Nigeria
National Data Repository:
Implementation Guide

Version 1.5
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Version History

S/No	Date	Author	Purpose
1	08 August, 2015	InductiveHealth Informatics	Initial Version
2	19-September, 2015	InductiveHealth Informatics	Draft version for review by Early Adopters
3	22-September, 2015	InductiveHealth Informatics	Pre-delivery version for review by CCFN and CDC
4	23-September, 2015	InductiveHealth Informatics	Delivery to IPs participating in NDR Early Adopter Program
5	29- September, 2015	InductiveHealth Informatics	Final revisions in preparation for delivery milestone
6	23-January, 2018	University of Maryland Baltimore	Revised to accommodate the current scope
7	7 July, 2019	University of Maryland, Baltimore	Revised to include re-architecture
8	27 March, 2020	University of Maryland, Baltimore	Revised to accommodate current scope
9	25 June, 2021	University of Maryland, Baltimore	Revised to accommodate current scope
10	20 March 2022	Public Health Information Survey and Surveillance Solution PHIS3	Revised to accommodate current scope
11	25 May 2022	Public Health Information Survey and Surveillance Solution PHIS3	Revised to accommodate current scope
12	19 July 2022	Public Health Information Survey and Surveillance Solution PHIS3	Revised to accommodate TB on NDR
13	18 August 2022	Public Health Information Survey and Surveillance Solution PHIS3	Revised to accommodate current scope COVID on NDR

Contents

List of Abbreviations

NDR – National Data Repository

EMR – Electronic Medical Record

XML – Extensible Markup Language

XSD – XML Schema Definition

IP - Implementing Partner

ART – Anti-Retroviral Therapy

PMTCT – Prevention of mother-to-child transmission

TB – Tuberculosis

API – Application Programming Interface

1 Overview

The purpose of this documents is to provide a developer guide that explains key elements of the information standard, supporting efficient development and verification of standardized individual-level messages. Adjudicate

It is important to note that this document will be continually updated based on new releases of the National Data Repository (NDR) Schema and based on feedback from Facilities and Implementing Partners during onboarding to the NDR.

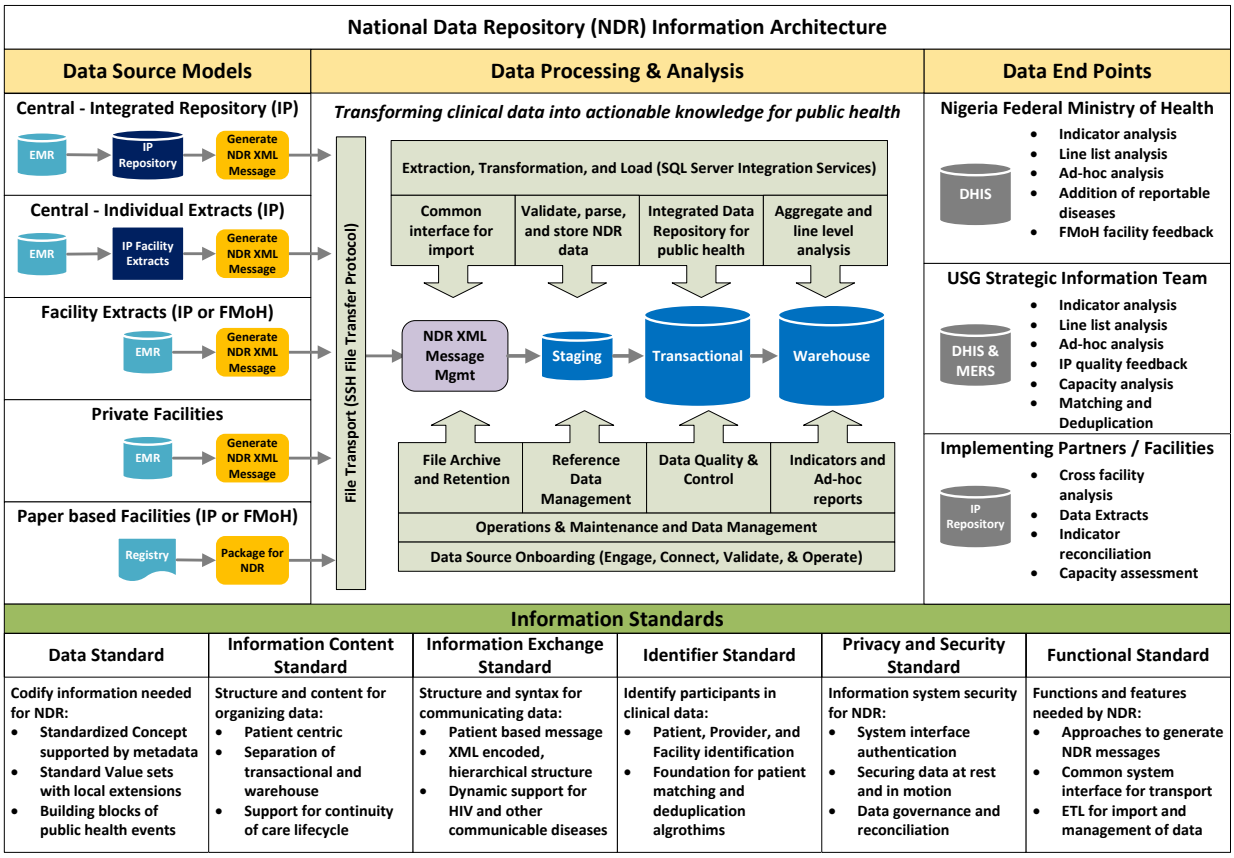
Documents and artifacts that extend and support the NDR Implementation Guide include:

1. **NDR Schema**: The NDR Schema is implemented as an XML Schema Definition (XSD) and governs the encoding, structure, and content for sending patient centric, Extensible Markup Language (XML) messages to the NDR
2. **Schema Change Log**: The Change Log captures all changes the NDR Schema across releases
3. **NDR Data Dictionary Workbook**: Captures all value set and codes defined for data elements, traces data elements from the NDR Schema to the Repository database and visualizes the physical data models for NDR databases.
4. **NDR Data Dictionary**: User guide that describes the information included in the NDR and how it is organized
5. **Validation Worksheet**:

Questions and feedback on the NDR Implementation Guide should be directed to hisupport@phis3project.org.ng

2 Information Exchange

The figure below demonstrates the Information Architecture for the NDR focusing on the movement of data across the platform supported by multiple information standards. This section further defines the overall technical implementation of the NDR Information Exchange.



2.1 Reporting Triggers

Reporting triggers document the healthcare events that should result in a message being transmitted to the NDR.

The table below defines which diseases are currently reportable to the NDR and the trigger events for when disease reports should be sent to the NDR. The benefit of defining what diseases are reportable to the NDR along with triggering events for each condition is to ensure consistency of reporting across Facilities and Implementing Partners.

It is important to note that as access to additional Program Areas within the Nigeria Federal Ministry of Health is obtained, the list of reportable diseases and reporting triggers will be extended.

Additionally, it is important to note that once a NDR reporting trigger has been engaged, data for the Patient's disease should be continually reported to NDR as an update.

For each time a facility wants to report data to the NDR, the EMR should be checked for all clients who meet any one of the listed trigger events and ONLY such clients' records should be sent to the NDR.

	Event	Action
1.1	Documented HIV test result in the EMR	Send an initial message for the client
1.2	Client Enrolled into HIV care and treatment program	Send an Initial message with all historic data for the client
1.3	Client Transferred in and this is documented in the EMR	Send an Initial message with all historic data for the client
1.4	Client has a follow-up visit documented in the EMR	Send an Update message for this client with updated data for the client
1.5	Client's record on the EMR was updated	Send an Update message for this client with updated data for the client
1.6	Client record deleted on the EMR	Send a Redacted message for this client
1.7	Client transferred out	Send an Update message for this client with updated data for the client
1.8	Client documented as died	Send an Update message for this client with updated data for the client
1.9	Client documented as stopped after tracking	Send an Update message for this client with updated data for the client
1.10	Client documented as LTFU after tracking	Send an Update message for this client with updated data for the client

2.2 File Transport

Data transport is achieved to the NDR website over HTTPS using username, password authentication.

2.3 File Compression

To address file size and movement of data across networks and facilities, Implementing Partners should compress multiple XML files into a zip folder. Compressed files should NOT be encrypted using a password and compressed XML messages should be in the root of the archive file (i.e., do not use sub folders). Typical XML file sizes are within 1KB to 20KB per patient. The current limit for compressed ZIP files is 500MB.

2.4 Message Naming Convention

The table below defines the naming convention for the individual messages being sent to NDR by facilities and Implementing Partners. Each part of the file name should be separated by an underscore ("_") and use an .XML file extension. For example:

- 05151_39383933_15072015_221510.xml
- 10209_ 30003961_13062015_082909.xml
- 09216_ 30003961_13062015_082909.xml

	File Name Part	Notes
1	State and LGA code for the facility	Use the NDR data dictionary to get the State and LGA codes for the facility and concatenate to form this field. Two-digit State Code then Three-digit LGA Code
2	Identifier assigned by FMoH to uniquely identify Facility	
3	Patient Identifier	

	File Name Part	Notes
4	Date (DDMMYYYY)	

If a compressed archive file is transmitted, the file should follow the convention defined in the table below and use a .ZIP file extension. For example:

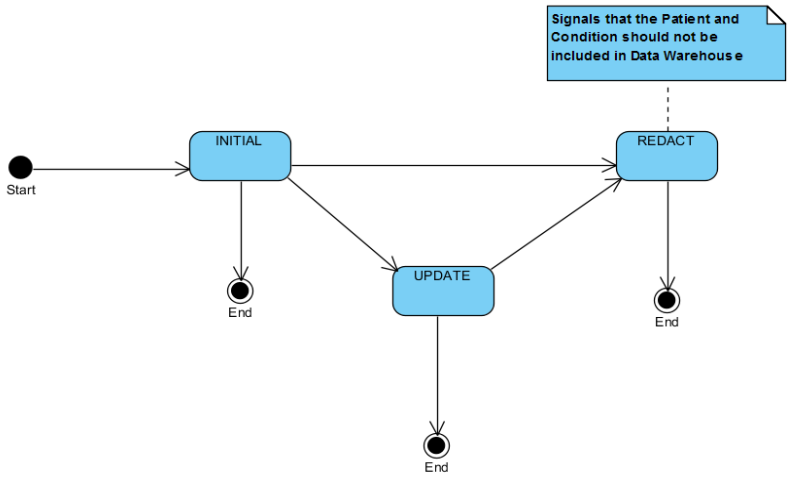
- 09216_15072015_221510.zip

	File Name Part	Notes
1	State and LGA code for the facility	Use the NDR data dictionary to get the State and LGA codes for the facility and concatenate to form this field. Two-digit State Code then Three-digit LGA Code
2	Identifier assigned by FMoH to uniquely identify Facility	
3	Date (DDMMYYYY)	
4	Time based on 24 hour clock (HHMMSS)	Using West Africa Time (WAT)

2.5 Message State

The figure below specifies the sequence of events that an object goes through during its lifetime in the NDR. In the context of the NDR, definition of state allows additional data to be added for a Patient's Condition and enables facilities or Implementing Partners to communicate when a Patient, Condition, or Public Health event was incorrectly or erroneously entered into the EMR and subsequently reported to the NDR.

	State	Description	What to Include	Triggers
	Initial	When sending new records that do not exists in the NDR	All existing and historic client record	
	Update	When sending an update to an existing record in the NDR	Send only data elements that have changed using timestamps from the update encounter table	
	Redact	When deleting an existing record from the NDR		



2.6 Important Identifiers

The table below identifies the key identifiers that are used by the NDR.

	Identifier	Schema Element	Implementation Approach
1	Message Unique Identifier	MessageUniqueID	A unique value assigned to the NDR message.
2	Message Schema Version Number	MessageSchemaVersion	This number indicates which version of the XSD was used in generating the XML message. This number is important as it determines what data elements are expected and may determine what validation rules are applied during ingestion
3	Patient Identifier	PatientIdentifier	Represents how the Patient is uniquely identified within the EMR. This may take the form of a unique value assigned by the EMR or a unique value generated when the Patient is created in the EMR. It is critical that this value be unique for a Patient in the context of a facility's EMR.
4	Message Sending Organization	MessageSendingOrganization	The organization that is responsible for the facility. This may be an Implementing Partner, the facility itself, or another organization such as the FMoH.
5	Treatment Facility	TreatmentFacility	The facility where the Patient is receiving treatment. The NDR Team recognizes that a standardized list of all facilities is not readily available. Therefore, trading partners should use a consistent value to represent a facility.
6	Visit Identifier	VisitID	A unique value that represents a Patient's visit in the context of a Patient's chart.

2.7 Record Matching

When NDR receives a message into the Transactional database it will check if existing records exist for specific subject areas in NDR using the business logic defined in the table below. If a record match is detected, the record will be updated.

	Subject Area	Record Matching Approach
1	Patient	When the following are equal, a Patient is considered a match: • Treatment Facility • Patient Identifier
2	Patient Condition	When the following are equal, a Patient is considered a match: • Patient Identifier • Condition Code
3	Patient Address	If a Patient Address is associated to a Patient, the existing Patient Address will be updated. Otherwise, an address will be inserted.
4	Treatment Facility	When the following are equal, a Treatment Facility is considered a match: • Facility Name • Facility Identifier • Facility Type Code
5	Sending Organization	When the following are equal, a Sending Organization is considered a match: • Facility Name • Facility Identifier • Facility Type Code
6	Diagnosis Facility	When the following are equal, a Diagnosis Facility is considered a match: • Facility Name • Facility Identifier • Facility Type Code
7	Encounter	When the following are equal, an Encounter is considered a match: • Visit ID • Visit Date
8	Regimen	When the following are equal, a Regimen is considered a match: • Visit ID • Visit Date • Prescribed Regimen Type Code
9	Laboratory Report	When the following are equal, a Laboratory Report & Order / Result combination are considered a match: • Visit ID • Visit Date • Laboratory Resulted Test Code
10	HIV Testing Report	• When the following are equal, a HIV Testing Report combination are considered a matchClient Code • Treatment Facility

2.7.1 Changing Patient ID

It is important to note that a Patient's ID already submitted to the NDR should remain the same through the life cycle of that patient's record in the NDR for consistent matching and updating of the records. Implementers should therefore understand that changing a patient ID in the EMR without adequate notification to the NDR will mean creating duplicate records on the NDR with same clinical, encounter, regimen and lab details but different Identifier.

In the event of a changed patient identifier, the facility would supply the new patient identifier in the Patient Identifier tag and two new data elements, "**PatientIdentifierChanged**" True or False and "Old Patient Identifier" in the Identifier change sub-tag of patient demographics. If the **PatientIdentifierChage** is True, then it is expected that the Old patient identifier is supplied in the tag.

When the NDR reads an XML file, it checks the existence of data in the Identifier change tag. If present, it identifies a change in patient identifier has occurred for this patient thus it changes the existing patient identifier in the database that corresponds to the Identifier in the **OldPatientIdentifier** tag. The old patient identifier is then saved in the patient table of the database

2.7.2 Patient Biometric Information

Included in XSD 1.3 and higher is the fingerprint tag in Patient Demographics. The data expected for the fingerprint tag is listed below;

1. FingerPosition - (RightThumb, RightIndex, RightMiddle, RightWedding, RightSmall, LeftThumb, LeftIndex, LeftMiddle,LeftWedding, LeftSmall)
2. Template – (the encoded patient fingerprint data)
3. Date captured
4. Source – This is used to validate the source of the fingerprint data, it can either be N, M or UNK.

It is important to note that once data is supplied for fingerprint, the template and fingerprint position are required. The NDR requires a minimum of six fingers and a maximum of ten for all fingerprint data supplied in the above-mentioned position. The fingerprint is expected to be unique for every patient, and this will be used for patient de-duplication on the NDR

2.8 Documented Transfers for HIV

It is important to note that the process for communicating documented transfers for HIV (and non-HIV) patients will evolve in future phases of NDR based on feedback from Implementing Partners and parallel efforts by the United State Government Strategic Information Team to develop Patient matching and deduplication algorithms.

This section describes the process for communicating documented transfer to the NDR for HIV. A documented transfer is defined as:

1. Patient transfers from Treatment Facility A to Treatment Facility B
2. Treatment Facility A indicates that the Patient has transferred out
3. If available, Treatment Facility A indicates the name of the Treatment Facility where the Patient is transferring to
4. Treatment Facility B records that the Patient transferred in from Treatment Facility A along with the Unique Patient Identifier used by Treatment Facility A if available

Within the NDR Schema, Treatment Facility A would answer the following data elements within the HIVQuestionsType to indicate the Transfer out:

1. PatientTransferredOut = Set to true to indicate a transfer out
2. TransferredOutStatus = Set to the patient's ART status at time of transfer out
3. TransferredOutDate = Date of the transfer out
4. FacilityReferredTo = Treatment Facility information for the new Facility including Facility Name and Identifier

Within the NDR Schema, Treatment Facility B would answer the following data elements within the HIVQuestionsType to indicate the Transfer in:

1. TransferredInDate= Date the patient was transferred in
2. TransferredInFrom= Treatment Facility information for the previous Treatment Facility including Facility Name and Identifier
3. TransferredInFromPatId= Unique Patient Identifier used by previous Treatment Facility

When the NDR message is received from Treatment Facility A by the NDR:

1. Process the record as usual

When the NDR message is received from Facility B by the NDR:

1. The NDR will first check if TransferredInFrom and TransferredInFromPatId are both populated
2. If both values are populated, NDR will check if a patient currently exists with a Unique Patient Identifier and Treatment Facility matching the values of TransferredInFrom and TransferredInFromPatId
    a. If a match is found:
        i. The patient's Unique Patient Identifier and Treatment Facility (as assigned by the original Treatment Facility) will be pushed to the TRANSFERS table
        ii. The patient's Unique Patient Identifier and Treatment Facility will be updated with the values from TransferredInFrom and TransferredInFromPatId (as assigned by the new Treatment Facility)
        iii. The NDR message will then continue processing as usual
    b. If no match is found, normal business logic will be applied for processing

Since the NDR cannot control the order in which NDR messages will be received for patients across Treatment Facilities, if the NDR detects PatientTransferredOut is set to true, the NDR will first check if a documented transfer has already been executed by checking the TRANSFERS table. If a documented transfer has already been processed, the message will NOT be processed. If a documented transfer has NOT already been processed, the message will be processed as usual.

2.9 Developer Guidance

The list below provides guidance to developers for using the NDR Schema to create messages.

	Developer Guidance
1	If data is not available to populate an optional data element, do not send the data element
2	Prior to transmitting a message to the NDR, the message should be validated against the NDR Schema – all errors and warnings should be resolved before transmitting to the NDR
3	The NDR will not process a message if it fails validation against the NDR Schema
4	Messages should only be sent to NDR if new records have been added or existing records updated for a Patient since the last time data was transmitted to the NDR. If a drop request for data was executed, then messages should be sent with the entire history of the patients.
5	If an EMR uses a coded value that is not defined for a data element defined as CodeType, the developer should contact the NDR Development Team for guidance
6	If an EMR uses a coded value that is not defined for a data element defined as CodedSimpleType, the developer should place the code in Code and the description in CodeDescTxt

	Developer Guidance
7	Depending on the data element, an Enumeration may be defined to ensure consistency of coded response across facilities. It is important to note that Enumerated data elements will fail message validation if a non-enumerated value is utilized.
8	Within the NDR Schema, Visit ID is a required field when sending information such as Regimens, Encounters, and Laboratory Reports. If a Visit ID is not available in the EMR, a consistent value should be used by the developer as Visit ID is used in record matching.
9	Within the NDR Schema, Visit Date is a required field when sending information such as Regimens, Encounters, and Laboratory Reports. If a Visit Date is not available in the EMR, a consistent value should be used by the developer as Visit Date is used in record matching.
10	Given the variation across EMRs of how coded questions are modeled, if an EMR captures multiple values for a single data element (i.e., multi-select), then multiple answers should be passed in the NDR Schema separated by a pipe character ("|"). For example, if a Patient had a Fever and a Cough for "New symptoms/ diagnoses/ opportunistic infections" (ART064), then OtherOIOtherProblems data element would be modeled as: <OtherOIOtherProblems>5|6</ OtherOIOtherProblems >
11	For data elements that communicate a date (e.g., Visit Date, Date of ART Start), the NDR Schema uses the native xs:date datatype using the format "YYYY-MM-DD"
12	For data elements that communicate a date and time (e.g., Message Creation Time), the NDR Schema uses the native xs:datetime datatype using the format "YYYY-MM-DDThh:mm:ss.ms"
13	Developers should utilize the below substitution rules for handling special characters that conflict with XML syntax: 1. < Less-than character (<) 2. & Ampersand character (&) 3. > Greater-than character (>) 4. " Double-quote character (") 5. ' Apostrophe or single-quote character (')
14	The of other special characters is discouraged including a dash, question mark, guillemets exclamation point, accent character
15	Values in the XML Message should not contain leading or trailing white space or hidden line returns and breaks. For example, the following should not be transmitted to the NDR: <FacilityName> Central Medical Centre</FacilityName> <FacilityName>Central Medical Centre </FacilityName> <FacilityName> Central Medical Centre </FacilityName> <FacilityName>Central Medical Centre</FacilityName>
16	Within the NDR, for HIV, a patient is considered on ART when: 1. Date ART started (ART022) contains a valid date 2. ARV Drug Regimen (ART066) is available on an at least one HIV Encounter 3. Prescribed Regimen Type Code (REG005) equals ART for at least one Regimen

2.10 Binding Data to XML

To support data generation, the table below defines examples of Application Programming Interfaces (APIs) and third party (open source) tools to support automating the binding of data from EMR (or Implementing Partner) databases to the NDR Schema. For those unfamiliar, an excellent discussion on

XML data binding is available from Liquid Technologies [http://www.liquid-technologies.com/Tutorials/XML-Data-Binding.aspx].

An inherent benefit of using an API / Third Party Tool is the ability to validate the message against the NDR schema prior to submission to the NDR. This real-time validation will reduce the friction in processing data within the NDR and the need for follow-up with facilities (or Implementing Partners).

	EMR Architecture	API / Third Party Tool
1	**.NET**	Microsoft XML Schema Definition Tool (Xsd.exe) to generate classes to support mapping between database objects and schema
2	**.NET**	LINQ (Language-Integrated Query) to XML is a LINQ-enabled, in-memory XML programming interface that enables XML from within the .NET Framework programming languages
3	**Java**	Java Architecture for XML Binding (JAXB) allows Java developers to map Java classes to XML representations
4	**Java**	XMLBeans is a technology for accessing XML by binding it to Java types
5	**Java and .NET**	Mirth Connect Data Integration Engine for data integration and interoperability

2.11 Schema Validation

Defined in Developer Guidance section above, before an XML message is transmitted to the NDR, it must be validated against the NDR Schema. Typically, each message should be validated right after it is created using the validation features of the selected XML Binding API / Third Party Tool.

The figures below provide a schema validation example using the JAXB API for Java including sample output of a message that failed validation because it is missing the required MessageSendingOrganization data element in the Message Header.

```
//Validate Message Against NDR Schema (Version 1.2)
Marshaller jaxbMarshaller = jaxbContext.createMarshaller();
SchemaFactory sf = SchemaFactory.newInstance(XMLConstants.W3C_XML_SCHEMA_NS_URI);
Schema schema = sf.newSchema(new File("NDR 1.2.xsd"));

jaxbMarshaller.setProperty( Marshaller.JAXB_FORMATTED_OUTPUT, true );
jaxbMarshaller.setProperty(Marshaller.JAXB_ENCODING, "UTF-8");

jaxbMarshaller.setSchema(schema);

//Call Validator class to perform the validation
jaxbMarshaller.setEventHandler(new Validator());
```

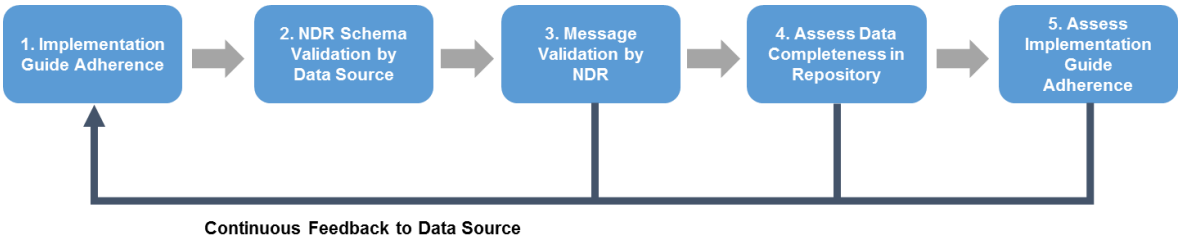
```
public class Validator implements ValidationEventHandler {

    public boolean handleEvent(ValidationEvent event) {
        System.out.println("\nEVENT");
        System.out.println("SEVERITY:  " + event.getSeverity());
        System.out.println("MESSAGE:  " + event.getMessage());
        System.out.println("LINKED EXCEPTION:  " + event.getLinkedException());
        System.out.println("LOCATOR");
        System.out.println("    LINE NUMBER:  " + event.getLocator().getLineNumber());
        System.out.println("    COLUMN NUMBER:  " + event.getLocator().getColumnNumber());
        System.out.println("    OFFSET:  " + event.getLocator().getOffset());
        System.out.println("    OBJECT:  " + event.getLocator().getObject());
        System.out.println("    NODE:  " + event.getLocator().getNode());
        System.out.println("    URL:  " + event.getLocator().getURL());
        return true;
    }
}
```

```
EVENT
SEVERITY:  2
MESSAGE:  cvc-complex-type.2.4.b: The content of element 'MessageHeader' is
not complete. One of '{MessageSendingOrganization}' is expected.
LINKED EXCEPTION:  org.xml.sax.SAXParseException: cvc-complex-type.2.4.b: The
content of element 'MessageHeader' is not complete. One of
'{MessageSendingOrganization}' is expected.
LOCATOR
    LINE NUMBER:  -1
    COLUMN NUMBER:  -1
    OFFSET:  -1
    OBJECT:  com.inductivehealth.ndr.schema.Container@76a9b9c
    NODE:  null
    URL:  null
```

2.12 Data Validation

Summarized in the figure below, NDR uses a multi-step process to validate adherence of NDR messages to the NDR Schema. In support of NDR objectives to provide a low barrier architecture for facilities to exchange data with NDR:

- Answers to coded data elements will be accepted into the NDR Transactional and Repository database that are not defined in the Implementation Guide
- The NDR Schema has a limited number of required data elements
- The NDR Team will continuously provide feedback to the NDR data sources with recommendations for enhancing Implementation Guide adherence



2.13 Sample Code

A series of sample projects have been developed by the NDR Team to support facilities and Implementing Partners in binding EMR data to the NDR Schema.

2.14 Message Validation Summary

The web portal will provide validation summary of every file submitted to the NDR once the files have been completely processed. Implementing partners or facilities should click on the “View Errors” button after the uploaded file has been processed to view and download validation errors in uploaded batches.

3 NDR Schema

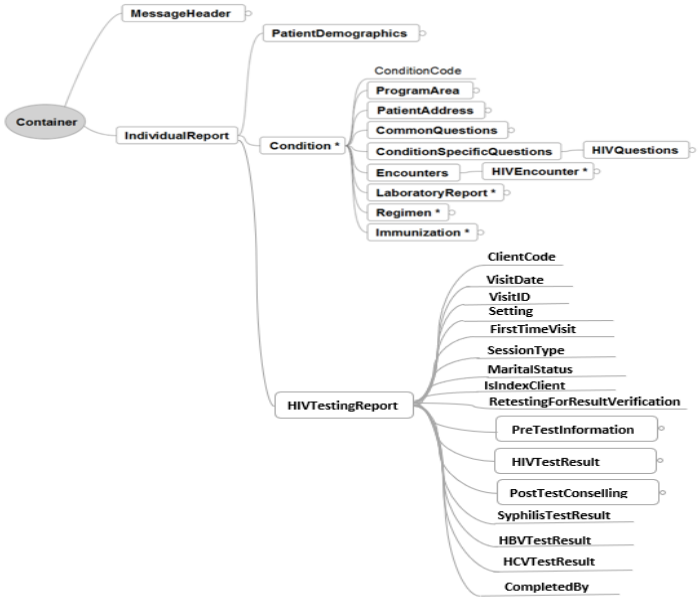
As defined in the Information Exchange Standards deliverable, the NDR Schema is the basis for how data should be sent to the NDR from the EMRs. Summarized in the figure below, the NDR Schema is implemented as an XML Schema Definition (XSD) and governs the encoding, structure, and content for sending patient-centric, Extensible Markup Language (XML) messages to the NDR. Fundamentally, the NDR Schema has been developed to be agnostic of EMR architectures while providing a low barrier solution for Implementing Partners.

It is important to note that the NDR Schema is designed to generate a Patient specific message. Therefore, a single message should only contain information for a single Patient.

The NDR Schema has evolved over time with major and minor releases. Major releases use the 1.x numbering scheme where the x represents the version. Minor releases use the 1.x.yy numbering scheme where the ‘x’ represents the major version and the ‘yy’ represents the update number.
The current version of the NDR Schema is Version 1.5.4. The changelog between releases is captured in the XSD changelog document.
The NDR will accept and process messages developed using major versions of the schema and will apply relevant validations for that major version where possible. The NDR will however, only process the latest minor version for the specified major version. For example, the NDR will process XML message generated against XSD versions 1.4 and 1.5 but will only process 1.5 messages if they match the current 1.5.4 minor release.

3.1 Schema Element Structure

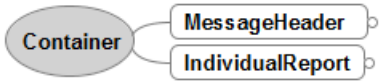
This section describes each of the structures defined within NDR Schema. Each sub-section includes an



overview of the structure, graphical representation of the NDR Schema, and a table that defines data elements including whether an enumeration has been defined within the NDR Schema.

3.1.1 Container

The root element in the message is the Container which holds the Message Header and an Individual Report. Both elements are required components of the Container.



Container									
Seq	**Field Name**	**Field Identifier**	**Purpose**	**XML Element**	**DT**	**Use**	**Occurs**	**Enum**	**Value Set**
1	Message Header	N/A	Holds metadata on the message itself	MessageHeader	MessageHeaderType	R	[1..1]	N	
2	Individual Report	N/A	Holds information on the Patient and their condition(s)	IndividualReport	IndividualReportType	R	[1..1]	N	

Sample XML

```
<Container>
    <MessageHeader>
       ….
    </MessageHeader>
    <IndividualReport>
       ….
    </IndividualReport>
</Container>
```

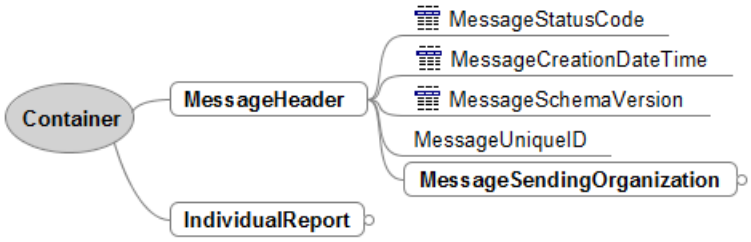
3.1.2 **Message Header**

The Message Header contains elements describing the message itself. All the elements in the Message Header are required items and all must be present in the message. Message Status is either “Initial”, “Updated”, or “Redacted” depending on the trigger event causing the creation of the message.

It is important to note that the Message Sending Organization should be set to the organization that is responsible for sending NDR messages on behalf of the Patient’s Treatment Facility. The Message Sending Organization may be an Implementing Partner, the Treatment Facility in the case of a private facility, or another organization. The Message Sending Organization determines how data is grouped for reporting purposes. The message sending organization must have been onboarded to the NDR prior to the sending of messages or the data will not be processed. The FacilityID element in the MessageSendingOrganization tag is important as this usually represent the shortname of the entity and is critical to file ingestion.

++++++++++++++

Additionally, the Message Unique ID plays a critical role in providing the NDR Team with a non-sensitive identifier to use when communicating feedback about the message to the message sender. The Message Unique ID should uniquely identify the message itself.



MessageHeader									
Seq	Field Name	Field Identifier	Purpose	XML Element	DT	Use	Occurs	Enum	Value Set / Notes
1	Message Status Code	MSG001	Documents the message as either initial, updated, or redacted	MessageStatusCode	CodeType	R	[1..1]	Y	MESSAGE_STATUS Messages with a status of Redacted will not be included in data analysis or indicator generation
2	Message Creation Date Time	MSG002	Provides date and time the message was created	MessageCreationDateTime	dateTime	R	[1..1]	N	
3	Message Schema Version	MSG003	Provides the schema version the message was created to	MessageSchemaVersion	decimal	R	[1..1]	N	Literal value of 1.4 or later should be utilized
4	Message Unique ID	MSG004	Uniquely identifies the message	MessageUniqueID	StringType	R	[1..1]	N	
5	Message Sending Organization	MSG005	Provides information on the type of organization that sent the message to the NDR	MessageSendingOrganization	FacilityType	R	[1..1]	N	

Sample XML

```
<MessageHeader>
        <MessageStatusCode>INITIAL</MessageStatusCode>
```

```
        <MessageCreationDateTime>2015-08-26T18:02:50.07</MessageCreationDateTime>
        <MessageSchemaVersion>1.2</MessageSchemaVersion>
        <MessageUniqueID>4567</MessageUniqueID>
        <MessageSendingOrganization>
            <FacilityName>Fictional Implementing Partner Name</FacilityName>
            <FacilityID>3930299292</FacilityID>
            <FacilityTypeCode>IP</FacilityTypeCode>
        </MessageSendingOrganization>
</MessageHeader>
```

3.1.3 Individual Report

The Individual Report consists of Patient Demographics and Condition. Both elements are required components of the Individual Report.

It is important to note that multiple Condition elements are allowed if more than one condition is being sent for the same Patient.

dividualReport									
Seq	Field Name	Field Identifier	Purpose	XML Element	DT	Use	Occurs	Enum	Value Set / Notes
1	Patient Demographics	N/A	Holds information on the Patient's Demographics including the Patient's Treatment Facility	PatientDemographics	PatientDemographicsType	R	[1..1]	N	
2	Condition	N/A	Holds information on a Patient's Condition(s)	Condition	ConditionType	R	[1..*]	N	

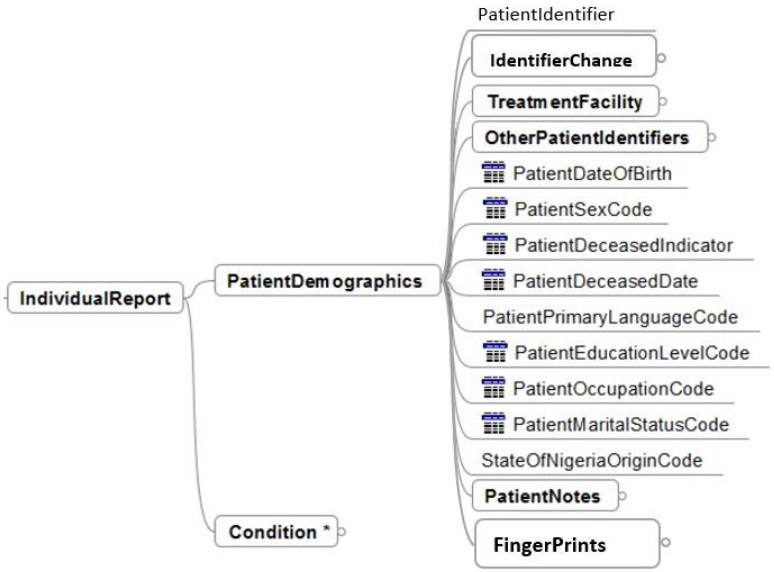
Sample XML

```
<IndividualReport>
        <PatientDemographics>
          ...
        </PatientDemographics>
        <Condition>
          ...
        </Condition>
 </IndividualReport>
```

3.1.4 **Patient Demographics**

This element contains information about the Patient, such as date of birth, sex, occupation and other patient demographic information.

It is important to note that for matching purposes, the NDR will utilize the Patient Identifier (PAT001) and the Treatment Facility (PAT002) to determine if a Patient currently exists in the NDR.


IndividualReport
PatientDemographics
Condition *
PatientIdentifier
IdentifierChange
TreatmentFacility
OtherPatientIdentifiers
PatientDateOfBirth
PatientSexCode
PatientDeceasedIndicator
PatientDeceasedDate
PatientPrimaryLanguageCode
PatientEducationLevelCode
PatientOccupationCode
PatientMaritalStatusCode
StateOfNigeriaOriginCode
PatientNotes
FingerPrints

PatientDemographics									
Seq	Field Name	Field Identifier	Purpose	XML Element	DT	Use	Occurs	Enum	Value Set / Notes
	Patient Identifier	PAT001	The unique identifier serves to link all records of patient encounters for a particular patient within a facility. The unique patient identifier is a single identifier that is permanently assigned and cannot be reused once it has been created.	PatientIdentifier	StringType	R	[1..1]	N	
2	Identifier Change		The Identifier change captures a change in a patients' identifier	IdentifierChange	Boolean	0	[0..1]	N	
3	Treatment Facility Name	PAT002	The facility at which the current treatment or care is being provided	TreatmentFacility	FacilityType	R	[1..1]	N	
4	Other Patient Identifiers	PAT003	Other patient identifiers that may exist in the EMR for the patient	OtherPatientIdentifiers	IdentifiersType	O	[0..1]	N	
5	Patient Date Of Birth	PAT004	Date of birth of the patient	PatientDateOfBirth	date	R	[0..1]	N	
6	Patient Sex Code	PAT005	The sex of the patient	PatientSexCode	CodeType	R	[0..1]	Y	SEX
7	Patient Deceased Indicator	PAT006	Indicates if the patient has died	PatientDeceasedIndicator	boolean	O	[0..1]	N	
8	Patient Decease Date	PAT007	Date of death	PatientDeceasedDate	date	O	[0..1]	N	

PatientDemographics									
Seq	Field Name	Field Identifier	Purpose	XML Element	DT	Use	Occurs	Enum	Value Set / Notes
9	Patient Primary Language Code	PAT008	Primary language used by patient	PatientPrimaryLanguageCode	CodeType	O	[0..1]	N	LANGUAGE
10	Patient Education Level Code	PAT009	Highest level of formal education and training attained in an academic setting	PatientEducationLevelCode	CodeType	O	[0..1]	Y	EDUCATIONAL_LEVEL
11	Patient Occupation Code	PAT010	Occupation status of patient	PatientOccupationCode	CodeType	O	[0..1]	Y	OCCUPATION_STATUS
12	Patient Marital Status Code	PAT011	The marital status of the patient	PatientMaritalStatusCode	CodeType	O	[0..1]	Y	MARITAL_STATUS
13	State Of Nigeria Origin Code	PAT012	State of origin if patient is Nigerian	StateOfNigeriaOriginCode	CodeType	O	[0..1]	N	STATES
14	Patient Notes	PAT013	Notes about the patient that do not contain personally identifying information	PatientNotes	NoteType	O	[0..1]	N	
15	Finger Prints		Finger prints of patients	FingerPrints	string	O	[0..1]	N	

Sample XML

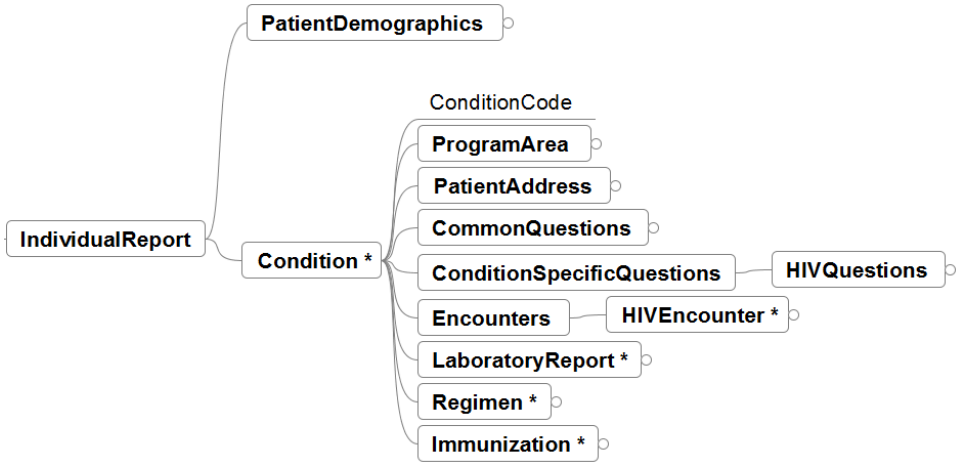
```
<PatientDemographics>
    <PatientIdentifier>19283746</PatientIdentifier>
     <IdentifierChange>
           <PatientIdentifierChange>true</ PatientIdentifierChange >
           <OldPatientIdentifier>19283776</OldPatientIdentifier>
     </IdentifierChange>
       <TreatmentFacility>
         <FacilityName>Central Medical Centre</FacilityName>
         <FacilityID>39383933</FacilityID>
         <FacilityTypeCode>FAC</FacilityTypeCode>
       </TreatmentFacility>
    <OtherPatientIdentifiers>
      <Identifier>
       <IDNumber>678-251-0-1234</IDNumber>
       <IDTypeCode>PN</IDTypeCode>
      </Identifier>
    </OtherPatientIdentifiers>
    <PatientDateOfBirth>1976-07-11</PatientDateOfBirth>
    <PatientSexCode>F</PatientSexCode>
    <PatientDeceasedIndicator>true</PatientDeceasedIndicator>
    <PatientDeceasedDate>2015-08-10</PatientDeceasedDate>
    <PatientPrimaryLanguageCode>ENG</PatientPrimaryLanguageCode>
    <PatientEducationLevelCode>3</PatientEducationLevelCode>
    <PatientOccupationCode>EMP</PatientOccupationCode>
    <PatientMaritalStatusCode>M</PatientMaritalStatusCode>
    <StateOfNigeriaOriginCode>15</StateOfNigeriaOriginCode>
    <PatientNotes>
        <Note>Notes about the patient that do not contain personally identifying information</Note>
    </PatientNotes>
    <FingerPrints present="true">
    <dateCaptured>12-09-2019:90.6:30</dateCaptured>
    <RightHand>
          <RightIndex>Rk1SACAyMAAAAAC6AAABBAEsAMUAxQEAAhBYGoDOADH8AEBhADobAEBfAFoeAE</RightIndex>
<RightMiddle>Rk1SACAyMAAAAAEUAAABBAEsAMUAxQEAAxBUKUBvACCGAEB1A</RightMiddle>
<RightWedding>Rk1SACAyMAAAAAEaAAABBAEsAMUAxQEABBBXKkCcACYAIRightWedding>
<RightSmall>Rk1SACAyMAAAAADYAAABBAEsAMUAxQEABRAqH4CkA</RightSmall>
   </RightHand>
```

```
  <LeftHand>
  <LeftThumb></ LeftThumb >
  <LeftIndex></ LeftIndex >
  <LeftMiddle></ LeftMiddle >
  <LeftWedding></ LeftWedding >
  <LeftSmall></LeftSmall>
  </LeftHand>
  <source>N</source>
  </FingerPrints>
</PatientDemographics>
```

3.1.5 **Condition**

The Condition element is illustrated below. More than one Condition can be included in the XML message for a Patient.

