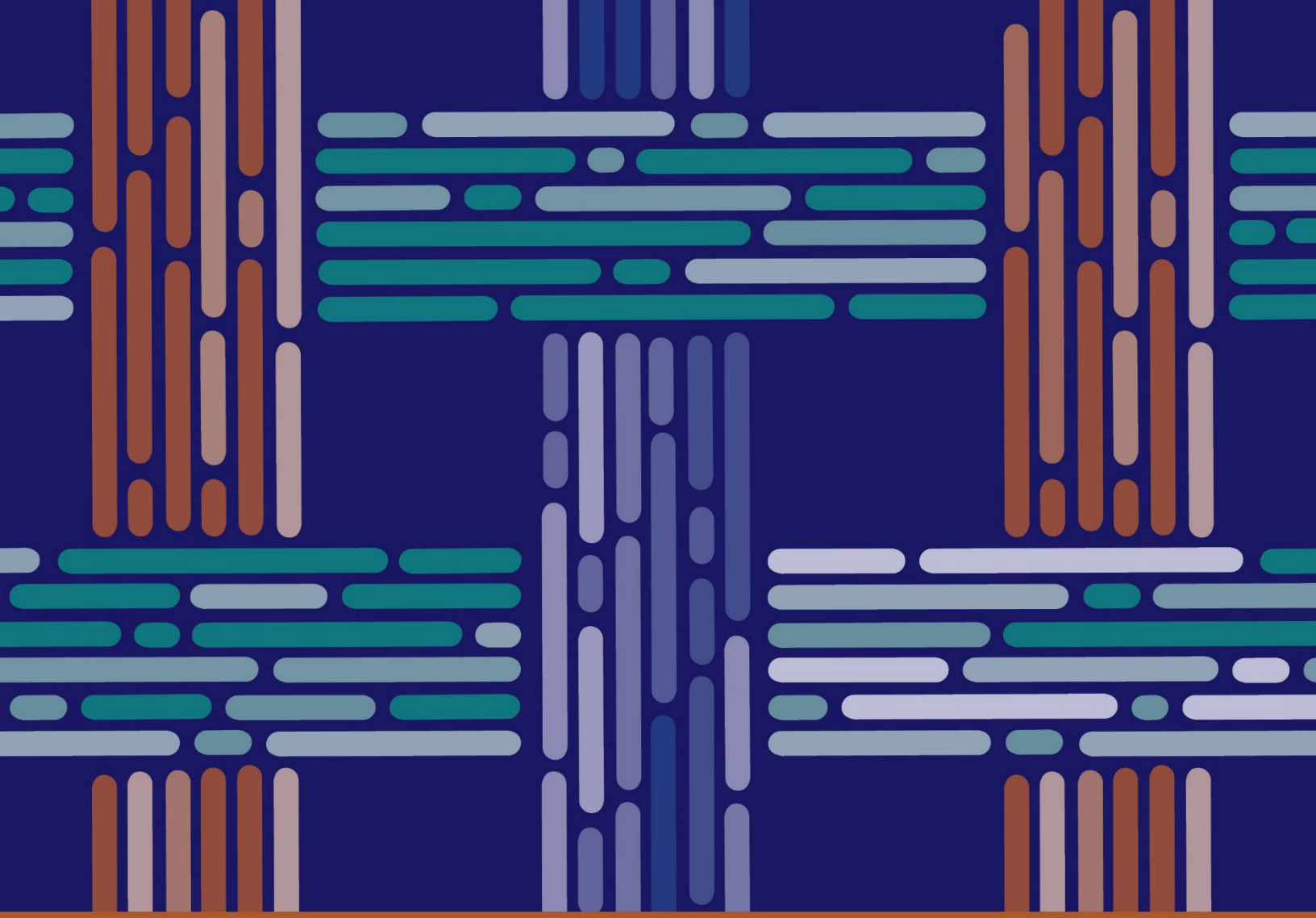

Quality of Tuberculosis Services Assessment

Global Tools (revised)

April 2024

USAID
FROM THE AMERICAN PEOPLE

TB DIAH
Tuberculosis Data, Impact Assessment and Communications Hub

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Tuberculosis Data, Impact Assessment and Communications Hub

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Contents

Abbreviations

aDSM	active drug safety monitoring
AIDS	acquired immunodeficiency syndrome
AE	adverse events
AFB	acid-fast bacillus
ART	antiretroviral therapy
ARV	antiretroviral(s)
BPaLM	a combination of bedaquiline, pretomanid, linezolid, and moxifloxacin
CPT	co-trimoxazole preventive therapy
CSF	cerebrospinal fluid
CHW	community health worker
DK	don't know
DOT	directly observed therapy
DR-TB	drug-resistant tuberculosis
DS-TB	drug-sensitive tuberculosis
DST	drug-susceptibility testing
ECG	electrocardiogram
FBO	faith-based organization
FM	fluorescence microscope
FDC	fixed-dose combination
FNAC	fine needle aspiration cytology
FQ	fluoroquinolone
HIV	human immunodeficiency virus
3HP	a combination of rifapentine and isoniazid
IGRAs	Interferon-Gamma Release Assays
INH	isoniazid
IRIS	immune reconstitution inflammatory syndrome
JSI	John Snow Inc.
LAM	lipoarabinomannan
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 TB Program
PLHIV	people living with HIV
QA	quality assurance
QC	quality control

QTSA	Quality of Tuberculosis Services Assessment
RIF	rifampicin
RR-TB	rifampicin-resistant tuberculosis
SMS	short-message service
SOP	standard operating procedure
TB	tuberculosis
TB DIAH	Tuberculosis Data, Impact Assessment and Communications Hub
TPT	TB preventive treatment
TST	tuberculin skin test
Ultra	Xpert MTB/RIF Ultra
USAID	United States Agency for International Development
WHO	World Health Organization
XDR-TB	extensively drug-resistant tuberculosis

Introduction

Background

The Quality of Tuberculosis Services Assessment (QTSA) is a health facility survey designed to assess the quality of TB services at TB diagnosis and treatment facilities to identify strengths and weaknesses in the quality of TB care. Survey results provide National TB Programs (NTP) and other TB stakeholders with information they can use to develop interventions to improve the quality of TB services.

The QTSA was originally developed by the MEASURE Evaluation project with technical input from colleagues at the United States Agency for International Development (USAID) Washington. In 2020, the QTSA portfolio was integrated into the TB Data, Impact Assessment and Communications Hub (TB DIAH) project, and since then, TB DIAH has innovated new tools and updated existing tools, developed the QTSA Global Implementation Guide, and conducted the QTSA in several high TB-burden countries around the world.

What is new in the 2024 edition of the QTSA Global Tools?

This second edition of the QTSA tools reflects the most up-to-date World Health Organization (WHO) normative guidance for TB prevention, diagnosis, and treatment services, including updated guidance on the use of molecular WHO-recommended rapid diagnostics (WRDs), treatment regimens for drug-sensitive TB (DS-TB) and drug-resistant TB (DR-TB), diagnosis and treatment of pediatric TB, and other changes in TB terminology and definitions. It also reflects the various improvements that were made to the tools over the course of country-level adaptation and implementation.

This document presents the detailed structure and content of the four standardized global QTSA tools and also contains other relevant procedural tools, such as consent forms.

Importance of Country Adaptation

The QTSA Global Tools need to be adapted to country-specific protocols and NTP guidelines prior to survey implementation. The availability of specific types of TB services at different levels of the health system varies from country to country, and global guidance regarding TB prevention, diagnosis, and treatment is continually evolving. In addition, countries may use different terminology from what is used in the Global Tools for items such as health administrative units (e.g., district, province, and ward), names of TB registers (e.g., TB patient logbook, TB confirmed cases register), and other health system or TB service delivery details that are specific to a country setting. Therefore, these tools must be carefully adapted and customized to align with the context and priorities of each country prior to use.

Overview of the QTSA Global Tools

The QTSA consists of four standardized survey tools that are designed to evaluate the quality of care from multiple perspectives, including that of the health facility, TB service provider, and people on TB treatment.

Figure 1. Overview of QTSA survey tools

Facility Audit

The facility audit assesses the TB services offered, availability and functionality of facility infrastructure and equipment, and the resources available at sampled facilities to provide people with TB person-centered care. It is administered to the individual(s) in charge of the health facility unit, the TB focal person(s), and/or other service providers who are engaged in the provision of TB services.

Provider Interview

The provider interview assesses the technical competence, knowledge, and practices of TB service providers at sampled health facilities in the provision of clinical care and management of TB services. It is administered to service providers who are actively engaged in the provision of clinical care, such as the TB focal person and/or other staff in charge of specific TB-related services.

Patient Interview

This interview assesses the perspectives and experiences of a person receiving TB care and services. It is administered to people who are receiving TB treatment at sampled health facilities.

Register Review

The register review assesses the number and type of TB services that were provided to people with TB during a specified period of time and TB-related patient outcomes. It includes a review of the relevant TB registers at sampled health facilities (i.e., TB laboratory registers, TB treatment registers, DR-TB treatment register, TB contact register) and extracts of specific service statistics and treatment outcome data.

Other QTSA Products and Resources

The QTSA Global Implementation Guide is a companion resource for the tools and contains detailed information on the background, purpose, and methods used in the QTSA, as well as guidance and steps for implementation.

The QTSA Global Tools have been adapted and used in several high TB-burden countries. The country-specific tools and reports, which contain tool adaptations and add-on modules, are also available on the TB DIAH website.

Quality of TB Services Assessment: Facility Audit

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)		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

*DK = don't know

1. Facility Characteristics *ADAPT PRIOR TO IMPLEMENTATION			
1.1	**Facility Classification**		
1.1.1	What type of facility is this?	Primary …….. Secondary …… Tertiary ……	1 2 3
1.1.2	Who is the managing authority of the TB clinic?	Government/public ……..….. Military/paramilitary …….. Nongovernmental organization (NGO)/not-for-profit ……..…….. Private, for-profit ……..……... Mission/faith-based ……..…….. Other (specify) _____	1 2 3 4 5 96
1.1.3	Is this location considered urban, peri-urban, or rural?	Urban ……..……... Peri-urban ……..…….. Rural ……..……..……..	1 2 3
1.1.4	Does this facility provide outpatient services, inpatient services, or both?	Outpatient only ……..….. Inpatient only ……..…… Both inpatient and outpatient …….....	1 2 3
1.2	**Facility Capacity**		
1.2.1	On average, how many people receive services at this facility during a typical month? **[ENTER VALID RANGE]**	Number of people _____ Don't know ……..……	88
1.2.2	Out of these people, how many receive TB services during a typical month? **[PROBE: How many people are evaluated or treated for TB during a typical month?]** **[ENTER VALID RANGE]**	Number of people _____ Don't know ……..……	88
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 ……..……	88
1.2.4	Out of these staff, how many usually work full-time in the TB unit? **[ENTER VALID RANGE]**	Number of staff _____ Don't know ……..……	88
1.2.5	How many usually work part-time in the TB unit? **[ENTER VALID RANGE]**	Number of staff _____ Don't know ……..……	88

2. Availability of TB Services ***ADAPT PRIOR TO IMPLEMENTATION**			
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
2.2	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 TB diagnosis services to children?	Yes …… No ……....	1 0
2.2.2	Is there an onsite laboratory for TB diagnosis at this facility (unit or clinic)?	Yes …… No ……....	1 0
2.2.3	Does this facility collect a sputum specimen from new presumptive TB clients?	Yes …… No ……....	1 0
2.2.4	**[ASK ONLY IF 2.2=NO]** Does this facility collect sputum specimens from persons presumed to have TB to send to an offsite diagnostic laboratory for testing?	Yes …… No ……....	1 0
2.3	Is there an X-ray onsite at this facility?	Yes …… No ……....	1 0
2.3.1	**[ASK ONLY IF 2.3=NO]** Does a mobile X-ray (e.g., an X-ray truck) visit the facility?	Yes …… No ……....	1 0
2.3.2	**[ASK ONLY IF 2.3.1=YES]** How frequently does the mobile X-ray visit the facility?	Every week…… Every two weeks……. Every month…….. Every quarter…… Other (specify)…….	1 2 3 4 96
2.4	Does this facility provide any HIV-related services, such as counseling, testing, care, or treatment?	Yes …… No ……....	1 0
2.5	Do providers in this facility prescribe treatment for TB or manage people who are on TB treatment?	Yes …… No ……....	1 0
	[ASK THE NEXT 3 QUESTIONS ONLY IF 2.5=YES]		
2.5.1	Are people on TB treatment charged a fee for TB medicines?	Yes …… No ……....	1 0
2.5.2	Does this facility provide TB treatment services to children?	Yes …… No ……....	1 0
2.5.3	Does this facility provide treatment for drug-resistant TB (DR-TB)?	Yes …… No ……....	1 0
2.5.3.1	**[ASK ONLY IF 2.5.3=NO]** (a) Has this facility referred people with TB elsewhere for second-line treatment for DR-TB in the past 12 months?	Yes …… No ……..... Don't know ……..….	1 0 88

2. Availability of TB Services *ADAPT PRIOR TO IMPLEMENTATION			
	[ASK ONLY IF 2.5.3.1 (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
	[ASK ONLY IF 2.5.3.1 (b)=YES (1 or 2)] (c) Are the results recorded?	Yes, observed …….. Yes, not observed … No …… Don't know ……	2 1 0 88
2.6	Some health facilities use community health workers (CHWs) to provide additional support to people with TB. Does this facility work with CHWs or volunteers who support people with TB?	Yes …… No …….....	1 0
2.7	(a) Has this facility referred people with TB 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 2.7 (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 2.7 (b)=YES (1 or 2)] (c) Are the results recorded?	Yes, observed …….. Yes, not observed …. No …… Don't know ……	2 1 0 88
2.8	Does this facility provide transport assistance?	Yes …… No ……... Don't know……	1 0 88
2.9	Typically, how many days per week are TB-related services offered at this facility?	Days _____ Don't know …….....	 88
2.10	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"]** **[ENTER VALID RANGE AND CAP AT MAXIMUM]**	Years _____ Don't know ……	88

3. TB Screening and Diagnosis *ADAPT PRIOR TO IMPLEMENTATION				
3.1	**TB Screening and Diagnosis Methods**			
	Now, I will ask if this facility provides specific TB screening and 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. TB Screening and Diagnosis *ADAPT PRIOR TO IMPLEMENTATION				
3.1.1	**[ASK ONLY IF 2.1=YES]** Screening for TB by clinical symptoms and signs	1	0	88
3.1.2	**[ASK ONLY IF 2.1=YES]** Screening for TB by X-ray	1	0	88
3.1.3	**[ASK ONLY IF 3.1.2=YES]** Are people with TB charged a fee for screening X-rays?	1	0	88
[ASK THE REMAINING QUESTIONS IN SECTION 3 ONLY IF 2.2=YES (diagnostic facility)]				
3.1.4	Diagnosis of TB by clinical symptoms and signs	1	0	88
3.1.5	Diagnosis of TB by X-ray	1	0	88
[ASK THE NEXT 4 QUESTIONS ONLY IF 3.1.5=YES]				
3.1.5.1	Diagnosis of TB by conventional X-ray	1	0	88
3.1.5.2	Diagnosis of TB by digital X-ray	1	0	88
3.1.5.3	Diagnosis of TB by computer assisted digital X-ray (CAD)	1	0	88
3.1.5.4	Are people with TB charged a fee for diagnostic X-rays?	1	0	88
3.1.6	Diagnosis of TB by smear microscopy	1	0	88
3.1.7	Diagnosis of TB by culture	1	0	88
3.1.8	Diagnosis of TB by GeneXpert	1	0	88
3.1.9	Diagnosis of TB by urine lipoarabinomannan (LAM)	1	0	88
3.1.10	Diagnosis of TB in children using stool-based testing with GeneXpert	1	0	88
3.1.11	Diagnosis of TB in children using stool-based testing with TrueNat	1	0	88
3.1.12	Diagnosis of TB by Fine Needle Aspiration Cytology (FNAC)	1	0	88
3.1.13	Diagnosis of TBM by testing cerebrospinal fluid (CSF)	1	0	88
3.1.14	Diagnosis of TB by TrueNat	1	0	88
3.1.15	Diagnosis of TB by another method (specify) _____	1	0	88
3.1.16	Are people with TB charged a fee for diagnostic laboratory tests?	1	0	88

