Operational Guide
Find and Treat all Missing Persons with TB

Toolbox
ALLIES APPROACH: INTERACTIVE LEARNING

SOURCE
Allies Approach
www.end-stigma.com (Access from June 2018)
This self-learning course is part 2 of the KNCV Stigma reduction toolbox. Part 1 is the self-learning course.

PURPOSE
This interactive course is developed for health workers working with TB patients and providing people centered care. The course allows participants to explore, question, clarify and affirm their values and beliefs about (DR-) TB stigma, meet with their peers, challenge themselves, improve their environment and move for change, such that they develop self-awareness and comfort with the provision of people-centered (DR-) TB treatment and care.

USE
Interactive workshop for HCWs. The workshop can also be organized for TB advocates, managers, advocates, community members and people from the media.
The toolbox provides exercises and other training materials that will be used to customize the workshop to the needs of the target audience. The toolbox includes five modules:
(1) Countering stigmatization of health workers; (2) Heart-feelings-affective— empathy building exercises; (3) Head-thinking-cognitive;
(4) Communication/counseling; (5) Hands-actions-solutions. Each proposed activity has a specific objective, methodology and duration so activities can be carefully selected.

RESULTS
The participants should be able to:
1. Appreciate their own value to the fight against (DR-) TB
2. Define and identify (DR-) TB related stigma
3. Empathize with patients
4. Serve patients in a non-judgmental manner regardless of who they are
5. Understand and uphold patient-provider confidentiality
6. Address stigma in the context of service provision.

TIME
1 – 2 days.

BUDGET
Costs depend on the workshop duration and number of participants (20–30).

EVIDENCE/EXPERIENCE
This tool is under development and needs to be piloted.
ALLIES APPROACH (STIGMA SELF-LEARNING COURSE)

SOURCE
Allies Approach
www.end-stigma.com (Access from June 2018)
This self-learning course is part 1 of the KNCV Stigma reduction toolbox. Part 2 is the Interactive learning.

PURPOSE
This e-Learning course is developed for health workers working with TB patients and providing people centered care. The course aims to raise awareness of stigmatization of TB patients in health care facilities and to provide the basic information needed to enable participants to provide dignified and respectful care without risking TB transmission.

USE
Self-learning for health care workers. The course can also be used for TB advocates, managers, advocates, community members and media.

RESULTS
Learners who complete this e-learning course, will know:
- What (DR-) TB stigma is
- What the causes of TB stigma are
- Why it is important to address stigma
- Basics to reduce stigma in your health facility, including:
  » Knowing the rights to decent work as a health worker
  » Strategies for improving health worker's working conditions
  » The impact of transmission control measures upon patients
  » The rights and responsibilities of patients with TB
  » Which TB terminology to use to avoid stigma.

TIME
1 hour.

BUDGET
The course is free and can be done in participants' own time.

EVIDENCE/EXPERIENCE
This tool is under development and needs to be piloted.
BUILDING THE CAPACITY OF CIVIL SOCIETY ORGANIZATIONS IN TB CONTROL

SOURCE
TB CARE I. Building the capacity of Civil Society Organizations in TB control
http://www.challengetb.org/library/hss

PURPOSE
To provide a methodology and tools to build the capacity of junior CSOs through training, mentoring, inclusion in the TB network and a learning M&E approach.

USE
The guide provides capacity building approach, facilitator's and participants' manuals to facilitate:
- 4 days training for junior CSOs in community TB prevention & care and how to strengthen the performance of their organization
- One-day mentoring workshop for mature CSOs on how to mentor the young CSOs
- One-day Stakeholders Meeting to strengthen the collaboration among stakeholders in the field of community involvement in TB

The M&E framework provides guidance on how to measure the results of the capacity approach and to learn from the data.

RESULTS
CSOs have gained competencies to work in community TB prevention and care. They have an activity workplan including plans to further strengthen their organizational performance. Mature CSOs have competencies and plans to mentor the young CSOs.

TIME
For training, workshop and meeting: 1 month. Mentoring for a period of 1 year.

BUDGET
For 4 days of training, a one-day workshop and a one-day stakeholders meeting. Budget may be needed to transport mentoring CSOs.

