




# REVISED NATIONAL TUBERCULOSIS CONTROL PROGRAM

## NATIONAL GUIDLEINE FOR PARTNERSHIP
## 2014

**Central TB Division, Directorate General of Health Services,**
**Ministry of Health and Family Welfare, Nirman Bhawan, New Delhi**
**www.tbcindia.nic.in**

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## Government of India

**Central TB Division, Directorate General of Health Services,**
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**www.tbcinidia.nic.in**

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## PROCESS of PARTNERSHIP

1. The guideline envisages a greater decentralization to the state and district level with the State/District Health Societies playing a more active role and the Centre having a policy and guidance role. In order to facilitate greater coordination between various partners and Revised National TB Control Program there would be a PPM Coordinator at state and district level.

2. The NRHM guideline to utilize up to 5% of the total NRHM funds as grant in Aid to NGOs as well as public private partnerships as delineated in the NRHM implementation framework would be maintained. Funds for NGOs and other partners at the State and below level would be reflected in the Annual State Programme Implementation Plans.

3. Health is a state subject and decentralization is a priority. Thus it is up to the states to determine the priority areas of partnerships according to local context and state priorities. While reflecting fund allocation for NGOs and other partners in the State PIP the role of the NGOs and other partners would also be defined by the state.

4. NGOs and other partners must be used for supplementing capacities in some key areas where the formal health delivery system is unable to provide continued attention.

5. Non-government partners with the required level of competence would be selected to work at the state/district levels respectively. Under this partnership guideline for some activities the entire district may be covered and for other the district may identify deficient blocks and thus prioritize the engagement of partners in those blocks.

6. NGOs and other partners would be encouraged to work in unserved and underserved areas which would be areas in hilly, tribal, desert regions or peri-urban areas and slums. The State and the District Health Societies would have the flexibility to categorize unserved and underserved areas for focused attention.

7. The DTO would be a member of the District NGO Committee formed by District Health Society (as per NRHM NGO guidelines) for selection of NGOs in the district. He would inform the District NGO Committee of the selection of NGOs and private partners.

8. The District Health Society and State Health Society may initiate the partnership process through online display of partnership requirement ( the geographical areas where partnership are required and the functional areas like ACSM etc. where partnerships are required) on state website and/ or on notice board of District and State Health Society.

9. A PPP partner will be eligible for multiple partnership options.

10. The PPP partner applying for a partnership option must provide details of itself as provided in the format A along with a concept note.

11. Application along with requisite documents can be submitted in the office of DTO, in the format provided, and after desk review of the documents by PPM Coordinator, acknowledgement will be issued with ID number to track the status.

12. The District / State Health Society would finally accord the approval for selected partnership and the selected partner information would be made available online or on notice board of the concerned district/state officials of RNTCP under intimation to the State TB Cell.

13. The District Health Society would be decision making body for partnership at district level and stat level partnerships would be finalized by State Health Society. A copy of the relevant application, including formats, will be sent to the State TB Cell for information.

14. The period of the contract would be up to a period of three years subject to annual review and continuation contingent upon satisfactory performance and the need of the programme.

15. The process of scrutiny of the document submitted/appraisal of document should be completed **within 30 days** of last date of submission of application.

16. The agreement/MOU would be signed within a month of approval of application. The first installment would be released within one month of signing the agreement/MOU with NGO and other partners. The Private sector partner/NGO/PP would start providing services at the earliest but not later than one month of releasing of funds.

17. The review of the partnership would be done on the basis of agreed upon activities and outcomes as laid down in the MOU.

18. Every quarter a review of the partnership would be done at District level involving the NGOs, other partner organizations (private sector partners), DTO, CMO,STO and State PPM Coordinator. The meeting would be chaired by District Collector and the partners would report their progress and constraints in the meeting. The meeting would serve as a forum for discussing any problem faced in implementation and the support required from the government machinery.

19. The performance review of the PPM partner would be done bi annually and in case lack of satisfactory performance the contract may be terminated by either party with one month written notice

20. The State and the Centre may commission external evaluations as and when required to analyse and improve the programme. The STO would be empowered to conduct external evaluation of upto 5% NGOs/private partners to be selected on a random basis. However care should be taken that the same NGOs/private partners are not subjected to repeated, multiple evaluations unless there is a specific reason for doing so.

**The updated list of approvals and collaborations must be maintained at the district and state level for all partnership options. The updated list has to be sent to CTD each quarter.**

## Guidance Note for Program Managers

- **Definition of Partner for Public Private Partnership:***: Any registered entity which would include NGOs, CBOs, federation of SHGs, Registered Medical Practitioners (Allopathic/AYUSH), clinics, companies, nursing homes, hospitals, health care providers, individuals, organizations, bodies, agencies etc. Registration should be under any of the Indian laws / Acts including but not limited to Society Registration Act, Trust Act, Charitable Trust Act, Companies act, partnership firm, Cooperatives Act etc*

- The PPP strategy is for reaching the unreached and also to reach patients even if they are accessing private / other sector as RNTCP in this case would act as an enabler and not provider of services.

- The PPP seeks to form partnership in its true sense and thus the DTO and STO would provide an enabling environment for the NGO/private partner adopting required flexibility and making sustained efforts to provide Universal Access to TB care.

- Designate a nodal person in state / district for coordination with NGOs-PPs/Private sector and Central TB Division.

- Ensure that NGOs are registered in Planning Commission NGO portal http://ngo.india.gov.in while applying / forming partnership with NGOs.

- Undertake assessment of gaps in health service delivery in RNTCP in different districts of your state. Identify the geographical and functional gaps. The identified gaps would form the basis for formation of partnership and this information may be displayed on your state website and office of STOs/DTOs.

- The cost of stamp paper (Rs.100) for signing the MOU to be borne by the SHS/ District Health Society through its own budget.

- Date of start of contract period to be decided mutually by the DTO & Partner on date of signing and should be mentioned.

- RNTCP to facilitate the process of development of annual work plan for the NGO/PP under different partnership options.

- RNTCP would monitor the performance of the PPP partner with outputs as agreed upon in the annual workplan submitted by PPP partner.

- RNTCP would ensure that at least one activity of the PPP partner is monitored each quarter by the RNTCP functionary of the district / state.

- RNTCP functionary should participate in PPM activity each quarter.

- The process of renewal of MOU would be on the basis of performance as per the review and quarterly reports submitted. It should be started two months before the MOU ends with the partner.

- Provision should be made in RNTCP budget for dissemination of the Guideline for Partnerships and dissemination workshop/s should be organised at state /regional level.

- Annual review of partnership should be undertaken by the state and the report of the same should be sent to CTD for record.

**Format A**

1. Name of the organization/private practitioner/partner:

2. Postal Address
   District:
   State: Pin code:
   Telephone: Fax:
   Email:

3. Legal Status :(Society/Trust/Company/Partnership Firm/Others)

4. Registration Details:

5. Registered in Planning Commission Portal for NGOs(ngo.india.gov.in):

6. Bank Account Details of NGO: (Account No and Bank)

7. Contact Person: (including telephone and email id)

8. Has your organization ever been blacklisted by any organization/ Government:

9. Key areas of Work (Provide detail in not more than 2 pages):

10. Key stakeholders: (Youth/Women/Elected representatives etc):

11. Partnership Option under which application applied:

12. Geographical Area of Work:

13. Details of budget required:

14. Documents required:
    - Detailed Concept Note
    - Registration certificate / papers
    - Annual Report/Activity Report
    - Audited Report of last financial Year (if applicable)
    - FCRA registration details
    - List of Governing Board Member with contact details

15. Date of Application:

## Memorandum of Understanding

## Revised National Tuberculosis Control Programme

**Memorandum of Understanding (MoU) for the participation of Non-Governmental Organisations (NGOs)/Private Providers/PPP Partner**

This MOU is executed on between the District/State Health Society [Name of the District/State Health Society] having its office at [Address], acting through its Jt. Secretary – State TB Officer (Hereinafter called "the Grantor, which expression shall unless exclude by or repugnant to the context include its successors in-interest, executors, administrators and legal representatives) And [Name of NGO/ Private Provider / private sector partner] hence forth referred to as PPP Partner, having its office at [address] acting through its(Hereinafter called "the Grantee", which expression shall unless excluded by or repugnant to the context include its successors it, interest, executors, administrators and legal representatives).
WHEREAS the Grantor plans to implement "RNTCP (Revised National TB Control Programme) the partnership option

1. [list out the partnership option]

through the Grantee

AND WHEREAS the Grantor has agreed to engage the services of the Grantee, subject to terms and as hereunder.

1. The activities would be implemented in the District/s of _____ [Name of District/s], in the State/s / Union Territory of _____ [Name of States / UTs] for performance of the following activities in accordance with RNTCP policy;

**2. Project Location**

The PPP Partner would be providing the services as specified above at the following location/ (s) as decided in consultation with concerned DTO/STO

a. Urban/ Rural
b. District/ TU/ Block/ (s): _____

c. Urban Wards/ Panchayats covered: _____

d. Population Covered:_____

**3. Period of Co-operation:**

The PPP Partner agrees to perform all activities outlined in the guideline for partnerships in above mentioned area. The duration of cooperation will be from ___/___/_____ (dd/mm/yyyy) to ___/____/____ (dd/mm/yyyy) or the day of the starting the activity / function whichever is later.

Contract will normally be signed for a period of three year, renewable every year as per the needs of the programme, subject to satisfactory performance. The contract can be terminated by the District Health Society/ State Health Society or the PPP Partner any time with one month prior notice. The contract will automatically end on the last day of the contract if not renewed.

**4. Terms, conditions and specific services during the period of the MOU.**

A. **The District/State Health Society shall (ple**ase strike out whichever is not applicable)

i. Provide financial and material support to the NGO/ PP for carrying out the activities as mentioned in the partnership guideline.

ii. Provide relevant copy of technical guidelines, updates, manuals & circulars, etc.)

iii. Provide RNTCP drugs, logistics and laboratory consumables for use as per RNTCP policy as outlined the partnership guideline

iv. Periodically review the performance and activities being undertaken by the NGO/ PP Partner

**B. The NGO/Private Provider / PPP Partner will: -**

i. Perform all activities as agreed upon and signed under the partnership option MoU.

ii. Submit utilization certificate indicating expenditure during the quarter and available unspent balance to the respective State/District Health Society on quarterly basis.

iii. Maintain adequate documentation of as per RNTCP policy which is mentioned under the partnership option. On completion of tasks in the said project the Grantee will furnish to the Grantor a copy of an administrative /yearly report covering the details of project activities and studies undertaken by it. The Grantor shall have a right to call upon the Grantee to furnish such additional supplementary reports, or other documents, papers or writing as in the opinion of the Grantor are necessary or proper in connection with completion of the project

iv. Submit quarterly performance report to DTO/STO.

v. Get commodity assistance as per guideline.

vi. The Grantee shall not delegate, transfer or assign sublet this MOU in whole or in part or otherwise, the obligations under this MOU to any person, firm or company or any other institution/ organization without obtaining the prior written approval of the grantor.

**5. Grant-in-Aid**

Fund shall be released by the respective health society in the name of the NGO/Private Provider/ PPP Partner for initial six months and subsequently bi-annually, within 30 days of the satisfactory completion activities and submission of required documents. The NGO/Private Provider will submit utilization certificate indicating expenditure during the particular quarter and available unspent balance to the respective State/District Health Society on quarterly basis. The subsequent release will depend on the unspent balance and committed liability (if any).

**6. Fund Management**

Funds under this MOU shall be placed at the disposal of the Grantee in separate account opened by it, subject to its furnishing to the Grantor a letter of commitment containing such conditions as may be approved by the Grantor from the bank that the bank shall not exerciser a lien over the said account or may right to set off or adjust any amount due to payable under any loan or credit arrangement which the Grantee may be having or may have with the bank against the amounts standing to the credit of the Grantee in the said amount.

The Grantee shall install and maintain separate books of accounts on cash basis accounting along with proper vouchers for expenditure incurred and with details of outstanding liabilities, if any. The Grantor shall have the right to inspect by its authorized officers of independent agencies the books of accounts and other

records relating to the project fund kept by the Grantee any time during the agreement period or thereafter.

## 7. Grievance Redressal Mechanism

All grievances will be addressed within a period of thirty days by DTO/STO of the concerned district/ states. Final decision will rest with state/ district Health Societies. Annual review would be a platform for addressing grievance of PPM partners.

## 9. Right over Information/data

All documents, information, statistics and data collected by the Grantee in the discharge of the obligation under the MOU incidental or related to it (whether or not submitted to the Grantor) shall be the joint property of the Grantor, and the Grantee

## 10. Indemnity

The Grantee hereby agrees to always keep the Grantor indemnified and harmless from all claims /demands / action and proceedings which may arise by reason of any activity undertaken by Grantee if the activity is not in accordance with the approved guidelines.

This MOU shall be enforceable in courts situated at [Place and State] ; any suit or application for enforcement of the above shall be filed in the competent court at [name of the place] and no other district of [State]or outside [State] shall have any Jurisdiction in the matter

## 11. Termination Mechanism

The partnership may be terminated by either side through written notice of one month. In case services of PPM partner are discontinued, unspent balance, if any will be refunded by the partner.

If the Grantor at any stage decides that the Grantee has misutilised the amounts (or any part thereof) already received from the Grantor or has fraudulently claimed any covenants, stipulation or obligations hereunder a commits a breach of any of the terms, conditions or provision of this MOU on its part to be observed and performed, or it at any stage reasonable ground exist to apprehend the breach of the terms and condition of the MOU in future or that the continuance of this project

may be prejudiced or be in jeopardy he/she may revoke this MOU wholly or partially and ask the Grantee to refund the amount received till then along with interest accrues, if any after giving at least fifteen days' notice and an opportunity of being heard to the Grantee.

**12. Necessary approval of State Health Society has been obtained**:

Yes/ No/ Not applicable.

**13. Enclosures**:

Copy of the National Guideline for Partnership.

Copy of Application Format

_____ _____

Signature of STO/DTO
(on behalf of the respective SHS/DHS)

Signature of authorised signatory
(on behalf of the NGO/ PP)

Seal

Seal

## Option 1: Advocacy Communication and Social Mobilization

### a. ACSM at Community level

### Introduction

There is an unmet need for improved advocacy, communication, and social mobilization (ACSM) to support ongoing TB control efforts in most districts. Improved ACSM is expected to achieve the following outcomes:

- Mobilization of local political commitment and resources for TB
- Improved case detection and treatment adherence
- Empower people and communities affected by TB
- Reduced stigma and discrimination against persons and families affected by TB.

The PPP Partner will be expected to coordinate with District RNTCP units to implement a minimum set of advocacy, communication, and social mobilization interventions in a district, either by themselves or with partners. Implementing partners can include (PRI), Self-Help Groups (SHG), faith-based organizations, Community-based organizations, Rotary Club chapters, other NGOs, Panchayati Raj institutions, etc. The activities should reach an area with a minimum of 1,00,000 population, but preferably should cover 10,00,000 (1million) population or greater.

### Eligibility

Any registered entity registered under Act of parliament viz. Society registration Act/Indian Trust Act/Companies Act etc (NGO/ private agency/institution) with capacity to carry out ACSM activity with at least 1 year experience in social mobilization activities/advocacy/public health/health communication activities and grass root level activities. Local presence and familiarity with local culture will be desirable.

### Budget

**Budget: Rs 2,50,000 per 1 million population per year, pro-rata for population covered.**If a larger population is covered with a larger series of ACSM activities, then RNTCP support for the scheme would be scaled up on a pro-rata basis.

The budget will include cost of activities and transportation/ mobility cost for the staff of PPP partner to undertake these activities in the area of coverage. The PPP partner will be expected to undertake certain minimum number of activities every month as per agreed upon plan within the assigned /agreed upon geographical area/population within the district.

