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TUBERCULOSIS
PROJECT
SOUTH AFRICA



health

Department:
Health
REPUBLIC OF SOUTH AFRICA

TB Diagnostic Tools

URC

TB Recording & Reporting Tools

- **Case Identification Register (GW 20/13)**
- **Facility TB Treatment Card (GW 20/12)**
- **Patient TB Treatment Card (GW 20/15)**
- **TB Register (GW 20/11)**
- **Referral Book (GW 20/14)**

NATIONAL HEALTH LABORATORY SERVICE

PATIENT DETAILS												CLINIC DETAILS												CLINICAL DETAILS											
 AAAA0027												Clinic Name												Diagnosis											
Surname PLEASE PRINT CLEARLY												Sister's Name												Current Treatment											
First Name												Clinic (Responsibility) Code												TB Sputum Specimen (✓ Tick)											
File Number												Telephone Number												Suspect											
Identity Number												(CODE)												At 2-3 mths											
Date of Birth												Fax Number												At 5-7 mths											
Age												(CODE)												Other											
Patient's Physical Address												Health District												TEST INVESTIGATION											
District Code												District Code												TICK TESTS REQUIRED											
Gender: MALE <input type="checkbox"/> FEMALE <input type="checkbox"/>												TEST DETAILS Date Collected <input type="text"/>												✓											
																								Time Collected <input type="text"/> h <input type="text"/>											
Specimen Type <input type="text"/>												TB Smear AFB												TB Culture for Mycobacterium TB bacilli											
												TB Sensitivity (HR + E)												TB Sensitivity: other specify:											
												HIV Antibody												HB											
												RPR												Rh											
												Glucose												MCS (not TB)											
												Other tests:																							


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Laboratory Sputum Request form

- To request the appropriate test from the laboratory

Accurate completion of the lab forms enhances:

- ✓ Patient details (*Name; Address; etc.*)
- ✓ Patient Registration details – *to enable follow-up testing results at the lab*
- ✓ Appropriate tests
- ✓ Early diagnosis
- ✓ Differentiating between Pre-treatment and follow-up sputum

Purpose

- 'Index of suspicion' – especially amongst facility staff.
- Early diagnosis of TB cases.
- Prompt initiation of treatment for positive cases.
- Initial defaulters.
- Turn-Around-Time (TAT)

Calculate indicators monthly and quarterly

Differences between 'Suspect' Register and Case Identification and Follow-up Register

'Suspect' Register

- Only Suspects

Case Identification & Follow-up Register

- Suspects
- Case Holding
 - Follow-up sputum's
- TAT

“TB Identification & Follow-up” Register

- Nickname
- Telephone/Cellphone number
- “Patient”
 - Suspect
 - TB case
- Results – not just Positive or Negative
 - If 'Positive' – enter Grading(scanty; +; ++; +++)

“TB Identification & Follow-up” Register (2)

- Turn Around Time (TAT)
 - < 24hrs (1 day)
 - 24hrs – < 48hrs (1 – 2 days)
 - 48hrs – < 72hrs (2 – 3 days)
 - 72hrs – < 120hrs (3 – 5 days)
 - > 120hrs (5 days)

“TB Identification & Follow-up” Register (3)

- Culture
 - Date Sputum produced for Culture (*Specimen collection date*)
 - Date Culture results received
 - Culture results
 - DST done Y/N
 - Resistance (only tick those drugs for which the patient is resistant to)
 - Culture TAT
 - < 4 weeks
 - 4 – 6 weeks
 - > 6 weeks

“TB Identification & Follow-up” Register (4)

- Diagnosed TB Patients:
 - Date Rx started + Registration number
 - Died before treatment started
 - Lost to follow-up (*Primary defaulters*)
- Remarks
- Results – not just Positive or Negative
 - If 'Positive' – enter Grading (**scanty; +; ++; +++**)
 - Please record grading in **RED**

Indicator 1

- Proportion of PHC headcounts age 5 yrs and over who were identified as TB 'suspects'

Number of TB 'suspects' identified
Total PHC headcount age 5 yrs and over

Indicator 2

- Proportion of TB 'suspects' whose sputum was tested for TB

$$\frac{\text{Number of TB 'suspects' whose sputum was tested}}{\text{Number of TB 'suspects' identified}}$$

Indicator 3

- Proportion of TB 'suspects' tested who were sputum smear-positive

Number of smear-positive cases detected

Number of TB 'suspects' whose sputum was tested

Indicators 4

- Proportion of Smear Positive TB 'suspects' on Treatment

$$\frac{\text{Number of smear-positive cases started on treatment}}{\text{Number of TB 'suspects' tested smear positive}}$$

