This publication was produced for review by the United States Agency for International Development. It was prepared by Rose Schneider, Fabio Luelmo, and Diana Roses, through the Global Health Technical Assistance Project.
TB CHILD SURVIVAL HEALTH GRANTS PROGRAM EVALUATION ANNEXES

DISCLAIMER
The authors' views expressed in this publication do not necessarily reflect the views of the United States Agency for International Development or the United States Government.
CONTENTS

ANNEX 1A: CRITICAL EVENTS & TIMELINE ................................................................. 1

ANNEX 1B: EVOLUTION OF TB CATEGORY RFA GUIDANCE ................................. 3

ANNEX 2: LIST OF DOCUMENTS REVIEWED............................................................ 5

ANNEX 3: MEETINGS IN WASHINGTON, D.C., WITH USAID, PVO HQ STAFF, CORE AND CSTS ........................................................................................................... 7

ANNEX 4: SELECTED COMPILED INTERVIEW GUIDES .......................................... 9

ANNEX 5: COUNTRY SCHEDULE AND MEETINGS .................................................. 19

ANNEX 6: MAIN PROJECT DATA, PROJECT STATUS, USAID MONITORING AND EVALUATION TEAM COMMENTS * ........................................................................ 25

ANNEX 7: WHAT THE PVOS ARE SAYING: .............................................................. 33

ANNEX 8: SUGGESTED ROLE FOR USAID NGO/PVO TB PORTFOLIO GRANTEES .... 35

ANNEX 9: KEY ELEMENTS OF A TECHNICALLY SOUND TB CONTROL PROGRAM .... 37

ANNEX 10: RECOMMENDED OPERATIONAL INDICATORS FOR NGO/PVO PROJECTS TO STRENGTHEN TB SERVICE DELIVERY AND COMMUNITY-BASED TB ACTIVITIES ...... 39

ANNEX 11: USE OF SELECTED INDICATORS BY USAID GRANT-SUPPORTED TB PROJECTS * ............................................................................................................. 43

ANNEX 12: SUGGESTED NEXT STEPS FOR THE USAID TB GRANTS PORTFOLIO ...... 45

ANNEX 13: SCOPE OF WORK...................................................................................... 47
## ANNEX 1A: CRITICAL EVENTS & TIMELINE

<table>
<thead>
<tr>
<th>CRITICAL EVENTS &amp; TIMELINE</th>
<th>September</th>
<th>October</th>
<th>November</th>
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<th>February</th>
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<td>RFA Issued</td>
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| **FY07 & FY08 Award Schedule** |           |         |          |          |         |          |       |       |     |      |     |        |
| RFA Issued                  |           | X       |          |          |         |          |       |       |     |      |     |        |
| RFA Conference              |           |         | X        |          |         |          |       |       |     |      |     |        |
| Applications Due            |           |         |          | X        |         |          |       |       |     |      |     |        |
| Review of Applications      |           |         |          |          | X       |          |       |       |     |      |     |        |
| Applications Results Announced |       |         |          |          |          | X       |       |       |     |      |     |        |
| Awards Made                 | X         |         |          |          |         |          |       |       |     |      |     |        |

<p>| <strong>Award management (Simultaneous to solicitation)</strong> |           |         |          |          |         |          |       |       |     |      |     |        |
| Cooperative Agreement       | X         |         |          |          |         |          |       |       |     |      |     |        |
| New Grantees Workshop       |           |         | X        |          |         |          |       |       |     |      |     |        |
| DIP Development             |           |         |          |          | X       |          |       |       |     |      |     |        |
| DIPs Reviewed               |           |         |          |          |         | X        |       |       |     |      |     |        |
| Mini-University–Formal Discussion of DIP |       |         |          |          |          |          |       |       |     |      |     |        |
| Annual Reports Due          |           |         |          |          |         |          |       |       |     |      | X  |        |
| Mid-Term Evaluation Due (Year 2 or 3) |       |         |          |          |         |          |       |       |     |      |     |        |
| Final Evaluation Due (Year 4 or 5) |       |         |          |          |         |          |       |       |     |      |     |        |</p>
<table>
<thead>
<tr>
<th>Year</th>
<th>Guidance Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>2003</td>
<td>Apply only if there is a clearly defined role for the PVO within the context of the national TB control program. Applicants do not necessarily have to address all elements of the DOTS strategy but should identify their primary niche within the overall DOTS framework.</td>
</tr>
<tr>
<td>2004</td>
<td>Apply only if there is a clearly defined role for the PVO within the context of the national TB control program. Given the varied needs at the country level and technical expertise required, applicants are not required to address all elements of the DOTS strategy. PVOs may propose 100% LOE in TB or as part of an integrated child/maternal health or HIV/TB program.</td>
</tr>
<tr>
<td>2005</td>
<td>Apply only if there is a clearly defined role for the PVO within the context of the national TB control program. Given the varied needs at the country level and technical expertise required, applicants do not need to address all elements of the DOTS strategy in their proposal. PVOs must identify their contribution to the national TB program within the context of the DOTS framework and how other actors are addressing the other components of DOTS. 100% of LOE devoted to TB control and prevention; however, at least 20% may be attributed to HIV if an aspect of the TB program strengthens linkages with a related HIV program.</td>
</tr>
<tr>
<td>2006</td>
<td>USAID states PVOs have a strategic role to play in TB programs, should identify comparative advantage.</td>
</tr>
<tr>
<td>2007</td>
<td>The following sub-elements are most applicable to this program: DOTS Expansion and Enhancement, TB/HIV, MDR TB, TB Care and Support, and Host Country Strategic Information Capacity. Applicants are encouraged to address only the elements of the Strategy in their proposal that can be supported using the organizational comparative advantage. Applicants do need to clearly identify their contribution to the national TB program within the context of the STOP TB Strategy framework and how other actors are addressing the other key elements. Under the TB category, 100% of the LOE is to be devoted to TB and/or TB/HIV control and prevention activities. Underperforming interventions: 1. Prevention and detection of TB suspects: reducing diagnostic delay; reducing default rates; improving social mobilization; reducing stigma; improving community-based approaches to TB and TB/HIV diagnosis; and treatment; improving linkages to other health interventions.</td>
</tr>
<tr>
<td>2008</td>
<td>PVOs should focus on underperforming areas, hard-to-reach groups, and technical areas or approaches that are within their organization’s comparative advantage.</td>
</tr>
</tbody>
</table>

RFA support of WHO DOTS strategy is appropriate. PVOs could apply only if role was already clearly defined in National TB strategy, which limits PVO’s TB community expansion.

RFA misses a focus to increase patient access to TB services; measurable indicators not reported during project. CDR not reported. Need to use conversion rate indicator. The past performance requirement does not encourage new partners. Situational analysis needs to include more specifics on key indicators for project area populations, little focus on use of a framework/table of summary indicators. Recognize that PVOs have limited experience working in all technical components of the Stop TB strategy and are not involved in state-of-the-art TB programming and technical issues. If awarded, USAID will ensure that external technical expertise is available and the team leader for the mid-term and final evaluations of the project. In addition, the proposal does not need to present the organization’s technical capacity and plans to obtain the necessary technical expertise to implement all of the proposed activities for the project and budget appropriately for this expertise.
ANNEX 2: LIST OF DOCUMENTS REVIEWED

- DIPs, annual reports, MTEs, and FEss from all eight projects
  - Romania: DIP, first year annual report, MTE report, third year annual report, FE report
  - Ukraine: DIP, first year annual report, MTE report, FE report
  - Mexico: DIP, first year annual report, MTE report, third year annual report
  - South Africa: DIP, first year annual report, MTE report, third year annual report
  - Indonesia: DIP, first year annual report, MTE report
  - Philippines: DIP, first year annual report, MTE report
  - Malawi: DIP, first year annual report
  - Zambia: N/A
- Project overviews as provided through CSHGP for all eight projects
- TB technical reference materials
- RFAs from 2003–2008
- Feedback letters from CSHGP to grantee:
  - Indonesia: DIP feedback and DIP approval letters
  - Mexico: DIP, MTE, and third year report letters
  - Philippines: DIP feedback letter
  - South Africa: DIP, first annual report letters
- CORE TB working group paper: The Expansion of Community-Based Tuberculosis Programming: Critical Program Design Issues for New Partners
- FY08 CORE TB working group workplan
- USAID TB mechanisms (updated 7/2007)
## ANNEX 3: MEETINGS IN WASHINGTON, D.C., WITH USAID, PVO HQ STAFF, CORE AND CSTS

<table>
<thead>
<tr>
<th>Name</th>
<th>Organization</th>
<th>Project Site</th>
<th>Email</th>
<th>Call/Meeting</th>
<th>Date/Time</th>
<th>Position</th>
</tr>
</thead>
<tbody>
<tr>
<td>Jill Boezwinkle</td>
<td>USAID</td>
<td>N/A</td>
<td><a href="mailto:jboezwinkle@usaid.gov">jboezwinkle@usaid.gov</a></td>
<td>Completed</td>
<td>Tues 2/19 2pm</td>
<td>CTO CSHGP TB backstop</td>
</tr>
<tr>
<td>Cheri Vincent</td>
<td>USAID</td>
<td>N/A</td>
<td><a href="mailto:cvincent@usaid.gov">cvincent@usaid.gov</a></td>
<td>Completed</td>
<td>Mon 2/18 8am</td>
<td>TB team; TB CSHGP lead Philippines, Malawi</td>
</tr>
<tr>
<td>Irene Koek</td>
<td>USAID</td>
<td>N/A</td>
<td><a href="mailto:ikoek@usaid.gov">ikoek@usaid.gov</a></td>
<td>Completed</td>
<td>Tues 2/19 12:30pm</td>
<td>Infectious Diseases Division Chief TB team</td>
</tr>
<tr>
<td>Christy Hanson</td>
<td>USAID</td>
<td>N/A</td>
<td><a href="mailto:chanson@usaid.gov">chanson@usaid.gov</a></td>
<td>Completed</td>
<td>Tues 2/19 12:30pm</td>
<td>TB team South Africa backstop</td>
</tr>
<tr>
<td>Clydette Powell</td>
<td>USAID</td>
<td>N/A</td>
<td><a href="mailto:cpowell@usaid.gov">cpowell@usaid.gov</a></td>
<td>Completed</td>
<td>Tues 2/19 12:30pm</td>
<td>TB team Indonesia backstop</td>
</tr>
<tr>
<td>Carolyn Mohan</td>
<td>USAID</td>
<td>N/A</td>
<td><a href="mailto:cmohan@usaid.gov">cmohan@usaid.gov</a></td>
<td>Completed</td>
<td>Tues 2/19 12:30pm</td>
<td>TB team</td>
</tr>
<tr>
<td>D'Arcy Richardson</td>
<td>PATH</td>
<td>Ukraine</td>
<td><a href="mailto:drichardson@path.org">drichardson@path.org</a></td>
<td>Completed</td>
<td>Fri 2/29 10:30 am</td>
<td>Technical Director, TB Program</td>
</tr>
<tr>
<td>Amie Bishop</td>
<td>PATH</td>
<td>Ukraine</td>
<td><a href="mailto:jbschooley@projectconcern.org">jbschooley@projectconcern.org</a></td>
<td>Completed</td>
<td>Fri 2/29 10:30 am</td>
<td>Country Program Leader</td>
</tr>
<tr>
<td>Alka Dev</td>
<td>DOW</td>
<td>Romania</td>
<td><a href="mailto:jbschooley@projectconcern.org">jbschooley@projectconcern.org</a></td>
<td>Completed</td>
<td>Wed 2/27 2pm</td>
<td>Program Manager</td>
</tr>
<tr>
<td>Janine Schooley</td>
<td>PCI</td>
<td>Mexico</td>
<td><a href="mailto:jbschooley@projectconcern.org">jbschooley@projectconcern.org</a></td>
<td>Completed</td>
<td>Mon 3/3 9am</td>
<td>VP Tech. Services &amp; Prog. Dev.</td>
</tr>
<tr>
<td>Elena McEwan</td>
<td>CRS</td>
<td>Philippines</td>
<td><a href="mailto:emcewan@crs.org">emcewan@crs.org</a></td>
<td>Completed</td>
<td>Fri 2/22 10 am</td>
<td>Senior Health Technical Advisor</td>
</tr>
<tr>
<td>Krist Roy</td>
<td>CARE</td>
<td>Indonesia</td>
<td><a href="mailto:kroy@care.org">kroy@care.org</a></td>
<td>Completed</td>
<td>Fri 2/22 2pm</td>
<td>Technical Advisor, Children's health</td>
</tr>
<tr>
<td>Luis Benavente</td>
<td>MCDI</td>
<td>South Africa</td>
<td><a href="mailto:lbemavente@mcdi.org">lbemavente@mcdi.org</a></td>
<td>Completed</td>
<td>Mon 2/25 3pm</td>
<td>Senior Health Project Officer</td>
</tr>
<tr>
<td>Sandy Dalebout</td>
<td>Project Hope</td>
<td>Malawi</td>
<td><a href="mailto:sdalebout@projecthope.org">sdalebout@projecthope.org</a></td>
<td>Completed</td>
<td>Wed 2/27 10am</td>
<td>Technical Associate</td>
</tr>
<tr>
<td>Kayt Erdahl</td>
<td>Project Hope</td>
<td>Malawi</td>
<td><a href="mailto:kroy@projecthope.org">kroy@projecthope.org</a></td>
<td>Completed</td>
<td>Wed 2/27 10am</td>
<td>Program Officer</td>
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<tr>
<td>Krist Roy</td>
<td>CARE</td>
<td>Zambia</td>
<td><a href="mailto:kroy@care.org">kroy@care.org</a></td>
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<td>Fri 2/22 2pm</td>
<td>Technical Advisor, Children's health</td>
</tr>
<tr>
<td>Ann Hendrix-Jenkins</td>
<td>CORE</td>
<td>TB WG</td>
<td><a href="mailto:annhjenkins@gmail.com">annhjenkins@gmail.com</a></td>
<td>completed</td>
<td>Mon 2/25 12:30pm</td>
<td>TB WG coordinator</td>
</tr>
<tr>
<td>Elena McEwan</td>
<td>CORE</td>
<td>TB WG</td>
<td><a href="mailto:emcewan@crs.org">emcewan@crs.org</a></td>
<td>completed</td>
<td>Fri 2/22 10am</td>
<td>TB WG co-chair</td>
</tr>
<tr>
<td>Khrist Roy</td>
<td>CORE</td>
<td>TB WG</td>
<td><a href="mailto:kroy@care.org">kroy@care.org</a></td>
<td>completed</td>
<td>Fri 2/22 2pm</td>
<td>TB WG co-chair</td>
</tr>
<tr>
<td>Jim Ricca</td>
<td>CSTS</td>
<td>All</td>
<td><a href="mailto:James_G_Ricca@macrointernational.com">James_G_Ricca@macrointernational.com</a></td>
<td>completed</td>
<td>Tues 2/26 10am</td>
<td>TB projects support</td>
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### Websites

