Government of India
Ministry of Health and Family Welfare
National AIDS Control Organization
6th Floor, Chandralok Building,
36-Janpath, New Delhi-110001

Guide to Supervision, Monitoring & Evaluation for

HIV-TB Collaborative Activities

January 2016

Central TB Division
Directorate General of Health services
Ministry of Health and Family Welfare
Government of India, New Delhi

Basic Services Division
National AIDS Control Organization
Ministry of Health and Family welfare
Government of India, New Delhi

Government of India
Ministry of Health and Family Welfare

PREFACE

Tuberculosis is commonest opportunitistic infection (OI) in persons living with HIV (PLHIV) & foremost cause of death among people living with HIV. To mitigate the effect of dual burden of HIV and TB co-infection the Ministry of Health and Family Welfare, Government of India through its National AIDS Control Organisation (NACO) and Central TB Division (CTD) has been undertaking joint collaborative efforts as per the National Framework for HIV TB collaborative activities in India. Supervision, Monitoring and Evaluation of TB-HIV activities are of utmost importance for strengthening the quality of the services.

NACO BSD and Central TB Division, Ministry of Health and Family Welfare, Government of India developed a guide to ensure best Supervision, Monitoring and evaluation practices that promote discipline, accountability and efficiency and also incorporate the revised indicators at Global and National levels for monitoring TB/HIV collaborative activities. An e-consultative process was initiated to seek inputs and help to develop Guide in order to meet the uniform pattern of monitoring as Global and National data requirements.

The Guide of Supervision, Monitoring and Evaluation, includes comprehensive material, detailed performas and annexures containing checklist /tools, details on monitoring and evaluation for ready reference to support the effective supervision and monitoring and evaluation.for the state , District RNTCP-NACP staff and other who are assigned with the responsibility of service delivery and supervision and monitoring.

I aapreciate the coordinated efforts made by RNTCP-NACP technical team and everyone involved in its initiative. This Guide of Supervision, Monitoring and Evaluation will be valuable guidance for Program managers at various levels focusing on implementing Supervision, Monitoring and Evaluation strategies to strengthen quality of TB /HIV collaborative activities services.

Use and application of the Guide to Supervision, Implementation and Evaluation by the responsible and efficient officers will help in the effectiveness, efficiency and sustainability of Government of India's response to TB/HIV, through strengthened co-ordination, improved Supervision, Monitoring and Evaluation thereby quality of care.

(Dr. S.D. Khaparde)
Deputy Director General (TB)
Central TB Division
MOHFW, GOI
New Delhi

(Dr. R. S. Gupta)
Deputy Director General (BSD)
National AIDS Control Organization
MOHFW,GOI
New Delhi

Acknowledgement

The **"Guide to Supervsion, Monitoring and Evaluation of TB HIV Collaborative Activities"** has been prepared jointly by Basic Services Division (HIV/TB), Central TB Division, Ministry of Health and Family Welfare, Government of India under the guidance of Dr. R S Gupta DDG (BSD), Dr. S.D.Khaparde (DDG-TB).

The writing group for different chapters comprised of Dr Rajesh Deshmukh, Dr Amar Shah, Dr. Sanjay Sinha, Dr Rajeev Vishnoi, Dr.Rakesh Dayal, Dr Lalit Mehndru, Dr. Sanjay Suryawanshi, Dr. Shankar Dapkekar, Dr. Rajeev Pathak, Dr. Umesh Tripathi, Dr. Rajandra Gadhvi, Dr. Silajit Sarkar, Dr. Dixit Kapadiya, Dr Kamal Chand Naik, Dr Deepak Balasubramanian, Dr Shibu Balakrishnan, Dr. Delphina, Ms. Tina Mitra, Dr. Pankaj Nimavat, Dr. Bhavin Vadra, Dr. Jignesh Patel, Dr. Hiren Thanki, Dr. Sandeep Rathod, Dr. Amit Karad, Dr. Kshitij Dewan, Dr. Jiban J Baishya, Dr. Anwar S, Mr. Prasad Sant, Dr. Govind Bansal, Ms. Dhriti Bania, Mr. Praveen Gupta, Mr. Haresh Patel, Mr. Amarnath Babu, Dr. Sanjay Singh.

Valuable guidance to the development of the module has been made by Dr. A.S. Rathore DDG-CST/NACO, Dr. Neeraj Dhingra (DDG –TI, M&E)/NACO, Dr.Naresh Goel DDG LS/NACO, Dr. Devesh Gupta ADDG TB, Dr. V.S.Salhotra, Additional DDG (TB), Dr. Raghuram Rao, DADG (RR/CTD), Dr. K.S.Sachdeva, former Addl. DDG (TB), Dr. P. Kumar Director National TB Institute Bangalore, Dr.Rohit Sarin National Institute of Tuberculosis and Respiratory Diseases, New Delhi, Dr. Gangakhedkar.R.G (NARI,Pune), Dr. Padmariya National Institute of Research in Tuberculosis, Chennai. Dr Nicole S (CDS,WCO India), Dr. A. Sreenivas NPO (TB/WHO), Dr. B. B. Rewari NPO (ART), Dr. Ranjani Ramchandran NPO (LABs/WHO), Dr. Malik Parmar NPO (DRTB/WHO), Central TB Division consultants, Dr. Kiran Rade, Dr.Ashu Pandey, Dr. Mayank Ghedia, Dr. Anand S, Dr. Syed Imran, Dr. Jyoti Jaju, Dr. Shika D, Dr. Arindham Moitra, Dr. Mohan Kohli, Dr. S.N Rai, Ms.Rina S, Ms. Smirty K, Dr. Bharti Kalotte, Ms. Sheffali, Mr. Ashish, RNTCP Consultants, Joint Directors/BSD of all SACS, State TB officers, State TB Demonstration centre Directors, Regional Coordinators, Development Partners , NACO BSD, CST, TI, BS, Lab Divisions and various experts of National Technical Working Group HIV TB who extended their valuable comments /suggestions on earlier drafts of this document. Valuable support was received from Dr. Rajesh Deshmukh NC WHO & PO (HIV/TB)/BSD/NACO, Dr. Jyoti Sharma TO (HIV/TB)/BSD/NACO, Dr. Sujith P TO (M&E) /BSD/NACO, Ms. Meena Arya TA /BSD/NACO in content designing ,compilation, editing and re-writing the document after inputs from experts. We also acknowledge the contributors of source documents referred especially WHO for revised Monitoring indicators 2015.

These contributions of everyone involved in this endeavour are gratefully acknowledged.

Acronyms and abbreviations

NACP	National AIDS Control Programme
RNTCP	Revised National Control Programme
MDG	Millennium Development Goal
PMDT	Programatic Management of Drug Resistance TB
HSS	HIV Sentinel Surveillance
ICF	Intensified (TB) case finding
IPT	Isoniazid Preventive Therapy
INH	Isoniazid
M&E	Monitoring and Evaluation
CPT	Co-Trimoxazole Preventive Therapy
IEC	Information, Education and Communication
RR-TB	Rifampicin Resistant TB
3Is	Innovative intensified TB case finding and appropriate treatment at high burden Anti-Retroviral Therapy (ART) centres in India
DAPCU	District AIDS Prevention & Control Unit
CBNAAT	Cartridge Based- Nucleic Acid Amplification Test
SIMS	Strategic Information Management System
SIMU	Strategic Information Management Unit
CBO	Community Based Organisation
CSC	Care and Support Centre
NSP	New Sputum Positive
TI	Targeted Interventions
C&DST	Culture & Drug Sensitivity Test
AIC	Air Borne Infection Control
CCC	Community Care Centre
EID	Early Infant Diagnosis
STI	Sexually Transmitted Infection
RTI	Reproductive Trac Infection
PHI	Peripheral Health Institution
PHC	Peripheral Health Centre
STS	Senior Treatment Supervisor
STLS	Senior TB Lab Supervisor
STO	State TB Officer
MO	Medical Officer
SA	Secretarial Assistant
DTC	District TB Centre
DTO	District TB Officer
EQAS	External Quality Assessment Scheme
PALS	PPTCT ART Linkage System
DACO	District AIDS Control Officer

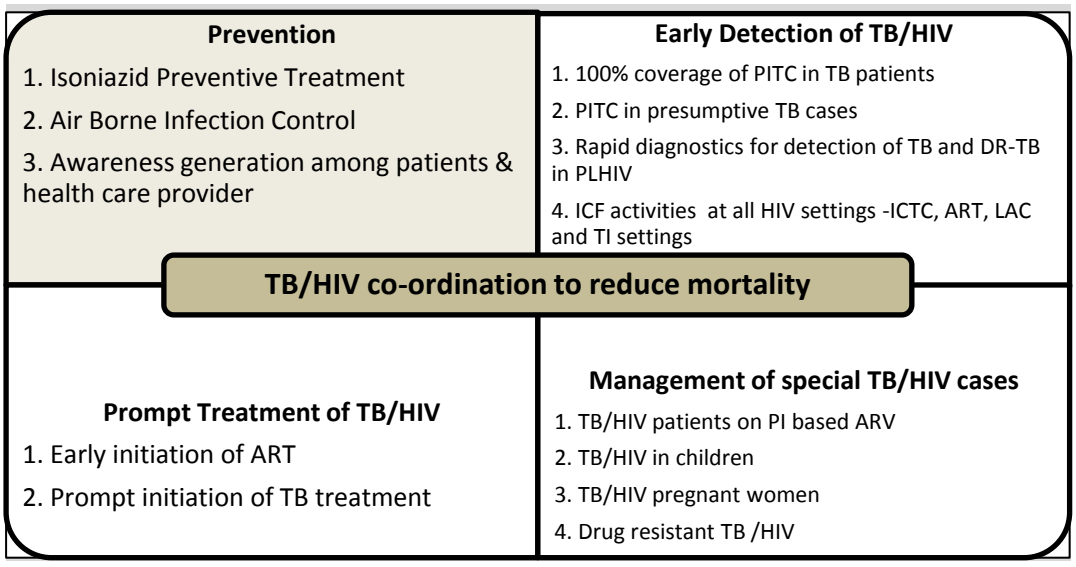
Chapter-1: Background

Tuberculosis (TB) is one of the most common causes of morbidity and leading cause of mortality in people living with HIV (PLHIV). India has second highest burden of HIV /TB cases in World.To mitigate the effect of dual burden of HIV and TB co-infection the National AIDS Control program and Revised National TB Control program (RNTCP) of Government of India has been undertaking joint collaborative efforts as per the National Framework for HIV TB collaborative activities since 2001.

RNTCP and NACP both aim for promote access to TB care in all HIV Patients and HIV care to all TB patients. To achieve this, it is necessary to ensure early detection of either infection among all co-infected cases and to ensure early initiation of TB treatment followed by ART and completion of TB treatment with good drug compliance. The community must have full access to TB and HIV prevention, care and treatment, including children, elderly, migrants and people living with HIV and with other clinical risk factors.

1.1: Components of TB/HIV Collaborative Activities:

The goal of collaborative TB/HIV activities is to decrease the burden of TB and HIV in populations affected by both diseases by expanding the scope of TB and HIV programmes and of their partners. These collaborative activities will be more successful in the presence of effective implementation of national HIV and TB control strategies that are based on four pronged strategy summarised below is foundation of strong collaboration between NACP and RNTCP i.e. National Framework 2013.



Existing HIV/TB collaborative activities

1. Strong NACP-RNTCP coordination mechanisms at national, state and district level
2. Joint monitoring and evaluation with standardized reporting shared between NACP and RNTCP
3. Joint training of key programme and field staff in HIV/TB activities
4. Operational research to strengthen implementation of HIV/TB collaborative activities

5. Implementation of basic infection control measures at ART centres e.g. fast tracking of chest symptomatics
6. Specific service delivery coordination activities are as follows:

Activities to reduce burden of HIV among TB patients:

a) Provider initiated HIV testing and counselling (PITC) among TB patients
b) Provision of co-trimoxazole preventive therapy (CPT) for HIV infected TB patients
c) Provision of Anti-Retroviral Therapy (ART) for HIV infected TB patients
d) Provision of HIV prevention education for patients with presumptive or diagnosed TBcases

Activities to reduce burden of TB among HIV infected individuals:

a) Intensified (TB) case finding (ICF) at ICTC
b) Intensified (TB) case finding (ICF) at ART centres and Link ART centres
c) Air borne infection control measures for prevention of TB transmission at HIV care settings
d) Implementation of Isoniazid preventive treatment (IPT) for all PLHIV (On ART + Pre-ART)

Collaborative TB/HIV activities aim to decrease the burden of disease and are critical for universal access to diagnostic, care and prevention services for people living with HIV and TB. Regular supervision, monitoring and evaluation (S,M&E) of TB /HIV programme in country is needed to improve the quality, effectiveness, coverage and delivery of services,identify the gaps, develop solutions and bridge the gaps in service provision.

1.2: Aims and Objectives of Supervision, Monitoring & Evaluation Guide

Aim of this guide

This guide to **Supervision, Monitoring and Evaluation (**SM&E) has been developed to assist the program managers and staff of RNTCP and NACP programmes at various levels to effectively implement collaborative TB-HIV activities. It is intended to facilitate the quality implementation of TB HIV collaborative activities, collection of standardized data, and help in the interpretation and dissemination of these data for programme improvement. It also aims to ensure uniformity across all stakeholders involved in TB-HIV collaborative activities and harmonisation of data collection at various levels by developing a core set of globally accepted, standardized indicators for monitoring and evaluating programme performance. The data collected using these standardized indicators will provide further evidence for policies related to collaborative TB/HIV activities.

Objectives:

1. Facilitate effective supportive upervision and monitoring of TB-HIV collaborative activities to reduce morbidity and mortality due to TB -HIV through prevention, early detection and prompt management of TB and HIV .
2. To ensure that activities are implemented as planned, and that the TB-HIV data recorded and reported is accurate and valid
3. Incorporate a system of **analysis, supervision and review** which leads to remedial action to improve performance and improve indicators.
4. Serve as a tool to facilitate following:

- **Commitment** of higher authorities at different levels.
- **Integration** of HIV & TB supervision and monitoring with General healthsystem both in the state and the district.
- **Streamline** new programme activities related to–-TB-HIV, **Engagement** of all care providers –Public and Private, other government healthfacilities/,Medical colleges,NGO,CBOs etc

5. **Ensure equitable provision** of services to all sections of the community including targeted populations (high risk groups) such as female sex workers, men having sex with men, injecting drug users, migrants and Bridge poulations .
6. Understand the concept and applicability of supervision and monitoring at different levels using standerdised checklist.
7. Serve as ready reference for different stake holders.
8. Provide a set of standardized tool for supervision and monitoring for basic services related to TB & HIV

Target audience: Administrators, Program Managers, General health system staff, other stake holders and key program staff from NACP and RNTCP at various levels

Chapter -2 : HIV/TB Program Supervision

2.1: Concept of Supervision

Supervision is a systematic process for increasing efficiency of the health personnel by developing their knowledge, perfecting their skills, improving their attitudes towards their work and increasing their motivation.

Supervision is carried out in direct contact with the health personnel. It is a two-way communication between supervisors and those being supervised. It should not be a fault finding exercise but a supportive ,collaborative effort to identify problems and find solutions.

It must also be realized that health personnel at all levels need ongoing support for solving problems and to overcome difficulties. They also need constructive feedback on their performance and continuous encouragement in their work.

a) Objectives of supervision

i) To ensure equitable provision of services to all sections of the community
ii) To build capacity of the health staff to implement the program procedures correctly.
iii) To increase the involvement and commitment of staff at different levels.
iv) To provide timely and actionable feedback
v) To address human resource capacity building needs
vi) To ensure un-interrupted supplies of logistics
vii) To ensure accurate and valid data recording and reporting

2.2: Supportive supervision

Supportive supervision from National, State and District level to institutional /facility level is an essential element of routine Supervision, monitoring and evaluation of the programmes. Good supportive supervision includes assessment of quality of services delivery for entire processes related to Client /patient related services, validation of recording and reporting...Periodic systematic review of the routine monitoring systems may be carried out by the supportive supervision team. This should ideally involve members of both the NACP and RNTCP programmes. Activities may include: validating the group cohort report and analysis; validating the quarterly report; conducting additional register tallies and taking a systematic sample of patient cards to measure quality of care and validate core indicators such as TB status assessed and recorded at last visit. Finally, TB and HIV district supervisors can reconcile HIV and TB register data to cross-check registration of TB patients into HIV care or ART and of HIV patients into TB treatment. Supportive supervision should detect and discuss difficulties in data management and to provide an opportunity for learning. Simple supervision tools such as score cards or certificates of excellence awarded for good reporting and recording delivered at time of supervision for accurate recording and reporting may be used to motivate health workers.

The supportive supervision approach emphasizes on:

- Constructive feedback,
- Joint problem solving, and
- Two-way communication between supervisors and those being supervised.

b) Supervisory Protocol & Tools / Checklist

1. Supervisory protocol at all level for different categories of Staff is annexed at **Annexure 1**
2. Program Supervision tool in TB-HIV at State Level is annexed at **Annexure 2**
3. Supervisory Checklist for Designated Microscopic Centre (DMC) is aannexed at **Annexure 3**
4. Supervisory Checklist for ICTC is annexed at **Annexure 4**
5. Supervisory Checklist at ART Centres is annexed at **Annexure 5**
6. 3I's Project Supervisory check list and reporting form is annexed at **Annexure 6**
7. Supervisory Report Format is annexed at **Annexure 7**

d) Pre-requisites for effective Supervision

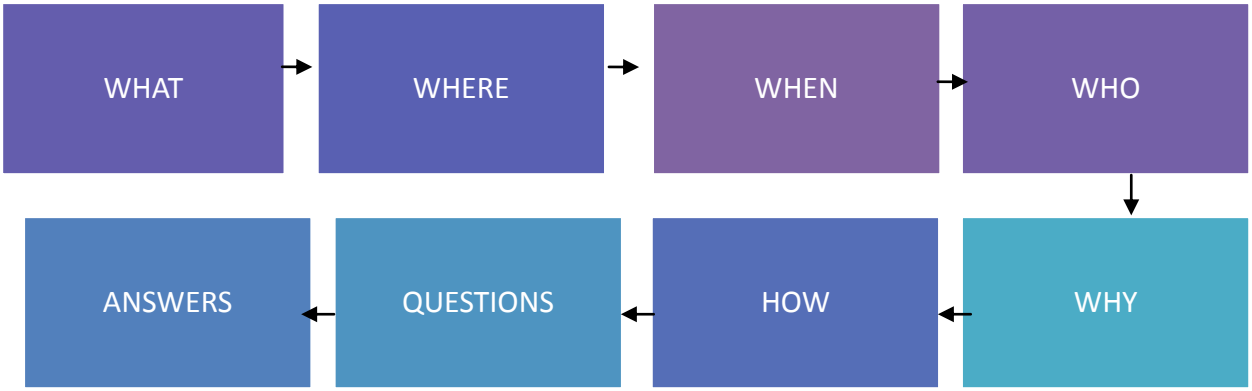
- ✓ Plan ahead: Advance Tour Planning (ATP ,follow protocol)
- ✓ Inform about your visit
- ✓ Acquaint yourself with baseline data of area/facility to be visited -Use job aides and checklists
- ✓ Set example –demonstrate correct practices
- ✓ Record important observations of the visit -Communicate the observations to staff and appropriate authorities -Keep track of actions taken on the recommendation

Process of Supervision

Systematic cycle of expectations and evaluations

Source : *RNTCP Training Module ,GOI*

Elements of Supervision



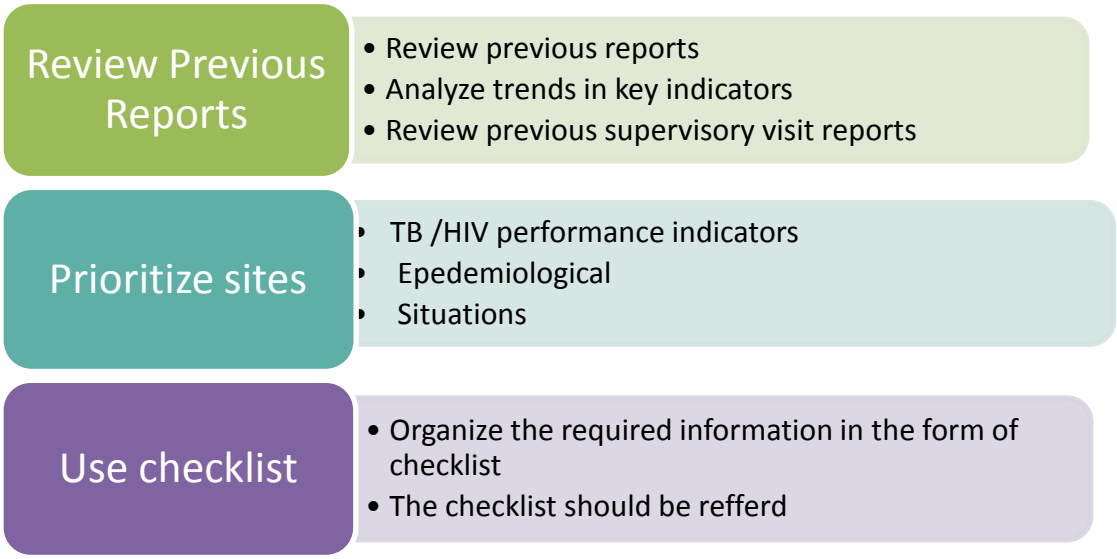
2.3: Joint HIV/TB Supervisory Visits

To strengthen implementation of collaborative activities at different levels joint supervisory visits should be undertaken by a national team (NACP&RNTCP) to at least one state per quarter. Similarly

state teams (SACS & STC) should visit at least one district every month. These states and districts are chosen based on key HIV/TB performance indicators. Observations made in joint supervisory visits should be discussed in review meetings at various levels. A copy of the observations and recommendations made should also be submitted to higher authorities and the Institution facility visited.

To aid in joint field visits and review meetings NACP and RNTCP jointly developed monitoring indicators and targets. Performance indicators and targets for HIV/TB collaborative activities target are shown in A**nnex 15.**

Preparing for supervisory visits



Chapter -3: Monitoring and Evaluation

3.1: Concept of Monitoring and Evaluation and its Importance:

Monitoring is the process of observing whether an activity or service is occurring as planned and to ensure they are on course, on-schedule in meeting the objectives and performance targets. It implies systematic and purposeful observation, aiming to identify any diversion from the planned course of actionand to achieve expected results. This facilitates the most effective and efficient use of human , financial and other resources for the achievement of maximum health benefit for the population served – which is especially relevant in areas where resources are limited.

Monitoring is the routine tracking of service and programme performance using input, process and outcome information collected on a regular and ongoing basis from policy guidelines, routine record-keeping, regular reporting and surveillance systems, and occasional health facility observations and client surveys. This helps in identifying the need for more formal evaluation of activities and find timely solutions to the problems.In a well-designed M&E system, monitoring will contribute greatly to evaluation.

Evaluationis the *episodic* assessment of results that can be attributed to programme activities; it uses monitoring data and often indicators that are not collected through routine information systems. Evaluation allows exploration of the causes of failure to achieve expected results on schedule and the mid-course corrections that might be necessary. **Process evaluation**assesses progress in programme implementation and coverage. **Outcome and impact evaluation** measure the effect of programme activities on the target population.

3.2: Monitoring and Evaluation Framework

Monitoring in TB-HIV programs is of utmost importance for ongoing program planning and implementation. A good monitoring strategy moves beyond the widely used case detection and treatment outcome indicators and applies the concept of input, process, output, outcome and impact indicators as a M&E framework for measurement and achievement of key program activities.**Inputs,** such as money, staff time and policies, must result in **outputs,** such as efficient supply systems, new or improved services, trained staff. These outputs are often the result of specific **processes**, such as training sessions for staff, that are key activities aimed at achieving the outputs. If these outputs are well designed and reach the populations for which they were intended, the programme or project is likely to have positive short-term effects or **outcomes**, such as an increased number of people living with HIV screened for TB symptoms or of TB patients tested for HIV. These positive short-term outcomes should lead to changes in the longer-term **impact**of programmes, reflected in fewer new cases of TB or HIV.

Monitoring and Evaluation Framework				
Context **Environmental, cultural, political, and socio-economic**				
INPUT	**PROCESS**	**OUTPUT**	**OUTCOME**	**IMPACT**
Basic resources necessary	**Programme activities**	**Results at the programme level** (measure of programme activities)	**Results at level of target population**	**Ultimate effect of project in long term**
Policies, people, money, equipment	Training, logistics, management, IEC/BCC	Services, service use, knowledge	Behaviour, safer practices	TB incidence, HIV prevalence, morbidity, mortality

Monitoring/Process Evaluation **Outcome/Impact Evaluation**

Source: Adapted from Development of health programme evaluation: report by the Director–General. Geneva : World HealthOrganization;1978(document A31/10).

The independent M&E systems that exist for TB and HIV programmes may not adequately capture the programme effort expended on collaborative TB/HIV activities or may result in duplication of effort, conflicting data collection requirements, and difficulties in evaluating the performance of collaborative activities as a whole. Therefore a core group of simple indicators as recommended, including those to trigger actions, is essential for the programmes to work effectively together.

3.3: Rationale for Monitoring and Evaluation for Collaborative TB/HIV Activities

Monitoring and evaluating TB/HIV collaborative activities provides the means to assess the quality, effectiveness, coverage and delivery of comprehensive services and ensure continuous quality improvement of servicess.

Effective M&E for TB/HIV collaborative activities will facilitate the cross-checking, reconciliation of data between the two programmes at various levels and also facilitate accountability for resources allocated for activities.

The M&E system is structured to ensure the most efficient use of resources to generate the data needed for decision-making. It guides data collection and analysis to increase consistency and enable managers to track trends over time. Establishing standard indicators, reporting and recording mechanisms support the streamlining of M&E processes.

3.4: Methodology of Monitoring & Evaluation of HIV/TB Collaborative Activities

There are various suggested methods by which monitoring and evaluation of TB /HIV activity occurs. The major ones are listed below.

a. Routine monitoring mechnisms in HIV TB

Similar to other national programme,RNTCP-NACP uses the data collected routinely for patient care to inform programme management. Both RNTCP and NACP use program standerdised records/registers as the information source for disease specific indicators monitoring . In RNTCP , the patients records and TB registers are used to prepare quaterly reports which provide information on patient registration and progress during the quarter, and treatment outcome using cohort analysis of groups of all patients starting treatment during previous specified time periods. These reports are analysed locally preferably in conjunction with supportive supervision or meetings, and are then sent to district , state and national levels for further aggregation, analysis, dissemination and management of the programme.This is presently strengthened by NIKSHAY "web based case based" electronic reporting system.Similarly NACP uses records /registers at different facilities like ICTC,F-ICTC,ART etc and monthly reports are sent electronically through the Strategic Management Information System (SIMS),online reporting system at various levels.TB HIV reports are standerdised and integrated in the RNTCP and NACP reporting systems based on records/registers at various facilities ,and submitted online at various level without duplicating the efforts.

b. Surveillance and Surveys conducted by NACP & RNTCP

HIV Sentinel Sureillance in India, since its inception in 1998, has evolved into a credible and robust system for HIV epidemic monitoring and acclaimed as one of the best in the world. Sentinel surveillance provides essential information to understand the trends and dynamics of HIV epidemic among different risk group in the country. It aids in refinement of strategies and prioritisation of focus for prevention, care and treatment interventions under the National AIDS Control Programme (NACP). HIV estimates of prevalence, incidence and mortality developed based on the findings from HIV Sentinel Surviellance enable the programme in assessing the impacts at a macro level.These are important tools to measure disease burden such as the prevalence of HIV and tuberculosis. These are either separate stand alone surveys undertaken periodically or sentinel surveillance from selected treatment sites.NACO has guidelines for recording and reporting these activities.

c. Country situational analysis

This important tool brings together all the available information on disease epidemiology (including surveillance and survey data), and programme structure, function, output and impact within the context of the overall health system. The analysis identifies strengths weaknesses and gaps in the programme and is often carried Oout as part of planning cycle in preparation of a strategic multi year programme plan.

d. **Joint Program Reviews RNTCP and NACP**

NACP& RNTCP conduct regular review meetings at national and state level. Joint national review of HIV/TB activities should be done with participation of state programme managers of both programmes. This meeting is held jointly by NACO and CTD.

Review Checklist for TB/HIV activities at state level is place at Annex 25 .Similar joint review meeting should be held at state level by adding one additional day to one of the quarterly RNTCP review meetings, inviting all district nodal officers for HIV/AIDS or DAPCU officer and SACS officials. The joint review meetings should be organised in close coordination by SACS and STC. The schedule of joint meetings should be communicated to NACO and CTD and representatives from CTD or NACO should participate in the same.

e. External programme reviews

External programme reviews e.g. Joint Monitoring Mission(JMM) , Common Review Mission (CRM), usually lasting one to two weeks, are organized at the request of the programme, often in preparation of a multi-year strategic program plan. It usually involves forming a team of international and national experts on programme management or technical aspects of the programme, with local implementation partners, Ministry of Health programme staff, civil society and donors are also represented. The team meets at national level for one to two days, to be orientated with a pre-prepared situational analysis, and to agree on a review methodology. The reviewers then travel throughout the country in sub- teams to observe the programme at all levels (national regional district health centre and community), using agreed tools to examine records, observe activities, and interview key informants including health staff, clients, other care providers and civil society All this information is then synthesized and brought together at national level to inform the final report with key findings and recommendations to government and stakeholders. Usually a summary of key findings is presented to ministry of health senior representatives prior to the teams departure.

One specific issue to note for TB/HIV activities should be a part of both TB and HIV programme reviews, preferably bringing key staff from both programmes together. Reviewers should ensure that review findings are shared with and owned by both TB and HIV programmes.

3.5: Program Evaluation

a. Internal Evaluation Protocol

Internal Evaluation forms an integral component of RNTCP & NACP supervision and monitoring strategy. It acts as a tool to evaluate if good program practices are adopted and quality services are provided to the community. These evaluations also offer an opportunity for program managers to look into all aspects of program critically and recommend corrective actions . These activities help program managers in understanding determinants of good as well as poor performance ,replication of good practices and take appropriate measures for improvement.

Objectives of Internal Evaluation

1. To provide a systematic framework for assessment of program performance, financial & logistics management, recording and reporting, and quality of care received by patients.
2. To give recommendations for improving the quality of program implementation and performance with a realistic action plan and time line.
3. To monitor efforts to improve and maintain program quality and performance over time.

3.5.1) Centrally driven Internal evaluation (**CIE**): One state per month is selected for evaluation of program activities based on the performance so that all big states are visited once in every 2 years. In the selected state at least 2 districts are evaluated. CIE provides an opportunity to review performance in select district and to review overall performance of the state, programmatic challenges. It facilitates the centre to understand, address and support actions for improving quality of HIV/TB collaborative activities in the state and its implementation. The CIE team consists of representatives from NACO, CTD, WHO, SACS's Officers from other state etc.

3.5.2) State Internal Evaluation (SIE): To deliver effective TB HIV service at all level the RNTCP involving State team including State AIDS Control Society (SACS) under takes state Internal evaluation (SIEs) of two districts in a quarter to review the performance in the districts.

Selection of districts: Upto 30 million – 2 districts per quarter; 30-100 million – 3 districts per quarter; >100 million – 3-4 districts per quarter. Aim to cover all districts at least once in 3-4 years. In States/UTs with 4 or less districts, 1 district or TU per quarter may be evaluated alternating selection between a well performing district and an under performing district.

State Internal Evaluation team members

a. State TB Officer or Deputy STO
b. STDC Director / representative (where STDC exists)
c. One DAPCU & One DTO of a district other than the one being evaluated
d. WHO RNTCP consultants
e. Medical college representative
h. Consultant from other programmepartners (IMA, CBCI etc.)
i. State Accountant
j. State IEC Officer
k. State TB HIV Coordinator

Selection of DOT Centres:

• The team should visit the DOT Centres attached to each of the 5 selected DMCs (and Medical College conveniently selected) Co-located with ICTC/FICTC.

• Also identify and visit 5 more DOT Centres in the district with unique characteristics such as those attached to a medical college where DMC, ICTC & ART Centres are collocated.(other than the one conveniently selected for visit)., Selection of patients:

• In each of the 2 DMCs with low case load 4 New Sputum Positive (NSP) patients are selected randomly and one previously treated case conveniently (5 X 2= 10 patients)

• In each of the DMCs at DTC & 2 TU level DMC, 4New Sputum Positive patients are selected randomly and 1 patient each of the types Relapse, TAD and Failure are conveniently selected. Also select 1 TB/HIV patient and 1 DRTB patient.

Selection of ICTC/FICTC:

5 ICTC/ FICTC are selected out of these as follows:

1. Two ICTC/F-ICTC that are screening and referring higher number of presumptive TB cases

2. Fourth and fifth ICTC/FICTC is selected randomly from remaining ICTC/FICTC (preferably from different TU)

Selection of ART Centres:

• The team should visit the ART Centres attached to each of the 5 selected ICTC/FICTC (and Medical College conveniently selected).

• Also identify and visit 5 more ART Centres in the district with unique characteristics such as those attached to a medical college (other than the one conveniently selected for visit).

Activities performed in Internal Evaluation:

- Triangulation of data, for all the TB Units in the district
- Visits to ICTC, ART centre, DMC, DOT Centre, Medical College etc. Patient home visit for interview
- Compilation of the report
- Communication of Key observations to district authorities
- De-briefing of the findings to NACO& CTD staff
- Knowing best practices and challenges in implementation of services and recommendations

Submission of IE report to BSD/NACO and STC / CTD - soft copies are sent to Basic services Division/NACO and CTD by member secretary of SWG electronically as soon as possible and the hard copies, with cover page signed by allmembers, by courier not later than a week. * All relevant formats included in annexures.

