Guideline for ACCESS TB/ MDRTB Indicators

The Access to Health Fund

February, 2019
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<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Access</td>
<td>The Access to Health Fund</td>
</tr>
<tr>
<td>BHS</td>
<td>Basic Health Staff</td>
</tr>
<tr>
<td>CHW</td>
<td>Community Health Worker</td>
</tr>
<tr>
<td>DOT</td>
<td>Directly Observed Treatment</td>
</tr>
<tr>
<td>DST</td>
<td>Drug susceptibility testing</td>
</tr>
<tr>
<td>DR-TB</td>
<td>Drug-resistant TB</td>
</tr>
<tr>
<td>FB</td>
<td>Fund Board</td>
</tr>
<tr>
<td>FM</td>
<td>Fund Manager</td>
</tr>
<tr>
<td>HIV</td>
<td>Human Immunodeficiency Virus</td>
</tr>
<tr>
<td>INGO</td>
<td>International Non-Governmental Organization</td>
</tr>
<tr>
<td>M&amp;E</td>
<td>Monitoring and Evaluation</td>
</tr>
<tr>
<td>M.tuberculosis</td>
<td><em>Mycobacterium tuberculosis</em></td>
</tr>
<tr>
<td>MoHS</td>
<td>Ministry of Health and Sports</td>
</tr>
<tr>
<td>MNCH</td>
<td>Maternal, Newborn and Child Health</td>
</tr>
<tr>
<td>NSP</td>
<td>National Strategic Plan</td>
</tr>
<tr>
<td>NTP</td>
<td>National Tuberculosis Programme</td>
</tr>
<tr>
<td>RIF</td>
<td>Rifampicin</td>
</tr>
<tr>
<td>RR-TB</td>
<td>Rifampicin-resistant TB</td>
</tr>
<tr>
<td>TB</td>
<td>Tuberculosis</td>
</tr>
<tr>
<td>TB-ACF</td>
<td>TB Active Case Finding</td>
</tr>
<tr>
<td>TSG</td>
<td>Technical Strategic Group</td>
</tr>
<tr>
<td>VHW</td>
<td>Village Health Worker</td>
</tr>
<tr>
<td>WFP</td>
<td>World Food Programme</td>
</tr>
<tr>
<td>WHO</td>
<td>World Health Organization</td>
</tr>
<tr>
<td>WRD</td>
<td>WHO Approved Rapid Diagnostics</td>
</tr>
</tbody>
</table>
Introduction

Four donors – Sweden, Switzerland, the United Kingdom, and the United States – are committed to continue pooling funding in 2019-2023 to increase access to quality essential health services for underserved and vulnerable people in conflict-affected areas, and to enable the health system to sustain these gains. The follow-on mechanism (henceforth, The Access to Health Fund), will be open to like-minded donors interested in joining.

The Access to Health Fund builds on four core priorities:

a. A focus on conflict-affected areas and on work with both the MOHS and EHOs;
b. A focus on equity and a rights-based approach targeting vulnerable populations;
c. A focus on supporting the delivery of an Essential Package of Health Services;
d. Strengthening the health system’s capacity to ensure sustainable essential services with a particular focus on vulnerable, underserved people in conflict-affected areas.

The Access to Health has defined a number of intervention areas:

a. Essential Health Services (Maternal, Newborn and Child Health)
b. Essential Health Services (Nutrition)
c. Essential Health Services (Sexual Reproductive Health and Rights)
d. HIV/Harm Reduction
e. Tuberculosis
f. Malaria
g. Health in Prisons
h. Health Systems Strengthening

Purpose of the TB indicator guideline

The primary purpose of this document is to provide stakeholders with essential information on the TB core indicators for Access that were derived from the National Monitoring and Evaluation Plan of the National Tuberculosis Programme. This guideline will help to promote data quality, accuracy, validity, reliability, completeness, timeliness, integrity and confidentiality of data and a clearer understanding of indicator definitions. Partners are strongly encouraged to integrate the core indicators into their ongoing monitoring and evaluation (M&E) activities where appropriate. These indicators are designed to help partners assess the current state of their activities, their progress towards achieving their targets, and their contribution towards the national response. This guideline is designed to improve the quality and consistency of data collected at the partner level, which will enhance the accuracy of conclusions drawn when the data are aggregated.
Commonly Asked Questions

Indicators are important for two reasons. First, they can help evaluate the effectiveness of activities. Second, when data from programmes are analyzed collaboratively, the indicators can provide critical information on the effectiveness of the response at national level.

Q1: Where do I find information on calculating and interpretation TB indicators for the Access to Health TB grants?

- **In this guideline.** This guideline includes detailed information for the calculation of each tuberculosis indicator required under the Access grant. This guideline includes numerator and denominator (if applicable) definitions, frequency of reporting, Data source required, a summary interpretation of the indicator, and references for additional resources.

Q2: Are these indicators aligned with the National Strategy?

- Yes. The Access TB indicators were reviewed in line with National Monitoring and Evaluation Plan on Tuberculosis. It should be noted that as programmatic information needs evolve, the Access to Health will continue to periodically review its core indicators to ensure that they are aligned with national programmes and remain responsive to supplying the critical data for an effective response.

