

# Public Private Mix TB control programme in Mumbai

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### IMPORTANT NOTICE

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*We would like to stress here that these technical notes are not prescriptive. Their purpose is not to "say what should be done" but to present experiences that have given positive results in the context in which they were carried out.*

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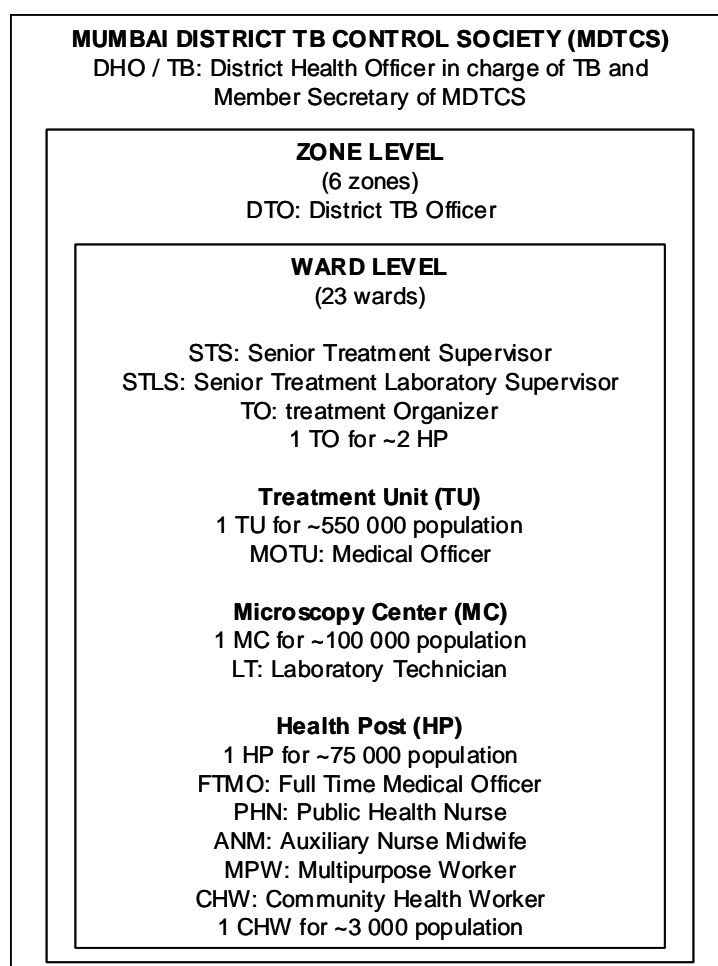
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## 1. Context, rational and history of the programmes

In India, each year around 1.8 million new cases of tuberculosis (TB) including 800 000 sputum positive infectious cases occur, leading to around 400 000 deaths annually. A Revised National TB Control programme (RNTCP) implementing the WHO recommended strategy of DOTS<sup>1</sup> to control TB and prevent multidrug resistance was formulated and implemented in a phased manner. At the end of March 2004, 851 million people are covered by RNTCP (around 83% of the Indian population) and have access to free TB treatment under DOTS through the public health system. Mumbai is entirely covered (12.7 million people) by the RNTCP.

Tuberculosis control in Mumbai is managed by the Mumbai District TB Control Society (MDTCS), which has deputed officials from the Municipal Corporation of Greater Mumbai (BMC). MDTCS operates through the various municipal health infrastructures available for implementing the programme.

### *RNTCP structure in Mumbai*



<sup>1</sup> DOTS : directly observed treatment short-course

Diagnosis and categorization are carried out by microscopy centres (MC), Treatment Units (TUs, for EPTB<sup>2</sup>) and Health Posts (HP). DOTS is delivered in every HP and in some dispensaries and TUs.

In Mumbai, RNTCP achieves a detection rate of 82% of new sputum positive cases and a cure rate of 86% in the first quarter of 2004.

However, various studies assessing the health seeking behaviour of TB cases have indicated that 60% of the patients with a longstanding cough and seeking health care have private practitioners as their first contact due to convenience, hours of operation and issues of confidentiality, which are drawbacks of the public health system. Another study has noted that 88% to 85% of urban patients with tuberculosis first went to a private practitioner. Among people treated at government run programmes, private providers had diagnosed 64% of the patients. This situation is true across all socio-economic strata in both rural and urban areas. Many patients from the poorest segment of society complete TB treatment in the private sector often becoming indebted.

Patients seeking private health care usually shop for treatment, incurring costs and delays in treatment. A survey conducted in Maharashtra on patients treated in the public health centres has shown that a patient with the symptoms of tuberculosis had seen an average of 2.9 doctors before being sent to the Mumbai municipal services and 2.5 doctors for the Pune municipal services.

In addition, TB management by the private practitioners is often not up to standards:

- When examining a patient the private doctors prefer to use x-rays instead of sputum to diagnose tuberculosis. X-rays are not specific tools and there are inter and intra observer errors leading to over diagnosis (10%).
- A survey carried out on one hundred private medical practitioners from the slums of Mumbai showed at least eighty different treatment regimens being prescribed for patients suffering from pulmonary tuberculosis. The majority of these regimens was inappropriate (unsuitable combination of antibiotics, wrong dosages, and varying length of treatment duration).
- Notification of cases of tuberculosis under private care is not yet implemented.
- Private practitioners have no means to ensure compliance. As a result the defaulter rate is very high: only 5 to 59% of patients that have tuberculosis finish their treatment correctly.

Therefore, it is imperative to involve the private sector in the national TB control programmes and special schemes setting a framework for public-private collaboration have been developed under RNTCP. However, the actual involvement of private practitioners in RNTCP requires to implement procedures for collaboration at field level and conduct intensive promotion and advocacy to private medical practitioners (PMPs).

