ADDIS ABABA CITY ADMINISTRATION HEALTH BUREAU

STANDARD OPERATING PROCEDURES

FOR

ART SCALE UP TO HEALTH CENTERS AND PRIVATE FACILITIES

JULY 2006

Addis Ababa City Administration Health Bureau

Standard Operating Procedures

For

Decentralizing ART Initiation and Follow Up Care to Public Health Centers and Private Facilities

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The Addis Ababa City Adminstration Health Bureau

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FOREWORD

Universal access to free Ante retroviral Therapy was launched in our country in January /2005, when there were 04 hospitals providing the service. The demand was however growing faster partly due to the previously well established VCT program in the city, and because of the free access. The ART program was limited to Hospitals, which couldn't cope up with the fast rising demand.

The bureau, as a result, considered the scale up to the Health Centers and Private facilities, which were obviously the next assets.

The urgent need to scale up ART to Health Centers and to Private/NGO facilities has prompted the Addis Ababa Health Bureau to produce an initial Standard Operating Procedure (SOP) for ART Initiation and Follow Up Care to Health Centers and Private Facilities.

This has become an important stepping stone to enable continued scale up of the ART program, maintaining quality of the service. Effective ART program implementation necessitates interaction between hospitals (Federal and Regional), Health Centers, Private facilities, Sub Cities and partners under the coordination of the Addis Ababa City Administration Health Bureau, which is directed in the document.

Currently, 18 out of 23 Health Centers are initiating ART. The scale up will continue using this Standard Operational Procedure Document. Besides 09 private Hospitals are providing free Ante retroviral drugs. The process will continue to involve as many health facilities as possible, to address the needy.

Finally the bureau would thank organizations and individuals that contributed to the development of this important document, which will be further matured according to the experience we get in the process of implementation.

Alemnesh Wolde,MD,MPH

Head,Addis Ababa Health Bureau

PREFACE

The Ante retroviral drugs were being prescribed at private facilities as early as 2003, on pay basis in Addis Ababa. The VCT program was also getting well organized since 2003, when at least 100,000 people get tested annually. Currently this has come up to an average monthly uptake of 23,000, with a total of more than 200,000 getting tested annually.

After the ART program was universally made freely accessible in March of 2005, this made the limited number of Hospitals unable to tolerate the burden which intern has an impact on the service quality.

A consultative meeting was called with all relevant partners, on March 03/2006,to discuss on the options of further scale up of the ART. Here it was possible to agree on the fact that Health Centers and the private facilities are the next assets of further ART scale up.

The challenges faced when starting the scale up were:

1) Health Centers and Hospitals do have poor referral communication

2) The federal Hospitals did not have formal connection with Health Bureau, Health Centers and Sub Cities

3) There was no consensus as to which types of patients need to be attended at Health Centre level, and at what rate should a hospital send patients to the respective Health Centre. Because for example, if Zewditu Hospital sends patients without any number limit, the health centre might fail to accommodate and patients will suffer and Health centre scale up might become a reason to default.

4) It was necessary to clarify the criteria as to which type of patients need to be transferred, like interest/will of the patient, clinical parameters ,required documents the patient needs to fulfill like Kebele ID etc. Besides, issue of clinical Mentorship for the Health Centers, amount of drug a patient should have at hand when transferred out from a Hospital, the time range a patient should register at a Health Center, when he/she should collect the first drugs from the Health Centre, how patient flow should look like, what the role of facility staff at the client stops, and, mechanism of ensuring the arrival of transferred out patients at the Health Center , the laboratory sample transfer, drug distribution and Management etc. all needed to be clarified.

That is why the bureau drafted the first Standard Operational Procedure document which was subjected for repeated comments by individuals, and major Regional meetings, held on June 2-3 /06 and Aug 3-4/06 .

This led us to the first workable document, and the scale up was tried by transfer out of stable patients from the Hospitals according to the document. Six Catchment Areas called by the Hospital of the catchment area are established. Catchment teams formulated, that consist of Hospitals, Health Centers and sub cities of a catchment area as well as major supporting partners. Weekly catchment meetings were scheduled and continued to be persistently conducted using the tools in the SOP.

The SOP has then helped to develop intimacy and functional communication between Hospitals and Health Centers of a given catchment. Patients transferred out are listed and brought to the catchment meetings by the hospital representative, and those received are listed and presented by the Health centre delegate to cross check, according to a listing format in the SOP.

It was possible to get a lot of practical lessons during the implementation, Feed backs were persistently collected during the catchment meetings, and it was then possible to mature it further.

Currently the Document encompasses procedure for reception of stable patients on ART at Health Centers, and that of ART initiation of new patients by Health Centers.

Besides the next assets for scale up, namely the private facilities were considered and Standard Operational Procedure prepared, commented by the private sectors on a meeting held on Oct 15/06 as well as by all relevant partners ,and incorporated into this SOP document which led to the private facility free Ante retroviral provision scale up recently .

The primary objective of this guideline is thus to improve access to quality Ante retroviral Therapy services by efficient scale up to Health centers and to the private sector with proper handling of patients flowing between these facilities.

The SOP has therefore set out to introduce the required steps, related forms and checklists, and the responsibilities and required coordination between the key stakeholders to ensure the success of the decentralization process as per the rollout plan by the Addis Ababa City Administration Health Bureau.

Please note that detailed technical considerations can be found in the appendices.

The document is ready for further update in future too.

ACKNOWLEDGEMENT

This Standard Operational Procedure is prepared in executing the plan designed to address the current urgent need to ART ART Scale up in Addis Ababa

Besides, the bureau would acknowledge the following Organizations who are members of the ART Task Force at AAHB (with the exception of DACA), and provided feed back in the process. These are:

FMOH/HAPCO

Drug Administration and Control Authority

AA HAPCO

Clinton HIV/AIDS Initiative

Johns Hopkins University

FHI Ethiopia

RPM PLUS

AMREF

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ACRONYMS

AAHB	Addis Ababa Health Bureau
ART	Ante retroviral Therapy
ARV	Ante retroviral
CCF-C	Christian's Children Fund of Canada
CHF	Congestive Heart Failure
FMOH	Federal Ministry of Health
HAPCO	HIV/AIDS Prevention and Control Office
HC	Health Center
Hct	Haematocrit
Hgb	Hemoglobin
HMIS	Health Management Information System
HO	Health Officer
LFT	Liver Function Test
MD	Medical Doctor
M&E	Monitoring & Evaluation
MOU	Memorandum of Understanding
NGO	Non Governmental Organization
OPD	Out Patient Department
PIHCT	Provider Initiated HIV Counseling and Testing
PMTCT	Prevention of Mother to Child Transmission
QA	Quality Assurance
RFT	Renal Function Test
SOP	Standard Operational Procedure
STI	Sexually Transmitted Illnesses
TB	Tuberculosis
TOR	Terms of Reference
WBC	White Blood Cells

2. Introduction

Addis Ababa, capital of Ethiopia, situated at the heartland of Ethiopia, in an area of 540 square kilometres, is divided in to 10 administrative sub cities and 99 Kebeles.

According to the 1994EC Statistics Authority, the total Projected Population for 1999EC is -----out of which ----is male and ----female. The population pyramid is broad based, typical of a developing world. The main causes of morbidity and mortality are communicable diseases that could be prevented through interaction of primary health care activities. HIV /AIDS, Tuberculosis, and nutritional deficiencies assuming greater importance.

The Addis Ababa Health Bureau is responsible for the overall Health activity in the city. There are health departments at each sub city. HIV is a priority health agenda in Adds Ababa. The city is among the hugely affected urban areas of the nation at an adult prevalence of 11.7%, according to the 2005 surveillance report by MOH. There are 207,000 people living with HIV/AIDS, out of which 46,000 require Ante retroviral Therapy .Besides there are 14,000(as 2003 surveillance shows) children living with HIV/AIDS, among which an estimated of 4,900 require Ante retroviral Therapy.

The City has 13 public Hospitals (05 under the bureau) ,and 24 Health Centres. In addition there are 15 Private General, 07 specialized Hospitals as well as 89 Higher ,110 medium , 98 lower ,90 specialized clinics (ENT, ophthalmology, Dentistry, etc.

Since National HIV/AIDS policy was set in 1998, there are different programs being scaled up in the prevention and control of the epidemic. The bureau has involved the private sector as well in the fight against the HIV/AIDS, first with the Voluntary Counselling and Testing in 2004, which proved a breakthrough for public private partnership , and currently with free ARV provision at the private sector.

There are 153 Centres for Voluntary Counselling and testing currently, out of which 65 % are private/NGO facilities, with reasonably good recording and reporting system. Besides, there are 33 PMTCT Centres. About 104,000,186,000,196000 and 226,114 get HIV Counseling and testing in 1995EC (2002-2003), 1996 EC (2003-2004), 1997 EC (2004-2005) and 1998EC (2005-2006) respectively, with a monthly average uptake of about 23,000.

ART was initiated in Addis in 2003 on a fee basis. Universal free access was possible in the public sector in March of 2005, when 04 public Hospitals began the service. Ante retroviral Therapy was limited to Hospital level, which led to inconvenience to patients due to accessibility problems, and let the hospitals saturate, which intern compromises quality. It was therefore very crucial that Health Centers begin providing Ante retroviral Therapy, for which the development of this document was needed.

Currently all public Hospitals in Addis Ababa provide free Ante retroviral Therapy, and after we developed the first draft working Document(Standard Operational Procedure for ART Decentralization to Health Centers in July/06,and recently for the private sector, it was possible to scale up Ante retroviral Therapy to Health Centers and private Hospitals. Currently, there are 18 Health centers that initiate Ante retroviral Therapy, and 09 private Hospitals providing free Ante retroviral Drugs.

In effect, 22,856 people took ART (100 %achievement of road map targets), 984, are children((plan was 895.In the Health Centers ,260 clients are initiated up to end of OCT ,and additional 53 initiated in 1st week of Nov,511are transferred out from Hospitals ,all proved to be received at the Health centers by the cross check which is done weekly at the catchment team meetings between the sending hospital and receiving Health Centre of the catchment.

To further support the decentralization of ART initiation and follow up care to Health Centers, the following is required:

- Efficient, decentralized management
- Strong relationships between Hospitals, Health Centers, and community services. To facilitate this linkage, an ART Joint Catchment Area Team must be established for each hospital catchment area consisting of the Hospital, Sub city Health Departments, Sub city HIV Desk, Health Centers, and partners.
- Referral systems must be established /strengthened and clinical mentorship should be in place.

The Addis Ababa City Administration Health Bureau has prepared this Standard Operating Procedure to scale up ART Initiation and Follow up Care to Health Centers (SOP) and to Private/NGO Facilities, clarifying criteria for initiation and/or transfer at the different levels , defining roles and responsibilities of health care providers and institutions, in the end to ensure an effective and organized ART scale up thereby improving access to the needy.

3. Standard Operating Procedures for ART Initiation and Follow Up Care at Health Centers

The health centers providing ART initiation and/or follow up care will play a pivotal role in supporting the expansion of care and treatment. The health centers will provide ART initiation and/or follow up care; prescription refills and adherence counseling; perform basic laboratory tests; and identify patients that require transfer back to the hospitals (**see Appendix I**: Minimum ART Package at Health Centers and Private/NGO Facilities).

Enabling Health Centers to provide initiation and/or follow up care will require two phases: **1) preparation** and **2) implementation.**

Phase 1: Preparation. During this phase the following must be done:

i. Accreditation: The AAHB is responsible for accrediting all health centers to begin providing ART initiation and/or follow up care. The Federal Ministry of Health/HAPCO is currently preparing National *Minimum Health Center Accreditation Requirements for ART Initiation and Follow Up Care*. In the meantime, the AAHB is following the minimum site requirements for ART initiation, as defined in the National Guidelines, with the following **exceptions** based on the realities on ground:

   A dedicated ART clinic is not a prerequisite for starting follow up
   - The ART Clinic may begin providing ART follow up care with one trained Health Officer/MD
   - An ART pharmacy trained nurse can provide adherence counseling/dispense refills in the absence of a druggist. In case the dispensing nurse has some difficult technical encounters, he/she will consult the MD, HO, or can communicate by telephone to the regional pharmacy unit
   - No minimum laboratory equipment requirements, since testing will be outsourced

   The AAHB will conduct an accreditation assessment of each site prior to initiation of ART and/or ART follow up care. Through this process, identified gaps will be categorized as major (no-go) and minor (go, but to be attended in the short term).

ii. Gap Filling: In communication with the catchment area team, the AAHB, and partners, the Health Center must identify solutions to the identified gaps (major and minor) and begin filling these gaps immediately.

iii. Determining absorption capacity at the Health Center: The absorption capacity of each Health Center needs to be determined and agreed upon by the Catchment Area Team and communicated to the Hospital so that an appointment schedule can be designed. The situation from Health Center to Health Center will differ, thereby influencing the uptake of stable patients. Should a Health Center begin reaching capacity, this information should be communicated to the respective hospital during the catchment team meeting.

