

UNITED REPUBLIC OF TANZANIA



MINISTRY OF HEALTH, COMMUNITY DEVELOPMENT, GENDER,
ELDERLY AND CHILDREN

NATIONAL OPERATIONAL GUIDELINE FOR COMMUNITY BASED TB, TB/HIV AND DR-TB INTERVENTIONS

National TB and Leprosy Programme (NTLP)
P.O. Box 9083
Dar es Salaam

MAY 2016

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FOREWORD

The Government has been committed to improve access to quality health services including primary health care since the 1960s. During this period the Ministry responsible for Health (now known as the Ministry of Health, Community Development, Gender, Elderly and Children, MoHCDGEC) realized the importance of strengthening a linkage between health facilities and the community in the provision of health services at community level.

Tuberculosis (TB) is one of the major public health problems in the country with a prevalence of 528/100,000 population. Currently, the health system is detecting only 36% of the estimated cases, with the remaining 64% going undiagnosed in the community. One of the challenges for TB control in the country is that a number of TB cases are not reached by the current health system and program interventions. Other challenges include inadequate community awareness on TB and its control measures, long distances to TB diagnostic facilities, and ultimately delayed medical seeking behaviour. In order to address the identified challenges, the MoHCDGEC through the National TB and Leprosy Programme (NTLP) adapted the ENGAGE TB approach so as to sensitize and encourage a wider range of stakeholders to involve themselves in community-based activities. These include Non-Governmental Organizations (NGOs), Civil Society Organizations (CSOs) and other Non-State Actors (NSAs) who are actively involved in community-based activities, particularly in Primary Health Care, Reproductive and Child Health, HIV/AIDS and Social Economic activities. Unfortunately, TB control has not been included in their list of priorities or activities despite their capacity to easily reach the community. This strategy has been a success. To date about 20 CSOs have engaged in TB control activities compared to four years back, where by only five NGOs were implementing TB interventions. Based on this positive experience, the country is therefore expecting more CSOs to work in this area, a fact that calls for a clear guidance on community TB service provision.

The MoHCDGEC has therefore developed these National Operational Guideline for TB, TB/HIV and DR-TB interventions to provide guidance to implementers.

This document is translating the overarching policy guideline for community health and will strengthen collaboration between implementers and linkage between the community and health facilities providing TB, TB/HIV and DR-TB services.

Moreover, since Government guideline are living documents, the Ministry will strive to revise, improve and update this document based on availability of new scientific and technological advances in the field, and the opinion of end users of this document during implementation. Your feedback is therefore very vital. The MoHCDGEC urges all stakeholders and partners engaged in community TB, TB/HIV and DR-TB control to fully comply with this guideline and support the provision of the services in the country.



Prof. Muhammad Bakari Kambi
Chief Medical Officer

ACKNOWLEDGEMENTS

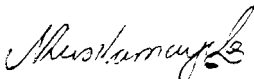
This operation guideline for community based TB, TB/HIV and DR- TB interventions is the product of collective efforts of many individuals, partner institutions, Non-Governmental Organizations and other Civil Society Organizations including EGPAF, AGPAHI, Mary-Land University, KNCV, PATH, AMREF, MKUTA and NACOPHA.

The Ministry of Health, Community Development, Gender, Elderly and Children (MoHCDGEC) through the National TB and Leprosy Programme (NTLP) wishes to extend sincere gratitude to all those who have devoted their efforts, time, energy and knowledge towards the development of this guideline. Appreciation go to Dr. Beatrice Mutayoba (Programme Manager-NTLP) and Dr. Liberate Mleoh (Deputy Programme Manager) for their leadership. Ms. Lilian Ishengoma (Community TB Care Coordinator - NTLP) and Rose Olotu (Community TB/ HIV advisors – PATH/ KNCV) for their tireless work, technical guidance and coordination during development of the guideline. Furthermore I would like to acknowledge with great appreciation, other NTLP staff, NACP staff and CHP staff and Regional and District TB and Leprosy coordinators, TB/HIV officers, district HBC coordinators and other individuals for their technical support towards development of these guideline.

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As it is not possible to mention each individual, I extend similar thanks to all those who in one way or another gave their inputs into the production of the guideline.

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Dr Neema Rusibamayila

Director of Preventive Services

ACRONYMS

ACF	Active Case Finding
AIDS	Acquired immune deficiency syndrome
ARVs	Anti Retro Viral
CBOs	Community Based Organizations
CHMT	Council Health Management Team
CCHP	Comprehensive Council Health Plans
CHP	Community Health Programme
CHW	Community Health Worker
CI	Contact investigation
CORPs	Community Owned Resource Persons
CSO	Civil Society Organization
CSW	Commercial Sex Worker
CTC	Care and Treatment Clinics
DMO	District Medical Officer
DOT	Directly Observed Treatment
DRS	Drug Resistance Surveillance
DR TB	Drug Resistant Tuberculosis
DTLC	District Tuberculosis and Leprosy Coordinator
EQA	External Quality Assurance
Ex-TB	Formal Tuberculosis Patient
GBV	Gender Based Violence
HB-DOT	Home Based DOT
HIV	Human immunodeficiency virus
HTC	Home Testing and Counselling
IDP	Internally Displaced Persons
IDU	Intravenous Drug Users
IEC	Information Education and Communication
IGAs	Income Generating Activities
IPC	Infection prevention control services
KPs	Key Populations

LTBI	Latent Tuberculosis Infection
M& E	Monitoring & Evaluation
MDR	Multi Drug Resistant
MKUTA	Mapanbano ya Kifua kiuu na UKIMWI Tanzania
MSM	Men having Sex with Men
MOHCDGEC	Ministry of Health, Community Development Gender, Elderly and Children
MVCCs	Most Vulnerable Children
NGOs	Non-Governmental organization
NTLP	National Tuberculosis and Leprosy Programme
OVC	Orphan and Vulnerable Children
PHDP	Positive Health, Dignity and Prevention
PITC	Provider Initiated Testing and Counselling
PLHIV	People Living with Human Immune Virus
POLARG	President Office Regional Administration and Local Government
PIWDs	People Injecting With Drugs
RCH	Reproductive and Child Health
RHMT	Regional Health Management Team
RMO	Regional Medical officer
RTLCC	Regional Tuberculosis and Leprosy Coordinator
SACCOs	Savings and Credit Co-operatives
STI	Sexually Transmitted Infections
TB	Tuberculosis
TBHIV	Tuberculosis and Human Immune Deficiency Virus
TFNC	Tanzania Food and Nutrition Centre
TSQ	Tuberculosis screening questionnaires
VAC	Violence against Children
VDCs	Village Development Committees
VEO	Village Executive Officer
VICOBA	Village Community Banks
WEO	Ward Executive Officer
WHO	World Health Organization

Definition of Terms

Advocacy: Is a set of coordinated activities for creating political and social will and influencing decision makers to take actions to support an achievable policy goal.

Community: Is a group of people, based on common values and norms, who live within a geographically defined area and who share a common language, culture or values.

Community-based TB activities: These cover a wide range of activities that contribute to detection, referral and treatment of people with drug-susceptible, drug-resistant and HIV-associated TB. They are conducted outside the premises of formal health facilities (e.g. hospitals, health centres and clinics), in communities and community-based structures (e.g. schools, places of worship, congregate settings, markets) and homesteads¹.

Community Involvement: The process whereby a community takes responsibility for identifying, analysing, prioritising and addressing its problems. The community should have authority and control over its resources, management and ownership for health and development activities.

Community Health Worker (CHW): Female and/or male individuals chosen by the community and trained to address health issues of individuals and communities in their respective localities, working in close relationship with health facilities. A CHW acts as a catalyst and a change agent to enable people to take control and responsibility for their own efforts achievement in the health².

Community volunteers: These are people who have been systematically sensitized about TB prevention and care, either through a short, specific training scheme or through repeated, regular contact sessions with professional health workers. Their profile, roles and responsibilities vary greatly between projects/interventions, and their time is often compensated by incentives in kind or in cash¹.

Contact investigation (CI): This is a systematic process intended to identify previously undiagnosed cases of TB among the contacts of an index case³.

1 Global TB report 2015, WHO

2 National Community Based Health Program Policy Guideline (MOHSW, 2014)

3 Recommendations for investigating contacts of persons with infectious tuberculosis in low- and middle-income countries, WHO, 2012

Direct Observed Treatment (DOT): Means that a trained health care provider or other designated individual, including family members observe the patient swallow all the tablets.

Health: A state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.

Health Promotion: Defined by the World Health Organization's (WHO) 2005 Bangkok Charter in a Globalized World as "the process of enabling people to increase control over their health and its determinants, and thereby improve their health".

Health Education: Is defined as any combination of learning experiences designed to help individuals and communities improve their health, by increasing their knowledge or influencing their attitudes.

Health service integration: Refers to combine health care services and components of health care services that are currently delivered and/or managed separately, for the purpose of optimizing the use of scarce resources, maximizing coverage of services, and improving health outcomes.

Influential person: This can be any person generally respected and trusted by the community and are ready to engage with community to effect positive change.

Initial lost to follow-up: Refers to TB patients who not yet started treatment or have missed treatment for less than two months consecutively.

Linkage: Means a network to enhance patients to receive continuum of care of different services.

Lost to follow up TB cases: Is a TB patient who did not start treatment or whose treatment was interrupted. Such a patient should be traced and brought back to DOT clinic to start or re-start treatment.

Primary Health Care: As stated at Alma Ata Conference: "Primary health care is essential health care based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full participation and at a cost that the community and country can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination."

Executive Summary

Tanzania ranks 6th among 30 highest TB burden countries in the world and 4th in Africa. The most recent WHO modeled estimates in 2015 show that the prevalence of TB all forms in Tanzania stands at 528 per 100,000 with incidence of 327 per 100,000 and case detection rates determined at 36%. In 2015, Tanzania notified a total of 62,180 cases of all forms of TB¹. WHO Global TB report of 2015 estimated that Tanzania is missing approximately 108,429 TB cases of all forms each year².

Community based activities in the control of TB, TBHIV and DR-TB is among the main pillar in the End TB strategy, the fourth National Health strategic Plan and the fifth NTLP strategic plan. The engagement of CSOs, Former TB patients groups, TB patients, families and other communities members is a main approach in realizing this important pillar. In this regard a guideline on how to implement community TB, TB/HIV and DR-TB activities is needed to provide guidance, coordination and leadership to all the mentioned stakeholders.

This operational guideline offer a coordinative and integrative framework to provide guidance to all community based TB, TB/HIV and DR-TB stakeholders in the planning, implementation, and scale up of community based TB, TB/HIV and DR-TB prevention, diagnosis, treatment, and care activities. The motivation that led to the development of this guideline was to enhance efficient provision of quality and systematic community based TB, TB/HIV, and DR-TB interventions.

The guideline describes key community based TB, TB/HIV and DR TB interventions; roles and responsibilities for different levels of care provision; and monitoring and evaluation for community-based TB, TB/HIV, and DR-TB interventions. It will be used by anyone who needs to implement TB, TB/HIV and DR TB control activities.

1 NTLP data, 2015

2 Global Tuberculosis Report (WHO, 2015)

CHAPTER ONE

INTRODUCTION

1.1 Background

Community based Tuberculosis activities in Tanzania

Communities in Tanzania continue to face challenges in accessing quality health care services. In responding to these challenges, approaches such as expanding health care interventions to outside clinic and hospital setting have been implemented for over a decade. This is termed Community based health care.

Community Based TB Care has been implemented in the country since 2003 whereby community members have been trained and supervised to provide Directly Observed Treatment (DOT) to TB patients at home. This complements DOT coverage which is now national wide with high treatment success rates. Community mobilization activities for TB control have empowered TB patients to participate in TB and TB-HIV control activities. The main objective is to decentralize TB services beyond health facilities and into the communities. It does not replace health-facility TB control services but embraces Primary Health Care (PHC) approach of community engagement on TB control and makes care more accessible to patients and their families. Currently, there are over 400 ex TB patients groups. Community contribution in TB case notification has been increased from 15% (2013) to 19% (2014) of all TB cases notified nationally¹ Furthermore, 89% of the TB patients received treatment through Community (home based) DOT in 2014² and their treatment success is 91.1%.

Despite of the national DOTs coverage and higher proportion of home based DOT, a number of challenges still exist in the control and prevention of TB in Tanzania. These include delays by patients in seeking care which indicates persistent transmission of TB in the community, passive participation of the

1 NTLP Annual report, 2014

2 NTLP data, 2014

community in TB care and control, stigma associated with TB and HIV and emerging threat of drug-resistant TB. Nevertheless, TB/HIV and DR-TB have yet to be well engaged in community TB care activities.

ENGAGE TB approach is currently used engaging NGOs and other CSOs for building and strengthening community systems to increase early TB case detection, services delivery and treatment success.

TB, TB/HIV, DR-TB situation in Tanzania

Tuberculosis (TB): Tanzania is among the highest TB burden countries in Africa which contribute to 85-89% of the global TB burden. The most recent WHO modeled estimates in 2015 show that the prevalence of TB all forms in Tanzania stands at 528 per 100,000 with incidence of 327 per 100,000 and case detection rates determined at 36%³. According to 2015 data Tanzania notified a total of 62,180 cases of all forms of TB⁴. WHO Global TB report of 2015 estimated that, Tanzania is missing approximately 108,429 TB cases of all forms each year.

The estimated population mortality rate has been decreasing since the 1990s and in 2014 was estimated at 58/100,000 population. TB-related mortality of HIV -infected TB cases specifically is 52/100,000. TB cases mortality rates are higher among males than females in the age range 40-54 years and increased in adults aged 65 years and above. The notified death rate has progressively been declining since 2006 from 8% to 5.6% in 2014 (NTLP data, 2014).

TB/HIV: HIV remains a major driver of the TB epidemic. In Tanzania Mainland, HIV/TB co- infection has decreased to 34.8% in 2014 as compared to 37% in 2012 and 2013. In the year 2014 63,151 TB cases were notified, among the notified cases (91%) were counseled and tested for HIV. The testing results shows that 19,890 (36%) cases were found to be co-infected with HIV which is less by 1% compared to the co-infection rate in 2013. Furthermore, analysis shows that among of the co-infected cases 19,131 (96%) cases were registered at HIV care and Treatment clinics (CTCs) for care and treatment services.

³ Global Tuberculosis Report (WHO, 2015)

⁴ NTLP data, 2015

Among them 19,222 (97%) were put on Co-trimoxazole Preventive Therapy (CPT) while 16,437 (83%) were initiated ART in both TB clinic and CTCs within the three months reporting period after a two weeks tolerance period following starting TB treatment. Overall treatment success for those co-infected patients was 78% with death rate of 8% in 2013 (NTLP report, 2014). The inter-related epidemiological patterns of HIV and TB present opportunities for joint programming and response at all levels including community level. This will lead into efficient use of resources for the high impact results.

Drug resistant TB: According to the National Drug Resistance Survey (2006/7), DR-TB patients have been cumulatively enrolled on treatment from November, 2009 to December, 2014. There has been an increase of DR-TB-HIV co-infection from 27% in 2012 to 45% in 2014 mostly attributed to the scale up of X-pert MTB RIF technology in the country. Major drivers of DR-TB include; poor patient follow-up of drug sensitive TB and poor adherence to treatment by some of patients of which community engagement is potential to reduce the faults. Treatment outcomes of the three cohorts show that; treatment success of the enrolled cases have been favorable at 75% (2009), 75% (2010), 75% (2011) and 89% (2012) surpassing global targets for treatment success rate which are set at 75%⁵.

1.2 Rationale

Engagement of NGO and other CSOs, former TB patients groups and communities is a main approach in realizing this important pillar. Through ENGAGE TB approach, NTLP have sensitised a number of CSOs to integrate TB control activities into their plans. To date, there are various implementers of community Based TB, TB/HIV and DR-TB activities. In this regard a guideline on how to implement the activities is needed to provide guidance, coordination and leadership to all stakeholders. These call for guidance for efficient TB control interventions at community level.

⁵ Implementation Framework for Expanded Decentralization of DR-TB Services in Tanzania (MoHSW, 2015)

1.3 Scope of the guideline

The principles in these guideline are aligned with the National strategic plan for TB and Leprosy 2015-2020 in line with Global End TB strategy 2016-2035, and are complementary to existing guideline to engage NGOs and other CSOs and communities in TB prevention and care at community level. This guidance also emphasizes that CSOs providing facility-based TB services like hospitals, health centres or clinics integrate community based TB services.

The guideline are intended to provide guidance to community TB stakeholders at all level of health from national, regional, district and community to implement quality, accessible and safe community based TB, TB/HIV, and DR-TB care and treatment support services.

These guideline are intended for five main sets of actors:

- Ministry of Health, Community development, Gender, Elderly and Children (MOHCDEGEC), Presidents Office Regional Administration and Local Government (PORALG) through National Tuberculosis and Leprosy Programme (NTLP) and National AIDS Control Programme (NACP) for coordination and monitoring of Community Based TB, TB/HIV and DR TB interventions in the country.
- RHMTs, CHMTs, for coordination and monitoring of Community Based TB, TB/HIV and DR TB services in their localities.
- NGOs and other CSOs working on HIV, TB, TB/HIV, DR-TB and other development initiatives (e.g. advocacy, education, agriculture or income generation schemes) that intend to integrate TB prevention and care services in their field work.
- Funding agencies, academia and research stakeholders (especially those with interest and expertise in operational and implementation research) can also benefit from this guidance to support community based TB interventions.
- Community Based TB service providers and community members at large.

