

International Standards for Tuberculosis Care (ISTC) and Patients' Charter: New Advances in Tuberculosis Care

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Tuberculosis (TB) is the number one single infectious disease killer, taking nearly 3 million lives per year. So great is concern about TB that in 1993, the World Health Organization (WHO) declared TB a "global emergency." Successful and widely accepted DOTS strategy was designed and implemented since the year 1994.⁽¹⁾ Though major progress has been obtained in global TB control due to DOTS, the major and current task in hand was the achievement of MDG and related Stop TB Partnership targets. In meeting the contextual needs, new **Stop TB Strategy** was developed in 2006 to effectively address the prevailing constraints.⁽²⁾

The Stop TB Strategy puts its focus in multi-sectoral approach with special consideration in quality. Two sets of documents International Standards for Tuberculosis Care (ISTC) and Patients' Charter have been developed and endorsed by WHO to support the components as defined by the Stop TB Strategy for the effective implementation (uniform and qualitative) of tuberculosis control programme by the National Tuberculosis Control Programmes in different countries.⁽²⁾ ISTC outlines the standards to be followed during the delivery of any TB related services while the Patient Charter which is a legal document aids in the creation of patient friendly environment in health facilities with a focus in the rights and responsibilities of TB patients in line with ISTC. A brief discussion on ISTC and Patients' Charter will help understand the purpose and adopt the issues.

INTERNATIONAL STANDARDS FOR TUBERCULOSIS CARE (ISTC)⁽³⁾

International Standards for Tuberculosis Care (ISTC) was developed by Tuberculosis Coalition for technical Assistance (TBCTA) in association with Centers for Disease Control and Prevention (CDC), American Thoracic Society (ATS) and World Health Organization (WHO) in 2006 with its recent revision in 2009. National Tuberculosis Programme (NTP) has adopted ISTC in 24th of March, 2007 and incorporated these standards in its policies.⁽⁴⁾

The purpose of ISTC is to describe a widely accepted level of care that all practitioners (public and private) should seek to achieve in managing patients who have, or are suspected of having, tuberculosis. The Standards are intended to facilitate the effective engagement of all care providers in delivering high quality care for patients of all ages, including those with sputum smear-positive, sputum

smear-negative, and extra-pulmonary tuberculosis, tuberculosis caused by drug-resistant *Mycobacterium tuberculosis* complex (*M. tuberculosis*) organisms, and tuberculosis combined with HIV infection and other comorbidities. Thus, all providers who undertake evaluation and treatment of patients with tuberculosis must recognize that, not only are they delivering care to an individual, they are assuming an important public health function that entails a high level of responsibility to the community, as well as to the individual patient.

Standards are divided into 4 different areas which are as follows:

Standards for Diagnosis

1. All persons with otherwise unexplained productive cough lasting two-three weeks or more should be evaluated for tuberculosis.
2. All patients (adults, adolescents, and children who are capable of producing sputum) suspected of having pulmonary tuberculosis should have at least two sputum specimens submitted for microscopic examination in a quality-assured laboratory. When possible, at least one early morning specimen should be obtained.
3. For all patients (adults, adolescents, and children) suspected of having extra pulmonary tuberculosis, appropriate specimens from the suspected sites of involvement should be obtained for microscopy, culture, and histo-pathological examination.
4. All persons with chest radiographic findings suggestive of tuberculosis should have sputum specimens submitted for microbiological examination.
5. Diagnosis for smear negative TB should be based on three sputum negative samples followed by one course of antibiotic trial with positive Chest x-ray.
6. Diagnosis of Child TB should be based on clinician's investigation and Judgment

Standards for Treatment

7. The practitioner must not only prescribe an appropriate regimen, but also utilize local public health services and other agencies, when necessary, to assess the adherence of the patient and to address poor adherence when it occurs.