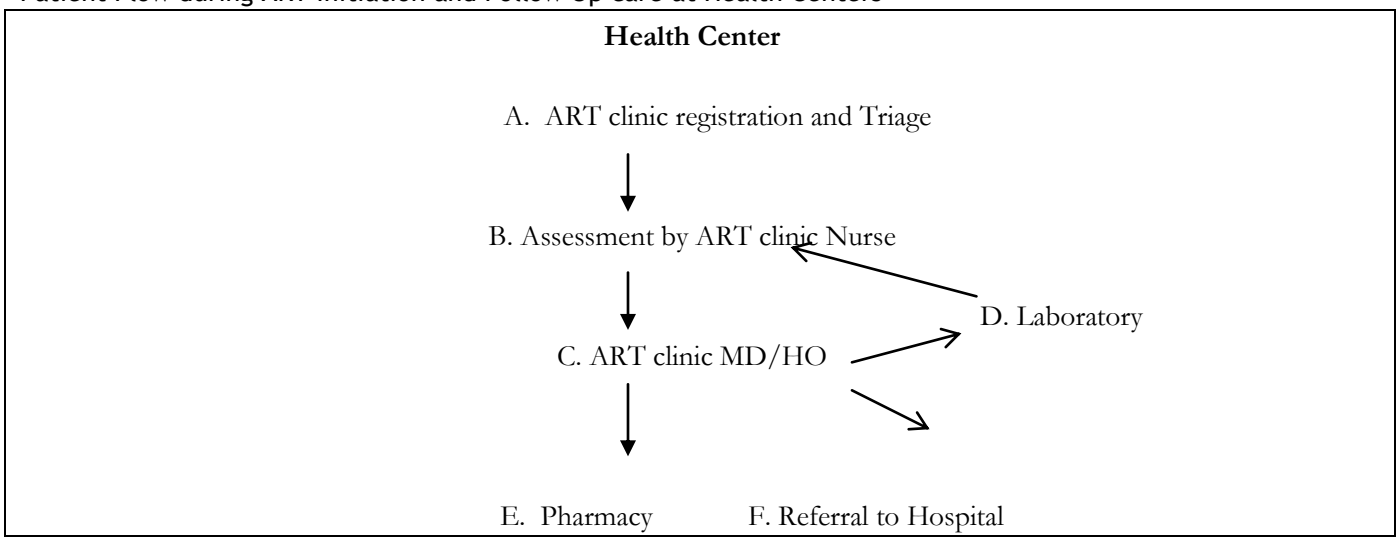
iv. Supply quantification: Based on each Health Center's identified absorption capacity, the amount of required supplies must be quantified, including ARVs.

v. Set the Start Date: In consultation with the Catchment Area Team, each Health Center should set a start date to begin providing ART initiation and/or follow up care, and confirm this with all relevant stakeholders (including the AAHB).

Once all of the above tasks have been completed, the Health Center can begin providing ART initiation and/or follow up care.

Phase 2: Implementation. Health Center's will provide ART follow up care as follows:

Patient Flow during ART Initiation and Follow Up care at Health Centers



3.1. Initiating ART at Health Centers

The Addis Ababa Health Bureau has begun accrediting Health Centers for ART initiation. Health Centers that are accredited to begin initiating treatment must follow the National Implementation Guidelines and National Treatment Guidelines. In addition, the Addis Ababa Health Bureau recommends the following procedures for initiation of ART at Health Centers.

3.1.1. Patient Identification and Referral

3.1.1.1 Patient Identification

Healthcare facilities should proactively identify patients that are HIV positive and may be in need of ART. Once a patient is identified to be HIV positive, they should be referred to the ART clinic for evaluation. Entry points to care include: (i) intra-facility referrals through VCT, PICT, PMTCT, etc; (ii) referrals from other health institutions (both public and private facilities); (iii) self-referrals; and (iv) community health worker referrals.

A.1.Referral Procedures

A.1.1.Intra-institutional Referrals

Departments within a health facility should refer patients to the ART clinic using the intra-institutional referral form (**see Appendix II**). The referring department should communicate with the ART clinic to ensure the patient was enrolled

A.1.2. Inter-institutional Referrals

Health facilities should refer patients for HIV services by determining the patient's respective ART center (health center or hospital) based on the patient's Kebele ID and cross-checking the HIV/AIDS Services Map which will be updated regularly by the Addis Ababa Health Bureau (**see Appendix III**). Patients should be informed and encouraged to attend their respective health center, or in case of objections, the catchment referral hospital. However, if strong objections persist, the patient may choose to attend the hospital of their choice.

Patients referred to their selected health institution should be provided with completed referral form from the referring facility (**see Appendix IX**) with documentation of all necessary medical findings, including the HIV result (date of test, site). Referrals across catchment areas should be clearly noted.

A.1.3. Self Referrals

Patients who present at a healthcare facility seeking HIV medical care without an official referral should be encouraged to bring a copy of their HIV results, if possible. HIV patients with an official referral form that states their status do not need to be re-tested. Patients without an official referral form indicating their HIV status should be tested again.

A.1.4. Community Health Worker Referrals

Community health workers should refer HIV positive patients (including chronically ill/bedridden clients) to their respective health facility (based upon their kebele and HIV/AIDS Services Map) using the Community Health Worker Referral Form (in development– to be distributed by AAHB when available)

3.1.1.2. Process of Initiating ART at Health Centers

Prior to initiating ART for patients at Health Centers, patients will be triaged, confirm registration eligibility, staged, and counseled (**see Appendix IV: Patient Flow for ART Initiation**).

A.1. Patient Registration

i. The **Triage Nurse** will triage all patients that present in the ART clinic and identify those patients that require assessment and management. Acute patients will be referred immediately to a doctor/health officer. Non-emergency patients will be directed to ART Clinic Registration.
ii. Patients who present at the ART clinic (both new and returning patients) will be seen by the clerk at the ART clinic for registration. The **Clerk** will:
    1. Interview the patients and reason for the visit. Identify those clients in need of HIV/AIDS services and confirm registration eligibility to receive care based upon social criteria (residency and catchment area confirmed – needed for Health Centers only) and medical criteria (confirmed HIV positive status).

> **Note:** Patients without official record of their HIV status must be retested through PICT. Patients are not required to undertake VCT again, though this can be recommended if the health care provider believes further counseling would be beneficial.

    2. Determine the availability of previous medical records:
        a. New Patients: If the patient has been to the facility before, refer the patient to the card room to bring their previous chart to the ART clinic. If the patient has no previous medical records, issue a new medical card and medical ID
        b. Existing Patients: Pull existing medical records from ART registration files
    3. Register the patient in the Pre-ART registration book
    4. Attach the intake form and HIV result/referral form to the medical card.
    5. Complete Part A of the intake form; direct the patient to the ART clinic nurse

A.2.Tasks per Visit per Skill

Each member of the ART clinic will play an essential role in supporting patients enrolled in the HIV/AIDS clinic. Patients will be seen by various members of the multidisciplinary team based upon the type of visit indicated. Staff members will be responsible for standard activities, for both new and follow-up patients as detailed in the National Implementation Guidelines and National Treatment Guidelines. See **Appendix V** for a detailed summary of the schedule of actions to be taken during initial visits by the ART Nurse, MD/HO, Adherence Counsellor, and Laboratory.

A.3. Patient Reappointment

Upon completion of the clinic visit, the patient should return to registration whereby the **Clerk** will:

- Review the patient's record and note the schedule given to the patient for the next visit

- Register the patient on patient appointment calendar and tell the patient when to return

A.4. Patient Tracing

All health facilities providing ART should trace patient lost to follow-up. Patient tracing is a process that requires complete patient agreement and confidentiality. Methods of patient tracing include direct home contact through telephone, visit by health care staff, and/or contact with home based care providers/community based organizations. Health centers should choose patient tracing mechanisms based on resources available.

3.2. Initiating ART Follow Up Care at Health Centers

The Addis Ababa Health Bureau has begun accrediting Health Centers to provide ART follow up care. Health Centers that are accredited to begin initiating treatment must follow the National Implementation Guidelines and National Treatment Guidelines. In addition, the Addis Ababa Health Bureau recommends the following procedures for initiation of ART Follow Up Care at Health Centers (**See *Appendix VI: Checklist for Initiation of ART Follow Up Care at Health Centers)***.

3.2.1. Patient Identification and Referral

The hospitals providing ART care play a pivotal role in supporting the decentralization of follow up care to the health centers. The hospital initiates ART; provides follow up care; identifies patients eligible for transfer; counsels patients on transferring to HCs; and refers the patients to the HCs. **See Appendix VII** for a Schematic Presentation of Hospital Patient Transfer Process**.**

3.2.1.1. Identifying Stable Patients for Health Center Follow Up

Referring hospitals will determine which clients should be referred to the health centers for follow up based on defined clinical criteria and patient interest **(see Appendix IIX:** Definition of a Stable Patient Eligible for Transfer).

Parameters for identifying patients for Follow Up/Refill at Health Center Level:

1) Clinical Eligibility Criteria: Patients who meet the clinical criteria are eligible for transfer to health centers (**see Appendix IIX, Section A**).
2) Patient interest: Patients who meet the clinical eligibility criteria must also fully consent to be transferred to the Health Centers. All ART staff should take time to counsel patients on the advantages of transferring to the health center; this may take several counseling sessions (for more details, **see Appendix IIX, Section B)**.

Once stable patients have been identified for referral to the catchment health center, the Hospital health care provider must complete the "ART Transfer Form" and "Supplemental ART Transfer Form" **(see Appendix IX and X, respectively)**.

3.2.1.2. Counsel on Health Center Transfer

Once the clinical eligibility criteria for referral are met, the patient should be counseled on the benefits of the referral by the medical staff members involved in the recent medical follow up of the patient. Patients will not be forced to go to a Health Center; rather, due emphasis should be given on the advantages of the referral, with specific attention to the system/process as a whole. The counseling process should include a discussion of:

- Why the patient is eligible for referral and why he/she is referred

- Benefits and concerns
- Services the patient will receive at the HC and services the patient will have to come to the hospital for (e.g. CD4 testing)
- Logistics of the referral:
    - Whom to contact at the HC and when
    - How and when to contact the hospital staff if any problem occurs
    - How patient tracking will be done to ensure the patient arrives at the health center and receives quality care

Patients that are not willing to transfer have the right to remain at the hospital and must be fully accommodated there.

3.2.1.3. Transferring the Patient to the Health Center

Once a patient is ready to be transferred to the health center, the transferring nurse/physician should:

1) Determine the patient's respective health center based on the patient's kebele (verified by looking at patient ID) and cross-checking the HIV/AIDS Services Map which will be updated regularly by Addis Ababa Health Bureau (**see Appendix III**). Patients can be transferred across catchment areas and transfers can occur from all health institutions including public, private, and NGO facilities.
2) Inform the patient to report to the Health Center in 7 days
3) Prescribe a 1 month supply of ARVs and any necessary OI medications
4) Perform CD4 Test and LFT/RFT (only if not determined recently and need to be done within next 2 months). **Note:** Patients should not be transferred until after the results have been reviewed by the hospital staff.
5) Complete the ART Transfer Form **(Appendix IX)** and Supplemental ART Transfer Form **(Appendix X**) for the patient to bring to the Health Center

The ART Transfer Form will include the following information **(see Appendix X):**

- All pre ART and ART conditions
- Current health status of the patient
- Demographic data
- Summarized social and family history related to ART
- Major past medical/treatment history
- Current and past OI treatment and prophylaxis
- ART status: start date, staging at initiation, current regimen, change of regimen, response, drug toxicity, etc.
- Laboratory tests run and results, including the most recent CD4 count and due dates
- Date of last ARV and OI prescriptions and how long prescribed for

The Draft Supplemental ART Transfer Form will include the following pertinent information (see Format **in Appendix X** – Note: this is an interim format until further directives from FHAPCO):

- Family support
- Preventive tasks
- Links with other HIV continuum of care services

3.2.2. Process of Initiating ART Follow Up Care at Health Centers

3.2.2.1. Patient Triage and Registration

(See **Appendix XI**: ART Clinic Registration and Triage Flowchart for Follow Up Care)

A.1. Triage

When a referred patient reaches the health center, they will be triaged by the ART clinic nurse.

- If he/she has an unexpected emergency condition, he/she will be taken to the physician for consultation and may be taken to an emergency clinic/referral hospital for possible intervention (IV resuscitation, etc.) if needed.
- If stable, the patient will be sent to the ART Registration Desk.

A.1.1. Registration

New Patients

Patients will be interviewed by the data clerk and screened for Registration Eligibility (see definition below) at the Heath Center.

If **eligible**, the clerk will:

1. Find the patient card, records (identity and address), card number and unique ART ID
2. Attach ART Transfer Form to the chart
3. Prepare a Follow Up Card (**See Appendix XII- ART Follow Up Card/Blue Card**), supplemental patient information (blank sheets) as needed, and patient passport (when available)
4. Refer the patient to the ART Nurse for follow up visit and refill
5. Documents remain at ART adherence room

If **ineligible** the clerk will:

1. Clarify reason of ineligibility to patient
2. Direct patient to the proper health facility within their catchment area

Registration Eligibility Criteria for Health Center Referral:

1. Catchment area: Clients seeking follow up care at health centers are served strictly according to their catchment area. However, a transfer across catchment areas is allowed.
2. Client ID: Serves as a means of identifying the client's catchment
3. Referral Document: ART Transfer Form from hospital – MANDATORY

Revisiting Patients

Using the patient registration book, the clerk will identify patients appointed for the day's visit and:

- Identify which patients are present, as scheduled
- Arrange the patient files for the ART nurse
- Refer the patient to the ART nurse waiting area.

3.2.2.2. Task per Visit per Skill

A.1. ART Clinic Nurse

The ART Clinic Nurse will evaluate all patients coming to the health centre for follow up appointments. Tasks include:

i. Checking vital signs
ii. Identifying reason for visit
iii. Adherence assessment
iv. Discussion regarding social support, disclosure, preventive measure issues
v. Partially fills blue card(weight, functional status, month of ART, etc
vi. Transfers patients to ART Physician/HO as indicated

Note: After the first three months of providing ART follow up care at the Health Center, the nurse can follow stable patients on her own

A.2. ART Clinic MD/HO

During the first three months of providing ART follow up care at the Health Center, patients will be seen monthly by an MD or HO to allow the Health Center staff to become comfortable providing such care.

