



MITRA

Partners for Tuberculosis Control in Banten Province, Indonesia

Annual Report

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List of abbreviations and acronyms

ACS	Advocacy, Communication, and Social Mobilization
AED	Academy for education and development
AIDS	Acquired Immune Deficiency Syndrome
ARI	Acute Respiratory Infection
BCC	Behavior Change Communication
CBGP	Community Based Growth Promotion
CBO	Community-Based Organization
CBS	Community-Based Structures
CBTO	Community-Based Treatment Observer
CCF	Christian Children's Fund
CDR	Case Detection Rate
CES	Christian Extension Services
CHC	Community Health Club
Chiefdom	Third level administrative unit in Sierra Leone, under the District.
CII	CARE International Indonesia
C-IMCI	Community-Based Integrated Management of Childhood Illnesses
CME	Continuing Medical Education
CO	Country Office (CARE Indonesia)
COPE	Client Oriented Provider Efficient
CRS	Catholic Relief Services
CSP	Child Survival Project
CSTS	Child Survival Technical Services
DHMT	District Health Management Team
DIP	Detailed Implementation Plan
District	Second level administrative unit in Indonesia, under the Region and above the Province
DMO	District Medical Officer, in charge of DHO
DOTS	Internationally-recommended TB control strategy
EPI	Expanded Programme in Immunization
FBO	Faith-Based Organization
HBLSS	Home-Based Life Saving Skills
HH	Household
HMIS	Health Management Information Systems
HIV	Human Immune Deficiency Virus
HLS	Household Livelihood Security
IEC	Information Education and Communication
IMCI	Integrated Management of Childhood Illnesses
IDAI	Indonesian Pediatricians Association
IDI	Indonesian Physicians Association
ISA	Institutional Strengths Assessment
ISTC	International Standard in Tuberculosis Care
ITN	Insecticide Treated Mosquito Net

KNCV	Royal Netherlands TB Association
KPC	Knowledge, Practice and Coverage
LNGO	Local Non-Governmental Organization
LQAS	Lot Quality Assurance Sampling
MCH	Maternal and Child Health
MDR	Multi-Drug Resistance
M&E	Monitoring and Evaluation
MMR	Maternal Mortality Rate
MNC	Maternal and Newborn Care
MOH	Ministry of Health
MoU	Memorandum of Understanding
MTE	Mid-Term Evaluation
NACSA	National Commission for Social Action
NID	National Immunization Day
NGO	Non-Governmental Organization
NTP	National Tuberculosis Program
ORS	Oral Rehydration Solution
PCI	Project Concern International
PDPI	Indonesian Pulmonologist Association
PHU	Peripheral Health Unit
PKK	Voluntary organization of wives of administrators
PM	Program Manager
PP	Private Provider
PPO	Provincial Project Officer
PRCA	Participatory Rural Communication Appraisal
PVO	Private Voluntary Organization
QA	Quality Assurance
QOC	Quality of Care
Region	The largest administrative unit at the sub-national level
Reproductive age	Refers to women aged 15-49 years
RH	Reproductive health
SFCG	Search For Common Ground
SCM	Standard Case Management
SWS	Safe Water System
TA	Technical Assistance
TBA	Traditional Birth Attendant
TC	Team Coordinator
TNA	Training Needs Assessment
TOT	Training of Trainers
TT	Tetanus Toxoid
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
VA	Vitamin A
WRA	Women of Reproductive Age

Table of Contents

Introduction.....	7
A. Overall Project Progress and Accomplishments.....	9
Project Start-Up Activities.....	9
Detailed Implementation Plan (DIP).....	10
Table 1. Project implementation activities, progress and accomplishments.....	13
B. Factors Impeding Progress.....	17
C. Technical Assistance Required by the Project.....	17
D. Substantial Changes.....	17
E. Monitoring and Evaluation Plan.....	18
F. Sustainability.....	18
G. Specific Information.....	18
H. Behavior Change Strategy.....	19
Summary of Strategy:.....	19
Channels of Communication:.....	19
BEHAVIOR Framework.....	20
Monitoring table.....	21
I. For Project's in Their Final Year.....	23
J. For Programs Receiving Family Planning Support.....	23
K. TB Program Monitoring and Evaluation.....	23
L. Project Management System.....	23
Financial management system.....	23
Human resources.....	24
Communication system and team development.....	24
Local partner relationship.....	24
Government coordination/collaboration.....	24
M. Mission Collaboration.....	25
MITRA and the USAID Mission Strategy.....	25
N. Workplan year 2 activities.....	27
O. Results Highlights.....	27
P. Topics in the USAID Annual Report Guidelines that do not apply.....	28
Q. Other Relevant Aspects.....	28
R. Presentations.....	28
Annex 1. Memorandum of Understanding.....	30
Annex 2. Microlevel Action Plan Selecting Poor-Performing Areas.....	36
Annex 3. Scoring Sheet for Identifying Poor-Performing Areas.....	37
Annex 4. Performance of TB Program in Banten Province 2005 - 2006.....	39
Annex 5. MITRA work plan year 2.....	40
Annex 6. Project Data Form.....	43

Introduction

This is the first annual report for the MITRA (**M**embangun **I**ntegrasi Program **T**uberkulosis di **R**epublik **I**ndonesia) project, implemented in partnership by CARE International Indonesia (CII) and its primary implementing partners: National Tuberculosis Program (NTP – at the National level, in Banten Province, and with participating District Health Officials in Tangerang City, Tangerang District, Cilegon, and Pandeglang District), primary government health centers (*Puskesmas* with DOTS facilities) in the four districts, the Royal Tuberculosis Association (KNCV), and the government/province planning committee (*BAPEDA*).

