International HIV/AIDS Alliance

Together to end AIDS

PATH

Community-based TB and HIV integration

WORKBOOK

for the Good Practice Guide

Abbreviations

ACSM	Advocacy, communication, and social mobilisation
AIDS	Acquired immunodeficiency syndrome
ART	Antiretroviral therapy
CBO	Community-based organisation
CCM	Country coordinating mechanism
CPT	Co-trimoxazole preventive therapy
CSO	Civil society organisation
DFID	Department for International Development (UK)
DOT	Directly observed therapy
FDCs	Fixed-dose combination drugs
HCT	HIV counselling and testing
HIV	Human immunodeficiency virus
IEC	Information, education, and communication
IPT	Isoniazid preventive therapy
MDR-TB	Multidrug-resistant tuberculosis
MOU	Memorandum of understanding
NGOs	Non-governmental organisations
NTP	National tuberculosis control programme
PATH	Program for Appropriate Technology in Health
PWUDs	People who use drugs
STIs	Sexually transmitted infections
TB	Tuberculosis
UNAIDS	Joint United Nations Programme on HIV/AIDS
USAID	United States Agency for International Development
XDR-TB	Extensively drug-resistant tuberculosis

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Good practice guide series: This workbook accompanies the International HIV/AIDS Alliance's Good Practice Guide on Community-based TB and HIV Integration, which is one in a series of good practice guides produced by the International HIV/AIDS Alliance in a range of technical areas, including: HIV prevention; Human rights and GIPA; family centred programming for children;

Sexual and reproductive health and HIV integration; and HIV and drug use. To download Alliance publications, please visit www.aidsalliance.org/publication-search.aspx.

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Section 1: How to use this workbook

This workbook accompanies the International HIV/AIDS Alliance's **Good Practice Guide on Community-based TB and HIV Integration**.

Specifically this workbook accompanies the actions described in Chapter 3 of the guide, titled "How to integrate TB activities into your HIV work." The purpose of the workbook is to support you in completing each action step described in the guide for your own organisation. By the end of the workbook, you should have all the elements of an organisational TB/HIV integration plan together for your own group.

The workbook sections and tools are matched to the guide as follows:

Guide section	Workbook section
TB guide Section 3 Introduction	Workbook section 1: How to use this workbook
Action 1: Understand TB, TB/HIV, and the global context	None
Action 2: Know the TB situation in your country	Workbook section 2 Tool 2.1: Organisation of TB service delivery Tool 2.2: Epidemiology of TB Tool 2.3: National policies and guidelines Tool 2.4: National TB objectives, targets and activities Tool 2.5: Successes and challenges Tool 2.6: The Cough-to-Cure Pathway Tool 2.7: Logical linkages between challenges and activities Tool 2.8: Advocacy planning Tool 2.9: Communication planning Tool 2.10: Social mobilisation planning Tool 2.11: Service delivery planning
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Section 1: How to use this workbook

Guide section	Workbook section
Action 4: Create or strengthen appropriate partnerships	Workbook section 4 Tool 4.1: Partner identification and selection Tool 4.2: Partnership plan checklist and sample memorandum of understanding
Action 5: Plan, implement and measure the success of your activities	Workbook section 5 Tool 5.1: Planning and monitoring and evaluation checklist Tool 5.2: Work plan template Tool 5.3: Sample TB screening tools Tool 5.4: Sample referral slips Tool 5.5: Monitoring template Tool 5.6: Evaluation template Tool 5.7: Sample results reporting forms
Action 6: Fund your activities	Workbook Section 6 Tool 6.1: Existing and potential donors Tool 6.2: Fundraising plan and timeline Tool 6.3: Fundraising application checklist

Throughout this workbook, we have tried to provide you with examples to help you understand how to use the tools provided. Following the examples, there are blank templates to use for your own work. You can do so electronically, or you can print them out and work on hard copies.

We have tried to include as many tools as possible that may be useful to your organisation. You may choose to use all of them, or you may choose only specific ones that fit your situation best. You may already have other ways you complete the steps described in the guide. If they are working for you, there is no need to change the way you do things. There is no one right way to use these tools. It is up to you to decide what is best for you. We suggest you review them as you go through the sections of the guide, and decide how you would like to use them. If you do choose to use tools for a particular action step, we recommend you complete the tools before moving on to the next section of the guide.

Section 1: How to use this workbook

As you use these tools, you may find that you would like to adapt them for your own purposes, or you need to change them in some way to be easier for you to use. That is welcomed. These are for your benefit, so feel free to modify them in whatever way you please. The workbook is available to you in Word format to make it easy for you to enter information directly into the documents, and to change the templates as needed.

We hope this workbook helps your organisation build a strong TB/HIV integration plan and contributes to the success of your important work. We welcome any feedback or suggestions on the guide or the workbook. You may submit feedback to:

Dr Gitau Mburu
Senior Advisor, International HIV/AIDS Alliance
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Section 2

Use this section of the workbook together with the corresponding Action in the Guide, *Action 2: Know the TB situation in your country*

Tool 2.1: Organisation of TB service delivery

Tool 2.2: Epidemiology of TB

Tool 2.3: National policies and guidelines

Tool 2.4: National TB objectives, targets and activities

Tool 2.5: Successes and challenges

Tool 2.6: The Cough-to-Cure Pathway

Tool 2.7: Logical linkages between challenges and activities

Tool 2.8: Advocacy planning

Tool 2.9: Communication planning

Tool 2.10: Social mobilisation planning

Tool 2.11: Service delivery planning

Tool 2.1:
Organisation of TB service delivery

This tool can help you understand how your national TB control programme is organised and who your national TB programme (NTP) points of contact are at national and local levels.

Step 1: Use this space to draw a picture of how the programme is organised from the central level to the local level, starting with the ministry of health and ending with the smallest unit of service where people with TB are treated (such as the primary health centre or health post, or in the community). Include laboratory services as well. If your programme has developed a graphic already, you can copy it and paste it here.

What are possible issues?

Major challenges related to programme organisation may include:

- TB services may not be delivered at the same level or in the same location as HIV services. This increases the burden on clients in terms of time, inconvenience and cost of transportation, which in turn increases the likelihood that they will not go for services.
- The TB programme (NTP) may be understaffed at some or all levels due to a lack of adequate funding, or poor distribution of the existing resources. This may have an impact on the speed, quality or availability of services.
- The TB and HIV control programmes may not be well coordinated, leading to gaps in care or duplication of effort.

These are only examples of some common challenges. Your programme may function well, or it may face different problems.

Tool 2.1:
Organisation of TB service delivery

Questions about the organisation of TB services (write answers on this sheet)

National TB programme organisation

1. How many positions does the NTP have in its central unit? Are they all filled?
2. Does the NTP have a line in the national or ministry of health budget to fund its activities? What percentage of the TB budget is covered by the national government?
3. Does the TB programme have grants from the Global Fund to Fight AIDS, Tuberculosis and Malaria (Global Fund) or other donor money for TB or TB/HIV? What percentage of the TB budget is covered by outside donors?
4. Where are national-level data on TB kept, and is it possible to access that information?
5. When does the NTP plan its work for the following year? Are civil society organisations (CSOs) invited to participate?
6. When does the NTP hold review meetings? Are CSOs invited to participate?
7. Do the NTP and national AIDS control programme (NACP) have a formal coordinating mechanism? Are CSOs invited to participate? When are meetings held?
8. For what time period is the current national TB strategy valid? When will the NTP start planning the next strategy

Service delivery

1. Where does someone with TB symptoms go for diagnosis of TB?
2. Where does someone with TB go for HIV counselling and testing? HIV treatment?
3. Where does a person with TB go for treatment?
4. If drug-resistance is suspected, where does the programme send the sputum specimen for testing
5. If a person must be treated for drug-resistant TB, where is the treatment given?
6. Does the TB programme provide any incentives and enablers to support people on treatment, such as transportation vouchers or food packages?
7. Does the NTP work with CSOs to find and deliver care to people with TB? Does the NTP provide any budget for CSOs?
8. Are there any major issues you know about that affect programme performance, such as drug stockouts, lack of human resources, lack of laboratory supplies, or others?

Tool 2.1:
Organisation of TB service delivery

Step 2: Use the template to fill in the names and contact information for key people working within the NTP at the national level and at the other levels where you will interact with the programme. Contacts may include the NTP manager and lower-level managers (provincial and district levels); data managers or monitoring and evaluation (M&E) managers; focal people for TB/HIV, community-based care, advocacy, communication and social mobilisation (ACSM), or CSOs if they exist in your programme; and nurse supervisors or outreach workers at the local level. You can add or subtract rows or change this table to fit your own needs. This is an example – a blank template is provided on the following pages.

Example of National TB programme contact list

Location	Position	Name	Phone	**Email**	Notes
NTP Central Unit	NTP manager	Dr Rose Mbwala	075-22-3467	drrose@ntp.org	Prefers meetings on Thursdays
	TB/HIV focal point	Mr Simon Shrestha	075-21-5678	mrsimon@ntp.org	Newly appointed
	M&E/data manager	Mrs Hsieh Wang	075-22-9876	mrsevelyn@ntp.org	Updated data available on the 15th of the month
Western Province Unit	Provincial TB manager	Dr D. Phiri	087-32-0987	phiri@ntp.org	On medical leave until June 2013
Western Province Lungta District Unit	District medical officer	Dr Sara Farai	087-34-3847	sillons@ntp.org	
Lungta District Yiasu Health Centre	DOTS nurse	Mrs Hassan Tembe	087-34-5123	none	
Lungta District Yiasu Health Centre	Community health worker	Mr John Bikindu	087-34-1122	none	

Tool 2.1:
Organisation of TB service delivery

National TB programme contact list

Location	Position	Name	Phone	Email	Notes

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Tool 2.1:
Organisation of TB service delivery

Location	Position	Name	Phone	Email	Notes

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Tool 2.2: Epidemiology of TB

Use this tool to review the basic information about the burden of TB in your country and the area where you work. First, we will go through an example of what you can find in the World Health Organization (WHO) *Global Tuberculosis Report* and other WHO resources, which summarise data for each country, and then you can fill out a template for your own country.

Imagine you have a meeting with your country's NTP to discuss priorities for community-based support. You will need to be well prepared for the meeting! To do so, you need to be familiar with the TB situation in your country and to understand what the numbers mean.

The first place to go to find this information will be the WHO *Tuberculosis country profiles* website available at: www.who.int/tb/country/data/profiles/en/index.html. This provides the most up-to-date data available for every country in the world that reports on TB. (If you live in one of the 22 high-burden countries for TB, you can also find a similar one-page summary of key TB data for your country in one of the annexes of the WHO *Global tuberculosis report*.) An example from Kenya appears on the next page. We discuss what each of the key sections circled in red means on the following pages. The discussion is quite detailed, and so you may decide to use this only as a reference when reviewing your own country data. Regardless of how you approach it, this is essential information for you to understand as a CSO working on TB.

***TIP**: Remember that data available in the global reports lag behind real time. This is because it takes a long time to treat TB and report final treatment outcomes for every person diagnosed during a calendar year. So for many indicators used on the one-page summary, they will be referring to data for people with TB who were diagnosed one or two years ago. You may be able to get more recent data directly from the NTP, but the data in the global reports are easily accessible to everyone.*

Key resources

Reviewing TB data can be confusing, even for people working in the NTP. It may be useful to review data as a group, and to have some references handy that provide definitions of TB terms if you need reminders. This reference includes definitions and discussions about TB indicators:

World Health Organization (2004), *Compendium of indicators for monitoring and evaluating national tuberculosis programs.* Available at: www.who.int/tb/publications/tb_compendium_of_indicators/en/index.html

If you are working on Global Fund-related HIV and TB projects, you will also want to be familiar with its monitoring and evaluation guidance. You can also access the Global Fund Monitoring and Evaluation Toolkit at: http://www.theglobalfund.org/en/me/documents/toolkit/

Tool 2.2: Epidemiology of TB

Kenya

World Health Organization

Tuberculosis profile

| High TB burden | High HIV burden |

1 2 3 4 5 6 7

Population 2011 — **42 million**

Estimates of TB burden * 2011	Number (thousands)	Rate (per 100 000 population)
Mortality (excludes HIV+TB)	9.2 (4.7–15)	22 (11–36)
Prevalence (includes HIV+TB)	120 (63–200)	291 (152–475)
Incidence (includes HIV+TB)	120 (110–120)	288 (276–300)
Incidence (HIV+TB only)	47 (45–49)	113 (109–118)
Case detection, all forms (%)	81 (78–85)	

TB case notifications 2011

New cases		(%)	Retreatment cases		(%)
Smear-positive	37 085	(39)	Relapse	3 356	(34)
Smear-negative	30 394	(32)	Treatment after failure	263	(3)
Smear-unknown / not done	9 416	(10)	Treatment after default		
Extrapulmonary	17 069	(18)	Other	6 398	(64)
Other	0	(0)			
Total new	**93 964**		**Total retreatment**	**10 017**	
Other (history unknown)	0				
Total new and relapse	**97 320**		**Total cases notified**	**103 981**	

New cases	Smear-positive	Smear-negative/ unknown/ not done	Extrapulmonary
M:F ratio	1.6	1.2	1.2
Age < 15	985	2 008	2 795

Laboratories	2011
Smear (per 100 000 population)	3.8
Culture (per 5 million population)	0.7
Drug susceptibility testing (per 5 million population)	0.1
Is second-line drug susceptibility testing available?	Yes, outside country
Is there a national reference laboratory?	Yes

Treatment success rate 2010 (%)

New smear-positive and/or culture-positive	87
New smear-negative/extrapulmonary	85
Retreatment	79

Is rifampicin used throughout treatment for new patients? Yes

TB/HIV 2011	Number	(%)
TB patients with known HIV status	97 136	(93)
HIV-positive TB patients	38 172	(39)
HIV-positive TB patients on co-trimoxazole preventive therapy (CPT)	37 147	(97)
HIV-positive TB patients on antiretroviral therapy (ART)	24 497	(64)
HIV-positive people screened for TB		
HIV-positive people provided with IPT		

Estimates of MDR-TB burden 2011*	New	Retreatment
% of TB cases with MDR-TB	3.1 (0.1–7.1)	10 (2.1–18)
MDR-TB cases among notified pulmonary TB cases	2 400 (77–5 500)	1 000 (210–1 800)

Reported cases of MDR-TB 2011	New	Retreatment	Total
Cases tested for MDR-TB	92 (<1%)	1 195 (12%)	1 393
Laboratory-confirmed MDR-TB cases	17	149	166
Patients started on MDR-TB treatment			156

Financing TB control	2012	2013
Total budget (US$ millions)	53	51
Available funding (US$ millions)	21	16
% of budget funded	41	31
% available funding from domestic sources	46	55
% available funding from the Global Fund	51	23