3.1.17	**[ASK ONLY IF 3.1.8=YES]** Is there a GeneXpert on-site at this facility or are samples sent to another facility for testing?	Yes, onsite …… No, offsite…….. Don't know ……	1 0 88
3.1.18	**[ASK ONLY IF 3.1.17=1 (facility has GeneXpert unit on-site)]** Which Xpert cartridge is currently being used for TB diagnosis? **[SELECT ALL THAT APPLY]**	Xpert MTB/RIF…….. Xpert Ultra…… Xpert MTB/RIF and Ultra Xpert MTB/XDR …... Don't know……	1 2 3 4 88
3.1.19	**[ASK ONLY IF 3.1.8=NO]** Is this facility interested in implementing Xpert testing on-site?	Yes …….. No ……... Don't know ……..……	1 0 88

3. TB Screening and Diagnosis *ADAPT PRIOR TO IMPLEMENTATION			
3.1.19.1	Is there an Xpert testing facility located within 40 km of this facility?	Yes …… No …… Don't know ……	1 0 88
3.1.19.2	**[ASK ONLY IF 3.1.19=YES]** What would be the expected number of samples to be tested per week using GeneXpert?	Samples per week _____ Don't know ……	88
3.1.19.3	**[ASK ONLY IF 3.1.19=Yes]** Do you have a reliable supply of electricity to ensure continuous operation of the GeneXpert instrument during a 2 hour run?	Yes …… No…… Don't know ……	1 0 88
3.1.19.4	**[ASK ONLY IF 3.1.19=YES]** Do you have adequate space to accommodate a GeneXpert instrument and the appropriate environmental operating conditions?	Yes …… No …… Don't know ……	1 0 88
3.1.19.5	**[ASK ONLY IF 3.1.19=YES]** Do you have a functioning diagnostic data connectivity solution such that diagnostic instruments can be monitored and reporting performed remotely?	Yes …… No …… Don't know ……	1 0 88
3.1.20	Is there a Truenat Analyzer on site at this facility?	Yes …… No …… Don't know ……	1 0 88

[ASK THE NEXT 3 QUESTIONS ONLY IF 3.1.20=YES] Do you have the following consumables available to run the tests?		**Yes**	**No**	**DK**
3.1.20.1	Trueprep® AUTO MTB Sample Pretreatment Pack	1	0	88
3.1.20.2	Trueprep® AUTO v2 Universal Cartridge Based Sample Prep Kit	1	0	88
3.1.20.3	Truenat Chip Packs	1	0	88
	[ASK THE NEXT 3 QUESTIONS ONLY IF 3.1.20.3=YES] Do you have the following packs?			
3.1.20.3.1	MTB Chip Pack for TB Detection	1	0	88
3.1.20.3.2	MTB Plus Chip Pack	1	0	88
3.1.20.3.3	MTB RIF-Dx Chip Pack	1	0	88
3.1.21	**[ASK ONLY IF 3.1.20 = YES]** Do you have a Truelab micro-PCR printer?	1	0	88

3.1.22	**[ASK ONLY IF 3.1.6=NO/DK OR 3.1.8=NO/DK]** (a) Has this facility referred people with TB elsewhere for TB diagnostic testing in the past 12 months?	Yes …… No …… Don't know ……	1 0 88
	[ASK ONLY IF 3.1.20 (a)=YES] (b) Is there a record or register of the patient referrals for TB diagnostic testing?	Yes, electronic …… Yes, paper …… No …… Don't know ……	2 1 0 88

3. TB Screening and Diagnosis *ADAPT PRIOR TO IMPLEMENTATION					
	[ASK ONLY IF 3.1.20 (b)=YES (1 or 2)] (c) Are the results recorded?	Yes, observed …….. Yes, not observed …… No…… Don't know ……	2 1 0 88		
3.2	**Drug-Susceptibility Testing (DST)**				
			Yes	**No**	**DK**
3.2.1	Is first-line DST available at this facility?		1	0	88
[ASK THE NEXT 8 QUESTIONS ONLY IF 3.2.1=YES] What methods are used to detect resistance to first-line drugs?			**Yes**	**No**	**DK**
3.2.1.1	Xpert MTB/RIF to detect resistance to rifampicin (RIF)		1	0	88
3.2.1.2	Xpert Ultra to detect resistance to RIF		1	0	88
3.2.1.3	Xpert MTB/XDR to detect resistance to INH as a reflex test		1	0	88
3.2.1.4	Truenat to detect resistance to RIF		1	0	88
3.2.1.5	Line probe assays (LPAs) (e.g., MTBDRplus)		1	0	88
3.2.1.6	Solid culture		1	0	88
3.2.1.7	Liquid culture		1	0	88
3.2.2	Is second-line DST available at this facility?		1	0	88
[ASK THE NEXT 5 QUESTIONS ONLY IF 3.2.2=YES] What methods are used to detect resistance to second-line drugs?			**Yes**	**No**	**DK**
3.2.2.1	Xpert MTB/XDR to detect resistance to fluoroquinolones (FQs), second line injectables drugs, and ethionamide		1	0	88
3.2.2.2	LPAs (e.g., MTBDRsl)		1	0	88
3.2.2.3	Solid culture		1	0	88
3.2.2.4	Liquid culture		1	0	88
3.2.3	**[ASK ONLY IF 3.2.1=NO/DK OR 3.2.2=NO/DK]** (a) Has this facility referred people with TB elsewhere for follow-up drug susceptibility testing in the past 12 months?	Yes …… No …… Don't know ……	1 0 88		
	[ASK ONLY IF 3.2.3 (a)=YES] (b) Is there a record or register of patient referrals for drug-resistant TB (DR-TB) diagnostic testing?	Yes, electronic …….. Yes, paper …… No …….. Don't know ……..……	2 1 0 88		
	[ASK ONLY IF 3.2.3 (b)=YES (1 or 2)] (c) Are the results recorded?	Yes, observed …….. Yes, not observed…… No…… Don't know ……	2 1 0 88		
3.3	**TB Case Notification**				

3. TB Screening and Diagnosis *ADAPT PRIOR TO IMPLEMENTATION				
		Yes	**No**	**DK**
3.3.1	Does this facility notify the National TB Program (NTP) when people are diagnosed with TB?	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?			

*DK = don't know

4. Contact Investigation and Management *ADAPT PRIOR TO IMPLEMENTATION				
	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]			
4.1.1	For adult contacts	1	0	88
4.1.2	For child contacts	1	0	88
4.2	Does this facility keep records of TB contact investigations (e.g., a contact register)?	1	0	88

*DK = don't know

5. TB/HIV Services [ASK ONLY IF 2.4=YES (facility provides TB/HIV services) *ADAPT PRIOR TO IMPLEMENTATION				
	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 people with presumed TB	1	0	88
5.2	HIV testing and counseling for people with confirmed TB	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 people with TB elsewhere for HIV testing and counseling in the past 12 months?	Yes ……. 1 No ……... 0 Don't know ……... 88		

5. TB/HIV Services [ASK ONLY IF 2.4=YES (facility provides TB/HIV services) *ADAPT PRIOR TO IMPLEMENTATION				
	[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 ….. Yes, paper ……. No ……..….. Don't know ……		2 1 0 88
	[ASK ONLY IF 5.4 (b)=YES (1 or 2)] (c) Are the results recorded?	Yes, observed….. Yes, not observed No…… Don't know ……		2 1 0 88
		Yes	**No**	**DK**
5.5	TB preventive treatment (TPT)	1	0	88
	[ASK THE NEXT 4 QUESTIONS ONLY IF 5.5=YES] What type of TPT is available at this site?	**Yes**	**No**	**DK**
5.5.1	Isoniazid (INH) + pyridoxine	1	0	88
5.5.2	3HP (a combination of rifapentine and isoniazid)	1	0	88
5.5.3	Q-TIB	1	0	88
5.5.4	INH for children	1	0	88
5.5.6	3HP for children	1	0	88
5.5.7	Is TPT available through a differentiated service delivery model (e.g., community support group, multi-month scripting, etc.)?	1	0	88
5.5.8	**[ASK ONLY IF 5.5=NO/DK]** (a) Has this facility referred people with TB elsewhere for TPT in the past 12 months?	Yes …… No ……..….. Don't know ……..…		1 0 88
	[ASK ONLY IF 5.5.8 (a)=YES] (b) Is there a record or register of the patient referrals for TPT?	Yes, electronic ….. Yes, paper ……. No ……..….. Don't know ……		2 1 0 88
	[ASK ONLY IF 5.5.8 (b)=YES (1 or 2)] (c) Are the results recorded?	Yes, observed ….. Yes, not observed No…… Don't know ……		2 1 0 88
		Yes	**No**	**DK**
5.9	HIV care and treatment services to TB/HIV co-infected individuals	1	0	88
	[ASK THE NEXT 3 QUESTIONS ONLY IF 5.9=YES]			
5.9.1	Co-trimoxazole preventive therapy (CPT) for TB/HIV co-infected individuals	1	0	88
5.9.2	Viral load testing for TB/HIV co-infected individuals (i.e., whether test is done on-site or off-site)	1	0	88
5.9.3	ART for TB/HIV co-infected individuals	1	0	88

5. TB/HIV Services [ASK ONLY IF 2.4=YES (facility provides TB/HIV services) *ADAPT PRIOR TO IMPLEMENTATION								
5.9.3.1	**[ASK ONLY IF 5.9.3=YES]** Screening for symptoms of anti-TB and antiretroviral (ARV) drug interactions				1	0	88	
	[ASK THE NEXT 2 QUESTIONS ONLY IF 5.9.3.1=YES]							
	Do staff members provide the following information to TB/HIV co-infected individuals on antiretroviral therapy (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**
5.9.3.1.1	What to do if individuals experience anti-TB and ARV drug interactions	1	0	88	1	2	3	88
5.9.3.1.2	What to do if signs and symptoms of immune reconstitution inflammatory syndrome (IRIS) become evident	1	0	88	1	2	3	88

*DK = don't know

6. TB Treatment Services [ASK ONLY IF 2.5=YES (treatment facility)] *ADAPT PRIOR TO IMPLEMENTATION				
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 directly observed therapy (DOT)	1	0	88
6.1.5	Community-based DOT	1	0	88
6.1.6	Video DOT	1	0	88
6.1.7	Home-based treatment	1	0	88
6.1.8	Reminder phone calls or short-message service (SMS) texts to support individuals' adherence to treatment	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 people with TB	1	0	88
6.1.12	Tracking people with TB who miss an appointment	1	0	88

6. TB Treatment Services [ASK ONLY IF 2.5=YES (treatment facility)] *ADAPT PRIOR TO IMPLEMENTATION				
6.1.12.1	**[ASK ONLY IF 6.1.12=YES]** Follow-up phone calls or SMS texts to people with TB if they miss an appointment	1	0	88
6.1.12.2	**[ASK ONLY IF 6.1.12=YES]** Home visits to people with TB 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 individual with TB registered for treatment at the facility at least once a month during the treatment period?	1	0	88
6.2.2	Do you ask people with TB about side effects and/or adverse events (AE) 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 and/or AEs in the individual's chart?	1	0	88
6.2.2.2	**[ASK ONLY IF 6.2.2=YES]** How often are individuals on TB treatment screened for side effects and/or AEs?	At every follow-up visit to 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/treat side effects and AEs from TB medication?	1	0	88

6.3	**Counseling and Education on TB Treatment**							
	Do staff members provide the following information to people with TB 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
6.3.3	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 and/or AEs	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	1	0	88	1	2	3	88

6. TB Treatment Services [ASK ONLY IF 2.5=YES (treatment facility)] *ADAPT PRIOR TO IMPLEMENTATION			
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	**Taking Treatment without Facility Supervision**		
	The next couple of questions ask about people with TB taking treatment without the supervision of a health professional from the facility (for example, someone who is taking treatment supervised by their family or a treatment supporter).		
6.4.1	Does this facility have people with TB whose treatment is supervised by someone other than a health provider from this facility?	Yes …… No …….. Don't know ……	1 0 88
6.4.2.1	**[ASK ONLY IF 6.4.1=YES]** Who supervises their treatment?	Health provider from another facility …….. CHW or other volunteer ….. Family member …… Co-worker …….. No one …….. Don't know …… Other (specify) _____	1 2 3 4 5 88 96
6.4.2.2	**[ASK ONLY IF 6.4.1 =YES]** How often do individuals taking TB treatment without the supervision of a health provider typically collect their medications (or have their medications delivered by a treatment support) during the intensive phase?	Weekly ……..…… Twice a month …….. Monthly…….. Don't know …….... Other (specify) _____	1 2 3 88 96
6.4.2.3	**[ASK ONLY IF 6.4.1 =YES]** How often do individuals taking TB treatment without the supervision of a health provider typically collect their medications (or have their medications delivered by a treatment supporter) during the continuation phase?	Weekly ……..…… Twice a month …… Monthly …… Don't know …….... Other (specify) _____	1 2 3 88 96
6.4.3	**[ASK ONLY IF 6.4.1 =YES]** Does the facility monitor the intervals at which people on TB treatment (or their treatment supporters) should collect their medications?	Yes…….. No …….. Don't know ……	1 0 88
6.4.3.1	**[ASK ONLY IF 6.4.3=YES]** How does the facility monitor the intervals at which medications should be collected? **[SELECT ALL THAT APPLY]**	Check empty blisters …….. Phone call …… SMS …….. Through the patient card … Don't know …… Other (specify) _____	1 2 3 4 88 96

*DK = don't know

7. Drug-Resistant TB (DR-TB) Treatment Services [ASK ONLY IF 2.5.3=YES (facility provides DR-TB treatment)]

***ADAPT PRIOR TO IMPLEMENTATION: National TB Programs (NTPs) are updating treatment guidelines as more evidence becomes available on the effectiveness of shorter all-oral regimens to treat DR-TB. The regimens that appear below are intended to be illustrative only. The questions in this section should be based on the regimens available in the country at the time of the survey, and may include regimens not listed in this tool.**

The next set of questions asks about the DR-TB treatment services at this facility.

