MONITORING AND EVALUATION (M&E) PLAN

FOR

INTENSIFIED MALARIA CONTROL PROJECT—II

INDIA

2012—2015 (PHASE II)

Directorate of National Vector Borne Disease Control Programme
Directorate General of Health Services
Ministry of Health & Family Welfare
22, Sham Nath Marg
Delhi 110054

LIST OF CONTRIBUTORS

National Vector Borne Diseases Control Programme

- Dr. G S Sonal — Additional Director
- Dr. Avdhesh Kumar — Additional Director
- Dr. Suman Lata Wattal — Deputy Director
- Dr. Sher Singh Kashyotiya — Asst. Director
- Dr. Thakor Hitendrasinh G — Consultant- M&E
- Dr. Munish Joshi — Consultant -Training
- Mr. Nitin Sagar — Consultant – Finance
- Mrs. Nagalakshmi S. — Consultant - Finance

CONTENTS

ACRONYMS

ACT	Artemsinin-based Combination Therapy
ACT-AL	Artemsinin-based Combination Therapy- Artemether -Lumefantrine
API	Annual Parasite Incidence
ASHA	Accredited Social Health Activist
BCC	Behavior Change Communication
CBO	Community Based Organization
CHC	Community Health Centre
CSO	Civil Society Organization
DMO	District Malaria Officer
FBO	Faith Based Organization
GFATM	Global Fund to Fight AIDS, Tuberculosis and Malaria
GoI	Government of India
HH	Household
HR	Human Resources
HSS	Health System Strengthening
IMCP	Intensified Malaria Control Project
IPC	Inter Personal Communication
IRS	Indoor Residual Spray
ITN	Insecticide Treated Nets
LLIN	Long Lasting Insecticidal Nets
LQAS	Lot Quality Assurance Sampling
M&E	Monitoring & Evaluation
MDG	Millennium Development Goals
MESST	Monitoring & Evaluation Systems Strengthening Tool
MIS	Management Information System
MOHFW	Ministry of Health and Family Welfare
MPW	Multi Purpose Health Worker
MTS	Malaria Technical Supervisor
NE	North East
NGO	Non Government Organization
NIMR	National Institute for Malaria Research
NRHM	National Rural Health Mission
NVBDCP	National Vector Borne Diseases Control Programme
Pf	*Plasmodium falciparum*
PHC	Primary Health Centre
PMMR	Programme Management, Monitoring and Review
PMU	Project Management Unit
PR	Principal Recipient
PR1	Principal Recipient 1—National Vector Borne Diseases Control Programme
PR2	Principal Recipient 2 (Caritas India)
Pv	*Plasmodium vivax*
QA	Quality Assurance
RBM	Roll Back Malaria Partnership
RBM-MERG	Roll Back Malaria Monitoring and Evaluation Reference Group
RDT	Rapid Diagnostic Test
SC	Sub-Center

SDA	Service Delivery Area
SHG	Self Help Group
SRs	Sub Recipients
TBD	To be decided
TOT	Training of Trainers
VBD	Vector Borne Diseases
VBDCP	Vector Borne Diseases Control Programme

1.0 BACKGROUND

The Global Fund to Fight AIDS, Tuberculosis, Malaria (GFATM) Round 9 supported project***—"Intensified Malaria Control Project—II (IMCP—II)"*** plans to scale up effective preventive and curative interventions in those areas of the country (the seven (7) North Eastern (NE) states in India), where the intensity of malaria transmission is the highest, difficulties in accessibility on account of terrain, forests are considerable, and the health care delivery system constraints are the most severe. Prolonged rainy season and warm/humid physical environment conducive for vector proliferation; peculiar agricultural practices (shifting cultivation); increasing drug and insecticide resistance; population migration; long international borders with neighboring countries that are highly endemic for malaria; together with problems of unrest in some parts, render the NE states highly vulnerable. In addition, the NE states are inhabited by a large number of tribal populations having own socio-political structures, livelihood practices.

The IMCP—II aims for universal coverage by effective interventions thereby catalyzing decline in malaria related mortality and morbidity and contributing to achievement of national goals and Millennium Development Goals (MDGs). The project will draw from the experiences gained and lessons learned during the implementation of GFATM Round 4 supported 'Intensified Malaria Control Project (IMCP)' since 2005 (2005-2010) as well as the activities by the national programme—National Vector Borne Diseases Control Programme (NVBDCP) of the Government of India (GoI) supported with domestic resources.

The NVBDCP is a principal recipient of the Round 9 grant (hereinafter referred to as principal recipient 1 —PR1). It will implement malaria control interventions through the state VBDCP authorities, who will be the sub recipients (SRs). A non-governmental consortium led by Caritas India will complement the NVBDCP efforts. The Caritas India is the other principal recipient of the Round 9 grant for malaria (hereinafter referred to as principal recipient 2—PR2). The SRs in the PR2 consortium include: Futures Group International India Private Limited (Futures Group) as SR1, Voluntary Health Association of India (VHAI) as SR2 and Christian Medical Association of India (CMAI) as SR3.

1.1 Project Goal, Objectives and Service Delivery Areas (SDAs)

Goal:
To reduce malaria related mortality and morbidity in project areas by at least 30% by 2015 as compared to 2008.

Objectives and Service Delivery Areas (SDAs):

- To achieve near universal coverage by 2015 by effective preventive intervention (Long Lasting Insecticidal Nets--LLIN) for population living in high risk project areas from 42% (2009-10).
  - SDA: Insecticide Treated Net--ITN (LLIN)

- To achieve at least 80% coverage by parasitological diagnosis; and prompt, effective treatment of malaria through public and private health care delivery systems in project areas by 2015.
  - SDA: Diagnosis (RDT)

- SDA: Prompt, effective treatment (Artemisinin based Combination Treatment--ACT, Injectable artemisinin derivatives)

- To achieve at least 80% coverage of villages in project areas by appropriate BCC activities by 2015 to improve knowledge, awareness and responsive behavior with regard to effective preventive and curative malaria control interventions.
  - SDA: Community outreach/ Inter Personal Communication--IPC
  - SDA: Mass media

- To strengthen programme planning and management, monitoring and evaluation, and coordination and partnership development to improve service delivery in project areas.
  - SDA: Health System Strengthening--HSS: Human resources [technical and management assistance, planning and administration assistance, monitoring and evaluation (M&E) assistance teams]
  - SDA: HSS: Information systems (M&E)
  - SDA: Coordination and partnership development (public-private/ Non-Government Organization--NGO/ Faith Based Organization (FBO), etc)

- To strengthen health systems through training, capacity building to improve service delivery in project areas.
  - SDA: HSS: Human resources (training/capacity building)

1.2 Project Strategies

- **Prevention:**
  - Distribution of LLIN amongst high risk population with Annual Parasite Incidence (API) ≥ 2 (per 1000 population) in project areas to achieve near universal coverage. LLIN to be distributed @ 2 LLIN per household, assuming a household consists of 5 persons.
  - Continuation of re-impregnation of conventional nets with synthetic pyrethroids in areas registering API ≥ 2 till the time they are completely covered by LLIN.
  - Continuation of Indoor Residual Spraying (IRS) in areas with API ≥ 2 already under IRS coverage, as per programme policy, till the time epidemiological and ecological evidence give adequate reasons for withdrawal of IRS.
  - Increased involvement of community based structures, networks, including sustained and correct use of LLIN

- **Early diagnosis and complete treatment:**
  - Increased use of multivalent RDTs from 2012 for parasitological diagnosis especially in the remote areas without easy access to microscopy centers, i.e., where microscopy results are not available within 24 hours of reporting fever to a health care provider
  - Use of Artemisinin based Combination Treatment (ACT) for treatment of *Pf* cases
  - Increased involvement of community based structures & networks; private providers

- **Behaviour Change Communication (BCC):**
  - Evidence based BCC
  - Community outreach, IPC based consistent messaging through community based structures /networks to bring about behaviour change both in adoption of preventive interventions as well as in seeking early diagnosis and appropriate treatment
  - Intensified BCC activities prior to and during high transmission season

- Limited use of mass media, mainly radio (in areas with reasonable reach) to reinforce messages delivered through community outreach, IPC

- **M&E:**
  - Increased focus on performance based programme planning
  - Strengthening of programme planning and management structures and operations at national, regional, state and district levels
  - Establishment of sentinel surveillance for severe malaria cases and deaths to complement existing disease surveillance; establishment of lot quality assurance sampling in addition to periodic large scale population and household surveys, to gauge outcomes
  - Reporting from private sector and other non-health sectors
  - Joint planning and review with implementing partners
  - Periodic evaluation to provide direction for future planning
  - Evidence generation through operational research

- **Coordination and partnership development:**
  - Increased advocacy for developing coordination and partnership with other departments/programs within Ministry of Health and Family Welfare (MOH&FW), non-health public sector organizations, corporate sector, NGOs/ FBOs, international agencies

- **Capacity Building:**
  - Provision of systematic induction and refresher training to all levels of programme/ project staff/ consultants, medical and paramedical personnel, health workers and community health volunteers in government/ non-government health care service delivery with malaria related responsibilities
  - Provision of training to private sector health care providers; and medical, paramedical personnel with partner organizations
  - Assessing effectiveness of capacity through periodic reviews

1.3 What is included in this document?

This document outlines a GFATM Round 9 project specific M&E plan for the Principal Recipient 1(PR1) National Vector Borne Disease control Programme and its SRs for the **Phase II (October 2012 –Sept. 2015)**. This plan is based on the GFATM M&E plan guidelines (2009)[1] and broad guidelines given in the National M&E Framework for the country programme. An overview of project Management Information System (MIS) is also presented in this document that will be established for project related data recording/ compilation, reporting, analysis, and results dissemination.

1.4 Who would be using this document?

This document is intended to provide guidance to PR1 including their sub recipients (SRs), namely the states of Arunachal Pradesh, Assam, Manipur, Meghalaya, Mizoram, Nagaland and Tripura and their districts (SSR), especially in relation to indicators and targets as in the GFATM Round 9 project performance framework[2]. In addition, Principal Recipient 2 and its SRs may refer to the document.

[1] Guidelines for submission of an M&E plan for Global Fund grants. 2009
[2] Presented in section 2.3 of this document

2.0 GFATM ROUND 9 PROJECT MONITORING AND EVALUATION (M&E) PLAN

Monitoring is a regular, systematic process of measuring performance against set targets and benchmarks in a programme/ project, while it is ongoing. Evaluation periodically assesses current versus desired performance standards and seeks to analyze whether the needs are met as envisaged and any gap, bottleneck so as to improve further performance in similar or different contexts. M&E thus, are the cornerstones of any programme/ project. Through M&E, the programme/ project performance, results at all levels (impact, outcome, output, process and input) can be measured to provide the basis for accountability and evidence-based decision-making at both programme and policy level. Increasingly, most governments, donors/funders, organizations emphasize on time bound performance-based funding including the GFATM; therefore, a robust M&E plan delineating framework, systems and processes is critical.

The GFATM grant agreement essentially includes a Performance Framework, a document through which the PR and the Global Fund commonly agree the indicators to be used and the targets to be achieved to demonstrate performance and consequently, to ensure continued funding. The M&E plan is an essential document that provides background information for the indicators included in the Performance Framework; describes how the M&E system will work, allow for data collection, processing, analysis and transformation into strategic information for use at local/ country/ global levels and produce results to be reported to the GFATM.

At present, the national programme for malaria control—NVBDCP, GoI, which is the PR1 has a national M&E plan—'Country Monitoring & Evaluation Framework in Malaria Control'. A Health Management Information System (HMIS) also exists across the country that is responsible for capturing of programmatic, financial and logistics information. For measuring outcomes, and impacts, surveys and studies are additionally commissioned. The Caritas India (PR2) too has existing project related M&E systems and process that include MIS (both computerized and paper based).

However, for providing guidance on Round 9 project M&E including measuring the indicators in the performance framework for NVBDCP (PR1), this project M&E plan has been prepared.

An M&E Systems Strengthening Tool designed by the GFATM and partners to guide allocation of investments in M&E before grant signature was discussed at a workshop held on February 8 – 9, 2010 at the Caritas India office at New Delhi. The overall objective of the workshop was to facilitate improvements in the M&E systems and processes of the national programme and PR2 and the quality of data generated to measure success of implemented activities. More specifically, the workshop assessed M&E frameworks and capacities of the project's implementing entities; evaluated how the project M&E activities would be linked and integrated within the national M&E System; and helped development of a costed action plan to strengthen project M&E systems. The MESST workshop was once again held in July 2011 at Guwahati to review and revise the M&E framework. The project M&E plan is consistent with the national programme M&E framework and has been fine-tuned based on the deliberations in the M&E systems strengthening workshop.

This project M&E plan describes the following: overall guiding principles; logical framework, description of the Round 9 project indicators devised to measure the performance of SDAs relevant for PR1, their data sources, data collection and reporting frequencies, data quality

assurance, information products for results dissemination, action plan, implementation arrangements, training/ capacity building on M&E and an overview of the project MIS. Linkages with the national M&E system are also underscored.

The indicators (11 in number) are devised as standardized measures of performance and results. These are expected to verify whether activities are being/ have been implemented as planned within specific timelines; ensure transparency and accountability; detect any shortfall and/ or constraint; provide valid and timely feedback to the decision maker(s), key stakeholders for informed planning and strategizing; as well as document and disseminate empirical evidence on 'lessons learned', thereby improving effectiveness of malaria control service delivery.

The purpose of the project M&E plan is to provide guidance on the project M&E efforts—both programmatic and financial as well as to foster and institutionalize capacity for robust M&E within the PR1 and their SRs towards steering focus on the intended 'results'. Effective tracking of performance is expected to impact the delivery of services by the stakeholders.

The project M&E plan document is dynamic and open to refinements over the project period as the activities progress over the project life.

2.1 M&E Guiding Principles

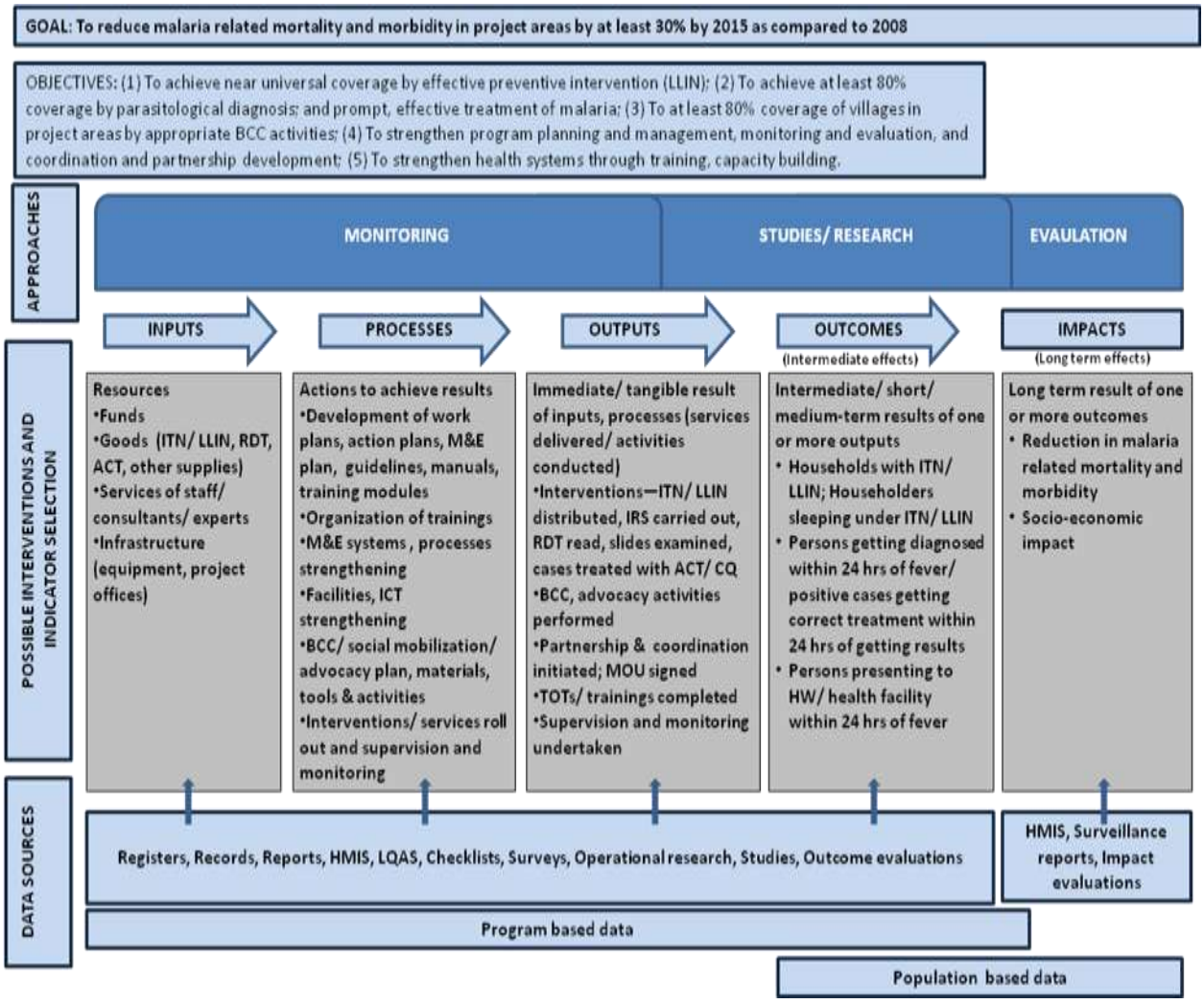
The project M&E will be guided by the following principles:

- M&E will be part and parcel of the IMCP—II and will be worked out in line with the NVBDCP strategies and plans, according to the principle of "The Three Ones" – one national malaria control coordinating body, one national malaria control strategy, and one national M&E plan.
- A logical framework (Input-Process-Output-Outcome-Impact) will be applied for M&E.
- NVBDCP—the PR1 will work closely with the PR2 (Caritas Consortium) M&E team, to harmonize M&E strategies, approaches and methodologies, work plans, activities; share best practices, identify innovations for M&E of malaria control.
- M&E will follow established standards, ensuring quality, reliability, transparency, and usefulness.
- M&E indicators are SMART (specific, measurable, achievable, realistic, and time bound) for measuring performance over the project life toward achieving desired objectives and goals.
- MIS will be intrinsic to M&E and standard data sources and approaches will be used for programmatic, logistics, financial data collection, collation and analysis. The MIS data collection tools (forms/ checklists) will be put in use subsequent to stakeholder consensus and will be based on those used in the national programme.
- Data quality audit including on site verification will be in-built element within the overall M&E/ MIS.
- Results dissemination and use will be key constituents.
- Technical and management aspects of M&E will draw from the recommendations of the Advisory body at NVBDCP.

2.2 M&E Framework

The M&E framework assists in understanding the inputs, processes, outputs, outcomes, impacts stemming from situation analysis/ assessment of stakeholder needs and capacity; review of resources/ logistics, collaboration planning, etc. in addition to the relevant approaches and methods to measure these elements. The framework allows for consideration of various malaria control interventions and delivery strategy and choice of indicators, targets and methods or sources of data collection.

A schematic on the M&E framework for Intensified Malaria Control Project—II is illustrated below that indicates an overview of inputs, processes, outputs, outcomes, impacts as well as links between the goals, objectives and outcomes, impact.



2.3 M&E Indicators

A set of SMART (specific, measurable, achievable, realistic, and time bound) indicators has been devised that will measure progress made in service delivery by the PR1 and their SRs towards achieving desired project objectives according to agreed targets; judge effectiveness of the donor funding; identify the gaps; and enable evidence based decision making, prioritization of actions. These indicators will be measured at programmatic—output/ process/ input level. The measurement of impacts/ outcomes will be the responsibility of the national programme—NVBDCP, GoI, the PR1. The PR2 and their SRs will devise additional programmatic indicators for sub-national levels, especially in relation to processes, outputs.

The SDAs and the indicators as in the performance framework (PF) for PR1 for Phase II of Round 9 Renewal proposal are presented below:

Reference no. as in PF	Service Delivery Area (SDA)	Indicator
1.1	Insecticide-treated nets (ITNs)	Number of LLIN distributed in LLIN eligible areas (API ≥ 2) by functionaries of PR1
2.1	Diagnosis	Number of fever cases tested with RDT by ASHAs (PR1)
2.2	Diagnosis	Number of fever cases tested with RDT at public sector health facilities (Sub-center, PHC, CHC, etc.) of PR1
2.3	Prompt, effective treatment	Number of Pf cases treated with ACT by ASHA (PR1)
2.4	Prompt, effective treatment	Number of Pf cases treated with ACT at public sector health facilities (Sub-center, PHC, CHC, etc.) of PR1
2.5	Prompt, effective treatment	Percentage of ASHAs with no reported stock outs of nationally recommended antimalarial drugs lasting more than one week at any time during the past 1 month
2.6	Prompt, effective treatment	Percentage of public sector facilities with no reported stock outs of nationally recommended anti-malarial drugs lasting more than one week at any time during the past 1 month
3.1	BCC-Community outreach	Number of miking activity conducted in PR1 areas by PR1
4.1	HSS: Information system	Number of supervisory visits to district periphery in a quarter by District VBDCP (Malaria) Officer (program/project) and report submitted to state program officer/district chief medical officer of PR1
5.1	HSS: Service delivery (Training)	Number of Malaria Technical Supervisor (MTS) trained /retrained by PR1
5.2	HSS: Health workforce (training /capacity building)	Number of ASHAs trained / re-trained (by PR1)

For each indicator, the following information is included:

- rationale and what it measures;
- indicator definition;
- baseline values with dates and relevant data source (if available);
- targets set for the life span of the grant;

- data source, such as, management information system, registers/ records, base record etc.;
- frequency of data collection (monthly, quarterly, annually, etc.);
- frequency of reporting/dissemination;
- agency responsible for data collection and reporting;
- level of use;
- strengths and limitations;
- programme implication.

Such comprehensive information will facilitate understanding of an indicator, and more importantly its analysis and use to improve performance.

Apart from this the **outcome and the Impact indicators** that are defined for the project are as follows:

Outcome Indicators

Linked to Obj.	Indicator	Baseline	Year	Target Y1	Target Y2	Target Y3	Comments
1	Percentage of households in high risk areas (API >2) with at least two LLINs	42	2010	70	80	90	• Baseline remains same as in Round 9 proposal. • A survey is expected in 2013 for which the process has been initiated. The report is expected by the end of 2013 and will provide further information (the target in Year2 of Phase1 was 77). The targets may be re-visited after the above-mentioned survey results are available. Surveys conducted in year4 & year5 will provide results by the end of same years. The formats for the surveys will be adapted from Malaria Indicator Survey (MIS); information will be collected from LLIN beneficiaries on a sample basis. • The targets are also set in the background of variable supply-side situation. • The data source will be report from survey.
1	Percentage of household residents who slept under LLIN the previous night	57.6	2010	60	70	80	• The data for baseline has been obtained from external evaluation conducted at the end of Round 4 IMCP. • The figures reflect a positive change towards adoption of preventive measure like bed net. • A survey is expected in 2013 for which the process has been initiated. The report expected in 2013 will provide further information (the target in Phase1 was 50). Surveys conducted in year4 & year5 will provide results in the end of same years. The formats for the surveys will be adapted from Malaria Indicator Survey (MIS); information will be collected from LLIN beneficiaries on a sample basis.
2	Percentage of persons reporting fever within last two weeks, who have obtained a test result (RDT/ microscopy) within 24 hours following onset of Fever	0.3	2010	30	50	70	• The data for baseline has been obtained from external evaluation conducted at the end of Round 4 IMCP. • Although the data might not be representing real field situation; yet it could be reflecting a scenario wherein the desired effects of the project interventions were yet to be observed. Disaggregation of data showed varying findings as the scaling up of vector control and EDCT components were at varying pace in different states. Further, fever as a presenting symptom is a common occurrence in India. With inadequate knowledge and awareness, delay in seeking appropriate treatment is known. • However, with extra inputs in HR, IEC/BCC and increased surveillance, knowledge and awareness about malaria, appropriate health seeking behaviour are expected to improve substantially resulting in achievement of desired outcomes in Phase2. • As mentioned in Phase1 PF, after the data for baseline was available, the targets for this indicator were revisited. A survey is expected in 2013 for which the process has been initiated. The report expected in 2013 will provide further information (the target in Phase1 was 60). • This indicator, as a proxy indicator for BCC, will indicate the percentage of people who know the symptoms of malaria, EDCT, appropriate treatment seeking. • Surveys to be conducted in year 2 & year 3 will provide results in the end of same years.
2	Percentage of malaria (confirmed) hospital admissions among all hospital admissions in sentinel sites	TBD	2012	TBD	TBD	TBD	• Sentinel sites are being established for the first time in NE states to improve management of malaria for in-patients and to capture data related to admissions, case fatality rate, age-specific mortality, etc. • Sentinel site hospitals in each state have been identified and have started functioning. • In the initial years of newly established sentinel sites and improved referrals, reporting, it is expected that the admissions due to malaria will increase and would subsequently decline. • The baseline will be re-visited and targets will re-set once data for Jan-Dec 2012 from functional sentinel sites are available in Jan-Mar 2013. • The data source would be report from Sentinel Site Hospitals. The reports will be due in the succeeding year (1st quarter) of reporting year. • The data source would be report from Sentinel Site Hospitals.

TBD = To be decided

The **Impact Indicators** identified are as follows:

Impact Indicators

Linked to goal(s) #	Impact indicator	Baseline			Targets						Comments
		value	Year	Source	Year 1 2012	Report due date	Year 2 2013	Report due date	Year 3 2014	Report due date	
1	API (Annual Parasite Incidence)--malaria positive cases per thousand population	3.82	2010	Surveillance systems	3.4	30-June-13	3.06	30-Jun-14	2.67	30-Jun-15	• The annual data for the preceding year is collected from the States in the months of January to March every year. Further data aggregation and report preparation take another 2-3 months. Therefore, the final figures are available only in May-June in the next year. • Introduction of bi-valent RDTs for detection of both Pf and Pv cases is planned together with re-trainings and continued motivation of ASHA/Community Health Volunteers, community mobilization and further strengthening of health systems, recording/reporting. Consequently, the number of positive cases may increase initially but is expected to decline subsequently. Therefore, the targets are set accordingly though the API based on the reported figures may be relatively low currently (2011, 2012). • Report will be for calendar year that will be received in reporting year, e.g report for 2012 (calendar year) will be received in 2013.
1	Number of deaths with malaria confirmation	290	2010	Surveillance systems	261	30-June-13	232	30-June-14	203	30-June-15	• The annual data for the preceding year is collected from the States in the months of January to March every year. Further data aggregation and report preparation take another 2 months. Therefore, the final figures are available only in May-June in the next year. • The number of deaths has also shown decline (in 2010, 2011) relative to the estimates in the Round 9 proposal. This can be attributed to improvements in EDCT by way of providing RDT and ACT at the grassroots. This in turn, may have resulted in less number of severe and complicated malaria cases and subsequent mortality. However, the estimates in Phase 2 have not been changed as per the trend of malaria mortality in project areas because malaria is and remains a local and focal disease, wherein upsurges/outbreaks cannot be predicted. • The surveillance system for malaria in the country only captures the absolute number of deaths due to malaria (and not the overall number of death at facility level); therefore no percentage value is provided. Report will be for calendar year that will be received in reporting year, e.g. report for 2012 (calendar year) will be received in 2013.

Details for each indicator identified in Performance Framework

Indicator 1.1: Number of LLIN distributed in LLIN eligible areas (API ≥ 2) by functionaries of PR1

Rationale and what it measures:	Mosquito nets treated with insecticides provide much more effective protection by killing mosquitoes as well as repelling them. In areas with high malaria transmission particularly in rural tribal areas, ITN/ LLIN are one of the principal strategies for preventing malaria. ITN/ LLIN have been shown to reduce malaria-related morbidity and mortality in areas with high and moderate endemicity in various settings across the world including Asia. In India, ITN/ LLIN is one of the key vector control interventions in addition to indoor residual spraying (IRS). In recent years, the use of LLIN is being emphasized as these are mosquito nets with the insecticide incorporated in the fibre, which does not allow removal of insecticide even after 20 washes. Furthermore, LLIN does not require periodic treatment (usually after every six months) with insecticide and needs replacement only after 3-5 years (the usual time period before an LLIN under condition of normal usage either gets torn or loses its insecticidal effect). These attributes make LLIN more cost-effective as compared to ITN. The criteria for selection of target population for LLIN are high risk area requiring vector intervention and (1) difficult for conducting and supervising spray operations (remote, inaccessible areas, hilly terrain, forested area etc.) or (2) areas where bed net usage and acceptability are high. The unit of area for coverage will be village. For further details, please refer to national programme documents.[3] (3) Special groups like *Jhoom* cultivators and children in tribal residential schools. To initiate involvement of civil society in LLIN distribution as well as pre- and post-distribution actions, 15% of the total quantity of LLIN to be procured under the Round 9 project will be distributed by the PR2 consortium. The indicator measures the distribution of LLIN in targeted areas by community health volunteers (ASHAs)/ workers with government organizations.
Indicator definition:	No. of LLIN distributed in eligible areas (API ≥ 2) by PR1
Baseline values with dates and relevant data source (if available):	3427242 (2012), Surveillance system
Targets set according to frequency of	Year 1 (excluding baseline): 2720000 (P1: 0 ; P2: 0; P3: 0; P4: 2720000 [cumulative annually]

[3] For further details, please refer to: Operational Manual for Implementation of Malaria Programme 2009 and Country Monitoring & Evaluation Framework in Malaria Control 2009

measurement:	Year 2 (excluding baseline): 1,225,207 (P5: 0; P6: 919,207, P7: 0; P8—306,000) [cumulative annually] Year 3: (excluding baseline): 23,60,000 (P9: 0; P10: 1,416,000; P 11: 0; P12: 944,000 [cumulative annually]
Data source:	VC3 forms/ LLIN distribution record sheet
Data collection method:	Routine Health Service statistics
Frequency of data collection:	Bi-annually
Frequency of reporting / dissemination:	Bi-annually
Supporting documents	➢ Line-listing of households in eligible villages; letter of approval for the same from DMO; ➢ Receiving of LLIN by Health worker/ASHAs; ➢ Recording of receipt of LLIN in stock register of SC/PHC ➢ Sign / thumb impression / receiving from beneficiaries (householders) against household list; ➢ Certification of beneficiary list by village Pradhan / Village council etc. ➢ Record of receipt of payment made to ASHAs; ➢ Photographs of distribution; ➢ Report on VC3 and submission to SC/PHC/ DMO/ SPO
Agency responsible for data collection/ reporting:	SSRs and SRs of PR1
Level of use:	National / Sub-national
Strengths and limitations:	It provides a reasonable measure of the number of LLIN distributed by PR1. This indicator is also closest in estimating number of LLIN owned by households, if such data are not collected/ collated through surveys. This is a quantitative indicator. For prevention, use of LLIN correctly and consistently is important. Hence, this may not truly reflect effective prevention by LLIN. The indicator is also dependent on specified no. of LLIN procured, supplied to SRs and their districts & distributed on time; local transmission dynamics.
Project/ programme implication:	This indicator is a measure of project performance and addresses the needs of the national programme. Timely distribution of LLIN and subsequent follow up for correct and consistent use by beneficiaries will improve coverage of effective prevention measure ultimately impacting the disease trend. The NVBDCP, stakeholders may monitor the pace at which LLIN coverage is expanding and prioritize accordingly.