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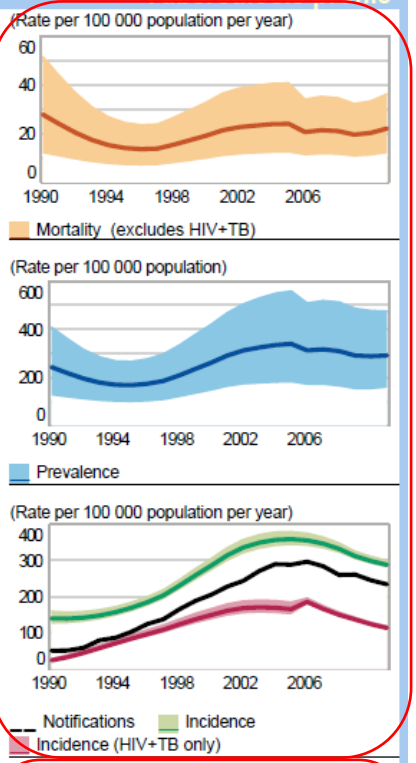

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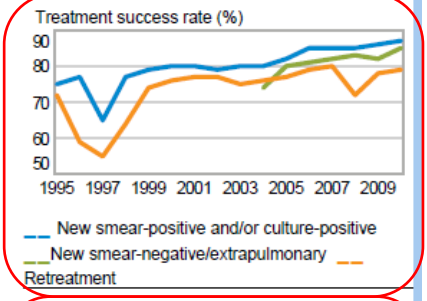

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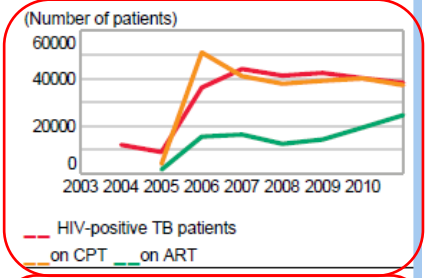

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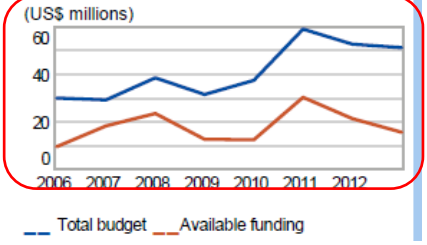

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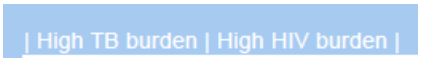
Tool 2.2:
Epidemiology of TB

How to look at the country profile

1 At the top of the page, you will find whether your country has been designated as a high-burden country for TB and/or HIV. This will give you an idea of how important TB/HIV co-infection is in determining the progress toward TB elimination in your country. In the case of Kenya, it has a high burden of both diseases, and so TB/HIV is a big concern for stopping TB.



2 The first box on the profile provides scientists' *estimates* (best guess) about how much TB exists in a country, based on prevalence survey information or mathematical models. These numbers are important for you to understand, but are not the most important numbers for you to track as they are only estimates. The first column of numbers provides the total estimated *number* for each category, and the second column provides the estimated *rate*, or number of people with TB per every 100,000 people living in the country. The numbers in parentheses represent a range of values that the real number is likely to fall within. In this example from Kenya, we see the number 9.2 in the first column for mortality. We see from the column heading that this number represents thousands of people, so we multiply 9.2 x 1,000 and understand that WHO thinks that about 9,200 people died with TB in Kenya in 2011. The TB mortality rate for Kenya in 2011 was estimated at 22 deaths per 100,000 people in the country per year.

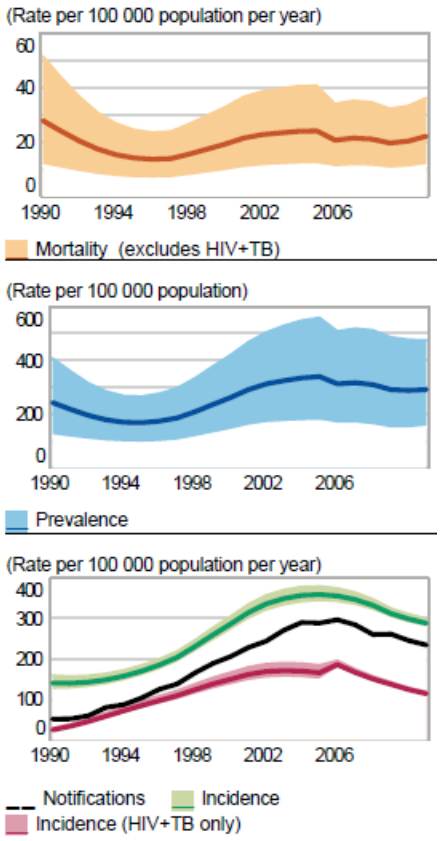
It is important to note that in the table it says that the estimate of mortality excludes people with TB/HIV. This means that anyone who was known to be HIV positive and may have died with TB is not counted in the numbers. That is because HIV-associated TB deaths are counted by the HIV programme as AIDS deaths rather than TB deaths, and WHO does not want to double-count them. What this means in a country like Kenya, with a high burden of HIV, is that the estimates for mortality are probably low – they underestimate the real TB death toll because people with HIV are not included in the mortality calculation.

Estimates of TB burden * 2011	Number (thousands)	Rate (per 100 000 population)
Mortality (excludes HIV+TB)	9.2 (4.7–15)	22 (11–36)
Prevalence (includes HIV+TB)	120 (63–200)	291 (152–475)
Incidence (includes HIV+TB)	120 (110–120)	288 (276–300)
Incidence (HIV+TB only)	47 (45–49)	113 (109–118)
Case detection, all forms (%)	81 (78–85)	

The other numbers *do* include people with TB/HIV. In this example, WHO estimates that prevalence and incidence were about the same in 2011, at 120,000 people. Prevalence counts all the people with TB that exist during the year, even if they became ill before the year started, while incidence counts only the people who became ill in the current year. The prevalence rate is 291/100,000 and incidence rate is 288/100,000. When compared with other high-burden countries, Kenya is somewhere in the low–middle in terms of the burden of disease. South Africa's estimated incidence was 993/100,000 in 2011, while Brazil's was 42/100,000.

Tool 2.2: Epidemiology of TB

It is important to know what is happening in any one year, but it is also important to know how things have changed over time. Are they getting better or worse? In the case of mortality, prevalence and incidence, we want to see these numbers going *down* over time. You can look at the graphs to the right of the table to see what has happened in Kenya since 1990.



What we see is that mortality (first graph) has gone down and then up again, and has not changed much since 2006. Prevalence (middle graph) went down and then up, and is now steady. Incidence (lower graph) is coming down slowly. All of these graphs point to the fact that Kenya is making gains in TB, but that more needs to be done to accelerate progress. To decrease mortality, we may need to advocate with the government to increase funding for new TB diagnostic tools, so people with TB can be diagnosed earlier in their disease when they have a better chance of being cured. We may also need to make sure everyone with TB receives HIV counselling and testing so that appropriate treatment can be provided as early as possible. To decrease prevalence and incidence, we may need to put more people with TB/HIV co-infection on isoniazid preventive therapy (IPT). These are just examples of how looking at the data can help you think of interventions to stop TB. To decide in real life, you will gather more information about why these numbers are not decreasing faster before you develop interventions. (This is how you will use the Cough-to-Cure Pathway and your project cycle in Tool 2.6).

3 The next table on the page is one of the most important to understand how your national TB programme is performing in finding and recording people with TB. The table below reports the actual data from Kenya's NTP for the year 2011. It is divided into new cases and retreatment cases. Here, we can see that a total of 93,964 new cases of TB were reported in Kenya in 2011. Of these, 37,085 were smear-positive, representing 39% of all new cases. Of note, we see that 10% of new cases did not have a smear result recorded – there is room for improvement, since everyone should have a result. There were 10,017 retreatment cases reported in 2011. The good news is that very few of them (3%) were people who had failed treatment. Relapses

TB case notifications 2011					
New cases		(%)	Retreatment cases		(%)
Smear-positive	37 085	(39)	Relapse	3 356	(34)
Smear-negative	30 394	(32)	Treatment after failure	263	(3)
Smear-unknown / not done	9 416	(10)	Treatment after default		
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Other	0	(0)			
Total new	**93 964**		**Total retreatment**	**10 017**	
Other (history unknown)	0				
Total new and relapse	**97 320**		**Total cases notified**	**103 981**	

(people who became sick again after treatment) were 34% of retreatment cases. Most of the retreatment cases fell into the "Other" category, meaning that we don't know what happened to these people before they were treated again. There is room for improvement here as well, either in making sure health care providers know how to interview clients and categorise them properly, or how to fill in the reporting forms.

One thing we can do with this table is to compare the total number of cases notified with what WHO estimated as the total number of cases that existed in the first table (diagnosed or undiagnosed). We see that Kenya actually notified 97,320 new and relapse cases of TB in 2011 (this is the sum of the people who are registered during the year as a new episode of TB). WHO estimated the incidence of these cases to be 120,000. Dividing the actual number of cases notified by the estimated cases, we get the percentage of existing cases that Kenya detected – in this case, 97,320/120,000 x 100% = 81%. This percentage is called the *case detection rate*. If the WHO estimate is correct, then Kenya did not find and report about 19% of existing cases, or 22,680 cases of TB. These are cases we would need to continue looking for using interventions such as new diagnostic tools, new community-based approaches, and stigma reduction activities. The case detection rate is a tricky number, though, and depends on a very good estimate. Sometimes it is not possible to make one very accurately. For this reason, WHO no longer favours using this measure and instead relies on the case notification rate as a measure of performance. Even if your country still uses and reports on this measure, as many countries do, it is a measure that should only be estimated at the national level, not at provincial or district level.

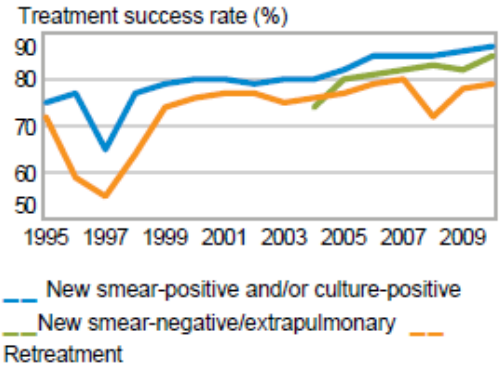
4 The next table shows how well your NTP is performing in treating people diagnosed with TB. The treatment success rate shows what percentage of the people started on TB treatment during a one-year period completed their treatment. Remember, this percentage includes those whose cure was confirmed by a laboratory test (usually a sputum smear) plus the people who completed their treatment but did not have a test at the end.

In Kenya, for the people who were notified as having TB in the year 2010, we see three separate success rates that vary from a high of 87% for smear- or culture-positive TB to a low of 79% for retreatment. How good is this? The current global target for treatment success by the year 2015 is 90% for all categories, so Kenya is getting close except in the category of retreatment. This may be because some of the people being retreated for TB have drug-resistant TB that has not been diagnosed, or because they are often more likely to become lost to follow-up (since some of them did not complete treatment the first time around).

Treatment success rate 2010 (%)	
New smear-positive and/or culture-positive	87
New smear-negative/extrapulmonary	85
Retreatment	79

Tool 2.2:
Epidemiology of TB

We also want to look at how Kenya has done over time on treatment success. The graph to the right of the table shows us the same breakdown as the table, but for the years since 1995. We see steady improvements for people with smear- or culture-positive TB (blue line) and those with smear-negative or extrapulmonary TB since 1997. However, for people being retreated for TB, there is a noticeable dip in 2008 that we might want to investigate. And overall, it seems that the difference in success rates for the first two categories versus retreatment is growing larger. So Kenya may need to redouble its efforts to retreat people with TB successfully. One potential intervention would be more intensive community-based support for these clients.



5 The TB/HIV data table is also critically important for your work as a CSO. It gives you the key information about how your NTP is performing in addressing the issue of TB/HIV co-infection. In our example from Kenya, we see that in 2011 there were 97,136 people with TB who knew their HIV status, equal to 93% of all people with TB. This is very good performance, but still a little less than the 100% target.

Next, we see that of all the people diagnosed with TB in 2011, a high percentage was co-infected with HIV: 39%, or 38,172 people. This reflects the very large impact the HIV epidemic in Kenya has had on TB, and the synergy between the two diseases. Next, we see that 37,147 people (97%) with both diseases have been placed on co-trimoxazole preventive therapy (CPT), a life-saving intervention. This is also a very encouraging result. However, only 64% of HIV-positive people with TB were started on antiretroviral therapy (ART). The current global recommendation is that all (100%) of them should be placed on ART, so there may be some work to do here. However, that recommendation was given in 2012, after the group of people (cohort) reported below. We will have to wait to see what happens with the cohort for 2013 to see the real performance. In the meantime, we can advocate at the national level for rapid adoption of the new recommendation.

The next two indicators, people screened for TB and provided with IPT, are blank in this table. This is another area for investigation to find out why these are not reported. We know that TB is a leading killer of people with HIV, so it is important for them to be screened at each visit. The global recommendation also calls for all HIV-positive people who do not have active TB to be put on IPT. We do not know the reason why these figures are not reported for Kenya. We have to investigate further and ask “Why?” before we decide this is a problem that needs to be addressed.

TB/HIV 2011	Number	(%)
TB patients with known HIV status	97 136	(93)
HIV-positive TB patients	38 172	(39)
HIV-positive TB patients on co-trimoxazole preventive therapy (CPT)	37 147	(97)
HIV-positive TB patients on antiretroviral therapy (ART)	24 497	(64)
HIV-positive people screened for TB		
HIV-positive people provided with IPT		

Tool 2.2: Epidemiology of TB

6 The two tables on multidrug-resistant TB (MDR-TB) help you understand how the country is doing in expanding the accessibility of diagnosis and treatment for MDR-TB. The first table estimates the burden of MDR-TB, and the second table reports on what is actually happening in the country. Estimates are often based on a survey of all or part of the TB cases to see what percentage is MDR-TB. In Kenya, the percentage of new cases with MDR-TB is estimated at 3.1%. MDR-TB in newly diagnosed people always represents transmission of MDR-TB from someone else. The higher the number, the more people with MDR-TB who are going undiagnosed and untreated in the community, thereby infecting other people.

Estimates of MDR-TB burden 2011*	New	Retreatment
% of TB cases with MDR-TB	3.1 (0.1–7.1)	10 (2.1–18)
MDR-TB cases among notified pulmonary TB cases	2 400 (77–5 500)	1 000 (210–1 800)

Reported cases of MDR-TB 2011	New	Retreatment	Total
Cases tested for MDR-TB	92 (<1%)	1 195 (12%)	1 393
Laboratory-confirmed MDR-TB cases	17	149	166
Patients started on MDR-TB treatment			156

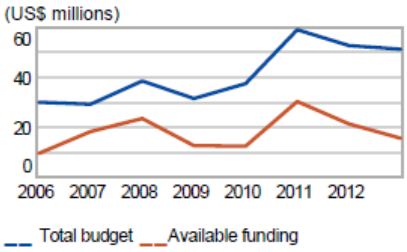
WHO estimates that 10% of people being retreated for TB have MDR-TB. This is a higher number than among people with new TB because all of these people have been treated before, and the TB in their bodies has had a chance to develop resistance to the medications they were given. That is one of the reasons why it is important to provide anyone who is being retreated for TB with a drug susceptibility test to see if the TB bacteria are resistant to first-line drugs.

