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Ministry of Health & Family Welfare
निर्माण भवन, नई दिल्ली-110108
Nirman Bhavan, New Delhi-110108

DO No. Z-28015/81/2020-TB-Part(1)
Dated: 04th September 2020

Sub: Rapid Response Plan to mitigate impact of COVID-19 Pandemic on TB Epidemic and National TB Elimination Program (NTEP) activities in India-Reg.

India had made significant progress towards the goal of Ending TB till 24th March 2020 and then, the nation-wide lockdown due to COVID-19 has affected all the key strategic interventions resulting in almost 60% decline in TB case notification during the lockdown period. This may not only lead to significant morbidity and mortality due to TB disease, but also an increased likelihood of active transmission in the household contacts.

In continuation to the D.O. No Z-28015/192/2020-TB dated 11th August 2020 and D.O. No. Z-28015/81/2020-TB-Part(1) dated 01st September 2020 on Bi-directional TB-COVID screening and screening of TB among ILI/SARI cases by the Union Secretary (HFW), a rapid response plan for National Tuberculosis Elimination Programme (NTEP) has been prepared with the following objectives:

1) To implement rapid response measures for normalizing and expanding coverage of TB services to pre-COVID-19 levels and beyond
2) To revitalize TB elimination efforts of the country by adopting novel strategic interventions

It is requested that the programme maybe reviewed at your level and necessary instructions be issued to all concerned for adapting and effectively implement the interventions outlined in the rapid response plan as per the local context.

Yours Sincerely,

(Dr K S Sachdeva)

(Encls: As above)

To:

1) Addl Chief Secy / Principal Secretary (Health) of all State/UTs

Copy for information to:

1) Commissioner (Health) / MD(NHM) of all State/UT's

2) PPS to Addl. Secy & DG (H) / Addl. Secy & MD(NHM), MOHFW/GOI

3) PPS to Director General of Health Services, MOHFW/GOI

4) PS to Joint Secy (VS), MOHFW/GOI

Rapid Response Plan to mitigate impact of COVID-19 Pandemic on TB Epidemic and National TB Elimination Program (NTEP) activities in India

Objectives:

- To implement rapid response measures for normalizing and expanding coverage of TB services to pre-COVID-19 levels and beyond
- To revitalize TB elimination efforts of the country by adopting novel strategic interventions to accelerate the NTEP response

Background:

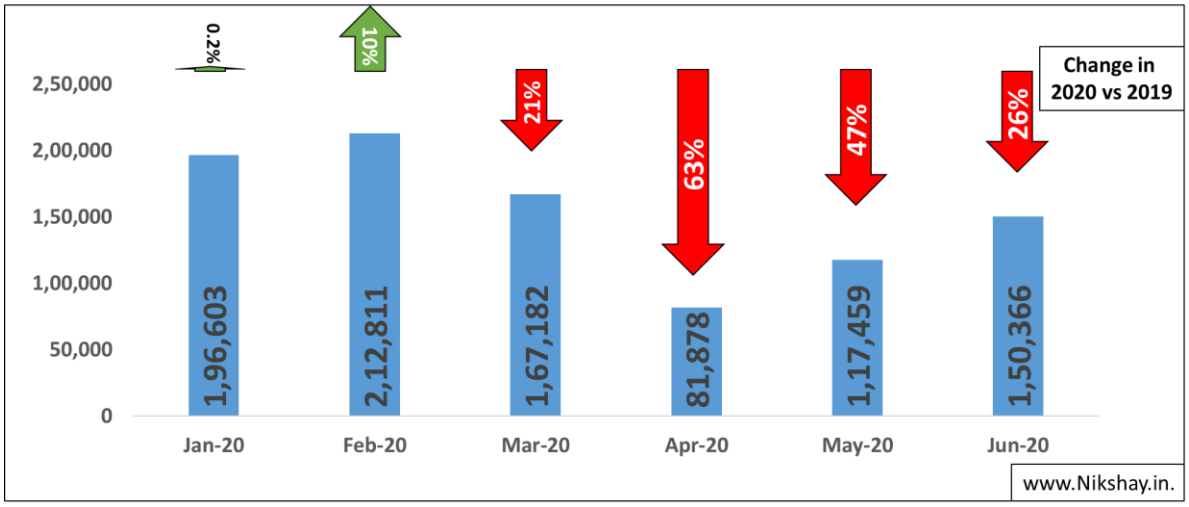
As the nation moves from Millennium Development Goals (MDGs) to the more ambitious and universal Sustainable Development Goals (SDGs), augmenting our efforts with a holistic approach towards health, elimination of Tuberculosis (TB) from India would be critical. Ever since Honourable PM gave a clarion call to End TB by 2025, five years ahead of Sustainable Development Goals target, the period 2020-25 has become very crucial and significant progress needs to be made during the period towards Ending TB.

