Central Level Internal Evaluation - Punjab

Revised National Tuberculosis Control Programme

Field Visit Report

FIELD VISIT REPORT

SUMMARY	
Names of team members Central team 1. Dr Sanjay Kumar Mattoo, Jt. Dir (TB), CTD 2. Dr. P Kumar, Consultant NTI Bangalore 3. Dr. Khalid U.K., From NITRD, New Delhi 4. Dr. Jignesh Patel MO STDC Gujarat 5. Dr. Chetna from NTI Bangalore 6. Dr. Tasnim Ara Syed, WHO/RNTCP Consultant, J&K 7. Dr. Deepak Balasubramanian, WHO/RNTCP Consultant, CTD 8. Dr. Himanshu Jha, Consultant CTD 9. Mr. Upendra Singh, Consultant CTD 10. Mr Ramcharan- Finance consultant, CTD 11. Mr Prabhas Jha, PFMS Consultant, UNION 12. Dr. Sandeep Rathod, WHO Consultant, Haryana State team 1. Dr. Jastej Singh Kular, STO Punjab 2. Dr Vishal, STDC Director, Patiala 3. Dr. Priyanka Agarwal, WHO RNTCP Consultant 4. Dr. Deepak, STDC Patiala 5. Dr. Rajesh Bhasker, MO-STC 6. Dr. Pooja Kapoor, WHO RNTCP Consultant 7. Dr. Asrafjeet Singh Chahal, Epidemiologist, STDC Patiala	**Name of the State** Punjab
	Dates of visit 10th to 14th December 2018

Key recommendations for the State

- Engagement of general health system, including medical officers, general pharmacists and laboratory technicians for providing RNTCP services.
- State to expedite recruitment of RNTCP contractual staff for overall improvement of program implementation.
- Decentralized training at all levels to build capacity of the program staff and better outcomes.
- Private provider incentive, Daily regimen of treatment, CBNAAT services, sample collection and transport mechanisms to serve as enablers for private providers to be engaged with programme. Chemists mapping in Nikshay to be completed in the State and utilization of Schedule H1 to ensure validation of data to be streamlined.
- Newer diagnostic algorithm to be implemented effectively for better CBNAAT utilization. Offer of CBNAAT testing to patients in public and private sector to be streamlined through establishing of sputum collection & transport services, engaging the services of Indian Postal Service and creation of hubs for sample collection.
- Sensitization of paediatricians on newer guidelines and capacity building on pediatric sample collection procedures to be done.
- Free Chest X ray services to be made available in health facilities under Education department.
- DMCs to be made operational in 18 non-functional sites and establishment of 148 DMCs in non-DMC PHCs with Lab technicians from health system as per new policy decision.
- Preparation of visit calendar for SIE, EQA, OSE and training of the EQA microbiologist for carrying supervisory activities to be completed.

- Decentralization of Nikshay entry to the PHI level utilizing the services of general health system and training of DEOs on Nikshay version 2.0. Backlog entries to be completed at the earliest.
- Increase enrolment of Bank Account from present 45% (21069/47064) to successfully implement DBT schemes with daily monitoring of progress of bank detail updation.
- Statutory Audit report to be submitted to CTD.
- State to initiate payment of private providers for notification through PFMS.
- Nikshay Aushadi entries to be decentralized to Block level and subsequently PHI level.
- Recruitment of contractual staff for SDS to be done. Existing trained manpower in the SDS may be retained at the State level to ensure efficient drug & logistic management.
- Additional space may be made available for SDS.
- Contractual agency may be engaged to distribute drug from State to Districts.
- Local procurement of Tab. Pyridoxine for TB preventive therapy to be completed.
- Meeting of State TB forum to be held.
- Action plan to be formulated for all TB free blocks in the State.

STATE LEVEL

Note: After completing the field visit, use the following template to collate the findings. Teams are required to submit one report containing the state level findings and findings for each district visited. Findings and recommendations for the state level are based on the visits to State level institutions, e.g. State TB Cell, State TB Training and Demonstration Centre (STDC), Intermediate Reference Laboratory (IRL), State Drug Store (SDS), DOTS-Plus site, State AIDS Control Society (SACS) etc. and interviews with state level authorities, e.g. STO, Deputy STO, STDC Director, STDC Microbiologists, APO, MO State TB Cell, State PPM Coordinator, DR-TB committee members, State Accountant, State IEC Officer, Chairman of State Task Force (STF) for Medical Colleges.

Name of State: Punjab

1. Observations

1.1. Organization of TB services in the State

Review the organization of TB services, the various relevant departments in the state directorate of health services and their mechanisms of co-ordination with TB.

Observations and gaps

- The State has established 134 TB Units and aligned with NHM Blocks.
- The State has 265 microscopy centres (~1 per lakh population), 29 CBNAAT laboratories and 1 culture DST laboratory. NRL is supporting all 22 districts of the State.
- Second line DST is being carried out within State at IRL Patiala.
- 12595 Treatment support centres are registered in NIKSHAY.
- Three nodal Drug Resistant TB Centres are established in the State (1 per 1.5 million population).
- Free Chest X-Ray services being provided to all presumptive TB cases in all health department facilities.
- Daily Regimen has been launched across the state since 30th October'17.
- State Drug Controller has issued letter to Zonal licensing authority for maintaining Schedule H1 record of Anti-TB drugs and implemented across State.
- MD (NHM) issued communication for all District IMA chapters to notify TB cases and for District Commissioner to monitor the same.
- ECG machines procured for all District DRTB centres in the States though State budget.
- TB Care services are restricted to only health facilities (which are microscopy centres) out of more than 652 health facilities across the States.
- 11 District DRTB centres established in the State. (Except the 3 Nodal DRTB centres) and also 11 OPD based DRTB centre are functional.
- The IRL has not applied for the NABL accreditation process.

Recommendations

- **All health facilities need to be utilized for TB care services. Non-DMC PHIs to be made treatment centres (drug dispensing point) and sample collection centres. Subsequently, health and wellness centres to be made as screening, drug dispensing and sample collection centres.**
- **Functional District DRTB centres need to be established in all the districts so that decentralized DRTB services can be provided to the patients.**

1.2. Political and administrative commitment

Note the extent of political commitment to health in general, and TB in particular. Assess the level of involvement of the State Health Secretary and the Director of Health Services in the TB programme.

Note the systems in place for the Health Secretary and Director of Health services to conduct systematic monitoring and review of the RNTCP. Review the NRHM support to the programme and discuss.

Observations and gaps

- High-level of political and administrative commitment of the state level authorities.
- In General, the State has rolled out free diagnostics Schemes which benefits to patients in general and also, TB patients who are taking in-patients services (previously treated and drug resistant TB) and investigations for pre-treatment evaluation and X-Ray.
- State leadership has expressed their commitment and called up on to eliminate the TB in Punjab before 2023, two years ahead of national target.
- The TB patients are getting benefitted by provision of "Panjeeri" from Markfed and linkage to Antyodaya Yojana, which is state health and nutrition schemes which are being rolled out above the existing RNTCP related health service benefits.
- TB care facilities are established across the state as per the norms and most of human resources are sanctioned from the State and recruited except some positions which still requires to be recruited.
- State share is being provided for the budget proposed under NHM.
- State TB forum constituted; communication sent to districts for formation of TB forums
- TB free blocks nominated in all the districts of State.
- Tuberculosis issue is still not being taken to Panchayati Raj Institutes, Local Urban Bodies, Gaon Kalyan Sameeti which is required to expand services and prevention of the disease.
- Involvement of political leaders (MPs and MLAs) has not been undertaken to the extent necessary.
- Sub-optimal involvement of general health system including urban health facilities in programme implementation.
- Engagement of general health system, including medical officers, general pharmacists and laboratory technicians for providing RNTCP services required to improve.

Recommendations

- **Sensitization of MPs, MLAs, PRIs and ULBs need to be undertaken within 3 months. Partner organization - REACH can be requested to coordinate.**
- **District administrators to be sensitized on TB care services.**
- **Village Kalyan Sameeti, VHNSC, Panchayati Raj Institutes to be engaged effectively for supporting TB care and prevention.**

1.3. Capacity of the State TB Cell (STC) in programme monitoring

Evaluate the capacity of the STC in programme management. Any vacancy of staff in the STC. Note the frequency of supervisory visits by the STO/ staff of STC. Note the frequency of review meetings, the type of programme data analysis that is done at state level and the feedback provided to districts. Assess the role of the STDC in supporting the state in supervision and quality control.

