Annexure 16

Monitoring Indicators

Sr. No.	Indicator name	Numerator	Denominator	Source of data	Remarks
1	Estimated incidence rate	Estimated incidence TB cases occurred in a year	Population in lac in year	State wide estimation by DHR	Annually
2	Estimated prevalence rate	Estimated number of TB cases prevalent in a year	Population in lac in year	State wide estimation by DHR	Annually
3	Estimated TB mortality rate	Estimated number of TB cases died due to TB in a year	Population in lac in year	State wide estimation by DHR	Annually
4	Estimated MDR-TB incidence rate	Estimated MDR-TB cases	Population in million in year	State wide estimation by DHR	
5	Estimated HIV-TB case incidence rate	Estimated HIV-TB cases	Population in lac in year	State wide estimation by DHR	
6	Annualized Total TB Case Notification Rate	All forms of TB Cases Notified during specified Period * multiplier to convert it annualized	Population in Lac in year	NIKSHAY	
7	Proportion of estimated incident TB cases notified	Number of TB cases notified	Estimated number of TB cases in a year	NIKSHAY	

8	New TB Case Notification Rate A)MicrobiologicallyConfirmed B)Clinically Diagnosed	Number of New TB Cases Notified during specified Period A) Microbiologically Confirmed B)Clinically Diagnosed	Population in lac in a year	NIKSHAY	
9	Recurrent TB Case Notification Rate A)Microbiologically Confirmed B)Clinically Diagnosed	Number of retreatment TB Cases Notified during specified Period A) Microbiologically Confirmed B)Clinically Diagnosed	Population in lac in a year	NIKSHAY	
10	Number of notified cases of all forms of TB - microbiologically confirmed plus clinically diagnosed, new and recurrent (By Age, SEX, HIV status)			NIKSHAY	
11	Proportion of microbiologically confirmed TB cases notified	Number of microbiologically confirmed TB cases notified	Total number of TB cases notified	NIKSHAY	
12	Presumptive TB Cases Examination Rate	Number of Presumptive TB Cases Examined during specified Period	Population in Lakh during mid of specified Period	NIKSHAY (PMR)	
13	Average time to diagnosis of TB patients from the onset of symptoms	Summation of (difference between date of onset of symptoms and date of diagnosis of TB)	Total number of TB patients diagnosed	E-NIKSHAY	
14	Average time to initiation of treatment from diagnosis	Summation of (difference between date of diagnosis and date of initiation of	Total number of TB patients initiated on treatment	NIKSHAY	

		treatment of TB)			
15	Proportion of New TB Cases with RR/MDR TB	Number of RR/MDR TB Cases diagnosed among New TB Cases during specified Period × 100	Number of New TB Cases Diagnosed during specified Period	NIKSHAY	
16	Proportion of patients reported any ADR affecting treatment during month (partially or complete discontinuation of treatment)	Total number of patients reported any ADR affecting treatment continuation.	Total number of patients on treatment	E- NIKSHAY	
17	Proportion of patients interrupted treatment (missed doses >3 doses) during month	Number of patients missed doses (>3 doses) during month	Total number of patients on treatment	E- NIKSHAY	
18	Proportion of TB patients screened for Diabetes	Number of TB patients screened for Diabetes	Number of TB patients notified	E-NIKSHAY	
19	Proportion of patients diagnosed with Diabetes	Number of TB patients diagnosed with Diabetes	Number of TB patients tested for Diabetes	E- NIKSHAY	
20	Proportion of TB-Diabetes patients linked with diabetes care services	Number of TB-Diabetes patients linked with diabetes care services	Number of TB-Diabetes patients notified	E-NIKSHAY	
21	Proportion of Paediatric Cases among Total TB Cases	Number of Paediatric TB Cases Notified during specified Period × 100	Number of Total TB Cases Notified during specified Period	E-NIKSHAY	
22	Proportion of pulmonary TB patients whose household contacts were screened for TB within one month of initiation of treatment	Number of pulmonary TB patients whose house hold contacts were screened	Number of TB patients registered for treatment one month prior	E- NIKSHAY	
23	Proportion of TB patients diagnosed out of household	Number of TB patients diagnosed during household	Number of household contacts screened for TB	E-NIKSHAY	

	contact screening	contact screening			
24	Proportion of eligible children given chemoprophylaxis for 6 months	Number of eligible children given chemoprophylaxis for 6 months	Number of children eligible for chemoprophylaxis	E-NIKSHAY	
25	Percentage of notified TB cases, all forms, contributed by non-NTP providers - private/non-governmental facilities	Number of TB cases notified by non-NTP providers	Number of TB cases notified in a period	NIKSHAY	
26	Number of TB cases (all forms) notified among key affected populations/high risk groups (HIV, prisoners/ migrants/refugees.IDPs)			E-NIKSHAY	

Interim outcome indicators

Sr. No.	Indicator name	Numerator	Denominator	Source of data	Remarks
1	Proportion of microbiologically confirmed patients converted	No. of microbiologically confirmed patients converted at end of 3 months	Total number microbiologically confirmed patients initiated on treatment 3 months prior	NIKSHAY	
2	Proportion of mono- / poly-drug resistant pulmonary TB patients converted	No. of mono- / poly- drug resistant TB patients converted at end of 6 months	Total number of mono- / poly- drug resistant TB patients initiated on treatment 6 month prior	E-NIKSHAY	
3	Proportion of RR/MDR pulmonary TB patients	No. of RR / MDR pulmonary TB patients	Total number RR / MDR pulmonary TB patients	E-NIKSHAY	

	converted at end of 6 months	converted at end of 6 months	initiated on treatment 12 month prior		
4	Proportion of RR/MDR TB patients died by 6 months	No. of RR / MDR TB patients died by 6 months	Total number RR / MDR TB patients initiated on treatment 12 month prior	E-NIKSHAY	
5	Proportion of RR/MDR TB patients lost to follow up by 6 months	No. of RR / MDR TB patients lost to follow up by 6 months	Total number RR / MDR TB patients notified 12 month prior	E-NIKSHAY	