In order to achieve End TB by 2025, the programme in India has been renamed as National TB Elimination Programme (NTEP) and is implementing TB prevention and control activities on mission mode. Intensive measures have been taken for the last three years to improve TB case finding in public as well as private sector including active case finding, decentralising molecular diagnostic and therapeutic services, enforcing mandatory TB notification, private sector engagement and extending public health actions. For a multi-sectoral response linkage have been established with other national health programs and other line ministries. Additionally, various enablers have been provisioned like incentives for TB notification, incentives for nutrition, support for patients in tribal areas and community engagement.

With the rapid increase in TB notification, India is closing the gap in 'Missing million TB cases' (24 lakh cases notified in 2019 against estimated 27 lakh TB cases). The number of missing TB cases has now been reduced to 2.9 lakh in 2019 as against more than 10 lakhs in 2017.

While India was on the right track till 24th March, the national and state specific lockdown due to COVID-19 has affected all the key strategic interventions resulting in almost 60% decline in TB notification during the lockdown period and moving back to the period where gap between estimated TB case and notified TB cases is increasing. During the period Jan-June, 2020 almost 5.7 lakh cases (62% drop of notifications) could not be notified against the estimated target due to COVID-19 and lockdown situations and only 42% TB patient received one or more NPY DBT payment during the same period.

Figure 1: Impact of COVID-19 on TB notification under NTEP –
January - June 2020 vs 2019



The overall impact of COVID-19 pandemic can be seen in terms of 26% reduction in TB case notification as compared with same period during last year. The month-on-month variation in the number of TB notifications as compared to the previous year is shown in above Figure. Moreover, the decline was much higher among children (70%) and among females (as compared to men).

TB being a bacterial infectious disease primarily affecting the lungs is transmitted through droplet nuclei. One pulmonary TB patient, if untreated, can infect 10-15 individuals in a year. In such circumstances, when TB patients are not able to access health services and are confined within their homes, there is all likelihood of an active intense transmission in the household contacts. Further, lack of medical attention will not only cause significant morbidity to TB patients but can also lead to TB related deaths due to non-diagnosis/non-treatment/discontinuation of anti-TB medication due to the lockdown.

Recent modelling studies to understand the potential effect of the COVID-19 response on TB epidemiology has been published by Stop TB Partnership indicates that over and above the existing cases, there would be an additional 514,370 TB cases and 151,120 TB deaths over the next 5 years

Challenges in TB service delivery during COVID-19 Pandemic:
Like any other national health program in India, the National TB Elimination Program (NTEP) has faced a setback in the light of COVID-19 Pandemic due to various reasons

COVID-19 induced situation	Effect on TB services
Closure of Public and Private health facilities	Reduced access to TB services for diagnosis and reduced TB notification
Fear of contracting COVID-19 in institutional setting	Reduced uptake of TB services by public, non-implementation of active TB case finding campaigns in high risk population which is compounded with

	stigma of COVID-19 detection as well as TB and difficulty in supply chain management
NTEP program officers and field health workers involved in COVID-19 activities	Minimal focus on TB service provision and planned activities implementation e.g. active case finding, private sector engagement, case holding of already diagnosed patients, contact tracing, pre-treatment investigations and initiation of treatment for DR-TB patients, community, and patient provider meeting
Patients stranded in different geographic location due to lockdown	Reduced TB adherence and struggle to gain medicines through health system
Non-availability of private courier and transport services	Difficulty in sample collection and dispatch to molecular diagnostic laboratory and Culture Drug Susceptibility Laboratory
Use of NTEP labs for COVID-19 testing	Reduction in capacity for TB testing and diagnosis of newer cases, diagnosis of DR-TB and follow up of existing cases
Lockdown related restriction on public and patient mobility	Affected provision of other TB program related services like HIV, Diabetes and Direct Beneficiary Transfer payment

This document assimilates proposed interventions for a rapid response from NTEP to mitigate the impact caused by COVID -19 on TB services.