It is important to note that Condition has been designed to be as flexible as possible with only a small number of required data elements. This is to enable the reporting of diseases other than HIV to the NDR.



ConditionType									
Seq	Field Name	Field Identifier	Purpose	XML Element	DT	Use	Occurs	Enum	Value Set / Notes
1	Condition Code	N/A	Patient's Condition	ConditionCode	CodeType	R	[1..1]	N	
2	Program Area	N/A	Program Area of the Condition	ProgramArea	ProgramAreaType	R	[1..1]	N	
3	Patient Address	N/A	Patient's Address	PatientAddress	AddressType	O	[0..1]	N	
4	Common Questions	N/A	Common Questions about the condition	CommonQuestions	CommonQuestionsType	O	[0..1]	N	
5	Condition Specific Questions	N/A	Condition specific questions	ConditionSpecificQuestions	ConditionSpecificQuestionsType	O	[0..1]	N	
6	Encounters	N/A	Encounters	Encounters	EncountersType	O	[0..1]	N	
7	Laboratory Reports	N/A	Laboratory Reports	LaboratoryReport	LaboratoryReportType	O	[0..*]	N	
8	Regimens	N/A	Regimens	Regimen	RegimenType	O	[0..*]	N	
9	Immunizations	N/A	Immunizations	Immunization	ImmunizationType	O	[0..*]	N	

3.1.6 **Condition Code**

Condition code contains the diagnosed condition being included in the Condition element for this Patient.

ConditionCode									
Seq	Field Name	Field Identifier	Purpose	XML Element	DT	Use	Occurs	Enum	Value Set / Notes
1	**Condition Code**	**COM001**	**The code that represents the Condition**	**ConditionCode**	**CodeType**	**R**	**[1..1]**	**N**	**CONDITION_CODE**

Sample XML

```
<Condition>
    <ConditionCode>86406008</ConditionCode>
        …
</Condition>
```

3.1.7 Program Area

Program area denotes the Program Area in which the condition exists.

ProgramArea									
Seq	**Field Name**	**Field Identifier**	**Purpose**	**XML Element**	**DT**	**Use**	**Occurs**	**Enum**	**Value Set / Notes**
1	**Program Area Code**	**COM002**	**Logical grouping of the Condition Code**	**ProgramAreaCode**	**CodeType**	**R**	**[1..1]**	**N**	**PROGRAM_AREA**

Sample XML

```
<Condition>
        …
    <ProgramArea>
        <ProgramAreaCode>HIV</ProgramAreaCode>
    </ProgramArea>
        …
</Condition>
```

3.1.8 Patient Address

This address provides the current geo-location of the Patient.

It is important to note the Patient Address does not allow granular address information to be transmitted (e.g., Street Address).

PatientAddress									
Seq	**Field Name**	**Field Identifier**	**Purpose**	**XML Element**	**DT**	**Use**	**Occurs**	**Enum**	**Value Set / Notes**
1	Address Type Code	PAT014	Defines the type of address information being provided (home, temporary, legal, etc)	AddressTypeCode	CodeType	R	[1..1]	N	ADDRESS_TYPE Default to H for Home
2	Ward / Village	PAT015	Ward or village where this address is located	WardVillage	StringType	O	[0..1]	N	
3	Town	PAT016	Town in which this address is located	Town	StringType	O	[0..1]	N	
4	LGA	PAT017	Local Government Area for this address	LGACode	CodeType	R	[0..1]	N	LGA
5	State	PAT018	State in which this address is located	StateCode	CodeType	R	[0..1]	N	STATES
6	Country Code	PAT019	Country in which this address is located	CountryCode	CodeType	O	[0..1]	N	COUNTRY Default to NGA for Nigeria
7	Postal Code	PAT020	Postal code (if used) for this addressed	PostalCode	StringType	O	[0..1]	N	
8	Other Address Information	PAT021	Notes about this address	OtherAddressInformation	StringType	O	[0..1]	N	

Sample XML

```
<Condition>
    …
    <PatientAddress>
        <AddressTypeCode>H</AddressTypeCode>
        <WardVillage>Central</WardVillage>
        <Town>Abuja</Town>
        <LGACode>236</LGACode>
        <StateCode>15</StateCode>
        <CountryCode>NGA</CountryCode>
        <PostalCode>12345</PostalCode>
        <OtherAddressInformation>Enter notes about the address if needed</OtherAddressInformation>
    </PatientAddress>
    …
</Condition>
```

3.1.9 **Common Questions**

The Common Questions section cover general information about the Patient's condition and is reusable across Conditions.

CommonQuestions									
Seq	**Field Name**	**Field Identifier**	**Purpose**	**XML Element**	**DT**	**Use**	**Occurs**	**Enum**	**Value Set / Notes**
1	Hospital Number	COM003	Number that represent the hospital	HospitalNumber	StringType	O	[1..1]	N	
2	Diagnosis Facility	COM004	If known, the facility at which the original diagnosis was made	DiagnosisFacility	FacilityType	O	[0..1]	N	
3	Date Of First Report	COM005	Date of the first report for this condition for this patient	DateOfFirstReport	date	O	[0..1]	N	
4	Date Of Last Report	COM006	Date of the last report for this condition for this patient	DateOfLastReport	date	O	[0..1]	N	
5	Diagnosis Date	COM007	Earliest known date of diagnosis of this condition for this patient	DiagnosisDate	date	O	[0..1]	N	
6	Patient Die From This Illness	COM008	Did the patient die from this condition	PatientDieFromThisIllness	boolean	O	[0..1]	N	
7	Patient Pregnancy Status Code	COM009	Is the patient pregnant	PatientPregnancyStatusCode	CodeType	O	[0..1]	Y	PREGNANCY_STATUS
8	Estimate Delivery Date	COM010	If pregnant, when is the estimated delivery date?	EstimatedDeliveryDate	date	O	[0..1]	N	
9	Patient Age	COM011	The age of the person in years. Input when a patient does not know his/her date of birth. Calculate when the date of birth is known.	PatientAge	int	O	[0..1]	N	Age Units are assumed to be Years

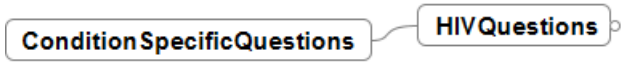
Sample XML

```
<CommonQuestions>
    <HospitalNumber>HN0012</HospitalNumber>
    <DiagnosisFacility>
        <FacilityName>Diagnosing Facility</FacilityName>
        <FacilityID>10101</FacilityID>
        <FacilityTypeCode>FAC</FacilityTypeCode>
    </DiagnosisFacility>
    <DateOfFirstReport>2015-08-29</DateOfFirstReport>
    <DateOfLastReport>2015-08-29</DateOfLastReport>
    <DiagnosisDate>2012-09-02</DiagnosisDate>
    <PatientDieFromThisIllness>false</PatientDieFromThisIllness>
    <PatientPregnancyStatusCode>P</PatientPregnancyStatusCode>
    <EstimatedDeliveryDate>2015-11-13</EstimatedDeliveryDate>
    <PatientAge>40</PatientAge>
</CommonQuestions>
```

3.1.10 **Condition Specific Questions**

Condition Specific Questions are focused question related to a specific condition. For HIV, these questions are within the HIV Questions data element, and generally follow Care Card Page 1 of the National Forms.

As additional diseases are on boarded to the NDR, the available list of Condition Specific Questions will be expanded.



HIVQuestions									
Seq	Field Name	Field Identifier	Purpose	XML Element	DT	Use	Occurs	Enum	Value Set / Notes
1	**Care Entry Point**	**ART011**	**The entry point into HIV care**	**CareEntryPoint**	**CodeType**	**O**	**[0..1]**	**Y**	**CARE_ENTRY_POINT**
2	**Date of Confirmed HIV test**	**ART012**	**Date of First Confirmed HIV test**	**FirstConfirmedHIVTestDate**	**date**	**O**	**[0..1]**	**N**	

HIVQuestions									
Seq	Field Name	Field Identifier	Purpose	XML Element	DT	Use	Occurs	Enum	Value Set / Notes
3	Mode of HIV Test	ART013	Mode of HIV Test (Antibody or PCR)	FirstHIVTestMode	CodeType	O	[0..1]	Y	HIV_TEST_TYPE
4	Where	ART014	Location (facility or testing point) where patient was confirmed positive	WhereFirstHIVTest	StringType	O	[0..1]	N	
5	Prior ART	ART015	Prior ART received	PriorArt	CodeType	O	[0..1]	N	PRIOR_ART
6	Date Medically eligible	ART016	Date determined medically eligible to start ART	MedicallyEligibleDate	date	O	[0..1]	N	
7	Why Eligible	ART017	Why medically eligible to start ART	ReasonMedicallyEligible	CodeType	O	[0..1]	Y	WHY_ELIGIBLE
8	Date Initial Adherence Counseling Completed	ART018	Date Initial Adherence Counseling Completed	InitialAdherenceCounselingCompletedDate	date	O	[0..1]	N	
9	Date Transferred in	ART019	Date transferred in from another treatment facility on ART	TransferredInDate	date	O	[0..1]	N	
10	Facility transferred From	ART020	Location transferred from	TransferredInFrom	FacilityType	O	[0..1]	N	
11	Transferred In From Patient Identifier	ART103	Unique patient ID at facility transferred from	TransferredInFromPatID	StringType	O	[0..1]	N	
12	First ART Regimen	ART021	First ARV regimen prescribed for this patient	FirstARTRegimen	CodedSimpleType	O	[0..1]	N	ARV_REGIMEN

HIVQuestions									
Seq	Field Name	Field Identifier	Purpose	XML Element	DT	Use	Occurs	Enum	Value Set / Notes
13	Date ART started	ART022	Refers to the date a patient begins the first, original ART regimen in the system (or document the date a patient started in any programme or under care of another practitioner if this date is known)	ARTStartDate	date	O	[0..1]	N	
14	Clinical Stage at start of ART	ART023	WHO clinical stage when medically eligible	WHOClinicalStageARTStart	CodeType	O	[0..1]	Y	WHO_STAGE
15	Weight	ART024	Body weight (in kg) at start of ART	WeightAtARTStart	int	O	[0..1]	N	
16	Height (if child)	ART025	Height (in cm) at start of ART (for children)	ChildHeightAtARTStart	int	O	[0..1]	N	
17	Function	ART026	Functional status at start of ART	FunctionalStatusStartART	CodeType	O	[0..1]	Y	FUNCTIONAL_STATUS
18	CD4 at start of ART	ART027	Baseline CD4 count or percentage or TLC count if medically eligible	CD4AtStartOfART	StringType	O	[0..1]	N	
19	Patient transferred out	ART046	Indicator for whether the patient has transferred out	PatientTransferredOut	boolean	O	[0..1]	N	
20	Patient transferred out (status	ART200	ART status of patient when transferred out	TransferredOutStatus	CodeType	O	[0..1]	Y	ART_STATUS
21	Patient transferred out date	ART045	Date when patient transferred out	TransferredOutDate	date	O	[0..1]	N	

HIVQuestions									
Seq	Field Name	Field Identifier	Purpose	XML Element	DT	Use	Occurs	Enum	Value Set / Notes
22	Facility Referred To	ART047	Name of the facility referred to	FacilityReferredTo	FacilityType	O	[0..1]	N	
23	Patient has died	ART048	Has the patient died (any cause)	PatientHasDied	boolean	O	[0..1]	N	
24	Patient has died ART status	ART201	ART/Pre-ART status at death	StatusAtDeath	CodeType	O	[0..1]	Y	ART_STATUS
25	Patient has died date	ART049	Date of death	DeathDate	date	O	[0..1]	N	
26	Source of death informati on	ART050	Source of death information	SourceOfDeathInformation	StringType	O	[0..1]	N	
27	Cause of Death: HIV related:	ART051	Indicates whether the cause of death was HIV related	CauseOfDeathHIVRelated	CodeType	O	[0..1]	Y	YNU
28	Drug Allergies	ART052	List of known drug allergies	DrugAllergies	StringType	O	[0..1]	N	
29	Date enrolled in HIV care	ART005	Date enrolled into HIV care	EnrolledInHIVCareDate	date	R	[0..1]	N	
30	Initial TB Status	ART102	Initial TB status	InitialTBStatus	CodeType	O	[0..1]	Y	TB_STATUS
31	Stopped Treatment		Has patient stopped treatment	PatientStoppedTreatment	Boolean	O	[0.. 1]	N	
32	Stopped Treatment Date		Date stopped treatment	StoppedTreatmentDate	Date	O	[0... 1]	N	
33	Reason Stopped Treatment		Reason the patient stopped treatment	StoppedTreatmentReason	StringType	O	[0.. 1]	N	

Sample XML

```
<ConditionSpecificQuestions>
    <HIVQuestions>
        <CareEntryPoint>3</CareEntryPoint>
        <FirstConfirmedHIVTestDate>2012-06-14</FirstConfirmedHIVTestDate>
        <FirstHIVTestMode>HIVAb</FirstHIVTestMode>
        <WhereFirstHIVTest>Clinic Testing Name</WhereFirstHIVTest>
        <PriorArt>N</PriorArt>
        <MedicallyEligibleDate>2012-10-06</MedicallyEligibleDate>
        <ReasonMedicallyEligible>3</ReasonMedicallyEligible>
        <InitialAdherenceCounselingCompletedDate>2012-10-06</InitialAdherenceCounselingCompletedDate>
        <TransferredInDate>2012-12-07</TransferredInDate>
        <TransferredInFrom>
            <FacilityName>Medical Centre</FacilityName>
            <FacilityID>FM1651653</FacilityID>
            <FacilityTypeCode>FAC</FacilityTypeCode>
        </TransferredInFrom>
        <TransferredInFromPatId>6598123</TransferredInFromPatId>
        <FirstARTRegimen>
            <Code>1b</Code>
            <CodeDescTxt>AZT-3TC-NVP</CodeDescTxt>
        </FirstARTRegimen>
        <ARTStartDate>2012-10-06</ARTStartDate>
        <WHOClinicalStageARTStart>3</WHOClinicalStageARTStart>
        <WeightAtARTStart>69</WeightAtARTStart>
        <ChildHeightAtARTStart>116</ChildHeightAtARTStart>
        <FunctionalStatusStartART>A</FunctionalStatusStartART>
        <CD4AtStartOfART>99</CD4AtStartOfART>
        <PatientTransferredOut>true</PatientTransferredOut>
        <TransferredOutStatus>A</TransferredOutStatus>
        <TransferredOutDate>2013-01-05</TransferredOutDate>
        <FacilityReferredTo>
            <FacilityName>Medical Hospital</FacilityName>
            <FacilityID>CF03487</FacilityID>
            <FacilityTypeCode>FAC</FacilityTypeCode>
        </FacilityReferredTo>
        <PatientHasDied>true</PatientHasDied>
        <StatusAtDeath>P</StatusAtDeath>
        <DeathDate>2013-01-15</DeathDate>
        <SourceOfDeathInformation>Hospital notification</SourceOfDeathInformation>
        <CauseOfDeathHIVRelated>N</CauseOfDeathHIVRelated>
        <DrugAllergies>Penicillin</DrugAllergies>
        <EnrolledInHIVCareDate>2012-06-14</EnrolledInHIVCareDate>
```

```
                    <InitialTBStatus>2</InitialTBStatus>
                    <PatientStoppedTreatment>true</PatientStoppedTreatment>
                    < StoppedTreatmentDate >true</ StoppedTreatmentDate >
< StoppedTreatmentReason >true</ StoppedTreatmentReason >
                </HIVQuestions>
            </ConditionSpecificQuestions>
```

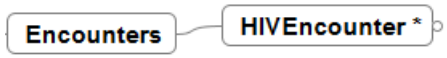
3.1.11 **Encounters**

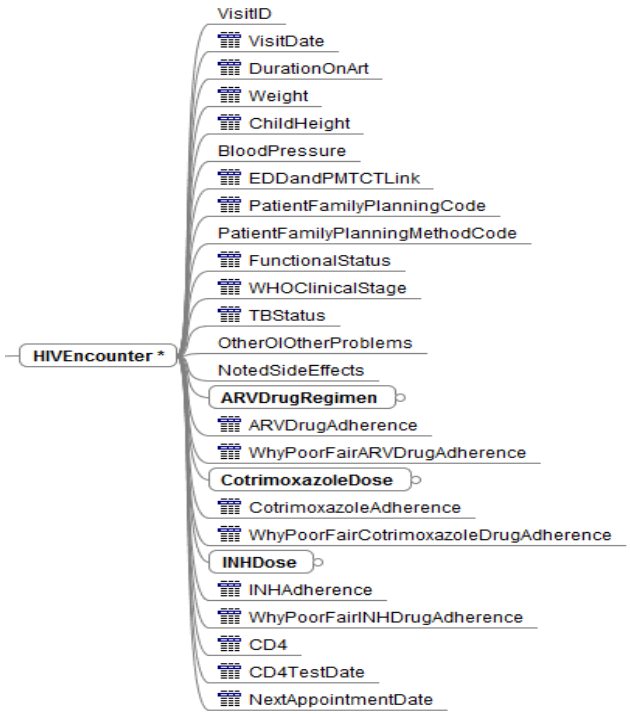
Encounters are questions regularly captured during a clinical encounter related to the condition.

For HIV, encounter questions are within the HIV Encounter data element, and generally follow Care Card Page 2 of the National Forms.

An HIV Encounter data element is created for each of a Patient's Encounter.

It is important to note that the HIV Encounter questions include discrete questions related to Regimens and Laboratory Results (e.g., ARV Drug Regimen, Latest CD4 Result). If the EMR captures these discrete values as part of the Encounter, the values should be transmitted as defined below. If the EMR does not capture the Regimen and Laboratory Results as discrete questions, then the detailed Regimen and Laboratory Result information should be transmitted as defined in the NDR Schema.




HIVEncounter *
VisitID
VisitDate
DurationOnArt
Weight
ChildHeight
BloodPressure
EDDandPMTCTLink
PatientFamilyPlanningCode
PatientFamilyPlanningMethodCode
FunctionalStatus
WHOClinicalStage
TBStatus
OtherOIOtherProblems
NotedSideEffects
ARVDrugRegimen
ARVDrugAdherence
WhyPoorFairARVDrugAdherence
CotrimoxazoleDose
CotrimoxazoleAdherence
WhyPoorFairCotrimoxazoleDrugAdherence
INHDose
INHAdherence
WhyPoorFairINHDrugAdherence
CD4
CD4TestDate
NextAppointmentDate

HIVEncounter									
Seq	**Field Name**	**Field Identifier**	**Purpose**	**XML Element**	**DT**	**Use**	**Occurs**	**Enum**	**Value Set / Notes**
1	Visit Identifier	ART101	The identification code or number used to uniquely identify the clinical visit	VisitID	StringType	R	[1..1]	N	
2	Visit Date	ART053	Patient encounter information is collected and updated every time a patient visits a health facility. This date applies to all outpatient encounter data for that date.	VisitDate	date	R	[1..1]	N	
3	Duration (in Months) on ART	ART055	Duration (in Months) on ART	DurationOnArt	int	O	[0..1]	N	
4	Weight (kg)	ART056	Current Weight (kg)	Weight	int	O	[0..1]	N	
5	Height (if child) (cm)	ART057	Current Height (if child) (cm)	ChildHeight	int	O	[0..1]	N	
6	Blood Pressure (mmHg) Adults Only	ART058	Current Blood Pressure (mmHg) Adults Only	BloodPressure	StringType	O	[0..1]	N	
7	EDD and PMTCT Link	ART059	EDD and PMTCT Link	EDDandPMTCTLink	CodeType	O	[0..1]	Y	EDD_PMTCT_LINK
8	Patient Family Planning Code	ART060	Describes status of use of family planning	PatientFamilyPlanningCode	CodeType	O	[0..1]	Y	FAMILY_PLANNING_STATUS

HIVEncounter									
Seq	**Field Name**	**Field Identifier**	**Purpose**	**XML Element**	**DT**	**Use**	**Occurs**	**Enum**	**Value Set / Notes**
9	Patient Family Planning Method Code	ART202	Describes type of family planning method used	PatientFamilyPlanningMethodCode	CodeType	O	[0..1]	Y	FAMILY_PLANNING_METHOD
10	Functional Status	ART061	Functional Status	FunctionalStatus	CodeType	O	[0..1]	Y	FUNCTIONAL_STATUS
11	WHO Clinical Stage	ART062	Current WHO Clinical Stage	WHOClinicalStage	CodeType	O	[0..1]	Y	WHO_STAGE
12	TB Status	ART063	Current TB Status	TBStatus	CodeType	O	[0..1]	Y	TB_STATUS
13	Other Ois/Other Problems	ART064	New symptoms/ diagnoses/ opportunistic infections	OtherOIOtherProblems	CodeType	O	[0..1]	N	OI_OTHER
14	Noted Side Effects	ART065	Possible medication side-effects or other problems	NotedSideEffects	CodeType	O	[0..1]	N	ADVERSE_REACTIONS
15	ARV Drug Regimen	ART066	ARV Drug Regimen	ARVDrugRegimen	CodedSimpleType	O	[0..1]	N	ARV_REGIMEN
16	ARV Drugs Adherence	ART067	ARV Drugs Adherence	ARVDrugAdherence	CodeType	O	[0..1]	Y	ADHERANCE
17	Why Poor /Fair adherence	ART068	Why Poor /Fair adherence	WhyPoorFairARVDrugAdherence	CodeType	O	[0..1]	Y	ADHERANCE_POORFAIR_REASON

HIVEncounter									
Seq	Field Name	Field Identifier	Purpose	XML Element	DT	Use	Occurs	Enum	Value Set / Notes
18	Cotrimoxazole Dose	ART069	Cotrimoxazole Dose	CotrimoxazoleDose	CodedSimpleType	O	[0..1]	N	OI_REGIMEN
19	Cotrimoxazole Adherence	ART070	Cotrimoxazole Adherence	CotrimoxazoleAdherence	CodeType	O	[0..1]	Y	ADHERANCE
20	Why Poor /Fair adherence	ART071	Why Poor /Fair adherence	WhyPoorFairCotrimoxazoleDrugAdherence	CodeType	O	[0..1]	Y	ADHERANCE_POORFAIR_REASON
21	INH Dose	ART072	INH Dose	INHDose	CodedSimpleType	O	[0..1]	N	TB_REGIMEN
22	INH Adherence	ART073	INH Adherence	INHAdherence	CodeType	O	[0..1]	Y	ADHERANCE
23	Why Poor /Fair adherence	ART074	Why Poor /Fair adherence	WhyPoorFairINHDrugAdherence	CodeType	O	[0..1]	Y	ADHERANCE_POORFAIR_REASON
24	CD4	ART076	Latest CD4 result	CD4	int	O	[0..1]	N	
25	Latest CD4 result date	ART104	Latest CD4 result date	CD4TestDate	date	O	[0..1]	N	
26	Next Appt Date	ART082	Date of next scheduled appointment	NextAppointmentDate	date	O	[0..1]	N	

Sample XML

It is important to note that this example demonstrates how multiple values can be passed for single data elements (OtherOIOtherProblems and NotedSideEffects).

```
<Encounters>
    <HIVEncounter>
        <VisitID>4567891</VisitID>
        <VisitDate>2014-02-08</VisitDate>
        <DurationOnArt>20</DurationOnArt>
        <Weight>73</Weight>
        <BloodPressure>126/95</BloodPressure>
        <EDDandPMTCTLink>NK</EDDandPMTCTLink>
        <PatientFamilyPlanningCode>FP</PatientFamilyPlanningCode>
        <PatientFamilyPlanningMethodCode>FP3</PatientFamilyPlanningMethodCode>
        <FunctionalStatus>W</FunctionalStatus>
        <WHOClinicalStage>3</WHOClinicalStage>
        <TBStatus>2</TBStatus>
        <OtherOIOtherProblems>3|5</OtherOIOtherProblems>
        <NotedSideEffects>4|2|6</NotedSideEffects>
        <ARVDrugRegimen>
            <Code>1b</Code>
            <CodeDescTxt>AZT-3TC-NVP</CodeDescTxt>
        </ARVDrugRegimen>
        <ARVDrugAdherence>F</ARVDrugAdherence>
        <WhyPoorFairARVDrugAdherence>8</WhyPoorFairARVDrugAdherence>
        <CotrimoxazoleDose>
            <Code>CTX480</Code>
            <CodeDescTxt>Cotrimoxazole 480mg</CodeDescTxt>
        </CotrimoxazoleDose>
        <CotrimoxazoleAdherence>P</CotrimoxazoleAdherence>
        <WhyPoorFairCotrimoxazoleDrugAdherence>10</WhyPoorFairCotrimoxazoleDrugAdherence>
        <INHDose>
            <Code>HE</Code>
            <CodeDescTxt>Isoniazid-Ethambutol</CodeDescTxt>
        </INHDose>
        <INHAdherence>F</INHAdherence>
        <WhyPoorFairINHDrugAdherence>7</WhyPoorFairINHDrugAdherence>
        <CD4>145</CD4>
        <CD4TestDate>2013-03-28</CD4TestDate>
        <NextAppointmentDate>2013-04-30</NextAppointmentDate>
    </HIVEncounter>
    <HIVEncounter>
    …
    </HIVEncounter>
    <HIVEncounter>
    …
```

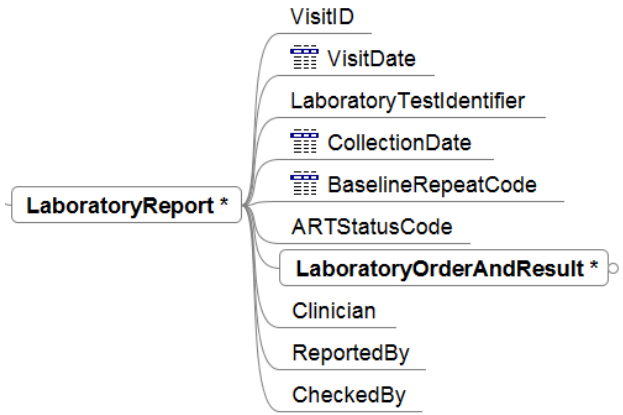
```
    </HIVEncounter>
</Encounters>
```

3.1.12 **Laboratory Report**

The Laboratory Report is utilized to capture detailed information on the Patient's Laboratory Reports.

It is important to note that the Laboratory Report element has been designed to support multiple conditions.

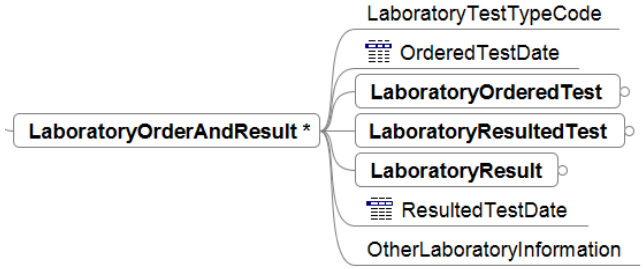
Within the NDR Schema, a single Laboratory Report can include multiple Laboratory Results.



LaboratoryReport									
Seq	Field Name	Field Identifier	Purpose	XML Element	DT	Use	Occurs	Enum	Value Set / Notes
1	Visit Identifier	LAB001	The identification code or number used to uniquely identify the clinical visit	VisitID	StringType	R	[1..1]	N	
2	Visit Date	LAB002	Visit date applies to all outpatient encounter data for that date.	VisitDate	date	R	[1..1]	N	
3	Lab Registration No	LAB205	Lab Registration No	LaboratoryTestIdentifier	StringType	O	[0..1]	N	
4	Sample Collection Date	LAB500	Collection Date	CollectionDate	date	R	[0..1]	N	
5	Baseline/ Repeat	LAB196	Baseline/Repeat	BaselineRepeatCode	CodeType	O	[0..1]	Y	TESTING_STATUS
6	Patient's ART status	LAB192	Patient's ART status	ARTStatusCode	CodeType	O	[0..1]	N	ART_STATUS If a Laboratory Report is being sent for a condition other than HIV, this data element would not be sent.
7	LaboratoryOrderAndResult	N/A	Repeating block comprised of Resulted Tests	LaboratoryOrderAndResult	LaboratoryOrderAndResult	R	[1..*]	N	
8	Name of Clinician	LAB212	Clinician	Clinician	StringType	O	[0..1]	N	
9	Reported by	LAB214	Reported by	ReportedBy	StringType	O	[0..1]	N	
10	Checked by	LAB216	Checked by	CheckedBy	StringType	O	[0..1]	N	

3.1.13 **Laboratory Order and Result**

Each Laboratory Report can include 1 or many Laboratory Order and Result pairings.



Laboratory Order and Result									
Seq	**Field Name**	**Field Identifier**	**Purpose**	**XML Element**	**DT**	**Use**	**Occurs**	**Enum**	**Value Set / Notes**
1	Laboratory Test Type Code	LAB600	Laboratory Test Type Code	LaboratoryTestTypeCode	CodeType	O	[0..1]	N	*This field is not currently used in the schema*
2	Ordered Test Date	LAB601	Ordered Test Date	OrderedTestDate	date	R	[0..1]	N	
3	Laboratory Ordered Test	LAB602	Laboratory Ordered Test	LaboratoryOrderedTest	CodedSimpleType	O	[0..1]	N	*This field is not currently used in the schema*
4	Laboratory Resulted Test	LAB603	Laboratory Resulted Test	LaboratoryResultedTest	CodedSimpleType	R	[1..1]	N	LAB_RESULTED_TEST
5	Laboratory Result	LAB604	Laboratory Result	LaboratoryResult	AnswerType	R	[1..1]	N	
6	Resulted Test Date	LAB605	Resulted Test Date	ResultedTestDate	date	R	[0..1]	N	
7	Other Laboratory Information	LAB606	Other Laboratory Information	OtherLaboratoryInformation	StringType	O	[0..1]	N	

Sample XML

```
<LaboratoryReport>
    <VisitID>259430</VisitID>
    <VisitDate>2010-03-10</VisitDate>
    <LaboratoryTestIdentifier>lt65498</LaboratoryTestIdentifier>
    <CollectionDate>2010-03-10</CollectionDate>
    <BaselineRepeatCode>B</BaselineRepeatCode>
    <ARTStatusCode>P</ARTStatusCode>
    <LaboratoryOrderAndResult>
        <OrderedTestDate>2010-03-10</OrderedTestDate>
        <LaboratoryResultedTest>
            <Code>80</Code>
            <CodeDescTxt>Viral Load</CodeDescTxt>
        </LaboratoryResultedTest>
        <LaboratoryResult>
            <AnswerNumeric>
                <Value1>16000</Value1>
            </AnswerNumeric>
        </LaboratoryResult>
        <ResultedTestDate>2010-03-10</ResultedTestDate>
        <OtherLaboratoryInformation>Information such as clinical indication for the test that was provided
          with the lab order</OtherLaboratoryInformation>
    </LaboratoryOrderAndResult>
    <Clinician>Clinician Name</Clinician>
    <ReportedBy>Reporter Name</ReportedBy>
    <CheckedBy>Checkedby Name</CheckedBy>
</LaboratoryReport>
```

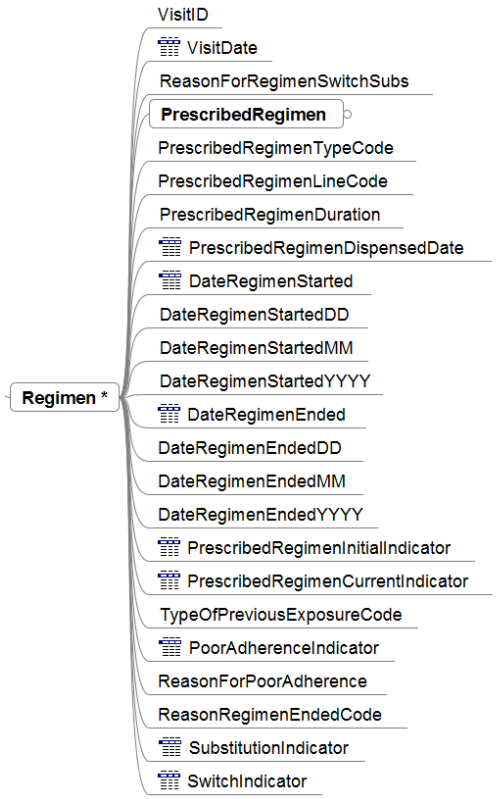
3.1.14 **Regimen**

A Regimen represents the prescribed course of medical treatment for the promotion or restoration of health. In the context of NDR, the Regimen will typically represent the medication that a Patient has been prescribed.

In the context of HIV, Regimens for ARV, Tuberculosis, and Other Opportunistic Infections should be transmitted to NDR.

It is important to note that the Regimen element has been designed to support multiple conditions.

It is important to note that in future versions of the NDR Schema, Regimen will be extended to include the actual medications that comprise the Regimen.


Regimen *
VisitID
VisitDate
ReasonForRegimenSwitchSubs
PrescribedRegimen
PrescribedRegimenTypeCode
PrescribedRegimenLineCode
PrescribedRegimenDuration
PrescribedRegimenDispensedDate
DateRegimenStarted
DateRegimenStartedDD
DateRegimenStartedMM
DateRegimenStartedYYYY
DateRegimenEnded
DateRegimenEndedDD
DateRegimenEndedMM
DateRegimenEndedYYYY
PrescribedRegimenInitialIndicator
PrescribedRegimenCurrentIndicator
TypeOfPreviousExposureCode
PoorAdherenceIndicator
ReasonForPoorAdherence
ReasonRegimenEndedCode
SubstitutionIndicator
SwitchIndicator

Regimen									
Seq	**Field Name**	**Field Identifier**	**Purpose**	**XML Element**	**DT**	**Use**	**Occurs**	**Enum**	**Value Set / Notes**
1	Visit ID	REG001	The identification code or number used to uniquely identify the clinical visit	VisitID	StringType	R	[1..1]	N	
2	Visit Date	REG002	Visit date applies to all outpatient encounter data for that date.	VisitDate	date	R	[1..1]	N	
3	Reason For Regimen Switch Subs	REG003	Reason for regimen switch or substitution	ReasonForRegimenSwitchSubs	CodeType	O	[0..1]	N	REGIMEN_SUB_SWITCH_REASON
4	Prescribed Regimen	REG004	Prescribed regimen	PrescribedRegimen	CodedSimpleType	R	[0..1]	N	
5	Prescribe Regimen Type Code	REG005	Type of prescribed regimen	PrescribedRegimenTypeCode	CodeType	R	[0..1]	N	REGIMEN_TYPE
6	Prescribe Regimen Line Code	REG006	Prescribed regimen line	PrescribedRegimenLineCode	CodeType	O	[0..1]	N	REGIMEN_LINE
7	Prescribe Regimen Duration	REG007	Duration of prescribed regimen	PrescribedRegimenDuration	CodeType	R	[0..1]	N	Note: While defined as a CodeType, developers should use this fields to pass the number of days that a regimen was prescribed. For example, if 30 days, the field would contain 30
8	Prescribe Regimen Dispense Date	REG008	Prescribed regimen dispensed date	PrescribedRegimenDispensedDate	date	R	[0..1]	N	

Regimen									
Seq	Field Name	Field Identifier	Purpose	XML Element	DT	Use	Occurs	Enum	Value Set / Notes
9	Date Regimen Started	REG009	Date regimen started	DateRegimenStarted	date	O	[0..1]	N	
10	Date Regimen Started DD	REG010	Date regimen started DD	DateRegimenStartedDD	StringType	O	[0..1]	N	
11	Date Regimen Started MM	REG011	Date regimen started MM	DateRegimenStartedMM	StringType	O	[0..1]	N	
12	Date Regimen Started YYYY	REG012	Date regimen started YYYY	DateRegimenStartedYYYY	StringType	O	[0..1]	N	
13	Date Regimen Ended	REG013	Date regimen ended	DateRegimenEnded	date	O	[0..1]	N	
14	Date Regimen Ended DD	REG014	Date regimen ended DD	DateRegimenEndedDD	StringType	O	[0..1]	N	
15	Date Regimen Ended MM	REG015	Date regimen ended MM	DateRegimenEndedMM	StringType	O	[0..1]	N	
16	Date Regimen Ended YYYY	REG016	Date regimen ended YYYY	DateRegimenEndedYYYY	StringType	O	[0..1]	N	
17	Prescribe Regimen Initial Indicator	REG017	Is this the initial regimen prescribed	PrescribedRegimenInitialIndicator	boolean	O	[0..1]	N	
18	Prescribe Regimen Current Indicator	REG018	Is this the current regimen prescribed	PrescribedRegimenCurrentIndicator	boolean	O	[0..*]	N	

Regimen									
Seq	**Field Name**	**Field Identifier**	**Purpose**	**XML Element**	**DT**	**Use**	**Occurs**	**Enum**	**Value Set / Notes**
19	Type Of Previous Exposure Code	REG019	Type of previous exposure	TypeOfPreviousExposureCode	CodeType	O	[0..*]	N	PRIOR_ART
20	Poor Adherence Indicator	REG020	Is poor adherence noted?	PoorAdherenceIndicator	boolean	O	[0..1]	N	
21	Reason For Poor Adherence	REG021	Reason for Poor adherance	ReasonForPoorAdherence	CodeType	O	[0..1]	N	ADHERANCE_POORFAIR_REASON
22	Reason Regimen Ended Code	REG022	Reason Regimen Ended	ReasonRegimenEndedCode	CodeType	O	[0..1]	N	REGIMEN_STOP
23	Substitution Indicator	REG023	Substitution Indicator	SubstitutionIndicator	boolean	O	[0..1]	N	
24	Switch Indicator	REG024	Switch Indicator	SwitchIndicator	boolean	O	[0..1]	N	

Sample XML

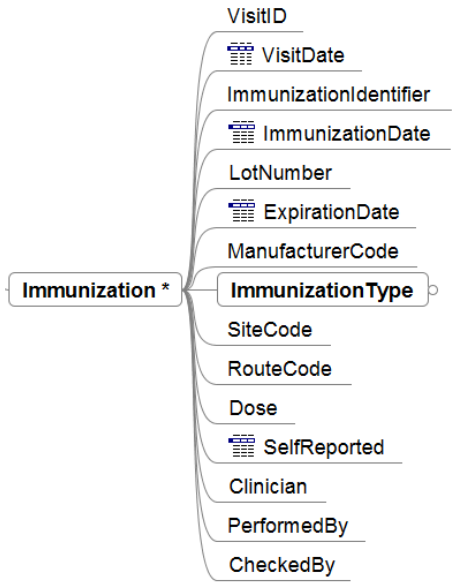
```
<Regimen>
    <VisitID>5468</VisitID>
    <VisitDate>2015-01-10</VisitDate>
    <ReasonForRegimenSwitchSubs>string</ReasonForRegimenSwitchSubs>
    <PrescribedRegimen>
        <Code>1b</Code>
        <CodeDescTxt>AZT-3TC-NVP</CodeDescTxt>
    </PrescribedRegimen>
    <PrescribedRegimenTypeCode>ART</PrescribedRegimenTypeCode>
    <PrescribedRegimenLineCode>10</PrescribedRegimenLineCode>
    <PrescribedRegimenDuration>30</PrescribedRegimenDuration>
    <PrescribedRegimenDispensedDate>2010-03-10</PrescribedRegimenDispensedDate>
    <DateRegimenStarted>2015-01-10</DateRegimenStarted>
    <DateRegimenStartedDD>10</DateRegimenStartedDD>
    <DateRegimenStartedMM>01</DateRegimenStartedMM>
    <DateRegimenStartedYYYY>2015</DateRegimenStartedYYYY>
```

```
        <DateRegimenEnded>2015-02-10</DateRegimenEnded>
        <DateRegimenEndedDD>10</DateRegimenEndedDD>
        <DateRegimenEndedMM>02</DateRegimenEndedMM>
        <DateRegimenEndedYYYY>2015</DateRegimenEndedYYYY>
        <PrescribedRegimenInitialIndicator>false</PrescribedRegimenInitialIndicator>
        <PrescribedRegimenCurrentIndicator>true</PrescribedRegimenCurrentIndicator>
        <TypeOfPreviousExposureCode>N</TypeOfPreviousExposureCode>
        <PoorAdherenceIndicator>true</PoorAdherenceIndicator>
        <ReasonForPoorAdherence>8</ReasonForPoorAdherence>
        <ReasonRegimenEndedCode>6</ReasonRegimenEndedCode>
        <SubstitutionIndicator>false</SubstitutionIndicator>
        <SwitchIndicator>false</SwitchIndicator>
    </Regimen>
```

3.1.15 **Immunization**

One or more immunizations can be provided in the immunization.