HIV-TB

Sr. No.	Indicator name	Numerator	Denominator	Source of data	Remarks
1	Proportion of notified new and recurrent TB patients with documented HIV status	Number of notified new and recurrent TB patients with documented HIV status x 100	Number of new and recurrent TB patients notified	NIKSHAY	
2	Proportion of notified new and recurrent TB patients with documented HIV-positive status	Number of notified new and recurrent TB patients with documented HIV-positive status	Number of new and recurrent TB patientsnotified	NIKSHAY	
3	Proportion of HIV-positive new and recurrent TB patients on ART during TB treatment	Number of HIV-positive new and recurrent TB patients on ART during TB treatment	Number of HIV-positive new and recurrent TB patients notified	NIKSHAY	
4	Proportion of people living with HIV newly enrolled in HIV care and screened negative for TB, started on TB preventive therapy	Number of people living with HIV newly enrolled in HIV care and screened negative for TB, started on TB preventive therapy	Number of people living with HIV newly enrolled in HIV care and screened negative for TB	NACP (Patient visit register / monthly report)	

5	Mortality among HIV-positive new and recurrent TB patients	Number of HIV-positive new and recurrent TB patients died	Number of HIV-positive new and recurrent TB patients notified	NIKSHAY	
6	Risk of TB among health care workers relative to the general population, adjusted for age and sex	Number of TB patients notified per 100,000 health care workers in a year	Number of TB patients notified per 100,000 population in a year		
7	Proportion of people living with HIV in care who are screened for TB in HIV care or treatment settings *1.ICTC/FICTC* *2.ART* *3.TI settings* *4.CSCs*	Number of persons enrolled in HIV care whose TB status was assessed and recorded at their last visit during the reporting period	Number of persons enrolled in HIV care and seen for care during the reporting period	NACP (Patient visit register / monthly report)	
8	Proportion of people living with HIV who are TB symptom screen positive out of those who are screened for TB	Number of people living with HIV found to have anyone of the symptoms suggestive of TB	Number of people living with HIV who were screened for presence of TBsymptoms during their last visit to HIV care or treatment facility	NACP (Patient visit register / monthly report)	
9	Proportion of people living with HIV who are tested for TB out of those who are symptom screen positive	Number of people living with HIV who are investigated for TB	Number of people living with HIV who were TB symptom screen positive during the reporting period	NACP (HIV-TB line list / monthly report)	
10	Proportion of people living with HIV diagnosed with active TB out of those who are tested	Number of people living with HIV diagnosed as having active TB	Number of people living with HIV investigated for presence of active TB during the reporting	NACP (HIV-TB line list / monthly report)	

			period		
11	Proportion of people living with HIV who are started on TB treatment out of those diagnosed as having active TB	Number of people living with HIV started on TB treatment and registered in the TB register	Number of people living with HIV diagnosed to have active TB through intensified TB case finding	NACP (HIV-TB line list / monthly report)	
12	Proportion of people living with HIV having TB symptoms who receive a rapid molecular test (e.g. CBNAAT)as a first test fordiagnosis of TB	Number of people living with HIV having TB symptoms who were investigated using a rapid molecular test (e.g. CBNAAT) as a first test	Number of people living with HIV having TB symptoms identified through intensified case finding at HIV care and treatment facilities during the reporting period	NACP (HIV-TB line list)	
13	Proportion of HIV-positive new and recurrent TB patients detected and notified out of the estimated number ofincident HIV-positive TB cases	Number of HIV- positive new and recurrent TB patients registered during the reporting period	Estimated number of incident TB cases among people living with HIV (with low and high uncertainty bounds)		
14	Proportion of HIV-positive new and recurrent TB patients who receive co-trimoxazole preventive therapy	Number of HIV- positive new and recurrent TB patients notified during the reporting period who are started or continued on co-trimoxazole preventive therapy during TB treatment	Number of HIV- positive new and recurrent TB patients notified during the reporting period	NIKSHAY	
15	Proportion of health care facilities providing services for	Number of health care facilities having	Number of health care facilities evaluated	NIKSHAY	

	people living with HIV that have TB infection control practices	"demonstrable" TB infection control practices that are consistent with international guidelines	for TB infection control practices during the reporting period		
16	Proportion of people living with HIV who complete a course of TB preventive therapy	Total number of persons who completed the course of treatment for latent TB infection during the reporting period	Total number of persons in HIV care who were newly started on treatment for latent TB infection 12 to 15 month earlier	NIKSHAY	
17	Proportion of people living with HIV in care who ever received a course of TB preventive therapy	Number of persons who received at least one complete course of treatment for latent TB infection ever, by the end of the reporting period	Number of persons currently in HIV care at the end of the reporting period	NIKSHAY	
18	Proportion of presumptive TB patients having documented HIV status	Total number of presumptive TB patients who have a documented HIV test result	Total number of presumptive TB patients who are investigated for TB during the reporting period	E-NIKSHAY (PMR)	
19	Proportion of patients having multidrug-resistant or rifampicin-resistant TB with known HIV status	Total number ofmultidrug-resistant and rifampicin-resistant TB patientshaving documentedHIV status	Total number of multidrug- resistant and rifampicin- resistant TBpatients registered duringthe reporting	NIKSHAY	

			period		
20	Proportion of HIV-positive patients treated for multidrug-resistant or rifampicin-resistant TB who are also on ART	Number ofHIV-positive multidrug- resistant and rifampicin- resistant TB patientswhoare onsecond-line TBtreatmentand newlystartedor alreadyonART	Number of HIV-positive multidrug- resistant and rifampicin- resistant TBpatients registered duringthe reporting period	NIKSHAY	
21	Proportion of HIV-positive TB patients on protease inhibitor-based ART regimen receiving rifabutin-containing anti-TB treatment	Number of HIV-positive TB patients on protease inhibitor- based ART who received rifabutin-containing anti-TBtreatment regimen	Number of people living with HIV on protease inhibitor-based ARTwhoare diagnosedas havingactive TBduring thereporting period	NIKSHAY	

Drug resistant -TB

Sr. No.	Indicator name	Numerator	Denominator	Source of data	Remarks
1	Proportion of previously treated microbiologically-confirmed cases receiving DST at the start of treatment	No. of previously treated microbiologically-confirmed cases receiving DST at the start of treatment x 100	No. of previously treated TB cases notified	E-NIKSHAY	

