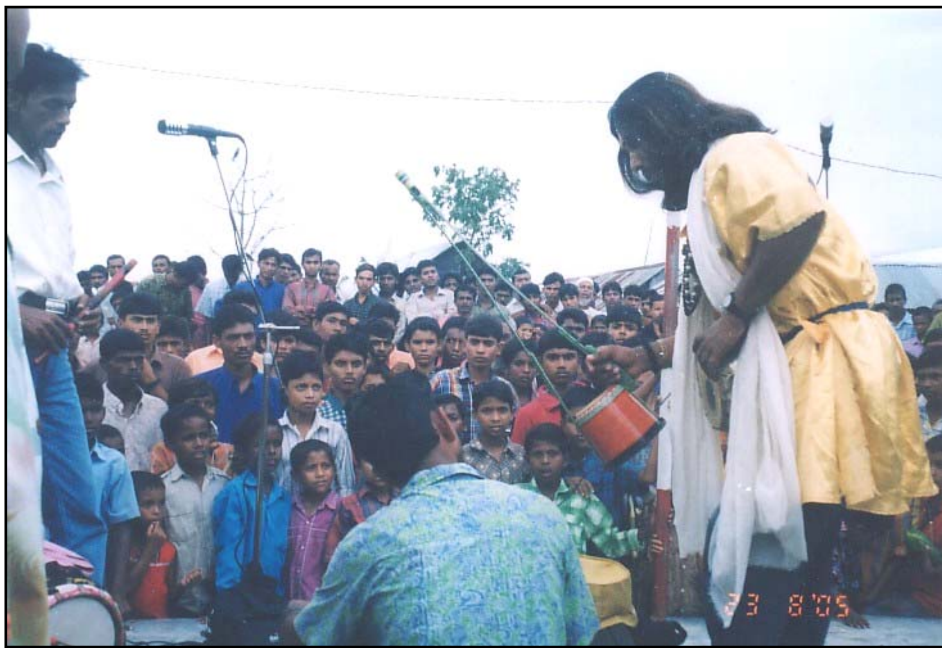
Advocacy, Communication and Social Mobilization



Training Manual for TLCAs

BANGLADESH

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1. INTRODUCTION TO ACSM

Definition:
Advocacy, Communication and Social Mobilization (ACSM) is a multi-level strategy for promoting and sustaining safe behavior among individuals and communities by disseminating health messages through a variety of communication channels.

The goals of ACSM:

ACS strategies in TB/Leprosy aim to create a demand for information and services relevant to recognition of early symptoms, completion of treatment (For TB - through DOT), defaulter tracing, and management of side effects.

Specific objectives

Some specific ACS objectives include:

- Develop knowledge and skills of individuals and communities to identify the early sign/symptoms of TB/Leprosy.
- Promote care-seeking behavior of people; specially people with cough and suspected Leprosy lesions.
- Promote treatment under DOT.
- Promote regular treatment and Follow-up examinations.

2. INTERACTION WITH THE PATIENTS AND COMMUNITY

The most important thing is our attitude towards patients. Let patients feel that we understand their sufferings and we are aware of their problem in the same way that they themselves are aware of it (empathic relationship). For this we should listen very well to the patient's problems.

There is no doubt that there are several barriers for patients as well as for us to over-come all problem patients have. However, an empathic relationship (as explained above) with the patients and good information on the disease can limit the barriers in favor of continuity of treatment.

2.1 Communication

2.1.1 Definition:

Communication is defined as the process by which people attempt to share, meaning via the transmission of symbolic messages.

2.1.2 Communication Types:

- Verbal and Non verbal
- One way and Two way

2.1.3 Elements of communication:

- Sender
- Message
- Media
- Receiver
- Feedback

2.1.4 Aspects of Communication:

- Listening
- Observing
- Speaking

2.2 Inter personal communication (IPC)

2.2.1 Definition:

Interpersonal communication is face to face verbal or non-verbal exchange of information & feeling between two or more people.

2.2.2 Qualities of a good communicator:

- Empathy *(trying to understand how another person feels)*
- Respect for others
- Having good communications skill
- Tolerance for values & beliefs different from one's own.
- Unbiased attitude towards others
- Gentleness
- Patience
- Friendliness

2.2.3 Important tips for a communication:

Active listening: Listening is the key of communication. Through listening to patients. Active listening is characterized by paying attention to what is being said and also observing non-verbal communication of the client. Giving full attention is demonstrated by actions such as having eye contact and nodding.

Reflection: This helps to show that the provider has empathy and respect for the client and her feelings

Summarizing and paraphrasing: Miscommunication can happen very easily when two people discuss something. To prevent miscommunication when listening to client's problem or when sharing information with a client it is useful to summarize or paraphrase what has been said.

Praise and encouragement: It helps to build a client's sense of confidence and reinforce desired behavior. Giving information should be based on what the client already knows. Information should be given clearly and in non-technical language so that the client understands.

2.3 Selective perception:

2.3.1 Definition:

Selective perception means that:
01. People select what they want to see.
02. They also interpret selectively what they see.
03. They also choose what they want to remember and forget.

A proverb related to Learning: "I here I forget, I see I remember, I do I understand."

2.3.2 Types of questions:

- Open question
- Closed question
- Leading question
- Forced choice question
- Multiple choice question
- Probing question.

2.3.3 Quality of message

The message should be:

- Accurate
- Brief
- Clear
- Direct to the point and
- Easy

2.4 Reception of Patients

2.4.1 Definition:

Reception is the first contact with the patients.

By cordial reception, patient should:
- Feel comfort.
- Think worker as a friend, well-wisher and dependable person to express his or her problems.

2.4.2 How patient should be received cordially?

Patient should be received with smiling face and with cordial manner. During receiving a patient we have to consider his/her age group, sex etc.

