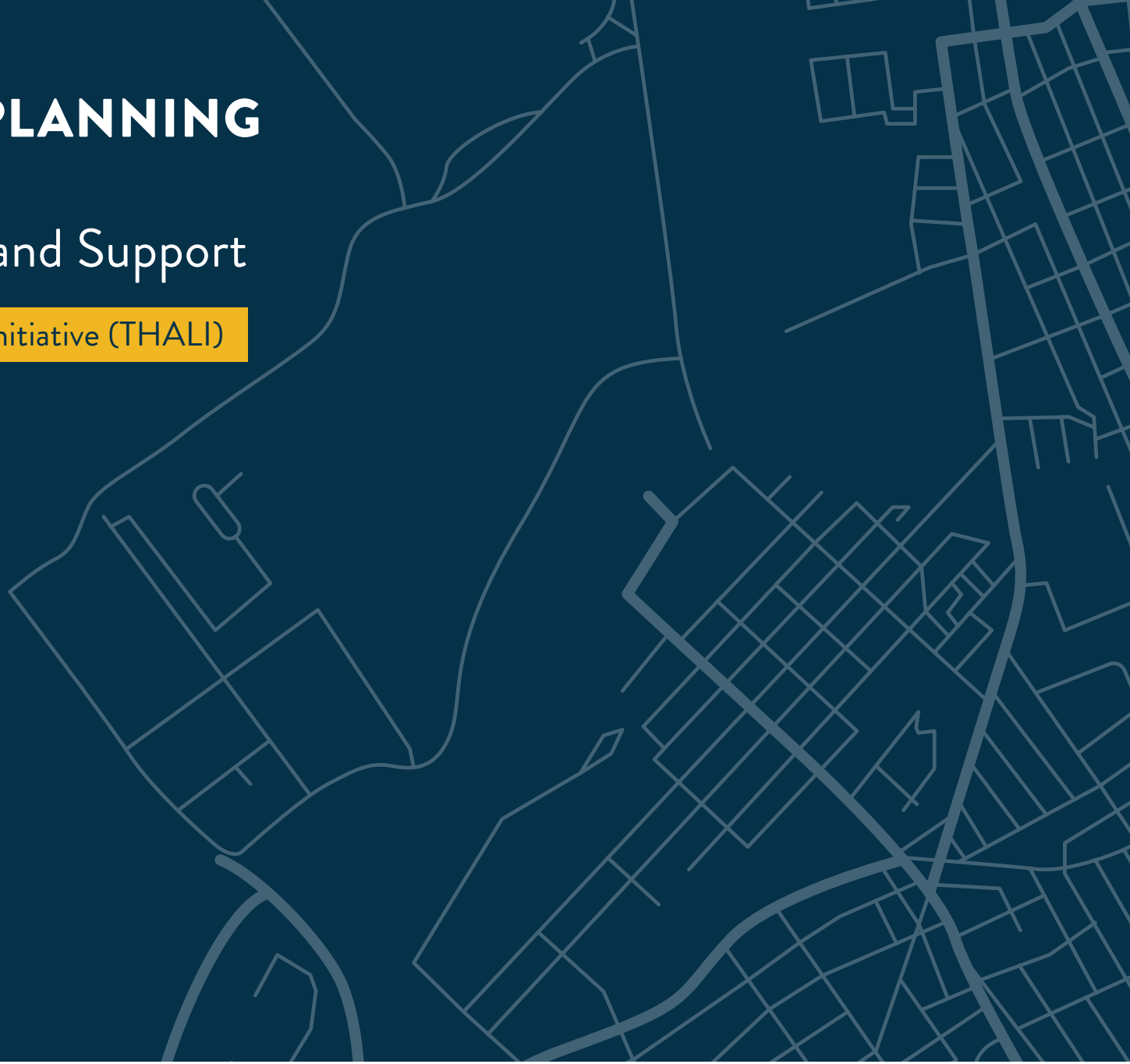
A GUIDE TO MICROPLANNING AND OUTREACH

for TB Prevention, Care and Support

Tuberculosis Health Action Learning Initiative (THALI)



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A Guide to Microplanning and Outreach for TB Prevention, Care and Support

This guidance document describes a microplanning strategy for focused care and support activities developed under the Tuberculosis Health Action Learning Initiative (THALI) funded by the United States Agency for International Development (USAID) and implemented by KHPT and TB Alert India. It presents the project's microplanning processes within the context of a patient-centric framework that is responsive to every TB patient's needs, conditions, situations, contexts and challenges. It offers a step by step guide to planning that is integrated within the state NTEP's existing systems and structures.

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ABBREVIATIONS

AIDS	Acquired Immuno Deficiency Syndrome
CC	Community Coordinator
CHW	Community Health Worker
DMC	Designated Microscopy Centre
DOT	Directly Observed Treatment
HIV	Human Immunodeficiency Virus
HRA	High Risk Area
IPC	Interpersonal Contact
LFU	Lost to Follow Up
LGM	Large Group Meeting
MDR TB	Multi Drug Resistant TB
MERL	Monitoring, Evaluation, Research and Learning
MPR	Monthly Progress Review
MTB	Mycobacterium tuberculosis
NSP	National Strategic Plan
NTEP	National Tuberculosis Elimination Programme
PCS	Prevention, Care and Support
PHC	Primary Healthcare Centre
PRAD	Patient Referral and Diagnosis
PSG	Patient Support Group
RANA	Risk and Needs Assessment
SGM	Small Group meeting
STS	Senior Treatment Supervisor
STLS	Senior Tuberculosis Laboratory Supervisor
TB	Tuberculosis
TBHV	Tuberculosis Health Visitor
THALI	Tuberculosis Health Action Learning Initiative
TU	Tuberculosis Unit

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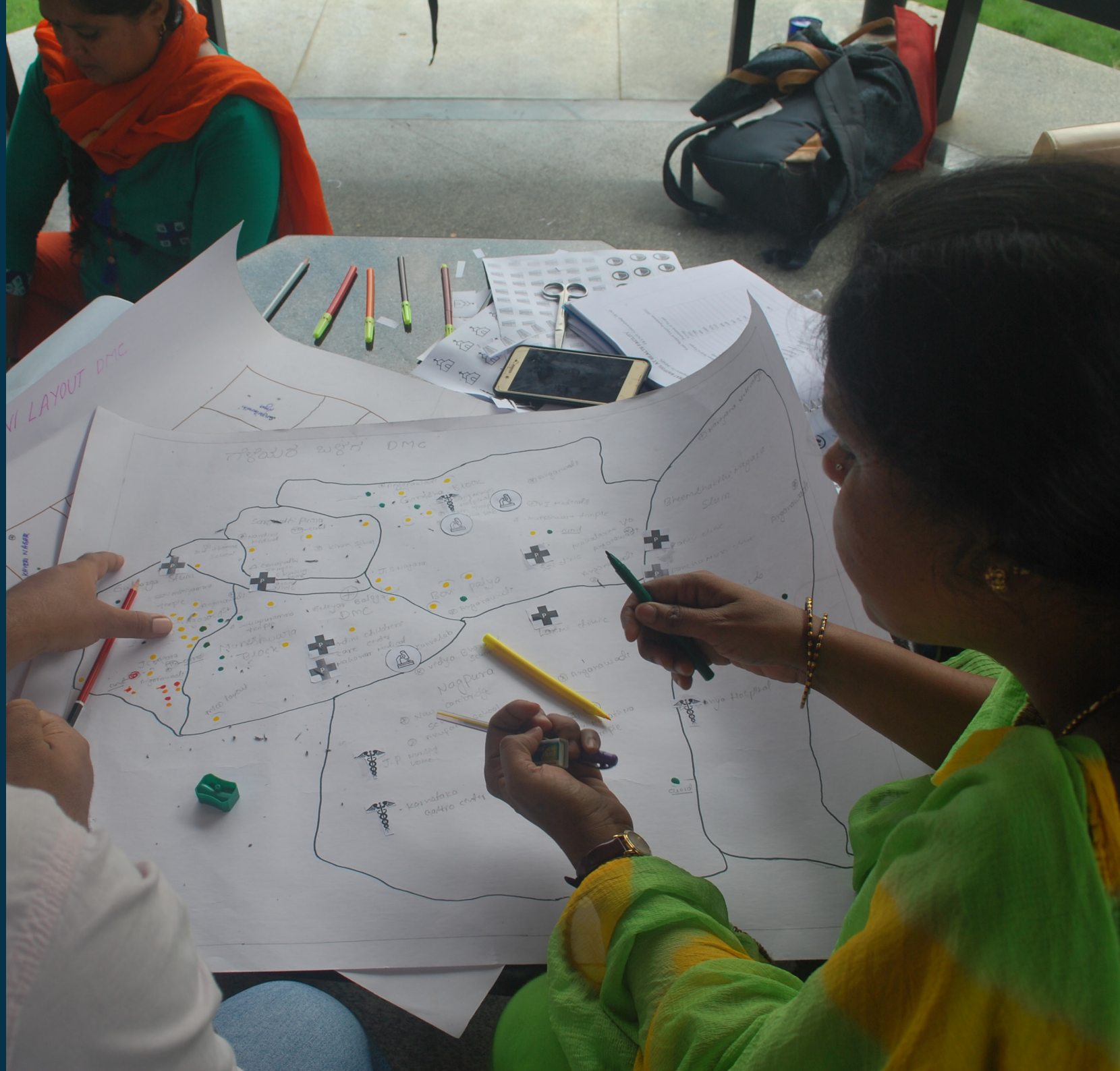


SECTION

01

Introduction

About Tuberculosis (TB)

TB is an infectious disease usually caused by Mycobacterium tuberculosis (MTB). Tuberculosis generally affects the lungs, but can also affect other parts of the body. Most infections do not have symptoms, in which cases they are known as latent tuberculosis.

The classic symptoms of active TB

Chronic cough, sometimes with blood-containing sputum

Fever

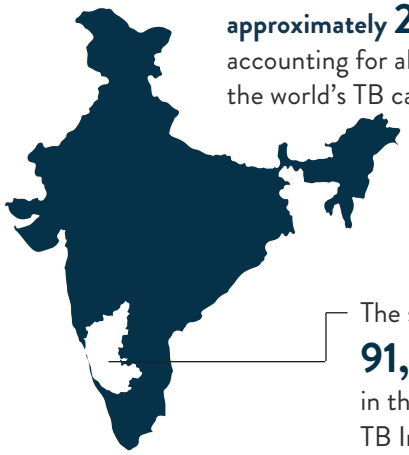
Night sweats

Loss of appetite

Weight loss

- TB spreads through the air when people who have active TB in their lungs cough, spit, speak, or sneeze. People with latent TB do not spread the disease.
- Conditions which predispose individuals to TB include overcrowding or being in close proximity with an infected person, diseases which lower human immunity like HIV/AIDS and diabetes, under-nutrition, and smoking.
- The very young and the elderly are also vulnerable due to their age and, therefore, lower immunity levels. TB continues to remain a public health concern globally and India is no exception to this.

The need for microplanning



According to World Health Organisation's Global TB Report 2019, the estimated incidence of TB in India was **approximately 2,690,000** accounting for about a quarter of the world's TB cases

The state of Karnataka notified **91,703 TB cases** in the year 2019, according to the TB India Report 2020 (135 cases/ one lakh population)

Although different levels of intervention, care and support services are required for patients based on the type of TB, gender, vulnerability profile and duration of treatment, there are no guidelines or prioritization plans for such patient-centric interventions.

The National Strategic Plan for Tuberculosis Elimination (2017-2025) has an umbrella approach for all TB patients, with a focus largely on cases of Multi-drug Resistant TB (MDR - TB).

Other vulnerabilities, including age, co-morbidities, addictions and occupation are not specifically addressed. In this context, the microplanning tool provides an effective outreach model to reach out to a greater number of TB patients within a short period of time, and also to provide priority-based interventions for vulnerable TB patients.

Tuberculosis Health Action Learning Initiative (THALI)

The Tuberculosis Health Action Learning Initiative (THALI) is a patient-centric, family-focused TB prevention and care initiative supporting vulnerable people gain access to quality TB care services from health care providers of the patient's choice. In the first two years of the project, which is funded by the United States Agency for International Development (USAID), Karnataka Health Promotion Trust (KHPT) and implementation partner TB Alert India worked in 3 districts in the two large cities of Bengaluru (Karnataka) and Hyderabad (Telangana). In Years 3 and 4, based on input from USAID and the state governments, additional geographies were added to THALI, expanding its reach to 15 districts of Karnataka, 6 districts of Telangana and 3 districts of Andhra Pradesh.