2	Proportion of new microbiologically-confirmed cases receiving DST at the start of treatment	No. of new microbiologically-confirmed cases receiving DST at the start of treatment x 100	No. of new TB cases notified	E-NIKSHAY	
3	Proportion of Previously Treated TB Cases with RR/MDR TB	Number of RR/MDR TB Cases diagnosed among Previously Treated TB Cases during specified Period × 100	Number of Previously Treated TB Cases Diagnosed during specified Period	NIKSHAY	
4	Proportion of New TB Cases with RR/MDR TB	Number of RR/MDR TB Cases diagnosed among New TB Cases during specified Period × 100	Number of New TB Cases Diagnosed during specified Period	NIKSHAY	
5	Number of microbiologically confirmed, drug resistant TB cases (RR-TB and/or MDR-TB) notified (By Sex and Age)			NIKSHAY	
6	Proportion of diagnosed MDR-TB patients initiated on treatment	Number of MDR-TB patients initiated on treatment	Number of MDR-TB patients diagnosed	NIKSHAY	
7	Annualized MDR TB case notification rate	Number of MDR TB cases notified in a specified period x multiplier to convert annualized	Population in a year	NIKSHAY	
8	Proportion of estimated MDR TB cases notified	Number of MDR TB cases notified in a year	Estimated number of MDR-TB cases in a year		
9	Proportion of MDR-TB patients tested for second line Drug susceptibility at initiation of treatment	Number of MDR-TB patients tested for second line DST	Number of MDR-TB patients notified	E-NIKSHAY	

10	Proportion of MDR TB cases diagnosed as XDR TB	Number of MDR TB cases diagnosed as XDR	Number of MDR patients notified	NIKSHAY	
11	Proportion of diagnosed XDR TB cases put on treatment	Number of XDR TB cases started on treatment	Number of XDR TB cases diagnosed	NIKSHAY	
12	Proportion of MDR TB cases diagnosed with additional drug resistance	Number of MDR TB cases diagnosed with additional drug resistance	Number of MDR patients notified	NIKSHAY	

Outcome of treatment indicators

Sr. No.	Indicator name	Numerator	Denominator	Source of data	Remarks
	Drug sensitive patients				
1	Proportion of TB patients declared **(treatment outcome)** *Cured* *Treatment completed* *Successfully treated* *Died* *Failure* *Lost to follow up* *Regimen changed* *Not evaluated*	No. of TB cases declared **(treatment outcome)**	Total No. of TB patients registered in a quarter that ended 12 months prior	NIKSHAY	
2	Proportion of patients followed at 6 / 12 / 18 month after completion of treatment	No. of patients followed at 6/12 month after completion of treatment	Total number of patients who had completed treatment 6/12/18 months prior	E-NIKSHAY	
3	Proportion of TB patients **developing recurrence of TB**	No. of TB Patients developing recurrence	Total no. of Notified Patients completed	E-NIKSHAY	

	within 1 year of completion of treatment	of TB within one year of completion	treatment before one year prior		
4	Proportion of HIV-TB patients declared **(treatment outcome)** *Cured* *Treatment completed* *Successfully treated* *Died* *Failure* *Lost to follow up* *Regimen changed* *Not evaluated* **by Age / Sex / HIV status*	No. of HIV-TB cases declared **(treatment outcome)**	Total No. of HIV-TB patients registered in a quarter that ended 12 months prior	E-NIKSHAY	
	Drug resistant TB				
5	Proportion of DRTB Patients declared **(treatment outcome)** *Cured* *Treatment completed* *Successfully treated* *Died* *Failure* *Lost to follow up* *Regimen changed* *Not evaluated*	No. of DRTB Patients declared **(treatment outcome)**	Total No. of DRTB patients cohort registered 33 months prior	E-NIKSHAY	
6	Proportion of DRTB patients declared **Failure due to** *culture non-conversion at end of IP* *culture reversion in CP*	No. of DRTB cases declared Failure due to **(reason)**	Total No. of DRTB patients cohort registered 33 months prior	E-NIKSHAY	

	Additional drug resistance *Adverse drug reaction*				
	Drug resistance other than MDR				
7	Proportion of DRTB patients declared **(treatment outcome)** *Cured* *Treatment completed* *Successfully treated* *Died* *Failure* *Lost to follow up* *Regimen changed* *Not evaluated*	No. of DR-TB cases declared cured	Total No. of DR-TB patients registered in a quarter that ended 15 months prior	E-NIKSHAY	

Private sector indicators

Sr. No.	Indicator name	Numerator	Denominator	Source of data	Remarks
1	Proportion of private sector health facilities registered in NIKSHAY (health facility wise) - Single clinic - Multiple - Laboratory	Number of private health registered in NIKSHAY	Number of private health facilities in area	NIKSHAY	
2	Proportion of private sector health facilities notifying TB out of registered (health facility wise) - Single clinic - Multiple - Laboratory	Number of private health facilities notifying TB	Number of private health facilities registered	NIKSHAY	
3	Proportion of TB patients notified from private sector	Number of TB patients notified from private sector	Total number of TB patients notified	NIKSHAY	
4	Proportion of new and recurrent TB patients notified from private sector	Number of TB new and recurrent TB patients notified from private sector	Total number of new and recurrent TB patients notified	E-NIKSHAY	

5	Proportion of microbiologically confirmed among TB cases among total notified cases from private sector	Number of microbiologically confirmed TB patients notified from private sector	Total number of TB patients notified from private sector	NIKSHAY	
6	Proportion of the DRTB patients notified from private sector	Number of DR-TB patients notified from private sector	Total number of DR-TB patients notified	NIKSHAY	
7	Proportion of the pediatric TB patients notified from private sector	Number of pediatric TB patients notified from private sector	Total number of pediatric TB patients notified	NIKSHAY	
8	Proportion of TB patients (notified from private sector) with known HIV status	Number of TB patients (notified from private sector) with known HIV status	Total number of TB patients notified from private sector	NIKSHAY	
9	Proportion of previously treated TB patients (notified from private sector) received DST at the beginning of treatment	Number of previously treated TB patients (notified from private sector) received DST at the beginning of treatment	Total number of TB patients notified from private sector	NIKSHAY	
10	Proportion of new TB patients (notified from private sector) received DST at the beginning	Number of new TB patients (notified from private sector) received DST at the beginning of	Total number of TB patients notified from private sector	E-NIKSHAY	

	of treatment	treatment			
11	Proportion of TB patients declared (treatment outcome) *Cured* *Treatment completed* *Successfully treated* *Died* *Failure* *Lost to follow up* *Regimen changed* *Not evaluated*	Number of TB patients declared (treatment outcome) *Cured* *Treatment completed* *Successfully treated* *Died* *Failure* *Lost to follow up* *Regimen changed* *Not evaluated*	Total number of TB patients notified from private sector	E-NIKSHAY	