Q3: Which indicators do I report on and when?

- **Partners are expected to report on indicators as per their grant agreement and log frame.** Under no circumstances should a partner try to force inappropriate data into the indicator measurement. There are other opportunities to report achievements not related to the required indicators in the narrative report. If a partner has any questions regarding reporting, they should contact the Fund Manager’s Office before submission of the report. This guideline also provides information on the frequency of reporting.

Q4: Do I need to disaggregate data by sub-categories?

- Yes. For the indicators that clearly state in the guideline that sex and age data are required. In addition, **disability disaggregated data** will be requested after establishment of the disability theme by the Fund. The challenge for partners is to ensure that data remains disaggregated from the collection point all the way to reporting.
Q5: What are the data sources we should use when collecting information?

- Primary Data sources for partners can include: (i) nationally representative, population-based sample surveys; (ii) specially-designed surveys and questionnaires, including surveys of specific population groups; (iii) patient-tracking systems; (iv) programme monitoring reports; and, (v) routine health information systems. **Each indicator has a defined data source.** Some names of the tools may be different in your organization compared to what is listed in this guideline, so please check with the Access to Health to ensure your data sources are the right ones.

Q6: Which reporting template should we use to report indicator data?

- The Access to Health will provide each partner with an updated TB reporting template at least one month prior to the reporting deadline. These templates will have your targets filled in and is based on your log frame and grant agreement.

Please contact the Access to Health office at +95-1-657280-7 for further information and support.
A Public Health Questions Approach to M&E

Determining Collective Effectiveness

Monitoring and Evaluating National Programs

Outcomes and Impacts Monitoring

Are collective efforts being implemented on a large enough scale to impact the epidemic?
Survey; Surveillance

Outcomes

Are interventions working/making a difference?
Outcome Evaluation Studies

Outputs

Are we implementing the program as planned?
Outputs Monitoring

Activities

What are we doing? Are we doing it correctly?
Process Monitoring and Evaluation; Quality Assessments

Understanding Potential Responses

Inputs

What interventions and resources are needed?
Needs, Resource, and Response Analysis; Input Monitoring

What interventions can work (efficacy and effectiveness)? Are we doing the right things?
Special Studies: Operations Research; Formative Research; Research Synthesis

What are the contributing factors?
Determinants Research; Analytic Epidemiology

Problem Identification

What is the nature and magnitude of the problem?
Situation Analysis; Surveillance

The Third One: Monitoring and Evaluation of HIV Programs  John Puvimanasinghe, Wayne Gill and Eduard Beck
Reporting flow for TB to Access to Health Fund

The Access to Health Fund

The Access to Health M&E Unit

IP HQ M&E unit

Feedback system

Township reports

Community volunteer monthly report

Feedback system

FMO

IP HQ

IP Township volunteer level

Village level
Reporting flow for TB activities to NTP

Electronic reporting flow for TB
# The Access to Health: TB/ MDRTB Indicators

<table>
<thead>
<tr>
<th>INDICATOR REFERENCE</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Goal:</strong> Reduction in TB burden in areas and populations supported by the Access Fund</td>
</tr>
<tr>
<td><strong>Impact</strong></td>
</tr>
<tr>
<td>TB Mortality Rate</td>
</tr>
<tr>
<td><strong>Impact</strong></td>
</tr>
<tr>
<td>TB Incident Rate</td>
</tr>
<tr>
<td><strong>Objective:</strong> Pursuing high quality DOTS; Enhancing the quality and expanding services to all TB patients, to sustain and further improve case detection and treatment success rates</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>1</th>
<th>Outcome</th>
<th>TB Treatment</th>
<th>Case notification rate of all forms of TB per 100,000 population-bacteriologically confirmed plus clinically diagnosed</th>
</tr>
</thead>
<tbody>
<tr>
<td>2</td>
<td>Outcome</td>
<td>TB Treatment</td>
<td>TB Treatment success rate (All forms)</td>
</tr>
<tr>
<td>3</td>
<td>Output</td>
<td>Referral examined</td>
<td>Number of suspected cases examined</td>
</tr>
<tr>
<td>4</td>
<td>Output</td>
<td>TB Treatment</td>
<td>Number of notified cases of bacteriologically confirmed TB</td>
</tr>
<tr>
<td>5</td>
<td>Output</td>
<td>TB Treatment</td>
<td>Number of notified TB cases of all forms of TB</td>
</tr>
<tr>
<td>6</td>
<td>Output</td>
<td>Patient Support</td>
<td>Number of volunteers trained and supported</td>
</tr>
<tr>
<td>7</td>
<td>Output</td>
<td>Patient Support</td>
<td>Number of MDR-TB patients receiving allowance for transport for diagnosis and treatment (disaggregated by sex)</td>
</tr>
<tr>
<td>8</td>
<td>Output</td>
<td>Empowerment of Community Volunteers</td>
<td>Number of community health workers/community volunteers trained and actively involved in MDR TB activities at community level</td>
</tr>
<tr>
<td>9</td>
<td>Output</td>
<td>Empowerment of Community Volunteers</td>
<td>Number of DOT providers received training and provide DOT for MDR TB patients</td>
</tr>
<tr>
<td>10</td>
<td>Output</td>
<td>Patient Support</td>
<td>Number of MDR-TB patients receiving DOT through volunteers</td>
</tr>
</tbody>
</table>
### At a Glance Sheet for the Access to Health TB/MDRTB Indicators