THALI's overarching goal is to increase TB case finding and improve TB treatment outcomes.

Key objectives

To demonstrate community-centred and community-driven interventions to improve health seeking behaviour and service delivery to increase TB case finding and improve treatment outcomes among people diagnosed and initiated on treatment.

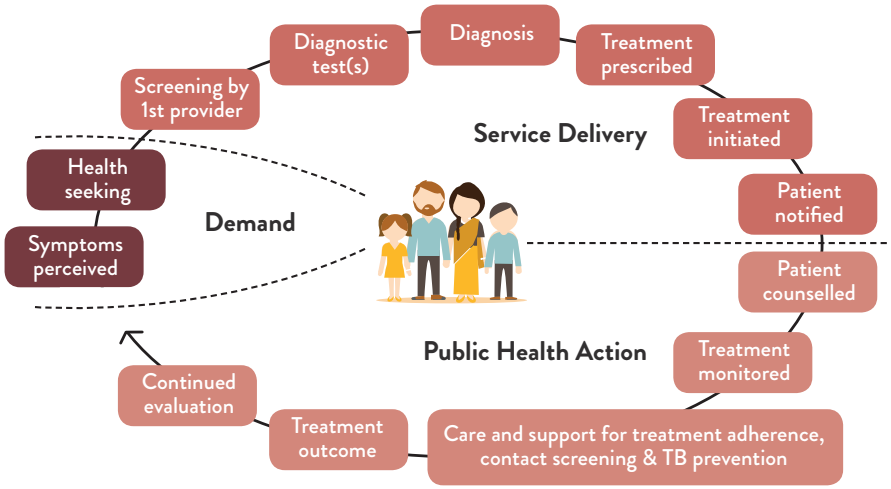
To support and develop capacity of the NTEP, and leverage public resources to improve access to acceptable and quality TB services from public and private care providers, thereby increasing case finding and improving treatment outcomes.

To develop and demonstrate models and innovations which may be scaled up and replicated.

THALI's approach

THALI's approach to eliminate TB involves multi-sectoral collaboration, integration with the NTEP, and the demonstration of evidence-based models and innovations that address the needs and service gaps identified in the continuum of TB care (see figure on the right).

Illustration 1: Continuum of Care



THALI's strategic framework

THALI offers a platform for an integrated and collaborative approach to TB elimination. It engages closely with the state NTEP to build capacities to improve TB case finding and case holding through efficient systems for patient centric service delivery. It promotes a multi-stakeholder approach that calls for an engagement with community structures, frontline health workers, the NTEP and non- traditional investors towards resource optimization, evidence generation, innovation and learning, with a focus on improving outcomes for all TB patients and ultimately, supporting the government's goal of TB elimination by 2025.

THALI's key activity streams

01 Community Engagement

Aims to demonstrate community-centred and community-driven interventions to improve

- health seeking behaviour and service delivery to increase TB case finding
- treatment outcomes among people diagnosed and initiated on TB treatment

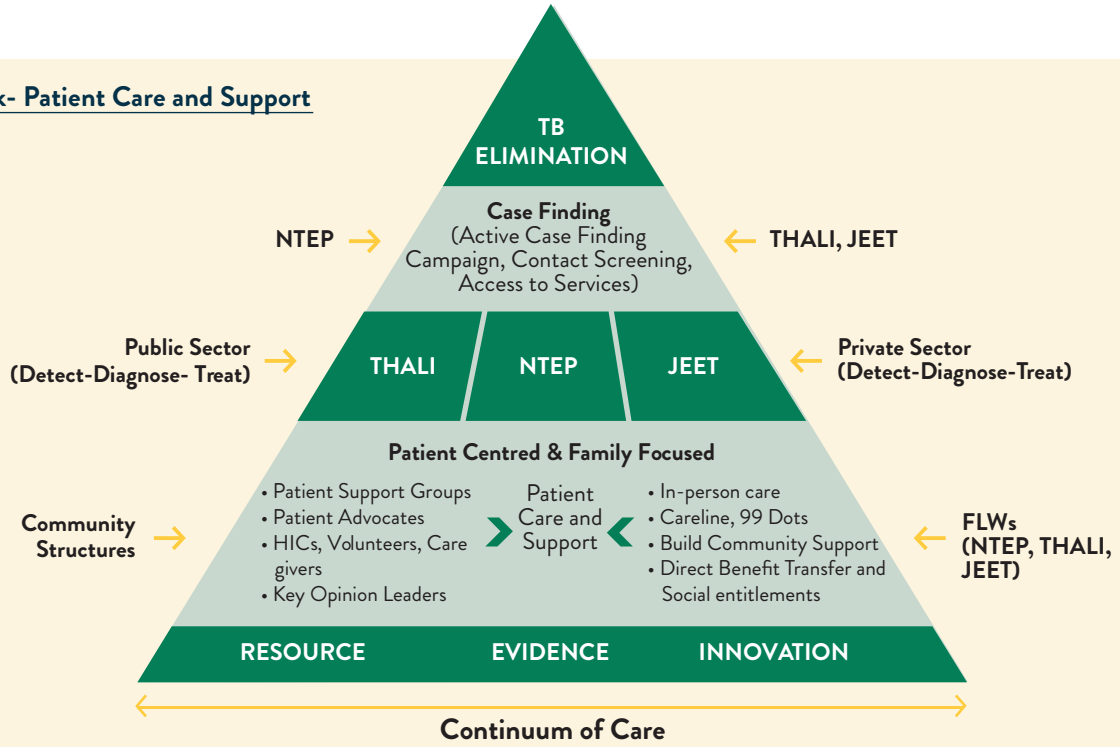
02 Government Engagement

Aims to support and develop the capacity of the NTEP, and leverage public resources to improve access to acceptable and quality TB services, thereby increasing TB case finding and improving treatment outcomes.

03 Cross-platform THALI activities

- Monitoring, Evaluation, Research and Learning (MERL)
- Partnerships and Communications
- Demonstration of technology-based solutions to improve efficiency

Strategic Framework- Patient Care and Support



FLWs- Frontline Workers, HICs- Health Information Centres, JEET- Joint Effort for Elimination of Tuberculosis, RNTCP- Revised National Tuberculosis Control Programme

Community Engagement

Community engagement forms the backbone of THALI's interventions and it's two pillars are:

MICROPLANNING

Microplanning refers to the process of identification, assessing, prioritising and documenting the needs of the community in any given focus area. These "focus areas" are identified to have a high concentration of communities that are potentially at greater risk of developing TB than others. Microplanning helps to plan outreach activities of the project, that build efficient mechanisms for service delivery and sustained behavioural impact among the communities in these focus areas.

OUTREACH AND COMMUNICATION

Community-centred outreach refers to processes that build sustained community-level contacts (with individuals, families and larger groups) within the target population in a given focus area. Effective outreach involves maximum coverage, regular contact, and consistent provision of follow-up services to ensure quality TB treatment, as well as care and support services to patients across the continuum of care. Outreach also includes contextualized communication to promote appropriate health seeking behaviour among high-risk populations and TB patients through various platforms/ media deemed most suitable for creating behaviour change.

SECTION

02

Target Populations and THALI Outreach Workers

The primary target population for THALI includes TB patients and their families who need care and support services for better treatment outcomes.

Secondary target population groups include the following:

The urban poor concentrated in designated 'notified', or undesignated urban slums

High-risk occupation groups such as construction workers, painters, miners and garment industry labour

Persons with co-morbid conditions, like HIV/AIDS, under-nutrition and diabetes

Tribal populations, especially indigenous tribes with poor access to quality health services

Vulnerable sub-populations including women, children and the elderly who tend to be additionally marginalized, neglected and prone to inequitable access to health care

THALI project relies on a cadre of outreach workers called Community Health Workers (CHWs) at the field level.

The CHWs are responsible for identifying target populations, assessing their needs, linking them to timely TB treatment, care and support services, carrying out behaviour change communication at individual and household level as well as ensuring regular follow up for better treatment outcomes. The next layer of staff includes the Community Coordinators (CCs) who are responsible for handholding and providing supportive supervision to CHWs to ensure quality of outreach activities and alignment with the expected outcomes of THALI program.

The Microplanning process is implemented by the CHWs, in close collaboration with the NTEP staff, with the support of CCs. This process is intended to support the CHWs develop outreach plans and activities for each of their areas of operation.

SECTION

03

THALI's Alignment with NTEP Structure

THALI has aligned all its activities to meet the goals and objectives of the Government of India's National Strategic Plan. KHPT has also configured its program processes to align functionally and administratively with the NTEP's structure. This allows for better coordination, greater ownership and seamless transition of program innovations, models and learnings to the NTEP after THALI's closure.

The NTEP structure comprises a State TB Cell, District TB Centre, Tuberculosis Units and Designated Microscopy Centres.

The **Designated Microscopy Centre (DMC)** is configured for a population of 1,00,000. The DMC is the smallest unit at which all programs related to TB are implemented.	At the next level is the **Tuberculosis Unit (TU)** which is configured for a Population of 2,50,000.
Each DMC has a Tuberculosis Health Visitor (TBHV), Lab Technician and Pharmacist (the Lab Technician and Pharmacist sometimes are shared resources for the National Health Mission and NTEP).	Each TU is headed by a STS (Senior Treatment Supervisor).
Bengaluru has 104 DMCs with 72 in Bengaluru city and 34 in Bengaluru Urban district. On average, there are 145 patients under care at each DMC.	Bengaluru, for example, has 24 TUs.

THALI staff align with the NTEP's organizational structure at all levels, as seen in the illustration below.

Illustration 3: THALI- NTEP manpower alignment

THALI		NTEP	LEVELS
Zonal Coordinator	↔	District Tuberculosis Officer (DTO)	District level
Taluk Coordinator (TC)	↔	Medical Officer Tuberculosis Centre (MOTC) and City Tuberculosis Officer (CTO) (3)	Zonal level
Community Coordinator (CC)	↔	Senior Treatment Supervisor (STS) and Senior TB Laboratory Supervisor (STLS)	TU level
Community Health Workers (CHW)	↔	Tuberculosis Health Visitor (TBHV)	DMC level

In the context of Microplanning, the THALI and NTEP staff (CHWs, TBHVs, CCs and STS) at the DMC and TU level are responsible for outreach and follow-up for TB patients, and are closely involved in the process of developing microplans. ***See Annexure 1 for roles and responsibilities of TBHV and STS.***

SECTION

04

Microplanning Tools and Processes

Microplanning

As the name itself suggests, microplanning refers to the process of identification, assessing, prioritising and documenting the needs of individual community members in any given focus area and planning to reach them and provide services through optimum resource allocation. Microplanning is used to identify priority communities, address barriers, and develop work plans for outreach with solutions.

Specific objectives of the microplanning process

To define the focus area for the CHW by assessing the concentration of Chest Symptomatic cases and TB patients in the given geography

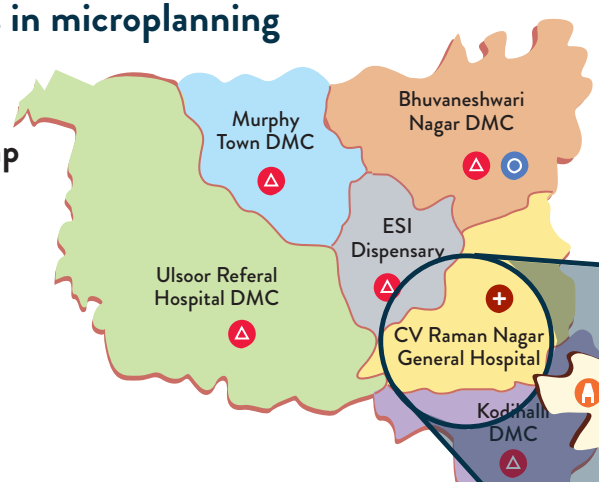
To develop a detailed understanding of the focus area and DMC area for planning the CHW's outreach activities

To support the front line workers/ grassroot workers (CHWs and TBHVs) in developing comprehensive patient-centric care, support and communication plan on a monthly basis for every TB patient and their families to ensure positive treatment outcomes

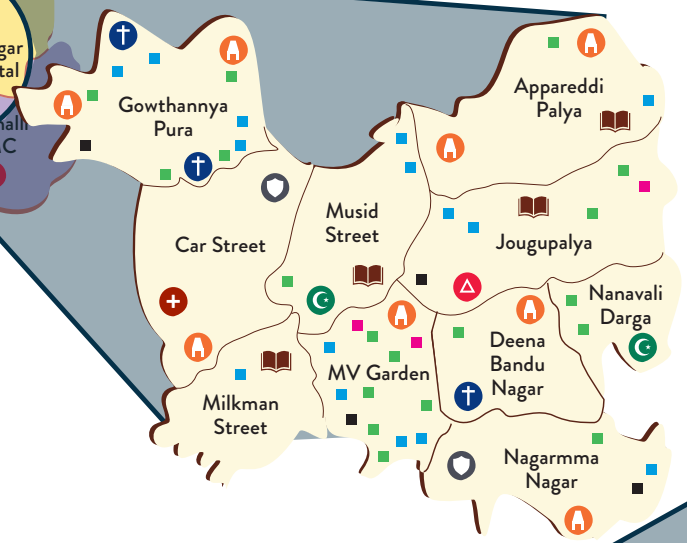
The microplanning tools and processes described below were developed jointly by the THALI and NTEP staff.

