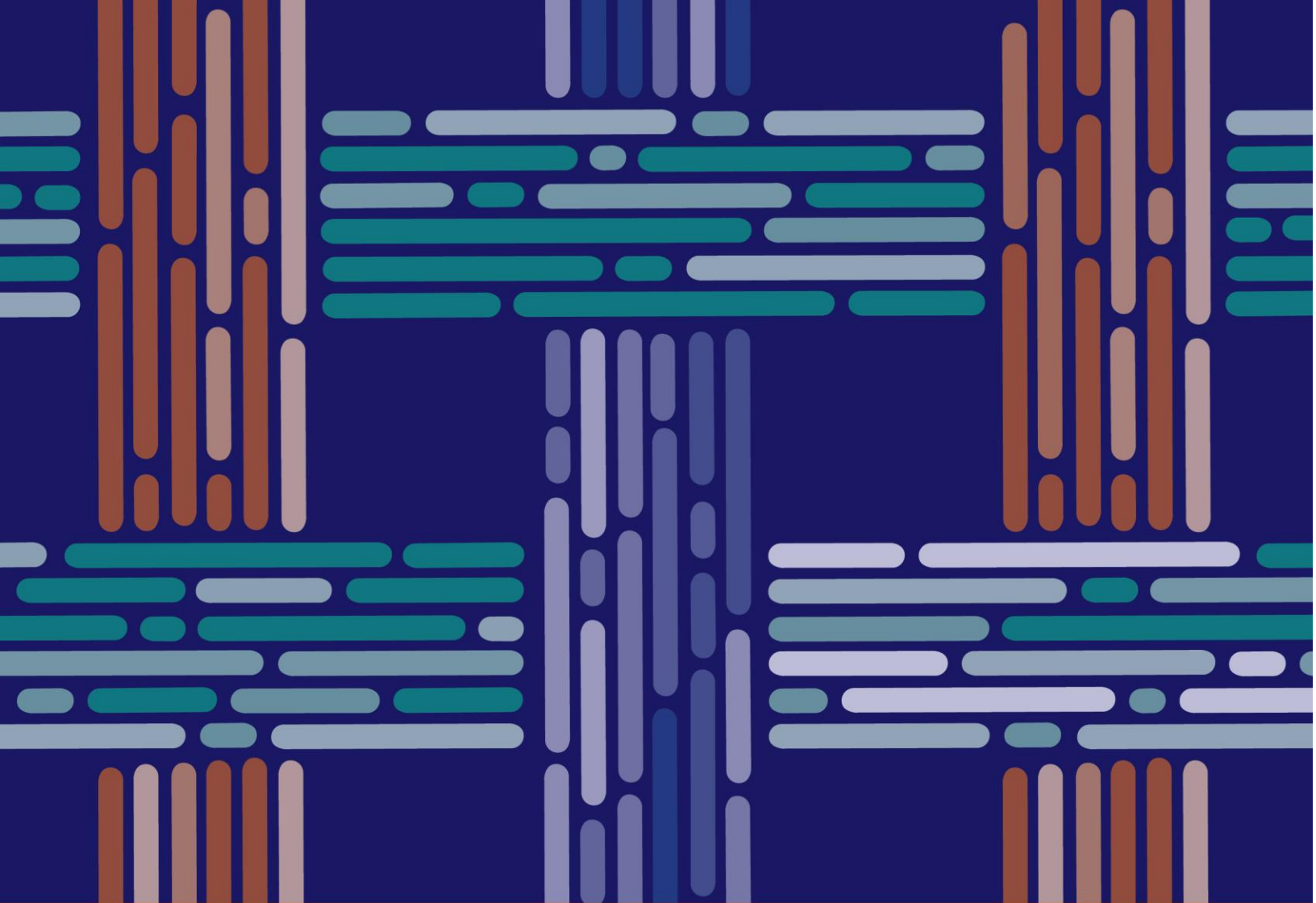




Quality of Tuberculosis Services Assessment

Global Tools

May 2020



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ABBREVIATIONS

AFB	acid-fast bacilli
ART	antiretroviral therapy
ARV	antiretroviral
CAD4TB	diagnosis of tuberculosis by computer assisted digital X-ray
CHW	community health workers
DK	don't know
DOT	direct observation of treatment
DR-TB	drug-resistant tuberculosis
DS-TB	drug-susceptible tuberculosis
DST	drug-susceptibility testing
ECG	electrocardiogram
FBO	faith-based organization
FDC	fixed-dose combination
FM	fluorescence microscope
INH	isoniazid
IRIS	immune reconstitution inflammatory syndrome
JSI	John Snow, Inc.
LED	light-emitting diode
LPA	line probe assay
MCH	maternal and child health
MDR-TB	multidrug-resistant tuberculosis
MGIT	Mycobacteria Growth Indicator Tube
MTB	mycobacterium tuberculosis
NGO	nongovernmental organization
NR	no response
NTP	National Tuberculosis Control Program
PLHIV	people living with HIV/AIDS
QA	quality assurance
QC	quality control

QTSA	Quality of TB Services Assessment
RIF	rifampin
RR-TB	rifampicin-resistant tuberculosis
SOP	standard operation procedure
3HP	combination of rifapentine and isoniazid
TPT	tuberculosis preventive therapy
Unk	unknown
USAID	United States Agency for International Development
WHO	World Health Organization

INTRODUCTION

The Quality of Tuberculosis Services Assessment (QTSA) is conducted with the support of four tools: the Facility Audit, the Provider Interview, the Patient Interview, and the Register Review. MEASURE Evaluation—a project funded by the United States Agency for International Development (USAID)—developed these four tools with the assistance of colleagues at USAID.

These tools exist in a generic format that demonstrates the content and topics covered in the QTSA. They are not meant to be used without proper adaptation by a country. For instance, some countries may have different names for their health administrative units (e.g., district, province, ward, or woreda) or the name of their tuberculosis (TB) registers (e.g., TB patient logbook, TB confirmed cases register). The tools must be customized to fit the country priorities and context in which they will be used. Note that these tools were designed to be administered electronically and may need to be restructured if used in hard copy format.

A short description of each tool is provided below:

Facility Audit

The facility audit is administered to the individual(s) in charge of the health facility unit, TB focal person(s), and/or others who have knowledge of TB services to determine the availability and functionality of the facility infrastructure, equipment, and resources expected to serve TB clients with high-quality care. The facility audit targets the structural factors and the process of the quality of care dimensions.

Provider Interview

The provider interview is administered to the individual(s) in charge of the health facility, TB focal person(s), and/or staff in charge of TB-related services to understand the clinical processes of TB counseling, diagnosis, and treatment. This tool evaluates the technical competence, knowledge, and practices of the provider in clinical procedures and management of TB services.

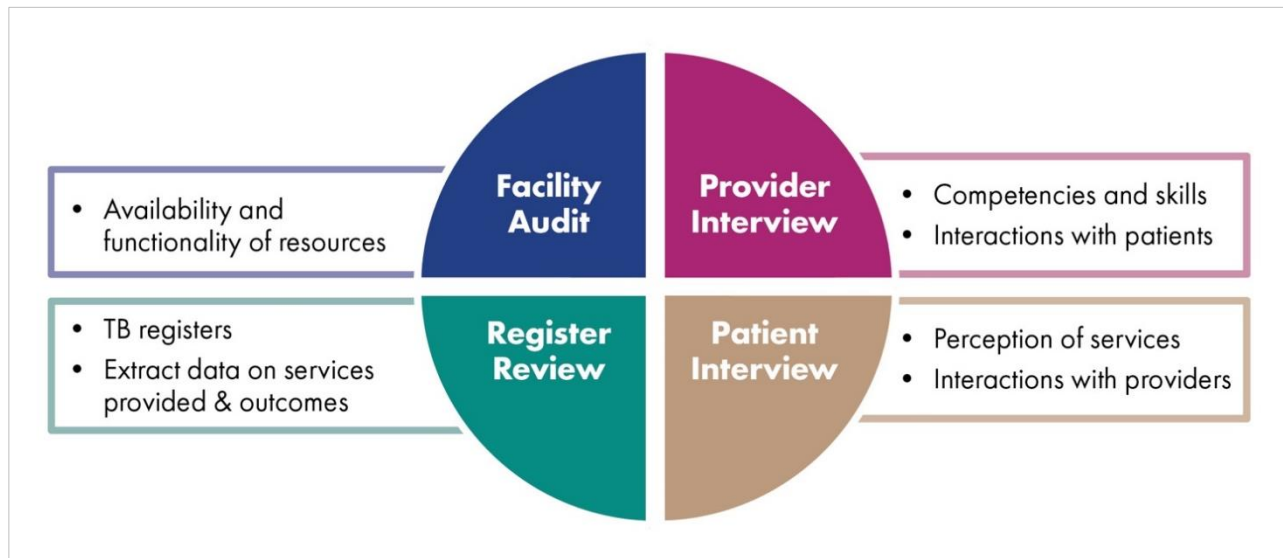
Patient Interview

The patient interview is administered to TB patients receiving diagnosis, care, and/or treatment to collect information about the client's experience at the health facility or service delivery point. It provides data on the client's perspective of the quality of service related to the TB program.

Register Review

The register review involves the extraction of data using the appropriate registers (e.g., laboratory registers and TB treatment registers) to record patient outcomes and services provided.

Figure 1. Overview of the survey tools



This document presents detailed information about the structure and content of the tools. It also includes a generic version of all the associated consent and assent forms needed.

More information on the QTSA purpose, methods, and steps for implementation can be found in the QTSA Global Implementation Guide: <https://www.measureevaluation.org/resources/publications/ms-19-170/>

MEASURE Evaluation also adapted the QTSA tools for use in several country assessments. These examples are available here: <https://www.measureevaluation.org/our-work/tuberculosis/quality-of-tb-services-assessments>

QUALITY OF TB SERVICES ASSESSMENT: FACILITY AUDIT

Before the site visit to the facility, ensure that the staff members that are best able to answer the questions are available. Some of the staff that may be required include manager or in charge for clinical services, TB designated staff, pharmacist, laboratory scientist, etc.

Start of Facility Visit					
		(a) Visit Date	(b) Visit Start Time [Use the 24-hour clock system, e.g., 14:30]	(c) Interviewer ID	(d) Interviewer Name
001	Visit 1	___/___/___	Hours Minutes		_____
002	Visit 2 (if needed)	___/___/___	Hours Minutes		_____

Facility Identification		
*ADAPT PRIOR TO IMPLEMENTATION TO REFLECT STRUCTURE OF ADMINISTRATIVE LEVELS		
		(a) Code (b) Name
010	Region/province/state (Level 1)	_____
011	District/county (Level 2)	_____
012	Facility	_____
013	Location of facility _____	

Facility Structure				
	[OBSERVE THE FACILITY OR WHERE TB SERVICES ARE DELIVERED AND INDICATE WHETHER THERE ARE SIGNS (E.G., CHEST CLINIC, PULMONARY SERVICES, ETC.) ANNOUNCING AVAILABILITY OF TB SERVICES AT EACH OF THE FOLLOWING LOCATIONS] *ADAPT PRIOR TO IMPLEMENTATION	Yes	No	DK
020	Outside the building	1	0	88
021	Inside the building	1	0	88
022	On the door of the TB unit	1	0	88

The staff member who is best able to answer the questions in the following sections is either the **TB focal person** or the **in-charge for clinical services**

1. Facility Characteristics			
*ADAPT PRIOR TO IMPLEMENTATION TO REFLECT STRUCTURE OF HEALTHCARE SYSTEM			
1.1	Facility Classification		
1.1.1	What type of facility is this?	Primary 1 Secondary 2 Tertiary 3	
1.1.2	Who is the managing authority of the TB clinic?	Government/public 1 Military/paramilitary 2 NGO/not-for-profit 3 Private, for-profit 4 Mission/faith-based 5 Other (specify) 96	
1.1.3	Is this location considered urban, peri-urban, or rural?	Urban 1 Peri-urban 2 Rural 3	
1.1.4	Does this facility provide outpatient or inpatient services, or both?	Outpatient only 1 Inpatient only 2 Both inpatient and outpatient 3	
1.2	Facility Capacity		
1.2.1	On average, how many patients are seen at this facility during a typical month? [ENTER VALID RANGE]	Number of patients .. Don't know 888	
1.2.2	Out of these patients, how many are TB patients? [PROBE: How many patients are evaluated or treated for TB during a typical month?] [ENTER VALID RANGE]	Number of patients .. Don't know 888	
1.2.3	How many staff are working in this facility (full- or part-time) as of the first of the year? [ENTER VALID RANGE]	Number of staff Don't know 888	
1.2.4	Out of these staff, how many usually work full-time in the TB unit or interact with TB patients? [ENTER VALID RANGE]	Number of staff Don't know 888	
1.2.5	How many usually work part-time in the TB unit or interact with TB patients? [ENTER VALID RANGE]	Number of staff Don't know 888	

2. Availability of TB Services			
	I would like to ask about TB services that are currently available at this facility.		
2.1	Does this facility provide any form of screening for TB?	Yes No	1 0
2.1.1	[ASK ONLY IF 2.1=YES] Does this facility provide screening for TB by clinical symptoms and signs?	Yes No	1 0
2.1.2	[ASK ONLY IF 2.1=YES] Does this facility provide screening for TB by X-ray?	Yes No	1 0
2.1.2.1	[ASK ONLY IF 2.1.2=YES] Are patients charged a fee for screening X-rays?	Yes No	1 0
2.2	Does this facility provide TB diagnosis services?	Yes No	1 0
[ASK THE NEXT 3 QUESTIONS ONLY IF 2.2=YES]			
2.2.1	Does this facility provide diagnosis services for children?	Yes No	1 0
2.2.2	Is there an onsite laboratory for TB diagnosis at this TB facility (unit or clinic)? *ADAPT PRIOR TO IMPLEMENTATION	Yes No	1 0
2.2.3	Does this facility request a sputum sample from new presumptive TB clients?	Yes No	1 0
2.2.4	[ASK ONLY IF 2.2=NO] Does this facility collect sputum specimens of persons presumed to have TB to send to an offsite diagnostic laboratory for testing?	Yes No	1 0
2.3	Does this facility provide any HIV-related services, such as counseling, testing, care, or treatment?	Yes No	1 0
2.4	Do providers in this facility prescribe treatment for TB or manage patients who are on TB treatment?	Yes No	1 0
[ASK THE NEXT 3 QUESTIONS ONLY IF 2.4=YES]			
2.4.1	Are patients charged a fee for TB medicines?	Yes No	1 0
2.4.2	Does this facility provide TB treatment services to children?	Yes No	1 0
2.4.3	Does this facility provide treatment for drug-resistant TB (DR-TB)?	Yes No	1 0
2.4.3.1	[ASK ONLY IF 2.4.3=NO] (a) Has this facility referred patients elsewhere for second-line treatment for DR-TB in the past 12 months?	Yes No Don't know	1 0 88
	[ASK ONLY IF 2.4.3.1 (a)=YES] (b) Is there a record or register of the patient referrals for second-line treatment for DR-TB?	Yes, electronic Yes, paper No Don't know	2 1 0 88

2. Availability of TB Services			
	[ASK ONLY IF 2.4.3.1 (b)=YES (1 or 2)] (c) Are the results recorded?	Yes, observed No, observed Not seen Don't know	2 1 0 88
2.5	Some health facilities use community-based health workers (CHWs) to provide additional support to TB patients. Does this facility work with CHWs or volunteers who support TB patients?	Yes No	1 0
2.6	(a) Has this facility referred patients elsewhere for management of other medical conditions, e.g., diabetes, etc. in the past 12 months?	Yes No Don't know	1 0 88
	[ASK ONLY IF 2.6 (a)=YES] (b) Is there a record or register of the patient referrals for the management of other medical conditions?	Yes, electronic Yes, paper No Don't know	2 1 0 88
	[ASK ONLY IF 2.6 (b)=YES (1 or 2)] (c) Are the results recorded?	Yes, observed No, observed Not seen Don't know	2 1 0 88
2.7	Does this facility provide transport assistance?	Yes No	1 0
2.8	Typically, how many days per week are TB-related services offered?	Days Don't know	88
2.9	Approximately, how many years have TB-related services been available at this facility? [ENTER EXACT NUMBER OF YEARS; IF LESS THAN 1 YEAR, ENTER "0"; IF GREATER THAN 25 YEARS, ENTER "25"] *ADAPT PRIOR TO IMPLEMENTATION—USE REASONABLE RANGE AND CAP AT MAXIMUM	Years Don't know	88

3. TB Diagnosis [ASK ONLY IF 2.2=YES (diagnostic facility)]				
3.1	TB Diagnosis Methods *ADAPT PRIOR TO IMPLEMENTATION			
	Now, I will ask if this facility provides specific TB diagnosis services. For each service, I would like to know whether this facility offered the service at any time in the past 12 months.	Offered last 12 months?		
		Yes	No	DK
3.1.1	Diagnosis of TB by clinical symptoms and signs	1	0	88
3.1.2	Diagnosis of TB by X-ray	1	0	88
	[ASK THE NEXT 4 QUESTIONS ONLY IF 3.1.2=YES]			
3.1.2.1	Diagnosis of TB by conventional X-ray	1	0	88
3.1.2.2	Diagnosis of TB by digital X-ray	1	0	88
3.1.2.3	Diagnosis of TB by computer assisted digital X-ray (CAD4TB)	1	0	88
3.1.2.4	Are patients charged a fee for diagnostic X-rays?	1	0	88
3.1.3	Diagnosis of TB by smear microscopy	1	0	88

3. TB Diagnosis [ASK ONLY IF 2.2=YES (diagnostic facility)]				
		Yes	No	DK
3.1.4	Diagnosis of TB by culture	1	0	88
3.1.5	Diagnosis of TB by GeneXpert	1	0	88
3.1.6	Diagnosis of TB by another method (specify) _____	1	0	88
3.1.7	[ASK ONLY IF 3.1.3=NO/DK OR 3.1.5=NO/DK]		Yes	1
	(a) Has this facility referred patients elsewhere for TB diagnosis, either via smear microscopy or GeneXpert, in the past 12 months?		No	0
			Don't know	88
	[ASK ONLY IF 3.1.7 (a)=YES]		Yes, electronic	2
	(b) Is there a record or register of the patient referrals for TB diagnosis?		Yes, paper	1
			No	0
			Don't know	88
	[ASK ONLY IF 3.1.7 (b)=YES (1 or 2)]		Yes, observed	2
	(c) Are the results recorded?		No, observed	1
		Not seen	0	
		Don't know	88	
3.2 Drug Susceptibility Testing (DST)				
		Yes	No	DK
3.2.1	Is first-line drug susceptibility testing available at this facility?	1	0	88
	[ASK THE NEXT 5 QUESTIONS ONLY IF 3.2.1=YES]	Yes	No	DK
	What methods are used to detect resistance to first-line drugs?			
3.2.1.1	GeneXpert) to detect resistance to Rifampicin	1	0	88
3.2.1.2	Line probe assays (e.g., MTBDRplus to MTBDRsl)	1	0	88
3.2.1.3	Solid culture	1	0	88
3.2.1.4	Liquid culture	1	0	88
3.2.1.5	Any other method used to detect resistance to first-line drugs? (specify) _____	1	0	88
3.2.2	Is second-line drug susceptibility testing available at this facility?	1	0	88
	[ASK THE NEXT 4 QUESTIONS ONLY IF 3.2.2=YES]	Yes	No	DK
	What methods are used to detect resistance to second-line drugs?			
3.2.2.1	Line probe assays (e.g., MTBDRplus to MTBDRsl)	1	0	88
3.2.2.2	Solid culture	1	0	88
3.2.2.3	Liquid culture	1	0	88
3.2.2.4	Any other method used to detect resistance to second-line drugs? (specify) _____	1	0	88
3.2.3	[ASK ONLY IF 3.2.1=NO/DK OR 3.2.2=NO/DK]		Yes	1
	(a) Has this facility referred patients elsewhere for DR-TB diagnosis, e.g., drug sensitivity testing, in the past 12 months?		No	0
			Don't know	88
	[ASK ONLY IF 3.2.3 (a)=YES]		Yes, electronic	2
	(b) Is there a record or register of the patient referrals for DR-TB diagnosis?		Yes, paper	1
			No	0
		Don't know	88	