MITRA focuses on four of six districts of Banten province, covering a total population of 6,188,365. These four districts account for about 68.6% of the current TB cases (all types) in the entire province. The Case Detection Rate (CDR) for the project area was 62.8%. The project is targeting a total of 47,000 patients in four years, out of which smear-positive or active pulmonary TB cases are expected to be 19,667. The project plans to incrementally increase the CDR from the baseline of 62% in year one to 85% by year four, inline with the National TB Program target. About 807 communities will benefit from the project's interventions.

CARE International Indonesia (CII) began implementation of the MITRA project in October 2005. The project's goal is to decrease morbidity and mortality caused by tuberculosis in the four districts in Banten Province, achieve an 85% case detection rate, and maintain at least 88% treatment success rate in the areas of Tangerang City, Tangerang District, Cilegon, and Pandeglang District.

The project's strategic objectives (SO) are to (1) create sustainable community-based TB control structures (and therefore increase community participation in the National TB Program); (2) strengthen the delivery capacity of the district and provincial TB programs and increase coordination at all levels in order to improve program quality; and (3) increase private participation in the TB program.

The goal will be achieved through four major activities which are (1) empower the community and increase community volunteer capacity to implement community-based TB control activities and therefore mobilize communities to seek care; (2) strengthen health care delivery systems – NTP, private health services as well as the private practitioners – to provide quality services to the mobilized communities; (3) problem solve with other stakeholders to ensure implementation of DOTS components not addressed by the project; (4) advocate, share, and disseminate lessons learned to the National, Provincial and District level partners and participants.

The project supports National TB Program (NTP) goals for TB control by strengthening three areas of their TB control program in Banten Province: empowerment of the community to participate in TB control activities, provision of trained human resources for health services (including private health facilities), and support of the Province and District health information and reporting system. Through this partnership, the project is directly addressing three (text in bold) of the five components of the DOTS strategy: (1) Sustained political commitment; (2) **Access to quality-assured TB sputum microscopy**; (3) **Standardized short-course chemotherapy for all cases of TB under proper case management conditions, including direct observation of treatment**; (4) Uninterrupted supply of quality-assured drugs; and (5) **Recording and reporting that enables outcome assessment**. MITRA, in behavior change

strategy formulation, is working with the National TB Program at the district and health center levels to address the other key component of the strategy: to improve the health-seeking practices of the community and the adherence of TB patients. The project builds on current successful collaboration projects between CARE, the Government of Banten Province, and the Ministry of Health in the National TB Control Program.

A. Overall Project Progress and Accomplishments

(Table 1)

This report covers the project's progress from October 1, 2005 through September 30, 2006. During the first year of project implementation, MITRA has: **a)** recruited and trained project staff; **b)** intensively discussed project area selection and provided updates on project baseline data; **c)** established, coordinated, and developed key project elements; **d)** presented the DIP, work plan, and internal communication/ coordination systems as well as the monitoring, evaluation, and reporting system; **e)** signed a technical arrangement (TA) between CII and Banten Province Health Officials (Annex 1); **f)** improved communication and awareness processes among government health staff who are not directly involved but are closely related to the TB program (medical unit directors, nurses and other staff); and **g)** socialized TB and DOTS to all sub-district and village leaders in and around selected government health centers. This first year has also served to strengthen project design elements and key relationships and thereby increase the likelihood of success.

Project Start-Up Activities

The project has established a close partnership with the NTP Manager and her team at the National level, the KNCV Representative for Banten Province, who has also become the Provincial Project Officer (PPO) for Indonesia's DOTS Expansion Project for Banten Province, the TB team in Banten Province and the four districts, Project Concern International's (PCI) child survival project in Pandeglang District, PKK (the local organization organized by wives of the local government), and health coordinators for the city and district, sub-district, and village level. KNCV's financial support ceased at the end of September 2006 and was replaced by NTP-Global Funds starting October 2006. KNCV will continue to provide technical assistance and support through the NTP.

Banten Province Technical TB Officer and the KNCV Representative for Banten (PPO) have extensively participated in key project meetings and the design of the Detailed Implementation Plan (DIP). MITRA is currently establishing the TB core management team, which presently consists of the CII program manager and coordinators and NTP TB officers at the Province and District levels who oversee project implementation and operation. A team of members of the CII field staff, government health centers' TB officers, other volunteers, and the PKK's community health workers (called "*Kader*") complement the MITRA TB team in the field, providing direct services to TB patients and the community.

Detailed Implementation Plan (DIP)

The DIP workshop was held on March 22 and 23, 2006. The DIP was presented in the mini-university in Washington in June 2006.

Coordination Meetings

The project held the first coordination and strategic planning meeting at the province and district levels in May 2006. In the first meeting, the government planning committee (*BAPEDA*), KNCV, and the Health Officials team from Banten province and all districts were invited. The outcome of the meeting was an agreement of each entity's roles and responsibilities in TB Program implementation. Also discussed were the strategies for improved TB programming. The guidelines established towards this end were:

- a) MITRA, under CARE and with the local MOH officials, has identified the poor performing areas in each district. (Annex 2)
- b) A system and methodology was collaboratively developed with the local officials to identify what is to be considered poor performing, a sample of which can be seen in Annex 3.
- c) Work with the district and sub-district MOH officials to strengthen the DOTS TB program.

After the first meeting a series of meetings were held at the district and sub-district levels to fine tune micro-planning as to which would be the selected 'poor performing' areas where MITRA would focus its attention in the first year of its implementation. The first of these meetings was done for Cilegon and Pandeglang districts' *BAPEDA*, health officials, all chiefs of the health centers, medical profession organizations, and local NGO/CBO/ FBO representatives. The outcome of this meeting was: three project areas (*Puskesmas*) in Cilegon (Pulo Merak, Cibeber, and Ciwandan) and six project areas in Pandeglang district (Bojong, Labuan, Jiput, Panimbang, Picung, and Banjar) were selected based on criteria developed by the district DOTS implementation team. The criteria were based on, for example, TB program data and staff performance, availability of local NGO/CBO/FBOs, and activity of health kaders in the area.

