World Vision India

MONITORING AND EVALUATION PLAN

THE GLOBAL FUND ROUND 9 TB PROJECT

STRENGTHENING CIVIL SOCIETY INVOLVEMENT IN TUBERCULOSIS CARE AND CONTROL IN INDIA

Grant No: IDA-910-G17-T

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2. LIST OF ABBREVIATIONS

ACSM : Advocacy Communication and Social Mobilization

BRS : Bank Reconciliation Statement

CCM : Country Coordinating Mechanism

CQI : Continuous Quality Improvement

CTD : Central TB Division

DC : District Coordinator

DOTS : Directly Observed Treatment Short Course

DRTB : Drug Resistance Tuberculosis

FO : Finance Officer

LEAP : Learning through Evaluation with Accountability and Planning

MDR : Multi Drug Resistance

M&E : Monitoring and Evaluation

MESS : Monitoring and Evaluation Systems Strengthening

NSP : New smear positive

PM : Program Manager

PMU : Program Management Unit

PR : Primary Recipient

QA : Quality Assurance

RNTCP : Revised National TB Control Program

SR : Sub Recipient

SSR : Sub Sub Recipient

TB : Tuberculosis

WVI : World Vision India

3. EXECUTIVE SUMMARY

The Global Fund (GF) has approved a country proposal submitted by India CCM for TB through a Round 9 grant. The grant has been awarded for a period of five years with a first phase of 2 years. There are three PRs – Central TB Division, International Union against TB and Lung Disease (The Union) and The World Vision India (WVI) in the Round 9 TB Grant. The National programme Division will provide treatment support in this proposal with focus on MDR TB while The Union and World Vision India will implement civil society components of the proposal.

The approved funding for World Vision India as PR over 5 years is US $ 10.9 million with approved Phase I budget as US$ 3.73 million. With the overall goal to decrease morbidity and mortality due to drug resistant TB (DR-TB) in India and improve access to quality TB care and control services through enhanced civil society participation, World Vision India along with The Union as Principal Recipients envisages to strengthen the quality of basic DOTS services through civil society participation and improve access to marginalized and vulnerable populations.

While signing the grant agreement, Global Fund has attached few condition precedents to the disbursement of the grant as described in Annex A of the Grant agreement.

Submission of this Monitoring and Evaluation Plan ("The M&E Plan") by World Vision India is to meet and satisfy the condition precedent as set out for the second disbursement of the grant that would be subject to the satisfaction of the following condition(s):

B.2.a. the delivery by the PR to the Global Fund of a plan for monitoring and evaluating planned activities ("the M&E Plan") that follows guidelines from the Global Fund and that incorporates the recommendations made by the program stakeholders and the Global Fund upon completion of the Monitoring and Evaluation Systems Strengthening Tool. Such a plan should be devised in collaboration with the other PR (The Union) and shall demonstrate, in particular the linkages between the Program's management information system (MIS) and the National M&E Plan clearly evidencing how the program will contribute to the strengthening of the National M&E System. The plan should also include clear guidelines and reporting mechanisms for the sub recipient.

This M&E Plan is being submitted hereby for the fulfillment of the above mentioned condition and has attempted to address the requirements as mentioned above in B.2.a. This plan has been developed in consultation with the other PR, The Union. Consultative meetings took place in World Vision India office where the two PRs discussed various coordination issues, common M&E system and data collection and reporting tools, and the web based M&E system that World Vision India is taking lead to develop by utilizing its private resources. Both the PRs have also discussed the possibility of having such coordination meeting frequently and on a consistent basis.

B.2.b. the delivery by the PR to the Global Fund of a costed action plan resulting from the recent Monitoring and Evaluation Systems Strengthening Workshop;

World Vision India participated in the MESS Tool workshop conducted for the PRs in January and later conducted the MESS tool workshop for SRs in June, and follow up in early October 2010. The action steps were discussed during these workshops and recommendations were made. These recommendations were converted into Action Plan which can be found in Section 3.3. This action plan has been costed , which can be found in Section 11 of this document.

B.2.c. the delivery by the PR to the Global Fund of a revised budget for the Program Term ("the revised budget") if the action plan and the budget listed above results in amendments to the Program Budget as approved at the time of the effective date of this grant agreement;

This condition is not applicable to us as no budget revision is being made, hence no separate submission of the revised budget.

Monitoring and Evaluation is a key component of Performance-based Funding. Through M&E, the programme results at all levels (impact, outcome, output, process and input) can be measured to provide the basis for accountability and informed decision-making at both programme and policy level.

Following are the objectives behind development of this M&E Plan:

- To commonly agree with Global Fund on the indicators to be used, targets to be achieved, to demonstrate performance and consequently ensure continued funding.
- To constitute a reference document for the Project Management Unit (PMU) of the Principal Recipient (PR) for monitoring the implementation of project activities being implemented under the Global Fund Rd 9 project and effectiveness in reaching predetermined targets.
- To constitute a reference document for all Sub Recipients (SRs) under the project to undertake monitoring of their own set of activities.
- To define all standard indicators that will be reported to Global Fund as part of this project.
- To define tools for program review by putting in place mechanism for routine data collection, analysis and reporting
- To put in place supportive supervision plan for monitoring SRs
- To define uniform data collection and reporting tools for the SRs.
- To describe a system for quality assurance with emphasis on ensuring the delivery of accurate and reliable project data.

The salient features of this monitoring and evaluation plan are as follows:

- It was jointly developed by the PR and the SRs. Series of workshops and consultations were organized for the purpose including a 5 day M&E Toolkit workshop from June 7-11, 2010. The final workshop was organized from October 4-8, 2010 to bring closure to development of this plan, tools, supportive supervision plan and checklists.

- The Performance Framework for WV India was developed in close consultation with CTD and the Union. The project specific indicators selected to monitor and evaluate the project activities are drawn from National M&E Plan and are clearly linked to the RNTCP outcome indicators.

- Project Monitoring Unit (PMU) of World Vision India PR would be responsible for monitoring activities at the SR and the State level. The SR would be responsible for monitoring activities at the district level. PMU has developed SR Monitoring Team with a team of Monitoring and Evaluation Officer along with a Finance Officer. Details of SR Monitoring are further found in details in this M&E Plan.

- The project will utilize the existing RNTCP reporting formats to collect information on outcome indicator related data for NSP case detection, treatment outcome, and programme quality related data such as treatment initiation interval, while project specific data not included within RNTCP formats and specifically process indicators will be collected through specific project reporting tools developed by the project and are attached here in as Annexure D.

- Through the capacity building plan as specified later in this document, PR will build capacity of the SR in data reporting, data validation, data analysis and data quality. Some quality assurance tools are attached hereby, whereas some more tools would be developed later in quarter 3.

- The PMU Team would conduct joint supportive monitoring visits along with the State and District TB Officers. The PMU team would also regularly coordinate with other PRs, The Union and CTD to share learning.

4. INTRODUCTION

World Vision India is one of the National Offices within the global network of close to 98 locally incorporated and registered national bodies within the World Vision International (WVI) partnership, World Vision India (WV India) has the double advantage of being an Indian non profit organization with its own Board of Directors and local management leadership while adhering to the parent organization's commitments to rigorous professionalism, financial transparency and cost efficiency.

WV India is the convener of the **NGO TB Consortium** the member organizations of which include the most active, technically respected and financially stable stakeholders in TB programming in India. World Vision India is also a member of several NGO networks and Government forums, like Women Development Corporation, Indian Council for Child Welfare etc. which address social and economic issues at various levels. World Vision India is now also a member of Planning Commission of India. World Vision India is also a member of the international partnership of World Vision, which works in 100 countries. World Vision International has consultative status with UN - ECOSOC (Economic and Social Council) as well as official relations with key UN agencies including UNICEF, WHO, UNHCR and ILO

World Vision is one of the most significant civil society partners of the Global Fund internationally. Four National Offices are Principal Recipients of GF grants and the total multilateral donor grant portfolio stands at more than $140 million. A total of seventeen World Vision National Offices have been involved in implementing eleven projects in TB, twelve projects in HIV and AIDS and four projects in malaria funded by the Global Fund. These projects are located in Africa, Asia and Pacific, Latin America and the Caribbean, and Middle East and Eastern Europe regions.

The relevant strengths of WV India that lend credibility to its being one of the PRs include the following:

Technical: WV India has an extensive network of relief and development projects in the country – 134 Area Development Programs (ADP) in 26 states benefiting over 5,000 communities. It also has been implementing a TB project funded by the Canadian International Development Agency (CIDA) in eight districts of Andhra Pradesh state from 2002 to '07, and subsequently the India TB Follow up program in

five districts of the same state and the TB Mainstreaming project in five ADPs across five states, both with private funding. These three programs focused on community TB care, private sector engagement and ACSM. A current grant (coming to a closure in December 2010) from USAID/India is being used to implement ACSM interventions in 80 districts across the country, through 6 sub recipients. World Vision India is well positioned to access technical assistance from other Global Fund projects of World Vision in other country offices and learn from their experiences.

Managerial: WV India has been managing projects in India for the last 50 years. It is locally registered as an Indian charity, led by an indigenous Board of Directors. All projects are run by a total of 2,000 Indian national staff, 1,600 of whom are regular staff. Within India, there is a growing support base of 242,000 local child sponsors, who together with corporate donors gave US$3.5 million in 2009. World Vision India also manages grants and cooperative agreements from a diverse funding base that includes ten countries in the World Vision International Partnership, as well as bilateral donors such as USAID, DFID, AusAID, CIDA, and the EU, as well as local funding sources like State Innovations in Family Planning Services Agency (SIFPSA).

Financial: WV India manages an average budget of US$50 million a year for its projects. In fiscal year 2009, it managed a budget of US$56 million, making it one of the largest international NGOs in the country in terms of budget. WV India also currently implements a total of US$ 4.4 million USAID grants in India. To ensure accountability, compliance and efficiency, WV India undergoes annual statutory audits by Deloitte Haskins and Sells, annual internal audits by a team of 14 chartered accountants and a biennial Partnership audit by WV International. For the last round of **Partnership Audits** that was completed in February 2009, WV India received **limited risk** category its financial systems, protocols and transactions.

WV India is well experienced in the disbursement of funds to partners to finance local activities. Each of the 134 ADPs is treated like a local partner. They are regularly visited for both financial monitoring and programmatic support-a-vision by the nine regional teams. Regular visits are done for the purposes of mentoring, technical assistance and problem solving.

Monitoring and Evaluation: The process of collecting, analyzing, and reporting on indicators and using the information for project management is led by a Monitoring and Evaluation Unit at the National Level, which has several experts for this purpose. The current Program Director of R9 TB Grant was

the former head of the National Monitoring and Evaluation Unit, and was pioneer in establishing effective M&E System, including the monitoring system which is currently being used to report to the World Vision India Board. For many grant-funded projects, monitoring is a day-to-day part of project management. Evaluations are required at mid-term and at the end of projects to ensure lessons are captured and project refinements are done. For ADPs, World Vision India, collects transformational development indicators (TDI) within a framework called LEAP (Learning and Evaluation with Accountability and Planning), World Vision International's global management information system. The LEAP framework works to ensure that community input is incorporated into all aspects of the programming cycle, including assessment, project design, implementation, and monitoring & evaluation to achieve community and donor objectives and results. LEAP institutionalizes the reflection and transition processes into all project cycles to further achieve project success.

Experiences from the other grant funded project and from World Vision India project has been used to develop this M&E Plan. Many of the tools have been adapted, or modified from the other grants and are being used in this project. However many of the tools are exclusively developed for the purpose of this project and were developed in consultations with the Sub Recipients.

4.1 Sub-Recipients to World Vision India

The sub recipients involved in implementing the project are Adventist Development and Relief Agency (ADRA), CARE India, German Leprosy Relief Agency (GLRA), LEPRA India, Southern Health Improvement Society (SHIS) and TB Alert India. A proper assessment of these organizations were conducted, report is being submitted separately.

5. MESS TOOL – AN ANALYSIS

A MESS Tool workshop was conducted for the Primary Recipients on January 15, 2010 and for the Sub Recipients on June 11-14, 2010 focusing on identifying capacity gaps and October 6-8, 2010 focusing on developing tools and action steps for building M&E capacity of the PR and SR.

5.1 Strength of M&E Systems

- Strong experience in implementing projects at the community level, with effective M&E systems in place for more than 250 projects across the country for over 2 decades.
- Organizational structure includes full fledged M&E Department from program level to the National Office level
- Working with multiple donors and ability to adapt M&E and reporting systems to donors specific requirements
- Trained personnel in M&E at different level with continuous capacity building plan to upgrade the skills in M&E
- Partners in R9 are already partners in TBACSM project. The M&E mechanisms and reporting relationships are in place but needs to be further adapted for R9.
- Good infrastructure facility including communications, laptops etc are already in place for data flow
- Quality Assurance Mechanism in the form of Systematic Results Review in place for reviewing and validating program data

- Skills like capacity to conduct household surveys and LQAS for regular monitoring of indicators have been mainstreamed in the organization.

- Experience in developing and implementing quality assurance system including development of quality assurance tools, supervisory checklist.

- Web based M&E system for data entry, analysis and repository on which M&E system for R9 can be housed.

- Systematic capacity building activities in Monitoring and Evaluation

- All projects of World Vision are community based and inherit skills in social mobilization and advocacy at the community level.

- All projects of World Vision have a very well defined monitoring and evaluation plan, data collection frequency, methodology and tools well defined.

- Standardized reporting system is in place in all programs, with review mechanisms at various level to check the timeliness, completeness and accuracy of the data

- Computerized reporting system with features of data aggregation and analysis as per requirements

- Good practices in all offices/programs for data back which are well defined in the organizational IT guidelines.

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5.2 Weaknesses in M&E Systems

- SRs not having exclusive M&E Departments in their own organizations.
- M&E Capacity of the organizations assessed as not to be outstanding.
- Comprehensive M&E system and training plan needs to be in place for the SRs.
- Indicators not clearly defined, and there are no tools to collect data, nor analysis protocols are place for this project.
- Quality Assurance Mechanism including the QA tools and protocols are not in place.
- PR and SR do not have policy on data disclosure and dissemination.
- Monitoring and Evaluation systems will have to be adapted for GFATM R9
- Clear guidelines and capacity building of SR to avoid duplication in reporting at community level activities
- Mechanism to review reporting at various level and data validity in the current USAID funded ACSM project
- Clearly written down data quality policy/guidelines

5.3 Action Step Recommendation

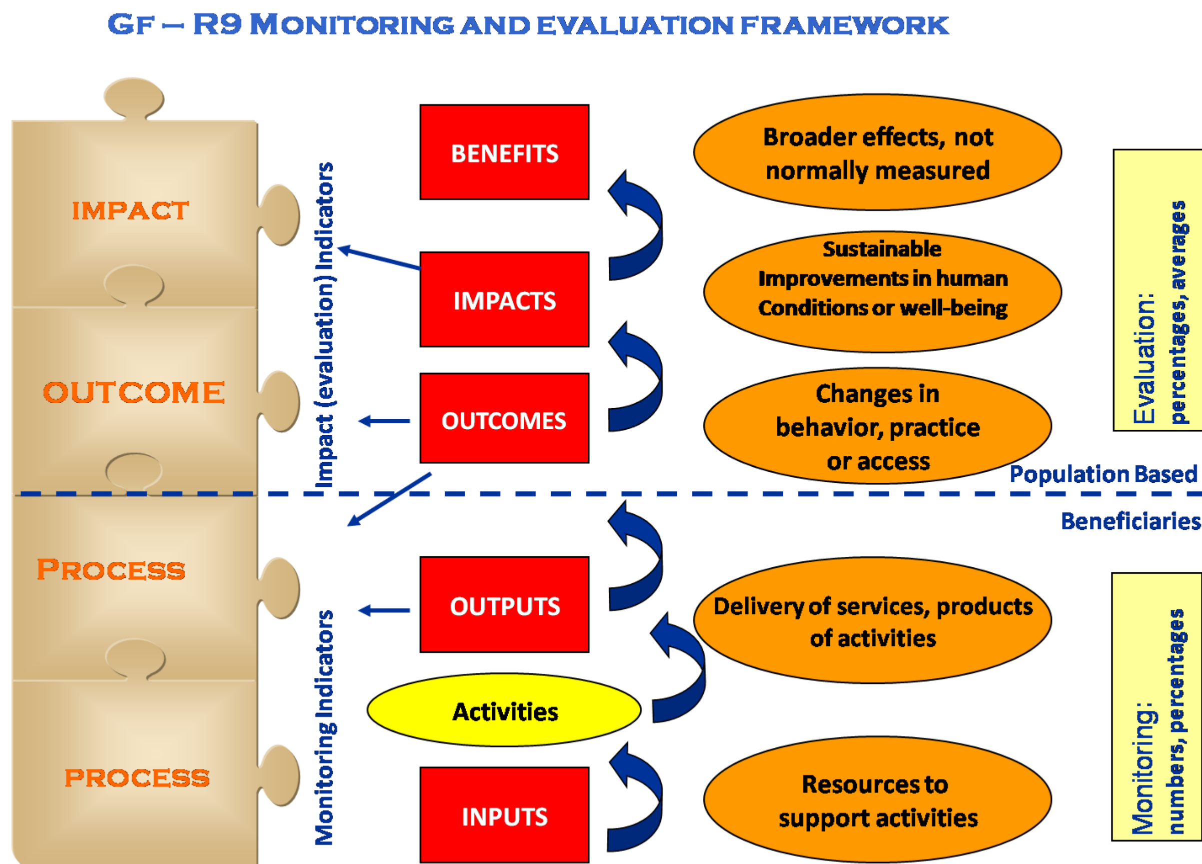
PLANNED STRENGTHENING MEASURES					
Description of the Strengthening Measure	**Responsibility**	**Timeline**	**Funding** (Specify amount and Source)	**Technical Assistance** (Specify if needed , LoE, and type of TA)	**Impact on workplan and budget** (Specify Yes/No)
Develop comprehensive M&E plan	World Vision	Jun-10	No	No	No
Develop data collection tools	World Vision and SRs	July -10	No	No	No
Field testing of the tools	World Vision and SRs	July -10	No	No	No
Development of web based M&E System	World Vision India	Nov-10	Private funds	No	No
Comprehensive Training Plan for SRs on data Monitoring and Evaluation including data collection, quality check and reporting	World Vision	Sep-10	In built in GFATM	Yes	No
Clear guidelines and training and mentoring plan for the SR to avoid duplication in	World Vision	Sep-10	In built in GFATM	Yes	No

reporting					
Written plan for report review and data quality check at different level	World Vision	Dec-10	No	Yes	No
Develop comprehensive plan for building capacity in M&E	World Vision	Aug-10	Built in R9 grant	No	No
Developing Quality Assurance Plan and follow up plan on quality issues	World Vision	Sep-10	Internal funding	Yes	No
Adaption and development of Quality Assurance Tools	World Vision	Dec-10	Internal funding	Yes	No
Capacity building of the PMU and SR on Continuous Quality Improvement and Assurance (CQI)	World Vision	Dec-10	Internal funding	Yes	No
Data disclosure policy/position paper	World Vision	Sep-10	No	No	No
Periodic data quality audit plan by PR	World Vision	Sep-10	Internal	No	No

6. INDICATOR DEFINITIONS AND MEASUREMENTS

World Vision India normally uses Logical Framework to describe the theoretical model for any Project's M&E. However for this project Performance Framework as agreed between the Global Fund and World Vision India forms the basis of the M&E. While further working on this M&E Plan, World Vision India used the following picture shown as **Diagram I** as a theoretical base to work on details of this M&E Plan, the indicators, definition, which one to monitor and which one to evaluate. The ***M&E Framework*** template is attached as **Annexure A** and ***Indicator Reference Sheet*** is attached as **Annexure B.**

Diagram I



Indicators are developed to tell the project whether or not what has been planned is actually happening or has happened. They are systematic measures, direct or indirect, that provide evidence to verify

progress toward reaching targets or standards. While workings on these indicators, following were our three guiding questions:

- How as a project would we know whether we are heading for success or failure?
- How as a project would we measure improvement?
- How as a project would we notice when a change has occurred?

