

Job Description for Case managers / mentor mothers /RCT Volunteers

Activities	Indicator	Target
a. Conduct 2 community mobilization sessions monthly to create demand for HTS services through working with community volunteers/home visits.	Number of community mobilization sessions conducted to create demand for HTS services.	24
b. Screen mobilized HTS clients for HIV infection	Proportion of mobilized clients screened for HIV infection.	100
c. Link all identified HIV positives clients to care	Proportion of clients identified positive linked to ART	100
d. Link all HIV negative clients to other prevention services	Proportion of clients identified negative linked to other services	100
e. Dispose off waste appropriately to avoid the spread of infection.	Following approved waste disposal guidelines	
f. Conduct family member testing of index clients for HIV including the sexual partners	Proportion of family member of index client who know their HIV sero Status	100
g. Track all sexual contacts for newly diagnosed HIV patients tracked and tested for HIV using (APN)	Percentage of client's sexual partners lined listed, tracked and tested for HIV	100
h. Conduct follow-up of all newly diagnosed positive clients not linked same day and ensure they linked into care.	Proportion of newly diagnosed HIV positive clients that missed same day linkage, tracked and outcomes documented	100%
g. Conduct 2 health education sessions per week at facility level to create demand for HTS services.	Number of health education sessions conducted	104
Conduct immediate follow-up of patients who miss their clinic appointment and ensure they are brought back to care.	Proportion of clients missed appointment tracked and brought back to care.	100%
	Proportion of clients missed appointment tracked and outcomes documented in missed	100%

	appointment register	
Conduct 4 health education sessions per month on appointment keeping to all ART patients accessing care, treatment and support at facility.	Number of health education sessions on appointment keeping conducted.	4
Form one peer /Family support group per quarter to support adherence and mutual support among PLHIV clients.	Number of peer support groups formed per quarter	4
Conduct one peer support meeting per month to enhance adherence support.	Number of peer support meetings conducted	4
Conduct/ provide referral services to all clients in need of further care and support to other service providers.	Proportion of clients referred to other service providers for enhanced support	100%
Track of all referred clients to assess whether they received services they were referred.	Proportion of clients that received services they were referred for.	100%
Document all referrals made per month and ensure an updated Community linkage register with outcomes.	Proportion of clients referred with document outcomes in linkage and referral register	100%
Conduct 7 intensive Adherence counseling sessions at clinic days for non-suppressed clients per week at facility level.	Number of intensive adherence counselling sessions	357
Conduct two home visits each week for adherence support and linkage to care per week at community level.	Number of home visits conducted for adherence support and linkage to care	104
Conduct at least one Health Education sessions on benefits of ART and adherence to treatment at facility and community outreaches	Number of health education sessions conducted to promote adherence	52
Track all newly initiated clients and ensuring they attend second visit following ART initiation	Proportion of clients followed/Reminded to attend their clinic visit following ART initiation	100%
Sending pre-appointment reminders to all general ART clients and ensure clinic attendance	Proportion of clients on appointment called / reminded of their appointment keeping	100%
Conduct pre-registration/ booking of clients in appointment register to support clinic attendance and management	Proportion of clients registered in appointment register attending/honoring their clinic	100%

	days	
	Proportion of clients who missed their appointment date documented in appointment register	100%
Assess all clients accessing care and treatment for Malnutrition using MUAC /Weight, Height)	Proportion of clients attending clinic assessed for malnutrition	100%
Provide referral services for malnourished patients to other units for further management	Proportion of clients identified and referred for further management	100%
Conduct TB screening for all presumptive TB cases.	Proportion of clients screened for TB using ICF	100%
Follow up cases not adhering to treatment and ensuring they come back to care.	Proportion of defaulting client tracked and brought back to care	100%
Develop a work plan for activities to be conducted monthly and have a report on activities made.	Number of workplans developed based on facility performance requirements	12
Map client direction using client locator forms and ensure they are filed in clients file	Proportion of clients file with client locator forms	100