

National Mobile HIV Services Guidelines



'Reaching Out to Remote Communities'

March 2009



NATIONAL AIDS COUNCIL



MINISTRY OF HEALTH

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Table of Contents

Table of Contents.....	ii
Table of Figures.....	iii
Foreword.....	iv
Acknowledgements.....	v
Abbreviations.....	vi
Chapter 1: Introduction	1
1.1 Status of the HIV and AIDS Epidemic (2009).....	1
1.2 Aim of these Guidelines	1
1.3 Operational Principles.....	2
1.4 Mobile HIV Services Definitions and Terms	3
1.5 Mobile HIV Services Models	4
1.6 Associated HIV Community-based Services.....	7
1.7 Mobile site categorization	7
1.8 District Health Office (DHO) Responsibilities.....	7
1.9 Mobile HIV Service Units.....	8
1.10 MHS Units Members Knowledge & Skills.....	8
1.11 Members of HIV Mobile Unit.....	9
1.12 Mobile HIV Unit Equipment	10
Chapter 2: Counselling and HIV Testing (CT)	11
2.1 Introduction	11
2.2 Counseling and HIV Testing.....	11
2.3 HIV Post-test counseling	11
2.4 The National Testing Algorithm	12
Chapter 3: Prevention of Mother to Child Transmission (PMTCT)	13
Chapter 4: Post exposure prophylaxis (PEP).....	16
Chapter 5: Antiretroviral Therapy (ART).....	19
Chapter 6: Monitoring and Evaluation	27
Appendix	38
Indicators for Mobile HIV Services.....	39

Table of Figures

<i>Figure 1 Health Facility Host Site</i>	<i>4</i>
<i>Figure 2 Outreach Centre Host Site.....</i>	<i>5</i>
<i>Figure 3 Community-based Host Site.....</i>	<i>6</i>
<i>Figure 4 The national HIV testing algorithm.....</i>	<i>12</i>
<i>Figure 5 HAART for PEP</i>	<i>12</i>
<i>Figure 6 Post Exposure Prophylaxis</i>	<i>17</i>
<i>Figure 7- Site selection criteria</i>	<i>22</i>

Foreword

The Government of the Republic of Zambia has an obligation, and is committed to providing the country with equitable access to cost effective and quality health care, as close to the family as possible. It is against this background that the Ministry of Health is committed to achieving universal access to ART for both adults and children by 2010. This can only be achieved through the expansion and integration of Health services which are provided at either static facility and embarking on mobile service provisions.

The '*National Mobile HIV Services Guidelines*' outline among other approaches, the establishment of mobile Counselling and Testing (CT), Prevention of Mother To Child Transmission (PMTCT) and Antiretroviral Therapy (ART) services and enhancing linkages with other health within the framework of a continuum of care for HIV positive people

It is hoped that these guidelines will provide guidance and help accelerate efforts towards universal access to CT, PMTCT and ART services by all Zambians. It will be periodically updated as management evolves with changing times, and as need dictates.

This document has mainly been written for use by health care providers and gives guidance on how to implement integrated mobile health services at the community level.

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Abbreviations

3TC	Lamivudine
AIDS	Acquired Immunodeficiency Syndrome
ANC	Ante Natal Clinic
ARVs	Antiretroviral drugs
ART	Antiretroviral Treatment
AZT	Zidovudine (see ZDV also)
CO	Clinical Officer
CPs	Cooperating Partners
CT	Counselling and Testing
CTX	Co-trimoxazole
DBS	Dried Blood Spots
DATF	District AIDS Task Force
DHO	District Health Office
EFV	Efavirenz
FTC	Emtricitabine
GB	Gigabytes
HAART	Highly Active Antiretroviral Therapy
HIV	Human Immunodeficiency Virus
HMIS	Health Management Information System
LPV/r	Lopinavir boosted with Ritonavir
MAS	Mobile ART Services
MHS	Mobile HIV Services
MO	Medical Officer
MoH	Ministry of Health
MoH HQ	Ministry of Health Headquarters
NAC	National HIV/AIDS/STI/TB Council
NVP	Nevirapine
OI	Opportunistic Infection(s)
PCR	Polymerase Chain Reaction
PCP	Pneumocystis jirovecii pneumonia
PEP	Post Exposure Prophylaxis
PHO	Provincial Health Office
PLWHA	People Living with HIV and /or AIDS
PMTCT	Prevention of Mother-to-Child Transmission
RN	Registered Nurse
TB	Tuberculosis
TDF	Tenofovir
ZDV	Zidovudine
ZDHS	Zambia Demographic and Health Survey

Chapter 1: Introduction

1.1 Status of the HIV and AIDS Epidemic (2009)

Zambia is one of the Sub Sahara African countries worst affected by the HIV and AIDS pandemic. HIV transmission in Zambia occurs mainly through heterosexual contact exacerbated by high-risk sexual practices, gender inequity, and high levels of poverty, stigma and discriminatory practices and high prevalence of sexually transmitted infections. Another common mode of transmission is through mother-to child transmission.

The HIV prevalence currently stands at 14.3% (2007 ZDHS). Of about 470,000 babies born annually in Zambia, approximately 82,000 babies are born of HIV infected mothers. Without PMTCT interventions 35% of the babies will acquire HIV infection however with PMTCT intervention (currently at 60% coverage) the transmission is reduced to 10-15%. There is therefore need to care for and manage the patients with HIV and AIDS. The focus must be on providing cost-effective and quality health care and support as close to the family as possible.

The introduction of HIV mobile services, including antiretroviral therapy (ART) services is a very exciting step forward in Zambia's response to the HIV pandemic. This initiative supports Zambia's national strategic framework on HIV, and Zambia's goals of increasing the number of people living with HIV that are accessing life-saving treatment.

It is in view of the foresaid factors that the Zambian Ministry of Health through the National AIDS Council embarked on a consultative process to develop the National Mobile HIV Services Guidelines that shall provide the framework of operationalizing the concept of Mobile HIV Services provision.

1.2 Aim of these Guidelines

The aim of these guidelines is to:

- Ensuring that services provided by mobile HIV units fall within Zambia's national strategic plan on HIV and AIDS
- Ensuring that mobile ART, PMTCT and CT activities undertaken fall within the District action plan
- Ensure standardized delivery of HIV related services at all sites where mobile ART, PMTCT and CT services will be implemented
- Ensuring that services provided by the HIV clinic units falls within the national guidelines
- Define the minimum standards in the package of care provided through mobile HIV services
- Ensure that Mobile Units have representation from the Provincial Health Offices, District Health Offices, Health Facilities (public and private), and Cooperating

Partners and are able to implement and operationalize integrated mobile HIV services

1.3 Operational Principles

Mobile HIV Services provide a mechanism for the enhancement of the Ministry of Health's response to HIV in underserved and/or remote communities. This innovation will support sites that do not have the full complement of facilities and human resources to provide comprehensive HIV services. The mobile HIV services provide an opportunity for the Ministry of Health and its cooperating partners to deliver HIV services to persons who do not have access to health facilities with all the required HIV services.

General principles related to the operations of the mobile HIV units include:

- Mobile HIV units operate under the jurisdiction and oversight of the district health offices.
- The services provided by the mobile HIV service units should be within accepted medical and ethical standards, as determined by Ministry of Health and Medical Council of Zambia
- Care provided to patients by the mobile HIV service units should focus on a continuum of care which includes HIV education, HIV prevention, counselling and HIV testing, psychosocial support, opportunistic infection management, and antiretroviral therapy.
- The mobile HIV units operate following a pre-determined schedule which is communicated to the supporting site, host sites and clients
- The mobile HIV services unit will not provide a transport service for patients to and from referral facilities
- Data will be collected at the host site, analyzed and reported to the District Health Office (DHO)

1.4 Mobile HIV Services Definitions and Terms

HIV Services: Services required to provide Counselling and HIV Testing (CT), Prevention of Mother to Child Transmission (PMTCT) and Antiretroviral Therapy (ART)

Mobile HIV Services (MHS): HIV Services that are offered at a *host site* outside the work station of the *supporting site* on a regular basis. The services provided by the mobile unit at the host site should be complementary to provide a package that is comprehensive¹

Supporting Site: A health facility that is fully accredited² to provide HIV services as a standalone site that has resources to support other facilities to provide the same services

Host Site: A *fixed* or *dynamic site* (see section 1.7) that functions as a service point for mobile HIV service delivery

Outreach centre: A fixed site/premises (may not be a health facility), associated with a host site

Mobile ART Service (MAS): A mobile service that provides antiretroviral therapy

E-First: is a data entry mode supported in SmartCare in which data is entered directly into the software application by the clinical provider and the patient leaves with the current visit information updated on his/her smartcard

E-Fast: is a data entry mode supported in SmartCare in which data is entered by a dedicated data entry person or healthcare provider after the patient has been seen by clinical provider. The current visit information is updated on patient's smartcard the same day before the patient leaves the site

E-last: is a data entry mode supported in SmartCare in which data is entered from paper records. A dedicated data entry person or a healthcare provider enters this data into SmartCare. The patient's smartcard is updated with the current visit the next time the patient visits that health site. In the case of power failure or no power at the mobile, or need for paper backups, the e-last mode is preferred