Steps in microplanning

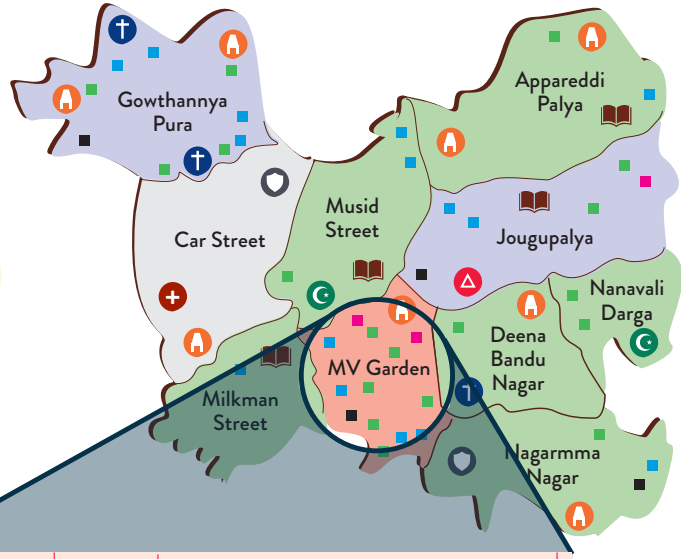
1. Ulsoor TU Map



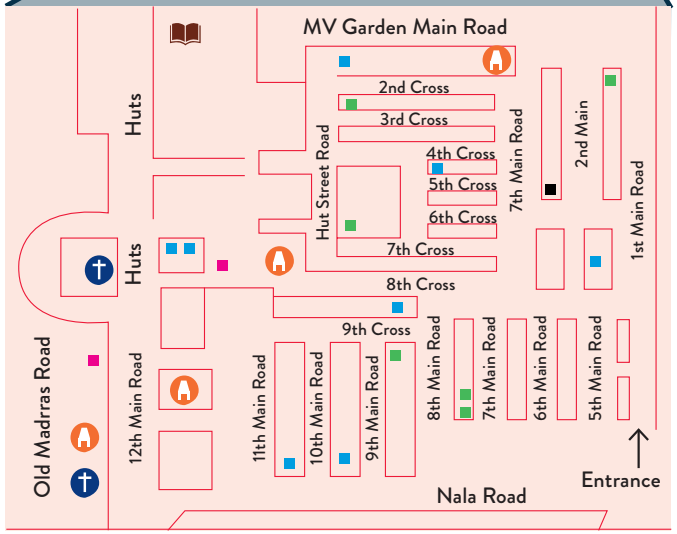
2a. CV Raman Nagar DMC Map



2b. CV Raman Nagar Segmented DMC Map



3. MV Garden Focus Area Map



PHC	○	Death	■
PHC DMC	△	Cured	■
General Hospital	+	Temple	
Medical College		Church	
MDR	■	School	
On Treatment	■	Masjid	

TOOL 1

Tuberculosis Unit Map

The first level of microplanning is at the TU level. THALI considers the importance of every TB patient in achieving program objectives. Microplanning starts at a broader level to obtain a better view of the spread and concentration of TB patients in the area and then zoom into smaller specific geographies to prepare for patient-centred planning. Each TU currently caters to a population of 4 to 4.5 lakh persons in Bengaluru. On average, there are about five DMCs in each TU area.

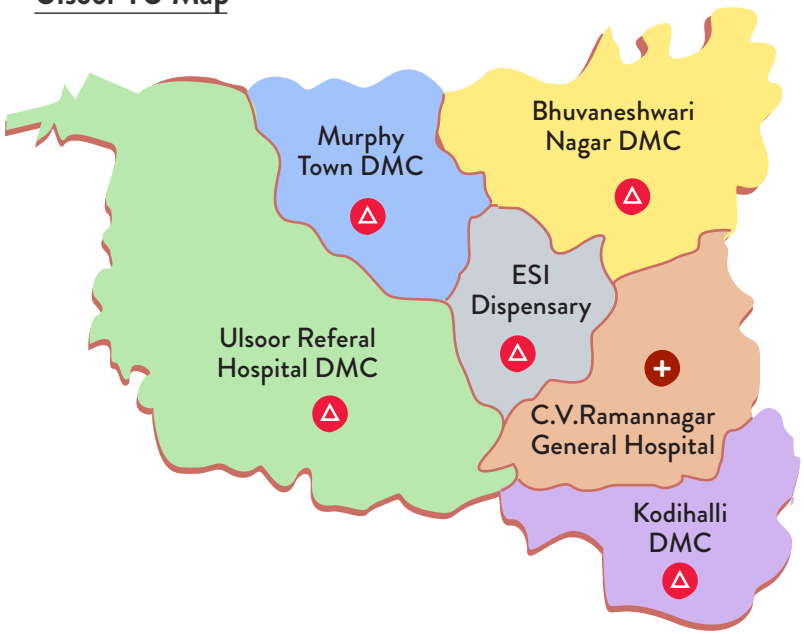
Following will be plotted on the TU map, using legends convenient to frontline workers

1. Available health system facilities: DMC, Primary Health Centres (PHCs), TU Headquarters, and Sub-Centres
2. Services: CBNAAT centres, Diagnostic centres (X-Ray and lab facilities, sputum testing centres), NTEP functionaries (STS, STLS, TBHV)
3. Institutions: Old age homes, orphanages and other children's institutions, de-addiction centres and prisons
4. High-risk pockets: Slums, brick kilns, construction worker sheds, residential areas with migrant workers, factories such as garment factories and incense factories
5. Number of TB patients in the TU area
6. Demarcation of the TU into corporation wards
7. Facilities for patient referrals outside TUs
8. Names and key information about important individuals in the area, such as the Council members of each ward, ASHA workers, and other influential leaders.

The team will follow the steps below in developing the TU-level maps

1. The TU-level map is developed in consultation with the STS and TBHV
2. Outline the map of the TU and locate the number of wards
3. Demarcate the ward numbers in different colours
4. Facilitate discussion with the STS and TBHV to spot all the facilities/services/ institutions in the map (as listed above)
5. Mark the TB patients in the in the TU area.
6. Include both TB patients who are currently on treatment and those who have completed treatment.
7. Insert the legends for each facility/services in the map.

Ulsoor TU Map



PHC		Death	
PHC DMC		Cured	
General Hospital		Temple	
Medical College		Church	
MDR		School	
On Treatment		Masjid	

TOOL 2

Cluster Map/DMC Map

STAGE 1:
After TU-level mapping, the next level of microplanning would be undertaken at the level of the DMC, which covers a population of 1,00,000 on average.

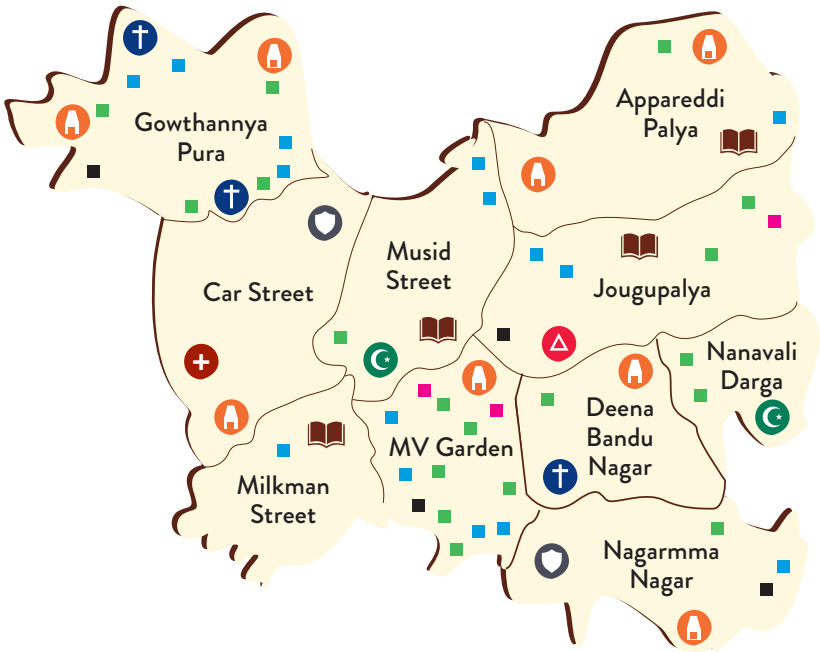
Following will be plotted on the DMC map

1. The slums/ focus areas with the population
2. TB patients, identified by NTEP, who are currently on treatment
3. TB patients, identified the THALI team, who are currently on treatment
4. TB patients who have completed treatment
5. Private sector patients identified throught the Joint Effort for Elimination of Tuberculosis (JEET) project (wherever JEET is being implemented)
6. High-risk areas including construction sites, old age homes, orphanages, garments, small-scale industries, and the unorganised sector (high risk and high volume industries).
7. Health functionaries and FLWs- TBHVs, THALI CHWs, ASHAs, Anganwadi Workers (AWWs) and health inspectors.
8. Infrastructure and landmarks- Anganwadi centres, Corporator's office and residence, community halls, park, temples, mosques, ration shops, churches, schools (both private and government), Indira canteens
9. Youth groups and Self-help Groups (SHGs)
10. DOTS centre: ASHA, AWW, Clinics, Pharmacies.
11. Preferred providers where people of the geographic area go for treatment.

The team will follow the steps below while developing the DMC level-maps

1. The THALI CHW and the TBHV responsible for the given DMC area will jointly develop the DMC-level microplan
2. The information needed to plot the map will be obtained from appropriate information sources such as the CHWs, TBHVs, STS and other PHC staff or ASHAs.
3. They will focus on the verified number of TB patients in the area who are currently on treatment
4. They will also highlight the lost to follow-up (LFU) cases in the DMC area
5. Insert the legends for each facility/services in the map

CV Raman Nagar DMC Map



PHC		Death	
PHC DMC		Cured	
General Hospital		Temple	
Medical College		Church	
MDR		School	
On Treatment		Masjid	

TOOL 2 Cluster Map/DMC Map

STAGE 2: Segmentation of the DMC Map

Once the DMC-level maps are done, the team will segment the DMC area according to the number of TB patients and their concentration. The segments will be drawn according to the criteria shown below.

Segmentation of DMC areas

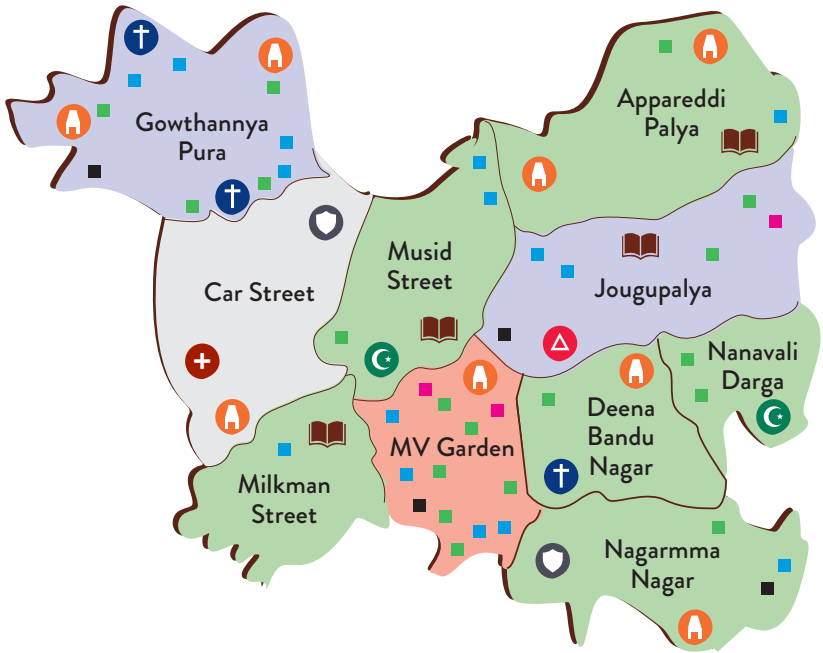
Criteria

- 0 cases - no patient (white)
- 1-5 cases - Low priority (green)
- 6-10 - Medium priority (yellow)
- >10 - High priority (red)

Focus area maps will be developed only where there are patients

The purpose of the segmentation is to help CHWs and TBHVs prioritise those segments within the DMC area that show a high concentration of TB patients, both under treatment and those who complete treatment, as well as LFU cases.