*(For example certain number of community meetings, minimum number of street plays, peer support group meetings along with DOT Provider[treatment supporter] have to be organized by the NGO in the assigned area. Exact number of proposed activities should be reflected in the annual work plan which needs to developed on need basis by the NGO and submitted to the district at the time of signing of MoU)*

There will be flexibility about the activities depending upon the assessment of the situation by the PPP partner and deliverable (activities proposed in the annual work plan with the time line) identified by the PPP partner for the district in consultation with the RNTCP officials of the district.

**Role of PPP partner**

- Plan and undertake a series of ACSM activities in consultation with the District Health Society and in close coordination with District TB Officer or representative deputed by him/her and as per the plan submitted under the partnership option.
- Submit **annual workplan** to the District Health Society apprising them of specific ACSM activities to be carried out in the year.
- Involve the DTO or a representative deputed by him to observe ACSM activity planned by the PPP partner. Key opinion makers in the area and people representatives should be invited for the activities.
- The PPP partner would submit separate detailed report of each ACSM activity carried out in the quarter along with the photographs and other related documents of the activities.
- The activities planned should be based on the need assessment, programme performance, and should be linked to work plan submitted.
- Reproduce good quality communication materials, ideally using prototype materials obtained from the District / RNTCP website, which can be adapted for the local language and context if necessary. The key messages of RNTCP should not be changed and the materials need to be approved by the DTO.

**Role of RNTCP (DTO/STO)**

- The role of the DTO/STO will include joint planning with the PPP partner for identification of issues that needs to be addressed to strengthen ACSM component.

- District Health Society will help the PPP partner in identification of pockets within the district which needs attention for awareness generation, social mobilization and community empowerment.

- District Health Society will also share ACSM District plan with the PPP partner in order to avoid duplication of efforts.

- DHS will make available prototype material developed by the district/ state/ centre. DTO would monitor and supervise ACSM activities in the field.

**Reporting Mechanism**

The following document should be submitted by the ACSM partner:

- Annual Work Plan
- Quarterly Progress Report (The progress report should specify the date of each activity, target group, population covered, description of the activity, involvement of key opinion makers and RNTCP officials, outcome of the activity and follow-up to the activity. Each report should have photograph of the activity. The report should have both quantitative and qualitative aspects to highlight ACSM activity as also the involvement of stakeholders in RNTCP. The PPP partner should submit relevant document like list of participants with signature wherever applicable)
- Utilization Certificate(UC)

**Monitoring Mechanism**

- DTO would monitor and supervise ACSM activities in the field. The ACSM activity should be monitored in terms of involvement of community, quality of program, accuracy of the RNTCP messages disseminated.

- RNTCP will very outcome in terms of increased referral from the project area and number of notification of TB cases from the area.

- The program should be validated by the report submitted by the partner each quarter. Biannual review of ACSM activities should be carried out by the DTO. Responsible representative of partner should attend monthly review meeting held by district/State

## b) ACSM for Youth

### General Description

The overarching goal of Revised National Tuberculosis Control Program (RNTCP) in the next five years is universal access to TB care. To achieve the same, ACSM will be used to increase demand for early diagnosis and treatment and simultaneously improve standards of care.The demand will be created by focusing on audience based targeted interventions and community mobilisation. Existing community structures will be empowered to identify suspects, facilitate referrals, provide patient support and effectively supervise DOTS provision in order to increase adherence and treatment completion.

In this context it becomes imperative that we focus on target audience which would provide us incremental results in the years to come. RNTCP has thus focussed on youth as the target audience which would form the core of the ACSM activities. Youth in this partnership option would be school children and college going youth for which NGOs/private sector partners would be encouraged to apply.

### Requirements/Eligibility Criteria

The PPP partner must be a registered entity with experience of working in public health and presence in the district with focus on advocacy, community mobilization, health campaign and formation of community based organizations (clubs, Mahila Mandal, SHGs etc). Preference would be given to NGOs/PP having prior experience of involving school children and college going youth for advocacy and communication in health program.

### Budget

The budget for the partnership would be for involvement of 10 high schools and at least one college in a district.

| Sl.No. | Detail | Amount |
|---|---|---|
| 1 | School activities@20000 per school(10 schools) | 200000 |
| 2 | College activities(1 college) | 50000 |
| 3 | Documentation | 10000 |
| 4 | Administration and contingency | 15% |

### Role of the PPP partner

The PPP partner would have to undertake the following activities:

- Involve schoolchildren of **10 high schools in the district as model for ACSM** on TB control.
- Provide quarterly plan for involvement of school and colleges.
- Ensure **formation of school health club** with focus on TB control. Each club should have at least 10 members including one school teacher
- Organize **quiz, elocution competition, poster competition, essay competition** with involvement of school health clubs
- Organize **health talk show** in each school with involvement of RNTCP officials.
- Organize **plays/rallies** with involvement of college going youth.
- Involve NSS in college for ACSM activities.
- Give annual award for the best work done for ACSM for college and school.
- Utilize youth for referral of chest symptomatic cases.
- Utilize clubs for reaching families of children.

**Role of the District Health Society**

- Provide IEC and ACSM material for partner involve under this partnership option.
- Facilitate finalization of ACSM activity for the quarter
- Facilitate the selection of school and college for ACSM activities.
- Ensure involvement of RNTCP officials in ACSM activities.
- Ensure involvement of Medical Officer for Health talk show in school and college.
- Ensure orientation of PPP partner on RNTCP.

**Reporting Mechanism**

The PPP partner would provide quarterly report of all the activities carried out in the quarter with photograph and separate one page report for each activity.

**Monitoring Mechanism**

The monitoring of PPP partner would be done on the basis of reports submitted and as per RNTCP norms by the STS on behalf of the DTO

## c) ACSM for Panchayati Raj Institution

### General Description

Advocacy, Communication and Social Mobilization (ACSM) is an important component of the TB control strategy to ensure long-term and sustained impact. The overarching goal of Revised National Tuberculosis Control Program (RNTCP) in the next five years is universal access to TB care. To achieve the same, ACSM will be used to increase demand for early diagnosis and treatment and simultaneously improve standards of care. In this context the involvement of policy makers becomes crucial. Advocacy seeks to ensure that there is strong commitment for TB control; while policy advocacy informs politicians and administrators how an issue will affect the country and outlines actions to take to improve laws and policies, programme advocacy targets opinion leaders at the community level on the need for local action.

### Requirements/Eligibility Criteria

The PPP partner must be a registered entity with at least 2 year experience of advocacy with members of Parliament and state legislature/Panchayati Raj elected representatives and preparing advocacy briefs/reference materials.

### Budget

| Sl.No. | Detail | Amount |
|---|---|---|
| 1 | Advocacy workshop with PRI representatives @12000 per workshop<br>(a. Resource person=2000*2<br>b. Reference material=Rs100*25 participants<br>c. Refreshment=100*25<br>d. Venue Charges= 3000) | 120000 |
| 2 | Documentation (Newsletter for PRI) | 10000 |
| 3 | Administration and contingency expenses | 15% |

### Role of the NGO/private partner

The PPP partner partner would have to undertake the following activities:

- Submit quarterly action plan for advocacy initiatives
- Organize ten advocacy workshops for elected PRI representatives.
- Get advocacy material and newsletter content approved by RNTCP
- The advocacy workshop should have involvement of the DTO
- Preparation of bi annual newsletter for PRIs.

**Role of the State Health Society**

- Facilitate and approve advocacy work plan for the quarter.
- Facilitate coordination with elected representatives.
- Provide feedback on the reference material prepared for advocacy.
- Provide approval for newsletter content developed by the partner.
- Participate as key resource person in advocacy workshops.
- Provide resource material for development of advocacy material by PPP partner.

**Reporting Mechanism**

The PPP partner would provide quarterly report of all the activities carried out in the quarter with photograph and separate one page report for each activity.

**Monitoring Mechanism**

The monitoring of PPP partner would be done on the basis of reports submitted and as per RNTCP norms by the STO.

## Option 2: Diagnosis and Treatment

### a) Designated Microscopy Centre

### General Description

A private health facility having its own laboratory serves as an approved microscopy centre and is designated as such by the RNTCP. Patients are not charged for AFB microscopy, and the materials for microscopy are provided to the microscopy centre by the Programme. This may be effectively displayed in form of a signage etc.

In general, this should be considered for heavily utilized laboratories already having a large volume of patients being examined for diagnosis. It may also be considered for areas where the governmental infrastructure is not sufficient to ensure effective RNTCP implementation and where an effective private organization is currently working in the health field in this area.

### Role of PPP partner

- The health facility must strictly adhere to RNTCP policies on sputum microscopy as outlined in the Manual for Laboratory Technicians and the Laboratory Technicians Module, including proper maintenance of a TB Laboratory Register. Ensure that qualified medical practitioners are involved in referral of patients for sputum

- LT should also preserve slides for cross checking by STLS as per quality assurance protocol of RNTCP. All diagnosed TB patients must be informed of the availability of free services and referred to Government public health institution or DOT centres for categorization and treatment.

- If trained doctor is available in such health facility, the categorization should be done by him/her. It is the laboratory's responsibility to ensure that the results of microscopy are conveyed to the referring institution/worker/doctor, generally within one day. This should be strictly ensured for patients found to have one or more positive AFB smears.

- In case its services are disrupted for any reason, the laboratory should inform all referring physicians and the DHS in advance.

### Role of District Health Society

- The District Health Society will provide training and technical guidance and perform laboratory quality control.

- District Health Society should ensure that the smear-positive patients who live outside the area of services of the microscopy centre are referred appropriately.

- The TB programme will monitor diagnostic quality and will list the facility as a designated RNTCP microscopy centre, as long as services are free and performance is acceptable. This may be conveyed at all forums to the referring doctors and may also be displayed in the PHI Directory.

- The District Health Society should ensure that the microscopy centre provides feedback on results of evaluation of patients referred by PPs within the stipulated time.

- District Health Society should provide a signboard to be displayed prominently in local language that it is a government-approved RNTCP laboratory for carrying out sputum microscopy for TB free of cost**.** The District Health Society should ensure that the system guarantees the initiation of treatment within a week of the diagnosis. Review of approval as microscopy centre on an annual basis must also be carried out.

- The District Health Society will provide Laboratory materials and reagents as well as laboratory forms and TB Laboratory registers. If needed and available, the TB Programme may provide a binocular microscope unless functioning binocular microscope is already available.

**Grant-in-Aid**

Rs 30 per slide for ZN smear microscopy and Rs 40 for florescent microscopy, but subject to review if fewer than 4% of suspects examined for diagnosis are found to be Bacteriological positive. The review would be done by DTO every quarter and with a provision for discontinuation if the partnership is not working. The laboratory has to agree to EQA under the RNTCP.

**Requirements/Eligibility Criteria**

The health facility must have available necessary infrastructure, a trained microscopist, and a room for the laboratory. The health facility staff must undergo modular training in microscopy as per RNTCP guidelines; only specified LTs who have been successfully trained will conduct sputum examinations; the Laboratory Forms and Laboratory Register will be maintained as per RNTCP policy and the facility will be open to on site monitoring by STLS/DTO and other RNTCP supervisory staff. Binocular microscope should be used for carrying out sputum microscopy. Reagents of good quality should be used and properly maintained. A

nodal person should be designated by the concerned institution for reference in case of any issues observed by the supervisory staff.

Preference should be given to involving the most heavily utilized laboratories. The laboratory should, on an average, have at least 2 chest symptomatics for sputum examination/day after 1 year of participation in the programme.

**Reporting Mechanism**

Record-keeping is to be done per RNTCP policy. The PPP microscopy centre would send monthly report to the TU as per the reporting format for public health institution having DMC.

**Monitoring Mechanism**

The TB Programme will monitor diagnostic quality (two smears taken for diagnosis and two for follow-up, proportion of positive smears, proportion of smear-negative cases, if any). Monitoring of the DMC would be carried out by the STLS. Biannual review of the DMC should be carried out by the DTO/STO.

## b) Designated Microscopy cum Treatment Centre

### General Description

The NGO/private lab/agency serves as a microscopy and/or treatment centre and is designated as such by the RNTCP.

### EligibilityCriteria

The following criteria would make a NGO/private lab/agency eligible for the partnership option:

- The NGO/private lab/agency must be registered and should have a minimum of 6 months experience in the area of operation(technical area/microscopy)
- Availability of necessary infrastructure preferably including a room with laboratory facilities (water, sink, etc.).
- Necessary equipment including a Binocular Microscope/ Fluorescent microscope to undertake smear microscopy
- Necessary staff preferably should include at least one Medical officer (allopathic) and one Laboratory technician (Laboratory technician with minimum degree/diploma in lab technology by an institution certified by AICTE) and/ or volunteers required in the field.
- The PPP Partner should have an average 100 samples per month processing capacity

### Role of the PPP Partner

- The PPP Partner provides AFB microscopy and TB treatment services free of charge. The PPP Partner will have a Display board / certificate of DMC in the facility and free availability of services.
- Adhere to Technical policy for collection and examination of sputum and for providing anti-TB treatment is strictly followed as per RNTCP policy.
- Record-keeping and quality control are also to be done per RNTCP policy.
- Ensure the treatment of all patients found to have a positive AFB smear, and for ensuring follow-up treatment and sputum examinations for all patients placed on treatment.
- Ensure referral for treatment of patients found to be smear-positive but who live outside the PPP Partner catchment area. All sputum smear-negative cases should be given antibiotics as per diagnostic algorithm of RNTCP, free of cost, before they are sent for X-ray examination, as laid down in the diagnostic algorithm.

- In the case of patients with chest symptoms who are found to have negative AFB smears or are suspected to have other forms of tuberculosis, the PPP Partner facility will either evaluate the patient as per RNTCP policy, or will refer the patient to an identified referral centre for such evaluation. In case of MDRTB suspect as per the PMDT criteria sputum collection and

transportation to IRL /C&DST lab as per PMDT guidelines. All anti-TB medications and other services under the RNTCP will be provided free of cost.

The microscope if provided by RNTCP and unused materials and reagents will have to be returned to DHS in the event that the PPP Partner ceases to function as a microscopy cum treatment centre.

**Role of the District Health Society/District TB Centre**

- The TB Programme will provide training and technical guidance and will perform laboratory quality control.
- Training / retraining / update training costs (including TA/DA) would be borne by RNTCP for the PPP Partner personnel. Interpersonal communication will be an essential part of the LT training.
- Assist the PPP Partner facility in ensuring evaluation of smear-positive patients who live outside the catchment area of the PPP Partner facility and have been referred by the PPP Partner for treatment. The TB Programme will list the facility as an approved RNTCP microscopy centre, as long as performance is satisfactory and RNTCP policies are adhered to.
- District Health Society should provide a signboard to be displayed prominently in local language that it is a government-approved RNTCP laboratory for carrying out sputum microscopy for TB free of cost. Certification of the PPP lab and treatment centre would be renewed annually and lab should be covered under EQA.
- The RNTCP will provide commodity assistance of laboratory materials and reagents (including sputum containers, equipment for waste disposal, and civil works) as needed, as well as laboratory forms and TB Laboratory Register. Anti-TB drugs will also be provided for patients, started on RNTCP treatment, who live in the catchment area of the PPP facility.
- If needed, the RNTCP may provide a microscope to the PPP partner, the criteria of which will be decided by the STO and will be based on the need of program.

***Grant-in-Aid***

Honorarium of LT and honorarium for part time medical officer at the treatment centre would be as per NRHM norms for the state and an additional 15% cost would be provided for administrative and contingency expenses.

