REPUBLIC OF KENYA

MINISTRY OF HEALTH

National TB Preventive Treatment Standard Operating Procedures

2019

NATIONAL TUBERCULOSIS, LEPROSY AND LUNG DISEASE PROGRAM

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PREFACE

The Division of National Tuberculosis, Leprosy and Lung Disease Programme (NTLD-P) in collaboration with the Division of National Aids and STI Control Programme (NASCOP) continue to provide technical guidance on TBHIV co-infection prevention and management. Kenya has made tremendous gains in reducing the co-infection rate through adopting focused interventions and will endeavor to continue the fight bearing in mind also the varied nature of the epidemic across all counties.

This document on Tuberculosis Preventive Therapy Standard Operating Procedures has been developed to aid health care workers and other users in TB preventive therapy with the ultimate focus of further reducing the co-infection rate which currently stands at 27 %.

In order to achieve this, continuous collaboration from various multi stakeholders in Kenya and adoption of more advanced preventive, curative and diagnostic technologies is key.

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ACKNOWLEDGEMENTS

This document seeks to provide guidance to health care workers on provision of Isoniazid Preventive Therapy. It has been developed through a multi- sectoral collaborative effort.

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LIST OF ACRONYMS

AIDS	Acquired Immune Deficiency Syndrome
AMC	Average Monthly Consumption
AMR	Anti-Microbial Resistance
ART	Anti-Retroviral Therapy
ARV	Antiretroviral
CASCO	County AIDS and STI Coordinator
CAT 1	Category 1
CAT 2	Category 2
CCC	Comprehensive Care Centre
CHS	Centre for Health Solutions – Kenya
CHMT	County Health Management Team
CLHIV	Children Living with HIV
CPT	Cotrimoxazole Preventive Therapy
CQI	Continuous Quality Improvement
CTLC	County TB and Leprosy Coordinator
DAR	Daily Activity Register
D/F-CDRR	District/Sub-county/Facility Consumption Data Report and Request
D/F-MAPS	District/Sub-county/Facility Monthly ARV Patients Summary
DHIS	District Health Information System
DQA	Data Quality Assessment
DST	Drug Susceptibility Testing
HIV	Human Immunodeficiency Virus
ICF	Intensified Case Finding
INH	Isoniazid
IPC	Infection Prevention and Control
SDP	Service Delivery Point
TPT	TB Preventive Treatment

LIST OF FIGURES AND TABLES

TB Preventive Treatment at a Glance

Tuberculosis Preventive Treatment (TPT), refers to therapy offered to individuals who are considered to be at risk for TB disease in order to reduce the risk. Also referred to as Latent TB Infection (LTBI) treatment or preventive therapy. It is national policy to provide preventive treatment to:

- All asymptomatic People Living with HIV (PLHIVs) aged over 12 months
- All children aged less than 5 years, regardless of their HIV status, exposed to bacteriologically confirmed TB
- Prisoners
- Health care workers

Before initiation of TPT, all eligible persons should be subjected to symptom-based screening to rule out active TB and to prevent emergence of antimicrobial resistance (AMR). Persons screening negative for TB and are eligible, should be initiated on appropriate TPT regimen to reduce the risk of progression from LTBI to active TB disease.

In addition to symptom-based screening, chest x-ray (CXR) can be used to augment TB screening. However, access to CXR should not delay initiation of TPT

Providing TPT for PLHIV, not only reduces the individual patient's risk but also helps to mitigate TB transmission to others. The World Health Organization (WHO) Latent Tuberculosis Infection: Updated and Consolidated Guidelines for Programmatic Management 2018 strongly recommends the provision of TPT to HIV-infected adults and children who are unlikely to have active TB based on simple symptom screening.

Preventive Treatment Options

- Daily Isoniazid for 6
- Daily Isoniazid for 9 months
- Daily isoniazid plus rifampicin for 3 months
- Weekly rifapentine plus isoniazid for 3 months (12 doses)

Currently, the Ministry of Health (MOH) recommends six months of isoniazid preventive therapy (IPT) **once in a lifetime alongside pyridoxine** (Vit. B6).