NACP & RNTCP have jointly made incredible progress with regards to ensuring quality diagnostic and treatment services, but therein lies the risk of complacency creeping into the program. Further the program has expanded to involve all health care providers thorough strategy, TB/HIV collaborative activities, provision of DRTB services etc.

b. Internal Evaluation Formats are annexed at Annexure 30

c. Internal Evaluation Field Visit Report are annexed at Annexure 31

Chapter 4: Revised Case Definitions, Recording & Reporting:

4.1: Case Definitions

Bacteriological confirmed TB case (Definitive TB Case) refers to a presumptive TB patient from whom a biological specimen is positive for acid fast bacilli, or positive for Mycobacterium tuberculosis on culture, or positive for tuberculosis through Quality Assured Rapid Diagnostic molecular test.

Clinically diagnosed TB case (probable TB) refers to a presumptive TB patient who is not bacteriologically confirmed, but has been diagnosed with active TB by a clinician on the basis of X-ray abnormalities, histopathology or clinical signs with a decision to treat the patient with a full course of Anti-TB treatment.

Bacteriologically confirmed or clinically diagnosed cases of TB are also classified according to:

- anatomical site of disease;
- history of previous treatment;
- drug resistance;

Classification based on anatomical site of disease

Pulmonary tuberculosis (PTB) refers to any bacteriologically confirmed or clinically diagnosed case of TB involving the lung parenchyma or the tracheo-bronchial tree. A patient with both pulmonary and extrapulmonary TB should be classified as a case of PTB.

Extra Pulmonary tuberculosis (EPTB) refers to any bacteriologically confirmed or clinically diagnosed case of TB involving organs other than the lungs such as pleura, lymph nodes, intestine, genitourinary tract, joint and bones, meninges of the brain etc., is called as extra-pulmonary TB

Milliary TB is classified as PTB because there are lesions in the lungs. A patient with both pulmonary and extra pulmonary TB should be classified as a case of PTB.

Classification based on history of previous TB treatment

New case

A TB patient who has never had treatment for TB or has taken anti-TB drugs for less than one month is considered as a new case.

Previously treated patients have received 1 month or more of anti-TB drugs in the past.

Recurrent TB case

A TB Patient previously declared as successfully treated (cured/treatment completed) and is subsequently found to be bacteriologically confirmed TB case is a recurrent TB case.

After Treatment failure patients are those who have previously been treated for TB and whose treatment failed at the end of their most recent course of treatment.

Treatment after loss to follow-up patients has previously been treated for TB and was declared lost to follow-up at the end of their most recent course of treatment

Other previously treated patients are those who have previously been treated for TB but whose outcome after their most recent course of treatment is unknown or undocumented.

Transferred In: A TB patient who received for treatment in a Tuberculosis Unit, after registered for treatment in another TB unit is considered as a case of transferred in.

Classification based on drug resistance

Mono resistance: A TB patient, whose biological specimen is resistance to one first-line anti-TB drug only

Poly drug resistance: A TB patient, whose biological specimen is resistance to more than one first-line anti-TB drug (other than both isoniazid and rifampicin).

MDR TB case: A TB patient, whose biological specimen is resistant to both isoniazid and rifampicin with or without resistance to other first line drugs, based on the results from a quality assured laboratory.

Rifampicin resistance (RR): resistance to rifampicin detected using phenotypic or genotypic methods, with or without resistance to other anti-TB drugs.

Rifampicin Resistant TB not be defined independent from MDR TB and recommended its inclusion in the definition of MDR TB

XDR TB Case: An MDR TB case whose recovered M. tuberculosis isolate is additionally resistant to a fluoroquinolone (ofloxacin, levofloxacin, or moxifloxacin) and a second-line injectable anti TB drug (kanamycin, amikacin, or capreomycin) at a quality assured Laboratory

Probable Peadiatric TB is a case diagnosed based on the presence of abnormalities consistent with TB on radiography, a history of exposure to an infectious case, evidence of TB infection (positive

TST) and clinical findings suggestive of TB in children in event of negative or unavailable microbiological results.

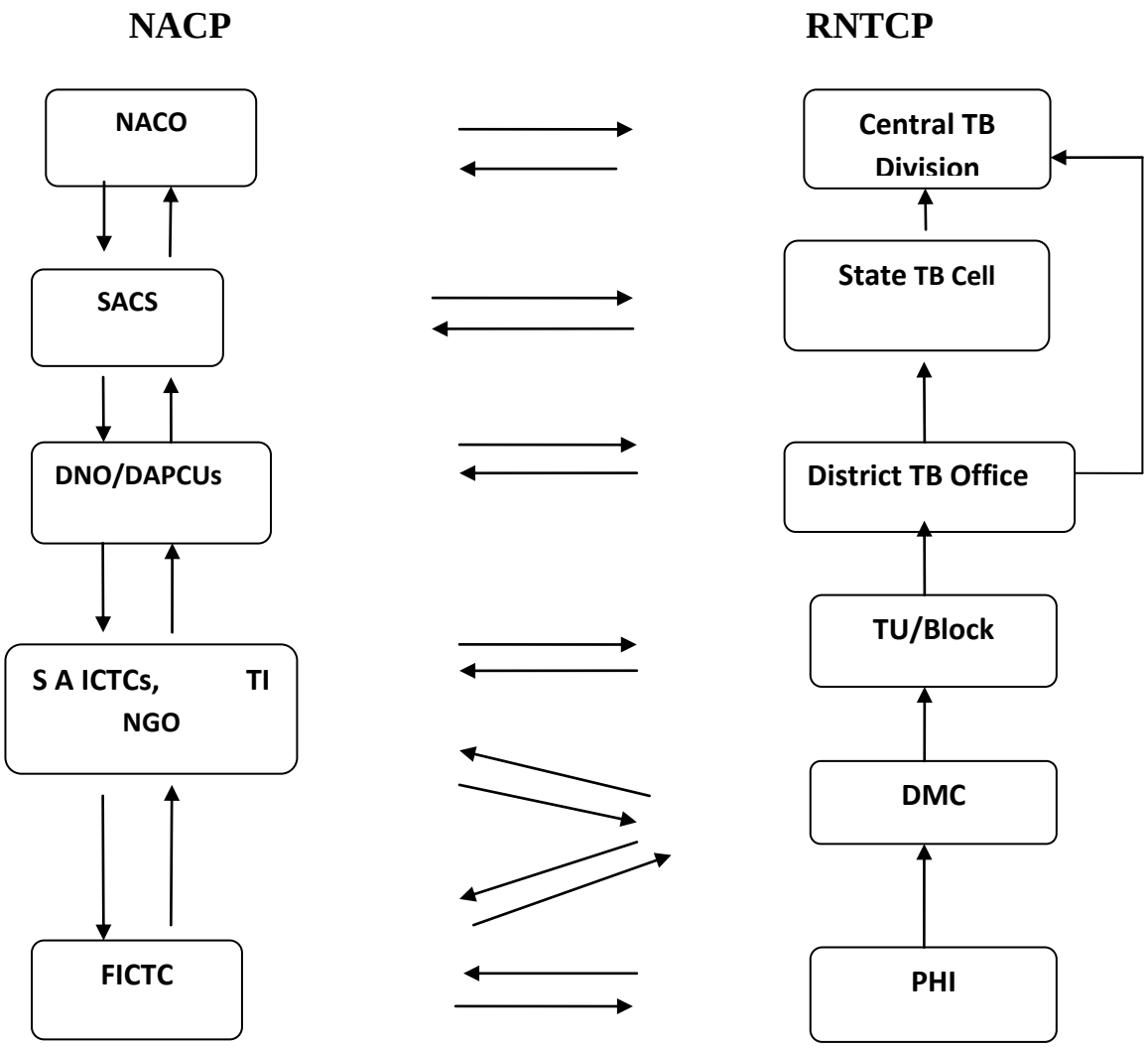
Lost to follow up (Earlier termed as Default) : A patient after treatment initiation has interrupted treatment consecutively for ≥ 2 months.

Not Evaluated: A TB patient for whom no treatment outcome is assigned this includes former "transfer out" to another treatment unit as well as cases for whom the treatment outcome is unknown to the reporting unit..

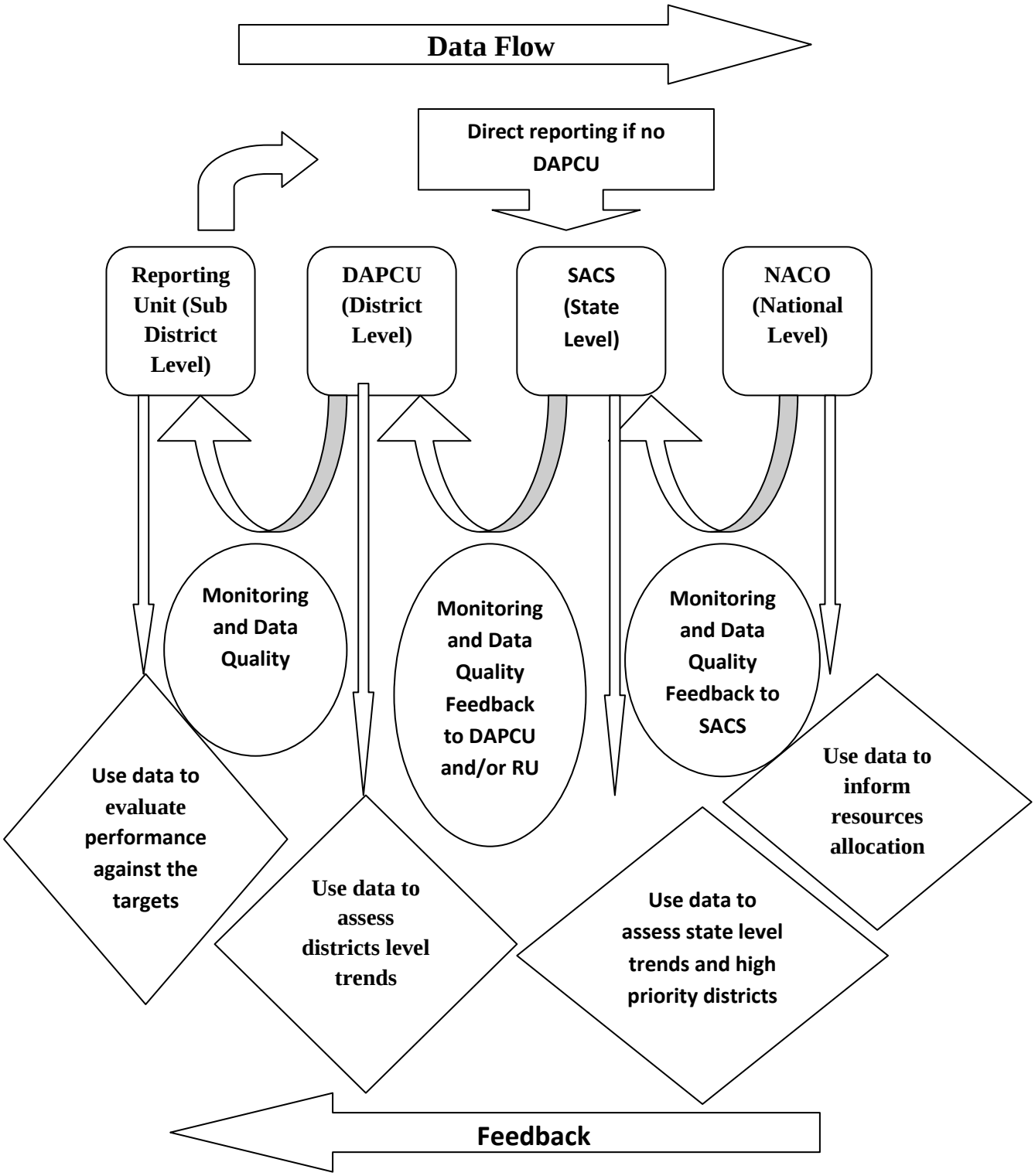
4.2: Recording and Reporting

The RNTCP and NACP programs use standardised records and reporting system, (Paper based & electronic) at different levels and these reporting systems are used for monitoring.

Level of Monitoring in NACP & RNTCP



Data Flow , Feedback & Data Use in Strategic Management Information System (SIMS)



a. Recording and reporting mechanisms:

The forms, registers and reports presented in this document are designed for paper-based recording and reporting systems. Records and reports are annexed at page no. 164-173.

HIV/TB Records Maintained at Different Facilities

S.No.	Name of the register	Register maintained at	Register to be maintained by	Timeline for entry	Data Entry into SIMS
1.	ICTC HIV-TB Collaboration activity register	SA ICTC	ICTC Counsellor	Daily in regular coordination with Senior Treatment Supervisor, TB program	Section E SIMS
2.	ART Centre TB/HIV Register	ART Centre	Staff Nurse at ART	Daily	Monthly Progress Report
3.	RNTCP Sputum Microscopy (Lab) Register	Designated Microscopic Centre	Lab Technician	Daily	NIKSHAY
4.	RNTCP PMDT Refferal for Culture & DST Register for Diagnosis & FU Cultures (A-III)	District TB Centre	Sr. DR-TB & HIV Coordinator	Daily	NIKSHAY
5.	RNTCP TB Register	Tuberculosis Unit	Senior Treatment Supervisor (STS)	Daily	NIKSHAY
6.	PMDT Culture & DBT Register (A-IV)	C & DST Lab	Lab. Technician C & DST Lab	Daily	NIKSHAY
7.	RNTCP Drug Stock Register	State Drug Store / District Drug Store	Pharmacists of DDS, SDS	Daily/Regularly as per Indent & Supply	Stock Reports excel /NIKSHAY
8.	NACP Drug Store Register	ART	Pharmacists	Daily	Inventory Management System(IMS)

Details of records & reporting regarding RNTCP & PMDT reports please refer RNTCP Training course of program managers and PMDT guidelines, May 2012.

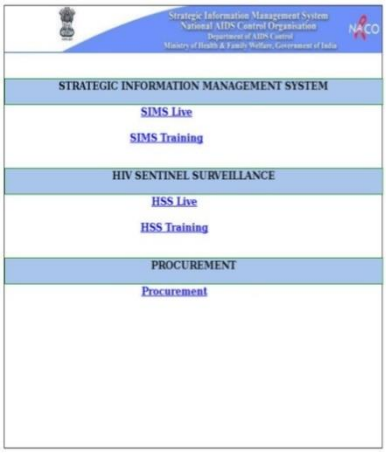
Following table clarifies the reporting FORMATS USED BY nacp & rntcp w.r.t. TB/HIV

	Essential HIV/TB recording and reporting
HIV/TB coordination activities	Quarterly report on HIV/TB collaborative activities by SACS sent to NACO/CTD Minutes of State Coordination Committee meetings sent to centre and reported in RNTCP state PMR Minutes of state TB/HIV working group meeting sent to national level . Minutes of District Coordination Committee meeting sent to State TB Cell and SACS and reported on RNTCP District PMR Minutes of Monthly HIV/TB meeting sent to State TB Cell and SACS by district
Intensified TB case finding at ICTCs /LAC	Monthly line-list of ICTC referrals of presumptive TB cases and TB diagnostic outcomes jointly prepared by ICTC counsellor and STS Monthly ICTC TB-HIV Report Consolidated state ICF at ICTC monthly report
Intensified TB case finding at ART centres/LAC Plus centre	Monthly line-list of ART referrals of presumptive TB cases and TB diagnostic outcomes jointly prepared by ART centre staff nurse and RNTCP STS. Monthly ART centre TB-HIV report as a part of 4-page monthly report of ART centres. TB/HIVregister at ART centre jointly maintained by ART centre staff nurse and RNTCP STS Consolidated state ICF at ART centre monthly report
HIV-testing of TB /DR TB patients	RNTCP Quarterly Reports (Case Finding Report)), PMDT reports INCLUDING cbnaat reporting formats.
HIV-testing of presumptive TB cases	RNTCP laboratory register, RNTCP Quarterly Report (Programme management report PHI, TU, District and state)
Provision of CPT to HIV-infected TB patients	RNTCP Quarterly Report (Results of Treatment Report)
Provision of ART to HIV-infected TB patients	RNTCP Quarterly Report (Results of Treatment Report)

4.2.1: Electronic & web based case based system for reporting.

a: Strategic Management Information System (SIMS)

The strategy ensures high quality of data generation systems through surveillance, programme monitoring and research; strengthening systematic analysis, synthesis, development and dissemination of knowledge products in various forms; emphasis on knowledge translation as an important element of policy making and programme management at all levels; and establishment of robust evaluation systems for outcome as well as impact evaluation of various interventions under the programme.



SIMS: A web based electronic reporting system has been developed by National AIDS Control Organization

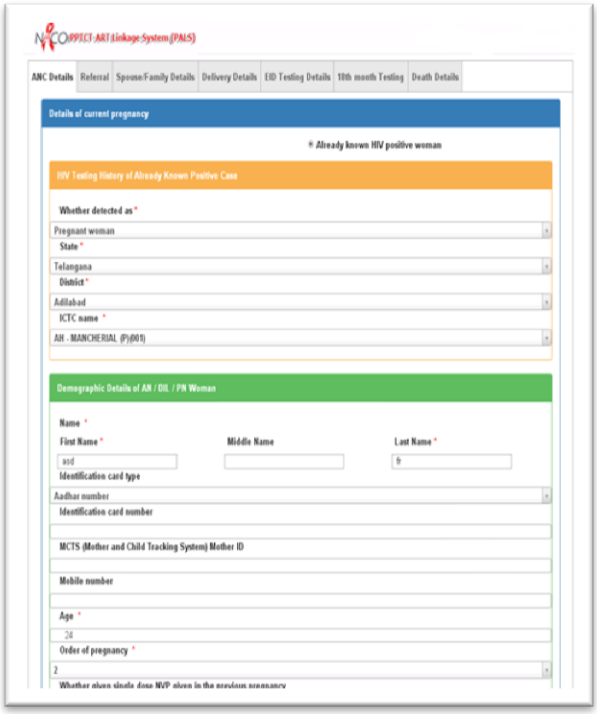
The ***Strategic Information Management Unit (SIMU)*** comprises of Monitoring & Evaluation Division, Research Division, Surveillance & Epidemiology Division and Data Analysis & Dissemination Unit. The division generates and manages crucial information on the entire spectrum of the HIV epidemic and its control including HIV vulnerabilities and risk behaviours,levels, trends and patterns of spread of HIV and factors contributing to it, disease progression, requirements and regimens, planning and implementing interventions, monitoring service delivery and tracking beneficiaries, effectiveness and impact of interventions. Another key function of SIMU is to promote data use for policy making, programme planning, implementation and review at National, State, District and Reporting unit levels.SIMS is an integrated web-based reporting, data management & decision support system, with monthly reporting from over 20,000 Reporting Units (RUs) across the country, covering all programme components.

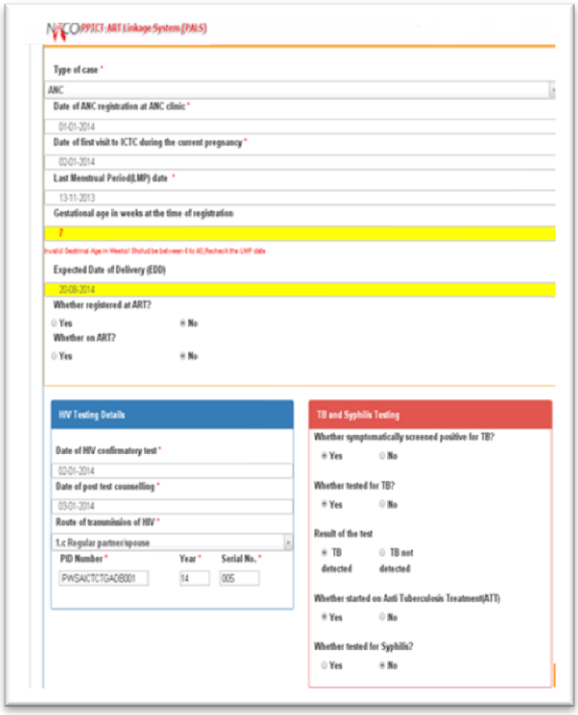
Modules in SIMS

1. Administrator Module:	• This module covers the following aspects of SIMS • Reporting Unit management (creating new reporting units, deleting defunct ones etc.) • User management (creating and modifying users for the reporting units) and managing access to users at different levels) • User access management (control the user access at different levels of the hierarchy)
2. Management Information System Input:	• Management of all data entry formats • Management of data validation in the data entry formats • Searching for data and exporting data
3. ***Management Information System Output:***	• Output reports • Data entry status • Activated/ Deactivated status of reporting units • Data Status • Data item report • Customized output reports

b: PPTCT and ART Linkage System (PALS) :

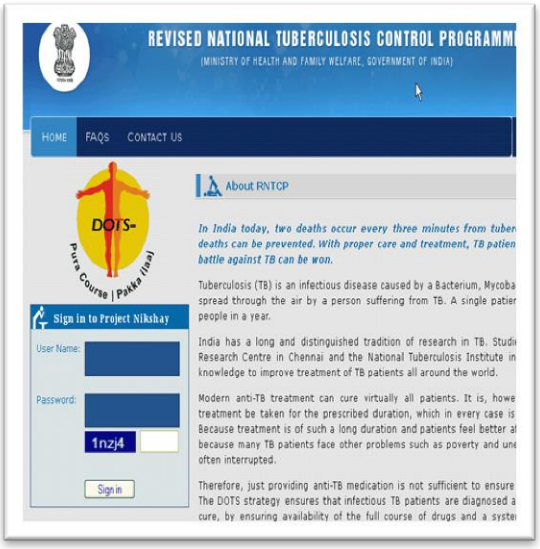
PALS is the E-Tracking tool for PPTCT continuum of care, follow up of mother and baby for >24 months. It is a reporting cum tracking tool which collects, retains and updates individual wise details of all HIV positive pregnant women who attend the facility during Antenatal period or Directly In labor or during Post Natal period. The information related to TB cases among pregnant women screening & linkages to ATT, ART is included in PALS.





c : NIKSHAY (RNTCP)

RNTCP in collaboration with National Informatics Centre (NIC) undertook the initiative to develop a Case-based Web online application "Nikshay", since May 2012 with components as illustrated in the following diagram: :



NIKSHAY is a web based electronic reporting system has been developed by RNTCP with the support of National Informatic Centre

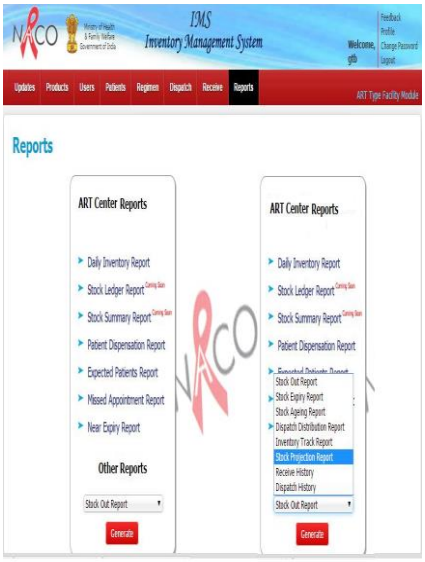
Components	
	Master management
	User details
	TB patients registration & bdetails of diagnosis, DOT provider, HIV status , follow up, contact tracing , outcomes
	Details of solid and liquid culture & DST,LPA,CB-NAAT details
	DR-TB patient registration with details
	Referral and transfer of patients
	Private health facility registration and TB natification
	Mobile application for TB notification
	SMS alerts to patients on registration
	SMS alerts to program officers
	Automated periodic reports
	Case finding
	Sputum conversion
	Treatment outcome
	TU and District level Program management

HIV/TB activities are implemented with close coordination between two national programmes having different reporting systems. Data quality is ensured as the software does not itself generate information and almost all information is digitized from the source which exists in the program; the inherent quality of data of the program is transferred. Transcription errors are checked, Nikshay already has internal validations for most of the variables based on the logic flow and conditionality's. To ensure quality case management, notification of all TB cases including private sector Nikshay is an incremental step to close the gap of missing TB cases in India.

Details of records &reporting regarding RNTCP &PMDT reports please refer RNTCP Training course of program managers and PMDT guidelines ,May 2012.

d: Inventory Management System (IMS)

NACO undertook strenthening of national HIV commodities distribution by designing and deploying the Inventory Management System (IMS) programme across suppliers, state warehouses and 470 CST (also called ART) centres in India. After an extensive pilot in two states from Dec-Feb 2014, NACO decided to implement the solution across the entire supply chain.



In IMS, inventory is tracked starting from the supplier level to dispensations made to patients at POC facility level. Low-cost bar code and web-based technologies have been leveraged to provide a scalable and asset light solotion. NACO continues to refine IMS to accommodate user feedback and is poised to upgrade the existing system to more powerful, versatile and robust system in coming months.

Chapter 5: Monitoring and Evaluation Indicators

5.1: Indicators

An indicator is a variable used to measure progress towards the stated goals, objectives and targets of the programme, allowing managers to assess progress towards benchmarks. It is a specific measure of programme performance that is tracked over time by the monitoring system. The value of an indicator in itself is usually of limited use but rather unexpected values or changes in the indicator suggest the need for further investigation.

- Performance indicators
- Logical framework approach
- Formal surveys
- Rapid appraisal methods
- Impact evaluations etc

Figure below lists standard selection criteria for judging the relevance of specific indicators.

5.2: Categorization of indicators for collaborative TB/HIV activities

The National Framework for HIV TB collaborative activities in India clearly outlines the key set of activities essential for addressing the challenge of HIV- TB.The indicators included in this guide for monitoring and evaluation of implementation of these collaborative activities.

5.2.1: Core indicators for global and national monitoring and reporting

Systematic measurement and reporting of these indicators provide insights into the progress in implementation, coverage of services and impactof collaborative TB/HIV activities. This information can be used in the process of policy development, programme planning, and resource mobilization and allocation. The data elements required for documentation of these indicators should be routinely captured and should be periodically reported to national and state level and consolidated annually for global- and national-level reporting.

5.2.2: Core indicators for only national-level monitoring and reporting

A set of core indicators is required for routine monitoringof implementation of collaborative TB/HIV activities at national level, particularly the quality of care provided.Ongoing monitoring of these indicators is necessary for effective programme management at national, state and facility level, as they help in identification of weaknesses in programme implementation and thusfacilitate improvement. Data required to measure these indicators should be an integral part of management information system of the RNTCP and NACP, and captured systematically on a regular basis.

5.2.3: Additional indicators for use at national level

Additional indicators that facilitate the monitoring of activities that contribute to quality of services, gain efficienciesand avoid duplication of efforts are used at national and State and facility level depending on the local epidemic situation and availability of resources.

Disaggregation by age and sex: To seek information disaggregation by age & sex wherever possible, indicators relating to collaborative TB/HIV activities to be disaggregated by age into adults (aged 15 years and above) and children (aged 0–4 and 5–14 years) and by sex.

5.3: Summary of indicators in addition to the existing indicators in the program:

A. Core global and national indicators

Essential indicators to monitor and report progress at both global and national level include:

A.1 Proportion of registered new and relapse TB patients with documented HIV status
A.2 Proportion of registered new and relapse TB patients with documented HIV-positive status
A.3 Proportion of people living with HIV newly enrolled in HIV care with active TB disease
A.4 Proportion of HIV-positive new and relapse TB patients on ART during TB treatment
A.5 Proportion of people living with HIV newly enrolled in HIV care and screened negative for TB, started on TB preventive therapy
A.6 Mortality among HIV-positive new and relapse TB patients
A.7 Risk of TB among health care workers relative to the general population, adjusted for age and sex

B. Core National Indicators

In addition to the core indicators in section A, the following are also core indicators essential for national-level monitoring and reporting. They have been grouped into various categories

Indicators to measure the cascade of intensified TB case finding

B.1 Proportion of people living with HIV who are screened for TB in HIV care or treatment settings
B.2 Proportion of people living with HIV who are TB symptom screen positive out of those who are screened for TB
B.3 Proportion of people living with HIV who are tested for TB out of those who are symptom screen positive
B.4 Proportion of people living with HIV diagnosed with active TB out of those who are tested
B.5 Proportion of people living with HIV who are started on TB treatment out of those diagnosed as having active TB

Indicators to measure access to TB diagnostic test for people living with HIV

B.6 Proportion of people living with HIV having TB symptoms who receive a rapid molecular test as a first test fordiagnosis of TB
B.7 Proportion of people living with HIV having TB symptoms who receive a TB culture test as a first test fordiagnosis of TB

Indicators to measure access to early ART for HIV-positive TB patients

B.8 Proportion of HIV-positive new and relapse TB patients who are started on ART within 8 weeks of TB diagnosis
B.9 Proportion of HIV-positive new and relapse TB patients having profound immune suppression (CD4 cell count < 50) who are started on ART within 2 weeks of TB diagnosis

Other indicators

B.10 Proportion of HIV-positive new and relapse TB patients detected and notified out of the estimated number ofincident HIV-positive TB cases
B.11 Proportion of HIV-positive new and relapse TB patients who receive co-trimoxazole preventive therapy
B.12 Proportion of health care facilities providing services for people living with HIV that have TB infection control practices
B.13 Proportion of people living with HIV who complete a course of TB preventive therapy

C. Additional Indicators

These are additional indicators that have been grouped into various categories

Indicators for expanded intervention or measurement

C.1 Proportion of presumptive TB patients having documented HIV status
C.2 Proportion of people living with HIV currently in care who are detected as having TB during the reporting period
C.3 Proportion of people living with HIV currently on ART who develop TB disease
C.4 Proportion of people living with HIV in care who ever received a course of TB preventive therapy

Indicators to measure diagnosis and treatment of HIV associated TB in special situations

C.5 Proportion of patients having multidrug-resistant or rifampicin-resistant TB with known HIV status
C.6 Proportion of HIV-positive patients treated for multidrug-resistant or rifampicin-resistant TB who are also on ART
C.7 Proportion of HIV-positive TB patients on protease inhibitor-based ART regimen receiving rifabutin-containing anti-TB treatment

Indicators to measure integration and optimization of services for implementation of collaborative TB/HIV activities

C.8 Proportion of TB basic management units providing HIV testing and counselling services
C.9 Proportion of health facilities providing TB services that also provide ART services
C.10 Proportion of facilities providing TB services that also provide HIV prevention services
C.11 Proportion of HIV care and treatment facilities that also provide TB prevention and care services
C.12 Proportion of maternal and child health care facilities also implementing intensified TB case finding
C.13 Proportion of opioid substitution therapy centres also providing TB and HIV services
C.14 Proportion of prison health centres also providing TB and HIV services
C.15 Proportion of Urban PHC also providing TB and HIV services

Indicators to measure community engagement

C.15 Proportion of NGOs and CBOs that implement TB/HIV activities
C.16 Percentage of new HIV-positive TB patients registered in the basic management unit referred by communityhealth workers and volunteers

5.4: Existing Indiactors TB HIV collaborative activities:

Performance Indicator	Data Source						
State and district-level coordination							
a. Proportion of Districts with at least 2 DCC Meetings over past 4 quarters	RNTCP District PMR Qtrly Report						
Intensified Case Finding							
a. Proportion of ICTC/ART centre reporting on HIV/TB ICF activities *	NACO SIMS						
b. Number of ICTC clients referred to DMC as presumptive TB cases							
c. Number of (b) who are diagnosed with TB							
d. Among (c), number/percentage of diagnosed TB patients put on DOTS							
e. Number of ART clients referred to TB diagnostic facilities as presumptive TB cases							
f. Number of (e) who are diagnosed with TB							
g. Among (f), number/percentage of diagnosed TB patients put on DOTS							
Isoniazid Preventive Treatment (IPT)							
a. Number of ART clients NOT having symptoms suggestive of TB during last visit	NACO IPT monthly report						
b. Number out of (a) assed for eligibility for IPT							
c. Number out of (b) initiated on IPT							
HIV testing of TB patients and HIV care, support and treatment							
a. Number /percentage of presumptive TB cases with known HIV status**	RNTCP PM report						
b. Number /percentage of presumptive TB cases found to be HIV positive**	RNTCP PM report						
c. Number/ percentage of registered new and relapseTB patients with known HIV status	RNTCP CF and SC QtrlyRprts						
d. Number of registered new and relapseTB patients found to be HIV-positive	RNTCP CF QtrlyRprts						
e. Number/ percentage of new and relapseHIV-positiv patients receiving CPT during TB treatment ‡	RNTCP RT QtrlyRprts						
f. Number/ percentage of new and relapseHIV-positive TB patients receiving ART during TB treatment ‡	RNTCP RT QtrlyRprts						
g. Mortality among HIV-positive new and relapse TB patients	RNTCP RT QtrlyRprts						

* "yes" if reports received for past 6 months..** only in high prevalent settings ‡ For previous year's TB patient cohort.