<table>
<thead>
<tr>
<th>No.</th>
<th>Indicator</th>
<th>Numerator</th>
<th>Denominator</th>
<th>Source</th>
<th>Reporting frequency</th>
<th>NOTE:</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Case notification rate per 100,000 population- all forms of TB</td>
<td>Number of new and relapse cases of TB in a specified time period</td>
<td>Estimated population in a specified time period, usually one year</td>
<td>TB register, NTP TB-07 report (Routine facility information system for recording and reporting of TB cases)</td>
<td>Annual</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>TB Treatment success rate</td>
<td>Number of TB cases registered in a specified time period that was successfully treated</td>
<td>Total number of TB cases registered in the same period</td>
<td>TB register, NTP TB-08 report (Routine facility information system for recording and reporting of TB cases)</td>
<td>Annual</td>
<td>Same approach for MDR-TB</td>
</tr>
<tr>
<td>3</td>
<td>Number of suspected cases examined</td>
<td>Total number of presumptive/suspected TB cases who are referred by community health workers, community volunteers and implementing partner’s mobile team and/or clinic received sputum testing, Xpert MTB/RIF testing and/or chest X ray screening during the reporting period.</td>
<td>NA</td>
<td>Township TB referral record, Implementing partner’s register (Routine implementing partner information system for recording and reporting of TB cases)</td>
<td>Six monthly, Annually</td>
<td>Disaggregated by sex</td>
</tr>
<tr>
<td>4</td>
<td>Number of notified cases of bacteriologically confirmed TB</td>
<td>Number of notified bacteriologically confirmed TB cases who are detected among the referral cases of community health workers and community volunteers.</td>
<td>NA</td>
<td>Township TB register and Implementing partner’s register (Routine implementing partner information system for recording and reporting of TB cases)</td>
<td>Six monthly, Annually</td>
<td>Disaggregated by sex</td>
</tr>
<tr>
<td>5</td>
<td>Number of notified TB cases of all forms of TB</td>
<td>Number of notified TB cases (all forms-bacteriologically confirmed plus clinically diagnosed) who are detected among the referral cases of</td>
<td>NA</td>
<td>Township TB register and Implementing partner’s register (Routine implementing partner information system for recording and reporting of TB cases)</td>
<td>Six monthly, Annually</td>
<td>Disaggregated by sex</td>
</tr>
<tr>
<td>No.</td>
<td>Indicator</td>
<td>Numerator</td>
<td>Denominator</td>
<td>Source</td>
<td>Reporting frequency</td>
<td>NOTE:</td>
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<td>---------------------------------------------------------------------------</td>
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<td>------------------------------------------------</td>
</tr>
<tr>
<td>6</td>
<td>Number of volunteers trained and supported (Disaggregated by sex)</td>
<td>Number of volunteers trained and supported</td>
<td>NA</td>
<td>Training records and commodity distribution records</td>
<td>Every Six months, Cumulative Annually</td>
<td>Disaggregated by sex</td>
</tr>
<tr>
<td>7</td>
<td>Number of MDR-TB patients receiving allowance for transport for diagnosis and treatment</td>
<td>Number of patients receiving allowance for transport during treatment taken period</td>
<td>NA</td>
<td>Patient support record forms</td>
<td>Every six month, Cumulative Annually</td>
<td>Disaggregated by sex</td>
</tr>
<tr>
<td>8</td>
<td>Number of community health workers trained and actively involved in MDR TB activities at community level</td>
<td>Number of community health workers/ community volunteers trained and actively involved in MDR TB activities at community level.</td>
<td>NA</td>
<td>Training record, meeting attendance record and report tracking record</td>
<td>Every six month, Cumulative Annually</td>
<td>Disaggregated by sex</td>
</tr>
<tr>
<td>9</td>
<td>Number of DOT providers received training and provide DOT for MDR TB patients</td>
<td>Number of community health workers/ community volunteers trained and provided DOT service for MDR TB patients.</td>
<td>NA</td>
<td>Training record and DOT Book</td>
<td>Every six month, Cumulative Annually</td>
<td>Disaggregated by sex</td>
</tr>
<tr>
<td>10</td>
<td>No. of MDR-TB patients receiving DOT through volunteers</td>
<td>Number of confirmed and treated MDR TB patients who received DOT by community volunteers.</td>
<td>NA</td>
<td>DOT Book</td>
<td>Every six month, Cumulative Annually</td>
<td>Disaggregated by sex</td>
</tr>
<tr>
<td>11</td>
<td>Number of staff from Ministry of Health and Sports (MoHS), Implementing Partners (IPs), Ethnic Health Organisations (EHOs), local Non-Governmental Organisations (NGOs), Community-Based</td>
<td>Number of staff from MoHS, IPs, local NGOs and CBOs (at central, regional and township level), trained in AEI &amp; CS in a calendar year (disaggregated by sex and age).</td>
<td>NA</td>
<td>IP training records</td>
<td>Six monthly and Cumulative Annually</td>
<td>Disaggregated by sex and age</td>
</tr>
<tr>
<td>No.</td>
<td>Indicator</td>
<td>Numerator</td>
<td>Denominator</td>
<td>Source</td>
<td>Reporting frequency</td>
<td>NOTE:</td>
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<tr>
<td></td>
<td>Organisations (CBOs), and volunteers who are trained in all cross-cutting</td>
<td></td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td></td>
<td>themes (as part of package)</td>
<td></td>
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</tr>
<tr>
<td>12</td>
<td><strong>Number and percentage of feedback that were addressed by the Implementing</strong></td>
<td>Number of feedback received by implementing partners that were addressed in the reporting period based on the IP's procedure.</td>
<td>Total number of feedback received by implementing partners through verbal and written feedback channels to provide feedback in the reporting period. (as defined in the procedure).</td>
<td>IP reports and Feedback Mechanism Records</td>
<td>Six monthly</td>
<td>NA</td>
</tr>
</tbody>
</table>
1. Case notification rate per 100,000 population- all forms of TB