Observations and gaps

- Agenda of DTO review meeting of 2017 and 2Q18 were available, but action taken report had not been prepared.
- Nearly 9 supervisory visits undertaken by the STO in the past 3 months.
- Data is analysed and displayed in State TB cell
- No internal evaluation done in the states in 2017 & 2018

Recommendations

- **All DTOs need to be reviewed under the chair of Secretary Health and MD-NHM at least twice in year and monthly under the Chair of STO/DHS in person or through VC while conducting robust monitoring at District and State level.**

- **Preparation of visit calendar for SIE for carrying monitoring visits to be completed.**

1.4. TB Case Finding Activities, TB Treatment Services and TB Patient Support

Observations and gaps

- State Could able to achieve 199 / Lakh Population Presumptive TB Examination Rate ,153/Lakh Annualised Total TB case Notification from Public sector & 39/Lakh Annualised Total TB case Notification from Private sector that is less than the expected norms in Private sector till 3Q18
- Treatment Success Rate for Public sector 88% (New case) & 78% (Retreatment Cases) were reported in Nikshay Portal for 2018 (Till 3Q18).
- Nutritional support being provided to MDR Patients with the support of local NGOs in some of the districts of Punjab
- High Protein Supplementary diet "Panjari" is being provided to MDR & XDR TB patients from state resources
- Presumptive TB Examination Rate is in increasing trend from 157 (2015) to 199(2018) per lakh population in 2018 though Quality of Presumptive referral is major issue.
- TB Case Notification (Public Sector) is in increasing trend from 38192 to 35215 (Till 3Q18) against target of 28389.
- TB Case Notification (Private Sector) is in increasing trend from 6722 (2017) to 9593 (Till 3Q18) against target of 22500 though there is ample capacity for more improvement in Private sector notification
- There is 247 DMC were functioning out of 265 DMC existing in the State as of now.
- There is 127 Functioning X Ray Health Facilities available within district except few non-functional in Fatehgarh district CHCs.
- Schedule H1 implementation is observed to be suboptimal which was reflected as low Private sector TB case notification by chemist sector (511-under schedule H in 2018)
- Only 13% Unreached Population is covered under Active TB Case finding since April 18 to October 18, from which 2965 Presumptive TB identified, out of them 188 (6%) where turned out to be Microbiological confirmed & 88 (3%) were found to be sputum positive on microscopy.
- Negligible Errors found in EQA protocol happening at State.
- Mass level PRI sensitization & Media workshop once in a year is required to reach to unreached community in districts of Punjab
- Treatment Success Rate for New Case is 88% throughout (since 2015 to 3Q18) but For Previously Treated TB cases it was 78% (3Q18) & DR TB Cases it was around 43% since beginning of the Program
- All Visited TB patients found to be regular on their TB Treatment except few places where centralised TB Treatment provision happened (100 TB patients taking DOT from 1 MGG DOT Centre)
- All visited public sector TB patients received free diagnosis and Free TB drugs under RNTCP
- Annually around 8000 Diagnosed TB patients not able to initiated on TB treatment in 2017 & this year also same would be not initiated on treatment just because of poor recording & reporting system & not having proper refer & feedback mechanism established throughout the districts of Punjab.
- TB patients has to travel to District HQ on their own pocket for Diagnosis (CBNAAT)
- TB_HIV Co infected TB Patients is not initiated with 99 DOT ICT based treatment adherence system Now a days because Universal Envelop is not make available at state level
- For NIKSHAY Poshan Yojana, 4186 / 6168 (68%) DBT benefits provided till 3Q18 to TB patients under NIKSHAY Poshan Yojana (INR 42 lakhs)
- Food, Civil supplies & consumer affairs department -Punjab has issued directives to all DFSO to issue Antodaya Ann Yojana Cards to MDR & XDR TB patients in the State.
- Nutritional support being provided to MDR Patients with the support of local NGOs in Faridkot, Firozpur, Sangrur, Patiala, Hoshipur and Bhatinda
- Directive Health services has issued letter to all civil surgeon to involve RBSK Team in the screening & awareness of TB during School & Anganwadi visit
- High Protein Supplementary diet "Panjari" is being provided to MDR & XDR TB patients from state resources

Recommendations

- **State level Review should include Districts wise PHI which are not referring 2-3% Chest symptomatic for sputum examination**
- **Felt need of sensitization of Medical officer and field staff.**
- **State should give guidance to districts for how districts can improve their Presumptive TB case Referral from Public as well as from Private sector**
- **State should ensure following key activities to improve Public sector Notification**
- **2-3% chest symptomatic from their New Adult OPD**
- **All Chest symptomatic should undergone X ray Examination simultaneously with sputum examination**
- **Active TB Case finding should be in campaign mode at least thrice in a year with involvement of General Health care staff**
- **Key Population like (PLHIV, EP, Paediatric) should be prioritized for CBNAAT test**
- **State should ensure that all Private Practitioner / Chemist association /Laboratory Association should be sensitized at regular interval at respective district level for (Free CBNAAT utilization & Free Drugs (FDC) availability & Free PHAFN facility) in CME for to get them fully engaged with RNTCP**
- **Reasons should be sought for Non-functioning of DMCs & try to resolved it as early as possible**
- **State should convert existing Public health facility which have Functioning BM, Trained LT & Infrastructure availability in to DMC for to resolve accessibility & convenience issues for local area.**
- **Optimal utilization should be ensured as per New TOG diagnosis algorithm that each presumptive TB should undergone for X ray chest examination which will definitely increase missed out smear negative TB case detection.**
- **Non-Functioning X ray unit should be identified & let it make functional for optimal utilization**
- **Orientation of chemists for schedule H1 implementation, monthly meeting with drug control officers for review of reports and field visit for understanding implementation challenges for private sector notification improvement; for that district may print and provide schedule H1 registers to chemists.**
- **Active TB Case finding should be happened as per guideline in clinical, geographical & socially vulnerable area / group & unreached area with quality Presumptive TB identification with involvement of General Health Care Staff & of course quality Supervision & Monitoring during ACF will definitely give good output than expected.**
- **ACF should be repeated biannually in same HRG area with quality Preplanning, Supervision & Monitoring**
- **EQA Protocol should be regularly happened at each district or club with another district under strict supervision of DTO to get good quality result for action for to improve smear microscopy at field level.**
- **Any kind of quality TB Awareness at Mass level should definitely impact on community & will resulted in increasing Case detection as well as strengthen treatment adherence within the state.**
- **Improve New TB case success rate (up to 90%) with good treatment adherence activities & improve Previously TB case success rate (up to 85%) & DR TB Case Outcome by following mechanism**
- **-strengthening loss to follow up retrieval actions at real time for to keep such patients on TB Treatment adherence.**
- **-Timely referring & addressing adverse drug effects at nearby health facility**
- **-General Health Care staff including ASHAs should be sensitized regarding identification of Drugs side effects & providing proper counselling to TB patients**
- **De-Centralization of DOT centre is required to be done at MGG DOT Center.**
- **State has to strengthen their efforts to keep all TB patients remain on treatment adherence with the help of General Health Care staff including ASHA & PRI members sensitization.**
- **Sustain Free TB diagnosis and Free TB drugs services to Public sector patients & recommended to extend such services to private sector TB patients who are willing to use CBNAAT and FDC**
- **Proper implementation of New TOG & Good recording Reporting system with strengthen refer feedback mechanism at regular interval between intra & inter districts of Punjab state will definitely give good output in improving this indicator**
- **TB patients Transport support in form of Sputum collection & Transport system implemented through NGO _partnership scheme or Effectively using Indian Postal services or courier services**

- **99 DOT like ICT technic should be used for to get treatment adherence on real time & one can prioritise his /her Priority (High Risk) for interventions.**
- **A Pilot should be tested for Newer ICT like MERM should be used for Monitoring Treatment Adherence in DS & DR TB patients also.**
- **Mission mode bank account details collection involving general health system staff along with daily monitoring in NIKSHAY and PFMS to utilize available DBT funds and 100% DBT coverage for all notified TB patients**
- **Good initiative, sustain such types of Nutrition support to needy TB patients by getting help of Local NGO or Donor or under CSR.**

1.4. Capacity of the State TB cell in financial monitoring

Assess the systems in place for financial monitoring. Assess the capacity of the human resource involved in financial monitoring at the STC. Review the State Action Plan for the financial year, including the budget and expenditure till date. Study the fund flow system and note the time taken for the state to release funds to the districts after receiving funds from the central level. Note whether the state has submitted the audit report and utilization certificate for the previous financial year in time. Review the adequacy of delegation of administrative and financial powers to STOs and DTOs. Review the SOEs of relevant heads and compared with action plan.

Observations and gaps

- The average expenditure reported by State for last three years is only 54% with respect to release of funds.
- Only 23.54% expenditure reported up to September, 2018, whereas 75% was expected.
- Statutory Audit report is not yet reported even not yet signed for the FY 2017-18. The due date was 31st July, 2018.
- Pace of utilization is low.
- PFMS Implementation at State level has not taken place.