1.4 Process of developing guideline

The National Guideline for Community Based TB, TB/HIV, and DR-TB Services have been developed by the MOHCDGEC through NTLP in collaboration with implementing partners and other stakeholders in TB control. Relevant content has been drawn from various documents in line with the National Community Based Health Programme Policy Guideline including; WHO ENGAGE-TB guideline, National ENGAGE TB operational Guideline, NTLP manual, NTLP implementation reports, National Guideline for Community Based HIV and AIDS services, Adaptation and Implementation Guide for Recommendations for Investigating Contacts of Persons with Infectious Tuberculosis in Low- and Middle-income Countries by USAID. The Guideline were first drafted by MOHCDGEC staff and a National consultant as a template where other participants built on during the workshop held on February 2016, in Morogoro, Tanzania; the second workshop was conducted in April 2016 in Morogoro, Tanzania whereby inputs were added by NTLP, NGOs and other stakeholders in collaboration with an International Consultant. Finally, the document was shared in the meeting which was conducted at the end of April in Bagamoyo - Pwani region which involved various stakeholders including community members, civil society organizations and government officials for them to buy in the guideline before printing.

Through this process the guideline have improved in framework and material content.

1.5 Overall goal of the guideline

The overall goal of this guidance document is to enhance efficient provision of quality and systematic community based TB, TB/HIV, and DR-TB interventions.

The **specific objectives** of the document are to:

- 1) To describe community based TB, TB/HIV, DR-TB services and approaches in Tanzania.
- 2) To provide guidance for implementation of community based TB, TB/HIV, DR-TB control interventions.

- 3) To describe roles and responsibilities of different stakeholders in the provision of community TB, TB/HIV, DR-TB interventions.
- 4) To provide guidance for monitoring and evaluation of community based TB, TB/HIV, DR-TB control interventions.

1.6 Guiding principles

The following are considered essential for designing, implementing, recording, and reporting of Community TB care programs, which should target all people in need of these services. Community TB, TB/HIV and DR-TB service programs should be *comprehensive*. They should include medical and nursing care, legal advice, referrals, emotional, socioeconomic, and spiritual support. Cooperation at all levels including involving all key players i.e. MOHCDGEC, POLARG and TFNC is of paramount importance.

- **Using a continuum of care approach:** Community TB, TB/HIV and DR-TB programs should be *provided along a continuum of care* which provides comprehensive care and support; and links health-facility services with services at home and in the community.
- **Using holistic approach:** Community TB, TB/HIV and DR-TB programs should be *integrated with appropriate prevention activities*. These include cough hygiene and infection control measures; provision of Positive Health, Dignity and Prevention packages (PHDP) for TB, TB/HIV and DR-TB and care services for orphans, vulnerable children and key populations in TB control including Elderly, Prison, Children and other populations in congregate settings.
- **Family/Patient Centered:** Community TB, TB/HIV and DR-TB programs should be provided in *family/ Patients-centered approach*. TB Patients, Family or household members are key actors to support the Programme.
- **Community Ownership:** Community TB, TB/HIV and DR-TB programs should be *owned by communities*.

- **Community Involvement:** Community members should be involved in the programs and participate fully in planning, implementation and monitoring.
- **Using a SBCC approach:** Community TB, TB/HIV and DR-TB programs should use communication to promote and facilitate behavior change and support the requisite social change for the purpose of improving health outcomes. Thus it works at one or more levels: the behavior of individual, collective actions taken by groups, social and cultural structures and the enabling environment.
- **Focusing on Sustainability:** Community TB, TB/HIV and DR-TB program planning and implementation should focus on sustainability.
- **Gender equity centered:** Community TB, TB/HIV and DR-TB services model requires fair distribution of gender roles and responsibilities. Families and communities should address the gender issues in supporting TB patients, PLHIVs, key populations and other vulnerable groups.

CHAPTER TWO

2. COMMUNITY BASED TB CARE APPROACHES

Community TB care covers a wide range of activities and services that contribute to the detection, referral, and treatment support of people with TB, DR-TB and TB/HIV. These are conducted outside the premises of formal health facilities in communities and community based structure for example schools, places of worship, congregate settings, markets, factories and homesteads.

For better implementation of community TB care in Tanzania, three approaches are employed: Patient Centred Treatment, Community engagement and CSOs engagement.

2.1 Patient Centered Treatment (PCT)

In PCT, TB patients are given an option to choose where they would like to be supervised during their daily treatment, in a health facility or at home. A patient who chooses to be supervised at a health facility will receive their daily treatment under the supervision of a health care worker (HCWs). A patient who chooses to take daily treatment at home will be supervised by a treatment supporter of his/her own choice who has been trained in directly observed treatment (DOT) and how to record daily medication⁶.

PCT makes easier for patients to complete their treatment without compromising the principles of directly observed treatment. It has been recognized that health facility directly observed treatment puts too much demand on patients and health care workers.

HCWs should provide patients and families with basic information on TB, including reassurance that TB is curable; the treatment process and duration; drug side effects, including how to identify them and what to do if they occur; and the importance of adhering to and completing treatment. Explain the necessity

⁶ Patient Centred Treatment Guideline, MOHSW, 2005

of directly observed treatment either in a facility or at home, and communicate with patients and their families in a supportive manner and be ready to answer their questions.

Note: The choice of receiving treatment in a facility or at home can only be offered to new patients. Previously treated TB patients can only be offered this choice after they have completed the first three months (initial phase) of treatment, which includes daily streptomycin injection.

A patient should be given time to decide and the TB treatment should start at health facility until a patient chooses otherwise.

Note: For details, refer to *How to Provide Patient-Centered TB Treatment, 2005*.

2.2 Engagement of communities

Community engagement is defined as a process of working collaboratively with and through communities to address issues affecting their wellbeing. It is critical to improve the reach and sustainability of TB interventions, helping save lives of this top infectious killer disease. The fight to End TB epidemic by 2030 can only be won with community engagement as a heart of the TB response. Various community TB care approaches lay out the path to make enhanced community engagement a reality and expand the base for the global TB response.

For the purpose of this guideline, the following groups/ individuals have been identified as key stakeholders on this response:

- TB/DR TB patients
- Community health workers
- Community based volunteers including Ex TB patients' groups, HUWANYU, PLHIV support groups
- Community Owned Resource Persons (CORPs) including Traditional healers, traditional birth attendants, local community leaders, religious leaders and other influential people.

- Drug dispensers of “Duka la Dawa muhimu” Accredited Drug Dispensing Outlets (ADDO) and Pharmacy
- Sputum fixers

TB and DR- TB patients

These are people confirmed to have TB or DR TB. They are key stakeholders in TB/ DR TB treatment. They should adhere to the treatment and by doing so, they contribute in TB control as they stop more TB/ DR TB transmission in the community.

Community health workers

Community Health Workers (CHWs) are people with some formal education at least form four, with passes including Biology at D grade or above⁷. This will qualify him/her to join the basic CHWs training. The CHWs will be given specific training to acquire knowledge and skills necessary to provide community based health services including TB prevention, early TB case detection, patient care and support as well as community mobilization activities to promote effective communication and participation among community members to increase demand for TB prevention, diagnosis, treatment and care services. *Their roles and responsibilities are discussed in chapter 4*

Community volunteers (CVs) including Ex TB patients’ groups, HUWANYU, PLHIV support groups

These are community members who have been sensitized about specific and often time- bound service required to benefit their family and wider community and provide their time and energies to render such services without any monetary compensation. Their work which may take several hours every day, is often supported through incentives in-kind or in cash provided by the community they serve or by the health program. They are usually motivated for being useful to their communities and recognise the need to do something and are proud to help others.

⁷ National community based health program policy guideline (MoHSW, 2014)

The work and services rendered by the CHWs and CVs actualize their full potential in the presence of effective support from the health system and of the possibility of a two-way referral between health facilities or public health services and the community. Such referral systems require a regular link. CHWs and CVs can serve as important links between the health system and the communities they serve. NGOs/ CSOs working on community-related TB activities should have an active, cooperative working relationship with them.

Community Owned Resource Persons (CORPs)

A Community Owned Resource Person is an individual identified by the community to promote health services at community level. A wide range of community members, including traditional healers, traditional birth attendants, local community leaders, religious leaders and other influential people should be encouraged to participate in TB care and control. These people should be consulted when defining the roles that they should play in the community TB care and control effort. A top-down approach should be avoided. A consultative process with consensus-building around roles and responsibilities of the community vis-à-vis those of the health care system is likely to result in a stronger partnership between the health care system and the community and enhanced community ownership of the program. The tasks that may be undertaken by this group are highlighted above.

Qualities of a CORP

A Community Owned Resource person should be an: -

- Effective communicator who understands what to say and to whom with accuracy.
- Resourceful by being able to identify human and financial resources for the community's problems and concerns.
- Empathetic – Able to understand and experience another person's feelings and respond in a sincere and sympathetic manner.
- Patient – calm and able to let people move at their preferred pace, not overly anxious.

- Trustworthy/honest – able to be trusted with individual and family confidential matters. Anything a man or woman says to a CORP should be kept confidential.
- Able to be respected and accepted by the community and also to respect the individual/families despite their problems, or social status.

Drug dispensers from “Duka la Dawa muhimu” (ADDO) and Pharmacy

Drug dispensers are people trained and employed to dispense medicines in ADDOs and Pharmacies based on doctor’s prescriptions.

Key Steps in drug dispensers’ involvement

- Mapping and identification of ADDOs and Pharmacies in intervention area
- Mapping of TB diagnostic centers available in the intervention area
- Consultative meetings and stakeholder consensus building including owners
- Assessment of knowledge and practice related to TB
- Distribution of tools for screening, referral and registration of presumptive TB cases
- Train drug dispensers and owners on TB screening, use of tools, recording and reporting
- sensitization of HWs in the intervention area
- supervision

Sputum fixers

Sputum fixers are medical attendants/ any person who trained on laboratory procedures for preparation of sputum sample prior to AFB staining process. They are capable of making sputum smears on glass slides and fix them at dispensary level, ready for being sent to nearby TB diagnostic center. They usually supported to transport slides with fixed smears to TB diagnostic Centers

for microscopy and bring the results for TB initiation at dispensary level in case of confirmed TB.

Selection criteria for sputum fixers

The following are the attributes of sputum fixers:

- Living in areas with limited access to TB diagnostic centers
- Should be a member and resident of the communities they are going to serve
- Accepted and trusted by community members/specific target group including PLHIV and PWID
- Ability to read and write (Standard seven, form four or form six will be an added advantage)
- Good communication and interpersonal relationship skills.
- Willing to volunteer in community TB initiatives with minimal incentives.
- Honest and reliable (trustworthy).
- Non-discriminative with respect to gender, tribe, job, colour, political affiliation and any other form of discrimination as defined by the community
- Energetic with ability to work
- Ability and willingness to work in challenging environment and conditions

Process of selecting sputum fixer

- Job advertisement through the VEO office to all community members in order to show Voluntarism
- Receive and short-list applicants for oral interview by a panel of HCW, implementing partner, VEO and VHC at the facility
- Recruitment with regard of gender balanced

2.3 Engagement of NGOs and other CSOs (ENGAGE-TB)

2.3.1 Concept of ENGAGE TB

The ENGAGE-TB approach aims to integrate community based TB activities into the work of Civil Society Organizations (CSOs). CSOs working in communities are in a unique position to contribute to community health. They usually easily penetrate in communities including people in isolated or neglected parts of the community when the formal health system cannot reach them. They are familiar with the community's culture and language, they can communicate about the community's needs, and they can mobilize people in the community to influence decisions for the community.

CSO refers broadly to the organizations and institutions that operate outside the state and the private sector. They include:

- **NGOs** that are usually registered and have legal status;
- **Community-based organizations (CBOs)** that are usually local and run by community members; they may not be registered;
- **Faith-based organizations (FBOs)** that are connected with and supported by a religious group; larger ones may be registered as NGOs but smaller ones are often similar to CBOs;
- **Networks and associations of people or organizations** working on particular issues such as TB, HIV infection or diabetes are membership organizations. They provide support to members and engage in advocacy and education on the issues they are concerned with. Some take the form of coalitions or consortia. Larger ones may be registered as NGOs⁸. (ENGAGE TB implementation Manual, WHO 2013)

In this guideline, the term used to include all the organizations and groups in the above list is “NGOs and other CSOs”, or “NGOs/CSOs”.

NGOs/CSOs can use the ENGAGE-TB approach to support their work with communities on TB, by:

⁸ National ENGAGE TB Operational Guideline, MOHSW, 2013

- finding more people who might have TB and linking them to TB services;
- supporting people to start and complete TB treatment;
- raising community awareness on prevention and increasing demand for TB testing, treatment and support;
- advocating for better access to TB diagnostics, treatment and care; and
- Advocating for policy changes to facilitate greater access to services, e.g. task-shifting that allows nurses, CHWs or CVs to do sputum collection and provide DOT in the community.

The NTLP is responsible for the whole programme, including activities at community level. It should form partnerships with NGOs and CSOs and help them to carry out community-based TB activities in a way that contributes to national efforts. It has a key role in encouraging NGOs/CSOs that do not work on TB to integrate TB into their activities, by providing resources, facilitating support and responding to their needs. This helps to improve national outcomes in TB case detection, notification and treatment success.

2.3.2 Six ENGAGE-TB components

The six ENGAGE-TB components provide a systematic framework for establishing partnerships between the NTLP and NGOs/CSOs for NGOs/CSOs to integrate TB activities. Not all components of the framework have to be addressed by every NGO if there are capacity constraints. The most important priorities are **to find a way to select the TB tasks that will be implemented** and **to ensure that the outcomes are monitored and reported**. The other components support these two main priorities.

The following are the six ENGAGE TB components:

- Creating an **E**nabling environment
- Developing **N**ew tools
- **G**athering information

- **A**ssessing tasks
- **G**etting the evidence
- **E**nhancing capacity

The six components are more elaborated as follows:

- **Situation analysis:** CSOs should conduct a situation analysis to identify the specific needs and tasks that will be undertaken to integrate community TB control activities into their plans for implementation. The analysis should involve information-gathering at the respective level of their jurisdiction to analyze and understand the existing situation before implementation of TB control activities.
- **Enabling environment:** The MOHSW has established ENGAGE-TB policies and operational guideline to enable effective engagement of CSOs in TB control activities. Regions and districts have to ensure a good environment for ENGAGE-TB implementation in their respective areas according to national policies. The established National CSOs Coordinating Body, which represents the interests of CSOs, should systematically share and disseminate lessons learned by individual member organizations.
- **Guideline and tools:** National operational guideline for ENGAGE-TB, a handbook for CHWs to use in complement with other NTLG guideline, should be used by CSOs to implement TB control activities at the community level.
- **TB task identification:** TB is intricately linked with HIV and is also closely related to social determinants of health and non-communicable diseases such as poverty, crowding, malnutrition, drug and alcohol use, and diabetes mellitus. Therefore, the task identification needs to consider the opportunities, capacities, and comparative advantages of the CSOs working in such areas and decide how best to address TB in their target populations and areas of work.

- **Monitoring and evaluation:** Engagement of CSOs in delivery of community-based TB activities should be routinely monitored to inform their contribution in TB control and to ensure quality and effectiveness of their involvement. CSOs should ensure that planned activities are aligned with MOHSW policies and guideline. Existing standardized TB forms and registers linked with the national TB monitoring and evaluation system must be used to allow the system to determine the contribution of community-based TB activities to national TB control efforts.
- **Capacity-building:** CSOs engaged in TB activities should conduct needs assessments to identify the capacity of and skills needed by health care workers, CHWs, and volunteers to implement identified community-based TB control activities.

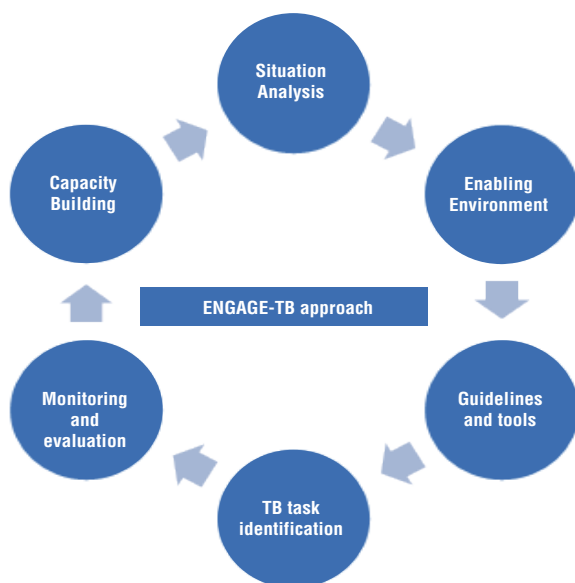


Figure 1: ENGAGE-TB approach.

Note: For details on the ENGAGE-TB approach, refer to the national ENGAGE-TB operational guideline (2013).

2.3.3 Mechanism which NGOs and other CSOs work on TB in communities

NGO/CSO community projects and programmes can use community systems to contribute to TB control through three main types of activity:

- ***Providing TB services in the community:*** This includes TB awareness and prevention, TB screening, sputum collection and transport, treatment support, home-based care (HB-DOT) and TB education.
- ***Providing support for people needing or using TB services,*** including reducing TB stigmatization in families and health facilities, helping people to access TB services for instance sputum fixing at remote located DOT centres, providing transport, psychological, economic and legal support to TB patients and communities on TB control issues.
- ***Enabling environment for TB activities by:***
 - Mobilizing communities to act on stigma, basic rights and access to health services and basic standards of housing, nutrition, water, sanitation and hygiene;
 - Linking community services with the formal health system and its personnel and institutions; and
 - Engaging in local level advocacy to ensure responsiveness to needs such as for TB laboratory equipment or Anti TB medicines at health facilities.

