



IMPACT
Initiative to Manage People Centered Alliances in Control of Tuberculosis (TB)
India, State of West Bengal
(10+ 9 districts)
September 30, 2008 - September 29, 2013

2nd Annual Report

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CARE India Contact:

Dr. Muhammad Musa
CEO & Country Director, CARE India
27, Hauz Khas Village
New Delhi 110016
India
Tel: 11-2656-6060
Fax: +91-11-26564084 & 26529671
Email: www.careindia.org

CARE USA Contact:

Dr. Khrist Roy, Children's Health
CARE USA
151 Ellis St. NE
Atlanta, GA 30303
USA
Tel: 404-979-9236
Fax: 404-589-2624
Email: kroy@care.org

Acronyms

ACDR	Annual Case Detection Rate
AIDS	Acquired Immune Deficiency Syndrome
ANM	Auxiliary Nurse Midwife
ASHA	Accredited Social Health Worker
AWW	Aanganwadi Worker
BCC	Behavior Change Communication
BMFR	Bi Monthly Finance Report
BNP+	Bengal Network of Positive People
BRGF	Backward Region Grant Fund
CBO	Community Based Organization
CDR	Case Detection Rate
CHC	Community Health Center
CMOH	Chief Medical Officer of Health
CR	Cure Rate
CSW	Commercial Social Worker
DIP	Detail Implementation Plan
DMC	Designated Microscopy Center
DOTS	Direct Observed Therapy – Short Course
DTC	District Tuberculosis Center
DTO	District Tuberculosis Officer
ER	Economic Rehabilitation
FBO	Faith Based Organization
GLRA	German Leprosy and TB Relief Association
GoI	Government of India
GoWB	Government of West Bengal
GP	Gram Panchayat
GR	General Relief
HIV	Human Immunodeficiency Virus
ICDS	Integrated Child Development Services
ICTC	Integrated Counseling and Treatment Centers
IEC	Information Education Communication
IMA	Indian Medical Association
IMPACT	Initiative to Manage People Centred Alliances in control of Tuberculosis
MDR	Multiple Drug Resistance
MoHFW	Ministry of Health and Family Welfare
MOTC	Medical Officer Tuberculosis Center

MPR	Monthly Progress Report
NACP	National AIDS Control Program
NGO	Non-Governmental Organization
NQPP	Non Qualified Private Practitioners
NREGS	National Rural Employment Guarantee Scheme
NRHM	National Rural Health Mission
NSP	New Smear Positive
NTP	National Tuberculosis Program
NGO	Non Government Organization
PHC	Primary Health Center
PHI	Primary Health Institution
PLHA/PLWHA	People living with HIV and AIDS
PNGO	Partner Non Government Organization
PRI	Panchayat Raj Institution
QPP	Qualified Private Practitioners
QPR	Quarterly Progress Report
RKS	Rogi Kalyan Samiti
RMP	Rural Medical Practitioner
RNTCP	Revised National Tuberculosis Control Program
SACS	State AIDS Control Society
SHG	Self Help Group
SHIS	Southern Health Improvement Society
ST	Scheduled Tribe
STC	State Tuberculosis Cell
STI	Sexually Transmitted Disease
STLS	Senior Tuberculosis Laboratory Supervisor
STO	State Tuberculosis Officer
STS	Senior Treatment Supervisor
TB	Tuberculosis
TI	Targeted Interventions
TSR	Treatment Success Rate
TU	Tuberculosis Unit
USAID	United States Association for International Development
USHA	Urban Social Health Activist
WB	West Bengal
WHO	World Health Organization

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Annual Work Plan Contributors

Basant Mohanty – State Director, CARE India (Orissa & West Bengal)

Bandita Sengupta – Project Manager IMPACT CARE West Bengal

Pradeep Kumar Mishra – M&E Officer IMPACT CARE West Bengal

Soumen Pandey – District Program Officer IMPACT CARE West Bengal

Santanu Bhaumik - District Program Officer IMPACT CARE West Bengal

Basab Roj - District Program Officer IMPACT CARE West Bengal

Khrist Roy – Technical Advisor Child Health and Nutrition team, CARE Atlanta

Introduction

IMPACT project has completed second year of implementation. This Annual report explains the achievement and progress based on the Detail Implementation Plan (DIP) for the period October 2009 to September 2010. As reported earlier the project is implementing in collaboration with Revised National TB Control Program (RNTCP), National AIDS Control Program (NACP) and Bengal Network of Positive people (BNP+); corporate partner – Eli Lilly; and several local NGOs in five districts of West Bengal. The project has started implementation in 28 poor performing TUs of these five districts: Malda, Mursidabad, Hoogly, Howrah and Bardhaman. The rest of the 10 poor performing TUs identified during DIP preparation will be covered in the third year. Extension to these TUs which are spread over in four districts will depend on other key partners implementing the Global fund project for round 9. The project partnered with Corporate partner Eli Lilly to extend psychosocial counselling support to the MDR TB patients in two DOTS Plus sites of the state which covers five districts. MDR TB patients from the five districts of Kolkata, North 24 Parganas, Jalpaiguri, Darjeeling and Kochbehar are being benefited through this initiative. It covers a population of 46.4 million people and around 10,000 TB & MDR TB patients will be benefited from project activities.

The project goal is to decrease morbidity and mortality caused by tuberculosis, MDR-TB, and TB-HIV co-infection in the West Bengal (WB) state in India.

The project strategic objectives are:

1. *Intensify and expand community-based DOTS especially in the poor performing Tuberculosis Units (TU);* The project identified and built capacity of non-qualified private practitioners (NQPP). The motivated and sensitized NQPPs are referring TB suspects from the community. This has resulted in an increased number of sputum tests being done in TUs with low case detection. Community-based volunteers have been identified and sensitized to generate awareness among TB patients and to follow up, thereby ensuring compliance of treatment and reduction of defaulters.
2. *Strengthen the case holding and completion of treatment among re-treatment and MDR patients in order to prevent the increase in load of MDR TB;* The project stressed on improving patient contact both at the health facility level and household level to ensure treatment compliance of re-treatment cases. Regular home visits especially for the CAT II patients were done by project staff. Patient provider meetings were organized to address the problems faced by the patients during treatment. The project also tried to utilize these interactions to identify poor TB patients and linked them with social welfare schemes of local self government or Panchayat. To improve the treatment adherence and treatment follow-up of MDR TB patients, psychosocial counselling support is being provided by counsellors at the two DOTS Plus sites of the state. The project has till date provided counselling support to 121 MDR TB patients and 96 MDR TB patients has been followed up. By now 121 MDR TB patients admitted in DOTS plus site and counselled. Follow up patients are those who were discharged and counselling support provided to them. What happened to the others?
3. *Strengthen the TB-HIV coordination at the state and district level to improve cross-referrals and ensure treatment for suspected TB-HIV co-infection;* District and state level TB/HIV coordination meetings have been regularized. The project ensured the involvement of BNP+ people in these meetings. The TI NGOs are being identified and sensitized in selected districts of IMPACT project area. District and block level sensitization on TB/HIV coordination activities for all concerned staff was conducted by RNTCP to improve upon cross-referrals.



A. Main accomplishments

1) **Linking Poor TB patients** with Social welfare schemes- As a follow up of the state level advocacy effort to involve local administration and local self help government to support poor TB patients with various poverty alleviation schemes of government, each Programme Officer made similar efforts at the district level. In four districts necessary government order was issued in this regard. This was further carried down at the block and the Gram Panchayet level through system. In district where the district level order was not available, effort was made to sensitize at the gram panchayet level. This initiative has been highly appreciated both at the state and national level. In the last state level quarterly review meeting, the STO has requested DTOs of non CARE districts and other global fund partners in the state to replicate this activity in other districts. During this period **1118 poor TB patients** have been linked up through Panchayat welfare schemes. In some areas these poor patients have received cash of Rs 300/- to Rs 2000/- and other places nutritious food items such as; 6 Kilogram wheat, egg, milk etc. **110 Gram Panchayats** have supported the above TB patients with following social welfare schemes:

(1) Backward Region Grant Fund (BRGF). (2) 12th finance commission grant fund (3) National Rural Employment Guarantee Scheme (NREGS) (4) General Relief (GR), Special GR (5) Panchayat untied fund & Rogi Kalyan Samiti (RKS) fund- supported by National Rural Health Mission (NRHM) (6) Economic Rehabilitation (ER)

2) **Patient Provider Meeting (PPM)** – Although conceptualized in RNTCP since long, Patient provider meeting was never seen as an opportunity to address problems faced by the patients and was not practiced in the state. CARE took the initiative and includes this as an important project activity. Necessary government orders were issued by the Chief Medical Officer of Health in all the districts to initiate the process with definite roaster plan. The meeting is now institutionalized in all districts and is conducted regularly in each PHI every month. Special attention is given to CAT II patients. **758** such meetings have been organized and **5748** of Category I, II and III have attended the meeting to discuss their problems and concerns. Out of this **1893** Category-II patients were counselled during this patient provider meeting.

3) **Involvement of NQPP for improving referral of TB patients**

Non-Qualified Private Practitioners (NQPPs) are private practitioners who do not have any medical qualification and practice the treatment of TB in the rural & urban slum community on their own. They are also locally known as Rural Medical Practitioner (RMP) and have a strong base & created network in the community. The NQPP plays a crucial role in meeting the health care needs not in a systematic process of treatment procedure. With the support of RNTCP, CARE has identified and sensitized the NQPPs for referral of TB suspects. In this reporting period, **1713 NQPPs** have been sensitized throughout 5 districts (Bardhaman, Malda, Mursidabad, Haora & Hugli) in the state.