5.5: Core Global and National Indicators for Monitoring and Reporting

Indicator A.1

Proportion of registered new and relapseTB patients with documented HIVstatus

Definition	Number of new and relapse TB patients who had an HIV test result recorded in the TB register expressed as a percentage of the number registered during the reporting period.
Numerator	Number of new and relapse TB patients registered during the reporting period who had an HIV test result recorded in the TB register.
Denominator	Total number of new and relapse TB patients registered in the TB register during the reporting period.
Purpose	To measure the ability of HIV and TB programmes to ensure that the HIV status of TB patients is ascertained.
Rationale	HIV infection rates are higher among TB patients than in the general population. Knowledge of HIV status helps promote safe behaviour, reduce HIV transmission, and improve access to appropriate HIV care and support for TB patients, including early ART. All TB patients with undocumented HIV status should be offered an HIV test, preferably at the time of TB diagnosis and within the same settings where they receive TB care. Alternatively, a well functioning referral system should be in place to ensure counselling, testing and feedback of HIV testing data to the referring TB unit.
Periodicity	Data should be recorded on a daily basis and reported in the quarterly report on TB case registration in the treatment unit (TU).
Source of information	TB registers at the tuberculosis unit, quarterly report on TB case registration.
Responsibility	RNTCP

Indicator A.2

Proportion of registered new and relapse TB patients with documented HIV-positive status

Definition	Number of registered new and relapse TB patients who are found to be HIV-positive expressed as a percentage of the number registered with documented HIV status during the reporting period.
Numerator	Total number of new and relapse TB patients registered during the reporting period who are documented as HIV-positive.
Denominator	Total number of new and relapse TB patients registered during the reporting period having a documented HIV status, positive or negative.
Purpose	To assess the prevalence of HIV among registered TB patients.
Rationale	Measurement of the proportion of HIV-positive TB patients defines a population group eligible for specific interventions aimed at reducing the burden of HIV among TB patients, such as co- trimoxazole preventive therapy and ART, and also provides a denominator for measurement of uptake of these interventions. It also helps in targeting of resources, strategic planning and monitoring the effectiveness of HIV prevention interventions over time. Documented HIV status also influences patient care, for example partner

	testing, referral to support group, and provision of co- trimoxazole preventive therapy and ART.
Periodicity	Data should be recorded on the patient TB treatment card and in the TB register on a daily basis and reported in the quarterly report.
Source of information	TB registers at the TU unit and quarterly report on TB case registration.
Responsibility	RNTCP

Indicator A.3

Proportion of people living with HIV newly enrolled in HIV care with active TB disease

Definition	Total number of people living with HIV having active TB expressed as a percentage of those who are newly enrolled in HIV care (pre-ART or ART) during the reporting period.
Numerator	Total number of persons who have active TB disease during the reporting period out of those newly enrolled in HIV care.
Denominator	Total number of persons newly enrolled in HIV care during the reporting period (pre-ART plus ART).
Purpose	To measures the burden of active TB among people living with HIV who are newly enrolled in HIV care. It also indirectly measures the extent of effort to detect HIV-associated TB early.
Rationale	The primary aim of intensified TB case finding in HIV care settings and provider-initiated HIV testing and counselling in TB patients is early detection of HIV-associated TB and prompt provision of ART and TB treatment.
Periodicity	Data should be recorded on a daily basis and reported to national or sub national level as part of routine reporting.
Source of information	Pre-ART and ART register, RNTCP lab register / CBNAAT records
Responsibility	NACP

Indicator A.4

Proportion of HIV-positive new and relapse TB patients on ART during TB treatment

Definition	Number of HIV-positive new and relapse TB patients who receive ART during TB treatment expressed as a percentage of those registered during the reporting period.
Numerator	Total number of HIV-positive new and relapse TB patients started on TB treatment during the reporting period who are already on ART or started on ART during TB treatment.
Denominator	Total number of HIV-positive new and relapse TB patients registered during the reporting period.
Purpose	To measure the extent to which HIV-positive TB patients receive ART

	during TB treatment.#
Rationale	Prompt TB treatment and early ART are critical for reducing the mortality due to HIV-associated TB and must be the highest-priority activity for both the NACP and RNTCP.
Periodicity	Data should be recorded on a daily basis and reported in the quarterly report on TB case findings.
Source of information	TB register at the tuberculosis unit, Pre-ART register and ART register.
Responsibility	In countries having national web-based data systems with individual case records routinely updated by health facilities, data may be accessible to all concerned simultaneously, thus providing complete data. In the absence of an electronic medical recording system the RNTCP and NACP should jointly ensure complete recording and reporting of the data for this indicator.

Indicator A.5

Proportion of people living with HIV newly enrolled in HIV care started on preventive therapy

Definition	Number of patients who are started on treatment for latent TB infection expressed as a percentage of the total number newly enrolled in HIV care during the reporting period.
Numerator	Total number of people living with HIV newly enrolled in HIV care who are started on treatment for latent TB infection during the reporting period.
Denominator	Total number of persons newly enrolled in HIV care, that is, registered in the pre-ART or ART register during the reporting period.
Purpose	To measure the extent to which people living with HIV newly registered in HIV care are started on the treatment for latent TB infection.
Rationale	All persons in HIV care should be screened for TB at every visit using a clinical algorithm recommended by WHO. Adults and adolescents living with HIV who do not report any one of the symptoms of current cough, fever, weight loss or night sweats are unlikely to have active TB and should be offered TB preventive therapy, that is, treatment for latent TB infection. Similarly, children who do not have poor weight gain, fever or current cough should be offered this therapy to reduce the risk of developing active TB, both in persons on ART and without ART.
Periodicity	Data should be recorded on a daily basis and reported quarterly to the national or subnational level.
Source of information	Patient ART white card, pre-ART register, ART register.
Responsibility	NACP.

Indicator A.6

Mortality among HIV-positive new and relapse TB patients

Definition	Number of deaths among documented HIV-positive new and relapse TB patients expressed as a percentage of those registered during the reporting period.
Numerator	Total number of HIV-positive new and relapse TB patients who died before the start or during the course of TB treatment.
Denominator	Total number of HIV-positive new and relapse TB patients registered during the reporting period.
Purpose	To measure the impact of collaborative TB/HIV activities on mortality due to HIV-associated TB.
Rationale	Mortality among HIV-positive TB patients is significantly higher than among HIV-negative TB patients. The risk of death is higher if HIV-associated TB is detected late or treatment is delayed. To minimize this risk, close collaboration between the NTP and NACP is necessary for provision of optimal clinical care in the form of early diagnosis and prompt treatment of both HIV and TB.
Periodicity	Data should be recorded on a daily basis and reported quarterly to the national or subnational level in the quarterly report on TB treatment outcomes in the basic management unit and annually to WHO.
Source of information	TB register maintained at the tuberculosis unit.
Responsibility	RNTCP

Indicator A.7

Risk of TB among health care workers relative to the general population, adjusted for age and sex

Definition	The relative risk of developing TB disease among health care workers employed in facilities providing care for TB or HIV expressed as a ratio of the TB case notification rate among health care workers to the TB notification rate in the general population during the same period, adjusted for age and sex if appropriate.
Numerator	The TB notification rate among health care workers, that is, the total number of TB patients registered among health care workers per unit number of health care workers in the reporting unit during the reporting period.
Denominator	The TB notification rate in the general adult population, that is, the total number of TB patients registered per unit number of adult population in the reporting unit during the reporting period.
Purpose	To estimate the relative risk of developing TB among health care workers compared to the general population, providing an indirect measure of the impact of TB infection control activities implemented in health care

	facilities.
Rationale	Health care workers share the background risk of TB in the population. Additionally, due to involvement in patient care, their exposure to infectious TB is higher than for the general population. If TB infection control measures are effectively implemented in health care facilities, exposure can be minimized and the risk of acquiring TB reduced, and the relative risk of TB disease would be close to 1.
Periodicity	Data should be collected continuously and reported annually to the national and subnational level.
Source of information	Hospitals / PHI health records, TB register at the tuberculosis unit.
Responsibility	RNTCP.

5.6: Core indicators for only national-level monitoring and reporting

No.	Indicator	Numerator	Denominator	Purpose	Rationale, methodology, Information source & Responsibility	Periodicity
Indicators to measure the cascade of intensified case findings						
B.1	Proportion of people living with HIV in care (including PMTCT) who were screened for TB at 1.ICTC/FICTC 2.ART 3.TI settings 4.CSCs	Number of persons enrolled in HIV care whose TB status was assessed and recorded at their last visit during the reporting period	Total number of persons enrolled in HIV care and seen for care during the reporting period	To assess the extent of implementation of the recommendation to screen all people living with HIV in care for presence of TB symptoms at every visit to HIV care and treatment facilities	**Rationale**: Intensified TB case finding should be implemented at all HIV care and treatment facilities and TB status of people living with HIV should be assessed at every visit during the reporting period. It is also important to monitor implementation of the entire cascade of care, starting from symptom screening to diagnosis and treatment of TB. **Source of information and**	Online Monthly reporting
B.2	Proportion of people living with HIV who are TB symptom screen positive out of those who are screened for TB	Total number of people living with HIV found to have anyone of the symptoms suggestive of TB	Total number of people living with HIV who were screened for presence of TB symptoms during their last visit to HIV care or treatment facility	To assess the effectiveness of mechanisms established by the NACP and NTP to ensure that all people living with HIV presenting to HIV care and treatment facilities are screened for TB, undergo investigation if found to have symptoms and receive treatment if found to have TB. These indicators help assess the quality of TB screening and strength of the referral linkages between the NACP and NTP		
B.3	Proportion of people living with HIV who are tested for TB out of those who are symptom screen positive	Total number of people living with HIV who are investigated for TB	Total number of people living with HIV who were TB symptom screen positive during the reporting period			
B.4	Proportion of people living with	Total number of people living	Total number of people living with			

	HIV diagnosed with active TB out of those who are tested	with HIV diagnosed as having active TB	HIV investigated for presence of active TB during the reporting period		**responsibility**: SIMS and routine reporting system NACP	
B.5	Proportion of people living with HIV who are started on TB treatment out of those diagnosed as having active TB	Total number of people living with HIV started on TB treatment and registered in the TB register	Total number of people living with HIV diagnosed to have active TB through intensified TB case finding			

No.	**Indicator**	**Numerator**	**Denominator**	**Purpose**	**Rationale, methodology, Information source & Responsibility**	**Periodicity**
Indicators to measure access to TB diagnostic tests for people living with HIV						
B.6	Proportion of people living with HIV having TB symptoms who receive a rapid molecular test (e.g. CBNAAT) as a first test for diagnosis of TB	Total number of people living with HIV having TB symptoms who were investigated using a rapid molecular test (e.g. CBNAAT) as a first test	Total number of people living with HIV having TB symptoms identified through intensified case finding at HIV care and treatment facilities during the reporting	To assess the extent of access to rapid molecular tests as a first test for diagnosis of TB among people living with HIV; alternatively, access to	**Rationale**: Sputum microscopy has low sensitivity for diagnosis of TB among people living with HIV. WHO recommends use of CBNAAT as the initial diagnostic test for TB among people living with HIV, as it is more sensitive and specific for diagnosis of pulmonary TB than the conventional sputum microscopy. Therefore people living with HIV having presumed TB should have access to facilities using rapid molecular tests such as CBNNAT or liquid culture facilities.	Information should be collected quarterly and maintained at national and subnational level to monitor the progress

B.7	Proportion of people living with HIV having TB who receive a TB culture test as a first test for diagnosis of TB	Total number of people living with HIV having TB symptoms who were investigated using LPA/liquid TB culture as a first test	period	LPA/liquid TB culture may be measured	**Methodology:** The RNTCP should ensure that laboratory recording and reporting tools recommended by WHO are used and information of culture tests among people living with HIV having presumed TB is systematically recorded. *(10)* The NACP and RNTCP should maintain an inventory of HIV care and treatment centres having access to Xpert or liquid culture facilities. Countries are encouraged to establish a mechanism for consolidation and reporting of this information to national and subnational level regularly. **Source of information:** CBNAAT register /C&DST resister *(10)*. Responsibility: RNTCP CBNAAT and culture facilities exist.	

No.	Indicator	Numerator	Denominator	Purpose	Rationale, methodology, Information source & Responsibility	Periodicity
Indicators to measure access to early ART for HIV positive TB patients						
B.8	Proportion of HIV-positive new and relapse TB patients who are started on ART within 8 weeks of TB diagnosis	Total number of HIV- positive new and relapse TB patients started on ART within 8 weeks of TB diagnosis	Total number of HIV-positive new and relapse TB patients detected during the reporting period	To assess timeliness of ART initiation after TB diagnosis among HIV-positive persons	**Rationale:** ART greatly improves survival and quality of life of TB patients living with HIV. While TB treatment should be started immediately, preferably the same day as TB diagnosis, ART should be started within 8 weeks of TB diagnosis. **Responsibility**: NACP and R N TCP.	Information should be collected quarterly

No.	Indicator	Numerator	Denominator	Purpose	Rationale, methodology, Information source & Responsibility	Periodicity
Indicators to measure access to TB diagnostic tests for people living with HIV						
B.9	Proportion of HIV-positive new and relapse TB patients having profound im-munosuppres-sion (CD4 cell count < 50) who are started on ART within 2 weeks of TB	Total number of HIV-positive new and relapse TB patients having CD4 counts less than 50 cells per cubic millimetre who are started on	Total number of HIV- positive new and relapse TB patients detected during the reporting period having CD4 counts less than 50 cells per cubic millimetre	To assess timeliness of ART initiation after TB diagnosis among HIV-positive persons	**Rationale:** Initiation of ART within 2 weeks of starting TB treatment is life saving for patients with profound immunosuppression. However, CD4 testing should not be a barrier for early ART. Responsibility: NACP and R NTCP.	Data should be collected on a daily basis and reported to national or state level as a part routine reporting

	diagnosis	ART within 2 weeks of TB diagnosis				
Other indicators						
B.10	Proportion of HIV-positive new and relapse TB patients detected and notified out of the estimated number of incident HIV-positive TB cases	Total number of HIV- positive new and relapse TB patients registered during the reporting period	Estimated number of incident TB cases among people living with HIV (with low and high uncertainty bounds)	To assess the efforts for TB case finding among people living with HIV undertaken by the NACP and NTP	**Rationale:** This indicator helps evaluation of TB case finding efforts, which involves provider-initiated HIV testing and counselling among TB patients, intensified TB case finding at all HIV care and treatment facilities at every patient visit, optimal access to services for key populations such as drug users, sex workers and prisoners, and strong linkages between the NACP and R NTCP. Methodology: **Responsibility:** RNTCP and NACP.	Data for numerator should be collected on a daily basis at the facility level but aggregated annually at national level and reported to WHO using most recent available estimates for denominator

No.	Indicator	Numerator	Denominator	Purpose	Rationale, methodology, Information source & Responsibility	Periodicity
B.11	Proportion of HIV-positive new and relapse TB patients who receive co-trimoxazole preventive therapy	Number of HIV-positive new and relapse TB patients registered during the reporting period who are started or continued on co-trimoxazole preventive therapy during TB treatment	Total number of HIV- positive new and relapse TB patients registered during the reporting period	To measure the capacity of the NTP and NACP to provide co-trimoxazole preventive therapy to HIV-positive TB patients	**Rationale:** Co-trimoxazole preventive therapy reduces morbidity and mortality among HIV-positive TB patients. It should be provided immediately to all HIV-positive TB patients irrespective of CD4 count and may be stopped when CD4 counts are higher than 350 or 500 cells per cubic millimetre, depending on national policy. **Source of information:** TB register at the Tuberculosis unit. **Responsibility:** RNTCP.	Data should be collected on a daily basis and reported in quarterly report

No.	Indicator	Numerator	Denominator	Purpose	Rationale, methodology, Information source & Responsibility	Periodicity
B.12	Proportion of health care facilities providing services for people living with	Number of health care facilities having "demonstrable" TB infection control prac-	Total number of health care facilities evaluated for TB infection control practices during the	To assess the extent o implementat on of TB infection control practices at HIV and	**Rationale:** All health care facilities in general should have a TB infection control policy. While it is critical to implement it in all health facilities in countries having high HIV prevalence, as in sub-Saharan Africa, it should be implemented at least in HIV and TB care facilities in countries having low or concentrated HIV epidemics. Demonstrable minimum TB-infection control	Data should be collected and analysed annually

	HIV (including PMTCT) that have TB infection control practices	tices that are consistent with international guidelines	reporting period	TB care and treatment facilities	measures consistent with international guidelines include: 1. a written infection control plan; 2. a designated person responsible for implementing infection control practices; 3. well ventilated waiting area (e.g. windows and doors open) and clear display of messages on cough hygiene; 4. patients with presumptive TB identified on arrival at the facility and separated from other patients to be fast-tracked through all waiting areas, including consultation, investigations and drug collection; 5. TB symptoms occurring among health care workers are immediately investigated and, if diagnosed with TB, treated, registered and reported. **Source of information:** AIC assessment reports **Responsibility:** NACP and R N TCP.	
B.13	Proportion of people living with HIV who complete the course of ISONAIZID preventive therapy	Total number of persons who completed the course of treatment for latent TB infection during the reporting period	Total number of persons in HIV care who were newly started on treatment for latent TB infection 12 to 15 month earlier	To assess the adherence of people living with HIV during the course of TB preventive therapy	**Rationale:** Regular and complete treatment of latent TB infection is necessary for protection against development of active TB among people living with HIV. **Source of information**: Pre-ART and ART registers **Responsibility:** NACP.	Data should be collected on a daily basis but reported quarterly to State & national state level

5.7: Optional indicators for national-level monitoring and reporting

No.	Indicator	Numerator	Denominator	Purpose	Rationale, Information source & Responsibility	Periodicity
Indicators for expanded intervention or measurement						
C.1	Proportion of presumptive TB patients having documented HIV status	Total number of presumptive TB patients who have a documented HIV test result	Total number of presumptive TB patients who are investigated for TB during the reporting period	To enhance detection of HIV-infected individuals and early detection of HIV- positive TB patients	**Rationale**: A large proportion of people living with HIV are unaware of their HIV status. HIV testing among presumptive TB cases offers an entry point to the continuum of HIV prevention, care, support and treatment. **Source of information**: Laboratory register /CBNAAT register, **Responsibility:** R NTCP.	Data should be recorded on a daily basis and may be reported quarterly

No.	Indicator	Numerator	Denominator	Purpose	Rationale, Information source & Responsibility	Periodicity
C.2	Proportion of people living with HIV currently in care who are detected as having TB during the reporting period	Total number of HIV-positive TB patients registered during the reporting period	Total number of persons enrolled in HIV care (pre-ART and ART) during the reporting period	To measure the overall burden of TB among the people living with HIV currently in HIV care. While the global indicator A.3 measures burden of TB among people living with HIV who are newly	**Rationale:** In well performing programmes review of this indicator over a period of time will indicate the impact of collaborative TB/HIV activities on the disease burden. **Source of information:** TB register at Tuberculosis unit, pre-ART and ART registers. **Responsibility:** R NTCP and NACP.	Data should be collected on a daily basis and may be reported quarterly to national or subnational level

				enrolled in HIV care, this indicator measures the overall burden.		
C.3	Proportion of people living with HIV currently on ART who develop TB disease	Total number of people living with HIV currently on ART who develop active TB disease during the reporting period	Total number of people living with HIV enrolled in HIV care who are currently on ART	To measure the burden of active TB among people living with HIV while on ART. It indirectly measures the extent of TB transmission among people living with HIV while they are on ART	**Rationale:** People living with HIV have a higher baseline risk of acquiring TB than HIV-negative persons. ART reduces this risk significantly, though it remains higher than HIV-negative persons. In high TB and HIV settings this risk increases due to ongoing transmission. Early identification of TB, prompt initiation of ART, TB infection control in health facilities and treatment of latent TB infection can help reduce the risk. A stable or increasing proportion of people living with HIV developing active TB while on ART, over a period of time, points to weak implementation of these interventions. **Source of information**: ART register, TB register at the basic management unit. **Responsibility:** NACP.	Data should be collected on a daily basis and may be reported quarterly to national or subnational level
C.4	Proportion of people living with HIV in care who ever received a course of TB preventive therapy	Total number of persons who received at least one complete course of treatment for latent TB infection ever, by the end of the reporting period	Total number of persons currently in HIV care at the end of the reporting period	To assess the overall coverage of TB preventive therapy among people living with HIV in care	**Rationale:** A high level of coverage of both ART and TB preventive therapy minimizes the risk of incident TB among people living with HIV and hence reduces mortality. **Source of information:** Pre-ART and ART register, **Responsibility:** NACP & RNTCP	Data should be collected routinely and be reported to State & National level

No.	Indicator	Numerator	Denominator	Purpose	Rationale, Information source & Responsibility	Periodicity
Indicators to measure diagnosis and treatment of HIV associated TB in special situations						
C.5	Proportion of patients having multidrug-resistant or rifampicin-resistant TB with documented HIV status	Total number of multidrug-resistant and rifampicin-resistant TB patients having documented HIV status	Total number of multidrug-resistant and rifampicin-resistant TB patients registered during the reporting period	To assess the extent of provider-initiated HIV testing and counselling among patients with multidrug-resistant or rifampicin-resistant TB	**Rationale:** HIV-associated multidrug-resistant or rifampicin-resistant TB has very high mortality if undetected. The knowledge of HIV status helps promote safe behaviour and reduce HIV transmission. It also facilitates prompt HIV care and support, including early ART. **Source of information:** DR TB treatment card and register register. **Responsibility:** RNTCP	Data should be collected routinely and be reported to State & National level
C.6	Proportion of HIV-positive patients treated for multidrug-resistant or rifampicin-resistant TB who are also on ART	Total number of HIV-positive multidrug-resistant and rifampicin-resistant TB patients who are on second-line TB treatment and newly started or already on ART	Total number of HIV-positive multidrug-resistant and rifampicin-resistant TB patients registered during the reporting period	To measure the extent to which HIV-positive multidrug-resistant and rifampicin-resistant TB patients on second-line TB treatment are also on ART	**Rationale:** Prompt treatment for multidrug-resistant or rifampicin-resistant TB and early ART, both are critical to reduce mortality due to HIV-associated multidrug-resistant or rifampicin-resistant TB. **Source of information:** DRTB treatment card and register, pre-ART and ART registers. **Responsibility:** NACP and R NTCP.	

C.7	Proportion of HIV-positive TB patients on protease inhibitor-based ART regimen receiving rifabutin-containing anti-TB treatment	Number of HIV-positive TB patients on protease inhibitor- based ART who received rifabutin-containing anti-TB treatment regimen	Total number of people living with HIV on protease inhibitor-based ART who are diagnosed as having active TB during the reporting period	To assess the extent of use of rifabutin in HIV-positive TB patients receiving protease inhibitor- based ART regimen	**Rationale:** Rifamycins in general are potent inducers of cytochrome P450 enzymes, which also metabolize protease inhibitors. When used together, they may render subclinical doses for protease inhibitors and cause drug resistance. But rifabutin is a less potent inducer of cytochrome P450 enzymes than other rifamycins and hence is recommended in place of rifampicin *(11)*. **Source of information:** COE and RNTCP TB and Drug record Documenting patients requiring Rifabutin **Responsibility:** NACP.	Data should be collected routinely and be reported to State & National level

No.	Indicator	Numerator	Denominator	Purpose	Rationale, Information source & Responsibility	Periodicity
Indicators to measure integration and optimization of services for implementation of HIV/TB collaborative activities						
C.8	Proportion of TB diagnostic facilities (with HIV testing and counselling services within the facility	Number of of TB diagnostic facilities (with HIV testing and counselling services within the facility	Total number of colocated (within single facility) DMC &ICTC existing during the reporting period	To assess the extent of access to HIV testing and counselling services for TB patients	**Rationale:**. Access c to diagnostic services an be improved if HIV testing and counselling services are integrated into existing TB or general health facilities.Source of information: List of DMC with integrated HIV testing and counselling services In the same facility. Responsibility: NACP and RNTCP.	Reported quarterly to the national and subnational level. Facility mapping may be undertaken annually, along witha review of progress
C.9	Proportion of health facilities providing TB & also provide ART services	Number of health facilities providing TB & ART services (ART initiation and management)	Total number of health facilities providing TB services during the reporting period	To assess the extent of integration of ART services within TB care settings	**Rationale:** HIV clinical services including ART initiation and management can be provided through stand-alone ART facilities or by integration of the services into general health or TB facilities. The NACP and NTP promotes such integration (facilities where patients receive both ART and TB treatment services)to enhance access. **Source of information:** List of facilities with integrated TB and ART services. **Responsibility**: NACP and RNTCP	Data may be reported routinely at national and state level through the existing Mechanism

C.10	Proportion of facilities providing TB services that also provide HIV prevention services	Total number of health facilities providing TB services found to be equipped to provide HIV prevention services	Total number of health facilities providing TB services that are evaluated for availability of HIV prevention services	To assess the extent of access of HIV prevention services to TB patients	**Rationale:** In high TB and HIV burden settings, TB services offer a platform for provision of HIV prevention services to TB patients. These facilities are deemed to be equipped for provision of prevention services if the following services are available (decision based on local HIV epidemic and national guidelines): 1. availability of condom box and promotion of male and female condoms; 2. screening and treatment for sexually transmitted infections; 3. promotion of safe sex practices among high-risk groups; 4. safe needle exchange services for people who inject drugs; **Source of information**: List of TB facilities providing HIV prevention services. **Responsibility:** NACP and RNTCP.	Data may be reported routinely at national and state level through the existing Mechanism
No.	**Indicator**	**Numerator**	**Denominator**	**Purpose**	**Rationale, Information source & Responsibility**	**Periodicity**
C.11	Proportion of HIV care and treatment facilities (including PMTCT) that also provide TB prevention and care services	Number of HIV care and treatment facilities having at least one member of staff capacitated to provide TB symptom screening, provision of TB preventive therapy and anti- TB treatment	Total number of HIV care or treatment facilities existing during the reporting period	To assess the extent of implementation of TB prevention and care services within HIV care and treatment settings	**Rationale:** The WHO-recommended 3I's (Intensified TB case finding, Isoniazid preventive therapy and Infection control for TB) should be implemented routinely at all HIV care and treatment facilities to minimize burden of TB among people living with HIV. **Source of information:** List of staff at HIV care facilities who are trained in the 3I's. **Responsibility:** NACP and RNTCP.	Data may be reported routinely at national and state level through the existing Mechanism

C.12	Proportion of maternal and child health care facilities also implementing intensified TB case finding	Total number of maternal and child health care facilities implementing intensified TB case finding	Total number of maternal and child health sites (antenatal care, maternity, postpartum clinics, family planning clinics, well child and sick child clinics) existing during the reporting period	To assess the extent of integration of intensified TB case finding activities within maternal and child health care settings	**Rationale:** TB in HIV-positive pregnant women is associated with adverse pregnancy outcomes and higher maternal and child mortality. It also increases the risk of mother-to-child transmission of HIV. Provider-initiated HIV testing and counselling and intensified TB case finding should be implemented in maternal and child health settings for early detection of HIV-associated TB. Children, especially those exposed to HIV or TB, should also be systematically screened. Source of information: PPTCT ,Antenatal, postnatal and child care register. Responsibility: NACP PPTCT, RNTCP and maternal, neonatal and child health programme.	Data may be reported routinely at national and state level through the existing Mechanism
C.13	Proportion of opioid substitution therapy centres also providing TB and HIV Services	Number of centres having at least one member of staff capacitated to undertake intensified TB case finding and treatment and HIV testing and counselling	Total number of opioid substitution therapy centres existing during the reporting period	To assess the extent of integration of intensified TB case finding and HIV testing and counselling services in settings having populations vulnerable for both TB and HIV	**Rationale:** Prisons are known to have high burden of both TB and HIV. Similarly, injection drug users are more vulnerable to HIV infection and hence TB. The health facilities catering to these populations should be equipped to implement TB/HIV interventions through training of staff, linkages with diagnosis and treatment services, and other measures. The NACP and RNTCP should include these populations as priority groups for programme implementation. **Source of information**: Existing health records Of the facilities and NACP RNTCP TB/HIV Records **Responsibility:** NACP and RNTCP.	Data may be reported routinely at national and state level through the existing Mechanism

C.14	Proportion of prison health centres also providing TB and HIV services		Total number of prison health centres existing during the reporting period			Data may be reported routinely at national and state level through the existing Mechanism
Indicators to measure community measurement						
C.15	Proportion of NGOs and CBOs that implement TB/ HIV activities	Total number of NGOs and CBOs implementing TB/HIV activities	Total number of NGOs and CBOs with the potential to implement or integrate TB/ HIV services into their ongoing work, which existed during the reporting period	To measure the extent of engagement of NACP and NTP with NGOs and CBOs in implementation of TB/ HIV activities	Rationale: NGOs and CBOs provide services to communities that have limited access to TB and HIV services. The NACP and RNTCP should identify such key stakeholders (existing and potential) for community-based TB/HIV activities, and the existing community-based structures best suited to implementation of TB/HIV activities. They should also assess the capacity of existing NGOs and CBOs to use these structures and make systematic efforts to engage with them. Source of information: Tools developed by NGOs and CBOs in consultation with NACP and RNTCP. Responsibility: NACP and RNTCP	Data may be reported routinely at national and state level through the existing Mechanism
C.16	Percentage of new HIV-positive TB patients registered in the TU referred by community health workers and volunteers	Number of registered new HIV-positive TB patients who were referred by community health workers or volunteers to the health facilities for TB diagnosis or HIV testing	Total number of new HIV-positive TB patients registered in the basic management unit during the reporting period	To measure the contribution of community health workers and volunteers in detection of new HIV-positive TB patients	Rationale: Community health workers and volunteers who are systematically sensitized about TB prevention and care by NGOs and CBOs should refer TB symptom-positive persons for TB investigation and HIV testing to a health facility. Source of information: Refferal register, TB laboratory register, TB register. Responsibility: RNTCP.	Data may be reported routinely at national and state level through the existing Mechanism

REFERENCES:

1. National Framework for Joint HIV/TB Collaborative Activities; National AIDS Control Organisation; Ministry of Health and Family Welfare, Government of India, November 2013.
2. Supervision and Monitoring Strategy in Revised National Tuberculosis Control Program, Ministry of Health and Family Welfare, Government of India, March 2015.
3. Training course of program managers Program supervision and evaluation: Revised National TB Control Program ; Central TB Division, Ministry of Health and Family Welfare, Government of India April 2011.
4. A guide to monitoring and evaluation for collaborative TB/HIV activities – 2009 revision. World Health Organization,United States President's Emergency Plan for Aids Relief & The Joint United Nations Programme on HIV/AIDS
5. A guide to monitoring and evaluation for collaborative TB/HIV activities - 2015 revision, World Health Organization, PEPFAR, United States President's Emergency Plan for Aids Relief & Global Fund
6. HIV Sentinel Surveillance operational manual for ANC &STD sentinel sites: National AIDS Control Organisation; Ministry of Health and Family Welfare, Government of India 2012-13
7. Definitions and reporting framework for tuberculosis revisions; World Health Organization; 2013 revision.
8. Integrated Training Module for HIV/TB Collaborative Activities; National AIDS Control Organisation; Ministry of Health and Family Welfare, Government of India 2015
9. WHO policy on collaborative TB/HIVactivities: guidelines for national programmes and other stakeholders.Geneva: World Health Organization; 2012 (http://www.who.int/tb/publications/2012/tb_hiv_policy_9789241503006/en/).
10. PMDT Guidelines , Ministry of Health and Family Welfare, Government of India May 2012
11. Annual Report: National AIDS Control Organisation; Ministry of Health and Family Welfare, Government of India 2014
12. Annual Status Report, TB India , Revised National TB Control Programme; Ministry of Health and Family Welfare, Government of India 2014
13. Airborne Infection Control guidelines; Ministry of Health and Family Welfare, Government of India 2010

ANNEXURES:

Annexure 1: Supervisory staff Protocol for TB HIV Collaborative activities

Annexure 2 : Program Supervision tool in TB-HIV at State Level

Annexure 3: Supervisory Checklist for Designated Microscopic Centre (DMC)

Annexure 4 : Supervisory Checklist for ICTC

Annexure 5 : Supervisory Checklist at ART Centres

Annexure 6: *3 I Project Supervisory check list and reporting form

Annexure 7 : Supervisory Report format

Annexure 8.:National TB HIV Coordination Committee (NTCC)

Annexure 9: National Technical Working Group On TB-HIV Collaborative Activities (NTWG)

Annexure 10: State TB-HIV Co-ordination Committee (SCC)

Annexure 11: State HIV/TB Working Group (SWG)

Annexure 12: District Coordination Committee

Annexure 13: Generic Agenda Items for monthly HIV/TB coordination meeting

Annexure 14: Review meeting checklist for State and district level TB-HIV collaboration for use by PD SACS/DAPCU

Annexure 15 Review checklist for TB-HIV activities at state level

Annexure 16: Review meeting checklist for district level TB-HIV collaboration for use by DAPCU

Annexure 17: Monitoring tools for HIV/TB State level

Annexure 18: Monitoring Tool for HIV-TB collaborative activity (SIMS)

Annexure 19: Monitoring Tools for HIV/TB (NIKSHAY)

Annexure 20: DAPCU Monthly Report Part A

Annexure 21: DAPCU Monthly Report Part B

Annexure 22: Monitoring tool – ICTC

Annexure 23: Monitoring tool – FICTC

Annexure 24: Monitoring tool - TI NGO

Annexure 25: HIV- TB monitoring indicators and reporting mechanism at CSC level

Annexure 26: Monitoring tool - Care and Support Centre (CSC)

Annexure 27: Monitoring tool - OST centre

Annexure 28: ART Centre Airborne Infection Risk Assessment Tool

Annexure 29: Health Care Facility Airborne Infection Risk Assessment Tool

Annexure 30: Internal Evaluation Formats

Annexure 30.1: Form 1: Review of TU reports and TB registers

Annexure 30.2: Form 2 a: Data collection at the State level

Annexure 30.3: Form 2b : Data collection at the district level

Annexure 30.4: Form3 : Data collection at the DMC level

Annexure 30.5: Form 4: Data collection at the DOT Centre

Annexure 30.6: Form 5a NSP DMC

Annexure 30.7: Form 5 b-S+ RT DMC

Annexure 30.8: Form 5c DR-TB

Annexure 30.9: Form 7: Form for observations at the TU Drug store

Annexure 30.10: Form 8: for review of the Medical College during Internal Evaluation

Annexure 31 : Central Level Internal Evaluation Format

Annexure 31.1: State Level

Annexure 31.2: District level

Annexure 32: Quarterly report on TB case registration in the tuberculosis unit (TU)

Annexure 33: ICTC HIV-TB Collaboration Activity Register

Annexure 34: ICTC Positive Line list for General Client

Annexure 35 : Monthly Input Formats for Integrated Counseling and Testing Centres (ICTC)

Annexure 36 : Monthly HIV TB Report at Integrated Counseling and Testing Centres (ICTC)

Annexure 37: HIV-TB Line list for 3I Project ART sites

Annexure 38: HIV-TB Register for 3I Project ART sites

Annexure 39: HIV-TB Intensified TB Case Finding ICF 3I Project ART Monthly report

Annexure 1: Supervisory staff Protocol for TB HIV Collaborative activities:

S.NO.	**Levels**	**Category off Supervisor**	**Field visits (No. of days/month)**	**Objective**	**Facilities to be visited**	**Patients visits***
1	National	Officials from Ministry of Health & FW , GOI	TB/HIV inclusive as a supervisory agenda in their routine field visits for supervision	Supervision of TB-HIV Collaborative activities	State TB Cell, SACS,DTC,TUs, DMCs, PHIs, DOT Centre, Drug Store, DRTB Site, ICTC Centre, , ART Centre,CSC,DACPU Wherever existing	As required
2		Program Managers and Nodal officers for HIV and TB	At least 2 per quarter			
3		Central Internal Evaluation	As per RNTCP guidelines	Evaluation of Programme Performance including all aspects such as data validation etc..		As per protocol
5		NACO and CTD	One state per quarter	Joint Supervision of TB-HIV Collaborative activities		At least 3 patients per visit

S.NO.	Levels	Category of Supervisor	Field visits (No. of days/month)	Objective	Facilities to be visited	Patients visits*
6	State	Officials from Ministry of Health & FW , GOI, State and State Health Society	TB/HIV inclusive as a supervisory agenda in their routine field visits for supervision	Supervision of TB-HIV Collaborative activities	DTC,DAPCU (if existing)TUs, DMCs, PHIs, DOT Centre, Drug Store, DRTB Site, ICTC Centre, , ART Centre,CSC As per protocol	As required
7		STO,State TB HIV Coordinators ,SACS program officials /STDC offices)	As per RNTCP guidelines	Supervision of HIV- TB activities. Cover all districts in the State every 6 month		At least 3 patient per visit
8		State internal Evaluation	As per RNTCP guidelines	Evaluation of Programme Performance including all aspects such as data validation etc..		As per protocol
10		Joint Visit by SACS and STC officials	Two district per quarter	Supervision of TB-HIV Collaborative activities	DTC,DAPCU (if existing)TUs, DMCs, PHIs, DOT Centre, Drug Store, DRTB Site, ICTC Centre, , ART Centre,CSC	At least 3 patient per visit

11	District	District Health Society Members (District Magistrate, CMHO and other District Officials)	HIV TB inclusive as a supervisory agenda in their routine field visits for supervision	Supervision of Programme		As required
12		DTO, District AIDS Control officers.(DNO)/DAPCU		Supervision of Programme Cover all TU every month and HIV TB diagnostic facilities every quarter	NGO and PP health facilities	As required
15	District	DR TB-HIV Supervisor	as per RNTCP guidelines	Supervision of HIV TB Progamme activities including likage for DRTB services		2-3 patients every visits (co-infected or MDR-TB patient)
14	PHC Level	MO-PHI		Supervision of HIV TB activities at all Sub-centre every month	DMC,ICTC,CSCs within PHC, DOT Centres,PPs	At least 3 patients per visit

S.NO.	Levels	Category of Supervisor	Field visits (No. of days/month)	Objective	Facilities to be visited	Patients visits*
16	Sub-District Sub-District Sub-District	STS	As per RNTCP guidelines 18-20 days per month 18-20 days 5-7 days	Supervision of HIV TB collaborative activities	DMC,ICTC,F-ICTC,Non-DMC PHI , ART Centre (if present in TU) LAC,DOT Centres ,NGO and PP heath facilities	As per RNTCP guidelines
17		STLS		Supervision of programme cover all DMC at least twice a month		
13		Block Medical Officer/MOTC & HIV	TB HIV inclusive as a supervisory agenda in their routine field visits for supervision	Supervision of Programme Cover all TU every month and HIV TB diagnostics facilities every quarter		At least 3 patient per visit
18	Sub-PHC level	PHI Level Supervisors (MPHS)		Supervision of HIV TB programme activities	DMC; DOT Centres	Patient visits as per NHM activities

***Patient to be visited with consent and ensuring confidentiality, no stigma & discrimination policy*.**

Reiterate to patient that *"the given information, shall be kept absolutely confidential and will be used for the introducing appropriate interventions for the strengthening the implementation of TB/HIV services. Anonymity will be maintained and willingness to answer the questions is highly appreciated please."*

Interview to assess HIV counselling and testing services, knowledge of HIV status, awareness of risk associated with TB/HIV co-infection , CPT & ART linkages, quality services & any other qualitative inputs at HIV/TB settings.

