

National Guidelines for Community Engagement in TB Prevention and Care

National TB Programme, Ministry of Health and Child Care, Zimbabwe
Harare 2014



FOREWORD

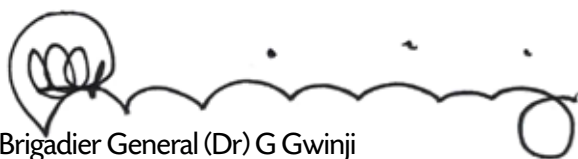
Zimbabwe is one of the 22 countries in the world contributing to 80% of the global burden for tuberculosis (TB). In 2013 a total of 35,566 patients with TB of all types were notified i.e. a notification rate of 269 TB patients per 100,000 of the population. The case detection rate in 2013 was estimated at 46% which indicates the great need for more intensified effort and innovation to find the “missing” TB patients. The epidemiology of TB is firmly driven by HIV and 72% of the TB patients who tested for HIV in 2013 were HIV positive. TB remains among the top five conditions causing adult mortality for the country and is also the commonest cause of death among people living with HIV.

The National Surveillance System for TB shows that National treatment success rates for smear positive TB patients are steadily increasing but remain below the global target of 87%. The death rate among TB patients has declined slowly but remains relatively high at eight percent in 2012. Default rates have been coming down over the years and were at four percent in 2012. The negative treatment outcomes indicate a need to provide comprehensive package of care, follow-up and support if TB is to be effectively controlled.

Diagnostic capacity for Drug Resistant TB (DR-TB) has significantly improved since 2011 more-so with the introduction and rollout of the use of GeneXpert in Zimbabwe. The number of patients with DR-TB has increased significantly from 2008 (1 patient) to 382 in 2013. DR-TB patients are found in all provinces. The Ministry adopted a community based ambulatory care approach to DR-TB prevention, care and management in accordance with current recommendations from the World Health Organisation (WHO).

Globally an estimated one third of people with TB are still either not diagnosed or not reported. Even when people with presumptive TB are identified, TB is often not diagnosed and treatment is initiated late. Innovative actions beyond the routine health system interventions are required to identify all TB cases early and put them on treatment.

The purpose of the document is to provide guidance on how to involve and collaborate with communities in TB control activities, contributing to increased early TB case detection, treatment adherence and access to quality patient centred TB services. The guidelines also aim to facilitate the empowerment of people affected by TB leading ultimately to zero stigma on TB and HIV. These guidelines are meant to be used by the Health Care Workers and Managers at different levels of the Health System, NGOs and CSOs working in the community in health or other programs, and all other public and private formal or informal health care providers.



Brigadier General (Dr) G Gwinji
Secretary for Health and Child Care Zimbabwe

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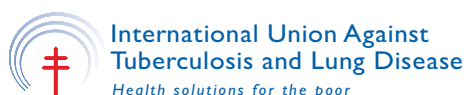
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TB CARE I



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ABBREVIATIONS

ACSM	Advocacy, Communication and Social Mobilisation
ART	Antiretroviral Therapy
CBO	Community Based Organisation
CHW	Community Health Worker
CPT	Cotrimoxazole Preventive Therapy
CSO	Civil Society Organisation
CTBC	Community Based TB Care
DHT	District Health Team
DOT	Direct Observed Therapy
DR	Drug Resistant
EHT	Environmental Health Technician
FBO	Faith Based Organisation
FDC	Fixed Dose Combination
FGD	Focus Group Discussion
HIV	Human Immunodeficiency Virus
IEC	Information Education and Communication
ISTC	International Standards of TB Care
MDR-TB	Multi-drug Resistant TB
M&E	Monitoring and Evaluation
MoHCC	Ministry of Health and Child Care
NGO	Non-Governmental Organisation
NTP	National TB Program
PAR	Participatory Action Research
PHC	Primary Health Care
PPM	Public Private Mix
R&R	Recording and Reporting
SWOT	Strengths Weaknesses Opportunities Threats
VHT	Village Health Team
VHW	Village Health Worker
WHT	Ward Health team
SMS	Text message through mobile phone
TB	Tuberculosis
TB REACH	Grant support funded by Canadian Government to increase TB case detection using innovative approaches in poor and vulnerable populations

1. INTRODUCTION

1.1 TB Situation Globally and in the African Region

In 2012 8.6 million people became ill with Tuberculosis (TB), around the world 1.3 million died from the disease, 320,000 of which were HIV positive peopleⁱ. Among the total number of deaths an estimated 170,000 died from Multi-Drug Resistant TB (MDR-TB). Although most TB cases and deaths occur among men (male/female ratio is calculated to be 2.55), the burden of the disease is high among women, with 410,000 women dying from TB. The estimated number of deaths among HIV negative children is 74,000.

The Africa Region had approximately one quarter of the world's TB cases, and the highest rates of cases and deaths relative to the population (an average of 255/100,000, compared to 122/100,000 globally). In 2011 the global treatment success rate continued to be good at 87% among all new TB cases, compared to 79% in the Africa Region.

The Missed TB Patients

An estimated one third of people with TB (3 million) are still either not diagnosed or unreported. Even when people with presumptive TB are identified, they are often not diagnosed and are treated late. For the patient, this means that the disease causes more damage and can be more difficult to treat. For the community, it means that more people can become infected by the disease because the untreated TB patient continues to spread the disease.

