Minutes of the Meeting on Intensified Monitoring of 25 select districts held on 27th October 2005 held at Nirman Bhavan, New Delhi

A meeting was organized under the chairmanship of Shri Deepak Gupta, Additional Secretary (Health) on 27th October 2005. Mr Taufiqur Rahman (Fund Portfolio Manager, GFATM) and Mr. Ramesh Chandra (Country Coordinator, UNOPS) from the Global Fund for AIDS, TB and Malaria (GFATM) also attended the meeting. The list of participants from the selected districts, respective RNTCP Consultant is annexed.

Following brief welcome and introductory remarks by DDG-TB, Shri Deepak Gupta-Additional Secretary (DG) appreciated the efforts of Central TB Division under the leadership of Dr LS Chauhan (DDG-TB), the State and District Programme Managers and WHO Consultants in achieving the global targets of 85% cure rate and 70% detection rate amongst new smear positive patients at the national level. AS (DG) mentioned that the real programme performance would be when every district in the country achieves these targets, which would then lead to achieving the desired epidemiological impact. He also mentioned that in his view, besides the two objectives of RNTCP, there is a need to ensure "Equity of RNTCP services" so that they reach the poorest of poor, the marginalized and under privileged and hard to reach population, so that case detection is increased in those populations and emphasized the need to orient systems and efforts to serve these groups. AS (DG) recalled that a meeting was organized in May 2003 to review performance of 25 select districts with low case detection rates. He observed that low case detection rate of 30-40% even with good cure rates would not have the desired epidemiological impact on TB control activities.

Mr Taufiqur Rahman thanked the Chair and highlighted the mechanism of GFATM funding and emphasized that GFATM funding is based on the achievements of the targets proposed by the respective countries in the project areas.

DDG (TB) in his presentation highlighted the following objectives of the meeting:

1. To review the performance of 25 selected districts.
2. To identify challenges in implementation of the good quality program and solutions to the same.
3. To build the capacity of the select DTOs on:
    a. Step wise approach to improve case detection through Public Private Mix
    b. Monitoring and Supervision Strategy
    c. EQA processes and reporting
4. To draw up plans for improving the program in the select districts in next six months

He also briefed about the mode of selection of the districts which was based on population (> 2 million), trends in programme performance indicators and field review by senior officials from centre and state. Prior to this meeting, 25 districts were identified; district profile and TU-DMC wise analysis of these 25 select districts were obtained and analyzed prior to the meeting at CTD and all DTOs were requested to come with their action plan in form of a presentation.

AS and DDG-TB stressed that the purpose of the meeting was not a fault finding mission but to identify constraints in implementation of RNTCP and address these issues not only

in the select districts but also to see how performance can be improved in other similarly placed districts. It was stated that the performance of high population districts (and states like Bihar and Uttar Pradesh) will determine the level of national performance.

This was followed by presentations from the individual districts.

The major observations and actions recommended are:

Intensified Monitoring: The recommendations of the meeting on intensified monitoring of the 25 select districts include:

- The 25 select districts will be monitored regularly at the National level. Follow up meeting would be held after 6 months.
- The districts should submit a detailed action plan (along with Gantt chart) for next 6 months to improve programme performance and address district specific problems identified (see Annex I & II) in the review meeting.
- DTOs should submit fortnightly progress reports on specific issues and common constraints (Annex 1 & 2) to the state and CTD on activities undertaken towards improving the performance.
- STO to closely monitor performance of districts with reference to issues discussed during the review meeting (Annex I & II).
- DTOs of the 25 select districts to submit their tour reports immediately after a field visit to the STO at least for the next 3 months. Thereafter they may submit their tour reports on a monthly basis.
- DTOs are programme managers and should minimize clinical work at the DTC so as to provide maximum time to programme implementation, supervision and monitoring.
- CTD to plan visits to some of these select districts over the next 6 months.
- Minutes of meeting of State Review meetings to be monitored at CTD and progress reports/action taken reports to be regularly reviewed with the State. The STO, assisted by the headquarter consultant should send a compliance report on the minutes in next 3 months.

AS said he would like to go through the reports of Consultants for select districts every month /fortnight whenever they visit the district.

In recognition of the efforts of *good programme managers* in the country and to encourage continued support to the programme, the following were recommended:

- Letter from Secretary-Health, GoI may be sent to states complimenting performance by good STOs/ DTOs
- Such identified DTOs may be rewarded at national level on World TB Day. They would be also sent to other states for field visits to share experiences.
- To invite 2-3 good performing districts for such review meetings at the national level for sharing their experiences.
- States to grade DTOs based on objective assessment on a regular basis.

