stopped or lost	<i>When applicable</i> HIV care/ART card (summary & encounter pages): copy to ART register	Write STOP or LOST on the encounter date line. Circle on the summary page and record the date (dd/mm/yyyy). Write STOP or LOST on the right side of the ART register as the outcome at the end of the month.	Patient who has missed a drug pick-up is considered LOST (temporary). That patient may reappear later and not be dropped from the drug supply (DROP or lost to follow-up). <i>2006: No. 53 &56.</i>
73. If stopped ART, reason	<i>When applicable</i> HIV care/ART card (summary & encounter pages): copy to ART register	1 = toxicity/side-effects 2 = pregnancy; for example, planned treatment interruption in first trimester 3 =treatment failure 4 = poor adherence 5 = illness, hospitalization 6 = drug out of stock 7 = patient lacked financial resources 8 = other patient decision 9 = other planned treatment interruption 10 = other	STOP is when a patient intentionally stops an ART regimen (usually but not always in discussion with the clinical team) either through a planned interruption from ART or following poor adherence. <i>2006: No.54 & 57</i>
74. Date ART restarted	<i>When applicable</i> HIV care/ART card (summary & encounter pages): copy to ART register	Write RESTART on the encounter date line and record the date (dd/mm/yyyy) on the summary page. Write RESTART and the new regimen code on the right side of the ART register as the outcome at the end of the month.	<i>2006:No.55 & 58</i>
75. Date transferred out with records (see codes)	<i>Once</i> HIV care/ART card (summary & encounter pages): copy to pre-ART and ART registers.	Write TO (with location- see No.73) on the encounter date line and the date (dd/mm/yyyy) on the summary page. In the pre-ART register write TO with the date and location. In the ART register write TO as the outcome at the end of the month with the location transferred to.	
76. Location transferred	<i>Once</i> HIV care/ART card (summary & encounter pages): copy to pre-ART and ART registers.	Free text	For tracking transfer in and transfer out, between facilities within each system.
77. If dropped (lost to follow-up),	<i>When applicable</i> HIV care/ART card	In card, record DROP on encounter date line.	Patient who has not been seen for X months since last missed appointment

Standard data variables for the three interlinked patient monitoring systems for HIV care/ART, MCH/PMTCT and TB/HIV and their coding

Variable name	Periodicity of collection and where recorded	Coding (full words, abbreviations or coding numbers may be used)	Notes
indicate date	(Summary and encounter page): copy to pre-ART register or ART register at the end of the month.	In pre-ART register, record LTF and date dd/mm/yyyy. In ART register, record DROP at the end of the month.	after X number of follow-up attempts by health facility. This needs to be nationally adapted to indicate when patients are dropped from the facility's drug supply order. Recommended to use 3 months since last missed appointment. The definition may differ for pre-ART patients according to national guidelines.
78. Date of death	<i>Once</i> HIV care/ART card (summary & encounter pages): copy to pre-ART or ART register	Write dead on the encounter date line and record the date (dd/mm/yyyy) on the summary page of the card. In the pre-ART register write DEAD with the date. In the ART register write DEAD as the outcome at the end of the month.	Death due to any cause, not just HIV.
IV. Follow-up education, support and preparation for ARV therapy			
79. Basic HIV Education, transmission	<i>When applicable</i> HIV care/ART card	dd/mm/yyyy	Note important information and comments.
80. Prevention: abstinence, safer sex, condoms	<i>When applicable</i> HIV care/ART card	dd/mm/yyyy	Note important information and comments.
81. Prevention: household precautions, what is safe	<i>When applicable</i> HIV care/ART card	dd/mm/yyyy	Note important information and comments.
82. Post-test counselling: implications of results	<i>When applicable</i> HIV care/ART card	dd/mm/yyyy	Note important information and comments.
83. Positive living	<i>When applicable</i> HIV care/ART card	dd/mm/yyyy	Note important information and comments.
84. Testing partners	<i>When applicable</i> HIV care/ART card	dd/mm/yyyy	Note important information and comments.
85. Disclosure	<i>When applicable</i> HIV care/ART card	dd/mm/yyyy Free text	List to whom disclosed.
86. Family/living situation	<i>When applicable</i> HIV care/ART card	dd/mm/yyyy	Note important information and comments.
87. Shared confidentiality	<i>When applicable</i> HIV care/ART card	dd/mm/yyyy	Note important information and comments.

