2022

Sultanate of Oman
Ministry of Health
Directorate General for Diseases Surveillance & Control

Guidelines for Directly Observed Therapy (DOT) in the Management of Tuberculosis (TB) in Oman

Version 1, November 2022

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Abbreviations

CB DOT	Community Based Directly Observed Therapy
DOT	Directly Observed Therapy
DST	Drug Susceptibility Testing
EPTB	Extra Pulmonary Tuberculosis
FAMCO	Family and Community Medicine Doctor
FDC	Fixed-Dose Combination
HC	Health Center
HIV/AIDS	Human Immunodeficiency Virus/Acquired Immune Deficiency Syndrome.
HCW	Health Care Worker
ID	Infectious Diseases
LTBI	Latent Tuberculosis Infection
MTB	Mycobacterium Tuberculosis
NTBCP	National Tuberculosis Control Program
PCA	Patient Centered Approach
PPM	Public Private Mix
PTB	Pulmonary Tuberculosis
RH	Rifampicin 150 mg + Isoniazid 75 mg
RHZE	Rifampicin 150 mg +Isoniazid 75 mg+ Pyrazinamide 400 mg + Ethambutol 275 mg
RIF	Rifampicin
RR	Rifampicin Resistance
TB	Tuberculosis
TBFP	Tuberculosis Focal Point
VOT	Video Observed Treatment
WHO	World Health Organization
WRD	WHO Endorsed Rapid Diagnostic
X pert/MTB/RIF	Automated polymerase chain reaction (PCR) test for the detection of Mycobacterium Tuberculosis Complex and Rifampicin Resistance

1. Introduction

TB remain a major global public health concern. It causes ill health for approximately 10 million people each year and it is one of the top ten causes of death worldwide. According to WHO 2017 global TB report tuberculosis has been the leading cause of death from a single infectious agent ranking above HIV/AIDS for the past 5 years. On the other hand, with timely and correct diagnosis cure is achievable.

Direct Observed Therapy course (DOT) is the key effective control policy recommended by the World Health Organization (WHO) for the management of TB. Community engagement is defined as the process of working collaboratively with and through communities to address issues affecting their well-being. As a 2003 WHO report on community contribution to TB care pointed out "Organized community groups, peer groups, chosen members of the community, and family members all have the potential to act as supervisors to ensure completion of treatment and hence cure". A meta-analysis for treatment success showed that Community Based Directly Observed Therapy (CB DOT) was superior to clinic DOT in terms of improve compliance and treatment success rate (Wright et al. BMC Infectious Diseases (2015) 15:210).

In Oman, the diagnostic and treatment services are free of charge to all patients with presumptive or confirmed tuberculosis of all forms.

The aim of this document is to provide the guidelines for DOT for uncomplicated pulmonary bacteriologically confirmed TB patients. However, patients with complicated pulmonary TB should be treated in the hospital until their clinical condition improve and no continuous clinical or public health need for their admission.

This guideline will list all the available DOT methods tailored to patient centered approach taken into consideration local resources and patient characteristics and constraints.

2. Objectives:

Primary Objectives:

- To outline the DOT protocols and method for implementation.
- To outline role and responsibilities of DOT to all concerns.

Secondary objectives:

- To ensure effective and complete treatment of all cases.
- Prevent transmission among community of MTB.
- Prevent development of drug resistance.

3. Definitions of TB Disease Registration Group

Category	Definition
Bacteriologically confirmed TB case	Is one from whom a biological specimen is positive by smear microscopy, culture or WRD (such as Xpert MTB/RIF).
Clinically diagnosed TB case	Is one who does not fulfil the criteria for bacteriological confirmation but has been diagnosed with active TB by a clinician who has decided to give the patient a full course of TB treatment. This definition includes cases diagnosed based on X-ray abnormalities or suggestive histology and extra pulmonary cases without laboratory confirmation. Clinically diagnosed cases subsequently found to be bacteriologically positive (before or after starting treatment) should be reclassified as bacteriologically confirmed.

3.1. Direct Observed Therapy (DOT)

WHO defines DOT as any person observing the patient taking medication in real time. The treatment observer does not need to be a health-care worker but could be a friend, a relative or a layperson who works as a treatment supervisor or supporter under supervision of health care worker. Observed treatment may also be achieved with real time video recording, which is called Video Observed Treatment (VOT).

This ensures that a TB patient takes the right drugs, in the right doses, at the right intervals. DOT is recommended in the initial phase of treatment with FDCs, at least for all bacteriologically confirmed cases, and in the continuation phase of rifampicin-containing regimens. Patients' and health workers' compliance is a key factor in treatment success.

3.2. Community DOT

Community-based TB activities in general are the activities conducted outside the premises of formal health facilities (e.g. hospitals and clinics) in community-based

structures (e.g. schools, home and places of worship). Community health workers and community volunteers carry out community-based TB activities.