Strategies adopted to involve NQPPs to reduce the burden of TB in the community include:

(1) Identification of active NQPPs (2) Sensitize NQPPs on TB & link them to RNTCP (3) Develop referral slips for NQPPs (4) Use of referral slips by NQPP (5) Ensure recording of the referrals in laboratory registers placed at DMCs

Regular follow-ups and meetings are simultaneously being conducted by CARE field staff. This helped to increase the involvement of private practitioners for referral of TB suspects and follow-up. In the words of Tasleudin Ahmed, a NQPP practicing in Karkoch GP of Gazole block, Malda district, *"This provides us lot of satisfaction that we are working hand in hand with the Government in the fight against TB"*.

4) **Involvement of community-based volunteers** for creating awareness among TB patients and regular follow-up of TB patients to improve compliance during the reporting period - the project has identified and sensitized **2948** community-based volunteers with the support of RNTCP. These volunteers

are engaged for creating awareness on TB and follow-up of TB patients in the community to improve case holding and reduce absentees and defaulters.

5) **Doer and Non-doer survey**- The Doer/Non-doer survey has been implemented during the 2nd quarter on two key behaviours - a) *Re-treatment patients who are taking treatment regularly as prescribed under DOTS* and b) *NQPP who are regularly referring TB cases in the community*. BCC strategy developed based on the analysis of the study has been given in **Annexe 3**

6) **Advocacy with the Department of Women and Child Development** for involvement of Anganwadi workers for ongoing awareness of TB patients - CARE advocated with the Department of Women and Child Development to involve Anganwadi workers for creating awareness on TB during their regular home visits and mothers meetings. In this regard, an order has been issued by the Government of West Bengal Department of Women and Child Development to all the five CARE intervention districts. The initiative has been appreciated by the state RNTCP who requested other key partners in the state to take a similar initiative in non-CARE districts.

7) **IMPACT team participation** in Annual the All Together Maternal and Child Survival Health program – the IMPACT team attended the Asia region workshop at Lucknow organized by CARE-USA during July 2010. The team has presented the key strategies and achievements of the IMPACT project during the workshop through poster presentation. Cross learning happened from CARE Zambia's TB project.

8) **Documenting case studies** from field - A case study on a TB patient of the Hugly district who has started DOTS treatment with the effort of CARE and RNTCP has been published in the April-June 2010 quarter Partners Speak newsletter. Partners speak newsletter comes once in each quarter. This newsletter printed and published by the secretariat of partnership for TB care and control in India. (Copy attached)

9) **BCC activities** - World TB day was observed in all 5 districts in collaboration with the DTO. The prioritized events were the audio jingles, health quiz, rally, and other competitions on TB-related issues. Local folk media was extensively used in Malda and Murshidabad where locally named "Gambhira" was organized in all CARE intervention blocks. Audio jingles on TB awareness were aired at two important railway stations (Bardhaman & Durgapur) for 12 consecutive 14 days starting from March 24th, 2010. In Howrah and Hugly districts, a mass quiz on TB, a rally involving school children, and mike announcements were organised on this day.

10) **Development of IEC materials** – The IMPACT project has developed pocket hand-books for Non-Qualified Private Practitioners, leaflets with messages on the Dos and Don'ts for TB patients, and leaflets for MDR TB suspects. A handbook for the DOTS Plus providers has also been developed. Preparation for a module on the counselling of MDR TB patients is currently underway. On World TB day 2010, various posters and banners reflecting TB messages has been designed in collaboration with the district TB cell.

11) **Operation research** was initiated in the Mursidabad district to know the pattern of migration among TB patients who migrate due to agricultural work.

12) **A number of checklists** for TB patient home visits, NQPPs and volunteers' records, and TB patients linked with welfare schemes have been developed during this reporting period. A monthly tracking system has been established for analyzing these records. That a part one referral slip has been produced and accepted by the RNTCP system that is being used by NQPPs.

Patient Home visit- CARE staff has used the patient visit checklist during their ongoing visit to patient's home for counselling and follows up. This checklist mainly focussed on the TB patient's knowledge, accessibility and practice. In a month on an average 500 to 600 TB patients of all categories are covered through checklist. While analysing and reviewing critical process level information's collected through this checklist, it was observed that INH prophylaxis not being given to children under 6 years of age who are in contact with sputum positive patients and streptomycin injection received from untrained private practitioners are emerging as major problem in all five districts. This information has been well taken by

State TB officer, RNTCP for further action. *The detail analysis attached herewith for information in result highlight section.*

B. Activity Status

Project Objectives/ Results	Related Key Activities (as outlined in DIP)	Status of Activities	Comment
Objective-1: Intensify and expand community-based DOTS especially in the poor performing Tuberculosis Units (TU)			
1. Increased number of NGOs/FBOs and private providers that are involved	1.1. Build the capacity of partner NGOs (GLRA & SHIS) to undertake TB control activities	Ongoing	The capacity of PNGOs has been developed through ongoing capacity building and review of activities.
	1.2. Partner with IMA to enhance the participation of private providers.	On target	Recently the IMA has received the global fund and CARE is coordinating with IMA for collaborative effort. Activities are likely to start from October 2010.
	1.3. Partner with the association of Non-Qualified Private Practitioners to enhance the participation of private providers.	Ongoing	All 5 districts have started sensitizing NQPPs for referral of TB suspects. NQPPs are referring TB suspects using referral slips developed under the project and recognised by RNTCP. The project organized bi-annual meetings with all sensitized NQPPs who are referring TB suspects in Mursidabad district.
2. Increased number of CDBP in inaccessible rural and urban slums to support patient-convenient DOT	2.1. Identify, network, and implement the model in migrant communities. District identified Bardhaman/ Murshidabad.	Ongoing	A concept note has been developed to study the pattern of migration among TB patients who are migrating to other districts for agricultural work. Data collection starts September 2010.
	2.2. Identify urban slums and train IPP-VIII and RCH workers.	On target	Listing of these groups is done. CARE has facilitated the training of 233 IPP-VIII and RCH workers with the support of RNTCP. This was a non-budgeted activity. In most cases RNTCP bore the cost as CARE facilitated. These groups have been sensitized recently. The follow-up will be captured in next year
	2.3. Identify rural inaccessible pockets and train ASHA/Volunteers/Link persons.	Ongoing	Listing completed. A formal communication has been issued by the Department of Women and Child Development to involve the AWWs for creating awareness on TB during the mothers meetings in each village. During the reporting period, the project has identified and sensitized 2948 community-based

			volunteers with the support of RNTCP.
	2.4. Identify and train DOTS providers - through capable local partners - who are accessible to patients.	Ongoing	Listing completed. The project has sensitized 2948 community-based volunteers and 1529 NQPPs with the support of RNTCP.
3. Increased number of stakeholders engaged in advocating for TB control	3.1 Identify and sensitize PRI/SHGs and FBOs for DOTS TB advocacy.	Ongoing	PRI/SHGs and FBOs have been identified in all districts and sensitization is ongoing.
	3.2 Spearhead state/district/TU-level NGO coordination meetings.	Ongoing	CARE is participating in NGO coordination meetings at the state level. District-level committees are yet to be formed.
4. Increased community knowledge about TB; Improved health-seeking behaviour and treatment compliance; Utilization of local language IEC materials	4.1 Perform Doer and Non-doer analysis to develop BCC strategies; Select and print existing IEC materials in local language.	On target	BCC training has been facilitated by CARE-USA for IMPACT staff during December 2009. Then the Doer and Non-doer survey was implemented on re-treatment cases and Non-Qualified Private Practitioners (NQPPs). IEC materials have been printed in local languages. Attached is the report on the Doer and Non-doer survey as well as the IEC materials as an annexure.
Objective-2: Strengthen the case holding and completion of treatment among re-treatment and MDR patients in order to prevent the increase in load of MDR TB			
1. Community-level providers are equipped to provide DOTS and manage adverse reactions	1.1. Identify and train providers and adverse reaction managers closer to the community.	On target	Mapping of DOT providers, NQPPs, QPPs and TB patients is complete. NQPPs are being used for referring TB suspects. The DOT providers' training occurred in the district Howrah and ongoing training for DOT providers will occur during their monthly meeting with the support of CARE.
2. Social support systems are strengthened for patients	2.1 Link patients to welfare schemes or alternate sources of livelihood to overcome the economic burden of the disease.	Ongoing	A government order from the Additional Chief Secretary of the Gov't. of West Bengal has issued a letter (attached in Annex-7) to all district magistrates for supporting TB patients through welfare schemes. On this basis, CARE has facilitated district-level pursuance of orders and has linked the TB patients with welfare schemes. The head of the Gram Panchayat Department at the Panchayat level has taken initiative and linked poor TB patients with cash and at some places, nutritious food items.
	2.2 Sensitize local Panchayets/SHGs on DOTS/MDR TB	Ongoing	SHGs are being sensitized on DOTS and MDR TB to enhance support to the TB patients. 485 SHGS are being

	to enhance support available to the patient.		sensitized at this time.
	2.3 Support reimbursement costs for transportation of patients, sputum sample and pre evaluation tests.	Ongoing	CARE has provided support for transportation and blood test costs to MDR TB patients in two identified DOTS Plus sites (Kolkata and Jalpaiguri). This objective has been supported by the Eli Lilly fund.
	2.4 Provide counselling support to patients and family members.	Ongoing	Counselling support has been provided to MDR TB patients at DOTS Plus sites and during home visits to re-treatment patients. Two counsellors have been appointed and capacitated in two districts with the support of Eli Lilly.
3. Improved case holding as a result of positive health-seeking behaviour and treatment adherence	3.1. Develop localized need-based communication strategy/materials to generate awareness about MDR TB.	Ongoing	A counselling training module preparation has been initiated and is in the final version. This module will be used to build capacity of district as well as peripheral health staff like ANM/DOT provider in coordination with RNTCP. This will also include job aids. BCC material with information on MDR TB patients has been developed and focuses on creating awareness among MDR TB suspects regarding the DOTS plus treatment process, culture tests, follow-ups, etc. An external consultant is supporting the development of the counselling module in due consultation with RNTCP and the Gov't. of West Bengal.
	3.2. Create a cadre of psychosocial counselors to support patients on treatment at the district TB center and CDST.	Completed	Two counsellors have been appointed for providing the support as mentioned. In Kolkata training was organized for all STS in consultation with RNTCP. A session on counselling and tips for effective counselling was included in the training curriculum to better equip them to support CAT IV patients
	3.3. Identify and counsel category II and IV patients through joint planning with district RNTCP.	Ongoing	CAT II patients are regularly counselled through individual home visit and during patient provider meetings. CAT IV patients are counselled by counsellors at the DOTS Plus site and home visits.