¹ Refer to the Medical Council of Zambia "Accreditation Guidelines" and PMTCT, CT guidelines

² Refer to the Medical Council of Zambia "Accreditation Guidelines" and PMTCT, CT guidelines

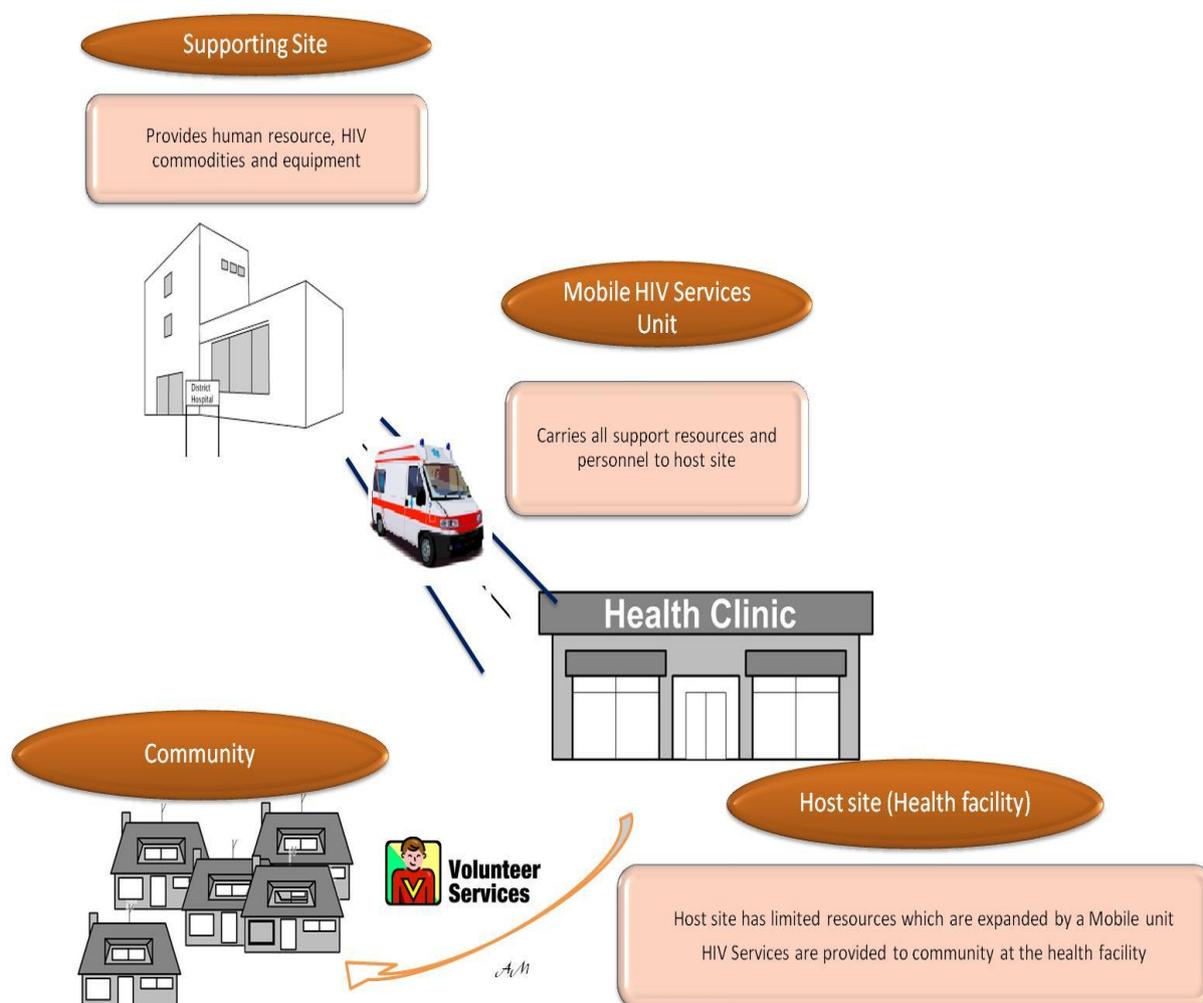
1.5 Mobile HIV Services Models

Three basic models of mobile HIV service provision will be supported by the Ministry of Health throughout Zambia. Mobile HIV services offered at a:

a. Health Facility Host Site

In this model a Mobile HIV Service (MHS) unit is dispatched from the supporting site to provide clinical and material support to a remote community through a health facility (see figure 1). The health facility may be a health centre or health post. The host site and the MHS unit are able to provide a comprehensive HIV service package. All or part of the HIV services (CT, PMTCT and ART) can be provided at this site.

Figure 1 Health Facility Host Site

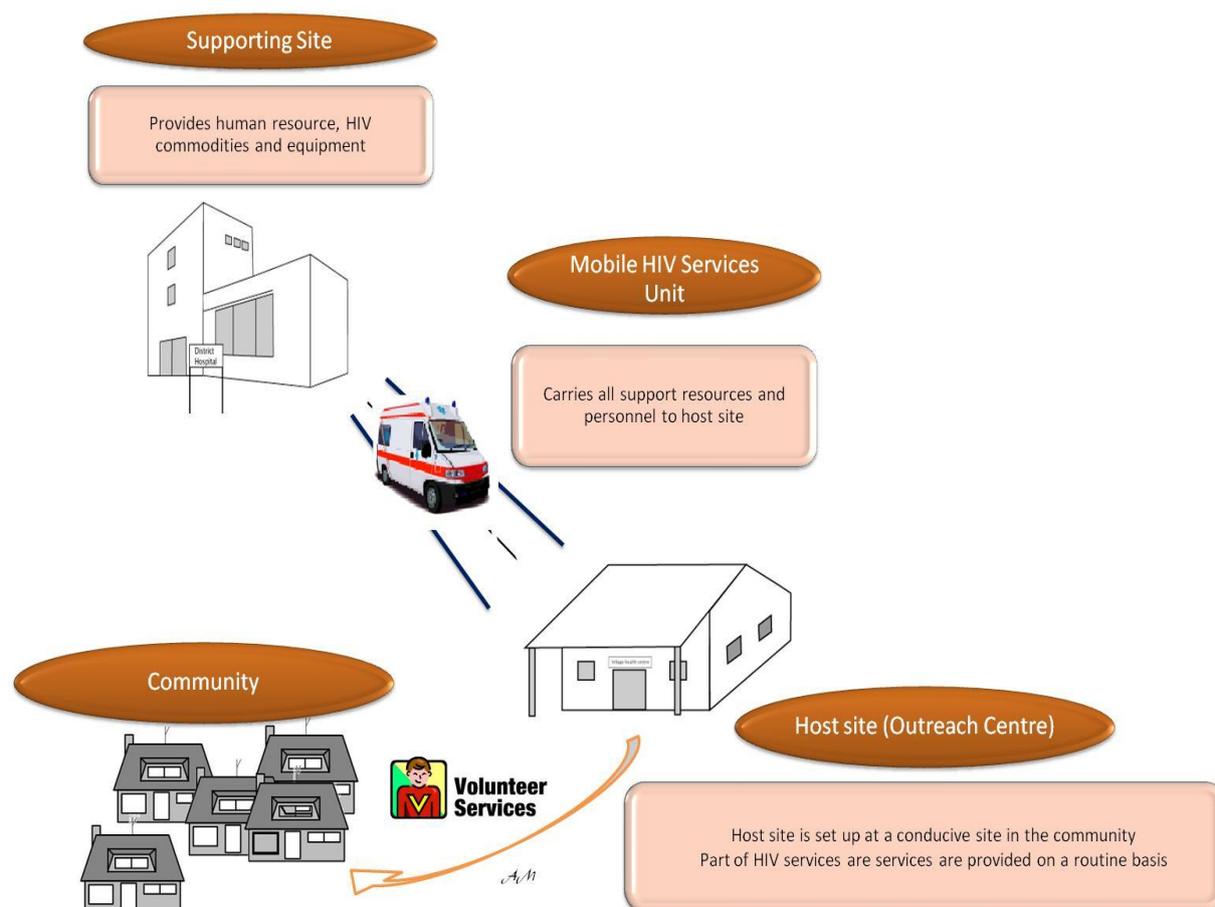


b. Outreach Centre Host Site

In this model a Mobile HIV Service (MHS) unit is dispatched from the supporting site to provide clinical and material support to a remote community through a health facility associated outreach centre. The outreach centre has very limited facilities and may or may not be a health facility, such as a community hall. This site is used routinely for recurring mobile health service provision. Only part of the HIV services may be offered at outreach centres depending on the facilities available:

- CT services can be offered provided privacy for counselling sessions can be guaranteed, and there is provision for safely conducting the rapid HIV test
- PMTCT services can be offered provided there are facilities for Maternal and Child Health services
- ART services **should not be** offered at these host sites as they do not offer a comprehensive ART package