EVIDENCE/EXPERIENCE
Piloted in Indonesia, Nigeria and Ethiopia by KNCV, FHI 360 and ATS. Positive experiences with the approach documented the source document. In Ethiopia, Addis Ababa, female headed NGOs were engaged and started supporting case-finding and LTFU tracing in the poorest neighborhoods through their network and using coffee ceremonies at members houses as gathering places.
COMMUNITY REFERRAL FORM (EXAMPLE FROM ZIMBABWE)

SOURCE

PURPOSE
Inform the health facility staff about the presumptive TB patient who is referred by the CHW or CV.

USE
The Community referral form will be used by the CHW or CV when referring a presumptive TB patient to the health facility. The form provides patient data, TB related signs and symptoms and by whom the patient is referred. The referral process is elaborated.

RESULTS
Appropriate community referral.

TIME
10 minutes to fill the form.

BUDGET
N/A.

EVIDENCE/EXPERIENCE
This guide, including the community referral form has been guiding HCWs, CSOs and other stakeholders in Zimbabwe to implement an effective community TB care program. The simplicity of language used in the guidelines helps non-clinicians to understand and apply the concepts effectively in their day to day community work.
DIGITAL ADHERENCE TECHNOLOGY FOR TREATMENT SUPPORT

SOURCE

PURPOSE
Provide (from a distance) patient support through digital technologies.

USE
Use mobile phones, SMS, Video-supported treatment for TB (VOT), Electronic Dose Monitors and 99DOTS to provide treatment adherence support to patients. These low-cost technologies allow patients and health care workers to be connected, monitor patients’ treatment, provide dosing instructions and differentiate care based on adherence data. Some of these adherence technologies will be piloted by KNCV for use in TB care from 2018-2020.

RESULTS
Increased patient treatment adherence and increased treatment success rates.

TIME
Estimated 1½ years to set up and pilot the digital application in-country.

BUDGET
5 weeks consultancy support over a period of 12-15 months including needs assessment, workshops for introduction of the technology and data utilization, technical support during the development and piloting of the digital adherence technology.

EVIDENCE/EXPERIENCE
The handbook describes several country level experiences with adherence technologies:
- Use of SMS in Kenya for TB and HIV treatment support (Page 14 -Box 2.1)
- Electronic dose monitors and 99DOTS for both DS-TB and DR-TB patients in India (Box 2.2, page 17)
- VOT for TB patients in the USA and Mexico (Box 2.3, page 21)
FOTOVOCES (PHOTOVOICES)

SOURCE
Fotovoces (Spanish)  
(TB CARE I)

PURPOSE
TB patients create a photo exhibition to explore their strengths, priorities, and worries related to their life and to the disease. The photo documentary is used to dialogue with community members, health care workers and policy makers about TB patients lives, the disease and the quality of care.

USE
The Community referral form will be used by the CHW or CV when referring a presumptive TB patient to the health facility. The form provides patient data, TB related signs and symptoms and by whom the patient is referred. The referral process is elaborated.

RESULTS
The images can reduce stigma and misconceptions around TB in the community and catalyze improvements in the quality of care from patients’ perspectives.

TIME
Production of the set of images takes 2-3 months, through weekly sessions with patients training them as photographers using photodocumentary.

BUDGET
For TOT, coach and printing of the photos, around 35,000 USD depending on local costs.

EVIDENCE/EXPERIENCE
The images and patient experiences produced by the group of involved patients are still used in the Dominican Republic (since 2012 TB CARE I) as a rotating exposition as well as in specific developed audiovisual materials in order to reduce stigma.
FROM THE INSIDE OUT

SOURCE
KNCV and The Work for change
www.end-stigma.com (Access to site in June 2018)

PURPOSE
Provide a thorough evidence-based and holistic approach to addressing self-stigma in people affected by TB or DR-TB.

USE
Training groups of 15-20 people with TB, using a participatory and adult learning approach.

RESULTS
Participants will experience empowerment from the inside out and the possibility of living a life realising their full potential.

TIME
3 days.

BUDGET
For 3 days of training for a group of 15-20 people.

EVIDENCE/EXPERIENCE
The tool will be piloted in 2018.
INTERNATIONAL STANDARDS FOR TUBERCULOSIS CARE (ISTC)

SOURCE

PURPOSE
To describe a widely accepted level of care that all practitioners, public and private, should seek to achieve in managing (presumptive) TB patients.