Recommendations

- **Re-allocation of funds should be done by taking prior approval from State or district Authority.**
- **All the bills should be well supported by voucher.**
- **SOE should be verified and duly signed by STO and DTO.**
- **Finance Management training is required.**
- **Full time accountant is required at District level.**
- **Only one bank account for RNTCP programme needs to be maintained at State and District. Idle bank account should be closed with immediate effect.**
- **State and District should avoid keeping negative balance in SOE.**
- **Opening balance should be matched with the Audit report and UC's.**
- **No reports of concurrent audit are available at State.**
- **Supervisory visits have not taken place from last two years.**
- **Opening balance difference of Rs. 71343/- of FY 2017-18 should be reconciled on priority.**
- **SOE should be generated from PFMS.**
- **All the expenditure should be recorded though PFMS in-case of DBT and non-DBT payments.**
- **Historical data should be entered in PFMS by using post-facto method.**
- **Pending DBT payment for NPY should be processed.**
- **DBT for all four Schemes i.e. Nutrition Support, TB Patient (Tribal), TB treatment supporter, Private Practitioner should be started.**
- **DBT report should be available at DTC and STC.**

1.5. Human resources

Review staffing and training status of the State TB Cell. Assess whether the STO is full time and note the proportion of districts with full time District TB officers. Review vacancy status of key RNTCP staff in the state. Note the proportion of STS, STLS, and LT who are employed on a contractual basis, and

assess the systems in place for maintaining quality in recruitment and retention of staff. Assess plans and systems in place for training (induction training for new and turnover staff, retraining and update training for existing staff).

Observations and gaps

- Full time STO in place.
- 22 DTOs covering all districts in place
- Induction training has been done for 21 DTOs
- Update training for Nikshay Aushadhi done at state level
- Trainings imparted at state level and at STDC for induction and retraining's
- Vacant posts at state level: Out of 6 sanctioned posts,4 posts are filled (67%)
- Vacant posts at district level: Out of 520 sanctioned ,359 posts are filled (69%)
- STS:out of 134 posts 109 are in place. Vacant-25 (81%)
- STLS: Out of 59 posts 40 are in place. Vacant-19 (68%)
- DMC LT: Out of 268 posts 208 are filled. Vacant-60 (77%)
- TB-HV: Out of 102 posts 80 filled Vacant-22 (78%) MO-DTC from general health staff available only at 3 DTCs State IEC officer post abolished by NHM
- State Drug store Pharmacist to be recruited

Recommendations

- **Recruitment process at state and district level to be expedited for RNTCP key staff.**
- **STDC Patiala to be given all required human resource**
- **Medical College staff to be involved in sensitization of private practitioners and IMA members**
- **District level trainings to be undertaken for RNTCP key staff and MOs**
- **MO-DTCs to be posted by health services**
- **TB Health Visitors to be recruited and posted for urban population in districts**
- **State IEC officer post has been abolished by NHM it should be revived and recruitment done**
- **State Drug Store Pharmacist to be recruited and trained in Nikshay Aushadhi**

1.6. Drug management system

Visit and evaluate the state drug store. Review the system for storage and distribution of RNTCP drugs. Note any shortages / stock-outs / expiry in the past one year. Assess the systems in place for managing such situations. Assess whether state is procuring anti-TB drugs.

Observations and gaps

- Trained regular pharmacist at SDS Punjab maintaining the drug store as per RNTCP guidelines
- Well maintained stock register matching with available drugs
- State has rolled out NIKSHAY Aushadhi in all districts by training district pharmacists
- FEFO principle followed rigorously
- Twice Physical verification done by STO Punjab despite of recent joining and still learning the overall process of supply chain and logistic
- State regularly communicating with central TB division about drug situation especially shortage of drugs and cartridges
- Most of the time DRTB boxes for shorter and conventional DRTB regimen prepared at SDS Punjab, at times districts are also provided with loose drugs and cartons
- Loose medicines regularly supplied to Nodal DRTB sites through district drug stores and monitored by SDS Punjab during supervisory visits
- Decentralised PMDT logistic material procurement
- Single state drug store catering to 22 districts
- Insufficient space in SDS Punjab and use of pallets to keep drug boxes
- Post of contractual pharmacist and store assistance vacant and general health system pharmacist at SDS recently got transferred
- Full use of NIKSHAY Aushadhi for receipt and acknowledgement is yet to started

- No hired agency to deliver the drugs to districts on regular basis and districts usually send vehicle for drug collection as and when required
- No rodent control measures, SDS drug not having door closure in place
- Decentralised reconstitution of drugs resulting in less monitoring of supply chain management at district/sub-district level
- State in last one year has faced stock out of Pediatric FDC (16.2.18 to 20.3.18, 7.5.18 to 11.6.18, 25.7.18-25.9.18) and CBNAAT cartridges (1.5.18 and 11.5.18)
- Moxifloxacin (176630 tablets) and Kanamycin (500mg-2002 vial) (1gm- 148 vial) expired in 2018
- State has procured INH 300mg through Punjab Medical Service Co-operation but pyridoxine wasn't available in market required quantity for IPT initiative

Recommendations

- **Trained human resource to be retained as it will help state in better SCM**
- **State may consider satellite drug store for reducing the congestion and space scarcity issue of SDS Punjab**
- **Hiring of contractual agency at central level may be considered so that drug supplied are sent directly from SDS Punjab instead of waiting for districts to send vehicle**
- **NIKSHAY Aushadhi portal to be fully utilised for monitoring of supply chain management at each level**
- **Monthly/quarterly review of drug situation may be considered and districts drug consumption may be reviewed based on NIKSHAY Aushadhi portal**
- **Reconstitution may be monitored during supervisory visit to districts**
- **State to consider chalking out plan for FDC provision to private sector patients in planned manned with focus of high TB patient notification facilities**
- **Any kind of logistic and drugs shortage to be addressed in coordination with central TB division**

1.7. Involvement of other health sectors (public and private)

Review efforts undertaken to involve private practitioners, NGOs, corporate sector, other government health facilities outside health department and other partners in RNTCP. Note the extent to which medical colleges and TB hospitals are involved in RNTCP. Review the activities of the medical college State Task Force. Review the coordination with IMA and major NGOs at the State level.

Involvement of Medical Colleges:

- Punjab has 8 medical Colleges in state 3 govt and 5 private, which are all involved
- All have DMC and Treatment Support Centre and 3 govt colleges have CBNAAT sites
- 6 PG thesis and 1 OR has been undertaken by medical colleges
- STF meetings have been conducted regularly 4 in 2018 and all colleges conduct regular core committee meetings
- 2.4 Lakhs have been budgeted in PIP in current financial year for PG thesis & OR
- 48,000 has been paid for PG thesis in current financial year
- TOG, PMDT trainings have been done for 7 medical colleges and 261 faculty members and 265 SR & JR have been imparted trainings
- State Task force mechanism is working well.

Co-ordination with IMA:

- State level meetings have been conducted with IMA by State TB Control society to involve private practitioners
- All districts collaborate with district IMA branches and conduct CMEs and meetings
- CBNAAT facilities are being provided to IMA members
- District Patiala is in the process of arranging CME with IMA members and work out modalities for keeping FDC in their respective clinics.

Involvement of NGOs/Chemists:

- One state level meeting done with state drug controller and district drug controllers
- Under Global Fund JEET (Joint Efforts for Elimination of TB) 8 districts have undertaken activities for Pvt sector engagement and Axshya project has undertaken community-based activities in 4 districts
- District level involvement of local NGOs for LT out sourcing

District level CMEs conducted for NGO
Selected Chemists are to keep Registers for Schedule H1 drugs
Camps being conducted at districts by Axshya

Other Govt Sector:

- ESI and Railways have been involved in districts

Constraints and gaps

- Single Labs and private Practitioners not involved in smaller districts
- Chemists have been given wrong message from administration
- **Medical officers to be provided to medical colleges where posts are vacant**
- **CGHS and armed forces not involved at state and district level**

Recommendations

- **Labs and private practitioners to be given public health action from RNTCP staff**
- **Chemists sensitizations to be done at district level with clear guidelines for their involvement**
- **CGHS and armed forces to be involved in districts**
- **Patiala initiative of IMA involvement can act as model for other districts**
- **Railways can be approached from state level for co-ordination with RNTCP**

1.8. Assess Advocacy Communication Social Mobilization (ACSM) activities

Assess the state IEC action plans and their implementation, the role of the IEC officer in the State TB Cell and the steps undertaken to increase advocacy for TB control. Review the State IEC reports and the IEC materials prepared by the State. Note the extent of utilization of budgeted funds for IEC activities.

