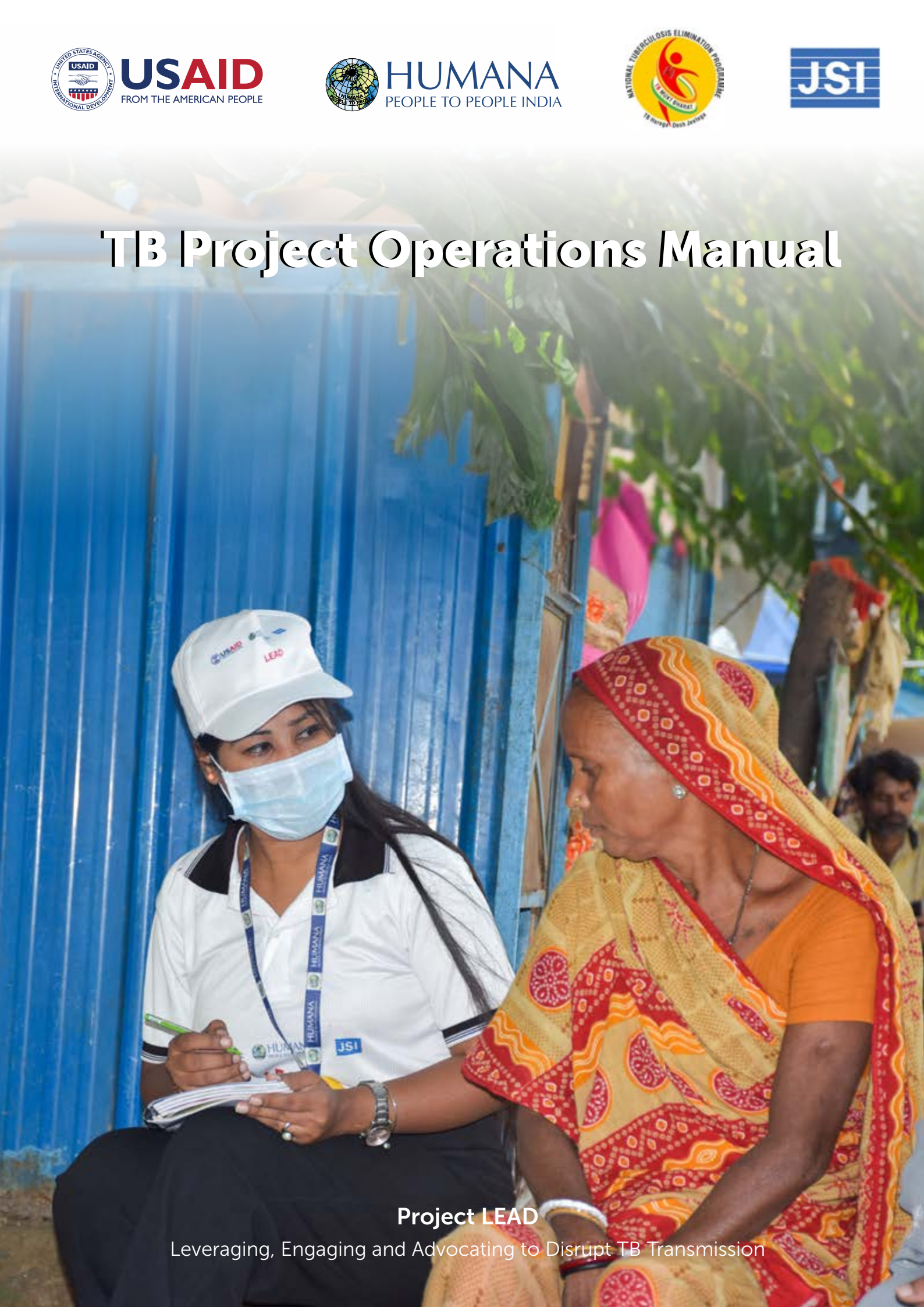
USAID
FROM THE AMERICAN PEOPLE

HUMANA
PEOPLE TO PEOPLE INDIA

JSI

TB Project Operations Manual



Project LEAD

Leveraging, Engaging and Advocating to Disrupt TB Transmission

TB Project Operations Manual

Project LEAD

Leveraging, Engaging and Advocating to Disrupt TB Transmission

ACKNOWLEDGMENT

This Operations Manual is made possible by the generous support of the American people through the United States Agency for International Development (USAID). The contents are the responsibility of Humana People to People India and do not necessarily reflect the views of USAID or the United States Government.

Contents

Abbreviations and Acronyms

A/C	Bank Account
ACF	Active Case Finding
AI	Artificial Intelligence
AIDS	Acquired Immuno deficiency Syndrome
AQI	Air Quality Index
CBNAAT	Cartridge-based NAAT
CFO	City Field Officer
CPL	City Project LEAD
COPD	Chronic Obstructive Pulmonary Diseases
CSO	Civil Society Organization
CT Scan	Computed Topographic Scan
CXR	Chest X-Ray
DBT	Direct Bank Transfer
DRTB	Drug Resistant TB
DSTB	Drug Susceptible TB
DTO	District TB Officer
EPTB	Extra Pulmonary TB
FNAC	Fine Needle Aspiration Cytology
HHCs	Household contacts
HIV	Human Immunodeficiency Virus
HPPI	Humana People to People India
IEC	Information Education Communication
JSI	John Snow Institute
KVP	Key and Vulnerable Population
LEAD	Leveraging Engaging and Advocating for Disruption of TB transmission
LPA	Line Probe Assay
LTFU	Lost to Follow up
M&E	Monitoring and Evaluation
MIS	Management Information System
MoH	Ministry of Health
MTB	Mycobacterium TB
NAAT	Nucleic Acid Amplification Test
NACP	National AIDS Control Program
NGO	Non-Government Organization
NHM	National Health Mission
NPY	NIKSHAY Poshan Yojana
NTEP	National TB Elimination Program
NTP	National TB Program
NUHM	National Urban Health Mission
PIP	Program Implementation Plan
PMU	Project Management Unit
PP	Private Providers
PTB	Pulmonary TB
PwTB	People with TB
RR/MDR	Rifampicin Resistant/Multi-Drug Resistant
SCT	Sputum Collection and Transportation
STO	State TB Officer
TB	Tuberculosis
TG	Transgender
TIFA	TB Implementation Framework Agreement
ToR	Terms of Reference
TPT	TB Preventive Treatment
UDST	Universal Drug Susceptivity Testing
USAID	U.S. Agency for International Development
XDR	Extensively Drug Resistant

Introduction

This TB Operational Manual is for training the Field Teams across the project's sites of Project LEAD (Leveraging, Engaging and Advocating to Disrupt TB Transmission). This project was implemented in four megacities in India, Delhi, peri-urban Mumbai, Howrah and Hyderabad from May 2023-April 2024. The manual serves the dual purpose of being a guidance document as well as a description of the model of LEAD, with its holistic approach for contributing to ending TB among marginalised and vulnerable people in urban settings.

Humana People to People India (HPPI) aims to demonstrate a replicable and scalable urban-based TB operational model for Key and Vulnerable Population (KVP) to the National TB Elimination Program (NTEP). To achieve this, one has to reach the high risk and hard-to-reach underprivileged, migratory, slum and homeless population and facilitate standard TB care and support to them.

Objective

The Central TB Division (CTD), NTEP, Ministry of Health and Family Welfare (MoHFW), need urgent solutions to reach out and serve the marginalized, highly vulnerable and hard-to-reach migratory, slum and homeless population with TB. In this regards CTD was interested in partnering with HPPI via the TB Implementation Framework Agreement (TIFA) initiative. This TIFA-supported TB project will establish and demonstrate context-specific, culturally appropriate and effective TB-care cascade for the marginalized and underprivileged population of 4 large metropolitan cities of India, namely Delhi, peri-urban Mumbai, Howrah and Hyderabad. The experiences and lessons learnt by the project will be utilized by the CTD/NTEP as a model which can be taken on a larger scale to promptly reach out and treat hundred and thousands of TB-affected ultra-poor urban people across the country. This project is vital to fulfil one of the urgent requirements of the CTD/ NTEP of achieving the TB elimination goal by 2025.

LEAD_PPT

Objectives of the TB Operational Manual

- **To train and orient the project staff and Field Officers (FOs) on how to implement and monitor Project LEAD in the 4 cities of India**
  - How
  - o Module reading
  - o Group work
  - o Role plays
- **To utilize the document as a key reference guide during project implementation and monitoring**
  - How
  - o Mid-course correction
  - o On-site training
  - o Mentoring and supportive supervision
- **To utilize it further to operationally assist similar future TB projects with the urban marginalized population of India**
  - How
  - o Design new projects

MODULES OF THE TB OPERATIONAL MANUAL

- **Target Population**
- **Mapping of the targeted KVP and healthcare services in the 4 metropolitan cities**
- **Outreach, TB education, screening and identification of presumptive TB cases**
- **Testing of the presumptive TB cases at the health facilities (public and private)**
  - o Specimen collection and transportation to Cartridge-based NAAT (CBNAAT) and Truenat*
  - o Referral services
  - o Chest X-Ray (CXR)
- **Treatment support**
  - o Treatment initiation
  - o Treatment adherence support, follow-up visits to the patients and counselling, patient-tracking and retrieval of Lost-to-Follow-ups (LTFUs)
  - o Community Directly Observed Therapy (DOT)
  - o Linking the people with TB to other service providers
- **Engagement of informal healthcare providers for TB education and referrals**
- **Engagement of community stakeholders as NIKSHYA Mitras**
- **Monitoring and Evaluation (M&E) of the project**
  - o Overall M&E plan
  - o General M&E framework
  - o List of Indicators
  - o Data collection formats
- **The plan of sustainability of the project activities and resource mobilization for TB elimination, dissemination of learning**
- **Annexure: Training schedule of Project Staff (ToT) and Field Officers**

---

* The Xpert MTB/RIF is a cartridge-based nucleic acid amplification test (NAAT) for rapid tuberculosis diagnosis and rapid antibiotic sensitivity test. It is an automated diagnostic test that can identify Mycobacterium tuberculosis (MTB) DNA and resistance to rifampicin (RIF).

Truenat is a chip-based, point-of-care, rapid molecular test for diagnosis of infectious diseases. The technology is based on the Taqman RTPCR (Real Time Reverse Transcription Polymerase Chain Reaction) chemistry which can be performed on the portable, battery operated Truelab Real Time micro PCR platform.

Module: Target Population

1

The Key Targeted Population of the Project

- Homeless people
- Slum dwellers
- Migratory people
- Mobile population

Why they are vulnerable to TB: These population groups have a high burden of TB and have a higher risk of getting infected by TB. Following are the critical factors that make them much more vulnerable to TB.

- **Epidemiological evidences: Scientific studies show high burden of TB (both latent and active TB), especially in people from the homeless community**
- **Health System factors**
  - o Having poor access to day-time health services due to job-related matters/ priorities (clash between working and clinic hours) and fear of losing daily wages, and not having personal identity documents which are generally needed to seek the public healthcare.
  - o Overall poor coverage by TB and health services in the national program
- **Community factors**
  - o Poor knowledge and risk perception of TB
  - o Living in unhygienic, closed and congested places which are ideal for TB transmission
  - o Higher chances of comorbidities like malnutrition, addiction to drugs, alcohol and smoking and HIV infection which facilitate conversion of TB infection to TB diseases
  - o High level of poverty, stigma, gender inequality and social inequities

Homeless population: You will find many people living under the open sky or in temporary establishments in the large metropolitan cities. They have no real home to stay in. They generally hail from villages and small towns and have come to the capital cities for jobs. Many are illiterate and do not have identification documents, bank accounts etc. Malnutrition, drug addiction and alcoholism, mental illnesses, no schooling and child labor, violation of rights, gross gender disparity and extreme

poverty are common among them. People from the homeless community frequently change their location across the cities.

Location-wise, homeless people are divided into three groups like below:

1. **Homeless in the real sense:** Those who live on the streets or public places and keep on changing their locations due to police raids, job-hunting, or other factors. Such people are seen on the footpaths, railway platforms, under fly-overs, around the religious places like temples, gurudwaras, parks and sitting benches, even cemeteries. They are work as labourers, porters, rickshaw pullers, street vendors, rag pickers and beggers. Some may be involved in criminals activities like mugging and drug-traffcking.

(Homeless people sleeping on the railway platforms. Source: HPPI)

2. **Those living in shelter homes:** Some of the homeless people live in shelter homes like night shelters, vagabond homes, mental asylums, elderly homes and orphanages. They stay there either to spend the nights or for longer periods, as long as they get food and drinking water in those places. Some of them live with their families in the shelters.

(Homeless people in temporary shelters. Source: HPPI)

3. **Those living in temporary establishments like shanties (juggies):** People from the homeless community mostly raise illegal temporary establishments with bamboo, bricks and unused cloth or big plastic sheets, especially around the metro-stations (Delhi), on both sides of the railway tracks along the city railways (peri-urban Mumbai and Howrah), around construction sites, stadiums, cinema halls, shopping malls and large living complexes (in all cities). Many of them stay with their families in the juggis. Police raids and demolition drives by the municipal corporations are a common phenomenon that forces them to change their locations frequently and build new juggis.

(Juggis. Source: HPPI)

4. **Slum dwellers:** A slum is a highly populated urban or peri-urban residential area consisting of densely packed housing units of weak building quality and often associated with poverty.

(Slums. Source: HPPI)

The people living in the slums are better off than the people from the homeless community, as they have access to drinking water, jobs and livilihood opportunites, civic amenities, social welfare benefits, social security and health and TB services. In general, the TB burden is much less in the slum population than among the homeless.

According to the Indian census, three types of slums are identified in the large metropolitan cities.

Registered slums

- **Notified slums/registered slums:** These are notified as 'Slum' by State, UT Administration or Local Government under any Act, including a 'Slum Act'.

Unregistered slums

- Recognized slums: These are recognized as 'Slum' by State, UT Administration or Local Government, Housing and Slum Boards, but may not have been formally notified as 'slum' under any act.
- Identified slums: These are compact areas of at least 300 people or about 60–70 households of poorly built, congested tenements, in unhygienic environments usually with inadequate infrastructure and lacking proper sanitary and drinking water facilities.

Please remember, in our project, we will focus only on unregistered slums, where people live under poorer and much more unhygienic conditions, not on registered slums.