Indicator 2.1: Number of fever cases tested with RDT by ASHAs (PR1)

Rationale and what it measures:	A patient with fever and no other obvious cause of fever is considered a case of suspected malaria.[4] Any trained health worker/ health professional/ health volunteer observing a case of suspected malaria must immediately initiate a diagnostic test by: microscopy of blood for malarial parasites and/or Rapid Diagnostic Test (RDT), since under NVBDCP, anti malarial treatment is given

[4] For definition, please refer to Operational Manual for Implementation of Malaria Programme 2009.

	only on the basis of a positive diagnosis. Under the programme, slide examination by microscopy for malaria is the standard diagnostic tool & wherever a microscopy result can be made available within 24 hours, it will be maintained as the only routine method for diagnosis of malaria. However, due to deficient availability of lab technicians at certain PHCs and the huge time lag between slide collection and reporting of results from the PHC, especially in remote and inaccessible areas, which is often more than 24 hours, RDTs are supplied and used for diagnosis, especially by community level volunteers/ workers. The criteria for selection of such villages (or sub-center areas, where village data is not available) are: • Pf % > 30 and SfR > 1%: • Consistently high API and deaths are reported • Inaccessible areas that are frequently cut off during transmission season; areas with limited road and public transportation facility. As the RDT is done, a blood slide is also taken and a primary case record of cases is filled in by trained ASHA at village level, which is actually a line-list of all fever cases.[5] If the RDT is positive, appropriate anti malaria treatment is started immediately and the blood slide is not sent for examination, in such case, the slide preparation will be restricted to quality assurance testing. If severe malaria is suspected, referral is arranged. Quality training/ capacity building is a pre-requisite for administration of RDTs.[6] ASHAs at village level play an important role in malaria case detection and treatment. According to an In-depth review of malaria control programme,[7] treatment by private providers/ self-treatment is done in 34% cases in Assam. The PR1, their SRs have an extensive network of community health volunteers (ASHAs) at the grassroots (village level) across the project areas. They are expected to complement the national programme efforts in early case detection and complete treatment, especially in remote and inaccessible areas. The indicator measures the number of people reporting fever being tested with RDT by trained ASHAs according to NVBDCP guidelines.[8]
Indicator definition :	No. of fever cases tested with RDT at community level by trained ASHAs of PR1 and its SRs.[9]
Baseline values with dates and relevant data source (if available):	362,056 (2012); Surveillance system, Monthly epidemiological data,

[5] For further details, please refer to: Operational Manual for Implementation of Malaria Programme 2009 and Country Monitoring & Evaluation Framework in Malaria Control 2009

[6] For further details, please refer to: Operational Manual for Implementation of Malaria Programme 2009 and Country Monitoring & Evaluation Framework in Malaria Control 2009

[7] In depth review of malaria control programme. National Institute of Malaria Research (NIMR), Indian Council of Medical Research. 2007

[8] As the RDT is done, a blood slide is also taken and a primary case record of cases is filled in according to NVBDCP guidelines.

[9] ibid.

Targets set according to frequency of measurement:	Year 1: 777,851 (P1: 175,960; P2: 42,493; P3: 282,562; P4: 276,836) [Cumulative annually] Year 2: 947,148 (P5: 214,257; P6: 51,742; P7: 344,060; P8: 337,089) [Cumulative annually] Year 3: 1,284,826 (P9: 290,644; P10: 70,189 P11 466,725; P12: 457,268;) [Cumulative annually]
Data source:	M 4 forms (Provider wise)
Data collection method:	Routine Health service statistics
Frequency of data collection:	Monthly
Frequency of reporting/dissemination:	Monthly
Supporting documents	➢ Indent submitted to SC monthly by ASHA ➢ Compiled indent submitted to DMO monthly and receiving of indent from DMO; ➢ Receiving of commodities from DMO; ➢ Stock Register at PHCs (list of villages, ASHAs and no. of stock released/ balance etc.); ➢ Receiving of stock (RDT, ACT, etc.) by ASHA; ➢ Recording of receipt of stock register of ASHA; ➢ M –ASHA register by ASHA as RDT is used in fever cases; ➢ M1 form by SC at the end of month; ➢ Record of receipt of payment made to ASHAs; (countersigned by DMO / VBDC / MTS).
Agency responsible for data collection/ reporting:	PR1 and its SRs and SSRs
Level of use:	National/Sub-national
Strengths and limitations:	Provides a reasonable measure of the number of fever cases tested with RDT especially in remote and inaccessible areas through community health volunteers (ASHAs) associated with government organizations. This indicator also serves as line listing of fever cases. This is a quantitative indicator. For early case detection, reporting/ administering RDT correctly within 24 hrs of fever is important. Hence, this may not truly reflect early detection of fever cases. The indicator is also dependent on specified no. of RDT procured, supplied to districts & distributed on time; local transmission dynamics; case detection. Further, quality assurance of RDT needs to be in place for optimal results. Detection of malaria cases, if not followed by immediate, appropriate and complete treatment, may pose problems.
Project/ programme implication:	This indicator is a measure of project performance and addresses the needs of the national programme. Timely RDT followed by appropriate and complete treatment (if positive for malaria) immediately through ASHAs will improve early case detection and prompt treatment ultimately impacting the disease trend. The NVBDCP, stakeholders may monitor how and where RDT is being utilized and prioritize accordingly.

Indicator 2.2: Number of fever cases tested with RDT at Public sector health facilities (Sub-center, PHC, CHC etc.) of PR 1

Rationale and what it measures:	According to the national programme guidelines, RDTs are also used in health facilities in emergencies, especially for treatment of severe and complicated malaria requiring immediate medical attention in the absence of the laboratory technician, or, in remote and inaccessible areas, where slide microscopy is not easily available, RDT use is recommended. It is estimated that nearly 50% of fever cases approach the private sector / civil society facilities for treatment due to poor access to service delivery points in the public sector.[10] The PR1, their SRs have an extensive network of primary and secondary level health care units across the project areas. The indicator measures fever cases tested with RDT by trained personnel at Government health facilities.[11]
Indicator definition:	Number of fever cases tested with RDT at public sector health facilities (Sub-center, PHC, CHC etc.) of PR1 and its SRs.[12]
Baseline values with dates and relevant data source (if available):	1267342 (2012); Surveillance System
Targets set according to frequency of measurement:	Year 1: 2,333,553 (P1: 527,880; P2: 127,479; P3: 847,685; P4:830,509) [cumulative annually] Year 2: 2,210,012 (P5: 499,933; P6: 120,731; P7: 802,807; P8: 786,541) [cumulative annually] Year 3: 1,927,240 (P9: 435,967; P10: 105, 283; P11: 700,088; P12: 685,902) [cumulative annually]
Data source:	M forms
Data collection method:	Routine health service statistics
Frequency of data collection:	Monthly
Frequency of reporting/dissemination:	Monthly
Supporting documents	➢ Compiled indent submitted to PHC/DMO monthly and receiving of indent from SC/PHC by DMOs; ➢ Receiving of commodities from DMO by SC/PHC; ➢ Stock Register at SC/PHC/DMO (no. of stock released /balance etc); ➢ M1 Register by health facility with RDT used in fever cases; ➢ M4 form submitted by SC/PHC/HF at the end of month;
Agency responsible for data collection/ reporting:	PR1, SRs and SSRs (districts)
Level of use:	National/Sub-national
Strengths and limitations:	Provides a reasonable measure of the number of fever case detection (using RDT) by Government health facilities, especially in remote and inaccessible areas. This indicator also serves as line listing of fever cases at health facilities.

[10] Joint Monitoring Mission report. 2007
[11] As the RDT is done, a blood slide is also taken and a primary case record of cases is filled in according to NVBDCP guidelines
[12] ibid

	This is a quantitative indicator. The indicator is also dependent on specified no. of RDT procured, supplied to SSRs districts & distributed on time; local transmission dynamics; case detection. Further, quality assurance of RDT needs to be in place for optimal results. Detection of malaria cases, if not followed by immediate, appropriate, complete treatment, may pose problem.
Project implication:	This indicator is a measure of project performance and addresses the needs of the national programme. Timely case detection using RDT followed by initiation of immediate and appropriate, complete treatment (if positive for malaria) will improve early case detection and prompt treatment ultimately impacting the disease trend. The NVBDCP, stakeholders may monitor how, where RDT is being utilized and prioritize accordingly.

Indicator 2.3: Number of Pf cases treated with ACT by ASHAs (PR1)

Rationale and what it measures:	As the result of RDT is known immediately, appropriate treatment of malaria cases is to be initiated at once, according to the national programme guidelines. The currently selected ACT for treatment of Pf cases is artesunate (3 days) + sulphadoxine-pyrimethamine (single dose on 1st day) However, from 2013 the ACT-AL has been recommended for the treatment of Pf cases in the NE states. The use of a combination treatment delays the development of resistance. The anti-malarial for *vivax* malaria is chloroquine for three days and primaquine for 14 days as per prescribed guidelines, [primaquine is not recommended for pregnant women and infants].[13] The indicator measures the fever cases that tested positive with RDT and administered complete antimalarials treatment by community health volunteers (ASHAs) associated with PR1.
Indicator definition:	Number of fever cases diagnosed as malaria (Pf) positive by RDT who are administered complete anti-malarial regimen according to the national malaria treatment policy at community level by trained community health volunteer/ (ASHAs) with PR1 and their SRs.
Baseline values with dates and relevant data source (if available):	189,46 (2012) Surveillance system
Targets set according to frequency of measurement:	Year 1: 31,114 (P1: 5,660; P2: 1,275; P3: 13,788; P4: 10,391) [Cumulative annually] Year 2: 33,769 (P5: 6,143; P6: 1,384; P7: 14,964; P8: 11,278) [Cumulative annually] Year 3: 40,997 (P9: 7,458; P10: 1,680 P11 18,167; P12: 13,692;) [Cumulative annually]
Data source:	M forms
Data collection method:	Routine health service statistics
Frequency of data collection:	Monthly
Frequency of reporting/dissemination:	Monthly

[13] For further details, please refer to: Operational Manual for Implementation of Malaria Programme 2009; Country Monitoring & Evaluation Framework in Malaria Control 2009; National Vector Borne Diseases Control Programme Drug policy 2010

Supporting documents	➢ Indent submitted to SC monthly by ASHA; ➢ Compiled indent submitted to DMO monthly and receiving of indent from DMO; ➢ Receiving of commodities from PHC/SC; ➢ Stock Register at ASHA/SC/PHC (list of villages, ASHAs and no. of stock released/balance etc.); ➢ Receiving of stock (RDT, ACT, etc.) by ASHAs; ➢ Recording of receipt of stock register of ASHA; ➢ M-ASHA register by ASHA as RDT is used in fever cases; ➢ M4 form by SC at the end of month;
Agency responsible for data collection and reporting:	PR1, SRs and SSRs
Level of use:	National/Sub-national
Strengths and limitations:	Provides a reasonable measure of the number of fever cases treated with ACT by ASHAs at community level. This is a quantitative indicator. For treatment initiation within 24 hours of onset of fever and complete treatment, supervision and monitoring is important. Hence, this may not truly reflect treatment adherence. The indicator is also dependent on specified no. of ACT procured, supplied to PR1 districts & distributed on time; local transmission dynamics; case detection. Further, quality assurance of ACT administration needs to be in place.
Project implication:	This indicator is a measure of project performance and addresses the needs of the national programme. Timely administration of ACT regimen to Pf cases immediately after detection will improve early case detection and complete treatment ultimately impacting the disease trend. The NVBDCP, stakeholders may monitor how, where ACT is being utilized. Till the issue of QA is resolved, this indicator will be tied to the National Programme performance.

Indicator 2.4: Number of Pf cases treated with ACT at public sector health facilities (Sub-Centers/PHC/CHC etc.) of PR1.

Rationale and what it measures:	According to the national programme guidelines, all treatment providers in the country, including health facilities of non-government/ private sector, are to adhere to the norms of providing appropriate and complete treatment regimen to malaria positive cases as per the Drug Policy revised from time to time. The indicator measures the fever cases that tested Pf positive with RDT, administered complete ACT regiment at public sector health facilities (Sub-Centers/PHC/CHC etc.).
Indicator definition:	Number of fever cases diagnosed as malaria (Pf) positive by RDT /microscopy who are administered complete ACT regimen by trained personnel at health facilities of PR1, their SRs according to the national malaria treatment policy.
Baseline values with dates and relevant data source (if available):	94328 (2012) Surveillance system
Targets set according to frequency of measurement:	Year 1: 93.343 (P1: 16,980; P2: 3,826; P3: 41,363; P4:31,174) [cumulative annually] Year 2: 78,791 (P5: 14,333; P6: 3,229; P7: 34,915; P8: 26,314) [cumulative annually]

	Year 3: 61,496 (P9: 11,187; P10: 2,520; P11: 27,251; P12: 20,538) [cumulative annually]
Data source:	M forms
Data collection method:	Routine health service statistics
Frequency of data collection:	Monthly
Frequency of reporting/dissemination:	Monthly
Supporting documents	➢ Compiled indent submitted to DMO monthly and receiving of indent from DMO by PHC; ➢ Receiving of commodities from DMO by PHC; ➢ Stock Register at PHC (no. of stock released/balance etc.); ➢ Register by PHC with RDT used in fever cases; ➢ M1, M4 form by PHC at the end of month;
Agency responsible for data collection and reporting:	PR1, SRs and SSRs
Level of use:	National/Sub-national
Strengths and limitations:	Provides a reasonable measure of the number of fever cases treated with ACT by trained personnel at government facilities, especially in remote and inaccessible areas. This is a quantitative indicator. For treatment initiation within 24 hours of onset of fever and treatment adherence, supervision and monitoring is important. Hence, this may not truly reflect complete treatment of Pf cases. The indicator is also dependent on specified no. of ACT procured, supplied to PR1 districts & distributed on time; local transmission dynamics; case detection.
Project implication:	This indicator is a measure of project performance and addresses the needs of the national programme. Timely administration of ACT regimen to Pf cases immediately after detection will improve early case detection and complete treatment ultimately impacting the disease trend. The NVBDCP, stakeholders may monitor how, where ACT is being utilized and prioritize accordingly. Till the issue of QA is resolved, this indicator will be tied to the National Programme performance.

Indicator 2.5: Percentage of ASHAs of PR1 with no reported stock outs of nationally recommended anti-malarial drugs lasting more than one week at any time during the past 1 month

Rationale and what it measures:	According to the national programme guidelines, fever cases have to be tested for malaria and appropriate treatment should begin within 24 hours. In hard to reach and inaccessible areas in North Eastern states ASHAs have been deployed and trained to complement the government's program of malaria control and provide malaria management to the doorsteps of the community. In order to achieve this aim all logistics including nationally recommended anti-malarial drugs must be available with the ASHAs. Ensuring adequate and continued supply of the recommended anti-malarial drugs is key to the delivery of prompt

	and effective treatment and success in preventing and controlling malaria. The indicator measures the Percentage of ASHAs with ACT available for treatment of Pf positive cases as detected by RDK in SDAs.
Indicator definition:	*Numerator:* Number of ASHAs with nationally recommended anti-malarial drugs (ACT) available on the day of survey (Health provider survey) and with no stock-outs lasting one week or longer at any time in the past one month. *Denominator:* Total number of ASHAs surveyed with nationally recommended anti-malarial drugs (ACT). Analysis and reporting by segregating data into hard to reach and inaccessible areas will be undertaken.
Baseline values with dates and relevant data source (if available):	TBD (2012)
Targets set according to frequency of measurement:	TBD Targets will be provided once the baseline data is available at the end of the year Two (Phase I). This target will be non cumulative.
Data source:	Health provider survey questionnaire
Data collection method:	Health Provider Survey
Frequency of data collection:	At the end of year/phase 1 through Health provider survey
Frequency of reporting/ dissemination:	Annually
Agency responsible for data collection and reporting:	PR1
Level of use:	National / Sub-national
Strengths and limitations:	Provides a measure of adequate logistic supply with the ASHAs for treatment of Pf positive malaria cases. This is also a proxy indicator for supply chain management and capacity to manage malaria outbreak promptly and effectively. This is a quantitative indicator. For treatment initiation within 24 hours of onset of fever and treatment adherence adequate supply of nationally recommended drugs must be available. The indicator is dependent on specified no. of ACT procured, supplied to districts & distributed on time by PR1; local transmission dynamics; Supply chain management issues of PR1.
Project implication:	This indicator is a measure of project performance and addresses the needs of the national programme. Timely administration of ACT regimen to *Pf* cases immediately after detection is possible only if adequate quantity of ACT is available with the ASHAs. This will ensure appropriate and prompt management of *Pf* positive cases and impact disease trends. Till the issue of QA is resolved, this indicator will be tied to the National Programme performance.

Indicator 2.6 Percentage of Public sector health facilities (SC/PHCs/Hospitals etc. of PR1) with no reported stock outs of nationally recommended antimalarial drugs lasting more than one week at any time during the past 1 month

Rationale and what it measures:	Approximately 50% of fever cases visit government health facilities in remote and hard to reach areas of North Eastern states. The SRs of PR1 have an extensive network of primary and secondary level health care units across the project areas. They are expected to complement the national programme efforts in early case detection and complete treatment, especially in remote and inaccessible areas. This is possible only if adequate supply of recommended antimalarial drugs (ACT) is available in the government health facilities. Ensuring adequate and continued supply of the recommended antimalarial drugs is key to the delivery of prompt and effective treatment at health facilities and success in preventing and controlling malaria. The indicator measures the Percentage of government health facilities in the SDAs with adequate stock of ACT to treat promptly and appropriately Pf positive cases.
Indicator definition:	*Numerator:* Number of government health facilities *(SC/PHCs/ Hospitals)* in SDAs with nationally recommended anti-malarial drugs available on the day of health facility survey and with no stock-outs lasting one week or longer at any time in the last one month. *Denominator:* Total number of government health facilities (*SC/ PHCs / Hospitals)* surveyed with nationally recommended anti-malarial drugs. Analysis and reporting by segregating data into hard to reach and inaccessible areas will be undertaken.
Baseline values with dates and relevant data source (if available):	TBD (2012)
Targets set according to frequency of measurement:	TBD Target will be provided once the baseline data is available at the end of the year one. This target will be non cumulative.
Data source:	Health Facility Survey questionnaire
Data collection method:	Health Facility Survey
Frequency of data collection:	At the end of year/phase one through Health Facility Survey
Frequency of reporting/ dissemination:	Annually
Agency responsible for data collection and reporting:	PR and SRs
Level of use:	National/Sub-national
Strengths and limitations:	Provides a measure of adequate logistic supply with government health facilities for treatment of Pf positive malaria cases. This is also a proxy indicator for supply chain management and capacity to manage malaria outbreak promptly and effectively. This also provides with information on case load on these government facilities. The stock out situation may occur at the outpatient clinic while reasonable quantity of ACT may be available at the pharmacies. Non disbursement of the ACT may happen within the facilities. These gaps will be identified and plugged during the supervisory visits. The indicator is also dependent on the quantity of ACT procured, supplied to PR2 districts & distributed on time

	by PR1; local transmission dynamics; Supply chain management issues of PR2.
Project implication:	This indicator is a measure of project performance and addresses the needs of the national programme. Timely administration of ACT regimen to Pf cases immediately after detection will improve case management and ultimately impacting the disease trend. The NVBDCP and stakeholders may monitor how and where ACT is being utilized and prioritized accordingly.

Indicator 3.1 Number of Miking activity conducted in PR1 Areas by PR1.

Rationale and what it measures:	BCC is a systematic process that motivates individuals, families, communities, to improve knowledge, to change inappropriate or unhealthy behavior or to continue appropriate or healthy behavior such as improving the use of LLIN/ ITN or early and appropriate care seeking practices, treatment adherence, acceptance of indoor residual spray, etc. BCC is a key supportive strategy for the principal malaria prevention and treatment strategies under NVBDCP. Since the proposed project areas are mostly rural, tribal and hence, least likely to have access to mass media, BCC will be mostly based on direct, inter-personal communication and community outreach activities supported by appropriate BCC tools. Standard messages on malaria prevention and control by Infotainment through popular folk song & drama, skits, puppetry by local groups/ animators would be more acceptable to the target population. Other specific activities will include, amongst others, community/group sessions at village level. The participants will include: villagers, opinion leaders/ influencers, community based organizations/ SHGs, *Panchayat*, Village Health & Sanitation Committees, etc. Based on the experience of Phase I, this indicator has been modified and instead of "Number of People reached through infotainment activities, activity based indicator 'No. of miking activities conducted has been included in Phase II. The indicator measures the BCC activities through miking, where messages on prevention and control are disseminated at village level by government organizations during IRS, LLIN distribution and Anti-malaria month.
Indicator definition:	Number of miking activities conducted as against the targeted
Baseline values with dates and relevant data source (if available):	Not available
Targets set according to frequency of measurement:	Year 1: 72,274 (P1: 18,068; P2: 18,068; P3: 18,068; P4: 18,068) [cumulative annually] Year 2: 72,274 (P5: 18,068; P6: 18,068; P7: 18,068; P8: 18,068) [cumulative annually] Year 3: 72,274 (P9: 18,068; P10: 18,068; P11: 18,068; P12: 18,068) [cumulative annually]
Data source:	BCC input forms

Data collection method:	Routine health services statistics
Frequency of data collection:	Quarterly
Frequency of reporting/ dissemination:	Quarterly
Supporting documents	➢ Monthly/quarterly plan of activity including budget estimate and approval by appropriate authority; ➢ A note on prevailing rate for activity; ➢ Bill/voucher for payment made, then receiving of payment with date of activity [bill/voucher for refreshments (if any) and any other expenses (if any)]; ➢ Receiving of payment made to peripheral workers (if any) and accounting for such payments; ➢ Certification of conduction of activity with feedback by a sample of attendees (2-3), village Pradhan /Head of village; ➢ Activity report (include photographs, as possible).
Agency responsible for data collection and reporting:	PR, SRs and SSRs
Level of use:	National/Sub-national
Strengths and limitations:	It provides a measure of localized BCC activity through community outreach programmes towards enhancing knowledge, behaviour change amongst the target community by government organizations. However, the outcome and impact of various BCC activities are always synergistic as reinforcement of messages is done through application of BCC channel mix. This is a quantitative indicator. For gauging effectiveness of BCC activities and behaviour change amongst target populations, knowledge and adoption of appropriate actions for prevention and control of malaria need to be measured. Hence, this may not truly reflect actual behavior change. An attempt will be made to capture the relative contribution of various BCC activities as well. The household survey tools will be designed to capture data related to: Contribution of Interpersonal Communication (through the use of Community Health Volunteers/ ASHA); Contribution of Mid-media activities (wall writings, school activities etc.) and Contribution of mass media (Radio jingles). As baseline values are not available these will be generated through household surveys and trends will be monitored over the project period.
Project implication:	This indicator is a measure of project performance and addresses the needs of the national programme. BCC through community outreach programmes if carried out effectively and complemented by appropriate service provision will improve early case detection and complete treatment, correct and daily use of LLIN, acceptance of IRS; ultimately impacting the disease trend. The NVBDCP and stakeholders may monitor where and when BCC activities are to be focused.

Indicator 4.1: Number of supervisory visits to district periphery in a quarter by District VBDCP (Malaria) Officer (program / project) and report submitted to state program officer / district chief medical officer of PR1

Rationale and what it measures:	Supervisory visits to the community level apart from providing support to the community workers, will monitor reporting of malaria cases, logistics, number of LLINs/ ITNs distributed (in selected areas), use of ITNs by the beneficiaries, number of houses sprayed, etc. (consecutive physical verification will be done while monitoring). This will help DVBDC/DMO to identify the bottle necks in the implementation of the program and hence undertake course corrective measures. Additionally it will provide opportunity to the DMO to interface with the key community level influencers. A standardized check list will be used during the field visit to ensure the completeness and quality of the supervisory visit. These visits will also serve to authenticate the reports and data sent from the community level and upwards.
Indicator definition:	Number of field supervisory visits conducted by *District VBDCP (Malaria) Officer (program/project)* to the community and checklist duly filled and submitted by the *District VBDCP (Malaria) Officer (program /project) and report submitted to state program officer / district chief medical officer of PR1* in a quarter against the targeted visits
Baseline values with dates and relevant data source (if available):	219 (2012)
Targets set according to frequency of measurement:	This is a non-cumulative target as periodic visit in each quarters are important. Each DVBDC/DMOs/District Officers has to conduct on supervisory visit per month and report submitted to CMO (@ 464 per quarter). Year 1: 464 * 4 = 1856 Year 2: 464 * 4 = 1856 Year 3: 464 * 4 = 1856
Data source:	Supervisory visit report, PMMR
Data collection method:	Interview and direct observation during on site visit.
Frequency of data collection:	Quarterly
Frequency of reporting/dissemination:	Quarterly
Agency responsible for data collection and reporting:	PR, SRs, SSRs
Level of use:	National / Sub-national
Strengths and limitations:	Provide the authenticated data and clear picture pertaining to project activities. Ensure DVBDC /DMOs /District Officers' involvement in the community based activities in the target population as well as provide adequate support to the community level worker. Also ensures that monitoring of logistics supplied to volunteers. During the course of program implementation the visit

	may become more of ritual. The supportive supervision may reduce to instructional and administrative work.
Project implication:	This indicator is a measure of community level monitoring in the project and addresses the needs of the national programme. Supervisory visits along with supportive measures will ensure accurate case detection and complete treatment, correct and daily use of LLIN, impacting the performance of the volunteers at the community level and also ultimately disease trend. It will strengthen the overall project and also help to keep a pulse on the progress of project implementation. DVBDC/DMOs/District Officers will be familiar with community and well aware of the field challenges.

Indicator 5.1: Number of Malaria Technical Supervisor (MTS) trained/retrained by PR1

Rationale and what it measures:	Under the project, Malaria Technical Supervisors at sub-district level area engaged. S/He is trained to supervise the field activities under the project. A specific training module on malaria for MTSs is available with NVBDCP and structured trainings are planned in collaboration with government organizations and Medical Colleges. These MTSs will be trained under the Round 9 GFATM project. Training of MTSs is proposed towards improving their knowledge and skills for malaria control as well as enhancing access to quality service provision at community level. This indicator measures the number of MTSs trained towards creating trained cadres of MTSs for improved malaria prevention and control service supervision including case detection and treatment using RDT/ ACT, LLIN distribution and follow-up, BCC activities, data recording and reporting.
Indicator definition:	Number of *Malaria Technical Supervisor (MTS) trained /retrained by PR1* with structured training modules focused on knowledge and skill development for malaria prevention and control and supervision of the programme.
Baseline values with dates and relevant data source (if available):	158 (2012) trained during Phase I of IMCP-II Quarterly Physical achievement reports
Targets set according to frequency of measurement:	Year 1: 75 (P1: 0; P2: 75; P3: 75 P4: 75) [cumulative annually] Year 2: 0 (P5: 0; P6: 0; P7: 0; P8: 0) [cumulative annually] Year 3: 225 (P9: 125; P10: 225; P11: 225; P12: 225) [cumulative annually]
Data source:	Training report, PMMR
Data collection method:	Routine training records.
Frequency of data collection:	Quarterly
Frequency of reporting/dissemination:	Quarterly
Supporting documents	Attendance sheet, Registration form, Pre test& post test,

	Feedback form, Training report, Bills and vouchers for payments
Agency responsible for data collection and reporting:	PR and SRs
Level of use:	National/Sub-national
Strengths and limitations:	The indicator provides a measure of the capacity building of *Malaria Technical Supervisor (MTS) trained by PR1*on malaria prevention and control including supervision through structured, standardized training sessions. The training quality and consequent knowledge and skill building amongst trainees, may need to be assumed satisfactory and standardized. Qualitative assessments may need to be conducted for ascertaining the same. Further orientations will also be required.
Project implication:	This indicator is a measure of project performance and addresses the needs of the national programme. Increasing number of trained MTSs is a step towards strengthening service provision through supervision at sub-district level and creation of a strong sub-district level cadre of 'influencers'/ change agents.

Indicator 5.2: Number of ASHAs trained / re-trained (by PR1)

Rationale and what it measures:	The National Rural Health Mission (NRHM) launched in 2005 is the flagship programme of the GoI. The objective is to make quality health care accessible, acceptable, affordable and accountable to the vulnerable, the rural poor. Under NRHM, a village level and based female community health volunteer--Accredited Social Health Activist (ASHA) who is selected by the community is being established as a linkage between the community and the health facility. She is trained to take care of community health needs and paid incentives by the concerned national health programme(s) for the services provided. As NVBDCP is under the ambit of NRHM, anti-malaria interventions at village level are envisaged through ASHA, who comprise the first level of contact with health care system. In many NE states, where malaria is endemic, ASHAs are involved in prevention and control activities. Capacity building of ASHA through structured training sessions hence, is important. A specific training module on malaria for ASHAs is available with NVBDCP and structured trainings are planned in collaboration with non-government organization, medical colleges. Training of ASHA/ volunteer is proposed towards improving their knowledge and skills for malaria control as well as enhancing access to quality service provision at community level. This indicator measures the number of ASHA (15,300)/ volunteers (5700) trained towards creating trained cadres of ASHA/ volunteer for improved malaria prevention and control service delivery including case detection and treatment using RDT/ ACT, LLIN distribution and follow-up, BCC activities, data recording and reporting. Though some of the ASHAs have been trained in Phase I, however, with the introduction bivalent RDTs and of other effective anti-malarial drugs they may need to be retrained.

Indicator definition:	Number of ASHAs trained / retrained with structured training modules (including on new interventions) focused on knowledge and skill development for malaria prevention and control.
Baseline values with dates and relevant data source (if available):	New Indicator.
Targets set according to frequency of measurement:	Year 1: 4500 (P1: 0; P2: 0; P3: 2250; P4: 2250) [cumulative annually] Year 2: 13,500 (P5: 3375; P6: 3375; P7: 3375; P8: 3375) [cumulative annually] Year 3: 0 (P9: 0; P10: 0; P11: 0; P12: 0) [cumulative annually]
Data source:	Training report, PMMR
Data collection method:	Routine training records.
Frequency of data collection:	Quarterly
Frequency of reporting/dissemination:	Quarterly
Supporting documents	Attendance sheet, Registration form, Pre test& post test Feedback form, Training report, Bills and vouchers for payments
Agency responsible for data collection and reporting:	PR and SRs
Level of use:	National/Sub-national
Strengths and limitations:	The indicator provides a measure of the capacity building of ASHAs/community health volunteers on malaria prevention and control at village level through structured, standardized training sessions. The training quality and consequent knowledge and skill building amongst trainees, may need to be assumed satisfactory and standardized. Qualitative assessments may need to be conducted for ascertaining the same. Without appropriate incentives/ recognition for services delivered, continued motivation of ASHAs may pose a challenge. Further orientations will also be required.
Project implication:	This indicator is a measure of project performance and addresses the needs of the national programme. Increasing number of trained ASHAs is a step towards strengthening service provision at community level and creation of a strong village based cadre of 'influencers'/ change agents.
Agency responsible for data collection and reporting:	PR 1 supported by Caritas India (PR2), SRs—VHAI, CMAI supported by Futures Group
Level of use:	National/Sub-national
Strengths and limitations:	This will give the effectiveness of BCC activities among targeted population. The convertibility of imparted knowledge also measured. The gaps may be identified in course of BCC and midterm correction will be initiated. This is a quantitative indicator of the convertibility of the imparted knowledge on malaria via multiple channels. The knowledge gained/ retained may not necessarily be adopted leading to behavior changes.

2.4 M&E Data Recording/ Compilation, Reporting, Analysis, Use

A well-designed and fully functional system for routine data collection/ recording, compilation, reporting, analysis is set up for monitoring progress in performance according to the defined targets and for harmonization of data recording and reporting with PR1and its SRs and between the PR2. The system will comprise of identified project personnel with the PR1 and its SRs at national and sub-national levels, who will be assigned clear responsibilities and accordingly will be capacitated through trainings in coordination with Caritas India.