Further, Indicators were developed to:

- Specify how results of this project would be measured?
- Provide the parameters for monitoring and evaluation
- Determine and verify the intended (or unintended) results of this project
- Determine the extent to which direct or indirect target groups have been served

The M& E Framework template is attached as Annexure A and Indicator Reference Sheet is attached as Annexure B. These indicators therefore serve as a basis of program and project reporting. They would be reported quarterly or wherever specified annually. The information would come through the routine reporting system; the management information system (MIS) of this project which is further explained in details in the next section.

While working on the project monitoring and evaluation system, we have attempted to focus on a few critical indicators. Data would be collected to show trends, and support programming process. ***While working on these indicators and data collection tools and methods we have considered that we need to be good stewards, hence measure only what matters.***

Following definitions were considered while defining the indicators and working on the tools and the measurement process.

Input: What have we done?

Output: What have we been able to deliver as a result of activities?

Outcome: What has been achieved as a result of the outputs?

Impact: What has been the result of the outcomes? What contributions are being made towards the goal?

7. ROUTINE DATA COLLECTION, ANALYSIS AND REPORTING

7.1 Routine data (programmatic indicators) that will be collected/reported routinely from service delivery points and other intermediate levels to the National level

The routine data that will be collected routinely from service delivery points have been discussed in Section 7.2. Annexure A describes all these indicators with definitions, when the information would be collected and who is responsible. Annexure B also further explains the rationale behind these indicators, defining of numerator and denominator, data tool, data collection methodology and how the data would be interpreted. Various data tools are also summarized in section 7.2, and data flow described in section 7.3.

Process Indicators:

As described in the Reporting Formats attached as **Annexure C,** there are two levels of routine data collections for the process indicators: Data collection at the District Level and Data collection at the State Level. Reporting of all process indicators at the district level would be responsibility of the District Coordinators who would be adequately trained on this. They would also maintain data collection tools, before consolidating data at the district level. All data collection tools are summarized in section 7.2 and are attached as **Annexure D**.

Reporting of all the State level process indicators described in next section and the tools are summarized in section 7.2 as part of the process indicators. The reporting format and tools are attached as **Annexure C and D.** Reporting of all process indicators at the state level is responsibility of the Project Manager of each Sub Recipients.

Outcome Indicators and Impact Indicators:

There are no specific tools designed for these categories of indicators. National Program already has in place tools and mechanisms to gather information on outcome and impact indicators. The project will bank upon the National M&E System to provide this information.

7.2 Data collection and reporting tools

Data collection tools for all types of indicators for this program are summarized below, with tools attached as **Annexure D.**

Sl. No	Indicator name	Reference tool
	Outcome Indicator	
1	Case Detection Rate: New Smear Positive Cases	TB register
2	Treatment success rate-New Smear Positive Cases	TB register
3	Average default rate of smear positive re-treatment patients in 374 districts	TB register
	Process indicators	
4	Number of districts with new smear positive case detection rate≥70% in 74 districts	Quarterly report on case finding
5	Percentage & number of target districts where at least 90% of all smear positive cases started RNTCP DOTS within 7 days of diagnosis	Quarterly report on Programme management
6	Percentage & number of target districts	Quarterly report on Programme

	where at least 40% of registered TB patients (all forms) are supervised through community volunteers	management
7	Percentage of population with correct knowledge about TB (mode of transmission, symptoms, treatment & curability)	Survey tool to be developed by The Union
8	Number of people trained (TOT) at State level on NGO/CBO/PPRNTCP scheme	Attendance sheet and Training report
9	Number of NGOs sensitized at District level on community mobilization and RNTCP schemes	Attendance sheet and Training report
10	Number of people trained and retrained on interpersonal skills and soft skills (through State level TOT and District level health staff at District level)	Attendance sheet and Training report
11	Number and percentage of target districts with an active District TB Officer	Quarterly report on Programme management
12	Number of Rural Health care providers sensitized on referrals, DOTS provision and eligible RNTCP schemes	Attendance sheet and Training report
13	Percentage of sputum positive initial defaulters successfully retraced and enrolled in DOTS	RNTCP laboratory register and List of Initial Defaulter
14	Number of district level TB forums functional	To be developed

7.3 Information/report flow and feedback mechanisms

Information/report and feedback mechanism for this project have been divided into two categories: Program and Finance. Information flow and feedback mechanism for both are shown as separate diagrams.

Program information/report and feedback mechanisms

For programs, District Coordinator is the first source of information. District Coordinator who is responsible for coordinating activities and reporting for two districts would work alongside with the District TB Officer and the local NGOs working the SR in the implementation of the project activities. District Coordinator would get the information from them and provide it to the Sub Recipient on the monthly basis. SR Project Manager would receive the information, review it and provide feedback to the DC within 10 days. Within the same quarter, Project Manager would also validate this information and send it to the PMU M&E Officers on a quarterly basis.

The information for the State Level Activities would be provided by the SR Project Manager as and when the activities are completed. The M&E Officers at the PMU would review the same and provide immediate feedback to the Project Manager. Within the quarter they would also validate the information.

Diagram 2 below illustrates the information flow and feedback mechanism for Programs at the District level and State level.

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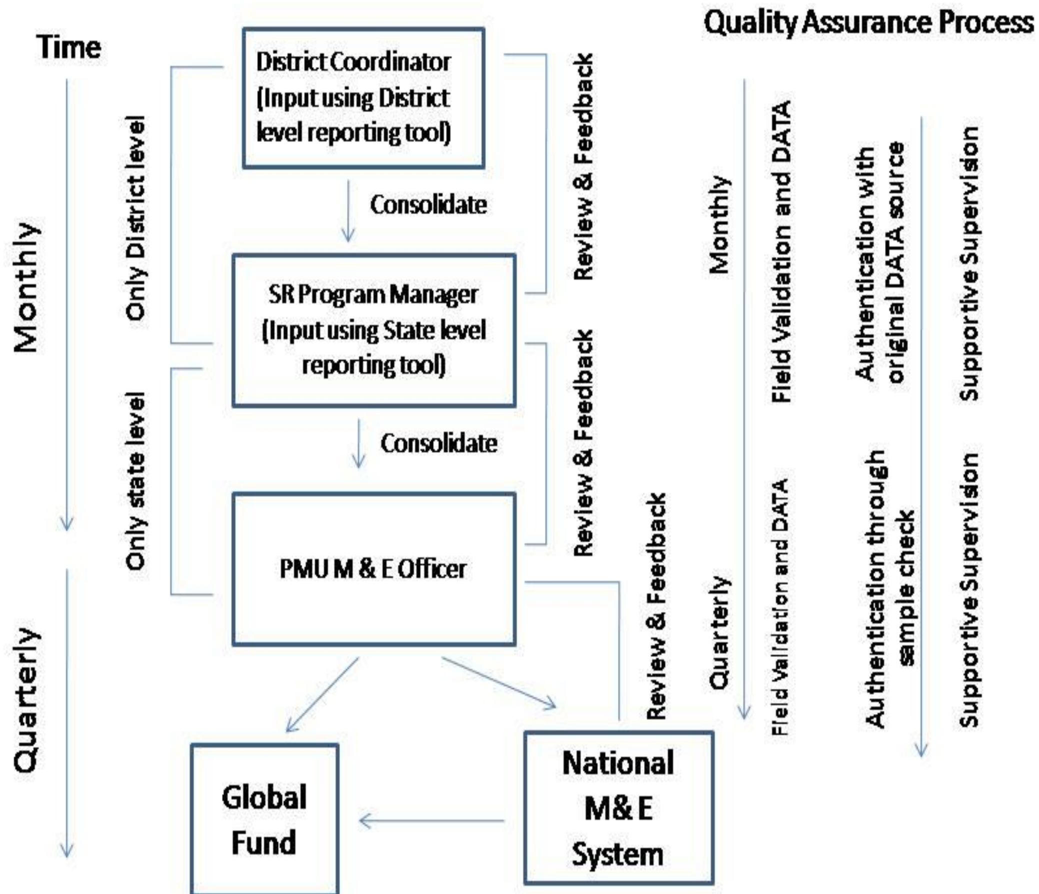
Diagram 2



Finance information/report and feedback mechanisms

Finance data will also flow at two levels, District and the SR level. However there is some difference in the data flow and feedback mechanism as compared to the programs. The Sub Sub Recipients (SSR) of the SR would directly be responsible for data reporting at the District level. The data reported by each SSR would be reviewed by the Finance Officer of the SR. For better program monitoring, unlike program data that would be reported on a monthly basis, finance data would be reported on a weekly/ fortnightly

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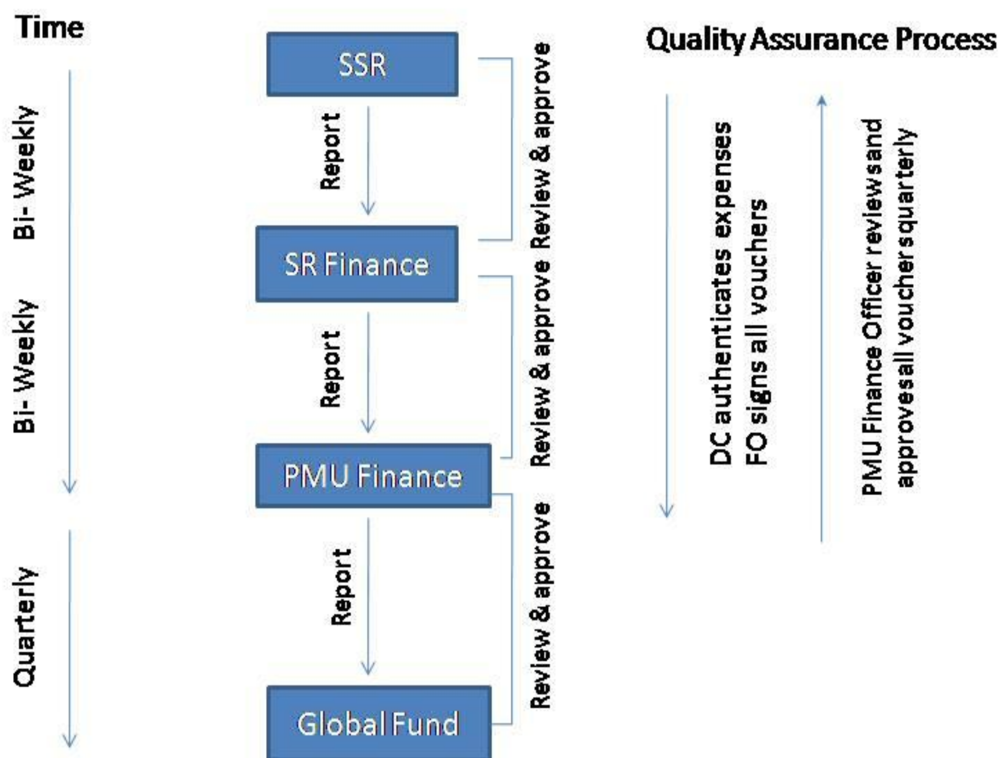
basis by the SSR to the SR and the PMU. Feedback to the SSR would be done by the SR, primarily on the accuracy of the data, and by the PMU to the SR on the underspending/ overspending.

Similarly SR would also report to the PMU for the expenses incurred by the SR. This data would flow to the PMU on a weekly/fortnightly basis. The PMU Finance Team would review overall data and provide feedback to the SR on the financial controls. **Diagram 3,** below illustrates the data flow and feedback mechanism for Finance.

Diagram 3



7.4 Infrastructures available for data capturing and reporting (paper-based system, computers, internet connections, etc.)

World Vision India is working on the web-based Finance and Monitoring System. The proposal and systems requirement document (SRS document) for web based system is being submitted as a separate attachment to **Annexure J** of this document. World Vision India is using its private resources to develop this system. This system would exclusively be used for Global Fund Round 9 Program. Both the civil society PRs; The Union and World Vision India spent couple of days in discussing this system and ensuring that it meets the requirement of both the PR and contribute to the overall National M&E. The process of development is in progress. Till the system is launched by mid November, paper based M&E System is in place, however while system goes live in mid November, it will be ensured that all data for the previous reporting periods are also uploaded to ensure that we have data on line for the entire period of the project since the commencement of this project.

Paper back up data would be maintained by all District Coordinators for the program data. The tools mentioned here would all be maintained at the SSR levels for data validation purposes. However for the Finance System, only vouchers would be maintained as hard copies, and report generated from the system could be filed. Finance system would capture all the vouchers related to cash, bank and journal entry and develop report as and when required.

7.5 Information products, timeline, and target audience

World Vision India would submit following information products as described in the table below:

SN	Information Products	Timeline	Target Audience
1	Quarterly Reports (Program and Finance)	Quarterly	Global Fund, CTD and internal

			stakeholders
2	Annual Reports	Annual	Global Fund, CTD, Board of World Vision India, Board of SR Partners and General Public
3	Annual Audit Reports	Annual	Global Fund, World Vision India, Statutory Requirement of the Government
4	Documentation on human interest stories	Annual	Global Fund, World Vision India communications
5	Documentation on promising practices	Bi- Annual	Global Fund, World Vision India communications
6	Report on Operations Research	March 2012	Global Fund, USAID and World Vision India
7	Reports on the pilot studies	March 2012	Global Fund, USAID and World Vision India

Normal practice in all World Vision India programs is to submit Semi- Annual and Annual Reports. These reports are shared with all the stakeholders. However for Global Fund Round 9 Proposal, World Vision India has put in place a practice of submitting quarterly reports to the Global Fund. The template of the quarterly reporting format is attached as **Annexure C, Tool 3.** Similar practice is followed for all the grants that World Vision India receives. This report is required to be submitted within 20 days of the closure of the preceding quarter. These reports would be available on the online web system that project is designing.

Other information products as mentioned in the table above would also be made available on the online system of this project.

7.6 Information dissemination strategy

Dissemination plan include ways and methods in which we intend to disseminate learning and other information from our initiatives and exchange knowledge and experiences from the field to wider stake holders. Dissemination of project related information will be primarily targeted towards creating general awareness, i.e. all necessary stakeholders will be aware of the Axshya project and how they pool resources and work in partnership. After the initial stages, dissemination will be more focused on addressing wider audience and promote results and achievements through research papers, good practices documents, workshops, newsletters as mentioned in table in section 7.5.

Quarterly News Letter

This publication is intended to report progress of the work carried out by various partners. Certainly, this news letter would carry opportunities for field level practitioners to share their grass roots experiences and knowledge from their work sites dealing with various situations of TB. Such opportunities will give readers to increase their understanding on vulnerabilities, and resilience of TB related scenarios. This will also include human interest stories, good practices and other general information that will give readers chance to reflect, re-think, and learn from others.

World Vision India has no plans to publish its own news letter, but would disseminate what is mentioned above by contributing the newsletter **“Partnership Speak”** published by The Union and **“SHWAAS”** published by the NGO TB Consortium.

Sharing of progress reports (quarterly) with stakeholders:

The report would represent a systematic narrative review (both quantitative & qualitative) of the existing evidence of the project progress involving multiple interventions by various partners across seven states. The quarterly report received from all partners would be compiled and will be distributed to multiple levels of govt. offices, donors, and partners, private sector at local level and also to the community after translating it into respective local language. The report would provide intended to report progress of the work carried out by various partners to share their experiences, conceptual reflections and methodological innovations. This becomes vital secondary information/data for other organisations coming into the target community, planning for government programmes; researchers etc.

Presentations at workshops, Seminar/ Conferences, National, State District level meetings and global platforms.

World Vision will regularly participate in various meetings being organized at various levels so as to transfer newly acquired knowledge, information or findings to broader recipients such as TB health care providers, policy makers etc. These meetings are important to establish and manage professional relationships of TB stakeholders. This would also help in wider publicity and in strengthening civil society partnerships. World Vision India is also active member of various global civil society coalitions for health issues, and is active across sectoral and geographic boundaries. World Vision would proactively engage in creating platforms or in partnership with others to acts as dissemination, lessons learned from implementation and other practices. Consistent level of dissemination to government and private players for sustained efforts towards eradicating TB will be given priority.

World Vision India would also participate in global forums such as World TB Conferences organized by The Union against Lung Diseases and Tuberculosis (The Union) and present papers. We anticipate the first one to be presented in the 2011 conference. Such global conferences organized by various donors and multilateral agencies would be used as platform to

disseminate the findings of pilot studies and research studies being conducted as part of this project.

Operations research sharing: Operations research is an essential that would contribute to the body of knowledge and improve the quality of intervention with deep analysis of problems/issues. An international workshop will be organized to disseminate key findings and learnings to wider civil society organizations and other stakeholders for on TB. The research findings would be put into journal articles and would be submitted to health related journals for being published.

Documentation of Promising Practices and Human Interest Stories: Documentation of Promising Practices and Human Interest Stories for wider dissemination will be initiated during the mid course of this project. This publication is expected to be released in the beginning of second phase.

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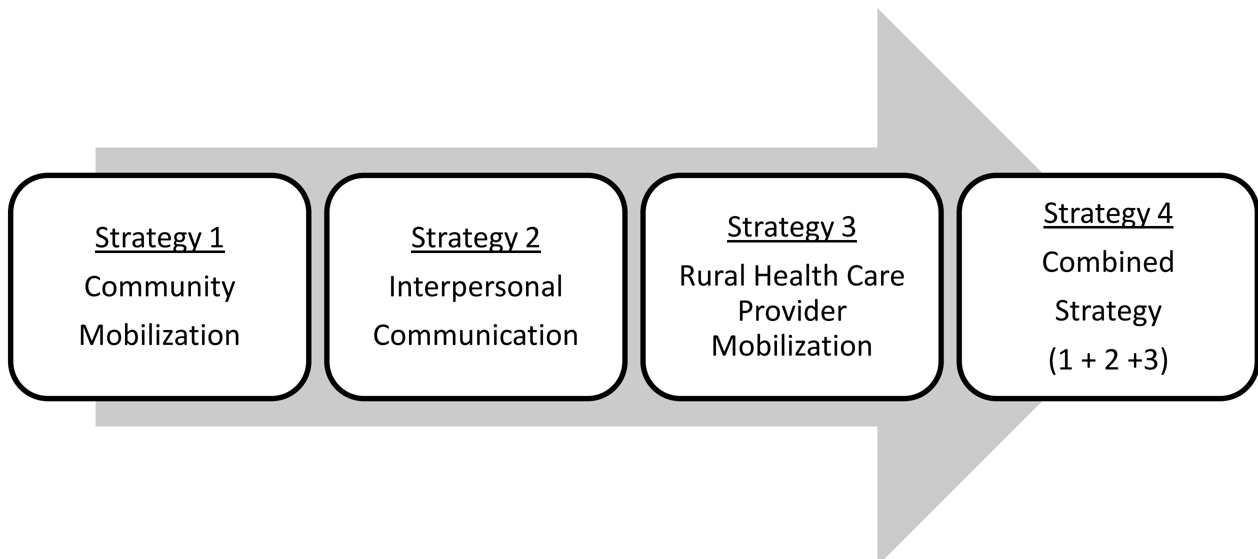
8. EVALUATIONS, REVIEWS, SURVEY, SURVEILLANCE, OR SPECIAL STUDIES

There are no major reviews, evaluations or surveys planned within World Vision India PR work plan, however there is an Operations Research Study planned in the work plan. The aim of the Operations Research Study is ***"Exploring Effective ACSM Strategies to help address Key Challenges to TB control in India."*** The study is to test four different ACSM Strategies as described in **diagram 5** using quasi experimental design in experimental and control districts. 4 experimental and 4 control districts would be selected and each district would implement one strategy from the diagram below.