It is important to note that for Version 1.2 and higher of the NDR Schema that Immunizations can be transmitted, however they will not be parsed into the Transactional or Repository databases.



Immunization									
Seq	Field Name	Field Identifier	Purpose	XML Element	DT	Use	Occurs	Enum	Value Set / Notes
1	Visit ID	VAC001	The identification code or number used to uniquely identify the clinical visit	VisitID	StringType	R	[1..1]	N	
2	Visit Date	VAC002	Visit date applies to all outpatient encounter data for that date.	VisitDate	date	R	[1..1]	N	
3	Immunization Identifier	VAC003	Immunization identifier number	ImmunizationIdentifier	StringType	O	[1..1]	N	
4	Immunization Date	VAC004	Date of immunization	ImmunizationDate	date	O	[0..1]	N	
5	Lot Number	VAC005	Lot number	LotNumber	StringType	O	[0..1]	N	
6	Expiration Date	VAC006	Expiration date	ExpirationDate	date	O	[0..1]	N	
7	Manufacturer Code	VAC007	Manufacturer code	ManufacturerCode	StringType	O	[0..1]	N	
8	Immunization Type	VAC008	Type of immunization given	ImmunizationType	CodedSimpleType	R	[1..1]	N	VACCINE_TYPE
9	Site Code	VAC009	Site of immunization administration	SiteCode	CodeType	O	[0..1]	N	VACCINE_SITE
10	Route Code	VAC010	Route of Immunization	RouteCode	CodeType	O	[0..1]	N	VACCINE_ADMINISTER
11	Dose	VAC011	Dose	Dose	StringType	O	[0..1]	N	
12	Self Reported	VAC012	Is this immunization record self reported?	SelfReported	boolean	O	[0..1]	N	
13	Clinician	VAC013	Clinician	Clinician	StringType	O	[0..1]	N	
14	Performed By	VAC014	Performed by	PerformedBy	StringType	O	[0..1]	N	
15	Checked By	VAC015	Checked by	CheckedBy	StringType	O	[0..1]	N	

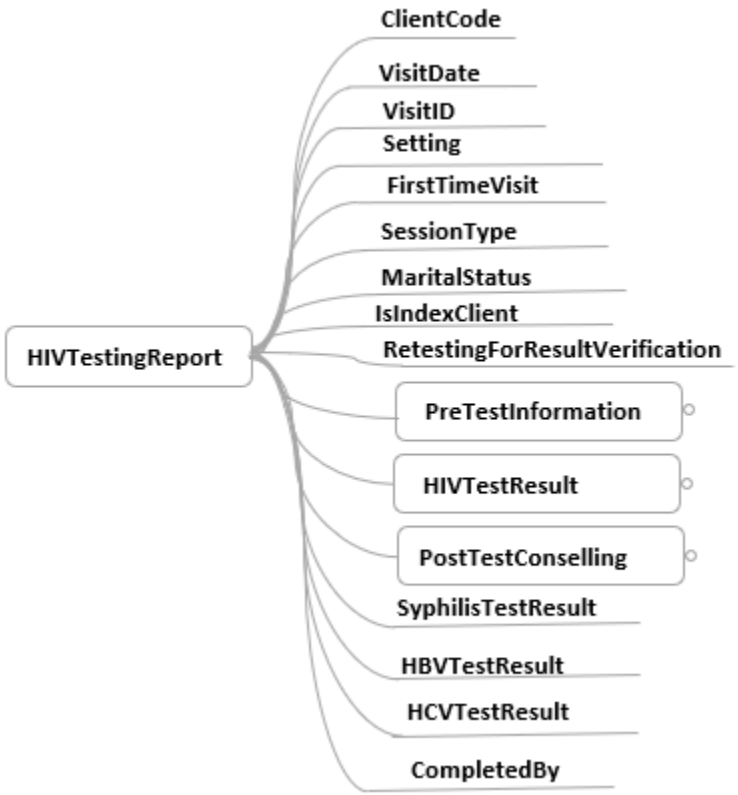
Sample XML

```
<Immunization>
    <VisitID>98702</VisitID>
    <VisitDate>2014-11-22</VisitDate>
    <ImmunizationIdentifier>vac21654</ImmunizationIdentifier>
    <ImmunizationDate>2014-11-22</ImmunizationDate>
    <LotNumber>98184</LotNumber>
    <ExpirationDate>2015-10-24</ExpirationDate>
    <ManufacturerCode>BAY</ManufacturerCode>
    <ImmunizationType>
        <Code>138</Code>
        <CodeDescTxt>Td (adult)</CodeDescTxt>
    </ImmunizationType>
    <SiteCode>LA</SiteCode>
    <RouteCode>IM</RouteCode>
    <Dose>0.5 mL</Dose>
    <SelfReported>false</SelfReported>
    <Clinician>Clinician Name</Clinician>
    <PerformedBy>Performedby Name</PerformedBy>
    <CheckedBy>Checkedby Name</CheckedBy>
</Immunization>
```

3.1.16 HIV Testing Report

The HIV Testing Report is utilized to capture detailed information of the patient's HIV test. The HIV Test Report generally follows the client intake form of the National forms.

It is important to note that for matching purposes, the NDR will utilize the Client Code to determine if a client currently exists in the NDR


HIVTestingReport
ClientCode
VisitDate
VisitID
Setting
FirstTimeVisit
SessionType
MaritalStatus
IsIndexClient
RetestingForResultVerification
PreTestInformation
HIVTestResult
PostTestConselling
SyphilisTestResult
HBVTestResult
HCVTestResult
CompletedBy

HIV Testing Report								
Field Name	Field Identifier	Purpose	XML Element	DT	Use	Occurs	Enum	Value Set / Notes
Client code	N/A	Client code for HTS	ClientCode	stringType	R	[1..1]	N	
Visit Date	N/A	Visit date applies to all encounter data for that date.	VisitDate	date	R	[1..1]	N	
Visit ID	N/A	The identification code or number used to uniquely identify the clinical visit	VisitID	stringType	R	[1..1]	N	
Settings	N/A	HIV testing setting	setting	CodeType	R	[1..1]	Y	
First time visit	N/A	Patient first time visit	FirstTimeVisit	CodeType	R	[1..1]	Y	
Session type	N/A	Type of session	SessionType	CodeType	O	[0..1]	Y	
Referred from	N/A	Where Patient is referred from	ReferredFrom	CodeType	O	[0..1]	Y	
Marital status	N/A	Marital status	MaritalStatus	CodeType	O	[0..1]	Y	
Number of children less than 5	N/A	Number of children owned by client	NoOfOwnChildrenLessThan5Years	int	O	[0..1]	N	
Number of wives	N/A	Number of wives client have	NoOfAllWives	int	O	[0..1]	N	

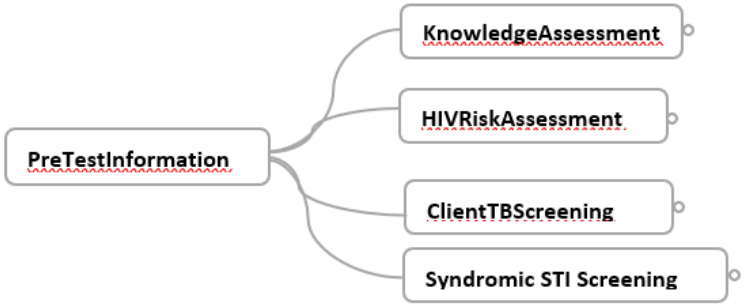
Is index client	N/A	Is client an index client	IsIndexClient	StringType	O	[0..1]	Y	
Index Client ID	N/A	ID of Index client	IndexClientId	StringType	O	[0..1]	N	
Retesting for result verification	N/A	Is client testing for result verification	ReTestingForResultVerification	CodeType	O	[0..1]	Y	
Pretest Information	N/A	Client pretest information	PreTestInformation	PreTestInformationType	O	[0..1]	N	
HIV result	N/A	Client HIV result	HIVTestResult	HIVTestResultType	O	[0..1]	N	
Posttest counselling	N/A	Client post test counselling	PostTestCounselling	PostTestCounsellingType	O	[0..1]	N	
Syphilis test result	N/A	Client Syphilis test result	SyphilisTestResult	CodeType	O	[0..1]	Y	
HBV test result	N/A	Client HBV test result	HBVTestResult	CodeType	O	[0..1]	Y	
HCV test result	N/A	Client HCV test result	HCVTestResult	CodeType	O	[0..1]	Y	
Index notification services	N/A	Index notification services	IndexNotificationServices	IndexNotificationServicesType	O	[0..1]	N	
Completed by	N/A	Clinician that completed the test	CompletedBy	StringType	O	[0..1]	N	
Date completed	N/A	Completion date	DateCompleted	StringType	O	[0..1]	N	

Sample XML

```
<HIVTestingReport>
        <ClientCode>HTS780934</ClientCode>
        <VisitDate>2020-03-20</VisitDate>
        <VisitID>347949</VisitID>
        <FirstTimeVisit>N</FirstTimeVisit>
        <SessionType>1</SessionType>
        <MaritalStatus>S</MaritalStatus>
        <IsIndexClient>N</IsIndexClient>
        <ReTestingForResultVerification>N</ReTestingForResultVerification>
        <PreTestInformation>
            ...
        </PreTestInformation>
        <HIVTestResult>
          ...
        </HIVTestResult>
        <PostTestCounselling>
            ...
        </PostTestCounselling>
        <SyphilisTestResult>R</SyphilisTestResult>
        <HBVTestResult>Pos</HBVTestResult>
        <HCVTestResult>Pos</HCVTestResult>
        <CompletedBy>Super User</CompletedBy>
    </HIVTestingReport>
```

3.1.17 Pretest Information

This element contains pre-test information of the client spanning across knowledge assessment, HIV risk assessment, Client TB screening and Syndromic STI screening as captured in the client intake form of the national forms.

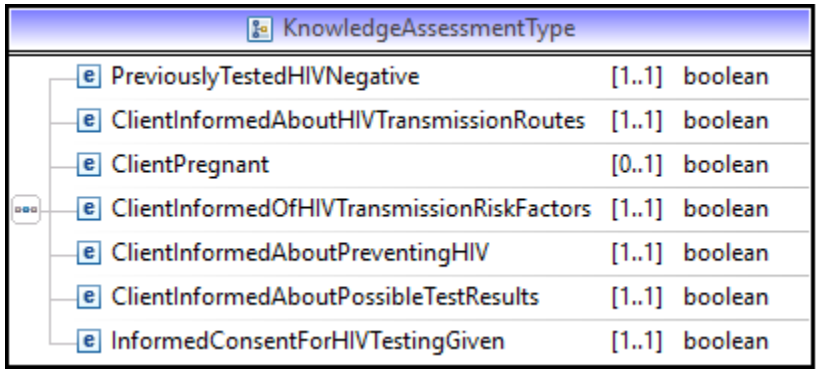


Pretest Information								
Field Name	Field Identifier	Purpose	XML Element	DT	Use	Occurs	Enum	Value Set / Notes
Knowledge Assessment	N/A	Client Knowledge Assessment	KnowledgeAssessment	KnowledgeAssessmentType	O	[0..1]	N	
HIV Risk Assessment	N/A	Client Risk Assessment	HIVRiskAssessment	HIVRiskAssessmentType	O	[0..1]	N	
Client TB Screening	N/A	Client Screening for TB	ClinicalTBScreening	ClinicalTBScreeningType	O	[0..1]	N	
Syndromic STI Screening	N/A	Syndromic STI Screening	SyndromicSTIScreening	SyndromicSTIScreeningType	O	[0..1]	N	

```
<PreTestInformation >
                    <KnowledgeAssessment>
                          …
                    </KnowledgeAssessment>
                    <HIVRiskAssessment>
                         …
                    </HIVRiskAssessment>
                    <ClinicalTBScreening>
                              …
                     </ClinicalTBScreening>
                    <SyndromicSTIScreening>
                          …
                    </SyndromicSTIScreening>
 </PreTestInformation>
```

3.1.17.1 Knowledge Assessment

This element contains assessment questions on the client's knowledge about HIV transmission methods, how to prevent it types of HIV results among others as captured in the client intake form.



Knowledge Assessment								
Field Name	Field Identifier	Purpose	XML Element	DT	Use	Occurs	Enum	Value Set / Notes
Previously Tested HIV Negative	N/A	To know if a client had a negative result in their first test	PreviouslyTestedHIVNegative	Boolean	O	[1..1]	N	
Client Informed About HIV Transmission Routes	N/A	To ensure the client is informed of possible transmission routes for HIV	ClientInformedAboutHIVTransmissionRoutes	Boolean	O	[1..1]	N	
Client Pregnant	N/A	To know if a client should be considered for the PMTCT program	ClientPregnant	Boolean	O	[0..1]	N	
Client Informed About Preventing HIV	N/A	To ensure a client is informed on how to prevent HIV	ClientInformedAboutPreventingHIV	Boolean	O	[1..1]	N	
Client Informed About Possible Test Results	N/A	To ensure client is told what HIV results are available	ClientInformedAboutPossibleTestResults	Boolean		[1..1]	N	
Informed Consent For HIV Testing Given	N/A	To confirm that client's informed consent was sought before the test	InformedConsentForHIVTestingGiven	Boolean		[1..1]	N	

Sample XML

```
<KnowledgeAssessment>
    <PreviouslyTestedHIVNegative>true</PreviouslyTestedHIVNegative>
    <ClientInformedAboutHIVTransmissionRoutes>true</ClientInformedAboutHIVTransmissionRoutes>
    <ClientPregnant>true</ClientPregnant>
    <ClientInformedOfHIVTransmissionRiskFactors>true</ClientInformedOfHIVTransmissionRiskFactors>
    <ClientInformedAboutPreventingHIV>true</ClientInformedAboutPreventingHIV>
    <ClientInformedAboutPossibleTestResults>true</ClientInformedAboutPossibleTestResults>
    <InformedConsentForHIVTestingGiven>true</InformedConsentForHIVTestingGiven>
</Knowledge Assessment>
```

3.1.17.2 HIV Risk Assessment

This element contains assessment question on client's exposure to risk factors that could lead to HIV infection as captured in the client intake form.

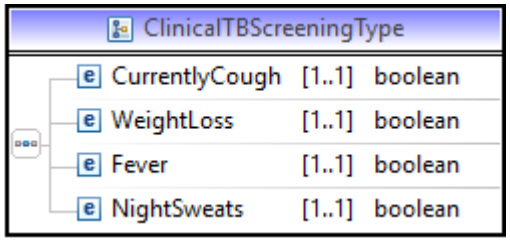
HIV Risk Assessment								
Field Name	**Field Identifier**	**Purpose**	**XML Element**	**DT**	**Use**	**Occurs**	**Enum**	**Value Set / Notes**
Ever Had Sexual Intercourse	N/A	To know if a client is sexually active or exposed via sexual intercourse	EverHadSexualIntercourse	Boolean	O	[1..1]	N	
Blood Transfusion In Last 3 Months	N/A	To know if a client had been exposed via blood transfusion in the past 3 months	BloodTransfussionInLast3Months	Boolean	O	[1..1]	N	
Unprotected Sex With Casual Partner in Last 3 Months	N/A	To know if a client had been exposed via unprotected sex with casual partners in the past 3 months	UnprotectedSexWithCasualPartnerinLast3Months	Boolean	O	[1..1]	N	
Unprotected Sex With Regular Partner In Last 3 Months	N/A	To know if a client had been exposed via unprotected sex with regular partner in the past 3 months	UnprotectedSexWithRegularPartnerInLast3Months	Boolean	O	[1..1]	N	
More Than 1 Sex Partner During Last 3 Months	N/A	To know if a client has various sex partners in the past 3 months	MoreThan1SexPartnerDuringLast3Months	Boolean		[1..1]	N	
STI In Last 3 Months	N/A	To know if a client had been diagnosed of any sexually transmitted infection in the past 3 months	STIInLast3Months	Boolean		[1..1]	N	

Sample XML

```
<HIVRiskAssessment>
  <EverHadSexualIntercourse>true</EverHadSexualIntercourse>
  <BloodTransfussionInLast3Months>true</BloodTransfussionInLast3Months>
  <UnprotectedSexWithCasualPartnerinLast3Months>true</UnprotectedSexWithCasualPartnerinLast3Months>
  <UnprotectedSexWithRegularPartnerInLast3Months>true</UnprotectedSexWithRegularPartnerInLast3Months>
  <MoreThan1SexPartnerDuringLast3Months>true</MoreThan1SexPartnerDuringLast3Months>
  <STIInLast3Months>true</STIInLast3Months>
</HIVRiskAssessment>
```

3.1.17.3 Clinical TB Screening

This element contains assessment questions to ascertain if a client is Tuberculosis symptomatic as captured in the client intake form.



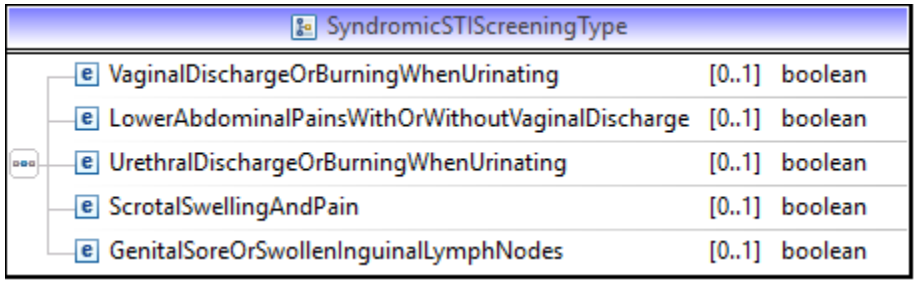
Clinical TB Screening								
Field Name	Field Identifier	Purpose	XML Element	DT	Use	Occurs	Enum	Value Set / Notes
Currently Cough	N/A	To know if a client has a cough now	CurrentlyCough	Boolean	O	[1..1]	N	
Weight Loss	N/A	To know if a client is experiencing weight loss	WeightLoss	Boolean	O	[1..1]	N	
Fever	N/A	To know if a client is feeling feverish	Fever	Boolean	O	[1..1]	N	
Night Sweats	N/A	To know if a client sweats abnormally at night	NightSweats	Boolean	O	[1..1]	N	

Sample XML

```
<ClinicalTBScreening>
  <CurrentlyCough>true</CurrentlyCough>
  <WeightLoss>true</WeightLoss>
  <Fever>true</Fever>
  <NightSweats>true</NightSweats>
</ClinicalTBScreening>
```

3.1.17.4 Syndromic STI Screening

This element contains assessment questions to ascertain if a client's is Tuberculosis symptomatic as captured in the client i ntake form.



Syndromic STI Screening								
Field Name	**Field Identifier**	**Purpose**	**XML Element**	**DT**	**Use**	**Occurs**	**Enum**	**Value Set / Notes**
Vaginal Discharge Or Burning When Urinating	N/A	To know if a female client is experiencing vaginal discharge or burn when urinating	VaginalDischargeOrBurningWhenUrinating	Boolean	O	[0..1]	N	
Lower Abdominal Pains With Or Without Vaginal Discharge	N/A	To know if a female client is experiencing abdominal pain	LowerAbdominalPainsWithOrWithoutVaginalDischarge	Boolean	O	[0..1]	N	

Urethral Discharge Or Burning When Urinating	N/A	To know if a male client is experiencing urethral discharge or burn when urinating	UrethralDischargeOrBurningWhenUrinating	Boolean	O	[0..1]	N	
Scrotal Swelling And Pain	N/A	To know if a male client is has a swollen scrotum and is experiencing pain	ScrotalSwellingAndPain	Boolean	O	[0..1]	N	
Genital Sore Or Swollen Inguinal Lymph Nodes	N/A	To know if a male client is has a genital sore or swollen inguinal lymph nodes	GenitalSoreOrSwollenInguinalLymphNodes	Boolean	O	[0..1]	N	

Sample XML

```
<SyndromicSTIScreening>
  <VaginalDischargeOrBurningWhenUrinating>true</VaginalDischargeOrBurningWhenUrinating>
  <LowerAbdominalPainsWithOrWithoutVaginalDischarge>true</LowerAbdominalPainsWithOrWithoutVaginalDischarge>
  <UrethralDischargeOrBurningWhenUrinating>true</UrethralDischargeOrBurningWhenUrinating>
  <ScrotalSwellingAndPain>true</ScrotalSwellingAndPain>
  <GenitalSoreOrSwollenInguinalLymphNodes>true</GenitalSoreOrSwollenInguinalLymphNodes>
</SyndromicSTIScreening>
```

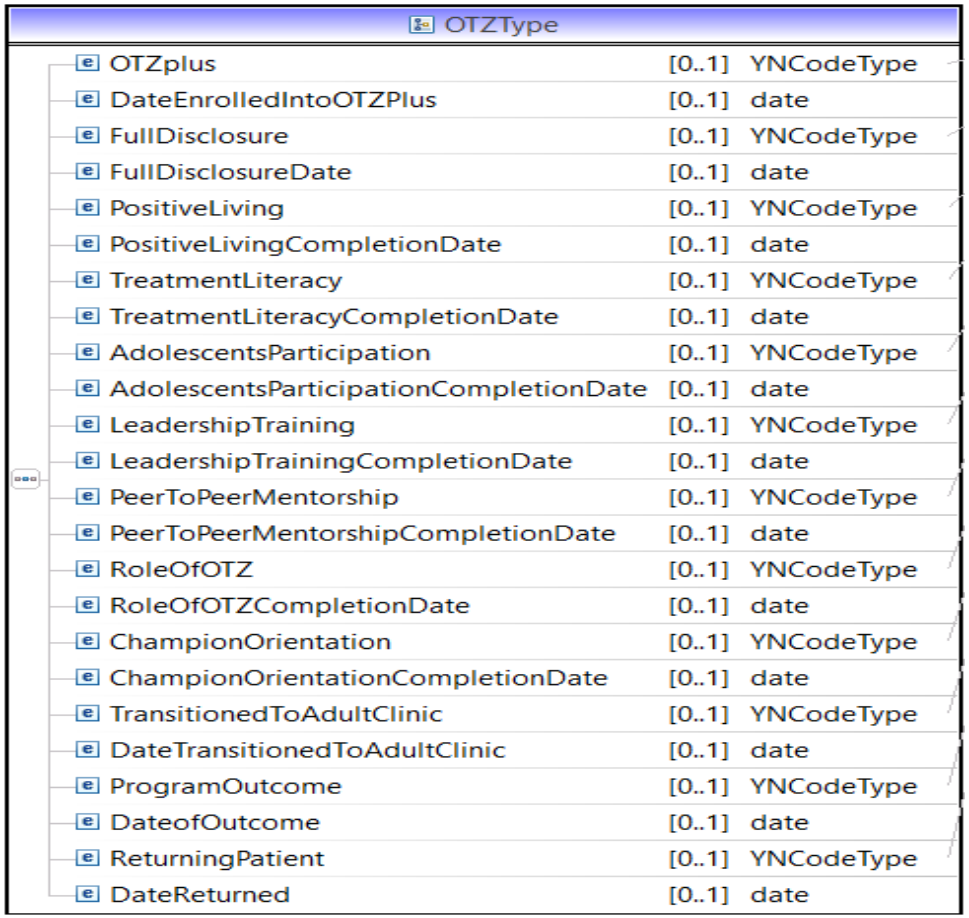
3.1.18 HIV Test Result

This element contains …

3.1.19 Post Test Counselling

3.1.20 Operation Tripple Zero (OTZ)

This element contains information on OTZ program as captured in the OTZ form.



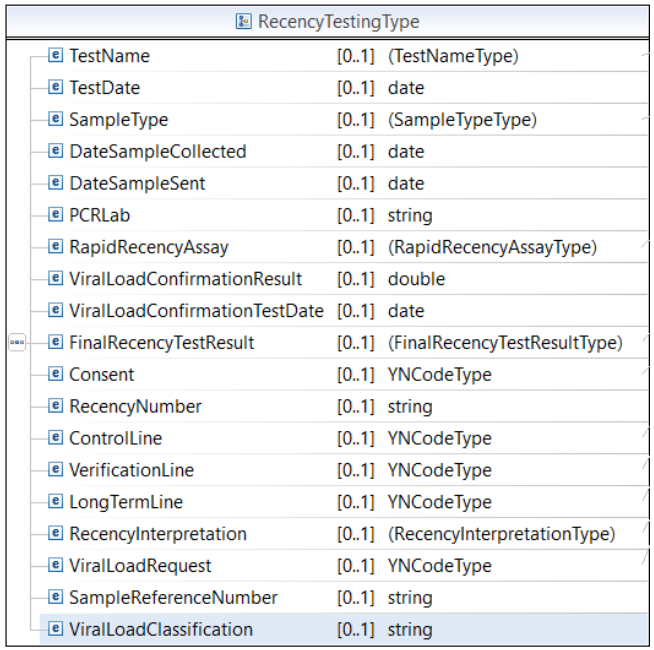
OTZType		
OTZplus	[0..1]	YNCodeType
DateEnrolledIntoOTZPlus	[0..1]	date
FullDisclosure	[0..1]	YNCodeType
FullDisclosureDate	[0..1]	date
PositiveLiving	[0..1]	YNCodeType
PositiveLivingCompletionDate	[0..1]	date
TreatmentLiteracy	[0..1]	YNCodeType
TreatmentLiteracyCompletionDate	[0..1]	date
AdolescentsParticipation	[0..1]	YNCodeType
AdolescentsParticipationCompletionDate	[0..1]	date
LeadershipTraining	[0..1]	YNCodeType
LeadershipTrainingCompletionDate	[0..1]	date
PeerToPeerMentorship	[0..1]	YNCodeType
PeerToPeerMentorshipCompletionDate	[0..1]	date
RoleOfOTZ	[0..1]	YNCodeType
RoleOfOTZCompletionDate	[0..1]	date
ChampionOrientation	[0..1]	YNCodeType
ChampionOrientationCompletionDate	[0..1]	date
TransitionedToAdultClinic	[0..1]	YNCodeType
DateTransitionedToAdultClinic	[0..1]	date
ProgramOutcome	[0..1]	YNCodeType
DateofOutcome	[0..1]	date
ReturningPatient	[0..1]	YNCodeType
DateReturned	[0..1]	date

Operation Tripple Zero (OTZ)								
Field Name	**Field Identifier**	**Purpose**	**XML Element**	**DT**	**Use**	**Occurs**	**Enum**	**Value Set / Notes**
OTZ plus	NA	To know the type of program the patient is enrolled	OTZplus	CodedType	R	[0..1]		
Date Enrolled into OTZ Plus	NA	To document the de patient is enrolled into the OTZ Plus program	DateEnrolledIntoOTZPlus	Date	R	[0..1]		
Full Disclosure	NA	To document patient disclosure information for the program	FullDisclosure	CodedType	R	[0..1]		
Full Disclosure Date	NA	To know the date full patient disclosed information	FullDisclosureDate	Date	R	[0..1]		
Enrolled By	NA	To document information about who enrolled the patient into the OTZ program	EnrolledBy	StringType	R	[0..1]		
Positive Living	NA	To know positive living of a patient	PositiveLiving	CodedType	R	[0..1]		
Positive Living Completion Date	NA	To know positive living completion data of a patient	PositiveLivingCompletionDate	Date	R	[0..1]		
Treatment Literacy	NA	To know patient treatment literacy	TreatmentLiteracy	CodedType	R	[0..1]		
Treatment Literacy Completion Date	NA	To know treatment literacy completion date for patient	TreatmentLiteracyCompletionDate	Date	R	[0..1]		
Adolescents Participation	NA	To document adolescent participation into the program	AdolescentsParticipation	CodedType	R	[0..1]		
Adolescents Participation Completion Date	NA	To document date of adolescent participation	AdolescentsParticipationCompletionDate	Date	R	[0..1]		
Leadership Training	NA	To document leadership training completion date of a patient	LeadershipTraining	Coded	R	[0..1]		
Leadership Training Completion Date	NA	To document leadership training completion date of a patient	LeadershipTrainingCompletionDate	Date	R	[0..1]		
Peer-to-Peer Mentorship	NA	To document peer-to-peer mentorship of patient	PeerToPeerMentorship	Coded	R	[0..1]		
Peer-to-Peer Mentorship Completion Date	NA	To document peer-to-peer mentorship date of a patient	PeerToPeerMentorshipCompletionDate	Date	R	[0..1]		
Role of OTZ in 95-95-95	NA	To know the role of OTZ in 95-95-95	RoleOfOTZ	Date	R	[0..1]		
Role of OTZ in 95-95-95 Completion Date	NA	To know the role of OTZ in 95-95-95 date of a patient	RoleOfOTZCompletionDate	Date	R	[0..1]		
OTZ Champion Orientation	NA	To document OTZ champion orientation	ChampionOrientation	Coded	R	[0..1]		

OTZ Champion Orientation Completion Date	NA	To document OTZ champion orientation completion date	ChampionOrientationCompletionDate	Date	R	[0..1]		
Transitioned to Adult Clinic	NA	To document patient transition to adult clinic details	TransitionedToAdultClinic	Coded	R	[0..1]		
Date Transitioned to Adult Clinic	NA	To document date patient transitioned to adult clinic	DateTransitionedToAdultClinic	Date	R	[0..1]		
OTZ Program Outcome	NA	To document OTZ program outcome	ProgramOutcome	CodedType	R	[0..1]		
Exited By	NA	To deocument who existed a patient from a program	ExitedBy	StringType	R	[0..1]		
Returning Patient	NA	To document returning patient	ReturningPatient	CodedType	R	[0..1]		
Date Returned	NA	To capture the date	DateReturned	Date	R	[0..1]		
Reactivated By	NA	To document who reactivated the patient	ReaactivatedBy	StringType	R	[0..1]		

3.1.21 Recency Testing Type

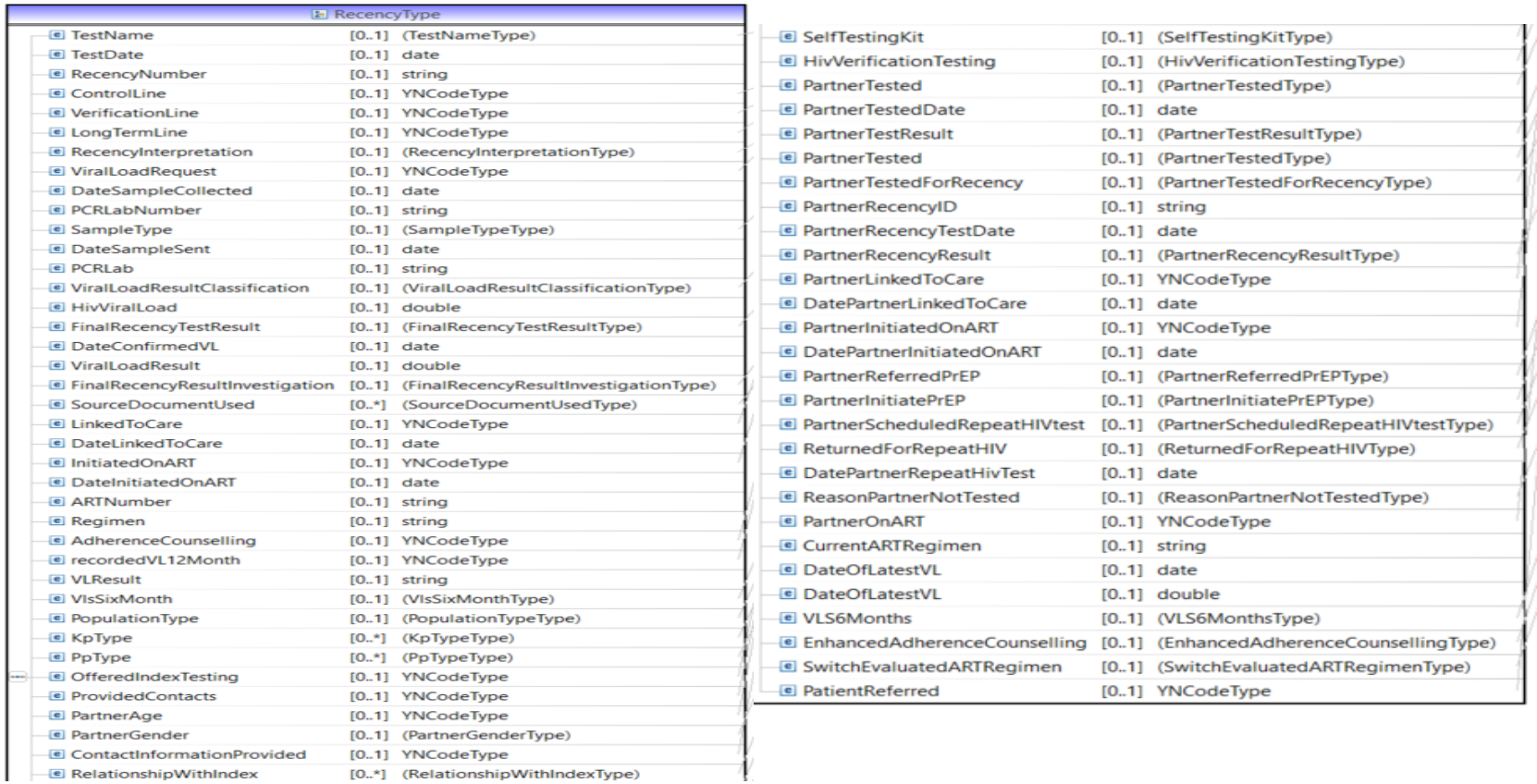
This element contains information on Recency program as captured in the Recency form.



Recency Testing Type								
Field Name	**Field Identifier**	**Purpose**	**XML Element**	**DT**	**Use**	**Occurs**	**Enum**	**Value Set / Notes**
Test Name	NA	To document test name to run	TestName	StringType	R	[0..1]		
Test Date	NA	To document the actual test date	TestDate	Date	R	[0..1]		
Sample Type	NA	The field records sample types to capture	SampleType	CodedType	R	[0..1]		
Date Sample Collected	NA	To record the date sample was collected for tracking	DateSampleCollected	Date	R	[0..1]		
Date Sample Sent	NA	To document the date sample is send from the facility to the lab	DateSampleSent	Date	R	[0..1]		
PCR Lab	NA	The field will document PCR Lab name	PCRLab	CodedType	R	[0..1]		
Rapid Recency Assay	NA	To document type of laboratory investigation	RapidRecencyAssay	CodedType	R	[0..1]		
Viral Load ConfirmationResult	NA	To document viral load confirmation date	ViralLoadConfirmationResult	Double	R	[0..1]		
Viral LoadConfirmation Test Date	NA	To document viral load confirmation test date	ViralLoadConfirmationTestDate	Date	R	[0..1]		
FinalRecencyTestResult	NA	The filed records the final recency test result	FinalRecencyTestResult	CodedType	R	[0..1]		
Consent	NA	To document patient consent before the commencement	patient consent	CodedType	R	[0..1]		
RecencyNumber	NA	To document patient recency number to distinguish program area	RecencyNumber	Double	R	[0..1]		
ControlLine	NA	Documentation of control line for the program	ControlLine	CodedType	R	[0..1]		
VerificationLine	NA	To provide verification line for the patient	VerificationLine	CodedType	R	[0..1]		
LongTermLine	NA	The documentation of long term line in the program	LongTermLine	CodedType	R	[0..1]		
RecencyInterpretation	NA	To document recency interpretation	RecencyInterpretation	CodedType	R	[0..1]		
ViralLoadRequest	NA	The documentation of viral load requestion	ViralLoadRequest	CodedType	R	[0..1]		

SampleReferenceNumber	NA	To document sample ference number	SampleReferenceNumber	StringType	R	[0..1]		
ViralLoadClassification	NA	The variable documents viral load classification	ViralLoadClassification	StringType	R	[0..1]		

3.1.22 Recency Type



Recency Type

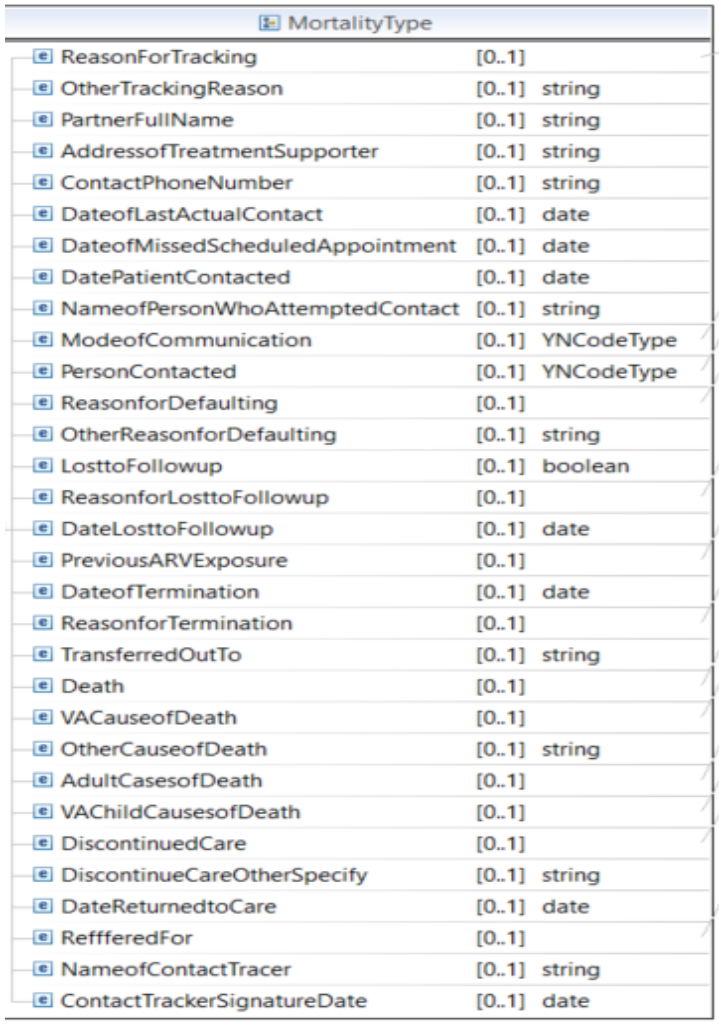
Field Name	Field Identifier	Purpose	XML Element	DT	Use	Occurs	Enum	Value Set / Notes
TestName	NA	The field used to document name of test	Test Name	StringType	R	[0..1]		
TestDate	NA	To document test date for patient	Test Date	Date	R	[0..1]		
RecencyNumber	NA	To document recency number for the patient	Recency Number	StringType	R	[0..1]		
ControlLine	NA	Field use for documenting control line	Control Line	CodedType	R	[0..1]		
VerificationLine	NA	The field is used to document verification line	Verification Line	CodedType	R	[0..1]		
LongTermLine	NA	Field used for document long term line	Long TermLine	CodedType	R	[0..1]		
RecencyInterpretation	NA	To document patients recency interpretation	Recency Interpretation	CodedType	R	[0..1]		
ViralLoadRequest	NA	To document Viral Load Request	Viral Load Request	CodedType	R	[0..1]		
DateSampleCollected	NA	The field documents date of sample collection	Date Sample Collected	Date	R	[0..1]		
PCRLabNumber	NA	The field documents PCT laboratory number	PCR Lab Number	StringType	R	[0..1]		
SampleType	NA	To document sample type collected	Sample Type	CodedType	R	[0..1]		
DateSampleSent	NA	To document date sample Sent to PCR Lab	Date Sample Sent	Date	R	[0..1]		
PCRLab	NA	To document the name of the PCR Lab	PCR Lab	StringType	R	[0..1]		
ViralLoadResultClassification	NA	To document viral load result classification	Viral Load Result Classification	CodedType	R	[0..1]		
HivViralLoad	NA	To document HIV viral load test result	HIV Viral Load	double	R	[0..1]		
FinalRecencyTestResult	NA	To document final recency test result on NMRS	Final Recency Test Result	CodedType	R	[0..1]		
DateConfirmedVL	NA	The field is used date confirmed VL	Date Confirmed VL	Date	R	[0..1]		
ViralLoadResult	NA	This field documents viral load result	Viral Load Result	Double	R	[0..1]		
FinalRecencyResultInvestigation	NA	To document final recency result investigation	Final Recency Result Investigation	CodedType	R	[0..1]		
SourceDocumentUsed	NA	To record the source document used	Source Document Used	CodedType	R	[0..1]		
LinkedToCare	NA	The field documents linked to care	Linked To Care	CodedType	R	[0..1]		
DateLinkedToCare	NA	To document date linked to care of patient	Date Linked to Care	Date	R	[0..1]		
InitiatedOnART	NA	To document patient initiation on ART initiation details	Initiated On ART	CodeType	R	[0..1]		
DateInitiatedOnART	NA	To document patient date of date initiated on ART	Date Initiated On ART	Date	R	[0..1]		
ARTNumber	NA	The field documents ART Number	ART Number	StringType	R	[0..1]		
Regimen	NA	To document patient Regimen	Regimen	StringType	R	[0..1]		
AdherenceCounselling	NA	To document Adherence Counselling interactions	Adherence Counselling	CodedType	R	[0..1]		

recordedVL12Month	NA	To document the recorded VL 12 Month	Recorded VL 12 Month	CodedType	R	[0..1]		
VLResult	NA	The field document VL Result	VL Result	CodedType	R	[0..1]		
VlsSixMonth	NA	The recording of Vls Six Month	Vls Six Month	CodedType	R	[0..1]		
PopulationType	NA	The documentation of population type	Population Type	CodedType	R	[0..1]		
KpType	NA	The recording of key population type	KP Type	CodedType	R	[0..1]		
PpType	NA	The data element records Pp Type	Pp Type	CodedType	R	[0..1]		
OfferedIndexTesting	NA	The data element records offered Index Testing	Offered Index Testing	CodedType	R	[0..1]		
ProvidedContacts	NA	To record provided contacts details	Provided Contacts	Codedtype	R	[0..1]		
PartnerAge	NA	The documentation of partner age	Partner Age	CodedType	R	[0..1]		
PartnerGender	NA	To document Partner's Gender	Partner Gender	CodedType	R	[0..1]		
ContactInformationProvided	NA	To record contact information provided	Contact Information Provided	CodedType	R	[0..1]		
RelationshipWithIndex	NA	The records relationship with index	Relationship With Index	CodedType	R	[0..1]		
SelfTestingKit	NA	The documentation of Self-Testing Kit	Self-Testing Kit	CodedType	R	[0..1]		
HivVerificationTesting	NA	To document HIV Verification Testing	HIV Verification Testing	CodedType	R	[0..1]		
PartnerTested	NA	To record Partner Tested	Partner Tested	CodedType	R	[0..1]		
PartnerTestedDate	NA	To document Partner Tested Date	Partner Tested Date	Date	R	[0..1]		
PartnerTestResult	NA	The field documents Partner Test Result	Partner Test Result	StringType	R	[0..1]		
PartnerTested	NA	The field documents Partner Tested	Partner Tested	CodedType	R	[0..1]		
PartnerTestedForRecency	NA	To document Partner Tested for Recency	Partner Tested for Recency	CodedType	R	[0..1]		
PartnerRecencyID	NA	The documentation of Partner Recency ID	Partner Recency ID	StringType	R	[0..1]		
PartnerRecencyTestDate	NA	To document Partner Recency Test Date	Partner Recency Test Date	Date	R	[0..1]		
PartnerRecencyResult	NA	Partner Recency Result	Partner Recency Result	String	R	[0..1]		
PartnerLinkedToCare	NA	Partner Linked to Care	Partner Linked to Care	CodedType	R	[0..1]		
DatePartnerLinkedToCare	NA	To capture Date Partner Linked to Care	Date Partner Linked to Care	Date	R	[0..1]		
PartnerInitiatedOnART	NA	The field captures Partner Initiated On ART	Partner Initiated On ART	CodedType	R	[0..1]		
DatePartnerInitiatedOnART	NA	To capture Date Partner Initiated On ART	Date Partner Initiated On ART	Date	R	[0..1]		
PartnerReferredPrEP	NA	To capture Partner Referred PrEP	Partner Referred PrEP	CodedType	R	[0..1]		
PartnerInitiatePrEP	NA	The field documents Partner Initiate PrEP	Partner Initiate PrEP	CodedType	R	[0..1]		
DateOfLatestVL	NA	The documentation of Date Of Latest VL	Date Of Latest VL	Date	R	[0..1]		
PartnerScheduledRepeatHIVtest	NA	Partner Scheduled Repeat HIV test	Partner Scheduled Repeat HIV test	CodedType	R	[0..1]		
ReturnedForRepeatHIV	NA	Returned For Repeat HIV	Returned For Repeat HIV	Coded	R	[0..1]		