<table>
<thead>
<tr>
<th>Website</th>
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<td>CORE</td>
<td><a href="http://www.coregroup.org">www.coregroup.org</a></td>
</tr>
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<td>CSTS</td>
<td><a href="http://www.childsurvival.com">www.childsurvival.com</a></td>
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<td>TB WG - Core</td>
<td><a href="http://www.coregroup.org/working_groups/tb.cfm">http://www.coregroup.org/working_groups/tb.cfm</a></td>
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### USAID Missions

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<th>Name</th>
<th>Agency</th>
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<tbody>
<tr>
<td>Molly Lindner</td>
<td>USAID Mexico City</td>
<td>Mexico</td>
<td><a href="mailto:mlindner@usaid.gov">mlindner@usaid.gov</a></td>
</tr>
<tr>
<td>Ratna Kurniawati</td>
<td>USAID Jakarta</td>
<td>Indonesia</td>
<td><a href="mailto:rkurniawati@usaid.gov">rkurniawati@usaid.gov</a></td>
</tr>
<tr>
<td>Lisa Baldwin</td>
<td>USAID Jakarta</td>
<td>Indonesia</td>
<td><a href="mailto:lbaldwin@usaid.gov">lbaldwin@usaid.gov</a></td>
</tr>
<tr>
<td>Nellie Gqwaru</td>
<td>USAID Pretoria</td>
<td>South Africa</td>
<td><a href="mailto:ngqwaru@usaid.gov">ngqwaru@usaid.gov</a></td>
</tr>
<tr>
<td>AyeAyeThwin</td>
<td>USAID Philippines</td>
<td>Philippines</td>
<td><a href="mailto:AAThwin@usaid.gov">AAThwin@usaid.gov</a></td>
</tr>
<tr>
<td>Alina Yurova</td>
<td>USAID Ukraine</td>
<td>Ukraine</td>
<td><a href="mailto:Ayurova@usaid.gov">Ayurova@usaid.gov</a></td>
</tr>
<tr>
<td>Alisa Cameron</td>
<td>USAID Malawi</td>
<td>Malawi</td>
<td><a href="mailto:Acameron@usaid.gov">Acameron@usaid.gov</a></td>
</tr>
<tr>
<td>Catherine Chiphazi</td>
<td>USAID Malawi</td>
<td>Malawi</td>
<td><a href="mailto:cchiphazi@usaid.gov">cchiphazi@usaid.gov</a></td>
</tr>
<tr>
<td>George Sinyangwe</td>
<td>USAID Zambia</td>
<td>Zambia</td>
<td><a href="mailto:gsinyangwe@usaid.gov">gsinyangwe@usaid.gov</a></td>
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### PVO Field

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<td>N/A</td>
<td>PATH</td>
<td>Ukraine</td>
<td>N/A</td>
</tr>
<tr>
<td>DOW</td>
<td></td>
<td>Romania</td>
<td>N/A</td>
</tr>
<tr>
<td>Blanca Lomeli</td>
<td>PCI</td>
<td>Mexico</td>
<td><a href="mailto:blomeli@projectconcern.org">blomeli@projectconcern.org</a></td>
</tr>
<tr>
<td>Sylvia Delosa</td>
<td>CRS</td>
<td>Philippines</td>
<td></td>
</tr>
<tr>
<td>(Khrist Roy)</td>
<td>CARE</td>
<td>Indonesia</td>
<td><a href="mailto:kroy@care.org">kroy@care.org</a></td>
</tr>
<tr>
<td>Farshid Meidany</td>
<td>MCDI</td>
<td>South Africa</td>
<td><a href="mailto:mcdi@mweb.co.za">mcdi@mweb.co.za</a></td>
</tr>
<tr>
<td>Patrick Chipungu</td>
<td>Project Hope</td>
<td>Malawi</td>
<td><a href="mailto:chipungupr@yahoo.co.uk">chipungupr@yahoo.co.uk</a></td>
</tr>
<tr>
<td>N/A</td>
<td>CARE</td>
<td>Zambia</td>
<td>N/A</td>
</tr>
<tr>
<td>Janine Schooley</td>
<td>PCI HQ</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Clara</td>
<td>PCI HQ</td>
<td>Mexico</td>
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</table>
ANNEX 4: SELECTED COMPILED INTERVIEW GUIDES

Interview Questions for Headquarters Staff/Backstops of PVO CSHGP TB projects

Please discuss the major responsibilities of your backstop role:

- Planning and project design
- Technical assistance
- Monitoring and evaluation—data analysis
- Guidance for implementation of USAID recommendations
- Other

Please discuss other key roles you play:

- Analyzing lessons learned
- Participation in working groups—informing Core Group
- Providing direct input to USAID

Please discuss which tools/mechanisms are most helpful in supporting the field’s TB programs for monitoring field work:

- Project design
- DIP and mid-term evaluations
- Annual reports
- Field visits
- Web sites
- Other

Please discuss the key indicators your TB program is using to monitor progress:

- Which key process indicators do you monitor?
- What is your program’s progress on process indicators/activities?
- Which key indicators of quality, coverage and impact of TB program activities do you monitor?
- What is your program’s progress on these key indicators of quality, coverage and impact?
- What is your advice on the tracking of these indicators?
- Which indicators are most valuable to track?
Please discuss what the field tells you are the key issues in implementing their TB program:

- What do they say is going well and should be expanded?
- What do they say are key constraints and how they can be resolved?
- What other key issues do you see in implementation of the current program?
- What do you see as issues if TB programs were to be greatly expanded in your organization?
- What lessons learned do you have for future TB programs?

How does this TB grant influence other programs in your organization?

- Has your organization expanded its TB work? Please discuss.
- Is your organization considering future expansion of TB programs? Please discuss.
- What are the organization’s plans for sustaining the TB program/s?

What is your organization’s comparative advantage in TB programming?

- What gap is your organization filling?
- What other gaps in TB programming can your organization fill?
- What kinds of resources would be needed to fill these needs?

Please now brag about your organization’s achievements/accomplishments with the TB program.

---

**Interview Questions for the CORE Group in Support of the PVO TB programs**

Please discuss the key role/responsibilities of the CORE Group in support of the CS TB programs.

Please discuss the key role/responsibilities of the TB Working group in support of the CS TB Groups:

- Coordination of PVOs working in CS TB programs?
- Coordination of PVOs working in other TB programs?
- Other roles?
Please discuss how the CORE Group and the TB Working group support TB programming:

- Coordination
- Planning and project design
- Technical assistance
- Monitoring and evaluation
- Guidance for implementation of USAID recommendations
- Providing TA, input on USAID’s broader TB intervention

Please discuss which tools/mechanisms CORE uses in supporting CS TB programs work:

- Technical updates
- Listserves
- Brown bags
- Elluminate sessions
- Project design
- DIP
- Annual reports
- Field visits
- Other tools/mechanisms?

Please discuss which tools the TB WG has developed to support the CS TB programs.

Please discuss the indicators CORE/TB Working Group use to monitor progress:

- Which key process indicators do you monitor?
- What is the portfolio’s progress on process indicators/activities?
- Which key indicators of quality and coverage of TB services does CORE monitor?
- What is the portfolio’s progress on these key indicators of quality and coverage?

What is CORE’s comparative advantage?

- What gap is the TB WG filling?
- What other gaps could your organization fill?
What is your advice on improvements to make in supporting CSTS TB and other TB programs?

*********************************************************************

Interview Questions for the CSTS in Support of the CSTS TB programs

Please describe briefly CSTS and who is responsible for support to the CSTS TB programs.

Please discuss the key responsibilities of CSTS in support of the CS TB programs:

- Coordination of PVOs working in CS TB programs?
- Coordination of PVOs working in other TB programs?
- Technical assistance?
- Creation of tools/resources?
- Other roles?

Please discuss how CSTS works in the following areas of TB programming:

- Coordination
- Planning and project design technical assistance
- Monitoring and evaluation
- Guidance for implementation of USAID recommendations
- Developing lessons learned
- Other

Please discuss other key roles CSTS may be playing:

- Analyzing lessons learned for individual PVO programs
- Analyzing lessons learned across the CS TB portfolio
- Providing TA, input on USAID’s broader TB intervention
- Interaction with other TB mechanisms funded by USAID
- Other?

What is CSTS’s comparative advantage in supporting CSTS TB programs?

- What gap is CSTS filling?
- What other gaps could CSTS fill?
Please discuss which tools/mechanisms CSTS uses in supporting the field’s TB programs work:

- Project design
- DIP
- Annual reports
- Field visits
- Other tools/mechanisms?

Please discuss the indicators (if any) CSTS uses to monitor progress:

- Which key process indicators do you monitor?
- What is the portfolio’s progress on process indicators/activities?
- Which key indicators of quality and coverage of TB services does CORE monitor?
- What is the portfolio’s progress on these key indicators of quality and coverage?
- What is your advice on the tracking of these indicators?
- Which indicators are most valuable to track?

Please discuss what the field staff tells CSTS the issues are in implementing their TB program.

- What do they say is going well and should be expanded?
- What do they say are key constraints and how they can be resolved?
- What other key issues do you see in implementation of the current TB programs?