Standard data variables for the three interlinked patient monitoring systems for HIV care/ART, MCH/PMTCT and TB/HIV and their coding

Variable name	Periodicity of collection and where recorded	Coding (full words, abbreviations or coding numbers may be used)	Notes
88. Reproductive choices, prevention MTCT	<i>When applicable</i> HIV care/ART card Maternal health card	dd/mm/yyyy	Note important information and comments.
89. Child's blood test	<i>When applicable</i> HIV care/ART card	dd/mm/yyyy	Note important information and comments.
90. Progression of disease	<i>When applicable</i> HIV care/ART card	dd/mm/yyyy	Note important information and comments.
91. Available treatment/propylaxis	<i>When applicable</i> HIV care/ART card Postpartum record	dd/mm/yyyy	Note important information and comments.
92. Malaria prevention IPT	<i>When applicable</i> HIV care/ART card Maternal card, ANC register and Postpartum record	dd/mm/yyyy	Note important information and comments.
93. Follow-up appointments, clinical team	<i>When applicable</i> HIV care/ART card	dd/mm/yyyy	Note important information and comments.
94. CTX, INH prophylaxis	<i>When applicable</i> HIV care/ART card Postpartum record	dd/mm/yyyy	Note important information and comments.
95. ART -- educate on essentials (locally adapted)	<i>When applicable</i> HIV care/ART card	dd/mm/yyyy	Note important information and comments.
96. Why complete adherence needed	<i>When applicable</i> HIV care/ART card maternal health card	dd/mm/yyyy	Note important information and comments.
97. Adherence preparation, indicate visits	<i>When applicable</i> HIV care/ART card maternal health card	dd/mm/yyyy	Note important information and comments.
98. Indicate when READY for ART: DATE/result Clinical team discussion	<i>When applicable</i> HIV care/ART card	dd/mm/yyyy	Note important information and comments.
99. Explain dose, when to take	<i>When applicable</i> HIV care/ART card	dd/mm/yyyy	Note important information and comments.
100. What can occur, how to	<i>When applicable</i> HIV care/ART card	dd/mm/yyyy	Note important information and comments.

Standard data variables for the three interlinked patient monitoring systems for HIV care/ART, MCH/PMTCT and TB/HIV and their coding

Variable name	Periodicity of collection and where recorded	Coding (full words, abbreviations or coding numbers may be used)	Notes
manage side effects			
101. What to do if one forgets dose	<i>When applicable</i> HIV care/ART card	dd/mm/yyyy	Note important information and comments.
102. What to do when traveling	<i>When applicable</i> HIV care/ART card	dd/mm/yyyy	Note important information and comments.
103. Adherence plan (schedule, aids, explain diary)	<i>When applicable</i> HIV care/ART card	dd/mm/yyyy	Note important information and comments.
104. Treatment supporter preparation	<i>When applicable</i> HIV care/ART card	dd/mm/yyyy	Note important information and comments.
105. Which doses, why missed	<i>When applicable</i> HIV care/ART card	Codes for why poor/fair adherence: 1 Toxicity/side effects 2 Alcohol 3 Share with others 4 Felt better 5 Forgot 6 Inability to pay 7 Too ill 8 Depression 9 Drug stock out—dispensary 10 Patient lost/ran out of pills 11 Delivery/travel problems 12 Stigma, disclosure or privacy 13 Other (specify)	Note important information and comments.
106. ARV support group	<i>When applicable</i> HIV care/ART card	dd/mm/yyyy	Note important information and comments.
107. How to contact clinic	<i>When applicable</i> HIV care/ART card	dd/mm/yyyy	Note important information and comments.
108. Symptom management/palliative care at home	<i>When applicable</i> HIV care/ART card	dd/mm/yyyy	Note important information and comments.
109. Caregiver booklet	<i>When applicable</i> HIV care/ART card	dd/mm/yyyy	Note important information and comments.
110. Home-based care -- specify	<i>When applicable</i> HIV care/ART card	dd/mm/yyyy	Note important information and comments.
111. Support groups	<i>When applicable</i> HIV care/ART card	dd/mm/yyyy	Note important information and comments.

