IMPACT
Initiative to Manage People Centered Alliances in Control of Tuberculosis (TB)
India, State of West Bengal
(10+ 9 districts)

1st Annual Report

September 30, 2008 - September 29, 2013

Cooperative Agreement No: **GHS-A-00-08-00006-00**

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Introduction

CARE-India is implementing IMPACT (Initiative to Manage People Centered Alliances in Control of Tuberculosis) in collaboration with the implementing partners: 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 ten districts of West Bengal. In the initial phase, five districts will be covered: Malda, Mursidabad, Hoogly, Howrah & Bardhaman. The project has started implementing in 28 Tuberculosis Units (TU) in these districts. The overall project covers a population of 46.4 million people in ten districts of West Bengal. The population covered in the poor performing TUs is given in annexe 4. Around 10,000 TB & MDR TB patients will benefit 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)
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
3. Strengthen the TB-HIV coordination at state and district level to improve cross referrals and ensure treatment for suspected TB-HIV co-infection

This annual report will reflect on planning progress and implementation start up in these districts in particular and the state as a whole.

A. Main accomplishments

1) **The Detailed Implementation Plan** has been prepared after consultation with state and district TB Officers during May'09 and feedback/inputs from the peer review process of USAID. Partner organizations, GLRA and SHIS, along with corporate partner, Eli Lilly, and community organizations such as Bengal Network of Positive People actively participated in the workshop.

2) **CARE participated in the state level quarterly review meeting** on June 12th and 13th, where the goals, objectives and activities of the project were shared with the state and district level officials. Soon after the DIP workshop, the State TB Officer was replaced and the project had to start fresh discussion with the new STO. As advised by the new STO, a detailed operational guideline for the project was developed and shared with the concerned District TB Officers and State Officials.

3) **Consultative workshop with the DTOs of the first phase** districts and state level officials and partners took place on July 18th. Through this process, the detailed activities were agreed upon and the timeline for preparing a TU specific plan was set. It was good to see the ownership of the RNTCP and health department develop as they are now taking active participation in selection of block level NGO staff to their capacity building and

introducing them to the general health system. A joint visit was made with a WHO consultant and DTO to understand TU specific problem areas.

4) **CARE participated in TB/HIV coordination committee meeting** where the major topic was to make the district level meetings regular and meaningful. The meeting also stressed the involvement of a network of positive people and other NGOs in the committee.

5) **CARE participated in the DOTS Plus Site meeting** where the importance of psychosocial counselling for MDR patients was stressed. CARE's support in this regard with the Government of West Bengal (GoWB) was also discussed.

6) **CARE met with the state chapter of Indian Medical Association** (IMA), the designated recipient of global funds, to involve private practitioners and with BNP+ to finalize the letter of engagement with them.

7) **Advocacy with the STO was completed** regarding linking of poor TB patients to the welfare schemes. In this regard, a database of various welfare schemes was prepared and shared with the STO. Necessary advocacy was also done with the Additional Chief Secretary of West Bengal, and he has issued a letter to all the District Magistrates to extend support to IMPACT in implementing this activity. CARE PO and NGO staff will follow this up at the district and block level

8) At the district level, **CARE's Programme Officers are paying regular visits** (both jointly with the DTO and individually) to the Tuberculosis Units. Situational analysis in preparation of the TU specific action plan is ongoing.

Formal agreement with SHIS and GLRA was completed. Block level staff selection and their training was also completed with full participation from the district TB Officers. The district TB officers provided technical training and introduced the TU level supervisory staff to the newly appointed NGO staff.

The partner NGOs will be responsible for implementing project activities at the TU level. Generally a rural TU consists of two blocks or two blocks and one municipality. In case of urban TUs, the whole area is a municipal corporation or a municipality. The broad activities which will be carried out at the TU level are as follows:

- Mapping of existing DOT provider and TB patients
- Analysis of PHI(Peripheral Health Unit) report
- Identify TU wise resource person for conducting various sensitization/training programmes
- Sensitization of local NGOs/FBOs on RNTCP and DOTS
- Identification of volunteers in each village and linking them to system
- Listing of non qualified private practitioners
- Training of non qualified private practitioners

- Listing of qualified private practitioners
- Organize sensitization programmes for QPP with support from RNTCP and IMA
- Regular follow up with the trained QPP to involve them in the programme
- Identify AWW, ASHA worker, RCH workers, IPP VIII workers and organize sensitization in coordination with RNTCP
- Identify SHGs, PRI, CBOs and sensitize them on RNTCP
- Link the poor TB patients with welfare schemes
- Strengthen and participate in monthly TU level meeting

Geographical coverage of two partners and detailed roles and responsibilities of project staff are in Annex 3.

During this period, the average CNR for NSP cases in the implementing TUs is 77% and TSR is 85%. Four project staffs were trained on RNTCP and IMPACT. 62 NGO staff of SHIS & GLRA received a three day training on RNTCP, DOTS, IMPACT, and counselling skills. State level sensitization for the STO, other state officials and DTOs were also accomplished.

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. Increase number of NGOs/FBOs and private providers that are involved	1.1 Identify NGOs/FBOs and build their capacity to undertake TB control activities	On target	IMPACT has partnered with two NGOs. During this reporting period, 62 NGO staffs were trained on DOTS TB. Through these partners more local NGOs/FBOs and private providers will be sensitized
	1.2 Partner with IMA to enhance the participation of private providers	On target	CARE has partnered with the state chapter of IMA and signed a letter of engagement. IMA has not yet received the global

			fund. District level coordination with IMA was also started.
	1.3 Partner with association of non qualified private practitioners to enhance the participation of private providers	On target	Discussion with the non qualified private practitioners' association has started in two districts. One batch training of NQPP in Malda district completed. Districts are under the listing and mapping process for identification of NQPP.
2. Increase in number of CBDP in inaccessible rural and urban slums to support patient convenient DOT	2.1 Migrant population community identified, networked and model implemented. District identified Bardhaman and Murshidabad	On target	This activity is expected to be initiated in the next quarter Oct to Dec 2009
	2.2. Urban slum identified , IPP VIII and RCH workers trained	On target	Mapping of DOT provider, NQPP, QPP & TB patients are in process
	2.3 Rural inaccessible pockets identified and ASHA/Volunteers and Link persons trained	On target	Mapping process is going on. Mapping of DOT provider, NQPP, QPP & TB patients are under process
	2.4 Through capable local partners identify and train DOT providers who are accessible to patients	On target	Mapping of DOT provider, NQPP, QPP & TB patients are in process
3.Increased number of stakeholders are engaged in	3.1 Identify and sensitize PRI/SHGs and FBOs for DOTS TB advocacy	NA right now as this activity begins in the	We will return to this mid-October