DatePartnerRepeatHivTest	NA	Date Partner Repeat HIV Test	Date Partner Repeat HIV Test	Date	R	[0..1]		
ReasonPartnerNotTested	NA	Current ART Regimen	Reason Partner Not Tested	CodedType	R	[0..1]		
PartnerOnART	NA	Returned For Repeat HIV	Partner On ART	CodedType	R	[0..1]		
CurrentARTRegimen	NA	Date Partner Repeat HIV Test	Current ART Regimen	StringType	R	[0..1]		
DateOfLatestVL	NA	Patient Referred	Date Of Latest VL	Date	R	[0..1]		
VLS6Months	NA	Partner Test Result	VLS 6 Months	StringType	R	[0..1]		
EnhancedAdherenceCounselling	NA	Partner Tested	Enhanced Adherence- Counselling	CodedType	R	[0..1]		
SwitchEvaluatedARTRegimen	NA	Partner Tested for Recency	Switch Evaluated ART Regimen	CodedType	R	[0..1]		
PatientReferred	NA	Partner Recency ID	Patient Referred	CodedType	R	[0..1]		

3.1.23 Mortality

This element contains information on Mortality program as captured in the Mortality form

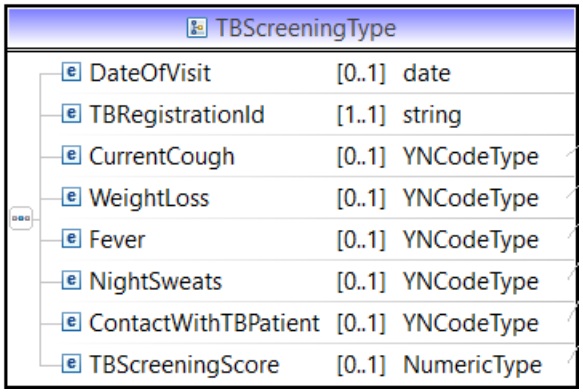


MortalityType		
ReasonForTracking	[0..1]	
OtherTrackingReason	[0..1]	string
PartnerFullName	[0..1]	string
AddressofTreatmentSupporter	[0..1]	string
ContactPhoneNumber	[0..1]	string
DateofLastActualContact	[0..1]	date
DateofMissedScheduledAppointment	[0..1]	date
DatePatientContacted	[0..1]	date
NameofPersonWhoAttemptedContact	[0..1]	string
ModeofCommunication	[0..1]	YNCodeType
PersonContacted	[0..1]	YNCodeType
ReasonforDefaulting	[0..1]	
OtherReasonforDefaulting	[0..1]	string
LosttoFollowup	[0..1]	boolean
ReasonforLosttoFollowup	[0..1]	
DateLosttoFollowup	[0..1]	date
PreviousARVExposure	[0..1]	
DateofTermination	[0..1]	date
ReasonforTermination	[0..1]	
TransferredOutTo	[0..1]	string
Death	[0..1]	
VACauseofDeath	[0..1]	
OtherCauseofDeath	[0..1]	string
AdultCasesofDeath	[0..1]	
VAChildCausesofDeath	[0..1]	
DiscontinuedCare	[0..1]	
DiscontinueCareOtherSpecify	[0..1]	string
DateReturnedtoCare	[0..1]	date
ReffferedFor	[0..1]	
NameofContactTracer	[0..1]	string
ContactTrackerSignatureDate	[0..1]	date

Mortality Type								
Field Name	**Field Identifier**	**Purpose**	**XML Element**	**DT**	**Use**	**Occurs**	**Enum**	**Value Set / Notes**
Reason for Tracking	NA	To capture the reason for tracking a patient	ReasonForTracking	coded	R	[0..1]		
Other Tracking Reason	NA	To capture other reasons not on the option	OtherTrackingReason	string	R	[0..1]		
Partner full name	NA	To capture full name of partner	PartnerFullName	string	R	[0..1]		
Address of treatment supporter	NA	To document treatment support's address	AddressofTreatmentSupporter	string	R	[0..1]		
Contact phone number	NA	To capture contact phone number of a patient	ContactPhoneNumber	string	R	[0..1]		
Date of Last Actual Contact	NA	To capture date of last contact with the client	DateofLastActualContact	date	R	[0..1]		
Date of Missed Scheduled Appointment	NA	To document date missed scheduled appointment	DateofMissedScheduledAppointment	date	R	[0..1]		
Date Patient Contacted	NA	To know the date the patient was contacted	DatePatientContacted	date	R	[0..1]		
Name of person who attempted contact	NA	To document the name of person who attempted to contact the patient	NameofPersonWhoAttemptedContact	string	R	[0..1]		
Mode of Communication	NA	To know the mode at which communication is done with the patient	ModeofCommunication	coded	R	[0..1]		
Person Contacted	NA	To know the person contacted	PersonContacted	coded	R	[0..1]		
Reason for Defaulting	NA	To document the reason for defaulting	ReasonforDefaulting	coded	R	[0..1]		
Other Reason for Defaulting	NA	What are other reasons for defaulting	OtherReasonforDefaulting	string	R	[0..1]		
Date Patient Contacted	NA	What is the data the patient was contacted?	DatePatientConctacted	date	R	[0..1]		
Name of person who attempted contact	NA	To the person who attempted to contact a patient	NameofPersonWhoAttemptedContact	string	R	[0..1]		
Mode of Communication	NA	To know the mode of communication with the patient	DateLosttoFollowup	coded	R	[0..1]		
Person Contacted	NA	To know who was contacted	PreviousARVExposure	coded	R	[0..1]		
Reason for Defaulting	NA	To know the reason for defaulting	DateofTermination	coded	R	[0..1]		
Other Reason for Defaulting	NA	To know other reasons for defaulting	OtherReasonforDefaulting	string	R	[0..1]		
Lost to follow up	NA	To determine status of a patient	LosttoFollowup	boolean	R	[0..1]		

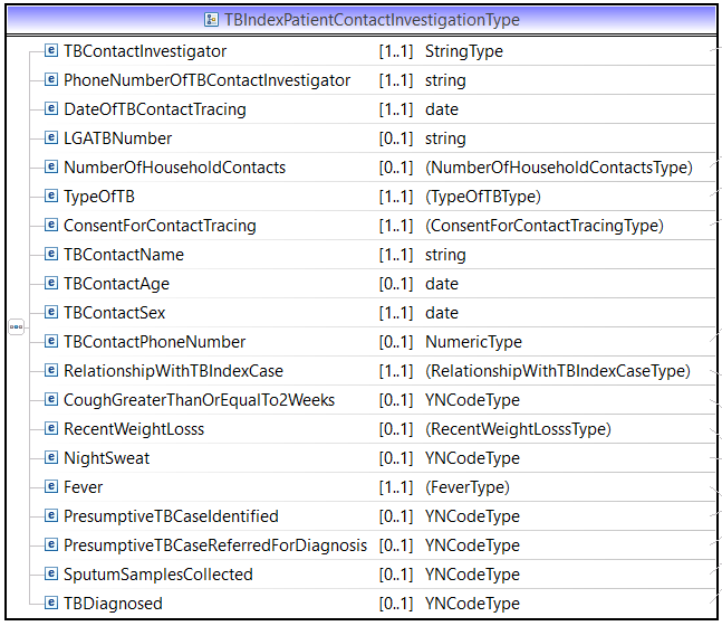
Reason for lost to follow up	NA	To know the reason for lost to follow up	ReasonforLosttoFollowup	coded	R	[0..1]		
Date Lost to follow up	NA	To document lost to follow-up date	DateLosttoFollowup	date	R	[0..1]		
Previous ARV exposure	NA	To ascertain of patient is previously known	PreviousARVExposure	coded	R	[0..1]		
Date of Termination	NA	To ascertain termination date of patient	DateofTermination	date	R	[0..1]		
Reason for Termination	NA	To know the reason for termination	ReasonforTermination	coded	R	[0..1]		
Transferred out to	NA	To document transferred out to another facility details	TransferredOutTo	string	R	[0..1]		
Death	NA	To death information of patient	Death	coded	R	[0..1]		
VA Cause of Death	NA	To know VA cause of death of patient	VACauseofDeath	coded	R	[0..1]		
Other cause of death (specify)	NA	To know other cause of death not listed in the option above	OtherCauseofDeath	string	R	[0..1]		
Adult Cases of Death	NA	To know adult cases of death	AdultCasesofDeath	coded	R	[0..1]		
VA Child Causes of Death	NA	To know child causes of death	VAChildCausesofDeath	coded	R	[0..1]		
Discontinued Care	NA	To document patient discontinued care	DiscontinuedCare	coded	R	[0..1]		
Discontinue Care other specify	NA	To know other discontinued care reasons	DiscontinueCareOtherSpecify	string	R	[0..1]		
Date Returned to Care	NA	To know the exact date loss to follow-up patient returned to care	DateReturnedtoCare	date	R	[0..1]		
Referred for	NA	To know the reason patient referred for	ReffferedFor	coded	R	[0..1]		
Name of Contact Tracer	NA	To know who did the contact tracing	NameofContactTracer	string	R	[0..1]		
Contact Tracker Signature date	NA	To document contact tracker signature date	ContactTrackerSignatureDate	date	R	[0..1]		

3.1.24 TB Screening Type



TB Screening Type								
Field Name	**Field Identifier**	**Purpose**	**XML Element**	**DT**	**Use**	**Occurs**	**Enum**	**Value Set / Notes**
Date Of Visit	NA	To document patient Date Of Visit	DateOfVisit	Date	R	[0..1]		
TB Registration Id	NA	To document TB Registration ID	TBRegistrationId	StringType	R	[0..1]		
Current Cough	NA	The documentation of Current Cough	CurrentCough	CodedType	R	[0..1]		
Weight Loss	NA	To record Weight Loss during visit	WeightLoss	CodedType	R	[0..1]		
Fever	NA	To determine if patient has Fever	Fever	CodedType	R	[0..1]		
Night Sweats	NA	To determines TB symptoms of Night Sweats	NightSweats	CodedType	R	[0..1]		
Contact with TB Patient	NA	To determine contact with TB patient	NightSweats	CodedType	R	[0..1]		
TB Screening Score	NA	To ascertain TB Screening Score	TBScreeningScore	NumbericType	R	[0..1]		

3.1.25 TB Index Patient Contact Inv

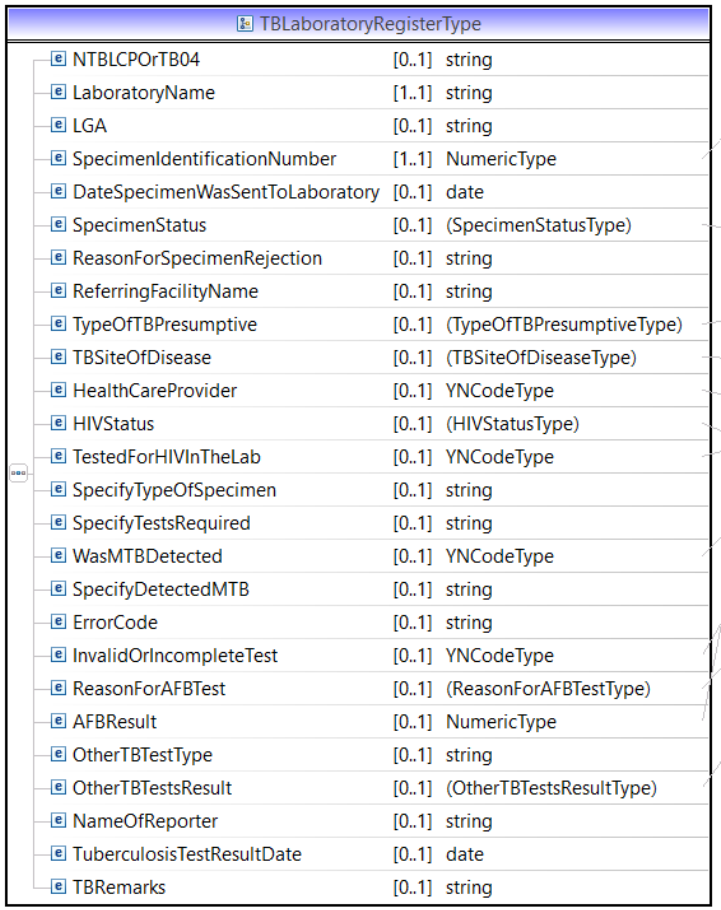


TB Index Patient Contact Inv								
Field Name	**Field Identifier**	**Purpose**	**XML Element**	**DT**	**Use**	**Occurs**	**Enum**	**Value Set / Notes**
TB Contact Investigator	NA	To document TB Contact Investigator	TBContactInvestigator	StringType	R	[1..1]		
Phone Number of TB Contact Investigator	NA	The documentation of Phone Number of TB Contact Investigator	PhoneNumberOfTBContactInvestigator	StringType	R	[1..1]		
Date of TB Contact Tracing	NA	To document Date of TB Contact Tracing	DateOfTBContactTracing	Date	R	[1..1]		
LGA TB Number	NA	The field will document LGA TB Number	LGATBNumber	StringType	R	[0..1]		

Number of Household Contacts	NA	To document Number of Household Contacts	NumberOfHouseholdContacts	Numeric	R	[0..1]		
Type of TB	NA	To document Type of TB	TypeOfTB	CodedType	R	[1..1]		
Consent for Contact Tracing	NA	To document Consent for Contact Tracing	ConsentForContactTracing	StringType	R	[1..1]		
TB Contact Name	NA	The documentation of TB Contact Name	TBContactName	StringType	R	[1..1]		
TB Contact Age	NA	The documentation of TB Contact Age	TBContactAge	Numeric	R	[0..1]		
TB Contact Sex	NA	To document TB Contact Sex	TBContactSex	CodedType	R	[1..1]		
TB Contact Phone Number	NA	The field will document TB Contact Phone Number	TBContactPhoneNumber	StringType	R	[0..1]		
Relationship with TB Index Case	NA	The field documents Relationship with TB Index Case	RelationshipWithTBIndexCase	CodedType	R	[1..1]		
Cough Greater than or Equal to 2 Weeks	NA	The documentation of Cough Greater Than or Equal to 2 Weeks	CoughGreaterThanOrEqualTo2Weeks	Boolean	R	[0..1]		
Recent Weight Loss	NA	To document Recent Weight Loss	RecentWeightLosss	Numeric	R	[0..1]		
Night Sweat	NA	The filed documents Night Sweat	NightSweat	CodedType	R	[0..1]		
Fever	NA	The documentation of Fever	Fever	CodedType	R	[1..1]		
Presumptive TB Case Identified	NA	The field will record Presumptive TB Case Identified	PresumptiveTBCaseIdentified	CodedType	R	[0..1]		
Presumptive TB Case Referred for Diagnosis	NA	The field document will document Presumptive TB Case Referred for Diagnosis	PresumptiveTBCaseReferredForDiagnosis	CodedType	R	[0..1]		
Sputum Samples Collected	NA	The documentation of Sputum Samples Collected	SputumSamplesCollected	CodedType	R	[0..1]		
TB Diagnosed	NA	The field will document TB Diagnosed	TBDiagnosed	CodedType	R	[0..1]		

1.1.19 Presumptive TB Registration

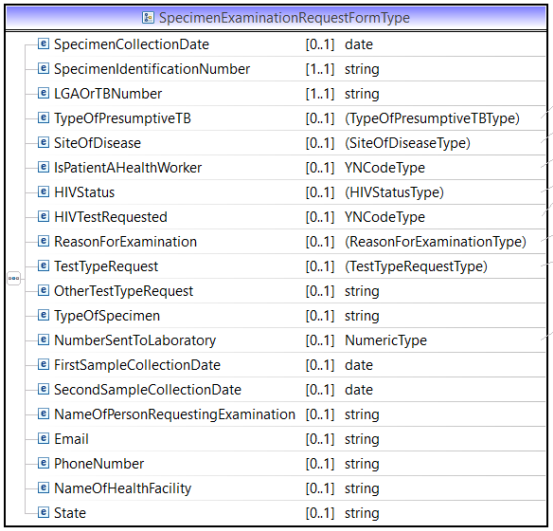
1.1.20 TB Laboratory Registration



TB Laboratory Registration Type								
Field Name	**Field Identifier**	**Purpose**	**XML Element**	**DT**	**Use**	**Occurs**	**Enum**	**Value Set / Notes**
NTBLCP or TB04	NA	To document NTBLCP or TB04	NTBLCPOrTB04	StringType	R	[0..1]		
LaboratoryName	NA	To document LaboratoryName	LaboratoryName	StringType	R	[1..1]		
LGA	NA	To document LGA	LGA	StringType	R	[0..1]		
Specimen Identification Number	NA	To document Specimen Identification Number	SpecimenIdentificationNumber	Numeric	R	[1..1]		
Date Specimen Was Sent to Laboratory	NA	To document Date Specimen Was Sent to Laboratory	DateSpecimenWasSentToLaboratory	Date	R	[0..1]		
Specimen Status	NA	The documentation of Specimen Status	SpecimenStatus	Coded	R	[0..1]		
Reason for Specimen Rejection	NA	To document Reason for Specimen Rejection	ReasonForSpecimenRejection	StringType	R	[0..1]		
Referring Facility Name	NA	For the documentation of Referring Facility Name	ReferringFacilityName	StringType	R	[0..1]		
Type of TB Presumptive	NA	To document Type of TB Presumptive	TypeOfTBPresumptive	CodedType	R	[0..1]		
TB Site of Disease	NA	The documentation of TB Site of Disease	TBSiteOfDisease	CodedType	R	[0..1]		
Health Care Provider	NA	Documentation of Health Care Provider	HealthCareProvider	CodedType	R	[0..1]		
HIV Status	NA	To document HIV Status of patient	HIVStatus	CodedType	R	[0..1]		
Tested For HIV In the Lab	NA	To document Tested for HIV In the Lab	TestedForHIVInTheLab	CodedType	R	[0..1]		
Specify Type of Specimen	NA	To document Specify Type of Specimen	SpecifyTypeOfSpecimen	Specify Test Required	R	[0..1]		
Specify Test Required	NA	To document Specify Test Required	SpecifyTestRequired	Specify Test Required	R	[0..1]		
Was MTB Detected	NA	For the documentation of Was MTB Detected	WasMTBDetected	Boolean	R	[0..1]		
Specify Detected MTB	NA	For documentation of Specify Detected MTB	SpecifyDetectedMTB	Specify Test Required	R	[0..1]		
Error Code	NA	The field to document Error Code	ErrorCode	Specify Test Required	R	[0..1]		

Invalid or Incomplete Test	NA	The documentation of Invalid or Incomplete Test	InvalidOrIncompleteTest	CodedType	R	[0..1]		
Invalid or Incomplete Test	NA	To document Invalid or Incomplete Test	InvalidOrIncompleteTest	CodedType	R	[0..1]		
AFB- Result	NA	The documentation of AFB-Result	AFBResult	Numeric	R	[0..1]		
Other TB Test Type	NA	To document Other TB Test Type	OtherTBTestType	StringType	R	[0..1]		
Other TB Tests Result	NA	The documentation Other TB Tests Result	OtherTBTestsResult	CodedType	R	[0..1]		
Name of Reporter	NA	The field to document Name of Reporter	NameOfReporter	StringType	R	[0..1]		
Tuberculosis Test Result Date	NA	The field to document Tuberculosis Test Result Date	TuberculosisTestResultDate	Date	R	[0..1]		
TB Remarks	NA	The field to document TB Remarks	TBRemarks	StringType	R	[0..1]		

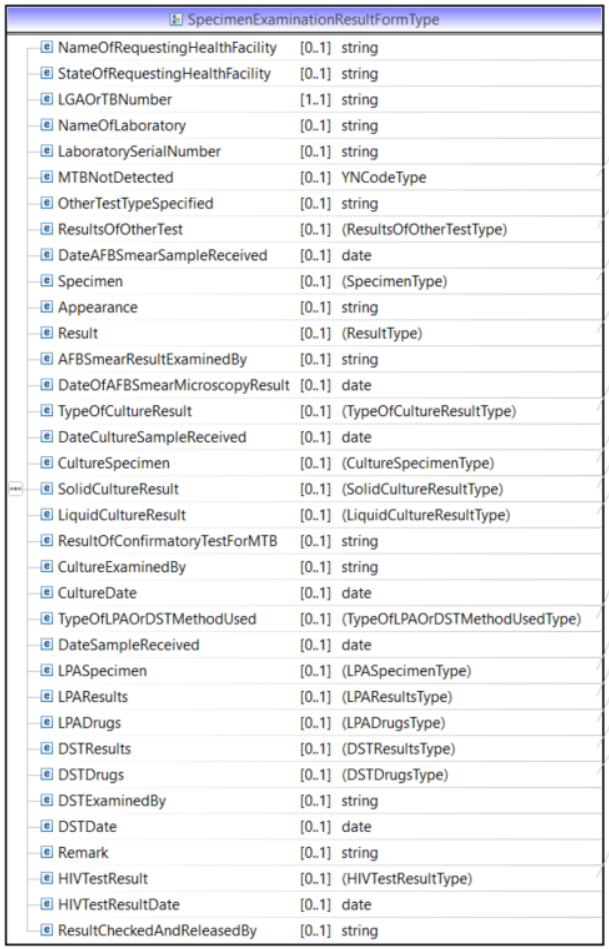
1.1.21 Specimen Examination Request Form Type



Specimen Examination Request Form Type								
Field Name	**Field Identifier**	**Purpose**	**XML Element**	**DT**	**Use**	**Occurs**	**Enum**	**Value Set / Notes**
Specimen Collection Date	NA	To document Specimen Collection Date	SpecimenCollectionDate	Date	R	[0..1]		
Specimen Identification Number	NA	The documentation of Specimen Identification Number	SpecimenIdentificationNumber	StringType	R	[1..1]		
LGA or TB Number	NA	To document LGA or TB Number	LGAOrTBNumber	StringType	R	[1..1]		
Type of Presumptive TB	NA	The field documents Type of Presumptive TB	TypeOfPresumptiveTB	CodedType	R	[0..1]		
Site of Disease	NA	The field to store Site of Disease	SiteOfDisease	CodedType	R	[0..1]		
Is Patient a Health Worker	NA	The documentation of is Patient a Health Worker	IsPatientAHealthWorker	CodedType	R	[0..1]		
HIV Status	NA	The documentation of HIV Status	HIVStatus	CodeType	R	[0..1]		

HIV Test Requested	NA	To document HIV Test Requested	HIVTestRequested	CodeType	R	[0..1]		
Reason for Examination	NA	The documentation of Reason for Examination	ReasonForExamination	CodeType	R	[0..1]		
Test Type Request	NA	The documentation of Test Type Request	TestTypeRequest	CodeType	R	[0..1]		
Other Test Type Request	NA	To document Other Test Type Request	OtherTestTypeRequest	StringType	R	[0..1]		
Type of Specimen	NA	The documentation of Type of Specimen	TypeOfSpecimen	StringType	R	[0..1]		
Number Sent to Laboratory	NA	To documentation Number Sent to Laboratory	NumberSentToLaboratory	NumericType	R	[0..1]		
First Sample Collection Date	NA	The documentation of First Sample Collection Date	FirstSampleCollectionDate	Date	R	[0..1]		
Second Sample Collection Date	NA	To document Second Sample Collection Date	SecondSampleCollectionDate	Date	R	[0..1]		
Name Of Person Requesting Examination	NA	Name Of Person Requesting Examination	NameOfPersonRequestingExaminatio n	StringType	R	[0..1]		
Email	NA	To document Email	Email	StringType	R	[0..1]		
Phone Number	NA	The documentation of Phone Number	PhoneNumber	StringType	R	[0..1]		
Name Of Health Facility	NA	The documentation of Name Of Health Facility	NameOfHealthFacility	StringType	R	[0..1]		
State	NA	To document the State	State	StringType	R	[0..1]		

1.1.22 Specimen Examination Result Form Type

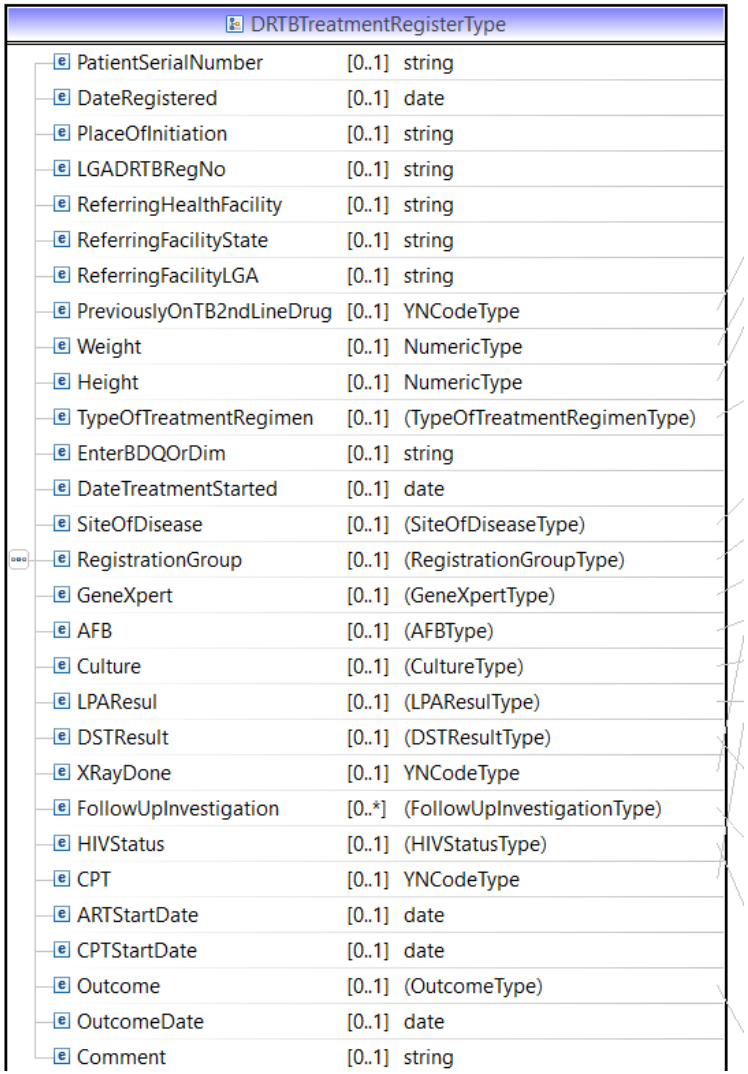


SpecimenExaminationResultFormType		
NameOfRequestingHealthFacility	[0..1]	string
StateOfRequestingHealthFacility	[0..1]	string
LGAOrTBNumber	[1..1]	string
NameOfLaboratory	[0..1]	string
LaboratorySerialNumber	[0..1]	string
MTBNotDetected	[0..1]	YNCodeType
OtherTestTypeSpecified	[0..1]	string
ResultsOfOtherTest	[0..1]	(ResultsOfOtherTestType)
DateAFBSmearSampleReceived	[0..1]	date
Specimen	[0..1]	(SpecimenType)
Appearance	[0..1]	string
Result	[0..1]	(ResultType)
AFBSmearResultExaminedBy	[0..1]	string
DateOfAFBSmearMicroscopyResult	[0..1]	date
TypeOfCultureResult	[0..1]	(TypeOfCultureResultType)
DateCultureSampleReceived	[0..1]	date
CultureSpecimen	[0..1]	(CultureSpecimenType)
SolidCultureResult	[0..1]	(SolidCultureResultType)
LiquidCultureResult	[0..1]	(LiquidCultureResultType)
ResultOfConfirmatoryTestForMTB	[0..1]	string
CultureExaminedBy	[0..1]	string
CultureDate	[0..1]	date
TypeOfLPAOrDSTMethodUsed	[0..1]	(TypeOfLPAOrDSTMethodUsedType)
DateSampleReceived	[0..1]	date
LPASpecimen	[0..1]	(LPASpecimenType)
LPAResults	[0..1]	(LPAResultsType)
LPADrugs	[0..1]	(LPADrugsType)
DSTResults	[0..1]	(DSTResultsType)
DSTDrugs	[0..1]	(DSTDrugsType)
DSTExaminedBy	[0..1]	string
DSTDate	[0..1]	date
Remark	[0..1]	string
HIVTestResult	[0..1]	(HIVTestResultType)
HIVTestResultDate	[0..1]	date
ResultCheckedAndReleasedBy	[0..1]	string

Specimen Examination Result Form Type								
Field Name	**Field Identifier**	**Purpose**	**XML Element**	**DT**	**Use**	**Occurs**	**Enum**	**Value Set / Notes**
Name of Requesting Health Facility	NA	To document Name of Requesting Health Facility	NameOfRequestingHealthFacility	StringType	R	[0..1]		
State of Requesting Health Facility	NA	To document State of Requesting Health Facility	StateOfRequestingHealthFacility	StringType	R	[0..1]		
LGA or TB Number	NA	To document LGA or TB Number	LGAOrTBNumber	StringType	R	[1..1]		
Name of Laboratory	NA	For the documentation of Name of Laboratory	NameOfLaboratory	StringType	R	[0..1]		
Laboratory Serial Number	NA	To document Laboratory Serial Number	LaboratorySerialNumber	StringType	R	[0..1]		
MTB Not Detected	NA	The field to document MTB Not Detected	MTBNotDetected	CodedType	R	[0..1]		
Other Test Type Specified	NA	To document Other Test Type Specified	OtherTestTypeSpecified	StringType	R	[0..1]		
Results of other Test	NA	To document Results of other Test	ResultsOfOtherTest	CodedType	R	[0..1]		
Date AFB Smear Sample Received	NA	For the documentation of Date AFB Smear Sample Received	DateAFBSmearSampleReceived	Date	R	[0..1]		
Specimen	NA	To document Specimen	Specimen	CodedType	R	[0..1]		
Appearance	NA	To document Appearance	Appearance	StringType	R	[0..1]		
Result	NA	For the documentation of Result	Result	Numeric	R	[0..1]		
AFB Smear Result Examined By	NA	To record AFB Smear Result Examined By	AFBSmearResultExaminedBy	StringType	R	[0..1]		
Date of AFB Smear Microscopy Result	NA	To document Date of AFB Smear Microscopy Result	DateOfAFBSmearMicroscopyResult	Date	R	[0..1]		
Type of Culture Result	NA	To record the Type of Culture Result	TypeOfCultureResult	CodedType	R	[0..1]		
Date Culture Sample Received	NA	The documentation of Date Culture Sample Received	DateCultureSampleReceived	Date	R	[0..1]		
Culture Specimen	NA	The documentation of Culture Specimen	CultureSpecimen	CodedType	R	[0..1]		
Solid Culture Result	NA	For the documentation of Solid Culture Result	SolidCultureResult	StringType	R	[0..1]		

Liquid Culture- Result	NA	Liquid Culture- Result	LiquidCultureResult	StringType	R	[0..1]		
Result of Confirmatory Test for MTB	NA	The field is to document Result of Confirmatory Test for MTB	ResultOfConfirmatoryTestForMTB	StringType	R	[0..1]		
Culture Examined By	NA	To document Culture Examined By	CultureExaminedBy	StringType	R	[0..1]		
Culture Date	NA	To document Culture Date	CultureDate	Date	R	[0..1]		
Type of LPA or DST Method Used	NA	To record Type of LPA or DST Method Used	TypeOfLPAOrDSTMethodUsed	CodedType	R	[0..1]		
Date Sample Received	NA	For the documentation of Date Sample Received	DateSampleReceived	Date	R	[0..1]		
LPA Specimen	NA	For the documentation of LPA Specimen	LPASpecimen	CodedType	R	[0..1]		
LPA Results	NA	For the documentation of LPA Results	LPAResults	StringType	R	[0..1]		
LPA Drugs	NA	To document LPA Drugs	LPADrugs	CodedType	R	[0..1]		
DST Results	NA	To document DST Results	DSTResults	StringType	R	[0..1]		
DST Drugs	NA	To document DST Drugs	DSTDrugs	CodedType	R	[0..1]		
DST Examined By	NA	To document DST Examined By	DSTExaminedBy	StringType	R	[0..1]		
DST Date	NA	For the documentation of DST Date	DSTDate	Date	R	[0..1]		
Remark	NA	To document Remark	Remark	StringType	R	[0..1]		
HIV Test Result	NA	For the documentation of HIV Test Result	HIVTestResult	CodedType	R	[0..1]		
HIV Test Result Date	NA	For the documentation of HIV Test Result Date	HIVTestResultDate	Date	R	[0..1]		
Result Checked and Released By	NA	To document Result Checked-And Released By	ResultCheckedAndReleasedBy	StringType	R	[0..1]		

1.1.23 DR-TB Treatment Register Form

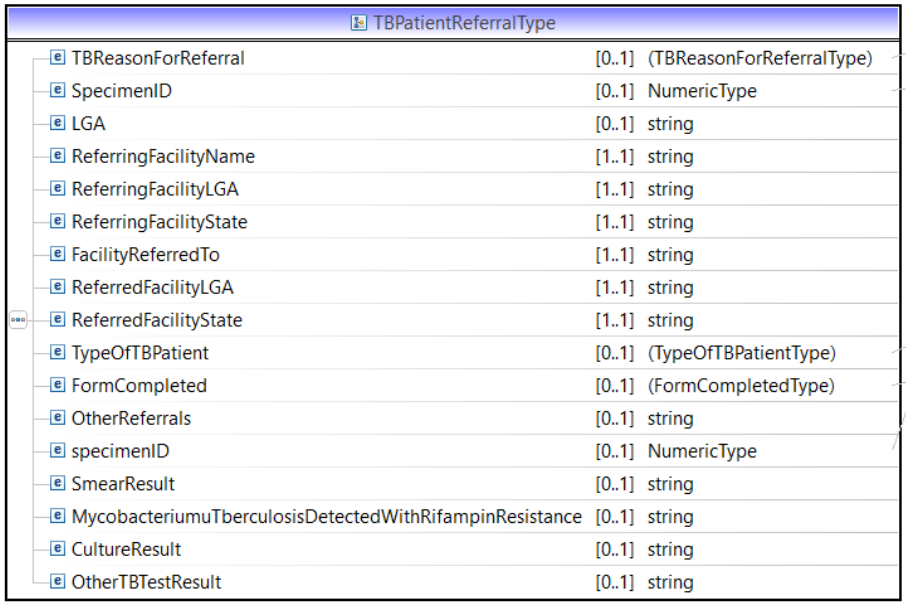


DR-TB Treatment Register Form								
Field Name	**Field Identifier**	**Purpose**	**XML Element**	**DT**	**Use**	**Occurs**	**Enum**	**Value Set / Notes**

Patient Serial Number	NA	To record Patient Serial Number	PatientSerialNumber	StringType	R	[0..1]		
Date Registered	NA	To document Date Registered	DateRegistered	Date	R	[0..1]		
Place Of Initiation	NA	For the documentation of Initiation	PlaceOfInitiation	StringType	R	[1..1]		
LGA DRTB RegNo	NA	To document LGA DRTB RegNo	LGADRTBRegNo	StringType	R	[0..1]		
Referring Health Facility	NA	To document Referring Health Facility	ReferringHealthFacility	StringType	R	[0..1]		
Referring Facility State	NA	For the documentation of Referring Facility State	ReferringFacilityState	StringType	R	[0..1]		
Referring Facility LGA	NA	For the documentation of Referring Facility LGA	ReferringFacilityLGA	StringType	R	[0..1]		
Previously On TB 2nd Line Drug	NA	For the document of Previously On TB 2nd Line Drug	PreviouslyOnTB2ndLineDrug	CodedType	R	[0..1]		
Weight	NA	For the documentation of Weight	Weight	NumericType	R	[0..1]		
Height	NA	To document Height	Height	NumericType	R	[0..1]		
Type f Treatment Regimen	NA	For the storage of Type of Treatment Regimen	TypeOfTreatmentRegimen	CodedType	R	[0..1]		
Enter BDQ Or Dim	NA	The documentation of Enter BDQ Or Dim	EnterBDQOrDim	StringType	R	[0..1]		
Date Treatment Started	NA	The documentation of Date Treatment Started	DateTreatmentStarted	Date	R	[0..1]		
Site of Disease	NA	To record Site of Disease	SiteOfDisease	CodedType	R	[0..1]		
Registration Group	NA	The documentation of Registration Group	RegistrationGroup	CodedType	R	[0..1]		
GeneXpert	NA	The documentation of GeneXpert	GeneXpert	CodedType	R	[0..1]		
AFB	NA	The documentation of AFB	AFB	CodedType	R	[0..1]		
Culture	NA	For the documentation of Culture	Culture	CodeType	R	[0..1]		
LPA Result	NA	For the documentation of LPA Result	LPAResul	CodeType	R	[0..1]		
DST Result	NA	For the documentation of DST Result	DSTResult	CodeType	R	[0..1]		
Xray Done	NA	The documentation of Xray Done	XRayDone	CodeType	R	[0..1]		
Follow Up Investigation	NA	To documentation of Follow Up Investigation	FollowUpInvestigation	CodeType	R	[0..1]		
HIV Status	NA	To document HIV Status	HIVStatus	CodedType	R	[0..1]		

CPT	NA	This documents CPT	CPT	CodedType	R	[0..1]		
ART Start Date	NA	For the documentation ART Start Date	ARTStartDate	Date	R	[0..1]		
CPT Start Date	NA	The documentation of CPT Start Date	CPTStartDate	Date	R	[0..1]		
Outcome	NA	The documentation of Outcome	Outcome	CodedType	R	[0..1]		
Outcome Date	NA	The documentation of Outcome Date	OutcomeDate	Date	R	[0..1]		
Comment	NA	The documentation of Comment	Comment	StringType	R	[0..1]		

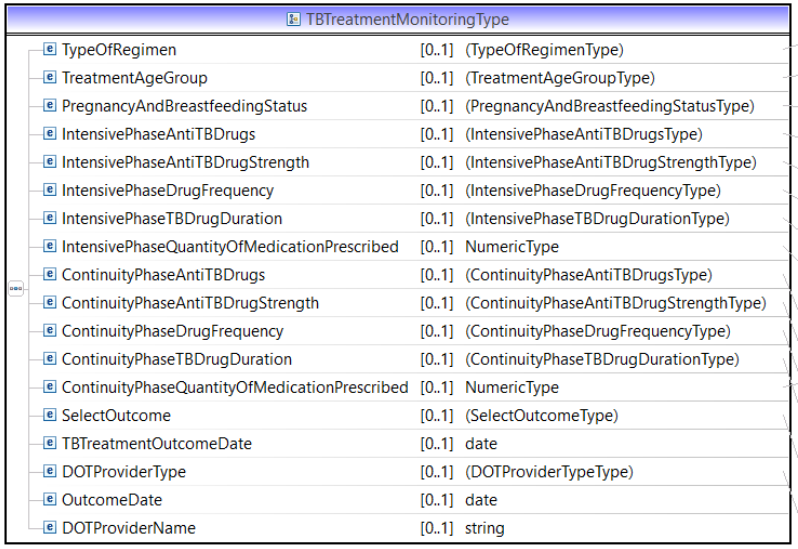
1.1.24 TB Patient Referral or Transfer



TB Patient Referral or Transfer								
Field Name	**Field Identifier**	**Purpose**	**XML Element**	**DT**	**Use**	**Occurs**	**Enum**	**Value Set / Notes**

