**Data Mapping Introductory Script**

**Date**

**Partner**

**Facility name**

**Assessor**

**Time started**

**Time stopped**

*INSTRUCTIONS TO ASSESOR:*

This exercise should immediately follow the in-brief with the facility. Ideally, it should be completed with head of the ART unit, but if he/she is too busy or unavailable it should be completed with the person who is primarily responsible for updating documentation in the register. If it is still not feasible, it is ok to postpone this activity until the head of the ART unit is available.

**Note:**

* Do not read the questions word for word but rather ask the nurse to pretend that you are a newly identified positive patient. Have them walk you through the steps of initiating ART, noting when the ART number is given and whether it is documented if a patient initially refuses treatment
* Probe the nurse as to how they complete monthly report, how indicators are calculated including counting those that are considered lost to follow-up. Try not to make any assumptions about the facility’s processes.
* Ask what data source(s) they use for monthly reporting each for PEPFAR and MOH.
* Report back the results of the data flow to the team and use this information to help the team prepare for the recount

***Script:***

*To begin, we would like you to walk us through the treatment cascade at your facility. Please describe the process that a patient goes through from the time of ART initiation, through drug pickup and on-going treatment and care. We are also interested in understanding how this process may differ for different populations (e.g. pregnant women, pediatrics, patients in the community). We are interested in learning how services are recorded and patient data are tracked throughout the cascade. Finally, we would like to hear how ART information is recorded in the ART unit, including the pharmacy, and how data is aggregated and verified before monthly/quarterly reporting.*

**ANTIRETROVIRAL THERAPY –** *FOR COMPLETION WITH ART NURSE*

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| **Guiding Questions** | **Sketch Data Flow. Note differences for new or returning patients.** |
| **When a patient is confirmed HIV positive, describe what happens between HIV+ confirmation and ART initiation. How are the services recorded and what tools/registers are used.**  **Consider the following-probes:**  Tell me how patients are started on ART in this facility.   * *In what month and year did the facility begin providing antiretroviral therapy (ART)?* * *How is ART initiation documented?* * *At what point in the patient flow is an ART code assigned? Where is this recorded?* * *Does this process differ between inpatient and outpatient clinics? For pregnant women? Pediatrics? TB patients?* * *Who do patients see prior to the doctor or health care provider (triage nurse, medical assistant etc.)?* * *Describe the process for filing out the patient files*   + *When are the patient files pulled?*   + *When are the files moved to doctor’s office?*   + *Who is responsible for filing patient files after appointment concludes?* * *Describe the process for updating the ART register*   + *At what point(s) in the patient visit are the registers filled?*   + *Who enters the data into the registers?* * *Describe the process for updating the Daily Activity Sheet*   + *At what point(s) in the patient visit is the activity sheet updated?*   + *Who updates the activity sheet?* * *How is the patient checked out, including scheduling for the next visit?* * *How do you determine if a patient has defaulted?* * *How do you determine if a patient is lost to follow-up?* * *How do you document defaulted and lost patients? What is the process for separating files for missed appointments? For defaulters? For inactive patients?* * *When are viral load tests performed? What tools are used to document that a viral load test has been requested?* * *What is the process of obtaining results and where are the VL results documented?* |  |

**PHARMACY** *FOR COMPLETION WITH PHARMACY STAFF*

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| **Guiding Questions** | **Sketch Data Flow. Note differences for new or returning patients.** |
| **From the first prescription received at a pharmacy to refills, what happens with a patient’s health information? How are pharmacy pick-ups recorded, and where? Consider the following-probes:**  Tell me what happens when a patient comes to the pharmacy to pick up their ARVs.   * *How is their ART code confirmed before they receive their ARVs?* * *How is dispensation information added to the patient file?* * *How is this information transferred or updated in the ART register?* * *When does the database get updated (if applicable)?* * *Can patients go directly to the pharmacy for pick-up?* * *How often do patients pick up ARVs? Does this differ for new and established patients? For patients on MMD?* * *What documentation do they bring?* * *How does this differ between first prescription and refills?* * *Opportunities for quality checks?* * *Do you currently have and/or have you ever had expired ARV drugs within the stocks at your facility?* * *Do you have a standard report or log you use for reporting stocks of expired ARV drugs? If so, to whom do you report this information?* |  |