Recording and Reporting Mechanism under National Progamme

The NVBDCP has defined systems, processes and forms, registers, for programmatic data collection, recording and reporting as well as for integration within the HMIS of MOH&FW. The routine data in relation to case management and vector control are captured through programme Health Management Information System (HMIS). Other data sources are: sentinel surveillance of severe cases and deaths, household and health facility survey, central evaluations, annual planning and review meetings, supportive supervision visits. The programme HMIS is a software application, which includes a series of forms for recording and reporting as mentioned below, and which generates, maintains and transmits quality data across different tiers of the health care delivery system. Routine data (village wise) will be collected on M-ASHA and M1 formats and compiled in M4. Processes (e.g., interventions, trainings, communication), outputs (services delivered, activities conducted) in each quarter will be compiled using pre-designed forms.

National Programme of India for Malaria Control was having a record keeping and reporting mechanism few years back with about more than 17 forms to be filled up at various levels. Integration of all Public Health Programmes and concerted service delivery under the umbrella of NRHM along with changing data and information needs of NVBDCP have prompted the revision and simplification of the HMIS. New interventions like RDTs, ACT, ITNs which have been introduced in recent past, are expensive inputs into the programme and it becomes important to closely monitor their utilization. Reporting on training activities, field visits, logistics & LQAS are done as part of Programme management Monitoring. So, in 2008, the recording and reporting mechanism was revised with the technical support from the World Bank, GF (using Monitoring and Evaluation System Strengthening Tool -MESST) and the inputs from the programme implementers in various states of the country. It has been initially implemented in the project states covered under the World Bank and Global Fund Support in 2009 and has now been extended to whole of the country.

Revised Management Information System (MIS)

The Management Information System (MIS) is a series of recording and reporting formats to be maintained and transmitted by different tiers of the health care delivery system. The records and reports are maintained in such a way that high quality reliable data is generated from them. This data is the treasure house of information from which a series of indicators are derived at different levels. For the purpose of routine recording and reporting the following M1 to M4 Formats and VC1 to VC 12 Formats and Programme Management Monitoring Report are used.

1. Case Detection and Management ***(Annexure 1-6)***
   - **M1** : Report of Surveillance by **ASHA (M-ASHA**)/ MPW/ Health facility
   - **M2** : Laboratory Request for Slide Examination
   - **M3** : Record of slide Examination in PHC Laboratory
   - **M4:** Fortnightly Report of Cases From Sub-centre/ PHC/ District/ State
     (M4- Health facility wise, M4- Provider wise)

- Sentinel surveillance formats

2. Integrated vector Control ***(Annexure 7-12)***
   - **VC1**: Primary record of IRS
   - **VC1S**: Wall Stencil
   - **VC2**: District IRS output Form
   - **VC3**: Primary record of bed-net (LLINs) delivery and impregnation
   - **VC 4**: Bed-net Delivery and Impregnation form
   - **VC 5**: District Annual Stock report on vector control supplies
   - **VC-6**. IVM Plan - Block level
3. Programme Management Monitoring Report (***Annexure -13***)

Case Detection and Management

Forms M-ASHA, M1, M2, M3 and M4 of the HMIS are concerned with case-management data and are given in Annexure1-6.

1. M Register : M Register for ASHAs/ CHV

Whenever an ASHA/ FTD holder sees a patient having fever, the details of the patient are recorded in M Register of ASHA. Both, positive and negatively tested cases are recorded. Even if the patient is not tested for any reason, the details of the patient are recorded in M Register. Even those cases where the patient does not belong to her village, but may only be a visitor, is also recorded in M Register. Any patient, with fever suspected to be suffering from malaria is entered in M Register. At the end of the month, ASHAs provide the total of details of total suspected cases, RDT positive and Total positive (RDT& slide)

M Register (**Annexure 1**) is meant for recording patients of fever seen in one reporting year. For each month a new page in M Register is started. The serial numbers begin fresh each year and continue over the months till the end of the year. This number is also applicable when labeling the sides/ RDTs. All PHCs and MPWs/ ASHAs/ CHVs are given a unique code for identification. On the thin film of slide and RDT the unique identification number is written. This is PHC code/ ASHA Code/ S. No. With this unique identification number it is possible to ascertain precisely which ASHA prepared a particular slide/ RDT. Blood test is done in all patients of fever as soon as possible.

All fever cases which approach the ASHA/ MPW/ CHV are screened using RDT and blood slides. Fever cases which turn out to be RDT positive will be provided treatment immediately and the positive RDT along with the blood slide is stored by ASHA/ MPW/ CHV for Quality Assurance (QA) at a later date.

Medicines are administered according to the test result and age of the patient, referring to the dosage chart in the Register. In these columns, she tick marks (√) the day for which dose has been administered. The date of completion of treatment in *Pv* cases should be the date on which the last dose of PQ was administered. If the patient is pregnant, or exhibits signs of severe malaria, the patient is referred. In case of death of patient the Date/ Place of death is to be mentioned.

Stock Position:

Whenever medicines are received or supplied from the MPW or from the PHC, s/he enters the number of tablets or blisters received in the relevant columns in the row “Received during the month” in the page on Stock Keeping given at the end of M Register (Annexure 1-S). At the end of the month, she counts the number of tables or blisters of each type remaining and enters these numbers in the relevant columns in the row “In stock at end of the month”. The stock at the ‘end of the month’ becomes the ‘opening balance at the beginning’ of the following month.

Transport of slides & result of slides
The slides collected by ASHAs/ private providers/ community health volunteers are delivered at sub-centre by them or by any of their representative on day to day basis which is transported to the PHC lab biweekly, by MPW (M) and MPW (F). The results are conveyed back by MPW (M) and MPW (F) to these providers in subsequent visit or through communication tools if available.

1. Fortnightly /Monthly Surveillance Report of Fever Cases by MPW/ Health facility (M1)
This is the primary case record for all suspected malaria cases i.e. it is actually a line list of all fever cases. This form is filled by any health facility/ worker which are directly involved in case detection and treatment. Whether collection is through Active / Passive case detection and it is filled as A or P. For all purposes the ASHA/ CHV/ MO PHC are passive agencies. Therefore in these cases the entry will be always P. It is only an MPW who can be involved in both types of collections. Fever cases coming to the MPW on their own are entered as P while fever cases detected actively are entered as A. The MPW will compile M4-SC by compiling the M1 of all ASHAs and adding his/ her own M1.

All deaths due to malaria are investigated in detail by an officer no lesser in rank than the DMO/ DVBDCO or MO-PHC. The proforma prescribed for the detailed investigation of malaria death and important epidemiological considerations is given in ***Annexure 20***.

2. Laboratory Request Form for Slide Examination (M2)
In areas where RDTs are supplied, RDT and preparation of Blood slide are done at the same time. However, only if the RDT is negative, the blood slide is forwarded to Lab for further examination. Areas where RDTs are not supplied also rely on microscopy for diagnosis. M2 i.e. the Laboratory Request Form for Slide Examination, is filled in duplicate by ASHA/ CHV/ MPW whenever blood slides need to be sent to the Lab. It is sent to PHC lab whenever required. The result of microscopy and feedback on smear quality are filled by the LT. All efforts are made by LT to examine the slides on the day of receipt or the following day and send the results back to ASHA/ CHV/ MPW on the same day as examination of blood slides. The results obtained are entered into M1 by ASHA/ CHV/ MPW.

3. Record of slide Examination in PHC Laboratory (M3)
M3 is the Sub-centre wise record, of slides examined in the PHC Lab. Slides reach the lab from the ASHA/ CHV/ MPW of the SC area. Slides are also collected and examined for suspected malaria cases referred from the PHC OPD. Therefore, at the beginning of each year, the M3 register is divided into sections for different sub-centers as well as PHC OPD. In each sub-centre section Serial Nos are started fresh at the beginning of each year. Record of slides sent along with M2 is entered serially into M3. As soon as M2 is received Col 3 to 10 are entered from M2 followed by the date of receipt. The remarks column can indicate the quality of smear and other information like reasons of delay in examination.

4. Fortnightly Report of Cases – Sub-centre/ PHC/ District/ State (M4) is a village-wise/ provider-wise / sub-centre wise monthly consolidation of all M1 forms belonging to a sub-center/ PHC area. The M1 is received by the MPW from ASHAs/ CHVs after 7 days of completion of the reporting fortnight. The MPW then compiles all M1s of his sub-centre area into M4. During compilation the Sub-centre MPW will fill out aggregates of each health care provider in Sub-centre area in one row and in the last row enter the compilation of his own M1. The report is made in triplicate and 2 copies are forwarded to PHC. The PHC compiles the report received from all Sub-centers including the cases detected at the PHC in M4 format at PHC. This report is compiled in **two formats** i.e. **health facility wise** report and **provider wise report (M4 HF wise and M4 Provider wise).** Both these reports are submitted to the district.

The timeline for submission of the report by different levels is mentioned in Table in 'Data quality' paragraph. The district is required to enter Sub-centre wise data from M4 of PHCs into National Anti-Malaria Management Information System (NAMMIS) as soon as the reports are received to avoid delay in transmission of reports. The state office compiles the reports received from all the districts and sends this district wise report to the Directorate of NVBDCP where it is compiled state wise and national report is generated every month. Compilation of monthly reports at the end of year generates the annual data which stands corrected as and when the errors if any are detected and rectified

Historically weekly fever surveillance was conducted through the mechanism of the weekly telegram also referred to as MF3. This has now been integrated with IDSP. The MO PHC is required to furnish this to the Nodal Officer of IDSP in the district. The DMO/ DVBDCO will coordinate with IDSP for obtaining relevant information in this regard.

Sentinel Surveillance:
Under the externally funded projects sentinel surveillance has been initiated from 2008. Under this, two or three hospitals are identified in high endemic districts (especially in project districts) for monitoring the trend of severe malaria and spatial distribution of cases at local level to identify the areas of operation for identification of deficiencies and taking corrective actions by the District Malaria Officer. One recording and one reporting format have been developed for recording and reporting of the OPD and Indoor malaria cases at these sites ***(Annexure 14, 14R***).

Reporting of Integrated vector Control
The recording and reporting formats for vector control activities ***(Annexure 7-12)*** including Indoor residual spraying (IRS) and distribution of Long Lasting Insecticidal Nets (LLINs) are also developed during the revision of reporting formats in 2008. Accordingly, simplified (but sufficient for information) formats have been introduced in the programme for the vector control activities.

Flow of Information
Various records maintained at different levels are compiled to generate different programme reports. The flow of reports in the system is as follows:

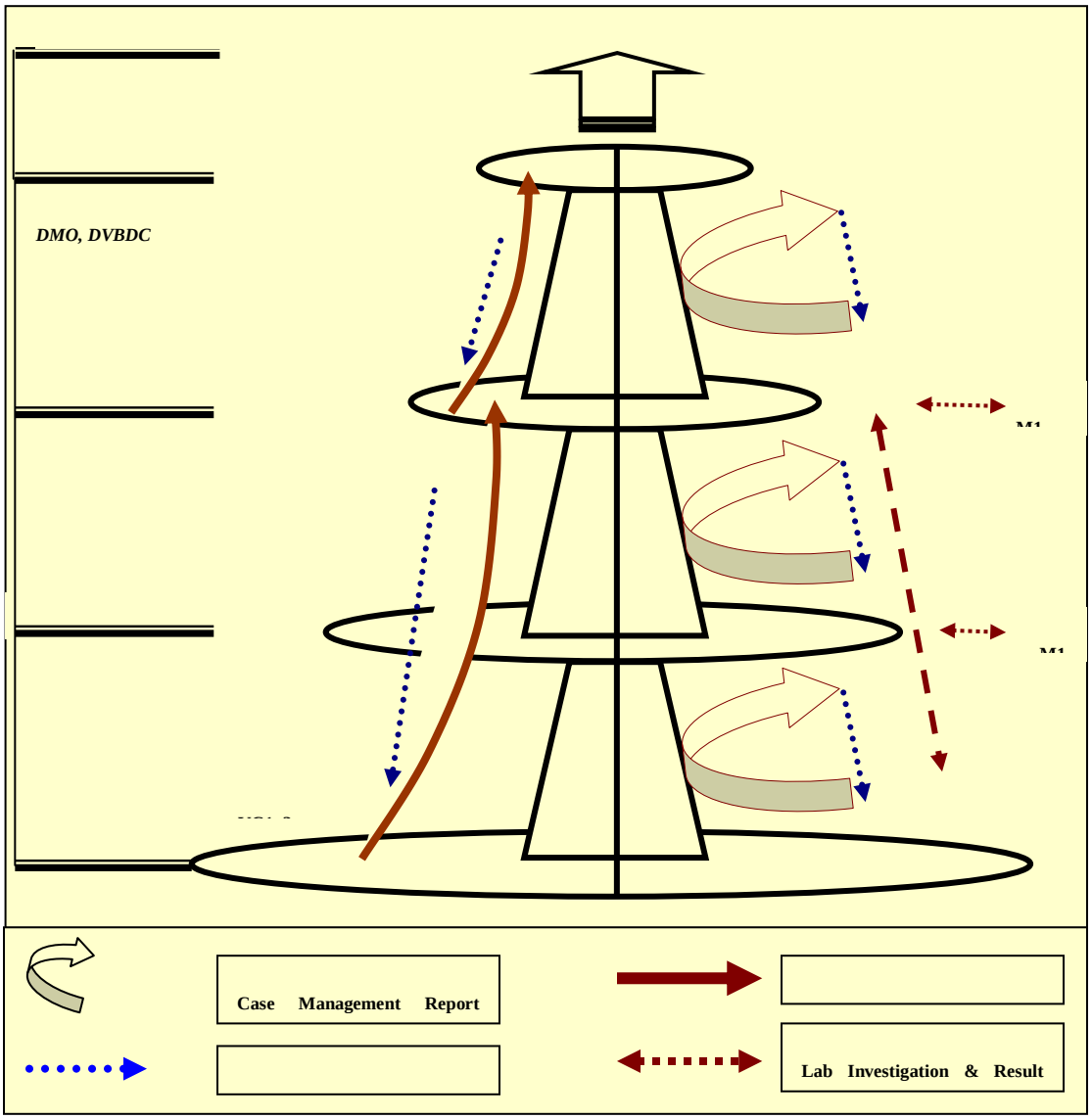
Surveillance/ Case detection & Management
The Report of Surveillance by ASHA/ MPW/ Health facility (M/M1) is maintained at every level diagnosing and treating cases like ASHAS/ AWWs/ CHVs at village level, MPWs at Sub-centre level and MO-PHCs. The M1 is submitted to the Sub-centre fortnightly, where it is compiled village/ health care provider wise into Fortnightly Report of Cases (M4) by MPW (M) or in his absence by MPW (F). Sub-centre M4 is submitted by MPW to the MO-PHC. At the PHC the report is further compiled for all the sub-centers in the PHC area, the PHC data is further added to it. Thus at PHC level the village wise data of all the sub-centers under it is available.

PHC level M4 is sent to the district where data is entered in the Web-based HMIS i.e. NAMMIS which if not possible sent manually to state. Thus, at district level, the sub-center wise data of all the PHCs under it is available. Laboratory Request Form for Slide Examination (M2) is sent along with slides transported to lab for examination. All slides sent to lab for examination are entered in the Record of slide Examination in PHC Laboratory (M3) and result is transmitted back (indicated by dashed line) in the M2. The districts send the PHC wise compiled report to the State. Thus, the PHC wise information is available at the State level.

The states compile the reports received from districts and send the district wise report every month to the NVBDCP. Thus, district wise information is available at the NVBDCP. At PHC, District, State and National level the reporting unit wise data is reviewed and the feedback is given to the reporting units either during discussion at the monthly meetings or by communication methods (Letters /email

/telephone) along with the action to be taken based on the epidemiological indicators defined for each level detailed in the country M&E Plan. The flow of reports in the HMIS and their feedback paths are given in the following figure. The feedback pathways are shown by blue Dotted arrows.

Fig: Flow of Information in malaria HMIS



Programme Management Monitoring Report

This report of various activities (such as training, IEC/BCC activities, Quality assurance, logistics, supervisory visits) ***(Annexure 13)*** is compiled quarterly by the district and sent to state after reviewing the status at local level.

Role of Health Care Staff in Data Management

I) Village Level (ASHAs/ AWW/ CHV)

- To maintain the record of all fever cases in M-ASHA Register and provide fortnightly report of the same to the MPW by 21st of the same month for the 1st Fortnight and the 7th of following month for the 2nd Fortnight.

- To enter slides of cases which are to be sent to lab for examination in M2 and arrange for their transportation the same day. To lab. On receipt of results in the completed M2 from lab, to enter the results against respective fever cases in M- ASHA register.
- To determine and analyze simple indicators. These indicators are displayed in front the ASHAs or AWWs or CHVs house/ *Panchayat Ghar*. Each month the surveillance / case finding indicators of the current and previous fortnight are updated. Any significant increase over the previous fortnight is brought to the notice of the MPW and MO-PHC.

II) Sub-centre Level MPW-(M) / MPW-(F)

MPW (M) or in his absence MPW (F) is the principle supervisor of the sub-centre area and is also the person who would conduct the annual bed-net survey with assistance from ASHAs/ AWWs/ CHVs. His roles are:

- Compilation of all M1 forms received at the end of the fortnight and prepare the Sub-centre's Fortnightly Report of Cases in M4 and submit it to the MO-PHC by the 25th of the month for the first fortnight and 10th of following month for the second fortnight.
- To undertake the annual household bed-net surveys in the eligible villages of the sub-centre during the pre-transmission season to ascertain the bed net requirement and enumerate bed nets available in the households to and enter the details in VC 4. Send copy of this form to MO-PHC for use in district level planning.
- To conduct impregnation and distribution of bed nets in all the targeted villages and fill the VC 4 format. To submit the VC 4 at the completion of village level activity to MO-PHC.
- To determine and analyze simple indicators. The surveillance / case finding indicators are charted every 15 days, village wise, for the current and previous fortnight. Any significant increase over the previous fortnight should be brought to the notice of MO-PHC. The vector control interventions are recorded for each village of the sub-centre on completion of it.

III) PHC Level

i) MO-PHC: MO-PHC is the officer in-charge of all malaria prevention and control activities in the area of PHC. He holds a position of immense responsibility as he is the signing authority for all reports to be furnished by the PHC. He has the following roles in reporting:

- Compilation of all reports received at the end of the fortnight from sub-centers and prepare the PHC's Fortnightly Report of Cases in M4 and submit it to the District Malaria Officer (DMO) by the 28th of the month for the first fortnight and 13th of following month for the second fortnight.
- To compile VC 1 received from the SFWs into the VC 2 and send the IRS Output Report to DMO within 15 days of completion of all IRS activities in the PHC area.
- The MO-PHC facilitates the conduction of bed-net survey by MPW (M)/ ASHAs for enumeration of bed-nets in households in VC3 during the pre-transmission season. He provides full cooperation to the DMO and furnishes all relevant information to the DMO.
- Compiles VC 3 received from the MPWs into the VC 4 and send this Bed-net Output Report to DMO within 15 days of completion of all activities.
- The surveillance / case finding indicators are charted every 15 days, at least sub-centre wise and compared with the corresponding fortnight of the previous year. Comparison of occurrence of cases in the year with the corresponding period of the previous year. Sub-centre wise tabulation of all Vector control indicators are done during the transmission season at the completion of the activity.

ii) Health Supervisor/ Malaria Inspector: Health Supervisor/ Malaria Inspector assist the MO-PHC in

all malaria control activities. He therefore is the second in guard in the PHC area and is responsible in assisting in all reporting responsibilities

- To assist in the compilation of all reports received at the end of the fortnight from sub-centers and prepare the PHC's Fortnightly Report of Cases in M4.
- To assist in the compilation of VC 1 received from the SFWs into the VC 2.
- To assist in the compilation of all VC 3 received from the MPWs into the VC 4.
- To assist in the analysis of reports generated.

iii) **Lab Technician**: Lab Technician is responsible for malaria microscopy and its reporting at the PHC Laboratory. He has the following roles in malaria diagnosis:

- To receive the M2 format along with the slides sent for examination by the peripheral workers like ASHAs/ AWWs/ CHVs and also from the PHC OPD.
- To enter all slides received from the periphery or PHC-OPD in M3.
- To examine all the sides received preferable on the same day. Enter the results in M3 correctly and arrange for transportation of results back to the fieldworker on the following day for timely initiation of treatment.
- To maintain the M3 up to date and to prevent back backlog of slides.
- To assist the MO-PHC in the compilation of M4.

iv) District Level -District Malaria Officer (DMO)/ District VBD Control Officer (DVBDCO)

DMO is the person in-charge of all malaria prevention and control activities the District. For recording and reporting he has the following responsibilities which he will execute with help from District Vector Borne Disease Consultant (DVBDC) and Assistant Malaria Officer (AMO), if present.

- Compilation of all reports received at the end of the fortnight from PHC's and preparation of District Fortnightly Report of Cases in M4 and timely submission to the state by the 30th of the month for the first fortnight and 15th of following month for the second fortnight.
- To compile VC 2 received from PHCs into a district level IRS Output Report and send it to state within 30 days of completion of all IRS activities in the PHC area.
- The DMO coordinate with MO-PHC to ensure undertaking of bed-net survey by MPW (M)/ ASHAs for enumeration of bed-nets in households in VC3 during the pre-transmission season. He also ensures that this information is duly collected from the MO-PHC so that it is available for the development of Annual District Action Plans.
- To compile VC 4 received from the PHCs into district level Bed-net Output Report and send it to the state within 15 days of completion of all activities.
- The DMO compiles District Annual Stock Report on Insecticides in VC5 based on PHC stock registers within 15 days of completion of the reporting year and send to the state.
- The DMO oversees the maintenance of a yearly log of LLINs distributed in VC6.
- The Programme Management Monitoring Report is compiled at the end of each quarter and sent to the state no later than the 15th day of the following month.
- To analyze and tabulate preferably sub-centre wise fortnightly surveillance/ case finding indicators and compare with the corresponding fortnight of the previous year as well as comparison of occurrence of cases in the year with the corresponding period of the previous year. Vector control indicators are charted during the transmission season at the completion of the activity for all sub-centers. The indicators are used for analysis.

v) State Level - State Programme Officer (SPO)

At the state level the State Programme Officer is responsible for all reporting requirements to be furnished to the National Vector Borne Disease Control Programme, Delhi.

- Compilation of all District Fortnightly Report of Cases in M4 received from districts and preparation of State level report and timely submission to the state by the 5th of the following month for the first fortnight and 20th of following month for the second fortnight.
- To compile District level VC 2 received, into State IRS Output Report and send it to NVBDCP, Delhi within 45 days of completion of all IRS activities in the districts.
- To compile District Bed-net Output Reports (VC 4) received, into State level Bed-net Output Report and send it to NVBDCP, Delhi within 15 days of completion of all activities.
- The State compiles District Annual Stock Report on Insecticides in (VC5) and sends it to the centre no later than 30 days of completion of the reporting year.
- The District the Programme Management Monitoring Reports received by the state is compiled at the end of each quarter and sent to the centre no later than the 21st day of the following month.
- To analyze and tabulate at least district wise fortnightly surveillance/ case finding indicators and compare with the corresponding fortnight of the previous year. Comparison of cumulative occurrence of cases in the year with the corresponding period of the previous year is done. Vector control indicators are recorded during the transmission season at the completion of all activity. The indicators are used for analysis at the state level.

vi) National Level NVBDCP, Delhi has the overall responsibility of compilation of all State level reports on case management, integrated vector control and programme management. The national level analyzes this data and provides feedback to states on key observations. The indicators are used to analyze the status of each state at the National Level and compare it with the corresponding period of the previous year.

Data Quality:

Under the programme it is important to ensure that the data collected through reports are complete, accurate and consistent. This is possible only when records are maintained immaculately on a regular basis and a system of verification of reports exists. Therefore, the quality of data is the responsibility of the supervisory staff and the Officer In-charge/ signing authority of the reports. It is necessary to verify data during onsite visits of villages, sub-centers and districts. During field visits the supervisory staff like MTS, DVBDC consultants, DMO and other PHC/ District /State/ Centre level personnel crosscheck M1 for the individual patient records and visit patients diagnosed and treated in the previous month. Similarly a sample of reports are reworked from the records to check for their validity e.g. the BMO recheck the compilation of M4 of all Sub-centers into M4 at PHC each month. The reports are tracked for timeliness and complete each time they are received. The time schedule for each report is mentioned in Table below.

Timeline for reporting at each level

S. N.	Report	Time Schedule
1	Fortnightly Report by ASHA/ Community Health Volunteer/ MPW/ PHC (M1)	Ist Fortnight- 21st of the month IInd Fortnight- 7th of following month
2	Fortnightly Report of cases (M4-SC)	Ist Fortnight- 25th of the month IInd Fortnight- 10th of following month
3	Fortnightly Report of cases (M4 PHC)	Ist Fortnight- 28th of the month IInd Fortnight- 13th of following month
4	Fortnightly Report of cases (District)	Ist Fortnight- 30th of the months IInd Fortnight- 15th of following month
5	Fortnightly Report of cases (State)	Ist Fortnight- 5th of the following month

		IInd Fortnight- 20th of following month
6	IRS output (VC2) – Round wise	PHC – 15 days of completion of Spray District – 30 days of completion of spray State - 45 days of completion of Spray
7	Bednet Delivery and Impregnation form (VC 4)	PHC – 15 days of completion of activity District– 30 days of completion of activity State - 45 days of completion of activity
8	District Programme Management Monitoring Report (PMMR)	15th day of the following quarter
9	State Programme Management Monitoring Report (PMMR)	21st day of the following quarter

Feedback Mechanisms, Data sharing and Transparency

There is a two way flow of information in system of data management. A system of preliminary tracking of reports for data timeliness, completeness and consistency and a system for prompt feedback on such discrepancies observed are established at all levels. Beside this there is timely review of all reports received on epidemiological and programme management aspects. Any unusual deviations in various monitoring parameters are communicated to the reporting units. The Centre/ State/ District / PHCs have established this system through regular letters e-mails and review meetings, with their respective reporting units to notify the observations made. The reporting unit responds within one week to such correspondence with required clarifications.

The centre/ district and state also come up with Annual reports at the end of year for the reporting units which are widely disseminated. In this annual report the discrepancies and corrections are made as observed during the period and final data is used for annual planning for the next year identifying the sub-centers which are to be targeted for intervention based on the guidelines given time to time from the Directorate of NVBDCP and the State office.

Programme Review:

Regular review of program by authorities is a way of taking stock of programme progress as well as it provides opportunity of interacting with the implementing partners to address administrative issues. Such reviews are organized at regular interval which reflects commitment of the highest order. Detailed review of all the activities is done during these meetings. The norms for such review are as follows:

S. No	Level	Type of review	Time schedule
1	Centre	Quarterly review of States by Centre	1 per 3 months
2	State	Quarterly review of District by State (in First month of the following quarter)	1 Per Quarter
3	District	Monthly review of NVBDCP under chairmanship of District collector	1 Per month per District
4	District	Monthly review of NVBDCP by DMO/ DVBDCO with his staff	1 Per month per District

The participation of highest level administrative officials is ensured in programme monitoring. Wherever possible the Health Secretary is involved in such programme reviews at State level. The District collector also reviews the programme as per the prescribed norm especially in the

transmission season. Micro-planning of IRS as well as continuous monitoring of its implementation is a District Collector driven initiative. The checklists to be used by Health Secretary and District Collector in such reviews are given in ***Annexure 15 & 16*** respectively.

Reporting mechanism under the IMCP-II:

Under IMCP-II a quarterly reporting format have been designed and distributed to all the Project states of North-East. These reports include indicators, targets and their achievements and the reasons for variance. The states have been communicated about the explanation for filling up this format in writing as well as during the review meetings held from time to time. The states have to submit it within 30 days of the end of the Quarter which is compiled at the national level and submitted to the GF within 45 days of the end of the quarter. The Caritas India (PR2) is also involved in various activities (Case detection, LLIN distribution, BCC). PR2 is having its own reporting format according the performance framework as agreed with the GF. The PR2 reports the activities done by their volunteers during each quarter in their quarterly submission. The guidelines regarding filling up the quarterly report are also discussed during the review meetings and in the project steering committee meetings to solve any problems in reporting including avoidance of double reporting and timely submission of reports. They are as follows:

Guidelines and explanation for reporting mechanism under the IMCP-II (PHASE II):

From October 2012, the implementation of the Phase II of the IMCP-II has been started. As per the agreement with the GF, a revised reporting format including revised indicators has been developed. All the states are requested to send the quarterly reports of the activities of the project in the given format **(Annexure A)** from Quarter 9 onwards. The explanation of the indicators and how to fill up have been given in this communication.

Explanations of the indicators used for quarterly reporting in IMCP-II- (Phase II)

A quarterly reporting format given at the Annexure A is to be used for quarterly reporting of the performance of IMCP-II implementation by each district and state. It is felt that it needs further definition / explanation, so that correct reporting is done by all. It includes the indicators No. 2.5 and 2.6 which are to be collected through LQAS or will be available after household surveys and other indicators which are collected from the epidemiological /surveillance reports. It should be ensured by all the districts that the backup record should be available at the district office to match the report which they have submitted to the state. There should be no discrepancy in the record and the report. The reasons for variance have to be given by all the districts /states for the variation in achievement against the target for that particular quarter for each indicator. The column of remark is given for explanation. However, it is to be removed in the reporting by the state. The clarification and explanation given for each indicator is as follows:

Indicator 1.1: Number of LLIN distributed in LLIN eligible areas (API ≥ 2) by functionaries of PR1

Here, the district / state will have to give the total number of LLINs distributed in their area by functionaries of Government healthcare services (GHS) only. It is a non-cumulative target, so the achievement of that particular quarter is only to be included in it. If there is no distribution of LLIN in that quarter, the report for it should be zero. (Data source: VC 4)

Indicator 2.1: Number of fever cases tested with RDT by ASHA (PR1)

Here, the district / state will have to give only the total number of fever cases tested with RDT by

ASHA or other community volunteer of GHS during that particular quarter. It is a non cumulative target, so the achievement of that particular quarter is only to be included in it. (Data source: M4- provider wise)

Indicator 2.2: Number of fever cases tested with RDT at Public sector health facilities (Sub-centre, PHC, CHC, etc.) of PR1

Here, the district / state will have to give only the total number of fever cases tested with RDT at Public sector health facilities (Sub-centre, PHC, CHC, etc.) of GHS during that particular quarter. It is a non cumulative target, so the achievement of that particular quarter is only to be included in this. (Data source: M4- provider wise)

Indicator 2.3: Number of Number of Pf cases treated with ACT by ASHA (PR1)

Here, the district / state will have to give only the total number of Pf cases treated with ACT by ASHA or other community volunteer of GHS during that particular quarter. It is a non cumulative target, so the achievement of that particular quarter is only to be included in this. (Data source: M4- provider wise)

Indicator 2.4: Number of fever cases tested with RDT at Public sector health facilities (Sub-centre, PHC, CHC, etc.) of PR1

Here the district / state will have to give only the total number of Pf cases treated with ACT at Public sector health facilities (Sub-centre, PHC, CHC, etc.) of GHS during that particular quarter. It is a non cumulative target, so the achievement of that particular quarter is only to be included in this. (Data source: M4- provider wise)

Indicator 2.5: Percentage of ASHAs with no reported stock-outs of nationally recommended anti-malarial drugs lasting more than one week at any time during the past one month

Here, the data can be collected from the randomly selected M4 report, if reporting of the same is available in the M4 (column no 32) submitted by all the SCs. Alternatively, the data collected through LQAS by MTSs or any other supervisors should be analyzed and reflected here. It is also a Non-Cumulative Quarterly Targets. Data collected from minimum 95 interviews of ASHA/CHVs in a district done in that particular quarter through LQAS should be used here. Please mention both numerator and denominator and then calculate the percentage. It is calculated as follows:

$$\% = \frac{\text{No. of ASHAs who reported no stock-out of nationally recommended anti-malarial drugs lasting more than one week at any time during the past one month}}{\text{No. of ASHAs interviewed / record checked during the LQAS/ from the M4 in that particular quarter}} * 100$$

If the data is collected from randomly selected M4, then the denominator should be total number of ASHA records of a single month examined and the numerator should be how many of them were having no stock-out of nationally recommended anti-malarial drugs lasting more than one week at any time during the past one month. The target here is 100%. It means that all the ASHAs should have anti-malarial available with them to treat a case. Here, the emphasis is on availability of ACT, Chloroqunie and Primaquine. The indicator is used to measure the availability of anti-malarial drugs at the field level which is most important to deliver the service at the field level to save the life of affected ones.