What we see in Kenya is that WHO estimates that in 2011 there were about 3,400 people with MDR-TB out of new and retreatment cases reported. The next table of reported MDR-TB cases will tell us how well the programme is doing in finding them. Here, we see that Kenya tested 1,393 people for MDR-TB in 2011. Kenya found only 17 cases among people with newly diagnosed TB, and 149 among people being retreated, for a total of 166 cases of MDR-TB reported. This number is only 5% of the expected total number of MDR-TB cases. As with most countries, Kenya will need to expand these services rapidly to find and treat people with MDR-TB appropriately. CSOs could play a role in expansion, for instance, through advocacy efforts aimed at government decision-makers, who can increase funding for diagnostic tools and purchase of second-line drugs for treatment, or by providing community treatment support for people diagnosed with MDR-TB.

7 The last table and graph on the page provide information on the level of funding for TB activities and where that funding comes from. The first line in the table gives the total budget if all desired TB activities were fully funded. In Kenya, the total budget was $53 million in 2012 and has dropped to $51 million in 2013. However, the funding available is less than half of that required: for 2013, available funding is only $16 million, or about 31% of what is needed. Clearly more financial resources are needed, and advocacy may support efforts to fund the NTP. The last two lines in the table tell us what percentage of the available funding comes from which sources. In Kenya, 55% of the available funding for 2013 comes from the government, an increase over 2012. Only 23% of the funding is

coming from Global Fund, a sharp drop from the 51% contribution in 2012. The graph on the right shows us the trend in total budget (blue line) and available funding (brown line) since 2006. The worrying message from looking at this graph is that the gap between the two lines is getting larger, meaning that a smaller proportion of the total budget needed for TB activities is being met. This means that many activities the NTP needs or wants to do to reduce the burden of TB cannot be done.

Financing TB control	2012	2013
Total budget (US$ millions)	53	51
Available funding (US$ millions)	21	16
% of budget funded	41	31
% available funding from domestic sources	46	55
% available funding from the Global Fund	51	23



This completes our review of the country profile information. Now you can use the following pages in the workbook to do this analysis for your own country. The analysis will help you identify some of the potential issues that your NTP will face in trying to stop TB.

Tool 2.2: Epidemiology of TB

Country profile analysis

Use the form below to help you analyse your country's TB data.

Location (numbers from our example above)	Question	Answer	Questions to help with your analysis
1	Is your country a high-burden country for TB?	☐ Yes ☐ No	• How important is TB as a health issue in our country? • How important is TB/HIV co-infection as a health issue in our country?
	A high-burden country for HIV?	☐ Yes ☐ No	
2	What is the estimated TB mortality and mortality rate?	_____total _____/100,000	• Do the graphs to the right show decreases, increases or no change over time? Is this good or bad? • Are these numbers and rates high, medium or low when compared with other countries?
	What is the estimated TB prevalence and prevalence rate?	_____total _____/100,000	
	What is the estimated TB incidence and incidence rate?	_____ total _____/100,000	
3	How many total cases were notified in the year?	_____	
	How many new cases were notified?	_____	
	What percentage of the new cases notified were smear-positive?	_____%	• Is this percentage well above the percentage of other new cases diagnosed? • Does this suggest that non-smear-positive cases are being under-diagnosed?

Tool 2.2:
Epidemiology of TB

Location (numbers from our example above)	Question	Answer	Questions to help with your analysis
3 (cont.)	What percentage of the new cases notified were smear-negative?	_____%	• Is this percentage similar to the percentage of smear-positive cases? • Does this suggest that new diagnostic tools such as Xpert could help improve diagnosis?
	What percentage of the new cases notified were smear unknown?	_____%	• Is this percentage more than 2–3%? • What does this show about programme performance?
	What percentage of the new cases notified were extrapulmonary?	_____%	• Is this percentage high? Does this suggest that there may be many HIV-positive people with TB?
	How many retreatment cases were notified?	_____	• Is this a high percentage of the total cases reported in the year? • Does this make sense when compared to treatment success among new cases? • What does this mean about how well our country is performing in treating people with TB the first time around?
	What percentage of retreatment cases notified were relapses?	_____%	• Is this percentage relatively high? • Does this make sense when compared to treatment success among new cases?
	What percentage of retreatment cases notified were treatment after failure?	_____%	• Is this percentage relatively high? • What does this suggest about the possibility of higher rates of MDR-TB among new cases?
	What percentage of retreatment cases notified were treatment after default?”	_____%	• What does this suggest about treatment support efforts?

3 (cont.)	What percentage of retreatment cases notified were classified as "other?"	_____%	• Is this a relatively high percentage? • What does this suggest about recording and reporting?
	How many new + relapse cases were notified?	_____	• How does this compare with the estimated number of incident TB cases from the first table? • What does this suggest about how well the programme is performing in finding people with TB?
4	What was the treatment success rate for new smear- and/or culture-positive cases?	_____%	• Have we reached our national target for treatment success? • Does treatment success vary significantly for these three categories of TB cases? • What do these percentages suggest about the performance of the programme in treating people with TB? • Looking at the graph to the right, what has the trend been for treatment success—are we doing better, worse, or about the same?
	What was the treatment success rate for new smear- negative and extrapulmonary cases?	_____%	
	What was the treatment success rate for retreatment cases?	_____%	
5	What percentage of people with TB knows their HIV status?	_____%	• Have we met our national targets for HIV counselling and testing in people with TB? • Is the HIV co-infection rate high among people with TB? What might this mean for TB case-finding activities? • Does our country have a policy related to CPT for people with TB/HIV? Have we met our targets? • Does our country have an updated policy on ART for people with TB/HIV? Have we met our targets? • How close are we to screening all people living with HIV for TB? • Does our country have a policy that supports providing IPT for people living with HIV? Have we met our targets?
	What percentage of people with TB is co-infected with HIV?	_____%	
	What percentage is on CPT?	_____%	
	What percentage is on ART?	_____%	
	What percentage of people living with HIV is screened for TB?	_____%	
5 (cont.)	What percentage of people living with		

	HIV is provided with IPT?	_____%	
6	How many cases of MDR-TB does WHO estimate among people with new TB?	_____total _____%	• Are these relatively high percentages, especially among those with newly diagnosed TB? • What does this suggest about our country's approach to treating TB in people with newly diagnosed TB and in people with retreatment TB?
	How many cases of MDR-TB does WHO estimate among people with retreatment TB?	_____total _____%	
	How many laboratory-confirmed cases of MDR-TB were reported among people with new TB in the year?	_____	• How do these numbers compare with the estimated number of existing cases of MDR-TB? • Are these numbers in line with any targets set for treatment of people with MDR-TB (in Global Fund grants or the national strategy)? • What does this suggest about our country's efforts to make treatment of MDR-TB accessible to everyone who needs it?
	How many laboratory-confirmed cases of MDR-TB were reported among people with retreatment TB in the year?	_____	
7	What is the total TB budget for the most recent year?	_____	• Does our country have sufficient funds available to stop TB? • Does the percentage of available funds provided by the government indicate a strong commitment to TB? • Are outside donors providing the majority of support for our TB programme? What are the implications for the future? • Looking at the graph, does the trend show improvement in the funding situation, or is the funding gap becoming larger?
	What percentage of the total TB budget is actually available to the programme?	_____%	
	What percentage of the available funds is provided by the government?	_____%	
	What percentage of the available funds is provided by Global Fund?	_____%	

Tool 2.2: Epidemiology of TB

Now that you have looked at your country's TB profile, write down the top three to five concerns or questions that you have about progress on stopping TB and TB/HIV based on your analysis. You can then use these as a starting point to do some further investigation, start discussions with the NTP about areas to support, or plan your own activities. Refer back to this list when you fill out **Tool 2.5**: **Successes and challenges.**

1.

2.

3.

4.

5.

Tool 2.3:
National policies & guidelines

Use this tool as a checklist to make sure you have copies of all the current national policies, guidelines and other important documents that will ensure your TB work is in line with the NTP's policies. Some of these documents may not be available in your programme.

Document	Questions to consider
☐ Current national TB strategy	• What time period does it cover? _____ • Was it developed in consultation with partners, including CSOs? • Does it include the goal, objectives and targets? • Does it discuss the role of CSOs? • Does it include a budget estimate?
☐ NTP annual work plan	• Was the work plan developed in consultation with partners? • Was it available at the beginning of the annual cycle? • Are CSO activities included in the work plan? • Do CSO activities have budget allocated to them?
☐ TB treatment guidelines *(combined or separate documents)*	• When were the guidelines last updated? _____ • Do they address TB treatment for children? • Do they discuss TB/HIV treatment? • Do they address drug-resistant TB treatment?
☐ TB/HIV guidelines	• Do the guidelines include information on the country's policy on IPT? • Do the guidelines describe how the country will achieve intensified case-finding?
☐ Infection control policy and guidelines	• Are there guidelines that describe how to implement infection control? • Do the guidelines cover community infection control?
☐ Community-based TB care guidelines	• Do the guidelines describe a standard referral process? • Do they describe how CSOs should interact with local health facilities? • Is there a specific position named in the guidelines responsible for supervising CSO activities?
☐ TB reporting guidelines	• Are the definitions in the reporting guidelines clear and consistent? • Are the lines and methods of reporting clear? • Are the timelines for reporting clear?
☐ TB forms (for recording and reporting)	• Are the same forms used throughout the country? • Do the forms include a place for reporting of HIV status? • Is training or support available to help you fill in the forms correctly?

Tool 2.4:
National TB objectives, targets, and activities

Fill in the template below by referring to your country's national TB strategy and any work plans for the current year. Add more rows as needed.

National TB programme goal:			
	National TB control objectives	Targets	Planned activities
1			
2			
3			
4			
5			
6			
7			

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Now take your country's objectives and targets, and do an analysis of where it stands in reaching those targets. Below is an example. On the next page, you can use the blank template to do the analysis for each objective in your country. One problem you may encounter in doing this exercise is that the NTP does not have easily measurable objectives, or its targets are unclear. Do the best you can with the information available.

	National TB programme objective (from your national strategy document)	**Target** (from the national strategy, Global Fund plans, etc.)	**Current performance** (from the annual TB report of the country or WHO)	**Analysis: success or challenge?**
EXAMPLE	Increase treatment success to 90% by 2015.	90% treatment success for new smear-positive pulmonary TB.	Since 2005, treatment success has been steadily increasing. For 2011 (the latest year with complete data available), treatment success = 80% nationally, but varied among individual districts from a low of 62% to a high of 87%.	Challenge. Although treatment success continues to improve and some districts have almost reached the target, we are still below the national target of 90%, and some districts are doing poorly. May need to focus improvement efforts on lowest-performing districts.

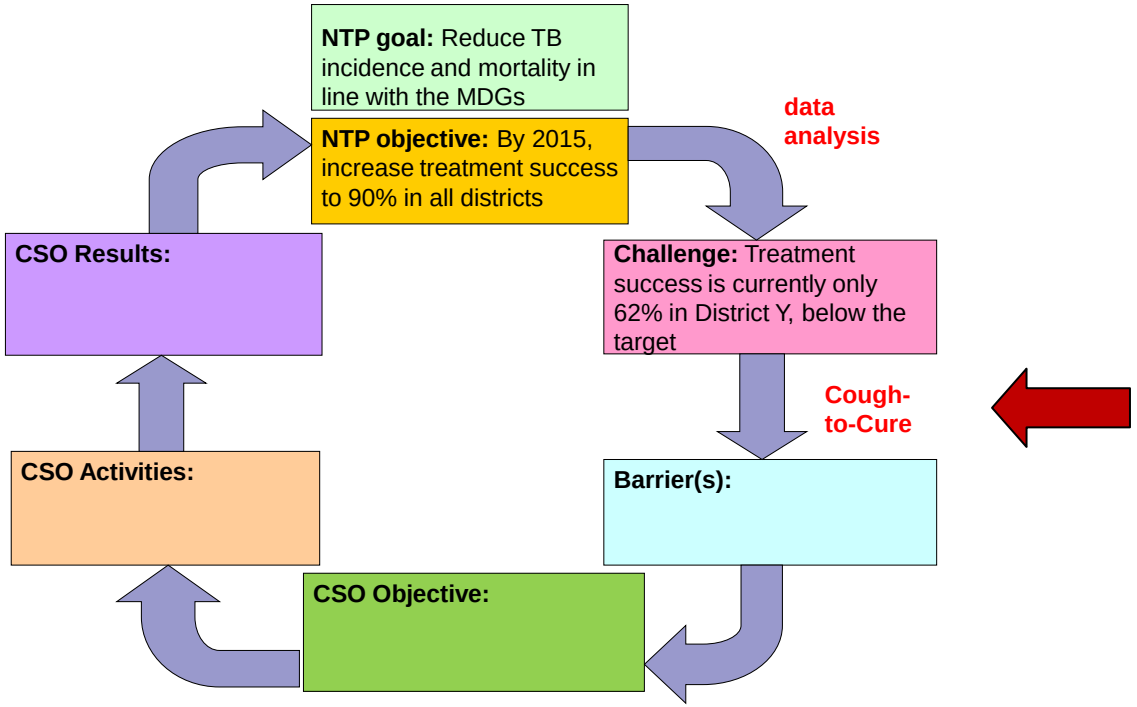
Tool 2.5:
Successes & challenges

	National TB programme objective (from your national strategy document)	**Target** (from the national strategy, Global Fund plans, etc.)	**Current performance** (from the annual TB report of the country or WHO)	**Analysis: success or challenge?**
1				
2				
3				
4				

Tool 2.5:
Successes & challenges

	National TB programme objective (from your national strategy document)	**Target** (from the national strategy, Global Fund plans, etc.)	**Current performance** (from the annual TB report of the country or WHO)	**Analysis: success or challenge?**
5				
6				
7				

In Tool 2.4 you listed the NTP goal, objectives and activities. In Tool 2.5 you assessed the performance of the NTP in reaching its targets and accomplishing its objectives. You did so by analysing programme data. Then you identified the places where the NTP faces challenges in reaching its targets. Now that you have identified the challenge areas, you will use the Cough-to-Cure Pathway as a framework to identify the potential reasons (barriers) for each of the challenges that the NTP faces, using a client-centred perspective. Taking the example used in the previous tool, here is where you are in the project planning, implementation and evaluation cycle:



Now go to the next page to see an example of how to use the Cough-to-Cure Pathway to 1) identify which step in the Pathway is linked to your challenge, and 2) what the barriers might be in reaching your target. Then you can do this for your own identified challenge on the blank Pathway form provided. You can go through this process for each challenge you would like to address.

