## Guidance on how to measure contributions of public-private mix to TB control

Project report to the Tuberculosis Control Assistance Programme (TB CAP)

Project number: APA4, C3-01

The World Health Organization

Management Sciences for Health

The Union

## BACKGROUND

Most countries now have a wide array of providers that contribute to TB control through various Public-Private Mix (PPM) approaches. Their activities include, for example, referral of patients with TB symptoms, collection of sputum smear samples, smear microscopy, culture and DST, treatment, absentee retrieval, drug management, record maintenance etc. Some countries are also engaging providers not traditionally part of national TB programmes (NTP) in programmatic management of multi-drug resistant TB (MDR-TB), TB/HIV collaborative activities, ACSM, etc<sup>1</sup>.

There is a wealth of experience from numerous evaluations of small to medium size PPM initiatives showing positive impact on case detection and treatment success rates. However, continuous routine monitoring of contribution by PPM to TB control on a national scale is still rare. In most countries, the usual reporting by NTPs of case notifications and treatment outcomes alone does not include important contributions of various providers to TB control efforts.

It is essential to continuously measure specific contributions of different provider categories in order to:

- monitor progress of PPM in relation to national TB control plans and targets;
- justify continued financial support for PPM activities, and;
- target the resources effectively.

A new recording and reporting system for TB control was developed by The Union, KNCV, CCDC and WHO in 2006-2007, which includes advice on how to monitor PPM on national and sub-national level<sup>2</sup>. It includes revised registers and forms, designed to capture PPM data (see annex 1). However, it does not include practical guidance on how to ensure effective data collection and management. Some practical advice on data collection for PPM monitoring and evaluation have been provided by WHO<sup>3</sup>, but since that publication there have been much experiences on how to monitor and evaluate PPM.

A project was therefore conducted by WHO, The Union and MSH in 2008-2009 to develop practical guidance to countries on how to measure PPM contribution to TB control. The project included:

- 1. A desk review of methodologies used for measuring PPM contribution to TB control in project evaluations and published operational research projects;
- 2. Country visits for assessment of feasibility, quality and relevance of existing models for PPM monitoring on national scale, in three selected countries with scaled up PPM initiatives (India, Philippines and Mexico), and one WHO region (Eastern Mediterranean Region);
- 3. A consultation meeting in Mexico, December 2009, including the partner organizations and representatives of NTPs, to consolidate information and draft recommendations;

<sup>&</sup>lt;sup>1</sup> Engaging all health care providers in TB control - guidance on implementing public-private mix approaches. WHO/HTM/TB/2006.360. Geneva: World Health Organization, 2006.

<sup>&</sup>lt;sup>2</sup> Revised TB recording and reporting forms and registers – version 2006. WHO/HTM/TB/2006.373. Geneva: World Health Organization, 2006

<sup>&</sup>lt;sup>3</sup> Practical tools for involvement of private providers in TB control - A guide for NTP-managers. WHO/CDS/TB/2003.325. Geneva: World Health Organization, 2003

## INDICATORS TO MEASURE PPM CONTRIBUTION

## Key indicators for PPM surveillance

The following two indicators are recommended for routine PPM surveillance on national, regional and global level, and should be reported at least annually. It is expected that information on these two indicators will be available from all countries in WHO's annual report on global TB control.

## Proportion of listed providers actively engaged by NTP

## Definition:

<u>Numerator</u>: Number of providers, by category (e.g. public and private clinics, hospitals, institutions, health insurance health facilities, workplace health facilities, informal providers, etc.) who are participating in DOTS implementation (referral / diagnosis / treatment / reporting of TB cases)

Denominator: All listed providers in respective category.

*Data source:* Yearly inventory of listed providers with identification of how many are actively collaborating with NTP

**Reporting frequency:** Yearly

## Note:

- Depending on availability of data on listed providers (which may, for example, be restricted to only formal health care providers unless a mapping of providers have been done through a PPM national assessment), the indicator may be reported for selected provider categories only.
- This indicator may be further disaggregated by type of involvement and type of provider.