Note: The patients' previous follow up cycle from the transferring hospital will remain respected at the receiving Health Centers (e.g. patients on monthly follow up will come monthly and be seen by the MD/HO; but patients with 2 and 3 monthly cycle of follow up at hospitals will continue their 2 and 3 monthly trend at Health Centers respectively.)

After this 3 month start-up period of the health center, all starting refill patients will be seen by the HO/MD for counseling and refill or as needed.

The MD/HO will:

i. Provide a clinical evaluation and assess any indications for referral back to the hospital (and write referral if needed)
ii. Evaluate (and document) patient's response to treatment including:
    - Acute medical problems
    - Identified/Screened OIs; OI Prophylaxis
    - Regimen side effects
    - Immune Reconstitution Syndrome
    - Adherence to treatment
iii. Review family and social support; preventative strategies; disclosure status, etc.
iv. Request lab tests including CD4 as indicated (process detailed in Laboratory Section)

v. Provide adherence counseling and provide feedback to the patient on their current health status

A.3. Patient Reappointment

Upon completion of the clinic visit, the patient should return to registration whereby the **Clerk** will:

- Review the patient's record and note the schedule given to the patient for the next visit
- Register the patient on patient appointment calendar and tell the patient when to return

3.2.2.3. HMIS

A.1. Recording and Reporting

A.1.1.Recording

When the patient on ART follow up is assessed for transfer to the health center, all pre-transfer activities will be registered in the ART Registration Book (see below). In addition, the Hospital/Health Center ART Transfer Format **(see Appendix XIII**) will be completed.

a. ART Registration Book: After each patient is assessed to be transferred out, registration will be done using the code described below and written on the remark space on the ART Registration Book and Patient Card.

ART Follow Up Registration Codes:
E – Eligible for transfer out
C – Counseled for Transfer out
A – Agreed to Transfer Out
TO – Transferred out
ECATO – Patient is fully transferred out
N – Write in front of main code (e.g. patient is not eligible (NE); or counseled and not agreed (NA)

Hospital/Health Center ART Transfer Format (**see Appendix XIII)**: this form will be filled weekly by the hospitals (and health centers) and be used to fill the weekly Catchment Area Reporting Template.

Note: this form will replace the previously used patient appointment form.

A.1.2.Reporting

Each week, the data clerk at the hospital and health center must fully document all transferred out and transferred in patients using the Hospital/Health Center Patient Transfer Format **(see Appendix XIII)**. These formats will be transferred to the Joint Catchment Area Team where the responsible sub city will pick up this information. In case of more than one sub city per catchment area, the sub city related to the referral hospital is responsible.

Progress and challenges of the ART follow up process by the Hospital and Health Centers will be reported weekly to the Catchment Area Team throughout the first six weeks of the implementation phase via the Hospital Reporting Template and Health Center Reporting Template **(see Appendix XIV and Appendix XV** respectively.) The frequency of these reports will later be decided by the AAHB and the Catchment Area Team.

A designated member of the Health Center will provide a report to the Catchment Area Team of those patients transferred in to the Health Center **(see Appendix XIII for Hospital/Health Center Patient Transfer Form**). The reporting format will be returned back to the Health Center after the Catchment

Team Secretary records the information on the Catchment Area Team reporting format (**see Appendix XVI).**

3.2.2.4. Role of the Joint Catchment Area Team

The Joint Catchment Area Team will manage the decentralization process. The team will be comprised of members from the catchment area hospital, health centers, Sub-city health desk, and key partners. As routines mature, the Joint Catchment Team will concentrate on ensuring strong linkages between facilities; thus, some initial responsibilities will likely shift from the Joint Catchment Team to the Sub City. The initial key responsibilities include:

- Determining the health center absorption schedule (number of clients referred/day or month) and revising this target based upon factors including hospital burden, health center capacity, and road map targets.
- Facilitating communication between the health center and hospital to clarify activities
    - A name-based directory will be given to all facilities and daily communication by phone will be created. AAHB, respective sub cities, and partners will ensure availability of phones.
- Overseeing and facilitating Monitoring and Evaluation/Quality Assurance activities for the catchment area (**see Appendix XVII:** Function of the M&E/QA Team).
- Monitoring patient arrival to the HC.
    - Manage monthly regional and catchment area list of clients transferred out and transferred in to Health Centers and Hospitals using ART unique patient IDs.
- Conducting weekly review meetings to strengthen communication and address outstanding challenges.
- Facilitating communication to the catchment population on the availability of HIV/AIDS services. This includes information concerning the costs associated with these services **(see Appendix XIIX: Costs Associated with HIV/AIDS Services).**

3.2.2.5. Role of the Sub-City Team

Each sub-city will organize patient tracing mechanisms in collaborations with catchment area health institutions and report all activities performed to trace patients lost to follow up. The subcity will monitor the transfer process, identify gaps, and develop recommendations. To facilitate these duties of the subcities, a Subcity Team meeting will be held every two (2) weeks to monitor the patient transfer process and address any problems that arise. The meeting will be chaired by a member of one of the subcities (elected by the team members). The meeting will be attended by the 10 Subcity ART focal members, partners, and the AAHB M&E team.

3.2.2.6. Patient Tracing

It is essential that the process of transferring patients to Health Centers does not increase a patient's risk of defaulting. Thus, patient tracing must be conducted to ensure minimal loss to follow up. Patient tracing is a process that requires complete patient agreement and confidentiality. Methods of patient tracing include direct home contact through telephone, visit by health care staff, and/or contact with home based care providers/community based organizations.

A.1. Patients Transferred within the Catchment Area

The Joint Catchment Area Team must cross check the patients transferred out of the hospital against the patients who have registered at health centers. It is the responsibility of the hospital to trace any patients identified as lost to follow up that should have registered at the health center. Hospitals must trace any patients that have not presented at the Health Center within 4 weeks of their initial appointment (and may begin tracing patients earlier if resources allow). Once the patient has registered at the Health Center, it is the responsibility of the Health Center to trace the patient when needed.

A.2. Patients Transferred outside of the Catchment Area

Each subcity will be responsible for cross checking the arrival and loss of patients across catchment areas. For transfers across catchment areas, the sub city will compile a monthly report and bring this to the biweekly Sub-city Team Meeting. The monthly reports will be cross-checked during the meeting to identify any patients lost to follow up. The sub cities will communicate this to the hospitals responsible for tracing.

The duration of the applicability of these tracing mechanisms stands in relation to the level of success of minimizing the lost for follow up. In case the patient load is high, the intensity of the tracing may be reduced.

A.3. Cohort Analysis

The cohort analysis will not be affected upon transferring a patient out to the health center. The starting date (or starting month) is on the transfer form that is filled in by the hospital. The starting month will be entered by the receiving health center in the register book and the cohort reporting will occur subsequently by the health center based on the entry made in the ART register from the health center.

3.3. Further Operational Considerations for ART Initiation and Follow Up Care at Health Centers

3.3.1. Laboratory

Routine Laboratory testing should be done according to the National ART Laboratory Monitoring Schedule. Certain laboratory tests, such as CD4 and Chemistry (LFT, RFT) will not be available in all Health Centers. In these instances, samples will be collected by a laboratory technician at the HC, safely stored, and transported to a referral laboratory.

For laboratory tests unavailable at the HC, the testing process will be as follows:

MD/HO:

- Informs the patient about the need for the test, where to give the laboratory request, where the lab test will be done, and when results will arrive
- The MD/HO fills CD4 and/or Blood Chemistry requests and sends the patient to Health Center Laboratory

Laboratory Technician:

- Receives request, draws blood in to test tube, labels it and registers it in Lab Registration Book.
- Explains where the test is going to be done, makes appointment for the patient to return to collect result
- The collected blood will be stored appropriately and will be taken, together with the request, by the delegated laboratory to perform the testing
- The testing organization will do the testing and return the results to the Health Center Lab Technician within 1 week.
- The Lab Technician will give the results to the ART nurse who will attach them to the patient file and send to the MD/HO for review

Note: Sample Collection

- Laboratory Samples will be collected twice a week
- Patient appointments to collect results should be arranged accordingly
- The AA-RHB will coordinate the sample transfer with both the designated laboratory for testing and Health Center

For more details, **see Appendix XIX:** Sample Collection Procedures

3.3.2. Pharmacy

After the patient is seen by the ART nurse and/or the MD/HO, patients should be referred to the pharmacy for ARV refill collection. **See Appendix XX** for details on ARV distribution to Health Centers.

The pharmacy technician will:

- Receive the ART prescription and review regimen split and dosage
- Provide adherence counseling
- Refill the ARV prescription
- Confirm the next appointment, synchronizing with appointment at ART clinic
- If the pharmacy technician recommends a different appointment date, he/she can discuss with the ART nurse prior to scheduling
- Complete required registration formats

3.3.3. Referral Back to the Hospital

When clinically required, patients should be referred to the hospital for exam/admission. Such instances could include:

- Delayed ADR
- Pregnancy
- Severe co-morbid illnesses
- Life-threatening OIs
- Need for second line therapy
- Need for immediate laboratory testing

Any patient that needs to be referred back to the hospital once s/he has been initiated at or transferred to the respective health center should be referred to the Health Center's catchment-area hospital. When referral to a hospital is required, the MD/HO should complete the ART Hospital Referral Form (**See Appendix XXI**) prior to sending the patient to the hospital. In case the patient at the health center originates from a hospital other than the referral hospital, the referring health center should request a copy of the patient's original file from the originating hospital. This file will be sent to the new referral hospital so that the hospital has all relevant patient history and data.

3.3.4. Registers and Formats

All health centers providing ART initiation and/or follow up care should have the standard registers and formats developed by Federal HAPCO and the Addis Ababa Health Bureau (**See Appendix XXII: Registers and Formats**).

3.3.5. HMIS

3.3.5.1. Recording

Patients confirmed eligible for ART initiation or follow up at their respective Health Center will be registered in the appropriate ART registration book provided by the FMOH using the hospital unique patient ID.

3.3.5.2. Reporting

All health centers will submit reports as required to their respective Joint Area Catchment Team, Subcity, and the Addis Ababa Health Bureau using the standardized formats provided.

3.3.6. Monitoring and Evaluation

To ensure quality HIV/AIDS care is being provided, a Monitoring & Evaluation (M&E)/Quality Assurance (QA) team will be established at regional, catchment area (as a function of the Joint Catchment Area Team), and health institution level. A TOR will be prepared for all levels of the M&E/QA teams (**see Appendix XVII:** Function of the M&E/QA Team). Key tasks will include:

- Development of standard care practices, targets, and indicators
- Preparation of M&E tools
- Preparation of evaluation schedule
- Using the developed tools, the ART program will be evaluated and successes and gaps will be identified
- Revise strategies and targets based upon feedback

Monitoring and Evaluation Tools

Quality assurance of the decentralization will be maintained by regular review meetings of the Catchment Area Team and regional team; site visits to the Hospitals and Health Centers; record review; and the early involvement of experienced hospital staff as clinical mentors;

a. Review meetings:

- Will be conducted monthly among the Regional Team and weekly among the Catchment Area Team (organized by the Chairman and Secretary of the respective teams)
- The meetings will be used as an opportunity to identify gaps, challenges, successes (both technical and administrative); and update the care standards and SOPs
- The AAHB will conduct quarterly review meetings for all ART care providers

b. Site assessments:

- The Chairman and Secretary of the Catchment Area Team will assign a team and organize monthly site assessments for supportive supervision
- The selected team will develop a checklist, assign and train data collectors, and analyze the data monthly
- The analyzed data will be reviewed during the Catchment Area Team and Regional Team meetings and strategies will be developed to address any gaps/challenges and replicate successes.

c. Record Review:

Data from respective health institutions will be collected, summarized, and presented at the review meeting. Discussion will be held and gaps identified and corrected.

d. Patient exit interview:

A standard exit interview questionnaire will be established by the regional QA team. Patient exit interviews will be done every 6 months in conjunction with the site visits and the findings will be presented to all levels of the team. The exit interview will be done by selected individuals having no direct relationship with the health institution.

e. Clinical mentoring:

Clinical mentoring will be used to strengthen the capacity of the health care providers at the health centers. The mentorship program will be implemented as follows:

- The responsibility criteria for clinical mentors will be established by the AAHB
- The Regional QA team will select clinical mentor/s for each ART health center
- The AAHB will make an arrangement for leave with the mentors' permanent hospitals according to a prepared monthly schedule of clinical mentorship.
- The selected clinical mentor will be trained on the goals, targets, and principles of clinical mentoring. The mentor will be oriented where, how frequently, and how to do clinical mentorship
- Specified purpose of clinical mentors will be given to each clinical mentor with indicators, which states how the performance of the mentor is to be evaluated by regional team (expected outcome and how to measure)
- Orientation of clinical mentoring and the role of the mentors will be given to the respective health institution and catchment team to facilitate supervision
- The mentors will work at the mentoring hospital at least once per week during regular clinic hours.

Note: Motivation/compensation to be determined.

Criteria for selection of clinical mentors

- Extensive ART and training experience
- From mentoring hospitals of the respective health center
- Outsiders as needed

4. Standard Operating Procedures for Initiation and Follow Up of ART at Private/NGO Facilities

The Public-Private partnership started in Addis Ababa two years ago when the private sector began working with the AAHB to provide VCT services. The AAHB provided training for nurses and laboratory technicians as well as VCT test kits and related supplies. Experience showed that when certain services are provided for free at a given private facility, patient demand greatly increases. Today, 60% of the VCT sites are run by private/NGO facilities, and 57% of clients are seeking services from the private sector.