- For older age group of clients:
  Addressing – Chacha/Chachi, Kaka/Kaki, Bhai/Apa/Didi etc.
  Greetings – Salam/Adab/Nomosker/Good morning and so on.
  Physical contact – Hand shake, touching shoulder (among same gender)
  Asking – To have a seat.

- For same age group of clients:
  Addressing – Bhai/Apa/Didi etc.
  Greetings – Salam/Adab/Nomosker/Good morning and so on.
  Physical contact – Hand shake, touching shoulder (among same gender)
  Asking – To have a seat.
- For younger age group of clients:
  Addressing – By name or Choto Bhai/Choto bone etc.
  Greetings – As responded by the recipient.
  Physical contact –Touching shoulder. (Among same gender)
  Asking – To have a seat.

2.5 Conducting a health education session

2.5.1 Preparation for the sessions:

- Objective of the session.
- Up to date information.
- Organized information.
- Mental preparation about approach to be used to help the audience learn & practice.
- Make available all necessary materials.
- Select appropriate visual aids.
- Test the equipment to be used.

2.5.2 Conduct the session:

- Be punctual in session.
- Greet & welcome participants, Ensure good relationship.
- Introduce self & anyone else who may assisting
- Acknowledge the presence of leaders & influential people.
- Introduce the topic in a stimulating way.
- Communicate clearly.
- Utilize prepared approach for presenting.
- Use common examples.
  - ✓ Which do the patients know?
  - ✓ Which are comparable to the messages.
- Encourage the audience to participate & ask questions.
- Provide information of services availability
- Teaching; means – **EDIP**
  - ✓ **E** -Explain (Tell)
  - ✓ **D** -Demonstrate (Show)
  - ✓ **I** -Imitate (Do)
  - ✓ **P** -Practice (Review)
- Take feedback; To check –
  - ✓ Patients'/peoples' understanding.
  - ✓ Patients'/peoples' realization.
- Thank audience for participation.

2.5.3 Evaluation of session:

- Ask a few question from the content to assess their learning & understanding

Ask their opinion about usefulness of the session & how they might use what they learned. Involvement of general people by conducting Health Education Sessions for case finding

2.5.4 Quality of a good health care provider:

- Acceptable to the community
- Self-motivated & responsible to duties
- A man of good personality but friendly
- Have respect to others beliefs & expectations
- Empathetic with the feelings of community people
- Have vast knowledge of assigned topic/duties
- Well trained
- Able to understand the reality
- Clever enough to utilize all opportunities

2.6 Group Health Education at different settings

2.6.1 Health education program at OPD of UHC/Sador Hospital/Other (FWC/RD/SC):

In OPD everyday a lot of people from different villages of the Upazila are coming to seek care. It is an opportunity for us to disseminate information about TB/Leprosy in different places of the Upazila through them - are coming to UHC for their health problem. We know OPD of UHC/other is a busy place; people come to UHC/other centers with their different health problems, so you have to consider this thing before arranging the session. If you request the responsible person – (who gives ticket to the out patients) to stop giving ticket for few minutes to arrange a session then it will be easier to conduct session. After completion of the session the responsible person can start giving ticket again.

Remember, in the OPD of UHC HE session should be arranged in each working day. For other OPD (FWC, RD, CC etc) HE program should be arranged during field visit - if clinic is open and clients are available.

2.6.2 HE program at UHC – ID

HE program in Indoor of UHC (with admitted patients and their attendant) should be arranged weekly 2 (One in female word, one in Male word). To arrange HE program you can discuss with on duty nurse.

2.6.3 HE program with School teachers/Students

During field visit, you can go to the school, discuss with the Teachers and arrange sessions for them. It is better to arrange session in each class (if students' number is not very few).

2.6.4 HE program in the clinic with the patients' attendants

You can make a group comprising all the attendants in the clinic, and conduct sessions for them.

2.6.5 HE program at the community during field visit

Depending upon work schedule we have to visit the field for different purposes. Remember that field visit should be cost effective i.e. multi purpose works in a visit; e.g.: Suppose you want to go to Village "Sundarpur" of "Maigbug "union for visiting a DOT provider and supply medicines to him. You can think about the way you have planned to run; if there are any other DOT providers? – You can visit and conduct a HE session on TB/Leprosy – if there is any gathering of people. Any VD or Cured patients? – Visit them and conduct HE programs. Any FWC or RD? – Think about conducting HE session, any gathering of people? – Try to conduct HE session – If situation permit you. Any absentee/Defaulter patients – Visit their house and conduct HE sessions.

2.7 Objective, contents and materials for conducting group HE session for case finding

Objective:
After completion of the session the participants will be able to suspect TB/Leprosy, report to clinic voluntarily and refer suspected TB/Leprosy cases to the clinic.

Contents:
- Signs/Symptoms of TB/Leprosy
- Why treatment needed?
- Facilities – free of cost examination and treatment.

Materials can be used:
- Flip chart – TB/Leprosy
- Atlas.

2.8 Passive Contact checking of TB patients

It is observed that contacts of positive cases in some cases are diagnosed very late (even after one year of suffering). To promote early case detection among contacts it is recommended to systematically enquire with all diagnosed positive cases for the their contacts or neighbors, if anybody having symptoms of TB and to note in the treatment cards. In case contacts having coughs for two weeks or more do the sputum examination.

Also enquire for contact children who are apparently not healthy and ask to bring the child to the clinic. TLCAs will score such children using the scoring chart (shown in annex of TB manual). TLCAs will refer the child with score 5 or above to MO for assessment.

2.9 Health education for case holding

2.9.1 Pretreatment HE

Before starting treatment you have to educate the patient about his/her disease, responsibility and role in the community.