Community DOT is the process of continuing the TB treatment under DOT for patients with uncomplicated pulmonary TB that do not have any risk factors or co morbidities that require prolonged inpatient admission where the patient will be assessed by a case management team at hospital and assign a community based treatment option.

3.3. Video DOT (VOT)

VOT is the use of a videophone or other video/computer equipment to observe the TB patients taking their medications at a remote location from the health care worker.

The following need to be considered for video DOT:

- Video picture must be sufficiently clear to discern the shape, color and size of the pills.
- Ability to visually evaluate the patient's general health in real time.
- Patients receiving video DOT is familiar **with instrument use.**
- Patient must be motivated to take their medications.
- Trial period of health center based DOT for an initial period before instituting VOT.

3.4. Case Management Team:

Case management team, is a team who consist of clinical and public health personal who will discuss the clinical and public health aspects of each patient based on clinical and socio-economic background, social constraints, adherent to counselling and appropriate treatment and follow-up to decide on the type of DOT assigned to the patient.

3.4.1. The case management team consists of:

- Treating physician (ID / Pulmonologist/ TB focal point physician).
- Director/Incharge of communicable disease Department at DGHS.
- TB focal point nurse at treating institute.
- Social worker (at hospital).
- FAMCO/Head of Health Centre at the catchment area health center.
- Governorate Focal Point Pharmacist.

The main responsibility of the team is:

At Hospital level:

- Carry out detail clinical assessment of patient including all important laboratory investigations and decide type of DOTS category assigned to patient.
- Reporting of case - TB through e-notification (Tarassud) (see annex 19.1).
- Maintain TB treatment card see (annex 19.2).
- Counselling of the patient for isolation.
- Counselling of importance of adherence to treatment (DOTS).
- Discuss public health aspects of each patient based on clinical and socio-economic background, social constraints, adherent to counselling and appropriate treatment and follow-up with Public health team.
- Regular assessment of progress of patient while on treatment and appropriate investigation to be carried out.

At time of discharge:

- Joint decision to be taken by Clinical and Public health team (Case management team).
- Discuss the indications for discharge and review criteria of check-list (see annex 19.3).
- Decide on the plan of collecting medicine and investigation (Treatment institute or catchment area health center).
- Assign TB focal point at the health center for follow-up of CB DOT.
- Assign community health staff or other DOT provider based on risk assessment for follow-up of CB DOTS.
- Direct access to the regional focal point to discuss any issues regarding management or follow-up in catchment area.

4. DOT Delivery Options

4.1. Health Centre Based

It is the most preferred method of DOT. For patients who live close to a health facility, the best treatment supporter would be one of the staff in the health facility, if it is convenient to the patient.

4.2. Community Nurse Based

It is the preferred method for those who cannot attend health care facility.

4.3. Community supporter group (volunteers especially trained in cDOTS).

Community support groups (CSGs) are groups of volunteers who work as links between the community and the health system to promote health. Such volunteers can be trained to be a DOT provider (any person who is willing and is accept to the patient, and also easily approachable and answerable to the health system can be a treatment supporter e.g. cured TB patient, member of Oman women associations etc...). Those volunteers will be under the supervision of the TB focal point at the catchment area health center.

4.4. Public health inspector

A public health inspector can participate in community DOT including patients whom are difficult to reach or migrants.

4.5. Family member based

A highly committed and cooperative family member who can be trained in DOT under the supervision of the TB focal point at the catchment area health center.

4.6. Video DOT Based (VOT)

VOT is the use of a videophone or other video/computer equipment to observe the TB patients taking their medications at a remote location from the health care worker.

5. DOT Settings

- Health centers at the catchment area
- Home
- Workplace
- Schools/Collage/University clinics
- Private institute (upon approval of PPM policy and certifying the participating institute as DOT provider).

6. DOT Protocol

- Once a patient is notified as Pulmonary TB, the case is admitted in the in-patient facility (regional or tertiary hospital) and the initial phase of treatment is introduced.
- Case management team, which consist of clinical team, and public health team will assess the clinical and socio-economic background, social constraints, adherent to counselling and appropriate treatment and follow-up, etc. for the patient and assign him/her for the appropriate type of DOT.

6.1. Consider discharging from Hospital patients:

- Who do not have a continuing clinical or public health need for admission with pulmonary TB.
- Who is being confirmed as rifampicin resistant **Negative** on nucleic acid amplification test or culture or do not have risk factors for multidrug-resistance.

6.2. The patient should meet the following before discharge:

- At least 2 weeks of adequate treatment (under DOT) have being completed.
- The patient is showing tolerance to the prescribed treatment.
- There is resolution of cough and clinical improvement on treatment; for example, remaining afebrile for a week.
- There is agreement to adhere to treatment.
- There are no immunocompromised people, such as transplant recipients, people with HIV and those on anti-tumour necrosis factor alpha or other biologics, in the same accommodation.
- The patient's initial smear grade was 2 or less.
- There is no extensive pulmonary involvement, including cavitation
- There is no laryngeal TB.
- Contact screening and people at risk such as children < 5 years are already placed on preventive therapy.
- Adequate home settings in terms of proper isolation room and ventilation should be ensured.