The private sector is an important asset for ART scale up. Making ARVs free for the private sector will increase access for patients while decreasing the burden on the public sector, enabling further acceleration of ART care. Furthermore, the private sector/NGOs can have several advantages over the public sector facilities including:

- Better infrastructure and facilities
- More, better trained and/or better motivated staff
- Patients may be less prone to stigma
- Patients can see their preferred physician

The AAHB will begin accrediting private/NGO facilities to provide ART initiation and follow up care; prescription refills and adherence counseling; and laboratory monitoring (see **Appendix I**: Minimum ART Package at Health Centers and Private/NGO Facilities).

4.1 Requirements for Initiating ART at Private Facilities

4.1.1 Accreditation

The AAHB is responsible for accrediting all private and NGO health facilities to begin providing free ART initiation and follow up care. Sites will be evaluated based upon the minimum site requirements for ART initiation, as defined in the National ART Implementation Guidelines. In addition to the Minimum Requirements defined by the National Guidelines, the AAHB will take into account additional factors, including the following:

- Availability of TB and other HIV programs
- Potential patient load
- Previous performance (related to HIV and other services)
- Participation in important meetings

The AAHB will conduct an accreditation assessment of each site prior to initiation of ART follow up care. Through this process, identified gaps will be categorized as major (no-go) and minor (go, but to be attended in the short term.

Accredited sites will be monitored regularly by the AAHB through direct site supervision.

4.1.1.1. Human Resources Requirements

Private/NGO facilities must meet the same human resources requirements as public facilities (see National ART Implementation Guidelines).

4.1.1.2. Infrastructure and Equipment Requirements

Private/NGO facilities must meet the same infrastructure and equipment (medical and office) requirements as public facilities (see National ART Implementation Guidelines).

4.1.2. Policies, Standards, Guidelines, and SOPs

Private health institutions will perform ART care according to the National and Regional policies, guidelines, and SOPs, and will adopt any future changes that are made. Sites will use the National and Regional reporting formats, forms, records, and registers (to be provided by the AAHB). The AAHB will work to avail additional support as needed in collaboration with partners.

4.1.3. Memorandum of Understanding

A Memorandum of Understanding will be signed between the RHB and Private/NGO Health institutions and will be utilized as one of the tools for evaluating the health institutions for accreditation renewal (**See Appendix XXV**).

4.1.4. Costs and Payments

The health institutions will provide ARV drugs for free, but other costs including laboratory monitoring and consultation fees will be based on the health facilities standard pricing. Patients *will not* directly or indirectly pay for ARV drugs. The AAHB will compile and widely distribute an estimated overview of annual costs for ART care in private facilities so that patients can make an informed choice about seeking services in the private sector. **Note:** Patients who enroll in private facilities cannot return to public sites for occasional follow up (e.g. necessary laboratory monitoring).

Private/NGO facilities will post the cost of various services including consultation and Hematology, Chemistry, CD4 testing, and others. There is no fee cap for other ART services; however, the AAHB will observe the situation and consider corrective measures in the case of signification cost deviations.

4.1.5. Termination of Partnership

A termination of the partnership could occur under certain circumstances such as:

- Failure to adhere to the MOU
- If a facility chooses to no longer continue the partnership
- If a facility faces situations beyond its control to proceed with necessary services

In the event the private facility looses accreditation and termination of services is needed, the RHB and the private facility will make certain that service provisions are not suddenly interrupted so the patients are not put at risk. A detailed plan to transfer care of the patients will be put in place and executed. This will be the joint legal responsibility of the RHB and the private facility.

4.2 Patient Identification and Registration

4.2.1. Patient Type

The AAHB will begin accrediting private/NGO facilities to provide adult and adolescent ART care. Thus, sites will initially be provided adult first and second line drugs. Support for Pediatric ART and PMTCT programs will follow, however, pediatric patients and pregnant mothers will not be served at the private facilities unless there is a Pediatric/Obstetrics Unit and/or a PMTCT program.

4.2.2. Informed Choice

The AAHB will inform patients about the availability of ART in the public and private sector, including the differences between facilities and the estimated costs for ART care. This information will be available at public and private institutions so that patients fully understand the advantages and disadvantages of care in the public/private sectors. In addition, the Bureau will provide community sensitization on the

availability of ART care at private facilities and will work hard in increasing demand and increasing awareness among the community of the private sector partnership in the fight against HIV/AIDS.

4.2.3. Referrals

Patients on ART that present at a private/NGO clinic **MUST** have complete referral documentation from any other private or public facility.

In cases where the private/NGO facility needs to refer a patient to another facility, the referring facility must complete all standard referral formats with complete information. When transferring a patient to a public hospital, it is recommended that the facility use the appropriate hospital within that catchment area. However, referrals to Health Centers must be within the served catchment area. The Bureau will provide a document showing the details of public ART Sites (**See Appendix III: HIV/AIDS Services Map**) to all private facilities. Referral of cases that cannot afford the hospital admission needs to have proper documentation.

Note: There will be no referral of patients to the public sector for free lab tests. However, patients that can no longer afford the services in the private sector may be completely transferred back to the public sector facility for ongoing care.

4.2.3.1. Inter-Facility

Health institutions will transfer in/out patients if there is proper indication which includes medical explanations and/or patient preferences. The health institution will create linkages with appropriate public health facilities through a review meeting, telephone call, and completing a referral form (**see Appendix IX: Inter-Institutional Referral Form**).

4.2.3.2. Catchment Areas

Patients are not restricted to a specific private facility based on their residence.

4.2.4. Patient Flow

Patient flow will differ by facility, based on resources, infrastructure, and internal practices. Recommended patient flow and visit schedule are outlined in **Appendix IV: Patient Flow for ART Initiation** and **Appendix V: Schedule of Actions to be Taken During Visits**.

4.2.5. Social Support

Private facilities should be linked to appropriate community care and support services. The AAHB will provide facilities with the Directory of HIV Care and Support Services (produced by AA-HAPCO) as soon as it is available.

4.3 Other Operational Considerations

4.3.1. Laboratory

Private/NGO facilities must meet the minimum laboratory requirements as outlined in the National ART Implementation Guidelines. The laboratory tests done at the facility must be done by trained laboratory technicians. Private facilities must offer the following tests within its laboratory:

- HCT/Hgb
- WBC and Differential

- Sputum Smear
- Liver & Renal function tests
- Blood glucose

A licensed testing centre can be arranged outside the facility for CD4 and other sophisticated tests such as Viral Load. The Addis Ababa Regional Laboratory will assess all private laboratories being used for outside testing to confirm quality of services and provide external quality assurance.

4.3.2. Pharmacy, Drugs, and Supplies

As per the National Implementation guidelines, private/NGO facilities should have one pharmacy personnel assigned to dispensing ARVs and providing counseling. However, this can be adjusted based on the degree of patient flow. In addition, at least room should be dedicated for adherence counseling and drug dispensing.

Adult first and second line ARVs will be available as follows:

1) Institutions already providing ART on a pay basis must provide the list of patients per regimen to determine the initial drug supply.

2) Based on the facilities monthly report of drug consumption, additional drugs will be provided.
3) Similar to the procedure at public Hospitals, drugs will be quantified and ordered from Pharmid by the AAHB. Pharmid will transport the drugs directly to the facilities.

Note: Facilities will be provided a regular supply of drugs every 4 months which will include 1 month of buffer stock. All communication related to the ARV stock must be communicated to the AAHB and not directly Pharmid.
The AAHB will conduct random audits to reconcile patient files against pharmacy records.

4.3.3. Registers and Formats

All private/NGO facilities providing ART initiation and/or follow up care should have the standard registers and formats developed by Federal HAPCO and the Addis Ababa Health Bureau (**See Appendix XXII: Registers and Formats**).

4.3.4. Training

All staff providing ART care must participate in the National ART Training if they have not already received training during pre-service.

There may be additional training obligations for private sector staff including trainings related to PMTCT, Pediatric ART, and Provider Initiated Counseling and Testing. Private facilities are required to send relevant staff for further training when needed. In these cases, the costs of the trainings will be covered by the organizing institution.

4.3.5. Health Education and Social Mobilization

Private/NGO facilities have the obligation to provide health education and disseminate IEC materials. The Bureau will provide available education materials to the private facilities (e.g., Cassettes, Brochures, Posters, etc.). Interested Private facilities can work with the Bureau in mobilizing the community in

HIV/AIDS prevention, care, and treatment. These mobilization activities include creating awareness at community organizations, health education at health facilities, and participating in campaigns and home visits.

4.3.6. HMIS

Private and NGO facilities will assign all patients with a unique patients ID number (according to the list of IDs that the AAHB provides each site). Patients who transfer from the public sector into a private facility will keep their public sector Unique ID. Private and NGO facilities will keep track of patients that transferred from the public sector and will regularly provide the AAHB with a list of names and Unique IDs for patient tracing purposes.

4.3.6.1. Patient Tracing

Private/NGO facilities must design a mechanism to detect patients who failed to collect their drugs in a timely manner. This can include a unique linking system that might include telephone calls or home visits by a home-based care worker.

4.3.7. Monitoring and Evaluation

The AAHB will conduct regular supervisory visits to ensure that the private/NGO facilities are following the MOU and quality care is being provided.

4.3.7.1. Quality Assurance

The health facilities will participate in quality assurance activities that the region implements, including but is not limited to review meetings, case reviews, and workshops on laboratory quality assurance.

4.3.7.2. Supervision

Regular supportive supervision with a prepared checklist will be performed by the AAHB to monitor the overall program and ensure quality of care.

4.3.7.3. Review Meetings

Quarterly review meetings will be arranged to discuss all relevant issues observed during the previous months. Best practices as well as specific deviations will be examined.

4.3.7.4. Reporting

Private/NGO facilities must generate monthly reports according to the standard reporting format provided by the AAHB. Reports should be sent to the Health Bureau and a copy should be sent to the respective subcity where the institution is located.

4.3.7.5 Role of Partners

The partners working in collaboration with the AAHB will act on behalf of the Bureau as needed to support the private/NGO facilities. **Note:** All communication between partners and private/NGO facilities must be facilitated by the AAHB first. Partners include (but are not limited to):

- John Hopkins University – technical and clinical assistance for ART and M&E for hospitals
- JPHIEGO – VCT and PMTCT at hospitals
- RPM+ -- pharmacy and ARV supply issues
- PHARMID – ARV supply issues
- FHI – technical and clinical assistance for ART and M&E for health centers/clinics

Appendix I: Minimum ART Initiation and Follow Up Package at Health Centers and Private/NGO Facilities

1) Patient triage and management for emergency condition
2) Patient need assessment and appropriate link
3) Care for acute medical care
4) Screening and managing for common opportunistic infection
5) Screening and administration of OI prophylaxis
6) Specific care related to ART initiation including*
    - Evaluation of readiness to start treatment
    - ART initiation
    - Management of patients enrolled in pre-ART care

6) Specific follow up art care including
    - Evaluation of response for treatment
    - Evaluation for adverse drug reaction (side effects)
    - Evaluation for drug adherence
    - Evaluation for IRIS and treatment failure

7) ARV drug dispensing
8) Laboratory investigations as indicated
9) Counseling and support on HIV/ART related issues including
    - Adherence counseling
    - Positive living
    - Partner notification
    - Preventive measures
    - Family and community support
    - Addressing community barriers in HIV prevention

10) Linking with comprehensive HIV care (nutrition, socioeconomic support)
11) Identification of indication and referral to hospital

* Not required for sites only providing ART follow up care

Appendix II: Intra-Institutional Referral Form

INTRA INSTITUTIONAL REFERRAL FORM

Code No _____
Date _____

Name of Health Institution: _____
Patient/Client Name: _____
Referred From (Dept): _____
Referred To (Dept): _____

Summary of Patient Result: _____

Reasons for Referral _____

Referred By: _____ Signature: _____

INTRA INSTITUTIONAL REFERRAL FORM

Code No _____
Date _____

Name of Health Institution: _____
Patient/Client Name: _____
Referred From (Dept): _____
Referred To (Dept): _____

Summary of Patient Result: _____

Reasons for Referral _____

Referred By: _____ Signature: _____

Appendix III: Addis Ababa HIV/AIDS Service Map

Hospitals				SUBCITY		Health center			
Name	Type of service			Subcity Name	Kebele	Name of health center	Available services at health center		
Tikur Anbessa	1. VCT	2. STI	3.PMTCT	Lideta	01/18,15/1/17	Lideta HC	1	2	3
							4	5	6
							7	8	9
	4. Pre-ART - Chronic Care	5. Refill Adults	6. Refill Pediatric				10	11	12
					09/10,07/14, 11,12	Tekle Haimanot HC	1	2	3
							4	5	6
	7. Adult ART 1st Line	8. Adult ART 2nd Line	9. Pediat. ART 1st Line				7	8	9
							10	11	12
					04/06,05/08	Beletisachew HC	1	2	3
							4	5	6
							7	8	9
	10.Pediat ART 2nd Line	11. Lab - equipment	12. Lab - Sample transfer				10	11	12
					02/03	Wereda 24 HC	1	2	3
							4	5	6
							7	8	9
							10	11	12
Zewditu Hospital	1. VCT	2. STI	3.PMTCT	Kirkos S.C	01/19,15/16, 17/18	Kasanchis HC	1	2	3
							4	5	6
							7	8	9
							10	11	12
	4. Pre-ART - Chronic Care	5. Refill Adults	6. Refill Pediatric		08/09,10, 11/12,13/14	Kirkos HC	1	2	3
							4	5	6
							7	8	9
							10	11	12
	7. Adult ART 1st Line	8. Adult ART 2nd Line	9. Pediat. ART 1st Line		02/03,04, 05/06/07,20/21	Mesholekia HC	1	2	3
							4	5	6
							7	8	9
							10	11	12
	10.Pediat ART 2nd Line	11. Lab - equipment	12. Lab - Sample transfer	Akaki-Kality S.C	01/03,02/04,0/06	Akaki HC	1	2	3
							4	5	6
							7	8	9