Objective: After completion of the session, the participant will be able to complete prescribed treatment regularly, report to clinic if any problem and refer TB/Leprosy suspect to the clinic.

Contents:
- Diagnosis of his/her disease.
- Cause
- How to cure?
- Benefit of regular treatment

- Daily doses from the FDP and its importance (For TB) and for leprosy – Daily self-administer doses.
- Probable side effects/complications
- **Personal hygiene**, Using piece of cloth during coughing, sputum not in the floor, in a pot etc.
- Patient' responsibility to referring suspect (better to give information on the 1st day about the disease by which he/she has been suffering from, another day about other disease TB/Leprosy)
- Next clinic day.

Materials can be used:
- Flipchart/Atlas
- Drugs (Anti-TB/Anti-Leprosy)
- Patients' treatment card
- "Self retaining card" (Patients' identity card)

2.9.2 HE to continue regular treatment

Some patients may be reluctant to take medicines regularly. In this case you have to find out the real cause and **look together with the patient** how to overcome the problem.

Objective: After completion of the session the participant will be able to complete prescribed doses regularly.

Contents:
- Cause finding and remove.
- Benefit of regular treatment.
- Danger of irregular/incomplete treatment.

Materials can be used:
- Flipchart/Atlas
- Drugs (Anti-TB/Anti-Leprosy)
- Patients' treatment card
- "Self retaining card" (Patients' identity card)

2.9.3 HE at completion of treatment

Objective:
After completion of the session the participant will be able to report to clinic if any problem occur (related to the patient's disease – TB/Leprosy) and refer suspect.

Contents: same as before
- Thanks for completion of treatment.
- Signs symptoms of reactivation (Relapse)
- Reporting
- Disseminate information to the community about availability of TB/Leprosy services.
- Referral of suspects.

Materials can be used:

- Flipchart/Atlas
- Patients' treatment card
- "Self retaining card" (Patients' identity card)

2.9.4 HE on care for anesthetic palm/sole - Leprosy.

Objective:

After completion of the session the participant will be able to prevent further worsening of present status of the palm/sole and prevent ulcer.

Contents:

- Cause explanation.
- Probable danger for anesthetic part.
- How to keep the part out of danger.
- Cares.
- Reporting to the clinic – if any problem
- Using protective appliances (For plantar surface – foot wear, for palm gloves or other protective appliances)

Materials can be used:

- Flipchart
- Protective Footwear/Other appliances.
- Bowl, Water, Pumice stone, Vaseline/Oil etc.

2.9.5 HE on Ulcer care - Leprosy

For caring ulcer you have to keep in mind about **5Cs.**

- C = Cause finding and remove
- C = Clean the ulcer
- C = Cover the ulcer
- C = Crutch (For rest)
- C = Complaint (Reporting to the clinic for any worsening)

Objective:

After completion of the session the participant will be able to care his/her ulcer at home that worsening can be prevented and finally healed.

Contents:

- 5 Cs

Materials can be used:

- Flipchart
- Bowl, Water, Pumice stone/Surgical blade with handle, Vaseline/Oil etc.
- Gauze, Bandage, PP etc.
- Crutch
- Antibiotics

2.10 What patient should know about his/her disease

1. What disease is she / he suffering from?
Tell about his /her disease in a way that patients feels enough confidence that you are the right person to relieve his/her sufferings.

2. What is the cause of this disease?
Explain in a very simple way that it caused by a germ.

3. How does it spread from one person to another?
This germ spread through coughing and sneezing. However a patient under treatment can't spread the germ.

4. What measures can she / he take to stop spreading?
- Talk about personal hygiene, use of handkerchief during coughing, not to spit here and there.
- Keep the doors and windows open when ever possible. The air follow will takeout the germs from the room.

5. Is it a curable disease?
- Assure the patient that with this treatment he will be completely cured provided that he/ she took prescribed drugs regularly.

6. What can we do to cure him / her?
- We can provide free service/ investigation / drugs / eventually hospital admission.
- Our service remains open Saturday to Thursday from 8 AM to 5 PM.

7. What kind of help do we need from the patient to cure him / her?
- We want the patient to comply with the treatment.
- Try to find out if there is any problem for the patient to comply with the treatment. Look for the solutions together.

8. What is the duration of treatment?
- 6 to 9 months for TB and maximum up to one year for Leprosy.

9. What could be the out-come of regular treatment?
- They will be cured
- They will be able to enjoy life again as before
- No spreading of the disease to healthy people.

10. What is the danger of irregular treatment/ no treatment?
- Treatment that is interrupted or incomplete can't cure the disease. This may result in death in TB and disability in Leprosy.

11. When to suspect some one for Leprosy / TB?
- Explain simply the suspected lesion of Leprosy with-out mentioning color or anesthesia (i.e. any non itching skin lesion except birth mark) and for TB, cough for more than 3 weeks.

In hospital / clinic, patients with specific problems should receive individualized information of his / her own problem (s) and needs such as self care. Each Leprosy patient with grade 1 / grade 2 disability should know how to take care of his / her limbs to prevent further damage. I.e. ***What, why, how and when?***

1. Why do they need to examine their hand, feet and eye everyday?
2. How to examine?
3. What to do if there is a problem?
4. Why do they need daily soaking?
5. When to do dressing?
6. How to do dressing?
7. Why do they need this special shoe?
8. Why to do exercise and how to do?

2.11 What patient should know about his/her disease

In Hospital we suggest general HE session for all patients together on:

1. Aim of Damien Foundation activities
   I.e. we want to help to control TB/ Leprosy from the community they live in.
2. What do we expect from them?
   - 1st of all that they comply with their treatment.
   - 2nd, when they go back to their own community send suspects to us, to support and motivate others, to spread positive news, reduce stigma.