Review meeting Protocol for all Program staff

Level	Type of Review	Chairperson	Participants	Frequency
National	RNTCP performance review	DDG (TB)	STOs	Biannual
	Medical College performance review	DDG (TB)	ZTF members	Annual
	TB-HIV collaborative activities	DDG-TB	Members of National Working Group for TB-HIV collaborative activities	Quarterly
	Laboratory Committee	Chairperson Laboratory Committee / DDG (TB)	Members of Laboratory Committee	Biannual
	National DOTS-Plus Committee	Chairperson National DOTS- Plus Committee / DDG (TB)	Members of National DOTS-Plus Committee	Biannual
	National Technical Working Group (NTWG) for PPM Activities	Chairperson NTWG for PPM Activities / DDG (TB)	NTWG for PPM Activities members	Biannual
	National Operational Research Committee	Chairperson National OR Committee / DDG (TB)	National OR Committee members	Biannual
	National Airborne Infection Control (AIC) Committee Members	National AIC Committee Chairperson / DDG (TB)	National AIC Committee members	Biannual
Zonal	Medical College performance review	ZTF Chairperson	STF members	Annual
	RNTCP Performance Review including one day exclusively for PMDT activities	DDG (TB)	Regional Directors, STOs, DTOs of selected districts	Annual
State	State Health Society Review (RNTCP included as an agenda item)	PS (Health), MD-NRHM	Director Health Services, CMHO , All programme heads in state,	Quarterly

Level	Type of Review	Chairperson	Participants	Frequency
	RNTCP performance review	STO	DTO	Quarterly
	Performance review of Under-performing districts	STO	DTO	Biannual
	Medical college performance review	STO/ STF Chairperson	Nodal Officers from all medical colleges	Quarterly
	State Operational Research Committee Meeting	STO/ STF Chairperson	State OR Committee Members	Quarterly
	State TB-HIV Co-ordination committee meeting	PS (Health)	Members of State TB-HIV Cordination Committee	Biannual
	State Working Group Meeting for HIV/TB collaborative activities	PD-SACS / STO	Members of State Working Group for HIV/TB collaborative activities	Quarterly
	State DOTS-Plus Committee meeting	PS (Health)	State DOTS-Plus Committee members	Quarterly
	Review of RNTCP Accounting	State Accountant	District level Accountant	Biannual Review and One for PIP
	Review of Drug management	State Drug Store Manager	District Drug Storekeepers	Biannual
	Review of data management	State epidemiologist and state Statistical Assistant	District DEO/Statistical assistant	Biannual
	Workshop for Other Sector Health Facilities such as Railways, ESI, CGHS, Mines, etc…	STO	Representatives from Other sector Health facilities	Annual
	Review Meeting of Partners	STO	All Partners	Biannual
District	District Health Society Review (RNTCP included as an agenda item)	District Magistrate / Chairman District Health Society.	CMHO, All programme heads in district, Block Medical Officers, MO-PHIs (infrequently)	Quarterly

Level	Type of Review	Chairperson	Participants	Frequency
	CMHO Monthly Meeting with Block Medical Officers and MO-In charge PHCs (RNTCP included as an agenda item)	CMHO	All Block Medical Officers, MO-In-charge PHC, and Superintendent CHC.	Monthly
	RNTCP performance review	DTO	MOTC, STS and STLS	Monthly
	Medical college performance review	Core Committee Chairman of the respective Medical College	Core Committee Members of the respective Medical College and DTO	Quarterly
	TB-HIV District Coordination Committee meeting	Chairperson of TB-HIV District Coordination Committee	Members of District TB-HIV Coordination Committee	Quarterly
	Review of Drugs and Logistics	DTO and DTC Pharmacist	Pharmacists/Incharge Storekeeper of all TUs and PHIs	Quarterly
	DOTS-Plus site committee meeting	Chairperson/Coordinator DOTS-Plus site	DOTS-Plus site committee members, DTOs / Sr.DOTS-Plus-TB-HIV Coordinator	Monthly
	Workshop with Partners and other sector hospitals such as Railways, ESI, CGHS, IMA, AYUSH, NGOs, External funded projects etc…	CMHO/DTO	Representative from Partners	Biannual
	Review of TB-HIV collaborative activities along with RNTCP monthly meeting	DAPCU/DTO	ICTC/CCC Counsellors, STS,_DOT-Plus-TB-HIV Coordinator	Monthly
Block	Block Level Meeting with MO-In-charge PHI and other staff. (RNTCP included as an agenda item)	Block Medical Officer	MO-I/C-PHC and other staff.	Monthly
PHI	Monthly Meetings with Staff (RNTCP included as an agenda item)	MOIC, PHC	MPHS/ANM/MPW/ASHA	Monthly

Annexure I8 A

TB Notification reporting format for **Laboratory**

Period of reporting: From ...../...../..... To ...../...../.....

Health Establishment code for TB Notification

Name of the Laboratory :.....

Registration Number:..... Telephone (with STD):.....

...../.....

Mobile number:.....

Complete Address: .....

.....

Sr No	Name of TB Patient (surname first)	Father / Husband's name	Age (yrs)	Sex (M/F/O)	GoI issued identification number *	Complete residential address	PIN number	Patient Phone number	Date of TB Diagnosis	Date of sputum collection	Date of result	Type of Test result (smear microscopy positive / culture positive / MTB on LPA / MTB on Xpert / MTB in FNAC / TB on Histopath/ DST	DST results for each drug tested (R=resistant / S=sensitive/NA=not available) Rif, INH, SM, EMB, Ofx, Km, Eto, Cipro, Capr, etc $							
													Rif	INH	SM	EMB	Ofx	Km	—	—

*** Aadhaar, driving license, voter ID, ration card, PAN no, passport no etc**

Laboratories include those Health Establishments carrying out any of the RNTCP endorsed TB diagnostics

Signature:.....Date: ...../...../.....

Annexure I8 B

TB Notification reporting format for Medical practitioners / Clinics/Hospitals/Nursing homes

Period of reporting: From ...../...../..... To ...../...../.....

Name of the health facility / practitioner :.....(single/Multi)
Registration Number:..... Telephone (with STD):.....
Mobile number:.....
Complete Address: .....

Health Establishment code for TB Notification

...../.....