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advocating for TB control		last quarter	
	3.2 Spearhead state/district/TU level NGO coordination meets	On target	CARE is member of the state level coordination committee. Similar committees at the district level will be formed
4. Increase knowledge in the community about TB. Improved health seeking behaviour and treatment compliance. Local language IEC materials used	4.1 Doer and non doer analysis to develop BCC strategies, select and print existing IEC materials in local language	Will be delayed possibly until early next year	To be coordinated with CARE Atlanta, MOH, and other partners
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			
. 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 provider, NQPP, QPP & TB patients are under process
2. Social support systems strengthened for patients	2.1 Link patients to welfare schemes or alternate source of livelihood to overcome economic burden of the disease	On target	Advocacy done at the state level to issue government order to the District Magistrates. IMPACT will follow this up at the district level and necessary sensitization will be done for the Block Development Officers
	2.2 Sensitize local Panchayets/SHGs on DOTS/MDR TB to enhance support available to the patient	Not Applicable-year two	

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		activity	
	2.3 Support reimbursement cost for transportation of patients, sputum sample and pre evaluation tests	Not Applicable- year two activity	
	2.4 Counselling support to patient and family members.	Not Applicable	Year two activity
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 on MDR TB	Not on target	This activity will be delayed as it is complex and needs inputs from RNTCP at all levels and other key players nationally. It is best taken in the third quarter of next year.
	3.2 Create a group of psychosocial counsellors to support patients on treatment at the District TB center and DOTS Plus site	Not on target	This activity will be delayed as it is complex and needs inputs from RNTCP at all levels and other key players nationally. It is best done in the third quarter of next year.
	3.3.Joint planning with district RNTCP to identify and counsel category II and IV patients	On target	Mapping of CAT II patients and listing of probable CAT IV patients have been initiated in two districts.
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			

1. TB/HIV coordination strengthened	1.1 Participate and strengthen the state and district level TB/HIV coordination committees	Ongoing	CARE recognised as a member of state level TB-HIV coordination committee in a meeting held on May 28, 2009 where the IMPACT project objective in addressing TB-HIV was shared. District level meetings held in one district.
	1.2. Encourage district/state IMA chapter and BNP+ to be included in the district TB/HIV coordination committee	On target	BNP+ has been included in the state level committee.
2.Improved TB case finding in high risk groups	2.1 Develop/adopt/implement localized need based communication strategies aimed at high risk populations	On target	The activity will be initiated in this quarter.
	2.2 Sensitize PLHA networks towards their umbrella agency BNP+	On target	The activity will be initiated in this quarter.
	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	On target	The activity will be initiated in this quarter.
	2.4 Establish sputum collection centres, especially where access to diagnosis is not possible (e.g CSW, truckers)	Not on target	This activity will depend on RNTCP's need.

C. FACTOR IMPENDING PROGRESS

- CARE India was in the transitional phase and had projects which were closing down. The transfer of staff from one project (INHP) to another (IMPACT) took some time.
- The change of the STO at the initial stage of the programme had a considerable effect. The process of sensitizing the state level was done afresh**.**

D. IDENTIFIED AREAS FOR TECHNICAL ASSISTANCE

- BCC strategy will be developed during January-March 2010
- Mid-term evaluation will be conducted in five districts in January 2011
- Phase out plan for five districts will be made during the 1st quarter of 2011
- Further assistance provided through regular telecommunication with CUSA and USAID representatives

E. SUBSTANTIAL CHANGES

No substantial changes beyond the revised DIP. After the visit of the USAID team on September 14-15, more clarifications were included in sections where it was asked for. The DIP was thoroughly revised and rechecked for any inconsistencies.

F. SUSTAINABILITY PLAN

IMPACT's Sustainability Plan using the CSSA framework will be developed between January and March 2010. In the meantime, the following efforts are being targeted for sustainability. The project has planned to link the welfare schemes with the TB patients. In this regard the Additional Chief Secretary of West Bengal has already issued a letter to all District Magistrates to extend their support to the project staff in implementing this activity. Additionally, another plan is to create one volunteer in each village who will be linked with ANM.

G. SPECIFIC INFORMATION

The requested information from the DIP consultation is being communicated through the revised DIP.

H. INFORMATION SPECIFIC TO YEAR ONE PROJECTS

TB project progress on monitoring indicators and benchmarks

ACDR, CR & TSR -TU WISE- NSP cases

CUMULATIVE RESULT OF Q3-08 to Q2-09 considering 2009 population in Denominator

Sl. No	Name of district	TU Name	TU Population (2009)	ACDR (annualized case detection rate)	ACDR (%) is the same as CNR as a %)	CR	TSR
1	**Bardhaman**	Asansol	572852	41.0	54.7	85.2	85.2
2		Bhatar	477656	51.7	68.9	81.5	86.9
3		Durgapur	487909	48.6	64.8	84.9	85.6
4		Guskara	433152	55.4	73.9	87.9	87.9
5		Katwa	405925	76.4	101.8	85.5	87.3
6		Khandaghosh	330078	35.4	47.3	90.2	90.2
7		Khandra Ukhra	370158	57.3	76.4	81.8	83.9

