NATIONAL INSTITUTE FOR MEDICAL RESEARCH
MUHIMBILI MEDICAL RESEARCH CENTRE
P.O.Box 3436, Dar es Salaam, Tanzania.

IRRSSIA STUDY

Score chart for diagnosis of TB in children.

SCORE IF SIGN OR SYMPTOM PRESENT						
	0	**1**	**2**	**3**	**4**	**Score**
General features						
Duration of illness	Less than 2 weeks	2-4 weeks		More than 4 weeks		
Failure to thrive or weight loss	Weight gain	No weight gain or weight faltering		Weight loss		
TB contact	None	Reported (but no documentation) smear-negative or EPTB		Smear positive (with documentation)		
TST	Negative, not done			Positive		
Malnutrition not improved after four weeks of therapy				Present		
Unexplained fever not responding to appropriate therapy			Positive			
Local features						
Chest x-ray				TB-suggestive features like infiltration, cavity, or hillar lymph nodes		
Painless, enlarged lymph nodes		Any non-cervical lymph nodes		Positive cervical lymph nodes		
Swelling of bones or joints				Positive		
Unexplained ascites or abdominal mass				Positive		
Central nervous system findings: meningitis, lethargy, irritability and other behaviour changes				Positive		
Angle deformity of the spine					Positive	
TOTAL SCORE A score of **7 or more** indicates a high likelihood of TB. Refer the child for TB treatment.						

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IRRSSIA STUDY FORM II

Majibu kutokana na uchunguzi wa sampuli za mgonjwa. Jaza fomu tofauti kwa kila sampuli kutoka kwa mgonjwa

LABORATORY INVESTIGATIONS

Namba ya Utambulisho ya Mradi _____ Tarehe:____/____/_____.

Namba ya Mgonjwa ya Hospitali _____

HP No.: _____ CP/HC No.:_____

Age:_____ Sex:____

Number of samples collected:_____

Sample material:

☐ Pleura fluid ☐ Lymph node biopsies ☐ Cerebrospinal fluid
☐ Ascites ☐ Fine needle aspirates ☐ Other: _____
☐ Tissue

Lymph Node Site: ☐ Cervical ☐ Inguinal ☐ Other: _____
☐ Axillary ☐ Mediastinal

AFB microscopy: ☐ Positive ☐ Negative

Cytology/histology:

_____

_____

_____

MTP64: ☐ Positive ☐ Weak Positive ☐ Negative ☐ Uncertain

TAARIFA MUHIMU:weka alama kama sampuli imepatikana.

☐ Sampuli kwaajili ya culture imepatikana na kupelekwa maabara CTRL ☐ Hapana
☐ Sampuli kwaajili ya GeneXpert imepatikana na kupelekwa CTRL ☐ Hapana
☐ Sampuli ya damu imepatikana na kutengeneza DBS and DPS ☐ Hapana

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IRRSSIA STUDY FORM III

(fomu ya sampuli kwaajili ya MTB Culture and GeneXpert at CTRL)

Namba ya Utambulisho ya Mradi _____ Tarehe:____/____/_____.

Namba ya Mgonjwa ya Hospitali _____

Sample received from: _____

Sample material:

- ☐ Pleura fluid
- ☐ Ascites
- ☐ Lymph node biopsies
- ☐ Fine needle aspirates

Date sample collected: _____(dd/mm/yy)

Volume of sample received: _____ml

Date sample tested: _____

MTB Culture:	☐ Positive	☐ Negative	☐ Contamination
GeneXpert:	☐ Positive	☐ Negative	☐ Invalid
Rif resistance:	☐ Yes	☐ No	

QUESTIONNAIRE – CHILDREN BELOW THE AGE OF 18 (CRF 01)

Unique Study Number: _____ **Date:** _____

Consultant: _____

Hospital:

- **Muhimbili National hospital**
- **Mbeya Referral Hospital**
- **Other**

Department: OPD IPD

Is the patient on TB drugs? Yes. No

For outpatients, from which hospital was the patient referred? _____

Hospital patient number of the referring hospital: _____

PATIENT IDENTIFICATION

Name of patient: _____ **Study Number**: _____

Age: _____(years) Mobile#: _____

Close relative contact (1):_____Close relative contact (2): _____

Gender: Male Female

1. **Respondent:** Patient Parent Spouse Child Other, relative/friend

Address: Region_____Village_____Street_____

2. **Living with:**

one parent (mother/father) both parents Relatives Orphanage
Others, please specify_____