7.1	What is the DR-TB treatment regimen most often used at this facility?	Standard long regimen for multi-drug resistant (MDR)/rifampicin-resistant TB (RR-TB)……	1
		Standard shorter regimen for MDR/RR-TB with injectables	2
		Standard shorter all oral regimen for MDR/RR-TB ……..	3
		Standard all oral 6-month regimen for MDR/RR-TB (a combination of bedaquiline, pretomanid, linezolid, and moxifloxacin [BPaLM])……	4
		Don't know	88
		Other (specify) _____	96

7.2	**Which DR-TB treatment regimens are available at this facility?**	**Yes**	**No**	**DK***
7.2.1	Standard long regimen	1	0	88
7.2.2	Standard shorter regimen with injectables	1	0	88
7.2.3	Standard shorter all oral regimen	1	0	88
7.2.4	Standard all oral 6-month regimen (BPaLM)	1	0	88
7.2.5	Other (specify) _____	1	0	88

7.3	**Standard Long Regimen [ASK ONLY IF 7.2.1=YES]**			
	Which medications are used in the standard long 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 individuals are eligible for this regimen? ***ADAPT PRIOR TO IMPLEMENTATION—CHECK GUIDELINES**	**Yes**	**No**	**DK**
7.3.8.1	Those with confirmed or suspected resistance to a medication in the shorter RR/MDR-TB regimen	1	0	88
7.3.8.2	Those with exposure to any of the second-line medication in the shorter RR/MDR-TB regimen for more than 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 medications in the shorter MDR-TB regimen	1	0	88

7. Drug-Resistant TB (DR-TB) Treatment Services [ASK ONLY IF 2.5.3=YES (facility provides DR-TB treatment)] ***ADAPT PRIOR TO IMPLEMENTATION: National TB Programs (NTPs) are updating treatment guidelines as more evidence becomes available on the effectiveness of shorter all-oral regimens to treat DR-TB. The regimens that appear below are intended to be illustrative only. The questions in this section should be based on the regimens available in the country at the time of the survey, and may include regimens not listed in this tool.**				
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	**Standard Shorter Regimen with Injectables [ASK ONLY IF 7.2.2=YES]**			
	Which medications are used in the standard shorter regimen with injectables? **[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
	[ASK ONLY IF 7.2.2=YES] Which individuals are eligible for this regimen? ***ADAPT PRIOR TO IMPLEMENTATION—CHECK GUIDELINES**	**Yes**	**No**	**DK**
7.4.8.1	Those with no resistance or suspected ineffectiveness to any of the medications in the shorter RR/MDR-TB regimen	1	0	88
7.4.8.2	Those with no exposure to any of the second-line medications in the shorter RR/MDR-TB regimen for more than 1 month	1	0	88
7.4.8.3	Those with no known intolerance or risk of toxicity (e.g., drug-drug interactions) to any of the medications in the shorter RR/MDR-TB regimen	1	0	88
7.4.8.4	Females who are not pregnant	1	0	88
7.4.8.5	Those without extra-pulmonary 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	**Standard Shorter All Oral Regimen [ASK ONLY IF 7.2.3=YES]**			
	Which medications are used in the standard shorter all oral 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. Drug-Resistant TB (DR-TB) Treatment Services [ASK ONLY IF 2.5.3=YES (facility provides DR-TB treatment)] ***ADAPT PRIOR TO IMPLEMENTATION: National TB Programs (NTPs) are updating treatment guidelines as more evidence becomes available on the effectiveness of shorter all-oral regimens to treat DR-TB. The regimens that appear below are intended to be illustrative only. The questions in this section should be based on the regimens available in the country at the time of the survey, and may include regimens not listed in this tool.**				
7.5.x		1	0	88
7.5.x+1	Other (specify)_____ _	1	0	88
	[ASK ONLY IF 7.2.3=YES] Which individuals are eligible for this regimen? ***ADAPT PRIOR TO IMPLEMENTATION—CHECK GUIDELINES**	**Yes**	**No**	**DK**
7.5.8.1	Those with no resistance to fluoroquinolones (FQs)	1	0	88
7.5.8.2	Those with no exposure to any of the second-line medications in the shorter all oral RR/MDR-TB regimen for more than 1 month	1	0	88
7.5.8.3	Those with no known intolerance or risk of toxicity (e.g., drug-drug interactions) to any of the medications in the shorter RR/MDR-TB regimen	1	0	88
7.5.8.4	Those without extra-pulmonary disease	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	**Standard All Oral 6-month Regimen (BPaLM) [ASK ONLY IF 7.2.4=YES]**			
	Which medications are used in the standard all oral 6-month regimen (BPaLM)? **[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
	[ASK ONLY IF 7.2.4=YES] Which individuals are eligible for this regimen? ***ADAPT PRIOR TO IMPLEMENTATION—CHECK GUIDELINES**	**Yes**	**No**	**DK**
7.6.8.1	Those with RR/MDR-TB or RR/MDR-TB and resistance to FQs (pre-extensively drug-resistant TB [XDR-TB])	1	0	88
7.6.8.2	Those with confirmed pulmonary TB and all forms of extrapulmonary TB except for TB involving the CNS, osteoarticular, and disseminated (miliary) TB	1	0	88
7.6.8.3	Adults and adolescents aged 14 years and older	1	0	88

7. Drug-Resistant TB (DR-TB) Treatment Services [ASK ONLY IF 2.5.3=YES (facility provides DR-TB treatment)] ***ADAPT PRIOR TO IMPLEMENTATION: National TB Programs (NTPs) are updating treatment guidelines as more evidence becomes available on the effectiveness of shorter all-oral regimens to treat DR-TB. The regimens that appear below are intended to be illustrative only. The questions in this section should be based on the regimens available in the country at the time of the survey, and may include regimens not listed in this tool.**				
7.6.8.4	Those with RR/MDR-TB who have not had a previous exposure to bedaquiline, pretomanid, linezolid, or delamanid for more than 1 month	1	0	88
7.6.8.5	Females who are not pregnant or breastfeeding	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	**Other Regimen [ASK ONLY IF 7.2.5=YES]**			
	Which medications are used in this regimen? **[INSERT LIST OF MEDICATIONS IN REGIMEN]**	**Yes**	**No**	**DK**
7.7.1		1	0	88
7.7.2		1	0	88
7.7.3		1	0	88
7.7.x		1	0	88
7.7.x+1	Other (specify) _____	1	0	88
	[ASK ONLY IF 7.2.5=YES] Which individuals are eligible for this regimen? ***ADAPT PRIOR TO IMPLEMENTATION—CHECK GUIDELINES**	**Yes**	**No**	**DK**
7.7.8.1		1	0	88
7.7.8.2		1	0	88
7.7.8.3		1	0	88
7.7.8.x		1	0	88
7.7.8.x+1	Other (specify) _____	1	0	88
7.7.9	**[ASK ONLY IF 7.2.5=YES]** What is the usual duration of this regimen? **[ENTER 6–30]**	Months _____ Don't know		88
7.8	**Ancillary Drugs**			
		Yes	**No**	**DK**
7.8.1	Does this facility have ancillary drugs for management of side effects and/or adverse events (AEs) for people with DR-TB?	1	0	88
	[ASK ONLY IF 7.8.1=YES] Which ancillary drugs are available? ***ADAPT PRIOR TO IMPLEMENTATION—CHECK GUIDELINES**	**Yes**	**No**	**DK**

7. Drug-Resistant TB (DR-TB) Treatment Services [ASK ONLY IF 2.5.3=YES (facility provides DR-TB treatment)] ***ADAPT PRIOR TO IMPLEMENTATION: National TB Programs (NTPs) are updating treatment guidelines as more evidence becomes available on the effectiveness of shorter all-oral regimens to treat DR-TB. The regimens that appear below are intended to be illustrative only. The questions in this section should be based on the regimens available in the country at the time of the survey, and may include regimens not listed in this tool.**				
7.8.1.1	Antidepressants	1	0	88
7.8.1.2	Vitamin B6 (pyridoxine)	1	0	88
7.8.1.3	Ibuprofen or Paracetamol	1	0	88
7.8.1.x		1	0	88
7.8.1.x+1	Other (specify) _____	1	0	88
7.8.2	Does this facility participate in active pharmacovigilance (e.g., active drug safety monitoring (aDSM) and management?)	1	0	88
7.8.3	Does this facility provide any type of palliative care services to people with DR-TB?	1	0	88
	[ASK ONLY IF 7.8.3=YES] Which type(s) of palliative care services does this facility provide to people with DR-TB? **[SELECT ALL THAT APPLY]**	Psychosocial support …… Legal aid……..….. Co-infection management…….. Don't know……. Other (specify___)		1 2 3 88 96
7.9	**DR-TB Treatment Equipment**			
7.9.1	Does this facility have at least one electrocardiogram (ECG) machine? **[OBSERVE]**	Yes, observed …. Yes, not observed No …… Don't know ……..		2 1 0 88
7.9.1.1	**[ASK ONLY IF 7.9.1=YES]** Is the machine working? **[OBSERVE]**	Yes …… No …….. Don't know ……		1 0 88
7.9.1.2	**[ASK ONLY IF 7.9.1=YES (1 or 2)]** How many ECGs are performed for people with DR-TB per week, on average? **[ENTER VALID RANGE]**	Number _____ Don't know ……		88
7.10	**Pediatric DR-TB Treatment**			
7.10.1	Does this facility provide DR-TB treatment for children under age 15?	Yes …… No …….. Don't know ……		1 0 88
7.10.1.1	**[ASK ONLY IF 7.10.1=YES]** Does this facility have any pediatric formulations for second-line drugs available?	Yes …… No …….. Don't know ……...		1 0 88

*DK = don't know

8. Pediatric Services [ASK ONLY IF 2.2.1=YES OR 2.5.2=YES (facility sees children)] *ADAPT PRIOR TO IMPLEMENTATION					
8.1	**Pediatric TB Diagnosis [ASK ONLY IF 2.2.1=YES (facility provides children with diagnosis services)]**				
	Can you tell me how children are screened 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 8.1.2=YES (1 or 2)]**				
	How are children with presumptive TB evaluated?	Yes, unprompted	Yes, prompted	No	DK
8.2.1	Use clinical algorithms to diagnose children with TB	2	1	0	88
8.2.2	By X-ray	2	1	0	88
8.2.3	Use spontaneously produced sputum for testing	2	1	0	88
8.2.4	Use sputum induction to get samples for testing	2	1	0	88
8.2.5	Test sputum with sputum smear microscopy	2	1	0	88
8.2.6	Test sputum with culture	2	1	0	88
8.2.7	Test sputum with Xpert	2	1	0	88
8.2.8	Use gastric aspiration to get samples for testing	2	1	0	88
8.2.9	Test gastric aspirate with Xpert	2	1	0	88
8.2.10	Use nasopharyngeal aspiration to get samples for testing	2	1	0	88
8.2.11	Test nasopharyngeal aspirate with Xpert	2	1	0	88
8.2.12	Test stool samples with Xpert	2	1	0	88
8.2.13	Test urine with lipoarabinomannan (LAM)	2	1	0	88
8.2.14	Test cerebrospinal fluid (CSF)	2	1	0	88
8.2.15	Test lymph node aspirate	2	1	0	88
8.2.16	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?	Yes, unprompted	Yes, prompted	No	DK
8.3.1	Child contact of confirmed individual with TB	2	1	0	88
8.3.2	Referral from a maternal and child health (MCH) or child health clinic	2	1	0	88
8.3.3	Referral from a nutrition clinic	2	1	0	88
8.3.4	Child living with HIV/AIDS	2	1	0	88

8. Pediatric Services [ASK ONLY IF 2.2.1=YES OR 2.5.2=YES (facility sees children)] *ADAPT PRIOR TO IMPLEMENTATION					
8.3.5	Child exposed to HIV/AIDS	2	1	0	88
8.3.6	Other (specify) _____	2	1	0	88
8.4	**Pediatric TB Treatment [ASK ONLY IF 2.5.2=YES (facility provides children with treatment services)]**				
	The next set of questions asks about medications that are used to treat children with TB. *ADAPT PRIOR TO IMPLEMENTATION—CHECK GUIDELINES	**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 (i.e., for treating TB disease, not TB preventive treatment [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 shorter 4-month treatment regimen for DS-TB for eligible children?	1	0	88	
8.4.4	Does this facility use the same medications used for adults but cut up for children?	1	0	88	
8.4.5	How is the dosage determined for children?	Fixed in the kit ..... 1 Weight ..... 2 Don't know ..... 88 Other (specify)_____ 96			

*DK = don't know

9. Community Health Workers (CHWs) [ASK ONLY IF 2.6=YES (facility uses CHWs)] *ADAPT PRIOR TO IMPLEMENTATION				
	In this section, we would like to learn about the links your facility has with CHWs that provide support to people with TB.			
9.1	**Services Provided by CHWs** *ADAPT PRIOR TO IMPLEMENTATION—CHECK GUIDELINES			
	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. Community Health Workers (CHWs) [ASK ONLY IF 2.6=YES (facility uses CHWs)] *ADAPT PRIOR TO IMPLEMENTATION				
9.1.4	**[ASK ONLY IF 2.2.4=YES (facility uses an offsite lab)]** Collection and transportation of specimens to a laboratory for diagnostic testing	1	0	88
9.1.5	**[ASK ONLY IF 6.1.5=YES (community-based directly observed therapy (DOT) facility)]** 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 individuals with TB	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
9.2	**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	Nongovernmental organization (NGO(s))	1	0	88
9.2.2	Faith-based organization (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 (i.e., 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 at the community level were carried out by TB staff from this health facility in the past 3 months? **[ENTER 0–20]**	Visits _____ Don't know ……..		88

*DK = don't know

10. Policies, Protocols, and Guidelines *ADAPT PRIOR TO IMPLEMENTATION					
	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, no observe**	**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 the provision of TB preventive treatment(TPT)	2	1	0	88
10.1.4	Guidelines for TB infection control	2	1	0	88
10.1.5	**[ASK ONLY IF 2.4=YES (facility provides TB/HIV services)]** TB/HIV guidelines (i.e., for management of HIV and TB coinfection)	2	1	0	88
10.1.6	Educational materials about TB (i.e., posters on walls, leaflets, brochures, and/or pamphlets) in local languages for distribution	2	1	0	88
10.1.6.1	**[IF 10.1.6=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, t obserd**	**Don' have**	**DK**
10.2.1	Flowcharts or algorithms on TB diagnosis among children	2	1	0	88
10.2.2	Algorithm for laboratory testing of persons with presumptive TB	2	1	0	88
10.2.3	Guidelines on the use of chest X-ray for TB screening and diagnosis	2	1	0	88
10.2.4	**[ASK ONLY IF 3.1.6=YES (facility does smear microscopy)]** Smear microscopy manual or guidelines	2	1	0	88
10.2.5	**[ASK ONLY IF 3.1.8=YES (facility has GeneXpert)]** Algorithm for use of GeneXpert/Truenat for TB diagnosis	2	1	0	88
10.3	**Treatment Facilities [ASK ONLY IF 2.5=YES]**				
10.3.1	Essential drugs or medicines list	2	1	0	88

10. Policies, Protocols, and Guidelines *ADAPT PRIOR TO IMPLEMENTATION					
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 2.5.3=YES (facility provides drug-resistant TB (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
10.3.5	Guidelines on providing palliative care to people with DR-TB	2	1	0	88

*DK = don't know

11. Staff Capacity to Deliver TB Services *ADAPT PRIOR TO IMPLEMENTATION				
	Did any providers of TB services at this facility receive new or refresher training in the following topics in the last 24 months?	**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 sputum 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	Management of children with presumptive TB (*to be adapted in settings where newer diagnostic methods such as SOS-based stool tested for children are being scaled up)	1	0	88
11.8	Prescription of drugs for TB treatment	1	0	88
11.9	Management of drug-sensitive TB (DS-TB) treatment	1	0	88
11.10	Screening and diagnosis of drug-resistant TB (DR-TB)	1	0	88
11.11	Management of DR-TB treatment	1	0	88
11.12	Management of TB/HIV coinfection	1	0	88
11.13	TB infection control	1	0	88

*DK = don't know

12. Supervision and Feedback Practices *ADAPT PRIOR TO IMPLEMENTATION					
Next, I would like to ask about supervision and feedback on TB services this facility receives from upper levels.					
12.1	Has a supervisor from any upper level office come here on a supervisory visit within the past 3 months?	Yes …… No …….. Don't know ……			1 0 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 they 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 laboratory (e.g., assess lab procedures, review lab records, assess turn-around-time, etc.)		1	0	88
12.1.4	Assess TB data (e.g., completeness, quality, and/or timely reporting of registers, treatment cards, quarterly or monthly reports, etc.)		1	0	88
12.1.5	Discuss the performance of the facility based on TB service data		1	0	88
12.1.6	Complete a supervisory checklist		1	0	88
12.1.7	Provide a record of written comments or suggestions from their visit		1	0	88
12.1.8	**[ASK ONLY IF 12.1.7=YES]** May I see the written comments or suggestions?		1	0	

*DK = don't know

13. Availability of Basic Equipment *ADAPT PRIOR TO IMPLEMENTATION								
[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 observ	Don' 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. Availability of Basic Equipment *ADAPT PRIOR TO IMPLEMENTATION								
[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 observ	Don' have	DK*	Yes	No	DK
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

*DK = don't know

14. TB Laboratory Procedures [ASK ONLY IF 2.2.2=YES (facility has an onsite lab)] *ADAPT PRIOR TO IMPLEMENTATION									
	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 acid-fast bacillus (AFB)	1	0	88					
14.2	Light microscope	1	0	88	1	0	1	0	88
	[ASK THE NEXT 3 QUESTIONS ONLY IF 14.1 (a)=YES]								
14.2.1	Carbol fuchsin stain	1	0	88	1	0			
14.2.2	Sulfuric acid (20–25% concentration) or acid alcohol	1	0	88	1	0			
14.2.3	Methyl blue stain	1	0	88	1	0			
14.3	Fluorescence microscope (FM) light-emitting diode (LED)	1	0	88	1	0	1	0	88

14. TB Laboratory Procedures [ASK ONLY IF 2.2.2=YES (facility has an onsite lab)] *ADAPT PRIOR TO IMPLEMENTATION									
14.3.1	**[ASK ONLY IF 14.3 (a)=YES]** Auramine stain for fluorescence microscopy	1	0	88	1	0			
14.4	**[ASK IF 14.2(a) or 14.3(a)=YES]** Does the facility meet biosafety requirements for microscopy (i.e., at least level 1)?	1	0	88	1	0			
	[ASK THE NEXT 6 QUESTIONS ONLY IF 3.1.17=1 (facility has GeneXpert unit onsite)]								
14.5	GeneXpert module **[AT LEAST ONE SHOULD BE FUNCTIONAL]**	1	0	88	1	0	1	0	88
	Module used by facility:	(a) Used in facility?			**[ASK ONLY IF (a)=YES]** (b) Observed?		**[ASK ONLY IF (b)=YES]** (c) Functioning?		
		N	**N**	**DK**	**Y**	**N**	**Y**	**N**	**DK**
14.5.1(a)	6 color	1	0	88	1	0	1	0	88
14.5.1(b)	10 color	1	0	88	1	0	1	0	88
14.5.2	**[ASK ONLY IF 3.1.18=1 OR 3]** At least 1 valid Xpert MTB/RIF cartridge (i.e., not expired)	1	0	88	1	0	1	0	88
14.5.3	**[ASK ONLY IF 3.1.18=2 OR 3]** At least 1 valid Xpert Ultra cartridge (i.e., not expired)	1	0	88	1	0	1	0	88
14.5.4	**[ASK ONLY IF 3.1.18=4]** At least 1 valid Xpert MTB/XDR cartridge (i.e., not expired)	1	0	88	1	0	1	0	88
14.5.5	Does the facility meet biosafety requirements for Xpert testing (i.e., at least level 1)?	1	0	88	1	0			
14.6	**[ASK ONLY IF 3.2.1.5=YES OR 3.2.1.6=YES OR 3.2.2.3=YES OR 3.2.2.4=YES (facility uses solid or liquid culture)]** TB culture or growth medium (e.g., Mycobacteria growth indicator tube [MGIT] 960)	1	0	88	1	0			
14.7	Biosafety hood or cabinet	1	0	88	1	0	1	0	88
14.7.1	Does the facility meet biosafety requirements for culture (i.e., at least level 2)?	1	0	88	1	0			
	Quality Control/Quality Assurance (QC/QA)								
	I would like to ask you about QC/QA procedures for TB diagnosis services provided in the laboratory at this facility.								