## Reporting Mechanism

Record-keeping is to be done as per RNTCP policy. The PPP microscopy and treatment centre would send monthly report to the TU as per the reporting format for public health institution having DMC.

## Monitoring Mechanism

The TB Programme will monitor diagnostic quality two smears taken for diagnosis and two for follow-up, proportion of positive smears, proportion of smear-negative cases, if any). Monitoring of the DMC cum treatment centre would be carried out by the STLS and ensure feedback as per EQA guidelines. Biannual review of the DMC cum treatment centre should be carried out by the DTO/STO. The process of renewal of MOU should be started two months before the MOU ends with the PPP partner.

## c) Providing Quality Assured Culture and Drug Susceptibility Testing Services

### Introduction

The programme is in the process of establishing a nation-wide network of quality assured sputum culture and drug susceptibility testing (C&DST) laboratories for the diagnosis and follow-up of drug resistant TB (DR-TB) patients and XDR patients. To supplement the planned sputum culture and DST laboratories in the public sector, this partnership option will help to involve established and well-functioning mycobacteriology laboratories in the non-governmental / private / corporate sector in assisting RNTCP's sputum/specimen mycobacterial C&DST activities.

### Eligibility

An existing well-functioning mycobacterial culture and DST laboratory in the private/NGO sector can apply under this scheme. The applicant laboratory should have adequate infrastructure, equipment and staff to undertake the sputum culture & DST activities. The laboratory should be willing to undergo the process of certification as per RNTCP guidelines and also to undergo routine quality assurance and annual proficiency testing with an RNTCP National Reference Laboratory (NRL) as per RNTCP guidelines. Once the laboratory is certified under RNTCP, a memorandum of understanding is to be signed between the respective institution in which the laboratory is located and the State Health Society of the respective state in which the institution is situated. The sputum culture and DST services are to be provided free of charge to all RNTCP patients/ DRTB suspects who have been referred by the programme to the respective laboratory for examination.

### Budget

| **Technology** | **Diagnosis (culture+DST) (Per specimen)** | **Follow-up (Per specimen)** |
|---|---|---|
| LJ (Solid Culture) | Rs. 400 per Culture per specimen<br><br>Rs. 1200 per DST for HR per specimen<br><br>Rs.1600 per DST for HR OK per specimen | Rs.400 per Culture per specimen |
| LPA | Rs. 2000 per LPA for HR per specimen | - |
| Liquid Culture | Rs. 400 per Culture per specimen<br>Rs. 1600 per DST for HR per specimen<br>Rs.2000 per DST for HR OK per specimen | Rs.400 per Culture per specimen |
| CBNAAT | Rs1800 | |

* DST for drugs other than HROK will be reimbursed at Rs500/- per drug for DST for LJ as well as Liquid culture

Contamination allowed: 5% in solids; 10% in liquids; CBNAAT 10%; LPA 10% (Invalid/ indeterminate and contaminated)

**Responsibilities of the PPP Partner:**

- Maintain adequate infrastructure, equipment, consumables and staff for the laboratory ( as assessed by NRL )to be fully functional at all times
- Keep the records and submit reports as per RNTCP guidelines including indicators for Culture and DST laboratories.
- RNTCP certification for relevant first line and second line Anti TB drug will be mandatory
- Timely reporting of contamination of the samples to the concerned DTO
- Perform repeat culture for sputum samples received for patients whose earlier samples were reported to be contaminated.
- On diagnostic and f/u cultures positive at months 6 or later of Rif resistance private lab will have to send the isolates of the diagnostic samples to the nearest lab certified for doing SLDST if not included in in the lab – the costing will be as per the sputum transportation scheme
- Report the result of follow up to IRL and concerned DOTS Plus site / DRTB Centre and DTO concerned within a day through email.
- Provide the sputum culture service free of charge to all RNTCP patients/ MDRTB suspects whose samples / patients have been sent / referred from the programme.
- Effectively coordinate with the respective NRL, IRL and STO for routine external quality assurance and annual proficiency testing of the laboratory at regular intervals.

**Responsibility of the respective DTO:**

- Co-ordinate with the respective institution where the laboratory is located, the respective District TB Officers and NRL in relation to service provision, training, supervision and quality assurance.
- Provide financial and RNTCP/ PMDT standard records and reports to the private partner for implementation of the scheme.
- Provide relevant technical guidelines and updates under RNTCP.
- The necessary formats, records and reports will also be provided to the laboratory by the programme
- Coordinate followup sputum specimen collection from MDR TB patients on RNTCP IV regimen in special sterile containers at DMC of the catchment area as per RNTCP DOTS Plus/PMDT guidelines.
- Coordinate repeat sputum specimen collection from MDR patients on RNTCP Cat IV treatment when required by the lab in case of contamination loss of specimen in transit, breakage etc.

- Coordinate between the Lab technician of DMC (collection centres) and the private partner for timely pick up & transport of specimen to the C&DST lab.
- The programme will provide training to the laboratory staff if required
- Ensure that timely payment to laboratory is made on a six monthly basis
- Periodically review the activities undertaken by the lab and provide appropriate feedback.
- Supervision and monitoring of the performance of the lab technician.

**Reporting Mechanism**

Provide routine regular reports on the progress of PMDT activities are sent to CTD and the State level PMDT Committee as per the formats and records provided by RNTCP. Private partner will follow the same electronic reporting and recording system as per RNTCP

**Monitoring Mechanism**

The PPP partner would be monitored by the STDC and DTO on a quarterly basis and also through reports submitted by the PPP partner. STO would ensure quality control monitoring in coordination with State level DOTS-Plus Committee.

**Payment Mechanism**

The initial payment by RNTCP will be based on a pre-decided estimated number of cultures / DST / tests for MDR suspects / patients as per RNTCP DOTS-Plus implementation plans. The payments will be made where the end result of activity is reported with the understanding that a small proportion of samples will require retesting because of technical reasons for which there will be no additional payments. Payment of repeat test for contaminated samples should be permissible only up to 5% in Solid Culture (LJmedia) and 10% for Liquid Culture,10% for CBNAAT and 10% invalid results in LPA. No payment for repeat test beyond this ceiling.

## d) DR TB Centre

### General Description

M. tuberculosis strains that are resistant to the two most potent anti-TB drugs, viz., Isoniazid and Rifampicin, are termed as multidrug-resistant TB (MDR-TB) strains. The Revised National Tuberculosis Control Programme is implementing all components of WHO Stop TB Strategy and has a vision to provide universal access to quality TB care including access to quality assured diagnosis and management of Drug Resistant Tuberculosis. any state aspiring to engage private /NGO institutes as DR-TB Centres to compensate for non-availability of a suitable government institute; may work out their own MoU with terms and conditions as agreed upon by the respective state health societies and the concerned institute under consultation with CTD. The RNTCP rolled out services for diagnosis and management of multi-drug resistant TB (MDR-TB) have been scaled up and currently these services are available in all 35 states/UTs. Various options under this partnership would be:

1. DR TB Centre with Indoor Facilities

2. DR TB Centre with Outdoor Facilities

3. Specialist consultation charges for Govt. DR TB Centres

### Option 1: DR TB Centre with Indoor Facilities

Requirements/Eligibility Criteria for private partner (option A)

1. It should be a Tertiary Care Hospital.

2. Separate Ward for Male & Female should be available and Air Changes per Hour and other infection control measures as per National Airborne Infection Control Guidelines for DRTB centre.

3. All the PMDT services (beds, investigations and ancillary drugs for management of adverse drug reactions) to be provided free of cost to the patient.

4. Relevant special like Pulmonologist, Physician, Psychiatrist, Dermatologist, Gynaecologist, Paediatrician etc. should be available or linkages for their services should be are established.

5. All necessary paramedic staff should be in place for indoor services

6. DR-TB Centre Committee to be formed.

7. Members of DRTB Committee should be trained in PMDT.

**Role for Private partner (Option 1)**

• To designate a special ward compliant with National AIC guidelines and at least 10 beds earmarked for indoor management of DRTB patients according to National PMDT Guidelines.

• Routine clinical laboratory investigation facility to be made available for pre-treatment evaluation and monitoring

•Doctors and Nursing staff should be available from the institute for round the clock services to the DRTB patients.

• Ancillary drugs to be provided as per DR-TB Centre Committee`s advise

• Services / facilities to diagnose and manage adverse drug reactions (ADRs) as per National PMDT Guidelines

• Services / facilities to diagnose and manage the comorbid conditions

•Records and Reports to be maintained for PMDT including registration, follow-up, referral and transfer (if required) of patients as per guidelines update the same on day to day basis using Nikshay

• Quarterly reports to be submitted electronically

•All doctors in the hospital should be following Standards for TB Care in India and notify all TB cases even from their respective clinics/institution through Nikshay

•Ensure coordination with implementing district officers and staff as well as laboratory for proper follow-up of patients till outcomes

The services to be provided by the partner organisation would include at least:

| **Sl No** | **Investigations** | Minimum No. of times test will be done |
|---|---|---|
| 1 | Complete blood count | 1 |
| 2 | Blood sugar | 1 |
| 3 | LFT | 1 |
| 4 | Blood Urea | 1 |

| | | |
|---|---|---|
| 5 | Serum Creatinine | 6 |
| 6 | TSH | 1 |
| 7 | Urine routine & microscopy | 1 |
| 8 | Pregnancy test | 1 |
| 9 | Chest X ray | 3 |
| 10 | Indoor Stay for a maximum of 7 days | 1 |
| 11 | Food for a maximum of 7 days | 1 |
| 12 | Specialist Consultation | As required |
| 13 | Ancillary drugs for management of adverse drug reaction and comorbidities | As required |

The DR TB Centre cannot deny services to any eligible patient from the geographical area assigned to the centre.

This does not restrict the DR TB Centre from extending any further services to the patients, if clinically deemed necessary

In cases of re-admission/ extension of stay beyond 7 days:

a. In cases of re-admission/ extension of stay due to cause/s secondary to TB or side-effects of second line anti-TB drugs or co-morbidity management, the additional cost will be borne by the state health society from RNTCP funds.

The decision regarding the cause of re-admission/ extension of stay will be decided by DR TB Centre committee under intimation of State PMDT Committee.

**Role of RNTCP**

• Provide Remuneration of Sr. Medical Officer & Statistical Assistant & Counsellor for – DR-TB Centre.

•Provide training, formats and registers, IEC material for PMDT

• National Training of DR-TB Centre committee doctors

• Provide Second Line Anti TB Drugs and provide Computer and Internet Facility

• Provide access to NIKSHAY for online data management and patient tracking

•In cases of re-admission/ extension of stay due to cause/s other than TB, RNTCP would advocate for the patient to be linked up with social welfare schemes.

Grant in Aid

A. Indoor basis:

• Package cost per day for MDR-TB cases will be Rs 800/- including pre-treatment evaluation, bed charges, meal and ancillary drugs.

•In house Specialist Consultation charges would be applicable at Rs 200/day/patient.

B. For patient convenience, if he/she is partially or completely managed on ambulatory basis at the district level under guidance of DR TB Centre Committee

•Rs 500/- per day if pre-treatment investigations is done at the district level and patient is admitted to the ward

•Rs 500/- one time for only DR TB Centre decision based on reports sent from the districts, if pre-treatment investigation and treatment initiation is done at the district level in case patient refuses to get admitted. This will also be applicable if the district's request for follow up advise over email/phone/post on decisions of DR TB Centre for either change in regimen, adverse drug reaction management, co-morbidity management etc. without patient admission to the DR TB Centre)

C. In cases of re-admission/ extension of stay due to cause/s secondary to TB or side-effects of second line anti-TB drugs or co-morbidity management or emergency / surgical interventions:

• Charges up to Rs. 800/day/patient (including bed and meals + investigations and ancillary drugs)

• In case of emergent need of ICU Rs 5000/day will be applicable (including bed and meals + investigation and emergency drugs)

• In case of surgical intervention, the actual cost of pre-operative, operation and post-operative care will be reimbursed against the bill on concessional rate as mutually agreed between the hospital and the state health society.

**Option 2: DR TB Centre on Outdoor basis**

Eligibility for Private Sector

• It should be a Tertiary / Secondary Care Hospital or a Nursing Home or a Poly-clinic with an eminent Physician / Pulmonologist available round the clock.

• Separate designated clinic for DR TB patient management should be available and comply to the National Guidelines for Air-borne Infection Control for out-patient settings

• Relevant specialties like Pulmonologist, Physician, Psychiatrist, Dermatologist & Gynaecologist etc. should be available or linkages for these services are established

• DR-TB Centre Committee to be formed with the above group of doctors.

•PMDT Training of DR-TB Centre committee doctors.

•All doctors in the hospital should be following Standards for TB Care in India and notify all TB cases even from their respective clinics/institution through NIKSHAY

**Role of Private Sector**

•Routine clinical laboratory investigation facility to be made available for pre-treatment evaluation and monitoring

•To renovate (in keeping with the National Airborne Infection Control Guidelines and National Guidelines for Programmatic Management of Drug Resistant TB (PMDT) provided for the purpose) and designate a special clinic area designated for MDR – TB out-patient services with a earmarked well ventilated preferably open air waiting area separate from other waiting areas, away from clinics managing immune-suppressed and vulnerable cases where the patients who will be eligible to avail DR TB services under the RNTCP will be fast-tracked, segregated and counselled in accordance with the RNTCP guidelines

•Doctors and Nursing staff should be available from the institute. Round the clock consultation services made available, if required by the patients.

• Ancillary drugs to be provided as per DR-TB Centre Committee`s advise

• Management of adverse drug reactions (ADRs) as per National PMDT Guidelines

• Records and Reports to be maintained for PMDT including registration, follow-up, referral and transfer (if required) of patients as per guidelines update the same on day to day basis using Nikshay

• Quarterly reports to be submitted electronically

•Ensure coordination with implementing district officers and staff as well as laboratory for proper follow-up of patients till outcomes

The services to be provided by the partner organisation would include at least:

| Sl No | Investigations | Minimum No. of times test will be done | Rate for tests* |
|---|---|---|---|
| 1 | Complete blood count | 1 | 138 |
| 2 | Blood sugar | 1 | 25 |
| 3 | LFT | 1 | 275 |
| 4 | Blood Urea Nitrogen | 1 | 55 |
| 5 | Serum Creatinine | 6 | 56 |
| 6 | TSH | 1 | 125 |
| 7 | Urine routine & microscopy | 1 | 39 |
| 8 | Pregnancy test | 1 | 69 |
| 9 | Chest X ray | 3 | 70 |

*Rates are based on rate of CGHS Delhi rates and are subject to revision as and when updated in CGHS website

**Role of RNTCP**

•Remuneration of Sr. Medical Officer & Statistical Assistant and Counsellor for – DR-TB Centre

• Training, formats and registers for PMDT

•Second Line Anti TB Drugs

•Computer and Internet Facility

•Provide access to NIKSHAY for online data management and patient tracking

**Grant in Aid for 2. Outdoor option:**

•For diagnostic tests of MDR –TB patients, private partner would be reimbursed as per rates given above (applicable for the area) by RNTCP.

•In case of ambulatory care of MDR TB patients Rs200/day/per patient consultation charges would be applicable

**Option 3: Specialist consultation charges for Public Sector DR TB Centres**

Eligibility for Private Sector

•It should be preferably a registered institution or private sector partner willing to make visits and provide special consultation to DR TB patients managed at the DR TB Centre in public sector or private sector (Option A & B above) of relevant specialities Pulmonologist, Physician, Psychiatrist, Dermatologist & Gynaecologist etc. as per the need of the concerned DR TB centre.