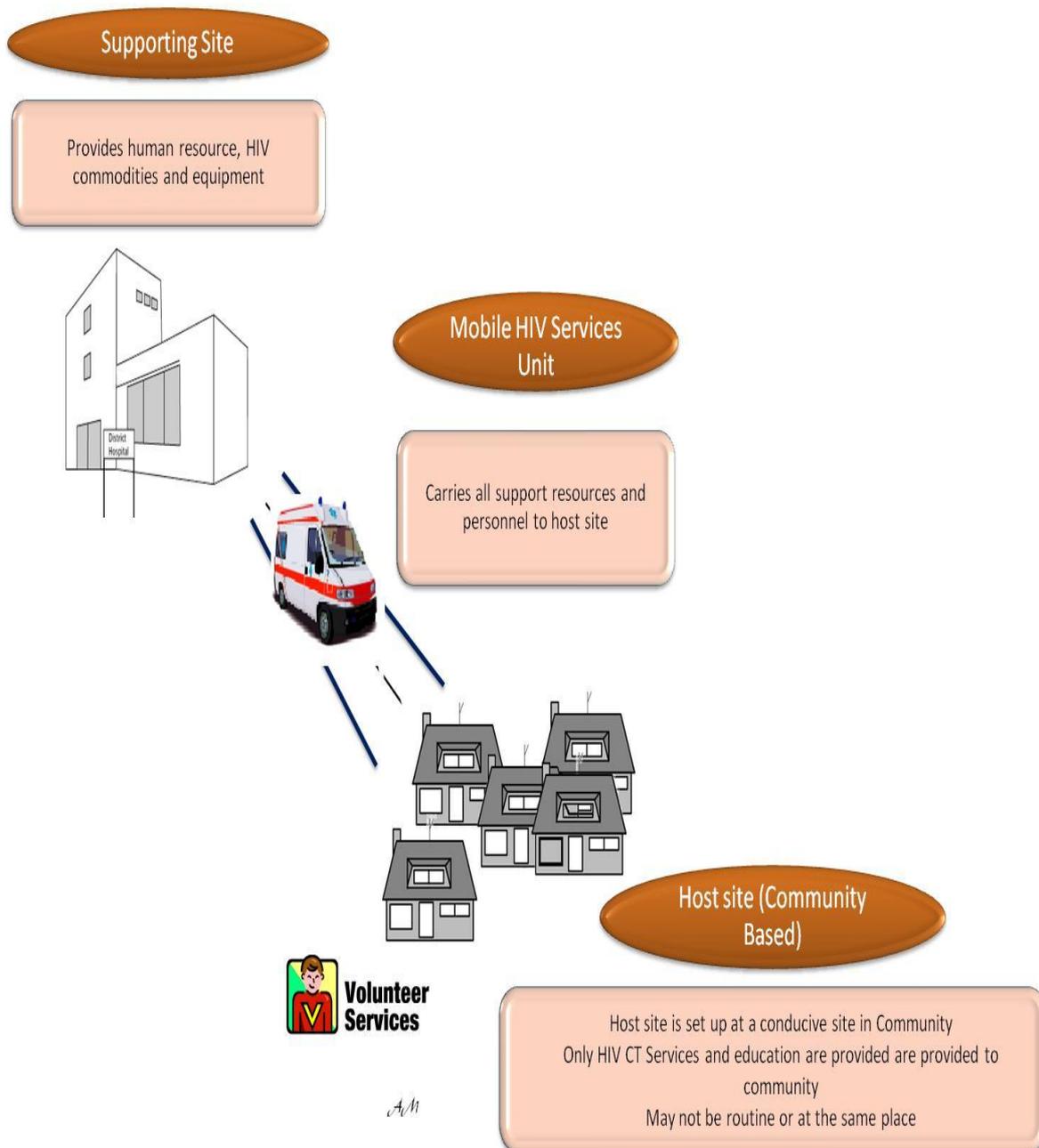
Figure 2 Outreach Centre Host Site



c. Community-based Host Site

In this model a Mobile HIV Service (MHS) unit is dispatched from the supporting site to provide clinical and material support to a remote community through a community based site. The community based site has very limited facilities and **is not** a health facility. The difference from an outreach centre host site is that the services are not routinely offered from this site. Only CT services may be offered at these host sites provided privacy for counselling sessions can be guaranteed, and there is provision for safely conducting the rapid HIV test

Figure 3 Community-based Host Site



1.6 Associated HIV Community-based Services

Volunteer services that are community based such as HIV and ART education, advocacy, community mobilization, adherence support and patient tracking (after defaulting treatment) should be offered as part of the continuum of care.

1.7 Mobile site categorization

Mobile HIV Services can be divided into the following categories based on the site selected to provide the services:

- Fixed health facility – such as a health centre or health post. The MHS unit offers routine comprehensive HIV services at the facility
- Fixed premises (may not be a health facility), associated with a host health facility. The same site is used for routine recurring MHS provision
- Dynamic site where mobile service provision is event-based and may change often (e.g.: VCT event or blood donation drive)

1.8 District Health Office (DHO) Responsibilities

Mobile HIV Service will be coordinated and operated from the DHO. The DHO will provide leadership in the implementation and operationalization of these guidelines. It is thus expected that the DHO will:

- Determine which host sites to use, taking into consideration factors such as distance, travel time and clinic catchment populations of proposed health centres to be supported
- Provide medications and medical consumables required for the provision of the HIV services
- Report achievements relating to CT, PMTCT and ART uptake, and ART adherence to Ministry of Health National through Health Management Information System (HMIS) and SmartCare
- Provide the required Staffing of the MHS units
- Provide oversight for the provision of the mobile HIV services through support supervision and regular monitoring and evaluation
- Determine the working area and operational reporting structure for the mobile HIV services units
- Liaise with the District AIDS Task Force (DATFs)

1.9 Mobile HIV Service Units

The team that is constituted by DHO at the supporting site has the following characteristics;

- The MHS unit provides clinical and supportive services
- The MHS unit is multi disciplinary and may include members from the medical, nursing, clinical, laboratory, pharmacy, community, counselling and data management support staff to provide comprehensive support to a host facility
- Each MHS unit is self-sufficient, carrying with it all necessary equipment, medications and logistical needs to be able to provide Counselling and HIV Testing (CT) services; limited scope of Antiretroviral therapy (ART) services; and Prevention of Mother To Child Transmission (PMTCT) services to clients in a confidential manner, within minimum space as provided for at host site
- The MHS unit provides services in any acceptable and conducive structure which should provide a confidential work space for the mobile staff and the clients
- Patient care data is managed by both the supporting and host sites (where applicable)

1.10 MHS Units Members Knowledge & Skills

All members of the HIV mobile units will be oriented and receive training in:

- Basic HIV facts for information, ensuring that all unit member have a universal message for clients
- National guidelines for the delivery of CT, PMTCT, ART and OI treatment
- Monitoring and evaluation systems and procedures
- Quality control procedures
- Tools and aids to be used by the units

1.11 Members of HIV Mobile Unit

Each mobile HIV unit will consist of at least four staff, with the minimum of:

Table 1 – Mobile HIV unit staffing

Staff	Minimum Number required	Criteria
Medical Officer or Clinical Officer	1	<ul style="list-style-type: none"> • Qualified and register with the Medical Council of Zambia • Certified by in MOH in approved curriculum for ART, OI's & PMTCT (depending on service being provided) • Computer literate (added advantage)
Nursing staff	2	<ul style="list-style-type: none"> • Qualified and registered with the General Nursing Council of Zambia • Certified by in MOH in approved curriculum for ART, OI's & PMTCT (depending on service being provided) • Trained and registered as a CT Counsellor • Computer literate (added advantage) • Need to include a pharmacy technologist for dispensing and adherence counselling
Pharmacy technologist/dispenser	1	<ul style="list-style-type: none"> • Qualified and register with the Medical Council of Zambia • Certified by in MOH in approved curriculum for ART, OI's & PMTCT (depending on service being provided) • Trained as an CT/adherence counsellor • Computer literate (added advantage)
Field Assistant / Data Entry Clerk	1	<ul style="list-style-type: none"> • Computer literate • Trained HIV educator • Certified by in MOH in approved curriculum for SmartCare and HMIS
Community Volunteers (Preferably from host site)	1	<ul style="list-style-type: none"> • Able to read and write • Trained in HIV services • Computer literate (added advantage)

1.12 Mobile HIV Unit Equipment

The mobile HIV unit operates on the principle of a unit that is equipped with knowledge, skills, medical equipment, medication, medical consumables, and logistical equipment is transported to an identified host site, where they will deliver mobile HIV services. The delivery of these services should not interrupt the normal operations of the host site.

The minimum standards for equipment and medical supplies for the mobile HIV unit are per current National protocols in VCT, PMTC and ART. The following kits provide a list of items that may be included in the various mobile kits (additional items be added as necessary):

General (CT, PMTCT, ART) Mobile Kit

- Clinical coats and Aprons
- Disinfectant/JIK; Swabs
- Examination and Sterile Gloves
- Sharps bottles/boxes
- First Aid Box
- Medicine trolley –with ARVS, CTX and OIs drugs
- Weighing scales, BP machine (digital), Stethoscope, Thermometers
- Specimen bottles
- Creatinine clearance calculator
- Transport: Vehicle (primarily for mobile HIV services), motor-bikes (for sample referral), bicycles for adherence support and patient tracking

CT Mobile Kit

- Rapid HIV test kits (Determine and Uni-Gold)
- Pipettes (for Determine)

PEP Mobile Kit

- CT kit
- Eye Flash (for washing accidental spills in the eyes)

Laboratory Mobile Kit

- Rapid diagnostic Kits (e.g. urinalysis, glucose, malaria rapid diagnostic test, Hemocues Test (Hb), Pregnancy test, RPR)
- Equipment for laboratory testing (syringes (different volumes), test tubes, lancets, etc)
- Portable fridge and/ or cooler box for lab samples

Health Medical Records Mobile Kit

- Lockable mobile filing boxes/cabinets (with all appropriate registers, forms, and stationary)
- Laptop with extra battery
- Flash drives (1 GB)

Chapter 2: Counselling and HIV Testing (CT)

2.1 Introduction

Counselling and testing for HIV (CT) has been an effective HIV transmission risk reduction strategy since 1994. With the introduction of ART, CT is provided as an entry point to care and support for People living with HIV and AIDS in the Zambian communities.