Indicator 2.6: Percentage of public sector facilities with no reported stock-outs of nationally recommended anti-malarial drugs lasting more than one week at any time during the past one month

Here, the data can be collected from the randomly selected M4, if reporting of the same is available in the M4 (column no 32) submitted by all the PHCs/SCs. Alternatively, the data collected through LQAS by MTSs or any other supervisors should be analyzed and reflected here. It is also a Non-Cumulative Quarterly Target. Data collected from minimum 95 interviews of SC/HCs's staff in a district done in that particular quarter through LQAS should be used here. Please mention both numerator and denominator and then calculate the percentage. It is calculated as follows:

$$\% = \frac{\text{No. of SC/HCs who reported no stock-out of nationally recommended anti-malarial drugs lasting more than one week at any time during the past one month}}{\text{No. of SC/HCs' staff interviewed during the LQAS or record checked from the M4 in that particular quarter}} * 100$$

If the data is collected from M4, then the denominator should be total number of randomly selected SC/HC records of a single month examined and the numerator should be how many of them were having no stock-out of nationally recommended anti-malarial drugs lasting more than one week at any time during the past one month. The target here is 100%. It means that all the SC/HCs should have anti-malarial to treat a case. Here, the emphasis is on availability of ACT, Chloroqunie and Primaquine. The indicator is used to measure the continuous availability of anti-malarial drugs at the field level which is most important to deliver the service at the field level to save the life of affected ones.

Indicator 3.1: Number of miking activity conducted in PR1 areas by PR1 (as prescribed in the project)

Here, the district will report the number of miking activity conducted in PR1 areas by PR1 prescribed in the project. There are five different types of infotainment activities planned in the project. The district should report total number of miking activity conducted by the PR1in areas covered by PR. The record of each activity should be maintained by the district, which can be later on verified by the Central /State supervisory officers and LFA. (Data source: PMMR)

Indicator 4.1: No. of supervisory visit to district periphery in a quarter by district VBDCP (malaria) officers (programme /project) and report submitted to state programme officer/ district chief medical officers

Here, the total number of visits to district periphery in that particular quarter made by the district VBDCP officers (Including DMOs, Dist. VBD consultant and other District level officers). They should submit the report of all the visits. So, if 10 visits are reported in the quarterly report, 10 visit reports should be available at the district office for verification and only the expenditure of these 10 visits should be reflected under the supervision and M&E activity head in the SoE for project. (Data source: PMMR)

Indicator 5.1: Number of malaria technical supervisor (MTS) trained / retrained by PR1

Here, the number of malaria technical supervisors (MTSs) trained/retrained during that particular quarter only should be mentioned. It also a NON-Cumulative Quarterly Target. The MTSs who were trained /retrained in previous quarters should not be included in it. (Data source: PMMR)

Indicator 5.2: Number of ASHAs trained/retrained by PR1

Here, the number of ASHAs trained/retrained during that particular quarter only should be mentioned. It also a NON Cumulative Quarterly Target (for states). The ASHAs who were trained/ retrained in previous quarters should not be included in it. (Data source: PMMR)

Quarterly Report of Intensified Malaria Control Project-II-(Phase II)

Name of State:				**Quarter :**	**Q-**	
Reported for the period _____201_ to _____ ___ 201___						
Objective Number	**SDA [database category]**	**Output/ 'Coverage' indicators**	**Target**	**Achievement**	**Reasons for variance**	**Remarks/ Explanations**
1.1	Insecticide-treated nets (ITNs)	Number of LLIN distributed in LLIN eligible areas (API≥2) by functionaries of PR1				NON Cumulative Quarterly Targets /Achievements
2.1	Diagnosis	Number of fever cases tested with RDT by ASHA (PR1)				NON Cumulative Quarterly Targets/Achievements
2.2	Diagnosis	Number of fever cases tested with RDT at Public sector health facilities (Sub-centre, PHC, CHC, etc.) ofPR1				NON Cumulative Quarterly Targets/Achievements
2.3	Prompt, effective treatment	Number of Pf cases treated with ACT by ASHA (PR1)				NON Cumulative Quarterly Targets/Achievements
2.4	Prompt, effective treatment	Number of Pf cases treated with ACT at Public sector health facilities (Sub-centre, PHC, CHC, etc.) of PR1				NON Cumulative Quarterly Targets/Achievements
2.5	Prompt, effective treatment	Percentage of ASHAs with no reported stock-outs of Nationally recommended anti-malarial drugs lasting more than one week at any time during the past one month				NON Cumulative Quarterly Targets/Achievements. Data collected from LQAS. Minimum 95 interviews) (% = No. of ASHAs who reported no stock-out of Nationally recommended anti-malarial drugs lasting more than one week at any time during the past one month / No. of ASHAs interviewed *100)
2.6	Prompt, effective treatment	Percentage of public sector facilities with no reported stock outs of nationally recommended anti-malarial drugs lasting more than one week at any time during the past 1 month				NON Cumulative Quarterly Targets/Achievements. Data collected from LQAS. Minimum 95 interviews. (% = No. of public sector facilities with no reported stock outs of nationally recommended anti-malarial drugs

						lasting more than one week at any time during the past 1 month /No. of Public sector Health facilities interviewed *100)
3.1	BCC-Community outreach/ IPC	Number of miking activity conducted in PR1 areas by PR1				NON Cumulative Quarterly Targets/Achievements
4.1	HSS: Service delivery	No. of supervisory visit to district periphery in a quarter by district VBDCP (malaria) officers (programme/project) and report submitted to state programme officer/ district chief medical officers of PR1				NON Cumulative Quarterly Targets/Achievements.
5.1	HSS: Health Workforce	Number of Malaria Technical Supervisor (MTS) trained/retrained by PR1				NON Cumulative Quarterly Targets/Achievements
5.2	HSS: Health Workforce	Number of ASHAs trained/re-trained (by PR1)				NON Cumulative Quarterly Targets/Achievements

Sign: SPO /DVBDO Date:

Quarterly Report of Intensified Malaria Control Project-II-(Phase II) *Annexure A*

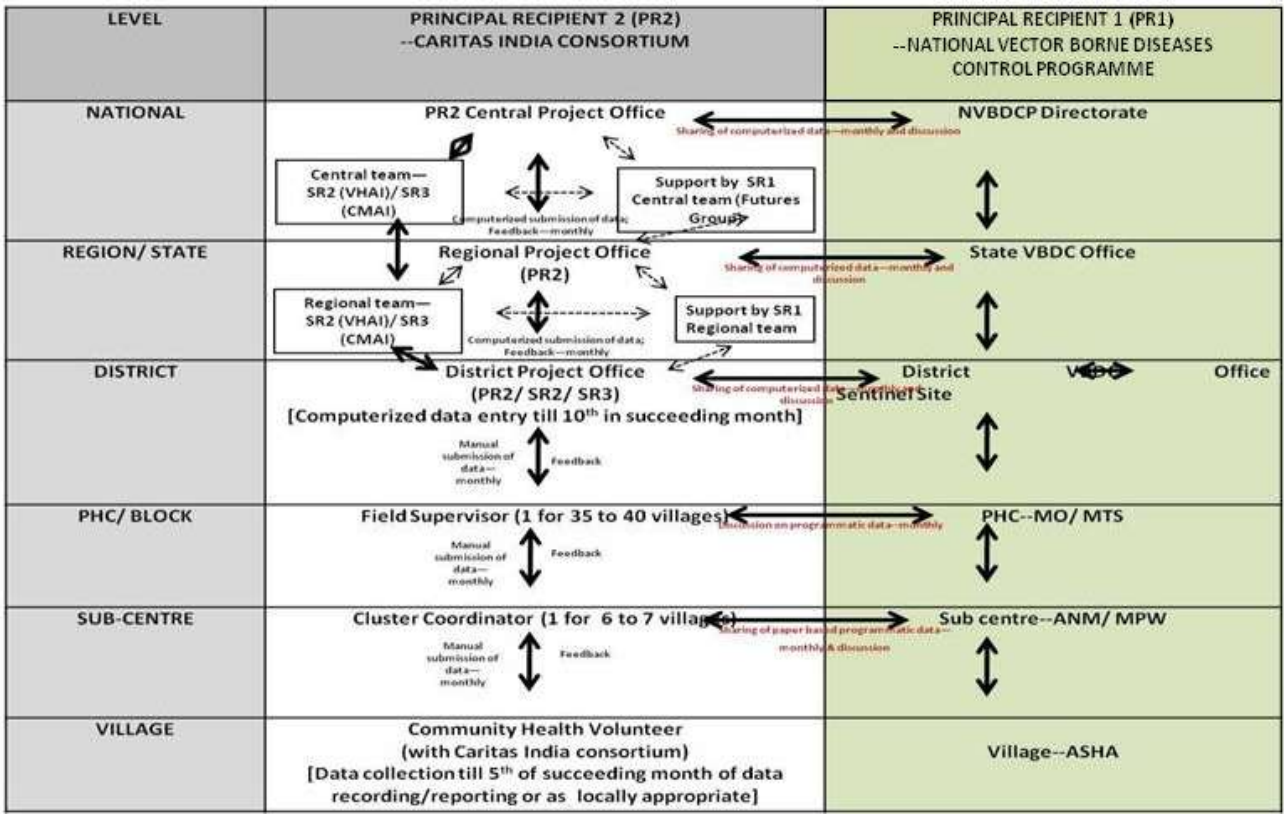
Name of State:				**Quarter :**	**Q:**
Reported for the period _____-201_ to _____ 201__					
Objective Number	**SDA [database category]**	**Output/ 'Coverage' indicators**	**Target**	**Achievement**	**Reasons for variance**
1.1	Insecticide-treated nets (ITNs)	Number of LLIN distributed in LLIN eligible areas (API≥2) by functionaries of PR1			
2.1	Diagnosis	Number of fever cases tested with RDT by ASHA (PR1)			
2.2	Diagnosis	Number of fever cases tested with RDT at Public sector health facilities (Sub-centre, PHC, CHC, etc.) ofPR1			
2.3	Prompt, effective treatment	Number of Pf cases treated with ACT by ASHA (PR1)			
2.4	Prompt, effective treatment	Number of Pf cases treated with ACT at Public sector health facilities (Sub-centre, PHC, CHC, etc.) of PR1			
2.5	Prompt, effective treatment	Percentage of ASHAs with no reported stock-outs of Nationally recommended anti-malarial drugs lasting more than one week at any time during the past one month			
2.6	Prompt, effective treatment	Percentage of public sector facilities with no reported stock outs of nationally recommended anti-malarial drugs lasting more than one week at any time during the past 1 month			
3.1	BCC-Community outreach/ IPC	Number of miking activity conducted in PR1 areas by PR1			
4.1	HSS: Service delivery	No. of supervisory visit to district periphery in a quarter by district VBDCP (malaria) officers (programme/project) and report submitted to state programme officer/ district chief medical officers of PR1			
5.1	HSS: Health Workforce	Number of Malaria Technical Supervisor (MTS) trained/retrained by PR1			
5.2	HSS: Health Workforce	Number of ASHAs trained/re-trained (by PR1)			

Date: **Sign: SPO /DVBDO**

A data analysis system at district, regional levels through regular letters and e-mails with their respective reporting units will inform about any unusual deviations in fever/ disease trend. The respective reporting unit will respond within one week of such correspondence with required clarifications/ support, as necessary in consultation with the national programme. Thus, the national programme will have continued access to peripheral level data from non-government organizations, while PR2 will have a well defined system for reporting and feedback on the Performance Framework indicators, logistics and fund flow.

Under IMCP-II, an attempt will be made to initiate mainstreaming of private health care providers who are already involved in diagnosis and treatment of fever/ malaria cases. In the Year 1, mapping of such providers at district and sub-district (village) levels will be done. Selected providers will be provided trainings on NVBDCP guidelines. Consultation will be held with NVBDCP, state and district VBDCP authorities on supply of logistics (RDT, ACT) to a subset of private providers. These providers will be encouraged to not charge for diagnosis by RDT and ACT treatment. Each of them will be provided the standardized NVBDCP data input forms, which will be duly completed at the time of consultation. At village level, the respective Cluster Coordinator will collect these forms by the 5th of the succeeding month for data collection, or on a mutually agreed date for data collation at village level for onward transmission to the Field Supervisor as well as to the Sub centre.

The programmatic data flow and feedback across PR1, their SRs and Caritas India (PR2) is presented in the schematic below.



2.4.1 Project Management Information System (MIS)

The country programme is having a web-based HMIS called NAMMIS. However, due to various field level operational difficulties the operationalization has not been possible throughout the country, though some of the states including some NE states are entering the data in NAMMIS.

The project MIS under the GFATM Round 9 project developed by PR1 will relate to performance indicators, as well as finance and logistics. The key focus will be to:

- assist the SRs in programmatic planning and monitoring and initiate prompt remedial actions, as necessary
- assist the SRs to dovetail financial and logistics management and thereby maintain necessary discipline
- assist the SRs to disseminate necessary information on time by acting as clearing house for all information related to project M&E
- ensure timely reporting and feedback across the different levels including generation of reports and graphics related to prevention, case diagnosis and treatment, BCC, training, etc.
- integrate and feed into the national M&E system.

The NAMMIS a application software providing efficient, reliable quality data collection/ compilation, processing, analysis solutions using state of art technologies will fulfill all M&E data requirements under GFATM Round 9 project. The key stakeholders will include the PR2, their SRs and NVBDCP (GoI). The MIS will be user friendly and linkages will be established with the national programme HMIS. Access will be available to PR2, their SRs and the NVBDCP through unique user names and passwords. The authorized users will get access to disaggregated state wise, district wise and sub centre wise information. The MIS will have requisite security feature to prevent unauthorized access. The MIS will have both programmatic and financial modules and hence, necessary financial/ logistics details will be entered on to MIS and any request for funds, stocks, etc. by SRs will not be logged in if they have not entered their performance and/ or if their performance is deficient against pre-determined targets as well as if necessary expenditure/ audit statements are pending.

The system will alert the concerned project personnel about any lag, delay, bottleneck and inconsistency in project performance for prompt initiation of remedial action. The alerts will be pre-set, based on the performance related timelines. The MIS will have in-built checks and validations to guide the user if data entry errors are committed. This will ensure that only valid entry is taken into consideration. Every entry made at a lower level of reporting (for example, SSR/ SR level) will be verified at the higher level (for example, at SR/ PR level) besides on site sample verifications.

2.4.2 Supervision and Routine Monitoring

Supportive supervision and monitoring are planned throughout the project life to carry out process evaluation; to assess, motivate and guide project volunteers/ personnel; to strengthen/ sustain knowledge and skills; and to provide feedback in relation to quality delivery of services including rational use of RDTs and medicines; as well as financial and logistics matters. A major focus will be on: identification and resolution of bottlenecks and challenges; ensuring timely collection and submission of reports and feedback, etc.; as well as meeting various training, funding, logistics needs, etc.

Under the Round 9 project, the following supportive supervision and monitoring activities are planned.

- Supportive supervision and routine monitoring by central level (by Officers and Consultants) through at least one visit to the districts in each quarter and preparation/ dissemination of reports with feedback.
- Supportive supervision and routine monitoring by regional level (by Officers and Consultants) through at least one visit to each district in each quarter and preparation/ dissemination of reports with feedback.
- Supportive supervision and routine monitoring by district level (by District Project Manager/ Data Entry Operator/ MTS and SRs) through at least one visit to each village in each quarter and preparation/ dissemination of reports with feedback.
- Monitoring of volunteers, peripheral health facilities on weekly basis by Malaria Technical supervisors.

An annual supervision and monitoring plan will be developed for field visits. The plan will be disseminated to different levels to prepare them for the visit. However, at least twice annually the visits will be conducted without notice so as to check the real situation.

Apart from this, specific monthly performance reporting formats have been developed which has to be submitted by the State Consultants, District VBD Consultants and the MTSs on monthly basis, within a prescribed time through a designated email ID for each cadre. The formats for State Consultants, District Consultants and MTS and monitoring sheet for monitoring the submission of these reports are given at ***Annexure 17,18,19,*** respectively***.***

All deaths due to malaria are to be investigated by a Medical Officer and have to report within one week of death to the State Programme Office using the format given at ***Annexure 20.*** After identifying the causes and deficiencies, public health actions are to be taken in that specific area for further prevention of transmission and deaths.

On-site visit using standardized checklists given at **Annexure 21, 22, 23 24, 25 & 26** used under NVBDCP will be the key mechanism for supportive supervision. The visits will include: direct observation method, desk review of records and registers, feedback received from the higher reporting level, and patient interview, as appropriate. At regular intervals, few households will be visited and/ or focus group discussion will also be organized at village level. Previous supervision and monitoring reports will be scanned for getting an overview of the field level situation. This will also help in gauging improvements as well as in assessing the follow up actions taken, if any. The bottlenecks and gaps observed during the visit will be noted. If possible, ready solutions will be provided on the spot or within an agreed time period and/ or it will be ensured that prompt, clear feedback is provided within a fortnight so that remedial measures could be initiated. Quality Assurance will also be a key element of the supervision and monitoring plan to check the quality of the malaria control program at field level including data quality.

Supervision and monitoring reports will be completed with specific recommendations and disseminated within 10 days of completion of a visit. The reports will be discussed in the monthly review and planning meetings at district levels. At the national level planning and review meetings (detailed below), a synthesis of the reports will be presented with special focus on the status and coverage of services, performance analysis vis-à-vis targets. Districts that

register good performance and districts at the other end of the performance scale will be invited to present a situation analysis and issues and concerns.

2.4.3 Review and Planning

Regular meetings will be extremely important for review and planning to take stock of project progress - both programmatic and financial, in relation to the plan and identify needs and gaps, bottlenecks and challenges and determine the way forward. Issues related to data (programmatic, logistics and financial) as well as various activities carried out by the PRs, their SRs will be presented and discussed. Discussion will also be held on planning, implementation and M&E coordination and capacity building issues. Information on best practices/ innovations and success stories will be shared. The minutes/ record notes will be shared for feedback/ action, as necessary.

Under IMCP-II, the main forum for review and planning for the PR will be annual review and planning meeting at national/ regional level and monthly review and planning meeting at district level.

- Annual review and planning meeting are planned at national/ regional level, which will serve as a platform for exchange between PR and the SRs, cross learning and consensus building on the annual action plan for the succeeding year. Feedback from the GFATM will also be disseminated and discussed. The participants at the national/ regional level meeting will include: SPOs, technical managers and experts, financial manager, data and documentation officers from the central level; ROHFW Officers, M&E/ MIS officers and other stakeholders. The minutes/ record notes will be shared with participants, for action/ feedback, as necessary.

- Monthly review and planning meetings are planned at district level to review project performance at district/ village level. Periodically, personnel/ consultants from regional/ national level will organize supervisory visits around the scheduled time for these meetings, so that they are able to participate and provide inputs. Progress regarding district action plan under Round 9 project will be reviewed as well. The participants at the district level meeting will include: district project officers, field supervisors, and regional/ national project staff/ consultants. Selected community health volunteers with good and average performance will be included too. Once in six months, the representative from the district VBDCP office, MO PHC, selected Multipurpose Health Workers; ASHAs will be invited. The minutes/ record notes will be shared with participants, regional/ central levels for action/ feedback, as necessary.

The review and planning meetings will help in successful implementation of the project and will be an important medium for strengthening government and non-government sector linkage, networking.

2.4.4 Storage of Data

All programmatic data (forms, registers, reports, etc.) will be stored and maintained at each level safely and securely for five years and all finance, logistics related logs, registers, etc. for eight years. These will be made available to the officials during on site supervision and monitoring, review meetings, evaluations for quality check/ assessment/ audit/ analysis. At sub-district level, the data will be stored in cupboards; whilst at other levels, the data will be stored in CDs.

2.5 Evaluation, Special Studies

Evaluations and special studies are envisaged at periodic intervals to understand:

- Effectiveness of project in terms of achievement of target outputs, outcomes and impact
- Efficiency in terms of resource utilization, integration/timely completion of activities
- Appropriateness in terms of outputs, outcomes and impact achieved relative to plan
- Unintended outcomes and impacts--both positive and negative that affected achievement of objectives and goals

The lessons learnt and best practices will facilitate strategic planning and decision making towards improvement in service delivery and acceptance of available interventions.

Independent evaluations will be planned under NVBDCP in Year 1 and Year 3 of the GFATM Round 9 project with technical support by WHO, independent experts, ICMR/ NIMR Institutes, Regional Offices of Health & Family Welfare (ROH&FW) and State/ District VBDCP Offices. The Caritas India and their SRs will provide necessary support and facilitate visits in their project areas and facilities. The evaluation will be using specific checklists that will cover PRs' SDAs/ activities as well, in a disaggregated manner. Likewise, special studies are planned under NVBDCP and its partner organizations like NIMR, which will also be supported by the PR2 consortium, right from the protocol/ tool development to field level investigations to data analysis and report preparation.

Apart from this, periodic evaluation (twice in a year) will be done through Lot Quality Assurance Sampling (**LQAS**) Surveys which will be conducted by the MTSs in the service delivery areas. This will give information on whether a specific area has passed or failed in achieving a specific target for coverage, awareness, service delivery etc. The collective sample size of 95 for the district / state will give an estimate of the achievement with a 95% confidence interval.

A joint mission involving multilateral agencies and independent experts and led by the WHO is also planned under NVBDCP to review the malaria control programme including the GF grant supported components.

2.6 M&E Data Quality Assurance (QA)

For ensuring precise planning, timely and quality data are critical. M&E data quality includes various dimensions[14], such as:

- **Reliability:** This signifies that the data do not change according to who is recording/ collecting and using them and when or how often they are used. Consistent data recording and reporting with standardized tools and processes/ protocols such as, forms, registers, manual/ guidelines and standardized trainings will be stressed under Round 9 project thereby ensuring reliability.

[14] Source: Data Quality Audit Tool: guidelines for implementation. Chapel Hill, NC, MEASURE Evaluation, 2008 (http://www.cpc.unc.edu/measure/tools/monitoring-evaluation-systems/data-quality-assurance-tools/dqa-auditing-tool-implentation-guidelines.pdf, accessed 15 September 2008).

- **Accuracy:** This signifies that the data reflects the reality as designated to measure. In other words, tackling of data errors to the minimum at the time of recording/ compilation/ reporting at different levels will ensure accuracy. Under Round 9 project, guidelines with specific instructions on random checks will be developed for accurate data.

- **Timeliness:** This signifies up-to-date data and availability, as needed. Regular review, supervision and monitoring will ensure timely data recording, compilation and analysis under the Round 9 project.

- **Completeness:** This signifies all-inclusive and not partial recording. Under Round 9 project, a special emphasis will be on complete data collection in each month from various service providers and end users through regular supervision and monitoring review.

- **Integrity:** This signifies that data are protected from deliberate bias or manipulation in addition to maintenance of confidentiality according to national and/or international standards. Under Round 9 project, maximum efforts will be made to ensure data integrity. Manual/ guidelines, trainings will emphasize on this dimension.

- **Precision:** This signifies that the data measures what is intended to be measured and have the necessary detail. Under Round 9 project, precise forms and standardized methods and trained personnel will be used, as necessary, for ensuring precision regarding programmatic/ financial data.

A data quality management system will be established (at various reporting levels) to ensure that the performance and financial/ logistics related data conform to the desired quality in terms of above-mentioned elements. During the field level supervision and monitoring, a checklist will include data quality topic. The Central/ Regional Project Office consultants, M&E and MIS experts from the national/ regional level will visit the project districts at least once in a quarter.

The records, registers and forms with the community health volunteers and health facilities will be randomly checked on site and verified/ cross checked. Any mistake in recording/ registration will be corrected. Interviewing a sample of clients/ care takers/ beneficiaries will also form part of verification of reports on services provided. At certain intervals, on site direct observation of data recording, reporting, including completion of MIS forms correctly/legibly, uploading on to the MIS, etc. will be noted. On the spot feedback will be provided for mitigation.

A monthly report will be generated to keep track of all problems and solutions. The reports will also be tracked for timeliness and completeness (according to set timelines/ standards), as those are received. It will be emphasized that release of resources (funding, commodities, etc.) will be affected. Every planning and review meeting at district level will follow up on the progress in achieving the pre-determined targets related to all indicators and activities besides discussing data quality issues. A synthesis of field visit reports and data quality related reports will be shared for further remedial actions.

Further, periodic verification/ validation by PRs' designated personnel/ consultant is envisaged. While PRs and their SRs collect, clean, validate, verify the data, such (external) reviewers will also verify the completeness and accuracy of the collected data from time to time.

Managers and supervisors are responsible for ensuring good quality data at the source point that is at the level of community health volunteer. Efficient processes will be in place to monitor,

evaluate and improve the quality of the data collected over time. Managers and supervisors are also responsible for ensuring CHVs and field supervisors are trained and would provide on job assistance at the time of field visits. Data collection systems will be proficient to capture and validate all the information required, and will also provide an audit trail of changes.

The key processes to ensure data quality will therefore include:

- Identification of capacity gaps and resource needs through on site assessment of data reporting and management systems and their resolution through trainings.
- Use of standardized tools and methods.
- Data cleansing/validation to identify and correct errors, inaccurate records or data. The process will involve checking/correcting typos, digit/spelling errors, removing duplicates, incomplete, inconsistent and inaccurate data and making sure the data are useful. Forms (input/ output) will also be checked. The MIS will have automated data cleansing/ validation facilities. In addition, data entry operators at all levels will be trained specifically on data cleansing.
- Data verification in terms of cross checking and confirmation of 5% of data for accuracy. The verification is planned to be addressed by different methods like by phone call, training site visits.

2.7 M&E Information Products

On an annual basis, the project team at national, regional and district levels will compile progress in project SDAs, activities, together with any project review/ audit/ evaluation data, as available into an annual report. This report will provide a summary of the various data collected during the year along with an analytic component that examines progress and trends, bottlenecks and challenges. The timeline for the annual report will be such that the information will guide the annual plan development. The annual report will be shared with PR2 and other stakeholders for wider circulation. Project guidelines, presentations, any other publication, etc. will also be shared with key stakeholders. The information products will also serve as tools for re-planning and advocacy.

2.8 M&E Coordination and Institutional Arrangements

Under Round 9 project, the Caritas India consortium will complement the national efforts for malaria control. Effective coordination with Caritas India consortium and with state/ district VBDCP authorities for M&E is extremely important. The structures, mechanisms and roles for M&E coordination will be clearly articulated under the project, although these will remain dynamic and might be adjusted/ modified, as needed. While it will be necessary to have structures and mechanisms at central and regional levels for overall coordination; it will be equally imperative at the district and sub district levels to standardize M&E particularly in relation to programmatic data recording, and reporting.

At the central level, a broad based **Project Steering Committee** with representations from NVBDC and Caritas India networks is responsible for overseeing, reviewing and advising on planning, implementation and M&E coordination. The Project Steering Committee will meet quarterly. The structure and Terms of reference of the Project Steering Committee is as under:

Structure of PSC: The PSC will be chaired by the Director, NVBDCP. The Additional Director,

NVBDCP, will be the Vice Chair. The PSC will include: the senior IMCP-II project officials with NVBDCP and Caritas India, technical expert. The Additional Director, NVBDCP (In charge of GFATM) will serve as the Member Secretary to the PSC. Additional members will be added and/or invited at the discretion of the PSC. A rapporteur for each PSC meeting will be elected.

Thus, the PSC structure for the tenure of IMCP-II will be as under:

1. Director, NVBDCP (Chair)
2. Additional Director, NVBDCP or his/her designate (Vice Chair)
3. Joint Director, NVBDCP, In-charge GFATM (Member Secretary)
4. M&E Consultant, NVBDCP (Member)
5. Finance Consultant, NVBDCP (Member)
6. Procurement Consultant, NVBDCP (Member)
7. Training Consultant, NVBDCP (Member)
8. Project Director, Caritas India (Member)
9. Project Manager, Caritas India (Member)
10. Project Manager Technical, Caritas India (Member)
11. Project Grant and Finance Manager, Caritas India (Member)

Roles and Responsibilities: The PSC will take decisions based on the consensus principle. Specifically, the PSC will have the following responsibilities:

- Provide guidance, as well as overall strategic policy and management direction to the project related programmatic, financial and administrative matters.
- Intervention with SRs on the targets indicators & discussion on the performance framework and agreements on the targets & ensuing SRs and SSRs are in compliance of this.
- Preparation of Annual Action Plan for the SRs and SSRs based on the programmatic norms & the GFATM requirements (on logistic & financial aspects and M&E).
- Monitoring the effectiveness of coordination between the implementation partner, addressing any conflicting issues & situation that are existing or likely to arise.
- Quarterly review and assess the progress of the project, based upon project performance framework, project Monitoring and Evaluation Plan, including progress made towards measurable impacts.
- Review and monitor financial and logistics performance and management in line with GFATM requirements.
- Review and approve the outline of, and subsequently the project report(s) and all project documents.
- Review the extent and effectiveness of stakeholder involvement at the national and sub national levels, particularly in reference to other non-government/ government sector that have an interest or impact in the domain of malaria control, and discuss challenges, resolution of potential conflicts.
- Ensure documentation of innovations, best practices, success stories and advocate at various platforms, as appropriate.

2.9 Financial reporting

The financial reporting/financial statements are powerful project management tools. Information from these reports/statements, if analyzed and interpreted properly, leads to better decision-making. It also helps monitor the progress of project implementation and check variance from planned activities and budgets. However, to achieve this, it is necessary to have standardized tools. Hence, the financial management guidelines have been prepared separately by this Directorate to assist programme managers to cull out the relevant information and to assist them in managing the programme. These guidelines are an attempt to codify the procedures.

The financial reporting formats for the states under these guidelines are annexed at ***Annexure 27 to 31*** as follows:

Annexure 27: Format for 'Project Management Reports/ Statement of Expenditure for the year'
Annexure 28: Status report of funds availability for the quarter ended on _____
Annexure 29: Receipts and payments account for the period from 1st April ___to 31st Mar ____
Annexure 30: Income and expenditure account for the period from 1st April ___ to 31st Mar ___
Annexure 31: Balance sheet as on 31st March ____

NATIONAL VECTOR BORNE DISEASE CONTROL PROGRAMME

M REGISTER- ASHA/ FTD

Annexure 1

Name of the Block----- **Name of ASHA/AWW/Community Volunteer:** **Name of the Reporting month----------Year----------**

Name of the Subcentre_____ **Code No. of ASHA:**

Name of the Village----------

Sl. No./ Slide No.	Name of the Head of family	Name of the patient	Age* (in Y/M)	Sex (tick)		Date of RDT/ slide	Result of RDT		Result of Slide		Date of starting Treatment	Treatment Given							**Date of Completion of Treatment**	Date of Referral	if Died Date / Place	Date of visit by supervisor (Remarks)
												Pv				Pf						
				M	**F** (write **P** if pregnant)		**Pv**	**Pf**	**Pv (+/-)**	**Pf (+/-)**		Day 1 (CQ+PQ)	Day 2 (CQ+PQ)	Day 3 (CQ+ PQ)	Day 4-14 (PQ)	Day 1 (ACT-AL)	Day 2(ACT-AL +PQ)	Day 3(ACT-AL)				
1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	16	17	18	19	20	21	22
Totals																						
							Total RDT positive (Col 8 + Col 9) (A)		**Total slide positive (Col 10 + Col 11) (B)**		**Total Malaria cases (RDT+slide) (A+B)**											
Total suspected cases (total M +F)																						

*Age in completed yrs for >=1 year or in completed months for less than 1yr. Please add 'Y' and 'M' after the numericals to differentiate beteween 'year' and 'month'

**Slide No. will have Sl No/ Provider code/Village Code/Sub centre code)

General Instructions:

All cases of suspected malaria seen by ASHAs/ FTDs should be recorded in this form, irrespective of whether they are tested or treated.

