Ministry of Health
& Family Welfare
Government of India

NATIONAL FRAMEWORK FOR

JOINT TB-TOBACCO

COLLABORATIVE ACTIVITIES

National Framework for JOINT TB-TOBACCO COLLABORATIVE ACTIVITIES

Revised National TB Control Programme

National Tobacco Control Programme

May 2017

Directorate General of Health Services
Ministry of Health & Family Welfare
Government of India

Table of Contents

Foreword

Tuberculosis and tobacco use are major public health burdens that are largely preventable. In India, tobacco use and TB are common conditions.The vast numbers of tobacco users (nearly 275 million adults) according to Global Adult Tobacco Survey (GATS) contribute adversely to the sustainability of TB case management due to the strong association between tobacco use and TB treatment outcomes. The economic burden of tobacco use in India amounted to a staggering Rs.1,04,500 crore in 2011. Another study conducted in 2004 using health care data from National Sample Survey Organization (NSSO), estimated that the tobacco-attributable cost of TB was three times higher than the expenditure on overall TB control in the country.This grave scenario necessitates implementation of new approaches and interventions that have potential to curb the growing convergence of both, TB and tobacco epidemics.

Patients with TB need and should receive counselling and assistance in stopping tobacco use. Recently, the World Health Organization (WHO) Tobacco Free Initiative, the WHO Stop TB Department, and the International Union against Tuberculosis and Lung Diseases (The Union) called for inclusion of brief tobacco cessation advice in standard TB case management. They advocated for a joint collaboration, wherein activities can be planned and carried out, within the framework of the existing health system.

Against this background, the 'National Framework for Joint TB-Tobacco Collaborative Activities' has been developed by the Directorate General of Health Services with support from domain experts, WHO and The Union. The framework provides guidelines for programme managers of Revised National Tuberculosis Programme (RNTCP) and National Tobacco Control Programme (NTCP) on the implementation of tobacco cessation services as an integral part of TB case management. Further, screening of TB symptoms in tobacco users registered at the National Tobacco Quitline and Tobacco Cessation Centres will increase TB case detection and identify TB case relapse at early stages. The implementation of the 'National Framework for Joint TB-Tobacco Collaborative Activities' is a step in the right direction for addressing co-morbidities, as reduction in the prevalence of tobacco use is expected to bring about collateral benefits in the control of TB in India.

We are confident that the experience gained and lessons learnt from this intervention will further strengthen our approach towards addressing other co-morbidities.

Dr Jagdish Prasad
Director General Health Services
Directorate General of Health Services
Ministry of Health & Family Welfare
Government of India, New Delhi

Preface

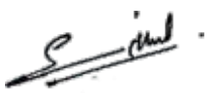
Tuberculosis (TB) and tobacco use are two major public health challenges that independently cause considerable health and economic burden in the country, with serious socio-economic implications. India is the second largest consumer of tobacco products in the world with as many as 35% adults (15 years and above) consuming tobacco. India also has the highest burden of TB globally, with an estimated 2.8 million incident cases being registered per year. There is ample evidence, both globally and nationally, to demonstrate the adverse association between the TB and tobacco epidemics. Tobacco use has been found to be strongly associated with relapse of TB as well as mortality from TB. Therefore, in India, where both tobacco use and TB are common conditions at the population level, even a modest increase in relative risk of TB due to tobacco use, more specifically with respect to smoking, amounts to a significant attributable risk of TB infection to the population.

Since there is a direct relationship between the TB and tobacco epidemics, the RNTCP and NTCP share similar concerns and are inherently interdependent. Recognising this, a national workshop was organised in collaboration with WHO to deliberate on implementation strategies for enabling coordination between the two programmes.The evidence was discussed with stakeholders and experts and a decision was taken to develop and implement a collaborative framework to achieve projected national targets for both programmes.

The collaboration between RNTCP and NTCP creates an opportunity within the health care system by providing cessation services to every TB patient who is a tobacco user to overcome the addiction. In addition, every TB patient who is not a tobacco user will be made aware of the consequences of being exposed to secondhand smoke. The collaboration through tobacco control efforts at the national and state level will contribute in increasing the TB case detection rates by screening of 'TB Symptoms Complex' in users who are accessing tobacco cessation services, either through Tobacco Cessation Centres or through the National Tobacco Quitline.

It is a historical step for both programme divisions to come together to introduce the 'National Framework for Joint TB-Tobacco Collaborative Activities' which will guide programme managers and health care providers at various levels to coordinate integrated interventions for reducing prevalence of TB and tobacco use in the population.We commend the continued support and contribution of partners such as the National Institute of Tuberculosis and Respiratory Diseases, the National Institute of Mental Health and Neuro Sciences (NIMHANS), The International Union Against Tuberculosis and Lung Disease (The Union), WHO Country Office for India, and other domain experts in outlining the framework. We are confident that the systematic implementation of the framework at various levels and settings in conjunction with routine TB treatment and tobacco cessation services will help in reducing the disease burden due to both conditions and alleviate human suffering and economic loss to the nation.

Dr Mohammed Shaukat
Advisor (NCD)
Dte. General of Health Services
MoHFW/GoI, New Delhi



Dr Sunil D. Khaparde
Deputy Director General
Central TB Division
Dte.General of Health Services
MoHFW/GoI,New Delhi

Acknowledgements

The 'National Framework for Joint TB-Tobacco Collaborative Activities' provides guidelines for programme managers of the Revised National Tuberculosis Programme and the National Tobacco Control Programme to undertake coordinated and joint actions for addressing the co-morbidities of two diseases. It outlines a clear set of processes and procedures that need to adopted in order to implement tobacco cessation services, which are an integral part of TB case management. The framework is an outcome of series of deliberations with stakeholders, including a national consultation (Workshop on Collaborative Framework for National Programmes on Tuberculosis, Tobacco and Diabetes) held in June 2015 at New Delhi.

Our sincere gratitude to the World Health Organization Country Office for India (WCO-India) for providing technical expertise and guidance at every stage of its development. This document would have not been possible without the dedicated support and inputs received from partners, external agencies and state and district level programme managers. DOTS providers are also acknowledged for sharing their experience regarding implementation of 'Brief Advice'.

We express our gratitude to Shri C. K. Mishra, Secretary (Health & Family Welfare), MoHFW, Government of India (GoI); Dr Jagdish Prasad, Director General Health Services, MoHFW, GoI; Dr A. K. Panda, Additional Secretary & Mission Director, National Health Mission, MoHFW, GoI; Shri Arun Kumar Jha, Economic Advisor, MoHFW, GoI; Shri Amal Pusp, Director, MoHFW, GoI; Dr Sunil D. Khaparde, Deputy Director General-TB, Central TB Division (CTD), GoI; Dr Mohammed Shaukat, Advisor, NCD, Directorate General of Health Services (Dte. GHS), GoI for providing constant leadership and encouragement.

We are also grateful to Dr Henk Bekedam, WHO Representative to India; Dr Prakin Suchaxaya, Coordinator Health Programmes, WCO-India; and Dr Fikru Tullu, Team Leader-NCD, WCO-India for their support in this endeavour.

We would like to acknowledge the efforts of the core team comprising of Dr Raghuram Rao, Dr L Swasticharan (Dte.GHS), Dr Malik Parmar, Dr Pradeep Joshi, Ms Vineet Gill Munish, Mr Praveen Sinha (WCO-India), Dr Bhavin Vadera, Dr Mahesh Gorla (CTD Consultant) who undertook extensive research and worked with multiple agencies to update the information.

The guidance document was reviewed by Dr Rohit Sarin, Dr Pushpender K. Varma (National Institute of TB & Respiratory Diseases), Dr Chinmoyee Das (Dte.GHS), Dr Sadhana Bhagwat, Dr Ranjani Ramachandran (WCO-India), Dr Rana J. Singh, Mr Ashish Pandey (The Union), Dr Amar Shah (CTD), Dr Monika Arora (Public Health Foundation of India). They provided insightful comments to enrich the document and their contributions are acknowledged. We are also grateful to the communication team at WCO-India for editing and designing the framework.

We now look forward to seeing the guidelines being used extensively, contributing to a better management of co-morbidities and benefiting the TB and Tobacco control strategies. We hope this framework will go a long way in helping the government achieve its ambitious target of eliminating TB by 2025.

Acronyms

ACSM	Advocacy, Communication and Social Mobilisation
ANM	Auxiliary Nurse Midwife
ASHA	Accredited Social Health Activist
CHC	Community Health Centre
COTPA	Cigarettes and Other Tobacco Products Act
CTD	Central Tuberculosis Division
DDG TB	Deputy Director General Tuberculosis
DLCC	District Level Coordination Committee
DGHS	Directorate General of Health Services
DMC	Designated Microscopy Centre
DNO	District Nodal Officer
DOTS	Directly Observed Treatment Short course
DTC	District Tuberculosis Centre
DTCC	District Tobacco Control Cell
DTO	District Tuberculosis Officer
IEC	Information, Education and Communication
M&E	Monitoring and Evaluation
MoHFW	Ministry of Health and Family Welfare
MO-PHI	Medical Officer- Peripheral Health Institution
NCC	National Coordination Committee
NCD	Noncommunicable Disease
NHM	National Health Mission
NRT	Nicotine Replacement Therapy
NTCP	National Tobacco Control Programme
OPD	Out-Patient Department
PHCs	Primary Health Centres

PHI	Peripheral Health Institution
RNTCP	Revised National Tuberculosis Control Programme
SLCC	State Level Coordination Committee
SNO	State Nodal Officer
STCC	State Tobacco Control Cell
STDC	State Training and Demonstration Centre
STLS	Senior Tuberculosis Laboratory Supervisor
STO	State Tuberculosis Officer
STS	Senior Treatment Supervisor
TCC	Tobacco Cessation Centre
TB	Tuberculosis
TCC	Tobacco Cessation Centre
TU	Tuberculosis Unit
WHO	World Health Organization

1 Introduction

Tuberculosis (TB) is an infectious bacterial disease caused by Mycobacterium tuberculosis. It most commonly affects the lungs, as also other organs of the human body. It is transmitted from person-to-person via droplets from the throat and lungs of people with the active respiratory disease

1.1 Global Burden of TB and Tobacco

In 2013, nine million people suffered from TB and 1.5 million died from the disease across the world. However, over 95% of TB deaths occur in low- and middle-income countries and the disease remains one of top five causes of death for women aged 15 to 44 years[1].

In 2010, an estimated six million people died globally from tobacco use with 72% of them hailing from low- and middle-income countries.

Tobacco use is the leading preventable cause of disease and death in the world. Worldwide, tobacco use accounts for more than six million deaths (5.4 million deaths due to tobacco use and 0.6 million due to secondhand smoke) each year and is expected to cause more than eight million deaths by the year 2030.[2] According to The Tobacco Atlas, in 2010, tobacco was estimated to have killed six million people worldwide 72% of whom were in low- and middle-income countries.[3]

1.2 Burden of TB and Tobacco in India

India is a country with nearly 1.23 billion people, representing 17.5% of the world population. It has the largest number of TB cases in the world (estimated at 2.8 million incident cases per annum) with an incidence rate of 217/100,000 per year for 2015. Treatment success for new and relapsed TB cases registered in 2014 was close to 74%.[4,5]

India is the third largest producer and second largest consumer of tobacco in the world.[6] Nearly one million Indians die due to tobacco use every year, which is much more than the combined mortality resulting from HIV/AIDS, TB and Malaria. As per GATS 2010, there are 275 million adult tobacco users in India. Key findings from the GATS survey:[7]

- More than one- third (35%) adults in India use tobacco in some form or the other;
- Use of smokeless tobacco is much more prevalent than smoking tobacco;
- Prevalence of smokeless tobacco use (26%) is almost twice that of smoking tobacco (14%);
- About 5% adults use both, smoking as well as smokeless tobacco;
- Prevalence of tobacco use is higher in rural areas as compared to urban areas; and
- Women use mainly the chewing forms of tobacco.

2 Evidence of TB and Tobacco Co-morbidity

Tobacco smoke contains toxic chemicals which cause disturbances in the bronchial surface of the lung. It weakens immunity of the patient to fight with the TB bacteria.The following evidence emerges from several studies conducted to look at the association of TB and tobacco use in India and globally.[8-13]

- Almost 38% of TB deaths are associated with the use of tobacco;
- Prevalence of TB is three times higher among ever-smokers as compared to that of never-smokers;
- Mortality from TB is three to four times higher among ever-smokers as compared to never-smokers;
- Smoking contributes to 50% of male deaths in the 25-69 age group from TB in India;
- Exposure to tobacco smoke has been found to affect TB by increasing risk of TB infection and risk of developing TB; affecting clinical manifestations and increasing risk of relapse among TB patients; affecting bacteriological conversion (sputum smear or culture) and outcome of treatment in TB patients; and increasing TB mortality and resistance to anti–tubercular drugs.

Two critical findings from a pilot carried out in Gujarat

1. *High tobacco use found among TB patients*
2. *The intervention of 'Brief Advice' helped 67.3% of these patients to quit tobacco use*

Recent Efforts to Address TB and Tobacco Co-morbidity

Moving forward from research-to-action, the Ministry of Health & Family Welfare (MoHFW), implemented ajoint pilot project within the existing Revised National Tuberculosis Control Programme (RNTCP) and National Tobacco Control Programme (NTCP) in 2010 in Vadodara, Gujarat. Tobacco cessation services were offered as 'Brief Advice'to TB patients registered for the Directly Observed Treatment Short course (DOTS) and among those who were using tobacco in any form,based on the model recommended by WHO and The Union.

'Brief Advice' for tobacco cessation based on the five A's (Annexure 3), was incorporated in the ongoing TB Control Programme in Vadodara District of Gujarat. Tools were developed for education, training and capturing data. All registered TB patients receiving DOTS who used tobacco in any form were offered 'Brief Advice' during routine interaction for treatment. The pilot showed that tobacco use was high among TB patients on treatment. At the end of the treatment, 67.3% patients who were offered 'Brief Advice' were able to quit tobacco use.[8]

A similar study was conducted under the coordination of the Central TB Division (CTD) in Jaipur District of Rajasthan with encouraging results. Around 75% TB patients had quit tobacco use after getting counselled by the DOTS provider. Studies proved that it is indeed feasible to introduce the 'Brief Advice' service as a cost-effective intervention for tobacco cessation among TB patients with careful monitoring. A logical conclusion that emerged was to make tobacco cessation an integral part of all TB control programmes.

3 National Programmes for TB and Tobacco Control

Since the mid 2000's, efforts to strengthen TB and tobacco control have been intensified with national policies and programmes delving deep into the root cause of prevention, control and treatment. The Revised National Tuberculosis Control Programme (RNTCP) was launched in 1993, in a phased manner and has over the last 25 years progressed steadily towards its goals. Meanwhile, the NTCP which was also a centrally sponsored scheme has strived to facilitate effective implementation of Tobacco Control Laws (COTPA 2003) and has since established State and District Tobacco Control Cells to ensure ground level implementation.

3.1 Revised National TB Control Programme

The RNTCP was based on the internationally recommended DOTS strategy that was launched in 1997. The programme later expanded across the country in a phased manner with support from the World Bank and other development partners. A major milestone was achieved when nation-wide coverage of RNTCP was established by March 2006. In terms of treatment of patients, RNTCP has been acknowledged as the largest and fastest expanding TB control programme in the world.