Observations and gaps

- Newer initiatives taken by the state for ACSM has demonstrated success.
  1. Involvement of Nehru Yuva Kendra for social engagement of youths at district and block level has been undertaken and state has issues advisory to all the districts.
  2. TB awareness activities has been undertaken by Rashtriya Bal Swasthya Karyakram in form of interactive sessions on TB with school children.
  3. Advocacy activities with MarkFed (Marketing federation, Punjab Government) has led to provision of high calorie "Panjiri' to Drug resistant TB patients.
  4. Advocacy with Food and Supplies department has led to provision of 5 kg wheat to drug resistant TB cases.
- State ACSM action plan is in place and is in concordance with NHM action plan.
- No IEC Officer is in place past one and a half year.
- State quality group for ACSM is not in place and never has been formed.
- No capacity building workshop on advocacy, communication and social mobilization has been conducted in the last one year.
- IEC materials need to be designed for thematic areas like Daily regimen, Drug resistant TB diagnosis and management, Nikshay Poshan Yojana, joint TB-HIV and other comorbidities like tobacco and Diabetes.

Recommendations

- **IEC officer recruitment should be done as soon as possible.**
- **Capacity building workshops should be conducted before World TB day 2019, as that will help District officers to plan in efficient way.**
- **State quality group for ACSM should be formed according to the guidelines provided by Central TB**

Division.

- **IEC material conceptualization, design and development should be done in close collaboration with subject and language experts.**

1.9. TB/HIV

Review state level coordination between TB and HIV programmes and the frequency of meetings between the RNTCP and SACS. Interview SACS authorities regarding coordination with TB. Review cross referral linkages between TB and VCT/ART services. Review monthly TB/HIV cross referral reports at state level.

Observations and gaps

- Regular State level TB-HIV Coordination committee and TB-HIV working group meetings happening in State
- Good coordination with NTCP observed for TB-Tobacco activities implementation
- District TB officers nominated as District AIDS Control Officers in all districts
- Majority of the districts conducting District coordination committee meetings (except for Muktsar & Tarn Tarn)
- Periodic Joint visits carried out from State level to districts to identify shortcomings and address the same
- Nearly 94% of the PLHIV attending the ART centre screened for PLHIV
- 99DOTS sleeves not available in State for past 1 year
- Only 20% of the PLHIV initiated on TB preventive therapy

Recommendations

- **Coordination with NCD to be strengthened.**
- **99DOTS sleeves for ICT based adherence monitoring to be proposed in the PIP.**
- **Coverage of TB preventive therapy to be improved to cover all PLHIV**

1.10. Intermediate Reference Laboratory (IRL) and management of MDR-TB

Review the status of the IRL with regards to its function in quality assurance of smear microscopy. Review reports on OSE, panel testing and RBRC available with IRL. Review plans for building capacity of IRL on culture and DST, note current status and assess the commitment and the realistic timelines.

Observations and gaps

- Regular microbiologist in place and IRL has been certified for Liquids Culture for Second Line Drugs by NITRD in January 2018.
- FIND Support in terms of provision of 2 Technical Officers, 3 Laboratory Technicians, 1 Data Entry Operator and 3 Laboratory Attendants.
- Presently in the state, there are 3 Nodal DRTB Centres, and 11 District DRTB Centres.
- From the program, the IRL has one IRL Microbiologist, 1 Laboratory Technician, I Data Entry Operator.
- Since 2017, IRL has not undertaken supervisory visits to the DMCs, not undertaken EQA activities for the DMCs
- AMC for the state (IRL and DMCs) has expired in December 2017 and currently Microscope at *IRL* is not covered under AMC
- Maintenance of the records and reports at the IRL and the completeness of the reports is suboptimal.
- Biomedical Waste Management Guidelines not been followed.
- Delay in the initiation of treatment at DR-TB Centre after diagnosis.
- High Contamination rates were observed in Liquid Culture.
- Turnaround time was observed to 7 to 13 days in LPA.
- LPA is not being performed on daily basis. As per the protocol, the controls to be run along with batches and not to be processed prior and kept.
- Lab register at IRL was observed to be incomplete.

Recommendations

- **To hasten the process of filling up the vacant post of Microbiologist and Senior Laboratory Technician**

for EQA activities

- **EQA training of the Microbiologist, the Laboratory Technicians to be undertaken on priority basis.**
- **Microbiologist at the IRL along with the team members to undertake EQA visits to the DMCs**
- **AMC for the Microscopy activities at the IRL and the DMCs in the state.**
- **The Microbiologist at the IRL in conjunction with the team to regularly review the records and reports being maintained at the IRL and ensure timely submission of the relevant reports. (Quarterly reports pertaining to EQA, LPA, Laboratory Performance Indicator and CBNAAT) to CTD within a week of the completion of the quarter).**
- **Regular feedback with the DTCs, DMCs to be strengthened.**
- **Across all the units within the IRL, Biomedical Waste Management System to be implemented.**
- **Standard Operating Procedures to be implemented optimally for all the procedures being performed at the IRL.**
- **As BSL3 is now functional lab to expedite the service delivery for LC&DST in second line**

District level

Note: After completing the field visit, use the following template to collate the findings. Teams are required to submit findings for each district visited. District level findings and recommendations are based on field visits and interviews with district level authorities, e.g. District Magistrate, Chief Medical Officer of Health Services, District TB Officer (DTO), and NRHM DPM. Field visit in each district will include a visit to the District Headquarter, District TB Centre, sub district level TU, designated microscopy centre (DMC), including DMCs in other sectors, CBNAAT labs and PHIs. In addition, some districts will have additional activities to be reviewed, e.g. medical college involvement, NGO involvement, TB/HIV collaborative activities, DR-TB etc.

Name of District: Patiala

I. Political and administrative commitment

Assess the extent of political and administrative commitment based on discussions with the STO, DTOs, and district authorities / health officials, e.g. Chief Medical Officer, District Magistrate, etc. Make a bulleted list of achievements, constraints and gaps, and recommendations.

Observations and gaps

- Overall good programme implementation in the district
- Good commitment forms the District level authorities and regular review of program implementation.
- The district has established facilities with latest diagnostic technology and treatment
- Meeting was done by CIE team with the DC, Patiala and it was observed that he is well versed with the programme and regular review meeting of RNTCP is being conducted under his chairmanship.
- DC instructed the civil surgeon to organize a meeting of IMA and other practitioners involved in management of TB. He also directed to begin activities for TB free villages with involvement of rural development and public health and sanitation department along with activities of Swach Bharat Mission.
- Civil surgeon was also instructed to make all the DMCs functional and plan for additional TU and DMC at CHC Tripuri.
- DC was aware of vacancies and assured that he would push the matter further.
- Good coordination was observed and appreciated between DTO, STDC, IRL, Medical college and NHM.
- 4 DMCs are non-functional in district.
- Institutional DOT services not being supported by general health system.
- DTC pharmacist has many additional duties like School Health Programme, VIP and emergencies duties.
- No pharmacist deputed to manage TU drug store at Rajpura and Nabha.

Recommendations

- **Non-functional DMCs to be made functional by deputing regular LTs for sputum microscopy.**
- **Institutional DOT services to be supported by general health system.**
- **DTC pharmacist should be available full time.**
- **Pharmacist to be deputed to manage TU drug store at Rajpura and Nabha.**

II. Case finding activities

Analyse and interpret findings, including trends, related to Presumptive TB examined, inclusiveness of providers in the RNTCP network and efforts made to enhance case finding under DOTS. Review of laboratory registers and discussions with chief medical officer and DTO of the district, in-charge of sub-district level health services (Block Medical Officer, MOTC, etc), medical officers, etc. Review access issues including patient delay, provider delay, and accessibility to DMC etc. Review process of treatment initiation. Make a bulleted list of achievements, constraints and gaps, and recommendations.

Observations and gaps

- TB patients are receiving free diagnostic and treatment services. No patient informed that they were

charged for services in public sector

- District has notified 4485 TB cases till November 2018 and achieved annual TB notification target
- The patient interviews revealed that more than 80% of the patients on reaching the public sector have been initiated on treatment within one week of diagnosis.
- Only 87% (3935/4557) of diagnosed TB patients initiated on treatment
- Vacancies in the DMCs is affecting the case finding activities.

Recommendations

- **ACSM activities to be strengthened to improve the case finding activities.**
- **Addressing the DMC LT vacancies would help to improve the case finding activities.**
- **Referral from private sector to be improved.**
- **Paediatric case finding activities to be strengthened. To explore supportive visits to the Medical Colleges and CMEs to strengthen the paediatric case finding activities.**

III. Laboratory

Assess the structure, access and quality of the designated microscopy centre network and CBNAAT labs. Review laboratory procedures, human resources (LT, STLS), equipment, records and reports. Review implementation and results of laboratory quality assurance, including IRL activities. Make a bulleted list of achievements, constraints and gaps, and recommendations.