8		Memari	472297	82.4	109.8	78.0	80.4
9		Purbosthali	394143	39.6	52.8	89.7	89.7
District total			**7667193**	**53.7**	**71.6**	**84.7**	**86.0**
10	**Haora**	Domjur	345814	34.4	45.9	80.8	82.3
11		Gabberia	566115	40.6	54.2	69.8	75.4
12		Jagadishpur Kona	473233	76.9	102.6	72.0	76.5
13		Jagatballavpur	475792	38.3	51.0	78.4	84.7
14		T.L.Jaiswal	537293	46.0	61.3	77.0	79.0
15		Uluberia	612246	39.7	52.9	82.1	85.2
District total			**4735707**	**47.0**	**62.6**	**78.5**	**82.1**
16	**Hugli**	Ahmedpur	456581	52.1	69.5	82.7	83.3
17		Arambag	628243	44.4	59.2	88.6	89.9
18		Khanakul	610886	39.3	52.4	82.7	90.6
19		Po ba	568495	84.6	112.8	77.9	82.1
20		Tarakeshwar	526960	65.7	87.5	82.8	84.0
District total			**5584484**	**51.8**	**69.0**	**83.0**	**85.0**
21	**Malda**	Araidanga	457359	74.6	99.4	83.3	86.1
22		Gazole	592337	90.8	121.1	81.7	85.4
23		Man kchak	592336	53.2	70.9	81.9	82.8
District total			**3645577**	**75.8**	**101.1**	**82.3**	**84.1**
24	**Mursidabad**	Amtala	453736	42.1	56.1	76.3	88.9
25		Domkal	587542	42.6	56.7	89.7	89.7
26		Jangipur	608637	60.6	80.8	83.9	86.7
27		Kandi	554597	46.5	62.0	86.0	86.4
28		Salar	558240	46.2	61.6	84.1	84.1
District total			**6497141**	**62.0**	**82.7**	**86.1**	**87.7**

Sourced from RNTCP Epi-Info package

CR & TSR -TU WISE- Retreament Cases- CUMULATIVE RESULT OF Q3-08 to Q2-09

District name	TU Name	Cure Rate	TSR
Bardhaman	Asansol	22.9	68.6
	Bhatar	41.3	62.7
	Durgapur	34.6	71.3
	Guskara	45.9	70.4
	Katwa	43.8	69.8
	Khandaghosh	47.8	71.7
	Khandra Ukhra	41.4	77.9
	Memari	52.6	73.7
	Purbosthali	23.7	69.7
	District total	**36.3**	**72.1**
Haora	Domjur	41.2	71.8
	Gabberia	32.2	63.3
	Jagadishpur Kona	35.9	67.6
	Jagatballavpur	44.2	86.0

	T.L.Jaiswal	29.6	68.6
	Uluberia	40.3	68.2
	District total	**39.0**	**72.3**
Hugli	Ahmedpur	41.1	67.8
	Arambag	39.8	75.7
	Khanakul	39.6	79.2
	Polba	26.6	60.4
	Tarakeshwar	41.8	77.6
	District total	**36.5**	**70.7**
Malda	Araidanga	38.6	67.0
	Gazole	40.4	75.8
	Manikchak	41.1	63.6
	District total	**43.8**	**69.9**
Mursidabad	Amtala	44.8	77.6
	Domkal	56.8	82.4
	Jangipur	42.9	68.8
	Kandi	55.1	69.4
	Salar	45.2	65.8
	District total	**50.0**	**74.2**

Sourced from RNTCP Epi-Info package

I. PROJECT MANAGEMENT SYSTEM

1. Financial management system

Salaries and Benefits

The Project manager, Monitoring & Evaluation Officer, Program Officer & Administrative Assistant are compensated by the project. National and International staff salaries are expended according to the planned budget.

Travel

The Project Manager attended the health and nutrition workshop in Bali, Indonesia

Supplies

The fund is allocated for regular monthly office supplies and supplies required by the project to be operational during the project lifetime.

Others

Funds were spent on the following project activities:

- Training supplies
- Project workshops and meetings

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

2. Human resources:

The Project manager, Monitoring & Evaluation officer, three program officers for five districts and one Administrative Assistant are continuing their defined activities on a regular basis. In the 2nd year of the project, one more Program Officer will be recruited. 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. Quarterly review meetings of internal staff members are being organized for tracking the progress and provision of support as required.

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 process to make the reporting pattern under IMPACT uniform was established by developing the electronic reporting system using the internet; manuals have been developed on how these reporting systems are to be operated. A close collaborative effort has been made with government, IMA, BNP+, and Eli Lily for mutual agreed activities to achieve the goal.

5. PVO coordination/collaboration in India

CARE is a member of the National TB Consortium (NTC) headed by World Vision. The other national level coalition is ICAT. NTC and ICAT have formed the Partnership for TB care and control. One regional meeting for the eastern region was held in Kolkata during August'09 where CARE actively participated. 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 has been identified as the partner NGO of IMPACT
- Agreement signed with SHIS for Malda and Mursidabad
- Agreement with GLRA signed for remaining three districts (Howrah, Hugli and Bardhaman
- Selection of Block Coordinators completed for all districts
- Training of 62 Block Coordinators, 5 Project Coordinator and NGO accountant of SHIS and GLRA completed
- With the joint effort of DTOs, MO-TC, CARE PO and Block Coordinators, the situation analysis and block plan development process is occurring

K. Mission Collaboration

During DIP preparation, inputs were taken from USAID mission. There is regular consultation for activity tracking. USAID CSHGP and local mission visit is expected in Kolkata September 14-15th 2009, followed with a feedback visit to CARE India's headquarters in New Delhi. Feedback from the visit will be incorporated into the next year workplan.

L. Any other relevant aspects

New Guidelines, TB Funding and Projects that might alter the project implementation

SHIS/GLRA

SHIS and GLRA are implementing an ACSM project funded by the local USAID mission in nine districts of West Bengal. It was therefore a conscious decision on part of CARE to work in the remaining 10 districts. Initially, the GLRA/SHIS projects were sanctioned for one year; recently it has received extension till March 2011.

IMA and Global Fund

The global fund for IMA has not yet been released. The project was scheduled to start in September, but the fund has not yet been transferred to IMA

New RNTCP Guidelines and how they Impact CARE project

RNTCP has recently changed the guideline for screening of TB suspects. Instead of three weeks cough, any person suffering from cough for more than two weeks will be screened for TB. The number of sputum samples to be examined for diagnosis is also changed from three to two. Accordingly all the modules will be changed for 2010. The other revision which will be made in the future modules is a change in the number of categories of treatment. There will be no CAT III drugs. All first line treatment will be of CAT I and CAT II.

One important revision which was made one year ago was in the revision of the NGO and private practitioners' scheme. The schemes were changed, but very few NGOs have signed under the new schemes so far. The main reason for this was lack of clarity on the part of both NGOs and district officials on the new schemes. Therefore, the number of NGOs who are currently under schemes are much fewer than those which have been reported in the baseline figure in the DIP.