Annexure 2 : Program Supervision tool in TB-HIV at State Level:

A. Politico-administrative aspects:

S.No.	Check Points	Observations
Review of Resources		
1	Is there full time STO in place?	
2	Is STO trained at National level?	
3	Is State TB HIV coordinator in place and trained at the National level?	
4	Is there full time trained DTOs in the districts? Proportion of full time DTOs trained at the National level.	
5	Are the state level programme review meetings held regularly? No held in last one year.	
6	Is PS/ MD NHM reviewing the meeting? Number of State level review meetings of DTOs in a year chaired by PS-Health/ MD-NHM.	
7	Is the state level review meetings participated by APD SACS or JD-CST, SACS?	
8	Is State Coordination committee (TB HIV) meeting held regularly under the chair of PS, Health? No. held in last one year.	
9	Is State Technical Working Group meeting held regularly under the chair of PD-SACS? No. held in last one year.	
10	Is there update discussion and review of the initiatives taken on NCC & NTWG recommendations for HIV TB Collaborative activities in the state?	
11	Is there adequate availability of stock and supply of logistics from NACP and RNTCP (formats and register) to district?	
12	Is there a proper logistic supply and management mechanism in the state for supply and storage of HIV testing kits in the district?	
13	Has the state developed a tool for sharing of data of RNTCP & NACP at the district and state level with quarterly analysis and feedback to RNTCP & NACP facilities?	
14	Is the state has provided guidelines to districts, ART, Link ART Centres, CCC for diagnosing TB among HRGs with rapid TB diagnostics (CBNAAT –machine) and districts linked with sample transport to these centres?	
15	Is there adequate availability of Rifabutin and supply management to replace for Rifampicine to TB HIV co-infected patients on 2nd line ART?	
16	Is the state utilizing the standardmonitoring and evaluation indicators provided in the A guide to monitoring and evaluation for collaborative TB/HIV activities?	

B. Politico-administrative Aspects

S.No.	Check Points	Observations
Review of Resources		
1	Is DTO trained in Intensified TB HIV package?	
2	Are MO-DTC, MOTCs and DMC MOs trained in Intensified TB HIV package?	
3	Is DCC formed in the districts and DCC meetings held regularly with minutes of meetings shared in last four quarters?	
4	Is actions taken based on the decisions/suggestions in DCC?	
5	Is monthly TB HIV coordination meeting among NACP and RNTCP are held regularly?	
6	Is SOP is in place in the lab. with availability of cartridges? (After observing the CBNAAT lab)	
7	Is the district sharing the minutes of the meetings and the data to SACS and State TB Cell on regular basis?	
8	Is all DMCs have functional collocated HIV screening/ testing facilities?	

B. DIAGNOSTIC ASPECTS

Please write "Yes" or "No" in the column "Observations"

S.No.	Check Points	Observations
Review of Resources		
1	Is there facility for sputum Culture & DST Lab in the district?	
2	Is there facility of TB rapid diagnostics (CB-NAAT) available in the district?	
3	If yes for Q.2, the no. and any type of health facilities (Public/Private).	
4	If yes for Q.2, is the rapid TB diagnostics offered to presumptive TB cases among children and PLHIV?	
5	Are Sr. DRTB HIV supervisor, STLS & LTs undergone training in CB-NAAT diagnostics?	
6	Is SOP is in place in the lab. with availability of cartridges? (After observing the CBNAAT lab)	
7	Is there any other diagnostic facility available in the district? If Yes, name the available facilities separately.	
8	Is EQA in place in the district?	
9	Has OSE visits planned by IRL in last one year? Observe the OSE reports available in the district.	
10	Is there facility of Medical College involved in RNTCP?	

11	Are there facilities for diagnosing smear negative & EPTB cases?	
12	Is the ART/ Linked ART facilities available in the district?	

District Review of Resources		
1	Number of DTCS meetings per year [In District Annual report]	
2	% of DTCS meetings chaired by DM [In Dst Annual report]	
3	DM sensitized [In Dst Annual report]	
4	District action plan, including IEC, and with budget linked to activity, made for current Financial Year [In Dst& State Annual	
5	% expenditure of released funds (last Financial Year) [In Dst Annual report]	
6	NGO/PP included as members of DTCS [In Dst Annual report]	
7	Medical college and other sectors with health facilities represented in DTCS.	
8	Functional computer with DEO and electronic connectivity	
9	Transport availability for supervisory activity of DTO	

Review of resources

S.No.	**Check Points**	**Observation**
1	Is DMCs/ICTC is accessible to catering population in the area?	
2	Is there any signage for DMC/ICTC available in the PHI?	
3	Is at least one trained Medical Officer available in the health facility?	
4	2 Is a full-time trained Lab Technician (LT) available for sputum microscopy?	
5	Have provisions been made for sputum collection when LT is absent?	
6	Is a functional binocular microscope available?	
7	Is the Binocular microscope stored as per guidelines	
8	Has the binocular microscope undergone any servicing	

9	6 Has the binocular microscope undergone any servicing during last 12 months?	
10	Are all essential lab consumables available adequately?	
11	7 Are all essential lab consumables available adequately?	
12	Is running water, electricity available for the binocular microscope?	
13	Is there facility for testing HIV in the lab?	
14.	Is there adequate HIV testing kits available in the DMC? (Calculate as per the diagnosed no. of TB cases)	
15	Is there facility for proper storage of HIV testing kits?	

Review of forms, registers, records and reports

1	Are the referral ICTC & ART centre referral form available at the DMCs?	
2	Are the copy of the ICTC/ART centre referrals kept at the DMCs?	
3	Are the Lab Forms for Sputum Exams filled correctly, completely and legibly?	
4	Is the Lab Register filled correctly, completely and legibly?	
5	Are there 2 sputum smears for diagnosis in at least 8/10 patients?	
6	Are there 2 sputum smears for follow-up in at least 8/10 patients?	
7	6 Are positive results written as scanty, 1+, 2+ or 3+ in red and negative in black/blue?	
8	Are results up-to-date?	
9	Does the Lab register have the summary abstract completed at the end of the Lab register?	
10	Does the lab register maintaining the HIV screened results in the register?	
11		

Annexure 3: Supervisory Checklist for Designated Microscopic Centre (DMC)

Please write "Yes" or "No" in the column "Observations"

A.	**Diagnostic Aspects**	Check Points	Observations
1	**Review of Resources**		
2	**Review of forms, registers, records and reports**		
3	**Internal Quality Control Issues**		
4	**Interpersonal Communication of service providers with patients**		
5	**Observe the Lab technician preparing smears for examination**		
6	**Observe the Lab technician examining slides under the microscope**		
7	**Exit-interviews of at least 2 patients**		
B.	**Treatment Aspects**	Check Points	Observations
1	**Review of Registers**		
2	**Review of Treatment Cards**		
3	**Review of TB Register**		
C.	**Patient Interview of at least 1 patients each among NSP, TB-HIV, and re-treatment /MDR TB case every field-visit day**	Check Points	Observations
D.	**Interview and observe respective DOT-providers**	Check Points	Observations
E.	**Review organization of direct observation of treatment**	Check Points	Observations
F.	**Inspect the drug storage area**	Check Points	Observations
G.	**Review ACSM activities**	Check Points	Observations
1	Is their visible IEC material in the area/centre?		
2	Is patient information booklet available/used?		
3	Number of patient provider meetings / community meeting held in the area/centre		

Annexure 4 : Supervisory Checklist for ICTC

A. Monitoring Details		
Monitoring Visit Date		Time
Name of the ICTC		
ICTCCode		
Type of ICTC	☐ Stand alone ☐ Facility ICTC☐ PPP ICTC	
ICTC infrastructure	☐ Adequate ☐ Inadequate	
ICTC laboratory infrastructure	☐ Adequate ☐ Inadequate	
Blood collected at	☐ ICTC ☐ Laboratory	
If blood collection is going on at Laboratory then specify the distance from the ICTC	☐ Close to ICTC ☐ Away from ICTC	
Minimum Physical infrastructure	☐ Adequate ☐ Inadequate (Please refer page 12 in Operational Guidelines for Integrated Counseling and Testing Centers, July 2007)	
Consumables	☐ Adequate ☐ Inadequate (Please refer page 13 in Operational Guidelines for Integrated Counseling and Testing Centers, July 2007)	
Availability of signage board for ICTC in the premises of institution	Yes☐No☐	

B. Staff Details & Training

Sr.No.	Name	Designation	Met during visit Yes / No	Encircle the trainings for which they undergone
1		ICTC in charge	Yes☐No☐	1.Induction 2. Refresher 3.Full Site 4.Team training 5. other (Specify)_____9. Not trained
2		Counselor	Yes☐No☐	1.Induction 2. Refresher 3.Full Site 4.Team training 5. other (Specify)_____9. Not trained
3		Lab. Technician	Yes☐No☐	1.Induction 2. Refresher 3.Full Site 4.Team training 5. other (Specify)_____9. Not trained
4		Doctor	Yes☐No☐	1.Induction 2. Refresher 3.Full Site 4.Team training 5. other (Specify)_____9. Not trained
5		Doctor	Yes☐No☐	1.Induction 2. Refresher 3.Full Site 4.Team training 5. other (Specify)_____9. Not trained
6		Staff Nurse	Yes☐No☐	1.Induction 2. Refresher 3.Full Site 4.Team training 5. other (Specify)_____9. Not trained

C. Personal Protective Equipment (PPE)

1. Is Personal Protective Equipment (gloves, aprons, etc.) available to and utilized by the laboratory staff?	Yes ☐ No ☐

If No, please explain: _____

2. Kits for handling delivery of an HIV-positive pregnant woman, The kit will consist of the following:

Plastic disposable gowns	Yes ☐	No ☐
Disposable goggles for protection of the eyes	Yes ☐	No ☐
Face mask	Yes ☐	No ☐
Disposable shoe covers	Yes ☐	No ☐
Two pairs of long gloves	Yes ☐	No ☐

D. Bio-safety (Lab related)		
Sr.No.	Material	Available
1	Sodium hypochlorite solutionavailable.	Yes☐No☐
2	Whether solution is prepared on daily basis?	Yes☐No☐
3	Sharps disposable container	Yes☐No☐
4	Whether color coded container is used for the disposal of waste?	Yes☐No☐

E.Check list for ICTC Lab		
Sr. No.	**Check list**	
1.	Are essential laboratory equipments present? Refrigerator Centrifuge Needle Destroyer Micropipette	 Yes☐No☐ Yes☐No☐ Yes☐No☐
2.	Is refrigerator temperature reading taken / documented? (If "Yes", report the frequency of temperature reading)	Yes☐No☐ Frequency _____
3	ICTCs sent samples, which will include 20% of all positive samples and 5% of all negative samples collected in the first week of every quarter, for cross-checking to the SRL/NRL once every quarter under EQAS.	Yes ☐No ☐
2	Rapid HIV diagnostic kits stored at a temperature of 4–8 °C.	Yes ☐No ☐
3	Adherence to standard operating procedures (SOPs)	Yes ☐No ☐
4	Correct interpretation of results	Yes ☐No ☐
5	Regular calibration, monitoring and maintenance of equipment carried out	Yes ☐No ☐
6	Proper documentation.	Yes ☐No ☐
7	All re-usable supplies and equipment should be disinfected by sterilization or washing with soap and bleach solution or kept in daily prepared Sodium hypochlorite solution	Yes ☐No ☐
8	Availability of PEP Drug	Yes ☐No ☐

F. Document Details		
Sr.No.	Material	Available
1	ICTC Operational Guideline July 2007	Yes☐No☐
2	Training Manuals	Yes ☐No ☐
3	Consent forms	Yes ☐No ☐
4	Lab Result format	Yes ☐No ☐
5	Supervisory Visit Register	Yes ☐No ☐
6	Patients Linked with ART Center	Yes ☐No ☐
7.	PID Register for General Clients and Pregnant Women	Yes ☐No ☐
8.	ICTC Register for General Cleints (Non-ANC Cases)	Yes ☐No ☐
9.	ICTC Register for ANC Clients	Yes ☐No ☐
10	ICTC Post-natal Follow-up Register	Yes ☐No ☐
11.	ICTC HIV–TB Collaborative Activities Register	Yes ☐No ☐
12	Laboratory register	Yes ☐No ☐
13	Stock Register	Yes ☐No ☐
14	IEC Material available (Flipcharts, posters, leaflets etc)	Yes ☐No ☐
15	Condom available for distribution & demonstration	Yes ☐No ☐
G. Reports		
Sr.No.	Reports	Submission
1	SIMS Monthly ICTC report	Yes ☐No ☐
2	Monthly HIV–TB report on HIV–TB collaborative activities	Yes ☐No ☐
3	Details of referrals to and from various facilities	Yes ☐No ☐
4	Line listing of HIV positive person	Yes ☐No ☐
5	Weekly Stock Report	Yes ☐No ☐

H. General questions for Counselor /Nurse		
Sr.No.	Questions	Answers
1	What is the age range for adolescent?	
2	Explain about exclusive breastfeeding.	
3	When should we start the ART to HIV positive Pregnant women?	
4	When should we start giving the Nevirapine syrup to new born baby of HIV positive mother?	
5	Name the five opportunistic infections (OI).	
6	Complete the following abbreviations.	
	PEP	
	SIMS	
	DOT	
	EID	
	ST I& RTI	

Comments:_____

_____

Name, Designation and Signature of the Supervisor	
	Sign.---------- Date:----------

Annexure 5 : Supervisory Checklist at ART Centres

S. No	Indicators	Y/N	Observation	Recommendation	Means of verification
1	Has all ART staff received training on four symptom TB screening/ICF?				Discussion with staff (review the staff turnaround time and comment on training status)
2	Does all the ART staff screen patients for TB?(CCC/Staff Nurse)				Discussion with staff. Review whether green cards are being stamped by CCC/SN for ICFat every visit
3	Is there a point person responsible for monitoring turn-around time from TB screening to diagnosis, and from TB diagnosis to treatment initiation?				Records and discussion with staff
	Is the Ten point screening tool for TB/DR TB available in the centre and is being used				Observation and discussion with staff
4	Is the monthly HIV-TB line-list available and updated regularly?				Records and discussion with staff
5	Is the monthly HIV-TB line-list jointly prepared by ART staff nurse and RNTCP STS?				Records and discussion with staff
6	Is the HIV-TB register available and updated regularly?				Records and discussion with staff
7	Is the HIV-TB register jointly maintained by ART staff nurse and RNTCP STS?				Records and discussion with staff
8	Does the ART staff attend the monthly and/or quarterly HIV-TB coordination meeting?				Records and discussion with staff
9	Are the HIV-TB meeting minutes and action taken reports available with the staff?				Meeting minutes and action taken reports
10	Total number of patients visiting the ART center in the last one week				Patient visit register
11	Of the total number visiting, number referred for TB testing in the last one week				HIV-TB register (Line List)(comment on the % of TB referral)
12	Of the total number referred for TB testing, number who received TB test results in the last one week				HIV-TB register (comment on the % of TB testing).
	Out of the total number of patients in Pre-ART care, newly diagnosed with HIV-TB, how many have been initiated on ART?				Review HIV-TB register 2 months prior to visitmonth. Column no 12,13
	Whether all patients with HIV-TB co-infection have been initiated on CPT				Review HIV-Tb register 2 months prior to visiting month. Column no 14
13	Has a Hospital Infection Control Committee been constituted?				Discussion with nodal officer/medical officer

14	Is the ART center Nodal Officer a member of the Hospital Infection Control Committee?				Discussion with nodal officer/medical officer
15	Is a nurse or a point person been assigned to carry out AIC activities at the facility?				Discussion with nodal officer/medical officer
16	Have all staff received training on AIC within the past year?				Discussion with NO/MO
17	Is there clear display of messages on cough hygiene/etiquette?/ Fast Tracking of Cough symptomatics				Observation
18	Are patients with a cough identified on arrival at the facility, given guidance on cough etiquette and separated from other patients?				Observation and discussion with staff and patients
19	Are all cough symptomatic fast-tracked through all waiting area, including consultation, investigations, and drug collection and documented?				Observation and discussion with staff and patients
20	Are supplies readily available for coughing patients (tissues, surgical masks and cloths) and are being used?				Observation and stock register
21	Are patients crowded in waiting areas or hallways?				Observation
22	Is the waiting area well ventilated (i.e. windows and doors are open when feasible)				Observation
23	Do staffs monitor natural and/or mechanical airflow daily?				Observation and discussion with NO/MO
24	Is regular cleaning and maintenance of directional and extractor fans conducted?				Observation and discussion with NO/MO
25	What ART regimen is being given to patients with HIV-TB co-infection? (Already On ART as well as newly diagnosed HIV-TB cases)		Already On ART	New diagnosed	Observation of white cards of patients/ Discussion with Doctors
26	Whether Co-trimoxazole is available in the centre?				Discussion with Pharmacist. Observation
27	Whether ATT is available in the ART centre (Only applicable for ART centres dispensing daily ATT)				Discussion with Pharmacist. Observation
Additional remarks:					

Annexure 6: *3 I Project Supervisory check list and reporting form

*3 I Project Supervisory check list and reporting form		
I D code _____		
Code of the entry _____ ___		
1	Name Supervisor ##	
2	State Name of the state #	
3	Site Name of the site ##	
4	Visit day date of visit <dd/mm/yyyy>	
5	* CBNAAT site related questions	
6	Start Date project start date <dd/mm/yyyy>	
7	Security Is security available #	
8	AC Whether AC Installed and running #	
9	Power Whether power backup available #	
10	internet Whether Internet working #	
11	infra whether site upgraded with necessary furniture #	
12	fridge Whether Refrigerator for specimen storage available #	
13	thermo Availability of thermometer gauge and daily log book for it #	
14	BMW Whether Bio-medical Waste management for cartridges #	
15	Storage Whether cartridges stored in 2 to 28 degree C #	
16	SCTS Whether specimen Collection transportation mechanism in place #	
17	Lab link Linkage with the certified lab for invalid and error results #	
18	staff Availability of at least one dedicated staff for CBNAAT at the site #	
19	rr C&DST lab register available, updated and maintained #	
20	CBNAAT machine functional #	
21	caliber date of annual calibration <dd/mm/yyyy>	
22	TOTALTEST Till date number of tests performed ####	
23	Entry CBNAAT number of CBNAAT test result updated in Nikshay ####	

* ART centre checklist

ART link no of ART centres linked to ART centre ##	
Link ART no of link ART centres linked to ART centre ##	
training is all key staff trained in 3 I project #	
knowledge is key staff knowledge adequate #	
retraining if not adequate which staff need retraining? Pls. mention _____	
stamp Is 4 symptom screening stamp available? #	
screening Is 4 symptom screening being done # (check patient visit register and green book of 10 patients randomly for4 S stamp)	
Fast track Are TB symptomatic being fast tracked # (from observation of flow of patients)	
How fast If fast tracking in place, what is the mechanism?	
MLL Are the details of screening entered in the Master line list by ART centres? # (check cards for the same day)	
TB Number of TB patient diagnosed till last month ### (cumulative drug sensitive TB patient from ART centre)	
TOT Lead time in sharing of report with ART centre in days ## (check last one month report of MLL and C&DST register)	
Put on TB Number of TB patient on daily FDC till last month ### (cumulative from start of project)	
Put on in Number of TB patient on intermittent regimen ### (cumulative from start of project)	
Reason of putting on intermittent regimen **(give 3 top reasons)**	
MDRTB Number of M/XDR TB diagnosed ### (cumulative)	
Put on MDR No of M/XDR TB patients initiated on treatment ### (denominator is number of M/XDRTB patients diagnosed)	
Rx card Are TB treatment card of patients being maintained at ART centres #	
Rx Nikshay No of TB patients(all category) entered in Nikshay ### (registered all cases from the beginning of the project)	
DOTS99 Is 99 DOTS being implemented #	

DOT link all TB patients linked to their concerned TU for DOT provision? #	
adherence no of TB pt assessed for Treatment Adherence ## (from pt Rx card and pt interview 20%of put on Rx and 99D OTS)	
Actual and no of TB pat found adhered to treatment ##	
ADR rate Number of TB-HIV pt with documented ADR during Rx ## (among pt put on Rx after project start)	
store : Are drug storing conditions as per guidelines? # (away from sunlight, dust..)	
div Are Drug issue vouchers available? # (from DTC to ART centre)	
Line list HIV-TB line list and HIV-TB register being maintained and updated #	
AIC assess AIC risk assessment performed? #	
When AIC If not, when is AIC risk assessment planned? <dd/mm/yyyy>	
If AIC adeq. AIC measures implementation #	
*** Monthly Indicators (last reporting month using triangulation between C&DST register, HIV-TB line list, Master Line List)**	
PLHIV Act No of PLHIV under active care ##### (data source monthly ART report last month)	
Attendance Number of PLHIV attending ART Centre in the month (Pre ART and ART) #### (data source: from MLL)	
Screened out of above no of PLHIV screened with 4 symptom complex #### (data source: from MLL)	
Presumptive out of above no of PLHIV with presumptive TB ### (data source: MLL, white card, line list)	
Referred Out of above no of PLHIV with presumptive TB referred for diagnosis ### (including USG, his to..all)	
tested out of above no of PLHIV with presumptive TB tested for TB in CBNAAT ###	
Pul TB ART out of tested no diagnosed as bact confirm PTB in pre ART ###	
Pul TB Clinic Out of tested no diagnosed as clinical PTB in pre ART care ###	
Ep bacteria out of tested no diagnosed as bact confirm EPTB in pre ART ###	
RpuTB PRT out of tested no diagnosed as RR TB PTB already on pre ART ###	
RepbatPRT out of tested no diagnosed as RR TB EPTB already on ART ###	
Ep clinical Out of tested no diagnosed as clinical EPTB in pre ART care ###	

Pul TBART out of tested no diagnosed as bact confirm PTB already on ART ###	
Pul TBCli A Out of tested no diagnosed as clinical PTB already on ART ###	
Epbat ART out of tested no diagnosed as bact confirm EPTB already on ART ###	
Epclini AT Out of tested no diagnosed as clinical EPTB already on ART ###	
R pul TB ART out of tested no diagnosed as RR TB PTB already on ART ###	
Rep bat ART out of tested no diagnosed as RR TB EPTB already on ART ###	
Put on FDC Number of TB patient on daily FDC in last month ###	
Put in to Number of TB patient on intermittent regimen last month ###	
Rx MDRTB Number put on M/XDR TB Rx last month ###	

* monthly indicators for stocks and reporting (ART stock last month)

stock Cartridge stock at beginning of the month ####	
cartuti cartridge utilized in a month ####	
reccart cartridge received in a month ####	
balancart available stock at the end of the month ####	
Drug stock 4FDC stock at beginning of the month #### (UOM= strip)	
Druguti 4FDC utilized in a month ####	
Rec. drug drugs received in a month ####	
balandrug available drug stock at the end of the month ####	
Report email last month report from ART centre sent to hivtbartreports@gmail.com #	

*treatment of TB (for smear conversion take data one quarter before, for outcome take data four quarter before)

Dsmr convrt Number of TB-HIV pt with smear result available at the end of IP ##	
Nsmr convrt Number of TB-HIV pt with smear result positive at the end of IP ##	
dRx Outcom No of TBHIV pt with treatment outcome available ##	
nRx outcom No of TBHIV pt with successful Rx outcome ## (cured + treatment completed)	

* Treatment of HIV in HIV- TB Co infected PLHIV

*From TB HIV register Data 2 months prior to reporting month)

TB pt total no of TB pt enrolled in TBHIV register 2 month prior ###	
CPT out of above, number of TB patients initiated on CPT ###	
ART out of above, number of TB patients initiated on ART ###	
***IPT status(From master line list of reporting month)**	
IPT number of PLHIV newly initiated on IPT during the month ####	
Com IPT number of PLHIV who completed IPT during the month ####	

**These 3I Project reports will be used through out the country as an when the services are rolled out in the country and our subject to change as per the recommendations of the Ntional Technical Working Group (HIV/TB)*

Annexure 7: Supervisory Report format

Supervisory Report format: The supervisory report would be in the following format	
Report of Supervision	
Name of health facility:	Date & time of visit:
Name of the supervisor:	Designation :
Persons interviewed:	
Activities observed-please focus on the following areas:	Problems identified
Administrative (HRD and Financial) Diagnostic, Drugs and Lab consumables Treatment and Follow up, Records and Reports, IEC/ ACSM,PPM etc)	
Recommendations with persons responsible and Time frame	
Follow up actions taken, based on the previous recommendations	
Name and signature of Supervisor	
Comments from Program Manager (DTO/STO/SACS officer)	
Date	Name & signature

Annexure 8: National TB HIV Coordination Committee (NTCC)

Composition of committee:

Chairman: Secretary, Department of AIDS Control, Ministry of Health and Family Welfare, Government of India.

1. Vice chairperson of the NTCC is Additional Secretary, Department of AIDS Control, Ministry of Health and Family Welfare, Government of India
2. Nominee from Ministry of Health and Family Welfare, Government of India - concerned joint secretary
3. Deputy Director General (TB), Dte. GHS Ministry of Health and Family Welfare, Government of India
4. Deputy Director General, Care, Support and Treatment Division, Department of AIDS Control, Ministry of Health and Family Welfare, Government of India
5. Nodal person for HIV, WHO India
6. NationalProfessional Officer (TB), WHO India
7. Director, National Institute of Research in TB (NIRT), Chennai
8. Director, National AIDS Research Institute (NARI), Pune
9. Project Director, Karnataka State AIDS Control Society, Bengaluru, Karnataka.
10. Project Director, Uttar Pradesh State AIDS Control Society, Lucknow, U.P.
11. Civil Society organisation Representative – TB, Global Health Advocates, New Delhi
12. Civil Society organisation Representative – HIV, President, Indian Network for Positive People INP+)
13. National Program Officer (ART) DAC.MOHFW.GOI
14. Program Officer (HIV-TB) DAC/ MOHFW/GOI
15. Member secretary : Deputy Director General, Basic Service Division, DAC, Ministry of Health and Family Welfare, Government of India

The Terms of Reference for the committee are:

To strengthen co-ordination mechanisms between NACP and RNTCP at National, State and District level
To review and adopt policies for strengthening implementation of joint TB/HIV activities

1. To suggest strategies for roll out and scale up of activities aimed at minimizing mortality and morbidity associated with TB/HIV
2. To review implementation of joint TB/HIV activities and identify key areas for strengthening.

The NTCC will meet at least once in every quarter or as per need with the permission of the chairperson.

Annexure 9: National Technical Working Group On TB-HIV Collaborative Activities (NTWG)

Composition of NTWG: Chairperson: Deputy Director General, Basic Service Division, DAC, Ministry of Health and Family Welfare, Government of India

Members:

1. Deputy Director General (TB), Dte. GHS Ministry of Health and Family Welfare, Government of India
2. CMO-TB(in charge for the TB-HIV activities) at Central TB Division,MoHFW
3. Medical officer- HIV, WHO India country Office, New Delhi
4. Medical officer/National Professional Officer (TB), WHO India, New Delhi
5. National consultant ,TB/HIV,CTD,MoHFW,New Delhi
6. TB/HIV researcher, National Institute of Researchin TB (NIRT), Chennai.
7. Joint Director/In charge TB/HIV activities at State AIDS Control Society nominated by DAC,(Annual rotation)
8. State TB officer Nominated by CTD(Annual rotation)
9. DDG(CST),Dept of AIDS Control,NACO,MoHFW
10. National Program Officer (ART). DAC,NACO,MoHFW
11. National Program Officer (ICTC). DAC, NACO, MoHFW.
12. Civil Society organisation Representative – TB, Global Health Advocates, New Delhi
13. Civil Society organisation Representative – HIV, President, Indian Network for Positive People (INP+)
14. Member secretary:Program Officer (HIV-TB), DAC, MOHFW.

The Terms of Reference for the committee are:

1. To strengthen NACP-RNTCP co-ordination at National, State and District level.
2. To review, Optimize and plan for futureTB/HIVcollaborative activities as envisaged in NACP-IV and the National Strategic plan(2012-17)
3. To develop strategies for rollout and scale up TB/HIV interventions as recommended for implementation by NACP and RNTCP.
4. Strengthening mechanism for joint supervision and monitoring including standardized recording, reporting and data sharing between NACP and RNTCP as per the national framework for TB/HIV Collaborative activities.
5. Identify key areas for research and facilitate conduct of Operational research to improve programme implementation or research for impact assessment of TB/HIV interventions. The NTWG will meet at least once in every quarter.