3. THE STOP TB STRATEGY

3.1 Vision, Goal and Objectives

Vision: A WORLD FREE OF TB

Goal: To dramatically reduce the global burden of TB by 2015 in line with the Millennium Development Goals and the Stop TB Partnership targets

Objectives:

- Achieve universal access to high-quality diagnosis and patient-centered treatment
- Reduce the human suffering and socioeconomic burden associated with TB

• Protect poor and vulnerable populations from TB, TB/HIV and multi-drug-resistant TB
• Support development of new tools and enable their timely and effective use

3.2 Targets

MDG 6, Target 8: Halt and begin to reverse the incidence of TB by 2015

• Targets linked to the MDGs and endorsed by Stop TB Partnership:

- By 2005: detect at least 70% of new sputum smear-positive TB cases and cure
- at least 85% of these cases

- By 2015: reduce prevalence of and deaths due to TB by 50% relative to 1990

- By 2050: eliminate TB as a public health problem (<1 case per million population)ISION A WORLD FREE OF TB

3.3 Components of the STOP TB Strategy:

3.3.1 Pursue high-quality DOTS expansion and enhancement

a. Political commitment with increased and sustained financing.
b. Case detection through quality-assured bacteriology
c. Standardized treatment with supervision and patient support
d. An effective drug supply and management system
e. Monitoring and evaluation system, and impact measurement

3.3.2 Address TB / HIV, MDR-TB and other challenges

• Implement collaborative TB/HIV activities
• Prevent and control multidrug-resistant TB
• Address prisoners, refugees and other high-risk groups and special situations

3.3.3 Contribute to Health System strengthening

• Actively participate in efforts to improve system-wide policy, human resources, financing, management, service delivery, and information systems
• Share innovations that strengthen systems, including the Practical Approach to Lung Health (PAL)
• Adapt innovations from other fields

3.3.4 Engage all care providers

• Public-Public, and Public-Private Mix (PPM) approaches
• International Standards for TB Care (ISTC)

3.3.5 Empower people with TB, and Communities

- Advocacy, communication and social mobilization
- Community participation in TB care
- Patients’ Charter for Tuberculosis Care

3.3.6 Enable and promote research

- Programme-based operational research
- Research to develop new diagnostics, drugs and vaccines

4. THE PATIENTS’ CHARTER FOR TUBERCULOSIS CARE

4.1 Introduction

The patients’ Charter for Tuberculosis Care (The Charter) outlines the rights and responsibilities of people with Tuberculosis. It empowers people with the disease and their communities through this knowledge. Initiated and developed by patients from around the world, the “The Charter” makes the relationship with healthcare providers a mutually beneficial one.

The Charter sets out the ways in which patients, the community, health providers (both private and public) and governments can work as partners in a positive and open relationship with a view to improving tuberculosis care and enhancing the effectiveness of the healthcare process. It allows for all parties to be held more accountable to each other, fostering mutual interaction and a “positive partnership”.

The Patients’ Charter for Tuberculosis care practices the principle of Greater Involvement of People with Tuberculosis (GIPT). This affirms that the empowerment of people with the disease is the catalyst for effective collaboration with health providers and authorities and is essential to victory in the fight to stop tuberculosis. The Charter, the first global “patient-powered” standard for care, is a cooperative tool, forged from common cause, for the entire tuberculosis community.

4.2 Patients’ Rights:

The patients’ have the right to –

Care:

- The right to free and equitable access to tuberculosis care, from diagnosis through treatment completion, regardless of resources, race, gender, age, language, legal status, religious beliefs, sexual orientation, culture or having another illness.
- The right to receive medical advice and treatment which fully meets the new International Standards for Tuberculosis Care, centering on patients’ needs, including those with multidrug-

resistance tuberculosis (MDR-TB) or tuberculosis – human immunodeficiency virus (HIV) co-infections and preventative treatment for young children and other considered to be at high risk.

- The right to benefit from proactive health sector community outreach, education and prevention campaigns as part of comprehensive care programs.

Dignity:

- The right to be treated with respect and dignity, including the delivery of services with out stigma, prejudice or discrimination by health providers and authorities.
- The right to quality healthcare in a dignified environment with moral support from family, friends and the community.

Information:

- The rights to information about what healthcare services are available for tuberculosis and what responsibilities, engagements and direct or indirect costs are involved.
- The right to receive a timely, concise and clear description of the medical condition with diagnosis, prognosis (an opinion as to the likely future course of the ill ness) and treatment proposed, with communication of common risks and appropriate alternatives.
- The right to know the names and dosages of any medication or intervention to be prescribed. Its normal actions and potential side-effects and its possible impact on other conditions or treatments.
- The right of access to medical information which relates to the patient's condition and treatment and to a copy of the medical record if requested by the patient or a person authorized by the patient.
- The right to meet, share experiences with peers and other patients and to voluntary counseling at any time from diagnosis through treatment completion.

Choice:

- The right to second medical opinion, with access to previous medical records.
- The right to accept or refuse surgical interventions if chemotherapy is possible and to be informed of the likely medical and statutory consequences within the context of a communicable disease.
- The right to choose whether or not to take part in research programs without compromising care.

Confidence:

- The right to have personal privacy, dignity, religious beliefs and culture respected.
- The right to have information relating to the medical condition kept confidential and released to other authorities contingent upon the patient's consent.

Justice:

- The right to make a complaint through channels provided for this purpose by the health authority, and to have any complaint dealt with promptly and fairly.

- The right to appeal to a higher authority if the above is not respected and to be informed in writing of the outcome.

Organization:

- The right to join or to establish organizations of people with or affected by tuberculosis and to seek support for the development of these clubs and community based associations through the health providers, Authorities and civil society.

- The right to participate as "stakeholder" in the development, implementation, monitoring and evaluation of tuberculosis policies and programs with local, national and international health authorities.