Tool 2.6:
The Cough-to-Cure Pathway

Continuing with our example of low treatment success, we go through the following steps:

Step 1: What challenge are we trying to address? Treatment success is currently only 62% in District Y, below the target of 90%.

Step 2: Which step in the Cough-to-Cure Pathway is our challenge most closely linked with? Continue and complete treatment.

Step 3: What are the likely individual, community and system barriers that contribute to our challenge? (filled in below for this example)

Ideal	• Community members have knowledge of TB symptoms. • Community members know when, where and how to seek care. • The community supports care-seeking behaviour for people with TB symptoms. • Health facilities provide the community with information about TB symptoms and where to seek care for free.	• Community members know the facility to visit for TB evaluation. • Community members trust the facility to provide quality services. • The community encourages care-seeking behaviour. • Health facility is available nearby, with trained staff and client-friendly services.	• People with TB symptoms have the correct information about where to go for evaluation and how to produce sputum. • People with TB symptoms trust the facility to give them an accurate diagnosis. • Laboratory equipment and supplies are available to diagnose TB and test for HIV. • Staff are trained to diagnose TB. • Staff are trained to provide HIV counselling and testing. • Services are provided in a timely manner for free.	• People with TB receive thorough client education, and understand the importance of treatment. • A treatment supporter is identified for each person with TB. • Quality drugs are available for treatment. • Treatment support is provided, and DOT is done at a place and time convenient for the person with TB. • People with TB do not face stigma or discrimination.	• People with TB receive ongoing encouragement and education from health care providers and community volunteers. • Regular monitoring of treatment is done, including a final sputum. • Side effects are identified quickly and addressed. • Treatment supporters help people with TB cope with ongoing treatment. • Quality drugs are available.
Cough-to-Cure Pathway	**Recognise illness and the need to seek care**	**Seek care at a health facility that can diagnose TB**	**Complete diagnosis for TB, including HIV counselling and testing**	**Begin treatment for TB**	**Continue and complete treatment**
Individual barriers					• **DOT conflicts with work schedules** • **No money for transportation** • **Poor understanding of the need to complete treatment** • **Side effects of medications**
Community barriers					• **Stigma prevents people from continuing treatment** • **Community members are not engaged as treatment supporters**
System barriers					• **Drug stockouts** • **Inconvenient times for DOT at clinic, and no community-based DOT provided** • **No transportation subsidy**

Tool 2.6:
The Cough-to-Cure Pathway

Use the blank Pathway below to go through the steps for your identified challenge. Repeat for each challenge you would like to address.

Step 1: What challenge are we trying to address? _____

Step 2: Which step in the Cough-to-Cure Pathway is our challenge most closely linked with? _____

Step 3: What are the likely individual, community and system barriers that contribute to our challenge? (fill in below)

Ideal	• Community members have knowledge of TB symptoms. • Community members know when, where and how to seek care. • The community supports care-seeking behaviour for people with TB symptoms. • Health facilities provide the community with information about TB symptoms and where to seek care for free.	• Community members know the facility to visit for TB evaluation. • Community members trust the facility to provide quality services. • The community encourages care-seeking behaviour. • Health facility is available nearby, with trained staff and client-friendly services.	• People with TB symptoms have the correct information about where to go for evaluation and how to produce sputum. • People with TB symptoms trust the facility to give them an accurate diagnosis. • Laboratory equipment and supplies are available to diagnose TB and test for HIV. • Staff are trained to diagnose TB. • Staff are trained to provide HIV counselling and testing. • Services are provided in a timely manner for free.	• People with TB receive thorough client education and understand the importance of treatment. • A treatment supporter is identified for each person with TB. • Quality drugs are available for treatment. • Treatment support is provided, and DOT is done at a place and time convenient for the person with TB. • People with TB do not face stigma or discrimination.	• People with TB receive ongoing encouragement and education from health care providers and community volunteers. • Regular monitoring of treatment is done, including a final sputum. • Side effects are identified quickly and addressed. • Treatment supporters help people with TB cope with ongoing treatment. • Quality drugs are available.
Cough-to-Cure Pathway	**Recognise illness and the need to seek care**	**Seek care at a health facility that can diagnose TB**	**Complete diagnosis for TB, including HIV counselling and testing**	**Begin treatment for TB**	**Continue and complete treatment**
Individual barriers					
Community barriers					
System barriers					

Once you have identified a list of potential barriers, you will need to decide which of the barriers are real issues, and of these, which barriers your organisation can help remove. It is not enough to guess at what the problems might be. You have to have evidence that they are the real problems. Otherwise, you may be developing solutions for the wrong problems, and wasting time and resources without seeing improvements. To gather the information you need to confirm your ideas about the barriers, you can do several things. You can hold focus groups or individual interviews with people with TB in the community to understand their views of the barriers they face. You can do the same with the TB programme manager, TB clinic staff or outreach workers. You can review data from the programme. However you go about it, be sure to confirm your identified barriers with evidence. Once you have a list of the real barriers, you may need to prioritise them further because of limited resources, time or expertise. To do so, you can use a simple template like the one below to help sort out which barriers you want to address, or which ones you want to address first. These are generally the ones that would fall into the green boxes, although there are many exceptions to this rule. Use your own judgment about the situation to decide which are most important for your organisation.

	Less important (removing this barrier would benefit only a few of our target group, or only improve outcomes a little)	**Somewhat important** (removing this barrier would benefit at least 50% of our target group or make a moderate improvement in outcomes)	**Most important** (removing this barrier would benefit most of our target population or make a significant improvement in outcomes)
Very feasible to succeed (our organisation has existing capacity to address this barrier and it is politically feasible to do so)			Most desirable box for a barrier to fall in
Somewhat feasible to succeed (our organisation needs only a little help to succeed, there is some political opposition that can be overcome, or success will take a long time)			
Difficult to succeed (our organisation does not have this expertise, there is strong political opposition that is difficult to overcome, or there are other factors that work against success, such as geography)	Least desirable box for a barrier to fall in		

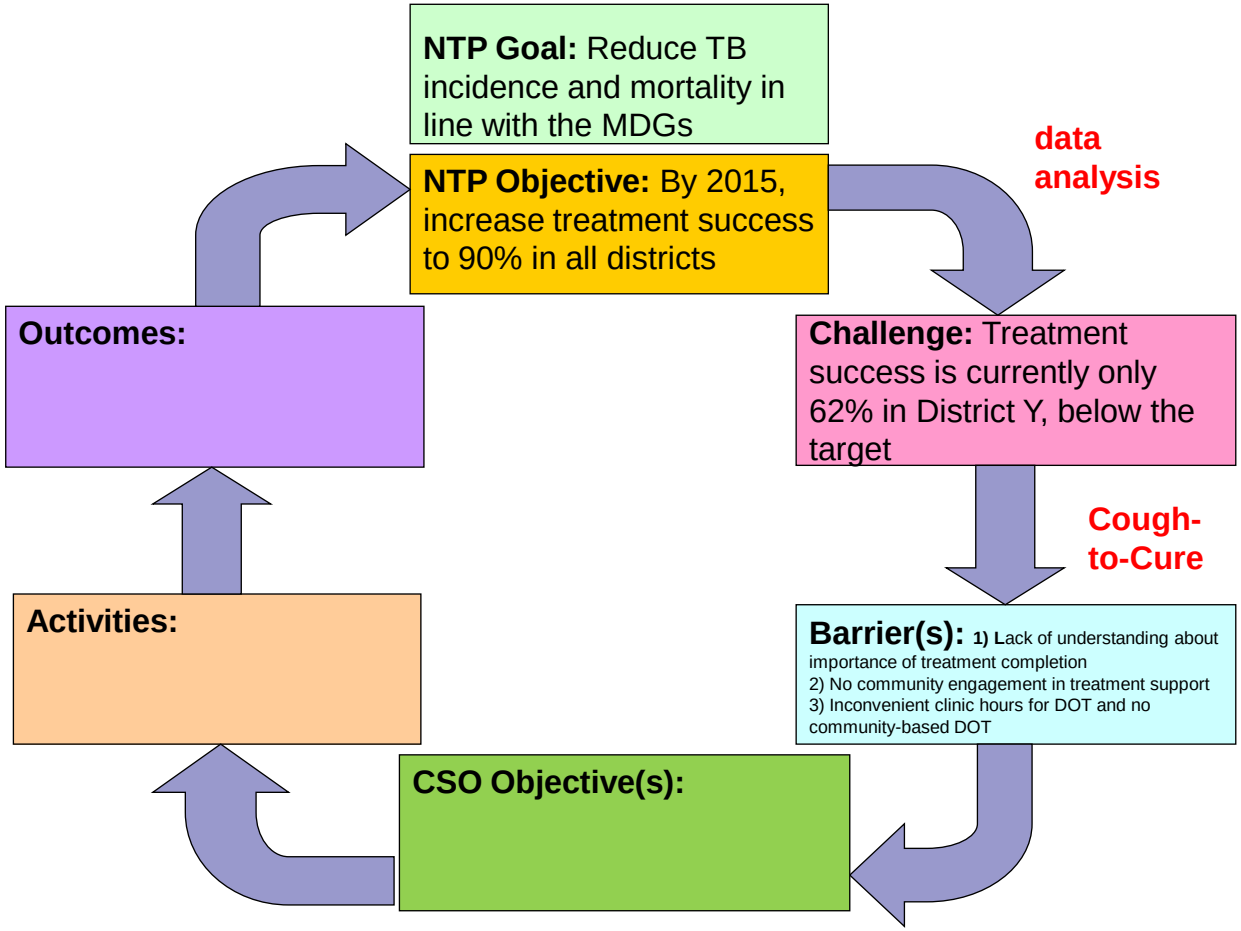
Tool 2.7:
Logical linkages between challenges and activities

Assume we have gone through the process of verifying the real barriers when it comes to low treatment success in our example. We have discovered that the main problems include all of the barriers we originally listed. Now we need to prioritise them, and we do so using this template.

	Less important (removing this barrier would benefit only a few of our target group, or only improve outcomes a little)	**Somewhat important** (removing this barrier would benefit at least 50% of our target group or make a moderate improvement in outcomes)	**Most important** (removing this barrier would benefit most of our target population or make a significant improvement in outcomes)
Very feasible to succeed (our organisation has existing capacity to address this barrier and it is politically feasible to do so)		Poor understanding of need to complete treatment	Lack of community engagement in treatment support
Somewhat feasible to succeed (our organisation needs only a little help to succeed, there is some political opposition that can be overcome, or success will take a long time)		Clinical hours conflict with work	Stigma
Difficult to succeed (our organisation does not have this expertise, there is strong political opposition that is difficult to overcome, or there are other factors that work against success, such as geography)	Side effects of medication	Drug stockouts No transportation subsidy	No money for transport

From our prioritisation exercise, we choose three of the barriers that we feel our organisation can address. We know stigma is important, but it will take a longer time to address, and our organisation has decided to concentrate on successes we can accomplish within one year. We choose to address the poor understanding of the need to complete treatment, lack of community engagement in treatment support, and conflicting clinic hours as three barriers that are appropriate for us to tackle this year.

Tool 2.7:
Logical linkages between challenges and activities



Now we have completed the **Barriers** identification step in our planning cycle, we are ready to write our objectives and choose the activities we will do to accomplish those objectives.

As you can see, there is a logical connection between each step we take in the process. When we get to the next steps, we will easily be able to explain what problems our activities are trying to address, and the results we hope to see as an outcome of those activities.

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Tool 2.7:
Logical linkages between challenges and activities

Developing objectives is one of the most challenging parts of project planning for many people, whether you work in a CSO or in a government department. Here is a brief tutorial to make writing objectives easier.

Make your objectives **SMART**:

Specific	• Single focus or result. • No overlap with other objectives. • What do I want to accomplish? • For whom? • Where? • When?
Measurable	• Can it be quantified or measured? • How much? • How many? • How will I know when it is accomplished?
Attainable	• Can we really do this? • Is this achievable and easy to put into action? • Considers limits, such as resources, personnel, cost and time frame.
Relevant	• Does this connect to the larger goal? • Does this seem worthwhile? • How important is this objective to our desired result?
Time-bound	• This is the objective's "due date". • When do we expect the change to happen or the activity to be completed? • Keeps activities on track and moving.

Examples of well-written objectives:

- By December 2015, increase the case notification rate in District X from 200/100,000 to 225/100,000.
- Recruit and train 25 home-based care volunteers to provide TB/HIV services to 250 clients in District Z by April 2014.
- Implement a national advocacy campaign to ensure that TB is declared an emergency in our country by March 2014.
- By May 2015, increase the percentage of people with TB in Province B who are counselled and tested for HIV and receive their results from 60% to 85%.

The general format of an objective that you can use to develop your own is as follows:

By (a certain time), we will (do a specific activity) in (a specific place) to achieve (this measurable result).

We will continue to build our example on the next page, and then you can practise developing your own objectives and activities to address your identified barriers.