The second meeting was held in Tangerang city. The participants included those from Tangerang city and the district's *BAPEDA*, health officials, all chiefs of health centers, medical profession organizations, and local NGO/CBO/FBO representatives. The results were the selection of six project areas in the city and ten project areas in district based on several criteria such as those mentioned above, with additional information such as the number of TB patients detected (the TB pocket area), shared problems faced in each area, hard to reach populations (accessibility problems), and numbers of poor people living in the area. An action plan of community-based DOTS activities for the first six months was also discussed.

As of May 2006, because of the availability and capacity of project resources (vehicles and staffs capacity), MITRA's implementation is focused on 25 project areas (health center areas and sub-districts) out of 107 health centers targeted in four districts for the first twelve months of implementation. The focus will gradually increased to improve the TB community based DOTS in the area. Each field officer is responsible for two to three project areas. Based on these interactions, MITRA field officers in Cilegon and Pandeglang were relocated to their base on

June 1, 2006, and the program has since started implementing and doing activities at the community level by orienting all sub-district and village leaders in selected health center areas to TB and DOTS.

Overall, numerous project activities have been completed and some year two activities have already been initiated. Some project activities are ongoing and will continue from year one onwards. The project is proceeding towards the attainment of its objectives. Activities related to BCC (Behavior Change Communication) have been delayed by 2 months on account of the twin observation of ‘*Ramadan*’ and ‘*Hari Raya*’. The tables below give a more composite picture of the same.

Table 1. Project implementation activities, progress and accomplishments

Objective 1: To create sustainable community-based TB control structures		
Key Activities (DIP log frame outline)	Status of Activities	Comments
Output 1: Build capacity of community-based organizations to implement TB control activities		
1. Identify Community-Based Structures (CBS) and community organizations <input type="checkbox"/> No. 3.5 in DIP workplan	Completed; 17 organizations have been identified	Identification of the existing CBO/FBO/NGOs was done together with the community leaders and Government health center (<i>Puskesmas</i>) teams
2. Sign contracts or MoUs <input type="checkbox"/> No. 3.3 in DIP workplan	Initiated; developing and signing of MoU is an optional activity; details of work understanding and modalities are still being constructed and will continue in year 2 for the remaining activities (<i>see workplan</i>)	1) MoU between CII and Province Health Official signed 2) MoUs with selected partners (several organizations have been identified, such as <i>PKK, Aisiyah, Paguyuban TB</i>) are being discussed
3. Orient local government and community and religious leaders to TB and DOTS	Completed; in 25 identified project areas (891 community leaders and volunteers) and eight villages (381 community and religious leaders, health workers, and participants from community groups)	Done with key partners (Province, District, and Health center TB teams) as discussed in DIP workshop and coordination meeting
4. Identify communities for capacity building and for organizing and implementing community based TB control activities, specifically in hard to reach areas. <input type="checkbox"/> No. 11.1.1 in DIP workplan	Initiated, activity scheduled in year 2 (<i>see workplan</i>)	Several hard to reach communities have been identified to be involved in TB control activities

Output 2: Build capacity of volunteer health workers to generate community awareness and support TB patients and their families to fully participate in DOTS		
1. Identify volunteers for the role of community based treatment observers (CBTO or the <i>PMO</i>) in selected communities <input type="checkbox"/> No. 11.2.2 in DIP workplan	Initiated, activity scheduled in year 2; kaders/volunteers from two CBOs (<i>PKK</i> and <i>Paguyuban Pulo Merak</i>) are identified and are willing to participate in TB control activities as treatment observers (<i>PMO</i>)	<i>PKK</i> kaders and village coordinators will be trained
2. Develop and use the manual on training of treatment observers <input type="checkbox"/> No. 6.1 and 11.2.3 in DIP workplan	Initiated, ongoing activity; first draft of training module for treatment observer coordinator in Bahasa Indonesia and English	Training module and curriculum for treatment observers and health kaders/volunteers has been developed and pre-tested. Inputs from pilot training are being incorporated.
Output 3: Use behavior change communications activities to increase the TB health-seeking practices of the community		
1. Use formative research to develop communication strategy and tools <input type="checkbox"/> No. 13.2 in DIP workplan	Ongoing; BCC province team established; BCC material library is actively being compiled to include, for example, flipcharts, vcd (TB movie), and leaflets collected from NTP, District Health Office, KNCV, and other NGO/CBOs (LKC, <i>PKK</i> , and <i>PCI</i>)	
2. Organize BCC workshop <input type="checkbox"/> No. 13.1 in DIP workplan	Rescheduled; to be conducted in year 2 (Nov-06)	The workshop was planned to be conducted in Aug-06, but was re-scheduled to be done in Nov-06 after ' <i>Ramadan</i> ' and ' <i>Hari Raya</i> ', as the Province BCC team suggested