Standard data variables for the three interlinked patient monitoring systems for HIV care/ART, MCH/PMTCT and TB/HIV and their coding

Variable name	Periodicity of collection and where recorded	Coding (full words, abbreviations or coding numbers may be used)	Notes
112. Community support	<i>When applicable</i> HIV care/ART card	dd/mm/yyyy	Note important information and comments.
113. Postpartum care and hygiene	<i>When applicable</i> Postpartum record	No/Yes	Tick '√' appropriate
114. Nutrition	<i>When applicable</i> Postpartum record	No/Yes	Tick '√' appropriate
115. Danger signs	<i>When applicable</i> Postpartum record	No/Yes	Tick '√' appropriate
116. Follow-up visits	<i>When applicable</i> Postpartum record	No/Yes	Tick '√' appropriate
117. Hygiene, cord care and warmth	<i>When applicable</i> Postpartum record	No/Yes	Tick '√' appropriate
118. Special advice if low birth weight	<i>When applicable</i> Postpartum record	No/Yes	Tick '√' appropriate
V. ANC/Labour and delivery			
119. ANC number	<i>At first visit</i> Maternal health card: ANC and L & D registers copy to ANC register, HIV care/ART card (encounter page), pre- ART and ART registers	[Number]	Number assigned based on national system
120. Gravida	<i>At first visit</i> Maternal health card	[Number]	Number of all pregnancies (including current one)
121. Para (parity)	<i>At first visit</i> Maternal health card: copy to labour record	[Number]	Number of all births (includes stillbirths and death immediately after birth)
122. Last menstrual period (LMP)	<i>At first visit</i> Maternal health card	dd/mm/yyyy	
123. Estimated date of delivery (EDD)	<i>At first visit</i> Maternal health card Copy to the HIV care/ART card, Pre-ART and ART registers	dd/mm/yyyy	
124. Contact person/next of kin	<i>At first visit</i> Maternal health card	Free text	
125. Preferred site of delivery	<i>At first visit</i> Maternal health card	Free text	

Standard data variables for the three interlinked patient monitoring systems for HIV care/ART, MCH/PMTCT and TB/HIV and their coding

Variable name	Periodicity of collection and where recorded	Coding (full words, abbreviations or coding numbers may be used)	Notes
126. Mode of transportation	<i>At first visit</i> Maternal health card	Free text	Preferred mode of transportation to the facility if women chooses to give birth at health facility.
Previous pregnancy and outcome current pregnancy			
127. Birth order	<i>At first visit</i> Maternal health card	[Number] and year of pregnancy	Record history of previous pregnancies according to birth order (start with the first pregnancy and circle current)- and record the year each pregnancy happened.
128. Place of delivery	<i>At first visit</i> <i>Update as needed</i> Maternal health card, labour record	Write in for previous pregnancy Home, hospital, health center, or other (specify) Tick '√' appropriate in L & D section	If pregnancy ended with abortion record place care was received.
129. History of prolonged labour	<i>At first visit</i> <i>Update as needed</i> Maternal health card,	Yes/No	
130. Mode of delivery	<i>At first visit</i> <i>Update as needed</i> Maternal health card L & D register	Spontaneous Vaginal delivery, assisted vaginal delivery, operative delivery	(Previous and current pregnancy sections)
131. Indication for operative delivery	<i>When applicable</i> Maternal health card	Free text	Indicate this under “mode of delivery” when applicable (previous and current pregnancy sections).
132. Birth weight	<i>At first visit</i> <i>Update as needed</i> Maternal health card (previous and current pregnancy sections), labour record	g[rams]	
133. Condition of baby at birth (birth outcome)	<i>At first visit</i> <i>Update as needed</i> Maternal health card, labour record L & D register	Tick '√' appropriate or code Live birth Dead Stillbirth Fresh Macerated	Record condition of baby at discharge.
134. Serious obstetric complications	<i>At first visit</i> Maternal health card (previous and current pregnancy sections) L & D register	Free text Tick '√' PPH if appropriate in L & D section of maternal card	During pregnancy, birth and postpartum for mother and newborn
ANC, Delivery, Postpartum			
135. Gestation in weeks	<i>Each ANC visit</i> <i>At delivery or abortion</i> Maternal health card	Number of weeks	Of current pregnancy

Standard data variables for the three interlinked patient monitoring systems for HIV care/ART, MCH/PMTCT and TB/HIV and their coding