Strategy for revival of NTEP services in COVID-19 / Post COVID-19 scenario:

1) Diagnostic Algorithm

- Inclusion of **bi-directional TB-COVID screening**: COVID screening for all diagnosed TB patients and TB screening for all COVID positive patients (detailed note placed at Annexure 1)
- **TB screening and testing for all presumptive ILI/SARI/COVID cases** in all COVID Zones (detailed note placed at Annexure 1)
- Integrated TB-COVID laboratory services including pre treatment evaluations for DR-TB and DS-TB for optimal utilization of platform technologies
- Restore diagnostics capacity currently diverted for COVID-19 testing by provisioning additional equipments
- Referral linkages to COVID Care Centres, COVID Health Centres and COVID dedicated hospitals
- **Introduce lung health concept** providing diagnostic services for all priority acute / chronic respiratory diseases with the support of free diagnostic initiative
- Biomedical Waste Management (BMWM): Adequate disposal of waste as per standard biomedical waste management guidelines

2) Case Finding - Public Sector

- Intensified case finding for TB & COVID in priority OPDs like Chest, Medicine,

HIV, Paediatrics, Dialysis, NCD, Cancer, etc

- Decentralized molecular diagnostics at block levels for TB & COVID screening – **Replacement of smear microscopy by NAAT testing** for all presumptive TB cases
- Effective sample collection and transportation system from Sub Centre to PHC, PHC to CHC and from CHC to District /CDST/IRLs
- **Home sample collection services** in Red Zones / Containment areas
- Active TB case finding campaign in green zone and areas with no / minimal COVID cases
- Hand washing facilities or corners may be established at the government health facilities and patients need to be educated for mandatory use of mask, physical distancing, and cough etiquette as per directives of the government.
- SHC - Health & Wellness Centres (HWCs) through
  - ✓ CBAC and house to house survey
  - ✓ Population enumeration and enlisting vulnerable population (pre-designed checklist) and quarterly house to house systematic active case finding among vulnerable population
  - ✓ Ensuring follow-up of symptomatic but sputum negative cases for completion of diagnostic algorithm including X-ray
  - ✓ Tele-consultation and video-consultation for SHC-HWC with CHC/DH
- **Contact tracing for close household and workplace contacts** for all infectious TB cases
  - ✓ Rule out active TB and initiate close contacts on TB preventive therapy (TPT)
  - ✓ Monitor and follow up contacts for quarterly screening and adherence to TPT
- A systematic active TB case finding campaign to be initiated after mapping of those areas with rapid decline of TB case notification due to COVID-19 especially in the green and orange zone initially. While undertaking such activities, mass media should be judiciously utilized, and all relevant local stakeholders should be taken into confidence to avoid unnecessary gathering of the patients or healthcare workers
- **Special strategy for Urban Slums** – In collaboration with NUHM and Urban Local Bodies; mobile vans, doorstep screening, sample collection & transportation, referral linkages for diagnosis & treatment
- **Migrants Strategy**– migrants mapping, camp-based approach, active case finding, patient tracking and patient support

3) Case Finding - Private Sector

- Directive through local administration for reopening private clinics / hospitals / laboratories
- IMA, IAP, ICS, FOGSI and other professional medical bodies may be issued instructions from state administration for provision of TB care and should be informed about mandatory notification and availability of provision for free drugs

and diagnostics from NTEP

- Personalized outreach through JEET / PPSA / Other NGO / NTEP staff to private providers for reopening facilities – Focus on high volume private practitioners / hospitals / facilities
- During physical visit to private provider physical distancing norms, wearing of masks, cough etiquettes, hand washing, etc should be followed. Advice the private provider that notification can also be made by calling Nikshay Sampark at 1800-11-6666 and providing patient details.
- Patient support to existing private sector TB patients through JEET / PPSA / Other NGO / NTEP staff physically
- E-pharmacy, doorstep sample collection and inclusion of private courier services/postal services
- Focused enforcement of mandatory notification and Schedule H1 implementation – monitoring drug sales in private sector
- Utilization of call centre (NIKSHAY SAMPARK) and other state level call numbers for follow up, drug refills, treatment outcomes

4) Sample collection and transportation services

- **Collecting of sputum samples:**
  - ✓ Collection of sputum is to be carried out in open well-ventilated area in public as well as private labs. Health Care Workers (HCWS) should observe Standard Operational Procedures (SOPs) for sample collection and handling.
  - ✓ Until specimen transport mechanism is completely restored, only priority specimens (including specimens from People Living with HIV/ AIDS, Paediatric, Extra-pulmonary) to be sent to the linked laboratory for diagnosis.
  - ✓ These specimens are to be stored in the refrigerator (2-8 degree Celsius) with appropriate labelling (including patient name, NIKSHAY-ID and date of specimen collection) for subsequent testing.
- **Reception and unpacking in the laboratory:**
  - ✓ Washing hands with soap and water after collecting, receiving and testing specimens.
  - ✓ Not eating/ drinking in the laboratory area
  - ✓ Restricting access to the laboratory premises. In laboratories with more than one technician posted, adequate distance between the personnel must be maintained.
  - ✓ Universal safety precautions including appropriate disposal of biomedical waste and repeated hand washing must be strictly followed while receiving and testing samples along with social distancing advisory implementation.