(Rag pickers. Source: HPPI)

Migratory people/Migrants: These are typically people who hail from the villages and semi-urban areas and have come to the large metropolitan and capital cities to work as security guards, domestic helps, rickshaw pullers, auto-drivers, street vendors, informal healthcare providers, traditional healers and contractual laborers at construction sites. Many of them fall in the categories of homeless people or slum dwellers. Often, 10–15 people rent and share one-room apartments. The rooms mostly have no ventilation, are cold and damp and ideal places for TB transmission. Many of such migrant colonies are located near to small or medium-size factories of the cities (in the slums) where they work. They are grossly underpaid in general. Other than TB, HIV infection is common in them due to frequent sexual acts with the local female and transgender sex workers. In places like Howrah, many poor women of the villages and semi-urban areas visit the city on a daily basis for contractual jobs, as well as commercial sex work, to earn their livelihoods. The challenge to work with the migratory population is their frequent and long absences from the cities. This is when they stay in their villages for cultivation, and again come back to the cities in search of jobs when the cultivation season is over. Tracking people with TB (PwTB) from these populations, who have frequent inter-state movements, needs specific city-wise strategies.

(Migrant workers. Source: HPPI)

Mobile population: They move around from city to city, engage in small businesses. They stay in one place for a couple of months and then move to other cities. They are seen mostly at the outskirts of the cities. Alcoholism, drugs, malnutrition and sometimes HIV infections make them vulnerable to TB.

Other populations: The project will also work with the following population groups, in close collaboration with the local NGOs who implement targeted interventions (TI) of the HIV programmes.

1) Sex workers
2) Transgender people
3) People who inject drugs (PWID)

Comparative analysis of the targeted groups of the project

Targeted Groups	Socio-economic status	Access to civic amenities	Access to healthcare	TB burden	Mobility
Homeless a) Roadside b) Shelter-home c) Juggis	Ultra-poor	Negligible	Negligible/ nil	Very high	Frequent movements in the city, alcoholism, drugs,
Unregistered slums	Poor	Ok	Ok	High	Not much movement like others, occasional interstate movement
Migrants	Poor	Poor	Poor	High	Interstate movements
Mobile population	Poor	Negligible	Negligible/ nil	High	Interstate movement, temporary stay in the city
Others (HIV high-risk groups, PLHIV)	Poor	Ok	Ok	High	Frequent movement in andoutside the city

(Reference: HPPI's Evaluation Report of the Homeless Project of Delhi)

Training Methodologies

- Module reading in groups: 40 minutes
- Engage the city-wise teams to develop detailed lists of the targeted population of their cities in Project LEAD – Group work and presentations, followed by discussions: 20 minutes
- Total time: 60 minutes

Module: 2

Mapping of the Targeted KVP and Healthcare Services in the 4 Metropolitan Cities

What is Mapping

Mapping means identification of locations associated with the targeted groups, their geolocations and estimated population in those locations. These locations are called hotspots. The mapping operation described here is in the context of the large metropolitan cities of India where the LEAD Project is being implemented including Delhi, peri-urban Mumbai, Howrah and Hyderabad.

Mapping means collection of data and information about the three key things of our project, like

- Targeted population of LEAD and the hotspots where they are located
- Key community stakeholders
- Health and other service providers who provide services to the targeted population[3]
  - Informal healthcare providers and pharmacists in and around the hotspots
  - Private diagnostic centers where CXR can be done, close to hotspots
  - Public health facilities close to hotspots which provide free-of-cost TB diagnostic and treatment services under NTEP
  - Non-profit healthcare providers
  - Community DOT providers

Why Mapping is Required

So, the objectives of the mapping are:

1. To estimate the size and the site/geography of the targeted population
2. To identify the key community stakeholders and influencers
3. To have a detailed stock of the available service delivery facilities (both public and private) available in the cities for diagnosing and treating TB around the targeted population
4. To help in developing day-to-day work distribution plans of the field officers of the project according to the locations of the targeted population

Who Should be Mapped

- Targeted community members
- Community stakeholders
- Healthcare facilities and health-care providers

Who are the Targeted Populations to be brought under Mapping

- Slums – unregistered (chawl)
- Colonies of migrant laborers and migratory population
- Refugee colonies
- Colonies of Internally Displaced People (IDP)
- Shanties along railway tracks and other places,
- Homeless people: those living on the roadside, people living in juggis, and night shelters, porters of the railway stations, rickshaw pullers and migrant laborers
- Homes for vagabonds and abandoned people, orphanages, old-age homes
- Large- and medium-sized construction sites where migrant laborers work and live
- Urban-based mobile populations.
- Others (context-specific, please specify with rationale of their mapping)

Target population

- **Delhi –** Mostly homeless (say around 70%), and partially a combination of unregistered slum dwellers, migratory populations and mobile populations
- **Rest of the cities –** A combination of homeless, dwellers in unregistered slums, migratory populations and mobile populations; there is no proportional distribution
- **As per the project agreement, each city team should screen at least 150,000 people for TB at least once. Therefore, the mapping of the cities should identify the targeted hotspots which house around 150,000 members of the targeted communities per city**

Who are the Community Stakeholders to be brought under Mapping

These are people who are friends, colleagues, co-habitants, and close associates of the PwTB , who know about the possible movements, whereabouts, workplaces, sleeping places, eating points and addiction points (alcoholism, drugs) of the PwTB and who help the project staff to track and locate the PwTB during their treatment.

- Local vendors like tea vendors, vegetable/fruit vendors, roadside food corners, and local shops
- Local police
- Supervisors and owners of the night shelters, destitute homes and slums factory owners and supervisors, construction site supervisors
- Job contractors or contractual, daily job-givers
- Religious places – temples, gurudwaras, churches, mosques (the places people can get food, and sleep)
- Local charitable trusts, NGOs, CBOs (the places people can get food, and sleep) Local community leaders, elected representatives (ward councilors)
- Workers' Associations
  - o Cycle/Rickshaw pullers
  - o Auto-drivers, porters
  - o Cab drivers
  - o Domestic helps
- Slum development committees
- Municipal corporations, Urban Development Bodies
- Others (context-wise, please specify)

Who are the Healthcare Providers and which Facilities should be brought under Mapping

We will map 7 types of healthcare providers and facilities that are located in and around the hotspots

Private

1. Informal healthcare providers – map at least 150 of such providers per city
   - Registered Medical Practitioners (RMPs), quacks, traditional healers Bangali doctors – who are popular and visited by the targeted community members
   - Pharmacists or Chemists
2. Private diagnostic centers for CXR

Public/municipal/NTEP

3. Public/municipality health facilities which provide 'free-of-cost' TB diagnostic and treatment services under the NTEP (like chest clinics of Delhi, municipality clinics of peri-urban Mumbai, etc)
4. Patient Provider Support Agencies (PPSA) of the NTEP

Non-profit

5. Non-profit/charitable trust-supported hospitals and health camps, de-addiction centers, which are meant to serve the poor urban community members

Community-based

6. Community treatment supporters who are located in the hotspots
7. Local NGOs, CBOs, PLHIV organizations working with TB and HIV

Mapping Methodologies

1. Identification of the sites/geographies of the targeted population (hotspots) in a city – to be done by the City Team Lead
2. Direct collection of information from – to be done by the Supervisors and Field Officers
   - Community members through personal interviews and focus group discussions (FGDs) per hotspot.
     - Community members - 5 personal interviews;
     - Community members - 1 to 2 FGD's interviews
   - Community stakeholders through personal interviews per hotspot
     - Community stakeholders - 1 to 2 interviews
   - Healthcare providers and facilities through personal interviews per hotspot
     - Healthcare providers - 1 to 2 interviews
3. Secondary data collection, to estimate the size of the (approximate number) of the targeted population, through desk-review – to be done by the city-level MIS Officer
   a. Records of the local municipal offices
   b. Local census data
   c. Scientific research papers (TB prevalence research in the targeted population)
   d. Evaluation reports of previous health/development projects with the same targeted population
   e. Data from local DTO offices, especially the coverage QA data of the National Active Case Finding (ACF) campaigns
   f. Data from local NGOs and CBOs, especially those implementing TB and HIV projects in the KVP
4. Compilation of city-wise information and development of the final mapping document – to be done by the M&E Manager of PMU with the support from the Technical Advisor

Identification of the Sites/Geographies of the Targeted Population (hotspots) in a City

Typically, the targeted populations, in most of the urban cities of India, are present in certain common areas like railway platforms, along railway tracks, under flyovers, close to metro stations, in night shelters and destitute homes, around busy market places (sabzi mandis) and interstate bus stations, near religious places, traffic signals, large and medium construction sites, business malls, rickshaw/autorickshaw stands and large residential complexes. Moreover, the people without homes and permanent residences are present across the cities and at roadsides, but can be traced in all the places in the cities mentioned above, including public parks and footpaths.

Please remember, our targeted communities in the urban cities prefer to stay close to those places where,

1. They have easy access to food, and shelter for sleep
2. They can beg and earn money
3. They can find daily wage-based jobs
4. They can easily access their workplaces (small and medium-sized factories located close to the unregistered slums)
5. They can find buyers and sell their items

The sites are also known as hotspots, meaning with population groups expected to have a high TB burden due to a number of socio-economic factors. Therefore, the mapping exercises will aim to identify urban-based hotspots in terms of geography and estimated population.

Identify and list down all the possible hotspots (full addresses, directions, landmarks and ward numbers of their locations) after consultation with the State TB Officers, District TB Officers, City TB Officers, local municipality officers, elected ward members, and if possible, local media people.

Direct Collection of Information

Reach the sites by using google maps or city maps. Confirm with the local stakeholders of those places if the targeted population groups (whom you try to identify for your projects) are actually present there. If not, find out which are the nearby places where they can be identified/found. If yes, find out how many of KVP members or households are there (make a rough estimation).

Collection of Information for Mapping

- From key community stakeholders
- From the community members

What Information Should be Collect from the Stakeholders (Key informants)

- Confirmation of the location of the KVP in the site (in accordance with the requirements of the Project LEAD)
- Key information of the targeted population as observed by the stakeholders in terms of their types, livelihoods, daily routines, at what time they are generally present in the site, addiction habits, rough estimate of the population, movements (for homeless and migratory population) their health-seeking behaviors, challenges they generally face and any other relevant points
- Stakeholders' points of interaction with the community members and the kinds of influence they have on them in terms of providing help, jobs, food, shelter, security, health and other services; legal and administrative actions taken against community members during breaches of existing laws, if any, like drug abuse, crime, hidden sex work, illegal occupation of public places, forcible shifting to other places during demolition drives by the city municipalities
- Key Informant Interview Tool (below) can be used for collecting information from the stakeholders. Before starting the interview, one needs to introduce themselves and the explain the purpose of the interview
- Time for key informant interview: 5–10 minutes

Key Informant Interview Tool for Mapping
Name of the hotspot
Name of the Key Informant (if agrees to disclose)
Date and time of interview
Types (Choose from the list of all possible key community stakeholders and influencers given above) Questions (should be open ended) 1. Confirm the name and location of the hotspot first. 2. Since when have you been coming to this place? 3. Do you know if the targeted population (mention what type of population you are searching for) lives in this place? 4. Can you tell me their exact locations in this place? 5. Do you have any idea how many of them stay here? How many households or juggis? 6. Do you know anything about their livelihoods? 7. Do you know which places they visit to seek healthcare? Name of popular healthcare providers? 8. Do you interact directly with them? 9. In which ways do you have interactions with the members of the targeted communities? 10. Do you know anybody suffering from TB or who has had TB in this place?

Information to be Collected from the Members of the Targeted Communities

- The approximate number of population (ask total number of households)
- The key livelihood options
- Health-seeking practices – which places do they visit for healthcare, self-treatment
- Any PwTB under treatment in the place
- If someone suffered from TB in the past
- From which health facilities did they get TB medicines
- Level of stigma and discrimination around the PwTB – do they visit the PwTB house/ help the PwTB to reach the hospital
- If there is anybody in the place who provides TB medicines to the PwTB (community DOT providers)
- The challenges they generally face to seek services at the municipality clinics/hospitals
- Do they face discrimination in those facilities
- The key persons in their community who influence their lives in various ways – by giving employment, food, shelter, houses on rent, electricity, etc,
- At what time of day/night are the KVP-members present in maximum numbers at their sites
- **FGD (Focused Group Discussion), 1-2 per site,** is the best way to elicit this information (tool on the adjacent page). After introduction, purpose of the interview should be explained to the community members. This should be done respectfully. The total number of participants in each FGD should not be more that 15 and ideally it should have at least 30% women participation
- Time for each FGD: 15-20 minutes

FGD Tool for Mapping
Name of the hotspot
Name of the community members (if agree to disclose)
Date and time of FGD
Types of targeted population (Choose from the list of 'which targeted population we should bring under mapping' as given above) – Questions (should be open-ended) 1. Confirm the name of the hotspot first. 2. Since when have you been staying in this place? 3. What are your places of origin? From which places did you migrate here? 4. How many of you stay here? How many households or juggis are here? 5. What are your livelihoods? What cooking fuel is used in the locality (domestic air-pollution)? 6. At which time of the day, are you available in this place in highest numbers? 7. Who are the people here to help you with jobs, shelters and free food? 8. Which places do you visit to seek healthcare? Name of preferred/popular healthcare providers. Do you have any known person in your community who provides TB medicines to the PwTB (community treatment supporter)? 9. Do you know anybody suffering from TB or who has already had TB in your place? If so, where did the PwTB seek treatment? 10. What challenges do you generally face in your day-to-day life? (Give leads during the FGD like presence or lack of civic amenities like provision of aadhar cards and bank accounts, access to water, electricity, schools, public and health services, discrimination and exploitation, socio-economic situations, stigma, especially related to TB, gender disparity, etc.

Mapping Process of the Healthcare Providers and Services

- Find out which are the healthcare providers in discussions with the community members and community stakeholders who are located in or close to the hotspots, and which are preferred, popular in those communities
- Conduct personal interviews with the healthcare providers/facilities and pick up the following information as shown in the table below during the interviews

Critical Lessons Related to Mapping:

1. Mapping is not a TB survey. Mapping is the way to know the location and size of the targeted population-groups in the identified hotspots.
2. Don't talk about TB in the beginning because it is highly stigmatized and prevents the people to give you the correct information.
3. While identifying yourselves, it is better to say that you have come from the Department of Health, and want to know the health profile of poor people over there.
4. Motivate people by saying that Government of India aims to eliminate TB by 2025, and everyone should support the government to achieve that, the way they had supported the efforts of polio eradication.
5. Explain that the information of mapping will be utilized by the Department of Health to serve the poor people better for TB and by ensuring that they access all the benefits that the government has been offering to the PwTB.