# Proportion of new bacteriologically confirmed cases detected by referral/diagnosis by different types of providers *Definition:*

<u>Numerator:</u> Number of bacteriologically confirmed cases registered from among those referred (for diagnosis or after diagnosis), by provider category <u>Denominator:</u> All bacteriologically confirmed cases detected *Sources:* 

- Standard laboratory register with information about referring provider, or
- Treatment register, if referral source is noted

## **Reporting frequency:** Yearly or quarterly

## Note:

- Bacteriologically confirmed cases is the minimum reporting requirement. In many settings, depending on scope of PPM and types of provider engaged, it may also be relevant to report on proportion of all cases, proportion of MDR-TB cases, proportion of patients infected with HIV, etc.
- This indicator may be disaggregated by type of providers, and by referral/diagnosis

## Additional indicators for PPM evaluation on national and sub-national level

Depending on PPM strategy, stage of PPM scale up, specific data needs and availability of data, additional indicators may be added (table 2)

Indicator	Definition	Data source	Note					
Proportion of Basic Management Units (BMU) that have implemented public- private mix	Number of BMU (e.g. districts, township, etc) that have implemented PPM / total number of BMUs	Yearly report from BMUs on whether PPM is implemented or not	This indicator may also be expressed as proportion of population "covered" by PPM					
Among all patients with symptoms of TB reporting to NTP, the proportion referred by different types of providers	Number of patients with symptoms of TB referred by a specific type of provider / all patients with symptoms of TB reporting to NTP	Standard laboratory register with information on referring provider	This indicator is easiest for pulmonary TB cases referred for sputum smear microscopy, but may be extended to other categories, including MDR-TB.					
Proportion of TB patients receiving treatment from different types of providers	Number of new cases who received treatment from a specific type of provider / all cases registered for treatment in NTP	Standard TB register with information on treating provider	This indicator may be disaggregated by provider type, as well as by type of TB					
Treatment outcomes among TB cases treated by different types of providers	Standard treatment outcome indicators (treatment success, cure, completion, default, failure, transfer out, and death), disaggregated by treating provider type	Standard TB register with information on treating provider	This indicator may be disaggregated by type of TB					

Table 2. Additional indicators for monitoring PPM

At the startup of PPM, and when PPM is extended to new provider categories, it necessary to monitor quality of care, most importantly treatment outcome. This should be done for each different provider category. This requires disaggregated cohort analysis, which may be resource demanding unless electronic case based registers are used. If and when treatment outcomes are up to standard, disaggregated cohort analysis by provider type can be discontinued, while overall treatment outcomes will be used as indictor of any quality problem in specific provider categories.

When new providers are engaged in TB diagnosis, e.g. doing smear-microscopy, Xray, culture, DST, or any other test, the quality of diagnosis should be monitored through External Quality Assurance and other approaches, just for any other diagnostic center in NTP. Similarly, new providers engaged in TB/HIV collaborative activities and programmatic management of MDR need to monitored with regards to standard quality indicators.

## TOOLS

The most essential tools are:

- 1. The PPM National Situation Assessment Tool
- 2. Standard laboratory register with information about referring provider
- 3. Standard TB treatment register with information about treating provider

The PPM National Situation Assessment Tool provides guidance on how to establish the number of listed providers and the number among them who are actively engaged through PPM.

The new recommended recording and reporting system for NTPs includes instructions on how to obtain and enter information about referring provider and treating provider in treatment cards and in the laboratory and treatment registers, and how to report information in the yearly report on programme management (see annex).

It is paramount that all facilities introduce the routine to record source of referral and place of treatment in order to obtain the basic information for reporting on PPM contribution.

All basic management units should report on PPM indicators at least annually. In the few countries that have introduced electronic registers, it will be easy to extend to quarterly reports on PPM indicators.

In order to ensure adequate PPM reporting, it is advisable for all countries to move towards electronically case based registers, which will also greatly improve general NTP performance monitoring and TB surveillance.

## **ROLE DIVISION**

NTP is ultimately responsible for collecting and reporting on these indicators. However, public and private partner organizations may also contribute depending on the type of engagement.

In many countries, PPM approaches are being implemented by an intermediary organization, such as an NGO, a professional association, or a franchising organization. When such an organization is implementing TB control in a designated geographical area, or basic management unit (BMU), they will naturally take the responsibility for monitoring implementation, including all aspects of PPM. If an intermediary organization is responsible for selected activities in a given geographical area, such as the engagement of individual private practitioners, they may take on the specific duties concerning the monitoring of PPM contribution. For example, the intermediary organization may conduct situation analysis with listing of all available providers, and monitoring how many of them are actively engaged. They may also help NTP putting in place the appropriate recording and reporting routines, e.g.

concerning the recording of source of referral and place of treatment in regular NTP registers.

