Improving case finding for childhood TB in Cambodia

Contact Tracing for childhood TB

The Collaboration between Cambodia NTP and TBCARE I/JATA

RIT/JATA
CENAT
Ministry of Health
Implementation of 14 Operational Districts/Hospitals

- 1. Kg Cham
- 2. Sampov meas
- 3. Bakan
- 4. Battambang
- 5. Moung Russey
- 6. Mongkol Borei
- 7. Preah Net Preah
- 8. Ochrov
- 9. Kg Speu
- 10. Kong Pisey
- 11. Kompong Trabek
- 12. Preah Sdach
- 13. Prey Veng
- 14. Prey Chhor
Activities to Strengthen Childhood TB

1. Clinical and Managerial Training for TB physicians based on NTP Childhood TB Guideline

2. Tuberculin Skin Test (TST) Training provided to TB nurses

3. Orientation Workshop for implementation of childhood TB for TB supervisors, RH TB physicians, health center staff, Community DOTS NGOs

4. X-ray Reading Skill Training

5. Supply of X-ray films and cassettes (children size)

6. Regular supportive supervision from central and RH levels
Contact Tracing: Activities at Field

1. Community Level (Community DOTS NGOs):
   - Assist in contact tracing and case TB suspected identification
   - Provide TB education to villagers and encourage parents to refer children suspected cases to referral hospital
   - Provide all possible transport supports to refer children suspected cases to referral hospital for diagnosis
   - Assist in providing of DOT and treatment follow up

2. Health Center level
   - Identify children with symptoms and signs suggested of TB through routine OPD service or outreach activities
   - Conduct contact tracing by asking TB patients whether they have children with TB symptoms or not
   - Encourage parents to refer children with TB symptoms to referral hospital
Activities at Hospital

3. Hospital Level:
- Provide TB diagnosis and treatment to children
- Refer children who diagnosed as TB patients to health center for treatment and follow up
- Refer children with severe conditions to provincial referral hospital or national hospital for further diagnosis and treatment
Approach to Diagnose Childhood TB
National Guideline for Diagnosis and treatment for TB in children

Summary:
- Careful history (including history of TB contact and symptoms consistent with TB)
- Clinical examination (including growth assessment)
- Tuberculin Skin Test (TST)
- Bacteriological confirmation whenever possible
- Investigation relevant for suspected pulmonary TB and suspected extra pulmonary TB
- HIV testing

In Case where specimens (esp. sputum) could not obtained for examination or examination result is negative or not available, the presence of three or more of the following should strongly suggest a diagnosis of TB:

- Chronic symptoms suggestive of TB
- Physical signs highly suggestive of TB
- A positive TST or close contact with newly diagnosed smear positive case
- Chest X-ray suggestive of TB
Arrangement Time at hospital level for Referral and diagnosis

1. Diagnosis TB for children must be done at referral hospital by training TB physicians based on NTP guideline

2. Hospital has to fix schedule to provide TB diagnosis and inform the health center and community so that patients will meet TB physicians (1 or 2 or 3 days per week or every morning)

3. Hospital has to fix the appointment place to receive children referred from health center and community

4. Health center and community have to refer children to hospital on the right time at the right place
Monitoring and Supervision

1. Monitoring and supervision for childhood TB is integrated into routine supervision from OD TB supervisor (every month to RH and HC)

2. Additional supervision and monitoring can be done by TB supervisors or TB specialist/staff from all levels (NTP)
## Progress

<table>
<thead>
<tr>
<th></th>
<th>Q2, 2011 (Baseline)</th>
<th>Q3, 2011</th>
<th>Q4, 2011</th>
<th>Q1, 2012</th>
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</thead>
<tbody>
<tr>
<td>Referral</td>
<td>282</td>
<td>2784</td>
<td>2795</td>
<td>7526</td>
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<tr>
<td>TB detected</td>
<td>107</td>
<td>609</td>
<td>559</td>
<td>973</td>
</tr>
</tbody>
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### Chart

- **Referral**: Increase from Q2, 2011 to Q1, 2012.
- **TB detected**: Significant increase from Q4, 2011 to Q1, 2012.
Lesson Learnt

1. Limited diagnostic capacity of some TB physicians leads to under or over diagnosis of childhood TB, need to improve their skill.

2. Some nurses do not have acceptable TST Skill. Refresher training is needed.

3. Contact tracing and referral of TB suspects from HC and community are needed in collaboration with Community DOTS partners/NGOs at the fields.

4. Transportation support is needed since most of the parents are poor and need to come to referral hospital two times due to TST.

5. Monitoring and supervision from central level (TB specialist) is needed to improve clinical skill.