Use a fresh form for each month. Start with patient number "1" at the beginning of the year and continue over the months. Use more than one sheet per month if needed. Mention sheet number. Cases that presented to you during the month should be included in that month's form, irrespective of when fever first appeared.

Patients who return with symptoms within one month of starting treatment should be referred. Patients returning with symptoms after one month should be considered as new cases, recorded, tested and treated if positive.

MONTHLY STOCK KEEPING

Month_____Year_____

S. No.	Item	Opening Balance at the beginning of the month (a)	Received during the Month (b)	Total (c=a+b)	Utilization during the Month (d)	Balance at the end of the Month (e=c-d)
1	RDT					
2	CBP-ACT					
3	CQ					
4	ACT Packs					
5	AS Tablets					
6	SP Tablets					
7	PQ small					
8	PQ Large					
9	Slides					
10	Lancets					

Whether stock out of RDT was reported during the month: Yes/ No
Whether stock out of ACT was reported during the month: Yes/ No

Annexure 2

NATIONAL VECTOR BORNE DISEASE CONTROL PROGRAMME

M1

M1 : Report of Surveillance by ASHA/ MPW/ Health facility

All cases of suspected malaria should be recorded in this form, irrespective of whether they are tested or treated.

Year: Fortnight I/ II

Use a fresh form for each month. Start with patient number "1" each month. Use more than one sheet per month if needed. Mention sheet number. Cases that presented to you during the month should be included in that month's form, irrespective of when fever first appeared.

Sheet No.

Patients who return with symptoms within one month of starting treatment should be referred. Patients returning with symptoms after one month should be considered as new cases, recorded, tested and treated if positive.

PHC: Subcenter: Village:

PHC code: Subcenter code: Provider: Provider code

Serial Number	Village name	Village/ Provider code	Name of patient (Suspected Malaria Case)	Head of Family	Active (A)/ Passive (P)	Age (Y/M)	Sex (M/F) P if Pregnant	SC (Y/N)	ST (Y/N)	Duration of fever (days)	Date of RDT/ BSC	Result of RDT		Blood slides					Date of starting treatment	Treatment (number of tablets)					Suspected Severe malaria (√)	Date of referral	Date of death	Verified by (signature)
												Pv Pos (√) Neg (-)	Pf Pos (√) Neg (-)	Slide No (Sl No Pd/Vil Cd/SC/ Cd)	Date of dispatch of slide to lab	Date of receiving report	Pv : Pos (√) Neg (-)	Pf : Pos (√) Neg (-)		Combiblister Pack	CQ	PQ (2.5 mg)	PQ (7.5mg)	ACT AL				
1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29
TOTALS																												

Mixed infection are to be recorded as Pf

Positive results are to be marked in Red

Use "991", "992" etc for village code when patient is not a usual resident of your village.

** in case of pregnant women refer to MPW or MO PHC*

****Slide No. will have Sl No/ Provider code/Village Code/Sub centre code)**

This section is to be filled in at the end of the month

Totals will be entered by the MPHW who consolidates this form to M4

	Summary		cases
1	Pf (col 14+ Col 19)		
2	Pv (col 13 + Col 18)		
	Total		

Did you report an outbreak of fever in your area during the fortnight? Y / N

During the fortnight, did it happen that you could not do the RDT on any patient because you did not have RDK? Y / N

Did it happen that you could not have stocks of ACT during the fortnight? Y / N

Enter numbers of kits or tablets

Stock Position	RDT	CQ	PQ Small	ACT AL Yellow	ACT Green	ACT Red	ACT White	PQ Large	Slides	Lancets
Opening Balance										
Received during the fortnight										
Total of above										
Utilization										
Balance										

Annexure 3

M 2

M 2 Laboratory Request Form for Slide Examination

NATIONAL VECTOR BORNE DISEASE CONTROL PROGRAMME

For the use of ASHA/village level volunteer/MPHW

Village: **Village code:** **Provider code:**

Subcenter:

1	2	3	4	5	6	7	8	9	10	11	12
Slide No.	**Name of patient**	**Age**	**Sex**	**Duration of fever**	**Active /Passive (A/ P)**	**Date of dispatch**	**Slide received date**	**Pv : Pos (√) Neg (-)**	**Pf : Pos (√) Neg (-)**	**Feed-back on smear quality by LT (Poor/ satisfactory/ good)**	**Result recd date**

Fill the first 7 columns and send to lab along with slide(s)

Fill this form even if there is only one slide.

The "Slide received date", "Result" and "Feedback on smear quality" columns will be filled by the laboratory and the form returned to the provider

In the last column, "Result received date", enter the date on which the result reached you

Once you get this form back from the lab, enter the result in your form M1

The form has to be filled in duplicate; One copy is retained and one copiey is sent to Lab. Lab results are sent back in same fom

Annexure 4

M3

M3 Record of Slide Examination in PHC Laboratory

NATIONAL VECTOR BORNE DISEASE CONTROL PROGRAMME

Name of District

Name of Subcentre:

Serial Number	Date of Examination	Village Code	Provider Code	Slide Number	Name of patient	Age	Sex (M/F)	Duration of Fever	Date of dispatch of Slide to lab	Date of receipt of slide in lab	Results		Date of sending Result to Worker	RDT Result if done		Remarks
											Pv	Pf - R, G, RG		Pv	Pf	
1	2	3	4	5	6	7	8	9	10	11	12	13	14			15

M4 Annexure 5

M4- Fortnightly Report of Cases SC/ PHC/ District/ State

NATIONAL VECTOR BORNE DISEASE CONTROL PROGRAMME

Subcenter/ PHC: Year: Month: Fortnight: I/ II

Subcenter/ PHC Code:

S. No.	Village/ Subcentre / PHC/ District/ State Name	Village/ Subcentre / PHC/ District/ State Code	Population	Total fever cases recorded during fortnight in M1	RDT			Blood slides						Total tested (RDT + Slide) [Col 6 + Col 9]	Total Pv [Col 7A + Col 12]	Total Pf (RDT + Slide) [Col 7B + Col 13]	Total Malaria Cases [Col 15 + Col16]	Distribution of Total Malaria Cases									Pf Cases Treated with ACT	Severe cases treated with Inj artesunate	Outbreaks reported (Y / N)	Stock out of antimalarials/ RDTs last fortnight		No of malaria cases referred	No of deaths (RDT or slide positive)	Name/ Age/ Sex of Death Cases
					No of RDT performed	No of RDT positive		No of slides taken	Slides Examined		No of slides reported within 24 hours of slide collection	Pv	Pf					Passive	0-4 y		5-14 y		15+ y		SC	ST	Pregnant Women				No of facilities reporting stockout of RDT	No of facilities reporting stockout of ACT			
						Pv	Pf		Total	Passive									M	F	M	F	M	F										
1	2	3	4	5	6	7A	7B	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35
	MPW M																																		
	MPW F																																		
	SC Subtotal																																		
	PHC																																		
	TOTALS																																		

Stock Position	RDT	CQ	PQ small	ACT AL packs Yellow	ACT AL packs Green	ACT AL packs Red	ACT AL packs White	PQ Large	Inj Artesunate at PHC		Slides	Lancets
Opening Balance												
Received during the month												
Total of above												
Utilization												
Balance												

Annexure 6

M4- Provider Wise

NATIONAL VECTOR BORNE DISEASE CONTROL PROGRAMME

District:

Subcenter/ PHC: Year: Month: Fortnight: I/ II

Subcenter/ PHC Code:

S. No.	Provider	Population	Total fever cases recorded during fortnight in M1	RDT			Blood slides						Total tested (RDT + Slide) [Col 5+ Col 8]	Total Pv [Col 6A + Col 11]	Total Pf (RDT + Slide) [Col 6B + Col 12]	Total Malaria Cases [Col 14 + Col15]	Pf Cases Treated with ACT	No of malaria cases referred	No of deaths Reported (RDT or slide positive)
				No of RDT performed	No of RDT positive		No of slides taken	Slides Examined		No of slides reported within 24 hours of slide collection	Pv	Pf							
					PV	PF		Total	Passive										
1	2	3	4	5	6A	6B	7	8	9	10	11	12	13	14	15	16	17	18	19
	ASHAs																		
	Subcentres/ PHCs/ Govt Hospitals																		
	Private providers																		
	TOTALS																		

Annexure 7

VC1. Primary record of IRS

(Superior Field Worker's Diary)

Village _____Village Code_____

Sub-Centre _____ PHC_____

Round _____

Planned Date _____/_____/_____

Date of Spray _____/_____/_____

Code of squad _____

Names of SFW / FWs

1._____ 2. _____ 3._____

4._____ 5._____ 6._____

SUMMARY

	Total No.	No. covered		% covered
		Partial	Complete	
Houses				
Rooms				
Population				

Insecticide_____

Sprayed houses (only)								
Sl. No	**Head of Family**	**No. Inhabitants**	**Total Rooms**	**No. of Rooms Sprayed**		**No. of Rooms missed**		**Remarks**
				RCS	**RPS**	**RR**	**RL**	
1	*2*	*3*	*4*	*5*	*6*	*7*	*8*	*9*
1								
2								
3								
4								
5								
6								
7								
8								
9								
10								
11								
12								
13								
14								
15								
16								
Total								

Pumps Issued:_____

Pumps Functional:_____

Insecticide Received:_____

Insecticide Used:_____

Insecticide Balance:_____

SFW Signature_____ **MPHW Signature_____**

MOPUP actuvity

RCS: Rooms completely sprayed
RPS: Rooms partially sprayed
RR: Rooms refused
RL: Rooms locked

Annexure 7A
VC - 1S

Wall Stencil

Squad No/ DATE/ INSECTICIDE/ SPRAY ROUND
Sprayed Rooms / Total Rooms/ Signature of SFW

Example:

Date of Spray = 8/5/08
Insecticide Round = DDT I
No. Of Rooms Sprayed = 3
Total No. of Rooms = 4
Sd = Signature

Annexure - 8

VC2 - IRS output Report Form

Round_ Insecticide_____ Name of Insecticide

Name of Village/ Sub-Centre/ PHC	Code of village	Total Population	Planned date for spray	Date (s) Sprayed	Code of squad	Stock position			Coverage								
						Qty of insecticide received	Qty of insecticide used	Qty of balance insecticide	Total No.of Houses	No. Houses sprayed	% Houses sprayed	Total No. of Rooms	Rooms completely sprayed	Rooms partially sprayed	% Rooms completely sprayed	Population in sprayed houses	% Population protected
1	*2*	*3*	*4*	*5*	*6*	*7*	*8*	*9*	*10*	*11*	*12*	*13*	*14*	*15*	*16*	*17*	*18*
Subcentre1																	
Village 1																	
Subcentre 2																	
Village 2																	
Village n																	
PHC Total																	

District Report Only			
Status of Spray Squads	**No.**	**Status of Spary Pumps**	**No.**
Spray Squads Required		**Spray pumps present**	
Spray Squads Engaged		**Spray Pumps certified functional by DMO/ CMHO/ CDMO**	

Signature

Date of dispatch/approval

_____

PHC MO_____

_____

_____

Annexure 9

VC3. Primary record of bednet delivery and impregnation

Village _____Village Code_____

Sub-Centre _____PHC_____

Activity	Planned Date	Actual Date
Survey		
Impregnation		
Distribution		

SUMMARY

	Total No.	No having at least two Effective Bednets (col 10)	% Covered
Houses			

Name of volunteer/ASHA/AWW_____

S1. No	Name of Head of family	Number of persons living in family	No. bed nets required for total coverage	Number of bed nets (including community owned) available in household survey		No. of bed nets distributed		No. of ITNs impregnated (out of Col 5 & 7)	Total Effective Bednets (Col 6+ col 8 + col 9)
				ITNs	LLINs*	ITNs	LLINs		
1	2	3	4	5	6	7	8	9	10
Total									

* LLINs within life span to be counted.

Volunteer's name and signature_____

Health worker's name and signature_____

Synthetic Pyrethroid	Quantity
Available before impregnation	
utilized for impregnation	
Balance after impregnation	

This form is filled in by ASHA or another village volunteer under guidance from MPHW.
Columns 1-7 are filled by survey in advance of delivery by a person, who will inform the villagers about the planned impregnation or delivery, the date and about correct use of the nets.
Number of persons living in household includes only those living there permanently or for prolonged period.
No. of bed nets required: 1-2 persons:1 bed net ; 3-5 persons:2 bed nets; 6-7 persons: 3 bed nets; 8-10 persons: 4 bed nets

Annexure - 10

VC 4. Bednet Output Report Form

Name of District/ PHC:

Name of PHC/ sub-centre/village with net impregnation target population	Village Code	Total Popu-lation	Total No of Houses	No. bed nets required for total coverage	Survey		Number of bed nets (including community owned) available in household survey		Distribution		No. of bed nets distributed		Impregnation		No. of ITNs impregnated	Total Effective Bednets	Synthetic Pyrethroid			No of Households with Two Bed nets	Population Coverage (% of households with at least two effective bedtnets)
					Planned date of Survey	Actual date of Survey	ITNs	LLINs*	Planned date of distribution	Actual date of distribution	ITNs	LLINs	Planned date of impregnation	Actual date of impregnation			Qty Pyrethroid received	Qty Pyrethroid utilized	Qty Balance pyrethroid		
1	*2*	*3*	*4*	*5*	*6*	*7*	*8*	*9*	*10*	*11*	*12*	*13*	*14*	*15*	*16*	*17*	*18*	*19*	*20*	*21*	*22*
Sub-centre Total																					
Sub-centre 2 total																					
PHC Total																					

**** LLINs within life span to be counted***

Annexure - 11

VC 5. District Annual Stock report on Insecticides

Name of District: _____

Year: _____

Name of PHC	Material	Opening balance as on 1st Jan. Qt.	Date of Expiry of Col 3	Received during the year	Date of Expiry of Col 5	Total availabe (Cols 3 + 5)	Qt. Used 1st rd	Qt. Used 2nd rd	Qt. Used 3rd rd for Malathion	Total for all rounds	Qt. Expired	Closing Balance as on 31st Dec.	Disposal of expired insecticides	Remarks
1	*2*	*3*	*4*	*5*	*6*	*7*	*8*	*9*	*10*	*11*	*12*	*13*	*14*	*15*
PHC- 1	DDT													
	Malathion													
	Pyrethroids													
PHC- 2	DDT													
	Malathion													
	Pyrethroids													
PHC- n	DDT													
	Malathion													
	Pyrethroids													
District Store	DDT													
	Malathion													
	Pyrethroids													
District Total	DDT													
	Malathion													
	Pyrethroids													

Annexure - 12

VC 6 - District LLIN Log

Name of sub-centre/ village	Number of LLINs delivered by year							
	20_ _	20_ _	20_ _	20_ _	20_ _	20_ _	20_ _	20_ _
Sub-centre 1								
Village 1								
Village 2								
Village 2								
Sub-centre 1 total								
Sub-centre n								
Village 1								
Sub-centre n total								
PHC total								

Annexure - 13

Directorate National Vector Borne Disease Control Programme

Programme Management Monitoring Report

A- Monitoring and Evaluation For Quarter_____

Sl.No	District/ State	Activities	Norm	Total Conducted in the Quarter (No)	Specify Details
1		Quarterly review of Districts by State (in First month of the following quarter)**	1 Per Quarter		
		Monthly review of NVBDCP under chairmanship of District collector/ CMHO **	1 Per month per District		
		Field visits by DMO (10 Days in a month in each District)***	Minimum of 10 Days per month per District		
		Field visits by District Consultant (10 Days in a month in each District)***	Minimum of 10 Days per month per District		
		Field visits by MTS and (15 Days in a month in each District)	Minimum of 15 Days per month per District		

***** Specify date of meeting***

****** Specify dates and vilages visited***

B. Field Visit Outputs - Quality of Services								
S. No.	Indicators	DMO		DVBDC Consultant		MTS		
		No.	%	No.	%	No.	%	
1	No of Pf Malaria cases diagnosed visited by the supervisory staff in the Quarter (at least 2 patients per visit)							
2	No of Pf Malaria cases visited who were diagnosed positive for malaria and received treatment within 1 day of reporting to a health facility							
3	No of Bednet beneficiaries visited in the Quarter (at least 2 benificiaries per visit)							
4	No of Bednet beneficiaries visited in the Quarter who utilised bednets previous night							
5	No of houses visited in IRS targeted villages (at least 2 benificiaries per visit)							
6	No of houses visited in IRS targeted villages which had complete good quality spray							
NB: Use NA where Not Applicable								

PMMR

C- Training Report for Quarter_____

Sl.No	District/ State	Category of Staff	Total No. Sanctioned	Total No. In Position	Total No. of Courses in the Quarter	Date of Trainings	Total No. Trained in the Quarter	Total No. Trained since July 2005
1		DMO						
		DVBDCP Consultants						
		Medical Specialists						
		Private Practitioners (IMA, NGOs etc)						
		PHC-MO						
		MTS						
		LTs (induction) **						
		LTs (reorientation)**						
		Health supervisors (M)						
		Health supervisors (F)						
		MPWs (M)						
		MPWs (F)						
		ASHAs/ Community Volunteers						
		Others (specify)						

NB: Use NA where Not Applicable

***** To be filled in State level report fron information obtained from RD Office***

D. BCC Campaign for Malaria Control

S. No.	Activities & Related Details	Level of Implementation						
		State	District	Block	Municipal Corporation (Other than District/ Block headquarters)	Municipal Council/ Town areas (Other than District/ Block headquarters)	Sub- Centre	Village
I	**Major Activity : Advocacy workshops at different levels**							
	Number							
	Organization(s)/ Institution (s) responsible for implementation							
	No. of participants (please attach list)							
	No. of Organizations carried out activities on prevention and control of VBD (attah details)							
	Expenditure incurred							
	Remarks							
II	**Major Activity : Inter-sectoral Coordination meeting**							
	Number							
	Organization(s)/ Institution (s) responsible for implementation							
	No. of participants (please attach list)							
	No. of Organizations carried out activities on prevention and control of VBD							
	Expenditure incurred							
	Remarks							
III	**Major Activity : programme Communication**							
a	**Print Media (newspaper advertisements, poster, leaflets/ handbills/ pamphlets, gate folders, stickers, booklets, calendars, brochures, banners, Flip charts, Flash cards, any other)**							
	Number							
	Organization(s)/ Institution (s) responsible for implementation							
	No. of Organizations carried out activities on prevention and control of VBD (attah details)							
	Expenditure incurred							
	Remarks							
b	**Electronic Media (Television- National/Regional/ cable, Radio-National/ regional/ FM/ locl, cable/ Satellite network, Cinema Slides, videos, cassettes/ CDs, any other**							
	Number							
	Organization(s)/ Institution (s) responsible for implementation							
	No. of Organizations carried out activities on prevention and control of VBD (attah details)							
	Expenditure incurred							
	Remarks							
c	**Outdoor Publicity (Hoardings, wall painting / signs, signage, DDC/FTD signboards, Glow signs, Tin plates, Public announcements/ miking/ drum beating, Exhibition/ Health mela, any other)**							
	Number							
	Organization(s)/ Institution (s) responsible for implementation							
	No. of Participants (Please attach list)							
	No. of Organizations carried out activities on prevention and control of VBD (attah details)							
	Expenditure incurred							
	Remarks							
d	**Folk media& Inter-personal communication (Group meeting, Door to Door campaigns. Plays, skits, song & drama, Q & A sessions, any other)**							
	Number							
	Organization(s)/ Institution (s) responsible for implementation							
	No. of Participants (Please attach list)							
	No. of Organizations carried out activities on prevention and control of VBD (attah details)							
	Expenditure incurred							
	Remarks							
IV	**Major Activity : monitoring & Evaluation ***							
a	**Concurrent evaluation**							
	Number (Please attach state wise/ district wise compiled reports)							
	Organization(s)/ Institution (s) responsible							
	Expenditure incurred							
	Remarks							
b	**Consecutive evaluation**							
	Number (Please attach state wise/ district wise compiled reports)							
	Organization(s)/ Institution (s) responsible							
	Expenditure incurred							
	Remarks							

PMMR

E- District Wise Logistic Monitoring

State/ District -

Stock Position as on Quarter Ending_____

Sl.No.	District/ PHC	Chloroquine Tab.	Chloroquine Tab. (600 mg)	Combi Blister Pack (CQ+PQ)	Primaquine 7.5 mg Tab.	Primaquine 2.5 mg Tab.	E-Mal Inj	Quinine Sulphate Tab.	Quinine Injection	S+P Comb. Tab.	Artesunate Tab.	ACT Comb. (Artemisinine+SP)	R.D. Kits	DDT 50% (in MT)	Malathion 25% (in MT)	Synthetic Pyrethroid 2.5% (in MT)	Synthetic Pyrethroid 5% (in MT)	Malathion Technical (in MT)	ITNs	LLINs	K.Othrine Flow 2.5% (in ltrs.)	SAG Injection	Amphotericin Injection	Fenthion (in ltrs.)	Temephos (in ltrs.)	Pyrethrum Extt. (in ltrs.)
Total																										

1. Wheather all peripheral institutions have adequate stock of drugs and other required logistics- Yes/ No.

2. No (%) of health facilities (PHCs, SCs, ASHAs, FTDs) visited by District poersonnel/ MTS where stock out were observed. No_____:_____%

3. Which of these functionaries are user for RDK

4. Remarks

Above information may be sent at fax no- 011- 23985310 , 011- 23968329

Annexure 14

Sentinel Site - Malaria Register
NATIONAL VECTOR BORNE DISEASE CONTROL PROGRAMME

Period From To

Sentinel site: District/Sub-district/ CHC/PHC/ Medical College/ Public Sector/ Private sector……

Name of district

S. No.	Date	Name of patient (Father's/ spouse's name)	Addresss - Subcentre	Village (with landmark)	Age (Yrs)	Sex (M/ F)	Pregnant (Y/ N)	ST/ SC	Date of onset of fever	Date of first contact with Govt health system	Date of Reporting to Sentinel site	Investigations for malaria			Diagnosis *	Date of initation of treatment	Whether Admitted (Yes/ No)	If Admitted			
												Place of Investigation	Blood slide (Pv/ Pf)	Result of Pf RDT (Pos/ Neg)				Date of Admission	Final Diagnosis *	Outcome (Cured & discharged/ referred/ Left without discharge/ died) [1]	Date of outcome

* Coding for Diagnosis/ Final Diagnosis			
1	Uncomplicated Malaria	UM	A patient with fever without any other obvious cause and confirmation of diagnosis (microscopy showing asexual malaria parasites in the blood and/or rapid diagnostic test (RDT) for malaria antigen in blood positive).
2	Severe Malaria	SM	A patient, who requires hospitalization for symptoms and/or signs of severe malaria with laboratory confirmation of diagnosis.

1 Coding of Outcomes		
1	Cured & discharged	CD
2	Referred	RF
3	Died	DD
4	Left without discharge	LD

Annexure 14

Sentinel Site Report
NATIONAL VECTOR BORNE DISEASE CONTROL PROGRAMME

Name of Sentinel site: ……..
Month/Year……Fortnight……

A.

Total New OPD Cases	Suspected Malaria Cases	Malaria Cases Confirmed			Pregnant women with Malaria	SCs/STs	Malaria Cases								Total
							less than 1 year		1-4 y		5-14 y		more than 15 y		
		Pv	Pf	Total			M	F	M	F	M	F	M	F	
1	2	3	4	5	7	9	10	11	12	13	14	15	16	17	18

B.

Total inpatients	Total inpatients admitted severe malaria	Severe Malaria Cases Cnfirmed			Pregnant women with severe Malaria	SCs/ STs	Severe Malaria Cases								Timelag between onset and reporting to Sentinel Site			Total Hospital Deaths	Deaths Due to Confirmed Malaria
							less than 1 year		1-4 y		5-14 y		more than 15 y						
		Pv	Pf	Total			M	F	M	F	M	F	M	F	< 3 days	3-7 days	>7 days		
1	2	3	4	5	7	8	9	10	11	12	13	14	15	16				17	18

Annexure -15

Secretary

Check List for Review of Malaria

1. What is the status of following Case Detection indicators?
   - Annual Blood Examination Rate (Surveillance), Total Malaria Cases, Pf Cases, Deaths; compared to the same period of last year

2. Financial
   - Have the SOEs of last quarter & UCs of last year been submitted to Dte NVBDCP by the state?
   - Have the SOEs of last quarter & UCs of last year been submitted by the districts?
   - Is the audit of the district & state society for the last financial year complete?
   - Have Funds been received from center and others source timely and are they adequate?
   - Have Funds been released to the districts on the bases of utilization and balances?
   - Are adequate funds available with districts?

3. Logistics
   - Have adequate Logistics been received from center and other sources?
   - Have logistics been distributed to the districts on the basis of technical rationale?
   - Is district wise monitoring of logistic position being done?
   - Are monthly logistics report being submitted by districts & state on time and being communicated to Dte NVBDCP regularly by 15th of following month?
   - Have the consignee receipts been submitted to Dte. NVBDCP for the items received up to the previous month ?

4. Human Resources / Training
   - Is adequately trained staff present against sanctioned posts?
   - Has the existing staff been rationally deployed so that least vacancies are present in high-risk areas?
   - Whether integration of LTs under different programmes for utilizing their services as multi purpose LTs, been done?

5. Programme Implementation
   - Has the State Action Plan for the next calendar year, been prepared (Dec) and submitted to Dte NVBDCP? Has the State Action Plan been incorporated in the NRHM PIP?
   - Were District Action Plans prepared and submitted by all districts (Nov)?
   - Have the districts completed preparation of District Microplan (pre-transmission season)? Are the micro-plans based on GIS mapping?
   - What is the Training Status of Staff regarding IRS (pre-transmission season)

6. Specific activity monitoring
   - What is the status of GIS mapping? Has the village wise data for all districts been sent to SPO?
   - Are RD Kits being provided to remote and inaccessible areas? Is the proforma on Monitoring of RD Kits being submitted to Dte NVBDCP regularly?
   - Have ASHAs been trained on the use of RDTs? How many are yet to be trained?

7. IEC/ BCC
   - What are the specific BCC activities that have been undertaken in last one quarter?

8. Inter- sectoral coordination
   - How many NGOs/ CBOs/ Military & Para-military Hospitals are involved in the programme in various districts?
   - Whether state transport corporation & other public transport are being used for transportation of blood slides and getting results?

Annexure -16

District Collector

Check List for Review of Malaria

1. What is the status of following Case Detection indicators?
   - ABER (Surveillance), Total Malaria Cases, Pf Cases, Deaths; compared to the same period of last year

2. Financial
   - Have the SOEs of the last quarter / UCs of the last year been submitted by the district to the state?
   - Is the audit of the district society for the last financial year complete?
   - Have Funds been received from State society and other sources timely and are they adequate?

3. Logistics
   - Have adequate Logistics been received from center and other sources?
   - Have logistics been distributed to all implementation points (PHCs, SCs, ASHAs, FTDs) on the basis of technical rationale?
   - Are monthly logistics report being submitted by the district on time?
   - Have all the consignee receipts been submitted?

4. Human Resources / Training
   - Is adequately trained staff present against sanctioned posts?
   - Has the existing staff been rationally deployed so that least vacancies are present in high risk areas?
   - Are trained LTs present in all PHCs?
   - Whether LTs are being used as multi-purpose LTs at PHCs?

5. Programme Implementation
   - Has the District Action Plan been prepared (Nov) and submitted by the district?
   - Has the district completed preparation of District Micro-plan (pre-transmission season) for IRS? Is the micro-plan based on GIS mapping?
   - Are the spray squads been trained/ reoriented for IRS (before commencement of spray)?
   - Has all the spray equipment been checked and certified?
   - Have personnel been nominated for supervision of IRS, area-wise?

6. Specific activity monitoring
   - What is the status of GIS mapping? Has the village wise data been sent to SPO?
   - Are RD Kits being provided to remote and inaccessible areas?
   - Have ASHAs been trained on the use of RDTs ? How many are yet to be trained?

7. IEC/ BCC
   - What are the specific BCC activities that have been undertaken in last one quarter?
   - Is the community being given prior information of spray rounds to improve acceptance of IRS (transmission season)? If yes, who is doing this?

8. Inter- sectoral coordination
   - How many NGOs/ CBOs/ Military & Para-military Hospitals are involved in the programme in the district? How many of these have been involved in the last quarter?
   - Whether state transport corporation & other public transport are being used for transportation of blood slides and getting results?

ANNEXURE - 17

FORMAT 'A': For Progress on Performance of Work by State Consultants under IMCP-II, NVBDCP

TO BE FILLED BY ALL STATE CONSULTANTS

Name of Consultant: _____State: _____
Designation:_____ Reporting
Month/Year:_____ Phone:_____ E-mail: _____

1. **Details of activities undertaken during the 'reporting month' (to be filled date-wise):**

Date	Activities (e.g. field visits, office work, documentation, reports, meetings, review) undertaken and major findings.
01/01/13	

2. Details of activities undertaken during the field visits in the 'reporting month':

Sl. No	District HQ/DH/SDH/ CHC/PHC/SC/Village visited during the month	Broad observations (details to be annexed)	Actions Proposed / Taken	Follow-up/ corrective actions taken on previous observations	Remarks (if any)
2.1					
2.2					
2.3					
2.4 Advance Tour program submitted for the next month (Y/N; No. of field visits proposed)…….					

3. Supervision of activities of District VBD Consultants/MTS (during field visits and reports):

S. No.	Date of field visit	Name of DVBD Consultant/MTS	Observations and actions taken
3.1			
3.2			
3.3			
3.4			
3.5			

4. Observations on financial management:

4.1 Monthly Statement of Expenditure Submitted (Y/N, If Y, on which date)_____:

Sl No	Opening Balance	Funds Received	Total Balance available	Expenditure till (date)……..	Balance as on (date)……
	A	b	c = (a + b)	d	e = (c - d)
4.2					

5. Recommendations:

6. Required corrective actions by the State (in your respective functional areas)/District:

Date:

Signature:
Name:
Designation of State Consultant:

Signature:
Name:
(SPO)

FORMAT 'B-1': TO BE FILLED BY STATE CONSULTANTS (PH) & CONSULTANTS (M&E) ONLY

1. **Status of HR under the project (vacancies, if any, and status of recruitment) as on last date of 'reporting month':**

Sl. No.	Category	No. Recruited	No. Trained	Comments if any
1.1	State Consultants			
1.2	Dist. VBD Consult.			
1.3	SSMO			
1.4	SSLT			
1.5	MTS			
1.6	LT			
1.7	Comments on status of Regular General Healthcare staff:			

2. **Trainings conducted for the project and program staff during the 'reporting month' (specify whether conducted as per plan, No. of trainees, deferred trainings, if any and the reason thereof)**

2.1 Induction trainings:

2.2 Refresher trainings:

3. **M & E Format implementation (as per guidelines):**

Sl No	Name of Dist./ Ho./SDH/ CHC/PHC/ SC/ASHA	M-ASHA (Y/N)	M1 (Y/N)	M2 (Y/N)	M3 (Y/N)	M4 HF (Y/N)	M4 PW (Y/N)	VC 1-6 (Y/N)	PMMR(Y/N)	Remarks
3.1										
3.2										
3.3										
3.4										
3.5										

4. **M & E Activities:**

4.1 Supervisory visits made by the state officers /consultants during the 'reporting month':

Officer / Consultant	No. of visits	Report submitted (Y/N)
SPO		
JD		
DD		
AD		
Entomologist		
Consultant (specify)		
Other (specify)		

4.2 Review meeting(s) held during the month with DMO/CMO (Y/N) Give dates of meeting and details:

4.3 Major Observations discussed in the review meeting:

4.4 Actions taken on the major observations of the previous review meeting

4.5 Entomological surveillance activities undertaken during the 'reporting month'(Y/N):
Details thereof:

5. NAMMIS Use:

5.1 Data entry being done in the NAMMIS at Dist. (Y/N; if no specify name):……..

5.2 Reasons for non-compliance (if any):

5.3 Actions taken for compliance:

5.4 Discrepancies (If any) in data verification observed during field visits. (give details):…….....

5.5 Feedback given to the districts (DMO and DVBDC) on epidemiological data analysis for the previous month (Y/N) (attach copy of feedback**):**

6. IRS Monitoring (when applicable):

A.