Training and supervision of PPM recording and reporting routines is important for NTP staff responsible for data entry and reporting, as well as for concerned staff in non-NTP facilities. Training on PPM monitoring should be part of the regular NTP training. The revised generic training modules for health facility and district level staff includes instructions on how to collect and record relevant PPM information (ref to modules).

## **IMPLEMENTATION STEPS**

The following steps are required to ensure collection, recording and reporting of essential PPM data:

- 1. Decide on PPM indicators to be used in the country
- 2. Develop / revise tools for data collection, recording and reporting.
- 3. Select reporting approach and introduce yearly or quarterly reporting form for PPM indicators as appropriate.
- 4. Determine role division, nationally and locally, for all relevant activities to ensure PPM monitoring
- 5. Update NTP operational guidelines and training material as required.
- 6. Train staff on how to fill forms, report on indicators, and supervision of recording and reporting practices
- 7. In all BMUs, as per the recommended recording and reporting system:
  - a. List all providers, by category, in the BMU
  - b. Identify which providers are engaged by NTP
  - c. Introduce standard referral forms for engaged providers
  - d. Introduce routine collection and recording of information on referring and treating provider in treatment card, laboratory register and treatment register
  - e. Introduce reporting practice, as per national policy
  - f. Evaluate / supervise recording and reporting practices

## **COUNTRY EXPERIENCES**

## Philippines

#### NTP Recording and reporting policies

The National TB Programme (NTP) in Philippines has developed a comprehensive policy for recording and reporting practices, which include the following PPM specific routines<sup>4</sup>:

- 1. Recording and reporting for NTP shall be implemented at all DOTS facilities in the country, including Public-Private Mix DOTS units (PPMD units)<sup>5</sup>, and government and private hospitals.
- 2. Quarterly reports should reflect the additionality of cases reported from various units in the province/city/municipality (e.g. PPM units, private physicians, hospitals, NGOs).

Basic indicators of PPM scale up are:

- Number of PPMD units established (disaggregated by units placed in public and private institutions respectively)
- Population living in areas with PPMD units

PPM indicators that should be monitored on facility level, and aggregated quarterly on province, region and national level, are:

- Number of trained referring physicians
- Number of physicians referring TB suspects (in the quarter)
- Number of physicians referring TB patients for treatment (in the quarter)
- Number of new ss+ cases detected by a private PPMD Unit and/or through referral from a private physician to a DOTS unit
- Proportion of all new ss+ that were detected by a private PPMD Unit and/or through referral from a private physician to a DOTS Unit.

#### Tools

Data for above indicators are collected through the following tools:

#### TB register and lab register

Both registers include information about source of referral. The TB register (see Annex 1) includes both a column for entry of categorical data on source of referral (public vs. private), as well as a column for the name of the referring physician. The categorical data entry is used for the reporting of contribution to case detection. The information about name of referring physician is used both for local management purpose as well as for enumerating number of referring physicians in a quarter.

## Referral forms

- 1. A simple form, which can be filled very quickly and includes information about:
  - Which DOTS unit the referral is intended for
  - Name of patient
  - Name of referring physician
  - Requested service (sputum smear microscopy, treatment, or other)
- 2. A detailed referral form, which provides information about patient history, clinical details, specific requests for investigation, a check-list for the receiving unit on actions to be taken, and a section for providing feed-back to the referring physician.
- 3. The standard transfer form which captures information about the referring unit, including PPM DOTS unit, but not the original source of referral. This means that in case of a private physician referring to a public DOTS unit (including publicly initiated PPMD unit) will not be credited for the original referral in case the patient is transferred for treatment in another unit after diagnosis.

<sup>&</sup>lt;sup>4</sup> Tuberculosis Manual of Procedures. Manila: Department of Health, 2005

<sup>&</sup>lt;sup>5</sup> A PPM DOTS Unit in the Philippines means a DOTS unit in a public or private institution which has implemented a PPM approach, including training private physicians to refer TB suspects.