Compilation of Mapping Information (hotspot wise)

Mapping Compilation Format						
Name of state:	Name of city:	Name of the district:				
Name of the Field Officers and Supervisors of the TIFA Project who did the mapping:						
Name and mobile contact number of the DTO: Geography of the hotspot: • Name: • Full Address: • Directions to reach: • Landmarks: • Municipality Ward Number:						
Information about the targeted populations in the hotspot (also include community stakeholders)						
Identify and list type/s of targeted populations present in the hotspot (homeless, slum dwellers, migrants, mobile etc.) – Use additional rows if multiple types of population are available in the hotspot	Estimated numbers of the targeted populations in the hotspots and the time when they are present in highest number in the hotspot	List the stakeholders and influencers of the targeted populations present in the hotspot, by names, profession and mobile numbers	What are the supports which are presently provided by the community stakeholders to the members of the targeted populations	Health- seeking behaviors of the targeted populations (which places do they visit for seeking healthcare)	Knowledge of TB (Use code) 1 – Know TB symptoms and transmission 2- Just heard about TB 3-No idea about TB	If any TB patient presently receiving treatment in the hotspot Yes/No
Information about the healthcare providers in or around the hotspots						
Type of healthcare providers/ faciliti es (Choose from the list given above)	Full address with landmarks of the providers/ fac ilities	Phone numbers/ mobile numbers and emails of the providers/fa cilities	Working hours (From – To)	Name and designation of the healthcare providers/ point persons of the facilities For all public/ municipal health facilities, collect name and contact numbers of the MOTC, MO, STS, LT, Radiographer, nurse, etc	Types of TB services available in the facilities (sputum microscopy, CBNAAT, Truenat, CXR, LPA, sputum culture test, TB treatment, DOT, HIV and diabetes testing, others) Others – Chest CT scan, gastric lavage for children, TB urine test	If the members of the targeted communit ies visit the providers/ facilities for seeking healthcare

Training Methodologies

- Module reading: 45 minutes
- Conduct mock mapping exercise of an identified hotspot via role plays and filling the mapping compilation format: 45 minutes
- Total time: 90 minutes

Module: 3

Outreach, TB Education, Screening and Identification of Presumptive TB Cases

Outreach means reaching the community members during their preferred time, which may be early morning, evening or night. The outreach team (FOs of the project who will be guided by their supervisors) should reach the hotspots according to the preferred time of the community. During the outreach, the FOs should educate the community members on TB, screen them for TB symptoms and identify the presumptive TB cases.

To achieve this, the field supervisors will guide their Field Officers (FOs) to prepare

1. Micro-plans for community outreach – this should include
   a. Obtaining community approval for the outreach activities from the community/local leaders. Developing the micro-plan in consultation with community leaders/members will be very helpful for implementation
   b. An implementation route-map in terms of marking starting point and end-point of daily activities. This will be highly useful to ensure the saturation coverage of the KVP sites
   c. Deciding the time and place of community outreach according to the time preference of the community members – please select the timing of the outreach as per the information gathered in the mapping
   d. Selecting the names of the field officers responsible for conducting the community outreach, hotspot wise
   e. Distributing reasonable daily workload of the field officers in terms of number of people to be reached/number of households to be reached

The mapping data will be fully utilized to prepare the micro-plan.

Suggested Microplanning Format of the Field Officers

Name of the field officer	Name of the supervisor	Name and location of the hot-spot for community outreach	Date of the outreach activities	Time of the outreach activities	Route- map (starting point and end point of the outreach activity)	Workload (Number of people to be reached and screened per day)	Accomplishment (to be filled up after the outreach activities)
		City					# people reached: # people screened: # presumptive cases detected:

2. Activities to be implemented during one-to-one, one-to-group, door-to-door campaigns of community outreach (Be courteous, respectful, pleasant while implementing the activities. If someone refuses to provide information, don't force them.)
   a. Self-introduction and purpose of visit
   b. TB education – on individual basis, in groups, community awareness generation and demand generation
   c. Symptomatic TB screening

Self-Introduction and Purpose of Visit

Please introduce yourself to the community members and explain the purpose of your visits to their sites clearly, confidently and humbly. This is critical for ice-breaking.

TB Education – We also Call it Door-to-Door or Person-to-Person TB Campaigns

Provide TB education briefly, either in small groups or in one-to-one communication, like terms of:

- What is TB
- How TB spreads
- How TB can be prevented
- How TB can be detected
- How TB is treated
- Where TB services are available free of cost

Do emphasize that 'TB is a curable and preventable disease' and that 'one should NOT stigmatize and discriminate the PwTB ' during TB education.

There will also be TB education and awareness generation activities in the hotspots through:

1. Community events of the project
   a. TB rallies – 20 per city
   b. Awareness camps – 20 per city
   c. Miking to disseminate critical TB messages
   d. Street plays (Nukkad Natak)
   e. Usage of IEC materials on TB, like posters, leaflets, banners during the community events
2. Others (depending on available resources from the NTEP) – World TB Day and World AIDS Day, and sharing of knowledge and information on TB through digital social networks wherever possible. Project office will be 24x7 TB information, linkage and service centre

Please remember, all TB education and awareness activities in the hotspots as described above should culminate into symptomatic TB screening and identification of TB presumptive cases.

Symptomatic TB Screening

This means to find out if the KVP members have any TB symptoms. If they have TB symptoms, then they are called TB presumptive cases or TB symptomatic.

Critical Points to Remember:

- Never use terminology like TB suspects.
- Conduct TB screening only after a TB education session and with the permission of the community member, not before that
- Try to screen everyone directly, not via somebody else, unless there are special situations[1]
- Maintain full confidentiality during the time of screening and assure the person that their information will be kept fully confidential
- For screening small children, ask their family members

If you reach a household/shelter home, try to screen all the present household/shelter members, of all age groups for TB. If you reach individuals, screen them for TB. Also screen children of all ages for TB.

As we ask the community members about the presence of the symptoms, we call it verbal symptomatic screening.

The project will utilize the following **verbal TB screening** tool for the same:

Sr No	Symptoms to be Verbally Screened	Responses
1	If the person is suffering from:	
a.	Cough of any duration	
b.	Recurrent fever/chills for 2 weeks or less (also enquire of night sweat, loss of appetite, chest pain or difficulty in breathing, of same duration)	
c.	Substantial loss of weight (more than 10%) in the last one month	
d.	Coughing blood	
2	Whether the person has a past history of TB:	
a.	Number of times the person/s had TB in the past	
b.	When the person/s had TB last time	
c.	If they completed TB treatment during that time	
3	If there is anyone currently suffering from TB and undergoing treatment	
4	If anyone has TB in body parts other than lungs or Extrapulmonary Tuberculosis (EPTB)	
5	If anyone died of TB in the family in the last five years	
6	Any smoker, alcoholic, HIV-infected, diabetic, drug user, PWID, patient of cancer, renal failure, steroid therapy in the family, and showing any of the symptoms as mentioned above	

[1] In a household, only the head or one person of the family wants to provide the screening answers on behalf of the other members like women and children. The mothers of the small children will answer the screening questions for their young children.

TB Screening Tool for Children

Sr No	Symptoms to be Verbally Screened	Responses
1	Do you have children below 14 years in the house?	
2	Is/are any of those children having cough for more than 2 weeks?	
3	Is/are any of those children having fever for more than 2 weeks?	
4	Is/are any of those children having loss of appetite for more than 2 weeks?	
5	Has/have any of those children lost weight/not gaining weight in the last one month?	
6	Is/are any of the children infected by HIV? (Ask only if the mother is known HIV positive).	
7	If any of the children have swollen glands in the necks/armpits?	
8	Is there any PwTB in the same household at present?	
9	Is the PwTB receiving treatment? If yes, go to q 10, otherwise q 13.	
10	Is the PwTB receiving treatment from the local govt. health facility free of cost? If the answer of q 10 is 'yes' go to q 11, otherwise q 12 treatment	
11	If the child/children below 6 years are given the tablets for TB prevention (INH prophylaxis) free of cost from the govt.?	
12	Is the PwTB getting treatment from a private doctor?	
13	Was there any PwTB in the same house hold in the last 5 years?	
14	Has any adult member of the household died of TB in the last 5 years?	
15	If any adult member/s of the same household is suffering from chronic cough at present?	

Please remember, other than the FOs of HPPI's TB projects, the community stakeholders, lay healthcare providers and pharmacists will also be taught to perform verbal, symptomatic TB screening by utilizing the above-shown screening tools.

All presumptive TB cases detected after the verbal symptomatic screening are candidates for TB diagnostic tests. The tests should preferably be done in the local public health facilities or private diagnostic labs, if the person prefers that. The preferred test to be made is the rapid molecular test, like GeneXpert or Truenaat.

Candidates for TB Diagnostic Tests

- Adults, adolescents and children with TB symptoms, if elicited during symptomatic screening
- Abnormalities are found in Chest X-rays (CXR) – if CXR reports are presented during the screening
- Person with past history of TB who didn't complete treatment
- Person with recurrent history of TB
- Household/close contacts of the PwTB

TB screening by CXR for the sub-clinical TB cases: TB may be present without symptoms or without distinct symptoms. We call it 'sub-clinical' TB or TB without symptoms. Sometimes, the person tries to hide symptoms due to stigma. Such cases should be screened by CXR.

Finding Cases without Obvious TB Symptoms (sub-clinical TB) in the Field and Getting them Screened by CXR

- Persons with known histories of comorbidities like HIV, diabetes, chronic lung ailments, being malnourished and emaciated, smoking, alcoholism, drugs
- Household/close contacts of the pulmonary PwTB
- Be very careful while asking about the HIV status. Ask about it if you are sure about the status of the person and his willingness to disclose the status

Screening of the Household Contacts of the PwTB

1. According to the national TB guidelines and WHO recommendations, all household contacts of pulmonary PwTB should be screened both symptomatically and by CXR. However, CXR facilities are limited in the public health facilities, and will increase the out-of-pocket expenditure of the families of the patients if done at private diagnostic centres. Therefore, the TB projects of HPPI will focus primarily on the symptomatic screening of household contacts of the PwTB.
2. Ideally, contact screening should be done by the Medical Officer or Nurse of the public health facilities, because this is basically a clinical job. However, these health staff are already overburdened and may not be in a position to symptomatically screen the household contacts. Secondly, the homeless and mobile nature of the targeted populations of HPPI's TB projects makes it highly challenging to bring the household contacts to the health facilities for TB screening by the health staff. To overcome these operational challenges, the FOs of HPPI will perform the primary level contact screening in the households/sites.
3. The general algorithm of contact screening in the projects will be as follows:

Screen all Household Contacts of the Pulmonary PwTB, both Symptomatically and CXR			
Symptomatic	Abnormal CXR findings	Both symptomatic, and abnormal CXR findings	Not symptomatic, and no abnormal CXR findings
Test for TB with GeneXpert or Truenaat	Test for TB with GeneXpert or Truenaat	Test for TB with GeneXpert or Truenaat	Initiate TB preventive treatment, preferably after clinical evaluation by the doctors/nurses of the health facilities
MTB (TB germ) detected		MTB (TB germ) not detected	
Start treatment for TB		Initiate TB preventive treatment after thorough clinical evaluation of the contacts by the doctors/ nurses of the health facilities	

Training Methodologies

- Module reading: 40 min
- Role plays: symptomatic TB screening by the FOs by using the screening tool: 30 minutes
- Total duration: 70 min

Module:

Testing of Presumptive TB Cases at the Health Facilities (Public and Private)

4

The TB testing will be facilitated by the direct interventions of the FOs of the LEAD Project with the following activities:

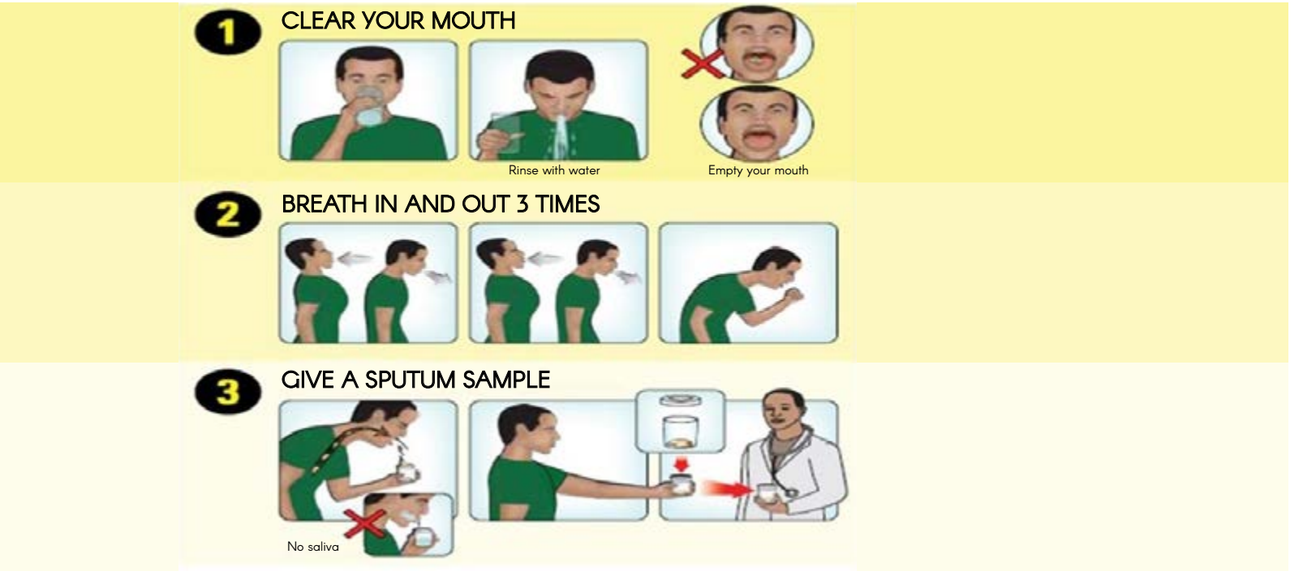
1. Sputum sample collection and transportation
2. Referral services
   a. Accompanied or direct referrals
   b. Indirect referrals

Sputum Sample Collection and Transportation – Sequence of Activities

Two samples are to be collected

- Sample ONE is collected 'ON THE SPOT'. Give instructions on how to produce and collect sputum. Explain why the sputum is needed and show the TB patient how to cough up.
- Sample TWO is collected on the SPOT at least one hour later (see below).
- Label the containers (not the lids) before collecting the sputum samples.
- Collect sputum in a well-ventilated area, preferably outdoors, and away from other people.
- Do not collect sputum in the toilet/closed space.
- Tell the patient to rinse his mouth well with water to remove food materials and others like chewing tobacco to ensure that the sputum samples are not mixed with them.
- The patient should take warm water a few minutes before taking a sample to increase sputum production. A few deep breaths, moderate thumping of the upper back of the patient or resting in a supine position also may elicit a productive cough.
- Quality of sputum is very important. Check whether the sample contains sufficient mucopurulent sputum, not saliva. If not, ask the coughing person to add more. Ensure that the patient should not spit in the container in the name of sputum collection.
- After collecting the sputum, be sure that the lid is closed tightly. Wipe off the outside of the container if needed.
- Wash your hands thoroughly with soap and water.
- Supervise collection of the second spot sample as the first sample, at least one hour apart.
- In circumstances a second spot sample cannot be produced, the second sample is collected by the patient upon awakening the next morning and is brought to the health facility in the morning.
- Send the samples with the request form from health facility to the laboratory.

