# GUIDELINES
# IN CONDUCTING THE WORKSHOP
## ON STRENGTHENING PMDT CASE FINDING, CASE HOLDING AND REFERRAL SYSTEM

A Step-by-Step Guide
**in Support of the Tuberculosis Control Program**

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# *Guidelines in Conducting the Workshop on Strengthening PMDT Case Finding, Case Holding and Referral System*

## A Step-by-Step Guide in Support of the Tuberculosis Control Program

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## Abbreviations

| | |
|---|---|
| ADR | Adverse Drug Reaction |
| CHO | City Health Office/r |
| CXR | Chest X-ray |
| DOH | Department of Health |
| DOH RO | Department of Health Regional Office |
| DOT | Directly Observed Treatment |
| DOTS | Delivery of TB Services |
| DRTB | Drug-resistant TB |
| DST | Drug Susceptibility Testing |
| iDOTS | Integrated Delivery of TB Services |
| LCE | Local Chief Executive |
| MDR | Multidrug-resistant |
| MHO | Municipal Health Office/r |
| MSWDO | Municipal Social Welfare and Development Officer |
| MTB/RiF | *Mycobacterium tuberculosis*/Rifampicin |
| PCC | Provincial Coordinating Committee |
| PHN | Public Health Nurse |
| PHO | Provincial Health Office/r |
| PMSA | Provincial Multisectoral Alliance |
| PIR | Performance Implementation Review |
| PPD | Purified Protein Derivative |
| PPE | Personal Protective Equipment |
| RCC | Regional Coordinating Committee |
| RHU | Rural Health Unit |
| RO | Regional Office |
| RTDL | Rapid TB Diagnostic Laboratory |
| SB | *Sangguniang Bayan* (municipal legislative council) |
| STC | Satellite Treatment Center |
| TBDC | TB Diagnostic Committee |
| TC | Treatment Center |

## Tools Index

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Input 1. Background on DRTB and PMDT
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How to Pack a Sputum Specimen Package

## About this Toolkit

This toolkit presents the tools, templates, and steps in conducting the Workshop on Strengthening PMDT Case Finding, Case Holding and Referral System in support of the tuberculosis (TB) control program. The tools and templates in this toolkit were based on the collective experiences of local government partners of the **IMPACT Project**.

### For whom is this toolkit?

This toolkit is intended primarily for NTP staff at the Department of Health (DOH) regional offices who are assigned to provide technical assistance to provinces and highly urbanized cities (HUCs), and also for DOH Health Development Management Officers (DMOs) and Provincial/City Health Office NTP team members assigned to conduct the Workshop on Strengthening PMDT Case Finding, Case Holding and Referral System in the province or HUC.

### What does this toolkit contain?

This toolkit consists of a manual explaining the background and rationale for the Workshop on Strengthening PMDT Case Finding, Case Holding and Referral System, and the step-by-step guide for conducting the workshop.

Users of this toolkit may reproduce the tools and templates, including the PowerPoint presentations, provided in this package.

## Introduction

The magnitude of the TB problem has placed the Philippines third among the 30 high-TB burden countries in incident TB cases per 100,000 population, and fifth among the top 30 countries with high multidrug-resistant TB (MDRTB) burden in thousand incident cases (WHO Global TB Report 2017). TB continues to be the country's 8th leading cause of death (DOH, 2013) and 8th top cause of illness (DOH, 2014). The 2016 National Tuberculosis Prevalence Survey showed that the burden of TB remains high among Filipino adults and is higher than previously estimated. About 1 million Filipinos are expected to have the TB disease and may not even know it. Factors associated with high prevalence include weaknesses in health systems and poor health-seeking behavior. Poverty and malnutrition further fuel the spread of TB. While the national government and its development partners have made significant investments in the TB control program, TB remains a major public health challenge with serious economic consequences. TB morbidity and premature mortality result in economic losses valued at PhP8 billion ($171 million) annually (Peabody J. et al., 2005).

The institution of the Directly Observed Treatment, Short Course (DOTS) strategy in 1996 and its nationwide implementation in the public health sector starting 2002 have enabled the country to make significant progress in TB control. Program performance, however, remains variable across cities and municipalities. Moreover, while the TB control program continues to gain broader support and greater momentum, it needs to keep pace with the rate of infection.

The Innovations and Multisectoral Partnerships to Achieve Control of Tuberculosis (IMPACT), a five-year technical assistance (TA) project funded by the United States Agency for International Development (USAID), sought to respond to the abovementioned challenges. The Project provided TA to the Department of Health (DOH) National TB Control Program (NTP) and worked directly with 43 provinces and cities – in Luzon, Visayas, and Mindanao, including the Autonomous Region in Muslim Mindanao – with the greatest burden of TB disease and lowest performance in both case detection and cure rates. IMPACT engaged both public and private sectors at the national and local levels to detect and successfully treat TB cases.

Guided by a harmonized blueprint of technical assistance and research initiatives, as well as the USAID TB Portfolio Results Framework, the Project worked with other USAID cooperating agencies and key partners involved in TB control. IMPACT measured the outcomes of project interventions against a set of national program indicators and targets identified in the enhanced Philippine Plan of Action to Control Tuberculosis (PhilPACT) 2010–2016. IMPACT was implemented from October 2012 to September 2017, with an extension period of seven months from October 2017 to April 2018.

The goal of IMPACT was to reduce TB prevalence by 30%, achieve 85% case detection rate for all forms of TB, and 90% cure rate for new smear-positive cases in all participating sites by 2017 relative to the 2010 baseline.

The Project aimed at achieving three objectives:

- strengthen demand for TB services through adoption of healthy behaviors within families;
- improve supply of TB services, including the availability and quality of public sector services and selective expansion of private sector providers; and
- remove policy and systems barriers to support supply of, and demand for TB services.

IMPACT complemented the health programs of USAID/Philippines and other development partners. Its activities are aligned with the principles of the United States Government Global Health Initiative and the Government of the Philippines' Universal Health Care agenda (*Kalusugan Pangkalahatan)*.

## PART 1
## Background

Multidrug-resistant tuberculosis (MDRTB) threatens the gains of the National Tuberculosis Control Program (NTP) because it is costly and difficult to treat, and may lead to transmission, development of extensively drug-resistant (XDR) TB, and death. Data on Programmatic Management of Drug-resistant TB (PMDT) showed an increasing trend of patients who interrupted or defaulted from treatment. Cohort analysis for the years 2008, 2009 and 2010 showed defaulter rate of 26%, 33% and 36%, respectively. The increasing defaulter rate has affected treatment success rate showing the following results: 64%, 56% and 42%, respectively. This may lead to an increase in the number of new MDRTB cases, and worse, the emergence of extensively drug resistant TB. This underscores the need to strengthen basic DOTS implementation to avoid the emergence of MDRTB. It also calls for a program that will detect most of the MDRTB cases and ensure they receive quality care, which includes adequate medical management, psychosocial and emotional support, quality laboratory services and availability of quality-assured second-line anti-TB and ancillary drugs.

The Philippines is one of the few countries that had earlier recognized the need to address MDRTB and had piloted it in Metro Manila in 2000. The issuance of a DOH policy on the programmatic management of MDRTB in 2008 initiated the integration of this initiative with the NTP (PhilPACT 2010–2016).

PMDT, in its early stage of nationwide expansion is still highly centralized. PMDT facilities such as treatment centers (TCs) and satellite treatment centers (STCs) are located in the main cities and/or municipalities in some parts of the country. Presumptive DRTB cases are identified in the local health centers (LHC) and/or private DOTS facilities and are referred to TCs/STCs for diagnosis and treatment. Other aspects of program implementation such as training, drug management and program monitoring are supervised by DOH Regional Offices. Current involvement of City and Provincial Health Office is limited to assisting patients who need to be referred back or decentralized to their original health center for continuation of treatment. Challenges in the referral system and case holding were encountered, which led to increase in the rate of early defaulters and poor treatment outcome.

The **Workshop on Strengthening PMDT Case Finding, Case Holding and Referral System** was designed to (1) analyze the existing processes and procedures involved in case finding, case holding and referral; (2) discuss the ideal set-up of a PMDT facility (RHU level or TC/STC level); (3) identify issues and gaps that impede effective case finding, case holding and referring procedures; (4) address the identified issues and gaps through a participatory approach; and (5) develop an enhanced PMDT referral system.

**Expected Outputs**

1. Flow diagram of existing PMDT case finding, case holding and referral system in DOTS facilities
2. List of gaps and issues in PMDT case finding, case holding and referral system
3. Regional, provincial and city/municipal strategies and activities to address the identified gaps
4. List of the roles and responsibilities of the different stakeholders and development partners in each e aspect of PMDT implementation based on gap analysis
5. Implementation plan of strategies and activities
6. Proficiency in proper sputum packaging and transport of specimens

**Outcomes**

1. Increased case finding
2. Increased treatment success rate
3. Enhanced PMDT referral and feedback system

**Assumptions**

1. There is an identified TC/STC for the province/highly urbanized city.
2. The participants have background knowledge of managing MDRTB patients or have undergone some training on PMDT.

## Conducting the Workshop

**Facilitators of the workshop**

Facilitators and resource speakers for this workshop should have background knowledge on the following:

1. 2013 Manual of Procedures of the National TB Control Program, 5th edition
2. AO 2014-0032: Guidelines for the Scaling up and Use of Xpert MTB/RIF as Rapid Diagnostic Tool Under the National TB Control Program
3. AO 2015-0260: Revised Diagnostic Algorithm Using Xpert MTB/RIF
4. DM 2016-0285: Implementation of Xpert as Primary Diagnostic for Presumptive DRTB and Selected Vulnerable Populations
5. AO 2016-0040: Revised Policies and Guidelines on the Implementation of the Programmatic Management of Drug-resistant Tuberculosis (PMDT)
6. PMDT Implementing Guidelines 2017

**Preparations for the workshop**

1. **Ask participants to bring NTP data**

In the letter of invitation to participants, request them to bring their provincial and municipal data on retreatment cases for the past three years. This will include the number and rate of Relapse, Treatment After Failure (TAF), Return After Lost to Follow-up (TALF), Previous Treatment Outcome Unknown (PTOU) and Others (based on MOP, 5th Edition).

Ask representatives from the TC/STC to bring the accomplishment report and cohort analysis of their cases in the past three years, if applicable. Request for the list of names and addresses of PMDT patients for decentralization and those who defaulted, if available.

These data will be used to analyze the gaps and issues on referral system and case holding that will be done in Workshop 2.

2. **Prepare the venue**

There are two types of spaces that you will need for this workshop: (a) a space for the lecture and plenary presentations, and (b) areas where two groups can hold separate group discussions.

Ideally, the two areas for the workshops must be separate to allow the two groups to discuss freely without disturbing each other. The workshop areas should have a wall where participants can post their cards, and table space where participant can write and gather around to discuss.

3. **Coordinate with the head of the treatment center or satellite treatment center to be visited**

One of the activities for this workshop is a visit to a TC/STC. Do the necessary preparations (including hiring a vehicle and ordering snacks for the participants) and coordination to ensure that participants can tour around the TC/STC without disturbing its normal operations. Request the staff at the TC/STC to briefly orient the participants on the following:

a) actual supervised treatment of patients, including identifying and managing adverse events, and recording intake of drugs, adverse events and their management;
b) sputum collection and transport;
c) recording and reporting, including the forms used and the logbooks for both presumptive DRTB and Category 4 Register;
d) drug and supplies management: uninterrupted supply of drugs and proper storage system; and
e) infection control.