TB/HIV Co-infection

TB is the main cause of illness and death for people living with HIV, accounting for about one quarter of deaths. In 2012, in countries with high levels of HIV, up to 80% of people with TB tested positive for HIV. Of all co-infected TB/HIV patients, 75% live in Africa. Treatment outcomes are worse among HIV positive TB patients and the treatment success globally for all new HIV positive patients was 73% compared to 87% among HIV negative patients.

MDR-TB

MDR-TB continues to have a high death toll among patients. Of the estimated 450,000 MDR-TB patients worldwide, the death rate is around 38%. Access to treatment has improved and in 2011 more than 80% of the 92,000 newly detected MDR-TB patients were started on treatment. However, in the Africa region only 51% of the diagnosed MDR-TB patients were able to get enrolled on treatment. Access to ambulatory care (facility based) differs significantly between countries depending on their national policies and practices, and only few countries have community based MDR-TB care or palliative care through home-based services for patients with advanced disease.

1.2 TB Situation in Zimbabwe

Zimbabwe is one of the 22 countries in the world with the highest burden of TB. In 2013 a total of 35,566 patients with TB of all types were notified i.e. a notification rate of 269 TB patients per 100,000 of the population. The case detection rate is only 46%, which shows the need for more intensified activities to find TB patients at an early stage, particularly among the most vulnerable and affected populations.

TB is the second leading cause of death nationally and the most common cause of death among people living with HIV. Seventy percent of the TB patients who tested for HIV in 2012 were HIV positive, but only 65% of them initiated ARTⁱⁱ.

TB is among the top 10 causes of infant deaths and top five causes of death in children aged 1-4 (Inter-censal DHS 2008). TB was also among the top 10 causes of maternal mortality in 2008.

At the national level, treatment success rates of smear positive TB patients are steadily increasing from 79% in 2008 to 81% in 2011 (WHO report 2013) which is still below the global target of 87%. The death rate among these patients has remained at a steady but high 8% since 2009. In the same period, defaulting rates have come down from 7% to 4%, but 56% of the patients have no evaluated treatment outcome.

The detection of patients with MDR-TB has now progressed, thanks to improvements in the diagnostic capacity of services. This has led to an increase in the number of patients with drug resistant TB (DR-TB) from 2008 (1 patient) to 382 in 2013. MDR-TB patients are found in all provinces, although most of the patients are found in the cities of Harare and Bulawayo, and the province of Manicaland. This is most likely attributable to poor access to diagnostic services in the other provinces. Treatment is available at the two national referral hospitals for hospitalised patients and the initiation phase of treatment, and is now available in all provinces for the continuation phase of treatment.

1.3 Rationale for Community Involvement

Community participation is one of the components of 'Primary Health Care' accepted in 1978 during the Alma Ata Conference to reach the goal of "Health for All by the year 2000". In the past, the global health community has questioned the effectiveness and sustainability of Community Health Worker (CHWs) programs, but in the last decade there has been renewed enthusiasm in the light of the evidence showing their impact on health, in the areas of child survival, nutrition and HIV/AIDS care.

Globally, community involvement in TB prevention and care is substantial. Since most countries are not routinely recording and reporting community contribution data on notification and treatment outcomes, most of the evidence of the successfulness of community contributions comes from separately collected project data. There are many examples of successful outcomes both globally and in Africa, such as TB REACH funded projects and the ENGAGE-TB pilot project. Community based treatment support (Community DOT) is better documented than other community activities of TB control and examples of 50% of patients in India and 88% in Kenya being treated by treatment supporters, show the importance of the community contribution.

CHWs are employed by governments and NGOs to provide preventive and curative medical services in their communities. An effective and sustainable community health program requires CHWs' tasks and responsibilities to be clear, a long term remuneration policy, strong collaboration with the clinic staff, and mentoring and training.

The MoHCC of Zimbabwe started its CHW program in 2009 to expand access to health services and enhance community support for health through NGOs and all other types of community workers and volunteers. These community and village health workers (VHWs) also play a role in TB prevention/care and treatment supporters are used to provide DOT in the community according to the National TB Guidelinesⁱⁱⁱ. A study by N. Mlilo TB CARE^{iv} on whether there is a difference in treatment outcomes for those on Health Worker DOT and those on Community based DOT revealed that there is no distinction between treatment outcomes. Community TB referral systems in Zimbabwe are still weak, and there is an enormous potential to more actively involve communities in early TB detection in collaboration with local health care providers. TB data collection systems of National TB Programmes (NTPs) need to urgently integrate community contributions to detection and treatment success to show its impact and cost efficiency as well as to give credit and proper feedback to communities on their performance.

1.4 The Purpose of the Guidelines

The purpose of this document is to provide guidance on how to involve and collaborate with communities in TB control activities. This will contribute to an increase in early TB case detection, treatment adherence and access to quality patient centred TB services as well as the empowerment of people affected by TB, aiming for zero stigma for both TB and HIV.

The guidelines are meant to be used by the health service providers and TB staff at different levels of care, NGOs and CSOs working in the community in health or other programs, and all other public/private formal or informal health care providers.