5) Treatment Services

- **Modified DOT modalities** – through CHO SHC/HWC, digital adherence technologies, call centre, treatment supporter – family DOTS
- Provide at least **monthly supply of drugs** with the option of **home delivery**
- State / District program managers and field functionaries should ensure there is adequate stock of anti-tubercular drugs available with the programme as well as

the private chemists to cater to the patients currently on treatment in their respective geographical area.

- Decentralized drug refills through home visits by SHC-HWC and through JEET/PPSA/NGOs in urban areas/intervention areas
- Monitoring of Adverse Drug Reactions through call centre, tele-consultation
- Universal DST and Pre-treatment evaluations for DR-TB to bridge gap between diagnosed and initiated on treatment
- Utilization of **isolation facility for infectious DS-TB / DR-TB patients**
- Intensified co-morbidity management – HIV, DM, other NCDs including TB-COVID. Cross referrals and linkages for diagnosis, co-morbidity management and continuum of care
- **Management of other priority acute / chronic respiratory illnesses** with support of free drugs initiative
- **Airborne Infection Control** in all public health facilities in OPD/IPD, patient registration/waiting areas etc to ensure infection control, adequate social distancing, and staff safety (e.g. disinfection protocols, patient appointment system etc.)

Consultation / Treatment in an OPD setting

- Opening of OPD should be based on directions as per orders of the local administration. Clear timings of the clinical practice to be mentioned
- For individuals showing up at facilities providing non COVID essential services in exceptional cases, **triaging** should be carried out.
  - ✓ Entry point screening during triaging would help minimize contact between probable COVID and non COVID cases. If possible, temporary structures outside the public facilities could be set up to facilitate triaging.
  - ✓ Establish a triage area to pre-screen the patients for symptoms for COVID. Temperature readings as part of the routine assessment of patients should be taken before initiating any consultation. Temperature should be recorded at every visit preferably through an infrared thermometer. Physical distancing should be maintained in clinical and triage areas.
  - ✓ Prepare the waiting area, bathrooms, and patient consultation rooms to ensure availability of proper supplies like:
  - ✓ Tissues, alcohol-based hand rub / soap at wash basin / sinks
  - ✓ Place chairs 6 feet apart, when possible. Install physical barriers (e.g. glass or plastic window/curtain) at reception/triage areas to limit close contact with any potentially infectious patients.
  - ✓ Any TV, takeaway IEC materials, toys, reading materials, remote controls or other communal objects in the clinic may be removed or regularly cleaned
  - ✓ On a regular schedule, wipe all touchable surface areas with an approved surface cleaner.
    - ➢ Remember to include tables, chair arms, doorknobs, light switches, hangers, and anything else with which people come in contact
    - ➢ If surfaces are dirty, they should be cleaned using a detergent or soap

and water prior to disinfection

- ✓ Use appropriate PPEs and ask the patient and patient's attendant to wear mask. Maintain a distance of at least one metre unless examining the patient. Physically examine patients only if absolutely essential. Discard gloves carefully post examination.
- ✓ Once the Staff reaches home, it is recommended to:
  a) Leave bags, keys, and other personal objects in a box at the entrance of house and do not touch anything without washing hands first.
  b) Take off shoes, sanitize phones, remove clothes and put them in a bag inside the dirty clothes basket. Bleach.
  c) Shower and wash the most exposed areas, like hands, fists, neck, and face, really well.
- ✓ All frontline health workers should be trained in protocols for COVID screening, isolation and triage which are to be followed for anyone arriving with acute onset of cough, fever, and breathlessness within the last 14 days. Protocols are evolving and therefore the most updated provided on websites of
  - ➢ MoHFW/ICMR/ NCDC/CTD must be used.
  - ➢ Fever clinics should be established at CHC/UCHC to which patients could be referred from peripheral facilities. The scheduling of visits to fever clinics could be managed through staggered appointments facilitated through telephone calls to the clinic or through centralized helplines.