Variable name	Periodicity of collection and where recorded	Coding (full words, abbreviations or coding numbers may be used)	Notes
	Labour record: copy to HIV care/ART card		
136. Weeks postpartum	At each postpartum visit Maternal health card	Number of weeks	Since delivery
137. Infant feeding intention	Update Maternal health card	EBF = exclusive breastfeeding RF = replacement feeding MF = mixed feeding	Tick '√' or code appropriate
138. Urine protein	When applicable Maternal health card	0, +, ++, +++	
139. Syphilis test	At first visit Maternal health card Postpartum record Child health card ANC register	Negative, Positive, Unknown Tick '√'	
140. Syphilis treatemnt	When applicable Maternal health card Child health card	Record the dose of IM Peniclline(PCN) 1st, 2nd, 3rd	
141. Fundal height	Each ANC visit Maternal health card	cm	
142. Fetal presentation	Each ANC visit after 32 weeks of gestation Maternal health card	Head, Breach, Transverse	
143. Iron folate dispensed	When applicable Maternal health card Postpartum record	Yes/No and No.dispensed Tick '√'	
144. HIV status	At first visit(Maternal) L & D register at admission, child health card Maternal health card For family members HIV care card (summary page)	Positive, Negative, Unknown - mother is not present (orphan) or status not known for another reason (e.g. Declined testing)	Tick '√' appropriate
145. Partner testing	When applicable ANC register, HIV care/ART card (summary & follow-up and support pages)	Positive, Negative, Unknown Record comments in follow-up and support page of HIV care/ART card.	
146. Haemoglobin	When applicable Maternal health card	gm/dl	
147. Blood group and RH	When applicable Maternal health card	A ⁺⁻ , B ^{+/-} , AB ^{+/-} , O ⁺⁻	
148. TT Date	When applicable Maternal health card Postpartum record	dd/mm/yyyy write the TT dose as TT1, TT2,TT3 TT4,TT5	

Standard data variables for the three interlinked patient monitoring systems for HIV care/ART, MCH/PMTCT and TB/HIV and their coding

Variable name	Periodicity of collection and where recorded	Coding (full words, abbreviations or coding numbers may be used)	Notes
		Tick '√'	
149. Malaria IPT	<i>When applicable</i> HIV care/ART card Maternal health card, Postpartum record, ANC register	dd/mm/yyyy, 1 st , 2 nd , 3 rd	
150. Insecticide Treated Net (ITN)	<i>When applicable</i> HIV care/ART card Maternal health card Postpartum record	dd/mm/yyyy Write date ITN provided	Insecticide Treated Net was provided or woman referred to obtain the net.
151. Mebendazole	<i>When applicable</i> Maternal health card Postpartum record	dd/mm/yyyy Tick '√'	
152. Vitamin A	<i>When applicable</i> Maternal health card Postpartum record	Record date(dd/mm/yyyy) and units given Tick '√'	
153. Delivery Conducted by	<i>When applicable</i> Maternal health card	Tick '√' appropriate Nurse/midwife, doctor, TBA, other	
154. Condition of mother at or immediately after birth	<i>When applicable</i> Maternal health card L & D register	Free text Alive/dead	Record condition of mother at discharge.
155. Reason for referral	<i>When applicable</i> Maternal health card Postpartum record	Free text Write in referral reason and site on maternal health card; referral time and explanation on postpartum record.	
156. Admission time	<i>Once</i> Labour record	hh:mm	
157. Stage of labour	<i>When applicable</i> Labour record	Tick '√' appropriate Not in active labour/active labour	
158. Time active labour started	<i>Once</i> Labour record	hh:mm	Record time at onset of labour
159. Time membranes ruptured	<i>Once</i> Labour record	hh:mm	
160. Time second stage starts	<i>Once</i> Labour record	hh:mm	
161. Hours since arrival	<i>When applicable</i> Labour record	1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12	During entry; Not in active labour
162. Hours in active labour	<i>When applicable</i> Labour record	1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12	For those with active labour

Standard data variables for the three interlinked patient monitoring systems for HIV care/ART, MCH/PMTCT and TB/HIV and their coding

Variable name	Periodicity of collection and where recorded	Coding (full words, abbreviations or coding numbers may be used)	Notes
163. Hours since ruptured membranes	<i>When applicable</i> Labour record	hh:mm	
164. Vaginal bleeding	<i>When applicable</i> Labour record	Enter appropriate symbol 0, +, ++	
165. Amniotic Fluid	<i>Every hour during active labour</i> Labour record		Meconium-stained
166. Strong contractions in 10 minutes	<i>When applicable</i> Labour record	Tick '√' appropriate	
167. Fetal heart rate	<i>Every hour</i> Labour record	Beats per minute	
168. T (axillary)	<i>Every hour</i> Labour and postpartum records	°C/°F	Temperature
169. Pulse	<i>Every hour</i> Labour and postpartum records	Beats per minute	
170. Blood Pressure	<i>Every hour</i> Labour and postpartum records <i>Each ANC visit</i> Maternal health card	Systolic/Diastolic	
171. Urine voided	<i>Once</i> Labour and postpartum record	No/Yes	
172. Cervical dilation	<i>Every hour</i> Labour record	cm	
173. Oxytocin	<i>When applicable</i> Labour record	hh:mm	Time/given
174. Problem	<i>When applicable</i> Labour record	Free text Indicate time of onset hh:mm	Describe and indicate the time of onset of the medical problem.
175. Treatments other than normal supportive care	<i>During labour</i> Labour record	Free text	Write treatment given for the problem.
176. Planned maternal treatment	<i>At or after delivery</i> Labour and postpartum records	Free text	
177. Time to administer ARV drugs	<i>Once</i> Labour record	hh:mm	During labour administer only 3TC and ART every 12 hours.