- Patient should be advised not to travel during the first weeks of treatment (Until having sputum microscopy conversion).

  ***If the patient is transferred to areas, where they may come into contact with HIV positive or immunocompromised patients, three negative sputum microscopy smears taken on separate occasions over a minimum of 14 days must be obtained in addition to above.**

6.3. Public health team notification

Clinical team **MUST** notify the Directorate of Disease Surveillance and Control (DDSC) at the Directorate General of Health Services (DGHS) about the discharge date of the patient in order for the arrangement to be set for the chosen type of DOT.

- All cases should undergo proper counseling, which should be documented, that is performed by the designated staff nurse who has undergone training for the same in the hospital. The counselling will be on the following aspects:
  - ❖ General information on the transmission of the disease.
  - ❖ Information on the adverse effects of the medications.
  - ❖ General infection control measures (Mainly isolation, use of mask and limit visitors).
  - ❖ Maintain good lifestyle (Proper diet and exercise).
  - ❖ Defaulter retrieval policy and other crucial information that is to be imparted depending on the characteristics of individual cases.
- The process has to be recorded and the counseling checklist (see annex 19.3) will be prepared for documentation for each patient. Educational material for patients and caregivers will be made for this use.
- A consenting process will be introduced for the index case and a family member who will be responsible for the case. A consent form should be signed by the patient and counselling nurse (see annex 19.4).
- For non-Omani TB patient enrolled in community DOT consent form should be signed by the sponsor and the patient prior to discharge (see annex 19.5).

- The patient and family will be introducing to the TBFP of the community team/nurse according to the chosen DOT method and communication established.
- TBFP at hospital should send all the patients documents to the health center at patient's catchment area.
- Case will be referred to the health center at the patient's catchment area with all necessary referral and documents that has to be maintained in the health center.
- The TBFP at the Health center will receive the patient and introduce him or her to community staff/ community supporter volunteer with all the required documents that have to be used for recording during the staff visits based on Treatment plan.
- The community nurse should follow symptom, signs and side effects of the patient started on community DOTS and register any findings on follow up checklist (see annex 19.6).
- The TB focal point physician / treating physician should perform treatment outcome evaluations in their clinical unit at regular time intervals (e.g. quarterly).
- The DOT provider must inform TB focal point at the patient's catchment area health center for missed doses or adverse drug reaction (ADR).
- The regional TB team will inform the National TB focal point in case of patient defaulting or other constraints.
- The retrieval process will be followed according to the defaulter retrieval policy (see annex 19.7).

6.4. Patient's Criteria for continuing in- hospital treatment

TB patients should continue to receive in-hospital treatment in the following circumstances:

- Patient's condition is critical and not suitable for outpatient treatment.
- Having co-morbidities that requiring inpatient treatment.
- Unable to attend daily DOT treatment.
- Having severe adverse drug reactions require in patient monitoring.
- Substance or alcohol abuse which increase the risk of defaulting treatment under ambulatory DOT.
- Poor family support.

7. Roles and Responsibilities:

7.1. TB clinical Team

The TB clinical team which consist of treating physician (ID / Pulmonologist/ TB focal point physician, TB focal point nurse and preferably social worker are responsible for clinical management, assess severity of the case and need for extended hospitalization and the readiness for community DOT.

7.2. DOT providers

DOT provider is a person who works as a treatment supervisor or supporter, which includes HCW such as community nurse/Public health inspector, community supporter (volunteer), highly committed family member. The following roles and responsibilities under the supervision of the TBFP at the patient's catchment area health center are expected

- Provide TB medication through DOT and documenting swallowing the medicine in the treatment card.
- Reports promptly to the TBFP at the health center any individuals who are missing doses of anti-TB medication, and any adherence issues.
- Reports promptly to the TBFP at the health center any individuals who show signs or symptoms of side effects to the anti-TB medication.
- Maintaining patient confidentially with all encounters.
- Participates in the tuberculosis education within the community.
- Document and update the contact list.

- The recorded sheet has to be submitted to the TBFP of the health center per week.
- The same process will be followed for both the phases of treatment.

7.3 TBFP of the HC

- The TBFP will be responsible for collecting the weekly-recorded forms
- These forms should be forwarded to Regional TBFP at the governorates on a monthly basis unless otherwise informed.

7.4. Governorate TBFP

- The governorate TBFP will update the information of the individual patients in tarassud.
- Liaise with the TBFP at the health center and overviewing the patient placed on different DOT.
- Ensure arrangement of Anti-TB medication with TBFP at health center and Regional Pharmacist to ensure adequate supply at health center for the patient started on community DOT.
- Monthly review meeting will be between the regional TBFP and the epidemiologist regarding each case on DOTS treatment. The meeting will be recorded and documented.