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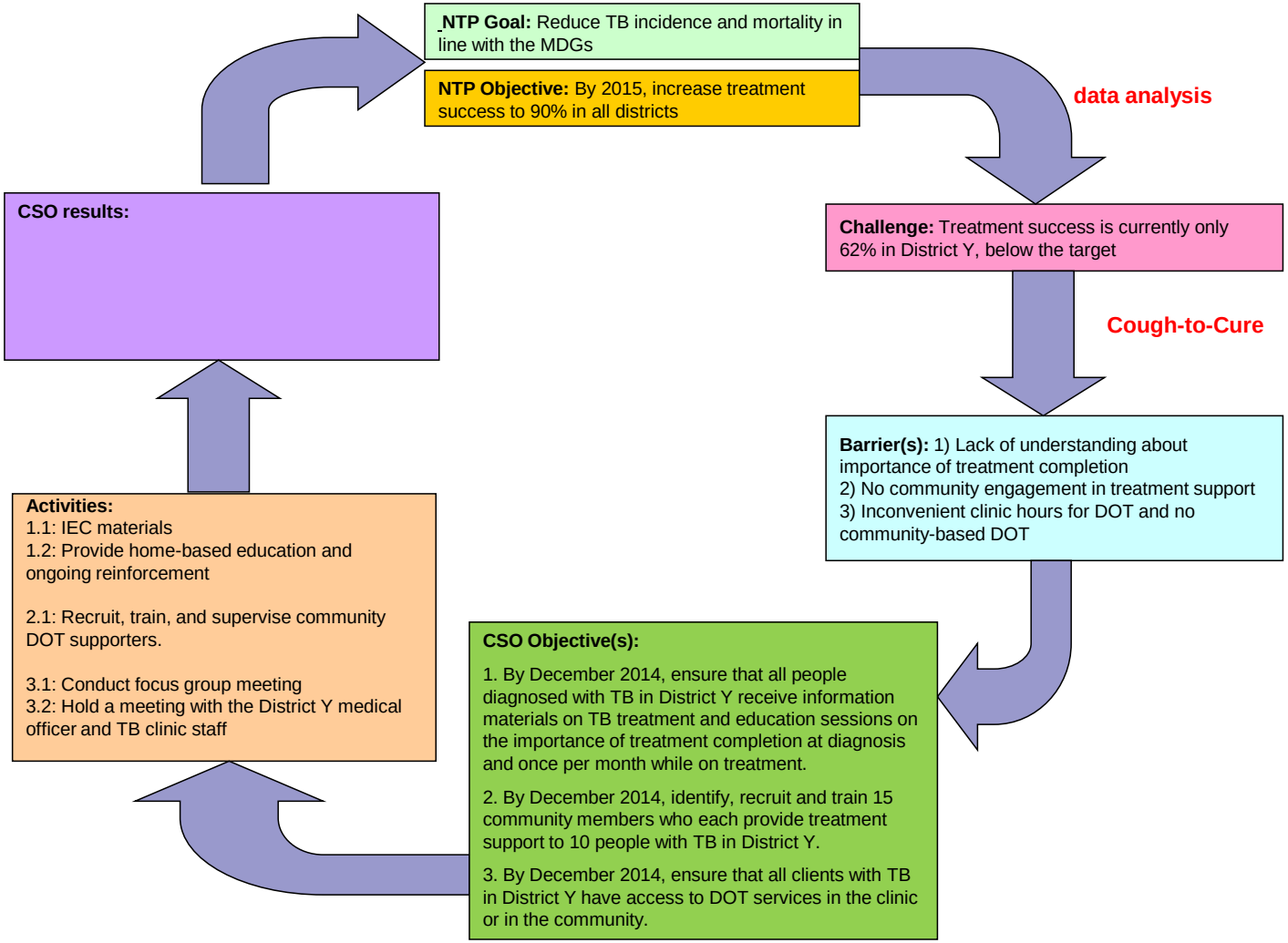
Tool 2.7:
Logical linkages between challenges and activities

Developing a logical plan is a key element of success for your TB/HIV activities. It allows you to communicate clearly with the NTP, NACP, partners and donors about how your activities relate to the country's TB strategy. It gives them confidence that your activities will support their objectives and help reach the targets. The information here is the same as in the project cycle diagram on the next page. However, with multiple barriers and objectives, you can put more information in a table format. Now practise this for your own barriers on the blank page that follows. You can add tables if you are addressing more than one objective or challenge. **NOTE: To help you develop the details of activities that can be put into this table, you can use Tools 2.8–2.11 before you complete the table.**

Example of *TB/HIV* barriers, objectives *and* activities matrix

TB control objective: By 2015, increase TB treatment success to 90% in all districts		
Challenge: Treatment success is currently only 62% in District Y, well below the target of 90%.		
Key barriers (from Cough-to-Cure analysis)	**Objectives to address barriers**	**Activities to address barriers**
1. People with TB have a poor understanding of the need to complete treatment (individual).	By December 2014, ensure that all people diagnosed with TB in District Y receive information materials on TB treatment, and education sessions on the importance of treatment completion, at diagnosis and once per month while on treatment.	1.1: Develop and distribute a simple flyer or other appropriate information, education and communication (IEC) materials for District Y community members diagnosed with TB. 1.2: Provide home-based education and ongoing reinforcement of the importance of treatment completion to District Y community members with TB, using our existing home-based care staff.
2. Community members are not engaged as treatment supporters (community).	By December 2014, identify, recruit and train 15 community members who each provide treatment support to 10 people with TB in District Y.	2.1: Recruit, train and supervise community DOT supporters.
3. Clinic hours are inconvenient for clients who need DOT, and no community-based DOT is provided (system).	By December 2014, ensure that all clients with TB in District Y have access to DOT services in the clinic or in the community.	3.1: Conduct focus group meeting with community members with TB to understand how clinic hours can be changed to better meet their needs. 3.2: Hold a meeting with the District Y medical officer and TB clinic staff to present findings of the focus group discussion, advocate for a change in clinic hours, and offer to provide community-based DOT in collaboration with the clinic.

Tool 2.7:
Logical linkages between challenges and activities



International HIV/AIDS Alliance
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Tool 2.7:
Logical linkages between challenges and activities

Organisation*:* _____

TB/HIV barriers, objectives and activities matrix for (dates): _____ **to** _____

TB control objective:		
Challenge:		
Key barriers (from Cough-to-Cure analysis)	**Objectives to address barriers**	**Activities to address barriers**

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What is advocacy?

Advocacy is defined by the Stop TB Partnership as a set of coordinated activities that are designed to:

- place TB higher on the political agenda
- strengthen government commitment to implement or improve TB control policies
- increase and sustain financial and other resources for stopping TB.

Advocacy **changes** policies, laws, funding, media coverage and/or practices. It **targets** decision-makers, community leaders, policymakers and other people in positions of influence. Advocacy activities may occur at the local, provincial, national or international level. Indicators of the success of advocacy include: new or improved policies, laws, programmes or practices that enable positive changes (for example, access to TB care and treatment for HIV-positive people); more funding, more human resources, more material resources; or better coverage in the media.

There are three specific types of advocacy in which you may engage:

- **Policy advocacy** informs politicians and administrators how TB and TB/HIV affect the country, and requests specific actions to improve laws and policies.
- **Programme advocacy** targets decision-makers/opinion leaders to make decisions and take action to implement specific improvements at a programme level (such as the NTP).
- **Media advocacy** prompts the media to cover TB-related topics regularly and in a responsible manner to raise awareness of problems and possible solutions.

Your advocacy objectives, activities, target audiences and methods will depend on what the problem is and who can make the changes needed to address it. The next pages will guide you through a process of analysing what the issue is, what change you want to see, and how you will go about making that change. You can then translate that information into a CSO objective and related activities.

Key resources

For detailed information and training on advocacy, see the resources below.

You can access a number of useful TB advocacy documents on the ACTION website at:
http://www.action.org/resources/ending-tb/publications

PATH (2012). Advocacy to improve global health: a training course for advocacy strategy development. Available at:
http://www.path.org/publications/detail.php?i=2165

PATH (2013). Policy advocacy for health. Available at:
http://www.path.org/publications/files/ER_app_workshop_curric.pdf

USAID and Stop TB Partnership (2011). Overcoming barriers to TB control: the role of advocacy, communication, and social mobilization. Available at:
http://www.path.org/publications/detail.php?i=2030

Tool 2.8:
Advocacy planning

Key resources

Advocacy Partnership (2011). TB/MDR-TB advocacy toolkit. Available at: http://www.stoptb.org/assets/documents/global/awards/cfcs/TB_MDR%20Advocacy%20Tool%20Kit.pdf

PATH (2007). Ten steps to developing a strategic advocacy agenda. Available at:http://www.path.org/publications/files/ER_advocacy_ten_steps.pdf

International HIV/AIDS Alliance (2002). Advocacy in action – A toolkit to support NGOs and CBOs. Available at: http://www.aidsalliance.org/publicationsdetails.aspx?id=142

OSI, TAG (2006), 'Civil society perspectives on TB/HIV: highlights from a joint initiative to promote community-led advocacy'. Available at: www.soros.org/initiatives/health/focus/phw/articles_publications/publications/highlights_20060811

You can access many additional advocacy, communication and social mobilisation resources through the ACSM community of practice. Available at: http://www.aidsportal.org/web/acsm/resources;jsessionid=D17DB2489EB1524E2DBE69158284EDD5.node1

Tool 2.8:
Advocacy planning

Advocacy planning matrix example

Advocacy activities may be able to address some of the challenges and barriers you have identified by using the Cough-to-Cure Pathway (Tool 2.6). You can use the step-by-step process below to develop the details of how you will implement advocacy activities to make the desired change you would like to see. An example is provided, and then you have a blank template you can use for each barrier you would like to address with advocacy activities. Make as many copies as you need to develop activities for each barrier. Remember, advocacy seeks to influence decision-makers who have the power to change a situation for a large number of people (a nation, a community). If you are working to influence individual behaviour or small groups of people, you are probably doing communication work instead. You can use the communication planning tool (2.9) to develop the details of those activities.

Question	Answer
What TB control challenge would we like to address with advocacy activities?	Despite a high burden of HIV in our country, only 50% of people diagnosed with TB are receiving HIV counselling and testing.
What are the barriers we have identified through the Cough-to-Cure Pathway that can be addressed with advocacy?	There is no national TB/HIV policy that supports universal access to HIV counselling and testing for people diagnosed with TB.
What specific change (outcome) do we want to see as a result of our advocacy activities?	Development, approval and dissemination of a national policy on TB/HIV that includes a specific requirement for universal access to HIV counselling and testing for all people diagnosed with TB.
What activities will we do to see?	1. Joint meeting with the NTP and NACP managers and CSO representatives to discuss the issue and offer support to them to approach the minister of health. 2. Group meeting with the NTP and NACP managers, CSO representatives and the minister of health to ask for his or her support in rapid policy development and dissemination. 3. Meeting with journalists to brief them on the issue and invite them to a community event with affected people's organisations. 4. Develop and publicly issue an annual "report card" on TB/HIV for the ministry of health to track its progress in resolving the concerns we have raised. Specifically include the percentage of people with TB receiving HIV counselling and testing as part of the report card.

Question	Answer
How will we measure the success of this advocacy work?	Interim measures of advocacy success (outputs): 1. Minister of health agrees to achieve universal HIV counselling and testing for people with TB. 2. Journalists produce five articles on TB/HIV that include information about the lack of HIV counselling and testing for all people with TB. 3. Community event held that is covered by the media and demands universal access to HIV counselling and testing for people with TB. 4. Report card issued with media coverage that reports on ministry of health progress and any continuing concerns. Final measure of advocacy success (outcome): 1. National policy on TB/HIV is developed and approved by the ministry of health and disseminated to all providers. It includes a requirement for universal access to HIV counselling and testing for all people diagnosed with TB. The ultimate impact we would like to see is that 100% of people diagnosed with TB receive HIV counselling and testing and know their results. This can be measured through the annual data generated by the NTP.

Now try this on the next page for a TB challenge and related barriers you have identified in your country or region.

Tool 2.8: Advocacy planning

Advocacy planning matrix

Organisation:_____ **Time period:**_____

Question	Answer
What TB control challenge would we like to address with advocacy activities?	
What are the barriers we have identified through the Cough-to-Cure Pathway that can be addressed with advocacy?	
What specific change (outcome) do we want to see as a result of our advocacy activities?	
What person or group has the ability to make the change we want to see?	
What messages do we need to deliver to this person or group to convince them to make the change?	
What activities will we do to deliver these messages?	
Who is best suited to deliver the messages?	
When will we deliver these messages?	
How will we measure the success of this advocacy work?	

What is communication?

In TB, communication is often defined as activities designed to:

- create and improve knowledge about TB/HIV (symptoms, curability) and TB services (diagnosis, treatment)
- change attitudes and behaviours of people with TB, family members and the community, health care providers, and the general public.

Communication is a two-way process of sharing information and experience. It **changes** knowledge, attitudes and behaviours related to TB and HIV. Communication may **target** people with TB, community members, the general public, health care providers, decision-makers, donors or the media. The ultimate goal of communication is to change behaviour by improving knowledge or understanding, changing attitudes and reducing stigma, or changing priorities.

There are many different forms of communication. In TB/HIV, we think of written communication such as flyers or posters, verbal communication such as one-on-one counselling or group trainings, and mass media communication such as radio or TV broadcasts. The methods you use will depend on the audiences you are trying to reach and the messages you want to give to them.

The following pages will provide you with an example of communication planning and a step-by-step process to work through to plan your own communication activities.

Key resources

For detailed information and training on communication, see the resources below.

USAID and Stop TB Partnership (2011). Overcoming barriers to TB control: the role of advocacy, communication, and social mobilization. Available at: http://www.path.org/publications/detail.php?i=2030

Health Communication Partnership (2004). The role of communication in achieving global TB control goals. Available at: http://www.stoptb.org/assets/documents/countries/acsm/Summary.pdf

You can access many additional advocacy, communication and social mobilisation resources through the ACSM community of practice. Available at: http://www.aidsportal.org/web/acsm/resources;jsessionid=D17DB2489EB1524E2DBE69158284EDD5.node1

Tool 2.9: Communication planning

Communication planning matrix example

Communication activities may be able to address some of the challenges and barriers you have identified by using the Cough-to-Cure Pathway (Tool 2.6). You can use the step-by-step process below to develop the details of how you will implement communication activities to make the desired change you would like to see. An example is provided, and then you have a blank template you can use for each barrier you would like to address with communication activities. Make as many copies as you need to develop activities for each barrier.

Question	Answer
What TB control challenge would we like to address with communication activities?	Treatment adherence among people with TB is low, and as a result the treatment success rate is only 72% in District Y.
What are the barriers we have identified through the Cough-to-Cure Pathway that can be addressed with communication?	Health care providers do not provide adequate information about anti-TB drugs and the length of treatment, and do not have the skills to establish a trusting relationship with their clients.
What specific change (outcome) do we want to see as a result of our communication activities?	Health care providers in District Y strengthen their skills in interpersonal communication and counselling, and use those skills to better support treatment completion for their clients with TB.
What audience are we trying to reach with our **communication** activities?	Doctors and nurses in District Y TB facilities.
What messages do we need to deliver to our audience?	1. Treatment success in District Y is below our national target. One of the barriers identified is that clients with TB do not have a good understanding of the need to continue through a full course of treatment. 2. Client education and ongoing counselling are an important part of TB treatment success, and doctors and nurses play a critical role in this process. 3. Using the skills they learn in a one-day training on client communication and counselling can improve the District's TB indicators, increase their client's satisfaction with services, and increase their own job satisfaction.
What activities will we do to deliver these messages and by what methods?	One-day trainings on interpersonal communication and counselling, TB education for clients, and techniques for ongoing treatment support.

Tool 2.9:
Communication planning

Question	Answer
How will we measure the success of this communication work?	Interim measures of communication success (output): 1. All doctors and nurses who serve people with TB receive training in interpersonal communication and counselling for treatment adherence. 2. Doctors and nurses have improved knowledge and skills on interpersonal communication and counselling, as measured by pre- and post-training tests. Final measure of communication success (outcome): 1. Doctors and nurses use their new skills to provide thorough TB treatment information to their clients and support them on an ongoing basis throughout the course of treatment. The ultimate impact we want to see from doing this activity is that treatment adherence improves and thus treatment success in District Y increases. What we want to see is that treatment success increases from 72% to a higher percentage, ideally to our national target. We can measure that by looking at changes in the annual District Y treatment outcome data over the next several years.