The outreach activities have been ongoing in most areas, but there is still a gap in some hard to reach rural areas. Strengthening of mobile CT services increase community awareness, improve CT uptake and increase access of other HIV services. Mobile CT services should be offered at a host site for groups and families on a regular basis. In order to provide a meaningful and comprehensive outreach package to the community, the CT services should be provided by a multi disciplinary mobile HIV service unit which may include members from the medical, nursing, clinical, laboratory, pharmacy, community; and counselling services. These services are provided in a confidential and conducive environment.

2.2 Counseling and HIV Testing

The current standard Zambia National HIV Testing Algorithm is used to conduct HIV testing. Trained personnel in Counselling and HIV testing as per Zambian Counselling Council standards, National PMTCT and VCT programmes should perform counselling and HIV testing and provide the result on the spot. During the outreach sessions, HIV testing is performed in a conducive place that will provide privacy, where a health provider takes blood for a rapid HIV test. The person trained in rapid HIV testing takes blood samples, applying current National Algorithms for testing. After the test has been performed, the health care provider enters the results in the Laboratory HIV Test Register. The register is kept confidential. The advantage of the rapid test is that it can be done in a short period of time and therefore the results are available same day.

2.3 HIV Post-test counseling

HIV post-test counselling should be provided to all clients. Clients should receive their results, regardless of their HIV status on the same day. All HIV positive clients ideally, should have a clinical assessment and based on eligibility criteria be referred to an ART programme. HIV positive clients should receive counselling about partner notification and disclosure, stigma and discrimination and shared confidentiality. HIV results and the post-test counselling sessions should be recorded in the Counselling Register.

Client-initiated HIV testing to determine HIV status provided through voluntary counselling and testing remains critical to the effectiveness of HIV prevention.

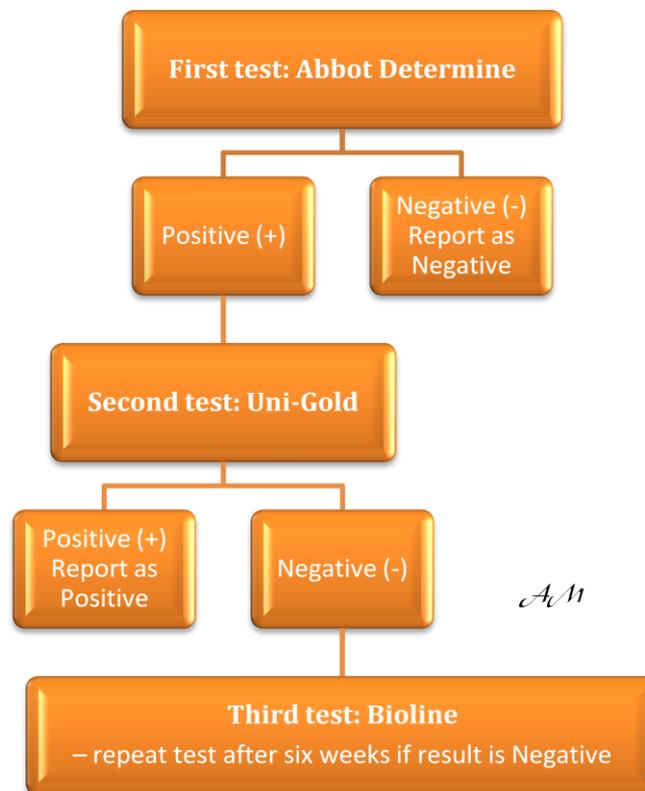
2.4 The National Testing Algorithm

Ministry of health in its current national HIV testing algorithm recommends the following testing kits:

- Abbot Determine HIV Test
- Uni-Gold HIV Test
- Bioline HIV 1/2 Test

The national HIV Counselling and Testing guidelines encourage the use of rapid tests so that results are provided in a timely fashion and can be followed up immediately with a first post-test counselling session for both HIV negative and HIV positive individuals/couples.

Figure 4 The national HIV testing algorithm



Note: Advise negative clients to repeat test after six weeks

Chapter 3: Prevention of Mother to Child Transmission (PMTCT)

3.1 Introduction

Mother-to-Child Transmission (MTCT) is by far the largest source of HIV infection in children below the age of 15 years. According to UNAIDS estimates, more than 90 percent of children who acquire the virus through Mother-to-Child Transmission, do so before birth, during birth, or through breastfeeding.

The Zambia National PMTCT Programmed uses an opt-out approach. The first step in the PMTCT programme is for all pregnant women to know their HIV status. The opt-out approach means that HIV testing is part of the routine laboratory processes undertaken during pregnancy should the woman give consent.

It is recommended that, counselling and testing for HIV, is done together with other antenatal procedures. The blood should be collected, tested and results given the same day.

3.2 Antenatal care services

Provision of Antenatal care during the mobile outreach visits aims at making pregnancy and delivery a safe experience for the mother. It is also intended to build the foundation for the delivery of a healthy baby.

All pregnant women meeting the criteria for ART should be treated with HAART. Those on ART prior to pregnancy should continue HAART throughout pregnancy. However, if the regimen contains Efavirenz (EFV), inform the mother on the need of substituting this drug as it has been associated with teratogenicity in the first trimester. However, the mother is encouraged to continue with the same regimen if no alternative drugs are available.

Mobile HIV services provide an appropriate platform for clients that might not have easy access to the Health Services. Some of the key activities of MHS will include the following:

- To remind the HIV positive mothers that may deliver at home about ARV doses for self administering at the beginning of labour, and for the baby within 72hours of birth, preferably as soon as possible after delivery
- Request that the HIV positive mother goes to the health facility within 72 hours after delivery for the NVP, 3TC and AZT syrup baby doses and for immunizations
- Monitoring side effects and adherence for both the mother and infant if on HAART
- Provide infant feeding counselling to parents and guardians
- Encourage parents and guardians on importance of partner testing

3.3 Paediatric care in PMTCT

Paediatric care of PMTCT includes:

- Monitoring adherence to chosen infant feeding practice and provision of necessary support.
- HIV positive mothers who opt for breastfeeding should be supported for safe transition from exclusive breastfeeding to supplementary feeding
- Dispensing of Cotrimoxazole to prevent *Pneumocystis jirovecii* Pneumonia (PCP) and other opportunistic infections from 6 weeks of age to 12 months
- Encourage frequent clinical visits to monitor clinical signs of HIV infection and provide routine paediatric care including immunizations

All MHS units should offer collection of DBS for PCR HIV testing and referral to ART for positive babies

3.4 Counselling and HV Testing

For babies less than 12 months do HIV diagnosis using PCR at 6 weeks. For babies with no access to Early Infant HIV Diagnosis using PCR, test the baby at 12 months and re-test the baby at 18 months using rapid tests. It should be noted that for as long as the baby continues to breast feed he/she remains at risk for contracting HIV infection.

HIV positive mothers should also be monitored at all baby contacts including during immunization, clinic and outreach visits especially during mobile HIV service provision. In addition the mothers should be encouraged to follow their regular appointments for HIV care. Referral mechanisms and procedures for babies and mothers needing additional clinical care should be determined during the mobile clinics. Mothers should also be provided with appropriate patient education materials.

An expanded role for the trained community counsellors should provide on-going counselling for clients, follow-up of defaulters, and sensitization of community members on the importance of HIV testing. The community counsellors should be part of the mobile HIV services unit.

HIV testing for the brothers and sisters of HIV exposed infants as well as children presenting with clinical signs of HIV infection through the counselling and testing services should be considered. Partners or husbands of HIV positive women should also be offered HIV testing.

3.5 Prophylaxis with Cotrimoxazole for babies

Pneumocystis jirovecii pneumonia (PCP) is the leading killer of HIV infected babies. Primary prophylaxis against *Pneumocystis jirovecii* should therefore be provided through the use of oral Cotrimoxazole suspension for at least the first year of life. Cotrimoxazole is given to all HIV-exposed babies i.e. all babies born from HIV positive mothers starting at six weeks of life and continues until at least 12 months if the baby still tests HIV positive.

MHS units should provide CTX prophylaxis to eligible patients -children and adults. The MHS unit should care adequate supplies of CTX to provide prescriptions and refills.

3.6 Clinical evaluation and follow-up of babies

All children should be registered at birth, and protected from violence, abuse and neglect. Follow-ups on HIV exposed babies should be frequent. Babies growth should be monitored and development of milestones. HIV positive children should be clinically evaluated and assessed for eligibility.

