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 **BASICS**

BASICS PEDIATRIC HIV TOOLKIT

**GUIDE FOR INTERVIEWS FOR
PEDIATRIC HIV CASE
IDENTIFICATION, REFERRAL, AND
CARE AT THE COMMUNITY LEVEL**



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Interview Guide
Pediatric HIV Case Identification, Referral and Care
at the Community Level

Date: _____
 Interviewer(s) _____

Interviewees	Name of District
Name _____	Title _____
Name _____	Title _____
Name _____	Title _____

1. What do you think are the key health problems of children in this community?

List what is mentioned spontaneously:

- a. _____
- b. _____
- c. _____
- d. _____

Probe: Pneumonia? Diarrhea? HIV?

2. Where do parents and caretakers take infants and children for treatment in this community?

First _____
 Second _____

Probe -? govt. clinic, govt. hosp, private doctors, faith healers, traditional healers

3. What are the reasons that a parent might not go to a health facility when a child has symptoms?

Probe for transport, cost reasons.

4. Please describe what you know or what you have heard happens to babies who are born to HIV-infected mothers in this community.

(Probe for reasons if there is lack of identification or quick deterioration without care; for stigma; for lack of knowledge that babies can be treated, etc.)

OVERVIEW OF GROUPS (NGOs, FBOs) WORKING IN THE COMMUNITY

A

Groups (NGOs, FBOs) working on child health in the district						
Names of Groups/NGOs,FBOs						
Child health activities (check those that apply for each group)						
IMCI (malaria, ARI, CDD, malnutrition)						
Home Mgt of Malaria						
Nutrition						
Other						

Comments:

B.

Groups (NGOs, FBOs) Working on HIV/AIDS in the District						
Names of Groups/NGOs, FBOs						
HIV/AIDS Activities						
Home based care						
Behavior change communications						
Youth education						
Condom social mktg/distribution						
OVC						
PLWHA groups						
Other						

Comments:

C.

Groups (NGOs, FBOs) working on pediatric HIV						
Names of Groups/ NGO, FBO						
Activities related to Pediatric HIV (check those that apply for each group)						
IMCI-HIV						
Nutrition						
Infant feeding						
ART						
Care (CTX, etc.)						
Referral						
PMTCT follow up						
OVC						
Family support						
Psychosocial support/counseling						
Other						

Comments:

8. Identification and referral of infants suspected of HIV or exposed to HIV:

a. Who usually identifies and refers infants suspected of being infected with HIV?

b. What does this person/these groups do when they suspect a baby might have or been exposed to HIV?

c. To where are infants referred if they are known or suspected of being exposed to HIV?

9. What are the barriers to care and treatment that community members experience when they seek care for a child who might have HIV?

List all and probe regarding stigma, transport, cost, HCW attitudes, capacity of HCWs to recognize HIV in infants and children.

10. What is the attitude of parents towards getting an infant or child tested for HIV?

11. How are community members learning about pediatric HIV/AIDS, ways to get babies tested, treated, etc.

12. How many infants or children do you know of in this community who are HIV infected?

Are being treated for HIV?

13. Are there any community services for families with infants or children with HIV?

Adherence support?

Counseling?

14. How many CORPS or VHWs or TBAs live in your community?

CORPS ____

VHWs ____

TBAs ____

15. Please check all that apply in your surrounding community.

___ When a child is referred from the household to a health facility, there is a form that the provider gives to the parent to take with the child to the facility or organization to which the child is being referred.

Comment:

___ There are clear messages to the community about pediatric HIV, such as where to get care, what the signs and symptoms are, etc.

Comment:

___ There are village/community health workers who talk to mothers about common childhood illnesses, and HIV symptoms, care and treatment.