NGOs/CSOs need in order to work effectively on TB

Reaching more people with community-based TB activities requires NGOs/CSOs to identify and provide a set of TB services in collaboration with the NTLP and the health system.

Larger NGOs may already have sufficient funding and other support that enables them to integrate community based TB activities into their existing portfolio of work. Some smaller organizations may not have enough resources or capacity to do this. However, they may have potential to develop their capacity. The resources and support especially needed include:

- **Funding** to ensure their stability as organizations (core funding) while they implement their activities;
- **Technical support, mentoring and resources** to assist them in delivering services, documenting activities and engaging in advocacy;
- **Training and capacity-building** for running their organization or group and for implementing their TB activities, including mentorship and technical support;
- **Linkages and partnerships** may be established to support their contributions to community health.

2.3.4 Collaboration between NTLP and NGOs/CSOs

NTLP operate at national, regional, district and health facility levels. At national level, the NTLP is responsible for development of TB strategy, policy and for overall programme management. TB service delivery are supervised by a regional and district TB coordinators. The NTLP basic management unit (BMU) is at district level which is responsible for all community TB programmes/interventions in its catchment area. Services are usually provided through hospitals, health centres and dispensaries.

NGOs/CSOs need to link with the NTLP at any of these levels depending on the NGOs/CSOs size, resources and the type of work they do. Base on the WHO recommendations, the following are the best ways of linking that will also bring in other organizations and groups that are not already engaged:

- Through CSOs coordinating body (NCB) that brings NGOs and other CSOs together as a coalition or network. This should be set up and independently managed by the NGOs/CSOs, who can then more systematically engage in partnership with government but also act as advocates. The NCB should act as an “umbrella” body for NGOs/CSOs to develop a working relationship and engage with the NTLP at all levels, health providers and each other. This provides the NTLP with a clear contact point for active and systematic collaboration and for hearing about the needs, constraints and lessons learnt by NGOs/CSOs in planning, resourcing and implementing community-based TB activities.

The NCB is a structure that aimed at serving to attract more and more NGOs and CSOs that have not been aware of or involved in TB activities on a continuing basis. This has the potential to extend TB activities to more communities and to neglected parts of the population.

In Tanzania NTLP has supported the start-up and development of the NCB since 2012. With NTLP support, the NGOs/CSOs can now work together to monitor progress, address bottlenecks and highlight new ideas and approaches. Their partnership can also be used to establish the basic ENGAGE-TB components to support their activities.

2.3.5 Integration of community-based TB activities into other programmes

Integration of community-based TB activities into health and other development programmes is the heart of the ENGAGE-TB approach. Almost any health or development programme could integrate one or more of TB activities listed below into their on-going community-based works:

Table 1: Integration of community-based TB activities into other programmes⁹

Theme	Possible activities
Prevention	Awareness-raising, information, education, communication (IEC), behaviour change communication (BCC), infection control, training providers
Detection	Screening, contact tracing, sputum collection, sputum transport, training providers
Referral	Linking with clinics, transport support and facilitation, accompaniment, referral forms, training providers
Treatment adherence support	HB DOT support, adherence counselling, stigma reduction, pill counting, training providers, home-based care and support
Social and livelihood support	Cash transfers, insurance schemes, nutrition support and supplementation, voluntary savings and loans, inclusive markets, training providers, income generation
Advocacy (cross-cutting)	Ensure availability of supplies, equipment and services, training providers, governance and policy issues, working with community leaders
Stigma reduction (Cross-cutting)	Community theatre/drama groups, testimonials, patient/peer support groups, community champions, sensitizing and training facility and CHWs and leaders

(i) Integrating TB into RCH

The continuum of RCH care includes the period before conception through pregnancy, childbirth and infancy. It includes care at home, in the community, and in the health system.

Community-based TB activities can be integrated into different stages of the RCH continuum of care. This can include the routine activities of community midwives and RCH community workers, CHWs or CVs before and during pregnancy and after the baby is born. TB activities can take place during household visits, health promotion at community level, maternity outreach services and when linking pregnant women, mothers

⁹ Engage TB Implementation Manual (WHO, 2013)

and their children to health facilities. RCH community workers can play a key role in identifying and supporting those who also need or use TB services (Annex 1).

(ii) Integrating TB and HIV activities at community level

The MOHCDGEC through NTLP and NACP has been implementing TB and HIV collaborative activities within health systems since 2008. However, these activities are mostly not integrated at community level. It is important to target everyone at risk from TB in communities as well as everyone at risk from HIV infection.

Although TB and HIV epidemics often affect the same people, not everybody in an affected community has both diseases. Some people will need both HIV and TB care, support and treatment; others may need them only for TB or only for HIV infection. It is important that communities and CHWs/ CVs understand that HIV infection and TB are separate diseases and need different treatments and different methods of prevention. However, there are large numbers of people with undiagnosed TB and/or undiagnosed HIV infection. Increased screening, case-finding and early treatment are priorities for both diseases.

All PLHIV should be screened for TB, and those confirmed not having TB should receive IPT, which can prevent latent TB from becoming active TB. TB screening and treatment (IPT) should be integrated into all HIV programmes. Similarly, HIV counselling and testing should be integrated into all TB programmes. All people who have presumptive or confirmed TB should be offered an HIV test. Anyone with TB disease who tests positive for HIV should be linked to HIV treatment and care services (Annex 2).

(iii) Integrating TB within PHC

Primary Health Care (PHC) reaches across many different sectors “Multi-Sectoral” and it includes everything affecting health in communities. It is involving several different sectors. It also includes the activities of different types of health care providers, such as CHWs, mobile clinics and outreach teams from health facilities.

NGOs, CSOs and FBOs should therefore engage with PHC providers to support and increase the integration of TB activities into their work. Depending on the local context and needs, PHC programmes could, for example, work with CHWs and outreach or mobile teams to integrate TB activities into the following range of PHC activities:

- education on common community health problems and methods of preventing and controlling them;
- appropriate treatment of common diseases and injuries;
- promotion of food supply and healthy nutrition;
- adequate supply of safe water, basic sanitation and hygiene;
- RCH care, including family planning;
- vaccination against the major infectious diseases; and
- Provision of essential drugs.

(Annex 3)

Integrating TB into agriculture programmes

Most agriculture programmes supported by NGOs use group approaches for their work. These can include “farmer field and livelihood schools” for adults and young people, farmers’ clubs, associations and cooperatives. Group members meet regularly throughout an agricultural season or cycle to improve farmers’ decision-making capacity, life skills and agricultural practices by sharing their experience and knowledge.

The structured learning provided by farmer field and livelihood schools and other group approaches is adaptable to local situations and priorities. Learning about TB prevention and improving social and livelihood support for those affected can therefore be easily integrated into group activities. TB screening and referrals for TB diagnosis can also be included. It is important to have a reliable health system to receive and support such referrals and to ensure that confidentiality is protected, especially for people in small, close-knit rural communities (Annex 4).

(iv) Integrating TB into a livelihoods development programmes

Livelihood development programmes are aimed at improving the quality of life of people and communities who are marginalized, vulnerable or stigmatized. The objective is to create opportunities for people to move out of poverty and powerlessness.

Health is an integral part of livelihood programmes, along with food and nutrition, water and sanitation, education and shelter. Community-based TB activities should therefore fit naturally into the activities of livelihoods programmes. Livelihood programme officers like Community Development Officers working closely with their communities and community structures, such as village development committees can also link with CHWs and volunteers, midwives, water and sanitation and agriculture workers for integration of community TB activities (Annex 5).

(v) Integrating TB into education programmes

The education sector has a vital role to play in supporting community efforts against TB. Ignorance about TB contributes to myths and stigmatization and hence increased spread of TB.

Recently, NTLIP discovered TB cases (smear positive TB) among pupils and students in the country. Education on TB should therefore be included in school curricula and it should be known that education on TB prevention is one contribution that the education sector can make quite easily by teaching children to cover their mouths and noses when they cough and sneeze and explaining the benefits of sunlight and ventilation. Other activities and lessons should also be included that can contribute to TB stigma reduction, screening, treatment and advocacy (Annex 6).

(vi) Integrating TB into water, sanitation and hygiene (WASH) programmes

Water, sanitation and hygiene (WASH) are essential for maintaining health and preventing disease. Sputum is body waste that can infect other people and must be safely disposed of, just like urine or faeces. WASH programmes can therefore integrate TB into disease prevention by promoting better hygiene (Annex 7).

CHAPTER THREE

3. COMMUNITY BASED TB, TB/HIV, DR-TB INTERVENTIONS

TB is a public problem. It is diagnosed in health facilities, but it lives in the community. Action in the community is therefore essential in a country's efforts against TB. It is also important to link community action on TB with the work of the NTLP so that the efforts of the health system are extended and reach as many people as possible. The following are the key community TB interventions:

- Community Active TB Case Finding
- Sputum fixing intervention
- Treatment support
- Lost to follow up tracing
- Health education and Counselling
- Infection Prevention and Control

3.1 Community Active TB Case Finding

TB tends to concentrate in poor and marginalised communities who face many barriers to access health services due to lack of awareness, competing priorities for time and money, disconnection with health services leading to lack of regular service and experienced and skilled personnel. Linking diagnosis to treatment has reportedly been challenging in community-based TB screening interventions with high initial lost to follow-up rates. Innovative strategies complementing facility-based case detection are needed to address these barriers. One such strategy is Active Case Finding (ACF) from the community, which involves systematically searching for TB individuals who would not spontaneously present to a health facilities and bringing them into care. It focuses in improving early TB case detection by reducing delays in presentation to a health facility and hence reduces TB transmission in the community.

3.1.1 Contact investigation

Contact investigation (CI) is a systematic process intended to identify previously undiagnosed cases of TB among the contacts of an index case. It may result in earlier identification of cases, possibly leading to decreased disease severity and reduction in transmission of *Mycobacterium tuberculosis* in general community. People in close proximity to TB smear positive patient are at high risk of developing TB, not only health care providers, but also any staff, including volunteers, who have contact with persons with TB and have not yet been diagnosed and started treatment. Children under five and PLHIV in these roles are at particular risk of rapid progression to TB disease if they become infected or re-infected due to exposure to *Mycobacterium tuberculosis*.

Table 2: Definitions of Contact investigations¹⁰

TERM / CONCEPT	DEFINITION
Index case (index patient)	The initially identified case of new or recurrent TB or DR TB is a person of any age in a specific household or other comparable setting in which others may have been exposed to.
Contact	Any person who has been exposed to an index case.
Household contact	A person who shared the same enclosed living space for one or more nights or for frequent or extended periods during the day with the index case during the 3 months before commencement of the current treatment episode.
Close contact	A person who is not in the household but shared an enclosed space, such as a social gathering place, workplace or facility, for extended time periods during the day with the index case during the 3 months before commencement of the current treatment episode.

¹⁰ Recommendations for Investigating Contacts of Persons with Infectious Tuberculosis in Low- and Middle-Income Countries by WHO, 2012

Contact investigation consists of two components: contact identification and prioritization, and clinical evaluation and it should be conducted for household and close contacts when the index case has any of the following characteristics:

- A child <5 years of age.
- New DR TB cases (bacteriologically confirmed)
- Sputum smear-positive pulmonary TB
- Gene-Xpert positive TB (+MTB Rif)

i) Contact identification and prioritization

This is a systematic process to identify contacts with or at increased risk for development of TB. For purposes of this guideline, the definition of contact identification and prioritization includes an interview with the index case to obtain the names and ages of contacts and an assessment of contacts' risk for having (generally based on the presence of symptoms compatible with TB) or developing TB, to determine those for whom clinical evaluation (defined below) is indicated. The assessment of contacts will be done using community TB screening questionnaires (TSQ) – (Ask- cough of any duration, weight loss, fever, and excessive night sweats). Those who qualify for clinical evaluation, will be referred to the nearest health facility.

Model for Contact Investigation

There are two ways of conducting CI:

a) Active contact investigation - Household visitation

Household visitation (active contact investigation) is the most useful approach. A household visit provides a check on the information obtained from the index case regarding the numbers of persons residing in the household and the physical and social structure of the house. It also serves to build a stronger connection between the clinic staff, the family, and the community. In this approach the person conducting the CI should visit the home of the index patient to identify the household contacts, conduct interviews, and develop a priority list of contacts for clinical evaluation.

b) Passive contact investigation—Contact invitation

If household visits are not possible, a less-desirable approach is “contact invitation,” (passive contact investigation) in which contacts are invited to visit the clinic by the index case for evaluation. A modification of this approach is to instruct the index case to tell household members to visit the clinic if they have symptoms compatible with tuberculosis.

Steps for conducting TB contact investigation

- Obtain list and particulars of confirmed TB cases from DOT providers at TB clinic
- With assistance of an index case, screen all contacts
- List all contacts with signs and symptoms of TB in your community TB screening form
- Provide referral to all presumptive TB cases for diagnosis
- Register all presumptive TB cases in a community presumptive TB register
- Follow up sputum examination results
- Ensure all confirmed TB cases have initiated TB treatment
- Update your community presumptive TB register

ii) Contact clinical evaluation

This is a systematic process for the diagnosis or exclusion of active TB among contacts. Clinical evaluation is undertaken if the results of contact identification and prioritization indicate a risk for having or developing TB. For the purposes of this guideline, the definition of contact clinical evaluation includes, at a minimum, a more extensive assessment of symptoms compatible with TB. Additional components may include:

- A more detailed medical history
- A physical examination
- Microbiological assessment of specimens from sites of suspected involvement

- Radiographic examinations
- Invasive diagnostic tests

3.1.2 House to house TB screening

CHWs/ volunteers might need to conduct ACF at household level. This involves house to house search of household members with TB related signs and symptoms. The following are steps to be followed:

- List the particulars of all house hold members
- Conduct TB screening to all house hold members using community TB screening form
- Provide referral to all presumptive TB cases for diagnosis
- Register all presumptive TB cases in a community presumptive TB register
- Follow up sputum examination results and update your community presumptive TB register
- Ensure all confirmed TB cases are initiated on TB treatment.

Note: House to house TB screening is recommended in high TB prevalence areas and which reported TB outbreak.

3.2 Sputum fixing intervention

3.2.1 Sputum collection, smearing, fixing and transportation of smear slides

Sputum collection

For all presumptive TB cases, two sputum specimens should be collected one at spot and the second in the morning (spot-morning). Sputum specimen should be prepared and fixed in the same day to avoid contamination. Patients considered at risk of not returning for investigations, spot - spot sputum collection should be considered not less than one hour after the first sample.

Sputum smearing and fixing

Sputum fixing is a preparation of sputum sample prior to AFB staining process whereby portion of sputum sample is taken, then smeared on glass slide, dried, finally heated gently in order to kill available organisms and to avoid washed out during staining.

Normally, sputum fixing is performed in TB laboratories mainly for TB diagnosis. In these guideline, sputum fixing is referring the same procedure performed in selected dispensaries located in areas with no nearby TB diagnostic centres. In this case this procedure is performed by trained CHWs/CVs or medical attendants or health workers whom are referred as sputum fixers.

Transportation of sputum smear slides

Smear should be transported in slide boxes for TB diagnosis within 48 hours. The smear microscopy results should be followed up immediately for early TB treatment initiation at DOT Centre to smear positives.

3.2.2 Site /health facility selection for sputum fixing for AFB microscopy

Selection criteria

A health facility located in hard to reach area

- Without TB diagnostic services
- Having a ventilated outdoor space/ ventilated room for smearing and fixing
- Availability of clean water source
- Availability of appropriate and safe hazard waste disposal method(s)

Procedures for selecting site/HF for sputum fixing for AFP microscopy

- District to prepare a list of health facilities and map them in relation to TB services
- District to conduct baseline assessment of sites/ HFs for sputum fixing
- Analyse finding Prepare report

- Site/ HFs selection for sputum fixing
- Orient CMT, CHMT and Village Health committees from the selected sites/HFs.

3.3 Treatment support

The aim of TB treatment is to cure TB patients and restore quality of life, prevent death, avoid relapse, prevent emergence of drug-resistant organisms, and prevent transmission of TB to others. In order to achieve favourable treatment outcomes, close follow up and support of a patient are highly emphasized.

3.3.1 Direct Observed Treatment (DOT)

'DOT' is direct observation of treatment. It means that a trained health care provider or other designated individual, including family members observe the patient swallow all the tablets. This ensures that a TB patient takes the right drugs, in the right doses and at the right intervals. DOT can either be health facility based or home based or combined health facility/home based in case of community DR TB ambulatory care during intensive phase. In a health facility based DOT, a facility health workers supervise the patient at DOT clinic while home-based DOT, a TB dose is observed by a treatment supporter from the community in the patient's home.

A combined facility/community-based DOT is mainly applied in the treatment of DR TB during intensive phase whereby facility health workers supervise the morning dose and a DR TB Supporter supervises doses during the evenings, weekends, and holidays. The facility should be the one closest to the patient's home. During the injectable phase, a facility nurse should inject the patient each morning.

Intake of TB medications must be observed throughout treatment period. Doses are administered once daily for susceptible TB and twice a day for DR TB.