Sl No	Name of CHC /PHC/ SC / Village	Micro-plan prepared and available	No.of House /rooms listed	No.of House /rooms sprayed	Reported coverage (%)	Quality of Spray (Good / Unsatisfactory/ Poor)
6.1						
6.2						
6.3						
6.4						

B.

Sl No	Name of CHC/PHC/ SC/Village	Prior intimation to village given (Y/N)	Involvement of GHS staff (MO/ ANM/MPW/ Supervisors specify)	Personal protection measures undertaken (specify appliances used)	Record maintained in VC1-2 formats (Y/N)
6.5					
6.6					
6.7					
6.8					
6.9	Specific reasons for low coverage of IRS:				
6.10	Any other comment on IRS:				

7. LLIN distribution: (When applicable):

7.1 Identified SCs for LLIN distribution (No. of SCs):

7.2 SCs covered under 100% distributions of LLINs (No. of SCs):

7.3 NVBDCP guidelines for distribution followed (Y/N; specify):

7.4 LLINs being used by the villagers {verify in at least 10 households in the visited village (name the village and % household using LLINs)}:

8. Observations on reports of Sentinel Sites (SS) for malaria:

8.1 No. of SS sanctioned and functional: sanctioned……. / functional…….

8.2 Availability of HR at SS(Y/N): SSMO…../LT……..

8.3 Report(s) received from the number of SSs for the previous month out of total functional: Received…… / Total functional SS……

8.4 No of completed reports received from how many SS:

8.5 Feedback given to the SSs (including copy to concerned DMO and DVBDC) on data analysis for the previous month (Y/N) (attach copy of feedback):

9 IEC/BCC activities undertaken during the 'reporting month' (both program and project):

9.1 Number:

9.2 Types of Activity:

10. Reporting of malaria cases from private providers during the 'reporting month' (give details):

11. Stock Monitoring: Stock report submitted by the State and districts for the previous month (with all the details) (to be filled up if PSCM Consultant post is vacant).

Sl No.	Item	Health Centers having stock less than required	
		Name of CHC/PHCs (stock <3 mths)	Name of SC (stock <1 mth)
11.1	RDT		
11.2	ACT (Adult)		
11.3	ACT (9-14)		
11.4	ACT (5-8)		
11.5	ACT (1-4)		
11.6	ACT (<1)		
11.7	Chloroquine		
11.8	Primaquine		
11.10	Inj. Artesunate		
11.11	Action taken to replenish stock:		
11.12	Actions taken based on the review done at state and observations from SAMS on the districts' stock position:		

12. Recommendations for the improvement of Program/ Project in the State:

Date:

Signature:
Name:
Designation of Consultant:

Signature:
Name:
(SPO)

FORMAT 'B-2': TO BE FILLED BY STATE CONSULTANTS (PROCUREMENT & SUPPLY CHAIN MANAGEMENT) ONLY

1. **Details of Logistic (decentralized and buffer) procured by the state as on last date of 'reporting month':**

Item	Opening balance for the month	Technical Requirement	Purchased during the month	Total balance	Issued to districts	Consumptions	Balance	Expiry
Inj Quinine (No.)								
Tab CQ (No.)								
Tab PQ 2.5 mg (No.)								
Tab PQ 7.5mg (No.)								
SP-ACT								
RDT								
Pyrethrum extract (Lit)								

2. **Status of the supplies from the GoI**

Item	Opening balance for the month	Received during the month	Total balance	Issued to districts	Consumptions	Balance	Expiry
DDT (MT)							
Malathion (WDP) (MT)							
Malathion Technical (Lit)							
Synthetic pyrethroid (Kg)							
Temephos (Lit)							
LLIN (No.)							
Malaria RDT (No. of tests)							
ACT (Adult)							
ACT (9-14)							
ACT (5-8)							
ACT (1-4)							
ACT (<1)							
Inj Artesunate (No.)							
Any other (specify)…….							

3. **Comment on good storage practices for drugs, diagnostics and commodities:**

4. **Status of distribution of drugs, diagnostics and commodities from the districts (visited) to peripheral health facilities:**

5. **Details of post-dispatch testing of RDTs for Quality control /Assurance:**

6. **Availability of transportation for drugs and diagnostics from state to districts:**
7. **Reporting format VC (2 & 6) used at State/ district level(Y/N):**
   If no, reasons for not using:
   ……

8. Stock Monitoring:

8.1 Stock report submitted by the State and districts for the previous month (with all the details) to SAMS: Yes / No.

8.2 If no, Name of defaulting district(s): ……..

8.3 Status of stock on the basis of review of the district and state stock position (as on last date of 'reporting month'):

Sl No.	Item	Health Centers having stock less than required	
		Name of CHC/PHCs (stock <3 mths)	Name of SC (stock <1 mths)
8.3.1	RDT		
8.3.2	ACT (Adult)		
8.3.3	ACT (9-14)		
8.3.4	ACT (5-8)		
8.3.5	ACT (1-4)		
8.3.6	ACT (<1)		
8.3.7	Chloroquine		
8.3.8	Primaquine		
8.3.9	Inj. Artesunate		
8.3.10 Action taken to replenish Stock:			
8.3.11 Actions taken based on the review done at state and observations from SAMS on the districts' stock position:			

9. LLIN distribution (when applicable):

9.1 Total LLIN required by the state to cover high risk population (SCs with API ≥2):
9.2 Total LLIN received in the year:
9.3 Total LLIN distributed till date:
9.4 % of HH covered by LLIN so far:
9.5 % of HH using LLINs among those HH visited during the 'reporting month':
9.6 Additional LLINs required (remaining, including replacement):

10. Are the stock registers maintained properly? Yes/No
If No, describe the problems and possible solutions.

11. Has the State sent all the consignee receipts? Yes/No.
If no, give details

12. Suggested actions on supply chain management by the state:

Date:

Signature:
Name:
(Procurement & Supply Chain Management Consultant)

Signature:
Name:
(SPO)

FORMAT 'B-3': TO BE FILLED BY STATE CONSULTANTS (FINANCE)/ ACCOUNT ASSISTANTS ONLY

1. **Financial Position for the Quarter (specify): ……..**

(Amount in Rs)

Sl No	Budget Head	Opening Balance	Funds Received	Balance Available for utilization	Utilization Reported*	Balance
1	Domestic Support					
2	GFATM – IMCP-II					
3	Decentralized Commodities					
	Total					

** Attach the consolidated FMR in the prescribed format*

2. **Whether the Financial Monitoring Report(FMR) is in consonance with the books of accounts (including districts visited) : Yes/No**

   If no, name of the defaulting district(s):

3. **District Financial Monitoring Report (FMR) for the 'previous month' received by the state? Yes/No**

   If no, name of the defaulting district(s):

   Specify reasons for default:

4. **UC and audited report for last financial year submitted : Yes/No**

5. **Whether advances (i.e. releases to the districts) are reported as expenditure in FMR? Yes/No**

6. **Whether all districts have been covered while preparing the last FMR? Yes/No**

   If no, name of the defaulting district(s):

7. **Whether 'Books of Accounts' are computerized using *Tally software* at district level: Yes / No**

   If no, name of the defaulting district(s):

   Specify reasons for default:

8. **Reasons for major operational constraints experienced in the financial issues:**

9. **Suggestions to address these constraints:**

Date:

Signature:
Name:
Designation of Consultant/Assisstant:

Signature:
Name:
(SPO)

FORMAT 'B-4': TO BE FILLED BY STATE CONSULTANTS (IEC/BCC) ONLY

1. IEC /BCC activities undertaken under the Project and Programme

Dates and venue of IEC/BCC activities conducted during the month

Date	Venue	Conducted by	Type of activity	Project / Programme activity	No. of participants	Type of IEC material used	Expenditure incurred (Rs)

2. Supervisory visits conducted by the state/district officials during the activity (Y/N)

2.1 State Officials (specify):

2.2 District Officials (specify):

3. Observations made by the supervisory officials during the IEC activities:

3.1 State Officials (specify):

3.2 District Officials (specify):

4. Involvement of NGOs (including Caritas partners) and coordination with them (give details):

5. Involvement of private healthcare providers in IEC/BCC activities during the month(give details):

6. Awareness about malaria and anti-malaria services in the community:

(By interviewing people in the visited village):

Name places where awareness carried out……..

Sl. No.	Awareness about	By observation N/D= (%)	Through LQAS N/D= (%)
6.1	Symptoms of malaria		
6.2	Cause of malaria		
6.3	Availability of treatment		
6.4	Preventive measures for malaria		

N/D= Numerator/Denominator

Comments:

7. IEC/BCC activity implementation issues (if any):

8. Suggestions for improvements:

Date:

Signature:
Name:
Consultant (IEC/BCC)

Signature:
Name:
(SPO)

Guidelines for Filling up Formats for Progress on Performance of Work by Contractual staff under IMCP-II, NVBDCP

General Guidelines

1) MTS format is to be countersigned by the reporting MO I/C of PHC.
2) District Consultant's format is to be countersigned by concerned DMO/DVBDC Officer.
3) State Consultant's format is to be countersigned by concerned SPO.
4) All formats to be filled-up in soft copy and emailed to concerned official(s) as specified below so as to reach by every 15th of next month (e.g. January 2013 report should reach by 15th February 2013 and so on…).
5) Separate sheet(s) may be attached wherever needed.
6) These progress reports on 'Performance of Work' would be considered while extending the tenure of contractual staff.

Format	Meant for Official (State/Distt)	Reports to….		Dedicated email id for sending to Dte. NVBDCP
AB1	Consultant M&E, PH	SPO	National M&E Consultant	malaria.mne@gmail.com
AB2	Consultant PSM	SPO	National Procurement Consultant	malaria.procurement@gmail.com
AB3	Consultant Finance/ Account Assistant	SPO	National Finance Consultant	malaria.finance@gmail.com
AB4	Consultant IEC/BCC	SPO	National IEC Consultant	malaria.iecbcc@gmail.com
DC	District VBD Consultant	DMO/DVBDCO; State M&E Consultant; SPO	National M&E Consultant	malaria.mne@gmail.com
MT	MTS	District VBD Consultant; DMO/DVBDCO	State M&E Consultant*; SPO	Dedicated email id** to be provided by concerned SPO/ State Consultants/DMO/DVBDCO

**Dedicated email id to be made by States/ Districts and to be communicated to all concerned for receiving progress formats in soft copy.
*State M&E Consultants would be provided a format for communicating 'compiled status of MT formats' to Dte. NVBDCP in due course.

Definitions

1) Reporting month: The month during which various activities have been undertaken and for which reporting is done.
2) Previous month: The month preceding the 'reporting month'.
3) Next month: The month following the 'reporting month'

Abbreviations

ASHA	Accredited Social Health Activist
AD	Assistant Director
ANM	Auxiliary Nurse Midwife
ACT	Artesunate Combination Therapy
BCC	Behavior Change Counseling
CHC	Community Health Centre
CMO	Chief Medical Officer
CQ	Chloroquine
DMO	District Malaria Officer
DVBDC	District Vector Control Disease Consultant
DVBDCO	District Vector Borne Diseases Control Officer
DD	Deputy Director
DH	District Hospital
EDCT	Early Diagnosis and Complete Treatment
FMR	Financial Management Report

GFATM	Global Fund for AIDS, Tuberculosis and Malaria
GoI	Government of India
GHS	General Health Staff
GSP	Good Storages Practices
HF	Health Facility
HQ	Head Quarter
HR	Human Resource
HH	House Hold
IMCP	Intensified Malaria Control Project
IEC	Information, Education and Communication
IRS	Indoor Residual Spray
IDSP	Integrated Disease Surveillance Programme
JD	Joint Director
LT	Laboratory Technician
LLIN	Long Lasting Insecticidal Net
LQAS	Lot Quality Assurance Sampling
MTS	Malaria Technical Supervisor
M&E	Monitoring and Evaluation
MO	Medical Officer
MPW	Multi Purpose Worker
N/D	Numerator/ Denominator
N	No
No.	Number
NAMMIS	National Anti Malaria Management Information System
NGO	Non-Governmental Organization
NVBDCP	National Vector Borne Disease Control Programme
PHC	Primary Health Centre
PMMR	Programme Management and Monitoring Review
PSCM	Procurement and Supply Chain Management
PQ	Primaquine
RDT	Rapid Diagnostic Kit
SAMS	Strategic Alliance Management Services
SDH	Sub-Divisional Hospital
SC	Sub-Centre
SSMO	Sentinel Site Medical Officer
SSLT	Sentinel Site Lab Technician
SPO	State Programme Officer
SS	Sentinel Sites
UC	Utilization Certificate
VBD	Vector Borne Diseases
VC	Vector Control
Y	Yes

Guidelines for filling up Format 'A' (For all State Consultants)

All questions are mandatory to be answered.

Sl. No. 1: The consultants have to fill the details of activities for each working day of the month (date-wise). Further, a brief of activities performed on that day including field visits must be mentioned.

Sl. No. 2: Under this head, the details of field visits undertaken by the consultants have to be filled. Major observations may be highlighted in this section in brief. Further, detailed report of field visits may be attached as 'Annexure'.

Sl. No. 3: Under this section, the name of the District VBD Consultant/ MTS is to be provided where the field visit was made with major observations along with actions taken.

Sl. No. 4: Under this section; financial details are to be filled. The consultant is advised to verify the financial information available at the state level.

Sl. No. 5: Mention relevant recommendations.

Sl. No. 6: Give information regarding corrective actions to be taken district/ state-wise.

Guidelines for filling up Format 'B1'
{For State Consultants (PH) and (M & E)}

All questions are mandatory to be answered.

Sl. No. 1: The status of HR is to be entered in this section. If there is vacancy, then the status of recruitment process must be given. Further the status/requirement of regular Medical/ paramedical staff may also be provided.

Sl. No. 2: Under this section, the trainings undertaken (induction/refresher) should be specified. Specify whether the training was planned or not. Number of trainees to whom training was given in that batch must be specified.

Sl. No. 3: To be filled as per the details given there.

Sl. No. 4: To be filled as per the details given there.

Sl. No. 5: To be filled as per the details given there.

Sl. No. 6: To be filled as per the matrix given below (for 'quality of spray'):

Coverage→ Quality↓	More than 80%	60-80%	Less than 60%
Uniform	Good	Unsatisfactory	Poor
Patchy	Unsatisfactory	Poor	Poor

Further, in case of non-acceptance of IRS, please specify the reasons of non-acceptance by the community. In case there is any deviation in the micro plan available at state level, the revision should be mentioned in the report and its reasons.

Sl. No. 7: To be filled as per details given there.

Sl. No. 8: As per details given there.

Sl. No. 9: Under this section, the activities pertaining to IEC/BCC as planned (under PIP) and the achievements are to be mentioned.

Sl. No. 10: Give details as per the private health facilities reports.

Sl. No. 11: Under this section the status of stock is to be entered. Further the physical verification of items must be done at district level and should be matched with the reports available at state level.

Sl.No.12: Give your own views and suggestions.

Guidelines for filling up Format 'B2'
{For State Consultants (Procurement and Supply Chain Management)}

All questions are mandatory to be answered.

Sl. No. 1: As per details given there.
Sl. No. 2: As per details given there.
Sl. No. 3: Shall be given training about Good Storage Practices (GSPs).
Sl. No. 4: Take list from DMO and physically verify the stock on the spot at the Peripheral HF (to be visited) both from stock register and store.
Sl. No. 5: As per the guidelines given in the SOPs for QA, refer to the Website of NVBDCP.
Sl. No. 6: Give details of mechanism of transport for drugs and diagnostics to district level.
Sl. No. 7: Mention the status of submission of completely and correctly filled formats.
Sl. No. 8: As per the details given there.
Sl. No. 9: As per the details given there.
Sl. No. 10: As per the details given there.
Sl. No. 11: As per the details given there.
Sl. No. 12: Give your own views and suggestions.

Guidelines for filling up Format 'B3'
{For State Consultants (Finance)}

All questions are mandatory to be answered.

Sl. No. 1: As per details given there.
Sl. No. 2: As per details given there.
Sl. No. 3: As per details given there.
Sl. No. 4: As per details given there.
Sl. No. 5: As per the details given there.
Sl. No. 6: As per the details given there.
Sl. No. 7: As per the details given there.
Sl. No. 8: Give your own views and suggestions.
Sl. No. 9: Give your own views and suggestions.

Guidelines for filling up Format 'B4'
{For State Consultants (IEC/BCC)}

All questions are mandatory to be answered.

Sl. No. 1: As per details given there.
Sl. No. 2: As per details given there.
Sl. No. 3: As per details given there.
Sl. No. 4: As per details given there.
Sl. No. 5: As per the details given there.
Sl. No. 6: As per the details given there.
Sl. No. 7: Give your own views and suggestions.
Sl. No. 8: Give your own views and suggestions.

Checklist for monitoring the submission of monthly reporting formats by the project staff

Name of the state: **Year:**

					Date of submission											
No.	**Level**	**Position**	**Name of Consultant/ MTS**	**Name of District / Sub-Dist.**	**Jan**	**Feb**	**Mar**	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**
	State-	M &E Consultants														
		Public Health Consultants														
		Finance Consultants														
		Procurement Consultants														
		NGO/PPP Consultants														
	Dist	DVBDC														
		DVBDC														
		DVBDC														
		DVBDC														
		DVBDC														
		DVBDC														
		DVBDC														
	Sub-Dist	MTS														
		MTS														
		MTS														
		MTS														
		MTS														
		MTS														

Please add rows as required

ANNEXURE - 18

FORMAT 'DC': For Progress on Performance of Work by District VBD Consultants under IMCP-II, NVBDCP

TO BE FILLED BY DISTRICT VBD CONSULTANTS ONLY

Name of the Consultant:_____ **State:** _____
Phone:_____ **District:**_____
E-mail:_____ **Reporting for the Month/Year:**_____

1. **Details of activities undertaken (including visits) during the 'reporting month' (to be filled date-wise):**

Date	Activities (e.g. field visits, office work, documentation, reports, meetings, review) undertaken and major findings.
01/01/2013	

2. **Details of activities undertaken during the field visits in the 'reporting month' and important observations:**

Sl. No.	District HQ/DH/SDH/ CHC/PHC/SC/Village visited during the month	Broad observations (details to be	Actions Proposed/ Taken	Follow-up/corrective actions on	Remarks (if any)

		annexed)		**previous observations**	
2.1					
2.2					
2.3					
2.4	Advance Tour program submitted for the next month (Y/N; No. of field visits proposed)……				

3. Supervision of activities of MTS (during field visits and reports):

Sl. No.	**Date of field visit**	**Name of MTS**	**Observations and actions taken**
3.1			
3.2			
3.3			
3.4			
3.5			

4. Epidemiological Situation (monitor trend using 'Epidemic Threshold Chart' and describe changes, if any):

Sl. No	**Presence of (in previous month/Yr …….)**	**Yes/No**	**If yes, where (Name of PHCs/ SCs/Villages)**
4.1	Increase in no. of malaria cases compared to previous month of the same year		
4.2	Any death due to malaria in the previous month		
4.3	Increased fever cases in the previous month compared to same month in previous year		

5. Stock Monitoring:

Sl No.	**Item**	**Health Centers having stock less than required**	
		Name of CHC/PHCs (stock <3 mths)	**Name of SC(stock <1 mth)**
5.1	**RDT**		
5.2	**ACT (Adult)**		
5.3	**ACT (9-14)**		
5.4	**ACT (5-8)**		
5.5	**ACT (1-4)**		
5.6	**ACT (<1)**		
5.7	**Chloroquine**		
5.8	**Primaquine**		
5.9	**Inj. Artesunate**		
5.10 Action taken to replenish Stock:			

6. M & E Format implementation:

Sl No	**Name of CHC/PHC/SC/ASHA**	**M-ASHA (Y/N)**	**M1 (Y/N)**	**M2 (Y/N)**	**M3 (Y/N)**	**M4 HF (Y/N)**	**M4 PW (Y/N)**	**VC 1-6 (Y/N)**	**PMMR(Y/N)**	**Remarks**
6.1										
6.2										
6.3										

6.4										
6.5										
6.6	**If not implemented, why?**									

7. NAMMIS use:

7.1 Data entry being done in the NAMMIS at Dist. (Y/No; if no, specify name):

7.2 Reasons for non-compliance (if any):

7.3 Actions taken for compliance:

8. IRS Monitoring (when applicable):

A.

Sl No	Name of CHC/PHC/ SC/Village	Micro-plan prepared and available	No. of House /rooms listed	No. of House/ rooms sprayed	Reported coverage (%)	Quality of Spray (Good / Unsatisfactory/Poor)
8.1						
8.2						
8.3						
8.4						

B.

Sl No.	Name of CHC/PHC/ SC/Village	Prior intimation to village given (Y/N)	Involvement of GHS staff (MO/ANM / MPW / Supervisors /; specify)	Personal protection measures undertaken (specify appliances used)	Record maintained in VC1-2 formats (Y/N)
8.5					
8.6					
8.7					
8.8					
8.9	**Specific reasons for low coverage of IRS:**				
8.10	**Any other comments on IRS:**				

9. LLIN distribution (When applicable):

9.1 Identified SCs for LLIN distribution (No. of SCs):

9.2 SCs covered under 100% distribution of LLINs (No. of SCs):

9.3 NVBDCP guidelines for distribution followed (Y/N; specify):

9.4 LLINs being used by the villagers {verify in at least 10 households in the visited village (name the village and % households using LLINs)}:

10. Observations on reports of Sentinel Sites (SS) for malaria:

10.1 No. of SS sanctioned and functional: sanctioned……/functional……

10.2 Availability of HR at SS(Y/N): SSMO…../LT……..

10.3 Report(s) received from the number of SSs for the previous month out of total functional: Received…….. /Total functional SS: ……..

10.4 No of completed reports received from how many SS:

10.5 Feedback given to the SSs on data analysis for the previous month (Y /N) (attach copy of feedback):

11 Observations on reports from IDSP (regarding integration with IDSP):

12 Observations on NGOs (Including Caritas India) /PPP activities:

13 Observations on vector monitoring (where done):

14. Observations on IEC/BCC activities

14.1 IEC/BCC activities carried out during the 'reporting month' in your area:

Dates and venue of IEC/BCC activities conducted during the month

Date	Venue	Conducted by	Type of activity	Project / Programme activity	No. of participants	Type of IEC material used	Expenditure incurred (Rs)

14.2 Awareness about malaria (by interviewing 35 people in the visited village/ LQAS):

Name places where awareness carried out……..

S. No.	Awareness about	By observation N/D=(%)	Through LQAS N/D=(%)
1.	Symptoms of malaria		
2.	Cause of malaria		
3.	Availability of treatment		
4.	Preventive measures for malaria		

N/D=Numerator/Denominator

15 Comments on Human resource management: (vacancies, training needs etc.):

16 Observations on reports of LQAS from MTSs (when done).

17 Comments on financial management:

SoE of previous month submitted: No / Yes on the date …….

If no, Reasons for the delay:

18 Actions taken by DVBD Consultant:

Date:

Signature:
Name:
(DVBD Consultant)

Signature:
Name:
(DMO/DVBDCO)

Guidelines for Filling up Formats for Progress on Performance of Work by Contractual staff under IMCP-II, NVBDCP

General Guidelines

1) MTS format is to be countersigned by the reporting MO I/C of PHC.
2) District Consultant's format is to be countersigned by concerned DMO/DVBDC Officer.
3) State Consultant's format is to be countersigned by concerned SPO.
4) All formats to be filled-up in soft copy and emailed to concerned official(s) as specified below so as to reach by every 15th of next month (e.g. January 2013 report should reach by 15th February 2013 and so on…).
5) Separate sheet(s) may be attached wherever needed.
6) These progress reports on 'Performance of Work' would be considered while extending the tenure of contractual staff.

Format	Meant for Official (State/Distt)	Reports to….		Dedicated email id for sending to Dte. NVBDCP
AB1	Consultant M&E, PH	SPO	National M&E Consultant	malaria.mne@gmail.com
AB2	Consultant PSM	SPO	National Procurement Consultant	malaria.procurement@gmail.com
AB3	Consultant Finance/ Account Assistant	SPO	National Finance Consultant	malaria.finance@gmail.com
AB4	Consultant IEC/BCC	SPO	National IEC Consultant	malaria.iecbcc@gmail.com
DC	District VBD Consultant	DMO/DVBDCO; State M&E Consultant; SPO	National M&E Consultant	malaria.mne@gmail.com
MT	MTS	District VBD Consultant; DMO/DVBDCO	State M&E Consultant*; SPO	Dedicated email id** to be provided by concerned SPO/ State Consultants/DMO/DVBDCO

**Dedicated email id to be made by States/ Districts and to be communicated to all concerned for receiving progress formats in soft copy.
*State M&E Consultants would be provided a format for communicating 'compiled status of MT formats' to Dte. NVBDCP in due course.

Definitions

1) Reporting month: The month during which various activities have been undertaken and for which reporting is done.
2) Previous month: The month preceding the 'reporting month'.
3) Next month: The month following the 'reporting month'

Abbreviations

ASHA	Accredited Social Health Activist
AD	Assistant Director
ANM	Auxiliary Nurse Midwife
ACT	Artesunate Combination Therapy
BCC	Behavior Change Counseling
CHC	Community Health Centre

CMO	Chief Medical Officer
CQ	Chloroquine
DMO	District Malaria Officer
DVBDC	District Vector Control Disease Consultant
DVBDCO	District Vector Borne Diseases Control Officer
DD	Deputy Director
DH	District Hospital
EDCT	Early Diagnosis and Complete Treatment
FMR	Financial Management Report
GFATM	Global Fund for AIDS, Tuberculosis and Malaria
GoI	Government of India
GHS	General Health Staff
GSP	Good Storages Practices
HF	Health Facility
HQ	Head Quarter
HR	Human Resource
HH	House Hold
IMCP	Intensified Malaria Control Project
IEC	Information, Education and Communication
IRS	Indoor Residual Spray
IDSP	Integrated Disease Surveillance Programme
JD	Joint Director
LT	Laboratory Technician
LLIN	Long Lasting Insecticidal Net
LQAS	Lot Quality Assurance Sampling
MTS	Malaria Technical Supervisor
M&E	Monitoring and Evaluation
MO	Medical Officer
MPW	Multi Purpose Worker
N/D	Numerator/ Denominator
N	No
No.	Number
NAMMIS	National Anti Malaria Management Information System
NGO	Non-Governmental Organization
NVBDCP	National Vector Borne Disease Control Programme
PHC	Primary Health Centre
PMMR	Programme Management and Monitoring Review
PSCM	Procurement and Supply Chain Management
PQ	Primaquine
RDT	Rapid Diagnostic Kit
SAMS	Strategic Alliance Management Services
SDH	Sub-Divisional Hospital
SC	Sub-Centre
SSMO	Sentinel Site Medical Officer
SSLT	Sentinel Site Lab Technician
SPO	State Programme Officer
SS	Sentinel Sites
UC	Utilization Certificate
VBD	Vector Borne Diseases
VC	Vector Control

Guidelines for filling up Format 'DC'
{For District VBD Consultants}

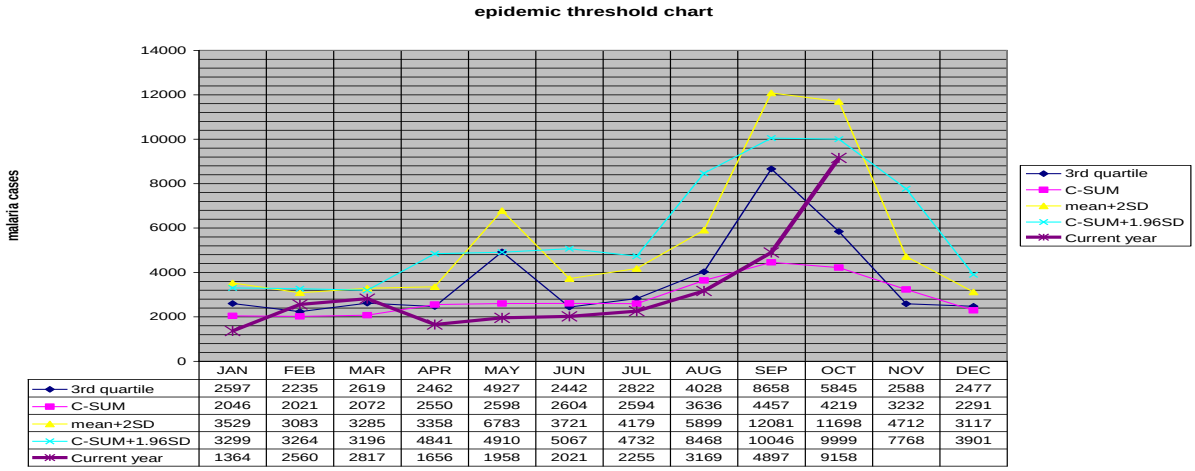
All questions are mandatory to be answered.

Sl. No. 1: The consultants have to fill the details of activities for each working day of the month (date-wise). Further, a brief of activities performed on that day including field visits must be mentioned.

Sl. No. 2: Under this head, the details of field visit under taken by the consultants have to be filled. Major observations may be highlighted in this section in brief. Further, detailed report of field visits may be attached as 'Annexure'.

Sl. No. 3: Under this section, the name of the MTS is to be provided where the field visit was made with major observations along with actions taken.

Sl. No. 4: Fill the data for the graph provided and comment accordingly (Pl. refer to Annexure)



	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC
3rd quartile	2597	2235	2619	2462	4927	2442	2822	4028	8658	5845	2588	2477
C-SUM	2046	2021	2072	2550	2598	2604	2594	3636	4457	4219	3232	2291
mean+2SD	3529	3083	3285	3358	6783	3721	4179	5899	12081	11698	4712	3117
C-SUM+1.96SD	3299	3264	3196	4841	4910	5067	4732	8468	10046	9999	7768	3901
Current year	1364	2560	2817	1656	1958	2021	2255	3169	4897	9158		

Sl. No. 5: To be filled as per details given there.

Sl. No. 6: To be filled as per details given there.

Sl. No. 7: As per details given there.

Sl. No. 8: To be filled as per the matrix given below (for 'quality of spray'):

Coverage→ Quality↓	More than 80%	60-80%	Less than 60%
Uniform	Good	Unsatisfactory	Poor
Patchy	Unsatisfactory	Poor	Poor

Further, in case of non-acceptance of IRS please specify the reasons of non-acceptance by the community. In case there is any deviation in the micro plan available at district level, the revision should be mentioned in the report and its reasons.

Sl. No. 9: As per details given there.

Sl. No. 10: As per details given there.

Sl. No. 11: As per details given there.

Sl. No. 12: As per details given there

Sl. No. 13: As per details given there.

Sl. No. 14: As per details given there.

Sl. No. 15: As per details given there.

Sl. No. 16: As per details given there.

Sl. No. 17: Under this section, financial details are to be filled. The consultant is advised to verify the financial information with the data available at the district level.

Sl. No. 18: Give specific details.