Indicator 5

Proportion of smear positive TB Suspects who died
before treatment started

Number of smear-positive TB Suspects who died before starting on
treatment

Number of TB Suspects tested smear-positive

Indicator 6

Proportion of primary (initial) defaulters

Number of smear-positive TB Suspects not on treatment

Number of TB Suspects tested smear-positive

Indicator 7

Proportion of Smear Microscopy Results back within 48hrs
(Turn Around Time)

Number of smear microscopy results back within 48hrs
Number of specimens sent for smear microscopy

Patient Clinic / Hospital Card (GW 20/12)

SOUTH AFRICA
NATIONAL TUBERCULOSIS CONTROL PROGRAMME

GW 20/12
Nov-06

PATIENT CLINIC/ HOSPITAL CARD

Registration Number:

Registration Date:

Sub-District: _____ Facility: _____

PATIENT DETAILS

Surname: _____ Full Name(s): _____ Nickname: _____

ID Number/Date of birth:

Age: Gender: M F

Residential Address (Where you live):

Tel/Cellphone: _____

Work address (Name of company/employer):

Tel: _____

NEXT OF KIN* or FRIEND DETAILS (Contact person - not staying with the patient)

Surname: _____ Full Name(s): _____ Nickname: _____

Residential Address (Where he/she lives):

Tel/Cellphone: _____

Work address:

Tel: _____

PATIENT CATEGORY

N New Patient RC Relapse AFB positive PTB (Retreatment after Cure)
 RF Re-treatment after Failure (AFB positive PTB) RD Re-treatment after default (AFB positive PTB)
 OR All Other Re-treatment cases, not included in the above mentioned categories

CLASSIFICATION OF DISEASE

ICD10 Code (According to list in the back of the TB Register):

Pulmonary TB: Extra PTB: Site for Extra PTB: _____ Both:

NOTIFICATION INFORMATION

Has patient been notified? Y N Notification date:

Notified by (Print name): _____

*The printing of these materials was supported by funding from USAID through the TASC II TB project"

Page 1

- Format – landscape for Patient details
- 'Patient Registration'
 - “Newly Registered”
- Layout of “Patient details”
- “Next of Kin' Details”
- ID Number
- Patient Category – according to WHO
 - We have added an extra category
 - All other ReRx

Page 1 (2)

- Classification of Disease
 - ICD10 codes – *see attachment*
 - Select
 - Pulmonary
 - Extra PTB
 - Both
 - If Extra PTB or Both
 - Write down the site
 - » e.g. Lymph nodes
 - » Meningitis
 - » Miliary
 - Notification Information
 - At this stage it is still required – GW17/5

Page 2

- Sputum Results
 - Space for 2- and 3-month results
- Culture:
 - Focus on Resistance instead of Susceptibility
 - Cultures & DST need to be done for
 - Non-converters
 - Re-treatment cases (After Relapse; Failure or Defaulted)
 - Contacts of Drug Resistant TB
 - Cultures need to be done
 - Smear Negative HIV Positive cases

Page 2 (2)

- Regimen and Dosages:
 - Added:
 - Treatment Start Date
 - “Other” regimen – for variations in 'normal' regimens
 - Doses of drugs during Intensive phase as well as Continuation phase
 - Other TB Drugs
- Recording of treatment:
 - Extra row to record Streptomycin
 - Column at end of Rows to calculate 'Number of dosages'

- Treatment Supervisor
 - To be monitored during Intensive phase,
and
 - Again reviewed during continuation phase

Page 3

- Clinical Progress Notes:
 - HIV Status
 - Other Medical Conditions
 - Other Chronic Treatment; e.g. Hypertension
- Addition: Basis of Diagnosis – if not diagnosed according to Smear Microscopy
 - X-rays; Skin Test; Other – Please specify
- Progress Notes:
 - Weight
 - Return Date
 - Signature

Page 4

- Progress Notes - *cont...*:
- Patient Contacts (*close contacts*)
 - *NB: monitoring of Children on Prophylactic Treatment*
 - *To be recorded on the Child's 'Road to Health' card*
- Referred Patients:
 - If name of facility is known – if patient 'Move-Out' or 'Transferred-Out', to be entered
 - If patient has 'Moved' or 'Transferred' – did patient continue treatment – was acknowledgement slip sent back to the referral facility

Page 4 (2)

- **“Moved out”** = A patient that has moved from one facility to another within the same Sub-district/LSA/Local Municipality Area
- **“Transfer out”** = A patient that has transferred from one facility to another facility in another sub-district/LSA/Local Municipal Area; District; Province or Country

- Treatment Outcomes
 - MDR TB added under 'Treatment Failure'
 - Treatment Outcome date = NB
 - last known date that patient had treatment – in case patient has died or defaulted