Standard data variables for the three interlinked patient monitoring systems for HIV care/ART, MCH/PMTCT and TB/HIV and their coding

Variable name	Periodicity of collection and where recorded	Coding (full words, abbreviations or coding numbers may be used)	Notes
178. Time ARV drugs taken	Once Labour record	hh:mm	
179. Birth time	At or after birth Labour record	hh:mm	
180. Resuscitation	At or after birth Labour record	Tick '√' appropriate No/Yes	
181. Preterm	At or after birth Labour record	Tick '√' appropriate No/Yes	
182. Second Baby	At or after birth Labour record	?	If twins
183. Planned newborn treatment	At or after birth Labour record	Free text	
184. Placenta Complete	After birth Labour record	Tick '√' appropriate No/Yes	
185. Time delivered	Once Labour record	hh:mm	
186. Estimated blood loss	Once Labour record	ml	
187. Monitoring after birth	Every 5-15 min for 1st hour, 2hrs, 3hrs, 4hrs, 8 hrs, 12 hrs, 16 hrs, 20 hrs, 24 hrs Postpartum record	Record the time.	
188. Bleeding	At indicated times Postpartum record	0, +, ++	
189. Uterus	At indicated times Postpartum record Tick on maternal health card if uterus firm	Hard/round	
190. Vulva	At indicated times Postpartum record	Free text	Indicate condition of vulva.
191. Problem with breast feeding	At every PP visit Maternal health card	Yes/No	
192. Perineum	When applicable Maternal health card	Free text	Indicate condition of perineum.
193. Breasts	When applicable Maternal health card	Free text	Indicate condition of breasts.
194. Lochia	When applicable Maternal health card	Free text	Indicate condition of lochia.
195. Newborn: breathing	At indicated times Postpartum record	Normal/abnormal	
196. Warmth	At indicated times Postpartum record	No/Yes	

Standard data variables for the three interlinked patient monitoring systems for HIV care/ART, MCH/PMTCT and TB/HIV and their coding

Variable name	Periodicity of collection and where recorded	Coding (full words, abbreviations or coding numbers may be used)	Notes
197. Newborn abnormal signs	When applicable Postpartum record	Free text	
198. Feeding observed	At indicated times Postpartum record	Tick '√' appropriate and write comments Feeding well/Difficulty	
199. Treatment of mother or newborn given	When applicable Postpartum record	Free text Indicate time treatment given Hh:mm	List treatment and time given.
200. If death (mother or newborn)	When applicable Postpartum record	dd/mm/yy hh:mm Free text	Explain cause.
201. Risk of bacterial infection and treatment	When applicable Postpartum record	Tick '√' if yes	
202. BCG immunization	When applicable Postpartum record Maternal health card	Tick '√' if yes	
203. OPV -0	When applicable Postpartum record Maternal health card	Tick '√' if yes	
204. Hep-0	When applicable Postpartum record Maternal health card	Tick '√' if yes	
205. Vitamin K	When applicable Maternal health card	Tick '√' appropriate No/Yes	
206. RPR result and treatment	When applicable Postpartum record	Tick '√' if yes	
VI. Infant follow-up			
207. Exposed infant No.	Once HIV Care/ART card		
208. Infant feeding counseling support	When applicable Maternal health card Labour record Child health card	Tick '√' if yes Circle or code Yes/No in the maternal card	
209. Infant feeding practice	When applicable HIV care/ART card (encounter page) Maternal health card (in visits and L & D sections), child health card, exposed infant register at 3 months, labour and postpartum records, L & D register	Tick '√' or code appropriate EBF = exclusive breastfeeding, RF = replacement feeding, MF = mixed feeding, breast milk and other fluids	Add complementary feeding as an option as appropriate, defined as breast milk in addition to other solids or fluids after 6 months.
210. [Infant] HIV test	When applicable	dd/mm/yy	

Standard data variables for the three interlinked patient monitoring systems for HIV care/ART, MCH/PMTCT and TB/HIV and their coding