Comment:

___ Adults in the community commonly get tested for HIV.

Comment:

15., continued

___ People know about HIV disease, such as how people get sick, who needs ART and who does not.

Comment:

___ People know where to go for treatment.

Comment:

___ People trust health care workers to treat them well if they have HIV/AIDS.

Comment:

**Interview Guide:
Program Planning/Management for Pediatric HIV Services:
District Level**

Date: _____

Interviewer(s) _____

	Name of District _____
Interviewees	
Name _____	Title _____
Name _____	Title _____
Name _____	Title _____

I. Basic Health Statistics			
Total District Population:			
No. of Children under 15 years			
No. of Children under 5 years			
No. of Children under 2 years			
Child mortality Rate:			
Infant mortality Rate:			
Immunization coverage			
		BCG	
		DPT 1-3	
HIV prevalence			
ANC sites			
General population			
Care and Treatment Targets and Actuals (District)			
<i>Note: if no targets are set for the item at district level, put N/A</i>			
	Target	Actual	
Number of Adults on Cotrimoxazole prophylaxis		Total	
		M	F
Number of Children on Cotrimoxazole prophylaxis		(<15)	
		(<2)	
		M	F
Number of adults on ART		Total	
		M	F
Total number of children < 15 yrs on ART		Total	
		M	F
Total number of children < 2 years on ART		Total	
		M	F
Number of Adults tested		Total	
		M	F

Total number of Adults HIV +	M	F
Number of Children <15 yrs tested	Total	
	M	F
Number of Children <15 HIV +	M	F
Number of Children < 2 years tested (PCR)	Total	
	M	F
Number of Children < 2 years positive	M	F

II. Health Facilities in the District and the HIV Services Provided

Name of facility	HIV testing and counsel.	PMTCT	CD4 count	PCR test (type)	CTX prophyl-axis	ART	HBC	Referrals for community services	IMCI
Name of facility	HIV testing and counsel.	PMTCT	CD4 count	PCR test (type)	CTX prophyl-axis	ART	HBC	Referrals for community services	IMCI

SEE Community Assessment Form:

The following questions can be answered through an interview with a community group or group of community health workers. If the district can provide this information, use what they provide here and add additional groups/information during the community visit.

III. Community-Level Activities in HIV/AIDS, child health, and pediatric HIV in the District

A.

Groups (NGOs, FBOs) working on child health in the district						
Names of Groups/NGO,FBO						
Child health activities (check those that apply for each group)						
IMCI (malaria, ARI, CDD, malnutrition)						
Home Mgt of Malaria						
Nutrition						
Other						

Comments:

B.

Groups (NGOs, FBOs) Working on HIV/AIDS in the District						
Names of Groups/ NGO, FBO						
HIV/AIDS Activities						
Home based care						
Behavior change communications						
Youth education						
Condom social mktg/distribution						
OVC						
PLWHA groups						
Other						

Comments:

C.

Groups (NGOs, FBOs) working on pediatric HIV						
Names of Groups/ NGOs, FBOs						
Activities related to Pediatric HIV (check those that apply for each group)						
IMCI-HIV						
Nutrition						
Infant feeding						
ART						
Care (CTX, etc.)						
Referral						
PMTCT f/u						
OVC						
Family support						
Psychosocial support/counseling						
Other						

Comments:

IV. PROGRAM PLANNING AND MANAGEMENT

A. Planning:

1. Is there a Comprehensive District Health Plan? Yes ___ No ___
2. Are there child survival or MCH activities in the district health plan (annual)? Yes ___ No ___
3. In the health plan, is there a district HIV/AIDS plan? Yes ___ No ___
 - a. Is there a Pediatric HIV section with a plan of activities (work plan)? Yes ___ No ___
 - b. If yes, note major activities planned.

B. Coordination:

1. No. of RCH coordination meetings during the last 12 months. _____
2. No. of district AIDS coordination meetings during the last 12 months. _____

C. Supervision:

1. Is there a structured supervisory report/tool being used to guide supervision?
 - If yes, - is there a section on Pediatric HIV? ___ Yes ___ No
 - Is there a section on child health services? ___ Yes ___ No

D. Referral

1. Is there a described (written) referral system plan? ___ Yes ___ No
2. Are there forms for referral between different sites? (HC to District; Dispensary to HC)