4. **Prepare the materials listed below.**

**(a) For the facilitator**

- PowerPoint presentations for the lectures (three PPT files)
  - Overview of the PMDT workshop
  - Background on DRTB and PMDT
  - Case finding and referral procedures
    - Lecturer for this presentation should update slide #19 and provide the following information
      - Name and picture of PMDT treatment facility and rapid TB diagnostic laboratories (RTDL) in the Region
      - Operating hours or schedule for receiving referrals
      - Complete address
      - Contact information
      - Name of PMDT treatment facility head/physician
  - Other indications for Xpert MTB/RIF testing
  - Case holding for PMDT
  - Video on sputum packaging
- Equipment for presentations: LCD Projector, 3 laptops (1 for projector screen, 1 laptop/group x 2 groups) and white projector screen

Below is a checklist of materials needed per session.

| Session | Needed materials |
|---|---|
| Opening program | • Voice file of the Philippine National Anthem |
| Expectations settings | • Meta cards or their equivalent<br>○ Size: rectangular, approximately one-third of a legal-size paper or 210mm x 100mm<br>○ Color: four different colors (e.g., yellow, green, pink, blue)<br>○ Number: four meta cards (of different colors) for each participant<br>• Permanent thick black or blue marker pens |
| **Workshop 1:** Review of the existing case finding, case holding and referral system | • Meta cards or their equivalent<br>○ Color: one color only |

| Session | Needed materials |
|---|---|
| | ○ Number: 10 to 15 meta cards per group (participants will be grouped per DOTS facility)<br>● Permanent thick black or blue marker pens |
| **Workshop 2:** Identification of gaps and issues in case finding, case holding and referral system<br><br>**Workshop 3:** Finding solutions | ● Meta cards or their equivalent<br>○ Color: one color per agency (e.g., pink for RHU, red for PHO, blue for TC/STC, and yellow for DOH RO)<br>○ Number: 10 to 15 meta cards per group (there will be two groups for the workshop)<br>● Permanent thick black or blue marker pens<br>● Print out of titles of rows and columns of Workshops 2 and 3 templates |
| **Workshop 4**: Stakeholders' roles and responsibilities in PMDT | • Meta cards or their equivalent<br>○ Color: one color only<br>○ Number: 10 to 15 meta cards per group (there will be two groups for this workshop)<br>● Permanent thick black or blue marker pens<br>● Print out of titles of rows and columns in Workshop 4 template |
| **Workshop 5:** Development of enhanced two-way PMDT referral system | • Meta cards or their equivalent<br>○ Color: one color only<br>○ Number: 10 to 15 meta cards per group (there will be two groups for this workshop)<br>● Permanent thick black or blue marker pens |
| **Demonstration and return demonstration on proper sputum packaging** | ● Specimen container with specimen<br>● Transparent small plastic bag/biohazard bag<br>● Absorbent scrap paper<br>● Ice packs<br>● Secondary container<br>● Styrobox with label<br>● Masking tape<br>● Documents inside brown envelope and plastic envelope<br>● Gloves<br>● Permanent marker |

## Forms for Workshop 2

### Group 1: Case finding and referral procedures

| Particulars | DOTS Facility | TC/STC | PHO/CHO | DOH Regional Office |
|---|---|---|---|---|
| Identification of presumptive DRTB cases | | | | |
| Forms used | | | | |
| Feedback mechanism from TC and STC | | | | |
| Coordination | | | | |
| Recording and reporting system | | | | |
| Monitoring system | | | | |

### Group 2: Case holding

| Particulars | DOTS Facility | TC/STC | PHO/CHO | DOH Regional Office |
|---|---|---|---|---|
| Pre-enrolment requirements | | | | |
| Contact tracing | | | | |
| Coordination and feedback mechanism at all levels of the health care system | | | | |
| Management of decentralized cases:<br>● DOT<br>● Identification of treatment partner<br>● Drug management (e.g., storage, forecasting, inventory management)<br>● Management of adverse drug reaction | | | | |
| Tracing of interrupters | | | | |
| Recording and reporting<br>● Update of Treatment Card<br>● Patient's booklet<br>● ADR recording<br>Drug inventory and requisitions | | | | |
| Monitoring<br>● Follow-up sputum test<br>● Blood chemistry and chest X-ray | | | | |

| Particulars | DOTS Facility | TC/STC | PHO/CHO | DOH Regional Office |
|---|---|---|---|---|
| • Follow-up for clinical evaluation | | | | |
| Infection control mechanisms<br>• Availability of PPEs<br>• Ventilation | | | | |

## Forms for Workshop 3

### Group 1: Case finding and referral procedures

| Particulars | GAPS | | | | SOLUTIONS | | | |
|---|---|---|---|---|---|---|---|---|
| | DOTS Facility | TC/STC | PHO/CHO | DOH Regional Office | DOTS Facility | TC/STC | PHO/CHO | DOH Regional Office |
| Identification of presumptive DRTB cases | | | | | | | | |
| Forms used | | | | | | | | |
| Feedback mechanism from TC and STC | | | | | | | | |
| Coordination | | | | | | | | |
| Recording and reporting system | | | | | | | | |
| Monitoring system | | | | | | | | |

### Group 2: Case holding

| Particulars | GAPS | | | | SOLUTIONS | | | |
|---|---|---|---|---|---|---|---|---|
| | DOTS Facility | TC/STC | PHO/CHO | DOH Regional Office | DOTS Facility | TC/STC | PHO/ CHO | DOH Regional Office |
| Pre-enrolment requirements | | | | | | | | |
| Contact tracing | | | | | | | | |

| Particulars | GAPS | | | | SOLUTIONS | | | |
|---|---|---|---|---|---|---|---|---|
| | DOTS Facility | TC/STC | PHO/CHO | DOH Regional Office | DOTS Facility | TC/STC | PHO/ CHO | DOH Regional Office |
| Coordination and feedback mechanism at all levels of the health care system | | | | | | | | |
| Management of decentralized cases:<br>● DOT<br>● Identification of treatment partner<br>● Drug management (e.g., storage, forecasting, inventory management)<br>● Management of adverse drug reaction | | | | | | | | |
| Tracing of interrupters | | | | | | | | |
| Recording and reporting<br>● Updated Treatment Card<br>● Patient's booklet<br>● ADR recording<br>● Drug inventory and requisition | | | | | | | | |
| Monitoring<br>● Follow-up sputum test<br>● Blood chemistry and chest X-ray<br>● Follow-up for clinical evaluation | | | | | | | | |

| Particulars | GAPS | | | | SOLUTIONS | | | |
|---|---|---|---|---|---|---|---|---|
| | DOTS Facility | TC/STC | PHO/CHO | DOH Regional Office | DOTS Facility | TC/STC | PHO/ CHO | DOH Regional Office |
| Infection control mechanisms<br>● Availability of PPEs<br>● Ventilation | | | | | | | | |

*Note: Arrange the prepared printout of titles of columns and rows of Workshop Template 2 and post them on the wall or whiteboard following the format of the template. Print one title per bond paper. This is where participants will post meta cards during Workshop 2. Leave an equal space on the right side of the table for the solutions under Workshop 3.*

**(b) Materials for individual participants**

- Printout copy of the PowerPoint presentations
- Pens and writing pads

*Note: You may put all materials for each participant in a plastic envelope. These materials should only be distributed after Workshop 1.*

**(c) Materials for the groups**

- Meta cards or their equivalent (the card should be rectangular, approximately one-third of a legal-size paper or 210 mm x 100 mm in size)
- A roll of masking tape and a pair of scissors (for each group)
- Permanent thick black or blue marker pens

*Note: The above materials should be distributed to each group at the start of each workshop.*

## Workshop Proper

**SUGGESTED PROGRAM**

| **Day 1** | |
|---|---|
| **Time** | **Activity/ Session** |
| 8:00 AM – 8:30 AM | Registration |
| 8:30 AM – 9:30 AM | **Opening Program**<br>● Singing of the Philippine National Anthem<br>● Welcome Messages<br>● Setting of Expectations<br>● Overview of the Workshop |
| 9:30 AM – 10:30 AM | **Workshop 1:** Review of the existing referral system or case-holding mechanism<br><br>**Plenary Presentation** for Workshop 1 |
| 10:30 AM – 12:30 PM | **Visit to a Treatment Center or Satellite Treatment Center** |
| 12:30 PM – 1:30 PM | Lunch |
| 1:30 PM – 4:00 PM | **Input 1:** Background on DRTB and PMDT<br><br>**Input 2:** Case finding and referral procedures<br><br>**Input 3.** Other indications for Xpert MTB/RIF testing<br><br>**Input 4**: Case holding for PMDT |
| 4:00 PM – 5:00 PM | **Workshop 2:** Identification of gaps and issues in case finding, referral procedures and case holding |
| **Day 2** | |
| **Time** | **Activity/Session** |
| 8:00 AM – 8:15 AM | Recapitulation of Day 1 activities |
| 8:15 AM – 9:00 AM | **Workshop 3:** Finding solutions |
| 9:00 AM - 10:00 AM | **Workshop 4**: Stakeholders' roles and responsibilities in PMDT |
| 10:00 AM – 12:00 PM | **Plenary Presentation** for Workshops 2, 3 and 4 |
| 12:00 NN – 1:00 PM | Lunch |
| 1:00 PM - 3:00 PM | **Workshop 5**: Development of enhanced two-way PMDT referral system<br>**Plenary Presentation** for Workshop 5 |
| 3:00 PM – 4:30 PM | Demonstration and Return Demonstration of Proper Sputum Packaging |
| 4:30 PM – 5:00 PM | **Agreements and Next Steps**<br><br>**Closing Program** |

## How to run the workshop

**Singing of the Philippine National Anthem** (5 minutes)
Ask someone from the participants to lead the singing of the Philippine National Anthem, or simply play the voice file of the Philippine National Anthem.

**Expectation setting** (25 minutes)
The purpose of this exercise is to give the facilitator an idea about the needs (learning needs as well as logistical requirements) of the participants, and to customize the workshop accordingly based on participants' expectations.

- ❑ Distribute four meta cards (of various colors: yellow, green and pink, blue) to each participant.
- ❑ Tell participants to list down their expectations on the different elements of this workshop, as follows:
    - Content or activity (yellow)
    - Facilitator/s (green)
    - Participants or their expectations of themselves as participants (pink)
    - Other aspects of the workshop such as food, venue and accommodation (blue)
- ❑ Remind them of the basic rules of writing in meta cards:
    - Only one idea per card
    - A maximum of three lines of writing per card
    - Write legibly and use large print so the words can be read from a distance
- ❑ After the participants have written down their expectations, ask them to post their cards on the board or a designated wall. The cards should be displayed for the duration of the workshop, so participants and facilitators can check whether expectations are being met as the workshop progresses.
- ❑ Process the expectations provided by the participants by reviewing the cards and clustering them based on the different workshop elements:
    - **Expectations on the activity** – See how the expectations match the workshop plan that has been prepared. This activity will only cover two major topics – overview of DRTB and PMDT, and case finding for PMDT – and five workshops with specific outputs. If participants expressed a need for other topics, explain why they are not covered in this workshop, or tell them in which training program these topics are likely to be covered. Do not raise hopes that you will change your plan to suit their content expectations if that is not possible.
    - **Expectations on the facilitator/s** – Clarify your role as facilitator of the workshop. Emphasize that your role is to guide them in the group discussions, so they can come up with the expected outputs of the workshop.
    - **Expectations on themselves as participants** – Highlight the fact that there will be five group discussions in this two-day workshop. The most important expectation from all participants is to actively participate in the activities by being on time, being present in all discussions, and sharing their ideas.

- **Other aspects of the workshop** – Assure participants that logistics have been prepared with their comfort and safety in mind, and whatever requirements they have should be raised with the workshop's administrative staff.

After you have processed the expectations, it will also be a good idea to state what you expect from the participants – to set the tone for what is and what is not acceptable behavior during the workshop. This can now be the perfect time to present some workshop rules such as:

- always be on time,
- put mobile phones on silent mode,
- refrain from reading or sending text messages during group discussions or lectures, and
- go outside the workshop area when they need to take an urgent and important call.

**Welcome messages** (*10 minutes)*

❑ Request highest-ranking officer/s from the DOH Regional Office or Provincial Health Office to give the welcome remarks. Their opening message is critical in stimulating participants' interest in the workshop, so ask the speaker to relate the topic or content of the training program to their work in the National TB Control Program.

**Overview of the two-day workshop** (*10 minutes)*

Your messages in this opening activity should provide clear information about what the entire workshop is about. Below are a few examples of ways to introduce the workshop.

- Present the rationale of the workshop. Relate the objectives, activities and content to participants' real work situations to increase their interest level and focus on the workshop.
- Review the objectives. Present what participants should know or be able to do after this workshop.
- Present how the objectives will be met through the different learning activities, particularly the lectures and workshops/group discussions.

You may use the PowerPoint presentation included in the USB that comes with this guide for this workshop orientation **(Filename: Overview on PMDT CF, CH, RS).**

You will facilitate five group discussions. Before conducting each group discussion, provide clear instructions so participants know exactly what is expected of them. Instructions should include the following:

- Present the activity either written, orally, by using visual aids or a combination of these methods.
- Give clear instructions on what the participant will do in each workshop. Tell them the purpose of the activity, the expected outputs, and how they will report after completing the activity.
- Give a time limit for any activity. Tell participants how much time they will have to complete the workshop and alert them when there are only five more minutes remaining, so they can wrap up their discussion.
- Orient participants on the TC/STC visit.

**Orientation on the visit to the TC/STC** (*10 minutes*)

- ❑ Divide the participants into groups with 5–7 members each.