3. **Education/day-care:**

home-care nursery primary school
Form I-IV Form IV-VI Others (Please mention) _____

4. **Religion**:

Muslim Christian Other, please mention_____

PERSONAL AND PAST MEDICAL HISTORY

5. **Tobacco use (adolescents):** □ Yes □ No ____weeks/months /years
6. **Smoking (adolescents):** □ Yes □ No ____weeks/months /years
7. **Alcohol (adolescents):** □ Yes □ No ____weeks/months /years

8. **Associated Diseases**

Asthma: □ Yes □ No
Chronic diarrhoea □ Yes □ No
Renal Disease: □ Yes □ No
Liver Diseases: □ Yes □ No
Diabetes Mellitus: □ Yes □ No
Cardiac disease: □ Yes □ No
Other: □ Yes □ No
Describe other: _____
_____

9. **Medication**: ***Please write the names of the medication***

_____

PAST HISTORY OF TUBERCULOSIS

10. **Has the child been in contact with a person with known tuberculosis?**

□ Yes □ No

If yes, who was/were the contact person(s)?

_____

If yes, when was the child in contact with this (these) person(s)?

_____

11. **Has the child previously been diagnosed with pulmonary tuberculosis?**

□ Yes □ No

12. **Has the child previously been diagnosed with extrapulmonary tuberculosis?**

□ Yes □ No

13. **Has the child previously been treated for tuberculosis?**

□ Yes □ No

14. **If the child has been treated, what was the treatment outcome?**

□ Cured
□ Treatment Completed
□ Treatment Interrupted

15. **If treated, when was the last time the child completed any TB treatment?**_____

HEALTH-SEEKING BEHAVIOUR

Health seeking behavior for TB patients
Please remind the patient and respondent that this survey is confidential.

16. <u>Please ask if the patient has experienced any of the following symptoms</u>

<u>General Symptoms</u>

Fever: □ Yes □ No ____weeks/months

What kind of fever does the child have?

□ High-grade □ Low-grade

When does the child have fever?

□ Morning □ Day-time □ Evening □ Night □ all day

Failure to gain weight □ Yes □ No ____weeks/months

Loss of weight: □ Yes □ No ____weeks/months

Loss of appetite: □ Yes □ No ____weeks/months

Night Sweat: □ Yes □ No ____weeks/months

Fatigue: □ Yes □ No ____weeks/months

Body weakness: □ Yes □ No ____weeks/months

Frequent cold: □ Yes □ No ____weeks/months

Neck mass: □ Yes □ No ____weeks/months

Other: □ Yes □ No ____weeks/months

<u>Respiratory Symptoms</u>

Cough: □ Yes □ No ___weeks/months

Sputum: □ Yes □ No ___weeks/months

Cough with Sputum: □ Yes □ No ___weeks/months

Cough with blood: □ Yes □ No ___weeks/months

Chest pain: □ Yes □ No ___weeks/months

Difficult in breathing: □ Yes □ No ___weeks/months

<u>Abdominal Symptoms</u>

Swelling of/in stomach: □ Yes □ No ___weeks/months

Fullness of the stomach: □ Yes □ No ___weeks/months

Vomiting: □ Yes □ No ___weeks/months

Chronic diarrhea: □ Yes □ No ___weeks/months

Other: □ Yes □ No ___weeks/months

Describe other: _____

_____

\

<u>Neurological Symptoms</u>

Headache: □ Yes □ No ___weeks/months

Irritability □ Yes □ No ___weeks/months

Photophobia: □ Yes □ No ___weeks/months

Vomiting: □ Yes □ No ___weeks/months

Dizziness: □ Yes □ No ___weeks/months

Vertigo: □ Yes □ No ___weeks/months

Weakness/Numbness of extremity:

□ Yes □ No ___weeks/months

Visual disturbance: □ Yes □ No ___weeks/months

Other: □ Yes □ No ___weeks/months

Describe other: _____

_____

_____

17. What were the major symptoms that first made you seek care for your child?

□ Prolong Cough	□ Coughing blood	□ Breathlessness
□ Chest pain	□ Fever	□ Weight loss
□ Fatigue\Weakness	□ Loss of appetite	□ Night sweats
□ Bone pain	□ Lymph node swelling	□ Diarrhoea
□ Abdominal pain	□ Others (specify) _____	

18. When did you or the child first notice the symptoms?

_____

19. Did you give the child any self-medication before you sought care?

□ Yes □ No

20. When did you first seek medical advice for the child after noticing the symptoms?

Mention the exact date: ___/___/_____

(If you don't remember the exact date but it was on the beginning of the month fill 05, if it was in the middle of the month fill 15 and if it was on the end of the month fill the 25).