Annexure 10: State TB-HIV Co-ordination Committee (SCC)

Proposed composition:

1. Secretary, Health: **Chairman**
2. Director Health Services: Vice Chairman
3. Mission Director, National Rural Health Mission, Vice Chairman
4. Director Medical Education and Research: Member
5. Project Director, SACS: Member
6. Additional Project Director, SACS: **Member, Secretary**
7. State TB Officer: Member
8. Director, STDC: Member
9. DAPCU Nodal Officer at SACS : Member
10. Joint Director / Dy. Director, ICTC, SACS: Member
11. Dy. State TB Officer / Assistant Programme Officer (APO): Member
12. RNTCP and NACP consultants and Regional coordinators: Member
13. State HIV/TB coordinator
14. Representative of NGOs working with RNTCP: Member
15. Representative of NGOs working with NACP: Member

Note*: The Chairman of the Committee if need arises can invite a person as special invitee whenever required for the betterment of the programme. In case the Chairman is not available for the meeting, a nominee of the chairperson may preside over the deliberations*

Terms of Reference

1. To ensure implementation of collaborative TB-HIV activities as per national framework
2. To ensure that all District Nodal Officer for NACP and DTO for RNTCP **are in place**
3. To address issues related to sub-optimal detection of HIV/TB and linkage to DOTS and ART services
4. Policy decisions to implement all new initiatives recommended by the NTWG
5. To take measures to strengthen participation of general health system staff in HIV/TB activities
6. To take measures to strengthen TB infection control practices at all health facilities particularly those caring for TB and HIV/AIDS patients

Note: Expenditure for this meeting may be booked under the NACP budget for basic services division in SACS

Annexure 11: State HIV/TB Working Group (SWG)

Proposed composition:

1. Project Director, SACS: Chairman
2. Additional Project Director, SACS: **Member, Secretary**
3. State TB Officer: Member
4. Director, STDC: Member
5. DAPCU Nodal Officer at SACS : Member
6. Joint Director / Dy. Director, ICTC, SACS: Member
7. Dy. State TB Officer / Assistant Programme Officer (APO): Member
8. RNTCP and NACP consultants and Regional coordinators: Member
9. State HIV/TB coordinator
10. Representative of NGOs working with RNTCP: Member
11. Representative of NGOs working with NACP: Member

Generic Agenda for quarterly SWG meetings

1. Review of actions taken by districts on recommendations of last SWG meeting
2. Review of progress in bridging service delivery gap like co-locationof HIV andTB testing facilities, ART facilities, TB culture and DST facilities, etc.
3. Review of performance of Intensified TB case finding activities at ICTC, ART centers, Link-ART centers
4. Review performance of HIV testing of TB/DR-TB patients and presumptive TB cases (in HP states)
5. Review linkage of HIV infected TB/DR-TB patient to DOT, CPT and ART
6. Review of timeliness of ART initiation of HIV/TB cases enrolled at ART centers
7. Review implementation of Isoniazid Preventive Treatment (IPT)
8. Review of timeliness of reporting on HIV/TB from all facilities implementing ICF activities
9. Review implementation of co-ordination meetings at district level (DCC and monthly HIV/TB meeting) –specimen minutes of these meetings may be discussed
10. Discussion on observation of joint HIV/TB field visits made during the quarter and plan for the next quarter
11. Review of airborne infection control measures at all HIV and TB /DR-TB care settings
12. Review availability and supplies of logistics e.g. referral formats, CPT, HIV test kits, Rifabutin, Isoniazid etc.
13. Review issues in human resource management e.g. vacancies, appointment process, training, re-orientation etc.
14. Discussion and decisions on communications received from NACO and CTD during the quarter

Note: Expenditure for this meeting may be booked under the NACP budget for basic services division in SACS

Annexure 12: District Coordination Committee

Proposed composition:

1. Chairman : District Magistrate/Collector or CEO ZillaPanchayat
2. Vice Chairman : Chief Medical Officer / District Health Officer or equivalent
3. Member Secretary : DAPCU Nodal Officer/ District TB Officer (in non A and B districts)
4. Member : Medical Superintendent, DistrictHospital
5. Member : Medical Superintendent, MedicalCollegeHospital
6. Member : City TB Officers (where applicable);
7. Member : MS of Hospital providing ART Services (where applicable)
8. Member : ART Centre Medical Officer (where applicable)
9. Member : Representative of NGO / CBO involved in NACP
10. Member : Representative of NGO / CBO involved in RNTCP

Note: Chairman of DCC, if need arises can invite a person as special invitee whenever required for betterment of programme. In case the Chairman is not available for the meeting, a nominee of the chairperson may preside over the deliberation

Terms of Reference

1. To strengthen coordination between RNTCP and NACP staff in the District.
2. To review performance of all HIV/TB activities implemented in the district as pernational framework, and provide guidancefor improvement
3. To address issues related to human resources including filling of vacancies, training of key programme staff and general health staff in HIV/TB activities
4. To ensure participation of general health system staff in implementation of HIV/TB activities
5. To ensure that appropriate infection control measures are taken at all facilities providing HIV /TB /DR-TB care
6. To ensure safe injection practices in facilities providing health facilities to prevent HIV
7. To promote participation of NGO/CBO and Private Practitioners in implementation of TB-HIV activities

Generic agenda for DCC meeting

1. Review of actions taken on recommendations of previous DCC meeting
2. Review of progress to bridge service delivery gaps e.g. HIV testing facilities, ART facilities, TB culture and DST facilities etc.
3. Review of Number (%) of TB patients or presumptive TB cases (in HP states) offered HIV testing –TB unit wise and PHI wise
4. Review of Number (%) of referrals of presumptive TB cases out of total attendees from HIV care settings (ICTC, ARTC, Link ART centers and TI NGO etc.) to RNTCP DMCs –Unit Wise
5. Review of linkage of HIV infected TB cases to DOTS, CPT and ART
6. Review of performance indicators of the district specially - HIV-TB death rates –TB unit Wise
7. Review of implementation of Isoniazid Preventive Treatment (IPT)
8. Review of Airborne infection control activities at HIV and other health care settings
9. Performance of NGO/PP involved in HIV/TB activities in the district
10. Review of Joint ACSM activities conducted during the quarter
11. Any other priority issues***Note: SACS to provide budget to DAPCU officer/DNO or DTO to make the expenditure for organization of this meeting from NACP budget for basic services division***

Annexure 13: Generic Agenda Items for Monthly HIV/TB Coordination Meeting

Two-three days Prior to monthly meeting RNTCP STS should handover completed line-list of presumptive TB cases for previous month to the ICTC and ART center counsellor/staff nurse, and obtain Line-list for current month

instead

ICTC counsellors to hand over the completed line list of previous month to STS in first week of every running month. Further the STSs to ensure TB diagnosed and initiated on treatment in his area and hand over the completed list to ICTC Counselor in last week of running month so that the district ICTC counsellor can prepare the monthly report of previous month

1. The first agenda item should be validation of monthly report generated from completed line-list by ICTC counsellor or ARTC staff nurse in the first week of running month . These validated reports should then be sent to SACS and STC
2. ICTC counsellor at every ICTC to ensure that all TB suspects referred by him/her are reaching DMC in the same premises by crosschecking the lab register
3. Counsellors at stand-alone ICTC will be responsible for sharing data for F-ICTC in their jurisdiction
4. Review of Number (%) of referrals of presumptive TB cases from all HIV care settings like ICTC, ART and Link ART center and the TI NGO, to RNTCP–Unit Wise
5. ART center MO/staff nurse should provide feedback on enrollment of HIV/TB patients at ART center and status of ART initiation to concerned STS by referring to ART center HIV/TB register
6. RNTCP STS should provide feedback on status of TB treatment initiation of patient referred outside the district
7. The RNTCP STS should provide TB treatment outcome of all patients in the HIV/TB register to ART staff nurse
8. Review of Number (%) of TB patients /presumptive TB cases offered HIV testing –TB unit /DMC wise
9. Review of linkage of HIV infected TB cases to DOTS, CPT and ART
10. Review of availability of logistics like, HIV test kits, referral formats, CPT, Rifabutin, Isoniazid etc.
11. Discussion on field observations of DTO/DNO /district ICTCT supervisors, District HIV/TB supervisor etc.

Note: SACS to provide budget to DAPCU officer/DNO or DTO to make the expenditure for organization of this meeting from NACP budget for basic services division

Annexure 14: Review meeting checklist for State and district level TB-HIV collaboration for use by PD SACS/DAPCU

1. Are DCC meetings conducted in all districts for previous quarter?
2. Are monthly TB-HIV meetings conducted in all past 3 months in all districts?
3. Are all DTO/DPO/ART MO trained in TB-HIV module, Intensified TB-HIVpackage and ART centre staff module?
4. Are all District TB HIV and DOTS plus supervisor/ STS/counselors trained in TB-HIV module, Intensified TB-HIV package and ART centre staff module?.
5. Are all necessary logistics available in adequate amount for TB HIV collaboration –referral to ICTC forms, referral to ART centre form, CPT etc.?
6. Is the collaborative activities established at all TB and HIV care settings – ICTCs / ART Centres/CCCs and the RNTCP diagnostic and treatment services?
7. Are TB-HIV collaborative activities also established in NGOs and Private Medical Practitioners facilities involved in NACP and RNTCP?
8. What proportion of ICTC/ART centre/CCC clients/patients screened for TB symptoms in past quarter?
   - What Proportion of above are diagnosed TB and
   - Among those diagnosed TB number in DOTS

9 What proportion of registered TB patients in the districts screened for HIV in past quarter?
   - What Proportion of above are found Sero-positive and
   - Among those diagnosed sero-positive number linked to CPT and ART services

10 Are appropriate measures to prevent the spread of TB in facilities caring for HIV/AIDS patients taken in all districts?

11 Are measure taken to prevent spread of HIV infection through safe injection practices in those facilities providing RNTCP treatment services?

Annexure 15: Review checklist for TB-HIV activities at state level

	State and district-level coordination	
a	Whether TB-HIV State Coordination Committee (SCC) functional at state level?	
b	No. of SCC meetings held in last 4 quarters	
c	Number of TB-HIV State Working Group meetings held in last 4 quarters	
d	Proportion of districts with at least two DCC meeting in past 4 quarters	
e	Proportion (%) of all ICTC counsellors attend HIV/TB monthly coordination meeting	
f	Proportion (%) of ART centre staff attend HIV/TB monthly coordination meeting (ART SMO/MO, ART Staff Nurse)	
g	No. of field visits made to the districts jointly by officers from SACS and STC(in last 4 quarters)	
	Infrastructure	
a	Total no. of stand-alone ICTCs in the state as per last month CMIS report	
b	Distribution of ICTCs as per the district category (A,B,C,D)	
c	No. of Facility integrated ICTCs in the state as per last month CMIS report	
d	No. of PPP ICTCs functional in the state as per last month CMIS report	
e	No. of ART centres in the state as per last month CMIS report	
f	No. of LAC (Link ART Centres) functional in the state as per last month CMIS report	
	No. of LAC plus (Link ART Centres) functional in the state as per last month CMIS report	
g	No. of Designated Microscopy Centres (DMC) in the state (latest RNTCP PMR)	
h	No. of co-located ICTC and DMC as per latest RNTCP PMR	
	Intensified TB Case Finding at ICTCs and ART Centres	
a	Proportion of ICTC reporting on ICF as per last month CMIS report	
b	Total no. of clients who attended ICTCs during the month	
c	No.(%) of ICTC clients referred to RNTCP as presumptive TB case	
d	No. (%) of the referred TB suspects from ICTCs who are diagnosed with TB	
e	No.(%) of diagnosed TB patients from ICTCs who are initiated on DOTS treatment	
	Intensified TB Case Finding at ART Centres	
a	Proportion of ART centres reporting on ICF as per last month CMIS report	
b	No. (%) of ART centre attendees referred to RNTCP as presumptive TB cases	
c	No. (%) of the referred cases from ART centres diagnosed with TB	
d	No.(%) of diagnosed TB patients out of above initiated on DOTS treatment	
e	Number percentage of ART centre NOT having TB symptoms (Monthly ART centre IPT report)	

f	Number percentage of above patients assessed for eligibility for Isoniazid Preventive Treatment (IPT)	
g	Number percentage of above patients initiated on IPT	
	HIV testing of presumptive TB cases (High HIV prevalence settings)	
a	Number of presumptive TB cases tested at DMC (latest quarterly PMR)	
b	Number (%) out of above with known HIV status	
c	Number (%) out of above found HIV infected	
	HIV testing of TB patients (all states)	
a	Total Number of TB patients registered during the quarter ((latest RNTCP case finding report))	
b	Number of TB patients with known HIV status (RNTCP case finding report)	
c	Number of TB patients with known HIV status from previous quarter (RNTCP sputum conversion report)	
d	No. (%) of registered TB patients found to HIV infected (RNTCP case finding report)	
	No. (%) of registered TB patients found to HIV infected (RNTCP sputum conversion report)	
	No. (%) of HIV infected TB patients receiving CPT infected (RNTCP sputum conversion report)	
	No. (%) of HIV infected TB patients receiving ART (RNTCP sputum conversion report)	
e	No. (%) of HIV infected TB patients receiving CPT in corresponding quarter last year (RNTCP results of treatment report)	
f	No. (%) of HIV infected TB patients receiving ART during TB treatment in corresponding quarter last year (RNTCP results of treatment report)	
g	No. (%) of HIV infected TB patients initiated on ART as per latest month ART CMIS report	
	No. (%) of all New HIV Infected TB Patients with treatment success ie. Cure +treatment completed. (RNTC Results of Treatment report one year back)	
	No. (%) of all New HIV Infected TB Patients died (RNTC Results of Treatment report one year back)	
	No. (%) of all Previously treated HIV Infected TB Patients with treatment success ie. Cure +treatment completed. (RNTCP Results of Treatment report one year back)	
	No. (%) of all Previously treated HIV Infected TB Patients died (RNTCP Results of Treatment report one year back)	
	Human Resources	
a	No. (%) of ICTCs with vacancy of ICTC counsellor (ICTC CMIS report)	
b	No. (%) of ICTCs counsellors trained in TB-HIV	
c	No. (%) of ICTCs with vacancy of Laboratory Technicians	
d	Is the 10 point counselling tool for TB available at all the ICTCs and ART centres ?	Yes/No

Source of information*: NACO CMIS/SIMS for ICTC and ART centres and RNTCP quarterly reports*

Annexure 16 : Review meeting checklist for district level TB-HIV collaboration for use by DAPCU

1. Is a District coordination committee formed in the district?

2. Was DCC meeting conducted in the district for previous quarter?

3. Was monthly TB-HIV meeting conducted in all past 3 months in the district?

4. Are the DTO/DPO/ART MO trained in TB-HIV module, Intensified TB-HIV package, ARTcentrestaffmoduleand 10 point counseling tool?

5. Are the District TB HIV and DRTB supervisor/ STS/counselors trained in TB-HIV module, Intensified TB-HIV package, ART centre staff module and 10 point counseling tool?

6. Are all necessary logistics available in adequate amount for TB HIV collaboration –
    a. referral to ICTC forms
    b. referral to ART centre form
    c. TB/HIV linelist register
    d. Monthly reporting format – ICTC
    e. Monthly reporting format – F-ICTC
    f. HIV testing Kits
    g. CPT
    h. IEC material

7. Is the collaborative activities established at all TB and HIV care settings – ICTCs / ART Centres/CCCs and the RNTCP diagnostic and treatment services?

8. Are TB-HIV collaborative activities also established in NGOs and Private Medical Practitioners facilities involved in NACP and RNTCP?

9. a) What proportion of ICTC/ART centre/CCC clients/patients screened for TB symptoms in past quarter?
    b) What Proportion of above are diagnosed TB
    c) Among those diagnosed TB number in DOTS

10 a)What proportion of registered TB patients in the district screened for HIV in past quarter?
    b)What Proportion of above are found Sero-positive and
    c)Among those diagnosed sero-positive number linked to CPT and ART services

11 Are appropriate measures to prevent the spread of TB in facilities caring for HIV/AIDS patients taken in the district?

12 Are measure taken to prevent spread of HIV infection through safe injection practices in those facilities providing RNTCP treatment services?

Annexure 17:Monitoring tools for HIV/TB State level

Monitoring tools for HIV/TB State level			
Sr No	**Indicator**	**Data Source**	**Basic Data Entry Source**
1	Proportion of registered all TB patients with documented HIV testing and result status	CFR	Original TB Treatment card, TB Register
2	Proportion of the HIV positivity among total registered with documented HIV positive status	CFR	Original TB Treatment card, TB Register
3	Proportion of registered TBHIV patients put on CPT (Early Iniation of CPT)	SCR	Original TB Treatment card, TB Register
4	Proportion of registered TBHIV patients put on ART (Early Iniation of ART)	SCR	Original TB Treatment card, TB Register
5	Proportion of registered TBHIV patients put on CPT	RTR	Original TB Treatment card, TB Register
6	Proportion of registered TBHIV patients put on ART	RTR	Original TB Treatment card, TB Register
7	Loss to follow up proportion of all TBHIV patient cohort	RTR	Original TB Treatment card, TB Register
8	Death proportion of all TBHIV patient cohort	RTR	Original TB Treatment card, TB Register
9	Proportion of PLHIV screened for TB in ART Centre	HIV TB Monthly Report	Master Line List of Reporting Month
10	Proportion of PLHIV who are screened (4 symptoms complex) for TB in ART Center	HIV TB Monthly Report	Master Line List of Reporting Month
11	Proportion of PLHIV who are having TB symptom screen positive (4 symptom complex) out of those who are screened for TB	HIV TB Monthly Report	Master Line List of Reporting Month
12	Proportion of PLHIV who are tested for TB out of those who are four symptom (screening) positive	HIV TB Monthly Report	Master Line List of Reporting Month

13	Proportion of PLHIV diagnosed with active TB (Bacterilogically and Clinically Diagnosed, Pulmonary and ExtraPulmonary) out of those who are tested	HIV TB Monthly Report	Master Line List of Reporting Month
14	Proportion of PLHIV who are started on TB treatment out of those diagnosed as having active TB	HIV TB Monthly Report	Master Line List of Reporting Month
15	Proportion of PLHIV diagnosed with Rifampicin Resistance M. TB Detected out of those who are tested	HIV TB Monthly Report	Master Line List of Reporting Month
16	Proportion of PLHIV having TB symptoms who receive a rapid molecular test (CBNAAT) as a first test for TB diagnosis	HIV TB Monthly Report	Master Line List of Reporting Month
17	Proportion of PLHIV who are started on DR TB (Cat IV,V) treatment out of those diagnosed	HIV TB Monthly Report	Master Line List of Reporting Month
18	Proportion of PLHIV who complete a Full course of INH prophylaxis (TB preventive therapy)	HIV TB Monthly Report	Master Line List of Reporting Month
19	Proportion of Clients referred to RNTCP from ICTC	Monthly ICTC Report	Monthly ICTC Report
20	Proportion of TB patients Diagnosed among referral from ICTC	Monthly ICTC Report	Monthly ICTC Report
21	Proportion of TB patients put on DOTS among referral from ICTC	Monthly ICTC Report	Monthly ICTC Report

Annexure 18: Monitoring Tool for HIV-TB Collaborative Activity (SIMS)

A) Basic Facilities and HIV-TB cross referral:

S.No.		Source	Value	Proportion
1	Total number of DMCs under the TB unit	Annexure M	a	
2	Number of DMCs providing HIV testing facilities	DTO	B	=b/a*100
7	Total number of ICTC/FICTC counselors posted	DTO	C	
8	Number of ICTC/FICTC counselors trained in HIV-TB	MO-TC and DTO	D	=D/C*100
3	Total number of ICTC/FICTC submitted completed HIV-TB line-list for previous month	MO-TC	E	
4	Total number of ICTC/FICTC attendee (including PPTCT) last month	MO-TC	F	
5	Total number of ICTC to RNTCP cross referral of TB suspects in last month	HIV-TB line-list and review of DMC lab register	G	=G/F*100
6	Out of TB suspects referred from ICTC/FICTC number of TB patients diagnosed	HIV-TB line-list and review of DMC lab register	H	=H/G*100

B) For districts/TB units implementing PITC:

1	Total number of TB suspects undergone HIV testing this month	ICTC and DMC lab register	A	
2	Total number of TB suspects confirmed as TB cases	Lab register of DMC	B	
3	Total number of TB suspects confirmed as HIV infected person	ICTC lab register	C	=C/A*100

c) Cross Referral from RNTCP to ICTC/FICTC and linkages

S.No.	Variable	Source		Proportion
1	Number of **new** TB cases diagnosed last month	Lab register of DMC(a)		
2	Number of **new** TB cases undergone HIV testing	Lab register of DMC(s)		=s/a*100
3	Number of **new** TB cases having HIV infection	Lab register of DMC/TB register(b)		=b/a*100
4	Number of **Relapse** TB cases diagnosed	Lab register of DMC/TB register(c)		
5	Number of **Relapse** TB cases undergone HIV testing	Lab register of DMC/TB register(r)		=r/c*100
6	Number of **Relapse** TB cases having HIV infection	Lab register of DMC/TB register(d)		=d/c*100
7	***Total number of TB-HIV co-infected patients diagnosed this month***	TB register and HIV-TB linelist(e)		
8	Number of TB HIV Co-infected patients(New) who were linked to ART center	TB Register or Linked ART center/ART center (f)		=f/e*100
9	Number of TB HIV Co-infected patients(Relapse) who were linked to ART center	TB register or Linked ART center/ART center(g)		=g/e*100
10	Number of TB HIV Co-infected patients provided CPT	Linked ART center/ART center(h)		=h/e*100

D) HIV-TB collaborative activity and linkage with PMDT:

1	Number of TB-HIV co-infected patients whose samples were sent last month for MDR-TB diagnosis	ICTC and DMC, MDR-TB line list/TB register		
2	Number of TB -HIV co-infected patients whose samples were sent for MDR-TB diagnosis last month and found positive for MDR-TB	Referral for CDST register		

Annexure 19: Monitoring Tools for HIV/TB (NIKSHAY)

- Monitoring and evaluation is one of the cornerstones of a country's response to fighting HIV/AIDS, TB and malaria and strengthening health and community systems.
- Investing in strengthening a national monitoring and evaluation system is important as it will eventually save resources.
- NIKSHAY is web based case based system developed by RNTCP for real time recording and reporting, which will help in programme monitoring. HIV related data also been captured in NIKSHAY for TB cases registered under programme and can be used as tool for monitoring HIV TB collaborative activities at District, State, National or Global level. Following indicators can be extrapolated from NIKSHAY for HIV TB monitoring.

Core list of indicators –

1) **Core indicators for global and national monitoring and reporting from NIKSHAY**
   - ***a)*** **Proportion of registered new and relapse TB patients with documented HIV status**
     i) Disaggregation by age into adults (aged 15 years and above) and children (aged 0-4 and 5-14 years)
     ii) Disaggregation by sex
     iii) Data source- NIKSHAY
   - ***b)*** **Proportion of registered new and relapse TB patients with documented HIV-positive status**
     i) Disaggregation by age into adults (aged 15 years and above) and children (aged 0-4 and 5-14 years)
     ii) Disaggregation by sex
     iii) Data source- NIKSHAY
   - **c) Proportion of HIV-positive new and relapse TB patients on CPT during TB treatment**
     i) Disaggregation by age into adults (aged 15 years and above) and children (aged 0-4 and 5-14 years)
     ii) Disaggregation by sex
     iii) Data source- NIKSHAY
   - **d) Proportion of HIV-positive new and relapse TB patients on ART during TB treatment**
     i) Disaggregation by age into adults (aged 15 years and above) and children (aged 0-4 and 5-14 years)
     ii) Disaggregation by sex
     iii) Data source- NIKSHAY
   - **e) Mortality among HIV-positive new and relapse TBpatients**
     i) Disaggregation by age into adults (aged 15 years and above) and children (aged 0-4 and 5-14 years)
     ii) Disaggregation by sex
     iii) Data source- NIKSHAY

2) **Core indicators for only national-level monitoring and reporting from NIKSHAY**
   - **a) Proportion of presumptive TB patients having documented HIV status**
     i. Data source- Programme Management Report of NIKSHAY
   - **b) Proportion of HIV-positive new and relapse TB patients who are already on ART at the time of TB diagnosis**

i. Disaggregation by age into adults (aged 15 years and above) and children (aged 0-4 and 5-14 years)
ii. Disaggregation by sex
iii. Data source- NIKSHAY

c) Proportion of HIV-positive new and relapse TB patients who are started on ART within 2 weeks of starting anti-TB treatment

i. Disaggregation by age into adults (aged 15 years and above) and children (aged 0-4 and 5-14 years)
ii. Disaggregation by sex
iii. Data source- NIKSHAY

3) **<u>Optional indicators for use at national level</u>**

a) Proportion of patients having multidrug-resistant or rifampicin-resistant TB with documented HIV status

i. Disaggregation by age into adults (aged 15 years and above) and children (aged 0-4 and 5-14 years)
ii. Disaggregation by sex
iii. Data source- NIKSHAY PMDT Module

b) Proportion of patients having multidrug-resistant or rifampicin-resistant TB with documented HIV positive status

i. Disaggregation by age into adults (aged 15 years and above) and children (aged 0-4 and 5-14 years)
ii. Disaggregation by sex
iii. Data source- NIKSHAY PMDT Module

c) Proportion of HIV-positive patients treated for multidrug-resistant or rifampicin-resistant TB who are also on ART

i. Data source- NIKSHAY PMDT Module

d) Proportion of HIV-positive TB patients on protease inhibitor-based ART regimen receiving Rifabutin-containing anti-TB treatment

i. Data Source- NIKSHAY

4) Operational indicators for use at National level

a) No. & % of districts with direct access to rapid molecular diagnostics as the first point of test for presumptive TBHIV case
b) No. & % of the districts with any shortage of kits during the reporting quarter/ period
c) No. & % of the districts implementing IPT for PLHIV
d) No. & % of the labs for testing HIV & TB covered under quality control mechanism for both HIV testing & TB diagnostics
e) No. & % of the districts with adequate availability of CPT
f) No. & % of the ART centres/ Link ART centres with adequate availability of ART
g) No. & % of the districts with HIV testing facility in the private sector covered under quality control mechanism
h) No. & % of the districts with HIV testing facility in the NGO sector covered under quality control mechanism

Annexure 20: DAPCU Monthly Report Part A

DAPCU Monthly Report Part A - Quantitative Section				
District:_Central Delhi_____ State:__Delhi_____	Email Contact number:	Category (A/B):_B	ANC prevalence as per HIV Sentinel Surveillance (specify year)___0.5_____/___2008_____	Reporting Month/Year:__Month __/__Year____

I. DAPCU Staff details:

		District AIDS Control Officer (DACO)	District Programme Manager (DPM)	District ICTC Supervisor (DIS)	District Assistant-Monitoring & Evaluation (DA-M&E)	District Assistant-Accounts (DA-Accounts)	District Assistant-Programme (DA-Programme)
1.1	Sanctioned						
1.2	In place						
1.3	Vacant since						

II a. HIV/AIDS facilities in the district and status for the month

Sl.No	Description	Targeted Interventions	OST center	Link Worker Scheme	Standalone/ PPP ICTCs	FICTCs	Blood Banks	Blood Storage Units	STI Clinics	ART Centre	Link ART Centre	CSC	Others *
2a.1	Number of facilities												
2a.2	Number of facility reports received												
2a.3	Percentage of facility reports received												
2a.4	Number of vacancies												
2a.5	Number of untrained staff												
2a.6	Number of facilities with stock out**												

II b. Mention reasons for deviations and actions initiated/to be initiated for improvement:

III a. HIV/AIDS facilities visited during the reporting month (It should be number of facilities visited and not the total visits; joint visits to a facility should be counted as one facility visit)

Sl.No.	Description	Targeted Interventions	OST center	Link Worker Scheme	Standalone/PPP ICTCs	FICTCs	Blood Banks	Blood Storage Units	STI Clinics	ART Centre	Link ART Centre	CSC	Others*
3a.1	DACO												
3a.2	DPM												
3a.3	DIS												
3a.4	DA-M&E												
3a.5	DA-Accounts												
3a.6	DA-Programme												

III b.The analysis should include joint visits made by DAPCU team; and provide information whether at least 1/3rd of the facilities are visited in the month so that all the facilities are visited in a month/quarter:

IV a. Financial status of the district facilities (in Rs)

Sl. No	Budget released	Advance liquidated or settled during the month	Total advance pending
4a.1			

Institutional/ Operational Expenses

		Budget for the Year	Amount released (cumulative)	Expenditure during the month	Cumulative expenditure	Bills submitted to SACS
4a.2	DAPCU					
4a.3	Others 1 (Specify): _____					
	Others 2 (Specify): _____					

IV b. Mention about long pending advances in the district, challenges faced and efforts made by DAPCU:

V a. Key Program Indicators - Targeted Interventions								
Sl.No		**FSW**	**MSM**	**Core Composite**	**IDU**	**TG**	**Truckers**	**Migrants**
5a.1	No. of Targeted Interventions							
	High-Risk Groups/Bridge Population	**FSW**	**MSM**		**IDUs**	**TG**	**Truckers**	**Migrants**
5a.2	Estimated number of HRGs/ Bridge population based on mapping/SNA							
5a.3	Number of HRGs/Bridge population being targeted through all interventions (as per TI contract)							
	High Risk Groups/Bridge Population	**FSW**	**MSM**		**IDUs**	**TG**	**Truckers**	**Migrants**
5a.4	Number of HRGs/Bridge population registered in TI							
5a.5	Number of HRGs regularly contacted by PEs (FSW, MSM, TG, IDU), contacted Bridge Population (Truckers, Migrants)							
5a.6	Number of HRGs/ Bridge population attended STI Clinic							
5a.7	Number of STI cases treated during the month							
5a.8	Total target for HRGs/Bridge population for testing at ICTCs (Semi Annual for HRGs/Annual target for Bridge population - excluding positives)							
5a.9	Number of HRGs/Bridge population tested at the ICTCs in the district during the month							
5a.10	Number of HRGs/Bridge population found HIV positive in the month							
5a.11	Number of positive HRGs/Bridge population registered at the ART centres in the district in the month							
5a.12	Total monthly demand for condoms							
5a.13	Total free condoms distributed to HRGs in the month							
5a.14	Total target for social marketing of condoms							
5a.15	Total number of condoms sold (through social marketing)							
5a.16	Total monthly demand for needles and syringes among IDUs in the month		Needles				Syringes	
5a.17	Total needles and syringes distributed among IDUs in the month		Needles				Syringes	

V b. Were HRGs of theTIs regularly contacted for outreach activities and achieved the targets of RMC, ICTC tests and free condom distribution - Mention reasons or challenges below for not achieving the targets:

V c. OST services		Target	Achievement
5c.1	Total number of clients registered at the OST centre till the reporting month (cumulative)		
5c.2	Total number of clients started on OST by the centre till the reporting month (cumulative)		
5c.3	Of the total number of clients started on OST by the centre till the reporting month, number referred by IDU TIs (cumulative)		
5c.4	Total number of clients completed treatment and were taken off from medication after treatment in the month (cumulative)		

V d. Link Worker Scheme		Estimated number as per mapping	Cumulative contacted	Cumulative tested at ICTC	Cumulative HIV positive	Cumulative referral to STI	Cumulative STI cases treated
5d.1	FSW						
5d.2	MSM						
5d.3	IDU						
5d.4	Truckers						
5d.5	Migrants						
5d.6	Vulnerable population						

VI a. Key HIV Counselling and Testing Indicators		Annual Target	No. Tested	Positive	Percentage
6a.1	Number of General clients tested for HIV (General population + HRG + Bridge population)(Excluding FICTC) and positivity rate				
6a.2	Number of ANC tested in all the ICTCs (Excluding FICTC) and positivity rate				
6a.3	Number of general clients tested at FICTC and detected reactive after 1st test				
6a.4	Number of ANC tested at FICTC and detected reactive after 1st test				

VI b. Have all the HIV positives identified got registered at ART Center? If not mention reasons. Provide reasons if target for tests are not achieved and efforts made by DAPCU:

* Targets were calculated with the efforts made by DNO (DSACS) and DAPCU staff of Delhi.

VII. Other Key Program Indicators for the month		Achievement
VII a. PPTCT Services		
7a.1	Number of pregnant women registered at ART	
7a.2	Number of pregnant women initiated on ART	
VII b. Inter-linkages of ICTC with STI Clinics, TIs, RNTCP and Blood Banks		
7b.1	In-Referral from FICTC to stand alone ICTC	
7b.2	In-Referral from STI clinics to ICTCs	
7b.3	In-Referral from TIs to ICTCs	
7b.4	In-Referral from BBs to ICTC	
7b.5	Out-referral from ICTCs to STI Clinics	
7b.6	Out-Referral from ICTCs to DMCs (RNTCP)	
7b.7	Number of TB cases identified in the district	
7b.8	In-Referral from DMCs (RNTCP) to ICTCs	
7b.9	Number of HIV-TB co-infected identified	

VII c. Blood Transfusion Services		Annual Target	Achievement
7c.1	Number of blood units collected by Blood Bank through voluntary blood donation		
7c.2	Number of HIV positive cases detected by the Blood Banks among the blood donors		
VII d. STI/RTI Services			
7d.1	Total number of visits to Designated STI/RTI Clinic		
7d.2	Clinic visit with STI/RTI complaint and were diagnosed with an STI/RTI		
VII e. Mention reasons below for low achievement for targets, referrals and linkages:			
Two ANCs HIV Positives are under follow-up.			
VII f. ART Services			
7f.1	Number of new Pre-ART registrations at all ART centres during the month		
7f.2	Number of Pre-ART registrations at all ART centres cumulative		
7f.3	Total number of PLHIV alive and on ART at all ART centres		
7f.4	Number of PLHIV on ART who are Lost to Follow-up (LFU)		

VII g. Mention reasons below for LFU in the district and efforts made by DAPCU to reduce the LFUs:

VIII a. Social Protection		Schemes	Entitlement
8a.1	Number of PLHIV applied for social benefit schemes/entitlements (cumulative)		
8a.2	Number of PLHIV sanctioned with social benefit schemes/entitlements (cumulative)		
8a.3	Number of HRGs applied for social benefit schemes/entitlements (cumulative)		
8a.4	Number of HRGs sanctioned with social benefit schemes/entitlements (cumulative)		
VIII b. Mention challenges faced and efforts made by DAPCU:			

IX. Stigma and Discrimination		Reported during the month	Responded during the month	Reported cumulative	Responded cumulative
9.1	Number of stigma and discrimination cases reported in the district				
X. District AIDS Prevention and Control Committee (DAPCC) meeting					
10.1	Date of last DAPCC meeting (dd-mm-yyyy)				
10.2	Number of DAPCC meetings held during the financial year				

*** Describe other facilities**

**Should mention the number of facilities with stock outs of important consumables. Important consumables would include: For TI NGOs: Free condoms, Lubricants, Needles/Syringe (IDU), STI Medicine; For LWS NGOs: Free condoms; For ICTCs: HIV test Kits 1, 2 & 3, Needles/Syringe, Free condoms; For Blood Banks: All Test kits, Blood Grouping Sera; For Blood Storage centres: Blood Grouping Sera; For STI clinics: STI Colour coded kits, Free condom; For ART Centre: ART drugs, OI drugs, CD4 tests Reagent, Free Condoms; For Link Art Centre: ART Drugs, OI Drugs, Free condoms; For CSC: Free Condoms; For SRL: HIV test kits 1, 2 & 3, ELISA kits

Facilities which report stock outs should prepare a detail report and send it to SACS. DAPCUs should follow up on these till resolved.