Inter Aide started working on the involvement of private medical practitioners by supporting a pilot study of the methodology developed by UCITC (Universal Care Initiative for Tuberculosis Control) on the area of two health posts. Having assessed the response of the

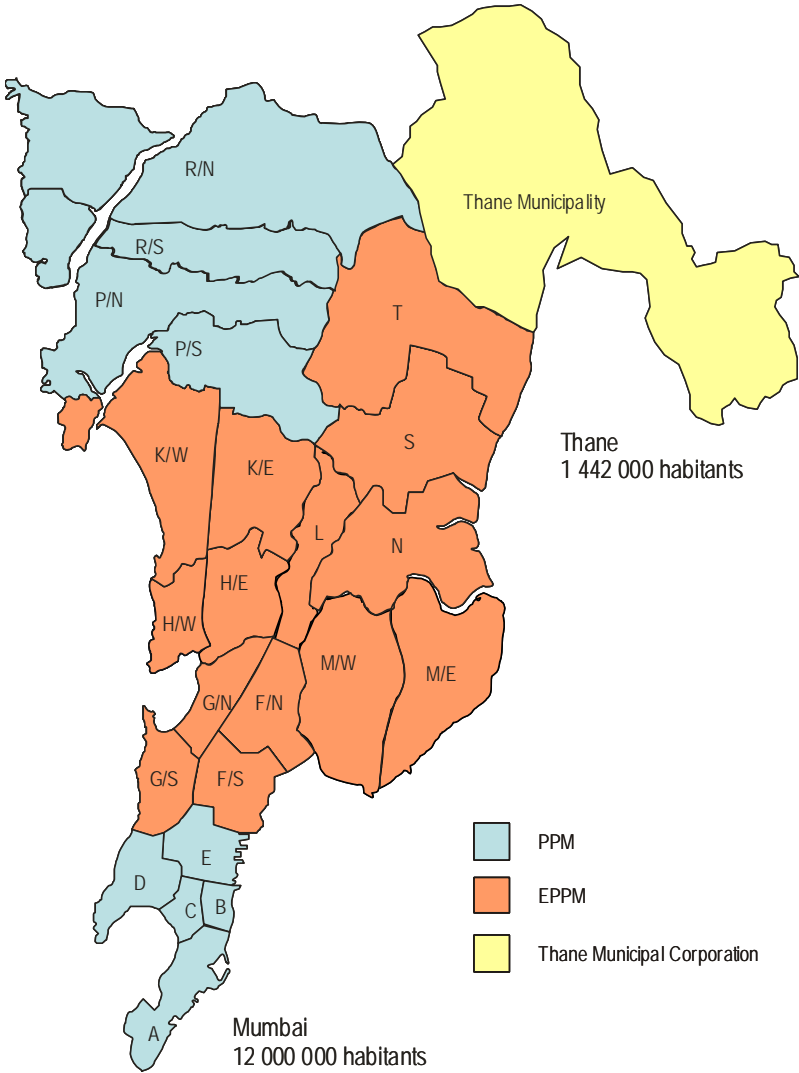
<sup>2</sup> Extra pulmonary TB

private sector to the pilot project, it was decided to extend and test the model on a larger population. Coincidentally, the WHO was also looking for local partners for studying various aspects of involving PMPs in RNTCP. This was an opportunity for UCITC to put its model to test on a larger population of 2.6 million in Zone 4 in the framework of a WHO operational research project of Public Private Mix (PPM) starting from March 2002 and jointly implemented by MDTCS, UCITC, Inter Aide (zone 4) and MSF (zone 1).

In view of the positive impact of the PPM on RNTCP results and increased patient outreach, Inter Aide and the MDTCS decided to extend the programme to the remaining zones of Mumbai (except zone 1, already covered by MSF in the framework of the PPM project), starting from September 2003. This programme is called the Extended Public Private Mix Programme (EPPM).

The set up of a public Private Mix programme in Thane Municipal District is currently in project.

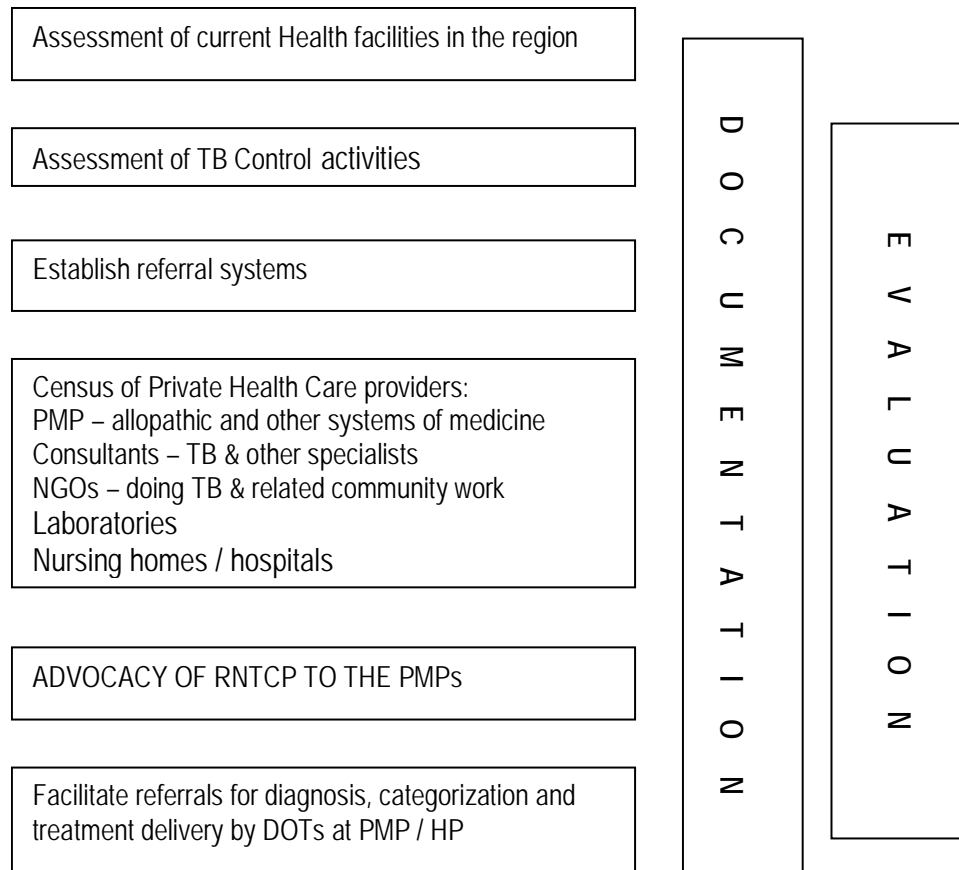
***Public Private Mix programmes in Mumbai and Thane Municipal District***