Objective-3: Strengthen the TB-HIV coordination at the state and district level to improve cross-referrals and ensure treatment for suspected TB-HIV co-infection			
1. TB/HIV coordination strengthened	1.1. Participate in and strengthen the state and district-level TB HIV coordination committees.	Ongoing	CARE is being recognised as a member of the district-level coordination committee. CARE staff are participating in the TB-HIV coordination committee meetings regularly.
	1.2. Encourage District/State IMA chapter to be included in District/State TB-HIV co-ordination committee.	Ongoing	CARE met with BNP+ members and IMA members in a 4-day BCC training and discussed their possibilities of future involvement. BNP+ has been included in the state-level committee.
2.Improved TB case finding in high-risk groups	2.1. Develop/adapt and implement localized need-based TB communication strategies aimed at HIV/high-risk populations.	Ongoing	Intensified TB/HIV activities have been initiated in the districts. Necessary materials will be prepared next quarter.
	2.2. Sensitize PLHA networks towards TB control through their umbrella agency BNP+.	Ongoing	The PLHA network has been sensitized in Bardhaman. The other district networks will be sensitized in consultation with RNTCP
	2.3. Build capacity of TI NGOs to generate awareness, carry out intensified case finding among high-risk groups, improve cross-referrals, provide DOTS, and support patients.	Ongoing	In the Bardhaman district, TI NGO staff have been sensitized for improving the cross-referrals and support to TB patients.
	2.4. Encourage District/State IMA chapter to be included in District/State TB-HIV co-ordination committee.	Ongoing	IMA has initiated activities under the global fund. Necessary discussion with the state chapter will be initiated next quarter.
	2.5. Establish sputum collection centers, especially where access to diagnosis is not possible (e.g. CSWs, truckers).	On target	Hard-to-reach and inaccessible pockets were identified jointly with RNTCP. Suitable institutions were identified to set up sputum collection centers. During this reporting period, 19 such centres have been established through the IMPACT initiative in Bardhaman (14), Malda (1) and Mursidabad (4)

			districts.
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C. FACTORS IMPENDING PROGRESS

- The frequent change of DTOs at the district level had substantial impact on the ownership of various initiatives. At present there are only two full-time DTOs in the two districts. Since the project is working closely with RNTCP, many district-level initiatives are being delayed.
- The transfer of Medical Officers and the resulting unfilled positions have created problems especially for conducting patient provider meetings and other CB sessions.
- In districts like Bardhaman, more than 30% of the NGO staff are changed during the period due to their low performance level. Similar instances have also been observed in the case of the Howrah district. The partner NGO for the same districts is GLRA.

D. IDENTIFIED AREAS FOR TECHNICAL ASSISTANCE

- Operation research will be conducted during September-November 2010.
- Mid-term evaluation will be conducted in five districts in first quarter of 2011.
- Phase out plans for five districts will be made during the 1st quarter of 2011.

E. SUBSTANTIAL CHANGES

No major changes. Discussion with the state level RNTCP officials will be held during first quarter of 2011 for selection of rest 10 poor performing TUs.

F. SUSTAINABILITY PLAN

A sustainability assessment workshop will be held after MTE and sustainability plan will be developed accordingly. This will need to be done better using the SA frame work. Here we can write (please coordinate with action plan – a Sustainability Assessment Workshop will be held after MTE for project staff and partners by CARE Atlanta and sustainability plan will be chartered after that) The project has been able to ensure some amount of support (in kind or cash) for poor TB patients from the Panchayati Raj departments. The Joint Secretary of Women and Child Development and the Welfare Department has issued a letter to all district program officers of ICDS for ongoing awareness on TB and follow-up of TB patients in the community. During the year, 2663 villages are being equipped with one volunteer for generating awareness on TB and performing regular home visits to TB patients.

G. SPECIFIC INFORMATION

There is no specific information for the report.

H. INFORMATION SPECIFIC TO YEAR ONE PROJECTS

TB project progress on monitoring indicators and benchmarks

Comparative analysis of NSP cases -TU WISE- IMPACT- 2008-2009-Q1&Q2-2010														
Sl. No	District	TU Name	Annual Case Detection Rate (ACDR)				Cure Rate (CR)				Treatment Success Rate (TSR)			
			2008	2009	Q1-2010	Q2-2010	2008	2009	Q1-2010	Q2-2010	2008	2009	Q1-2010	Q2-2010
1	Bardhaman	Asansol	46.4	57.0	49.3	62.4	88.1	82.5	88.7	87.2	88.1	82.5	90.3	88.5
2		Bhatar	81.6	77.6	62.5	75.9	83.8	72.6	80.0	77.3	88.5	78.0	80.0	78.7
3		Durgapur	60.0	57.9	52.5	66.7	82.8	86.3	86.0	85.1	84.1	87.2	86.0	85.1
4		Guskara	94.2	92.3	81.3	101.0	82.5	87.7	84.1	89.4	83.3	88.1	84.1	89.4
5		Katwa	71.6	86.1	80.1	90.7	81.4	81.0	81.0	82.9	82.4	83.3	82.3	82.9
6		Khandagho sh	50.7	48.5	42.0	50.1	90.7	89.1	92.0	85.7	90.7	89.1	92.0	85.7

7		Khandra Ukhra	57.2	60.2	56.2	87.9	81.9	83.3	85.7	88.0	86.0	85.1	88.6	88.0
8		Memari	100.2	99.1	102.8	99.4	80.7	76.5	82.7	82.9	83.0	77.6	82.7	83.8
9		Purbosthali	49.3	50.4	51.4	69.0	95.3	82.3	85.7	82.1	95.3	82.3	85.7	82.1
TU TOTAL			67.9	69.9	64.2	78.1	85.3	82.4	85.1	84.5	86.8	83.7	85.7	84.9
District total			71.9	72.6	68.5	83.0	84.5	83.0	84.8	84.4	85.7	84.3	85.7	84.8
10	Haora	Domjur	46.0	42.4	46.3	55.5	85.1	76.4	63.0	75.8	86.5	78.1	63.0	75.8
11		Gabberia	46.0	52.3	48.0	67.8	77.0	72.5	70.5	70.1	79.7	78.1	78.7	70.1
12		Jagadishpur Kona	112.3	95.8	108.2	92.4	84.1	66.1	68.4	75.0	85.6	69.0	68.4	78.1
13		Jagatballavpur	57.8	48.2	54.9	58.3	85.4	65.4	37.5	71.1	91.0	74.1	62.5	84.2
14		T.L.Jaiswal	61.5	61.0	50.6	53.6	79.6	83.0	83.8	85.5	80.8	85.1	83.8	87.0
15		Uluberia	54.6	56.4	47.0	58.4	81.9	81.5	33.3	77.1	84.0	84.0	41.7	80.0
TU TOTAL			63.0	59.4	59.2	64.3	82.2	74.1	59.4	75.8	84.6	78.1	66.3	79.2
District total			63.4	61.7	63.9	64.2	83.4	76.5	76.0	77.5	85.6	80.1	78.7	79.8
16	Hugli	Ahmedpur	62.0	94.0	99.3	89.9	84.6	80.5	85.2	86.9	85.1	83.3	85.2	86.9
17		Arambag	66.8	57.5	57.7	80.6	88.2	88.9	85.9	85.7	89.3	90.4	89.1	85.7
18		Khanakul	48.4	48.0	48.0	41.9	84.4	82.3	87.1	82.5	95.5	88.0	93.5	87.3
19		Polba	111.7	109.5	102.3	138.8	75.2	76.9	70.6	77.2	80.5	81.5	75.6	80.0
20		Tarakeswar	86.0	80.2	69.8	96.1	82.1	85.1	85.1	80.4	83.4	87.6	88.5	81.5
TU TOTAL			75.0	77.9	75.4	89.5	82.9	82.7	82.8	82.6	86.8	86.2	86.4	84.3
District total			70.2	66.2	61.9	72.3	82.8	83.1	82.8	81.0	85.1	85.4	85.2	82.4
21	Malda	Araidanga	107.0	92.7	81.6	96.8	82.6	82.5	80.2	80.6	84.9	84.8	81.3	82.8
22		Gazole	118.0	113.9	67.5	73.8	82.1	81.4	80.4	82.2	84.3	85.5	81.4	82.2
23		Manikchak	66.0	74.1	94.5	99.0	81.3	84.7	80.3	83.2	81.9	86.0	80.3	84.0
TU TOTAL			97.0	93.6	81.2	89.9	82.0	82.8	80.3	82.0	83.7	85.4	81.0	83.0
District total			81.9	97.5	97.1	115.1	62.1	82.0	82.1	82.8	62.9	84.1	82.5	83.6
24	Mursidabad	Amtala	55.9	56.1	64.6	62.3	78.1	78.7	79.1	84.7	86.9	87.6	86.0	86.4
25		Domkal	56.0	53.3	55.4	65.4	90.3	87.1	93.1	88.2	90.3	87.1	93.1	88.2
26		Jangipur	80.7	81.3	68.3	92.0	82.8	83.2	84.1	88.7	85.2	85.0	84.1	92.5
27		Kandi	59.8	68.5	67.3	67.3	86.5	85.9	86.8	86.4	86.5	87.1	89.7	88.9
28		Salar	59.9	66.4	63.1	75.5	84.2	85.2	86.4	86.7	84.5	88.1	86.4	88.0
TU TOTAL			62.5	65.1	63.7	72.5	84.4	84.0	85.9	86.9	86.7	87.0	87.9	88.8
District total			83.3	81.3	78.2	92.7	86.3	86.2	86.6	87.8	87.8	87.6	88.0	89.3
Project Total			73.1	73.2	68.8	78.9	83.3	81.2	78.7	82.4	85.7	84.1	81.5	84.0