7.5. Community support group DOT provider

Under the supervision of the TBFP at the health center community supporter group DOT provider has the following responsibility:

- Provide TB medication through DOT and documenting swallowing the medicine in the treatment card.
- Reports promptly to the TBFP at the health center any individuals who are missing doses of anti-TB medication, and any adherence issues.
- Reports promptly to the TBFP at the health center any individuals who show signs or symptoms of side effects to the anti-TB medication.
- Maintaining patient confidentially with all encounters.
- Participates in the tuberculosis education within the community.
- Requirement for the Community support Group:
  - Education: High school diploma at a minimum.
  - Knowledge: become familiar with Medical terminology.
  - Skills to: Read, write and speak Arabic, English and preferably other language e.g. Aurdo.
  - Have good communication skills.

They should be able to:

- Conduct interview related to supporting the TB treatment with the patient and hid/her contacts.
- Work effectively with people from various economic, cultural and social Backgrounds.
- Promptly and accurately communicate issues such as adverse drug reactions and non-adherence.
- Assist patients in accepting the required medical care and treatment.
- Work with special needs of diverse populations such as immigrant.

8. Recommended Treatment Regimen for Adult:

The main objective is:

- To achieve peak serum level of all drugs simultaneously.
- To obtain maximum bactericidal effect.

Treatment regimens consist of two phases:

8.1. Initial intensive phase

The objective of combining four drugs is to achieve rapid killing of actively multiplying bacillary population. Smear conversion at the end of 2 month will occur in >90 %. Infectious patients quickly become non-infectious (within about 2 weeks) and symptoms improve when given proper dosage of quality assured drugs in right combination. Patient support in taking medication-using DOT is essential in the initial phase for every single dose.

8.2. Continuation phase:

During continuation phase two drugs are used for 4 months will eliminate the remaining bacilli thus preventing subsequent relapses. At least once a week observation of drug intake is desirable.

Case Definition	Treatment Category	Treatment Regimen	
		Intensive Phase	Continuation Phase
New Case **Pulmonary** **Extra-pulmonary**	New	2 HRZE	4 HR
Previously treated cases <u>without</u> drug resistant (Relapse, treatment after failure, treatment after loss to follow up and other previously treated cases)	Retreatment Xpert/MTB/RIF result: MTB positive/ rifampicin resistant (RR) **NOT** detected	2 HRZE	4HR (WHO recommendation 2017)

9. WHO Recommended Formulation of FDC (Adult) Used in Oman

FDC Formulation		
FDC4	**RHZE**	**Rifampicin 150mg + Isoniazid 75mg + Pyrazinamide 400mg + Ethambutol 275mg**
FDC2	**RH**	**Rifampicin 150mg + Isoniazid 75mg**

10. Procedures

Registration and treatment initiation

- Once diagnosed patient should be notified electronically by e-notification through tarassud platform.
- All patient information, contact tracing, and LTBI results should be entered in the e-notification system.
- Treatment card should be filed with date and initials of DOT provider on daily basis.
- Community DOT TB treatment Consent form should be signed by the patient and TB focal point.
- A copy of the following documents should be sent along with the patient upon referring the patient to the health center at the patient's catchment (Discharge summary, TB notification form, Treatment card, Community DOT consent form and DOT Follow up check list).
- Anti TB medication treatment kit labeled with patient details should be sent to catchment area health center upon Discharge.

11. Follow up

Patient category	Follow up sputum examination for (sputum positive)
Bacteriologically confirmed and Clinically diagnosed new Cases Previously Treated patients (X-pert/MTB must be done) Relapse Treatment after failure Treatment after loss to follow-up Other previously treated	End of 2nd month End of 3rd month if smear- positive at the end of 2nd month[$] End of 5th month* End of treatment

[$]If sputum is positive at 2nd month sputum AFB & culture should be sent.
*Culture should be send end of 5th month.

12. Monitoring and Response to Treatment

Monitoring of tuberculosis patients on treatment include:

- Bacteriological monitoring for pulmonary TB cases by examination of sputum smears at 2, 3, 5 and 6 months of treatment.
- Clinical monitoring by symptomatic improvement and weight gain including patients who are clinically diagnosed pulmonary TB.
- Monitoring the drug intake during intensive phase and drug collection during the continuation phase by reviewing the treatment cards.
- Patient weight should be monitored each month and dosage should be adjusted if weight changes.
- Adverse events: should be monitored and recorded for all medications given, along with bacteriological response.

Response to treatment in both new and re-treatment bacteriologically confirmed cases should be monitored by sputum smear examination and culture at the end of the intensive phase of treatment, end of fifth month and end of treatment. If sputum continue to be positive at 2nd month sputum microscopy and culture should be sent.