E. HUMAN RESOURCES/TRAINING

Position	Positions		No. trained in MCH	No. trained in ART	HIV C&T	No. trained in ped ART	Communi-ty service delivery	Other
	<i>sanctioned</i>	<i>filled</i>						
Medical Officer.	..							
Asst MO								
Clinical Ofcr								
Nursing Ofcr								
Nurse Midwife								
Registered nurse								
Public Health nurse								
Nurse attendant								

Position	Positions		No. trained in MCH	No. trained in ART	HIV C&T	No. trained in ped ART	Community service delivery	Other
	sanctioned	filled						
VCT counselor								
Counselors								
Lab technician								
Lab. Technologist								
Lab assistant								
Pharmacist								
Pharm tech								
Pharm asst								
X Ray Tech								

B. Health Information System

1. Are there compiled performance data/reports sent from HC/dispensaries to district level?
 Yes _____ No _____ What is the frequency of reporting? _____

2. How is the data in the reports used?

2. Copy of report form secured. Yes _____ No _____

If there are such reports, what data is included?

Indicator	Yes (check)
No. of Children < 15 yrs tested?	
No. of Children < 15 yrs found HIV +?	
No. of Children < 2 yrs tested (PCR)?	
No. of Children < 2 years found HIV+?	
No. of Children <15 on ART?	
No. of Children < 2 on ART?	
No. of Children on Cotrimoxazole prophylaxis?	

Interview Guide: Facility Assessment of Pediatric HIV Services *(for use at regional and district hospital level and district health center and dispensary level)*

Name of District _____	
Interviewees	
Name _____	Title _____
Name _____	Title _____
Name _____	Title _____

Type of Facility: <input type="checkbox"/> Referral Hospital <input type="checkbox"/> Regional Hospital <input type="checkbox"/> District Hospital <input type="checkbox"/> Health Center <input type="checkbox"/> Dispensary		Linked to: Regional Hospital Name..... District Hospital Name..... Health Center (1)..... Health Center (2)..... Health Center (3)..... Health Center (4)..... Dispensaries (Number).....	
Site Characteristics			
Type of site		<input type="checkbox"/> Public (government) <input type="checkbox"/> Private, (NGO) <input type="checkbox"/> Private, (FBO) <input type="checkbox"/> Other (specify: _____)	
Location of the site: Town:	___ Urban ___ Rural ___ Semi-urban/peri-urban		
Services offered at the site	<input type="checkbox"/> Out-patient MCH <input type="checkbox"/> ANC <input type="checkbox"/> TB clinic <input type="checkbox"/> Labor and Delivery <input type="checkbox"/> Nutrition <input type="checkbox"/> Out-patient pediatric <input type="checkbox"/> In-patient pediatric <input type="checkbox"/> General/Family practice/OPD <input type="checkbox"/> Other (specify: _____)		

Service Statistics (for the previous year before the assessment)