3. TB Diagnosis [ASK ONLY IF 2.2=YES (diagnostic facility)]				
	[ASK ONLY IF 3.2.3 (b)=YES (1 or 2)] (c) Are the results recorded?	Yes, observed	2	
		No, observed	1	
		Not seen	0	
		Don't know	88	
3.3	TB Case Notification *ADAPT PRIOR TO IMPLEMENTATION			
		Yes	No	DK
3.3.1	Does this facility report TB patients to the NTP?	1	0	88
3.3.2	[ASK ONLY IF 3.3.1=NO OR DK] Does this facility keep a record of TB case notifications?	1	0	88
3.3.2.1	[ASK ONLY IF 3.3.2=YES] How are TB case notifications recorded? _____			

4. Contact Investigation and Management				
	The next couple of questions are about contact investigation and management. I would like to know whether this facility offered the following services at any time in the past 12 months.	Yes	No	DK
4.1	Contact investigation and management according to TB program guidelines	1	0	88
	[ASK THE NEXT 2 QUESTIONS ONLY IF 4.1=YES] *ADAPT PRIOR TO IMPLEMENTATION			
4.1.1	For adult contacts	1	0	88
4.1.2	For child contacts	1	0	88

5. TB/HIV Services [ASK ONLY IF 2.3=YES (facility provides TB/HIV services)]				
	Now, I will ask if the facility provides specific TB/HIV services. For each service, I would like to know whether this facility offered the service at any time in the past 12 months.	Offered last 12 months?		
		Yes	No	DK
5.1	HIV testing and counseling for presumptive TB patients	1	0	88
5.2	HIV testing and counseling for confirmed TB patients	1	0	88
5.3	[ASK ONLY IF 5.1=YES OR 5.2=YES] Recency testing for HIV	1	0	88
5.4	[ASK ONLY IF 5.1=NO/DK OR 5.2=NO/DK] (a) Has this facility referred patients elsewhere for HIV testing and counseling in the past 12 months?	Yes	1	
		No	0	
		Don't know	88	
	[ASK ONLY IF 5.4 (a)=YES] (b) Is there a record or register of the patient referrals for HIV testing and counseling?	Yes, electronic	2	
		Yes, paper	1	
		No	0	
		Don't know	88	

5. TB/HIV Services [ASK ONLY IF 2.3=YES (facility provides TB/HIV services)]								
	[ASK ONLY IF 5.4 (b)=YES (1 or 2)] (c) Are the results recorded?			Yes, observed	2			
				No, observed	1			
				Not seen	0			
				Don't know	88			
				Yes	No	DK		
5.5	TB preventive therapy			1	0	88		
	[ASK THE NEXT 4 QUESTIONS ONLY IF 5.5=YES] What type of TB preventive therapy (TPT) is available at this site? *ADAPT PRIOR TO IMPLEMENTATION PER NATIONAL AIDS PROGRAM GUIDELINES			Yes	No	DK		
5.5.1	INH (6, 9, 12 months or continuous)			1	0	88		
5.5.2	3HP (rifapentine and isoniazid)			1	0	88		
5.5.3	Q-TIB			1	0	88		
5.5.4	Is TPT available through a differentiated service delivery model (e.g., community support group, multi-month scripting, etc.)?			1	0	88		
5.5.5	[ASK ONLY IF 5.5=NO/DK] (a) Has this facility referred patients elsewhere for TB preventive therapy in the past 12 months?			Yes	1			
				No	0			
				Don't know	88			
	[ASK ONLY IF 5.5.5 (a)=YES] (b) Is there a record or register of the patient referrals for TB preventive therapy?			Yes, electronic	2			
				Yes, paper	1			
				No	0			
				Don't know	88			
	[ASK ONLY IF 5.5.5 (b)=YES (1 or 2)] (c) Are the results recorded?			Yes, observed	2			
				No, observed	1			
				Not seen	0			
				Don't know	88			
				Yes	No	DK		
5.6	HIV care and treatment services to TB/HIV coinfecting patients			1	0	88		
	[ASK THE NEXT 3 QUESTIONS ONLY IF 5.6=YES]							
5.6.1	CPT for TB/HIV coinfecting patients			1	0	88		
5.6.2	Viral load testing for TB/HIV co-infected patients			1	0	88		
5.6.3	ART for TB/HIV coinfecting patients			1	0	88		
5.6.3.1	[ASK ONLY IF 5.6.3=YES] Screening for symptoms of anti-TB and ARV drug interactions			1	0	88		
	[ASK THE NEXT 2 QUESTIONS ONLY IF 5.6.3.1=YES]							
	Do staff members provide the following information to TB/HIV coinfecting patients on ART and if so, is the information provided verbally and/or by written patient literacy materials?	(a) Provide information?			[ASK ONLY IF (a)=YES] (b) How is information provided?			
		Yes	No	DK	Verbally	Written	Both	DK
5.6.3.1.1	What to do if patients experience anti-TB and ARV drug interactions	1	0	88	1	2	3	88
5.6.3.1.2	What to do if signs and symptoms of immune reconstitution inflammatory syndrome (IRIS) become evident	1	0	88	1	2	3	88

6. TB Treatment Services [ASK ONLY IF 2.4=YES (treatment facility)]							
6.1 Available Services							
	Now, I will ask if the facility provides specific TB treatment services. For each service, I would like to know whether this facility offered the service at any time in the past 12 months.	Offered last 12 months?					
		Yes	No	DK			
6.1.1	Prescription of drugs for TB treatment	1	0	88			
6.1.2	TB treatment and follow-up during the intensive phase	1	0	88			
6.1.3	TB treatment and follow-up during the continuation phase	1	0	88			
6.1.4	Facility-based direct observation of treatment (DOT)	1	0	88			
6.1.5	Community-based DOT *ADAPT PRIOR TO IMPLEMENTATION	1	0	88			
6.1.6	Video DOT *ADAPT PRIOR TO IMPLEMENTATION	1	0	88			
6.1.7	Home-based treatment *ADAPT PRIOR TO IMPLEMENTATION	1	0	88			
6.1.8	Reminder phone calls or SMS texts to support patients' adherence to treatment *ADAPT PRIOR TO IMPLEMENTATION	1	0	88			
6.1.9	Psychosocial or other adherence support	1	0	88			
[ASK THE NEXT 3 QUESTIONS ONLY IF 6.1.9=YES]							
6.1.9.1	Counseling with a psychologist or social worker	1	0	88			
6.1.9.2	One-on-one counseling (face-to-face) by medical staff (doctor or nurse)	1	0	88			
6.1.9.3	One-on-one peer counseling (face-to-face) by lay counselor	1	0	88			
6.1.10	Nutritional support or food baskets	1	0	88			
6.1.11	Support group for TB patients	1	0	88			
6.1.12	Patient tracking of those who miss an appointment	1	0	88			
6.1.12.1	[ASK ONLY IF 6.1.12=YES] Follow-up phone calls or SMS texts to TB patients if they miss an appointment *ADAPT PRIOR TO IMPLEMENTATION	1	0	88			
6.1.12.2	[ASK ONLY IF 6.1.12=YES] Home visits to TB patients if they miss an appointment	1	0	88			
6.2 Treatment Practices							
	Now, I will ask you about TB treatment practices at this facility.	Yes	No	DK			
6.2.1	Does this facility review the progress of each TB patient registered for treatment at the facility at least once a month during the treatment period?	1	0	88			
6.2.2	Do you ask patients about symptoms of drug side effects when they visit the facility for treatment?	1	0	88			
6.2.2.1	[ASK ONLY IF 6.2.2=YES] Do you capture all reported side effects in the patient's chart?	1	0	88			
6.2.2.2	[ASK ONLY IF 6.2.2=YES] How often are patients screened for side effects? *ADAPT PRIOR TO IMPLEMENTATION	At every follow-up visit to the facility 1 Only during the initiation phase 2 Don't know 88 Other (specify) 96					
6.2.3	Do you have ancillary medications to manage side effects?	1	0	88			
6.3 Patient Counseling and Education on TB Treatment							
	Do staff members provide the following information to TB patients and if so, is the information provided verbally and/or by written patient literacy materials?	(a) Provide information?			[ASK ONLY IF (a)=YES] (b) How is information provided?		
		Yes	No	DK	Verbally	Written	Both DK
6.3.1	What test results mean	1	0	88	1	2	3 88
6.3.2	How TB is spread to others	1	0	88	1	2	3 88

6. TB Treatment Services [ASK ONLY IF 2.4=YES (treatment facility)]								
		Yes	No	DK	Verbally	Written	Both	DK
6.3.3	The need for a treatment supporter	1	0	88	1	2	3	88
6.3.4	How TB medication should be taken, e.g., dosage, frequency, etc.	1	0	88	1	2	3	88
6.3.5	The importance of treatment adherence	1	0	88	1	2	3	88
6.3.6	Options available for treatment support, e.g., DOT	1	0	88	1	2	3	88
6.3.7	What to do when experiencing side effects	1	0	88	1	2	3	88
6.3.8	What to do if they run out of medicines	1	0	88	1	2	3	88
6.3.9	What to do if they need to leave for more than a month to an area beyond the facility catchment area *ADAPT PER NTP GUIDELINES ON TRANSFERS DURING TB TREATMENT	1	0	88	1	2	3	88
6.3.10	Is there a private room available for individual counseling where no one can hear or see what is going on?				Yes No Don't know			1 0 88
6.4	Patients Taking Treatment without Facility Supervision							
	The next couple of questions ask about TB patients taking treatment without the supervision of a health professional from the facility (for example, someone who is taking treatment supervised by their family).							
6.4.1	How often do these TB patients taking treatment typically collect their medications?				Weekly Twice a month Monthly Don't know Other (specify)			1 2 3 88 96
6.4.2	Does the facility monitor the intervals at which the patient should collect treatment?				Yes No Don't know			1 0 88
6.4.2.1	[ASK ONLY IF 6.4.2=YES] How does the facility monitor the intervals at which the patient should collect treatment? *ADAPT PRIOR TO IMPLEMENTATION				Check empty blisters Phone call SMS Through the patient card Don't know Other (specify)			1 2 3 4 88 96

7. DR-TB Treatment Services [ASK ONLY IF 2.4.3=YES (facility provides DR-TB treatment)] *ADAPT PRIOR TO IMPLEMENTATION			
	The next set of questions asks about the DR-TB treatment services at this facility.		
7.1	What is the preferred DR-TB treatment regimen to use at this facility? *ADAPT PRIOR TO IMPLEMENTATION	Standard WHO long regimen Standard shorter regimen with injectables Shorter modified regimen without injectables Don't know Other (specify)	1 2 3 88 96

7. DR-TB Treatment Services [ASK ONLY IF 2.4.3=YES (facility provides DR-TB treatment)]				
*ADAPT PRIOR TO IMPLEMENTATION				
	Which DR-TB treatment regimens are available at this facility? *ADAPT PRIOR TO IMPLEMENTATION	Yes	No	DK
7.2.1	Standard WHO long regimen	1	0	88
7.2.2	Standard shorter regimen with injectables	1	0	88
7.2.3	Shorter modified regimen without injectables	1	0	88
7.2.4	Other (specify) _____	1	0	88
7.3 Standard WHO Long Regimen [ASK ONLY IF 7.2.1=YES]				
	Which medications are used in this regimen? [INSERT LIST OF MEDICATIONS IN REGIMEN]	Yes	No	DK
7.3.1		1	0	88
7.3.2		1	0	88
7.3.3		1	0	88
7.3.x		1	0	88
7.3.x+1	Other (specify) _____	1	0	88
	[ASK ONLY IF 7.2.1=YES] Which patients are eligible for this regimen? *ADAPT PRIOR TO IMPLEMENTATION—CHECK GUIDELINES FOR ANSWERS	Yes	No	DK
7.3.8.1	Those with confirmed resistance or suspected ineffectiveness to a medicine in the shorter MDR-TB regimen (except isoniazid resistance)	1	0	88
7.3.8.2	Those with exposure to any of the second-line medicines in the shorter MDR-TB regimen for >1 month	1	0	88
7.3.8.3	Those with an intolerance or risk of toxicity (e.g., drug-drug interactions) to any of the medicines in the shorter MDR-TB regimen	1	0	88
7.3.8.4	Females who are pregnant	1	0	88
7.3.8.5	Those with extrapulmonary disease	1	0	88
7.3.8.6	Other (specify) _____	1	0	88
7.3.9	[ASK ONLY IF 7.2.1=YES] What is the usual duration of this regimen? [ENTER 6–30]	Months Don't know		88
7.4 Shorter Standard Regimen [ASK ONLY IF 7.2.2=YES]				
	Which medications are used in this regimen? [INSERT LIST OF MEDICATIONS IN REGIMEN]	Yes	No	DK
7.4.1		1	0	88
7.4.2		1	0	88
7.4.3		1	0	88
7.4.x		1	0	88
7.4.x+1	Other (specify) _____	1	0	88

7. DR-TB Treatment Services [ASK ONLY IF 2.4.3=YES (facility provides DR-TB treatment)]				
*ADAPT PRIOR TO IMPLEMENTATION				
	[ASK ONLY IF 7.2.2=YES] Which patients are eligible for this regimen? *ADAPT PRIOR TO IMPLEMENTATION—CHECK GUIDELINES FOR ANSWERS	Yes	No	DK
7.4.8.1	Those with no resistance or suspected ineffectiveness to a medicine in the shorter MDR-TB regimen (except isoniazid resistance)	1	0	88
7.4.8.2	Those with no exposure to any of the second-line medicines in the shorter MDR-TB regimen for >1 month	1	0	88
7.4.8.3	Those with no intolerance to any medicine in the shorter MDR-TB regimen or risk of toxicity from a medicine in the shorter regimen (e.g., drug-drug interactions)	1	0	88
7.4.8.4	Females who are not pregnant	1	0	88
7.4.8.5	Those with no extrapulmonary disease	1	0	88
7.4.8.6	Other (specify) _____	1	0	88
7.4.9	[ASK ONLY IF 7.2.2=YES] What is the usual duration of this regimen? [ENTER 6-20]	Months Don't know		88
7.5 Shorter Modified Regimen without Injectables [ASK ONLY IF 7.2.3=YES]				
	Which medications are used in this regimen? [INSERT LIST OF MEDICATIONS IN REGIMEN]	Yes	No	DK
7.5.1		1	0	88
7.5.2		1	0	88
7.5.3		1	0	88
7.5.x		1	0	88
7.5.x+1	Other (specify) _____	1	0	88
	[ASK ONLY IF 7.2.3=YES] Which patients are eligible for this regimen? *ADAPT PRIOR TO IMPLEMENTATION—CHECK GUIDELINES FOR ANSWERS	Yes	No	DK
7.5.8.1		1	0	88
7.5.8.2		1	0	88
7.5.8.3		1	0	88
7.5.8.x		1	0	88
7.5.8.x+1	Other (specify) _____	1	0	88
7.5.9	[ASK ONLY IF 7.2.3=YES] What is the usual duration of this regimen? [ENTER 6-20]	Months Don't know		88
7.6 Other Regimen [ASK ONLY IF 7.2.4=YES]				
	Which medications are used in this regimen? [INSERT LIST OF MEDICATIONS IN REGIMEN]	Yes	No	DK
7.6.1		1	0	88
7.6.2		1	0	88
7.6.3		1	0	88
7.6.x		1	0	88
7.6.x+1	Other (specify) _____	1	0	88

7. DR-TB Treatment Services [ASK ONLY IF 2.4.3=YES (facility provides DR-TB treatment)]				
*ADAPT PRIOR TO IMPLEMENTATION				
	[ASK ONLY IF 7.2.4=YES] Which patients are eligible for this regimen? *ADAPT PRIOR TO IMPLEMENTATION—CHECK GUIDELINES FOR ANSWERS	Yes	No	DK
7.6.8.1		1	0	88
7.6.8.2		1	0	88
7.6.8.3		1	0	88
7.6.8.x		1	0	88
7.6.8.x+1	Other (specify) _____	1	0	88
7.6.9	[ASK ONLY IF 7.2.4=YES] What is the usual duration of this regimen? [ENTER 6–30]	Months Don't know		88
7.7	Ancillary Drugs			
		Yes	No	DK
7.7.1	Does this facility have ancillary drugs for management of side effects?	1	0	88
	[ASK ONLY IF 7.7.1=YES] Which ancillary drugs are available? [INSERT STANDARD DRUGS THAT SHOULD BE AVAILABLE]	Yes	No	DK
7.7.1.1		1	0	88
7.7.1.2		1	0	88
7.7.1.3		1	0	88
7.7.1.x		1	0	88
7.7.1.x+1	Other (specify) _____	1	0	88
7.7.2	Does this facility participate in active pharmacovigilance, e.g., active TB drug-safety monitoring and management (aDSM)?	1	0	88
7.8	DR-TB Treatment Equipment			
7.8.1	Does this facility have at least one electrocardiogram (ECG) machine? [OBSERVE]	Yes, observed Yes, not observed No Don't know		2 1 0 88
7.8.1.1	[ASK ONLY IF 7.8.1=YES, OBSERVED] Is the machine working?	Yes No Don't know		1 0 88
7.8.1.2	[ASK ONLY IF 7.8.1=YES (1 or 2)] How many ECGs are performed per week, on average? [ENTER VALID RANGE]	Number Don't know		88
7.8.2	Does this facility have audiometry equipment? [OBSERVE]	Yes, observed Yes, not observed No Don't know		2 1 0 88
7.8.2.1	[ASK ONLY IF 7.8.2=YES (1 or 2)] What type of equipment?	Shoebox Standard machine Don't know Other (specify)		1 2 88 96

7. DR-TB Treatment Services [ASK ONLY IF 2.4.3=YES (facility provides DR-TB treatment)] *ADAPT PRIOR TO IMPLEMENTATION			
7.8.2.2	[ASK ONLY IF 7.8.2=YES (1 or 2)] How many audiometry tests are performed per week, on average? [ENTER VALID RANGE]	Number Don't know	88
7.9	Pediatric DR-TB Treatment		
7.9.1	Does this facility provide DR-TB treatment for children under age 15?	Yes No Don't know	1 0 88
7.9.1.1	[ASK ONLY IF 7.9.1=YES] Does this facility have any pediatric formulations for second-line drugs available?	Yes No Don't know	1 0 88

8. Pediatric Services [ASK ONLY IF 2.2.1=YES OR 2.4.2=YES (facility sees children)]					
8.1	Pediatric TB Diagnosis [ASK ONLY IF 2.2.1=YES (diagnostic facility sees children)]				
	Can you tell me how children are evaluated for TB disease?	Yes, unprompted	Yes, prompted	No	DK
8.1.1	Identify children with presumptive TB by symptoms	2	1	0	88
8.1.2	Once identified, all children with presumptive TB are evaluated at this facility	2	1	0	88
8.1.3	Once identified, all children with presumptive TB are referred for evaluation to another site	2	1	0	88
8.1.4	Other (specify) _____	2	1	0	88
8.2	Children with Presumptive TB [ASK ONLY IF 8.1.3=YES (1 or 2)]				
	How are children with presumptive TB evaluated?	Yes, unprompted	Yes, prompted	No	DK
8.2.1	Use clinical algorithm to determine if a child has TB	2	1	0	88
8.2.2	By X-ray	2	1	0	88
8.2.3	Use sputum induction to get samples from children for testing	2	1	0	88
8.2.4	Use gastric aspiration to get samples from children for testing	2	1	0	88
8.2.5	Test samples from nasopharyngeal aspirates	2	1	0	88
8.2.6	Test sputum with smear microscopy	2	1	0	88
8.2.7	Test sputum with culture	2	1	0	88
8.2.8	Test sputum with GeneXpert	2	1	0	88
8.2.9	Other (specify) _____	2	1	0	88
8.3	Children at Risk for TB				
	Can you tell me how children are identified as being at risk for TB? *ADAPT PRIOR TO IMPLEMENTATION	Yes, unprompted	Yes, prompted	No	DK
8.3.1	Child contact of confirmed TB patient	2	1	0	88
8.3.2	Referral from an MCH or child health clinic	2	1	0	88
8.3.3	Child living with HIV/AIDS	2	1	0	88

