Coversheet for household

Name of Data Collector
Other, specify
Date Enrollment/HOSENG
Time of Record
Village/Cluster
District
Corresponding health facility
Study Arm

Household ID
Household occupied?
Household consent given?
Reason for refusal
Other, specify

Are there any household members absent today?
Will any of the absent members return within the next 3 months?
Are any of these absent members older than 12 years of age?
Are any of these absent members HIV-negative or unknown HIV status?
Demographics for individual

Household ID

Individual ID

First name

Last name

Year of birth (day and month optional)

Who is the main caregiver for the child?

Is the child an orphan?

Yes, single orphan

Yes, double orphan

No

Gender

Female

Male

Are you pregnant?

Yes

No

Expected date of delivery (mm/yyyy)

Next scheduled ANC visit? (mm/yyyy)

(Leave blank if no scheduled ANC visit)

Completed years of primary schooling

Completed years of secondary schooling

Completed years of tertiary schooling

Employment status (click all that apply)

Employed in Lesotho

Employed in RSA

Self-employed with regular income

Younger than school age

Student (primary to tertiary)

Subsistence farming

Housewife

No regular income / unemployed

What is the profession of the individual?


<table>
<thead>
<tr>
<th>Question</th>
<th>Options</th>
</tr>
</thead>
<tbody>
<tr>
<td>Other, specify</td>
<td></td>
</tr>
<tr>
<td>Cell phone</td>
<td></td>
</tr>
<tr>
<td>Will individual provide cellphone number?</td>
<td>Yes, No, no phone, No, refused to give</td>
</tr>
<tr>
<td>Country code</td>
<td></td>
</tr>
<tr>
<td>Cellphone number (please do not include country code or spaces)</td>
<td></td>
</tr>
<tr>
<td>Owner of cellphone</td>
<td>Participant, Family member/friend, Other</td>
</tr>
<tr>
<td>Is the individual absent?</td>
<td>Yes, No</td>
</tr>
</tbody>
</table>
Absent members - individual level

Reason for being absent

Specify other reason

When will he/she back?

What is his/her HIV status?

Proof of HIV status or ART drugs given?

OraQuick left for him/her?
- Yes
- No, individual <12yrs
- No, household refused OraQuick
- No, absent individual is mentally not able to perform oral HIVST (according to household members)
- No, Other reasons

Other, specify

Please select which health center or health worker the test will be brought back to:
- 
- 
- Other
Other, specify

Data entry for this individual is complete.
Are there any more individuals in this household?

If Yes: Please press F4 and select 'Yes' in the popup
This is the end of the visit. Would you like to move to the next Visit?

If No: Please save the Form and go back to the Home Page
CAGE

Do you ever drink alcohol?  
☐ Yes  
☐ No  
☐ Refused to answer

How often do you have a drink containing alcohol?  

Have you ever felt you should cut down on your drinking?  

Have you ever been annoyed at others for criticising your drinking?  

Have you ever felt bad or guilty about your drinking?  

Have you ever taken a drink first thing in the morning to get rid of a hangover or steady your nerves?
### HIV status

<table>
<thead>
<tr>
<th>Question</th>
<th>Options</th>
</tr>
</thead>
<tbody>
<tr>
<td>Have you ever tested for HIV?</td>
<td>Yes, No, I don't know, Refused to answer</td>
</tr>
<tr>
<td>When was your last HIV test?</td>
<td>12 or more months ago, less than 12 months ago</td>
</tr>
<tr>
<td>What was the result of the last HIV test?</td>
<td></td>
</tr>
<tr>
<td>Proof of HIV status provided (bukana)?</td>
<td>Yes, No</td>
</tr>
<tr>
<td>Proof of HIV-negative status within last 4 weeks?</td>
<td>Yes, No</td>
</tr>
<tr>
<td>Are you on ART (medication against HIV; not from a traditional healer)?</td>
<td></td>
</tr>
<tr>
<td>Did they stop ART within the last 4 weeks?</td>
<td>Yes, No</td>
</tr>
<tr>
<td>Proof he/she is on ART (bukana or drugs)?</td>
<td>Yes, No</td>
</tr>
</tbody>
</table>
HIV testing

HTC consent given?  
- Yes
- No, consent refused
- No, no HIV testing needed, individual can provide proof (bukana/drugs) that he/she is on ART
- No, no HIV testing needed, individual can provide proof (bukana) of an HIV-positive result
- No, no HIV testing needed, individual can provide proof (bukana) of an HIV-negative result within the last 4 weeks
- No, no HIV testing, because child is too young for Determine

Give reason

Other, specify

OraQuick used for this individual?