It was also recommended that **all states** should *conduct the review meetings* on similar lines as adopted at the national level.

- It has been noted that the technical competence/ knowledge of the DTOs is sub-optimal. Being programme leaders in the district it is expected that highest level of competence is attained by all. All DTOs were directed to familiarize themselves with the revised MO modules (1-9) and Strategy Document on Supervision and Monitoring and other documents published by CTD, and ensure all RNTCP guidelines are followed in their districts. RNTCP Consultants should facilitate the process. This must be done for all DTOs in the country. DTOs who performed poorly in the test at the meeting would undergo a refresher training. CTD will send separate communication on this to the concerned STOs.
- To assess the technical competence/ knowledge of programme managers, a written test (for 1 hour) may be conducted at the beginning of review meeting. This would help in objective assessment of DTOs and also to identify key areas to focus on capacity building of DTOs. DTOs may undertake similar exercises in their districts.
- Trend analysis of TB suspect examination rates at DTCs so as to monitor decentralization of diagnostic services in the district
- Trend analysis of performance of TUs – to identify under- performing TUs and take remedial actions. MO-TCs from select under-performing TUs (MO-TCs) and better performing TUs may be invited for the state level review meetings.
- DTCS meetings and programme review meetings at the district level to be held as per the guidelines stated in Strategy Document on Supervision and Monitoring of RNTCP. Minutes of such meetings to be shared with State. State to monitor the same.

Programme performance: Some of the common problems identified in the 25 select districts include staff vacancy; non established or non-functioning DMCs; poor financial management; poor referrals and high initial default rate; high default rates; low commitment of MOs/ paramedical staff/DOT providers; lack of supervision and limited involvement of other sectors.

Vacancy of key program staff:

- Vacancy of key program staff (DTO/MO-TC/STS/STLS/ DMC-LT) in the districts to be monitored strictly every quarter. It was noted that in many districts vacancies have been there for several months, sometimes over a year.
- All districts while appointing contractual staff should prepare a panel list (including separate panel list for reserved categories) which would be valid for one year to ensure quick replacement in case of vacancy.
- It was observed that some districts were carrying out fresh appointments of contractual staff (new staff) every year. Such practices adversely affect the programme implementation and monitoring and should be discouraged. Extension or dissolution of contracts should be strictly linked to performance. CTD would further ensure this by sending a DO letter to this effect to States/Districts.
- LTs should be made more accountable towards maintenance of Binocular Microscopes. A functional BM, as a result of good maintenance should be considered as one of the factors for assessing the performance of LTs during their performance review for extension of their contract. This is a special problem in Bihar. STO and all Consultants especially in Bihar should ensure that DTCS Chairperson are sensitized about the same and take necessary action.

- In resource limited states, sputum microscopists (such as BCG vaccinators, Lab Attendants, etc) may be identified and trained so as to carry out sputum microscopy where full time LTs are not available in the DMCs.
- DTOs with the help of CDMO/CDHO should ensure DMCs with heavy OPD have a full time trained LT available at all times.
- DTCSs and STCSs should ensure that full utilization of provisions made under RNTCP for appointment of contractual staff (including 2nd MO-DTCs, LTs and TBHVs).

Non established and Non functioning DMCs

- DMCs to be established as per population norms (i.e. 2001 census extrapolated to 2006) –atleast one per 1 lakh population.
- Minor repairs for maintenance of DMCs to be undertaken from DTCS funds
- In areas where there is lack of public or private health facility as a DMC, sputum collection centres to be established. This area which has been neglected needs to be strengthened.
- Functional binocular microscopes are essential. States to monitor availability of functional BMs in the DMCs and DTOs to ensure the same.

Financial Management related issues

- Irregularities/ delays in fund flow from state to district have been noted in several states especially UP and Bihar. All states should closely monitor and ensure smooth fund flow to the districts so as to avoid shortage of funds especially in contractual services and laboratory consumables heads. Streamlining of fund flow mechanisms from state to districts
- Delays in payment of contractual staff salaries, has been viewed seriously at the meeting, states and districts should ensure that payments of salaries are made regularly and in time.
- Budget for lab consumables should be need based and not necessarily as per population norms. Districts with high TB suspect examination rate can request and utilize more funds under this head.
- Bills for vehicle hiring for DTO/ MO-TCs and POL of STS should be cleared on priority basis to ensure regular supervision and motivation among supervisory staff.
- It was noted that certain districts were submitting SOEs which were contradictory to the actual fund available with DTCS. These differences were quoted to be due to promised disbursement from state which had not been received in the DTCS but yet mentioned in the SOEs. Such "on paper SOEs" are strongly objectionable and the states should avoid such practices.
- State to ensure that the districts submit their SOEs on time. This will help in timely disbursement of funds from CTD to State and subsequently to the districts.
- Consultants to monitor and assess fund status in the districts and intimate the state (and CTD if required) about the districts with likely deficiencies or deficits well in time.
- All districts should send their Annual Action Plans to State with a copy to the Centre so that the State and CTD can disburse funds as per the needs.