8. Pediatric Services [ASK ONLY IF 2.2.1=YES OR 2.4.2=YES (facility sees children)]					
		Yes, unprompted	Yes, prompted	No	DK
8.3.4	Child exposed to HIV/AIDS	2	1	0	88
8.3.5	Other (specify) _____	2	1	0	88
8.4 Pediatric TB Treatment [ASK ONLY IF 2.4.2=YES (treatment facility sees children)]					
	The next set of questions asks about medications that are used to treat children with TB. *ADAPT PRIOR TO IMPLEMENTATION—CHECK GUIDELINES FOR ANSWERS		Yes	No	DK
8.4.1	Does this facility use fixed-dose combinations (FDCs)?	1	0	88	
8.4.1.1	[ASK ONLY IF 8.4.1=YES] Are any of the FDCs available in liquid form?	1	0	88	
8.4.2	Does this facility use loose or single-drug formulations (for treating TB disease, not TPT regimen)?	1	0	88	
8.4.2.1	[ASK ONLY IF 8.4.2=YES] Which loose drugs are used? _____				
8.4.2.2	[ASK ONLY IF 8.4.2=YES] Does this facility use loose pills cut up or mixed with food?	1	0	88	
8.4.3	Does this facility use the same medications used for adults but cut up for children?	1	0	88	
8.4.4	How is the dosage determined for children?	Fixed in the kit 1 Weight 2 Don't know 88 Other (specify) 96			

9. Community-based Health Workers (CHWs) [ASK ONLY IF 2.5=YES (facility uses CHWs)]				
	In this section, we would like to learn about the links your facility has with CHWs that provide support to TB patients. *ADAPT PRIOR TO IMPLEMENTATION			
9.1	Services Provided by CHWs *ADAPT PRIOR TO IMPLEMENTATION ACCORDING TO GUIDELINES FOR CB SERVICES			
	What types of services do the CHWs provide?	Yes	No	DK
9.1.1	Education about TB in the community	1	0	88
9.1.2	Screening for TB symptoms	1	0	88
9.1.3	Referral for TB diagnosis	1	0	88
9.1.4	[ASK ONLY IF 2.2.4=YES (facility uses an offsite lab)] Collection and transportation of specimens to a diagnostic laboratory	1	0	88
9.1.5	[ASK ONLY IF 6.1.5=YES (community-based DOT facility)] Direct observation of treatment (DOT)	1	0	88
9.1.6	Adherence counseling	1	0	88
9.1.7	Trace or locate clients who miss follow-up visits	1	0	88
9.1.8	Contact tracing for confirmed TB patients	1	0	88
9.1.9	Psychosocial support	1	0	88
9.1.10	HIV testing and counseling	1	0	88
9.1.11	Other (specify) _____	1	0	88

9. Community-based Health Workers (CHWs) [ASK ONLY IF 2.5=YES (facility uses CHWs)]					
9.2 Financial Support for CHWs					
		Yes	No	DK	
9.2	Do the CHWs receive payment for their services?	1	0	88	
	[ASK ONLY IF 9.2=YES] Who financially supports the CHWs?	Yes	No	DK	
9.2.1	NGO(s)	1	0	88	
9.2.2	FBO(s)	1	0	88	
9.2.3	Government	1	0	88	
9.2.4	Individual donors	1	0	88	
9.2.5	Other (specify) _____	1	0	88	
9.3 Management of CHWs					
9.3.1	Do CHWs associated with this facility receive training in TB, such as screening, diagnosis, or treatment?	1	0	88	
9.3.2	[ASK ONLY IF 9.1.5=YES] Does the facility have an up-to-date list of CHWs who provide DOT?	1	0	88	
9.3.3	Does the facility keep a record of the performance of the CHWs?	1	0	88	
9.3.4	Does the facility TB focal person meet regularly (monthly or quarterly) with CHWs?	1	0	88	
9.3.5	Do staff members from this facility do community-level supervision of the CHWs?	1	0	88	
9.3.5.1	[ASK ONLY IF 9.3.5=YES] How many supervision visits to community level in the past 3 months were carried out by TB staff from this health facility? [ENTER 0–20]	Visits Don't know			88

10. Policies, Protocols, and Guidelines					
*ADAPT PRIOR TO IMPLEMENTATION—WHATEVER SERVICES ARE PROVIDED MUST HAVE ALL APPROPRIATE GUIDELINES					
	Next, I'd like to assess the availability of copies of approved and required protocols, policies, and messages on TB services available at the facility. Do you have the following documentation, and if so, may I see it?	Yes, observed	Yes, not observed	Don't have	DK
10.1 General					
10.1.1	Flowcharts or algorithms on TB screening	2	1	0	88
10.1.2	Guidelines for diagnosis and treatment of TB among children	2	1	0	88
10.1.3	Guidelines for TB infection control	2	1	0	88
10.1.4	[ASK ONLY IF 2.3=YES (facility provides TB/HIV services)] TB/HIV guidelines, i.e., management of HIV and TB coinfection	2	1	0	88
10.1.5	TB posters on walls, leaflets, brochures, and/or pamphlets in local languages for distribution, i.e., educational materials about TB	2	1	0	88

10. Policies, Protocols, and Guidelines					
*ADAPT PRIOR TO IMPLEMENTATION—WHATEVER SERVICES ARE PROVIDED MUST HAVE ALL APPROPRIATE GUIDELINES					
10.1.5.1	[IF 10.1.5=YES, OBSERVED, DETERMINE THE AMOUNT OF TB EDUCATIONAL MATERIALS AVAILABLE TO PATIENTS]	Sufficient educational materials available in multiple forms (i.e., posters, brochures, or patient pamphlets) Limited educational materials available (i.e., a single poster or few pamphlets, inadequate supply for all patients)			1 0
10.2	Diagnostic Facilities [ASK ONLY IF 2.2=YES]				
	Do you have the following documentation, and if so, may I see it?	Yes, observed	Yes, not observed	Don't have	DK
10.2.1	Flowcharts or algorithms on TB diagnosis	2	1	0	88
10.2.2	Guidelines on the use of chest X-ray for TB screening and diagnosis	2	1	0	88
10.2.3	[ASK ONLY IF 3.1.3=YES (facility does smear microscopy)] Smear microscopy manual or guidelines	2	1	0	88
10.2.4	[ASK ONLY IF 3.1.5=YES (facility has GeneXpert)] Algorithms for GeneXpert	2	1	0	88
10.3	Treatment Facilities [ASK ONLY IF 2.4=YES]				
10.3.1	Essential drug or medicines list	2	1	0	88
10.3.2	[ASK ONLY IF 6.1.4=YES or 6.1.5=YES (facility-based or community-based DOT facility)] A training manual for DOT providers or volunteers	2	1	0	88
	[ASK THE NEXT 2 QUESTIONS ONLY IF 2.4.3=YES (facility provides DR-TB treatment)]				
10.3.3	Guidelines on clinical management of DR-TB	2	1	0	88
10.3.4	Guidelines on use of short regimens for DR-TB treatment	2	1	0	88

11. Staff Capacity to Deliver TB Services				
	Did any providers of TB services at this facility receive new or refresher training in the following topics in the last 24 months? *ADAPT PRIOR TO IMPLEMENTATION—DEFINE WHAT CONSTITUTES TRAINING	Yes	No	DK
11.1	Screening algorithm for TB	1	0	88
11.2	Screening or diagnosis of TB based on X-rays	1	0	88
11.3	Diagnosis of TB based on clinical symptoms or examination (for adults)	1	0	88
11.4	Diagnosis of TB based on sputum tests using smear microscopy	1	0	88
11.5	Diagnosis of TB based on sputum tests using culture	1	0	88
11.6	Diagnosis of TB using GeneXpert	1	0	88
11.7	Prescription of drugs for TB treatment	1	0	88
11.8	Management of DS-TB treatment	1	0	88
11.9	Identification of presumptive DR-TB	1	0	88
11.10	Management of DR-TB treatment	1	0	88
11.11	Management of TB/HIV coinfection	1	0	88
11.12	TB infection control	1	0	88

12. Supervision and Feedback Practices					
	Next, I would like to ask about supervision and feedback from upper levels.				
12.1	Has a supervisor from any upper level office come here on a supervisory visit within the past 3 months? *ADAPT PRIOR TO IMPLEMENTATION	Yes	1		
		No	0		
		Don't know	88		
[ASK THE REST OF THE QUESTIONS IN THIS SECTION ONLY IF 12.1=YES]					
12.1.1	During the past 3 months, how many supervisory visits has this facility received from an upper level office? [ENTER 1–12]	Visits			
		Don't know	88		
	The last time that a supervisor from outside the facility visited, did he or she do any of the following?	Yes	No	DK	
12.1.2	Assess the pharmacy, e.g., drug stockout, expiry, records, etc.	1	0	88	
12.1.3	Assess the TB data, e.g., completeness, quality, and/or timely reporting of registers, treatment cards, quarterly or monthly reports, etc.	1	0	88	
12.1.4	Discuss the performance of the facility based on TB service data	1	0	88	
12.1.5	Complete the supervisory checklist	1	0	88	
12.1.6	Provide a record of written comments or suggestions from their visit	1	0	88	
12.1.7	[ASK ONLY IF 12.1.6=YES] May I see the written comments or suggestions?	1	0		

13. Availability of Basic Equipment								
	[ASK TO OBSERVE IF THE FOLLOWING BASIC EQUIPMENT AND SUPPLIES USED IN THE PROVISION OF CLIENT SERVICES ARE AVAILABLE AND FUNCTIONAL IN THE FACILITY TODAY]	(a) Have equipment?				[ASK ONLY IF (a)=OBSERVED] (b) Functioning?		
	Equipment	Yes, observed	Yes, not observed	Don't have	DK	Yes	No	DK
13.1	Adult weighing scale	2	1	0	88	1	0	88
13.2	Child weighing scale – 250-gram gradation	2	1	0	88	1	0	88
13.3	Infant weighing scale – 100-gram gradation	2	1	0	88	1	0	88
13.4	Measuring tape-height board or stadiometer	2	1	0	88	1	0	88
13.5	Thermometer	2	1	0	88	1	0	88
13.6	Stethoscope	2	1	0	88	1	0	88
13.7	Blood pressure apparatus (may be digital or manual sphygmomanometer with stethoscope)	2	1	0	88	1	0	88
13.8	Light source (flashlight acceptable)	2	1	0	88	1	0	88
13.9	Intravenous infusion kits	2	1	0	88	1	0	88
13.10	Oxygen concentrators	2	1	0	88	1	0	88
13.11	Oxygen cylinders	2	1	0	88	1	0	88
13.12	Central oxygen supply	2	1	0	88	1	0	88
13.13	Flowmeter for oxygen therapy (with humidification)	2	1	0	88	1	0	88
13.14	Oxygen delivery apparatus (key connecting tubes and mask or nasal prongs)	2	1	0	88	1	0	88

The staff member who is best able to answer the questions in the following section is either a lab technician or the TB focal person.

14. TB Laboratory Procedures [ASK ONLY IF 2.2.2=YES (facility has an onsite lab)]										
Diagnostic Tests and Equipment										
	[ASK TO OBSERVE IF THE FOLLOWING TB TESTS/EQUIPMENT ARE USED IN THIS FACILITY AND ARE AVAILABLE AND FUNCTIONAL IN THE FACILITY TODAY]	(a) Used in facility?			[ASK ONLY IF (a)=YES] (b) Observed?		[ASK ONLY IF (b)=YES] (c) Functioning?			
		Y	N	DK	Y	N	Y	N	DK	
14.1	Ziehl-Neelsen test for AFB	1	0	88						
[ASK THE NEXT 3 QUESTIONS ONLY IF 14.1 (a)=YES]										
14.1.1	Carbol fuchsin stain	1	0	88	1	0				
14.1.2	Sulfuric acid (20–25% concentration) or acid alcohol	1	0	88	1	0				
14.1.3	Methyl blue stain	1	0	88	1	0				
14.2	Fluorescence microscope (FM) LED	1	0	88	1	0	1	0	88	
14.2.1	[ASK ONLY IF 14.2 (a)=YES] Auramine stain for fluorescence microscope	1	0	88	1	0				
[ASK THE NEXT 3 QUESTIONS ONLY IF 3.1.5=YES (facility has GeneXpert)]										
14.3	GeneXpert module [AT LEAST ONE SHOULD BE FUNCTIONAL]				1	0	1	0	88	
14.3.1	At least 1 valid Xpert MTB/RIF cartridge, i.e., not expired				1	0	1	0	88	
14.3.2	Xpert MTB/RIF Ultra cartridge	1	0	88	1	0	1	0	88	
14.4	[ASK ONLY IF 3.2.1.3=YES OR 3.2.1.4=YES OR 3.2.2.2=YES OR 3.2.2.3=YES (facility uses solid or liquid culture)] TB culture or growth medium (e.g., MGIT 960)	1	0	88	1	0				
14.5	Biosafety hood or cabinet	1	0	88	1	0	1	0	88	
							Y	N	DK	
14.5.1	[ASK ONLY IF 14.5 (b)=YES] Is the biosafety hood or cabinet certified?						1	0	88	
Quality Control/Quality Assurance										
	I would like to ask you about quality control and quality assurance procedures for TB diagnosis services provided in the laboratory at this facility.									
14.6	For smear microscopy tests, what type of quality control and quality assurance do you use in this facility? *ADAPT PRIOR TO IMPLEMENTATION	None Internal QC/QA only External QC/QA only Both internal and external QC/QA Don't know							0 1 2 3 88	
[ASK THE NEXT 2 QUESTIONS ONLY IF 14.6=1, 2, 3]										
14.6.1	Do you maintain records of the results from the quality control procedures?	Yes No Don't know							1 0 88	

14. TB Laboratory Procedures [ASK ONLY IF 2.2.2=YES (facility has an onsite lab)]			
14.6.2	Do you have guidelines and procedures for quality control (either internal or external) for the specimens assessed in this facility?	Yes No Don't know	1 0 88
14.6.2.1	[ASK ONLY IF 14.6.2=YES] May I see the quality control guidelines?	Yes No	1 0

The staff member who is best able to answer the questions in the following section is either a lab technician, a nurse, or a sputum collector.

15. Management of Specimens				
*ADAPT PRIOR TO IMPLEMENTATION DEPENDING ON WHO IS BEST ABLE TO ANSWER THESE QUESTIONS—MIGHT MOVE DIAGNOSIS QUESTIONS TO SECTION 2 AND TREATMENT QUESTIONS TO SECTION 5 IF APPLICABLE				
15.1	Specimen Collection			
	The next few questions are about specimen collection.			
15.1.1	[DON'T READ THE ANSWER UNTIL THE RESPONDENT HAS HAD A CHANCE TO ANSWER UNPROMPTED] When is sputum collected by patients or when do you ask the patients to collect sputum? <i>[Answer: Immediately out of bed in the morning (before eating or drinking anything) after they have brushed their teeth and rinsed their mouth with only water.]</i>	Correct, unprompted Correct, prompted ... Incorrect Don't know	2 1 0 88	
15.1.2	Are there SOPs for specimen collection? [OBSERVE]	Yes, observed Yes, not observed No Don't know	2 1 0 88	
15.1.3	Are there approved laboratory request forms? [OBSERVE]	Yes, observed Yes, not observed No Don't know	2 1 0 88	
15.1.4	Were there any stockouts of specimen management supplies (e.g., sealable, leakproof sputum containers) in the past 6 months?	Yes No Don't know	1 0 88	
15.2	Onsite Laboratory [ASK ONLY IF 2.2.2=YES (facility has an onsite lab)]			
	Now, I would like to ask you about the management of sputum samples and turnaround time for the laboratory.	Yes	No	DK
15.2.1	Do you maintain any sputum containers that are sealable and leakproof at this service site for collecting sputum?	1	0	88
15.2.1.1	[ASK ONLY IF 15.2.1=YES] May I see a sputum container?	1	0	
15.2.2	On average, how many working days does it take to receive specimens in the laboratory at this facility? [ENTER VALID RANGE]	Days	Don't know	88
15.2.3	On average, how many working days does it take to receive specimen results from the laboratory at this facility? [ENTER VALID RANGE]	Days	Don't know	88

15. Management of Specimens				
*ADAPT PRIOR TO IMPLEMENTATION DEPENDING ON WHO IS BEST ABLE TO ANSWER THESE QUESTIONS—MIGHT MOVE DIAGNOSIS QUESTIONS TO SECTION 2 AND TREATMENT QUESTIONS TO SECTION 5 IF APPLICABLE				
15.3	Offsite Laboratory [ASK ONLY IF 2.2.4=YES (facility uses an offsite lab)]			
	Next, I would like to ask you about offsite laboratory procedures.			
	What testing services are offered by the offsite laboratory?	Yes	No	DK
15.3.1.1	Smear microscopy	1	0	88
15.3.1.2	GeneXpert	1	0	88
15.3.1.3	First-line drug susceptibility testing (other than GeneXpert)	1	0	88
15.3.1.4	Second-line drug susceptibility testing	1	0	88
15.3.2	Does this facility have the contact details of their laboratory? [OBSERVE]	Yes, observed	2	
		Yes, not observed	1	
		No	0	
		Don't know	88	
15.3.3	Is there an up-to-date specimen dispatch list? [OBSERVE]	Yes, observed	2	
		Yes, not observed	1	
		No	0	
		Don't know	88	
15.3.4	Does the facility maintain records of results of sputum tests conducted offsite? [OBSERVE]	Yes, observed	2	
		Yes, not observed	1	
		No	0	
		Don't know	88	
15.3.5	Does the facility have access to a specimen transport service?	Yes	1	
		No	0	
		Don't know	88	
15.3.5.1	[ASK ONLY IF 15.3.5=YES] What type of service is used?	Lab staff	1	
		Courier service	2	
		Implementing partner	3	
		Don't know	88	
		Other (specify)	96	
15.3.5.2	[ASK ONLY IF 15.3.5=YES] What type of specimens are picked up?	Only TB	1	
		TB and others	2	
		Don't know	88	
15.3.6	Does the facility use a cooler box reserved for transportation of specimens?	Yes	1	
		No	0	
		Don't know	88	
15.3.7	On average, how often does specimen transportation to the laboratory occur? [ENTER 1 FOR DAILY, 2 FOR EVERY 2 DAYS, ETC.] *ADAPT PRIOR TO IMPLEMENTATION	Days		
		Don't know	88	
15.3.8	On average, how many days does it take to receive the results at the facility? [ENTER VALID RANGE]	Days		
		Don't know	88	

15. Management of Specimens					
*ADAPT PRIOR TO IMPLEMENTATION DEPENDING ON WHO IS BEST ABLE TO ANSWER THESE QUESTIONS—MIGHT MOVE DIAGNOSIS QUESTIONS TO SECTION 2 AND TREATMENT QUESTIONS TO SECTION 5 IF APPLICABLE					
	How are TB test results returned to this facility? *ADAPT PRIOR TO IMPLEMENTATION BASED ON SOPs	Yes, unprompted	Yes, prompted	No	DK
15.3.9.1		2	1	0	88
15.3.9.2		2	1	0	88
15.3.9.3		2	1	0	88
15.3.9.x		2	1	0	88
15.3.9.x+1	Other (specify) _____	2	1	0	88
15.4 Sputum Investigation—Treatment [ASK ONLY IF 2.4=YES (treatment facility)]					
	Now I would like to ask you about sputum investigations ordered during treatment.		Yes	No	DK
15.4.1	[ASK ONLY IF 6.1.2=YES (facility provides intensive phase treatment)] Does this facility request sputum during the last week of the initial phase of treatment for drug-susceptible TB?		1	0	88
15.4.2	[ASK ONLY IF 6.1.3=YES (facility provides continuation phase treatment)] Does this facility request sputum in the last month of the continuation phase of treatment for drug-susceptible TB?		1	0	88
15.4.3	Does this facility request drug susceptibility testing for patients who were previously treated for TB, including GeneXpert?		1	0	88
15.4.4	Does this facility request drug susceptibility testing for patients who fail to convert on treatment, including GeneXpert?		1	0	88
15.4.5	Does this facility request any type of drug susceptibility testing for suspected DR-TB, including GeneXpert? *ADAPT PRIOR TO IMPLEMENTATION DEPENDING ON DST GUIDELINES		1	0	88
15.4.6	[ASK ONLY IF 2.4.3=YES (facility provides DR-TB treatment)] Does this facility request monthly smears and cultures throughout treatment for DR-TB? *ADAPT PRIOR TO IMPLEMENTATION		1	0	88

The staff member who is best able to answer the questions in the following sections is a pharmacy staff person or the TB focal person.