NOTE: DAPCU should prepare a detailed report wherever issues identified.
Note: The report is to be reported by 15th of every month to SACS by email as well as hard copy and to DAC by email to unaco@gmail.com

Annexure 21: DAPCU Monthly Report Part B

DAPCU Monthly Report Part B - Qualitative Section						
I. Did the DAPCU receive feedback on the last month DMR (Yes/No):						
II. Mention details of SACS/DAC officials visits to the DAPCU, if any (Name and designation, purpose, dates):						
III. Mention the last DAPCU review meeting conducted by SACS and attended by DAPCU (mention the date):						
IV. District level meetings held (Specify participants and Important issues discussed in the meeting)						
Meeting	Date of meeting	Total Number of meetings	Number of persons attended	Participants attended (Designation)	Status on last meeting key decisions	Key decisions of the current meeting, if any
1. Program review meeting with HIV/AIDS facilities						
2. HIV/TB coordination meeting with Select HIV/AIDS facilities						
3. ART-CSC coordination meeting with Select HIV/AIDS facilities						
4. Coordination meeting with NHM						
5. DAPCC meeting						
6. Meetings with other line departments for initiation or strengthening program						
7. Other meetings (State HIV-TB Coordination Meeting at NDTB Centre)						

V. Sensitization activities coordinated by DAPCU (Provide details of training, workshops etc., participants, purpose and follow-up plans)

Target group and activity	Number of sensitization activities	Number of Participants	Purpose	Follow-up plans
1				

VI. IEC Activities (including campaigns) coordinated and addressed stigma & discrimination cases by DAPCU ***(Write brief about activities undertaken and issues redressed)***

VI.a	Name of IEC Activity	Number attended/covered	Activities undertaken	Output
1				

VI. b: Stigma and discrimination cases responded during the month (Describe):

VII. Accomplishments during the month:

VIII "Stock outs" reported or observed ***(specify type and facilities):***

Type of facility	Number of facilities	Name of the item	Efforts made for resolution

IX. Major problems/challenges identified during field visits:

Name of the facility	Observations	Action initiated/suggested
ICTC		
F-ICTC		
PPTCTC		
DSRC		
TI-NGO		
Joint TI-NGO		

X. Support requested from SACS:

XI. Any other information or suggestions to bring quality improvement of the program:

Signature of DACO

(DAPCU prepares this report using the monthly reports received from the facilities, outcome of the district or state level meetings and field visit observations of DAPCU staff. This report is prepared by DACO with the support from DPM or DIS and other DAPCU staff

Annexure 22 : Monitoring tool - ICTC

Name of ICTC: Date of Visit:
Address of ICTC:

Name	Designation
Visiting officer/s	
Staff met during visit	
	Medical Officer –In charge
	Counsellor
	Lab Technician
Follow-upon previous visit(*For action points, refer to previous visit reports*)	
Date of last visit:	**Name of the officer visited last time:**
Action points of last visit	**Action taken (Status)**

Human Resource				
Total No. of staff sanctioned	**Total No. of staff in place**	**Total no. of post vacant**	**Total No. of staff trained**	**Remarks (reason for turnover/not trained**

Key Indicators for last 3 months (these may be obtained before visiting facility)

Key Indicators	Month -1	Month -2	Month -3	Remarks
Date of reporting in SIMS				
Total tested (General +HRGs)				
% of HIV Positive (General+HRGs)				(Denominator: Number of General +HRGs tested , Numerator: number General + HRGs positives identified)

% of Referred to ART for registration				Denominator: number General + HRGs positives identified, Numerator: number General + HRGs registered at ART centre)
ANC Registered				Registered in Hospital
% of ANC Tested				Denominator: number ANC Registered Numerator: number ANC Tested)
% of HIV Positive among ANC				Denominator: Number of ANC tested , Numerator: number ANC positives identified)
Number of HIV Positive ANC Deliveries in month				
Number of Positive ANC linked to ART				
In referrals from TIs				
In referral from STI Clinic				
Out referral to STI Clinic				
%of referrals from ICTC to RNTCP				Denominator: Number of General + HRGs tested , Numerator: number General + HRGs referred)
TB patients tested for HIV				
TB-HIV patients co-infected				

Equipment

Equipment	No in place	Working	AMC (Y/N)	Calibration (Y/N)	Remarks
Centrifuge					
Micro Pipettes			NA		
Needle Destroyer			NA		
Refrigerator					
Thermometer					
Colour coded Waste Disposal					

Equipment	No in place	Working	AMC (Y/N)	Calibration (Y/N)	Remarks
bins					
Computer				NA	
Internet Connection			NA	NA	
Sample transport box					

IEC and registers

IEC and registers	No in place	Available or not available	If not available since when	Remarks
Condom outlet				
Complaint box				
IEC material for clients				
IEC material for display				
Registers				

Stock and consumables status as on date_____:

Stock / Commodity	Average Consumption/ last month	Available stock	Expiry date	Remarks (excess/ shortage/ storage)
HIV Test Kit 1 (Name: _____)				
HIV Test Kit 2 (Name: _____)				
HIV Test Kit 3 (Name: _____)				
HIV Test Kit 4 (Name: _____)				
PEP Drug				
Nevirapine Tablet				
Nevirapine Syrup				
Syringes and needles				
Safe delivery kits				
Condoms				
Others specify				

General Observations (besides those discussed above):

- Sign board for ICTC
- Counselling room (AV privacy and space)
- Universal Precautions and waste disposal mechanism
- EQAS mechanism
- Lab (is it within ICTC or in General Lab)
- Submission of SOE and UC
- Other
  If any, Corrective actions are taken after last visit of Officer from SACS/NACO /Evaluation etc to the facility.

Support extended by the visiting officer
(Briefly list the support extended to the ICTC during the visit)

Observations/Suggestions: (For facility if any):

Sl. No.	**Observation**	**Suggestion**	**Responsible person**	**Time line**

Signature of visiting officer:

Annexure 23: Monitoring tool - FICTC

Name of FICTC: Date of Visit:

Address of FICTC:

Name	Designation
Visiting officer/s	
Staff met during visit	
	Medical Officer –In charge
Follow-upon previous visit(*For action points, refer to previous visit reports*)	
Date of last visit:	**Name of the officer visited last time:**
Action points of last visit	**Action taken (Status)**

Human Resource			
Total No. of staff in place	**Total no. of post vacant**	**Total No. of staff trained**	**Remarks (reason for turnover/not trained**

Key Indicators	Month -1	Month -2	Month -3	Remarks
Total tested (all)				
Total Found positive after first test				
ANC Registered				
ANC Tested				
ANC Tested direct in labour				
Total ANC Found positive after first test				
Positive Deliveries in month				
Number of ANC Clients tested for Syphilis (VDRL/RPR Test)				
Number of ANC Clients found reactive for Syphilis				
Number of patients diagnosed and treated for various STI/RTI(Non ANC)				
Number of STI/RTI patients tested for Syphilis (VDRL/RPR Test)				
Of Above, Number found reactive for syphilis				
Referred to ICTC				
In referral from OBG/GYN (ANC)				
In referral from STI Clinic				
In referral from RNTCP				
In referral from TI				

Stock and consumable status as on date_____:

Stock	Average Consumption/ last month	Available stock	Expiry date	Remarks (excess/ shortage/ storage)
HIV Test Kit 1 (Name: _____)				
Whole Blood Test kits				
Availability of essential STI/RTI drugs				
Safe delivery kits				
Condoms				
Others specify				

IEC and registers

IEC and registers	No in place	Available or not available	If not available since when	Remarks
Condom outlet				
Complaint box				
IEC material for clients				
IEC material for display				
Registers				

General Observations (besides those discussed above):

Support extended by the visiting officer
(Briefly list he support extended to the FICTC during the visit)

Observations/Suggestions: (For facility if any):

Sl. No.	**Observation**	**Suggestion**	**Responsible person**	**Time line**

Signature of the visiting officer

Annexure 24: Monitoring tool - TI NGO

Name of TI NGO: Date of Visit:
Address of TI NGO:

Type of Intervention: FSW/MSM/IDU/Migrant/Truckers (pl. tick whichever is applicable)
Target as per TI Contract:

Name	**Designation**
Visiting officer/s	
Staff met during visit	
Follow-upon previous visit(*For action points, refer to previous visit reports*)	
Date of last visit:	**Name of the officer visited last time:**
Action points of last visit	**Action taken (Status)**

Human Resource				
Total No. of staff sanctioned	**Total No. of staff in place**	**Total no. of post vacant**	**Total No. of staff trained**	**Remarks (reason for turnover/not trained**

Infrastructure	**Observation**	**Remarks**
Project Office		Separate space for counselling, STI clinic etc.
DIC		(Proximity/ location of the DIC (near a hotspot) to sex work sites or IDU hotspots)Is the timing of the DIC as per the needs of the HRG)
Clinical infrastructure and space for STI treatment		Is Audio Visual privacy ensured?

Key Indicators for last 3 months:

Key Indicators	Observation	Remark
Date of Reporting in SIMS		
Targets as per TI contract		
Number of HRG's Registered		
Number HRGs as active population		(Number of HRGs availing services once in last 6 months).
Proportion of HRG's regularly contacted by peers		(Denominator: Number of HRGs as active population, Numerator: number of HRGs regularly contacted by peers)
Proportion of HRGs attending RMC		(Denominator; Number of active population of HRGs ; Numerator: Number of HRGs attending RMC)
Proportion active population of HRGs accessed STI services at Govt. DSRC		(Denominator: Number of HRGs as active population; Numerator: Number of active population of HRGs accessed services at DSRC)
Number of HRG's treated for STI		(Denominator: Number of HRGs detected with symptomatic STI; Numerator: Number of HRG's provided treatment at PPP clinic/DSRC.
Proportion of condom demand met with distribution:		(Denominator: Number of condoms required per demand from peer educators; Numerator: Number of condoms supplied)
Proportion of Needle/Syringe distribution meeting demand		(Denominator: Number of needles/syringes required per demand from peer educators; Numerator: Number of needles/syringes supplied)
Proportion of HRGs got tested for HIV at ICTC		(Denominator: Number HRGs in active population less number of HRGs already found HIV positive Numerator: Number HRGs in active population less number of HRGs already found HIV positive referred to ICTC)
Proportion of HRG's found HIV positive		(Denominator: Number of HRG referred to ICTC Numerator: Number HRGs found HIV positive at to ICTC)

Key Indicators	Observation	Remark
Proportion of HIV positive HRG's linked to ART		Denominator: Number of HRG found HIV positive at ICTC, Numerator: Number of HRGs found positive and registered at ART centre)
Proportion of HRGs Referred to DOT/RNTCP		(Denominator: Number HRGs in active population less number of HRGs already detected with TB and on TB treatment Numerator: Number HIV positive HRGs and suspected TB HRGs in active population less number already on TB treatment referred to DOT/RNTCP
Proportion of HRGs availing for social entitlements/schemes		(Denominator: Number HRGs in active population applied for social entitlements/schemes Numerator: Number HRGs in active population sanctioned with social entitlements/schemes

Equipment's

Equipment and registers	No. in place	No. Working	Remarks
STI Clinic -Speculum			
STI Clinic –Proctoscope			
Computer			Also check AMC
Internet Connection			
TV with CD/DVD player			

IEC and registers

IEC and registers	No in place	Available or not available	If not available since when	Remarks
Condom outlet				
Complaint box				
IEC material for clients				
IEC material for display				
Registers(17 in HRGs TIs)				

Stock Status as on date_____

Consumables or kits	Average consumption per month	Stock position	Expiry date	Remarks (including shortage/ excess/ storage)
Needle/Syringe				
Condoms				
Lubes (MSM project)				

If STI Clinic available with in TI NGOStock Status as on date_____

Consumables or kits	**Average Consumption / last month**	**Stock position**	**Expiry date**	**Remarks (including shortage/ excess/ storage)**
Kit 1 (Grey) UD, ARD, cervicitis				
Kit 2 (Green) Vaginitis				
Kit 3 (White) GUD				
Kit 4 (Blue) GUD				
Kit 5 (Red) GUD				
Kit 6 (Yellow) LAP				
Kit 7 (Black) IB				
RPR Test Kit/TPHA				
Any other (specify)				

Key observations(in addition to the ones discussed above):

- Master Register available in soft copy (Y/N) :
- Are micro plan for each hotspot and service map for HRGs available and updated?
- Is abscess management for IDU adequate?
- Is the disposal of used needle and syringes done as per guidelines (Refer to waste disposal guidelines applicable to IDUs)
- Are the materials (social mapping, IEC materials) prominently displayed in the DIC
- Availability of recreational materials for the HRG (Television/VCD/playing materials)
- Are all the fixed assets codified and updated?
- Are all books of accounts (Cash book, Ledger, Voucher folio) updated?
- Are UC/SOE submitted to SACS on time?
- Interaction between various functionaries in TI
- Advocacy and awareness conducted by TI NGO with key stakeholders
- Availability of adequate space for Drop in Centre:
- Interactions with Peers, KPs and HRGs (if any):

- If any, Corrective actions are taken after last visit of Officer from SACS/NACO /Evaluation etc to the facility.

Support extended by the visiting officer
(Briefly list the support extended to the TI during the visit)

Observations/Suggestions: (For facility if any):

Sl. No.	**Observation**	**Suggestion**	**Responsible person**	**Time line**

Signature of visiting officer:

Annexure 25: HIV- TB monitoring indicators and reporting mechanism at CSC level

Indicator No.	Indicator	Tools to capture	By whom	Actions to be taken
1	Number of PLHIV who are on Anti Tuberculosis Treatment (ATT) during registration or TB screening by CSC staff	CRF (Section C.11) / MPR-II	PC/Counsellors/ORWs	Follow up mechanism will be initiated (every month for a quarter)
2	Number of PLHIV screened for TB by CSC staff through ICF	CRF (Section C.11) / MPR-II	PC/Counsellors/ORWs	Immediately linked to ART and provided counselling at CSC
3	Number of PLHIV referred to nearest TB testing facility	Referral register/ ORW register	PC/Counsellors/ORWs	Collect the referral slip (Part C) with test result from the DMC *(by ORW)*
4	Number of PLHIV got the testing done and received the test result from the TB testing facility	Referral Slip / MPR-II	PC/Counsellors/ORWs	Collection of test result from the DMC *(by ORW)*
5	Number of PLHIV reported with Pulmonary TB positive	Referral Slip / MPR-II	PC/Counsellors/ORWs	Immediately linked to ART and conduct home visit to do ICF for family members and provided counselling at CSC
6	Number of PLHIV reported with Extra Pulmonary TB	Referral Slip / MPR-II	PC/Counsellors/ORWs	Immediately linked to ART and conduct home visit to do ICF for family members and provided counselling at CSC
7	Number of PLHIV initiated on ATT	CRF (Section H) / MPR-II	PC/Counsellors/ORWs	Follow up mechanism will be initiated (every month for a quarter)
8	Number of PLHIV completed ATT treatment in the reporting period	MPR-II	PC/Counsellors/ORWs	Followed up after six months

Annexure 26: Monitoring tool - Care and Support Centre (CSC)

Name of CSC: Date of Visit:

Address of CSC:

Name	Designation
Visiting officer/s	
Staff met during visit	
Follow-upon previous visit(*For action points, refer to previous visit reports*)	
Date of last visit:	**Name of the officer visited last time:**
Action points of last visit	**Action taken (Status)**

Human Resource				
Total No. of staff sanctioned	**Total No. of staff in place**	**Total no. of post vacant**	**Total No. of staff trained**	**Remarks (reason for turnover/not trained**

Number of ART centre/s linked	**Name of the ART centre linked**
Total "Pre-ART" registration at the ART Centre	**Total "on-ART" registration at the ART centre**
Proportion of PLHIV registered in HIV care at the ART centre, registered in the CSC *Denominator: total number of PLHIV (Pre /On ART) registered in HIV care at ART centre.* *Numerator: out of total registered in ART centre, number of (Pre/ON ART) PLHIV registered in CSC*	

Annexure 27: Monitoring tool - OST centre

Name of OST: Date of Visit:

Address of OST:

Name	Designation
Visiting officer/s	
Staff met during visit	
Follow-upon previous visit(*For action points, refer to previous visit reports*)	
Date of last visit:	**Name of the officer visited last time:**
Action points of last visit	**Action taken (Status)**

Human Resource				
Total No. of staff sanctioned	**Total No. of staff in place**	**Total no. of post vacant**	**Total No. of staff trained**	**Remarks (reason for turnover/not trained**

Key Indicators

Indicator	Observation	Remarks
Is the centre Government led or NGO led		
Are the reports being regularly submitted by the OST centre?		
Is the centre located near the hotspot/s or easily accessible to the clients		
Total number of target allocated to the centre		
Total no. of clients registered for OST till this month (Cumulative)		
Total number of clients regularly accessing OST in the month ('Regular' defined as >24/30 days or >25/31 days)		
Total no. of clients completed the treatment		

Total Loss to Follow-up (LFU) Out of the expected OST clients, total number of clients who did not receive OST on even one day during the reporting month		
New LFU(Out of the expected OST clients, number of clients who were in treatment till preceding month but did not receive OST on even one day during the reporting month)		
Total no. of clients dropped out (drop out defined as clients not receiving the medicines for 7 days continuously in a given month) (Cumulative)		
Reasons for any increase / decrease in drop-out rates?		
Are the drop outs being followed up in the field?		

IEC and registers	No in place	Available or not available	If not available since when	Remarks
Condom outlet				
Complaint box				
IEC material for clients				
IEC material for display				
Are the records in place and updated regularly				

Stock status as on date :

Indicator	Observation	Remarks
Is the storing site of the OST medicines satisfactory as laid down in the SOP (storage space and condition)		
Is there any discrepancy in the medicine stocks?		

Referral & linkages made for the OST clients

Services	No. of referrals made	No. of clients who used the referred services	Follow- up plan/ Remarks
ICTC			
ART			
RNTCP			
Detoxification			
Rehabilitation			
Others (like welfare services, legal aid, etc)			

Support extended by the visiting officer
(Briefly list the support extended to the OST during the visit)

Observations/Suggestions: (For facility if any):

Sl. No.	Observation	Suggestion	Responsible person	Time line

Signature of the visiting officer

Annexure 28: ART Centre Airborne Infection Risk Assessment Tool

(Disclaimer: The information collected in this risk assessment tool is solely for the purpose of quality improvement pertaining to the Airborne Infection Control policies and practices in the facility.

The information thus collected either through interviews, observations and measurements would be kept confidential within the health system.)

Date of Assessment Visit: ….. / …… / …..

Members of the Risk Assessment Team			
SN	**Name**	**Designation**	**Signature**
1			

A. General Information	
1. State and District:	
2. Name of the Health Care Facility where ART centre is located:	
3. Type of Health Care Facility: (choose from list below) :	
a. **Tertiary Care Facility:** Medical College Private Multi-Specialty Hospital b. **Secondary Care Facility:** District Hospital. General Hospital , Sub-District Hospital (SDH) , Rural Hospital (RH) , Community Health Center (CHC), Private centre	

B. Health care facility Information
4. Total Number of Staff at facility :
a. Number of Medical Officers (including PG Residents) :
b. Number of Nursing Staff :
c. Number of other paramedical staff –including pharmacists, counselors, Data Managers) :
d. Number of other paramedical staff - Class IV (including sweepers, dressers, janitors etc.):
e. Number of non medical staff including Data Managers :
f. Total Bed strength of hospital
g. Total daily OPD attendance

5 ADMINISTRATIVE CONTROL					
	Elements/Indicators	**Yes**	**Requested for**	**No**	**Comments**
5(A)	**Guidelines and Policies**				
5.a 1	Facility level infection control (IC) committee or bio-medical waste (BMW) management committee in place.				
5.a 2	Composition of the IC Committee / BMW management Committee (including departments covered) :				
5.a 3	Is the ART center Nodal Officer a member of the HICC?				
5.a 4	Is Nodal Officer also designated for IC activities?				
5.a 5	Is Nodal Officer trained on IC control activities?				
5.a 6	How often does the committee meet?				
5.a 7	When was the most recent committee meeting?				
5.a 8	Are the minutes of these meetings available for review				
5.a 9	Facility IC/BMW management plan available in written form?				
5.a 10	Is there an institutional policy to provide N-95 or FFP2 (or higher) respirators to staff who have contact with patients with DR TB and other infectious airborne diseases?				
5.a 11	Is a site-specific "facility infection control plan" including AIC been developed and is available to staff at ART center				
5.a 12	Has a facility risk assessment for AIC been performed at least annually?				
5.B)	**Trainings**				
5.b 1	Is Infection control education/training for staff been performed in last 2 years?				
5.b 2	Is an Occupational Health Program/HCW surveillance (TB screening and treatment) in place at this facility?				
5.b 3	Is Staff training plan for Infection Control /or bio-medical waste in place?				
5.b 4	Is Standardized training material on IC training of staff available?				
5.b5	* Has AIC training for ART centre staff conducted in last 2 years?				
***Please fill the details related to ART staff training in table 6**					
5.C)	**Information and Education**				
5.C)	**Information and Education**				
5.c 1	Is information on AIC available for all patients and visitors and is offered by staff?				
5.c 2	Is all information and educational material systematically checked to prevent inclusion of stigmatizing or discriminatory language?				
5.c 3	Observe whether patients routinely asked/monitored by Staff nurse and Care coordinator for cough or other symptoms (4S+/-) of TB upon entering/waiting in the facility?				
5.c 4	Observe whether Staff Nurse and Care coordinator person/s give cough etiquette guidance?				
5.c 5	Are patients with cough or other symptoms of TB promptly separated and fast tracked?				
5.c 6	Are signages for cough etiquette displayed?				

5	ADMINISTRATIVE CONTROL				
	Elements/Indicators	**Yes**	**Requested for**	**No**	**Comments**
5.D)	**Monitoring and Reporting**				
5.d 1	Does the Care Coordinator does routine ICF for all clients with any of the four symptoms and record it in remark column of patient visit register?				
5.d 2	Does the ART center maintain the line-list for all suspected TB case referrals?				
5.d 3	Is the fast tracking of cases also done at other services such as pharmacy, laboratory etc within the institution?				
5.d 4	Are all patients diagnosed with TB are notified in accordance with national program policies?				
5.d 5	Does the ART center have an updated HIV-TB register?				
5.d 6	Is the TB – HIV line list maintained and monitored for timely TB diagnosis to treatment initiation?				
5.d 7	Are tissues, masks, bins etc available for coughing patients?				
5.d 8	Are TB AIC practices monitored daily *[if yes, provide details(name, designation and contact) of the point person]*				
5.E)	**Passive Surveillance**				
5. e 1	Is Disease Surveillance in HCWs is a part of the facility IC/BMWM plan?				
5.e 2	Does it contain active screening for TB in staff?				
5.e 3	Does it contain passive reporting of TB diagnosed/treated among staff?				
5.e 4	Who is responsible for collecting TB in health care worker information? (specify in remark column)				
5.e 5	Describe total number of health system staff treated for TB from any source (RNTCP or private) in past 2years, by cadre of staff above: (specify no. in remark column)				
5.e 6	Is active screening for TB done for ART staff?				
5. e 7	If information available; total number of ARTC staff treated for TB from any source (RNTCP or private) in past 2 years?				
5.F)	**Environmental**				
5. f 1	Does the facility design, patient flow and triage system comply with what is outlined in the infection control plan and/ or national infection control policy?				
5. f 2	Is the waiting area well ventilated (i.e windows and doors open when feasible) and there is clear display of messages on cough hygiene in all areas frequented by patients?				
5. f 3	Are patients crowded in hallways or waiting areas?				
5. f 4	Are sputum samples collected in a well-ventilated, clearly designated area away from others, preferably others?				
5. f 5	Is regular cleaning and maintenance of directional and extractor fans conducted?				
5. f 6	If Ultra Violet lighting is used are routine cleaning and maintenance conducted and documentation logs maintained?				
5. f 7	Do staffs monitor natural and/or mechanical airflow daily (especially in waiting rooms and at least one exam room)?				
5.f 8	Any other measures taken by centres for AIC ? if yes write in comments column.				

5 ADMINISTRATIVE CONTROL					
	Elements/Indicators	**Yes**	**Requested for**	**No**	**Comments**
5.G)	**Personal Protective Equipment (PPE)**				
5.g 1	Are surgical masks available for patients with cough or other TB symptoms?				
5.g 2	Are N-95 or FFP2 (or Higher) respirators readily available to all staff that have contact with patients with TB or suspected of having TB in the center?				
5. g 3	Are staffs trained on proper fit of respirators and documentation of training is available?				

6. Staff Trainings Details (write yes if carried out in last 2 yrs.)

Sl.No	Health Care Workers	Number in Place	Training in AIC (Yes/No)	Remarks
1	SMO			
2	MO			
3	Staff Nurse			
4	Counselor			
5	Laboratory Technician			
6	Care Coordinator			
7	Data Manager			
8	RNTCP Staff (LT) / DOT Centre			

Burden of Airborne Infection:

ART Centre: In the last 3 months

7 People Living with HIV/AIDS (PLHIV) on Anti- Retroviral Treatment (ART)		
Number of PLHIV in active care	Number of PLHIV alive and on ART	Average number of PLHIV visiting the ART center per day (source: visit register)

8	TB-HIV co-infection and referrals			
Number of PLHIV referred to TB diagnostic facility	Of the referred, number of patients diagnosed with TB	Of the diagnosed, number receiving Revised National Tuberculosis Control Program (RNTCP) treatment	Total patients enrolled in HIV-TB register	Total number of patients initiated on Co-trimoxazole preventive therapy (CPT)

9 If RNTCP DMC exists

At the Facility level: In the last 3 months (irrespective of quarter)

1. Number of TB suspects examined by smear microscopy:
2. Number of TB cases diagnosed by smear microscopy:

All facilities, regardless of whether DMC exists (DOT Center)

At the Facility level: In the last 3 months (irrespective of quarter)

3. Number of TB patients enrolled for DOTS at the DOT center:
4. Number of TB patients managed indoor at the facility level:

10	Cartridge Based Nucleic Acid Amplification test (CBNAAT) Testing- TB (for last 3months)		
Is CBNAAT testing facility available in the hospital?	Number of PLHIV referred for CBNAAT testing from the ART center	Of the referred, number of patients diagnosed with TB	Of the referred, number of patients diagnosed with DRTB

Annexure 29 : Health Care Facility Airborne Infection Risk Assessment Tool

Key Observations and Recommendations:

(Include ACH calculations and other readings in the relevant section for each of the rooms subjected to environmental assessment, MUST USE photographs to explain the suggested modifications as Annexure)

Observations	Recommendations with timelines and responsible person
1. Existing IC Activities / Staff Involved / Focal points for AIC in the Facility having ART centre Please describe what IC activities of any type are occurring in the institute (including sanitary/waste management activities, what staffs are involved and responsible, whether any IC committee exists and is functional, how frequently they meet. Consider who might be appropriate to designate as focal point(s) for AIC activities, and how AIC activities can be supplement and strengthen existing IC activities. How can this facility put in place the mechanism and empower the right people to achieve the AIC Guidelines requirements for ART centre specifically managerial activities .	
Facility IC plan, including AIC measures Comment on what IC plan / manual / guidelines are available at the facility, what they include, any AIC elements, to what extent the plan is implemented and monitored. Considering THIS facility, what key elements of the Generic Facility Infection Control Plan (Appendix 4, Page 66) should be prioritized in the new/revised IC plan that will be developed as a result of this assessment? (in other words, after discussion with the administrators, which AIC policies, procedures, and activities should be included, and for what area of the facility, and who would be responsible for implementation and monitoring?). Summarize administrative activities by area as well, for subsequent ease of implementation.	
Re-thinking or re-organization of spaces available, and decompression of crowded places & waiting areas for the ART services Please comment on what is observed in terms of use of available space, with special attention towards crowded places, waiting areas, and high risk areas. Provide explanatory photographs (even phone camera is fine) and/or floor plan sketch (hand sketch is fine) in Annexure to help explain. Make recommendations on how spaces should be re-organized (i.e. re-organization of service delivery areas / waiting) or revised/renovated (structurally) to achieve reduced risk of airborne transmission where that risk is currently high. Organize your suggestions by areas. [Renovation suggestions can be general here; Specific details on renovations are to be included in the next section]	

Renovation of the ART Centre facility to reduce risk of airborne transmission In consultation with engineers/architects if available, please comment on specific recommended renovations, including statement of weaknesses observed and expected benefit of renovation, and specific detailed suggestion on how it should be done. This includes any additional changes required for improved ventilation. Use pictures / drawings where possible. Organize suggestions by areas.
Training of frontline HCWs (doctors, nurses, paramedical staff) in the ART facility on infection control What training / sensitization have various cadres of staff had on any infection control (including universal precautions, waste management). This could have included avian or swine flu prevention. How do you suggest staff are trained on the AIC activities for TB and DRTB and policies? Which staff, when, how, and by whom?
Budget available in the facility for AIC measures & maintenance of the ART centers On discussion with the administrators and the State, describe the costs expected in implementation, and what budgetary options are available to implement the recommendations.
Surveillance of TB in HCWs in the ART centre Please comment on what currently is done for instances of suspected TB among HCW (all levels) at the ART centre , and what opportunities are available to systematically collect instances of persons diagnosed and treated for TB over the pilot project period. How can this information be systematically kept and updated by the facility administration?
Any other issues:

Annexure 30: Internal Evaluation Formats

Basic information of the district: _____, State_____

Note: This information has to be provided by the DTO prior to IE and may be emailed to team members sufficiently in advance if so desired
The district also needs to compile and keep ready the information about the monthly laboratory abstracts of all DMCs for the quarter prior to IE (Modified Annexure M)

1	Implementing RNTCP since	
2	Population in current year (projected population)	
3	Urban Population	
4	No. of TUs	
5	No. OF DMCs	
6	No. of PHIs in the district	
7	No. of PHCs (including new PHCs)	
8	No. OF CHCs	
9	No. of District Hospitals /General Hospitals	
10	No. of Medical Colleges	
11	Implementing DOTS-Plus since	
12	IRL assigned to the district	
13	DRTBsite for the district	
14	Dispensaries/hospitals of other sectors like ESI/Railways, etc (please specify) (Include only those where a MO is posted)	
a		
15	TB/HIV collaboration centres	
a	Number of ICTCs in the district	
b	Number of ART centres in the district	
c	Number of CCCs in the district	
d	Number of TI sites in the district	
e	Number of ICTC and DMCs co-located	
15	State if the district is predominantly a tribal district or has any other geographical or socio political characteristic	

Status of Human Resources

Staff	Sanctioned	In place		**In place and trained**
		Govt	RNTCP contractuals	
DTO				
MODTC				
MOTCs				
DOTS-Plus/TB-HIV coordinator				
STS				
STLS				
MO-PHIs				
LTs				

DMC LTs				
MPWs (including MPHS)				
Other DOT providers				
ICTC counsellors				
ICTC LTs				
District ICTC supervisor				
No. of DMCs without LTs				
No. of PHIs without Medical Officers				

Annexure 30.1: Form 1: Review of TU reports and TB registers

Review each TU report, TB register, Lab registers and treatment cards. Abstract the following information for the most recent quarter for which treatment outcomes are available. For example, if you are conducting the IE during the fourth quarter 2009, then select all new smear positive patients registered in quarter 3, 2008. Validate the outcome in the TB register after triangulation with treatment card and Lab registers.