Observations and gaps

- The district has 17 DMCs, 03 CBNAAT Labs and 01 DRTB Centre.
- 2 DMCs have LTs through NGO-PP Schemes and 6 DMCs have contractual LTs.
- EQA is being undertaken regularly
- Of the 17 DMCs,4 DMCs do not have full time LTs. The STLS is undertaking the role of LT in the DMC (Rajendra Medical College).
- The DTC DMC is not functional due to LT Vacancy. (Model Town Civil Hospital).
- The Laboratory Register at the DMC visited is not complete
- Of the 5 Sanctioned posts of STLS only 2 STLS are in place.
- Supervisory visits of the IRL have not taken place at the DMC visited for the past 2 years

Recommendations

- **To ensure utilisation of the services of the LTs from the General Health System/LTs from ICTCs for the existing LT vacancies at the DMCs.**
- **To ensure filling up the vacancy of the DTC DMC LT and the DTC TU STLS at the earliest.**
- **DTO to ensure training the newly recruited LTs in the programme.**
- **LT and STLS to ensure regular reconciliation of the feedbacks from the referring and referred health facilities (inclusive of the CBNAAT Centres) to ensure completion of the records and reports (TB Laboratory Register and the TB Notification Register)**
- **To hasten the process of the establishment of additional DMCs within the public sector hospitals identified**
- **RBRC needs to be strengthened**

IV. Treatment and treatment support

Analyse and interpret findings related to treatment and treatment observation based on discussions with patients, Treatment Supporter, STS, medical practitioners, review of treatment cards, Data Validation with TB Notification register, lab registers & NIKSHAY, and observation of treatment support centres. Make a bulleted list of achievements, constraints and gaps, and recommendations.

Observations and gaps

- Daily regimen anti TB treatment has been implemented since 31st October-2017, and 5400 patients put on treatment till November 2018
- Patient interviews revealed that for more than 90% of the patients, initial home visits have been undertaken

and the relevant investigations have been undertaken prior to the treatment initiation.
- Patient interviews revealed that more than 95% were satisfied with treatment initiation leading to symptom relief and improvement in the health condition.
- Patient interviews revealed more than 95% of the patients have received the monetary incentives.
- Due to the human resource constraints, at the institution-based Treatment Support Centres, all the patients 'treatment supervision is not happening on daily basis.
- Of the 8 sanctioned posts of TB-Health Visitors, only two are in place

Recommendations
- **Institution based treatment support to be decentralised to the pharmacies for ensuring uninterrupted supervision of the treatment support services.**
- **The vacant posts of the TB-HVs to be filled on priority basis.**
- **Regular weekly reconciliation of the feedback and entries in the Laboratory Register, TB Notification Register, the examination form for the Biological specimen and the treatment card.**

V. Recording, reporting, monitoring and supervision

Review recording, reporting, monitoring and supervision at each level based on scrutiny of all available record and reports, and discussions with DTO, DPC, MOTCs, and STS/STLS. Make a bulleted list of achievements, constraints and gaps, and recommendations.

Observations and gaps
- Regular review of the programme activities every month by the district authorities, including District Commissioner, Civil surgeon and DTO
- Nearly 84 visits carried out by the DTO in the past year and key issues being addressed in the blocks including sensitization, selection of treatment supporters, organization of village mela etc.
- Vehicle available with DTO for carrying out supervisory activities, while MOTC using their own vehicles. Tour diary being maintained by all staff.
- NIKSHAY is managed from block levels by STS
- All approved activities approved in last 2 financial years carried out
- Enrolment is sub-optimal (56%) and also updation of diagnosis & treatment details (31% cure rate of patients registered in 2016) needs improvement.
- POL not claimed by supervisory staff for 3 staff from 2017 and remaining staff from 2015

Recommendations
- **NIKSHAY entries to be decentralized to PHI level with involvement of DEO of NHM/General health system.**
- **Real-time updation of Nikshay entries to be carried out.**
- **Process of payment of POL to supervisory staff to be streamlined through simplified & minimal documentation.**

VI. Human Resource Development

Analyse and interpret findings related to human resources development based on discussions with authorities and health personnel at different levels. Review HRD related activities for staffing and training, including the district action plan. Make a bulleted list of achievements, constraints and gaps, and recommendations.

Observations and gaps
- Full time committed and very well trained DTO who is MD in Chest and TB is managing the RNTCP in district.
- MOIC in place in all the TB units
- Only 53% (23/43) of the sanctioned HR under RNTCP in the district in place. Vacant HR posts at district includes 1 District Public Private Mix coordinator, 1 District Programme coordinator, 6 TB Health Visitors, 3 Senior TB Treatment Supervisor, 3 Senior TB Laboratory Supervisor, 4 Lab technicians, 1 DEO, 1 Accountant

- Pharmacist not available at Samana & Nabha blocks to look after RNTCP drug store
- Knowledge gaps were observed in the visit for implementation of revised technical and operational guidelines which need repetitive trainings and handholding
- 5 labs are non-Functional due to non-availability of Lab technicians.

Recommendations

- **Filling up of the vacant posts under RNTCP under guidance of state NHM keeping in loop state TB cell**
- **Pharmacist may be deputed at Samana & Nabha blocks to look after RNTCP drug store**
- **Sensitization of the medical officers in Nabha. Handholding of the RNTCP staff and supervisory staff of the general health system to be undertaken on revised technical and operational guidelines which need repetitive trainings and handholding**
- **District need to engage LTs from NGO under RNTCP partnership scheme with approval.**

VII. Drugs and supplies

Review drug and logistics management system in the district, including drug store, documentation, reserve stocks, mode of supplies, etc. Discuss with DTOs, MOTCs, medical officers, pharmacist and Treatment Supporters. Make a bulleted list of achievements, constraints and gaps, and recommendations.

Observations and gaps

- Pharmacist at DDS from regular govt service trained in Nikshay Aushadhi twice from NTI
- Second Line drug store maintained very meticulously
- Stock registers maintained in First Line drug store
- Stock register in Second Line Drug Store maintained for shorter MDR and MDR regimen from 1 January 2018
- Vehicle for transporting drugs being provided by CMO office to all TUs
- Nikshay Aushadi training of STS completed
- The TU Drug Store visited at Rajpura (A.P. Jain Civil Hospital), has seepage in the walls.
- The TU Drug Stores are being managed by the STS, hampering the supervisory activities of the STS.
- Lab consumables and drug store to be kept in separate space
- Pharmacist has been assigned emergency duties by district authorities apart from RNTCP and school Health activities
- Reserve drugs not available as stocks received are low
- Second Line drugs are not available in time to Patients
- Nikshay Aushadhi training of TU Pharmacists and PHI level staff at district level

Recommendations

- **In conjunction with the hospital authorities, DTO to ensure relocation of the TU drug stores to seepage proof area.**
- **To explore the possibility of management of the TU Drug Stores by the pharmacist at the Rajpura Civil Hospital.**
- **Separate space for Drugs and Lab consumables in DTC Store**
- **Pharmacist to be kept for RNTCP work as she has been trained for national level in Nikshay Aushadhi**
- **Ensure reserve drugs in DTC Drug store**
- **Second Line drugs to be provided to Treatment supporter in time**
- **Nikshay Aushadhi training to PHI level staff to be undertaken**

VIII. Public-private collaborative activities

Assess the level of participation of private sector, NGOs, medical colleges, TB hospitals and non-health ministry governmental health providers (e.g. ESI, Coal & Mines, Railways, etc) based on meetings with appropriate representatives and discussions with district authorities and medical personnel, and review of relevant data. Make a bulleted list of achievements, constraints and gaps, and recommendations.

Observations and gaps

- Following CME conducted by the DTO for the IMA doctors, the involvement of the Simrita Nursing Hospital doctors in the programme has improved in terms of TB Notification, Referral for CBNAAT Centres and referral of the patients for treatment from the Government Health Facility.
- CME for sensitization of around 100 private doctors conducted in July 2018.
- Project JEET has started working in the district in 2018 for engagement of private sector to enhance notification and initiate public health action.
- Project Axshya has been working in the district since 2011 and important activities are community based active case finding (Axshya Samvad) and increasing district hospital referrals.
- District has engaged the services of NGO Sevabharti for providing 2 Lab Technicians to the district.
- Sub-optimal effort from District to engage private sector where more than half of TB patients are expected to be seeking care.
- Only 150 cases notified in 2018 as against 278 cases notified in 2017 during the same period
- Only 12% (16/131) private health facilities notifying to programme in 2018
- Engagement of private practitioners with RNTCP to be increased from present 40% (16/40)
- Effective of use provisions of Schedule H1 to increase TB notification is yet to take off in district.
- Referral of presumptive TB patients from private providers for CBNAAT testing is very low.
- Gaps and apprehensions have been observed in the knowledge level of private providers regarding the latest diagnostic and treatment regimen available in RNTCP.