16. Management of Supplies and Commodities				
	[OBSERVE THE PLACE WHERE THE SUPPLIES AND COMMODITIES ARE STORED AND ASK THE FOLLOWING] Do the supplies and commodities storage conditions comply with the following standards? *ADAPT PRIOR TO IMPLEMENTATION—ENSURE DATA COLLECTORS KNOW HOW TO ASSESS THE CONDITIONS	Yes	No	DK
16.1	Room or store is clean and dust-free	1	0	88
16.2	Supplies and commodities are stored to prevent water damage	1	0	88
16.3	Room or store is adequately ventilated	1	0	88

16. Management of Supplies and Commodities				
		Yes	No	DK
16.4	Room or store is properly lit	1	0	88
16.5	Supplies and commodities are stored away from direct sunlight	1	0	88
16.6	Room or store has proper temperature	1	0	88
16.7	Supplies and commodities are stored without direct contact with walls or floors	1	0	88

17. Drug Stock [ASK ONLY IF 2.4=YES (treatment facility)]						
[ASK TO GO TO THE MAIN SITE IN THE FACILITY WHERE ROUTINE MEDICINES ARE STORED. FIND THE PERSON MOST KNOWLEDGEABLE ABOUT STORAGE AND MANAGEMENT OF MEDICINES IN THE FACILITY. INTRODUCE YOURSELF, EXPLAIN THE PURPOSE OF THE SURVEY, AND ASK THE FOLLOWING QUESTIONS.] I would like to know if the following medicines are available today in this facility. If any of the medicines I mention are stored in another location in the facility, please tell me where it is stored so I can go there to verify. *ADAPT PRIOR TO IMPLEMENTATION						
	Drugs and medicines available at the facility during the assessment according to NTP guidelines. [CHECK TO SEE IF AT LEAST ONE IS VALID, I.E., NOT EXPIRED]	Observed, at least one valid	Observed, none valid	No stock observed	Never stocked	DK
17.1.1	Isoniazid	3	2	1	0	88
17.1.2	Rifampicin	3	2	1	0	88
17.1.3	Pyrazinamide	3	2	1	0	88
17.1.4	Ethambutol	3	2	1	0	88
17.1.5	Isoniazid + rifampicin (2FDC)	3	2	1	0	88
17.1.6	Isoniazid + ethambutol (EH) (2FDC)	3	2	1	0	88
17.1.7	Isoniazid + rifampicin + pyrazinamide (RHZ) (3FDC)	3	2	1	0	88
17.1.8	Isoniazid + rifampicin + ethambutol (RHE) (3FDC)	3	2	1	0	88
17.1.9	Isoniazid + rifampicin + pyrazinamide + ethambutol (4FDC)	3	2	1	0	88
17.1.10	Streptomycin injectable	3	2	1	0	88
17.1.11	INH single tablets	3	2	1	0	88
17.1.12	3HP (rifapentine and isoniazid)	3	2	1	0	88
17.1.13	Q-TIB	3	2	1	0	88
	*ADD PEDIATRIC FORMULATIONS OF FDCs	3	2	1	0	88
	*ADD SECOND-LINE MEDICATIONS PER CURRENT DR-TB REGIMENS	3	2	1	0	88
				Yes	No	DK
17.2	Does the facility maintain a buffer stock of anti-TB medication?			1	0	88
17.3	Did any anti-TB medicine stockouts occur in the last six months?			1	0	88
17.3.1	[ASK ONLY IF 17.3=YES] Did any patient go without TB treatment because of stockouts within the last six months?			1	0	88

The staff member who is best able to answer the questions in the following section is either the infection control focal person or the TB focal person.

18. Infection Control					
	I'm going to ask about infection prevention measures, and then I'd like to see the supplies used for infection control.	Yes	No	DK	
18.1	General				
18.1.1	Has a staff member been designated as an infection prevention and control focal point with specifically articulated duties?	1	0	88	
18.1.2	Are patients routinely asked about cough when entering the facility?	1	0	88	
18.1.3	Is cough triage implemented (patients that are coughing are separated from others and fast-tracked for evaluation)?	1	0	88	
18.1.4	Is there a separate waiting area in the facility to isolate potentially infectious individuals?	1	0	88	
18.1.5	Does a cough monitor or other designated person assist with separation and triage of coughing patients?	1	0	88	
18.1.6	Are surgical masks available for presumptive and confirmed TB patients?	1	0	88	
18.1.6.1	[ASK ONLY IF 18.1.6=YES] Are surgical masks worn by presumptive and confirmed TB patients?	1	0	88	
18.1.7	Is a system in place to screen and evaluate staff for TB disease?	1	0	88	
18.1.7.1	[ASK ONLY IF 18.1.7=YES] Have any staff been diagnosed with active TB disease in the last 2 years?	1	0	88	
18.1.7.1.1	[ASK ONLY IF 18.1.7.1=YES] How many full-time staff had active TB disease in the last 2 years? [MUST BE 0-1.2.4 (# of full-time staff working in TB)]	Staff Don't know			88
18.1.7.1.2	[ASK ONLY IF 18.1.7.1=YES] How many part-time staff had active TB disease in the last 2 years? [MUST BE 0-1.2.5 (# of part-time staff working in TB)]	Staff Don't know			88
18.1.8	Are staff offered an HIV test annually?	1	0	88	
18.1.9	Are staff offered ART if HIV-positive?	1	0	88	
18.1.10	Where do HIV-positive staff receive ART? *ADAPT PRIOR TO IMPLEMENTATION	Within the facility Referred out Don't know Other (specify)			1 2 88 96
18.2	Resources in Service Areas				
	[PLEASE CHECK IF THE FOLLOWING RESOURCES USED FOR INFECTION CONTROL ARE AVAILABLE IN THE FACILITY WHERE TB PATIENTS ARE RECEIVING SERVICES ON THE DAY OF ASSESSMENT—ASK TO SEE THEM]	Yes, observed	Yes, not observed	Don't have	DK
18.2.1	An updated and approved infection prevention and control plan	2	1	0	88
18.2.2	An annual TB infection prevention and control risk assessment	2	1	0	88
18.2.3	Supplies for coughing patients (tissues, surgical masks, etc.)	2	1	0	88

18. Infection Control					
		Yes, observed	Yes, not observed	Don't have	DK
18.2.4	A confidential log for all staff with presumptive or confirmed TB	2	1	0	88
18.2.5	Patient waiting areas are either outdoors or indoors with access to continuous fresh air	2	1	0	88
18.3	Supplies in Examination Areas				
	[PLEASE CHECK IF THE FOLLOWING ITEMS ARE AVAILABLE IN THE CLIENT EXAMINATION AREAS, E.G., TB TESTING AREA, SERVICE PROVISION, GENERAL LAB AREAS. FOR ITEMS THAT YOU DO NOT SEE, ASK TO HAVE THEM SHOWN TO YOU]	Yes, observed	Yes, not observed	Don't have	DK
18.3.1	Running water (piped, bucket with tap or pour pitcher)	2	1	0	88
18.3.2	Hand washing soap (may be liquid soap)	2	1	0	88
18.3.3	Alcohol-based hand rub	2	1	0	88
18.3.4	Medical waste receptacle (pedal bin) with lid and plastic bin liners	2	1	0	88
18.3.5	Other waste receptacle	2	1	0	88
18.3.6	Sharps container (i.e., safety box)	2	1	0	88
18.3.7	Disposable latex gloves	2	1	0	88
18.3.8	Disinfectant (e.g., chlorine, alcohol)	2	1	0	88
18.3.9	Single use standard disposable syringes with needles or auto-disable syringes with needles	2	1	0	88
18.3.10	Gowns	2	1	0	88
18.3.11	Eye protection/goggles or face protection	2	1	0	88
18.3.12	Injection safety precaution guidelines for standard precautions	2	1	0	88
18.3.13	Needles destroyer	2	1	0	88
18.3.14	Methylated spirit and glycerin 70:30	2	1	0	88
18.4	Specimen Collection				
	Are specimens collected in any of the following designated areas?	Yes, observed	Yes, not observed	No	DK
18.4.1	Outside the screening and treatment area	2	1	0	88
18.4.2	Away from other patients	2	1	0	88
18.4.3	In a separate room	2	1	0	88
18.4.4	In a well-ventilated area, e.g., open air or with open windows	2	1	0	88
18.5	N-95 and FFP2 Respirators [ASK TO SEE THEM]				
	*ADAPT PRIOR TO IMPLEMENTATION—MAINLY FOR DR-TB	Yes, observed	Yes, not observed	No	DK
18.5.1	Are N-95 and FFP2 respirators readily available for staff?	2	1	0	88
18.5.1.1	[ASK ONLY IF 18.5.1=YES (1, 2)] Have staff been trained on the proper fit of the respirators?		1	0	88

18. Infection Control			
18.5.1.2	[ASK ONLY IF 18.5.1=YES (1, 2)] How often do facility staff members use the N-95 and/or FFP2 respirators according to national guidance?	Never Seldom Half of the time ... Most of the time Always	1 2 3 4 5

End of Facility Visit			
		(a) Visit Result	(b) Visit End Time [Use the 24-hour clock system, e.g., 14:30]
003	Visit 1	Completed 1 Partially completed 2 Records unavailable 3 Facility refused 4 Postponed 5 Other (specify) 96	Hours Minutes
004	Visit 2 (if needed)	Completed 1 Partially completed 2 Records unavailable 3 Facility refused 4 Other (specify) 96	Hours Minutes

QUALITY OF TB SERVICES ASSESSMENT: PROVIDER INTERVIEW

Start of Facility Visit					
		(a) Visit Date	(b) Visit Start Time [Use the 24-hour clock system, e.g., 14:30]	(c) Interviewer ID	(d) Interviewer Name
001	Visit 1	__/__/__	Hours Minutes		_____
002	Visit 2 (if needed)	__/__/__	Hours Minutes		_____

Facility Identification			
*ADAPT PRIOR TO IMPLEMENTATION TO REFLECT STRUCTURE OF ADMINISTRATIVE LEVELS			
		(a) Code	(b) Name
010	Region/province/state (Level 1)		_____
011	District/county (Level 2)		_____
012	Facility		_____
013	Location of facility _____		

Facility Characteristics			
020	Does this facility provide TB diagnostic services?	Yes No	1 0
021	Does this facility provide TB treatment services?	Yes No	1 0
022	[ASK ONLY IF 021=YES] Is this facility a DOT site?	Yes No	1 0
023	Does this facility provide any HIV-related services, such as counseling, testing, care, or treatment?	Yes No	1 0

Participant Consent			
030	Provider number		
Eligibility Screening Questions			
Instructions to the interviewer: [Approach one of the clinic staff, introduce yourself (Hello. My name is) and ask him/her if s/he is willing to answer questions about their experience providing TB care at this facility. If the staff member agrees, tell him/her that you have a couple of preliminary questions. To ensure that the provider meets the criteria for the study, please obtain the following information.]			
031	Do you provide care to TB patients?	Yes No	1 0
032	[ASK ONLY IF 031=YES] Have you been working at this facility for more than 6 months?	Yes No [No response]	1 0 99
[If either of the screening questions is No or No response, the provider is NOT eligible for this study—thank them and find the next available staff member. If the provider is eligible for the study (i.e., both screening questions are YES), it is essential that you gain their informed consent before beginning the interview. Read the service provider consent form to the provider and record their response below.]			
033	[SELECT THE APPROPRIATE RESPONSE BASED ON THE INFORMED CONSENT]	Consented Declined	1 0
[If they declined to give consent, (1) thank the provider, (2) record 'Provider refused' in the "End of Facility Visit" section at the end of the survey, and (3) approach another provider. If consented, continue with the interview.]			

1. Education and Experience			
1.1	Sex [OBSERVE AND SELECT THE APPROPRIATE RESPONSE. ASK ONLY IF UNSURE.]	Male Female [No response]	1 2 99
1.2.1	In what year were you born? [YEAR MUST BE ?-?. IF UNKNOWN, SELECT 88, or IF NO RESPONSE, SELECT 99.]	Year Don't know [No response]	 88 99
1.2.2	How old were you on your last birthday? [AGE MUST BE ?-?. COMPARE AND CORRECT 1.2.1 AND 1.2.2 IF THEY ARE INCONSISTENT]	Years Don't know [No response]	 88 99

1. Education and Experience			
1.3	What was the highest level of schooling you reached to become a practicing healthcare provider? *ADAPT PRIOR TO IMPLEMENTATION	Diploma 1 Associate degree 2 Bachelor's degree 3 Master's degree 4 Doctorate 5 Nonformal degree (specify) 95 _____ Other health degree (specify) 96 _____ Other non-health degree (specify) 97 _____ [No response] 99	
1.4	How would you best describe your current occupational category at this facility? For example, are you a registered nurse or physician? *ADAPT PRIOR TO IMPLEMENTATION	Community health worker 1 Medical assistant 2 Medical doctor/clinical officer 3 Nursing associate or auxiliary 4 Registered nurse 5 Other (specify) 96 _____ [No response] 99	
1.5	Are you a manager or in-charge for any clinical services?	Yes 1 No 0 [No response] 99	
1.6	Are you the TB focal or designated TB staff at this facility?	Yes 1 No 0 [No response] 99	
1.7	How many years and months have you been working in this facility? [YEARS MUST BE 0-?. MONTHS MUST BE 0-11.]	Years ... Months .. [No response] 99	
1.8	Typically, how many hours a week do you usually work at this facility? [MUST BE 1-40?]	Hours per week [No response] 99	
1.9	Approximately, how many patients do you personally see or care for in this facility in a typical week? [ENTER 1-?]	Number of patients [No response] 999	
1.10	How many years and months have you been providing TB related services at this facility? [MUST BE ≤ 1.7]	Years ... Months ... [No response] 99	
1.11	How many hours a week do you provide TB-related services? [MUST BE ≤ 1.8]	Hours per week [No response] 99	
1.12	Approximately, how many TB patients, or their contacts, do you personally see or care for in this facility in a typical week? [MUST BE ≤ 1.9]	Number of patients [No response] 999	

2. Training					
	Now I will ask about training you received on specific TB-related services. Have you received any training, initial or refresher, on [Service]?	Yes, within 24 months	Yes, over 24 months	No	[NR]
2.1	TB/HIV Services				
2.1.1	HIV testing and counseling for TB patients onsite	2	1	0	99
2.1.2	Referral for HIV testing and counseling for TB patients	2	1	0	99
2.1.3	Preventive treatment for TB infection (INH + Pyridoxine), either on site or via referral	2	1	0	99
2.1.4	HIV care and treatment services to TB/HIV coinfecting patients	2	1	0	99
2.1.4.1	[ASK ONLY IF 2.1.4=YES (1, 2)] ART for TB/HIV coinfecting patients	2	1	0	99
2.1.4.2	[ASK ONLY IF 2.1.4=YES (1, 2)] Identification of TB/HIV drug interactions	2	1	0	99
2.1.4.3	[ASK ONLY IF 2.1.4=YES (1, 2)] Identification of immune reconstitution inflammatory syndrome (IRIS)	2	1	0	99
2.1.4.4	[ASK ONLY IF 2.1.4=YES (1, 2)] CPT for TB/HIV coinfecting patients	2	1	0	99
2.1.4.5	[ASK ONLY IF 2.1.4=YES (1, 2)] Viral load testing for TB/HIV coinfecting patients	2	1	0	99
2.2	TB Diagnostic Services				
2.2.1	Diagnosis of TB by clinical symptoms and signs	2	1	0	99
2.2.2	Diagnosis of TB by sputum smear microscopy	2	1	0	99
2.2.3	Diagnosis of TB by X-ray	2	1	0	99
2.2.4	Diagnosis of TB by Xpert MTB/RIF (GeneXpert)	2	1	0	99
2.2.5	Diagnosis of drug-resistant TB	2	1	0	99
2.2.5.1	[ASK ONLY IF 2.2.5=YES (1, 2)] TB culture or growth medium (e.g., MGIT 960)	2	1	0	99
2.2.5.2	[ASK ONLY IF 2.2.5=YES (1, 2)] Line probe assays (LPAs)	2	1	0	99
2.2.6	Referral for drug-resistant TB diagnosis	2	1	0	99
2.3	TB Treatment Services				
2.3.1	Prescription of drugs for TB treatment	2	1	0	99
2.3.2	Direct observation of treatment (DOT)	2	1	0	99
2.3.3	Video DOT *ADAPT PRIOR TO IMPLEMENTATION	2	1	0	99
2.3.4	TB treatment follow-up services, e.g., phone calls or home visits to TB patients if they miss an appointment, SMS text reminders to support patients' adherence to medications and treatment, etc. *ADAPT PRIOR TO IMPLEMENTATION	2	1	0	99
2.3.5	Identification of and referral for patients who fail treatment	2	1	0	99
2.3.6	Treatment of drug-resistant TB	2	1	0	99
2.3.7	Referral for drug-resistant TB treatment	2	1	0	99

3. TB Services Provided				
	Now I will ask if you currently provide certain TB-related services. Have you provided [service] in the last 12 months?	Yes	No	[NR]
3.1.1	Screening of TB by clinical symptoms and signs	1	0	99
3.1.2	Screening of TB by X-ray	1	0	99
3.2	TB Diagnostic Services [ASK ONLY IF 020=YES (diagnostic facility)]			
3.2.1	Diagnosis of TB by clinical symptoms and signs	1	0	99
3.2.2	Diagnosis of TB by conventional X-ray	1	0	99
3.2.3	Diagnosis of TB by digital X-ray	1	0	99
3.2.4	Diagnosis of TB by computer assisted digital X-ray (CAD4TB)	1	0	99
3.2.5	Diagnosis of TB by smear microscopy	1	0	99
3.2.6	Diagnosis of TB by Xpert MTB/RIF (GeneXpert)	1	0	99
3.2.7	What Is the most common method you use for diagnosing TB in this facility? *ADAPT PRIOR TO IMPLEMENTATION			
3.2.8	First-line drug susceptibility testing	1	0	99
	[ASK THE NEXT 5 QUESTIONS ONLY IF 3.2.8=YES] What methods do you use to detect resistance to first-line drugs?	Yes	No	[NR]
3.2.8.1	Xpert MTB/RIF (GeneXpert) to detect resistance to Rifampicin	1	0	99
3.2.8.2	Line probe assays (e.g., MTBDRplus to MTBDRsl)	1	0	99
3.2.8.3	Solid culture	1	0	99
3.2.8.4	Liquid culture	1	0	99
3.2.8.5	Any other method used to detect resistance to first-line drugs? (specify)	1	0	99
3.2.9	[ASK ONLY IF 3.2.8=NO or NR] Referral for first-line drug susceptibility testing	1	0	99
3.2.10	Second-line drug susceptibility testing	1	0	99
	[ASK THE NEXT 5 QUESTIONS ONLY IF 3.2.10=YES] What methods do you use to detect resistance to second-line drugs?	Yes	No	[NR]
3.2.10.1	Xpert MTB/RIF (GeneXpert) to detect resistance to Rifampicin	1	0	99
3.2.10.2	Line probe assays (e.g., MTBDRplus to MTBDRsl)	1	0	99
3.2.10.3	Solid culture	1	0	99
3.2.10.4	Liquid culture	1	0	99
3.2.10.5	Any other method used to detect resistance to second-line drugs? (specify)	1	0	99
3.2.11	[ASK ONLY IF 3.2.10=NO or NR] Referral for second-line drug susceptibility testing	1	0	99
3.3	TB Treatment Services [ASK ONLY IF 021=YES (treatment facility)]			
3.3.1	Prescription of drugs for TB treatment	1	0	99
3.3.2	TB treatment and follow-up	1	0	99
3.3.3	[ASK ONLY IF 022=YES (DOT facility)] Direct observation of treatment (DOT)	1	0	99
3.3.4	Video DOT *ADAPT PRIOR TO IMPLEMENTATION	1	0	99
3.3.5	Reminder phone calls or SMS texts to support patients' adherence to treatment *ADAPT PRIOR TO IMPLEMENTATION	1	0	99