Sr No	Name of TB Patient (surname first)	Father / Husband's name	Age (yrs)	Sex (M/F/O)	GoI issued identification number *	Complete residential address	PIN no	Patient Phone number	Date of TB Diagnosis	Date of TB treatment initiation	Site of Disease (P / EP)	Patient Type (New TB case/ Recurrent TB case/ Treatment change)	Basis of diagnosis (Smear microscopy / culture / PCR / LPA/ FNAC/Histo-pathology/Clinical exam/X-Ray)	Weight in Kg	Drugs and dosages (in mg) H/R/Z/E/S/ O/K/Cs/Eto/ Levo/Mx/Cpr/ Other (specify)

*** Aadhaar, driving license, voter ID, ration card, PAN no, passport no etc**

Private practitioner / Clinic (single) will include any Health Establishments where TB cases are treated or diagnosed clinically / radiologically and the medical services are provided by single medical practitioner
Hospital / Clinic / Nursing Home (multi-practitioners) will include any Health Establishments where TB cases are treated or diagnosed clinically / radiologically & medical services are provided by more than one practitioner

Signature:.....Date: ...../...../.....

Page 1

TB Notification reporting format for
Medical practitioners / Clinics/Hospitals/Nursing homes

Period of reporting: From ...../...../..... To ...../...../.....

Health Establishment code for TB Notification

Name of the health facility / practitioner :.....(single/Multi)

Registration Number:..... Telephone (with STD):.....

...../.....

Mobile number:.....

Complete Address: .....

Patient ID	Patient home visit Done (Y/N)	If Yes, done by	Patient counselling Done (Y/N)	Type of treatment adherence (DOT/ SMS/ Phone/ Nil)	Status of patient (regular/ Not regular / defaulted)	Month at which FU examination done	Status at FU examination (SM/Cult) (Pos/Neg)	Clinical improvement (Yes/No)	No of contacts	No of contact symptomatic	No found to have TB among contact	No of contacts initiated on anti-TB treatment	No of contacts offered chemoprophylaxis	HIV testing offered (No/Neg /Pos)	DST testing offered (No/RIF resistance /RIF sensitive/ Indeterminate)	Treatment Outcome (C/TC /F/D /LTFU/TO /RC)

C=Cured, TC=Treatment Completed F=Failure D=Died LTFU=Lost to FollowUp TO=Transferred Out RC=Regimen Change

This information on page 2 is to be submitted during treatment and after treatment completion with sosupdation in Nikshay with public health action support by local public health staff.

Signature:.....Date: ...../...

Page 2

Financial Reporting requirements under RNTCP at various levels

Annexure 19

Level I-At State TB Cell

	Name of report	Basis of Preparation and Key Checks	Frequency/Timelines	Responsibility	Assisted by	To Whom
1	Financial Monitoring Report(FMR)	• Should be prepared from Book of Accounts • Only actual expenditures to be reported • Proper classification of expenditure/sub heads to be ensured	Quarterly, to be submitted within 21 days from the close of quarter.	STO/ APO	State accountants	FMG NHM , GoI with copy to CTD
2	Statement of Expenditure(SOE)	Consolidated SOE along with individual SOE of STCS, DTCS/MTCS	Quarterly, to be submitted within 21 days from the close of quarter.	STO	State accountants	CTD-MoHFW & State NHM
3	Statement of Fund position	To be submitted with FMR and SOE Should be duly reconciled with FMR, SOE and books of accounts	Monthly	STO	State accountants	CTD-MoHFW & State NHM
4	Utilisation certificate	Should be prepared sanction wise Should be as per Form 19A Final UC should be as per the expenditures certified in audit report	Annual By 31st July along with the audited statements	STO/APO	State accountants	CTD-MoHFW & State NHM
5	Statement confirming State's contribution	Should provide details of instruments indicating the fund transfer to STC through SHS NHM.	Quarterly	STO/APO	State accountants	CTD-MoHFW & State NHM
6	Preparation of Final Accounts	This will be prepared by STC for the purpose of Annual Audit		STO	State accountants	
7	Audited statement of accounts and Audit reports of STC	As per Audit Format given in NRHM Financial Manual	Annual , to be submitted by 31st July of following year	STO	State accountants	CTD-MoHFW & State NHM

- Format of all these will be provided in updated guideline for NRHM Financial Management for state and districts.
- Bank Reconciliation Statement should be submitted on a quarterly basis along with the FMR.
- Executive Summary of concurrent audit report should be submitted on a quarterly basis. This is being carried by NHM.

Level II - at district Level

	Name of report	Basis of Preparation and Key Checks	Frequency/Timelines	Responsibility	Assisted by	To Whom
1	Financial Monitoring Report(FMR)	• Should be prepared from Book of Accounts • Only actual expenditures to be reported • Proper classification of expenditure/sub heads to be ensured	Quarterly, to be submitted within 15 days from the close of quarter.	DTO	District accountant	State/State TB Cell
2	Statement of Expenditure(SOE)	SOE of District TB Cell	Quarterly, to be submitted within 15 days from the close of quarter.	DTO	District accountant	STC
3	Statement of Fund position	To be submitted with FMR and SOE Should be duly reconciled with FMR, SOE and books of accounts	Monthly	DTO	District accountant	STC
4	Utilisation certificate	Should be prepared sanction wise Should be as per Form 19A Final UC should be as per the expenditures certified in audit report	Annual By 21st July along with the audited statements	DTO	District accountant	STC
6	Preparation of Final Accounts	This will be prepared by STC for the purpose of Annual Audit		DTO	District accountant	
7	Audited statement of accounts and Audit reports of DTC	As per Audit Format provided in NRHM financial guidelines	Annual , by 21st July of following year	DTO	District accountant	STC

Guidelines on activities under ACSM

District teams must formulate ways to strengthen the planning and implementation of the programme initiatives listed below reported in the Quarterly Report on Programme Management and Logistics (QRPML). All efforts need to be made to ensure that the outcome of the initiatives listed below contribute to the achievement of programmatic objectives including better case finding, treatment adherence, notification etc.

Activities	Objective
Patient Provider Meetings	Patient support and improving case holding/treatment adherence
Community Meetings	Improving levels of awareness about TB in the community to improve referrals, adherence and address stigma
School-based activities	Improving levels of awareness, referrals
Sensitisation of PPs, NGOs, PRIs, Others	For advocacy, building allies for support, additional resources, improving case finding, case notification etc.
Outdoor Publicity	Improving levels of awareness about TB, referrals, adherence and addressing stigma etc.