S. NO.	Name of TU	TU report			TB Register			Difference in NSP cure rate (use only %) (b-a)	TU report			TB Register		
		NSP registered	NSP cured (No.)	Cure rate (a)	NSP registered	NSP cured (No.)	Cure rate (b)		SP-RT registered	SP-RT cured (No.)	Cure rate (c)	SP-RT registered	SP-RT cured (No.)	Cure rate (d)
1														
2														
3														
4														
5														
Total (district)														

NSP=New smear-positive patients

SP RT= Smear positive retreatment excluding others

If there is a difference between TU report and TB register, what are the reasons for the same (eg: error in counting, lack of knowledge, misclassification of "treatment completed" patients as "cured", false reporting, etc)_____

Please, also, give the following information

S. No.	Name of the TU	No. of SP patients whose treatment outcome was reported	No. of treatment cards of SP available
1			
2			
3			
Total (district)			

Annexure 30.2: Form 2 a: Data collection at the State level	
Elicit the following information by discussion with the STO and other officials. It is not essential to ask questions in the order given below.	
Interview with STO	
Supervision, monitoring and Evaluation	
1. Does the STO conduct technical and administrative review with all DTOs at least quarterly? (Say yes, only if minutes of the meeting are available)?	(Yes/No)
2. Is there a tour diary/tour report of the STO?	(Yes/No)
If yes, please review the last two months' reports and list the following:	
Month/Year	
No. of visits in the month	
No. of TUs visited*	
3. Was the programme performance reviewed by the Secretary Health for any quarter in the last 3 quarters?	(Yes/No)
4. No. of quarterly review meetings attended by the Director of Health Services in the last 3 quarters: ____	
5. Is RNTCP performance reviewed in the NRHM review meetings by Mission Director NRHM?	(Yes/No)
6. Mention major supports received from NRHM additionalities for the state RNTCP. Mention if there are any constraints in coordination with NRHM and suggestions to resolve them. Use separate sheets.	
7. Has the STO and STDC faculty undergone data management training?	
8. Is the state and district data analysed and displayed at STC/STDC?	
9. Is there a focussed review mechanism for underperforming district/Tus in the state	
10. Is there a system for effective feedback on programme performance to Districts/TUs? Check whether the state is publishing District and TU level perf, feedback letters from STC/STDC to districts etc.	
11. Number of State internal evaluations conducted by state in the last 4 quarters.-Review the SIE reports and comment	
Drugs and Logistics	
1. Is there a designated store-keeper for the State Drug stores?	(Yes/No)
a. Is he computer literate?	(Yes/No)
b. Has he undergone training in drug logistics under RNTCP?	(Yes/No)
2. Has there been any drug shortage or expiry of drugs in the state in the past 1 year? If yes how was it managed? Use separate sheet if required	(Yes/No)
3. Is the stock register maintained as per RNTCP guidelines?	(Yes/No)
a. Does the Stock register give Expiry-wise details of closing stocks?	(Yes/No)
b. Are drugs being issued as per FEFO principles?	(Yes/No)
c. Are Issues to DTCs based on DTC Qtr reports ie. quarterly or based on Indents ie. monthly or need-based?	(Yes/No)
e. Are SIVs being prepared for issue of drugs to DTCs?	(Yes/No)
f. Are acknowledgements being regularly sent to the GMSDs for drugs received at the SDS?	(Yes/No)
g. Check if Physical Verification is done regularly by the STO / Dy STO/Designated Officer at State level	(Yes/No)
4. Inspect the State drug store	

a. Are there racks in the store (as per RNTCP guidelines)	(Yes/No)
b. Do the drug cartons/PWBs clearly indicate the drug & its DOE	(Yes/No)
c. Are the drugs kept away from the walls and off the floor	(Yes/No)
d. Are there enough drugs to last 3 months	(Yes/No)
e. Have drugs been stacked drug-wise & expiry-wise?	(Yes/No)
f. Are adequate storage arrangements available at the SDS?	(Yes/No)
g. Check if Fire-Extinguishers/ exhaust fans are installed in the SDS?	(Yes/No)
5. Check whether State Quarter Report has been prepared on the basis of the WRDR format?	(Yes/No)
a.To check if the State Qtr Report has been correctly consolidated from its DTC Reports, ask for all the DTC Qtr Reports & the State level qtr report that is to be compared in the format given	(Yes/No)
6. Check whether 2nd line drugs are stored seperately from the 1st line drugs	(Yes/No)
a. Is a seperate Stock Register mainatined for 2nd line drugs & as per RNTCP guidelines?	(Yes/No)
b. Does stock Register contain separate folios for Loose drugs & for IP/CP 3-monthly boxes?	(Yes/No)
c. Are IP/CP 3- monthly boxes being prepared as per RNTCP guidelines?	(Yes/No)
d. Does the 2nd line drug store have an AC fitted? What is the power back up facility available in case of a power failure?	(Yes/No)
e. Are adequate storage arrangements in place as in case of 1st line drugs?	(Yes/No)
f. Is the DOTS-Plus site monthly report received at the SDS regularly & whether issues to them are based on these reports?	(Yes/No)
g. Are incomplete IP/CP boxes received from districts regularly for repacking?	(Yes/No)
h. Inspect the state drug store, review the records and reports pertaining to drug logistics, discuss with state pharmacist and STO and comment on the mechanism of distribution of drugs to the districts with suggestions for improvement. Use separate sheets	
State Action Plan	
a. Had the state prepared the State Action Plan for the current financial year? (Yes/No)	(Yes/No)
b. If yes, has the state been able to work on the priority areas for achieving the objectives planned? Review State action plan. (Yes/No)	(Yes/No)
c. Examine the SOE of the last 4 quarters. Has the state able to release fund to district according to the action plan under each head? If not what are the constraints? Discuss in extra sheet separately if required.	(Yes/No)
d. Examine the latest SOE of the state and districts – are funds available under each head at the beginning of the quarter.	(Yes/No)
e. Are there sufficient funds under contractual head & lab consumables head (sufficient for at least 2 months)	(Yes/No)
f. No. of months in which salary of the contractual staff was delayed for more than 10 days in the last 3 months _____. Reasons for delay: _____	
IRL	
a. Is there an IRL in place?	(Yes/No)
b. Is there a microbiologist in place and trained?	(Yes/No)
c. has the IRL received accreditation for C&DST?	(Yes/No)
d. If not what are the constraints in getting accreditation. Use separate sheeets if necessary.	
e. Is continuous supply of electricity and water assured in the IRL?	(Yes/No)

f.Inspect IRL and comment on, infrastructure including equipments, HRD and recording and reporting related to EQA and C&DST . Use separate sheet.	
g. Number of OSE visits conducted by IRL team in the last 4 quarters.	
h. Review the reports of IRL OSE visits available and comment on the quality of reports and action taken on the report -use separate sheet.	
i. Are the specifications for lab consumables and chemicals procured by the district as per the guidelines? Yes/No (refer to QA guidelines for the same). If no, what are the corrective actions being taken _____	(Yes/No)
j. Has the State been visited by the NRL in the last one year? (Yes/No), if Yes review the report and see whether the recommendation of the NRLs have been complied with or not.	(Yes/No)
Medical Colleges	
1. Number of Medical Colleges in the State	
2.Number involved in RNTCP (Number having DMC and DOT centre)	
3.If there is any medical college, not involved in RNTCP- explore reasons and suggest steps to involve them-use separate sheets	
4. Number of STF meetings conducted in the last 4 quarters	
5.Is there an operational research committee with STF? If yes what is the frequency of OR committee meetings?	
6.Number of OR proposals submitted from the medical colleges to the OR committee in the last 4 quarters	
7. Out of which how many were forwarded to the Zonal OR committee	
8. Number of ORs sanctioned	
9. Number of ORs for which fund was released.	
10. Number of PG theses proposals submitted to state OR committee in the last 4 quarters	
11. Number of PG theses proposals approved	
Status of TB-HIV co-ordination (The team to visit one nearby ICTC and ART centre is available)	
a. How many state coordination committee meetings for TB-HIV have been organized in last one year? ____	
b. How many state working group meetings for TB-HIV have been conducted in last one year? ____	
c. Number of Joint TB/HIV visits conducted by STCand SACS in the last one year. Review the reports and comment.	
d. Review the mechanism of procurement and distribution of cotrimoxazol for decentralised CPT. Use separate sheet.	
e. Discuss on training status of key staff of both RNTCP and HIV programme in intensified TB/HIV package. Use separate sheets.	
ACSM activities:	
a. Has the State has an IEC action plan?	
b. Is this plan in line with the overall IEC plan of the NRHM of the state?	
c. If yes, have the IEC activities been carried out as per the action plan (please also see the relevant records for the same)? (Yes/No)	
d. Reasons for deviation in the action plan, if any: _____	

e. Have the state conducted any capacity building workshop or training for ACSM in the last 4 quarters? If yes give details, use separate sheet.	
f. How many districts have been visited by the State IEC officer in the last 4 quartres? Comment on the contribution the State IEC Officer has done to the districts-use separate sheet.	
e. List the major ACSM initiative happened in the state in the last 4 quarters. _____	
Involvement of Other sectors:	
a. Has the districts done line listing of all the major health facilities under other sectors (PPs, NGOs, ESI, Railways, Steel, CGHS, Coal, Mines, etc.) in the districts? Say yes if the list is available (Yes/No)	
b. Has the districts been able to identify the facilities for involvement on a priority basis? (Yes/No)	
c. Number of NGO/PP schemes (signed and unsigned) in the last 4 quarters	
d. Do the state have IMA/CBCI/GF projects? If yes review the activities and comment on the additional inputs the projects provide and suggest improvements if required-use separate sheets.	
e. Any constraints faced:	
DOTS-Plus	
1. Has the state DOTS-Plus committee formed?	
2. If yes how frequent the committee meet? Review minutes	
3. Is the DOTS-Plus action plan (initial/expansion plan) prepared and submitted to CTD? If yes review the action plan	
4. Number of DOTS-plus sites proposed	
5. Number of DOTS-plus sites where civil works for MDR ward has been completed	
6. Number of IRLs proposed in the action plan	
7. Number of IRLs accredited	
8. Review the DOTS-Plus TB register, treatment cards, IRL Lab register	
a. Is the Treatment cards at DOTS-Plus site updated ?	
b. If yes what is the frequency of updation?	
c. What is the mechanism in place for updating the treatment cards? Discuss, use separate sheet if required	
d. Is the DOTS-Plus TB register complete and up to date?	
e. If IRL and DOTS-Plus site are at State headquarters, triangulate data of IRL Lab register, DOTS-Plus treatment card and DOTS-Plus TB Register. Take the cohort of patients registered 12-15 months earlier (if the programme started recently, take one quarter which is earliest)	
9. Visit MDR-TB ward	
d. Is the MDR Ward located away from other wards?	
a. Is the bed spacing adequate? (at least 6 feet between beds)	
b. Is there sufficient cross ventillation? (Look whether the area of Windows and Doors constitute more than 10% of the Floor area)	
c. Is there a mechanism to keep the windows open at all times and seasons?	
d. If assisted ventilation (eq. exhaust fans) is used, are they kept switched on at all times?	
e. Is there a restriction for visitors?	
f. Check whether the following activities for general and cough hygiene practiced	
1) Hand washing facilities with water, soap or hand wash solution used by doctors, health workers and patients.	
2) Frequent wet mopping of the ward	
3) Any IEC material on Cough hygiene displayed in the ward?	

4) Do patients cover their mouth and nose while coughing and sneezing using surgical mask or cloth?	
5) Are measures of safe collection and disposal of sputum adequate?	
6) Interview the patients and assess their knowledge regarding cough hygiene and etiquettes, sputum disposal, proper use of surgical mask.	
Also interview at least two patients using the DOTS-Plus patient interview format.	
Constraints	
What are the major administrative and technical constraints in RNTCP implementation in the state, and what are the STO's major recommendations for improving implementation of RNTCP in the state? Use additional sheets if required.	

Annexure 30.3: Form 2b : Data collection at the district level	
Elicit the following information by discussion with the DTO & his staff and district officials. It is not essential to ask questions in the order given below.	
1. Supervision	
a. Does the DTO conduct technical and administrative review with all MOTCs, STS, STLS at least monthly (Say yes, only if minutes of the meeting are available)?	(Yes/No)
b.Is there a tour diary/tour report of the DTO?	(Yes/No)
If yes, please review the last two months' reports and list the following:	
Month/Year	
No. of visits in the month	
No. of TUs visited*	
No. of MCs visited (other than the MCs in the TU)*	
*If a TU or MC is visited more than once in the month it will still be counted only once. However, it will be counted in the number of visits in the month.	
c. Was the programme performance reviewed by the District Magistrate for any quarter in the last 4 quarters?	(Yes/No)
d. No. of monthly meetings held by the CS/CMO in which RNTCP was discussed in the last 3 months: ____	
e. Are vehicles for supervisory visits available for DTO, MODTC and MOTCs? Check expenditure under vehicle hiring/POL heads (as the case may be) in SOEs of last 3 quarters and supervisory visits conducted by DTO, MODTC and MOTCs. Constraints if any: use separate sheet if required.	
f. Is there any documentary evidence of the supervisory visits of STSs and STLSs?	
2. Drugs and Logistics	
1. Is there a designated store-keeper for the district stores?	(Yes/No)
a. Is he computer literate?	(Yes/No)
b. Has he undergone training in drug logistics under RNTCP?	(Yes/No)
2. Has there been any drug shortage or expiry of drugs in the district in the past 1 year?	(Yes/No)
3. Is the Stock Register mainatined as per RNTCP guidelines?	(Yes/No)
a. Does the Stock register give Expiry-wise details of closing stocks?	(Yes/No)
b. Are drugs being issued as per FEFO principles?	(Yes/No)
c. Are drugs received from only the SDS or as transfers from other DTCs?	(Yes/No)
d. Are Issues to TUs based on TU Qtr reports ie. quarterly or based on Indents ie. monthly or need-based?	(Yes/No)
e. Are DIVs being prepared for issue of drugs to TUs?	(Yes/No)
f. Are acknowledgements being regularly sent to the SDS for drugs received at the DTC?	(Yes/No)
g. Check if Physical Verification is done regularly by the DTO / Medical Officer	(Yes/No)
3. Inspect the district drug store	(Yes/No)
a. Are there racks in the store (as per RNTCP guidelines)	(Yes/No)
b. Do the drug cartons/PWBs clearly indicate the drug & its DOE	(Yes/No)
c. Are the drugs kept away from the walls and off the floor	(Yes/No)
d. Are there enough drugs to last 3 months	(Yes/No)

e. Have drugs been stacked drug-wise & expiry-wise?	(Yes/No)
f. Are adequate storage arrangements available at the DTC Store?	(Yes/No)
g. Check if Fire-Extinguishers/ exhaust fans are installed in the DTC store?	(Yes/No)
4. Is Reconstitution being done regularly at the DTC?	(Yes/No)
a. Are acknowledgements being given to TUs for incomplete drug boxes received from the field level?	(Yes/No)
b. Is a Reconstitution Register maintained?	
c. Are reconstituted drugs entered into the Stock Register	
5. Check whether District Quarter Report has been prepared on the basis of the WRDR format?	
a.To check if the DTC Qtr Report has been correctly consolidated from its TU Reports, ask for all the TU Qtr Reports & the DTC qtr report that is to be compared in the format given	
3. District Action Plan	
a. Had the district prepared the District Action Plan for the current financial year? (Yes/No)	(Yes/No)
b. If yes, has the district been able to work on the priority areas for achieving the objectives planned? [Review district action plan] (Yes/No)	(Yes/No)
c. Has the district utilised opportunities of additionalities under NRHM? Mention important additionalities district was able to get/planned in the Action Plan from NRHM/-use additional sheet if required.	(Yes/No)
d. Examine the SOE of the last 4 quarters. Has the district able to spend according to the action plan under each head? If not what are the constraints? Discuss in extra sheet separately if required.	(Yes/No)
e. Examine the latest SOE of the district – are funds available under each head at the beginning of the quarter.	(Yes/No)
f. Are there sufficient funds under contractual head & lab consumables head (sufficient for at least 2 months)	(Yes/No)
g. No. of months in which salary of the contractual staff was delayed for more than 10 days in the last 3 months _____. Reasons for delay: _____	
h. Are book of accounts maintained by the DTO?	(Yes/No)
i. What are the major administrative and technical constraints in RNTCP implementation in the district, and what are the DTO's major recommendations for improving implementation of RNTCP in the district? Use additional sheets if required.	
4. EQA Implementation in the district:	
a. Are there labs which should be included as DMCs but are not? (Check OPD attendance of each health facility of the district for a given time period. This should be available with the DTC as preparation for IE of the district) Also are there DMCs which should be closed?	
b. Are the PHIs other than DMCs doing sputum microscopy? If yes, give reasons.	
c. Do all the STLS submit their TU-OSE checklist to the DTO every month? (Yes/No). Say yes, if checklists for all DMCs are available for the last month	
d. Are the specifications for lab consumables and chemicals procured by the district as per the guidelines? Yes/No (refer to QA guidelines for the same). If no, what are the corrective actions being taken _____	
e. Regarding RBRC (please fill this section based on the information and records of the last RBRC round)	
i. Who does the blinding and coding of the slide boxes: _____	

ii. Is RBRC by STLS done in a blinded fashion? (Yes/No) (Please see the schedule of STLS for RBRC at DTC and the arrangements made by DTO for RBRC)	
iii. Is the umpire reading done in a blinded fashion? (Yes/No)	
iv. Has the feedback by DTO based on RBRC report and TU-OSE checklists from STLS sent to DMCs? (Yes/No) If yes, when and how? _____	
v. Has the RBRC report (Annexure E) and monthly lab summary for the district (Annexure M) been sent to IRL/STDC? (Yes/No) If yes, when and how? _____	
vi. Is the monthly sample for RBRC as per the EQA guidelines? (Yes/No)	
f. No. of DMCs that reported major errors in random blinded cross checking in the current year/previous year ___	
g. Were the steps taken by the district adequate to improve the situation in these DMCs? (Yes/No)	
h. Are any STLS working as LT? (Yes/No). If yes, why _____	
i. Based on the above and visit to DMCs, is QA protocol being followed? (fully/partially/not followed)	
j. Has the district sent the Annexure F to NRL ? Review the latest annexure F and comment.	
k. Has the district been visited by the IRL/NRL in the last one year? (Yes/No)	
l. If yes, has action taken report sent to NRL/IRL? Review the IRL/NRL report and ATR and comment whether the recommendations have been complied with.	
5. Monitoring and Evaluation	
1. Has the DTO undergone data management training?	
2. Is the district data is analysed and displayed at DTC?	
3. Is there a satisfactory system for effective feedback on programme performance to TU/PHI levels?	
4. Referral for treatment and Feedback mechanism	
a. Is an updated DOT directory available? (Yes/No)	
b. During the monthly review meeting of the RNTCP staff, are the patients referred for treatment within the district to other TUs reviewed and accounted for? (Yes/No)	
c. No. of patients referred to other TUs within the district in the last quarter: _____ (summation of information from all the TU reports)	
d. Out of these, no. put on DOT: _____. If patients missed during inter TU referral is high, are efforts taken by the district to resolve this issue sufficient? (Yes/No)	
e. How is the information about the patients referred for treatment to other districts compiled and conveyed? _____	
f. No. of patients referred to other districts in the last quarter: _____	
g. Out of these (g) , no. whose feedback was received:_____	
h. Out of these (h), no. put on DOT:_____	
i. Constraints, if any:_____	
j. What is the system for sending feedback for the diagnosed TB patients received from other districts (list the evidence)? _____	
k. Review the communication systems in districts -phone, computer, e-mail, epicentre, backup systems etc and comment.	
6. Status of TB-HIV co-ordination . (The team to visit one nearby ICTC and ART centre if available)	

a. How many district coordination committee meetings for TB-HIV have been organized in last six months? ____	
b. What is the training status of relevant NACP and RNTCP staffs on TB-HIV modules? _____	
c. How many monthly TB-HIV reports for cross referrals from ICTCs are available with the DTO for the last 3 months against number expected? _____ out of _____(____%)	
d. TB patients from amongst ICTC referral being put on DOTS (both HIV positive as well as negative) in the last one year - ___ out of _____ (____%)	
7. IEC activities:	
a. Is the Communication Facilitator appointed for the district? (Yes/No)	
c. Have the district carried out the IEC activities as per the IEC action plan ?(please also see the relevant records for the same)? (Yes/No)	
d. Reasons for deviation from the action plan, if any: _____	
e. Has the State IEC Officer visited the district in the last 2 quarters?	
e. list of major activities done in last 2 qtrs_____	
8. Involvement of Other sectors:	
a. Has the district done line listing of all the major health facilities under other sectors (PPs, NGOs, ESI, Railways, Steel, CGHS, Coal, Mines, etc.) in the district? Say yes if the list is available (Yes/No)	
b. Do the district have IMA/CBCI project for involving PPs?	
c. If yes, comment on the acheivements and constraints with the project, visit some PP/NGO facility and interview stakeholders. Use separate sheet	
d. Has the district been able to identify the facilities for involvement on a priority basis? (Yes/No)	
e. Record being kept at district level for fund release to NGOs-SOEs, Ucs?	
DOTS-Plus	
Compare TB registers of All TUs with District referral register for C&DST (for the quarter -2 quarters prior to IE)	
a. Number of MDR TB suspects in the last quarter-consolidated from TB registers	
c. Number of MDR suspects whose sputum was send for C&DST check District Register for C&DST	
4. Is there a delay in idetifying MDR suspects in the field?	
5. Review the mechanism of collection and transport of samples to IRL. Comment-use separate sheet	
6. Is there a delay in sending the samples for C&DST?	
7. Is the drug logistics for DOTS-Plus as per guidelines?	
8. Number of MDR TB patients on DOTS-Plus in the district?	
10. Is there a provision for free pre treatment evaluation for MDR TB treatment?	
11. How are minor adverse effects managed at field level?	
12. Has all key staff trained in DOTS-Plus?	
Constraints if any:	
20. **Comment on the knowledge and supervision by key RNTCP Staff:**	
1. Review ATP and Supervisory reports of DTO, MOTCs, STSs and STLSs. Comment on the issues reported and corrective actions taken.	
2. Comment on any quality improvement in programme area as a result of action on specific recommendation from these supervisory reports.	
3. Interview Supervisory staff and comment on the knowledge aspect of the programme.	
4. Do the district have any performance appraisal system for the staff?	

Annexure 30.4: Form3 : Data collection at the DMC level

Discussion with the Medical Officer (MO) of the DMC & general observations

1	Are all MOs in the DMC trained in RNTCP?	
2	Are all medical officers identifing chest symptomatics and referring for sputum microscopy?	
3	Is the DMC accessible for all patients in time and place? (discuss timing of DMC, availability of LT, sputum collection and transportation facilities etc with MO and comment on the accessibility issues in the commends and recommendation.)	
4	Is the Supervisory Register available and maintained?	
5	Is there any visible IEC material in the DMC campus?	
6	Does the DMC have adequate drug stock to last one month?	
7	How many sputum collection centres are functioning in the area of the DMC?	
8	Does the MO review patient treatment activities with health workers on a fortnightly basis?	
9	Does the MO visit irregular / defaulting patient to bring them back on treatment?	
10	Review the system of transportation of PWB, treatment cards etc from PHI to DOT centres and comment. Use the section for comments and recommendations.	
Observe the Laboratory and the laboratory register. Complete 1 form for each DMC		
For the previous quarter: name of the quarter	_____	
1	Population of the DMC	
2	No. of new adult out patients in the last quarter	
	(please also include the OPD of the PHIs other than DMCs which are expected to refer the patients. This may be done with the help of the DTO/his representative from the monthly PHI reports of those PHIs)	
3	No. of TB suspects in the quarter	
4	Out of (3), no. of diagnosed sputum positive patients in the quarter	
5	Out of (3), no. of diagnosed sputum positive patients referred outside the district	
		Yes/No
7	Is there a functional binocular microscope in the MC?	
8	Is a trained LT doing the sputum microscopy	
9	Are there adequate supplies of reagents, slides and other consumables for the next one-month?	
10	Are the lab reagents freshly prepared?	
11	If yes, where are they prepared (at MC/TU/District)?	
12	Are the names and addresses in the TB laboratory register written legibly?	
13	Are the positive results written in red & negative in blue/black?	
14	Is there a summary of the microscopy activities at the end of each month?	
15	Is the LT preserving slides for review by the STLS as per the quality assurance protocol?	
16	Is the STLS reviewing slides preserved by the LT during the on site evaluation?	
17	Are the reports of TU-OSE done by STLS available in the DMC (at least for last month)?	
18	Is corrective action as suggested in TU-OSE report being carried out by the DMC? (current status may be used as an assessment about the corrective actions taken)	

19	Is the DMC getting feedback on the results of RBRC done at district level?	
20	Check one randomly selected positive and one negative slide. Is the quality of slides prepared satisfactory in terms of smear thickness, evenness, size and staining?	
21	Is the bio-medical waste from the DMC disposed as per Bio-Medical Waste (management and handling) Rules 1998?	
22	Is there a system for collecting sputum samples and keeping it for smear preparation and examination later in case trained LT is on leave or specimen arrived at a time when the lab is closed? Discuss with MO and LTs to find out the mechanism in place if any and also any accessibily problems in the DMC and report below.	
Commends and Recommendations for this particular DMC-		
1		
2		
3		
4		
5		

Annexure 30.5: Form 4: Data collection at the DOT Centre

Name of the DOT Centre:

	Observe the DOT centre & PWBs and records. Complete 1 form for each DOT centre	**Yes/No**
	Name and designation of the immediate supervisor of this DOT centre (eg. ANM/MPW in case of community DOT provider, MO in PHC DOT Centre etc)	
1	Are patient-wise drug boxes being marked and maintained for each patient?	
2	Are the facilities (clean water, disposable cups, privacy) for DOT satisfactory?	
3	Is there adequate arrangement available for providing Inj SM (if Cat II patients are receiving treatment at this DOT centre)?	
4	Is there consistency between the number of doses on treatment card and drug box? (check any 2 boxes)	
	Box 1 (name_____)	
	Box 2 (name_____)	
5	Are prompt home visits made to bring irregular patients back on treatment? (For patients who have missed doses, check relevant section on treatment card for entries)	
6	Have any of the drugs in the Patient Wise Boxes (PWBs) crossed the date of expiry	
	Box 1 (name_____)	
	Box 2 (name_____)	
7	Is home address verification done for patients before start of treatment? (Check treatment cards for entries in the section for Initial home visit)	
8	Is the DOT provider is supervised adequately by immediate supervisor?	
Interview of the DOT provider (use questions a to d to arrive at answer for Question No. 8):		
a	How are drugs given to a patient in the CP (does the DP mention – first dose is under observation, empty blister pack is to be collected)	
b	When is follow up sputum examination done (Does the DP mention – 2, 4 & 6 months for NSP patients. Further does s/he mention 22nd, 23rd, 24th dose for IP & 16th, 17th, 18th dose for end of treatment sputum examination)	
c	If a patient does not come for taking his/her scheduled dose when should house visit be done in IP & CP	
d	If a patient does not come for taking his/her scheduled dose how should it be marked in the treatment card (Does the DP mention circle at the date & to write reasons in the remarks column)	
9	**Based on above interview is it felt that the DP requires re-training? (Yes/No)**	
If this DOT centre is a PHI and has other DOT centres attached to it then ask the following regarding monitoring Please look at the original treatment cards maintained with the MO. (All the MPWs will have the duplicate cards in which they mark the doses & the original cards should be with the MO & these should be updated at the monthly meetings)		
		Yes/No
1	Are the original cards available for all DOT centres at the PHI?	
2	Do the original treatment cards have the basis for the type of the patients?	

3	Were these updated within the last one month?	
4	Does the PHI staff update these cards?	
5	Does the PHI staff prepare the monthly PHI report?	
6	Is there any visible IEC material at the DOT Centre?	
7	Number of patient provider meeting held in the DOT centre in the last quarter?	
8	Is the patient information booklet available and used?	
9	Is the programme being reviewed on case to case basis using patient treatment card with peripheral health workers and supervisors?	
10	Are community DOT providers getting honararium as per guidelines? If not comment on any issue regarding the provision of honararium -use separate sheet is required.	
11.	**Any other issues of concern observed in the PHI of the DOT centre**	
	Recommendations for this particular DOT Centre-	
1		
2		
3		
4		
5		

	Annexure 40.6: Form 5a NSP DMC:_____		
Case finding ***Patients TB Number***			
1	Pl. indicate if patient interviewed (P), relative interviewed (R) (give relationship & reason for not interviewing the patient on the reverse page)		
2	Age of the patient (write completed age in years)		
3	Sex of the patient (M=Male, F=Female)		
4	Is the patient aware that he/she is/was undergoing treatment for TB?		
5	Did the patient know about TB disease prior to acquiring it?		
6	Havethe patient attended any patient provider interaction meeting/community meeting on TB?		
7	What was the predominant presenting symptom? Cough [C], Fever [F], Heamoptysis [H], Breathlessness [B], Chest pain (P), Others(specify) [O]		
8	Who is the first health care provider, the patient has approched with the symptom? Government [G], Private modern medicne practionioner [P], NGO hospital [N], Other govt/corporate sector[O], non qualified practionioner[Q], Ayush [A]		
9	No.of days between onset of symptoms to first consultation		
10	No.of visits to any health facility before sputum was examined		
11	Who refered the patient for sputum examination? Government [G], Private modern medicne practionioner [P], NGO hospital [N], Other govt/corporate sector[O], non qualified practionioner[Q], Ayush [A], ICTC [I], ART centre[T]		
12	No of days between first consultation and sputum examination		
13	Did the patient found the location of DMC accessible in time and place? If the answer is no, then describe the issues in accessibility separately on the reverse page for each patient. [yes-Y, no-N]		
14	Did the patient provided two sputum samples for diagnosis ? [yes-Y, no-N]		
15	Did the patient have to pay for sputum examination at the DMC? If yes, provide details on extra sheets		
	Case holding		
16	No.of days between diagnosis and start of treatment		
17	Does the patient give past history of anti-TB treatment (> 1 month)?		
18	Did the patient mention that the staff visited his residence to verify the home address, prior to start of treatment?		
19	Does the patient know the correct duration of treatment for his TB?		
20	Does the patient have to pay to travel to the DOT centre?		

21	Did the patient find the location and timing of the DOT centre convenient? If the answer is no, give details on the reverse page.	
22	Did the patient take at least 20 of 24 doses under direct observation in the IP? If no, provide details of how treatment was taken? Use extra sheet if required.	
23	Did the patient have to pay for TB drugs after being registered in the RNTCP? If yes, provide details on extra sheets.	
24	Did the patient take 1st weekly dose under supervision in the CP? If no, provide details of how treatment was taken? Use extra sheet if required.	
25	Has the patient completed treatment?	
26	Did the patient mention that he provided 2 sputum samples at the end of Rx?	
	Contact information	
27	No. of children under 6 years of age in the household	
28	Out of the children under 6 years of age in the household, no. screened for TB	
29	Out of the screened number diagnosed as having TB	
30	Out of the children under 6 years of age in the household, no. received chemoprophylaxis	
31	Number of members in the house	
32	Out of them number who had/having cough	
33	Out of the number of household contacts who had/have cough, number evaluated for TB	
	Others	
34	Is the patient aware of cough ettiquetts?	
35	Have you observed whether the patient is practising cough ettiquette ?	
36	Has the patient any other co-morbidities -Diabetes[D], HIV[H], COPD [C], Others (specify)[O]	
37	Smoking status- nonsmoker [N], past-smoker[X], current smoker [C]	
38	If current or past smoker, Has the patient received any help to stop smoking from health provider -yes [Y],no[N]	
	TB/HIV	
39	Has the patient been offerred HIV counselling and testing?	
40	Does the patient know his HIV status? If no explore the reasons and mention them in the report	
41	Is the patient on CPT (if patient if HIV+ve?) If no explore the reasons and mention them in the report	
42	Has the patient been referred to ART centre?	
43	Is the patient on ART? If no explore the reasons and mention them in the report	

Annexure 30.7: Form 5 b-S+ RT DMC:_____

	Patients TB Number	
1	Pl. indicate if patient interviewed (P), relative interviewed (R) (give relationship & reason for not interviewing the patient on the reverse page)	
2	Age of the patient (write completed age in years)	
3	Sex of the patient (M=Male, F=Female)	
4	Have the patient attended any patient provider interaction meeting/community meeting on TB?	
5	Type of patient- Relapse[R], Failure[F], TAD[D]	
6	Source of previous treatment RNTCP[R], others [O]	
7	Did the patient found the location of DMC accessible in time and place? If the answer is no, then describe the issues in accessibility separately on the reverse page for each patient. [yes-Y, no-N]	
8	Did the patient have to pay for sputum examination at the DMC? If yes, provide details on extra sheets	
	Case holding	
9	Did the patient mention that the staff visited his residence to verify the home address, prior to start of treatment?	
10	Does the patient know the correct duration of treatment for his TB?	
11	Does the patient have to pay to travel to the DOT centre?	
12	Did the patient find the location and timing of the DOT centre convenient? If the answer is no, give details on the reverse page.	
13	Did the patient take at least 20 of 24 doses under direct observation in the IP in the previous treatment cycle (if under RNTCP)? If no, provide details of how treatment was taken? Use extra sheet if required.	
14	Did the patient have to pay for TB drugs after being registered in the RNTCP? If yes, provide details on extra sheets.	
15	Did the patient take all doses under direct observation in the IP in the present treatment schedule? If no, provide details of how treatment was taken? Use extra sheet if required.	
16	Is the patient smear positive at 4months in retreatment schedule?	
17	Has the patients sputum sent for C&DST?	
18	If the patient is a TAD, ask about the reasons for default and whether the reasons have been addressed now? comment on it in the report.	
19	If the patient is a failure or relapse-check whether the previous treatment was regular, what is the total duration of treatment in months, (from the previous treatment card). comment on it in the report.	
	Contact information	
20	No. of children under 6 years of age in the household	
21	Out of the children under 6 years of age in the household, no. screened for TB	
22	Out of the children under 6 years of age in the household, no. received chemoprophylaxis	
23	Number of memebrs in the house	

24	Out of them number who had/having cough	
25	Out of the number of hosehold contacts who had/have cough, number evaluated for TB	
	Others	
26	Is the patient aware of cough ettiquetts?	
27	Has the patient any other co-morbidities -Diabetes[D], HIV[H], COPD [C], Others (specify)[O]	
28	Smoking status- nonsmoker [N], past-smoker[X], current smoker [C]	
29	If current or past smoker, Has the patient received any help to stop smoking from health provider -yes [Y],no[N]	
30	Has the patient been offered HIV counselling and testing?	
31	Does the patient know his HIV status? If no explore the reasons and mention them in the report	
32	Is the patient on CPT (if patient if HIV+ve?) If no explore the reasons and mention them in the report	
33	Has the patient been referred to ART centre?	
34	Is the patient on ART? If no explore the reasons and mention them in the report	

Annexure 30.8: Form 5c DR-TB		
	Patients TB Number	
1	Pl. indicate if patient interviewed (P), relative interviewed (R) (give relationship & reason for not interviewing the patient on the reverse page)	
2	Age of the patient (write completed age in years)	
3	Sex of the patient (M=Male, F=Female)	
	Previous Anti TB treatment	
4	Has the patient missed any doses in IP/CP?	
5	If yes, How many missed doses in IP (0-<5 doses, 1-5-10 doses, 2->10 doses)	
6	How many missed doses in CP (0-<5 doses, 1-5-10 doses, 2->10 doses)	
7	Outcome of the treatment (c-cured, t-treatment completed, d- defaulted, f-failure)	
8	Was Cat II repeated? If yes, cause to be documented in remarks	
	H/o Previous Anti-TB Treatment Prior to DOTS	
9	How many courses of Anti TB treatment the patient has taken before Cat IV?- RNTCP/Non RNTCP	
10	Whether the patient has taken any second line treatment during any of these courses?	
11	Did the patient have any severe adverse drug reaction during any of the first line treatment courses?	
	DOTS Plus	
12	Was the gap between date of eligibility as MDR suspect & date of diagnosis more than 4 months? Y-Yes, N-No	
13	Was the gap between date of diagnosis as MDR and date of initiation of Cat IV more than 2 weeks?	
14	Did the patient have to pay for relevant pretreatment investigations?	
15	Was the patient reimbursed the travel cost to the DOTS-Plus site?	
16	Did the patient suffer any major adverse reaction for which he/she had to be admitted to the DOTS-Plus site?	
17	Is the DOT center accessible and acceptable?	
18	Is the patient aware about his illness?	
19	Is the DOTS Plus treatment card properly marked by the DOT provider?	
20	Is the treatment card at the PHI updated regularly and correctly?	
21	Does the patient face any difficulty in getting the daily injectable?	
22	How many doses has the patient missed in IP and CP	
23	How many retrieval actions have been undertaken and documented	
	Contact information	
24	How many members are there in the patients family?	
25	Out of them no. having cough?	
26	Out of the above number evaluated for TB?	
27	Out of the number evaluated, number found to be smear positive	
28	Of the number found smear positive, number screened for MDR TB?	
	TB/HIV	

29	Has the patient been offerred HIV counselling and testing?	
30	Does the patient know his HIV status? If no explore the reasons and mention them in the report	
31	Is the patient on CPT (if patient if HIV+ve?) If no explore the reasons and mention them in the report	
32	Has the patient been referred to ART centre?	
33	Is the patient on ART? If no explore the reasons and mention them in the report	
	Others	
34	Is the patient aware of cough ettiquetts?	
35	Have you observed whether the patient is practising cough ettiquette ?	
36	Has the patient any other co-morbidities -Diabetes[D], HIV[H], COPD [C], Others (specify)[O]	
37	Smoking status- nonsmoker [N], past-smoker[X], current smoker [C]	
38	If current or past smoker, Has the patient received any help to stop smoking from health provider -yes [Y],no[N]	

If the team visited a DMC which was located at a TU then please record the following

Name of the TU

a	Is stock register maintained as per SOP Manual for drug stores?	**Yes/No**
b	Does the Stock register give Expiry-wise details of closing stocks?	**Yes/No**
c	Are drugs being issued as per FEFO principles?	**Yes/No**
d	Are there enough drugs to last 3 months?	**Yes/No**
e	Do the drug cartons/PWBs clearly indicate the drug & its DOE	**Yes/No**
f	Is the DOE of the drug highlighted with a marker pen on cartons/PWBs?	**Yes/No**
g	Have drugs been stacked drug-wise & expiry-wise?	**Yes/No**
h	Have proper storage conditions been maintained at the TU Store?	**Yes/No**
i	Are enough racks availabe in the store?	**Yes/No**
j	Are incomplete drug boxes being regularly sent back to DTCs for reconstitution?	**Yes/No**
k	Where is the figure of patients put on treatment taken - From the consolidated PHI reports or the TB Register?	**Yes/No**

Annexure 30.10: Form 8: for review of the Medical College during Internal Evaluation

Name of Medical College: _____

1	**DMC**	Yes/No
a.	Is there a DMC in the Medical College hospital? (If Yes, please record the information about the same as per the format for visit to DMC)	
b.	Is there any other lab facility in the hospital where sputum microscopy is being performed?	
c.	If yes in "b", please name it: _____	
d	Is it being quality assured for sputum microscopy under RNTCP?	
2	**DOT Centre**	
a.	Is there a DOT centre in the hospital? (If Yes, please record the information about the same as per the format for visit to the DOT centre)	

3 Human Resource Status (based on interview with nodal officer and relevant records)

a. Medical college staff training/sensitization status in the TB-Chest, Medicine, ENT, Pediatric, Surgery, PSM and Gynecology Depts. (Training as per plan proposed in MO Modules, NTF recommendations)

	Category of staff	**Number in place (a)**	**Out of (a) No trained in RNTCP**	**Out of (a), Total sensitized in RNTCP**
	Faculty trained as "Trainer"			
	Faculty members			
	PG students & Residents			
	Interns			
	Staff Nurses			

b.	Contractual Staff under RNTCP:			
	Staff	Sanctioned	In place	Trained
	Medical Officer			
	STLS			
	LT			
	TBHV			

		Yes/No
c.	Core committee formed?	
d.	If yes, has the core committee met this quarter to review and monitor RNTCP implementation in the College?	