Recommendations

- **The involvement of the Private Nursing Home to be further strengthened by regular supervisory visits by the DTO, CME programs and exploring the option of setting up the Treatment Support Centre**
- **Comprehensive plan needs to be devised by District TB Cell for engagement of Private providers (Allopathic), AYUSH practitioners, pharmacies and potential partners for putting together a robust notification system in place.**
- **Professional bodies like IMA, IAP And FOGSI have to be roped in for providing technical support to the program and RNTCP has to establish and maintain the momentum for strong collaborations.**
- **CMEs need to be conducted at regular intervals for providing latest updates of RNTCP.**
- **Liaison with Drug Regulatory department has to be established for implementation of H1 schedule in pharmacies**
- **Private sector referrals for CBNAAT testing needs to be increased by setting up a referral system.**

IX. Advocacy, Communication and Social Mobilization

Review ACSM activities-based district IEC action plans, activities, reports and interviews with district authorities, health care workers (public and private) and community representatives. Make a bulleted list of achievements, constraints and gaps, and recommendations.

Observations and gaps

- Social support for DRTB patients for 6 months from April 2018 (Wheat 5 kg/person/month). 24 patients given the benefit. (Dept of food and civil supplies)
- Sensitization meetings planned with Private practitioners
- Awareness generation camps being organized
- RBSK collaboration for School based activities
- Patient provider meetings are being held regularly
- IEC material displayed at TUs, DMCs and PHIs
- Active Case Findings done in March using mobile van at Bhadson, Kalomajra, Dudhan Sadhan, Shutrana.

- Camps conducted all over Patiala for Active Case finding for 12 days
- Sensitization of PRIs/NGOs/PPs is planned
- Whatsapp groups created for new guidelines percolation to PPs
- Minimal ACSM materials seen outside of RNTCP facilities
- Target population does not attend community meetings
- TB Free Blocks need more aggressive awareness in different areas
- PRIs to be involved in community

Recommendations

- **PRIs to be involved in future for social mobilization in community**
- **CMEs to be conducted for PPs of Patiala**
- **IMA Patiala is very vibrant it needs to be involved actively**
- **TB Free villages to be identified as blocks are very big as suggested by DM Patiala**
- **IEC material to be installed beyond hospital buildings**
- **JanNiti NGO may be involved in awareness activities**
- **Red Ribbon clubs may be involved for ACSM activities**
- **Employer Led model may also include TB related activities**

X. Health System

Identify issues and factors within the health system that facilitate, or act as constraints, for the smooth implementation of the TB programme. Make a bulleted list of achievements, constraints and gaps, and recommendations.

Observations and gaps

- TB Units has been aligned with all NHM block as per National Strategic Plan
- Nodal Officers designated at TU level for supervision and monitoring of programme who are also trained.
- Good involvement of ANM and ASHA workers in giving DOTS to TB patients.
- MO DTC is not deputed to support DTO in supervision and monitoring.
- LTs from general health system not very supportive in doing sputum microscopy in DMCs as a result of which 4 DMCs are non-functional.
- Treatment Support Centres at the health facilities are defunct as no health worker is being deputed by the general health system to manage these.
- If at all they are functional they are being managed by STS which is affecting their routine supervision and monitoring.

Recommendations

- **4 non-functional DMCs to be made functional**
- **DMC to be established in 10 PHCs as per new guidelines**
- **Additional TU to be made functional at Tripuri CHC**
- **Health Worker/Staff Nurse/ANM s to be deputed to manage DOT centre in health facility.**

XI. TB-HIV

Assess status and plans in implementation of TB-HIV collaborative activities. Review coordination at district and sub-district level and reports of cross referrals. Make a bulleted list of achievements, constraints and gaps, and recommendations.

Observations and gaps

- Regular District coordination committee and monthly review meetings
- All the DMCs are co-located with HIV screening facilities
- TB Co morbidities (TB HIV, TB-DM, TB-Tobacco) Contact of TB patients were not adequately screened for chest symptoms from Public sector health facility OPD
- Nearly 39% (1848/4705) of the notified TB cases know their HIV status and 3% (57/1848) cases were co-

infected with HIV
- ICTC counsellor trained in TB-HIV collaborative activities
- Monthly reports being submitted through SIMS web portal
- Only 0.4% (140/32798) of the clients attending the ICTC were referred for TB testing, with 2 (1.4%) TB cases diagnosed and none initiated on treatment
- 10-point counselling tool not visible in the ICTC
- TB-HIV register being maintained in the Rajinder Hospital ICTC, with columns being improperly filled up
- Lack of reconciliation of the reports by the ICTC Counsellor and the STS

Recommendations
- **TB co morbidity (TB HIV, TB-DM, TB-Tobacco) & Contact of TB patient should be adequately screened for chest symptoms from Public sector health facility OPD**
- **STS and ICTC Counsellor to regularly reconcile the relevant records and reports. (preferably on weekly basis).**
- **HIV-TB Coordination Committee Meeting minutes to be documented.**
- **10-point counselling tool to be displayed prominently in all ICTCs.**
- **Referral of presumptive TB cases from ICTC to be improved, with emphasis on quality referral.**

XII. DR-TB

Implementation of the DR-TB, Review the mechanism of collection and transport of samples to IRL, diagnostic and treatment related challenges. Make a bulleted list of achievements, constraints and gaps, and recommendations

Observations and gaps
- The district has one DR-TB Centre.
- The samples from the DMCs are being sent across
- DR-TB Committee has been constituted.
- Sample collection & transport mechanism available for only 2 days at the Block level
- There is deficiency of thermocol boxes for transportation of the sputum samples from DMCs.
- SMO DR-TB Centre is vacant at the district
- Statistical Assistant is vacant at the district.
- DR-TB Counsellor post is not sanctioned for the DR-TB Centre.
- The DR-TB Supervisor is not able to supervise the DR-TB activities, however, due to the vacancies is restricted to the activities at the DR-TB Centre.

Recommendations
- **Vacant posts to be filled on a priority basis and those not sanctioned may be proposed in the PIP.**
- **Sample collection & transportation mechanism to be established in all DMCs on all days, and appropriate boxes are to be made available.**

XIII. Programme management

Review programme management capacity, including financial management, procurement of goods and services, etc. Adequacy of delegation of administrative and financial powers of STOs and DTOs. Make a bulleted list of achievements, constraints and gaps, and recommendations.

Observations and gaps
- Salary to contractual HR and treatment supporters being disbursed on time
- PFMS is fully functional in district
- DTO is a good manager and even with limited staff he is managing the RNTCP well in the district.
- DTO is regularly supervising and monitoring the programme and updating and supporting the staff in management of the programme.
- He has good coordination with NHM, medical college, STDC and another programme and private sector.

- Good intersectoral coordination with HIV, NPCDCS, RBSK, NUHM, IDSP and Mental Health.
- DBT has been given to 1106 TB patients
- One additional DMC opened Urban Dispensary at UPHC at Bishan Nagar and City Branch.
- Under new initiatives patients have been started on Bedaquiline, Delaminid.
- ACSM van with CBNAAT machine is being utilised to do Active Case Finding in remote areas.
- 2 TB Free blocks have been identified and sensitisation done in these blocks.
- Regular supply of drugs and consumables to the subdistrict by the DTC.
- All available RNTCP staff trained in latest RNTCP guidelines.
- Only 23% (948/4127) benefits paid under Nikshay Poshan Yojana
- No MO DTC available to support DTO in programme management
- Involvement of pharmacist at sub district level for management of TB patients and stock management of RNTCP drugs is not supportive.
- The contractual staff is not submitting the POL claims due the lengthy process for submitting and receiving the claims

Recommendations

- **General health system should fully support RNTCP like any other health programme**
- **MO DTC to be deputed to support DTO in programme management.**
- **Pharmacist to be deputed at sub district level for management of TB patients and stock management of RNTCP drugs**
- **Fixed amount to be reimbursed to STS and STLS in lieu of POL bills**
- **Pending DBT payment for NPY should be processed.**
- **DBT for all four Schemes i.e. Nutrition Support, TB Patient (Tribal), TB treatment supporter, Private Practitioner should be started.**
- **All the bills should be well supported by voucher.**
- **SOE should be verified and duly signed by DTO.**
- **Finance Management training is required.**
- **Full time accountant is required.**
- **Only one bank account for RNTCP programme needs to be maintained. Idle bank account should be closed with immediate effect.**
- **District should avoid keeping negative balance in SOE.**
- **SOE should be generated from PFMS.**
- **Historical data should be entered in PFMS by using post-facto method.**

District level

Note: After completing the field visit, use the following template to collate the findings. Teams are required to submit findings for each district visited. District level findings and recommendations are based on field visits and interviews with district level authorities, e.g. District Magistrate, Chief Medical Officer of Health Services, District TB Officer (DTO), and NRHM DPM. Field visit in each district will include a visit to the District Headquarter, District TB Centre, sub district level TU, designated microscopy centre (DMC), including DMCs in other sectors, CBNAAT labs and PHIs. In addition, some districts will have additional activities to be reviewed, e.g. medical college involvement, NGO involvement, TB/HIV collaborative activities, DR-TB etc.