**Source from RNTCP Epi-Info package*

Comparative analysis of Retreatment cases –TU WISE- IMPACT- 2008-2009- Q1&Q2-2010					
District name	TU Name	Treatment Success Rate (TSR)			
		2008	2009	Q1-10	Q2-10
Bardhaman	Asansol	71.6	71.3	79.3	88.9
	Bhatar	64.7	51.7	70.0	60.0
	Durgapur	72.8	71.4	63.0	65.4
	Guskara	68.0	80.3	68.8	76.7
	Katwa	63.1	76.1	60.0	72.7

	Khandaghosh	74.2	70.2	50.0	70.0
	Khandra Ukhra	82.9	69.8	65.5	65.8
	Memari	72.7	63.2	80.0	52.4
	Purbosthali	66.1	71.9	78.6	64.0
TU TOTAL		70.7	69.6	68.3	68.4
District total		72.6	71.5	67.4	68.7
Haora	Domjur	66.9	67.3	67.9	58.6
	Gabberia	62.8	69.7	53.1	74.1
	Jagadishpur Kona	78.1	56.9	55.1	43.2
	Jagatballavpur	80.9	74.1	94.1	77.8
	T.L.Jaiswal	70.7	67.0	80.4	70.5
	Uluberia	68.0	65.5	93.1	56.8
TU TOTAL		71.2	66.8	73.9	63.5
District total		73.5	67.4	70.0	63.8
Hugli	Ahmedpur	70.1	67.3	81.5	66.7
	Arambag	80.8	72.6	85.7	72.2
	Khanakul	76.0	80.5	55.6	80.0
	Polba	66.0	65.9	75.0	63.4
	Tarakeshwar	77.3	78.7	52.9	84.2
TU TOTAL		74.0	73.0	70.1	73.3
District total		73.1	70.2	67.1	70.2
Malda	Araidanga	61.7	70.7	65.4	82.9
	Gazole	69.4	68.9	63.6	72.0
	Manikchak	63.9	69.3	72.7	69.2
TU TOTAL		65.0	69.6	67.2	74.7
District total		66.5	69.7	70.1	69.5
Mursidabad	Amtala	75.2	73.5	42.9	80.0
	Domkal	75.2	80.1	76.5	93.8
	Jangipur	65.1	80.4	77.3	81.3
	Kandi	64.1	82.5	83.3	77.3
	Salar	64.4	56.3	52.6	70.0
TU TOTAL		68.8	74.6	66.5	80.5
District total		71.8	74.1	74.6	75.1
Project Total		70.0	70.7	69.2	72.1

I. PROJECT MANAGEMENT SYSTEM

1. Financial management system

Expenses compare to Annual Budget

DIRECT COSTS		ITD (Sep 08 - Aug 10)		% expenditure
		Budget Year 1 & Year 2	Actual	
I.	Personnel	121,994	130,215	107
II.	Fringe Benefits	0	0	0
III.	Travel	55,396	30,987	56
IV.	Equipment	11,583	9,793	85
V.	Supplies	2,760	2,860	104

VI.	Contractual	132,983	101,483	76
VI.	Other	53,163	37,985	71
	Total Direct Costs	377,881	313,323	83
VII.	Indirect Costs (ICR)	37,070	31,060	84
	Total Costs	414,951	344,384	83

2. Human resources

During this reporting period one Program Officer has been appointed for the district of Hugly. Now the project Human Resource positions are four Program Officers for five districts, one Monitoring & Evaluation Officer, one Administrative Assistant and one Project Manager. They are continuing their defined activities on a regular basis. The project continued to receive technical backstopping from the CARE USA CSHGP and support from the CARE India Office.

3. Communication system and team development

The project has provided electronic and telecommunication means to all the staff for effectively managing the channel of communication at different levels. Bi-monthly review meetings of internal staff members are being organized for tracking the progress and provision of support as required. Monthly meetings with NGO staff are organised each quarter for field-level review and analysis.

4. Local partner relationships

CARE has maintained relationships with all partners and has ensured the effective coordination for smooth management of IMPACT program activities. A close collaborative effort has been made with government, IMA, BNP+, and Eli Lilly for mutual agreed activities to achieve the goal.

5. PVO coordination/collaboration in India

The CARE-IMPACT project has been represented in the Partnership for TB care and control regional meeting at Kolkata. The main objective of this partnership is to bring together and synergize civil society contribution to TB care and control

J. Local Partner Organization Collaboration and Capacity Building

- SHIS and GLRA are continuing as partner NGOs of the IMPACT project.
- A reorientation program for PNGO staff has been conducted in district locations separate from the regular monthly review meetings.
- At present 62 Block coordinators, 4, 5 Project coordinators, and the NGO accountants of SHIS and GLRA are working under the IMPACT project

K. Mission Collaboration

Ongoing consultations have been made when required for project planning and BCC strategy development process.

L. Any other relevant aspects

IMA and Global Fund

The global fund for IMA has been released recently. CARE is coordinating with IMA for collaborative intervention in IMPACT-operated areas.

Annexes

- Annex 1: M&E Table
- Annex 2: Workplan
- Annex 3: BCC strategy based on Doer and Non-doer survey results
- Annex 4: Poster Presentation on IMPACT Project presented at Lucknow “All Together for Maternal and Child Health workshop”
- Annex 5: Results Highlight - Linking poor TB patients with welfare schemes
- Annex 6: Geographical coverage of partners and their roles and responsibilities

Annex-1: M&E Table

Annex-I- INDICATOR TRACKING TABLE- IMPACT PROJECT PERFORMANCE				
Project Period: September 30, 2008 - September 29, 2013				
	Description of Indicator	Project Targets	TOTAL ACHIEVEMENT (09-10)	COMMENTS/REMARKS
Sl.No.	Goal: To decrease morbidity and mortality caused by tuberculosis in the Child Survival program area			
1.1	Increase TB case detection rates (CDR) to 70% by the end of project.	100% of TUs in WB reach CDR 70%	Out of 28 TUs, 14 TUs have detected > 75%, 7 have detected between 65-75% and 7 TUs are below 65% detection rate	As per RNTCP report of 2 nd quarter 2010
1.2	Increase Cure Rate (CR) to at least 85% by the end of project	85% Cure Rate	13 TUS have cure rate over 85%, 13 TUs have cure rate between 75-85% and 2 TUs have less than 75% cure rate	As per RNTCP report of 2 nd quarter 2010
1.3	Increase Treatment Success Rate (TSR) to 90% by the end of project	90% TSR	1 TU has achieved more than 90% success rate, 23 TUs have success rate between 80-90% and rest 4 have less than 80% success rate	As per RNTCP report of 2 nd quarter 2010
1.4	80% patients put on Category IV treatment (MDR patients) completed treatment	80% cat-IV patients completed treatment	Till date 200 MDR TB patients have been put on treatment out of which 5 patients have died and 11 patients have defaulted	The state has started MDR treatment since Dec'08. The cohort is therefore still not completed
1.5	Increased the treatment completion rate of Retreatment cases to 80%	80% TC for Retreatment cases	6 TUs have achieved success rate above 80%,9 TUs have between 70-80% success rate and 13 TUs have success rate below	1893 re treatment cases were counselled in patient provider meeting by project staff

			70%	
1.6	Increased referral from HIV ICTC to RNTCP to 20%	20% referral of HIV ICTC to RNTCP	Out of 66823 clients attending ICTC, 2641 TB suspects referred to RNTCP i.e; 4% referral	This data reflects of state total figure for Q3-09, Q1-10 and Q2-10.
Objective 1: : Intensify and expand community based DOTS especially in the poor performing TUs				
1.1	Increase in number of community level and accessible DOTS providers to 10000 (Baseline is 3537). The number includes all DOT providers other than ANM	6463 potential DOTS providers created and involved	2948 Community based volunteers have been identified and sensitized and they are participating in the programme	These volunteers are creating awareness in the community and following up the TB patients through home visit as and when needed
1.2	Increase in number of NGOs participating in RNTCP to 60	20 NGOs linked to RNTCP	7 local NGOs participating in RNTCP activities with the effort of IMPACT project	Though they have not been formally linked with RNTCP through schemes, they are participating in the programme through their ongoing other field level activities
1.3	Increase in number of NQPP & QPP referring TB suspects to RNTCP (Now 182 NQPP & 37 QPP are participating which will be increased to 5000)	4781 private providers (3818 NQPPs & 963 QPPs) has referred TB suspects	1529 NQPPs sensitized and referring TB suspects	
1.4	5% of TB patients treated/reported by QPP	5% TB patients treated & reported	NA	IMA will initiate their activity in next quarter. CARE will follow up with the practitioners after their sensitization. Need a comment – as the IMA related work for TB has not yet started