Now try planning your own communication activities using the blank matrix on the following page.

Tool 2.9: Communication planning

Communication planning matrix

Organisation:_____ **Time period:**_____

Question	Answer
What TB control challenge would we like to address with communication activities?	
What are the barriers we have identified through the Cough-to-Cure Pathway that can be addressed with communication?	
What specific change (outcome) do we want to see as a result of our communication activities?	
What audience are we trying to reach with our communication activities?	
What messages do we need to deliver to our audience?	
What activities will we do to deliver these messages and by what methods?	
How will we measure the success of this communication work?	

Tool 2.10:
Social mobilisation planning

What is social mobilisation?

Social mobilisation in TB is a long-term process of building alliances, engaging stakeholders and increasing community participation to:

- bring visibility and a sense of urgency to the issue of TB (including TB/HIV and MDR-TB)
- give a push or add momentum to communication and advocacy efforts
- help society, officials and the media realise that TB issues are important and urgent
- involve community members and other sectors in the fight against TB.

Social mobilisation **changes** level of interest, participation and commitment to ending TB. It **targets** all relevant sectors of society, such as communities, policymakers, influential individuals, businesses and religious institutions. Successful social mobilisation results in increased attention to TB as an issue, more people and groups involved in the fight against TB, and increased energy – all of which result in increased *action* to combat TB. In doing social mobilisation, you are really taking two different but interconnected steps. First, you are designing activities that will engage new groups in the fight against TB; second, you are working with these groups to take specific actions to stop TB. This is an important point. Once you mobilise a group of people, you must have something specific for them to do, otherwise they will quickly lose interest in participating.

Social mobilisation can be divided into the target groups you are trying to mobilise:

- Political mobilisation engages decision-makers and politicians to raise the profile of the TB issue in support of the advocacy and communication activities that you may be implementing.
- Government mobilisation engages government officials and departments.
- Corporate mobilisation engages the business sector in fighting TB.
- Beneficiary mobilisation engages affected people and their families.
- Community mobilisation engages community organisations such as churches, schools, leaders, women's groups and others.

As CSOs, you will often be doing community mobilisation and beneficiary mobilisation work. However, there will still be times when mobilising other sectors will be important to accomplishing your objectives.

Planning social mobilisation follows the same general process steps as the planning for advocacy or communication activities. An example is provided on the next page, followed by a blank template to plan your own social mobilisation activities.

Key resources

USAID and Stop TB Partnership (2011). Overcoming barriers to TB control: the role of advocacy, communication, and social mobilization. Available at: http://www.path.org/publications/detail.php?i=2030

The Global Fund (2011). Community systems strengthening framework August 2011. Available at: www.theglobalfund.org/WorkArea/DownloadAsset.aspx?id=5485

Tool 2.10:
Social mobilisation planning

Key resources

International HIV/AIDS Alliance (2006), 'All together now! Community mobilisation for HIV/AIDS'.
Available at: www.aidsalliance.org/Publicationsdetails.aspx?Id=228

International HIV/AIDS Alliance (2006), 'Tools together now! 100 participatory tools to mobilise communities for HIV/AIDS'. Available at: www.aidsalliance.org/Publicationsdetails.aspx?Id=229

Mercy Corps (2009). Guide to community mobilization programming. Available at: http://www.mercycorps.org/sites/default/files/CoMobProgrammingGd.pdf

You can access many additional advocacy, communication and social mobilisation resources through the ACSM community of practice. Available at: http://www.aidsportal.org/web/acsm/resources;jsessionid=D17DB2489EB1524E2DBE69158284EDD5.node1

Social mobilisation planning example

Social mobilisation activities may be able to address some of the challenges and barriers you have identified by using the Cough-to-Cure Pathway (Tool 2.6). You can use the step-by-step process below to develop the details of how you will implement social mobilisation activities to make the change you would like to see. An example is provided, and then you have a blank template you can use for each barrier you would like to address with social mobilisation activities. Make as many copies as you need to develop activities for each barrier.

Question	Answer
What TB control challenge would we like to address with social mobilisation activities?	Certain TB treatment units in rural areas of District Z have low treatment success rates (below 60%) and a high percentage of clients who are lost to follow-up ("default" in the data reporting).
What barriers have we identified through the Cough-to-Cure Pathway that can be addressed with social mobilisation?	Community-based DOT and treatment support are not available in the rural areas of District Z.
What specific change (outcome) do we want to see as a result of our social mobilisation activities?	1. One community group in the area of each poorly performing TB treatment unit is participating in the fight against TB and is linked with the TB treatment unit. 2. Each community group provides treatment support services to community members with TB throughout their course of treatment.

Tool 2.10:
Social mobilisation planning

What groups or individuals are we trying to mobilise with our activities?	One community group from each area.
Who can help mobilise them?	1. The village leaders in those areas. 2. The TB treatment unit managers.
What activities will we do to mobilise these groups?	1. Conduct a rapid situation analysis to create a list of existing community groups in those areas. 2. Meet with the village leaders and TB treatment unit directors to get their support for the use of community-based DOT and treatment support. 3. Have a meeting in each area with the village leader, community groups and the TB treatment unit manager to explain the problem and invite their participation in community-based TB care.
Once they are mobilised, what do we want them to do?	1. Attend a one-day training on providing DOT and treatment support for people with TB. 2. Provide DOT and treatment support to members of their community who are being treated for TB, equivalent to 10 people with TB per year for each community group member.
How will we measure the success of this social mobilisation work?	Interim measures of success (output): 1. At least one community group agrees to participate in each area. 2. All groups participate in the one-day training. Final measure of success (outcome): 1. All trained community groups are providing DOT and treatment support services at the target level to people with TB in their communities. The ultimate impact we want to have is a decrease in the percentage of people lost to follow-up (default) and an increase in the treatment success rate for each treatment unit. We are aiming to reach the national target. We can measure our progress by looking at the treatment outcome data for these treatment units over the next several years and comparing it with the current data.

Now use the blank matrix on the following page to try developing your own social mobilisation activities.

Tool 2.10:
Social mobilisation planning

Social mobilisation planning matrix

Organisation:_____ Time period:_____

Question	Answer
What TB control challenge would we like to address with social mobilisation activities?	
What barriers have we identified through the Cough-to-Cure Pathway that can be addressed with social mobilisation?	
What specific change (outcome) do we want to see as a result of our social mobilisation activities?	
What groups or individuals are we trying to mobilise with our activities?	
Who can help mobilise them?	
What activities will we do to mobilise these groups?	
Once they are mobilised, what do we want them to do?	
How will we measure the success of this social mobilisation work?	

Planning service delivery is an activity that should be done in close collaboration with the local units of the NTP and NACP to ensure that activities are in line with national guidance and meet other regulatory requirements. It is not possible to cover all aspects of service delivery planning in this tool, so we will focus mainly on possible community-based services you can incorporate into your current work. There are some additional resources below that you can consult for more information on service delivery topics.

Key resources

Elisabeth Glaser Pediatric AIDS Foundation. 'Clinical standard operating procedure (SOP) templates: implementation of tuberculosis activities at HIV/AIDS service delivery sites'. Available at: www.pedaids.org/Publications/Toolkits#Clinical_Standard_Operating_Procedure__SOP__Templates

Granich, R., Akolo, C., Gunneberg, C., Getahun, H., Williams, P., Williams, B. (2010) 'Prevention of tuberculosis in people living with HIV', *Clinical Infectious Diseases* HIV. Clin Infect Dis. 2010 May 15;50 Suppl 3:S215-22. doi: 10.1086/651494. Available at: www.ncbi.nlm.nih.gov/pubmed/20397951

Tool 2.11:
Service delivery planning

Below is a template that lists HIV-related activities you may be engaged in providing already, along with suggested TB activities that can be added on with minimal inputs of additional staff or resources. This will help you think about where to start integrating TB into your HIV work. Tick the HIV activities in the list that you are already implementing, and then tick suggested TB activities that your organisation might be able to incorporate easily.

HIV activities	Suggested complementary TB activities
☐ **Advocacy, outreach and education** ☐ HIV policy advocacy ☐ HIV resource mobilisation advocacy ☐ HIV prevention education ☐ HIV education for the general public ☐ Stigma reduction ☐ World AIDS Day events ☐ Production and distribution of educational materials ☐ Other _____	☐ **Advocacy, outreach and education** ☐ TB policy advocacy ☐ TB resource mobilisation advocacy ☐ TB prevention education ☐ TB education for the general public ☐ Stigma reduction ☐ World TB Day events ☐ Production and distribution of educational materials ☐ Other_____
☐ **Prevention and diagnosis** ☐ Condom distribution ☐ Prevention of mother-to-child transmission (PMTCT) ☐ Male circumcision ☐ Referral for HIV counselling and testing ☐ HIV counselling and testing ☐ Other_____	☐ One-to-one TB/HIV education ☐ Community-based screening for TB symptoms using a questionnaire ☐ Referral of people with TB symptoms for evaluation at a health facility ☐ Screening of people living with HIV for TB symptoms ☐ Referral of people living with HIV for TB evaluation ☐ Screening of women and children for TB at PMTCT locations ☐ Referral of women and children with TB symptoms for evaluation
☐ **Clinic-based treatment** ☐ ART ☐ CPT ☐ IPT ☐ Laboratory services ☐ Other_____	☐ One-on-one client education on TB/HIV ☐ TB symptom screening ☐ Sputum collection and transport ☐ Sputum smear microscopy ☐ DOT ☐ Peer treatment support groups

☐ **Community-based treatment** ☐ ART ☐ CPT ☐ IPT ☐ Other _____	☐ Family and community education on TB/HIV ☐ Distribution of educational materials ☐ TB symptom screening and referral for evaluation ☐ Community-based sputum collection and transport ☐ DOT ☐ Contact tracing
☐ **Treatment support** ☐ Home visits ☐ Nutritional support ☐ Transportation ☐ Financial support/microloans ☐ Peer support groups ☐ Other_____	☐ Family and community education on TB/HIV ☐ Distribution of educational materials ☐ TB symptom screening and referral for evaluation ☐ Community-based sputum collection and transport ☐ Contact tracing ☐ Instruction on community infection control ☐ Tracing of clients lost to follow-up ☐ Peer support groups ☐ DOT ☐ Nutritional support ☐ Transportation ☐ Financial support/microloans
☐ **Training** ☐ Training for health care providers from the national health system ☐ Training for private health care providers ☐ Training for community volunteers ☐ Other _____	☐ **Training** ☐ Training for health care providers from the national health system ☐ Training for private health care providers ☐ Training for community volunteers ☐ Other _____

Section 3

Use this section of the workbook together with the corresponding Action in the Guide, *Action 3: Choose activities appropriate for your organisation*.

Tool 3.1: Situation analysis

Tool 3.2: Organisational analysis

Tool 3.3: Activity prioritisation matrix

Tool 3.1: Situation analysis

Use this tool to develop a snapshot of the current situation in the area(s) where you are working. It will help you understand the bigger picture in which your activities function, and analyse the TB and HIV challenges this area faces. You can copy the tool if you would like to do this analysis for more than one area. There are blank spaces in case you want to add other information that is important to you.

Basic information

Geographic area	
Total population	
Male **(Hint: break all of these subcategories into total number and percentage of total population)**	
Female	
Adults 45 years and above	
Adults 15–44 years	
Children < 15 years	

TB/HIV profile

Indicator	For the area	For the country	Comparison
Number of people with TB notified in most recent reporting year			
Case notification rate			
Percentage of total notified people who were new			
Percentage of total notified people who were retreatment			
Treatment success rate for new TB			
Treatment success rate for retreatment TB			
Percentage of people lost to follow-up (default) as a treatment outcome			
Percentage of people with TB who died as a treatment outcome			
Percentage of people with TB with a known HIV status			

Percentage of people with TB who were HIV positive			
Percentage of people with TB/HIV on CPT			
Percentage of people with TB/HIV on ART			
Number of people diagnosed with HIV			
Percentage of people with HIV who were screened for TB			
Percentage of people with HIV on IPT			
Number of MDR-TB cases notified			
Number of people with MDR-TB started on treatment			

Are there any specific groups in the area who are most affected by TB/HIV or who lack access to services? (for example, migrants, children, prisoners, certain ethnic groups, slum dwellers)

1.

2.

3.

Major barriers identified through the Cough-to-Cure analysis (three to five)

1.
2.
3.
4.
5.

Organisations working in TB/HIV in this area (including NTP or NACP units)

Organisation	Activities	Client population and location	Timeframe for work	Funding source

With the information above, can you identify specific barriers or population groups that are not being addressed by the existing or planned activities of others? These will be areas to consider for action by your organisation.

1.
2.
3.
4.
5.

Tool 3.2:
Organisational analysis

Use this tool to help you understand the capacity of your organisation to work in TB/HIV, and where there may be gaps or challenges in staffing, expertise, financing or other areas that you need to fill in order to be successful.

Organisational snapshot

Overview	
Name of your organisation	
Year of establishment	
Name of executive director	
Years in the position	
Headquarters address	
Location of any field offices	
Policies	
Does your organisation have a strategy that includes TB/HIV integration?	☐ Yes ☐ No
Staffing	
Number of full-time paid staff	
Number of part-time paid staff	
Number of volunteers at headquarters	
Number of volunteers in the field or community	
Number of technical staff or volunteers	
Number of administrative or maintenance staff or volunteers	
Financing and management	
Annual budget for the past three years	Year:_____Amount:_____ Year:_____Amount:_____ Year:_____Amount:_____
Major sources of funding and approximate percentage of budget	Source:_____%: _____ Source:_____%: _____ Source:_____%: _____ Source:_____%: _____ Source:_____%: _____
Size of largest grant you have managed	
Through what year does your organisation have funding available?	
Do you have a financial accounting system in place that has received an external audit?	☐ Yes ☐ No
What is the name and position of the person responsible for donor reporting?	

Tool 3.2:
Organisational analysis

Partnerships	
List your main partners at national and local levels in this column (add rows as needed)	Describe the nature of your partnership in this column (What do you do together?)

Organisational activities

Check the boxes in the tables below for the activities that your organisation is already implementing.