USE
National TB programs use the international standards to communicate with private and public providers, with patients and community organizations about the quality of TB diagnosis and care. These common standards are necessary to promote the effective engagement of all providers in delivering high quality care. Having generally agreed-upon standards will empower patients to evaluate the quality of care they are being provided. Good care for individuals with TB is also in the best interest of the community. The ISTC include standards for diagnosis, treatment, and public health responsibilities.

All people involved in TB control can use these standards to review and improve the quality of TB diagnosis and care by different stakeholders and the national TB guidelines.

RESULTS
Engagement of all care providers in providing quality TB care and empowerment of TB patients and communities to require quality care.

TIME
N/A.

BUDGET
N/A.

EVIDENCE/EXPERIENCE
The standards in the ISTC are all supported by existing WHO guidelines and policy statements, many of which had recently been developed using rigorous methodology, including systematic reviews.
INVENTORY STUDY

SOURCE
WHO (2012). Assessing tuberculosis under-reporting through inventory studies:
http://www.who.int/tb/publications/inventory_studies/en/

PURPOSE
To measure the extent to which diagnosed TB patients are notified, as a basis for certification or strengthening of TB surveillance, improved estimates of TB incidence and better diagnosis and treatment of TB patients.

USE
Inventory studies compare the number of TB patients meeting standard case definitions in all or in a sample of public and private health facilities with the records of TB patients notified to local and national authorities. Comparisons are made through a process called record-linkage, in which duplicate and unique records are identified. Depending on existing systems for data management, records can be linked either using existing databases or linkage may need to be preceded by special efforts (for a limited time period) to collect data on the number of patients diagnosed by all health-care providers in the country, or by all health-care providers in a random sample of well-defined geographical areas. In certain circumstances, the results from inventory studies can be combined with a type of modeling called capture-recapture analysis to estimate TB incidence.

RESULTS
A measurement of under-reporting in a geographical area

TIME
6 months.

BUDGET
US$ 120,000-300,000

EVIDENCE/EXPERIENCE
Several countries have conducted national inventory studies to measure TB under-reporting during the last decade, including the Netherlands (61), the UK, French Guiana (62), Egypt (63), Yemen (64), Iraq (65), Pakistan (66) and Kenya (67).
‘KNCV APPROACH TO IMPLEMENTATION OF EFFECTIVE CONTACT INVESTIGATION AND TREATMENT OF LATENT TUBERCULOSIS INFECTION’

SOURCE
KNCV Tuberculosis Foundation
connie.erkens@kncvtbc.org
(Document will be available in June 2018)

PURPOSE
To provide an operational guide to countries and KNCV consultants advising countries on the implementation and evaluation of CI policy and guidelines and best practices.

USE
Many TB programs incorporate CI as an important element of their care and prevention strategy in their national TB strategic plan. However few high burden countries implement the CI policy widely or systematically. This operational guide support national TB programs to

RESULTS
Countries committed to implement and improve CI practices will benefit from a practical approach and tools to develop, implement and step up CI practices, monitor implementation and assess the impact of CI at district level.

TIME
N/A.

BUDGET
N/A.

EVIDENCE/EXPERIENCE
This tool is under development and needs to be piloted. The approaches recommended by KNCV are based on published literature and WHO guidelines and referenced in the document where applicable.
LEAP MHEALTH TOOL

SOURCE
AMREF
www.leaphealthmobile.com

PURPOSE
Build capacity of community healthcare workers and mentor them on the job through mobile phone application.

USE
Leap is an mHealth platform, that is used to train CHWs and CVs, mentor them, and chat within the peer group to support each other. Leap provides training content, case studies, job aids, and reporting tools. Every country needs to develop its own training content for Leap.

RESULTS
The capacity of CHWs and CVs is built enabling them to perform better.

TIME
6-months to develop and pilot training content.

BUDGET
Technical support from a training specialist.
Leap support to install and use the mhealth technology.