The receiving unit should feed back information to the referring physician. The recommended practice is that the referring physicians is consulted by telephone before a patients is initiated on treatment. At a later stage, patients are advised to return to the referring physician, with the feedback form including all relevant clinical information.

#### DOTS directory

This is a directory that includes name, address, and phone numbers of all DOTS units (including PPM DOTS Units), by region and province. The directory should be used by referring physicians to identify the relevant DOTS unit to refer to.

#### Treatment card

The standard treatment card includes information about name of referring physician as well as place of treatment. This information is transferred into the TB register.

#### Quarterly reports

The case finding report disaggregates all cases with regards to source (public vs. private), since 2007. The treatment outcome report does not disaggregate with regards to source (private vs. public). However, since all PPMD Units submit their own report, the disaggregation is made automatically with regards to place of treatment. (Currently, no treatment is done outside the PPMD units, e.g. by referring individual physicians, so there is no need to disaggregate treatment outcome further).

#### Electronic recording and reporting

The National Epidemiological Center (NEC), which is responsible for disease surveillance and health statistics in the country, have piloted (together with DOH/NTP) an Electronic TB Register (ETR) in one region. The record keeping on facility level has not been changed and paper registers are still used there. However, instead of using paper-based quarterly report forms, the DOTS units faxes copies of the treatment register to the provincial level, where the individual level data is entered into a case-based register. The entered data is checked and validated on provincial level. Inconsistencies, signs of incorrect data entry in the paper register, and indications of incorrect diagnosis or categorisations are fed back directly to the DOTS unit. The electronic register is accessible directly by NEC and DOH. Contribution to case detection by public vs. private providers can be calculated directly from this register.

It was not possible to get a detailed account of the resource requirement for ETR, but it seems to be rather resource demanding. Several provinces had recruited special staff for the data entry (whereas others had re-assigned staff part time). A detailed evaluation of the system is awaited, and integration with other disease monitoring system may be attempted to achieve efficiency gains. From a PPM perspective, this system offers the opportunity to on-demand (quarterly) data on contribution to case detection, down to facility level. Since the whole TB register is sent for data entry, and the electronic register is on individual level, there is no need for separate quarterly or yearly reporting on PPM.

As with the use of paper-based quarterly reports, the system depends on correct data entry on facility level. Presently, only the PPMD Units are consistently entering source of referral into TB registers. Therefore the national level statistic on contribution of private sector is likely to be a gross underestimate. Training of staff in all DOTS will be required to obtain correct data.

#### Data on PPM contribution to MDR management

There is a separate recording and reporting system for MDR management in the Philippines. It includes information about the source of referral, the place of the last treatment, the type of treatment provided there, and the place of MDR treatment under the PMDT approach.

A special referral form is used, which should be used by the referring DOTS unit. The current policy is that only DOTS units (including PPM DOTS Units) can refer to a PMDT center. This means that source of referral of MDR cases corresponds to the status of the DOTS unit (public or private), not the original source of referral. However, data about last type of provider treating (public vs. private) is available.

Box	1.	Summary	of PPM	contribution	in	The	Philippines	
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Summary of the main PPM indicators for 2007	
Total Number of PPMD Units	220
Number of PPMD Units, in private institutions	72
Population coverage	34% (30 million/89 million)
Trained private physicians	33% (5,000/15,000)
Actively referring physicians	8% (1,200/15,000)
% new ss+ cases refrred from private, in PPM areas	18% (5615/~39,000)
% new ss+ cases referred from private, nationally	7% (5,650/85,740)
% new ss+ cases on DOTS treatments in private facilities	3% (2,720/ 85,740)
% Treatment success, new ss+, private	88% (cure rate: 86%)
% MDR cases under PMDT referred from private	47% (147/313)
%MDR cases treated (GLC approved) in private	100% (313/313)

Trend of case detection rate



Figure. Private sector contribution to case detection rate in Philippines (=private sector notification rate / estimated incidence of new ss+) (Source: PhilCAT, 2008)

#### India

India introduced an extensive PPM recording and reporting system in 14 cities where PPM was scaled up and intensified. Sic broad categories of providers were engaged, categorized as follows:

- **H** Health department facility (Govt.)
- G Govt. facilities outside health department
- M Medical college (public and private)
- C Corporate sector
- **P** Private provider
- N NGOs

The following indicators were monitored quarterly for each provider category:

#### **Outcome Indicators :**

- 1. Contribution to referral of chest symptomatics
- 2. Contribution to diagnosis of smear positive cases
- 3. Contribution to new smear positive TB cases registered for treatment
- 4. Contribution to DOT provision
- 5. Sputum conversion rate, by provider category
- 6. Treatment outcome, by provider category

#### **Process Indicators :**

- 7. Proportion of listed providers engaged through PPM
- 8. Proportion of engaged providers supervised

Existing laboratory registers, treatment cards and TB treatment registers were used, while staff were trained to obtain and record information about source of referral and place of treatment.