Encourage participation of community members in all aspects of PMTCT care, from counselling, testing, referral and follow up HIV positive mothers to be supplied with adequate amounts of required drugs after being tested and also encourage facility based delivery

Chapter 4: Post exposure prophylaxis (PEP)

4.1 Introduction

Post exposure prophylaxis services are also offered by the mobile HIV service units to all individuals presenting themselves to the mobile ART unit within 72 hours of accidental exposure to HIV. There are two main indications for PEP namely:

- *Occupational exposure*; A health care provider who is exposed at work will be eligible for post-HIV exposure prophylaxis in accordance with the National Guidelines for Antiretroviral Drug Therapy (MoH NAC 2007 ART Protocol)
- *Non – occupational exposure*; A victim of sexual assault will be eligible for post – HIV exposure prophylaxis in accordance with the National Guidelines for Antiretroviral Therapy (MoH NAC 2007 ART Protocol)

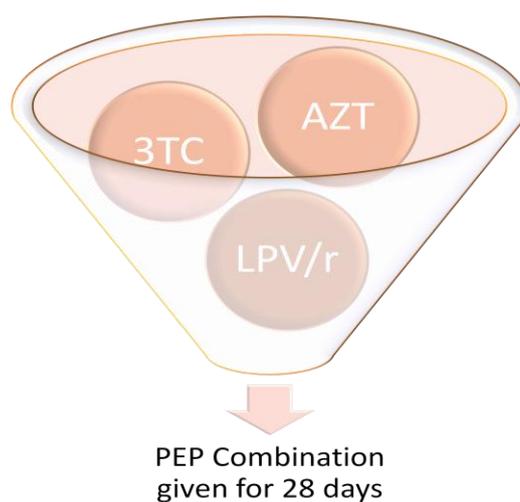
In the event of accidental exposure to HIV, caregivers will be able to access Post Exposure Prophylaxis, following the laid procedure.

4.2 Post Exposure Prophylaxis Package

Post exposure prophylaxis entails a package (see *figure 6*) that includes:

- HIV counselling and testing immediately after exposure
- PEP is offered only if the HIV test is negative
- Short – course (four weeks) antiretroviral therapy, which should be a 3 drug regimen for all treated exposures is: AZT+3TC+LPV/r for 28 days, (the alternative should be TDF / FTC / LPV/r)

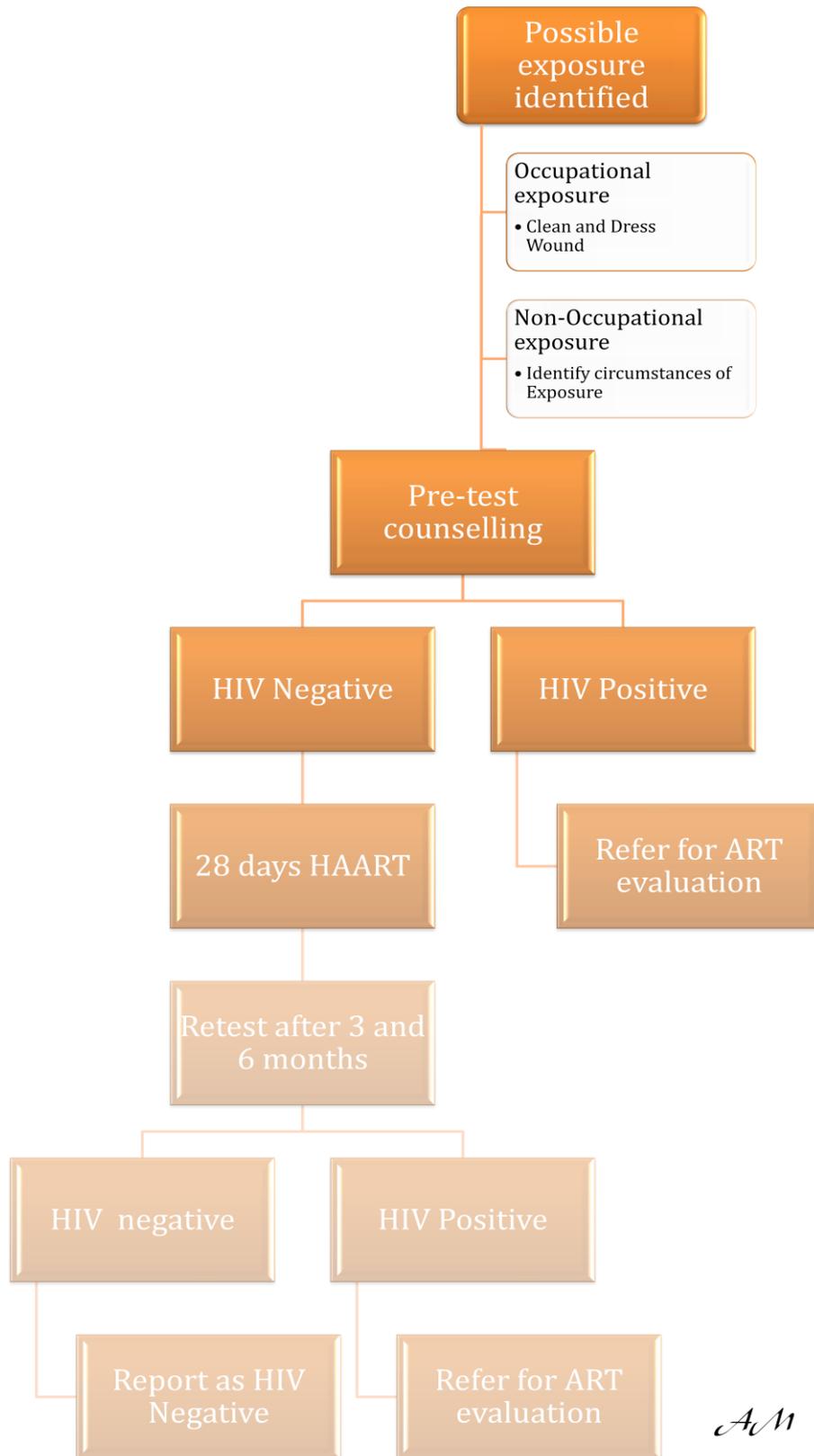
Figure 5 HAART for PEP



Art

- Repeat HIV testing after 3 months and 6 months. If the test is positive refer patient to ART centre for further evaluation .

Figure 6 Post Exposure Prophylaxis



AM

4.3 Universal precautions

Mobile HIV services units work with HIV positive clients, and people who's HIV status may be unknown, all clients, and client's samples should be treated as potentially infectious, and therefore strict adherence to recognized universal safety precautions should be followed at all times; including:

- Washing hands regularly, particularly after examining a patient or handling any samples of body fluids
- Wearing latex examination gloves when examining a patient or undertaking procedures on a patient, and when handling any body fluids or contaminated items
- Wearing protective clothing such as laboratory coat, facemasks and protective eyewear
- Clean up any spilt body fluids on surfaces as soon as they happen, with a disinfectant

Chapter 5: Antiretroviral Therapy (ART)

5.1 Introduction

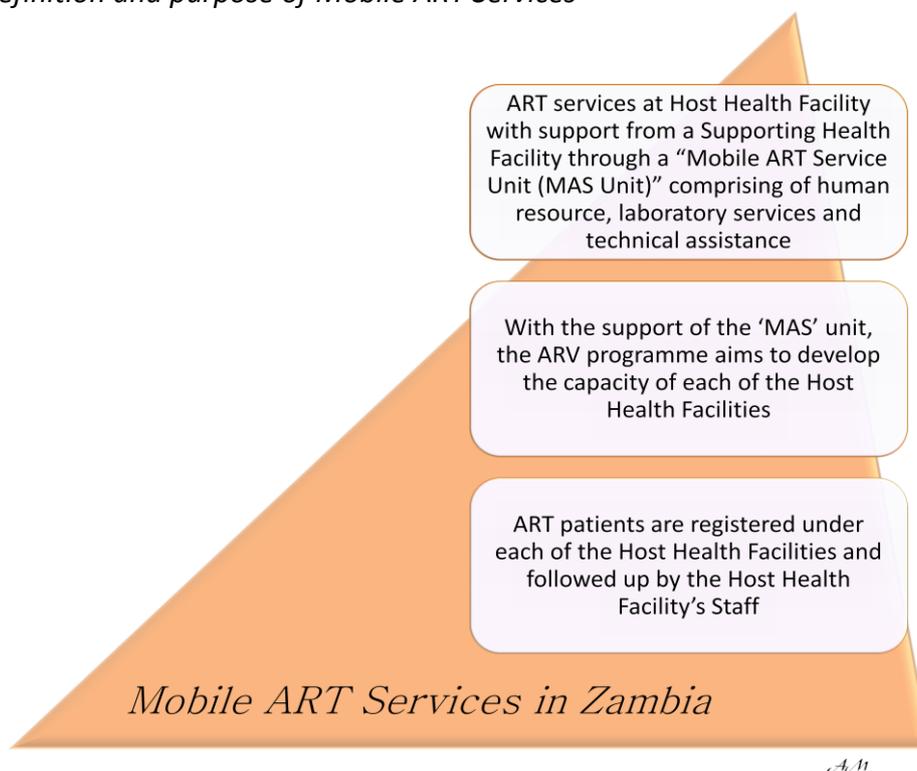
The purpose and definition of Mobile ART service

As the Ministry of Health, Zambia emphasizes the need to provide services as close to the family as possible, decentralization of ART treatment sites as close as possible to the community also becomes a priority. However, the resource of health facilities is limited especially in rural areas. Rural Health Centres do not have all the resources to provide the ART services. Assistance, in terms of human resources and laboratory service, from higher levels, i.e. District Hospital and the DHO teams, becomes imperative.