14. TB Laboratory Procedures [ASK ONLY IF 2.2.2=YES (facility has an onsite lab)] *ADAPT PRIOR TO IMPLEMENTATION			
14.8	What type of QC/QA do you use for laboratory tests conducted in this facility?	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 14.8=1, 2, 3]		
14.8.1	Do you maintain records of the results from the QC/QA procedures?	Yes …… No …… Don't know ……	1 0 88
14.8.2	Do you have guidelines and procedures for QC/QA (i.e., either internal or external) for the specimens assessed in this facility?	Yes …… No …… Don't know ……	1 0 88
14.8.2.1	**[ASK ONLY IF 14.8.2=YES]** May I see the QC/QA guidelines?	Yes …… No ……	1 0

*DK = don't know

15. Collection, Management, and Transportation of Specimens *ADAPT PRIOR TO IMPLEMENTATION *ALTERNATIVE ORGANIZATION STRUCTURE IS TO MOVE DIAGNOSIS-RELATED QUESTIONS TO SECTION 2 AND TREATMENT RELATED QUESTIONS TO SECTION 5			
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 RESPOND UNPROMPTED]** When is sputum collected by individuals with TB or when do you ask the individual to collect sputum? ***[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.]***	Correct, unprompted Correct, prompted ... Incorrect …… Don't know ……	2 1 0 88
15.1.2	Are there standard operating procedures (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, leak-proof sputum containers) in the past 6 months?	Yes…… No…… Don't know ……	1 0 88

15. Collection, Management, and Transportation of Specimens *ADAPT PRIOR TO IMPLEMENTATION *ALTERNATIVE ORGANIZATION STRUCTURE IS TO MOVE DIAGNOSIS-RELATED QUESTIONS TO SECTION 2 AND TREATMENT RELATED QUESTIONS TO SECTION 5				
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 turn-around-time for the laboratory.		**Yes**	**No**	**DK***
15.2.1	Do you maintain any sputum containers that are sealable and leak proof 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 hours does it take for the laboratory to receive specimens from service sites within this facility? **[ENTER VALID RANGE]**	Hours _____ Don't know …….....		88
15.2.3	On average, how many hours does it take for service sites within the facility to receive specimen results from the laboratory? **[ENTER VALID RANGE]**	Hours _____ Don't know …….....		88
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	Sputum Smear microscopy	1	0	88
15.3.1.2	Xpert MTB/RIF	1	0	88
15.3.1.3	Xpert Ultra	1	0	88
15.3.1.4	Xpert MTB/XDR	1	0	88
15.3.1.5	Truenat	1	0	88
15.3.1.6	First-line drug-susceptibility testing (DST) (other than Xpert)	1	0	88
15.3.1.7	Second-line DST	1	0	88
15.3.1.8	Other (specify)	1	0	88
15.3.2	Does this facility have the contact details of the laboratory? **[OBSERVE]**	Yes, observed …….. Yes, not observed … No …….. Don't know ……		2 1 0 88
15.3.3	Is there an up-to-date specimen referral register (i.e., one with the dispatch list, date sent, date results returned)? **[OBSERVE]**	Yes, observed …….. Yes, not observed … No …….. Don't know ……		2 1 0 88
15.3.4	Does the facility maintain records of results of specimen testing that is conducted offsite? **[OBSERVE]**	Yes, observed …….. Yes, not observed …. No…….. Don't know ……		2 1 0 88

15. Collection, Management, and Transportation of Specimens *ADAPT PRIOR TO IMPLEMENTATION *ALTERNATIVE ORGANIZATION STRUCTURE IS TO MOVE DIAGNOSIS-RELATED QUESTIONS TO SECTION 2 AND TREATMENT RELATED QUESTIONS TO SECTION 5			
15.3.5	Does the facility have access to a specimen transport service?	Yes …… No …….. Don't know ……..	1 0 88
15.3.5.1	**[ASK ONLY IF 15.3.5=YES]** What type of service is used?	Lab staff …… Courier service …….. Implementing partner Don't know …….. Other (specify)_____	1 2 3 88 96
15.3.5.2	**[ASK ONLY IF 15.3.5=YES]** What type of specimens are picked up?	Only TB …….. TB and others …….. Don't know ……	1 2 88
15.3.6	Does the facility use a cooler box reserved for transportation of specimens?	Yes …… No …….. Don't know ……	1 0 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.]**	Days _____ Don't know ……..	 88
15.3.8	On average, how many days does it take to receive specimen results back from the laboratory? **[ENTER VALID RANGE]**	Days _____ Don't know ……..	 88

	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	Results are brought back to the facility (i.e., by lab staff, courier, implementing partner, etc.)	2	1	0	88
15.3.9.2	Results are sent by email	2	1	0	88
15.3.9.3	Results are sent by text message	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 2.5=YES (treatment facility)]** ***ADAPT PRIOR TO IMPLEMENTATION**			
	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 intensive phase of treatment for drug-sensitive TB (DS-TB)?	1	0	88
15.4.2	**[ASK ONLY IF 6.1.3=YES (facility provides continuation phase treatment)]** Does this facility request sputum during the last month of the continuation phase of treatment for DS-TB?	1	0	88

15. Collection, Management, and Transportation of Specimens *ADAPT PRIOR TO IMPLEMENTATION *ALTERNATIVE ORGANIZATION STRUCTURE IS TO MOVE DIAGNOSIS-RELATED QUESTIONS TO SECTION 2 AND TREATMENT RELATED QUESTIONS TO SECTION 5				
15.4.3	Does this facility request drug-susceptibility testing (DST) (i.e., including Xpert) for individuals who were previously treated for TB?	1	0	88
15.4.4	Does this facility request DST (i.e., including Xpert) for individuals who fail to convert on treatment?	1	0	88
15.4.5	Does this facility request any type of DST (i.e., including Xpert) for suspected drug-resistant TB (DR-TB)? *ADAPT PRIOR TO IMPLEMENTATION DEPENDING ON DST GUIDELINES	1	0	88
15.4.6	[ASK ONLY IF 2.5.3=YES (facility provides DR-TB treatment)] Does this facility request monthly smears and cultures throughout treatment for DR-TB?	1	0	88

*DK = don't know

16. Management of Supplies and Commodities *ADAPT PRIOR TO IMPLEMENTATION *ENSURE DATA COLLECTORS KNOW HOW TO ASSESS THE CONDITIONS				
[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?		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
16.4	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

*DK = don't know

17. Drug Stock [ASK ONLY IF 2.5=YES (treatment facility)]

*ADAPT PRIOR TO IMPLEMENTATION

[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.

	Drugs and medicines available at the facility during the assessment. [CHECK TO SEE IF AT LEAST ONE IS VALID, I.E., NOT EXPIRED]	Observed, at least one valid	Observe, none valid	No stock observed	Never stocked	DK*

17. Drug Stock [ASK ONLY IF 2.5=YES (treatment facility)] *ADAPT PRIOR TO IMPLEMENTATION						
17.1.1	Isoniazid (INH)	3	2	1	0	88
17.1.2	Rifampicin (RIF)	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	INH + RIF (2FDC)	3	2	1	0	88
17.1.6	INH + ethambutol (EH) (2FDC)	3	2	1	0	88
17.1.7	INH + RIF + pyrazinamide (RHZ) (3FDC)	3	2	1	0	88
17.1.8	INH + RIF + ethambutol (RHE) (3FDC)	3	2	1	0	88
17.1.9	INH + RIF + pyrazinamide + ethambutol (4FDC)	3	2	1	0	88
17.1.10	Streptomycin injectables	3	2	1	0	88
17.1.11	INH single tablets	3	2	1	0	88
17.1.12	3HP (a combination of rifapentine and INH)	3	2	1	0	88
17.1.13	Q-TIB	3	2	1	0	88
	***ADD PEDIATRIC FORMULATIONS OF FIXED-DOSE COMBINATIONS (FDCs)**	3	2	1	0	88
	***ADD PEDIATRIC FORMULATIONS OF TPT**	3	2	1	0	88
	***ADD SECOND-LINE MEDICATIONS PER CURRENT DRUG-RESISTANT TB (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 6 months?			1	0	88
17.3.1	**[ASK ONLY IF 17.3=YES]** Did any individual go without TB treatment because of stockouts within the last 6 months?			1	0	88

*DK = don't know

18. Infection Control *ADAPT PRIOR TO IMPLEMENTATION				
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 individuals routinely asked about cough when entering the facility?	1	0	88
18.1.3	Is cough triage implemented (i.e., individuals that are coughing are separated from others and fast-tracked for evaluation)?	1	0	88

18. Infection Control *ADAPT PRIOR TO IMPLEMENTATION					
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 designated person assist with separation and triage of coughing individuals?		1	0	88
18.1.6	Does the facility provide medical/surgical masks to people with presumed and people with confirmed TB?		1	0	88
18.1.6.1	**[ASK ONLY IF 18.1.6=YES]** Are medical/surgical masks consistently worn by people with presumed TB and people with confirmed TB at the facility?		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 staff at this facility had active TB disease in the last 2 years?	Staff _____ Don't know			88
18.1.8	Are facility staff offered TB infection testing?		1	0	88
18.1.8.1	**[ASK ONLY IF 18.1.8=YES]** Which test is used?	Mantoux tuberculin skin test (TST) ..... Blood test (IGRA)..... Don't know ..... Other (specify) _____			1 2 88 96
18.1.8.2	**[ASK ONLY IF 18.1.8=YES]** If facility staff have a positive test result, are they provided TB preventive treatment (TPT)?		1	0	88
18.1.9	Are facility staff offered an HIV test annually?		1	0	88
18.1.10	Are facility staff offered antiretroviral therapy (ART) if they are HIV-positive?		1	0	88
18.1.11	**[ASK ONLY IF 18.1.10=YES]** Where do HIV-positive staff receive (antiretroviral therapy) ART?	From this 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 PEOPLE WITH TB ARE RECEIVING SERVICES ON THE DAY OF ASSESSMENT—ASK TO SEE THEM]	Yes, observed	Yes, not observed	No	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 individuals (e.g., tissues, medical/surgical masks, etc.)	2	1	0	88

18. Infection Control *ADAPT PRIOR TO IMPLEMENTATION					
18.2.4	A confidential log for all staff with presumptive or confirmed TB	2	1	0	88
18.2.5	Waiting areas for people with TB 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 AREA, AND LAB. FOR ITEMS THAT YOU DO NOT SEE, ASK TO HAVE THEM SHOWN TO YOU]	Yes, observed	Yes, not observed	No	DK
18.3.1	Running water (e.g., 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]**				
		Yes, observed	Yes, not observed	No	DK

18. Infection Control *ADAPT PRIOR TO IMPLEMENTATION					
18.5.1	Are N-95 and/or 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
18.5.1.2	**[ASK ONLY IF 18.5.1=YES (1, 2)]** How often do facility staff members use the N-95 and/or FFP2 respirators?		Never ……..... 1 Rarely …… 2 Half of the time….. 3 Most of the time … 4 Always ……... 5		

*DK = don't know

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 Tme [Use the 24-hou clock system, e.g., 130]	(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 …….....	1
		No ……	0
021	Does this facility provide TB treatment services?	Yes……	1
		No ……	0
022	[ASK ONLY IF 021=YES] Does this facility provide directly observed therapy (DOT)?	Yes …….....	1
		No……..……	0
023	Does this facility provide any HIV-related services, such as counseling, testing, care, or treatment?	Yes ……	1
		No ……..……....	0

Participant Consent			
030	Provider number		
Eligibility Screening Questions			
Instructions to the interviewer: **[Approach one of the clinic staff, introduce yourself (Hello. My name I.....) and ask them if they are willing to answer questions about their experience providing TB care at this facility. If the staff member agrees, tell them 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 people with TB?	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 *ADAPT PRIOR TO IMPLEMENTATION			
1.1	Sex **[OBSERVE AND SELECT THE APPROPRIATE RESPONSE. ASK ONLY IF UNSURE.]**	Male ……..…… Female ……..……..….. Other …….. [No response] ……..……..…..	1 2 96 99
1.2	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
1.2.1	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 *ADAPT PRIOR TO IMPLEMENTATION			
1.3	What was the highest level of schooling you reached to become a practicing healthcare provider?	Diploma …… Associate degree …… Bachelor's degree …… Master's degree …… Doctorate…… Nonformal degree (specify)_____ Other health degree (specify) _____ Other non-health degree (specify) _____ [No response] ……	1 2 3 4 5 95 96 97 99
1.4	How would you best describe your current occupational category at this facility? For example, are you a registered nurse or physician?	Community health worker (CHW) …… Medical assistant …… Medical doctor/clinical officer …… Nursing associate or auxiliary …… Registered nurse …… Lab Technician …… Other (specify) _____ [No response] ……	1 2 3 4 5 6 96 99
1.5	Are you a manager or in-charge for any clinical services?	Yes …… No …… [No response] ……	1 0 99
1.6	Are you the TB focal or designated TB staff at this facility?	Yes …… No …… [No response] ……	1 0 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-?]**	Hours per week _____ [No response] ……	99
1.9	Approximately, how many patients (i.e., all types of patients) do you personally see or care for in this facility in a typical week? **[ENTER 1-?]**	Number of individual_____ [No response] ……	99
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 people with TB, or their contacts, do you personally see or care for in this facility in a typical week? **[MUST BE ≤ 1.9]**	Number of individuals _____ [No response] ……	99