**Definition:** Number of new and relapse TB case notified in a given year, per 100 000 population

**Numerator:** Number of new and relapse cases of TB in a specified time period

**Denominator:** Number of persons/total population

\[
\text{CNR (all forms of TB cases) per 100,000 pop} = \frac{\text{All forms of TB cases} \times 100,000}{\text{Population}}
\]

**Data source:** TB register, NTP TB-07 report (Routine facility information system for recording and reporting of TB cases)

**Reporting frequency:** Annual

**Interpretation:** All forms of TB cases notified (bacteriologically confirmed plus clinical diagnosed TB cases both pulmonary and extra pulmonary) in a given year, per 100 000 population. The term “notification” means that TB is diagnosed in a patient and is reported within the national surveillance system.
2. **TB Treatment success rate**

**Numerator:** Number of TB cases registered in a specified time period that was successfully treated (cured plus treatment completed).

**Denominator:** Total number of TB cases registered in the same period (bact. confirmed + clinically diagnosed).

**Data source:** TB register, NTP TB-08 report (Routine facility information system for recording and reporting of TB cases)

**Reporting frequency:** Annual

**Interpretation:** Percentage of TB cases successfully treated (cured plus treatment completed) among TB cases notified (all forms (bact. confirmed + clinically diagnosed)) to national health authorities during a specified period, usually one year.
3. Number of suspected cases examined (Disaggregated by sex)

**Numerator:** Total number of presumptive/suspected TB cases who are referred by community health workers, community volunteers and implementing partner’s mobile team and/or clinic **received sputum testing, Xpert MTB/RIF testing and/or chest X ray screening** during the reporting period.

**Data source:** Township TB referral record, Implementing partner’s register (Routine implementing partner information system for recording and reporting of TB cases)

**Reporting frequency:** Six monthly, Annually

**Interpretation:** Presumptive TB means a patient who presents with symptoms or signs suggestive of TB infected and this is previously called “TB suspect”. This indicator counts the individuals, not number of sputum or chest X ray testing. Actual results are head counts rather than frequency of visits for the same client. However, patient who received treatment and included already in tuberculosis treatment outcome should be count and reported for their second time referral.

**Additional Information:** This indicator does not include in NTP M&E indicator but community volunteers and implementing partner’s mobile team and/or provide major contribution on active TB case detection in the Access to Health TB grant setting. This indicator will be collected by organizations working with community health workers, community volunteers and implementing partner’s mobile team and/or clinic.

Only the Access to Health supported TB examined cases should be counted and reported.
4. **Number of notified cases of bacteriologically confirmed TB (Disaggregated by sex)**

**Numerator:** Number of notified bacteriologically confirmed TB cases who are detected among the referral cases of community health workers and community volunteers.

**Data source:** Township TB register and Implementing partner’s register (Routine implementing partner information system for recording and reporting of TB cases)

**Reporting frequency:** Six monthly, Annually

**Interpretation:** A bacteriologically confirmed (both pulmonary and extra pulmonary) TB case includes all new and retreatment cases confirmed by-

1. smear and/or culture;
2. WHO-recommended rapid molecular diagnostics (e.g. Xpert MTB/RIF);
3. extra-pulmonary cases with lab confirmation by identification of M. tuberculosis (not by histology alone)

Actual results are head counts rather than frequency of visits for the same client. However, patient who received treatment and included already in tuberculosis treatment outcome should be count and reported for their second time treatment.

**Additional Information:** This indicator will be collected by organizations working with community health workers, community volunteers and implementing partner’s mobile team and/or clinic.

*Only the Access to Health supported TB cases should be counted and reported.*
5. Number of notified TB cases of all forms of TB (Disaggregated by sex)

**Numerator:** Number of notified TB cases (all forms-bacteriologically confirmed plus clinically diagnosed) who are detected among the referral cases of community health workers and community volunteers.