- ❑ Remind the groups that they have to see the different stations in the TC/STC (see list below). Assign the initial station in the TC/STC that each should visit first and then tell them to rotate to other stations. This should be done to avoid overcrowding in any part of the TC/STC.
    1) DOT area for supervised treatment
    2) Sputum collection area
    3) Drug and supply management, which includes temperature log, stock cards, inventory log, and requisition forms
    4) Recording and reporting, which include the forms used and the logbooks for both presumptive DRTB and Category 4 Register
    5) Laboratory, particularly the GeneXpert machine, if available in the TC/STC compound

- ❑ Remind the groups that they should spend a maximum of 15 minutes per station.

- ❑ Remind participants to bring pens and paper so they can write their insights or questions on PMDT implementation in the TC/STC.

*Note: For more efficient use of time, be sure to select a TC/STC that is near the workshop venue to save on travel time.*

**PMDT orientation** (*10 minutes*)

- ❑ While still at the workshop venue, ask the head of the TC/STC to give a brief orientation on the set-up of the facility. Ask him/her to present the various elements necessary in PMDT implementation:

    1) actual DOT and recording of DOT visit of patients;
    2) sputum collection and transport;
    3) recording and reporting, including the forms used and the logbooks for both presumptive DRTB and Category 4 Register;
    4) drug management: uninterrupted supply of drugs and proper storage system; and
    5) infection control.

## *Workshop 1: Review of the Existing Case Finding, Referral System and Case- holding Mechanism in DOTS Facility and PMDT Facility (1 hour)*

In this workshop, you will ask the participants to enumerate the existing step-by-step case-finding processes conducted at the RHU level, case-holding mechanism and PMDT referral system in the DOTS facility and the TC/STC by creating a process flow.

**Learning objective for Workshop 1**

After Workshop 1, the participants should be able to describe in detail the current processes and procedures on the following:

1. From identifying presumptive DRTB cases and managing DRTB patients, including the documents that are prepared at every step of the process
2. Referral process and feedback mechanisms between DOTS facility and TC/STC
3. Process of contact tracing and screening
4. Coordination and processes involved in decentralization, including means of communication between facilities
5. Processes involved in monitoring patient's treatment progress
6. Mechanisms for defaulter or interrupter tracing
7. Supply chain management for MDRTB drugs
8. Recording and reporting systems at the DOTS facility and the TC/STC levels

**Preparations** (*10 minutes*)

- ❑ Group the participants based on the DOTS facilities where they work. Ask participants from the PHO to join any group/DOTS facilities covered by their office.

- ❑ Distribute the following materials to each group:
  - Meta cards or their equivalent – only one color; 10 to 15 meta cards per group (participants are grouped per DOTS facility)
  - Manila paper or any large sheets of paper where participants can post their meta cards (1–2 sheets of manila paper for each group)
  - Thick permanent marker pens (black or blue ink)
  - Rolls of masking tape and a pair of scissors

- ❑ Tell each group that they have to draw a flow diagram of the existing PMDT referral system and case-holding mechanism in the DOTS facility and the TC/STC.

- ❑ Do not give inputs on the ideal referral system and case-holding mechanism. Your main role is to *draw out* from participants the actual system of PMDT implementation in their respective provinces.

- ❑ Tell each group to assign a documenter who will keep notes on the details of the different processes and procedures in preparation for the presentation. They also have to assign a presenter who will report the group's outputs to the larger group during the plenary presentation.

**Running the workshop** (*30 minutes*)

- ❑ Assign each group one topic based on the composition of the group.

- ❑ Ask participants to use the meta cards in coming up with the flow diagram by writing down each step of the referral or case-holding mechanism in each card. Remind them of the basic rules in writing on meta cards:
  - Only one step per card
  - A maximum of three lines of text per card
  - Writing should be in clear capital letters, big enough to be read when the cards are posted on the wall or laid down on a table

- ❑ Once all steps are written on meta cards, ask participants to post the cards on the wall or whiteboard assigned to them, and then connect the steps by drawing arrows between them.

- ❑ During the workshop, the cards may be changed, replaced or discarded as the discussion continues. The cards can also be moved around the wall or whiteboard until the structure of the flow diagram is clearly organized and displayed.

- ❑ To help you facilitate the workshop, use the questions presented below.

**Guide questions for Group 1: Case finding and referral procedures**

1. How do you identify presumptive DRTB cases who need to be referred to a PMDT TC/STC?
2. What documents do you prepare for the referral? What forms do you use to refer patients?
3. Describe the processes involved in monitoring or tracking patients if they went to the TC/STC for consultation.
4. Did you get feedback from the TC/STC? How was the feedback given, if there was any?
5. How do you know if your patient has already started on DRTB treatment?

**Guide questions Group 2: PMDT case-holding mechanism**

*Note: This is applicable to DOTS facilities with MDRTB patients on treatment.*

Tell this group to review the elements of case holding at two levels: TC/STC level and DOTS facility level (i.e., decentralized cases).

1. What did your facility do upon learning that the patient is ready to be treated?
2. What other procedures did you do for the household members of the patient?
3. If the patient was started on DRTB treatment, was the patient referred back to your DOTS facility for continuation of treatment (decentralization)? How was this coordinated? Was there coordination between the DOH RO and PHO? Explain the coordination system. What were the roles of the DOH RO, PHO/ CHO and DOTS facility in decentralization?

4. If applicable, how is the patient's treatment progress monitored such as monitoring of weight, chest X-ray, blood chemistry, clinical progress/medical examination, and adverse events?
5. How is coordination done in all levels of implementation in terms of patient management, drug management, etc.? What are the means of communication between the DOTS facility and the TC/STC?
6. How do you follow up on patients who have stopped or interrupted treatment?
7. How are drugs replenished? Does the DOTS facility pick up the drugs or does the TC/STC deliver them?

**Plenary presentation for Workshop 1** (*20 minutes*)

Once the discussion is complete and final outputs are agreed upon, ask both groups to go back to the plenary area for the presentations.

Ask the presenter of each group to report the final output of their group's discussion (i.e., the flow diagram). Members of the non-presenting group may ask questions for clarifications.

In reviewing the outputs, check for completeness of the flow diagrams.

- For the PMDT case finding and referral procedures, make sure that the group covers the steps from identification of presumptive DRTB cases, to referring presumptive DRTB cases for laboratory tests, feedback mechanisms from TC/STC to DOTS facility, recording and reporting system, and to the monitoring system.

- For the PMDT case-holding mechanism, make sure the group presents the existing process that DOTS facilities are implementing for completing enrollment requirements, contact tracing, coordination and feedback mechanisms among all offices in the health system, management of decentralized cases (which includes DOT, identification of treatment partner, drug management, management of adverse drug reaction), tracing of interrupters, recording and reporting (including update of Treatment Card, Patient's booklet, ADR recording , drug inventory and requisition), monitoring (which includes follow-up sputum test, blood chemistry, follow-up for clinical evaluation), as well as infection control mechanisms (such as availability of personal protective equipment, ventilation).

## *Visit to a Treatment Center or Satellite Treatment Center (2 hours –including travel time to and from the TC/STC)*

As facilitator, you should be able to explain the rationale behind the visit to the TC or STC. Use the following key points for explanation:

- The purpose of the visit is for the participants to observe and describe the ideal set-up for PMDT in a TC or STC, so they will better understand their roles as part of the overall implementation of PMDT. Like a machine, PMDT will not work if some of the parts are not performing as they should.
- The exposure also aims for the participants to gain first-hand experience on how DRTB patients are managed at the TC/STC level because once a DOTS facility becomes an iDOTS, the participants are expected to perform the same management tasks.

- The exposure aims to develop proactiveness so that if there is a system breakdown somewhere, they'll know where and how to trace the problem and troubleshoot at their level. And if it does not work, they can elevate the problem to those who can address them.
- Knowing what happens after referring to the TC/STC will help the DOTS facility staff clearly explain to the patient the processes and procedures in DRTB diagnosis and treatment and the importance of the services being offered at the TC/STC.

**Learning objectives for visiting the TC/STC**

After visiting the TC/STC, the participants should be able to:

1. describe the actual conduct of supervised treatment, and sputum collection and transport at the TC/STC;
2. describe the infection control measures being implemented in the facility especially in the DOT area;
3. describe the drug and supply management system at the TC/STC;
4. compare the recording and reporting system at the TC/STC with that in DOTS facilities; and
5. if an Xpert machine is available in the TC/STC compound, describe the GeneXpert test.

**Tour around the stations** (*40–60 minutes*)

❑ Tell the groups to go around the different stations based on the rotation system (agreed during the pre-tour orientation):

1) DOT area;
2) Drug and supply management, which includes temperature log, stock cards, inventory log and requisition forms;
3) Recording and reporting, which includes the forms used and the logbooks for both presumptive DRTB and Category 4 Register; and
4) Laboratory, particularly the GeneXpert, if available in the TC/STC compound.

❑ Each group should spend a maximum of 15 minutes per station.

❑ Make sure that the participants see the actual process of receiving presumptive DRTB clients and the actual management of patients currently receiving DRTB treatment.

**Synthesis of TC/STC visit** (*10 minutes*)

❑ After the visit, gather all the participants at the workshop venue.
❑ Before giving the lectures/inputs, conduct a plenary discussion regarding what the participants observed at the PMDT facility.
❑ To guide you in your discussion as facilitator, you may discuss the following questions if the participants do not have any questions.

**Discussion points after the TC/STC visit:**

1. Describe the TC/STC's process for observing and recording DOT visit of patients.
2. How is sputum collected and transported to and from the TC/STC?

3. What is the TC/STC's recording and reporting system? What are the forms and logbooks used for both presumptive DRTB and Category 4 Register?
4. How does the TC/STC ensure uninterrupted supply of drugs? How are drugs stored?
5. How is supervised treatment done in the TC/STC? How do we address patient's DOT if they live far from the TC/STC?
6. How is infection control implemented?

## *Input 1: Background on Drug-resistant Tuberculosis and PMDT*
*(45 minutes)*

In this lecture, you will discuss the following topics: TB classification based on drug susceptibility testing, emergence and magnitude of drug-resistant TB, PMDT framework and implementation in the Philippines, and available treatment regimens for DRTB.

At the end of this lecture, the participant should be able to:
1. define drug-resistant TB (DRTB), multidrug-resistant TB (MDRTB), and extensively drug-resistant TB (XDRTB), and classify TB disease based on drug-susceptibility testing;
2. enumerate the causes of and the cross-cutting factors contributing to the spread of drug-resistant TB;
3. describe the magnitude and socioeconomic consequences of the drug-resistant TB problem in the world and in the Philippines;
4. define Programmatic Management of Drug-resistant Tuberculosis (PMDT) and the rationale for its implementation under the National TB Control Program; and
5. describe the standard framework for PMDT and the implementation of PMDT in the Philippines.

You may use the PowerPoint presentation included in the USB that comes with this guide in your presentation **(Filename: Input 1. Background on DRTB and PMDT)**. You should review the slides and become familiar with all contents before presenting.

To help you prepare for this lecture, you may study the following documents:
1) DOH Department Memorandum No. 2017-0281 – Implementing Guidelines on Programmatic Management of Drug Resistant Tuberculosis (PMDT), Department of Health, Philippines
2) 2013 Manual of Procedures of the National Tuberculosis Control Program, 5th Edition, Department of Health, Philippines
3) Global TB Report, World Health Organization, 2017

**Things to highlight in this lecture:**

- Majority of acquired drug-resistant TB is caused by improper exposure to anti-TB drugs either due to incomplete number of drugs and duration of intake, and poor quality of drugs.
- The magnitude of the drug-resistant TB problem in the country is not only felt by persons affected by TB, but by everyone in the country. This is not just a health but also a socioeconomic problem.
- In the context of discussing PMDT under the NTP framework, highlight the fact that managing drug-susceptible and drug-resistant TB should have the five elements of DOTS. Political will must be sustained, diagnosis should be accurate and timely, supply is uninterrupted, treatment is supervised, and patient is monitored. All the five elements are important. Supervision of treatment is the key element that ensures treatment completion.

## *Input 2: Case Finding and Referral Procedures for PMDT*
### *(45 minutes)*

In this lecture, you will discuss case-finding strategies for DRTB such as identification of presumptive DRTB, options for referring presumptive DRTB, and give a background on Xpert MTB/RIF test and TB disease classification.

At the end of this lecture, the participant will be able to:

1. identify their roles and tasks related to DRTB case finding;
2. identify presumptive DRTB cases properly;
3. refer presumptive TB and DRTB cases;
4. perform proper collection, handling and storage of quality specimen for Xpert MTB/Rif test;
5. understand the results of Xpert MTB/Rif test; and
6. understand the procedures of referring presumptive DRTB.

You may use the PowerPoint presentation included in the USB that comes with this guide in your presentation (**Filename: Input 2. Case Finding and Referral Procedures**). You should review the slides and familiarize yourself with all the contents before presenting.