Implementing Isoniazid Preventive Therapy

Tuberculosis Screening/ Intensive Case Finding (ICF)

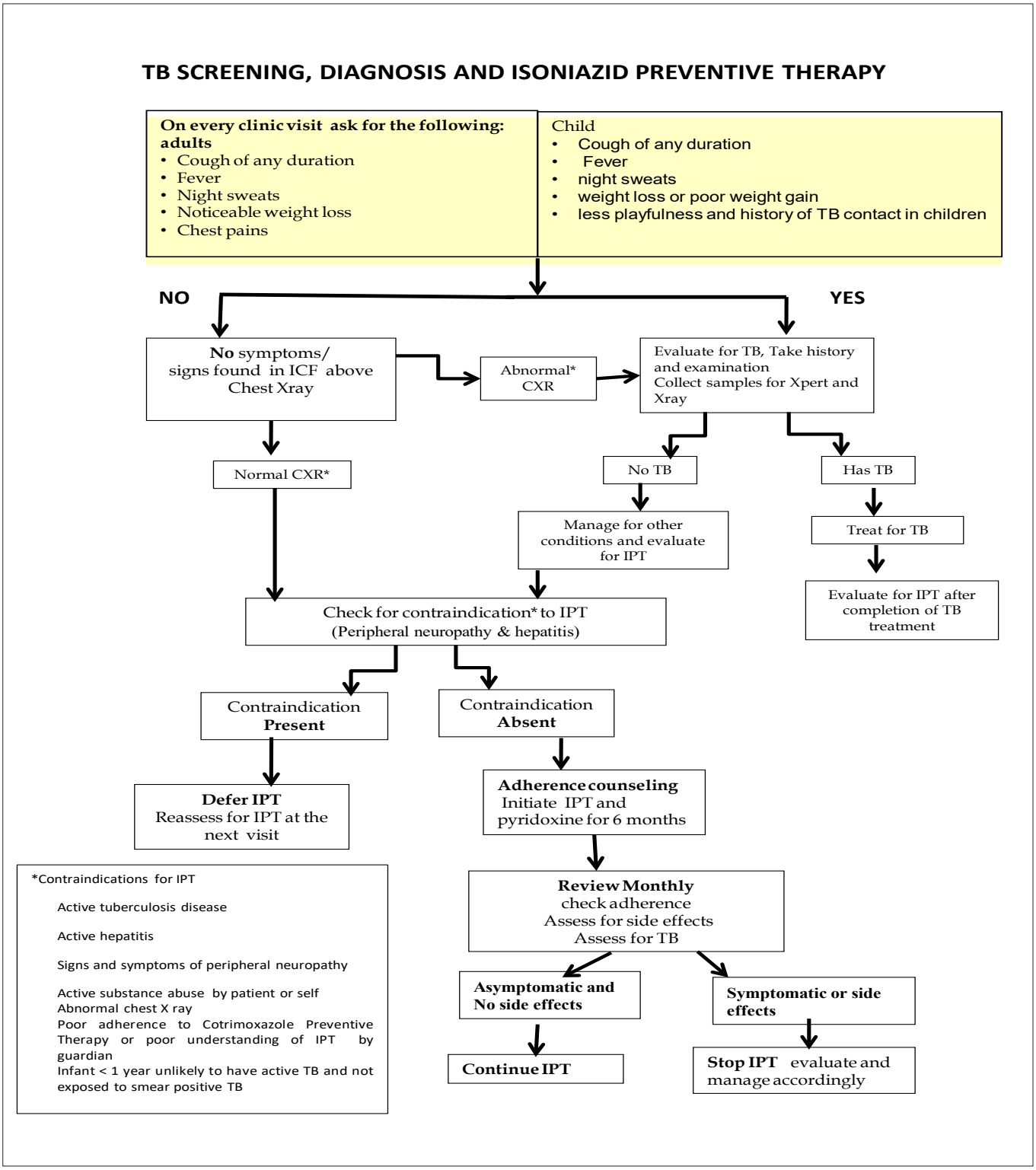
Every child under the age of 5 years exposed to a person with bacteriologically confirmed TB should be screened for active disease. Likewise, PLHIVs should be screened for TB on every visit using the standard MOH ICF/IPT tool.