The Proposal in Support of 'Treatment Adherence and Follow up of MDR TB Patients' in West Bengal in partnering with Eli lily has been approved. Through this partnership, IMPACT will address the strategic objective 2 of the project by providing psychosocial support to MDR TB patients. Support will also be given through pre-treatment support and transportation for poor TB patients coming for diagnosis and follow up tests. The selection process for the position of counsellor has already been completed. The module for counselling will be developed soon.

Annexes

- **Annex 1: M&E Table**
- **Annex 2: Workplan**
- **Annex 3: Social Behavior Change Strategy for New Partners**
- **Annex 4: Papers or Presentations about Project**
- **Annex 5: Results Highlight**
- **Annex 6: Geographical coverage of partners and their roles and responsibilities**
- **Annex 7: CSHGP Project Data Form**

Annex 1: M&E Table

INDICATOR TRACKING TABLE- IMPACT PROJECT PERFORMANCE
Period: September 30, 2008 - September 29, 2013

	Description of Indicator	Project Targets	Total Achievement (08-09)	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%	**45-121%**	As per RNTCP report
1.2	Increase Cure Rate (CR) to at least 85% by the end of project	85% Cure Rate	**69-90%**	As per RNTCP report
1.3	Increase Treatment Success Rate (TSR) to 90% by the end of project	90% TSR	**75-90%**	As per RNTCP report
1.4	80% patients put on Category IV treatment (MDR patients) completed treatment	80% cat-IV patients completed treatment		The state has started MDR treatment during Dec'08 only in Kolkata district. However the treatment outcome will be available in 2011
1.5	Increased the treatment completion rate of Retreatment cases to 80%	80% TC for Retreatment cases	**60-86%**	100 retreatment cases were counselled by project staff during last quarter
1.6	Increased referral from HIV ICTC to RNTCP to 20%	20% referral of HIV ICTC to RNTCP	**2.9% referral from ICTC to RNTCP in 5 districts**	As per RNTCP report 257 cases (2.9%) referred from ICTC to RNTCP during Jan-April09
	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	**2 community level DOTS providers identified in rural pockets of Mursidabad**	Out of 37 cases referred by community level DOT providers, 31 reported to DMC and examined. I NSP case detected.
1.2	Increase in number of NGOs participating in RNTCP to 60	20 NGOs linked to RNTCP	**Local NGOs are being identified**	With changing RNTCP guidliens on NGO partnership, it will take some time for STO and NGOs to apply for newer schemes
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)	**752 NQPPs identified and shortlisted for training and 18 of**	

		has referred TB suspects	**them trained**	
1.4	5% of TB patients treated/reported by QPP	5% TB patients treated & reported	**Ongoing, difficult to estimate**	Systems not in place to quantify effect.
1.5	5% of TB patients referred by QPPs into the DOTS RNTCP system	5% TB patients referred	**Ongoing, difficult to estimate**	Systems not in place to quantify effect.
1.6	5% of TB patients treated/reported by NQPP	5% TB patients treated & reported	**63 TB cases reported**	The absolute number of referral done by NQPP is reflected for July-Sep09 quarter and the RNTCP routine quarterly report is not capturing the number of referral cases in this quarter. So percentage couldn't be obtained. Out of 78 cases 63 were reported to DMC and 53 sputum examined & 3 NSP cases detected
1.7	5% of TB patients referred by NQPPs to the DOTS RNTCP system	5% TB patients referred	**78 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 communit y	to be initiated in Oct-Dec09 quarter	
	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 from Govt. providers.	Mapping of CAT II patients and listing of probable CAT IV patients have been initiated in two districts. Effort is on to ensure the accessiblity of Injection Provider by addressing the gap in Patient Provider meeting
2.2	100% line listed category II patients receive counseling support	A cadre of counsellor s created and trained for ensuring 100% Cat-II patients are	**100 Retreatment cases counselled**	Psycho Social counsellor appointed

		counselled		
2.3	100% MDR patients linked & benefitted through welfare schemes	100% MDR patients are linked with welfare schemes	**Ongoing with PRI**	Advocacy done at the state level to issue government order to the District Magistrates. IMPACT will follow this up at the district level and necessary sensitization will be done for the Block Development Officers
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	**NA**	This is second year activity
	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	Increased HIV ICTC clients referred to RNTCP systems to 20% from 3%	17% of HIV ICTC clients referred to RNTCP systems	**257 cases (2.9%) referred from ICTC to RNTCP**	This is based on RNTCP report of 5 distiricts collected during Jan-April'09
3.2	At least 80% of 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	**66 TB patients (25.6%) are diagnosed**	This is based on RNTCP report of 5 distiricts collected during Jan-April'10
3.3	Around 50% of HIV positive TB patients are put on Cotrimoxazole prophylactic therapy	50% HIV+ TB patients are put on CPT	**Not available**	
3.4	50% of NGOs providing TI services are also promoting DOTS	50% NGOs promoted DOTS	**NA**	This activity will be initiated in this quarter
3.5	By end of project 10 PLHA network is activele engaged	1PLHA Network is active in each district	**2 district level PLHA network sensitised**	2 ICTC and TU level coordination meeting attended by IMPACT project staff & sensitised the PLHA network

3.6	10% of TB suspects are referred to HIV ICTC	10% TB suspects referred	**455 (5.4%) cases referred from RNTCP to ICTC**	This is based on RNTCP report of 5 districts collected during Jan-March'09
	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	**2 community level volunteers identified as DOTS providers**	They have started referring cases. Out of 37 cases, 31 reported to DMC and examined. I NSP case 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	**Ongoing**	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	**ongoing**	Identification of hard to reach areas ongoing
	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	**Ongoing**	Identification of NGOs/FBOs
1.2.2	Increased Non Qualified Private providers participated in RNTCP to 4000	3818 NQPPs are identified, trained and linked to RNTCP	**752 NQPPs identified and shortlisted for training and 18 of them trained**	The absolute number of referral done by NQPP is reflected for July-Sep09 quarter and the RNTCP routine quarterly report is not capturing the number of referral cases in this quarter. So percentage couldn't be obtained. Out of 78 cases 63 were reported to DMC and 53 sputum examined & 3 NSP cases detected
1.2.3	Increased to 1000 QPPs and oriented/trained for referral	At least 963 QPPs oriented for referral	**NA**	IMPACT relies on IMA and GF to move this forward and the funds have not yet come through