## 2. Methodology of the Public Private Mix programmes

### 2.1 Methodology for involving PMPs by a one-to-one advocacy

#### Steps in implementing a PPM programme



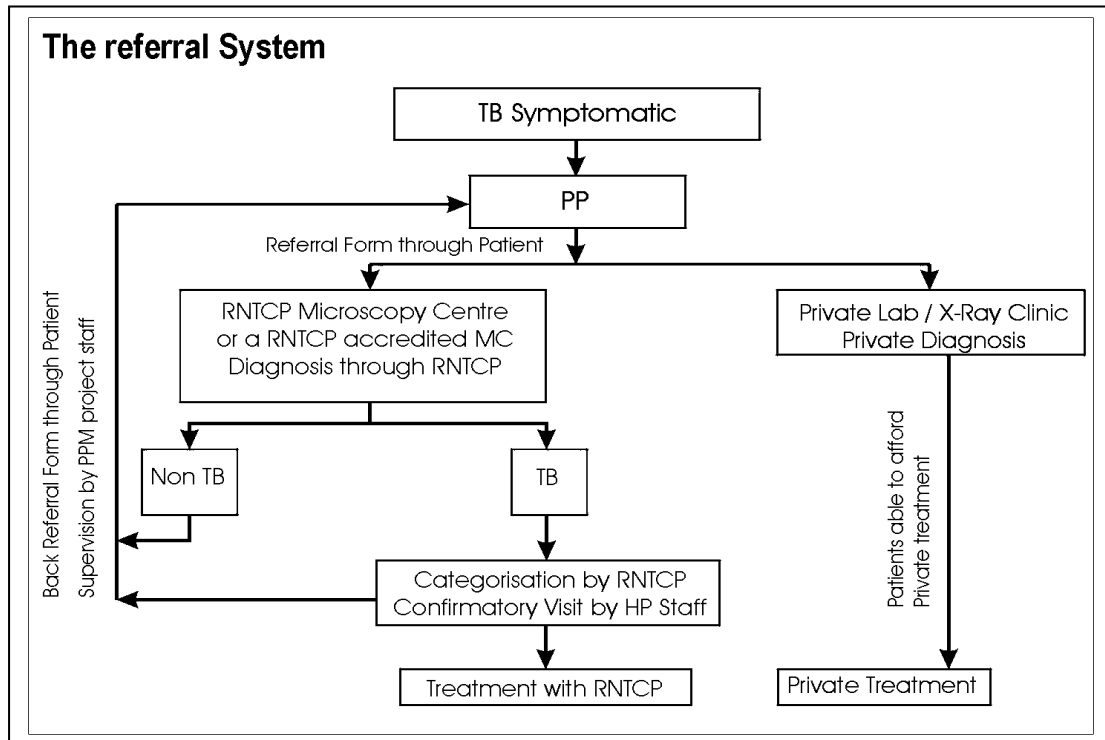
The PPM project is based on the set up of a referral system from PMPs to RNTCP, asking PMPs to refer TB suspects for diagnosis and treatment to public health facilities.

Assessing the public health system prior to setting up the referral system is a prerequisite as the referrals will be sustained only if the patients sent by PMPs receive adequate treatment from the public health facilities.

Then, a referral system is designed, with flow charts showing where patients should be sent according to their place of residence and available public health facilities.

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This is followed by a systematic one-to-one approach of all PMPs for advocacy. Advocacy is the main function of the PPM and should be carried out systematically and meticulously. Special IEC material developed for the PPM is used for this purpose.

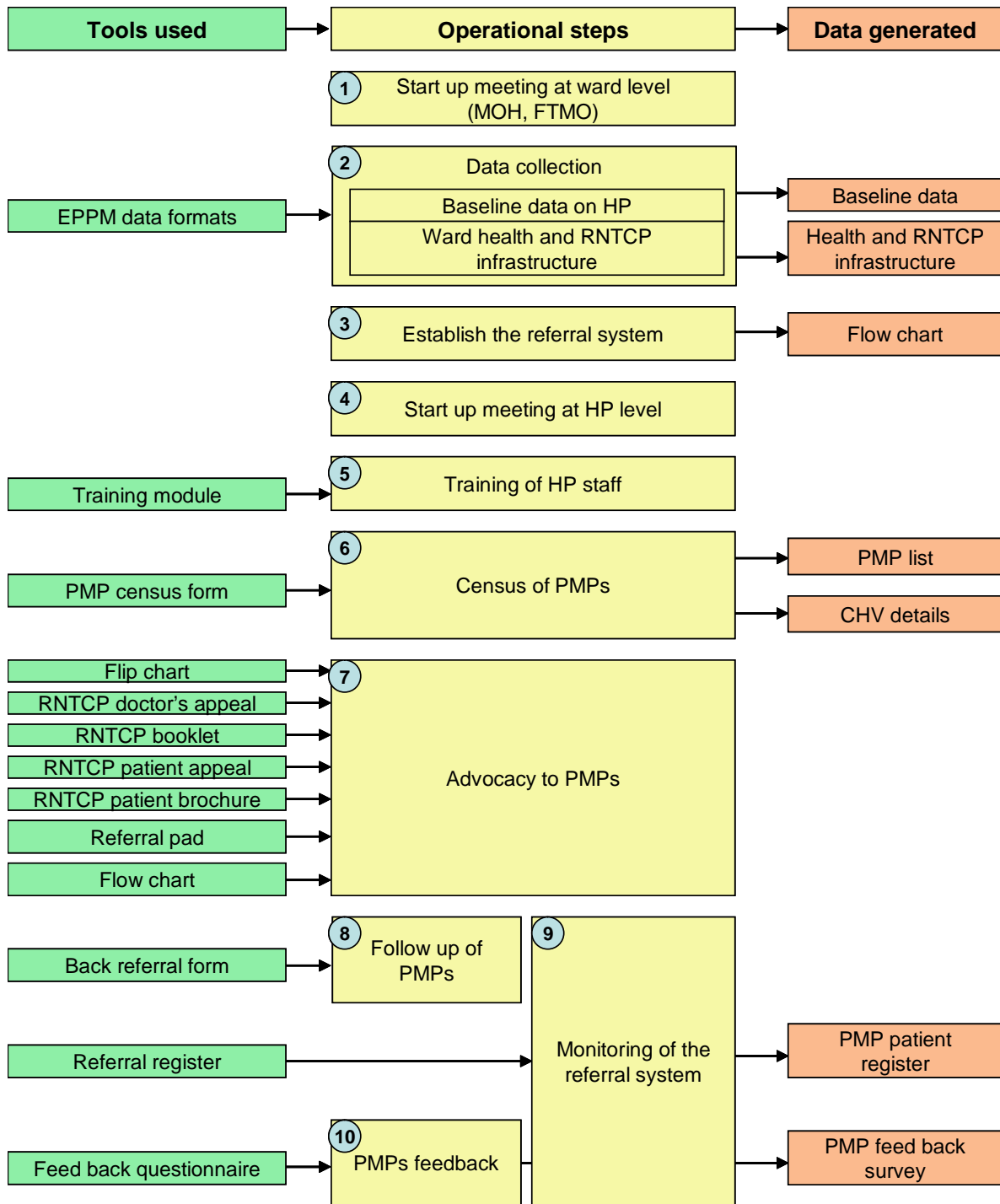
During the individual meeting, the PMP is informed about the RNTCP: the current policies, infrastructure in the area and the facilities available to the PMP for their patients. A pad with referral forms is handed out to the PMP to refer his patients to the RNTCP facilities, as per the flow chart. The back side of the referral form is used for recording sputum results. A carbon copy of each referral form remains in the referral pad, allowing for follow up of patients referred by PMPs.