Having been found in a situation of having an urgently scale up ART services in remote communities and with only few areas having the necessary resources and capacities for the scale up, Ministry of Health ARV Programme proposed to introduce Mobile ART Services.

The definition and purpose of Mobile ART Services in Ministry of Health system is as follows:

Figure 7 Definition and purpose of Mobile ART Services



5.2 The merit of using health facility

Considering the merits of using health facility as listed below, the Ministry of Health strongly recommends the use of health facility as host sites for Mobile ART Services provision:

- Health facilities usually have already developed good relationship with community
- In absence the of mobile ART unit, the clients can continue to receive quality services
- It a more cost effective approach

5.3 Scope of work by MAS

Mobile ART Services will be expected to manage patients with uncomplicated HIV or with no complications ART. Only stable HIV patients should be considered for initiating HAART at a MAS site. For an eligible treatment naive patient to be initiated on ART at a MAS site s/he **should not be in need of a referral for the following:**

1. Patient has a condition requiring referral to a district clinician:
 - a. severe illness
 - b. any condition in stage 4 with 2 exceptions:
 - i. non-severe oesophageal thrush
 - ii. chronic Herpes simplex ulcerations
2. Patient is currently on TB treatment
3. Patient has jaundice or known liver problem
4. Patient has a chronic condition such diabetes mellitus, asthma, hypertension etc
5. Patient is a child with weight less than 10kgs
6. Patient is not treatment naive
7. Patient is an injecting drug user/addict

5.4 District Health Office Role

The District Health Office plays the pivotally role of coordinating and implementing this programme. In collaboration with key stakeholders the DHO will:

- Monitor and evaluate the programme
- Promoting stakeholder collaboration in the programme
- Develop the implementation plan
- Organize and arrange the Mobile ART Services (MAS) Unit activities
- Requisition/procure all the of necessary commodities
- Report to the Province Health Office
 - MOH Centre
 - PHO
 - CPs
- Liaise with the DATFs

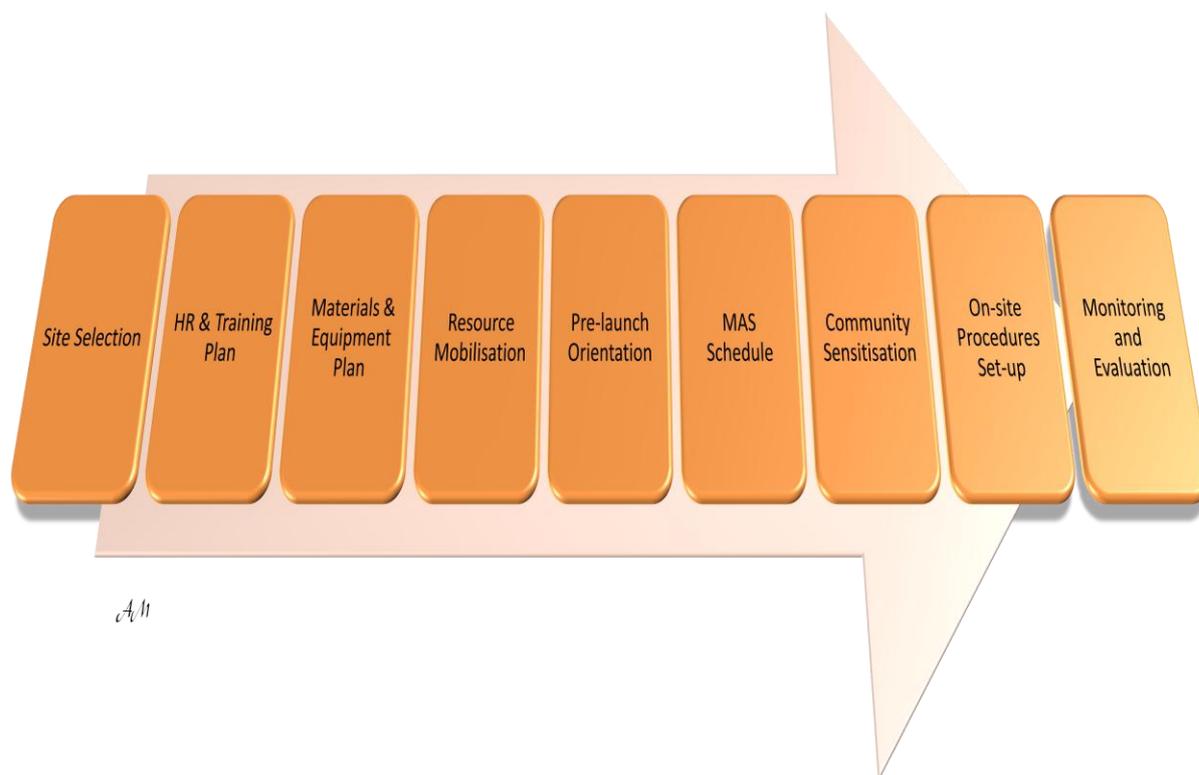
5.5 Planning

Development of a good implementation plan followed by thorough preparation will lead to positive outcomes. The DHO plays pivotal role in effectively developing and sound plan for the MAS activities. To develop an effective plan, a situation analysis is required to identify the needs in the district. DHO should conduct a thorough situation analysis with broad consultation with all relevant stakeholders.

5.6 Steps for Setting-up Mobile ART Services (MAS)

The following steps are recommended to follow when setting up MAS. IT is also encouraged for DHOs to modify these steps (if necessary) and document these modifications so as to optimize on the implementation. See figure 8.

Figure 8- Steps in setting up MAS



5.7 Site Selection

A mobile ART site should be selected after considering the following:

Figure 7 Site selection criteria



DHO's are advised to operate only mobile ART services at a level within their capacity of oversight. To limit in efficiencies in management, mobile ART services must be expanded in a phased approach. In the initial phase it is recommended that easy to manage sites are opened. After selection of ART sites, DHO can develop the ART expansion plan phases.

5.8 Human Resource and Training Plan

List up the necessary human resources and develop the training plan. The necessary skills and trainings are as follows:

- ART/OI management skills and training
- Paediatric ART/OI management
- Psychosocial counselling skills and training
- PMTCT training
- DCT skills and training
- DBS for Early infant diagnosis
- Adherence counselling skills and training
- Data management training
- Commodity (laboratory & pharmacy) management training

5.9 Materials and Equipment Acquisition Plan

List the necessary materials and equipment and develop the logistic plan. The necessary materials and equipment needed at the mobile ART site are listed in Chapter 1 (section 1.12).

5.10 Resource Mobilisation

In line with the DHO plan, DHO should start mobilising the required resources:

- To allocate the necessary staff
- To conduct the necessary trainings
- To request/procure the necessary materials and equipment
- To organize the “Mobile ART Service Unit”

Composition of Mobile ART unit :

- Medical officer, CO/Medical ,licentiate (trained in ART/OI management
- Nurse who trained on ART and OI management
- Pharmacy technician/Dispenser trained in ART/OI and ART logistics

See Chapter 1, section 1.9 for more details

To avoid burn out of the staff, the unit members should work in shifts. With time members of the MAS Unit can be reduced as the capacity of Host Health Centre develops.

5.11 Pre-Launch Orientation

Orientation of the supporting and host sites must be conducted. There should also be distribution of necessary equipment to the host site prior to starting of the services. All implementers of this programme should fully understand the concept of Mobile ART Services. This will promotes ownership of the program.

The following should be addressed;

- How to prepare the support and host ART clinics
- How to book the HIV positive clients for ART service day
- How to keep the records, registers books and patients files
- How the host site can manage ART clients :-
 - Defaulter tracing
 - Adherence and compliance counselling
 - ARV side effects discussions
- Establish and strengthen existing referral system

The host MAS site should have the following:

- Waiting, Screening, Dispensing, Counselling and testing spaces .
- Adequate privacy
- Control of nosocomial infection (especially TB)

DHO and Partners should distribute the necessary materials discussed in Section 5.1

5.12 Mobile ART Services Schedule

Each Health Facility should develop its own schedule. To do this, they should avoid an overlap with other activities such as ANC, under five clinics, etc. This mobile ART service should be offered at least every two weeks and also when need arises. This will enable follow up of side effects particularly the Nevirapine related ones.

For convenience, ART service days must be held on fixed working days. Alternative arrangements can be made for public Holidays.