CV Raman Nagar Segmented DMC Map



PHC		Death	
PHC DMC		Cured	
General Hospital		Temple	
Medical College		Church	
MDR		School	
On Treatment		Masjid	

TOOL 3

Focus Area Map (High-Risk Area Map)

After completion of the DMC-level mapping, the team will map the focus area within each DMC area. The focus area will be defined by the concentration of TB patients both under treatment and those who complete treatment, as they are both significant for providing care and support services. The focus area map, the last level of the microplanning, is aimed at supporting CHWs and TBHVs in developing individual patient-centric plans for outreach and follow-up.

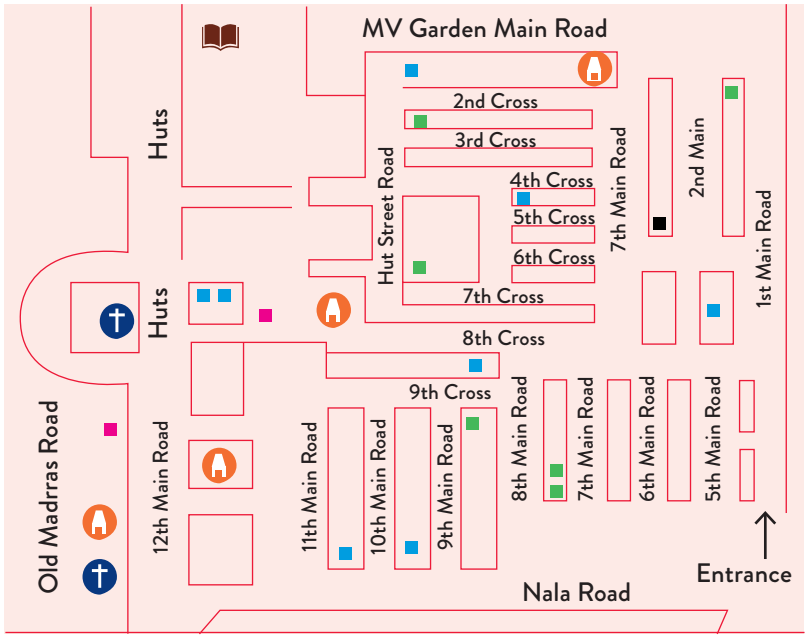
Following will be plotted on the focus area map

1. Individual TB patients who are currently under treatment (both NTEP and THALI)
2. Individual TB patients who have completed treatment
3. Private sector patients (under the JEET project)
4. Patients with co-morbidities such as HIV and Diabetes, patients over 60 years of age, alcoholic patients
5. Migrant patients
6. LFU cases
7. Houses of TB patients who died in the last one year
8. Lanes and streets within the area
9. Infrastructure and landmarks like the Anganwadi centre, community halls, private clinics and labs, temples/mosques/churches

The team will follow the steps below in developing the focus area maps

1. The CHWs and TBHVS will ascertain the focus areas depending on the concentration of TB patients plotted in the DMC-level maps.
2. They will develop the maps at the community level in consultation with the TBHV and local health workers.
3. The TB patients are represented by different colours for indicating case characteristics and level of priority. The individual TB patients will be prioritised as seen below:
   HIGH Priority - Intensive phase (IP) of treatment, Co-morbidities such as HIV or diabetes, or alcoholic patients
   MEDIUM Priority - regular treatment
   LOW Priority - completed treatment
4. Insert the legends for each facility/services in the map.

MV Garden Focus Area Map



PHC		Death	
PHC DMC		Cured	
General Hospital		Temple	
Medical College		Church	
MDR		School	
On Treatment		Masjid	

Updating of the Microplans / Maps

The maps at the focus area levels will be updated every month to include new cases and to revisit the individual outreach and PCS plans for the CHWs and TBHV. The TU-level and DMC maps can be revisited every six months to assess and analyse the shifts in the concentration of the TB patients in the area. Since the infrastructure is likely to remain the same, the CHWs may use the same map and use removable stickers or bindis to indicate patients.

Microplanning Tools

Once the maps are ready, CHWs will be able to plan their outreach based on the numbers of Chest Symptomatics and patients in a given geography, and carry out their activities according to the plan. To effectively capture and facilitate the process of case finding, case holding and prevention, care and support, the following tools will be used by CHWs.

Microplanning Tools used for Outreach

TB patient line list

Purpose

- To plan and implement in-person care and support for TB patients
- To plan the number of visits
- To plan PSG meetings based on clustering of patients.

Process

TB patients' line list to be updated from the DMC register or NIKSHAY data.

Frequency

Monthly

Patient Referral and Diagnosis (PRAD) form

Purpose

- To refer TB symptomatics for testing and diagnosis

Process

Whenever a TB symptomatic is identified (during interpersonal contact, group meetings and during contact tracing). The PRAD form is issued during follow-up

Frequency

For each referral, at the time of making referral

Risk and Needs Assessment (RANA)

Purpose

- To assess the risk and needs of the patients
- To customise intervention and support patients to complete their treatment successfully

Process

Whenever a patient is initiated on treatment, the treatment initiator (TBHV/STS/ Pharmacist/ CHW) will assess the patient and fill the RANA form

Frequency

At the time of initiation of treatment

Patient Care and Support (PCS) form

Purpose

- To capture in-person care and support activities done for the patient
- To capture the status of the risks and needs of the patient, future tests and end results.

Process

After RANA, the PCS form is filled once consent is taken from the TB patient. It has to be updated after each visit.

Frequency

At each in-person care and support visit for the patient.

CHW Planning / DMC-level Planning

Based on the progress of the previous month and the updated list of patients, the planning for subsequent months must be done at the beginning of each month. Patients have to be segregated by their phase of treatment, Intensive Phase (IP) or Continuation Phase(CP). Field activities, along with plans for interpersonal contact (IPC), Patient Support Group (PSG) meetings and community engagement activities have to be filled into the monthly planner of the CHW diary, as explained above.

Prioritization

Prioritization of outreach for TB patients by CHWs/ TBHVs will be done according to the table below. Patients who are in the IP will be checked on / followed up by CHWs on a weekly basis and patients who are in the CP will be followed up with at least once in 15 days. For active cases within households and surrounding houses, patients who are 3+ AFB positive will be given first priority. The prioritization process helps frontline staff reach the neediest patients on time, to provide them required services. The table (on the right) shows a schedule of visits, with each ● representing one visit.

CHWs also focus on high-risk occupation sites (if patients are found) in and around DMC areas. These include garment factories, construction sites, factories etc.. This will be done through IPC and Large Group Meetings.

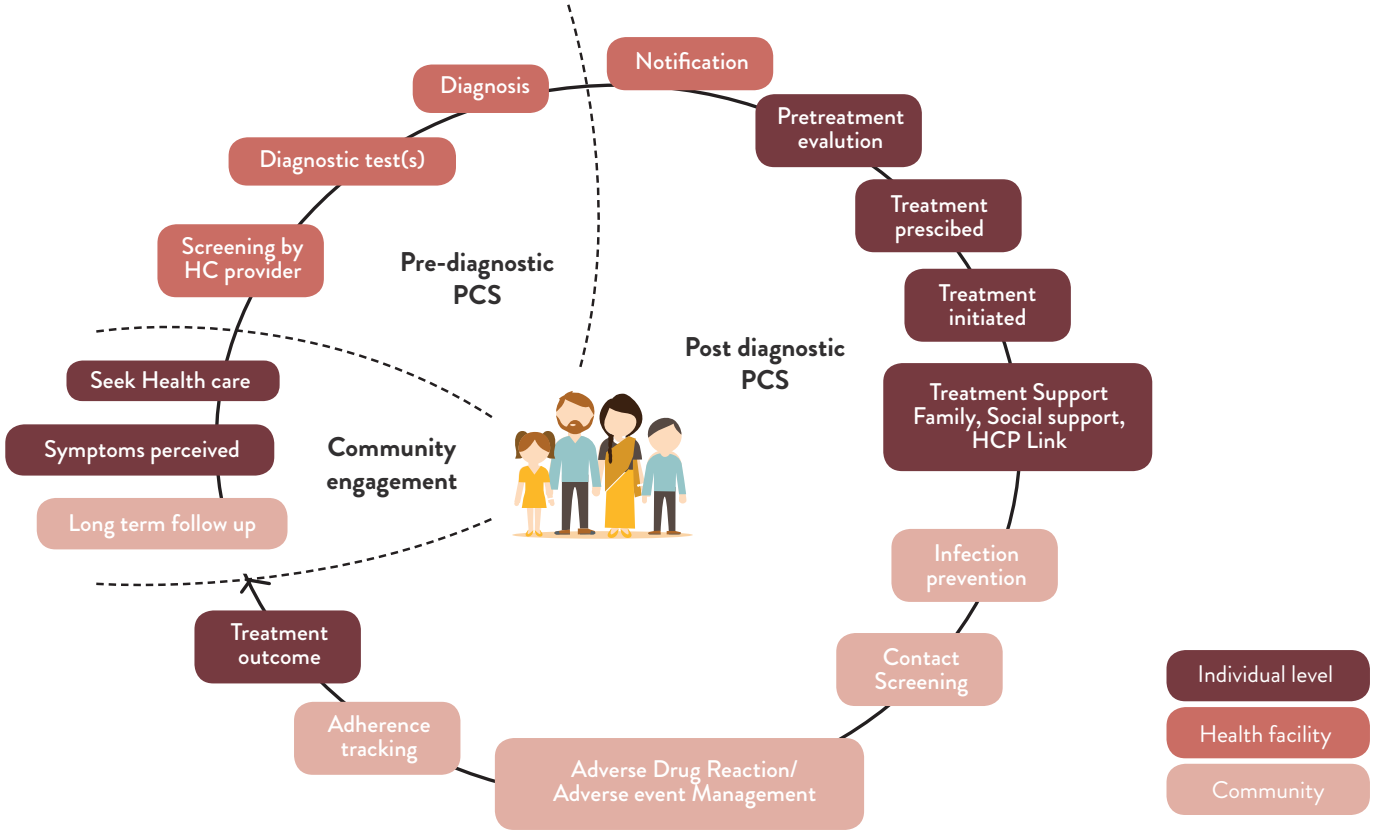
	Week 1	Week 2	Week 3	Week 4
>10 patients (High priority area)	●●	●●	●●	●●
6-10 patients	●	●	●	●
1-5 patients		●		●
Accompanied referral for treatment initiation	●	●	●	
Weekly Progress Review Meeting with CC	●	●	●	●
Meeting with DMC/ Data collection at DMC		●		●
TU-level meeting				●
Patient Support Group meeting of TB patients and family members/caregivers				●
Small group meetings at institutions in high risk areas				●
No patients (low risk area)	ACF campaign twice a year			
District Level - Monthly Progress Review (MPR) Meeting				●

Each dot (●) represents one home visit by CHW.

In-Person Care and Support

The NSP has clearly stated that a good patient support plan is imperative for treatment success, and should be developed at the time of initiation of treatment. The main objective of THALI is to develop a patient-centric and family-focused care and support model to ensure positive treatment outcomes for all TB patients. This support is shown in the figure below.

Prevention, Care and Support (PCS) Activities at Different Levels



Activities carried out by CHW as part of patient care and support

To achieve comprehensive PCS for TB patients, CHWs will carry out the following activities to complement the activities of TBHVs and STSs.

No.	Activity/Intervention	Methods	Tools
1	Patient + family support contact (house visit/ community)	Monthly plan	Monthly planning tool
2	Risk and needs assessment at individual and family level (medical and social) 1. Identify children below the age of 60 months (5 years) and refer to the paediatrician and follow-up 2. Contact screening 3. Follow-up for those >60 years (focus on adherence) 4. Comorbidities (HIV and Diabetes) - follow up frequency will increase	Patient + family visits Assessment of the following: • Treatment adherence, • Family support • Comorbidities • Nutritional status	Contact screening (currently PCS Card)
3	Identification of patients who need special care and referring them to higher level (CC/STS)	Risk assessment carried out during patient contact	RANA, PCS Card
Other Forms/Formats			
4	Filling up applications for patient welfare schemes	CHW helps fill forms and CC arranges for a camp to compile all applications forms and support submission	
5	Conducting follow-up tests- Sputum, HIV, Anaemia, Diabetes	Local facility (private or public) based on patient choice	PCS Card
6	Mobilization of nutritional support for patients	Engaging Corporator, MLA, Anganwadi centres, mid-day meal schemes, sponsors, Akshaya Patra	PCS Card
7	Facilitation of TB Patient Support Groups	Monthly meetings at DMC or PHI focusing on emotional support, adherence, side-effects etc	PSG reporting format
8	Identification of TB Patient advocates	Identification and enabling of patient advocates to help other patients/represent patients' interests to health authorities	Line list of PAs

These activities by the CHWs will enable the patient to overcome the barriers in the way of adherence and to complete the full course of treatment properly, resulting in successful treatment outcome.