Objective 2: To strengthen the delivery capacity of the district and provincial TB program		
Key Activities (DIP log frame outline)	Status of Activities	Comments
Output 1: Build capacity of district health workers to manage DOTS-related activities		
1. Identify District Health Office and health center staff who will be trained in DOTS □ No. 12.1 in DIP workplan	Completed; all health center for training have been identified	
2. Carry out training needs assessment □ No. 12.1 in DIP workplan	Completed; training needs assessment conducted by NTP, CARE, and medical/professional organizations (<i>IDI, PDPI, PPNI, IBI</i>)	
3. Conduct training and follow up □ No. 12.1, 12.2, and 12.3 in DIP workplan	Initiated; DOTS training scheduled in year 2	DOTS orientation for 23 staff members conducted at 1 health center in Pandeglang (Jul-06)
Output 2: Develop effective working partnerships with the National TB Program (NTP), KNCV, WHO, district and provincial tuberculosis officials and other stakeholders (IDAI, IDI) to implement and coordinate key tuberculosis activities		
1. Participate in TB partners forum □ No. 5.1.1 in DIP workplan	Ongoing; MITRA team regularly participates and has attended 2 meetings and 2 workshops	Project representatives participated in TB Partnership forum (Nov 2005), STOP TB Partnership meeting (Mar 2006), and the workshop on ACS and PPM (Sep 2006)
2. Regularly meet and discuss project issues with stakeholders at the National level □ No. 5.1.2 in DIP workplan	Ongoing; coordination meeting with NTP conducted every 3-months (Feb, May, July, and Sep); this is regularly organized and actively participated in.	
3. Identify and solve program problems with counterparts at provincial and district level □ No. 5.2.1, 2.1.3, and 5.3.1, 2.2.3 in DIP workplan	Ongoing; PM and TCs participated in TB quarterly M&E meeting at each province and district level (in Feb, May, and July)	Coordination and planning meeting held at the province (May 17) and district (May 18 and 24) levels
4. Disseminate lessons learned to all partners □ No. 3.6 in DIP workplan	Ongoing; shared the results of the qualitative analysis of drop-outs with the province and district MOH and partners.	

Objective 3: To increase private participation in the TB program		
Key Activities (DIP log frame outline)	Status of Activities	Comments
Output 1: Build capacity of private practitioners to adopt DOTS strategy for TB treatment		
1. Identify willing private providers and carry out training needs assessment □ No. 15.1 in DIP workplan	Completed in 25 health center focus areas. Ongoing throughout the life of the project for other areas.	Numbers of PPs and clinics in 25 areas have been identified
2. Identify midwives, especially in remote areas to use DOTS □ No. 15.6 in DIP workplan	Initiated; to be conducted in year 2 for the remaining activities (<i>see workplan</i>)	Need more assessment in midwives work load. Nurses are a possible alternative (being looked into by CARE and <i>Puskesmas</i> team, <i>IBI</i> and <i>PPNI</i>)
3. Identify industries who are willing to connect with the district/health center DOTS network □ No. 15.11 in DIP workplan	Initiated; to be conducted in year 2 for the remaining activities (<i>see workplan</i>)	Industries are not yet identified

B. Factors Impeding Progress

- Key DOTS personnel at the Province MOH changed in June 2006. The incoming officer was oriented to MITRA.
- The devolution of central government functions to provinces and district is still not clear, making some decisions and responsibilities difficult to gauge.
- Staffing at government primary health care center, especially for laboratory technicians in Pandeglang district, has been poor. This prevents meaningful TB case diagnosis.
- CARE Indonesia's Health Program Leader resigned. This affected the communications internally in CARE Indonesia. The new Health Program Leader has been hired.
- The MOH reporting system, though thorough, is slow. This impedes information gathering.

C. Technical Assistance Required by the Project

The mid-term evaluation (MTE) is slated to take place in the quarter between July to September of 2007. The project expects backstopping from Atlanta and the identification of a consultant for the MTE.

BCC workshop is slated to take place in November 2006. The project expects to identify an appropriate consultant with both a BCC and DOTS TB background.

For sustainability plan and strategies, the project will discuss with local coordinating partners (*BAPEDA* and *NTP*) in November 2006 and plan to conduct the sustainability workshop with all stakeholders in January 2007. A teleconference with *CSSA* technical staff will be held in November 2006.

D. Substantial Changes

No substantial changes have been made to the program description and the DIP that require a modification to the Cooperative Agreement.

E. Monitoring and Evaluation Plan

There are two areas that the project is currently monitoring and evaluating: (1) the Internal Project MITRA and (2) the MOH (NTP) DOTS information system.

Internal project monitoring is done by broadly monitoring process indicators as listed in the DIP Midterm Evaluation and those developed in the microplan with the MOH and NTP officials. This activity is routinely done in the project on a monthly basis.

The project monitors and evaluated the MOH (NTP) DOTS information system by (a) working with it, (b) accessing it, and (c) giving inputs to it. This activity is done on a quarterly basis when the MITRA team routinely meets with the District and Province team. MITRA is working with the District level officials to help incorporate and routinely analyze two other important indicators: data desegregation for (i) the poor and vulnerable population and (ii) pediatric TB case detection rate through utilization of the pediatric score sheet.

For related process indicators please see Table 1. For the latest output indicators in the project districts please see Annex 4.

F. Sustainability

MITRA will meet with local coordinating partners (*BAPEDA* and NTP) in November 2006 to plan to conduct the sustainability workshop with all stakeholders in January 2007. This workshop will identify ways in which the work MITRA is involved with will continue past the projects end date.

MITRA is in an advanced stage of conversation with CSTS consultants to hold a teleconference on CSSA framework as applicable to TB projects. This is slated for November 2006.

G. Specific Information

No specific information was requested for this annual report.

H. Behavior Change Strategy

Behavior Change Communication (BCC) Strategy (Health Seeking for TB)

An indicative BCC strategy is outlined below in line with the USAID given format, but the final version will be presented after the BCC workshop which is slated to take place in November 2006.

In line with Indonesia NTP's Advocacy, Communication, and Social Mobilization (ACSM) strategy, CARE will develop the BCC strategy. This strategy will be shared with and inputs will be obtained from NTP and local TB officials (province and districts) in November and onwards, after "Ramadan" and 'Hari Raya'. MITRA project staff will complete the strategy design and develop materials to be discussed at the BCC workshop.