Hospitals				SUBCITY		Health center			
Name	Type of service			Subcity Name	Kebele	Name of health center	Available services at health center		
							10	11	12
					07/08/09salogoraFA 10/11/serity FA,12/13	Kality HC	1	2	3
							4	5	6
							7	8	9
							10	11	12
St. Peter's Hospital	1. VCT	2. STI	3.PMTCT	Addis Ketema S.C	01/02/03,04/05 06/07,08/09/18 10/11/12	Addis Ketema HC	1	2	3
	4. Pre-ART - Chronic Care	5. Refill Adults	6. Refill Pediatric				4	5	6
	7. Adult ART 1st Line	8. Adult ART 2nd Line	9. Pediat. ART 1st Line				7	8	9
	10.Pediat ART 2nd Line	11. Lab - equipment	12. Lab - Sample transfer				10	11	12
					13/15,16/17, 19/20 ,14/21	Wereda 7 HC	1	2	3
							4	5	6
							7	8	9
							10	11	12
St. Paulo's Hospital	1. VCT	2. STI	3.PMTCT	Gulele S.C	07/17,09/15, 11/14,10/11/12	Selam HC	1	2	3
	4. Pre-ART - Chronic Care	5. Refill Adults	6. Refill Pediatric				4	5	6
	7. Adult ART 1st Line	8. Adult ART 2nd Line	9. Pediat. ART 1st Line				7	8	9
	10.Pediat ART 2nd Line	11. Lab - equipment	12. Lab - Sample transfer				10	11	12
					01/02,03/04, 05/06,08/16,18	Shiromeda HC	1	2	3
							4	5	6
							7	8	9
							10	11	12
Yekatit 12 Hospital	1. VCT	2. STI	3.PMTCT	Bole S.C	01/02,03/05, 04/06/07,08/09 ,12/13,11,10,16,21 ,22,14/15,17/19	Bole HC	1	2	3
	4. Pre-ART - Chronic Care	5. Refill Adults	6. Refill Pediatric				4	5	6
	7. Adult ART 1st Line	8. Adult ART 2nd Line	9. Pediat. ART 1st Line				7	8	9
	10.Pediat ART 2nd Line	11. Lab - equipment	12. Lab - Sample transfer				10	11	12
Minilik Hospital	1. VCT	2. STI	3.PMTCT	Yeka S.C	09/10,11/12,13/14 08/15	Yeka HC	1	2	3
	4. Pre-ART - Chronic Care	5. Refill Adults	6. Refill Pediatric				4	5	6

Hospitals				SUBCITY		Health center			
Name	Type of service			Subcity Name	Kebele	Name of health center	Available services at health center		
	7. Adult ART 1st Line	**8.** Adult ART 2nd Line	**9.** Pediat. ART 1st Line				7	8	9
	10. Pediat ART 2nd Line	**11.** Lab - equipment	**12.** Lab - Sample transfer				10	11	12
	1. VCT	**2.** STI	**3.**PMTCT		16/17/18/Ankorcha FA,19/loke20/21/yekq bado &tafo	**Kotebe HC**	1	2	3
	4. Pre-ART - Chronic Care	**5.** Refill Adults	**6.** Refill Pediatric				4	5	6
	7. Adult ART 1st Line	**8.** Adult ART 2nd Line	**9.** Pediat. ART 1st Line				7	8	9
	10. Pediat ART 2nd Line	**11.** Lab - equipment	**12.** Lab - Sample transfer				10	11	12
					01/02,03/04,06/07 05	**Entoto No 1 HC**	1	2	3
							4	5	6
							7	8	9
							10	11	12
ALERT Hospital	**1.** VCT	**2.** STI	**3.**PMTCT	Nifas Lafto S.C	03/05,06/08,02,01, 9/14	**Wereda 23/N/L No 2**	1	2	3
	4. Pre-ART - Chronic Care	**5.** Refill Adults	**6.** Refill Pediatric				4	5	6
	7. Adult ART 1st Line	**8.** Adult ART 2nd Line	**9.** Pediat. ART 1st Line				7	8	9
	10. Pediat ART 2nd Line	**11.** Lab - equipment	**12.** Lab - Sample transfer		10/18,11,12/13, 16/17,15	**Wereda 19/N/L No 1**	10	11	12
							1	2	3
							4	5	6
							7	8	9
				Kolfe Keranio S.C	01/05,02/03,04,06,07 08/09,10/11,13/14,12 15/16 ***	**Kolfe HC**	10	11	12
							1	2	3
							4	5	6
							7	8	9
Ras Desta Damtew Hospital	**1.** VCT	**2.** STI	**3.**PMTCT	Arada S.C	10,11/12,17,13/14,15/16	**Arada HC**	10	11	12
	4. Pre-ART - Chronic Care	**5.** Refill Adults	**6.** Refill Pediatric				1	2	3
	7. Adult ART 1st Line	**8.** Adult ART 2nd Line	**9.** Pediat. ART 1st Line				4	5	6
	10. Pediat	**11.** Lab -	**12.** Lab -				7	8	9
					01/02,03/09,04/05,	**Gulele HC**	10	11	12

Hospitals				SUBCITY		Health center			
Name	**Type of service**			**Subcity Name**	**Kebele**	**Name of health center**	**Available services at health center**		
	ART 2nd Line	equipment	Sample transfer		06,07/08		1	2	3
							4	5	6
							7	8	9
					11/12,13/14,15/16	**Kebena HC**	10	11	12
							1	2	3
							4	5	6
							7	8	9

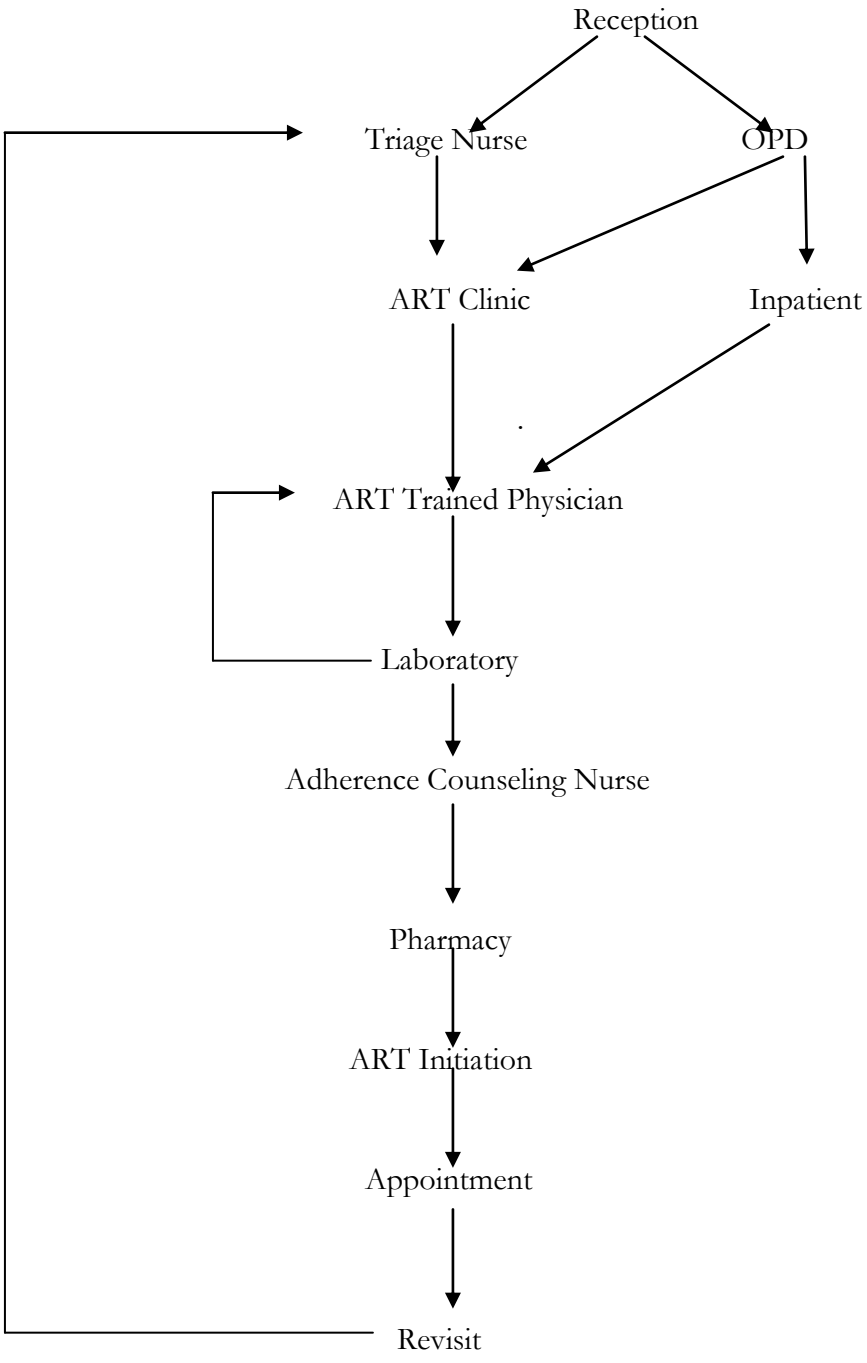
Note:

1) All services shaded are available at the respective Health Facilities
2) Patients are strongly encouraged to stay with the Health Center related to their kebele (all patients should have ID (Kebele/driving license, etc.) in order to confirm identity on the referral paper and HIV results).
   In case no ART is available or in case of strong objections by the patients:
3) Patients are strongly encouraged to visit the hospital related to their sub city. In case of objections by the patients, they are free to choose a hospital of their choice.

*** Kolfe SC those people from kebele with *** are served nearer to Kolfe H.C while the other also get service at wereda 24 health center thus if patients come from kebeles which are nearer to W24 H.C , the physician may consider referring patient to w24 health center

DNA PCR diagnosis for children under 18 months is available at all hospital ART clinics through sample collection/delivery to EHNRI and is free of charge

Appendix IV: Patient Flow for ART Initiation



Appendix V: Schedule of actions to be taken during visits

	ART Nurse	Physician/Health Officer	Adherence Counsellor	Laboratory

Visit One: (Patient's first visit to the ART clinic)
 	
Goal: Patients will be assessed and necessary samples will be taken
	• Complete history and clinical evaluation
	• Height and Weight
	• Baseline clinical investigations and clinical staging
	• Evaluate for OIs and ensure that TB is adequately excluded
	• If OIs suspected, refer to the MD/HO for further evaluation and treatment.
	• If no indication to consult the MD/HO, send the patient to the lab for baseline tests.
	• Cotrimoxazole prophylaxis commenced
		• Baseline clinical investigations and clinical staging
		• Evaluate and treat OIs
		• Ensure that TB is adequately excluded:
		  ○ History of TB contact
		  ○ Gastric aspirates or induced sputum
		  ○ Chest radiograph (if clinically indicated and possible)
		• Cotrimoxazole prophylaxis commenced
		• If indicated, refer patient to the **hospital** (ideally, the HC's catchment area hospital)
			• Psychosocial Assessment
			• HIV/AIDS Education – issues around disclosure, stigma, nutrition, positive living
				• Receive patient and explain tests to be done:
				  • CD4 Count
				  • FBC
				  • LFT, ALT, AST, LDH, CPK (for AZT candidates)
				  • Urea and electrolytes
				  • Chest x-ray:
				  • Sputum AFBs x 3 – all symptomatic patients
				• Draw samples and arrange for testing or sample transport using designated sample collector and sample transport format.
				• Direct patient to ART registration clerk
				• When results are complete, send to ART nurse for filing

Visit 2:	• Review patient records • Attach laboratory results • Assess for new medical conditions • Counsel patient on ARVs and importance of adherence • Record findings and direct patient to MD/HO	• Brief history & physical as needed • Review results from previous week's investigations and ensure TB adequately excluded (defer ART in case of TB per guidelines) • Review results from baseline investigations, including CD4 results and determine eligibility for treatment • Evaluate and treat OIs • Classify eligibility for ART • If eligible, finalize treatment plan for next visit and refer patient to adherence counselor. • If ineligible, provide pre-ART care and direct the patient to ART pharmacy	• Conduct ART Education and Adherence Counselling – how the virus works, OIs, prophylaxis, intro to ARVs, importance of adherence • Explain the importance of bringing a contact person to the next session. • ARV readiness assessed by team *(multidisciplinary clinic meeting)*	• Review of laboratory results • Review CXR & AFB smear results; defer ART in case of TB as per guidelines