3. TB Services Provided				
	Now I will ask if you currently provide certain TB-related services. Have you provided [service] in the last 12 months?	Yes	No	[NR]
3.3.6	Patient tracking of those who miss an appointment	1	0	99
3.3.6.1	[ASK ONLY IF 3.3.6=YES] Follow-up phone calls or SMS texts to TB patients if they miss an appointment *ADAPT PRIOR TO IMPLEMENTATION	1	0	99
3.3.6.2	[ASK ONLY IF 3.3.6=YES] Home visits to TB patients if they miss an appointment	1	0	99
3.3.7	Treatment of drug-resistant TB	1	0	99
3.3.8	[ASK ONLY IF 3.3.7=NO or NR] Referral for drug-resistant TB treatment	1	0	99
3.4	TB/HIV Services [ASK ONLY IF 023=YES (facility provides TB/HIV services)]			
3.4.1	HIV testing and counseling for TB patients onsite	1	0	99
3.4.2	Referral for HIV testing and counseling for TB patients	1	0	99
3.4.3	TB preventive therapy	1	0	99
	[ASK THE NEXT 3 QUESTIONS ONLY IF 3.4.3=YES] What type of TB preventive therapy (TPT) do you provide? *ADAPT PRIOR TO IMPLEMENTATION PER NATIONAL HIV/AIDS PROGRAM GUIDELINES	Yes	No	[NR]
3.4.3.1	INH (6, 9, 12 months or continuous)	1	0	99
3.4.3.2	3HP (rifapentine and isoniazid)	1	0	99
3.4.3.3	Q-TIB	1	0	99
3.4.4	HIV care and treatment services to TB/HIV coinfecting patients	1	0	99
	[ASK THE NEXT 3 QUESTIONS ONLY IF 3.4.4=YES]			
3.4.4.1	CPT for TB/HIV coinfecting patients	1	0	99
3.4.4.2	Viral load testing for TB/HIV coinfecting patients	1	0	99
3.4.4.3	ART for TB/HIV coinfecting patients	1	0	99
3.4.4.3.1	[ASK ONLY IF 3.4.4.3=YES] Screening for symptoms of anti-TB and ARV drug interactions	1	0	99

4. TB Case Management				
	Now, I want to ask you a few more questions about the management and care of TB patients as part of your work in this facility.			
4.1	Establishing Rapport and Building Trust			
	The interpersonal relationship between provider and patient is very important for successful treatment outcome, especially since TB requires taking medications for many months. What are some things you do to establish rapport and build trust with your patients? [SELECT ALL THAT THE RESPONDENT MENTIONS, BUT DO NOT PROMPT]			Yes
4.1.1	Be consistent in what is done and told to the patient			1
4.1.2	Be flexible in meeting the patient's needs			1
4.1.3	Communicate clearly			1
4.1.4	Have an open mind about the patient's cultural beliefs			1
4.1.5	Listen carefully to the patient			1
4.1.6	Recognize and address the patient's fears about the illness			1
4.1.7	Suggest behavior changes respectfully			1

4. TB Case Management						
		Yes				
4.1.8	Treat the patient with dignity and respect	1				
4.1.9	Other (specify) _____	1				
4.1.10	None of the above	1				
4.2 Patient Assessment [ASK ONLY IF 020=YES]						
	As part of the initial patient assessment to determine their understanding of TB, what do you ask the patient to tell or explain to you? [SELECT ALL THAT THE RESPONDENT MENTIONS, BUT DO NOT PROMPT]	Yes				
4.2.1	Patient's previous medical/psychosocial history	1				
4.2.2	Attitudes/beliefs towards TB	1				
4.2.3	Knowledge of TB	1				
4.2.4	Ability to follow the TB treatment plan	1				
4.2.5	Potential barriers to treatment, e.g., lack of transportation, TB medications will be too expensive, etc.	1				
4.2.6	Resources, e.g., family, other social support, finances	1				
4.2.7	Other (specify) _____	1				
4.2.8	None of the above	1				
4.3 TB/HIV Information						
	What type of information do you discuss with patients concerning TB/HIV? For each type of information, please tell me if it is given verbally and/or in writing. [SELECT ALL THAT THE RESPONDENT MENTIONS, BUT DO NOT PROMPT. FOR THE TOPICS MENTIONED, ASK IF THE INFORMATION IS PROVIDED VERBALLY AND/OR IN WRITING.]					
	Topics	(a) Provide information?	[ASK ONLY IF (a)=YES] (b) How is information provided?			
		Yes, unprompted	Verbally	Written	Both	[NR]
4.3.1	General information about TB/HIV coinfection	1	1	2	3	99
4.3.2	HIV prevention	1	1	2	3	99
4.3.3	Advise TB patients to get tested for HIV	1	1	2	3	99
4.3.4	HIV care and treatment services to TB/HIV coinfecting patients	1	1	2	3	99
4.3.5	TB/HIV drug interactions	1	1	2	3	99
4.3.6	What to do if they experience TB/HIV drug interactions	1	1	2	3	99
4.3.7	What to do if signs and symptoms of immune reconstitution inflammatory syndrome (IRIS) become evident	1	1	2	3	99
4.3.8	Other (specify) _____	1	1	2	3	99
4.3.9	None of the above	1				
4.4 Counseling						

4. TB Case Management						
	To ensure your patients have a good understanding of the treatment process, what type of information or topics, excluding TB/HIV, are discussed with patients during diagnosis and treatment visits? For each type of information, please tell me if it is given verbally and/or in writing. [SELECT ALL THAT THE RESPONDENT MENTIONS, BUT DO NOT PROMPT. FOR THE TOPICS MENTIONED, ASK IF THE INFORMATION IS PROVIDED VERBALLY AND/OR IN WRITING.]					
	Topics	(a) Provide information?	[ASK ONLY IF (a)=YES] (b) How is information provided?			
		Yes, unprompted	Verbally	Written	Both	[NR]
	General TB Information					
4.4.1	Test results	1	1	2	3	99
4.4.2	What the test results mean	1	1	2	3	99
4.4.3	How TB is spread to others	1	1	2	3	99
4.4.4	That TB can be cured	1	1	2	3	99
	TB Treatment Information					
4.4.5	The need for a treatment supporter	1	1	2	3	99
4.4.6	How long treatment will last	1	1	2	3	99
4.4.7	The treatment phase they are in	1	1	2	3	99
4.4.8	Treatment status or progress	1	1	2	3	99
4.4.9	Importance of taking medications regularly	1	1	2	3	99
4.4.10	How the medications should be taken, e.g., dosage, frequency, etc.	1	1	2	3	99
4.4.11	Importance of taking medications for the full course of treatment	1	1	2	3	99
4.4.12	Options available for treatment support, e.g., DOT	1	1	2	3	99
4.4.13	What to do if they run out of their medications	1	1	2	3	99
4.4.14	Possible side effects of TB medication	1	1	2	3	99
4.4.15	What to do if they experience side effects from the TB medication	1	1	2	3	99
4.4.16	Other (specify) _____	1	1	2	3	99
4.4.17	None of the above	1				
	[ASK ONLY IF 021=YES (treatment facility)] What do you do when a patient misses their treatment? [SELECT ALL THAT THE RESPONDENT MENTIONS, BUT DO NOT PROMPT] *ADAPT PRIOR TO IMPLEMENTATION					Yes
4.5.1	Advise them to return for treatment	1				
4.5.2	Counsel and continue treatment from where they stopped	1				
4.5.3	Counsel and repeat lab investigation	1				
4.5.4	Follow up and track by contacting their school or workplace	1				
4.5.5	Follow up and track by home visit	1				
4.5.6	Follow up and track by phone	1				
4.5.7	Follow up and track by SMS	1				
4.5.8	Record missed day and extend treatment	1				
4.5.9	Other (specify) _____	1				
4.5.10	None of the above	1				

5. Infection Prevention and Control					
	Now I would like to ask you some questions about your knowledge and practices to prevent transmission of TB among healthcare workers and patients within the facility.				
5.1	Training				
5.1.1	Have you ever received any training on TB infection control?	Yes	1	No	0
		[No response]	99		
5.1.1.1	[ASK ONLY IF 5.1.1=YES] When did the training occur?	Within the past 24 months	1	Over 24 months ago	2
		[No response]	99		
5.2	Knowledge				
	I would like to ask you some questions about your knowledge of preventing transmission of TB within the facility.	Yes	No	DK	[NR]
5.2.1	Should doors and windows be left open whenever a patient presumed or confirmed to have TB is in the room?	1	0	88	99
5.2.2	Can fans (ventilators) be used in TB wards to reduce the transmission of TB?	1	0	88	99
5.2.3	Should presumed or confirmed TB patients be separated from other patients?	1	0	88	99
5.2.4	Should healthcare providers minimize the time TB patients spend in the health facility?	1	0	88	99
5.2.5	Can surgical masks protect healthcare providers from inhaling the TB bacteria?	1	0	88	99
5.2.6	Can the use of respiratory protection, such as N95 particulate respirators, by healthcare providers protect them from inhaling the TB bacteria?	1	0	88	99
5.3	Practices				
	What do you do whenever you are with presumed or confirmed TB patients and/or working in the TB wards?	Yes	No		[NR]
5.3.1	Use a mask/respirator whenever treating TB presumptive or confirmed patients	1	0		99
5.3.2	Give priority to coughing patients, i.e., attend to patients who are coughing first	1	0		99
5.3.3	Educate TB patients on cough etiquette, i.e., covering their mouth with hand, tissue, or elbow while coughing or sneezing, not spitting on the floor, etc.	1	0		99
5.3.4	Turn on fans to exhaust air outside the room, or blow air in the direction away from others while treating TB presumptive or confirmed cases	1	0		99
5.3.5	Request for TB diagnostic testing if the patient is symptomatic	1	0		99
5.3.6	Always screen all family members of confirmed TB patients for TB symptoms	1	0		99
5.3.7	Discuss with family members or those living with your TB patients, basic information and skills to protect household members and contacts from infection	1	0		99

6. Supervision			
	Now I would like to ask you some questions about supervision that you have personally received.		
6.1	Has anyone from a higher or upper-level office ever come for a supervisory and monitoring visit to check your work?	Yes	1
		No	0
		[No response]	99

6. Supervision			
6.1.1	[ASK ONLY IF 6.1=YES] When was the last time someone from an upper-level office came here on a supervisory visit? *ADAPT PRIOR TO IMPLEMENTATION BASED ON THE COUNTRY SUPERVISORY/MONITORING GUIDELINES	Within the past 3 months 1 More than 3 months ago 2 [No response] 99	
[ASK THE REST OF THE QUESTIONS IN THIS SECTION ONLY IF 6.1.1=1]			
6.1.1.1	During the past 3 months, how many times have you been supervised or monitored by someone from an upper-level office? [ENTER 1-?]	Number of visits [No response] 99	
	The last time you were personally supervised, what did your supervisor do during the visit? [SELECT ALL THAT THE RESPONDENT MENTIONS, BUT DO NOT PROMPT]		Yes
6.1.1.2	Assess the pharmacy, e.g., drug stockout, expiry, records, etc.		1
6.1.1.3	Assess the data, e.g., completeness, quality, and/or timely reporting		1
6.1.1.4	Discuss the performance of the facility based on the TB service data		1
6.1.1.5	Complete a supervisory checklist		1
6.1.1.6	Other (specify) _____		1
6.1.1.7	The last time you were personally supervised, did your supervisor give you a record of written comments or suggestions? [ASK TO SEE IT]	Yes, observed 2 Yes, not observed 1 No 0 [No response] 99	

7. Incentives and Improvements			
7.1	In addition to your official remuneration, what other nonmonetary incentives have you received for the work you do? [READ THE OPTIONS BELOW "NONE" AND SELECT ALL THAT APPLY]	[None] 0 Time off/vacation 1 Uniforms, vests, caps, etc. 2 Discount medicine, free medical care.... 3 Training..... 4 Other (specify) 96 [No response] 99	
7.2	As a TB service provider or health worker, what are the three most important things that could be done to improve your ability to provide high quality TB care to your patients? 1) _____ 2) _____ 3) _____		

End of Facility Visit			
		(a) Visit Result	(b) Visit End Time [Use the 24-hour clock system, e.g., 14:30]
003	Visit 1	Completed 1 Partially completed 2 Provider unavailable 3 Provider refused 4 Postponed 5 Other (specify) _____ 96	Hours Minutes
004	Visit 2 (if needed)	Completed 1 Partially completed 2 Provider unavailable 3 Provider refused 4 Other (specify) _____ 96	Hours Minutes

Thank your respondent and move to the next data collection point if different from current location.

QUALITY OF TB SERVICES ASSESSMENT: PATIENT INTERVIEW

Start of Facility Visit					
		(a) Visit Date	(b) Visit Start Time [Use the 24-hour clock system, e.g., 14:30]	(c) Interviewer ID	(d) Interviewer Name
001	Visit 1	___/___/___	Hours Minutes		_____
002	Visit 2 (if needed)	___/___/___	Hours Minutes		_____

Facility Identification			
*ADAPT PRIOR TO IMPLEMENTATION TO REFLECT STRUCTURE OF ADMINISTRATIVE LEVELS			
		(a) Code	(b) Name
010	Region/province/state (Level 1)		_____
011	District/county (Level 2)		_____
012	Facility		_____
013	Location of facility _____		

Participant Consent			
020	Patient number		
Eligibility Screening Questions			
Instructions to the interviewer: [When a patient has finished his/her consultation with the clinic staff, introduce yourself (Hello. My name is) and ask him/her if s/he is willing to answer questions about their experience receiving TB care at this facility. If the patient agrees, tell him/her that you have a few preliminary questions. To ensure that the patient meets the criteria for the study, please obtain the following information:]			
021	[Is the patient at least 15 years old? Ask if you're not sure.]	Yes No	1 0
022	[ASK ONLY IF 021=YES] Have you been diagnosed with TB or are you being treated for TB at this facility? If so, what type of TB do you have, i.e., drug susceptible or drug resistant (RR-TB, MDR-TB, etc.)?] *ADAPT IF THERE ARE OTHER TERMS PATIENTS USE TO REFER TO DS OR DR TB	No, they do not have TB Yes, drug susceptible TB Yes, drug resistant TB Yes, unknown TB type Don't know if they have TB [No response]	0 1 2 3 88 99
023	[ASK ONLY IF 022=YES (1-3)] [If 022=1 (drug susceptible)] Have you been receiving TB treatment at this facility for at least 2 weeks? If 022=2 or 3 (drug resistant/unknown)] Have you been receiving TB treatment at this facility for at least 4 weeks?	Yes No [No response]	1 0 99
[If any of the screening questions are No, Don't know, or No response, the patient is NOT eligible for this study—thank the patient and wait for the next available patient.			
If the patient is eligible for the study (i.e., all questions are YES), it is essential that you gain their informed consent before beginning the interview. Read the patient consent form to the patient and record their response below.]			
024	[SELECT THE APPROPRIATE RESPONSE BASED ON THE INFORMED CONSENT]	Consented Declined	1 0
[If they declined to give consent, (1) thank the patient, (2) fill in the patient refusal form, (3) record 'Patient refused' in the "End of Facility Visit" section at the end of the survey, and (4) wait for another patient.			
If consented, continue with the interview.]			

1. Patient Characteristics			
1.1	Sex [OBSERVE AND SELECT THE APPROPRIATE RESPONSE. ASK ONLY IF UNSURE.]	Male Female [No response]	1 2 99
1.2.1	In what year were you born? [YEAR MUST BE 1929–2004.]	Year Don't know [No response]	 88 99
1.2.2	How old were you on your last birthday? [YEARS MUST BE 15–90. COMPARE AND CORRECT 1.2.1 AND 1.2.2 IF THEY ARE INCONSISTENT BY MORE THAN 3 YEARS]	Years Don't know [No response]	 98 99
1.3	What is the highest level of education you have completed?	None Primary Secondary Postsecondary [No response]	0 1 2 3 99
1.4	What is your marital status now?	Never married Currently living with a partner (unmarried) Married Separated Divorced Widowed [No response]	1 2 3 4 5 6 99
1.5	Do you live in an urban or rural area?	Urban Rural [No response]	1 2 99
1.6	What is your employment status? *ADAPT PRIOR TO IMPLEMENTATION ACCORDING TO DHS CATEGORIES	Employed full-time Employed part-time Self-employed Unemployed Retired Student [No response]	1 2 3 4 5 6 99
1.7	What is your average monthly household income? *ADAPT PRIOR TO IMPLEMENTATION	??? ??? ??? ??? ??? [No response]	1 2 3 4 5 99
1.8	Is this health facility close enough for you to get here easily?	Yes No [No response]	1 0 99

1. Patient Characteristics			
1.9	On average, how long does it take you to get to this facility from your home? [HOURS MUST BE 0–XX; MINUTES MUST BE 0–59] *ADAPT PRIOR TO IMPLEMENTATION	Hours Minutes	
		Don't know	88
		[No response]	99
1.10	What type of transportation do you use most often to get to this facility? [SELECT ALL THAT APPLY] *ADAPT PRIOR TO IMPLEMENTATION	Bicycle Bus Car Motorcycle Taxi Walking Other (specify) [No response]	1 2 3 4 5 6 96 99
1.11	Do you smoke?	Yes No [No response]	1 0 99

2. Cascade of Care			
	Now, I would like to ask about the care that you have received for this disease.		
2.1	How long after you first started having symptoms, such as coughing, did you go to the clinic?	Within 1 week 1-2 weeks More than two weeks Don't know [No response]	1 2 3 88 99
2.2	When you found out that you might have this disease, where did you get tested?	At this clinic At a different clinic Don't know [No response]	1 2 88 99
2.3	How long after you were tested were you told you had this disease?	Within two days Within one week 1-2 weeks More than two weeks Don't know [No response]	1 2 3 4 88 99
2.4	How long after you were told you had this disease did you start treatment?	Within two days Within one week 1-2 weeks More than two weeks Don't know [No response]	1 2 3 4 88 99

2. Cascade of Care			
2.5	How long have you been on treatment? *ADAPT PRIOR TO IMPLEMENTATION ACCORDING TO NTP TREATMENT PROTOCOLS FOR DS- & DR-TB	Less than 3 months 3-6 months 7-9 months 10-24 months More than 2 years Don't know [No response]	1 2 3 4 5 88 99
2.6	What phase of treatment are you in now?	Intensive Continuation Don't know Other (specify) [No response]	1 2 88 96 99

3. Availability of TB Services				
	Now I would like to ask you about your experience with this facility in general.	Yes	No	[NR]
3.1	Do you always talk to the same healthcare providers every time you visit this facility?	1	0	99
3.2	Do you have difficulties in getting care for your disease in this facility because of a language barrier?	1	0	99
3.3	Have you ever been turned away from receiving care for your disease during official working hours at this facility?	1	0	99
3.4	Do you collect the medicines for your disease at this facility?	1	0	99
3.4.1	[ASK ONLY IF 3.4=YES] Are the medicines always available?	1	0	99
3.4.2	[ASK ONLY IF 3.4=YES] Are you told how to take the medicines each time you collect them?	1	0	99
3.4.3	[ASK ONLY IF 3.4=YES] Have you been given written instructions on how to take your medicines?	1	0	99
3.5	[ASK ONLY IF 1.11=YES (patient smokes)] Has a healthcare provider at this facility talked with you about quitting smoking?	1	0	99
3.6	Are the clinic hours convenient for you?	1	0	99
3.6.1	[ASK ONLY IF 3.6=NO] Why is that? _____			
		Yes	No	[NR]
3.7	Are the waiting time(s) before talking to healthcare providers at this facility generally acceptable to you?	1	0	99
3.8	During today's visit, about how long did you wait to talk to any provider? [HOURS MUST BE 0–10; MINUTES MUST BE 0–59] *ADAPT PRIOR TO IMPLEMENTATION	Hours Minutes		88 99
		Don't know [No response]		88 99

3. Availability of TB Services				
3.9	During today's visit, how long did you spend with your providers, e.g., healthcare provider, lab, pharmacist, etc.? If you saw more than one provider, please add up the total time. [HOURS MUST BE 0–5; MINUTES MUST BE 0–59] *ADAPT PRIOR TO IMPLEMENTATION	Hours Minutes	Don't know 88 [No response] 99	
			Yes	No
				[NR]
3.10	Have you ever gone to another health facility to receive care for your disease?		1	0
3.10.1	[ASK ONLY IF 3.10=YES] Why did you go to another health facility? 			