Goal of RNTCP

To decrease mortality and morbidity due to TB and reduce transmission of infection until TB ceases to be a major public health problem in India.

3.1.1 Programme Structure

A well-oiled organisational structure of RNTCP was constituted with clearly demarcated roles and responsibilities for those in-charges of overseeing the different functions, across the national, state, district, sub-district levels and the peripheral health institutions. A new sub-district level was created, namely the Tuberculosis Unit (TU) that was tasked with undertaking.

Systematic monitoring and supervision of diagnostic and treatment aspects of the programme.

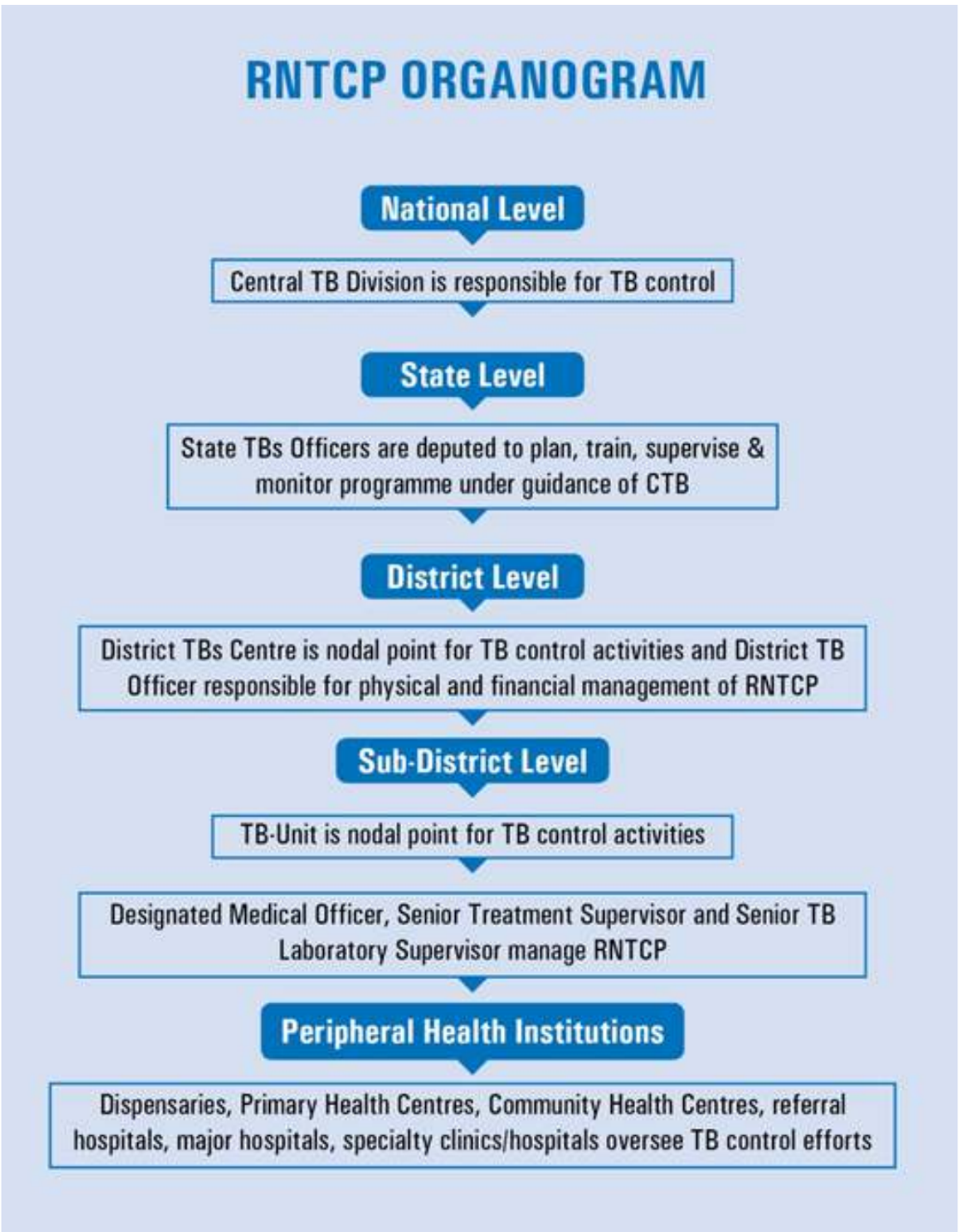


Figure 1: RNTCP's organisational structure

National level (Central TB Division): The Central TB Division (CTD) is part of the Directorate General of Health Services, Ministry of Health and Family Welfare (MoHFW), and is responsible for TB control in the entire country. It is headed by a National Programme Manager, the Deputy Director General TB (DDG TB) and is implemented under the umbrella of the National Health Mission (NHM).

State level: At the State level, the State Tuberculosis Officer (STO) is responsible for planning, training, supervising and monitoring the programme in their respective states, as per guidelines of the State health societies. Each of these technically follows instructions of the CTD for programme implementation.

District level: The district is the key level for the management of primary health care services. The District Tuberculosis Centre (DTC) is the nodal point for TB control activities and the District TB Officer (DTO) at the DTC has overall responsibility of physical and financial management of RNTCP at the district level. It follows the guidelines that have been set by the District Health Society.

Sub-district level (Tuberculosis Unit - TU): The TU is the nodal point for TB control activities in the sub-district. A team, comprising of a designated Medical Officer – TB Control (MO-TC), Senior Treatment Supervisor (STS) and Senior Tuberculosis Laboratory Supervisor (STLS) at the TU have the overall responsibility of managing RNTCP at the sub-district level. Currently, there are 3644 TUs functioning in the programme. Under the current Five Year Plan (2012-2017) proposal, these TUs will be further aligned at the block level.

Peripheral Health Institutions (PHIs): At this level you have the dispensaries, Primary Health Centres (PHCs), Community Health Centres (CHCs), referral hospitals, major hospitals, specialty clinics/ hospitals (including other health facilities) within the district. Some of these PHIs will also be DMCs.

3.1.2 Diagnostic Facilities for TB Detection and Treatment

The RNTCP has a quality assured laboratory network for bacteriological examination of sputum that operates in a three-tier system that comprises of Designated Microscopy Centre (DMC), an Intermediate Reference laboratory (IRL) and a National Reference laboratory (NRL). The DMC is the most peripheral laboratory under RNTCP and it caters to a population of around 100,000 (50,000 in tribal and hilly areas). There are >13,000 Designated Microscopy Centres (DMCs) across the country.

The programme provides free testing facilities for patients and suspects, including Drug Resistant TB (DR-TB), Paediatric TB and HIV-TB, Extra-Pulmonary TB. The RNTCP laboratory services include state-of-the-art testing facilities that provide rapid testing methods such as Line Probe Assay (LPA) and Cartridge Based Nucleic Acid Amplification Tests (CB-NAAT), in addition to a range of conventional diagnostic modalities such as Direct Smear Microscopy, LED-Florescence Microscopy (LED-FM) and solid and liquid culture. Under the current strategy, the programme is rapidly expanding the laboratory and newer technology platform capacity to achieve universal access to quality assured diagnosis. As of March, 2017, there were 65 culture and Drug Susceptibility Testing labs, 51 LPA and 628 CB-NAAT labs functional in the country.

All TB patients, including those with co-morbidities such as TB-HIV or TB- diabetes, registered under the programme are provided free quality assured treatment services through a network of providers. These include the entire gamut ranging from community volunteers to tertiary care dedicated institutions specialising in TB treatment and care.

3.2 National Tobacco Control Programme (NTCP)

The NTCP was launched in the year 2007-08 with the primary objectives of creating awareness about the harmful effects of tobacco consumption; reducing production and supply of tobacco products; ensuring effective implementation of provisions under "The Cigarettes and Other Tobacco Products (Prohibition of Advertisement and Regulation of Trade and Commerce, Production, Supply and Distribution) Act, 2003" (COTPA); and helping people quit tobacco use through Tobacco Cessation Centres.

The NTCP is being implemented through a three-tiered structure comprising of a National Tobacco Control Cell (NTCC), State Tobacco Control Cell (STCC) and District Tobacco Control Cell (DTCC).

NTCP's Roll-out Strategy: 3-Tier Organisational Structure

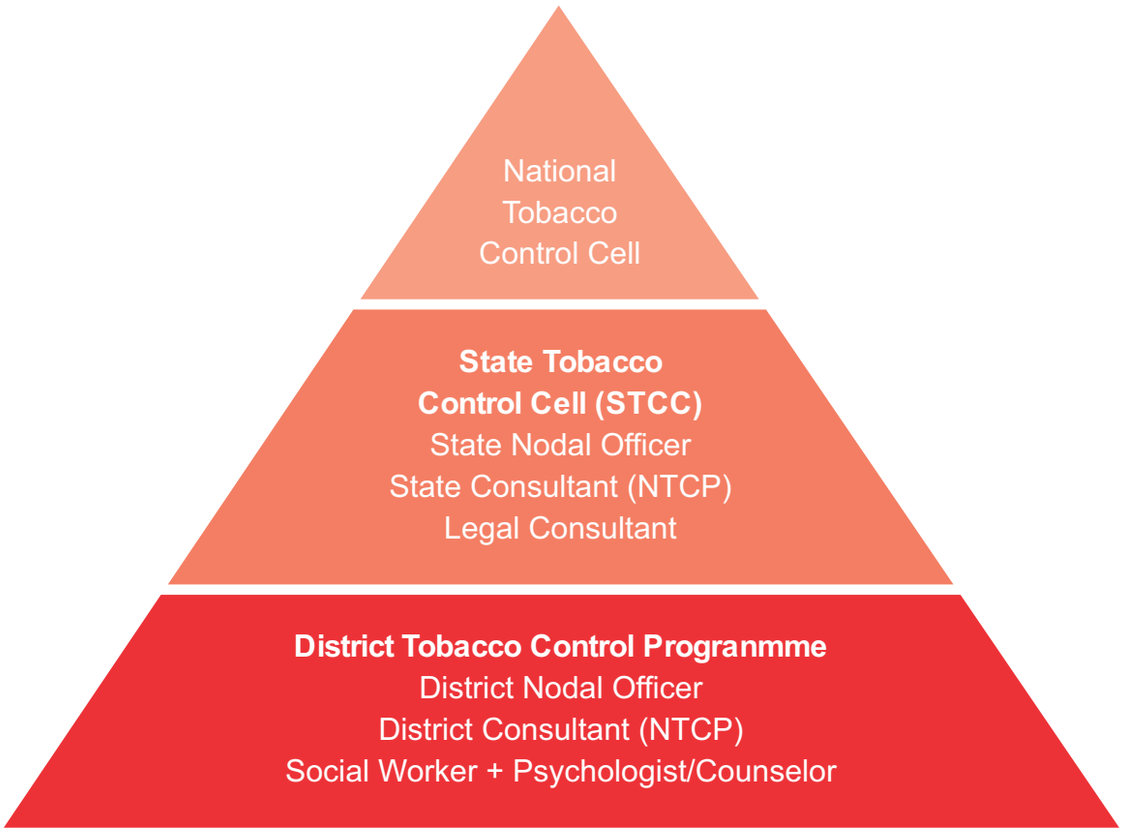


Figure 2: NTCP's Roll-out Strategy: 3-Tier Organisational Structure

National Tobacco Control Cell (NTCC): The NTCC has been set up under the Ministry of Health & Family Welfare to undertake overall policy formulation, planning and monitoring and evaluation of different activities envisaged under the programme. Some of its major components and activities include:

- Conducting public awareness/mass media campaigns for awareness building and behavioural change;
- Establishing tobacco product testing laboratories;

- Setting up a National Tobacco Regulatory Authority (NTRA);
- Conducting advocacy establishing and intersectoral linkages;
- Carrying out research including the Global Adult Tobacco Survey (GATS) and the Global Youth Tobacco Survey (GYTS);
- Ensuring monitoring and evaluation;
- Expanding tobacco cessation facilities;
- Setting up a National Tobacco Quitline and helpline; and
- Organising review meetings and monitoring visits for implementing NTCP.

State Tobacco Control Cell (STCC): The STCC is headed by a State Nodal Officer, who is a Senior Officer from the State Department of Health, preferably on a full-time basis. His/her chief mandate is to look after all the NCD programmes. The STCC is envisaged to be established as a sub-set of the State NCD Cell for optimum resource utilisation. Under the STCC is the State Level Coordination Committee (SLCC) that is headed by the Chief Secretary or his nominee and Principal Secretary/Secretary (Health) as Member Secretary. Every state is supposed to have this coordination committee that is responsible for overall implementation of the NTCP and COTPA. States may form a small working group with representatives from key departments to monitor activities under NTCP on a day-to-day basis. In order to review progress, the working group may meet on a monthly basis, while the SLCC must meet every quarter. Some of the major activities carried out by the STCC include:

- Training of multiple stakeholders for tobacco control through state level advocacy, workshops/sensitisation programmes;
- Integrating tobacco control with other health programmes/activities;
- Incorporating tobacco control in the state level IEC campaign; and
- Strengthening monitoring and enforcement of COTPA.

District Tobacco Control Cell (DTCC): Every identified district is mandated with having a DTCC that is established as a sub-set of the District NCD unit for optimum resource mobilisation. It is responsible for overall planning, implementation, and monitoring of different activities. Additionally, it is assigned the task of achieving the physical and financial targets that have been set under the programme at the district level. Under the DTCC is the District Level Coordination Committee (DLCC) which is constituted in each district. It is chaired by the Collector or District Magistrate and has the District Nodal Officer as its Member Secretary, who is expected to convene meetings of the Committee. Some of the major activities of the DTCC include:

Intensifying efforts

By March 2016:
- *State Tobacco Control Cells were established in all 35 States/UTs;*
- *District Tobacco Control Cells were established in more than 400 districts.*

Nest on the anvil:
- *Tobacco Cessation Centres to be established in all NTCP destricts.*

- Conducting training and capacity building of relevant stakeholders;
- Carrying out school awareness programmes;
- Setting up and expanding tobacco cessation facilities, including support for pharmacological treatment of tobacco dependence; and
- Launching an Information Education Communication (IEC) media campaign.

Each District has also been provided support for establishing a Tobacco Cessation Centre (TCC) at the District hospital. The TCC is supported by a Counsellor who is supposed to provide brief and intensive counselling for tobacco addiction. At the district level, efforts are to be made to provide regular tobacco cessation services at the out-patient department (OPD) of the district hospital, where those who want to quit tobacco use can be referred and counselled as per a set protocol.

Box 1: Two successful initiatives with scope for scale-up

1. National Tobacco Quitline: Counselling via toll-free number

The MoHFW has set up a toll-free National Tobacco Quitline, under the NTCP on a pilot basis. It aims to provide telephonic counselling to those desirous to quit tobacco. The toll-free number 1800-11-2356 is a national number and can be accessed from all tele-service providers. The services are currently provided in two languages i.e. English and Hindi, from 8.00 am to 8.00 pm six days a week, except on Mondays. Once a tobacco user gets registered with the Quitline, a Quit Tobacco pack is sent by mail or post to him/her. A minimum of four proactive calls are placed by the Counsellor after the tobacco user is registered with the Quitline. As of March 2017, more than 46,000 tobacco users were counselled through this Quitline.