The detailed Operations Research Study design is being submitted as separate enclosure as part of Annexure I. Key contents of the study design are being briefly discussed here. World Vision India has worked with Maharashtra Association for Anthropological Studies (MASS), one of the members of the NGO TB Consortium in developing this research design. World Vision India would enter into a Memorandum of Understanding with MAAS to implement this research.

Study Design: A quasi-experimental study design with a non-equivalent control group will be used to evaluate the effectiveness of ACSM strategies. The pre and post-design will be used for evaluating

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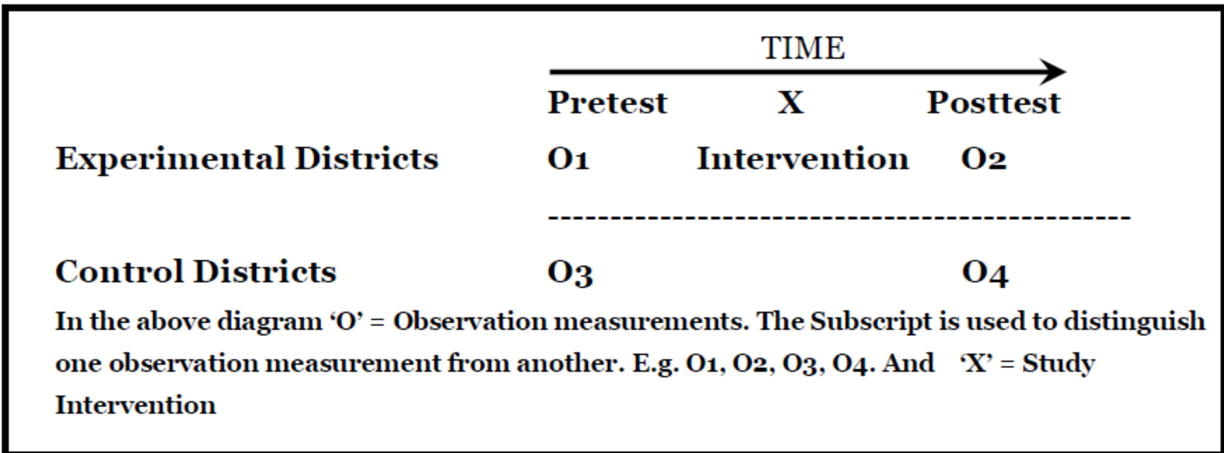
the performance of the ACSM programme strategies in the experimental and control districts. The following diagram details the scheme of operation.



The feasible milestones are proposed as follows:

1. **Phase – 1:** Baseline Situation Assessment
    a. Starting on 15th October 2010
    b. Ending on 15th December 2010
2. **Phase – 2:** Planning and Preparatory phase for Intervention
    a. Starting on 16th December 2010
    b. Ending on 15th February 2011
3. Baseline Report Submission: 31st January 2011
4. Protocol Submission of Planning and Preparatory Phase: 15th February 2011
5. **Phase – 3:** Intervention
    a. Starting on 1st March 2011
    b. Ending on 30th November 2011 (after nine months)
6. **Phase – 4:** End-line Evaluation
    a. Starting on 1st December 2011
    b. Ending on 31st January 2012
    c. End-line Report Submission: 15th March 2012.

Following are some of the considerations for sample selection:

- Percentage of ST and SC population in the experimental and control districts have bearing on the areas of enquiry; it should be factored cognizance taken at the time of the

- Considering the selection of districts and areas of enquiry and factoring sampling error and confidence limits for different sample sizes, it is suggested that there is a significant improvement in increasing the size of the sample of general community members till 500 per district.

- Sampling strategy: Three talukas (sub districts) per district will be randomly selected, and assign sample probability proportional to ST and SC population. The sampling households will then be selected randomly. In this case, the sample size would also vary for each taluka (sub districts), again with probability proportional to the indicators (ST and SC population).

- For TB patients and private sector providers sampling, a quota sample of 50 each per district which will be total of 400 TB patients and 400 private sector providers from 8 districts. Then assign sample randomly following probability proportional to the available numbers.

Following table summarizes the total sample size:

Study Component	**Per District Sample**	**Total Sample from 8 Districts**
General Community Members	500	4,000
TB Patients	50	400
Rural Health Care Providers	50	400
Key Informants (Convenience Sampling)	10-15	80-120

Other details of the proposal can be read through the attached research design

9. DATA QUALITY ASSURANCE MECHANISMS AND RELATED SUPPORTIVE SUPERVISION

9.1 Data quality assurance mechanisms

World Vision India as part of its Monitoring and Evaluation system already has in place Data Quality Assurance Mechanism. The Quality Assurance Unit of World Vision India conducts periodic Results Review for ensuring data quality. This review focuses more on authenticity of data being reported. This review primarily focuses on ***minimizing risk that can threaten the viability and reputation of the organization.***

Quality Assurance Mechanism in World Vision India also follows the similar nature of quality components as suggested by Global Fund namely: Reliability, Accuracy, Timeliness, Completeness and Integrity. The Results Review System of World Vision India has a scoring based on the above component. The same quality assurance system applies for Programs and Finance Data. While the results review system would ensure that quality standards are complied for program data, the Internal Audit system would ensure that same standards are complied by the Finance System. This GF R-9 project would also be subject to Results Review and Internal Audit at least twice during the life of the grant.

The table below describes the framework and the process that this project has put in place or would be putting in place.

SN	Data Quality Component	Definition	Process in Place
1	Reliability	The data generated by a program's information system are based on protocols and procedures that do not change according to who is using them and when or how often they are used. The data are	While designing M&E System of the project along with the Partners, certain protocols were agreed, for indicator reporting. Annex A and B clearly articulates those protocols for each indicators in terms of how

		reliable because they are measured and collected consistently.	data would be collected, reported, analyzed and used. The Supervisory Checklist at various levels would ensure the consistency.
2	Accuracy	The Accuracy dimension refers to how well information in or derived from the database or registry reflects the reality it was designated to measure.	For every indicator to be reported in the M&E system, the project has defined the source of information. The Project Manager will validate all the information provided by the DC by personally visiting the District in each quarter and cross tally the data reported with the source tool. Same would be done by the M&E Officer from the PMU to validate the information reported by the SR for the State level.
3	Timeliness	Timeliness refers primarily to how current or up-to-date the data are at the time of release, by measuring the gap between the end of the reference period to which the data pertain and the date on which the data becomes available to users.	Supervisory checklist have been developed for various levels and attached as Annexure E to ensure that data is being reported timely, and is available to all concerned on a timely manner. The web based reporting system would also have current information available.
4	Completeness	Completeness means that an information system from which the results are derived is	The Supportive Supervisory Checklist at all levels would also ensure that data reported is complete, and there is no pending

		appropriately inclusive.	information, or information not being provided.
5	Integrity	Integrity is when data generated by a program's information systems are protected from deliberate bias or manipulation for political or personal reasons	M&E Protocols as discussed with the partners take the data manipulation as serious offence. Supportive SR Monitoring by the PMU would ensure that there is a data integrity and this is part of the PMU checklist.

9.2 Human resources and technical capacity needs for data management and for ensuring data quality.

Capacity in Quality Assurance has been identified as one of the weaknesses during the SR Assessments and MESS Tool workshop with the partners. None of the SRs have in place quality assurance practices in their organization. The PR has developed capacity building plan for building SR capacity in the data quality and data management. Details have been discussed in Section 8: Capacity Building.

9.3 Plans for assessing consistency of primary data during data analysis.

The table below shows the data source tool for each indicator. The supervisory checklist developed for the SR Program Manager and M&E Officers at the PMU have been developed to ensure that data as reported are consistent with the original source of data. For example, number of people trained is consistent with the number of names in the attendance sheet. The table below describes the original source of data, and the tool for assessing consistency, along with the person responsible.

Impact and Outcome data is being reported by the National M&E System, and WHO have in place the mechanism to ensure consistency on those indicators, hence project is not concentrating on

developing any system to measure the consistency for the impact and the outcome indicators. Project will thus ensure the consistency for the process indicators.

SN	Indicator	Reference tool for source data	Checklist for consistency	Person Responsible
1	Number of districts with new smear positive case detection rate≥70% in 74 districts	Quarterly report on case finding	PMU Supervisory checklist	M&E Officer
2	Percentage & number of target districts where at least 90% of all smear positive cases started RNTCP DOTS within 7 days of diagnosis	Quarterly report on Programme management	PMU Supervisory checklist	M&E Officer
3	Percentage & number of target districts where at least 40% of registered TB patients (all forms) are supervised through community volunteers	Quarterly report on Programme management	PMU Supervisory checklist	M&E Officer
4	Number of people trained (TOT) at State level on NGO/CBO/PPRNTCP scheme	Attendance sheet and Training report	PMU Supervisory checklist	M&E Officer
5	Number of NGOs sensitized at District level on community mobilization and RNTCP schemes	Attendance sheet and Training report	SR Supervisory Checklist	SR Program Manager
6	Number of people trained and retrained on interpersonal skills and soft skills (through State level TOT and District level health staff at District level)	Attendance sheet and Training report	SR Supervisory Checklist	SR Program Manager
7	Number and percentage of target districts with an active District TB Officer	Quarterly report on Programme management	SR Supervisory Checklist	SR Program Manager
8	Number of Rural Health care providers sensitized on referrals, DOTS provision and eligible	Attendance sheet and Training report	SR Supervisory	SR Program Manager

	RNTCP schemes		Checklist	
9	Percentage of sputum positive initial defaulters successfully retraced and enrolled in DOTS	RNTCP laboratory register and List of Initial Defaulter	SR Supervisory Checklist	SR Program Manager
10	Number of district level TB forums functional	To be developed	SR Supervisory Checklist	SR Program Manager

9.4 Data Quality Assessments.

Data quality assessments would be developed at two level, data quality assurance using the framework described in section 9.1 and Results Review to ensure what has been reported is out there in the field. While the tools and process for the former have been developed, work is required to be done with the Quality Assurance Department of World Vision India to modify its tools for Data Quality Assessment to incorporate requirement of this project. The Project Director who was instrumental and led the setting of the Quality Assurance System of World Vision India would work with the M&E Officers to develop the tools and processes for the Data Quality Assessment, and would give those tools to the Quality Assurance Department to conduct the Data Quality Assessment. Since PMU Team is one of the stakeholders in the whole system, it would be good for the third party to do the assessment, hence the Quality Assurance Department of World Vision India.

World Vision India is committed to conduct quarterly validation of the data being reported and Data Quality Assessment at least twice in the life of the project.

9.5 Development and utilization of tools and guidelines / checklists for data quality assurance/assessments and for supervision.

As discussed in Section 9.3, following tools have been developed for data quality assurance and supervision and are attached as **Annexure E**

- District Coordinator's Supervisory Checklist
- Program Manager's Supervisory Checklist
- Monitoring and Evaluation Officer's Supervisory Checklist
- PMU Finance Officer's Supervisory Checklists
- SR Finance Officer's Supervisory Checklists

Further following tools will be developed for ensuring data quality using the same framework as mentioned in 9.1

- Training observation checklist for assuring quality of the training.
- Training report and attendance sheet supervisory checklist for ensuring consistency in numbers being reported with what have been actually trained.
- Exit interview form to measure the retention of the learning
- Supervisory checklists for reviewing the consistency between the various forms and registers being maintained as original data source and what has been reported.

9.6 Supportive supervision for M&E and data quality.

The primary purpose of the supportive supervision is to ensure the data quality, and ensuring that what has been planned has also been implemented. Much of the supportive supervision time would be used for data validity and consistency. Supervisory checklists as discussed in the previous sections have been developed for these supportive supervision visits.

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Table below describes the Supportive Supervision Protocols as agreed by SRs and the PMU during the meeting on October 6-8, 2010.

SN	Positions	Supportive Supervision Protocol	Tool
1	PMU Finance	Once in a quarter supportive supervision visit to each SR	Finance Supportive Supervision Checklist
2	PMU Monitoring and Evaluation (Programs)	Once in a quarter supportive supervision visit to each SR Each District atleast once in the year	PMU Programs Supportive Supervision Checklist
3	SR Program Manager	Once in a quarter each District	SR Program Managers Supportive Supervision Checklist
4	SR Finance Officer	Each SSR atleast once in a quarter	SR Finance Officers Supportive Supervision Checklist
5	District Coordinator	Each SSR once in every fifteen days.	District Coordinators Supportive Supervision Checklist

9.7 Finance Monitoring Mechanism

The finance review and monitoring mechanism will supplement the 'review and monitoring' system effectively followed by the SR. The 'Project Monitoring Unit' will verify whether the system has been implemented by the SR effectively. The documentation in this regard will be verified along with the audit / verification trail followed by the Finance Officer.

These vouchers should have been reviewed for their genuineness and authenticity by the program officers / district coordinators. Each of the vouchers should have been reviewed and authorized for

payment as per procedure generally followed for all its projects. Therefore the review by the FO will be in addition to the above.

The FO should visit each SSR at least once every quarter. The period of the visit should be adequate and sufficient to complete the process. At the end of the visit, the FO should submit in detail a 'trip report' mentioning the review and verification procedures covered during the visit, observations, recommendations and the follow up actions if any required. During the next visit, the FO should refer to the previous 'trip report' and see if all the recommendations have been implemented with immediate effect. Where the recommendations are material the FO should visit the SSR again and see if capacity building is required in certain areas.

The following are some of the areas that the Finance Officer will verify during his 'review and monitoring' visit to the SSR,

1. Whether every voucher is adequately supported by bills and other documents wherever necessary.
2. Whether the voucher actually belongs to the AXSHYA India project.
3. Whether the Project Manager or the District Coordinator has reviewed and initialed the bill.
4. Whether the amount in the bill and the voucher is the same.
5. Whether the purpose of the expense indicated in the narration is in line with the activity to be carried out as per the line item in the budget.
6. Whether the voucher has been accounted by the SSR accountant under AXSHYA India project, under the specific line item and expense head as per the Finance Monitoring Tool.
7. Has the expense been reported in the FMT in line with the book of account of the SSR.
8. Has the tax component under the expense been reported separately in the FMT
9. Whether the Bank charges is reported separately under the FMT.
10. Whether the bank account balance in the FMT is in line with the books of account
11. Whether the Bank statement is available filed in chronologically by the SSR.
12. Whether Bank Reconciliation Statement is being prepared by the SSR for the dedicated bank account
13. Whether the BRS has been prepared correctly as per the generally accepted procedures.

14. Whether the amounts reported as 'cheques issued but yet to be debited' has actually been debited in the bank account in the ensuing period.
15. In the case of petty cash, whether the 'impress cash' is in line with the policy of the organization or as per the recommendation of the SR as the case may be.
16. Whether the physical cash is being verified at the end of each day by a person other than the staff handling the petty cash.
17. Whether there are difference in the physical cash when compared to the petty cash book and how the same has been settled.
18. Every voucher should be signed with date, as an indication that he has verified the same and has found them to be correct.
19. Whether the vouchers pertaining to AXSHYA India project are being filed separately
20. Whether advance / suspense taken for an activity is settled within 24 hours
21. In the case of travel advance, the same should be settled within 5 working days on return from travel

10. M&E COORDINATION

The GF Rd 9 proposal has three Principal Recipients viz Central TB Division (CTD) (Government of India - GoI), and a partnership of 16 NGOs organized under 2 civil society PRs (the International Union against Tuberculosis and Lung Disease, or 'The Union', and World Vision India). The civil society partners will undertake intensified Advocacy Communication and Social Mobilization (ACSM), community based support and care, increasing participation of traditional healers, and sensitization of private practitioners and Non-Government Organizations (NGOs) for involvement in RNTCP schemes. Advocacy by civil society is expected to strengthen political commitment and increased allocation of Resources for TB programme specifically at state level. Although civil society activities are independent of the programme activities for the purpose of the project, they integrate within the overall context of the national programme and hence close coordination between civil society PRs with the Programme is essential at all levels.

Diagram 4 below illustrates the coordination for M&E at all levels.

Coordination between all stakeholders

National Coordination Committee: A national coordination committee has been established and will be chaired by the national programme manager. It includes representation from all program stakeholders including state level programme officers, technical partners to the program and experts in ACSM. This committee will meet regularly and will be the one platform to exchange project related information between civil society PRs and RNTCP. There will be active sharing of data at District and State level between civil society partners and programme staff, while regular and active sharing of information at national level will takes place in the National Coordination Committee meetings. These meetings will review progress of the project and make course corrections.

The first meeting of the National Coordination Committee is scheduled for October 19, 2010. The Union and World Vision India have already entered into a good harmonious relationship and have met

on various occasions to coordinate between them. Sharing of tools and training manuals are classical examples of coordination with both civil society PRs.

Similar Coordination committees will be formed at State and District level between Programme managers and civil society implementing agencies (SRs) to jointly monitor the programme activities. There are States where multiple civil society partners are working and requires regular coordination. With the State TB Officers and WHO Consultants, State and District level coordination committees will be formed that would regularly review the program performance and ensure synergy between all the partners.

Coordination with existing RNTCP M&E system

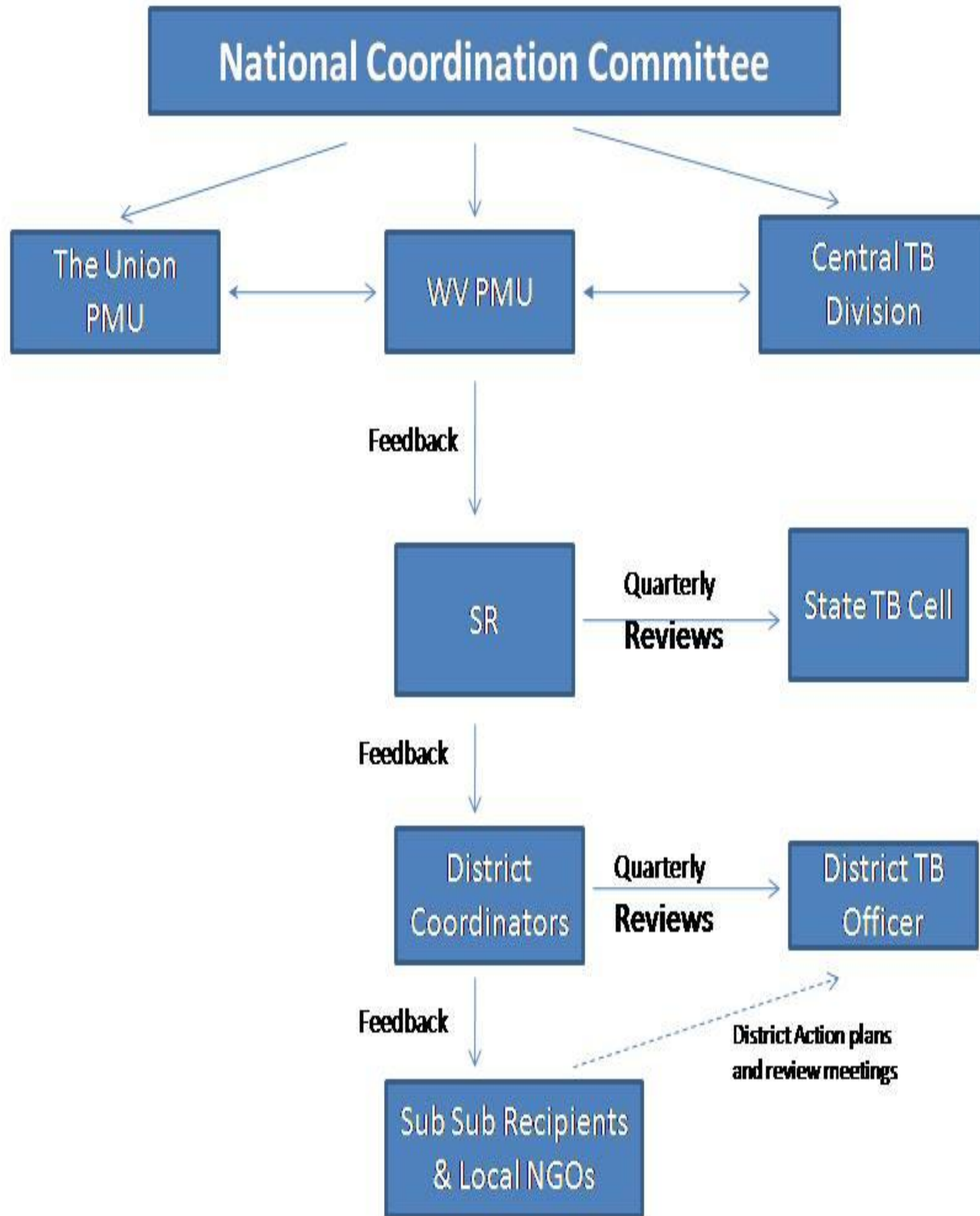
RNTCP has a systematic monitoring mechanism which accounts for the outcome of every patient put on treatment. There is a standardized recording and reporting structure in place. The cure rate and other key indicators are monitored regularly at every level of the health system and supervision is intensified if an area is not meeting the desired expectations. Routine reporting in the RNTCP is generated from the peripheral health institution (PHI) level upwards. The existing national reporting formats captures data including case finding, smear conversion rates, treatment outcomes and other programme interventions including ACSM and trainings. The RNTCP also monitors status on key staff positions and training; involvement of medical colleges, partners and stakeholders. The RNTCP also has a well established system of quarterly programme review at district and state level where available data on programme performance are reviewed from higher level. This GF supported project will utilize the existing RNTCP mechanism of recording and reporting available at district and state level to report outcomes on case finding, case holding and treatment outcomes. As there would be co-implementation of activities in each of the project districts by both the RNTCP and civil society partners in this project, it will not be possible to attribute any incremental performance to one agency. However, as all efforts in this project are towards supporting the national strategy it would be appropriate to attribute all improvement to the national programme. This mechanism will ensure that there is no parallel reporting on TB outcome indicators or duplication of existing efforts. Several activities and processes under the civil society component are unique. Therefore process and output indicators for ongoing monitoring will have to be unique for which a separate tool will be required.