Low referrals and high initial default rates

- All TB suspects with cough for 3 weeks or more to be referred for sputum microscopy. Director Health Services may direct all their Medical Officers to strictly follow the RNTCP guidelines.
- DTOs should undertake TU/DMC wise analysis to identify under performing PHIs, reasons for low referrals, and take corrective actions. *This is a critical issue to improve service delivery.*
- Consultants of the 25 select districts to identify treatment seeking behaviour of patients in select TUs with low CDR. The exercise should be completed in one month and reported to state and CTD. *A copy of the report should be shared with AS*
- Districts with problems of cross migration between districts for diagnostic or treatment services to conduct inter district meetings on a monthly basis with bordering districts to strengthen referral for treatment. Consultants should facilitate such cross-linkages.
- DTOs may also develop linkages with Practitioners of Indian Systems of Medicine (ISM) to improve referrals.
- Area specific strategy to be adopted so that Non-registered Rural Medical Practitioners can also refer their patients to general health System for management of TB patients as per RNTCP guidelines. They may also be involved as DOT providers.

Low commitment from MOs/paramedical workers/ DOT providers

- Poor supervision and monitoring is a significant reason for sub optimal performance. All programme staff to follow RNTCP supervisory protocols as defined in the Strategy document on Supervision and Monitoring. States to ensure necessary directives are issued to all health staff through their CDHO/CDMO to follow RNTCP guidelines.
- States where private practice by government doctors is allowed need to ensure (through directives) that all government doctors prescribe anti-TB treatment available under RNTCP, keeping the larger benefit of the common man, community, state and nation as a whole.
- DOT provision by DOT Providers to be monitored by MPW/MPHS; MO of PHI; STS, MO-TCs/DTO.
- All MO-PHIs to ensure initial address verification prior to initiation of treatment, as it facilitates patient counseling, greater compliance to treatment and prompt default retrieval action.

Involvement of other sectors

- Line listing of all important health care providers like Private Practitioners, NGOs, and other public sector health facilities should be undertaken. These partners once identified need to be prioritized (for involvement) based on ABC analysis. They should be followed up on a regular basis for continued sensitization, support and participation in the programme.
- Problems encountered in the involvement of ESI/CGHS/ports/mines/steel and other public sector central level health facilities in the districts should be intimated to CTD for follow up and further support from centre.
- All medical colleges to follow RNTCP guidelines. State, NTF, ZTF and STF should review the performance of each medical college in RNTCP.

Sensitization of CMOs and DMs

- DTOs with the support of STO, STF Members and WHO Consultants should sensitize DMs and CMOs of their districts about RNTCP, its policies and performance in the district on a regular basis. DO Letters to District Collectors from CTD/State may be sent by email with a copy to consultants so as to further follow up on the same.
- Divisional Commissioners of Bihar, Chattisgarh, Jharkhand, Madhya Pradesh, Orissa, and Uttar Pradesh may be invited to Delhi by MOHFW for sensitization on RNTCP. This may be planned in mid January 06.
- STO with the support of DHS should sensitize the CMOs and CDHOs formally at the State Level on RNTCP.
- All the above mentioned activities should be undertaken on a regular basis.

District specific issues and monitoring points are given in the Annex I.

Some additional observations and recommendations made based on performance of RNTCP in states of Uttar Pradesh and Bihar is as follows:

- STO to ensure letter from Election Commissioner with reference to implementation of RNTCP in the state is shared with all DMs.
- AS directed CTD to organize his meeting with Chief Secretary (Bihar) after elections.
- Health Minister and Secretary (Health)-GOI may be requested to review performance of RNTCP in the state of Bihar with the concerned state level officials and further strengthen its implementation.
- AS directed the Consultants in UP to convey to Principal Secretary -Health and Special Secretary-Health that they should ensure timely release of funds to the districts from the state atleast under contractual and lab consumables head.
- The State Accountant should monitor the availability of funds under various heads in the districts so that they can predict shortage of funds at least 3 months prior and thus avoid fund shortage in the districts.
- CTD to review best practices for implementation in Eastern and Western UP and Bihar – identify problems and possible solutions to address them. A draft report may be prepared by end December 05.
- WHO Consultants should review "Treatment seeking behaviour/pattern for TB" in their respective districts/ block wise where case detection is found to be low. They should also analyze TB Suspect examination trends in all the DTCs since the time of implementation of RNTCP to see the workload at DTC and decentralization of diagnostic services. These should be reported by December end.