2. mCessation Programme: Health information via mobile text messages

The programme is part of the Digital India Initiative and provides evidence-based behavioural change (short) text messages on mobile phones, which include health information on tobacco use hazards, tips on quitting, and encouragement for those attempting to do so. The unique feature of the programme is that tobacco users who want to quit, can register by giving a missed call to 011-22901701, or by registering at: http://www.nhp.gov.in/quit-tobacco. After getting registered, the user gets regular mobile text messages based on his/her type of tobacco usage. The content library consists of messages for smokeless users, smokers, and for those who consume tobacco in both ways. The programme is currently available in English and Hindi and will be expanded to other regional languages in a phased manner. As of March 2017, about 21,00,000 users registered themselves for mCessation services.

4 Tuberculosis and Tobacco Collaborative Framework

The framework for TB and tobacco collaboration has been developed after establishing a clear understanding of what it will achieve and how it will be implemented.

4.1. Purpose

The national framework for TB-tobacco collaborative activities between the two national programmes, namely RNTCP and NTCP, aims to reduce the burden of co-morbidity due to TB and tobacco use.

4.2. Objectives

- To establish mechanisms of collaboration between RNTCP and NTCP for addressing TB and tobacco use co-morbidity;
- To identify tobacco users among registered TB patients and provide 'Brief Advice' for tobacco cessation to motivate them to quit tobacco use;
- To screen for active TB symptoms in tobacco users registered at Tobacco Cessation Centres (TCC), NCD clinics and National Tobacco Quitline/mCessation initiatives;
- To strengthen long-term outcomes among cured TB patients (who use tobacco in any form) through initiatives planned under NTCP (Quitline, m- cessation initiatives, etc); and
- To enhance effectiveness of tobacco cessation services by expanding the outreach to susceptible population.

4.3. Implementation Strategy

A 5-step implementation strategy has been adopted to ensure smooth coordination between RNTCP and NTCP.

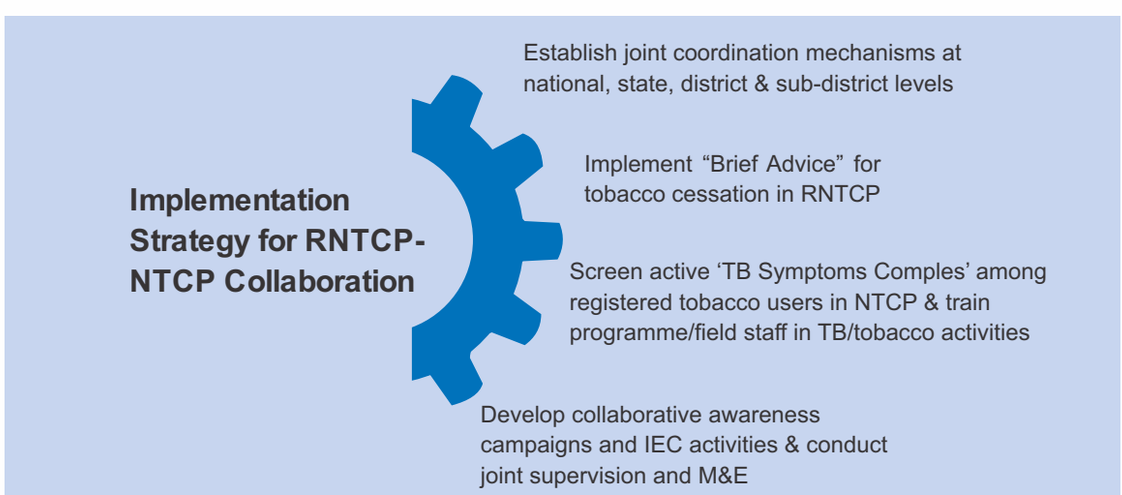


Figure 3: Implementation strategy for RNTCP-NTCP collaboration

5 Coordination Mechanism between RNTCP and NTCP at National, State and District levels

To ensure success of the initiative and achievement of objectives, there has to be smooth coordination and convergence across levels with respect to both RNTCP and NTCP programmes.

5.1. National Level Coordination Mechanism

Suitable existing mechanisms at the national level under both RNTCP and NTCP will be used for providing overall guidance and necessary coordination. The coordinating body will comprise Deputy Director Generals of CTD and NTCP, Dte.GHS; Additional/Deputy Additional Director Generals of CTD and NTCP, Dte. GHS; Director NTCP and RNTCP, MoHFW, representatives from academia; civil society organisations, WHO and other domain experts. The key functions of the coordinating body are to:

- Strengthen coordination mechanisms between RNTCP and NTCP at the national, state and district level for addressing TB and tobacco co-morbidity;
- Provide guidance to states for implementing the TB- tobacco collaborative activities;
- Suggest strategies for roll-out and scale-up of activities aimed at minimising mortality and morbidity associated with TB -tobacco co-morbidity;
- Review, optimise and plan for future TB-tobacco collaborative activities based on reports shared by the states; and
- Regularly review normative tools and training materials based on feedback from the field.

5.2. State Level Coordination Mechanisms

The State can use existing mechanisms for coordinating the TB-tobacco collaborative activities. The State TB Committee can be pressed into service with participation of the State Nodal Officer. Alternately, under NTCP, in the SLCC framework, the State TB Officer and the Director of State Training and Demonstration Centre (STDC) of the TB programme should be included in the SLCC for collaboration between the two programmes at the state level. States may also use an existing Committee, other than SLCC and include state officials of RNTCP and NTCP in the same. The key functions of the Coordination Committee are to:

- Ensure implementation of joint collaborative activities implemented at state level;
- Review status of trainings conducted at district level for DOTS care providers on ‘Brief Advice’;
- Ensure timeliness of reporting from district level;
- Review performance indicators agreed under a collaborative framework;
- Review outcomes of the joint monitoring of the collaborative activity;

- Ensure availability of manpower and supplies of Nicotine Replacement Therapy (NRT) for tobacco cessation interventions; and
- Support and provide measures for involvement of other stakeholders for implementing 'Brief Advice'.

5.3. District Level Coordination Mechanisms

At the district level, a mechanism similar to state level can be replicated. District TB Committee to include District Nodal Officer from NTCP as Committee member. Alternatively, District TB Officer (DTO) to be included as Committee member in the existing District Level Coordination Committee (DLCC) of NTCP. This will facilitate coordination of activities at district and sub-district levels. The key functions of the Coordination Committee at the district level are to:

- Strengthen coordination between RNTCP and NTCP staff in the district;
- Address issues related to training of key programme staff and general health staff;
- Promote participation of NGOs/CBOs and other private practitioners in implementing' Brief Advice';
- Review availability of NRT at the Tobacco Cessation Centre;
- Ensure timeliness of reports from peripheral health institutions; and
- Review outcomes of joint monitoring of the collaborative activity.

6 Activities for Coordination between RNTCP and NTCP

There is ample evidence showing that tobacco use in TB patients causes high rates of relapse, morbidity and mortality. This clearly points to the need for TB patients to be drawn into tobacco cessation activities, especially given the fact that they will be in regular contact with health workers and may be more motivated than healthy persons to quit tobacco use. A system has been already established in TB programmes, wherein the status of tobacco use is being recorded (Figure 4).

Addiction related information

Current Tobacco user Yes No

If yes, Smoking Smokeless Linked for cessation Yes No

If tobacco user, status of tobacco use at end of treatment Quit Not quit

Figure 4: Portion of TB treatment card

The introduction of select interventions in the form of 'Brief Advice' will be easy and will hold promise of better outcomes. On the other hand, the Tobacco Cessation Centre and other cessation platforms will help to screen and identify latent TB infection and TB relapse cases in the community and support early initiation of TB management.

6.1. Integrating 'Brief Advice' for Tobacco Cessation in RNTCP

All healthcare professionals who are responsible for implementing DOTS must be trained and counselled on the different processes and steps that need to be followed with respect to helping patients quit tobacco use and be tested for TB in a timely and efficient manner. Some of these steps include:

- Enquiring status of tobacco use with every patient who gets registered as a TB case;
- Recording information about tobacco use in the revised TB treatment card (Annexure 1);
- Offer to the patient 'Brief Advice' on how to quit tobacco use based on 5 As and 5 Rs model;
- Follow-up with the patient by providing 'Brief Advice' at least twice a week and check on his/her quitting status;
- Observe patients and note if s/he is showing signs of quitting tobacco use after completion of intensive phase (two months of regularly providing 'Brief Advice'). If not, encourage him/her to avail cessation services at the TCC or National Tobacco Quitline. Meanwhile, ensure that the Treatment Supporter (DOTS Provider) continues to provide 'Brief Advice' and record the final status of quitting at the completion of TB treatment;

- Make sure that the Treatment Supporter fills up and maintains the TB treatment Card and makes it available at the District TB Centre for future reference and follow-up. The District TB Centre must ensure that information related to tobacco use is duly filled in the TB Treatment card;
- Send the information recorded in the TB treatment card as feedback through the existing HMIS (NIKSHAY) under RNTCP;
- Enhance the skill of Treatment Supporter regarding the process of providing 'Brief Advice' to tobacco users; try and motivate registered TB patients to avail National Tobacco Quitline/ mCessation SMS services for getting regular tips and SMS for quitting the tobacco habit. Both the services are user friendly and available for free. Registration for mCessation can be done by giving a missed call on 011–22901701; and
- Explore the mechanism for introducing a follow-up column regarding 'Brief Advice' in the digital TB treatment card.

6.2. Involvement of NTCP in TB Case Finding

For enhanced case finding of TB patients through NTCP, the following process has been indicated:

- Screening four symptoms of active TB- 'TB Symptoms Complex' among tobacco users registered at the District Tobacco Cessation Centre (TCC), National Tobacco Quitline/mCessation. 'TB Symptoms Complex' comprises of cough that has persisted for more than two weeks, fever of more than two weeks and experiencing of significant weight loss and night sweat and referring for further confirmation and management;
- Training modules for NTCP Programme Staff and Training modules for National Tobacco Quitline to include chapter on 'TB-Symptoms Complex' to identify active TB cases among persons registered for tobacco cessation; mCessation algorithm to include SMS on 'TB-Symptoms Complex';
- TB infection control guidelines to be implemented in TCC;
- Teachers' training modules prepared for tobacco control to include information on 'TB-Symptoms Complex' for increasing awareness among children and young adults; and
- TCC and National Tobacco Quitline to support in identifying TB relapse cases, as there is increased risk of relapse of TB among tobacco users.

7 'Brief Advice' for Tobacco Cessation: The 5 A's and 5 R's Approach

Health workers should ask everyone in the community if they smoke and/or chew tobacco and urge every tobacco user to quit by providing clear, strong and personalised advice. 'Brief Advice (5 A and 5 R)' approach is one of the programmatic approaches which advice against stopping smoking/tobacco chewing based on the individual's preferences, needs and circumstances. People who smoke/chew should be asked how interested they are in quitting and if so, assistance should be provided. People who are not ready to quit should also be asked to consider the possibility and encouraged to seek help in the future.

The Treatment Supporter (DOTS Provider) must try to motivate the tobacco-user to think about quitting. This is important because there are so many other forces acting that are difficult to control: physiological compulsions to use tobacco, learned habits, social pressures and accessibility, amongst others. Engaging the mind of the tobacco-user, bolstering it with new knowledge and a sense of caring by the health professional can help motivate the patient to change. Follow-up will be important to help keep the tobacco-user on track, until s/he is confident about remaining tobacco-free and is sure of preventing relapse.

This simple intervention by a healthcare professional/Treatment Supporter can help motivate patients to change their behaviour. This is important even for patients who have adequate knowledge about why they should quit using tobacco, because of the nature of addiction, and is even more important for those who do not have such knowledge. The intervention helps them to think about the importance of quitting tobacco use because of the respect the healthcare professionals enjoy in society.

Box 2: 5 A's approach of 'Brief Advice for Tobacco Cessation

5A's Approach of 'Brief Advice' for Tobacco Cessation

'Brief Advice' for quitting tobacco use consists of 5 'A's

1. ASK the patient if s/he is a tobacco user, during the course of every visit.

2. Briefly ADVISE against continuing tobacco use and link the current condition/ailment to continued tobacco use, where possible. e. g, "Quitting smoking/tobacco use would improve your health and aid in early recovery from illness."

3. ASSESS readiness to quit by asking the patient whether s/he is ready to quit tobacco use at this time. e.g, "How recently have you thought about quitting tobacco?"

4. ASSIST the tobacco user in making a quit plan.

5. ARRANGE for follow-up by setting the next contact date.

Box 3: 5 R's approach of 'Brief Advice for Tobacco Cessation

5R's Approach of 'Brief Advice' for Tobacco Cessation

Relevance of quitting: If the tobacco user is not yet thinking about quitting tobacco use, the doctor/counsellor/ Treatment Supporter (DOTS provider) will promote greater awareness to the patient regarding the relevance of quitting.

Risks of continuing: Risks of continuing use of tobacco should be pointed out to a TB patient. The risk of relapse, especially within the first six months after treatment has been completed; risks of disease among household contacts who are already infected, especially children; long-term risk of heart disease, asthma, bronchitis etc are aspects related to tobacco use that must be understood.

Rewards of quitting: Ask the patient to mention potential benefits of stopping tobacco use beyond the benefits related to his/her TB disease. Underscore the most relevant ones and feel better with the knowledge that TB is being cured and that s/he will be able to perform better in physical activities. The person will also be able to save money and live a better life. S/he will once again be able to relish food and find sense of smell and taste getting restored,

Roadblocks to quitting: Many tobacco users are largely unaware of the potential harm that continued tobacco use can do to them. If the patient is not ready to quit, the doctor/counsellor/Treatment Supporter (DOTS provider) must not push the patient. People usually need time to change the mindset. If the patient is at least thinking about quitting, the doctor/counsellor/Treatment Supporter (DOTS provider) can find out the roadblocks which the patient is experiencing with respect to quitting and help him/her to overcome these. This process will assist the patient to get ready for quitting tobacco use, in a sensitive yet firm manner.

Repetition: The assessment of readiness to quit tobacco use at every visit to DOTS centre. If not ready to quit, repeat intervention at a later stage.

8 Linkages between TB and Tobacco Control Programme

A systematic step-wise plan that strengthens service provision both for RNTCP and NTCP will ensure strong linkages between the two progammes. This will help programme managers to stay on track and reach maximum number of tobacco users and TB patients, bringing them under the ambit of treatment.

8.1 Service Provision in RNTCP

Service provision under RNTCP relates to mostly the 'Brief Advice' that is given to TB patients and the feedback that is sought on TB diagnosis of tobacco user clients.

'Brief Advice' for improving TB treatment outcomes: All TB patients who have been diagnosed and registered under RNTCP will be screened for tobacco use. The Medical Officer at Peripheral Health Institution (MO-PHI) will be responsible for capturing the tobacco use information from the TB patient on the treatment card. The referral of TB patients to the nearest Tobacco Cessation Clinic will be done after the completion of Intensive Phase by MO-PHI after inputs have been received from the Treatment Supporter (patient not able to quit after giving repeated 'Brief Advice').

Tobacco Quit status can be said to be achieved when a person has abstained and has not used any tobacco products in the last 12 weeks, 6 months and 1 year. Since the DOTS treatment spans over 6 months, the milestone for tobacco quitting under TB programme can be 12 weeks and further follow-up can be done with respect to tobacco quit status in case the TB patient is being followed up for at 1 year. The same definition will be used in the TB treatment card for indicating quit status. The information about quit status will be recorded at the end of TB treatment considering the possibility that the patient might relapse and re-initiate tobacco use.