Other, specify

Please select which health center or health worker the test will be brought back to:

- [ ]
- [ ]
- [ ]
- [ ] Other

Other, specify

HIV testing (click all that apply)

Is this the person you test and train on OraQuick?  
- Yes
- No

OraQuick results

- [ ] Positive
- [ ] Negative

Determine result

- [ ] Positive
- [ ] Negative

UniGold results

- [ ] Positive
- [ ] Negative

What was the final result after parallel testing?

- [ ] HIV-positive
- [ ] HIV-negative
- [ ] Indeterminate
### TB screening

**Are you currently on TB treatment?**
- [ ] Yes
- [ ] No
- [ ] Refused to answer

**When did you start taking TB treatment?**
(dd/mm/yyyy)

**History of TB in the past?**

**Was it treated?**
- [ ] Yes, fully treated (6 months)
- [ ] Yes, partially (less than 6 months)
- [ ] No
- [ ] I don't know

**What is his/her HIV status?**
- [ ] HIV-positive
- [ ] HIV-negative
- [ ] Unknown
- [ ] Indeterminate

### Any signs of TB (in HIV-negative)?

**Cough (persistently since 2 weeks)**
- [ ] Yes
- [ ] No

**Lost weight (without trying) of more than 1.5 kg in a month**
- [ ] Yes
- [ ] No

**Fever (persistently since 2 weeks)**
- [ ] Yes
- [ ] No

**Night sweats (persistently since 2 weeks)**
- [ ] Yes
- [ ] No

**Child fails to thrive/faltering growth or sign of severe malnutrition**
- [ ] Yes
- [ ] No

**Child has been in contact with someone with TB disease**
- [ ] Yes
- [ ] No

### Any signs of TB (in HIV-positive)?

**Cough (of any duration)**
- [ ] Yes
- [ ] No

**Lost weight (without trying) of more than 1.5 kg in a month**
- [ ] Yes
- [ ] No
<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fever (of any duration)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Night sweats (of any duration)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Child fails to thrive/faltering growth or sign of severe malnutrition</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Child has been in contact with someone with TB disease</td>
<td></td>
<td></td>
</tr>
<tr>
<td>On-spot sputum collected?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Reason sputum not collected</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other, specify</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Condoms provided?  

- Yes  
- No  
- Refused
VMMC

VMMC referral accepted?  
☐ Yes  
☐ No
VIBRA eligibility

<table>
<thead>
<tr>
<th>Eligibility criteria</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
</tr>
</thead>
<tbody>
<tr>
<td>Has a body weight of &lt;35 kg?</td>
<td>Yes</td>
<td>No</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Currently in care for high blood pressure (hypertension) or high blood sugar (diabetes)?</td>
<td>Yes</td>
<td>No</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>HIV-positive individual is physically, mentally, or emotionally not able to participate in the study, in the opinion of the investigators or study staff</td>
<td>Yes</td>
<td>No</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>HIV-positive individual wishes to get care outside the study districts</td>
<td>Yes</td>
<td>No</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Eligible for VIBRA</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nurse entering data</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Specify the name of the other nurse</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
VIBRA demographics

Was this person re-tested for HIV?  
☐ Yes  
☐ No, they are known HIV+ defaulters, i.e. have already been re-tested.

How do you travel to the nearest health facility?  
☐ Taxi  
☐ Walk  
☐ Horse/donkey  
☐ Bicycle  
☐ Own car  
☐ Driven by friend/family member

How long does it usually take you to travel one-way to the nearest health facility? (minutes)  

How much does it usually cost you to travel one way to the nearest health facility? (If child, include cost of caregiver) (Loti/Rand)  

Would you lose any money during the time you need to access the health facility?  
☐ Yes  
☐ No

How much money would you lose? (Loti/Rand)

How many children do you have?  

Would you need to pay a caregiver for your children (or other people you take care of) while accessing the health facility?  
☐ Yes  
☐ No  
☐ I don't have children/persons to take care of

Will you tell a close person (friend or family member) that you tested HIV-positive? (If child, will somebody else than the caregiver know?)  

Do you live with an HIV-positive household-member?  

Do you have regular sexual partner(s)?  