HIV activities
Advocacy, outreach and education ☐ HIV policy advocacy ☐ HIV resource mobilisation advocacy ☐ HIV prevention education ☐ HIV education for the general public ☐ Stigma reduction ☐ World AIDS Day events ☐ Production and distribution of educational materials ☐ Other _____
Prevention and diagnosis ☐ Condom distribution ☐ PMTCT ☐ Male circumcision ☐ Referral for HIV counselling and testing ☐ HIV counselling and testing ☐ Other _____
Clinic-based treatment ☐ ART ☐ CPT ☐ IPT ☐ Laboratory services ☐ Other _____

Community-based treatment
- ☐ ART
- ☐ CPT
- ☐ IPT
- ☐ Other _____

Treatment support
- ☐ Home visits
- ☐ Nutritional support
- ☐ Transportation
- ☐ Financial support/microloans
- ☐ Peer support groups
- ☐ Other_____

Training
- ☐ Training for health care providers from the national health system
- ☐ Training for private health care providers
- ☐ Training for community volunteers
- ☐ Other _____

☐ Other (describe)

TB activities

Advocacy, outreach and education
- ☐ TB policy advocacy
- ☐ TB resource mobilisation advocacy
- ☐ TB education for the general public
- ☐ Stigma reduction
- ☐ World TB Day events
- ☐ Production and distribution of educational materials
- ☐ Other _____

Case-finding and diagnostic services
- ☐ Community-based screening for TB symptoms
- ☐ Referral for TB testing at a health facility
- ☐ Community-based sputum collection
- ☐ Sputum smear microscopy
- ☐ Other diagnostic testing (such as culture, MGIT, Xpert)
- ☐ TB contact tracing

Clinic-based treatment
- ☐ DOT
- ☐ Laboratory services
- ☐ Other _____

Community-based treatment
- ☐ DOT
- ☐ Instruction on infection control in the community (such as cough etiquette)
- ☐ Other _____

Treatment support ☐ Home visits ☐ Nutritional support ☐ Transportation ☐ Financial support/microloans ☐ Peer support groups ☐ Tracing of people with TB who are lost to follow-up ☐ Other_____
Training ☐ Training for health care providers from the national health system ☐ Training for private health care providers ☐ Training for community volunteers ☐ Other _____
☐ Other (describe)

Population groups

Check the groups that your organisation currently works with, and estimate the number of people in *each of* those groups:

Group	Number of people served
☐ Women	
☐ Children	
☐ People living with HIV	
☐ People who use drugs	
☐ Migrants	
☐ Displaced persons/refugees	
☐ Slum dwellers	
☐ Homeless people	
☐ Prisoners	
☐ Miners	
☐ Diabetics	
☐ Other _____	

Tool 3.3:
Activity prioritisation matrix

Below is a simple matrix that can help you decide which activities are most appropriate for your organisation if you have to choose from a large number of options. List your potential activities in the first column. Then put a tick in each box for which you can reply "yes" to the statement heading each column. At the end, add up the number of ticks for that activity and enter it in the last column. The activities with the highest numbers are the most appropriate activities for your organisation. Of course, there will always be times when you want or need to do something that may be more challenging. Remember to consider carefully the potential costs and risks before you decide to take on those activities.

Activity number	Addresses a gap that no other group is filling	We have existing technical expertise to implement	We have existing staff or volunteers to implement	We have existing funding to implement	We have time available to implement	This activity complements other work we are doing now	This activity will benefit >50% of our existing client population	This activity will produce measurable improvements in TB/HIV outcomes	Total number of ticks

Section 4

Use this section of the workbook together with the corresponding Action in the Guide, *Action 4: Create or strengthen appropriate partnerships*

Tool 4.1: Partner identification and selection

Tool 4.2: Partnership plan checklist and sample memorandum of understanding

Tool 4.1:
Partner identification and selection

You need to be strategic when selecting your partners. Your decisions should be based on the likelihood that particular organisations will help you produce the results you would like to achieve. All of the tools in Workbook Section 3 will be useful in going through these exercises, so you should review them and keep them handy as you go through this process of partner identification. Tool 3.1, the Situation Analysis, helped you identify programmatic gaps that your organisation might fill, and listed the other organisations working in your area. The Organisational Analysis (Tool 3.2) helped you identify any gaps in your organisation's capacity to implement TB-related activities. Finally, the Activity Prioritisation Matrix (Tool 3.3) helped you choose the activities you are best suited to implement, and to identify gaps that remain in your capacity to implement those activities. It also listed the activities that would be helpful to implement, but are lower priority for your organisation. Go back to these tools and review the information you have to remind yourself of the gaps you have identified. Potential partners should complement your organisation's work and add to your strengths and technical expertise. The partnerships you create should be ones that can fill gaps for the activities you have chosen to do, or can do the activities your organisation has not prioritised.

Below are a few simple questions you can ask yourselves to help you start the process of selecting your partners. You can answer these questions using the template on the next page. An example is provided, followed by a blank template you can use.

Ask yourself:

- Does this organisation/partner have specific technical expertise that my organisation does not possess?
- Can this organisation/partner fill a funding gap that my organisation is experiencing in order to implement certain activities?
- Can this organisation/partner fill the geographical or population coverage gaps that my organisation is experiencing?
- Does this organisation have political connections that can be useful for our work?
- Are there other benefits to partnering with this group?
- Are there some drawbacks if I partner with this organisation?
- Are there other organisations besides these with whom we should consider partnering?

***Comment**: Identifying the right partner organisations to complement your programme is a difficult process. It needs a very careful review, not only of the organisation's capabilities and technical expertise, but also of its reputation and credibility, and how its other partnerships have functioned in the past – all of which may have an impact on your own partnership with this organisation. You can use the "potential drawbacks" column in the template on the following pages to record any possible issues you might encounter in working with a partner.*

Tool 4.1:
Partner identification and selection

Example of potential partner analysis

Organisation: ___Community Activists for Health_____ Project: _____Fight TB, 2014–2015_____

Potential partner	Benefits						Potential drawbacks
	Has necessary technical expertise	Has necessary funds or other resources	Has necessary geographic coverage	Reaches key target groups	Has necessary political power	Other (describe)	
Metta Community Helpers			✓	✓			Are sub-recipients under Global Fund. May not have time for activities.
District Association of Private Physicians	✓				✓	✓ (history of partnerships with this group)	Have a poor relationship with the NTP.
Best Clothing Company, Ltd.		✓		✓			Low priority topic for the company. Will require advocacy.
District Y Primary Care Clinic	✓	✓	✓				
World Health Organization country office	✓				✓		Agreements take a long time to be approved.

Once you have completed the table, review and discuss your potential partners. You can gather more information on the selected partners by using Tool 3.2 *(Organisational analysis)* to assess their organisational strengths. Decide which of the partners are best suited to this project and clearly describe why you would like to have them as partners. Then move to the next step of discussing your project with partners and developing partnership agreements.

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Tool 4.1:
Partner identification and selection

Potential partner analysis

Organisation: _____ Project: _____

Potential partner	Benefits						Potential drawbacks
	Has necessary technical expertise	Has necessary funds or other resources	Has necessary geographic coverage	Reaches key target groups	Has necessary political power	Other (describe)	

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Tool 4.2: Partnership plan checklist and sample memorandum of understanding

A partnership plan defines the way in which different organisations will work together to achieve a common set of objectives. To make a partnership work smoothly, it is important that all aspects of the project and the relationships among the partners are as clear as possible to avoid misunderstandings. The checklist below can help you plan the partnership to make it successful and efficient. Write all of these aspects into a document that the partners sign, and provide *each partner* with a copy of the plan so that everyone is aware of how the partnership will function. This document complements your work plan, which describes what each partner will do and by when. A sample partnership plan follows this checklist. It is only a sample, and you can modify it to make it work for your situation. Following the sample plan, we also include a real-life sample of a memorandum of understanding (MOU) for a project to show you another way to approach an agreement with partners. No one way is right or wrong. Just remember that the more detail you can put in your plan, the easier it will be for partners to participate in the project as you intended them to do. The final sample in this tool is a task matrix. A task matrix is an easy way to see which partners are responsible for which kinds of activities in your project. It summarises the details you will develop in your work plan. If you find it useful, you may adapt it for your own needs.

Partnership plan checklist

✓	Partnership plan item
	Project name
	Start and end dates of the project
	Brief project description
	Geographic area of the project
	Lead organisation and project director contact information
	Partner organisations and contact person information
	Roles and responsibilities of each organisation
	Decision-making • Who will be involved in decisions about project strategy? • Who will be involved in developing the work plan • Who will be involved in decisions about problems • Who will be involved in decisions about budget and finance • Who approves project-related documents and products (such as presentations) • How credit will be given to each organisation in the partnership

Tool 4.2: Partnership plan checklist and sample memorandum of understanding

✓	Partnership plan item
	Communication • Who is the contact person for each group • What information will be communicated • How you will communicate (phone, email, meetings) • How often you will communicate • Who is responsible for external communication (with donor, the media, etc.)
	Reporting and monitoring • Who is the point person in each group • Who will be involved in monitoring the project • How project-related data will be shared • What information be reported • What format that information should take • When reporting is due
	Project budget and allocations of budget to partners • How project funds will be managed • How funds will be provided to each partner • When funds will be provided • Requirements for receiving funds • How any other project resources will be used or shared (vehicles, office equipment, etc.)
	Project partner calendar
	Partnership evaluation • How the partnership function will be evaluated • When evaluation will be done

Tool 4.2: Partnership plan checklist and sample memorandum of understanding

Sample partnership plan agreement

Project name: Fight TB
Start and end dates: 1 January 2014–31 December 2015

Project description:
This is a two-year project funded by World Health Foundation that is aimed at increasing TB case-finding and treatment success among people living with HIV in one districts with the heaviest burden of HIV and of HIV-related mortality in the country. The project will used 25 trained community volunteers to conduct community education and home-based TB screening of people living with HIV, followed by referral to the health clinic for those with symptoms based on a standard questionnaire. In addition, volunteers will conduct contact tracing in households of people diagnosed with TB during the project period. They will provide treatment support for all community members diagnosed with TB. The expected outcomes of the project are an increase in TB case notification rates from 110/100,000 to 150/100,000 and an increase in treatment success from 80% to 90% in the district by December 2015.

Geographic area: District Y in Country A

Lead organisation and contact:
Community Activists for Health (CAH)
Andrea Solara, Project Director
P.O. Box 224
Newtown 65432

Mobile: 7586970
Email: asolara@cactivists.com
Website: www.cactivists.com

Partner organizations and contacts

Partners Against TB (PAT)
Simon Apani
65 Electric Avenue
Someville 65789

Mobile: 4356219
Email: sapan1@pat.org
Website: www.PartnersATB.org

Tool 4.2: Partnership plan checklist and sample memorandum of understanding

District Y Primary Care Clinic

Teresa Patan
99 Liberation Street
Hopeton 65222

Mobile: 8675309
Email: terpat@yahoo.com
Website: www.CountryANTP.org

Roles and responsibilities

Community Activists for Health: CAH is the lead organisation for this project, responsible for all aspects of project management and for overseeing all implementation activities. CAH will be responsible for:

- donor communication
- external communication
- work plan development and monitoring
- budget development and monitoring
- sub-agreements with partners
- procurement and tracking of all project equipment and supplies
- reporting
- implementation
- reporting
- implementation activities in District Y.

Partners Against TB: PAT is a partner on this project. PAT is responsible for the following general areas, further detailed in the work plan:

- implementation activities in prisons in District Y
- participation in project management activities.

District Y Primary Care Clinic: District Y Primary Care Clinic is a partner on this project. The clinic is responsible for the following activities, further detailed in the work plan:

- training of trainers for community outreach work
- supervising community volunteers in District Y
- supporting project M&E and reporting by working with CAH to collect and analyse project data
- providing diagnostic and treatment services to all people diagnosed with TB in District Y
- participation in project management activities.

Decision-making

CAH will participate in all decisions related to project activities to ensure consistency with the overall agreement with World Health Foundation. CAH will involve partners in developing the annual work plan and budget through a weeklong planning meeting at CAH offices held one month before the start of each project year. If problems arise related to project implementation, decisions will be taken in consultation with concerned partners. CAH will remain the final decision-making body in the event that partners cannot be reached or there is a disagreement about how to proceed. All documents and other materials produced as a result of this project must be reviewed and approved by CAH prior to their distribution. This review should be built into project schedules.

Credit for project activities will be shared by all the partners. The project will develop a logo that includes all partner logos. This is the official logo that will be used on all documents, presentations and other materials produced by the project. Any information distributed about project activities will use the Fight TB project name and will identify all partners in the project.

Communication

External communication with the donor and the media are the sole responsibility of CAH. If partner organisations receive media inquiries, they should consult with CAH before agreeing to comment or provide information on the project.

The contact persons listed above will be responsible for communication between the three partners. Regular communication will include the following:

- monthly project meetings held at CAH offices on the first Thursday of each project month.
- weekly email communication to provide any updates on implementation activities. CAH will circulate any important project-related correspondence from the Global Fund or the NTP to all partners within two days of its receipt
- phone calls as needed for urgent matters that require immediate decisions.

Agendas for all meetings will be circulated at least one day prior to the meeting. All meetings and other communication will be documented in writing and circulated to all partners within one week.

Reporting

The contact persons listed above are responsible for reporting to CAH on progress from their organisations on a quarterly basis. The report should include the following information:

- status of work plan activities
- data related to those activities (indicators defined in the work plan)

- problems or challenges encountered during the reporting period and how they were addressed
- plans for the upcoming quarter.

The quarterly reports are due on the following dates:

- 20 March
- 20 June
- 20 September
- 20 December

In addition to the quarterly report for December, an annual report summarising all progress during the project year is required. The annual report is also due on 20 December and should follow a similar format to the quarterly reports. The annual report should include a one-page highlighted success story related to the work of the organisation on this project. A sample is attached to this plan.

Project budget and allocations to partners

The total project budget for this two-year project is $350,000. Budget allocations will be made to partners based on activities developed in the work plan and negotiations with the finance manager at CAH. Payments will be made to partner organisations as follows:

- 25% of budget at project start to cover start-up costs
- quarterly from the second quarter onwards to cover budget of anticipated activities for the quarter.

Release of funds will not be made until accounting for existing funds has been provided, activities have been completed, and progress reports have been received and approved by the project director.

The project has one vehicle assigned for its use. This vehicle will be used primarily by CAH for project implementation and monitoring activities. If partner organisations require use of the vehicle for project activities, they should communicate their needs in advance to the project director.

Tool 4.2: Partnership plan checklist and sample memorandum of understanding

Project calendar

Please refer to the work plan for detailed activity due dates. In addition, this calendar provides key project management-related dates for year 1 of the project.

12–17 December 2013:	Year 1 work plan development meeting
10 January 2014:	Project launch press conference
6 February:	Monthly partners' meeting
3 March:	Monthly partners' meeting
20 March:	First quarterly progress report due to CAH
4 April 4:	Monthly partners' meeting
5 May:	Monthly partners' meeting
3 June 3:	Monthly partners' meeting
20 June:	Quarterly report due to CAH
2 July:	Monthly partners' meeting
4 August:	Monthly partners' meeting
5 September:	Monthly partners' meeting
20 September 20:	Quarterly report due to CAH
5 October:	Monthly partners' meeting
4 November:	Monthly partners' meeting
5 December:	Annual partners' meeting
20 December:	Quarterly and annual reports due to CAH

Partnership evaluation

In addition to evaluating progress on the activities and objectives of the project, partners will assess how the relationship between the organisations is functioning on a quarterly basis, and make adjustments as needed to ensure that the project is going smoothly. During the regular partners' meetings for each quarter, the agenda will include a check-in on any partnership issues (such as communication, payments, etc.). Any changes will be documented in the minutes of the meeting.