2. COMMUNITY INVOLVEMENT IN TB CONTROL AND PATIENT CENTRED SERVICES IN ZIMBABWE

2.1 Community Involvement in TB in Rural Settings

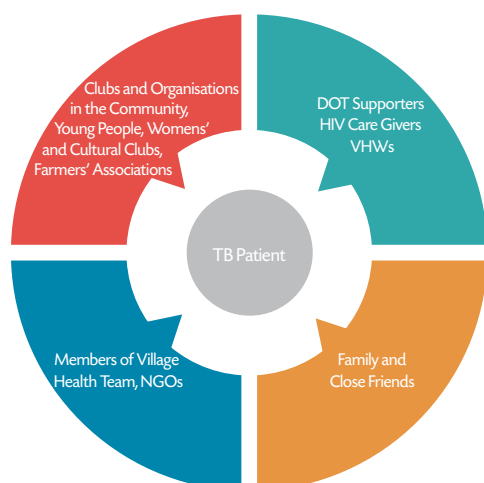
In Zimbabwe the VHW program (as part of the MoHCC) has as its key principle, the Primary Health Care Policy. The programme was reactivated in 2009 and has around 11,000 VHWs working in rural settings. The community selects VHWs according to set criteria established by the National VHW Program, each VHW covers several villages, with an average of 100 families. There are currently 120 VHWs per district in all the 63 rural districts of the country. Alongside the VHWs, there are also CHWs supported by Civil Society Organisations (CSOs) and Non-Governmental Organisations (NGOs).

Table 1. Tasks of CHWs

Prevention	Diagnosis/Treatment and Care	Community Mobilisation
Health education	Early identification of people with TB symptoms	Organise activities to mobilise the community for TB control
Trace contacts of TB patients	Refer clients for diagnosis	Coordinate with the village health team for TB and HIV activities at village level
	Tracing lost to follow up patients	Advocate for TB related resources
	DOT for TB and DR-TB	Set up Stop TB committee within health centre committee or ward committee
	Support TB/HIV patients and their families in treatment adherence and prophylaxis	
	Report to the nurse in charge (or other assigned staff) on identification of presumptive TB/HIV patients and treatment follow up.	

The role of VHWs consists of health promotion, disease surveillance, support to the outreach activities and some basic primary health care activities in the villages, both TB and HIV are part of the package. The VHW receives supervision by the nurse in charge of the rural health clinic and organised refresher trainings by the local or district health team. As the leader in health at village level, the VHW coordinates health activities together with the village health team (VHT) composed of the village leaders and all other stakeholders which are committed to health.

Figure 1: Possible players in TB prevention and care at Primary Health Care (PHC)



Different kinds of support groups, including home based care groups, are organised at village level and give psycho social and economic support, as well as organising awareness raising activities for HIV positive people. These groups should broaden their scope and incorporate TB activities which include awareness raising and stigma reduction, early identification of TB symptoms, TB treatment adherence support and the organisation of cultural or other creative activities.

The VHW collaborates with all local care providers, such as home based care givers, traditional healers, faith healers, volunteers, faith based organisations and community based organisations (CBOs). CBOs can be organised around all types of issues: youth cultural groups, sports clubs, women's groups, farmers organisations etc. In some villages community members are part of health clubs which develop preventive health activities according to the locally identified needs.

The clinic operates at ward level and the community work is coordinated by the 'Nurse in Charge' of the clinic (or other assigned staff) and supported by the Ward Health Teams. The involvement of the community in decision making is through the VHT and the Health Centre Committee (see Figure 2).

Figure 2. Community Involvement in Health System



TB control activities should be organised through meetings which include all relevant stakeholders. These meetings should be designed to analyse the magnitude and type of the TB problem and what the community itself can do to improve the TB situation. A Stop TB Committee should be set up as part of the Health Centre Committee to plan community TB activities together with the clinic nurse. The Stop TB committee, including CHWs and supported by the clinic nurse is responsible for the planning, implementation and monitoring/evaluation of the TB prevention and care activities. The Stop TB committee should be a mix of interested stakeholders from different backgrounds who represent the community, such as teachers, church leaders, employers, youth leaders etc. Representatives of people with a higher risk of getting TB, such as vulnerable groups living crowded in poor housing, migrant workers and people living with HIV and ex-TB patients should also play an important role in the Stop TB committees. Preferably, the locally elected community leader should be the chair of the committee and one of the CHWs should be the secretary and meetings should be held on a quarterly basis. The planning of TB and HIV activities should be done by the Stop TB committee involving all interested local parties and the implementation of the annual plan should be monitored by the same committee.

Community Involvement in TB in Urban Settings

In urban settings community systems are different both in social structures as well as in the type and organisation of the health services. In crowded urban neighbourhoods with poor housing, the risk of TB infection and active disease are elevated because of higher TB transmission and the presence of at risk populations. Although there are no VHWs in urban areas, there are health promoters who have an important role to play in preventive and public health services. These health promoters are attached to the health facility, and come to the (poly) clinic several days per week. They do promotional activities in the waiting rooms of their health facility as well as in the community, visiting house to house or organising educational sessions at schools, health committees and churches. Stop TB committees should also be set up in urban settings with people from different sectors and organised social groups, such as neighbourhood committees and CSOs. Health promoters and CHWs also need to be part of these committees.

Collaboration with the Education Sector

Schools, technical colleges and universities can play a vital role in the fight against TB. Children and young people are still shaping their own behaviour and are eager to learn. They have proven to be strong peer educators (in HIV and reproductive health programs) and health promoters to their own families as well as being the parents of the future. While relevant information on TB should be integral part of the school health curriculum, the teaching methodology is as important as the content. Actively involving children and young people in school TB projects such as creative activities around TB where they take the lead, can result in a higher long term impact on the healthy behaviour of young people and those around them. With simple information on TB transmission, prevention, possible cure and the link with HIV, young people can reduce stigma.