6) Patient Support Services

- **Each district needs to identify a person who can handle TB patient/public related calls** and assist them for required service uptake (Sample collection, drug delivery, linkage with treatment supporter or nearby HWC or PHI providing treatment)
- All confirmed TB patients need to be provided with **TB ID cards** which should allow unrestricted mobility and assist TB patients for availing the TB diagnosis, treatment and follow up or DBT scheme
- Efforts to be made to reduce patient visit to the healthcare facilities and all services to be offered under one roof / **single window system** (TB, HIV, DM testing, sample collection for UDST, bank detail collection and treatment initiation with one month medicine provision to each TB patients with linkage of the patient to nearest health facility and treatment supporter in the closest locality)
- Nutritional counselling support and home-based counselling through ANM/ASHAs
- Call centre support for reporting adverse drug reactions, drug refills, DBT, any other social support
- Offer tele-consultation & video-consultation for interaction with doctors
- Peer counsellors through Community Engagement NGOs / partners
- All health facilities (including private health facilities and PHIs), treatment support centers need to ensure prompt initiation of all diagnosed TB patients on TB treatment and counselling of TB patients for Infection prevention of contacts

and reporting of any symptomatic in family or in surrounding.

- For program / PPSA /NGO partner staff:
  - ✓ List of all TB patients should be maintained at the PHC/ SHC level.
  - ✓ Delivery of DOTS to TB patients through ASHAs/ ANM/ volunteers to be ensured, closer to the community, with minimum or no travel.
  - ✓ Routine screening for presumptive TB cases to continue at primary level facilities with diagnostic services to be provided uninterrupted at designated facilities as per advisories issued by National Tuberculosis Elimination Programme.
  - ✓ In case those TB patients already diagnosed do not turn up for treatment initiation / continuation due to lockdown or any other 'administrative / psychological / social barrier' STS / CHO / ANM / ASHA / Treatment supporter should contact the patient at the earliest, in his household (if necessary) and initiate on TB treatment.
  - ✓ In case of Private notified TB patients, private healthcare providers need to contact local NTEP / JEET / PPSA / NGO project staff who may be requested to contact the said private TB patient at the earliest for treatment and other service linkages to avoid initial loss to follow up.
  - ✓ Use of digital health technologies should be intensified to support patients and programmes through improved communication, counselling, care, and information management, among other benefits.

7) Provider Support Services

- Guidelines for Standard precautionary measures for healthcare workers in all health facilities including healthcare workers surveillance for communicable / non-communicable diseases
- Ensure adequate PPE for NTEP and NGO staff along with trainings
- Timely pay out of salaries, performance-based incentives, incentives to informants, incentives to private providers
- Sensitization of universal safety precautions for all medical and para medical staff including private sector
- Training of outreach workers governmental and non-governmental in personal protection along with provision of adequate PPEs
- Graded plan for relieving NTEP staff from COVID duties
- Transition from paper-based reporting to 100% digital recording and reporting

8) Direct Benefit Transfers (DBT) Services

- All districts to list scheme wise beneficiaries like patients whose Nikshay Poshan Yojana (NPY) benefits are pending at various levels and clear the backlog within a month. All pending payments for NPY, Treatment supporter, tribal patients, private provider and informants should be cleared within a month.
- Patients who were diagnosed but whose bank details were not available, need to be contacted by CHO / SHC-HWC / peripheral healthcare workers and NGO / partner agencies for collection and submission of bank account details in Nikshay and ensure prompt payments

- Treatment providers play a crucial role in assisting TB patients for treatment adherence and completion for successful treatment outcome. All STS, DPC and District PPM coordinator need to complete the NIKSHAY portal data either through visit to health facilities, contacting TB patients whose follow up were due during lockdown and couldn't happen, facilitate patient sample collection from their home/patient visit to nearest healthcare facilities from where sample can collected and dispatched for testing
- JEET / PPSA / other NGO partners also need to be involved in beneficiary identification, bank account details collection, etc

9) Demand Generation activities

- Intensive local IEC on TB & COVID
- Address stigma due to COVID and improve health seeking behaviour
- IEC for sustaining social distancing, personal hygiene, ban in spitting, wearing of masks, etc
- Targeted IEC activities for key populations like migrants, urban slums, HIV vulnerable populations, miners, labourers, etc
- Community engagement activities for local advocacy, reduce stigma, improve health seeking behaviour, peer support, etc

10) Rationale use of Personal Protective Equipments (PPEs)