In the districts where NTCP is not being implemented or is functional, TB patients can be referred to the National Tobacco Quitline (toll free number-1800-11-2356) for further counselling. Information on tobacco use, type of tobacco use and quitting status at the completion of treatment will be captured by the Senior Treatment Supervisor (STS) from the treatment card of the respective TB units and transferred thereafter in the NIKSHAY platform.

Box 4: Key steps in the 'Brief Advice' Intervention

The MO-PHI will provide 'Brief Advice' for tobacco cessation at his/her first contact. The patient will be provided with an information flyer about the quitting benefit with the TB treatment card. The information flyer can be obtained from the District Tobacco Control Cell (DTCC). Treatment Supporter (ANM/ASHA/teacher etc.) as stipulated in RNTCP will provide subsequent 'Brief Advice' to the registered TB patient and do follow-up at least twice in a week with the patient, as s/he comes to collect TB drugs. A job-aid card will be given to each Treatment Supporter which will contain step-by-step counselling technique to implement 'Brief Advice (Annexure 3)'.

The final status of tobacco quitting will be recorded in the treatment card after completion of TB treatment. The STS will ensure completeness of treatment card and motivate. Medical officer-Incharge of the health facility will make sure that the patient is regularly receiving 'Brief Advice', if the patient is taking TB treatment from institutes (public and private health facilities). The Treatment Supporter will advise and assess the quitting status of the TB patient on every visit. If the patient does not quit after the completion of Intensive Phase (IP), s/he will be referred to the nearest Tobacco Cessation Centre (TCC). The patient can also be referred earlier to the TCC if s/he has withdrawal symptoms. The patient will be referred to the nearest TCC using the treatment ID card mentioned at Annexure 2.

As the RNTCP migrates to Daily Regime treatment and involves family members as Treatment Supporter, Brief Advice will be provided/ reinforced by frontline workers or trained health care professionals on regular basis.

Feedback on TB diagnosis of tobacco user clients referred to DMC: The DTO will share the quarterly feedback report about the final diagnosis of the TCC clients who were referred from the TCC to the nearest DMC, based on suspected TB symptoms. The feedback report can be generated from the NIKSHAY 'Case Finding' output report and feedback information subsequently updated in the 'Tobacco Cessation Form' at point number 25 (significant current co-morbidity disorder) provided at Annexure 4.

8.2 Service Provision in NTCP

Service provision under NTCP entails identifying of suspected TB cases from among tobacco users and referring the TB patient from the DOTS centre for counselling.

Identification of suspected TB cases among tobacco users: Intensified TB case finding will be conducted among clients at the Tobacco Cessation Centre (TCC)/National Tobacco Quitline/mCessation through screening of four symptoms of active 'TB Symptoms Complex'.

The 'TB Symptoms Complex' comprises cough of more than two weeks, fever more than two weeks, night sweat and significant weight loss. The TCC will be responsible for implementing Infection Control Measure Guidelines to reduce exposure of TB infection among TCC clients. The Guidelines are placed at Annexure 7. The National Tobacco Quitline will screen the four symptoms of suspected TB in their registered clients. The Directory of TB health institutes will be provided to the counsellors of the 'National Tobacco Quitline' from which they can guide the patient to the nearest centre.

Box 5:Critical role of counseling in TB control

Critical role of counseling in TB control

The clients at TCC suspected with TB shall be referred to the nearest DMC facility for TB diagnosis with the RNTCP Laboratory Request Form (Annexure 6). The Psychologist/Counsellor posted at the TCC will be responsible for referring the suspected TB patient with Laboratory Request Form. S/he will also record the screening of TB symptoms in the 'Tobacco Cessation Form' at point no.16 (positive for any TB symptoms).

The Psychologist/Counsellor will obtain the RNTCP Laboratory Request Form from the nearest DMC. Following which, the information compiled in the 'Tobacco Cessation Form' will be shared with the DTCC on a regular basis along with other reports. The DTCC will then share the information with the STCC accordingly. The clients referred from the TCC will be transferred back to the TCC after getting the TB services.

In the National Tobacco Quitline, If the client is found positive for any of the 'TB Symptom Complex' symptoms, s/he will be encouraged to visit the nearest health centre for detailed check-up and the essential details (name, age, sex, address) will be recorded in the online software.

Linking the suspected TB patient through digital initiative: The Quitline software will have provision to generate the report on a real-time basis. The dashboard part of the software will provide information about the profile of suspected TB clients. Administrative link of the dashboard will be shared with the CTD division to extract information for further necessary action. A mechanism will be explored to link the 'National Tobacco Quitline' dashboard report with the 'TB Missed Call' initiative of the RNTCP programme. The 'TB Missed Call' will ensure that the suspected TB patient has visited the health facility for the diagnosis of TB. Further, the counsellors at the Quitline services will be trained for identifying TB symptoms and recording information. By conducting screening of TB symptoms, TCC/Quitline will also support to retrieve interrupters. They will identify relapse of TB in their regular clients who have completed TB treatment as there is increased risk of relapse of TB disease among tobacco user/s.

TB patient referred from the DOTS centre for counseling: The TB patients referred to the Tobacco Cessation Centre (TCC) from the nearest PHI shall be followed up with intensive counselling services. Based on results of the 'Fagerstrom Test for Nicotine Dependence', patients will be managed as per the treatment protocol stipulated under the Tobacco Dependence Treatment Guideline. Medication available for tobacco cessation can be broadly divided into the following two groups:

- Nicotine Replacement Therapy (NRT)
- Non Nicotine Replacement Therapy

In the 12thFive Year Plan, there is a provision of Rs. 200,000 per annum under the DTCC budget for providing Pharmacological Treatment of Tobacco Dependence at the district level. In this context, procurement and storage of NRT drugs should be strictly guided by the extant NHM Guidelines/ State NHM Guidelines, whichever is more applicable.

The TCC will update the information about the referral in the 'Tobacco Cessation Form (Intake and Follow Up)' at point number 9 (Annexure 4). The DTCC after compiling information from TCC will share quarterly feedback with DTO on the quitting status of the referred TB patient.

9 Sensitisation & Training of Health Staff for TB–Tobacco Collaborative Activities

States will conduct Training of Trainers (ToT) at the state level to train all district TB officers and district NTCP officers for implementing the collaborative framework. Experts from the Tobacco Cessation Centre at the state level will also be utilised as resource persons for training.

An e- Learning training capsule will be developed to sensitise both Treatment Supporter and counsellors posted at Tobacco Cessation Centre/ National Tobacco Quitline about the 'Brief Advice' and Screening of 'TB Symptom Complex' respectively. Job-aid for Treatment Supporter will also be prepared on similar lines. The National Tobacco Control Cell may be contacted for resource persons for trainings which will be conducted as part of routine RNTCP trainings.

To optimally utilise the existing platform for training, the DOTS care provider/ Treatment Supporter will be trained in conducting regular ongoing trainings at the district level. Here, the District TB Officer, NTCP District Nodal Officers and NTCP counsellors may be requested to serve as resource persons. Under the NTCP programme, a dedicated chapter on TB screening will be included in the NTCP programme managers' manual. The programme staff of the NTCP will be trained for screening TB complex during their regular NTCP training. Further options will be explored to revise and include the TB screening chapter in the existing training module for doctors, health workers and the Accredited Social Health Activists (ASHA), to be used under the NTCP programme.

Sensitisation of stakeholders, administrators and partners at the state/local level will be the joint responsibility of RNTCP staff and NTCP at the state and district levels.

10 Awareness and IEC

The activities pertaining to Information, Education and Communication (IEC) aim to favourably change knowledge, attitudes, and practices among various stakeholders. They play a very critical role in bringing about awareness on TB symptoms and treatment, as also highlighting the harmful effects of tobacco use, with a view to induce health seeking behaviour. The IEC campaign must therefore inform, educate and persuade people to realise their roles and responsibilities and the benefits that will accrue to them if they invest in the right practices.

Sensitisation about the collaborative activity is required to generate awareness, both at the staff and community levels. The programme and hospital staff needs to be aware about the purpose and mechanism of the collaboration. The community needs to be informed regarding inter- linkages between the two diseases and the associated increased risks that they are likely to face. Key messages that must then be included in the various IEC materials will be developed and shared with States for further adaptation in local languages. Some of the efforts that can be made to increase awareness are:

- Develop and display/air IEC materials/public service announcements (PSA) on co-morbidities;
- Develop TB-tobacco posters under NTCP and share these with RNTCP Division and vice versa for further updating, if needed;
- Strive to make all the DOTS centres/clinics tobacco-free;
  - Display IEC materials at TUs, DMCs and Tobacco Cessation Clinics;
  - Display IEC materials at DMCs and TUs with clear mention of the hazards of tobacco use, along with 'Brief Advice';
- Prominently put up materials related to hygiene and TB awareness at the Tobacco Cessation Centres;
- Step up awareness building efforts at both units for patients and staff members;
- Sensitise all stakeholders (partners, policymakers and administrators) on a regularly basis;
- Programme divisions to make every effort to sensitise the community about the ill effects of TB and tobacco use; and
- Make available Quitline brochures to all registered TB patients who are using tobacco in any form.

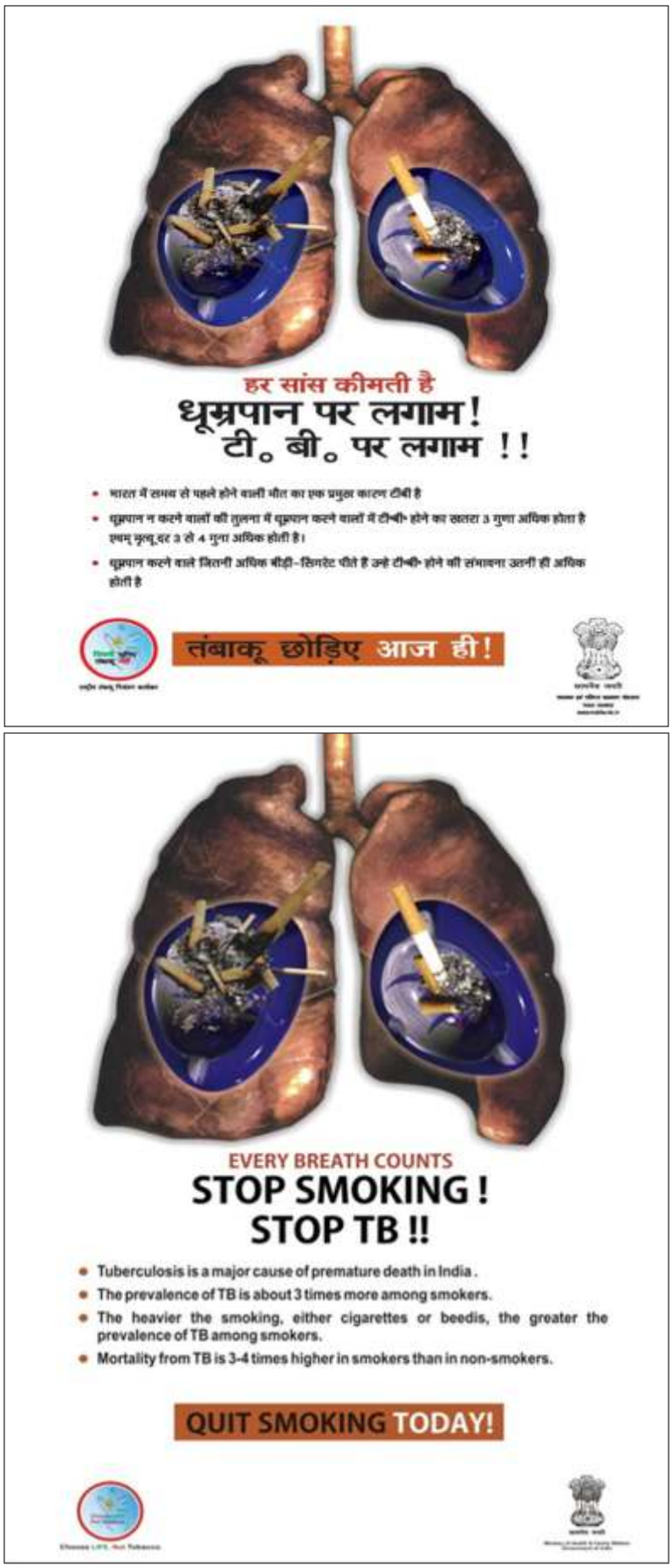


Figure 5: TB-Tobacco Posters

11 Recording and Reporting

Recording and reporting is an important component to guide and monitor the progress for any initiative in the programme. The existing mechanism of both programmes will be utilised for reporting and recording, with necessary revision in existing formats. The formats will be used by various facilities as prescribed in both programmes. The information collected in the reporting and recording formats will then be utilised in the review meetings.

11.1 Revised National Tuberculosis Control Programme

A number of the indicators and reporting formats under RNTCP have in recent times undergone changes and modifications.

Indicators under RNTCP

Proportion of registered TB patients screened for tobacco use	Proportion of screened TB patients identified as tobacco user	Proportion of screened TB patients linked to tobacco cessation services	Proportion of TB patients who have successfully quit tobacco use
Numerator= No. of TB patients screened for tobacco use Denominator=No. of TB patients registered in the reporting quarter	Numerator= No. of screened TB patients identified as tobacco users Denominator=No. of TB patients screened for tobacco use	Numerator=No. of Screened TB patients identified as tobacco users linked to tobacco cessation services at the end of Intensive Phase (Tobacco Cessation Centre/National Tobacco Quitline/ mCessation) Denominator=No. of screened TB patients identified as tobacco users	Numerator=No. of TB patients provided 'Brief Advice' for tobacco cessation and who have successfully quit tobacco use on completion of TB treatment Denominator=No. of TB patients screened as positive tobacco users

The information for all the above will be recorded in the TB treatment card and the indicators will be recorded in NIKSHAY/Quarterly Report on Programme Management and Logistics (QRPML).

Reporting Formats: Reporting template of TB Treatment Card is being captured in the NIKSHAY platform. The report can be made available and generated through NIKSHAY at TU level and above under the 'Case Finding' output report. NIKSHAY can generate reports on a monthly/quarterly basis on the following:

- Number of registered TB patients who use tobacco products and the type of tobacco (smoke/smokeless);
- Number of registered TB patients linked to cessation services at the completion of intensive phase after regularly providing 'Brief Advice'; and
- Number of registered TB patients who were tobacco users and have quit tobacco use at the end of TB treatment.

11.2 National Tobacco Control Programme

The list of indicators and reporting formats have been developed and shared with concerned officials across levels.

Indicators under NTCP

Proportion of registered clients at Tobacco Cessation Centre and screened for 'TB Symptom Complex'	Proportion of attendees at TCC found positive for TB symptoms and diagnosed with TB	Proportion of identified TB patients referred by RNTCP to avail TCC services after completion of Intensive Phase
Numerator=No. of attendees/clients at TCC screened for four symptoms of TB Denominator=No. of clients registered at TCC in reporting quarter	Numerator=No. of attendees suspected for TB among attendees at TCC (found positive for TB symptoms) Denominator=Total no. of attendees at TCC screened for TB symptoms	Numerator=No. of TB patients referred by RNTCP after giving regular 'Brief Advice' Denominator=No. of total attendees at TCC
This information will be recorded in point no. 16 of 'Tobacco Cessation Form' provided at Annexure 4 and indicator shall be reported in Quarterly Report of DLCC	This information will be recorded in point no. 25 of 'Tobacco Cessation Form' provided at Annexure 4 and indicator shall be reported in Quarterly Report of DLCC	This information will be recorded in point no. 9 of 'Tobacco Cessation Form' provided at Annexure 4 and indicator shall be reported in Quarterly Report

Reporting Formats: Quarterly reporting template by the National Tobacco Control Programme (Part B) is provided at Annexure 5. Part B will capture the following additional information.