## Tools and Data Management

Special tools have been designed to support PPM programme implementation. Data management is also an important part of the programme as it enables continuous documentation, monitoring and evaluation.

The table below details the tools used in implementing the different steps of the PPM and the data generated by each step.

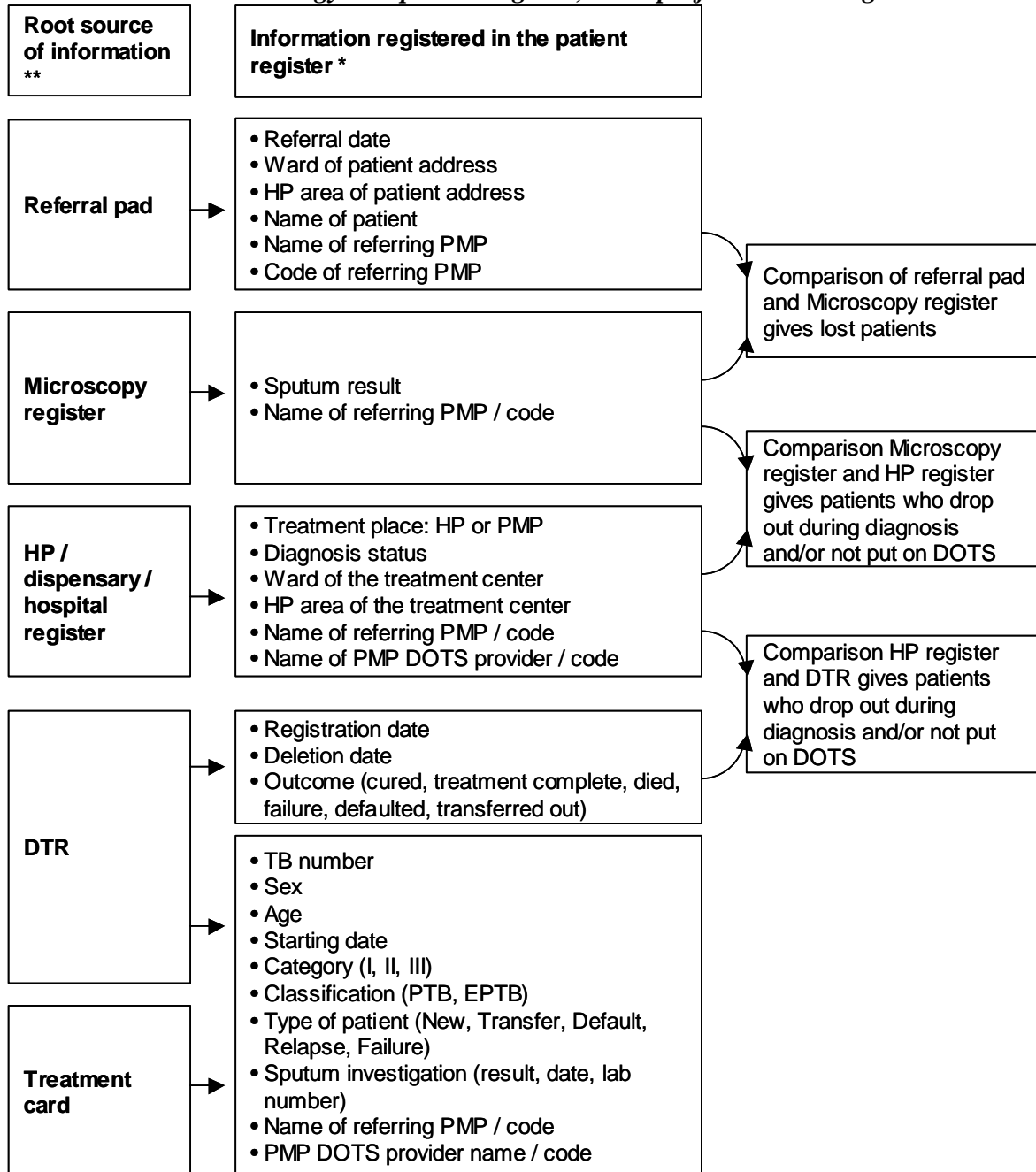
*PPM methodology: implementing the PMP referral system*



## Reporting and Monitoring

The patient register is the main monitoring tool of the programme. This register keeps track of all the information for each patient referred by a PMP to the RNTCP. The following figure details the different sections of the patient register and its root source of information.

### *PMP methodology: the patient register, main project monitoring tool*



\* The quantity of information registered is variable depending on the case of the patient: for example, non TB referred patients will have only referral and diagnosis information whereas TB referred patients put on DOTS will have the complete information

\*\* Most information can be taken from different source documents, which enables cross-checking

Reporting is carried out on a monthly basis and discussed at monthly review meetings.

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Reports generated are:

- Programme results (information on coverage, PMP participation, patients referred, impact on RNTCP registrations): monthly, quarterly and annually / ward-wise,
- Sputum conversion and treatment outcomes: quarterly,
- PMP profile: annually.

## 2.2 Organisation and Variations in Methodology

### Organisation

The implementation of the project relies on the collaboration of various agencies:

- MDTCS: RNTCP staff and PPM project staff,
- BMC: HP, dispensary and hospital staff,
- UCITC: project data management team,
- NGOs (MJK, Navnirman, Path, Alert India, UCITC): PPM project field staff,
- Inter Aide: representatives.

The organisation varies from one area to the other depending on:

- Which agency implements the project at HP level: either project staff appointed by MDTCS or project staff belonging to partner NGOs,
- The level of involvement of HP staff in the implementation of the project.

#### *Example for Mumbai*

Functions	Activities	Staff profile	Agency
Mumbai level management	Responsible for the overall implementation of the PMP project	Programme manager	MDTCS
EPPM / PPM level management	Planning and designing of tools and trainings Organization and monitoring of activities Sensitization and training of HP staff Sensitization of PMPs	Project coordinator	MDTCS
Zonal level management	Coordination with city, zone and ward RNTCP staff Support to HP staff / MDTCS project staff / NGO staff in the implementation of project activities Reporting	Zonal coordinator	MDTCS
HP level implementation	PMP census Sensitization and advocacy to PMPs Follow up visits to PMPs Feed back to PMPs (thank you note) Entry of referral and DOTS provider information in HP register	Project officer	MDTCS Partner NGOs
		Health post / RNTCP staff	BMC / MDTCS
Data management	Consolidation and analysis of data	Data manager	UCITC
	Collection, entry and cross checking of data	Data operator	UCITC
Financial and technical support	Technical support to project staff and NGOs Financial support to MDTCS and partner NGOs	Representatives and consultant	Inter Aide

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## Variations in Methodology

Although the overall methodology is the same, some differences can be observed between the PPM and the EPPM programmes and within the EPPM programme between zones covered by a partner NGO and zones covered by MDTCS project staff. These differences are relative to:

- The involvement of HP staff in the field work,
- The geographical expansion of the programme.