Annexure

Guidelines for using the 'Epidemic Threshold Chart'

Pl. open Excel file (named 'epidemic_threshold_calculation_sheet') and proceed as per following steps:

1. **Enter month-wise data of total malaria cases for last five years** in the blank (white area) for the 'health centre' for which the epidemic threshold chart is to be prepared. The chart can be prepared for Sub-centre, PHC or District (accordingly, the concerned data is to be entered).
2. **This will lead to calculation of indicators like mean, C-sum, Mean+2SD and C-sum+2SD** in the yellow area and followed by its graph on second sheet automatically.
3. Then **enter the monthly data of that 'health centre' in the last blank line (white area i.e. for current year) in the first sheet**. You may put week-wise data, if available (if not available, put fortnight/month-wise data). This will help in detecting the impending epidemic/outbreak at an early stage.
4. **Compare weekly/fortnightly/monthly situation of current year with the corresponding week/fortnight/month** of five-year-threshold i.e. C-sum (Light Blue line) or mean (Red line). These are Alert threshold lines.

4.1 Alert threshold not crossed:

In this situation, the figure of specific week/fortnight/month will be less than the Alert (Early Warning Signal) line-graph of the threshold. In such case continue surveillance, observe the trend, reassess the situation; and take action accordingly.

If Alert threshold is not crossed by the end of first 3 weeks (if weekly data has been entered) of the current month. In this situation, watch the trend during the fourth week, as explained above. Investigate and take appropriate action according to the findings.

4.2 Alert threshold crossed:

Alert threshold is crossed when malaria cases for the specific week/fortnight/month of the current year are more than the cases for the corresponding week/fortnight/month of the threshold figure/line-graph. This constitutes an 'Early Warning Signal' for impending outbreak situation and needs further confirmation. Outbreak is suspected if strongly corroborated with other factors such as climatic, entomological, parasitological, human factors (migration, construction of Projects) etc. should be analyzed. This may give further clues regarding the area/ population affected.

4.2.1 Contain outbreak focus (if indicated):

A focus of outbreak, if identified, can be contained at an early stage. In this way, early detection and containment of malaria outbreak will prevent large scale epidemic.

This may be taken as 'trigger' for investigation. In this situation epidemiological investigation will be required to study other Early Warning Signals (EWS). One has to consider the normal seasonal increase in number of cases. Identification of impending outbreak and taking corrective measures will indeed be an appreciative initiative of District Medical Officer, VBD consultant and Rapid Response Team (RRT).

4.3 Epidemic threshold crossed (if the Csum+1.96 SD or Mean +2SD line is crossed by the brown line- of current year)

In this situation epidemic is strongly suspected. The number of cases are more than C-Sum + 1.96 SD. The epidemic may be in rising phase or has already reached the peak. Subjective judgment will be necessary to identify such a 'public health emergency' and will require rapid investigation and adequate response.

4.3.1 Rapid investigation

The Rapid investigation should be carried out within 48 hours to find out the cause of increase in no. of cases, area/ population affected, duration of the epidemic, etc.

4.4 Epidemic confirmed

Contain the epidemic as per guidelines. The Operational Manual (2009) gives comprehensive guidelines for containment of malaria epidemic. Visit NVBDCP website for details

ANNEXURE 19

FORMAT 'MT': For Progress on Performance of Work by MTS under IMCP-II, NVBDCP

TO BE FILLED BY MTS ONLY

Name of MTS:_____ **State:**_____
Phone:_____ **District:**_____
E-mail:_____ **Report for the Month/Year:**_____
PHC HQ:_____

1. Details of activities undertaken during field visits in the 'reporting month' and important observations:

Date	Name of Visited CHC/PHC/SC/ Village	Observations and actions taken including follow up of observations of previous visit(s)

2. Epidemiological Situation (describe only the changes, if any)

Sl. No	Presence of (in previous Month /Yr …….)	Yes/No	If yes, where (Name of PHCs/ SCs/ Villages)
2.1	Increase in no. of malaria cases compared to previous month of same year.		
2.2	Any death due to malaria in the previous month		
2.3	Increased fever cases in the previous month compared to same month in previous year		

3. Supervision of activities of MPWs /ASHAs/ Village (Presence in HF/villages, EDCT, IRS, LLIN distribution and usage, maintenance of records)

Sl.No.	Date	Name of MPW/ ASHA/ Village	Observations and actions taken
3.1			
3.2			
3.3			
3.4			
3.5			
3.6			
3.7			
3.8			

4. Stock Monitoring:

Sl No.	Item	Health Centers having stock less than required	
		Name of CHC/PHC (stock <3 months)	Name of SC (stock <1 month)
4.1	RDT		
4.2	ACT (Adult)		

4.3	**ACT (9-14)**		
4.4	**ACT (5-8)**		
4.5	**ACT (1-4)**		
4.6	**ACT (<1)**		
4.7	**Chloroquine**		
4.8	**Primaquine**		
4.9	**Inj. Artesunate**		
4.10 Action taken to replenish Stock:			

5. M & E Format implementation:

Sl No	Name of CHC/PHC/SC/ASHA	M-ASHA (Y/N)	M1 (Y/N)	M2 (Y/N)	M3 (Y/N)	M4 HF (Y/N)	M4 PW (Y/N)	VC 1-6 (Y/N)	PMMR(Y/N)	Remarks
5.1										
5.2										
5.3										
5.4										
5.5										
5.6	**If not implemented, why?**									

6. IRS Monitoring (when applicable):

A.

Sl No.	Name of CHC/PHC/ SC/Village	Micro-plan prepared and available	No. of House /rooms listed	No. of House / rooms sprayed	Reported coverage (%)	Quality of Spray (Good / Unsatisfactory/Poor)
6.1						
6.2						
6.3						
6.4						

B.

Sl No	Name of CHC/PHC/ SC/Village	Prior intimation to village given (Y/N)	Involvement of GHS staff (MO/ANM / MPW / Supervisors / specify)	Personal protection measures undertaken (specify appliances used)	Record maintained in VC1-2 formats (Y/N)
6.5					
6.6					
6.7					
6.8					
6.9	**Specific reasons for low coverage of IRS :**				
6.10	**Any other comments on IRS:**				

7. LLIN distribution (When applicable):

7.1 Identified SCs for LLIN distribution (No. of SCs):

7.2 SCs covered under 100% distribution of LLINs (No. of SCs):

7.3 NVBDCP guidelines for distribution followed (Y/N; specify):

7.4 LLINs being used by the villagers {verify in at least 10 households in the visited village (name the village and % households using LLINs)}:

8. Observations on IEC/BCC activities:

8.1 IEC/BCC activities carried out during the 'reporting month' in your area: Dates and venue of IEC/BCC activities conducted during the month:

Date	Venue	Conducted by	Type of activity	Project / Programme activity	No. of participants	Type of IEC material used	Expenditure incurred (Rs)

8.2 Awareness about malaria (by interviewing 35 people in the visited village/ LQAS):

Name places where awareness carried out:			
S. No.	**Awareness about**	**By observation N/D= (%)**	**Through LQAS N/D= (%)**
1.	Symptoms of malaria		
2.	Cause of malaria		
3.	Availability of treatment		
4.	Preventive measures for malaria		

N/D=Numerator/Denominator

Date:

Signature:
Name:
(MTS)

Signature:
Name:
(MO I/C of PHC)

Guidelines for Filling up Formats for Progress on Performance of Work by Contractual staff under IMCP-II, NVBDCP

General Guidelines

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9) State Consultant's format is to be countersigned by concerned SPO.
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11) Separate sheet(s) may be attached wherever needed.
12) These progress reports on 'Performance of Work' would be considered while extending the tenure of contractual staff.

Format	Meant for Official (State/Distt)	Reports to….		Dedicated email id for sending to Dte. NVBDCP
AB1	Consultant M&E, PH	SPO	National M&E Consultant	malaria.mne@gmail.com
AB2	Consultant PSM	SPO	National Procurement Consultant	malaria.procurement@gmail.com
AB3	Consultant Finance/ Account Assistant	SPO	National Finance Consultant	malaria.finance@gmail.com
AB4	Consultant IEC/BCC	SPO	National IEC Consultant	malaria.iecbcc@gmail.com
DC	District VBD Consultant	DMO/DVBDCO; State M&E Consultant; SPO	National M&E Consultant	malaria.mne@gmail.com
MT	MTS	District VBD Consultant; DMO/DVBDCO	State M&E Consultant*; SPO	Dedicated email id** to be provided by concerned SPO/ State Consultants/DMO/DVBDCO

**Dedicated email id to be made by States/ Districts and to be communicated to all concerned for receiving progress formats in soft copy.
*State M&E Consultants would be provided a format for communicating 'compiled status of MT formats' to Dte. NVBDCP in due course.

Definitions

4) Reporting month: The month during which various activities have been undertaken and for which reporting is done.
5) Previous month: The month preceding the 'reporting month'.
6) Next month: The month following the 'reporting month'

Abbreviations

ASHA	Accredited Social Health Activitist
AD	Assistant Director
ANM	Auxiliary Nurse Midwife
ACT	Artesunate Combination Therapy
BCC	Behavior Change Counseling
CHC	Community Health Centre
CMO	Chief Medical Officer
CQ	Chloroquine
DMO	District Malaria Officer

DVBDC	District Vector Control Disease Consultant
DVBDCO	District Vector Borne Diseases Control Officer
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DH	District Hospital
EDCT	Early Diagnosis and Complete Treatment
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GoI	Government of India
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HF	Health Facility
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IRS	Indoor Residual Spray
IDSP	Integrated Disease Surveillance Programme
JD	Joint Director
LT	Laboratory Technician
LLIN	Long Lasting Insecticidal Net
LQAS	Lot Quality Assurance Sampling
MTS	Malaria Technical Supervisor
M&E	Monitoring and Evaluation
MO	Medical Officer
MPW	Multi Purpose Worker
N/D	Numerator/ Denominator
N	No
No.	Number
NAMMIS	National Anti Malaria Management Information System
NGO	Non-Governmental Organization
NVBDCP	National Vector Borne Disease Control Programme
PHC	Primary Health Centre
PMMR	Programme Management and Monitoring Review
PSCM	Procurement and Supply Chain Management
PQ	Primaquine
RDT	Rapid Diagnostic Kit
SAMS	Strategic Alliance Management Services
SDH	Sub-Divisional Hospital
SC	Sub-Centre
SSMO	Sentinel Site Medical Officer
SSLT	Sentinel Site Lab Technician
SPO	State Programme Officer
SS	Sentinel Sites
UC	Utilization Certificate
VBD	Vector Borne Diseases
VC	Vector Control
Y	Yes

Guidelines for filling up Format 'MT'
{For District VBD Consultants}

All questions are mandatory to be answered.

Sl. No. 1: The MTS has to fill the details of activities for each working day of the month (date-wise). Further, a brief of activities performed on that day including field visits must be mentioned.

Sl. No. 2: Major observations may be highlighted in this section in brief. Further, detailed report may be placed as Annexure.

Sl. No. 3: Under this section, the name of the MPWs/ASHAs is to be provided where the field visit was made with major observations along with actions taken.

Sl. No. 4: Under this section the status of stock is to be entered. Further the physical verification of items must be done at CHC/PHC/SC level and should be matched with the reports available at district/block level.

Sl. No. 5: To be filled as per details given there.

Sl. No. 6: To be filled as per the matrix given below (for 'quality of spray'):

Coverage→ Quality↓	More than 80%	60-80%	Less than 60%
Uniform	Good	Unsatisfactory	Poor
Patchy	Unsatisfactory	Poor	Poor

Further, in case of non-acceptance of IRS please specify the reasons of non-acceptance by the community. In case there is any deviation in the micro plan available at block level, the revision should be mentioned in the report and its reasons

Sl. No. 7: To be filled as per details given there.

Sl. No. 8: Under this section, the activities pertaining to IEC/BCC plan (under PIP) and the achievements are to be mentioned.

Annexure 20

INVESTIGATION REPORT FOR DEATH DUE TO MALARIA

Investigation to be done by District Malaria Officer/AMO/ District VBD Consultants in consultation with a Medical Officer

Date of Investigation:_____

1. Basic information:

- Name of the deceased _____Age (in years)_____Sex _____
- In adult female, indicate status of pregnancy and its complications, if any:_____
- Date of onset of illness _____ Date of Death _____
- Date of first contact with health care provider (ASHA/MPW/SC/PHC/CHC/District Hospital/ Other (specify) _____
- Occupation of the deceased:_____
- Complete address (usual place of residence)_____

  _____

  _____
- Place where disease started_____
- History of movements (within 3 weeks preceding from the date of onset of illness)

  _____

  _____
- Source of information: Relatives/Paramedical staff/ Treating physician/ Specialist/other (specify)___

2. Major Signs and symptoms (S/S) with duration:

Other signs/ symptoms:

S/S	Duration	S/S	Duration	S/S	Duration	S/S	Duration
Fever		Anaemia		Jaundice		Rash	
Bleeding		Diarrhoea		Dyspnoea		Oliguria/anuria	
Neck rigidity		Altered Sensorium		Convulsions		Coma	

_____

_____

H/O of chronic illnesses (Diabetes, hypertension, asthma, HIV etc)_____

Relevant History in the past:_____

H/O of similar illness in family/neighbourhood in the past:_____

3. Parasitological Investigation:

Date	Date of RDT Testing/Collection of slide	Place of test	Results (Pf/Pv/Other)	Date of Receipt of result
RDT				
Blood slide				

4. Other Biochemical/Pathological investigations done (specify): _____

_____

_____

5. Diagnosis: Clinical Diagnosis:_____

Confirmed Diagnosis: Malaria (Pf or PV specify) _____ other _____

6. Treatment before hospitalization: Date of starting treatment _____

Details of Treatment given before hospitalization:

Name of Drug	Dose	Date		Route of Administration
		From	To	

7. Treatment after admission to hospital:

Name of Drug	Dose	Date		Route of Administration
		From	To	

- Other supporting treatment_____

_____

_____

8. Cause of Death:

Confirmed Malaria (*Pf*/*Pv*/Others)	Clinically suspected Malaria	Others (Specify)

- Post-mortem diagnosis (if undertaken)_____

9. Public health follow-up preventive/control actions taken by State/District/local health authorities in affected area:

10. Remarks of the investigating officers:

Name and Signature of DMO/ Assistant DMO/VBD Consultant

Name/ Signature Medical Officer

Annexure - 21

NATIONAL VECTOR BORNE DISEASE CONTROL PROGRAMME

Programme Check List

Move to district & spend half day to obtain the following informations:

S.No		Response
A	**Name of the District**	
1	Is a full time DMO present	
2	Please review staff position especially vacancy	
3	Epidemiological situation during the last three years*	
4	Any out break reported during last three years	
5	What control measures initiated.	
	RDKits	
6	Total no of RD Kits alloceted to district	
7	No. dispached to PHCs	
8	Whether National Guideline followed for distribution of RD Kits.	
9	Check the stock of RD kits with expiry at district	
	Logistics	
10	Is proper storage facility availble for Insecticides/ RD Kits etc present at district level	
11	Are all drugs and commodities within their period of expiry	
12	Is the principle of first expiry first out (FEFO) being followed	
13	Is the stock register being maintained	
14	Has the last due consignee receipt been submitted by the District to the State? If yes show which one.	
	Bednets	
15	Were Bednets supplied to the District in the last 1 year?	
16	If yes, provide the details of the numbers received	
17	Were Bed nets distributed in the District during last one year?	
18	If yes, Nos distributed. Are records for the above distribution available at district	
19	No. of PHCs where bednets have been distributed	
20	Whether bednets distributed in inaccessible and in poor IRS coverage PHCs	
	Hatcheries	
21	Are hatcheries maintained in the District?	
22	Total no of hatcheries in the District	
	NGO/ PPP	
23	Is there any NGO/ PPP involvement in the district? If yes mention the type of involvement	
	Finances & Reports	
24	Has the SOE of the last month been submitted	
Select two endemic PHCs from 2 districts each, verify records & move to 2 villages for IRS, bednet distribution plan (at least 2 working days in each village)		

B	**Name of the PHC**	
1	Vacancy Position in PHCs	
2	Epidemiological situation of PHCs during last three years.*	
3	No. of outbreaks if any reported.	
4	What additional inputs provided to control out break	
5	Time lag between slide,collection, examination and RT	
6	Quality of microscopes and B/S and reagents	
	RDKits	
7	No. of RD Kits received	
8	No. of distributed to sub centers.	
9	Whether RD Kits sent to inaccessible areas.	
10	What is the mechanism of supervission for proper use of RD Kits	
11	Is there information flow from the Sub Centre/village to PHCs about the results.	
12	Whether ASHAS are trained for use of RD Kits and Treatment to patiant	
	Logistics	
13	Are adequate stocks of drugs & commodities present in the PHC (physical verification)	
14	Is proper storage facility availble for Insecticides/ RD Kits etc	
15	Are all drugs and commodities within their period of expiry	
16	Is the principle of first expiry first out (FEFO) being followed	
17	Is the stock register being maintained	
	Bednets	
18	Were Bednets supplied to the PHC in the last 1 year? Or directly to villages	
19	If yes, provide the details of the numbers received during last year.	
20	Select 4 villages where bednets have been distributed in large nos.	
21	Place and frequency of bednet impregnation	
22	Collect the list 2 villages from PHCs and physically verify the distribution and use.**	
23	Comments on commodity not using bednets	
	Hatcheries	
24	Are hatcheries maintained in the PHC? If yes state the no.	
25	Are record of hatcheries subcentre & village wise maintained? If yes show the records	
	Reports	
26	Have all the reports for the last completed month been submitted? If yes show. (Note down which month)	
	***Epidemiological situation to be taken in MF4 proforma.**	
	****Follow the guideline for Physical verification of bednets.**	
C	**Name of Subcentre**	**Response**
1	Does the Health Worker have Subcentre Report of NVBDCP of the the last month (last due report)	
2	No of Passive slide collection & found positive (Last month)	
3	No of Active slide collection & found positive (Last month)	

4	Did the health worker take the blood slides collected by active surveillance to the laboratory and transport results back		
5	Have all the slides for the month completed been sent to PHC for examination		
6	Does the Health Worker have the Work report of ASHAs within the subcentre area (last due report)		
7	Are adequate stocks available at the subcentre		
8	Are Insecticides & RD Kits being stored as per guidelines		
		1	**2**
D	**Name of Village of ASHA visited**		
1	Name of ASHA		
2	Is the ASHA trained especially on blood slide collection and use of RDT? If yes see demonstration		
3	No of Passive slide collection & found positive (Last month)	/	/
6	Were the results of blood slides received within 24 hours from the lab		
7	No of fever cases who completed RT in the last month		
8	Is the Register of ASHA under NVBDCP being maintained up to date (verify by seeing the register)		
9	Has the ASHA submittted its last due Report? (If yes ask for the report)		
10	Was ASHA visited by the health worker in the last one month and inquired about cases of malaria		
11	Does the ASHA have adequte stock of commodities & drugs		
12	Are there any drugs at risk of expiry		
13	No of RDTs used in the last month		
14	No of fever cases found positive for malaria using RD kits in the last month		
15	Are RD kits being stored as per guidelines		
D	**Patient Visit (ASHA 1)**	**Response**	
		1	**2**
1	Name of patient		
2	Did the ASHA collect blood slide of the patient		
3	Did the ASHA use RD kit for examination		
4	Was treatment started within 24 hours of the Blood slide collection/ RD Kit		
5	Did ASHA tell about methods of personal protection to be used for prevention against malaria		
6	Was any money charged for diagnosis or treatment		
E	**Patient Visit (ASHA 2)**		
1	Name of patient		
2	Did the ASHA collect blood slide of the patient		
3	Did the ASHA use RD kit for examination		
4	Was treatment started within 24 hours of the Blood slide collection/ RDT		
5	Did ASHA tell about methods of personal protection to be used for prevention against		

	malaria	
6	Was any money charged for diagnosis or treatment	
F	**IRS Activity (Applicable in Transmission season)**	
1	Name of Village	
2	Was prior information given to villagers about IRS activity	
3	Were the MO PHC and HW (M) present at the time of IRS for supervision	
4	Was road map present with the spray squad	
5	Rate of discharge of spray equipment	
6	Name of insecticide used	
7	Was the insecticise for IRS stirred	
8	Distance of nozzle from spray surface	
9	No of houses in the village/ Covered	
10	Was mud plastereing done after IRS (to be ascertained on follow up)	

Summary of Observations

Annexure 22

DIRECTORATE NATIONAL VECTOR BORN DISEASE CONTROL PROGRAMME

Plan for Bed net verification by visiting Nodal Officer/ Special Teams.

1. At State Head Quarter:- Select the district to be visited
2. At District :- Select 2 PHCs which have received maximum bed nets.
3. At PHCs :- Select 4 villages were maximum bed nets were distributed and Verify as follows :- Visit about 50% of houses in each village where bed nets have been distributed.

Sl.no	Physical Verification	No./ percent
	Whether nets are actually available with the beneficiary household and their numbers (no. of nets present / no. of nets distributed).	
	Whether nets are being used regularly? Yes/ No. (no. of households reporting regular use of bed nets /no. of households visited)	
	Whether nets were used previous night also. Yes/ No. (no. of households reporting use of bed nets previous night / no. of households visited)	
	Whether any pregnant women is in the in the house? Yes/No(enumeration of no. of pregnant woman in the house holds visited)	
	If Yes, did she sleep under the bed net previous night. (No of pregnant women who slept under bed net previous night/ total no. of pregnant women)	
	Is there an under 5 Child in the family? (enumeration of no. of under 5 children in the house holds visited)	
	If Yes, did she/ he sleep under the net previous night. (No of under 5 children who slept under bed net previous night/ total no. of under 5 children)	
	Do the families have their own bed nets? If Yes, when were these bed nets impregnated with insecticide last.	

Annexure 23

Verification of ASHAs

1. In the villages selected for bed net verification and for supervision of IRS rounds the ASHAs are to be visited

Sl.no	Physical Verification	No./ percent
1	No of ASHAs verified	
2	Are the ASHAs trained especially on blood slide collection and use of RDT? If yes see demonstration (No. of ASHAs who successfully demonstrated the use of RDTs/ no. of ASHAs verified)	
3	ASHA s who carried the blood slides collected to the lab for examination (no. of ASHAs who had transported slides / no of ASHAs verified)	
4	Register of ASHAs under NVBDCP being maintained up to date (verify by seeing the register) (no. of ASHAs who had maintained registers up to date/ no of ASHAs verified)	
5	Have the ASHAs submitted their last due Report? (If yes ask for the report) (no of ASHAs who had submitted previous report/ no of ASHAs verified	
6	Do the ASHAs have adequate knowledge of antimalarial drug schedule, particularly ACT (no. of ASHAs who could remember the drug schedule / no of ASHAs verified)	
7	Are there any drugs at risk of expiry (no. of ASHAs who had drugs at risk of expiry/ no of ASHAs verified)	
8	Is ACT supplied to ASHAs. (no. of ASHAs who had ACT / no of ASHAs verified)	

Annexure 24

NATIONAL VECTOR BORNE DISEASE CONTROL PROGRAMME

Check List for Malaria Technical Supervisor

Name of State: **Name of the Supervisor:**

Name of the District: **Date of Supervision:**

S.No		Response	
	To be used when a PHC is visited		
A	**Name of the PHC**		
		Sanctioned	In position
1	LTs		
2	Health Supervisors		
3	MPWs		
B.	**Microscopy services**	Supplied	Functional
1	Monocular Microscopes		
2	Binocular Microscopes		
	(all information to pertain to previous month)		
3	No. of fever cases recorded in OPD register		
4	No. of blood slides received in the lab from OPD (a)		
5	No. of blood slides received from periphery/ field in the previous month (b)		
6	Total No. of slides received in the lab during the month (a+b)		
7	No. of blood slides from OPD which were examined within 24 hours (d)		
8	No. of slides received from periphery/ field which were examined within 24 hours (e)		
9	Total No. of slides examined at the laboratory within 24 hours of collection/receipt (d+e)		
10	Total number of slides which were examined after a time lag of 24 hours		
11	No. of slides remaining unexamined at the end of the month (backlog)		
12	Have slides been sent for crosschecking in the previous month? If yes, is any feedback received?		
13	Names of subcentres which did not send slides to PHC		
C	**RD Kits**		
1	Are RD Kits being used at PHC for diagnosis routinely. If yes, why?		
2	No. of RD Kits used at the PHC in the reporting period (if proportion is higher than 10% of total suspected malaria cases tested, why? inform MO)		
3	Are there any complaints received about functioning of RD Kits? If so, have necessary intimation and action been taken?		

D	**Logistics**	
1	Are adequate stocks of antimalariala available in the PHC for next two months? Mention the item in short supply if any	
2	During transmission season, are adequate stocks of insecticides available for population identified for IRS (for next round)?	
3	Are RD kits/ drugs stored properly as per programme guidelines?	
4	Are insecticides stored properly as per programme guidelines?	
5	Are there any drugs and commodities at risk of expiry within 6 months?	
6	Is the principle of first expiry first out (FEFO) being followed?	
7	Is the indent being placed monthly?	
8	How are the stocks of drugs and insecticides transported to the PHC?	
9	Is the stock register being maintained; is it updated?	
E	**Bed nets**	
1	No of bed nets supplied to PHC in the year	
2	No of bed nets distributed so far	
3	Are records for the above distribution available with the PHC? If yes Scrutinize the records.	
4	Has the plan for distribution in the given areas been followed in the distribution of these bed nets (actual plan versus distribution)	
5	Was verification of the distribution to the beneficiaries undertaken from PHC?	
F	**Hatcheries**	
1	No of hatcheries maintained in the PHC? If yes state the no. of functional hatcheries in PHC area.	
2	Are record of fish released in breeding sites in PHC area maintained? If yes see the records	
3	Are the fishes replenished regularly in the potential water bodies?	
G	**IRS activities at PHC (during the transmission season)**	
1	Is the micro-action plan for IRS available at PHC?	
	Does the micro-action plan address the following:	
2	What is the IRS target population of PHC ?	
3	Is the insecticide available adequate for the two rounds of IRS?	
4	Is the insecticide within its expiry date?	
5	Are the equipments for IRS certified by DMO?	
6	Is the route chart for IRS available at PHC?	
7	Is the IEC Plan for IRS available at PHC?	
8	Are adequate funds for spray wages available?	
9	Is the activity monitoring plan available at PHC?	
10	Has the Micro-action Plan been executed as per planned till date?	
H	**Reports**	
1	Has the M4-SC and M4-PHC of the completed fortnight been submitted? Verify	
Dated:	**Signature of MTS**	

NATIONAL VECTOR BORNE DISEASE CONTROL PROGRAMME

Check List for Malaria Technical Supervisor

Name of State: **Name of the Supervisor:**

Name of the District: **Date of Supervision:**

S.No		Response
H	**Name of Subcentre**	
1	Has the Health Worker sent M4-SC of the the last fortnight?	
2	No. of RDT used in the last month	
3	No. of RDT found positive	
4	No of slides collected	
5	No of slides sent on the same day for microscopy	
6	No of reports received within 24 hours of slide collection	
7	Does the Health Worker have the M1 of previous fortnight of ASHAs within the subcentre area	
8	Are two months stock of ACT/CQ/PQ/SP/RDK available at the subcentre?	
9	Are any drugs/RDK at risk of expiry within six months	
10	Are Insecticides & RD Kits being stored as per guidelines?	
11	Were Bed nets distributed in the SC area in this year?	
12	If yes, check and note details	
13	No of bed nets distributed to priority villages.	
14	Was verification of the distribution to the benificiaries undertaken by MPW	
15	If yes, No of beneficiaries verified by a house visit?	
16	Is record of community owned bed nets available village wise? If yes see	
17	**IRS activity (applicable in transmission season)**	
a.	Ckeck the VC 2 of Subcentre and verify data during village visit	

NATIONAL VECTOR BORNE DISEASE CONTROL PROGRAMME

Check List for Malaria Technical Supervisor

Name of State: **Name of the Supervisor:**

Name of the District: **Date of Supervision:**

	Name of Village		
I	**IRS activity (applicable in transmission season)**		
1	Was prior information given to villagers about IRS activity?		
2	Were the HW (M) present at the time of IRS for supervision		
3	Was route chart present with the spray squad?		
4	Rate of discharge of spray equipment		
5	Name of insecticide used		
6	Was the spray suspension for IRS stirred ?		
7	Was the spray done as per guidelines		
8	were safety measures taken by spray squads		
9	Were empty insecticide containers disposed as per guidelines		
10	No of houses in the village/ Covered		/

NATIONAL VECTOR BORNE DISEASE CONTROL PROGRAMME

Check List for Malaria Technical Supervisor

Name of State: **Name of the Supervisor:**

Name of the District: **Date of Supervision:**

J	**Name of the village:**	
	Name of ASHA / CHV	
1	Is She/he trained especially on blood slide collection and use of RDT? When possible see demonstration	
2	No. of RDT used in the last month	
3	No. of RDT found positive	
4	No of slides collected	
5	No of slides sent on the same day for microscopy	
6	No of reports received within 24 hours of slide collection	
7	Is the M1 of ASHA being maintained and submitted on time? (verify by seeing the M1 of previous fortnight)	
8	Was ASHA visited by the health worker in the last one month and inquired about cases of malaria?	
9	Does the ASHA have two months stock of RDT & anti-malarial drugs?	
10	Are there any RDTs/ antimalarials at risk of expiry within six months?	
11	Are RD kits/ antimalarials being stored as per guidelines?	

NATIONAL VECTOR BORNE DISEASE CONTROL PROGRAMME

Check List for Malaria Technical Supervisor

Name of State: **Name of the Supervisor:**

Name of the District: **Date of Supervision:**

S.No		
D	**Patient Visit (ASHA 1)**	**Response**
1	Name of patient	
2	Did the ASHA collect blood slide of the patient?	
3	Did the ASHA use RDT for examination?	
4	Was treatment started within 24 hours of the Blood slide collection/ RD Kit	
5	Did ASHA tell about methods of personal protection to be used for prevention against malaria?	
6	Was any money charged for diagnosis or treatment	
7	Was the patient given Bed net (if introduced in the area)	
8	Was he/ she using the bed net?	
9	Was the bed net treated at regular period?	
E	**Patient Visit (ASHA 2)**	
1	Name of patient	
2	Did the ASHA collect blood slide of the patient?	
3	Did the ASHA use RDT for examination?	
4	Was treatment started within 24 hours of the Blood slide collection/ RD Kit	
5	Did ASHA tell about methods of personal protection to be used for prevention against malaria?	
6	Was any money charged for diagnosis or treatment	
7	Was the patient given Bed net (if introduced in the area)	
8	Was he/ she using the bed net?	
9	Was the bed net treated at regular period?	

Dated: **Signature of MTS**

NATIONAL VECTOR BORNE DISEASE CONTROL PROGRAMME

Check List for Malaria Technical Supervisor

Name of State: **Name of the Supervisor:**

Name of the District: **Date of Supervision:**

Summary of Observations
Action taken by the Supervisor
Follow-up of previous visits' suggestions:
Action suggested
Dated: **Signature of MTS**

ANNEXURE 25

FORMAT FOR VERIFICATION OF DATA QUALITY DURING ON SITE VISIT

Level of verification: District / PHC **Name of the Unit**_____
Quarter of verification_____ **No of Subunits expected to report (PHCs/ SCs)**_____

Percentage of subunits reporting:
(Number of reports received for the verified period / total number of subunits (PHCs/SCs) X 100) ____/____ %
% of indicators for which backup records are present (No of indicators for which backup records are present/ Total No of indicators X 100): _____/ 9* 100 = _____ %

Indicator	As per report submitted by unit	As per onsite verification	% Verification Factor*	Are backup records present (Y/N)	Timeliness of receipt of data	Remarks and suggested action
Number of LLIN distributed in LLIN eligible areas (API≥2) by functionaries of PR1						
Number of fever cases tested with RDT by ASHA						
Number of fever cases tested with RDT at Public sector health facilities (Sub-centre, PHC, CHC, etc.)						
Number of Pf cases treated with ACT by ASHA						
Number of Pf cases treated with ACT at Public sector health facilities (Sub-centre, PHC, CHC, etc.)						
Number of infotainment activities performed						
No. of supervisory visit to district periphery in a quarter by district VBDCP (malaria) officers (programme/project) and report submitted to state programme officer/ district chief medical officers						
Number of malaria technical supervisor (MTS) trained						
Number of ASHAs trained/retrained						

Name of verifying officer
Signed:

Designation:

% Verification Factor for indicator
(Achievement reflected in the indicator as per quarterly report/ Actual achievement as per onsite verification X 100)
* ***Check separately for each indicator that is being reported under physical achievements***
If % Verification factor is <100% it implies under-reporting; If % Verification factor is >100% it implies over-reporting e.g. If the quarterly report indicates under the indicator 'Number of Pf cases treated with ACT' a figure of 90 while during onsite verification 100 cases were found from compilation. The % Verification Factor of data is 90% and there is underreporting.