Population of catchment area (adult+children)..... _____

Number of hospital beds..... _____

Number of pediatric beds..... _____

Number of deliveries (2008)..... _____

Number of immunizations (DPT 1) (2008)..... _____

Number of women attending PMTCT (2008)..... _____

Number of women tested in the past year (2008) _____

Number of women who tested positive in the past year (2008)..... _____

Number of women receiving NVP (2008)..... _____

Number of babies receiving NVP ART (2008)..... _____

Number of HIV tests done (2008)..... _____

Number of children tested for HIV (2008)..... _____

Number of infants or children who tested positive for HIV (2008)..... _____

Number of children seen outpatient (2008)..... _____

Number of children enrolled in nutritional programs (2008)..... _____

Services Available	
HIV counseling and Testing (check those that apply)	VCT ___ adults ___ children For infants and children: Routine offer of testing ___ inpatient ___ outpatient Diagnostic Testing & Counseling (DTC) ___ inpatient ___ outpatient
CTC/ART <input type="checkbox"/> Yes <input type="checkbox"/> No Since what dates? (mm/yyyy)	Adults <input type="checkbox"/> Yes <input type="checkbox"/> No Start Date: ___/___/___ Children <input type="checkbox"/> Yes <input type="checkbox"/> No Start Date: ___/___/___
PMTCT <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Referral of HIV-positive women to CTC If yes, when? _____ (postpartum or antenatal) <input type="checkbox"/> Partner counseling and testing
Pediatric/MCH/Child Health services	<input type="checkbox"/> Growth monitoring <input type="checkbox"/> Immunization <input type="checkbox"/> IMCI <input type="checkbox"/> Cotrimoxazole for HIV-exposed children <input type="checkbox"/> Bednets/ ITN
Psychosocial support to families with HIV? (check all that apply) ___ Individual counseling ___ Support groups ___ Outreach to community Other _____ Psychosocial support to families with HIV? (check all that apply) ___ Individual counseling ___ Support groups ___ Outreach to community Other _____ If outreach workers find a child in the home of a family who is sick/suspected of being HIV infected, what do they do? _____	
For infants and children exposed to HIV, who/which service is responsible for each of the following elements of care:	_____ Identification of exposed infants and children _____ Provide CTMZ prophylaxis _____ Refer for testing _____ Do clinical assessment _____ Prescribe ART _____ Monitor ART after 3 months _____ Provide adherence support

In the MCH clinic, when an infant or child has symptoms/is suspected of being HIV infected, what does the provider do?	<input type="checkbox"/> refer to CTC <input type="checkbox"/> refer to OPD <input type="checkbox"/> refer for testing – to where? _____ <input type="checkbox"/> provide testing <input type="checkbox"/> start cotrimoxazole <input type="checkbox"/> start ART
Where is pediatric HIV care located?	<input type="checkbox"/> MCH <input type="checkbox"/> OPD <input type="checkbox"/> CTC <input type="checkbox"/> Pediatric HIV specialty clinic <input type="checkbox"/> Other (specify: _____)
Is site engaged in pediatric HIV research activities	<input type="checkbox"/> Yes, please describe: <input type="checkbox"/> No

Organizations working in site	
<i>Name:</i>	<input type="radio"/> Child Health <input type="radio"/> Maternal Health <input type="radio"/> STI <input type="radio"/> Care and Treatment /Adults <input type="radio"/> Care and Treatment /Peds <input type="radio"/> PMTCT <input type="radio"/> VCT <input type="radio"/> HBC <input type="radio"/> OVC
<i>Name:</i>	<input type="radio"/> Child Health <input type="radio"/> Maternal Health <input type="radio"/> STI <input type="radio"/> Care and Treatment /Adults <input type="radio"/> Care and Treatment /Peds <input type="radio"/> PMTCT <input type="radio"/> VCT <input type="radio"/> HBC <input type="radio"/> OVC
<i>Name:</i>	<input type="radio"/> Child Health <input type="radio"/> Maternal Health <input type="radio"/> STI <input type="radio"/> Care and Treatment /Adults <input type="radio"/> Care and Treatment /Peds <input type="radio"/> PMTCT <input type="radio"/> VCT <input type="radio"/> HBC <input type="radio"/> OVC
<i>Name:</i>	<input type="radio"/> Child Health <input type="radio"/> Maternal Health <input type="radio"/> STI <input type="radio"/> Care and Treatment /Adults <input type="radio"/> Care and Treatment /Peds <input type="radio"/> PMTCT <input type="radio"/> VCT <input type="radio"/> HBC <input type="radio"/> OVC
<i>Name:</i>	<input type="radio"/> Child Health <input type="radio"/> Maternal Health <input type="radio"/> STI <input type="radio"/> Care and Treatment /Adults <input type="radio"/> Care and Treatment /Peds <input type="radio"/> PMTCT <input type="radio"/> VCT <input type="radio"/> HBC <input type="radio"/> OVC

Guidelines	
Guidelines present on site	Response
Guidelines for Clinical Management of HIV/AIDS (ART, OIs)	<input type="checkbox"/> Yes, specify: _____ <input type="checkbox"/> N/A <input type="checkbox"/> No <input type="checkbox"/> Observed
Guidelines for PMTCT	<input type="checkbox"/> Yes, specify: _____ <input type="checkbox"/> N/A <input type="checkbox"/> No <input type="checkbox"/> Observed
Guidelines for counseling and testing for adults	<input type="checkbox"/> Yes, specify: _____ <input type="checkbox"/> N/A <input type="checkbox"/> No <input type="checkbox"/> Observed
<i>Handbook on Pediatric AIDS in Africa (ANECCA)</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No
Other relevant guidelines
Are there information, education and communication (IEC) materials available for the patients	<input type="checkbox"/> General HIV education <input type="checkbox"/> General ART issues <input type="checkbox"/> ARV side effects and their management <input type="checkbox"/> Opportunistic infections <input type="checkbox"/> Medication use