EVIDENCE/EXPERIENCE
Leap is being used in Kenya for the training and mentoring of CHWs. An evaluation showed that the mLearning training is complementary to F2F learning in enhancing the skills and knowledge of CHWs. Source “Effectiveness of mobile learning and face-to-face approaches in training community volunteers in Kenya; a comparative study”.
MATCH: Mapping and Analysis for Tailored Disease Control and Health System Strengthening

SOURCE
KIT (2017). Mapping and Analysis for Tailored Disease Control and Health System Strengthening

PURPOSE
To identify most pertinent groups of missing TB patients throughout the pathway of care at sub-national level.

USE
MATCH employs existing data, makes it available to NTPs and other stakeholders for usage, builds capacity to analyze these data and supports the development of sub-national differentiated responses. Three components have been identified within the approach: (1) collating multiple sources of data linked to geographical areas; (2) analyzing these data to identify program weaknesses and challenges; (3) development of differentiated responses.

RESULTS
TB managers and coordinators can use this tool to gain insights into their data as well as analytical considerations required to better exploit available data which are routinely collected by the program. The stepwise analytical framework described will allow them to move beyond the common practice where a single national TB program strategy is used to mitigate the TB epidemic towards a more tailored and locally adaptive response strategy, fitted to the locally contextual needs and possibilities.

TIME
1-3 months.

BUDGET
$US 20,000-50,000.

EVIDENCE/EXPERIENCE
This tool was launched in October 2017 and is built on the wide experience of KIT. Since it has just been launched there is no systematic documentation of results.
PATIENT-CENTERED CARE PACKAGE

SOURCE
TB CARE I
http://www.challengetb.org/library/hss

PURPOSE
Tools that enable TB patients and communities to have their voices heard for patient-centered care.

USE
The package includes the PCA booklet defining the concepts of patient centered care and the principles of patient-centered care. The package includes also tools that assess, implement and M&E patient centered care: Quote TB Light, Patient Costing Tool, TB literacy toolkit.

RESULTS
Patient-centered care is an important aspect of quality TB prevention and care.

TIME
The time needed for the use of specific tools is mentioned under each section describing the tool.

BUDGET
Costs indications are mentioned under each specific tool.

EVIDENCE/EXPERIENCE
Different tools have been used in different countries, but there is no systematic documentation of results.
PATIENT PATHWAY ANALYSIS (PPA)

SOURCE

PURPOSE
The patient pathway analysis (PPA) methodology was developed to better understand the alignment between patient care seeking and TB service availability.

USE
The PPA aims to describe the steps TB patients take from the initial point of seeking care to the point of being cured. At the same time, the analysis reviews the availability of TB screening, diagnosis, and treatment at various levels of the health system.

RESULTS
The results can inform programmatic priority setting and planning for more patient-centered availability of services.

TIME
The process for completing a PPA is likely to require between 0.5 and 0.75 FTE staff between three to five weeks, depending on data availability.

BUDGET
US$ 7,500-12,000 (depending on staff needed, e.g., TB manager, epidemiologist, junior researcher etc.)

EVIDENCE/EXPERIENCE
In the Philippines, national and regional PPAs were undertaken with this methodology using existing national survey and NTP data [68]. The authors concluded that the PPA identified opportunities for strengthening access to care for all forms of TB and for accelerating the time to diagnosis by aligning services to where patients initiate care. Similar assessments were done in Kenya [69], Pakistan [70], and Indonesia [71].
PPM TOOLKIT

SOURCE
Challenge TB/Stop TB partnership/WHO

PURPOSE
The toolkit consists of 14 tools (the first 7 tools on basic aspects of PPM implementation, the other 7 tools on engagement of specific types of care providers):
1. Rationale and generic approach
2. National situation assessment
3. Operational guidelines
4. Advocacy, communication and social mobilization
5. Monitoring and evaluation
6. International Standards for Tuberculosis care
7. Resources and budgeting
8. Engaging private practitioners
9. Engaging hospitals
10. Engaging nongovernmental organizations
11. Engaging workplaces
12. Engaging social security organizations
13. Engagement for TB/HIV collaboration
14. Engagement for programmatic management of drug-resistant TB

USE
The WHO policy on engaging all care providers in TB care and control provides guidance on practical steps that countries should undertake to involve various providers in TB control efforts. There is no one-size-fits-all PPM approach. PPM should be planned based on a national situation assessment.
Main steps in the generic PPM approach:
1. A national situation assessment
2. Creating national resources for PPM
3. Developing national operational guidelines on PPM
4. Local implementation
5. Supervision and monitoring