Patient Treatment Card (GW20/15)

Purpose:

- Used as a personal record for when patient has to access care in another facility – where there are no records
- A summarized copy of the facility record (GW20/12):
 - Patient identification
 - Disease identification
 - Diagnosis and Treatment
 - Treatment progress

The image shows a photograph of a 'Patient Treatment Card (GW20/15)'. The form is divided into two main columns. The left column is titled 'PATIENT IDENTIFICATION AND RECORDS' and contains a table for recording patient information, followed by sections for 'MEDICAL HISTORY', 'PHYSICAL EXAMINATION', and 'LABORATORY TESTS'. The right column is titled 'PATIENT TREATMENT CARD' and contains sections for 'TREATMENT', 'MEDICATIONS', 'NUTRITIONAL CARE FOR BREAST FEEDING', and 'NUTRITIONAL INFORMATION'. The form includes various checkboxes, text boxes, and a grid for data entry.

Patient Treatment Card (GW20/15)

Challenge:

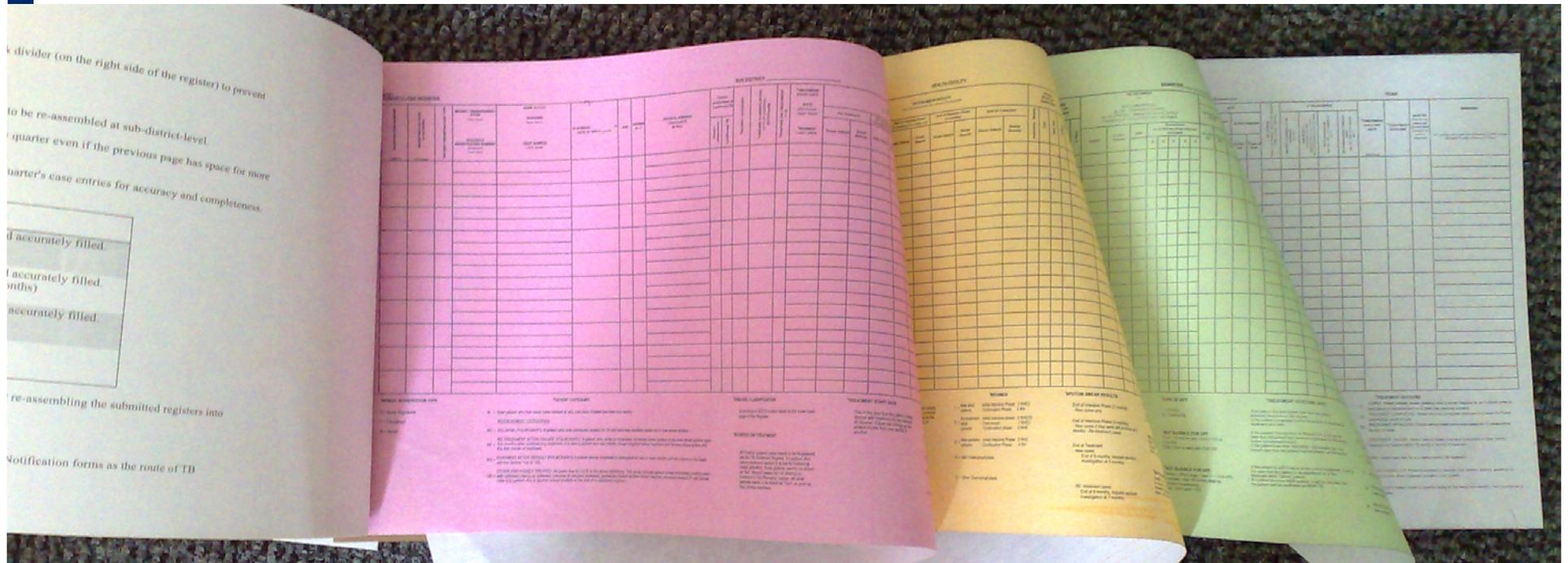
- Completeness of information

The image shows a Patient Treatment Card (GW20/15) with two pages. The top section is titled "RESEARCHER AND OCCASIONS" and contains four checkboxes: "Researcher 1 - New case", "Researcher 2 - Recurrence and relapse", "Researcher 3 - Other", and "Treatment occasion". Below this are two small tables. The first table has columns for "Drug", "Date", "Dose", and "E", and a row for "Number of doses". The second table has a single row for "Number of doses".

The middle section is titled "A) REFERENCE PHASE" and contains a large grid with columns labeled "Week" (1-28) and "Day" (1-7). The grid is currently empty.