TB Reason for Referral	NA	To document TB Reason for Referral	TBReasonForReferral	CodeType	R	[0..1]		
Specimen ID	NA	For the documentation of Specimen ID	SpecimenID	NumericType	R	[0..1]		
LGA	NA	To document LGA field	LGA	StringType	R	[0..1]		
Referring Facility Name	NA	To document Referring Facility Name	ReferringFacilityName	StringType	R	[1..1]		
Referring Facility LGA	NA	To document Referring Facility LGA	ReferringFacilityLGA	StringType	R	[1..1]		
Referring Facility State	NA	To document Referring Facility State	ReferringFacilityState	StringType	R	[1..1]		
Facility Referred To	NA	To document Facility Referred To	FacilityReferredTo	StringType	R	[1..1]		
Referred Facility LGA	NA	For the documentation of Referred Facility LGA	ReferredFacilityLGA	StringType	R	[1..1]		
Referred Facility State	NA	For the documentation of Referred Facility State	ReferredFacilityState	StringType	R	[1..1]		
Type Of TB Patient	NA	To documents Type of TB Patient	TypeOfTBPatient	CodedType	R	[1..1]		
Form Completed	NA	For the documentation of Form Completed	FormCompleted	CodedType	R	[0..1]		
Other Referrals	NA	To document other Referrals	OtherReferrals	StringType	R	[0..1]		
Specimen- ID	NA	To document Specimen- ID	specimenID	NumericType	R	[0..1]		
Smear Result	NA	To document Smear Result	SmearResult	StringType	R	[0..1]		
MycobacteriumuTuberculosis Detected With Rifampin Resistance	NA	For the documentation of MycobacteriumuTuberculosis Detected With Rifampin Resistance	MycobacteriumuTberculosisDetected WithRifampinResistance	StringType	R	[0..1]		
Culture Result	NA	For the documentation of Culture Result	CultureResult	StringType	R	[0..1]		
Other TB Test Result	NA	For the documentation of other TB Test Result	OtherTBTestResult	StringType	R	[0..1]		

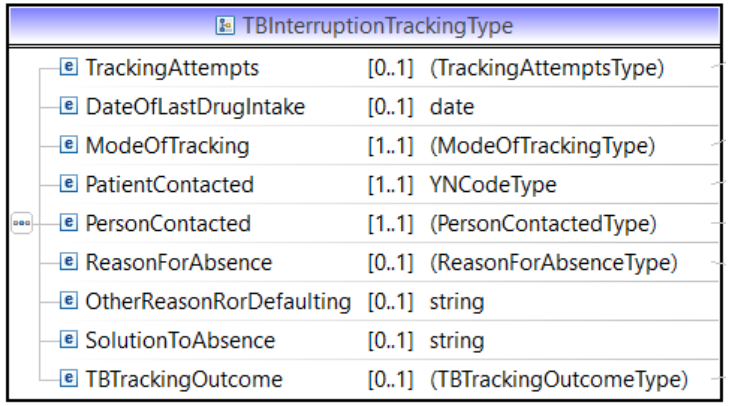
1.1.25 TB Treatment Monitoring Form



TB Treatment Monitoring Type								
Field Name	**Field Identifier**	**Purpose**	**XML Element**	**DT**	**Use**	**Occurs**	**Enum**	**Value Set / Notes**
Type Of Regimen	NA	Type Of Regimen	TypeOfRegimen	CodedType	R	[0..1]		
Treatment Age Group	NA	Treatment Age Group	TreatmentAgeGroup	CodedType	R	[0..1]		
Pregnancy And Breastfeeding Status	NA	Pregnancy And Breastfeeding Status	PregnancyAndBreastfeedingStatus	CodedType	R	[0..1]		
Intensive Phase Anti TB Drugs	NA	Intensive Phase Anti TB Drugs	IntensivePhaseAntiTBDrugs	CodedType	R	[1..1]		
Intensive Phase Anti TB Drug Strength	NA	Intensive Phase Anti TB Drug Strength	IntensivePhaseAntiTBDrugStrength	CodedType	R	[1..1]		
Intensive Phase Drug Frequency	NA	Intensive Phase Drug Frequency	IntensivePhaseDrugFrequency	CodedType	R	[1..1]		
Intensive Phase TB Drug Duration	NA	Intensive Phase TB Drug Duration	IntensivePhaseTBDrugDuration	CodedType	R	[1..1]		
Intensive Phase Quantity of Medication Prescribed	NA	Intensive Phase Quantity of Medication Prescribed	IntensivePhaseQuantityOfMedicationPrescribed	NumericType	R	[1..1]		
Continuity Phase Anti TB Drugs	NA	Continuity Phase Anti TB Drugs	ContinuityPhaseAntiTBDrugs	CodedType	R	[0..1]		

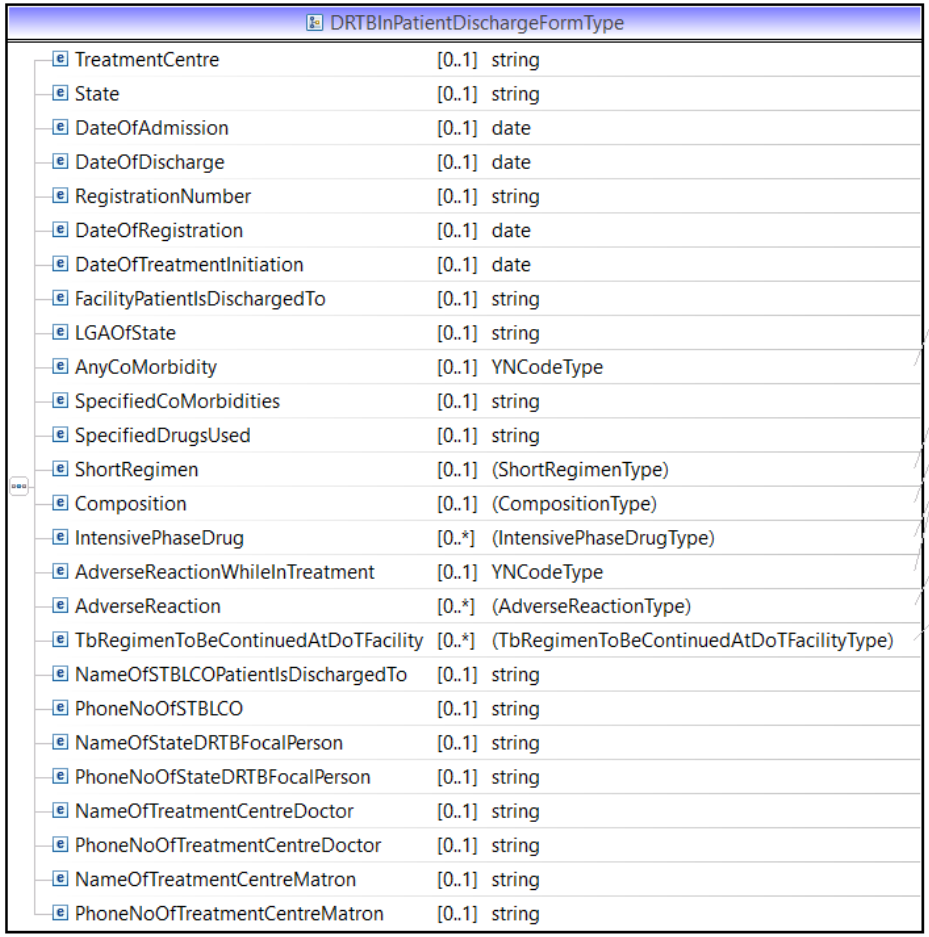
Continuity Phase Anti TB Drug Strength	NA	Continuity Phase Anti TB Drug Strength	ContinuityPhaseAntiTBDrugStrength	CodedType	R	[0..1]		
Continuity Phase Drug Frequency	NA	Continuity Phase Drug Frequency	ContinuityPhaseDrugFrequency	CodedType	R	[0..1]		
Continuity Phase TB Drug Duration	NA	Continuity Phase TB Drug Duration	ContinuityPhaseTBDrugDuration	CodedType	R	[0..1]		
Continuity Phase Quantity of Medication Prescribed	NA	Continuity Phase Quantity of Medication Prescribed	ContinuityPhaseQuantityOfMedication Prescribed	NumericType	R	[0..1]		
Select Outcome	NA	Select Outcome	SelectOutcome	CodedType	R	[0..1]		
TB Treatment Outcome Date	NA	TB Treatment Outcome Date	TBTreatmentOutcomeDate	Date	R	[0..1]		
DOT Provider Type	NA	DOT Provider Type	DOTProviderType	CodedType	R	[0..1]		
Outcome Date	NA	Outcome Date	OutcomeDate	Date	R	[0..1]		
DOT Provider Name		DOT Provider Name	DOTProviderName	StringType	R	[0..1]		

1.1.26 TB Interruption Tracking Type



TB Interruption Tracking Type								
Field Name	**Field Identifier**	**Purpose**	**XML Element**	**DT**	**Use**	**Occurs**	**Enum**	**Value Set / Notes**
Tracking Attempts	NA	To document Tracking Attempts	TrackingAttempts	Coded	R	[0..1]		
Date of Last Drug Intake	NA	To document Date of Last Drug Intake	DateOfLastDrugIntake	Date	R	[0..1]		
Mode of Tracking	NA	The documentation of Mode of Tracking	ModeOfTracking	Coded	R	[0..1]		
Patient Contacted	NA	To record Patient Contacted	PatientContacted	Coded	R	[0..1]		
Person Contacted	NA	To capture Person Contacted	PersonContacted	Coded	R	[0..1]		
Reason For Absence	NA	To document the Reason For Absence	ReasonForAbsence	Coded	R	[0..1]		
Other Reason or Defaulting	NA	To document Other Reason or Defaulting	OtherReasonRorDefaulting	String	R	[0..1]		
Solution to Absence	NA	The field documents Solution to Absence	SolutionToAbsence	String	R	[0..1]		
TB Tracking Outcome	NA	To document TB Tracking Outcome	TBTrackingOutcome	Coded	R	[0..1]		

1.1.27 DR-TB In-Patient Discharge Form



DR-TB In-Patient Discharge Form								
Field Name	**Field Identifier**	**Purpose**	**XML Element**	**DT**	**Use**	**Occurs**	**Enum**	**Value Set / Notes**

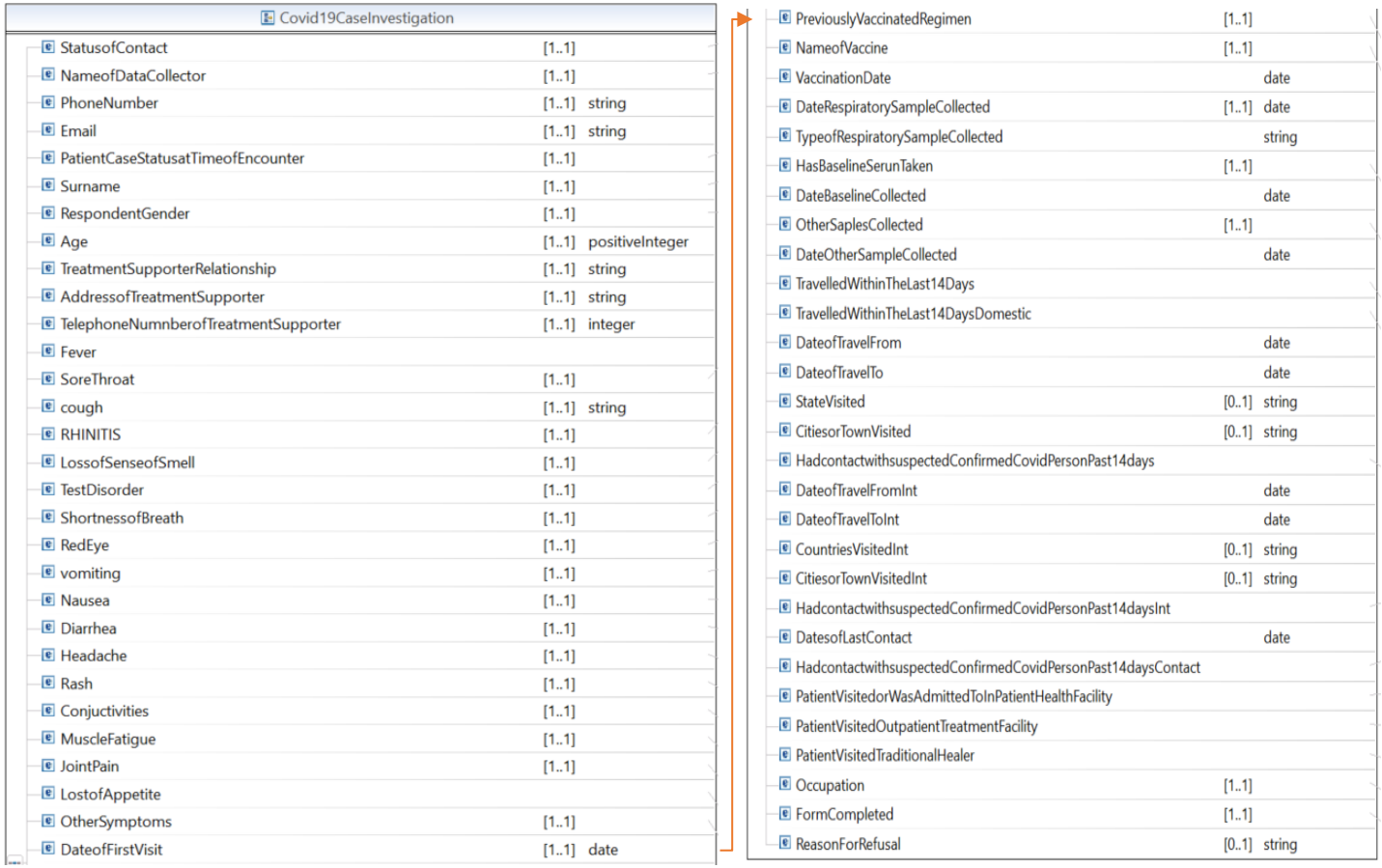
Treatment Centre	NA	The Treatment Centre	TreatmentCentre	String	R	[0..1]		
State	NA	The documentation of State of program implementation	State	String	R	[0..1]		
Date Of Admission	NA	To document Date of Admission	DateOfAdmission	Date	R	[0..1]		
Date Of Discharge	NA	The documentation of Date of Discharge	DateOfDischarge	Date	R	[0..1]		
Registration Number	NA	The documentation Registration Number	RegistrationNumber	String	R	[0..1]		
Date of Registration	NA	To document Date of Registration	DateOfRegistration	Date	R	[0..1]		
Date Of Treatment Initiation	NA	To document Date Of Treatment Initiation	DateOfTreatmentInitiation	Date	R	[0..1]		
Facility Patient is Discharged To	NA	To record detail of Facility Patient is Discharged To	FacilityPatientIsDischargedTo	String	R	[0..1]		
LGA of State	NA	LGA of State	LGAOfState	String	R	[0..1]		
Any Co Morbidity	NA	The documentation of Any Co Morbidity	AnyCoMorbidity	Coded	R	[0..1]		
Specified Co Morbidities	NA	Specified Co Morbidities	SpecifiedCoMorbidities	String	R	[0..1]		
Specified Drugs Used	NA	Specified Drugs Used	SpecifiedDrugsUsed	String	R	[0..1]		
Short Regimen	NA	To document Short Regimen	ShortRegimen	Coded	R	[0..1]		
Composition	NA	To document Composition	Composition	Coded	R	[0..1]		
Intensive Phase Drug	NA	The documentation of Intensive Phase Drug	IntensivePhaseDrug	Coded	R	[0..1]		
Adverse Reaction While in Treatment	NA	To document Adverse Reaction While in Treatment	AdverseReactionWhileInTreatment	Coded	R	[0..1]		
Adverse Reaction	NA	The documentation Adverse Reaction	AdverseReaction	Coded	R	[0..1]		
TB Regimen to Be Continued at DoT Facility	NA	To record TB Regimen to Be Continued at DoT Facility	TbRegimenToBeContinuedAtDoTFacility	Coded	R	[0..1]		
Name Of STB LCO Patient is Discharged to	NA	To document the Name Of STB LCO Patient is Discharged to	NameOfSTBLCOPatientIsDischargedTo	String	R	[0..1]		
Phone No of STBLCO	NA	The documentation of Phone No of STBLCO	PhoneNoOfSTBLCO	String	R	[0..1]		
Name Of State DRTB Focal Person	NA	The documentation Name Of State DRTB Focal Person	NameOfStateDRTBFocalPerson	String	R	[0..1]		

Phone No of State DRTB Focal Person	NA	To document Phone No of State DRTB Focal Person	PhoneNoOfStateDRTBFocalPerson	String	R	[0..1]		
Phone No of Treatment Centre Doctor	NA	The documentation of Phone No of Treatment Centre Doctor	PhoneNoOfTreatmentCentreDoctor	String	R	[0..1]		
Name of Treatment Matron	NA	To document the Name of Treatment Matron	NameofTreatmentMatron	String	R	[0..1]		
Phone No of Treatment Centre Matron	NA	To document Phone No of Treatment Centre Matron	PhoneNoOfTreatmentCentreMatron	String	R	[0..1]		
Name Of Treatment Centre Doctor	NA	To document the Name Of Treatment Centre Doctor	NameOfTreatmentCentreDoctor	String	R	[0..1]		

1.1.28 TB Referral for Community and Facility

1.1.29 Referring facility name

1.1.30 COVID-19 Case Investigation



Covid19CaseInvestigation		
StatusofContact	[1..1]	
NameofDataCollector	[1..1]	
PhoneNumber	[1..1]	string
Email	[1..1]	string
PatientCaseStatusatTimeofEncounter	[1..1]	
Surname	[1..1]	
RespondentGender	[1..1]	
Age	[1..1]	positiveInteger
TreatmentSupporterRelationship	[1..1]	string
AddressofTreatmentSupporter	[1..1]	string
TelephoneNumnberofTreatmentSupporter	[1..1]	integer
Fever		
SoreThroat	[1..1]	
cough	[1..1]	string
RHINITIS	[1..1]	
LossofSenseofSmell	[1..1]	
TestDisorder	[1..1]	
ShortnessofBreath	[1..1]	
RedEye	[1..1]	
vomiting	[1..1]	
Nausea	[1..1]	
Diarrhea	[1..1]	
Headache	[1..1]	
Rash	[1..1]	
Conjuctivities	[1..1]	
MuscleFatigue	[1..1]	
JointPain	[1..1]	
LostofAppetite		
OtherSymptoms	[1..1]	
DateofFirstVisit	[1..1]	date
PreviouslyVaccinatedRegimen	[1..1]	
NameofVaccine	[1..1]	
VaccinationDate		date
DateRespiratorySampleCollected	[1..1]	date
TypeofRespiratorySampleCollected		string
HasBaselineSerunTaken	[1..1]	
DateBaselineCollected		date
OtherSaplesCollected	[1..1]	
DateOtherSampleCollected		date
TravelledWithinTheLast14Days		
TravelledWithinTheLast14DaysDomestic		
DateofTravelFrom		date
DateofTravelTo		date
StateVisited	[0..1]	string
CitiesorTownVisited	[0..1]	string
HadcontactwithsuspectedConfirmedCovidPersonPast14days		
DateofTravelFromInt		date
DateofTravelToInt		date
CountriesVisitedInt	[0..1]	string
CitiesorTownVisitedInt	[0..1]	string
HadcontactwithsuspectedConfirmedCovidPersonPast14daysInt		
DatesofLastContact		date
HadcontactwithsuspectedConfirmedCovidPersonPast14daysContact		
PatientVisitedorWasAdmittedToInPatientHealthFacility		
PatientVisitedOutpatientTreatmentFacility		
PatientVisitedTraditionalHealer		
Occupation	[1..1]	
FormCompleted	[1..1]	
ReasonForRefusal	[0..1]	string

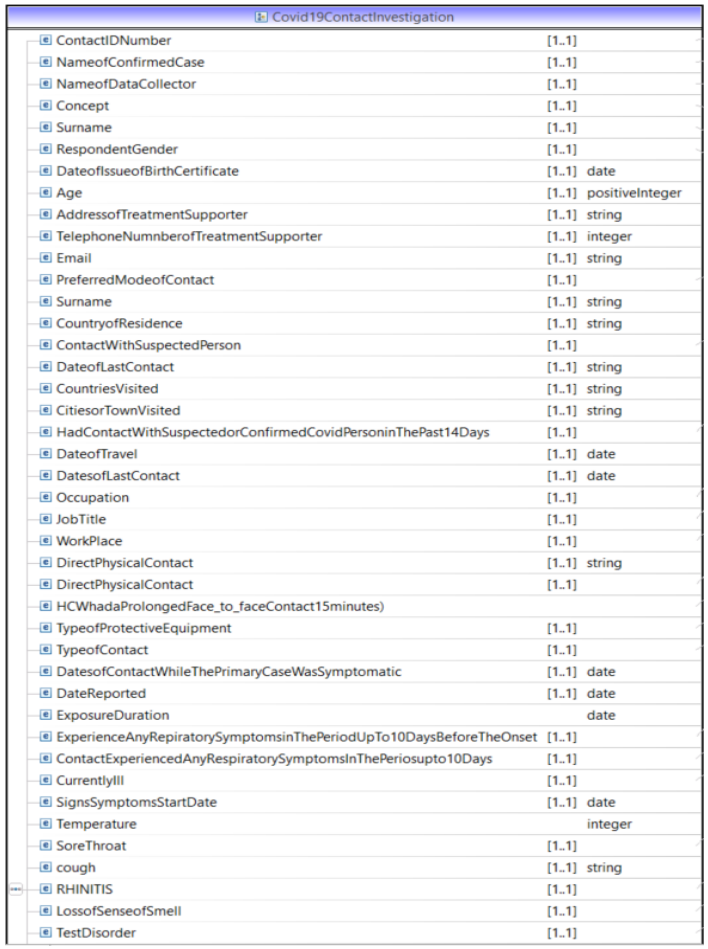
COVID19 Case Investigation Form								
Field Name	**Field Identifier**	**Purpose**	**XML Element**	**DT**	**Use**	**Occurs**	**Enum**	**Value Set / Notes**
Status of Contact	NA	The variable documents patient's status of contact status of patient	StatusofContact	String	R	[0..1]		
Name of Data Collector	NA	The documentation of data collector name	NameofDataCollector	String	R	[0..1]		
Phone Number	NA	Documents the phone number of data collector	PhoneNumber	String	R	[0..1]		
Email	NA	Stores email address of the collector.	Email	String	R	[0..1]		
Patient Case Status at Time of Encounter	NA	This variable document patient case status at time of encounter	PatientCaseStatusatTimeofEncounter	CodeType	R	[0..1]		
Surname	NA	The documentation of patient surname	Surname	String	R	[0..1]		
Respondent Gender	NA	Respondent gender documentation	RespondentGender	String	R	[0..1]		
Age	NA	The documentation of patient age	Age	Integer	R	[0..1]		
Treatment Supporter Relationship	NA	The field documents relationship with treatment supporter	TreatmentSupporterRelationship	String	R	[0..1]		
Address of Treatment Supporter	NA	Documents treatment supporter address	AddressofTreatmentSupporter	String	R	[0..1]		
Telephone Number of Treatment Supporter	NA	The field documents telephone number of treatment supporter	TelephoneNumberofTreatmentSupporter	CodeType	R	[0..1]		
Fever	NA	The field records information on fever	Fever	CodeType	R	[0..1]		
Sore Throat	NA	Sore throat documentation of the patient	SoreThroat	CodeType	R	[0..1]		
Cough	NA	The field documents cough information	cough	CodeType	R	[0..1]		
RHINITIS	NA	The documentation of RHINITIS in COVID-19 program	RHINITIS	CodeType	R	[0..1]		
Loss of Sense of Smell	NA	The documentation of loss of Sense of smell on the form	LossofSenseofSmell	CodeType	R	[0..1]		
Test Disorder	NA	The variable stores test disorder	TestDisorder	CodeType	R	[0..1]		

Shortness of Breath	NA	The documentation of Shortness of Breath	ShortnessofBreath	CodeType	R	[0..1]		
Red Eye	NA	Here the patient is examined for red eye	RedEye	CodeType	R	[0..1]		
Vomiting	NA	The field documents the patient's if the patient vomits	vomiting	CodeType	R	[0..1]		
Nausea	NA	The documentation of nausea	Nausea	CodeType	R	[0..1]		
Diarrhea	NA	This field documents diarrhea condition of the patient	Diarrhea	CodeType	R	[0..1]		
Headache	NA	The field captures information on patient's headache	Headache	CodeType	R	[0..1]		
Rash	NA	To document rash information	Rash	CodeType	R	[0..1]		
conjunctivitis	NA	The documentation of conjunctivitis	Conjunctivitis	CodeType	R	[0..1]		
Muscle Fatigue	NA	To document muscle fatigue	MuscleFatigue	CodeType	R	[0..1]		
Joint Pain	NA	The documentation of joint pain of a patient	JointPain	CodeType	R	[0..1]		
Loss of Appetite	NA	To record loss of appetite	LossofAppetite	CodeType	R	[0..1]		
Other Symptoms	NA	The documentation of other symptoms	OtherSymptoms	CodeType	R	[0..1]		
Date of First Visit	NA	Recoding of date of first visit	DateofFirstVisit	CodeType	R	[0..1]		
Previously Vaccinated	NA	To document previously vaccinated	PreviouslyVaccinated	CodeType	R	[0..1]		
Previously Vaccinated Regimen	NA	The capturing of previously vaccinated regimen	PreviouslyVaccinatedRegimen	CodeType	R	[0..1]		
Name of Vaccine	NA	The recording of name of vaccine	NameofVaccine	StringType	R	[0..1]		
Vaccination Date	NA	The documentation of vaccination date	VaccinationDate	Date	R	[0..1]		
Date Respiratory Sample Collected	NA	To document date respiratory sample collected	DateRespiratorySampleCollected	Date	R	[0..1]		
Type of Respiratory Sample Collected	NA	To document the type of respiratory sample collected	TypeofRespiratorySampleCollected	CodeType	R	[0..1]		
Has Baseline SerunTaken	NA	To know if baseline Serun has been taken	HasBaselineSerunTaken	CodeType	R	[0..1]		

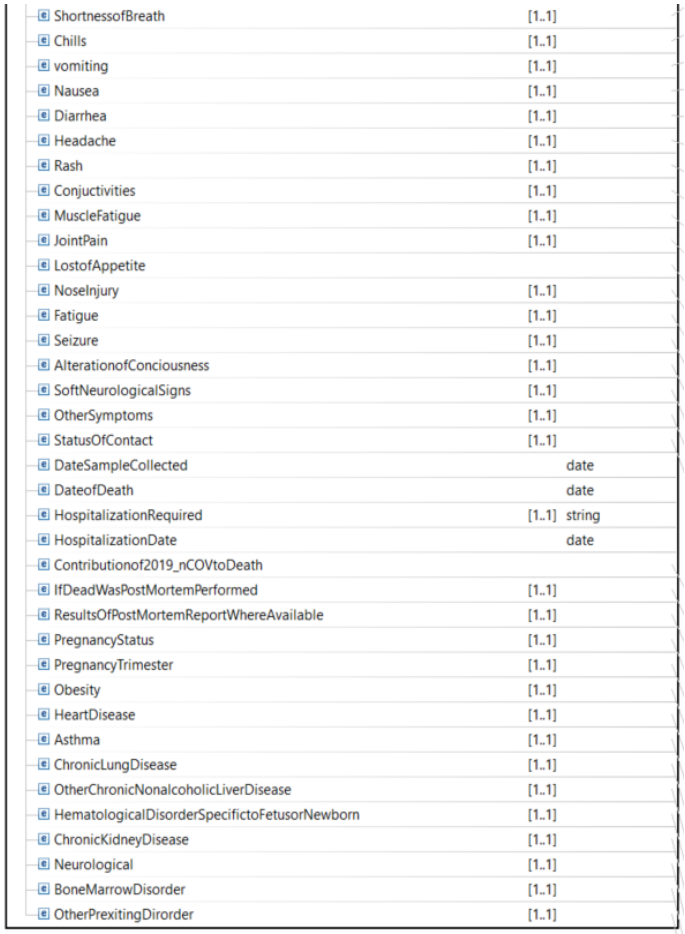
Date Baseline Collected	NA	To document date baseline collected	DateBaselineCollected	Date	R	[0..1]		
Other Samples Collected	NA	To document other samples collected	OtherSamplesCollected	CodeType	R	[0..1]		
Date Other Sample Collected	NA	The documentation of date other sample collected	DateOtherSampleCollected	Date	R	[0..1]		
Travelled Within The Last 14 Days	NA	To document information on travelled within the last 14 days	TravelledWithinTheLast14Days	CodeType	R	[0..1]		
Travelled Within The Last 14 Days Domestic	NA	To record information on travelled within the last 14 days domestic	TravelledWithinTheLast14DaysDomestic	CodeType	R	[0..1]		
Date of Travel From	NA	To document date of travel from	DateofTravelFrom	Date	R	[0..1]		
Date of Travel To	NA	To record date of travel to	DateofTravelTo	Date	R	[0..1]		
State Visited	NA	The documentation of state visited	StateVisited	String	R	[0..1]		
Cities or Town Visited	NA	Information of cities or town visited	CitiesorTownVisited	String	R	[0..1]		
Had contact with suspected Confirmed Covid Person Past 14 days	NA	To document information on had contact with suspected confirmed covid person past 14 days	HadcontactwithsuspectedConfirmedCovidPersonPast14days	CodeType	R	[0..1]		
Date of Travel From	NA	To document the date of travel from	DateofTravelFrom	Date	R	[0..1]		
Date of Travel To	NA	The documentation of date of travel to	DateofTravelTo	Date	R	[0..1]		
Countries Visited	NA	This field documents countries visited	CountriesVisited	StringType	R	[0..1]		
Cities or Town Visited	NA	The field documents cities or town visited	CitiesorTownVisited	StringType	R	[0..1]		
Had contact with suspected Confirmed Covid Person Past 14 days	NA	The record if the patient had contact with suspected confirmed covid person past 14 days	HadcontactwithsuspectedConfirmedCovidPersonPast14daysInt	CodeTypS	R	[0..1]		
Dates of Last Contact	NA	The documentation of dates of last contact	DatesofLastContact	Date	R	[0..1]		
Had contact with suspected Confirmed Covid Person Past 14 days Contact	NA	To record if the patient had contact with suspected confirmed covid person past 14 days contact	HadcontactwithsuspectedConfirmedCovidPersonPast14daysContact	CodeType	R	[0..1]		

Patient Visited or Was Admitted To Patient Health Facility	NA	Patient visited or was admitted to patient health facility	PatientVisitedorWasAdmittedToInPatientHealthFacility	CodeType	R	[0..1]		
Patient Visited Outpatient Treatment Facility	NA	The documentation of patient visited outpatient treatment Facility	PatientVisitedOutpatientTreatmentFacility	CodeType	R	[0..1]		
Patient Visited Traditional Healer	NA	The field records Patient Visited Traditional Healer	PatientVisitedTraditionalHealer	CodeType	R	[0..1]		
Occupation	NA	The documentation of Occupation	Occupation	String	R	[0..1]		

1.1.31 COVID 19 Contact investigation



Covid19ContactInvestigation		
ContactIDNumber	[1..1]	
NameofConfirmedCase	[1..1]	
NameofDataCollector	[1..1]	
Concept	[1..1]	
Surname	[1..1]	
RespondentGender	[1..1]	
DateofIssueofBirthCertificate	[1..1]	date
Age	[1..1]	positiveInteger
AddressofTreatmentSupporter	[1..1]	string
TelephoneNumnberofTreatmentSupporter	[1..1]	integer
Email	[1..1]	string
PreferredModeofContact	[1..1]	
Surname	[1..1]	string
CountryofResidence	[1..1]	string
ContactWithSuspectedPerson	[1..1]	
DateofLastContact	[1..1]	string
CountriesVisited	[1..1]	string
CitiesorTownVisited	[1..1]	string
HadContactWithSuspectedorConfirmedCovidPersoninThePast14Days	[1..1]	
DateofTravel	[1..1]	date
DatesofLastContact	[1..1]	date
Occupation	[1..1]	
JobTitle	[1..1]	
WorkPlace	[1..1]	
DirectPhysicalContact	[1..1]	string
DirectPhysicalContact	[1..1]	
HCWhadaProlongedFace_to_faceContact15minutes)		
TypeofProtectiveEquipment	[1..1]	
TypeofContact	[1..1]	
DatesofContactWhileThePrimaryCaseWasSymptomatic	[1..1]	date
DateReported	[1..1]	date
ExposureDuration		date
ExperienceAnyRepiratorySymptomsinThePeriodUpTo10DaysBeforeTheOnset	[1..1]	
ContactExperiencedAnyRespiratorySymptomsInThePeriosupto10Days	[1..1]	
CurrentlyIll	[1..1]	
SignsSymptomsStartDate	[1..1]	date
Temperature		integer
SoreThroat	[1..1]	
cough	[1..1]	string
RHINITIS	[1..1]	
LossofSenseofSmell	[1..1]	
TestDisorder	[1..1]	



ShortnessofBreath	[1..1]	
Chills	[1..1]	
vomiting	[1..1]	
Nausea	[1..1]	
Diarrhea	[1..1]	
Headache	[1..1]	
Rash	[1..1]	
Conjuctivities	[1..1]	
MuscleFatigue	[1..1]	
JointPain	[1..1]	
LostofAppetite		
NoseInjury	[1..1]	
Fatigue	[1..1]	
Seizure	[1..1]	
AlterationofConciousness	[1..1]	
SoftNeurologicalSigns	[1..1]	
OtherSymptoms	[1..1]	
StatusOfContact	[1..1]	
DateSampleCollected		date
DateofDeath		date
HospitalizationRequired	[1..1]	string
HospitalizationDate		date
Contributionof2019_nCOVtoDeath		
IfDeadWasPostMortemPerformed	[1..1]	
ResultsOfPostMortemReportWhereAvailable	[1..1]	
PregnancyStatus	[1..1]	
PregnancyTrimester	[1..1]	
Obesity	[1..1]	
HeartDisease	[1..1]	
Asthma	[1..1]	
ChronicLungDisease	[1..1]	
OtherChronicNonalcoholicLiverDisease	[1..1]	
HematologicalDisorderSpecifictoFetusorNewborn	[1..1]	
ChronicKidneyDisease	[1..1]	
Neurological	[1..1]	
BoneMarrowDisorder	[1..1]	
OtherPrexitingDirorder	[1..1]	

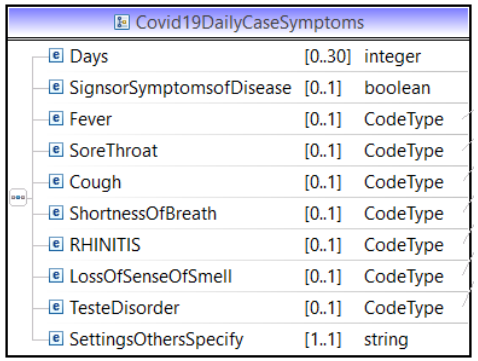
COVID19 Contact Investigation								
Field Name	**Field Identifier**			**DT**	**Use**	**Occurs**	**Enum**	**Value Set / Notes**
Contact ID Number	NA	The documentation of contact ID number	ContactIDNumber	StringType	R	[0..1]		
Name of Confirmed Case	NA	To document the name of confirmed case	NameofConfirmedCase	StringType	R	[0..1]		
Name of Data Collector	NA	Name of data collector	NameofDataCollector	StringType	R	[0..1]		
Surname	NA	The documentation of surname	Surname	StringType	R	[0..1]		
Respondent Gender	NA	To record respondent gender	RespondentGender	CodeType	R	[0..1]		
Date of Issue of Birth Certificate	NA	To document date of issue of birth certificate	DateofIssueofBirthCertificate	Date	R	[0..1]		
Age	NA	The documentation of age	Age	Integer	R	[0..1]		
Address of Treatment Supporter	NA	The documentation of address of treatment supporter	AddressofTreatmentSupporter	StringType	R	[0..1]		
Telephone Number of Treatment Supporter	NA	To document telephone number of treatment supporter	TelephoneNumberofTreatmentSupporter	IntegerType	R	[0..1]		
Email	NA	To document patient email	Email	StringType	R	[0..1]		
Preferred Model of Contact	NA	The recording of referred model of contact	PreferredModelofContact	CodeType	R	[0..1]		
Surname	NA	To document surname	Surname	StringType	R	[0..1]		
Country of Residence	NA	To document country of residence	Countryof Residence	StringType	R	[0..1]		
Contact With Suspected Person	NA	The documentation of contact with suspected person	ContactWithSuspectedPerson	StringType	R	[0..1]		
Date of Last Contact	NA	The documentation of date of last contact	DateofLastContact	Date	R	[0..1]		
Countries Visited	NA	The documentation of countries visited	CountriesVisited	StringType	R	[0..1]		
Cities or Town Visited	NA	The documentation of cities or town visited	CitiesorTownVisited	StringType	R	[0..1]		
Had contact with Suspected or Confirmed Covid Person in The Past 14 Days	NA	To document had contact with suspected or confirmed covid person in the past 14 days	HadContactWithSuspectedorConfirmedCovidPersoninThePast14Days	CodeType	R	[0..1]		
Date of Travel	NA	To record date of travel	DateofTravel	Date	R	[0..1]		

Dates of Last Contact	NA	To document dates of last contact	DatesofLastContact	date	R	[0..1]		
Occupation	NA	The field that records occupation	Occupation	CodeType	R	[0..1]		
Job Title	NA	To document job title	JobTitle	CodeType	R	[0..1]		
Workplace	NA	To document workplace	WorkPlace	CodeType	R	[0..1]		
Direct Physical Contact	NA	To input direct physical contact	DirectPhysicalContact	CodeType	R	[0..1]		
Direct Physical Contact	NA	To document direct physical contact	DirectPhysicalContact	CodeType	R	[0..1]		
HCWhada Prolonged face-to-face Contact 15 minutes)	NA	A filed for HCWhada prolonged face-to-face contact 15 minutes)	HCWhadaProlongedFace_to_faceContact15minutes)	CodeType	R	[0..1]		
Type of Protective Equipment	NA	To document type of protective equipment	TypeofProtectiveEquipment	CodeType	R	[0..1]		
Type of Contact	NA	The document of type of contact	TypeofContact	CodeType	R	[0..1]		
Dates of Contact while the Primary Case was Symptomatic	NA	To document dates of contact while the primary case was symptomatic	DatesofContactWhileThePrimaryCaseWasSymptomatic	Date	R	[0..1]		
Date Reported	NA	The documentation of date reported	DateReported	date	R	[0..1]		
Exposure Duration	NA	To document exposure duration	ExposureDuration	StringType	R	[0..1]		
Experience any Respiratory Symptoms in the period up to 10 days before the on set	NA	To document experience any respiratory symptoms in the period up to 10 days before the on set	ExperienceAnyRepiratorySymptomsinThePeriodUpTo10DaysBeforeTheOnset	CodeType	R	[0..1]		
Contact Experienced any Respiratory Symptoms in the Periods up to10 Days	NA	The documentation of contact experienced any respiratory symptoms in the periods up to 10 days	ContactExperiencedAnyRespiratorySymptomsInThePeriosupto10Days	CodeType	R	[0..1]		
Currently Ill	NA	To document currently Ill	CurrentlyIll	CodeType	R	[0..1]		
Signs Symptoms Start Date	NA	To document signs symptoms start date	SignsSymptomsStartDate	Date	R	[0..1]		
Temperature	NA	The documentation of temperature	Temperature	Integer	R	[0..1]		
Sore Throat	NA	To document sore throat	SoreThroat	CodeType	R	[0..1]		
cough	NA	To document cough	cough	CodeType	R	[0..1]		
RHINITIS	NA	The documentation of RHINITIS	RHINITIS	CodeType	R	[0..1]		