	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	**Ongoing**	To be finetuned after the BCC workshop
1.3.2	10,000 broadcasting events for community awareness on TB take place in the project area	10000 broadcasting events organised	**Ongoing**	To be finetuned after the BCC workshop
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 awared	**Ongoing**	To be finetuned after the BCC workshop
	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	**NA**	PRIs were motivated to participate in Patient Provider meeting. Selective PRIs will be trained
1.4.2	125 SHG oriented/trained for DOTS TB advocacy.	125 SHGs trained	**NA**	SHG selection process is on
1.4.3	125 FBOs oriented/trained for DOTS TB advocacy	125 FBOs trained	**NA**	FBOs identification process is on
	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	**ongoing**	To be scheduled after the first cohort of MDR patients start treatment
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	**To be done in this year**	To be scheduled after the first cohort of MDR patients start treatment
	Output 2.2: Strengthen social support systems of patients			
2.2.1	30 counselors trained for retreatment and MDR patients	30 counsellors trained	**Ongoing**	Master counsellor identified
2.2.2	250 PRIs, 125 FBO and 125 SHGs sensitized to DOTS and MDR TB	250 PRIs, 125 FBO and 125 SHGs sensitized to DOTS and MDR TB	**Ongoing**	Initial conversations with these groups begun

	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	**To be done after counsellors are in place in each district**	
	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	**5 at district level and 22 TU level meeting**	This is the number of District & TU meeting attended by IMPACT project staff
	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	**5 at district level in July-Sept09 quarter and 2 at state level in last 2 quarters**	Alongwith this all DTOs & MO-Tus were interacted for preparation of TU & Block level planning and situation analysis. By now all five districts plan has been developed
3.1.2	Problems identified and addressed through TB-HIV coordination committees	Identified gaps being discussed in coordination meetings		CARE has been included as an active member of State & District level TB-HIV coordination committee
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**	2 ICTC and TU level coordination meeting attended by IMPACT project staff & sensitised the PLHA network
	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	**NA**	To be done more intensely this year
3.2.2	5000 PPs identified and trained for identification of high risk areas and link them to RNTCP PP schemes	5000 PPs trained	**18 NQPPs were sensitised**	

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	**NA**	To be done more intensely this year

NA-Not Achieved

Annex 2: Workplan

IMPACT -WORK PLAN –Oct '09 TO Sept '10							
Result	**Activities**	**Year-2**				**Personnel**	**Remarks**
		Q1	**Q2**	**Q3**	**Q4**		
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 partner NGOs (GLRA) to undertake TB control activities	X				PO	
	1.2. Partner with IMA to enhance the participation of private providers.	X				PO/PM	
	1.3. Partner with association of non-qualified practitioners to enhance the participation of private providers.	X				PO	
2. Increase in number of CBDP in inaccessible rural and urban slums to support patient convenient DOT	2.1. Migrant population community identified, networked and model implemented. District identified Bardhaman/ Murshidabad.	X	X	X	X	PO	
	2.2. Urban slum identified, IPP-VIII and RCH workers trained.	X	X	X	X	PO	
	2.3. Rural inaccss ble pockets identified and ASHA/Volunteers/Link persons trained.	X	X	X	X	PO	
	2.4. Through capable local partners identify and train DOTS providers who are accessible to patients.	X	X	X	X	PO	
3. Increased number of Stakeholders are engaged in advocating for TB control.	3.1. Identify and sensitize PRIs/ SHGs and FBOs for DOTS-TB advocacy.	X	X	X	X	PO	
	3.2. Spearhead State/District/TU level NGO coordination meets	X	X	X	X	PO/PM	
4. Increase knowledge in the community about TB. Improved health seeking behavior and treatment compliance. Local language IEC materials used.	4.1. Doer and Non-doer analysis to develop BCC strategies, select and print existing IEC material in local language.	X	X	X	X	PROJECT TEAM	

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							
1. Community level providers are equipped to provide DOTS and manage adverse reactions	1. Identify and train providers and adverse reaction managers closer to the community.	X	X			PO	
2. Social support strengthened for patients.	2.1. Link patients to welfare schemes or alternate sources of livelihood to overcome economic burden of disease	X	X	X	X	PO	
	2.2. Sensitize local panchayats/SHGs and ASHAs to DOTS and MDR TB to enhance support available to the patient.	X		X		PO	
	2.3 Support reimbursement cost for transportation of patients and sputum sample and pre-evaluation test.	X	X	X	X	PO	
	2.4. Counseling support to patient and family members	X	X	X	X	PO	
3. Improved case holding as a result of positive health seeking behaviors and treatment adherence	3.1. Develop localized need based communication strategy/materials to generate awareness about MDR TB.	X	X	X	X	PROJECT TEAM	
	3.2. Create a cadre of psychosocial counselors to support patients on treatment at the district TB center and CDST.					PO/PM	
	3.3. Joint planning with district RNTCP to identify and counsel category II and IV patients.	X	X	X	X	PO	
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							
1. TB-HIV Co-ordination strengthened	1.1. Participate 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	
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 population	X				PROJECT TEAM	
	2.2. Sensitize PLHA networks towards TB control through their umbrella agency BNP+		X	X		PO/PM	
	2.3. Build capacity of TI NGOs to generate awareness, carry out intensified case finding among high risk groups, improving cross-referrals, provide DOTS and support patients	X	X			PO	
	2.4. Encourage District/State IMA chapter to be included in District/State TB-HIV co-ordination committee.	X	X			PO/PM	
	2.5. Establish sputum collection centers, especially where access to diagnosis is not possible (e.g. CSWs, truckers)	X	X			PO	
Other Project Activities							
	Implement/Follow-up capacity-building activities	X	X	X	X	PO	
	Identification &Capacity Building of Private Practitioners	X	X			PO	
	Co-ordination meeting with stakeholders at District/State/National Level	X	X	X	X	PO/PM	
	Review of developed MIS formats		X			MEO	
	Project Reporting	X	X	X	X	PM	

Annex 3: Social Behavior Change Strategy

Not Applicable

Annex 4: Papers or Presentations about Project

Not Applicable

Annex 5: Results Highlight

CARE IMPACT's work with non qualified private practitioners and its role in community mobilization

18 NQPPs were trained in the Mursidabad district on RNTCP & DOTs activities. NQPPs have also started referring TB cases. In this district in Sept 2009, 76 suspect cases were referred- out of which 53 sputum were examined and 3 NSP cases detected.