## *Input 3: Other Indications for Xpert MTB/RIF Testing*
### *(30 minutes)*

This lecture will cover other indications for rapid diagnostic test other than the ones discussed in the previous lecture. This is important as these indications are low risk for DRTB and there is an algorithm to follow when these cases are screened using Xpert MTB/RIF test.

**Objectives**

At the end of this lecture, the participant will be able to:

1. know other indications for Xpert MTB/RIF testing,

2. interpret the results of Xpert MTB/RIF testing, and
3. follow the recommended algorithm for diagnosis using Xpert MTB/RIF and TB treatment.

You may use the PowerPoint presentation included in the USB that comes with this guide in your presentation (**Filename: Input 3. Other Indications for Xpert MTB/RIF**). You should review the slides and familiarize yourself with the contents before presenting.

## *Input 4: Case-holding Mechanisms*
### *(30 minutes)*

One of the challenges faced by PMDT health workers is the high lost-to-follow-up rate among patients due to adverse drug reactions, poor health systems, and socioeconomic factors. Input 4 covers the tasks and roles of health workers, and the different processes and procedures involved in ensuring that patients continue and complete their treatment.

**Objectives**

At the end of this lecture, the participant will be able to:

- perform the roles of healthcare workers in managing patients with DRTB,
- perform the processes and procedures for treatment initiation,
- determine the appropriate treatment regimen using DST results and patient's history of drug use,
- know the necessary forms for treatment initiation of patients with DRTB,
- know the schedule and necessary laboratory exams for treatment monitoring, and
- perform the processes to ensure patient treatment adherence.

You may use the PowerPoint presentation included in the USB that comes with this guide in your presentation (**Filename: Input 4. Case Holding for PMDT**). You should review the slides and familiarize yourself with the contents before presenting.

## *Workshop 2: Identification of Gaps and Issues in PMDT Case Finding, Referral System and Case Holding*
*(45 minutes)*

In this workshop, you will divide the participants into two groups (case finding and referral group, and case holding group). Ask them to identify gaps and issues in PMDT case finding, referral procedures and case holding in their province using the data from the records and reports they brought with them.

**Learning Outcomes**

At the end of this workshop, the participants should be able to:

- utilize their data to analyze the root causes of the identified gaps and issues in the referral system and in case holding, and
- properly state the issues and gaps in complete sentences.

**Preparations**

❑ Before the workshop, have the Workshop 2 form below copied and posted on a wide wall or whiteboard using meta cards for each title of the columns and rows. Be sure that the contents of the meta cards can be seen by all members of the group.

❑ Divide the participants into two groups – case finding and referral group, and case holding group. Below are the criteria for grouping participants:

- Case finding and referral group: health staff from DOTS facilities who have had experience in referring DRTB patients to TC/STC and staff from the TC/STC who receive the referrals from the DOTS facility
- Case holding group: health staff from DOTS facilities and TC/STC who have had experience handling patients on DRTB treatment.

❑ Remind each group to assign a documenter and a rapporteur for the plenary presentation that will take place after the Workshop 4.

❑ Once the participants have joined their respective groups in their designated areas, distribute the following materials to each group:

- Meta cards or their equivalent (the card should be rectangular, approximately one-third of a legal-size paper or 210 mm x 100 mm in size (multi-colored; assign color for each agency – RHU, CHO/PHO, DOH RO, TC/STC)
- A roll of masking tape and a pair of scissors
- Copies of the Workshop 2 form written and posted on the wall or whiteboard where participants can post their meta cards
- Thick permanent marker pens (black or blue ink)

## Forms for Workshop 2

**Group 1: Case finding and referral system**

What were the gaps or issues you encountered in identifying and referring presumptive DRTB?

| Particulars | DOTS Facility | TC/STC | PHO/CHO | DOH Regional Office |
|---|---|---|---|---|
| Identification of presumptive DRTB cases | | | | |
| Forms used | | | | |
| Feedback mechanism from TC/STC | | | | |
| Coordination | | | | |
| Recording and reporting system | | | | |
| Monitoring system | | | | |
| Others | | | | |

**Group 2: Case holding**

What were the gaps you encountered in ensuring continuity of DRTB patients' treatment?

| Particulars | DOTS Facility | TC/STC | PHO/CHO | DOH Regional Office |
|---|---|---|---|---|
| Pre-enrolment requirements | | | | |
| Contact tracing | | | | |
| Coordination and feedback mechanism at all levels of the healthcare system | | | | |
| Management of decentralized cases:<br>● DOT<br>● Identification of treatment partner<br>● Drug management (e.g., storage, forecasting, inventory management)<br>● Management of adverse drug reaction | | | | |
| Tracing of interrupters | | | | |
| Recording and reporting<br>● Update of Treatment Card<br>● Patient's booklet | | | | |

| Particulars | DOTS Facility | TC/STC | PHO/CHO | DOH Regional Office |
|---|---|---|---|---|
| ● ADR recording<br>● Drug inventory and requisitions | | | | |
| Monitoring<br>● Follow-up sputum test<br>● Blood chemistry and chest X-ray<br>● Follow-up for clinical evaluation | | | | |
| Infection control mechanisms<br>● Availability of PPEs<br>● Ventilation | | | | |
| Others | | | | |

*Note: These forms should be copied on the wall or whiteboard before the start of the workshop.*

**Instructions for participants (Workshop 2)**

❑ Ask the participants from the DOTS facilities to bring out their provincial and municipal data on retreatment cases, and those from the TC/STC their accomplishment report and cohort analysis for the past three years.

❑ Ask each group to list down the gaps and issues in their province's PMDT implementation.

- Group 1 will list down gaps encountered in the referral system – from the identification of presumptive DRTB cases to the two-way referral system (from the DOTS facility to TC/STC and vice versa). They need to compare their records in the past three years with that of the TC/STC and check if the number of presumptive DRTB patients they have identified and referred is equal to the number of presumptive DRTB patients received by the TC/STC. If the numbers are not equal, participants from the RHU side and TC/STC side should discuss and determine the gaps and issues why records on both sides do not tally or are not consistent. They should do the same when analyzing gaps on feedback mechanisms. To assist them in their analysis, they can use the categories posted on the wall as guide for their discussion (s*ee table for Group 1. Referral System)*.

- Group 2 will list down gaps in case holding along the different levels of the health care system (DOTS facility, TC/STC, PHO/CHO and DOH Regional Office). For this group, participants should use the data in the TC/STC accomplishment report, cohort analysis, and list of names and addresses of decentralized PMDT patients and those who defaulted. This should be compared with the RHU data on decentralized patients still on treatment and those who defaulted. Any discrepancies and issues identified in case holding should be discussed by the group.

❑ While discussing, each group should assign one member to start working on the PowerPoint presentation of their final output. Although they will not be presenting the outputs immediately after

Workshop 2, they need to start working on their presentation to save on time as they will also need to include the outputs of Workshops 3 and 4 in their presentation before the plenary.

❑ Remind participants again of the basic rules of writing in meta cards:
- Only one idea per card
- A maximum of three lines of text per card
- Write legibly and use large print so the words can be read from a distance

❑ Remind participants of some basic guidelines in stating gaps and issues:

1. **As much as possible, write in complete sentences, not phrases.**

| | |
|---|---|
| Avoid: | Accessibility issue on sending presumptive DRTB to TC (geographic, fund for transport) |
| Write: | RHU is unable to send presumptive DRTB to TC because of inaccessibility and lack of funds for transportation. |

| | |
|---|---|
| Avoid: | Non-compliance with pre-enrollment requirements like social case study report and DSSM results |
| Write: | Patients do not comply with pre-enrollment requirements like submission of social case study report because they have to pay for it.<br><br>Patients do not submit barangay clearance because they have to pay for it. |

2. **Use the active, not passive, form of the verb.**

| | |
|---|---|
| Avoid: | No acknowledgment form received by the RHU from TC/STC. |
| Write: | RHU does not receive acknowledgement form from TC/STC. |

| | |
|---|---|
| Avoid: | MDRTB patients are not reported to the RHU from BHS. |
| Write: | BHS health workers do not report to RHU the treatment status of MDRTB patients. |

3. **Use present tense of the verb to properly describe *what is* happening, or the current situation.**

| | |
|---|---|
| Avoid: | Most patients referred for screening will not return to the referring unit the acknowledgment form. |

| | |
|---|---|
| Write: | Most patients referred for screening do not return the acknowledgement form to the referring unit. |

4. **Be specific. Avoid vague sentences.**

| | |
|---|---|
| Avoid: | Financial incapacity of patients for DRTB screening |
| Write: | Patients are unable to go to TC/STC for DRTB screening because they don't have money for transportation. |

| | |
|---|---|
| Avoid: | GIDA areas accessibility to GeneXpert. |
| Write: | Patients/presumptive DRTB cases in GIDAs are unable to access GeneXpert services because they do not have money for transportation. |

- ❑ During the workshop, you as facilitator should **ask questions** that can help participants specifically identify gaps and issues in the PMDT referral system and case holding mechanism. See examples below:

| | |
|---|---|
| Initial gap or issue stated: | Lack of knowledge on how to report on MDRTB. |
| *Ask:* | *Who lacks knowledge? Why are they not aware of MDRTB reporting?* |
| Re-written gap or issue: | DOTS facilities personnel do not know how to report MDRTB cases because they have not been trained on PMDT. |

| | |
|---|---|
| Initial gap or issue stated: | No recording tool for presumptive DRTB cases. |
| *Ask:* | *What specific recording tool is missing in the facility?* |
| Re-written gap or issue: | RHUs do not have a standard logbook for recording presumptive DRTB cases. |

| | |
|---|---|
| Initial gap or issue stated: | No update on new NTP-MOP. |
| *Ask or clarify:* | *Why is there no update on the new NTP-MOP? or Are staff not updated on the new NTP-MOP?* |

| | |
|---|---|
| Re-written gap or issue: | Hospital staff not informed about or not updated on the new NTP-MOP. |

❑ Remind participants to avoid putting all the blame on the patients.

| | |
|---|---|
| Initial gap or issue stated: | Low educational attainment of patients. |
| Ask or clarify: | *Why do you think this is an issue? How does having low educational attainment affect patients' (health seeking) behavior/compliance with treatment?* |
| Re-written gap or issue: | Patients find it difficult to understand the process for diagnosis or treatment. |

| | |
|---|---|
| Initial gap or issue stated: | Lack of knowledge of patient as to why they are referred. |
| *Ask or clarify:* | *What is the reason for this?* |
| Re-written gap or issue: | Health workers did not properly orient presumptive DRTB patients on why they were being referred to TC/STC. |

| | |
|---|---|
| Initial gap or issue stated: | Patients are stubborn, have negative attitude. |
| *Ask or clarify:* | *Why do you say they are being stubborn? They are stubborn because…?*<br><br>*Give specific examples of situations when patients had been stubborn, and how this affected treatment compliance.* |
| Re-written gap or issue: | Patients refuse to comply with treatment/submit sputum because they have not been properly oriented on the importance of complying with these requirements. |

Note that there are two types of gaps that are usually identified – gaps in the ***inputs*** (e.g., lack of funds, lack of training) and gaps in the ***process*** (e.g., DOTS facility submits incomplete data in Referral Form). However, sometimes participants cite situations that are actually **not gaps, but rather *results*** of the gaps in the system. Therefore, you need to help them get to the **root cause** of the gaps by posing questions that will delve deeper into the situations.