Loss of Sense of Smell	NA	The documentation of loss of sense of smell	LossofSenseofSmell	CodeType	R	[0..1]		
Test Disorder	NA	To document test disorder	TestDisorder	CodeType	R	[0..1]		
Shortness of Breath	NA	To document shortness of breath	ShortnessofBreath	CodeType	R	[0..1]		
Chills	NA	To document chills	Chills	CodeType	R	[0..1]		
vomiting	NA	The documentation of vomiting	vomiting	CodeType	R	[0..1]		
Nausea	NA	To document nausea	Nausea	CodeType	R	[0..1]		
Diarrhea	NA	The field will document diarrhea	Diarrhea	CodeType	R	[0..1]		
Headache	NA	To document headache	Headache	CodeType	R	[0..1]		
Rash	NA	The documentation of Rash	Rash	CodeType	R	[0..1]		
Conjunctivitis	NA	To document Conjunctivitis	Conjunctivitis	CodeType	R	[0..1]		
Muscle Fatigue	NA	To document Muscle Fatigue	MuscleFatigue	CodeType	R	[0..1]		
Joint Pain	NA	To document Joint Pain	JointPain	CodeType	R	[0..1]		
Lost of Appetite	NA	To document Loss of Appetite	LostofAppetite	CodeType	R	[0..1]		
Nose Injury	NA	The documentation of Nose Injury	NoseInjury	CodeType	R	[0..1]		
Fatigue	NA	The field will document Fatigue	Fatigue	CodeType	R	[0..1]		
Seizure	NA	The documentation of Seizure	Seizure	CodeType	R	[0..1]		
Alteration of Consciousness	NA	To document Alteration of Consciousness	AlterationofConciousness	CodeType	R	[0..1]		
Soft Neurological Signs	NA	To document Soft Neurological Signs	SoftNeurologicalSigns	CodeType	R	[0..1]		
Other Symptoms	NA	To document Other Symptoms	OtherSymtops	CodeType	R	[0..1]		
Status of Contact	NA	To document Status of Contact	StatusOfContact	CodeType	R	[0..1]		
Date Sample Collected	NA	Date Sample Collected	DateSampleCollected	Date	R	[0..1]		
Date of Death	NA	The document Date of Death	DateofDeath	Date	R	[0..1]		
Hospitalization Required	NA	To document Hospitalization Required	HospitalizationRequired	CodeType	R	[0..1]		
Hospitalization Date	NA	To document Hospitalization Date	HospitalizationDate	Date	R	[0..1]		
Contribution of 2019_n COV to Death	NA	To document Contribution of 2019_n COV to Death	Contributionof2019_nCOVtoDeath	CodeType	R	[0..1]		
Discharged Date Time	NA	Documentation of Discharged Date Time	DischargedDateTime	date	R	[0..1]		

If Dead was Postmortem Performed	NA	The documentation of If Dead was Postmortem Performed	IfDeadWasPostMortemPerformed	CodeType	R	[0..1]		
Results of Postmortem Report where Available	NA	The documentation of Results of Postmortem Report where Available	ResultsOfPostMortemReportWhereAvailable	CodeType	R	[0..1]		
Pregnancy Status	NA	The documentation of Pregnancy Status	PregnancyStatus	CodeType	R	[0..1]		
Pregnancy Trimester	NA	To document Pregnancy Trimester	PregnancyTrimester	CodeType	R	[0..1]		
Obesity	NA	The documentation of Obesity	Obesity	CodeType	R	[0..1]		
Heart Disease	NA	To document heart disease	HeartDisease	CodeType	R	[0..1]		
Asthma	NA	The documentation of Asthma	Asthma	CodeType	R	[0..1]		
Chronic Lung Disease	NA	To document Chronic Lung Disease	ChronicLungDisease	CodeType	R	[0..1]		
Other Chronic Nonalcoholic Liver Disease	NA	To document other Chronic Nonalcoholic Liver Disease	OtherChronicNonalcoholicLiverDisease	CodeType	R	[0..1]		
Hematological Disorder Specific to Fetus or Newborn	NA	To document Hematological Disorder Specific to Fetus or Newborn	HematologicalDisorderSpecifictoFetusorNewborn	CodeType	R	[0..1]		
Chronic Kidney Disease	NA	The documentation of Chronic Kidney Disease	ChronicKidneyDisease	CodeType	R	[0..1]		
Neurological	NA	The documentation of Neurological	Neurological	CodeType	R	[0..1]		
Bone Marrow Disorder	NA	The documentation of Bone Marrow Disorder	BoneMarrowDisorder	CodeType	R	[0..1]		
Other Preexisting Disorder	NA	The documentation of other Preexisting Disorder	OtherPreexitingDisorder	CodeType	R	[0..1]		

1.1.32 COVID-19 Daily Case Symptom



COVID-19 Daily Cases Symptoms								
Field Name	**Field Identifier**	**Purpose**	**XML Element**	**DT**	**Use**	**Occurs**	**Enum**	**Value Set / Notes**
Days	NA	Days	Days	Integer	R	[0..1]		
Signs or Symptoms of Disease	NA	Signs or Symptoms of Disease	SignsorSymptomsofDisease	Boolean	R	[0..1]		
Fever	NA	Fever	Fever	CodedType	R	[0..1]		
Sore Throat	NA	Sore Throat	SoreThroat	CodedType	R	[0..1]		
Cough	NA	Cough	Cough	CodedType	R	[0..1]		
Shortness of Breath	NA	Shortness of Breath	ShortnessOfBreath	CodedType	R	[0..1]		
RHINITIS	NA	RHINITIS	RHINITIS	CodedType	R	[0..1]		
LossOfSense Of Smell	NA	LossOfSense Of Smell	LossOfSenseOfSmell	CodedType	R	[0..1]		
Teste Disorder	NA	Teste Disorder	TesteDisorder	CodedType	R	[0..1]		
Settings others Specify	NA	Settings others Specify	SettingsOthersSpecify	StringType				

1.1.33

HIV Testing Report								
Field Name	Field Identifier	Purpose	XML Element	DT	Use	Occurs	Enum	Value Set / Notes
Client code	N/A	Client code for HTS	ClientCode	string	R	[1..1]	N	
Visit Date	N/A	Visit date applies to all encounter data for that date.	VisitDate	date	R	[1..1]	N	
Visit ID	N/A	The identification code or number used to uniquely identify the clinical visit	VisitID	string	R	[1 1]	N	
Settings	N/A	HIV testing setting	Setting	CodeType	R	[1..1]	Y	
First time visit	N/A	Patient first time visit	FirstTimeVisit	CodeType	R	[1 1]	Y	
Session type	N/A	Type of session	SessionType	CodeType	O	[0..1]	Y	
Referred from	N/A	Where Patient is referred from	ReferredFrom	CodeType	O	[0..1]	Y	
Marital status	N/A	Marital status	MaritalStatus	CodeType	O	[0..1]	Y	
Number of children less than 5	N/A	Number of children owned by client	NoOfOwnChildrenLessThan5Years	int	O	[0..1]	N	
Number of wives	N/A	Number of wives client have	NoOfAllWives	int	O	[0..1]	N	
Is index client	N/A	Is client an index client	IsIndexClient	StringType	O	[0..1]	Y	
Index Client ID	N/A	ID of Index client	IndexClientId	StringType	O	[0..1]	N	
Retesting for result verification	N/A	Is client testing for result verification	ReTestingForResultVerification	CodeType	O	[0..1]	Y	
Pretest Information	N/A	Client pretest information	PreTestInformation	PreTestInformationType	O	[0..1]	N	
HIV result	N/A	Client HIV result	HIVTestResult	HIVTestResultType	O	[0..1]	N	
Posttest counselling	N/A	Client posttest counselling	PostTestCounselling	PostTestCounsellingType	O	[0..1]	N	
Syphilis test result	N/A	Client Syphilis test result	SyphilisTestResult	CodeType	O	[0..1]	Y	
HBV test result	N/A	Client HBV test result	HBVTestResult	CodeType	O	[0..1]	Y	
HCV test result	N/A	Client HCV test result	HCVTestResult	CodeType	O	[0..1]	Y	

Index notification services	N/A	Index notification services	IndexNotificationServices	IndexNotificationServicesType	O	[0..1]	N	
Completed by	N/A	Clinician that completed the test	CompletedBy	StringType	O	[0..1]	N	
Date completed	N/A	Completion date	DateCompleted	StringType	O	[0..1]	N	

3.2 Reusable Complex Types

This section defines those complex types that are reusable within the NDR Schema.

AnswerType						
Seq	**XML Element**	**DT**	**Use**	**Occurs**	**Value Set**	**Notes**
1	AnswerCode	CodeType	O	[0..1]		
2	AnswerDate	date	O	[0..1]		
3	AnswerDateTime	dateTime	O	[0..1]		
4	AnswerNumeric	NumericType	O	[0..1]		
5	AnswerText	StringType	O	[0..1]		

CodedSimpleType						
Seq	**XML Element**	**DT**	**Use**	**Occurs**	**Value Set**	**Notes**
1	Code	CodeType	R	[1..1]		
2	CodeDescTxt	StringType	O	[0..1]		

CodedType						
Seq	**XML Element**	**DT**	**Use**	**Occurs**	**Value Set**	**Notes**
1	Code	CodeType	R	[1..1]		
2	CodeDescText	StringType	R	[1..1]		
3	CodeSystemCode	StringType	R	[1..1]		
4	Text	StringType	O	[0..1]		

ConditionSpecificQuestionsType						
Seq	XML Element	DT	Use	Occurs	Value Set	Notes
1	HIVQuestionsType	HIVQuestionsType	O	[0..1]		

EncountersType						
Seq	XML Element	DT	Use	Occurs	Value Set	Notes
1	HIVEncounter	HIVEncounterType	O	[0..*]		

FacilityType						
Seq	XML Element	DT	Use	Occurs	Value Set	Notes
1	FacilityName	StringType	R	[1..1]		
2	FacilityID	StringType	R	[1..1]		
3	FacilityTypeCode	StringType	R	[1..1]	FACILITY_TYPE	Is included as an Enumeration

IdentifiersType						
Seq	XML Element	DT	Use	Occurs	Value Set	Notes
1	Identifier	IdentifierType	R	[1..*]		

IdentifierType						
Seq	XML Element	DT	Use	Occurs	Value Set	Notes
1	IDNumber	StringType	R	[1..1]		
2	IDTypeCode	CodeType	R	[1..1]	IDENTIFIER_TYPE	

NoteType						
Seq	XML Element	DT	Use	Occurs	Value Set	Notes
1	Note	StringType	R	[1..1]		

NumericType						
Seq	XML Element	DT	Use	Occurs	Value Set	Notes
1	ComparatorCode	StringType	O	[0..1]		

NumericType						
Seq	XML Element	DT	Use	Occurs	Value Set	Notes
2	Value1	decimal	R	[1..1]		
3	SeperatorCode	StringType	O	[0..1]		
4	Value2	decimal	O	[0..1]		
5	Unit	CodedType	O	[0..1]	MEASURE_UNITS	

3.3 Value Sets

Summarized in the figure below, value sets defined in this document are detailed in the **NDR Data Dictionary Workbook** and utilize international standards when available. Where needed, locally defined value sets have been developed in accordance with FMoH tools.

ID	CODING_SYSTEM	VALUE_SET_CODE	VALUE_SET_NAME	VALUE_SET_DESCRIPTION
1	HL7	ADDRESS_TYPE	Address Type	Address Type
2	LOCAL	ADHERANCE	Adherance	Level of Adherance
3	LOCAL	ADHERANCE_POORFAIR_REASON	Adherance Poor Fair Reason	Reason for Poor or Fair Adherance
4	LOCAL	ADVERSE_REACTIONS	Adverse Reactions	Adverse Reactions
5	LOCAL	ART_STATUS	ART Status	ART Status
6	LOCAL	ARV_REGIMEN	ARV Regimen	ARV Regimen
7	LOCAL	CARE_ENTRY_POINT	Care Entry Point	Care Entry Point
8	SNOMED-CT	CONDTITION_CODE	Condition Code	List of all infectious disease. This is an intrinsic value set base
9	ISO	COUNTRY	Country	Country code
10	LOCAL	EDD_PMTCT_LINK	EDD PMTCT Link	EDD PMTCT Link
11	LOCAL	EDUCATIONAL_LEVEL	Educational Level	Educational Level
12	LOCAL	FACILITY_TYPE	Facility Type	Facility Type
13	LOCAL	FAMILY_PLANNING_METHOD	Family Planning Method	Family Planning Method
14	LOCAL	FAMILY_PLANNING_STATUS	Family Planning Status	Family Planning Status
15	LOCAL	FUNCTIONAL_STATUS	Functional Status	Ambulatory ability
16	LOCAL	HIV_TEST_TYPE	HIV Test Type	HIV Test Type
17	HL7	IDENTIFIER_TYPE	Identifier Type	List of identifier types
18	LOCAL	INTERRUPT	Interrupt	Type of interruption

19	LOCAL	INTERRUPTION_REASON	Interruption Reason	Reason for interruption
20	LOCAL	LAB_RESULTED_TEST	Lab Resulted Test	Lab Resulted Test
21	ISO	LANGUAGE	Language	Language
22	LOCAL	LGA	LGA	Nigerian Local Governmental Authority
23	HL7	MARITAL_STATUS	Marital Status	HL7 Marital status
24	UCUM	MEASURE_UNITS	Units of Measure	Units of Measure based on UCUM standard
25	LOCAL	MESSAGE_STATUS	Message Status	Message Status
26	LOCAL	OCCUPATION_STATUS	Occupation Status	Occupation Status
27	LOCAL	OI_OTHER	OI Other	OI Other
28	LOCAL	OI_REGIMEN	OI Regimen	OI Regimen
29	LOCAL	PREGNANCY_STATUS	Pregnancy Status	Pregnancy Status
30	LOCAL	PRIOR_ART	Prior Art	Indicates if the patient has history of prior anitretroviral ther
31	LOCAL	PROGRAM_AREA	Program Area	Program Area
32	LOCAL	REGIMEN_LINE	Regimen Line	Regimen Line
33	LOCAL	REGIMEN_STOP	Regimen Stop	Reason Regimen Stopped
34	LOCAL	REGIMEN_SUB_SWITCH_REASON	Reason for Substitution or Switch	Reason for Substitution or Switch
35	LOCAL	REGIMEN_TYPE	Regimen Type	Regimen Type
36	HL7	RELATIONSHIP	Relationship	HL7 Relationship
37	HL7	SEX	Sex	HL7 Administrative sex
38	LOCAL	STATES	States	Nigerian State FIPS Codes
39	LOCAL	TB_REGIMEN	TB Regimen	TB Regimen
40	LOCAL	TB_STATUS	TB Status	TB Status
41	LOCAL	TESTING_STATUS	Testing Status	Testing Status
42	HL7	VACCINE_ADMINISTER	Vaccine Method of Administration	Method of vaccination administration
43	HL7	VACCINE_SITE	Vaccine Site	Anatomical site of vaccination
44	NIP	VACCINE_TYPE	Vaccines administered (CVX)	Vaccine administered
45	HL7	VALUE_TYPE	Value Type	HL7 Value type
46	WHO	WHO_STAGE	WHO Stage	WHO Stage
47	LOCAL	WHY_ELIGIBLE	Why Eligible	Why Eligible
48	HL7	YNU	YNU	HL7 Yes/No indicator plus Unknown (null flavor)

49	LOCAL	SYPHILIS_TEST_RESULT	Syphilis test result	Syphilis test result
50	LOCAL	TIME_OF_HIV_DIAGNOSIS	Time of hiv diagnosis	Time of hiv diagnosis
51	LOCAL	HBV_STATUS	Hbv status	Hbv status
52	LOCAL	HCV_STATUS	Hcv status	Hcv status
53	LOCAL	ROM_INTERVAL	Rom interval	Rom interval
54	LOCAL	MODE_OF_DELIVERY	Mode of delivery	Mode of delivery
55	LOCAL	FEEDING_DECISION	Feeding decision	Feeding decision
56	LOCAL	MATERNAL_OUTCOME	Maternal outcome	Maternal outcome
57	LOCAL	VISIT_STATUS	Visit status	Visit status
58	LOCAL	INFANT_RAPID_TEST_RESULT	Infant rapid test result	Infant rapid test result
59	LOCAL	INFANT_PCR_RESULT	Infant pcr result	Infant pcr result
60	LOCAL	CHILD_STATUS	Child status	Child status
61	LOCAL	TIMING_OF_ARV_PROPHYLAXIS	Timing of arv prophylaxis	Timing of arv prophylaxis
62	LOCAL	INFANT_ARV_TYPE	Infant arv type	Infant arv type
63	LOCAL	18MONTH_INFANT_OUTCOME	18Month infant outcome	18Month infant outcome
64	LOCAL	PARTNER_REFERRED_TO	Partner referred to	Partner referred to
65	LOCAL	PARTNER_SYPHILIS_STATUS	Partner syphilis status	Partner syphilis status
66	HL7	HTS_SETTING	HIV Testing Setting	HIV Testing Setting
67	HL7	POS_NEG	Postive or Negative	Postive or Negative
68	HL7	REACTIVE_STATUS	Reactive or Non reactive	Reactive or Non reactive
69	HL7	RECENCY_TEST_STATUS	Recent or Long term	Recent or Long term
70	HL7	SESSION_TYPE	Session Type	Session Type
71	HL7	INDEX_RELATION	Index Relation or Type	Index Relation or Type
72	HL7	CLIENT_SEX	Male or Female	Male or Female
73	HL7	RECENCY_TEST_NAME	Recency test name	Recency test name
74	HL7	RECENCY_INTERPRETATION	Recency Interpretation	Recency Interpretation
75	HL7	SAMPLE_TYPE	Sample type	Type of sample sent to PCR lab
76	HL7	PCR_LAB	PCR Lab	PCR lab where samples are sent
77	LOCAL	VIRAL_LOAD_PERIOD	Viral Load at 32-36 Weeks GA	Viral Load at 32-36 Weeks GA
78	LOCAL	VIRAL_LOAD_PERIOD	Viral load other at any time during PMTCT	Viral load other at any time during PMTCT

79	LOCAL	PMTCT_ENTRY_POINT	ANC	ANC
80	LOCAL	PMTCT_ENTRY_POINT	L&D	L&D
81	LOCAL	PMTCT_ENTRY_POINT	Postantal Ward	Postantal Ward
82	LOCAL	PMTCT_ENTRY_POINT	Postpartum <=72hrs	Postpartum <=72hrs
83	LOCAL	PMTCT_ENTRY_POINT	Postpartum >72hrs	Postpartum >72hrs
84	LOCAL	ART_INITIATION_TIMING	Prior to this pregnancy	Prior to this pregnancy
85	LOCAL	ART_INITIATION_TIMING	Initiated ART during pregnancy <36 weeks gestation period	Initiated ART during pregnancy <36 weeks gestation period
86	LOCAL	ART_INITIATION_TIMING	Initiated ART during pregnancy >=36 weeks gestation period	Initiated ART during pregnancy >=36 weeks gestation period
87	LOCAL	ART_INITIATION_TIMING	Initiated ART at L&D	Initiated ART at L&D
88	LOCAL	ART_INITIATION_TIMING	Initiated ART after delivery (postpartum)	Initiated ART after delivery (postpartum)
89	LOCAL	HIV_RE-TESTING	Remained HIV Negative	Remained HIV Negative
90	LOCAL	HIV_RE-TESTING	Seroconverted to HIV Positive	Seroconverted to HIV Positive
91	LOCAL	IDENTIFIER_TYPE	HIV Exposed Infant	HIV Exposed Infant
92	LOCAL	OPERATION_TRIPLE_ZERO	OTZ plus	OTZ plus
93	LOCAL	OPERATION_TRIPLE_ZERO	Full Disclosure	Full Disclosure
94	LOCAL	OPERATION_TRIPLE_ZERO	Full Disclosure Date	Full Disclosure Date
95	LOCAL	OPERATION_TRIPLE_ZERO	Enrolled By	Enrolled By
96	LOCAL	OPERATION_TRIPLE_ZERO	Positive Living	Positive Living
97	LOCAL	OPERATION_TRIPLE_ZERO	Positive Living Completion Date	Positive Living Completion Date
98	LOCAL	OPERATION_TRIPLE_ZERO	Treatment Literacy	Treatment Literacy
99	LOCAL	OPERATION_TRIPLE_ZERO	Treatment Literacy Completion Date	Treatment Literacy Completion Date
100	LOCAL	OPERATION_TRIPLE_ZERO	Adolescents Participation	Adolescents Participation
101	LOCAL	OPERATION_TRIPLE_ZERO	Adolescents Participation Completion Date	Adolescents Participation Completion Date
102	LOCAL	OPERATION_TRIPLE_ZERO	Leadership Training	Leadership Training
103	LOCAL	OPERATION_TRIPLE_ZERO	Leadership Training Completion Date	Leadership Training Completion Date
104	LOCAL	OPERATION_TRIPLE_ZERO	Peer-to-Peer Mentorship	Peer-to-Peer Mentorship
105	LOCAL	OPERATION_TRIPLE_ZERO	Peer-to-Peer Mentorship Completion Date	Peer-to-Peer Mentorship Completion Date
106	LOCAL	OPERATION_TRIPLE_ZERO	Role of OTZ in 95-95-95	Role of OTZ in 95-95-95
107	LOCAL	OPERATION_TRIPLE_ZERO	Role of OTZ in 95-95-95 Completion Date	Role of OTZ in 95-95-95 Completion Date

108	LOCAL	OPERATION_TRIPLE_ZERO	OTZ Champion Orientation	OTZ Champion Orientation
109	LOCAL	OPERATION_TRIPLE_ZERO	OTZ Champion Orientation Completion Date	OTZ Champion Orientation Completion Date
110	LOCAL	OPERATION_TRIPLE_ZERO	Transitioned to Adult Clinic	Transitioned to Adult Clinic
111	LOCAL	OPERATION_TRIPLE_ZERO	Date Transitioned to Adult Clinic	Date Transitioned to Adult Clinic
112	LOCAL	OPERATION_TRIPLE_ZERO	OTZ Program Outcome	OTZ Program Outcome
113	LOCAL	OPERATION_TRIPLE_ZERO	Differentiated Service Delivery Model (DSDM)	Differentiated Service Delivery Model (DSDM)
114	LOCAL	OPERATION_TRIPLE_ZERO	Facility Dispensing	Facility Dispensing
115	LOCAL	OPERATION_TRIPLE_ZERO	Community Dispensing	Community Dispensing
116	LOCAL	OPERATION_TRIPLE_ZERO	Multi-Month Dispensing (MMD)	Multi-Month Dispensing (MMD)
117	LOCAL	OPERATION_TRIPLE_ZERO	Exited By	Exited By
118	LOCAL	OPERATION_TRIPLE_ZERO	Returning Patient	Returning Patient
119	LOCAL	OPERATION_TRIPLE_ZERO	Date Returned	Date Returned
120	LOCAL	OPERATION_TRIPLE_ZERO	Reactivated By	Reactivated By
121	LOCAL	RECENCY_TESTING	Test Date	Test Date
122	LOCAL	RECENCY_TESTING	Date Sample Sent	Date Sample Sent
123	LOCAL	RECENCY_TESTING	Rapid Recency Assay	Rapid Recency Assay
124	LOCAL	RECENCY_TESTING	Viral Load ConfirmationResult	Viral Load ConfirmationResult
125	LOCAL	RECENCY_TESTING	Viral LoadConfirmation Test Date	Viral LoadConfirmation Test Date
126	LOCAL	RECENCY_TESTING	FinalRecencyTestResult	FinalRecencyTestResult
127	LOCAL	RECENCY_TESTING	Consent	Consent
128	LOCAL	RECENCY_TESTING	SampleReferenceNumber	SampleReferenceNumber
129	LOCAL	RECENCY_TESTING	ViralLoadClassification	ViralLoadClassification
130	LOCAL	RECENCY_TESTING	TestName	TestName
131	LOCAL	RECENCY_TESTING	TestDate	TestDate
132	LOCAL	RECENCY_TESTING	RecencyNumber	RecencyNumber
133	LOCAL	RECENCY_TESTING	ControlLine	ControlLine
134	LOCAL	RECENCY_TESTING	VerificationLine	VerificationLine
135	LOCAL	RECENCY_TESTING	LongTermLine	LongTermLine
136	LOCAL	RECENCY_TESTING	RecencyInterpretation	RecencyInterpretation
137	LOCAL	RECENCY_TESTING	ViralLoadRequest	ViralLoadRequest

138	LOCAL	RECENCY_TESTING	DateSampleCollected	DateSampleCollected
139	LOCAL	RECENCY_TESTING	PCRLabNumber	PCRLabNumber
140	LOCAL	RECENCY_TESTING	SampleType	SampleType
141	LOCAL	RECENCY_TESTING	DateSampleSent	DateSampleSent
142	LOCAL	RECENCY_TESTING	PCRLab	PCRLab
143	LOCAL	RECENCY_TESTING	ViralLoadResultClassification	ViralLoadResultClassification
144	LOCAL	RECENCY_TESTING	HivViralLoad	HivViralLoad
145	LOCAL	RECENCY_TESTING	FinalRecencyTestResult	FinalRecencyTestResult
146	LOCAL	RECENCY_TESTING	DateConfirmedVL	DateConfirmedVL
147	LOCAL	RECENCY_TESTING	ViralLoadResult	ViralLoadResult
148	LOCAL	RECENCY_TESTING	FinalRecencyResultInvestigation	FinalRecencyResultInvestigation
149	LOCAL	RECENCY_TESTING	SourceDocumentUsed	SourceDocumentUsed
150	LOCAL	RECENCY_TESTING	LinkedToCare	LinkedToCare
151	LOCAL	RECENCY_TESTING	DateLinkedToCare	DateLinkedToCare
152	LOCAL	RECENCY_TESTING	InitiatedOnART	InitiatedOnART
153	LOCAL	RECENCY_TESTING	DateInitiatedOnART	DateInitiatedOnART
154	LOCAL	RECENCY_TESTING	ARTNumber	ARTNumber
155	LOCAL	RECENCY_TESTING	Regimen	Regimen
156	LOCAL	RECENCY_TESTING	AdherenceCounselling	AdherenceCounselling
157	LOCAL	RECENCY_TESTING	recordedVL12Month	recordedVL12Month
158	LOCAL	RECENCY_TESTING	VLResult	VLResult
159	LOCAL	RECENCY_TESTING	VlsSixMonth	VlsSixMonth
160	LOCAL	RECENCY_TESTING	PopulationType	PopulationType
161	LOCAL	RECENCY_TESTING	KpType	KpType
162	LOCAL	RECENCY_TESTING	PpType	PpType
163	LOCAL	RECENCY_TESTING	OfferedIndexTesting	OfferedIndexTesting
164	LOCAL	RECENCY_TESTING	ProvidedContacts	ProvidedContacts
165	LOCAL	RECENCY_TESTING	PartnerAge	PartnerAge
166	LOCAL	RECENCY_TESTING	PartnerGender	PartnerGender
167	LOCAL	RECENCY_TESTING	ContactInformationProvided	ContactInformationProvided

168	LOCAL	RECENCY_TESTING	RelationshipWithIndex	RelationshipWithIndex
169	LOCAL	RECENCY_TESTING	SelfTestingKit	SelfTestingKit
170	LOCAL	RECENCY_TESTING	HivVerificationTesting	HivVerificationTesting
171	LOCAL	RECENCY_TESTING	PartnerTestedDate	PartnerTestedDate
172	LOCAL	RECENCY_TESTING	PartnerTestResult	PartnerTestResult
173	LOCAL	RECENCY_TESTING	PartnerTested	PartnerTested
174	LOCAL	RECENCY_TESTING	PartnerTestedForRecency	PartnerTestedForRecency
175	LOCAL	RECENCY_TESTING	PartnerRecencyID	PartnerRecencyID
176	LOCAL	RECENCY_TESTING	PartnerRecencyTestDate	PartnerRecencyTestDate
177	LOCAL	RECENCY_TESTING	PartnerRecencyResult	PartnerRecencyResult
178	LOCAL	RECENCY_TESTING	PartnerLinkedToCare	PartnerLinkedToCare
179	LOCAL	RECENCY_TESTING	DatePartnerLinkedToCare	DatePartnerLinkedToCare
180	LOCAL	RECENCY_TESTING	PartnerInitiatedOnART	PartnerInitiatedOnART
181	LOCAL	RECENCY_TESTING	DatePartnerInitiatedOnART	DatePartnerInitiatedOnART
182	LOCAL	RECENCY_TESTING	PartnerReferredPrEP	PartnerReferredPrEP
183	LOCAL	RECENCY_TESTING	PartnerInitiatePrEP	PartnerInitiatePrEP
184	LOCAL	RECENCY_TESTING	PartnerScheduledRepeatHIVtest	PartnerScheduledRepeatHIVtest
185	LOCAL	RECENCY_TESTING	ReturnedForRepeatHIV	ReturnedForRepeatHIV
186	LOCAL	RECENCY_TESTING	DatePartnerRepeatHivTest	DatePartnerRepeatHivTest
187	LOCAL	RECENCY_TESTING	ReasonPartnerNotTested	ReasonPartnerNotTested
188	LOCAL	RECENCY_TESTING	PartnerOnART	PartnerOnART
189	LOCAL	RECENCY_TESTING	CurrentARTRegimen	CurrentARTRegimen
190	LOCAL	RECENCY_TESTING	DateOfLatestVL	DateOfLatestVL
191	LOCAL	RECENCY_TESTING	VLS6Months	VLS6Months
192	LOCAL	RECENCY_TESTING	EnhancedAdherenceCounselling	EnhancedAdherenceCounselling
193	LOCAL	RECENCY_TESTING	PartnerSwitchEvaluatedARTRegimen	PartnerSwitchEvaluatedARTRegimen
194	LOCAL	RECENCY_TESTING	PatientReferred	PatientReferred
195	LOCAL	MORTALITY_TYPE	Reason for Tracking	Reason for Tracking
196	LOCAL	MORTALITY_TYPE	Other Tracking Reason	Other Tracking Reason
197	LOCAL	MORTALITY_TYPE	Partner full name	Partner full name

198	LOCAL	MORTALITY_TYPE	Contact phone number	Contact phone number
199	LOCAL	MORTALITY_TYPE	Date of Last Actual Contact	Date of Last Actual Contact
200	LOCAL	MORTALITY_TYPE	Date of Missed Scheduled Appointment	Date of Missed Scheduled Appointment
201	LOCAL	MORTALITY_TYPE	Lost to follow up	Lost to follow up
202	LOCAL	MORTALITY_TYPE	Reason for lost to follow up	Reason for lost to follow up
203	LOCAL	MORTALITY_TYPE	Date Lost to follow up	Date Lost to follow up
204	LOCAL	MORTALITY_TYPE	Previous ARV exposure	Previous ARV exposure
205	LOCAL	MORTALITY_TYPE	Date of Termination	Date of Termination
206	LOCAL	MORTALITY_TYPE	Reason for Termination	Reason for Termination
207	LOCAL	MORTALITY_TYPE	Transferred out to	Transferred out to
208	LOCAL	MORTALITY_TYPE	Death	Death
209	LOCAL	MORTALITY_TYPE	VA Cause of Death	VA Cause of Death
210	LOCAL	MORTALITY_TYPE	Other cause of death (specify)	Other cause of death (specify)
211	LOCAL	MORTALITY_TYPE	Adult Cases of Death	Adult Cases of Death
212	LOCAL	MORTALITY_TYPE	Discontinued Care	Discontinued Care
213	LOCAL	MORTALITY_TYPE	Discontinue Care other specify	Discontinue Care other specify
214	LOCAL	MORTALITY_TYPE	Date Returned to Care	Date Returned to Care
215	LOCAL	MORTALITY_TYPE	Referred for	Referred for
216	LOCAL	MORTALITY_TYPE	Name of Contact Tracer	Name of Contact Tracer
217	LOCAL	MORTALITY_TYPE	Contact Tracker Signature date	Contact Tracker Signature date
218	LOCAL	TB_SCREENING_TYPE	Date Of Visit	Date Of Visit
219	LOCAL	TB_SCREENING_TYPE	TB Registration Id	TB Registration Id
220	LOCAL	TB_SCREENING_TYPE	Current Cough	Current Cough
221	LOCAL	TB_SCREENING_TYPE	Weight Loss	Weight Loss
222	LOCAL	TB_SCREENING_TYPE	Night Sweats	Night Sweats
223	LOCAL	TB_SCREENING_TYPE	Contact with TB Patient	Contact with TB Patient
224	LOCAL	TB_SCREENING_TYPE	TB Screening Score	TB Screening Score
225	LOCAL	TB_INDEX_PATIENT_CONCTACT_INVESTIGATOR	TB Contact Investigator	TB Contact Investigator
226	LOCAL	TB_INDEX_PATIENT_CONCTACT_INVESTIGATOR	Phone Number of TB Contact Investigator	Phone Number of TB Contact Investigator
227	LOCAL	TB_INDEX_PATIENT_CONCTACT_INVESTIGATOR	Date of TB Contact Tracing	Date of TB Contact Tracing

228	LOCAL	TB_INDEX_PATIENT_CONCTACT_INVESTIGATOR	LGA TB Number	LGA TB Number
229	LOCAL	TB_INDEX_PATIENT_CONCTACT_INVESTIGATOR	Number of Household Contacts	Number of Household Contacts
230	LOCAL	TB_INDEX_PATIENT_CONCTACT_INVESTIGATOR	Type of TB	Type of TB
231	LOCAL	TB_INDEX_PATIENT_CONCTACT_INVESTIGATOR	Consent for Contact Tracing	Consent for Contact Tracing
232	LOCAL	TB_INDEX_PATIENT_CONCTACT_INVESTIGATOR	TB Contact Name	TB Contact Name
233	LOCAL	TB_INDEX_PATIENT_CONCTACT_INVESTIGATOR	TB Contact Age	TB Contact Age
234	LOCAL	TB_INDEX_PATIENT_CONCTACT_INVESTIGATOR	TB Contact Sex	TB Contact Sex
235	LOCAL	TB_INDEX_PATIENT_CONCTACT_INVESTIGATOR	TB Contact Phone Number	TB Contact Phone Number
236	LOCAL	TB_INDEX_PATIENT_CONCTACT_INVESTIGATOR	Relationship with TB Index Case	Relationship with TB Index Case
237	LOCAL	TB_INDEX_PATIENT_CONCTACT_INVESTIGATOR	Cough Greater than or Equal to 2 Weeks	Cough Greater than or Equal to 2 Weeks
238	LOCAL	TB_INDEX_PATIENT_CONCTACT_INVESTIGATOR	Recent Weight Loss	Recent Weight Loss
239	LOCAL	TB_INDEX_PATIENT_CONCTACT_INVESTIGATOR	Night Sweat	Night Sweat
240	LOCAL	TB_INDEX_PATIENT_CONCTACT_INVESTIGATOR	Presumptive TB Case Identified	Presumptive TB Case Identified
241	LOCAL	TB_INDEX_PATIENT_CONCTACT_INVESTIGATOR	Presumptive TB Case Referred for Diagnosis	Presumptive TB Case Referred for Diagnosis
242	LOCAL	TB_INDEX_PATIENT_CONCTACT_INVESTIGATOR	Sputum Samples Collected	Sputum Samples Collected
243	LOCAL	TB_INDEX_PATIENT_CONCTACT_INVESTIGATOR	TB Diagnosed	TB Diagnosed
244	LOCAL	TB_LABORATORY_REGISTRATION	TB Laboratory Registration Type	TB Laboratory Registration Type
245	LOCAL	TB_LABORATORY_REGISTRATION	NTBLCP or TB04	NTBLCP or TB04
246	LOCAL	TB_LABORATORY_REGISTRATION	LaboratoryName	LaboratoryName
247	LOCAL	TB_LABORATORY_REGISTRATION	Specimen Identification Number	Specimen Identification Number
248	LOCAL	TB_LABORATORY_REGISTRATION	Date Specimen Was Sent to Laboratory	Date Specimen Was Sent to Laboratory
249	LOCAL	TB_LABORATORY_REGISTRATION	Specimen Status	Specimen Status
250	LOCAL	TB_LABORATORY_REGISTRATION	Reason for Specimen Rejection	Reason for Specimen Rejection
251	LOCAL	TB_LABORATORY_REGISTRATION	Type of TB Presumptive	Type of TB Presumptive
252	LOCAL	TB_LABORATORY_REGISTRATION	TB Site of Disease	TB Site of Disease
253	LOCAL	TB_LABORATORY_REGISTRATION	Health Care Provider	Health Care Provider
254	LOCAL	TB_LABORATORY_REGISTRATION	Tested For HIV In the Lab	Tested For HIV In the Lab
255	LOCAL	TB_LABORATORY_REGISTRATION	Specify Type of Specimen	Specify Type of Specimen
256	LOCAL	TB_LABORATORY_REGISTRATION	Specify Test Required	Specify Test Required
257	LOCAL	TB_LABORATORY_REGISTRATION	Was MTB Detected	Was MTB Detected

258	LOCAL	TB_LABORATORY_REGISTRATION	Specify Detected MTB	Specify Detected MTB
259	LOCAL	TB_LABORATORY_REGISTRATION	Error Code	Error Code
260	LOCAL	TB_LABORATORY_REGISTRATION	Invalid or Incomplete Test	Invalid or Incomplete Test
261	LOCAL	TB_LABORATORY_REGISTRATION	AFB- Result	AFB- Result
262	LOCAL	TB_LABORATORY_REGISTRATION	Other TB Test Type	Other TB Test Type
263	LOCAL	TB_LABORATORY_REGISTRATION	Other TB Tests Result	Other TB Tests Result
264	LOCAL	TB_LABORATORY_REGISTRATION	Tuberculosis Test Result Date	Tuberculosis Test Result Date
265	LOCAL	SPECIMENT_EXAMINATION_REQUEST	TB Remarks	TB Remarks
266	LOCAL	SPECIMENT_EXAMINATION_REQUEST	Specimen Collection Date	Specimen Collection Date
267	LOCAL	SPECIMENT_EXAMINATION_REQUEST	Type of Presumptive TB	Type of Presumptive TB
268	LOCAL	SPECIMENT_EXAMINATION_REQUEST	Is Patient a Health Worker	Is Patient a Health Worker
269	LOCAL	SPECIMENT_EXAMINATION_REQUEST	HIV Test Requested	HIV Test Requested
270	LOCAL	SPECIMENT_EXAMINATION_REQUEST	Reason for Examination	Reason for Examination
271	LOCAL	SPECIMENT_EXAMINATION_REQUEST	Test Type Request	Test Type Request
272	LOCAL	SPECIMENT_EXAMINATION_REQUEST	Other Test Type Request	Other Test Type Request
273	LOCAL	SPECIMENT_EXAMINATION_REQUEST	Type of Specimen	Type of Specimen
274	LOCAL	SPECIMENT_EXAMINATION_REQUEST	Number Sent to Laboratory	Number Sent to Laboratory
275	LOCAL	SPECIMENT_EXAMINATION_REQUEST	First Sample Collection Date	First Sample Collection Date
276	LOCAL	SPECIMENT_EXAMINATION_REQUEST	Second Sample Collection Date	Second Sample Collection Date
277	LOCAL	SPECIMENT_EXAMINATION_REQUEST	Name Of Person Requesting Examination	Name Of Person Requesting Examination
278	LOCAL	SPECIMENT_EXAMINATION_REQUEST	Name Of Health Facility	Name Of Health Facility
279	LOCAL	SPECIMENT_EXAMINATION_REQUEST	Name of Requesting Health Facility	Name of Requesting Health Facility
280	LOCAL	SPECIMENT_EXAMINATION_REQUEST	State of Requesting Health Facility	State of Requesting Health Facility
281	LOCAL	SPECIMENT_EXAMINATION_REQUEST	LGA or TB Number	LGA or TB Number
282	LOCAL	SPECIMENT_EXAMINATION_REQUEST	Name of Laboratory	Name of Laboratory
283	LOCAL	SPECIMENT_EXAMINATION_REQUEST	Laboratory Serial Number	Laboratory Serial Number
284	LOCAL	SPECIMENT_EXAMINATION_REQUEST	MTB Not Detected	MTB Not Detected
285	LOCAL	SPECIMENT_EXAMINATION_REQUEST	Other Test Type Specified	Other Test Type Specified
286	LOCAL	SPECIMENT_EXAMINATION_REQUEST	Results of other Test	Results of other Test
287	LOCAL	SPECIMENT_EXAMINATION_REQUEST	Date AFB Smear Sample Received	Date AFB Smear Sample Received

288	LOCAL	SPECIMENT_EXAMINATION_REQUEST	Specimen source	Specimen source
289	LOCAL	SPECIMENT_EXAMINATION_REQUEST	Appearance	Appearance
290	LOCAL	SPECIMENT_EXAMINATION_REQUEST	Result	Result
291	LOCAL	SPECIMENT_EXAMINATION_REQUEST	AFB Smear Result Examined By	AFB Smear Result Examined By
292	LOCAL	SPECIMENT_EXAMINATION_REQUEST	Date of AFB Smear Microscopy Result	Date of AFB Smear Microscopy Result
293	LOCAL	SPECIMENT_EXAMINATION_REQUEST	Type of Culture Result	Type of Culture Result
294	LOCAL	SPECIMENT_EXAMINATION_REQUEST	Date Culture Sample Received	Date Culture Sample Received
295	LOCAL	SPECIMENT_EXAMINATION_REQUEST	Culture Specimen	Culture Specimen
296	LOCAL	SPECIMENT_EXAMINATION_REQUEST	Solid Culture Result	Solid Culture Result
297	LOCAL	SPECIMENT_EXAMINATION_REQUEST	Liquid Culture- Result	Liquid Culture- Result
298	LOCAL	SPECIMENT_EXAMINATION_REQUEST	Result of Confirmatory Test for MTB	Result of Confirmatory Test for MTB
299	LOCAL	SPECIMENT_EXAMINATION_REQUEST	Culture Examined By	Culture Examined By
300	LOCAL	SPECIMENT_EXAMINATION_REQUEST	Culture Date	Culture Date
301	LOCAL	SPECIMENT_EXAMINATION_REQUEST	Type of LPA or DST Method Used	Type of LPA or DST Method Used
302	LOCAL	SPECIMENT_EXAMINATION_REQUEST	Date Sample Received	Date Sample Received
303	LOCAL	SPECIMENT_EXAMINATION_REQUEST	LPA Specimen	LPA Specimen
304	LOCAL	SPECIMENT_EXAMINATION_REQUEST	LPA Results	LPA Results
305	LOCAL	SPECIMENT_EXAMINATION_REQUEST	LPA Drugs	LPA Drugs
306	LOCAL	SPECIMENT_EXAMINATION_REQUEST	DST Results	DST Results
307	LOCAL	SPECIMENT_EXAMINATION_REQUEST	DST Drugs	DST Drugs
308	LOCAL	SPECIMENT_EXAMINATION_REQUEST	DST Examined By	DST Examined By
309	LOCAL	SPECIMENT_EXAMINATION_REQUEST	DST Date	DST Date
310	LOCAL	SPECIMENT_EXAMINATION_REQUEST	Remark	Remark
311	LOCAL	SPECIMENT_EXAMINATION_REQUEST	HIV Test Result	HIV Test Result
312	LOCAL	SPECIMENT_EXAMINATION_REQUEST	HIV Test Result Date	HIV Test Result Date
313	LOCAL	DR_TB_TREATMENT_REGISTER	Result Checked and Released By	Result Checked and Released By
314	LOCAL	DR_TB_TREATMENT_REGISTER	Patient Serial Number	Patient Serial Number
315	LOCAL	DR_TB_TREATMENT_REGISTER	Date Registered	Date Registered
316	LOCAL	DR_TB_TREATMENT_REGISTER	Place Of Initiation	Place Of Initiation
317	LOCAL	DR_TB_TREATMENT_REGISTER	LGA DRTB RegNo	LGA DRTB RegNo