**Data source:** Township TB register and Implementing partner’s register (Routine implementing partner information system for recording and reporting of TB cases)

**Reporting frequency:** Six monthly, Annually

**Interpretation:** All forms of TB cases (both pulmonary and extra pulmonary) are bacteriologically confirmed and/or clinically diagnosed with active TB by a clinician.

Actual results are head counts rather than frequency of visits for the same client. However, patient who received treatment and included already in tuberculosis treatment outcome should be count and reported for their second time treatment.

**Additional Information:** This indicator will be collected by organizations working with community health workers, community volunteers and implementing partner’s mobile team and/or clinic.

    Only the Access to Health supported TB cases should be counted and reported.

**Note:**

It will be disaggregated by disability. (Please see page 29 for Operational definitions of Access to Health Fund for Disability)
6. Number of volunteers trained and supported (Disaggregated by sex)

**Numerator:** Number of volunteers trained and supported

**Data source:** Training records and commodity distribution records (e.g. stationary, health promotion materials etc...)

**Reporting frequency:** Every Six months, Cumulative annually

**Interpretation:**
'Trained' includes trained/ retrained in prevention and/or treatment and case management. However, retrained numbers should not be included in this indicator.

Volunteers must be trained and supported (supported is defined as given the resources required to perform their duties, which will include stationary, travel allowance, health promotion materials and TB prevention supplies).

Each partner should stop support to “inactive” volunteers and reallocate the Access to Health resources to support an active volunteer. “Inactive” volunteer is defined as a volunteer who does not submit their report(s) for four continuous months during a six month reporting period. The below table shows an example of a counting method used for measuring volunteers trained and supported.

**Example of trained and supported volunteer counting**

<table>
<thead>
<tr>
<th>January</th>
<th>February</th>
<th>March</th>
<th>April</th>
<th>May</th>
<th>June</th>
<th># Volunteer (T+S) Jan-Jun</th>
</tr>
</thead>
<tbody>
<tr>
<td>A (T+S)</td>
<td>A (T+S)</td>
<td>A (T+S)</td>
<td>A (T+S)</td>
<td>A (T+S)</td>
<td>A (T+S)</td>
<td>Count</td>
</tr>
<tr>
<td>B (T+S)</td>
<td>B (T+S)</td>
<td>B (T)</td>
<td>B (T)</td>
<td>B (T)</td>
<td>B (T)</td>
<td>Don’t count</td>
</tr>
<tr>
<td>C (T)</td>
<td>C (T+S)</td>
<td>C (T+S)</td>
<td>C (T+S)</td>
<td>C (T+S)</td>
<td>C (T+S)</td>
<td>Count</td>
</tr>
<tr>
<td></td>
<td>D(T+S)</td>
<td>D(T+S)</td>
<td>D(T+S)</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

A, B, C...= Represent name of volunteer  
T= Trained  
S= Support

Additional Information: The Access to Health will request supporting documentation for numerator figures used in calculating of reported figures, including volunteer coverage by township. The Access to Fund requests that partners provide the total number of volunteers trained in their narrative reports. Only the Access to Health Fund trained and supported volunteers should be counted and reported.
7. **Number of MDR-TB patients receiving allowance for transport for diagnosis and treatment**  
   (Disaggregated by sex)

**Numerator:** Number of patients receiving allowance for transport during treatment taken period

**Data source:** Patient support record forms

**Reporting frequency:** Every six month, Cumulative Annually

**Interpretation:** Registered MDRTB patients under the ACCESS Fund project will receive monthly allowance (in term of cash) during their treatment taken period.

MDRTB patients who had completed the treatment or who are defaulter or died will be excluded from the eligible list but patients who have been taken treatment 15 days or more in a month is entitled to receive patient support for the particular month.

**Additional Information:**

This indicator is mainly for implementing partners who support MDR TB patients under the Access Fund project areas. According to SOP for cash transfer to MDRTB Patients, MDRTB patients who have received an MDRTB Registration No on the 15th day of each month or earlier of the month, are entitled to receive the patient support. If a patient is referred-in from another partner under the Access Fund, the first service provider will count for that specific reporting period.
8. Number of community health workers/community volunteers trained and actively involved in MDR TB activities at community level
(Disaggregated by sex)

Numerator: Number of community health workers/community volunteers trained and actively involved in MDR TB activities at community level.

Data source: Training record, meeting attendance record and report tracking record

Reporting frequency: Every six month, Cumulative Annually

Interpretation:

Community volunteers who have been trained to provide MDRTB activities such as health education, contact tracing, case detection and directly observed treatment (DOT) to MDR TB patients as daily basis. “Training” includes the first time training and refresher training.

Volunteers must be trained and actively involved in 1) quarterly meeting at township level and/or 2) providing DOT service to MDRTB patient.

**DO NOT** count the “inactive” volunteers and each partner should stop support to “inactive” volunteers and reallocate the ACCESS Fund resources to support an active volunteer.

“Inactive” volunteer is defined as a volunteer who does not attend quarterly meeting for two times in six month period.

The below table shows as an example of a counting method used for measuring volunteers trained and supported.