In order to facilitate community based DOT, community members, including CBOs, religious groups, and current and former TB patient groups should be

encouraged to participate in TB care and control. The treatment for both TB and DR TB is long and often complicated. Success of treatment relies heavily on adherence, which in turn relies on: a good understanding by the patient of the fundamentals of TB and its treatment; commitment from the patient to participate in treatment; support of the patient by the family; and good communication between health care providers, the patient, and the family. Therefore it is imperative that a community health worker should:

- Supervise TB patients under home based DOT
- Facilitate establishment and empowerment of treatment support groups
- Inform TB/DR TB patient the importance of drug compliance and adherence (DOT)
- Remind the family members on importance of drug compliance and adherence Inform TB patient, family and community members on effects of poor compliance and adherence (DOT) including drug resistant TB.
- Involve community leaders and other influential people in difficult situations

3.3.2 Managing side effect

Side effects are the most important reason why patients default from treatment. These can occur at any time during treatment. In most cases they are mild, but occasionally they can be severe. It is important to detect and resolve them quickly:

Symptoms based approach to manage side effects of anti-TB drugs

Minor side effects

- These include: Anorexia, nausea or abdominal pain, Drowsiness, Flu syndrome (fever, chills, malaise, headache, arthralgia), Orange/red urine

Action: reassure the patient that there will be self - limitation and closely monitor the patient

Major side effects

- These include: Skin rash with or without itching, impaired hearing, Dizziness, Joint pain, Burning, numbness or tingling sensation in the hands or feet, jaundice, confusion, decrease urine output, shock, oedema of lower limbs

Action: stop the medications then refer the patient to health facility immediately

Daily DOT is an opportunity for early detection of side effects. The Community health service provider and the TB Supporter should be conversant with the potential side effects that could be produced by the regimen that the patient is receiving. The Supporter should have an easy mode of communication with a HCW

The TB Supporter should also monitor for signs that the patient is improving.

- Signs that treatment is working include decreased cough and sputum; and weight gain.
- If fevers or night sweats, difficulty breathing or haemoptysis persists to a patient, the supporter should notify the Community health service provider, who will arrange for appropriate medical referral.

3.3.3 Referral and Linkages to services

An Effective and functioning referral system is important to assist TB patients to continue receiving appropriate services of care, treatment and support within their respective communities. TB patients require other support services like nutrition, socio-economic and psychosocial and therefore should be linked to respective services such as:

- **Community nutrition services:** TB patient need proper nutrition counselling services in order to have favourable treatment outcome. The nutrition services comprises of: nutritional education, provision of IEC materials, identification and referrals for all clients with nutritional needs,

nutritional counselling, linkage to support groups (chronic diseases) replacement and therapeutic feeds.

- **Socio-economic support:** TB patients may require socio – economic support. In order to obtain these services, patients need to be linked to:
 - o Income generating groups such as VICOBA, SACCOS etc
 - o Social support groups such as Ex-TB , MKUTA etc

3.4 Lost to follow up tracing

Lost to follow up TB case is a TB patient who did not start treatment or whose treatment was interrupted for two consecutive months or more. Such a patient should be traced and brought back to DOT clinic to start or re-start treatment.

Note: Some TB patients may miss appointment for less than two months. These are termed “*Initial lost to follow up*” like those not initiated with TB treatment.

A health care provider at the facility will identify and provide a list of missed appointment and other lost to follow up TB patients with their physical contact address to the CHWs/ CVs for tracing as early as possible to avoid drug resistance. During tracing of lost to follow up and missed appointments, tracing of their contacts is very crucial.

3.5 Health education and Counselling

Counselling of TB patients and their families is essential and therefore quality training to health workers and CHWs/ CVs, with regular supervision and mentorship must be properly done. Components of counselling in the context of community health include

- Psycho-social support
 - Psycho-social support should be provided to TB patients, their families and community members, when necessary TB patients should be linked to spiritual support.
- TB and HIV related counselling and testing to families of index TB patient

Due to good relationship of TB and HIV, counselling and testing for HIV is very important to the family members as these are already Presumptive TB cases and according to the TB/HIV policy guideline, every Presumptive TB cases should be tested for HIV.

Health Education is a critical component of fight against TB. Health education has a goal of changing health related behaviour of the community. Intervention under health education may facilitate or empower community gathering, political and financial support and address the challenges of individual and social behavioural change. These challenges include:

- Delayed health seeking behavior
- Inadequate access to TB, TB/HIV, DR TB and leprosy diagnostic health facilities
- Inadequate knowledge of TB, TB/HIV, DR TB and leprosy symptoms and sign
- Stigma and discrimination
- Misconception and myths surrounding TB TB/HIV, DR TB and leprosy
- Poor adherence to TB TB/HIV, DR TB and leprosy treatment
- Insufficient resources allocation to TB TB/HIV, DR TB and leprosy control

3.5.1 Awareness creation on TB, TB/HIV and DR-TB

Awareness creation in TB control aims at increased TB/ DR-TB case identification and stigma reduction include the following activities:

- Conduct house to house visits including marginalized families and communities
- Participate in community gathering and special events at village and ward levels
- Distribution of IEC materials to community members.
- Provide testimonies

- Conduct health talks at health facilities and community level
- Conduct TB, TB/HIV and DR-TB sensitization campaign in schools, learning institutions, orphanage centers, prison, mining and mining communities
- Using existing groups in communities such as cultural troops, choirs, drama groups to convey messages on TB, TB/HIV and DR TB.

Key messages should focus on TB transmission, signs and symptoms, treatment and duration, prevention including infection control.

3.5.2 Advocacy at community level

Advocacy influences policy makers, funders and decision makers at international, national, regional, district and local levels through variety of channels to change or enhance policy and allocate necessary funding and resources to achieve TB, TB/HIV and DR-TB control activities. Advocacy is the tool with its primary work for behavioural change of public leaders and decision makers.

At community level advocacy activities for TB, TB/HIV and DR-TB includes:

- Advocacy meeting with community leaders (Councilors, Ward Executive Officer, Village Executive officer, religious leaders, CORPs, traditional healers, CSOs and patient organizations) to highlight them on issues relating to TB, TB/HIV and DR-TB control in order to garner support
- Resource mobilization activities (meeting with various partners including NGOs, CBOs, local Government authorities).
- Advocating for support from media to educate communities on sign and symptoms of TB, TB/HIV and DR-TB including prevention and control
- Advocating for inclusion of former and current TB, TB/HIV and DR-TB patients in planning, design, implementation and evaluation of TB, TB/HIV and DR-TB interventions

2.6 Infection Prevention and Control

2.6.1 Three levels of TB Infection control at community level

i) Administrative control measures

This is the most important level of control measures addressing the reduction of exposure of community, patients and family members to *Mycobacterium tuberculosis*. Unfortunately, the risk usually cannot be eliminated, but it can be significantly reduced with proper administrative control measures. The most important administrative control measures include:

- Assessment of the risk of transmission in community
- Early TB screening and referral of presumptive cases for early TB diagnosis
- Prompt initiation of appropriate anti-tuberculosis treatment.

Administrative measure can be agreed and applied by community members under village/ward leaders' guidance and supervision.

ii) Environmental control measures

This reduces the concentration of infectious droplet nuclei by a person who is infected. Since the exposure to infectious droplet nuclei usually cannot be eliminated, various environmental control measures can be used in high-risk areas to reduce the concentration of droplet nuclei in the air. Such measures include maximizing natural ventilation and controlling the direction of airflow. Community authorities should advocate for building modern houses with big windows, advocate to community members to open windows all the time and refer patients with cough for more than two weeks at the health facility for early diagnosis and treatment.

iii) Personal protective measures (respiratory protection)

This aims at protecting community members and family members in areas where the concentration of droplet nuclei cannot be adequately reduced by administrative and environmental control measures.

A weakened immune system enables latent TB to become active TB disease. The risk of acquiring TB can be reduced by staying healthy; eating adequate food; avoiding smoking, illicit drugs or too much alcohol; and getting prompt treatment for any health problems.

CHWs and CVs including sputum fixers should be encouraged to observe TB infection control. Creating Community awareness on importance of adherence to TB treatment will prevent the community against drug Resistant TB. DR-TB care providers at community level should be sensitized on risk of transmission. Before culture conversion, DR-TB patient should be provided with basic personal protective equipment (surgical masks) for use in the home setting where there are vulnerable groups like children under five, elderly and chronic ill people and PLHIV.

Note: Administrative control measures are the most important among the three levels. Environmental control measures and personal protective measures (respiratory protection) will not work in the absence of solid administrative controls. Each level operates at a different point in the TB infection control process.

3.6.2 Specific ways for TB Infection control

The following are some specific ways to prevent TB from spreading:

- **Cough hygiene and ventilation:** This includes covering the mouth and nose when coughing or sneezing, raising awareness on how TB is transmitted and ensuring that houses, clinics, workplaces and other “congregate settings” are well ventilated. This is particularly important for rooms where people with infectious TB spend a lot of time. Natural ventilation, by opening doors and windows, and sunlight in living spaces are very helpful.
- **Early diagnosis and case finding:** Diagnosing and treating active TB early stops it from being passed on to others. “TB case finding” refers to identifying people with signs and symptoms of active TB, and supporting them to be diagnosed and treated. When active TB is diagnosed in a

person, the people with whom he or she spends most time should also be screened for TB symptoms, particularly if they are children or PLHIVs and elderly.

- **BCG (bacillus Calmette - Guérin) vaccine:** This was first used in 1921 and continues to be the only vaccine for TB. It is provided at birth and it is useful in protecting children under five from TB meningitis and other severe forms.
- **Prevention with medication:** People with latent TB who are at increased risk of developing active TB, such as people living with HIV and children younger than five years who are in contact with a TB patient, could be given a course of the anti-TB drug isoniazid to prevent the development of TB. This prevention treatment is often called isoniazid preventive therapy (IPT).

2.6.3 Infection Control Measures in Special Settings

There are special settings in the community that are of high risk and call for special attention as far as TB infection, prevention and control is concerned.

These include: -

- Congregate settings e.g. Prisons
- Informal settlements (slums)
- Refugee and internally displaced persons (IDP) camps
- Learning institutions (schools, colleges)

TB spreads more readily in congregate setting due to longer duration of potential exposure, crowded environment, poor ventilation, and limited access to health care services. Security forces training camps (military, police national youth service etc)

In Prisons

All inmates on admission should be screened for TB. The prison and remand cell should follow and adhere to TB infection control guideline. There is a need for active advocacy and sensitization of relevant ministry and departments for the implementation of TB infection control guideline in the prisons.

Informal settlements (slums)

Adequate sensitization and advocacy on proper ventilation on the existing structures/ housing and practice of cough etiquette should be instructed. Screening, contact tracing and lost to follow up tracking should be highly emphasized in such settings for avoiding more transmission.

Learning institutions and schools

TB infection control should be incorporated in the school health program. Learning institutions should adopt and own TB environmental measure.

Public services transport

TB infection control should be implemented in public transport sectors such as buses, trains and air transport. There should be adequate ventilation by opening windows on both sides of the vehicles or applying mechanized ventilation. Advocacy and sensitization with different ministries and the community is required for this to succeed. Transportation of suspected DR-TB Patient's from one facility to another should be by well-ventilated means of transport with personal respiratory protective devices.

3.6.4 Infection control and legal implication

TB, DR-TB patient, and the community should be adequately educated on the importance of adhering to DOTS. If for any reason a patient with TB/ DR TB refuses to be treated or admitted to a special hospital, action shall be taken against him/her in accordance with the Public Health Act 2009.

CHAPTER FOUR

4. ROLES AND RESPONSIBILITIES

4.1 Roles of TB Patient

Some of key responsibilities of the TB, TB/HIV and DR-TB patient include:

- Take all medication doses under the supervision of treatment supporter
- Attend clinic visits as scheduled
- Provide quality sputum and other specimens when needed for monitoring
- Report all symptoms of possible medicine side effects
- Report any challenge associated with care
- Be informed on his/her choice of joining TB and former TB clubs
- Practice TB infection control measures as instructed/directed by HCWs and CHWs/ CVs
- Share TB control information with relatives/family members
- Advice contacts/family members with TB symptoms to visit health facility for investigation
- Provide information that will facilitate contact investigation

4.2 Roles of Treatment Supporter (TS)

Treatment supporter can be anyone (family member, spouse, relative, neighbours, health workers, or community workers) as decided by the patient. Selection of treatment supporter can base on the criteria including interested in the well-being of the patient, willing and able to carry out the task, living close to the patient, being accepted by the community and the patient and respect confidentiality.

A supporter will have to perform the following:

- Remind and encourage the patient taking their medicines everyday
- Supervise/observe the patient take their medicines every day (HB- DOT)
- Mark number of daily doses on the patient's identification card after the medicines are taken on daily bases
- Remind the patient on sputum collection for monitoring in case of bacteriologically confirmed cases
- Inform health care provider of any problems including side effects that may be experienced by the patient
- Accompany the patient to the health facility to obtain medicines (or a community health worker will need to visit and deliver the medicines) and whenever needed
- Inform the health care workers in case of travel so that the patient can select another supporter
- Report to the health facility in case the patient refuse to take his/her medication for assistance and in case of any health complication

4.3 Roles of Family members

Family member can be parents, spouse, brother, sister, aunt, uncle, and children etc. who lives in the same household with the patient.

- Support the patient during the course of TB treatment that is emotional, nutritional, spiritually, and materials
- Comfort to the patient and avoid discrimination and stigmatization
- Accompanying the patients to health facility
- Encourage and motivate the patient to adhere on the medication
- Report to the health facility in case the patient refuse to take his/her medication and in case of any health complication
- Advice any symptomatic family member to visit a diagnostic health facility for investigation

4.4 Roles of CHWs

- Carry out community based TB activities accordingly to National Guideline
- Empower community members on TB, DR-TB and TB/HIV information through effective social mobilization
- Identify people with presumptive TB and refer or escort them to health facility
- Ensure referral feedback of presumptive case from health facility
- Ensure all TB cases are on treatment
- Supervise the patient and his/her treatment supporter during treatment (refer 3.3.1)
- Collect and provide data to health facilities and CSOs implementing TB, TB/HIV and DR-TB

NOTE: Household screening for DR-TB contact is a role of health care workers and not community health care workers

4.5 Roles of Community members

- Be informed and involved in TB control activities
- Participate in identification of CHWs with accordance to the National operational guideline for community TB, TB/HIV and DR-TB intervention
- Support CHWs/ CVs with needs and resources to implement community TB, TB/HIV and DR-TB activities
- Determine appropriate and sustainable ways for motivating and supporting CHWs/ CVs
- Engage in improving and sustaining community TB, TB/HIV and DR-TB activities within their communities
- Work towards the elimination of stigma and discrimination at community level

- Collaborate with CHWs/ CVs to identify vulnerable population including OVC/MVC, KP, PLHIV, GBV/VAC, PWD and assist them to access relevant services
- Use and take ownership of community TB, TB/HIV and DR-TB services

4.6 Roles of Influential People

- Ensure linkage with community TB providers (Ex TB clubs, CHWs, etc)
- Provide spiritual, emotional support and counselling to patients
- Sensitize communities about caring for patients at home
- Strive to reduce stigma and discrimination in communities and within families

4.7 Roles of Traditional healers

- Be informed about TB, TB/HIV, DR-TB
- Identify all presumptive TB cases and refer them to community health care worker or health facility for investigation
- Work closely with CHWs/ CVs to seek and make use of updated TB, TB/HIV, DR-TB, HIV/AIDS and STI information Work in partnership with CHWs/ CVs to advocate for TB screening, HIV testing and referral to health facilities
- Report to CHWs/ CVs for lost to follow up patients
- Support and advocate for adherence to treatment

4.8 Roles of Community groups (Ex-TB patients' groups, IGA, Spiritual, PLHIV support groups)

- Provide community with basic information on TB, TB/HIV and DR-TB
- Sensitize the community on elimination of TB/HIV related stigma and discrimination
- Serve as role models/share personal experience on dealing with TB, TB/HIV and DR-TB disease and its prevention (testimony)

- Promote adherence to TB treatment and others services
- Link TB patients with IGA for poverty reduction in the community
- Link TB, TB/HIV and DR-TB patient to spiritual and psychosocial support
- Facilitate positive behaviour change practices in the communities (Alcoholics, IDU, CSW, MSM)

4.9 Roles of CORPS within their communities on TB control activities.

- Be informed on TB, TB/HIV and DR-TB control
- Find out issues and concerns the community has about TB, TB/HIV and DR-TB control services
- Lease with other CHWs to mobilise and sensitise the community and ex TB patients to form groups in a complimentary way and not competing or conflicting with them.
- Make TB as one of their main agenda in all their meetings/forums.
- Dispels rumours and corrects misconceptions related to TB disease
- Promote TB treatment and control in the community Identify presumptive TB patients and refer them to community health worker
- Facilitate initiation of TB treatment to all confirmed TB patients and ensure completion of their treatment
- Provide feedback to local authorities about what communities are saying on quality of TB, TB/HIV and DR-TB services at the health facility.
- Record correctly information of TB presumptive, referred and on TB treatment.
- Submit their reports monthly to the CHWs or at health facility
- Participated in planning, implementation, monitoring and evaluation on TB control services for the respective areas

4.10 Roles of Para-social, Para-legal workers

- Be informed on TB control
- Work in partnership with CHWs/ CVs to provide support and care to TB, TB/HIV and DR-TB Provide feedback to the CHWs/ CVs on TB, TB/HIV and DR-TB activities
- Educate and counsel community members on TB, TB/HIV and DR-TB
- Facilitate legal proceedings to TB, TB/HIV and DR-TB patients who refuse to take medication or refused to be admitted to specialized hospital in accordance with the Public Health Act 2009.