Security:

- The right to job security after diagnosis or appropriate rehabilitation upon completion of treatment.
- The right to nutritional security or food supplements if needed to meet treatment requirements.

4.3 Patients' responsibilities (TB patients)

The patients' have the responsibility to:

Share information:

- The responsibility to provide the health care giver as much information as possible about present health, past illness, any allergies and any other relevant details.
- The responsibility to provide information to the health provider about contacts with immediate family, friends and others who may be vulnerable to Tuberculosis or may have been infected by contact.

Follow treatment:

- The responsibility to follow the prescribed and agreed treatment plan, and to conscientiously comply with the instructions given to protect the patients' health, and that of others.
- The responsibility to inform the health provider of any difficulties or problems with following treatment or if any part of the treatment is not clearly understood.

Contribute to Community Health:

- The responsibility to contribute community well-being by encouraging others to seek medical advice if they exhibit the symptoms of Tuberculosis.

- The responsibility to show consideration for the rights of other patients and healthcare providers, understanding that this is the dignified basis and respectful foundation of the tuberculosis community.

Show Solidarity:

- The moral responsibility of showing solidarity with other patients, marching together towards cure.

- The moral responsibility to share information and knowledge gained during treatment and to pass this expertise to others in the community, making empowerment contagious.

- The moral responsibility to join in efforts to make the community tuberculosis free.

5. INTERNATIONAL STANDARDS FOR TB CARE

5.1 Introduction

The purpose of the International Standards for tuberculosis care (ISTC) is to describe a widely accepted level of care that all practitioners, public and private, should seek to achieve in managing patients who have, or are suspected of having tuberculosis. The standards are intended to facilitate the effective engagement of all care providers in delivering high-quality care for patients of all ages, including those with sputum smear-positive, sputum smear-negative, and extra pulmonary tuberculosis, tuberculosis cause by drug-resistance *Mycobacterium tuberculosis* complex (*M. tuberculosis)* organism, and tuberculosis combined with human immunodeficiency virus (HIV) infection.

5.2 Standard for Diagnosis

STANDARD 1.

All persons with otherwise unexplained productive cough lasting two–three weeks or more should be evaluated for tuberculosis.

STANDARD 2.

All patients (adults, adolescents, and children who are capable of producing sputum) suspected of having pulmonary tuberculosis should have at least two, and preferably three, sputum specimens obtained for microscopic examination. When possible, at least one early morning specimen should be obtained.

STANDARD 3.

For all patients (adults, adolescents, and children) suspected of having extrapulmonary tuberculosis, appropriate specimens from the suspected sites of involvement should be obtained for microscopy and, where facilities and resources are available, for culture and histopathological examination.

STANDARD 4.
All persons with chest radiographic fi ndings suggestive of tuberculosis should have sputum specimens submitted for microbiological examination.

STANDARD 5.
The diagnosis of sputum smear-negative pulmonary tuberculosis should be based on the following criteria: at least three negative sputum smears (including at least one early morning specimen); chest radiography fi ndings consistent with tuberculosis; and lack of response to a trial of broad-spectrum antimicrobial agents. (NOTE: Because the fl uoroquinolones are active against *M. tuberculosis complex* and, thus, may cause transient improvement in persons with tuberculosis, they should be avoided.) For such patients, if facilities for culture are available, sputum cultures should be obtained. In persons with known or suspected HIV infection, the diagnostic evaluation should be expedited.

STANDARD 6.
The diagnosis of intrathoracic (i.e., pulmonary, pleural, and mediastinal or hilar lymph node) tuberculosis in symptomatic children with negative sputum smears should be based on the fi nding of chest radiographic abnormalities consistent with tuberculosis and either a history of exposure to an infectious case or evidence of tuberculosis infection (positive tuberculin skin test or interferon gamma release assay). For such patients, if facilities for culture are available, sputum specimens should be obtained (by expectoration, gastric washings, or induced sputum) for culture.

5.3 Standards for Treatment

STANDARD 7.
Any practitioner treating a patient for tuberculosis is assuming an important public health responsibility. To fulfi ll this responsibility the practitioner must not only prescribe an appropriate regimen but, also, be capable of assessing the adherence of the patient to the regimen and addressing poor adherence when it occurs. By so doing, the provider will be able to ensure adherence to the regimen until treatment is completed.

STANDARD 8.
All patients (including those with HIV infection) who have not been treated previously should receive an internationally accepted fi rst-line treatment regimen using drugs of known bioavailability. The initial phase should consist of two months of isoniazid, rifampicin, pyrazinamide, and ethambutol. The preferred continuation phase consists of isoniazid and rifampicin given for four months. Isoniazid and ethambutol given for six

months is an alternative continuation phase regimen that may be used when adherence cannot be assessed, but it is associated with a higher rate of failure and relapse, especially in patients with HIV infection. The doses of antituberculosis drugs used should conform to international recommendations. Fixed-dose combinations of two (isoniazid and rifampicin), three (isoniazid, rifampicin, and pyrazinamide) and four (isoniazid, rifampicin, pyrazinamide, and ethambutol) drugs are highly recommended, especially when medication ingestion is not observed.

STANDARD 9.

To foster and assess adherence, a patient-centered approach to administration of drug treatment, based on the patient's needs and mutual respect between the patient and the provider, should be developed for all patients. Supervision and support should be gender-sensitive and age-specifi c and should draw on the full range of recommended interventions and available support services, including patient counseling and education. A central element of the patient-centered strategy is the use of measures to assess and promote adherence to the treatment regimen and to address poor adherence when it occurs. These measures should be tailored to the individual patient's circumstances and be mutually acceptable to the patient and the provider. Such measures may include direct observation of medication ingestion (directly observed therapy—DOT) by a treatment supporter who is acceptable and accountable to the patient and to the health system.