Variable name	Periodicity of collection and where recorded	Coding (full words, abbreviations or coding numbers may be used)	Notes
sent	Child health card, infant HIV care/ART card (summary page), exposed infant register: copy to mother HIV care/ART card (summary page), pre-ART and ART registers		
211. HIV test type	<i>When applicable</i> Child health card, HIV care/ART card (summary page), exposed infant register.	Tick '√' or code appropriate Ab = antibody HIV test, Virological test	
212. [Infant]HIV test result	<i>When applicable</i> Child health card, infant HIV care/ART card (summary page), exposed infant register: copy to mother HIV care/ART card (summary page), pre-ART and ART registers	Tick '√' or code appropriate Positive , Negative , Unknown	
213. presumptive Clinical diagnosis of severe HIV infection in infants	<i>When applicable</i> HIV care/ART card summary page	Tick '√'	
214. [Infant] cotrimoxazole given	<i>When applicable</i> Child health card, infant HIV care/ART card (summary & encounter pages), Exposed infant register: copy to mother HIV care/ART card (summary page), pre-ART and ART registers Link with TB treatment card	Tick '√' if infant was provided	Cotrimoxazole should be started at 4 - 6 weeks, and stopped when infant is confirmed negative. "CPT" on TB treatment card
215. Final status of infant	<i>Once</i> Child health card, infant HIV care/ART card (summary page), exposed infant register: copy to mother HIV care/ART card (summary page), pre-ART and ART registers	Dead if dead; P if positive; N if negative and no longer breastfeeding; N/BF if negative and still breastfeeding; or U if status unknown. Tick Yes/No on child health card	Final status at 18 months (if not sooner for dead or positive). If dead, write in date of death if known.
216. Action(s) needed during infant follow up visit	<i>When applicable</i> Child health card	Free text	
VII. TB/HIV			
TB suspects			
217. TB Suspect Number	<i>Once</i> At registration	How generated?	Is there a standard protocol to generate these numbers?
218. Date sputum collected	<i>When applicable</i>	dd/mm/yyyy	

Standard data variables for the three interlinked patient monitoring systems for HIV care/ART, MCH/PMTCT and TB/HIV and their coding

Variable name	Periodicity of collection and where recorded	Coding (full words, abbreviations or coding numbers may be used)	Notes
219. Date sputum sent to laboratory	<i>When applicable</i>	dd/mm/yyyy	
220. Date results received	<i>When applicable</i>	dd/mm/yyyy	
221. TB Treatment card opened	<i>When applicable</i>	dd/mm/yyyy	
222. Observations/c linician's diagnosis	<i>When applicable</i>	Free text	
TB laboratory			
223. Lab. serial No.	<i>Once</i> At receipt of specimen Copy to TB treatment card	How generated?	Is there a standard protocol to generate these numbers?
224. Date specimen received	<i>Once</i> At receipt of specimen	dd/mm/yyyy	Gives possibility to assess lead time between date of diagnosis and date of start treatment
225. Name of referring facility	<i>Once</i> At receipt of specimen, From referral slip	Free text Or coding	Facility that referred (sent) the patient (or specimen or slides) for sputum smear microscopy examination Referring facility is any health care provider formally engaged in any of the following TB control functions (DOTS): referring TB suspects/cases, laboratory diagnosis, TB treatment and patient support during treatment. Use standardized type of referring facility (see block 2 of the <i>Yearly Report on Programme Management in BMU</i>).
226. Reason for sputum smear microscopy examination	<i>Once</i> At receipt of specimen, From referral slip	Tick '√' if diagnosis Write month if follow-up	
227. Results of sputum examination	<i>When applicable</i> Copy to TB suspect register and TB treatment card, TB register	Fill in result for each specimen (1, 2, 3): (NEG): 0 AFB/100 fields; (1-9) exact number if 1 to 9 AFB/100 fields; (+): 10-99 AFB/100 fields; (++) : 1-10 AFB/field; (+++) : > 10 AFB/field	Is this the appropriate code??
228. Remarks	<i>When applicable</i>	Free text	Include ...[what for example?]