In his concluding remarks AS directed all the DTOs to ensure that benefits of the programme reach the common man. AS noted that the performance of Bareilly district and to some extent Rampur, was good. AS stated that he would personally monitor the performance of 50 selected districts and review their performance in meeting after 6 months. DDG was requested to identify these districts. Detailed district profile of these districts should be obtained at CTD**.**

The district presentations were followed by a presentation on EQA by Dr. Yamuna, highlighting the RNTCP EQA protocol, and defining the responsibilities of DTO, STLS and LT.

Dr. Mandal in his presentation on "Supervision and Monitoring strategy" highlighted the methodology and emphasized that supervision is not a fault finding exercise but is a systematic process for increasing the efficiency of health workers by developing their knowledge, perfecting their skills, improving their attitudes towards their work and increasing their motivation. During the meeting it had been noted that many DTOs had not gone through the strategy document. Implementation of Strategy document would be an important monitoring point for CTD.

The presentations were followed by a MCQ test for all the DTOs. The results of the test were evaluated and DTOs given feedback. DDG highlighted the need for DTOs to be technically sound for the good of the patient, the programme and also to earn support and respect from superiors and district administrators, including District Magistrates.

Annex I: Specific issues and monitoring points for 25 select districts

District	Specific Issues	Monitoring points
Karimnagar (Andhra Pradesh)	- Low CDR (44%); low referral of suspects (84 per lakh) and low cure rates (68%) - No full time/regular DTO since launch of RNTCP in the district. - 40/141 MOs posts vacant till end of May 05 though filled recently and thus untrained newly recruited staff. - Paramedical staff not owning the program	- Trends of referral of chest symptomatics - Training of all MOs - Letter from DHS/CMO to all medical personnel to follow and support RNTCP guidelines - The district may attempt to improve CDR to 50% by Dec 05 and 60% by Mar- 60%; - Review by CTD after 6 months
Kamrup (Assam)	- Low CDR (56%); high initial default rate (16%) - I additional TU planned, No DMC in District Hospital - Low referrals from the PHI level - Low involvement of ESI - High default rates esp. in Guwahati city, due to a large migratory population, resulting in low success rates - Guwahati being a large TU catering to an urban population of around 10 Lakhs requires more number of TBHVs - Need for streamlining of administrative procedures to ensure that all issues related to DTCS can be addressed /approved faster - Delayed reimbursement of allowances e.g. POL money leading to lack of motivation among the supervisory staff	- TU and DMC at district hospital to be established by Dec 2005; - ESI involvement to be monitored – Nov 05 - Involvement of tibetian Hospital; Paramilitary hospital; TB Hospital to be monitored - Report on all health facilities involved in Kamrup – (other sectors) to be submitted and their performance monitored - Special focus on urban slums - DTO with support of consultants to analyze reasons for high default rate in Guwahati and submit a report in 3 months - To appoint TBHVs as per norms - To strengthen inter-district referrals with the support of STO - DHS/DTO to sensitize DMs on process and procedures - The district may attempt to improve CDR to 60% by Dec 05 and 70% by Mar 06.
Gaya (Bihar)	- Low CDR (24%), low referral of chest symptomatics (44 per lakh); - 24/34 DMCs functional - Civil works – 24 completed, 9 – work started, but not completed, 1 – room not finalized	- All DMCs to be made functional - To do a TU wise analysis and submit an action plan for improvement of performance

	- Salary of contractual staff – not paid since Jan 05 - Supply of lab consumables is not regular - DTCS meeting not held regularly - Poor interest of MOTCs and MOICs in RNTCP	- Sensitization of DMs and CMOs on RNTCP - The district may attempt to improve CDR to 35% by Dec 05 and 50% by Mar 06.
Muzzafarpur (Bihar)	- Low CDR (39%) and referrals (50 per lakh)- declining performance - 15/33 DMCs functional (41 lakh population) - Administrative commitment and prioritization of RNTCP with DM/CS - Vacant positions of Supervisory and technical staff. Second MO-DTC not in place since 1 year - Financial bottlenecks for procurement of laboratory consumables - Poor drug and logistic management - MOs at TUs and DMCs/PHIs not adhering to RNTCP guidelines	- Establish DMCs as per population norms; All DMCs to be made functional - DTO to carry out field supervision - To monitor fund flow; availability of lab consumables and drug and logistic management in the district - Filling up of vacancies
Patna (Bihar)	- Low CDR (57%) - Problems related to purchase of consumables - Poor involvement of medical College - Poor logistic and financial management - AMC contract for BMs in the state awarded to a Delhi based firm – 'Light Instruments' –the firm has not fulfilled the agreement for AMC of BMs in spite of advance fund provision	- AS to discuss with Health Secretary and DM of Patna about issues in RNTCP implementation in Patna - The district may attempt to achieve 70% CDR - Legal Action to be initiated against Light Instruments for the AMC of the microscopes.