Special forms were developed for recording number of listed providers, different types of engagement of them, number of supervision visits, etc.

Data were reported quarterly, using paper based reports. Due to the requirement to have disaggregated information on several performance indicators quarterly reports were prepared separately for each provider category. This meant that six copies of each quarterly report was send from each of the 14 cities each month.

The experience in India showed that it is feasible to conduct detailed monitoring of many PPM indicators if sufficient resources are in place. In each of the 14 cities there was a designated PPM consultant and one field supervisor. All programme were trained on how to enter correct information, while the distrcut supervisors were trained on data extraction and reporting of PPM indicators. However, the system was judged to be too cumbersome for regular and countrywide reporting. India is now introducing regular report on only proportion of providers engaged, and contribution to case detection of new smear positive cases.



14 Intensified PPM DOTS Sites: Contribution by Different Health Sectors to New Smear Positive Case Detection; 4q04-4q05





## Mexico

To be added

#### Eastern Mediterranean Region

WHO Regional Office for the Eastern Mediterranean Region (EMRO) has developed an online reporting system for NTPs, the DOTS Quarterly Online system ("DQonline"), which includes key PPM indicators. The webpage is displayed below.



EMRO Stop TB website with the link to the DQonline system on the right side.

Most of the countries in the region have introduced the revised recording and reporting system and have established routines to record and report source of referral and place of treatment for all TB patients. Trough DQonline, EMRO is able to monitor PPM performance across the region quarterly and yearly. Yeraly data for key indicators are shown in the figures below. As can be seen, several countries have a large contribution by non-NTP providers in case detection. However, some countries like Pakistan and Afghanistan, with very large private sectors, have so far very modest contribution by non-NTP providers to case detection.



Proportion of all TB cases tat were referred or diagnosed by non-TB providers, and the proportion of all TB cases that were treated by non-NTP providers. (Note: In Lebanon, Syria, Jordan, and Yemen, all TB treatment takes place in public NTP facilities. Private providers are the most common first contact for people with TB symptoms in these countries. They have become successfully engaged to refer suspects and cases to NTP. In the other countries, non-NTP providers are also engaged in treatment)



Status in 2008 with regards to four regional PPM indicators used in EMRO.

## ANNEX 1: Forms from the revised recording and reporting system (WHO 2006).

Note: Circled elements are those that have been changed or where new instructions on how to fill the forms have been developed.

Tuberculosis Programme		Form 1
Request for Sputum Smear Microsco The completed form with results should be sent promptly by	opy Examination	on e referring facility
Referring facility <sup>1</sup>	Date	
Name of patient	Age	Sex: □ M □ F
Complete address		
Reason for sputum smear microscopy examination:		
OR Group Number of month of treatment: BM	U TB Register No.	2
Name and signature of person requesting examination		
1. Including all public and private health facility/providers 2. Be sure to enter the patient's BMU TB Register No. for follow-up of pat	tients on chemothera	ару

## RESULTS (to be completed in the laboratory)

Laboratory Serial No. \_

Date	Sputum	Visual appearance <sup>4</sup>			RESULTS									
collected <sup>3</sup>	Specimen		NEG	(1-9)	(+)	(++)	(+++)							
	1													
	2													
	3													

3. To be completed by the person collecting the sputum 4. Blood-stained, muco-purulent, saliva

Examined by

Date \_

Signature \_

Tuberculosis Programme

Form 2

#### TB Laboratory Register

Lab. serial No.	Date specimen received	Name (in full)	Sex M/F	Age	Complete address (patients for diagnosis)	Name of referring facility <sup>1</sup>	Reason fo smear m exami Diagnosis (tick)	or sputum icroscopy nation Follow-up (month)	R spu mi exal	esults tum sn crosco minatio 2	of hear py mis 2 3	BMU and TB Register No. (after registration)	Remarks
			-				)						
			-										
			-			-							
			-			-							
						-							