They are summarized in the table below.

	<b>Z4: PPM project (WHO)</b>	<b>Z2, 3, 5: EPPM project with UCIT/MDTCS operator</b>	<b>Z2, 3, 5: EPPM project with NGO operator</b>
<b>Project staff</b>	Project staff are employed by MDTCS on WHO funding	Field and zonal project staff are employed by the MDTCS on Inter Aide funding	Field project staff are employed by the NGO, zonal project staff are employed by the MDTCS, both on Inter Aide funding
<b>Implication of RNTCP and HP staff</b>	The project is implemented by the project team in all HP and later gradually handed over to RNTCP staff and HP staff	The project is implemented by the project team in the model unit. In the other HP, HP staff and RNTCP staff implement the project with project team training / counseling / monitoring	The project is implemented by the NGO in all HP with the monitoring of MDTCS zonal coordinators. Hand over to HP and RNTCP staff is forecasted in the long term.
<b>Geographical expansion</b>	The speed of coverage depends on the workforce available for the project team. The project is launched in a few HP. New HP are started when the first are running. (Start with 2 HP/Project officer (PO), then 4HP/PO, etc.)	For each zone, the project is started in one ward. In this ward, the project is launched in a model unit health post and later gradually replicated in other health posts. When replication has been started, the project is launched in a model unit in another ward.	The speed of coverage depends on the workforce available for the project team. The project is launched in a few HP. New HP are started when the first are running.

In the PPM project, the entire implementation was carried out by project staff, with a hand over to HP and RNTCP staff at the end of the project. This hand over will be carried out by implementing a “module for involvement of private medical practitioners in RNTCP” which was designed in the framework of the project and describes the methodology and allocates the different activities to HP and RNTCP staff, mainstreaming PPM programmes into RNTCP

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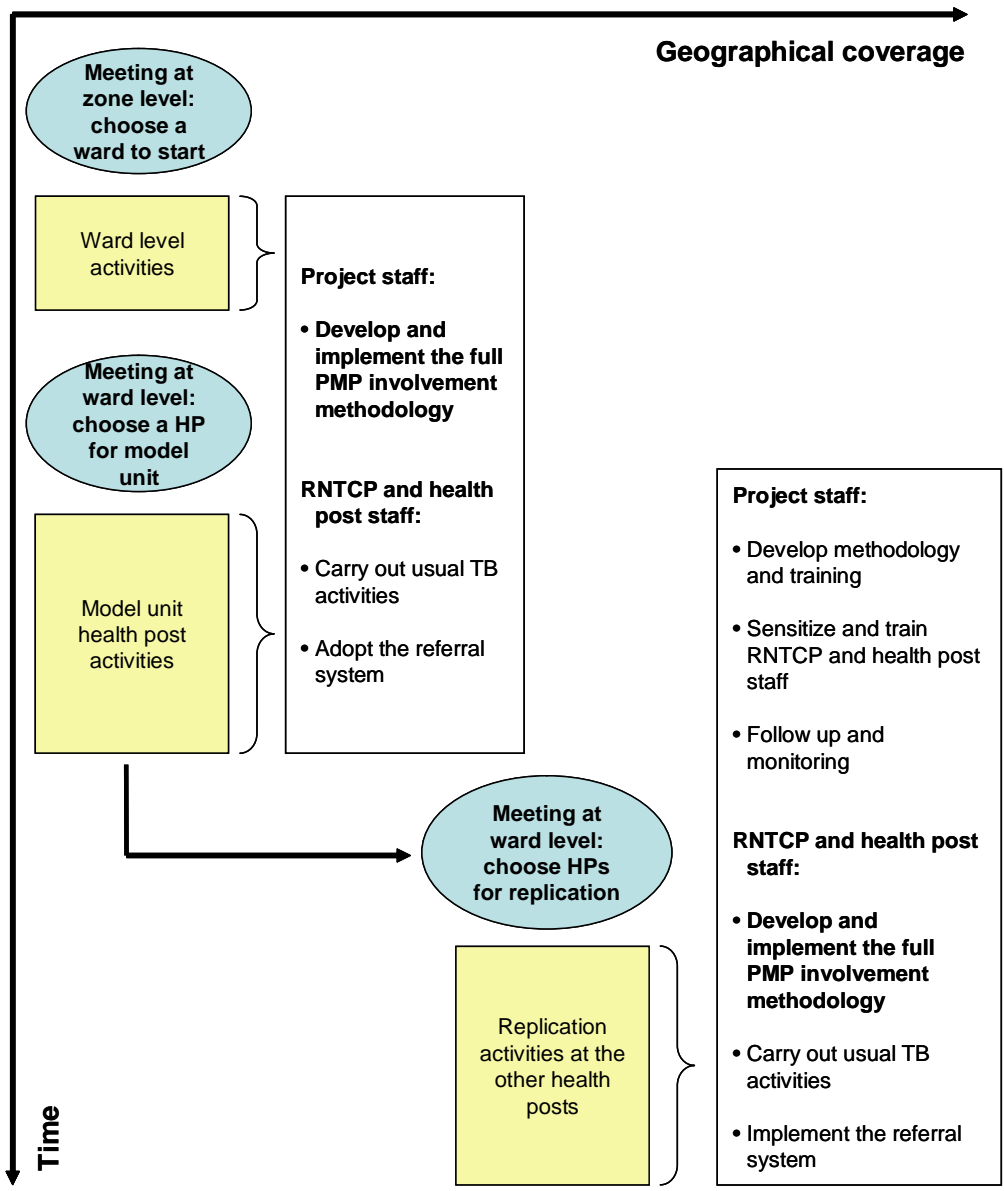
activities and procedures. The last 6 months of the PPM project are focused on supporting the implementation of this module by public health staff. It is too soon to judge the success of the hand over.

In view of the difficulties to involve HP and RNTCP staff after implementation has been carried out and the threats on the sustainability of the involvement of private medical practitioners, it was decided to try to involve HP and RNTCP from the start of the project in EPPM.

This involvement of HP and RNTCP staff from the beginning also results in a lower cost of the project with less project staff needed. The methodology developed in EPPM requires 1 project coordinator at city level and 1 zonal coordinator and one project officer for each zone (one zone covering about 2 million inhabitants) for 3 years. The quantity of staff required varies depending on the size of the population and the time frame for implementation.