Broad Behavior Change Goal: Improve Health Seeking Practices

Specific behavior Objectives:

- (1) Persons with TB symptoms will go to DOTS facilities to get diagnosed and treated
- (2) TB patients will complete their medication and have their follow-up sputum examinations as scheduled

Summary of Strategy:

This project will increase the number of new TB patients treated with quality clinical and microscopic diagnosis and case management. Individual behavior will be changed by increasing education about availability of free anti-TB drugs at DOTS facilities, changing attitudes toward seeking care at DOTS facilities, and improving access to and quality of health services for the community.

Education and attitude will be addressed through direct communication activities using printed and audio-visual IEC materials as well as drama performed by community volunteers and current and former TB patients, and through training community health nurses and health facility staff to improve their counseling skills regarding TB diagnosis and treatment. The access and quality of services will be improved by increasing capacity of government and private health staff and linking private health services to government health centers and district health offices, as well as district health offices to province administration through improved record keeping and communication.

Channels of Communication:

Printed materials: CARE will provide leaflets, banners, posters, bags, calendars, and t-shirts to trained kaders and volunteers for distribution at activities for increasing community awareness. Flipcharts and leaflets will also be produced and used as BC communication tools by health kaders and volunteers. Banners and posters will be placed in the health centers, local government offices, markets, streets, and other strategic places for public viewing.

Audio-visual materials: A series of short-movies (20-25 minutes in duration) will be created and distributed in video compact disc (vcd) format. The movies will be created using local people (possibly ex-TB patients) and locations to show the lives of TB patients in different settings common in the project area. The media will then be used by health promoters, kaders, and volunteers.

Drama or dialog: Life-dramas or dialogs (scenarios) will be used as media for TB campaigns for events such as the TB Day, celebrations like Independence Day, and TB education activities in school and among youth groups. The dramas will be performed by the students or youth groups and also ex-TB patients. The purpose will be to raise the students' and youth awareness of TB disease, prevalence, and consequences.

Community involvement: TB support groups and village health committees will be formed to create communication in each village about TB and to reduce stigma. The above mentioned tools will be used by MOH staff, CARE staff, and health volunteers one on one with community groups and community members.

BEHAVIOR Framework

Priority and Supporting Groups	Behavior	Key Factors	Activities
<i>In order to help:</i>	<i>To:</i>	<i>We will focus on:</i>	<i>Through:</i>
TB suspects (general population or people with TB symptoms)			
TB patients			
Family of TB patients			
Community volunteers (kaders and PMO coordinators)			
Health personnel			

Behavior change indicators will be monitored and evaluated in accordance with project's M&E plan.

Monitoring table

Priority Group	Awareness	Knowledge	Attitudes/ Skills	Trial	Behavioral maintenance
TB suspects					
TB patients					
Families of TB patients					
Community volunteers (kaders)					
Health care staff					

I. For Project's in Their Final Year

This project is not in its final year.

J. For Programs Receiving Family Planning Support

This program is not involved with family planning.

K. TB Program Monitoring and Evaluation

Please refer to Section E and Annex 4.

L. Project Management System

Financial management system

Country Office Expenditure Report

Salaries and Benefits

The Country Director, Assistant Country Director, Administrative and Finance Coordinator, Health Program Leader, Project Manager, and all project staffs are being paid for by the project. National and International staff salaries were expended according to planned budget.

Travel

The project covered the expenses of international travel to the CORE TB training in Chennai, India in February 2006 and to USA for CARE's Child Survival annual meeting in June 2006.

Supplies

Funds were spent on the following project activities:

- Training supplies
- Project workshops
- Stationary and office supplies

Contractuals

CII obtained the services of technical assistance for baseline assessment from two independent consultants (1) on the KPC survey and (2) on the health facility assessment and community perception and participation in DOTS.

Others

Expenditure on fuel, vehicle repairs, and maintenance were spent according to the allocated budget lines.

Burn Rate

Burn rates are line with project duration.

Human resources

The project continued to receive technical backstopping from the CARE USA Health team based in Atlanta and support from CARE International Indonesia Country Office. Technical support in the areas of administration and financial management of the program was received from the project backstop and this contributed to the successful implementation of quality programming.

The Project Manager continued to effectively manage the affairs of the project on a daily basis. Staff include: Training Coordinator and Partnerships Officer, Training Coordinators (2), Field Officers (12), and Project Support Unit: Finance Officer, Administrative Officer, Security Guard, Driver, and Office Helper.

Hiring and orientation of project staff is complete and ongoing capacity efforts of project staff for timely implementation of planned activities are in progress.

Communication system and team development

The project emphasized the development of staff to ensure the quality programming of Child Survival activities.

The availability of electronic communication with staff at the base level has also provided a boost to staff capacity building efforts. The staff has the opportunity to browse technical websites and download relevant materials from other health projects through the internet.

Local partner relationship

CARE has maintained a positive relationship with participating partners of the project and has ensured communication and collaboration with partners at all times. CARE partners include the MOH at the province, district, and subdistrict level; KNCV; NTP; *PKK Aisiya, Paguyuban*; WHO, IDAI, IDI, PCI, PDPI, PPNI, and HARFA.

Government coordination/collaboration

CARE has actively coordinated project activities with NTP, Provincial and District Health Officials, and other health related NGOs in the country in general and the district in particular.

At the district level, the project staff has participated in district level coordination meetings organized by the District Health Office to discuss project activities including implementation strategies. The project is working with the Province TB team, District TB team, health centers TB team, and other NGOs to activate the province and district level tuberculosis-integrated movements (*GERDUNAS*) to coordinate the activities of the TB control program.

At the national level, CII participates in MOH task force meetings and working groups (e.g., malaria, nutrition, and tuberculosis) and STOP TB Partnerships. The CARE CS project constantly collaborates with USAID Mission CSP in the sharing and exchange of information and innovations in health.