Community Coordinator's Planning / TU-level Planning

Based on the CHW plans, the CCs will draw up their plans, keeping in mind the capacities of CHWs and the extent of support they require from CCs to carry out their responsibilities in the field. CCs will plan to monitor and supportively supervise the CHWs through accompanying visits to the field and handholding support to CHWs, as well as weekly progress review meetings. They will also oversee the documentation and reporting, identifying and rectifying inconsistencies. If need be, they will conduct a capacity-building session on implementation / documentation. Additionally, CCs will also plan to visit TUs and attend TU level meetings with the NTEP, so that the progress at TU level can be shared and they can advocate for collaborative planning and implementation of THALI and NTEP activities.

Monitoring and Review

Regular reviews will help understand the program's progress, allow analysis of the gaps and formulation of a plan to fill those gaps.

Weekly Meetings led by CC

- Every week
- CHWs, concerned CC

Monthly Progress Consolidation cum Review Meeting led by CC

- Monthly
- CHWs, concerned CC

Monthly Progress Review Meeting (District Level) led by District Lead

- Monthly
- District team with District/Project Lead

CHW Diary

To ease the burden of maintaining a number of formats for different activities, THALI piloted a single diary which helps CHWs in planning outreach as well as completing documentation. The CHW Diary is a comprehensive single book of records that compiles all the formats related to referrals, diagnosis and in-person follow-up. This diary can potentially replace multiple record books, communication materials and planning calendars, and integrate all required documentation into one single record.

Implementing organisations may consider developing a single diary for ease of documentation by their cadre of frontline workers. The CHW diary contains the following information:

Section 1 –
General Section

(Filling of this section will be a one-time activity, Maps and other details to be created separately)

1. Brief details of the CHW – 1 page
2. Brief description of the DMC, with details of contact persons details such as health facility staff and Key Opinion Leaders – Upto 2 pages.
3. Community Engagement Activities – Details of Community Structures with numbers of referrals each month- Upto 2 pages
4. Microplanning Maps – TU Map and DMC Map – 1 page each, High-risk Area (HRA) Map – 1 page for each HRA.
5. List of Holidays – 1 page

Section 2 –
Monthly Specific Sections

(This section has to be filled / updated / planned every month).

1. Monthly Planner – 12 pages for 12 months
2. Demand Generation Sheet with Targets and Achievements section – 1 Page
3. Line list of Chest Symptomatics / Prospective TB cases referred (Referral line list) – 4 to 5 Pages
4. Line list of patients to be followed up for in-person care and support – 4 to 5 Pages
5. Prevention, Care and Support Card (PCS Cards) – 50 cards beginning with one page of codes.
6. Line list of persons requiring INH prophylaxis (Children younger than 60 months and Persons Living with HIV) – 2 Pages
7. BCC materials – Hard copies of all BCC materials.

ANNEXURE 01

Roles and responsibilities of STS and TBHVs

Role of Senior Treatment Supervisor (TU Level)

1. Assist District TB Officer *DTO) and Medical Officer TB Control to carry out all TB control activities under NTEP including Programmatic Management of DRTB (PMDT), TB/HIV coordination and Public –Private Mix.
2. Coordinate with all concerned to ensure that all contacts of sputum positive patients are screened for TB
3. Assist the Medical Officer in organizing DOT services for TB patients in his/her assigned TU
4. Ensure retrieval of LFU cases as per schedule.
5. Maintain the TB Register, incorporating required information with respect to all cases diagnosed in the Block/TB Unit; ensure notification of TB Cases in his/her assigned TB Unit
6. Supervise referral and feedback/transfer-in & out activities for TB patients in assigned TB Unit
7. In close coordination with STLS, assist MOTC in preparation of Quarterly Reports on case finding, sputum conversion & treatment outcome, Programme Management and submission to the DTO. 8. Supervise each PHC in the area at least once every month, on a systematic schedule.
8. Assist DTO and MOTC in ensuring regular supply of drugs and other logistics to all PHIs in the Block/TB Unit.
9. Ensure maintenance of NTEP Drug Stock Register at all stocking points; Monitoring of consumption of drugs with respect to their shelf life and ensure that no drugs get expired.
10. Retrieve unconsumed medicine boxes of patients who have defaulted/died/transfer out etc. and assist in reconstitution of medicine boxes at the district level
11. Visit all patients at home before registration and provide health education and counselling to the patients and family.
12. Facilitate organizing patient provider interaction meetings and community meetings.
13. To facilitate change management with respect to use of ICT & Nikshay tools for concerned data entry, validation & its use for public health action
14. Assist PMDT Coordinator by providing line-list of DRTB suspects and updating the TB Treatment cards of MDR-TB patients on a fortnightly basis, in coordination with STLS
15. Any other job assigned as per program need
16. Identify and facilitate the training of recognized DOT Providers

Role of TB Health Visitors

1. Ensure regularity of DOT for all types of TB patients, as per NTEP guidelines
2. Responsible for decentralization of DOT services and supervision of DOT Centres in the assigned geographic area
3. Verify address of all diagnosed TB patients and educate patients and their families on the plan of treatment.
4. Arrange time and place for DOT, according to the patient's convenience.
5. Ensure that follow-up smear/culture/Drug Sensitivity Testing examinations of sputum are carried out as per the stipulated schedule.
6. Maintain the Treatment Card and record information and transfer this information to the original Treatment Card at the Community Health Centre/PHC/DMC/ treatment centre during periodic meetings.
7. Assist the DTO in establishing TB Surveillance systems (TB Case Notification activities, ICT\)
8. Take steps for immediate retrieval of defaulters; During the intensive phase it should be no later than the day after the default, and during the continuation phase within a week of the default.
9. Assist STS in PMDT, TB/HIV collaborative activities and PPM activities
10. Maintain relevant records. Line-listing of PP/NGO, one-to-one interactions/ sensitization for involvement.
11. To facilitate change management with respect to use of ICT & Nikshay tools for concerned data entry, validation & its use for public health action
12. Any other job assigned as per programme need

Source: http://upnrhm.gov.in/site-files/careers/TOR_NTEP_positions.pdf

ANNEXURE 02

TB patient line list

Patient Referral Line list

Si no	PRAD Id	Patient Name	Contact no & Alternate Contact no	Address	Name of DMC / TU referred to (Code)	Date of referral	Test result /Reason for not testing	Treatment initiation date/ Reason for not initiating treatment	Mode of C&S (Inperson/ RNTCP/ Careline)

In person Care Patient Line List

PCS ID	Nikshay Id	Patient Name	Contact no & Alternate Contact no	Treatment initation date	Contact Tracing done First Month (Yes/ No)	Contact Tracing done End of IP (Yes/ No)	Contact Tracing done end of CP (Yes/ No)	Weight at the time of treatment initiation

Social Protection Support provided by the project																		Date of First followup test	Date of second follow-up test	Patient treatment Outcome	Date of treatment Outcome declaration	Priority for next follow-up visit (Bindi , Date with pencil)	Post treatment follow-up Remarks
Aadhaar		Bank account		Ration Card		DBT		Linked for free Drugs		Nutrition Support		Livelihood Support		Health Related Schemes		Any other Social security scheme							
Need Identified	Support provided	Need Identified	Support provided	Need Identified	Support provided	Need Identified	Support provided	Need Identified	Support provided	Need Identified	Support provided	Need Identified	Support provided	Need Identified	Support provided	Need Identified	Support provided						

ANNEXURE 03

Patient Referral and Diagnosis (PRAD) form

THALI Patient Referral and Diagnosis (PRAD) Form ***PRAD ID:***

1. Details of referring doctor/staff Sector of referring health facility: ☐ Private ☐ Public ☐ THALI

Name of referring provider..... Date of referral DD/MM/YYYY
HCP code HCF code

2. Patient details

Patient's Name:		**Age** .....yrs Date of birth DD/MM/YYYY	**Gender:** ☐ M ☐ F ☐ TG
Religion : ☐ Hindu ☐ Muslim ☐ Christian ☐ Other	**Education :** ☐ Cannot Read/Write ☐ <5 std ☐ 5-10 std. ☐ 12th ☐ Diploma ☐ Graduate ☐ Post Graduate	**Marital Status:** ☐ Single ☐ Married ☐ Widowed ☐ Separated/divorced	**Occupation :**

Patient's address (with landmarks):
TU Name: DMC Name: Pin Code :

Mobile number

Other phone no.

Aadhar no. (if available)

HIV status ☐ Positive ☐ Negative ☐ Unknown
Key population status: ☐ Contact of any TB
☐ Contact of DR-TB ☐ Diabetes ☐ Tobacco
☐ Mining ☐ Migrant
☐ Urban slum code:.....
☐ Health care worker ☐ other: specify.....

3. Symptoms or complaints

Symptom	**Symptom**	**Symptom**	☐ Details of any other symptoms .... ☐ No symptoms
☐ Cough, If Yes,No. of days .... ☐ Fever, If Yes,No. of days ..... ☐ Loss of weight ☐ Blood in sputum	☐ Chest pain ☐ Breathing difficulty ☐ Loss of appetite ☐ Poor weight gain (in Child)	☐ Nightsweats ☐ Weakness ☐ Lump/swelling	

4. Reason for testing H/o anti-TB medication ≥1 month: ☐ Yes ☐ No ☐ Unknown

Clinical Impression: ☐ Presumptive Pulmonary TB ☐ Presumptive Extra Pulmonary TB (site.....) ☐ Presumptive Non TB Mycobacteria (site.....) ☐ Presumptive DR-TB	☐ Failure of 1st line drugs ☐ Follow up smear +ve ☐ Discordance resolution ☐ Presumptive INH / mono / poly resistance ☐ Presumptive XDR-TB (write code.....)

5. Test/s prescribed Type of specimen ☐ Sputum ☐ Other (Specify)

Microbiological confirmation ☐ Microscopy ☐ CBNAAT(GeneXpert) ☐ LPA ☐ Culture ☐ DST ☐ Other microbiological test	**Non-microbiological test/s** ☐ Chest X Ray ☐ TST (Mantoux, PPD) ☐ IGRA ☐ Cytopathology ☐ Histopathology	**Other test/s** ☐ HIV ☐ Hb% ☐ Blood Sugar ☐ Other Specify_____

6. Details of facility where patient is referred for tests

Is SCT support provided for the patient ☐ Yes ☐ No If Yes, Date of SCT DD/MM/YYYY

Name of facility/lab. LAB HCF Code

Reason for not reaching the facility for test:

7. Results Date of Sample collection DD/MM/YYYY NIKSHAY ID Generated:

Microscopy (☐ ZN ☐ Florescent)			Result				
	Lab Sr .No	Visual Appearance	Negative	Scanty	1+	2+	3+
Sample A							
Sample B							

Date tested: DD/MM/YYYY Date of report collection: DD/MM/YYYY

Cartridge Based Nucleic Acid Amplification Test (CBNAAT) – Xpert MTB/RIF

Sample	☐ A ☐ B	Lab Sr. no :
M. Tuberculosis	☐ Detected ☐ Not Detected ☐ N/A	
Rif Resistance	☐ Detected ☐ Not Detected ☐ Indeterminate ☐ N/A	
Test	☐ Error (Please arrange a fresh sample)	

Date Tested: DD/MM/YYYY Date of report collection: DD/MM/YYYY

Other test results: Specify test/s.....
Result:.....
Date tested: DD/MM/YYYY Date of report collection: DD/MM/YYYY

8. Diagnosis and treatment initation details Date of diagnosis: DD/MM/YYYY
☐ MTB confirmed ☐ Clinical diagnosis ☐ TB ruled out ☐ Other diagnosis.....
Date of treatment initiation: DD/MM/YYYY. Sector of treatment: ☐ Private ☐ Public

Risk and Needs Assessment (RANA)

Risks and Needs Assessment (RANA)

District name: _____ **TU Name:**_____ **DMC Name:**_____ **Facility Name:**_____