- Sputum should be sent to the laboratory within 24–48 hours, but no later than 5 days after collection. Ideally, they should be sent to the labs soon after the collection.
- Sputum samples should be stored in a refrigerator (4–8 degrees); if there is a delay of more than 24 hours, till then, store in cool dry place away from direct sunlight.
- Field Officers should fill two referral forms per patient and submit with the specimen for sputum microscopy, Xpert MTB/RIF, LPA or culture. It is very important that FOs fill in the form correctly and indicate by ticking the specific investigation requested.



(Collection procedure of sputum samples)

(Sputum collection cup)

Referral Services

We will perform referral services under the following conditions:

1. For young children where sputum collection is highly challenging
2. If the person can't produce sputum
3. The person is not willing to give sputum samples
4. If the screening is done by community members and stakeholders where they are not able to collect the sputum samples of the TB presumptive cases
5. In states like Telangana, where HIV counselling and testing is compulsory for all presumptive TB cases as a state-level policy and their presence is a must at the healthcare facilities for the same

Referrals may be direct or accompanied where a field officer or community member brings the TB presumptive case to the health facility for TB testing. This is a preferred way for referral as it ensures testing of the presumptive cases.

OR

Indirect where the TB presumptive case is told to visit the local health facility for TB testing, as accompaniment of the person is not feasible.

In both the circumstances, please provide clear information to the TB presumptive case in terms of:

1. Name of the health facility where TB test will be done
2. Timing
3. Distance and mode of communication
4. Name of lab technician, if available
5. Likely waiting period, which is common in the public healthcare facilities
6. Follow-up of the referral to be done, both by the TB presumptive case and by the lab technician of the facility

More importantly, give a brief to the patient about TB and TB testing (preparing the patient for TB testing) by using the pre-TB-test counselling checklist as shown below.

Collect the Test Reports After the Test

If TB is detected, ensure comorbidity testing for HIV and diabetes, preferably in the same health facility or hospital.

Please fill in the referral forms in all the cases of SCT and referrals by all means.

Humana People to People India Sr. No. TB Presumptive Referral Slip (To be retained by the project/Informal Healthcare Service Provider)		
Name of the TB Presumptive:	Age:	Sex:
Residential address with landmarks:		
Mobile number:		
Name of next-of-kin:		
Mobile number of next-of-kin:		
Duration of predom-inant TB symptom/s		
Date of detection in the community /Informal Healthcare facility:		
Date of referral: Name of the health facility referred for X-ray:		
Name and designation who referred:		
Signature of the referring person:		
Contact Number of the referring person:		

Humana People to People India Sr. No. TB Presumptive Referral Slip (Presumptive part- to be given to the presumptive)	
Name of the TB Presumptive:	Age: Sex:
Residential address with landmarks:	
Mobile number:	
Name of next-of-kin:	
Mobile number of next-of-kin:	
Duration of predom-inant TB symptom/s	
Date of detection in the community /Informal Healthcare facility:	
Date of referral:	Name of the health facility referred for X-ray:
Name and designation who referred:	
Signature of the referring person:	
Contact Number of the referring person:	

Special point in terms of enrollment of the presumptive TB cases:

Provision to enroll presumptive TB cases without log-in in NIKSHAY is now possible through TB Arogya Sathi App or informant enrollment provision in NIKSHAY

Please remember

Get a CXR done for all TB presumptive cases, and sub-clinical TB cases (sub-clinical TB cases are already described in the preceding chapter) that are identified in the project.

CXR can be done

1. At public health facility – However, this is not always possible because of a long waiting period after seeking appointment, logistic issues like deficiency of X-ray films, vacancy of positions of radiographers, absence of specialist radiologist who can interpret the Xrays
2. At private diagnostic center – Please keep the option of getting the CXR done at the private diagnostic center, provided there are funds available for that in the projects.
3. The doctor can also advise CT scan of the chest, which can be done in most private diagnostic centers. The test will be more expensive than CXR.
4. The doctor can also advise Tuberculin Skin Test (Mantoux test) to support the diagnosis of TB in small children.

10 Point pre-TB Test Counselling Checklist to Prepare the TB Presumptive patient for TB Testing (To be used by the FOs by maintaining strict confidentiality and in the friendliest manner):

The FO will present 10 key messages to the person going to be tested for TB

- Your sputum will be taken and tested at the health facility (mention the name and location of the health facility) to see if there are TB germs or not.
- You will get your sputum test report on.....(Mention specifically the date and time of availability of the report 'IN THE PREFERRED PLACE OF YOURS, FROM ME'. (Don't just say to the patient 'come after these many days to get your report').
- The sputum test is the confirmatory test for TB and we ensure high quality of sputum testing for TB on behalf of the health facility.
- The test is free of cost as the Government provides free TB services to the citizens of the country.
- If your sputum test becomes positive for TB, please don't worry at all. The Medical Officer/doctor of the health facility will provide you the best quality medicines that will cure you completely from TB. They will also give you medicines to relieve your cough.
- Please remember that TB is completely curable, and that TB treatment is provided free of cost from the Government.
- We will keep the result of your sputum test report and other information absolutely confidential.
- Please cover your mouth during coughing, sneezing or talking, and don't spit here and there, use facemask.
- A photograph of your chest (Chest X-ray) will also be taken at the health facility, for which I will take you there. You don't have to pay your transportation and X-ray cost
- We wish you a speedy recovery from your cough. Thank you very much for visiting us and giving us the chance to serve you.

The FOs should collect the test reports (sputum and CXR) from the respective health facilities and diagnostic centres, well on time, and visit the patients with their reports, to facilitate their treatment initiation as described in the next chapter.

Training Methodologies

- Module reading: 50 minutes
- Do role-plays to demonstrate: 40 minutes
  - sputum sample collection
  - referral
  - pre-TB test counselling
- Total duration: 90 min

Module: Treatment Support

5

If the treatment of TB is completed by strictly following it and without missing a single dose, TB will be cured for sure.

Challenges of TB Treatment

- A PwTB, right after the diagnosis may go into a phase of denial with lots of doubts over the diagnosis
- They may escape treatment initiation or stop treatment in between without telling anyone because of a strong sense of stigma and fear of discrimination. The following types of challenges may be faced in the project:
  - A patient who fails to initiate treatment is known as 'initial lost-to-follow-up'
  - A patient who stops medications after treatment initiation for less than a month is known as a 'treatment interrupter'
  - A patient who stops medications after treatment initiation for more than a month is known as 'lost-to-follow-up (LTFU)'

What Happens if TB Treatment is Delayed or Interrupted

- If treatment is delayed or not initiated, the PwTB can infect his close contacts (10-15 close contacts may be infected per year by one PwTB).
- If the treatment is interrupted or becomes irregular, it can lead to treatment failure, Drug-Resistant TB, permanent lung-tissue damage, even death of the patient.

Treatment support initiatives aim to overcome the challenges of TB treatment. The key objectives of such initiatives of LEAD projects in the 4 targeted cities are to accelerate and maximize successful completion of TB treatment.

The FOs of the LEAD project will be responsible for implementing initiatives on the ground for treatment initiation and adherence, under the guidance and monitoring of their field supervisors.

Please remember the points given in the table below (critical information for the project staff and the FOs).

The Key Strategies to Ensure Successful Completion of Treatment:

This is like a chain reaction. It should start from the time when you visit the KVP site and educate people on TB and screen them for symptoms. The presumptive PwTB who are detected, should be prepared well for TB testing. Once they get tested and found to have TB, they should be prepared well for treatment initiation. When they are initiated on treatment, prepare them well for treatment adherence. This chain of events can ensure successful treatment completion most effectively. So, a well-planned preparation is necessary at the following 3 critical levels in the line of Continuum of Care to ensure successful treatment completion

- TB testing
- TB treatment initiation
- TB treatment adherence

A good preparation is possible by 1. sharing correct information regarding TB and the services, 2. listening to the patient's problems well and addressing their needs and challenges with assurance, motivation, and promises to help, 3. linking them to other services to solve their socio-economic problems that may arise due to TB; legal services, social welfare schemes, access to basic civic amenities (ID proof, bank account), specialist psychological counselling for deep-rooted mental problems, and social protections.

A WELL-PREPARED, KNOWLEDGEABLE AND MOTIVATED PwTB IS MOST LIKELY TO COMPLETE THE DUE COURSE OF TREATMENT WITHOUT ANY HASSLES.

Patient-centered approach:

WHO strongly endorses a patient-centered approach in the diagnosis and treatment of TB. Pillar one of the End TB Strategy explicitly adopts a patient-centered approach, which puts 'patients at the heart of service delivery'. A patient-centered approach recognizes that the direct beneficiary of TB care is the individual who is sick, and that strategies must be designed with this individual's rights and welfare in mind. The objective is to provide high quality TB diagnosis, treatment and care to all patients without them having to incur catastrophic costs.

Description of the Treatment Support Initiatives of Project LEAD

Treatment initiation – It means that the PwTB is registered to the NTEP for treatment after evaluation of the doctor of the health facility, like:

1. He is enrolled in the NIKSHAY online system with a unique NIKSHAY ID
2. He is allotted a patient-wise box according to his type of TB, body weight, and other factors, like comorbidity conditions (HIV and diabetes) and rifampicin resistance
3. The DOT provider is selected according to his choice and preference

Duties of the FOs in Treatment Initiation

Remember, if someone is diagnosed with TB, the treatment must be initiated as soon as possible or at least within 7 days of the diagnosis. It can benefit the patient in two ways:

- Relieves the TB symptoms of the patient, like chronic cough, fever, lack of appetite, weakness, etc. and reduces the chances of lung tissue damage and death

- Makes the TB patient non-infective to his close contacts within 2-3 weeks of starting the treatment

Ensure Early Treatment Initiation:

The Field Officers should not wait for the patient to reach them to collect the report after the testing, rather they should be pro-active to find the probable PwTB in the field and hand over the report. This is because of the mobile nature and poor socio-economic status of the patient.

If the patient tests positive for TB, the next step will be to initiate their treatment at the local public health facilities or chest clinics. The treatment should be initiated at the earliest as mentioned above.

For a TB-positive test result, the FO should prepare the patient to visit the health facilities (chest clinics) for clinical evaluation and treatment initiation by the Medical Officers. The FO will counsel the PwTB by utilizing the post-test counselling checklist, maintaining strict confidentiality and behaving in the friendliest manner.

Objectives of post-TB Test Counselling

- To ensure that the patient has no doubt and feels no stigma regarding his/her positive sputum report.
- To convince the patient about the genuineness of treatment in NTEP, which is also free of cost
- To prevent initial lost-to-follow-up

16 Point Post-TB test Counselling Checklist to Prepare the PwTB for Treatment (To be used by the FOs)

Steps of post-TB test counselling:

- Ensure that you are talking to the PwTB within a confidential environment.
- Remain cordial, warm and supportive throughout your conversation with the patient and be ready to answer any of their doubts or questions.
- If the patient is minor, woman or elderly, include parents/spouse of the patient during the counselling.
- Please talk to the patient in very simple words which they can understand.
- Tell them what TB is, TB symptoms, how it is spread, how it is diagnosed, how to get cured from TB, with a strong message that there is nothing to worry about if one has TB, as it is a curable disease.
- After that, tell them about the NTEP in which The Government of India is providing high quality TB services to the citizens of the country free of cost, to which the patient is fully entitled according to their constitutional right.
- Emphasize on the fact that the sputum of the PwTB was tested under maximum care in the health facility, therefore, there was no chance of error in the result.
- Tell them that the medicines used by the Government to treat TB are the best medicines available for TB treatment in the country, free of cost, and can cure TB completely if taken as per the advice of the doctors of the health facility.
- Hand over the sputum result to the patient and tell the patient that TB germs have been found in their sputum. Please assure the PwTB to not feel threatened about that. They should understand that TB can be completely cured, and they can do all their normal routine work like before, during the time of TB treatment.
- Advise the PwTB that they should meet the doctor of the health facility with the test result at the earliest so that the doctor can start their treatment for TB. The PwTB should obey the advice of the doctor by all means. Assure them that they will be taken to the doctor of the health facility. They don't have to go alone to visit the doctor.

- Educate the PwTB on the functions of the health facility, its working hours, unavoidable waiting time, and if needed, names of the doctor and treatment supervisor who will be responsible for his treatment.
- Fix an appointment with the patient to visit the hospital and agree on the preferred place of the patient from where they can be picked up to go to the health facility.
- Re-emphasize that the PwTB should not have doubt about the diagnosis because this is the best testing facility available to detect TB in the country. Also re-emphasize that only the Government can give him the best TB treatment of the country which is free of cost and known as DOTS.
- Tell them that their blood will also be tested[2] at the time of treatment in the health facility. This will be part of his treatment. If any abnormality is detected in the blood, they will receive 'free-of-cost' treatment from the health facility for that along with the TB treatment, and they will be alright after that.
- Remind the PwTB to cover their mouth during coughing/sneezing, not to spit here and there, and to use a facemask.
- Wish the patient complete recovery from TB and tell them that you are always there to help.

Bring the Patient to the Health Facility for Treatment Initiation:

After the post-TB test counseling, bring the PwTB to the health facility for treatment initiation, and inform the doctor and treatment supervisor of the health facility in advance about the PwTB. Ensure that the PwTB carries an identification document, address-proof, contact number and bank savings account details. At the health facility, please ensure treatment initiation, UDST, comorbidity screening for HIV and diabetes. If positive for HIV and diabetes, ensure the initiation of the treatments (ART for HIV infection and anti-diabetic treatment for diabetes) as well. Link the patient to the NPY/DBT scheme of the NTEP (monthly incentive of INR 500.00 per patient for nutritional support).