Samastipur (Bihar)	- Low CDR (28%); low referrals; high default rate (13%)
	- 22 DMCs for 37 lakh population
	- Frequent change of DTOs (3 DTOs in last 2 quarters) and contractual staff every year
	- Poor financial management & delay in administrative approvals
	- Lack of adequate funds leading to-
	  - Delayed payments of contractual staff
	  - Civil works remains incomplete (of
		- To discourage frequent changes of contractual staff.
		- Streamlining of fund flow and financial management in the district
		- To complete pending civil works in all DMCs
		- The district may attempt to improve CDR to 35% by Dec 05 and 45% by Mar 06.

	12 planned DMCs) - Shortage of lab consumables (upper limit crossed)	
Raipur (Chattisgarh)	- Suspect Examined per lac population (93) & Case detection rate (56%) are low due to poor OPDs, low involvement of NGOs & other sector. - No DTCS meeting held in 2005. - Railway & ESI dispensaries not fully involved. - Lack of full co-ordination of Medical College Raipur. - Supervisory activities are not regular by MO-TCs, BMOs and other field staff.	- Strengthen involvement of Medical college and other sectors - Intensify supervision at all levels - The district may attempt to improve CDR to 60% by Dec 05 and 65% by Mar 06.
Ranchi (Jharkhand)	- CDR 70%, with variations between TUs. Suspect examination rate (12 per lakh) much below the desired levels. - Vacant Post of LTs in 9 DMCs - Untrained status of MO-TCs, MO-DTC, MOs & LTs - Incomplete involvement of general health services in the programme.	- Filling up of all vacant posts - Increased involvement of General health systems - Training of all key programme staff - Letter/telephonic conversation by AS with STO to monitor programme in the state. All pending trainings in the state to be completed immediately - The district may attempt to improve CDR up to 70%. - Full involvement of Medical College
Gulbarga (Karnataka)	- Central Level evaluation recently concluded - Recommendations of state level IE not adhered to. - Low CDR (56%) and cure rate (56%), however success rate is 73%.	- All recommendations of Central IE to be undertaken - Compliance report/Action taken report to be submitted to state/CTD and followed fortnightly. - AS to discuss personally with Mr. Thangarajan on performance of Gulbarga - Strengthen supervision at field level.
Mallapuram (Kerala)	- Low CDR (36%) - Large number of private practitioners in the district - Poor involvement of Medical College	- Consultant to review minutes of meeting held in 2004 and follow up. - Participation of Govt health facilities; general hospitals and specialty hospitals to be strengthened and monitored.

Indore (MP)	- Low CDR (36%) and high initial default rate (10%) - Three DMCs non- functional - 2 out of 5 MO-TC vacant - 60% DMCs under performing - Big Private Sector and other health sectors - Slums (2 Lakh) and large scale of migration (25,000/Y)	- Programme failing due to large scale private practice by government doctors; Letter from DHS to all MOs to follow RNTCP guidelines. - Strengthen involvement of PPs - Increase coordination between VHAI and DTC - To identify 5 DMCs which will act as model DMCs in the district To monitor CDR in areas covered by NGOs separately - The district may attempt to improve CDR to 50% by Dec 05 and 55% by Mar 06.
Cuttack (Orissa)	- Low CDR (40%) and Low referral of symptomatics– Referral from 21 / 25 DMCs is less than 2% - Weak monitoring & supervision at all levels - Cure rate is low (60%) and success rate is 74% - follow up sputum not being performed as per guidelines - DOT rate is low	- Meeting to be planned in mid January (15th January) in Orissa, to review RNTCP in the state and consolidate financial reports. State to submit consolidated reports by 15th January (DANIDA project ends in Dec 2005) - Streamlining of fund flow mechanisms from state to districts - State to ensure SOEs are submitted in time and accurate (not "on Paper SOEs")- may be facilitated during quarterly review meetings where reports are submitted by DTOs, state consolidates the reports and funds are disbursed in a timely manner electronically by email. - Release of funds to districts to be intimated by State to districts - Consultants to monitor and assess fund status in the districts and flag of districts with likely deficiencies or deficits. - Internal evaluation of Ganjam to be planned - Request for 2nd MO DTC in Ganjam
Ganjam (Orissa)	- High CDR (91%); - Quality of sputum microscopy poor - Categorization of patients need to be verified - Very low cure rate (61%); success rate (74%) - Poor financial management (Financial status presented by DTO – quoted as on paper with negative budget)	