Below are examples of questions that you may ask to find the root causes of the above situations.

| | |
|---|---|
| Initial gap or issue stated: | Patients referred (to the Treatment Center) are not qualified for MDRTB screening. |

| | |
|---|---|
| *Ask or clarify:* | *How did this happen? What are the reasons patients who were referred to TC/STC turned out to be not qualified for MDRTB screening?* |
| Re-written gap or issue: | DOTS facility personnel do not know how to properly identify presumptive DRTB patients that should be referred to TC/STC. |

| | |
|---|---|
| Initial gap or issue stated: | Identification and referral of presumptive DRTB are not very clear to some health workers. |
| *Ask or clarify:* | *Why is the process for identifying and referring presumptive DRTB not clear to some health workers?* |
| Re-written gap or issue: | DOTS facility personnel have not been trained on PMDT. |

| | |
|---|---|
| Initial gap or issue stated: | Patients bring home their medicines. |
| *Ask or clarify:* | *What are the reasons patients bring home their medicines?* |
| Re-written gap or issue: | (Because) Patients are allowed to bring home their medicines.<br><br>*What is the reason for this?*<br><br>(Because) health workers at the DOTS facilities are not given orientation on PMDT guidelines/protocols. |

## Sample Output for Workshop 2:
## Gaps and Issues in the PMDT Case Finding and Referral System

| Particulars | DOTS Facility | Treatment Center/ Satellite Treatment Center | Provincial Health Office/ City Health Office | DOH Regional Office |
|---|---|---|---|---|
| Identification of presumptive DRTB cases | Frontliners/health personnel (MHO, PHN and midwives) not trained on PMDT<br><br>MDR patients prefer to be treated (or diagnosed) by private MDs who are not trained on NTP<br><br>Private MDs are not trained on PMDT, specifically on how to identify presumptive DRTB cases<br><br>RHU does not have a micros-copist to conduct DSSM | Patients are required to submit CXR even if they are smear positive<br><br>Patients referred to TC/STC are not aware why they are referred to TC/STC (since referring units failed to set expectations of presumptive DRTB)<br><br>TC/STC receives patients from private MDs who are not oriented on PMDT | TBDC members are not oriented on the revised NTP-MOP | GeneXpert in one TC is not functioning<br><br>Regional TB culture lab is not functioning |
| Forms used | RHU has no available referral forms | TC/STC receives Form 7 not properly filled out, or incompletely filled out (e.g., no contact numbers of referring facility)<br><br>TC/STC receives Form 7 without proper attachments (DSSM within the month, CXR with comparison) | No available referral forms | |

| Particulars | DOTS Facility | Treatment Center/ Satellite Treatment Center | Provincial Health Office/ City Health Office | DOH Regional Office |
|---|---|---|---|---|
| Existing guidelines or protocols | Municipality has no existing policies/ordinances supportive of NTP | | PHO has no policy or ordinance supportive of NTP | |
| Feedback mechanism from TC/STC | RHU does not receive immediate feedback from TC/STC on referred presumptive MDRTB cases<br><br>RHU does not receive information from TC/STC of referred presumptive DRTB cases from other facilities<br><br>Patients do not give the result/ return slip to RHU | Patients and RHUs are not aware of TC/STC schedule for screening presumptive DRTB cases | | |
| Coordination between RHU, PHO, CHD, and TC/STC | RHUs do not receive information from TC/STC of referred presumptive DRTB from other facilities, specifically from private MDs<br><br>There is no coordination between RHU and TC/STC in referring presumptive DRTB cases | TC/STC personnel are not properly informed in advance of presumptive DRTB cases that will go to the center for screening | There is no coordination between PHO and TC/STC regarding the number of DRTB patients screened and enrolled in their respective catchment province | DOH-RO does not have updated list of NTP point persons at the RHU level |
| Recording and reporting system | RHU does not completely fill out TB presumptive master list and DRTB presumptive master list. There is not enough supply of recording and reporting forms at the RHU | | TC/STC does not submit to PHO copy of quarterly reports of referred and screened presumptive DRTB cases per province or per municipality | |

| Particulars | DOTS Facility | Treatment Center/ Satellite Treatment Center | Provincial Health Office/ City Health Office | DOH Regional Office |
|---|---|---|---|---|
| | RHU does not receive reports on the total number of presumptive DRTB cases that were referred to TC/STC (cases seen at STC/ TC) | | | |
| Monitoring system | RHU does not follow up on the status of referred presumptive DRTB cases with TC/STC | | PHO does not conduct regular monitoring because of no, or limited transportation allowance, or PHO does not have vehicle for monitoring<br><br>PHO does not have official monitoring forms<br><br>PHO does not receive feedback from DOH-RO | |
| Others | Patients in GIDAs could not access services of GeneXpert because of lack of money for transportation<br><br>Patients could not go for DRTB screening due to lack of money for transportation | | Not all provinces in the region have TC/STC, which makes it difficult for patients to seek treatment<br><br>Existing GeneXpert sites are not enough to serve the region<br><br>Not all provinces in the region have functional PCC or PMSA | |

## Sample Output for Workshop 2:
## Gaps and Issues in the PMDT Case holding Mechanism

| Particulars | DOTS Facility | Treatment Center/ Satellite Treatment Center | Provincial Health Office/ City Health Office | Regional Health Office |
|---|---|---|---|---|
| Pre-enrolment requirements | RHU personnel are not aware of PMDT enrolment requirements | Patients do not comply with pre-enrollment requirements like social case study report and DSSM results | PHO personnel do not know the pre-enrollment requirements | |
| Contact tracing | RHU personnel are not aware of the procedure for contact tracing | TC/STC personnel are not able to trace all contacts because of limited funds of the TC/STC | No support coming from PHO for contact tracing | |
| Coordination and feedback mechanism | RHU is not furnished with acknowledgement slips, these slips go straight to TC/STC especially if patient is decentralized | TC/STC does not furnish acknowledgement forms to the referring unit, and patients do not pass through the RHU (to submit return slip) | TC/STC does not report decentralized DRTB patients to the PHO | |
| Management of decentralized cases:<br>● DOT<br>● Identification of treatment partner<br>● Drug management (e.g., storage, forecasting, inventory management) | Patients refuse to take medications because of false sense of wellbeing<br><br>Patients have difficulty complying with treatment due to adverse reaction to medicines | TC/STC seems to be "asking favor" from RHU when decentralizing patient<br><br>Patients are allowed to bring home their medicines | | |

| Particulars | DOTS Facility | Treatment Center/ Satellite Treatment Center | Provincial Health Office/ City Health Office | Regional Health Office |
|---|---|---|---|---|
| Management of adverse drug reaction | No financial or logistic support is extended to treatment partners<br><br>RHU is unsure if remaining drugs are returned to TC/STC<br><br>Patients are not regularly seen by the MHO<br><br>RHUs are not aware of diagnosed MDRTB patients who went directly to the TC/STC or were referred by private MDs to TC/STC | | | |
| Tracing interrupters | | Tracing is usually done only through phone call/text<br><br>Patients who were lost to follow-up went outside the catchment area; therefore, difficult to trace | PHO does not provide transport and communication support for tracing of interrupters | |
| Recording and reporting<br>● Update of Treatment Card<br>● Patient's booklet<br>● ADR recording<br>● Drug inventory and requisitions | TC/STC does not report to RHU the status of treatment of MDRTB patients<br><br>RHU has no separate recording for DRTB patients<br><br>RHU personnel are not trained on how to report MDRTB cases | | PHO has no reporting mechanism for referred presumptive DRTB patients from the RHUs<br><br>PHO does not have record of MDRTB cases | PMDT data are not included in the NTP reporting form |

| Particulars | DOTS Facility | Treatment Center/ Satellite Treatment Center | Provincial Health Office/ City Health Office | Regional Health Office |
|---|---|---|---|---|
| Monitoring<br>● Follow-up sputum test<br>● Blood chemistry and chest X-ray<br>● Follow-up clinical evaluation | There is no PMDT monitoring on the RHU level | | PHO has limited resources for monitoring (limited allowance for transportation; no available vehicle for monitoring, lack of manpower) | Monitoring of MDRTB is not included in the NTP reporting system |
| Infection control mechanisms<br>● Availability of PPEs<br>● Ventilation | | | | |

## *Workshop 3: Identify solutions to the challenges and gaps in case finding, referral, and case-holding in your region*
## *(45 minutes)*

In this workshop, you will ask the two groups to identify solutions to the identified gaps and issues in the referral system and case-holding mechanism in their province (results of Workshop 2).

**Learning Outcomes**

At the end of this workshop, the participants should be able to:

- formulate solutions to address the root causes of the gaps and issues identified in the referral system and case holding in the DOTS facilities and in the TC/STC facilities, and
- identify the key facilities/agencies responsible for each solution.

**Instructions to Participants**

- ❑ Ask participants to re-join their respective groups (referral system and case holding groups) in their assigned workshop area.

- ❑ Tell each group to formulate solutions to address and mitigate the enumerated gaps and issues. Add more columns to the table of Workshop 2 you posted on the wall using the template of Workshop 3 as guide. *(Refer to template of Workshop 3 below.)*

- ❑ Remind them that possible solutions may not be limited to programmatic solutions but may also include involvement of local chief executives and other members of Comprehensive and Unified Policy (CUP) for TB Control.

- ❑ Ask the Referral System Group to find better ways to improve the flow of the existing PMDT referral system so that all presumptive DRTB cases are referred and given proper TB services. Specifically, they have to list down appropriate strategies and activities to address the root causes of the identified gaps and issues in the referral system.

- ❑ Ask the Case Holding Group to enumerate approaches to strengthen the case-holding mechanisms. Specifically, ask them to list down interventions and activities needed to address the identified gaps and issues in PMDT implementation to increase the rate of MDRTB cases who finish/complete treatment and reduce cases of lost to follow-up.

- ❑ Instruct each group to encode and add their Workshop 3 final output to the PowerPoint presentation with their Workshop 2 output.

- ❑ Distribute materials for the workshop
  - Meta cards or their equivalent (the card should be rectangular, approximately one-third of a legal-size paper or 210 mm x 100 mm in size)
  - Permanent thick marker pens (black or blue). The number of required marker pens depends on the size of the group.
  - Rolls of masking tape and a pair of scissors

## Templates for Workshop 3

**Group 1: Referral System**
**What are the possible solutions to the gaps or issues you encountered in the referral system?**

| Particulars | GAPS | | | | SOLUTIONS | | | |
|---|---|---|---|---|---|---|---|---|
| | DOTS Facility | TC/ STC | PHO/ CHO | DOH Regional Office | DOTS Facility | TC/ STC | PHO/ CHO | DOH Regional Office |
| Identification of presumptive DRTB | | | | | | | | |
| Forms used | | | | | | | | |
| Feedback mechanism from TC and STC | | | | | | | | |
| Coordination | | | | | | | | |
| Recording and reporting system | | | | | | | | |
| Monitoring system | | | | | | | | |
| Others | | | | | | | | |

**Group 2: Case-holding Mechanism**
**What are the possible solutions to the gaps you encountered in case holding?**

| Particulars | GAPS | | | | SOLUTIONS | | | |
|---|---|---|---|---|---|---|---|---|
| | DOTS Facility | TC/STC | PHO/CHO | DOH Regional Office | DOTS Facility | TC/STC | PHO/CHO | DOH Regional Office |
| Pre-enrolment requirements | | | | | | | | |
| Contact tracing | | | | | | | | |
| Coordination and feedback mechanism at all levels of the healthcare system | | | | | | | | |

| Particulars | GAPS | | | | SOLUTIONS | | | |
|---|---|---|---|---|---|---|---|---|
| | DOTS Facility | TC/STC | PHO/CHO | DOH Regional Office | DOTS Facility | TC/STC | PHO/CHO | DOH Regional Office |
| Management of decentralized cases:<br>• DOT<br>• Identification of treatment partner<br>• Drug management (e.g., storage, forecasting, inventory management)<br>• Management of adverse drug reaction | | | | | | | | |
| Tracing of interrupters | | | | | | | | |
| Recording and reporting<br>● Update of Treatment Card<br>● Patient's booklet<br>● ADR recording<br>● Drug inventory and requisitions | | | | | | | | |
| Monitoring<br>● Follow-up sputum test<br>● Blood chemistry and chest X-ray<br>● Follow-up for clinical evaluation | | | | | | | | |
| Infection control mechanisms | | | | | | | | |

| Particulars | GAPS | | | | SOLUTIONS | | | |
|---|---|---|---|---|---|---|---|---|
| | DOTS Facility | TC/STC | PHO/CHO | DOH Regional Office | DOTS Facility | TC/STC | PHO/CHO | DOH Regional Office |
| • Availability of PPEs<br>• Ventilation | | | | | | | | |
| Others | | | | | | | | |

❑ Remind participants of some basic guidelines in stating solutions:

**Write complete sentences, not noun phrases.**

| | |
|---|---|
| Avoid: | Proper sending of return slip from STC/TC to the referring facility |
| Write: | ▪ TC/STC to send properly filled-out return slip directly to the referring facility<br>▪ TC/STC to send email messages to the referring facility |

| | |
|---|---|
| Avoid: | Directory of TCs/STCs nationwide provided to all RHUs |
| Write: | DOH-RO or PHO to provide all RHUs with directory of TCs/STCs located nationwide |