Generally, 1-2 sputum samples should be collected for smear examination at each follow up sputum examination.

13. Outcome

Treatment outcome should be recorded in the e-notification (tarassud) quarterly and at the end of the treatment course for each patient. The following table is showing the outcome definitions in accordance with WHO 2013 revision of definitions and reporting framework. (Updated December 2014 and January 2020).

The outcome definitions are for patients treated with **First Line Drugs.**

Treatment outcome	Definition
Cured	A pulmonary TB patient with bacteriologically confirmed TB at the beginning of treatment who was smear- or culture-negative in the last month of treatment and on at least one previous occasion.
Treatment completed	A TB patient who completed treatment without evidence of failure BUT with no record to show that sputum smear or culture results in the last month of treatment
Treatment failure	A TB patient whose sputum smear or culture is positive at the end of fifth month or later during treatment.
Died	A TB patient who dies for any reason before starting or during the course of treatment.
Lost to follow-up	A TB patient who did not start treatment or whose treatment was interrupted for 2 consecutive months or more.
Not evaluated	A TB patient for whom no treatment outcome is assigned. This includes cases for whom the treatment outcome is unknown to the reporting unit.

14. Infection Prevention and Control

- Minimize the number and duration of visits a person with TB makes to an outpatient department while they are still infectious.
- Single room isolation is recommended for suspected infectious or confirmed pulmonary or laryngeal TB who will remain in hospital. If this is not possible prioritization of the service should be undertaken and patient waiting time should be kept to minimum.
- Patients who are suspected infectious or confirmed pulmonary TB should not be admitted to a ward containing people who are immunocompromised.
- Any suspected infectious or confirmed pulmonary or laryngeal TB will need to wear a face mask whenever they leave their room.

- Patients should be educated on simple respiratory hygiene measures, such as covering the mouth and nose with a tissue when coughing or sneezing and disposing of the tissue in a waste basket.
- For people deemed to be at high risk of multidrug resistance, provide care in a negative pressure room.
- Staff and visitors should wear N95 face masks during contact with a person with suspected or known TB patient (including MDRTB) while the person is thought to be infectious.
- Restrict visitors at home and advise to wear surgical mask if meeting people.
- Maintain good ventilation at home and personal hygiene.

15. Legal Aspect

As per public health law.

16. Key Performance Indicators (KPI) for DOTS

Indicator	Total No of patients/Percentage			Target
	Omani	**Non-Nationals**	**Total**	
Total TB cases Diagnosed				
Total number of Bacteriologically confirmed Pulmonary TB				
Total sputum positive				
Total No. of patient under DOT				
No. of patient under health center based DOT				
No. of patient under community nurse based DOT				
No. of patient under health inspector based DOT				
No. of patient under family member based DOT				
No. of patient under community support group based DOT				
No. of patient under VOT based DOT				

Total No of patient who needed change in DOTS options at least once				
Total No of patient needed change in drugs				
Non-adherence to treatment at least for duration not less than 2 weeks				
Number of Defaulters				
Adverse events documented				
Average of in-patient admission				