4.11 Roles of Drug Dispensers

- Identify and refer all presumed TB clients and refer them for investigations
- Educating presumptive TB cases on TB symptoms, importance of early diagnosis, and risks associated with not complying with the referral
- Facilitate referrals of TB contacts
- Refer to health facility clients on TB treatment who experience adverse effects
- Keep records of all referrals made
- Make follow up of referred presumptive TB clients:
- Provide health education on TB transmission and prevention.

4.12 Roles of Local government executive leaders

(Ward Extension Officers, Village/Street Chairperson)

- Provide time for CHWs/ CVs to talk about TB prevention, care and support during each community meetings
- Mobilization of resource for community TB, TB/HIV and DR-TB activities
- Conduct dialogue meetings with CHWs/ CVs so as to identify challenges and risk behaviour for key TB affected population

- Create demand for community TB, TB/HIV and DR-TB care in their community
- Incorporate community TB, TB/HIV and DR-TB care activities into local plans, budgets and supervise its implementation
- Facilitate multi sectorial collaborations for implementation of community TB, TB/HIV and DR-TB care services

4.13 Roles of Health facilities for community TB, TB/HIV and DR-TB care

TB diagnostic centers

- Receive TB referrals from CHWs/CVs, investigate them and initiate treatment accordingly and provide feedback.
- Receive sputum smear slides from sputum fixers and perform microscopy, record the results properly and provide feedback
- Ensure enough stock of laboratory reagents and supplies for microscopy for the facility and for sputum fixers
- Provide regular assistance mentorship to sputum fixers
- Provide information for lost to follow up tracing

TB clinics

- Record all confirmed TB cases in unit/district register
- Facilitate lost to follow up and TB contact tracing by provision of particulars to CHWs/ CVs.
- Educate for TB disease TB patients and their families/ treatment supporters
- Initiate and monitor treatment to all TB patients under HB-DOT
- Link TB patients who are co-infected with other diseases such as HIV, diabetes, cancers, to relevant clinics
- Work closely, supervise and mentor/train CHWs/ CVsto ensure quality implementation of TB, TB/HIV and DR-TB care

- Ensure quality data in recording and reporting at health facility level
- Refer all DR-TB clients to the DTLC

Other health facility departments e.g. Wards, CTC, RCH, HTC, OPD facilities in charges

- Be informed about TB, TB/HIV and DR-TB
- Conduct PITC and TB screening to patients in particular departments
- Record and refer all presumptive TB cases for TB diagnosis and treatment in case of positive TB

4.14 Roles of the CSOs

- Make TB, TB/HIV and DR TB as one of their priority agenda in communities
- Ensure TB control is effectively integrated into HIV community interventions
- Integrate TB, TB/HIV, DR TB activities into community based framework/plans
- Plan and implement community based TB, TB/HIV and DR-TB activities according to the national guideline
- Mobilize resources for community based TB, TB/HIV and DR-TB activities
- Share TB, TB/HIV and DR-TB control information including data with DMO (DTLC) and other stakeholders
- Work closely with TB, TB/HIV and DR-TB coordinators in respective areas of implementation
- Provide onsite mentorship and supervise CHWs
- Ensure effective linkages and referrals of people suspected of TB, TB/HIV and DR-TB
- Facilitate implementation of community TB, TB/HIV and DR TB interventions through strengthening linkage between the communities, Government and development partners

3.15 Roles of Development Partners

- Advocate for country adaptation of global policies and standards for TB, TB/HIV and DR-TB control at community level
- Facilitate sharing of experiences from other countries
- Provide technical and financial support for community TB, TB/HIV and DR-TB care in line with National priorities

3.16 Roles of Administrative levels

CHMT

- Conduct needs assessment and plan for district community TB interventions to be integrated into healthcare delivery systems
- Ensure integration of community TB, TB/HIV and DR-TB services in Comprehensive Council Health Plans (CCHP).
- Mobilization and allocation resource for community TB, TB/HIV and DR-TB care.
- Facilitate incentive of CHWs/ CVs for community TB, TB/HIV and DR-TB interventions
- Coordinate and supervise implementing partners for community TB, TB/HIV and DR-TB
- Facilitate multi sectorial collaboration for implementation of community TB, TB/HIV and DR-TB services
- Create community awareness and demand for community TB, TB/HIV and DR-TB services
- Support and ensure community involvement and participation in community TB, TB/HIV and DR-TB services
- Establish an effective networking, referral and feedback systems to ensure TB, TB/HIV and DR-TB continuum of care
- Build capacity of providers and supervisors for quality community TB, TB/HIV and DR-TB care

- Manage regular stocks of essential community TB, TB/HIV and DR-TB care equipment, supplies and drugs
- Conduct quarterly ENGAGE-TB stakeholder's meetings to review the quality of care provided
- Facilitate engagement of CSOs into community TB, TB/HIV and DR-TB control in the district.
- Collect, analyse and utilise data for community TB, TB/HIV and DR-TB care in a district and share reports to stakeholders.

RHMT

- Ensure Community TB, TB/HIV and Dr-TB Services are integrated in Regional Comprehensive Health Plans.
- Interpret policy guideline for Community TB, TB/HIV and DR-TB care
- Support, facilitate and coordinate implementation of Community TB, TB/HIV and DR-TB care in the region
- Facilitate engagement of CSOs into community TB, TB/HIV and DR-TB control in the region.
- Collect, analyse and utilise data for community TB, TB/HIV and DR-TB care in the region and share reports to stakeholders.

NTLP

- Develop and update Community TB, TB/HIV and DR-TB services policy, guideline, training manuals, IEC materials, SOPs and monitoring tools.
- Support, facilitate and coordinate implementation of Community TB, TB/HIV and DR-TB care in the country.
- Facilitate engagement of CSOs into community TB, TB/HIV and DR-TB control in the country.
- Facilitate integration of community TB, TB/HIV and DR-TB control activities into other health/ Non-health programmes

- Collect, analyse and utilise data for community TB, TB/HIV and DR-TB care in the country and share reports to stakeholders.
- Train and mentor of National trainers on community TB, TB/HIV and DR-TB care
- Prepare, disseminate and receive feedback on new policy guideline and standards for community TB, TB/HIV and DR-TB care
- Evaluate performance and impact of Community TB, TB/HIV and DR-TB care initiatives
- Conduct operational research on community TB, TB/HIV and DR-TB care for service delivery improvement

NACP

- Facilitate integration of community TB, TB/HIV and DR-TB control activities into other HIV programmes in the country

CHAPTER FIVE

5. MONITORING AND EVALUATION OF COMMUNITY TB, TB/HIV, AND DR-TB SERVICES

Monitoring and Evaluation (M&E) are processes involved in examining various program components to track and assess program progress and value. The purpose of M&E is to track implementation and outputs systematically, and measure the effectiveness of programmes. It helps determine exactly when a programme is on track and when changes may be needed. M&E form the basis for modification of interventions and assessing the quality of activities being conducted. It is essential in helping managers, planners, implementers, policy makers and donors acquire the information and understanding they need to make informed decisions about programme operations. It helps to identify the most valuable and efficient use of resources. M&E together provide the necessary data to guide strategic planning, to design and implement programmes and projects, and to allocate, and re-allocate resources in better ways.

5.1 Monitoring & Evaluation processes

Data collection

Data collection is the process of gathering and measuring information on targeted variables in an established systematic fashion, which then enables one to answer relevant questions and evaluate outcomes. Data collection on community TB, TB/HIV and DR TB activities is done by CHWs in collaboration with DTLC, TB/HIV Officer and Health facility in charge using standardized TB data collecting tools developed by the MOHCDGEC.

These standard data collection tools¹¹ include:

- Community TB/ DR TB Screening form “Fomu ya uchunguzi wa awali wa TB/DR TB ngazi ya jamii”

¹¹ NTLP Manual, 2013

- Community TB/ DR TB referral form “Fomu ya rufaa ya huduma za TB/DR TB ngazi ya jamii”
- Community Presumptive TB register “Rejesta ya wenye dalili za TB/ DR TB ngazi ya Jamii”
- Community lost to follow up register “ Rejesta ya waliokatisha/ wasioanza matibabu ya TB/ DR TB
- TB laboratory Register “ Rejesta ya maabara ya kifua kikuu”
- Laboratory Request Form “Fomu ya kuagiza na kutolea majibu ya vipimo vya makohozi”
- Community, Facility and district monthly/ quarterly reporting form for community TB, TB/HIV and DR-TB services “Fomu ya taarifa ya mwezi/ robo mwaka ya huduma za TB, TB/HIV na DR-TB ngazi ya jamii/ Kituo/ Wilaya”

i) Community TB Screening form “Fomu ya watu(wateja) waliofanyiwa uchunguzi wa awali wa TB/ DR TB katika jamii” (TB 12)

This form is used to record all people who have been screened for TB in the community including TB contacts. CHW or CHV should screen TB contacts and any other individual and record them with their TB screening results in the form (TB12). Any TB/ DR-TB contact screened must be linked with his/her Index case by writing a TB district number/ DR TB number of the index case.

ii) Community TB/ DR TB Referral form ”Fomu ya rufaa ya huduma za TB/DR TB ngazi ya Jamii (TB 15)”

This form is used to refer all TB/DR TB presumptive people identified at community level. The CHW/CHV should fill all required particulars and give a form to a TB presumptive person. CHW/CHV should help a TB/ DR-TB presumptive person to identify a nearest TB diagnostic health facility. A CHW/CHV should ensure initiation of TB/DR TB treatment for all TB/DR TB confirmed cases.

iii) Community Presumptive TB/DR-TB register “Rejesta ya wanaohisiwa kuwa na TB/DR-TB ngazi ya Jamii” (TB 13 A)

This is part A of TB13 register. The register is used to record all referred presumptive TB persons. The register should be regularly updated by CHWs/CHVs for monitoring and evaluation purpose and kept at community level, either by a group leader or an individual CHW/CHV.

iv) Community lost to follow up register “ Rejesta ya waliokatisha/ wasioanza matibabu ya TB/ DR TB (TB 13B)

This is part B of TB 13 register. The register is used to record all lost to follow up and missed appointment (initial lost to follow up) TB patients. The register should be regularly updated by CHWs/CHVs for monitoring and evaluation purpose and kept at community level, either by a group leader or any CHW/CHV. Recording will be immediate after receiving a list of lost to follow up TB patients and of those missed appointments. After tracing them, the register (TB 13B) will be updated with the tracing results/ feedback.

v) TB Laboratory register (TB 05) “ Rejesta ya maabara ya kifua kikuu”

This register will be used by sputum fixers to record the patient information in regard to sputum specimen and results.

NOTE: Accurate completion of these data collection tools is critical for monitoring performance and identifying trends in service delivery. All CHWs/CHVs shall be trained on the usage of the data collecting tools.

vi) Laboratory Request Form (TB/LEP 01) “Fomu ya kuagiza na kutolea majibu ya vipimo vya makohozi”

This form shall be filled by sputum fixers for requesting sputum microscopy examinations and through the same form, the sputum fixers will get feedback results as well. This form should be filled and attached with each particular smear slide to the TB diagnostic centre. The form will be taken back at the dispensary level for further required management decision. The registers (TB 05) should be updated with the results.

Data reporting

At monthly/ quarter basis, CHWs/CHVs shall tally data from the registers and enter this information into the standard Community, Facility and district monthly/ quarterly reporting form for community TB, TB/HIV and DR-TB services form (TB 14)

vii) **Community, Facility and district monthly/ quarterly reporting form for community TB, TB/HIV and DR-TB services “Fomu ya Taarifa ya robo mwaka ya huduma za TB ngazi ya jamii/ Kituo/ Wilaya ” (TB 14)**

This form should be filled by an Ex TB group or any CHW/CHV. It is used to provide a summary report based on indicators during the reporting month/ quarter and should be submitted to health facilities in-charge in which the group or CHW/CHV is affiliated. The reports will be verified at HFs through comparing between TB unit register, community presumptive TB registers and lost to follow up registers. After verification, the HF shall compile the reports (using the same form) for the catchment area and submit to the district level. The DTLC will use the same form to compiled community TB, TB/HIV and DR-TB report for the district. The information will help the DTLC to fill (TB 07) “Quarterly case notification report for TB and TB/HIV”

Community TB, TB/HIV and DR-TB services reporting mechanism

The report should follow the following channel:

- The reports from the communities shall be sent to the health facility of the catchment area by the 7th day of the first month of the next quarter.
- The reports from HFs shall be sent to the DTLC by the 14th day of the first month of the next quarter.
- The DTLC/TBHIV Officer will collect and compile the reports from all HFs, aggregate them and sent the district report to regional and national levels and share with stakeholders. The DTLC should verify the reports from facilities by correlating the data in the unit registers.

Implementers at all levels should retain copies of their reports for purpose of future utilization and planning. Information feedback shall be as follows:-

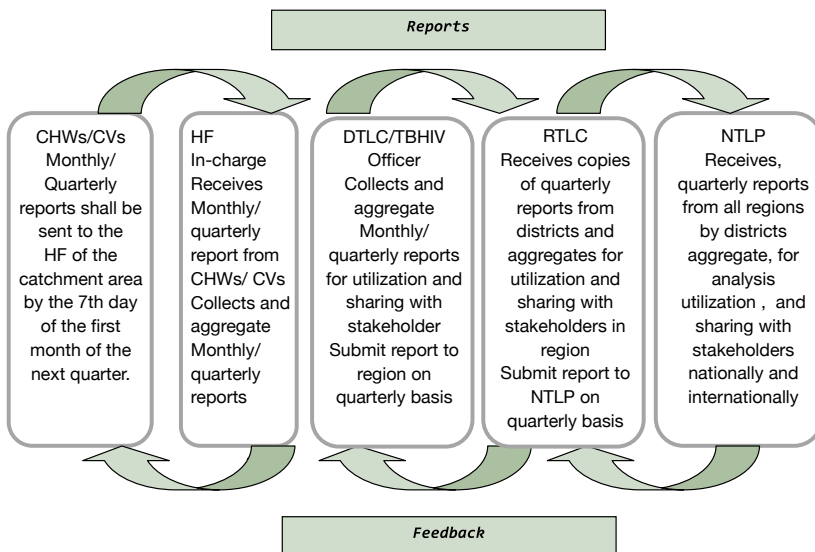


Figure 2: Information flow framework between community and health system¹²

Data analysis, interpretation and use

The community data generated at different levels should be analysed and used to make an informed decision and strategic planning of TB services in respective levels. Data summary reports and feedback shall be shared with all levels including the implementing stakeholders:

- CHWs/CHVs shall share these reports with
 - Health facility in charge in their catchment areas
 - Village government
 - Other group members
- Health facility in charge shall share these reports with
 - CSOs in their catchment area

¹² Community TB Care Handbook for CHWs (NTLP, 2013)

- o Ex TB groups or any other CHWs/CHVs
- o village authority
- o Other key stakeholders in the catchment area
- DMO shall share these reports with
 - o All health facilities in their District
 - o Local Government Authority
 - o Other key stakeholders in the District
- RMO shall share their reports with
 - o All Districts within their Region
 - o Other key stakeholders in the region
- NTLN Programme Manager shall share reports with
 - o Regional Medical Officers
 - o Other Ministries
 - o Implementing and development Partners
 - o Other key National and International stakeholders.

MOHCDGEC encourages documentation and publication of M&E data, best practices, and lessons learnt. Any publications or presentations based on community TB, TB/HIV and DR-TB data must be submitted to NTLN at all levels for clearance before submission. This includes abstracts for national and international conferences.

Data Storage

All community TB, TB/HIV and DR TB data collected is confidential, and shall be treated with the same level of protection as all other medical records. Every effort shall be made to ensure that records cannot be accessed by persons other than those who are authorized to do so. Data shall be stored in a highly secured manner for example in a lockable file cabinet, on a password-protected, secure computer, mobile phones or in other secure locations so that the information will remain protected.

5.2 Supportive Supervision and mentorship

The MOHCDGEC supportive supervision guideline describe supportive supervision as a “process which promotes quality outcomes by strengthening communication, identifying and solving problems, facilitating team work, and providing leadership and support to empower health care providers to monitor and improve their own performance”.

Mentorship is described as a process conducted by a person (the mentor(s)) or team for another person or groups (the mentee(s)) in order to help that other person or group do a job more effectively.

The purpose of supervision and mentorship in community TB, TB/HIV and DR TB care and control

The purpose of supervision at community level is to:

- Provide leadership and guidance to community TB, TB/HIV and DR-TB care providers through mentorship
- Monitor implementation of planned activities against defined programme goals and targets
- Monitor that all necessary tasks are properly performed.
- Ensure that training and resources including finance and supplies are properly used and are available to community TB, TB/HIV and DR-TB care providers to carry out their duties
- Ensure accountability and responsibility
- Ensure adherence to the set standards of community TB, TB/HIV and DR-TB care and control.
- Identify/address barriers to service delivery to improve community TB, TB/HIV and DR-TB services on a daily basis.

Supervision of the region by national level: The national level should supervise community TB, TB/HIV and DR-TB activities in the regions at least once per year. Regions with specific challenges should be visited more frequently. The supervision should be jointly done with implementing partners of the respective region.