### Example of trained and active volunteer counting

<table>
<thead>
<tr>
<th>January</th>
<th>February</th>
<th>March</th>
<th>April</th>
<th>May</th>
<th>June</th>
<th># Volunteer (T+S) Jan-Jun</th>
</tr>
</thead>
<tbody>
<tr>
<td>A (T)</td>
<td>A (T)</td>
<td>A (T+Q)</td>
<td>A (T)</td>
<td>A (T)</td>
<td>A (T+Q)</td>
<td>Count</td>
</tr>
<tr>
<td>B (T)</td>
<td>B (T)</td>
<td>B (T)</td>
<td>B (T)</td>
<td>B (T)</td>
<td>B (T)</td>
<td>Don’t count</td>
</tr>
<tr>
<td>C (T)</td>
<td>C (T+Q)</td>
<td>C (T)</td>
<td>C (T)</td>
<td>C (T)</td>
<td>C (T)</td>
<td>Count</td>
</tr>
<tr>
<td>D (T)</td>
<td>D (T)</td>
<td>D (T+Q)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

A,B,C.. = Represent name of volunteer
T= Trained Q= Attended a quarterly meeting

**Additional Information:** The Access Fund will request supporting documentation for numerator figures used in calculating of reported figures, including volunteer coverage by township. The Access Fund requests that partners provide the total number of volunteers trained in their narrative reports.

**Only the Access Fund trained and supported volunteers should be counted and reported**
9. **Number of DOT providers received training and provide DOT for MDR TB patients** *(Disaggregated by sex)*

**Numerator:** Number of community health workers/community volunteers trained and provided DOT service for MDR TB patients.

**Data source:** Training record and DOT Book

**Reporting frequency:** Every six month, Cumulative Annually

**Interpretation:**

Community volunteers who have been trained to provide directly observed treatment (DOT) to MDR TB patients as daily basis. “Training” includes the first time training and refresher training.

**DO NOT** count the volunteers who have been trained but not providing DOT service to patients for more than 3 month during the reporting period of six month.

**Example of counting method**

<table>
<thead>
<tr>
<th>January</th>
<th>February</th>
<th>March</th>
<th>April</th>
<th>May</th>
<th>June</th>
<th># Volunteer (T+S) Jan-Jun</th>
</tr>
</thead>
<tbody>
<tr>
<td>A (T)</td>
<td>A (T+D)</td>
<td>A (T+D)</td>
<td>A (T+D)</td>
<td>A (T+D)</td>
<td>A (T+D)</td>
<td>Count</td>
</tr>
<tr>
<td>B (T+D)</td>
<td>B (T+D)</td>
<td>B (T)</td>
<td>B (T)</td>
<td>B (T)</td>
<td>B (T)</td>
<td>Don’t count *</td>
</tr>
<tr>
<td>C (T)</td>
<td>C (T+D)</td>
<td>C (T)</td>
<td>C (T+D)</td>
<td>C (T+D)</td>
<td>C (T+D)</td>
<td>Count</td>
</tr>
<tr>
<td>D(T)</td>
<td>D(T)</td>
<td></td>
<td>D(T)</td>
<td></td>
<td>D(T+D)</td>
<td>Count</td>
</tr>
</tbody>
</table>

A,B,C,..= Represent name of volunteer

T= Trained D= Provided DOT service

*This does not indicate for MDRTB patients who had completed the treatment or who are defaulted or died at any point on treatment. The implementing partners can count DOT providers who stop from providing DOT service to patients due to 1) treatment completed, 2) patients refused/stopped treatment, 3) admitted to hospital.

**Additional Information:** the Access Fund encourages achieving DOT target at least 75% of enrolled patients.

The ACCESS Fund will request supporting documentation for numerator figures used in calculating of reported figures, including volunteer coverage by township. The ACCESS Fund requests that partners provide the total number of volunteers trained in their narrative reports.

**Only the Access Fund trained and supported volunteers should be counted and reported**
10. No. of MDR-TB patients receiving DOT through volunteers (Disaggregated by sex)

**Numerator:** Number of confirmed and treated MDR TB patients who received DOT by community volunteers.

**Data source:** DOT Book

**Reporting frequency:** Every six month, Cumulative Annually

**Interpretation:**

DOT is defined as Direct Observed Treatment for monitoring on daily drug taken, infection control measures and monitoring on side effect of MDR TB drugs during ambulatory treatment at the patient’s home. DOT is provided twice per day by a BHS for morning dose and by a community volunteer for evening dose¹.

**DO NOT** count death and loss to follow up cases.

**Additional Information:**

This indicator is mainly for implementing partners who support MDR TB patients under the Access Fund project areas.

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¹ TB Five Year National Strategic Plan 2011-2015; Page 99
### The Access to Health: Cross-cutting Indicators

<table>
<thead>
<tr>
<th>Output Indicator</th>
</tr>
</thead>
<tbody>
<tr>
<td>11. (5.1) Number of staff from Ministry of Health and Sports (MoHS), Implementing Partners (IPs), Ethnic Health Organisations (EHOs), local Non-Governmental Organisations (NGOs), Community-Based Organisations (CBOs), and volunteers who are trained in all cross-cutting themes (as part of package)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Definition</th>
<th>The number of staff from MoHS, IPs, EHOs, local NGOs, CBOs and volunteers trained in all cross-cutting themes conducted by IP and Access to Health Fund resource persons disaggregated by sex and age.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Numerator</td>
<td>Number of staff from MoHS, IPs, EHOs, local NGOs and CBOs and volunteers who trained in all cross-cutting themes in a calendar year (disaggregated by sex and age).</td>
</tr>
<tr>
<td>Denominator</td>
<td>N/A</td>
</tr>
<tr>
<td>Data Sources</td>
<td>IP training records.</td>
</tr>
<tr>
<td>Reporting Frequency</td>
<td>Six monthly, and Cumulative Annually</td>
</tr>
</tbody>
</table>

**What it measures:** The number of staff from MoHS, IPs, EHOs, local NGOs, CBOs and volunteers receiving all cross-cutting themes training conducted.