318	LOCAL	DR_TB_TREATMENT_REGISTER	Referring Health Facility	Referring Health Facility
319	LOCAL	DR_TB_TREATMENT_REGISTER	Previously On TB 2nd Line Drug	Previously On TB 2nd Line Drug
320	LOCAL	DR_TB_TREATMENT_REGISTER	Weight	Weight
321	LOCAL	DR_TB_TREATMENT_REGISTER	Height	Height
322	LOCAL	DR_TB_TREATMENT_REGISTER	Type f Treatment Regimen	Type f Treatment Regimen
323	LOCAL	DR_TB_TREATMENT_REGISTER	Enter BDQ Or Dim	Enter BDQ Or Dim
324	LOCAL	DR_TB_TREATMENT_REGISTER	Date Treatment Started	Date Treatment Started
325	LOCAL	DR_TB_TREATMENT_REGISTER	Site of Disease	Site of Disease
326	LOCAL	DR_TB_TREATMENT_REGISTER	Registration Group	Registration Group
327	LOCAL	DR_TB_TREATMENT_REGISTER	GeneXpert	GeneXpert
328	LOCAL	DR_TB_TREATMENT_REGISTER	AFB	AFB
329	LOCAL	DR_TB_TREATMENT_REGISTER	Culture	Culture
330	LOCAL	DR_TB_TREATMENT_REGISTER	LPA Result	LPA Result
331	LOCAL	DR_TB_TREATMENT_REGISTER	DST Result	DST Result
332	LOCAL	DR_TB_TREATMENT_REGISTER	Xray Done	Xray Done
333	LOCAL	DR_TB_TREATMENT_REGISTER	Follow Up Investigation	Follow Up Investigation
334	LOCAL	DR_TB_TREATMENT_REGISTER	HIV Status	HIV Status
335	LOCAL	DR_TB_TREATMENT_REGISTER	CPT	CPT
336	LOCAL	DR_TB_TREATMENT_REGISTER	ART Start Date	ART Start Date
337	LOCAL	DR_TB_TREATMENT_REGISTER	CPT Start Date	CPT Start Date
338	LOCAL	DR_TB_TREATMENT_REGISTER	Outcome	Outcome
339	LOCAL	TB_PATIENT_REFERRAL_OR_TRANSFER	Comment	Comment
340	LOCAL	TB_PATIENT_REFERRAL_OR_TRANSFER	TB Reason for Referral	TB Reason for Referral
341	LOCAL	TB_PATIENT_REFERRAL_OR_TRANSFER	Specimen ID	Specimen ID
342	LOCAL	TB_PATIENT_REFERRAL_OR_TRANSFER	Referring Facility Name	Referring Facility Name
343	LOCAL	TB_PATIENT_REFERRAL_OR_TRANSFER	Referring Facility LGA	Referring Facility LGA
344	LOCAL	TB_PATIENT_REFERRAL_OR_TRANSFER	Referring Facility State	Referring Facility State
345	LOCAL	TB_PATIENT_REFERRAL_OR_TRANSFER	Facility Referred To	Facility Referred To
346	LOCAL	TB_PATIENT_REFERRAL_OR_TRANSFER	Referred Facility LGA	Referred Facility LGA
347	LOCAL	TB_PATIENT_REFERRAL_OR_TRANSFER	Referred Facility State	Referred Facility State

348	LOCAL	TB_PATIENT_REFERRAL_OR_TRANSFER	Type Of TB Patient	Type Of TB Patient
349	LOCAL	TB_PATIENT_REFERRAL_OR_TRANSFER	Form Completed	Form Completed
350	LOCAL	TB_PATIENT_REFERRAL_OR_TRANSFER	Other Referrals	Other Referrals
351	LOCAL	TB_PATIENT_REFERRAL_OR_TRANSFER	Specimen- ID	Specimen- ID
352	LOCAL	TB_PATIENT_REFERRAL_OR_TRANSFER	Smear Result	Smear Result
353	LOCAL	TB_PATIENT_REFERRAL_OR_TRANSFER	MycobacteriumuTuberculosis Detected With Rifampin Resistance	MycobacteriumuTuberculosis Detected With Rifampin Resis
354	LOCAL	TB_PATIENT_REFERRAL_OR_TRANSFER	Culture Result	Culture Result
355	LOCAL	TB_TREATMENT_MONITORING_TYPE	Other TB Test Result	Other TB Test Result
356	LOCAL	TB_TREATMENT_MONITORING_TYPE	Type Of Regimen	Type Of Regimen
357	LOCAL	TB_TREATMENT_MONITORING_TYPE	Treatment Age Group	Treatment Age Group
358	LOCAL	TB_TREATMENT_MONITORING_TYPE	Pregnancy And Breastfeeding Status	Pregnancy And Breastfeeding Status
359	LOCAL	TB_TREATMENT_MONITORING_TYPE	Intensive Phase Anti TB Drugs	Intensive Phase Anti TB Drugs
360	LOCAL	TB_TREATMENT_MONITORING_TYPE	Intensive Phase Anti TB Drug Strength	Intensive Phase Anti TB Drug Strength
361	LOCAL	TB_TREATMENT_MONITORING_TYPE	Intensive Phase Drug Frequency	Intensive Phase Drug Frequency
362	LOCAL	TB_TREATMENT_MONITORING_TYPE	Intensive Phase TB Drug Duration	Intensive Phase TB Drug Duration
363	LOCAL	TB_TREATMENT_MONITORING_TYPE	Intensive Phase Quantity of Medication Prescribed	Intensive Phase Quantity of Medication Prescribed
364	LOCAL	TB_TREATMENT_MONITORING_TYPE	Continuity Phase Anti TB Drugs	Continuity Phase Anti TB Drugs
365	LOCAL	TB_TREATMENT_MONITORING_TYPE	Continuity Phase Anti TB Drug Strength	Continuity Phase Anti TB Drug Strength
366	LOCAL	TB_TREATMENT_MONITORING_TYPE	Continuity Phase Drug Frequency	Continuity Phase Drug Frequency
367	LOCAL	TB_TREATMENT_MONITORING_TYPE	Continuity Phase TB Drug Duration	Continuity Phase TB Drug Duration
368	LOCAL	TB_TREATMENT_MONITORING_TYPE	Continuity Phase Quantity of Medication Prescribed	Continuity Phase Quantity of Medication Prescribed
369	LOCAL	TB_TREATMENT_MONITORING_TYPE	Select Outcome	Select Outcome
370	LOCAL	TB_TREATMENT_MONITORING_TYPE	TB Treatment Outcome Date	TB Treatment Outcome Date
371	LOCAL	TB_TREATMENT_MONITORING_TYPE	DOT Provider Type	DOT Provider Type
372	LOCAL	TB_TREATMENT_MONITORING_TYPE	Outcome Date	Outcome Date
373	LOCAL	TB_TREATMENT_MONITORING_TYPE	DOT Provider Name	DOT Provider Name
374	LOCAL	TB_TREATMENT_MONITORING_TYPE	Tracking Attempts	Tracking Attempts
375	LOCAL	TB_TREATMENT_MONITORING_TYPE	Date of Last Drug Intake	Date of Last Drug Intake
376	LOCAL	TB_TREATMENT_MONITORING_TYPE	Mode of Tracking	Mode of Tracking

377	LOCAL	TB_TREATMENT_MONITORING_TYPE	Patient Contacted	Patient Contacted
378	LOCAL	TB_TREATMENT_MONITORING_TYPE	Person Contacted	Person Contacted
379	LOCAL	TB_TREATMENT_MONITORING_TYPE	Reason For Absence	Reason For Absence
380	LOCAL	TB_TREATMENT_MONITORING_TYPE	Other Reason or Defaulting	Other Reason or Defaulting
381	LOCAL	TB_TREATMENT_MONITORING_TYPE	Solution to Absence	Solution to Absence
382	LOCAL	DR_TB_IN_PATIENT_DISCHARGE	TB Tracking Outcome	TB Tracking Outcome
383	LOCAL	DR_TB_IN_PATIENT_DISCHARGE	Treatment Centre	Treatment Centre
384	LOCAL	DR_TB_IN_PATIENT_DISCHARGE	State	State
385	LOCAL	DR_TB_IN_PATIENT_DISCHARGE	Date Of Admission	Date Of Admission
386	LOCAL	DR_TB_IN_PATIENT_DISCHARGE	Date Of Discharge	Date Of Discharge
387	LOCAL	DR_TB_IN_PATIENT_DISCHARGE	Registration Number	Registration Number
388	LOCAL	DR_TB_IN_PATIENT_DISCHARGE	Date of Registration	Date of Registration
389	LOCAL	DR_TB_IN_PATIENT_DISCHARGE	Date Of Treatment Initiation	Date Of Treatment Initiation
390	LOCAL	DR_TB_IN_PATIENT_DISCHARGE	Facility Patient is Discharged To	Facility Patient is Discharged To
391	LOCAL	DR_TB_IN_PATIENT_DISCHARGE	LGA of State	LGA of State
392	LOCAL	DR_TB_IN_PATIENT_DISCHARGE	Any Co Morbidity	Any Co Morbidity
393	LOCAL	DR_TB_IN_PATIENT_DISCHARGE	Specified Co Morbidities	Specified Co Morbidities
394	LOCAL	DR_TB_IN_PATIENT_DISCHARGE	Specified Drugs Used	Specified Drugs Used
395	LOCAL	DR_TB_IN_PATIENT_DISCHARGE	Short Regimen	Short Regimen
396	LOCAL	DR_TB_IN_PATIENT_DISCHARGE	Composition	Composition
397	LOCAL	DR_TB_IN_PATIENT_DISCHARGE	Intensive Phase Drug	Intensive Phase Drug
398	LOCAL	DR_TB_IN_PATIENT_DISCHARGE	Adverse Reaction While in Treatment	Adverse Reaction While in Treatment
399	LOCAL	DR_TB_IN_PATIENT_DISCHARGE	Adverse Reaction	Adverse Reaction
400	LOCAL	DR_TB_IN_PATIENT_DISCHARGE	TB Regimen to Be Continued at DoT Facility	TB Regimen to Be Continued at DoT Facility
401	LOCAL	DR_TB_IN_PATIENT_DISCHARGE	Name Of STB LCO Patient is Discharged to	Name Of STB LCO Patient is Discharged to
402	LOCAL	DR_TB_IN_PATIENT_DISCHARGE	Phone No of STBLCO	Phone No of STBLCO
403	LOCAL	DR_TB_IN_PATIENT_DISCHARGE	Name Of State DRTB Focal Person	Name Of State DRTB Focal Person
404	LOCAL	DR_TB_IN_PATIENT_DISCHARGE	Phone No of State DRTB Focal Person	Phone No of State DRTB Focal Person
405	LOCAL	DR_TB_IN_PATIENT_DISCHARGE	Phone No of Treatment Centre Doctor	Phone No of Treatment Centre Doctor
406	LOCAL	DR_TB_IN_PATIENT_DISCHARGE	Name of Treatment Matron	Name of Treatment Matron

407	LOCAL	DR_TB_IN_PATIENT_DISCHARGE	Phone No of Treatment Centre Matron	Phone No of Treatment Centre Matron
408	LOCAL	COVID19_CASE_INVESTIGATION	Name Of Treatment Centre Doctor	Name Of Treatment Centre Doctor
409	LOCAL	COVID19_CASE_INVESTIGATION	Phone Number	Phone Number
410	LOCAL	COVID19_CASE_INVESTIGATION	Patient Case Status at Time of Encounter	Patient Case Status at Time of Encounter
411	LOCAL	COVID19_CASE_INVESTIGATION	Treatment Supporter Relationship	Treatment Supporter Relationship
412	LOCAL	COVID19_CASE_INVESTIGATION	Red Eye	Red Eye
413	LOCAL	COVID19_CASE_INVESTIGATION	Loss of Appetite	Loss of Appetite
414	LOCAL	COVID19_CASE_INVESTIGATION	Date of First Visit	Date of First Visit
415	LOCAL	COVID19_CASE_INVESTIGATION	Previously Vaccinated	Previously Vaccinated
416	LOCAL	COVID19_CASE_INVESTIGATION	Previously Vaccinated Regimen	Previously Vaccinated Regimen
417	LOCAL	COVID19_CASE_INVESTIGATION	Name of Vaccine	Name of Vaccine
418	LOCAL	COVID19_CASE_INVESTIGATION	Vaccination Date	Vaccination Date
419	LOCAL	COVID19_CASE_INVESTIGATION	Date Respiratory Sample Collected	Date Respiratory Sample Collected
420	LOCAL	COVID19_CASE_INVESTIGATION	Type of Respiratory Sample Collected	Type of Respiratory Sample Collected
421	LOCAL	COVID19_CASE_INVESTIGATION	Has Baseline Serun Taken	Has Baseline Serun Taken
422	LOCAL	COVID19_CASE_INVESTIGATION	Date Baseline Collected	Date Baseline Collected
423	LOCAL	COVID19_CASE_INVESTIGATION	Other Samples Collected	Other Samples Collected
424	LOCAL	COVID19_CASE_INVESTIGATION	Date Other Sample Collected	Date Other Sample Collected
425	LOCAL	COVID19_CASE_INVESTIGATION	Travelled Within The Last 14 Days	Travelled Within The Last 14 Days
426	LOCAL	COVID19_CASE_INVESTIGATION	Travelled Within The Last 14 Days Domestic	Travelled Within The Last 14 Days Domestic
427	LOCAL	COVID19_CASE_INVESTIGATION	State Visited	State Visited
428	LOCAL	COVID19_CASE_INVESTIGATION	Date of Travel From	Date of Travel From
429	LOCAL	COVID19_CASE_INVESTIGATION	Date of Travel To	Date of Travel To
430	LOCAL	COVID19_CASE_INVESTIGATION	Had contact with suspected Confirmed Covid Person Past 14 days	Had contact with suspected Confirmed Covid Person Past 14
431	LOCAL	COVID19_CASE_INVESTIGATION	Had contact with suspected Confirmed Covid Person Past 14 days Contact	Had contact with suspected Confirmed Covid Person Past 14
432	LOCAL	COVID19_CASE_INVESTIGATION	Patient Visited or Was Admitted To Patient Health Facility	Patient Visited or Was Admitted To Patient Health Facility
433	LOCAL	COVID19_CASE_INVESTIGATION	Patient Visited Outpatient Treatment Facility	Patient Visited Outpatient Treatment Facility
434	LOCAL	COVID19_CASE_INVESTIGATION	Patient Visited Traditional Healer	Patient Visited Traditional Healer

435	LOCAL	COVID19_CONTACT_INVESTIGATION	Contact ID Number	Contact ID Number
436	LOCAL	COVID19_CONTACT_INVESTIGATION	Name of Confirmed Case	Name of Confirmed Case
437	LOCAL	COVID19_CONTACT_INVESTIGATION	Name of Data Collector	Name of Data Collector
438	LOCAL	COVID19_CONTACT_INVESTIGATION	Concept	Concept
439	LOCAL	COVID19_CONTACT_INVESTIGATION	Respondent Gender	Respondent Gender
440	LOCAL	COVID19_CONTACT_INVESTIGATION	Date of Issue of Birth Certificate	Date of Issue of Birth Certificate
441	LOCAL	COVID19_CONTACT_INVESTIGATION	Age	Age
442	LOCAL	COVID19_CONTACT_INVESTIGATION	Address of Treatment Supporter	Address of Treatment Supporter
443	LOCAL	COVID19_CONTACT_INVESTIGATION	Telephone Number of Treatment Supporter	Telephone Number of Treatment Supporter
444	LOCAL	COVID19_CONTACT_INVESTIGATION	Email	Email
445	LOCAL	COVID19_CONTACT_INVESTIGATION	Preferred Model of Contact	Preferred Model of Contact
446	LOCAL	COVID19_CONTACT_INVESTIGATION	Surname	Surname
447	LOCAL	COVID19_CONTACT_INVESTIGATION	Country of Residence	Country of Residence
448	LOCAL	COVID19_CONTACT_INVESTIGATION	Contact With Suspected Person	Contact With Suspected Person
449	LOCAL	COVID19_CONTACT_INVESTIGATION	Date of Last Contact	Date of Last Contact
450	LOCAL	COVID19_CONTACT_INVESTIGATION	Countries Visited	Countries Visited
451	LOCAL	COVID19_CONTACT_INVESTIGATION	Cities or Town Visited	Cities or Town Visited
452	LOCAL	COVID19_CONTACT_INVESTIGATION	Had contact with Suspected or Confirmed Covid Person in The Past 14 Days	Had contact with Suspected or Confirmed Covid Person in Th
453	LOCAL	COVID19_CONTACT_INVESTIGATION	Date of Travel	Date of Travel
454	LOCAL	COVID19_CONTACT_INVESTIGATION	Dates of Last Contact	Dates of Last Contact
455	LOCAL	COVID19_CONTACT_INVESTIGATION	Occupation	Occupation
456	LOCAL	COVID19_CONTACT_INVESTIGATION	Job Title	Job Title
457	LOCAL	COVID19_CONTACT_INVESTIGATION	Workplace	Workplace
458	LOCAL	COVID19_CONTACT_INVESTIGATION	Direct Physical Contact	Direct Physical Contact
459	LOCAL	COVID19_CONTACT_INVESTIGATION	HCW had a prolonged face-to-face contact 15 minutes)	HCW had a prolonged face-to-face contact 15 minutes)
460	LOCAL	COVID19_CONTACT_INVESTIGATION	Type of Protective Equipment	Type of Protective Equipment
461	LOCAL	COVID19_CONTACT_INVESTIGATION	Type of Contact	Type of Contact
462	LOCAL	COVID19_CONTACT_INVESTIGATION	Dates of Contact while the Primary Case was Symptomatic	Dates of Contact while the Primary Case was Symptomatic

463	LOCAL	COVID19_CONTACT_INVESTIGATION	Date Reported	Date Reported
464	LOCAL	COVID19_CONTACT_INVESTIGATION	Exposure Duration	Exposure Duration
465	LOCAL	COVID19_CONTACT_INVESTIGATION	Experience any Respiratory Symptoms in the period up to 10 days before the on set	Experience any Respiratory Symptoms in the period up to 10
466	LOCAL	COVID19_CONTACT_INVESTIGATION	Contact Experienced any Respiratory Symptoms in the Periods up to10 Days	Contact Experienced any Respiratory Symptoms in the Perio
467	LOCAL	COVID19_CONTACT_INVESTIGATION	Currently Ill	Currently Ill
468	LOCAL	COVID19_CONTACT_INVESTIGATION	Signs Symptoms Start Date	Signs Symptoms Start Date
469	LOCAL	COVID19_CONTACT_INVESTIGATION	Temperature	Temperature
470	LOCAL	COVID19_CONTACT_INVESTIGATION	Loss of Sense of Smell	Loss of Sense of Smell
471	LOCAL	COVID19_CONTACT_INVESTIGATION	Test Disorder	Test Disorder
472	LOCAL	COVID19_CONTACT_INVESTIGATION	Chills	Chills
473	LOCAL	COVID19_CONTACT_INVESTIGATION	vomiting	vomiting
474	LOCAL	COVID19_CONTACT_INVESTIGATION	Nausea	Nausea
475	LOCAL	COVID19_CONTACT_INVESTIGATION	Diarrhea	Diarrhea
476	LOCAL	COVID19_CONTACT_INVESTIGATION	Headache	Headache
477	LOCAL	COVID19_CONTACT_INVESTIGATION	Rash	Rash
478	LOCAL	COVID19_CONTACT_INVESTIGATION	Conjunctivitis	Conjunctivitis
479	LOCAL	COVID19_CONTACT_INVESTIGATION	Muscle Fatigue	Muscle Fatigue
480	LOCAL	COVID19_CONTACT_INVESTIGATION	Joint Pain	Joint Pain
481	LOCAL	COVID19_CONTACT_INVESTIGATION	Lost of Appetite	Lost of Appetite
482	LOCAL	COVID19_CONTACT_INVESTIGATION	Nose Injury	Nose Injury
483	LOCAL	COVID19_CONTACT_INVESTIGATION	Fatigue	Fatigue
484	LOCAL	COVID19_CONTACT_INVESTIGATION	Seizure	Seizure
485	LOCAL	COVID19_CONTACT_INVESTIGATION	Alteration of Consciousness	Alteration of Consciousness
486	LOCAL	COVID19_CONTACT_INVESTIGATION	Soft Neurological Signs	Soft Neurological Signs
487	LOCAL	COVID19_CONTACT_INVESTIGATION	Other Symptoms	Other Symptoms
488	LOCAL	COVID19_CONTACT_INVESTIGATION	Status of Contact	Status of Contact
489	LOCAL	COVID19_CONTACT_INVESTIGATION	Date Sample Collected	Date Sample Collected
490	LOCAL	COVID19_CONTACT_INVESTIGATION	Date of Death	Date of Death
491	LOCAL	COVID19_CONTACT_INVESTIGATION	Hospitalization Required	Hospitalization Required

492	LOCAL	COVID19_CONTACT_INVESTIGATION	Hospitalization Date	Hospitalization Date
493	LOCAL	COVID19_CONTACT_INVESTIGATION	Contribution of 2019_n COV to Death	Contribution of 2019_n COV to Death
494	LOCAL	COVID19_CONTACT_INVESTIGATION	Discharged Date Time	Discharged Date Time
495	LOCAL	COVID19_CONTACT_INVESTIGATION	If Dead was Postmortem Performed	If Dead was Postmortem Performed
496	LOCAL	COVID19_CONTACT_INVESTIGATION	Results of Postmortem Report where Available	Results of Postmortem Report where Available
497	LOCAL	COVID19_CONTACT_INVESTIGATION	Pregnancy Trimester	Pregnancy Trimester
498	LOCAL	COVID19_CONTACT_INVESTIGATION	Obesity	Obesity
499	LOCAL	COVID19_CONTACT_INVESTIGATION	Heart Disease	Heart Disease
500	LOCAL	COVID19_CONTACT_INVESTIGATION	Asthma	Asthma
501	LOCAL	COVID19_CONTACT_INVESTIGATION	Chronic Lung Disease	Chronic Lung Disease
502	LOCAL	COVID19_CONTACT_INVESTIGATION	Other Chronic Nonalcoholic Liver Disease	Other Chronic Nonalcoholic Liver Disease
503	LOCAL	COVID19_CONTACT_INVESTIGATION	Hematological Disorder Specific to Fetus or Newborn	Hematological Disorder Specific to Fetus or Newborn
504	LOCAL	COVID19_CONTACT_INVESTIGATION	Neurological	Neurological
505	LOCAL	COVID19_CONTACT_INVESTIGATION	Bone Marrow Disorder	Bone Marrow Disorder
506	LOCAL	COVID19_DAILY_CASES_INVESTIGATION	Other Preexisting Disorder	Other Preexisting Disorder
507	LOCAL	COVID19_DAILY_CASES_INVESTIGATION	Days	Days
508	LOCAL	COVID19_DAILY_CASES_INVESTIGATION	No signs or Symptoms of Disease	No signs or Symptoms of Disease
509	LOCAL	COVID19_DAILY_CASES_INVESTIGATION	Fever	Fever
510	LOCAL	COVID19_DAILY_CASES_INVESTIGATION	Sore Throat	Sore Throat
511	LOCAL	COVID19_DAILY_CASES_INVESTIGATION	Cough	Cough
512	LOCAL	COVID19_DAILY_CASES_INVESTIGATION	Shortness of Breath	Shortness of Breath
513	LOCAL	COVID19_DAILY_CASES_INVESTIGATION	RHINITIS	RHINITIS
514	LOCAL	COVID19_DAILY_CASES_INVESTIGATION	LossOfSense Of Smell	LossOfSense Of Smell
515	LOCAL	COVID19_DAILY_CASES_INVESTIGATION	Taste Disorder	Taste Disorder
516	LOCAL	VAA_ADULT_CASES_OF_DEATH	Settings others Specify	Settings others Specify
517	LOCAL	VAA_ADULT_CASES_OF_DEATH	VA Adult Cases of Death	VA Adult Cases of Death
518	LOCAL	VAA_ADULT_CASES_OF_DEATH	AIDS	AIDS
519	LOCAL	VAA_ADULT_CASES_OF_DEATH	Diarrhea/Dysentery	Diarrhea/Dysentery
520	LOCAL	VAA_ADULT_CASES_OF_DEATH	Malaria	Malaria
521	LOCAL	VAA_ADULT_CASES_OF_DEATH	Maternal	Maternal

522	LOCAL	VAA_ADULT_CASES_OF_DEATH	Other Infectious Diseases	Other Infectious Diseases
523	LOCAL	VAA_ADULT_CASES_OF_DEATH	TB	TB
524	LOCAL	VAA_ADULT_CASES_OF_DEATH	Acute Myocardial Infarction	Acute Myocardial Infarction
525	LOCAL	VAA_ADULT_CASES_OF_DEATH	Breast Cancer	Breast Cancer
526	LOCAL	VAA_ADULT_CASES_OF_DEATH	Chronic Respiratory Diseases	Chronic Respiratory Diseases
527	LOCAL	VAA_ADULT_CASES_OF_DEATH	Cervical Cancers	Cervical Cancers
528	LOCAL	VAA_ADULT_CASES_OF_DEATH	Cirrhosis	Cirrhosis
529	LOCAL	VAA_ADULT_CASES_OF_DEATH	Colorectal	Colorectal
530	LOCAL	VAA_ADULT_CASES_OF_DEATH	Diabetes	Diabetes
531	LOCAL	VAA_ADULT_CASES_OF_DEATH	Esophageal Cancer	Esophageal Cancer
532	LOCAL	VAA_ADULT_CASES_OF_DEATH	Leukemia/Lymphomas	Leukemia/Lymphomas
533	LOCAL	VAA_ADULT_CASES_OF_DEATH	Lung Cancer	Lung Cancer
534	LOCAL	VAA_ADULT_CASES_OF_DEATH	Other Non-communicable Diseases	Other Non-communicable Diseases
535	LOCAL	VAA_ADULT_CASES_OF_DEATH	Prostate Cancer	Prostate Cancer
536	LOCAL	VAA_ADULT_CASES_OF_DEATH	Chronic Kidney Disease	Chronic Kidney Disease
537	LOCAL	VAA_ADULT_CASES_OF_DEATH	Stomach Cancer	Stomach Cancer
538	LOCAL	VAA_ADULT_CASES_OF_DEATH	Stroke	Stroke
539	LOCAL	VAA_ADULT_CASES_OF_DEATH	Drowning	Drowning
540	LOCAL	VAA_ADULT_CASES_OF_DEATH	Date Enrolled Into OTZ Plus	Date Enrolled Into OTZ Plus
541	LOCAL	VAA_ADULT_CASES_OF_DEATH	Homicide (assault)	Homicide (assault)
542	LOCAL	VAA_ADULT_CASES_OF_DEATH	Other Injuries	Other Injuries
543	LOCAL	VAA_ADULT_CASES_OF_DEATH	Suicide by Multiple Means	Suicide by Multiple Means
544	LOCAL	VAA_ADULT_CASES_OF_DEATH	VA Child Causes of Death	VA Child Causes of Death
545	LOCAL	VAA_ADULT_CASES_OF_DEATH	AIDS	AIDS
546	LOCAL	VAA_ADULT_CASES_OF_DEATH	Diarrhea/Dysentery	Diarrhea/Dysentery
547	LOCAL	VAA_ADULT_CASES_OF_DEATH	Encephalitis	Encephalitis
548	LOCAL	VAA_ADULT_CASES_OF_DEATH	Hemorrhagic fever	Hemorrhagic fever
549	LOCAL	VAA_ADULT_CASES_OF_DEATH	Malaria	Malaria
550	LOCAL	VAA_ADULT_CASES_OF_DEATH	Other Infectious Diseases	Other Infectious Diseases
551	LOCAL	VAA_ADULT_CASES_OF_DEATH	Pneumonia	Pneumonia

552	LOCAL	VAA_ADULT_CASES_OF_DEATH	Sepsis	Sepsis
553	LOCAL	VAA_ADULT_CASES_OF_DEATH	Meningitis	Meningitis
554	LOCAL	VAA_ADULT_CASES_OF_DEATH	Measles	Measles
555	LOCAL	VAA_ADULT_CASES_OF_DEATH	Other Cancers	Other Cancers
556	LOCAL	VAA_ADULT_CASES_OF_DEATH	Other Cardiovascular Diseases	Other Cardiovascular Diseases
557	LOCAL	VAA_ADULT_CASES_OF_DEATH	Other Defined Causes of Child Deaths	Other Defined Causes of Child Deaths
558	LOCAL	VAA_ADULT_CASES_OF_DEATH	Other Digestive Diseases	Other Digestive Diseases
559	LOCAL	VAA_ADULT_CASES_OF_DEATH	Bite of Venomous Animal	Bite of Venomous Animal
560	LOCAL	VAA_ADULT_CASES_OF_DEATH	Drowning	Drowning
561	LOCAL	VAA_ADULT_CASES_OF_DEATH	Falls	Falls
562	LOCAL	VAA_ADULT_CASES_OF_DEATH	Fires	Fires
563	LOCAL	VAA_ADULT_CASES_OF_DEATH	Accidental Poisoning by Other Specified Corrosives and Caustics not Elsewhere Classified	Accidental Poisoning by Other Specified Corrosives and Caus
564	LOCAL	VAA_ADULT_CASES_OF_DEATH	Road Traffic	Road Traffic
565	LOCAL	VAA_ADULT_CASES_OF_DEATH	Homicide (assault)	Homicide (assault)
566	LOCAL	VAA_ADULT_CASES_OF_DEATH	Birth asphyxia	Birth asphyxia
567	LOCAL	VAA_ADULT_CASES_OF_DEATH	Congenital malformation	Congenital malformation
568	LOCAL	VAA_ADULT_CASES_OF_DEATH	Neonatal Meningitis/Sepsis	Neonatal Meningitis/Sepsis
569	LOCAL	VAA_ADULT_CASES_OF_DEATH	Neonatal Pneumonia	Neonatal Pneumonia
570	LOCAL	VAA_ADULT_CASES_OF_DEATH	Preterm Delivery	Preterm Delivery
571	LOCAL	VAA_ADULT_CASES_OF_DEATH	Stillbirth	Stillbirth

4 Message Scenarios and Samples

This section provides sample messages for common scenarios when sending data to NDR. The sample messages documented below, are available as XML files within the NDR Implementation Guide package.

4.1 Scenario 1 – Initial

Patient has initial visit # 259430 on 10 March 2010 and is medically evaluated. The patient is placed on 3 regimens to control HIV and other infections as well as his CD4 is tested:

Laboratory Order / Result 1: CD4 / Numeric Value = 100

Regimen 1: AZT(300mg)+3TC(150mg)+NVP(200mg)
Regimen 2: Cotrimoxazole 480mg
Regimen 3: Ethambuthol/Isoniazid 400/150mg

The XML would have 3 instances of Regimen documenting the three Regimens with each instance having a Visit ID of 259430 and a Visit Date of 10 March 2010.

The XML would have 1 instance of a Laboratory Report will have one instance of a LaboratoryOrderAndResult

Sample Message

```
<?xml version="1.0" encoding="utf-8"?>
<Container>
<MessageHeader>
        <MessageStatusCode>INITIAL</MessageStatusCode>
        <MessageCreationDateTime>2015-08-26T18:02:50.07</MessageCreationDateTime>
        <MessageSchemaVersion>1.2</MessageSchemaVersion>
        <MessageUniqueID>4567</MessageUniqueID>
        <MessageSendingOrganization>
            <FacilityName>Fictional Implementing Partner Name</FacilityName>
            <FacilityID>3930299292</FacilityID>
            <FacilityTypeCode>IP</FacilityTypeCode>
       </MessageSendingOrganization>
</MessageHeader>
    <IndividualReport>
        <PatientDemographics>
            <PatientIdentifier>19283746</PatientIdentifier>
            <TreatmentFacility>
                <FacilityName>Central Medical Centre</FacilityName>
                <FacilityID>39383933</FacilityID>
                <FacilityTypeCode>FAC</FacilityTypeCode>
            </TreatmentFacility>
            <OtherPatientIdentifiers>
            <Identifier>
                <IDNumber>678-251-0-1234</IDNumber>
                <IDTypeCode>PN</IDTypeCode>
```

```
            </Identifier>
            </OtherPatientIdentifiers>
            <PatientDateOfBirth>1976-07-11</PatientDateOfBirth>
            <PatientSexCode>M</PatientSexCode>
            <PatientDeceasedIndicator>false</PatientDeceasedIndicator>
            <PatientPrimaryLanguageCode>ENG</PatientPrimaryLanguageCode>
            <PatientEducationLevelCode>3</PatientEducationLevelCode>
            <PatientOccupationCode>EMP</PatientOccupationCode>
            <PatientMaritalStatusCode>M</PatientMaritalStatusCode>
            <StateOfNigeriaOriginCode>15</StateOfNigeriaOriginCode>
        </PatientDemographics>
        <Condition>
            <ConditionCode>86406008</ConditionCode>
            <ProgramArea>
                <ProgramAreaCode>HIV</ProgramAreaCode>
            </ProgramArea>
            <PatientAddress>
                <AddressTypeCode>H</AddressTypeCode>
                <WardVillage>Central</WardVillage>
                <Town>Abuja</Town>
                <LGACode>236</LGACode>
                <StateCode>15</StateCode>
                <CountryCode>NGA</CountryCode>
                <PostalCode>12345</PostalCode>
                <OtherAddressInformation>Enter notes about
                 the address if needed</OtherAddressInformation>
            </PatientAddress>
            <CommonQuestions>
   <HospitalNumber>HN0012</HospitalNumber>
   <DiagnosisFacility>
<FacilityName>Diagnosing Facility</FacilityName>
<FacilityID>10101</FacilityID>
<FacilityTypeCode>FAC</FacilityTypeCode>
   </DiagnosisFacility>
   <DateOfFirstReport>2010-03-30</DateOfFirstReport>
   <DateOfLastReport>2010-03-30</DateOfLastReport>
   <DiagnosisDate>2010-03-10</DiagnosisDate>
   <PatientDieFromThisIllness>false</PatientDieFromThisIllness>
          <PatientAge>40</PatientAge>
            </CommonQuestions>
            <ConditionSpecificQuestions>
                <HIVQuestions>
                    <CareEntryPoint>3</CareEntryPoint>
```

```
        <FirstConfirmedHIVTestDate>2010-03-10</FirstConfirmedHIVTestDate>
        <FirstHIVTestMode>HIVAb</FirstHIVTestMode>
        <WhereFirstHIVTest>Clinic Testing Name</WhereFirstHIVTest>
        <PriorArt>N</PriorArt>
        <MedicallyEligibleDate>2010-03-10</MedicallyEligibleDate>
        <ReasonMedicallyEligible>3</ReasonMedicallyEligible>
        <InitialAdherenceCounselingCompletedDate>2010-03-10
          </InitialAdherenceCounselingCompletedDate>
        <FirstARTRegimen>
            <Code>1b</Code>
            <CodeDescTxt>AZT-3TC-NVP</CodeDescTxt>
        </FirstARTRegimen>
        <ARTStartDate>2010-03-10</ARTStartDate>
        <WHOClinicalStageARTStart>3</WHOClinicalStageARTStart>
        <WeightAtARTStart>73</WeightAtARTStart>
        <FunctionalStatusStartART>W</FunctionalStatusStartART>
        <CD4AtStartOfART>100</CD4AtStartOfART>
        <PatientHasDied>false</PatientHasDied>
        <EnrolledInHIVCareDate>2010-03-10</EnrolledInHIVCareDate>
        <InitialTBStatus>2</InitialTBStatus>
    </HIVQuestions>
</ConditionSpecificQuestions>
<Encounters>
    <HIVEncounter>
        <VisitID>259430</VisitID>
        <VisitDate>2010-03-10</VisitDate>
        <DurationOnArt>0</DurationOnArt>
        <Weight>73</Weight>
        <BloodPressure>120/87</BloodPressure>
        <PatientFamilyPlanningCode>FP</PatientFamilyPlanningCode>
        <PatientFamilyPlanningMethodCode>FP1
          </PatientFamilyPlanningMethodCode>
        <FunctionalStatus>W</FunctionalStatus>
        <WHOClinicalStage>3</WHOClinicalStage>
        <TBStatus>2</TBStatus>
        <ARVDrugRegimen>
            <Code>1b</Code>
            <CodeDescTxt>AZT-3TC-NVP</CodeDescTxt>
        </ARVDrugRegimen>
        <CotrimoxazoleDose>
            <Code>CTX480</Code>
            <CodeDescTxt>Cotrimoxazole 480mg</CodeDescTxt>
        </CotrimoxazoleDose>
```

```
        <INHDose>
            <Code>HE</Code>
            <CodeDescTxt>Isoniazid-Ethambutol</CodeDescTxt>
        </INHDose>
        <CD4>100</CD4>
        <CD4TestDate>2010-03-10</CD4TestDate>
        <NextAppointmentDate>2010-04-12</NextAppointmentDate>
    </HIVEncounter>
</Encounters>
<LaboratoryReport>
    <VisitID>259430</VisitID>
    <VisitDate>2010-03-10</VisitDate>
    <LaboratoryTestIdentifier>wlk9871</LaboratoryTestIdentifier>
    <CollectionDate>2010-03-10</CollectionDate>
    <BaselineRepeatCode>B</BaselineRepeatCode>
    <ARTStatusCode>P</ARTStatusCode>
    <LaboratoryOrderAndResult>
        <OrderedTestDate>2010-03-10</OrderedTestDate>
        <LaboratoryResultedTest>
            <Code>11</Code>
            <CodeDescTxt>CD4</CodeDescTxt>
        </LaboratoryResultedTest>
        <LaboratoryResult>
            <AnswerNumeric>
                <Value1>100</Value1>
            </AnswerNumeric>
        </LaboratoryResult>
        <ResultedTestDate>2010-03-10</ResultedTestDate>
    </LaboratoryOrderAndResult>
    <Clinician>Clinician Name</Clinician>
    <ReportedBy>Reporter Name</ReportedBy>
    <CheckedBy>Checkedby Name</CheckedBy>
</LaboratoryReport>
<Regimen>
    <VisitID>259430</VisitID>
    <VisitDate>2010-03-10</VisitDate>
    <PrescribedRegimen>
        <Code>1b</Code>
        <CodeDescTxt>AZT-3TC-NVP</CodeDescTxt>
    </PrescribedRegimen>
    <PrescribedRegimenTypeCode>ART</PrescribedRegimenTypeCode>
    <PrescribedRegimenLineCode>10</PrescribedRegimenLineCode>
    <PrescribedRegimenDuration>30</PrescribedRegimenDuration>
```

```
    <PrescribedRegimenDispensedDate>2010-03-10
          </PrescribedRegimenDispensedDate>
    <DateRegimenStarted>2010-03-10</DateRegimenStarted>
    <DateRegimenStartedDD>10</DateRegimenStartedDD>
    <DateRegimenStartedMM>03</DateRegimenStartedMM>
    <DateRegimenStartedYYYY>2010</DateRegimenStartedYYYY>
    <PrescribedRegimenInitialIndicator>true
          </PrescribedRegimenInitialIndicator>
    <PrescribedRegimenCurrentIndicator>true
          </PrescribedRegimenCurrentIndicator>
    <TypeOfPreviousExposureCode>N</TypeOfPreviousExposureCode>
    <SubstitutionIndicator>false</SubstitutionIndicator>
    <SwitchIndicator>false</SwitchIndicator>
</Regimen>
<Regimen>
    <VisitID>259430</VisitID>
    <VisitDate>2010-03-10</VisitDate>
    <PrescribedRegimen>
        <Code>CTX480</Code>
        <CodeDescTxt>Cotrimoxazole 480mg</CodeDescTxt>
    </PrescribedRegimen>
    <PrescribedRegimenTypeCode>CTX</PrescribedRegimenTypeCode>
    <PrescribedRegimenDuration>30</PrescribedRegimenDuration>
    <PrescribedRegimenDispensedDate>2010-03-10
          </PrescribedRegimenDispensedDate>
    <DateRegimenStarted>2010-03-10</DateRegimenStarted>
    <DateRegimenStartedDD>10</DateRegimenStartedDD>
    <DateRegimenStartedMM>03</DateRegimenStartedMM>
    <DateRegimenStartedYYYY>2010</DateRegimenStartedYYYY>
    <PrescribedRegimenInitialIndicator>true
          </PrescribedRegimenInitialIndicator>
    <PrescribedRegimenCurrentIndicator>true
          </PrescribedRegimenCurrentIndicator>
    <SubstitutionIndicator>false</SubstitutionIndicator>
    <SwitchIndicator>false</SwitchIndicator>
</Regimen>
<Regimen>
    <VisitID>259430</VisitID>
    <VisitDate>2010-03-10</VisitDate>
    <PrescribedRegimen>
        <Code>HE</Code>
        <CodeDescTxt>Isoniazid-Ethambutol</CodeDescTxt>
    </PrescribedRegimen>
```

```
                <PrescribedRegimenTypeCode>TB</PrescribedRegimenTypeCode>
                <PrescribedRegimenDuration>30</PrescribedRegimenDuration>
                <PrescribedRegimenDispensedDate>2010-03-10</PrescribedRegimenDispensedDate>
                <DateRegimenStarted>2010-03-10</DateRegimenStarted>
                <DateRegimenStartedDD>10</DateRegimenStartedDD>
                <DateRegimenStartedMM>03</DateRegimenStartedMM>
                <DateRegimenStartedYYYY>2010</DateRegimenStartedYYYY>
               <PrescribedRegimenInitialIndicator>true</PrescribedRegimenInitialIndicator>
               <PrescribedRegimenCurrentIndicator>true</PrescribedRegimenCurrentIndicator>
                <SubstitutionIndicator>false</SubstitutionIndicator>
                <SwitchIndicator>false</SwitchIndicator>
            </Regimen>
        </Condition>
    </IndividualReport>
</Container>
```

4.2 Scenario 2 – Update

The same patient from Scenario 1 has update visit # 261100 on 12 April 2010. The HIV regimen is renewed. His CD4 is tested:

Laboratory Order / Result 1: CD4 / Numeric Value = 110

Regimen 1: AZT(300mg)+3TC(150mg)+NVP(200mg)

The XML would have one new instance of Regimen documenting the regimen renewal. Each instance would have a Visit ID of 261100 and a Visit Date of 12 April 2010.