Tasks of Community Workers and Supportive PHC Staff

In the following table, the tasks of the different kinds of community workers and supporting health staff are listed. Chapter 3 will cover how collaboration can be organised between health staff and community workers, both governmental and CSOs.

Table 2. Tasks of Community Workers and Supportive PHC Staff.

Type of Cadre at Community Level	Main Tasks in TB and TB/HIV	Eventual Tasks
Village (government) and CHW (CSO)	Awareness raising and mobilisation, Coordinate with the village health team, Identify and Refer patient with TB symptoms, Treatment adherence support, Infection Control	
Collaborate with traditional and faith healers on early detection	Collect sputum/transport, DR-TB treatment	
Health promoters (urban)	Awareness raising and mobilisation, Identify and Refer patient with TB symptoms	Treatment support, Infection Control
Home Based Care givers (supported by HIV CSOs)	ART and TB Treatment adherence support	Contact tracing, Interrupters follow up, DR-TB treatment adherence support
Staff at PHC facility supporting community workers		
Environmental Health Technician (EHT)	Mentorship VHWs and Care givers, contact tracing, Interrupters follow up, Infection Control, sputum transport, awareness raising and mobilisation	Treatment adherence support
Nurse in Charge/TB focal person HC	Supervision and Training, follow up patients, collect data and feedback to community, MDR-TB treatment support	Supervising the administration of treatment, update and maintain data collection tools

2.2 Community Based DR-TB Treatment

CHWs involved in the community based treatment of TB patients can also be further trained to support the treatment of patients with DR-TB when the need arises. The treatment support of DR-TB patients requires more knowledge and skills and is much longer in duration.

CHWs' tasks in DR-TB prevention and care include:

1. Daily observation of treatment intake
2. Infection control measures

3. Nutritional advice and support in collaboration with community leaders
4. Psycho-social support
5. Side effect monitoring
6. Reminding patients of their follow up dates.

Besides treatment support, community workers can support early detection of DR-TB patients and prevention of DR-TB through collaboration with the PHC team in:

- Contact tracing of DR-TB patients at home
- Encouraging patients who have interrupted treatment to being again
- Finding patients who did not complete TB treatment in the past.

The primary health care worker at the health clinic has the responsibility to:

- When they have a patient who needs community based DR-TB treatment, train CHWs on the tasks in DR-TB.
- Have monthly contact with the community treatment supporter to report on the progress of patients and other TB supportive community activities.
- Respond promptly to any pressing questions community workers may have around DR-TB patient care (SMS/Text, telephone or in person).

2.3 Patient Centred Services

Working with communities to control TB can only be successful when health services are prepared and organise their TB services to respond effectively to both the higher demand created and to patients who are more informed and empowered. Nurses or other health staff, who are responsible for delivering patient care, need to be trained together with the local PHC team on how to apply patient centredness. They also should become empowered to start thinking “out of the box” and to adapt (TB) services to the needs of the patients using local solutions. The PHC worker is the direct link between the patient, the family and the community. The PHC team should involve communities in the design, implementation and monitoring of TB control activities.

As a joint initiative of community and local health services the impact of these activities will be stronger because planned activities, including resources, are based on the local circumstances, opportunities and creativity of community members and organised groups. The most essential components of patient centred care are written in the box below^v.

The Most Essential Components of Patient Centred Care:

1. Enable a partnership between the patient and the care provider and recognise patient’s rights as well as responsibilities (Patients’ charter)
2. Work as a health team aiming to deliver quality integrated services for people affected by TB
3. Empower patients to become engaged in the different aspects of TB control
4. Engage communities in planning TB activities and becoming involved in TB control.

Enable Partnership (Point 1 in box above): To help facilitate adherence to treatment, create an environment which enables a partnership relationship with the patient. Although the provider is seen as the expert in TB diagnosis and treatment, the experiences of the patient with the services or how to adhere to daily treatment are also of great importance. Both the provider and patient should team up to develop a tailored treatment package, fitting the personal situation of the patient, creating ownership and leading both to the curing of the disease and to self-efficacy.

The patients’ charter defines the rights of patients and health care providers, such as the right to care, information, dignity and confidentiality. The charter needs to be used to support specific situations where rights on TB treatment may be not respected in the workplace and for vulnerable/at risk groups such as migrants, miners as well as for women/girls if their rights to proper TB care are not recognised.

The patients’ charter also indicates the responsibility patients have to inform the health provider properly and to discuss any problems they may encounter in adhering to treatment.

Team work (Point 2): The whole package of TB services from identification of a possible TB patient upon arrival at the clinic, to successful treatment are activities which should be the responsibility of the health team headed by the nurse in charge, and monitored monthly. Below is an example of how teamwork in a health centre led to patient centred quality care in a densely populated poor neighbourhood of Harare.

The Patient Centred Mabvuku Polyclinic had 3% of defaulting patients among 265 TB patients before starting the project in 2009. They now have zero defaulting patients and a cure rate of 72%. The reasons for success were:

- The teamwork, all staff working to improve the quality of (TB) services
- Involvement of communities and leaders through an active health team
- EHT living in the community and supporting community outreach activities (household visits, contact tracing etc.)
- Active health promoters which are the critical voice of the community.