M. Mission Collaboration

The USAID mission has been supportive of CARE in general. CARE works with the Mission in Banten Province through BERSIH and the Safe Water System (SWS) in Tangerang District and City. MITRA coordinates these projects and the BHS-Health Services Program in Tangerang District. The mission staff met with the CARE team prior to the DIP writing and was very supportive during DIP. The CII team met three times at the USAID Mission office in Jakarta for USAID evaluation of the KNCV project in Banten. The MITRA Project Manager met the evaluators from the USA at the PCI office in Pandeglang.

Regular updates on the project progress are done on an annual basis. Moreover, the interactions are also held with the mission personnel (via telephone and e-mail).

MITRA and the USAID Mission Strategy

In the Strategic Plan for Indonesia for the period of FY 2004 – 2008, USAID/Jakarta will provide technical assistance to strengthen a **Moderate, Stable and Productive Indonesia**. USAID has identified four Strategic Objectives (SO). Through MITRA, CII will mainly support the Strategic Objective “Higher Quality Basic Human Services” and the Special Objective “Maintaining Healthy Ecosystems”. This will be achieved through the accomplishment of intermediate results, which in turn will be realized through a series of integrated activities with implementing partners. As illustrated in the results framework, USAID/Jakarta will achieve these objectives through three interrelated intermediate results (IR): (1) support of increased advocacy for higher quality services and maintenance of healthy ecosystems, (2) focus on improving the delivery of quality services and maintenance of healthy ecosystems at the local level, and (3) promotion of improved practices and behaviors at the community and household level.

Specifically, USAID aims to increase access to and utilization of key health and environmental services, particularly among the underserved, with an emphasis on improving local government delivery of these services. USAID will work primarily at the local level to mobilize constituents to advocate for increased investments, improve the delivery of basic services, promote and sustain behavior change, and maintain healthy ecosystems.

Through MITRA, CARE contributes to the Mission strategies of:

IR 1: Governments, community organizations and private sector mobilized to advocate for higher quality basic human services/ maintain healthy ecosystems, especially through the following activities: (1) increased investments in family planning, maternal and child health, nutrition, HIV/AIDS, and **TB** through advocacy efforts to decision makers at the national, provincial and district levels and (2) advocacy by networks of national and local NGOs, professional associations, and regional universities for quality health services for poor, vulnerable and marginalized populations.

IR 2: Basic human services delivered/ healthy ecosystems maintained effectively at the local level, especially through the following activities: (1) **community mobilization and training programs to promote better hygiene and public health** and (2) capacity-strengthening of the district health staff to plan, budget and manage health system performance.

IR 3: Improved practices and behaviors adopted at the community and household levels, especially through the following activities: (1) community information campaigns are conducted to promote HIV/AIDS, **TB**, and malaria awareness.

N. Workplan year 2 activities

Please see Annex 5.

O. Results Highlights

CARE's MITRA project is involved in increasing the tuberculosis diagnosis and cure rate in Banten province, located in northwestern Java. MITRA works with health clinics to improve service delivery.

A qualitative study by was done to assess the reasons people diagnosed with TB did not continue the Directly Observed Therapy Short course (DOTS) treatment program. The target population for this study was people over 18 years old who were diagnosed with sputum-positive TB and had dropped out of the national DOTS program in Banten Province, Indonesia including Cilegon district, Tangerang district, and Tangerang city. Purposive sampling was used to find the most diverse dropout population with regards to age, date of dropout, place of residence, and gender. The field staff that conducted the interviews was trained in interviewing techniques, the consent process, and the specific interview questions. This training also strengthened CARE's capacity to conduct future qualitative interviews.

Data collection included one day of pilot data and 6 days of data collection. All interviews were recorded using a voice tape recorder and the tapes were destroyed after transcription. The respondent population was between the ages of 21-75 years, 7 rural interviews and 15 urban interviews were conducted, 10 males and 12 females participated and 18 married and 4 unmarried respondents participated.

The preliminary findings suggest that treatment adherence among TB patients is influenced by place of residence, knowledge of diagnosis, knowledge of treatment, and community support. Many TB patients drop out of treatment because they "do not feel better", however most of those patients have only taken the medicine for a few weeks. Also those that mentioned "they do not feel better", may be experiencing side effects of treatment rather than TB symptoms. One participant reported, "The doctor said that had Tuberculosis. When he gave the medicine, I wasn't getting better. I felt sick, dizzy and then I vomitted. Maybe the medicine isn't appropriate to me". Also, a finding consistent with past research was that many patients report leaving treatment because they "feel better". Usually these patients have been taking treatment for at least one month and it is possible that some were misdiagnosed. When interviewed, another participant said, "It's just been 10 days, and I feel better". Several other patients mentioned they sought treatment in other clinics not offering DOTS due to problems with transportation or adverse reactions to medicine given at DOTS treatment centers.

The study brought up the patient's unawareness about the length of treatment and the treatment side effects which actively being incorporated in CARE's Behavior Change Curriculum (BCC) materials and in the development of CARE's training materials for treatment observers and treatment observer supervisors. Patient counseling on the duration of treatment, side effects of treatment and how to mitigate them, and continuation of treatment despite feeling worse or better will be central theme for training of health and volunteer staff. The BCC material and training

manual are activities that provide information to realize two of the three strategic objectives for MITRA to improve or create sustainable community-based TB control structures and strengthening the delivery capacity of the district and provincial TB program. MITRA also plans to ensure that the health clinics in which MITRA works all conform to the standard DOTS diagnosis procedures and treatment programs. Currently, some health clinics have the recommended three sputum tests and a treatment observer for each patient, but others do not fully comply. MITRA also plans to incorporate a forum in which all health clinics can learn about DOTS and how to implement DOTS in every clinic.