1.5	5% of TB patients referred by QPPs into the DOTS RNTCP system	5% TB patients referred	NA	IMA will initiate their activity in next quarter. CARE will follow up with the practitioners after their sensitization
1.6	5% of TB patients treated/reported by NQPP	5% TB patients treated & reported	5488 NSP cases detected during 3 quarters (Q4-09,Q1-10 & Q2-10) in CARE operated TUs. 6% of these cases were referred by NQPPs.	1529 NQPPs were trained in five districts on RNTCP & DOTS activities. NQPPs have also started referring TB cases using referral slip. In these districts in, 3295 TB suspect cases were referred but 2763 are reported- out of which 2656 sputum were examined and 330 NSP cases detected.
1.7	5% of TB patients referred by NQPPs to the DOTS RNTCP system	5% TB patients referred	3295 cases referred till now	
1.8	Model for implementing DOTS for migrant and itinerant population developed and implemented	OR carried out at least in one community	OR concept note developed and study under process	
Objective 2: Strengthen the case holding and completion of treatment among re-treatment and MDR patients so as to prevent the increase in load of MDR TB				
2.1	100% category II and IV patients have acceptable and accessible injection provider	Injection providers identified & trained	Injection received mainly from Govt. providers. 100% cat-II and IV patients are getting accessible injection provider	IMPACT project has developed one checklist for patient home visit which started capturing information on who is providing injection to the CAT II patients and how much is the patient paying for the service. The project will make necessary advocacy efforts with RNTCP based on the

				findings
2.2	100% line listed category II patients receive counseling support	A cadre of counsellors created and trained for ensuring 100% Cat-II patients are counselled	100% cat-II patients have received counselling support through ongoing home visit and during patient provider meeting one more counsellor appointed in this period	Psycho Social counsellor appointed and sensitized
2.3	100% MDR patients linked & benefitted through welfare schemes	100% MDR patients are linked with welfare schemes	No MDR TB patients linked with welfare schemes in this period NA Or check from MDR patient record for n'boring district	Efforts will be taken to link them in next quarter
2.4	Need based communication strategy to address default among category II and MDR TB is developed and implemented in all districts	Developed localized need based communication strategy/ module to generate awareness about MDR TB	Using BEHAVE framework the BCC strategy to address default among Category II has been developed. Few BCC materials have also been developed and distributed	<ol style="list-style-type: none"> 1. Leaflet on TB & DOTS developed in Bengali language for Volunteers, PRIs and AWWs. 20,500 printed and distributed. 2. Booklet on TB & DOTS developed in Bengali language for NQPPs. 3000 printed and distributed 3. Leaflet for MDR TB suspects developed in Bengali language. 5000 printed and distributed

				<p>4. Booklet on MDR TB for DOTS Plus providers developed in Bengali language and yet to be distributed- 300 printed</p> <p>5. Pamphlet on Do's and Don't in TB developed for TB patients. 10000 printed in Bengali and 1000 in Hindi.</p>
Objective 3: Strengthen the TB-HIV coordination at state and district level to improve cross referrals and ensure treatment for suspected TB-HIV co-infection				
3.1	At least 80% of ICTC referred. Referred patients complete diagnosis/ testing and all patients diagnosed of TB are put on DOTS	80% referred TB patients completed diagnosis and put on DOTS	Out of 2641 TB suspects referred by ICTC, only 454 reported at DMC and completed diagnosis. Out of them 125 were diagnosed as TB cases and put under DOTS.	This data reflects of state total figure for Q3-09, Q1-10 and Q2-10.
3.2	Around 50% of HIV positive TB patients are put on Cotrimoxazole prophylactic therapy	50% HIV+ TB patients are put on CPT	CPT has not yet been introduced	The matter has been discussed with state RNTCP and necessary order will soon be released to all PHI to provide cotrimoxazole
3.3	50% of NGOs providing TI services are also promoting DOTS	50% NGOs promoted DOTS	4 TI NGOs has been sensitized in Bardhaman district	12 staff of these 4 TI NGOs were trained on TB-DOTS
3.4	By end of project 10 PLHA network is active engaged	1PLHA Network is active in each	coordination established with 2 PLHA network	IMPACT project staff have attended 5 ICTC and TU level coordination meeting

		district		
3.5	10% of TB patients are referred to HIV ICTC	10% TB suspects referred	The data varies from 11.7% in Bardhaman to 72.7%	The policy has changed and 100% TB patients should be referred to ICTCs now as per the TB/HIV intensified package. Since the number of ICTCs are still less in some districts, referral is a problem. State AIDS cell will increase the number of ICTCs in next year

I- Intensify and expand community based DOTS especially in the poor performing TUs

Output 1.1: Increased access to DOTS services in urban slums, rural marginalized pockets and for migrant/itinerant population

1.1.1	50 slums/ inaccessible rural pockets are ensured with accessible DOTS providers	At least 50 slums & inaccessible rural pockets covered	2948 community level volunteers identified and sensitized in five districts. We have no separate data for slum areas specify for slum areas	They have started referring cases. Out of 531 suspects cases 415 cases were examined at DMC. 57 NSP cases detected i.e, 1% of total number of NSP cases detected.
1.1.2	Increased AWW/link workers/ volunteers/ ASHA/USHA oriented/trained on RNTCP as potential DOT provider to 10000	6463 potential DOTS providers created and involved	2948 community level volunteers identified and sensitized in five districts	Identification process is going on in each district
1.1.3	Increased sputum collection centers to 80 by end of project	18 sputum collection centres established	19 sputum collection centres established with the initiative of	These areas were identified in consultation with RNTCP and linked through local NGOs. Out of this Bardhaman- 14, malda-1

			IMPACT project	and Mursidabad-4. These sputum collection center have been established in close consultation with RNTCP using NRHM fund. Inaccessible areas were identified by the project and there are still some areas where more number can be established
Output 1.2: Enhance participation of NGOs/FBOs and private providers in DOTS provision				
1.2.1	Increased the number of NGO/FBOs partners implementing RNTCP schemes to 60	20 NGOs linked to RNTCP	7 FBOs were trained. 6 local NGOs trained	In 3 districts Malda, Mursidabad and Hugly these FBOs were trained. Local NGOs trained in Bardhaman district
1.2.2	Increased Non Qualified Private providers participated in RNTCP to 4000	3818 NQPPs are identified, trained and linked to RNTCP	1529 NQPPs sensitized and referring TB suspects	1529 NQPPs were trained in five districts on RNTCP & DOTs activities. NQPPs have also started referring TB cases using referral slip. In these districts in, 3295 TB suspect cases were referred but 2763 are reported- out of which 2656 sputum were examined and 330 NSP cases detected.
1.2.3	Increased to 1000 QPPs and oriented/trained for referral	At least 963 QPPs oriented for referral	NA	Though QPPs are identified but this intervention will be jointly made with the support of IMA. IMPACT project will be involved in follow up process of QPPs after the training imparted by IMA.
Output 1.3: Use need based and localized communication strategies to address identified gaps in knowledge				

and behaviors				
1.3.1	IEC developed and distributed among 300 non Bengali speaking communities in their native languages	300 non-bengali speaking communities covered	IEC materials developed both in Bengali and Hindi to cover Bengali and Non-Bengali speaking people	
1.3.2	10,000 broadcasting events for community awareness on TB take place in the project area	10000 broadcasting events organised	On World TB day one audio jingles spot program has been aired in 2 railway stations of Bardhaman district for fourteen consecutive days.	World TB day was observed in all 5 districts in collaboration with DTO. Priorities given on Audio Jingles, Health quiz, rally, and other competitions on TB related issues etc.
1.3.3	Around 90% of the population of the identified community knows about the signs and symptoms of TB and know that TB is curable	90% of selected communities made aware	NA	
Output 1.4: Increase number of stakeholders advocating for TB control				
1.4.1	250 PRI participate in a planned manner for DOTS activities	250 PRIs trained	139 PRIs trained	PRIs were motivated to participate in Patient Provider meeting. 139 PRIs have been trained during the reporting period till July'2010
1.4.2	125 SHG oriented/trained for DOTS TB advocacy.	125 SHGs trained	541 SHGs trained	SHG selection made and 541 SHGs were trained.
1.4.3	125 FBOs oriented/trained for DOTS TB advocacy	125 FBOs trained	113 FBO members trained of 7 Faith based	FBOs are identified in three districts (Malda, Mursidabad & Hugly) and 113 FBO members were trained till

			organisation	July'2010. Basically they are from Mosques.
II- Strengthen the case holding and completion of treatment among re-treatment and MDR patients so as to prevent the increase in load of MDR TB				
Output 2.1: Build capacity of community level providers to provide DOTS (including injections); and manage adverse reactions				
2.1.1	At least 200 injection providers trained in managing adverse reactions.	200 injection providers trained	Injection received mainly from Government providers who are already trained by RNTCP.	IMPACT project has developed one checklist for patient home visit which started capturing information on who is providing injection to the CAT II patients and will analyze the need of training. The project will do necessary advocacy based on the findings of the study
2.1.2	Around 200 injection providers identified and actively providing services to TB patients close to the community	200 trained injection providers providing services to TB patients	ANM or the government DOT providers are the official DOT providers in the community who provide services close to them. They are already trained.	IMPACT project has developed one checklist for patient home visit which started capturing information on who is providing injection to the CAT II patients and will analyze the need of training. The project will do necessary advocacy based on the findings of the study
Output 2.2: Strengthen social support systems of patients				
2.2.1	30 counselors trained for retreatment and MDR patients	30 counsellors trained	2 counsellors appointed and trained	These counsellors counseling the MDR TB patients in DOTS Plus site (Kolkata and Jalpaiguri)
2.2.2	250 PRIs, 125 FBO and 125 SHGs sensitized to DOTS and MDR TB	250 PRIs, 125 FBO and	139 PRIs, 113 FBOs, 541 SHGs	The content of the training was mainly on DOTS TB