8. The initial phase should consist of two months of Isoniazid (H), Rifampicin (R), Pyrazinamide (Z), and Ethambutol (E). The continuation phase should consist of Isoniazid and Rifampicin given for four months. Fixed dose combinations (FDCs) drugs are highly recommended during the treatment. For re-treatment cases, Injection Streptomycin (S) is added for 2 months during intensive phase (3 months) and Ethambutol (E) during continuation phase (5 months).
 9. To assess and foster adherence, a patient-centered approach to administration of drug treatment, based on the patient's needs further placing an effort in minimizing the cost implications to the patient due to the TB management procedures. In doing so, mutual respect between the patient and the provider should be developed for all patients.
 10. Periodic treatment monitoring through sputum examination (at the end of intensive phase, after 5 months and at the end of treatment) and clinical judgment.
 11. Patient counseling and education should begin immediately to minimize the potential for transmission and treatment adherence. Infection control measures appropriate to the setting should be applied
 12. Patients with or highly likely to have tuberculosis caused by drug-resistant (especially MDR/XDR) organisms should be treated with specialized regimens containing second-line anti-tuberculosis drugs.
 13. A written record of all medications given, bacteriologic response, and adverse reactions should be maintained for all patients.
- Persons with symptoms suggestive of tuberculosis
 - Children aged <5 years
 - Contacts with known or suspected immune-compromise, particularly HIV infection
 - Contacts of patients with MDR/XDR tuberculosis
19. close contacts of an infectious index patient and who, after careful evaluation, do not have active tuberculosis, should be treated for presumed latent tuberculosis infection with isoniazid.
 20. Each healthcare facility caring for patients who have, or are suspected of having, infectious tuberculosis should develop and implement an appropriate tuberculosis infection control plan.
 21. All providers must report both new and re-treatment tuberculosis cases and their treatment outcomes to local public health authorities, in conformance with applicable legal requirements and policies.

PATIENTS' CHARTER

Patient Charter was developed in tandem with the International Standards for Tuberculosis Care to promote a "patient-centered" approach in 2006 which was adopted by Nepal along with ISTC. The Patients' Charter for Tuberculosis Care (The Charter) outlines the rights and responsibilities of people with tuberculosis and practices the principle of Greater Involvement of People with Tuberculosis (GIPT).⁽⁵⁾ It empowers people with the disease and their communities through this knowledge. Initiated and developed by patients from around the world, The Charter makes the relationship with health care providers a mutually beneficial one or "Positive Partnership".⁽⁵⁾ Rights and responsibilities as stated by the charter are as follows:

Patient's rights

Standards for HIV and Co-Morbid Conditions

14. HIV counseling and testing for all suspected cases.
15. All patients with tuberculosis and HIV infection should be evaluated to determine if antiretroviral therapy is indicated during the course of treatment for tuberculosis.
16. Persons with HIV infection who, after careful evaluation, do not have active tuberculosis should be treated for presumed latent tuberculosis infection with isoniazid for 6-9 months.
17. All providers should conduct a thorough assessment for co-morbid conditions that could affect tuberculosis treatment response or outcome.

Standards for Public Health

18. All providers of care for patients with TB should ensure that persons who are in close contact with patients who have infectious TB are evaluated and managed in line with international recommendations. The determination of priorities for contact investigation is based on the likelihood that a contact:

- **Care:** All the confirmed Tuberculosis patients have right for free and equitable access to TB care.
- **Dignity:** TB patients have right to have high-quality health care in a dignified environment.
- **Information:** TB patients have right to know about the free availability of health-care services for TB.
- **Choice:** Patients have right to choose whether or not to take part in research activities.
- **Confidence:** TB patients have right to maintain respect for personal privacy, dignity, religious beliefs and culture while they are in treatment.
- **Justice:** Patients have right to make a complaint through channels provided for this purpose.
- **Organization:** TB patients have right to join, or to establish, organizations of people with or affected by TB.
- **Security:** Tuberculosis patients have right for job

security while they are under the treatment.

Patient's responsibility

- **Share information:** TB patients need to provide as much information as possible to health-care providers for the betterment of their treatment.
- **Follow treatment:** TB patients need to follow the prescribed and agreed treatment regimen which is prescribed within the NTP policy.
- **Contribute to community health:** TB patients can contribute the community by encouraging seeking medical advice for the suspects.
- **Solidarity:** TB patients can play major role in the community to share their expertise, information and knowledge gained

As pointed by Stop TB Strategy, NTP-Nepal has developed policies to engage all care providers (private, public and Non Government) underpinning efforts to strengthen health systems, provide quality services and advance human rights. In the context of achieving the targets, role of private and Non Governmental sector has been proved crucial. More than a decade long partnership of Health Research and Social Development Forum (HERD) with NTP and its stakeholders has revealed an ample importance of the non state providers in the delivery of TB services. HERD has emphasized a renewed focus in the implementation of ISTC and Patient Charter so as to ascertain quality TB services in a patient friendly environment through extensive advocacy and policy level influence.

(The statements or opinions expressed in the articles are the personal views of authors and do not represent the official views of HERD).

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