CXR where available can be used for additional screening but should not delay IPT initiation.

Those who do not have any symptoms or have a normal CXR are unlikely to have active TB disease. Isoniazid (INH) preventive therapy is outlined for such patients as indicated in the subsequent sections.

- Ask the adult patients for cough of any duration, fever, night sweats, weight loss and chest pain.
- Obtain history on current cough, fever, night sweats, weight loss or poor weight gain, reduced playfulness and history of TB contact in children.
- If the patient says "yes" to any of the questions, investigate appropriately based on the Algorithm for TB screening/diagnostic and IPT and manage.
- Those who screen negative to all the above questions, they should be prepared for IPT as per the algorithm (Figure 1).

Figure 1: Algorithm for TB Screening, Diagnosis and Isoniazid Preventive Therapy



Note: Chest Xray is recommended in this algorithm if available. If not available, proceed with the next decision step as per the algorithm.

Indications for Isoniazid Preventive Therapy

- Children living with HIV who are >12 months of age who screen negative for TB using the ICF tool
- Children living with HIV who are <12 months of age, who have contact with a bacteriologically confirmed TB and screen negative for TB using the ICF tool
- All HIV negative children under 5 years who have contact with a smear positive TB case and screen negative for TB using the ICF tool
- All PLHIV above 12 months of age who screen negative for TB using the ICF tool.
- Prisoners, irrespective of HIV status who screen negative for TB using the ICF tool
- Health care workers

NOTE:

- IPT can be started at any time after successful completion of TB treatment.
- IPT has not been shown to increase the risk of developing isoniazid-resistant TB.
- IPT is safe to use during pregnancy and in people with a past history of TB treatment.
- Avoid alcohol consumption while on IPT due to increased risk of hepatotoxicity.

Contraindications to IPT

Active TB disease

- Signs of and symptoms of hepatitis (jaundice, elevated liver enzymes)
- Symptoms of peripheral neuropathy
  - In adults and older children; persistent numbness, tingling or burning sensation in limb/s,
  - In younger children; regression in motor milestones, refusal to crawl, walk, or run). NB. If the client has any of the above contraindications, defer IPT and manage underlying cause of neuropathy Defer IPT: Manage underlying cause of neuropathy

NB. Defer IPT: in case of the following;

- Abnormal Chest x-ray
- Active substance use/ abuse
- Poor adherence to ART.

Manage the underlying condition and re-evaluate for IPT on the next visit

Initiation of IPT

Patient preparation

- Ask the patient about the following
  - Signs of liver disease (yellowness of eyes) and
  - Neuropathy (persistent numbness and burning sensation in the feet and hands).
  - Active substance or alcohol use / abuse
- Examine the patient for jaundice and tenderness in the right upper quadrant of the abdomen.
- Where available, routine liver function tests/ALT should be offered, but lack of LFTs/ ALT results should not delay the initiation of TPT in asymptomatic patients.
- If the patient does not have any abnormality based on the assessment above, assess for adherence using the criteria on the backside of the ICF/ IPT card.

Initiating IPT

- Start the client on 10mg of Isoniazid per kg (maximum 300mg) once daily and **pyridoxine - all patients on isoniazid should be initiated on concurrent pyridoxine.**

- Counsel the patient on the importance of adherence
- Provide information on potential side effects including anorexia, nausea, vomiting, abdominal discomfort, persistent fatigue, numbness, yellowing of eyes (jaundice) and pale stools.
- Record the indication of IPT in the ICF /IPT card and in the IPT register and book the patient for clinical review monthly
- Advise the patient to immediately contact their healthcare worker if they experience any of the listed side effects.

Duration and Dose of Isoniazid

IPT should be given at a dose of 10 mg/kg/day (maximum 300 mg) for a duration of 6 months. Children should be weighed at every visit and their dose adjusted according to their weight. Infection control measures should be given priority to reduce TB transmission in all settings that provide patient care.