## Sample Output for Workshop 3
## Suggested Solutions in the PMDT Case Finding and Referral System

| Particulars | GAPS | | | | SOLUTIONS | | | |
|---|---|---|---|---|---|---|---|---|
| | DOTS Facility | Treatment Center/ Satellite Treatment Center | Provincial Health Office/ City Health Office | DOH Regional Office | DOTS Facility | Treatment Center/ Satellite Treatment Center | Provincial Health Office/ City Health Office | DOH Regional Office |
| Identification of presumptive DRTB cases | Frontliners/ health personnel (MHO, PHN and midwives) not trained on PMDT | | | | | | | DOH RO to conduct PMDT training for health personnel |
| | Private MDs are not trained on PMDT, specifically on how to identify presumptive DRTB cases | | | | | | | DOH RO to conduct PMDT training for private MDs |
| | | Patients are required to submit CXR even if they are smear positive | | | | | | DOH RO to call the attention of TC/STC personnel who require patients to submit CXR |
| | | | TBDC members are not oriented | | | | | DOH RO to orient TBDC members on |

| Particulars | GAPS | | | | SOLUTIONS | | | |
|---|---|---|---|---|---|---|---|---|
| | DOTS Facility | Treatment Center/ Satellite Treatment Center | Provincial Health Office/ City Health Office | DOH Regional Office | DOTS Facility | Treatment Center/ Satellite Treatment Center | Provincial Health Office/ City Health Office | DOH Regional Office |
| | | | on the revised NTP MOP | | | | | the revised NTP MOP |
| | RHU does not have microscopist to conduct DSSM | | | | RHU to lobby to LCE to hire microscopist/ medtech; RHU to forge MOA with nearby DOTS facilities | | | |
| | | Patients referred to TC/STC are not aware why they are referred to TC/STC (since referring units failed to set expectations of presumpt-ive DRTB) | | | RHU to orient patients and families on PMDT and the reason for their referral to the TC/STC | | | |

| Particulars | GAPS | | | | SOLUTIONS | | | |
|---|---|---|---|---|---|---|---|---|
| | DOTS Facility | Treatment Center/ Satellite Treatment Center | Provincial Health Office/ City Health Office | DOH Regional Office | DOTS Facility | Treatment Center/ Satellite Treatment Center | Provincial Health Office/ City Health Office | DOH Regional Office |
| | | TC/STC receives patients from private MDs who are not oriented on PMDT | | | | | PHO /CHO to advocate with private MDs to follow NTP protocol<br><br>PHO to engage/re-engage private MDs on PMDT | |
| Forms used | RHU has no available referral forms | TC/STC receives Form 7 that are not properly filled out, or incompletely filled out (e.g., no contact numbers of referring facility) | No available referral forms | | RHU must fill out Form 7 completely and attach necessary documents<br><br>RHU to request PHO to reproduce and distribute forms | | PHO to request forms from DOH-RO | |
| Existing guidelines or protocols | Municipality has no existing TB policies/ ordinances | | PHO has no policy or ordinance | | RHU to lobby for the creation of local | | PHO to coordinate with Provincial | |

| Particulars | GAPS | | | | SOLUTIONS | | | |
|---|---|---|---|---|---|---|---|---|
| | DOTS Facility | Treatment Center/ Satellite Treatment Center | Provincial Health Office/ City Health Office | DOH Regional Office | DOTS Facility | Treatment Center/ Satellite Treatment Center | Provincial Health Office/ City Health Office | DOH Regional Office |
| | supportive of NTP | | supportive of NTP | | ordinance supporting the NTP | | Health Board on the creation of local ordinance supporting NTP | |
| Feedback mechanism from TC and STC | RHU does not receive immediate feedback from TC/STC on referred presumptive MDRTB cases<br><br>RHU does not receive information from TC/STC on referred presumptive DRTB cases from other facilities<br><br>Patients do not give the result/ | Patients and RHUs are not aware of TC/STC schedule for screening presumptive DRTB cases | | | RHU to coordinate with TC/STC re results of diagnosis | TC/STC to provide on-time feedback to RHU of status of referred presumptive MDRTB cases (at least through SMS)<br><br>TC/STC to properly send return slip to referring units<br><br>TC/STC to send | | |

| Particulars | GAPS | | | | SOLUTIONS | | | |
|---|---|---|---|---|---|---|---|---|
| | DOTS Facility | Treatment Center/ Satellite Treatment Center | Provincial Health Office/ City Health Office | DOH Regional Office | DOTS Facility | Treatment Center/ Satellite Treatment Center | Provincial Health Office/ City Health Office | DOH Regional Office |
| | return slip to RHU | | | | | advisory to all PHOs and RHUs regarding DRTB screening schedule | | |
| Coordination between RHU, PHO, CHD, and TC/STC | RHUs do not receive information from TC/STC of referred presumptive DRTB from other facilities, specifically from private MDs<br><br>There is no coordination between RHU and TC/STC in referring presumptive DRTB cases | TC/STC personnel are not properly informed in advance on presumptive DRTB cases who will go to the center for screening | There is no coordination between PHO and TC/STC regarding the number of DRTB patients screened and enrolled in their respective catchment province | DOH-RO does not have updated list of NTP point persons at the RHU level<br><br>RHUs must properly and completely fill out TB and DRTB presumptive master lists | RHUs must inform TC/STC about presumptive DRTB cases that they will refer to TC/ST (prior to patients' visit to TC/STC) | TC/STC must inform RHUs about referred presumptive DRTB from other facilities | PHO to establish coordination mechanism with TC/STC<br><br>PHO to update list of NTP point persons, including their contact numbers | |
| Recording and reporting system | RHU does not completely fill out TB presumptive | | TC/STC does not submit to PHO copy of quarterly | RHUs must follow up with TC/STCs on the status | | TC/STC should submit to PHO copy of | | |

| Particulars | GAPS | | | | SOLUTIONS | | | |
|---|---|---|---|---|---|---|---|---|
| | DOTS Facility | Treatment Center/ Satellite Treatment Center | Provincial Health Office/ City Health Office | DOH Regional Office | DOTS Facility | Treatment Center/ Satellite Treatment Center | Provincial Health Office/ City Health Office | DOH Regional Office |
| | master list and DRTB presumptive master list | | reports of referred and screened presumptive DRTB cases per province or per municipality | of referred patients for screening | | quarterly reports of referred and screened presumptive DRTB cases per province or per municipality | | |
| Monitoring system | RHU does not follow up on the status of referred presumptive DRTB cases with TC/STC | | PHO does not conduct regular monitoring because of no or limited transportation allowance, or PHO does not have vehicle for monitoring<br>PHO does not have official monitoring forms.<br>PHO does not receive feedback from DOH-RO | | | | PHO must conduct regular monitoring<br><br>PHO to provide vehicle for monitoring RHUs | DOH RO (c/o NTP budget on monitoring activities) must allow reimburse-ment of travel allowance of PHO NTP Coordinators<br><br>DOH RO to provide PHO with official monitoring forms and feedback on monitoring |

| Particulars | GAPS | | | | SOLUTIONS | | | |
|---|---|---|---|---|---|---|---|---|
| | DOTS Facility | Treatment Center/ Satellite Treatment Center | Provincial Health Office/ City Health Office | DOH Regional Office | DOTS Facility | Treatment Center/ Satellite Treatment Center | Provincial Health Office/ City Health Office | DOH Regional Office |
| Others | Patients in GIDA areas could not access GeneXpert services because of lack of money for transportation<br><br>Patients could not go for DRTB screening because of lack of transport-ation money | | Not all provinces in the region have TC/STC, which makes it difficult for patients to access treatment<br><br>Existing GeneXpert sites are not enough to serve the region<br><br>Not all provinces in the region have functional PCC or PMSA | | RHUs in GIDA to implement iDOTS<br><br>RHUs to lobby to LCE for financial support for DRTB patients | | PHO to propose provision of GeneXpert site or establish-ment of TC/STC in each province<br><br>PHO to create or reactivate PCC or PMSA | |

## Sample Output for Workshop 3:
## Suggested Solutions in the PMDT Case-holding Mechanism

| Particulars | GAPS | | | | SOLUTIONS | | | |
|---|---|---|---|---|---|---|---|---|
| | DOTS Facility | TC/STC | Provincial Health Office/ City Health Office | DOH Regional Office | DOTS Facility | TC/STC | Provincial Health Office/ City Health Office | DOH Regional Office |
| Pre-enrolment requirements | RHU personnel are not aware of PMDT enrolment requirements | Patients do not comply with pre-enrolment requirements like social case study report and DSSM results | | | RHU to facilitate the accomplish-ment of social case study reports and spot map | TC/STC to coordinate with RHUs on accomplish-ment of pre-enrolment requirements | | |
| Contact tracing | | TC/STC personnel are not able to trace all contacts owing to limited funds of the TC/STC | There is no support from PHO for contact tracing | | RHU to help facilitate transport of contacts to TC/STC using local ambulance or vehicle | TC/ STC to coordinate with RHU in facilitating contact tracing with appropriate instructions on procedure and logistics | RHU/PHO to forge MOA between district hospital and PHO to allow free chest X-ray for contacts | |
| Coordination and feedback mechanism | RHU is not furnished with acknowledge-ment slips, which go | TC/STC does not furnish acknowledge-ment forms to the referring | | | | TC/STC should furnish copy of acknowledge-ment slip to PHO and this | PHO to serve as the overall coordinating unit between TC/STC and | |

| Particulars | GAPS | | | | SOLUTIONS | | | |
|---|---|---|---|---|---|---|---|---|
| | DOTS Facility | TC/STC | Provincial Health Office/ City Health Office | DOH Regional Office | DOTS Facility | TC/STC | Provincial Health Office/ City Health Office | DOH Regional Office |
| | straight to TC/STC especially if patient is decentralized | unit, and patients do not pass through the RHU (to submit return slip) | | | | will be picked up by RHU at the PHO | RHU on case holding | |
| Management of decent-ralized cases:<br>● DOT<br>● Identificat-ion of treatment partner<br>● Drug manage-ment (e.g., storage, fore-casting, inventory manage-ment)<br>● Manage-ment of adverse drug reaction | RHU is unsure if remaining drugs are returned to TC/STC<br><br>RHUs are not aware of diagnosed MDRTB patients who went directly to the TC/STC or referred by private MDs to TC/STC | TC/STC seems to be "asking favor" from RHU when decentralizing patient | | | RHU to facilitate return and replenish-ment of 2nd line drugs to and from TC/STC in close coordination with TC/STC (via ambulance or personnel) | TC/STC to inform RHU of patients not directly referred by the RHU | | |

| Particulars | GAPS | | | | SOLUTIONS | | | |
|---|---|---|---|---|---|---|---|---|
| | DOTS Facility | TC/STC | Provincial Health Office/ City Health Office | DOH Regional Office | DOTS Facility | TC/STC | Provincial Health Office/ City Health Office | DOH Regional Office |
| Tracing of interrupters | | Patients who were lost to follow-up went outside the catchment area; hence, difficult to trace | PHO does not provide transport and communicat-ion support for tracing of interrupters | | | | PHO to provide transport and communicat-ion support for tracing interrupters | DOH RO to help trace interrup-ters who went outside the region |
| Recording and reporting<br>● Update of Treatment Card<br>● Patient's booklet<br>● ADR recording<br>● Drug inventory & requisit-ions | RHU personnel are not trained on how to report MDRTB cases<br><br>RHU has no separate recording for DRTB patients | | | | RHU to create own logbook for presumptive DRTB cases | | | DOH RO or PHO to conduct training on MDRTB recording and reporting for MHOs, PHNs, medtechs and RHMs |
| Monitoring<br>● Follow-up sputum test<br>● Blood chemistry and chest X-ray | There is no PMDT monitoring at the RHU level | | | Monitor-ing of MDRTB is not included in the NTP | | | PHO to include MDRTB in the NTP reporting system | |

| Particulars | GAPS | | | | SOLUTIONS | | | |
|---|---|---|---|---|---|---|---|---|
| | DOTS Facility | TC/STC | Provincial Health Office/ City Health Office | DOH Regional Office | DOTS Facility | TC/STC | Provincial Health Office/ City Health Office | DOH Regional Office |
| ● Follow-up for clinical evaluation | | | | reporting system | | | PHO to conduct training on supervision and PMDT monitoring for MHOs, PHNs, RHMs and medtechs | |

## *Workshop 4: Stakeholders' Roles and Responsibilities in PMDT (30 minutes)*

The purpose of Workshop 4 is to allow participants to discuss among themselves who will be responsible for the specific roles that were raised in Workshop 3 to address the gaps and issues identified in Workshop 2. Participants should list down other roles and responsibilities that they are already doing correctly but are still related to case finding, referral and case-holding mechanisms. This will allow them to get the whole picture of what they are doing correctly and what needs improvement.

All participants must agree to accept and perform their roles and responsibilities once these are finalized. Each facility/organization (RHU, TC/STC, PHO and DOH RO) should have a copy of everybody's roles and responsibilities, not only of their own. The participants should re-echo the agreements forged during this two-day workshop to all other members of the staff in the RHU, TC/STC, PHO and DOH RO implementing PMDT so they will be aware of these agreements and be able to perform the functions in their absence. Knowledge of the other stakeholders' roles and responsibilities will facilitate better analysis of issues that may arise in the future.

**Learning Outcome**

At the end of this workshop, the participants should be able to:

- clarify the roles and responsibilities of all the stakeholders involved in PMDT in their group based on the outputs of previous workshops.