Empower patients (Point 3): To become engaged in the different aspects of TB control. The empowerment process starts with providing relevant information on TB which has been adapted to and respects the patient's needs, values and past experiences at different stages of the treatment. The health worker should encourage the patient to take responsibility for their own health and to begin to support others as well. Some patients have shown to be excellent peer educators and advocates when the opportunity is given to them and they are treated as equal partners. They can encourage health seeking behaviour in their communities (because they have had experiences with the disease) and they can also reach out to more vulnerable patients or those which are difficult to reach and convince.

Engage communities (Point 4): The empowered health provider must recognise that patients and communities also have a equal role to play and are part of the solution in the fight against TB. The primary health worker must link up with community groups, CSOs, the commercial sector, other government sectors and local authorities to engage them in activities. This requires a shift away from traditional roles towards true partnerships, which will finally make direct patient care of a higher quality and TB control activities more (cost) effective and sustainable.

3. COLLABORATION BETWEEN DISTRICT GOVERNMENT, NGOS/CSOs AND OTHER STAKEHOLDERS

NGOs/CSOs and other stakeholders should support TB prevention and care and they should work in collaboration with the health services and the TB program to follow national guidelines and guarantee synergy of actions. The TB program needs all stakeholders to improve the district outcomes in TB case detection, notification and treatment success.

Situation Analysis

A situation analysis at district and/or community level is the first step in the planning of collaborative activities between health services and NGOs/CSOs. The local teams at the lowest level should be part of this exercise as they are the direct link with the communities. A situation analysis includes the following steps:

- Analysis of TB burden and epidemiological data, inventory of specific TB problems and its causes (late detection, high death or default rate, access to diagnostic or treatment services, patient delay, use of other providers etc.)
- Assessment of the most at risk populations (MARPs) in the area, and hard to reach groups (prisoners, slum dwellers/deprived populations, migrants, sex workers, miners etc.)
- Availability and (perceived) quality of public health and TB services: diagnostic and treatment services (Strengths Weaknesses Opportunities Threats (SWOT) analysis)
- Information on health seeking behaviour, stigma, knowledge TB (through surveys, focus group discussions, Participatory Action Research)
- Mapping stakeholders: A SWOT analysis of the available NGOs and CSOs and their willingness to take up TB/HIV activities?
- Assess the activities which can be done by NGOs and other CSOs
- Assess NGO/CSOs' working conditions and incentive policy
- Develop an activity plan for each organisation which includes an M&E framework.

Formalise the Collaboration

The second step is the formalisation of the collaboration. An agreement needs to be drawn up which describes the tasks, responsibilities and ways of communication. This agreement needs to be the result of discussions among all the stakeholders involved and the basis for good collaboration.

Capacity Building

The third step includes building the capacity of the different stakeholders through formal training, on the job training and mentoring. A capacity building plan needs to be developed, including the capacity building needs of the different stakeholders, the capacity building approach and activities. A training manual on the different aspects of community based TB activities is available for all types of CHWs, working in the public sector or through CSOs.

Supportive Supervision

The fourth step is regular supportive supervision which needs to be a collaborative effort with the district, provincial and central TB and health teams, using the NTP's supervision guidelines.

4. REFERRAL SYSTEM OF PATIENTS BETWEEN COMMUNITY AND HEALTH SERVICES

Referral to health facility of a person with presumptive TB by CHW:

- The CHW sends the person with presumptive TB with a referral slip to the health facility to be examined by a health worker
- At the health facility the patient receives a sputum container and is requested to produce one sputum sample on the spot and to also bring an early morning sputum sample to the health facility
- The result will be sent to the CHW by SMS and if positive for TB, the patient and treatment supporter are requested to come back to the health facility. The patient is counselled by the health worker to do an HIV test which if positive means procedures are initiated in coordination with the HIV clinic to also start Cotrimoxazole Preventive Therapy (CPT) and Antiretroviral Therapy (ART)
- The patient is registered at the health facility as a patient on community treatment, and the community worker receives the patient card and the referral form.

Referral of TB patient by health facility for Community TB treatment and care:

- When travelling to the health facility each day is not feasible (e.g. when it is too far away or transport costs are too high), patients are offered the option of community based treatment with a treatment supporter
- The CHW maintains the community register to keep a record of all patients receiving community DOT and to give monthly/quarterly information back to the health clinic
- The treatment supporter is (re)oriented on all the necessary basics of TB needed to perform their job and also in the correct reporting of the observed treatment doses taken
- Any problems experienced during treatment such as side effects or anything else which prevents adherence (work, moving, alcohol etc.) should be reported to the health facility by the treatment supporter and the patient should go to health centre (accompanied if needed).

Follow up of TB patients :

- The CHW (or other treatment supporter) observes the patient taking the medicines (DOT) and supports the patient during the treatment
- Agree at the start of the DOT with the patient and his/her family:
 - What the CHW and DOT supporter can do
 - The rights and responsibilities of the patient.
- Give practical advice on diet and make clear the need to eat before taking the medicine. Clarify any doubts of patients who might be struggling with the disease and possible misconceptions around TB and HIV.
- Consult the nurse or refer to clinic if problems are not able to be solved at the community level
- Accompany patients to the clinic
- Where patients cannot afford to buy extra food or the transport to visit the clinic, look for a practical solution with the support of the village committee or the TB staff at the clinic
- Patients should have their follow up visits at the health facility after 2 months, 3 months (if still sputum positive at 2 months), 5 months and at the end of treatment. During these visits they will be clinically reviewed and bring sputum samples (when they are sputum positive TB patients). The patient card should be brought to the health facility.