Table 1: Dose of INH for IPT

Weight range (kg)	Dose in mg	Number of 100mg INH tablets	Number of 300mg (Adult) tablet
<5	50	½ tablet	-
5.1-9.9	100	1 tablet	-
10-13.9	150	1 ½ tablet or	½ tablet
14-19.9	200	2 tablets	-
20-24.9	250	2 ½ tablets	-
>25	300	3 tablets or	or 1 tablet
Adults	300	3 tablets or	or 1 tablet

Children should be weighed at each visit and correct weight-based dosing confirmed

The current recommendation for use of IPT is once in a lifetime for PLHIV. However, children below the age of 5 in close contact with a bacteriologically confirmed TB patient should receive a repeat dose of INH for 6 months even if they had received IPT previously.

Dosing of Pyridoxine (Vit B 6) for all patients taking Isoniazid

All patients taking INH (whether for TPT or TB treatment) should receive daily pyridoxine to reduce the risk of developing peripheral neuropathy.

Table 2: Dosages for Pyridoxine (Vitamin B6)

Weight (kg)	Dosage
1-13.9 kg	12.5mg
14-25 kg	25 mg
>25 kg	50 mg
Adults	50 mg

Follow Up of Patients on IPT

- Patients on IPT should be followed up on monthly basis and clinic harmonized with routine CCC clinics.
- During each clinic visit, active monitoring of potential side effects should be done.
    - Common ADRs include: asymptomatic elevation of liver enzymes, hepatotoxicity, Peripheral neuropathies.
- Identify, document and report any suspected ADR to Pharmacy and Poisons Board (PPB).
- Reporting to the pharmacy and poisons board could be done using any of the methods below:
    - Fill in a hard copy of the yellow pharmaco-vigilance form and mailing it to Pharmacy and Poisons Board through the regional offices
    - Send an SMS or WhatsApp message to 0795 743 049
    - Enter ADR information directly in the yellow form on website *www.pv@pharmacyboardkenya.org*
    - Enter the information directly into a PPB Android App of the phone.
- Advise patient to return immediately if they develop complaints relating to ADRs as captured in Table 3.
- Assess for patient adherence to medication.
- Emphasize importance of adherence and give adherence messages during clinic visits.
- Screen for active TB during each clinic visit using symptom based intensive case finding (ICF) card/ tool.
- Update their ICF cards and IPT register at every visit and document the outcome on completion of therapy.

Table 3: Common INH Adverse Events

Rash
Consistent fatigue or weakness lasting more than 3 days
Persistent tingling and numbness of hands and feet
Jaundice
Loss of appetite
Nausea
Abdominal pain/ discomfort
Vomiting

If a patient develops signs and symptoms of TB:

Stop IPT and evaluate for TB disease. Obtain sputum for GeneXpert and any relevant investigations for TB such as culture and DST. If TB is confirmed, classify and manage as per the TB guidelines.

Management of complications of IPT

Table 4: Management of IPT Complications

Complication	Management
Hepatitis	**Rule out other causes of hepatitis and do LFTs/ALT** • Discontinue IPT in patients with ALT/AST more than three times the upper normal limits with signs and symptoms of liver disease or asymptomatic patients with ALT/ AST more than five times the upper normal limits.
Peripheral neuropathy	• In cases of mild peripheral neuropathy, double the daily dose of vitamin B6 (pyridoxine) until the symptoms disappear • If the peripheral neuropathy is severe or worsens, then discontinue Isoniazid immediately.

Table 5: Restarting IPT after Interruption

Scenario	Action
If patient had discontinued INH for less than 1 month	• Conduct adherence counselling, • Conduct ICF and if asymptomatic continue from where they left off. • Ensure they have completed a **6-month course**
If a patient had taken INH for less than 1 month in total and discontinued for any reason (like toxicity or loss to follow up)	• Conduct adherence counselling, • Address reasons for discontinuation • Conduct ICF and if asymptomatic • **Restart INH afresh** • Ensure they have completed a **6-month course**
If patient had discontinued INH for more than 1 month but less than 3 months	• Conduct adherence counselling, • Conduct ICF and if asymptomatic • Restart INH • Ensure they complete a **6-month course** within a **9-month period**
If patient discontinued for more than 3 months, or had discontinued more than once	• Do not re-initiate IPT

Follow up after completion of IPT

- Conduct symptom-based TB screening at every clinic visit for patients who have completed IPT.
- Update month 6, 12, 18, and 24 (from IPT completion), TB status for every patient in the IPT register.
- If a patient screens positive after completing IPT, manage according to national TB guidelines.