What do you see as issues if TB program were to be greatly expanded in the portfolio?—or for PVOs in another mechanism?

- How CSTS TB work contributed to the larger CSTS CS work?
- Has your organization expanded its TB work? Please discuss.
- Is CSTS considering future expansion of support to TB programs? Please discuss.
- What are the organization’s plans for sustaining TA to TB programs?

Please now brag about CSTS’s achievements/accomplishments in support of the TB program.
Interview Questions for Field Visits of PVO CSHGP TB projects

What staffing supports your TB project?

- How many staff are working with the TB project?
- What categories of staff are working with the TB project?
- What do you think is the quality of the technical expertise provided by your project?

Please discuss the major responsibilities of your TB team’s role/s

- Planning and project design
- Technical assistance
- Project implementation
- Monitoring and evaluation—data analysis
- Guidance for implementation of USAID recommendations
- Analysis of lessons learned
- Other

What gap is the project filling?

What kinds of technical assistance have you received? How frequently have you received TA, on what major areas?

How have you collaborated with partners?

- Host country government, national, district and local?
- Other organizations working in communities?
- Other collaboration agencies funded by USAID?
- Please discuss if and how your TB project is building partner capacity.

Please discuss which tools/mechanisms are more helpful in implementing quality field TB projects:

- Project design
- DIP and mid-term evaluations
- Annual reports
- Site visits
- Web sites
- Other
Project objectives

- What are your TB project’s objectives and targets?
- What is your progress in meeting these objectives and targets?

Please discuss the key indicators your TB project is using to monitor progress.

- Which key process indicators do you monitor?
- What is your project’s progress on process indicators/activities?
- Which key indicators of quality, coverage and impact of TB project activities do you monitor?
- What is your project’s progress on these key indicators of quality, coverage and impact?
- What is your advice on the tracking of these indicators?
- Which indicators are most valuable for you to track for project implementation?

Please discuss the key issues you have found in implementing your TB project:

- What is going well and should be expanded?
- What are key constraints and how they can be resolved?
- What other key issues do you see in implementation of the current project?
- What do you see as issues if TB projects were to be greatly expanded in your organization? Issues if TB project would be greatly expanded in Mexico?
- What lessons learned do you have for future TB projects?
- What is needed administratively to scale up activities? To add new activities?
- What is needed technically to scale up activities? To add new activities?

How does this TB grant influence other projects in your organization?

- Has your organization expanded its TB work because of this TB project? Please discuss.
- Is your organization considering future expansion of TB projects? Please discuss.
- What is the potential for sustainability of your TB activities?
- What are your organization’s plans for sustaining the TB project/s?

What is your organization’s comparative advantage in TB programming?

- What gap is your organization filling?
- What other gaps in TB programming can your organization fill?
- What kinds of resources would be needed to fill these needs?
Please now brag about your projects’ achievements/accomplishments with the TB project.

---

**Interview Questions for TB Promoters of PVO CSHGP TB projects**

Please present yourself with an introduction: your name, length of time you have worked as a promoter in the TB program, how you were chosen, and how many patients you are monitoring.

Please discuss your experience with the TB program as a promoter.

What training and other information have you received while in the TB program? Has it been sufficient? What other kind of training/information would you like to better do your job?

What supervision/support have you received to do your job? What suggestion do you have related to supervision and support in future projects?

What problems do your clients have to complete treatment?

What has been the coordination of your project with the Ministry of Health?

What are your ideas and recommendations for future TB programs to assure success?

---

**Interview Questions for TB Clients/patients of PVO CSHGP TB projects**

How did you first realize that you were ill?

What caused you to seek care—consult with a health provider?

Where did you go to seek care? What was the result?

What was the length of time between your signs and symptoms and your diagnosis?

How were you informed about your TB diagnosis? By whom were you informed?

How were the decisions made to on how and where you were going to receive your medications?
Are you satisfied with the process of your treatment?

How does your treatment actually work?

What does the promoter provide to you?

Does s/he provide the TB medications?

Does she come every day? Three times a week?

Do you take the pills yourself without direct observation by a promoter, health worker, or other person?

What suggestions do you have for any changes for the TB program for the future?
ANNEX 5: COUNTRY SCHEDULE AND MEETINGS

Mexico: March 3–March 7, 2008
PVO: Project Concern International
Project Site: Tijuana, Mexicali, Mexico

Monday, March 3: San Diego and Tijuana
Met with PCI staff in San Diego
  Janine Schooley: Vice President for Technical Services and Program Development
  Clara Eder: Director of Monitoring and Evaluation
  Blanca Lomelí: Project Manager, Solución TB

Met with Tijuana Jurisdiction staff (health center, district level)
  Dr. Paris Cerecer Callú, Head of TB in Tijuana Jurisdiction

Presentation on Voices and Images
  Liliana Andrade, Program Coordinator, PCI Mexico
  Patients—Alma and Juan

Tuesday, March 4, Tijuana
Visited patients with:
  Jesús Madrigal, Project Coordinator, Solución TB
  María Herlinda Ledezma Ruiz, Nurse, Central Zone TB program

Met with Promotoras
  16 promotoras

Meeting with PCI Staff
  Blanca Lomelí, Program Manager, Solución TB, Tijuana
  Jesús Madrigal, Project Coordinator, Solución TB, Tijuana
  Liliana Andrade, TB expansion coordinator for Baja, Solución TB
  Robertha Medina, Program Assistant, Solución TB Expansion
  Eva Mendoza, Community Coordinator, Solución TB

Wednesday, March 5, Tijuana and Mexicali
Rosarito Health Center (Tijuana)
  Dr. Edgar Alejandro Galaviz, Director of Rosarito Health Center
  María Isabel Reyna Martínez, Head of Nurses

Mesa Health Center (Tijuana)
  Dr. María de Lourdes de Rosas Hernández, Director, Mesa Health Center
  Lupita, Promotora

Met with PCI Mexicali Team (Mexicali)
  Enrique Gómez, Program Coordinator
  Jesús Madrigal, Project Coordinator
  Daniel Rangel, Program Assistant, Solución TB Expansion
**Wednesday, March 5, Mexicali**

*Meeting with Promotoras*

- María de la Luz Madrid
- Norma Loza O.
- Carmen Sibaja
- María del Rayo Morales
- Luz María Meza
- Lorena Gutiérrez
- Rosalía Lizarraga
- Patricia Liceaga
- Héctor Ayala
- Ada Medina

**Thursday, March 6, Mexicali**

*Meeting with personnel of Health Center Pro-Hogar*

Dr. Rafael Navarro Castillo, Director, Pro Hogar Health Center
Héctor Ayala, Promotor, Solución TB
José Sigüenza Durazo, Patient
Luis Carlos Hirales Ayon, Centro de Rehabilitación CIDA II
Patricia Pérez, Red TAES Estatal
PCI Team

*Meeting, Jurisdicción Sanitaria No. 1, Mexicali*

Dr. Juvenal Vidrio Rodríguez, Director, Jurisdicción No. 1
Dr. Yoloxóchitl Gómez Martínez, Subdirector Jurisdicción No. 1
Dr. Evila Gómez, Ex-Resp. Estatal tuberculosis
Dr. Ofelia Morales, Resp. Micobacteriosis Mexicali
PCI Mexicali Team

*Meeting with personnel of Industrial Health Center*

Dr. Arturo Galaviz, Director, Industrial Health Center
Dr. Ofelia Morales, Resp. Micobacteriosis Mexicali
Enf. María de la Luz Madrid, Promotora Solución TB
Claudio Pérez, Patient
PCI Mexicali Team

**Friday, March 7, San Diego**

*Debrief with USAID/Mexico*

Molly Lindner, Senior Public Health Specialist, USAID/Mexico

*Debrief with PCI staff*

Blanca Lomelí, Program Manager, Solución TB
Janine Schooley, Vice President for Technical Services and Program Development
Indonesia March 10–March 14, 2008
PVO: CARE
Project sites visited: Tangerang, Cilegon, Serang, Pandeglang

Monday, March 10, Tangerang
Met with MITRA Staff
- Frank Page, Urban Program Manager, CARE Indonesia
- Dr. Rahwat Setiawor, MITRA Program Manager, CARE Indonesia
- Field Officers

Pabuaran Tumpeng Puskemas (Health Center)
- Dr. Iradani Yupitaningtuan, Head of Health Center
- Mrs. Rahmayati, Nurse, Head of TB Program at health center
- Mr. Edi, Lab Technician

Patients:
- Mrs. Santi, Mr. Yunus, Mr. Edi, Mr. Sanen

Meeting with NTP, KNCV, USAID/Indonesia
- Dr. Jane Soepardi, Director, NTP
- Dr. Ameli Vanda, NTP
- Dr. Ira, NTP
- Ratna Kurniawati, TB Program Specialist, USAID/Indonesia
- Sjoerd Postma, KNCV Country Representative
- Cecep, KNCV
- Frank Page, Urban Program Manager, CARE Indonesia
- Dr. Rahwat Setiawor, MITRA Program Manager, CARE Indonesia
- Dr. Ranjani Gopinath, CARE consultant

Tuesday, March 11, Cilegon and Serang
Meeting at Pulomerak Puskesmas (Cilegon)

Patients
- Slamet Riyadi
- Suharti Ningsih
- Acih
- Suryati (PMO for sister Acih)

TB Support Group (“Paguyuban TB”)
- Peni (Suspect Surveillance)
- Endang (Secretary)
- Erik (Finance/Bendahara)
- Fatmawati (Leader)
- Sarman (Suspect Surveillance)
- Franki

District Health Staff and Public Health (Subdistrict) Staff
District Health Staff
- Mayeti, Head of Diagnosis of TB unit for Cilegon City
- Derlina, Laboratory Technician, diagnosis of TB unit for Cilegon City
- Sri Marlina, Supervisor of TB Program in Cilegon City

Health center staff
- Sugeng, Laboratory Technician
- Widiastuti, TB Program Manager
Meeting with Provincial Health Department, Banten Province (Serang)
Edi Supriatin, TB Supervisor, Banten Province
Agus Trimulya Prosetya, Head of Infectious Diseases, Banten Province

Wednesday, March 12, Labuan and Pandeglang
Labuan Puskesmas

Patients
Noy
Ruri
Sapari
Ycok
Pooni
Soni
Wanda
Meiti

PMO Coordinators
Aes
Eli
Nong
Neng

PMOs
Emilia
Iyoh
Enah

District Health Staff
Mamak Jameksari, Head of Communicable Diseases Program
Yudi Darmawan, TB Program Supervisor

Subdistrict Health Staff
Dr. Wirdani, Head of Public Health, Subdistrict
Dr. Edwin Afrian, Head of TB Program, Subdistrict
Hasan, TB Program, Subdistrict
Nurlaela, Laboratory Technician

TB Post, Pandeglang

Met with the village chief and leaders, PMOs and patients
Met with Banjar Health Center team
Dr. Iri Utami Periwi, Chief, Banjar Public Health Center
Dani, TB Officer, Banjar Public Health Center
Yadi Heryadi, Laboratory Technician, Banjar Public Health Center
Bidan Nenang, Midwives Officer, Banjar Public Health Center

Thursday, March 13, Cilegon
Cibeber Puskesmas

Patients
Renoldy
Maunah (mother of patient)
Hanidi
Yles

PMOs
Alon
Humedi
Ranaji
Mahad
Sayuti
Tri
Sufiyati
Hasmunah
Mashulayah
Hafido
Laela
Wati
Tati
Maskaneh
Nia
Munjiah
Muesiroh
Nana
Nani
Herlina
Haerani
Harun
Hasanah
Nawiah
Marhabah
Dubiah

Cibeber Health Center Staff
Dr. Ririn, Chief, Cibeber Health Center
Dr. Feni Sunarsih, Head of TB program
Dedy, TB Program
Suryati, Laboratory Technician

Friday, March 14, Tangerang and Jakarta
Debrief with CARE Mitra Staff
Frank Page, Urban Program Manager, CARE Indonesia
Dr. Rahwat Setiawor, MITRA Program Manager, CARE Indonesia
Dr. Ranjani Gopinath, CARE consultant
MITRA Field Officers