STANDARD 10.

All patients should be monitored for response to therapy, best judged in patients with pulmonary tuberculosis by follow-up sputum smear microscopy (two specimens) at least at the time of completion of the initial phase of treatment (two months), at five months, and at the end of treatment. Patients who have positive smears during the fifth month of treatment should be considered as treatment failures and have therapy modified appropriately. (See Standards 14 and 15) In patients with extra-pulmonary tuberculosis and in children, the response to treatment is best assessed clinically. Follow-up radiographic examinations are usually unnecessary and may be misleading.

STANDARD 11.

A written record of all medications given, bacteriologic response, and adverse reactions should be maintained for all patients.

STANDARD 12.

An areas with a high prevalence of HIV infection in the general population and where tuberculosis and HIV infection are likely to co-exist, HIV counseling and testing is indicated for all tuberculosis patients as part of their routine management. In areas with lower prevalence rates of HIV, HIV counseling and

testing is indicated for tuberculosis patients with symptoms and/or signs of HIV-related conditions and in tuberculosis patients having a history suggestive of high risk of HIV exposure.

STANDARD 13.
All patients with tuberculosis and HIV infection should be evaluated to determine if antiretroviral therapy is indicated during the course of treatment for tuberculosis. Appropriate arrangements for access to antiretroviral drugs should be made for patients who meet indications for treatment. Given the complexity of coadministration of antituberculosis treatment and antiretroviral therapy, consultation with a physician who is expert in this area is recommended before initiation of concurrent treatment for tuberculosis and HIV infection, regardless of which disease appeared first. However, initiation of treatment for tuberculosis should not be delayed. Patients with tuberculosis and HIV infection should also receive co-trimoxazole as prophylaxis for other infections.

STANDARD 14.
An assessment of the likelihood of drug resistance, based on history of prior treatment, exposure to a possible source case having drug-resistant organisms, and the community prevalence of drug resistance, should be obtained for all patients. Patients who fail treatment and chronic cases should always be assessed for possible drug resistance. For patients in whom drug resistance is considered to be likely, culture and drug susceptibility testing for isoniazid, rifampicin, and ethambutol should be performed promptly.

STANDARD 15.
Patients with tuberculosis caused by drug-resistant (especially multiple-drug resistant [MDR]) organisms should be treated with specialized regimens containing second-line anti-tuberculosis drugs. At least four drugs to which the organisms are known or presumed to be susceptible should be used, and treatment should be given for at least 18 months. Patient-centered measures are required to ensure adherence. Consultation with a provider experienced in treatment of patients with MDR tuberculosis should be obtained.

5.4 Standards for Public Health Responsibilities

STANDARD 16
All providers of care for patients with tuberculosis should ensure that persons (especially children under 5 years of age and persons with HIV infection) who are in close contact with patients who have infectious tuberculosis are evaluated and managed in line with international recommendations. Children under 5 years of age and persons with HIV infection who have been

in contact with an infectious case should be evaluated for both latent infection with *M. tuberculosis* and for active tuberculosis.

STANDARD 17.
All providers must report both new and re-treatment tuberculosis cases and their treatment outcomes to local public health authorities, in conformance with applicable legal requirements and policies.

6. ACSM IN DF BANGLADESH

In Damien Foundation - Bangladesh, we are practicing different types of ACSM activities in the field of Tuberculosis/Leprosy:

6.1 TB Club:

Each cured patient is a living signboard for the community that TB/Leprosy is curable and the treatment of TB/Leprosy is free of cost. The Damien Foundation Bangladesh is using this theme since 2000 to promote the TB/Leprosy control program at the community level and achieved highest case finding in several districts of the country. If patients are satisfied with the service provided by the service provider, then they can be used to promote the program in their community. They will look for symptomatic around them and send to the clinic. For further empowerment of the cured patients & strengthen their contribution, DF Bangladesh organizes TB Club members' training/meeting in two steps:

<u>TB Club members' training (At Upazila Level):</u>

To form a TB Club, a one-day training is organized at Upazila level for the selected cured patients of each Union. The TB club members are given responsibility to organize the TB Club meeting in the union level with other cured patients and community elite.

Different tasks for organizing TB Club members' Training at Upazila level:

a) Selection of 4 highly motivated & energetic (can read, write & count - Bangla) former patients from each union (from different locations of the union); if possible involve Female patients.

b) Making a list of those patients for each upazila mentioning their name, age (20 – 45 years), sex, occupation, detail address, treatment status, registration number with date, present physical condition etc.
c) Planning for training of those patients (4/union) at their Upazila headquarters.
d) Selection of training venue, taking permission, finalization of date after discussion with respective UH & FPO.
e) Distribution of letters to the respective patients.
f) Preparation of patients list (Union wise).
g) Collection of training materials, other logistics from project office.
h) Implementation of the program.
i) Distribution of patients list of the Unions to the respective TB Club members.
j) Collection of TB club meeting dates from the TB Club members of their respective Union.
k) Distribution of logistics to the members for organizing meeting at their Union.
l) Reporting to the project office.
m) Follow-up plan.

TB Club meeting (At Union Level):

After completion of the Upazila level Training, the members of the respective Union will organize meeting at union level involving all cured patients and local elite of that Union. DF representative will attend in the meeting on the respective meeting date and will facilitate the meeting. The TB Club members of the respective Union will do other tasks:
a) Selection of meeting date, venue, taking permission from the respective authority etc.
b) Distribution of letters to the respective patients and selected community elite.
c) Agenda selection of the meeting.
   I. Present status of case finding of that Union.
   II. Role of Cured patients & Local elite.
d) Report preparation of the meeting.
e) Making follow-up meeting plan (Next Year).