		125 SHGs sensitized to DOTS and MDR TB	have been sensitized.	with some focus on MDR TB
Output 2.3: Promote positive health seeking, treatment adherence and completion through BCC activities				
2.3.1	100% poor performing TUs have need based communication strategy available to address prevention and management of MDR	100% areas of selected Tus have communication strategy on MDR	DOTS Plus programme was initiated in five districts which are not CARE intervention areas. With support from Eli Lilly few activities only for MDR TB patients have been initiated in those districts	
Output 2.4: Strengthen monitoring and supervision through joint anticipatory planning with DTC				
2.4.1	Around 50 Joint meetings held at district and TU level on monthly basis	50 joint meetings held	On an average 6 joint meetings with RNTCP held per month by IMPACT project staff at district and TU level. During the year 60 joint meetings held in 5 districts.	This is based on the total number of meetings attended by IMPACT project staff with DTO/CMOH/MO-TU at District & TU meeting. This figure upto July'2010.
III- Strengthen the TB-HIV coordination at state and district level to improve cross referrals and ensure treatment for suspected TB-HIV co-infection				
Output 3.1: Advocacy and support coordination at state and district level				

3.1.1	At least 6 state & district level meetings attended and joint planning developed per quarter	6 per quarter district & state level meeting attended & planning developed	In 4 quarters all five districts POs have attended 6 such meetings. One state level meeting happened. What about the state level meetings	During the meeting CARE has presented the quarterly update with DTOs, STOs, WHO and other civil society bodies at district level.
3.1.2	Problems identified and addressed through TB-HIV coordination committees	Identified gaps being discussed in coordination meetings	7 meetings attended by POs of Bardhaman, Haora and Hugly district	CARE has been included as an active member of State & District level TB-HIV coordination committee. Main problem addressed was the lack of coordination between both the departments
3.1.3	At least 6 per quarter PLHA networks sensitized to TB control issues	6 per quarter PLHA network sensitised	2 district level PLHA network sensitised	1 ICTC and TU level coordination meeting attended by IMPACT project staff & sensitised the PLHA network. Please explain why it is not done better. TB/HIV coordination activities have just been initiated. We hope to get better report in next annual report.

Output 3.2: Intensified TB case finding in high risk groups

3.2.1	Minimum 20 TI NGOs identified and trained in DOTSNGOs to generate awareness, carry out intensified case finding among high risk groups, provide DOTS and support patients	20 TI NGOs trained	4 TI NGOs has been sensitized in Bardhaman district	12 staff of these 4 TI NGOs were trained on TB-DOTS.
3.2.2	5000 PPs identified and trained for identification of high risk areas and link	5000 PPs trained	NA	IMA has just initiated their activity and IMPACT staff will follow them up after

	them to RNTCP PP schemes			sensitization is complete
3.2.3	Capacity building of 4 BNP+ and 1 CSW network in each district and their involvement in TB case findings	4 BNP+ network trained and 1 CSW network in each district trained	2 BNP+ network has been identified and trained	One each in Bardhaman and Hugly district
NA-Not Achieved				

Annex 2: Workplan

Annex I: Project Work Plan- IMPACT						
Period- October 2010 TO September 2011						
Result	ACTIVITIES	Year-3				Personnel
		Q 1	Q 2	Q 3	Q 4	
Objective 1: Intensify and expand community-based DOTS especially in the poor performing TUs						
1. Increased number of NGOs/FBOs and private providers are involved	1.1. Build the capacity of identified NGOs/FBOs to undertake TB control activities.	X	X			PO
	1.2. Partner with IMA to enhance the participation of private providers.	X	X	X	X	PO/PM
	1.3. Follow up with sensitized non-qualified private practitioners to enhance the participation and improve case detection.	X	X	X	X	PO
2. Increased number of CBDP in	2.1. Identify, network, and implement the model in migrant communities. District identified Bardhaman/ Murshidabad	X	X	X	X	PO

inaccessible rural and urban slums to support patient-convenient DOT	2.2. Identify urban slums and train IPP-VIII and RCH workers.	X	X	X	X	PO
	2.3. Identify rural inaccessible pockets and train ASHA/AWW/Volunteers/Link persons.	X	X	X	X	PO
	2.4. Establish sputum collection centres through local NGOs with the support of RNTCP.	X	X			PO
	2.5. Identify and train DOTS providers - through capable local partners - who are accessible to patients.	X	X	X	X	PO
3. Increased number of stakeholders engaged in advocating for TB control	3.1. Identify and sensitize PRIs for DOTS-TB advocacy.	X	X	X	X	PO
	3.2. Identify and sensitize SHGs for DOTS-TB advocacy.	X	X			PO
	3.3. Follow up with sensitized SHGs/FBOs.	X	X	X	X	PO
	3.4. Advocate with PRIs for linking TB patients with welfare schemes thru Block development meetings and Block Sthayee Samiti meetings.	X	X			PO
4. Increased community knowledge about TB; Improved health-seeking behaviour and treatment compliance; Utilization of local language IEC materials.	4.1. Use innovative methods for mobilizing local resources (volunteers/SHG/PRI/FBO etc) to spread messages on TB.	X	X			PO/M EO/P M
	4.2. Implement BCC strategies developed by the project.	X	X			PO/M EO/P M
	4.3. Use existing BCC materials developed by IMPACT and RNTCP.	X	X	X	X	PO
	4.4. Improve patients knowledge through home contacts and Patient Provider Meeting (PPM).	X	X	X	X	PO
	4.5. Counsel TB patients and family members during home visits.	X	X	X	X	PO
	4.6. Conduct PPM on a monthly basis in each PHI.	X	X	X	X	PO
	4.7. Spread messages through cured TB patients.		X	X	X	PO
Objective 2: Strengthen the case holding and completion of treatment among re-treatment and MDR patients in order to prevent the increase in load of MDR TB						
1. Community-level providers are equipped to provide DOTS and manage adverse reactions	1.1. Facilitate training of poor performing DOT providers with a focus on counseling skills through RNTCP.	X	X			PO
	1.2. Identify and train new community-level DOT providers of urban slums and inaccessible pockets.	X	X	X	X	PO
	1.3. Advocate and mobilize with RNTCP resources for training/retraining of existing and new DOT providers.	X	X	X		PO/P M
	1.4. Advocate with RNTCP training of injection providers (NQPPs) on injection safety.	X	X			PO
2. Social support systems are strengthened for patients.	2.1. Advocate with PRIs/Municipal bodies linking TB patients with welfare schemes thru Block development meetings & Block Sthayee Samiti meetings.	X	X			PROJ ECT TEAM
	2.2. Sensitize local Panchayats/SHGs and ASHAs on DOTS/MDR TB to enhance support available to the patient.	X	X			PO
	2.3. Provide counseling support to patients (including absentee patient) and family members through a sensitized volunteer, NQPP, SHG, FBO, and/or PRI.	X	X	X	X	PO

	2.4. Support reimbursement costs for transportation of patients and sputum sample and pre-evaluation tests of MDR-TB patients.	X	X	X	X	Counselor
	2.5. Form TB support groups on a pilot basis.	X	X			PO
3. Improved case holding as a result of positive health-seeking behaviour and treatment adherence	3.1. Develop BCC materials to create awareness among Cat-II and MDR TB patients on MDR TB.	X		X		PO/MEO
	3.2. Organize patient provider meetings to ensure treatment adherence and follow-up of TB patients.	X	X	X	X	PROJECT TEAM
	3.3. Provide home contact and counseling support to Cat-II and irregular patients and family members.	X	X	X	X	PO
	3.4. Facilitate training of Gov't. DOT providers with focus on counseling skills.		X	X	X	PO
Objective 3: Strengthen the TB-HIV coordination at the state and district level to improve cross-referrals and ensure treatment for suspected TB-HIV co-infection						
1. TB-HIV Co-ordination strengthened.	1.1. Participate in and strengthen the state and district-level TB HIV coordination committees.	X	X	X	X	PO/PM
	1.2. Encourage District/State IMA chapter to be included in District/State TB-HIV co-ordination committee.	X				PO/PM
	1.3. Encourage regular participation of BNP+ in TB-HIV coordination committees.	X	X	X	X	PO
	1.4. Advocate with RNTCP for improving cross-referrals.	X	X	X		PO
2. Improved TB case finding in high-risk groups	2.1. Develop/adapt and implement localized need-based TB communication strategies aimed at HIV/high-risk populations.	X	X			PROJECT TEAM
	2.2. Build capacity of TI NGOs to generate awareness, carry out intensified case finding among high-risk groups, improve cross-referrals, provide DOTS, and support patients.	X	X			PO/PM
	2.3. Follow up with sensitized TI NGOs to generate awareness, carry out intensified case finding among high-risk groups, improving cross-referrals		X	X	X	PO
	2.4. Follow up with PLHA networks towards TB control through BNP+.	X	X	X		PO
	2.5. Facilitate with TI or other NGOs for establishing sputum collection centers, especially where access to diagnosis is not possible (e.g. CSWs, truckers).	X	X			PO
Other Project Activities						
1	Develop/review training/orientation materials					PM
	PNGO Staff Orientation					PM
	Review meetings with Partner NGOs	X	X	X	X	PO
	Participate in RNTCP review meetings held monthly/quarterly	X	X	X	X	PO
Other Project Activities						

2	Select second-phase TUs for IMPACT activities in consultation with RNTCP		X			PM
	Prepare a sustainable phase out plan for current 5 operational districts		X			PO/M EO
	Implement/Follow-up capacity-building activities	X	X	X	X	PO
	Coordinate inter-sectoral at the district and state level for BNP+, IMA, PRI, WCD and other line departments	X	X			PO/P M
	Hold coordination meetings with stakeholders at the district/State/National Level	X	X	X	X	PO/P M
3	Review monthly MPR, QPR, BMFR and provide feedback at each level	X	X	X	X	PROJ ECT TEAM
	Prepare a quarterly report of IMPACT project	X	X	X	X	MEO
	Prepare Annual Workplan and Operational Plan for project and Partner NGOs				X	PO/M EO/P M
	Prepare Annual report for 2010-11				X	MEO
	Perform small scale studies to understand the effectiveness of project activities	X		X		PO/M EO
	Document case studies	X	X	X	X	PO/M EO
	Prepare and select an external agency and facilitate Mid Term Evaluation (Jan 2011)	X	X	X	X	MEO/ PM
	Operation Research	X				MEO/ PO
	Project Reporting	X	X	X	X	PM/M EO

Annex 3: BCC strategy based on Doer and Non-doer survey results

Doer and Non-doer survey- An innovative step to accelerate action

Doer and non-doer analysis is used to understand the behavior of target audience. This provides clear representation of human behavior those who do and who don't practice any particular behavior. The analysis provides scope to seek response on 6 key behavior questions as follows;

1. What do you see as the advantages or good things of performing the behavior?
2. What do you see as the disadvantages or bad things of performing the behavior?
3. What makes it easier to perform the behavior?
4. What makes it difficult to perform the behavior?
5. Who approves or supports you doing the behavior?
6. Who disapproves or objects to you doing the behavior?