Trained is defined as attendance at a cross-cutting theme-related training or workshop. The themes include (i) gender mainstreaming and social inclusion, (ii) prevention of sexual exploitation, harassment and abuse (SEA and SHA), (iii) disability inclusion, (iv) accountability and responsiveness (Community Feedback Mechanism), (v) emergency preparedness and response for disaster risk reduction, and (vi) conflict sensitivity. For cross-cutting related trainings, specific training attendance tracking sheet capturing above information should use.

Only those staff and volunteers who attend the **entire training at least one day based on training curriculum** will be counted as trained. Half day sharing session should not be counted as training. Training/workshop reports should include documentation of overall satisfaction of training/workshop given, including lessons learnt for improving upon training/workshop methods and action plan of the participants.

Training is defined as an organized activity aimed at imparting information and/or instruction to improve the recipient’s performance or to help him or her attain a required level of knowledge or skill.
**Workshop** is defined as a class or seminar in which the participants work individually and/or in groups to solve actual work-related tasks to gain hands-on experience.

**Age** is defined 15-24 (youth), 25-59 (adult), 60 and over as senior/pensioner. These categories are defined using the most recent information from the 2014 census and existing pension laws. These definitions are subject to change.
### Output Indicator

<table>
<thead>
<tr>
<th>12. (5.2.) Number and percentage of feedback that were addressed by the Implementing Partners (IPs) in the reporting period based on the IP’s procedure (disaggregated by type of feedback)</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th><strong>Definition</strong></th>
<th>Number and percentage of feedback addressed in the reporting period based on the IP’s procedure, disaggregated by type of feedback (as defined in the procedure).</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Numerator</strong></td>
<td>Number of feedback received by IPs that were addressed in the reporting period based on the IP’s procedure (except positive feedback).</td>
</tr>
<tr>
<td><strong>Denominator</strong></td>
<td>Total number of feedback received by IPs through verbal and written feedback channels to provide feedback in the reporting period. (as defined in the procedure) (except positive feedback).</td>
</tr>
<tr>
<td><strong>Data Sources</strong></td>
<td>IP reports and Feedback Mechanism Records</td>
</tr>
<tr>
<td><strong>Reporting Frequency</strong></td>
<td>Six Monthly</td>
</tr>
</tbody>
</table>

**What it measures:** the extent to which feedback received by the IP through verbal and written feedback channels those are addressed by the IP based on a procedure that follows good practice.

Feedback refers to opinions, concerns, suggestions, questions, and complaints of anyone affected by the IP to improve any aspect in the interaction between themselves and the IP. This interaction can relate to decision-making processes, operations, standards of technical performance, communications or any other aspects in the IP’s work. Feedback also refers to the specific grievance of anyone who has been negatively affected by the IP or who believes that the IP has failed to meet a stated commitment. This commitment can relate to a project plan, beneficiary criteria, an activity schedule, a standard of technical performance, an organizational value, a legal requirement, staff performance or behavior, or any other point.²

Mechanisms to provide feedback are defined as verbal and written feedback communication tools that IPs utilise to collect feedback from the communities and give response in which they work to better understand their programs and projects from community members’ perspectives. These mechanisms give the IPs information to adjust their programs and projects to best meet individual and community needs.³

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² Definition adapted from HAP, The Guide to the HAP Standard, Published by Oxfam GB, 2008.

Examples of feedback channel includes but is not limited to outreach sessions, community engagement meetings, focus group discussions, quarterly rural health centre meetings, feedback forms, ready to post envelopes, in person direct feedback at the organisation and at the field through health staff, field focal, and volunteers, etc.

Addressed means that the IP has fully followed the procedure (see below) and decided that no further action can or will be taken in relation to the feedback.

Procedure refers to a specified series of actions defined by the IP based on the context and taking into account good practice, through which the IP processes feedback and ensures that feedback is reviewed and acted upon. The procedure clarifies the purpose and limitations of feedback, how feedback can be raised, types of feedback and steps to be taken in order to decide if the feedback requires any action and/or a response to the feedback provider, the response timeframe for communicating with the feedback provider, etc. The procedure needs to be documented and should be available on request.

If the feedback does not require any further action to be taken (e.g., positive feedback/thank you letter), it is necessary to record but no need to include in the calculation of percentage of feedback addressed.

Types of feedback are categorized as Suggestion, Positive Feedback, Negative Feedback, and Others.