21. How many different places did you go to seek help for the child's current symptoms?

_____places

22. How many times have you taken the child to a health facility with the same symptoms before?

□ First visit □ Second visit □ Third visit

□ > 3 visits □ don't remember

23. Which place did you first seek care for the child`s symptoms?

□ Regional Hospital	□ District hospital	□ Health center
□ Dispensary	□ Private Hospital	□ Traditional healer
□ Pharmacy	□ other, please specify_____	

24. Did the child get any medicine from there?

□ Yes □ No

25. If yes, what kind of medicine?

□ Antibiotics □ Anti-TB □ Herbs □ others, which_____

26. Were the child`s symptoms relieved after taking medicines?

□ Yes □ No

27. What kind of diagnosis did the child receive for the current illness?

_____

28. Were any tests done at the first medical service?

□ Yes □ No

29. What type of tests?

□ Blood test □ Urine test □ Sputum □ X-ray

□Others, please specify_____

30. Did you take the results back to the doctor?

□ Yes □ No

31. Could you estimate the total cost for the previous visits/investigations related to the child`s current illness?

Admission _____TZS
Consultations _____ TZS
Medication _____TZS
Laboratory tests/X-ray/CT_____TZS
Transportation _____TZS

□ All costs covered by Medial Insurance

32. Who referred the child here to this health facility?

□ myself □ Traditional healers □ Religious leaders
□ Pharmacy/drug shop □ Village health worker □ Government dispensary
□ Government health center □ Government hospital □ Private dispensary/hospital
□ Charitable/NGO □ Member of the family □ Other_____

33. Has your child received routine vaccination, by following the national children`s vaccination program?

□ Yes □ No

34. Has your child received BCG vaccination?

□ Yes □ No

35. Has the child ever been tested for HIV?

□ Yes □ No

36. What was the result of the HIV-test?

□ HIV positive □ HIV negative □ don't know □ don't agree to disclose HIV status

37. Before today, had you heard of the illness tuberculosis?

□ Yes □ No

38. Do you know any symptoms of tuberculosis?

□ Chronic cough □ Spitting blood □ Shortness of breath
□ Chest pain □ Fever □Weight loss
□ Tiredness □ Loss of appetite
□ Others Please specify_____ ***(Do not probe but ask for more symptoms)***

39. Do you know which parts of the body that can be affected by tuberculosis?

_____

40. Can tuberculosis spread from person to person?

□ Yes □ No □ Uncertain

41. In your household do you drink unboiled milk?

□ Yes □ No

42. In your household do you eat raw meat?

□ Yes □ No

43. Did you know that consumption of raw animal products, like uncooked dairy products can lead to gastrointestinal tuberculosis as a result of transfer of the disease from animals to humans?

□ Yes □ No

44. Can tuberculosis be cured with medicines?

□ Yes □ No □ Uncertain

45. Do you know how long it takes to treat tuberculosis?

□ Yes □ No

If yes, do you know the approximate duration of treatment? _____

46. Do people in your community associate tuberculosis with HIV?

□ Yes □ No □ Uncertain

If yes, why do they associate it with HIV? _____

47. Is there anything that would make it easier for people with tuberculosis to get treatment, not just in this clinic, but in other health facilities?

□ Yes □ No □ Uncertain

If yes, what could be done? _____

48. The moment you realized that the child may have contracted tuberculosis, did you have any problems deciding to seek care? If so, what types of problems?

_____

_____

_____

49. What fears do others have about TB that prevents them from seeking medical advice?

_____

50. If you consulted a traditional healer before seeking care at a modern health facility, what were the reasons which led you to first use the traditional healer?