Patient Provider Meetings

Facilitators: These meetings are organized by the DOT Provider. STS/ Medical Officer are to conduct these meetings. **Purpose:** The purpose of the meeting is to counsel patients in a group who are on treatment or who are about to begin treatment. This is an opportunity for free interaction between provider and patient and also an opportunity for patients to clarify their doubts, if any.

Target Group: Patients on treatment or who are about to begin treatment. There could be 5- 10 patients (minimum) in each such meetings. *(If there is large number of patients at one centre, small groups of about 10 patients may be made so that better interaction takes place between patients and providers*)

Place: These meeting are to be organized at the health facility. **Duration and Frequency**: These meetings can be organized once a month so that each patient who is on treatment has the opportunity to attend one such meeting during the intensive phase. ***(Frequency of such meeting would be more than one in a month when the number of patients is large at one health facility)***

Each meeting can be for half hour to one hour. The patient may be provided refreshments (tea etc.)

Kindly note that patient provider interaction meetings are additional to and are different from interpersonal communication that provider has with the patient while administering treatment.

Messages for Patients:

1. Basic information about tuberculosis, cough etiquette etc.
2. Importance of completing treatment
3. Side-effects of drugs and how to manage these
4. Importance of follow up sputum examination
5. Prophylaxis for children in the family
6. Do's and don'ts including protective measures, role of nutritious diet etc.

Health Communication Materials: Flip Book; Banner; Posters on TB etc.

Report writing: At the end of each meeting, a report may be prepared stating date and time of meetings, number of patients, name of facilitators and topic covered along with major concerned mentioned by the patients. The report is to be prepared by the STS. The list of patients who attended the meeting may be attached with the report. It may be more convenient to have register at each centre for such meetings and patients can put their name in the same register.

The STS should indicate organization of these meetings in their tour dairy indicating place, number of patients, presence of MO in the meeting and main points discussed in the meetings. These may be submitted by STS to MOTC on a monthly basis for onward submission to DTO to be included in quarterly PMR report.

Community Level Meetings

Facilitators: These meetings are organized by the STS and conducted by the Medical Officer.

Purpose: The purpose of the meeting is to create awareness about signs and symptoms of TB, availability of diagnosis and free treatment in the health facilities, availability of good quality drugs under the direct observation of the DOT provider. Provision of drugs in patient wise boxes, option of community DOT Providers can also be highlighted in these meetings.

Target Group: General public, patients, community leaders/ people's representative including SHGs, NGOs, Community Volunteers, Traditional healers, people practicing other systems of medicine. There should be at least 20-25 people in these meetings.

Place: These meeting are to be organized at the village or block level. These can be organized in the community centre, or any other important place in the community.

Duration and Frequency: These meetings can be organized once a month and each meeting could be for one hour to two hours.

The participants may be provided refreshments (tea/ snacks etc.)

Messages for Patients:

TB signs and symptoms; availability of diagnosis of good quality treatment in the health facility; location of nearest health facility; provision of drugs in patient-wise boxes; Importance of treatment under direct observation; Importance of completing of treatment; option of community DOT providers

(These may be given in the form of discussion, lecture. Street play can also be organized followed by discussion and question answer session)

Health Communication Materials:

Banner; Posters on TB; Pamphlets; mike; exhibition material; audio visual materials where possible

Report writing: At the end of each meeting a report may be prepared stating date and time of meetings, number of persons, name of facilitators and topic covered along with major concerned mentioned by the people. The report is to be prepared by the STS. List of persons who attended the meeting may be attached with the report.

STS should indicate organization of these meetings in their tour dairy indicating place, number of persons, presence of MO in the meeting and main points discussed in the meetings. These may be submitted by STS to MOTC on a monthly basis for onward submission to DTO to be included in Quarterly Report on Programme Management and Logistics (QRPML) or Programme Management Report.

School-based Activities

Awareness generation amongst students and teachers of schools and colleges regarding tuberculosis

Steps for organizing school activities

- ✓ Contact the department of school education at state/district level (whichever applicable) to bring them on board in the fight against TB.
- ✓ Take necessary approvals to enlist schools and colleges in the district.

- ✓ Organize training of trainers (TOT) for school teachers, who can also conduct school activities in a planned and coordinated manner to maximize impact. These can also be done in coordination with the school health programme.
- ✓ Display and distribute appropriate support materials like posters/charts/videos/pamphlets, etc. in local language that may be provided by the state government and for which the prototype may have been prepared by the centre.
- ✓ Help the schools utilize the opportunity innovatively by involving students in group activities like painting competitions, dramas/plays, road shows etc.

The initial visit to the school may include simple messages through quiz contests, games, essay writing, drawing and slogan competitions etc. on TB and related issues. Conclude the event with take home messages and how the students can participate in awareness generation; students and teachers can convey TB related key messages to parents, discuss the issue in the Village Health and Sanitation Committee meetings or with prominent people in the community etc. Some token gifts like pen, pencils, key rings, colour boxes, notebooks etc. can be distributed as prizes to the students.

The subsequent visit to the school/college can be done after 2-3 months to follow up and re-sensitization. Follow up visit should start with a quiz to gauge recall level of the information shared during the previous visit followed by planned activities and distribution of prizes.

In this context, following activities need to be carried out in time bound manner:

1. Issue letter with details from STOs to all the DTOs and municipal health officers, with copy to state/UT Education Director and CTD annually
2. DTO should ensure the preparation of block-wise enlisting of all the schools and colleges in the district to make sure no government/private school/college is missed out. For this purpose, DTOs can seek help from the District Education Officers.
3. Preparation of a detailed district specific action and monitoring plan containing – name of the district and block, name of the school, name of the health functionaries responsible to visit, date of visit, activity planned (specific), resource material required, name of the officials responsible for monitoring (monitoring on random basis covering nearer and remote areas). For this purpose can involve STS, Axshaya project and CBCI functionaries. The action and monitoring plan can be developed block-wise. At least 2 school activities should be monitored on monthly basis.
4. Submission of the district-wise action and monitoring plan by DTOs to the STOs.
5. Submission of the state/UTwise action and monitoring plan by STOs to the CTD.
6. Activity to be undertaken during the month of Aug/Sep 2012 (first visit) and Nov/Dec 2012 (second visit).
7. Submission of the district-wise report on outcome of the activity (covering both the visits) by DTOs to the STOs.