Name of District: Fatehgarh Sahib

I. Political and administrative commitment

Assess the extent of political and administrative commitment based on discussions with the STO, DTOs, and district authorities / health officials, e.g. Chief Medical Officer, District Magistrate, etc. Make a bulleted list of achievements, constraints and gaps, and recommendations.

Observations and gaps

- General health system medical officers' involvement for TB case finding and overall TB patient management is minimal
- Private sector involvement is suboptimal as evident from <50% achievement for private sector TB notification and only 9 patients notified through schedule H1 notification
- District TB forum not constituted yet

Recommendations

- **Instructions from DC/ CS for involvement of all medical officers and LT for TB elimination efforts and monthly review by district health society**
- **Rigorous implementation of private sector TB notification act, monthly review meeting of DTO with District IMA president and district drug control officer and letter to health facilities failing to notify TB cases to government**
- **District TB forum to be constituted as early as possible under chairmanship of DC and first meeting to be held for mass sensitisation and involving community**

II. Case finding activities

Analyse and interpret findings, including trends, related to Presumptive TB examined, inclusiveness of providers in the RNTCP network and efforts made to enhance case finding under DOTS. Review of laboratory registers and discussions with chief medical officer and DTO of the district, in-charge of sub-district level health services (Block Medical Officer, MOTC, etc), medical officers, etc. Review access issues including patient delay, provider delay, and accessibility to DMC etc. Review process of treatment initiation. Make a bulleted list of achievements, constraints and gaps, and recommendations.

Observations and gaps

- Patient travel to District HQ for CBNAAT testing from CHC Chanarthal, MGG & Amloh
- 2 DMC LT post were vacant since sept 2014 which was resulted in to non-functional of that DMC in turn No case detection
- 2 X- Ray health facility out of 6 is not functioning in the district

Recommendations

- **As Policy Presumptive TB Patients should get diagnostic services as close to his residence and need not travel to CBNAAT lab as it incurs out of pocket expenditure and may spread TB infection while**

travelling. Sputum collection & transportation mechanism should be established

- **New DMC LT which are recruited recently should be trained first & ensure their sustainability in Job though they were recruited through NGO partnership Guideline**
- **As per New TOG all presumptive TB should undergone Sputum as well as X ray examination simultaneously for Diagnosis purpose so existing X ray health facility should be made functional**

III. Laboratory

Assess the structure, access and quality of the designated microscopy centre network and CBNAAT labs. Review laboratory procedures, human resources (LT, STLS), equipment, records and reports. Review implementation and results of laboratory quality assurance, including IRL activities. Make a bulleted list of achievements, constraints and gaps, and recommendations.

Observations and gaps

- Out of 6 microscopy centers existing in the district, 3 microscopic centers have suboptimal performance for OPD case referral as well as testing which has resulted in low public sector TB case notification
- 20% single sputum examination in DMC Chanarthal
- Quality of microscope functioning is poor in Chanarthal & MGG, since last 1-year servicing of BM not done
- No STLS in entire district Hence, EQA protocol highly compromised
- No supervisory visit of IRL Punjab in 2018 and no communication on low performance of DMC

Recommendations

- **District authority should regularly review & monitored 2-3% chest symptomatic referred from New Adult OPD from all types of Government health facility**
- **As per guideline two sputum sample should be tested for presumptive TB referred for microscopy which will resulted in positive yield**
- **Microscope should be serviced regularly through AMC If require then have a process for condemnation**
- **EQA should be ensured as per guideline**
- **STDC and IRL to visit low performing DMCs in the district and resolve issue with district administration for better TB case detection and improvement of RNTCP**

IV. Treatment and treatment support

Analyse and interpret findings related to treatment and treatment observation based on discussions with patients, Treatment Supporter, STS, medical practitioners, review of treatment cards, Data Validation with TB Notification register, lab registers & NIKSHAY, and observation of treatment support centres. Make a bulleted list of achievements, constraints and gaps, and recommendations.

Observations and gaps

- All visited public sector TB patients received free diagnosis and drugs under RNTCP
- Decentralization of DOT provision is not there at MGG Public health facility where around 100 TB patients getting TB Treatment on daily basis
- Long term follow up still not happening in the field & not seen in the record also as per New TOG implementation

Recommendations

- **Free diagnosis and drugs services may also be extended to private sector TB patients using CBNAAT and FDC**
- **Decentralization of DOT provision is dial need for this Treatment support centre at MGG Public health facility where around 100 TB patients getting TB Treatment on daily basis to prevent hospital acquired infection as well as recurrence of infection**
- **Long term follow up should be happened as per TOG 2017 & should be monitored from district level**

V. Recording, reporting, monitoring and supervision

Review recording, reporting, monitoring and supervision at each level based on scrutiny of all available record and reports, and discussions with DTO, DPC, MOTCs, and STS/STLS. Make a bulleted list of achievements, constraints and gaps, and recommendations.

Observations and gaps

- Supervision and monitoring visits suboptimal due to lack of supervisory staff
- Supervisory registers and visit reports of MOTC completely missing at all levels
- Although DTO has issued instructions to field medical officers for improvement of TB notification performance, action taken reports submission from field and reminders from the district HQ are lacking
- Due to lack of refresher training of existing staff and no training for PMDT new guidelines, documentation is lacking in many aspects
- NIKSHAY portal data is not completely utilised for monitoring purpose
- Private sector mapping, chemist mapping is yet to be undertaken by district

Recommendations

- **After filling of vacant posts and training, monitoring of field visits and maintenance of supervisory report with follow up to be taken by district officials**
- **District to print RNTCP supervisory registers and all MOTCs to be instructed for carrying out supervisory visit as per RNTCP guidelines for addressing implementation gaps. Rigorous facility wise review at district HQ**
- **Repeated communications to low performing health facilities from district TB centers and follow up action of district review meeting/RNTCP indicators from NIKSHAY portal to be done. DO letter from CS or DC for improvement of performance for all key indicators with specific timelines**
- **STDC, IRL and State to plan a training calendar for all RNTCP staff for new initiatives. District to conduct phase-wise training of all cadres of medical officers, paramedical workers, chemists and private doctors for overall notification improvement**
- **District to monitor NIKSHAY portal on weekly basis and provide data driven feedback to all health facilities for DBT, treatment delay, UDST and other key indicators**
- **Planned mapping of private health facilities and chemists to be undertaken by district in NIKSHAY and analysis of performance of each reporting unit**

VI. Human Resource Development

Analyse and interpret findings related to human resources development based on discussions with authorities and health personnel at different levels. Review HRD related activities for staffing and training, including the district action plan. Make a bulleted list of achievements, constraints and gaps, and recommendations.

Observations and gaps

- Full time Trained DTO is there who has Master Degree in Pulmonary Medicine which is Good for to Manage RNTCP in the district in both ways Clinically as well as on public health point of view
- Post of one senior treatment supervisor (STS) and one senior TB laboratory supervisor (STLS) sanctioned in FY 2018-19 but are currently vacant
- Posts of District Program Coordinator, District Public Private Mix (PPM) Coordinator and RNTCP Accountant have not been filled as sanction has not been received from state NHM.
- General health system medical officers' involvement for TB case finding and overall TB patient management is minimal
- Due to Human Resource constrain within District & General Health care staff Minimal involvement leads to Centralized Notification Registration for Chanarthal Kalan TB Unit (all PHI) which was happening at District HQ right now.
- Knowledge gaps were observed in the visit for implementation of revised technical and operational

guidelines which needs Refresher Training & then on Job handholding

- 2 DMC LT post were vacant since sept 2014 which was resulted in to non-functional of that DMC in turn No case detection till November 2018 however General health care LTs are there but they somehow do not do RNTCP work

Recommendations

- **State / District Should immediately fill up of the vacant posts and training of same can be imparted as early as possible under guidance of NHM & in consultation with State TB Cell**
- **District to communicate state about required posts for overall private sector TB notification improvement and DPC for program management and monitoring purpose, immediately after recruitment of both DPC & DPPM, ensure for induction training should be immediately happened.**
- **State should intervene for better involvement of GHCS (General Health Care Staff) especially for improvement in Key indicator like TB case Finding & Management of TB cases**
- **implementation of New TOG especially for Notification at Diagnosing Health facility (PHI Notification Register for Each Public Health Facility) concept should be developed instead of Centralised Notification at District Level for whole TB Unit PHIs**
- **Refresher / Retraining of All MOs of PHI & Staff including ASHAs needs to be immediate recommendation.**
- **New DMC LT which are recruited recently through NGO Partnership Guideline should be trained first & ensure their sustainability in Program**

VII. Drugs and supplies

Review drug and logistics management system in the district, including drug store, documentation, reserve stocks, mode of supplies, etc. Discuss with DTOs, MOTCs, medical officers, pharmacist and Treatment Supporters. Make a bulleted list of achievements, constraints and gaps, and recommendations.