RESULTS
- Enhanced quality of diagnosis, treatment and patient support
- Increased case detection and reduced diagnostic delays
- Improved and equitable access
- Reduced cost of care and financial protection for the poor
- Ensured gathering of essential epidemiological data
- Improved management capacity

TIME
For full assessment and development of guidelines and PPM operational plan: up to 1.5 years

BUDGET
Consultant(s) for PPM and costing

EVIDENCE/EXPERIENCE
No information available.
QUOTE TB LIGHT

SOURCE

PURPOSE
To assess the quality of TB/HIV Care through the eyes of patients and based on the results develop a plan for improvement of the quality of TB care in a district or region.

USE
Quote-TB Light is a qualitative standardized research method including Focus Group Discussions (FGDs) and individual interviews. The FGDs aim to rank the importance score on the nine quality dimensions of TB services (Professional competence, availability of TB services, patient-provider interaction and counseling, support, affordability, communication and information, infrastructure, TB/HIV, and stigma). The performance of these services is assessed through individual interviews resulting in a performance score. Multiplying the importance score by the performance score results in the Quality Impact score, indicating which are the highest priorities to act on so that TB services can be improved.

RESULTS
Reports describing the Quality Improvement Assessment Results. These results are discussed at facility, district and national level to develop plans for improvement.

TIME
1 year for protocol development, ethical approval, train researcher teams and district TB coordinators, research, reporting and feedback meetings.

BUDGET
Consultant for protocol development, training and mentoring of researchers.
Team of 2 researchers for each region involved for a period of 3 weeks.

EVIDENCE/EXPERIENCE
The quality dimensions were qualitatively tested and validated through statistical analysis. The tool was used in Nigeria, Ethiopia, Tanzania, Indonesia, Cambodia and Tajikistan.
TB LITERACY TOOLKIT

SOURCE
TB CARE I. TB Literacy Toolkit.
http://www.challengetb.org/library/hss

PURPOSE
Increase awareness on TB, treatment and what it takes to complete treatment.

USE
The TB Literacy toolkit comprises multimedia resources and materials for use by community health educators, outreach workers, counselors and health care providers for educating their communities about how to control TB. The tools are designed to educate TB and HIV patients, their care givers and their communities about TB and what it takes to complete TB treatment. Included in the kit are patient video stories and TB/HIV informational brochures.

RESULTS
TB patients and community members are aware about the TB disease, the treatment and their rights and responsibilities.

TIME
Depends on the scope, target groups and intensity of the education activities.

BUDGET
Health education specialist to review and revise the current education program and providing the Training of Trainers.

EVIDENCE/EXPERIENCE
The toolkit was widely used in Mozambique and the acceptance of the tool was high.
TRAINING TB PREVENTION AND CARE FOR COMMUNITY HEALTH WORKERS IN ZIMBABWE

SOURCE
Training on TB prevention and care for community health workers in Zimbabwe
http://www.challengetb.org/library/country

PURPOSE
Build the capacity on TB prevention and care of CHWs, health promoters and community volunteers working at community level and for their mentors

USE
The training package on TB prevention and care includes the training curriculum for a 4 days training and manuals for the facilitator and participants. This skills-building training is particularly about how to prevent TB among the most vulnerable in our community and how to support both patients and affected families. The training also covers topics on how to empower communities to become healthy communities, health education, patients’ rights and advocacy for patient centered care.

RESULTS
CHWs are better equipped to play their role in community TB prevention and care and contribute to strengthen community systems for TB control.

TIME
5 days Training of Trainers and 4 days training

BUDGET
5 days Training of Trainers with 2 trainers and 25 participants.
4 days Training for CHWs with 3 trainers and 25 participants.