Footnotes appearing on first page of the register only

- Facility that referred (sent) the patient (or specimen or slides) for sputum smear microscopy examination. Use standardized type of referring facility according to block 2 of the Yearly Report on Programme Management in BMU. Referring facility is defined as any health care providers formally engaged in any of the following TB control functions (DOTS): referring-TB suspects/cases, laboratory diagnosis, TB treatment and patient support during treatment.
  Indicate the result for each specimen: (NEG): 0 AFB/100 fields; (1-9) exact number if 1 to 9 AFB/100 fields; (+): 10-99 AFB/100 fields; (++): 1-10 AFB/ field; (+++): > 10 AFB/ field
  On AFB/100 fields; (-): 0 AFB/100 f
- 2 Indicate the result for each specimen: (NEG): 0 AFB/100 fields; (1-9) exact number if 1 to 9 AFB/100 fields; (+): 10-99 AFB/100 fields; (++): 1-10 AFB/ field; (++): > 10 AFB/ field 3 Only for newly diagnosed sputum smear microscopy positive TB cases. Determine and write the name of the BMU and the TB Register No. of the patient. The aim is to crosscheck regularly whether all sputum smear microscopy positive patients are entered into a BMU TB Register and are receiving treatment.

Tuberculosis Programme

	Т	ubercu	losi	s Tre	eatn	nent	Ca	rd					BM	Ј ТВ	Reg	giste	r No				
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Sex: IM IF Date of registration	n:							_		Puln	nona	ry	□ E	ktrap	ulmo	onar	y, sp	ecify			
Age: Health facility:									Ту	pe o	of pa	atier	nt (ch	neck	one)						
Address:								New   Treatment after default     Relapse   Treatment after failure     Transfer in   Other, specify													
Name / address of community treatment supporter (if applicable)								_		Sp	utu	m sı	mea	r mi	cros	sco	рy		V	/eigh	t
I. INITIAL PHASE - prescribed regimen and d	losages	Refe	rral	by :		_			M	onth		Dat	е	Lal	b No	). F	Resu	lt		(kg)	
			lf-refe	erral						0											
CAT (I, II , III):		🗘 Co	mmu	inity r	mem	ber										+					
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Number of tablets per dose and dosage of S:			vate	tacilit	ty/pro	ovide	er /									+					
(RHZL) 3				speci		_		_					-		<b>FD</b> #						
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					~			~	H	/ too	t				Dai	e			Re	SCHL	_
Cotrimoxazele ARV					Othe	ſ	_	¥	CF	T st	art										$\rightarrow$
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Tick appropriate box after the drugs have	been a	dminis	tere	d																	
Daily supply: enter ✓. Periodic supply: enter X on day whe	en drugs ar	e collecte	ed and	l draw	a ho	rizont	al line	e ( —		•	throug	gh the	num	ber of	days	supp	lied.	Ø = d	rugs r	ot take	en
Day 1 2 3 4 5 6 7 8 Month	9 10	11 12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31

#### Tuberculosis Programme

#### Basic Management Unit TB Register – Left side of the register book

											тур	e of	pati	ient	3
Date of registration	BMU TB No.	Name	Sex M/F	Age	Address	Health facility <sup>1</sup>	Date treatment started	Treatment category	Site P / EP	N	R	F	D	т	0

Footnotes appearing on first page of the register only

1 Facility where patient's treatment card is kept. In case several copies are kept, the most peripheral facility should be entered. Use standardized type of health facilities according to block 2 of the Yearly Report on Programme Management in BMU. Health facility is defined as any health institution with health care providers formally engaged in any of the following TB control functions (DOTS): referring TB suspects/cases, laboratory diagnosis, TB treatment and patient support during treatment.

#### 2 Enter the treatment category:

- CAT I: New case of sputum smear microscopy positive, severe sputum smear microscopy negative PTB & EPTB e.g. 2(RHZE)/4(RH)
- CAT II: Re-treatment e.g. 2(RHZE)S/1(RHZE)/5(RHE)
- CAT III: New sputum smear microscopy negative PTB and EPTB e.g. 2(RHZE)/4(RH)

#### 3 Tick only one column:

- N=New A patient who has never had treatment for TB or who has taken antituberculosis drugs for less than 1 month.
- R=Relapse A patient previously treated for TB, declared cured or treatment completed, and who is diagnosed with bacteriological (+) TB (sputum smear microscopy or culture).
- F=Treatment after failure A patient who is started on a re-treatment regimen after having failed previous treatment.