IMPACT project is covering multi stakeholders at system and community level. It is pertinent on the project part to focus on the *“right behavior for right audience approach”* for improvement on the set target. For this purpose it was decided to identify two key behaviors that influenced the program objectives are; *a) Retreatment patients who are taking treatment regularly as prescribed under DOTS b) NQPP who are regularly referring TB cases in the community*

Steps of Doer and Non-doer survey

A- Retreatment cases

1. **Identify goal-** to improve the treatment success rate by reducing the number of Retreatment cases who are not taking regular treatment
2. **Define behavior-** Retreatment patients who are taking treatment regularly as prescribed under DOTS
3. **Audience-** Retreatment cases of all age groups
4. **Define behavior question-** Do you take treatment regularly?
5. **Ask 6 questions**
 - What do you see as advantages or good things when you take treatment regularly?
 - What do you see as the disadvantages or bad things when you take treatment regularly?
 - What makes it easier for you to take treatment regularly?
 - What makes it more difficult to take treatment regularly?

- Who do you think would approve or support while receiving services from DOT centre and taking treatment?
- Who do you think would disapprove or object to take treatment from DOT centre and taking treatment

B- Non Qualified Private Practitioners

1. **Identify goal-** To increase case detection by improving referral of TB cases through NQPP
2. **Define behavior-** NQPP who are regularly referring TB cases in the community
3. **Audience-** Non Qualified Private Practitioners
4. **Define behavior question-** Do you refer TB suspect?
5. **Ask 6 questions-**
 - What do you see as advantages or good things when you refer TB cases?
 - What do you see as the disadvantages or bad things when you refer TB cases?
 - What makes it easier for you to refer TB cases?
 - What makes it more difficult to refer TB cases?
 - Who do you think would approve or support during referral of TB cases to DOT centre for treatment?
 - Who do you think would disapprove or object during referral of TB cases to DOT centre for treatment?

Criteria followed for Retreatment cases- Bardhaman district

20 Doers and 20 Non-Doers have been selected from all re-treatment cases of Kandra and Durgapur TU who have initiated treatment between >1 month to 8 months (<9mths) before from the 1st day of date collection.

Reference period	Doers	Non Doers
Initiated treatment for >1 mths but <9 mths	If not missed a single dose	If missed even a single dose

Criteria followed for NQPP- Mursidabad district

20 doers and 20 non-doers have been selected from NQPPs who were identified, short listed and trained by IMPACT project before 5 months. Following to this they were also given referral slip for referring suspect TB cases to the nearest DMC.

Reference period	Doers	Non Doers
NQPPs who were Identified and trained under IMPACT project during Oct & Nov'09	If started referring after training by IMPACT	Though trained but not referring

Based on the result of doer and non doer survey, CARE developed following BCC strategies for IMPACT project area.

BEHAVE FRAMEWORK- based on the responses received thru DOER & NON DOER survey

1. Retreatment

Priority Group <i>In order to help</i>	Behavior <i>to</i>	Key Factors <i>will focus</i>	Activities <i>Through</i>
Retreatment patients who do not take TB medicines regularly	Take TB medicines regularly without missing of single dose till 8 months of treatment	<p>A. Addressing adverse effects of TB drugs</p> <p>B. Address loss of wages</p> <p>C. Address the motivational factor of DOT provider</p>	<p><u>A.</u></p> <ol style="list-style-type: none"> 1. Produce IEC materials- for patient & DOT providers 2. Initial counseling through TB support groups- piloting in one district (at Mursidabad district) 3. Periodic home visit to TB patients and their family members by DOT provider <p><u>B.</u></p> <ol style="list-style-type: none"> 1. Mapping all opportunities (not only financial) in support of TB patients 2. Awareness building with Panchayatraj institutions on TB at different level 3. Prioritization of TB patients (may be on differential amount, duration of treatment, household income - MDR TB-Cat-II-Cat-I, Cat-III. <p><u>C.</u></p> <ol style="list-style-type: none"> 1. Participation of DOT provider in Patient provider meeting 2. Improve follow up visit and counseling skill of DOT provider 3. Ensure Modular training for Govt. & private DOT provider with focus on counseling skill

Indicators	Decrease in number of TB patients who are not taking TB medicines	<p>A.</p> <ol style="list-style-type: none"> 1. No. of IEC materials produced for patient, DOT providers, Supervisors and MOs 2. No. of TB support group formed <p>B.</p> <ol style="list-style-type: none"> 3. No. of GP linked TB patients with social welfare schemes 4. No. of TB patients linked with social welfare schemes <p>C.</p> <ol style="list-style-type: none"> 5. No. of patient provider meeting held with the participation of DOT providers 6. No. of DOT provider trained on modular training in counseling skills 7. No. of DOT providers improved knowledge on counseling skills
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****A small exercise can be done to identify MDR TB patients among the repeat Retreatment patients (repeat Cat-II) in Jalpaiguri & Kolkata*

2. NQPPs

Priority Group <i>In order to help</i>	Behavior <i>to</i>	Key Factors <i>will focus</i>	Activities <i>Through</i>
NQPPs who are oriented by CARE and not referring the suspect TB patients to nearest DMC	Refer all TB suspects to nearest DMC for cough examination	<ol style="list-style-type: none"> a. TB suspect referred by NQPP given due importance by DMC b. RNTCP giving recognition to NQPPs who are referring TB suspects c. Improve upon RNTCP responsiveness towards NQPP 	<p>AB.</p> <p>A1. Use of referral slip by NQPP</p> <p>AB2. Referred patient directly testing sputum at DMC</p> <p>AB3. Letter from RNTCP for accepting the involvement of NQPP and motivation for more referral</p> <p>AB4. Thank you note by Govt. and/or other civil society bodies once in a quarter</p> <p>C.</p> <ol style="list-style-type: none"> 1. Submission of list of NQPPs at PHI level 2. Link sensitized NQPPs at PHI level 3. Follow up visit by NGO staff 4. Reorientation of sensitized NQPPs
Indicators	Improve referral of TB suspects and case detection	<ul style="list-style-type: none"> ● No. of NQPPs are using referral slip ● No. of TB suspects directly examined at DMC ● No. of NQPPs have been recognized with thank you note ● No. of NQPPs list submitted at PHI ● No. of NQPPs linked at PHI level ● No. of NQPPs have received reorientation 	

Annex 4: Poster Presentation on IMPACT Project presented at Lucknow



CARE-India
Supporting RNTCP to reduce burden of TB from West Bengal

IMPACT Project

(Initiative to Manage People Centered Alliances in control of Tuberculosis)
CARE India, Supported by USAID



- Contacts:
- Dr. Bandita Sengupta
 - Mr. Pradeep K. Mishra
 - Mrs. Anita Pal Choudhury
 - Mr. Santanu Bhoumik
 - Mr. Soumen Pandey
 - Mr. Basab Roj
 - Mr. Santanu Sengupta

Project Background

The goal is to support RNTCP to decrease the morbidity and mortality caused by tuberculosis, MDR TB and TB HIV co-infection in West Bengal in India.

SO-1: Increase the capacity of RNTCP to support TB patients with welfare schemes. SO-2: Increase the capacity of RNTCP to support TB patients with welfare schemes. SO-3: Increase the capacity of RNTCP to support TB patients with welfare schemes.

Our Partners

Our key strategies

- Identify potential volunteers and private health practitioners from community and build their capacity to improve referral of TB suspects, creating awareness and follow up of TB patients.
- Linking poor & marginalized TB patients with social welfare schemes of Government to increase compliances of TB cases and improve case holding.
- Psycho-social counseling of Cat-II (Retreatment) patients to improve case holding.

Map of West Bengal depicting program coverage area of IMPACT

Result-1: Linking Poor TB patient with Welfare schemes

Poor TB Patients linked up with social welfare schemes.

200 TB patients linked up

620 TB patients linked up

Result-2: Involvement of Non-Qualified Private Practitioners (NOQP)

Collaborative effort with RNTCP to sensitize NOQP.

Motivated NOQP using referral slip.

Result-3: Volunteerism of Community level volunteers

Community level volunteers sensitization, 2010.

RCC related used by volunteers for creating awareness on TB in community.

Result-4: Counseling TB patients

Patient provider meeting (PPM) used as effective forum for inter personal counseling and to bridge the gap between patient & provider.

Learning

Partnering with private practitioners and volunteers will definitely reduce the burden of TB in the community. Inter sector coordination will support the well being of TB patients for their livelihood during treatment period.

Letter of Govt. for linking TB patients with welfare schemes & involvement of CARE.

Letter of Govt. for involvement of AYW as volunteer in TB program for creating awareness in community.

Joint effort of CARE & RNTCP on World TB Day- 2010.