**Role of private sector**

• Willing to undergo national training on PMDT and to follow PMDT guidelines

• To cater to emergency cases in DR-TB centres promptly

• Attend calls from DR-TB centres within 24 hours in cases with no emergency

• Specialists should be following Standards for TB Care in India and notify all TB cases even from their respective clinics/institution through NIKSHAY

Budget: Specialist consultation charges for Public sector DR TB Centres:

•Honorarium up to Rs1000/specialist /visit (including consultations, emergency calls and travel cost to the centre).

•Specialist should be available for at least 5 visits per week or more as per requirement per visit. He/She should also be available for visits of any duration to attend emergency calls.

**Reporting Mechanism**

The PPP partner has to maintain records of specialist visit to DR-TB centres as per RNTCP norms.

**Monitoring Mechanism**

The monitoring of PPP partner would be done on the basis of reports submitted.

## e) Corporate Hospital/ clinics involvement in RNTCP

### General Description

The National Population Policy, 2001, advocates a partnership between non-government voluntary organizations and private sector organizations, including corporate houses (Planning Commission, 2001) to achieve the goals envisaged. The National Rural Health Mission (NRHM) envisages the participation of the private sector to ensure that the states make full use of the health care providers available in remote regions. Given the huge presence and significant share of the private health care delivery in the total health care scenario of the country RNTCP seeks to involve them systematically for greater reach of services.

### Requirements/Eligibility Criteria

A private sector hospital /clinics with OPD of at least 60 patients each day and equipped with adequate infrastructure and at least 20 beds to provide indoor services for RNTCP. The corporate entity should be ready to be accredited as per RNTCP norms and provide services as per RNTCP approved norms.

### Budget

The corporate entity would be provided support in terms of personnel as per RNTCP norms for medical colleges. The payment for the rest of the services would be as per actual services opted for by the private entity including:

1. Diagnosis of TB patient
2. Referral of TB patient
3. Reporting of TB patient

a. Reimbursement for diagnosis as per RNTCP norms for diagnostic tests.

b. For reporting TB case treated by partner=Rs.500/per case (payment after patient is confirmed to be a TB case by RNTCP).

c. Referral of TB patient= Rs 300/patient

### Role of the private partner

The private sector partner would undertake the following activities:

- Certification for providing RNTCP services
- Orientation training of staff on RNTCP.
- Diagnosis of TB patient both pulmonary and extra pulmonary as per RNTCP approved norms.

- Referral of TB patient to nearest RNTCP facility
- Treatment of patients as per RNTCP approved norms.
- Registration of Health facility under Nikshay using Health Institution registration format
- Notification of TB cases
- Provide reports on a quarterly basis

**Role of the State Health Society**

- Inspection and accreditation of corporate entity for providing TB services at state level.
- Training of staff on RNTCP
- Providing anti TB drugs for each patient being treated.
- Monitoring of services being provided

**Reporting Mechanism**

Provide quarterly report on TB control services being provided as per RNTCP reporting format. Notify TB cases being treated as per RNTCP format.

**Monitoring Mechanism**

The monitoring of PPP partner would be done on the basis of reports submitted and as per RNTCP norms by the STO or his representatives

## f) Improving TB control in Urban Slums

### Introduction

Urban growth has led to rapid increases in the population of urban slum dwellers. Despite the supposed proximity of the urban poor to urban health facilities, their access to them may be limited by inadequacies in the urban public health delivery system. Slum dwellers are often migrants, with different language and cultures. There are high concentrations of particular occupations such as rickshaw pullers, rag pickers, sex workers, and other urban poor categories like beggars and destitute, construction site workers, alcoholics, drug abusers, street children. As a result, the urban poor may be more vulnerable and worse off than their rural counterparts. Poor environmental conditions in the slums, along with high population density, make slum-dwellers more vulnerable to tuberculosis and other diseases of poverty.

Urban slum-dwellers require intensive focus and support from the tuberculosis programme, as these populations often are not able to access timely diagnosis or complete the full duration of anti TB treatment, and hence are at risk of unfavourable treatment outcomes including deaths, defaults, failures and drug resistance.

### Eligibility

Any registered NGO/Community based organization/Self-help group/private agency/private practitioners with capacity and commitment to provide sustained support for at least 3 years

### Role of NGO/Collaborating partner

- Mapping of slum population
- Coordinate with NUHM facility for slum intervention
- Quarterly work plan for slum
- Organize IEC activities in slum population for TB and service awareness
- Organize sensitizing sessions for private health care providers
- Intensified case finding
- Notify TB patients
- Counsel patients for diagnostic process completion, treatment initiation, treatment adherence, need to inform regarding pending migration, and default prevention
- Collect detailed information regarding place of residence, home village, and other information helpful to locate patients in the case of migration.
- Address special needs of patients, such as drug abuse, alcohol abuse
- Link and facilitate access of patients to appropriate welfare schemes

- Facilitate sputum collection and transportation to DMCs
- Conduct address verification for patients
- Provide DOT as per RNTCP guidelines and also cater to TB-HIV, DR-TB cases
- Retrieve patients who have interrupted treatment, and inform RNTCP staff of patients for whom retrieval efforts are not successful.
- Facilitate communication to RNTCP regarding impending migration of patients, so that appropriate referral or transfer can be arranged.
- Create slum level SHGs focussing on TB control.
- Create community level volunteers for coordinating awareness generation and TB control activities.

**Role of RNTCP (DTO/STO)**

- Training of NGO and Service providers and the cost to come from state budget for RNTCP.
- Provide Sputum cups, IEC material, and printed material
- Provide supervision, monitoring & evaluation of NGO activities & patient care
- Provide honorarium for individual DOT providers as per RNTCP norms.
- Supportive supervision including involvement of STS/MOs in awareness generation activities at slum level.
- Facilitate coordination with other government departments.

**Budget**

Budget to be provided would be based on target population in the slum area (slum would include slum population in the semi urban/peri-urban areas) which may vary from 20000 to 50,000 population. For a target slum of 20,000 the grant would be Rs.75000 per annum however for every new TB case referred and notified by PPP partner from the slum area and completing treatment, the PPP Partner would be provided Rs.1500 per case as performance incentive. Minimum 15 cases should be detected by the NGO per annum for a population of 20,000.The NGO would be provided 15% additional amount as administrative and contingency expenses.

**Reporting Mechanism**

The PPP partner should submit Quarterly report to the STO indicating the activities carried out with focus on case notification, DOT service, awareness generation, counselling of patients and additional services if any.

**Monitoring Mechanism**

The monitoring would be done on the basis of report submitted on DOT service, awareness generation, counselling of patients and additional services carried out by the PPP partner. Quarterly review of the performance of the PPP partner to be validated by field visits by STS.STS would be responsible for supervision of the PPP partner on behalf of DTO. Monitoring would be done on basis of work plan for the quarter, awareness generation activities carried out, self-help groups formed, home visits and counselling by volunteers/NGO workers

## Option 3: TB and comorbidities

### a) Referral of TB-HIV patients

### General Description

The treatment of HIV infected TB persons are done using RNTCP DOTS as per national policy. All known HIV positive TB patients are considered seriously ill regardless of sputum smear results. In addition to TB treatment under RNTCP, all HIV infected TB patients must be provided access to care and support for HIV-AIDS including ART. ART reduces TB case fatality rates and the risk of recurrent TB.

### Requirements/Eligibility Criteria (any one of the below)

- NGOs already undertaking NACP Targeted Intervention in the following identified HIV high populations and catering to a **minimum of 500** target population of Commercial sex workers, MSM (Men having Sex with Men), and/or IDUs (Injecting Drug Users).
- NGOs running a NACP accredited/funded **Care and Support Centre** for HIV.
- NGO should already be providing HIV care, including clinical care to the above described High risk populations and undertaking outreach activities in these populations
- NGOs already working on TB control with a minimum experience of 1 year.

### Budget

The PPP partner will be provided an administration cost of Rs.10,000 per 1,00,000 population on pro-rata basis. An additional amount of Rs.1000 per TB patient who is initiated on ART with support from PPP partner. The PPP partner will do all the expenses for the patient and one attendant will be given to trace, mobilize the patient along with one attendant and link them to the ART centre

### Role of the NGO/private partner

Under the Scheme, the PPP partner will be assigned a definitive field area/TU. The PPP partner shall be assigned the responsibility of

- Tracing of TB-HIV patients
- Counseling of TB-HIV patients on the importance of ART and free availability of evaluation for ART and treatment.
- Mobilizing the TB-HIV patients to ART centers and henceforth regularly maintain routine visits to the centre.
- Attend the District Meeting on TB –HIV collaboration for effective coordination

- Maintain records of these patients

**Role of the District Health Society**

The list of TB-HIV patients to be traced will be shared by RNTCP and NACP regularly on monthly basis with the concerned PPP partner. Make available ART guidelines from NACO.

**Reporting Mechanism**

The PPP partner would submit monthly report providing details of the tracing of TB-HIV patients, counseling and mobilizing of patients or each TB-HIV case as per RNTCP formats.

**Monitoring Mechanism**

The monitoring would be done on the basis of report submitted on patient traced, counseling of patients and referral of TB-HIV patients to ART centres by the PPP partner. Quarterly review of the performance of the PPP partner to be validated by the information from monthly report submitted and report by STS. STS and DRTB HIV Supervisor would be responsible for supervision of the PPP partner on behalf of DTO.

## b) Delivering TB-HIV interventions for high Risk groups (HRGs)

### Background

Care, Support & Treatment (CST) is an integral component of the National AIDS control programme. The delivery of care and treatment services for people living with HIV/AIDS is provided through a three-tier structure. The various levels where HIV care and treatment is provided include:

1. Centre of Excellence (CoE) & ART Plus Centres

2. ART Centres

3. Link ART Centres & Link ART Centre Plus

ART Centres are also linked with Care and support Centres. Care and Support Centres act as a vital link between the health care service delivery system and the community. These community-based care and support centres are part of the national response to meet the needs of PLHIV especially those from high risk groups and women and children living with and affected by HIV. CSCs will be run by District Level Networks (DLN) and NGOs.

Care and Support Centres will be seen as focal point for care & support services, counselling, peer education and will provide a comforting environment to PLHIVs. They will act as friendly places where PLHIV, key population, women and children will receive information on care and support, access to range of health referrals, education and linkages to social welfare schemes and entitlements , home visits ( family would be taken as a unit) , treatment education and SRH education counseling services. A major component of National AIDS Control Programme's response to HIV epidemic 'Targeted Interventions', which reach out to populations with high risk of contacting HIV infection to deliver a package of preventive and curative services.

Targeted Intervention Programmes have been undertaken for various categories of vulnerable population like commercial sex workers, truck drivers, MSM, eunuchs, etc. The concept of 'Targeted interventions' is based on the pillar of community ownership. These populations are most at risk of infection of HIV and also most often marginalized by society, difficult to reach and poor. NGOs undertaking these targeted interventions utilize peer educators to detect these populations, build bridges, and provide a package of preventive and curative services for the targeted communities. As per NACP guidelines, the NGO team providing these services include, outreach workers, and peer educators. Delivery of TB treatment under DOT by general health services to these populations is a challenge due to issues like high mobility and stigma.

However, schemes based on general population norms will not be available to NGOs serving scattered and heterogeneous target populations. These NGOs could be covering a number of very localized geographical areas in case of brothel based commercial sex workers and community care centres or huge geographic areas focusing smaller but more challenging populations like street based sex workers. Hence a dedicated RNTCP scheme is required to ensure equity of access and to expand TB-HIV interventions into these challenging populations.

**Eligibility**

- PPP partner already undertaking NACP Targeted Intervention in the following identified HIV high populations and catering to a **minimum of 500** target population of Commercial sex workers, MSM (Men having Sex with Men), and/or IDUs (Injecting Drug Users).

OR

- NGOs running a NACP accredited Care and Support Centre for HIV

- PPP partner being offered the RNTCP scheme should willing to undertake delivery of comprehensive TB care i.e. all components as described below

**Role of PPP partner**

Under the proposed partnership option PPP partner would undertake delivery of **'Comprehensive TB Care for HIV high risk populations'** which includes all of the following components:

1. Intensified TB Case Finding:
    a. TB symptom screening through outreach workers and peer educators at the time of each interaction with the member of target population & Referral of suspects for Diagnosis & treatment
    b. TB symptom screening for clients registered in Care and support Centres
    c. TB symptom screening for clients attending these PPP partner clinics
    d. TB symptom screening of family members of infected patients by outreach workers and linking them to designated microscopic centres ( DMC) under RNTCP

2. Patient friendly approach for Diagnosis and treatment categorization:
    a. Sputum collection & transportation **or** Facilitated referrals
    b. NGO staff to coordinate with the existing government health facilities for the diagnosis of smear negative pulmonary TB (for X-Ray) and Extra-pulmonary TB (for FNAC, etc)
    c. TB treatment categorization by PPP partner clinic medical officer

3. Undertake address verification before initiation of TB treatment.

4. Treatment provision:
    a. Treatment delivery to be organized by PPP partner by identification of appropriate community DOT provider in consultation with the diagnosed client/ DOT provision through PPP partner staff if convenient to the TB patient.

5. Adherence:
    a. PPP partner staff to ensure timely follow up of the patient and also undertake patients retrieval action in case of treatment interruption;
    b. Coordinate with local RNTCP programme staff to ensure smooth transfer, in case of anticipated migration of patient
    c. Monitoring, Supervision & Recording (on treatment cards) by PPP partner.

6. Monthly meeting: DTO and PPP partner

7. Outreach activities by PPP partner, outreach workers to include ACSM
    a. Increase visibility of RNTCP for HRG(High Risk Group)
    b. Community capacity building/CBO/community involvement in TB services
    c. Advocacy with PLHA networks for TB control

**Role of RNTCP (DTO/STO)**

- Training of PPP partner and Service providers
- Provide Sputum cups, IEC material, and printed material (treatment cards, identity cards etc.).
- Provide supervision, monitoring and evaluation of PPP partner activities and patient care
- Provide honorarium for individual DOT providers as per RNTCP norms.

**Budget: Rs 1.5lakh per PPP partner per 500 Target population (or one NACP-approved Care and Support Centre),**

The budget for the scheme is Consolidated Rs.1.5 Lakhs / annum for a target population of 500 or NACP accredited/funded Care and Support Centre for HIV, which is at least 10 bedded for the described activities. For NGOs catering to larger number of target population or running larger Care and Support Centre, would be provided financial package on a pro-rata basis.

**Reporting Mechanism**

The PPP partner should submit monthly report to the DTO and Quarterly report to the STO indicating the activities carried out as per RNTCP norms and formats for government run TUs in the district. PPP partner scrupulously maintains RNTCP records and submits monthly reports to the District TB Officer in the prescribed manner and in a timely fashion. The PPP partner should also submit quarterly workplan and UC to the DTO each quarter.

**Monitoring Mechanism**

The monitoring would be done on the basis of report submitted by the PPP partner. Biannual review of the performance of the PPP partner would be carried out and in case the PPP partner does not submit quarterly reports regularly, or if the quarterly reports show problems in programme implementation which do not improve after joint supervision, then the arrangement is liable to be cancelled and an alternative arrangement made by the DHS. Accounts must be audited every year and audited reports made available to the District Health Society no later than 15 June each year.

## c) Paediatric TB

### General Description

Children can present with TB at any age, but the most common age is between 1 and 4 years. Case notifications of childhood TB depend on the intensity of the epidemic, the age structure of the population, the available diagnostic tools, and the extent of routine contact investigation. The extent of childhood tuberculosis is unknown and is estimated to constitute about 6% out of all incident cases. This partnership option is an attempt to establish linkage private sector paediatricians and the national TB programme

### Requirements/Eligibility Criteria

The registered clinic / hospital / nursing home / private practitioners should have experience of at least 1 year in treatment of paediatric TB cases and preferably a member of Indian Academy of Paediatrics. The PP should be willing to diagnose and treat paediatric TB cases as per National Guideline on diagnosis and treatment of paediatric TB cases.