P. Topics in the USAID Annual Report Guidelines that do not apply

The areas which do not apply to this annual report are G., I., J., and Q.

Q. Other Relevant Aspects

There are not any other relevant aspects to report.

R. Presentations

King, K, Roy, K, Widyastuti, E, Maruti, AK, Iswari, B. "A rights-based approach to tuberculosis treatment adherence in Banten Province, Indonesia," presented at the American Public Health Association Conference, Boston, MA, November, 2006.

Annex 1. Memorandum of Understanding

Annex 2. Microlevel Action Plan Selecting Poor-Performing Areas

PUSKESMAS	Mitra Socialisation in Subdistrit and village Level.					Refrehsing DOTS for Puskesmas Staff					Training and refreshing for PMO					Community Education					Pasien Self Support group					Develop Pos TB					Monitoring and Evaluation meeting quarterly									
	JUNE					JULY					AUGUST					SEPTEMBER					OCTOBER					NOVEMBER					DECEMBER									
	I	II	III	IV	V	I	II	III	IV	V	I	II	III	IV	V	I	II	III	IV	V	I	II	III	IV	V	I	II	III	IV	V	I	II	III	IV	V	I	II	III	IV	V
Teluk Naga			X						X			X					X					X				X						X								
Kosambi		8							X			X					X					X				X						X								
Sepatan		8							X			X					X					X				X						X								
K. Barat					X				X			X					X					X				X						X								
Pakuhaji		6			X	X						X					X				X						X										X			
Sukadiri					X	X						X					X				X						X										X			
Mauk		13							X			X					X				X						X										X			
Kemeru					X	X						X					X				X						X										X			
Waliwis			X						X						X	X									X					X							X			
Kresek					X				X						X	X									X					X							X			

*Note: Developed with District MOH / KNCV

Annex 3. Scoring Sheet for Identifying Poor-Performing Areas

No	Puskemas	DOTS Program in Puskesmas	ACCESS	Human Resources	ACTIVE KADER	SCORE	CBO/NGO	CBO SCORE	Total
1	Cidasari	2	4	2	3	11	HARFA	0	11
2	Pagadungan	3	4	4	3	14	HARFA	0	14
3	Bangkonol	1	2	1	1	5	0	1	6
4	Pandeglang	4	4	4	4	16	HARFA	0	16
5	Banjar	3	4	4	1	12	0	1	13
6	Kaduhejo	4	4	4	4	16	HARFA	0	16
7	Mandalawangi	3	3	4	1	11	0	1	12
8	Cimanuk	3	4	3	4	14	HARFA	0	14
9	Cipeucang	3	3	3	4	13	HARFA	0	13
10	Saketi	3	4	3	4	14	HARFA, PCI	0	14
11	Bojong	4	4	4	1	13	0	1	14
12	Picung	4	3	4	1	12	0	1	13
13	Cisata	3	4	3	4	14	HARFA	0	14
14	Menes	4	4	4	4	16	HARFA	0	16
15	Cikedal	3	3	3	4	13	HARFA	0	13
16	Pagelaran	4	3	4	1	12	PCI	0	12
17	Labuan	4	4	4	1	13	0	1	14
18	Carita	2	4	2	1	9	0	1	10
19	Panimbang	4	3	3	1	11	0	1	12
20	Jiput	4	3	4	1	12	0	1	13

Explanation: Poor-Performing areas are identified from Puskemas based on their score (a higher score indicates poorer-performing), lack of CBO or NGO in their area, and their readiness for MITRA.

Annex 3. Scoring Sheet for Identifying Poor-Performing Areas (continued)

6 Puskemas that will be part of the MITRA intervention area:

1. PKM Banjar, MITRA Socialization, 3rd week of June
2. PKM Bojong, Mitra Socialization, 3rd week of June
3. PKM Picung, Mitra Socialization, 2nd week of June
4. PKM Labaun, Mitra Socialization, 4th week of June
5. PKM Panimbang, Mitra Socialization, 4th week of June
6. PKM Jiput, Mitra Socialization, 2nd week of June

Annex 4. Performance of TB Program in Banten Province 2005 - 2006

	Kabupaten Tangerang		Kota Tangerang		Kota Cilegon		Kabupaten Pandeglang		MITRA Project Area	
	2005	2006	2005	2006	2005	2006	2005	2006	2005	2006
Case Detection Rate	68.2%	55.8%	57.7%	62.7%	84.2%	60.9%	46.9%	69.8%	62.3%	61.8%
Treatment Success Rate	98.1%	98.8%	95.0%	93.2%	92.0%	n/a	88.0%	n/a	95.5% (2004)	97.3%

Note: For the year 2006 Data, the denominator has been adjusted for differing cohort periods

The case detection rates are showing two trends.

A) First, a decreasing CDR is evident for Cilegon and Kabupaten Tangerang. In Cilegon's case as it has historically performed well, it appears that the interruption of transmission of TB has taken place resulting in a lower CDR. In the case of Kabupaten Tangerang, the decline could either be a random effect, a reporting error, or a real decline and we need to study it better. b) B) Second, an increasing CDR for Kota Tangerang could again be seen as a random effect, a reporting error, or a real increase. The data backed by increased effort in the field makes us feel it might be a real increase in CDR. In the case of Pandeglang, due to increased efforts of the project area and establishment of functional laboratories the case detection has increased as the number of reporting centers has increased.

Overall, the project's CDR and TSR are in line with the projects aspirations.