Treatment Adherence Support, Follow-up Visits to the Patients and Counselling, including Patient-Tracking and Retrieval of LTFUs

Duties of the FOs in Treatment Adherence Support

After the treatment of the PwTB is initiated at the local health facility, the FO, with continuous support of the supervisor, will ensure that the patient adheres to treatment. This is highly challenging in case of homeless, mobile and migratory PwTB, where lost-to-follow-up is very common.

The FOs will implement the following activities following the treatment initiation.

Developing and Using Patient-wise Tracking Plans with Checklists for Patients on Treatment

The PwTB of the LEAD project are mostly homeless, mobile and migratory, and found in the large metropolitan cities. They are more prone to initial lost-to-follow-up and lost-to-follow-up. Additionally, most of them are semi-literate or illiterate, so to render adequate treatment education to them will be highly challenging. Tracking them for timely follow-up and handing over of the weekly doses of medicines will be equally challenging due to their mobile nature and frequent change of places.

To overcome these challenges, the FOs will spend some time with each of their PwTB, soon after their treatment initiation at the local health facilities/chest clinics, to

[2] Blood test for comorbidity like HIV and diabetes

1. Educate them on TB and its treatment, side effects of the medicines, emphasizing repeatedly on treatment adherence
2. Develop joint action plans for treatment to make the patients equally responsible for their successful treatment completion and cure
3. Collect all relevant information about their possible movements during the treatment course, contact details of the people within their networks who can provide information about them in case of sudden absence from the treatment without prior notice (common practice in the homeless and migratory people of the cities) and detailed addresses of their origins, from where they have migrated to the cities including contacts of the neighbours

To achieve this, the field officers will utilize the following treatment plan and checklist individually for all their TB patients, and utilize the information for follow-up, patient tracking, LTFU retrieval and monitoring treatment records/events on a day-to-day basis in the field.

Joint Treatment Plan and Patient Tracking Format (for individual patients)

Sr No	Information of the Patient	Responses of the Patient
1	Name	
2	Age	
3	Sex	
4	Mobile number (if present)	Self: Family member:
5	Treatment related information	NIKSHAY ID allocated by the NTEP: Name of the health facility which initiated treatment: Name and mobile number of the attending Medical Officer: Name and mobile number of the Senior Treatment Supervisor (STS): Name and mobile number of the community DOT provider if any: Start date of treatment: End date of treatment: Type of PwTB: • New: Pulmonary / Extra Pulmonary TB • Previously treated: Pulmonary / Extra Pulmonary TB Total number of doses to be taken by the patient during the treatment course:
6	Original address (address of the origin/ village)	• Village: • Block: • District: • State:
7	Neighbours of the patient at his/her origin/village	• Name: • Mobile number: • Name • Mobile number: (Continue the list if needed)
8	Current contact particulars of the patient with landmarks in the city (if multiple places, document each of them)	• Place of work: • Place of stay: • Place of night shelter: • Common places of all possible movements in the city:
9	People who know the patient and his possible movements in the city – Please cross-verify the information from people in the field as well	• Name: • Type[3]: • Mobile number: • Name: • Type: • Mobile number: (Continue the list if needed)

[3] like job contractors, local vendors, night shelters, religious places, NGOs/CBOs, pharmacists, informal healthcare providers, friends, co-workers etc.

Sr No	Information of the Patient	Responses of the Patient
10	Possible movement plan of the patient outside or within the city during the course of the treatment	1) No such plan 2) Can't say now 3) Yes a. Occasions i. Festive seasons ii. Informal/unplanned visits iii. Emergencies only b. Possible places of movements/visits i. Original village ii. Other places outside city (specify)
11	Name of preferred places of the patient where he can interact with the field officers for weekly follow-up, collection of new medicines and return of empty blister packs	
12	Points of agreement with the patient on a treatment plan following a meticulous education and counselling (tick point-wise)	• Patient has basic knowledge of TB • Patient has understood the treatment course fully as below o Duration and doses during Intensive Phase and Continuation Phase o Daily intake of pills o Weekly collection of pills and return of empty blister packs o Follow-up visits to the health facilities o Screening for HIV and diabetes during treatment initiation (blood test) o Patient knows the start and end date of his treatment and total number of pills to be consumed during the course of treatment o Patient understands the criticality of treatment adherence and timely treatment completion o Patient knows the common side effects of the medicines and how to respond in case of side effects o Patient has understood the importance of abstinence from alcohol/smoking/drugs during and after treatment o Patient has understood the important of TB preventive treatment of his close/household contacts o Patient has understood the importance of taking at least 3 meals a day while on treatment • Patient has understood the importance of having an ID document and a savings bank account for getting the benefits of the NTEP • Patient knows the names of his health facility and healthcare providers • Patient has understood that he has equal responsibility to get himself cured from TB

Conduct Home-visits

The FOs visit each of the PwTB at their place at the following frequency

- On a daily basis for 2 weeks of the treatment initiation
- Then weekly, for the rest of the treatment duration

Total Number of Visits

New patient (6 months or 24 weeks' treatment) = 14 + 22 = 36 visits

Previously treated patient (8 months or 32 weeks' treatment) = 14 + 30 = 42 visits

During the home visit the FOs will provide high quality treatment education to the patients to ensure treatment adherence.

Critical Points to be Addressed to Render High Quality Treatment Education to the Patients and Families at the Home Visits (Home visit checklist)

- The PwTB must take equal responsibility along with their treatment providers to get cured and to protect their close family members from TB. Their cooperation with the treatment providers is crucial. The cooperation should come from taking all doses of their medicines, completing all follow-ups, and ensuring initiation and completion of TB preventive treatment for all their family members.
- It is the PwTB democratic and constitutional right to demand high quality TB diagnostic and treatment services, and access to all critical information regarding TB case management (rights-based approach). TB services should be gender-responsive, should look after the unmet needs of women, children, elderly and KVP, never discriminate the PwTB based on financial and social status.
- At least a 6-month treatment regimen is a must to cure TB as the TB germs take longer time (not less than 6 months) to be killed and eliminated from the body. If treatment is stopped in the middle of treatment, the TB germs not only remain viable but can become stronger and resistant to the commonly used TB medicines. In such cases treatment of TB becomes difficult and takes much longer time to complete.
- TB treatment should be continued in case of minor side effects like nausea, red coloration of urine, metallic taste on the tongue, because these side effects are common and not harmful. Sudden stoppage of treatment due to these side effects can only worsen the condition of the patient.
- The PwTB should also know about the major side effects of the TB medicines, which they should immediately bring to the notice of their healthcare providers and field officers of the TB projects.
- The PwTB can resume their jobs during their treatments and become non-infective after 2-3 weeks of treatment.
- Cough hygiene (correct disposal of sputum), cough etiquette (covering mouth during coughing, sneezing, using facemask) and airborne infection control (keeping at least 6 feet distance while talking to the PwTB, good ventilation and sunlight in the places of the PwTB) at the household level should be strongly emph asized during treatment education.
- The patients should take their normal meals, at least 3-4 times a day, and stay away from smoking and drugs because those things can hinder their cure from TB. The DBT scheme of the NTEP should be utilized to buy food for the PwTB.
- Small children of the PwTB' families should be kept safely away from the patients, at least during the first month of treatment. If the small children become affected by TB, all efforts should be made to identify the source adult/adolescent PwTB in the families and nearby neighborhood.
- All family members who don't have active TB, should take TB preventive treatment according to the advice of the doctors/Medical Officers of the health facilities. The members should be well taught about TB infection and its difference from the active TB disease, and why a healthy close contact of a PwTB should complete the full course of TB preventive treatment.

- All family members who don't have active TB, should take TB preventive treatment according to the advice of the doctors/Medical Officers of the health facilities. The members should be well taught about TB infection and its difference from the active TB disease, and why a healthy close contact of a PwTB should complete the full course of TB preventive treatment.
- TB is just a disease like any other disease, which can happen to anybody, anytime. It doesn't downgrade the social status of a person and is fully curable as the TB germs can be eliminated after a course of treatment of at least 6 months. This should be the critical message for reducing stigma linked to TB.
- 'Hate TB but not the patient' should be the key campaign for reducing TB-related discrimination in the community.
- Female PwTBs might suffer worse due to greater stigma and discrimination both at the families and communities, with least resistance on their behalf. They find it difficult to visit the hospitals alone. They also get a minimum share of food in the households. They are maximally exposed to indoor, domestic air pollution from cooking with firewood/charcoal/cow dung cakes. Male family members should understand the challenges of female PwTB in their families and help to overcome them. 'If women remain sick, the whole family becomes sick'.

Address Lost-to-follow-up (LTFU)

Remember the key reasons of LTFU in TB (evidence-based)

The main factors associated with TB treatment non-adherence and lost-to-follow-up:

- Socio-economic factors: lack of transportation money, lack of social support, and poor patients – healthcare worker communication.
- Behavioral factors: feeling better after a few weeks of treatment, tobacco and alcohol use, knowledge deficit about duration of treatment and consequences of non-adherence and lost to follow up.

Based on the table above, LTFU cases should be addressed:

1. Minimizing the cases of LTFU
   - High quality pre-TB test and post-TB test counselling
   - Regular home visits after treatment initiation and problem solving
   - Fill out 'joint treatment plan and patient tracking format' for each of the patients right after the treatment initiation
   - Facilitate access to the civic amenities for the patient that can help him to utilize the full TB and other services from the NTEP, like getting an identity document and a savings bank account
   - Ensure support from the community stakeholders (NIKSHAY Mitra) for the PwTB in the form of food, shelter and monetary support
2. Retrieval of LTFU cases back to treatment
   - Track down the patient by utilizing the information collected in the 'Joint treatment plan and patient tracking format'
   - After tracking down the patient, interact with the patient to know the reason/s of their LTFU
   - Counsel the patient in accordance with that and bring them back to the health facility for clinical evaluation, and back to treatment
   - Intensify treatment adherence support for each of the LTFU patients.

Establish Appropriate, Context-Specific Treatment Support Centre

The typical concept of DOT – that the PwTB will visit the DOT provider daily at the same time for directly observed medicine intake – is operationally challenging in the

case of highly mobile, homeless and migratory populations of the large metropolitan cities. FOs will address this by developing various, context-specific strategies like

1. The field officers will supply fresh medicines to the PwTB in a pre-determined place and time, collect empty blister packs from them on a weekly basis, maintain the treatment records, like filling in patient treatment cards, and monitor the physical improvement of the patients. The patients will be adequately educated before treatment.
2. The field officers will select suitable service providers of various fields in the community (like supervisor of the night shelters, counsellor of the drug de-addiction centers, local vendors, pharmacists, lay healthcare providers, job contractors, etc.), who are frequently contacted by the community members and who can provide DOT to the PwTB. The field officers will provide weekly medicines to those providers and collect the empty blister packs of the previous weeks from them. The providers will be adequately educated before treatment.
3. The field officers will select a popular lay healthcare provider in the hotspot and help to develop a TB resource and DOT center in his clinic where the PwTB of the hotspot and adjoining places can come to take their medicines The healthcare provider will be adequately educated before treatment.
4. The field officers will identify a responsible family member or neighbor to provide DOT. They will be adequately educated before treatment.
5. The field officers of the TB projects will regularly monitor DOT by tallying the number of pills consumed from the empty blister packs with the number of medicines supplied.
6. To minimize initial LTFU and LTFU, the field officers will identify and create local treatment support groups with those people who know the movements of the PwTB very well (like job contractors, fellow workers and friends, vendors, supervisor of night shelters) and can inform the field workers in case of any of their unexpected movements and of possible destinations. The field workers will collect mobile numbers of such people before treatment initiation and keep them in the treatment records for ready communication (Community-based patient tracking).
7. The field officers will carefully note down important festive seasons that can fall in the treatment course of the TB patients and the time when the patients can return to their usual locations. Those periods will be marked, and the PwTB will be especially counselled before such periods to inform any kind of outstation movements, so that their treatment can be continued during their absence from the usual locations.
8. The field officers will promote family-centric TB care within the households in which the DOT providers will provide curative medicines to the PwTB and TB preventive treatment to the family contacts, including family-based TB education on cough hygiene and airborne infection control.
9. They will train and engage the cured PwTB to support PwTB on treatment as role models (TB Champions). The field officers will select cured PwTB from HPPI's previous TB projects, provide them basic training on TB and DOT, and engage them to spread TB awareness in their community, to do TB screening, sputum collection and transportation, facilitate treatment initiation and support, provide DOT, and support TPT to close family members of the PwTB, as the branded name of TB Champions, to showcase role –models in the communities.

Establish Project Strategies to Ensure Gender Responsive TB Services

1. Never discriminate PwTB based on gender.
2. Listen to the women and transgender PwTB carefully to understand their specific needs, issues and challenges during one-to-one and group meetings.
3. Maintain strict confidentiality. To achieve this, don't leak any information of the PwTB to

their neighbours upon enquiries, educate the family members to maintain the confidentiality about the PwTB, de-stigmatize the PwTB and their family members to dispel myths and misconceptions about TB and live lives with hopes by taking proper remedies like daily medications and food intake.

4. Accompany the women, transgender, children, and elderly patients to the health facilities, if they are not able to visit alone, if they are without any money to bear the transportation cost or don't find a person from their family to accompany them.
5. Cut short patients' hospital visits by doing sputum collection and transportation and organizing video-conferencing with healthcare providers for follow-ups.
6. Sensitize male family members of female PwTB to look after their needs, nutrition, and timely medicine intake and to bring them to the facilities for follow-up visits.
7. Link female PwTB to the nurses of female doctors if they hesitate to visit a male doctor or health staff.
8. Link poor, TB-affected families living in the slums to the Pradhan Mantri Ujjwala Yojana (PMUY) schemes, so that they can access and cook with cooking gas instead of burning coal or wood, thus preventing their exposure to in-house air pollution.
9. Mention specifically the special needs of female PwT B in the review meetings with stakeholders and ask for their support in terms of providing additional nutrition, social protection, family and community-level gender sensitization and de-stigmatization.
10. Organize TB sensitization meetings with local transgender communities and NGOs/CBOs working with the transgender communities.
11. Any incidences of violence, violation of human rights and discrimination at the family, community and/or health facility level against female PwTB, transgender, children, and elderly should be addressed by engaging community leaders and stakeholders, healthcare providers, elected representatives, legal advisors and local Women and Child Development commissions.
12. Segregate project data age group- and gender-wise.

Establish Linkages to other Service Providers in and around the Hotspots

The FOs will link the PwTB and their families to social welf are schemes of their interest, legal advisors to fight for and protect their human rights, MCH services in case of female PwTB, civic amenities like Aadhaar card, other identity documents and savings bank accounts, women and child protection campaigns, specially to mitigate domestic violence and discrimination of female PwTB, to local stakeholders (NIKSHAY MITRAs) for food, shelter, jobs, and to free-of-cost treatments of general ailments.