HUMAN RESOURCES

	Total Number	# of each type provider providing pediatric HIV Care	Number with relevant training Specify #				
			MCH	IMCI	IMCI-HIV	Gen'l ART	Pediatric ART
Medical Officer							
Asst MO							
Clinical officer							
Health Officer							
Nursing Officer							
Nurse Midwife							
Trained Nurse (certificate)							
Public Health Nurse							
Nurse attendant or hospital assistant							
Health Assistant							
VCT counselor							
Counselors							
Lab technician							
Lab technologist							
Lab assistant							
Pharmacist							
Pharm tech							
Pharm assistant							
Please comment on staff experience and attitudes about caring for infants and children with HIV.							

PHARMACY PRACTICE		
	# unexpired doses on hand	Stock card complete
AZT + 3TC + NVP		
AZT + 3TC + EFV		
D4T + 3TC + NVP		
D4T + 3TC + EFV		
Note if following suspensions present		
D4T		
3TC		
AZT		
NVP		
Cotrimoxazole		
D4T 30 mg tabs		

CLINICAL PRACTICE		
Condition	Mode of determining Diagnosis	Treat on Site or Refer
HIV in adults	<input type="checkbox"/> Rapid Test <input type="checkbox"/> ELISA <input type="checkbox"/> None	
HIV in children	<input type="checkbox"/> Rapid Test <input type="checkbox"/> ELISA <input type="checkbox"/> None	<input type="checkbox"/> Treat on site <input type="checkbox"/> Refer
HIV in children <18 m	<input type="checkbox"/> Rapid Test <input type="checkbox"/> DNA-PCR <input type="checkbox"/> None	<input type="checkbox"/> Treat on site <input type="checkbox"/> Refer
What opportunistic infections are you seeing in infants and children?	1. _____ 2. _____ 3. _____ 4. _____	1. <input type="checkbox"/> Treat on site <input type="checkbox"/> Refer 2. <input type="checkbox"/> Treat on site <input type="checkbox"/> Refer 3. <input type="checkbox"/> Treat on site <input type="checkbox"/> Refer 4. <input type="checkbox"/> Treat on site <input type="checkbox"/> Refer
Staging of HIV infection	<input type="checkbox"/> Done at baseline only <input type="checkbox"/> Done at each follow-up <input type="checkbox"/> Not done	
Staging system in use	<input type="checkbox"/> CDC <input type="checkbox"/> WHO	

SERVICE STATISTICS	
Question	Response
Number of infants born to HIV-positive mothers who return to the facility for follow-up	
Number of HIV-exposed infants on CTX prophylaxis	
Number of HIV-infected children who are currently on ART in the facility	_____ < 15 y.o _____ below 2 years _____ above 2 years
How many children (<15 y.o.) have been put on or referred for ART while on the in-patient ward (2005).	<input type="radio"/> None <input type="radio"/> Number: _____
How many children have been put on or referred for ART from the MCH/OPD/Ped OP clinic in last month?	<input type="radio"/> None <input type="radio"/> Number: _____
How many children have been put on or referred for ART because their parents are on ART?	<input type="radio"/> None <input type="radio"/> Number: _____