- Suggestion: It refers to an idea, plan or action that is suggested to your organization, project activities and services.
- Positive Feedback: It includes a positive statement of opinion about your organization, project activities and services, etc. Thank you feedback from communities should not be counted in the list of feedback addressed by IPs.
- Negative Feedback: It includes an expression of dissatisfaction, complaint or harassment relating to your organization, staff, project activities, services, etc.
- Others: It includes issues such as questions and concerns which are not relevant to describe in the categories mentioned above.

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4 Categories are adapted from Health for All Reporting Template
13. Operational definitions of Access to Health Fund for Disability
Rights of Persons with Disability Law, Myanmar, 2015:

“A person with disabilities refers to a person who is suffering from one or more long term physical, visual, speech, hearing, intellectual, psychological, mental, or sensory impairment, whether innate or not.”

“Disability refers to not being able to fully participate in the society due to physical, mental, or any other form of hindrances.”

UNCRPD, 2006:

“Persons with disabilities include those who have long-term physical, mental, intellectual or sensory impairments which in interaction with various barriers may hinder their full and effective participation in society on an equal basis with others.”

“Disability is an evolving concept and that disability results from the interaction between persons with impairments and attitudinal and environmental barriers that hinders their full and effective participation in society on an equal basis with others.”

Note: The term “long term impairment” is exceptional for people who inject drug/use drug (PWID/PWUD) suffering from acute or chronic mental health problems.

Washington Group Short Set Questions will be used to identify the person with disability and explained in the cross-cutting themes training. For reference, the Washington Group on Disability Statistics (2016), Short Set of Questions on Disability (PDF version) can be downloaded in this link


Number of persons with disability who receive the project services needs to be reported. The suggested indicators to report disability disaggregation are as follow.

MNCH
- Output 1.2.1 Number and percentage of appropriate EmOC referrals supported - Total
- Output 1.2.2 Number of appropriate EmOC referrals supported - hard to reach areas
- Output 1.2.3 Number of ECC referrals supported - Total
- Output 1.2.4 Number of ECC referrals supported - hard to reach areas
SRHR
- Output 3.2 Number of women received family planning service with SRHR information.
- Output 5.2 Number of women 30-49 who have been screened at least once for cervical cancer

TB
- Number of notified cases of all forms of TB (Disaggregated by sex)

Malaria
- Number of people with confirmed P.f malaria (by sex and age group) treated with chloroquine (plus primaquine)
- Number of people with confirmed P.v malaria (by sex and age group) treated with (plus primaquine)

IP needs to take record the achievement data related to disability in the above indicators. The disability identification will be according to the Washington Group questions.
14. Operational definitions for women representatives at decision-making positions
(for Health for All narrative report)
1) Number of women representatives at decision-making positions in village track/village health committee
2) Number of women representatives at decision making positions in peer groups/self-help groups

“Women representatives in decision-making” mean number of women in health decision-making positions at community level, such as leader/chairperson, secretary, and treasurer in related health committees or volunteer groups, those have more decision making authority than other ordinary members. The ordinary female members of the health committees or volunteer groups will not be counted as women in decision-making positions.

Representatives in the respective health committee or volunteer group should be elected by community to voice up and facilitate in addressing the health needs of the entire village with the help of health service providers.

Note: The achievements related with women representatives in decision making have to be reported in Health for All Narrative report. Therefore, IP needs to take record the relevant activities and achievements.
### Accountability, Equity and Social Inclusion Glossary of Terms

| Accountability | Accountability means using power responsibly. It means listening (and responding) to the voices of people, and keeping your commitments to others.  
| | In the context of accountability and health services, this refers to the commitments of health service providers (public and private) to all the people of Myanmar regardless of gender, ethnicity, religion, age or health status.  
| | Accountability also means building empowered, informed and capable communities and health system users. |

| Fairness (Equity) | Being fair and just to all people who use the health system.  
| | Recognising that people are different and need different support to ensure their rights are recognised. |

| Gender Equity | Being fair to women and men.  
| | Taking specific actions to address historical and social discrimination and disadvantages in Myanmar that prevent women and men from otherwise operating as equals. |

| Health Equity | All people have the opportunity to have the highest level of health.  
| | Understanding the different barriers to health that people face and working to address them.  
| | All people can access quality health care regardless of their socio-economic position, including age, disability, gender or other circumstances.  
| | Ensuring that health policies and services respond to the specific needs of different groups of people. |

| Inclusion | Involves all people in decisions that affect their health.  
| | Understanding diverse experiences and preferences, and enabling people from many different circumstances (e.g. cultural, linguistic and geographic) to participate in health care planning.  
| | Mutual respect, tolerance and making all people feel valued.  
| | Ensuring that all voices are considered in decision-making processes. |

| Empowerment | People – both men women and men – taking control over their lives.  
| | People setting their own agendas, gaining skills, building self-confidence, solving problems, and developing self-reliance. Supporting efforts by communities to carry out collective actions.  
| | Building confident and informed users of the health system.  
| | Creating ownership. |

| Conflict Sensitivity | Capacity of an organisation to understand the context in which it operates, how its activities influence that context and vice-versa, and to act upon that understanding to maximise positive impacts and avoid negative ones (“do no harm”). |