IPT in Special Circumstances

Table 6: IPT in Special Circumstances

Scenario	Action
Patients previously treated for TB (Secondary prophylaxis)	• Initiate IPT for another 6 months in PLHIV who successfully complete their first line TB treatment if they had not received IPT before.
IPT with ART and CTX (secondary prophylaxis)	• IPT, ART and CTX can be safely co-administered (WHO 2010)
IPT and Pregnancy	• Isoniazid is safe in pregnancy. Start IPT in all HIV positive pregnant women irrespective of their gestation period. • Advise women to complete IPT if a woman becomes pregnant while taking IPT. • Assure patient that IPT is safe while breastfeeding
IPT and MDR-TB	• Management of contacts of DRTB and PLHIV who have completed DRTB • should follow the national DRTB guidelines
IPT in children born to smear positive mothers	• If a baby is born to a bacteriologically confirmed pulmonary TB mother, assess the new-born for TB. This includes assessing the placenta for tubercles • Non-specific features suggestive of neonatal TB include: Fever, low birth weight, hepato-splenomegaly, irritability, feeding intolerance. • If the child has none of the above, give IPT for 6 months • Withhold BCG until 2 weeks after completion of IPT.

SOP on use of IPT Monitoring and Evaluation (M&E) tools

Table 7: Documenting and reporting TB screening and IPT uptake

Documentation	
Screening	All PLHIV, children <5years exposed to smear positive TB , prisoners and healthcare workers, shall be screened for TB as per the National guidelines using ICF/IPT tool. Record those screened in the following tools and registers: a. IPT/ICF card b. Daily Activity Register (DAR) for PLHIV. (Use the appropriate column against the patients CCC number at each visit when they are screened) c. Presumptive TB registerd d. TB Contact Management Registers for all contacts including children < 5 years of age exposed to bacteriologically confirmed TB. e. The TB screening registers for prisoners.
IPT Initiation	a) Clinicians should fully update the patient IPT /ICF card at the start of IPT and at every visit made for IPT refills. b) The facility Health Records Information Officers will record all PLHIVs started on IPT in the CCC IPT register, and at every subsequent visit made for IPT refills. c) The TB clinician/nurse will record all children under the age of 5 started on IPT in the TB clinic's IPT register, and at every subsequent visit made for IPT refills. **The IPT registers will be recorded as such:** • Serially record all patients in the IPT register beginning each calendar year, *(the number should indicate a serial number and year e.g. 1/2015).* • Indicate the IPT serial number in the ICF/IPT tool and the MOH 258 (appointment card) for PLHIV and ICF/IPT card for children < 5 years exposed to smear positive TB. • At the end of every month, draw a line to close the month and summarize the month as per criteria provided at the bottom of the IPT register *(Total started on IPT during the month disaggregated by age < 15 and 15+).* • The Facility serial numbers in the IPT register shall be continued in the following month. • For Each Month, identify the cohort that has 6 months since the IPT start date and indicate their 6 months outcomes. • New serial numbers shall be initiated in the beginning of the following calendar year. *(Use the codes provided at the bottom of the register)*
Follow up and monitoring	• The HCWs must document absence or presence of INH related ADRs at the back of the IPT/ICF card at every visit. • Identified ADRs should be summarized in the pharmacovigilance (PV) yellow form.

Commodity Management

i) SOP for Dispensing Isoniazid (INH)

Procedure for dispensing Isoniazid to eligible PLHIV; children under 5 years of age with contact to smear positive TB; eligible health-care workers and prisoners. Responsible persons: Pharmacists, pharmaceutical technologists and other health professionals (e.g HCWs at the TB clinic/MCH/CCC)

Procedure:

1. Dispense appropriate doses of Isoniazid to eligible patients at CCC pharmacy, TB clinic or MCH clinic.
2. Ensure that there is availability of a six-month dose of INH as well as B6 for each patient before initiation. As much as possible, store the medicines for continuing patients at separate area to avoid stock outs
3. Alternatively, a 6-month pack of INH can be labeled and ear marked for each initiated patient. Ensure that the prepacked INH/B6 for individual patient has an expiry of more than 6 months.
4. INH refill should be done on a monthly basis ensuring alignment with ARV refill appointments.
5. Use revised ART LMIS tools (2017) i.e. DAR ARVs and OIs or electronic dispensing tools (ADT) to fully document each dispensing encounter.
6. Adherence assessment and counselling should be on every visit and actively look out for side effects.

ii) SOP for reporting and ordering for INH for PLHIV, children under 5 with contact to smear positive TB, prisoners and eligible healthcare workers

Procedure for reporting and ordering for INH

Location: Central sites, standalone sites, satellite sites, and TB clinics.

Responsible persons: Pharmacists, Pharmaceutical technologists and other health professionals.

Procedure:

1. Submit monthly reports and orders for resupply from all CCCs and TB clinics offering IPT to KEMSA or central sites (as the case may apply).
2. Follow same timelines for reporting and ordering for ARVs and INH monthly reports.
3. Apply same formula for determining quantity for resupply of INH as that for ARVs i.e. [(AMC X 3)-SOH for central and stand-alone sites and [(AMC X 2)-SOH for satellite sites].
4. Use revised ART LMIS tools (2017) i.e. D/F-CDRR and D/F-MAPS (manual or electronic) for reporting and ordering for INH and Pyridoxine.
5. Submit filled D/F-CDRR and D/F-MAPS as per normal ARV reporting channels i.e. to KEMSA or central site.

Monitoring and Evaluation

i) Facilities implementing IPT should have the following tools:

(a) Recording tool

Table 8: Recording Tools

Tool	Use	SDP CCC	SDP MCH (PMTCT)	SDP TB clinic	Other SDPs
Adult and Paediatric ICF/IPT tool	At each visit and for any child contact for intensive case finding and IPT patient follow up	√	√	√	
IPT register	A record of all patients on IPT in the facility and their outcomes	√	√	√	Pharmacy
Presumptive TB register	For contacts of bacteriologically confirmed TB patients	√	√	√	All SDPs
TB Contact Management Register	Record of all household contacts of bacteriologically confirmed TB patients			√	
Daily activity register for CCC	A record of daily patient visits and services offered	√	√	√	Pharmacy
Pharmacovigilance tools	Record patients with ADR	√	√	√	Pharmacy
Pre ART/ART register	Records TB screening outcome in the cohort register	√	√		
Patient follow up form (Green card)	Record all the patient forms in every visit	√	√	√	
TB 5 Patient record card	Records patients previous IPT history and completion status			√	

(b) Reporting tools

Table 9: Reporting Tools

Tool	Use	SDP CCC	SDP MCH (PMTCT)	SDP TB clinic	Other SDPs
MOH 731	Comprehensive HIV/AIDS facility form	√	√		HRIO F I/C office
MOH 711	National Integrated form- RH/ HIV/TB/ Malaria	√	√	√	HRIO F I/C office
FCDRR	Facility consumption data report and request	√		√	Pharmacy
Daily activity register for TB and OI drugs	A record of daily patient visits and services offered	√		√	Pharmacy
Pharmacovigilance tools	Report patients with ADRs	√	√	√	Pharmacy

Table 10: Procedure for Recording and Reporting IPT

2. Reporting for IPT	
Various populations	**PLHIV** a) Use the MOH C&T Tally sheet to tally and count the persons started on IPT during the month. b) Transfer the Totals from tallying to MOH 731 departmental form and the Monthly summary form. **Children under 5 exposed to smear +ve TB** a) The SCTLC shall record all < 5 into the TIBU system. b) The health care worker at the TB clinic shall summarize the total number of exposed children under 5 years started on IPT. c) Transfer the total number of children <5 years to relevant section of MOH 711. **Prisoners** The health care worker at the prison shall make a monthly summary of the IPT register and transfer the totals to MOH 711.
Data Flow	a) Facility HRIO summarizes IPT related data from all the SDPs into facility summary tools for submission to the SCHRIO b) The Sub-County HRIO collates, aggregates and summarizes the number of clients started on IPT and the number screened for TB using MOH 731/711 summary sheets and enters into DHIS 2. c) The SCTLC enters IPT data for <5 years into TIBU system
Data Use	**DQA** The SCASCOs and SCTLC shall conduct Data Quality Assessments (DQA) at least once in a quarter. They will check on data complete- ness, accuracy and validity. **CQI** The CQI team at the health facility will check their performance every quarter and identify areas of improvement. **NB:** *There will be instructions at the beginning of all tools to aid in proper use of each of the registers*