Critical Lessons for the FOs in Overall TB Case Management

Mere TB education is not enough for effective treatment initiation and support. One has to put themselves in the shoes of the PwTB to feel how they feel, and then design the plans and interventions. All PwTB are not the same. So, generalization of plans and interventions will not work to successfully support the TB patients. One must plan for the individual PwTB according to his knowledge, attitudes, and practices and this will be greatly diverse. This is the crux of counselling TB patients.

In the following table, we will try to look into the stage-wise barriers that may arise from the perspective of the PwTB that can hamper 1. testing, 2. treatment initiation and 3. treatment adherence, and how we can mitigate/minimize them in our TB projects. To get such perspectives, a detailed discussion with each of the PwTB is essential, for which you, being a field officer of HPPI, must build trust in the patients towards you through your effective inter-personal communication (IPC), and assurance-providing skills.

TB Case Management Problem Analysis Table to Guide the FOs

Level of Continuum of Care	Possible barriers from the perspectives of the PwTB that hamper service utilization	Interventions
TB testing	Fear of diagnosis of TB and its implications	• Destigmatize TB in the eyes of the patient by removing myths and misconceptions about TB[4] through individual counselling with the key message that TB is curable and preventable • Reduce discrimination by general sensitizing of family and community members on TB • Facilitate regular interactive sessions between the key stakeholders, community members and PwTB (both cured and on-treatment) in the projects and emphasize the fact that TB is just like any other disease and does never mean 'end of life or social status.'
	Fear of losing daily wages if one has to visit the healthcare facility to get tested for TB	• Home sputum collection and transportation to avoid patient visiting the health facility for testing and losing daily wage • Bear transportation cost on behalf of the patient if project funds are allocated for the same • Mobilize funds from the community/ stakeholders to bear transportation cost of the patient
	Fear of visiting healthcare facility alone (mostly women)	• Accompanied referrals • Encourage male members of the family to accompany the female patient • Gender sensitization sessions in the families and communities
	Fear of losing money by bearing the expenses of testing and treatment of TB	• Assure that TB testing and treatment is totally 'free of cost' in all public healthcare facilities. The person doesn't have to pay anything..However, stress upon that X-rays are charged to the persons if it is not exempted for PwTB by district administration
Treatment initiation	Fear of disclosure as a PwTB in the community and family, which may lead to discrimination	• Assure the patient that confidentiality will be fully maintained throughout the treatment, both from the project and healthcare facility. Nobody will come to know about his TB-positive status • Community sensitization as described before for better acceptance of the PwTB and TB survivors • Couple counselling/counselling of close family members along with the TB patient to mitigate internal tension and discrimination • Link to legal aid if that is needed to protect from any violation of human rights
	Doubt about TB diagnosis	• Counsel the PwTB
	Fear of HIV testing which is necessary for all the newly diagnosed TB patient	• Ensure proper HIV counselling and testing of the TB patient at the ICTC (Integrated Counselling and Testing Centre)
	Hesitancy about taking the medicines for a long period and doubt about the Cure	• High-quality treatment education (see below)

[4] Like TB is a hereditary disease, TB happens due to curse of God/some powerful people or some heinous acts of the previous births, or all the other points mentioned in chapter 1

Level of Continuum of Care	Possible barriers from the perspectives of the PwTB that hamper service utilization	Interventions
Treatment initiation	Fear of losing the job as the patient is diagnosed with TB and put on treatments	• Assure the patient that he can start working after one month of treatment and continue working during the full course of treatment • Sensitize his job contractor to help him and to maintain confidentiality in the workplace
	Fear of visiting public healthcare facilities for treatment initiation due to absence of identity documents and discrimination by the healthcare Providers	• Facilitate issuance of identity cards (Aadhaar card) • Assure the health facility with the contact details of the patients and their regular tracking during course of treatment • General sensitization of the healthcare providers about the needs and challenges of the community members
Treatment adherence	Stop treatment when symptoms subside in the middle of treatment	• High quality treatment education (see below)
	Stop treatment due to side effects of the anti-TB Medicines	• High quality treatment education (see below)
	Fear of losing wages by bearing transportation cost during follow-up visits to the healthcare facility between treatment sessions	• Bear the transportation cost on behalf of the patients if project funds are allocated for the same • Mobilize funds from the community/ stakeholders to bear the transportation cost • Facilitate follow-up through video-conferencing with the health facilities if possible • Link the patients to the Nutrition support DBT (Direct Benefit Transfer) Scheme and Nikshya Mitra of the NTEP through the notification to the NIKSHYA and help them to open savings bank accounts. • Link patients and their families to relevant social welfare schemes through other organizations
	Fear of visiting healthcare facility between treatments for follow-up (mostly women)	• Accompanied referral • Encourage male members of the family to accompany the patient
	Depression, which is common in patients with a chronic illness like TB	• Check for signs of depression like below o continuous low mood or sadness. o feeling hopeless and helpless. o having low self-esteem. o suicidal thoughts but no attempts o feeling tearful. o feeling guilt-ridden. o feeling irritable and intolerant of others. o having no motivation or interest in things. o finding it difficult to make decisions o lack of sleep and appetite o chronic fatigue and tiredness

Level of Continuum of Care	Possible barriers from the perspectives of the PwTB that hamper service utilization	Interventions
Treatment adherence		• Counsel the patient with the assurance that TB is a temporary phase and will be fully cured, and life can remain normal even during the course of treatment • Help the patient to solve his socio-economic problems (as described above) which can exacerbate depression • Refer to specialist psychologist/psychiatrist in case of complications and severe depression like suicidal tendencies and attempts, complete speechlessness and/or inactivity

The Summary of the TB Diagnosis, Treatment and Care that the FOs Should Remember

Before diagnosis is confirmed, the patient must understand all relevant information about the disease, its symptoms, the tests, the need for follow-up and treatment, and that it is treatable and curable.

Once diagnosis is confirmed and treatment is to be initiated, the patient must understand the treatment regimen and its duration, the details of adverse drug reactions and what action to take if they encounter them, the importance of adherence and nutrition, the importance of air-borne infection control.

Training Methodologies

- Modular reading: 120 minutes
- Role-plays on post-test TB counselling, on developing joint treatment action plans with TB patients for tracking, on retrieval of LTFU cases, on roles and responsibilities of a community DOT provider, on dealing with a stigmatized female PwTB living in the juggi: 60 minutes
- Total duration: 180 minutes

Module: Engagement of Private Healthcare Providers

6

Description of the Private Healthcare Providers

Private healthcare providers are classified under

1. Profit-making
   a. Qualified
      i. Allopathic
      ii. AYUSH[5]
   b. Informal
      i. Informal healthcare providers – those that follow allopathic medicine
      ii. Traditional healers – those that follow spiritual practices
      iii. Pharmacists – dispensing medicines across the desk without prescriptions
   c. Formal
      i. Pharmacists – sometimes they dispense medicines across the desk without prescriptions
2. Non-profit-making
      i. NGO/CBO/FBO run health clinics
      ii. Hospitals of charitable trusts

HPPI will target mostly the 'informal' group in the private healthcare engagement initiative of its TB projects, because the key urban-based target groups of those projects generally seek healthcare with such providers.

What activities we expect the informal and traditional healthcare providers to perform in the TB projects:

1. Having right and basic knowledge of TB and the National TB Elimination Program
2. Screening of TB symptoms among their visiting patients by using the screening tool of the HPPI's TB projects and identify presumptive TB cases
3. Referral of presumptive TB cases to the local public healthcare facilities by properly filling in the referral forms
4. Sputum sample collection and transportation to the local public healthcare facilities
5. Community DOT provision
6. Creation of TB resource, referral and DOT centers in the community
7. Linking presumptive TB cases to the field officers of HPPI for testing

[5] AYUSH is an acronym for Ayurveda, Yoga and Naturopathy, Unani, Siddha and Homeopathy and are the six Indian systems of medicine prevalent and practiced in India and some of the neighbouring Asian countries with very few exceptions in some of the developed countries.

What the FO should do to Achieve this in the Field

- Provide basic education on TB
  - Mostly by one-to-one interaction (as formal TB training of these groups is not possible) and TB education
- Provide TB educational materials and referral slips (also sputum cups in case of sputum collection and transportation)
- Do follow-up visits and review their activities, including monitoring of DOT

Evaluation of the Engagement of the Private Healthcare Providers: HPPI will evaluate them by monitoring the number of presumptive TB cases identified and referred, number of TB cases detected, and number of TB cases that successfully completed treatment by private healthcare providers.

Training Methodologies

- Module reading: 20 minutes
- Role-play: Interaction of the FO with an informal healthcare provider: 10 minutes
- Total duration: 30

Module: 7

Stakeholder Engagement and Multi-Sectoral Accountability and Collaboration for TB Elimination

Project Strategy: Engage key stakeholders like local vendors, business groups, religious places, charitable trusts, job contractors, local NGOs/CBOs/FBOs, youth clubs and others to

- Support the PwTB with food, finances, and shelters
- Monitor each of the PwTB to ensure their treatment adherence, by visiting their households on a weekly basis
- Strengthen community linkages to the local public health facilities by regular communication with the healthcare providers with the help of the HPPI project
- Address issues like stigma, discrimination, gender, social inequity, violation of rights, TB in children and women, with community advocacy meetings and group discussions
- We call them Friends of the PwTB (we shouldn't use the term NIKSHAY MITRA as the roles of the stakeholders of LEAD project is not in the line of 'NIKSHAY MITRA' definition of the NTEP)

Project Activities to Engage Stakeholders: The stakeholders will be mobilized to participate in the monthly project review meetings for open interactions and joint problem solving together with the project supervisors, field officers, community members and service providers.

Training Methodologies

- Module reading: 10 minutes
- Role-play: Review meetings with key community stakeholders: 20 minutes
- Time: 30 minutes

Module: Monitoring and Supervision

8

The project leader will develop a city-specific monitoring and supervision plan (in accordance with the project activities and timeline) and a city-specific Monitoring/ Evaluation framework. They will ask help of the M&E Manager of the HPPI PMU for the same. The 3 members of the city team will perform monthly monitoring visits, while the members of PMU will conduct quarterly visits to the cities

Sr No	Names ofthe activities	Purposes	Timeline	Responsible person
1	Field visits	What is to be specifically performed		
	Visit the Health facilities and diagnostic clinics which provide TB Services to the targeted population of LEAD project	Cross-check the lab number/ NIKSHAY ID and TB number of the PwTB with their names, addresses, dates of diagnosis and treatment initiation as documented in the project records.		
	Interact with the Field Officers of the project, either one to one, one to group, or FGDs	Evaluate their level of knowledge in terms of implementation of field activities and recording-reporting, provide on-site and on-the-job training if needed.		
	Meet the Community members and stakeholders	Check their knowledge on TB and engagement with the projects, like if they support the PwTB and what kind of support		
	Meet and talk to the PwTB who were identified by LEAD project	Verify the PwTB physically in the field, check if the pill intakes are happening as per MOs advice, if any deviations are happening, and causes of such deviations. Also check the knowledge of the PwTB about TB, if they follow cough hygiene, if they house-hold contacts are screened for TB and take TPT Address issues of stigma and discrimination if any		

Sr No	Names ofthe activities	Purposes	Timeline	Responsible person
2	Organize project review meetings with field officers andproject staff	Monitor and review the performances of the field officers and project staff in terms of reaching the targets against their action plan, detect the gaps in project implementationand and do mid-course correction.		
	Organize monthly review meetings with the Health care providers linked to the project	Identify and address jointly the day-to-daychallenges faced by the PwTB while utilizing the services of the facilities. Address issues of stigma and discrimination if any		
3	Organize monthly meetings with the District TB Officers and quarterly meeting with the State TB Officers	Address jointly the common challenges faced by the PwTB and provide project performance reports and knowledge sharing. Attend district and state-level workshops to ensure replication and scale-up of project activities through the PIP of the NTEP		
	Organize 6-monthly review meetings with Central TB Division,	Provide project performance reports and knowledge sharing, achievements, challenge faced		
	Organize weekly review and project update meeting with JSI	Provide project performance reports and knowledge sharing, achievements, challenge faced		
	Perform project performance report analysis and feedback	• Check timeliness and completeness of the reports of the city teams • Analyse/validate data of the reports and detect deviations if any • Provide feedback on o Data deviations o Poor performances o Training needs o Good practices o Recommendations o Follow-up of previous recommendations o Others (to be specified)		

Sample of Monitoring and Evaluation framework of Project LEAD

Input	Process/ activities	Outputs/immediate Results of the activities	Outcome/remote Effects of the activities	Impact/final results
MONIOTORING			EVALUATION	
Human resources Logistics Project manuals and training IEC materials	- Do outreach - Screen - Test - Initiate treatment - Support treatment and preventive treatment - Engage communities and stakeholders	- People reached - People screened - People tested - People detected with TB - People put on treatment - People continuing treatment on the move - People put on preventive treatment - TB Champions created - Stakeholders engaged - Retrieval of the PwTB who left treatment in between	- People adhering to treatment - The PwTB who had left treatment, and brought back to treatment, and adhered to treatment - People cured from TB - People successfully completed treatment - People completed preventive treatment	Reduction in TB • Incidence • Mortality • Out of pocket expenditure of the patients

Formats and checklists that the FO will use in their day-to-day field operations other than data collection formats – already described in the modules above

1. Mapping compilation format
2. Microplanning format of the Field Officers (page number 21)
3. Verbal TB screening tool
   a. Adult
   b. Children
4. Referral forms for SCT and referrals of TB presumptive cases
5. Pre-TB test counselling checklist
6. Post-TB test counselling checklist
7. Joint treatment plan and patient tracking format
8. Home visit checklist

Monitoring & Evaluation – Indicators

S.No.	Indicators	Numerator	Denominator
1	Hotspots with migratory, slum and homeless populations and other Hard to Reach and High- risk urban poor, identified through city mapping in the interventionsites	# of reached hotspots with migratory, slum, and homeless populations and other Hard to Reach and High-risk urban poor	Total # of intervention sites mapped
2	Sensitized informal health service providers and pharmacists	# of informal health service providers and pharmacists who received sensitization/ training on TB	Total # of informal health service providers and pharmacists mapped
3	Presumptive TB cases referred by informal health service providers and pharmacists	# of presumptive TB cases referred by informal health service providers and pharmacists	Total # of presumptive TB cases detected by informal health service providers and pharmacists.
4	Labs engaged to perform X-ray for free/at reduced rate	# of labs that agreed to provide X- ray services for free or at a reduced rate	Total # of private x-ray labs mapped.
5	Awareness camps organized	# of awareness camps organized to spread awareness about TB	Total # of planned awareness camps.
6	People reached via TB awareness camps	# of individuals who attended the TB awareness camps	Total # of individuals targeted to be reached by TB awareness camps.
7	Rallies organized	# of rallies organized to raise awareness about TB.	Total # of planned rallies.
8	People participated in TB awareness rallies	# of individuals who participated in the TB awareness rallies	Total # of individuals targeted to participate in TB awareness rallies.
9	Miking/loudspeaker actions done in hotspots/pockets	# of instances where miking/loudspeaker actions were conducted in hotspots/pockets	Total # of planned miking/loudspeaker actions in hotspots/ pockets.
10	Hotspots covered by miking/ loudspeaker actions	# of hotspots/pockets where miking/ loudspeaker actions were conducted.	Total # of hotspots/ pockets targeted for miking/loudspeaker actions.
11	Nukkad natak/streetplays performed in hotspots/pockets	# of nukkad natak/ street plays conducted in hotspots/pockets.	Total # of planned nukkad natak/street plays in hotspots/ pockets.
12	People reached via nukkad natak/streetplays	# of individuals who watched the nukkad natak/street plays.	Total # of individuals targeted to be reached via nukkad natak/street plays.
13	Hotspots covered by nukkad natak/streetplays	# of hotspots/pockets where nukkad natak/ street plays were performed.	Total # of hotspots/ pockets targeted for nukkad natak/street plays.