Observations and gaps

- Centralised drug supply chain management with no involvement of general pharmacists
- District drug store not following FEFO principles and arrangement of racks not as per RNTCP guidelines
- PHI reports not available and drug supplies erratic with no review at district or block level
- NIKSHAY Aushadhi portal entries have not been started. DDS Fatehgarh Sahib not having stock register and regular entries of drugs
- Drugs racks insufficient and valuable drugs kept on the floor, suboptimal drug supervision by drug store pharmacist
- Short expiry drugs and drugs of died or loss to follow up patients not returned to SDS Punjab for reconstitution

Recommendations

- **Decentralisation of supply chain management with adequate recording and reporting on real time**
- **FEFO principle to be followed by DDS pharmacist and physical verification to be carried out by DTO on at least monthly basis**
- **All medical officers of PHC/CHC may be instructed to submit monthly PHI reports duly signed to DTO along with entry of received drugs into NIKSHAY Aushadhi portal**
- **NIKSHAY Aushadhi portal entries to be completed for all drugs at all levels by involvement of general pharmacists till the time vacant posts of STS and STLS are not filled**
- **Purchase of new racks, adequate labelling of each rack with expiry dates, avoidance of medicine stock on floor and disposal off of unwanted material from RNTCP District drug store**
- **FEFO principle along with submission of died/loss to follow up patient's drug boxes to SDS Punjab for reconstitution and maintenance of record of the same in stock register and NIKSHAY Aushadhi**

VIII. Public-private collaborative activities

Assess the level of participation of private sector, NGOs, medical colleges, TB hospitals and non-health ministry governmental health providers (e.g. ESI, Coal & Mines, Railways, etc) based on meetings with appropriate representatives and discussions with district authorities and medical personnel, and review of relevant data. Make a bulleted list of achievements, constraints and gaps, and recommendations.

Observations and gaps

- CME with private sector like IMA association, Chemist Association & Laboratory Association was not adequately informed regarding Now private sectors avail "Free Diagnosis & Free TB Treatment Services facility "from Public sector
- Private sector notification incentive and informant incentive is yet to be rolled out in district
- Schedule H1 implementation suboptimal resulting in only 9 private sector TB patients notified in 2018

Recommendations

- **CME with private sector like IMA association, Chemist Association & Laboratory Association will be kept & influential IMA HQ office barrier should be called for to convey messages that now private sectors avail "Free Diagnosis & Free TB Treatment Services facility "from Public sector**
- **District to start collecting bank details of private HF who have notified TB patients and start providing incentive under DBT scheme**
- **Orientation of chemists for schedule H1 implementation, monthly meeting with drug control officers for review of reports and field visit for understanding implementation challenges for private sector notification improvement, district may print and provide schedule H1 registers to chemists**

IX. Advocacy, Communication and Social Mobilization

Review ACSM activities-based district IEC action plans, activities, reports and interviews with district authorities, health care workers (public and private) and community representatives. Make a bulleted list of achievements, constraints and gaps, and recommendations.

Observations and gaps

- IEC at General places are not visible through out district

Recommendations

- **IEC at public places like chowk, bus stand and other strategic locations will be effective for generating Tuberculosis awareness at mass level. Mass media like Radio, newspaper and local channel may also be utilised for spreading TB awareness messages**

X. Health System

Identify issues and factors within the health system that facilitate, or act as constraints, for the smooth implementation of the TB programme. Make a bulleted list of achievements, constraints and gaps, and recommendations.

Observations and gaps

- DC and CS Fatehgarh Sahib regularly reviewing program for involvement of general health system
- All ICTC LTs have been trained under RNTCP for providing support to DMC
- Mobile medical unit medical officer trained at state level for providing microscopy services to presumptive TB patients
- Suboptimal involvement of SMO for program monitoring
- Coordination plan with other health programs like NUHM, IDSP, RBSK, School health is yet to be established
- General health system staff's contribution in overall TB case finding and patient management is suboptimal
- Despite centre and state communicated involvement of NUHM health facilities for TB case detection and for

acting as PHI, the sensitisation of such health facility staff is yet to be undertaken
- Considering only 2 blocks, the whole district is eligible for TB free initiative but multipronged approach with other health programs for intensification of TB case finding and patient management is missing

Recommendations
- **NUHM, IDSP, RBSK, NTCP and other health programs to be involvement for TB elimination**
- **Monthly coordination committee meeting to be held for systematic chalking and implementation of activities on ground**
- **TB free Fatehgarh Sahib initiative may be considered for better visibility of health system instead of single RNTCP program**
- **With rigorous training of all program officers and program staff, intensified TB case finding activities, DBT and other initiatives to be scaled up**

XI. TB-HIV

Assess status and plans in implementation of TB-HIV collaborative activities. Review coordination at district and sub-district level and reports of cross referrals. Make a bulleted list of achievements, constraints and gaps, and recommendations.

Observations and gaps
- TB Co morbidities (TB HIV, TB-DM, TB-Tobacco) Contact of TB patients were not adequately screened for chest symptoms from Public sector health facility OPD
- TB co morbidity (TB HIV, TB-DM, TB-Tobacco) & Contact of TB patient should be adequately screened for chest symptoms from Public sector health facility OPD
- No TB-HIV coordination committee meeting conducted since last 1 year
- Referral from ICTC to RNTCP is less than 1% from all 3 ICTC in the district during 3Q18
- PITC is yet to be implemented in the district
- No any clients (Patients) get counselling on Tuberculosis in all 3 ICTC settings

Recommendations
- **TB co morbidity (TB HIV, TB-DM, TB-Tobacco) & Contact of TB patient should be adequately screened for chest symptoms from Public sector health facility OPD**
- **TB-HIV coordination committee meeting should be conducted at least quarterly at district level under chairmanship of CS.**
- **Referral from ICTC to RNTCP should not be less than 5-8% which is a national average. QUALITY referral from HIV care settings to RNTCP should be ensured**
- **PSACS and STC may communicate to district for immediate implementation of PITC and organise training of all DTOs and key staff**
- **All clients (Patients) should get counselling on Tuberculosis especially on preventive aspects in all ICTCs**.

XII. DR-TB

Implementation of the DR-TB, Review the mechanism of collection and transport of samples to IRL, diagnostic and treatment related challenges. *Make a bulleted list of achievements, constraints and gaps, and recommendations*

Observations and gaps
- The district has one DR-TB Centre.
- The samples from the DMCs are being sent across by patient himself
- DR-TB Committee has been constituted
- Suboptimal utilization of CBNAAT as monthly tests conducted are only 80-100 tests per month resulting in

low DRTB case detection. 11 DRTB patients diagnosed using CBNAAT in year 2018 till December.

- Only 24 private sector TB patients offered CBNAAT under public health action component
- Pending decentralization of sputum sample collection and transportation with involvement of general health system LT by courier agencies/speed post.
- There is deficiency of Packaging Material for Falcon Tube for transportation of the sputum samples from DMC to CBNAAT Laboratory at District HQ.
- SMO DR-TB Centre is vacant at the district
- Statistical Assistant is vacant at the district.
- DR-TB Counsellor post is not sanctioned for the DR-TB Centre.
- The DR-TB Supervisor is not able to supervise & Monitored all types of DR-TB activities due to vacancy of District level another supervisory staff (STS, STLS, TBHV, DPPM, DPC) so she had to work for their assigned work also, so she could not able to justify her job 100%.
- Desired Treatment outcome at regular interval could not be achieved due to overburden of work on DPS.
- Travel fair to District HQ or Nodal DR TB Centre for follow up & ADR Management for MDR TB patients were not provided

Recommendations

- **Vacant posts of RNTCP at District level as well as DR TB Centre should be filled on a priority basis through District or State NHM in consultation with State TB Cell**
- **Optimal utilization should be ensured for all Publicly & Privately Notified TB patients as per U DST guideline**
- **Ensure sputum collection transportation system should be well established through NGO from Public & even from private sector which will pick up sputum samples from both centers & facilitate it to CBNAAT lab.at district HQ.**
- **All types of Packaging Material & training for how to pack it should be provided to all DMC LT where sputum collection & transportation facilities should be made available**
- **District DR TB Centre Committee should be constituted & start acting on New PMDT Guideline so many DR TB patients should able to get Shorter MDR TB Regimen rather than conventional MDR TB regimen**
- **Travel fare to District HQ or Nodal DR TB Centre for follow up & ADR Management for MDR TB patients should be provided**

XIII. Programme management

Review programme management capacity, including financial management, procurement of goods and services, etc. Adequacy of delegation of administrative and financial powers of STOs and DTOs. Make a bulleted list of achievements, constraints and gaps, and recommendations.

Observations and gaps

- For NIKSHAY Poshan Yojana, 46% of beneficiary details are missing in the NIKSHAY portal. Out of 976 benefits, 179 benefits have been given

Recommendations

- **Mission mode bank account details collection involving general health system staff along with daily monitoring in NIKSHAY and PFMS to utilise available DBT funds and 100% DBT coverage for all notified TB patients**