4	**Referral for treatment and feedback mechanism**	Yes/No
a.	Are all TB patients diagnosed by all departments of the hospital channeled through the DOT centre of the hospital?	
b.	If no, what are the constraints in the referral of TB patients to the DOT centre/TB Cell of the Medical College? _____	
c.	Are there any other source of anti-TB drugs (which are already available under RNTCP) available for OPD patients in the hospital?	
d.	Is any feedback regarding referred patients provided to the referring department by the DOT centre/TB cell of the Medical College?	
e.	Is a Referral for Treatment Register maintained in the Medical College hospital? (Yes/No)	
f.	If yes, where is the register located? _____	
g.	Are Referral for Treatment Forms used to refer patients diagnosed in the hospital to other centres within and outside the district?	
h.	Is a DOTS directory of relevant districts available at the Medical College DOT centre?	
5	**Indoor DOTS (based on visit to at least one ward in either TB-Chest/Medicine Department):**	Yes/No
a.	Are the RNTCP supplied drugs used in the wards for indoor patients?	
b.	Are there any other source of anti-TB drugs (which are already available under RNTCP) for indoor patients?	
c.	Are inpatients registered in the same TU where the Medical College is located?	
6	**TB/HIV Coordination (based on visit to VCTC and ART centre)**	Yes/No
a.	Is there a ICTC in the Medical College?	
b.	Is the standard cross-referral mechanism between the DMCs and ICTC established?	
c.	Is there a ART centre in the Medical College?	
d.	Is there a mechanism to put TB patients treated in the ART centre on DOTS?	
7	**<u>Operational research</u>**	
a.	Topics of the OR projects on RNTCP priority areas being carried out by the institute in the last one year:_____	
b.	Topic of the thesis on RNTCP priority areas initiated in the college in the last one year: _____	
		Yes/No
8	**Is the copy of the last monthly PHI report available in the Medical College?**	

Recommendations

(The team should meet the Superintendent/Dean of the Medical College along with the chairperson of the core committee and the nodal officer for RNTCP, to appraise their findings and recommendations)

Annexure 31 : Central Level Internal Evaluation Format

FIELD VISIT REPORT

SUMMARY	
Names of team members	Name of the State
	Dates of visit
Brief summary of findings	
Please attach a list of places visited and persons met (one consolidated list per State team).	

Annexure 31.1: STATE LEVEL

Note: After completing the field visit, use the following template to collate the findings. Teams are required to submit one report containing the state level findings and findings for each district visited. Findings and recommendations for the state level are based on the visits to State level institutions, e.g. State TB Cell, State TB Training and Demonstration Centre (STDC), Intermediate Reference Laboratory (IRL), State Drug Store (SDS), DOTS-Plus site, State AIDS Control Society (SACS) etc. and interviews with state level authorities, e.g. STO, Deputy STO, STDC Director, STDC Microbiologists, MO State TB Cell, DOTS-Plus committee members State Accountant, State IEC Officer, Chairman of State Task Force (STF) for Medical Colleges.

Name of State:

1. Observations

1.1. Organization of TB services in the State Review the organization of TB services, the various relevant departments in the state directorate of health services and their mechanisms of co-ordination with TB.
1.2. Political and administrative commitment Note the extent of political commitment to health in general, and TB in particular. Assess the level of involvement of the State Health Secretary and the Director of Health Services in the TB programme. Note the systems in place for the Health Secretary and Director of Health services to conduct systematic monitoring and review of the RNTCP. Review the NRHM support to the programme and discuss.
1.3. Capacity of the State TB Cell (STC) in programme monitoring Evaluate the capacity of the STC in programme management. Any vacancy of staff in the STC. Note the frequency of supervisory visits by the STO/ staff of STC. Note the frequency of review meetings, the type of programme data analysis that is done at state level and the feedback provided to districts. Assess the role of the STDC in supporting the state in supervision and quality control.
1.4. Capacity of the State TB cell in financial monitoring Assess the systems in place for financial monitoring. Assess the capacity of the human resource involved in financial monitoring at the STC. Review the State Action Plan for the financial year, including the budget and expenditure till date. Study the fund flow system and note the time taken for

the state to release funds to the districts after receiving funds from the central level. Note whether the state has submitted the audit report and utilization certificate for the previous financial year in time. Review the adequacy of delegation of administrative and financial powers to STOs and DTOs. Review the SOEs of relevant heads and compared with action plan.
1.5. Human resources Review staffing and training status of the State TB Cell. Assess whether the STO is full time and note the proportion of districts with full time District TB officers. Review vacancy status of key RNTCP staff in the state. Note the proportion of STS, STLS, and LT who are employed on a contractual basis, and assess the systems in place for maintaining quality in recruitment and retention of staff. Assess plans and systems in place for training (induction training for new and turnover staff, retraining and update training for existing staff).
1.6. Drug management system Visit and evaluate the state drug store. Review the system for storage and distribution of RNTCP drugs. Note any shortages / stock-outs / expiry in the past one year. Assess the systems in place for managing such situations. Assess whether state is procuring anti-TB drugs.
1.7. Involvement of other health sectors (public and private) Review efforts undertaken to involve private practitioners, NGOs, corporate sector, other government health facilities outside health department and other partners in RNTCP. Note the extent to which medical colleges and TB hospitals are involved in RNTCP. Review the activities of the medical college State Task Force. Review the coordination with IMA and major NGOs at the State level.
1.8. Assess Advocacy Communication Social Mobilization (ACSM) activities Assess the state IEC action plans and their implementation, the role of the IEC officer in the State TB Cell and the steps undertaken to increase advocacy for TB control. Review the State IEC reports and the IEC materials prepared by the State. Note the extent of utilization of budgeted funds for IEC activities.
1.9. TB/HIV *Review state level coordination between TB and HIV programmes and the frequency of meetings between the RNTCP and SACS. Interview SACS authorities regarding coordination with TB. Review cross referral linkages between TB and VCT/ART services. Review monthly TB/HIV cross referral reports at*

state level.
1.10. Intermediate Reference Laboratory (IRL) and management of MDR-TB ***Review the status of the IRL with regards to its function in quality assurance of smear microscopy. Review reports on OSE, panel testing and RBRC available with IRL. Review plans for building capacity of IRL on culture and DST, note current status and assess the commitment and the realistic timelines.***

1.11. Any other issues Discuss other issues as and when they emerge during the visit

2. Recommendations (state level)

2.1 Recommendations for the state level issues identified

Annexure 31.2 : District level

Note: After completing the field visit, use the following template to collate the findings. Teams are required to submit findings for each district visited. District level findings and recommendations are based on field visits and interviews with district level authorities, e.g. District Magistrate, Chief Medical Officer of Health Services, District TB Officer (DTO), NRHM DPM. Field visit in each district will include a visit to the District Headquarter, District TB Centre, subdistrict level TU, designated microscopy centre (DMC), including DMCs in other sectors. In addition, some districts will have additional activities to be reviewed, e.g. medical college involvement, NGO involvement, TB/HIV collaborative activities, DOTS-Plus etc.

Name of District: .....

I. Political and administrative commitment

Assess the extent of political and administrative commitment based on discussions with the STO, DTOs, and district authorities / health officials, e.g. Chief Medical Officer, District Magistrate, etc. Make a bulleted list of achievements, constraints and gaps, and recommendations.

Achievements

Constraints and gaps

Recommendations

II. Case finding activities

Analyse and interpret findings, including trends, related to TB suspects examined, inclusiveness of providers in the RNTCP network and efforts made to enhance case finding under DOTS. Review of laboratory registers and discussions with chief medical officer and DTO of the district, in-charge of sub-district level health services (Block Medical Officer, MOTC, etc), medical officers, etc. Review access issues including patient delay, provider delay, accessibility to DMC etc. Review process of treatment initiation. Make a bulleted list of achievements, constraints and gaps, and recommendations.

Achievements

Constraints and gaps

Recommendations

III. Laboratory

Assess the structure, access and quality of the designated microscopy centre network. Review laboratory procedures, human resources (LT, STLS), equipment, records and reports. Review implementation and results of laboratory quality assurance, including IRL activities. Make a bulleted list of achievements, constraints and gaps, and recommendations.

Achievements

Constraints and gaps

Recommendations

IV.Treatment and treatment support

Analyse and interpret findings related to treatment and treatment observation based on discussions with patients, DOT providers, STS, medical practitioners, review of treatment cards, triangulation with TB register and lab register, and observation of treatment centres. Make a bulleted list of achievements, constraints and gaps, and recommendations.

Achievements

Constraints and gaps

Recommendations

V. Recording, reporting, monitoring and supervision

Review recording, reporting, monitoring and supervision at each level based on scrutiny of all available record and reports, and discussions with DTO, MOTCs, STS/STLS. Make a bulleted list of achievements, constraints and gaps, and recommendations.

Achievements

Constraints and gaps

Recommendations

VI. Human Resource Development

Analyse and interpret findings related to human resources development based on discussions with authorities and health personnel at different levels. Review HRD related activities for staffing and training, including the district action plan. Make a bulleted list of achievements, constraints and gaps, and recommendations.

Achievements

Constraints and gaps

Recommendations

VII. Drugs and supplies

Review drug and logistics management system in the district, including drug store, documentation, reserve stocks, mode of supplies, etc. Discuss with DTOs, MOTCs, medical officers, pharmacist and DOT providers. Make a bulleted list of achievements, constraints and gaps, and recommendations.

Achievements

Constraints and gaps

Recomendations

VIII. Public-private collaborative activities

Assess the level of participation of private sector, NGOs, medical colleges, TB hospitals and non-health ministry governmental health providers (e.g. ESI, Coal & Mines, Railways, etc) based on meetings with appropriate representatives and discussions with district authorities and medical personnel, and review of relevant data. Make a bulleted list of achievements, constraints and gaps, and recommendations.

Achievements

Constraints and gaps

Recommendations

IX. Advocacy, Communication and Social Mobilization

Review ACSM activities based district IEC action plans, activities, reports and interviews with district authorities, health care workers (public and private) and community representatives. Make a bulleted list of achievements, constraints and gaps, and recommendations.

Achievements

Constraints and gaps

Recommendations

X. Health System

Identify issues and factors within the health system that facilitate, or act as constraints, for the smooth implementation of the TB programm. Make a bulleted list of achievements, constraints and gaps, and recommendations.

Achievements

Constraints and gaps

Recommendations

XI. TB-HIV

Assess status and plans in implementation of TB-HIV collaborative activities. Review coordination at district and sub-district level and reports of cross referrals. Make a bulleted list of achievements, constraints and gaps, and recommendations.

Achievements

Constraints and gaps

Recommendations

XII. DOTS-Plus

Assess preparation for the DOTS-Plus, implementation of the DOTS-Plus, diagnostic and treatment related challenges.

Achievements

Constraints and gaps

Recommendations

XIII. Programme management

Review programme management capacity, including financial management, procurement of goods and services, etc. Adequacy of delegation of administrative and financial powers of STOs and DTOs. Make a bulleted list of achievements, constraints and gaps, and recommendations.

Achievements

Constraints and gaps

Recommendations

XIV. Other issues

Assess any other areas not covered above, e.g., access to migratory population, urban poor, tribals, etc. Make a bulleted list of achievements, constraints and gaps, and recommendations.

Achievements

Constraints and gaps

Recommendations

Annexure 32: Quarterly report on HIV/TB collaborative activities

Name of SACS: _____ Quarter/Year _____

A. HIV/TB Co-ordination activities

State level:

State Coordination committee meeting	
• Date of last meeting	
• Are proceedings shared with NACO and CTD? (Yes/No)	
State Working group meeting	
• Date of last meeting	
• Are proceedings shared with NACO and CTD? (Yes/No)	

District Level:

Sr. No.	Name of District	Date of last District Coordination Committee (DCC) meeting	Are proceedings of DCC meetings received at SACS (Yes/No)	Number of Monthly HIV/TB meetings conducted during the quarter	Number of monthly meetings of which, proceedings are received at SACS
1					
2					

*use additional sheet to cover all districts in the state

Joint Supervision and monitoring:

1. **Joint supervision visits** conducted during the reporting quarter
   a. Name of districts visited: _____
   b. Date of visit: _____
   c. Are visit reports shared with NACO _____
2. **Joint review** of District nodal officer/DTO
   a. Is HIV/TB joint review done during the quarter (atleast once a year):_____
   b. Did SACS representative attend RNTCP quarterly DTO review meeting: _____
3. HIV/TB**reporting**:
   a. ICF at ICTC: Number of months of compiled state report sent to NACO in the quarter:___
   b. ICF at ART Centre: Number of months of compiled report sent to NACO:___
4. D**rugs and logistics**:
   a. Number of districts with CPT stock sufficient to last 3 months (information from RNTCP PMR at state level):____

Annexure 33: ICTC HIV-TB Collaboration Activity Register

Sno.	PID No.	HIV Status 1-Positive 2-Negetive	Suspected to have TB/MDRTB	Date of referral to RNTCP for TB/DRTB diagnosis	Result of Investigations			DRTB/Rif Resistant	Whether put on treatment (Anti TB/DRTB)	Referral from RNTCP for HIV testing				
					Sputum positive TB	Sputum Negative TB	Extra pulmonary TB			Registered TB Patient	Drug Resistant TB/Rif R patient	TB Suspects	Date of Testing for HIV	Tested Positive
			(Y / N)	(DD/MM /YY)	(Y / N)	(Y / N)	(Y / N)	(Y / N)	(Y / N)	(Y / N)	(Y / N)	(Y / N)	(Y / N)	(Y / N)
1	2	3	4	5	6	7	8	9	10	11	12	13	14	15

Annexure 34: ICTC Positive Line list for General Client

Sr. No	PID No.	Aadhaar No.	Name of Client	Age	Sex: 1- Male, 2- Female 3-TS/TG	Details/ Complete Address with Pin code	Taluka / Corporation	District	Education	Occupation of Client	Route of Transmission	Patients referred from	If referral from TI NGO, (write Name of TI NGO with Typology)	Client UID No. (if client is referred from TI NGO)	History of Migration
1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16

History of High risk exposure	Date of testing	Date of post test counseling	Date of pre ART Registration	Pre ART Reg. No. (SN/DNN/CNN/MM/YY/0000)	Baseline CD4 Count	Current CD4 Count (in last 6 month)	On ART Reg. No. (SN/DNN/CNN/MM/YY/0000)	Whether referred to RNTCP: 1- Yes 2- No 3- already registered in RNTCP	Whether TB Diagnosed: 1-Yes 2- No	Marital Status	Spouse testing done: 1-Yes 2-No 3-Pvt. Tested	If yes, Spouse PID Number: (DN/CNN/YY/0000)	Spouse result 1- Positive 2- Negative	Pre ART Registration of Spouse done 1-Yes 2-No	If eligible & received Social Benefits scheme write which of the following:	Remarks	If Death of Client Write date of Death	General Remarks: (for ICTC & ART)
17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35

Annexure 35 : Monthly Input Formats for Integrated Counseling and Testing Centres (ICTC)

HIV/TB indicators at Section A,B C&D are listed below

Section A: Point 8 & 9
Section B: Sub section iv: Point 4
Section C: Sub section ii: Point 21, 22, 23 & 24
Section D: Sub section i: Point 27, 28, 29 &30

ICTC Code			ICTC

Monthly Input Formats for Integrated Counseling and Testing Centres (ICTC)

1.Section A and C common for all ICTC Clients.
2.Section B for all clients excluding Pregnant women.
3. Section C Laboratory Information, Consumables, Staffing and Outreach Work
3.Section D only for Pregnant women.
4.Section E for HIV-TB collaboration for all ICTC clients(excluding Pregnant Women).

Section A : Summary Table : Status for the month

Indicator **(All fields are auto-generated from other sections)**	ICTC Clients (excluding Pregnant women)	ICTC Clients - Pregnant women/ Breastfeeding Mothers	**Total ICTC**
8. Number of ICTC clients referred to RNTCP (TB Microscopy center)	0		0
9. Number of HIV infected TB patients out of above	0		0

Section B: Progress Made During the Month by the ICTC [All clients excluding pregnant women]

iv. Linkages and referrals

Departments / Agencies	In referral - Tested					In referral - diagnosed as HIV Positive				Out referral			
	Male	Female	TS/TG	Total	Repeat test done (within 12 months)	Male	Female	TS/TG	Total	Male	Female	TS/TG	Total
1. TI NGO / CBO	0	0	0	0	0	0	0	0	0	0	0	0	0
4. RNTCP				0					0				0

Monthly Input Formats for Integrated Counseling and Testing Centres (ICTC)														
Section C: Laboratory Information, Consumables, Staffing and Outreach Work (All ICTC Clients including pregnant women)														
ii. Stock of HIV Test Kits and other Consumables (Section is Blocked for data entry, please enter data ONLINE)														
Description													**Units**	
Consumables	Name of Kit	Opening Stock	Number received this month	No. of Items Relocated (Inside the District)	No. of Items Relocated (Outside the District)	Expired items returned	Number Consumed	Control tests	Wastage / Damage (if any?)	Closing Stock	Batch Number	Expiry Date* (dd/mm/yy)	Quantity Indented	Date of Indent (dd/mm/yy)
21. Isoniazide 300mg														
22. Isoniazide 100mg														
23. Pyridoxine 50mg														
24. Pyridoxine 25mg														

Monthly Input Formats for Integrated Counseling and Testing Centres (ICTC)				
Section D: Progress during the month (only for Pregnant Women)				
i. Pregnancy, delivery and breastfeeding				
S. No	**Indicators (The indicators shown in orange colour are changed in comparison with the existing format. Please read Data Definition carefully before entering data in these fields)**	**During ANC**	**Directly in labor**	**Total**
		During this month	**During this month**	
27	Number of HIV +ve Pregnant Women referred to RNTCP Microscopic Center			**0**
28	Number Diagnosed with TB among HIV +ve Pregnant Women			**0**
29	Number of HIV Negative Pregnant Women referred to RNTCP Microscopic Center			**0**
30	Number Diagnosed with TB among HIV Negative Pregnant Women			**0**

Annexure 36 : Monthly HIV TB Report at Integrated Counseling and Testing Centres (ICTC)

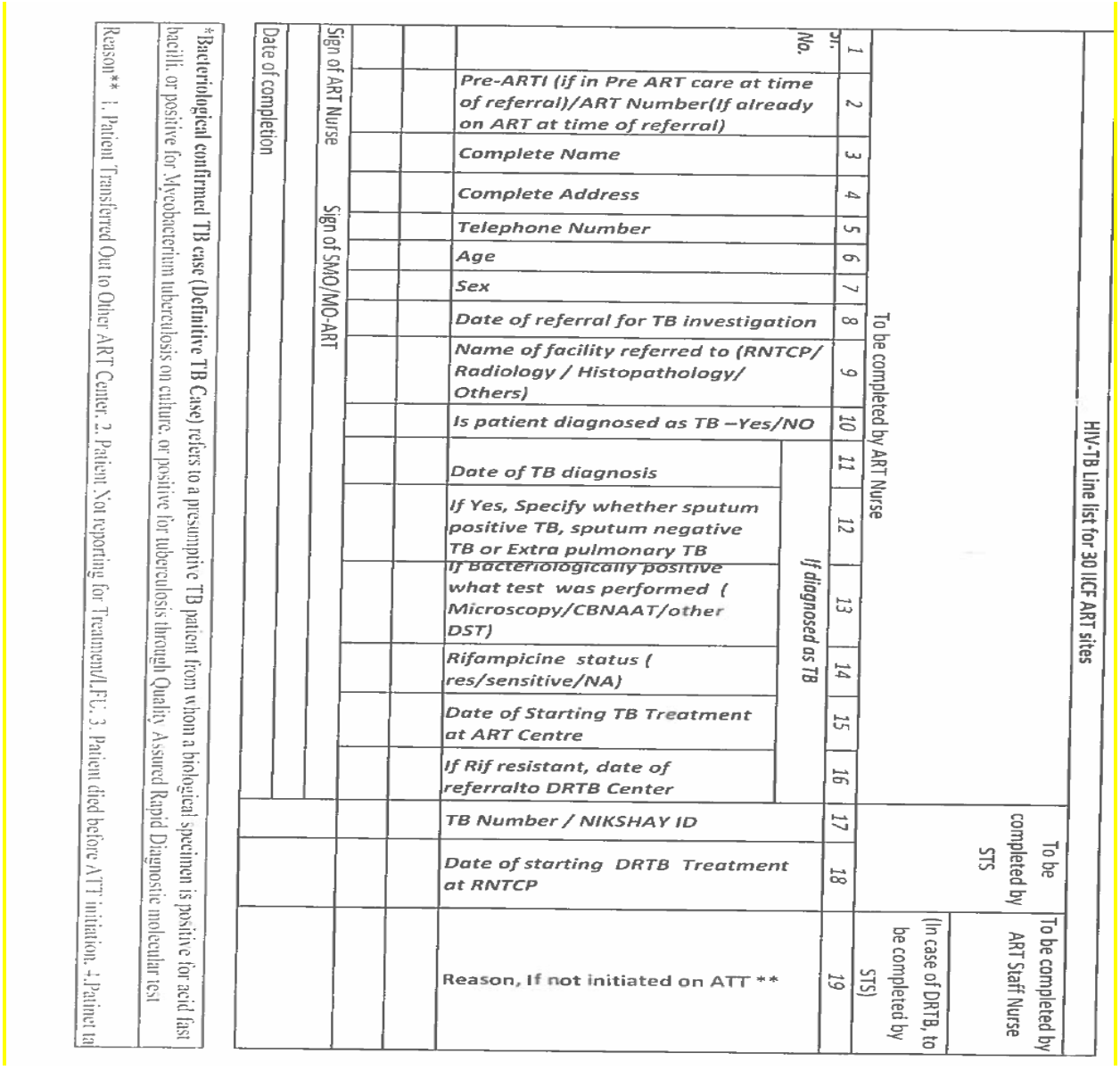
This section captures the report of preceding month and does not include section D (Pregnant Women)		
Monthly Input Formats for Integrated Counseling and Testing Centers (ICTC)		
Section E for HIV-TB(All Clients Excluding Pregnant Women)		
1. REFERRAL OF SUSPECTED TUBERCULOSIS CASES FROM ICTC TO RNTCP		
Indicators		
a) Number of client received pre-test counseling/information (except pregnant women)		
	HIV Positive	**HIV Negative**
b) Number of persons suspected to have TB referred to RNTCP Unit		
c) No of clients reached to RNTCP DMC out of (b)		
d) Of the referred TB suspects, Number diagnosed as having:	**0**	**0**
d.i) Sputum Positive TB		
d.ii) Sputum Negative TB		
d.iii) Extra-Pulmonary TB		
d.iv) Drug Resistant TB/Rif-Resistance		
e. Total No. of TB Diagnosed Clients put on treatment		
e.i) Out of (d.i, d.ii & d.iii) above, diagnosed TB patients, number receiving Anti-TB Treatment		
e.ii) Out of (d. iv) above, diagnosed TB patients, number receiving DRTB Treatment		

Section E for HIV-TB (All clients)

1. Referral of suspected tuberculosis cases from ICTC to RNTCP

Indicators		**Explanation**
a)	Number of client received pre-test counseling/information (except pregnant women)	Categorize and mention the number of clients (except pregnant women) who have received pre-test counseling/information into HIV positive and negative.
b)	Number of persons suspected to have TB referred to RNTCP Unit	Total number of suspected TB clients referred to RNTCP among those visiting ICTC is entered here. For reference, the total registration for comparison would be from the summary table of the monthly input format. This is filled in separately for HIV positive and negative.
c)	No of clients reached to RNTCP/DMC out of (b)	Total number of suspected TB clients reached to RNTCP among those referred from ICTC.
d)	Of the referred TB suspects, Number diagnosed as having: i. Sputum Positive TB ii. Sputum Negative TB iii. Extra-Pulmonary TB iv. Drug Resistant TB(DRTB)/Rif-Resistance	Out of the referred (in part b), the patients are tested for TB and categorized as follows as per RNTCP guidelines: Sputum positive TB, Sputum negative TB and Extra-pulmonary TB and Drug Resistant TB/Rifampicing Resistance Write their numbers separately for HIV positive and negative clients.
e)	Out of (d) above, diagnosed TB patients, number receiving Anti-TB/DRTB treatment.	e.i. Out of those diagnosed TB, (**d.i+d.ii +d.iii)** number of HIV positive and negative clients receiving Anti- TB treatment from RNTCP.
		e.ii. Out of those diagnosed drug resistant TB (**d. iv**), number of HIV positive and negative clients receiving DRTB treatment from RNTCP.

Annexure 37: HIV-TB Line list for 3I Project ART sites



HIV-TB Line list for 3I ICF ART sites

Sr. No.		To be completed by ART Nurse												To be completed by STS	To be completed by ART Staff Nurse (In case of DRTB, to be completed by STS)
									If diagnosed as TB						
1	Pre-ARTI (if in Pre ART care at time of referral)/ART Number(If already on ART at time of referral)	Complete Name	Complete Address	Telephone Number	Age	Sex	Date of referral for TB investigation	Name of facility referred to (RNTCP/ Radiology / Histopathology/ Others)	Is patient diagnosed as TB –Yes/NO	Date of TB diagnosis	If Yes, Specify whether sputum positive TB, sputum negative TB or Extra pulmonary TB	If Bacteriologically positive what test was performed (Microscopy/CBNAAT/other DST)	Rifampicine status (res/sensitive/NA)	Date of Starting TB Treatment at ART Centre	If Rif resistant, date of referralto DRTB Center	TB Number / NIKSHAY ID	Date of starting DRTB Treatment at RNTCP	Reason, If not initiated on ATT **
2																		
3																		
4																		
5																		
6																		
7																		
8																		
9																		
10																		
11																		
12																		
13																		
14																		
15																		
16																		
17																		
18																		
19																		

Sign of ART Nurse

Sign of SMO/MO-ART

Date of completion

*Bacteriological confirmed TB case (Definitive TB Case) refers to a presumpitive TB patient from whom a biological specimen is positive for acid fast bacilli, or positive for Mycobacterium tuberculosis on culture, or positive for tuberculosis through Quality Assured Rapid Diagnostic molecular test

Reason** 1. Patient Transferred Out to Other ART Center, 2. Patient Not reporting for Treatment/LFU, 3. Patient died before ATT initiation, 4.Patinet ta

**These 3I Project reports will be used through out the country as an when the services are rolled out in the country and our subject to change as per the recommendations of the Ntional Technical Working Group (HIV/TB)*

Annexure 38: HIV-TB Register for 3I Project ART sites

HIV TB register for 30 IICF ART sites																
1	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**11**	**12**	**13**	**14**	**15**	**16**	**17**
S. No.	**Date**	**HIV care (Pre-ART) registration number**	**Complete Name**	**Complete Address**	**Age**	**Sex**	**Specify whether sputum positive TB, sputum negative TB or Extra pulmonary TB**	**Is the Patient initiated on RNTCP treatment ?(Yes/No)**	**Date of Starting Treatment**	**TB Number with TU and District Name**	**Latest CD4 Count**	**Date of ART Initiation**	**ART Registration Number**	**Is the patient on CPT? (Yes/ No)**	**TB treatment Outcome***	**Remarks**
																Rifampicine status: sen/res/NA)

**These 3I Project reports will be used through out the country as an when the services are rolled out in the country and our subject to change as per the recommendations of the Ntional Technical Working Group (HIV/TB)*

Annexure 39: HIV-TB Intensified TB Case Finding ICF 3I Project ART Monthly report

3 b. HIV/TB -Intensified TB Case Finding			
TB Diagnosis & Treatment			
(From Completed HIV/TB Line-List- 1 month prior to reporting month)			
3b.1) Number of PLHIV attending ART Centre during the month (Pre ART and ART)			
3b.2)Out of above number of PLHIV screened for 4 symptoms			
3b.3) Out of above, number of PLHIV with presumptive TB (those with anyone/more symptoms out of 4S)			
3b.4) Out of above,number of PLHIV with presumptive TB referred from ART centre for TB diagnosis			
3b.5) Out of above, number of PLHIV with presumptive TB, tested for TB diagnosis			
3b.6) Out of the above number of PLHIV diagnosed as having TB :	**In Pre ART Care at time of TB diagnosis**	**Already on ART at time of TB diagnosis**	**Total**
(i) Pulmonary TB (Bacteriologically confirmed)			0
(ii) Pulmonary TB (Clinically diagnosed)			0
(iii) Extra-Pulmonary TB (Bacteriologically confirmed)			0
(iv) Extra Pulmonary (Clinically diagnosed)			0
3b.7) Total PLHIV Diagnosed with TB	0	0	0
3b.8) Out of **(3b.7),**, number of TB patients receiving RNTCP treatment			
3b.9) Out of **(3b.7),**, number of TB patients receiving Non-RNTCP treatment			
3b.10) Out of **(3b.7),** number of TB patients with RRTB (Rif Resistant TB)			
3b.11) Out of **(3b.10),** number of TB patients with RRTB (Rif Resistant TB) receiving Cat IV treatment			
3 c. Treatment of HIV in HIV TB co-infected PLHIV			
(From the HIV- TB register data -2 months prior to reporting month)			
3c.1) Total number of TB patients enrolled in HIV/TB register 2 months prior to reporting month			
3c.2) Out of **(3c.1)** number of TB patients initiated on CPT			
3c.3) Out of **(3c.1)** number of TB patients initiated on ART			
3 d. IPT Status (From Master Line List of Reporting Month)			
3d.1) Number of PLHIV newly initiated on IPT during this month			
3d.2) Number of PLHIV completed IPT during this month			

**These 3I Project reports will be used through out the country as an when the services are rolled out in the country and our subject to change as per the recommendations of the Ntional Technical Working Group (HIV/TB)*