EVIDENCE/EXPERIENCE
Developed and piloted in Zimbabwe and used as the national training curriculum for CHWs in tandem with the Community Guidelines. A total of 640 CHWs were trained using the training curriculum. The trained CHWs apply the skills obtained in the trainings to conduct effective awareness raising activities, health education as well as looking for potential TB cases in the communities. All this contributed to increased community contribution in TB case-finding (In 2016, community contribution was 9% of all notified TB cases, increasing to 17% in 2017) and case holding (The TB treatment success rate in 2016 was 81%, a significant proportion of patients (52%) were reported to have been supervised by trained CHWs for adherence support)
UNDERSTANDING AND CHALLENGING TB STIGMA, TOOLKIT FOR ACTION

SOURCE
Understanding and challenging TB stigma, toolkit for action; International HIV/AIDS Alliance and Zambart
http://targets.lshtm.ac.uk/resources/Publications/TB_and_Stigma_Eng2.pdf

PURPOSE
To help trainers plan and organize participatory educational sessions with community leaders or organized groups to raise awareness and promote practical action to challenge HIV and TB stigma and discrimination.

USE
The toolkit provides 8 training modules, exercises and background information to organize and facilitate stigma workshops for different groups.

RESULTS
Community leaders and other community groups have increased awareness and knowledge about TB stigma and willingness and skills to reduce TB stigma in their communities.

TIME
1 – 2 days.

BUDGET
One or two days’ workshop.

EVIDENCE/EXPERIENCE
No information available.
WHO TB SCREENING TOOL

SOURCE
WHO. Online Screen TB tool.
https://wpro.shinyapps.io/screen_tb/

http://apps.who.int/iris/bitstream/10665/181164/1/9789241549172_eng.pdf?ua=1&ua=1

PURPOSE
This tool is designed to aid in the design and prioritization of systematic TB screening programs among populations and groups of people at higher risk for TB. The tool uses the best available data in order to generate estimates of the size, yield, and cost of screening programs, specific to the group targeted for screening and the testing algorithm used.

USE
The tool is meant to be used as a preliminary prioritization activity, rather than for detailed planning. A head to head comparison of costs and yields of different screening and diagnostic approaches in different risk groups can be conducted using the tool. Users can vary some or all of the inputs to understand which strategies provide the best cost-benefit for a given country. Unlike other tools, this one makes the ethical risk of over-diagnosis transparent.

RESULTS
Estimates are generated of the size, yield, and cost of screening and diagnostics, specific to the group targeted for screening and the testing algorithm used.

TIME
1-3 days.

BUDGET
$US 500-1,000.

EVIDENCE/EXPERIENCE
The tool has been used in several countries such as Indonesia, DR Congo, and Botswana to inform NTPs on estimated false positive and negative patients, and numbers needed to screen to diagnose 1 patient simulating different screening algorithms. The modeling exercise guided in prioritizing risk groups, interventions and screening algorithms.
WHO TB EPIDEMIOLOGICAL REVIEW

SOURCE
http://www.who.int/tb/advisory_bodies/impact_measurement_taskforce/meetings/tf6_background_2c_epidemiological_reviews.pdf
WHO Standards and Benchmarks for tuberculosis surveillance and vital registration systems: http://www.who.int/iris/bitstream/10665/112673/1/9789241506724_eng.pdf?ua=1

PURPOSE
The TB epidemiological review aims to provide necessary background information to help understand the burden of TB disease and the characteristics of the TB epidemic in the country. It also seeks to provide an overview of the TB surveillance system and Monitoring and Evaluation (M&E) activities that are necessary to strengthen surveillance and measurement of TB burden.

USE
A wide variety of data are needed to complete the epi review, some of which are available from the NTP and some of which are available from open-access sources online. The epi-review is usually led by external consultants independent to the NTP, such as from WHO, CDC, KNCV, The Union or other organizations. Every national epi review team should involve key decision-makers, TB program managers and TB M&E staff.

RESULTS
It is best if a TB epi-review is scheduled before the development or revision of the National Strategic Plan or the Global Fund Concept Note (e.g., during a TB Program Review), as the review generates important evidence to support data-driven decision making and provides specific recommendations along with an investment plan to strengthen the M&E system.

TIME
1 month 1 FTE external staff (2 weeks field assessment, 2-3 weeks preparation and report writing), 2 weeks 1 FTE NTP M&E staff.

BUDGET
US$ 20,000-30,000.

EVIDENCE/EXPERIENCE
This tool has been used for epidemiological reviews in numerous countries. In 2017, KNCV used this tool in Nigeria, Swaziland, and Tanzania.