8. Submission of the state-wise report on outcome of the activity (covering both the visits) by STOs to the CTD.

Sensitisation of PRIs, NGOs, PPs etc.

Facilitators: These meetings are to be organized by the District PPM Coordinators/STS in consultation with DTO and other relevant cadres at the District and Sub-District levels.

Purpose: The purpose of these meetings/interactions is to create greater awareness about the need for public action on TB and generate specific commitment from target audience on how they would support TB control and care efforts.

Target Group: Elected representatives under the 3-tier Panchayati Raj System, community leaders, SHGs, NGOs, Community Volunteers etc.

Place: These meetings can be organized at the District, village or block level. These may be done individually, in groups or at any other available forums such as IMA meetings, hospitals/Clinics, NGO forums/offices, Gram Panchayat meetings etc.

Duration and Frequency: Meetings with each of these stakeholders must be organized a minimum one with each group per month. These meetings may be done individually but it is preferable to do this in groups.

Key Messages:

1. Facts about TB
2. RNTCP programme and services
3. The need to support the TB programme for a TB-free India

Health Communication Materials:

Banner, posters on TB, pamphlets, exhibition and audio visual materials where possible

Report writing: At the end of each meeting a report may be prepared stating date and time of meetings, number of persons met, name of facilitators and topic covered along with details of any commitments made by any participant. The report is to be prepared by the District PPM Coordinator/ STS. List of persons who attended the meeting may be attached with the report.

District PPM Coordinator/ STS should indicate organization of these meetings in their tour dairy indicating place, number of persons, presence of RNTCP officials/cadres in the meeting and main points discussed in the meetings. These may be submitted by District

PPM Coordinator to DTO and by STS to **DTO or MOTC** on a monthly basis for onward submission to be included in Quarterly Report on Programme Management and Logistics (QRPML) or Programme Management Report.

World TB Day

The World TB Day is observed each year globally on March 24. In India, numerous events and activities are organized at national, state, district, and community levels to draw public attention to TB as a major health problem and efforts being made under RNTCP for TB care and control. The World TB Day represents a worldwide call to action as well as helps mobilize political and social commitment at the national level. It is necessary to plan it well, to derive maximum benefit. As a major media event, the World TB Day provides a good opportunity to draw attention towards:

1. Good work done under RNTCP
2. Local/regional/national TB scenario to inform and emphasize the urgency
3. Role of different sections of society and service providers to bridge gaps
4. Gaps and what more needs to be done
5. Mobilize support of stakeholders and increase commitment from local leaders/health managers/ administrators to fight TB
6. Attract media attention/coverage to emphasize the urgency of TB control for wider understanding, support, and commitment
7. Co-opt new groups as partners such as businesses, private practitioners etc.
8. NGOs and professional bodies, which are important in the fight against TB

Plan for World TB Day at the start of the year while formulating the District Annual Action Plan and PIP.

Essential reading material:

1. Operational Handbook on ACSM for RNTCP
2. RNTCP Health Communication Strateg

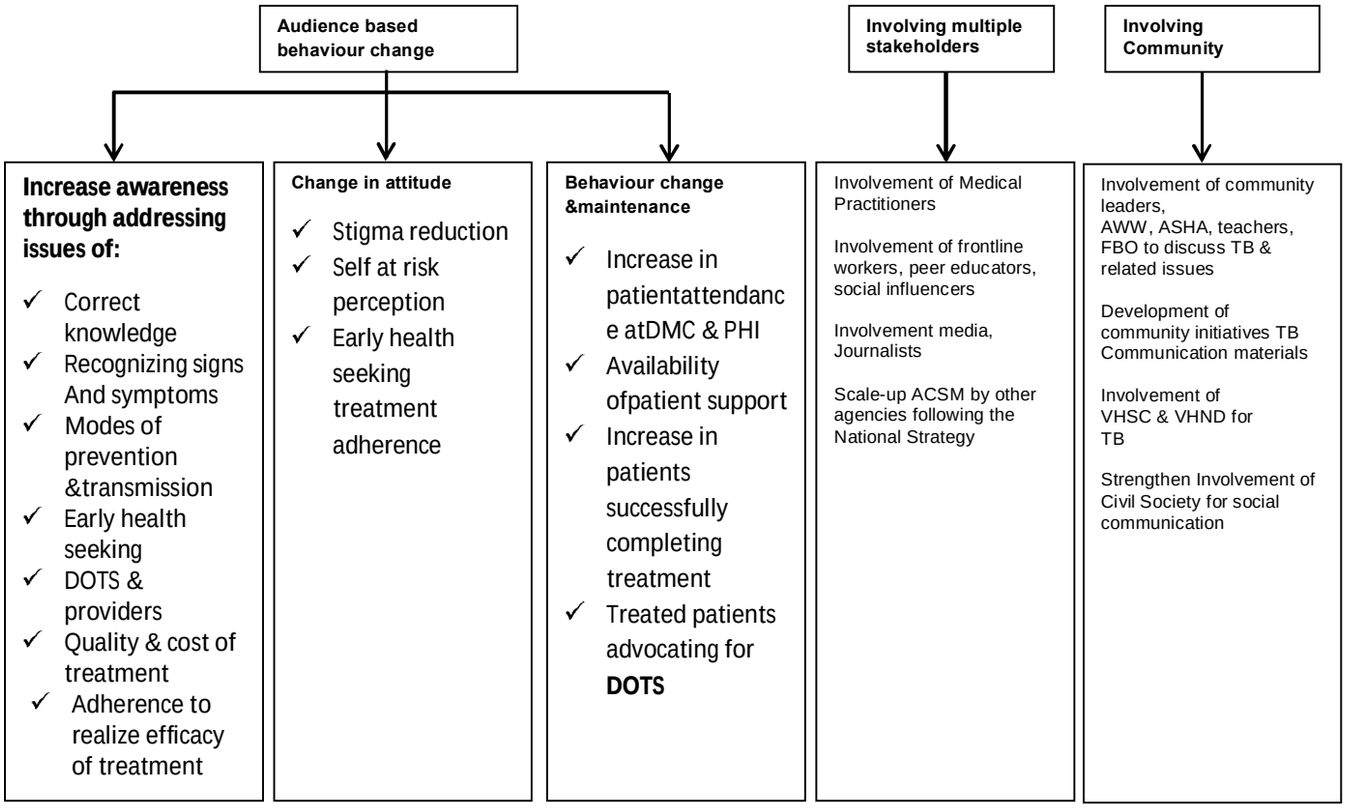
Strategic approach to plan ACSM activities

Strategies are broadly classified in to two groups

For greater demand for early diagnosis and treatment, improvement in thehealth seeking behaviourthrough empowered community structures andother stakeholders, using evidence based BCC strategies will be adopted.