2. Training *ADAPT PRIOR TO IMPLEMENTATION					
Now I will ask about training you received on specific TB-related services. Have you received any training, initial or refresher, on the following services? [READ THROUGH THE LIST OF SERVICES BELOW]		Yes, within 24 months	Yes, over 24 months	No	[NR]*
2.1	**TB/HIV Services**				
2.1.1	HIV testing and counseling for people with TB	2	1	0	99
2.1.2	TB preventive treatment (TPT)	2	1	0	99
2.1.3	HIV care and treatment services for TB/HIV coinfected individuals	2	1	0	99
2.1.3.1	[ASK ONLY IF 2.1.3=YES (1, 2)] ART for TB/HIV coinfected individuals	2	1	0	99
2.1.3.2	[ASK ONLY IF 2.1.3=YES (1, 2)] Identification of TB/HIV drug interactions	2	1	0	99
2.1.3.3	[ASK ONLY IF 2.1.43=YES (1, 2)] Identification of immune reconstitution inflammatory syndrome (IRIS)	2	1	0	99
2.1.3.4	[ASK ONLY IF 2.1.3=YES (1, 2)] Co-trimoxazole preventive therapy (CPT) for TB/HIV coinfected individuals	2	1	0	99
2.1.3.5	[ASK ONLY IF 2.1.3=YES (1, 2)] Viral load testing for TB/HIV coinfected individuals	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 GeneXpert	2	1	0	99
2.2.5	Diagnosis of TB by TrueNat	2	1	0	99
2.2.6	Diagnosis of TB by urine lipoarabinomannan (LAM)	2	1	0	99
2.2.7	Diagnosis of TB in children using stool-based testing	2	1	0	99
2.2.8	Diagnosis of drug-resistant TB (DR-TB)	2	1	0	99
2.2.8.1	[ASK ONLY IF 2.2.8=YES (1, 2)] TB culture or growth medium (e.g., Mycobacteria growth indicator tube [MGIT] 960)	2	1	0	99
2.3	**TB Treatment Services**				
2.3.1	Treatment of drug-sensitive TB (DS-TB)	2	1	0	99
2.3.2	Directly observed therapy (DOT)	2	1	0	99
2.3.3	Video DOT	2	1	0	99

2. Training *ADAPT PRIOR TO IMPLEMENTATION					
Now I will ask about training you received on specific TB-related services. Have you received any training, initial or refresher, on the following services? [READ THROUGH THE LIST OF SERVICES BELOW]		Yes, within 24 months	Yes, over 24 months	No	[NR]*
2.3.4	TB treatment follow-up services (e.g., phone calls or home visits to individuals if they miss an appointment, text messages to support treatment adherence, etc.)	2	1	0	99
2.3.5	Treatment of DR-TB	2	1	0	99

*NR = no response

3. TB Services Provided *ADAPT PRIOR TO IMPLEMENTATION				
	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	**TB Screening Services**			
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 (CAD)	1	0	99
3.2.5	Diagnosis of TB by sputum smear microscopy	1	0	99
3.2.6	Diagnosis of TB by GeneXpert	1	0	99
3.2.7	Diagnosis of TB by TrueNat	1	0	99
3.2.8	Diagnosis of TB by urine lipoarabinomannan (LAM)	1	0	99
3.2.9	Diagnosis of TB in children using stool-based testing	1	0	99
3.2.10	Diagnosis of TB by Fine Needle Aspiration Cytology (FNAC)	1	0	99
3.2.11	Diagnosis of TBM by testing cerebrospinal fluid (CSF)	1	0	99
3.2.12	What Is the most common method you use for diagnosing TB in this facility? _____			
3.2.13	First-line drug susceptibility testing (DST)	1	0	99
3.2.14	**[ASK THE NEXT 6 QUESTIONS ONLY IF 3.2.13=YES]** What methods do you use to detect resistance to first-line drugs?	**Yes**	**No**	**[NR]**
3.2.14.1	GeneXpert to detect resistance to rifampicin (RIF)	1	0	99
3.2.14.2	Xpert MTB/XDR to detect resistance to INH as a reflex test	1	0	99

3. TB Services Provided *ADAPT PRIOR TO IMPLEMENTATION				
	Now I will ask if you currently provide certain TB-related services. Have you provided **[service]** in the last 12 months?	**Yes**	**No**	**[NR]***
3.2.14.3	Line probe assays (LPAs) (e.g., MTBDRplus)	1	0	99
3.2.14.4	Solid culture	1	0	99
3.2.14.5	Liquid culture	1	0	99
3.2.14.6	Any other method used to detect resistance to first-line drugs? (specify) _____	1	0	99
3.2.15	**[ASK ONLY IF 3.2.14=NO or NR]** Referral for first-line DST	1	0	99
3.2.16	Second-line DST	1	0	99
	[ASK THE NEXT 5 QUESTIONS ONLY IF 3.2.16=YES] What methods do you use to detect resistance to second-line drugs?	**Yes**	**No**	**[NR]**
3.2.16.1	Xpert MTB/XDR to detect resistance to fluoroquinolones (FQs), second line injectables, and ethionamide	1	0	99
3.2.16.2	LPAs (e.g., MTBDRsl)	1	0	99
3.2.16.3	Solid culture	1	0	99
3.2.16.4	Liquid culture	1	0	99
3.2.16.5	Any other method used to detect resistance to second-line drugs? (specify) _____	1	0	99
3.2.17	**[ASK ONLY IF 3.2.16=NO or NR]** Referral for second-line DST	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)]** Directly observed of therapy (DOT)	1	0	99
3.3.4	Video DOT	1	0	99
3.3.5	Reminder phone calls or short-message service (SMS) texts to support individuals' adherence to treatment	1	0	99
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 individuals with TB if they miss an appointment	1	0	99
3.3.6.2	**[ASK ONLY IF 3.3.6=YES]** Home visits to individuals with TB if they miss an appointment	1	0	99
3.3.7	Treatment of drug-resistant TB (DR-TB)	1	0	99
3.3.8	**[ASK ONLY IF 3.3.7=NO or NR]** Referral for DR-TB treatment	1	0	99

3. TB Services Provided *ADAPT PRIOR TO IMPLEMENTATION				
	Now I will ask if you currently provide certain TB-related services. Have you provided **[service]** in the last 12 months?	**Yes**	**No**	**[NR]***
3.4	**TB/HIV Services [ASK ONLY IF 023=YES (facility provides TB/HIV services)]**			
3.4.1	HIV testing and counseling for individuals with TB	1	0	99
3.4.2	Referral for HIV testing and counseling for individuals with TB	1	0	99
3.4.3	TB preventive treatment (TPT)	1	0	99
	[ASK THE NEXT 3 QUESTIONS ONLY IF 3.4.3=YES] What type of TPT do you provide? ***ADAPT PRIOR TO IMPLEMENTATION PER NATIONAL HIV/AIDS PROGRAM GUIDELINES**	**Yes**	**No**	**[NR]**
3.4.3.1	INH + Pyridoxine	1	0	99
3.4.3.2	3HP (a combination of rifapentine and isoniazid)	1	0	99
3.4.3.3	Q-TIB	1	0	99
3.4.3.4	3RH	1	0	99
3.4.3.5	INH for children	1	0	99
3.4.3.6	3HP for children	1	0	99
3.4.4	HIV care and treatment services to TB/HIV coinfected individuals	1	0	99
	[ASK THE NEXT 3 QUESTIONS ONLY IF 3.4.4=YES]			
3.4.4.1	Co-trimoxazole preventive therapy (CPT) for TB/HIV coinfected individuals	1	0	99
3.4.4.2	Viral load testing for TB/HIV coinfected individuals	1	0	99
3.4.4.3	ART for TB/HIV coinfected individuals	1	0	99
3.4.4.3.1	**[ASK ONLY IF 3.4.4.3=YES]** Screening for symptoms of anti-TB and antiretroviral (ARV) drug interactions	1	0	99

*NR = no response

4. TB Case Management *ADAPT PRIOR TO IMPLEMENTATION		
	Now, I want to ask you a few more questions about the management and care of people with TB 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. TB Case Management *ADAPT PRIOR TO IMPLEMENTATION						
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
4.1.8	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	Individual'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, etc.)					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	Counsel people with TB to get tested for HIV	1	1	2	3	99
4.3.4	HIV care and treatment services to TB/HIV coinfected individuals	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. TB Case Management *ADAPT PRIOR TO IMPLEMENTATION						
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**					

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) Provie informati	**[ASK ONLY IF (a)=YES]** (b) How is information provided?			
		Yes, unprpted	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 and/or adverse events (AE) of TB medication	1	1	2	3	99
4.4.15	What to do if they experience side effects and/or AEs 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				

4. TB Case Management *ADAPT PRIOR TO IMPLEMENTATION		
	[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]**	Yes
4.5.1	Advise the individual 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	Track and follow-up by contacting the individual's family, school, or workplace	1
4.5.5	Track and follow-up by home visit	1
4.5.6	Track and follow-up by phone	1
4.5.7	Track and follow-up by short-message service (SMS)/text message	1
4.5.8	Record missed days and extend treatment	1
4.5.9	Other (specify) _____	1
4.5.10	None of the above	1

*NR = no response

5. Infection Prevention and Control *ADAPT PRIOR TO IMPLEMENTATION			
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 person with presumed or confirmed TB is in the room?	1	0	88	99
5.2.2	Can fans 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 people with TB spend in the health facility?	1	0	88	99
5.2.5	Can medical/surgical masks protect healthcare providers from inhaling TB bacteria?	1	0	88	99

5. Infection Prevention and Control *ADAPT PRIOR TO IMPLEMENTATION					
5.2.6	Can the use of respiratory protection, such as N95 particulate respirators, by healthcare providers protect them from inhaling TB bacteria?	1	0	88	99
5.3	**Practices**				
What do you do whenever you are with a person with presumed or confirmed TB and/or working in the TB/DR wards? **[DIR] Yes No**					
5.3.1	Use a mask/respirator whenever treating individuals with presumed or confirmed TB	1	0		99
5.3.2	Give priority to coughing individuals (i.e., attend to individuals who are coughing first)	1	0		99
5.3.3	Educate individuals with TB 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 individual is symptomatic	1	0		99
5.3.6	Always screen all family members of individuals with confirmed TB for TB symptoms	1	0		99
5.3.7	Discuss with family members or those living with individuals with TB, basic information and skills to protect household members and contacts from infection	1	0		99

*DK = don't know

**NR = no response

6. Supervision *ADAPT PRIOR TO IMPLEMENTATION			
Now I would like to ask you some questions about supervision that you have personally received.			
6.1	Has anyone from an upper-level office ever come for a supervisory and monitoring visit to check your work?	Yes …… No …… [No response] ……..	1 0 99
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 …… More than 3 months ago …… [No response] ……..	1 2 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?	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. Supervision *ADAPT PRIOR TO IMPLEMENTATION			
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, timely reporting, etc.)		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? **[OBSERVE]**	Yes, observed …….....	2
		Yes, not observed ……..	1
		No ……..	0
		[No response]……	99

7. Incentives and Improvements *ADAPT PRIOR TO IMPLEMENTATION			
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
		Discounted 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 people under your care? 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	Hours Minutes
		Partially completed ……..……..	2	
		Provider unavailable..……	3	
		Provider refused ……	4	
		Postponed ……..……..	5	
		Other (specify)_____	96	

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	
		Provider unavailable ..……....	3	Hours Minutes
		Provider refused ……...……..	4	
		Other (specify)_____	96	

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 an individual has finished their consultation with clinic staff, introduce yourself (Hello. My name I.....) and ask them if they are willing to answer questions about their experience receiving TB care at this facility. If the individual agrees, tell them that you have a few preliminary questions. To ensure that the individual meets the criteria for the study, please obtain the following information:]**			
021	**[Is the individual at least 18 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-sensitive TB (DS-TB) or drug-resistant TB (DR-TB))? **[ADAPT IF THERE ARE OTHER TERMS INDIVIDUALS USE TO REFER TO DS-TB OR DR-TB]**	No, they do not have TB ..... Yes, DS-TB ..... Yes, DR-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 sensitive)]** Have you been receiving TB	Yes	1

	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 months?	No …… [No response] ……	0 99
[If any of the screening questions are No, Don't know, or No response, the individual is NOT eligible for this study—thank the individual and wait for the next available individual. If the individual 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 individual and record their response below.]			
024	**[SELECT THE APPROPRIATE RESPONSE BASED ON THE INFORMED CONSENT]**	Consented …… Declined ……	1 0
[If individual declined to give consent, (1) thank the individual, (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 individual. If individual consented, continue with the interview.]			

Patient Characteristics ***ADAPT PRIOR TO IMPLEMENTATION**			
1.1	Sex **[OBSERVE AND SELECT THE APPROPRIATE RESPONSE. ASK ONLY IF UNSURE.]**	Male …… Female…… Other…… [No response]……	1 2 96 99
1.2	In what year were you born? **[YEAR MUST BE 1933–2005.]**	Year _____ Don't know …… No response ……	 88 99
1.2.1	How old were you on your last birthday? **[YEARS MUST BE 18–90. 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 current marital status?	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 …… Peri-urban …… Rural …… [No response] ……	1 2 3 99

Patient Characteristics *ADAPT PRIOR TO IMPLEMENTATION			
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**	_____ per month Don't know…… [No response] ……	 88 99
1.8	Is this health facility close enough for you to get here easily?	Yes …… No …… [No response] ……	1 0 99
1.9	What type of transportation do you use most often to get to this facility?	Bicycle…… Bus …… Car …… Motorcycle …… Taxi …… Walking …… Other (specify) _____ [No response] ……	1 2 3 4 5 6 96 99
1.10	On average, how long does it take you to get to this facility from your home? **[HOURS MUST BE 0–24; MINUTES MUST BE 0–59]**	Hours_____ Minutes_____ Don't know …… [No response] ……	 88 99
1.11	Do you currently smoke?	Yes …… No …… [No response] ……	1 0 99

2. Cascade of Care *ADAPT PRIOR TO IMPLEMENTATION			
Now, I would like to ask about the care that you are currently receiving for this disease.			
2.1	How long after you first started having symptoms, such as coughing, did you go to the clinic?	Within the first week …… Between the first and second week …… After more than two weeks…… Don't know …… [No response] ……	1 2 3 88 99
2.2	When you found out that you might have TB, where did you get tested?	At this clinic …… At a different clinic …… Don't know …… [No response] ……	1 2 88 99

2. Cascade of Care *ADAPT PRIOR TO IMPLEMENTATION			
2.3	How long after you were tested were you told you had this disease?	Within 2 days Within 1 week 1–2 weeks More than 2 weeks Don't know [No response]	1 2 3 4 88 99
2.4	How long after you were told you had TB did you start treatment?	Within 2 days Within 1 week 1–2 weeks More than 2 weeks Don't know [No response]	1 2 3 4 88 99
2.5	How long have you been on treatment? ***ADAPT PRIOR TO IMPLEMENTATION ACCORDING TO NATIONAL TB PROGRAM (NTP) TREATMENT PROTOCOLS FOR DRUG-SENSITIVE TB (DS-TB) & DRUG-RESISTANT (DR-TB)**	Less than 3 months 3–6 months 7–9 months 10–18 months 19–24 months More than 2 years Don't know [No response]	1 2 3 4 5 6 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 *ADAPT PRIOR TO IMPLEMENTATION				
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 getting care for your disease at 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 by 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. Availability of TB Services *ADAPT PRIOR TO IMPLEMENTATION				
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 (individual 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	Approximately how long did you wait to talk to a TB healthcare provider during your most recent visit to the facility? **[HOURS MUST BE 0–10; MINUTES MUST BE 0–59]**	Hours _____ Minutes_____ Don't know …… [No response] ……		 88 99
3.9	Approximately how long did you spend with the TB provider(s) (e.g., doctor, nurse, lab, pharmacist, etc.) during your most recent visit to the facility? If you saw more than one provider, please add up the total time. **[HOURS MUST BE 0–5; MINUTES MUST BE 0–59]**	Hours_____ Minutes_____ Don't know …… [No response] ……		 88 99
		Yes	**No**	**[NR]**
3.10	Have you ever gone to another health facility to receive care for your disease?	1	0	99
3.10.1	**[ASK ONLY IF 3.10=YES]** Why did you go to another health facility? _____			

*NR = no response

4. TB Practices *ADAPT PRIOR TO IMPLEMENTATION			
	Next, I would like to ask you about practices related to TB that you may have experienced.		
4.1	Were you examined by a healthcare provider at this facility during your first visit for TB?	Yes …… No …… [No response] ……	1 0 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 TB from one person to another?	Yes …… No …… [No response] ……	1 0 99

4. TB Practices *ADAPT PRIOR TO IMPLEMENTATION			
4.3	Were your family or close contacts examined/screened for TB?	Yes No Don't know [No response]	1 0 88 99
4.3.1	**[ASK ONLY IF 4.3=NO, NK, or NR]** Have you been told where to have your family or close contacts screened for TB?	Yes No Don't know [No response]	1 0 88 99
4.4	Who primarily supervises your treatment (i.e., who is your treatment supporter)?	Health worker at this facility Health worker in the community Family member Coworker Other (specify) _____ [No response]	1 2 3 4 96 99
4.5	On average, how many days per week does your treatment supporter 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 No Don't know [No response]	1 0 88 99
4.6.1	**[ASK ONLY IF 4.6=YES]** Why did you stop taking your medicine? **[SELECT ALL TI APPLY]**	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/get medicines due to work Was traveling 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 *ADAPT PRIOR TO IMPLEMENTATION	
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 THE 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 TB would experience to know they have the disease.	