NIKSHAY ID: _____ **Date of RANA:** _____ **Date of treatment initiation:** _____

Patient's full name: _____ **Age:** _____ **Gender (M/F):** _____ **Assessment done by (Name & Designation):**_____

A) DCM Category – tick (√)								
	Yes	**No**		**Yes**	**No**		**Yes**	**No**
1. Elderly patient (age ≥60 years)			**4.** Patient consuming alcohol			**7.** Patient with Diabetes		
2. Patient living alone &/or without family support			**5.** DRTB patient					
3. Previously treated patient			**6.** Patient co-infected with HIV					

B) Ask relevant questions and screen for following risk factors – tick (√)			**C) Ask relevant questions and screen for following social needs – tick (√)**		
	Yes	**No**		**Yes**	**No**
1. Does the patient understand TB disease and/or treatment?			**1.** Does the patient have Aadhaar card?		
2. Does the patient accept TB disease and/or treatment?			**2.** Does the patient have bank account?		
3. Patient is experiencing discrimination or denial of rights because of TB			**3.** What type of ration card does the patient have? a) BPL ☐ b) APL ☐ c) None ☐		
4. Patient is Migrant/Frequent traveller					

	Yes	**No**
Does the patient fall under any DCM category? (Tick based on section A):		

Details of In-person care – Differentiated Care Model (DCM)

Visit/contact number	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**								
Date of visit/contact	DD/MM	DD/MM	DD/MM	DD/MM	DD/MM	DD/MM	DD/MM	DD/MM	DD/MM	DD/MM	DD/MM	DD/MM	DD/MM	DD/MM	DD/MM	DD/MM
Type of contact (In-person=1; care giver=2, telephonic=3)																
Percentage of adherence as per NIKSHAY																
Risk code (codes to be mentioned here itself)																
Action code (codes to be mentioned here itself)																

ANNEXURE 04

Codes - Risk and Needs Assessment (RANA)

Codes to be used for recording risk/s identified and action/s taken during patient visit/contact

Risk code	Risk factors
A	Refusal for in-person care
B	Regular travel/migration
C	Plan of social event in near future
D	Recently faced crisis (**anything that prevents treatment adherence**)
E	Disease status not disclosed to immediate family
F	Persisting symptoms/no clinical improvement
G	Side effects/appearance of new symptoms
H	Bed ridden
I	Blood sugar not under control
J	No weight gain
K	Tobacco use
L	Lack of family support
M	Problem with access to drugs
N	Financial difficulties for daily living
O	Difficulty in getting DBT

Person may have multiple risk and multiple actions may be taken. Therefore, more than one option in risk and action is possible

Action codes for risk specific actions taken (along with adherence counselling to all patients)
A. Linked to careline /support group meetings
B. Facilitated linkage for medications **C.** Reminder system for medicine intake/ IDAT in pilot districts
D. Supported for disclosure
E. Reassurance and referral to a medical doctor for symptom relief
F. Ruled out DRTB
G. Tested for CD4/viral loads in case of TB-HIV
H. Reassurance and referral for management of side effects
I. Facilitated linkages to relevant specialist and/or tertiary care admission
J. Facilitated linkage to diabetic clinic/NCD clinic
K. Educated patient on diabetic diet and importance of regular physical activity
L. Nutritional counselling
M. Nutritional support/linkages
N. Educated the patients on disadvantage tobacco use
O. Identified primary care giver/explored support from neighbourhood
P. Educated patient on TB and treatment
Q. Family level counselling and support provided
R. Linked to RNTCP medications (as per patient's convenience) including injections (if required)
S. Facilitated livelihood support, assisted in getting ration card
T. Linkage to health-related schemes established
U. Assisted for DBT linkage
V. Facilitated action on DBT/Linked to DBT

ANNEXURE 05

Patient Care and Support (PCS) form

Date of PCS registration: DD/MM/YYYY

PCS ID:.....

PREVENTION CARE & SUPPORT CARD

ರೋಗ ತಡೆ ಆರೈಕೆ ಮತ್ತು ಬೆಂಬಲ ಕಾರ್ಡ್

PRAD ID .....

Nikshay Id:.....

Staff Name & Code:.....

Supervisor Name:.....

1. Patient Registration Details

Name:
Gender: ☐M ☐F ☐TG Age: .....Yrs, Date of Birth:
Current Address: ಪ್ರಸ್ತುತ ವಿಳಾಸ

Town:
Land Mark:
Permanent Address:

TU Name:
DMC Name:

Occupation: ಉದ್ಯೋಗ
Education: ವಿದ್ಯೆಣ ☐Cannot Read/Write ಓದಲು ಬರೆಯಲು ಬಾರದು
☐<5 std <5 ತರಗತಿ ☐ 5-10 std. 5–10 ತರಗತಿ
☐ 12th 12ನೇ ತರಗತಿ ☐ Diploma ಡಿಪ್ಲೋಮೋ
☐Graduate ಪದವಿ ☐ Post Graduate ಸ್ನಾತಕೋತ್ತರ ಪದವಿ
Religion: ☐ Hindu ☐ Muslim ☐ Christian ☐Other Specify----------
Marital Status: ವೈವಾಹಿಕ ಸ್ಥಿತಿ ☐Single ಒಬ್ಬಂಟಿ ☐ Married ವಿವಾಹಿತ/ತೆ
☐Widowed ವಿಧವೆ/ವಿಧುರ
☐ separated/divorced ಪ್ರತ್ಯೇಕವಾಗಿದ್ದಾರೆ/ವಿಚ್ಛೇದನವಾಗಿದೆ

Aadhaar No:

Contact No:
ಸಂಪರ್ಕ ಸಂಖ್ಯೆ:

Care Giver Name:
ಆರೈಕೆ ಮಾಡುವವರ ಹೆಸರು:

Relationship to Patient:
ರೋಗಿಯೊಂದಿಗಿನ ಸಂಬಂಧ

Care giver's Contact No:
ಆರೈಕೆ ಮಾಡುವವರ ದೂರವಾಣಿ ಸಂಖ್ಯೆ:

Treatment Supporter Name:
ಚಿಕಿತ್ಸಾ ಬೆಂಬಲಿಗರ ಹೆಸರು:

Treatment Supporter Contact no :
ಚಿಕಿತ್ಸಾ ಬೆಂಬಲಿಗರ ದೂರವಾಣಿ ಸಂಖ್ಯೆ:

Risk present ☐ No ☐ Yes
ಅಪಾಯ ಅಂಶ ಇಲ್ಲ ಇದೆ

Specify risk
ಅಪಾಯದ ಅಂಶವನ್ನು ಸೂಚಿಸಿ

2. Comorbidity and Treatment Details ಸಹಸೋಂಕುಗಳು ಮತ್ತು ಚಿಕಿತ್ಸಾ ವಿವರಗಳು

Co-existing Conditions
ಸಹ ಸೋಂಕಿನ ಸ್ಥಿತಿಗಳು: PCS ಕಾರ್ಡ್ ಮಾಡುವ ಪ್ರಾರಂಭದ ಸಮಯದಲ್ಲಿ

HIV Status: ಹೆಚ್ಐವಿ ☐ Unknown ☐ Positive ☐Negative

Initiated on ART: ☐ Yes ☐ No
ಸ್ಥಿತಿ ಗೊತ್ತಿಲ್ಲ ಪಾಸಿಟಿವ್ ನೆಗೆಟಿವ್

Diabetes Status: ☐ Unknown ☐ Yes ☐ No
ಮಧುಮೇಹ ಸ್ಥಿತಿ ಗೊತ್ತಿಲ್ಲ ಹೌದು ಇಲ್ಲ

If yes is patient on diabetes treatment ☐Yes ☐No
ಹೌದಾದರೆ ರೋಗಿ ಮಧುಮೇಹದ ಚಿಕಿತ್ಸೆಯಲಿದ್ದಾರಾ ಹೌದು ಇಲ್ಲ

Hb:%.....gm% ☐Not Available ದೊರೆಯುತ್ತಿಲ್ಲ

Other conditions Specify ಇತರ ಸ್ಥಿತಿಗಳನ್ನು ಸೂಚಿಸಿ.....

For women aged 15- 49yr
15–49ರ ವಯಸ್ಸಿನ ಮಹಿಳೆಯರಿಗೆ

On Oral Contraceptive Pills ☐ Yes ☐ No
ಗರ್ಭ ನಿರೋಧಕ ಮಾತ್ರೆಗಳ ಬಳಕೆ ಹೌದು ಇಲ್ಲ

Currently pregnant/ breast feeding ☐Yes ☐ No
ಪ್ರಸ್ತುತ ಗರ್ಭಿಣಿ / ಹಾಲುಡಿಸುತ್ತಿದ್ದಾರಾ ಹೌದು ಇಲ್ಲ

Nutritional Assessment at treatment initiation
ಚಿಕಿತ್ಸೆಯ ಪ್ರಾರಂಭದಲ್ಲಿ ಪೌಷ್ಟಿಕಾಂಶದ ಅಗತ್ಯದ ಅಂದಾಜು

Weight .....Kgs Height .....Cms
BMI .....Kg/m^2 MUAC..... .....Cms
(child <5 yrs, Pregnant women)

Basis of TB diagnosis
☐ Microbiologically Confirmed
☐ Microscopy
☐ CBNAAT/LPA
☐ Culture & Sensitivity
☐ Clinically Diagnosed

Type of TB :
☐ Pulmonary TB
☐ Extra Pulmonary TB

Treatment details ಚಿಕಿತ್ಸಾ ವಿವರಗಳು

History of TB treatment: ☐ New ☐ Previously treated for TB
ಈ ಹಿಂದಿನ ಟಿಬಿ ಚಿಕಿತ್ಸೆಯ ವಿವರ ಹೊಸದಾಗಿ ಈ ಮುಂಚೆ ಟಿಬಿಗೆ ಚಿಕಿತ್ಸೆ ನೀಡಲಾಗಿದೆ

Anti TB medication from: ☐ Private sector ☐ Public sector
ಟಿಬಿ ನಿರೋಧಕ ಔಷಧಿಗಳು ಖಾಸಗಿ ವಲಯ ಸಾರ್ವಜನಿಕ ವಲಯ

Name of the Health Care facility which initiated treatment:
ಟಿಬಿ ಚಿಕಿತ್ಸೆ ಪ್ರಾರಂಭ ಮಾಡಿದ ಸೇವಾ ಕೇಂದ್ರ:

Treatment Regimen Initiated: ☐ DS TB ☐ DR TB
ಪ್ರಾರಂಭಿಸಿದ ಚಿಕಿತ್ಸಾ ಕ್ರಮ

Receiving FDC: ☐ Yes ☐ No

Date of treatment initiation DD/MM/YYYY Date of initiation of CP: DD/MM/YYYY
ಚಿಕಿತ್ಸೆ ಪ್ರಾರಂಭದ ದಿನಾಂಕ ದಿ/ತಿಂ/ವರ್ಷ CP ಪ್ರಾರಂಭದ ದಿನಾಂಕ ದಿ/ತಿಂ/ವರ್ಷ

3. Contact Screening ರೋಗಿಯ ಸಂಪರ್ಕದಲ್ಲಿರುವವರ ತಪಾಸಣೆ

Date of screening ಸ್ಕ್ರೀನಿಂಗ್ ದಿನಾಂಕ	DD/MM/YYYY		DD/MM/YYYY		DD/MM/YYYY	
	<6 yrs <6 ವರ್ಷ	>6 yrs >6 ವರ್ಷ	<6 yrs <6 ವರ್ಷ	>6 yrs >6 ವರ್ಷ	<6 yrs <6 ವರ್ಷ	>6 yrs >6 ವರ್ಷ
# of household contacts ಮನೆಯಲ್ಲಿ ಇರುವವರ ಸಂಖ್ಯೆ						
# screened ತಪಾಸಣೆಗೊಂಡವರ ಸಂಖ್ಯೆ						
# with Symptoms ರೋಗಲಕ್ಷಣಗಳನ್ನು ಹೊಂದಿರುವವರ ಸಂಖ್ಯೆ						
# referred for test/doctor ಪರೀಕ್ಷೆ/ಡಾಕ್ಟರ್‌ಗೆ ಶಿಫಾರಸ್ಸಾದವರ ಸಂಖ್ಯೆ						
# Diagnosed ರೋಗ ಪತ್ತೆಯಾದವರ ಸಂಖ್ಯೆ						
# put on treatment ಚಿಕಿತ್ಸೆಗೆ ಒಳಗೊಂಡ ಸಂಖ್ಯೆ						