For ensuring supply of quality assured diagnosis andtreatment,enhancement of political will and commitment of policy makers atnational, state and community levelwill be focussed. This will be achievedby effectively engaging with other stakeholders including media, NGOs, patient support groups etc to support advocacy and communication.

The diagram below is an illustration of the broad strategy that would be adopted for designing activities.



Annexure 21

Bio Medical Waste Management

Categories of Bio-Medical Waste- There are 10 categories of the bio medical waste which as tabulated as below-

Option	Treatment & Disposal	Waste Category
Cat. No. 1	Incineration /deep burial	Human Anatomical Waste (human tissues, organs, body parts)
Cat. No. 2	Incineration /deep burial	Animal Waste Animal tissues, organs, Body parts carcasses, bleeding parts, fluid, blood and experimental animals used in research, waste generated by veterinary hospitals / colleges, discharge from hospitals, animal houses)
Cat. No. 3	Local autoclaving/ micro waving/ incineration	Microbiology & Biotechnology waste (wastes from laboratory cultures, stocks or specimens of micro-organisms live or attenuated vaccines, human and animal cell culture used in research and infectious agents from research and industrial laboratories, wastes from production of biological, toxins, dishes and devices used for transfer of cultures)
Cat. No. 4	Disinfections (chemical treatment /autoclaving/micro waving and mutilation shredding	Waste Sharps (needles, syringes, scalpels blades, glass etc. that may cause puncture and cuts. This includes both used & unused sharps)
Cat. No. 5	Incineration / destruction & drugs disposal in secured landfills	Discarded Medicines and Cytotoxic drugs (wastes comprising of outdated, contaminated and discarded medicines)
Cat. No. 6	Incineration , autoclaving/micro waving	Solid Waste (Items contaminated with blood and body fluids including cotton, dressings, soiled plaster casts, line beddings, other material contaminated with blood)
Cat. No. 7	Disinfections by chemical treatment autoclaving/micro waving& mutilation shredding.	Solid Waste (waste generated from disposable items other than the waste sharps such as tubing, catheters, intravenous sets etc.)
Cat. No. 8	Disinfections by chemical treatment and discharge into drain	Liquid Waste (waste generated from laboratory & washing, cleaning , house-keeping and disinfecting activities)
Cat. No. 9	Disposal in municipal landfill	Incineration Ash (ash from incineration of any bio-medical waste)
Cat. No. 10	Chemical treatment & discharge into drain for liquid & secured landfill for solids	Chemical Waste (chemicals used in production of biological, chemicals, used in disinfect ion, as insecticides, etc)

Note-

- Chemicals treatment using at least 1% hypochlorite solution or any other equivalent chemical reagent. It must be ensured that chemical treatment ensures disinfections.
- Mutilation/shredding must be such so as to prevent unauthorised reuse.
- There will be no chemical pre-treatment before incineration. Chlorinated plastics shall not be incinerated.
- Deep burial shall be an option available only in towns with population less than five lakhs and in rural areas.
- Chemicals treatment using at least 1% hypochlorite solution or any other equivalent chemical reagent. It must be ensured that chemical treatment ensures disinfections.
- Mutilation/shredding must be such so as to prevent unauthorised reuse.
- There will be no chemical pre-treatment before incineration. Chlorinated plastics shall not be incinerated.
- Deep burial shall be an option available only in towns with population less than five lakhs and in rural areas.
- The most essential part of hospital waste management is the segregation of Bio-medical waste. The segregation of the waste should be performed within the premises of the hospital/nursing homes. The colour coding, type of container to be used for different waste category and suggested treatment options are listed below.

COLOR CODING & TYPE OF CONTAINER FOR DISPOSAL OF BIO-MEDICAL WASTE

Colour Coding	Type of containers	Waste Category	Treatment Options as per Schedule 1
Yellow	Plastic bag	1,2,3,6	Incineration/deep burial
Red	Disinfected Container/ Plastic bag	3,6,7	Autoclaving/Micro waving/ Chemical Treatment
Blue/ White translucent	Plastic bag/puncture proof container	4,7	Autoclaving/Micro waving/ chemical treatment and destruction/shredding
Black	Plastic bag	5,9,10 (Solid)	Disposal in secured landfill

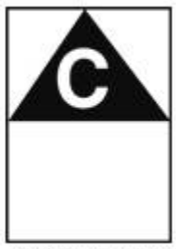
LABEL FOR BIO-MEDICAL WASTE CONTAINERS/BAGS-

Different labels for Bio-medical waste containers and bags shall be required for identification and safe handling of this waste. These labels for storage/transportation of Biomedical waste are as under-

BIOHAZARD SYMBOL
जैविक परिसंकट चिन्ह

BIOHAZARD
जैविक परिसंकट

CYTOTOXIC HAZARD SYMBOL
कोषिकाविष परिसंकट चिन्ह



CYTOTOXIC
कोषिकाविष

LABEL FOR TRANSPORT OF BIO-MEDICAL WASTE CONTAINERS/BAGS

	Day:_____ Month _____
	Year _____
Waste Category No. _____	Date of generation_____
Waste Class	
Waste Description	
Sender's Name & Address	Receiver's Name & Address
Phone No.:_____	Phone No.:_____
Telex No. _____	Telex No. :_____
Fax No. _____	Fax No. :_____
Contact Person _____	Contact Person:_____
In case of emergency please Contact:	
Name & Address:	
Phone No.	

Appendix

Drug dosages for first line anti-TB drugs

Drugs	Adult	Children
Isoniazid	5 mg/kg (4 to 6 mg/kg) daily	10 mg/kg (7-15 mg/kg) daily
Rifampicin	10 mg/kg (8-12 mg/kg) daily	15 mg/kg (10-20 mg/kg) daily
Pyrazinamide	25 mg/kg (20-30 mg/kg) daily	30 mg/kg (30-40 mg/kg) daily
Ethambutol	15mg/kg (12-18 mg/kg) daily	20 mg/kg (15-25 mg/kg) daily
Streptomycin	15 mg/kg (15-20 mg/kg) daily	15 mg/kg (12-18 mg/kg) daily