Strengthening National M&E system through civil society partnership:

1. Strengthening ACSM monitoring: Though RNTCP has a very well established and functioning MIS system, ACSM components in the programme is not captured well except two indicators, the number of 'patient provider interaction meetings' and 'community meetings' held from the quarterly programme management report. The M&E plan of the civil societies has a clear focus on ACSM activities including assessing the community need, monitoring various activities and evaluating the impact of ACSM on programme performance. This monitoring system will address one important area of MIS of the programme. The information will be shared with the National Programme M&E system there by addressing a major weakness of the existing system.

2. Review and Supervision: Regular Joint Review of the programme is planned as part of M&E plan at District, State and National level between programme managers and civil society implementing agencies. This will provide civil society perspective on availability and accessibility of TB services and also provide an opportunity for the programme to share its performance. Supervisory activities of the civil society partners envisaged under this project will complement the regular supervision by the programme.

Diagram 4



11. CAPACITY BUILDING

Findings from the SR assessments recognize the high need for capacity strengthening on various critical prerequisites for sustaining and reporting quality progress. And therefore, our capacity development initiatives are not isolated training interventions, but rather a strategically co-ordinated set of activities aimed for effective M&E and increasing overall program performance and management. The process of identifying specific needs was jointly done by SRs with WV India playing a supportive role. The complete capacity building plan is designed towards strengthening the performance capabilities of SRs involving a broad based and participatory approach. This will increase awareness and understanding of the capacity-development initiative and improve its chances of acceptance and success among our SR partners. The capacity building plan developed is fully comprehensive, so that the WV India and SRs can simultaneously benefit from the capacity-development initiatives in a strategic manner. Following 10 Capacity Building needs have been identified by the SR and the PMU.

1. Program Management
2. Understanding of Monitoring and Evaluation
3. Understanding Performance Framework and Performance based funding
4. Understanding Results Framework
5. Skills in using data collection tools
6. Advance skills in Excel as well as MS Access
7. Skills in data analysis
8. Understanding Quality Assurance
9. Using data quality tools and continuous quality improvement (CQI)
10. Data Quality Assessments.

World Vision India

	Action Plan Activity	2010				2011				Person Responsible
		1	2	3	4	1	2	3	4	
1.1	M&E Assessment									
1.1.1	Conduct M&E and Capacity Assessment of the PMU	x								WV
1.1.2	Conduct M&E and Capacity Assessment of the SR	x								WV
1.1.3	Identify M&E and Capacity gaps		x							WV
1.2	M&E Comprehensive Plan									
1.2.1	Develop comprehensive M&E Plan		x							WV/SR
1.2.2	Develop Capacity Building plan		x							WV
1.3	Data quality assurance									
1.3.1	Define Quality Assurance elements		x							WV
1.3.2	Develop quality assurance checklists			x						WV
1.3.3	Train SR on data quality			x		x		x		WV
1.3.4	Continuous quality initiatives (CQI)				x	x	X	x	x	WV/SR
1.3.5	Put in place mechanisms for data validity				x	x	X	x	x	WV/SR

1.3.5	Data Quality Assessment								X	WV
1.4	Capacity Building									
1.4.1	Understanding of Program Management and Monitoring and Evaluation	x	x							WV
1.4.2	Understanding Performance Framework and Performance based funding	x	x							WV
1.4.3	Understanding Results Framework		x							WV
1.4.4	Understanding of the M&E Plan for this project	x								WV
1.4.5	Skills in using data collection tools			x					x	WV
1.4.6	Advance skills in Excel as well as MS Access			x	x					SR
1.4.7	Basic skills in data analysis					x	X			WV
1.4.8	Knowledge of data quality concepts			x	x					WV
1.4.9	Skills in using data quality tools					x	X			WV
1.4.10	Skills in conducting data quality audit					x	X			WV
1.5	Reporting									
1.5.1	Define data elements for reporting	X								WV/SR
1.5.2	Develop data collection tool	X								WV/SR

1.5.3	Develop reporting format	X								WV/SR
1.5.4	Develop review mechanism		x							WV/SR
1.5.5	SR submit the reports		x	x	x	x	X	x	x	SR
1.5.6	PR submit the report to GF		x	x	x	x	X	x	x	WV

Program Management and General understanding of Monitoring and Evaluation

This topic is designed to equip individuals and organizations with advanced knowledge of Program Management and M&E mechanisms. The training would provide direction for improved tracking, communication and articulation of project outcomes. Given the complexities, WV India recognizes that M&E alone cannot satisfy all information needs. Capacities will be built around how to raise important research questions that cannot be comprehensively answered by regular monitoring and evaluation. It's much about creating evidence, conduct research and to document key learnings on specific TB interventions and to make how to address build evidence on thematic areas such as poverty and tuberculosis, multi-sectoral global health governance, tuberculosis and stigma etc.

Understanding Performance Framework and Performance based funding:

Partners have been oriented on understanding the close co-relation between performance in relation to achieving targets and consistent flow of funds. For each activity, the monitoring framework provides a conceptual model of successful implementation and its impact, making explicit the linkages about achieving targets and performance. The importance of gathering information on various indicators has been laid out and the 'how' part of collecting information is still in progress. From the recently conducted workshop, partners are aware as to what to monitor.

Understanding Results Framework

The M&E systems training will enable partners to for understanding programmatic gaps and making strategies to achieve intended results. The SRs would has been trained for project cycle management to identify capacity needs assessments and constraints for improved management of results. It will focus on appraisal to analysis, planning, action, monitoring and evaluation and in analyzing finding out what works and what doesn't and then asking why. The trained partners are expected to generate and meaningfully communicate up to date and valid policy relevant insights to various stakeholders.

Skills in using data collection tools

The tools to collect the information systems have been developed in consultation with partners and they are being tested in communities to ensure validity so that the data is useable at multiple levels. The methods for information collecting have been built into action planning to avoid unnecessary burden. The system is designed to have a steady flow of information about the progress of the results. Preliminary training will be given for various methods of collecting primary data. Skills would be imparted to gather necessary information through appropriate tools in cost effective way to find out what wanted to be known.

Basic skills in data analysis

One of our observations is that organizations spend a lot of time collecting information and then not have time to take action. It is important to get a balance between having enough information to enable us to act upon it and gathering too much so that we will never act! The idea is to use the practical evidence of and to critically reflect upon the relationship between actual practice and stated objectives. This analysis will draw out the real-life considerations that will have to be addressed, to improve our responsiveness and quality.

Quality Assurance and Data Quality Tools

Quality Assurance is one of the most important aspects of Program management and M&E. Capacity in Quality Assurance has been identified as one of the weaknesses during the SR Assessments and MESS

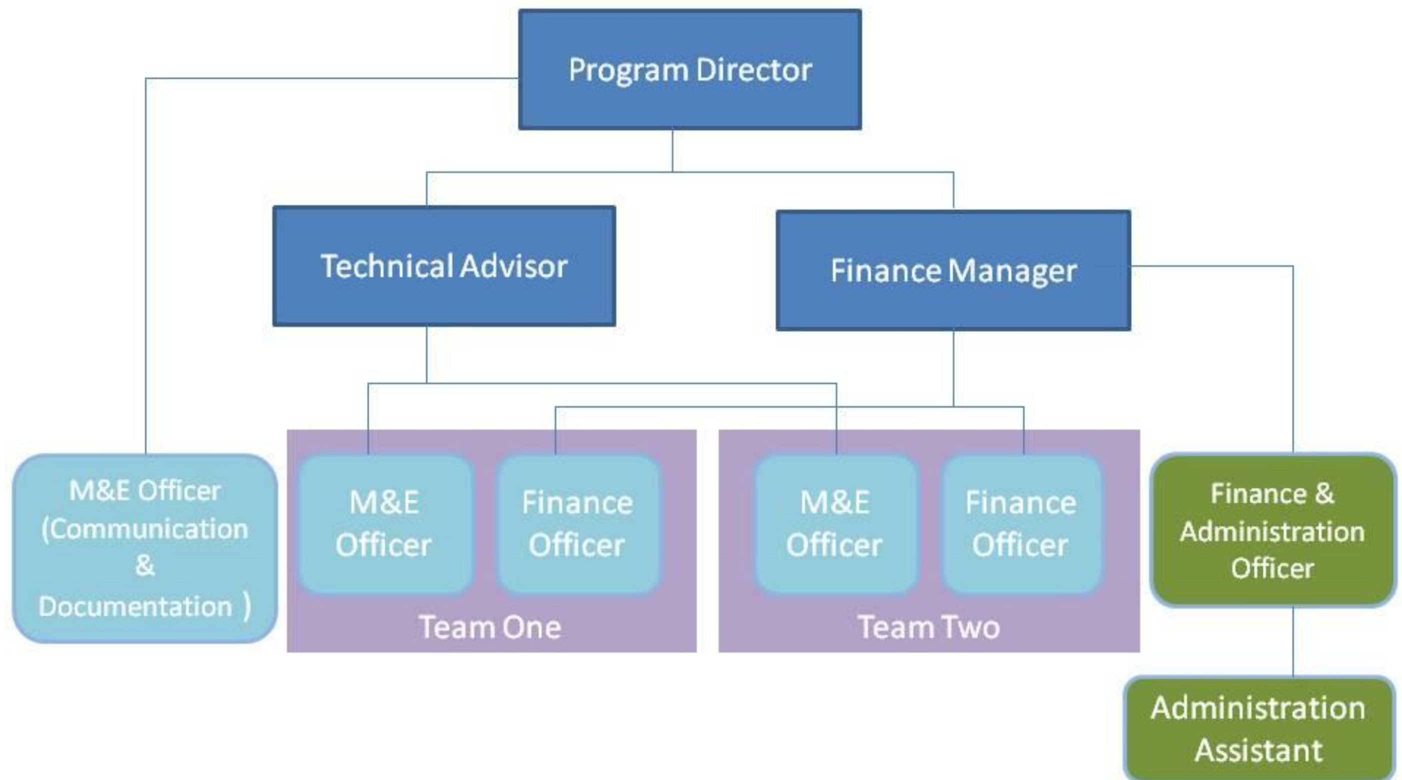
Tool workshop with the partners. None of the SRs have in place quality assurance practices in their organization. The PR has developed capacity building plan for building SR capacity in the data quality and data management. Using the framework as described below, project will build capacity around the Quality Assurance.

Skills in using Quality Assurance Tools and conducting Data Quality Assessments.

Project has developed several quality assurance tools, and few more have to be developed. During the quarterly review meetings, project will spend enough time to build capacity of the SR in using these quality assurance tools and conduct supportive supervision to ensure that these tools are being used.

Within World Vision India, Quality Assurance Department would help the project to build skills in data quality assessment. They would also conduct an independent data quality assessment at least twice in the life of the project. This review would focus more on authenticity of data being reported. This review primarily focuses on minimizing risk that can threaten the viability and reputation of the organization. The risk could be due to poor quality of data. Thus all steps would be in place to assure data quality

12. PMU ORGANOGRAM FOR M&E



Role of PMU in M&E

The Program Management Unit of World Vision India located in New Delhi would be responsible for the Monitoring and Supervision of this project.

1. Support from M&E unit of PMU: The monitoring and evaluation unit formed under the PMU will oversee and monitor & evaluate project activities.

2. Collaboration with Coordination committees: World Vision India through its PMU Director will collaborate with Coordination committee that is formed at National Level and also coordinate with The Union. However the Monitoring and Evaluation Unit would collaborate with the Coordination Committees formed at the State and district level between programme managers and civil society implementing agencies to jointly monitor the project activities.

3. Coordination with SRs and partners: SRs will organize regular quarterly meetings of civil society implementing staff and will conduct supervisory visits at service delivery levels.

4. Support SRs at all levels (District and State level) in aspects related to M&E (could include bringing the clarity on monitoring indicators, QPR generation etc.) where required

5. Review of QPRs and provide feedback to SRs

6. Regular monitoring visits – check up of registers, random data entry check for select indicators.

The PMU monitoring & evaluation unit is responsible in overall M&E of the project

13. M&E BUDGET AND WORKPLAN

13.1 Monitoring and Evaluation Work Plan

Ref No	Objective	Service Delivery Area (SDA)	Activity	Year 1				Year 2				
				Q1	Q2	Q3	Q4	Q5	Q6	Q7	Q8	
3.1.12	3	Monitoring and Evaluation (M&E)	OR Study on ACSM Model.								X	WV
4.3.2.1.	4	Monitoring and Evaluation (M&E)	Quarterly review meetings of rural health care providers with district TB officers.			X	X	X	X	X	X	All SRs
4.5.5.3	4	Monitoring and Evaluation (M&E)	Monitoring & evaluation visits			X	X	X	X	X	X	WV
4.5.6.1	4	Monitoring and Evaluation (M&E)	Review and M&E visits at district level by the implementing partners			X	X	X	X	X	X	All SRs
4.5.6.2	4	Monitoring and Evaluation (M&E)	Review and MI&E visits from states/regional/national to districts.	X	X	X	X	X	X	X	X	All SRs
4.5.7.2	4	Monitoring and Evaluation (M&E)	Project planning and review meeting at National level			X	X	X	X	X	X	WV
4.5.7.3	4	Monitoring and Evaluation (M&E)	Quartelry planning and review at state level			X	X	X	X	X	X	WV

13.2 Monitoring and Evaluation Budget - Year 1

Ref No	Objective	Service Delivery Area (SDA)	Activity	Year 1	Q1		Q2		Q3		Q4		Year 1	
				Unit Cost	Qty	US $	Qty	US $	Qty	US $	Qty	US $	Qty	US $
3.1.12	3	Monitoring and Evaluation (M&E)	OR Study on ACSM Model.	9,474	-	-	-	-	-	-	-	-	-	-
4.3.2.1 .	4	Monitoring and Evaluation (M&E)	Quarterly review meetings of rural health care providers with district TB officers.	126	-	-	-	-	27	3,489	40	5,621	67	9,111
4.5.5.3	4	Monitoring and Evaluation (M&E)	Monitoring & evaluation visits	4,516	-	-	-	-	21	13,219	21	13,219	42	26,438
4.5.6.1	4	Monitoring and Evaluation (M&E)	Review and M&E visits at district level by the implementing partners	516	-	-	-	-	213	26,792	213	26,792	426	53,583
4.5.6.2	4	Monitoring and Evaluation (M&E)	Review and MI&E visits from states/regional/national to districts.	95	2	703	5	3,091	109	28,618	103	27,026	219	59,438
4.5.7.2	4	Monitoring and Evaluation (M&E)	Project planning and review meeting at National level	265	-	-	-	-	1	6,316	1	6,316	2	12,632
4.5.7.3	4	Monitoring and Evaluation (M&E)	Quartelry planning and review at state level	2,131	-	-	-	-	8	4,326	7	3,066	15	7,392
GRAND TOTAL														**168,593**

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3.3 Monitoring and Evaluation Budget - Year 2

Amount in US $

Ref No	Objective	Service Delivery Area (SDA)	Activity	Year 2	Q5		Q6		Q7		Q8		Year 2		Total
				Unit Cost	Qty	US $	Qty	US $	Qty	US $	Qty	US $	Qty	US $	US $
3.1.12	3	Monitoring and Evaluation (M&E)	OR Study on ACSM Model.		-	-	-	-	1	25,463	-	-	1	25,463	25,463
4.3.2.1.	4	Monitoring and Evaluation (M&E)	Quarterly review meetings of rural health care providers with district TB officers.		74	#####	74	######	74	11,995	74	11,995	296	47,979	57,089
4.5.5.3	4	Monitoring and Evaluation (M&E)	Monitoring & evaluation visits		21	#####	21	######	21	13,880	21	13,880	84	55,520	81,957
4.5.6.1	4	Monitoring and Evaluation (M&E)	Review and M&E visits at district level by the implementing partners		213	#####	213	######	213	27,351	213	27,351	852	109,404	162,987
4.5.6.2	4	Monitoring and Evaluation (M&E)	Review and MI&E visits from states/regional/national to districts.	2,784	102	#####	102	######	102	27,883	101	27,048	407	110,697	170,135
4.5.7.2	4	Monitoring and Evaluation (M&E)	Project planning and review meeting at National level		1	#####	1	6,632	1	6,632	1	6,632	4	26,526	39,158
4.5.7.3	4	Monitoring and Evaluation (M&E)	Quartelry planning and review at state level		7	#####	7	3,088	7	3,088	7	3,088	28	12,353	19,745
GRAND TOTAL														387,941	######

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ANNEXURE A: M&E Framework Template

Indicator name	Baseline	Target (s)	Data source	Frequency of data collection	Entity responsible
Impact indicator					
TB incidence rate	75 new smear positive (NSP) cases per 100,000 population-2002	60 NSP cases per 100,000 population-2015	National Annual risk of TB infection (ARTI) survey	Annual	CTD
TB prevalence rate	370 bacillary positive TB cases per 100,000 population-2000	200 bacillary positive cases per 100,000 population-2015	Report of expert committee on TB Burden based on prevalence survey data	Annual	CTD
TB mortality rate	28 deaths per 100,000 population-2006	21 deaths per 100,000 population-2015	WHO Global TB Report	Annual	CTD
Outcome Indicator					
Case Detection Rate: New Smear Positive Cases	54 new smear positive cases per 100,000	≥51 (70%) new smear positive cases per 100,000	R & R TB system, quarterly reports	Quarterly	CTD