		- Letter issued to involve PHI (New) in the state. State and district officers to ensure their involvement and monitor their contribution to CDR.
Ludhiana (Punjab)	- Very high suspect examination rate (195 per lakh); but low CDRs (56%); High initial default rate (10%) - Migratory population being put on Non DOTS - Non cooperation of other sectors Like Railways, Municipal Corporation & ESI - Proper involvement of both private Medical Colleges (CMC & DMC) - Ludhiana- Municipal Corporation buying anti-TB drugs and running a parallel system in the district	- Mechanisms and systems to be identified to ensure all diagnosed patients are initiated on DOTS and necessary transfer-out mechanisms are followed. DTOs to coordinate with neighbouring districts. - Involvement of other sectors to be monitored - to be stopped immediately
Alwar (Rajasthan)	- CDR is 86%; suspect examination rate is 122 per lakh; initial default rate is 10%.- scope for improvement	- To submit action plan on major problems identified - Evaluate and analyze proportion of retreatment cases- trends and proportion arising out of RNTCP and from non RNTCP. – source of retreatment cases
Agra (UP)	- 29 DMCs for a population for 39 lac population - Vacancy of key programme staff(2 STS, 2 STLs and 5 DMC-LTs) - Declining NSP CDR (40% in 2q05) - Irregular and Incomplete Availability of Budget in all Heads - Delays in payment of salaries to contractual staff - Medical Officer untrained - CMO is not sensitized in Agra - Low involvement of Medical College(only 22 out of 100 diagnosed TB patients in Medical College have been put on DOTS - Poor field supervision	- Greater participation of Medical College - Establishment of DMCs as per population norms - Need for monitoring the progress of the 5 DMCs without full time LTs - Filling up of vacancy of key program staff - 2nd MO on contract basis may be appointed for DTC-Agra after state level approval for the same. - DTO Agra to take vehicle on hire instead of using the STDC vehicle which is also utilized for other activities like Pulse Polio Immunization rounds, etc. - A letter may be issued from the AS to DM-Agra about the smooth functioning of DTCS-Agra

Bareilly (UP)	- 28/36 DMCs functional - General awareness in the community and among providers good. - High suspect examination rate (191 per lakh) and high CDR (88%) - Budget for ATT Drugs given to ESI & Rly Hospital.	- Central level IE may be planned to learn from Bareilly experience (high TB suspect examination rate and CDR) - DO letter to shift ex-DTO Bareilly, Dr. R.K. Ratan - to State TB cell to strengthen the programme in the state. - Follow up on request for BMs and LTs for non functional DMCs - Budget for lab consumables – need based – and not as per population norms - Consultant – Bareilly to submit report on problems encountered in involvement of ESI and later to be taken up with ESI Directorate
Jaunpur (UP)	- Low CDR (42%); low referral of suspects; low cure rate and high default rate - Very low referrals at most DMCs - Shortage of funds in major heads over the past year - 2 STLS posts vacant since 8 months - DTO untrained since one year	- Vacancy of key programme staff to be filled and their training ensured - TU and DMC wise analysis with action plan linked to improve performance - The district may attempt to improve CDR to 50% by Dec 05 and 55% by Mar 06.
Kanpur Nagar (UP)	- 26 /41 DMCs functional - 6/26 DMCs without LTs in place - Low CDR (47%) and high initial default rate (20%) - Low cure rate (69%) and high default rate (14%) - Wrong categorization – increase in default. - No proper address verification & default retrieval - Lack of supervision- frequent transfers of contractual staff, No POL - Inadequate DOT Centres - DOT was not happening.	- Involvement of other sectors (ESI; CGHS etc) to be monitored - Strengthen supervision and monitoring - DTOs and MO-TCs to submit tour reports to State regularly - Fortnightly progress report to be monitored and evaluated
Muradabad (UP)	- Declining CDR - DMCs & DOT Centres less in number. - Supervision and monitoring weak at all levels – DTO, MO-TC, STS.	- DMC as per population norms - Problems of poor categorization in the district - POL to STS/STLS not released since Feb 2004 – to be released