Children Less than 6 years given IPT
6 ವರ್ಷಕ್ಕಿಂತ ಕೆಳಗಿನ ಮಕ್ಕಳಿಗಾಗಿ IPT ನೀಡಿದೆ

Name of child ಮಗುವಿನ ಹೆಸರು	Wt (Kg) ತೂಕ	Dose (Mg) ಡೋಸ್	M1	M2	M3	M4	M5	M6

Details of contacts referred through contact tracing
ರೋಗಿಯ ಸಂಪರ್ಕದಲ್ಲಿರುವವರಿಗೆ ಶಿಫಾರಸ್ಸು ಮಾಡಿದ ವಿವರಗಳು

Name of contact ಸಂಪರ್ಕದಲ್ಲಿರುವವರ ಹೆಸರು	Age ವಯಸ್ಸು	Gender ಲಿಂಗ	Relationship to index patient (code) ಸೂಚಿತ ರೋಗಿಯೊಂದಿಗಿನ ಸಂಬಂಧ (ಕೋಡ್)	PRAD ID ಗುರುರು	TB Y/N ಟಿಬಿ ಹೌದು/ಇಲ್ಲ

ANNEXURE 05

Patient Care and Support (PCS) form

4. Patient Follow Up Visit Details. ರೋಗಿ ಮಾತ್ರೆ ಸೇವನೆ ಮಾಡಲು ತಪ್ಪಿದೆಯಾ?

Sl no ಕ್ರ.ಸಂ.	Contact date ಭೇಟಿಯ ದಿನಾಂಕ	Mode of contact (Code) ಭೇಟಿಯ ರೀತಿ (ಕೋಡ್)	Person Contacted (Code) ಸಂಪರ್ಕಿಸಿದ ವ್ಯಕ್ತಿ (ಕೋಡ್)	Have you missed doses (Y/N) ತೆಗೆದುಕೊಳ್ಳಬೇಕಾದ ಮಾತ್ರೆಗಳ ತಪ್ಪಿಸಿದ್ದಲ್ಲಿ ಹೌದು/ಇಲ್ಲ	Reason for Missing doses ತಪ್ಪಿಸಿದ್ದಕ್ಕೆ ಕಾರಣ	Symptom (code) ರೋಗ ಲಕ್ಷಣಗಳು ಕೋಡ್	Risk factors (Code) ಅಪಾಯಕಾರಿ ಅಂಶಗಳು	Needs Assessed (Code) ಅವಶ್ಯಕತೆಗಳ ಅಂದಾಜು ಮಾಡಿದೆ ಕೋಡ್	Action Taken (code) ಕೈಗೊಂಡ ಕ್ರಮಗಳು	Record Weight in kg ತೂಕವನ್ನು ಕೆಜಿಗಳಲ್ಲಿ ದಾಖಲಿಸಿ	MUAC for children <5yrs, pregnant women in Cm <೨ ವರುಷದ ಮಕ್ಕಳಿಗೆ ಗರ್ಭಿಣಿ ಮಹಿಳೆಗೆ MUAC ಸೆಂಟಿಮೀಟರ್‌ನಲ್ಲಿ	Remarks ಷರಾ
1												
2												
3												
4												
5												
6												
7												
8												
9												
10												
11												
12												
13												
14												
15												
16												
17												
18												

Follow up lab test ಲ್ಯಾಬ್ ಪರೀಕ್ಷೆಗಳ ಅನುಸರಣೆ

Date of Follow up test ಅನುಸರಣಾ ಪರೀಕ್ಷೆಯ ದಿನಾಂಕ	Type of test done ಪರೀಕ್ಷೆ ನಡೆಸಿದ ವಿಧಾನ	Result ಫಲಿತಾಂಶ

Patient Treatment outcome (after discussion with HCP) ರೋಗಿಯ ಚಿಕಿತ್ಸೆಯ ಫಲಿತಾಂಶ (ಹೆಚ್‌ಸಿಪಿ ಜೊತೆ ಚರ್ಚೆಯ ನಂತರ)

☐ Cured ☐ Treatment completed ☐ Not Evaluated ☐ Loss to follow up ☐ Failure ☐ Regimen Change ☐ Death
ವಾಸಿಯಾಗಿದೆ ಚಿಕಿತ್ಸೆ ಪೂರ್ಣಗೊಂಡಿದೆ ಮಾಪನ ಮಾಡಿಲ್ಲ ಅನುಸರಣೆ ನಷ್ಟ ವೈಫಲ್ಯ ಚಿಕಿತ್ಸಾ ಕ್ರಮಗಳ ಬದಲಾವಣೆ ಸಾವು

☐ Others (specify) ..... ☐ ORW unable to follow up (reason) .....
ಇತರೆ (ಸೂಚಿಸಿ...) ಅನುಸರಣೆ ಮಾಡಲಾಗಿಲ್ಲ (ಕಾರಣ)...

New PRAD ID if applicable..... Outcome declaration date DD/MM/YYYY
ಹೊಸ PRAD ಗುರುತು ಅನ್ವಯಿಸಿದ್ದಲ್ಲಿ..... ಫಲಿತಾಂಶ ಪ್ರಕಟಿಸಿದ ದಿನಾಂಕ : ದಿ/ತಿಂ/ವರ್ಷ

5. Post Treatment Completion Follow Up *- once in 6 months till 2 years after completion of treatment*

ಪೂರ್ಣ ಚಿಕಿತ್ಸಾ ನಂತರದ ಅನುಸರಣೆ ಚಿಕಿತ್ಸೆ ಪೂರ್ಣಗೊಂಡ ಮುಂದಿನ 2 ವರ್ಷಗಳ ತನಕ ಪ್ರತಿ 6 ತಿಂಗಳಿಗೊಮ್ಮೆ

Follow up due date ಅನುಸರಣೆ ಮಾಡಬೇಕಾದ ದಿನಾಂಕ	Actual visit / phone date ಭೇಟಿ ಮಾಡಿದ/ ದೂರವಾಣಿ ಮಾಡಿದ ದಿನಾಂಕ	Mode of contact (Code) ಸಂಪರ್ಕ ವಿಧಾನ	General condition as reported by patient/ Family (Code) ರೋಗಿ ತಿಳಿಸಿದಂತೆ ಸಾಮಾನ್ಯ ಸ್ಥಿತಿ	Comorbid condition diagnosed if any (Code) ಸಹರೋಗಗಳ ಸ್ಥಿತಿಯ ನಿರ್ಣಯವಾಗಿದ್ದಲ್ಲಿ ಕೋಡ್	Weight in Kg (if available) ತೂಕ ಕೆಜಿಗಳಲ್ಲಿ	Referral for TB testing Y/N ಟಿಬಿ ಪರೀಕ್ಷೆಗೆ ಶಿಫಾರಸ್ಸು ಹೌದು/ಇಲ್ಲ	PRAD ID if Yes PRAD ಗುರುತು ಇದ್ದಲ್ಲಿ	Any contact has TB symptoms (Y/N) ರೋಗಿಯ ಸಂಪರ್ಕದಲ್ಲಿರುವವರಿಗೆ ಟಿಬಿ ರೋಗ ಲಕ್ಷಣಗಳಿದೆಯೇ (ಹೌದು/ಇಲ್ಲ)	PRAD ID if Yes PRAD ಗುರುತು ಇದ್ದಲ್ಲಿ	Remarks ಷರಾ

ANNEXURE 05

Codes - Patient Care and Support (PCS) form

Codes ಕೋಡ್ಸ್/ಸೂಚಿಗಳು

Section 3 Contact screening ಭಾಗ 3 ಸಂಪರ್ಕ ಪರಿಶೀಲನೆ

Relationship to index patient ರೋಗಿಯೊಂದಿನ ಸಂಬಂಧಗಳು (ಕೋಡ್/ಸೂಚ್ಯಾಂಶ)

1. Parent ತಾಯಿ–ತಂದೆ
2. Parent in law ಕಾನೂನಾತ್ಮಕ ಪೋಷಕರು
3. Spouse ಸಂಗಾತಿ/ಗಂಡ–ಹೆಂಡತಿ
4. Brother/Sister ಸಹೋದರ/ಸಹೋದರಿ
5. Son/Daughter ಮಗ/ಮಗಳು
6. Grand Son/Daughter ಮೊಮ್ಮಗ/ಮಗಳು
7. In laws (Son/ Daughter)
   ಕಾನೂನಾತ್ಮಕವಾಗಿ ನೋಡಿಕೊಳ್ಳುತ್ತಿರುವರು (ಮಗ/ಮಗಳು/ಅಳಿಯ/ಸೊಸೆ
8. Grand Parents ತಾತ ಅಜ್ಜಿಯರು
9. Friend/Roommate ಸ್ನೇಹಿತ/ರೂಂ ಮೆಟ್
10. Other ಇತರರು

Section 4 Patient follow up visit details ಭಾಗ 4 ರೋಗಿಯ ಅನುಸರಕಾ ಭೇಟಿಗಳ ವಿವರ

Mode of contact ಸಂಪರ್ಕ ವಿಧಾನ	**Person Contacted** ಸಂಪರ್ಕಿಸಿದ ವ್ಯಕ್ತಿ
1. In Person ವ್ಯಕ್ತಿಗತ ಭೇಟಿ 2. Phone ಫೋನ್ ಮೂಲಕ	1. Patient ರೋಗಿ 2. Caregiver ಆರೈಕೆ ಮಾಡುವವರು 3. Others ಇತರರು