In that meeting some responsibility should be given to the cured patients individually:
 I. Each cured patient will responsible of their 100 neighboring houses for referring suspects to the clinic.
 II. Providing DOT to the TB patients (if needed).
 III. Referring defaulter patients to the clinic.

It was observed that the number of TB suspects referred by the former patients is increasing day by day. During 2007, a total of 51,322 TB (23% of total) suspects were referred by the cured patients, of whom 3567 (23% of total) confirmed cases were diagnosed. They also refereed 4,130 (20% of total) Leprosy

suspects, among them 155 (23% of total) were confirmed as Leprosy cases. Some of the cured patients are also involved now as Fixed DOT Providers in the union level close to other patients' houses.

6.2 Village Doctors (VDs) Training:

Damien Foundation is the pioneer in involving the Village Doctors[1] in case finding and case holding activities of TB and Leprosy. The organization has trained more than 13,000 VDs in its working area on TB & Leprosy since 1997. The concept to involve VDs is because more than 80% of the people of Bangladesh live in the villages and there is a village doctor for an average of 2000 people. In the villages of rural Bangladesh, the people usually consult village doctors for many health problems, because of easy accessibility, at any time and at low cost. As such this provides an excellent opportunity to ensure patient friendly DOT and improved case finding.

In DF Bangladesh, we arrange two types of Training for Village Doctors:

a) One day Training: DF Bangladesh organizes a one-day Training on Tuberculosis/Leprosy for new VDs, who did not attend in any Training organized by DF Bangladesh. To organize this Training some important tasks should be done properly:
   I. Preparation of a Union wise list of all VDs and selection of new VDs.
   II. Selection of Training date, venue etc.
   III. Informing respective UH & FPO and taking permission.

[1] Un-official health's care provider, who usually uses western medicine for the treatment of common diseases.

IV. Distribution of invitation letter to the respective VDs signed by respective UH & FPO.
V. Organize the training.

In this training some responsibilities should be given to the VDS:

I. Disseminate information on TB/Leprosy to their community on TB/Leprosy (Signs/Symptoms, treatment facilities etc)
II. Supplying sputum pot to the TB suspects.
III. Referring suspected TB/Leprosy cases to the clinic.
IV. Provide DOT (for TB) and referring complicated cases to the clinic.
V. Motivate default patients and referring them to the clinic.

b) Three days Training: Considering the VDs contribution in our program, DF Bangladesh has started a 3 days Training on Management of Essential Common Diseases (including TB and Leprosy) for VDs. Selected VDs acting as Fixed DOT Provider and committed to our program are invited for this training. They are also responsible for:

I. Disseminate information on TB/Leprosy to their community on TB/Leprosy (Signs/Symptoms, treatment facilities etc)
II. Supplying sputum pot to the TB suspects and collection of sputum.
III. Referring suspected TB/Leprosy cases to the clinic.
IV. Provide DOT (for TB) and referring complicated cases to the clinic.
V. Motivate default patients and referring them to the clinic.

The number of TB/Leprosy suspects referred by VDs also increasing day by day. During 2007, a total of 30,943 (14% of total) TB suspects were referred by VDs, among them 2,340 (15% of total) were diagnosed as confirmed TB cases. Village doctors are also involved in providing DOT to the patients. During 2007, about 5, 500 VDs were involved as Fixed DOT Providers. Beside these, during this period; VDs referred 1,561 (8% of total) Leprosy suspects; among them 50 (7% of total) were confirmed as Leprosy cases.

6.3 Fixed DOT Providers Training:

DOT has been decentralized (for TB) to the community level to make it patient friendly through involving VDs, GOB Health and Family planning staffs, Other NGO staffs, Cured patients, School teachers, Religious leaders and Local elite. In each Unions there are such 5/6 FDPs to provide DOT to the patients.

DF Bangladesh organizes one day Training (Refresher training) for the FDPs yearly once at Upazila level. To organize the Training some important tasks are:

- Discussion with respective UH & FPO and taking permission.
- Training date & venue selection.
- Invitation letter distribution (signed by respective UH & FPO) among the FDPs (according to the prepared list of FDPs).
- Implementation of the program.

Responsibilities of FDPs:

I. Disseminate information on TB/Leprosy to their community on TB/Leprosy (Signs/Symptoms, treatment facilities etc)
II. Supplying sputum pot to the TB suspects and collection of sputum.
III. Referring suspected TB/Leprosy cases to the clinic.
IV. Provide DOT (for TB) and referring complicated cases to the clinic.
V. Keeping record.
VI. Motivate default patients and referring them to the clinic.

During the year 2007, about 6162 FDPs were involved in providing DOT at community level.

6.4 Review Meeting:

Review meetings are held in Upazila level involving different sectors (administration, education, health and Family planning etc.) to promote early case finding. TB/Leprosy situation of the respective Upazila is shared with the participants and the participants are insisted on promoting the TB/Leprosy services.

6.5 NGO Workers Orientation:

A one-day orientation on TB/Leprosy for different NGOs working in the same Upazila for health and non-health program is also carried out every year to promote TB/Leprosy case finding.

6.6 Scout & Girls' Guide Orientation:

A one-day orientation on TB/Leprosy for Scout and Girls' Guide is also carried out every year at District level to promote TB/Leprosy case finding.

6.7 Opinion Leader Orientation:

Considering role of the Opinion Leaders in the society, in DF Bangladesh we organize a one-day orientation on TB/Leprosy for Opinion Leaders to promote TB/Leprosy services.

6.8 G P/MO Training:

For further strengthening capacity of Medical Graduate/General Practitioners (GPs) for better management of TB/Leprosy, DF organizes a one-day orientation to introduce National guidelines (NTP).

6.9 GOB H & FP staff Training:

DF Bangladesh also organizes a one-day Training on TB Leprosy for GOB H & FP staff for further strengthening of their capacity to promote TB/Leprosy services.