S.No.	Indicators	Numerator	Denominator
14	IEC material distributed	# of Information, Education, and Communication (IEC) materials distributed to raise awareness about TB.	Total # of IEC materials available for distribution.
15	Individuals who are educated on TB by project staff during one-to- one or group presentations	# of individuals who received education on TB through one-to- one or group presentations.	Total # of individuals targeted for one-to-one or group presentations.
16	Individuals screened for TB symptoms (4S screening)	# of individuals screened for TB symptoms	Total # of people reached
17	People screened more than once for TB symptoms (4S screening)	# of individuals who underwent repeated screenings for TB symptoms	Total # of individuals screened for TB symptoms
18	Presumptive TB cases identified	# of individuals identified as presumptive TB cases through screening	# of individuals screened for TB symptoms
19	Presumptive TB cases referred/ facilitated for CXR – public	# of presumptive TB cases referred or facilitated for Chest X-ray in public healthcare facilities	# of presumptive TB cases identified
20	Presumptive TB cases referred/ facilitated for CXR – private	# of presumptive TB cases referred or facilitated for Chest X-ray in private healthcare facilities	# of presumptive TB cases identified
21	Presumptive TB cases accompanied for sputum testing	# of presumptive TB cases accompanied for sputum testing	# of presumptive TB cases identified
22	Presumptive TB cases whose sputum samples are collected and transported to the lab	# of presumptive TB cases whose sputum samples were collected and sent to the laboratory for testing.	# of presumptive TB cases identified
23	Test reports collected by the PwTB/ FO	# of test reports collected for confirmed TB cases by the Programmatic Management of TB (PwTB) or Field Officer (FO)	# of presumptive TB cases whose sputum samples are collected and transported to the lab
24	Presumptive TB cases availing molecular testing of sputum	# of presumptive TB cases that underwent molecular testing of sputum.	# of presumptive TB cases whose sputum samples are collected and transported to the lab
25	Presumptive cases tested for TB	# of all individuals tested for TB as presumptive cases.	# of presumptive TB cases whose sputum samples are collected and transported to the lab

S.No.	Indicators	Numerator	Denominator
26	Presumptive TB cases availing doctor's consultation for abnormal X-ray finding	# of presumptive TB cases that sought a doctor's consultation due to abnormal X-ray findings	Total # of presumptive TB cases with abnormal X-ray findings, sputum positive and consistent TB symptoms
27	Out of the total presumptive TB cases referred/facilitated for CXR, # of presumptive cases diagnosed with TB	# of presumptive TB cases diagnosed with TB out of the total referred/ facilitated for CXR.	Total X-ray facilitated (Private + Public)
28	Out of total sputum samples, # of presumptive cases diagnosed with TB	# of presumptive TB cases diagnosed with TB out of the total sputum samples collected.	Total # of sputum samples tested.
29	Total # of PwTB identified, all types	# of all types of identified patients with TB (PwTB)	Total presumptive tested all types
30	Diagnosed PwTB initiated on treatment	# of diagnosed PwTB who have started TB treatment	Total # of diagnosed PwTB
31	Diagnosed PwTB with UDST Done	# of diagnosed PwTB who underwent a Universal Drug Susceptibility Test (UDST).	Total # of diagnosed PwTB initiated on treatment
32	Diagnosed PwTB screened for co-morbidities – HIV	# of diagnosed PwTB screened for co-morbidity - HIV	Total # of diagnosed PwTB.
33	Diagnosed PwTB screened for co-morbidities - diabetes	# of diagnosed PwTB screened for co-morbidity - diabetes.	Total # of diagnosed PwTB
34	PwTB diagnosed with HIV	# of diagnosed PwTB identified as having HIV co-infection.	# of diagnosed PwTB screened for co-morbidities - HIV
35	PwTB diagnosed with diabetes	# of diagnosed PwTB identified as having diabetes co-morbidity.	# of diagnosed PwTB screened for co-morbidities - diabetes
36	PwTB with HIV initiated on treatment – ART	# of diagnosed PwTB with HIV co- infection who have initiated treatment for HIV (Antiretroviral Therapy - ART).	# of PwTB diagnosed with HIV
37	PwTB whose bank details are collected for NPY (Nikshay Poshan Yojna)	# of diagnosed PwTB for whom documents are collected for availing benefits under Nikshay Poshan Yojana.	# of diagnosed PwTB initiated on treatment
38	PwTB linked to NPY	# of diagnosed PwTB successfully linked to Nikshay Poshan Yojana for availing benefits.	# of PwTB whose bank details are collected for NPY (Nikshay Poshan Yojna)
39	Close contacts of the index Pulmonary PwTB identified	# of close contacts of the index (source) Pulmonary PwTB patient identified during contact tracing.	Estimated # of close contacts of the index TB cases

S.No.	Indicators	Numerator	Denominator
40	Close contacts of the index Pulmonary PwTB counselled and screened for TB	# of close contacts of the index Pulmonary PwTB who were counseled and screened for TB.	Total # of close contacts identified of the index Pulmonary PwTB
41	Presumptive contacts who were identified with TB-suggestive symptoms, after the TB screening	# of presumptive contacts (close contacts) who were identified with TB-suggestive symptoms during the screening process.	# of close contacts of the index Pulmonary PwTB counselled and screened for TB
42	Presumptive contacts tested for TB	# of presumptive contacts (close contacts) who were tested for TB.	# of presumptive contacts who were identified with TB-suggestive symptoms, after the TB screening
43	PwTB detected from the presumptive contacts who were tested for TB	# of diagnosed PwTB identified among the presumptive contacts who were tested for TB.	# of presumptive contacts tested for TB
44	PwTB put on treatment, detected from the presumptive close contacts	# of diagnosed PwTB among the presumptive contacts who were put on TB treatment.	# of PwTB detected from the presumptive contacts who were tested for TB
45	Eligible close contacts initiated on TB preventive treatment	# of eligible close contacts (who don't have active TB but are at high risk) initiated on TB preventive	Total # of eligible close contacts identified.
46	PwTB who were contacted and counselled daily by the field officer of the LEAD project in the first two weeks of treatment initiation	# of diagnosed PwTB who were contacted and counseled daily by the LEAD project's field officer in the first two weeks of TB treatment initiation.	Total # of diagnosed PwTB
47	PwTB who were contacted and counselled weekly by the field officer of the LEAD project after the first two weeks of treatment Initiation	# of diagnosed PwTB who were contacted and counseled weekly by the LEAD project's field officer after the first two weeks of TB treatment initiation.	Total # of diagnosed PwTB
48	Community treatment supporters engaged	Total number of community treatment supporters engaged	Total # of community treatment supporters mapped
49	PwTB who are receiving treatment from the community treatment supporters	# of PwTB who are currently receiving treatment support from community treatment supporters.	Total # of PwTB who have linked to community treatment supporters.
50	PwTB with planned/anticipated migration	# of diagnosed PwTB with planned or anticipated migration during treatment.	Total # of diagnosed PwTB initiated on treatment

S.No.	Indicators	Numerator	Denominator
51	PwTB who have provided contact details for the expected migration location	# of diagnosed PwTB who have provided their contact details for the expected migration location.	Total # of PwTB with planned/anticipated migration.
52	PwTB who moved during the treatment	# of diagnosed PwTB who moved to a different location during treatment.	Total # of diagnosed PwTB initiated on treatment
53	PwTB tracked and contacted out of who moved during treatment	# of diagnosed PwTB who were successfully tracked and contacted after moving during treatment.	Total # of PwTB who moved during treatment.
54	PwTB who moved that continue on treatment	# of diagnosed PwTB who moved during treatment and continued their TB treatment at the new location.	Total # of PwTB who moved during treatment.
55	PwTB initially lost-to-follow-up	# of PwTB who were initially lost- to-follow-up (did not continue with TB treatment) shortly after being diagnosed.	Total # of diagnosed PwTB
56	PwTB lost-to-follow-up within one month of treatment	# of PwTB who were lost-to- follow-up (did not continue with TB treatment) within one month of starting their TB treatment.	Total # of diagnosed PwTB initiated on treatment
57	PwTB lost-to-follow-up after one month of treatment	# of PwTB who were lost-to- follow-up (did not continue with TB treatment) after completing one month of TB treatment.	Total # of diagnosed PwTB initiated on treatment
58	PwTB lost-to-follow-up	# of PwTB who were lost-to- follow-up (did not continue with TB treatment) at any stage during their treatment.	Total # of diagnosed PwTB initiated on treatment
59	Lost-to-follow-up PwTB tracked and retrieved	# of diagnosed PwTB who were lost to follow-up but later tracked and retrieved to resume TB treatment.	# of PwTB lost-to-follow- up
59	Lost-to-follow-up cases that adhere to treatment	# of diagnosed PwTB who were previously lost to follow-up but returned and adhere to TB treatment.	# of lost-to-follow-up PwTB tracked and retrieved
60	PwTB who died during the treatment	# of diagnosed PwTB who died while on TB treatment.	Total # of diagnosed PwTB initiated on treatment

S.No.	Indicators	Numerator	Denominator
61	PwTB who died during the treatment	# of diagnosed PwTB who died while on TB treatment.	Total # of diagnosed PwTB initiated on treatment
62	Nikshay Mitras who supported the PwTB	# of Nikshay Mitras (TB treatment supporters) who provided support to PwTB	Total # of Nikshay Mitras engaged or mobilized to support the PwTB.
63	TB champions who supported in the project	# of individuals who actively support the project as TB champions.	Total # of TB champion enrolled in the project
64	Sensitization meetings conducted with key stakeholders (local vendors, companies/ industries, religious places, homeless resource centers, job contractors, local NGOs/CBOs/ FBOs)	# of sensitization meetings conducted with various key stakeholders as mentioned.	Total # of planned sensitization meetings.
65	Meetings organized with local public health facilities	# of meetings organized with local public health facilities to discuss TB-related matters.	Total # of planned meetings with local public health facilities.
66	Case stories collected by the project	# of individual case stories collected by the project.	Total # of individuals planned for collecting case stories.
67	Case stories where TB affected and stigmatized women benefitted from the project interventions in terms of treatment and psycho-social support	# of case stories showcasing the impact of project interventions on TB-affected and stigmatized women, highlighting their improved access to treatment and psycho-social support.	Total # of case stories collected.
68	PwTB who successfully completed treatment (we will report if information available from the NTEP)	# of PwTB who have completed their full course of TB treatment successfully as reported by the National Tuberculosis Elimination Program (NTEP).	Total # of PwTB who initiated on treatment under the project.
69	PwTB who adhere to treatment during the closure of the project	# of PwTB who continue to adhere to their TB treatment during the closure phase of the project.	Total # of PwTB who initiated on treatment under the project.

Module:

The Plan of Sustainability of the Project Activities, Resource Mobilization for TB Elimination, Dissemination of Learning

9

Project LEAD aims to develop an urban TB model, where sustainability of the project activities has to be ensured with specific strategies and activities. In the table below, we will briefly describe them.