Appendix V: Schedule of actions to be taken during visits

	ART Nurse	Physician/Health Officer	Adherence Counsellor	Laboratory

Week 3: ART Initiation	• Adherence counseling	**AFTER SEEING ADHERENCE COUNSELLOR:**
		• Weight and height
		• Review adherence counseling assessment
		• Evaluate patient preparation and understanding of ART
		• Explain possible side effects of ARVs included in treatment plan.
		• Commence ARVs if all is ok. Prescribe medication for one month.
		• Arrange follow up visit:
		  ○ In 2 weeks if on NVP
		  ○ In 4 weeks if on EFV
		• Document the plan on the medical record; direct patient to pharmacy for ARVs
			• ART Training 2 – how the ARV's work, adherence, resistance, treatment plan
			• Evaluate cotrimoxazole adherence, patient preparation, commitment to start
			• If good adherence, give unique ART code and write on medical record; identify contact schedule
			• Review medications and explain drug schedule
			• Explain possible side effects of ARVs included in treatment plan.
			• Document evaluation; refer patient to MD/HO	

Appendix V: Schedule of actions to be taken during visits

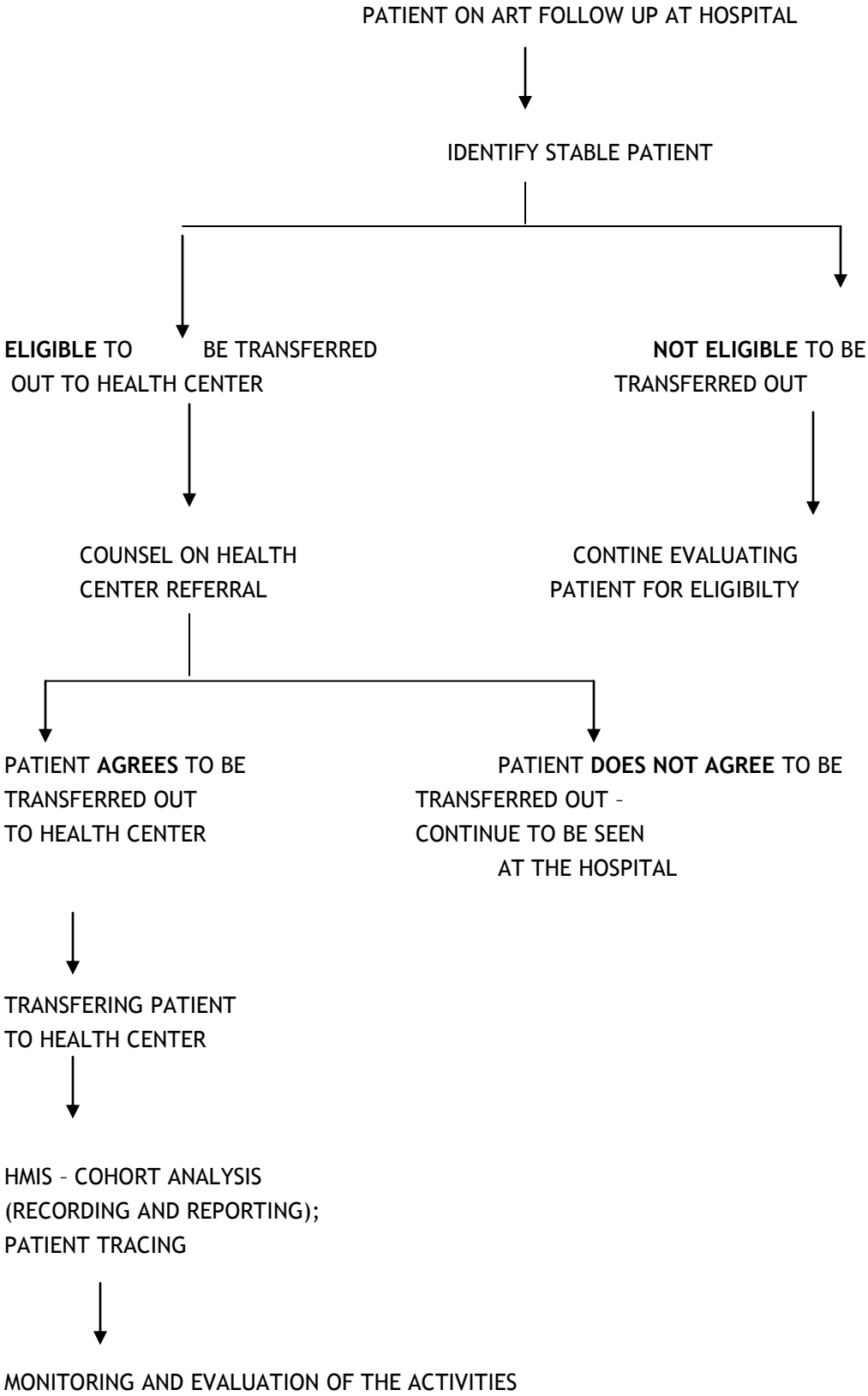
	ART Nurse	Physician/Health Officer	Adherence Counsellor	Laboratory
Post Initiation 2 Week Follow Up Visit	• Review patient medical; determine reason for visit; fill out relevant sections of the Follow Up card • Assess medical conditions and adherence • Refer to MD/HO if indicated • If laboratory testing required, direct patient to laboratory, otherwise, direct patient to adherence counsellor	• Complete history and clinical evaluation. • Evaluate ART adherence, tolerance & adverse effects (skin rashes, mouth ulcers, evaluate painful liver on palpation, painful pancreas, reflexes and test sensitivity (rule out neuropathies) • Do safety investigations according to guidelines. • If no adverse effects, double NVP dosage (after 2 weeks of initiation). • Adjust medication doses accordingly at each visit	• Adherence assessment (name drugs, schedule and doses missed) • Conduct follow up ART counseling session and reinforce exact drug schedule • Medication refill	• At 2 weeks for patients on NVP: LFT/ALT/AST/LDH bililirubin/alkaline phosphate/GGT • Conduct safety investigations as needed (at lab or through sample transport)
Post Initiation Monthly Follow Up Visit		• Complete history and clinical evaluation including weight, height, and nutrition. • Look for signs of toxicity (e.g. right upper quadrant tenderness, pallor, rash). • Do safety investigations according to guidelines. • Adherence assessment (name drugs, schedule and doses missed). • Review exact drug schedule for the patient and treatment buddy. • Adjust drug schedule if needed.	• Adherence assessment (name drugs, schedule and doses missed) • Issue medication for 4 weeks and arrange follow up. • Schedule following visits at **monthly intervals** to collect medication.	• Do safety investigations according to guidelines.

Schedule following visits at **monthly intervals** to collect medication. Patients should be seen **3-monthly** for clinical evaluation, toxicity bloods as per schedule. **If unwell** they may need to be seen more frequently to exclude adverse events, immune reconstitution, infection or treatment failure.

Appendix VI: *Checklist for Initiation of ART Follow Up Care at Health Centers*

Institute	Responsibility	Name of Person	Due Date	As per rollout schedule: Y/N
Hospital	Identify the stable patients as per draft SOP			
Hospital	Create an appointment schedule for the next quarter			
Hospital	Contact patients, set up appointments			
Hospital	Fill in transfer slips for each patient			
Hospital	Identify how much clinical mentoring is possible in this start up phase. Confirm availability for mentoring (name(s) - period)			
Hospital	ARV: Actual regimen per patient – quantify ARV requirements for the next quarter			
HC	Confirm the presence of trained HC staff at projected start dates			
HC	Confirm how many patients can be absorbed per day, week, month and quarter			
HC	Identify how much clinical mentoring is desired by the ART clinical team			
HC	Prepare filing system for transferred in patients			
HC	Identify necessary adjustments (immediate term like reshuffle of space, waiting area) to infra-structure			
HC	Provide bin card system. Provide secure place for ARV			
Sub City	Execute this checklist in communication with referral hospital, HCs concerned and external partners.			
Sub City	Communicate the result thereof to AA-RHB			
Sub City	Ensure presence of registers and formats for all relevant departments: • M&E (registers (ART, Pre-ART, formats, patient follow up cards) • ARV: prescription pads, registration formats • Laboratory: registration formats			

Appendix VII: Schematic Presentation of Hospital Patient Transfer Process



Appendix VIII: Definition of a Stable Patient Eligible for Transfer

Patient Eligibility Checklist (act as guiding baseline):

	Criteria Met: YES/NO
Clinical Criteria	
A. Stable **adult*** patients on 1st line regimens	
a. Clinical Criteria	
i. Minimum of 4-6 months on treatment	
ii. No new life threatening opportunistic infections	
iii. No major opportunistic infections requiring frequent follow up/admission	
iv. Improving response for treatment including weight gain, improved functional status	
v. CD4 count above 200/mm3 and with a rising trend	
vi. Ambulatory function	
vii. No other chronic illnesses: • TB (intensive stage) • Diabetes • Hypertension • CHF	
viii. None or mild drug toxicity • Liver • Kidneys	
b. Laboratory Criteria	
i. No anemia (Hgb>10g/dl)	
ii. Normal LFT	
iii. Normal RFT	
c. Satisfactory adherence	
Patient Interest	
B. Patient understands the pros and cons of having follow up care at the Health Center and is willing to transfer	

***NOTE: All pediatric patients and pregnant women will remain at the hospitals until the health centers are deemed ready to provide this specialized care.**

Once all of the above criteria are met, the patient is ready to be referred to the health center for ongoing follow up care/prescription refill.

Appendix IX: Patient Transfer Form (Hospital to Health Center)

FEDERAL MINISTRY OF HEALTH

HIV CARE/ART TRANSFER AND REFERRAL FORM

Referral No. _____ Card No. _____ Unique ART No. _____ Date of referral _____/_____/_____
(For all date use Ethiopian Calender in MM/DD/YY/Format)

Transferring/ Referring health facility _____

Transferred/ Referred to _____

Patient full Name _____ **Age** _____ **Sex** _____

Address: Region _____ **Zone** _____ **Woreda/Subcity** _____

Kebele (PA) _____ **House No.** _____ **Tel. No.** _____

1. Date confirmed HIV+ _____/_____/_____
   Patient started on ART ☐ No ☐ Yes
2. Why eligible for ART
   WHO Stage_____ CD4 (/mm³ or %)_____TLC (/mm³)_____ Transferred in form_____
3. Date ART Started _____/ _____/ _____
4. Original 1st line regimen & dose _____
5. Current regimen & dose _____
6. Reason for changing ART *(if applicable enter the reason for last change: use separate sheet if multiple changes)*
   Side effects (specify)_____
   Rx failure (specify criteria)_____
   Other (specify)_____
7. Last entry for ART adherence: ☐ Good ☐ Fair ☐ Poor
8. Other Current medications
   Cotrim ☐ No ☐ Yes (Start Date)_____/____/____ INH ☐ No. ☐ Yes (Start Date) ____/____/____
   TB RX ☐ No ☐ Yes (Start Date) _____/____/____ Flucon. ☐ No. ☐ Yes (Start Date) ____/____/____
9. Past ARV use for PMTCT
   Did patient or patient's mother (for children) received ARV for PMTCT
   Mother ☐ No ☐ Yes date____/_____/_____ Child ☐ No ☐ Yes date _____/_____/_____
   ARV used for PMTCT ☐ Nevirapine ☐ Other (specify) _____
10. Summary of other information

	Lab data					Summary of findings			
	LFT (IU/L)	RFT	TLC	CD4 (or CD4 %)	Viral Load Copies/mm³	wt (kg) Ht (cm)	Body surface area	WHO stage	Func. Status
Baseline									
Current									

11. Reason for transfer/ referral
    ☐ Change of address ☐ Closer to patients' home
    For better management (specify reason) _____
    Any other reason (specify) _____
12. Transferring/ referring clinician
    Name _____ Signature _____
    Telephone _____ E-mail _____

Use the intake and follow up forms to fill this form
Use E.C. in dd/mm/yy format for all dates
For current regimen, please record month of change

Age record
Months for children <5yrs
Completed years for = > 5yrs

Tr ART vrn 98
--ORIGINAL--

Appendix X: Draft Supplemental ART Transfer Form (Continuation of the above i.e. Appendix X)

SUPPLEMENTAL HIV CARE/ART TRANSFER AND REFERRAL FORM

Emergency Contact Information

Full Name of Treatment supporter _____ Age _____ Sex _____

Relation to Patient _____

Address: Region _____ Zone _____ Woreda/Subcity _____

Kebele (PA) _____ House No. _____ Tel. No. _____

Agreed Patient Tracing Mechanisms _____

Social History

Marital Status (single, married, not married with partner) _____

Disclosed to Partner (Yes/No) _____

Partner Tested (Yes/No) _____ Partner Status _____ Partner ART Status _____

Person for whom disclosure made _____

Adoptive Preventive Measures _____

Person/Family Supporting Patient _____

Other Notes (including allergies, additional medical conditions, additional medications, etc.)