Part B: Quarterly Reporting Template of National Tobacco Control Programme

S.No.	Activities	During the quarter	Up to the quarter in the Financial Year
15.	a. Number of persons screened for the TB symptoms complex referred to DOTS Centre		
	b. Number of persons found positive for the TB symptoms complex and referred to nearest Designated Microscopic Centre		
	c. Number of registered TB patients referred to TCC for tobacco cessation counselling after giving ''Brief Advice''		
16.	State may provide details of any other outstanding/important initiative/activity undertaken during the quarter at the State or district levels (including in non-NTCP districts of the States)		

Figure6: Portion of Part B of Quarterly Reporting Format of NTCP

- Number of registered clients at TCC screened for TB symptoms;
- Number of registered clients at TCC found positive for TB symptoms; and
- Number of registered clients diagnosed as TB patients.

The information from the 'Tobacco Cessation Form' from the TCC will be compiled at the district level and will be reported in Part B of the Quarterly Reporting Format at the District Tobacco Control Cell (DTCC). Next, the DTCC will on a quarterly basis share the report with the State Tobacco Control Cell (STCC).

The National Tobacco Quitline will be linked to the online dashboard which provides real time information on programme performance. A provision will be made in the dashboard software to provide real time information that includes details like name, age, address and mobile number of the clients who are suspected to be positive for TB symptoms. The administrative link to such information will be provided to the Central TB Division (CTD) which will then generate the report on an excel file, sharing the information with States for needful action. The provisional Dashboard report is provided at the Annexure 10 and will provide the following information:

- Number of registered clients at Quitline screened for TB symptoms;
- Number of registered clients at Quitline found positive for TB symptoms; and
- Number of registered clients at Quitline referred to the nearest DMC.

12 Supervision, Monitoring and Evaluation

The District Nodal Officers (DNO) of NTCP and District TB Officer (DTO) of RNTCP will participate in the quarterly review meetings of both programmes along with district level supervisors and coordinators of both programmes. In the meeting, the DTO will compile and share the information that has been captured in the 'Case Finding' as part of NIKSHAY. This will have information about the quitting status of registered TB patients using tobacco products. The DNO will share the information about the TCC clients who were suspected for TB and were referred to the Designated Microscopic Centre, from the reports complied from the TCC. Any gap in the reporting and recording will be discussed and resolved in the review meeting.

The DTO and DNO will also plan the joint monitoring visit, at least on a quarterly basis to TCC/DOTS centre based on the analysis of indicators in the quarterly reports. The State Nodal Officers (NTCP) and State TB Officer (RNTCP) will conduct joint monitoring visits to districts and prioritise them based on performance indicators and programme needs. The STO and SNO will also participate in the monthly/quarterly review meetings of both the programmes along with state level supervisors/coordinators/consultants of both the programmes. The STO and SNO officers shall be responsible for collation and compilation of reports from the districts and will do the quarterly reporting to national level authorities.

Regular supervision will be undertaken to ensure that the DOTS care-providers, including health workers are implementing skills imparted in training courses. Supervision of joint TB and tobacco control activities therefore should be included in the checklist for STLS and STS. The District TB Officer and District Nodal Officer-NTCP will jointly plan monthly supportive supervision to assess implementation of Brief Tobacco Advice in the treatment card.

13 Roles and Responsibilities of Programme Staff for Collaborative Activities

As per the hierarchy followed in the NTCP, the programme staff includes a state level consultant, a DNO consultant, a, counsellor and a data entry operator. Their roles and responsibilities are clearly assigned and are summarised below:

13.1 Roles and Responsibilities of RNTCP Staff

The RNTCP staff is assigned at the state and district level as also at the TB unit level and the DMC/PHC level. Each of these are assigned specific tasks which are summarised below:

State level (STO, STDC Director, APO, DEO)	District level (DTO, District Programme Coordinator, MO-DTC, DEO)	TB Unit level (MO-TC/BMO, STS, STLS)	DMC/PHI level (MO, LT, ANM, Staff Nurse, Health worker)
Invite State Nodal Officer of NTCP in State TB Committee meeting and actively participate and contribute in SLCC to discuss TB-tobacco collaborative issues on quarterly basis	Collaborate with DLCC/TCCs for implementation of TB- tobacco activities	Ensure screening of tobacco use at TB diagnosis centre and its report sharing with District TB officer	Give first 'Brief Advice' to registered TB patient
Review district level components of TB-tobacco collaborative activities on quarterly basis	Actively participate and contribute in DLCC outlined for TB-Tobacco collaborative activities	Train/motivate Treatment Supporter on 'Brief Advice'	Ensure completeness of records e.g. information related to tobacco use in TB treatment card

Align implementation of TB-tobacco collaborative activities in relation to expansion of NTCP programme in districts	Assist in training of sub-district staff and other staff involved in management of TB-Tobacco co-morbidities	Ensure that Treatment Supporter is giving regular 'Brief Advice' to registered patient and patient has been linked to cessation services at end of Intensive phase (Tobacco Cessation Centre/National Tobacco Quitline/ mCessation)	Ensure that patient is referred from PHI/TU/Treatment Supporter for intensive counselling for tobacco cessation and share feedback
Provide funds for relevant training pertaining to TB-tobacco collaborative activities	Conduct joint supervision of collaborative activities with District Nodal Officer (NTCP)	Ensure information about tobacco use and quitting status from treatment card is captured by Senior Treatment Supervisor of respective TB unit in NIKSHAY	Responsibility for collecting information and updating treatment card will rest with institutional Treatment Supporter of PHI/ Health worker
Involve in joint supervision of collaborative activities with State Nodal Officer (NTCP)	Ensure submission of accurate and timely reporting of TB-tobacco formats to state official along with feedback about progress of TB-tobacco collaborative activity		
	Collaborate with relevant stakeholders to strengthen TB-tobacco activity in the district		

13.2 Roles and Responsibilities of NTCP Staff

State level (SNO/State Consultant	DNO/Consultant	Counsellor	Data Entry Operator
Convene and coordinate SLCC meeting; invite STO to the meeting; and participate in the State TB Committee meeting	Collaborate with District TB Unit for implementation of TB-tobacco activity	Conduct screening of 'TB Symptom Complex' in clients attending NCD clinic/ TCC/registering at National Tobacco Quitline/ mCessation initiative and provide tobacco cessation counselling to TB patients referred from the DOTS centre	Compile accurate report of TB-tobacco collaborative activity in formats mentioned in the collaborative framework
Review components of TB-tobacco collaborative activities on quarterly basis from all districts	Convene DLCC meetings and invite District TB Officials to attend meetings as outlined in the TB-tobacco collaborative framework/ participate in District TB Committee meeting	Ensure proper display of IEC materials related to TB-tobacco collaborative activities at TCC and at all other events/activities	Provide feedback to SNO/ DNO/Consultant on any discrepancy for the indicator analysed
Align implementation of TB-tobacco collaborative activities in relation to expansion of NTCP programme in the districts	Assist/organise training of TCC involved in providing cessation services to ensure screening of 'TB Symptom Complex' Tobacco Cessation Clinic and its report sharing with District TB officer	Actively participate in training of TB-tobacco collaborative activity	Collaborate with data entry operator of District TB unit to exchange reports of TB-tobacco collaborative activity prepared from Form B of Quarterly Reporting Template and 'Tobacco Cessation Form' of TCC

Ensure that training on TB-tobacco collaborative activities are mainstreamed in ongoing training under NTCP at state and district level	Conduct joint supervision of collaborative activities with District TB Officer	Assist DNO/Consultant in preparing TB-tobacco collaborative activity action plan	Maintain records of TB-Tobacco collaborative activity with other NTCP records
Conduct joint supervision of collaborative activities with State TB officials	Ensure submission of accurate &timely reporting of Quarterly Reporting Template that contains information on TB-tobacco collaboration		
	Collaborate with relevant stakeholders to strengthen TB-tobacco activity in the district		

14 Implementation Plan

In 2014, programme managers of five states, namely Kerala, Gujarat, Himachal Pradesh, Chhattisgarh and Tripura were trained to implement the TB-tobacco collaboration activity. The implementation status of collaborative activities will be assessed and learning from the evaluation report used to expand the collaborative framework in other states and districts.

In the second stage, the programme will be implemented in districts where both programmes have a well developed infrastructure in terms of manpower, implementation of activities and utilisation of funds. While the 'Brief Advice' will be provided to every registered TB patient who is a tobacco user, screening of TB symptoms will be done in Tobacco Cessation Centres which are functional under the NTCP programme.

In the third stage, the National Tobacco Quitline will be linked for screening TB symptoms in registered clients. States will be encouraged to setup similar Tobacco Quitline services with the help of medical colleges/NGOs at the state level to cater to the increased utilisation of cessation services. The National Tobacco Quitline will share the patient profile of suspect TB to 'TB Missed Call' initiative for ensuring that s/he utilises health services. The mCessation services for screening TB Symptom Complex will also be explored in the third phase of services. A mechanism will be explored to introduce a follow-up column regarding 'Brief Advice' in the digital TB treatment card.

Referral for intensive counselling or National Tobacco Quitline will be made based on the patient's status of quitting tobacco use, at the end of the treatment. The collaborative framework will be implemented in the following manner in selected districts:

Activities	Responsibility
CTD and NTCP to send appropriate directives to state focal points to prepare action plan for implementation of TB–tobacco collaborative activities	CTD/NTCP Division
States to start implementing TB–tobacco collaborative activities as per state implementation plans	SNO (NTCP) and STO RNTCP consultants to support
Training of district and sub-district staff at state/regional level and for district level staff on Brief Tobacco Advice	State Nodal Officer (NTCP) and STO RNTCP consultants to support
Sensitisation of field level staff as part of regular ongoing training	DTO/DNO (NTCP)
Sensitisation of stakeholders (administrators, partners) at state and district levels	State Nodal Officer (NTCP) and STO RNTCP consultants to support

Initiation of implementation and reporting	State Nodal Officer (NTCP) and STO RNTCP consultants to support
Joint visits by – State level officials to district and sub-district level – National teams to states	STO/SNO CTD/NTCP
Linkage with National Tobacco Quitline/ mCessation/TB Missed Call services	CTD/NTCP

15 Tools for TB-Tobacco Collaborative Framework

The following sets of tools are available for implementing the TB-tobacco collaborative framework:

- TB Treatment Card and TB ID card;
- Job Aid for 'Brief Advice' - 5A's and 5R's approach for tobacco cessation;
- RNTCP Laboratory Request Form;
- Infection Control Measure Guidelines;
- Tobacco Cessation Form of the TCC;
- Quarterly Reporting Format of State and District Tobacco Control Cell;
- Flyer for the TB Patients- Tobacco Quitline Brochure;

REVISED NATIONAL TUBERCULOSIS CONTROL PROGRAMME

Treatment Card *TB Notification No/ NIKSHAY ID*_____

*State*_____ *City / District* _____ *TB Unit* _____ *PHI* _____

Name _____*Sex* ☐ *M* ☐ *F* ☐ *TG* *Age:*____ *Occupation*_____ *Socioeconomic status: APL/ BPL*

Complete Address: House No. _____ *Road:* _____*Ward/Village:* _____ *Town/City:* _____ *Taluka/Mandal:*_____ *District:*_____

State: _____ *Pin code*_____ *Important landmark:*_____ *Mobile:*_____ *Aadhar No.* _____*Area : Slum/Tribal/Migrant/Refugee*

Name and Address of contact person _____ _____*Mobile No.* _____

*Name of Treatment Supporter*_____*Designation* _____*Mobile No.:* _____

Initial home visit by _____ *Date* _____*Type of Treatment Adherence DOT / Family DOT / ICT supported, specify* _____ */ Other*__

Disease Classification

☐ *Pulmonary*
☐ *Extra Pulmonary*
Site _____

Type of Patient

☐ *New* ☐ *Recurrent*
☐ *Transfer in* ☐ *Treatment after Failure*
☐ *Treatment After LFU* ☐ *Others previously treated (Specify)*_____

Basis of Diagnosis

☐ *Microbiologically confirmed*
☐ *Clinical TB*

Investigations (ZN / FM / CBNAAT / Liquid C / Solid C)	Lab	Lab. No.	Test result	Sample sent to CDST (date)	DST result
Pre-treatment					
End of Intensive Phase					
End of treatment					

*H/O of Previous ATT:*___ *months of treatment*__ *months since end of last episode*
Source of treatment:- ❑ *Public* ❑ *Private* *Previous regimen:* _____

Other investigations (if any) with result

HIV related information

HIV Status:❑ *Unknown* ❑ *Reactive* ❑ *NR* *Date*_____ *PID*_____

CPT delivered on: (1) (2) (3) (4) (5) (6)

Initiated on ART: ☐ *No* ☐ *Yes* *Date & ART No.*_____

Diabetes related information

Diabetes Status:❑ *Unknown* ❑ *Diabetic* ❑ *Non-Diabetic*

*RBS*_____ *FBS*_____

Initiated on ADT: ☐ *No* ☐ *Yes* *Date & ADT No.*_____

Other co-morbidity

*Details*_____

	<6yrs	>6yrs
No of household contacts		
No screened		
No with symptoms		
No evaluated		
No diagnosed		
No put on treatment		

No of children less than 6 years given chemoprophylaxis = _____

Name	*Wt (Kg)*	*Dose (mg)*	*1*	*2*	*3*	*4*	*5*	*6*

Addiction related information

Current Tobacco user ❑ *Yes* ❑ *No*
If yes, ❑ *Smoking* ❑ *Smokeless* *Linked for cessation* ❑ *Yes* ❑ *No*
If tobacco user, status of tobacco use at end of treatment ❑*Quit* ❑ *Not quit*

H/o Alcohol intake❑ *Yes* ❑ *No*
If yes, linked for dead diction ❑ *Yes* ❑ *No*

Signature of MO with date _____

Date of initiation of intensive phase _____ Date of initiation of continuation phase _____

Dosage frequency ❑ *Daily* ❑ *Intermittent* *Drug formulations* ❑ *FDC* ❑ *Comb pack* ❑ *Loose drugs* *Drug packaging* ❑ *PWB* ❑ *Strips*

Weight Band: Adult: ☐ *25-39 Kg* ☐ *40-54 Kg* ☐ *55-69 Kg* ☐ *≥70 Kg* *Pediatric:* ☐ *4-7 Kg* ☐ *8-11 Kg* ☐ *12-15 Kg* ☐ *16-24 Kg* ☐ *25-39 Kg* ☐ *30-39 Kg*

Dosages: FDC / Combipack _____ per day *Height_____ (cm)*

Loose drugs						
Dose						
Pills						
			H	*R*	*Z*	*E*	*S*

Mark ✓ when doses are taken under direct observation, ✓ when the dose was not observed, O when missed the dose
Record CP from fresh line