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	population (72%) -2009	population-2015			
Treatment success rate-New Smear Positive Cases	87%-2008	≥85%	R & R TB system, quarterly reports	Quarterly	CTD
Average default rate of smear positive re-treatment patients in 374 districts	14%-2008	9%	R & R TB system, quarterly reports	Quarterly	CTD
Process indicators					
Number of districts with new smear positive case detection rate≥70% in 74 districts	27-3Q 2008	37	R & R TB system, quarterly reports	Quarterly	SR
Percentage & number of target districts where at least 90% of all smear positive cases started RNTCP DOTS within 7 days of diagnosis	38% (28)-3Q 2009	48% (35)	R & R TB system, quarterly reports	Quarterly	SR
Percentage & number of target districts where at least 40% of registered TB patients (all forms) are supervised through community volunteers	32% (24)-3Q 2009	40% (30)	R & R TB system, quarterly reports	Quarterly	SR

Percentage of population with correct knowledge about TB (mode of transmission, symptoms, treatment & curability)	NA	NA	KAP Survey	Quarterly	SR
Number of people trained (TOT) at State level on NGO/CBO/PPRNTCP scheme	0-2009	70	Training records	Quarterly	SR
Number of NGOs sensitized at District level on community mobilization and RNTCP schemes	600-2009	510	Training records	Quarterly	SR
Number of people trained and retrained on interpersonal skills and soft skills (through State level TOT and District level health staff at District level)	0-2009	7505	Training records	Quarterly	SR
Number and percentage of target districts with an active District TB Officer	340 (91%)-3Q 2009	≥355 (≥95%)	R & R TB system, quarterly reports	Quarterly	SR
Number of Rural Health care providers sensitized on referrals,	0-2009	4995	Training records	Quarterly	SR

DOTS provision and eligible RNTCP schemes					
Percentage of sputum positive initial defaulters successfully retraced and enrolled in DOTS	0-3Q 2009	5%	R & R TB system, quarterly reports	Quarterly	SR
Number of district level TB forums functional	0-2010	370	Project M&E records	Quarterly	SR

ANNEXURE B: Indicator Reference Sheet Template

Indicator	**TB Incidence rate**
Rationale	Incidence (cases arising in a given time period) gives an indication of the burden of TB in a population, and of the size of the task faced by a national TB control programme. Incidence is the number of new cases arising during a defined period.
Numerator	Estimated number of TB cases (all forms) occurring per year
Denominator	In 100,000 population
Data collection frequency	Annually
Measurement Tool	Annual Risk of TB Infection (ARTI)
Method of measurement	Nationwide survey of TB incidence or indirectly from measurements of prevalence (from surveys of the prevalence of TB disease)
Interpretation	The trend in TB incidence can be measured by assessing trends in case notifications if case-finding efforts and/or recording and reporting practices have not changed significantly. The notification rate can be a close proxy of TB incidence where the coverage and quality of the routine surveillance system is high.
Other relevant information	

Indicator	**TB prevalence rate**
Rationale	Indicator of burden of tuberculosis. It indicates the number of people suffering from tuberculosis at a given point in time. It is the number of new and previously occurring TB cases that exists at a given point in time.
Numerator	Number of bacteriologically confirmed TB cases
Denominator	In 100,000 population
Data collection frequency	Annual
Measurement Tool	Report on expert committee on TB burden based on prevalence survey data
Method of measurement	Measured by a population-based disease prevalence survey. Measurements of prevalence are typically confined to the adult

	population. Prevalence surveys exclude extra pulmonary TB as well as smear-negative and culture-negative TB.
Interpretation	It provides measure of the prevalence of bacteriologically confirmed TB disease. Prevalence respond quickly to improvement in national TB control programme
Other relevant information	

Indicator	**TB mortality rate**
Rationale	Mortality responds quickly to improvements in national TB control programme, as timely and effective treatment reduce the likelihood of people dying from the disease (thus reducing disease-specific mortality).
Numerator	Number of deaths due to TB (all forms)
Denominator	In 100,000 population
Data collection frequency	Quarterly
Measurement Tool	TB register
Method of measurement	The numerator is available from TB register or quarterly Treatment outcome report. Population-based mortality survey (verbal autopsy study) and sample vital registration
Interpretation	If national TB control programme of country is performing well, all the health facilities outside the public sector increasingly refer patients to DOTS and when public-private partnership (PPM) are being implemented, there will be reduction in the number and rate of TB deaths.
Other relevant information	

Indicator	**Case Detection Rate: New Smear Positive Cases**
Rationale	The proportion of estimated new smear-positive cases of TB detected (diagnosed) by DOTS programme provides an indication of the effectiveness of national TB programme in finding and diagnosing people with TB.
Numerator	Number of new smear-positive TB cases detected
Denominator	Estimated number of new smear-positive TB cases countrywide

Data collection frequency	Quarterly
Measurement Tool	TB Register
Method of measurement	The numerator is available from the TB register or quarterly case finding report. The denominator is a WHO estimation of new smear positive cases for that year, expressed as a percentage.
Interpretation	There is an emphasis on smear-positive cases because these are the "bacteriologically confirmed" cases that TB control program should be able to identify. They represent infectious cases of TB and are of the highest priority in terms of TB control.
Other relevant information	

Indicator	**Treatment Success Rate: New Smear Positive Cases**
Rationale	It is an outcome indicator. It measure program's capacity to retain patients through complete course of chemotherapy with a favorable clinical result.
Numerator	Number of new smear-positive pulmonary TB cases registered in a specific period that were cured plus the number that completed treatment
Denominator	Total number of new smear-positive pulmonary TB cases registered in the same period
Data collection frequency	Quarterly
Measurement Tool	TB Register
Method of measurement	Information is collected at TU level on monthly basis from TB register and subsequently collated at district level on quarterly basis. Each district report is collated at respective state level and submitted to CTD.
Interpretation	Cure rate of pulmonary smear positive cases is more valuable than the success rate because patients who completed treatment but who do not have bacteriological confirmation of cure could conceivably still have smear-positive TB disease. The large majority of successfully treated cases should have bacteriological confirmation of cure.
Other relevant information	

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Indicator	Average Default Rate of Smear positive Re-Treatment Cases
Rationale	The RNTCP category II consists of a heterogeneous group of patients, most of whom are smear-positive retreatment cases. These subgroups are different bacteriologically and pathogenetically and defaults of such patients are to be minimized in order to prevent resistance to first line of drugs.
Numerator	Number of smear positive re-treatment cases defaulted
Denominator	Total number of smear positive re-treatment cases in same period
Data collection frequency	Quarterly
Measurement Tool	TB register
Method of measurement	Information is collected at TU level on monthly basis from TB register and subsequently collated at district level on quarterly basis. Each district report is collated at respective state level and submitted to CTD
Interpretation	It underscores the importance of treatment adherence for achieving success. The low treatment efficiency in MDR cases makes it prudent to prevent development of MDR during primary treatment by strict adherence to DOTS, thereby making failed cases more amenable for re-treatment regimen. The focus of treating such cases should be on prompt defaulter retrieval.
Other relevant information	

Indicator	Number of districts with new smear positive case detection rate ≥70% in 74 districts
Rationale	This indicator measures national TB program's ability to diagnose and collect data on new smear-positive TB cases
Numerator	Count of districts with CDR of 70% or more
Denominator	NA
Data collection frequency	Quarterly
Measurement Tool	Quarterly report on case finding
Method of measurement	Quarterly reporting and review
Interpretation	A high case detection rate will mean that transmission by undiagnosed infectious TB patients is curtailed, leading to the impact of less TB

	disease and less TB mortality in the population.
Other relevant information	The information is collated at state level on quarterly basis from the case finding reports of the districts.

Indicator	**Percentage and number of target districts where at least 90% of all smear positive cases started RNTCP DOTS within 7 days of diagnosis**
Rationale	The priority is to initiate treatment of smear positive cases as soon as possible to make them non-infectious and to cut the chain of transmission of infection.
Numerator	Number of target districts where at least 90% of all smear positive TB patients are started on treatment within 7 days of diagnosis
Denominator	Total number of districts covered during the reporting quarter
Data collection frequency	Quarterly
Measurement Tool	Quarterly report on Programme management
Method of measurement	Quarterly reporting & record review
Interpretation	It reflects the quality of RNTCP programme
Other relevant information	First, for each district calculate proportion of smear positive patients that were put on DOTS within 7 days of diagnosis. Then count the number of districts where %age is at least 90% or above.

Indicator	**Percentage and number of target districts where at least 40% of registered TB patients (all forms) are supervised through community volunteers**
Rationale	Increased participation of community volunteers in DOT provision.
Numerator	Number of districts where at least 40% of registered TB patients (all forms) receiving DOT through community
Denominator	Total number of districts covered during the quarter
Data collection frequency	Quarterly
Measurement Tool	Quarterly report on Programme management
Method of measurement	Quarterly reporting & record review
Interpretation	It promotes health seeking behavior, adherence and support to the

	community. There is greater acceptability to the patients.
Other relevant information	First calculate proportion of cases that are receiving DOT through community volunteers for each district. Then count the no. of districts where proportion is 40% & above.

Indicator	**Number of people trained (TOT) at state level on NGO/CBO/PPRNTCP schemes**
Rationale	This would serve as additional workforce in resource limited settings at district level
Numerator	Number of people attended training session.
Denominator	NA
Data collection frequency	Quarterly
Measurement Tool	Attendance sheet and Training records
Method of measurement	Quarterly reporting and record review
Interpretation	Adequate TOT available to roll out the training
Other relevant information	

Indicator	**Number of NGOs sensitized at district level on community mobilization and RNTCP schemes**
Rationale	NGOs have an active role in health promotion in the community as a large majority of patients seek treatment from them. There are many areas where government agencies are not able to provide services to the population due to variety of reasons including geographical barriers.
Numerator	Number of NGOs participated in sensitization
Denominator	NA
Data collection frequency	Quarterly
Measurement Tool	Attendance sheet and Training records
Method of measurement	Quarterly reporting and record review
Interpretation	NGOs have confidence of the local population and provide much needed health and other services close to the homes of people. This

	proximity to and acceptability by the population gives NGOs a vital role in TB care service delivery. It also helps in de-centralization of DOT.
Other relevant information	

Indicator	**Number of people trained & retrained on interpersonal skills and soft skills (through state level TOT and district level health staff at district level)**
Rationale	These are personal attributes of health staff that enhances an individual's interaction with the people.
Numerator	Number of people trained from the participants list
Denominator	NA
Data collection frequency	Quarterly
Measurement Tool	Attendance sheet and Training records
Method of measurement	Quarterly reporting and record review
Interpretation	Understand the programme coverage in terms of training the health staff on soft skill. More the number of staff trained; better would the interaction be between patient and health care provider.
Other relevant information	

Indicator	**Number and percentage of target districts with an active District TB Officer**
Rationale	The RNTCP is implemented through TB Societies at the State and District levels. District TB Officer is responsible for effective implementation of TB control programme at district level. He follows the administrative guidelines of respective state and technical guidelines of CTD.
Numerator	Number of DTO in place
Denominator	Total number of sanctioned DTO post in target districts
Data collection frequency	Quarterly
Measurement Tool	Programme Management report of RNTCP

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Method of measurement	Quarterly reporting and record review
Interpretation	All DTO in place would enable smooth implementation of RNTCP
Other relevant information	

Indicator	**Number of Rural Health Care Providers sensitized on referrals, DOT provision and eligible RNTCP schemes**
Rationale	Rural Health Care Providers are more accessible and acceptable to the community. Sensitizing these RHCPs would lead to increase in referral of TB suspects and halt the wrong treatment practices prevailing outside the public health system.
Numerator	Number of rural Health Care Providers sensitized
Denominator	NA
Data collection frequency	Quarterly
Measurement Tool	Attendance sheet and Training records
Method of measurement	Quarterly reporting and record review
Interpretation	To increase the participation of Rural Health Care providers in symptomatic referrals and DOT provision
Other relevant information	

Indicator	**Percentage of sputum positive initial defaulters successfully retraced and enrolled in DOTS**
Rationale	Initial defaulters are a major problem among patients attending health facilities. A significant proportion of patients diagnosed at health facility die during the intervening period after diagnosis. We need to motivate and improve patient's perception of disease and the need for DOTS and convince them of the need for initiating and completing treatment
Numerator	Number of initial defaulters retraced
Denominator	Total number of initial defaulters in same period
Data collection frequency	Quarterly
Measurement Tool	RNTCP laboratory register and List of Initial Defaulter

Method of measurement	Quarterly reporting and record review
Interpretation	They are diagnosed sputum positive cases and need to be put on treatment immediately to cut the chain of transmission of infection.
Other relevant information	

Indicator	Number of district level TB forums functional
Rationale	Forum consist of women, cured patients, tribal population, and aged persons
Numerator	Count of district level functional TB forums
Denominator	NA
Data collection frequency	Quarterly
Measurement Tool	To be developed
Method of measurement	Quarterly reporting and record review
Interpretation	To understand enhance participation of women cured patients, tribal population, and aged persons in the TB programme.
Other relevant information	

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ANNEXURE C: Reporting Templates for Program and Finance

Tool 1: District Level Monthly Activity Reporting Form

SSR Name:
Sub Recipient Name:
Name of District:
Report for the month of:

Sl . No.	Indicator	Achievement
1	Number of NGOs sensitised at District level on community mobilisation and RNTCP schemes	
2	Number of people trained and retrained on interpersonal skills and soft skills for District level health staff at District level	
3	BCC toolkit roll out	
4	Number of community volunteers oriented in use of BCC toolkit	
5	Number of local NGOs trained to participate in RNTCP schemes	
6	Number of trained NGOs who applied for RNTCP schemes	
7	Number of NGO's sanctioned RNTCP schemes	
8	Number of community meetings held to address myths and misconceptions	
9	Number of meetings with District and Sub District Health staff to address service delivery gaps	
10	World TB Day and International Women's Day celebration	
11	Number of Patients' Charter brochures distributed	
12	Number of NGOs sanctioned with Sputum collection / transport schemes	
13	Number of DMCs established through Civil Society participation	
14	Number of Rural Health care providers sensitized on referrals, DOTS provision and eligible RNTCP schemes	
15	Number of sputum positive initial defaulters successfully retraced and enrolled in DOTS	
16	District level TB forums functional	
17	Number of CBOs trained in leadership and organizational management skills	
18	Number of grass root advocates identified	
19	Number of CBOs who participated in quarterly review meeting with DTO	

20	Number of sputum samples collected and transported to DMCs	
21	Number of TB patients on treatment that are linked to social support schemes	
22	Number of DR TB patients put on Community based support **(only in AP)**	
23	Number of trained RHC providers who participated in quarterly review meetings District program staff	
24	Number of small and medium enterprises (SME) sensitized on flexi-time DOTS **(only in AP)**	
25	Number of Joint meetings between ICTCs and DMCs to facilitate coordinated TB-HIV care	
26	Tri party agreements between District TB Society, Local NGO network and SR	
27	Number of support visits of SR staff to the district	

Tool 2: State Level Monthly Activity Reporting Form

Sub Recipient Name:
Name of State:
Report for the month of:

Sl . No.	Indicator	Achievement
1	Number of people trained (TOT) at State level on NGO/CBO/PPRNTCP schemes	
2	Number of State level TOT on interpersonal skills and soft skills	
3	Number of State level MLA advocacy forum established	
4	Number of State level MLA advocacy meetings conducted	
5	Number of medical colleges / NGO / Private sector hospitals sensitized for adoption of RNTCP DOTS plus guidelines	

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Tool 3 : Quarterly Program Reporting Form

AXSHYA INDIA PROJECT

Grant Agreement Number: IDA-910-G17-T

Name of the SR:

Report for the period:

Reporting Period: month/year to month/year

Primary HQ Contact **Primary Field Contact**

*Published June 2010 © **Axshya India** (A project funded by Global Fund under R-9 grant)*

Quarterly Reporting Template

The following report format should be used by each SR as the basis for the standardised quarterly report.

The programme report format should include the following elements. It should be in A4 size format using font Gills Sans MT size 11 for text and size 12 bold for headings.

1. Cover page
2. Table of contents
3. Glossary
4. Narrative summary of progress
5. Progress on result
6. Project Outcomes
7. Most significant change story
8. Project challenges
9. Adjustments in workplan
10. Appendices

Guidelines for Project Report

Cover page

The cover page should have the programme name as Axshya India, Grant Agreement Number that is reflected in your sub grant agreement, Name of the SR and period of reporting. Period of reporting means Quarter I or 2 or 3 or 4. Reporting period means, if the report is for first quarter, then reporting period means April – June, 2010.

Insert a good photograph on the cover page to make it interesting.

Under the Primary HQ Contact, please write the name, designation, complete mailing address, phone number and email ID for the person backstopping this project from the SR Head Quarters in India. Under the primary field contact please provide the same details for the person responsible for project execution at the field. In most of the cases it would be Program Manager.

All reports should have a copyright notice that includes the date the report was produced, along with the copyright symbol and the programme's name which is Axhshay India, e.g., *Published June 2010, © Axshya India*. Include the WV logo and SR logo somewhere on the cover page as well.

Table of contents

Use Table of Content Option from the References Tab of Word 2007. List the different main sections of the report. It may be useful to add in various sub-headings, marking significant places to find different themes and discussions.

Glossary

This is an alphabetical list of terms or words that are found in the document or related to the text of the document, that need some explanation or which may help the reader to a greater understanding. The list should also include the expansion of acronyms and abbreviations, *e.g., WV - World Vision*.

Narrative summary of progress

(Maximum two to three pages.)

This should include a summary of progress over the last three months, including reporting on key activities implemented over the last three months. The quarterly report should take the opportunity to reflect on the whole quarter and progress to date from the beginning of the programme. It should also reflect on any changes in the context since the start of the programme, which will have an impact.

Reporting by Results

This section should report the progress against the target as agreed in the performance framework. The data reported here should be doubly checked and ascertained before reporting. Once the report is submitted, no changes should be made on the data being reported.

Following Table should be used for this reporting.

SN	Indicators	Target for the quarter	Achievement for the quarter	Variance Explanation
1	Number of NGOs sensitised at District level on community mobilisation and RNTCP schemes			
2	Number of people trained and retrained on interpersonal skills and soft skills for District level health staff at District level			
3	BCC toolkit roll out			
4	Number of community volunteers oriented in use of BCC toolkit			
5	Number of local NGOs trained to participate in RNTCP schemes			
6	Number of trained NGOs who applied for RNTCP schemes			

7	Number of NGO's sanctioned RNTCP schemes			
8	Number of community meetings held to address myths and misconceptions			
9	Number of meetings with District and Sub District Health staff to address service delivery gaps			
10	World TB Day and International Women's Day celebration			
11	Number of Patients' Charter brochures distributed			
12	Number of NGOs sanctioned with Sputum collection / transport schemes			
13	Number of DMCs established through Civil Society participation			
14	Number of Rural Health care providers sensitized on referrals, DOTS provision and eligible RNTCP schemes			
15	Number of sputum positive initial defaulters successfully retraced and enrolled in DOTS			
16	District level TB forums functional			
17	Number of CBOs trained in leadership and organizational management skills			
18	Number of grass root advocates identified			
19	Number of CBOs who participated in quarterly review meeting with DTO			

20	Number of sputum samples collected and transported to DMCs			
21	Number of TB patients on treatment that are linked to social support schemes			
22	Number of DR TB patients put on Community based support **(only in AP)**			
23	Number of trained RHC providers who participated in quarterly review meetings District program staff			
24	Number of small and medium enterprises (SME) sensitized on flexi-time DOTS **(only in AP)**			
25	Number of Joint meetings between ICTCs and DMCs to facilitate coordinated TB-HIV care			
26	Tri party agreements between District TB Society, Local NGO network and SR			
27	Number of support visits of SR staff to the district			
28	Number of people trained (TOT) at State level on NGO/CBO/PPRNTCP schemes			
29	Number of State level TOT on interpersonal skills and soft skills			
30	Number of State level MLA advocacy forum established			
31	Number of State level MLA advocacy meetings			

	conducted			
32	Number of medical colleges / NGO / Private sector hospitals sensitized for adoption of RNTCP DOTS plus guidelines			

Project Outcomes

This section describes the outcomes of the ACSM Activities of the project and how it impacts the core indicator. This section is also important to ascertain attribution of the SR/Project to the overall program. Following Table should be used for this reporting.