	- PHIs other than DMCs involvement – Minimal. - MPWs involvement as DOT provider – Minimal. - NGOs, PPs & Distt. Hospital involvement – Minimal	immediately - Moradabad to review programme performace in Bareilly and replicate - DTO to review tour reports of AS to Moradabad and Rampur and submit action taken report on recommendations made during the visit - Involvement of NGOs/PPs and Minority pockets – to be monitored
Rampur (UP)	- High suspect examination rate (203 per lakh) and high CDR (78%) - Problem of migration of patients to neighbouring district/state - No vehicle available for DTO & MOTC.	- Monthly meeting with DTO of neighbouring districts and consultants – to manage migration/referrals/transfer outs - DTC to hire vehicle for field visits
Varanasi (UP)	- Low referrals at DMCs in rural areas, major proportion of cases coming from urban MCs - Shortage of funds in major heads over the past year - Shortage of loose drugs - Deficient participation of IMS BHU - 2 big NGO hospitals not participating in RNTCP	- BHU participation to be monitored - Urban institution involvement- 2 big NGOs – to be monitored - CTD to take up with State – Marwadi Sansthan supporting non DOTS programme in Varanasi – Organization receives funds from Kolkota based organization- STO WB to follow up and sensitize the organization to follow RNTCP guidelines
East Mednipur (West Bengal)	- Low CDR (50%); referral of suspects; One of the few districts of WB not in the desired target zone(of 70% CDR and 85% cure rate)	- To undertake TU/DMC wise analysis - To ensure worst performing DMC/TUs improve – improve the worst and rest will follow Letter of appreciation to Health Secretary, West Bengal from Secretary Health, GOI – for the support extended to the programme.
Vaishali (Bihar)	- Not represented in the meeting	-
Allahabad (UP)	- not represented in the meeting	

Annex II: Common constraints identified in the select 25 districts

Political and administrative commitment

1. Frequent transfer of DTO (11/25 new DTOs)
    a. Patna, Gaya, Vaishali, Moradabad, Cuttack, Kanpur, Purba Mednipur, Allahabad, Karimnagar, Samastipur
2. DMs not sensitized (6/25 districts)
    a. Patna, Cuttack, Varanasi, Agra, Indore, Samastipur
3. Low involvement of CMO (4/25 districts)
    a. Agra, Muzaffarpur, Karimnagar, Samastipur
4. DTCS meeting not held in 2005 (6/25 districts)
    a. Patna, Gaya, Ludhiana, Raipur, Muzaffarpur, Alwar
5. Vacancy of contractual staff (2/25 districts)
    a. Patna, Jaunpur
6. Avoidable bureaucratic delays (slow file movements jut like routine processing of files in ZP/DMs office)

Case finding/diagnosis

1. Less no of DMCs (2/25 districts)
    a. Moradabad 35 for 41 lac pop, Agra 29 for 40 lacs,
2. Less no of functional DMCs (7/25 districts)
    a. Kanpur 26/41, Allahabad 32/52, Raipur 8/18, Muzaffarpur 15/33, Karimnagar 31/35, Barielly 20% non functional
3. Limited involvement of
    a. Medical Colleges (8 districts)
        i. Agra, Patna, Ganjam, Moradabad, Cuttack, Ludhiana CMC, Barielly, Raipur, Karimnagar 2 Pvt Med Colleges
    b. NGOs (7/25 districts)
        i. Ganjam 0 /12, Cuttack 2/72, Kanpur 2 /18, Varanasi 2 major NGOs not involved, Raipur 3/9, Ranchi 18/108, Kamrup 8/150
        ii. NGO dot provider given incentive for 25% of patients only (Rampur)
    c. PPs (10/25 districts)
        i. Ganjam-0 /72, Cuttack 0/>500, Kanpur 10/282, Varanasi 2/98, Agra 28/121, Indore 45/402, Ranchi 14/1433, Malappuram, Kamrup 20/770, Patna
4. Poor maintenance of BMs (4/25 districts)
    a. Vaishali, 32/42 BMs working in Jaunpur, 5/20 BMs working in Muzaffarpur, 42/50 BMs working in Patna

Treatment related

1. Use of Non RNTCP drugs-Ludhiana
2. Poor involvement of the general health services
3. Difficult patients to treat:
    a. Migratory population
    b. Social Stigma
    c. Alcoholics

d. Non cooperative patients (using political influence and asking for PWB to be given at home)

Supervision

1. RNTCP 4 wheeler not working/ not available (with DM/DMO) 5/25 districts
    a. Rampur, Vehicle with ADMO-Medical – Cuttack, East Mednipur, Barielly, vehicle with DM-Samastipur
2. 2 wheeler for STS/STLS not available (3/25 districts)
    a. Moradabad 2/7, alwar 1 stolen, 1 not given Mallapuram
3. Limited/no MOTC field supervision
4. Less no of trained MOs (7/25 districts)
    a. Kanpur 57/102 trained, Varanasi 183/225 trained, Muzaffarpur 20/125 trained, Karimnagar 60/101 trained, Ranchi 155/352, Malappuram 194/232, Kamrup 137/194 trained
5. Less no of trained MOTC (2/25 districts)
    a. Ranchi 1/6, Malappuram 1/5
6. Unmotivated/ poorly motivated field staff