- **General Guidance** (Rationale use of Personal Protective Equipment guidelines issued by MoHFW)
  - ✓ Standard precaution always needs to be followed
  - ✓ PPEs are not alternative to basic preventive public health measures such as hand hygiene, respiratory etiquettes which must always be followed
  - ✓ Always follow the laid down protocol for disposing off PPEs as detailed in infection prevention and control guideline available on website of MoHFW
- **Doctors chamber/physical consultation (MO, Specialists, Nurses)**
  - ✓ Triple layer medical mask
  - ✓ Latex examination gloves
  - ✓ No aerosol generating procedures should be allowed
- **Handling specimens (Microbiologists, Bacteriologists, STLS, Sr. / Lab technician, Lab Attendants, Sputum Collection and Transportation Agents)**
  - ✓ Disposable N95 respirators (mask)
  - ✓ Disposable apron/ Surgical Gown / Normal Apron covered with plastic sheet (disposable/autoclavable /disinfected with hypochlorite)
  - ✓ Gloves (Vinyl or Latex)
  - ✓ Disposable Head gear (cap)
- **Outreach Staff (District level supervisory staff, STS, TB HV, NGO Supervisors / Field Officer, Treatment Coordinators)**
  - ✓ triple layer medical mask
  - ✓ latex examination gloves
- **Radio-diagnosis / Pharmacy counter / Stores / Laundry Help desk / Registration counter (X-ray techs, Radio techs, Pharmacists, Store Officer,**

Store Asst, Volunteers)

- ✓ triple layer medical mask
- ✓ latex examination gloves

11) Monitoring and Evaluation

- 100% transition to NIKSHAY including laboratory services and supply chain management
- Quarterly NIKSHAY based feedback to all States on State TB Index and Quality Index
- Strengthened support to districts through WHO NTEP Consultants – monthly visit to all districts
- Utilization of Medical College Faculty (Community Medicine Dept.) in conducting State Internal Evaluations (SIE) – once in a quarter to each district; ensure adequate budgetary support to Medical Colleges
- Data entry, data management and data driven decision to be taken at local level for specific intervention for overcoming the challenge and documentation of best practices with periodic feedback to state and centre

12) Surveillance

- Sub-national disease certification through third party agency
- Annual district level under-reporting survey and 50 district sentinel surveillance
- Completion of National TB Prevalence Survey through ICMR
- Commissioned Operational / Implementation research on priority research topics

13) Program Management, Staff and Administrative Support

- All respective States and Districts should report issues to competent authorities/ respective administration for urgent resolution of matters pertaining to drug supply, transportation of samples, patient mobility etc. Chief Secy / Principal Secy (Health) should send advisories to all district administrative and health functionaries for immediate operationalization of transportation services for samples/drugs and patient mobility even in containment zones as a measure for essential services.
- In Green Zone District, NTEP activities will resume normally with complete utilisation of the human resources, with immediate effect. In Orange Zone District, baring few officials, who are directed / involved by the local administration for COVID-19 related containment zone duties, the rest of the human resource shall function and cater to TB Services fully.
- In Red Zone District, human resources who are involved in both NTEP/COVID activities should play a more active role and will have to put extra effort to restore routine NTEP activities. They must ensure that routine activities under NTEP go unabated.
- TB programme managers of States and Districts must motivate, orient, counsel and perform periodic reviews of peripheral health care workers / TB workers, over the phone and video conference and to contribute to improving the service standards and optimal functioning of the NTEP program. Peripheral health workers (ANM/ASHA etc.) should ensure the adherence to treatment of TB

patients, over regular phone calls if not possible by physical visits.

- Ensure proper transport facilities and passes for staff of NTEP along the partner organizations like JEET, PPSA personnel.
- Expedite the filling of vacancies and release of funds to districts / contracted NGO partners
- Incentives and other rewards and recognition to motivate State/District staff
- Provide flexibility to districts to implement local level solutions and support scale-up of innovative ideas
- Strengthen supply chain monitoring through NIKSHAY AUSHADI and ensure uninterrupted drug supplies, including adequate buffer stock
- Utilize NHM flexibility for local procurements of anti TB drugs by ensuring rate contracts for 25% quantities of all anti TB drugs and inclusion in essential drug list of States
- Logistic and consumables: Provision of sufficient lab consumables, sputum cups, reagents, falcon tubes, recording and reporting formats, CBNAAT cartridges, Truenat chips, PPE kits and soap/sanitizer provision to NTEP staff / partner NGO staff
- NTEP field workers will need complete orientation on basic program activities (SOP, IPC, TB case finding, TB case holding, all 4 DBT scheme, tele-consultation, use of TB call center by general public and patients, new incentives to be rolled out, special package in COVID-19 containment areas)
- Civil Society Representatives and Community Based Organizations (CBOs) will also facilitate training for community representatives with the help of their network across the country.
- Partner agencies will support all NTEP related activities in community engagement, training of healthcare workers, capacity building of private healthcare providers as well as medical officers for handling TB patients, active TB case finding campaign, drug and logistics management, mission mode active TB case finding campaign and monitoring/identification of gap areas at local/district/state level and feedback to health system

Annexure 1: Guidance note on Bi-directional TB-COVID screening and screening of TB among ILI/SARI cases

Tuberculosis and COVID-19 are infectious diseases which primarily attack the lungs. They present with similar symptoms of cough, fever and difficulty breathing, although TB disease has a longer incubation period and a slower onset of disease. The prevalence of TB among COVID-19 patients has been found to be 0.37 – 4.47% in different studies. There has been an overall decline in TB notification by 26% during January to June 2020 as compared to previous year, due to the COVID-19 pandemic.