- D=Treatment after default A patient who returns to treatment, positive bacteriologically, following interruption of treatment for 2 or more consecutive months.
- T=Transfer in A patient who has been transferred from another TB Register to continue treatment. This group is excluded from the Quarterly Reports on TB Case Registration and on Treatment Outcome.
- O=Other previously treated– All cases that do not fit the above definitions. This group includes <u>sputum smear microscopy positive cases</u> with unknown history or unknown outcome of previous treatment, previously treated sputum smear microscopy negative, previously treated EP, and chronic case (i.e. a patient who is sputum smear microscopy positive at the end of re-treatment regimen).

Form 5

Tuberculosis Programme

Private facility/provider

Others <sup>5</sup>

#### Facility: Date of completion of this form: Name of BMU: Year: Signature: Block 1: Health care facilities/providers involved in TB control Total Facilities providing any Facilities providing HIV services Facilities with laboratory facilities number TB control services of Target Cumulative Target cumulative Cumulative No. Out of (e), No. Out of (e), No. Out of (e) Out of (c), No. Out of (c) facilities No. providing No. to involve in involved in providing HIV testing cumulative number involved in providing No. providing in the number to actually sputum smear sputum smear Lab. Quality culture services DST & counsel. to all TB ART to TB Facility/provider BMU<sup>2</sup> involve<sup>3</sup> involved microscopy Assurance (g) services patients patients miicroscopy type (a) (c) (d) (e) (f) (h) (i) (j) (b) Public facility

Yearly Report on Programme Management in Basic Management Unit

#### Block 2: Contribution by health care facilities/ providers in TB control

/		No. of new sputum s positive cases diagno	mear microscopy osed in a year	No. of new sputum smear microscopy positive cases started on treatment in year
1	TOTAL 6, 7			
	Facility /provider type <sup>1</sup>	Referred by <sup>8</sup>	Diagnosed by <sup>9</sup>	Treated by <sup>10</sup>
	Self-referral			
1	Public facility			
]	Private facility /provider			
V	Others			

#### Block 3: Contribution by trained and supervised community in TB control <sup>11</sup>

No. new sputum smear microscopy positive cases referred by the community	No. new sputum smear microscopy positive cases receiving treatment support by the community

Health facility is defined as any health institution with health care providers formally engaged in any of the following TB control functions (DOTS): referring TB suspects/cases, laboratory diagnosis, TB treatment and patient support during treatment. Facility types are indicative, consistent with the referral box of the TB Treatment Card and should be adapted to local context.

2 Known number of existing facilities (provider) in the BMU. The table may be adapted with more rows to incorporate facilities that are relevant for the country.

3 Facilities (providers) formally engaged in any of the following TB control functions (DOTS): referring TB suspects/cases, laboratory diagnosis, TB treatment and patient support during treatment.

4 The comulative number of facilities (providers) that was planned to be involved in the year of the report.

- 5 Other categories may include PHC facility, medical college, private NGO hospital, private NGO clinic, private practitioners, corporate health facilities, prison health service, army health facilities, pharmacies, traditional healers, etc.
- 6 Total number of new smear positive patients diagnosed and recorded in the TB Laboratory Register for the year.

7 Total number of new smear positive patients recorded in the BMU TB Register for the year.

8 New smear positive cases referred for diagnosis by each facility/provider category, as recorded in the column for "name of referring health facility" in the TB Laboratory Register.

9 New smear positive cases diagnosed by each facility/provider category recorded in the TB Laboratory Register of the facility/provider of microscopy service.

10 New sputum smear positive cases treated by respective provider category, as recorded in the column "health facility" in the BMU TB Register-

11 This block is filled based on the individual TB Treatment Card (referral box, name of treatment supporter) or from the TB Register (form D of the additional TB data -part 3). Community is defined as trained and regularly supervised informal practitioners, community worker/volunteer, family members, friends providing services outside a facility (health institution).

Note: This form could be filled only for selected period of time and for selected BMU.