Supervision of the district by the regional level: The regional level should supervise community TB, TB/HIV and DR-TB activities in the districts at least once per year. Regions with specific challenges should be visited more frequently. The supervision should be jointly done with implementing partners of the respective districts.

The regional team should visit each district twice per year. The district team should accompany the regional team to health facilities. Districts with specific challenges should be visited more frequently.

Supervision of health facilities by district level: The district level should supervise community TB, TB/HIV and DR-TB activities in each diagnostic centre at least once per month and each DOT centre once per quarter. Health facilities with specific challenges should be visited more frequently. The supervision should be jointly done with implementing partners of the respective facilities.

Supervision of community healthcare providers by health facilities: The HF should supervise community TB, TB/HIV and DR-TB activities in the community at least once per quarter. CHW/ community group with specific challenges should be visited more frequently. The supervision should be jointly done with implementing partners of the respective community.

Community Based TB, TB/HIV and DR-TB Supervision tools

The community TB, TB/HIV and DR-TB supervision checklist will be used by national, regional, district and health facility teams to supervise community based TB, TB/HIV and DR TB services (see Annex 9)

5.3 Indicators for community based TB, TB/HIV and DR-TB control performance

In order to measure performance of community TB, TB/HIV and DR-TB control interventions, the following indicators have been selected (developed) to monitor and evaluate the program

Table: Indicators for community based TB TB/HIV and DR-TB control performance

S/N	Indicator	Numerator/ Denominator	Level	Frequency
1	Number of referrals of presumptive TB patients (TB suspects) attributable to communities (e.g. CVs, community healthcare providers) expressed as a percentage of all presumptive TB patients in the facility/ district/region/ country	Numerator: Number of referrals of presumptive TB patients attributable to communities	Health Facility District/ region/ National	Quarterly; Annually
		Denominator: All presumptive TB patients in the district/ region/country		
2	Percentage of TB notifications from community referrals. This indicator measures the proportion of notified TB patients (all forms of TB) who were referred by a community health worker or community volunteer.	Numerator: Number of notified TB patients (All forms) who were referred by CHWs/ CHVs in the district/ region/country	Facility District/ region/ National	Quarterly; Annually
		Denominator: Number of all notified TB patients (All forms) in the district/region/ country		
3	Percentage of registered TB patients who received treatment support in the community: This indicator measures the proportion of TB patients who were supported during treatment by a community health worker or community volunteer in the district/ region/country	Numerator: Number of TB patients who were supported during treatment by a CHW/ CHV in the district/ region/country	District/ region/ National	Quarterly; Annually
		Denominator: Number of TB patients who were receiving treatment in the district/region/ country		

S/N	Indicator	Numerator/ Denominator	Level	Frequency
4	Percentage of registered TB patients who received treatment support in the community who were successfully treated: This indicator measures the proportion of TB patients who received treatment support from a community health worker or community volunteer (HB DOT) during their TB treatment and who were successfully treated in the district/region/country	Numerator: Number of TB patients who received Home-based treatment observation and/or adherence support and who were successfully treated.	District/ region/ National	Quarterly; Annually
		Denominator: Number TB patients who received Home based treatment observation and/or adherence support.	District/ regional/ National	Annually
5	Number of CSOs engaging in TB control in district, region or National	Number of CSOs		
6	Number of TB index cases whom their contacts have investigated for TB expressed as percentage of all index cases in a facility/ districts/ region or national	Numerator: Number of TB index cases whom their contacts have investigated for TB in a facility/ districts/ region or national		Quarterly; Annually
		Denominator: Number all Smear Positive TB cases in a facility/ districts/ region or national.		
7	Number of TB patients missed appointments and lost to follow up traced back to treatment expressed as percentage of all missed appointments and lost to follow up in a facility/ districts/ region/ national in a specific period	Numerator: Number of patients missed appointments and lost to follow up traced and put on treatment.	Facility/ District/ regional/ National	Quarterly reports, treatment cards, Community TB registers
		Denominator: Total number of patients who missed appointments and lost to follow up at the facility/ district/ region/country		

References

- Engage TB Implementation Manual (WHO, 2013)
- Global TB report 2015 (WHO, 2015)
- Global Tuberculosis Report (WHO, 2015)
- Implementation Framework for Expanded Decentralization of DR-TB Services in Tanzania (MoHSW, 2015)
- National community based health program policy guideline (MoHSW, 2014)
- National ENGAGE TB Operational Guideline (MOHSW, 2013)
- NTLP annual Report, 2013
- NTLP data, 2014
- NTLP Manual, 2013
- Patient Centred Treatment Guideline (MOHSW, 2005)
- Recommendations for Investigating Contacts of Persons with Infectious Tuberculosis in Low- and Middle-Income Countries (WHO, 2012)

Annexes

Annex 1: Community TB activities which can be integrated into RCH programmes

TB prevention in RCH settings	
1. TB awareness-raising, infection control (including cough hygiene), stigma reduction, IEC and BCC	<ul style="list-style-type: none"> • Train CHWs/CHVs, community midwives, NGO/CSO staff, mother-to-mother peer supporters and community leaders on the importance of TB screening and early treatment for pregnant women. • Target households to increase awareness, especially those with a person who has pulmonary TB.
2. Provide IEC materials and job aids on TB prevention for use by CHWs, CHVs and midwives	<ul style="list-style-type: none"> • Develop and provide culturally appropriate materials for use at household and community levels and in RCH clinics. • NGOs/CBOs should take a lead on developing materials, supported by larger NGOs/CSOs and the NTLP. All materials should be tested or pilot tested with the target audience to ensure they are easy to understand and are culturally acceptable.
3. Engage in specific BCC campaigns and stigma reduction aimed at informing women and families and dispelling myths about TB and HIV	<ul style="list-style-type: none"> • Train grassroots NGOs/CSOs, and mother-to-mother peer supporters to take a lead on BCC and stigma reduction at local level in local languages. • Hold events such as street theatre in public settings where women and families gather, e.g. markets, places of worship, antenatal clinics, and mother and child support groups.
4. Improve vaccination coverage, including BCG for infants.	<ul style="list-style-type: none"> • Engage grassroots NGOs/CSOs and mother-to-mother peer supporters to work with CHWs and RCH community outreach and vaccination campaigns, and ensure that all children needing vaccination are identified and able to access it. • Use regular community health outreach visits and child health days to reach the largest numbers.

TB case detection, referral and surveillance in RCH settings

<p>1. Screen, identify and refer mothers, their partners and child contacts with presumptive TB to the health facility for TB and HIV diagnosis and management</p>	
<p>2. Provide education on the importance of TB testing and linking to HIV testing and counselling for all mothers and family members who may benefit from it</p>	<ul style="list-style-type: none"> • Train CHWs and CHVs, NGOs/CSOs and mother-to-mother peer supporters to inform and support households and family groups (including male family members) and antenatal support groups on TB screening and HIV testing and counselling.
<p>3. TB contact tracing, sputum collection, sputum transport</p>	<ul style="list-style-type: none"> • Train CHWs, CHVs and community midwives on screening methods, TB contact tracing and sputum collection, safe storage and transport. • Ensure that under-fives and new-borns, who are vulnerable to TB, are identified during contact tracing as well as adults and older children. • Ensure that sputum collection and transport follow national policy and protocols; this will also depend on the availability of laboratory facilities.
<p>4. Referrals to link health facilities for women and children with presumptive TB</p>	<ul style="list-style-type: none"> • Ensure that systems are in place for referring patients from the point of contact in the community through to the health facility and re-referring them back to the community for ongoing adherence and other forms of support. • Ensure close linkages between community and health facilities, with agreed referral forms and recording systems. • Provide transport support (such as bus fares or lifts) where needed. • Provide accompaniment by peer supporters to assist mothers and young children in completing referral journeys and accessing TB care

TB treatment adherence support in RCH settings

1. Home-based TB DOT and adherence counselling	<ul style="list-style-type: none">• NGOs/CSOs and NTLP can work together to ensure that CHWs and CVs have the skills needed for these tasks.• In addition to DOT adherence support, include stigma reduction, home-based care and tracing of patients who are lost to follow-up; checking TB, HIV and antenatal appointment cards; and referring mothers on TB treatment for follow-up sputum smears.
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Social and livelihood support in RCH settings

1. Link pregnant women and mothers to local support mechanisms	<ul style="list-style-type: none">• Ensure access, when needed, to cash transfers, insurance, nutrition, voluntary savings and loan schemes and income generation projects.
2. Involve others in the home to create a suitable home environment for TB and other treatment	<ul style="list-style-type: none">• Ensure that psychological and physical support is available in the home and in peer support centres for mothers and children.• CHWs can link clients with local NGOs/CSOs for these activities.

TB Advocacy in RCH settings

1. Advocacy on supplies of TB and HIV drugs and laboratory tests	<ul style="list-style-type: none">• Monitor availability of essential supplies, drugs and tests, and advocate for consistent, good-quality supplies, equipment and human resources to be available at local facilities.• Advocacy can address medicine shortages and quality problems and local availability of equipment and tests, e.g. laboratory microscope, tests for TB and HIV screening (including for new-borns and infants).• In cases of emergency, local NGOs/CSOs and community health providers can advocate with national or international providers to provide supplies as a short-term solution, where resources are available.
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Note: CHWs, NGOs/CSOs and NTLP at all levels should work together to create effective coordination between RCH, TB and HIV services.

TB Advocacy in RCH settings

1. Advocacy on access to services	<ul style="list-style-type: none">• Bringing services closer to where people live is a priority for ensuring early access to diagnosis and treatment, particularly for pregnant women and mothers with young children who find it difficult to travel. Advocacy may be needed to ensure that TB and HIV treatment and diagnostic services are available at a local health centre.• Local NGOs/CSOs, CHWs and Village/Ward/ Facility health committees can act as advocates on behalf of mothers and children to ensure RCH, TB and HIV services.
2. Advocacy for policy changes	<ul style="list-style-type: none">• Policy changes may be needed at community level and all levels of the NTLP, RCH services, laboratory and pharmacy services. For example, changing policy to allow CHWs to collect and transport sputum or permitting trained midwives to initiate treatment for pulmonary TB. Task shifting to allow CHWs to do more at the household level should be encouraged.• NGOs/CSOs should work together within the NCB and with the NTLP to address needs and provide guidance for the country.
3. Advocacy for research	<ul style="list-style-type: none">• Research is an important part of TB activities, especially in community settings where it is not yet clear what approaches are the best for community-based TB activities. Operational research is a useful approach, allowing different types of evidence to be gathered and involving communities and NGOs/CSOs in asking and answering the research questions.• NGOs/CSOs, researchers and the NTLP should work in partnership to gather evidence of what works, for adoption by the NTLP and other departments.

TB stigma reduction in RCH settings

<p>1. Raise community awareness on stigma experienced by pregnant women, mothers and young children with TB.</p>	<ul style="list-style-type: none">• Address key issues of stigmatization affecting pregnant women and mothers, specifically blame, rejection by partner, marriage breakdown and loss of financial support.• Use public settings such as markets or community centres for stigma reduction events, such as street theatre, public testimonials, group discussions and participatory activities.
<p>2. Sensitize, train and mentor community leaders and MNCH and CHWs on stigma reduction</p>	<ul style="list-style-type: none">• Train NGO/CSO staff, TB/HIV patients, community leaders, mother-to-mother peer supporters and women's groups, on stigma reduction for mothers and young children with TB.
<p>3. Support CHWs to include stigma reduction during contact tracing</p>	<ul style="list-style-type: none">• Work with NTL staff and CHW supervisors to train and support CHWs on stigma reduction among families of mothers and children with TB.

Annex 2: Community TB activities which can be integrated into HIV programmes

TB prevention in HIV care	
1. TB awareness-raising in HIV care settings	<ul style="list-style-type: none"> • Educate people on TB when they attend HIV care services, for example at community centres during outreach, mobile and stand-alone voluntary counselling and testing sites and sexually transmitted infection clinics. • Educate providers and people attending clinics on cough hygiene. • Promote the TB Patients' Charter and International Standards for TB Care as part of HIV prevention work. • Educate community HIV care and support providers on TB prevention and the importance of IPT. • Provide integrated training to CHWs and CVs on TB/HIV stigma and TB/HIV literacy.
2. Community TB/HIV awareness-raising and stigma reduction	<ul style="list-style-type: none"> • Use radio and TV, printed brochures and posters to provide IEC on TB/HIV, using peer educators and people recovering from TB, supported by NGO/CSO communications and programme teams. • Emphasize prevention through cough hygiene, and promote ventilation and exposure to sunlight as additional measures to reduce risk. • Emphasize that TB can be cured with effective TB treatment and that it is a different disease from HIV infection, which can be controlled with ART.
TB detection in HIV care	
1. TB screening	<ul style="list-style-type: none"> • Develop standardized tools and simple TB screening protocols based on international guidance to help identify people at highest risk. • Train CHWs, staff and volunteers at HIV voluntary counselling and testing sites, community centres and households to use the screening tools and refer people with TB symptoms for diagnosis.

TB detection in HIV care	
2. Sputum collection and transport	<ul style="list-style-type: none"> Utilize standardized tools and simple TB screening protocols for sputum collection in households, community centres and health posts. Train CHWs, HIV outreach workers and carers to collect, store, label and transport sputum specimens to laboratories for examination.
TB contact tracing	<ul style="list-style-type: none"> Train CHWs and CVs on contact tracing in households and other community settings. Prioritize contacts of sputum positive patients, as they are most at risk, but also respect confidentiality to prevent the risk of stigma.
Referral between community HIV and TB services	
1. Link patients with clinics for TB diagnosis and care (clinical examination and treatment).	<ul style="list-style-type: none"> Ensure that TB patients can connect with TB services. They may need active support and accompaniment to access services, including transport. Develop referral linkages between TB services and community HIV services such as voluntary counselling and testing sites and community HIV centres, including back-referral to CHWs and peer supporters for ongoing support and follow-up.
2. Ensure that patients are able to get transport to TB services	<ul style="list-style-type: none"> Engage peer supporters to provide support and accompaniment where needed. Mobilize resources to pay fares or hire vehicle transport for those in need to travel from community HIV centres, voluntary counselling and testing or ART sites to TB centres.
3. Train providers on facilitating community referrals.	<ul style="list-style-type: none"> Work with CHW supervisors, TB and HIV clinic staff and peer supporters to develop and use a two-way referral system, with referral and back-referral forms and recording systems that are linked with national reporting mechanisms. Train peer supporters and other CVs on tracing TB and HIV clients who fail to keep appointments.

TB treatment adherence support in HIV settings

<p>1. Provide adherence counselling and support for TB treatment and IPT.</p>	<ul style="list-style-type: none"> • Train ART adherence counsellors, CHWs, peer support groups, peer educators, carers and family members on TB treatment and IPT. • Send SMS text reminders and appointment reminders, and trace patients who miss appointments. Monitor progress and side-effects, re-referring clients when needed. • Address stigma reduction as an important factor affecting TB and HIV treatment adherence.
<p>2. Home-based TB and HIV care and support including stigma reduction in family and community</p>	<ul style="list-style-type: none"> • Engage family members, peer supporters, CSOs and CHWs to provide integrated TB and HIV treatment adherence support, including preventive treatment with isoniazid and cotrimoxazole and support for dealing with the effects of stigmatization. • Also consider providing TB and HIV adherence support at community centres or HIV drop-in centres as an alternative for those who do not want to disclose their status. • Reinforce messaging on the importance of treatment adherence during pre-ART counselling and after initiation in community outreach and in IEC materials.

Social and livelihood support for people affected by TB/HIV

<p>1. Nutrition support and supplementation</p>	<ul style="list-style-type: none"> • Ensure that patients receiving treatment have access to adequate, balanced nutrition to support them in recovering from TB and opportunistic infections due to HIV infection, especially during the early stages of TB or HIV treatment. Note that this is a specific medical need apart from any longer-term food access issues
<p>2. Income generation and vocational training</p>	<ul style="list-style-type: none"> • If the organization is implementing income generation and vocational training etc. specifically include people with, affected by or at risk of HIV infection and TB.

TB advocacy in HIV settings	
1. Monitor availability of TB supplies, equipment and services and advocate for better access	<ul style="list-style-type: none"> • Engage CHWs, patient groups, community leaders, TB advocates and champions in monitoring activities. • Where available, use electronic messaging or cell phone reporting systems to communicate shortages to national level for rapid action and advocacy
2. Monitor policy barriers on access to TB and HIV services, especially for the most vulnerable groups.	<ul style="list-style-type: none"> • Train NGO leaders, TB and HIV advocates and champions on how to advocate, and measure its success using or adapting available tools. • Ensure advocacy at local and national levels, using mechanisms for partnership and collaboration, e.g. national networks such as the NCB for TB.
TB stigma reduction in HIV settings	
1. Raise public awareness on TB and HIV stigmatization.	<ul style="list-style-type: none"> • Train patient and peer support groups, TB champions and advocates in stigma reduction activities. • Use community theatre, public testimonials and disclosure by people living with TB and HIV, public community sensitization events in markets, sports events, places of entertainment.
2. Training and capacity-building	<ul style="list-style-type: none"> • Provide TB and HIV stigma reduction training for community leaders, CHW supervisors, peer support groups, teachers, religious leaders, health workers, NGO staff and people in authority, such as police. • Support disclosure and acceptance of people living with TB and HIV infection and taking treatment in affected communities and in workplaces, e.g. health facilities, schools.