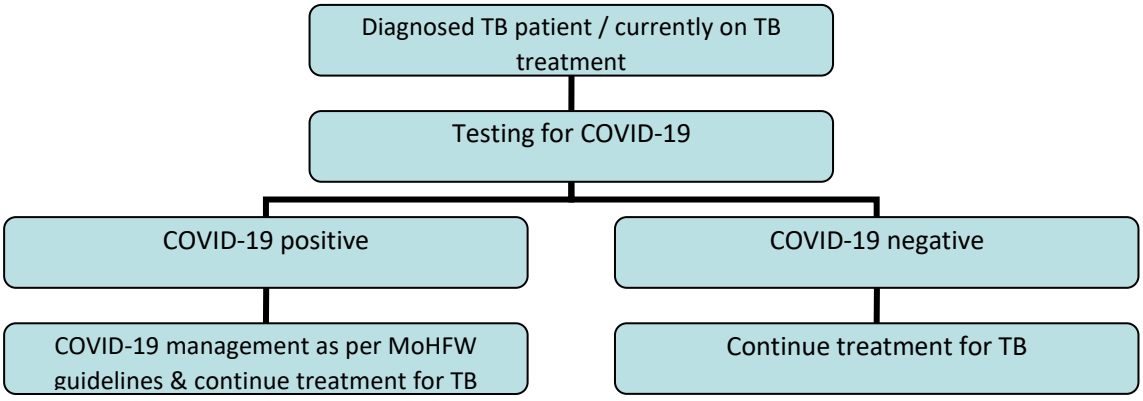
Studies have shown that history of active as well as latent TB is an important risk factor for SARS-CoV-2 infection. This not only results in increased susceptibility, but also rapid and severe symptom development and disease progression with poor outcomes. Tuberculosis is associated with a 2.1-fold increased risk of severe COVID-19 disease. In addition, TB patients also tend to have co-morbid or living conditions (malnutrition, diabetes, smoking, HIV etc) that increase their vulnerability. In order to address this dual morbidity of Tuberculosis and COVID-19, the following activities should be carried out:

A. Bi-directional TB-COVID screening
B. TB screening for ILI cases
C. TB screening for SARI cases

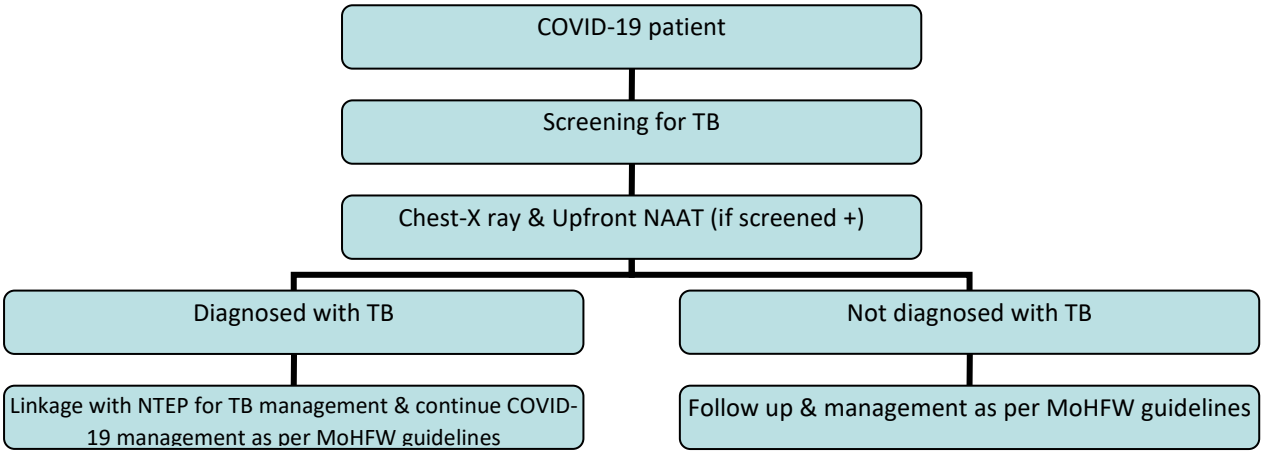
A. **<u>Bi-directional TB-COVID screening</u>**: COVID screening for all diagnosed TB patients and TB screening for all COVID positive patients should be conducted.