Do you know if any of your sexual partner(s) is also HIV-positive?
### HIV knowledge

<table>
<thead>
<tr>
<th>Question</th>
<th>Answer</th>
</tr>
</thead>
<tbody>
<tr>
<td>Is HIV spread by kissing?</td>
<td></td>
</tr>
<tr>
<td>Can a person get HIV by sharing kitchens or bathrooms with someone who has HIV?</td>
<td></td>
</tr>
<tr>
<td>Can you get HIV by touching someone who has HIV?</td>
<td></td>
</tr>
<tr>
<td>Can men give HIV to women?</td>
<td></td>
</tr>
<tr>
<td>Can women give HIV to men?</td>
<td></td>
</tr>
<tr>
<td>Must a person have many different partners to get HIV?</td>
<td></td>
</tr>
<tr>
<td>Does washing after sex help protect against HIV?</td>
<td></td>
</tr>
<tr>
<td>Can a pregnant woman give HIV to her baby?</td>
<td></td>
</tr>
<tr>
<td>Can a person get rid of HIV by having sex with a virgin?</td>
<td></td>
</tr>
<tr>
<td>Is there a cure for HIV?</td>
<td></td>
</tr>
</tbody>
</table>
Medical history

Have you ever been on ART? ____________________

Do you remember the dates you previously took ART?
- Yes
- No

When did you start taking ART? (mm/yyyy) ____________________

When did you stop taking ART? (mm/yyyy) ____________________

Why did you stop taking ART? ____________________

Other, specify ____________________

Do you remember the ART regimen?
- Yes
- No

What was the ART regimen? ____________________

If other please specify ____________________

Have you ever been on PMTCT/PEP/PrEP? ____________________

Do you remember when?
- Yes
- No

When did you start taking PMTCT/PEP/PrEP? (mm/yyyy) ____________________

When did you stop taking PMTCT/PEP/PrEP? (mm/yyyy) ____________________

Do you remember the PMTCT/PEP/PrEP regimen?
- Yes
- No

What was the PMTCT/PEP/PrEP regimen? ____________________

Have you been told that you have other diseases or health problems (besides HIV)? ____________________

What other diseases or conditions do you have? ____________________

Are you currently taking any medication? ____________________

Please specify ____________________
Do you currently smoke cigarettes/nicotine?

- Yes
- No
- Refused to answer

Do you currently smoke Dagga?

- Yes
- No
- Refused to answer
### Physical exam

<table>
<thead>
<tr>
<th>Question</th>
<th>Response Options</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Body weight (kilograms)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Does the patient report any diarrhea?</td>
<td>Yes, No</td>
<td></td>
</tr>
<tr>
<td>Date of onset (dd/mm/yyyy)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Frequency (Episodes Per Day)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Color</td>
<td></td>
<td></td>
</tr>
<tr>
<td>After examination, do you suggest referral with further consultation before starting ART?</td>
<td>Yes, No</td>
<td></td>
</tr>
<tr>
<td>Does the patient report any headache?</td>
<td>Yes, No</td>
<td></td>
</tr>
<tr>
<td>Date of onset (dd/mm/yyyy)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Location of headache</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pain intensity (1-10)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>After examination, do you suggest referral with further consultation before starting ART?</td>
<td>Yes, No</td>
<td></td>
</tr>
<tr>
<td>Does the patient report any other symptoms (other than diarrhea or headache)?</td>
<td>Yes, No</td>
<td></td>
</tr>
<tr>
<td>Other, specify</td>
<td></td>
<td></td>
</tr>
<tr>
<td>After examination, do you suggest referral with further consultation before starting ART?</td>
<td>Yes, No</td>
<td></td>
</tr>
<tr>
<td>Does the patient present oral thrush?</td>
<td>Yes, No</td>
<td></td>
</tr>
<tr>
<td>Does the patient present any abnormal skin lesions (incl. lips, scalp)?</td>
<td>Yes, No</td>
<td></td>
</tr>
<tr>
<td>Please specify</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Does the patient present any lymphadenopatie?</td>
<td>Yes, No</td>
<td></td>
</tr>
<tr>
<td>Specify location</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Does the patient present any other condition (other than oral thrush, abnormal skin lesion, lymphadenopathy)?:
- Yes
- No

Please specify:

Do(es) the condition(s) suggest referral with further consultation before starting ART?:
- Yes
- No

WHO stage:
- 1
- 2
- 3
- 4
Laboratory work

Haemoglobin done?
- Yes
- No

Haemoglobin result (g/dl)

If not done: specify reason

Other reasons

Creatinine done?
- Yes
- No

Creatinine result (micromol/l)

If not done: specify reason

Other reasons

eGFR (mL/min)

CD4-count done?
- Yes
- No

CD4 result (cells/microL)

If not done: specify reason

Other reasons

CrAg screening result
- Positive
- Negative
- Not done

If CrAg not done: specify reason

If CrAg not done for other reasons, specify

Venous blood has to be taken.
- Yes
- No

Did you take venous blood?