6.10 Community awareness through "Folk Song" / "Popular Theatre":

In DF Bangladesh we have 1 Folk Song team and/or 1 Popular Theatre team in each district of our project area. The respective teams disseminate TB & Leprosy information through "Folk Song / Popular Theatre" with in their assigned areas.

NB: Besides these, we organize Health Education Program with different group/in different places during field visits.

7. IEC / BCC MATERIALS

7.1 Definition and Types:

Definition:

IEC / BCC or Communication support materials may be anything whose utilization helps audience understand what we want to communicate to them.

Types:

Media Focused:

- Audio
- Visual
- Audio Visual

Customer Number Focused:

- For Mass Media
- Interpersonal Media

Target/User Focused:

- Customer Focused
- Provider Focused

List of IEC/BCC materials and uses:

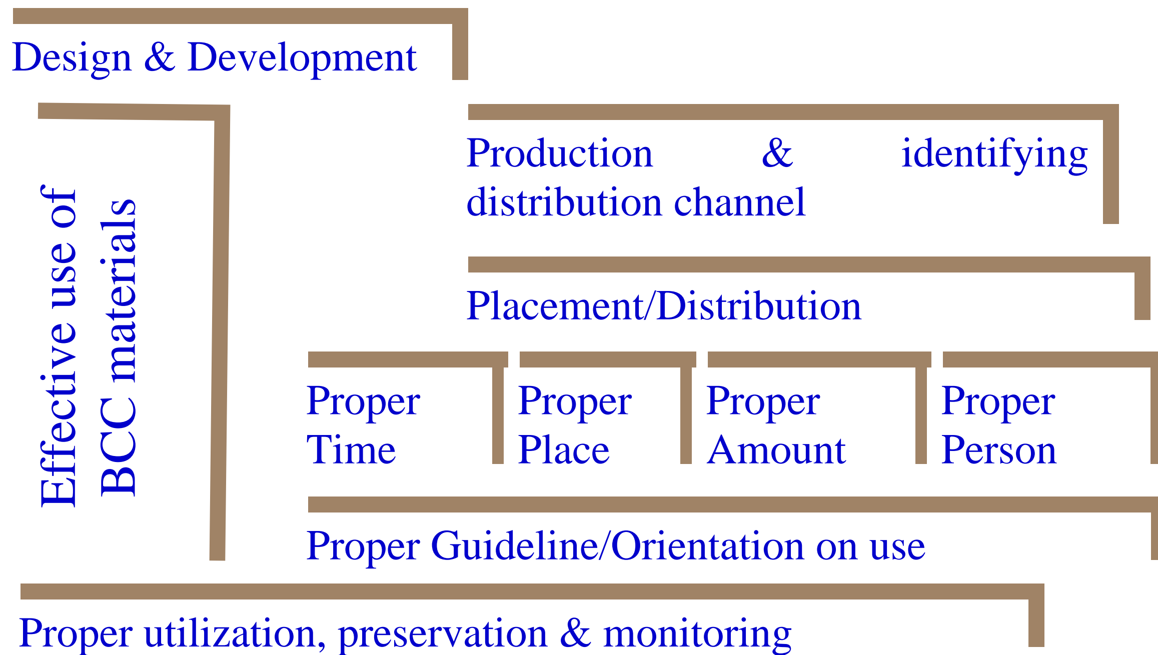
1. Flip chart
   (clinic HE, somity session, OPD, ECS)
2. Pamphlet
   (VD, Health worker, educated people)
3. Poster
   (*Hall room, Auditorium, Health fair, pharmacy, other health center, rally, waiting room, community center, Public gathe3ring places etc.)*
4. Leaflet *(Educated people, can read)*
5. Newsletter *(Educated people working in NGO, GOB worker, Library, Club etc.)*
6. Models/Samples
7. Video/Audio
8. Cue Cards

Usefulness of visual aids as communication

"Picture is worth a thousand words".
People understand more from what they see than what they hear.

7.2 Using IEC / BCC Materials

7.2.1 Diagram:



7.2.2 Are BCC materials important for IPC?

- BCC materials could be the tools for a provider/communicator for effective IPC session.

7.2.3 Why do we use BCC materials?

- Make verbal message clear because of visual supplementation.
- Helps emphasize the major discussion points and makes easier to remember and relate to the reality.
- Works as example and increases the capability.
- Increases audience attention & interest.
- Helps communicators to maintain consistency in providing message.
- Makes the message interesting/Audience are entertained.
- Helps the audiences understand and solve the problem.

7.2.4 How to use BCC materials effectively?

- Assess need of the audience.
- Select materials considering characteristics and types of the audience, session objectives & other aspects.
- Follow "How to use" guideline that comes with manual.

- Have a clear concept on key message of the material before hand, read the print material carefully, see and listen visual or audio materials attentively.
- Create appropriate environment for presentation, make sitting arrangement for the audience.
- Describe objective and what audience will learn from it.
- Attract audience attention to the topic and materials.
- Ensure that the audience is able to see & read it clearly, hear and understand the materials.
- Do not rush, give sufficient time to see and understand.
- Look at the audience, not at the materials.
- Encourage the audience to ask questions.
- Answer appropriately to the questions in easy and brief language.
- Ask the audience for feedback.

7.2.5 When to use BCC materials?

- Group education session (Community/other health facility).
- Counseling session.
- Service areas (e g: Waiting room, OPD/ID of hospital.
- Social gathering.
- Community events.
- During home visits.

7.2.6 Placement & preservation of BCC materials?

- Display the print material in proper place.
- Materials that are distributed among the audience; - read, explain the message and tell them how to preserve.
- Preserve BCC materials properly so that those are not destroyed.