COMMUNITY MODEL

GROUP 2
What are the TB activities that will be included in the model?

- Advocacy to solicit support of community leadership and other organs of civil societies
- Awareness raising at community level, distribution of IEC materials
- TB screening
- Sputum collection at community level
- Referrals of presumptive TB cases
- Contact tracing
- TB treatment adherence support
What are the TB activities that will be included in the model?

- Provision of sputum transportation service
- Defaulter tracing
- Establishing TB community centers (DOTS centers/Health posts)
- Map out existing support groups in the community
  - Sober houses, tobacco cession, reach for recovery, alcohol anonymous groups, IGA
- Linking TB patients with existing support groups where they exist
- Initiate HTS at the community level
What are the chronic lung condition activities that will be included in the model?

- Awareness raising activities on the risk factors of CLCs
- Referral of coughing patients
- Active follow up of coughing patients even after the first sputum examination turned out negative
- Update the existing TB screening tool to incorporate NCDs
- Establishment of Treatment adherence support
- Establish treatment support groups.
- Linking CLC patients to existing support groups
What are the TB activities that will be carried out by community volunteers?

- Conduct awareness raising activities
- Conduct systematic screening for active TB (proactive screening)
- Conduct contact Tracing/Visiting homesteads and screening households contacts, close contacts including MCEs of known TB patients as well as index case. (reactive screening)
- Collect sputum at community level.
- Sputum fixation.
- Ensuring the sputum samples reaches the testing sites.
- Responsible for follow up and receipt of TB tests results from the Health Facilities.
- Linking the clients bacteriologically confirmed TB cases to the facilities for care and treatment
- Referring and linking clients presenting with s/s for clinical diagnosis using a community referral tools.
- Make a follow up to ensure the patient reach the health facility.
- Treatment Adherence Support system through out the treatment period including tracing missed cases and lost to follow up
- Responsible for accurate and orderly record keeping.
- Conduct HTS
What are chronic lung conditions activities that will be carried out by community health workers?

- Conduct awareness raising activities
- Screen for TB and if the case is not TB refer to health facilities
- Create a system to make sure that the patient actually reach to the facility
- Periodic check up and follow up of coughing patients.
- Establishing support group in the community for chronic lung condition patients.
- Linking chronic lung condition patients with the existing support groups
What should be the linkage with the facility?

- Establishing referral systems for coughing patients
- Identify the entry points for coughing patients
- Develop referral forms and slips
- Establish a fast track and weaver system for coughing patients
What resources are needed to make the model functional?

- Human resources
- Finances (Ring fenced)
- Logistics and supplies
- IEC materials
- M & E tools
- Infrastructure (rooms, mobile labs)
- Information Communication Technologies
How will success be measured? Describe 2-3 indicators of success

- Number of patients with cough referred from the community
- Number of presumptive TB cases diagnosed with TB referred from the community
- Number of patients identified with chronic lung conditions attributable to the community health care workers