TBHIV /IPT RECORDING AND REPORTING

TBHIV recording and reporting is paramount to ensure data capture and information production for planning, decision making and other information purposes. To enable data capture the following tools are used in both TB and TBHIV settings; Presumptive Register, Contact Register, Clinical encounter Green card, ANC Register, HIV Care and treatment - Daily Activity Register and ART Cohort register. Information collected using these tools is further relayed in the monthly summary reporting tool MOH 731 which is uploaded in DHIS 2.

Presumptive TB register

This register is placed at service delivery points where clients identified with signs and symptoms of TB are documented and followed up for care.

The following data elements are collected through this register;

IPT started	Yes/No
Indicate if an eligible IPT client has been initiated on IPT	
Date IPT was started	

Contact register

To support active case finding, all TB patients' contacts are screened and followed up for a period of 6 months. To facilitate monitoring the following data elements are collected through the contact register

Data elements collected on TBHIV /IPT through the contact register:

Symptomatic Evaluate for TB include specimen type and collection date																						follow- up after treatment complition	
TB Symptom Screening (Use Key 1 below and indicate all that apply)	TB Symptom Screening Outcome : Symptomatic (S) or Asymptomatic (AS)	GENEXPERT (MT+RR, MTB+RS, MTB-ND)			Copy (POS/NE)		Culture (POS/NEG/ NO/Contaminated)		IPT initiation (if already on IPT) indicate Facility	Referred out for IPT (Y/N)? indicate facility or clinic name	Deferred IPT (Y/N)? indicate reason (abx trial, completed IPT, completed TBtx)	IPT (indicate date when patient collected medicine and dose dispensed)						IPT treatment outcome (see key 2 below) and date	Reason for discontinuation of IPT	Reason for discontinuation of IPT	Month 6 f/u TB status	Month 12 f/u status
		Date	Gxpert	Specimen type	Date	Results	Date	Results	Date Done	Date Done	Reason	Month 1	Month 2	Month 3	Month 4	Month 5	Month 6					

Clinical encounter Green card

The Clinical encounter is a facility-based tool that has been designed for patient encounter with a clinician or service provider to a client enrolling in care and at the same time record subsequent follow up visit. TB Screening: At every encounter, the client should be screened for active TB using the ICF tool and the final documented status should be entered in this section

Pr TB = Presumed TB,

No TB = Negative TB screen,

INH = Client was screened negative & started INH,

It also tracks clinical events such as INH prophylaxis, indicating date INH prophylaxis was initiated, as well as INH completion date.

Data elements collected through the green card on IPT:

TB screening	**(t)**	**TB Screening:** At every encounter, the client should be screened for active TB using the ICF tool and the final documented status should be entered in this section **Pr TB** = Presumed TB, **No TB** = Negative TB screen, **INH** = Client was screened negative & started INH, **TB Rx** = Client on TB treatment.

ANC Register

The Antenatal register is used for recording information concerning a woman's pregnancy at the initial and periodic follow-up visits at which health education for pregnant women is provided and checks on any danger signs and symptoms are done.

TB/HIV data elements captured through the ANC:

Screened for TB	**(ai)**	Enter one of the following options: **NS =** if no signs of TB from current assessment. **Pr TB =** Presumed TB, if a client is clinically or radiologically suspected to have TB but not confirmed through laboratory tests. **TB Rx =** if patient is already on treatment **ND=** Not Done

Care and treatment Daily Activity Register

This activity register covers the following aspects of HIV and TB treatment: patients newly enrolling on care with ART initiated or awaiting ART commencement, clients on treatment preparation and not yet on ART, those starting and continuing on ART, clients being screened for TB , and those started on INH prophylaxis. Additionally the register indicates patients assessed for nutritional status , the proportion of those malnourished among them and those provided with nutritional support.. It also documents the number of women aged 18 years and above who have had a clinical visit and the proportion screened for cervical cancer and those provided with family planning services for those under 15 years.