Month/ year	*1*	*2*	*3*	*4*	*5*	*6*	*7*	*8*	*9*	*10*	*11*	*12*	*13*	*14*	*15*	*16*	*17*	*18*	*19*	*20*	*21*	*22*	*23*	*24*	*25*	*26*	*27*	*28*	*29*	*30*	*31*	*Wt*

Retrieval Actions for Missed Doses

Date	By Whom	Whom contacted	Reason for missed doses	Outcome of retrieval action

Details of Adverse events

Date of adverse event	Details of symptoms	Action taken	Duration of management for adverse event	Outcome of adverse event

Post treatment follow up clinical & sputum

Follow up	Clinical	Sputum	CXR	Impression
6 mths of Rx				
12 mths of Rx				
18 mths of Rx				
24 mths of Rx				

Findings _____

Remarks

_____
_____
_____
_____
_____

Nutrition support (if any, give details) _____

Treatment outcome with date: _____ **signature of the MO with date:**_____

TB ID card for referring registered TB patient to nearest Tobacco Cessation Centre

TB identity card

Name: _____

Sex ☐ M ☐ F ☐ TGAge:____

Address:_____

_____

_____

Contact No: _____

PHI _____ TU _____ District _____

NIKSHAY ID:_____

Name and designation of treatment supporter:

_____

Contact number and address of treatment supporter:

_____

☐ CPT ☐ ART ☐ Diabetic ☐ Smoker

Date of starting treatment: (DD/MM/YYYY)

Weight Band:

Adult: ☐ 25-39 Kg ☐ 40-54 Kg ☐ 55-69 Kg ☐ ≥70 Kg

Pediatric: ☐4-7 Kg ☐8-11 Kg ☐12-15 Kg ☐16-24 Kg ☐ 25-39 Kg ☐30-39 Kg

Site of Disease

☐Pulmonary
☐Extra pulmonary

Type of Patient

☐New
☐Recurrent
☐Treatment after Lost to Follow up
☐Treatment after Failure
☐Previously treated other
☐Transfer in

Treatment regimen:☐New
☐Previously treated

_____

Smear follow-up results			
End IP		End Rx	
Post Rx Month __		Post Rx Month __	
Post Rx Month __		Post Rx Month __	

Treatment outcome: _____

Date:_____

Appointment dates

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

In case of side effects or queries please contact

Name and contact number:

_____
_____

RNTCP PMDT Treatment Card

NIKSHAY ID	CDL NIKSHAY ID	PMDT NIKSHAY ID	PMDT TB No

Patient's name: _____

Age: _____yrsGender: ☐ Male ☐ Female ☐ Transgender

Address: _____

_____

Marital status: _____

Occupation: _____

Contact No: _____

Name, designation of treatment supporter:_____

_____

Contact no:_____

State:_____District: _____

TB Unit: _____ PHI:_____

Initial home v: Date _____By:_____

DR TB Centre:_____

Reason for Testing	
☐ New ☐ Previously Treated	
☐ Presumptive TB ☐ Private Referral ☐ Presumptive NTM	
☐ Presumptive MDR TB	☐ At diagnosis ☐Contact of MDR/RR TB ☐ Follow up Sm+ve at end IP ☐ Private referral
☐ Presumptive H mono/poly	
☐ Presumptive XDR TB	☐ MDR/RR TB at diagnosis ☐ ≥ 4 months culture positive ☐ 3 monthly, for persistent culture positives (treatment month _____) ☐ Culture reversion ☐ Failure of MDR/RR-TB regimen ☐ Recurrent case of second line treatment

☐ Transfer in from Other DR TB Centre

Name of DR TB Centre _____

PMDT NIKSHAY ID_____

HIV Testing: Date:_____ Result:_____ PID no._____

Date of starting CPT: _____ Date of starting ART:_____

Contact tracing:

No of household contacts				
No of members screened				
No of presumptive TB cases identified				
No of presumptive TB cases evaluated				
No diagnosed with TB				
No of DR-TB diagnosed				

TB Site: □ Pulmonary □ Extra Pulmonary If extra pulmonary, pleasc specif ----------

Treatment regimen

□ Regimen for INH mono/poly resistant TB □ Regimen for MDR/RR TB □ Modified Regimen for MDR/RR- TB + FQ/SLI resistance □Regimen for XDR TB □ Modified Regimen for mixed pattem resistance □ Regimen with Bedaquiline for MDR-TB Regimen + FQ/SLI resistance □ Regimen with Bedaquiline for XDR-TB □ Regimen with Bedaquiline for failures fo regimen for MDR-TB □ Regimen with Bedaquiline for failures of regimen for XDR-TB □ Regimen for mixed pattern resistance

Initiation Date: ----------

Registration Date: ----------

Drugs and Dosages																				
Druge	H	R	E	Z	mK	mA	mC	xfL	xfM	sC	atE	SAP	zld	zfC	xmA	vlc	rlC	QDB		
Dose (mg)																				

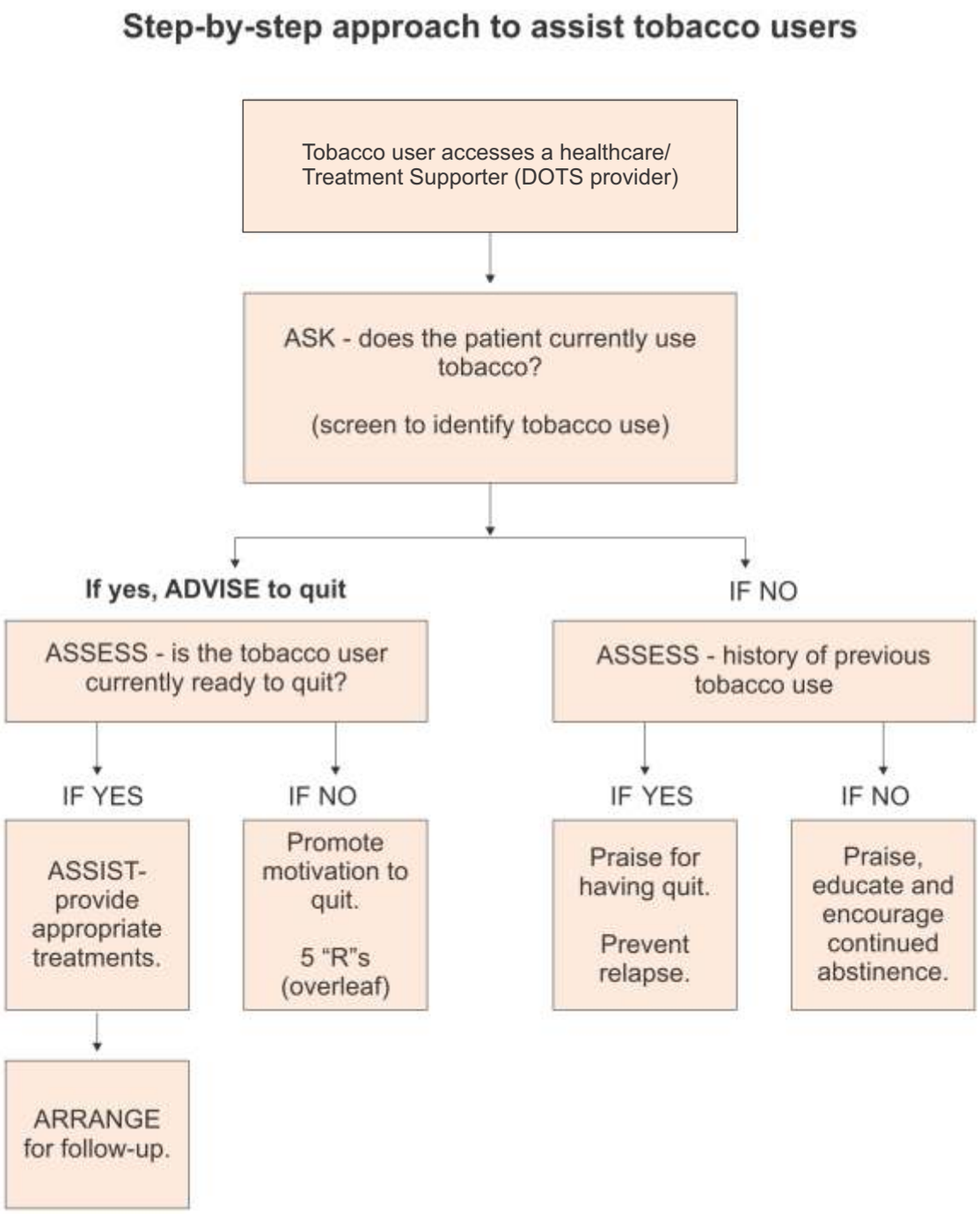
Patient eligible and consented for BDQ ☐ **Yes** ☐ **No**
If No, reason_____

Name & Signature of Treating Physician:_____

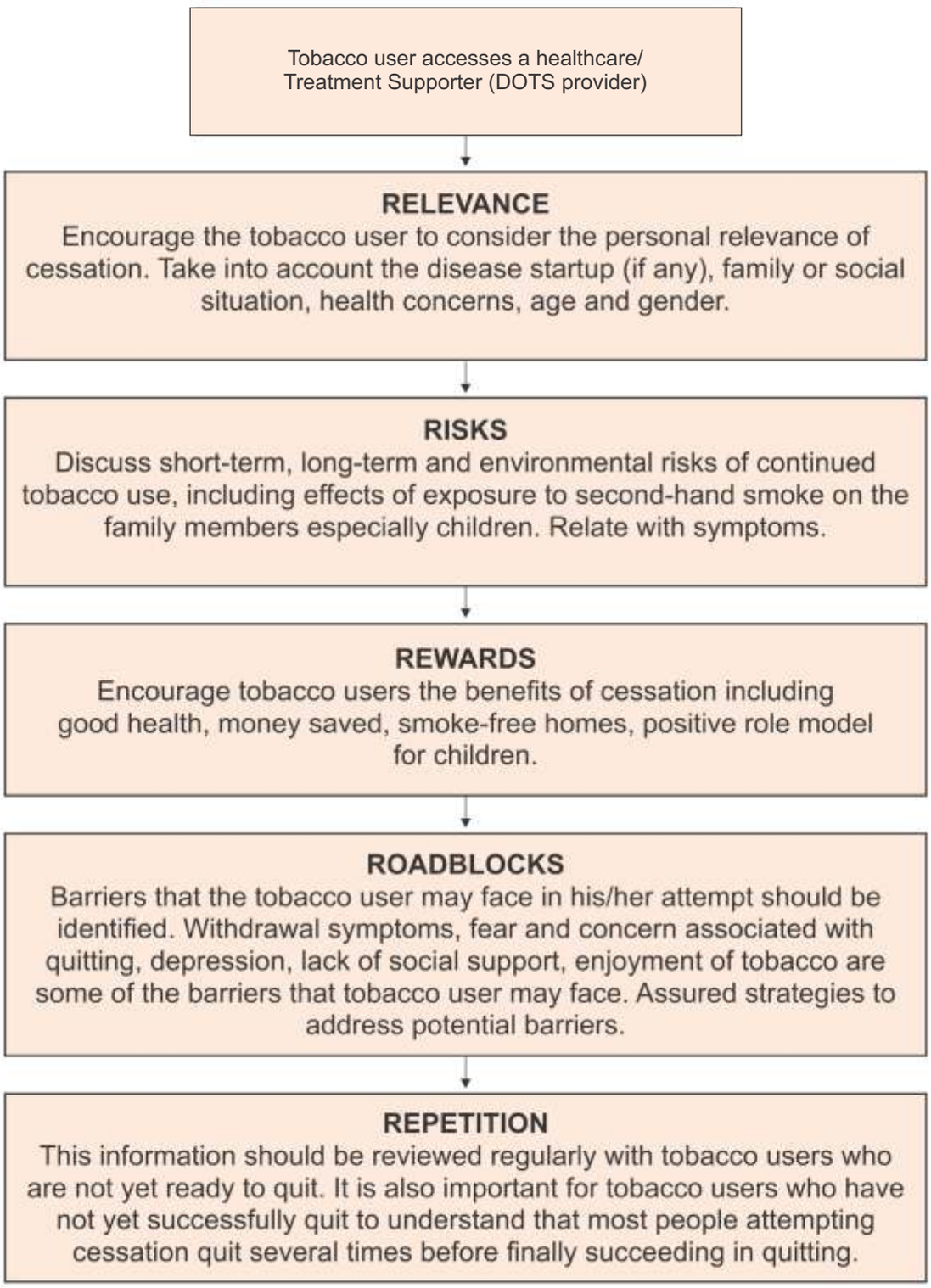
DR-TB Centre Committee meetings – dates and decisions

Date	Decision	Duration of indoor stay

Flow chart – 5As & 5 Rs model



Motivational intervention for tobacco users not willing to quit



The healthcare provider should review the strong message to quit and offer help.

*Quitting means a person who has not used any sort of tobacco product for the 'last 12 weeks'

5 As and 5 Rs Models

5A's for patients who are ready to quit

Ask- Ask about tobacco use

↓

Advise- Advise to quit

↓

Assess- Assess 'readiness' to make a quit attempt

↓

Assist- Assist in quit attempt

↓

Arrange- Arrange follow up

5R's for patients not ready to quit

Relevance- How is quitting most personally relevant you?

↓

Risks- What do you know about the risk fo smoking in that regard?

↓

Rewards- What would be the benefits of quitting in that regard?

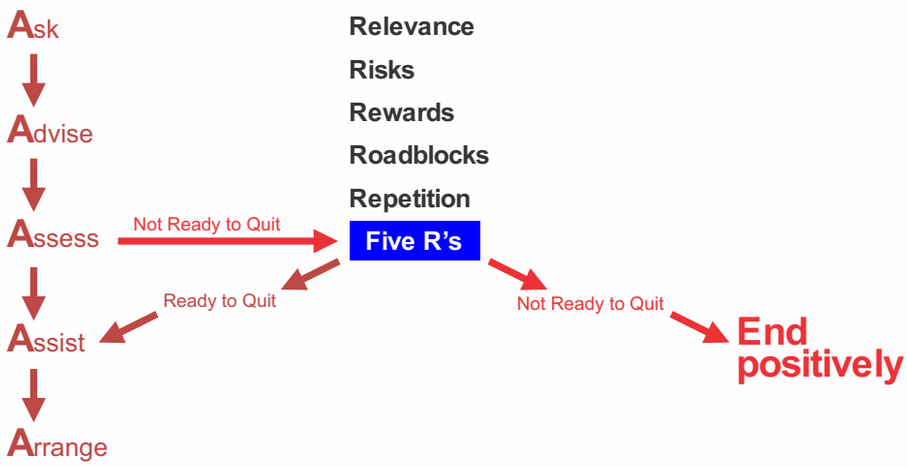
↓

Roadblocks- What would be difficult about quitting for you?

↓

Repetition- Repeat assessment of readiness to quit-if still not ready to quit repeat intervention a later date.

How to implement 5A's and 5R's?



Tobacco Cessation Form

SUGGESTED PROFORMA FOR PATIENT

TOBACCO CESSATION FORM (INTAKE AND FOLLOW-UP)

Note: This is the minimum required information for the database. Each health care facility is encouraged to maintain a detailed clinical record for each client.