Debrief with NTP, USAID/Indonesia, KNCV, CARE
Dr. Jane Soepardi, Director, NTP
Lisa Baldwin, Senior HIV/AIDS Technical Advisor, USAID/Indonesia
Ratna Kurniawati, TB Program Specialist, USAID/Indonesia
Mary Lengkong, KNCV Indonesia
Cecep, KNCV Indonesia
Frank Page, Urban Program Manager, CARE Indonesia
Dr. Ratma, MITRA Program Manager, CARE Indonesia
Heather VanSice, Assistant Country Director, CARE Indonesia

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South Africa, March 17–March 21, 2008
PVO: Medical Care Development International (MCDI)

Project Site: Ndwedwe, Ilimbne District

Monday, March 17, Durban
Meeting with MCDI Staff
Dr. Farshid Meidany, Program Manager/Chief of Party
Martha Benezet, Project Coordinator
Saha AmaraSingham, Senior Technical Advisor
Nazipo, TB/HIV Facility Coordinator

Meeting with Illembe District DoH Manager and TB Coordinator, Stanger
Dr. Nathi Shabane, District CDC (including TB) Coordinator
Mrs. S. Dube, District Manager

Tuesday, March 18, Ndwedwe
Nyuswa Health Center
Sis. Lungile Thusi, Nurse
Lungile Ngcobo, Patient Facility Liaison

Ndwedwe Community Health Center
Sis. B. Mpanza, Nurse
Sis. Ntuli, Enrolled Nurse
Sis. Ndloru, Enrolled Nurse (tracing team)
Mbuso Sibiya, Patient Facility Liaison

Visited TB Event, Department of Agriculture
Dr. Nathi Shabane, District CDC Coordinator

Wednesday, March 19, Ndwedwe
Montebello Hospital
DOT Observers
Smangele Msomi, Patient Facility Liaison
N. Mhlongo, Patient Facility Liaison
A. Mchanya, Patient Facility Liaison
Sis. BP Nguoso, Nurse (TB clinic)
Laboratory Technician

Thursday, March 20, Durban
Debrief with MCDI Staff
Martha Benezet, Project Coordinator
Nazipo, TB/HIV Facility Coordinator

Debrief with USAID/South Africa
Nellie Gqwaru, TB/HIV/AIDS Project Manager, USAID Pretoria
### ANNEX 6: MAIN PROJECT DATA, PROJECT STATUS, USAID MONITORING AND EVALUATION TEAM COMMENTS *

<table>
<thead>
<tr>
<th>SITE / TARGET</th>
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<th>MONITORING/ USAID COMMENTS/ RECOMMENDATIONS</th>
<th>COMMENTS REVIEW</th>
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<tbody>
<tr>
<td>PHILIPPINES MAGINDANAO PROVINCE, MINDANAO</td>
<td>Catholic Relief Services (CRS) Provincial Health Office (IPH0)</td>
<td>Oct 2005 Sep 2009 4 years DIP Apr 2006</td>
<td>$1.5 M $0.5 M $2.0 M</td>
<td>1. &gt; CDR SM (+) 2. &gt; Cure SM (+) Intermediate: &gt; # suspects for microscopy diagnosis &gt; participation of local government &gt; % successfully treated PTB(+) Strategies: QA &amp; &gt; µ laboratories Networking w/ PP Advocacy to local government units (LGUs)</td>
<td>I: CDR PTB(+) B: 69% (2004) T: 75% (2009) I: Cure rate B: 72% (2004) T: 85% (2009)</td>
<td>MTE Sep 2007 CDR 84% (06) CURE 78% (06) &gt; µ staff, upgrading 18 labs Lab. smear (+): 22% (04), 20 (05), 19 (06), 18 (2007)</td>
<td>On target MTE says the targets for number of cases and default (0.1%) are too high. True for default (1%) and failure (0%).</td>
<td>Good diagnosis of situation, very good indicators: baseline and targets. Monitored and reported most chosen indicators Smear positivity still very high. Target is wrong: with increased CD and access and less prevalence, smear positivity should diminish.</td>
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<td></td>
<td>28 municipalities Pop. &gt;15 yrs: 475,000 PTB (+): 5,152 in 4 years</td>
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<td>I: Default B: 6% T: 1% I: Failure B: 6% T: -</td>
<td>I: 3 sputum coll. B: 78% T: 85% I: Sp. positivity B: 17% T: 21%</td>
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<td>I: Sp conversion B: NA T: 80% I: % smear (+) / pulmonary cases B: NA T: NA</td>
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**MTE Sep 2007**

On target

MTE says the targets for number of cases and default (0.1%) are too high. True for default (1%) and failure (0%).

MTE report says acceptable 15–25% (wrong for general outpatients), target 21% (should be reduced from baseline)

Tr. completed targeted 100% (error in definition); achieved 15% that added to cure gives success 93% vs. target WHO 85%.

Good diagnosis of situation, very good indicators: baseline and targets. Monitored and reported most chosen indicators

Smear positivity still very high. Target is wrong: with increased CD and access and less prevalence, smear positivity should diminish.

Project target is cure, not success. WHO current target is success. IPHO success 2004: 83%, PHI 87% 2004

# suspects examined is good indicator of case detection. Data available to calculate positivity, but data on numerator was not reported
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<td>Project Concern International (Solución Project) / ISESALUD (Secretary of Health, Baja California)</td>
<td>MEXICO (2 districts: Tijuana and Mexicali; Baja Calif. Pop.: 2.5 M TB; 1,190 Contacts: 5,950)</td>
<td>Oct 2004 - Sep 2008 (4 years) DIP Jun 2005</td>
<td>$1.5 M $0.5 M $2.0 M</td>
<td>Goal: To expand DOTS w/ ISESALUD. Strategic Objectives: - Influence national strategy - &gt; Success 85% - &gt; Political commitment - DOTS in medical schools Objectives: - Improve/expand DOT w/ community HW &amp; develop DOTS model, &gt; community participation - Increase laboratory capacity - Develop strategies for high-risk groups (PLWHA, abusers) - Improve provider practices - Increase DOTS in medical schools - Improve information/communication/documentation and share tools &amp; results - Mobilize political commitment for state and local TB</td>
<td>I: Tr. Success B: 58% Jun 04 T: 85% I: N° New PTB enrolled T:1190 (4 yrs) I: % pats of ISESALUD in project B: 0 T: &gt;95% (Yr 4) I: % ISESALUD patents on DOTS B: 48% T: 95% I: Default B: 9.8% (4.3 in Tij, 15.0 Mex) T: &lt;3% (Project &amp; ISESALUD) I: &gt; Staff DOT B: 4 T: 38; absorb 10 I: &gt; 2 staff μ I: μ/day/staff B: 20 T: 16–18 I: % w/3 control I: % μ checked (+100%; -10%) &gt; 10% budget ISESALUD</td>
<td>MTE Sep 2006 - On target - Added 34 CHW (22Tij + 12Mex; 27 promotoras + 7 DOT) plus admin. - NTP negotiated expansion to 12 additional states with USAID mission support - Backlog in data entry 2006 - ISESALUD will absorb 4 staff Year 3 Report -299 on DOT prom - Success 80% 2006 (65Tij+95Mex) - option SAT 3/wk, DOT 3/wk, not accepted by govt. - Training PP on HIV, &lt;stigma, infection control - Training promot. - Advocacy: Info to 32 State TBO, CORE, USMBHA; webpage &lt;Solucióntb.org&gt; - Manual completed May07 - No absorption by SS (6+4 in 2007–8)</td>
<td>- Two different models: Tijuana: mostly DOT support (not DOT) by project-paid, community-based promotoras; Mexicali: mostly DOT support by facility-based, project-paid promotoras (most not DOT) - High salary cost may reduce sustainability and feasibility of expansion. - No hard data on achievement of targets (success, default, μ/day), mainly because district NTP ISESALUD does not share data. - Need to document models and incorporate results in webpage - Drug shortages (E, S) make patients buy; commitment of government not fulfilled; need to document lessons. - Expansion to 12 additional states does not appear to use staff experience or lessons from project; may exceed capacity of P. Concern</td>
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*Data were compiled by the Evaluation Team and may have some transcription errors.*
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<tr>
<td>INDONESIA</td>
<td>CARE &quot;Mitra&quot; Project, MOH, KNCV, WHO (Resources: INO, GFATM, GDF FDCs)</td>
<td>Oct 2005 Sep 2009 4 years DIP Sep 2006</td>
<td>$1.5 M $0.5 M $2.0 M</td>
<td>- Increase CDR  - Maintain treatment success rate  - Develop sustainable community structures  &gt; delivery capacity district &amp; province  &gt; private sector participation</td>
<td>I: CDR (new S+) B: 66%; T: 85% I: # suspects B: 6560 T: 7800 (&gt;20%) I: Treat. success B: 85%; T: 85–98% I: Village instit disseminate info B: 0; T: 1284 (25%) I: Worship place disseminate info B: 0; T: 710 (15%) I: # midwives trained DOTS B: 0 T: 285 (30%) I: new DOT centr B: 0; T: 60 I: % of trained PP, P hospitals, industrial clinics B: 0 T: #330, 125, 20 I: Knowledge of 3 weeks cough B: 30%; T: 70% Pandeglang: I: Coverage HF B: NA T: 34 (100%)</td>
<td>MTE Dec 2007, updated Mar 2008 CDR 71% Success 95.8%  - Behind schedule (25/107 Puskesmas) -% knowledge TB 2 symptoms 31 to 50 TB curable 87–94%— - # suspects 27953–35332–26161 (6m) increase 87% - # TB+ 05–07: 4137–4487–2489 (6m): increase 20% -113 posts in 26 villages, 2 TB groups, 152 CBTO coordinators, 495 CBTO, 988 Kader out of 1100 trained - 44 worship (9%) - 140 midwife (15%) -Training MD, staff, &amp; Lep staff stopped by gov (GFATM); - Trained 3 MD, 16 TB officers, 14 lab µ - 5 new DOTS centres in 5 villages -Trained 88 PP/ 1102; 2 Phosp. staff; 5 industry clinics Pandeglang: 34/34 H. fac (100%)</td>
<td>MTE Dec 2007 - Sign MOUs with local partners and scale up - Drop redundant or not-achievable indicators - Increase availability of IEC materials at Puskesmas / monitoring system - Over-diagnosis of children: identify reasons GFATM suspended, delayed training. 2 managers left, one replaced. Need to strengthen DTO. Health Facilities, TBO Did not expand further than first year’s 25 centers (out of 107). Delay expansion, lack of partnership w/ community organizations/ NGO - QA microscopy: high level of errors. Lab reports late No Puskesmas buffer stocks, drug shortages 1–3 months at district Dinkes, lack S (all said to be available at national / province warehouses) Information system from the NTP (MOH DOTS-TB) plus internal MITRA system for administration - Project behind schedule: GFATM funding and suspension; tsunami, and difficulties in changing managers delayed implementation - Good model based on trained volunteers and community groups, effective and sustainable - Good performance in covered areas, with adequate indicators, good impact on case detection - H. facilities and labs need better supervision (uneven-quality records) - Drug management is weak (stock-outs, no stocks for new patients at periphery, risk of stock-out with stopping of GFATM funding) - Diagnosis good but case detection still low, need to implement non-medical screening of suspects among adults attending HF for any reason (also in hospitals) - Project should document trends of indicators and train MITRA and health facility staff to interpret data for action and display</td>
</tr>
</tbody>
</table>