Standard data variables for the three interlinked patient monitoring systems for HIV care/ART, MCH/PMTCT and TB/HIV and their coding

Variable name	Periodicity of collection and where recorded	Coding (full words, abbreviations or coding numbers may be used)	Notes
TB Treatment			
229. BMU TB Register No	<i>Once</i> TB Treatment card After TB confirmed, copy to TB laboratory register, copy to TB register	How generated?	Is there a standard protocol to generate these numbers? Is this the register number or the patient number?
230. Disease site	<i>Once</i> TB Treatment card Copy to TB register	Tick '√' appropriate and/or write details Pulmonary/Extrapulmonary (EP) (specify)	
231. Type of patient	<i>Once</i> TB Treatment card Copy to TB register	Tick '√' appropriate and/or write details N, R, F, D, T, O N=New – A patient who has never Had treatment for TB or who has taken antituberculosis drugs for less than 1 month R = Relapse – A patient previously treated for TB, declared cured or treatment completed, and who is diagnosed with bacteriological (+) TB (sputum smear microscopy or culture) F = Treatment after failure – A patient who is started on a re-treatment regimen after having failed previous treatment D = Treatment after default – A patient who returns to treatment, positive bacteriologically, following interruption of treatment for 2 or more consecutive months. T = Transfer in – A patient who has been transferred from another TB Register to continue treatment O = Other previously treated – All cases that do not fit the above definitions	
INITIAL PHASE			
232. TB Treatment category	<i>Once</i> TB Treatment card Copy to TB register	Write in appropriate I, II , III	
233. Number of tablets per dose and dosage of S:	<i>When applicable</i> TB Treatment card Initial and continuation phase	[Number of tablets] Dosage	Number of tablets for RHZE, Cotrimoxazole, ARV, Other Dosage for S
234. Referral by	<i>When applicable</i> TB Treatment card laboratory register (name of referring facility)	Tick '√' appropriate and/or write details. Self-referral Community member Public facility	

Standard data variables for the three interlinked patient monitoring systems for HIV care/ART, MCH/PMTCT and TB/HIV and their coding

Variable name	Periodicity of collection and where recorded	Coding (full words, abbreviations or coding numbers may be used)	Notes
		Private facility/provider Other, specify	
235. Month of sputum smear microscopy	When sputum smear microscopy is done TB Treatment card	[Number 0-9 or as applicable]	Count months from treatment start (i.e. months of treatment).
236. Date of sputum smear microscopy	When sputum smear microscopy is done TB Treatment card	dd/mm/yyyy	
237. Drug administration	Each day drugs are administered Initial and continuation phase TB Treatment card (1-31 day of the month)	[Month name] Daily supply: enter ✓. Periodic supply: enter X on day when drugs are collected and draw a horizontal line (----) through the days supplied. Ø = drugs not taken	Fill the appropriate box after the drugs have been administered.
238. X-ray	Once At registration TB Treatment card Copy to TB register	dd/mm/yyyy Results: (-), (+), ND	At start of treatment alt. code: (Pos): Suggestive of TB, (Neg): Not suggestive of TB; (ND): Not Done.
239. Treatment outcome	When applicable TB Treatment card Copy to TB register, HIV care/ART card, ART register	dd/mm/yyyy Cure/Treatment completed/Died/Treatment failure/Default/Transfer out	Date of decision and tick the outcome
240. Comments/remarks	When applicable TB Treatment card, TB register	Free text	

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Participants in the May 2007 and September 2008 expert consultations:

Bold - attended both the May 2007 and September 2008 meetings; * Attended May 2007 meeting; ** Attended September 2008 meeting

*Bruce Agins (HIVQUAL - NYSDOH AIDS Institute, USA)

Priscilla Akwara (UNICEF)

*Robert Gass (UNICEF)

*Amy Bloom (USAID)

Anand Date (CDC GAP)

Laura Porter (CDC GAP)

*Nathan Shaffer (CDC GAP)

*Andrea Swartzendruber (CDC GAP)

*Alyssa Finlay (CDC, USA)

*K.J. Seung (Brigham and Women's Hospital, USA)

*John Milberg (HRSA-HIV/AIDS Bureau, USA)

**Mina Halpren (USA)

Alaisdair Reid (UNAIDS)

*Moses Bateganya (FXB Center Guyana)

**Deidre Thompson (CHAI, Guyana)

**Meg Osler (University of Cape Town, RSA)

*Vincent Tihon (National Department of Health, RSA)

Harry Hausler (University of the Western Cape, RSA)

*Andreas Jahn (Lighthouse Project, Malawi)

*Paluku Bahwere (Valid International, Malawi)

*Paula I. Fujiwara (IUATLD)

**Anthony D. Harries (IUATLD)

*Wuleta Lemma (Tulane University/FHAPCO, Ethiopia)

*Elizabeth Lowenthal (Baylor, Botswana)

*Mathabo Ntai (STI, HIV and AIDS Directorate, Lesotho)