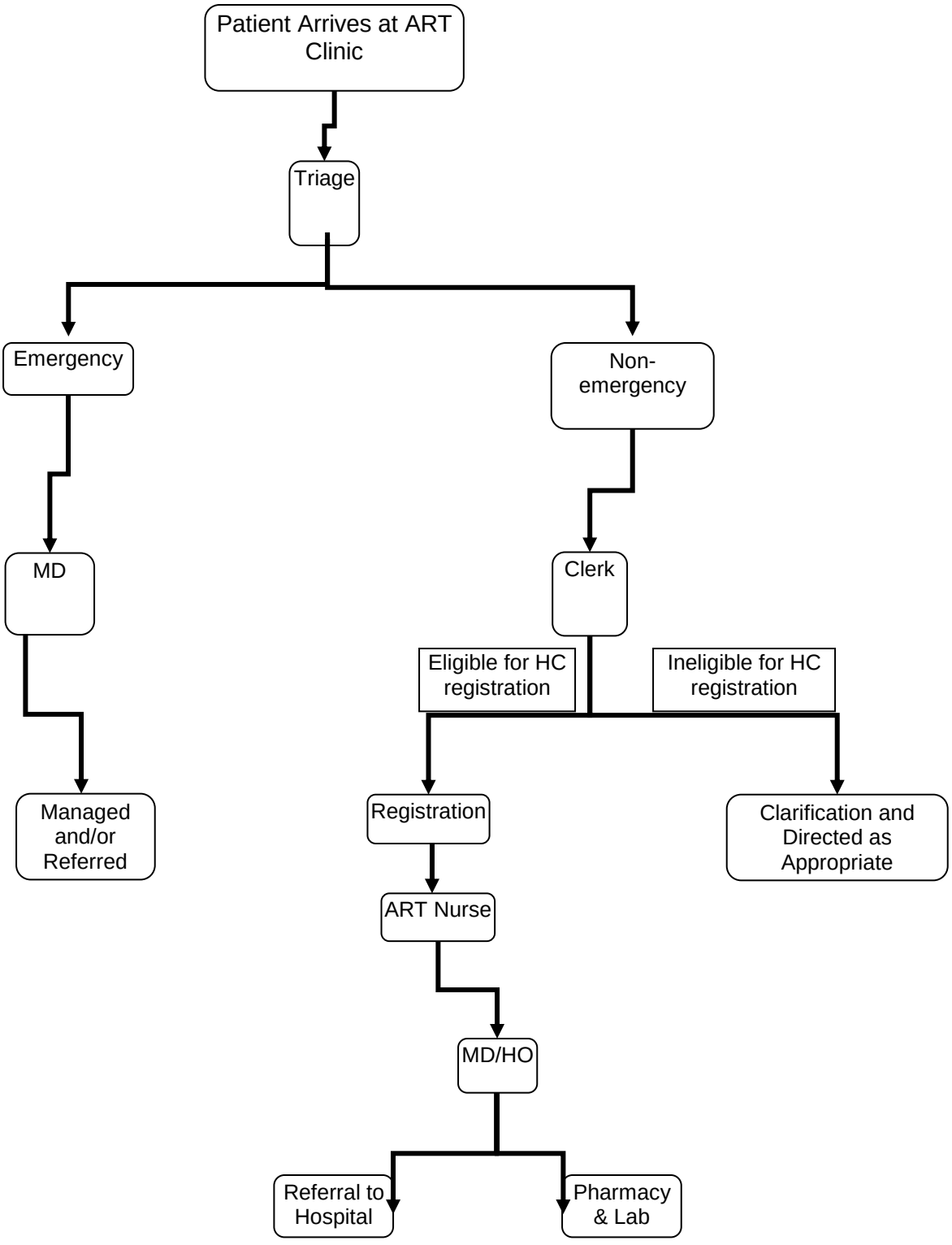
MD/HO

Linkages with other comprehensive HIV/AIDS Care programs/services (HBC, WFP, PLWHA association etc)

Name of Transferring Clinician _____

Signature _____ Date _____

Appendix XI: ART Clinic Registration and Triage Flowchart for Follow Up Care



Front page

HIV CARE/ART FOLLOW-UP FORM

FEDERAL MINISTRY OF HEALTH OF ETHIOPIA

Patient Card No. _____ Unique ART No. _____ TB Card No. _____

Name: _____ Age: _____ years Sex: ____M ____F

Date confirmed HIV+ _____ (DD/MM/YY)

Address: Woreda/Kifle Ketema _____ Kebele/ Peasant Association: _____ H. No. _____ Tel.: _____

P/F	Follow up date (S/US)	Months on ART	Wt KG	Pregnant EDD PMTCT FP If FP, FP Method / For children: height	Function Work Amb Bed	WHO Stage	TB Status	Side effects	OIs	Cotrimoxazole		Other meds dispensed	ARV drugs				CD 4 cells/ mm3 or % if < 5	Hg, RPR, TLC, Other lab	Elig	Why Elig	Elig + Ready	Next visit date
										Adh	Dispense		Adh	why	Dispense (dose/regcode	why changed						

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Back page

Follow-up date	Months on ART	Pregnancy/Family Planning	Functional status	TB status
S=Scheduled US=Unscheduled P= paying F= free	Duration in months since initiation of ART If PreART, leave blank 0 = ART initiation 1 week = 1 week 2 weeks = 2 weeks 3 weeks = 3 weeks 1 = 1 month ... If pt change regimen, add total no. of weeks since start of original regimen followed by '/' and the no. of weeks since start of new regimen	P = Pregnant If pregnant, give estimated due date (EDD) PMTCT = Referred to PMTCT FP= Not pregnant and on family planning If on FP, note methods (note: more than 1 method may be used): 1= condoms 2= oral contraceptive pills 3= injectable/implantable hormones (e.g. depo-provera) 4=Diaphragm/cervical cap 5=Intrauterine device 6=Vasectomy/tubal legation/hysterectomy	W=Working (able to perform usual work in or out of the house, harvest, go to school or, for children, normal activities or playing) A=Ambulatory (able to perform usual work in or out of the house, harvest, go to school or, for children, normal activities or playing) B=Bedridden (not able to perform activities of daily living)	No signs = no signs or symptoms of TB TB refer = TB suspected and referred for evaluation INH = currently on INH prophylaxis (IPT). TB Rx = currently on DOTS Sputum = TB suspected and sputum sample sent --, +, ++, or +++ = sputum results
Potential side effects	OIs or other problems (also use codes to left)	Adherence	Why poor/fair adherence	Dispense Dose/Regimen Code
Nausea Diarrhea Fatigue Headache BN burning/ numbness/ tingling Rash Anemia Abdominal pain Jaundice Fat changes CNS: dizzy, anxiety, nightmare, depression	Zoster BP, Bacterial Pneumonia PTB, Pulmonary Tuberculosis ETB, Extra pulmonary tuberculosis Thrush-oral, vaginal Ulcers-mouth, genital, DC or DA, Diarrhea Chronic/Acute PCP, Pneumocystis carinii pneumonia CT, CNS Toxoplasmosis CM, Cryptococcal Meningitis Hospitalization since last visit others, specify,	Estimate adherence using the table below: Adherence / % / Missed doses G(good) / > 95% / ≤ 3 doses F(fair) / 85-94% / 5-8 doses P(poor) / < 85% / ≥ 9 doses STOP = Stopped ART If STOP, In why column, note reason why stopped: 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	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 Other	Number of doses of treatment dispensed / Regimen code" Adult 1st Line Regimens: 1a(30)=d4t(30)-3TC-NVP 1a(40)=d4t(40)-3TC-NVP 1b(30)=d4t(30)-3TC-EFV 1b(40)=d4t(40)-3TC-EFV 1c = AZT-3TC-NVP 1d = AZT-3TC-EFV Adult 2nd Line Regimens: 2a = ABC-ddI-LPV/r 2b = ABC-ddI-NFV 2c= TDF-ddI-LPV/R 2d= TDF- ddI-NFV Child 1st Line Regimens 4a =d4T-3TC-NVP 4b = d4T-3TC-EFV 4c = AZT-3TC-NVP 4d = AZT-3TC-EFV Child 2nd Line Regimens 5a = ABC-ddI-LPV/r 5b = ABC-ddI-NFV 5c = TDF-ddI-LPV/R 5d = TDF-ddI-NFV Reason for chage If there is a change in the regimen, note reason why 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 8.Clinical treatment failur 9. immunologic failure 10. Virologic failure
Eligible Check when patient is medically eligible for ART	Why Eligible 1 Clinical only 3 TLC 2 CD4 4 Transfer In (TI)	Eligible and ready Check when patient is medically eligible AND ready (counselled for adherence) for ART	Follow-up status After follow-up date, in second column, write: TO = transferred out LOST = not seen since ... DEAD = died DROP = lost to follow-up, dropped from drug supply	

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Appendix XIII: Hospital & Health Center Patient Listing Format

Date of report: _____ **Facility completing report:** _____ **Weekly / Monthly Report (circle one)**

Name of Referring Hospital: _____
Name of Receiving Health Center: _____
If Weekly Report, list week (days): _____ **If Monthly Report, list month:** _____

Serial No	Unique ART code	Age	Sex	Address			Telephone No	Date of transfer out OR Date of transfer in	HC Patient is Transferred to
				subcity	keb	H./N			

Summary for Hospital: (to be completed by hospital staff)

Total No of patients transferred out of Hospital (during reporting period)	
Total No of patients ever transferred out of Hospital (total to end of reporting period)	

Summary for Hospital and Health Center: (to be completed by health center staff)

Total No of patients transferred into Health Center (during reporting period)	
Total No of patients on follow up at the HC (total to end of reporting period)	

Name of Personnel: _____ Signature: _____

Appendix XIV: Hospital Reporting Template

Draft Hospital Reporting Template (Catchment Area reporting only)

Hospital: _____ Period of Reporting: _____

	Name	Planned Start date	Actual Start date	Total Number of Stable Patients Identified for each HC	Cumulative planned Transferred **Out**	Cumulative actual Transferred **Out**	Analysis in case of deviation	R co ar
HC 1								
HC 2								
HC 3								
Total								

Refill Reporting

Target Reporting (initiating ART – in case applicable)

Health Facility	Name	Planned Weekly ART Uptake	Actual Weekly ART Uptake	Planned Cumulative Monthly ART Uptake	Actual Cumulative Monthly ART Uptake	Analysis in case of deviation	Recommendation for corrective action
Hospital							

1) Stable patients identified to date for each health center allows us to determine the gap between available stable patients and patients of that list that have been successfully appointed to be referred to the Health Center.
2) This is the number of successfully appointed patients for each of the Health Centers. This does **NOT** reflect the number of patients actually already arrived at the Health Center. The trend analysis will be important to follow to determine the success of transferring patients out.

Appendix XV: Health Center Reporting Template

Draft Health Center Reporting Template (Catchment Area reporting only)

Health Center:_____ Period of Reporting: _____

Refill Reporting

	Name	Planned Start date	Actual Start date	Cumulative planned Transferred in (registered only)	Cumulative actual Transferred in – **registered** at HC	Cumulative actual transferred in – started **refill** at HC	Analysis in case of deviation
Health Center							

Target Reporting (initiating ART – in case applicable)

Health Facility	Name	Planned Weekly ART Uptake	Actual Weekly ART Uptake	Planned Cumulative Monthly ART Uptake	Actual Cumulative Monthly ART Uptake	Analysis in case of deviation	Recommendation for corrective action
Health Center							

1) This number reflects the transferred in patients that **registered** upon directions by the hospital (request to register at the Health Center after 7 days). This allows us to track the rate of registration versus the appointment schedule of the related hospital of the previous week.
2) The rate of refill will allow us to monitor the success of follow through from being registered to actually starting the refill

Appendix XVI: Catchment Area Team Reporting Template

Draft Catchment Area Team Reporting Template (Regional reporting only)

Area Catchment:_____ Period of Reporting: _____

Refill Reporting

	Name	Total Number of Stable Patients identified for each HC	Cumulative planned Transferred **Out** as per appointment schedule	Cumulative actual Transferred **Out** as per appointment schedule	Cumulative actual transferred in – registered at HCs	Cumulative actual transferred in – started refill at HC	Analysis in case of deviation
Hospital							
HC 1							
HC 2							
HC 3							
HC 4							

Target Reporting (initiating ART – in case applicable)

Health Facility	Name	Planned Weekly ART Uptake	Actual Weekly ART Uptake	Planned Cumulative Monthly ART Uptake	Actual Cumulative Monthly ART Uptake	Analysis in case of deviation	Recommendation for corrective action
Hospital 1							
HC 1							
HC 2							
HC 3							
HC 4							

Draft Catchment Area Team Reporting Template (Page 2)