17. Requirements for DOT Implementation:

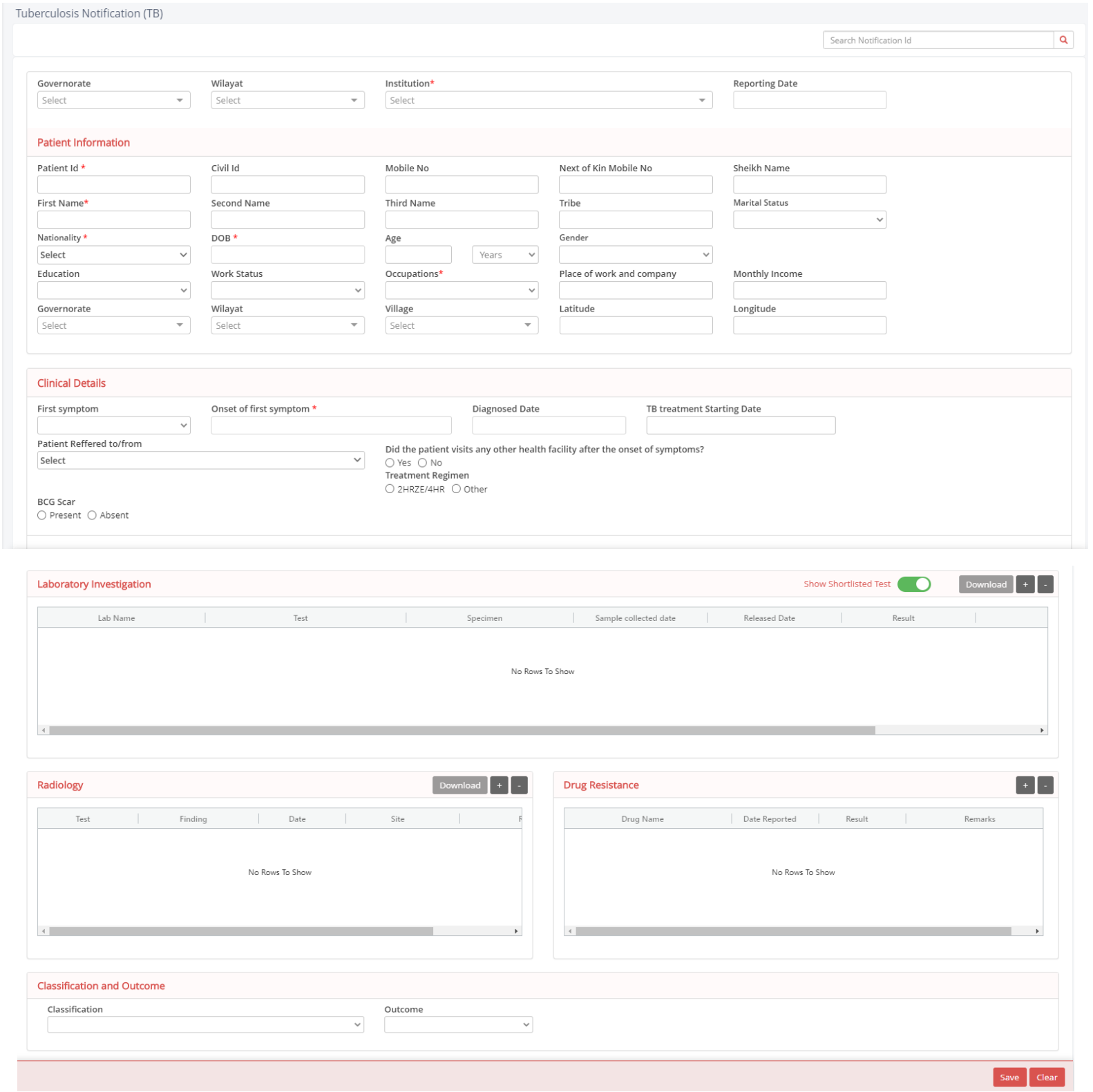
- Patient treatment support team.
- Counselling training for HCW involved in DOT implementation
- PHC staff training workshop for management of TB and adverse effects
- Training for HCW for implementation of the DOT guideline including a mechanism of follow up for patient on DOT
- Strict regulation for retained expatriate.

18. Revision and Audit

- The policy should be reviewed two years after the date effective.
- Audit: Regular audit should be undertaken. Audit tools may include feedback from patient /service users and DOT providers which should be developed locally to evaluate local process and procedures.

19. Annexes

19.1. TB Notification



19.2. Treatment Card

Directorate General for Disease Surviellance and Control
Department of Communicable Disease
TB & Acute Respiratory Diseses Section

TUBERCULOSIS TREATMENT CARD

PATIENT INFORMATION			
NAME		SEX	
INDEX NO		AGE	
NATIONALITY		WEIGHT	
ADDRESS			
TREATMENT INSTITUTION			
TRANSFER TO			
DATE OF DIAGNOSIS			
DATE OF DOTS START			

DISEASE SITE			
PULM	Bactorolo-gical Confirmed	MTB/RIF	
		SMEAR POSITIVE	
		SMEAR NEGATIVE	
	CLINICALLY DIAGNOSED		
EXTRA-PULMONARY, SPECIFY ( )			

TYPE OF PATIENT	
NEW	
RELAPSE	
PREVIOUSLY TREATED	

TB/HIV			
HIV TEST DATE		RESULT	
DATE OF ART START			
DATE OF CPT START			

SPUTUM EXAMINATION					SENSITIVITY					WEIGHT (KG)
MONTH	DATE	LAB NO.	RESULT	CULTURE	S	I	R	E	Z	
0										
2										
3										
5										
6										
END OF TREATMENT										

I. INITIAL PHASE

CAT I		CAT II		CAT III	

2HRZE	INH 300 MG	INH 150 MG	RIF 300 MG	RIF 150 MG	PZA 500 MG	EMB 400 MG	STREP 1 G

DAY / MONTH	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31

II. CONTINUATION PHASE

4 RH	5 RH	6 RH

DAY / MONTH	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31

SIDE EFFECTS

☐ NAUSEA ☐ JAUNDICE ☐ FATIGUE ☐ BLURRED VISION ☐ LOSS OF APPETITE ☐ VOMITING

☐ HEADACHE ☐ RASH ☐ BODY ACHES ☐ LOSS OF SENSATION ☐ OTHERS

TREATMENT OUTCOME

DATE

☐ CURED ☐ TREATMENT COMPLETED ☐ DIED ☐ TREATMENT FAILURE ☐ DEFAULT ☐ NOT EVALUATED

REMARKS

19.3. Check list for discharging TB patient

Directorate General for Disease Surveillance and Control
Department of Communicable Diseases
Tuberculosis & Acute Respiratory Diseases Section