If no, give reason

Other, specify
Does the patient need to be referred to the health facility for any clinical (medical history, physical exam) or laboratory result reason?

- Yes
- No

Specify reason
Readiness

What do you think: How would you remember to take your medication every day?

Mobile phone reminder  
![ ]

Alarm on a clock or watch  
![ ]

Ask someone to remind me  
![ ]

Use a calendar or diary  
![ ]

Take my tablets at the same time as I do something else every day (like brushing my teeth)  
![ ]

No reminders, I’ll just remember  
![ ]

Other reminder  
![ ]

If other reminder: specify

Is there anything that would stop you from taking your tablets every day?

Yes  ![ ]  No  ![ ]

If yes: specify

If you should start ART today, how ready are you?

Ready today  ![ ]  Thinking about starting in the coming days  ![ ]  Not ready  ![ ]

Indicate date of suggested ART start

Did the patient raise any issues or serious concerns that lead you to think that ART initiation should be delayed?

Yes  ![ ]  No  ![ ]

If yes: specify

Does the patient need to be referred to the health facility due to concerns with readiness?

Yes  ![ ]  No  ![ ]
### Adherence counseling

<table>
<thead>
<tr>
<th>Question</th>
<th>Answer Option</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adherence/education session delivered?</td>
<td>Yes</td>
<td>1</td>
</tr>
<tr>
<td>If no: give reason</td>
<td></td>
<td>2</td>
</tr>
<tr>
<td>If other reasons: specify</td>
<td></td>
<td>3</td>
</tr>
<tr>
<td>Adherence leaflet left?</td>
<td>Yes</td>
<td>4</td>
</tr>
<tr>
<td>If no: give reason</td>
<td></td>
<td>5</td>
</tr>
<tr>
<td>If other reasons: specify</td>
<td></td>
<td>6</td>
</tr>
</tbody>
</table>
VIBRA acceptance

Do you want to get your ARV refill through your VHW?  
☐ Yes  
☐ No  

If no: specify  

What is the name of the responsible VHW?  

Cellphone number of the VHW given to participant?  
☐ Yes  
☐ No  

If no: give reason  

Do you want to receive SMS (as reminders and lab result info) for the follow-up period?  
☐ Yes  
☐ No  

If no: specify why not  

Date of next follow-up visit (within 12-16 days) at the VHW? (dd/mm/yyyy)  

[Box for date]
ART dispensing

<table>
<thead>
<tr>
<th>Question</th>
<th>Options</th>
<th>Instructions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Which ART regimen provided?</td>
<td>TDF/3TC/EFV, ABC/3TC/EFV, AZT/3TC/EFV, Other</td>
<td>1. If other: specify</td>
</tr>
<tr>
<td>Cotrimoxazole (CTX) given?</td>
<td>Yes, No, because CD4 &gt;=350 cells/microL, No, because out of stock, No, because patient refused, No, other reason</td>
<td>2. If other reason: specify</td>
</tr>
<tr>
<td>Do you want to receive SMS appointment reminders for the follow-up visits at the health facility?</td>
<td>Yes, No</td>
<td>3. If no: specify why not</td>
</tr>
<tr>
<td>Date of next follow-up visit (within 12-16 days) at the health facility?</td>
<td></td>
<td>4. Date of next follow-up visit</td>
</tr>
</tbody>
</table>
## Work-up health facility

<table>
<thead>
<tr>
<th>Field</th>
<th>Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>pre-ART number (xx-xx/xxxxx)</td>
<td>1, 2, 3</td>
</tr>
<tr>
<td>ART number (x-xx/xxxxx)</td>
<td>4, 5, 6</td>
</tr>
</tbody>
</table>
Follow-up

Date today (mm/dd/yyyy)  
Subject ID  
ART number  
Currently pregnant?  
  Yes  
  No  
Date of last menses? (mm/yyyy)  
Pregnant at last visit?  
  Yes  
  No  
Please specify outcome  
Does the patient report a cough?  
  Yes  
  No  
Days since onset  
Is the cough productive?  
  Yes  
  No  
Does the patient report weight loss (without trying)?  
  Yes  
  No  
Does the patient report drenching/soaking sweats at night?  
  Yes  
  No  
Does the patient report having fevers?  
  Yes  
  No  
Does the patient report any headache, dizziness, disturbing dreams or a confused behaviour?  
  Yes  
  No  
Days since onset?  
Does the patient report any abdominal pain or nausea?  
  Yes  
  No  
Decrease of food intake?  
  Yes  
  No  
Does the patient report any vomiting?  
  Yes  
  No  
Days since onset
Frequency (episodes per day)

With blood?