5.13 Community sensitizations

This can be achieved through the following:

- Posters/ fliers/Signboards
- Community Health Volunteers
- PLWHA and other Self support groups
- Chiefs/ Leaders of community
- Person to person transfer of information
- Drama groups

5.14 On-site Procedure Set-up

Clinic set-up

The following should be put in place:

- Preparation of space for ART clinic
(Clean up the rooms, layout the furniture, bring in the registers, patients files, and other necessary requirements)
- Assignment of works to all Health Facility Staff
(Check Roles and responsibilities)
- Arrange for smooth patient flow system.
(e.g.; Numbered ticket is useful for this purpose)

The role of Host site staff and Mobile ART unit

As per MOH recommendation the Host Health facility staff should take a leading role in the provision of ART service. This is in conjunction with the Mobile ART Service unit;

Mobile ART Service Unit should provide the technical support (on the job training/bed side training), laboratory support and pharmacological support. Mobile ART Service Unit should refrain from doing everything within the unit. Host site staff need most of the help at the beginning. The MAS unit must make a deliberate effort to develop the capacity of the Host Health Facility staff.

HIV care and treatment

Clinicians must follow “National Guidelines on Management and Care for People Living with HIV and AIDS”. Each site should have all the recommended national policies and guidelines as reference. **Quality of ART service at the Host Health facility in conjunction with the mobile ART service unit support must be equal to that of Static ART sites.** In addition to this, clinicians must pay special attention to clients receiving care under Mobile ART Services because of the limited resources at the host site (which will provide follow up) and because of the intervals of the ART clinic days.

Particular attention should be paid to the following;

- Careful follow up for side effects
- Careful observation on IRIS and OIs
- Careful monitoring of ART adherence including defaulter tracing

Laboratory Supports for mobile ART sites

All laboratory testing will be undertaken at a centralized laboratory, requiring samples to be collected stored and transported from the host mobile unit site to the central laboratory. Requirements for laboratory testing samples are:

- Maintain a cold chain
- Blood samples should sent to the supporting site and should be analyzed within 24 hour
- Laboratory samples should be refrigerated immediately after drawing to ensure that the cold – chain is maintained

Stock management of drugs, testing kits, and other necessary equipments

HIV Commodities and consumables should never stock out, especially ARVs. The Logistic Management System used by the MoH if used properly will ensure that no stock outs are ever experienced. The MAS unit must plan ahead of each visit so that they do not run out commodities whilst in the field. They unit must also ensure that all equipment are in good work condition.

5.15 Monitoring and evaluation

Recording and Reporting

- Recording -Use of the SmartCare system (ART Forms and SmartCare Software) is encouraged however a paper-based system may be used if this is not feasible.
- MoH recommend using the “Pre-ART Register” and “ART Monthly Register” for management of PLWHA in care.
- Reporting-Use SmartCare and the revised HMIS
- Use national standard data collection tools (SmartCare ART Forms)

Evaluation

Technical support from MOH HQ, PHO and MOH cooperating partners

Chapter 6: Monitoring and Evaluation

6.1. Introduction

This section describes the SmartCare implementation framework and its use for mobile HIV services. It also discusses the paper based implementation in similar settings.

6.2. General challenges in mobile patient care and treatment

There are a number of cross cutting issues that affect the provision of mobile HIV services:

- Effective and timely patient identification and tracking when conducting follow up
- Continuity of patient care and management of referrals
- Monitoring and evaluation including generation of MoH reports for patient care and facility administration and management
- Unique patient identification to avoid double-counting at the supporting site and the host site

SmartCare can be operated in three usage/data modes – namely, eFirst, eLast and eFast modes (*see chapter one for definitions of these terms*). Resources and certain criteria determine the data entry mode and data collection tools that could be used in mobile sites:

- Electricity or alternative power source (battery, solar etc)
- Duration of service provision – few hours may warrant use of laptops and electronic data entry at the service point, while one day and longer may call for a combination of e-fast or e-last data entry modes
- Data collection – VCT or PMTCT service provision has lesser data elements to capture per interaction or patient visit. In such cases, data can be entered in e-first mode with smartcards being distributed. Data-heavy services such as ART would require further assessment – e-last mode may be preferred if ART paper forms are filled for backup first, followed by data entry at the associated health facility
- Personnel skills – In host sites (health facility associated site and community-based site), if laptops are used for data entry, the mobile unit personnel must be trained in using the keyboard and mouse instead of the touchscreen. Alternatively, the touchscreen must be connected to the laptop for data entry

Based on the current SmartCare implementation, the next section will describe how to effectively use the SmartCare system in full view of the above challenges.

6.3. Guidelines on Implementing VCT Programs in mobile settings

The national VCT program supports activities at both fixed and mobile/outreach sites. Data collection, collation and aggregation can be done via paper based and computerised methods. Paper based methods involve the usage of registers, activity sheets, tally sheets and aggregation report forms; while computer based methods involve the use of SmartCare. Both paper based methods and computerised methods anticipate that the mobile site can be a fixed location associated with a health facility, or a dynamically varying location associated with a health facility.

6.4. General Operational Considerations (VCT Programs)

- Patient/client data must be available at the mobile site as well as the associated health facility for referral and reporting purposes
- The same set of data tools are used at both the supporting and host (mobile) sites
- Data collected from CT activities in the outreach mobile sites are reported under the supporting health facility
- It must be ensured that patient ID numbers issued at the host facilities are unique

6.5. Specific Operational Guidelines (VCT Programs)

a) Paper based facilities

Paper based facilities would operate a mobile facility by means of existing processes, which involve maintaining the same type of paper documentation at the host (mobile) facility as that available at the supporting facility. As such, records of the host (mobile) facility are seen as an extension of the supporting facility.

b) Computerised facilities

SmartCare data collection, collation and aggregation at mobile facilities are done in either:

- a. *eFirst Mode*
OR
- b. *eFast Mode*
OR
- c. *eLast mode*

Each facility should select, and be aware of, one of SmartCare operation mode as listed above. Each operation mode is discussed below:

i) Mobile VCT service provision in *eFirst* Mode

In this SmartCare operation mode, the mobile VCT facility requires:

- a) SmartCare installed on a mobile laptop
- b) A SmartCare user
- c) A VCT service provider (who may be the same person under b, above)

In this mode, SmartCare is installed on a mobile laptop and taken to the mobile VCT location for data entry etc. Data entered into SmartCare would be merged back to the supporting facility SmartCare installation. Both the supporting facility's SmartCare computer and the SmartCare installation on the laptop **must have identical** facility information, with the site code being the only varying attribute.

ii) Mobile VCT service provision in *eFast* Mode

In this SmartCare operation mode, the mobile VCT facility requires:

- a) SmartCare installed on a mobile laptop
- b) A SmartCare user
- c) A VCT service provider (who may be the same person under b, above)

In this mode, SmartCare is installed on a mobile laptop and taken to the mobile VCT location for data entry etc. Data is collected onto the VCT primary paper documents (registers), and then entered into SmartCare. Data entered into SmartCare would be merged back to the supporting facility SmartCare installation. Both the supporting facility's SmartCare computer and the SmartCare installation on the laptop **must have identical** facility information, with the site code being the only varying attribute.

iii) Mobile VCT service provision in *eLast* Mode

In this SmartCare operation mode, the mobile VCT facility requires:

- a) Primary paper documents (registers, excluding tallies and aggregation forms – these are secondary documents that SmartCare would produce)
- b) A VCT service provider

In this mode, VCT services are provided at the mobile location using primary documents (secondary documents, such as tally sheets and aggregation forms are not used in this case, as they would be printed out from SmartCare, once the information is entered into the SmartCare at the fixed service VCT facility). Once data is collected onto registers, the registers are returned to the fixed parent facility for data entry onto SmartCare.

This mode avails the opportunity to use Smart Cards at the point of service, which ensures continuity of care.

6.6. Guidelines on Implementing PMTCT Programs in mobile settings

The section describes data collection, collation, service provision and data aggregation guidelines for the PMTCT program, performed under a mobile setting. MCH/PMTCT services are done via paper based and computerised methods. Paper based methods involve the usage of registers, activity sheets, tally sheets and aggregation report forms; while computer based methods involve the use of SmartCare. Both paper based methods and computerised methods anticipate that the mobile site can be a fixed location (outreach centre) associated with a health facility, or a dynamically varying location associated with a health facility.

6.7. General Operational Considerations (PMTCT Programs)

- Patient/client data must be available at the mobile site as well as the associated health facility for referral and reporting purposes
- The same set of data tools are used at both the Fixed sites and Mobile sites
- Data collected from the PMTCT activities in the outreach mobile sites are reported under the supporting health facility
- It must be ensured that patient ID numbers issued are mobile facilities are unique

6.8. Specific Operational Guidelines (PMTCT Programs)

a) Paper based facilities

Paper based facilities would operate a mobile PMTCT facility by means of existing processes, which involve maintaining the same paper documentation at the mobile facility as available at the main facility. As such, records of the mobile facility are seen as an extension of the main facility.

b) Computerised facilities

SmartCare data collection, collation and aggregation at mobile facilities is done in either:

- i) *eFirst Mode*
OR
- ii) *eFast Mode*
OR
- iii) *eLast mode*

Each facility should select, and be aware of, one of SmartCare operation mode as listed above. Each operation mode is discussed below:

i) Mobile PMTCT service provision in *eFirst* Mode

In this SmartCare operation mode, the mobile PMTCT facility requires:

- a) SmartCare installed on a mobile laptop
- b) ANC Card or Obstetric record book
- c) A SmartCare user
- d) A PMTCT service provider (who may be the same person under b, above)

In this mode, SmartCare is installed on a mobile laptop and taken to the mobile PMTCT location for data entry etc. Data entered into SmartCare would be merged back to the supporting facility SmartCare installation. Both the supporting facility's SmartCare computer and the SmartCare installation on the laptop **must have identical** facility information, with the site code being the only varying attribute.