**Comments Review**

- Project behind schedule: GFATM funding and suspension; tsunami, and difficulties in changing managers delayed implementation
- Good model based on trained volunteers and community groups, effective and sustainable
- Good performance in covered areas, with adequate indicators, good impact on case detection
- H. facilities and labs need better supervision (uneven-quality records)
- Drug management is weak (stock-outs, no stocks for new patients at periphery, risk of stock-out with stopping of GFATM funding)
- Diagnosis good but case detection still low, need to implement non-medical screening of suspects among adults attending HF for any reason (also in hospitals)
- Project should document trends of indicators and train MITRA and health facility staff to interpret data for action and display
<table>
<thead>
<tr>
<th>SITE / TARGET</th>
<th>ORGANIZATION / PARTNERS</th>
<th>START / END / DURATION DATE DIP</th>
<th>GRANT MATCH TOTAL</th>
<th>OBJECTIVES</th>
<th>INDICATOR BASELINE TARGETS</th>
<th>MONITOR STATUS / YEAR</th>
<th>MONITORING / USAID COMMENTS / RECOMMENDATIONS</th>
<th>COMMENTS REVIEW</th>
</tr>
</thead>
<tbody>
<tr>
<td>SOUTH AFRICA / KZN Ndwedwe Municipality of Ilembe Subdistrict, near Durban</td>
<td>MCDI (Medical Care Devel. Inc.) - Project NITHAP (TB/HIV) Durban Med Res Council; U. of Western Cape; U. of KwaZulu-Natal CAPRISA Sinosizo, TADSA, ARK KZN Dep Agric. Valley Trust KNCV</td>
<td>Oct 2004 Sep 2008 4 years DIP Jun 2005</td>
<td>$1.5 M $0.1 M $1.6 M</td>
<td>- Improve TB control - &gt; capacity of labs - &gt; capacity for treatment and prevention of TB in HIV+ (IPT, CPT); contact notification - &gt; access to VCT - strengthen PMTCT and expand coverage of HIV test in pregnant women / new mothers - support PLWHA - &gt; capacity district and H. facilities to implement NTCP and GFATM - &gt; capacity MCDI at HQ and field for TB Operations research - trace defaulters and those not evaluated - find reasons for poor adherence - evaluate the family DOT support efficacy - evaluate &quot;opt-out&quot; in HIV testing</td>
<td>I: Tr. outcome B: cure new 33% and retreatment 20% default 19%. transf. 18%. not evaluated 18% T: NA I: Sputum conversion (not monitored) B: KZN 37% T: NA I: # HBCV trained as DOT supporters, % supervised B: NA; T: NA I: % pts helped by supporter or nurse B: 0; T: NA I: DOT caseload DRAT (every 6 months) I: VCT referrals I: % Contact tracing I: #: % staff trained MTE Dec 2006 Few data on achieved vs targets Many objectives No impact targets Community DOT not started, contact not started. Most activities planned Recommended focusing training of nurses, HBV, community; new plan M&amp;E Third Year Report - Trained nurses, competition of HF, lab. assessment, SOP developed, revised DRAT - Involved traditional healers; subdistrict commit. (nurses), events pats/family - CBCV paid DoH (trained /absorbed), Trained fam. DOT Default : 11% (Q2/07) vs 19% - Tr. success DIP 39%, Q1/07 71%; Q2/07 77% (DRAT) (Annex M page 232)</td>
<td>- Lab tool assessment: recommendations very complex, not focused on smear quality (not per WHO recommendations) - There is very little real DOT, only patient support - High staff losses - Facility-based TB liaison persons useful, should be adopted by DOH, including real DOT - Need to concentrate on a few essential indicators and trends - TB activities linked to HIV</td>
<td>- Use of DRAT, but limited analysis data registers to improve quality of reporting - There are no trends of pooled data for the project area - Case notification seems 4 times more in 2007 than in 2003; success increased from 39 to 77% (data not easy to find in reports) - Field observation showed good DOH and MCDI staff involvement, good registers, analysis of effectiveness in HF walls, satisfactory CD. - Supervision is only by MCI, DOH has only one part-time DTO until now, no supervisors - Laboratory with weaknesses: one of the two microscopes out of order; third year evaluation noted too few fields read, hosp. lab in limit of load, data per slides and not for persons (S.Africa)</td>
<td></td>
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</tbody>
</table>

**NOTE:** The table above contains detailed information about the objectives, indicators, and monitoring status of a grant program focused on TB and HIV in South Africa. It includes specific activities, targets, and recommendations for improving the program's effectiveness. The data reflects the program's progress and challenges over time, highlighting areas for further improvement and the need for consistent analysis and reporting.
<table>
<thead>
<tr>
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<th>ORGANIZATION / PARTNERS</th>
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<th>COMMENTS REVIEW</th>
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<tbody>
<tr>
<td>MALAWI</td>
<td>PROJECT HOPE Ministry of Health (MOH), CHAM (Malawi Christian Hospital Association; agricultural estates (tea, private) TB CAP (FSH, FHI)</td>
<td>Oct 2006 Sep 2011 5 years DIP Jul 2007</td>
<td>$1.5 M $0.5 M $2.0 M</td>
<td>&gt; treatment outcomes &gt; case detection - Train/support CHW &gt; capacity μ (10 labs) - Outreach traditional healers, drug sellers, VCT centers, general community - Implement DOTS recording and reporting system; strengthen referral of TB suspects, of TB patients to VCT/DCT and of HIV patients to TB facilities; train healers and shopkeepers &gt; case management of TB and TB/HIV &gt; quality assurance - Improve recording &amp; reporting system &gt; microscopy quality &gt; access to microscopy &gt; community awareness of TB - Operations research - Improve management of TB services by district/zonal officers &gt; partner collaboration</td>
<td>Year 1. OCT 07 - Trained 20 staff, 10 microscopists, 173 community leaders - Monitored data for 3 hospitals, separated) - 88% TB/HIV on CPT - Baselines KAP, H Facilities, μ labs - Project manager to be changed</td>
<td>- Need district(s) consolidate and trends per quarter for the chosen impact indicators</td>
<td>- Very good DIP, good indicators. - Mostly oriented to strengthen service delivery including use of community to facilitate treatment - Will improve capacity sustainable with local resources Very ambitious set of objectives, but fitting the country program and (old) capacity</td>
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<tr>
<td>SITE / TARGET</td>
<td>ORGANIZATION / PARTNERS</td>
<td>START/END/DURATION DATE DIP</td>
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<td>ROMANIA</td>
<td>Doctors of the World (DOW), USA, MOH/NTP MOE, MOJ CRISS Red Cross Mentor: Population Services International (PSI)</td>
<td>Oct 2003 Sep 2006 3 years + no-cost extension of 1 year to Sep 2007 DIP Jun 2004</td>
<td>$1.7 M $0.4 M - DOW, OSI, GFATM T $1.9 M</td>
<td>Original RFA: -To strengthen NTP, add community outreach, and improve success in vulnerable populations (Roma). Changed Year 1 to: - Develop health education strategy - develop NTP capacity for health education to the general population. - strengthen skills of providers to improve tr. outcome (PHC, Roma CHW, PP &amp; nurses) - &gt; TB knowledge in high-risk populations (Roma, ex-prisoners) - increase adherence with incentives</td>
<td>KAP changes - Providers trained / performance H. fac. surveys - time, quality of attention % completion w/ incentives (Health facility indicators not available or poor quality)</td>
<td>Yr 1 Report NTP implementing GFATM #2: rejected planned activities - skills providers: trained GP, nurses; trained CHN &amp; RHM for Roma - Incentives: started with Red Cross, increased detection, drug consumption and attendance</td>
<td>Note that TB outpatients were not eligible for incentive coupons, so incentives did not promote less hospitalization Constraints: NTP capacity to implement GFATM; political changes in MOH; no baselines/indicators for impact - Prisons abandoned (few ex-prisoners); DOT supporter not successful, suspended; Bucharest activities canceled - IEC strategy abandoned; replaced for target medical education &amp; training teachers prim/sec education</td>
<td>Note that inpatient treatment; mass screening; non-standard prophylaxis; x-ray diagnosis; self-admin. treatment and poor coordination were not addressed by objectives. Good: flexibility, long-term possible benefits Poor: changes of directors; lack of baseline and concrete impact indicators; did not attempt to change obsolete policies; Insufficient diagnosis of rigidity of Soviet-era specialized system Long-term impact: - Applied experience in Chiapas, Mexico - &gt; acceptance of PVOs, recognition of role of community - CCM requested TA from DOW in implementing GFATM #6 Health ed. and community components</td>
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<td>SITE / TARGET</td>
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<tr>
<td>UKRAINE</td>
<td>PATH</td>
<td>Oct 2003 Sep 2006 DIP Jun 2004</td>
<td>$1.5 M $0.41 M</td>
<td>$1 M (USAID mission—3 more oblasts) $2.91 M</td>
<td>&gt; capacity and political support for DOTS, incl. legislative basis (contradictory) and preparation of oblasts &gt; quality of diagnosis &gt; quality of microscopy - use M&amp;E, use of data, introduce methods &lt; diagnostic delay &gt; case detection &gt; adherence to treatment Improve provider practices, referrals, TB/HIV care</td>
<td>I: Laws DOTS B: 2; T: NA I: Oblasts covered B: 2 + 3, T: NA I: QA microsc. B: NA T: NA I: % Smear + - I B: 0.03–8.4 - II B: 6.4–9.8 I: % on DOT B: 0–100 T: 100% I: Smear conv B: Donetsk 76 Kiev 65% T: NA I: Tr. Success B: 77%, T: 85% I: CDR B: Inc81.5%000 T: NA I: % Cure, comp B: NA, T: NA I: Failure rate B: 5.6 (Donetz) T: NA I: Default rate B: 8.9 (Donetz) T: NA I: % aware of 2 symptoms B: NA, T: NA I: % aware TB is curable B: NA, T: NA</td>
<td>Year 1 MOUs, TAG, order Donetsk, avail. literature, criteria expansion, manual QA and training materials μ - Revised reporting electronic system compatible with WHO approved by 4 oblast/cities, - Training curricula MTE Oct 2005 Constraints: lack of NT managing unit, resistance of specialists, lack guidelines and supervision, poor drug management, excess beds and TB hospitals; laws contradictory; no data-based action: Donetsk success 65% (reduced!); default 8.9 to 16.2; failure 5.6 to 10.9 Recommendations Carry out review, prepare guidelines, change obsolete practices, monitor indicators, QA μ</td>
<td>Final evaluation Laws DOTS: 14 Oblast cover: 5 % proficient μ: 72–95% Smear positivity: Level I: 0.5–5.5% Level II: 9.4–33% Coverage info. net 100% # of WHO indicators that can be measured: 18 % patients on DOT: 100% Smear conversion: Donetsk 67%(reduced!), Kharkiv 65%, Dnipro 72%, Kyiv 67%, Sevastopol 47% Developed national TB information system/ approved National review of the NTP Development of national manual Developed laboratory guidelines, training materials and curricula Trained and implemented QA panel testing of microscopy</td>
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<td></td>
<td>MOH</td>
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<td>Constraints</td>
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<td>TB Institute (Academy)</td>
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<td>-Lack of national NTP unit</td>
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<td>Kyiv City Administr.</td>
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<td>Resistance of specialists and national TB institute</td>
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<td>Donetska H. Admin.</td>
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<td>Contradictory, obsolete laws</td>
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<td>WHO Ukr. KNCV Red Cross</td>
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<td>against international standards</td>
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<td>Ukraine WB project TB/HIV</td>
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<td>No designated national TB lab</td>
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<td>Suspension of WB loan (for not implementing)</td>
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<td>Advanced age of lab staff, to be retired</td>
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<td></td>
<td>Excess TB beds and sanatoria</td>
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<td>Obsolete KAP of TB professionals</td>
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<td>Trend 2003–2005 showed small changes in case detection and completion rates in Donetsk, and deterioration of treatment outcomes in Kyiv; mainly due to high failure/ default rates. There seems to have been no effective corrective actions for several years</td>
</tr>
<tr>
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<tr>
<td>ZAMBIA</td>
<td>CARE NTLP CHAZ (Churches Ass) THAPAZ (Traditional Healer Ass) CoC (Chamber of Commerce)</td>
<td>Oct 2007 Sep 2012 DIP: N/A</td>
<td>$1.5 $0.53 $2.0</td>
<td>- Support NTLP DOTS - Decrease morbidity &amp; mortality of TB and TB/HIV - Facility-based DOT - Linkages w/ HIV services - Community-based care &amp; DOT</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
<td>Project in preparation</td>
</tr>
<tr>
<td>4 districts in Eastern Province: Chipata, Chadiz, Petuake, Lundazi</td>
<td>Pop 1.05 M TB: 22,581</td>
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ANNEX 7: WHAT THE PVOS ARE SAYING:

The following comments were made by NGO/PVOs as contributions to their participation in the evaluation.