### Budget

For referral of a paediatric TB suspect to RNTCP, who subsequently turns out to be a TB case, PP will be provided Rs. 100. For diagnosis and referral of a paediatric TB case to RNTCP for treatment, PP will be provided with additional Rs.300 .Additional 15% of the cumulative cost will be provided as an administration cost to the participating PP under this scheme.

### Role of the PPP partner

The PPP partner should undertake the following tasks:

- Identification and referral of paediatric TB cases
- Diagnosis and referral of paediatric TB cases to RNTCP facility for treatment
- Counselling of family members of the patient
- Maintain record of paediatric cases

### Role of the District Health Society

RNTCP would be responsible for the following:

- Provide RNTCP format for reporting to PP

- Sensitization of PP (non-specialist) on National guideline on diagnosis and treatment of Paediatric TB cases
- Provide the PPD supplied in the program
- Feedback to PP on patients referred

**Reporting Mechanism**

The PPP partner would submit monthly report providing details of pediatric TB patients, counseling of family members and referral of patients for each case as per RNTCP formats.

**Monitoring Mechanism**

The monitoring would be done on the basis of report submitted on patient diagnosed, counseling of patients and referral of patients to by the PP. Quarterly review of the performance of the PPP partner to be validated by the information from monthly report submitted and report by STS. MO would be responsible for supervision of the PPP partner on behalf of DTO.

## Option 4: Programme Management

### a. Case Management and reporting of TB cases

### General Description

Tuberculosis (TB) continues to be a major public health problem accounting for substantial morbidity and mortality in the country. Early diagnosis and complete treatment of TB is the corner-stone of TB prevention and control strategy. Inappropriate diagnosis and irregular/incomplete treatment with anti-TB drugs may contribute to complications, disease spread and emergence of Drug Resistant TB. In order to ensure proper TB diagnosis and case management, reduce TB transmission and address the problems of emergence of spread of Drug Resistant-TB, it is essential to have complete information of all TB cases.

In this scenario it is essential that all healthcare providers (clinical establishments run or managed by the Government (including local authorities), private or NGO sectors and/or individual practitioners) shall notify every TB case to local authorities i.e. District Health Officers, Chief Medical Officers of a district or Municipal health Officer of a Municipal Corporation / Municipality

### Requirements/Eligibility Criteria

A private sector provider/laboratory or NGO having a clinic with at least one allopathic doctor for initial diagnosis of TB cases in the area. The NGO/PP should have undergone training in at least the 1-day RNTCP module for Private Practitioners, or at least staff from the clinic should have undergone RNTCP DOT provider module training. The NGO/PP should have presence and at least cater to one TU for this scheme. Preference would be given to NGOs having experience of working under NACP for targeted Intervention.

### Budget/GIA

The PPP partner would be given payment would be based on:

a. For case management till outcome and subsequent then reporting = Rs500/patient.

b. For TB case reporting of a clinically confirmed TB case =Rs.100/per case (If enrolled in Nikshay, after verification and de-duplication)

c. Provision for Rs100 notification incentive for all care providers including ASHA/USHA/AWW/unqualified practitioners etc if suspect referred is diagnosed to be TB patient by MO/Lab.

d. For only Referral of a diagnosed TB case =Rs.200/case. This would be optional and private sector can just report and treat TB cases as per RNTCP approved treatment regimen [Standards for TB Care in India]

**Role of the PPP partner**

The PPP partner would be required to perform the following tasks:

- Diagnosis of TB
- Provide treatment for both pulmonary and extra pulmonary TB, ensure treatment completion and manage associate conditions.
- Report all TB cases as per RNTCP format on a monthly basis
- Refer TB cases to nearest RNTCP facility for complicated cases(optional)
- Maintain records as per RNTCP norms
- Provide monthly report as per RNTCP norms
- Submit UC on a quarterly basis for reimbursement

**Role of the District Health Society (DHS)**

- The DHS would provide training to PPP partner on RNTCP module
- Provide free anti TB drugs for the enrolled patients
- Provide literature for training and orientation for PPP partner workers
- Provide IEC material for display in the PPP partner facility
- Provide honorarium for DOTS provider as per norms
- Make payment for the services provided as per budget.

**Reporting Mechanism**

The PPP partner would submit monthly report providing details of the reported cases, referred cases and treatment completed as per RNTCP formats.

**Monitoring Mechanism**

The monitoring would be done on the basis of report submitted on DOT service, case referral, counseling of patients, and additional services carried out by the PPP partner. Quarterly review of the performance of the PPP partner to be validated by the information from DMC /lab registers, monthly report submitted and report by STS.STS would be responsible for supervision of the PPP partner on behalf of DTO.

## b. Sputum Collection and Sputum transport

### i) Sputum Collection

### Introduction

Quality assured sputum smear microscopy is the backbone of tuberculosis diagnosis. However, persons suspected of having TB are required to submit sputum specimens on between two and four times during diagnosis; if diagnosed with TB, again sputum specimens are required several times throughout treatment to monitor progress. To enhance equity and accessibility of TB health care delivery services, sputum collection should be as close and convenient to TB suspects and patients as possible.

RNTCP has established Designated Microscopy Centres (DMCs) in the entire country, but there are still areas where accessibility to DMCs is sub-optimal. Hence in these areas with sub-optimal access to DMCs, it is envisaged that NGO/private provider supported sputum collection centres can be established to provide ease of accessibility to patients. Sputum specimens collected will be subsequently transported to the nearest DMC, enhancing the coverage of RNTCP and improving convenience to patients.

### Eligibility

Any registered NGO/agency/institution/Diagnostic lab and their collection centre/PPP partner in "underserved" areas with convenient access at appropriate times to the population served. Underserved areas are defined as those settings with justifiably difficult access to microscopy services and low level of service delivery. This may be difficulty based on distance, accessibility, poor public transport network connectivity, population characteristics that complicate access to existing DMCs (e.g. a slum in an urban area, or tribal village). The institution should have an area conducive for sputum collection, including well ventilated open spaces for sputum expectoration. Eligibility may include a minimum of 20 patients a month on annual average, for the concerned partner NGO/Agency.

### Role of PPP partner

- Sputum collection from TB suspects[presumptive TB] referred from outpatients of the same facility, the surrounding community, and other facilities linked in the vicinity
- Collect diagnostic and follow up sputum specimens following RNTCP guidelines.
- Ensure adherence to guidelines on sputum collection in order to obtain good quality sputum samples.

- Ensure accurate recording in lab forms and dispatch lists, labelling, recording and packaging of samples.
- Maintain a register with patient and sample details
- Collaboration with DMC and arrangement/liaison with the agency transporting the sputum samples
- Ensure that there is timely communication of sputum results back to referring providers or patients and the same is reflected in the relevant sputum collection register.
- Sputum negative patients are counselled according to the guidelines and they should be followed up accordingly
- Standardized kits for transportation to be procured by the NGOs/agency etc.
- Packaging of sputum samples would be done by the PPP partner.

**Role of RNTCP (DTO/STO**)

- Identification of underserved areas for SCC, and planning in collaboration with prospective partner implementing scheme and nearby DMCs.
- Arrange for sputum microscopy at DMC and timely transmission of results for treatment initiation and follow up
- Training of the concerned staff of the PPP partner and provision of materials, including sputum cups. Training to incorporate Infection control practices and Personal Protection measures to be followed during Sputum collection and transport.
- Prototype of sputum transportation box to be made available and the source of procurement be specified to the PPM partner
- To ensure the mechanism for transport of sputum is in place prior to initiation of operations of a sputum collection centre.
- Quality Assurance in sputum collection and Transport should be followed and Quality of Samples in Sputum collection and yield of Sputum collection and transport mechanism to be reviewed regularly

**Budget/GIA**

Grant-in-aid will be Rs 10 per sputum sample collected for TB suspects / patient and Rs 50 per sample for MDR / XDR / Drug resistance TB suspect / patient. The budget will include cost of activities and transportation/ mobility cost for the staff of PPP partner / NGO to undertake these activities. For TB suspect, atleast **5% of the diagnostic patients should be diagnosed as bacteriological TB**. If patients diagnosed are less than 5%, then the reimbursement/grant in aid will be made prorate. The partner organization would also be provided 15% of budget for administrative and contingency expenses.

100% of the samples collected from MDR/XDR/DR TB suspect / patients and follow-up samples will be provided Grant-in-aid. The minimum 5% positivity is not applicable to this group of patients.

E.g. If a sputum collect centre has 1000 TB suspects, 40 Follow-up samples of TB patients, 4 MDRTB suspect for diagnosis and 2 MDRTB patients follow-up. Out of the 1000 TB suspects, 30 patients (3%) were diagnosed as TB during the year. Since the positivity rate is less than 5%, so the Grant-in-aid for TB suspects will be pro-rata to 3% i.e. 50 patients were expected out of 1000 TB suspects, but since only 30 patients were diagnosed, so grant in aid will be paid for only 600 TB suspects (1000 x 30/50). So the grant-in-aid / reimbursement will be (Rs. 10 X 600 TB suspects x 2 samples) + (Rs. 10 X 40 TB patients follow up x 2 samples)+ (Rs. 50 x 4 MDRTB suspect x 2 samples) + (Rs. 50 x 2 MDRTB patient follow-up x 1 sample). 15% of this total amount will be added as admin and contingency expenses.

Apart from above, Rs 350 per sputum collection box to be reimbursed by District. No. of boxes provided by District can be worked out according to the workload, and should be included in the MOU

**Specifications for the new sputum transporting box with**

(Safe, Convenient collection, Storage & Transporting of Sputum)

Specifications- Box of '6' Sputum Containers (2 Boxes)- 12 Pcs. Containers- Covered with Pocket & Double Handle Belt.

Specification of transportation box for MDR/XDR cases as per PMDT guideline

**Box of Sputum Container**- Made of **Special Medical Grade polypropylene**, Autoclavable, Translucent and Capacity- at least 6 Sputum Containers.

Plastic Sputum Container- Made of Special Medical Grade polypropylene

Lock type Screw Cap- Air tight- Thin Plastic Translucent, Autoclavable Diameter- 4 cm- Capacity- 30 ml. Cap is Made of Special Medical Grade Polypropylene

Cover-Made of Quality Water Resistant Washable Cloth, Double Handle Belt, One Outer Pocket for keeping the document.

**Reporting Mechanism**

The PPP partner should submit monthly report to the DMC and DTO and Annual report to the STO indicating therein number of samples collected. Report should be sent from sputum collection centre to DMC where it would be recorded and the SCC would also maintain register of sputum collected. The PPP partner should submit quarterly UC for reimbursement.

### Monitoring Mechanism

Monthly Monitoring and Supervision by STLS in terms of quantity and quality of samples collected and the same should be reported to the concerned authority .The performance of the collaborating partner should be judged on the basis of population density and the area covered. The partner would prepare list number of sputum samples collected at centre and the same would be validated from the lab register. LTs of the DMCs to be instructed to enter the name of the sputum collection centre apart form the PHI where the centre is located in the "Name of referring agency" column of the lab register. Quarterly review of the performance of the sputum collection centre to be validated by the information from DMC /lab registers.

## ii) Sputum Pickup and Transport

### Introduction

Quality assured sputum smear microscopy is the backbone of tuberculosis diagnosis. However, persons suspected of having TB are required to submit sputum specimens on between two and 4 times during diagnosis; if diagnosed with TB, again sputum specimens are required several times throughout treatment to monitor progress. To enhance equity and accessibility of TB health care delivery services, sputum collection should be as close and convenient to patients as possible. Sputum Collection Centres may help bridge this gap, but transportation of specimens is still required, which might be done by the same organization running Sputum Collection Centres, or a different organization altogether.

States should try to coordinate with Mobile Medical Units under NRHM and try to utilize their services for sputum transportation. However in areas where such coordination would require time or where the planned route of MMU does not converge with the needs of RNTCP.

### Eligibility

The eligible entity would be a registered PPP Partner with outreach workers, or private organization with the capacity to transport sputum specimens as per RNTCP guidelines.

### Role of PPP partner

- Coordinate with the assigned Sputum Collection Centres and the DMCs
- Transport samples safely to DMCs periodically
- Transport samples within 48 hours of collection

- Transportation to be done within 0-48 hours with cold chain for C& DST samples
- PPP partner would be responsible for frozen ice/gel packs for samples to be transported.
- Convey the results in dispatch lists and forms to the Sputum Collection Centres
- Maintain travel log book within detail of travel undertaken for sputum transport

**Role of RNTCP (DTO/STO**)

- Planning and allocation of Sputum Collection Centres in collaboration with DMC MO and external partners
- Training of the concerned staff and provision of materials listed
- Ensuring quality microscopy and timely transmission of results

**Budget**

An amount of Rs 25 per sample transported for routine sputum examination. For difficult areas (tribal, hilly, desert areas, islands), 30% extra cost may be considered. If the local rates are beyond the ceiling in the table below, this needs to be reviewed for consideration by the state /district health society (TB Sub-Committee*)*. The partner organization would be provided 15% as administrative and contingency expenses per year.

An amount as given below would be paid to PPM partner for transportation of two samples (per patient) for C&DST under cold chain.

| **From Pick up point to C& DST laboratory** | **1 Kg box** | **2 Kg box** |
|---|---|---|
| 0-50 Km | Up to Rs.250 | Up to Rs.300 |
| 50- 200 km | Up to Rs.300 | Up to Rs.350 |
| 200-500 | Up to Rs.320 | Up to Rs.375 |
| 500 and above | Up to Rs.375 | Up to Rs.450 |

**Reporting Mechanism**

The PPP partner should submit Quarterly report to the DTO indicating therein number of samples transported. The following document should be submitted by the PPM partner:

1. Details of transportation of sputum and number of sputum transported.
2. UC for the quarter.

**Monitoring Mechanism**

The monitoring would be done on the basis of number of sputum transported and quality of sputum transported by the PPM partner. Standard formats for delivering the sputum samples signed by receiving LT should be considered as documentation of validation. 10% of the samples transported in this form should be validated for entry in TB Laboratory register by LT / STLS and countersigned. STLS would be responsible for supervision of the PPM partner on behalf of DTO.

## C) Contact Tracing

### General Description

Revised National Tuberculosis Control Programme (RNTCP) recommends screening of all household contacts of smear-positive pulmonary tuberculosis (PTB) cases for tuberculosis (TB) disease. However it has been observed by that the TB treatment cards of source cases (new or retreatment smear-positive PTB patients started on treatment) lacked documentation of contact details. In order to address the gaps that exists the NGOs having good presence at the community level and private sector may be invited to provide the services as per RNTCP norms.

### Requirements/Eligibility Criteria

The PPP partner must be a registered entity with experience of working in public health and presence in the TU with focus on community mobilization, health campaign and formation of community based organizations (Mahila Mandal, SHGs etc)

### Budget

PPP partner payment would be made on the home visit for address verification and counseling contact tracing @Rs30 per patient. An additional amount of Rs 100 would be provided for each new patient identified through contact tracing. 15% additional payment of the total GIA would be made for administrative and contingency cost of the PPP partner .Separate payment would be made for sputum collection and transport as per norms. Partner would not be entitled to seperate incentive for notification

### Role of the PPP partner

The PPP partner would be required to perform the following tasks:

- PPP partner staff will go to DMC and collect information about sputum smear positive TB patients.
- PPP partner health worker will go to patients' houses/ places of work, identify the contacts, assess them for symptoms, counsel the family members, hand over a sputum cup to those with symptoms and request them to collect morning sample of the sputum on a specified day.
- PPP partner worker would make 3 home visits in 3 months after registration of TB patient

- PPP partner would undertake family counselling for TB control with emphasis on Airborne Infection control
- On the specified day, the worker will meet the contact and obtain the spot sample.
- Health worker will hand over both samples to a sputum collection centre. In remote areas the health worker would ensure transportation of the sputum sample to nearest DMC.
- The sputum collection centre will ensure that the samples are sent to the lab, tested and reports provided to the worker who deposited the samples.