The CBOPs (Community Based Operating Partners), already existing volunteers of earlier project CBDOTS, have started referring TB patients in selected TUs. In Sept 2009, 37 suspect TB cases were referred to DMC by these volunteers, out of which 31 sputum examinations were performed and 2 NSP cases were found. So far, through the IMPACT initiative, 5 referred TB patients from NQPPs and volunteers have completed diagnosis and are in DOTS.

Other districts have planned to conduct these trainings during Oct-Dec 2009.

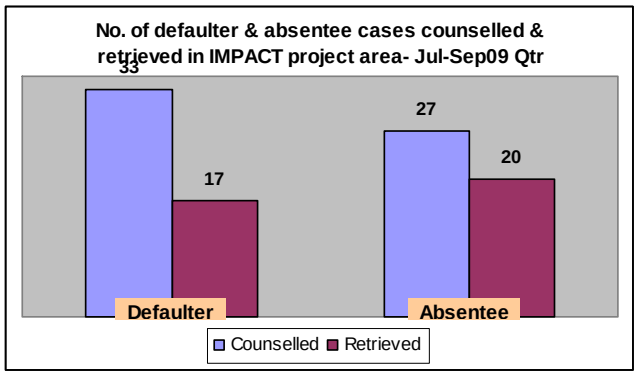
Case Referral and Outcomes

Referred By	TB suspect referred	Reported to DMCs	Examined sputum	NSP case detected
Trained NQPP	78	63	53	3
PRIs	2	2	2	0
NGO/ FBO	1	1	1	0
Other Volunteers	37	31	31	2
Grand Total	118	97	87	5

Other key information of Mursidabad & Malda;

- 17 defaulter TB patients and 20 absentee cases were retrieved. The counseling made for 33 defaulter cases and 27 absentee cases by BCs in two districts.
- 1196 NQPPs were identified and 760 short listed based on their active involvement.
- PNGO staff attended Four ICTC & TU level Coordination meetings.
- One HIV- ICTC client was referred to the RNTCP system, the figure of which was nil since long.

- 100 retreatment cases were counselled by block coordinators during their field visit.
- 109 new cases of intensive phases were counselled by BCs during their field visit.
- PRI was also involved in referring suspect TB patients (2 cases were referred and sputum was examined but no NSP cases were found)



District	Defaulter cases		Absentee cases	
	Counselled	Retrieved	Counselled	Retrieved
Mursidabad	29	13	25	18
Malda	4	4	2	2
Total	33	17	27	20

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

Geographical coverage of SHIS

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

Name of the districts	Name of the TU	No of blocks	No of Municipalities
Malda	Araidanga	2 (Ratua – I & II)	
	Gazole	2 (Gazole & Old Malda)	
	Manikchak	2 (Manikchak & Kaliachak – II)	
Murshidabad	Amtala	2 (Harihapara, Nowda)	
	Jangipur	3 (Suti-I, Raghunathganj-I & II)	1 (Jangipur)
	Domkol	2 (Domkal & Jalangi)	
	Kandi	2 (Kandi & Khargram)	1 (Kandi)
	Salar	3 (Bharatpur – I & II, Baraoa)	

Geographical coverage of GLRA

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

Name of the districts	Name of the TU	No of blocks	No of Municipalities
Bardhaman	Asansol		Asansol
	Durgapur		Durgapur
	Khandra-Ukhra	Pandabeswar, Andal, Ukhra	
	Guskara	Ausgram I & Mongolkot	
	Katwa	Katwa I & II	Katwa
	Bhatar	Bhatar & Manteswar	
	Purbasthali	Purbosthali I & II	
	Memari	Memari I & II	
	Khandoghosh	Khandoghosh & Maheshbati	
Hugli	Ahmedpur BPHC	Ahmedpur, Mogra	
	Arambagh SDH	Arambag ®, Goghat – I, Goghat-II	Arambag
	Khanakul RH	Khanakul-I, Khanakul-II, Pursurah	
	Polba	Pandua, Polba	
	Tarakeswar	Dhaniakhali, Tarakeswar	
Howrah	Domjur	Domjur	
	Gabberia	Panchla, Sankrail	

	Jagatballavpur RH	Amta-I, Jagatballavpur	
	Kona (Jagadishpur BPHC)	Jagadishpur (Kona)	Bally
	T.L.Jaisawal		Bally
	Uluberia SDH	Uluberia – I	Uluberia

Role and responsibilities of project staff

Project Coordinator:

- Field support to block coordinators wherever necessary.
- Develop individual block wise operating plan in line with Project operational guideline and Review
- Plan, review and monitor activities of block coordinators.
- Liaison with block and district level govt. counterparts in consultation with CARE PO.
- Documentation and submission of Monthly DAPAR, MPR, MFR, QPR, Bi monthly FR etc. to CARE.
- Monthly review and ongoing capacity building of block coordinators along with CARE PO.
- Organize sensitization programme for QPP with support from RNTCP and IMA.
- Support and facilitate TB-HIV Coordination activities.
- Support PO in conducting operational research
- Regular contact with CARE PO for effective program implementation.
- Regular Field visit to assess Program impacts as well as gaps in service delivery.
- Any other activity assigned by the project

Block / Urban coordinator :

- Responsible for proper block level implementation of activities as per plan and budget allocation.
- Coordination and liaison with MO PHI and TU officials in provision of accessible DOT
- Conduct additional Patient providers meeting at GP/ HAU level especially for CAT II patients
- Mapping of existing DOT provider(PHI wise) and identify additional DOT providers to meet gaps
- Identification of volunteers in each village/ward (contact person for RNTCP) and their capacity building
- Listing of Non Qualified Private Practitioner (NQPP) and other volunteers
- Conduct sensitization session of NQPPs and follow up
- Sensitization of local NGOs, FBOs on RNTCP and DOTS, wherever required
- Listing of sensitized Qualified Private Practitioner (QPP)
- Follow up of sensitized QPPs
- Reporting ,documentation and regular contact with District Coordinator/PO
- Support Volunteers in case referral, case holding and defaulters retrieval and link them with ANM
- Attend TU level meeting for Program planning & review.