Checklist for discharging TB patient from Hospital

The patient should achieve the following before discharge:

- □ At least 2 weeks of adequate treatment (under DOT) have been completed.
- □ The patient is showing tolerance to the prescribed treatment.
- □ There is resolution of cough.
- □ There is definite clinical improvement on treatment for example remaining afebrile for a week.
- □ There is agreement to adhere to treatment.
- □ There are no immunocompromised people such as transplant receipts, people with HIV and those on antitumor necrosis factor alpha or other biologics in the same accommodation*
- □ *If patients are transferring to area where they may come into contact with HIV positive or immunocompromised patient, they must have at least three negative sputum microscopy smears taken on separate occasion over a minimum 14 days in addition to above.
- □ The patient's initial smear grade was not high; for example, 2 or less.
- □ There is no extensive pulmonary involvement, including cavitation.
- □ There is no laryngeal TB.
- □ Contact screening and people at risk such as a children < 5 years are already placed on preventive therapy.
- □ The patient has a negative rifampicin resistance on Nucleic Acid Amplification Test (NAAT) or culture.

□ Adequate home setting in terms of room for isolation and ventilation.
□ Patient should advise not to travel during the first weeks of treatment (until having bacteriological conversion).
□ Public health team has been informed about discharge plan.
□ The appropriate type of DOT has been decided as per criteria mentioned in the text.
□ Counselling has been done by the designated staff on the following aspects :
- General information on the transmission of the disease.
- Information on the adverse effects of the disease.
- General infection control measures.
- Proper diet and exercise.

□ The patient doesn't have contraindication for outpatient treatment.
□ Critical condition which is not suitable for outpatient treatment:
- Having co-morbidities that require inpatient treatment.
- Unable to attend daily DOT treatment.
- Having severe adverse drug reactions require in patient monitoring.
- Having complications of the disease.
- Substance or alcohol abuse which increase the risk of defaulting treatment under ambulatory DOT.
- Poor family support.

19.4. Community DOTS TB treatment Consent form

تعهد بالالتزام بعلاج السل تحت الإشراف المباشر

INDEX NO:	**PATIENT NAME / اسم المريض :**
PHONE NO /رقم الهاتف:	**EMERGENCY CONTACT NO/هاتف الطوارئ:**
ADDRESS / العنوان:	

Community DOTS involves direct visual observation by a health care provider (e.g. community nurse public health staff) or a reliable trained person (e.g. family member or community support group) of a patient's daily swallowing of medication. Delivering medication to a patient without daily visual confirmation of ingestion does not constitute DOT.

I, _____

(Name of patient) understand and agree that:

1. The only way to get well is by taking my TB medicine exactly as my nurse or doctor advises me to do. If I do not follow these directions, my illness could come back worse than before. Then it could be harder to treat, take longer to treat, and could spread the disease to others.
2. I will be taking Anti- TB medications for a long time (6 months or more) in order to kill the TB bacteria.
3. I agree to cooperate with the supervised DOT provider who will support me to take my medicine and complete my treatment and get well.
4. I will be at: ❒ Home ❒ Work ❒ Clinic ❒ Other – Specify _____ between the hours of _____ (time) and _____ (time) for my DOT visit.
5. In case of an emergency of not been on time or the agreed place I will communicate with _____ (name of DOT provider) at _____ (phone number).

Patient Signature: _____

Date: _____ / _____ / _____

Family member signature _____

Date: _____ / _____ / _____

Nurse Signature: _____

Date: _____ / _____ / _____

MOIC & HOSPITAL STAMP

تتضمن المعالجة قصيرة الأمد تحت الاشراف المباشر(DOTS) لعلاج السل المجتمعية مراقبة بصرية مباشرة من قِبل مقدم الرعاية الصحية (مثل ممرضين صحة المجتمع) أو شخصًا مدربًا موثوقًا به (على سبيل المثال ، أحد أفراد العائلة أو مجموعة دعم المجتمع) لتناول المريض اليومي للأدوية. تقديم الدواء للمريض دون تأكيد الإشراف اليومي لابتلاع الأدوية لا يندرج تحت الاشراف المباشر(DOTS)

أنا _____

_ (اسم المريض) فهمت وأوافق على ما يلي:

1. الطريقة الوحيدة للحصول على نتائج جيدة هي أخذ دوائي لمرض السل تماماً كما نصحتني الممرضة أو الطبيب. إذا لم اتبع هذه التوجيهات ، فقد تنتكس حالتي وعلاجي يحتاج وقت أطول أو قد يكون من الصعب علاجي ويمكن أن ينشر المرض للآخرين.
2. سأتناول أدوية مضادة للسل لمدة (6 أشهر أو أكثر) لقتل جراثيم السل.
3. أوافق على التعاون مع موفر DOT الخاضع للإشراف والذي سيدعمني لأخذ دوائي وإكمال علاجي والحصول على ما يرام
4. سأكون في: ❒ المنزل ❒ العمل ❒ العيادة ❒ غير ذلك - حدد _____ بين ساعات _____ (الوقت) و _____ (الوقت) لزيارة DOT.
5. في حالة وجود حالة طارئة ولم أتمكن الحضور في الوقت المحدد أو المكان المتفق عليه ، سأتواصل مع _____ (اسم مزود DOT) على _____ (رقم الهاتف).