**Role of the District Health Society**

- Provide information of sputum positive pulmonary TB patients to PPP partner
- Training of PPP partner workers on RNTCP
- Provide sputum containers for sputum sample collection
- Provide feedback on result of sputum examination to PPP partner
- If the percentage of new cases is less than 3% review the partnership

**Reporting Mechanism**

The PPP partner would submit monthly report providing details of the contact tracing, referred cases and sputum collection/transport as per RNTCP formats

**Monitoring Mechanism**

The monitoring would be done on the basis of report submitted on patient visited, counseling of patients, and additional services (sputum collection and transport carried out by the PPP partner). Quarterly review of the performance of the PPP partner to be validated by the information from DMC /lab registers, monthly report submitted and report by STS.STS would be responsible for supervision of the PPP partner on behalf of DTO.

## d) Chemoprophylaxis of TB Cases

### General Description

Revised National Tuberculosis Control Programme (RNTCP) recommends screening of all household contacts of smear-positive pulmonary tuberculosis (PTB) cases for tuberculosis (TB) disease and 6-month isoniazid preventive therapy (IPT) for asymptomatic children aged <6 years. The WHO recommendation for the management of child contacts of a sputum smear–positive index case is rarely implemented, despite being incorporated widely into RNTCP guidelines. Close contacts to a TB case such as those living in the same household are at higher risk of infection than casual contacts. Among those that are infected, young children (<5 years) or those with immunodeficiency (e.g., HIV infected) are at increased risk of developing TB disease, usually within two years following infection.

### Requirements/Eligibility Criteria

The PPP partner must be a registered entity with experience of working in public health and presence in the TU with focus on community mobilization, health campaign and formation of community based organizations (Mahila Mandal, SHGs etc). Preference would be given to PPP partners have adequate staff or volunteer either trained in RNTCP or experiencing in TB control program.

### Budget/GIA

PPP partner would be made a payment on the basis of home visits @ Rs. 100 per visit from whom the TB suspect have been screened by DMC / PHI. Additional amount of Rs. 500 per case if the 6 months of IPT is completed with support of the partner or its volunteer. Additional 15% of the GIA would be provided as administrative and contingency expenses for PPP

### Role of the PPP partner

The PPP partner would be required to perform the following tasks:

- Undergo training as per RNTCP Module
- Take the list of smear positive pulmonary TB patients from RNTCP staff on a monthly basis.
- Make home visit for initial screening of for TB cases.
- Counselling of patient and family members

- Provide 6-month isoniazid preventive therapy (IPT) for asymptomatic children aged <6 years after ruling out active disease.
- Maintain separate record for IPT

**Role of the District Health Society**

The District Health Society has the following functions:

- Provide information of smear positive pulmonary TB patients to PPP partner
- Training of PPP partner workers on RNTCP
- Provide drugs to partner for INH prophylaxis

**Reporting Mechanism**

The PPP partner would submit monthly report providing details of the contact tracing, screening for TB, counseling and INH prophylaxis for each child cases as per RNTCP formats. Separate documentation should be maintained by PPP partner for each IPT cases

**Monitoring Mechanism**

The monitoring would be done on the basis of report submitted on patient visited, counseling of patients and family, and INH prophylaxis for each child carried out by the PPP partner. Quarterly review of the performance of the PPP partner to be validated by the information from DMC /lab registers, monthly report submitted and report by STS. STS would be responsible for supervision of the PPP partner on behalf of DTO.

## e) Promoting adherence of TB cases

### Introduction

RNTCP has prioritized decentralization of treatment services as a means of ensuring that treatment is maximally accessible and acceptable to patients.

PPP partner / Non-governmental organizations (NGOs) have a long history of supporting health services at the community level, often with remarkable effectiveness and rapport with communities. NGOs/PPP Partner also often have capacity to provide excellent treatment support, counselling for patients, and can contribute to public health oriented activities in TB treatment, namely address verification and default retrieval. Individual Private Hospitals, Nursing Homes, Clinics, and Private providers (PPs) also have many successful examples of delivering high-quality tuberculosis services to communities in cooperation with the TB programme, to the benefit of all. PPs are often more accessible to patients than public health services in terms of distance and convenience of timings, especially in urban areas.

NGOs have a major role to play in ensuring that free high-quality RNTCP drugs are provided to patients that meets National standards for public health accountability, is maximally effective, and is highly accessible and acceptable to patients.

### Eligibility

The PPP partner must be registered should have a minimum of one year experience in out-reach work in health or in related fields and have the necessary infrastructure. The PPP partner must provide a plan of action and should preferably have volunteers who live or work in the area. PPP partner must agree to provide services for patients in atleast one tuberculosis unit.

### Role of the PPP partner

**1. DOT services:**

- Identify, train, and supervise volunteers who will be providing DOT.
- Provide RNTCP treatment to patients at a time and place accessible and acceptable to patients.
- Ensure that treatment is provided strictly as per RNTCP policy, free of charge to patients for any service rendered
- Ensure that DOT providers maintain records as per RNTCP policy
- Ensure the collection of follow up sputum specimens
- Organize medical care for side effects at appropriate health services
- Facilitate payment of RNTCP DOT provision honorarium at current rate to community DOT providers
- Assist in providing continuity of care for referred or transferred patients.

**2. Counselling services for patients and families**

a. Provide package of counselling services to include emotional support, information on symptoms, disease, duration of treatment, importance of DOT adherence, side effects, referrals
b. Services and referrals for substance abuse harm reduction, including support for persons who abuse alcohol.
c. Retrieval efforts for interrupters, dropouts

*These roles apply equally for all categories of RNTCP treatment, including Category IV treatment for MDR-TB.*

**Role of the District Health Society**

- Coordinate the identification of partners, NGOs and PPs, assess eligibility, and assess needs for NGO treatment coordination and support.
- Identify the area where support is needed and the same is explained properly
- Provide training for DOT providers
- Provide treatment cards, Patient ID cards and ACSM material
- Provide literature for training & orientation is given as available and appropriate.
- Provide free anti-TB treatment drugs for patients registered under RNTCP.
- Provide sputum containers for follow up examinations.
- Provide records as required.
- Support default retrieval for PPs/private agency.
- Provide honorarium for individual DOT providers as per RNTCP norms.

**A. Budget NGOs supervising DOT services:**

Additional treatment support functions: Rs 75,000 for every 1 lakh population per annum, pro-rata for population served. (For example, if 5,00,000 population treatment services were supported with all services, Rs 3,75,000 per annum would be reimbursed.)

**B. For DOT:**

1. Cat I / II patients: As per existing RNTCP norms to the individual volunteer for each patient cured or treatment completed.
2. MDR patients: As per existing RNTCP norms to the individual volunteer for each MDR patient treatment completed.

An additional amount of Rs 150 would be provided to the PPP partner if it takes the responsibility of address verification and patient retrieval.DOT provider incentives are subject to revision as per RNTCP norms and the same would apply as and when revised by RNTCP.

**Reporting Mechanism**

The NGO/Private Provider/Private agency/collaborating partner should submit monthly report to the DTO and Quarterly report to the STO indicating the activities carried out with focus on DOT service, awareness generation, counselling of patients, initial home visit, default retrieval and additional services if any.

**Monitoring Mechanism**

The monitoring would be done on the basis of report submitted on DOT service, counselling of patients and additional services carried out by the NGO/ PP/agency. Quarterly review of the performance of the PPM partner to be validated by the information from DMC /lab registers, monthly report submitted and report by STS. STS would be responsible for supervision of the PPM partner on behalf of DTO.

## f) Lab Technician (Strengthening RNTCP diagnostic services)

### Introduction

This is a partnership option for supporting case detection through provision of trained LTs in such situations is applicable in settings where there is a need for operating a RNTCP-designated microscopy centre, based on population considerations and workload, but where the constraint in human resource (Laboratory Technician) has prevented the establishment of a designated microscopy centre, or its effective and uninterrupted functioning. The infrastructure of the proposed designated microscopy centre under this activity should be under the public sector (e.g. health department of the state/centre, medical colleges, Municipality, Corporation run labs, state run CDST labs other public sector health facilities like ESI, public sector undertakings, etc.).

In such an identified laboratory a PPP Partner working under this scheme could provide a solution for the human resource constraint by providing contractual laboratory technician(s) who will be recruited and maintained by the PPP Partner, but will be assigned to work under the head of the health facility in which the designated microscopy centre is located.

### Eligibility

Any registered PPP Partner with capacity and commitment to provide sustained support for at least 3 years is eligible to apply for this scheme. Preference may be given to that PPP Partner having previous experience in managing HR activities such as placement agencies or those having readily available trained or experienced paramedical personnel such as paramedical training institute or social-work organizations.

**Budget: As per existing RNTCP contractual LT salary, + 15% overhead cost and recruitment cost reimbursement equal to one month salary. If the LT is in a tribal / hilly / difficult area, additional fixed allowance as per RNTCP norms should be provided to LT as per tribal action plan.**

The recruitment cost, salary and overheads will be borne by RNTCP. The salary of the laboratory technician should be at par with the prevailing approved salary of such cadres of staff under RNTCP.

### Role of PPP Partner

- Recruitment of a suitable laboratory technician via a competitive mechanism
- RNTCP TOR should be utilised for recruitment of LTs
- Maintenance of the person on payroll and regular salary payments

- If there is a change in LT in the DMC, the PPP partner should ensure a candidate with suitable qualification (person with a minimum degree/diploma in lab technology and a minimum one year experience) is recruited and the DTO is informed for his training under RNTCP.
- Facilitating training of the LTs.
- Deployment of the person to work at the designated microscopy centre
- Payment of the honorarium of the LT.
- Supervision and monitoring of laboratory technician performance (with District RNTCP authorities as per RNTCP Guidelines), including conduction of performance appraisals as and when required in consultation with the DTO and the head of the health facility housing the designated microscopy centre.

**Role of RNTCP (DTO/STO)**

- The DTO shall analyze the availability of LT in coordination with NRHM and offer the scheme only when no LT are not available.
- The DTO will identify the facilities where there is a need for LT and invite applications and/or the interested and eligible agency may submit proposal indicating the availability of LTs. After selection of the agency and signing of MoU, the agency will provide eligible candidates who will be selected by a panel of not less than 3 persons, including one from the RNTCP
- Planning by DTO for identification of potential designated microscopy centres where such support will be required in order to improve access and quality of sputum microscopy.
- Coordination with the PPP partner and the health society in order to ensure timely payments to the PPP Partner and the laboratory technician.
- Ensure that the lab technician is trained as per RNTCP guidelines by LT trained in EQA guidelines.
- Ensure that the RNTCP external quality assessment protocol is implemented at the designated microscopy centre.
- Supervision and monitoring of the performance of the laboratory technician.

**Reporting Mechanism**

- Monthly attendance of the LT will be submitted to DTO for claiming salary of the LT. EQA records of the DMC will be used to appraise the performance of the LT

- The PPM partner would submit UC

**Monitoring Mechanism**

The partner should be able to provide the services of the LT for 100% of the contract period, including the duration of training of one LT. The performance of the LT should be satisfactory as assessed from the QA records and in comparison to other LTs in the district. Extension of contract would be linked to performance as per EQA records. The performance of the LT would be periodically monitored by STLS of the concerned TU.

## g) Tuberculosis Unit Model

### General Description

The PPP partner provides all RNTCP services earmarked for a Tuberculosis Unit. Strict compliance with the Technical and the Operational Guidelines of the RNTCP is mandatory. In general, this should only be considered in areas where the governmental infrastructure is not sufficient to ensure effective RNTCP implementation, and/or where an effective PPP partner is currently working in the field of health in this area. One PPP partner may cover more than one TU, but must meet all eligibility criteria for each TU.

### Role of the PPP partner

The PPP partner ensures full services for microscopy, treatment, direct observation, defaulter retrieval, recording and registration, supervision, etc. PPP partner should comply with the relevant sections of the Operational Guidelines of the RNTCP (particularly Chapter 2, Organizational Structures and Functions.) and ensure all programme implementation responsibilities. The PPP partner must also coordinate closely with all public and other health facilities in the area. The PPP partner must ensure the fulfillment of all the general functions of the Tuberculosis Unit. It is of utmost importance that the PPP partner scrupulously maintains RNTCP records (real time entry in Nikshay) and submits quarterly reports to the District TB Officer in the prescribed manner and in a timely fashion.

### Role of the District Health Society

The District Health Society provides technical orientation, guidance, and supervision. They ensure good integration of the TU operated by the PPP partner with other TUs in the District. They include the staff of the TU in all regular meetings of nodal RNTCP implementing staff. In the case of TU scheme, prior to rejecting any PPP partner proposal, the District TB Control Society/ State Health Society must seek the approval of the Central TB Division.

### Commodity Assistance

#### *In kind*

The RNTCP will provide materials for training and implementation, including formats and registers; and in-kind provision of anti-TB drugs, cotrimoxazole (if necessary) and microscopes. Up-gradation of microscopy facilities may be done as commodity assistance by the DHS, or by grant-in-aid. If required, a 2-wheeler for mobility of the STS/STLS will be provided. Laboratory consumables may be provided in kind or as grant-in-aid.

**Grant-in-Aid**

The available budget is given below. This is to be released by the District Health Society to the PPP partner on a yearly basis in two instalments.

**Start-up Activities (one-time only)**

| **Item** | **Amount (in Rs)** |
|---|---|
| Civil works for upgradation of Tuberculsosis Unit, microscopy centres | As per RNTCP norms |
| Funds for training of multi-purpose workers and other staff | As per RNTCP norms |
| Funds for training of multi-purpose supervisors and related staff | As per RNTCP norms |

| **Annual Grant-in-Aid** | **Amount (in Rs)** |
|---|---|
| Personnel<br>(PPP partner to ensure full-time, mobile staff to serve as Senior treatment Supervisor and Senior Tuberculosis Laboratory Supervisor) | **As per RNTCP norms for salary of STS/STLS** |
| Mobility support to the RNTCP staff – STS, STLS, MO-TC,LT, TBHV (TA / POL) | **As per RNTCP norms** |
| Honorarium to the non-salaried dot providers | **As per RNTCP norms** |
| General Support (to cover all administrative and technical costs of running the programme, including ensuring the presence of an MO of the TB Unit, book-keeping, getting the accounts audited annually by a chartered accountant, POL and maintenance of vehicles, phone calls, faxes, photocopying, accounting expenses, etc.) | **15% of the annual grant in Aid** |

*Separate amount would be provided for DOT provision as per norms approved for DOT provision for different category of patients. Honorarium @ 1000 per day for 7 days should be given to MO for field supervision monitoring

**Requirements/Eligibility Criteria**

The PPP partner must be registered, having a minimum of 1 year experience in health care. It should have the infrastructure, staff, or volunteers required in the field. The PPP partner should give a specific undertaking to the District Health Society indicating its commitment to provide effective, uninterrupted service in the area. The PPP partner must have an established health facility with a proven track record. All diagnosis, treatment, recording, reporting, and supervision must be done according to the RNTCP policy. Drugs and all other services under the RNTCP must

be provided free of cost to patients. The PPP partner must submit a detailed plan of action, including available staff, expected TB caseload, diagnostic policies and treatment procedures. The Memorandum/Letter of Understanding between the DHS and the PPP partner must be signed. Upon approval by the DHS and the State TB Cell, all relevant materials are forwarded to the Central TB Division, for review and approval.