- Meeting and appraisal of BMOH on project activities on a regular basis
- Participate and organize special events like observation of World TB day, World AIDS Day and world breast feeding week, Nutrition week, Women's day etc at community level.
- Mapping of TB patients (DMC wise) and follow ups
- Analysis of PHI report (number of referrals, no of TB patients etc.)
- Any other activity assigned by the project

BASIC INFORMATION -TU WISE- IMPACT

Sl. No	Name of district	District Population	TU Name	TU Population	NSP CDR % (Q2-09)	NSP TSR % (Q2-09)	
1st Phase- 5 districts							
1	**Bardhaman**	**7667193**	Asansol	572852	73	85	
2			Bhatar	477656	84	87	
3			Durgapur	487909	73	90	
4			Guskara	433152	81	91	
5			Katwa	405925	100	85	
6			Khandaghosh	330078	57	91	
7			Khandra Ukhra	370158	72	86	
8			Memari	472297	132	81	
9			Purbosthali	394143	53	88	
10	**Haora**	**4735707**	Domjur	345814	51	78	
11			Gabberia	566115	63	67	
12			Jagadishpur Kona	473233	108	63	
13			Jagatballavpur	475792	43	71	
14			T.L.Jaiswal	537293	68	83	
15			Uluberia	612246	61	81	
16	**Hugli**	**5584484**	Ahmedpur	456581	98	81	**Cure rate**
17			Arambag	628243	59	87	
18			Khanakul	610886	55	80	
19			Polba	568495	136	85	

20			Tarakeshwar	526960	93	85	
21			Araidanga	457359	108	82.9	
22	**Malda**	**3645577**	Gazole	592337	131	84.4	
23			Manikchak	592336	107	84.8	
24			Amtala	453736	69	92	
25			Domkal	587542	69	90	
26	**Mursidabad**	**6497141**	Jangipur	608637	93	104	
27			Kandi	554597	78	84	
28			Salar	558240	72	84	
Total- 1st Phase (28 TUs)		**28130102**		**14150612**	**81.7**		
2nd Phase (5 districts)							
29			Bolpur	614321	103	83	
30	**Birbhum**	**3337974**	Murarai	680664	89	74	
31			Rampurhat	614310	96	71	
32	**Kochbihar**	**2745994**	Sitalkhuchi	265143	70	84	
33			Chandrakona	620777	62	88	**Cure rate**
34			Dantan	424366	35	93	
35	**Medinipur-West**	**5782113**	Daspur	722626	26	94	
36			DHMID	522698	98	80	
37			Sabong	554546	49	87	
38	**Uttar-Dinapur**	**2705600**	Itahar	326411	69	86	
	Jalpaiguri	**3770832**					
Total- 2nd Phase (10 TUs)		**18342513**		**5345862**	**69.7**		
Total- 38 TUs in 10 districts		**46472615**		**19496474**			

District wise No. of Partner NGO staff

District	No. of Block Coordinator	No. of Project Coordinator	Total	Name of NGO
Bardhaman	19	1	20	
Haora	10	1	11	
Hugly	13	1	14	**GLRA**
Malda	6	1	7	
Mursidabad	14	1	15	**SHIS**
Total	**62**	**5**	**67**	

Annex 7: CSHGP Project Data Form

CSHGP Project Data Form (Sub Form 1 of 7)

Project: CARE India (2008 - 2013) TB Control

General Project Information: <Help>

Cooperative Agreement Number:	**GHN-A-00-08-00006-00**
CARE Headquarters Technical Backstop:	**Khrist Roy**
Field Program Manager:	**Bandita SenGupta**
Midterm Evaluator:	
Final Evaluator:	
Headquarter Financial Contact:	
Project Grant Cycle #:	**24**
Project Start Date:	**9/30/2008**
Project End Date:	**9/29/2013**
USAID Mission Contact Person:	**Manju Ranjan Seth**

Project Field Contact Information:

Field Program Manager

Name: **Bandita SenGupta**

Title:

Email:

Address1:

Address2:

City:

State:

Zip Code:

Country: India

Telephone:

Fax:

Alternate Field Contact

First Name:

Last Name:

Title:

Email:

Address1:

Address2:

City:

State:

Zip Code:

Country:

	India
Telephone:	**Fax:**
Project Web Site:	

Grant Funding Information:

USAID Funding:*(US $)*	**PVO Match:*(US $)***
$1,500,000	$562,475

Project Description:

Popula ion and beneficiaries: The project w ill cover a population of 46.4 million people w ith intensive activities (53% of West Bengal population) and w ill expand through the RNTCP to the remaining population by the end of he project. An additional detection of 34,485 cases of new sputum positives, treatment completion of 37,020 re-treatment, and 300 MDR patients is estimated.

Summary: The MPACT project w ill support positive health seeking behavior of patients linking them to w elfare schemes; improve community capacities to support patients to adhere and complete treatment; facilitate the par icipation of partners in TB/HIV interventions; build capacities of partners; and strengthen managerial capacities of state and district level RNTCP structures to sustain the developed linkages.

Problem Statement: Although the TB program in West Bengal has achieved a 68% case detection rate and 86% cure rate, there are several pockets at the sub-district level treatment units w here the

Project Location:

19 districts of West Bengal State in India

CSHGP Project Data Sheet (Sub Form 2 of 7)

Project: CARE - India (2008 - 2013) - TB Control Project

Partner Name:	Partner Type:	USAID $ Allocated:	Delete:

Save and Con inue

CSHGP Project Data Form (Sub Form 3 of 7)

Project: CARE India (2008 - 2013) TB Control

Project Location / Subareas: <Help>

Does this project collect, monitor and report on Rapid CATCH data for different *geographic* project subareas ?

Yes No

If this is true, click *Yes* and enter each distinct subarea name:
If this is false, click *No*.

CSHGP Project Data Form (Sub Form 4 of 7)

Project: CARE India (2008 - 2013) TB Control

Strategies: <Help>

The following 3 boxes list different kinds of general strategies, assessment tools and BCC strategies that could be

implemented during the life of this CSHGP project.
Please check those boxes that are planned for this project.