SN	Indicators	Achievement for the quarter			
		District 1	District 2	District 3	District ....
1	Case Detection Rate: New Smear Positive Cases				
2	Treatment success rate-New Smear Positive Cases				
3	Average default rate of smear positive re-treatment patients in 374 districts				

Most significant change story

(Maximum half a page.)

Establish what was the most significant change that took place for the participants in the programme during the reporting period. Include that story here.   Photos can be included in the appendices if this is appropriate and would be useful to at least one or the programme's stakeholders.

Challenges

(Maximum half a page.)

Record any programme management challenges that were encountered during the reporting period and their implications on the programme. If there have been any changes in the roles of stakeholders, these should be outlined. Highlight any notable examples of added value provided by any of the stakeholders during the reporting period (eg support office, community organisation, government partner).

Appendices

These should include:

- Relevant photos
- List of programme staff and their positions
- List of main partners (stakeholders actively engaged in programme activities)
- Annual Plan of Action (see separate format) for each project as part of the annual report

Tool 4: Detailed Budget Report

Ref No	Activity	Q1	Q2	Q3	Q4	Year	Q5	Q6	Q7	Q8	Year	Grant to Date

Tool 5: Variance Report

Ref No	Activity	Quarter I			Year to Date			Previous Year			Grant to Date		
		Budget	Actual	Variance	Budget	Actual	Variance	Budget	Actual	Variance	Budget	Actual	Variance

Tool 6: Report by objective

S. No	Objective	Quarter I			Year to Date			Previous Year			Grant to Date		
		Budget	Actual	Variance	Budget	Actual	Variance	Budget	Actual	Variance	Budget	Actual	Variance

Tool 7: Report by Service Delivery Area

S. No	SDA	Quarter I			Year to Date			Previous Year			Grant to Date		
		Budget	Actual	Variance	Budget	Actual	Variance	Budget	Actual	Variance	Budget	Actual	Variance

Tool 8: Report by Cost Category

S. No	Cost Category	Quarter I			Year to Date			Previous Year			Grant to Date		
		Budget	Actual	Variance	Budget	Actual	Variance	Budget	Actual	Variance	Budget	Actual	Variance

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ANNEXURE D: Data Collection Tools

Tool 1: Attendance sheet for Training Events

Name of SR: Date: dd/mm/yy

Name of State:

Name of District:

Name of SSR / Service Agreement:

	Description	Tick whichever applicable	
Training	State level ToT on NGO/CBO/PPRNTCP schemes		
	NGOs sensitization at District level on community mobilization and RNTCP schemes		
	Train and retrain on interpersonal skills and soft skills (through State level TOT and District level health staff at District level)		
	Community volunteers oriented in use of BCC toolkit		
	Rural Health care providers sensitized on referrals, DOTS provision and eligible RNTCP schemes		
	NGOs/CBOs trained in leadership and organizational management skills		
	Medical colleges and NGO hospitals sensitized for adoption of RNTCP DOTS plus guidelines		
	Small and medium enterprises (SME) sensitized on flexi-time DOTS		
	Pre test	Yes	No
	Post test	Yes	No
Meeting	Community meetings held to address myths and misconceptions		

					Meetings with District and Sub District Health staff to address service delivery gaps				
					State level MLA advocacy meetings				
					NGOs/CBOs quarterly review meeting with DTO				
					Trained RHC providers quarterly review meetings District programme staff				
					Joint meetings between ICTCs and DMCs to facilitate coordinated TB-HIV care				
Others									
Sl. No.	Name	Age	M	F	Institution*	Designation*	Contact address	Contact no	Signature

Number of Males:
Number of Females:
Total:

Photo documentation available Yes ☐ No ☐
* Not required if not applicable

____
Signature

Note: Separate attendance sheet should be maintained for each day

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Tool 2: Minutes of Meeting format

Name of SR: Date: dd/mm/yy

Name of State:

Name of District:

Starting and End Time:

Agenda exists: Yes ☐ No ☐

Venue:

Meeting presided over by:

Discussion on previous minutes of meeting:

Minutes of current meeting:

____

Signature

Note: Please attach attendance sheet and agenda

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Tool 3: Referral Slip

(To be filled in duplicate. Give one copy to the patient & retain one copy for the records)

Name of referring facility_________________

Name of health facility to which patient is referred________________________

Patient name: __________________________ Age: ____ M ☐ F ☐

Complete address____

____

Brief H/O illness____

____

Name: ___________________ Designation: __________________

Signature: ________________ Date referred: ________________

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Tool 4: Sputum collection and transportation form

(To be filled in duplicate)

Sample identification No.:

Name of DMC to which sample is transported:

Name of referring facility:

Patient name: ____________________________ Age: ________ Sex: M ☐ F ☐

Complete address

Brief H/O illness

____

Specimen Collectors name and Signature

Date: _____________

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Tool 5: List of initial defaulters

Name of TU: Date: dd/mm/yy

Name of SSR:

Name of District:

Name of SR:

Name of State:

Month:

Sl. No.	Name	Age	Sex		Address	Contact number	Date of Diagnosis	Lab Sl. No.	DMC	Reason for initial default
			M	F						

Name of Officer Reporting: ______________________ Signature__________________________

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Tool 6: MDR-TB patients initiated on DOTS-Plus

Name of TU: Date: dd/mm/yy

Name of SSR:

Name of District:

Name of SR:

Name of State:

Sl. No.	Name	Age	Sex		Name of referring facility	Date of diagnosis`	Date of starting treatment (DST)	TB No.	Was patient put on community support (Y/N)
			M	F					

____

Signature

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Tool 7: BCC Toolkit Roll-out Report

Name of SR: Date: dd/mm/yy

Name of State:

Sl. No.	Name of District	BCC tool kit rolled out		If yes, No. of Community Volunteers oriented		
		Yes	No	Male	Female	Total

Successes:

Challenges:

____

Signature

Note: Attach detailed list of participants for each District

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Tool 8: Monthly Report of MDR-TB patients initiated on DOTS-Plus

Name of SR: Date: dd/mm/yy

Name of State:

Name of District:

Sl. No.	Name	Age	Gender		Name of referring facility	Date of diagnosis`	Date of starting treatment (DST)	TB No.	Was patient put on community support (Y/N)
			M	F					

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Tool 9: NGO Schemes Status Report

Name of SR: Date: dd/mm/yy

Name of State:

Name of District:

Sl. No.	Name of NGO trained	Whether applied for RNTCP NGO scheme	If applied for				
			Number of Applications submitted	Number of Applications approved	Number of Applications Rejected	Number of Applications Pending	Name of Scheme approved

____

Signature

Tool 10: Initial Defaulter Retrieval Register

Name of SR:

Name of State:

Name of District:

Sl. No.	Name	Age	Sex		Address	Contact number	Date of Diagnosis	Lab Sl. No.	DMC	Reason for initial default
			M	F						

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Tool 11: Referral Register

Name of SR:

Name of State:

Name of District:

Sl. No.	Name	Age	Sex		Address	Date of Referral	Health facility to which patient is referred	Status of patient
			M	F				

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Tool 12: Sputum collection and transportation Register

Name of SR:

Name of State:

Name of District:

Sl. No.	Name	Age	Sex		Date of collection	Date of Transport	Sample identification No.	DMC	Lab. Sl. No	Sputum results (Pos/Neg)
			M	F						

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Tool 13: Stock Register

Name of SR:

Name of State:

Name of District:

No. of Patient Charter brochures printed:

Month	Year	Stock on first day of month	Distribution during month	Stock on last day of month			Year to date consumption	Signature
				SR	SSR	Total		
January	2011							
February	2011							
March	2011							
April	2011							
May	2011							
June	2011							
July	2011							
August	2011							
September	2011							
October	2011							
November	2011							
December	2011							
January	2012							
February	2012							
March	2012							

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Tool 14: Register of TB patients linked to social support schemes

Name of SR:

Name of State:

Name of District:

Sl. No.	Name	Age	Sex		Complete address	Diagnosis		TB No.	Social support scheme
			M	F		P/EP	Cat I/II/III		

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ANNEXURE E: Supportive Supervision Checklists

Tool 1: Field visit Supervisory Checklist for PMU Staff

Name of Staff	
State visited	
Name of SR / SSR	
Date of visit	

Sl. No	Assertion	Yes	No	Not applicable	Remarks
A	**Human Resources**				
1	Is there any changes in the staff				
2	Has the new staff been oriented				
3	Was the PMU informed about this change				
4	Has the staff been given enough training to perform the job				
B	**Regular Meeting with the State health staff**				
1	Has Program Manager taken efforts to establish relationship with the STO?				
2	Is there any evidence for this?				
3	Were you able to ascertain this during your visit to the STO				
4	Has the Program Manager attended quarterly review meetings with State Health Staff?				
5	Is there any evidence of this?				
C	**Progress against Performance Framework**				
1	Have the activities planned for this month been implemented?				
2	Is there any evidence of this?				
D	**Targets being met**				
1	Have the targets for this month been met?				
2	Is there any evidence for this?				
E	**Data validation**				
1	Did you validate the data being reported?				
2	Has the data provided been validated by SR?				
3	Is there any evidence of this?				

E	**Monitoring plan**				
1	Does the Program Manager have a monitoring plan?				
2	Is there a field visit plan for the Program Manager and District Coordinator?				
3	Is there evidence of SSR being monitored by PM and DC?				
F	**District action plan**				
1	Does the SSR have an action plan?				
2	Has this plan been incorporated into the District action plan?				

_____________________________ ___________________________

Signature of PR Program Staff

Signature of Project Manager (SR/SSR)

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Tool 2: Field visit Supervisory Checklist for SR Project Manager

Name of Staff	
District visited	
Date of Visit	

Sl. No	Assertion	Yes	No	Not applicable	Remarks
A	**Planning Process**				
1	Does the DC have knowledge of the SSRs detailed Work Plan for this month?				
2	Is the work plan in accordance with the Performance Framework				
3	Has the Wwork Plan been shared with the RNTCP officials				
4	Has the Work plan being incorporated into RNTCPs (DTC) district action plan?				
B	**Coordination and Networking**				
1	Did you find a harmonious relationship of DC with DTO during the visit?				
2	Is there an evidence of DC conducting review meeting of the SSRs?				
3	Has the DC visited the field activities of SSRs?				
4	Has the DC attended quarterly review meetings with District Health Staff/ DTO?				
C	**Progress against Performance Framework**				
1	Have the activities planned for this month been according to overall work plan?				
2	Did you find evidence that DC participated in major activities in implementation of the activities?				
3	Is the District Consistently achieving the targets as per the PF?				
D	**Field Visit of the TUs / DMC**				
1	Does the DC use cost effective means of transport during his filed visits?				
2	Has the DC made visits to all Districts under his purview?				
E	**FINANCE**				
1	Is the Petty cash being maintained by the District Coordinator?				
2	Did you verify the Petty Cash book?				

3	Did you find cash in the cash box in accordance with the cash balance Petty Register?				
4	Is the petty cash book updated daily?				
5	Are all the expenses of SSRs being authorized by District Coordinator?				
6	Were the payments beyond Rs 2000 made by cheque?				
E	**Monitoring & Evaluation**				
1	Is the District Coordinator reviewing the registers to be maintained by SSRs at district level?				
2	Is the District Coordinator reviewing and supporting in maintaining the files of SSRs?				
3	Is the District Coordinator regularly reporting the Data in M& E System?				
4	Is the Data reported by the SSRs being validated by District Coordinator?				
5	Did you visit the STO, DTO in this monitoring visit?				
6	Did you validate the data in M&E system being reported by District Coordinator?				
7	Did you sign all the supporting evidences such as registers, files, reports being maintained by District Coordinator?				
8	If gaps were found, did you coach the District Coordinator and SSRs in these M & E requirements?				

____________________________ ____________________________

Signature of Project Manager Signature of District Coordinator

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Tool 3: Field visit Supervisory Checklist for District Coordinator

Name of District Coordinator	
District visited	
Name of SSR	
Date of Visit	

Sl. No	Assertion	Yes	No	Not applicable	Remarks
A	**Program Planning**				
1	Is there a monthly date wise action plan available?				
2	Is there any evidence of program planning meeting held in the District?				
3	Has the SSR action plan been incorporated with the District Action plan?				
B	**Program implementation**				
1	Have the activities planned for the month been implemented?				
2	Have the targets for the District been achieved?				
3	Has the program progress been shared with the DTO?				
4	Has the selection of local NGO networks been done?				
5	Has the training of local NGO networks been done?				
6	Have sensitization meetings with Gaon Kalyan Samitis and other community groups been done?				
7	Have awareness programs on World TB Day been carried out?				
8	Have awareness programs on n International Women's Day been carried out?				
9	Has training to health staff on soft skills been imparted?				
10	Has capacity building for CBOs been done in the district?				
11	Have quarterly meetings of CBOs and DTO taken place?				
12	Have initial defaulters been retrieved?				

13	Have TB forums been formed in the Districts?				
14	Have these TB forums been oriented?				
15	Has support to DRTB patients been mobilized?				
16	Have Rural Health Care providers been selected?				
17	Have Rural Health Care providers been trained?				
18	Have quarterly meetings of Rural Health Care providers and DTO taken place?				
19	Have employees at the workplace been sensitized on TB control?				
20	Have Private Providers been sensitized on providing DOTS at the workplace?				
21	Have quarterly meetings of ICTCs and DMCs for sensitization and review of cross referrals taken place?				
22	Check – NGOs applied for RNTCP schemes				
23	Check – NGOs sanctioned RNTCP schemes				
24	Check – NGOs sanctioned with Sputum collection transportation schemes				
25	Have Patient Charter brochures been distributed?				
26	How many DMCs have been established through Civil Society participation?				
27	How many TB patients on treatment are linked to Social Support Schemes?				
28	How many MDR TB patients have been put on Community Based Support				
C	**Program review and monitoring**				
1	Is there any evidence of the last monthly / quarterly review meeting that was held?				
D	**Program budget and expenses**				
1	Have you analyzed that the expenditure is in line with the sanctioned budget?				
2	Are bills and vouchers available for all expenses booked?				
3	Is the Petty cash being maintained by the SSR?				
4	Did you verify the Petty Cash book?				
5	Did you find cash in the cash box in accordance with the cash balance Petty Register?				
6	Is the petty cash book updated daily?				
7	Are all the expenses of SSRs being				

	authorized by SSRs Program Manager?				
8	Were the payments beyond Rs 2000 made by cheque?				
E	**FINANCE**				
1	Is the Petty cash being maintained by the District Coordinator?				
2	Did you verify the Petty Cash book?				
3	Did you find cash in the cash box in accordance with the cash balance Petty Register?				
4	Is the petty cash book updated daily?				
5	Are all the expenses of SSRs being authorized by District Coordinator?				
6	Were the payments beyond Rs 2000 made by cheque?				
E	**Monitoring & Evaluation**				
1	Is the District Coordinator reviewing the registers to be maintained by SSRs at district level?				
2	Is the District Coordinator reviewing and supporting in maintaining the files of SSRs?				
3	Is the District Coordinator regularly reporting the Data in M& E System?				
4	Is the Data reported by the SSRs being validated by District Coordinator?				
5	Did you visit the DTO in this monitoring visit?				
6	Did you validate the data in M&E system being reported by SSR?				
7	Did you sign all the supporting evidences such as registers, files, reports being maintained by SSR?				
8	If gaps were found, did you coach the SSRs in these M & E requirements?				

____________________________ ____________________________

Signature of District Coordinator Signature of SSR Head

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Tool 4: Supportive Supervision Check List for PMU Finance

1. Review & Sign all vouchers with date & paid seal against the book of accounts.
2. BRS
3. Cash on hand.
4. Advance/Suspense.
5. Bank Account any other transaction.
6. Burn rate.
7. Line Item wise budget Vs Expenses.
8. Under Spend/Over Spend?
9. Expenses not related to project.
10. SSR Financial review & Monitoring by the SR.
11. SSR review & sign.
12. Cheque Vs cash payments.
13. Flow of Fund PR-SR-SSR
14. FMT
15. Book of Account complete.
16. Taxes & Bank charges separately reported.
17. Errors rectified on books of account quarterly base.
18. Error in previous quarter.
19. Up to Date/voucher entry.
20. Whether all staffs are 100% GF.
21. Whether all SSR's covered every 6 Months?
22. SR Trip Report reviewed and recommendation implemented.

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Tool 5: Supportive Supervision Checklist for SR Finance Officers

1. Review & Sign all vouchers with date & paid seal against the book of accounts.
2. BRS
3. Cash on hand & Advance/Suspense.
4. Bank Account any other transaction.
5. Line Item wise budget Vs Expenses & Burn rate.
6. Expenses not related to project.
7. SSR review & sign.
8. Cheque Vs cash payments.
9. FMT
10. Book of Account complete & Up to Date/voucher entry.
11. Taxes & Bank charges separately reported.
12. Errors rectified on books of account quarterly base.
13. Error in previous quarter.

14 Whether all SSR's covered every 6 Months?

14. SR Trip Report review and followup.

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Tool 6: Supportive Supervision Tool for PMU Finance Team

SL. NO.	COMPLIANCE WITH PRIOR MONITORING VISIT RECOMMENDATIONS	YES	NO	N. A.	Recommendation/Remarks /Comments
	SELECT ANY ONE OF THE FOLLOWING 4 OPTIONS (EITHER OF IA or IB or IC or ID - WITH ONLY "YES" ANSWERS)				
1A	Have more than 90% of previous World Vision India Monitoring visit report recommendations been implemented?				
1B	Have more than 75% to 89% of previous World Vision India Monitoring visit report recommendations been implemented?				
1C	Have more than 50% to 74% of previous World Vision India Monitoring visit report recommendations been implemented?				
1D	Have only less than 50% of previous World Vision India Monitoring visit report recommendations been implemented?				
2	Were Follow up responses sent within due date?				
	SCORE	**0**	**0**	**0**	
		TRUE	#DIV/0!		

SL. NO.	CASH AND BANKING	YES	NO	N. A.	Recommendation/Remarks /Comments
1	Is the Bank Account operated by atleast three signatory from the Project/Program?				
2	Are the National Director and CFO bank signatories?				