Contact screening by CHW, referral TB presumptive patients:

- The CHW can be involved in contact screening of the patient with smear positive lung TB. He/she will visit the household and use the screening tool to identify presumptive TB patients
- All persons with TB symptoms are referred to the health facility to give a sputum sample
- Parents/guardian of children under five living in a household with a smear positive pulmonary TB patient should be encouraged to bring them to nearest health facility for examination to exclude TB and start Isoniazid prophylactic treatment. The contact screening form should be filled in for this purpose
- People living with HIV are also requested to come to the health facility for examination, to exclude TB and start prophylactic treatment
- Health education will be given on the symptoms of TB, the ways of transmission and infection control measures in the household.

Interrupter follow up by CHW:

- TB patients on treatment who miss a date for review or for medicine collection should be traced immediately
- If this happens when on treatment at facility level, the nurse informs the EHT, who in turn informs the CHW. The EHT or the CHW contact the patient and discuss the reasons for interrupting and how to prevent it happening again. The patient may opt for community based treatment
- If a TB patient moves away or their whereabouts become unknown in spite of having tried to persuade them to continue, the CHW or treatment supporter should contact the TB focal person at health facility to find a joint solution
- If a TB patient is on community treatment and they do not show up for periodical review, the treatment supporter is contacted as well as the CHW.

5. MONITORING AND EVALUATION OF COMMUNITY INVOLVEMENT IN TB CONTROL

Monitoring and Evaluation (M&E) aims to collect and analyse information on what activities have taken place and what the results of these activities are. M&E is important for community TB and HIV activities to:

- Provide TB baseline information
- Provide information on how implementation is progressing
- Assess the quality and effectiveness of a programme or activity
- Report to bodies such as the NTP, donors, advocacy groups, community representatives on what has been achieved, any barriers or blocks to implementation, and lessons learned.

Data collected to monitor and evaluate activities of community involvement in TB control

There are two essential core indicators for measuring two important results of community-based TB activities; detection of TB patients and treatment outcomes (Table 3). They are measured in countries worldwide and published yearly in the WHO Global TB report. The data for these indicators are collected at clinic level and reported through district level and provincial level as part of the national monitoring system of the NTP. They focus on:

- The proportion of new TB patients referred by CHWs
- The proportion of successfully treated (treatment completed + cured) new TB patients who received treatment adherence support from CHWs.

Table 3. Two TB core outcome indicators to monitor community involvement in TB control

Indicator 1. Community Contribution to TB Referrals and new TB notifications	
Definition	Number of new TB (Male/Female) patients (all forms) diagnosed and notified with TB who were referred by CHWs and community volunteers, expressed as a percentage (%) of: All new TB patients notified in the health facility during a specified period
Numerator	Number of confirmed new TB patients (Male/Female) (all forms) referred by CHW to a health facility for diagnosis and notified in the health facility in a specified period
Denominator	Number of new TB patients (all forms) notified in the health facility in the same period
Purpose	To measure the level of effective engagement of CHWs in increasing new notifications of TB.
Measurement Tools	Presumptive TB patients are recorded on the 'persons with presumptive TB' register which specifies the type of referral (community or self-referral) Confirmation of the TB diagnosis of the patient is recorded in the TB register as having been referred by a CHW. Data is aggregated quarterly for the quarterly report on TB registration and for the yearly report on programme management in districts or health facility.

Indicator 2. TB Treatment success of TB patients supported in the community by CHWs	
Definition	Number of new TB patients (Male/Female) (all forms) successfully treated (cured plus completed treatment) who received support for treatment adherence from CHWs among all new TB patients (all forms) provided with treatment adherence support by CHWs in the health facilities in a specified period
Numerator	Number of new TB patients (Male/Female) (all forms) successfully treated and provided with treatment adherence support by CHWs in the health facilities in a specified period
Denominator	Total number of new TB patients (Male/Female) (all forms) given treatment adherence support by CHWs in the same period
Purpose	To measure the scope and quality of implementation of community-based TB activities particularly relating to treatment outcome of patients.
Measurement Tools	Community TB Register

The quarterly collected data should be analysed in a meeting between the CHWs and the clinic team in order to find solutions for any problems presented and take any necessary actions.

Other data collected to measure TB activities at community level

Alongside the vital information above, additional information (depending on the activities taken up by the community) should be collected for use and interpretation locally. This information includes:

- The number of patients (Male/Female) and age group who died
- The number of patients (Male/Female) and age group who interrupted/withdrew from treatment
- The number of retrieved patients (Male/Female)
- The proportion of smear positive TB patients who had their household visited for contact tracing (including follow up of found presumptive TB patients)
- The number of TB patients detected through contact tracing
- The number of health education sessions held; the number of people reached (disaggregated into Male/Female, age groups)
- The number of Stop TB committees established and active, developing their own TB activities with action plans.

Periodic evaluation: Provide a qualitative view of progress in community based activities^{iv}

The NTP will organise evaluations of community based TB activities every 3 to 5 years. NGOs and other CSOs will be asked to participate in this process alongside external reviewers.