TB stigma reduction in HIV settings

3. Take action against discrimination.	<ul style="list-style-type: none">• Support legal action for loss of work or property related to having TB or HIV infection, for example in law courts, employment tribunals, parliament or local councils.• Engage in public campaigns against specific forms of discrimination.• Train NGO/CSO leaders and coordinating bodies, networks of affected people and communities on how to act against discrimination and provide legal support to people affected by TB and HIV infection.
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Annex 3: Community TB activities which can be integrated into PHC programmes

TB prevention in PHC settings

1. Awareness-raising, infection control, stigma reduction, IEC, BCC, training of providers	<ul style="list-style-type: none">• Conduct surveys related to TB.• Develop and distribute IEC materials on TB.• Train on counselling and effective communication with people who may have TB.• Develop TB radio messages and jingles.• Include TB in PHC for both children and adults.• Engage in family and community dialogue on TB during home visits.• Promote BCG vaccination.
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TB detection in PHC settings

1. Screening, contact tracing, sputum collection and transport, training providers	<ul style="list-style-type: none">• TB screening of children under five during child health days and nutritional surveys, school health programmes and de-worming campaigns;• TB screening during outreach visits;• Training school health clinic staff on sputum collection and safe storage; and• Training providers at school and in the community on how to assess TB signs and symptoms and how to refer children for TB diagnosis and treatment.
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Referral to TB services from PHC settings	
1. Linking people at risk of TB with clinics, including transport support and facilitation	<ul style="list-style-type: none"> • Link people who might have TB to a referral or infectious disease hospital. • Provide transport support to help patients complete referral journeys. • Support transport of sputum specimens to the nearest health facility.
TB treatment and adherence support in PHC settings	
1. Home-based DOT, counselling, adherence, home visits, pill counting, stigma reduction, training providers, home-based care and support	<ul style="list-style-type: none"> • Conduct home visits to support adherence (at least weekly). • Provide training on counselling and effective communication skills (family and community dialogue). • Monitor treatment adherence and adverse drug effects. • Re-refer patients who have difficulties due to side-effects of anti-TB drugs or poor adherence.
TB surveillance in PHC settings	
1. Record data at community level; maintain summary records and registers on referrals and transfers at health facility.	<ul style="list-style-type: none"> • Engage community members to form a community monitoring body. • Train CHWs to maintain record sheets and registers. • Train school clinics to keep registers.
2. Report on the contribution of communities to TB services	<ul style="list-style-type: none"> • Develop a mechanism for reporting to the NTLP at district and national level.
• Social security, food and nutrition security, livelihoods in PHC settings	
1. Provide social safety nets to support people affected by TB, especially during the recovery phase of treatment.	<ul style="list-style-type: none"> • Consider food and nutrition supplementation and conditional and/or non-conditional cash transfers. • Develop community insurance schemes, and train providers to support people's access to inclusive markets, voluntary savings and loans and income-generating activities. • Link organizations with limited capacity with other organizations offering social, nutrition and livelihood support.

TB advocacy in PHC settings

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| <p>1. Monitor the availability of supplies, equipment and services at health facilities, and report any gaps and weaknesses.</p> | <ul style="list-style-type: none">• Engage community and faith-based leaders to add their voices to improve TB services.• Train health providers on stigma and barriers to community use of services. |
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Social mobilization and TB stigma reduction in PHC settings

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| <p>1. Use community theatre/drama groups, patient/peer support groups, community champions, testimonials, sensitizing/training facility and CHWs and leaders</p> | <ul style="list-style-type: none">• Design and conduct community “docudramas” on TB.• Identify and engage TB champions.• Host public testimonials by people who have been cured of TB.• Support peer-to-peer groups (e.g. school hygiene groups, women’s or men’s groups).• Train social mobilizers on TB. |
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Annex 4: Community TB activities which can be integrated into Agricultural programmes

TB prevention in agriculture programmes	
1. Engage farmers' groups members to promote TB prevention.	<ul style="list-style-type: none"> • Train members in TB awareness-raising among rural households (men, women and young people), including how to prevent/reduce the risk of TB and other diseases.
2. Improve community information on TB prevention through community sensitization and awareness-raising	<ul style="list-style-type: none"> • Use IEC materials, TB campaigns, school competitions, debates. • Increase capacity of community leaders through training on TB prevention. • Train lead farmers to be TB champions in rural communities. • Educate people on healthy living to reduce vulnerability to TB. • Link ultra-poor households with livelihood support schemes.
TB detection and referral in agriculture programmes	
1. Train group members to recognize TB symptoms and encourage community members with symptoms to be tested.	<ul style="list-style-type: none"> • Discuss TB signs and symptoms. • Establish an easy-to-use, reliable system for referral to CHWs or a clinic. Note: Issues of confidentiality and trust are particularly important in small communities and groups.
Social and livelihood support for people affected by TB in agricultural settings	
1. Integrate TB into training on life skills and confidence-building within agricultural learning	<ul style="list-style-type: none"> • Train ultra-poor caregiver and producer groups in TB screening, nutrition, production and use of nutritious foods and income generation to support affected families. • Develop/establish savings groups to support ultra-poor households and caregivers. • Establish livelihood support and cash transfer mechanisms for affected households. • Train selected community members on TB adherence support.

Annex 5: Community TB activities which can be integrated into Livelihood programmes

TB prevention in livelihoods development settings	
<p>1. Use livelihoods development programme supervision mechanisms to raise awareness on: TB basics, including transmission and prevention, signs and symptoms, stigma reduction, importance of nutrition for protection from disease, personal hygiene and living conditions</p>	
<p>2. Include education on aspects of TB during visits to families by programme officers, who generally use a checklist to monitor livelihoods and life skill development; education on TB can be included in this checklist.</p>	
<p>3. Integrate marginalized ultra-poor groups into the wider local community</p>	<ul style="list-style-type: none"> • Use an existing village committee or work with village leaders to set one up, to provide support to the target group and raise awareness about TB among the whole community. • Hold regular (monthly) village meetings called by the village committee to inform people about TB and other social issues; use media such as video shows to make a greater impact on the community. • The local manager of the livelihoods development programme can lead the task of forming the committee and facilitating the monthly meetings. • Organize and build the capacity of the committees so that they continue to address TB and other issues after the livelihoods development programme withdraws.

TB prevention in livelihoods development settings

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| <p>4. Address health in livelihoods programmes: Recruit and train CVs on prevention, detection and treatment of TB along with other health services</p> | <ul style="list-style-type: none">• Invite the health volunteers to village committee meetings to raise awareness on TB.• Health volunteers can organize community health forums to discuss TB along with other health issues. |
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TB detection in livelihoods development settings

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| <p>1. Train the programme officer on TB signs and symptoms so that she or he can identify people with TB symptoms during home or group visits</p> | <ul style="list-style-type: none">• The programme officer refers the person to a sputum collection point, or:• if a health volunteer is trained in sputum collection, the programme officer can ensure that she or he visits people with TB symptoms at home to collect sputum and send it to the laboratory for testing. |
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| <p>2. Link health volunteers in the livelihood programme to the local TB diagnostic facility.</p> | |
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| <p>3. If there are no health volunteers, link the programme officer with the local TB programme (NTLP) team to make sure that any presumptive cases of TB are tested and diagnosed.</p> | |
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| <p>3. Mobilize village development committees to support sputum transport from remote areas (livelihood programme staff can facilitate the process).</p> | |
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TB referrals in livelihoods development settings	
1. Livelihoods programme staff and programme health volunteers support referrals by identifying the nearest clinics, accompanying the patient and providing support for transport.	
2. Village development committees can also support referrals in the same ways.	
Treatment adherence support in livelihoods development settings	
1. Health volunteers associated with the livelihood programme can encourage patients to take their medicines regularly through DOT.	
2. If there are no health volunteers, the programme officer can support DOT during home visits, including counselling on treatment adherence and completion and the importance of adherence support by caregivers in the household.	
Social and livelihood support for people with TB	
1. Provide extra support to TB patients in livelihoods programmes, including:	<ul style="list-style-type: none"> • special stipends for income support during the TB treatment period, • special nutrition support to support recovery from TB and • Mobilizing additional care from village committees, e.g. child care support.
TB advocacy in livelihoods development settings	
1. Use livelihoods programme staff and events to educate people on TB and reduce social stigma around TB.	<ul style="list-style-type: none"> • Use social communication strategies such as community theatre/drama at local level.

TB advocacy in livelihoods development settings

2. Provide feedback from the field to meetings within or outside the organization, aimed at strengthening the TB programmes. For example, highlight issues such as supplies, quality of services, realities about transport and the challenges related to the referral services, as relevant

3. Contribute to policy dialogue with local and national government, on the basis of the programme's field observations.

Annex 6: Community TB activities which can be integrated into education programmes

TB prevention in educational settings	
<p>1. Early childhood development: “the earliest is the best”:</p>	<ul style="list-style-type: none"> • Engage school managers, teachers, young children and the national education service. • Implement TB activities in nurseries, early childhood development and pre-school centres. • Teach young children about hygiene and sanitation, such as cough hygiene, body and hand washing, drinking clean water and being in fresh air and sunshine. • Provide TB life skills education through play-based activities such as dramatic play, art, social games, songs and telling stories. • Develop a simple TB curriculum if not already available, and train preschool teachers to implement it
<p>2. Primary school</p>	<ul style="list-style-type: none"> • Engage teachers, children and academic authorities. • Implement TB activities in primary schools, villages and other places where children of this age group gather. • Continue training on TB life skills with more detailed focus on identifying signs of TB and what one should do if signs persist. Include basic information about HIV and other infections and drug abuse: <ul style="list-style-type: none"> - Include TB in the basic science curriculum. - Train children using the child-to-child approach so that they can train each other on TB awareness and prevention. - Train teachers on the child-to-child approach, BCC and active methods in order to facilitate implementation of TB activities. <ul style="list-style-type: none"> - Include TB in school activities, e.g. competitions, social games, trips of discovery. - Emphasize TB messages with materials such as booklets, flyers, T-shirts, pens and posters to help children and adults remember key information.

TB prevention in educational settings	
3. Secondary school	<ul style="list-style-type: none"> • Focus in more depth on scientific explanations of TB and its links with HIV infection, building on the TB learning in primary school. • Include information on prevention of HIV, sexually transmitted infections, drug abuse and tobacco use. • Engage teachers, adolescents and young people in implementing TB screening activities in junior schools and high schools.
1. Non-formal education	<ul style="list-style-type: none"> • Engage community facilitators, NTLP and NGO staff and supervisors to work on community TB education. • Train adult men and women on TB prevention through behaviour change, including cough/sneezing hygiene and safe disposal of sputum. • Include TB in literacy activities, focusing on how to prevent TB.
Detection	
Train teachers in TB screening of their pupils and fellow teachers	
Include TB prevention in adult literacy curricula.	
. Train literacy group members to screen fellow students for TB based on their growing knowledge and awareness.	
Referral	
Teachers and adult literacy class facilitators should refer those with TB signs and symptoms to CHWs or directly to health facilities, depending on their age.	

Treatment adherence support	
1. Teachers can support children taking TB medication to ensure adherence.	
2. Use parent–teacher association meetings as a forum for discussing adherence and improving TB treatment literacy.	
Advocacy	
1. Engage parent–teacher associations to increase awareness of TB and advocate for TB messages to be included in school curricula by school boards and government education departments.	
Stigma	
1. Increase knowledge and discussion about TB at all levels of schooling. Increased awareness and understanding are powerful ways to reduce stigma	

Stigma

2. Engage in specific anti-stigmatization activities using approaches such as the Understanding and challenging TB stigma toolkit (see resources list below).

3. Educate teachers and parents to recognize the signs and to act if children are being stigmatized when they or members of their family are known or thought to have TB or HIV infection.

Annex 7: Community TB activities which can be integrated into WASH programmes

Prevention	
1. Public awareness meetings and door-to-door hygiene and sanitation promotion	<ul style="list-style-type: none"> • Include TB messages as part of the overall promotion.
2. Develop IEC and BCC materials to link TB prevention with improved hygiene	<ul style="list-style-type: none"> • Promote ventilation, good cough hygiene and hand-washing with soap. • Use health surveillance assistants, CHWs and CVs to communicate messages.
Train health extension workers, CVs (WASH committees) and sanitation entrepreneurs (providing hardware, soap etc) on TB basics, counselling and the linkages between TB, HIV infection and WASH.	
Teach the basics of TB and HIV infection to school sanitation clubs.	
Promote good hygiene practices in families and communities.	
TB detection	
1. Screen family members with TB symptoms during door-to-door/household visits to promote sanitation and hygiene.	
2. Use the volunteer water and sanitation committees to identify and follow up cases within their membership and in the wider community, especially groups associated with WASH programmes.	

TB detection	
3. Deliver messages on TB and conduct screening for referrals during campaigns (for example, vaccination, water chlorination) or when dealing with emergency outbreaks such as cholera. This could be community wide or target certain groups e.g. schoolchildren.	
4. Invest in capacity and build skills for observation of symptoms and knowledge of health status of community members.	
Referral for TB services	
1. Use volunteer committees to refer people who may have TB to CHWs for screening and onward referral to health facilities for diagnosis and treatment.	
2. Establish partnerships/alliances, especially with clinics and laboratories, for follow-up, with diagnosis and treatment for those referred by CVs and workers.	
TB treatment adherence support	
1. Work to improve the sanitation facilities at TB treatment centres to encourage patients to attend (patients can sometimes discontinue treatment due to poor hygiene facilities at clinics).	

TB treatment adherence support	
2. Support community WASH volunteers to provide home-based DOT support to community members or ensure DOT support by others.	
TB advocacy	
1. Community groups should advocate for the provision of adequate WASH services and infrastructure in health facilities	
2. Promote improved coughing and sneezing behaviour in the community.	

Annex 8: Community TB, TB/HIV and DR – TB Monitoring and Evaluation Tools

a) Community TB/ DR TB Screening form



TB 12

Fomu ya watu (wateja) waliofanyiwa uchunguzi wa awali wa TB ,TB/HIV na DR-TB katika Jamii

Jina la Mwanakikundi/Mtoa huduma za afya ngazi ya jamii..... Jina la Kikundi/Asasi..... Mwezi wa kutolea taarifa(mm/yy)...../...../.....
 Jina la kitongoji/Mtaa..... kata..... wilaya.....

Na	Tarehe	Jina (majina matatu)	Jinsi (me/ke)	Umri (miaka)	Namba ya simu ya mteja	Namba ya simu ya mtu wakaribu	Mahali alipotokea mteja/alipochojwa (Waka)	Familia yenye mgonjwe wa TB/DR-TB /Andika namba ya wilaya ya	Familia isiyo na watu/Sehemu au nyingine (angalia)	Musanyiko wa watu/Sehemu au nyingine (angalia)	Matokeo ya mahojiano					Jina la kituo cha tiba alichopewa rufaa	Matokeo ya rufaa (angalia kielelezo B)	Maoni	
											Mgang'ani	D	H	KU	KI				
1																			
2																			
3																			
4																			
5																			
6																			
7																			
8																			
9																			
10																			
11																			
12																			
13																			
14																			
15																			

* KH= Kikichozi. D= Makohozi yaliyochanganyika na Damu, H= Homa, KU= Kupungua uzito, KI = Kutokwa jasho jingii kuliko kawaida hasa nyakati za usiku

Kielelezo A:	5. Duka la Dawaa
1. Shule	6. Magezea
2. Nyumba za Ibada	7. Waganga wa tiba asilia
3. Machimbo	8. Mengineyo (jata)
4. Mikutano ya hadhara	

Kielelezo B:
1. Hana TB
2. TB kwenye makohozi
3. TB sehemu nyingine
4. Rufaa haijafamikiwa

b) Community TB Referral form

WIZARA YA AFYA, MAENDELEO YA JAMI, JINSIA, WAZEE NA WATOTO



Mpango wa Taifa wa Kudhibiti Kifua kikuu na Ukoma (NTLP)
(Huduma shirikishi za TB, TB/UKIMWI na TB Sugu katika jamii)

Fomu ya Rufaa

1. Sehemu hii ijazwe na Mwanakikundi / Mtoa huduma za TB / DR TB ngazi ya jamii

Jina la mgonjwa (<i>Majina matatu</i>) Umri(<i>Miaka</i>).....	Namba ya HUWANYU..... Namba ya CTC.....
Tarehe ya rufaa (<i>Siku, Mwezi, Mwaka</i>)/...../.....	Jinsi: Me/ Ke
Rufaa kutoka Jina la Kikundi Jina la mtoa rufaa..... Namba ya mtoa rufaa..... Namba ya simu..... Sehemu nyingine (Shirika/taasisi) Jina.....	Rufaa kwenda Jina la kituo cha tiba..... Wilaya:.....
Dalili za TB (<i>Tiki panapohusika</i>) <ul style="list-style-type: none"> o Kikohozi zaidi ya wiki mbili o Homa zaidi ya wiki mbili o Kupungua uzito o Kutokwa na jasho usiku zaidi ya wiki mbili o Maumivu ya Kifua o Kukohoa makohozi yenye mchanganyiko na damu. 	Zingatia: <ul style="list-style-type: none"> o Uchunguzi na matibabu ya TB na TB sugu hutolewa bila malipo. o Kwa WAVIU ni kikohozi cha muda wowote