3	Are there any relatives who are bank signatories?				
4	Does the Project maintain a list of signatories for Bank Accounts?				
5	Is the accountant one of the bank signatory?				
6	Are there any Bank passbooks not updated for more than one month?				
7	Is cash (either Petty Cash or Cash in Hand) handled by Finance Officer?				
8	Are any fake/duplicate notes found in the cash?				
9	Is the cash verification register maintained				
10	Are cash refunds deposited into bank account on the same/next day?				
11	Is Daily cash verification done only on the day of transaction and not on a daily basis?				
12	Was there any cash shortage/excess during cash verification?				
13	Are cash refunds not deposited into bank a/c but spent directly/kept as cash on hand for expenses?				
14	Are there any cash payment in excess of Rs.3,000/-?				
15	Was daily cash verification done but not reviewed?				
16	Was official cash held by staff other than the Administration Assistant/Coordinator personally?				
17	Is there any evidence of cash rotation?				
18	Were Receipts issued for cash receipts from staff or others				
19	Does Receipts books have the Project name printed on it and is serially numbered?				
20	Are receipts obtained from NGO/Institute/Other Projects, where cash is transferred from SR,as per the agreement?				
21	Were there blank cheque/s signed or pre signed by any one or two signatory?				
22	Are cheques issued in the name of Project/Staff and transferred to staff personal account?				
23	Were any cheques issued and kept with the Project for more than one month?				
24	Are cheques issued deliberately during the financial year-end to reduce the bank closing balance?				
25	Were cheques issued in the name of individuals and not in the name of establishment for purchases made or services received?				
26	Were cheques issued and acknowledgement not available?				
	SCORE	**0**	**0**	**0**	
		TRU	94%		

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SL. NO.	FINANCIAL RECORDS AND REPORTS	E YES	NO	N. A.	Recommendation/Remarks /Comments
1	Is BRS prepared regularly,dated, signed and approved for every month?				
2	Is BRS prepared by accountant.?				
3	Is BRS sent to PMO /NO regularly every month?				
4	Does the BRS tally with bank pass book and Cash Book for every month?				
5	Are the variance reports of over/under 10 % clear and informative?				
6	Are vouchers numbered as per FM of SR/SSR?				
7	Is the accountant signature endorsed on the voucher/bills and bills vouchers reviewed before charged to books?				
8	Are vouchers approved by approving authority?				
9	Is the 'Paid' seal affixed?				
10	Are vouchers filed neatly and chronologically?				
11	Are Bills/Vouchers missing?				
12	Are Revenue stamps affixed on bills/vouchers for expenses exceeding Rs.5000/-?				
13	Are original bills enclosed with receipt?				
15	Are there any bills/vouchers which have been tampered with?				
16	Are EER expense sheet enclosed for advance settlements?				
17	Are Tour plan prepared and approved? Approved tour plan enclosed along with the bill/voucher.				
18	Are bills obtained on letter head for major purchases?				
19	Are Quotations enclosed along with the bills and filed separately?				
20	Are expenses supported with distribution records?				
21	Were any travelling expenses claimed by staff above the eligibility?				
22	Are bills and vouchers clear, complete and informative on the item of expense?				
23	Are there instances of credit purchases being evidenced with cash receipts?				

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24	Was there any non-refund from staff for personal use of telephones,vehicles, etc?				
25	Was Rubber stamps of other Vendor/Organizations found in custody of the Project?				
	SCORE	**0**	**0**	**0**	
		TRUE	#DIV/0!		

SL. NO.	**STATUTORY AND GENERAL MANAGEMENT**	**YES**	**NO**	**N.A.**	**Recommendation/Remarks /Comments**
1	Have funds been transferred to organization?				
2	Has there been refund of personal use of office vehicle,telephone etc deposited into local fund account?				
3	Has there been transfer or deposit of FCRA funds into Local account?				
4	Does the Project have TAN?				
5	Are TDS deduction receipts maintained and filed for the deductions made?				
6	Has TDS calculation been done as per statutory requirement?				
7	Has TDS been deducted on office rent payment,where applicable?				
8	Have Returns been filed on or before due date?				
9	Has Professional Tax been deducted as per statutory requirement?				
10	Has the Lease Deed been prepared,approved and signed?				
11	Has rent been paid as per the Rental agreement?				
12	Has the Lease Deed been renewed, where applicable?				
13	Are all project staff insured under Group accident Insurance policy?				
14	Does the Mediclaim insurance policy cover for all the staff?				
15	Is Cash in transit (Office to their target areas) and cash in safe policy taken?				
16	Are Insurance policies renewed on time?				
17	Are Leave register/records maintained?				
18	Are Leave applications submitted and maintained regularly?				

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19	Are Leave records updated in the Attendance register?				
20	Is a Telephone register maintained as per requirement?				
21	Does the Project maintain the MOU signed between SR/SSR/other NGO?				
22	Has Capacity building program given to community for maintaining their accounts?				
	SCORE	**0**	**0**	**0**	
		TRUE	#REF!		

SL. NO.	ASSETS	YES	NO	N.A.	Recommendation/Remarks /Comments
1	Are all assets insured?				
2	Is an Asset register maintained by the Project as per SR standard?				
3	Are assets above Rs.7,000/- and below Rs.7,000/- maintained separately?				
4	Is an AMC done for computers and other office equipments items?				
5	Is an asset IN/OUT, movement register,being maintained?				
6	Are all assets verified and documented every 6months/1 year?				
7	Is a vehicle logbook maintained and available with updated details?				
8	Are any loss of cash or any assets reported to PMU with FIR copy?				
	SCORE	**0**	**0**	**0**	
		TRUE	#REF!		

SL. NO.	PURCHASES AND DISBURSEMENTS	YES	NO	N.A.	Recommendation/Remarks /Comments

1	Are the Manager and Accountant involved in obtaining quotations?				
2	Has the Purchase Committee formed as per SR policy?				
3	Has the Purchase Committee decision and meeting records maintained in minute's books?				
4	Is there evidence of formation and change of Purchase Committee?				
5	Where large items are purchased, are two or more Project Staff involved?				
6	Are all major purchases recommended by Purchase Committee?				
7	Does Purchase Committee have control over cheques/ cash up to the point of purchase?				
8	Is the Purchase Committee involved in getting the bills/vouchers and payments as per FFM?				
9	Are approvals of major purchases done as per the purchase policy?				
10	Have bogus quotations been obtained?				
11	Have different quotations been obtained from same vendor?				
12	Have quotations been obtained from relatives of vendors?				
13	Are there three competitive quotations for major purchases above Rs.5,000/-?				
14	Is there sufficient documentation available where three quotations were not received?				
15	Was the relationship/familiarity of the vendor to the Project staff disclosed?				
16	Are quotations obtained from shops which did not deal with the required items?				
17	Are Purchase Orders issued to vendor in triplicate copy with pre-printed serial number?				
18	Is there evidence of quantity & quality of goods received?				
19	Were purchases made from shops, not approved by Purchase Committee?				
20	Are agreements made for contract activities?				
21	Are all contracts documented adequately?				
22	Has TDS been deducted from the contractors for amount paid in excess of Rs. 20,000/-?				
23	Was a distribution register maintained with all relevant details?				
24	Does the distribution records tally with the purchase?				
	SCORE	**0**	**0**	**0**	
		TRUE	#REF!		

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SL. NO.	ADVANCES/LOANS & OTHER RECEIVABLES	YES	NO	N.A.	Recommendation/Remarks /Comments
1	Are advances given to staff with supporting voucher/details enclosed/break ups?				
2	Does the Project give advance directly to the volunteers?				
3	Are cash refunds from advance settlement/any other source deposited into bank a/c the same/next day?				
4	Are huge cash advances given instead of Cheques/DDs for major purchases?				
5	Are new advances given to staff before settling an earlier advance?				
6	Have staff settled the advances within 5 working days as per the organization policy?				
7	Is an advance register maintained properly as per WVI standard like amount given/settled, voucher #, signature, settlement dates?				
8	Does Project or staff have proper approval of proposal before taking advance?				
9	Has the signature of beneficiary been obtained on the application and bills?				
	SCORE	**0**	**0**	**0**	
		TRUE	#REF!		

SL. NO.	HUMAN RESOURCES	YES	NO	N.A.	Recommendation/Remarks /Comments
1	Is appointment of staff done with proper approval?				
2	Has proper Job Description been issued and proper segregation of duties for the staff in place?				
3	Are salary and benefits paid as per the appointment order?				
5	Was salary increment paid as per the increment letter?				
6	Does the Project have a soft / hard copy of HR manual?				
7	Is a salary register maintained for contract staff?				

8	Is Attendance register maintained regularly and consistently?				
	SCORE	**0**	**0**	**0**	
		TRUE	#REF!		

SL. NO.	**FUNDING**	**YES**	**NO**	**N. A.**	**Recommendation/Remarks /Comments**
1	Are there any excess funds received by project against the fund request made?				
2	Are funding requests prepared with detail break-up and as per the need of project?				
3	Are funds received late by the project?				
4	Are funding received in excess of the approved annual budget of the Project?				
5	Does the funding agree to the project financial report?				
6	Are adequate records kept for local/other income, receipts and expenditures?				
	SCORE	**0**	**0**	**0**	

SL. NO.	**MONITORING**	**YES**	**NO**	**N. A.**	**Recommendation/Remarks /Comments**
1	Is there any monitoring plan to visit SSR by SR Finance team?				
2	Is there any monitoring plan visit evidence with the SSR by SR?				
3	Has the recommendation given by SR implemented by SSR?				
	SCORE	**0**	**0**	**0**	

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TOOL 7: SUPPORTIVE SUPERVISION TOOL FOR SR FINANCE

SL. NO.	COMPLIANCE WITH PRIOR MONITORING VISIT RECOMMENDATIONS	YES	NO	N.A.	Recommendation /Remarks /Comments
	SELECT ANY ONE OF THE FOLLOWING 4 OPTIONS (EITHER OF IA or IB or IC or ID - WITH ONLY "YES" ANSWERS)				
IA	Have more than 90% of previous LEPRA Society Monitoring visit report recommendations been implemented?				
IB	Have more than 75% to 89% of previous LEPRA Society Monitoring visit report recommendations been implemented?				
IC	Have more than 50% to 74% of previous LEPRA Society Monitoring visit report recommendations been implemented?				
ID	Have only less than 50% of previous LEPRA Society India Monitoring visit report recommendations been implemented?				
2	Were Follow up responses sent within due date?				
	SCORE	**0**	**0**	**0**	
		TRUE	######		

SL. NO.	CASH AND BANKING	YES	NO	N.A.	Recommendation /Remarks /Comments
1	Is the Bank Account operated by atleast Two signatory from the Project/Program?				
2	Are the Director and Sectary bank signatories?				
3	Are there any relatives who are bank signatories?				
4	Does the Project maintain a list of signatories for Bank Accounts?				

5	Is the accountant one of the bank signatory?				
6	Are there any Bank passbooks not updated for fifteen days ?				
7	Is cash (either Petty Cash or Cash in Hand) handled by Finance Officer?				
8	Are any fake/duplicate notes found in the cash?				
9	Is the cash verification register maintained				
10	Are cash refunds deposited into bank account on the same/next day?				
11	Is Daily cash verification done only on the day of transaction and not on a daily basis?				
12	Was there any cash shortage/excess during cash verification?				
13	Are cash refunds not deposited into bank a/c but spent directly/kept as cash on hand for expenses?				
14	Are there any cash payment in excess of Rs.3,000/-?				
15	Was daily cash verification done but not reviewed?				
16	Was official cash held by staff other than the Administration Assistant/Coordinator personally?				
17	Is there any evidence of cash rotation?				
18	Were Receipts issued for cash receipts from staff or others				
19	Does Receipts books have the Project name printed on it and is serially numbered?				
20	Are receipts obtained from NGO where cash is transferred from SSR,as per the agreement?				
21	Were there blank cheque/s signed or pre signed by any one or Three signatory?				
22	Are cheques issued in the name of Project/Staff and transferred to staff personal account?				
23	Were any cheques issued and kept with the Project for more than one month?				
24	Are cheques issued deliberately during the financial year-end to reduce the bank closing balance?				
25	Were cheques issued in the name of individuals and not in the name of establishment for purchases made or services received?				
26	Were cheques issued and acknowledgement not available?				
	SCORE	**0**	**0**	**0**	
		TRUE	94%		

SL.	FINANCIAL RECORDS AND REPORTS	YES	NO	N.A.	Recommendation /Remarks

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NO .					/Comments
1	Is BRS prepared regularly,dated, signed and approved for every month?				
2	Is BRS prepared by accountant ?				
3	Is BRS sent to SR /NO regularly every month?				
4	Does the BRS tally with bank pass book and Cash Book for every month?				
5	Are the variance reports of over/under 10 % clear and informative?				
6	Are vouchers numbered as per FM?				
7	Is the accountant signature endorsed on the voucher/bills and bills vouchers reviewed before charged to books?				
8	Are vouchers approved by approving authority?				
9	Is the 'Paid' seal affixed?				
10	Are vouchers filed neatly and chronologically?				
11	Are Bills/Vouchers missing?				
12	Are Revenue stamps affixed on bills/vouchers for expenses exceeding Rs.5000/-?				
13	Are original bills enclosed with receipt?				
15	Are there any bills/vouchers which have been tampered with?				
16	Are Travel expense sheet enclosed for advance settlements?				
17	Are activities plan prepared and approved? Approved tour plan enclosed along with the bill/voucher.				
18	Are bills obtained on letter head for major purchases?				
19	Are Quotations enclosed along with the bills and filed separately?				
20	Are expenses supported with distribution records?				
21	Were any travelling expenses claimed by staff above the eligibility?				
22	Are bills and vouchers clear, complete and informative on the item of expense?				
23	Are there instances of credit purchases being evidenced with cash receipts?				
24	Was there any non-refund from staff for personal use of telephones,vehicles, etc?				
25	Was Rubber stamps of other Vendor/Organizations found in custody of the Project?				

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26	Does the BRS tally with bank pass book and Cash Book for every month?				
27	Does DC miss the any authorization ?				
	SCORE	**0**	**0**	**0**	
		TRUE	######		

SL. NO.	**STATUTORY AND GENERAL MANAGEMENT**	**YES**	**NO**	**N.A.**	**Recommendation /Remarks /Comments**
1	Have funds been transferred to SSR ?				
2	Has there been refund of personal use of office vehicle,telephone etc deposited into local fund account?				
3	Has there been transfer or deposit of FCRA funds into Local account?				
4	Does the Project have TAN?				
5	Are TDS deduction receipts maintained and filed for the deductions made?				
6	Has TDS calculation been done as per statutory requirement?				
7	Has TDS been deducted on office rent payment,where applicable?				
8	Have Returns been filed on or before due date?				
10	Has the Lease Deed been prepared,approved and signed?				
11	Has rent been paid as per the Rental agreement?				
12	Has the Lease Deed been renewed, where applicable?				
15	Is Cash in transit (Office to their target areas) and cash in safe policy taken?				
22	Has Capacity building program given to SSR for maintaining their accounts?				
	SCORE	**0**	**0**	**0**	
		TRUE	#REF!		

SL. NO	**PURCHASES AND DISBURSEMENTS**	**YES**	**NO**	**N.A.**	**Recommendation /Remarks /Comments**

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.					
1	Are the Manager and Accountant involved in obtaining quotations?				
2	Has the Purchase Committee formed as per SSR policy?				
3	Has the Purchase Committee decision and meeting records maintained in minute's books?				
4	Is there evidence of formation and change of Purchase Committee?				
5	Where large items are purchased, are two or more Project Staff involved?				
6	Are all major purchases recommended by Purchase Committee?				
7	Does Purchase Committee have control over cheques/ cash up to the point of purchase?				
8	Is the Purchase Committee involved in getting the bills/vouchers and payments as per SSR Policy ?				
9	Are approvals of major purchases done as per the purchase policy?				
10	Have bogus quotations been obtained?				
11	Have different quotations been obtained from same vendor?				
12	Have quotations been obtained from relatives of vendors?				
13	Are there three competitive quotations for major purchases above Rs.5,000/-?				
14	Is there sufficient documentation available where three quotations were not received?				
15	Was the relationship/familiarity of the vendor to the Project staff disclosed?				
16	Are quotations obtained from shops which did not deal with the required items?				
17	Are Purchase Orders issued to vendor in triplicate copy with pre-printed serial number?				
18	Is there evidence of quantity & quality of goods received?				
19	Were purchases made from shops, not approved by Purchase Committee?				
20	Are agreements made for contract activities?				
21	Are all contracts documented adequately?				
22	Has TDS been deducted from the contractors for amount paid in excess of Rs. 20,000/-?				
23	Was a distribution register maintained with all relevant details?				
24	Does the distribution records tally with the purchase?				
	SCORE	**0**	**0**	**0**	

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		TRUE	#REF!		
SL. NO.	ADVANCES/LOANS & OTHER RECEIVABLES	YES	NO	N.A.	Recommendation /Remarks /Comments
1	Are advances given to staff with supporting voucher/details enclosed/break ups?				
2	Does the Project give advance directly to the volunteers?				
3	Are cash refunds from advance settlement/any other source deposited into bank a/c the same/next day?				
4	Are huge cash advances given instead of Cheques/DDs for major purchases?				
5	Are new advances given to staff before settling an earlier advance?				
6	Have staff settled the advances within One month working days as per the organization policy?				
7	Is an advance register maintained properly as per SSR standard like amount given/settled, voucher #, signature, settlement dates?				
8	Does Project or staff have proper approval of proposal before taking advance?				
9	Has the signature of beneficiary been obtained on the application and bills?				
10					
	SCORE	0	0	0	

		TRUE	#REF!		
SL. NO.	FUNDING	YES	NO	N.A.	Recommendation /Remarks /Comments
1	Are there any excess funds received by project against the fund request made?				
2	Are funding requests prepared with detail break-up and as per the need of project?				
3	Are funds received late by the project?				
4	Are funding received in excess of the approved annual budget of the Project?				
5	Does the funding agree to the project financial report?				

6	Are adequate records kept for local/other income, receipts and expenditures?				
	SCORE	**0**	**0**	**0**	
		TRUE	#REF!		

SL. NO.	**MONITORING**	**YES**	**NO**	**N.A.**	**Recommendation /Remarks /Comments**
1	Is there any monitoring plan to visit SSR by SR Finance team?				
2	Is there any monitoring plan visit evidence with the SSR by SR?				
3	Has the recommendation given by SR implemented by SSR?				
	SCORE	**0**	**0**	**0**	
		TRUE	#REF!		

ANNEXURE F: Sub Recipient (SR) Monitoring Plan

We have recently re- allocated support to SR in our Team. Please find below the matrix mentioning the person responsible from the PR Team to provide monitoring support to the respective Sub Recipients. This is an important communication and would help in future in addressing all the support to the SR. Please be in touch with the respective staff in the PR related to your organization.

The second table below also describes the communication matrix. All the issues and point of contact in the PR is mentioned in the communication matrix. I am sure this will help in addressing all the issues and support that SR requires in the future.

Table 1: Monitoring support to the Sub Recipients

<table>
<tr><th>SN</th><th>Partners Name</th><th>States Covered</th><th>PR Staff Name</th><th>Responsibilities</th></tr>
<tr><td>1</td><td>CARE</td><td>Jharkhand
Chhattisgarh
Madhya Pradesh</td><td rowspan="2">Amit Gordon – M&E Officer</td><td rowspan="7">All communications to SRs on routine and follow up issues.
Sub Grant Agreement and future modifications specially monitoring of conditions precedents
Monitoring the execution of workplan
Supportive Supervision through regular field visits
Monitor performance targets based on Performance Framework
Receive, review and give feedback on monthly and quarterly program progress reporting
Reviewing and quality assurance of the data reported in M&E system
Validating reported data through visiting source to authenticate the data being reported</td></tr>
<tr><td>2</td><td>LEPRA</td><td>Orissa
Madhya Pradesh</td></tr>
<tr><td></td><td></td><td></td><td></td></tr>
<tr><td>3</td><td>ADRA</td><td>Bihar</td><td rowspan="4">Blesson Samuel- M&E Manager</td></tr>
<tr><td>4</td><td>GLRA</td><td>West Bengal</td></tr>
<tr><td>5</td><td>SHIS</td><td>West Bengal</td></tr>
<tr><td>6</td><td>TB Alert</td><td>Andhra</td></tr>
</table>

Table 2: Communication Matrix

SN	Issues	Contact in the PR	E Mail	Phone	Remarks
1	Budget related queries and revisions	Mr. Daniel Premkumar Finance Manager	daniel_premkumar@wvi.org	+919650097275	While sending an email to Daniel mark a copy to the M&E Staff assigned to your SR as well
2	Financial Reporting	Mr. Daniel Premkumar Finance Manager	daniel_premkumar@wvi.org	+919650097275	While sending an email to Daniel mark a copy to the M&E Staff assigned to your SR as well
3	Fund Request	Mr. Daniel Premkumar Finance Manager	daniel_premkumar@wvi.org	+919650097275	While sending an email to Daniel mark a copy to the M&E Staff assigned to your SR as well
4	Issues related to Sub grant agreement and any modifications in future, including follow up on condition precedent	Concerned M& E Officer Blesson Samuel Amit Gordon	blesson_samuel@wvi.org amit_gordon@wvi.org	+919650097282 +919650097278	While sending an email to the M&E Staff assigned to your SR mark a copy to Daniel and Subodh as well
5	Issues related to performance framework	Concerned M& E Officer Blesson Samuel	blesson_samuel@wvi.org	+919650097282	While sending an email to the M&E Staff assigned to your SR mark a copy to Dr. Rajdeep and

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		Amit Gordon	amit_gordon@wvi.org	+919650097278	Subodh as well
6	Issues related to workplan, any changes or clarification	Concerned M& E Officer Blesson Samuel Amit Gordon	blesson_samuel@wvi.org amit_gordon@wvi.org	+919650097282 +919650097278	While sending an email to the M&E Staff assigned to your SR mark a copy to Dr. Rajdeep and Subodh as well
6	Technical Assistance including trainings and training need	Dr Rajdeep Srivastava	rajdeep_srivastava@wvi.org	+919650097277	While sending an email to Dr. Rajdeep mark a copy to the M&E Staff assigned to your SR as well
7	Organizational level issues including organizational development	Subodh Kumar	subodh_kumar@wvi.org	+919650097272	

Standard: Each SR is expected to be visited once in a quarter, and all districts are expected to be visited once in the year by someone in the PMU.