**Norah Namuwenge (MOH, Uganda)

**Marianne Calnan (MOH, Swaziland)

*John Mansoer (CDC/ NLTP, Kenya)

*Victor Ombeka (National TB/HIV Coordinator, Kenya)

*Fredrick Sawe (Walter Reed Project, Kenya)

*Anne Barsigo (National AIDS/STD Control Programme, Kenya)

**Helen Ayles (ZAMBART Project, University of Zambia, Zambia)

**Stella Chale (I-TECH, UNited Republic of Tanzania)

**Harriet Nuwagaba-Biribonwoha (ICAP/Columbia University, United Republic of Tanzania)

*Bonita Kilama (National AIDS Control Programme, United Republic of Tanzania)

*Eliud Wandwalo (National TB/Leprosy Programme, United Republic of Tanzania)

*Halima Youssoufou Bourdanne (El Rapha Health Center, Côte d'Ivoire)

**Leontine Gnassou (MEASURE Evaluation, Cote d'Ivoire)

**Renée Fiorentino (MEASURE Evaluation)

Tisha Mitsunaga (MEASURE Evaluation)

**Upama Khatri (MEASURE Evaluation, USA)

**Mary Tegger (I-TECH)

**Mark Myatt (Institute of Ophthalmology, United Kingdom)

*Dan Bleed (Thailand)

WHO Regional and Country Offices

Abdikamal Alisalad (AFRO)

Frank Lule (AFRO)

**Inam Chitsike (AFRO)

**Spes Ntabangana (AFRO/Gabon)

**Dick Chamla (AFRO/Zimbabwe)

*Leonard Mukenge (AFRO/Burkina Faso)

**Véronique Bertolotti (EMRO)

**Hany Ziady (EMRO)

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*Irina Eramova (EURO)

**Astrid Foo (WHO Guyana)

*Binod Mahanty (WHO India)

**Rex Mpazanje (WHO Kenya)

**Nguyen Thi Minh Thu (WHO Viet Nam)

**Nuha Hamid (WHO Sudan)

**Nazar Kibangou (WHO Djibouti)

WHO HQ

Sandy Gove, HIV/SSH/IMAI

Eyerusalem Negussie, HIV/SSH/IMAI

**Sisay Sirgu, HIV/SIR/IMAI

**Akiiki Bitalabeho, HIV/SSH/IMAI

**Joseph Perriens, HIV/SSH

*Siobhan Crowley, HIV/ATC

Reuben Granich, HIV/ATC

*Marco Vitoria, HIV/ATC

*Charlie Gilks, HIV/ATC

*Rene Ekpini, HIV/PHS

*Annette Verster, HIV/PHS

Chika Hayashi, HIV/SIR

Yves Souteyrand, HIV/SIR

**Jean Michel Tassie, HIV/SIR

**Dongbao Yu, HIV/SIR

*André Briend, CAH/NCH

*Bernadette Daelmans, CAH/NCH

*Peggy Henderson, CAH/NCH

Nigel Rollins, CAH/NCH

Lulu Muhe, CAH/NCH

*Robert Scherpbier, CAH/CIS

*Craig Shapiro, IVB

*Mark Spohr, IER/KMS

**Philippe Boucher, HCI/HSI

*Ana Betran, RHR/MPH

*Archana Shah, MPS

**Anuraj Shankar, MPS

**Razia Pendse, MPS

*Carmen Casanova, NHD/NPL

*Chantal Gegout, NHD/NPL

Christian Gunneberg, STB/THD

*Rose Pray

Organization abbreviation

CDC GAP	The Center for Disease Control Global AIDS Plan
CHAI	The William J. Clinton Foundation's " Clinton HIV/AIDS Initiative"
FXB	Francois- Xavier Bagnoud Center
HRSA	Health Resources and Services Administration of the US Department of Health and Human Services
ICAP	The international Center for AIDS Care and Treatment Programs
I-TECH	International Training and Education Center on HIV
IUATLD	The International Union Against Tuberculosis and Lung Disease
MEASURE/Evaluation	Monitoring and Evaluation to Assess and Use Results
MOH	Ministry of Health
NLTP	National Leprosy and TB Programs
UNAIDS	The Joint United Nations Programme on HIV/AIDS
UNICEF	The United Nations Children's Fund
USAID	United States Agency for International Development
WHO	The World Health Organization

IMA Team
HIV Department
World Health Organization
20 avenue Appia
CH-1211 Geneva 27
Switzerland
E-mail: imaimail@who.int
<http://www.who.int/hiv/capacity/>

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