General Strategies:	
Microenterprise ☐	Social Marketing ☐
Private Sector Involvement ☑	Advocacy on Health Policy ☐
Strengthen Decentralized Health System ☐	Information System Technologies ☐
Use Sustainability Framework (CSSA) ☐	

M&E Assessment Strategies:	
KPC survey ☑	Health Facility Assessment ☑
Organizational Capacity Assessment with Local partners ☐	Organizational Capacity Assessment for your own PVO ☐
Participatory Rapid Appraisal ☐	Participatory Learning in Action ☐
Lot Quality Assurance Sampling ☐	Appreciative Inquiry-based strategy ☐
Community-based Monitoring Techniques ☐	Participatory Evaluation Techniques(for mid-term or final evaluation) ☑
Use of Pocket PCs or Palm PDA Devices ☐	TB Cohort Analysis ☑

Behavior Change & Communication (BCC) Strategies:	
Social Marketing ☐	Mass Media ☐
Interpersonal Communication ☑	Peer Communication ☑
Support Groups ☑	Use of BEHAVE Framework ☑

Capacity Building: <Help>

Please check the box next to each capacity building area or group that is targeted for institutional strengthening during the life of this CSHGP project:

PVO	Non-Govt Partners	Private Sector	Govt	Community
US HQ (General) ☑ US HQ (CS Unit) ☑ Field Office HQ ☑ CS Project Team ☑	PVOs/NGOs (Int'l./US) ☐ Local NGO ☑ Networked Group ☑ Multilateral ☐	Pharmacists or Drug Vendors ☐ Business ☑ Traditional Healers ☐ Private Providers ☑	National MOH ☐ Dist. Health System ☑ Health Facility Staff ☑ Other National Ministry ☐	Health CBOs ☑ Other CBOs ☐ CHWs ☑ FBOs ☑

Project Interventions & Components: <Help>

Enter a percentage representing the amount of funds your project is targeting towards each intervention. If you are not implementing a particular intervention then leave the box blank. On the same line as the intervention percentage, check the boxes indicating whether or not this intervention is part

of an overall IMCI strategy and also check the kinds of training (CHW or HF)envisioned for this particular intervention. For each intervention implemented, check the specific intervention components that are planned.

Childhood Injury %	IMCI Integration ☑	CHW Training ☐	HF Training ☐
Control of Diarrheal Diseases %	IMCI Integration ☐	CHW Training ☐	HF Training ☐
Water/Sanitation ☐	Hand Washing ☐	ORS/Home Fluids ☐	Feeding/Breastfeeding ☐
Care Seeking ☐	Case Mngmnt./Counseling ☐	POU Treatment of water ☐	Zinc ☐
HIV/AIDS %		CHW Training ☐	HF Training ☐
OVC ☐	Treatment of STIs ☐	Behavior Change Strategy ☐	Access/Use of Condoms ☐
STI Treat. with Antenat. Visit ☐	ABC ☐	PMTCT ☐	Nutrition ☐
Home based care ☐	PLWHA ☐	ARVs ☐	HIV Testing ☐

Immunizations %	IMCI Integration	CHW Training	HF Training
Polio	Classic 6 Vaccines	Vitamin A	Surveillance
Cold Chain Strengthening	New Vaccines	Injection Safety	Mobilization
Measles Campaigns	Community Registers		
Infant & Young Child Feeding %	IMCI Integration	CHW Training	HF Training
ENA	Gardens	Comp. Feed. from 6 mos.	Hearth
Cont. BF up to 24 mos.	Growth Monitoring	Maternal Nutrition	PMTCT of HIV
Peer support	Promote Excl. BF to 6 Months	Intro. or promotion of LAM	Support baby friendly hospital
Malaria %	IMCI Integration	CHW Training	HF Training
Training in Malaria CM	Adequate Supply of Malarial Drug	Access to providers and drugs	Antenatal Prevention Treatment
ITN (Bednets)	ITN (Curtains and Other)	Care Seeking, Recog., Compliance	IPT

		☐	
Community Treatment of Malaria ☐	ACT ☐	Drug Resistance ☐	Environmental Control ☐
Maternal & Newborn Care ☐ %	IMCI Integration ☐	CHW Training ☐	HF Training ☐
Emerg. Obstet. Care ☐	Neonatal Tetanus ☐	Recog. of Danger signs ☐	Newborn Care ☐
Post partum Care ☐	Delay 1st preg Child Spacing ☐	Integr. with Iron & Folate ☐	Normal Delivery Care ☐
Birth Plans ☐	STI Treat. with Antenat. Visit ☐	Home Based LSS ☐	Control of post-partum bleeding ☐
PMTCT of HIV ☐	Emergency Transport ☐		
Pneumonia Case Management ☐ %	IMCI Integration ☐	CHW Training ☐	HF Training ☐
Pneum. Case Mngmnt. ☐	Case Mngmnt. Counseling ☐	Access to Providers Antibiotics ☐	Recognition of Pneumonia Danger Signs ☐
Zinc ☐	Community based treatment with antibiotics ☐		

Tuberculosis 100 %	IMCI Integration ☑	CHW Training ☑	HF Training ☑
Facility based treatment/DOT ☑	Microscopy ☐	Monitoring/Supervision Surveillance ☑	Community IEC ☑
Drug managment ☐	Advocacy/Policy ☑	Linkages with HIV services ☑	Community based care/DOT ☑
Pediatric TB ☐			
VitaminA and Micronutrients %	IMCI Integration ☐	CHW Training ☐	HF Training ☐
Supplementation ☐	Post Partum ☐	Integrated with EPI ☐	Gardens ☐
Iodized Salt ☐	Iron Folate in Pregnancy ☐	Zinc (Preventive) ☐	Food Fortification ☐

CSHGP Project Data Sheet (Sub Form 5 of 7)

Project: CARE India (2008 - 2013) TB Control

Target Beneficiaries: <Help>	
Number of Suspected TB Cases:	34,485
Population of Target Area:	46,400,000

Save and Con inue

CSHGP Project Data Form (Sub Form 6 of 7)

Project: CARE India (2008 - 2013) TB Control

Rapid CATCH Data:

Under the 'Sample Type' column please select either 30 cluster or LQAS to define the type of sample used for this particular survey. This information will be used in estimating the confidence interval for each indicator.

If data has already been entered for a particular phase, the date of first entry will appear under the 'Date' column and an 'X' will appear under the 'Entered' column.

Click on the Red link (under the 'Stage' column) to view / access / update Rapid Catch data for that phase of the project.

Date	Stage	Sample Type	Entered
26-Jun-09	DIP	◉ 30 Cluster ○ LQAS	X
	Mid Term	◉ 30 Cluster ○ LQAS	

	Final Evaluation	30 Cluster LQAS	