Client No. | | | | | | |

Date | | | | | | |

1. Name : _____

2. Age : _____
3. Gender : Male Female
4. Address : _____
   Ph. No. _____
5. Education (Numbers of years of formal education) _____
6. Marital Status: Unmarried Married Widowed

   Separated or Divorced Not Applicable

8. Occupation: Professional and Semiprofessional ☐

Skilled, Semiskilled & Unskilled worker ☐ Retired ☐

Housewives ☐ Students ☐ Others/ Not Classified. ☐

Unemployed ☐

9. Referred From Subcentre ☐ PHC ☐ CHC ☐ RNTCP ☐

10. Details of Tobacco use:

Type	Age at Starting Tobacco use	Smokeless tobacco/bidi/cigarette years (Numbers of cigs/bidis/sachets of tobacco used per day X No. of years of regular tobacco use)	Average numbers of cigarette/sachers amount of tobacco chewed per day in the last one month
Smokeless 1. 2. 3.			
Smoking 1. 2. 3.			

11. Expense per month on tobacco (Average month last year) Rs. _____

12. Alcohol use in the last 1 year:

Daily Drinking	
Regular Drinking (3 or more times a week)	
Social Drinking (<3 times/ week)	
None	

13. Average units per drinking day (30 ml spirit/60ml wine/1/2 mug beer= 1 unit) Units

14. Others Substance use: Yes No If Yes specify substance: _____

15. Number of previous attempts at quitting which lasted for at lasted one month .

16 Positive for the any of the four TB Symptoms Complex

Cough of any duration Weight Loss

Fever Night Sweats

17. Apply Fagerstrom Test (Annexure 2)

18. Tobacco use in first \-degree relatives: Smoking Smokeless Both None

19. History & Symptoms suggestive of:

Hypertension (yes, No) Diabetes (Yes, No)

Heart Attack (Yes, No) Stroke (Yes, No)

Oral/ Lung Cancer (Yes, No) Asthma/ Bronchitis (Yes, No)

Physical Examination

20. Weight Kgs. 21. Height cms. ___ 22. Pulse

23. BP Systolic Diastolic

24 Oral Cavity: Leukoplakia Yes, No Erythroplakia Yes, No

Sub mucous fibrosis Yes, No Denta Caries Yes, No

25. Significant current co-morbid disorder:

a)

b)

c)_____

26. Intervention: Behavioral Counselling

Behavioral Counselling+ Medication

Behavioral Counselling + NRT

_____

26. Follow up

	Date	No Change (or<50% reduction from baseline*)	Reduced use (50% or greater reduction from baseline*)	Stopped U s e	Lost to follow up	Cotinine test (+ve or_ve) or not done
2 weeks						
4 weeks						
6 weeks						
3 months						
6 months						

Any other remarks:

Part B: Quarterly Reporting Template of National Tobacco Control Programme

S.No.	Activities	During the quarter	Up to the quarter in the Financial Year
1.	No. of meetings of the SLCC with dates		
	No. of meetings of the Working Group with dates		
2.	Whether State Level Advocacy Workshops held If yes, attach reports/minutes		
	No. of participants in the Advocacy Workshops		
3.	Training of Trainers programmes held If yes, attach reports		
4.	Trainings on tobacco cessation for Health care providers If yes, attach reports		
	No. of Participants in the Trainings on tobacco cessation for Health care providers		
5.	Types of IEC materials adapted /developed (e.g. posters/stickers/handouts/wall paintings/hoardings etc.)		
	Examples of different IEC materials disseminated		
	Examples of instances of integration of tobacco control messages in other health / development campaigns		
6.	Details of meetings held with other relevant State Govt. departments		
	Details of training programmes of other departments in which STCC participated and made presentations on tobacco control		
7.	Details of meetings held with civil society organizations and professional bodies (e.g. NGOs, NSS, NCC, IDA, IMA etc.)		
8.	DTCCs set up in the State		
	Staff recruited by the DTCCs		
9.	Districts where District Level Co-ordination Committees have been set up		
	Districts where meetings of the District Level Co-ordination Committees have taken place		
	Total Meetings of the District Level Co-ordination Committees		
10.	Districts where enforcement squads have been set up to monitor compliance of COTPA		
	Visits conducted by the enforcement squads		
	Persons challaned and amount collected (information to be given month-wise in the format as annexed)		

	Details of complaints received through National Violations helpline		
	Details of such complaints where action has been taken		
11.	Trainings/sensitisation programmes for different stakeholders organised by district cells		
	Participants in the trainings/sensitization programmes at district level		
12.	Types of IEC materials adapted/ developed by DTCCs (e.g. posters/stickers/handouts/wall paintings/hoardings etc.)		
	PHCs, CHCs, Govt buildings, schools and other public places covered with these IEC materials		
13	Schools covered in the School Programmes by the district cells (i) Public Schools (ii) Private Schools (iii) Coaching Institutes		
	Details of children covered in these School Programmes		
	Details of School Programmes conducted		
14.	Number and names of districts where Tobacco Cessation Centres (TCCs) have been set up		
	Details of TCCs set up in the districts (indicate separately details of TCCs set up in the district hospitals, other government set-ups, NGOs, private set-ups etc.)		
	1. Whether staff is in place in these TCCs		
	2. Whether counsellors working in these TCCs are formally trained in cessation activities (indicate separately the total number of counsellors in place and the number of counsellors who have received formal training)		
	3. Have the TCCs arranged for any cessation trainings for healthcare providers/workers? If yes, indicate the number of trainings undertaken with details		
	4. Whether pharmacological treatment of tobacco dependence is available		
	5. Whether equipments such as Carbon Monoxide monitor and Spirometer have been procured		
	6. No. of persons who availed services at the TCCs		
	a. Number of persons who received counselling		
	b. Number of persons who received pharmacotherapy		
	c. Number of persons who received both		
	d. Number of persons who received counselling / pharmacotherapy and quit tobacco use		

15.	a. Number of persons screened for the TB symptoms complex referred to DOTS Centre		
	b. Number of persons found positive for the TB symptoms complex and referred to nearest Designated Microscopic Centre		
	c. Number of registered TB patients referred to TCC for tobacco cessation counselling after giving ‘‘Brief Advice’’		
16.	State may provide details of any other outstanding/important initiative/activity undertaken during the quarter at the State or district levels (including in non-NTCP districts of the States)		

RNTCP Laboratory Request Form

REFERRAL SLIP (Referring health facility copy) SR NO xxxxx	REFERRAL SLIP (Patient copy) SR NO xxxxx	REFERRAL SLIP (Lab Copy) SR NO xxxxx
Date: .....Lab referred to : ..... Name of referring HF: ..... Name of Patient: ..... Age: ..... yrs Sex: M / F Address of patient (with landmarks) .... Patient's / Contact person's Mobile number : _ _ _ _ _ _ _ _ _ _ Kindly tick ☐ Cough.....days ☐ Fever.....days ☐ Loss of weight .....days ☐ Night sweat.....days ☐ Blood in sputum/ cough.....days ☐ Contact of TB / MDR TB Stamp of HF Referred by (Name & Sign)	Date: .....Lab referred to : ..... Name of referring HF: ..... Name of Patient: ..... Age: ..... yrs Sex: M / F Address of patient (with landmarks) .... Patient's/ Contact person's Mobile number : _ _ _ _ _ _ _ _ _ _ Kindly tick ☐ Cough.....days ☐ Fever.....days ☐ Loss of weight .....days ☐ Night sweat.....days ☐ Blood in sputum/ cough.....days ☐ Contact of TB / MDR TB Stamp of HF Referred by (Name & Sign)	Date: .....Lab referred to : ..... Name of referring HF: ..... Name of Patient: ..... Age: ..... yrs Sex: M / F Address of patient (with landmarks) .... Patient's/ Contact person's Mobile number : _ _ _ _ _ _ _ _ _ _ Kindly tick ☐ Cough.....days ☐ Fever.....days ☐ Loss of weight .....days ☐ Night sweat.....days ☐ Blood in sputum/ cough.....days ☐ Contact of TB / MDR TB Stamp of HF Referred by (Name & Sign)

Annexures 7

Infection Control Measures Guidelines

1. Location and design
   a. Tobacco Cessation Centre (TCC) should have a well- ventilated waiting and seating area. Separate, well-ventilated waiting area for respiratory symptomatic should be made available wherever possible (larger ART Centres).
   b. Adherence to ventilation standards for airborne infection control (>12-15 ACH throughout during all hours of operation, in all seasons) should be ensured.
   c. TCC should be preferably located far away from Direct Microscopy Centre/DOT Centres.
   d. Open outdoor roofed additional waiting areas are encouraged, as are token systems to decompress crowded areas.
   e. As far as possible, use of re-circulating air conditioners in the waiting area should be avoided as these have been found to be leading to no air exchange.

2. General Hygiene:
   a. Hand washing facility (Universal Precaution) shall be in place for doctors, health care workers and patients.
   b. Running water, soap and alcohol hand rub solution shall be provided.
   c. Frequent wet mopping of the patient waiting area shall be undertaken.
   d. Lavatory shall be kept clean.
   e. An appropriate waste segregation and disposal system shall be in place.

3. Cough Hygiene for persons with respiratory infection:
   a. Cover the mouth and nose with a tissue/ handkerchief when coughing and dispose of used tissue in waste containers.
   b. Use a mask if coughing. Surgical mask may be issued to coughing patients.
   c. Perform hand hygiene (use an alcohol-based hand rub or wash hands with soap and water) after contact with respiratory secretions.
   d. Display sign boards requesting patients and family members with acute febrile respiratory illness to use respiratory hygiene/cough etiquette.
   e. Educate HCWs, patients, family members, and visitors on the importance of containing respiratory aerosols and secretions to help prevent the transmission of influenza and other respiratory infections.

4. Training of hospital staff:
   a. All the hospital staff shall be trained in Universal Workplace Precaution, Waste segregation and disposal and Air borne Infection Control Practices, with special reference to tuberculosis prevention.

National Tobacco Quitline Flyer

Do you know ?

- Tobacco contains nicotine which is a highly addictive substance.
- All forms of tobacco like bidi, cigarette, khaini, gutkha, pan and pan masala with tobacco, hookah etc are addictive and harmful for health.
- E-cigarettes which contain nicotine are also harmful.
- Tobacco smoke including second hand smoke contains more than 7000 chemicals, of which 69 are known to cause cancer.
- Nearly 50% of cancers in males and 25% in females (Indian Council of Medical Research) in India can be attributed to tobacco use.
- The majority of the cardio vascular diseases and lung disorders are directly attributable to tobacco consumption.
- Second hand smoke which is a mixture of smoke given by the burning end of tobacco products and the mainstream smoke exhaled by smokers, also harms non-smokers and unborn babies.
- Second hand smoke causes respiratory problems and various diseases in children. In non-smoking adults, it causes lung cancer and coronary health disease.

Types of Tobacco

Harmful Effects of Tobacco Use

- Tobacco use harms every part of your body from head to toe.
- It stains your teeth, gives you bad breath, ruins taste buds and makes it difficult to open the mouth.
- Tobacco use increases the risk of all cancers, more so oral and lung cancer and can cause brain stroke (paralysis), headaches and dizziness.
- In men tobacco use causes impotence and reduced sperm count.
- Smokers have trouble breathing, because smoking damages the lungs.
- Smoking increases your heart rate and blood pressure and causes heart disease and heart attacks.
- Tobacco use by females reduces their chances of pregnancy and causes various reproductive health problems like miscarriage, infertility, etc.
- It increases the risk of Tuberculosis (TB).

Oral Cancer

Non Smoker's Lungs | Smoker's Lungs

Quitting Tobacco is Possible

- Set a quit date. This date should be within 7 to 10 days.
- Avoid people, places and situations where tobacco is used.
- Don't keep any tobacco product with yourself and avoid company of people who use tobacco.
- When you feel the urge for using the tobacco, take deep breath and do some activity which you enjoy such as watching TV, listening to music and talking to your friends and colleagues. Keep saunf, elaichi, mishri, laung, etc in your mouth.
- Go for morning walk every day, make some time for exercise and drink plenty of water and fluids.
- Save the money you would have spent on buying tobacco and reward yourself and your loved one's with a gift with the money saved.
- Seek support of your family and friends to form a support group for your quit attempt.
- Be firm, stick to your decision to quit on your quit date.

Remember:

You may face withdrawal symptoms when you quit tobacco such as irritation, headache, insomnia, anger, chest tightness, intestinal disorder etc. This is so because you are no longer getting nicotine. These will remain for a few weeks. **Don't panic, consult us any time.**

Benefits of Quitting Tobacco

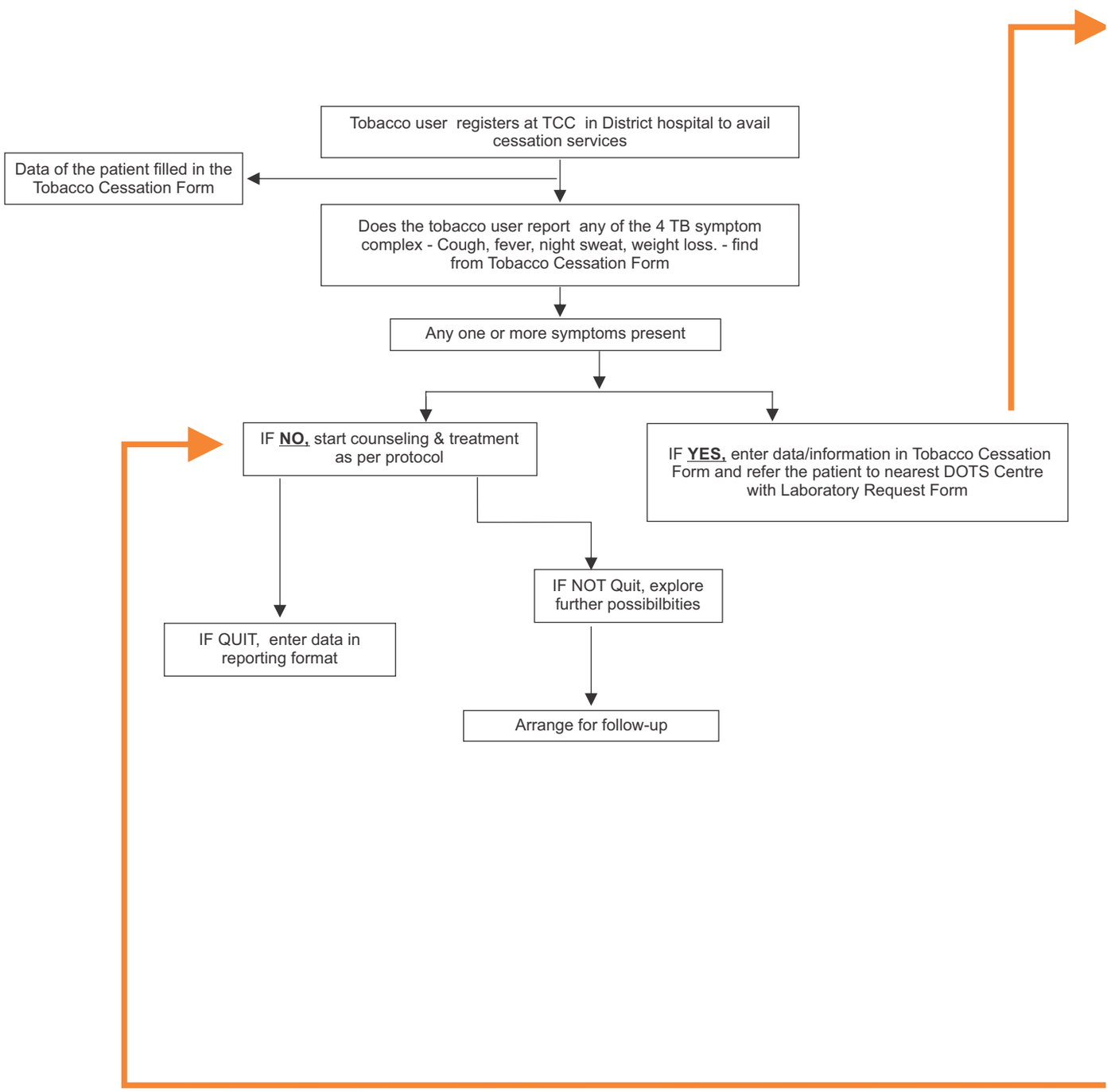
- In 20 minutes, blood pressure and pulse return to normal.
- In 8 hours, oxygen levels return to normal.
- In 24 hours, risk of heart attack begins to decrease.
- In 48 hours, sense of taste and smell improves.
- In 72hours, lung function improves.
- In 1-9 months, coughing and shortness of breath decreases.
- In 1 year, risk of coronary heart disease is about half that of a non-tobacco user.
- In 5 Years, stroke risk is reduced.
- In 10 years, risk of lung cancer is reduced by 50%
- In 15 years, risk of heart disease is similar to person who never smoked.