Annex 5. MITRA work plan year 2

Activities (Quarter)		2006/07				Responsible	Support Needed
		O-D	J-M	A-J	Ju-S		
SO 1	To create sustainable community-based TB control structures						
Output 1	Build capacity of community based organizations to implement TB control activities						
Activity							
Identify CBSs and assess them for willingness to partner with the project		x	x	x	x	FO	TC
Identify NGOs/CBOs and other organizations strong or in TB project implementation (<i>example the Cilegon District NTP team</i>)		x	x	x	x	FO	TC
MOU Signed with selected partners		x	x	x	x	PM	PLH
TB DOTS socialization to local government, community and religious leaders		x	x	x	x	FO	TC
Train and follow up with community committees		x	x	x	x	FO	TC
Build capacity of partners as needed or identified by interactions and the partners assessment tools			x	x	x	TC	PM/HTLP/PLH
Identify communities for capacity building for community organizing and implementing community based TB control activities		x	x	x	x	FO	TC
In selected remote villages with the HSP (USAID, local mission) <i>pilot</i> activation of the village health council		x	x	x	x	FO	TC
Output 2	Build capacity of volunteer health workers to generate community awareness and support TB patients and their families to fully participate in DOTS						
Activity							
Identify volunteers for (a) generating community awareness and (b) the community based treatment observers (CBTO/PMO) in selected communities		x	x	x	x	FO	TC
In poor performing selected areas identify and train community based PMOs and PMO supervisors		x	x	x	x	TC	PM
Do pilot testing of curriculum developed and successive iterations for PMOs and PMO supervisor		x				TC	PM
Develop and use the manual on training of treatment observers and kaders		x	x	x	x	TC	PM
Train, follow up and monitor CBTO activities (monthly meetings)		x	x	x	x	FO	PC
Orientation to all Kaders working in Poshiyandu/Polindes on symptoms of TB and early referral of suspects		x	x			FO	TC
Follow up, monitoring, and support				x	x	FO	TC
Follow up and support of CBTO activities		x	x	x	x	FO	TC
Finalization of training modules of both PMO and supervisors			x			PM	HTPL/Atlanta
Provide standard package of BCC tools and materials for CBTO			x	x		PM	TC/FO

Activities (Quarter)		2006/07				Responsible	Support Needed
		O-D	J-M	A-J	Ju-S		
Output 3	Use behavior change communications activities to increase the TB health-seeking practices of the community						
Activity							
Use formative research to develop communication strategy and tools		x				PM/TC	HTPL
Develop project wide BCC strategy		x				PM	HTPL
Organize BCC workshop		x				PM	HTPL
Use BCC materials to reach communities with BCC activities			x	x	x	FO	TC
Train community volunteers to use the tools			x	x	x	FO	TC
Assess the affect of BCC through monitoring			x	x	x	FO/TC	PM
Follow up and monitoring			x	x	x	FO	TC
SO 2	Strengthen the delivery capacity of the district and provincial TB program						
Output 1	Build capacity of district health workers to manage DOTS-related activities						
Activity							
DOTS and refresher training/orientation to identified staff as needed using NTP/KNCV material and resources. All MOs, all TOs, all nursing and paramedical staff		x	x			FO	TC/PM
Conduct the training and follow up			x	x	x	FO	TC
Special focus on Laboratory technician training and refresher training till all puskesmas report 100% for slide cross-check		x	x	x	x	TC/District DOTS laboratory team	PM
Focus on training and reporting for extended DOTS centers		x	x	x		FO	TC/PM
Output 2	Develop effective working partnerships with NTP, KNCV, WHO, Province and District health officials, and other stakeholders to implement and coordinate key TB activities						
Activity							
Participate in TB partners forum							
Participation at the central level, i.e. NTP meetings, MOH meetings, WHO meetings on TB and Social Welfare Ministry meetings		x	x	x	x	HTPL/PM	
Regularly meet and discuss project issues with stakeholders at national level		x	x	x	x	HTPL/PM	
Coordination with the INGO/NGO-Bilateral USAID, CIDA, KNCV, DFID and WHO coordinating committees like STOP TB, GFATM, GDF, GLC,		x	x	x	x	HTPL	ACD
Identify and solve program problems with counterparts at province and district level		x	x	x	x	FO/TC	PM
Participate at the province level MOH NTP meetings, Gerdunas meetings and province level program review meetings		x	x	x	x	PM	HTPL

Activities (Quarter)	2006/07				Responsible	Support Needed
	O-D	J-M	A-J	Ju-S		
Attend Province Program Review meeting	x	x	x	x	PM	HTPL
Participate at the district level MOH NTP meetings, Gerdunas meetings and province level program review meetings	x	x	x	x	FO/TC	PM
Attend District Program Review meeting	x	x	x	x	TC	PM
Disseminate lessons learnt to all partners*					PM	PLH
SO 3	Increase private participation in the TB program					
Output 1	Build capacity of private practitioners to adopt DOTS strategy for TB treatment					
Activity						
Identify willing private providers and carry out training needs assessment		x	x	x	TC	PM
Encourage (orient/socialize) the ISTC and DOTS to them as CME course		x	x	x	TC	PM/KNCV
Motivate PPs to enroll for ISTC course by generating awareness towards TB/DOTS.	x	x	x	x	PM	MOH
Develop linkages between PPs, community, and NTP	x	x	x	x	FO/TC	PM/MOH
Follow up on training, referral of patients and patient records		x	x	x	FO	TC
Monitor PP and NTP linkages			x	x	FO	TC
Follow up on training, referral of patients and patient records		x	x	x	TC	TC
Identify midwives, esp. in remote areas to use DOTS medicine	x	x	x	x	FO	TC
Identify interested midwives with district MOH and midwives association	x			x	FO/TC	PM/District MOH
Identify industries who are willing to link up with district/health centers DOTS network		x	x	x	FO/TC	PM/MOH
Identify interested industries with district MOH and chambers of commerce	x			x	TC	PM

Annex 6. MITRA Project Data Form