Narrative - Results, Corrective Action, Planned Activities next week

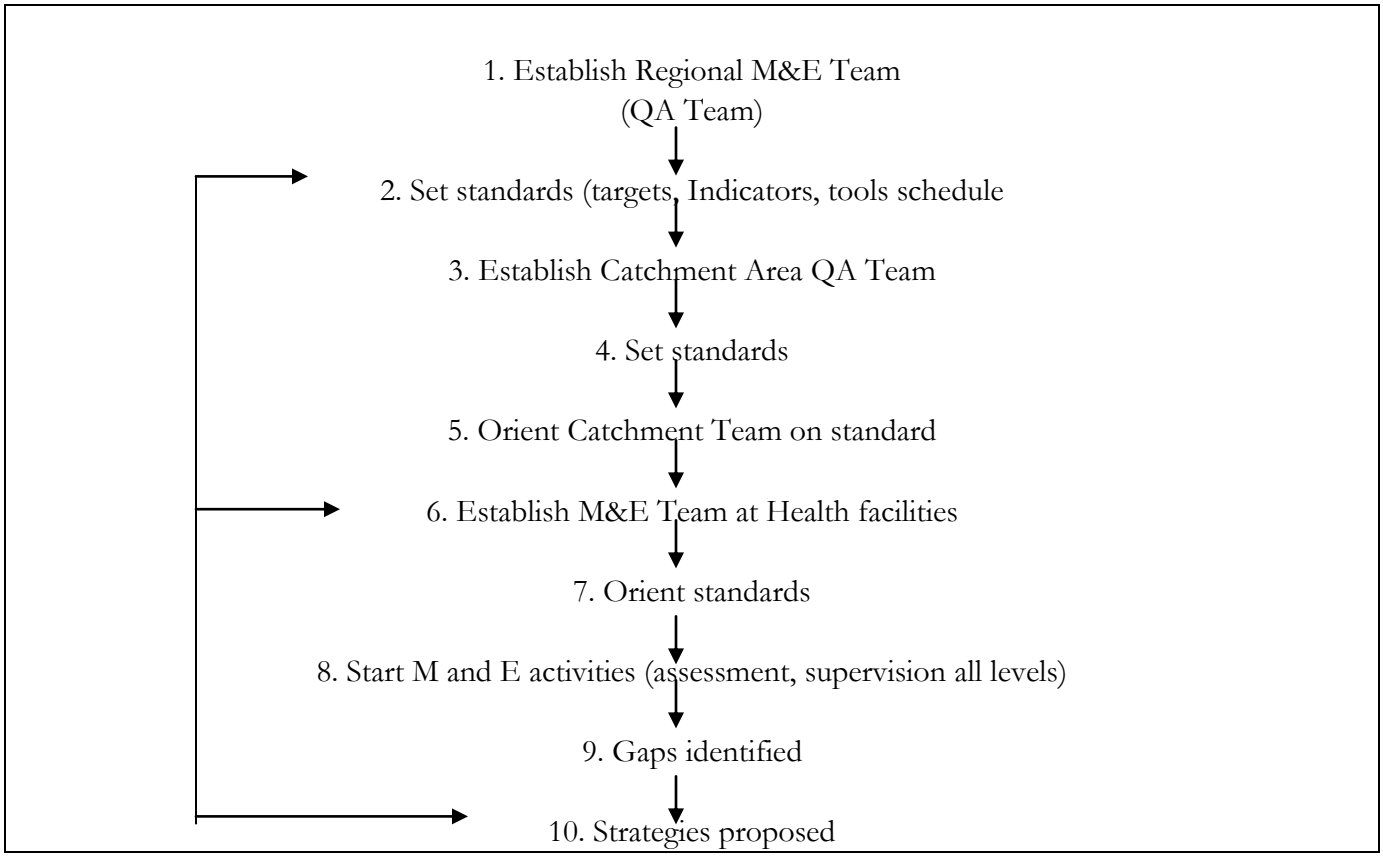
Ref. #	Planned Activities Last week	Results against planned activities	Planned Corrective action (if applicable)	Responsible person(s)
1				
2				
3				
4				
5				

Planned Activities Reporting Period _____ to _____

Ref. #	Planned Activities Next week	Responsible person(s)
1		
2		
3		
4		
5		

Name:_____ Signature:_____ Date:_____

Appendix XVII: Function of the M&E / QA Team



Monitoring and Evaluation/Quality Assurance Team Members

Regional Team:

- AAHB - CDC - Chairman
- AAHAPCO - Secretary
- Representatives of respective catchments
- Major Regional stake holders
- PLWHA members

Joint Catchment Area Teams:

- Respective Hospital (1)
- Respective sub city CDC & HAPCO (2)
- Respective Health centers (1-3)
- Partners

Health Institution ART team:

- Medical Director
- ART Focal person
- ART clinician
- ART nurse
- ART pharmacy technician
- Lab technician
- VCT counselor
- Data clerk

Appendix XIIX: Costs Associated with HIV/AIDS Services at Health Centers

Free services and supplies for patients include:

- ARVs; CD4, LFT, and RFT tests
- OI drugs, including cotrimoxazole
- Donated supplies

Patients will be required to pay for the following services*:

- Patient Card
- Health Center laboratory tests (excluding those listed above)
- Drugs (excluding ARVs and TB medication)

Patients will be exempted from payment of services if they come with a poverty certificate from their respective kebele or if the ART team or social worker deems the patient deserving of free provision.

Appendix XIX-Laboratory Sample Collection, Handling and Transfer

1-At sample collection site

For CD4/CD8 enumeration and hematology tests:

The specimen required is whole blood

Using vacutainer 5ml venous blood must be collected in EDTA and the sample must be transported with in 48 hours to the testing center.

The specimens must meet the following criteria:

1. Labeled with the patient's Unique ID No, Date and time of collection, and specimen number
2. Transported to the testing center as soon as possible; temperature controlled to 6°C - 30°C.
3. If sample preservation is for more than 48 hours before testing is eminent, 2.5 ml of a well mixed whole blood is made in 3ml cryovial and stored at minus 70 ^{0}C until the day if testing.

For Clinical chemistry tests:

The specimen required is serum:

1. Using vacutainer 5 ml of venous blood must be collected.
2. Separate the serum by centrifuging it at a speed of 4500 rev/mints for 15-20 mins.
3. Separate the serum(2ml) using a mechanical pipette in to a 3 ml cryovial

The specimens must meet the following criteria:

1. Label the sample serum with patient's identifiable codes (Unique ID No, date and time of collection, specimen number)
2. Send sample along the test request to testing site; if not possible store the sample at minus 20^{o}C until shipped to the testing laboratory.

Safety precautions

1. Follow Infection prevention principles. Assume that blood and body fluids from all patients are infectious.

2. Wear gloves for handling blood or body fluids. Change gloves when they become contaminated and wash hands after handling specimens. Do not handle door knobs, telephones, or other community objects while wearing gloves.

3. Wear protective clothing (lab coat, plastic apron, gown, face shield, etc.) while working with potentially infectious materials. Leave protective clothing in lab area. Wear closed-toe shoes (no sandals).

4. Use a mechanical pipetting devices when possible, and centrifuge specimens in safety carriers

5. Lab work surfaces should be decontaminated with a 10% bleach solution following any spill and at the completion of work activities. If a vacutainer is broken or blood is spilled, cover with 10% bleach and plastic-backed absorbent paper or "diaper" and let sit for 10 minutes. Double-glove, wipe up, and dispose of paper and gloves in an autoclave pan. Use 70% isopropanol for surfaces that might be damaged by bleach, such as the inside of centrifuges. Personnel should wash their hands after removal of protective clothing and before leaving the laboratory.

2- At testing site- Testing site will receive the sample by filling up the following register

HEALTH CENTER TRANSFER FORM OF BLOOD SAMPLE FOR LAB TEST

Name of health center	
Name of authorized Person	
Name of person and organization receiving sample	
Date of Sample Delivery	

Ser. No	ART unique No	Age	Sex	Requested lab test with request paper					Sample Type	Sample condition					Sample collection date	Date results to be returned	Remarks
				CD4	LFT	RFT	Hb	WBC		OK	Scanty	Hemolyzed	Clotted	Over growth			

3-Return the results when the next samples are delivered using the following format:

RETURN FORM FOR LABORATORY TEST RESULTS

Name of Referral Laboratory	
Name of Authorized Person	
Name of Facility Receiving Results	
Date of Test Results Delivery	

Ser. No	ART unique No	Sample Collection Date	Date sample received	Sample condition					Test profile results					Date of result issuance	Accepted or Rejected	Remarks
				OK	Scanty	Hemolyzed	Clotted	Over growth	CD4	LFT	RFT	Hb	WBC			

Appendix XX: ARV distribution

The ARV distribution to Health Centers needs to be further formalized between FMoH (PSLD) and Pharmid in communication with RPM+. Nevertheless, in the interim period, the following modalities for ARV distribution to Health Centers apply:

1) The average actual regimen split from the transferring hospital for adults on first line ARVs will be used in calculating the ARV requirements for the Health Centers

2) The Health Centers will receive four months of drugs for 175 patients supplied in two deliveries

3) The quantity associated with the second delivery will be kept at the Pharmid store, earmarked for the AA-RHB

4) The second delivery will occur based on monitoring the actual transfer in rate at each Health Center by the Pharmaceutical department of the AA-RHB in communication with Dr. Achamyeleh

5) The Pharmaceutical department of the AA-RHB will communicate the delivery request (location, timing, item and quantity) to RPM+ and Pharmid two weeks ahead of the requested delivery date to ensure a timely arrival of the ARV at the HCs

6) The transferring hospital will have the HC's quantity deducted from their periodic refill quantity

7) In case either the hospital or the health center is in need of additional ARVs due to a low transfer-out or low transfer-in rate, the AA-RHB will request an additional consignment from PSLD.

Appendix XXI: DRAFT - ART Hospital Referral Form (from Health Center to Hospital)

ART HOSPITAL REFERRAL FORM

Referral No. _____ *Card No.* _____ *Unique ART No.* _____ *Date of Referral* ____/____/____
(For all dates use Eth. Cal. in MM/DD/YY Format)

Patient Information

Transferring/Referring health facility _____
Transferred/Referred to _____ Department _____
Patient full Name _____ Age _____ Sex _____
Address: Region _____ Zone _____ Woreda/Subcity _____
Kebele (PA) _____ House No. _____ Tel. No. _____

HIV and ART History

Date of HIV Test _____ Date of ART Initiation _____
WHO Stage at Start of ART

	Problem List (opportunistic infections, toxicity etc)	Date of Diagnosis	Date of Treatment Completion

Current ART Regimen

ART Regimen	Date of Start	Date/Reason for Change

Summary of Other Information

Lab data					Summary of Findings			
	LFT (IU/L)	RFT	TLC	CD4 (or CD4%)	Wt (KG)	Ht (cm)	Func. Status	Other
Baseline								
Current								

Summary of Reason for Referral (including complications, adherence, treatment failure, etc)

Name of Transferring Clinician _____
Signature _____ Date _____

Appendix XXII: Registers and Formats

The registers and formats to be available at the health centers and private/NGO facilities prior to starting ART care are:

ART Follow Up Care:

- ART register
- Medical follow up card
- Health facility lab form
- ARV Prescription Pads
- Appointment calendar

Pre-ART Care & Initiation of ART:

- Pre-ART register – if not already available
- Intake form

The following reporting forms should be available prior to the first reporting period (monthly):

- ART and Pre-ART reporting form
- Lab reporting form
- ARV reporting form (supply management)

The following format is necessary during the Health Center ART follow up start up phase (not part of the monthly M&E reporting but part of the regional monitoring process):

- Weekly Transfer and Uptake Analysis by the Health facility

Appendix XXIII: Memorandum Of Understanding between the Addis Ababa Health Bureau and Private/NGO Facilities

Operational Agreement made on ARV Service Delivery between Addis Ababa city Administration health bureau and _____ hospital

Where As: the Addis Ababa Health Bureau has identified _____ hospital to initiate provision of Anti Retroviral services,

Where As: _____ hospital has been assessed for fulfilling the minimum criteria for ART service delivery as per the national ART implementation guide line,

Where As: _____ hospital has shown willingness to participate in the national ART scale up and expansion program,

Where As: the MOH had provided relevant training to care and treatment teams of the hospital, NOW THEREFORE, the party here to agree as follows:

ARTICLE I

AGREED FUNCTIONS OF THE ADDIS ABABA HEALTH BUREAU

The Addis Ababa Health Bureau shall:

1. Provide the hospital with all relevant policy directives, standard management and treatment guide lines,
2. Provide the hospital for free with a regular and steady supply of relevant Antiretroviral drugs with adequate shelf life to treat specified number of patients,
3. Provide training to care and treatment teams of the hospital,
4. Provide formats and registers relevant to ART service delivery as per the national M&E guide lines,
5. Conduct supportive supervision, monitor and evaluate the program activities and serve as Steward to the whole program implementation

ARTICLE II

AGREED FUNCTIONS OF_____HOSPITAL

1. Adhere to the three ones principles of the country's ART rollout program and perform accordingly ,
2. Maintain the minimum requirements for ART service delivery as per the national ART implementation guide line on clinical, pharmacy and laboratory minimum packages at all times,
3. Deliver the ART service by a multidisciplinary team in an appropriate ART practice set up and patient flow design.
4. Ensure safety and proper management of ARVs in the hospital.
5. Prescribe ARVs for free and handle the cost of ARV drugs storage and management without direct or indirect cost to the patient.
6. Ensure timely ordering and reporting on ARV use and requirements to prevent uninterrupted supply.
7. Return drugs/supplies provided to the facility by AAHB and or other relevant institution when interrupting contract in providing ART services
8. Adhere to the national standardized activity documentation, information storage & data compilation guidelines and timely report to the appropriate government authority.

9. Adhere to the national tracking mechanism using and assigning unique identification numbers to patients.
10. Agrees to establish appropriate and enabling information system for tracking patients upon defaulting if any,
11. Provide formal documentation upon patient transfer out and request appropriate transfer-in document form patients referred to its facility and maintain copies of these documents.
12. Receive guidance, technical assistance, training and supportive supervision from AAHB and or from a partner delegated by the AAHB to execute these activities.

ARTICLE III
LIABILITIES

1. Subject to the provision of this operational agreement both parties are liable to perform the functions specified on the agreement and any damage or demand arising out of malfunction or failure to perform the functions shall be indemnified or be the sole responsibility of the doer of the action.
2. Complying with the whole agreement and failure to adhere to the terms and conditions of this agreement shall result in its cancellation

ARTICLE IV
ENTRY INTO FORCE, REVIEW AND TERMINATION

This agreement:

1. Shall enter into force and be effective where and when it is duly signed by the contracting parties and shall remain effective for unlimited period of time.
2. may be amended or terminated by exchange of note between the parties pursuant to the provision,
3. disputes on interpretation of this agreement will be mutually solved with the view to successfully attain the goal and objectives of the implementation of the program,

In witness where of, the parties here to acting through their duly authorized respective official representatives have hereby signed the agreement at place and on the day and year specified below.

FOR AND ON BEHALF OF THE ADDIS ABABA CITY ADMINISTRATION HEALTH BUREAU **SIGNATURE**_____ **NAME**_____ **TITLE**_____ **PLACE**_____ **DATE**_____	**FOR AND ON BEHALF OF THE HOSPITAL** **SIGNATURE**_____ **NAME**_____ **TITLE**_____ **PLACE**_____ **DATE**_____