Does the patient report any diarrhea?

Days since onset

Frequency (episodes per day)

With blood?

Does the patient report any other symptoms?

Specify

Does the patient present oral thrush?

Does the patient present any skin rash?

itchy?

painful?

location

Does the patient present any lymphadenopathie?

Location

Does the patient present any other new condition?

specify

Did the patient miss any dose of ART on any day during the last month (30 days)?

If yes, how many days did he/she miss?

Specify reason for missing doses
Did the patient miss doses on two or more following days during the last month?

- Yes
- No

Did the patient go to any other health facility since last visit?

- Yes
- No

Clinic name

Reason

Did the patient disclose his/her HIV-status to others?

- Yes
- No
- Refused to answer

According to you: How well is the patient coping with the disease?

ART regimen modified today?

- Yes
- No

Give reason

Other, specify

ART regimen provided today

Other, specify

Isoniazid Preventive Therapy (IPT) given today?

- Yes
- No

Co-trimoxazole (CTX) given today?

- Yes
- No

Any other drugs given?

- Yes
- No

If yes: specify (name, and other info if available)

Next appointment date for follow-up visit (dd/mm/yyyy)

Name of person that performed the follow-up

Blood drawn today?

- Yes
- No

Date of (first) blood analysis (dd/mm/yyyy)

ALT, U/I

AST, U/I
<table>
<thead>
<tr>
<th>Test</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hemoglobin, g/dl</td>
<td>61</td>
</tr>
<tr>
<td>CD4, cells/microL</td>
<td></td>
</tr>
<tr>
<td>Creatinine, micromol/L</td>
<td>63</td>
</tr>
<tr>
<td>VL taken?</td>
<td>Yes</td>
</tr>
<tr>
<td>Date of VL analysis (dd/mm/yyyy)</td>
<td></td>
</tr>
<tr>
<td>VL: below detectable limit (&lt;20 copies/mL)</td>
<td>Yes</td>
</tr>
<tr>
<td>VL, c/mL</td>
<td></td>
</tr>
<tr>
<td>Any other tests performed today?</td>
<td>Yes</td>
</tr>
<tr>
<td>If yes: specify</td>
<td></td>
</tr>
</tbody>
</table>
## Adverse events

<table>
<thead>
<tr>
<th>Field</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Subject ID</td>
<td></td>
</tr>
<tr>
<td>ART number</td>
<td></td>
</tr>
<tr>
<td>Specify Adverse Event</td>
<td></td>
</tr>
<tr>
<td>Serious Adverse Event?</td>
<td></td>
</tr>
<tr>
<td>Start Date (dd/mm/yyyy)</td>
<td></td>
</tr>
<tr>
<td>Severity</td>
<td></td>
</tr>
<tr>
<td>Current ART regimen</td>
<td></td>
</tr>
<tr>
<td>Other, specify</td>
<td></td>
</tr>
<tr>
<td>Relationship to current ART</td>
<td></td>
</tr>
<tr>
<td>Stop Date (dd/mm/yyyy)</td>
<td></td>
</tr>
<tr>
<td>Outcome of AE</td>
<td></td>
</tr>
<tr>
<td>Initials of person filling in the form</td>
<td></td>
</tr>
</tbody>
</table>
## Tracing form

<table>
<thead>
<tr>
<th>Field</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individual ID</td>
<td></td>
</tr>
<tr>
<td>ART number</td>
<td></td>
</tr>
<tr>
<td>Date of information or tracing attempt</td>
<td></td>
</tr>
<tr>
<td>Date of death (dd/mm/yyyy)</td>
<td></td>
</tr>
<tr>
<td>Cause of death</td>
<td></td>
</tr>
<tr>
<td>Name of clinic</td>
<td></td>
</tr>
<tr>
<td>Date of transfer (dd/mm/yyyy)</td>
<td></td>
</tr>
<tr>
<td>Specify reason for stopping ART</td>
<td></td>
</tr>
</tbody>
</table>