PATIENT RECORDS AND MANAGEMENT	
Sample of 5 patient records/unit at the facility	
MCH CARD #1 (kept by caretaker)	Item completed
Unique patient identifier	<input type="checkbox"/> Yes <input type="checkbox"/> No
Date of birth	<input type="checkbox"/> Yes <input type="checkbox"/> No
Sex of patient	<input type="checkbox"/> Yes <input type="checkbox"/> No
Weight at birth	<input type="checkbox"/> Yes <input type="checkbox"/> No
Weight *	<input type="checkbox"/> Yes <input type="checkbox"/> No
Height *	<input type="checkbox"/> Yes <input type="checkbox"/> No
Who is the caretaker? (Mum/dad/family member/institution...)*	<input type="checkbox"/> Yes <input type="checkbox"/> No
Mother's HIV serostatus (PMTCT Status)	<input type="checkbox"/> Yes <input type="checkbox"/> No
Disclosure of HIV status of the child to caretaker	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A
Immunizations	
	OPV 1 AND BCG <input type="checkbox"/> Yes <input type="checkbox"/> No
	OPV 2-4;DPT 1-3 <input type="checkbox"/> Yes <input type="checkbox"/> No
	Measles <input type="checkbox"/> Yes <input type="checkbox"/> No

Select 5 records of children suspected of being HIV infected who are currently on the inpatient ward	
Pediatric Inpatient Ward Medical Record	
Unique patient identifier	<input type="checkbox"/> Yes <input type="checkbox"/> No
Date of birth	<input type="checkbox"/> Yes <input type="checkbox"/> No
Sex of patient	<input type="checkbox"/> Yes <input type="checkbox"/> No
Weight at birth	<input type="checkbox"/> Yes <input type="checkbox"/> No
Weight *	<input type="checkbox"/> Yes <input type="checkbox"/> No
Height *	<input type="checkbox"/> Yes <input type="checkbox"/> No
Who is the caretaker? (Mum/dad/family member/institution...)*	<input type="checkbox"/> Yes <input type="checkbox"/> No
Mother's HIV serostatus (PMTCT Status)	<input type="checkbox"/> Yes <input type="checkbox"/> No
Child's HIV status	<input type="checkbox"/> Yes <input type="checkbox"/> No
Disclosure of HIV status of the child to caretaker	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A
Clinical assessment findings and assignment of clinical stage (WHO/CDC staging) *	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A
Active opportunistic infection*	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A
Cotrimoxazole prophylaxis*	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A
Date of starting cotrimoxazole prophylaxis	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A
Tuberculosis treatment*	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A
Antiretroviral therapy (ART)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A

Total lymphocyte count*	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A
Hemoglobin *	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A
CD4 cell count (cells/□L)*	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A
CD4 cell percentage (%)*	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A
Severe Rash*	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A
Document mother's death	<input type="checkbox"/> Yes <input type="checkbox"/> No
Document father's death	<input type="checkbox"/> Yes <input type="checkbox"/> No

Select 5 random charts of children under 5 years old	
CTC PEDIATRIC PATIENT RECORD	
Unique patient identifier	<input type="checkbox"/> Yes <input type="checkbox"/> No
Date of birth	<input type="checkbox"/> Yes <input type="checkbox"/> No
Sex of patient	<input type="checkbox"/> Yes <input type="checkbox"/> No
Weight at birth	<input type="checkbox"/> Yes <input type="checkbox"/> No
Weight *	<input type="checkbox"/> Yes <input type="checkbox"/> No
Height *	<input type="checkbox"/> Yes <input type="checkbox"/> No
Who is the caretaker? (Mum/dad/family member/institution...)*	<input type="checkbox"/> Yes <input type="checkbox"/> No
Mother's HIV serostatus (PMTCT Status)	<input type="checkbox"/> Yes <input type="checkbox"/> No
Child's HIV status	<input type="checkbox"/> Yes <input type="checkbox"/> No
Disclosure of HIV status of the child to caretaker	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A

Clinical assessment findings and assignment of clinical stage (WHO/CDC staging) *	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A
Active opportunistic infection*	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A
Cotrimoxazole prophylaxis*	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A
Date of starting cotrimoxazole prophylaxis	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A
Tuberculosis treatment*	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A
Antiretroviral therapy (ART)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A
Total lymphocyte count*	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A
Hemoglobin *	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A
CD4 cell count (cells/ μ L)*	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A
CD4 cell percentage (%)*	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A
Severe Rash*	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A
Document mother's death If yes, date?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Document father's death If yes, date?	<input type="checkbox"/> Yes <input type="checkbox"/> No

Comments