4. TB Practices			
	Next, I would like to ask you about practices related to your disease.		
4.1	Were you examined by a healthcare provider at this facility during your first visit for your disease?	Yes 1 No 0 [No response] 99	
4.2	Has a healthcare provider at this facility talked with people you have close contact with, i.e., members of your family or those living with you, about how to prevent the spread of this disease from one person to another?	Yes 1 No 0 [No response] 99	
4.3	Were your family or close contacts examined for this disease?	Yes 1 No 0 Don't know 88 [No response] 99	
4.3.1	[ASK ONLY IF 4.3=NO, DK, or NR] Have you been told where to have your family or close contacts evaluated for this disease?	Yes 1 No 0 Don't know 88 [No response] 99	
4.4	Who supervises your treatment, i.e., who is your treatment partner?	Health worker at this facility 1 Health worker in the community 2 Family 3 Coworker 4 Other (specify) 5 [No response] 99	
4.5	On average, how many days per week does your treatment partner watch you take your medicines? [ENTER 0–7]	Days [No response] 99	
4.6	Have you ever stopped taking your medicines for a month or more, either on your own or because your doctor told you to stop?	Yes 1 No 0 Don't know 88 [No response] 99	

4. TB Practices			
4.6.1	[ASK ONLY IF 4.6=YES] Why did you stop taking your medicine?	My provider told me to stop Medicines were not available at the clinic Pharmacy was too far away Could not afford to buy medicines No time to buy or get medicines due to work Was travelling Forgot to take Was sick from the medicines or had side effects Other illness (not related to this disease) Other (specify) [No response]	1 2 3 4 5 6 7 8 9 96 99

5. TB Knowledge						
	Now I would like to ask about your knowledge and awareness of TB. [ASK THE LEADING QUESTION FIRST AND SELECT “UNPROMPTED” FOR ALL RESPONSES FROM THAT RESPONDENT WITHOUT NEEDING A PROMPT. THEN START PROMPTING EACH ITEM THAT WAS MISSED AND ANSWER ACCORDINGLY.]					
5.1	TB Symptoms					
	There are various symptoms an individual with this disease would experience to know s/he has the disease.					
	Can you tell me what symptoms a person with this disease will have? *ADAPT PRIOR TO IMPLEMENTATION	Yes, Unprompted	Yes, Prompted	No	DK	[NR]
5.1.1	Chronic cough (more than 3 weeks)	2	1	0	88	99
5.1.2	Coughing up mucus or phlegm	2	1	0	88	99
5.1.3	Blood-streaked mucus or sputum	2	1	0	88	99
5.1.4	Unexplained weight loss	2	1	0	88	99
5.1.5	Fever and/or chills	2	1	0	88	99
5.1.6	Night sweats	2	1	0	88	99
5.1.7	Persistent shortness of breath	2	1	0	88	99
5.1.8	Tiredness/fatigue	2	1	0	88	99
5.1.9	Pain in the chest or back	2	1	0	88	99
5.1.10	Other (specify) _____	-2	-1	0	88	99
5.2	TB Causes and Transmission					
	What do you think causes this disease or spreads it from one person to another?	Yes, Unprompted	Yes, Prompted	No	DK	[NR]
5.2.1	Microbes/germs/bacteria	2	1	0	88	99
5.2.2	Infected person coughing or sneezing	2	1	0	88	99
5.2.3	Crowded living conditions	2	1	0	88	99
5.2.4	Blood transfusions	-2	-1	0	88	99
5.2.5	Sharing utensils	-2	-1	0	88	99
5.2.6	Touching a person with TB	-2	-1	0	88	99
5.2.7	Through food	-2	-1	0	88	99

5. TB Knowledge						
		Yes, Unprompted	Yes, Prompted	No	DK	[NR]
5.2.8	Mosquito bites	-2	-1	0	88	99
5.2.9	Sexual contact	-2	-1	0	88	99
5.2.10	Other (specify) _____	-2	-1	0	88	99
5.3	TB Risk Factors					
	What do you think makes a person more at risk of getting TB?	Yes, Unprompted	Yes, Prompted	No	DK	[NR]
5.3.1	Way of living (lifestyle)	2	1	0	88	99
5.3.2	Smoking	2	1	0	88	99
5.3.3	Alcohol drinking	2	1	0	88	99
5.3.4	Fatigue	2	1	0	88	99
5.3.5	Malnutrition	2	1	0	88	99
5.3.6	Unhygienic practices	2	1	0	88	99
5.3.7	Poor ventilation	2	1	0	88	99
5.3.8	Pollution	2	1	0	88	99
5.3.9	Being HIV infected	2	1	0	88	99
5.3.10	Contact with or living with someone who has this disease	2	1	0	88	99
5.3.11	Inherited	-2	-1	0	88	99
5.3.12	Other (specify) _____	-2	-1	0	88	99
5.4	Drug Side Effects					
	What are the possible side effects patients may experience from using or taking medicines for this disease? *ADAPT PRIOR TO IMPLEMENTATION BY REVIEWING THE SIDE EFFECTS MOST COMMONLY EXPERIENCED BY TB PATIENTS AND INFORMATION GIVEN TO TB PATIENTS	Yes, Unprompted	Yes, Prompted	No	DK	[NR]
5.4.1	Nausea	2	1	0	88	99
5.4.2	Vomiting	2	1	0	88	99
5.4.3	Loss of appetite	2	1	0	88	99
5.4.4	Discolored urine or tears	2	1	0	88	99
5.4.5	Fever	2	1	0	88	99
5.4.6	Yellowish eyes	2	1	0	88	99
5.4.7	Problems with eyesight	2	1	0	88	99
5.4.8	Joint pain	2	1	0	88	99
5.4.9	Rash	2	1	0	88	99
5.4.10	Other (specify) _____	-2	-1	0	88	99
5.5	Can this disease be cured?	Yes No Don't know [No response]				1 0 88 99

5. TB Knowledge			
5.6	What is the usual time or typical period for treating drug susceptible TB? [MUST BE 0–12. ENTER '0' IF THEIR ANSWER IS <1 MONTH. ENTER '12' IF THEIR ANSWER IS >12 MONTHS.]	Months... Don't Know 88 [No response] 99	
5.7	What is the usual time or typical period for treating drug resistant TB? [MUST BE 0–30. ENTER '0' IF THEIR ANSWER IS <1 MONTH. ENTER '30' IF THEIR ANSWER IS >30 MONTHS.]	Months... Don't Know 88 [No response] 99	

6. Stigma/Discrimination						
	Next, I would like to ask you to rate the following statements.					
	How are you treated by others at this facility, where 1 is strongly disagree and 5 is strongly agree?	Strongly disagree	Disagree	Neither agree nor disagree	Agree	Strongly agree
6.1	Overall, I feel welcome in this health facility.	1	2	3	4	5
6.2	Overall, healthcare providers here treat me with respect.	1	2	3	4	5
6.3	Overall, the healthcare providers are friendly to me.	1	2	3	4	5
6.4	Overall, the healthcare providers treat me the same way I am treated when I receive care for other illnesses.	1	2	3	4	5
6.5	Healthcare providers here turn their face away when speaking with me.	1	2	3	4	5
6.6	People within this facility show discriminatory attitudes toward me because of my disease. *DEFINE DISCRIMINATORY ATTITUDES	1	2	3	4	5
6.7	Overall, I feel distressed, intimidated, or offended when interacting with healthcare providers at this facility.	1	2	3	4	5

7. Communication of TB Information				
	[ASK THE LEADING QUESTION FIRST AND SELECT "UNPROMPTED" FOR ALL RESPONSES FROM THAT RESPONDENT WITHOUT NEEDING A PROMPT. THEN START PROMPTING EACH ITEM THAT WAS MISSED AND ANSWER ACCORDINGLY.]			
	During your visits to this health facility, what information about this disease and its treatment were shared with you by the health workers?	Yes, Unprompted	Yes, Prompted	No [NR]
7.1	How the disease is spread to others	2	1	0 99
7.2	Cough hygiene, i.e., how to reduce the risk of making others sick by covering your mouth when you cough	2	1	0 99
7.3	That this disease can be cured	2	1	0 99
7.4	How long your treatment will last	2	1	0 99

7. Communication of TB Information					
		Yes, Unprompted	Yes, Prompted	No	[NR]
7.5	Danger signs of the disease getting worse	2	1	0	99
7.6	The importance of taking the medicines regularly	2	1	0	99
7.7	Side effects of the medicine	2	1	0	99
7.8	What to do if you have side effects from the medicine	2	1	0	99
7.9	The need for sputum tests at given points during your treatment	2	1	0	99
7.10	The importance of taking the medicines through the end of treatment	2	1	0	99
7.11	When to come back for the next care visit for this disease	2	1	0	99
7.12	Do you have materials (e.g., pamphlets) from the health facility to remind you of the treatment information provided by the provider or other facility staff?		Yes No [No response] ..		1 0 99

8. Patient – Provider Interaction				
	Next, I would like to ask you about your face-to-face meetings with healthcare providers at this facility.	Yes	No	[NR]
8.1	During your visits to this facility, do the healthcare providers usually explain things in a way you can understand?	1	0	99
8.2	During your visits to this facility, do the healthcare providers listen to your opinion and ideas on the best way to follow your treatment?	1	0	99
8.3	Do the healthcare providers at this facility discuss your status or progress with you at every scheduled appointment?	1	0	99
8.4	During your visits to this facility, do you think the healthcare providers give you a chance to ask questions about anything that concerns you?	1	0	99
8.5	During your visits to this facility, do you usually have enough time to discuss your health needs with the healthcare providers?	1	0	99
8.6	During your visits to this facility, do the healthcare providers tell you how this disease can affect your everyday life?	1	0	99
8.7	Do the healthcare providers at this facility address your worries about your disease seriously when you visit the facility?	1	0	99
8.8	During your visits to this facility, do the healthcare providers listen carefully to you?	1	0	99
8.9	During your visits to this facility, do the healthcare providers explain how to cope with your problems?	1	0	99
8.10	During your visits to this facility, do you worry that other patients can hear your conversation with your healthcare providers?	1	0	99
8.11	During your visits to this facility, do you think you have enough privacy during the examination?	1	0	99

9. TB/HIV Services					
	Next, I would like to ask you about the link between TB and HIV.	Yes	No	DK	[NR]
9.1	Have any healthcare providers in this facility told you about the link between TB and HIV?	1	0	88	99

9. TB/HIV Services					
	Next, I would like to ask you about the link between TB and HIV.	Yes	No	DK	[NR]
9.2	Have any healthcare providers in this facility told you how to prevent HIV infection?	1	0	88	99
9.3	After being told you had this disease, were you told to take an HIV test?	1	0	88	99
9.4	Have any healthcare providers in this facility told you where to get HIV treatment if you might need it?	1	0	88	99
9.5	Have any healthcare providers in this facility told you that you can get treatment for HIV and your disease at the same time if you might need this?	1	0	88	99
9.6	Are you taking treatment for HIV?	1	0	88	99
9.6.1	[ASK ONLY IF 9.6=YES] Have any healthcare providers in this facility told you about conditions in which the HIV treatment can make the symptoms of your disease worse?	1	0	88	99
9.6.2	[ASK ONLY IF 9.6=YES] Have any healthcare providers in this facility told you what to do if your symptoms get worse after starting HIV treatment?	1	0	88	99

10. Support					
	I would like to ask you about any support you receive from this facility.				
10.1	People with this disease sometimes also have other medical conditions, such as diabetes, HIV infection, or other illnesses. Do you have any other medical conditions?	Yes	No	DK	[NR]
		1	0	88	99
10.1.1	[ASK ONLY IF 10.1=YES] Who has discussed your other medical conditions with you?	No one	Only healthcare providers at this facility	Only healthcare providers outside this facility	Both healthcare providers at this facility and outside this facility
		0	1	2	3
					99
10.1.2	[ASK ONLY IF 10.1=YES] How do you feel your other medical needs have been met?	None have been met	Some have been met	Most have been met	All have been met
		0	1	2	3
					99
10.2	To support its patients, this facility offers various services to help you complete your treatment. Which, if any, of the following supportive services have you received from this facility? *ADAPT PRIOR TO IMPLEMENTATION	Yes	No	DK	[NR]
10.2.1	Free TB medicines	1	0	88	99
10.2.2	Home based treatment	1	0	88	99
10.2.3	Nutritional support/food basket	1	0	88	99
10.2.4	Rehabilitative services	1	0	88	99
10.2.5	Transport assistance	1	0	88	99
10.2.6	Small group TB health education session	1	0	88	99
10.2.7	One-on-one counseling (face-to-face) by medical staff (doctor or nurse)	1	0	88	99

10. Support					
		Yes	No	DK	[NR]
10.2.8	One-on-one peer counseling (face-to-face) by either a lay counsellor or a cured TB patient	1	0	88	99
10.2.9	Meeting with a social worker	1	0	88	99
10.2.10	Meeting with a psychologist	1	0	88	99
10.2.11	Other services (specify) _____	1	0	88	99
10.3	Which of the following services do you think would help you the most in continuing and completing your treatment, regardless of whether it is currently offered by this facility? *ADAPT PRIOR TO IMPLEMENTATION	Yes	No	DK	[NR]
10.3.1	Free TB medicines	1	0	88	99
10.3.2	Home based treatment	1	0	88	99
10.3.3	Nutritional support/food basket	1	0	88	99
10.3.4	Rehabilitative services	1	0	88	99
10.3.5	Transport assistance	1	0	88	99
10.3.6	Small group TB health education session	1	0	88	99
10.3.7	One-on-one counseling (face-to-face) by medical staff (doctor or nurse)	1	0	88	99
10.3.8	One-on-one peer counseling (face-to-face) by either a lay counsellor or a cured TB patient	1	0	88	99
10.3.9	Meeting with a social worker	1	0	88	99
10.3.10	Meeting with a psychologist	1	0	88	99
10.3.11	Other services (specify) _____	1	0	88	99

11. Affordability							
	Next, I would like to ask you about the costs of the care for your disease.				Yes	No	[NR]
11.1	Have you ever been unable to come to the health facility because of the cost?				1	0	99
11.2	Do you have to pay to see a healthcare provider at this facility?				1	0	99
	Next, I want to ask if you have received certain tests at this facility, and if so, I will ask if you have to pay for them.	(a) Have you had [test]?			[ASK ONLY IF (a)=YES] (b) Did you have to pay for it?		
		Yes	No	[NR]	Yes	No	[NR]
11.3	Sputum tests	1	0	99	1	0	99
11.4	Blood tests	1	0	99	1	0	99
11.5	X-rays	1	0	99	1	0	99

12. Infrastructure	
	Next, I would like to ask you about physical features of this facility. Please answer the questions about this facility only. Do not include any other facilities in your answer.

12. Infrastructure					
		Yes	No	DK	[NR]
12.1	During your visits to this facility, do you find the clinic area to be clean?	1	0		99
12.2	Are there enough comfortable places to sit in this facility?	1	0		99
12.3	During your visits to this facility, is drinkable water usually available?	1	0	88	99
12.4	During your visits to this facility, are the toilets usually clean?	1	0	88	99
12.4.1	[ASK ONLY IF 12.4=YES OR NO] During your visits to this facility, are the toilets always usable?	1	0	88	99

13. Overall Satisfaction			
13.1	Overall, how satisfied are you with the TB care you have received at this facility so far?	Very dissatisfied 1 Dissatisfied 2 Neither satisfied nor dissatisfied 3 Satisfied 4 Very satisfied 5 [No response] 99	
13.2	Is there anything you would like to see changed at this facility to improve the quality of care that you receive for your disease? _____ _____ _____		

End of Facility Visit			
		(a) Visit Result	(b) Visit End Time [Use the 24-hour clock system, e.g., 14:30]
003	Visit 1	Completed 1 Partially completed 2 Patient unavailable 3 Patient refused 4 Postponed 5 Other (specify) _____ 96	Hours Minutes
004	Visit 2 (if needed)	Completed 1 Partially completed 2 Patient unavailable 3 Patient refused 4 Other (specify) _____ 96	Hours Minutes

Thank your respondent and move to the next available patient.