Sr No	Sustainability Strategies	Activities	Project staff responsible	Expected outcome
1	Dissemination of project learning for advocacy	Develop and print project learning materials, like success stories, case studies, and evaluation/progress report Organize central level and state level dissemination meetings	Technical Advisor and M&E Manager of LEAD PMU Central level: Project Coordinator State level: City team leader	Greater responses of the donor-partners and CTD/MoH to scale up the project activities
2	Inclusion in Program Implementation Plan of NHM of the state and cities	Attend the PIP development workshops at state and city level and include the project activities in the PIP	City project team of LEAD	Project activities included in the PIP of NHM
3	NGO-PP schemes	Develop and submit project proposals to the DTO/CTO and STO for the NGO-PP schemes	Partnership office of HPPI in consultation with the project staff of LEAD	Grant under NGO-PP schemes of the NTEP available to continue TB services for the urban poor
4	Resource mobilization from various other sources	Project proposal development and submission to respond to the RFP of potential and CSR partners		Resource mobilization for continuing TB services for the urban poor

Annexure 1: Training Schedule – ToT of the Project Staff at the HPPI HQ in Delhi

Sr No	Topics	Duration in minutes	Methodologies	Facilitator/s
Day 1	Pre-test	20	Pre-test	PC (Project Coordinator)
	Sharing basic knowledge of TB and treatment	150	Module reading, TB quiz, film-shows	TA (Technical Advisor)
	Organization of NTEP	45	Module reading	TA
	End TB Strategy	30	Module reading	TA
	General concept of continuum of TB Care in key and vulnerable Populations	45	Module reading	TA
	Total	290		
Day 2	Orientation of Project LEAD	120	Power point presentation	PC
	Know the targeted population of your city project	60	Module reading and Group work	TA
	Mapping	90	Module reading and Role-plays	TA
	Total	270		
Day 3	Project outreach	70	Module reading and Role-plays	TA
	TB Testing	90	Module reading and Role-plays	TA
	Treatment support	180	Module reading and Role-plays	TA
	Total	340		
Day 4	Engagement of private sector	30	Module reading and Role-plays	TA
	Engagement of community stakeholders	30	Module reading and Role-plays, film-shows	TA
	Sustainability plan of the project	30	Module reading	TA
	M&E	180	Module reading	PC, M&E Manager
	Total	270		
Day 5	How to conduct training of the FOs	180	Mock training exercise	City team
	Finance and admin	90	PowerPoint presentation	Finance and Admin team of HPPI HQ
	Post-test and evaluation of training	20	Post-test	PC
	Total	290		

Annexure 2: Sample Training Schedule of Field Officers in the Project Cities to be given by the City Team

Day 1	Topic	Duration in min	Methodologies
1	Introductory session – Welcome address – Introduction of participants with ice-breaking (name, favourite food/colour/ film actor) – Training objectives – Expectations of the participants – Pre-test	60	
2	About HPPI	10	Power point
3	About Project LEAD	20	Power point
4	Film show	30	Film Atut Dor and discussions on the film – what you liked – what you learnt – what things could have been done better
5	Sharing of basic knowledge about TB	60	Film, lecture, power-point if needed, Q/A
6	Learning TB through games	60	Quiz, match-making
Day 2	**Topic**	**Duration in min**	**Methodologies**
	JD of a FO	60	Lecture, group work and presentation, Q/A
	Know your target community and challenges of working with them	60	Lecture, group work and presentation, Q/A
	Mapping – whom to map, what to map, how you should collect information from targeted communities, stakeholders, health services	120	Module reading, Lecture Role-plays, Filling up the mapping information, Q/A
Day 3			
	Outreach, screening and testing	120	Module reading, Lecture Role-plays, Filling up the mapping information, Q/A
1	Microplanning		
2	Screening		
3	SCT		
4	Pre-test counselling		
	Treatment support	150	Module reading, Lecture Role-plays, Filling up the mapping information, Q/A
1	Post-test counselling and Treatment initiation		
2	Information collection from the patient		
3	Tracking mobile patient		
4	Home-vist/patient-vist and counselling		
5	Providing medicines to the mobile patients through community members		
6	Retrieval of LTFU cases		

Day 4	Community engagement	120	Lecture, role-plays, films
1	Target community members		
2	Stakeholders		
3	Informal providers		
4	Cured PwTB/TCs		
5	Health service providers		
	Data collection and format filling	150	Presentation, lectures, format-filling exercises including online filling
Day 5	Recap of roles and responsibilities of the JDs	120	Group work and discussions
	Clarification of any topics	60	Q/A
	Post-test	30	
	Next steps		

Annexure 3: Monitoring and Evaluation Formats

https://docs.google.com/spreadsheets/d/1RJ_q6u3AL48R8HTlArtu5oJ2hHPB_q1j/edit?usp= drive_link&ouid=100464779516491069564&rtpof=true&sd=true

Annexure 4: TB Quiz Questions Used in the ToT

TB Quiz questions
1. Which germ causes Tuberculosis?
2. Who discovered the TB bacterium?
3. How is TB transmitted?
4. What is the difference between TB infection and TB disease?
5. Who is a presumptive TB case?
6. How do you screen for TB?
7. What are the 4 key symptoms of TB?
8. Which body sample is most commonly tested for TB?
9. What is the most preferred diagnostic test of TB?
10. How do you get your presumptive TB case tested for TB?
11. What do you mean by TB comorbidity?
12. Name a disease which is NOT a TB morbidity.
13. What is MDR TB?
14. What are the advantages of Genexpert test over sputum microscopy?
15. Name the 4 medicines which are used to treat Drug Sensitive TB.
16. What is FDC?
17. Name three categories of people who are more vulnerable to TB.
18. Who are eligible for TB preventive treatment?
19. What do you mean by Lost-to-follow-up cases?
20. What is relapse of TB?
21. When does treatment of TB become di cult?
22. What is the full form of NTEP?
23. By which year does India aim to eliminate TB?
24. What are the responsibilities of a Senior Treatment Supervisor in NTEP?
25. Who decides the DOT provider? Patient or Provider?
26. What is NIKSHAY?
27. What is CTD/Central TB Division?
28. What do you mean by NGO/PP scheme?
29. What is DBT?
30. Who are TB champions?

Annexure 5: Pre- and Post-Test Questionnaire for the ToT of the LEAD Project

Questionnaire for the ToT

Tick the most appropriate answer:

1. Who is not included in the target groups of the LEAD project?
   a. The homeless
   b. Slums
   c. Tribals
   d. Migrants
2. All the following are the targeted private healthcare providers in LEAD project except
   a. RMPs
   b. Pharmacists
   c. Qualified allopathic doctors
   d. 'Bangali' doctors
3. The total number of people to be screened for TB in the project in each of the cities is
   a. 100,000
   b. 150,000
   c. 200,000
   d. 250,000
4. The total number of informal healthcare providers who should be engaged with the city project is
   a. 120
   b. 150
   c. 180
   d. 210
5. A TB unit of the NTEP has
   a. Medical Officer TB Unit/MOTC
   b. Senior Treatment Supervisor
   c. Senior Lab Supervisor
   d. All the above
   e. None of the above
6. A TB Unit of the NTEP caters services to approximately
   a. 200,000 people
   b. 300,000 people
   c. 400,000 people
   d. 500,000 people
7. Who are eligible candidates of TB Preventive Treatment?
   a. All household contacts of the Pulmonary PwTB
   b. All close contacts of the Pulmonary PwTB
   c. People living with HIV and AIDS
   d. None of the above

8. What is the most important thing that should be considered before initiating TB Preventive Treatment?
   a. The contacts should not have active TB disease
   b. The contacts should have active TB disease
   c. The contacts should be infected by HIV
   d. None of the above
9. Which organization is our most primary contact in the LEAD project in terms of project review and management?
   a. CTD
   b. USAID
   c. JSI
   d. WHO
10. The drug(s) which are used to treat a drug-susceptible PwTB are
    a. Rifampicin
    b. Isoniazid
    c. Pyrazinamide
    d. Ethambutol
    e. All the above
11. The most preferred TB diagnostic test in our project is
    a. Sputum microscopy
    b. Genexpert
    c. Chest X-ray
    d. Any of the above
12. The final objective of TB screening is
    a. To educate people on TB
    b. To screen people for TB suggestive symptoms
    c. To identify Presumptive TB cases
    d. All the above
13. Which is the most important TB symptom?
    a. Cough for more than 1 week
    b. Cough for more than 2 weeks
    c. Cough for more than 3 weeks
    d. Cough for more than 4 weeks
14. Which are the functions of a Field Officer of the LEAD project?
    a. TB screening
    b. Sputum collection and transportation
    c. Treatment initiation
    d. Treatment adherence education
    e. Stakeholders' engagement
    f. DOT provision
    g. All the above
15. What are the ways of tracking a mobile PwTB ?
    a. Document the whereabouts and contact details of the PwTB during treatment education
    b. Find out all possible plans of the patient to travel during the treatment
    c. Call the patient during his travel
    d. Contact the people who know the patient if he is not traceable
    e. All the above
    f. None of the above

16. The key challenges with the TB patients of the LEAD project are
    a. Mobility and migration
    b. Alcoholism and drugs
    c. Malnutrition
    d. Unhygienic lifestyles
    e. All the above
    f. None of the above
17. How do we do TB screening?
    a. Identifying TB suggestive symptoms
    b. Chest X-ray
    c. Both of a and b
    d. None of a and b
18. A woman who stays in a juggi of Mumbai is diagnosed with TB. But she refuses to visit the hospital as she feels it will disclose her disease to the community people. What advice do you give to your Field Officers in such case?
    a. Educate and counsel the woman and build her confidence and trust
    b. Sensitize the family members, especially male members, to help the patient
    c. Accompany the woman to the hospital for treatment initiation, preferably with male members, and maintain strict confidentiality
    d. Do community sensitization without disclosing the status of the patient to the community members
    e. All the above
19. A chronically alcoholic rickshaw puller is diagnosed with TB. He had TB before, but he didn't complete the treatment, mainly due to his alcoholic habits. What do you suggest to your FOs to ensure his treatment adherence?
    a. Visit the patient every day to counsel and ensure that he takes the drugs
    b. Identify all the possible places where the patient can be traced during treatment
    c. Identify close friends of the patient, sensitize them on TB and mobilize them to monitor his treatment adherence (community monitoring)
    d. Facilitate his access to the DBT of the NTEP
    e. Link him to the local alcohol de-addiction centre if possible
    f. All the above
    g. Any of the above
20. All the below diseases are comorbidities of TB except
    a. Mental problems
    b. HIV
    c. Malaria
    d. Diabetes
21. India aims to eliminate TB by
    a. 2025
    b. 2030
    c. 2035
    d. 2040
    e. 2045

22. How does a FO know that his/her PwTB is improving with treatment? There is
    a. Decrease in the intensity of the TB symptoms
    b. Increase in appetite and body weight
    c. Increase in strength and stamina
    d. All the above
    e. Any of the above
23. A MDR TB is defined as having bacterial resistance to
    a. Pyrazinamide and Ethambutol
    b. Isoniazid
    c. Isoniazid and Rifampicin or Rifampicin
    d. Any of the above
24. The advantage of Genexpert over the sputum microscopy is
    a. It can also diagnose bacterial resistance to Rifampicin
    b. It can diagnose bacterial resistance to any other TB drugs
    c. It can also diagnose diabetes
    d. All the above
25. TB is
    a. A curable disease
    b. A preventable disease
    c. Both a curable and preventable disease
    d. Any of the above

Annexure 6: Pre- and Post-Test Questionnaire for the FO Training

Tick the most appropriate answer:

1. Tuberculosis (TB) is caused by a
    a. Bacterium
    b. Virus
    c. Worms
    d. None of the above
2. TB is transmitted through
    a. Sexual contact
    b. Contaminated blood
    c. Air
    d. Rotten food
3. TB mostly affects which organ of the human body?
    a. Lungs
    b. Heart
    c. Brain
    d. Kidneys
4. TB infection is
    a. Another name for the TB disease
    b. Presence of TB germs in the body but no TB disease
    c. All the above
    d. None of the above

5. The key symptoms of TB are
    a. Cough for more than 2 weeks
    b. Prolonged fever
    c. Weight loss
    d. Night sweats
    e. All the above
6. What do you mean by TB screening?
    a. Educating people on TB
    b. Finding people with symptoms suggestive of TB
    c. Both a and b
    d. None of the above
7. Which are the targeted populations of our project?
    a. Homeless
    b. Migrant
    c. Mobile
    d. Slum
    e. All the above
    f. None of the above
8. The name of our project is
    a. LED
    b. LADE
    c. LEAD
    d. LOUD
9. What body sample is mostly tested to diagnose TB?
    a. Blood
    b. Sputum
    c. Stool
    d. Urine
10. Along with a sputum test, what other tests should we do in our project for people with TB suggestive symptoms
    a. Chest X-ray
    b. Scan of the chest
    c. Stomach wash
    d. Urine and stool test
11. What challenges with the target population can you anticipate in the project?
    a. The target population is mostly migrant and mobile, so frequently change their location
    b. They are likely to be available in their places during evening or night time
    c. Alcoholism and drug addiction is common among them
    d. They have poor access to health centers to get their health problems treated
    e. Many a time, they don't have identity documents and bank accounts, which are required to avail the TB services from the health centers
    f. All the above

12. How will you track a PwTB who is homeless and mobile?
    a. List the names and mobile numbers of all the people in the location who know the TB patient
    b. Find out from the PwTB all the places he generally visits in search of food, shelter and daily wages
    c. Develop the trust and confidence in the TB patient that he will be cured from TB by taking the full course of the medicines
    d. Fix the places, as per the convenience of the PwTB, where he can meet you for counselling support, and receiving medicines on a weekly basis
    e. All the above
13. A PwTB is travelling to his village during the course of treatment. What actions will you take to ensure that the patient takes his daily medication during this time?
    a. Keep in contact with the patient, if he has a functional mobile phone, for continuing adherence counselling and motivation
    b. Note down the contact details of his family in the village, including his neighbors and friends, who can be reached and asked to track the patient if you lose contact
    c. Before starting the travel, explain well to the patient and hand over the necessary treatment documents so that he can continue taking medicines from the local health center of his village
    d. Find out the name and mobile number of the DTO (District TB Officer) of the district where his village is located so that the DTO can be contacted for any incidence of non-compliance from the patient and take the immediate necessary action
    e. All the above
14. TB is a
    a. Curable disease
    b. Preventable disease
    c. Both a and b
    d. None of the above
15. To be cured from TB, a patient must take all the doses of medicines for at least
    a. 6 months
    b. 7 months
    c. 8 months
    d. 9 months
16. You will visit the PwTB as follows after the treatment initiation
    a. Daily visit for the first 2 weeks of treatment initiation, followed by weekly visits till end of treatment
    b. Daily visit throughout the full course of treatment
    c. Daily visit for the first one month of treatment initiation, followed by monthly visits till end of treatment
    d. No patient visit is required in the project

17. Who will be the key persons in the project to give you full information about the targeted communities and the PwTB?
    a. Street vendors
    b. Pharmacists
    c. Job contractors
    d. Leaders of the slums
    e. Informal healthcare providers
    f. Local religious places like temples, gurudwaras, mosques
    g. Local NGOs, CBOs, and youth clubs
    h. Supervisors of shelter homes
    i. All the above
    j. None of the above
18. The PwTB should be tested for the following diseases after his diagnosis of TB
    a. HIV
    b. Diabetes
    c. Both a and b
    d. None of the above
19. What do you mean by mapping? It is
    a. To identify the high risk groups in the specific locations or hotspots
    b. To make a rough estimate of the targeted population in the hotspots
    c. To identify the people who influence the lives and activities of the targeted communities
    d. To find the service delivery points in and around the hotspots
    e. All the above
20. A female PwTB, who stays in a juggi, faces discrimination in her family. How do you help her?
    a. Counsel the family members well on TB
    b. Take help from influential community members to change the discriminatory behaviors of the family
    c. Arrange a meeting of the family members with the doctors and nurses of the health facilities
    d. All the above
21. What is TB preventive treatment? It is
    a. To provide medicines to prevent conversion of TB infection into active TB disease
    b. To be given to the household contacts of Pulmonary PwTB
    c. Also to be given to people living with HIV and AIDS
    d. All the above

HUMANA
PEOPLE TO PEOPLE INDIA

111/9-Z, Kishangarh, Vasant Kunj, New Delhi-110070
Telephone & Fax: 011- 47462222

E-mail: info@humana-india.org | Website: www.humana-india.org

Follow us on

Registered under Section 25 of the Companies Act, 1956
Registered under Foreign Contribution Regulation Act, 2010
Registered under Section 12A and 80G of the Income Tax Act, 1961

2023