Table 4. Periodic Evaluation of Community Involvement in TB Control

Periodic evaluation of community involvement in TB control	
Purpose	<p>Periodic evaluation provides a qualitative view of the progress of community-based TB activities. In particular, it helps to assess the contributions of CHWs to new case notifications and to treatment outcomes.</p> <p>It indicates whether community contributions are increasing or decreasing and also reflects the quality of the relations between NTPs and CSOs on the basis of variables such as the frequency of meetings, the quality of such meetings, the cooperation of people involved, the factors in success and the overall interest and drive of the NTP in involving CSOs in TB activities.</p>
Indicators	<ul style="list-style-type: none"> ▪ Existence of National and sub-national Stop TB Partnerships/Committees <ul style="list-style-type: none"> – Trends in membership: which stakeholders – Frequency of meetings – Existence of a year plan and grade of implementation of all types of community TB preventive and care activities (Table 1) – Spread to provincial, district and ward levels – Coordination between levels – Mechanisms for transferring knowledge, skills and resources. ▪ Quality of interaction with the NTP at various levels <ul style="list-style-type: none"> – Frequency of meetings – Quality of follow-up on agreed actions – Availability of TB diagnostic services and drugs. ▪ The relative contributions of NGOs, other CSOs and of the government to new case notifications and treatment success, with trends in these variables over time. ▪ Challenges and hurdles faced by different actors in government and civil society as well as successes and new opportunities.

Method	<p>Qualitative techniques should be used, including focus group discussions and key informant interviews. Appreciative inquiry techniques will help improve the quality of the feedback.</p> <p>NTP managers and provincial, district and clinic staff should be interviewed both singly and in groups. Similarly, representatives of CSOs at national, district and local levels should be interviewed singly and jointly.</p> <p>The main issues emerging from the interviews should be identified, shared and discussed at a meeting between the staff of the NTP at various levels and representatives of CSOs at various levels.</p> <p>The emphasis should be on sharing and learning in order to understand and improve the programme.</p>
Periodicity	Every 3–5 years during national or international reviews.
Strengths and Limitations	Provides a periodic assessment of the contributions CHWs (MoH and CSOs) as well as the quality of the relations with the NTP.
Responsibility	<p>The value of such studies depends on the professionalism and ability of the evaluators and the biases they may bring to the process.</p> <p>All CSOs and the NTP or health system implementing community-based TB activities will participate and share their views.</p> <p>The primary responsibility for organising such evaluations is with the NTP. They could coincide with the national TB reviews generally held every 5 years in each country.</p>

6. ANNEXES

6.1: Referral forms, Tools and Relevant ROR forms

1. Presumptive TB Referral Form
2. TB Screening Tool
3. Community TB register
4. TB Patient Treatment Card
5. TB/DR-TB Contact Tracing Form.

Presumptive Tuberculosis Referral Form

Name of the Client	Client's Contact Number
Age	Sex
Village	Headman
Nearest Dip tank	Nearest School
House Number	Street Address
Name of Company	Work Address
Nearest Health Facility	

Reasons for referring (signs and symptoms)

Tick the appropriate box	
Cough for 3 weeks or more	
Loss of weight	
Loss of appetite	
Chest pains	
Night sweats	
Fever	
Shortness of breath	
Contact	

Date of Referral	Township/Suburb
Referred by	Signature
Ward	District

Instructions

1. Name of the client with presumptive TB = Record the name client suspected of having TB.
2. Contact Number = Record the phone number if the client has cellphone or landline.
3. Age = Record the age of client or date of birth as indicated on the national identity card.
4. Sex = Record whether the client is a female or male.
5. Village= Record the name of the village where the client is coming from.
6. Headman = Record the name of the headman of the client.
7. Nearest Health Facility = Record the name of the closest health facility to where the client stays.
8. Nearest School = Record the name of the closest school to where the client stays.
9. Nearest Dip Tank = Record the name of the closest dip tank to where the client stays.
10. Date of Referral = Record the date when the patient was referred to the health facility.
11. Referred by = Record the name of the person who referred client.
12. Ward = Record the name of the ward where you are staying (the person who is filling the form).
13. Village = Record the name of the village where you are staying (the person who is filling the form).
14. District = Record the name of the district where you are staying (the person who is filling the form).
15. Signature = Sign your signature after completing the form.

TB Screening Tool

On Every Visit Ask the Follow Questions	YES	NO
Do you have cough? For how long? (Yes if for two weeks or more)		
Do you have night sweats? For how long? (Yes if for three weeks or more)		
Have you lost weight in the past two months? (Yes if patients has lost weight)		
Do you a fever or 'hot body'? For how long? (Yes if for three weeks or more)		
Has someone in your household had TB?		

Take the Following Action
<p>Patient is a TB Suspect if 'YES' is given to any of the above questions:</p> <ul style="list-style-type: none"> ▪ Collect two sputum specimens for AFB microscopy and send to laboratory ▪ Enter patient's information in the TB suspect register ▪ Ensure that you receive the AFB result and manage the patient as follows: <ul style="list-style-type: none"> ▪ If one or more AFB results are positive, start treatment and notify ▪ IF AFB results are negative, refer to a doctor for further assessment
<p>If 'NO' is given to all the questions, patient is not a TB suspect:</p> <ul style="list-style-type: none"> ▪ Repeat symptom screening on another visit (for OI patients every three months)

Instructions

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TB Patient Treatment Card

Health Facility and Code:

Patient TB Reg No.

Date of Registration

Name (Surname, First Name)	Sex	Age
	M F	
Physical Address (in full)		
Name and Address of next of kin OR Treatment Supporter		

Remember
TB can be cured - It is very important to the full treatment course, even if you feel well.