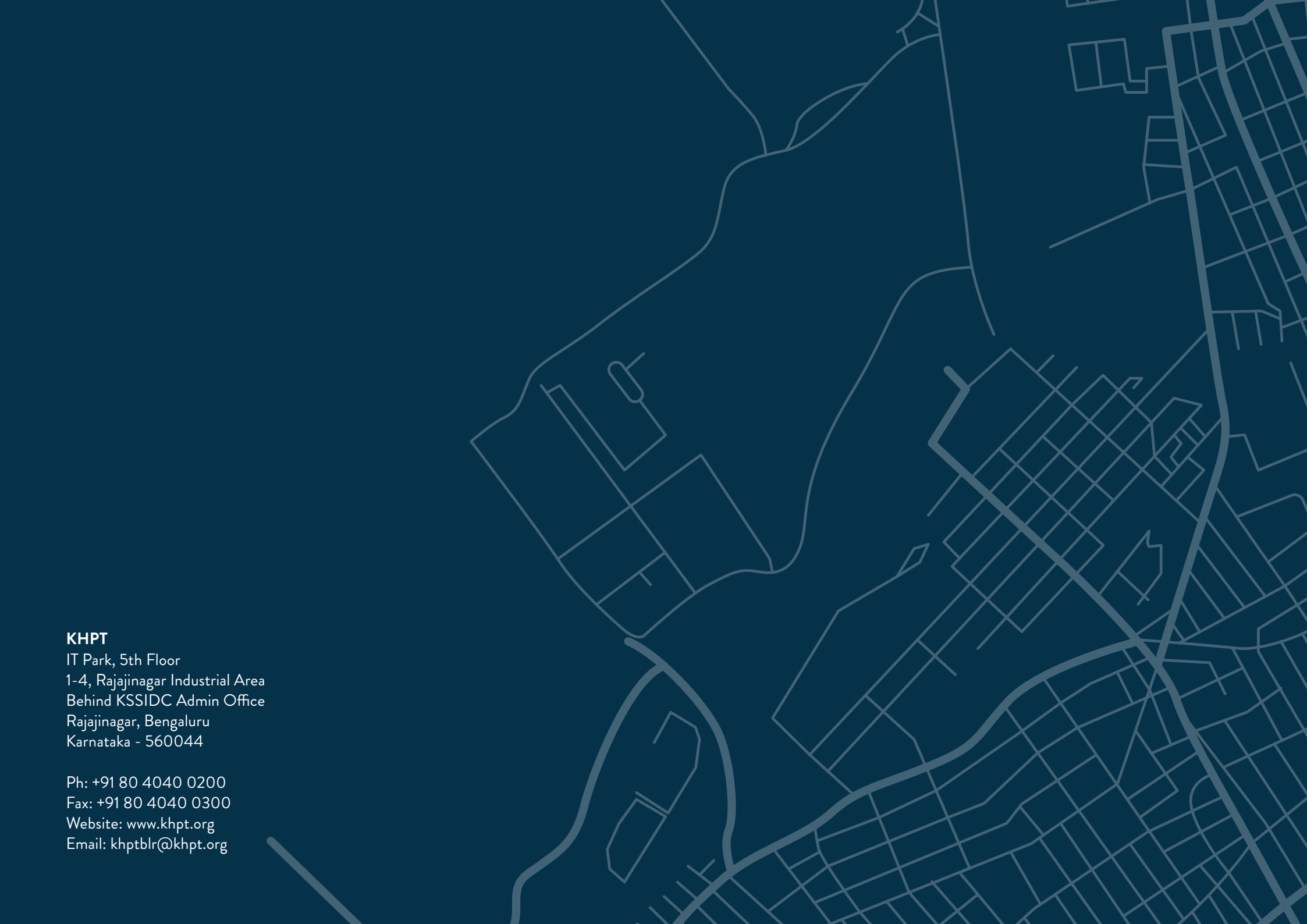
Symptom (code) **ರೋಗ ಲಕ್ಷಣಗಳು (ಕೋಡ್/ಸೂಚ್ಯಾಂಶ)**	**Risk Factors Code** **ಸೋಂಕು ಸಾಧ್ಯತೆಯ ಅಂಶಗಳು**
a. Nausea/ vomiting ವಾಕರಿಕೆ/ವಾಂತಿ	a. Poor understanding of TB disease and/or treatment ಟಿಬಿ ರೋಗ ಮತ್ತು / ಚಿಕಿತ್ಸೆಯ ಬಗೆಗೆ ಇರುವ ಅತ್ಯಲ್ಪ ತಿಳುವಳಿಕೆ
b. Red/orange urine discoloration, ಕೆಂಪು/ಕಿತ್ತಳೆ ಬಣ್ಣದಲ್ಲಿ ಮೂತ್ರ	b. Poor acceptance of TB disease and/or treatment ಓಬಿ ರೋಗ ಮತ್ತು / ಅಥವಾ ಚಿಕಿತ್ಸೆಯನ್ನು ಒಪ್ಪಿಕೊಳ್ಳದಿರುವುದು
c. Itching/ rash /skin lesions in mouth or nose ತುರಿಕೆ/ದದ್ದು/ಬಾಯಿ ಅಥವಾ ಮೂಗಿನ ಚರ್ಮದ ಗಾಯ	c. Regular travel/likely migration ಆಗಿಂದ್ಯಾಗೆ ಪ್ರಯಾಣ / ವಲಸೆ ಸಾಧ್ಯತೆ
d. Blurring of vision / pain in the eye / disturbance in colour vision ಕಣ್ಣು ಮಂಜಾಗುವುದು/ಕಣ್ಣಿನಲ್ಲಿ ನೋವು/ ಬಣ್ಣ ದೃಷ್ಟಿಯಲ್ಲಿ ವ್ಯತ್ಯಯ	d. Co-existing conditions (HIV/ DM / silicosis/ undernutrition/ pregnancy / breast feeding) ಜೊತೆಗಿರುಬಹುದಾದ ಆರೋಗ್ಯ ಪರಿಸ್ಥಿತಿ ಹೆಚ್ಐವಿ/ಡಿಎಂ/ ಸಿಲಿಕೋಸಿಸ್/ ಅಪೌಷ್ಟಿಕತೆ/ಗರ್ಭಧಾರಣೆ/ಮೊಲೆಯೂಡಿಸುವುದು
e. Dizziness/ loss of balance/loss of hearing/ ringing in the ears ತಲೆ ಸುತ್ತುವುದು/ದೇಹದ ಸಮತೋಲನ ಕಳೆದು ಕೊಳ್ಳುವುದು/ಕಿವಿ ಕೇಳದೇ ಹೋಗುವುದು/ಕಿವಿಯಲ್ಲಿ ಗುಯ್ ಸದ್ದು	e. Alcoholism ಮದ್ಯಪಾನ
f. Puffiness of face / swelling over feet/reduce in urine out put ಮುಖ ಊದಿಕೊಳ್ಳುವುದು/ಕಾಲು ಊತ/ಕಡಿಮೆ ಮೂತ್ರ	f. Tobacco Addiction ತಂಬಾಕು ಸೇವನೆ
g. Jaundice ಕಾಮಾಲೆ	g. Discrimination or denial of rights ತಾರತ್ಯಮವನ್ನು ಅಥವಾ ಹಕ್ಕುಗಳಿಂದ ವಂಚಿತರಾಗಿದ್ದಿರಾ
h. Tingling/ burning/ numbness, ಕೈಕಾಲು ಜುಮ್ ಎನಿಸುವುದು/ಉರಿ/ ಜೋಮು ಹಿಡಿಯುವುದು	h. Living Alone / No Care Giver ಒಬ್ಬರೇ ಇರುವುದು/ಯಾರೂ ಆರೈಕೆಗೆ ಇಲ್ಲದಿರುವುದು
i. Joint pains ಸಂಧಿಗಳ ನೋವು/ಕೀಲು ನೋವು	i. Lack of Family Support ಕೌಟುಂಬಿಕ ಬೆಂಬಲದ ಕೊರತೆ
j. Abnormal thoughts /altered behaviour/altered mood ಅಸಹಜ ಯೋಚನೆಗಳು/ಬದಲಾದ ನಡವಳಿಕೆ/ಬದಲಾಗುತ್ತಿರುವ ಮನಸ್ಥಿತಿ	j. Disease status not disclosed to immediate family ಕುಟುಂಬದ ಹತ್ತಿರದವರಿಗೂ ರೋಗಸ್ಥಿತಿಯ ಬಗ್ಗೆ ಹೇಳದಿರುವುದು
k. Swelling in the neck ಕತ್ತಿನಲ್ಲಿ ಊತ	k. Social Event or Crisis ಸಾಮಾಜಿಕ ಸಮಾರಂಭಗಳು ಅಥವಾ ಬಿಕ್ಕಟ್ಟು
l. Loss of appetite ಹಸಿವಾಗದಿರುವುದು	l. Financial difficulties ಹಣಕಾಸಿ ಬೆಂಬಲದ ಕೊರತೆ
m. Fatigue ಆಯಾಸ	m. Problem with access to drugs ಔಷಧಿ ಪಡೆಯಲು ಇರುವ ತೊಂದರೆಗಳು
n. Worsening of existing symptoms ಇರುವ ರೋಗಲಕ್ಷಣಗಳ ಹೆಚ್ಚಾಗುವಿಕೆ	n. Irregular to previous treatment ಚಿಕಿತ್ಸೆಯನ್ನು ರೂಡಿಸಿಕೊಳ್ಳುವಾಗ ತೊಂದರೆಯಾಗಿತ್ತೆ
o. Other specify..... ಇತರ–ವಿವರಿಸಿ	o. Symptoms persisting ಮುಂದುವರೆಯುತ್ತಿರುವ ರೋಗ ಲಕ್ಷಣಗಳು

Section 4 Patient follow up visit details ಭಾಗ 4 ರೋಗಿಯ ಅನುಸರಕಾ ಭೇಟಿಗಳ ವಿವರ

Needs Assessed ಅಗತ್ಯಗಳ ಅಂದಾಜಿನ ಸೂಚಿ	**Action Taken** ಕೈಗೊಂಡಿರುವ ಕ್ರಮಗಳು (ಸೂಚಿ)
a. Aadhaar ಆಧಾರ್	a. TB Awareness & Treatment literacy ಟಿಬಿ ಬಗ್ಗೆ ಅರಿವು ಮತ್ತು ಚಿಕಿತ್ಸೆ ಬಗ್ಗೆ ತಿಳುವಳಿಕೆ
b. Bank Account ಬ್ಯಾಂಕ್ ಖಾತೆ	b. Adherence counselling support ಚಿಕಿತ್ಸಾ ಬದ್ಧತೆಗೆ ಸಮಾಲೋಚನೆ ಬೆಂಬಲ
c. Ration Card (APL/ BPL) ಪಡಿತರ ಚೀಟಿ (ಎಪಿಎಲ್/ಬಿಪಿಎಲ್)	c. Nutritional advice & support ಪೌಷ್ಟಿಕ ಆಹಾರ ಕುರಿತಾದ ಸಲಹೆ ಮತ್ತು ಬೆಂಬಲ
d. DBT linkage ಡಿಬಿಟಿ ಸೇವೆಗೆ ಜೋಡಣೆ	d. Referral for Medical attention ವೈದ್ಯಕೀಯ ಶಿಫಾರಸ್ಸು
e. Link to free medicines ಉಚಿತ ಔಷಧಿ ಸೇವೆಗಳಿಗೆ ಜೋಡಣೆ	e. Linkage to alcohol deaddiction ಮದ್ಯಪಾನ ಬಿಡಲು ಸೇವಾ ಬೆಂಬಲ
f. Nutrition support ಪೌಷ್ಟಿಕ ಆಹಾರ ಬೆಂಬಲ	f. Linkage to tobacco cessation ತಂಬಾಕು ಸೇವನೆ ಬಿಡಲು ಸೇವಾ ಬೆಂಬಲ
g. Livelihood support ಜೀವನೋಪಾಯಕ್ಕೆ ಬೆಂಬಲ	g. Family level counselling and support ಕುಟುಂಬ ಮಟ್ಟದಲಲಿ ಸಮಾಲೋಚನೆ ಮತ್ತು ಬೆಂಬಲ
h. Health related schemes (Health Insurance etc) ಆರೋಗ್ಯದ ಯೋಜನೆಗಳು (ಆರೋಗ್ಯ ವಿಮೆ ಮುಂತಾದವು)	h. Sensitization of care giver ಆರೈಕೆ ನೀಡುವವರ ಸ್ಪಂದನೆ
i. Any other schemes ಬೇರೆ ಇತರ ಯೋಜನೆಗಳು	i. Support for disclosure ಟಿಬಿ ಇರುವ ಬಗ್ಗೆ ಹೇಳಿಕೊಳ್ಳಲು ಬೆಂಬಲ
	j. Livelihood Support provided ಜೀವನೋಪಾಯಕ್ಕೆ ಬೆಂಬಲ ನೀಡಿದೆ
	k. Link to RNTCP Medication ಆರ್ಎನ್‌ಟಿಸಿಪಿ ಔಷಧೋಪಾಚಾರಕ್ಕೆ ಸಂಪರ್ಕ
	l. Aadhaarlinkage ಆಧಾರ್ ಜೋಡಣೆ
	m. Supported in opening bank account ಬ್ಯಾಂಕ್ ಖಾತೆ ತೆರೆಯುವಲ್ಲಿ ಬೆಂಬಲ
	n. Supported the patient in getting a ration Card (APL/ BPL) ರೋಗಿಗೆ ಪಡಿತರ ಚೀಟಿ ಪಡೆಯುವಲ್ಲಿ ನೆರವು (ಎಪಿಎಲ್/ಬಿಪಿಎಲ್)
	o. DBT Linkage ಡಿಬಿಟಿ ಸೇವೆಗೆ ಜೋಡಣೆ
	p. Supported in enrolling in health related schemes ಆರೋಗ್ಯ ಸಂಬಂಧಿ ಯೋಜನೆಗಳಲ್ಲಿ ನೋಂದಣಿಗೊಳ್ಳಲು ಬೆಂಬಲಿಸಿದೆ
	q. Others (Specify in remarks column) ಇತರೆ (ಹೇಳಿಕೆಗಳಲ್ಲಿ ಸೂಚಿಸಿ)

Section 5 Post Treatment Completion Follow Up ಭಾಗ 5 ಚಿಕಿತ್ಸಾ ನಂತರದ ಪೂರ್ಣ ಅನುಸರಣೆ

Mode of contact ಸಂಪರ್ಕ ವಿಧಾನ	**General condition as reported by patient/ Family** **ರೋಗಿ/ಕುಟುಂಬ ತಿಳಿಸಿದಂತಿನ ಸಾಮಾನ್ಯ ಸ್ಥಿತಿ**	**Comorbid condition diagnosed if any** **ಸಹ ಸೋಂಕುಗಳ ಸ್ಥಿತಿ**
1. In Person ಮುಖತಃ 2. Phone ಫೋನ್ ಮೂಲಕ	1. Asymptomatic, ರೋಗಲಕ್ಷಣವಿಲ್ಲದ್ದು 2. Symptoms suggestive of TB, ಟಿಬಿ ಸೂಚಿಸುವ ರೋಗ ಲಕ್ಷಣಗಳು 3. Symptoms of other diseases/ comorbidity diagnosed ಇತರೆ ರೋಗ ಸೂಚಿತ ಲಕ್ಷಣಗಳು/ ಸಹ ರೋಗ ಹರಡುವಿಕೆಯ ಪತ್ತೆ 4. Death ಸಾವು 5. Migration/details not available ವಲಸೆ/ವಿವರ ಲಭ್ಯವಿಲ್ಲ	a. HIV ಹೆಚ್ಐವಿ b. Diabetes ಮಧುಮೇಹ c. Other specify ಇತರೆ–ಸೂಚಿಸಿ



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