5. TB Knowledge *ADAPT PRIOR TO IMPLEMENTATION						
Can you tell me what symptoms a person with TB will have?		Yes, Unprompte	Y Prompd	No	DK*	[NR] **
5.1.1	Chronic cough (more than 2 weeks)	2	1	0	88	99
5.1.2	Coughing up mucus or phlegm	2	1	0	88	99
5.1.3	Coughing up 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 Transmission**					
What do you think causes TB or spreads it from one person to another?		Yes, Unprompte	Y Prompd	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
5.2.8	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, Unprompte	Y Prompd	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. TB Knowledge ***ADAPT PRIOR TO IMPLEMENTATION**						
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 individuals may experience from using or taking medicines for TB? ***ADAPT PRIOR TO IMPLEMENTATION BY REVIEWING THE SIDE EFFECTS MOST COMMONLY EXPERIENCED BY INDIVIDUALS ON TB TREATMENT AND INFORMATION GIVEN TO THEM**		**Yes, Unprompte**	**Y Prted**	**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	Fatigue	2	1	0	88	99
5.4.11	Other (specify) _____	2	1	0	88	99
ASK the following five questions if the individual has drug-resistant TB (DR-TB) [022=2]						
5.4.12	Itchy skin	2	1	0	88	99
5.4.13	Darkening of skin	2	1	0	88	99
5.4.14	Ringing noise in the ear(s) (i.e., tinnitus)	2	1	0	88	99
5.4.15	Numbness in the limbs	2	1	0	88	99
5.4.16	Other (specify) _____	2	1	0	88	99
5.5	Can TB be cured?	Yes ……..……				1
		No……..……..				0
		Don't know ……..				88
		[No response] ……...				99

5. TB Knowledge ***ADAPT PRIOR TO IMPLEMENTATION**			
5.6	What is the usual time or typical period for treating drug sensitive TB (DS-TB)? **[MUST BE 0–12.** **ENTER '0' IF THEIR ANSWER IS <1 MONTH.** **ENTER '12' IF THEIANSWER IS >12 MONTHS.]**	Months _____ Don't Know……..……... [No response] ……	 88 99
5.7	What is the usual time or typical period for treating DR-TB? **[MUST BE 0–30.** **ENTER '0' IF THEIR ANSWER IS <1 MONTH.** **ENTER '30' IF IIR ANSWER IS >30 MONTHS.]**	Months _____ Don't Know……..……... [No response] ……	 88 99

*DK = don't know

**NR = no response

6. Stigma/Discrimination ***ADAPT PRIOR TO IMPLEMENTATION**						
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 no disagr	Agree	Strongly agree
6.1	Overall, I feel welcomed 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 at this facility show discriminatory attitudes toward me because of my disease.	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. Communication of TB Information					
7.1	How TB 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 TB can be cured	2	1	0	99
7.4	How long your treatment will last	2	1	0	99
7.5	Danger signs of the disease getting worse	2	1	0	99
7.6	The importance of taking the medicine(s) regularly	2	1	0	99
7.7	Side effects of the medicine(s)	2	1	0	99
7.8	What to do if you have side effects from the medicine(s)	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 medicine(s) through the end of treatment	2	1	0	99
7.11	When to come back for the next follow-up 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

*NR = no response

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

8. Patient – Provider Interaction *ADAPT PRIOR TO IMPLEMENTATION				
Next, I would like to ask you about your face-to-face meetings with healthcare providers at this facility.		Yes	No	[NR]*
8.11	Do you think you have enough privacy during the examination?	1	0	99

*NR = no response

9. TB/HIV Services *ADAPT PRIOR TO IMPLEMENTATION					
Next, I would like to ask you about the link between TB and HIV.		Y	No	DK*	[NR]**
9.1	Have any healthcare providers told you about the link between TB and HIV?	1	0	88	99
9.2	Have any healthcare providers told you how to prevent HIV infection?	1	0	88	99
9.3	After being told you had this disease, were you counseled to get 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 TB at the same time, if you might need it?	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

*DK = don't know

**NR = no response

10. Support *ADAPT PRIOR TO IMPLEMENTATION			
I would like to ask you about any support you receive from this facility during your treatment .			
10.1	People with this disease sometimes also have other medical conditions, such as diabetes, HIV infection, or other illness. Do you have any other medical conditions?	Yes…… No …… Don't know …… [No response] ……	1 0 88 99

10. Support *ADAPT PRIOR TO IMPLEMENTATION			
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 …… [No response] ……	0 1 2 3 99
10.1.2	**[ASK ONLY IF 10.1=YES]** 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 …… [No response] ……	0 1 2 3 99

10.2	To support people under their care, 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?	**Yes**	**No**	**DK***	**[NR] ** **
10.2.1	Free TB medicine(s)	1	0	88	99
10.2.2	Home-based treatment	1	0	88	99
10.2.3	Nutritional support (e.g., 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 sessions	1	0	88	99
10.2.7	One-on-one counseling (face-to-face) by medical staff (e.g., doctor or nurse)	1	0	88	99
10.2.8	One-on-one peer counseling (face-to-face) by either a lay counselor or person who has been cured of TB	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?	**Yes**	**No**	**DK**	**[NR]**
10.3.1	Free TB medicine(s)	1	0	88	99
10.3.2	Home-based treatment	1	0	88	99
10.3.3	Nutritional support (e.g., 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 (e.g., doctor or nurse)	1	0	88	99
10.3.8	One-on-one peer counseling (face-to-face) by either a lay counselor or a person who has been cured of TB	1	0	88	99

10. Support *ADAPT PRIOR TO IMPLEMENTATION					
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

*DK = don't know

**NR = no response

11. Affordability *ADAPT PRIOR TO IMPLEMENTATION							
	Next, I would like to ask you about the costs of 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

*NR = no response

12. Infrastructure *ADAPT PRIOR TO IMPLEMENTATION					
Next, I would like to ask you about the physical features of this facility. Please answer the questions about this facility only. Do not include any other facilities in your answer.		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	Are there toilets available for patients to use at this facility?	1	0	88	99
12.4.1	[ASK ONLY IF 12.4=YES OR NO] Are the toilets usually clean?	1	0	88	99

*DK = don't know

*NR = no response

13. Overall Satisfaction			
13.1	Overall, how satisfied are you with the TB services you have received at this facility so far?	Very dissatisfied ……..… Dissatisfied ……..….. Neither satisfied nor dissatisfied ….. Satisfied …….. Very satisfied …….. [No response] ……	1 2 3 4 5 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 ……...…… Partially completed ……... Patient unavailable ……... Patient refused ……...……..... Postponed …….. Other (specify) _____	1 2 3 4 5 96	Hours Minutes
004	Visit 2 (if needed)	Completed ……..……..… Partially completed ……... Patient unavailable ……... Patient refused ……...……..... Other (specify) _____	1 2 3 4 96	Hours Minutes

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 *ADAPT PRIOR TO IMPLEMENTATION				
Are the following documents used at this facility to record TB data?		Yes, electroic	Yes, paper	No
021	Presumptive TB register	2	1	0
022	TB laboratory register	2	1	0
023	Drug-sensitive TB (DS-TB) treatment register	2	1	0
024	Drug-resistant TB (DR-TB) laboratory register	2	1	0
025	DR-TB treatment register	2	1	0
026	TB preventive treatment (TPT) register	2	1	0
027	Contact Investigation register	2	1	0
028	Other (specify) _____	2	1	0

TB Services Provided [RESPONSES MUST MATCH THOSE PROVIDED IN THE FACILITY AUDIT] *ADAPT PRIOR TO IMPLEMENTATION			
029	Does this facility diagnose individuals using smear microscopy, and if so, are tests done on site or are specimens sent to another facility?	No …… Yes, on site …… Yes, sent out …….. Don't know …….	0 1 2 88
030	Does this facility diagnose individuals using culture, and if so, are tests done on site or are specimens sent to another facility?	No …… Yes, on site …… Yes, sent out …….. Don't know …….	0 1 2 88
031	Does this facility diagnose individuals using GeneXpert, and if so, are the tests done on site or are specimens sent to another facility?	No …… Yes, on site …… Yes, sent out …….. Don't know …….	0 1 2 88
032	**[ASK ONLY IF 031=1]** Which GeneXpert cartridge does the facility use?	Xpert MTB//RIF…… Xpert Ultra…… Xpert MTB/RIF and Ultra…….. Xpert MTB/XDR…….. Don't know……...	1 2 3 4 88
033	Does this facility perform drug susceptibility tests (DST)?	No …… Yes, on site …… Yes, sent out …….. Don't know …….	0 1 2 88
034	Does this facility initiate and manage the treatment of people with DS-TB?	No …… Yes …… Don't know …….	0 1 88
035	Does this facility initiate and manage the treatment of people with DR-TB?	No …… Yes …… Don't know …….	0 1 88
036	Does this facility provide HIV-related services?	No …… Yes …… Don't know …….	0 1 88
037	**[ASK ONLY IF 036 =1]** Does this facility provide TPT to people living with HIV (PLHIV)?	No …… Yes …… Don't know …….	0 1 88
038	Does this facility provide TPT to child contacts of people with confirmed TB?	No …… Yes …… Don't know …….	0 1 88

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

1. Presumptive TB Register ***ADAPT PRIOR TO IMPLEMENTATION**			
1.0.1	**[LOCATE RECORDS WITHIN THE SPECIFIED DATE RANGE]** *E.G., LAST 12 MONTHS (a) Start date (b) End date		 ___/___/_____ ___/___/_____
1.0.2	Which register(s) were used to determine the TB screening and diagnosis counts for people with presumed TB (i.e., to complete Section 1): **[SELECT ALL THAT APPLY]**	Presumptive TB register TB laboratory register Drug-sensitive TB (DS-TB) treatment register Drug-resistant TB (DR-TB) laboratory register DR-TB treatment register TB preventive treatment (TPT) register Contact investigation register Other (specify) No register(s) exists that contains information on TB screening and diagnosis services provided to people with presumed TB	1 2 3 4 5 6 7 96 0
1.1	**TB Screening and Diagnosis Totals**		
1.1.1	Number of people with presumptive TB **[ENTER 0 FOR NONE AND 999 IF UNABLE TO DETERMINE THE COUNT]**		
1.1.2	Number of people with presumptive TB who had any type of diagnostic test done (e.g., smear, culture, Xpert TB MTB/RIF, chest X-ray, clinical assessment, etc.) [MUST BE ≤ 1.1] **[ENTER 0 FOR NONE AND 999 IF UNABLE TO DETERMINE THE COUNT]**		
1.1.3	Number of people with presumptive TB who only had a clinical assessment to diagnosis TB [MUST BE ≤ 1.1.2] **[ENTER 0 FOR NONE AND 999 IF UNABLE TO DETERMINE THE COUNT]**		
1.1.4	Number of people who only had a clinical assessment who were confirmed to have TB [MUST BE ≤ 1.1.3] **[ENTER 0 FOR NONE AND 999 IF UNABLE TO DETERMINE THE COUNT]**		
1.1.5	Number of people with presumptive TB who received a bacteriological test (i.e., smear microscopy, culture, or Xpert test) [MUST BE ≤ 1.1.2] **[ENTER 0 FOR NONE AND 999 IF UNABLE TO DETERMINE THE COUNT]**		
1.1.6	Number of people with presumptive TB with bacteriological test results [MUST BE ≤ 1.1.5] **[ENTER 0 FOR NONE AND 999 IF UNABLE TO DETERMINE THE COUNT]**		

1. Presumptive TB Register *ADAPT PRIOR TO IMPLEMENTATION		
1.1.7	Number of people with presumptive TB with positive bacteriological test results [MUST BE ≤ 1.1.6] **[ENTER 0 FOR NONE AND 999 IF UNABLE TO DETERMINE THE COUNT]**	
1.2	**Smear Microscopy** **[VALID ONLY IF 029=1 or 2, and 1.1.4>0]**	
1.2.1	Number of people with presumptive TB who received a smear microscopy test [MUST BE ≤ 1.1.4] **[ENTER 0 FOR NONE AND 999 IF UNABLE TO DETERMINE THE COUNT]**	
1.2.2	Number of people with presumptive TB with smear microscopy test results [MUST BE ≤ 1.2.1 & ≤ 1. 1.5] **[ENTER 0 FOR NONE AND 999 IF UNABLE TO DETERMINE THE COUNT]**	
1.2.3	Number of people with presumptive TB with **positive** smear microscopy test results [MUST BE ≤ 1.2.2 & ≤ 1. 1.6] **[ENTER 0 FOR NONE AND 999 IF UNABLE TO DETERMINE THE COUNT]**	
1.3	**Culture** **[VALID ONLY IF 030=1 or 2 and 1.1.4>0]**	
1.3.1	Number of people with presumptive TB who received a culture test [MUST BE ≤ 1.1.4] **[ENTER 0 FOR NONE AND 999 IF UNABLE TO DETERMINE THE COUNT]**	
1.3.2	Number of people with presumptive TB with culture test results [MUST BE ≤ 1.3.1 & ≤ 1. 1.5] **[ENTER 0 FOR NONE AND 999 IF UNABLE TO DETERMINE THE COUNT]**	
1.3.3	Number of people with presumptive TB with **positive** culture test results [MUST BE ≤ 1.3.2 & ≤ 1. 1.6] **[ENTER 0 FOR NONE AND 999 IF UNABLE TO DETERMINE THE COUNT]**	
1.4	**GeneXpert** **[VALID ONLY IF 031=1 or 2 and 1.1.4>0]**	
1.4.1	Number of people with presumptive TB who received a Xpert test [MUST BE ≤ 1.1.4] **[ENTER 0 FOR NONE AND 999 IF UNABLE TO DETERMINE THE COUNT]**	
1.4.2	Number of people with presumptive TB with Xpert test results [MUST BE ≤ 1.4.1 & ≤ 1. 1.5] **[ENTER 0 FOR NONE AND 999 IF UNABLE TO DETERMINE THE COUNT]**	
1.4.3	Number of people with presumptive TB with Xpert test results **positive** for TB [MUST BE ≤ 1.4.2 & ≤ 1. 1.6] **[ENTER 0 FOR NONE AND 999 IF UNABLE TO DETERMINE THE COUNT]**	
1.4.4	Number of people with presumptive TB with Xpert test results **positive** for rifampicin (RIF) resistance [MUST BE ≤ 1.4.3] **[ENTER 0 FOR NONE AND 999 IF UNABLE TO DETERMINE THE COUNT]**	

