

Assessing the management of TB cases

Management of TB cases

Objectives: at the end of the assessment reviewers should comment on –

- the quality of case-finding;
- the quality of the information recorded;
- how well treatment is managed;
- how well the care of patients with multidrug-resistant TB (MDR-TB) is managed;
- actions that could be taken to improve case-management.

Background:

The management of patients with TB should be led by a designated manager. Good quality management starts with the timely and accurate registration of TB cases, and includes delivering appropriate treatment using standardized regimens of TB treatments as well as providing support for patients. Good quality management also ensures that patients who miss one or more doses of treatment are quickly followed up, and that contacts (see *TB contact investigation*), especially children, and others belonging to high-risk groups (see *TB case-finding in high-risk groups*) are investigated or assessed to determine whether they have active TB.

Location: health facilities providing TB services as part of the national TB programme or the basic management unit where the TB treatment register is usually located, or both

Staff to be interviewed: staff who manage or coordinate TB activities and relevant health workers

Assessment:

- a. How are TB services organized in the catchment area?
 - i. What boundaries define the catchment area (for example, which villages are included)? What is the size of the population served?
 - ii. Which facilities in the area identify, treat and notify TB patients? Are the data disaggregated by type of TB, including MDR-TB? (All public facilities should be considered in the assessment, such as outpatient clinics, hospital wards, laboratories, peripheral or satellite centres, general hospitals, specialty hospitals, medical colleges, health institutions run by state insurance schemes, health facilities run by public corporations, prison health services and military health services. All private facilities should also be considered in the assessment, such as private hospitals and clinics; corporate health services, hospitals

and clinics; services provided by civil society organizations, private practitioners, pharmacies and drug dispensaries; as well as traditional healers and informal providers.)

- iii. How are services coordinated among the facilities mentioned above?
How does this coordination work for patients with MDR-TB?
- b. Is the TB treatment register used at the basic management unit consistent with WHO's current recording and reporting forms and registries?
 - i. Are patients entered in the TB treatment register in numerical and chronological order, starting with 1 at the beginning of the calendar year?
 - ii. Have data from the laboratory register on positive sputum specimens been entered in the TB treatment register?
 - Check that all smear-positive patients have been registered in the TB treatment register at the basic management unit, including those with a single positive smear result.
 - Check that all smear-positive cases recorded in the laboratory register were recorded in the TB treatment register. If any smear-positive patients are missing from the TB treatment register, discuss the reasons why this occurred. Do these missing patients represent initial defaulters or patients who were transferred out before being registered? Also discuss the mechanisms in place to trace patients with positive sputum-smear results who do not attend the TB clinic.
 - Once a specimen is recorded as having been received by the laboratory, how long does it take before the patient is entered in the TB treatment register, and then how long does it take before treatment is started? How long does it take on average for each step to be completed?
 - Check that the correct TB registration numbers have been recorded in the laboratory register.
 - Check that test results and laboratory identification numbers have been accurately recorded in the TB treatment register at the basic management unit; also check that the diagnosis and results of follow-up sputum examinations have been recorded accurately.
 - iii. Are patients entered in the register using WHO's recommended case definitions? Are the criteria used to categorize TB patients aligned with these definitions?
 - iv. Is there a complete address for each patient or information on other ways to locate each patient?

- v. Are patients' treatment cards kept at the health facility where the treatment is provided and are the cards kept under appropriate conditions.
 - vi. Are sputum-smear microscopy results correctly transcribed from the laboratory register to the TB treatment register? (Randomly choose a number of patients and confirm whether their results at the time of diagnosis, at 2 months or 3 months of treatment, at 5 months of treatment, and at 6 months or 8 months of treatment have been correctly transcribed from the laboratory register to the TB treatment register.)
 - Are sputum follow-up examinations done on time?
 - Are positive sputum results entered in red ink in the TB treatment register?
 - vii. What proportion of patients have sputum conversion at the end of the intensive phase of treatment? (This should be determined for a cohort of patients.)
 - viii. What proportion of new TB cases are smear positive at 5 months or later after starting treatment?
 - ix. (Review the TB treatment register for the quarter of the previous year that corresponds to the current quarter.) Are treatment outcomes and their corresponding dates written in the TB treatment register for all patients who completed their treatment? Are the definitions of treatment outcomes aligned with the definitions established by WHO?
 - x. Are collaborative interventions that address co-infection with TB and HIV recorded in the TB treatment register with their start dates (for example, the start dates of antiretroviral therapy [ART] or co-trimoxazole preventive therapy [CPT])?
- c. How is treatment administered? Does the facility use directly observed treatment (DOT)?
- i. How many patients receive DOT? What type of DOT is used (for example, is it delivered at a hospital, at a health facility, in the community, within the patient's family)? Is DOT provided throughout the course of treatment or only during the intensive phase? Are there differences for delivering DOT to patients with MDR-TB?
 - ii. Are treatment supporters trained? If so, how? Are they supervised? If so, how? Do treatment supporters receive any incentives? Do the incentives differ for those who supervise patients with MDR-TB?
 - iii. Are fixed-dose combinations (FDCs) of anti-TB medications used? Are

patient kits used?

- iv. Do patients receive incentives, enablers or both (for example, food, transport vouchers or money) during their treatment? If yes, what do they receive? Who provides it (for example, the TB clinic or a local civil society organization)? Is a social-protection scheme available for TB patients?
- d. Has information from the TB treatment register and the laboratory register been correctly recorded on the TB treatment card? (Review TB treatment cards for a cohort of patients, including patients currently being treated and patients who have completed treatment. Cross-check the TB treatment cards against the TB treatment register and the laboratory register to ensure that information has been properly recorded on the treatment card.)
 - i. Do TB treatment cards include information on referrals, ART, date and result of HIV test, date CPT started, information on HIV care, and date of radiography and results?
 - ii. What is the procedure for recording which anti-TB medicines have been administered? (Review the procedure for ticking boxes on TB treatment cards.)
 - iii. Have the treatment cards of patients who were seen in peripheral health units been returned to and archived at the basic management unit?
- e. Were patients who defaulted or failed treatment appropriately managed? (Review the treatment cards for a selection of patients.)
- f. What is the process used for patients who are transferred to another basic management unit? Is there a form that is used when a patient being treated is transferred out? Are the treatment outcomes for patients who have been transferred communicated to the initial basic management unit?
- g. Is there a system for contacting patients who do not collect their medication or present to a health facility when requested? If yes, how is default tracing carried out? By whom? When is it undertaken?
- h. Is there any policy on offering psychosocial support to ensure adherence to treatment? If yes, is support offered to all patients or only to specific categories of patients? How is this support funded??
- i. Are interventions addressing TB in children offered as part of routine activities? (Review the interventions used to address TB in children, including those for the prevention and management of active disease.) (See *Assessing activities to address childhood TB*.)

Indicators for: Assessing the management of TB cases		
Indicator	Calculation	Source of information
Proportion of TB patients receiving DOT	Numerator: number of TB patients receiving DOT Denominator: total number of patients being treated for TB	Treatment cards
Conversion rate at the end of the intensive phase of treatment	Numerator: number of smear-positive TB patients who are still positive at the end of the intensive phase of treatment Denominator: total number of smear-positive TB patients who were treated	TB treatment register, quarterly reports
Treatment success rate	Numerator: number of TB patients who successfully completed treatment Denominator: total number of TB patients who were treated	TB treatment register, quarterly reports

DOT, directly observed treatment.