Therefore, a new approach was designed based on the selection of a model unit (MU) health post for each ward for the implementation of the project by project staff. After implementation of the project in the model unit, replication to the other health posts in the ward can start with the training of HP staff by project staff (see training module in annex). In this context, the model unit is used to train the project staff and develop awareness of particular problems in the ward and to showcase the project in the area and to other health posts' staff.

*EPPM methodology: a phased implication of public staff*



Thus, higher level of involvement of HP and RNTCP staff are looked for as more experience is gained on PPM programmes, with the issue of sustainability in mind.

The methodology forecasted for the Thane PPM project, carries yet a little further the search for HP and RNTCP staff involvement from the start. In the case of Thane, the project will be managed by a project coordinator appointed by the TMC TB control society and implemented by Alert India. Alert India will limit its role to training and supporting HP and RNTCP staff in the implementation of the project and monitoring project activities (its role would then be similar to that of project staff in Mumbai in the case of replicated health posts).

### 3. Results, barriers and success factors of the Public Private Mix programmes

#### 3.1 Results

On average, between 40 and 50% of the PMPs that have been sensitised refer at least one patient over the life of the project. Four main indicators can be used to monitor the performance of PPM programmes:

- % PMPs referring TB suspects: gives a measure of the effectiveness of the programme in terms of participation of PMPs to the referral system.
- % PMPs referring TB patients: gives information on the participation of PMPs but also on their capacity to diagnose actual TB cases and thus on the programme to give them guidelines for this diagnosis.
- PMPs annualised case detection rate (number of TB cases referred by PMPs per 100 000 inhabitants covered by the programme, annualised): gives a measure of the effectiveness of the programme in detecting TB cases. It can be noted that the relationship between the participation of PMPs (as measured through the % of PMPs referring TB patients out of total PMPs censused) and the PMPs annualised detection rate is not so straightforward. When high levels of participation seem to generate high PMPs annual detection rate, it also seems that relatively average participation can also lead to high detection rates, reflecting a concentration of referrals on a few PMPs. The concentration of TB cases referrals on a few active PMPs tends to increase with the seniority of the programme.
- Share of patients referred by PMPs in % of total RNTCP registration: gives a measure both of the coverage of the programme and its effectiveness in bringing new RNTCP registrations. Therefore, low percentages can be attributed either to low coverage or to a low share of patients referred by PMPs in total registration. This low share, in turn can be the result of a bad performance of the programme or of under documentation of PMPs referrals.

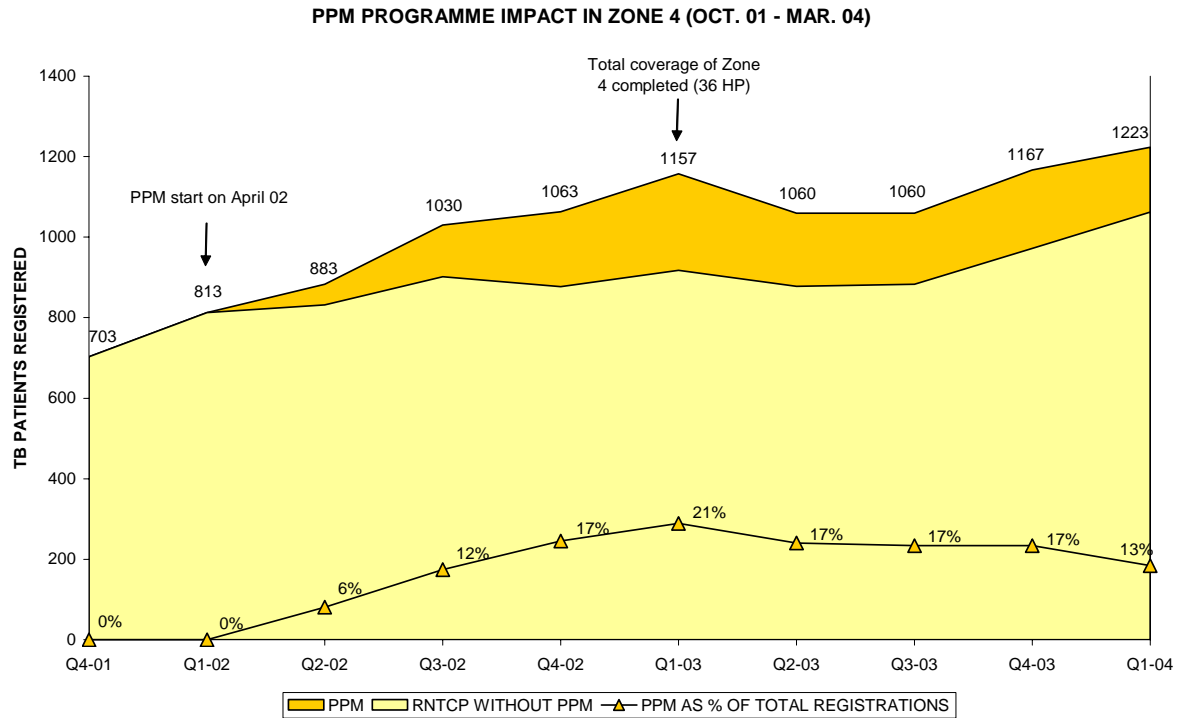
The results for the first quarter of 2004 are given bellow for illustration:

- A participation of PMPs to the referral of TB suspects, varying from 10% of total PMPs censused in PN to 57% in ME,
- A participation of PMPs to the referral of TB patients ranging from 7% in Ward PS<sup>3</sup> to 24% in wards ME and GN,
- An annualised PMPs detection rate varying from 22 cases per 100 000 inhabitants covered by the programme in Ward RN to 91 in Ward HW,
- A share of patients referred by PMPs out of the total number of patients registered under RNTCP comprised between 2% in Ward MW and 17% in RS.

In zone 4, where results can be analysed on a longer time period, the contribution of PPM to RNTCP case registrations rose continuously from the beginning of the project and peaked at 21% in the first quarter of 2003, just after total coverage of the area was achieved. Then the

<sup>3</sup> Mumbai is divided in 23 Wards : PS, ME, GN ; RN, HW are wards.

contribution stabilised around 17% for 3 quarters and started decreasing again in the first quarter of 2004, while total RNTCP registrations grew in the same period.



This decrease of PPM contribution in parallel to an overall increase of RNTCP registrations can reflect different things:

- An indirect effect of the PPM with the increase in the number of patients recruited directly by the public sector, essentially due to word of mouth and the improvement of the image of the public sector (see Tuberculosis Control, Involvement of Private Medical Sector, One to One Approach: Mumbai Experience, by J. Copreaux and Y. Dholakia),
- An underreporting of referrals by PMPs, with PMPs not using the referral pads, which could be explained by a decrease in PMPs follow up (less PMPs visits by project staff).