The XML would have 1 instance of LaboratoryReport will have a new instance of LaboratoryOrderAndResult

Sample Message

```
<?xml version="1.0" encoding="utf-8"?>
<Container>
<MessageHeader>
        <MessageStatusCode>UPDATED</MessageStatusCode>
        <MessageCreationDateTime>2015-09-08T16:18:36.12</MessageCreationDateTime>
        <MessageSchemaVersion>1.2</MessageSchemaVersion>
        <MessageUniqueID>4567</MessageUniqueID>
        <MessageSendingOrganization>
            <FacilityName>Fictional Implementing Partner Name</FacilityName>
```

```
            <FacilityID>3930299292</FacilityID>
            <FacilityTypeCode>IP</FacilityTypeCode>
        </MessageSendingOrganization>
</MessageHeader>
    <IndividualReport>
        <PatientDemographics>
            <PatientIdentifier>19283746</PatientIdentifier>
            <TreatmentFacility>
                <FacilityName>Central Medical Centre</FacilityName>
                <FacilityID>39383933</FacilityID>
                <FacilityTypeCode>FAC</FacilityTypeCode>
            </TreatmentFacility>
            <OtherPatientIdentifiers>
            <Identifier>
                <IDNumber>678-251-0-1234</IDNumber>
                <IDTypeCode>PN</IDTypeCode>
            </Identifier>
            </OtherPatientIdentifiers>
            <PatientDateOfBirth>1976-07-11</PatientDateOfBirth>
            <PatientSexCode>M</PatientSexCode>
            <PatientDeceasedIndicator>false</PatientDeceasedIndicator>
            <PatientPrimaryLanguageCode>ENG</PatientPrimaryLanguageCode>
            <PatientEducationLevelCode>3</PatientEducationLevelCode>
            <PatientOccupationCode>EMP</PatientOccupationCode>
            <PatientMaritalStatusCode>M</PatientMaritalStatusCode>
            <StateOfNigeriaOriginCode>15</StateOfNigeriaOriginCode>
        </PatientDemographics>
        <Condition>
            <ConditionCode>86406008</ConditionCode>
            <ProgramArea>
                <ProgramAreaCode>HIV</ProgramAreaCode>
            </ProgramArea>
            <PatientAddress>
                <AddressTypeCode>H</AddressTypeCode>
                <WardVillage>Central</WardVillage>
                <Town>Abuja</Town>
                <LGACode>236</LGACode>
                <StateCode>15</StateCode>
                <CountryCode>NGA</CountryCode>
                <PostalCode>12345</PostalCode>
                <OtherAddressInformation>Enter notes about the address
                      if needed</OtherAddressInformation>
            </PatientAddress>
```

```
            <CommonQuestions>
   <HospitalNumber>HN0012</HospitalNumber>
   <DiagnosisFacility>
<FacilityName>Diagnosing Facility</FacilityName>
<FacilityID>10101</FacilityID>
<FacilityTypeCode>FAC</FacilityTypeCode>
   </DiagnosisFacility>
   <DateOfFirstReport>2010-03-30</DateOfFirstReport>
   <DateOfLastReport>2010-03-30</DateOfLastReport>
   <DiagnosisDate>2010-03-10</DiagnosisDate>
   <PatientDieFromThisIllness>false</PatientDieFromThisIllness>
          <PatientAge>40</PatientAge>
            </CommonQuestions>
            <ConditionSpecificQuestions>
                <HIVQuestions>
                    <CareEntryPoint>3</CareEntryPoint>
                    <FirstConfirmedHIVTestDate>2010-03-10</FirstConfirmedHIVTestDate>
                    <FirstHIVTestMode>HIVAb</FirstHIVTestMode>
                    <WhereFirstHIVTest>Clinic Testing Name</WhereFirstHIVTest>
                    <PriorArt>N</PriorArt>
                    <MedicallyEligibleDate>2010-03-10</MedicallyEligibleDate>
                    <ReasonMedicallyEligible>3</ReasonMedicallyEligible>
                    <InitialAdherenceCounselingCompletedDate>2010-03-10
                      </InitialAdherenceCounselingCompletedDate>
                    <FirstARTRegimen>
                        <Code>1b</Code>
                        <CodeDescTxt>AZT-3TC-NVP</CodeDescTxt>
                    </FirstARTRegimen>
                    <ARTStartDate>2010-03-10</ARTStartDate>
                    <WHOClinicalStageARTStart>3</WHOClinicalStageARTStart>
                    <WeightAtARTStart>73</WeightAtARTStart>
                    <FunctionalStatusStartART>W</FunctionalStatusStartART>
                    <CD4AtStartOfART>100</CD4AtStartOfART>
                    <PatientHasDied>false</PatientHasDied>
                    <EnrolledInHIVCareDate>2010-03-10</EnrolledInHIVCareDate>
                    <InitialTBStatus>2</InitialTBStatus>
                </HIVQuestions>
            </ConditionSpecificQuestions>
            <Encounters>
                <HIVEncounter>
                    <VisitID>259430</VisitID>
                    <VisitDate>2010-03-10</VisitDate>
                    <DurationOnArt>0</DurationOnArt>
```

```
        <Weight>73</Weight>
        <BloodPressure>120/87</BloodPressure>
        <PatientFamilyPlanningCode>FP</PatientFamilyPlanningCode>
        <PatientFamilyPlanningMethodCode>FP1</PatientFamilyPlanningMethodCode>
        <FunctionalStatus>W</FunctionalStatus>
        <WHOClinicalStage>3</WHOClinicalStage>
        <TBStatus>2</TBStatus>
        <ARVDrugRegimen>
            <Code>1b</Code>
            <CodeDescTxt>AZT-3TC-NVP</CodeDescTxt>
        </ARVDrugRegimen>
        <CotrimoxazoleDose>
            <Code>CTX480</Code>
            <CodeDescTxt>Cotrimoxazole 480mg</CodeDescTxt>
        </CotrimoxazoleDose>
        <INHDose>
            <Code>HE</Code>
            <CodeDescTxt>Isoniazid-Ethambutol</CodeDescTxt>
        </INHDose>
        <CD4>100</CD4>
        <CD4TestDate>2010-03-10</CD4TestDate>
        <NextAppointmentDate>2010-04-12</NextAppointmentDate>
    </HIVEncounter>
    <HIVEncounter>
        <VisitID>261100</VisitID>
        <VisitDate>2010-04-12</VisitDate>
        <DurationOnArt>1</DurationOnArt>
        <Weight>73</Weight>
        <BloodPressure>135/85</BloodPressure>
        <PatientFamilyPlanningCode>FP</PatientFamilyPlanningCode>
        <PatientFamilyPlanningMethodCode>FP1</PatientFamilyPlanningMethodCode>
        <FunctionalStatus>W</FunctionalStatus>
        <WHOClinicalStage>3</WHOClinicalStage>
        <TBStatus>2</TBStatus>
        <ARVDrugRegimen>
            <Code>1b</Code>
            <CodeDescTxt>AZT-3TC-NVP</CodeDescTxt>
        </ARVDrugRegimen>
        <CD4>110</CD4>
        <CD4TestDate>2010-04-12</CD4TestDate>
        <NextAppointmentDate>2010-05-11</NextAppointmentDate>
    </HIVEncounter>
</Encounters>
```

```
<LaboratoryReport>
    <VisitID>259430</VisitID>
    <VisitDate>2010-03-10</VisitDate>
    <LaboratoryTestIdentifier>wlk9871</LaboratoryTestIdentifier>
    <CollectionDate>2010-03-10</CollectionDate>
    <BaselineRepeatCode>B</BaselineRepeatCode>
    <ARTStatusCode>P</ARTStatusCode>
    <LaboratoryOrderAndResult>
        <OrderedTestDate>2010-03-10</OrderedTestDate>
        <LaboratoryResultedTest>
            <Code>11</Code>
            <CodeDescTxt>CD4</CodeDescTxt>
        </LaboratoryResultedTest>
        <LaboratoryResult>
            <AnswerNumeric>
                <Value1>100</Value1>
            </AnswerNumeric>
        </LaboratoryResult>
        <ResultedTestDate>2010-03-10</ResultedTestDate>
    </LaboratoryOrderAndResult>
    <Clinician>Clinician Name</Clinician>
    <ReportedBy>Reporter Name</ReportedBy>
    <CheckedBy>Checkedby Name</CheckedBy>
</LaboratoryReport>
<LaboratoryReport>
    <VisitID>259430</VisitID>
    <VisitDate>2010-04-12</VisitDate>
    <LaboratoryTestIdentifier>wlk99456</LaboratoryTestIdentifier>
    <CollectionDate>2010-04-12</CollectionDate>
    <BaselineRepeatCode>B</BaselineRepeatCode>
    <ARTStatusCode>P</ARTStatusCode>
    <LaboratoryOrderAndResult>
        <OrderedTestDate>2010-04-12</OrderedTestDate>
        <LaboratoryResultedTest>
            <Code>11</Code>
            <CodeDescTxt>CD4</CodeDescTxt>
        </LaboratoryResultedTest>
        <LaboratoryResult>
            <AnswerNumeric>
                <Value1>110</Value1>
            </AnswerNumeric>
        </LaboratoryResult>
        <ResultedTestDate>2010-04-12</ResultedTestDate>
```

```
    </LaboratoryOrderAndResult>
    <Clinician>Clinician Name</Clinician>
    <ReportedBy>Reporter Name</ReportedBy>
    <CheckedBy>Checkedby Name</CheckedBy>
</LaboratoryReport>
<Regimen>
    <VisitID>259430</VisitID>
    <VisitDate>2010-03-10</VisitDate>
    <PrescribedRegimen>
        <Code>1b</Code>
        <CodeDescTxt>AZT-3TC-NVP</CodeDescTxt>
    </PrescribedRegimen>
    <PrescribedRegimenTypeCode>ART</PrescribedRegimenTypeCode>
    <PrescribedRegimenLineCode>10</PrescribedRegimenLineCode>
    <PrescribedRegimenDuration>30</PrescribedRegimenDuration>
    <PrescribedRegimenDispensedDate>2010-03-10</PrescribedRegimenDispensedDate>
    <DateRegimenStarted>2010-03-10</DateRegimenStarted>
    <DateRegimenStartedDD>10</DateRegimenStartedDD>
    <DateRegimenStartedMM>03</DateRegimenStartedMM>
    <DateRegimenStartedYYYY>2010</DateRegimenStartedYYYY>
    <PrescribedRegimenInitialIndicator>true</PrescribedRegimenInitialIndicator>
    <PrescribedRegimenCurrentIndicator>true</PrescribedRegimenCurrentIndicator>
    <TypeOfPreviousExposureCode>N</TypeOfPreviousExposureCode>
    <SubstitutionIndicator>false</SubstitutionIndicator>
    <SwitchIndicator>false</SwitchIndicator>
</Regimen>
<Regimen>
    <VisitID>259430</VisitID>
    <VisitDate>2010-03-10</VisitDate>
    <PrescribedRegimen>
        <Code>CTX480</Code>
        <CodeDescTxt>Cotrimoxazole 480mg</CodeDescTxt>
    </PrescribedRegimen>
    <PrescribedRegimenTypeCode>CTX</PrescribedRegimenTypeCode>
    <PrescribedRegimenDuration>30</PrescribedRegimenDuration>
    <PrescribedRegimenDispensedDate>2010-03-10</PrescribedRegimenDispensedDate>
    <DateRegimenStarted>2010-03-10</DateRegimenStarted>
    <DateRegimenStartedDD>10</DateRegimenStartedDD>
    <DateRegimenStartedMM>03</DateRegimenStartedMM>
    <DateRegimenStartedYYYY>2010</DateRegimenStartedYYYY>
    <PrescribedRegimenInitialIndicator>true</PrescribedRegimenInitialIndicator>
    <PrescribedRegimenCurrentIndicator>true</PrescribedRegimenCurrentIndicator>
    <SubstitutionIndicator>false</SubstitutionIndicator>
```

```
            <SwitchIndicator>false</SwitchIndicator>
        </Regimen>
        <Regimen>
            <VisitID>259430</VisitID>
            <VisitDate>2010-03-10</VisitDate>
            <PrescribedRegimen>
                <Code>HE</Code>
                <CodeDescTxt>Isoniazid-Ethambutol</CodeDescTxt>
            </PrescribedRegimen>
            <PrescribedRegimenTypeCode>TB</PrescribedRegimenTypeCode>
            <PrescribedRegimenDuration>30</PrescribedRegimenDuration>
            <PrescribedRegimenDispensedDate>2010-03-10</PrescribedRegimenDispensedDate>
            <DateRegimenStarted>2010-03-10</DateRegimenStarted>
            <DateRegimenStartedDD>10</DateRegimenStartedDD>
            <DateRegimenStartedMM>03</DateRegimenStartedMM>
            <DateRegimenStartedYYYY>2010</DateRegimenStartedYYYY>
            <PrescribedRegimenInitialIndicator>true</PrescribedRegimenInitialIndicator>
            <PrescribedRegimenCurrentIndicator>true</PrescribedRegimenCurrentIndicator>
            <SubstitutionIndicator>false</SubstitutionIndicator>
            <SwitchIndicator>false</SwitchIndicator>
        </Regimen>
        <Regimen>
            <VisitID>261100</VisitID>
            <VisitDate>2010-04-12</VisitDate>
            <PrescribedRegimen>
                <Code>1b</Code>
                <CodeDescTxt>AZT-3TC-NVP</CodeDescTxt>
            </PrescribedRegimen>
            <PrescribedRegimenTypeCode>ART</PrescribedRegimenTypeCode>
            <PrescribedRegimenLineCode>10</PrescribedRegimenLineCode>
            <PrescribedRegimenDuration>30</PrescribedRegimenDuration>
            <PrescribedRegimenDispensedDate>2010-04-12</PrescribedRegimenDispensedDate>
            <DateRegimenStarted>2010-03-10</DateRegimenStarted>
            <DateRegimenStartedDD>10</DateRegimenStartedDD>
            <DateRegimenStartedMM>03</DateRegimenStartedMM>
            <DateRegimenStartedYYYY>2010</DateRegimenStartedYYYY>
            <PrescribedRegimenInitialIndicator>false</PrescribedRegimenInitialIndicator>
            <PrescribedRegimenCurrentIndicator>true</PrescribedRegimenCurrentIndicator>
            <SubstitutionIndicator>false</SubstitutionIndicator>
            <SwitchIndicator>false</SwitchIndicator>
        </Regimen>
    </Condition>
</IndividualReport>
```

```
</Container>
```

4.3 Scenario 3 - Redact

The message from Scenario 1 is later needing to be redacted. The previously submitted message is included, with only the MessageStatusCode changed to REDACTED.

Sample Message

```
<?xml version="1.0" encoding="utf-8"?>
<Container>
<MessageHeader>
        <MessageStatusCode>REDACTED</MessageStatusCode>
        <MessageCreationDateTime>2015-09-09T18:20:22.42</MessageCreationDateTime>
        <MessageSchemaVersion>1.2</MessageSchemaVersion>
        <MessageUniqueID>4567</MessageUniqueID>
        <MessageSendingOrganization>
            <FacilityName>Fictional Implementing Partner Name</FacilityName>
            <FacilityID>3930299292</FacilityID>
            <FacilityTypeCode>IP</FacilityTypeCode>
        </MessageSendingOrganization>
 </MessageHeader>
    <IndividualReport>
        <PatientDemographics>
            <PatientIdentifier>19283746</PatientIdentifier>
            <TreatmentFacility>
                <FacilityName>Central Medical Centre</FacilityName>
                <FacilityID>39383933</FacilityID>
                <FacilityTypeCode>FAC</FacilityTypeCode>
            </TreatmentFacility>
            <OtherPatientIdentifiers>
            <Identifier>
                <IDNumber>678-251-0-1234</IDNumber>
                <IDTypeCode>PN</IDTypeCode>
            </Identifier>
            </OtherPatientIdentifiers>
            <PatientDateOfBirth>1976-07-11</PatientDateOfBirth>
            <PatientSexCode>M</PatientSexCode>
            <PatientDeceasedIndicator>false</PatientDeceasedIndicator>
            <PatientPrimaryLanguageCode>ENG</PatientPrimaryLanguageCode>
            <PatientEducationLevelCode>3</PatientEducationLevelCode>
            <PatientOccupationCode>EMP</PatientOccupationCode>
            <PatientMaritalStatusCode>M</PatientMaritalStatusCode>
            <StateOfNigeriaOriginCode>15</StateOfNigeriaOriginCode>
        </PatientDemographics>
        <Condition>
```

```
            <ConditionCode>86406008</ConditionCode>
            <ProgramArea>
                <ProgramAreaCode>HIV</ProgramAreaCode>
            </ProgramArea>
            <PatientAddress>
                <AddressTypeCode>H</AddressTypeCode>
                <WardVillage>Central</WardVillage>
                <Town>Abuja</Town>
                <LGACode>236</LGACode>
                <StateCode>15</StateCode>
                <CountryCode>NGA</CountryCode>
                <PostalCode>12345</PostalCode>
                <OtherAddressInformation>Enter notes about the address
                      if needed</OtherAddressInformation>
            </PatientAddress>
            <CommonQuestions>
   <HospitalNumber>HN0012</HospitalNumber>
   <DiagnosisFacility>
<FacilityName>Diagnosing Facility</FacilityName>
<FacilityID>10101</FacilityID>
<FacilityTypeCode>FAC</FacilityTypeCode>
   </DiagnosisFacility>
   <DateOfFirstReport>2010-03-30</DateOfFirstReport>
   <DateOfLastReport>2010-03-30</DateOfLastReport>
   <DiagnosisDate>2010-03-10</DiagnosisDate>
   <PatientDieFromThisIllness>false</PatientDieFromThisIllness>
          <PatientAge>40</PatientAge>
            </CommonQuestions>
            <ConditionSpecificQuestions>
                <HIVQuestions>
                    <CareEntryPoint>3</CareEntryPoint>
                    <FirstConfirmedHIVTestDate>2010-03-10</FirstConfirmedHIVTestDate>
                    <FirstHIVTestMode>HIVAb</FirstHIVTestMode>
                    <WhereFirstHIVTest>Clinic Testing Name</WhereFirstHIVTest>
                    <PriorArt>N</PriorArt>
                    <MedicallyEligibleDate>2010-03-10</MedicallyEligibleDate>
                    <ReasonMedicallyEligible>3</ReasonMedicallyEligible>
                    <InitialAdherenceCounselingCompletedDate>2010-03-10
                      </InitialAdherenceCounselingCompletedDate>
                    <FirstARTRegimen>
                        <Code>1b</Code>
                        <CodeDescTxt>AZT-3TC-NVP</CodeDescTxt>
                    </FirstARTRegimen>
                    <ARTStartDate>2010-03-10</ARTStartDate>
                    <WHOClinicalStageARTStart>3</WHOClinicalStageARTStart>
                    <WeightAtARTStart>73</WeightAtARTStart>
                    <FunctionalStatusStartART>W</FunctionalStatusStartART>
                    <CD4AtStartOfART>100</CD4AtStartOfART>
                    <PatientHasDied>false</PatientHasDied>
```

```
                <EnrolledInHIVCareDate>2010-03-10</EnrolledInHIVCareDate>
                <InitialTBStatus>2</InitialTBStatus>
            </HIVQuestions>
        </ConditionSpecificQuestions>
        <Encounters>
            <HIVEncounter>
                <VisitID>259430</VisitID>
                <VisitDate>2010-03-10</VisitDate>
                <DurationOnArt>0</DurationOnArt>
                <Weight>73</Weight>
                <BloodPressure>120/87</BloodPressure>
                <PatientFamilyPlanningCode>FP</PatientFamilyPlanningCode>
                <PatientFamilyPlanningMethodCode>FP1
                  </PatientFamilyPlanningMethodCode>
                <FunctionalStatus>W</FunctionalStatus>
                <WHOClinicalStage>3</WHOClinicalStage>
                <TBStatus>2</TBStatus>
                <ARVDrugRegimen>
                    <Code>1b</Code>
                    <CodeDescTxt>AZT-3TC-NVP</CodeDescTxt>
                </ARVDrugRegimen>
                <CotrimoxazoleDose>
                    <Code>CTX480</Code>
                    <CodeDescTxt>Cotrimoxazole 480mg</CodeDescTxt>
                </CotrimoxazoleDose>
                <INHDose>
                    <Code>HE</Code>
                    <CodeDescTxt>Isoniazid-Ethambutol</CodeDescTxt>
                </INHDose>
                <CD4>100</CD4>
                <CD4TestDate>2010-03-10</CD4TestDate>
                <NextAppointmentDate>2010-04-12</NextAppointmentDate>
            </HIVEncounter>
        </Encounters>
    </Condition>
</IndividualReport>
</Container>
```

4.4 Scenario 4 – Documented Transfer

Patient has initial visit # 9137 on 2 September 2014 at Central Medical Center and is medically evaluated. The patient is placed on 1 regimen to control HIV his CD4 is tested:

Laboratory Order / Result 1: CD4 / Numeric Value = 162

Regimen 1: AZT(300mg)+3TC(150mg)+NVP(200mg)

Patient then goes to Main Hospital Clinic on 10 October and indicates he wants to transfer there, bringing with him his Patient ID from Central Medical Center. He has initial visit #10111, his CD4 is tested and receives the same regimen on this date.

Laboratory Order / Result 1: CD4 / Numeric Value = 178

Regimen 1: AZT(300mg)+3TC(150mg)+NVP(200mg)

Sample Message – Center Medical Center (Orginial Treatment Facility)

```
<?xml version="1.0" encoding="utf-8"?>
<Container>
<MessageHeader>
        <MessageStatusCode>INITIAL</MessageStatusCode>
        <MessageCreationDateTime>2014-09-09T14:10:22.42</MessageCreationDateTime>
        <MessageSchemaVersion>1.2</MessageSchemaVersion>
        <MessageUniqueID>3219887</MessageUniqueID>
        <MessageSendingOrganization>
            <FacilityName>Fictional Implementing Partner Name</FacilityName>
            <FacilityID>3930299292</FacilityID>
            <FacilityTypeCode>IP</FacilityTypeCode>
        </MessageSendingOrganization>
        </MessageHeader>
        <IndividualReport>
        <PatientDemographics>
            <PatientIdentifier>abd987</PatientIdentifier>
            <TreatmentFacility>
                <FacilityName>Central Medical Centre</FacilityName>
                <FacilityID>39383933</FacilityID>
                <FacilityTypeCode>FAC</FacilityTypeCode>
            </TreatmentFacility>
            <PatientDateOfBirth>1971-05-15</PatientDateOfBirth>
            <PatientSexCode>M</PatientSexCode>
            <PatientDeceasedIndicator>false</PatientDeceasedIndicator>
            <StateOfNigeriaOriginCode>15</StateOfNigeriaOriginCode>
        </PatientDemographics>
        <Condition>
            <ConditionCode>86406008</ConditionCode>
            <ProgramArea>
                <ProgramAreaCode>HIV</ProgramAreaCode>
```

```
  </ProgramArea>
  <PatientAddress>
      <AddressTypeCode>H</AddressTypeCode>
      <LGACode>236</LGACode>
      <StateCode>15</StateCode>
      <CountryCode>NGA</CountryCode>
  </PatientAddress>
 <CommonQuestions>
  <HospitalNumber>HN0012</HospitalNumber>
  <DiagnosisFacility>
     <FacilityName>Diagnosing Facility</FacilityName>
     <FacilityID>10101</FacilityID>
     <FacilityTypeCode>FAC</FacilityTypeCode>
 </DiagnosisFacility>
 <DateOfFirstReport>2014-09-09</DateOfFirstReport>
 <DateOfLastReport>2014-09-09</DateOfLastReport>
 <DiagnosisDate>2014-09-02</DiagnosisDate>
 <PatientDieFromThisIllness>false</PatientDieFromThisIllness>
<PatientAge>44</PatientAge>
 </CommonQuestions>
  <ConditionSpecificQuestions>
      <HIVQuestions>
          <CareEntryPoint>3</CareEntryPoint>
          <FirstConfirmedHIVTestDate>2014-08-30</FirstConfirmedHIVTestDate>
          <FirstHIVTestMode>HIVAb</FirstHIVTestMode>
          <WhereFirstHIVTest>Local Testing Clinic</WhereFirstHIVTest>
          <PriorArt>N</PriorArt>
          <MedicallyEligibleDate>2014-09-02</MedicallyEligibleDate>
          <ReasonMedicallyEligible>3</ReasonMedicallyEligible>
          <FirstARTRegimen>
              <Code>1b</Code>
              <CodeDescTxt>AZT-3TC-NVP</CodeDescTxt>
          </FirstARTRegimen>
          <ARTStartDate>2014-09-02</ARTStartDate>
          <WHOClinicalStageARTStart>3</WHOClinicalStageARTStart>
          <WeightAtARTStart>78</WeightAtARTStart>
          <FunctionalStatusStartART>W</FunctionalStatusStartART>
          <CD4AtStartOfART>162</CD4AtStartOfART>
          <PatientHasDied>false</PatientHasDied>
          <EnrolledInHIVCareDate>2014-09-02</EnrolledInHIVCareDate>
          <InitialTBStatus>2</InitialTBStatus>
      </HIVQuestions>
  </ConditionSpecificQuestions>
```

```
            <Encounters>
                <HIVEncounter>
                    <VisitID>9137</VisitID>
                    <VisitDate>2014-09-02</VisitDate>
                    <DurationOnArt>0</DurationOnArt>
                    <Weight>78</Weight>
                    <FunctionalStatus>W</FunctionalStatus>
                    <WHOClinicalStage>3</WHOClinicalStage>
                    <TBStatus>2</TBStatus>
                    <ARVDrugRegimen>
                        <Code>1b</Code>
                        <CodeDescTxt>AZT-3TC-NVP</CodeDescTxt>
                    </ARVDrugRegimen>
                    <CD4>162</CD4>
                    <CD4TestDate>2014-09-02</CD4TestDate>
                    <NextAppointmentDate>2014-10-06</NextAppointmentDate>
                </HIVEncounter>
            </Encounters>
        </Condition>
    </IndividualReport>
</Container>
```

Sample Message – Main Hospital Clinic (As a Transfer In to new Treatment Facility)

```
<?xml version="1.0" encoding="utf-8"?>
<Container>
<MessageHeader>
        <MessageStatusCode>INITIAL</MessageStatusCode>
        <MessageCreationDateTime>2014-10-28T20:18:08.10</MessageCreationDateTime>
        <MessageSchemaVersion>1.2</MessageSchemaVersion>
        <MessageUniqueID>II9584</MessageUniqueID>
        <MessageSendingOrganization>
            <FacilityName>Implementing Partner OrganizationvName</FacilityName>
            <FacilityID>789147</FacilityID>
            <FacilityTypeCode>IP</FacilityTypeCode>
        </MessageSendingOrganization>
</MessageHeader>
    <IndividualReport>
        <PatientDemographics>
            <PatientIdentifier>pa982178</PatientIdentifier>
            <TreatmentFacility>
                <FacilityName>Main Hospital Clinic</FacilityName>
                <FacilityID>025YA987</FacilityID>
                <FacilityTypeCode>FAC</FacilityTypeCode>
```

```
    </TreatmentFacility>
    <PatientDateOfBirth>1971-05-15</PatientDateOfBirth>
    <PatientSexCode>M</PatientSexCode>
    <PatientDeceasedIndicator>false</PatientDeceasedIndicator>
    <StateOfNigeriaOriginCode>15</StateOfNigeriaOriginCode>
</PatientDemographics>
<Condition>
    <ConditionCode>86406008</ConditionCode>
    <ProgramArea>
        <ProgramAreaCode>HIV</ProgramAreaCode>
    </ProgramArea>
    <PatientAddress>
        <AddressTypeCode>H</AddressTypeCode>
        <LGACode>236</LGACode>
        <StateCode>15</StateCode>
        <CountryCode>NGA</CountryCode>
    </PatientAddress>
   <CommonQuestions>
    <HospitalNumber>987645</HospitalNumber>
    <DiagnosisFacility>
       <FacilityName>Diagnosing Facility</FacilityName>
       <FacilityID>10101</FacilityID>
       <FacilityTypeCode>FAC</FacilityTypeCode>
    </DiagnosisFacility>
   <DateOfFirstReport>2014-10-28</DateOfFirstReport>
   <DateOfLastReport>2014-10-28</DateOfLastReport>
   <DiagnosisDate>2014-09-02</DiagnosisDate>
   <PatientDieFromThisIllness>false</PatientDieFromThisIllness>
  <PatientAge>44</PatientAge>
   </CommonQuestions>
     <ConditionSpecificQuestions>
        <HIVQuestions>
            <CareEntryPoint>3</CareEntryPoint>
            <FirstConfirmedHIVTestDate>2014-08-30</FirstConfirmedHIVTestDate>
            <FirstHIVTestMode>HIVAb</FirstHIVTestMode>
            <WhereFirstHIVTest>Local Testing Clinic</WhereFirstHIVTest>
            <PriorArt>N</PriorArt>
            <MedicallyEligibleDate>2014-09-02</MedicallyEligibleDate>
            <ReasonMedicallyEligible>3</ReasonMedicallyEligible>
            <TransferredInDate>2014-10-10</TransferredInDate>
            <TransferredInFrom>
               <FacilityName>Central Medical Centre</FacilityName>
               <FacilityID>39383933</FacilityID>
```

```
                    <FacilityTypeCode>FAC</FacilityTypeCode>
                </TransferredInFrom>
                <TransferredInFromPatId>abd987</TransferredInFromPatId>
                <FirstARTRegimen>
                    <Code>1b</Code>
                    <CodeDescTxt>AZT-3TC-NVP</CodeDescTxt>
                </FirstARTRegimen>
                <ARTStartDate>2014-09-02</ARTStartDate>
                <WHOClinicalStageARTStart>3</WHOClinicalStageARTStart>
                <WeightAtARTStart>78</WeightAtARTStart>
                <FunctionalStatusStartART>W</FunctionalStatusStartART>
                <CD4AtStartOfART>144</CD4AtStartOfART>
                <PatientHasDied>false</PatientHasDied>
                <EnrolledInHIVCareDate>2014-09-02</EnrolledInHIVCareDate>
                <InitialTBStatus>2</InitialTBStatus>
            </HIVQuestions>
        </ConditionSpecificQuestions>
        <Encounters>
            <HIVEncounter>
                <VisitID>10111</VisitID>
                <VisitDate>2014-10-10</VisitDate>
                <DurationOnArt>1</DurationOnArt>
                <Weight>76</Weight>
                <FunctionalStatus>W</FunctionalStatus>
                <WHOClinicalStage>3</WHOClinicalStage>
                <TBStatus>2</TBStatus>
                <ARVDrugRegimen>
                    <Code>1b</Code>
                    <CodeDescTxt>AZT-3TC-NVP</CodeDescTxt>
                </ARVDrugRegimen>
                <CD4>178</CD4>
                <CD4TestDate>2014-10-10</CD4TestDate>
                <NextAppointmentDate>2014-11-14</NextAppointmentDate>
            </HIVEncounter>
        </Encounters>
    </Condition>
  </IndividualReport>
</Container>
```

4.5 Scenario 5 – Multiple Conditions

The patient from Scenario 1 is also diagnosed with Malaria during the initial visit. A second Condition element is included to provide information about the Malaria diagnosis.

Sample Message

```
<?xml version="1.0" encoding="utf-8"?>
<Container>
<MessageHeader>
        <MessageStatusCode>INITIAL</MessageStatusCode>
        <MessageCreationDateTime>2015-08-26T18:02:50.07</MessageCreationDateTime>
        <MessageSchemaVersion>1.2</MessageSchemaVersion>
        <MessageUniqueID>4567</MessageUniqueID>
        <MessageSendingOrganization>
            <FacilityName>Fictional Implementing Partner Name</FacilityName>
            <FacilityID>3930299292</FacilityID>
            <FacilityTypeCode>IP</FacilityTypeCode>
        </MessageSendingOrganization>
</MessageHeader>
    <IndividualReport>
        <PatientDemographics>
            <PatientIdentifier>19283746</PatientIdentifier>
            <TreatmentFacility>
                <FacilityName>Central Medical Centre</FacilityName>
                <FacilityID>39383933</FacilityID>
                <FacilityTypeCode>FAC</FacilityTypeCode>
            </TreatmentFacility>
            <OtherPatientIdentifiers>
            <Identifier>
                <IDNumber>678-251-0-1234</IDNumber>
                <IDTypeCode>PN</IDTypeCode>
            </Identifier>
            </OtherPatientIdentifiers>
            <PatientDateOfBirth>1976-07-11</PatientDateOfBirth>
            <PatientSexCode>M</PatientSexCode>
            <PatientDeceasedIndicator>false</PatientDeceasedIndicator>
            <PatientPrimaryLanguageCode>ENG</PatientPrimaryLanguageCode>
            <PatientEducationLevelCode>3</PatientEducationLevelCode>
            <PatientOccupationCode>EMP</PatientOccupationCode>
            <PatientMaritalStatusCode>M</PatientMaritalStatusCode>
            <StateOfNigeriaOriginCode>15</StateOfNigeriaOriginCode>
        </PatientDemographics>
        <Condition>
            <ConditionCode>86406008</ConditionCode>
```

```
            <ProgramArea>
                <ProgramAreaCode>HIV</ProgramAreaCode>
            </ProgramArea>
            <PatientAddress>
                <AddressTypeCode>H</AddressTypeCode>
                <WardVillage>Central</WardVillage>
                <Town>Abuja</Town>
                <LGACode>236</LGACode>
                <StateCode>15</StateCode>
                <CountryCode>NGA</CountryCode>
                <PostalCode>12345</PostalCode>
                <OtherAddressInformation>Enter notes about the address
                      if needed</OtherAddressInformation>
            </PatientAddress>
            <CommonQuestions>
   <HospitalNumber>HN0012</HospitalNumber>
   <DiagnosisFacility>
<FacilityName>Diagnosing Facility</FacilityName>
<FacilityID>10101</FacilityID>
<FacilityTypeCode>FAC</FacilityTypeCode>
   </DiagnosisFacility>
   <DateOfFirstReport>2010-03-30</DateOfFirstReport>
   <DateOfLastReport>2010-03-30</DateOfLastReport>
   <DiagnosisDate>2010-03-10</DiagnosisDate>
   <PatientDieFromThisIllness>false</PatientDieFromThisIllness>
          <PatientAge>40</PatientAge>
            </CommonQuestions>
            <ConditionSpecificQuestions>
                <HIVQuestions>
                    <CareEntryPoint>3</CareEntryPoint>
                    <FirstConfirmedHIVTestDate>2010-03-10</FirstConfirmedHIVTestDate>
                    <FirstHIVTestMode>HIVAb</FirstHIVTestMode>
                    <WhereFirstHIVTest>Clinic Testing Name</WhereFirstHIVTest>
                    <PriorArt>N</PriorArt>
                    <MedicallyEligibleDate>2010-03-10</MedicallyEligibleDate>
                    <ReasonMedicallyEligible>3</ReasonMedicallyEligible>
                    <InitialAdherenceCounselingCompletedDate>2010-03-10
                      </InitialAdherenceCounselingCompletedDate>
                    <FirstARTRegimen>
                        <Code>1b</Code>
                        <CodeDescTxt>AZT-3TC-NVP</CodeDescTxt>
                    </FirstARTRegimen>
                    <ARTStartDate>2010-03-10</ARTStartDate>
```

```
            <WHOClinicalStageARTStart>3</WHOClinicalStageARTStart>
            <WeightAtARTStart>73</WeightAtARTStart>
            <FunctionalStatusStartART>W</FunctionalStatusStartART>
            <CD4AtStartOfART>100</CD4AtStartOfART>
            <PatientHasDied>false</PatientHasDied>
            <EnrolledInHIVCareDate>2010-03-10</EnrolledInHIVCareDate>
            <InitialTBStatus>2</InitialTBStatus>
        </HIVQuestions>
    </ConditionSpecificQuestions>
    <Encounters>
        <HIVEncounter>
            <VisitID>259430</VisitID>
            <VisitDate>2010-03-10</VisitDate>
            <DurationOnArt>0</DurationOnArt>
            <Weight>73</Weight>
            <BloodPressure>120/87</BloodPressure>
            <PatientFamilyPlanningCode>FP</PatientFamilyPlanningCode>
            <PatientFamilyPlanningMethodCode>FP1</PatientFamilyPlanningMethodCode>
            <FunctionalStatus>W</FunctionalStatus>
            <WHOClinicalStage>3</WHOClinicalStage>
            <TBStatus>2</TBStatus>
            <ARVDrugRegimen>
                <Code>1b</Code>
                <CodeDescTxt>AZT-3TC-NVP</CodeDescTxt>
            </ARVDrugRegimen>
            <CotrimoxazoleDose>
                <Code>CTX480</Code>
                <CodeDescTxt>Cotrimoxazole 480mg</CodeDescTxt>
            </CotrimoxazoleDose>
            <INHDose>
                <Code>HE</Code>
                <CodeDescTxt>Isoniazid-Ethambutol</CodeDescTxt>
            </INHDose>
            <CD4>100</CD4>
            <CD4TestDate>2010-03-10</CD4TestDate>
            <NextAppointmentDate>2010-04-12</NextAppointmentDate>
        </HIVEncounter>
    </Encounters>
</Condition>
<Condition>
    <ConditionCode>61462000</ConditionCode>
    <ProgramArea>
        <ProgramAreaCode>OTH</ProgramAreaCode>
```

```
            </ProgramArea>
            <PatientAddress>
                <AddressTypeCode>H</AddressTypeCode>
                <WardVillage>Central</WardVillage>
                <Town>Abuja</Town>
                <LGACode>236</LGACode>
                <StateCode>15</StateCode>
                <CountryCode>NGA</CountryCode>
                <PostalCode>12345</PostalCode>
                <OtherAddressInformation>Enter notes about the address
                      if needed</OtherAddressInformation>
            </PatientAddress>
            <CommonQuestions>
               <HospitalNumber>HN0012</HospitalNumber>
               <DiagnosisFacility>
                 <FacilityName>Diagnosing Facility</FacilityName>
                 <FacilityID>10101</FacilityID>
                 <FacilityTypeCode>FAC</FacilityTypeCode>
               </DiagnosisFacility>
               <DateOfFirstReport>2010-03-30</DateOfFirstReport>
               <DateOfLastReport>2010-03-30</DateOfLastReport>
               <DiagnosisDate>2010-03-10</DiagnosisDate>
               <PatientDieFromThisIllness>false</PatientDieFromThisIllness>
               <PatientAge>40</PatientAge>
            </CommonQuestions>
        </Condition>
    </IndividualReport>
</Container>
```

4.6 Scenario 6 – Required Fields Only

This message contains only the basic required elements and does not convey information describing detailed information about the patient condition.

Sample Message

```
        <?xml version="1.0" encoding="utf-8"?>
        <Container>
        <MessageHeader>
                <MessageStatusCode>INITIAL</MessageStatusCode>
                <MessageCreationDateTime>2015-08-26T18:02:50.07</MessageCreationDateTime>
                <MessageSchemaVersion>1.2</MessageSchemaVersion>
```

```
        <MessageUniqueID>4567</MessageUniqueID>
        <MessageSendingOrganization>
            <FacilityName>Fictional Implementing Partner Name</FacilityName>
            <FacilityID>3930299292</FacilityID>
            <FacilityTypeCode>IP</FacilityTypeCode>
        </MessageSendingOrganization>
</MessageHeader>
<IndividualReport>
        <PatientDemographics>
            <PatientIdentifier>19283746</PatientIdentifier>
            <TreatmentFacility>
                <FacilityName>Central Medical Centre</FacilityName>
                <FacilityID>39383933</FacilityID>
                <FacilityTypeCode>FAC</FacilityTypeCode>
            </TreatmentFacility>
        </PatientDemographics>
        <Condition>
            <ConditionCode>86406008</ConditionCode>
            <ProgramArea>
                <ProgramAreaCode>HIV</ProgramAreaCode>
            </ProgramArea>
        </Condition>
    </IndividualReport>
</Container>
```