a. Eligibility Criteria

i. **COVID screening for diagnosed TB patients**: All newly diagnosed TB patients or those currently on treatment should be tested for COVID-19 (as per MoHFW guidelines). Based on the result of COVID-19 test, further management would be undertaken as per MoHFW guidelines. Even upon diagnosis of COVID, treatment of TB should continue uninterrupted.



ii. **TB screening for COVID positive patients**: All COVID-19 cases should be screened for TB symptoms using the 4-symptom complex (Cough for > 2 weeks, persistent fever for > 2 weeks, significant weight loss, night sweats), history of contact with TB case, history of TB and those symptomatic should be offered Chest X ray and upfront Nuclear Acid Amplification Test (NAAT) – CBNAAT/TrueNat) for diagnosis of Tuberculosis. Sample for TB should be collected in a segregated open or well-ventilated area under bright sunlight, identified exclusively for the purpose. Arrangement has to be made such that the sample reaches NAAT site in cold chain (transportation in ambient temperature using pre-frozen gel packs). Appropriate PPE should be used during sample collection, processing and performing the test. Universal safety precautions including hand washing must strictly be followed by patients and HCW while collecting, receiving and testing samples. Based on result of TB test, patient should be managed as per NTEP guidelines. Home sample collection services to test TB for those fulfilling the above criteria should be provided wherever possible.



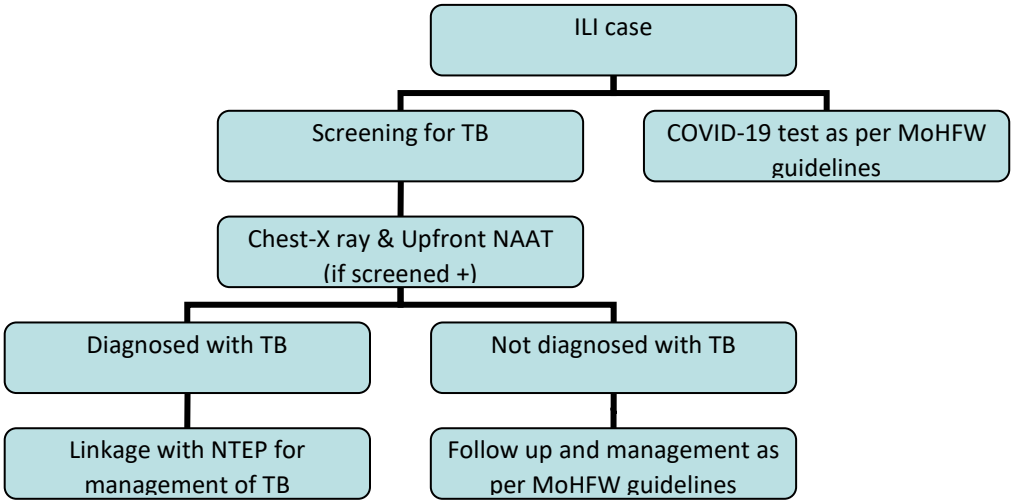
iii. For intensive management of TB-COVID co-morbid patients, linkages of TB service facilities with COVID Isolation facilities should be established. All COVID positive TB patient, will be admitted to a Dedicated COVID Care Centre/ Dedicated COVID Health Centre/ Dedicated COVID Hospital (level as per severity), if required.

iv. The information on COVID-19 screening among TB patients would be captured in the Nikshay portal. The updated CIF form of COVID-19 patients placed at Annexure 1.

B. **TB screening for ILI cases**:

a. *Eligibility Criteria*: Any ILI case with 4-symptom complex (Cough for > 2 weeks, persistent fever for > 2 weeks, significant weight loss, night sweats), history of contact with TB case, history of TB, ILI symptoms persisting >10 days

b. Diagnostic Algorithm for TB screening among ILI



c. Home sample collection services to test TB for those fulfilling the above criteria should be provided wherever possible, with adequate safety precautions.

C. **TB screening for SARI case**:

a. *Eligibility Criteria*: Any SARI case with 4-symptom complex (Cough for > 2 weeks, persistent fever for > 2 weeks, significant weight loss, night sweats), history of contact with TB case, history of TB, SARI symptoms persisting >10 days

b. Diagnostic Algorithm for TB screening among SARI