**Instructions to Participants**

- ❑ Ask participants to re-join their respective groups in their assigned workshop area.
- ❑ Ask the participants to discuss among themselves who will be responsible for the specific tasks and roles that were raised in Workshop 3 to address the gaps and issues they identified in Workshop 2. Ask them to consolidate all the roles and responsibilities of each office, including those they are already doing correctly.
- ❑ To facilitate their discussion, ask each office to list their own roles and responsibilities. They will then cross-check their list with that of the other offices and make sure that each aspect of referral system and case-holding mechanism is covered by all stakeholders/offices and no task/step is left unassigned.
- ❑ Once they finish, ask each group to add their collective Workshop 4 outputs to their PowerPoint Presentation with their Workshops 2 and 3 outputs.
- ❑ Tell them to use the template below.

## Templates for Workshop 4

**Group 1: Roles and responsibilities of different health offices in case finding and referral**

| Particulars | Roles and Responsibilities | | | |
|---|---|---|---|---|
| | DOTS Facility | TC/STC | PHO/CHO | DOH Regional Office |
| 1. Identification of presumptive DRTB | | | | |
| 2. Forms used | | | | |
| 3. Feedback mechanism from TC and STC | | | | |
| 4. Coordination | | | | |
| 5. Recording and reporting system | | | | |
| 6. Monitoring system | | | | |
| 7. Others | | | | |

**Group 2: Roles and responsibilities of different offices in PMDT case holding**

| Particulars | Roles and Responsibilities | | | |
|---|---|---|---|---|
| | DOTS Facility | TC/STC | PHO/CHO | DOH Regional Office |
| 1. Pre-enrolment requirements | | | | |
| 2. Contact tracing | | | | |
| 3. Coordination and feedback mechanism at all levels of the health care system | | | | |
| 4. Management of decentralized cases:<br>● DOT<br>● Identification of treatment partner<br>● Drug management (e.g., storage, forecasting, inventory management)<br>● Management of adverse drug reactions | | | | |
| 5. Tracing interrupters | | | | |
| 6. Recording and reporting<br>● Update of Treatment Card | | | | |

| Particulars | Roles and Responsibilities | | | |
|---|---|---|---|---|
| | DOTS Facility | TC/STC | PHO/CHO | DOH Regional Office |
| ● Patient's booklet<br>● ADR recording<br>● Drug inventory and requisitions | | | | |
| 7. Monitoring<br>● Follow-up sputum test<br>● Blood chemistry and chest X-ray<br>● Follow-up for clinical evaluation | | | | |
| 8. Infection control mechanisms<br>● Availability of PPEs<br>● Ventilation | | | | |
| 9. Others | | | | |

## Sample Output for Workshop 4
## Roles and responsibilities of different health offices in PMDT implementation

| Particulars | DOTS Facility | Provincial Health Office | TC/STC | Regional Office |
|---|---|---|---|---|
| Identification of presumptive DRTB | • Conduct proper history taking<br>• Do DSSM and tracking of referral from TC/STC<br>• Counsel presumptive and diagnosed DRTB cases and their families<br>• Facilitate transport of presumptive DRTB cases to TC/STC and contacts | | • Screen and initiate treatment if needed | • Conduct PMDT training for DOTS facilities personnel |
| Forms used | • Refer presumptive DRTB cases to TC/STC with properly filled-out referral form | | | • Provide DRTB referral forms |
| Existing guidelines or protocols | • Perform contact tracing with assistance of TC/STC<br>• Return nearly expiring drugs to TC/STC | | | • Include PMDT in all NTP activities (viz., PIR, RCC meeting, advocacy activities, monitoring) |
| Feedback mechanism with TC/STC | • Confirm with TC/STC the actual number of contacts traced<br>• Follow up patients who are interrupting treatment | | | |

| Particulars | DOTS Facility | Provincial Health Office | TC/STC | Regional Office |
|---|---|---|---|---|
| Coordination | • Coordinate with MSWDO, barangay (SB on health and midwife), PHO, CHO and TC/STC | | • Inform PHO and DOH-RO about the status of all referred presumptive DRTB patients | • Assist in coordinating decentralization, contact/interrupter tracing |
| Recording and reporting system | • Perform proper recording and reporting of presumptive DRTB cases and patients<br>• Ensure timely submission of reports to PHO | • Consolidate NTP reports and submit reports to RO (quarterly and annually) | | • Collect PMDT reports from PHO (provide report template during the RCC meeting) |
| Monitoring system | | • Monitor and supervise NTP implementation, including PMDT<br>• Conduct PIR to include PMDT | • Join PIR and other activities in the region | |
| Others | • Ensure DOT for all TB cases | • Advocate with LCE for support to NTP activities (in partnership with other agencies/partners)<br>• Advocate with private laboratories to participate in EQA | • Provide second-line drugs to decentralized patients<br>• Assist in the advocacy activities of CHD, PHO, RHU | |

## Plenary Presentation for Workshops 2, 3 and 4
*(1 hour and 30 minutes)*

Once the discussion of each group is finished and final workshop outputs are completed, you may now proceed with the plenary presentations.

❑ Ask the presenting group to report the consolidated outputs of Workshops 2, 3 and 4 using the PowerPoint presentation they prepared.

1. Gaps and issues in each step of the referral system or case holding mechanism
2. Recommendations/Solutions to improve the referral system and strengthen case-holding mechanism
3. Roles and responsibilities of different health offices in PMDT implementation

❑ Each group should assign a rapporteur and another person to take down notes during the feedback.

❑ Allot 20 minutes for each group to present; allot the rest of the time for the open forum.

❑ Ask members of the non-presenting group to provide inputs and comments to the presenting group. Make sure that no one person is dominating the feedback session.

❑ You may give some inputs on how to provide (and receive) feedback:

**For the giver of the feedback**

- First, examine your motives for giving the feedback: be sure your intention is to help improve the outputs, not to show how perceptive and superior you are.
- Explicitly identify and positively reinforce what was good about the presentation before identifying the gaps in the outputs. Specifically, start with positive feedback by pointing out the strengths and good points of their outputs, so they can build on them. And then point out what could be improved in their outputs.
- Be specific and clear in giving both positive and negative feedback. Avoid giving feedback such as "That's a brilliant presentation!" Point out which section of the presenting group's outputs is correct and why. In giving negative feedback, provide ideas and suggestions on how things could be done differently.

**For the receiver of the feedback**

- During or right after the presentation, discuss the feedback you get with your group and incorporate the comments and suggestions in your group's output.

## *Workshop 5: Creation of Two-way PMDT Referral System (1 hour and 30 minutes)*

In this workshop, the participants should be able to integrate all their outputs from Workshops 2 to 4 and come up with an enhanced version of their Workshop 1 output.

**Preparations**

- ❑ Ask participants to re-join their respective groups (referral system and case holding groups) in their assigned workshop area.

- ❑ Ask the Referral System Group to draw an enhanced referral system, specifying the roles and tasks of the DOTS facility and TC/STC in each step of the referral system *(see list below)*. Remind them that the enhanced system should address the gaps and issues enumerated in Workshop 2.
    - Identification of presumptive DRTB
    - Forms used
    - Existing guidelines or protocols
    - Feedback mechanism from TC and STC
    - Coordination
    - Recording and reporting system
    - Monitoring system

- ❑ Ask the Case Holding Group to draw an enhanced two-way case-holding mechanism for a DRTB case. This should specify the roles and tasks of the DOTS facility and the TC/STC in each step of the case-holding mechanism from preparation for initial treatment to actual DOT treatment to post-treatment:

    - Preparation for initial treatment
        - Pre-enrolment requirements
        - Contact tracing
    - During treatment
        - Management of decentralized cases, including DOT, treatment partner, drug management
        - Tracing interrupters
        - Recording and reporting
        - Monitoring, including follow-up sputum test, blood chemistry and chest X-ray; follow-up for clinical evaluation
        - Coordination and feedback mechanism at all levels of the health care system
    - Post-treatment

    Remind both groups that the enhanced referral system and case-holding mechanism they are developing will be used by personnel at the DOTS facilities as guide in PMDT implementation. Therefore, their outputs should be as clear and comprehensive as possible.