Health Benefits
- No bad breath
- Reduced risk of cancer
- Improved capacity of taste and smell

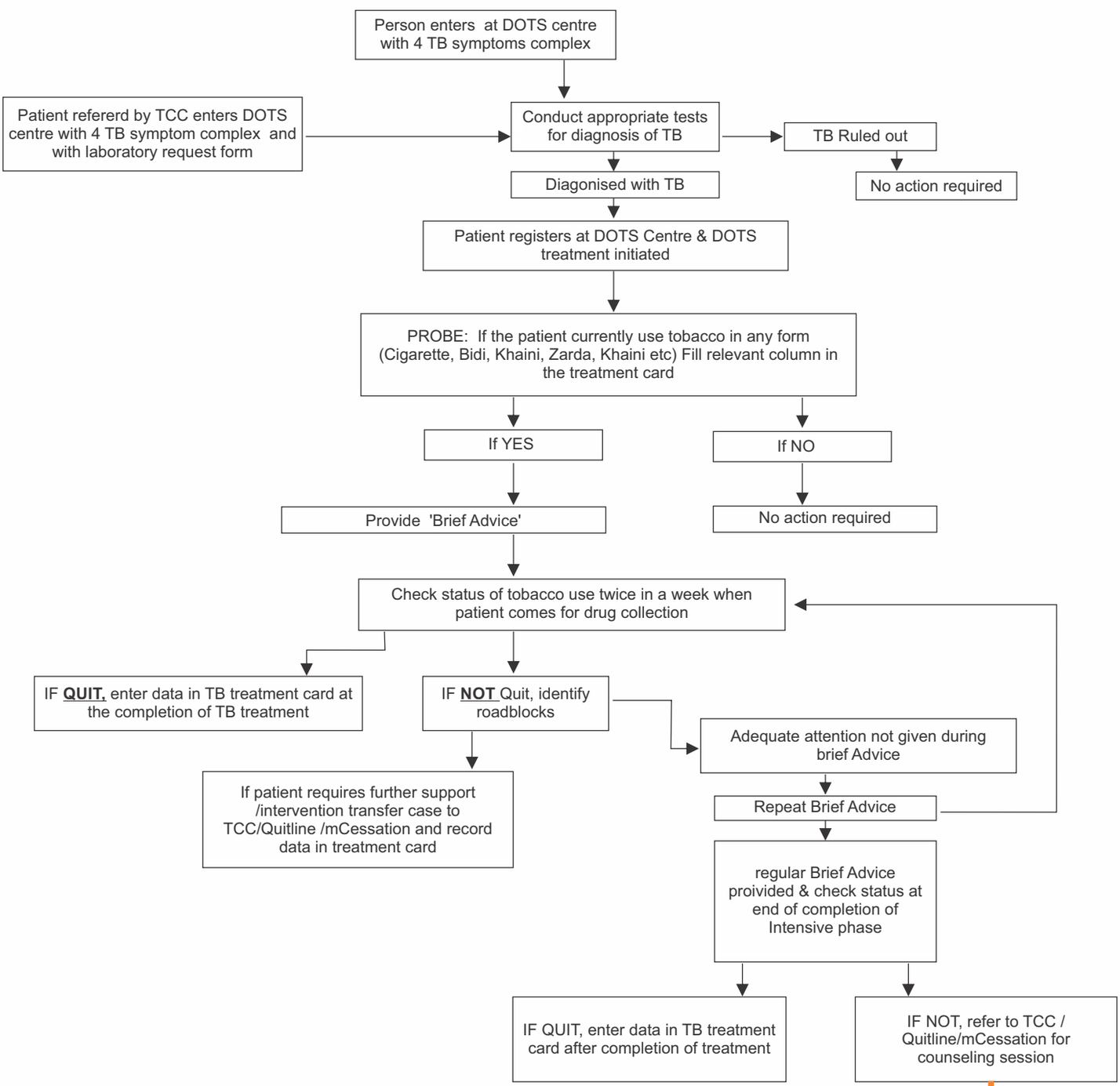
Financial Benefits
- Money saved
- Reduced health care expenditure

Social Benefits
- Tobacco free generation
- No negative impact on children
- You will be a good role model for your children

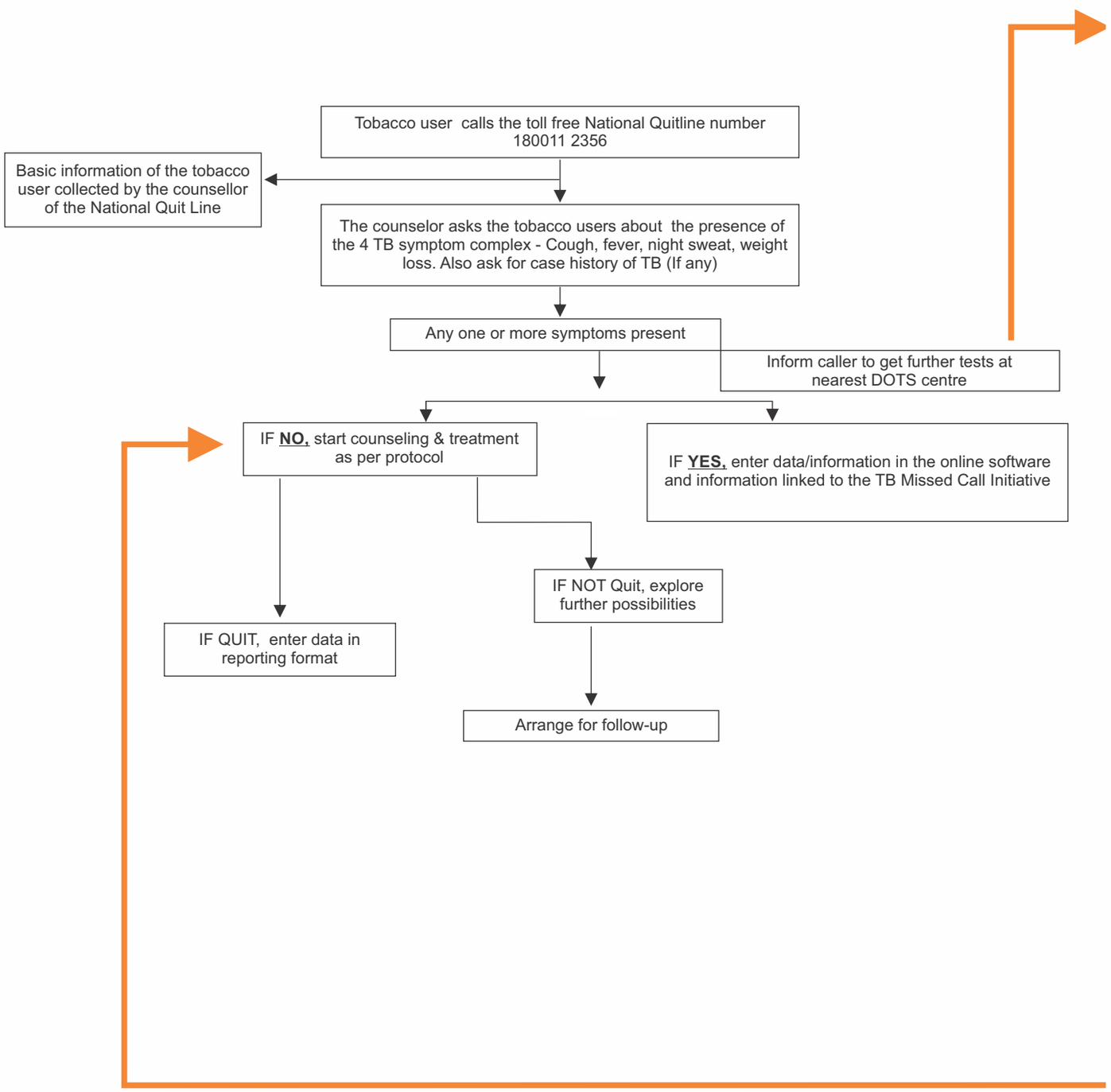
National Framework for Joint TB- Tobacco C



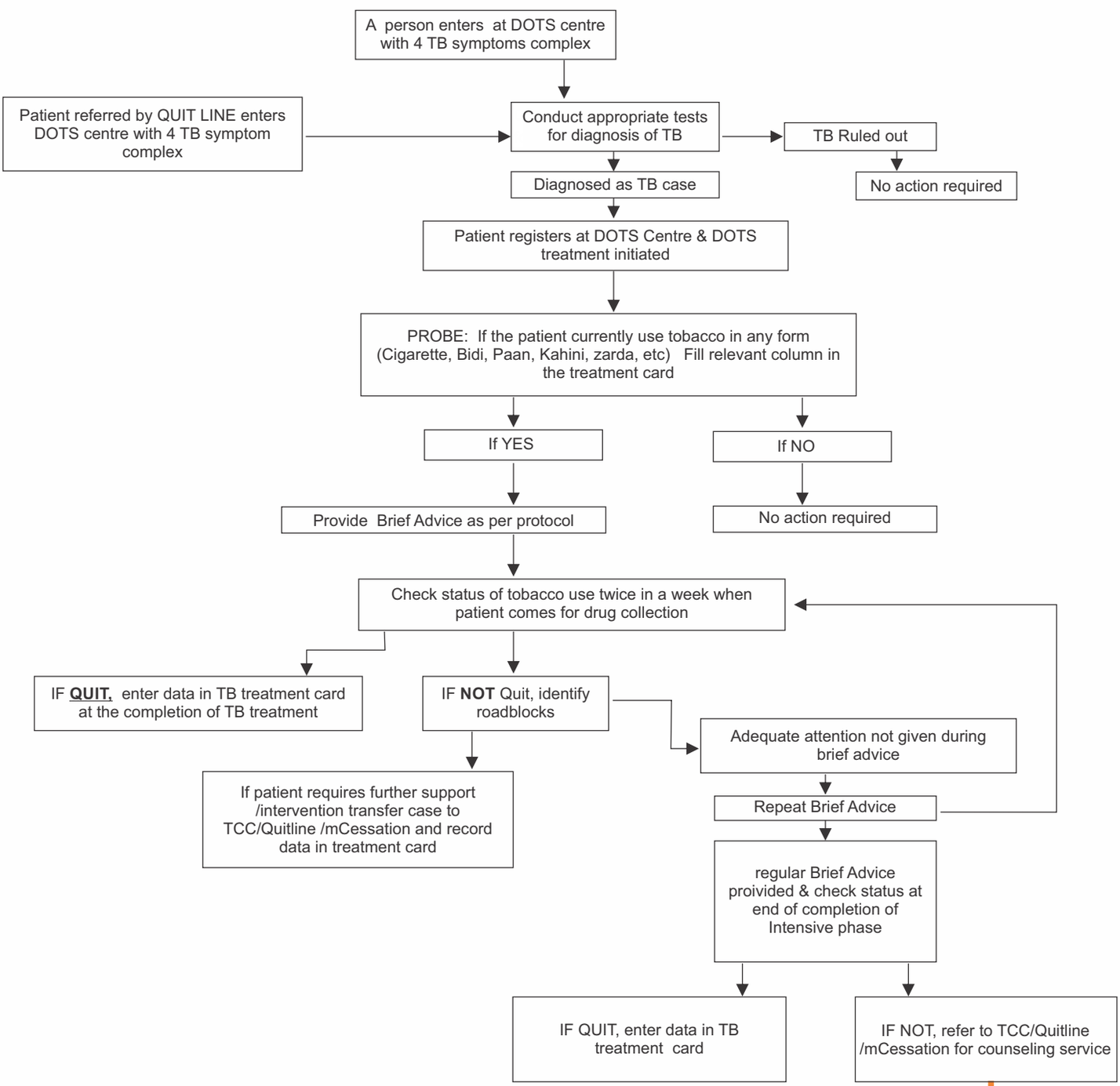
ollaborative Activities



National Framework for Joint TB-Tobacco Collaborative A



ctivities (National Tobacco Quitline)



National Tobacco Quitline Dashboard (Suggested)

References

1. Global Tuberculosis Control 2016. Geneva: World Health Organization; 2016.
2. Mathers et al Updated projections of global mortality and burden of disease, 2002-2030: data sources, methods and results. WHO 2006.
3. American Cancer Society Tobacco Atlas, 2015.
4. WHO 2016.Tuberculosis control in the South-East Asia Region Annual Report, 2016.
5. Directorate General of Health Services, TB India, Annual Report, 2016.
6. FAO 2003, Issues in Global Tobacco Economy: Selected case studies.
7. Global Adult Tobacco Survey, 2009-2010.
8. Kaur, et al.: Promoting tobacco cessation by integrating ''Brief Advice'' in tuberculosis control programme. WHO South-East Asia J Public Health 2013;2:28-33.
9. Prasad R, et al. A case control study of tobacco smoking and tuberculosis in India. Ann Thorac Med 2009;4:208-10.
10. WHO 2007, A WHO/ The Union monograph on TB and tobacco control: joining efforts to control two related global epidemics.
11. Wang J, Shen H. Review of cigarette smoking and tuberculosis in China: Intervention is needed for smoking cessation among tuberculosis patients. BMC Public Health 2009;9:292.
12. Schneider NK, Novotny TE. Addressing smoking cessation in tuberculosis control. Bull World Health Organ 2007;85:8201. 24.
13. Basu S, et al. Projected effects of tobacco smoking on worldwide tuberculosis control: Mathematical modelling analysis. BMJ 2011;343:d5506.
14. WHO report on the global tobacco epidemic, 2015.
15. Sarkar BK et al, A cluster randomized controlled trial of a brief tobacco cessation intervention for low-income communities in India: study protocol, Addiction. 2014 Mar;109(3):371-8. doi: 10.1111/add.12420.

World Health Organization
COUNTRY OFFICE FOR India

Developed for Ministry of Health & Family Welfare by WHO Country Office for India