### 3.2 Barriers and Success Factors

Barriers:	Potential solutions:
Lack of effectiveness and patient friendliness of the public health services: delays in diagnosis and start of treatment, shuffling of patients between services and bad attitude of public health staff.	It is better to launch the programme only in areas where the public TB control programme already reaches acceptable quality levels. In addition, the project team has a role of smoothing and facilitating the relationship between HP and PMPs. PMPs are given the contacts of the team and can call on them for concrete problem solving. In areas with low performance of the TB control programme, NGOs can bring support at HP level in addition to the PPM. For example, NGOs can open DOTS centres, operate microscopy labs or provide counselling in HP.
A bad image of public health services amongst PMPs and the population.	The involvement of public health staff from the advocacy stage of the project can better its image. Also, information on NTP and the results it achieves can help clear misconceptions on NTP.
Disagreement of PMPs with DOTS protocol (diagnosis by sputum, alternate day treatment)	The programme can include provision of information and technical support on TB management issues to PMPs to convince them of the effectiveness of DOTS
A bad image of PMPs amongst public health staff.	The involvement of public health staff from the advocacy stage of the project can improve the relationship by the multiplication of contacts with PMPs. Also, training delivered to public health staff should underline the necessity to involve PMPs in NTP and give tools to the staff to improve their communication with PMPs.
Difficult relationships between NGOs implementing the programme (when it is the case) and public health staff.	Having regular meetings to coordinate the activities of NGOs and public health staff and improve understanding of each others specific role and added value in the project
Low availability and commitment of public health staff for the implementation of the programme (when it is the case).	Commitment from the hierarchy should be sought through its integration in project planning and management from the start. The highest NTP representative for the city can be made responsible for achieving the programme, as it contributes to reach NTP targets.

Therefore, **success factors** are:

- A commitment of public health staff to the project, starting from the highest hierarchy.
- The involvement of public health staff from the start of the project at city (in project planning and management) as well as HP level (in project implementation).

- Improving communication and understanding between the various actors of the project (public health staff, PMPs, implementing NGOs) through the exchange of information and regular contacts and meetings.
- A well performing public TB control programme or the possibility to improve it through the support of NGOs.

## Abbreviations

ANM	Auxiliary Nurse Midwife
CBO	Community Based Organization
CHW	Community Health Worker
CTD	Central TB Division
DHO	District Health Officer
DHO / TB	District Health Officer in charge of TB
DTO	District TB Officer
DOTs	Direct Observed Treatment Short-course
EPTB	Extra pulmonary TB
GFATM	Global Fund for Aids, Tuberculosis and Malaria
HP	Health Post
IEC	Information, Education and Communication
LT	Laboratory Technician
MC	Microscopy Centre
MCH	Mother and Child Health
MDACS	Mumbai District AIDS Control Society
MDTCS	Mumbai District TB Control Society
MJK	Maharashtra Janavikas Kendra ( <i>Partner NGO, Mumbai</i> )
MO	Medical Officer
MOH	Medical Officer of Health
MPW	Multi-purpose Worker
NACO	National AIDS Control Organization
NACP	National AIDS Control Program
NSVK	Navnirman Samaj Vikas Kendra ( <i>Partner NGO, Malad, Mumbai</i> )
PATH	People's Association for Training and Health ( <i>Partner NGO</i> )
PHN	Public Health Nurse
PMTCT	Prevention of Mother To Child Transmission
PPM	Public-Private-Mix
PPs	Private Practitioners
RNTCP	Revised National Tuberculosis Control Program
STO	State TB Officer
STS	Senior Treatment supervisor
STLS	Senior Treatment Laboratory Supervisor
TO	Treatment Organizer
TU	Treatment Unit
UCITC	Universal Care Initiative for Tuberculosis Control
TB	Tuberculosis
UDP	Urban DOTS Program
VCCTC	Voluntary Confidential Counselling and Testing Centre

*\* Anaïs LE DORE is in Mumbai since March 2004. She is Programme Manager in charge of the relations with the public partners and authorities.*

## Annexure

### *Training module*

#### TRAINING MODULE

<b>Duration of training:</b>	2 sessions of half day each
<b>Place:</b>	HP premises
<b>Faculty involved:</b>	Project Coordinator, Zonal Coordinator, Project Officer Possibly: data manager, FTMO/ PHN from model HP
<b>Participants:</b>	Total HP staff: FTMO, PHN, ANM, MPW, CHV
<b>Methodology:</b>	Participatory

The training will be carried out in two sessions, the first session taking place at the inception of the EPPM in the health post, the second session taking place after the PPs census has been conducted.

The first session will cover:

- Introduction
- Methodology for project implementation
- Documentation
- Reporting

The second session will cover:

- Feed-back on census and reinforcement of the first session
- Medical aspects of TB
- Methodology for project follow-up

The following pages give a detailed outline of the two training sessions: purpose, contents, methodology, tools.

**FIRST TRAINING SESSION**

<b>Steps</b>	<b>Objective</b> <i>What HP staff should know / do after the training</i>	<b>Contents</b> <i>Essential information to be passed to HP staff</i>	<b>Methodology</b> <i>Organisation of the training session</i>	<b>Tools</b> <i>Material used for training</i>
Step 1 Introduction 15 – 30 min	1. Know about the PPM project  2. Understand the reason and purpose of PPs involvement  3. Know RNTCP targets	1. Purpose of the PPM project  2. Reasons for implementing this project: <ul style="list-style-type: none"> <li>• &gt;60% of patients visit PPs</li> <li>• Most don't get adequate treatment</li> <li>• Defaulter rate is high resulting in MDR</li> <li>• Getting treatment with PPs represents a high economic burden for families</li> <li>• Delays in treatment resulting in spreading of the disease</li> </ul> 3. The project works: result of PPM pilot project: increase of case detection  4. Target of 70% case detection for RNTCP	1. Brief introduction: <ul style="list-style-type: none"> <li>• Presentation of the project team</li> <li>• PPM= Public Private Mix project</li> <li>• The purpose of PPM is to motivate PPs to refer their patients to HP and / or become DOTS providers</li> </ul> 2. Participatory sequence: <ul style="list-style-type: none"> <li>• Question the participants: why is it important to involve PPs?</li> <li>• Write their answer on a board</li> <li>• Reword the question to insure maximum participation from participants.</li> </ul> 3. Summarize and rephrase to convey the contents, try using what participants said	Paper board or black board
Transition to step 2 5 - 10 min		Now that you know why we should involve PPs, we will explain the methodology developed to achieve PPs involvement: <ul style="list-style-type: none"> <li>• Find out and list the PPs in</li> </ul>	1. Announce the general outline of PPM methodology  2. Explain the proceeding for step 2: <ul style="list-style-type: none"> <li>• Breakdown of the participants in 3 groups: 2 groups with CHVs, 1 group with PHN,</li> </ul>	