- There is not much clarity regarding TB rapid-catch indicators and no clarity on what needs to be monitored and how often.
- They need comments on what USAID really didn’t agree with in the proposal before PVOs start writing the DIP. They want detailed feedback right after being awarded so that they don’t write the DIP and then find out that there were things in the proposal USAID didn’t agree with. They need more than a brief meeting.
- DIP guidelines are comprehensive, but not focused on TB. The discipline that it forces you to have is good. Many have adapted the DIP process for their other projects.
- It feels as though the guidance wants to see every level from household to NTP. They stated that it’s unreasonable to try to cover everything without partnerships.
- It may be useful to have PVO partnerships with local NGOs to help and manage.
- The big lag time between submission of proposal and notification of award is inconvenient. It can cause strained relationships with partners, and in some cases, partnerships have disappeared. Also, the lag time in getting feedback causes difficulties.
- They would like something like a concept paper process for the proposals. A lot of work and great proposals don’t get funded.
- They need more consistent formats.
- Guidelines aren’t being looked at as a whole cohesive system (from proposal/DIP to FE). It’s not contradictory, but more that it isn’t integrated and built on one another.
- There is a need for more resources (both time and money).
- What do you do when a very integrated MOH all of a sudden cuts the cord? They need more support for major issues like this.
- Some PVOs feel that linkages with mission are too difficult, given the small amount of resources.
- The delineation between CS and TB requirements is not clear.
- TRMs are overwhelming.
- The Mini-University very helpful to the field.
- The CSTS website is not user-friendly.
## Annex 8: Suggested Role for USAID NGO/PVO TB Portfolio Grantees

<table>
<thead>
<tr>
<th>NTP Level and Key Functions</th>
<th>Suggested Activities</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>National</strong></td>
<td></td>
</tr>
<tr>
<td>- Policy, Norms</td>
<td>• Coordinate with other partners (e.g., NTP, WHO, TBCAP) and with the USAID mission to share field observations and to promote sound norms and procedures and regular supplies</td>
</tr>
<tr>
<td>- Funding</td>
<td></td>
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<tr>
<td>- Drug Supply</td>
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<tr>
<td><strong>State</strong></td>
<td></td>
</tr>
<tr>
<td>- Supervision</td>
<td>• Coordinate planning, implementation, and monitoring with the NTP</td>
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<tr>
<td>- Quality assurance</td>
<td>• Provide data on activities done and observations from the field</td>
</tr>
<tr>
<td><strong>District</strong></td>
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</tr>
<tr>
<td>- Supervision of health facility staff</td>
<td>• Train health facility and NTP staff (supervisors) in coordination with the NTP; train DOT coordinators and DOT supporters/providers according to national norms; temporary support of additional staff to be absorbed by the public system</td>
</tr>
<tr>
<td>- Service delivery (diagnosis and case detection, treatment, management of TB/HIV)</td>
<td>• Develop sustainable models to increase access of the community and patients to diagnosis and treatment (including TB/HIV) that could be implemented with national or local resources</td>
</tr>
<tr>
<td><strong>Community</strong></td>
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<tr>
<td>- General (identifying TB suspects, supporting DOT, supporting TB patients, providing TB information, reducing stigma)</td>
<td>• Develop and test sustainable community TB information systems for the general population and specific groups</td>
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<tr>
<td></td>
<td>• Promote and support community initiatives to accelerate identification and examination of TB suspects, increase patient access to treatment, and increase treatment compliance</td>
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<td>• Develop community systems to facilitate DOT, document results, and measure effectiveness (smear conversion, cure, and success) through cohort analysis</td>
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<td></td>
<td>• Mobilize community groups (faith-based, commerce and industry, etc.) to support dissemination of TB information, reduce stigma, and mobilize local funding and volunteers</td>
</tr>
<tr>
<td>- Local NGOs/PVOs (TB care and support, community information)</td>
<td>• Coordinate with existing local PVO/NGOs to incorporate TB activities, offering training and guidance</td>
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<tr>
<td></td>
<td>• Promote development of new local PVOs/NGOs and patient/community groups for patient support and communication</td>
</tr>
<tr>
<td>- Private Providers (PP) (persons providing diagnosis and prescribing medicines for profit)</td>
<td>• Inform and train PPs to use the public system for TB patient treatment (including registration and follow-up); test methods to ensure data collection and provision of information to PPs on the patients referred</td>
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<tr>
<td></td>
<td>• Inform and train PPs on the national guidelines for diagnosis and treatment, in collaboration with medical societies and other groups</td>
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1 All levels include planning, training and monitoring, supervision and evaluation
Diagnosis and case detection

1. A TB case is a person which has bacteriological confirmation of TB or that has been diagnosed with TB by a doctor. Patients suspected of having pulmonary tuberculosis should be examined by sputum microscopy (and, if available, culture). Diagnosis of pulmonary TB should not be made without sputum examination (positive or negative results). The proportion of pulmonary smear positive TB is usually over two thirds of the pulmonary cases and more than 50% of the total TB cases diagnosed (rough indicator of criteria of medical diagnosis).

2. All persons with otherwise unexplained productive cough lasting two weeks or more should be evaluated for tuberculosis (sputum microscopy of 2 or 3 sputum specimens). The most productive groups are adults consulting health facilities for any reason, HIV infected persons and adult contacts of known TB cases. The proportion of adults attending health facilities and presenting cough of long duration may be 2–6%. The proportion of them with infectious (smear positive) TB varies with the prevalence of TB in the community, from 1–15%. Adults attending specialized TB dispensaries or hospitals may have over 20% positivity. HIV infected persons have 5 times the lifetime risk of developing TB, they should be controlled frequently.

3. The main purpose of case detection is to accelerate the initiation of treatment of the most infectious patients (pulmonary smear positive, with cough). If adults attend public health facilities, the main intervention is to enquire about cough and offer sputum microscopy; if patients do not attend public facilities the interventions are informing and mobilizing the community to consult when they have cough; facilitating access by expanding the network of public TB services; and involving private practitioners (formal and informal) to detect and refer TB suspects (or sometimes diagnose and treat TB). Information to the community to increase demand should not be done if the facilities are not prepared to provide appropriate services of diagnosis and treatment (at least information, sputum microscopy and regular supply of TB drugs free of charge to the patient).

4. The key indicator of impact of case detection intervention at national level is the case detection rate (CDR). The numerator is the number of new pulmonary smear positive cases reported and the denominator an estimate of the real TB incidence of those cases. The (WHO) estimates are for national level and the CDR should not be applied to smaller areas or populations, because there are large geographical variations in incidence. Simpler indicators for limited areas are a) the absolute number of new cases reported (total, pulmonary and pulmonary smear positive, from the district TB registers), and b) the number of suspects examined by microscopy and the positivity rate (from the laboratory registers). Progress in expansion of the TB services, patient access and use of TB services should increase the number of suspects examined and patients diagnosed and decrease the positivity of microscopy. Participation of the community is important for patient support, expanding DOT and mobilization of political commitment.

Treatment

5. All patients (including those with HIV infection) who have not been treated previously should receive an internationally accepted first line treatment regimen using drugs of known bioavailability. The initial phase should consist of two months of isoniazid (H), rifampicin (R), pyrazinamide (Z) and ethambutol (E). The preferred continuation phase consists of H and R given for 4 months, either daily or three times per week. H and E given for 6 months is an alternative continuation phase regimen. The doses of anti-

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6. A patient-centered approach to administration of drug treatment should be developed for all patients. A central element is the use of measures to assess and promote adherence to the treatment regimen and to address poor adherence when it occurs. These measures should be tailored to the individual patient’s circumstances and be mutually acceptable to the patient and the provider. Such measures may include direct observation of medication ingestion (directly observed therapy—DOT) by a treatment supporter who is acceptable and accountable to the patient and to the health system. DOT may be given at the health facility, by community health workers, by community volunteers and private providers, or by family members if backed by health staff or treatment supporters.

7. All patients should be monitored for response to therapy, best judged in patients with pulmonary tuberculosis by follow-up sputum microscopy at least at the time of completion of the initial phase of treatment (two months), at five months, and at the end of treatment. Patients who have positive smears during the 5th month of treatment should be considered treatment failures and receive a regimen with five initial drugs for 3 months (HRZE plus streptomycin) and three drugs (HR and E) in the continuation phase of 5 months. In patients with extra-pulmonary tuberculosis and in children, the response to treatment is best assessed clinically, particularly through monitoring weight gains and disappearance of symptoms. Follow-up radiographic examinations are usually unnecessary and may be misleading.

8. A written record of all medications given, bacteriologic response, and adverse reactions should be maintained for all patients. The outcome of treatment in cohorts of new pulmonary smear positive patients and its trend is the main indicator of program quality. Treatment success includes cure confirmed by bacteriology and treatment completion (clinical cure).

9. In areas with a high prevalence of HIV infection in the general population, where tuberculosis and HIV infection are likely to co-exist, HIV counseling and testing is indicated for all tuberculosis patients as part of their routine management. In areas with lower HIV prevalence rates, counseling and testing is indicated for tuberculosis patients with symptoms and/or signs of HIV-related conditions, and in tuberculosis patients having a history suggestive of high risk of HIV exposure. All patients with tuberculosis and HIV infection should be evaluated to determine if antiretroviral therapy is indicated during the course of treatment for tuberculosis. Appropriate arrangements for access to antiretroviral drugs should be made for patients who meet indications for treatment. Patients with tuberculosis and HIV infection should also receive co-trimoxazole as prophylaxis for other infections.

10. Patients who fail treatment and chronic cases should be assessed for possible drug resistance. For patients in whom drug resistance is considered to be likely, culture and drug susceptibility testing for H, R and E should be performed promptly. Patients with tuberculosis caused by drug-resistant (especially MDR) organisms should be treated with specialized regimens containing second-line anti-tuberculosis drugs. At least four drugs to which the organisms are known or presumed to be susceptible should be used and treatment should be given for 18–24 months.

Standards for Public Health Responsibilities

11. All providers of care for patients with tuberculosis should ensure that persons (especially children under 5 years of age and persons with HIV infection) who are in close contact with patients with infectious tuberculosis are evaluated and managed in line with international recommendations. Children under 5 years of age and persons with HIV infection who have been in contact with an infectious case should be evaluated for both latent infection with M. tuberculosis and for active tuberculosis.

12. All providers must report both new and retreatment tuberculosis cases and their treatment outcomes to local public health authorities, in conformance with applicable legal requirements and policies.
ANNEX 10: RECOMMENDED OPERATIONAL INDICATORS FOR NGO/PVO PROJECTS TO STRENGTHEN TB SERVICE DELIVERY AND COMMUNITY-BASED TB ACTIVITIES

The key indicators are shaded, and the trends during the time of the project should be reported and displayed.