QUALITY OF TB SERVICES ASSESSMENT: REGISTER REVIEW

Start of Facility Visit					
		(a) Visit Date	(b) Visit Start Time [Use the 24-hour clock system, e.g., 14:30]	(c) Interviewer ID	(d) Interviewer Name
001	Visit 1	___/___/___	Hours Minutes		_____
002	Visit 2 (if needed)	___/___/___	Hours Minutes		_____

Facility Identification		
*ADAPT PRIOR TO IMPLEMENTATION TO REFLECT STRUCTURE OF ADMINISTRATIVE LEVELS		
	(a) Code	(b) Name
010	Region/province/state (Level 1)	
011	District/county (Level 2)	
012	Facility	
013	Location of facility _____	

Data Collection Tools				
	Are the following documents used at this facility to record TB data? *ADAPT PRIOR TO IMPLEMENTATION—INCLUDE ANY IDENTIFICATION TO MAKE IT EASY TO RECOGNIZE, E.G., COLOR, SIZE, ETC.	Yes, electronic	Yes, paper	No
021	Presumptive TB register	2	1	0
022	TB laboratory register	2	1	0
023	TB treatment register	2	1	0
024	(Drug resistant) DR-TB laboratory register	2	1	0
025	DR-TB treatment register	2	1	0
026	TB preventive therapy register	2	1	0
027	Other (specify) _____	2	1	0

***ALL COUNTS (I.E., NUMERATORS AND DENOMINATORS) SHOULD BE ADAPTED PRIOR TO IMPLEMENTATION ACCORDING TO NTP GUIDELINES FOR TB SCREENING, DIAGNOSIS, AND TREATMENT**

1. Presumptive TB Register			
1.0	[LOCATE RECORDS WITHIN THE SPECIFIED DATE RANGE] *E.G., LAST 12 MONTHS (a) Start date _____ (b) End date _____		
1.1	TB Screening and Diagnosis Totals		
1.1	Number of patients with presumptive TB [ENTER 0 FOR NONE AND ALL 9's IF UNABLE TO DETERMINE THE COUNT]		
1.1.2	Number of patients with presumptive TB who had any type of diagnostic test done (e.g., smear, culture, Xpert MTB/RIF, chest X ray, clinical assessment, etc.) [MUST BE ≤ 1.1] [ENTER 0 FOR NONE AND ALL 9's IF UNABLE TO DETERMINE THE COUNT]		
1.1.3	Number of patients with presumptive TB confirmed by clinical diagnosis [MUST BE ≤ 1.1.2] [ENTER 0 FOR NONE AND ALL 9's IF UNABLE TO DETERMINE THE COUNT]		
1.1.4	Number of patients with presumptive TB who received either a smear microscopy, culture, or Xpert MTB/RIF (GeneXpert) test [MUST BE ≤ 1.1.2] [ENTER 0 FOR NONE AND ALL 9's IF UNABLE TO DETERMINE THE COUNT]		
1.1.5	Number of patients with presumptive TB with bacteriological test results [MUST BE ≤ 1.1.4] [ENTER 0 FOR NONE AND ALL 9's IF UNABLE TO DETERMINE THE COUNT]		
1.1.6	Number of patients with presumptive TB with positive bacteriological test results [MUST BE ≤ 1.1.5] [ENTER 0 FOR NONE AND ALL 9's IF UNABLE TO DETERMINE THE COUNT]		
1.2	Smear Microscopy [VALID ONLY IF 1.1.4>0]		
1.2	Does this facility perform smear microscopy, and if so, is it done on site or are specimens/slides sent to another facility?	No Yes, on site Yes, sent out .. Don't know	0 1 2 88
[THE NEXT 3 COUNTS ARE VALID ONLY IF 1.2>0]			
1.2.1	Number of patients with presumptive TB who received a smear microscopy test [MUST BE ≤ 1.1.4] [ENTER 0 FOR NONE AND ALL 9's IF UNABLE TO DETERMINE THE COUNT]		
1.2.2	Number of patients with presumptive TB with smear microscopy test results [MUST BE ≤ 1.2.1 & ≤ 1.1.5] [ENTER 0 FOR NONE AND ALL 9's IF UNABLE TO DETERMINE THE COUNT]		
1.2.3	Number of patients with presumptive TB with positive smear microscopy test results [MUST BE ≤ 1.2.2 & ≤ 1.1.6] [ENTER 0 FOR NONE AND ALL 9's IF UNABLE TO DETERMINE THE COUNT]		

1. Presumptive TB Register			
1.3	Culture [VALID ONLY IF 1.1.4>0]		
1.3	Does this facility perform culture, and if so, is it done on site or are specimens/slides sent to another facility?	No 0 Yes, on site 1 Yes, sent out .. 2 Don't know 88	
[THE NEXT 3 COUNTS ARE VALID ONLY IF 1.3>0]			
1.3.1	Number of patients with presumptive TB who received a culture test [MUST BE ≤ 1.1.4] [ENTER 0 FOR NONE AND ALL 9's IF UNABLE TO DETERMINE THE COUNT]		
1.3.2	Number of patients with presumptive TB with culture test results [MUST BE ≤ 1.3.1 & ≤ 1. 1.5] [ENTER 0 FOR NONE AND ALL 9's IF UNABLE TO DETERMINE THE COUNT]		
1.3.3	Number of patients with presumptive TB with positive culture test results [MUST BE ≤ 1.3.2 & ≤ 1. 1.6] [ENTER 0 FOR NONE AND ALL 9's IF UNABLE TO DETERMINE THE COUNT]		
1.4	GeneXpert [VALID ONLY IF 1.1.4>0]		
1.4	Does this facility perform GeneXpert tests, and if so, are they done on site or are specimens sent to another facility?	No 0 Yes, on site 1 Yes, sent out .. 2 Don't know 88	
[THE NEXT 4 COUNTS ARE VALID ONLY IF 1.4>0]			
1.4.1	Number of patients with presumptive TB who received a GeneXpert test [MUST BE ≤ 1.1.4] [ENTER 0 FOR NONE AND ALL 9's IF UNABLE TO DETERMINE THE COUNT]		
1.4.2	Number of patients with presumptive TB with GeneXpert test results [MUST BE ≤ 1.4.1 & ≤ 1. 1.5] [ENTER 0 FOR NONE AND ALL 9's IF UNABLE TO DETERMINE THE COUNT]		
1.4.3	Number of patients with presumptive TB with GeneXpert test results positive for TB [MUST BE ≤ 1.4.2 & ≤ 1. 1.6] [ENTER 0 FOR NONE AND ALL 9's IF UNABLE TO DETERMINE THE COUNT]		
1.4.4	Number of patients with presumptive TB with GeneXpert test results positive for rifampicin resistance [MUST BE ≤ 1.4.3] [ENTER 0 FOR NONE AND ALL 9's IF UNABLE TO DETERMINE THE COUNT]		

2. TB Laboratory Register *CHECK NTP GUIDELINES FOR EACH TB DIAGNOSTIC TEST OFFERED AT FACILITIES		
2.0	[LOCATE RECORDS WITHIN THE SPECIFIED QUARTER] (a) Start date (b) End date	____/____/____ ____/____/____
2.1	Smear Microscopy	
2.1.1	Number of diagnostic smears submitted to the laboratory [ENTER 0 FOR NONE AND ALL 9's IF UNABLE TO DETERMINE THE COUNT]	
2.1.2	Number of diagnostic smear results received from the laboratory [MUST BE ≤ 2.1.1] [ENTER 0 FOR NONE AND ALL 9's IF UNABLE TO DETERMINE THE COUNT]	
2.1.3	Number of diagnostic smear results received from the laboratory [WITHIN THE SPECIFIED TURNAROUND TIME] [MUST BE ≤ 2.1.2] [ENTER 0 FOR NONE AND ALL 9's IF UNABLE TO DETERMINE THE COUNT]	
2.1.4	Number of smear positive TB patients [MUST BE ≤ 2.1.2] [ENTER 0 FOR NONE AND ALL 9's IF UNABLE TO DETERMINE THE COUNT]	
2.1.5	Number of smear conversion tests submitted to the laboratory [ENTER 0 FOR NONE AND ALL 9's IF UNABLE TO DETERMINE THE COUNT]	
2.1.6	Number of smear conversion test results received from the laboratory [MUST BE ≤ 2.1.5] [ENTER 0 FOR NONE AND ALL 9's IF UNABLE TO DETERMINE THE COUNT]	
2.1.7	Number of smear conversion test results received from the laboratory [WITHIN THE SPECIFIED TURNAROUND TIME] [MUST BE ≤ 2.1.6] [ENTER 0 FOR NONE AND ALL 9's IF UNABLE TO DETERMINE THE COUNT]	
2.2	Culture	
2.2.1	Number of diagnostic culture tests submitted to laboratory [ENTER 0 FOR NONE AND ALL 9's IF UNABLE TO DETERMINE THE COUNT]	
2.2.2	Number of diagnostic culture test results received from laboratory [MUST BE ≤ 2.2.1] [ENTER 0 FOR NONE AND ALL 9's IF UNABLE TO DETERMINE THE COUNT]	
2.2.3	Number of diagnostic culture test results received from laboratory [WITHIN THE SPECIFIED TURNAROUND TIME] [MUST BE ≤ 2.2.2] [ENTER 0 FOR NONE AND ALL 9's IF UNABLE TO DETERMINE THE COUNT]	
2.2.4	Number of culture positive TB patients [MUST BE ≤ 2.2.2] [ENTER 0 FOR NONE AND ALL 9's IF UNABLE TO DETERMINE THE COUNT]	
2.2.5	Number of culture conversion test submitted to the laboratory [ENTER 0 FOR NONE AND ALL 9's IF UNABLE TO DETERMINE THE COUNT]	
2.2.6	Number of culture conversion test results received from the laboratory [MUST BE ≤ 2.2.6] [ENTER 0 FOR NONE AND ALL 9's IF UNABLE TO DETERMINE THE COUNT]	

2. TB Laboratory Register *CHECK NTP GUIDELINES FOR EACH TB DIAGNOSTIC TEST OFFERED AT FACILITIES		
2.2.7	Number of culture conversion test results received from the laboratory [WITHIN THE SPECIFIED TURNAROUND TIME] [MUST BE ≤ 2.2.6] [ENTER 0 FOR NONE AND ALL 9's IF UNABLE TO DETERMINE THE COUNT]	
2.3 GeneXpert		
2.3.1	Number of GeneXpert tests submitted to laboratory [ENTER 0 FOR NONE AND ALL 9's IF UNABLE TO DETERMINE THE COUNT]	
2.3.2	Number of GeneXpert test results received from the laboratory [MUST BE ≤ 2.3.1] [ENTER 0 FOR NONE AND ALL 9's IF UNABLE TO DETERMINE THE COUNT]	
2.3.3	Number of GeneXpert test results received from the laboratory [WITHIN THE SPECIFIED TURNAROUND TIME] [MUST BE ≤ 2.3.2] [ENTER 0 FOR NONE AND ALL 9's IF UNABLE TO DETERMINE THE COUNT]	
2.3.4	Number of GeneXpert tests with positive result for TB [MUST BE ≤ 2.3.2] [ENTER 0 FOR NONE AND ALL 9's IF UNABLE TO DETERMINE THE COUNT]	
2.3.5	Number of GeneXpert tests with positive result for resistance to rifampicin [MUST BE ≤ 2.3.4] [ENTER 0 FOR NONE AND ALL 9's IF UNABLE TO DETERMINE THE COUNT]	
2.3.6	Number of GeneXpert tests with negative result [MUST BE ≤ 2.3.2] [ENTER 0 FOR NONE AND ALL 9's IF UNABLE TO DETERMINE THE COUNT]	
2.3.7	Number of GeneXpert tests with error result [MUST BE ≤ 2.3.2] [ENTER 0 FOR NONE AND ALL 9's IF UNABLE TO DETERMINE THE COUNT]	
2.3.8	Does this facility perform GeneXpert tests with an Xpert MTB/RIF Ultra cartridge?	No 0 Yes 1 Don't know . 88
2.3.8.1	[VALID ONLY IF 2.3.8=YES] Number of Xpert MTB/RIF Ultra tests with a trace result [ENTER 0 FOR NONE AND ALL 9's IF UNABLE TO DETERMINE THE COUNT]	

3. TB Treatment Register		
3.0	[LOCATE RECORDS WITHIN THE SPECIFIED DATE RANGE] *MOST RECENT COHORT OF NEW AND RETREATMENT CASES FOR WHICH TREATMENT HAS BEEN COMPLETED AND OUTCOMES ASSIGNED (a) Cohort start date (b) Cohort end date	____/____/____ ____/____/____
3.1 TB Treatment		
3.1.1	Number of patients who started treatment (total cohort number) [ENTER 0 FOR NONE AND ALL 9's IF UNABLE TO DETERMINE THE COUNT]	

3. TB Treatment Register		
3.1.2	Number of clinically diagnosed TB patients who started treatment [MUST BE ≤ 3.1.1] [ENTER 0 FOR NONE AND ALL 9's IF UNABLE TO DETERMINE THE COUNT]	
3.1.3	Number of bacteriologically confirmed TB patients who started treatment [MUST BE ≤ 3.1.1] [ENTER 0 FOR NONE AND ALL 9's IF UNABLE TO DETERMINE THE COUNT]	
3.1.4	Number of new smear positive pulmonary TB cases registered for treatment *IF DIAGNOSTIC SMEAR TESTS ARE NO LONGER INDICATED IN NTP GUIDELINES, DELETE [MUST BE ≤ 3.1.1] [ENTER 0 FOR NONE AND ALL 9's IF UNABLE TO DETERMINE THE COUNT]	
3.1.5	Number of new smear positive pulmonary TB cases registered that were smear negative at the end of the initial phase of treatment *IF SMEAR CONVERSION TESTS ARE NO LONGER INDICATED IN NTP GUIDELINES, DELETE [MUST BE ≤ 3.1.4] [ENTER 0 FOR NONE AND ALL 9's IF UNABLE TO DETERMINE THE COUNT]	
3.2	TB/HIV	
3.2.1	Number of registered TB patients who had their HIV status documented in the TB register [ENTER 0 FOR NONE AND ALL 9's IF UNABLE TO DETERMINE THE COUNT]	
3.2.2	Number of registered HIV-positive TB patients (new and relapse) [MUST BE ≤ 3.2.1] [ENTER 0 FOR NONE AND ALL 9's IF UNABLE TO DETERMINE THE COUNT]	
3.2.3	Number of HIV-positive TB patients receiving CPT during TB treatment per NTP guidelines [MUST BE ≤ 3.2.2] [ENTER 0 FOR NONE AND ALL 9's IF UNABLE TO DETERMINE THE COUNT]	
3.2.4	Number of HIV-positive TB patients referred to ART care during TB treatment [MUST BE ≤ 3.2.2] [ENTER 0 FOR NONE AND ALL 9's IF UNABLE TO DETERMINE THE COUNT]	
3.2.5	Number of HIV-positive TB patients (new and relapse) who are started on or continuing ART, during TB treatment [MUST BE ≤ 3.2.4] [ENTER 0 FOR NONE AND ALL 9's IF UNABLE TO DETERMINE THE COUNT]	
3.3	TB Treatment Outcomes for New Cases *ENSURE THE DENOMINATOR IS CAPTURED IN SECTION 3.1	
3.3.1	Number of TB patients whose treatment was interrupted for 2 or more consecutive months (i.e., lost to follow-up) [MUST BE ≤ 3.1.1] [ENTER 0 FOR NONE AND ALL 9's IF UNABLE TO DETERMINE THE COUNT]	
3.3.2	Number of TB patients whose sputum smear or culture is positive at Month 5 or later during treatment (i.e., treatment failed) [MUST BE ≤ 3.1.1] [ENTER 0 FOR NONE AND ALL 9's IF UNABLE TO DETERMINE THE COUNT]	

3. TB Treatment Register		
3.3.3	Number of TB patients who died for any reason before starting treatment or during treatment [MUST BE ≤ 3.1.1] [ENTER 0 FOR NONE AND ALL 9's IF UNABLE TO DETERMINE THE COUNT]	
3.3.4	Number of TB patients for whom no treatment outcome is assigned—includes “transferred out” to another treatment unit and unknown treatment outcomes (i.e., not evaluated) [MUST BE ≤ 3.1.1] [ENTER 0 FOR NONE AND ALL 9's IF UNABLE TO DETERMINE THE COUNT]	
3.3.5	Number of TB patients at the beginning of treatment who were smear negative in the last month of treatment and on at least one previous occasion (i.e., cured) [MUST BE ≤ 3.1.1] [ENTER 0 FOR NONE AND ALL 9's IF UNABLE TO DETERMINE THE COUNT]	
3.3.6	Number of TB patients who completed treatment without evidence of failure, BUT there is no record to show that sputum smear or culture results in the last month of treatment and on at least one previous occasion are negative, either because they were not done or because results were not available (i.e., completed treatment) [MUST BE ≤ 3.1.1] [ENTER 0 FOR NONE AND ALL 9's IF UNABLE TO DETERMINE THE COUNT]	
3.3.7	Add the counts from 3.3.1 to 3.3.6 and enter here. Compare to the 3.1.1 count. They should be equal. If not, determine the cause of the discrepancy and fix. If it cannot be fixed, describe why not: 	
3.4 TB Treatment Outcomes for Retreatment Cases		
3.4.1	Number of retreatment TB patients (includes relapse, treatment after failure, treatment after lost to follow-up, or other previously treated patients without a documented outcome) who initiated a retreatment regimen [ENTER 0 FOR NONE AND ALL 9's IF UNABLE TO DETERMINE THE COUNT]	
3.4.2	Number of retreatment TB patients whose treatment was interrupted for 2 or more consecutive months (i.e., lost to follow-up) [MUST BE ≤ 3.4.1] [ENTER 0 FOR NONE AND ALL 9's IF UNABLE TO DETERMINE THE COUNT]	
3.4.3	Number of retreatment TB patients whose sputum smear or culture is positive at month 5 or later during treatment (i.e., treatment failed) [MUST BE ≤ 3.4.1] [ENTER 0 FOR NONE AND ALL 9's IF UNABLE TO DETERMINE THE COUNT]	
3.4.4	Number of retreatment TB patients who died for any reason before starting treatment or during treatment [MUST BE ≤ 3.4.1] [ENTER 0 FOR NONE AND ALL 9's IF UNABLE TO DETERMINE THE COUNT]	

3. TB Treatment Register		
3.4.5	Number of retreatment TB patients for whom no treatment outcome is assigned—includes “transferred out” to another treatment unit and unknown treatment outcomes (i.e., not evaluated) [MUST BE ≤ 3.4.1] [ENTER 0 FOR NONE AND ALL 9’s IF UNABLE TO DETERMINE THE COUNT]	
3.4.6	Number of retreatment TB patients who were smear negative in the last month of treatment and on at least one previous occasion (i.e., cured) [MUST BE ≤ 3.4.1] [ENTER 0 FOR NONE AND ALL 9’s IF UNABLE TO DETERMINE THE COUNT]	
3.4.7	Number of retreatment TB patients who completed treatment without evidence of failure, BUT there is no record to show that sputum smear or culture results in the last month of treatment and on at least one previous occasion are negative, either because they were not done or because results were not available (i.e., completed treatment) [MUST BE ≤ 3.4.1] [ENTER 0 FOR NONE AND ALL 9’s IF UNABLE TO DETERMINE THE COUNT]	
3.4.8	Add the counts from 3.4.2 to 3.4.7 and enter here. Compare to the 3.4.1 count. They should be equal. If not, determine the cause of the discrepancy and fix. If it cannot be fixed, describe why not: 	

4. DR-TB Laboratory Register *CHECK NTP GUIDELINES ON DR-TB SCREENING, DIAGNOSIS, AND TREATMENT, E.G., USE OF SOLID MEDIA (I.E., LJ), LIQUID MEDIA (I.E., MGIT), LINE-PROBE ASSAYS (LPA), OR OTHER MOLECULAR METHODS (I.E., MOLECULAR SEQUENCING), AS WELL AS SECOND-LINE DST, ETC. ADD SECTIONS TO ABSTRACT DATA ON SCREENING AND DIAGNOSIS BY METHODS, AS NEEDED.		
4.0	[LOCATE RECORDS WITHIN THE SPECIFIED DATE RANGE] *E.G., LAST 24 MONTHS (a) Cohort start date (b) Cohort end date	 ____/____/____ ____/____/____
4.1	DR-TB Screening and Diagnosis	
4.1.1	Number of presumptive TB cases eligible for and who received drug susceptibility testing (DST) [ENTER 0 FOR NONE AND ALL 9’s IF UNABLE TO DETERMINE THE COUNT]	
4.1.2	Number of presumptive TB cases with DST results [MUST BE ≤ 4.1.1] [ENTER 0 FOR NONE AND ALL 9’s IF UNABLE TO DETERMINE THE COUNT]	
4.1.3	Number of bacteriologically confirmed TB cases eligible for and who received DST [ENTER 0 FOR NONE AND ALL 9’s IF UNABLE TO DETERMINE THE COUNT]	
4.1.4	Number of bacteriologically confirmed TB cases with DST results [MUST BE ≤ 4.1.3] [ENTER 0 FOR NONE AND ALL 9’s IF UNABLE TO DETERMINE THE COUNT]	

4. DR-TB Laboratory Register *CHECK NTP GUIDELINES ON DR-TB SCREENING, DIAGNOSIS, AND TREATMENT, E.G., USE OF SOLID MEDIA (I.E., LJ), LIQUID MEDIA (I.E., MGIT), LINE-PROBE ASSAYS (LPA), OR OTHER MOLECULAR METHODS (I.E., MOLECULAR SEQUENCING), AS WELL AS SECOND-LINE DST, ETC. ADD SECTIONS TO ABSTRACT DATA ON SCREENING AND DIAGNOSIS BY METHODS, AS NEEDED.		
4.1.5	Number of bacteriologically-confirmed TB cases with DST results for rifampicin resistance [MUST BE ≤ 4.1.4] [ENTER 0 FOR NONE AND ALL 9's IF UNABLE TO DETERMINE THE COUNT]	
4.1.6	Number of bacteriologically-confirmed TB cases with DST results for rifampicin resistance who have RR-TB [MUST BE ≤ 4.1.5] [ENTER 0 FOR NONE AND ALL 9's IF UNABLE TO DETERMINE THE COUNT]	
4.1.7	Number of bacteriologically-confirmed RR-TB cases with DST results for fluoroquinolones and second-line injectable agents [MUST BE ≤ 4.1.6] [ENTER 0 FOR NONE AND ALL 9's IF UNABLE TO DETERMINE THE COUNT]	
4.1.8	Number of bacteriologically-confirmed RR-TB cases with DST results who are resistant to fluoroquinolones and/or second-line injectable agents [MUST BE ≤ 4.1.7] [ENTER 0 FOR NONE AND ALL 9's IF UNABLE TO DETERMINE THE COUNT]	
4.2	RR-TB Treatment	
4.2.1	Number of bacteriologically-confirmed RR-TB cases who started second-line treatment [MUST BE ≤ 4.1.6] [ENTER 0 FOR NONE AND ALL 9's IF UNABLE TO DETERMINE THE COUNT]	