The bottom section is titled "B) CONTINUATION PHASE" and contains a similar table to the first one, with columns for "Drug", "Date", "Dose", and "E", and a row for "Number of doses". Below this is another large grid with columns labeled "Week" (1-28) and "Day" (1-7), also currently empty.

TB Register (GW20/11)



TB Register (GW20/11) (2)

- 3 Registers in One
 - TB Treatment Register
 - DOT Register
 - TB/HIV Annex register

TB Register (GW20/11) (3)

- Wording:
 - Moved/Transfer versus Patient Registration Type
- Additions:
 - Moved / Transferred From, and
 - Previous Registration Number (*if available*)
- ID Number (or Date-of-birth)
- Patient on Chemo-Prophylaxis versus TB Treatment

TB Register (GW20/11) (4)

- Patient Category:
 - See legend
- Disease Classification:
 - Classification – ICD10 Code
- **NEW:** 'Started on Treatment' – Y/N
 - As we are going to use ETR.Net to notify TB, All diagnosed cases needs to be registered.
 - Even if they have died before treatment started or got lost before treatment started
 - If a patient was diagnosed, sputum results need to be filled in, but obviously the patient will not have a treatment start date nor a Regimen

TB Register (GW20/11)(5)

- If diagnosis was not done based on Smear Microscopy,
 - Indicate procedure(s)
- Cultures:
 - Cultures need to be done for
 - Non-converters
 - All Re-treatment cases
 - All HIV Positive Smear Negative cases
 - All contacts of Drug Resistant TB cases
 - DST done (Yes/No)
 - Focus on Resistance instead of Susceptibility
 - Tick those drugs for which the patient has a resistance

TB Register (GW20/11) (6)

- **DOT**
 - At end of Intensive Phase
 - Indicate whether the patient was on DOT throughout the intensive phase (Y/N)
 - Indicate the 'Type' of DOT according to legend
 - At End of Continuation phase
 - Indicate whether the patient was on DOT throughout the continuation phase (Y/N)
 - Indicate the 'Type' of DOT according to legend

TB Register (GW20/11) (7)

- HIV Status:
- If HIV Positive:
 - On ART at initiation of TB treatment (Yes/No)
 - CD4 Result
 - Last CD4 count if the patient is on ART
 - Current CD4 count if the patient is not yet on ART
 - ND – If CD4 count is required but was not done
 - On Cotrimoxazole (Yes/No/NE)
 - NE = Not eligible for CPT – *see legend*
 - On Anti-retroviral Treatment (ART) (Yes/No/NE)
 - NE = Not eligible for CPT – *see legend*

TB Register (GW20/11) (8)

- Treatment Stop date
- Outcome – according to Legend at bottom of page
- MDR-TB – To be ticked when patient has been diagnosed as being MDR
 - Either at end of Intensive phase, or
 - At end of treatment
 - If patient was still positive at end of treatment – a Failure, the patient start as a Re-treatment After Failure – if Culture and Susceptibility results comes back and patient is MDR, needs to be tick for initial treatment

TB HIV Indicators

1. % HIV Positive patients amongst all TB cases
2. % HIV Positive TB patients that were on ART **before** TB treatment was commenced
3. % HIV Positive TB patients with a CD4 Count less than
4. % HIV Positive TB patients on CPT
5. % HIV Positive TB patients on ART

How to calculate TB HIV Indicators

Example:

$$\frac{\text{Total Number of HIV Positive cases amongst All TB cases}}{\text{Total Number of TB cases started treatment for the same period}} \times 100$$

- number of HIV Positive TB cases that are on CPT

Challenges

- **Incomplete recording**
 - the patient information
 - Sputa – Date sputum collected and/or results
 - treatment stop date and
 - outcome.
- Collect sputa late (conversion).
 - **New Smear Positive PTB cases – after 2-months**
 - **Re-treatment Smear Positive PTB cases – after 3-months**
- Pink, Yellow and Green forms not forwarded, on time, to the Data-entry-level (Sub-district)
 - *Especially Yellow and Green forms*

Patient Referral Form (GW20/14) (2)

- Purpose of the Referral form
 - To ensure continuity of care:
 - Ensuring that the patient is referred properly (to a particular facility) and that he/she has reached the destination
 - By making proper use of acknowledgement slips
 - Pink form goes with the patient
 - Yellow form is sent directly to the facility
- **If the referring facility knows where the patient has been transferred to, (*only for patients that have transferred out – not moved-out*)**
 - **can get final outcome of the patient**

Challenges

- Incomplete recording e.g.
 - Physical address not complete
 - Only one/no sputum collected
 - Sputum collected, no results
 - Grading of sputum not done/not recorded
 - Smear Positive PTB patients without any recording whether they started on treatment or not, and if not – why not

We can stop TB