<table>
<thead>
<tr>
<th>Indicators</th>
<th>Comments</th>
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<tbody>
<tr>
<td><strong>Political commitment</strong></td>
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<tr>
<td>• Increased government budget (%)</td>
<td>Includes the expansion of project activities by government; absorption of project staff and/or staff functions by the public system; and increased public funding or staffing resulting from PVO/NGO efforts.</td>
</tr>
<tr>
<td>• Increase in government staff for essential services (microscopy, DOT, supervision, monitoring)</td>
<td></td>
</tr>
<tr>
<td>• Increase in local PVO and community groups supporting TB</td>
<td></td>
</tr>
<tr>
<td><strong>Coverage at district level:</strong></td>
<td></td>
</tr>
<tr>
<td>• Number of health facilities with DOTS services (^1) / total number of health facilities</td>
<td>At least for public health facilities, but may include NGO and private sector facilities.</td>
</tr>
<tr>
<td>• Population by TB microscopy unit and per microscopy reader</td>
<td>One microscopy laboratory (one microscopist) per 100,000–200,000 inhabitants (light microscopy), depending of the workload and population density.</td>
</tr>
<tr>
<td><strong>Diagnosis and case detection</strong></td>
<td></td>
</tr>
<tr>
<td>• Notification</td>
<td>Trend of total and pulmonary smear-positive TB cases reported. Quarterly and annual.</td>
</tr>
<tr>
<td></td>
<td><strong>(^1) Providing TB diagnosis and/or treatment according to national norms.</strong></td>
</tr>
</tbody>
</table>

| Trend of total and pulmonary smear-positive TB cases reported. Quarterly and annual. There is no target. In a good program the smear-positive cases reported should initially increase and then decrease, due to decrease of TB prevalence in the community. |
- **Number of TB suspects examined by sputum microscopy**

  This is a *rapid indicator* of case detection. It is the number of persons examined for diagnosis by microscopy obtained from the laboratory register or, in facilities without a laboratory, from a suspect register. About 5% of the adults attending outpatient facilities for any reason have cough of over 2 weeks.

  It is complemented by the positivity rate (% of persons examined that have positive sputum smears). The positivity is usually 5–15% in general facilities and ~20% in specialized TB or respiratory clinics, it should decrease with improved patient access and outpatient care, and with community mobilization.

  The trend is very useful for measuring impact in small areas and short-term projects. The number should increase as a result of community participation, ACSM, and involvement of private practitioners.

  A more complete indicator at health facility level is the % of adult outpatients with cough >2 weeks and % examined by sputum microscopy. Operational research (rapid and not costly) can give the real prevalence in adult outpatients.

---

### Diagnostic quality

<table>
<thead>
<tr>
<th>Diagnostic quality</th>
<th>Number of smear-positive cases/Total pulmonary TB</th>
<th>Indicator of medical criteria. Over 50% of all cases and over two-thirds of pulmonary TB should be sputum smear-positive</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Proportion of TB cases with bacteriological confirmation</td>
<td>Number of smear-positive cases /Total TB cases.</td>
<td>For staff and laboratory planning and to ensure quality. The optimum is more than 2 and less than 20 smears read per day per microscopist (light microscopy).</td>
</tr>
<tr>
<td>• Number of smears done and average per microscopist per day</td>
<td>For staff and laboratory planning and to ensure quality. The optimum is more than 2 and less than 20 smears read per day per microscopist (light microscopy).</td>
<td>It can be obtained monthly or annually, directly from the laboratory register.</td>
</tr>
<tr>
<td>• Proportion of major errors $^2$ in TB microscopy</td>
<td>Based on re-reading of a sample of slides by a reference laboratory. There are various valid systems to select the sample. Less than 1% error is desirable.</td>
<td>The existence of any system of quality assurance (QA) is essential to ensure microscopy quality.</td>
</tr>
</tbody>
</table>

---

$^2$ Reporting negative for positive or vice-versa.
### Treatment quality

- **Cohort analysis of treatment outcomes, mainly for new smear positive pulmonary cases**
  - % of cases cured and % of treatment completed (added is the % of treatment success)
  - % failure, % default, % death, % transfers.
  - Quarterly or annual. The same analysis can be done for re-treatments (defaults, relapses and failures in separate); and for chronic and MDR.

- **Sputum conversion rate**
  - It is a *rapid indicator*—a surrogate for the success rate. Proportion of new smear-positive patients that were examined by sputum microscopy and showed smear negativity 2 or 3 months after starting treatment.

### Knowledge, attitudes, and practices

- **% change in KAP**
- % of patients that participated in the selection of their DOT provider and place of treatment (staff practices)
- Number of patients referred for treatment by private providers to the public health facilities (trend)
- % of patients on DOT

- **Repeat KAP or focus group studies:**
  - Population knowledge that long duration cough may be TB, that TB is curable, and that treatment is free of charge in public facilities or interventions.
  - TB patient knowledge about treatment duration.
  - DOT is defined as direct observation of drug intake by another person (in a health facility, by health staff, by community health workers or volunteers, or by family members).

### TB/HIV

- % of TB patients tested for HIV
- % of new TB patients positive for HIV
- % of TB/HIV patients on CPT
- Number of TB/HIV patients on ART
- % deaths during TB treatment

For areas where the prevalence of HIV in the community and in TB patients is high, the recommended policy is to offer HIV testing to all TB patients, to treat all HIV-infected TB patients with CPT, and to provide ART as per national guidelines.

They measure the capacity to treat HIV infection in TB patients, and to reduce deaths during TB treatment.
# ANNEX 11: USE OF SELECTED INDICATORS BY USAID GRANT-SUPPORTED TB PROJECTS *

<table>
<thead>
<tr>
<th>INDICATOR</th>
<th>INDONESIA</th>
<th>PHILIPPINES</th>
<th>S. AFRICA</th>
<th>UKRAINE</th>
<th>ROMANIA</th>
<th>MEXICO</th>
<th>MALAWI</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. &gt; public TB budget/adoption of DOTS</td>
<td></td>
<td>B</td>
<td>T</td>
<td>M</td>
<td>B</td>
<td>T</td>
<td>M</td>
</tr>
<tr>
<td>2. &gt; public TB staff</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td>3. &gt; local PVOs/community groups</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td>4. DOTS coverage/expansion</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td>5. Population per microscopy unit</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. Case detection rate</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td>7. Case notification</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td>8. Examination of TB suspects (#, trend)</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td>9. Positivity of sputum microscopy</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>N</td>
<td>N</td>
<td>Y</td>
</tr>
<tr>
<td>10. % of TB cases smear positive</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td>11. # of smears per reader per day</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>12. Quality of microscopy (QA, % error)</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td>13. % patients on DOT</td>
<td>Y</td>
<td>N</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td>14. Treatment outcomes</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td>15. Sputum conversion rate</td>
<td>Y</td>
<td>O</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td>16. KAP population</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td>17. KAP patients</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>18. KAP staff</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>19. Number of referrals by PP</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>20. % TB patients HIV tested, % (+)</td>
<td>Y</td>
<td>O</td>
<td>Y</td>
<td>O</td>
<td>Y</td>
<td>O</td>
<td>Y</td>
</tr>
<tr>
<td>21. % of TB/HIV patients on CPT</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

* TB CHILD SURVIVAL HEALTH GRANTS PROGRAM EVALUATION ANNEXES 43
<table>
<thead>
<tr>
<th>INDICATOR</th>
<th>INDONESIA</th>
<th>PHILIPPINES</th>
<th>S. AFRICA</th>
<th>UKRAINE</th>
<th>ROMANIA</th>
<th>MEXICO</th>
<th>MALAWI</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>B</td>
<td>T</td>
<td>M</td>
<td>B</td>
<td>T</td>
<td>M</td>
<td>B</td>
</tr>
<tr>
<td>22. Number of TB/HIV patients on ARV</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>23. % deaths during TB treatment</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

B: Baseline in DIP  
T: Target in DIP  
M: Monitoring data in progress reports  
Y: Yes; N: Not used; O: Mentioned in Objectives, without specific measurements; (–) Progress not reported or not found  

* Other indicators were also used, depending on project objectives. The table was compiled by the review team and may contain inaccuracies.
ANNEX 12: SUGGESTED NEXT STEPS FOR THE USAID TB GRANTS PORTFOLIO

1. Clearly define the objectives and priorities of the portfolio, e.g., to support NGOs/PVOs’ efforts to:
   a. Improve delivery of TB services at peripheral level
   b. Develop strategies and sustainable models of community participation to improve patient access to TB care
   c. Address special issues (involvement of private practitioners, TB/HIV, operational research)

2. Revise the guidelines for project preparation and DIP, to:
   a. Simplify them and make them more TB-specific
   b. Include appropriate and measurable indicators that can be monitored during the life of the project by the health facility and project staff
   c. Focus on the essential interventions and monitoring
   d. Clearly differentiate TB-specific requirements, different from CS (e.g., focus of interventions, innovation in methods to apply known strategies)

3. Revise the level of USAID support to CS TB grants:
   a. Maintain the duration (4 or 5 years)
   b. Increase the amount for each project ($2 million to $3 million)
   c. Increase the number of projects supported per year, to accelerate experience and involvement of more PVOs/NGOs, and to form a pool of experienced staff
   d. Strengthen the capacity of CSTS and CORE and involve other institutions (TBCAP, WHO, CDC) to provide technical and managerial support

4. Review the procedures for monitoring, reporting and mid- and end-term evaluation:
   a. Reduce the length of the reports (table format) and reporting of data not used for action
   b. Standardize the methods of evaluation, with evaluators selected by USAID or a contracted agency (e.g., TBCAP) and not involved in the design of or technical assistance to the project evaluated
   c. Convene the interested parties (e.g., through CORE) to discuss the proposed changes and promote additional applications

5. Increase funding to the category so a larger number of proposals can be supported each year, at a level of $2–3 million for a period of 4–5 years.

6. Consider different mechanisms than the grant program for support to NTPs in special situations, such as countries where the NTP is unable to provide adequate services to community initiatives; where the political environment would interfere with the work of the NGOs/PVOs (e.g., no NTP management) or where external funding overwhelms the capacity for rational utilization.
ANNEX 13: SCOPE OF WORK

Global Health Technical Assistance Project (GH Tech)
Contract No. GHS-I-00-05-00005-00
SCOPE OF WORK (Revised GH Tech: 01-29-08)

I. USAID Child Survival Health Grants Program TB Portfolio Evaluation

Activity: Conduct an evaluation of the TB category of the Child Survival Health Grants Program (CSHGP) to determine the overall effectiveness of the category.

Contract: Global Health Technical Assistance Project (GH Tech), Task Order No. 01

II. PERFORMANCE PERIOD

Proposed dates: mid - February – early April, 2008

III. FUNDING SOURCE

USAID/GH/HIDN

IV. OBJECTIVES AND PURPOSE OF THE ASSIGNMENT

The primary objective of this evaluation is to determine the performance of the TB CSHGP grants and whether they are contributing to the overall Bureau of Global Health CSHGP program and TB Element objectives as well as provide recommendations for future direction of the category. The performance review should evaluate successes, constraints, failures, impact, and lessons learned. The team will look retrospectively and introspectively at the category as a whole and the eight TB grants to evaluate the main objectives as outlined in section VI. The results will be used to measure progress and results, gather successes and lessons learned, and inform USAID of recommendations for future design.

V. BACKGROUND

The Child Survival and Health Grants Program (CSHGP) is housed in the Bureau for Global Health’s Office of Health, Infectious Diseases and Nutrition (GH/HIDN). GH/HIDN strongly supports the role and contribution that PVOs/NGOs and their local partners play in improving the quality of life of some of the most disadvantaged populations in developing countries. The purpose of this program is to contribute to sustained improvements in child survival and health outcomes by supporting the work of PVOs/NGOs and their in-country partners. This work is aimed at reducing infant, child, maternal and infectious disease-related morbidity and mortality in developing countries. Sustained health improvements are achieved through capacity building of communities and local organizations and improved health systems and policies. In addition, the program seeks opportunities to scale up successful strategies to the national level and to contribute to the global capacity and leadership for child survival and health through the dissemination of best practices. In order to reach vulnerable populations, grantees work in a variety of settings from district to national level, and partner with local groups including community-based organizations, local NGOs and district and national health authorities.

The CSHGP created a TB category to address the gap in community-based TB program, expand the partners actively involved in TB and specifically build capacity in US-based PVO/NGOs. This program and the global TB strategy have developed over the past 5 years and it will be important to evaluate the partners based on the guidance and direction at the time the grants were awarded. This category focuses on PVOs and NGOs who have an established background in community-oriented programming. One to two $1,500,000 grants are awarded each year in the
TB category. Grantees are selected based on their ability to utilize their existing expertise and comparative advantage to implement a TB program.