Below are main TB/HIV indicators collected:

TB in HIV Care	
Screening and Results	Started on IPT

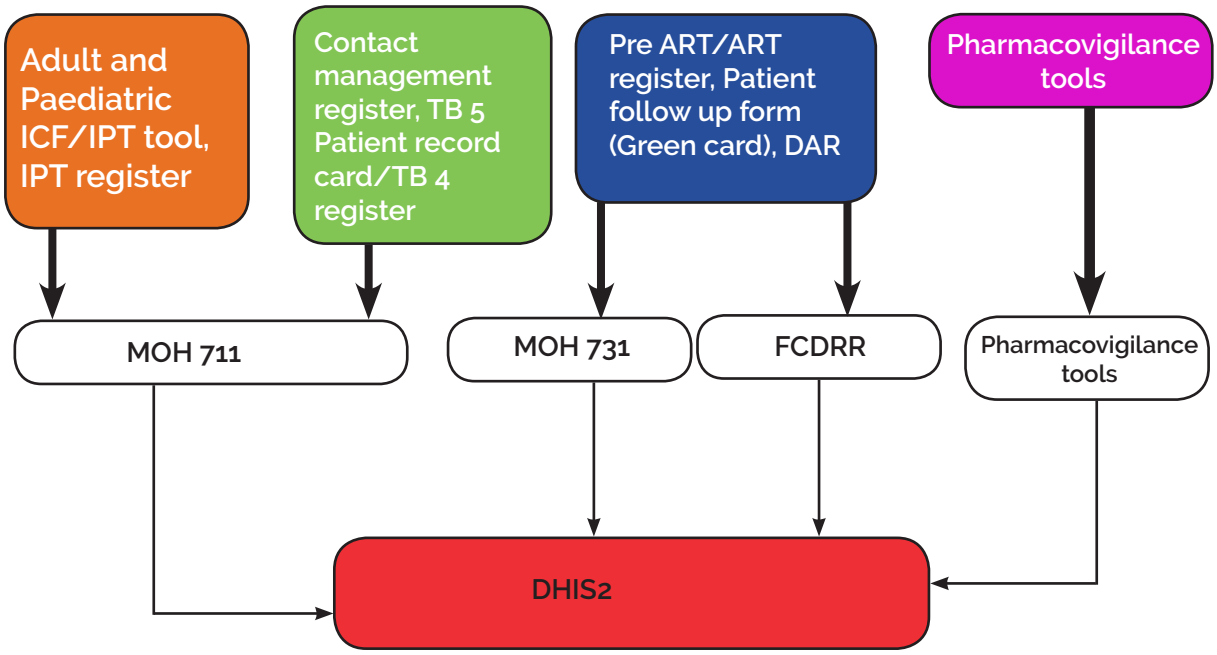
MOH 731 FACILITY AGGREGATION FORM

Data from the various registers is aggregated monthly at facility level. To facilitate this process, health care providers use an MOH 731 facility aggregation form which is later submitted to the Sub county HRIO for entry into DHIS 2.

Data Elements on TBHIV collected through MOH 731

3.7 TB Screening & presumed TB		
Screen for TB_<1	HV03-051	
Screen for TB _1-9	HV03-052	
Screen for TB _10-14	HV03-053	
Screen for TB _15-19	HV03-054	
Screen for TB _20-24	HV03-055	
Screen for TB _25+	HV03-056	
Screen for TB_Total	HV03-057	
Presumed TB_Total	HV03-058	
3.8 Starting IPT		
Start IPT_<1	HV03-059	
Start IPT _1-9	HV03-060	
Start IPT _10-14	HV03-061	
Start IPT _15-19	HV03-062	
Start IPT _20-24	HV03-063	
Start IPT _25+	HV03-064	
Start IPT_Total	HV03-065	
Completed IPT_12months	HV03-066	

Summary on TBHIV IPT Data MOH 711



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MINISTRY OF HEALTH

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