2. TB Laboratory Register *ADAPT PRIOR TO IMPLEMENTATION *CHECK NATIONAL TB PROGRAM (NTP) GUIDELINES FOR EACH TYPE OF TB DIAGNOSTIC TEST			
2.0.1	**[LOCATE RECORDS WITHIN THE SPECIFIED DATE RANGE] *E.G., LAST 12 MONTHS** (a) Start date (b) End date		___/___/_____ ___/___/_____
2.0.2	Which register(s) were used to determine the TB diagnosis laboratory counts (i.e., to complete Section 2): **[SELECT ALL THAT APPLY]**	Presumptive TB register……... TB laboratory register……... Drug-sensitive TB (DS-TB) treatment register…… Drug-resistant TB (DR-TB) laboratory register…… DR-TB treatment register …… TB preventive treatment (TPT) register ……... Contact investigation register …… Other (specify) …….. No register(s) exists that contains information on TB diagnosis laboratory counts……	1 2 3 4 5 6 7 96 0
2.1	**Smear Microscopy** **[VALID ONLY IF 029=1 or 2]**		
2.1.1	Number of diagnostic smears recorded **[ENTER 0 FOR NONE AND 999 IF UNABLE TO DETERMINE THE COUNT]**		
2.1.2	Number of diagnostic smear results recorded [MUST BE ≤ 2.1.1] **[ENTER 0 FOR NONE AND 999 IF UNABLE TO DETERMINE THE COUNT]**		
2.1.3	Number of diagnostic smear results recorded [WITHIN THE SPECIFIED TURNAROUND TIME] [MUST BE ≤ 2.1.2] **[ENTER 0 FOR NONE AND 999 IF UNABLE TO DETERMINE THE COUNT]**		
2.1.4	Number of ***positive*** diagnostic smear results recorded [MUST BE ≤ 2.1.2] **[ENTER 0 FOR NONE AND 999 IF UNABLE TO DETERMINE THE COUNT]**		
2.1.5	Number of smear conversion tests recorded **[ENTER 0 FOR NONE AND 999 IF UNABLE TO DETERMINE THE COUNT]**		
2.1.6	Number of smear conversion test results recorded [MUST BE ≤ 2.1.5] **[ENTER 0 FOR NONE AND 999 IF UNABLE TO DETERMINE THE COUNT]**		
2.1.7	Number of smear conversion test results recorded [WITHIN THE SPECIFIED TURNAROUND TIME] [MUST BE ≤ 2.1.6] **[ENTER 0 FOR NONE AND 999 IF UNABLE TO DETERMINE THE COUNT]**		
2.1.8	Number of positive smear conversion test results recorded **[ENTER 0 FOR NONE AND 999 IF UNABLE TO DETERMINE THE COUNT]**		

2. TB Laboratory Register *ADAPT PRIOR TO IMPLEMENTATION *CHECK NATIONAL TB PROGRAM (NTP) GUIDELINES FOR EACH TYPE OF TB DIAGNOSTIC TEST		
2.2	**Culture** **[VALID ONLY IF 030=1 or 2]**	
2.2.1	Number of diagnostic culture tests recorded **[ENTER 0 FOR NONE AND 999 IF UNABLE TO DETERMINE THE COUNT]**	
2.2.2	Number of diagnostic culture test results recorded [MUST BE ≤ 2.2.1] **[ENTER 0 FOR NONE AND 999 IF UNABLE TO DETERMINE THE COUNT]**	
2.2.3	Number of culture ***positive*** diagnostic tests recorded [MUST BE ≤ 2.2.2] **[ENTER 0 FOR NONE AND 999 IF UNABLE TO DETERMINE THE COUNT]**	
2.2.4	Number of culture ***positive*** diagnostic tests recorded [WITHIN THE SPECIFIED TURNAROUND TIME] [MUST BE ≤ 2.2.2] **[ENTER 0 FOR NONE AND 999 IF UNABLE TO DETERMINE THE COUNT]**	
2.2.5	Number of culture conversion tests recorded **[ENTER 0 FOR NONE AND 999 IF UNABLE TO DETERMINE THE COUNT]**	
2.2.6	Number of ***positive*** culture conversion test results recorded [MUST BE ≤ 2.2.5] **[ENTER 0 FOR NONE AND 999 IF UNABLE TO DETERMINE THE COUNT]**	
2.2.7	Number of ***positive*** culture conversion test results recorded [WITHIN THE SPECIFIED TURNAROUND TIME] [MUST BE ≤ 2.2.6] **[ENTER 0 FOR NONE AND 999 IF UNABLE TO DETERMINE THE COUNT]**	
2.3	**GeneXpert** **[VALID ONLY IF 031=1 or 2]**	
2.3.1	Number of Xpert tests recorded **[ENTER 0 FOR NONE AND 999 IF UNABLE TO DETERMINE THE COUNT]**	
2.3.2	Number of Xpert test results recorded [MUST BE ≤ 2.3.1] **[ENTER 0 FOR NONE AND 999 IF UNABLE TO DETERMINE THE COUNT]**	
2.3.3	Number of Xpert test results recorded [WITHIN THE SPECIFIED TURNAROUND TIME] [MUST BE ≤ 2.3.2] **[ENTER 0 FOR NONE AND 999 IF UNABLE TO DETERMINE THE COUNT]**	
2.3.4	Number of Xpert tests with ***positive*** result for TB recorded [MUST BE ≤ 2.3.2] **[ENTER 0 FOR NONE AND 999 IF UNABLE TO DETERMINE THE COUNT]**	
2.3.5	Number of Xpert tests with ***positive*** result for resistance to rifampicin (RIF) recorded [MUST BE ≤ 2.3.4] **[ENTER 0 FOR NONE AND 999 IF UNABLE TO DETERMINE THE COUNT]**	

2. TB Laboratory Register *ADAPT PRIOR TO IMPLEMENTATION *CHECK NATIONAL TB PROGRAM (NTP) GUIDELINES FOR EACH TYPE OF TB DIAGNOSTIC TEST		
2.3.6	Number of Xpert tests with ***negative*** result for TB recorded [MUST BE ≤ 2.3.2] **[ENTER 0 FOR NONE AND 999 IF UNABLE TO DETERMINE THE COUNT]**	
2.3.7	Number of Xpert tests with ***error*** result recorded [MUST BE ≤ 2.3.2] **[ENTER 0 FOR NONE AND 999 IF UNABLE TO DETERMINE THE COUNT]**	
2.3.8	Number of Xpert tests with indeterminate result recorded [MUST BE ≤ 2.3.2] **[ENTER 0 FOR NONE AND 999 IF UNABLE TO DETERMINE THE COUNT]**	
2.3.9	[VALID ONLY IF 032= 2 or 3 (Xpert Ultra cartridge used for testing)] Number of Xpert Ultra tests with a ***trace*** result recorded by the laboratory **[ENTER 0 FOR NONE AND 999 IF UNABLE TO DETERMINE THE COUNT]**	

3. Drug-Sensitive TB (DS-TB) Treatment Register *ADAPT PRIOR TO IMPLEMENTATION			
3.0.1	**[LOCATE RECORDS WITHIN THE SPECIFIED DATE RANGE]** *MOST RECENT COHORT OF PEOPLE WITH DS-TB WHOSE TREATMENT PERIOD HAS ENDED AND HAVE OUTCOMES ASSIGNED (a) Cohort start date (b) Cohort end date		___/___/_____ ___/___/_____
3.0.2	Which register(s) were used to determine the DS-TB treatment counts (i.e., to complete Section 3) **[SELECT ALL THAT APPLY]**	Presumptive TB register TB laboratory register DS-TB treatment register Drug-resistant TB (DR-TB) laboratory register DR-TB treatment register TB preventive treatment (TPT) register Contact investigation register Other (specify) No register(s) exists that contains information on DS-TB treatment counts	1 2 3 4 5 6 7 96 0
3.1	**TB Treatment** **[VALID ONLY IF 034=1]**		
3.1.1	Number of individuals with a new episode of TB who started treatment (total cohort number) **[ENTER 0 FOR NONE AND 999 IF UNABLE TO DETERMINE THE COUNT]**		
3.1.2	Number of clinically diagnosed individuals with TB who started treatment [MUST BE ≤ 3.1.1] **[ENTER 0 FOR NONE AND 999 IF UNABLE TO DETERMINE THE COUNT]**		

3. Drug-Sensitive TB (DS-TB) Treatment Register *ADAPT PRIOR TO IMPLEMENTATION		
3.1.3	Number of people with bacteriologically confirmed TB who started treatment [MUST BE ≤ 3.1.1] **[ENTER 0 FOR NONE AND 999 IF UNABLE TO DETERMINE THE COUNT]**	
3.1.4	Number of people with bacteriologically confirmed pulmonary TB who started treatment that were smear negative at the end of the intensive phase of treatment (i.e., smear conversion) *IF SMEAR CONVERSION TESTS ARE NO LONGER INDICATED IN NATIONAL TB PROGRAM (NTP) GUIDELINES, DELETE [MUST BE ≤ 3.1.4] **[ENTER 0 FOR NONE AND 999 IF UNABLE TO DETERMINE THE COUNT]**	
3.2	**TB/HIV** **[VALID ONLY IF 036=1]**	
3.2.1	[MUST BE ≤ 3.1.1] Number of people registered with a new episode of TB who had their HIV status documented in the TB register **[ENTER 0 FOR NONE AND 999 IF UNABLE TO DETERMINE THE COUNT]**	
3.2.2	Number of registered HIV-positive TB individuals [MUST BE ≤ 3.2.1] **[ENTER 0 FOR NONE AND 999 IF UNABLE TO DETERMINE THE COUNT]**	
3.2.3	Number of HIV-positive TB patients receiving co-trimoxazole preventive therapy (CPT) during TB treatment per NTP guidelines [MUST BE ≤ 3.2.2] **[ENTER 0 FOR NONE AND 999 IF UNABLE TO DETERMINE THE COUNT]**	
3.2.4	Number of HIV-positive TB individuals referred to antiretroviral therapy (ART) care during TB treatment [MUST BE ≤ 3.2.2] **[ENTER 0 FOR NONE AND 999 IF UNABLE TO DETERMINE THE COUNT]**	
3.2.5	Number of HIV-positive TB individuals who are started on or continuing antiretroviral therapy (ART), during TB treatment [MUST BE ≤ 3.2.4] **[ENTER 0 FOR NONE AND 999 IF UNABLE TO DETERMINE THE COUNT]**	
3.3	**TB Treatment Outcomes** **[VALID ONLY IF 034=1]** *ENSURE THE DENOMINATOR IS CAPTURED IN SECTION 3.1	
3.3.1	Number of individuals with a new episode of TB who were lost to follow-up (i.e., a person with TB disease who did not start treatment or whose treatment was interrupted for 2 or more consecutive months) *ADAPT PRIOR TO IMPLEMENTATION ACCORDING TO HOW THE DEFINITION OF LOST TO FOLLOW-UP IS DEFINED [MUST BE ≤ 3.1.1] **[ENTER 0 FOR NONE AND 999 IF UNABLE TO DETERMINE THE COUNT]**	
3.3.2	Number of individuals with a new episode of TB whose treatment failed (i.e., a person with TB disease whose treatment regimen needed to be terminated or permanently changed to a new regimen option or treatment strategy) [MUST BE ≤ 3.1.1] **[ENTER 0 FOR NONE AND 999 IF UNABLE TO DETERMINE THE COUNT]**	

3. Drug-Sensitive TB (DS-TB) Treatment Register *ADAPT PRIOR TO IMPLEMENTATION		
3.3.3	Number of individuals with a new episode of TB who died (i.e., a person with TB disease who died for any reason before starting or during the course of treatment) [MUST BE ≤ 3.1.1] **[ENTER 0 FOR NONE AND 999 IF UNABLE TO DETERMINE THE COUNT]**	
3.3.4	Number of individuals with a new episode of TB who were not evaluated (i.e., a person with TB disease to whom no treatment outcome was assigned, excluding those lost to follow up) [MUST BE ≤ 3.1.1] **[ENTER 0 FOR NONE AND 999 IF UNABLE TO DETERMINE THE COUNT]**	
3.3.5	Number of individuals with a new episode of TB who were cured (i.e., a person with bacteriologically confirmed pulmonary TB at the beginning of treatment who completed treatment as recommended by the national policy with evidence of bacteriological response and no evidence of failure. In this context, bacteriological response is defined as a bacteriological conversion with no reversion) 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 999 IF UNABLE TO DETERMINE THE COUNT]**	
3.3.6	Number of individuals with a new episode of TB who completed treatment (i.e., a person with TB disease who completed treatment as recommended by the national policy whose outcome does not meet the definition for cure or treatment failure) [MUST BE ≤ 3.1.1] **[ENTER 0 FOR NONE AND 999 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 Re-registered Cases** **[VALID ONLY IF 034=1]**	
3.4.1	Number of re-registered individuals with TB who initiated a retreatment regimen **[ENTER 0 FOR NONE AND 999 IF UNABLE TO DETERMINE THE COUNT]**	
3.4.2	Number of re-registered individuals with TB who were lost to follow-up (i.e., a person with TB disease who did not start treatment or whose treatment was interrupted for 2 or more consecutive months) *ADAPT PRIOR TO IMPLEMENTATION ACCORDING TO HOW THE DEFINITION OF LOST TO FOLLOW-UP IS DEFINED [MUST BE ≤ 3.4.1] **[ENTER 0 FOR NONE AND 999 IF UNABLE TO DETERMINE THE COUNT]**	
3.4.3	Number of re-registered individuals with TB whose treatment failed (i.e., a person with TB disease whose treatment regimen needed to be terminated or permanently changed to a new regimen option or treatment strategy) [MUST BE ≤ 3.4.1] **[ENTER 0 FOR NONE AND 999 IF UNABLE TO DETERMINE THE COUNT]**	

3. Drug-Sensitive TB (DS-TB) Treatment Register *ADAPT PRIOR TO IMPLEMENTATION		
3.4.4	Number of re-registered individuals with TB who died (i.e., a person with TB disease who died for any reason before starting or during the course of treatment) [MUST BE ≤ 3.4.1] **[ENTER 0 FOR NONE AND 999 IF UNABLE TO DETERMINE THE COUNT]**	
3.4.5	Number of re-registered individuals with TB who were not evaluated (i.e., a person with TB disease to whom no treatment outcome was assigned, excluding those lost to follow up) [MUST BE ≤ 3.4.1] **[ENTER 0 FOR NONE AND 999 IF UNABLE TO DETERMINE THE COUNT]**	
3.4.6	Number of re-registered individuals with TB who were cured (i.e., a person with bacteriologically confirmed pulmonary TB at the beginning of treatment who completed treatment as recommended by the national policy with evidence of bacteriological response and no evidence of failure. In this context, bacteriological response is defined as a bacteriological conversion with no reversion) [MUST BE ≤ 3.4.1] **[ENTER 0 FOR NONE AND 999 IF UNABLE TO DETERMINE THE COUNT]**	
3.4.7	Number of re-registered individuals with TB who completed treatment (i.e., person with TB disease who completed treatment as recommended by the national policy whose outcome does not meet the definition for cure or treatment failure). [MUST BE ≤ 3.4.1] **[ENTER 0 FOR NONE AND 999 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. Drug-Resistant TB (DR-TB) Laboratory Register **[VALID ONLY IF 033=1 or 2]** *ADAPT PRIOR TO IMPLEMENTATION *THE QUESTIONS IN THIS SECTION ARE LIMITED TO RIF, FQ AND 2L INJECTABLES TO BE ILLUSTRATIVE AND SHOULD BE ADAPTED TO REFLECT THE FIRST- AND SECOND-LINE DRUG-SUSCEPTIBILITY TESTING (DST) OPTIONS THAT ARE AVAILABLE. *CHECK NATIONAL TB PROGRAM (NTP) GUIDELINES ON DRUG-RESISTANT TB (DR-TB) SCREENING, DIAGNOSIS, AND TREATMENT, E.G., USE OF SOLID MEDIA (I.E., LJ), LIQUID MEDIA (I.E., MYCOBACTERIA GROWTH INDICATOR TUBE [MGIT]), LINE PROBE ASSAYS (LPA), OR OTHER MOLECULAR METHODS (I.E., MOLECULAR SEQUENCING), AS WELL AS SECOND-LINE DST, ETC.		
4.0.1	**[LOCATE RECORDS WITHIN THE SPECIFIED DATE RANGE]** *E.G., LAST 24 MONTHS (a) Cohort start date (b) Cohort end date	 ___/___/_____ ___/___/_____