This evaluation will cover the portfolio of TB grants awarded through the CHSGP since the introduction of this category. This includes the following grants:

South Africa* – Medical Care Development Inc. (MCDI) (2004 – 2008)
Malawi – Project Hope (2006 – 2011)

* Final site visits selected by the evaluation team members and USAID 1-28-08

The objectives for the TB programs within the CSHGP include fully supporting the World Health Organization’s Stop TB Strategy as the approach for TB prevention and control. Each CSHGP TB project programs according to at least one of the sub-elements of USAID’s TB Element, which is in-line with the Stop TB Strategy: DOTS Expansion and Enhancement, TB/HIV, MDR TB, TB Care and Support, and Host Country Strategic Information Capacity. In addition, projects should have a clearly defined role in their coordination with the National TB Program (NTP) and with other actors in addressing these key TB elements. Programs should also play a strategic role in the TB implementation by utilizing their comparative advantage and relevant experience.

There are two support mechanisms for all grants through this program including the CORE Group and CSTS. The CORE Group is a network organization of 47 NGO members collectively working in over 180 countries. CORE’s mission is to strengthen local capacity on a global scale to measurably improve the health and well-being of children and women in developing countries through collaborative NGO action and learning. NGOs participate in CORE’s eight working groups in the areas of IMCI, Malaria, Monitoring and Evaluation, Nutrition, Safe Motherhood and Reproductive Health, Social and Behavioral Change, HIV/AIDS, and Tuberculosis. USAID supports the CORE Group and in particular the various working groups. The TB working group provides a lessons sharing forum for the grantees as well as other CORE group members interested in learning more about community-based TB programming.

In addition, the CSHGP provides resources to ORC/Macro International under the Child Survival and Technical Support Plus Project (CSTS+). CSTS+ offers an array of services to CSHGP and its partners, including grantees, potential grantees and new partners. CSTS+ activities seek to enhance the contributions of grantees and their local partners to carry out effective, quality child and maternal health and infectious disease programs. CSTS+ gives technical support to its partners through a team with expertise in monitoring and evaluation, technical child survival and health interventions, organizational development, family planning/reproductive health, and health management information systems. As the team evaluates the introduction of new partners to TB and building the capacity of these partners, it will be important to assess the role these two partners.

VI. SCOPE OF WORK

The team will gather both qualitative and quantitative data based on the following objectives.

Overarching issues
- Determine if the grants are filling a gap in community-based TB by utilizing their existing expertise and comparative advantage.
- Determine if the category is implementing technically sound grants
- Determine if the category is actively involving new partners to community-based TB.
- Determine if USAID, through the CSHGP, is building the partners’ capacity in TB.
- Describe the main successes and lessons learned for each of the grants.
- Identify and describe factors affecting achievement of the program objectives and outcomes.
- Discuss contributing factors and barriers to achievement for objectives that were not fully achieved.
- Discuss any special outcomes, successes, constraints or circumstances observed.
- Identify recommendations for the category in the future.

Technical
- Evaluate the quality of technical expertise being implemented by the grantees.
- Evaluate to what extent the grants have met the technical and programmatic objectives.
- Determine if the grants are utilizing their comparative advantage to meet a gap or need for TB within the community/country.
- Evaluate to what extent the grants have contributed to the overall capacity building of community-based TB programs.

Management/Administrative
- Determine the cost-effectiveness, efficiency and timeliness of the management and administration of the projects.
- Determine the possible scale-up of the activities, or introduction of new activities, both administratively and technically.
- Determine if USAID’s oversight and management of the grants have aided or hindered their ability to accomplish results.
- Determine if the CORE group and CSTS have played a role in the grantees ability to build capacity and be successful in implementation.
- Evaluate the sustainability of the projects including determining whether the grants are effectively transferring organizational development skills to local partners.

Coordination:
- Determine how the grantees have collaborated with other partners working in the field of community-based TB control including USAID-funded cooperating agencies, stakeholders, and other organizations and groups.
- Determine how the grantees have collaborated and coordinated with the host country government at all levels.
- Evaluate how the grants relate to and work with the district, national and global TB efforts.
- Evaluate to what extent the grants have coordinated with and played a role in the global response to community-based TB, and the impact of the grants within the community and globally.

VII. METHODOLOGY

The evaluators should consider a range of possible methods and approaches for collecting and analyzing the information which is required to assess the evaluation objectives. Data collection methodologies will be discussed with, and approved by the USAID CSHGP TB team prior to the start of the assessment.

Document Review
- USAID/W will provide the team with background documents such as proposals, DIPS, mid-term and final evaluations. All team members will review these documents in preparation for the initial team planning meeting.

Team Planning Meeting
- A two-day team planning meeting will be held in Washington, DC before the evaluation begins. This meeting will allow USAID to present the team with the purpose, expectations, and agenda of the assignment. In addition, the team will:
  - clarify team members’ roles and responsibilities,
- establish a team atmosphere, share individual working styles, and agree on procedures for resolving differences of opinion,
- review and finalize the assignment timeline and share with USAID,
- develop data collection methods, instruments, tools and guidelines,
- review and clarify any logistical and administrative procedures for the assignment,
- develop a preliminary draft outline of the team’s report, and
- assign drafting responsibilities for the final report.

Interviews and Site Visits
- Conduct a thorough review of all 8 TB grants including conducting interviews and site visits. From this information the team will analyze their findings for the grants individually and category as a whole.
- The team will conduct phone and site visit interviews of all beneficiaries and partners in country at the district and national level as well as headquarters staff.
- With the assistance of GH Tech, the team will make all logistical preparations prior to in-country visits.
- The criteria for choosing the countries for site visits will be based on geographic diversity, representation of both established/completed and newer projects, and will cover projects with both a TB and TB/HIV emphasis. USAID will prepare a draft matrix that identifies pros/cons and other criteria to guide the team site visits.

VIII. TEAM COMPOSITION, SKILLS AND LEVEL OF EFFORT

Team Members:

Team Leader: The team leader will provide overall vision and guidance to the team. S/he will be responsible for the overall organization of the work as well as the overarching management and administration aspects of the SOW. S/he will take the lead in developing the tools and methods for the data collection. The team leader will facilitate preparation of the executive summary and the full report among the team members; assure that the draft and final products are prepared in accordance with the scope of work; and that the required revisions for the final report are incorporated.

The team leader should be an expert in international public health with a good understanding of TB and the current global strategy to combat it. This person should also have a strong background and familiarity with PVOs and community-based health programs. They should be familiar with USAID technical approaches and the global TB strategy.

Senior TB Specialist: The senior TB specialist will provide overall TB technical support and guidance. S/he will be responsible for the technical aspect of the SOW. This person should be an expert in the field of international TB control with an excellent understanding of the current global strategy. S/he should also have a good understanding of community – based TB programming. A good understanding of USAID is desired.

Coordination: This person will be a representative from the USAID TB Team. She will be responsible for the coordination aspect of the SOW. She will have knowledge of the existing players in global TB control as well as have a good understanding of how the CSHGP program, USAID/W TB Team and the grantees operate.

All team members will:
- Participate in the team planning meeting and all interviews and site visits
- Foster productive team working relationships
- Facilitate the preparation of all deliverables
- Maintain records and notes of all interviews and meetings
Level of Effort for each team member:

<table>
<thead>
<tr>
<th>Activity</th>
<th>Who</th>
<th>Estimated LOE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Background reading</td>
<td>Team Leader, Senior TB Specialist</td>
<td>3</td>
</tr>
<tr>
<td>Travel to DC</td>
<td>Senior TB Specialist</td>
<td>1</td>
</tr>
<tr>
<td>Team Planning Meeting – 2 days</td>
<td>Team Leader, Senior TB Specialist, Team Planning Meeting Facilitator (including 1 day prep)</td>
<td>2, 2, 3</td>
</tr>
<tr>
<td>Interviews/Meetings (DC)</td>
<td>Team Leader, Senior TB Specialist</td>
<td>3, 3</td>
</tr>
<tr>
<td>Travel to Selected Countries</td>
<td>Team Leader, Senior TB Specialist</td>
<td>2, 2</td>
</tr>
<tr>
<td>Field Work</td>
<td>Team Leader, Senior TB Specialist</td>
<td>16, 16</td>
</tr>
<tr>
<td>Travel to DC</td>
<td>Team Leader, Senior TB Specialist</td>
<td>1, 1</td>
</tr>
<tr>
<td>Interviews, Meetings &amp; Report Drafting</td>
<td>Team Leader, Senior TB Specialist</td>
<td>9, 9</td>
</tr>
<tr>
<td>Debriefings with USAID &amp; Grantees</td>
<td>Team Leader, Senior TB Specialist</td>
<td>1, 1</td>
</tr>
<tr>
<td>Return Travel</td>
<td>Senior TB Specialist</td>
<td>1</td>
</tr>
<tr>
<td>Report Finalization</td>
<td>Team Leader</td>
<td>3</td>
</tr>
<tr>
<td><strong>TOTAL LOES</strong></td>
<td>Team Planning Facilitator, Team Leader, Senior TB Specialist</td>
<td>3 day est., 40 days est., 39 days est.</td>
</tr>
</tbody>
</table>

A 6-day work week is authorized when the team is working in country.

**IX. LOGISTICS**

GH Tech will be responsible for the following technical and logistical support:
- Identify and recruit the team leader and technical specialist
- Arrange the schedule of interviews with grantees and partners
- Provide all in-country logistics.
- Provide administrative and management support to the team while on assignment
- Provide support and editing services for the preparation of the final versions of the deliverables

**X. DELIVERABLES AND PRODUCTS**

**Team Planning Meeting**
All team members will participate in a two-day team planning meeting in Washington at the beginning of the project as stated in section VII.

**Interviews and Site Visits**
Team members will conduct interviews and site visits in accordance with the guidelines set forth in section VII and the tools and methods established during the team planning meeting. The mission in each visited country will be contacted in advance and briefing/debriefing scheduled as requested.
USAID Debrief
The team will present the major findings to a USAID/W audience through a PowerPoint presentation at the conclusion of the evaluation. This debrief will include a discussion of past achievements and issues, as well as any recommendations the team has for future programming.

Stakeholder/Partner Debrief
The team will present the major findings to USAID partners and stakeholders (as appropriate) through a PowerPoint presentation at the conclusion of the evaluation and following the USAID debrief. This presentation will include only findings on past accomplishments and activities, with no recommendations for future programming.

Draft Executive Summary, Full Report
A complete draft report, not to exceed 30 pages (not including annexes) and which will include a clear executive summary will be submitted to USAID/W no later than two weeks after the final country visit. This report will include a summary of findings including feedback on performance and implementation, recommendations, analysis of the grants, and recommendations for improved implementation. USAID/W will have two weeks to provide comments and suggestions to the evaluation team which will be addressed in the final report.

After comments have been provided to the team, the final executive summary and full report will be prepared incorporating the comments received from the review of the draft. The team will submit the final but unedited report for USAID approval no later than one week after USAID has provided comments on the draft. USAID will share the final but unedited report with the partners/grantees to give them an opportunity to review and make comments. After the final but unedited draft report has been reviewed by USAID and the partners/grantees, GH Tech will have the document edited and formatted, and will provide the final report to USAID; each mission will receive a copy of their country study and a copy of the final report.

XI. RELATIONSHIPS AND RESPONSIBILITIES

GH Tech: A program manager will identify and recruit team members and will manage and support the team during the assignment period. Editing services will be provided by GH Tech for the final version of the executive summary and full report. Logistical support will be described as in section IX.

Julie Klement, Director
Linda Banda, Program Manager
GH Tech

USAID:
Points of Contact:

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For all budgetary, staffing, and technical matters:
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XIII. COST ESTIMATE - TBD

XIV. REFERENCES

Core Group:
http://www.coregroup.org/start.cfm

Tuberculosis CSHGP Technical Reference Materials (TRMs):
http://www.childsurvival.com/documents/trms/tech/Tuberculosis%202007.doc

WHO – TB
http://www.who.int/tb/en/

Stop TB Partnership
www.stoptb.org

USAID – TB

CSTS
http://www.childsurvival.com/
For more information, please visit http://www.ghtechproject.com/resources/