5. DR-TB Treatment Register		
5.0	[LOCATE RECORDS WITHIN THE SPECIFIED DATE RANGE] *MOST RECENT COHORT OF NEW AND RETREATMENT CASES FOR WHICH TREATMENT HAS BEEN COMPLETED AND OUTCOMES ASSIGNED (a) Cohort start date (b) Cohort end date	
5.1	DR-TB Treatment Outcomes	
5.1.1	Number of DR-TB cases who started second-line treatment [ENTER 0 FOR NONE AND ALL 9's IF UNABLE TO DETERMINE THE COUNT]	
5.1.2	Number of DR-TB cases whose treatment was interrupted for 2 or more consecutive months (i.e., lost to follow-up) [MUST BE ≤ 5.1.1] [ENTER 0 FOR NONE AND ALL 9's IF UNABLE TO DETERMINE THE COUNT]	

5. DR-TB Treatment Register		
5.1.3	Number of DR-TB cases with treatment failure per WHO guidelines and NTP specifications, which include the following: lack of culture conversion at the end of the intensive phase of treatment, reversion of culture from negative to positive during treatment, or evidence of acquired resistance to fluoroquinolones or second-line injectable drugs, or adverse drug reactions (i.e., treatment failed) [MUST BE ≤ 5.1.1] [ENTER 0 FOR NONE AND ALL 9's IF UNABLE TO DETERMINE THE COUNT]	
5.1.4	Number of DR-TB cases who died for any reason before starting treatment or during treatment [MUST BE ≤ 5.1.1] [ENTER 0 FOR NONE AND ALL 9's IF UNABLE TO DETERMINE THE COUNT]	
5.1.5	Number of DR-TB cases for whom no treatment outcome is assigned, includes "transferred out" to another treatment unit, those still taking treatment for DR-TB, and those with unknown treatment outcomes (i.e., not evaluated) [MUST BE ≤ 5.1.1] [ENTER 0 FOR NONE AND ALL 9's IF UNABLE TO DETERMINE THE COUNT]	
5.1.6	Number of DR-TB cases who were cured [MUST BE ≤ 5.1.1] [ENTER 0 FOR NONE AND ALL 9's IF UNABLE TO DETERMINE THE COUNT]	
5.1.7	Number of DR-TB cases who completed treatment without documentation of cure [MUST BE ≤ 5.1.1] [ENTER 0 FOR NONE AND ALL 9's IF UNABLE TO DETERMINE THE COUNT]	
5.1.8	Add the counts from 5.1.2 to 5.1.7 and enter here. Compare to the 5.1.1 count. They should be equal. If not, determine the cause of the discrepancy and fix. If it cannot be fixed, describe why not: _____ _____ _____	

6. TB Preventive Therapy (TPT) Register [VALID ONLY IF TPT IS PROVIDED AT THE SITE TO PLHIV AND/OR CHILD CONTACTS OF CONFIRMED TB PATIENTS]								
6.1	TPT for PLHIV							
6.1	[LOCATE RECORDS WITHIN THE SPECIFIED DATE RANGE] *MOST RECENT COHORT OF PLHIV ON TPT FOR WHICH TPT HAS BEEN COMPLETED (a) Cohort start date (b) Cohort end date	 						
6.1.1	Does this facility provide TPT to PLHIV?	<table border="1"> <tr> <td>No</td> <td>0</td> </tr> <tr> <td>Yes</td> <td>1</td> </tr> <tr> <td>Don't know</td> <td>88</td> </tr> </table>	No	0	Yes	1	Don't know	88
No	0							
Yes	1							
Don't know	88							
[THE NEXT 8 COUNTS ARE VALID ONLY IF 6.1.1=YES]								
6.1.2	Number of PLHIV initiated on TPT [ENTER 0 FOR NONE AND ALL 9's IF UNABLE TO DETERMINE THE COUNT]							

6. TB Preventive Therapy (TPT) Register [VALID ONLY IF TPT IS PROVIDED AT THE SITE TO PLHIV AND/OR CHILD CONTACTS OF CONFIRMED TB PATIENTS]		
6.2.5	Number of child contacts on TPT who interrupted TPT due to developing active TB while taking TPT [MUST BE ≤ 6.2.2] [ENTER 0 FOR NONE AND ALL 9's IF UNABLE TO DETERMINE THE COUNT]	
6.2.6	Number of child contacts on TPT who interrupted TPT due to loss to follow-up [MUST BE ≤ 6.2.2] [ENTER 0 FOR NONE AND ALL 9's IF UNABLE TO DETERMINE THE COUNT]	
6.2.7	Number of child contacts on TPT with no outcome recorded [MUST BE ≤ 6.2.2] [ENTER 0 FOR NONE AND ALL 9's IF UNABLE TO DETERMINE THE COUNT]	
6.2.8	Number of child contacts on TPT who completed treatment [MUST BE ≤ 6.2.2] [ENTER 0 FOR NONE AND ALL 9's IF UNABLE TO DETERMINE THE COUNT]	
6.2.9	Add the counts from 6.2.3 to 6.2.8 and enter here. Compare to the 6.2.2 count. They should be equal. If not, determine the cause of the discrepancy and fix. If it cannot be fixed, describe why not: _____ _____ _____	

7. Comments/Observations	
7.1	Please provide comments or observations you may have about the quality of the record keeping: _____ _____ _____ _____ _____

End of Facility Visit			
		(a) Visit Result	(b) Visit End Time [Use the 24-hour clock system, e.g., 14:30]
003	Visit 1	Completed 1 Partially completed 2 Records unavailable 3 Facility refused 4 Postponed 5 Other (specify) 96 _____	 Hours Minutes

End of Facility Visit			
		(a) Visit Result	(b) Visit End Time [Use the 24-hour clock system, e.g., 14:30]
004	Visit 2 (if needed)	Completed 1 Partially completed 2 Records unavailable 3 Facility refused 4 Other (specify) 96	Hours Minutes

APPENDIX 1. INFORMED CONSENT FORM: HEALTH FACILITY AUDIT

READ TO RESPONDENT:

Greetings. My name is _____, and I am working with [name of the local research organization, or LRO]. My organization is collaborating with the National Tuberculosis Control Program (NTP) of the Ministry of Health (MOH) in [city, country]. The organization I am working for, MEASURE Evaluation, and the MOH are interested in the quality of services that patients diagnosed and treated for tuberculosis (TB) are receiving. This assessment is being conducted by the NTP in collaboration with MEASURE Evaluation, which is funded by the United States Agency for International Development (USAID). This study is being sponsored by the USAID mission in [city]. The data collection is being carried out by professional interviewers from [LRO]. The assessment is currently taking place in several countries around the world.

Your answers will help policymakers, program managers, and researchers to develop interventions that will improve the quality of care in the TB program in order to ensure better health outcomes and well-being. Your facility was selected because it is a high priority facility for improving TB service availability and quality. We will be asking you questions about various TB-related services and will visit different service points to ask about service practices and to ask about and see availability of equipment, supplies, patient registers, and submitted facility reports. We will also be interviewing staff about their training and work experience, and we will interview patients who come for TB diagnostic and treatment services today.

Any information you provide that identifies you, your facility, and/or patients receiving services will be kept strictly confidential by the parties conducting this study. Once information that identifies you and your facility have been removed, the remaining information you provide may be shared publicly or with third parties, without additional informed consent from you or your legal representative. The information will be used for research purposes, shared with other stakeholders for further analysis, and published, but all identifier information relating to the facility and individual participants will first be deleted in order to ensure full confidentiality. In addition, the name of your facility will not be provided, and any reports by these researchers that use your facility data will only present information in aggregate form so that your facility cannot be identified.

We are asking for your help to ensure that the information we collect is accurate. If there are questions that would be more accurately answered by someone better informed of any specifics we ask about, we would appreciate if you would introduce us to that person to help us collect any missing or incomplete information.

If you decide to participate, I would like to stress that you or your facility will not receive any compensation for the expenses that you might incur during the visits from our team or the time you spend answering the questions.

If you choose to participate in this study, you may still withdraw from the study at any stage without giving any explanation for your withdrawal. Your answers will be kept confidential. We will not provide this information to any of your service providers or the MOH, even after the study has been completed.

In charge of this study is the principal investigator, [name of PI], reachable by email at [email of PI]. The outcome of this study will be disseminated in an open-source journal, and you may request a copy from the principal investigator.

This survey will take approximately 90–120 minutes.

Question	Answer (circle appropriate number or fill answer on the answer line)		Action for interviewer
1. Do you have any questions?			Answer respondent's questions
2. Do you want to participate?	Yes No, because:	1. Language not good enough 2. Time constraint 3. Not comfortable 4. Other, specify: _____	If the answer is yes : thank the respondent and go to the interview. If the answer is no : end the interview here and make sure to fill out Part I of the health facility audit with the respondent's information.
Either way, this form should be signed by facility in-charge or other staff representing the facility for the purposes of this assessment:			

Respondent's signature: _____
 (A duplicate of this signed questionnaire should be offered to the respondent.)

Respondent's thumbprint:

APPENDIX 2. INFORMED CONSENT FORM: SERVICE PROVIDER

READ TO PROVIDER:

Greetings. My name is _____, and I am working with [name of the local research organization, or LRO]. My organization is collaborating with the National Tuberculosis Control Program (NTP) of the Ministry of Health (MOH) in [city, country]. The organization I am working for, MEASURE Evaluation, and the MOH are interested in the quality of services that patients diagnosed and treated for tuberculosis (TB) are receiving.

You have been randomly selected to be part of an assessment of the quality of TB services, and this is why we would like to interview you. This assessment is being conducted by the NTP in collaboration with MEASURE Evaluation, which is funded by the United States Agency for International Development (USAID). The study is being sponsored by the USAID mission in [city]. The data collection is being carried out by professional interviewers from [LRO]. The assessment is currently taking place in several countries around the world.

The interview will take approximately 30–45 minutes. I will ask you some questions about your work as a healthcare provider, especially as it pertains to services related to TB disease, including the practices and experiences you have at this facility and other facilities where you work. The information you provide will be used only to understand how the MOH and donors could better support healthcare providers to improve the quality of TB services to ensure patients received the best care.

Any information you provide that identifies you will be kept strictly confidential by the parties conducting this study. Once information that identifies you and your facility have been removed, the remaining information you provide may be shared publicly or with third parties, without additional informed consent from you or your legal representative. The information will be used for research purposes, shared with other stakeholders for further analysis, and published, but all your personal information will first be deleted in order to ensure full confidentiality.

If you decide to participate, I would like to stress that you or your facility will not receive any compensation for the expenses that you might incur during the visits from our team or the time you spend answering the questions.

If you choose to participate in this study, you may still withdraw from the study at any stage without giving any explanation for your withdrawal. Your answers will be kept confidential. We will not provide this information to any of your service providers or the MOH, even after the study has been completed.

In charge of this study is the principal investigator, [name of PI], reachable by email at [email of PI]. The outcome of this study will be disseminated in an open-source journal, and you may request a copy from the principal investigator.

Are you willing to participate in this survey? *Circle answer:* **1. Agreed** **2. Refused**

Service provider's signature: _____

(A duplicate of this signed questionnaire should be offered to the service provider.)

Service provider's thumbprint:

APPENDIX 3. INFORMED CONSENT FORM: TB PATIENT

Minors should fill out Appendix 4 and have their legal guardian fill out Appendix 5. [Include country-specific information about emancipated minors.]

READ TO PATIENT:

Greetings. My name is _____, and I am working with [name of the local research organization, or LRO]. My organization is collaborating with the National Tuberculosis Control Program (NTP) of the Ministry of Health (MOH) in [city, country]. The organization I am working for, MEASURE Evaluation, and the MOH are interested in the quality of services that patients diagnosed and treated for tuberculosis (TB) are receiving. This assessment is being conducted by the NTP in collaboration with MEASURE Evaluation, which is funded by the United States Agency for International Development (USAID). The study is being sponsored by the USAID Mission in [city]. The data collection is being carried out by professional interviewers from [LRO]. The assessment is currently taking place in several countries around the world.

Your answers will help policymakers, program managers, and researchers to develop interventions that will improve the quality of care in the TB program in order to ensure better health outcomes and well-being. Any information you provide that identifies you will be kept strictly confidential by the parties conducting this study. Once information that identifies you has been removed, the remaining information you provide may be shared publicly or with third parties, without additional informed consent from you or your legal representative. The information will be used for research purposes, shared with other stakeholders for further analysis, and published, but all your personal information will first be deleted in order to ensure full confidentiality.

It is important for you to understand that your participation in this study is completely voluntary. We would be grateful if you would agree to participate in this study, but you are free to decline. If you decline, there will be no consequence for you, and you will receive all the care and treatment you need at the health facility, as you would usually. If you decline to participate, you will not lose any benefit that you are entitled to, such as receiving care and support that is provided at the facility.

If you decide to participate, I would like to stress that you will not receive any compensation for the expenses that you might incur during the visits from our team or the time you spend answering the questions.

If you choose to participate in this study, you may still withdraw from the study at any stage without giving any explanation for your withdrawal. Your answers will be kept confidential. We will not provide this information to any of your service providers or the MOH, even after the study has been completed.

In charge of this study is the principal investigator, [name of PI], reachable by email at [email of PI]. The outcome of this study will be disseminated in an open-source journal, and you may request a copy from the principal investigator.

This survey will take approximately 45–60 minutes.

Question	Answer (circle appropriate number or fill answer on the answer line)		Action for interviewer
1. Do you have any questions?			Answer patient's questions
2. Do you want to participate?	Yes	1. Language not good enough 2. Time constraint 3. Not comfortable 4. Other, specify: _____	If the answer is yes : thank the patient and go to the interview. If the answer is no : end the interview here and make sure to fill out Part I of the patient interview form with the patient's information.
Either way, this form should be signed by the patient (only if the patient is ages 18 and older):			

Patient's signature: _____
(A duplicate of this signed questionnaire should be offered to the patient.)

Patient's thumbprint:

APPENDIX 4 PART 1. ASSENT FORM: MINOR TB PATIENT (YOUNGER THAN AGE 18)

Non-minors should fill out the Appendix 3. [Include country-specific information about emancipated minors.]

READ TO PATIENT:

Hello. My name is _____, and I am working with [name of the local research organization, or LRO]. My organization is collaborating with the National Tuberculosis Control Program (NTP) of the Ministry of Health (MOH) in [city]. We are interested in the quality of services that tuberculosis (TB) patients are receiving. The data collection is done by professional interviewers from [LRO]. The study is currently taking place in several countries around the world.

Your answers to the questions we will ask you will help decision makers and researchers to develop interventions that will improve the quality of care in the TB program for better health outcomes and well-being. Any information you provide that may allow someone to recognize you will be removed. The remaining information you provide will be shared anonymously. The information will be used for research purposes and published, but all your personal information will first be deleted in order to ensure full confidentiality.

It is important for you to understand that your participation in this study is completely voluntary. We would be grateful if you would agree to participate in this study, but you are free to say no. If you say no, there will be no consequence for you, and you will receive all the care and treatment you need at the health facility, as you would usually. If you do not want to participate, you will not lose any benefit that you are entitled to, such as receiving care and support that is provided at the facility.

If you decide to participate, I would like to make sure that you know that you will not receive any payment for your time or health expenses.

Even if you choose to participate in this study in the beginning, you can decide to stop your participation at any time. You do not need to tell us why you want to stop participating. Your answers will be kept confidential. We will not share your answers with any facility staff at any time.

In charge of this study is the principal investigator, [name of PI], reachable by email at [email of PI]. The results of this study will be shared to the public in an article or report, and you may request a copy from the principal investigator.

This survey will take approximately 45–60 minutes.

APPENDIX 4 PART 2. INFORMED CONSENT FORM: PARENT OR GUARDIAN OF MINOR TB PATIENT

READ TO MINOR TB PATIENT'S LEGAL GUARDIAN:

Greetings. My name is _____, and I am working with [name of the local research organization, or LRO]. My organization is collaborating with the National Tuberculosis Control Program (NTP) of the Ministry of Health (MOH) in [city, country]. The organization I am working for, MEASURE Evaluation, and the MOH are interested in the quality of services that patients diagnosed and treated for tuberculosis (TB) are receiving. This assessment is being conducted by the NTP in collaboration with MEASURE Evaluation, which is funded by the United States Agency for International Development (USAID). The study is being sponsored by the USAID Mission in [city]. The data collection is being carried out by professional interviewers from [LRO]. The assessment is currently taking place in several countries around the world.

The answers provided by the minor ages 15–18 of whom you are the legal guardian will help policymakers, program managers, and researchers to develop interventions that will improve the quality of care in the TB program in order to ensure better health outcomes and well-being. Any information the child provides that identifies them will be kept strictly confidential by the parties conducting this study. Once information that identifies the child has been removed, the remaining information provided may be shared publicly or with third parties, without additional informed consent from the child, you, or your legal representative. The information will be used for research purposes, shared with other stakeholders for further analysis, and published, but all the child's personal information will first be deleted in order to ensure full confidentiality.

It is important for you to understand that the child's participation in this study is completely voluntary. We would be grateful if you would agree to allow the child to participate in this study, but you are free to decline. If you decline, there will be no consequence for you or the child, and they will receive all the care and treatment they need at the health facility, as they would usually. If you decline to let the child participate, they will not lose any benefit that they are entitled to, such as receiving care and support that is provided at the facility.

If you decide to allow the child to participate, I would like to stress that neither you nor the child will receive any compensation for the expenses that you might incur during the visits from our team or the time spent answering the questions.

If you choose to allow the child to participate in this study, you or they may still withdraw from the study at any stage without giving any explanation for your/their withdrawal. Their answers will be kept confidential. We will not provide this information to any of their service providers or the MOH, even after the study has been completed.

In charge of this study is the principal investigator, [name of PI], reachable by email at [email of PI]. The outcome of this study will be disseminated in an open-source journal, and you may request a copy from the principal investigator.

This survey will take approximately 45–60 minutes.

Question	Answer (circle appropriate number or fill answer on the answer line)		Action for interviewer
1. Do you have any questions?			Answer parent/guardian's questions
2. Do you allow the child to participate?	Yes No, because:	1. Language not good enough 2. Time constraint 3. Not comfortable 4. Other, specify: _____	If the answer is yes : thank the parent/guardian and obtain assent from child before starting interview. If the answer is no : end the interview here and make sure to fill out Part I of the patient interview form with the patient's information.
Either way, this form should be signed by the patient's legal guardian:			

Patient's legal guardian's signature: _____

(A duplicate of this signed questionnaire should be offered to the patient's parent/guardian.)

Patient's legal guardian's thumbprint:

APPENDIX 5. REFUSAL FORM: TB PATIENT

Instructions:	If a patient passes the screening questions but declines to give consent to participate in the study, fill in the patient refusal form as follows.	
	Visit Date:	Enter the date you visited the facility.
	Facility Identification:	Enter the facility identification information from the Patient Interview Form.
	Patient Demographics:	Enter the data that you captured from the screening questions. Make your best guess for the patient's age, e.g., 20–25.
	TB Status:	Enter the data that you captured from the screening questions.

Patient Refusals											
Interviewer ID: _____ Interviewer Name: _____											
Visit		Facility Identification					Patient Demographics			TB Status	
Rec #	Visit Date	[Lev 1] Code	[Lev 2] Code	Facility Code	Facility Name	Facility Location	Patient #	Age	Sex (F/M)	TB Type (DS/DR/Unk)	Treatment Duration
1											
2											
3											
4											
5											
6											
7											
8											
9											
10											

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