_____

_____

PATIENT AND HOUSEHOLD COSTS, estimate of the patient income level

51. How long does it take you to go to the nearest health facility?

□ Less than 30 minutes □ between 30 minutes and one hour □ More than one hour

52. How far is this hospital to your home (in Kilometers) _____

53. How long (on average) does it take you to this health facility, waiting for the child`s consultation and finally returning to your home\workplace? _____ Hours

54. How did you get to this health facility?

□ Walked □ Bicycle □Motorcycle □ Private car □ Dala Dala

55. If you have to take a Dala Dala, how much (on average) does it cost you to come to the clinic? _____TZS.

56. Do you usually have to make some special arrangements at home before coming to the clinic?

□ Yes □ No □ Uncertain

If yes, what arrangements? _____

57. What is the main income of your household?

□ Crop production □ Livestock □ Fishing
□ Hunting/ bee-keeping □ Poultry □ Farm wage
□ Other agricultural activity □ Wages (government) □ Wages (private)
□ Monetary savings (interest) □ Pensions
□ Property (rentals) □Self-employed payments (merchant)
□Other Specify_____

58. In the past 12 months, in what types of activities were you and any members of your household engaged? (Only income-generating activities)?

_____
_____
_____

59. How much did (NAME) earn (money) for the activities stated on average in the past 12 months? This should include not only salary or cash income: but also the value of goods produced or traded for other goods and services.

_____

60. Have any member of your household stopped working or reduced their work capacity because of the child`s illness?

□ Yes □ No

If yes, for how long? _____days

If yes, how much reduced working capacity? _____

61. Have you/or any member of your household lost any wages or income because of the child`s illness?

□ Yes □ No □ Uncertain

If yes, how much_____

62. Do you own a house?

□ Yes □ Renting a house □ living with relatives /friends □ Homeless

63. How many people live in your household: _____ (number of people)

How many: Men: _____Women:_____Elderly:_____Children (between 0-10):_____
Children (between 11-18): _____

64. How many siblings does the child have?_____sibling(s)

65. What is the main source of drinking water for members of your household?

□ Piped water 1=Piped into dwelling 2= Piped into yard/plot 3=Public tap 4=Neighbors' tap
□ Water from open well
□ Water from covered well or borehole
□ Running water 1=spring; 2=river/stream; 3=pond/Lake; 4=Dam
□ Rain water

□ Tanker truck
□ Water vendor
□ Bottled water
□ Others Specify _____

66. What kind of toilet facilities does your household have?

□ Flush toilet □ Pit toilet/latrine 1=traditional pit latrine 2=ventilated pit latrine (VIP)
□ No facility/bush/field □ other, please specify _____

67. Do you share these facilities with other households?

□ Yes □ No

68. Does your household have?

□ Electricity □ Paraffin lamp □ Radio
□ Television □ Telephone/mobile □ Iron (either charcoal or electricity)
□ Refrigerator

69. What is the main source of energy for lighting in your household?

□ Main electricity □ Solar □ Gas
□ Paraffin-hurricane lamp □ Paraffin-Wick lamp □ Firewood
□ Candles □ other, please specify _____

70. What is the main material for the walls of your house or house you are living?

□ Grass □ Poles and mud □ Cement bricks
□ Backed bricks □ Timber □Stones
□ Others Specify_____

71. What is the roofing material of your house or house you are living?

□ Grass/leaves/mud □ Iron sheets □ Tiles □ Concrete □ Asbestos
□ Others Specify_____

72. Does any member of your household own

□ A bicycle □ A motorcycle or motor scooter □ A car □ A bank account

73. How many acres of land for farming/grazing are owned by the household?

□ Arable land_____acres □ Land for grazing_____acres

74. How many meals does your household usually have per day?

Meals_____

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IRRSSIA STUDY FORM I

Sehemu hii inajazwa na anaejaza dodoso la mgonjwa. Taarifa kutoka kwenye file la mgonjwa

Namba ya Utambulisho ya Mradi _____ Tarehe:____/____/_____.

Namba ya Mgonjwa ya Hospitali _____

Age:_____ Sex:_____

Hb _____ ESR ____ WBC count: ____

HIV: ☐ Positive ☐ Negative ☐ Unknown

Biochemical tests:

☐ Protein: _____ ☐ Glucose: _____ ☐ Cell count: _____

PHYSICAL SIGNS:

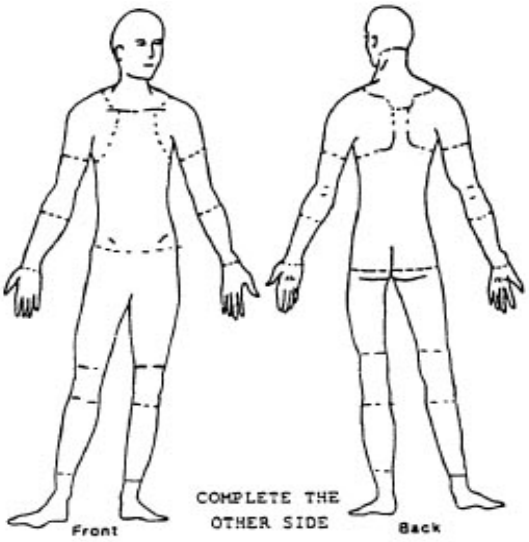
Weight: _____kg. Temperature: _____^{0}C.
Pulse rate: _____bpm BP:_____mmHg MUAC _____cm

Pallor:	☐ Yes	☐ No
Finger clubbing:	☐ Yes	☐ No
BCG scar:	☐ Yes	☐ No
Other:	☐ Yes	☐ No

LYMPH NODES:

Lymph node enlargement:	☐ Yes	☐ No
Matted:	☐ Yes	☐ No
Painful:	☐ Yes	☐ No
Discharge/Sinus:	☐ Yes	☐ No

DRAW ENLARGED LYMPH NODES OR OTHER FINDINGS:



CHEST FINDING

☐ Yes: _____weeks/months ☐ No ☐ Not Done

If **YES** describe findings:

_____

_____

_____

CARDIOVASCULAR SYSTEM

Murmur: ☐ Yes ☐ No ☐ Not Done
Other:
Describe Other:

_____

_____

_____

ABDOMEN

Mass:	☐ Yes	☐ No	☐ Not Done
Ascites:	☐ Yes	☐ No	☐ Not Done
Hepatomegaly:	☐ Yes	☐ No	☐ Not Done
Splenomegaly:	☐ Yes	☐ No	☐ Not Done
Other:	☐ Yes	☐ No	☐ Not Done

Describe Others:

_____

_____

_____

NEUROLOGICAL EXAMINATIONS

Level of consciousness:	☐ Alert	☐ Altered	☐ Stupor	☐ Coma
Neck Rigidity:	☐ Yes	☐ No		
Photophobia:	☐ Yes	☐ No		
Tone Upper limbs:	☐ Normal	☐ Abnormal		
Tone Lower limbs:	☐ Normal	☐ Abnormal		
Power Upper limbs:	☐ Normal	☐ Abnormal		
Power Lower limbs:	☐ Normal	☐ Abnormal		
Coordination:	☐ Normal	☐ Abnormal		
Exaggerated Reflexes:	☐ Yes	☐ No		
Other:	☐ Yes	☐ No		

Describe Others:

_____

_____

_____

Other findings (Skin, Unilateral swelling/joint tenderness, backache, stiffness, lump, deformity, limp)

_____

_____

_____

_____

_____

SPUTUM EXAMINATION: (kama mgonjwa amechukuliwa makohozi)

AFB microscopy:

	Date:(dd/mm/yy).	**Appearance ***	**Neg.**	+	++	+++
☐	**Sample 1**					
☐	**Sample 2**					
☐	**Sample 3**					

*visual appearance (blood stained, muco-purulent, saliva)

MTB Sputum Culture: ☐ Positive ☐ Negative

Date of positive culture:(dd/mm/yy): _____

GeneXpert: (sputum) ☐ Positive ☐ Negative

Rif resistance: ☐ Yes ☐ No

BACTERIOLOGY:

Gram stain: _____ **Bact. Culture:** _____

Other tests: _____

_____

OTHER INVESTIGATIONS

Chest X-Ray:

_____

_____

_____

Sonography/CT scan:

_____

_____

_____

Other:

_____

_____

_____

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IRRSSIA STUDY FORM IV

(Information obtained from DTLC)

Namba ya Utambulisho ya Mradi _____ Tarehe:____/____/_____.

Namba ya Mgonjwa ya Hospitali _____

Extra pulmonary: ☐ Yes ☐ No
Extra pulmonary with pulmonary: ☐ Yes ☐ No
Pulmonary: ☐ Yes ☐ No

Date of diagnosis: (dd/mm/yy): _____
Date of result communicated to the patient: (dd/mm/yy): _____
Date of started treatment: (dd/mm/yy): _____

TB TREATMENT OUTCOME:

- ☐ Cured
- ☐ Treatment completed
- ☐ Died
- ☐ Treatment Interrupted
- ☐ Transfer Out

What is the patient final diagnosis: _____
_____