توقيع المريض: _____

التاريخ: _____ / _____ / _____

توقيع فرد من العائلة _____

التاريخ: _____ / _____ / _____

توقيع الممرض: _____

التاريخ: _____ / _____ / _____

توقيع مسؤول المستشفى والختم

19.5. Consent of Sponsor undertaking responsibility of employee for Visa Medical Conditional Release

تعهد الكفيل بتحمل مسؤولية الحالة الصحية بعد فحص اللياقة البدنية لموظف

Employee Name:
……
Civil ID: ……
Nationality: ……
Passport Number: ……
Expiry Date: / /

I (Name)……
being the sponsor of above employee / as representative of the (Name of Organization)
……

After understanding the policies and procedures of MOH regarding medical fitness of employee& conditional fitness certify and accept the following:

- I undertake to follow the directions of MOH in providing proper treatment and sufficient care to the employee.
- I will be responsible for ensuring that the employee adheres to the instructions given for the treatment of the condition from MOH institutions or such other institutions as stipulated by law.
- I undertake to cooperate with authorities who will be verifying or inspecting for checking adherence to steps as directed by MOH.
- I undertake to cooperate with concerned authorities for legal action and repatriation in case employee is non -compliant to treatment.
- I undertake to provide and support adequate financial resources as per labor laws in Sultanate of Oman for the employee treatment and support.
- I understand that if I don't comply with the provisions of this undertaking I am acting against Public Health Law.

Name of Sponsor:
Civil ID:
Telephone Number:
Signature:
Date: / /
Copy of ID of sponsor to be attached

إسم الموظف:
.....
رقم بطاقة المقيم: .....
الجنسية : .....
رقم جواز السفر: .....
تاريخ الانتهاء: / /

أتعهد أنا /.....
كوني كفيلا للموظف المذكور أعلاه/ أو ممثلا عن المؤسسة التابع لها الموظف (اسم المؤسسة)
.....

أتعهد بالآتي فيما يخص صحة الموظف المذكور أعلاه، ووفقا لسياسات وإجراءات وزارة الصحة فيما يتعلق باللياقة البدنية:

- اتباع توجيهات وزارة الصحة في توفير العلاج المناسب والرعاية اللازمة للموظف المذكور
- أكون مسؤولاً عن ضمان التزام الموظف المذكور بالتعليمات المقدمة إليه من مؤسسات وزارة الصحة أو غير ذلك من المؤسسات التي ينص عليها القانون.
- أتعهد بالتعاون مع السلطات المختصة عن قيامها بالتحقق من مدى الالتزام بالخطوات المتبعة للعلاج والرعاية الصحية والوقائية وفقا لتوجيهات وزارة الصحة.
- أتعهد بالتعاون مع السلطات المعنية لاتخاذ الإجراءات القانونية وإعادة الموظف المذكور إلى وطنه في حالة عدم امتثاله للعلاج.
- أتعهد بتقديم المساعدة والموارد المالية لعلاج ودعم الموظف المذكور وفقًا لقوانين العمل في سلطنة عمان.
- إذا لم ألتزم بهذا التعهد أكون قد خالفت قانون الصحة العامة

إسم الكفيل :
الرقم المدني :
رقم الهاتف :
التوقيع :
التاريخ : / /
الرجاء إرفاق صورة من بطاقة الكفيل

19.6. Follow up Checklist for Patient on Community

Directorate General for Disease Surveillance and Control
Department of Communicable Diseases
Tuberculosis & Acute Respiratory Diseases Section

DOTS FOLLOW UP CHECKLIST

Name of patient: **Index no:**
Date: **Weight:**

A. Any sign and symptoms

- ☐ Cough
- ☐ Fever
- ☐ Night sweats
- ☐ Chest pain
- ☐ Loss of pain
- ☐ Loss of weight
- ☐ Hemoptysis
- ☐ Other…….

B. Anti-TB medication to be administered daily under DOTS:

- ☐ Given
- ☐ Not given

If not given why?

C. Any side effect from ATT medication:

- ☐ Yes
- ☐ No

List of side effect:

- ☐
- ☐
- ☐

If any positive findings in section A/B/C, please refer the patient to Health Center of catchment area

Name of recorder: **Date and stamp:**

19.7. Defaulter Retrieval Flow Char