The project area is liable to be visited by the officers of the Directorate General of Health Services, Ministry of Health and Family Welfare, Government of India, New Delhi and the State Health Officer. All the records and registers maintained, the staff, material, and equipment provided as well as the work done are liable to be inspected. If the work of the voluntary organizations is not up to the required standards, and/or if it does not comply with the standards laid down by the Government of India and if the RNTCP work is stopped, the assets acquired out of these grants, viz. vehicles, equipments, etc. are returnable or transferred to a new organization as per advice of the Government of India/DHS, and the grant-in-aid returned on pro-rata basis.

**Reporting Mechanism**

The PPP partner should submit monthly report to the DTO and Quarterly report to the STO indicating the activities carried out as per RNTCP norms and formats provided. PPP partner should maintain RNTCP records and submits quarterly reports to the District TB Officer in the prescribed manner and in a timely fashion.

**Monitoring Mechanism**

The monitoring would be done on the basis of report submitted by the PPP partner. Biannual review of the performance of the PPP partner would be carried out and in case the PPP partner does not submit quarterly reports regularly, or if the quarterly reports show problems in programme implementation which do not improve after joint supervision, then the arrangement is liable to be cancelled and an alternative arrangement made by the DHS. Accounts must be audited every year and audited reports made available to the District Health Society no later than 15 June each year. The participating PPP partner in this scheme is not eligible for any other partnership option in this TU. For eg if the TU is having 5 DMCs, PPP partner is not eligible to apply for DMC partnership options in this particular area.

## h) Nodal Agency for Capacity Building

### General Description

Engaging the private sector effectively is the single most important intervention required for RNTCP to achieve the overall goal of universal access and early detection. On the other hand, this sector remains largely unorganised, unregulated and un-empowered, with the technical quality of some sections of the sector remaining a concern. The uptake of different options for partnership has been sub optimal and operational issues exist which may be overcome by sustained capacity building efforts. These efforts of capacity building may best be facilitated by agency or NGO in close coordination with Revised National Tuberculosis Control Program. Sustained capacity building efforts have the potential of increasing coverage of health services, decrease in delays in treatment and ultimately improve patient outcomes and disease control.

### Requirements/Eligibility Criteria

The PPP partner must be a registered entity with at least 2 year experience of capacity building of NGOs/Private sectors preferably in public health. Preference would be given to institutions having experience of capacity building initiatives in RNTCP.

### Budget

| Sl.No. | Detail | Amount |
|---|---|---|
| 1 | Capacity building residential training for at state level @16500 per training<br>(a. Resource person=1500*4<br>b. Reference material=Rs200*25 participants<br>c. Refreshment=100*25<br>d. Venue Charges= 3000) | 66000 |
| 2 | Documentation | 10000 |
| 3 | Administrative and contingency expenses | 15% |

### Role of the NGO/private partner

The PPP partner would have to undertake the following activities:

- Provide quarterly action plan for capacity building of NGOs/private sector partner in each quarter.
- Coordinate with STO for organizing one day capacity building training for NGOs.
- Make arrangements for training of NGOs/private sector partner

- Organize four training in a year with specific focus on different issues(referral, documentation, community mobilization, planning etc) of RNTCP in coordination with STO
- Develop training module for capacity building of NGOs/private sector partner

**Role of the State Health Society**

- Facilitate and approve quarterly capacity building plan
- Make available resource material of RNTCP as per requirement.
- Provide approval for capacity building module developed by partner.
- Provide technical input on RNTCP as key resource person in training organized.

**Reporting Mechanism**

The PPP partner would provide quarterly report of all the activities carried out in the quarter with photograph and separate report for each activity.

**Monitoring Mechanism**

The monitoring of PPP partner would be done on the basis of reports submitted and as per RNTCP norms by the STO or his representatives.

## I) Capacity Building for Operational Research

### General Description

The RNTCP is based on global scientific and operational guidelines and evidence, and that evidence has continued to evolve with time. As new evidence became available, RNTCP has made necessary changes in its policies and programme management practices. To generate the evidence needed to guide policy makers and programme managers, the programme implemented measures to encourage operational research (OR). Previous efforts by the RNTCP to promote OR yielded some successes; but the number of studies has been very small and studies were not always linked to the main priorities of TB control. The programme requires more knowledge and evidence of the effectiveness of interventions to optimize policies, improve service quality, and increase operational efficiency. This has led to the realization of the need for a more proactive approach to promoting OR for the benefit of the TB control efforts. Furthermore, the programme must seek to better leverage the enormous technical expertise and resources existing within India and encourage capacity building on OR at state level to undertake OR as per the main priorities of TB control.

### Requirements/Eligibility Criteria

The registered institution / organization should have institutional capacity and focus on health related research issues. Some of the areas of research in institution should be on health and communicable diseases including tuberculosis. The researchers at the institution should preferably have training and expertise in different disciplines like medical anthropology, health and social sciences, public health and epidemiology. Some of the senior researchers in the institution should preferably have been involved in operations and sociological research in TB.

### Budget

The budget for this option of capacity building would be based on capacity building of batch of 20 participants who would be trained on Operational research on TB:

| Sl. No. | Detail | Unit Cost(Rs.) | Amount(Rs.) |
|---|---|---|---|
| 1. | Venue Charges( 20 participants for 2 days) | 40000 | 40000 |

| | | | |
|---|---|---|---|
| 2. | Food charges (2days) | 500/participant | 20000 |
| 3. | Honorarium for faculty (4persons) | 2000/faculty/day for two days | 16000 |
| 4. | Course material | 350/participant | 7000 |
| 5. | Documentation | 10000 | 10000 |
| 6. | Administrative and contingency expenses | 15% of Budget | |

**Role of the institution**

The institution will be primarily responsible for development of the capacity of 20 participants for carrying out operational research with focus on RNTCP PMDT/TBHIV. The organization will develop the capacity of one individual each from different districts/ organizations / NGOs on OR and then provide technical inputs for carrying out OR on RNTCP in their area after they complete their training from the institution till a period of one year. The organization will document the entire process from capacity building to OR by the participants.

**Role of the State Health Society**

The state health society will provide the OR priorities for the state as per its need and will also select the participants / organizations / institutions / NGOs whose capacity have to be built during the one year period by the institution. The state health society will identify a nodal person for coordination and monitoring the capacity building effort and coordinate with the individuals who would carry out OR.

**Reporting Mechanism**

The selected organisation would provide a report at the end of training for the participants whose capacity will be built on OR. The concerned organisation will submit a final report with result of the OR capacity building at the end of the agreement period.

**Monitoring Mechanism**

The monitoring of PPP partner would be done on the basis of reports submitted and as per RNTCP norms by the STO or his representatives

## J) Packing and transportation of TB drugs

### General Description

The country has reached the milestone of full country-wide PMDT coverage in the FY 2012-13. One of the biggest challenges under PMDT lies in the difficulty in preparation of a huge number of monthly patient wise boxes in different weight bands. As huge number of patient wise boxes and their labels are to be prepared country-wide, maintaining uniformity and an uninterrupted supply of drug boxes is a big concern for the programme. Central TB Division may need to hire an independent logistics agency/NGO/private sector partner for preparation of monthly boxes in line with the RNTCP guidelines.

### Requirements/Eligibility Criteria

Any registered Independent Logistics Agency/ NGO with capacity and commitment of at least 2-3 years relevant experience with the following facilities:

a) Bar-code Software for recording and Reporting

b) Adequate Manpower with experience of Carrying & Forwarding activities

c) Communication and Transportation facilities

### Budget

Where all the work is done by the Agency / NGO in the premises of the existing SDS, Manpower of helpers/packagers would be provided. The PPP partner will be provided Rs. 50 per monthly box of Cat IV box. Additional 15% will be provided as a fixed cost to the agency as overhead expenses. Any service tax, as applicable, will be provided as per actuals. The transportation cost to be fixed as per local arrangements which can be decided based on any of following criteria or their combination:

- Number and distance of district drug stores from SDS.
- Volume or weight of drug boxes
- Frequency of drugs transportation

### Role of the PPP partner

The PPP partner would be responsible for:

a) Plan and undertake series of activities pertaining to Packing & transportation of Anti-TB Drugs in consultation with STO and SDS. The activities planned should be based on the needs of the State.
b) Ensure accurate recording, reporting, dispatching, labelling and packaging of drugs
c) Procure cardboard boxes and labels as specified by STO and as per specified guidelines
d) Receive drugs from the supplier and repack the loose drugs into different boxes of weight bands
e) Label the boxes & mention the DOE on each box
f) Issue as per FEFO & transport the boxes to the districts
g) Ensure no damage while transporting.
h) Recruitment of Manpower required for the activity
i) Maintain complete record of all transactions
j) Pick up samples and send the same for testing
k) Co-ordination with STO and SDS other related agencies
l) Providing regular reports to STO and SDS.
m) The PPP partner is also expected to ensure adherence to as per RNTCP guidelines, updated by RNTCP time to time

**Role of the State Health Society**

The role of the STO will include joint planning with the PPP partner for issues that need to be addressed to strengthen the logistics components. STO will provide space in drug store for packaging of drugs. Ensure training of concerned PPP partner staff as per RNTCP guidelines. Supervise, monitor and evaluate PPP partner activities. State TB Officer should facilitate road permit, local taxes (if any) insurance mechanism etc and the cost should be borne by State Health Society.

**Reporting Mechanism**

The PPP partner would strictly adhere to the timeline set by RNTCP and submit monthly report to concerned SDS / STO as per the reporting format of RNTCP.

**Monitoring Mechanism**

The PPP partner would be monitored on the basis of the monthly report submitted with specific focus on the timeliness of the transportation, quality of packaging and record keeping as per RNTCP norms.

**ANNEXURE:1**

**Format for Utilization Certificate to be submitted by PPP Partner**

**UC for the Quarter……to……**

| | |
|---|---|
| Name of PPP Partner | |
| Date of MoU | |
| Name of District | |
| Name of Partnership Option | |
| Period of MoU | ……to…… |

## A. DETAILS OF GRANT-IN-AID RECEIVED

| **Half-yearly period for which grant was given** | **Cheque dated** | **Cheque number** | **Amount (Rs.)** |
|---|---|---|---|
| ……to…….. | | | |
| ……to…….. | | | |
| | Total amount received | | |

## B. EXPENDITURE

| **Approved Budget as per MoU** | **Total Grant Received till this Quarter** | **Cumulative Expenditure till this Quarter** | **Unspent Balance** |
|---|---|---|---|
| Rs. | Rs. | Rs. | Rs. |
| | A | B | c=a-b |
| | | | |

This is to certify that Grant-in-aid received from the……...(name of the Society) as per details mentioned above has been utilized as per terms of Memorandum of Understanding dated…..……....between ……...(name of PPP Partner) and the Society

Name of Head of PPP Partner:

Signature of Head of NGO/PP:

Date: Seal:

**ANNEXURE: 2**

**Name of the Organization:**
**Reporting Period:** **Year:**
**State:** **District:** **TU:**

**Detail of Activity Undertaken under Partnership Options**

**Partnership Option: Case Management and reporting of TB cases**

| No of patients in OPD | No of TB cases diagnosed | | No of patients Notified | No of TB patients referred to RNTCP | No of TB patients undergoing treatment | No of TB patients cured/treatment completed |
|---|---|---|---|---|---|---|
| | Pulmonary | EP | | | | |
| | | | | | | |
| | | | | | | |

Key Issues (if any)

Comments and Recommendations:

**Name of Reporting Officials** **Date of submission of report**

**Signature and seal**

**ANNEXURE3:**

**Name of the Organization:**
**Reporting Period:** **Year:**
**State:** **District:** **TU:**

**Partnership Option: Lab Technician**

| Sl No. | Number of LT provided | Number of LT working in RNTCP | Number of days of work by LT | Any existing vacancy | Remarks |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |

Key Issues (if any)

Comments and Recommendations:

**Name of Reporting Officials** **Date of submission of report**

**Signature and seal**

**ANNEXURE4:**

**Name of the Organization:**
**Reporting Period:** **Year:**
**State:** **District:** **TU:**

**Partnership Option: Paediatric TB**

| Sl No. | No of paediatric TB suspects identified | No of paediatric TB cases diagnosed | No of paediatric TB cases referred to RNTCP | No of paediatric TB cases treated | No of family members counselled |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |

Key Issues (if any)

Details of individual paediatric cases:

Comments and Recommendations:

**Name of Reporting Officials** **Date of submission of report**

**Signature and seal**

**ANNEXURE5:**

**Name of the Organization:**
**Reporting Period:** **Year:**
**State:** **District:** **TU:**

**Partnership Option: Referral of TB-HIV patients**

| Sl.No. | No. Of TB-HIV patients traced | No. Of TB-HIV patients Counselled | No. Of TB-HIV patients linked to ART centre | No. Of TB-HIV patients regularly taking ART | No of visits made to ART centre | No of district meetings<br><br>Attended for TB-HIV collaboration |
|---|---|---|---|---|---|---|
| | | | | | | |

Key Issues (if any)

Details of individual TB-HIV cases:

Comments and Recommendations:

**Name of Reporting Officials** **Date of submission of report**

**Signature and seal**

**ANNEXURE6:**

**Name of the Organization:**
**Reporting Period:** **Year:**
**State:** **District:** **TU:**

**Partnership Option: Contact Tracing**

| No of visits made to DMC | No of patient address taken from DMC | No of patients home visits made | No of contacts counselled | No of chest symptomatic identified | No of contacts provided sputum container | No of chest symptomatic undergone test for TB | No of new TB cases |
|---|---|---|---|---|---|---|---|
| | | | | | | | |
| | | | | | | | |

Key Issues (if any)

Details of individual TB cases:

Comments and Recommendations:

**Name of Reporting Officials** **Date of submission of report**

**Signature and seal**

**ANNEXURE7:**

**Name of the Organization:**
**Reporting Period:** **Year:**
**State:** **District:** **TU:**

**Partnership Option: Chemoprophylaxis of TB cases**

| No of visits made to DMC | No of patient address taken from DMC | No of patients home visits made | No of patients counselled | No of family members counselled | No of patients provided IPT | No of patients completed 6 months of IPT |
|---|---|---|---|---|---|---|
| | | | | | | |
| | | | | | | |

Key Issues (if any)

Details of individual IPT cases:

Comments and Recommendations:

**Name of Reporting Officials** **Date of submission of report**

**Signature and seal**

**ANNEXURE8:**

**Name of the Organization:**
**Reporting Period:** **Year:**
**State:** **District:** **TU:**

**Partnership Option: Corporate Hospital/ clinics involvement in RNTCP**

| No of patients in OPD | No of TB suspects identified | No of TB cases diagnosed | | No of TB cases notified | No of TB cases referred to RNTCP | No of TB cases undergoing treatment |
|---|---|---|---|---|---|---|
| | | Pulmonary | EP | | | |
| | | | | | | |

**2. No of staff trained in RNTCP**

**3. Details of TB patients undergoing treatment**

Key Issues (if any)

Comments and Recommendations:

**Name of Reporting Officials** **Date of submission of report**

**Signature and seal**

**ANNEXURE9:**

**Name of the Organization:**
**Reporting Period:** **Year:**
**State:** **District:** **TU:**

**Detail of Activity Undertaken under Partnership Options**

**Partnership Option:**

1. **Detail of the activity (ACSM / Urban Slum/ Nodal Agency for Capacity Building /Advocacy for involvement of PRI/ Youth Mobilization/Capacity building for OR etc. Use separate sheet for further details as applicable)**

| Sl No. | Date of activity | Type of activity | Location | Participants | Resource Persons | Remarks |
|---|---|---|---|---|---|---|
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |

**Each organisation would provide details in separate sheet of the tasks undertaken during the reporting period with respect to the partnership option undertaken:**

Key Issues (if any)

Comments and Recommendations:

**Name of Reporting Officials** **Date of submission of report**

**Signature and seal**

**ANNEXURE:10**

**Name of the Organization:**
**Reporting Period:** **Year:**
**State:** **District:** **TU:**

**Partnership Option: Sample Sputum Collection**

| Month | No. of New Adult OPD | No. of TB suspects whose sputum samples collected | No. of TB suspects found to be positive | No. of follow up patients whose sputum samples collected | No. of follow up patients found to be positive |
|---|---|---|---|---|---|
| | | | | | |

Key Issues (if any)

Comments and Recommendations:

**Name of Reporting Officials** **Date of submission of report**

**Signature and seal**

**ANNEXURE:11**

**Name of the Organization:**
**Reporting Period:** **Year:**
**State:** **District:** **TU:**

**Partnership Option: Sputum Transport**

1. **Details of Transportation**

| Date | Number of Sputum transported | Type of sample | Remarks |
|---|---|---|---|
| | | | |
| | | | |

Key Issues (if any)

Comments and Recommendations:

**Name of Reporting Officials** **Date of submission of report**

**Signature and seal**

**ANNEXURE:12**

**Name of the Organization:**
**Reporting Period:** **Year:**
**State:** **District:** **TU:**

## Partnership Option: Designated Microscopy cum Treatment Centre

### Monthly Report on Programme Management and Logistics

### Peripheral Health Institution Level

*Note:*

1. *All PHCs/ CHCs/ referral hospitals/ major hospitals/ specialty clinics/ TB hospitals/ Medical colleges to submit their monthly reports in this format.*
2. *PHIs without DMCs have to fill only the relevant details on page 2.*

Name of Peripheral Health Institution: _____

**TU: _____** **District: _____**

**Month: _____** **Year: _____**

**Medications**

**Adult Patient Wise Boxes**

| **Item (PWB)** | **Stock on first day of month (a)** | **Stock received during month (b)** | **Patients initiated on treatment (c)** | **Stock on last day of month (d)=a+b-c** | **Quantity Requested (e)= (c X 2) – d** |
|---|---|---|---|---|---|
| Regimen for New patients (NT) | | | | | |
| Regimen for previously treated patients (PT) | | | | | |

### Prolongation Pouches and Inj SM

| Item | Stock on first day of month (a) | Stock received during month (b) | Consumption during month (c) | Stock on last day of month (d) =(a+b)-c | Quantity Requested (e) =(cX2) –d |
|---|---|---|---|---|---|
| Prolongation pouches (Pouches each with 12 blister strips) | | | | | |
| Streptomycin 0.75 g (vials) | | | | | |

## RNTCP loose drugs

| Item | Unit of measure-ment | Stock on first day of month (a) | Stock received during month (b) | Patients initiated on treatment (c) | Stock on last day of month d=(a+b)-c (d) | Quantity Requested e=(cx2)-d (e) |
|---|---|---|---|---|---|---|
| **INH 300mg** | **Tablets** | | | | | |
| **INH 100mg** | **Tablets** | | | | | |
| **Rifampicin 150 mg** | **Capsules** | | | | | |
| **Ethambutol 800 mg** | **Tablets** | | | | | |

### Referral Activity (To be filled in by all PHIs from OPD Register)

| | | |
|---|---|---|
| a. | Number of new adult outpatient visits | |
| b. | Out of (a), number of TB suspects referred for sputum examination | |

### Microscopy Activity (To be filled in by only PHIs which are DMCs from Laboratory Register)

| | | |
|---|---|---|
| c. | Number of TB suspects whose sputum was examined for diagnosis | |
| d. | Out of (c), number of sputum smear positive patients diagnosed | |
| e. | Number of TB suspects subjected to repeat sputum examination for diagnosis | |

| | | |
|---|---|---|
| f. | Out of (e), number of sputum smear positive patients diagnosed | |
| g. | Total number of sputum smear positive patients diagnosed (d + f) | |

**Treatment Initiation (To be filled in by only PHIs which are DMCs from Laboratory Register and Referral for Treatment Register)**

| | | |
|---|---|---|
| h. | Of the smear-positive patients diagnosed (g), number put on DOTS | |
| i. | Of the number of smear-positive patients diagnosed (g), number put on RNTCP Non-DOTS (ND1 and ND2) | |
| J | Of the smear-positive patients diagnosed (g), the number referred for treatment to other TUs within the district | |
| k. | Of the smear-positive patients diagnosed (g), the number referred for treatment outside the district | |

**Laboratory Consumables (To be filled in by only PHIs which are DMCs)**

| Item | Unit of Measurement | Stock on first day of the Month | Stock received during the Month | Consumption during the Month | Stock on last day of the Month | Quantity requested |
|---|---|---|---|---|---|---|
| Sputum containers* | Nos. | | | | | |
| Universal containers for C & DST | Nos | | | | | |
| Slides | Nos. | | | | | |
| Carbol Fuchsin (1% solution) | Litres | | | | | |
| Methylene Blue (0.1% solution) | Litres | | | | | |
| Sulphuric Acid (25% solution) | Litres | | | | | |
| Phenolic solution (for disinfection-~40% pure solution) | Litres | | | | | |
| Immersion oil/ Liquid Paraffin (Heavy) | mL | | | | | |
| Methylated Spirit | Litres | | | | | |

* PHIs that are not DMCs, but have been supplied with sputum containers, should complete this row.

**Equipment in place (To be filled in by only PHIs which are DMCs)**

| Item | Number in place | In working condition |
|---|---|---|
| Binocular microscopes | | |

**Name of officer reporting (in Capital Letters) :** _____.

**Signature**: _____.

**Date**:

**ANNEXURE:13**

**Name of the Organization:**
**Reporting Period:** **Year:**
**State:** **District:** **TU:**

**Partnership Option: Designated Microscopy Centre**

| Sr No. | Name of Microscopy Centre | Nos. of TB suspects examined for diagnosis | Nos. of TB suspects found to be positive | Nos. of TB suspects undergoing repeat diagnostic examination | Nos. of TB suspects found to be positive on repeat diagnostic examination | Nos. of follow-up patients examined | Nos. of follow-up patients found to be positive | Total nos. of positive slides examined | Total nos. of negative slides examined | Total nos. of negative and positive slides examined |
|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | | | | | | |

Key Issues (if any)

Comments and Recommendations:

**Name of Reporting Officials** **Date of submission of report**

**Signature and seal**

**ANNEXURE:14**

**Name of the Organization:**
**Reporting Period:** **Year:**
**State:** **District:** **TU:**

**Partnership Option: Treatment Adherence**

| Month | No. of TB patients started on treatment under DOTS in the month (a) | No. of TB patients whose outcome is declared in the month (b) | No. of TB patients successfully treated out of "b" | No. of outcome other than successfully treated (outcome wise no.) |
|---|---|---|---|---|
| | | | | |

Key Issues (if any)

Comments and Recommendations:

**Name of Reporting Officials** **Date of submission of report**

**Signature and seal**

**ANNEXURE:15**

**Name of the Organization:**
**Reporting Period:** **Year:**
**State:** **District:** **TU:**

## Partnership Option: Tuberculosis Unit Model

**Tuberculosis Unit Level (including Tuberculosis Unit at DTC)**

Name of the TB Unit: _____. State: _____

Name of the District: _____. Quarter: _____.

Total population of the TB Unit (in numbers): _____ Year: _____

**Basic information of the TU**

| Stake- holders | Public Sector (including Govt. / Corporation Medical Colleges, Govt. health dept., other Govt. dept. and PSUs) | Private Sector (Private Medical College, Medical Practitioner, Private Clinics/Nursing Homes and Corporate sector) | NGOs | Community Volunteers | Total |
|---|---|---|---|---|---|
| Number of DMCs | | | | | |
| Number of Sputum collection centres | | | | | |
| Number of DOT Centres/providers | | | | | |

| | |
|---|---|
| Number of PHIs expected to submit monthly PHI reports | |
| Number of PHIs that submitted monthly PHI reports for all 3 months in the quarter | |

The following reports are enclosed (Tick [✓] to indicate that the report is enclosed)

- ❑ Quarterly Report on Case - Finding
- ❑ Quarterly Report on Sputum – Conversion
- ❑ Quarterly Report on Results of Treatment

If any report is not enclosed, give reason _____

### Supervisory activities (to be compiled from PHI reports and tour diaries)

| Type of Unit | Number of these visited * during quarter by | | |
|---|---|---|---|
| | MO-TC | STS | STLS |
| Designated Microscopy Centres | | | |
| DOT Centres/providers | | | |
| Patients | | | |

* Write only the number of health facilities visited and not the number of times that they were visited.

### Referral Activities

| | | |
|---|---|---|
| a. Number (%) of PHIs referring > 2% of new adult out patients for sputum examination | | |

**Microscopy Activities**

| | |
|---|---|
| b. Number of TB suspects whose sputum was examined for diagnosis | |
| c. Out of (b), number of sputum smear positive patients diagnosed | |
| d. Number of TB suspects subjected to repeat sputum examination for diagnosis | |
| e. Out of (d), number of sputum smear positive patients diagnosed | |
| f. Total number of sputum smear positive patients diagnosed (c + e) | |

### Treatment Initiation

| | |
|---|---|
| g. Of the smear-positive patients diagnosed (f), number put on DOTS within the TU | |
| h. Of the number of smear-positive patients diagnosed (f), number put on RNTCP Non-DOTS (ND1 and ND2) within the TU | |
| I Of the smear-positive patients diagnosed (f), number referred for treatment to other TUs within the district | |
| j. Of the smear-positive patients diagnosed (f), number referred for treatment outside the district | |

### MDR-TB case finding activity

| | |
|---|---|
| Number of MDR-TB suspects identified | |

**Quality of DOTS implementation**

| | |
|---|---|
| 1. Number (%) of all Smear Positive patients started on RNTCP DOTS treatment within 7 days of diagnosis (Information from TB Register) | |
| 2. Number (%) of all Smear Positive patients registered within one month of starting RNTCP DOTS treatment (Information from TB Register) | |
| 3. Number (%) of all cured smear positive patients* having end of treatment follow-up sputum examination done within one week of last dose (Information from TB Register) | |
| 4. Number (%) of patients (all forms of TB) registered during the quarter receiving DOT through a community volunteer (Information from TB Register) | |

* These cases should be from the same quarterly cohort which have been included in the report on Results of Treatment

### Medications

**Adult Patient Wise Boxes**

| Item | Unit of Measure-ment | Stock on first day of Quarter | Stock received during the quarter | Patients initiated on treatment | Stock on last day of Quarter (a+b) – (c) | Quantity Requested [(c/3) x 4] – (d) |
|---|---|---|---|---|---|---|
| | | (a) | (b) | (c) | (d) | (e) |
| Regimen for New Patients (Cat-I) | Boxes | | | | | |
| Regimen for Previously treated patients (CatII-2) | Boxes | | | | | |

**Prolongation Pouches and Inj SM**

| Item | Unit of Measurement | Stock on first day of Quarter | Stock received during the quarter | Consumption during the quarter | Stock on last day of Quarter (a+b) – (c) | Quantity Requested [(c/3) x 4] – (d) |
|---|---|---|---|---|---|---|
| | | (a) | (b) | (c) | (d) | (e) |
| Prolongation pouches | Pouches each with 12 blister strips | | | | | |
| Streptomycin 0.75 g | Vials | | | | | |

**Paediatric drugs (Including drugs for Adult Patients <30kgs)**

| Item | Unit of Measurement | Stock on first day of quarter | Stock received during quarter | Consumption during quarter | Stock on last day of quarter (a+b) – (c) | Quantity Requested [(c/3) x 4] – (d) |
|---|---|---|---|---|---|---|
| | | (a) | (b) | (c) | (d) | (e) |
| Paediatric PC 13 | Boxes | | | | | |
| Paediatric PC 14 | Boxes | | | | | |
| Paediatric PC 15 | Pouches each with 12 blister strips | | | | | |
| Paediatric PC 16 | Pouches each with 12 blister strips | | | | | |

**RNTCP Loose Drugs**

| Item | Unit of Measure-ment | Stock on first day of quarter | Stock received during the quarter | Consumption during quarter | Stock on last day of Quarter (a+b) – (c) | Quantity Requested [(c/3) x 4] – (d) |
|---|---|---|---|---|---|---|
| | | (a) | (b) | (c) | (d) | (e) |
| INH 300 mg | Tablets | | | | | |
| INH 100 mg | Tablets | | | | | |
| Rifampicin 150 mg | Capsules | | | | | |
| Ethambutol 800 mg | Tablets | | | | | |

**MDR treatment regimen**

| Item | Unit of measurement | Stock on first day of the Qtr | Stock received during the Qtr | Consumption during the Qtr | Stock on last day of the Qtr (a+b) –c | Quantity Requested for TU (c x 2) –d |
|---|---|---|---|---|---|---|
| | | (a) | (b) | (c) | (d) | (f) |
| IP ( ≤ 45 Kg Body wt ) | PWB | | | | | |
| IP ( > 45 Kg Body wt) | PWB | | | | | |
| CP ( ≤ 45 Kg Body wt) | PWB | | | | | |
| CP ( > 45 Kg Body wt) | PWB | | | | | |
| Na PAS for one month in 3 boxes (100 gms each) | Carton of 3 boxes | | | | | |

**Is there any drug at the risk of expiry*?** **Yes** ☐ **No** ☐

**If yes attach details**

* Regimen for new cases-12 months; Regimen for previously treated -14 months; PC 13 & PC 14 - 12 months; MDR treatment regimen -6 months

**Is there any expired drugs?** **Yes** ☐ **No** ☐

**If yes attach details**

*Laboratory Consumables**

| Item | Unit of Measure ment | Stock on first day of Quarter | Stock received during Quarter | Consumption during Quarter | Stock on last day of Quarter | Quantity requested |
|---|---|---|---|---|---|---|
| Sputum containers | Nos. | | | | | |

| | | | | | | |
|---|---|---|---|---|---|---|
| Universal containers for C & DST | Nos. | | | | | |
| Slides | Nos. | | | | | |
| Carbol Fuchsin (1% solution) | Litres | | | | | |
| Methylene Blue (0.1% solution) | Litres | | | | | |
| Sulphuric Acid (25% solution) | Litres | | | | | |
| Phenolic solution (for disinfection-40% pure solution) | Litres | | | | | |
| Immersion Oil/ Liquid paraffin (Heavy) | mL | | | | | |
| Methylated Spirit | Litres | | | | | |

**Equipment in place**

| Item | Number in place | In working condition |
|---|---|---|
| Binocular microscopes | | |
| Two-wheeler | | |

Vehicle for MO-TC: ☐ Jeep in working condition ☐Hired vehicle ☐None

**IEC**

Number of TB Patient Provider meetings held

**Name of Medical Officer Tuberculosis Control reporting (in Capital Letters):**

**Signature**: _____.

**Date**: _____.

**ANNEXURE:16**

**Name of the Organization:**
**Reporting Period:** **Year:**
**State:** **District:** **TU:**

Partnership Option: Delivering TB-HIV interventions to high HIV Risk groups (HRGs)

| Month | No. of TB suspects referred for diagnosis | No. of TB patients diagnosed | No. of TB patients put on treatment under DOTS | No. of TB patients whose outcome is declared | No. of TB patients successfully treated |
|---|---|---|---|---|---|
| | | | | | |

Key Issues (if any)

Comments and Recommendations:

**Name of Reporting Officials** **Date of submission of report**

**Signature and seal**