Partners		APR 10		MAY 10		JUN 10		JUL 10		AUG 10		SEP 10		OCT 10		NOV 10		DEC 10		JAN 11		FEB 11		MAR 11	
		PR	F	PR	F	PR	F	PR	F	PR	F	PR	F	PR	F	PR	F	PR	F	PR	F	PR	F	PR	F
ADRA														Blesson	Sudhir							Blesson	Sudhir		
CARE																								Amit	FO
GLRA											Sudhir					Blesson								Blesson	Sudhir
LEPRA													Sudhir	Amit										Amit	FO
SHIS											Sudhir					Blesson								Blesson	Sudhir
TBALERT									Sudhir					Amit								Blesson	Sudhir		

ANNEXURE G: Performance Framework

Performance Framework Year 1 & 2: Indicators, Targets, and Periods Covered — **TB**

Program Details

Country:	India
Disease:	Tuberculosis (TB)
Grant number:	IDA-910-917-T
Principal Recipient:	World Vision India

A. Periods covered and dates for disbursement requests and progress updates (typically completed by the Secretariat during Grant negotiations)process)

	Period 1	Period 2	Period 3	Period 4	Period 5	Period 6	Period 7	Period 8	Period 9
Period Covered: from	1-Apr-10	1-Jul-10	1-Oct-10	1-Jan-11	1-Apr-11	1-Jul-11	1-Oct-10	1-Jan-12	1-Apr-12
Period Covered: to	30-Jun-10	30-Sep-10	31-Dec-10	31-Mar-11	30-Jun-11	30-Sep-11	31-Dec-11	31-Mar-12	30-Jun-12
Date Progress Update due (typically 45 days after end of period)	14-Aug-10	14-Nov-10	14-Feb-11	15-May-11	14-Aug-11	14-Nov-11	14-Feb-12	15-May-12	14-Aug-12
Disbursement Request ? (Y,N)	N	Y	N	Y	N	Y	N	-	-

	Year 1	Year 2
Annual Report Due Date:	30-Sep-11	30-Sep-12

B. Program Goal, impact and ouctome indicators

Goals:	
1	Decrease morbidity and mortality due to drug resistant TB (DR-TB) in India and improve access to quality TB care and control services through enhanced civil society participation

Impact indicator number	Indicator	Baseline			Targets							Comments*
		value	Year	Source	Year 1	Report due date	Year 2	Report due date	Year 3	Year 4	Year 5	
1	TB Incidence rate	75 new smear positive (NSP) cases per 100,000 population	2002	National Annual Risk of TB Infection (ARTI) survey			67 NSP cases per 100,000 population	Jan-12			60 NSP cases per 100,000 population	Next round of ARTI survey will be conducted in 2014-15
2	TB prevelance rate	370 bacillary positive TB cases per 100,000 population	2000	Report of expert committee meeting on TB Burden based on prevalence survey data			280 bacillary positive cases per 100,000 population	Jan-12			200 bacillary positive cases per 100,000 population	TB prevalence survey at select sentinel sites to be repeated in 2014-15
3	TB mortality rate	28 deaths per 100,000 population	2006	WHO Global TB Report	26	Oct-11	25	Oct-12	24	23	21	

Outcome indicator number	Indicator	Baseline			Targets							Comments*
		value	Year	Source	Year 1	Report due date	Year 2	Report due date	Year 3	Year 4	Year 5	
1	Case Detection Rate : New Smear Positive Cases	54 new smear positive (NSP) cases per 100,000 population (72%)	2009	R&R system, quarterly reports	≥ 51 (70%)	1-Jun-11	≥ 51 (70%)	Jun-12	≥ 51 (70%)	≥ 51 (70%)	≥ 51 (70%)	
2	Treatment Success Rate : New Smear Positive Cases	87%	2008	R&R TB system, quarterly reports	≥ 85%	1-Jun-11	≥ 85%	Jun-12	≥ 85%	≥ 85%	≥ 85%	
3	Average default rate of smear positive re-treatment patients in 374 target districts	14%	2008	R&R TB system, quarterly reports	13%	1-Jun-11	12%	Jun-12	11%	10%	9%	Although this indicator applies to the 374 target districts that are covered by the two cicil society PRs it does reflect the overall programmatic success in decreasing default rates in those

* please specify source of measurement for indicator in case different to baseline source

C. Program Objectives, Service Delivery Areas and Indicators

Objective Number	Objective description
1	Establish and enhance capacity for quality assured rapid diagnosis of DR-TB suspects in 43 Culture and DST laboratories in India by 2015 (Central TB Division)
2	Scale-up care and management of DR-TB in 35 states/Union Territories of India resulting in the initiation of treatment of 65,200 additional cases of Drug Resistant over the project period (2010-2015) (Central TB Division)
3	To consolidate TB control efforts towards achieving the goal of TB control through sustainable and effective public-private partnership to involve all health care providers (World Vision and International Union Against Tuberculosis and Lung Disease)
4	To contribute towards national efforts in measuring the impact of RNTCP in relation to the MDG TB targets. (World Vision and International Union Against Tuberculosis and Lung Disease)

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Monitoring & Evaluation Plan, October 2010

Objective / Indicator Number	Service Delivery Area	Indicator	Baseline (if applicable)			Periodical targets for year 1 & 2									Tied to	Targets cumulative Y-over program term Y-cumulative annually	Baselines included in targets	Comments
			Value	Year	Source	P1	P2	P3	P4	P5	P6	P7	P8	P9[§]				
3.1	ACSM (Advocacy, communication and social mobilization)	Number of districts with new smear positive case detection rate ≥ 70% in 74 target districts	27	3Q 2009	R&R TB system, quarterly reports	n/a	n/a	n/a	30	n/a	n/a	n/a	37	n/a	GF & other donors (not national)	N - not cumulative	Y	By the end of the fifth year a total of 61out of 74 target districts will have case detection rates ≥ 70%. The PR will work in all 74 districts by the end of the first year.
3.2	ACSM (Advocacy, communication and social mobilization)	Percentage and number of target districts where at least 90% of all smear positive TB patients are started on treatment within 7 days of TB diagnosis	38% (28)	3 Q 2009	R&R TB system, quarterly reports	n/a	n/a	n/a	43% (32)	n/a	n/a	n/a	48% (35)	n/a	GF & other donors (not national)	N - not cumulative	Y	5% increase annually. The indicator refers to the 74 districts under World Vision. The PR will work in all 74 districts by the end of the first year.
3.3	ACSM (Advocacy, communication and social mobilization)	Percentage and number of target districts where at least 40% registered TB patients (all forms) are supervised through a community volunteer	32% (24)	3Q 2009	R&R TB system, quarterly reports	n/a	n/a	n/a	36% (27)	n/a	n/a	n/a	40% (30)	n/a	GF	N - not cumulative	Y	4% increase annually. The indicator refers to the 74 districts under World Vision
3.4	ACSM (Advocacy, communication and social mobilization)	Percentage of population with correct knowledge about TB (mode of transmission, symptoms, treatment and curability)	not available	not available	KAP Survey	n/a	n/a	n/a	n/a	TBD	n/a	n/a	n/a	n/a	GF & other donors (not national)	N - not cumulative	N	KAP study will be implemented in 374 NGO target districts in P2 and again in Year 3; targets for Phase 2 will be set according to baseline. The survey will also assess the following indicator, for which targets and results will be communicated to the Global Fund once the results become available: "Percentage of people in a selected community expressing accepting attitudes towards TB patients"
3.5	ACSM (Advocacy, communication and social mobilization)	Number of people trained (TOT) at State level on NGO/CBO/PPRNTCP scheme	0	2,009	Training records	0	50	50	70	70	70	70	70	70	GF	Y - over program term	N	WV is responsible for TOT in 7 states. The target is set based on 10 people trained per state. It is assumed that each TOT would conduct at least 3 trainings
3.6	ACSM (Advocacy, communication and social mobilization)	Number of NGOs sensitised at District level on community mobilisation and RNTCP schemes	600	2,009	Training records	0	0	150	300	510	510	510	510	510	GF	Y - over program term	N	15 NGOs per district will be sensitised. This activity is limited to 34 new districts that WV would be adding for GF program. Baseline is from USAID supported trainings that last up to September 2010. At the end of Phase 1 the activitiy will be evaluated with regard to actual number of NGOs signing up for RNTCP schemes. This will permit target setting for Phase 2 for "NGOs signed up in RNTCP schemes following sensitization".
3.7	ACSM (Advocacy, communication and social mobilization)	Number of people trained/retrained on interpersonal skills and soft skills (through State level TOT and district level health staff at district level)	0	2,009	Training records	0	75	1,955	3,805	3,805	5,655	5,655	7,505	7,505	GF	Y - over program term	N	15 people per State would be trained. They would then mentor and train at least 35 staff. Regarding districts: 50 staff per district would be trained in the first year. The same staff would then be provided with refresher in the second year.
3.8	HSS/Human Resources for Health	Number and percentage of target districts which an active District TB officer	340 (91%)	3Q 2009	R&R TB system, quarterly reports	n/a	n/a	n/a	n/a	n/a	n/a	n/a	≥355 (≥95%)	n/a	GF & other donors (not national)	N - not cumulative	Y	Indicator applies to 374 target districts of both NGO PRs; Target refers to filled posts/ deployed District TB Officer. Achievement of target will be shared responsibility of the three Rd 9 PRs: The Union, WV and CTD.
4.1	All care providers (PPM / ISTC - Public-Public, Public-Private Mix (PPM) approaches and International standards for TB care)	Number of rural health care providers sensitised on referrals, DOTS provision and eligible RNTCP schemes	0	2,009	Training records	0	690	1,140	2,220	2,775	3,330	3,885	4,440	4,995	GF	Y - over program term	N	Per District 30 rural health provider per year would be sensitised and encouraged to join RNTCP scheme. All rural health provider identified will be sensitized once.
4.2	Community TB Care	Number and % of sputum positives initial defaulters sucessfully retraced and enrolled in DOTS	0	3 Q 2009	R&R TB system, quarterly reports and project reports	0%	0%	0%	0%	5%	5%	5%	5%	5%	GF	N - not cumulative	N	Indicator applies to 74 target districts. Tracing 30 defaulters per district per quarter, 5% of these defaulters would be enrolled in DOTS. This 5% is commulative over the nine periods. M&E Plan will have clear description on numerator and denominator and data collection methodology. The experience from Phase 1 will be used to improve the data collection for this indicator; the results from Phase 1 will be used to inform target setting for phase 2.
4.3	Community TB Care	# of District level TB forums established and functional	0	2010	Project M&E records	0	0	0	0	74	148	222	296	370	GF	Y - over program term	N	From P5, it is expected that each quarter 1 new District level TB forum would be established per quarter. There is a 2-period delay between the estabsment of the DLTBF and the reporting that the network in functional.

ANNEXURE H: GF R9 Operational Plan

Ref No	Objective	Service Delivery Area (SDA)	Activity	Year 1				Year 2				
				Q1	Q2	Q3	Q4	Q5	Q6	Q7	Q8	
3.1.5.2	3	Training	Orientation trainings for community volunteers on behaviour change communication to use tool kits.		x	x	x		x	x	x	All SRs
3.1.7.1	3	Training	State Level TOTs for NGO/CBO/PP training		x	x						All SRs
3.1.7.2	3	Training	Select and train local NGO networks			x						All SRs
3.1.8	3	Training	Sensitization and regular meetings with Gaon Kalyan Samitis and other community groups.	x	x	x	x	x	x	x	x	All SRs
3.1.9.1	3	Communication Materials	Awareness programmes on WTBD day and International Womens Day				x				x	All SRs
3.1.10.2	3	Communication Materials	Patient charter - Printing			x						All SRs
3.1.12	3	Monitoring and Evaluation (M&E)	OR Study on ACSM Model.							x		WV
3.2.1.2	3	Planning and Administration	chandra		x	x		x	x			WV
3.2.2	3	Planning and Administration	Establish and meeting with corresponding bodies of MLAs at State level		x	x		x	x			WV
3.3.1	3	Training	Sensitize NGOs to register under RNTCP schemes for sputum collection / transport and microscopy.			x	x	x	x			All SRs

3.4.4.1	3	Training	Building state level TOT for training health staff in soft skills (7 states)		x	x						WV
3.4.4.2	3	Training	Training health staff in soft skills.			x	x		x		x	All SRs
3.4.4.3	3	Training	Half yearly following meetings with health staff					x		x		All SRs
4.1.1	4	Training	Capacity Building for 10 CBOs in each district.				x		x			All SRs
4.1.2	4	Training	Quarterly meetings of CBOs with District TB Officers.	x	x	x	x					All SRs
4.2.1	4	Planning and Administration	Sputum collection and transport	x	x	x	x					All SRs
4.2.2	4	Planning and Administration	Retracing Initial Defaulters	x	x	x	x					All SRs
4.2.3	4	Training	Develop and orient TB forums in districts with representation from cured patients, marginalized population, old age people, population living in slums and homeles, affected communities			x	x	x	x	x	x	All SRs
4.2.4	4	Training	Mobilize support for DRTB Patients in 7 pilot districts of Andhra Pradesh	x	x	x	x					WV SR - TB Alert
4.3.1	4	Training	Select and train rural health providers.		x		x					All SRs
4.3.2.1.	4	Monitoring and Evaluation (M&E)	Quarterly review meetings of rural health care providers with district TB officers.			x	x	x	x	x	x	All SRs
4.3.3	4	Training	Advocate with Medical colleges, secondary and tertiary non-government hospitals for adoption of WHO/STAG recommended and			x	x	x	x	x	x	WV

			RNTCP promoted DOTS plus guidelines.									
4.3.4.1	4	Training	Sensitize employees of workplace on TB control.			x	x	x	x	x	x	WV SR - TB Alert
4.3.4.2	4	Training	Sensitize PPs to provide DOTS in workplaces.			x	x	x	x	x	x	WV SR - TB Alert
4.4.1	4	Training	Quarterly Joint meetings of ICTCs and DMCs for sensitization and review of cross referrals.			x	x	x	x	x	x	All SRs
4.4.2	4	Training	Train District level networks of PLHIVs on TB care and control.						x			All SRs
4.5.1.8	4	Human Resources	Hiring Project director - WV PMU	x	x	x	x	x	x	x	x	WV
4.5.1.9	4	Human Resources	Hiring Technical Officer - WV PMU			x	x	x	x	x	x	WV
4.5.1.10	4	Human Resources	Hiring M&E Officer - WV PMU	x	x	x	x	x	x	x	x	WV
4.5.1.11	4	Human Resources	Hiring Finance Manager - WV PMU	x	x	x	x	x	x	x	x	WV
4.5.1.12	4	Human Resources	Hiring Finance Officers- WV PMU	x	x	x	x	x	x	x	x	WV
4.5.1.12B	4	Human Resources	Hiring Finance and Admn Coordinator - WV PMU	x	x	x	x	x	x	x	x	WV
4.5.1.12A	4	Human Resources	Hiring Programe Officers	x	x	x	x	x	x	x	x	WV
4.5.1.13	4	Human Resources	Hiring Admn Assistant - WV PMU	x	x	x	x	x	x	x	x	WV
4.5.4.14	4	Human Resources	Recruitment cost of staff at PMU									WV
4.5.2.3	4	Training	Training of Project staff					x	x	x	x	WV
4.5.3.1	4	Infrastructure and Other Equipment	Procurement of laptops	x								WV
4.5.3.2	4	Infrastructure and Other Equipment	Procurement of Desktops									WV
4.5.4.1	4	Human Resources	Hiring Programme Managers	x	x	x	x	x	x	x	x	All SRs

4.5.4.2	4	Human Resources	Hiring Asst. Programme Managers	x	x	x	x	x	x	x	x	All SRs
4.5.4.3	4	Human Resources	Hiring District Coordinators	x	x	x	x	x	x	x	x	All SRs
4.5.4.4	4	Human Resources	Hiring Finance & Admn Officer	x	x	x	x	x	x	x	x	All SRs
4.5.4.5	4	Human Resources	Hiring Finance & Admn Assistant	x	x	x	x	x	x	x	x	All SRs
4.5.4.6	4	Infrastructure and Other Equipment	Procurement of Laptops	x								All SRs
4.5.4.7	4	Infrastructure and Other Equipment	Procurement of desktops	x								All SRs
4.5.4.8	4	Infrastructure and Other Equipment	Procurement of UPS and Generator		x							WV SRs - CARE
4.5.4.9	4	Infrastructure and Other Equipment	Office Furniture for SRs		x							All SRs
4.5.4.10	4	Infrastructure and Other Equipment	Maintenance of equipment		x			x				All SRs
4.5.4.11	4	Planning and Administration	Office running cost - Direct costs.									WV, WV SRs.
4.5.5.3	4	Monitoring and Evaluation (M&E)	Monitoring & evaluation visits			x	x	x	x	x	x	WV
4.5.6.1	4	Monitoring and Evaluation (M&E)	Review and M&E visits at district level by the implementing partners			x	x	x	x	x	x	All SRs
4.5.6.2	4	Monitoring and Evaluation (M&E)	Review and MI&E visits from states/regional/national to districts.			x	x	x	x	x	x	All SRs
4.5.7.2	4	Monitoring and Evaluation (M&E)	Project planning and review meeting at National level			x	x		x		x	WV
4.5.7.3	4	Monitoring and Evaluation (M&E)	Quartelry planning and review at state level			x	x	x	x	x	x	WV
4.6.1	4	Overheads	Office running cost - Direct costs.			x	x	x	x	x	x	Union,WV & All SRs

4.6.1A	4	Overheads	Audit expenses				x				x	WV & All SRs
4.6.1B	4	Overheads	Office Rent	x	x	x	x	x	x	x	x	WV & All SRs
4.6.1C	4	Overheads	Head Office Support Cost (Management Fee)	x	x	x	x	x	x	x	x	WV & All SRs

ANNEXURE I: Operations Research Design for studying impact of ACSM Interventions

This report is being submitted as separate attachment along with this document.

ANNEXURE J: M&E and Financial System Business Proposal

This report is being submitted as a separate attachment along with this document.

ANNEXURE K: Standard Operating Procedure (SOP) Finance

This report is being submitted as a separate attachment along with this document