Yeukai
TB inorapika - Inwa mapiriti sokurairwa kwaunenge waitwa kusvikira wapedz zvisinei kuti wava kunzwa zvininani

Nanzelela lokthu
Ufuba (TB) luye lapheka - Kuqakathekile ukuba uginye wonke amaphilisi owaphiwayo aze aphele lanxa ususizwa ngcono

Pre-treatment weight		kg	
INTENSIVE PHASE Regimen-FDC			
Adults		Children	
Date/Weight in kg	Daily Dose in Tablets	Date/Weight in kg	Daily Dose in Tablets

Treatment Categories (Tick)
Category 1 (New Case) <input type="checkbox"/>
Category 2 (Retreatment) <input type="checkbox"/>
Category 3 (MDR) <input type="checkbox"/>

Diagnosis (Tick only one category)
PTB Sputum Positive <input type="checkbox"/>
PTB Sputum Negative <input type="checkbox"/>
PTB Sputum Not Done <input type="checkbox"/>
Extrapulmonary <input type="checkbox"/>

Patient Type (Tick)
New <input type="checkbox"/>
Relapse <input type="checkbox"/>
Retreatment after Default <input type="checkbox"/>
Retreatment after Failure <input type="checkbox"/>
Other, specify <input type="checkbox"/>

Sputum Status		
Date	Lab No.	Result
At Notification		
At end of intensive phase		
At end of 5 months		
At end of continuation phase		

HIV Testing and Counselling (circle)			
Offered Testing	Y N	Offer Accepted	Y N
HIV Result	0 1		U
Date			

HIV Care: OI Number			
CPT	Start Date	Stop Date	
ART	Start Date	Stop Date	
	Type of Regimen	1st Line <input type="checkbox"/>	2nd Line <input type="checkbox"/>
ART drugs/doses	Stop Date		

TB/DR-TB Contact Tracing Form

Province District Health Facility

1. Index case Details

Surname First Name TB/DR TB no.
 Physical Address (Place of residence/work):
 Phone Number Chief Village Head
 Nearest school/Dip tank
 Diagnosis
 Clinically diagnosed Sensitive TB Bacteriologically confirmed Sensitive TB DR-TB

Surname	First name	Age	Sex	Physical Address	Investigation Outcome	
					Presumptive TB client (Y/N)	Sputum collected during the visit (Y/N)

The officer conducting contact tracing should carry sputum containers with them, to collect spot sputum specimens.

Comments

Tracing Officer Designation Signature Date

Instructions on how to fill in the contact tracing form

ITEM	INSTRUCTION/DEFINITION
Province	Record the name of the province where contact tracing is being initiated
District	Record the name of the district
Health facility	Record the name of the health facility
Index Case Details	
Index case	The first case or patient who comes to attention as indicator of a potential public health problem. <ul style="list-style-type: none"> All pulmonary bacteriologically confirmed TB cases should be regarded as index cases and their contacts investigated for TB. All children with TB should be considered index cases. As young children are more vulnerable to TB infection, the purpose of contact investigation is to identify the source of TB transmission.
Surname	Record the surname of the index case
First name	Record the first name of the index case including the nickname
TB/DR-TB number	Record the TB/DR TB number of the index case as recorded in the TB register
Physical address	Record the physical address of the index case, include phone number, chief, village head, nearest school/ dip tank
Diagnosis	Tick the appropriate diagnosis in the space provided, the diagnosis is what is recorded in the TB register

Details of Contacts	
Contact	<p>Someone who has been exposed to <i>M. tuberculosis</i> by sharing air space with a person with infectious TB. The type of contact depends on the closeness and duration of exposure to the index case:</p> <ul style="list-style-type: none"> Household contacts, particularly, children less than 5 years of age should be assessed for TB. High priority should also be given to those who are HIV positive and those with other underlying risk factors for TB such as alcoholism, diabetes, etc. Contacts may also be found in aggregate settings such as workplace, schools (dormitories and classrooms), hostels, health facilities, prisons if prolonged contact with an index case has taken place.
Surname	Record the surname of the contact
First name	Record the first name of the contact including nickname
Age	Record the age of the contact in years
Sex	Record the sex of the contact (Male/Female)
Physical address	Record the physical address of the Index case to include phone number, chief, village head, nearest school/dip tank
Investigation outcome	Record 'Yes' if the TB contact investigations revealed that the contact was eventually a presumptive TB client. Record 'No', if the results of investigations did not point to signs and symptoms suggestive of TB disease.

6.2: REFERENCES AND USEFUL RESOURCES

1. ⁱWHO Global TB Report 2013
http://www.who.int/tb/publications/global_report/en/
2. ⁱⁱNational TB program report 2012
3. ⁱⁱⁱNational TB Guidelines, Fourth Edition October 2010, NTP Zimbabwe
4. ^{iv}“Does the type of treatment supporter influence tuberculosis treatment outcomes in Zimbabwe?” N. Mlilo, C. Sandy, A. D. Harries, A. M. V. Kumar, N. Masuka, B. Nyathi, M. Edginton, P. Isaakidis, M. Manzi, N. Siziba
5. ^vPatient Centered Approach, TB CARE I toolkit:
<http://www.tbcare1.org/publications/toolbox/access/>
6. ^{vii}Engage TB approach: Operational guidance integrating community-based tuberculosis activities into the work of nongovernmental and other civil society organizations.
http://www.who.int/tb/publications/2012/engage_tb_policy/en/
7. Building the Capacity of Civil Society Organizations
http://www.tbcare1.org/publications/toolbox/tools/hss/download.php?file=Capacity_Building_Approach.zip
8. TB CARE I Website:
Health System Strengthening Tools:
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