This mode avails the opportunity to use SmartCare and ANC Cards / Obstetric record book in a mobile facility, which ensures continuity of care.

ii) Mobile PMTCT service provision in *eFast* Mode

In this SmartCare operation mode, the mobile PMTCT facility requires:

- a) SmartCare installed on a mobile laptop
- b) ANC Card or Obstetric record book
- c) A SmartCare user
- d) A PMTCT service provider (who may be the same person under b, above)

In this mode, SmartCare is installed on a mobile laptop and taken to the mobile PMTCT location for data entry etc. Data is collected onto the PMTCT primary paper document – the ANC card or Obstetric record book, and then entered into SmartCare while the client is available. Data entered into SmartCare would be merged back to the supporting facility SmartCare installation. Both the supporting facility's SmartCare computer and the SmartCare installation on the laptop **must have identical** facility information, with the site code being the only varying attribute.

This mode avails the opportunity to use Smart Cards and ANC Cards / Obstetric record book in a mobile facility, which ensures continuity of care.

iii) Mobile PMTCT service provision in *eLast* Mode

In this SmartCare operation mode, the mobile PMTCT facility requires:

- a) Primary paper documents (ANC card or Obstetric records book, excluding tallies and aggregation forms – these are secondary documents that SmartCare would produce)
- b) A PMTCT service provider

In this mode, PMTCT services are provided at the mobile location using primary documents – ANC Cards or Obstetric record books. (Secondary documents, such as tally sheets and aggregation forms are not used in this case, as they would be printed out from SmartCare, once the information is entered into the SmartCare at the supporting service PMTCT facility). As the primary document is carried by the client, the primary documents must be completed in duplicate – one for the client and one for data entry at the main facility. Once data is collected onto the client cards/books (ANC Card or Obstetric record book), the duplicate cards/books are returned to the fixed parent facility for data entry onto SmartCare. Other secondary documents are also produced – such as registers and activity sheets, including the aggregation and reporting form.

This mode does not avails the opportunity to use Smart Cards as the client would have left by the time the data is entered into the SmartCare system.

6.9. Guidelines on Implementing ART Programs in mobile settings

The section describes data collection, collation, service provision and data aggregation guidelines for the ART program, performed under a mobile setting. ART services are done via paper based and computerized methods. Paper based methods involve the usage of registers, activity sheets, tally sheets and aggregation report forms; while computer based methods involve the use of SmartCare and ART forms. Both paper based methods and computerized methods anticipate that the mobile site can be a fixed location (outreach centre) associated with a health facility, or a dynamically varying location associated with a health facility.

6.10. General Operational Considerations

- Patient/client data must be available at the mobile site at time of service, and as well as the associated health facility – at end of service, for referral and reporting purposes
- The same set of data tools are used at both the Fixed sites and Mobile sites
- Data collected from the ART activities in the outreach mobile sites are reported under the supporting health facility
- It must be ensured that patient ID numbers issued are mobile facilities are unique

6.11. Specific Operational Guidelines

a) Paper based facilities

Paper based facilities would operate a mobile ART facility by means of existing processes, which involve maintaining the same paper documentation at the mobile facility is available at the main facility. As such, records of the mobile facility are seen as an extension of the main facility.

b) Computerised facilities

SmartCare data collection, collation and aggregation at mobile facilities is done in either:

iv) *eFirst* Mode

OR

v) *eFast* Mode

OR

vi) *eLast* mode

Each facility should select, and be aware of, one of SmartCare operation mode as listed above. Each operation mode is discussed below:

iv) Mobile ART service provision in *eFirst* Mode

In this SmartCare operation mode, the mobile ART facility requires:

- a) SmartCare installed on a mobile laptop
- b) ART forms
- c) A SmartCare user
- d) An ART service provider (who may be the same person under b, above)

In this mode, SmartCare is installed on a mobile laptop and taken to the mobile ART location for data entry etc. Data entered into SmartCare would be merged back to the supporting facility SmartCare installation. Both the supporting facility's SmartCare computer and the SmartCare installation on the laptop must have identical facility information, with the site code being the only varying attribute.

This mode avails the opportunity to use Smart Cards and ART forms in a mobile facility, which ensures continuity of care.

v) Mobile ART service provision in *eFast* Mode

In this SmartCare operation mode, the mobile ART facility requires:

- a) SmartCare installed on a mobile laptop
- b) ART forms
- c) A SmartCare user
- d) An ART Service provider

In this mode, SmartCare is installed on a mobile laptop and taken to the mobile ART location for data entry etc. Data is collected onto the ART primary paper document – the ART forms, while the client is available. Data entered into SmartCare would be merged back to the supporting facility SmartCare installation. Both the supporting facility's SmartCare computer and the SmartCare installation on the laptop **must have identical** facility information, with the site code being the only varying attribute.

This mode avails the opportunity to use Smart Cards and ART forms in a mobile facility, which ensures continuity of care.

vi) Mobile ART service provision in *eLast* Mode

In this SmartCare operation mode, the mobile ART facility requires:

- a) Primary paper documents (ART forms, excluding tallies and aggregation forms – these are secondary documents that SmartCare would produce)
- b) An ART service provider

In this mode, ART services are provided at the mobile location using primary documents – ART Forms. (Secondary documents, such as tally sheets and aggregation forms are not used in this case, as they would be printed out from SmartCare, once the information is entered into the SmartCare at the fixed service ART facility). As the primary document is NOT carried by the client, there is no need to duplicate the primary documents. Once data is collected onto the ART forms, the ART forms returned to the supporting facility for data entry onto SmartCare. Other secondary documents are also produced – such as registers and activity sheets, including the aggregation and reporting forms from, the main facility.

This mode does not avail the opportunity to use Smart Cards as the client would have left by the time the data is entered into the SmartCare system.

6.12. SmartCare Reports

SmartCare application will generate standard MoH reports for:

- Patient clinical care such as:
 - ANC Trifold Card for ANC / PMTCT service
 - Patient Summary Report for any SmartCare service – useful in ART service
 - These reports can be used at the mobile site for patient care, data backup

- Health facility registers:
 - Counselling Register – VCT / PMTCT service
 - Safemotherhood Card – ANC / PMTCT service
 - ART Registers – CD4 Monitoring, Treatment failure and regimen reports
 - These reports can be viewed/printed at the mobile site (if it is fixed health facility) or can be printed at the associated health facility (if the mobile site is treated as a sub-site of the associated health facility)

For mobile sites with associated health facility (scenarios B and C above), SmartCare user account creation, application of role based security, site configuration and central management of site codes **MUST be managed** at the supporting health facility.

6.13. Mobile HIV Service Reports

Every quarter a supporting site must complete a Mobile HIV Service report for all of its host sites. See Appendix for indicators in the report.

Appendix

Data Collection Tools

MOBILE HIV SERVICES REPORT	
Report date:	<input type="text"/>
Quarter reporting on	From: <input type="text"/> to: <input type="text"/>
Province	<input type="text"/>
District	<input type="text"/>
Name of Support Site	<input type="text"/>
Facility Code	<input type="text"/>
Mobile/Host site(s)	<input type="text"/>
Report Compiled by	<input type="text"/>
For more information / questions about the report, contact:	Name: <input type="text"/>
	Tel number: <input type="text"/> Fax: <input type="text"/>
	Email: <input type="text"/>
I verify that this information is complete and correct and that I have not misrepresented any information in this report	
Signed:	<input type="text"/>
Designation:	<input type="text"/>
Date:	<input type="text"/>

Indicators for Mobile HIV Services

Fill out this form for EACH Host Site Host Site Name and Code: <input type="text"/>	Disaggregation	Number
Indicators		
1. Number of people sensitized on abstinence and being faithful prevention	Male	
	Female	
2. Number of condoms distributed	Male	
	Female	
3. Number of people who accessed CT services and received their test results	Male	
	Female	
	Pregnant women	
4. Number of pregnant women accessing PMTCT	Females	
5. Number of pre – ART patients treated	Total Male	
	<1	
	1-4	
	5 – 14	
	15 – 49	
	>49	
	Total Female	
	<1	
	1-4	
	5 – 14	
	15 – 49	
	>49	
	6. Number of ART patients treated	Total Male
<1		
1-4		
5 – 14		
15 – 49		
>49		
Total Female		
<1		
1-4		
5 – 14		
15 – 49		
>49		
7. Number of people started on ART therapy		Total Male
	<1	
	1-4	
	5 – 14	
	15 – 49	
	>49	
	Total Female	
	<1	
	1-4	
	5 – 14	
	15 – 49	

National Mobile HIV Services Guidelines

8. Number of mothers offered and started PMTCT short course	Females	
9. Number of ART patients who did not attend a scheduled follow up visit	Male	
	Female	
10. Number of patients lost to the ART programme (e.g. due to death, stopped taking ART etc)	Male	
	Female	
11. Number of people who accessed adherence counselling	Male	
	Female	
12. Number of referrals to NZP+, Support Groups, CBOs and FBOs	Male	
	Female	