Finance related

1. Fund flow not smooth from state to district (especially in UP, Bihar)
2. Irregular payment of salaries (12/25 districts)
    a. Patna, Gaya, Rampur, Moradabad, Kanpur, Varanasi, Jaunpur, Agra, Allahabad, Muzaffarpur, Ranchi, Samastipur
3. Shortage of funds for contractual salary/ lab consumables (5/25 districts)
    a. Rampur; Jaunpur, Karimnagar, Ranchi, Samastipur

Annex III: List of Participants

1. Mr. Deepak Gupta – Additional Secretary, GoI
2. Mr. Taufiqur Rahman – Fund Portfolio Manger, GFATM, Geneva
3. Mr. Ramesh Chandra – Country Coordinator - UNOPS
4. Dr. L. S. Chauhan – DDG (TB)

DTOs

5. Dr. A. Rajesham – DTO, Karimnagar
6. Dr. M. Hazarika – DTO, Kamrup
7. Dr. Arun Ku. Maleto – DTO Muzzaffarpur
8. Dr. Rajendra padhy – DTO, Patna
9. Dr. Arjun Prasad – DTO Gaya
10. Dr. Md. Zafar Alam – DTO Samastipur
11. Dr. S. Prasad – DTO Ranchi
12. Dr. K.R. SSonwani – DTO Raipur
13. Dr. Chandrasekhar – DTO Gulbarga
14. Dr. N.M. Sebastian – DTO Mallapuram
15. Dr. M. Hargunamj – DTO Indore
16. Dr. Nagaja. N – DTO, Cuttack
17. Dr. P. Moharena – DTO, Ganjam
18. Dr. Anil Verma – DTO, Ludhiana
19. Dr. S. K. Garg – DTO Alwar
20. Dr. H. B. Singh – DTO, Agra
21. Dr. S.V. Garde – DTO Bareilly
22. Dr. P. C. Mishra – DTO, Jaunpur
23. Dr. J.P. Upadhyay – DTO, Kanpur Nagar
24. Dr. Pradeep Varshney – DTO Moradabad
25. Dr. Subhash Chandra – DTO, Rampur
26. Dr. V.K. Srivastav – DTO Varanasi
27. Dr. P. M. Deb – STO, West Bengal

Representatives from Central TB Division and WHO

28. Dr. V. S. Salhotra – Chief Medical Officer (TB)
29. Dr. P. P. Mandal – Chief Medical Officer (TB)
30. Dr. Suvanand Sahu- NPO (TB), WHO India
31. Dr. S.S. Lal – NPO (TB-PPM), WHO India
32. Dr. J Tonsing, RNTCP WHO Consultant, CTD
33. Dr. Y Mundade - RNTCP WHO Consultant, CTD
34. Dr. S Sehgal - RNTCP WHO Consultant, CTD
35. Dr. R Swamickan-RNTCP WHO Consultant, CTD
36. Dr. N Raizada – TB HIV WHO Consultant, CTD
37. Dr. T Shah - RNTCP WHO Consultant, CTD
38. Dr. P Sai Kumar- RNTCP WHO Consultant, CTD

RNTCP WHO (State/District) Consultants

39. Dr. M. Sukumar - WHO RNTCP Consultant, AP
40. Dr. Dilip Singh, WHO RNTCP Consultant, Assam
41. Dr. Amlan Data – WHO RNTCP Consultant, Bihar
42. Dr. R Varma - WHO RNTCP Consultant, Bihar
43. Dr. D. Parija - WHO RNTCP Consultant, Bihar
44. Dr. K Rade - WHO RNTCP Consultant, Bihar
45. Dr. Garima Pathak - WHO RNTCP Consultant, Chhatisgarh
46. Dr. Deepa Lavangare - WHO RNTCP Consultant, Jharkhand
47. Dr. More - WHO RNTCP Consultant, Karnataka
48. Dr. N. Rajendran - WHO RNTCP Consultant, Kerala
49. Dr. Kalpesh Rahevar - WHO RNTCP Consultant, MP
50. Dr. Meena Som - WHO RNTCP Consultant, Orissa
51. Dr. S. S. Khajuria - WHO RNTCP Consultant, Punjab
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53. Dr. Rajesh Raju - WHO RNTCP Consultant, UP
54. Dr. D.K. Gupta - WHO RNTCP Consultant, UP
55. Dr. Ashu Pandey - WHO RNTCP Consultant, UP
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