4. Drug-Resistant TB (DR-TB) Laboratory Register **[VALID ONLY IF 033=1 or 2]** ***ADAPT PRIOR TO IMPLEMENTATION** ***THE QUESTIONS IN THIS SECTION ARE LIMITED TO RIF, FQ AND 2L INJECTABLES TO BE ILLUSTRATIVE AND SHOULD BE ADAPTED TO REFLECT THE FIRST- AND SECOND-LINE DRUG-SUSCEPTIBILITY TESTING (DST) OPTIONS THAT ARE AVAILABLE.** ***CHECK NATIONAL TB PROGRAM (NTP) GUIDELINES ON DRUG-RESISTANT TB (DR-TB) SCREENING, DIAGNOSIS, AND TREATMENT, E.G., USE OF SOLID MEDIA (I.E., LJ), LIQUID MEDIA (I.E., MYCOBACTERIA GROWTH INDICATOR TUBE [MGIT]), LINE PROBE ASSAYS (LPA), OR OTHER MOLECULAR METHODS (I.E., MOLECULAR SEQUENCING), AS WELL AS SECOND-LINE DST, ETC.**			
4.0.2	Which register(s) were used to determine the DR-TB lab counts (i.e., to complete Section 4): **[SELECT ALL THAT APPLY]**	Presumptive TB register TB laboratory register Drug-sensitive TB (DS-TB) treatment register DR-TB laboratory register DR-TB treatment register TB preventive treatment (TPT) register Contact investigation register Other (specify) No register(s) exists that contains information on DR-TB lab counts	1 2 3 4 5 6 7 96 0
4.1	**DR-TB Screening and Diagnosis**		
4.1.1	Number of bacteriologically confirmed TB cases who received DST **[ENTER 0 FOR NONE AND 999 IF UNABLE TO DETERMINE THE COUNT]**		
4.1.2	Number of bacteriologically confirmed TB cases with DST results [MUST BE ≤ 4.1.1] **[ENTER 0 FOR NONE AND 999 IF UNABLE TO DETERMINE THE COUNT]**		
4.1.3	Number of bacteriologically-confirmed TB cases with DST results positive for rifampicin (RIF) resistance [MUST BE ≤ 4.1.2] **[ENTER 0 FOR NONE AND 999 IF UNABLE TO DETERMINE THE COUNT]**		
4.1.4	Number of bacteriologically-confirmed TB cases with DST results positive for RIF resistance who have rifampicin-resistant TB (RR-TB) [MUST BE ≤ 4.1.3] **[ENTER 0 FOR NONE AND 999 IF UNABLE TO DETERMINE THE COUNT]**		
4.1.5	Number of bacteriologically-confirmed RR-TB cases with DST results positive for fluoroquinolones (FQs) [MUST BE ≤ 4.1.4] **[ENTER 0 FOR NONE AND 999 IF UNABLE TO DETERMINE THE COUNT]**		
4.1.6	Number of bacteriologically-confirmed RR-TB cases with DST results positive for resistance to FQs and/or second-line injectable agents [MUST BE ≤ 4.1.5] **[ENTER 0 FOR NONE AND 999 IF UNABLE TO DETERMINE THE COUNT]**		
4.2	**RR-TB Treatment**		

4. Drug-Resistant TB (DR-TB) Laboratory Register **[VALID ONLY IF 033=1 or 2]** ***ADAPT PRIOR TO IMPLEMENTATION** ***THE QUESTIONS IN THIS SECTION ARE LIMITED TO RIF, FQ AND 2L INJECTABLES TO BE ILLUSTRATIVE AND SHOULD BE ADAPTED TO REFLECT THE FIRST- AND SECOND-LINE DRUG-SUSCEPTIBILITY TESTING (DST) OPTIONS THAT ARE AVAILABLE.** ***CHECK NATIONAL TB PROGRAM (NTP) GUIDELINES ON DRUG-RESISTANT TB (DR-TB) SCREENING, DIAGNOSIS, AND TREATMENT, E.G., USE OF SOLID MEDIA (I.E., LJ), LIQUID MEDIA (I.E., MYCOBACTERIA GROWTH INDICATOR TUBE [MGIT]), LINE PROBE ASSAYS (LPA), OR OTHER MOLECULAR METHODS (I.E., MOLECULAR SEQUENCING), AS WELL AS SECOND-LINE DST, ETC.**		
4.2.1	Number of people with bacteriologically-confirmed rifampicin-resistant TB (RR-TB) who started second-line treatment [MUST BE ≤ 4.1.6] **[ENTER 0 FOR NONE AND 999 IF UNABLE TO DETERMINE THE COUNT]**	

5. Drug-Resistant TB (DR-TB) Treatment Register **[VALID ONLY IF 035=1]** ***ADAPT PRIOR TO IMPLEMENTATION**			
5.0.1	**[LOCATE RECORDS WITHIN THE SPECIFIED DATE RANGE]** *MOST RECENT COHORT OF PEOPLE WITH DR-TB WHOSE TREATMENT PERIOD HAS ENDED ND HAVE OUTCOMES ASSIGNED (a) Cohort start date (b) Cohort end date		___/___/_____ ___/___/_____
5.0.2	Which register(s) were used to determine the DR-TB treatment counts (i.e., to complete Section 5): **[SELECT ALL THAT APPLY]**	Presumptive TB register TB laboratory register Drug-sensitive TB (DS-TB) treatment register DR-TB laboratory register DR-TB treatment register TB preventive treatment (TPT) register Contact investigation register Other (specify) No register(s) exists that contains information on DR-TB treatment counts	1 2 3 4 5 6 7 96 0
5.1	**DR-TB Treatment Outcomes**		
5.1.1	Number of people with DR-TB who started second-line treatment **[ENTER 0 FOR NONE AND 999 IF UNABLE TO DETERMINE THE COUNT]**		
5.1.2	Number of people with DR-TB who were lost to follow-up (i.e., a person with TB disease who did not start treatment or whose treatment was interrupted for 2 or more consecutive months) *ADAPT PRIOR TO IMPLEMENTATION ACCORDING TO HOW THE DEFINITION OF LOST TO FOLLOW-UP IS DEFINED [MUST BE ≤ 5.1.1] **[ENTER 0 FOR NONE AND 999 IF UNABLE TO DETERMINE THE COUNT]**		

5. Drug-Resistant TB (DR-TB) Treatment Register [VALID ONLY IF 035=1] *ADAPT PRIOR TO IMPLEMENTATION		
5.1.3	Number of people with DR-TB whose treatment failed (i.e., a person with TB disease whose treatment regimen needed to be terminated or permanently changed to a new regimen option or treatment strategy) [MUST BE ≤ 5.1.1] **[ENTER 0 FOR NONE AND 999 IF UNABLE TO DETERMINE THE COUNT]**	
5.1.4	Number of people with DR-TB who died (i.e., a person with TB disease who died for any reason before starting or during the course of treatment) [MUST BE ≤ 5.1.1] **[ENTER 0 FOR NONE AND 999 IF UNABLE TO DETERMINE THE COUNT]**	
5.1.5	Number of people with DR-TB who were not evaluated (i.e., a person with TB disease to whom no treatment outcome was assigned, excluding those lost to follow up) [MUST BE ≤ 5.1.1] **[ENTER 0 FOR NONE AND 999 IF UNABLE TO DETERMINE THE COUNT]**	
5.1.6	Number of people with DR-TB who were cured (i.e., people with bacteriologically confirmed pulmonary TB at the beginning of treatment who completed treatment as recommended by the national policy with evidence of bacteriological response and no evidence of failure. In this context, bacteriological response is defined as a bacteriological conversion with no reversion.) [MUST BE ≤ 5.1.1] **[ENTER 0 FOR NONE AND 999 IF UNABLE TO DETERMINE THE COUNT]**	
5.1.7	Number of people with DR-TB who completed treatment (i.e., a person with TB disease who completed treatment as recommended by the national policy whose outcome does not meet the definition for cure or treatment failure) [MUST BE ≤ 5.1.1] **[ENTER 0 FOR NONE AND 999 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 Treatment (TPT) Register *ADAPT PRIOR TO IMPLEMENTATION, particularly if National TB Program (NTP) guidelines have been updated to expand eligibility for TPT beyond people living with HIV (PLHIV) and child contacts and additional groups have been prioritized for TPT.			
6.1	TPT for PLHIV [VALID ONLY IF 037=1]		
6.1.1	**[LOCATE RECORDS WITHIN THE SPECIFIED DATE RANGE]** ***MOST RECENT COHORT OF PLHIV WHO COMPLETED TPT** (a) Cohort start date (b) Cohort end date		___/___/_____ ___/___/_____
6.1.2	Which register(s) were used to determine the TPT to PLHIV counts (i.e., to complete Section 6.1): **[SELECT ALL THAT APPLY]**	Presumptive TB register TB laboratory register Drug-sensitive TB (DS-TB) treatment register Drug-resistant TB (DR-TB) laboratory register DR-TB treatment register TB preventive treatment (TPT) register Contact investigation register Other (specify) No register(s) exists that contains information TPT provided to PLHIV	1 2 3 4 5 6 7 96 0
6.1.2	Number of PLHIV initiated on TPT **[ENTER 0 FOR NONE AND 999 IF UNABLE TO DETERMINE THE COUNT]**		
6.1.3	Number of PLHIV on TPT who interrupted TPT due to any type of adverse event **[MUST BE ≤ 6.1.2]** **[ENTER 0 FOR NONE AND 999 IF UNABLE TO DETERMINE THE COUNT]**		
6.1.4	Number of PLHIV on TPT who interrupted TPT due to death while taking TPT **[MUST BE ≤ 6.1.2]** **[ENTER 0 FOR NONE AND 999 IF UNABLE TO DETERMINE THE COUNT]**		
6.1.5	Number of PLHIV on TPT who interrupted TPT due to developing active TB while taking TPT **[MUST BE ≤ 6.1.2]** **[ENTER 0 FOR NONE AND 999 IF UNABLE TO DETERMINE THE COUNT]**		
6.1.6	Number of PLHIV on TPT who interrupted TPT due to loss to follow-up **[MUST BE ≤ 6.1.2]** **[ENTER 0 FOR NONE AND 999 IF UNABLE TO DETERMINE THE COUNT]**		
6.1.7	Number of PLHIV on TPT with no outcome recorded **[MUST BE ≤ 6.1.2]** **[ENTER 0 FOR NONE AND 999 IF UNABLE TO DETERMINE THE COUNT]**		
6.1.8	Number of PLHIV on TPT who completed treatment **[MUST BE ≤ 6.1.2]** **[ENTER 0 FOR NONE AND 999 IF UNABLE TO DETERMINE THE COUNT]**		

6. TB Preventive Treatment (TPT) Register *ADAPT PRIOR TO IMPLEMENTATION, particularly if National TB Program (NTP) guidelines have been updated to expand eligibility for TPT beyond people living with HIV (PLHIV) and child contacts and additional groups have been prioritized for TPT.			
6.1.9	Add the counts from 6.1.3 to 6.1.8 and enter here. Compare with the 6.1.2 count. They should be equal. If not, determine the cause of the discrepancy and fix. If it cannot be fixed, describe why not: _____ _____ _____		
6.2	**TPT for Child Contacts** **[VALID ONLY IF 038=1]**		
6.2.1	**[LOCATE RECORDS WITHIN THE SPECIFIED DATE RANGE]** ***MOST RECENT COHORT OF CHILD CONTACTS WHO COMPLETED TPT** (a) Cohort start date (b) Cohort end date		___/___/_____ ___/___/_____
	Which register(s) were used determine the TPT to child contact counts (i.e., to complete Section 6.2): **[SELECT ALL THAT APPLY]**	Presumptive TB register TB laboratory register DS-TB treatment register DR-TB laboratory register DR-TB treatment register TB preventive treatment register Contact investigation register Other (specify) No register(s) exists that contains information on TPT provided to child contacts	1 2 3 4 5 6 7 96 0
6.2.2	Number of child contacts initiated on TPT **[ENTER 0 FOR NONE AND 999 IF UNABLE TO DETERMINE THE COUNT]**		
6.2.3	Number of child contacts on TPT who interrupted TPT due to any type of adverse event **[MUST BE ≤ 6.2.2]** **[ENTER 0 FOR NONE AND 999 IF UNABLE TO DETERMINE THE COUNT]**		
6.2.4	Number of child contacts on TPT who interrupted TPT due to death while taking TPT **[MUST BE ≤ 6.2.2]** **[ENTER 0 FOR NONE AND 999 IF UNABLE TO DETERMINE THE COUNT]**		
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 999 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 999 IF UNABLE TO DETERMINE THE COUNT]**		

6. TB Preventive Treatment (TPT) Register *ADAPT PRIOR TO IMPLEMENTATION, particularly if National TB Program (NTP) guidelines have been updated to expand eligibility for TPT beyond people living with HIV (PLHIV) and child contacts and additional groups have been prioritized for TPT.		
6.2.7	Number of child contacts on TPT with no outcome recorded **[MUST BE ≤ 6.2.2]** **[ENTER 0 FOR NONE AND 999 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 999 IF UNABLE TO DETERMINE THE COUNT]**	
6.2.9	Add the counts from 6.2.3 to 6.2.8 and enter here. Compare with 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: _____ _____ _____	

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 ……..……... Partially completed ……..…… Records unavailable ……... Facility refused ……...…….. Postponed ……..…….. Other (specify) _____	1 2 3 4 5 96	Hours Minutes
004	Visit 2 (if needed)	Completed ……..…… Partially completed ……..…… Records unavailable ……... Facility refused ..... Other (specify) _____	1 2 3 4 96	Hours Minutes

Appendix 1. Informed Consent Form: Health Facility Audit and Register Review

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 TB Program (NTP) of the Ministry of Health (MOH) in [city, country]. The organization I am working for, the TB Data, Impact Assessment and Communications Hub (TB DIAH), and the MOH are interested in the quality of services that people diagnosed and treated for tuberculosis (TB) are receiving. This assessment is being conducted by the NTP in collaboration with TB DIAH, 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 has been conducted in several countries around the world.

Your answers will help policy makers, program managers, and researchers 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 see the 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 individuals 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 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. However, 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 it 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 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 the 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 TB Program (NTP) of the Ministry of Health (MOH) in [city, country]. The organization I am working for, the TB Data, Impact Assessment and Communications Hub (TB DIAH), and the MOH are interested in the quality of services that people 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 TB DIAH, 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 people with TB 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 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. However, 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 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: Individual with TB

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

READ TO INDIVIDUAL WITH TB:

Greetings. My name is _____, and I am working with [name of the local research organization, or LRO]. My organization is collaborating with the National TB Program (NTP) of the Ministry of Health (MOH) in [city, country]. The organization I am working for, the TB Data, Impact Assessment and Communications Hub (TB DIAH), and the MOH are interested in the quality of services that people diagnosed and treated for tuberculosis (TB) are receiving. This assessment is being conducted by the NTP in collaboration with TB DIAH, 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 policy makers, program managers, and researchers 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. However, 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 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 individual'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 individual 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 individual's information.
Either way, this form should be signed by the individual (only if the individual is ages 18 and older):			
Participant's signature: _____ *(A duplicate of this signed questionnaire should be offered to the individual.)* Individual's thumbprint:			

Appendix 4 Part 1. Assent Form: Individual with TB - Minor (Younger than Age 18)

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

READ TO MINOR INDIVIDUAL WITH TB:

Hello. My name is _____, and I am working with [name of the local research organization, or LRO]. My organization is collaborating with the National TB Program (NTP) of the Ministry of Health (MOH) in [city]. We are interested in the quality of services that people with tuberculosis (TB) 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 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. However, 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 with 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 Individual with TB

READ TO MINOR'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 TB Program (NTP) of the Ministry of Health (MOH) in [city, country]. The organization I am working for, the TB Data, Impact Assessment and Communications Hub (TB DIAH), and the MOH are interested in the quality of services that people with diagnosed and treated for tuberculosis (TB) are receiving. This assessment is being conducted by the NTP in collaboration with TB DIAH, 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 policy makers, program managers, and researchers 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. However, 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 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 individual interview form with the individual's information.
Either way, this form should be signed by the individual's legal guardian:			
Individual's legal guardian's signature: _____ *(A duplicate of this signed questionnaire should be offered to the individual's parent/guardian.)* Individual's legal guardian's thumbprint:			

Appendix 5. Refusal Form: Individual with TB

Instructions:	If an individual 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 individual's age, e.g., 20–25.
	TB Status:	Enter the data that you captured from the screening questions.

Patient Refusals												
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/ Unknown)*	*Treatment Duration*
1											
2											
3											
4											
5											
6											
7											
8											
9											

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