Child Survival Workshop

Annex 5: Results Highlight

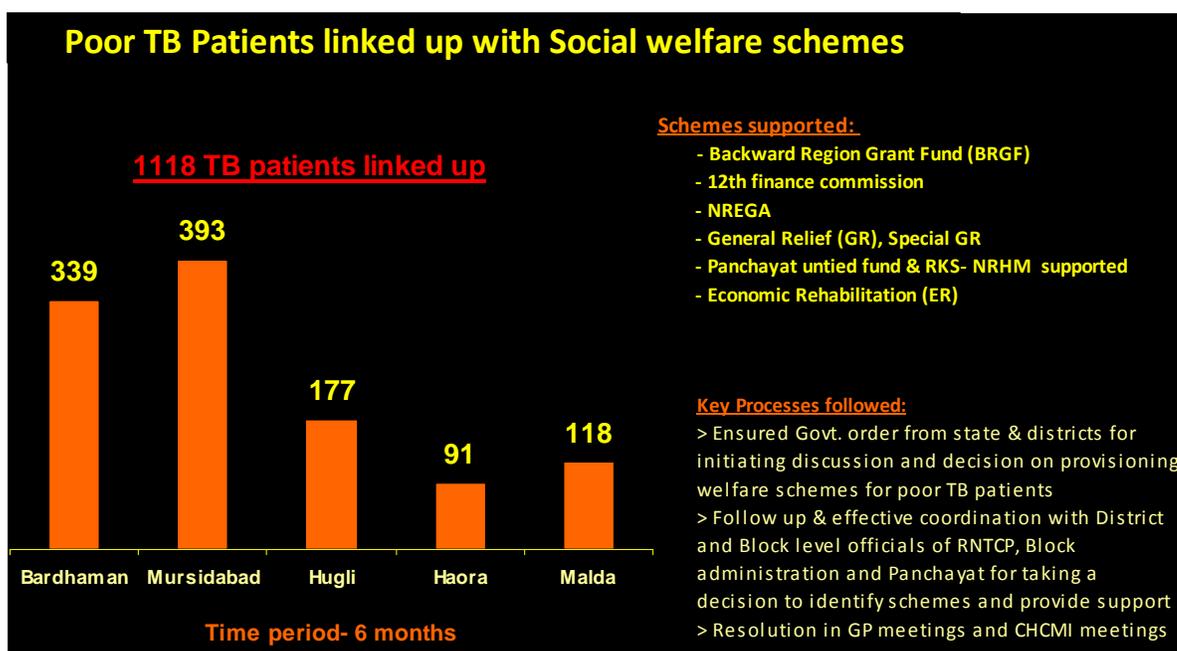
1. CARE IMPACT's work with non qualified private practitioners and volunteers their role in community mobilization

1529 NQPPs and 2948 volunteers were trained in five districts on RNTCP & DOTs activities. During the reporting period 3295 TB suspects were referred by NQPP and 556 referred by volunteers. Out of this 3851 TB suspects, 3086 sputum's were examined and 391 NSP cases detected. This is 13% of NSP cases detected out of referral by volunteers and NQPP. During April-June'2010 quarter two districts (Mursidabad and Malda) have started follow up training of active NQPPs to review the activities and share their experience.

IMPACT project has identified and sensitized 2948 community based volunteers and some of them started referring TB suspects. Not for this annual report, but for future reference can we also have TB cases diagnosed who were not sputum positive? Ok, we will do that

Referred By	No. of partners trained	No. of TB suspects referred	No. of TB suspects reported	No. of TB suspects examined	No. of NSP cases detected
Trained NQPP	1529	3295	2763	2656	330
Trained Volunteers	2948	556	463	430	61
TOTAL	4477	3851	3226	3086	391

2. Poor TB patients linked with welfare schemes



3. Patient Home visit findings- A qualitative result analysis

Data collected during May to July'2010 by IMPACT project staff																		
District	No. of TU covered	No. of Blocks / Municipalities covered	No. of TB patient interviewed (category wise)			TOTAL	No. of TB patient are aware that he/she is undergoing TB treatment	No. of TB patient know about the duration of taking treatment	No. of TB patient said that DOT centre is accessible for them	No. of TB patients taking DOT S and continuing treatment	No. of TB patients who said more than 7 days gap between diagnosis and initiation of treatment	No. of Cat-II patients who said they have received injection streptomycin from DOT providers	No. of TB patients who had spent some amount for the injection	No. of under 6 children are in patients' contact and total number of children	Out of which No. of children received INH prophylaxis	No. of TB patients attended patient provider meeting	No. of TB patients migrated during the course of treatment at any point of time	In Number
			Cat-I	Cat-II	Cat-III													
Haora	6	9	145	81	2	228	224	209	161	206	68	71	10	98	38	82	4	In Number
Hugly	4	11	42	205	0	247	243	222	211	227	121	191	10	89	41	97	1	
Malda	3	4	31	26	0	57	57	52	30	54	32	16	6	33	19	26	0	
Mursidabad	5	13	186	182	1	369	361	292	277	330	112	129	45	178	63	153	6	
Bardhaman	8	12	155	131	6	292	290	258	150	264	97	86	25	104	32	137	8	
N=Total	26	49	559	625	9	1175	1175	1033	829	1081	430	493	96	502	193	495	19	

A. The awareness level of TB patients on their own treatment is close to 100% and similar over 5 districts

B. 87% TB patients have knowledge on duration of treatment. hmmm not so sure of this one we would need to suggest at least one of the two things before we say this (a) good, but not very robust method – the patients say that they have this info from the volunteers (b) other more robust way would be a control population without volunteers who have less knowledge than the population with volunteers and the population without volunteers had suggested that the knowledge that they have comes from non-volunteer sources. If we do not have either (a) or (b) then we should delete this point.

C. The accessibility of DOT centre for TB patients is a major problem area to address quality DOTS. 30% of TB patients said they have less access to the DOT centre in terms of distance. Malda and Bardhaman is badly affected with this issue. The project is addressing this issue by identifying volunteers in these inaccessible areas

D. The gap of more than 7 days between diagnosis and initiation of treatment observed more than 40% in case of Malda and Hugly. Around 30% in other three districts. The project will advocate at the district level to minimize the gap

E. 21% of Cat-II patients are receiving the streptomycin injection either from NQPP, QPP etc. 79% of them received from ANM/DOT providers. This has been discussed with RNTCP and advocated to build capacity of these community based injection providers on injection safety.

F. Out of 625 Cat-II patients, more than 15% have paid some amount for receiving injection from private practitioners. It is highest in Malda, Mursidabad & Bardhaman. This also has been discussed with RNTCP so that necessary monetary support from NRHM can be provided to these patients

G. 38% of under 6 children receiving INH prophylaxis. It varies between 30-60% in five districts. The matter has been discussed with the STO so that necessary steps can be taken to address the problem. Very interesting – do you think we can follow up these children? If yes, lets discuss this in my next visit. We will discuss with you when you are here

H. Migration slightly affecting the disruption of TB treatment in case of Mursidabad and Bardhaman district

Annex 6: Geographical coverage of partners and their roles and responsibilities

Geographical coverage of SHIS

SHIS is implementing the project in 8 poor performing Tuberculosis Units in Malda and Murshidabad district. The blocks and Municipalities in these TUs are as follows:

TU wise Block list of SHIS- IMPACT

Name of district	TU Name	Block Name	Municipality name	Number of Block coordinators placed
Malda	Araidanga	Ratua-II		1
		Manikchak		1
	Gazole	Gazole		1
	Old Malda	Kaliachak-II		1
		Old Malda	Old Malda (M)	2
Mursidabad	Amtala	Hariharpara		1
		Nowda		1
	Domkal	Domkal		1
		Jalangi		1
	Jangipur	Suti-I	Jangipur (M)	2
		Raghunathganj-I		1
		Raghunathganj-II		1
	Kandi	Kandi	Kandi (M)	2
		Khargram		1
	Salar	Bharatpur-I		1
		Bharatpur-II		1
Burwa			1	
TOTAL		17	3	20

Geographical coverage of GLRA

GLRA is implementing the project in 20 poor performing Tuberculosis Units in Bardhaman, Howrah, Hugli district. The blocks and Municipalities in these TUs are as follows:

TU wise Block list of GLRA- IMPACT

Name of district	TU Name	Block Name	Municipality name	Number of Block coordinators placed	
Bardhaman	Asansol	Asansol (Municipal corporation)		2	
	Bhatar	Bhatar		1	
		Manteswar		1	
	Durgapur	Durgapur (Municipal corporation)		2	
	Guskara	Ausgram I	Gushkara (M)		2
		Mongolkot			1
	Katwa	Katwa-I	partly mixed Katwa Municipality		1
		Katwa-II			1
	Khandaghosh	Khandoghosh			1
		Raina-ii			1
	Khandra Ukhra	Loudaha			1
		Andal			1
	Memari	Memari-I	partly mixed Memari Municipality		1
		Memari-II			1
Purbosthali	Purbosthali-I			1	
	Purbosthali-II			1	
Haora	Domjur	Domjur		2	
	Gabberia	Panchla		1	
		Sankrail		1	
	Jagadishpur Kona	Jagadishpur (Kona)	Partly mixed Howrah (M) / Bally jagachha (rural Block)	1	
	Jagatballavpur	Amta-I		1	
		Jagatballavpur		1	
	T.L.Jaiswal	Bally (M) Partly mixed Howrah (M)		1	
Uluberia	Uluberia 1	Partly mixed Uluberia municipality		1	
	Uluberia 2			1	
Hugli	Ahmedpur	Balagarh		1	
		Mogra		1	
	Arambag	Arambag R	Arambagh (M)		2
		Goghat – I			1

		Goghat-II		1
Khanakul		Khanakul-I		1
		Khanakul-II		1
		Pursurah		1
		Pandua		1
Polba		Polba		1
		Dhaniakhali		1
Tarakeswar		Tarakeswar	Partly mixed with Tarakeswar Municipality	1
TOTAL		34	5	42

Annexure-7- Letter of Addl. Chief Secretary, Dept. of Health and Family Welfare instructing all the District Magistrates for extending supportive hand to needy TB patients and linking them with welfare schemes. This also ensures proper pursuance of various welfare schemes available for poor people in the community through BDO.