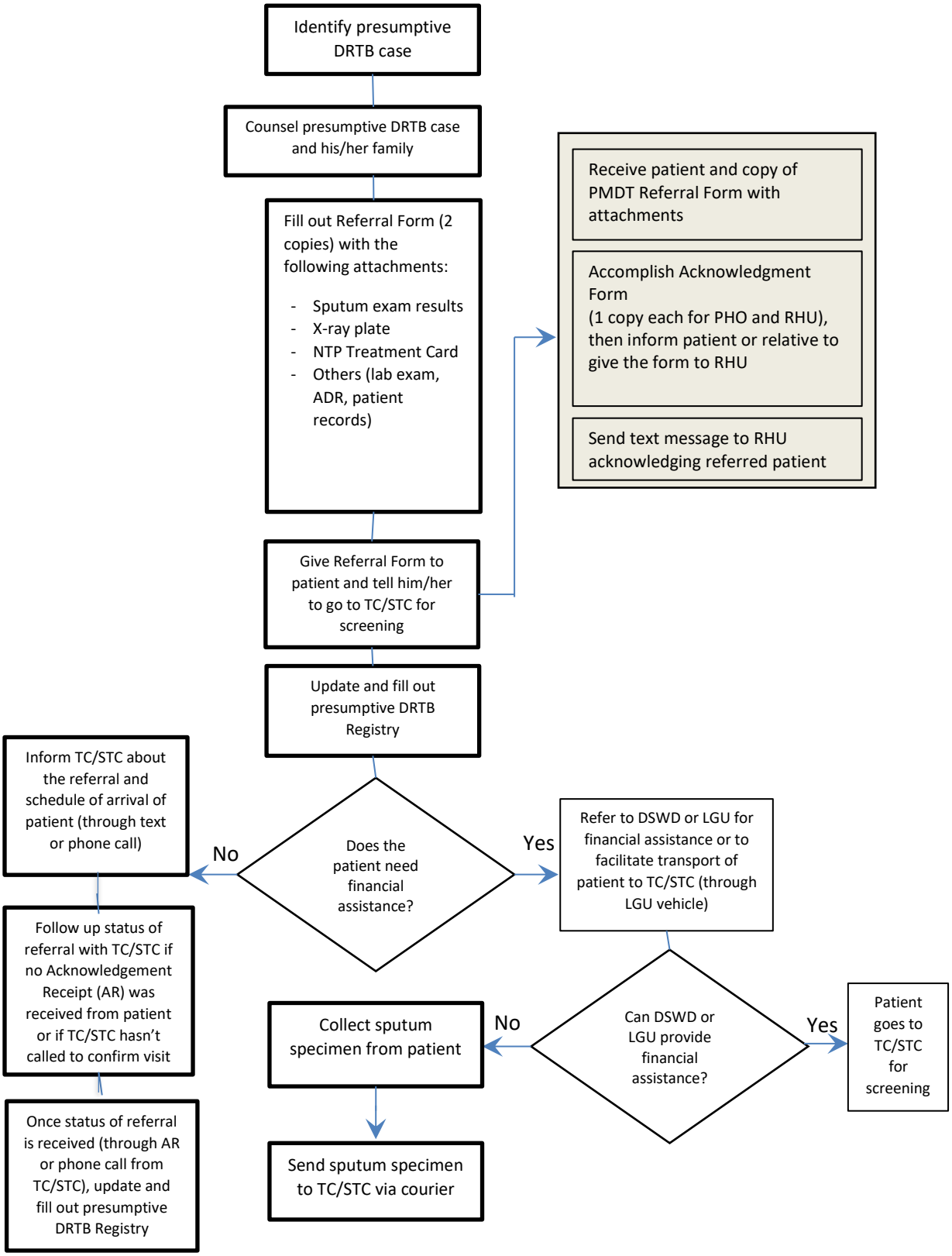
*See sample outputs below.*

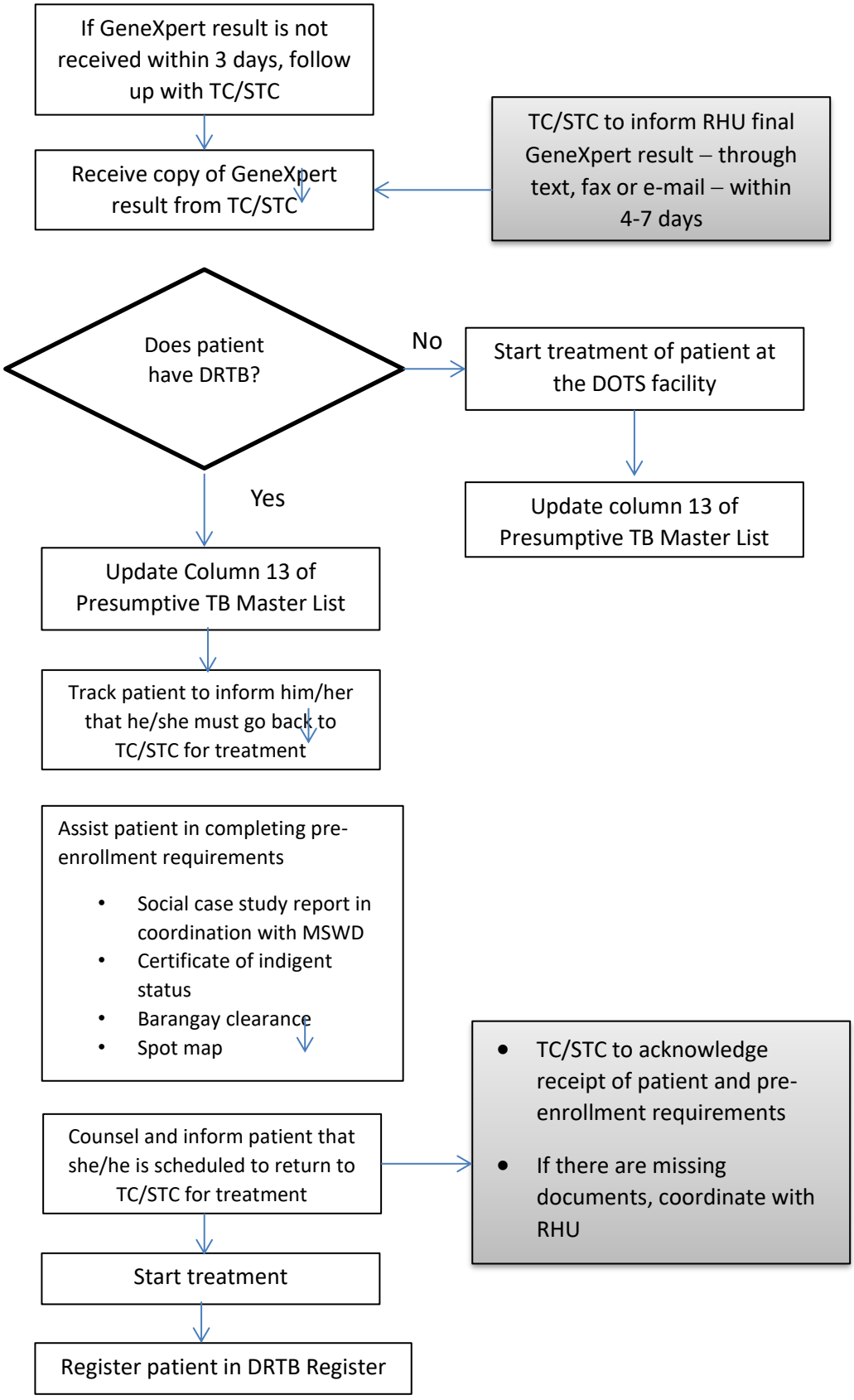
## *Plenary Presentation for Workshop 5*
## *(30 minutes)*

Once the discussion of each group is finished and final workshop outputs are completed, you may proceed with the plenary presentations.

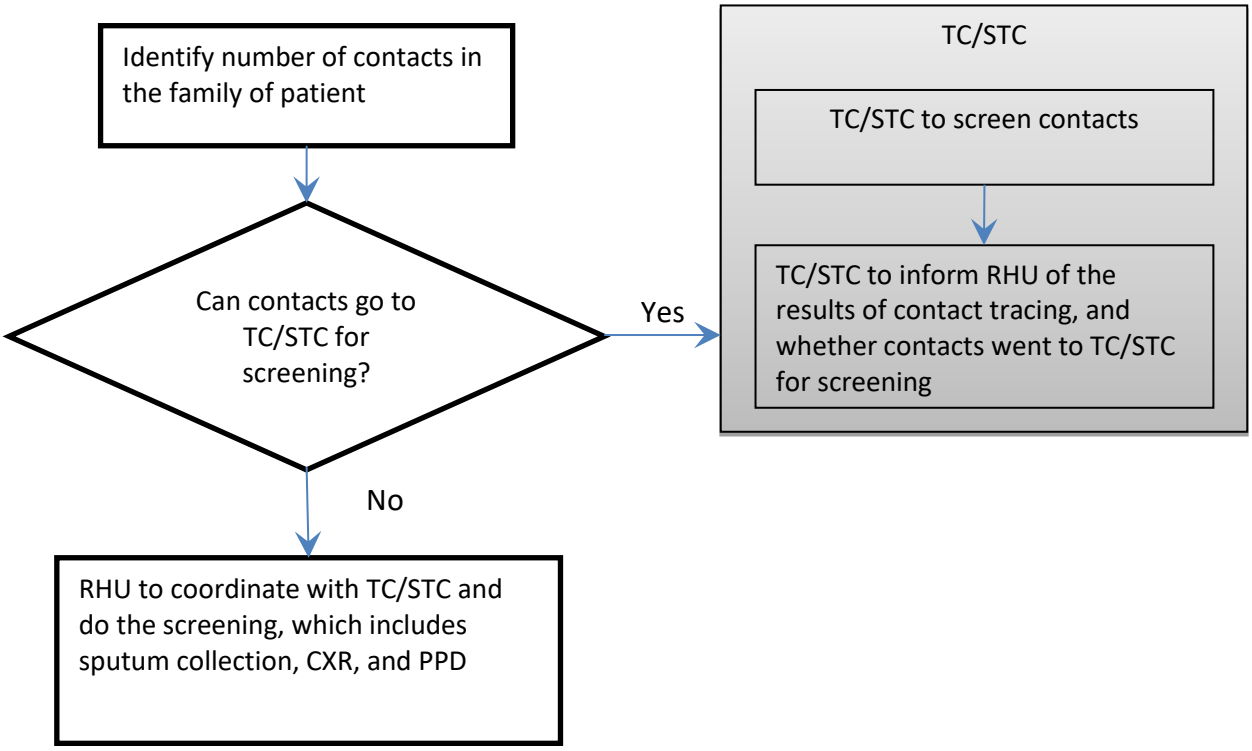
- ❑ Ask the presenter of each group to report the final output of the group's discussion. Group 1 should present the enhanced two-way referral system, while Group 2 should present the enhanced two-way case-holding mechanism.
    - ❑ Allot 15 minutes for each group to present; allot the rest of the time for the open forum.
    - ❑ Ask members of the non-presenting group to provide inputs and comments to the group presenting. Make sure no one person is dominating the feedback session.

## Sample Output for Workshop 5
## Enhanced two-way PMDT referral system and case-holding mechanism




If GeneXpert result is not received within 3 days, follow up with TC/STC
Receive copy of GeneXpert result from TC/STC
TC/STC to inform RHU final GeneXpert result – through text, fax or e-mail – within 4-7 days
Does patient have DRTB?
No
Start treatment of patient at the DOTS facility
Update column 13 of Presumptive TB Master List
Yes
Update Column 13 of Presumptive TB Master List
Track patient to inform him/her that he/she must go back to TC/STC for treatment
Assist patient in completing pre-enrollment requirements
Social case study report in coordination with MSWD
Certificate of indigent status
Barangay clearance
Spot map
TC/STC to acknowledge receipt of patient and pre-enrollment requirements
If there are missing documents, coordinate with RHU
Counsel and inform patient that she/he is scheduled to return to TC/STC for treatment
Start treatment
Register patient in DRTB Register

**Contact tracing**




**Other tasks of the RHU in PMDT case holding:**

**CONTACT TRACING**

- Identify number of contacts in the patient's family, then inform TC/STC and coordinate on logistics and further instructions (CXR, PPD, sputum collection)

**DECENTRALIZATION**

- Identify treatment partner/s and schedule them for orientation
- Conduct orientation of treatment partner/s
- Facilitate update of follow-up forms/stock cards
- Facilitate transport of patient upon follow-up with STC
- Follow up on patient for check-up at RHU at least once a month or two weeks before check-up at TC/STC

**DRUG MANAGEMENT**

- Inform STC and PHO about near-expiry medicines at least a month before expiration, and RHU to pick up the medicines

**INTERRUPTER TRACING**

- RHU to look for the patient after 48 to 72 hours of notification from TC/STC

**RECORDING AND REPORTING**

- Update the Presumptive TB Master List
- Update monthly the status of DRTB from TC/STC
- Submit quarterly report to PHO on the number of presumptive DRTB cases, number diagnosed, number treated and outcome of patients

**Other tasks of the TC/STC in PMDT case holding:**

**CONTACT TRACING**

- If family members could not go to the TC/STC for screening, coordinate with RHU for contact tracing instructions and means
- Respond to the queries of RHUs on patient updates

**INTERRUPTER TRACING**

- Inform RHU of origin and relocation of patient when said patient has interrupted treatment for three days
- Actively inform RHUs of necessary updates on patients: (1) monthly follow-up of patients and (2) interrupting patients

**DRUG MANAGEMENT**

- Receive and do inventory of received DRTB medicines

**RECORDING AND REPORTING**

- Email/Fax acknowledgement receipts to PHO

## *Training on Proper Packaging of Sputum Specimens (1.5 hours)*

For this activity, use the video included in this technical assistance package.

**Learning Outcome**

At the end of the video presentation, the participants should be able to demonstrate how to package sputum specimens properly.

**Prepare the following materials:**

- Specimen container with specimen
- Transparent small plastic bag/biohazard bag
- Absorbent scrap paper
- Ice packs
- Secondary container
- Styrobox with label
- Masking tape
- Documents inside brown envelope and plastic envelope
- Gloves
- Permanent marker

## *Agreements and Next Steps*
## *(30 minutes)*

This session serves as a venue to discuss the next steps participants will take after the workshop. The next activity/activities should be designed with the following objectives in mind:

1. obtain the involvement and commitment of participating LGUs and private sector partners to adopt the local referral system, case-holding mechanism and use of a local recording system for presumptive DRTB referrals;
2. increase NTP coordinators' understanding and knowledge of MDRTB and PMDT implementing guidelines; and
3. improve knowledge of NTP core teams in the proper referral of presumptive DRTB cases to a PMDT treatment center.

Below are suggested activities that may be conducted to attain these objectives.

**Option 1: Presentation of Results of PMDT Workshop to Municipal Health Officers**
*1 hour – 2 hours*

The PHO may present the findings and outputs of the workshop during the regular meeting with the local AMHOP or in a special meeting with municipal health officers, specifically

- the gaps and issues on the referral system and case-holding mechanism;
- the crafted local referral system, case-holding mechanism and recording system; and
- the roles and responsibilities of various partners in PMDT implementation.

After presenting the workshop outputs, the PHO should then secure the commitment of the MHOs to adopt: (1) the revised local referral system and case-holding mechanism, (2) recording system on PMDT, and (3) roles and responsibilities of various partners in PMDT implementation.

During this event, a simple signing ceremony may be conducted by DOH RO or PHO to secure commitment of various stakeholders in adopting the local PMDT referral system, case-holding mechanism and recording system, and commit to their roles in implementing PMDT in the province.

**Option 2: Dissemination of a Memorandum**

The PHO may simply release a memorandum to all MHOs and CHOs to adopt the enhanced PMDT referral system and case holding mechanism and ask them to commit to their roles in PMDT implementation in the province.

The PHO may also ask the participants to put together a simple work plan for PMDT implementation *(see table below*).

**Table 1. Sample work plan for strengthening PMDT implementation**

| Activity | Deadline | Lead Office/s |
|---|---|---|
| Present workshop outputs to MHOs, or disseminate to RHUs | Within second week of Month X | PHO |
| Participants to provide feedback to PHO regarding MHOs comments to workshop outputs | Last week of Month X | RHUs |
| Finalize PMDT referral system and case-holding mechanism | Last week of Month X | PHO and RHUs with DOH RO |
| Identify staff for training | Month Y | RHU |
| Conduct training of staff on PMDT basic course for RHUs | By end of Month Y | DOH RO and PHO |

## *Closing Program*
## *(15 minutes)*

**Learning or insights from the participants and closing messages**

Ask one participant from each RHU to share with the group his/her insights and learning from the workshops.

Request officers from the DOH Regional Office and Provincial Health Office and development partners to give short messages to the participants.

## Useful Resources

1. 2013 Manual of Procedures of the National TB Control Program, 5th edition
2. AO 2014-0032. Guidelines for the Scaling up and Use of Xpert MTB/Rif as Rapid Diagnostic Tool Under the National TB Control Program
3. DOH Department Memorandum 2016-0285. Implementation of Xpert as Primary Diagnostic for Presumptive DRTB and selected Vulnerable Population
4. PMDT Implementing Guidelines