		<p>the area</p> <ul style="list-style-type: none"> <li>• Design a system for referral</li> <li>• Motivate the PPs to participate and maintain the relationship with PPs</li> </ul>	<p>ANM and MPWs</p> <ul style="list-style-type: none"> <li>• 1 project staff will be responsible of explaining the methodology to 1 group</li> <li>• Each group will work on a particular aspect of PPM methodology</li> </ul>	
<p>Step 2 PPM methodology for implementation 60 - 90 min</p>	<p>1. Understand the PPM methodology</p> <p>2. Be able to use the tools</p>	<ul style="list-style-type: none"> <li>• Establish a referral system</li> <li>• Census of PPs</li> <li>• Sensitizing PPs / advocating RNTCP to PPs using the one-to-one approach</li> </ul>	<p>1. Project staff explain the procedure and show the tools to their group, allowing for questions and answers</p> <p>2. Project staff explain to their group which part of the methodology it will have to enact:</p> <ul style="list-style-type: none"> <li>• Group 1 (CHVs): census of PPs (census form)</li> <li>• Group 2 (CHVs): referral system (flow chart, microscopy centres list, referral pad, thank you note)</li> <li>• Groupe 3 (PHN, ANM, MPW): sensitizing and advocacy (flip chart, IEC material)</li> </ul> <p>3. Project staff explain the principle of the role play:</p> <ul style="list-style-type: none"> <li>• Designation of a person to enact a PP and a SW</li> <li>• Preparation of the role play by the group, project staff can help them out by answering questions</li> <li>• the SW has to explain to the PP how to fill the forms / use the tools and advocate,</li> <li>• the PP can ask questions</li> </ul> <p>4. The participants regroup and each group enacts its part one after the other. A project staff will act as animator to stress the difficulties and facilitate the role play</p>	<p>1. Project tools for referral:</p> <ul style="list-style-type: none"> <li>• Census form</li> <li>• Referral pad</li> <li>• Thank you pad</li> <li>• Flow chart</li> <li>• List of MC</li> </ul> <p>2. Project tools for IEC</p> <ul style="list-style-type: none"> <li>• Flip chart</li> <li>• IEC leaflets</li> </ul> <p>3. Panel with an exemplary of project tools for referrals to be hung in the HP</p> <p>4. Bullet point summary of the “first visit” to PPs on paper to be distributed</p> <p>5. Panel with bullet point summary of the “first visit” to PPs to be hung in</p>

			5. A project staff will summarize the procedure for the first visit to PPs, based on the bullet point summary to be distributed	HP
Step 3 Documentation and reporting 15 – 20 min	Write referring doctor name and DOTS provider name in: <ul style="list-style-type: none"> <li>The treatment card</li> <li>The HP register</li> </ul>	<ol style="list-style-type: none"> <li>Chest symptomatics / TB suspects referred by PPs to be entered in: <ul style="list-style-type: none"> <li>TB card</li> <li>HP register</li> </ul> </li> <li>DOTS provider name to be entered on: <ul style="list-style-type: none"> <li>TB card (duplicate card maintained at HP is PP is DOT provider)</li> <li>Register</li> </ul> </li> <li>STS will use this information to generate reports that will be periodically discussed at: <ul style="list-style-type: none"> <li>STS &amp; STLS meetings held at HO fortnightly</li> <li>Zonal monthly meetings</li> <li>PPM review meetings</li> </ul>                     These reports are transmitted to State TB office and Central TB Division                 </li> </ol>	<ol style="list-style-type: none"> <li>Explain how the cards and HP register have to be filled and by whom</li> <li>Show examples</li> <li>Inform on reporting</li> </ol>	<ul style="list-style-type: none"> <li>Blank treatment card</li> <li>HP register</li> </ul>
Closure of the training session	Thank all the participants Announce the proceeding for the next weeks: <ul style="list-style-type: none"> <li>PO will bring material to the HP (census forms, referrals pads, etc.)</li> <li>Whether PO will accompany HP staff in their first visit</li> <li>A debriefing and second training session will be held at the end of the PPs census</li> </ul>			

**SECOND TRAINING SESSION**

<b>Steps</b>	<b>Objective</b> <i>What HP staff should know / do after the training</i>	<b>Contents</b> <i>Essential information to be passed to HP staff</i>	<b>Methodology</b> <i>Organisation of the training session</i>	<b>Tools</b> <i>Material used for training</i>
Step 1 Feed-back and questions and answers on the first PP visit 30 min	1. Clear problems 2. Reinforce what was learnt in the first session		1. Open discussion with participants 2. Write on a board the problems / comments / suggestions made by participants 3. Give answers and summarize	Paper board or black board
Step 2 Medical aspects of TB 30 – 45 min	1. Understand basic medical aspects of TB  2. Be able to answer certain questions on TB / counsel TB patients	1. TB transmission 2. TB symptoms 3. DOTS 4. Side effects 5. Counseling aspects: <ul style="list-style-type: none"> <li>• Diet</li> <li>• Social acceptance</li> <li>• Economic aspects</li> <li>• Risk of default</li> <li>• Screening of children</li> </ul>	Slide show	Slides Projector
Step 3 Follow up visit 15 min	1. Know the schedule for the follow up visit and who should visit  2. Understand the	1. Schedule for HP staff follow up visits: <ul style="list-style-type: none"> <li>• Once a week for DOTS providers (ANM, MPW)</li> <li>• Fortnightly for referring PPs (PHN, FTMO, CHVs)</li> </ul>	1. Explanation 2. Distribute the bullet point summary of the follow up visit to PPs	1. Bullet point summary of the follow up visit to PPs on paper to be distributed

	<p>purpose of the follow up visit</p> <p>3. Know the procedure for the follow up visit</p>	<ul style="list-style-type: none"> <li>• Once a month for non referring PPs (FTMO)</li> </ul> <p>2. The PO will accompany HP staff on their first follow up visit and reinforce advocacy</p> <p>3. Procedure:</p> <ul style="list-style-type: none"> <li>• Check referral pads</li> <li>• Check whether thank you note was received</li> <li>• Give feed back on patients referred</li> <li>• Get feed back from PPs</li> <li>• Distribute IEC material when required</li> </ul>		<p>2. Panel with bullet point summary of the follow up visit to PPs to be hung in HP</p>
<p>Closure of the training session</p>	<p>Thank all the participants</p> <p>Announce the proceeding for the next weeks:</p> <ul style="list-style-type: none"> <li>• PO will come to accompany HP staff</li> <li>• Contact number of project staff in case of problems with PPs</li> </ul>			