NB. During each district visit the data at district level and at least one PHC should be verified. For each level of verification like district or PHC one format is to be used.

ANNEXURE 26

National Vector Borne Disease Control Programme

Checklist for Monitoring and Evaluation

Name of State_____ Name of District _____
Name of PHC visited_____ Name of Sub-centre(s) visited_____

Note: Ask the questions related to Vector Borne Diseases which are prevalent in the area and for which the control programmes exist.

Observations from the Field Visit

ASHA

	Name	Village	Education	Village resident (Yes/No)	Since when working	Whether trained for VBD (Y/N)
ASHA1						
ASHA 2						

Training of ASHA (Answer-Yes or NO)

Whether following subjects were covered in the training						
	Use of RDT	Collection of blood slide	Malaria Drug regimen	Dengue mosquito breeding and control	Drugs/ doses for MDA (LF)	
ASHA 1						
ASHA 2						
Whether having skills/knowledge						
ASHA 1						
ASHA 2						

Questions	**ASHA 1**	**ASHA 2**
Are the Registers of ASHA under NVBDCP being maintained up to date (verify by seeing the registers)		
When ASHA submitted the last due Report? (ask for the report)		
No of RDTs used in the last month		
No of fever cases found positive for malaria using RD kits in the last month		
Was blood slide also collected from patient tested by RDT		
No of slide collected & found positive (Last month)		
Were the results of blood slides received within 24 hours from the lab		
No of fever cases who completed RT in the last month		
Was ASHA visited by the health worker or MTS in the last one month?		
Does the ASHA have adequate stock of commodities & drugs (RDT, clean slides, needles, swabs, ACT, CQ etc)		
Are there any drugs at risk of expiry (Verify)		

Are RD kits being stored as per guidelines		
Was she involved in IRS		
Was she involved in Bed Nets distribution		
Did she refer any patient having fever more than two weeks to the PHC for investigations of Kala-azar in last 3 months		
Was she instrumental in completing the treatment of a case of Kala-azar		
Was she involved in last MDA for LF? If, yes, how did she convince reluctant persons to consume the drugs		
Was she ever involved in immunization against JE		
Was she involved in source reduction for control of Dengue and Chikungunya		
Is ASHA actively involved in VHSC		
Is she having difficulty in getting the incentive for her work? If yes, provide details		
Any problem faced in doing work?, If yes, possible solutions		
Interview of fever case treated by ASHA in last 2 weeks		
Did ASHA test the patient by RDT (Yes/NO)		
Did ASHA collect blood slide (Yes/No)		
Treatment started within 24 hours of test (Yes/No)		
Was money charged for test/treatment (Yes/No)		
What are the services usually provided by ASHA		

Sub-Centre

(Population:)

MPHW

	Name	Education	Residing at HQ village (Y/N)	Since when working	Where was trained for VBD
MPW M					
MPW F					
MPW (Contract)					

Questions	
Are Registers of Sub-centre under NVBDCP being maintained up to date (verify by seeing the register)	
When SC submitted the last due Report? (ask for the report)	
No of slides collected & found positive (Last month)	
Were all the slides for the last month sent to PHC for examination	
Are the results of blood slides usually received within 24 hours from the lab? If not, gap (in days) between slide collection and report received in last 5 instances	
Is RDT used by health worker? If yes, is blood slide also collected from patient tested by RDT	
No of fever cases who completed RT in the last month	
How many ASHAs were visited by Health worker in the last month	
Was Sub-Centre visited by the MTS/MO in the last one month?	
Does the SC have adequate stock of commodities & drugs (RDT, clean slides, needles, swabs, ACT, CQ, PQ etc)	
Are there any drugs at risk of expiry	

Are RD kits being stored as per guidelines	
Was Health worker involved in IRS	
Was health worker involved in Bed nets distribution	
Was health worker instrumental in the investigation and treatment of any case of Kala-azar in last 3 months	
Was Health worker involved in last MDA for LF? If, yes, how did he/she convince reluctant persons to consume the drugs	
Whether record of lymphoedma and hydrocele cases available in SC	
Does the worker understand the importance of early referral of AES/JE Cases to PHC/CHC	
Was Health worker involved in source reduction for control of Dengue and Chikungunya	
Did the health worker organized any social Mobilization drive for source reduction at village level	
Is Health worker actively involved in VHSC	
Any problem faced in doing work?, If yes, possible solutions	

Primary Health Centre

Name of PHC_____Population_____

Background information about PHC

No. of Sub-centre		No. of ASHA		No. of Dispensaries	
No. of Sub-Distt Hosp		No. of GP		No. of villages	

Human resources

M.O. I/C PHC : Contact Details

Name_____ Qualification_____ Designation_____

Office address_____

_____

Tel:_____(O), Tel: _____(R), Cell:_____
Fax:_____E-mail:_____

Since when working as PHC MO _____ Is he/she trained for VBD_____

Other Staff

Regular and incremental staff involved in VBD control

S. No.	Name of post (Regular/ contractual)	No. required	No. sanctioned	No. in position	No. trained	No. vacant	Timeline for training of untrained
1							

Comments on Human Resources:

Surveillance

Epidemiological Data (Attach Sub-centre-wise and month-wise epidemiological data for last 3 years)

Summary of malaria data in the PHC in the last year

Malaria				
	No. tested	Total positive	PF *	PV
Slides examined				
RDT performed by ASHA				
RDT performed by Others				
Total tested (Slides examined & positive RDT)				
No. of cases given radical treatment				
No. of PF cases treated with ACT				
No. of clinically suspected malaria deaths				
No. of confirmed (RDT or Slide positive) malaria deaths				
*Mixed infection would be counted as PF infection only.				

(Note: Visiting Officer should check the epidemiological data for consistency. If the data are not consistent it should be discussed with the MO I/C to understand the possible reasons and actions needed to make that consistent. (Provide the summary))

Was ABER less than 10% in any Sub-centre in the last three years? Yes/No

If yes, discuss with the MO to identify the possible reasons and actions needed to increase the ABER to more than 10% in all sub-centres.

Are trend charts and maps available at PHC level? Yes/No

No. of clinically suspected and confirmed malaria deaths investigated in the last year.
Comments on Epidemiological data

Laboratory

Name of LT		Since when working		When was trained/reoriented	

(Note: LTs posted under any programme are expected to work for all programmes. If this is not happening in this PHC, kindly mention it here.)

What is available in the lab (Yes/No)

Functional binocular microscope		JSB stain		New slides		Disposable needles	
Adequate light		Water supply		Lab Manual			

Whether results of blood slides are conveyed within 24 hours?

Backlog of blood slides present on the day of visit?

What are the reasons for backlog?

Are the blood slides sent for cross-checking?

Are results of cross-checking received in time?

What is the discrepancy rate?

Whether RDT done in PHC? Yes/No. If yes, why?

Is blood slide also collected from person who is tested by RDT? Yes/No

Proportion of persons tested for malaria by RDT in PHC so far during the current year:

No. of RDT kit picked up for quality assurance from any health facility under the PHC in the last Six months.

What were the results?

No. of ASHAs trained for RDT and treatment?

Comments on Laboratory Functioning

Logistics

	Opening balance in Jan 2009	Received in 2009	Total	Utilized	Balance	Expiring in 6 months
DDT (MT)						
Malathion (WDP) (MT)						
Malathion Technical (Lit)						
Synthetic pyrethroid (Kg)						
SP Flow (Lit)						
LLIN (No.)						
Malaria RDT (No. of tests)						
rk39 kits (No.)						
ACT (Packs) (Adult)						
ACT (Packs) (Children)						
Inj Arteether (No.)						
Inj Quinine (No.)						
Tab CQ (No.)						
Tab PQ 2.5 mg (No.)						
Tab PQ 7.5mg (No.)						
Miltefosine (No.)						
Inj Amphoterecin (B) (No.)						
Inj SSG vials (No.)						
Tab DEC (No.)						
Tab Albendazole (No.)						

Are the stock registers maintained properly? Yes/No If No, describe the problems and possible solutions.

Are all items within the expiry period? Yes/No If No, give details.

Items stocked out for more than one month? Give details.

Are items stored properly? Yes/No. If no, give details.

Are stocks adequate for next three months? Yes/No If No, give details.

Comments on Logistics

Bed Nets

LLIN /ITN Coverage in the PHC							
High endemic Sub-Centre *	Population	Total households	Estimated no. community owned nets	No. LLIN distributed	No. of ITN distributed	No. of households targeted	No. (%) household covered against the target so far (cumulative)
* Based on API, Pf%, mortality							

Has someone verified distribution of bed nets by field visit after the last distribution: Yes/No
If yes, give details of observations.

Has someone verified utilization of bed nets by field visit in the last six months: Yes/No If yes, give details of observations.

Comments on use and impact of bed nets

IRS for Malaria and Kala-azar

Round	Insecticide	Spray start date	Completion date	Population targeted	No. Population covered (%)	Rooms targeted	No. Rooms covered (%)
Malaria1							
2							
3							
Kala-azar 1							
2							

Comments on IRS for Malaria and Kala-azar

Supervision

How many Sub-centres were visited by MO in last 2 months?

How many ASHAs were visited by MO in last 2 months?

Whether MTS visited PHC in last one month?

Whether VBD Consultant/AMO/DMO visited PHC in last 3 months? Yes/No

If yes, name the personnel who visited.

Whether MO supervised during the last IRS drive for malaria and/or kala-azar? Yes/No
If yes, frequency of visits made?

Whether MO supervised bed nets distribution?

Other Vector Borne Diseases

Questions	
Whether record of lymphoedema and hydrocele cases available in PHC	
MDA coverage (%)	
Name sentinel/random sites under PHC for MF survey	
Population surveyed for MF	
No. (%) positive for MF	
Was any outbreak of Dengue/chikungunya detected in the last year?	
Were PRI including VHSC involved in source reduction	
Name the sentinel centre hospital for diagnosis and treatment of Dengue/chikungunya/JE	
Whether MO attended any Social Mobilization Workshop?	
What is coverage for immunization against JE in PHC area?	
Was any case of AES/JE treated in PHC during the last transmission season?	
Rk39 kits available	
No. of Kala-azar cases and deaths in the PHC area?	
No. of Kala-azar cases which have completed the treatment?	
Any problem faced by MO and others in doing their work?, If yes, possible solutions	

Hatcheries
No. of hatcheries maintained in Block:

No. of water bodies seeded with fish

Comments on Hatcheries

District

Background information: Give No.

No. of villages		No. of AWW		No. of ASHA	
CHC		PHC		Sub-centre	
Distt Hosp		Sub-Distt Hosp		ID Hosp	
Govt. Medical College Hosp		Other Hospitals in public sectors		Dispensaries	
Health posts		Private Medical College Hosp		Other Hospitals in Private sector including NGOs, trusts/FBOs	

Human resources

DMO: Contact Details

Name_____ Qualification_____ Designation_____
Office address_____
_____

Tel:_____(O), Tel: _____(R), Cell:_____

Fax:_____E-mail:_____

Since when working as DMO_____ Is DMO trained for VBD_____

Has DMO been given other job responsibilities _____

Other Staff

Regular and incremental staff involved in VBD control in district

S. No.	Name of post (Regular/ contractual)	No. sanctioned	No. in position	No. vacant	No. trained	Timeline for training of untrained
	VBD consultant					
	Con (Fin & Logistic)					
	DEO					
	Lab Tech	3*				
	MTS	6*				
	KTS					

Comments on Human Resources:

Sentinel Hospitals for Malaria/Dengue/Chikungunya/JE

Name of hospital	Name of diseases for which diagnostic facilities available	Name of diseases for which treatment facilities available

(Get data for Sentinel Hospital for one year)

Comments on Sentinel Hospital

Surveillance

Epidemiological Data (Attach Block/PHC-wise and month-wise epidemiological data for last 3 years)

Summary of malaria data in the District in the last year

Malaria (including Urban Malaria)				
	No. tested	Total positive	PF *	PV
Slides examined				
RDT performed by ASHA				
RDT performed by Others				
Total tested (Slides examined & positive RDT)				
No. of cases given radical treatment				
No. of PF cases treated with ACT				
No. of clinically suspected malaria deaths				
No. of confirmed (RDT or Slide positive) malaria deaths				
*Mixed infection would be counted as PF infection only.				

Urban Malaria: No. of towns with more than 1 lac population -

Name of town	Area	Population	Slides examined	Total malaria cases	PF	PV	Clinically suspected malaria deaths	Lab confirmed malaria deaths
	Slum							
	Other							
	Slum							
	Other							

(Note: Visiting Officer should check the epidemiological data for consistency. If the data are not consistent it should be discussed with the DMO to understand the possible reasons and actions needed to make that consistent. (Provide the summary))

Was ABER less than 10% in any Block/PHC? Yes/No

If yes, discuss with the DMO to identify the possible reasons and actions needed to increase the ABER to more than 10% in all Blocks/PHCs.

Are trend charts and maps available at District level? Yes/No

No. of clinically suspected and confirmed malaria deaths audited in 2008.

Comments on Epidemiological data

Diagnosis of malaria including use of RDT

No. of ASHAs trained for RDT and treatment in the district?

Is RDT used in Health Facilities (PHC/CHC/DH) in the district? Yes/No
If Yes, Why is RDT used in Health Facilities?

Is blood slide also collected from person who is tested by RDT in district hospital? Yes/No

Proportion of persons tested for malaria by RDT in District Hospital in last one year:

Does DMO send blood slides for cross-checking?

Are results of cross-checking received in time?

What is the discrepancy rate?

No. of RDT kit picked up for quality assurance from any health facility in the district in the last Six months.

What were the results?

Whether DMO has the copy of SOP for Quality Assurance (QA) for malaria microscopy and RDT? Yes/No

Whether DMO has been trained for QA for malaria microscopy and RDT?

Comments on QA and use of RDT

Logistics

	Opening balance in Jan 2009	Received in 2009	Total	Utilized	Balance	Expiring in 6 months
DDT (MT)						
Malathion (WDP) (MT)						
Malathion Technical (Lit)						
Synthetic pyrethroid (Kg)						
Pyrethrum extract (Lit)						
Temephos (Lit)						
LLIN (No.)						
Malaria RDT (No. of tests)						
Dengue IgM ELISA kits (No.)						
JE IgM ELISA kits (No.)						
Chikungunya IgM ELISA kits (No.)						
rk39 kits (No.)						
ACT (Packs) (Adult)						
ACT (Packs) (Children)						
Inj Arteether (No.)						
Inj Quinine (No.)						
Tab CQ (No.)						
Tab PQ 2.5 mg (No.)						
Tab PQ 7.5mg (No.)						
Miltefosine (No.)						
Inj Amphoterecin (B) (No.)						
Inj SSG vials (No.)						
Tab DEC (No.)						
Tab Albendazole (No.)						

Are the stock registers maintained properly? Yes/No If No, describe the problems and possible solutions.

Are all items within the expiry period? Yes/No If No, give details.

Items stocked out for more than one month? Give details.

Are items stored properly? Yes/No. If no, give details.

Are stocks adequate for next six months? Yes/No If No, give details

Has the District sent all the consignee receipts to the State? Yes/No. If no, give details

Comments on Logistics

Bed Nets

LLIN /ITNCoverage in the district							
High endemic Blocks/PHC *	Population	Total households	Estimated no. community owned nets	No. LLIN distributed	No. of ITN distributed	No. of households targeted	No. (%) household covered against the target so far (cumulative)
* Based on API, Pf%, mortality							

Comments on use and impact of bed nets

Entomological Monitoring

Areas surveyed for Aedes breeding?

Areas found positive for aedes breeding? Give HI, CI, BI.

Comments on Entomological monitoring:

IRS for Malaria and Kala-azar

Round	Insecticide	Spray start date	Completion date	Population targeted	No. Population covered (%)	Rooms targeted	No. Rooms covered (%)
Malaria1							
2							
3							
Kala-azar 1							
Kala-azar 2							

Comments on IRS

Supervision

How many PHC, CHC, Sub-centres were visited by DMO/AMO/VBD consultant or other district level officers in last 2 months?

Whether DMO/AMO/VBD consultant or other district level officers supervised IRS for malaria and/or kala-azar by field visit?

Has someone from the district (DMO/AMO/VBD consultant or other officers) supervised distribution of bed nets by field visit in last year: Yes/No If yes, give details of observations.

Has someone from the district (DMO/AMO/VBD consultant or other officers) verified utilization of bed nets by field visit in last year: Yes/No If yes, give details of observations.

Other Vector Borne Diseases

Questions	
Whether PHC-wise records of lymphoedema and hydrocele cases available in district (Attach a copy)	
Whether all PHCs covered under MDA?	
MDA coverage (%) in the district	
Name sentinel/random sites in district for MF survey	
Population surveyed for MF	
No. (%) positive for MF	
Name the sentinel centre hospital for diagnosis and treatment of Dengue/Chikungunya/JE	
Whether physician/pediatrician in the district hospital and other major hospitals in the district are trained for treatment of DHF/DSS?	
Whether action plans to prevent/control Dengue and Chikungunya available at District level?	
Whether adequate diagnostic facilities are available in the district hospital (SSH) for diagnosis of Dengue and Chikungunya (collect data on cases and death and lab data on samples tested in the last one year)	
Whether DMO/AMO/VBD consultant attended any Social Mobilization Workshop for control of dengue/chikungunya?	
Whether adequate facilities available in the district hospital (SSH) for diagnosis of JE(Collect copy of line list of cases/death, and lab data from SSH in the last one year)	
Whether physician/paediatrician in the district hospital (SSH) trained for treatment of AES/JE	
Whether fogging is done following detection of an AES/JE Case	
What is coverage for immunization against JE in district?	
No. of Kala-azar cases and deaths in district?	
No. of Kala-azar cases in the district which have completed treatment?	
Any problem faced in doing work?, If yes, possible solutions	

Hatcheries

No. of hatcheries maintained in the District:

No. of water bodies seeded with fish

Comments on Hatcheries

NGO/PPP

No. of NGOs/CBOs/FBOs/Corporate sector organisations involved and the areas for their involvement?

Finance

Funds received during current financial year (A)

Expenditure during current financial year till date (B)

Balance available (A-B)

UC and audited report for last financial year submitted Yes/No

Financial Monitoring Report (FMR) for the last Quarter submitted? Yes/No
(Get a copy of last FMR)

Whether advances are classified separately and not included in the FMR? Yes/No

What are major operational constraints experienced in the finance issues and what are your suggestions to address these constraints?

State

Background information: Give No.

No. of villages		No. of AWW		No. of ASHA	
CHC		PHC		Sub-centre	
Distt Hosp		Sub-Distt Hosp		ID Hosp	
Govt. Medical College Hosp		Other Hospitals in public sectors		Dispensaries	
Health posts		Private Medical College Hosp		Other Hospitals in Private sector including NGOs, trusts/FBOs etc	

Human resources

SPO: Contact Details

Name_____ Qualification_____ Designation_____
Office address_____
_____

Tel:_____(O), Tel: _____(R), Cell:_____
Fax:_____E-mail:_____

Since when working as NVBDCP SPO_____ Is SPO trained for VBD___

Is SPO dedicated for NVBDCP_____

If not what are other job responsibilities _____

Other Staff
Regular and incremental staff involved in VBD control

S. No.	Name of post (Regular/ contractual)	No. sanctioned	No. in position	No. vacant	Timeline for filling vacancy	No. trained	Timeline for training of untrained
	Con (M&E)	1					
	Con	1					

	(Training)						
	Con (Proc)	1					
	Con (Finance)	1					
	Con (PPP)	1					
	Entomologists	2					
	Insect Collector	2					
	DEO	1					
	Sec Assistant	1					
	Accountant	1					

Name of Training Institute:

S. No.	Name of post	No. sanctioned	No. in position	No. vacant	Timeline for filling vacancy

Comments on Human Resources:

Surveillance

Epidemiological Data (Attach district-wise and month-wise epidemiological data for last 3 years)

Summary of malaria data in the State in the last year

Malaria (including Urban Malaria)				
	No. tested	Total positive	PF *	PV
Slides examined				
RDT performed by ASHA				
RDT performed by Others				
Total tested (Slides examined & positive RDT)				
No. of cases given radical treatment				
No. of PF cases treated with ACT				
No. of clinically suspected malaria deaths				
No. of confirmed (RDT or Slide positive) malaria deaths				
*Mixed infection would be counted as PF infection only.				

Urban Malaria: No. of towns with more than 1 lac population -

Name of town	Area	Population	Slides examined	Total malaria cases	PF	PV	Clinically suspected malaria deaths	Lab confirmed malaria deaths
	Slum							
	Other							
	Slum							
	Other							

(Note: Visiting Officer should check the epidemiological data for consistency. If the data are not consistent it should be discussed with the SPO to understand the possible reasons and actions needed to make that

consistent. (Provide the summary))

Was ABER less than 10% in any district? Yes/No

If yes, discuss with the SPO to identify the possible reasons and actions needed to increase the ABER to more than 10% in all districts.

Are trend charts and maps available at State level? Yes/No

No. of clinically suspected and confirmed malaria deaths investigated in 2008.

Comments on Epidemiological data

RDT for Malaria
No. of ASHAs trained in the state for RDT and treatment of cases?

Is RDT used in Health Facilities (PHC/CHC/DH/state level hospitals) in the district? Yes/No
If Yes, Why is RDT used in Health Facilities?

No. of RDT kit picked up for quality assurance from any health facility in the state in the last Six months.

What were the results?

Whether all DMOs have been given the copy of SOP for Quality Assurance (QA) for malaria microscopy and RDT? Yes/No

Comments on availability and utilization of RDT

Logistics

	Opening balance in Jan 2009	Received in 2009	Total	Utilized	Balance	Expiring in 6 months
DDT (MT)						
Malathion (WDP) (MT)						
Malathion Technical (Lit)						
Synthetic pyrethroid (Kg)						
Pyrethrum extract (Lit)						
Temephos (Lit)						
LLIN (No.)						
Malaria RDT (No. of tests)						
Dengue IgM ELISA kits (No.)						
JE IgM ELISA kits (No.)						
Chikungunya IgM ELISA kits (No.)						
rk39 kits (No.)						
ACT (Packs) (Adult)						
ACT (Packs) (Children)						
Inj Arteether (No.)						
Inj Quinine (No.)						
Tab CQ (No.)						

Tab PQ 2.5 mg (No.)						
Tab PQ 7.5mg (No.)						
Miltefosine (No.)						
Inj Amphoterecin (B) (No.)						
Inj SSG vials (No.)						
Tab DEC (No.)						
Tab Albendazole (No.)						

Are the stock registers maintained properly? Yes/No If No, describe the problems and possible solutions.

Are all items within the expiry period? Yes/No If No, give details.

Items stocked out for more than one month? Give details.

Are items stored properly? Yes/No. If no, give details.

Are stocks adequate for next six months? Yes/No If No, give details

Has the State sent all the consignee receipts? Yes/No. If no, give details

Comments on Logistics

Bed Nets

LLIN /ITN Coverage in the state							
High endemic District *	Population	Total households	Estimated no. community owned nets	No. LLIN distributed	No. of ITN distributed	No. of households targeted	No. (%) household covered against the target so far (cumulative)
* Based on API, Pf%, mortality							

Has someone (state level officer) verified distribution of bed nets by field visit in last year: Yes/No
If yes, give details of observations.

Has someone (state level officer) verified utilization of bed nets by field visit in last year: Yes/No
If yes, give details of observations.

Comments on use and impact of bed nets

Entomological Monitoring: No. of Zones in the State-

Areas surveyed (Date of survey)	Vector detected	Adult density (PMH)	Larval density (per Dip) HI for Aedes	Susceptibility (Adult)	Susceptibility (Larva)	Bioefficacy to insecticide

Comments on Entomological monitoring:

IRS for Malaria

Round	Insecticide	Spray start date	Completion date	Population targeted	No. Population covered (%)	Rooms targeted	No. Rooms covered (%)
Malaria1							
2							
3							
Kala-azar 1							
Kala-azar 2							

Comments on IRS for Malaria

Supervision

How many districts, PHC, CHC, Sub-centres were visited by SPO in last 3 months?

Filaria

Questions	
Whether district-wise records of lymphoedema and hydrocele cases available in state (Attach a copy)	
Whether all districts covered under MDA?	
MDA coverage (%) in the state	
Compliance assessment done? If yes, give the copy of report.	
No. of sentinel/random sites in state for MF survey	
Population surveyed for MF	
No. (%) positive for MF	
Preparatory activities done before MDA?	
When was the last meeting of STF	
When was the last meeting of state TAC	
Funds released to all districts for MDA	

Dengue/Chikungunya/AES/JE

	Dengue	Chikungunya	AES/JE	Comments
No. of functional SSH in the state				
National guidelines for case management sent to all major hospitals				
Action plan and monthly calendar of activities available				
Data on cases and deaths and lab data available				Get a copy of the data

Kala-azar

Action plan available		
Road map for kala-azar elimination available		
Block-wise data on cases and deaths of Kala-azar and cases of PKDL available		Get a copy of the data
No. of Kala-azar cases which completed treatment?		
Quality assurance for rapid diagnostic kits for kala-azar in		

place (Yes/No)		
Whether pharmacovigilance data on use of miltefosine generated (Yes/No)		Get a copy of the data

Hatcheries

No. of districts maintaining hatcheries maintained in the State:

No. of water bodies seeded with fish
Comments on Hatcheries

NGO/PPP
No. of NGOs/CBOs/FBOs/Corporate sector organisations involved and the areas for their involvement?

Problems faced by SPO in doing his/her duties and possible solutions

Finance
Funds received during current financial year (A)

Expenditure during current financial year till date (B)

Balance available (A-B)

UC and audited report for last financial year submitted Yes/No

Financial Monitoring Report (FMR) for the last Quarter submitted? Yes/No
(Get a copy of FMR for the last quarter)

Whether advances are classified separately and not included in the FMR? Yes/No

Whether all districts have been covered while preparing the last 2 FMR? Yes/No

What are major operational constraints experienced in the finance issues and what are your suggestions to address these constraints?

Annexure 27

INTENSIFIED MALARIA CONTROL PROJECT
_____ (NAME OF SOCIETY)

Project Management Reports/ Statement of Expenditure* for the year _____

S. No	Expenditure Head	Physical targets for the year		Statement of Expenditure*					Cumulative for the project period	Remarks, if any
		Fixed	Achieved	(In Rupees)						
				Quarter 1	Quarter 2	Quarter 3	Quarter 4	Total		
1	**Human Resource**									
	Financial Consultant									
	Project Director/Coordinator									
	IEC Consultant									
	Assistant/Computer Operator									
	Secretarial Assistant									
	Accountant									
	Sub-total									
2	**Training**									
	To Community Volunteers in use of RDT, drug distribution and bed-net treatment , etc.									
	To Lab. Technician									
	To Medical Officers									
	Sub-total									
3	**Commodities & Products**									
	Bed-nets									
	Insecticide for bed net treatment									
	Rapid Diagnostic test kits									
	Sub-total									
4	**Drugs**									
	Arteether injections									
	Artesunate and SP Combination Therapy tablets									
	Sub-total									

5	**Planning & Administration**									
	Hiring of Vehicles									
	Field visits (travel related expenses)									
	Review meeting of District									
	Operational studies on impact and process indicator									
	Internal evaluation by special team									
	Preparation of reports and dissemination of information including publication at state level									
	Evaluation (Independent Agency)									
	Office expenses for State level									
	Office expenses for District level									
	IEC - Awareness Campaigns through (50%) state health system and (50%) NGOs/ CBOs/ Panchyat Raj Institutions									
	Sub-total									
6	**Operational Expenses**									
	Operational expenses for treatment of bed-nets									
	Sub-total									
	Grand Total									

* Consolidated information from all the implementing agencies in the State viz. DVBCS, NGOs/CBOs, etc/

_____ _____

(Member Secretary) **(Chairperson)**

Annexure 28

INTENSIFIED MALARIA CONTROL PROJECT
_____ (NAME OF SOCIETY)

STATUS REPORT OF FUNDS AVAILABLITY
FOR THE QUARTER ENDED ON _____

Sl. No.	Particulars	Amount (In Rupees)
1	Opening Balance B/F	
2	Funds received during the quarter	
	Total (A)	
3	Actual Expenditure incurred as per Category wise SOE	
4	Advance payments made	
	Total (B)	
5	Closing Balance [A – B] C/F	

Accountant/ Finance Officer **Member Secretary**

Annexure 29

INTENSIFIED MALARIA CONTROL PROJECT
_____ (NAME OF SOCIETY)

RECEIPTS AND PAYMENTS ACCOUNT
FOR THE PERIOD FROM 1ST April ____to 31st March _____

(In Rupees)

RECEIPTS			PAYMENTS		
	Amount of the current year	Amount of the previous year		Amount of the current year	Amount of the previous year
Opening Balance Cash in hand Bank Balance with			Transfer of funds to DVBDCP		
Grant-in-aid			Human Resources		
Gift/ / Donation if any			Training		
Transfer from other Agency/ DVBDCP/ SVBDCS			Commodities & Products		
Miscellaneous Receipts			Drugs		
Interest on Bank Deposit			Planning & Administration		
			Operational Expenses		
			Closing Balance Cash in hand Balance with bank in a/c no		
Total Rs.			Total Rs.		

Member Secretary **Chairperson**

Auditors with Rubber Stamp

Annexure 30

INTENSIFIED MALARIA CONTROL PROJECT
_____ (NAME OF SOCIETY)

INCOME AND EXPENDITURE ACCOUNT
For the period from 1st April _____ to 31st March _____

(In Rupees)

EXPENDITURE			INCOME.		
	Amount of the current year	Amount of the previous year		Amount of the current year	Amount of the previous year
Human Resources			Gift/ Grant/ Donation		
Training			Miscellaneous Receipts		
Commodity & Products			Interest on Bank Deposit		
Drugs			Transfer from Grant in aid		
Planning & Administration					
Operational Expenses					
Total Rs.			Total Rs		

Member Secretary **Chairperson**

Auditors with Rubber Stamp

Annexure 31

INTENSIFIED MALARIA CONTROL PROJECT
_____ (NAME OF SOCIETY)

BALANCE SHEET AS ON 31ST MARCH ----------

(In Rupees)

LIABILITIES	Amount of the Current year	Amount of the previous year	ASSETS	Amount of the Current year	Amount off the previous year
Opening balance Add: - Grant received during the year Less:- Expenditure for the year charged to GIA			Fixed Assets (at cost of acquisition)		
			Closing balance of consumables purchased out of GIA funds		
Out Standing Liabilities Expenses payable Other liabilities			Interest accrued but not received from banks etc.		
			Any loans/ advances given but not received up to 31st March		
			Cash in hand As on 31st March		
			Bank Balance As on 31st March (Bank reconciliation statement be prepared & enclosed)		
Total Rs.			Total Rs.		

Member Secretary **Chairperson**

Auditors with Rubber Stamp