.....x.....x.....x

2. Sehemu hii ijazwe na mtoa huduma wa kituo cha tiba.

Jina la Kituo cha Tiba	Huduma ya ugunduzi iliyotolewa. <ul style="list-style-type: none"> o Upimaji wa makohozi o Upimaji wa VVU o X-ray o Upimaji wa daktari (Physical examination)
Jina la mteja.....	
Tarehe ya kupokelewa mgonjwa. (<i>Siku, Mwezi, Mwaka</i>)/...../.....	Matokeo ya vipimo <ul style="list-style-type: none"> o Kuwepo kwa vimelea vya TB o Hakuna vimelea o Kifua kikuu nje ya mapafu
..... Jina la mhudumu wa afya Cheo

c) Rejesta wa wanaoisiwa kuwa na TB katika jami

Wizara ya Afya, Maendeleo ya Jamii, Jinsia, Wazee na Watoto
Mpango wa Taifa wa Kudhibiti Kifua kikuu na Ukoma



REJESTA YA WANAHOISIWA KUWA NA TB/DR-TB KATIKA JAMII

TB 13 A

Jina la kikuuli/Asasi/ Mkoa huduma za afya ngazi ya jamii:

N	Tarehe	Jina (majina matau)	Jinsi (Me/Ke)	Umri (Maka)	Mahali alipoitokea mtajalipoh (Kikozo A)	Makazi (Mtaa/kibongoji, namba ya simu, kina chini)	Sababu ya rufaa (kupima makohizi, kundi kwenye Kigoma WAZI, Mwaneyo)	Jina la kituo cha liba alichopewa rufaa	Hana TB kwenye makohizi	Matokeo ya rufaa (waka v. panapohusika)	Anepima VUU (waka v. kama jibu anenazo na DR-TB kwa chini)	Amanza tiba ya TB (waka v. kama jibu anenazo na DR-TB kwa chini)	Matokeo ya matibabu kutigana na DR-TB (che liba TB3/ che liba TB3/ DR-TB/4)	Maoni/ Maelezo mengine
1														
2														
3														
4														
5														
6														
7														
8														
9														
10														
11														
12														
13														
14														
15														

Kielelezo A:

1. Familia yenye mgonjwa wa TB/DR-TB (andika namba ya wilaya ya mgonjwa wa TB/DR-TB)
2. Familia yenye mgonjwa wa TB/DR-TB
3. Mhusiano wa watu/sababu nyngine (weka namba, Jaji kama iliyopandikwa kwenye formu ya TB 14)
4. Mgonjwa wa jaji

d) Rejista ya wagonjwa wa TB/ DR TB waliokatisha/ wasioanza matibabu

Wizara ya Afya, Maendeleo ya Jamii, Jinsia, Wazee na Watoto
Mpango wa Taifa wa Kudhibiti Kifua kikuu na Ukoma



REJESTA YA WAGONJWA WA TB/DR-TB WALIOKATISHA/WASIOANZA MATIBABU

Jina la kikundi/Asasi/ Mtoa huduma za afya ngazi ya jami: _____

TB 13 B

Na.	Tarehe ya ufuatiliaji	Jina (majina matatu), chini andiko ya namba TB/DR TB ya vilivyo ya mgonjwa kama alianza matibabu	Jinsi (Mw/Ke)	Umri (Miaka)	Sifa ya mgonjwa anayefuatilwa (Weka alama ya kema pamojohusiku)		Mahaali alipotokea mijaalipohojwa	Matokeo ya utatiliaji (weka alama ya kema pamojohusiku)			Amenuti kwenye matibabu (idho au hapana)	Kama hapana, toa sababu	Magoni/ Maleso mengine
					Ameanza matibabu ya TB/DR TB	Higianza matibabu ya TB/DR TB		Mida/ Miji	Baizo/ Mafasihi wa mtaakaji ndugu mtu wa karibu	Amepatikana			
					Ameanza matibabu ya TB/DR TB	Higianza matibabu ya TB/DR TB	Mida/ Miji	Baizo/ Mafasihi wa mtaakaji ndugu mtu wa karibu	Amepatikana	Hagipatikana	Amafenki		
1					Chini ya mwezi 2	Mkazi 2 au zaidi							
2													
3													
4													
5													
6													
7													
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15													

e) **Monthly/ Quarterly community summary report form**

Wizara ya Afya, Maendeleo ya Jamii, Jinsia, Wazee na Watoto
Mpango wa Taifa wa kudhibiti Kifua kikuu na Ukoma



TB 14

FOMU YA TAARIFA YA MWEZI/ROBO MWAKA YA HUDUMA ZA TB, TB/HIV NA DR-TB NGAZI YA JAMII/KITUO/WILAYA

Jina la kikundi/Asasi/CHW: _____

Jina la Kijiji.....Kata.....Wilaya.....

Taarifa ya Mwezi wa/ Robo ya _____mwaka 20_____

Tarehe ya uwasilishwaji wa ripoti: ____/____/20_____

Umri (miaka)	Idadi ya watu waliochunguzwa TB (jumla ya walioko katika fomu namba TB 12)		Idadi ya wahisiwa na waliopewa rufaa		Idadi ya wagonjwa wa TB/DR TB walioanza matibabu		Idadi ya wanaojua hali yao ya maambukizi ya VVU	
	KE	ME	KE	ME	KE	ME	KE	ME
0 - 14								
15 na zaidi								
JUMLA								

Walioacha matibabu ya TB				
Umri (miaka)	Idadi ya wagonjwa walioacha/wasioa nza matibabu matibabu na kufuatiliwa		Matokeo ya ufuatiliaji (<i>Angali kielelezo A</i>)	
	KE	ME	KE	ME
0 - 14			A=	A=
			H=	H=
			K=	K=
15 na zaidi			A=	A=
			H=	H=
			K=	K=
JUMLA			A=	A=
			H=	H=
			K=	K=

Kielelezo A	
A	Ameanza/karudi
H	Hajapatikana
K	Amekufa

Wanaoishi na mgonjwa wa TB ya mapafu				
Umri (miaka)	Idadi ya wagonjwa wenye TB/DR-TB ambao ndugu/ wanaoishi nae wamefuatiliwa		Idadi ya wagonjwa waliogunduliwa kutoka familia zenye wagonjwa TB/DR-TB wakati wa ufuatiliaji	
	KE	ME	KE	ME
0 - 14				
15 na zaidi				
JUMLA				

Jina la mtoa taarifa.....

Namba ya Simu.....

Annex 9: Community TB, TB/HIV and DR TB) supervision tool

Wizara ya Afya, Maendeleo ya Jamii, Jinsia, Wazee na Watoto



Mpango wa Taifa wa Kudhibiti Kifua kikuu na Ukoma

Fomu ya usimamizi elekezi wa huduma za kifua kikuu, kifua kikuu na UKIMWI na kifua kikuu sugu ngazi ya jamii

Jina la Mgonjwa: _____

Jinsi ya Mgonjwa _____ Umri _____

Namba ya matibabu ya mgonjwa wa kifua kikuu _____

Kituo cha Tiba: _____

Hali ya ndoa: _____

Jina la msimamizi wa matibabu: _____

Tarehe ya usimamizi shirikishi:/...../.....

Maelekezo:

Tafadhali jaza fomu hii kwa kumuhoji mgonjwa, familia na msimamizi wa matibabu nyumbani kwa mgonjwa.

- Tumia dodoso hili kila unapotembelea familia ya mgonjwa wakati wa usimamizi shirikishi.
- Elezea umuhimu wa dodoso kwa familia na mgonjwa na mhakikishie kuwa habari zote anazotoa zitakuwa za usiri mkubwa sana
- Elezea kuwa mahojiano yatachukua si zaidi ya dakika thelethini.
- Omba ridhaa ya familia na mgonjwa kuendelea na mahojiano.
- Baada ya kumaliza kujaza dodoso, jadiana matokeo ya usimamizi shirikishi na mkubwa wako wa kazi.

Mambo yanayohusu mgonjwa			
	Majibu tarajiwa	Ndiyo/ Hapana/ Sijui	Hatua ya kuchukuliwa
1. Muulize mgonjwa kama anaona dalili za kiafya zisizo za kawaida tangu aanze matibabu			Kama sivyo muhakikishie mgonjwa usalama wa dawa.
Usiulize zaidi. Angalia kwenye sanduku kama mgonjwa anatataja dalili za ugonjwa unaohusika	Ukurutu, kuwashwa kwa mwili.		
	Kichefuchefu/ kutapika		
	Maumivu ya tumbo		
	Maumivu ya viuongo		
	Kupoteza hamu ya kula		
	Kuona hafifu		
	Kuwa na ganzi mikononi /miguuni		
2. Kuna mwanafamilia mwingine anayekohoa? Dodosa kwa muda gani?			Kama ni kikohozi cha zaidi ya wiki 2, mshauri aende kituo cha tiba kwa uchunguzi.
3. Dodosa mgonjwa kujua kama anatumia njia salama ya kukohoa?			Kama sivyo, onyesha njia salama ya kukohoa.
Kama ndio, anatumia njia gani?	Anafunika mdomo kwa kitambaa, kiganja, kiwiko, masiki n.k		

Mambo yanayohusu mgonjwa			
	Majibu tarajiwa	Ndiyo/ Hapana/ Sijui	Hatua ya kuchukuliwa
4. Dodosa mgonjwa kama anajua njia salama za kutupa (dispose) makohozi? Mf. kukohoa kwenye kopo?			Kama hajui, mueleze njia salama.
5. Dodosa mgonjwa kama anajua jinsi ya kuwakinga wanafamilia wasiambukizwe ugonjwa?	Kujumuika na wanafamilia eneo lenye mzunguko mzuri wa hewa (nje) Kuepuka msongamano		Kama hajui, muelezee njia sahihi za kuwakinga wanafamilia.
6. Dodosa mgonjwa kama amepimwa VVU?			Kama hajapimwa, mpe refaa kwenda kwenye ushauri nasaha. Kama amepimwa zaidi ya miezi 6 iliyopita na hana maabukizi, mshauri akapimwe tena.
7. Dodosa mgonjwa kuhusu uhusiano kati ya familia na yeye hasa suala la unyanyapaa			Eleza:
8. Dodosa mgonjwa kuhusu maoni ya msimamizi wake wa matibabu			Eleza:
9. Uliza kama mgonjwa ana swali lolote			Jibu kulingana na swali.

Mambo yanayohusu mgonjwa			
	Majibu tarajiwa	Ndiyo/ Hapana/ Sijui	Hatua ya kuchukuliwa
10. Je, mgonjwa ameieleza familia ugonjwa alionao?			Kama hapana, jadiliana nae umuhimu wa kueleza na madhara ya kutoeleza familia.

Mambo yanayohusu FAMILIA ya mgonjwa			
	Majibu tarajiwa	Ndiyo/ Hapana/ Sijui	Hatua ya kuchukuliwa
11. Dodosa, wanafamilia wangapi wanaishi nyumba moja na mgonjwa?	Watoto wangapi wenye umri chini ya miaka 5? ____		
	Wazee (>miaka 60) _____		
	WAVIU _____		
12. Dodosa muda muafaka wa mgonjwa kumeza dawa?			Kama hamezi muda muafaka, toa maelezo na elimu
13. Kama mgonjwa alishawafahamisha familia ugonjwa alio nao: Dodosa wanafamilia kuhusu ufahamu wa ugonjwa anaoumwa ndugu yao? (jina la ugonjwa, jinsi unavyoenea, matumizi ya dawa, muda wa matibabu, jinsi ya kujikinga, chakula, usafi, maisha kwa ujumla).			Elimisha familia kulingana na majibu yao.

Mambo yanayohusu FAMILIA ya mgonjwa

	Majibu tarajiwa	Ndiyo/ Hapana/ Sijui	Hatua ya kuchukuliwa
14. Dodosa kama kuna mwanafamilia mwingine mwenye dalili za kifua kikuu? Dodosa kwa muda gani?			Kama kuna mwenye dalili mshauri aende kituo cha tiba kwa uchunguzi.
15. Wanafamilia wangapi wamechunguzwa kifua kikuu?			Taja idadi dhidi ya jumla ya wanafamilia.
16. Dodosa familia kuhusu ufahamu wa jinsi ya kuwakinga wanafamilia wasiambukizwe ugonjwa?	Kama ndio, dodosa njia (Anafunika mdomo kwa kitambaa, kiganja, kiwiko, masiki. Kujumuika na mgonjwa eneo lenye mzunguko mzuri wa hewa (nje)		Kama sivyo, Toa elimu.
17. Dodosa kama familia inajua njia salama za kutupa (dispose) makohozi? Mf. kukohoa kwenye kopo?			Kama hawajui, waeleze njia salama.
18. Chunguza uhusiano kati ya familia na mgonjwa hasa suala la unyanyapaa			Kama mgonjwa ananyanyapaliwa to elimu
19. Uliza kama wanafamilia wana swali lolote			Jibu kulingana na swali.

Mambo yanayohusu msimamizi wa matibabu

	Majibu tarajiwa	Ndiyo/ Hapana/ Sijui	Hatua ya kuchukuliwa
20. Mgonjwa anameza dawa inavyotakiwa?	Kama ndio dodosa umezaji, utunzaji wa dawa n.k		Kama hapana, toa maelezo:
21. Dodosa yafuatayo kuhusu uelewa na utendaji wa msimamizi wa matibabu	Aina ya matibabu ya mgonjwa na dozi yake		Kama kuna mapungufu, elimisha
	Madhara yanayoweza kuambatana na dawa		
	Jinsi ya kugundua madhara ya dawa na hatua za kuchukua		
	Ujazaji wa kadi ya matibabu		
	Utunzaji wa dawa		
	Uchunguzi wa kifua kikuu kwa wanafamilia ndani ya wiki mbili baada ya kugundulika mgonjwa.		
	Upimaji wa makohozi kwa wakati		
22. Uliza kama msimamizi wa matibabu ana swali au maoni			Jibu kulingana na swali.

**Mambo yanayohusu Mtoa huduma za kifua kikuu ngazi ya jamii/
mwanakikundi katika jamii.**

	Majibu tarajiwa	Ndiyo/ Hapana/ Sijui	Hatua ya kuchukuliwa
Taarifa za vikundi			
23. Idadi ya wana kikundi. wangapi wako hai?			
24. Idadi ya vikundi vya kijamii vinavyojihusisha na udhibiti wa kifua kikuu			
Uelewa wa vikundi/ mhudumu wa afya jamii			
25. Pima uelewa wa wanakikundi kwa kuwauliza maswali juu ya TB, TB/HIV na DR TB ikiwa ni pamoja uzuiaji wa maambukizi ya kifua kikuu katika jamii.			
Usimamizi shirikishi			
26. Toa na kujadili mrejesho wa usimamizi shirikishi uliopita			
27. Uwepo /upatikanaji wa vitendea kazi(orodhesha)			
28. Majukumu yaliyotekelezwa katika kipindi cha robo mwaka uliopita			
29. Uwezesaji uliotolewa kwa kikundi/mhudumu (vifaa, mafunzo, pesa, kutia moyo n.k)			

**Mambo yanayohusu Mtoa huduma za kifua kikuu ngazi ya jamii/
mwanakikundi katika jamii.**

	Majibu tarajiwa	Ndiyo/ Hapana/ Sijui	Hatua ya kuchukuliwa
30. Dodosa yafuatayo kuhusu uelewa na utendaji wa msimamizi wa matibabu	Aina ya matibabu ya mgonjwa na dozi yake		Kama kuna mapungufu, elimisha
	M a d h a r a yanayoweza kuambatana na dawa		
	Jinsi ya kugundua madhara ya dawa na hatua za kuchukua		
	Ujazaji wa kadi ya matibabu		
	Utunzaji wa dawa		
	Uchunguzi wa kifua kikuu kwa wanafamilia ndani ya wiki mbili baada ya kugundulika mgonjwa.		
	Upimaji wa makohozi kwa wakati		

**Mambo yanayohusu Mtoa huduma za kifua kikuu ngazi ya jamii/
mwanakikundi katika jamii.**

	Majibu tarajiwa	Ndiyo/ Hapana/ Sijui	Hatua ya kuchukuliwa
31. Idadi ya watu waliohisiwa kuwa na TB kupitia jamii husika			Jadili changamoto za utunzaji wa kumbukumbu na maazimio/mkakati wa kukabiliiana na changamoto.
(a) Idadi ya wagonjwa waliogundulika kuwa na TB			
(b) Idadi ya wagonjwa waliopo kwenye matibabu			
32. Idadi ya waliofuatiliwa na kurudishwa/ kuanzishiwa matiababu			
33. Angalia utunzaji wa kumbukumbu zote na ukamilifu wake			
34. Jadili changamoto katika utendaji wa kazi			
35. Uliza kama msimamizi wa matibabu ana swali au maoni			Jibu kulingana na swali.
TOA MREJESHO NA SHUKRANI KWA WAHUSIKA KWA USHIRIKIANO (KILA UMALIZAPO KUNDI)			

TAARIFA YA USIMAMIZI SHIRIKISHI WA HUDUMA ZA KIFUA KIKUU NGAZI YA JAMII

Toa taarifa ya usimamizi shirikishi wa huduma za kifua kikuu , kifua kikuu na UKIMWI na kifua kikuu sugu katika kituo cha huduma na wadau wanaohusika kwa kufuata vipengele vifuatavyo:

Matokeo ya usimamizi shirikishi (mazuri, mapungufu, changamoto)

Hatua zilizochukuliwa:

Maoni:

Jina la msimamizi shirikishi _____ Cheo _____
Sahihi _____ Tarehe _____ / _____ / _____