In addition, the partners will be asked for written feedback on the partnership at the end of the year to document any challenges and best practices. CAH will include this and its responses in the report back to the partners at the end of the year.

Tool 4.2: Partnership plan checklist and sample memorandum of understanding

Sample of Partnership Memorandum of Understanding

This sample MOU was drawn up between the Provincial Ministry of Health (MOH) in Cambodia and private sector pharmacies in the province in an effort to work together to implement the National Public-Private Mix Strategy for TB control. The MOU clearly outlines the objectives and the key responsibilities of each partner.

Memorandum of Understanding between MOH and Pharmacies

Kingdom of Cambodia
"Nation, Religion, King"
Ministry of Health
Provincial Health Department

Memorandum of Understanding between [private sector provider] and [Province] Provincial Health Department, Ministry of Health, Cambodia

Director: _____

Pharmacy/depot/cabinet: _____

Address: _____

Phone: _____

This Memorandum of Understanding (MOU) has been prepared with the objective to serve the public through support of public sector activities to increase case detection and treatment of tuberculosis (TB). The private sector providers and the Provincial Health Department (PHD) herein agree to integrate TB private-private mix (PPM) of directly observed therapy, short course (DOTS) for TB control activities in [province] Province. Both parties will agree to cooperate with each other as follows:

Private provider representative agrees to:

- Participate in TB PPM DOTS activities in [province] Province;
- Collaborate with PHD, National Tuberculosis Program (NTP), and operational district (OD) teams and related organisations for the duration of this agreement;
- Participate in the trainings and workshops related to TB, PPM, and referrals;
- Provide accurate and correct information about TB to clients presenting with TB-like symptoms by following the national TB guidelines;
- Refer all clients with TB-like symptoms to previously identified public DOTS services for follow-up and evaluation;
- Fill in the referral slip and provide clients with correct instructions on its use;
- Keep the referral records and provide information on referral activities to the PHD/OD teams as requested; and
- Remain open to monitoring and regular supervision from the PHD and OD teams.

(continued on next page)

Tool 4.2: Partnership plan checklist and sample memorandum of understanding

[Province] Provincial Health Department agrees to:

- Conduct regular assessments of private providers, with support from partner organisations;
- Provide general guidance and direction to the design and strategy of PPM activities;
- Cooperate with NTP, OD teams, and other partner organisations to organize and facilitate training workshops for private health providers in the TB PPM network;
- Provide technical support and instructional materials related to the TB PPM activities;
- Develop guidelines and reporting systems for clients presenting to private providers with TB-like symptoms;
- Strengthen and improve public DOTS services in accordance with national guidelines for diagnosis and treatment; and
- Design, implement, and monitor a system that acknowledges private provider contributions to TB control and fosters sustained engagement.

This MOU will be effective on the date of signing and will be valid for a period of one year. The MOU will be extended following a review and necessary updates and revisions as needed.

The undersigned agree to the terms of this MOU.

_____	_____
PHD Director	Private Health Provider
Date: _____	Date: _____

Tool 4.2: Partnership plan checklist and sample memorandum of understanding

Sample partner organisation task matrix

This tool will help you to define clear roles for each partner. *In* the *task* column, list all tasks that need to be done under this project. In consensus with all partners, assign tasks to each. This matrix is a live tool that needs to be reviewed regularly to measure progress and identify problems. It summarises the details that you have developed in your work plan about which organisation will perform which activity.

Partner task matrix from the United States Agency for International Development TB PPM Initiative in Cambodia

	Tasks	NTP	PATH	Pharmacy Association of Cambodia	Public Health Dept/Municipal Health Dept/ Operational District	Public providers	Private providers
Clinical tasks	Identify TB symptoms						
	Collect sputum samples						
	Refer TB suspects						
	Notify/record cases						
	Supervise treatment						

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Tool 4.2: Partnership plan checklist and sample memorandum of understanding

	Tasks	NTP	PATH	Pharmacy Association of Cambodia	Public Health Dept/Municipal Health Dept/ Operational District	Public providers	Private providers
	Smear microscopy						
	Diagnose TB						
	Prescribe treatment						
	Inform clients about TB						
Public health tasks	Strategy development						
	Identify supportive entities						
	Tool, IEC development						
	Follow up on defaulters						

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Tool 4.2: Partnership plan checklist and sample memorandum of understanding

	Tasks	NTP	PATH	Pharmacy Association of Cambodia	Public Health Dept/Municipal Health Dept/ Operational District	Public providers	Private providers
	Training of providers						
	Supportive supervision						
	Lab quality assurance						
	M&E						
	Supply management						
	Stewardship, financing, regulation						
	Advocacy						

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Tool 4.2: Partnership plan checklist and sample memorandum of understanding

Partner task matrix

Tasks	Your organisation	Partner A	Partner B	Partner C	Partner D	Partner E

Section 5

Use this section of the workbook together with the corresponding Action in the Guide, *Action 5: Plan, implement and measure the success of your activities.*

Tool 5.1: Planning and monitoring and evaluation checklist

Tool 5.2: Work plan template

Tool 5.3: Sample TB screening tools

Tool 5.4: Sample referral slips

Tool 5.5: Monitoring template

Tool 5.6: Evaluation template

Tool 5.7: Sample results reporting forms

Tool 5.1:
Planning & M&E checklist

Use this checklist to help you prepare a strong plan for the monitoring and evaluation of your project. It will take you through all of the important phases of project planning and implementation with M&E in mind.

Phase 1: Planning

Step 1: Conduct a needs assessment	
	Perform Cough-to-Cure gap analysis to identify TB control challenges and barriers
	Determine which gaps can be addressed with CSO activities
	Prioritise activities based on needs and resources

Step 2: Develop an action plan (work plan)	
	Identify current NTP TB control goals and objectives
	Develop CSO objectives that link to the NTP objectives
	Determine which geographic areas to target
	Identify key partners
	List specific activities for each objective and assign responsibility to specific partners
	Determine the timeline for each activity
	Identify resources and capacity-building needed for each activity
	Develop a budget to support capacity-building and implementation of activities

Step 3: Create an M&E framework to link inputs, activities, outputs and outcomes to each other and to NTP objectives	
	List CSO objectives (linked with NTP objectives)
	List activities under each objective
	Identify the critical inputs needed for each activity
	Define expected outputs for each activity
	Describe expected outcomes of the activities

Step 4: Draft an M&E plan	
	Identify which *outputs* to monitor. Determine data sources and data collection methods
	Identify which *outcomes* to monitor. Determine data sources and data collection methods
	Select indicators for outputs and outcomes, and create complete indicator descriptions
	Assign monitoring and reporting responsibilities among partners and determine timelines
	Create a data use plan to specify which trends to monitor and how to report data
	Develop a strategy to assure data quality for key indicators
	Determine which activities or outcomes need evaluation. Select evaluation methods according to time and resources available
	Assign evaluation implementation and reporting responsibilities, and determine timelines
	Develop a budget for M&E activities

Phase 2: Implementation

Step 1: Conduct routine monitoring	
	Collect data on indicators according to the M&E plan
	Analyse data to determine which activities are below, at or above target, based on your analysis of outputs and outcomes

	Document any problems or challenges in implementation
	Implement the data quality assurance strategy
	Develop and disseminate monitoring reports according to the M&E plan timeline

Step 2: Conduct evaluation	
	Conduct formative evaluation for new CSO interventions and adjust them accordingly
	Pre-test any communication messages.
	Plan for process, outcome and/or impact evaluation, including collection of baseline and final data
	Develop data collection tools, and train all those who will be collecting and analyzing data.
	Collect and analyse baseline data
	Determine whether and how activities should be modified, and whether resources need to be increased or redirected.
	Perform process and outcome evaluations according to the M&E plan timeline
	Collect and analyse end line data for impact evaluation, according to M&E plan

Step 3: Apply results to future CSO activity planning	
	Use M&E data to develop recommendations for future CSO programming
	Revise CSO strategic plan, CSO action plan and M&E plan for future CSO activities

Tool 5.2:
Work plan template

The template in this tool is designed to help you organise the objectives and activities you have developed into a framework that can clearly show the contribution you are making to the goals and objectives of the NTP. You can transfer the information you developed using any of the tools from Section 2 onto this template, so that everything is in one place and is organised according to the NTP objectives. There will almost always be more than one NTP objective that your objectives and activities contribute to. To make it simple, list them in the place that seems most logical to you – there is no need to repeat them. An example of a completed work plan is provided on the next page (continued from the example in Tool 2.7), followed by a blank template for your use. You can add or delete sections as needed. You may have only one objective, or you may have several under a section. Adapt the template to suit you. You will also see a column to list the organisation responsible and specific person in charge of the activity. This is especially important if you are doing joint planning with other CSOs, the NTP or others working in your area. Regardless, make sure one specific person is listed who is accountable for completing each activity.

Tool 5.2:
Work plan template

Example of a work plan

Organisation(s): The Positive Living Group, Hand in Hand for Health, Heath Actions Partners, Community Health Coalition
Project location: District Y
Timeframe: January–December 2014

NTP goal: _____Reduce TB incidence and mortality in line with Millennium Development Goals_____

CSO activities	Interim results expected (output)	Final results expected (outcome)	Organisation responsible, lead staff	Timeline (months)											
				1	2	3	4	5	6	7	8	9	10	11	12
NTP objective 1: By 2015, increase treatment success to 90% in all districts in the country.															
CSO target: By 2015, increase treatment success to 90% in District Y.															
CSO objective 1.1: By December 2014, ensure all people diagnosed with TB in District Y receive information materials on TB treatment**,** and education sessions on the importance of treatment completion**,** at diagnosis and once per month while on treatment.															
Activity 1.1.1: Develop and distribute simple flyer or other appropriate IEC materials for District Y community members diagnosed with TB.	350 brochures produced.	100% of people diagnosed with TB in District Y receive and understand educational information.	Positive Living Group Willy George		X	X	X								
Activity 1.1.2: Provide home-based education and ongoing reinforcement of the importance of treatment completion to District Y community members	All home-based care staff trained to provide TB education. Education and	All people diagnosed with TB in District Y have a good understanding of	Positive Living Group				X	X	X	X	X	X	X	X	X

Tool 5.2:
Work plan template

CSO activities	Interim results expected (output)	Final results expected (outcome)	Organisation responsible, lead staff	Timeline (months)											
				1	2	3	4	5	6	7	8	9	10	11	12
with TB, using our existing home-based care staff.	treatment support sessions conducted monthly for all people with TB in District Y.	TB and can explain the importance of completing a full course of treatment.													
CSO **objective** 1.2: By December 2014, identify, recruit and train 15 community members who each provide treatment support to 10 people with TB in District Y.															
Activity 1.2.1: Recruit, train and supervise 15 community DOT supporters.	15 community members trained to be community DOT supporters. Community DOT supporters are supervised on a weekly basis by health centre nurse.	150 people with TB in District Y have access to community-based DOT.	Hand in Hand for Health Vladimir Kreskin				X	X	X	X	X	X	X	X	X
CSO **objective** 1.3: By December 2014, ensure that all clients with TB in District Y have access to DOT services in the clinic or in the community.															
Activity 1.3.1: Conduct focus group meeting with community members with TB to understand how clinic hours can be changed	One focus group meeting conducted in District Y.	Specific barriers posed by current clinic hours are understood and	Health Action Partners Maria Ana Perez		X	X									

CSO activities	Interim results expected (output)	Final results expected (outcome)	Organisation responsible, lead staff	Timeline (months)											
				1	2	3	4	5	6	7	8	9	10	11	12
to better meet their needs.		documented. The community's suggestions on improvements are documented for discussion. A community representative is chosen to join the meeting with the medical officer.													
Activity 1.3.2: Hold a meeting with the District Y medical officer and TB clinic staff to present findings of the focus group discussion, advocate for a change in clinic hours, and offer to provide community-based DOT in collaboration with the clinic.	One meeting with District Y medical officer held.	Clinic hours are changed to better meet community needs. District Y medical officer agrees to a formal partnership with local CSOs to provide community-based DOT to people who cannot come to the clinic for DOT.	Community Health Coalition Shiva Mehta			X									

Tool 5.2:
Work plan template

Work plan

Organisation(s):_____ Time period:_____

Project location(s):_____

NTP Goal_____

CSO activities	Interim results expected (output)	Final results expected (outcome)	Organisation responsible, lead staff	Timeline (months)											
				1	2	3	4	5	6	7	8	9	10	11	12
NTP objective 1:															
CSO target:															
CSO objective 1.1:															
Activity															
Activity															
CSO objective 1.2															
Activity															
Activity															

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Tool 5.2:
Work plan template

CSO activities	Interim results expected (output)	Final results expected	Organisation responsible	Timeline (months)												
NTP objective 2																
CSO target:																
CSO objective 2.1																
Activity																
Activity																
CSO objective 2.2																
Activity																
Activity																

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Tool 5.3:
Sample TB screening tools

If your national programme does not have a standard TB screening tool for people living with HIV, you can use the samples below to develop a tool for your clients.

Sample TB screening tool used in Tanzania

MINISTRY OF HEALTH AND SOCIAL WELFARE
COLLABORATIVE TB/ HIV ACTIVITIES

TB SCREENING QUESTIONNAIRE FOR HIV/AIDS PATIENTS

Date: _____ **Reg. Number:** _____
Patient's name: _____
Physical Address: _____
Contact telephone (if available) _____
Area leader/ neighbor: _____
Sex: Male _____ Female: _____ Age _____

Tick appropriate response

Do you have the following:	Yes	No
1. Cough for two or more weeks?	{ }	{ }
2. Coughing up bloodstained sputum (haemoptysis)?	{ }	{ }
3. Fevers for two or more weeks?	{ }	{ }
4. Noticeable weight loss for new patients or a 3 kgs weight loss in a month (subsequent visit) ?	{ }	{ }
5. Excessive sweating at night for two or more weeks?	{ }	{ }

- If 'YES' to one or more questions:
  Do sputum examination and continue evaluation according to the TB diagnostic flowchart of the National Tuberculosis and Leprosy Program (NTLP)
- If 'No' to all questions: stop TB investigations and repeat screening at the subsequent visit (every month)

Tool 5.3:
Sample TB screening tools

Sample TB screening tool adapted from a tool used in Rwanda

	YES	NO
1. Has the individual had a cough for >2 weeks?	[ ]	[ ]
2. Has the individual had fevers for >2 weeks?	[ ]	[ ]
3. Has the individual had an observed weight loss >3 kg in last 4 weeks?	[ ]	[ ]
4. Has the individual had night sweats for >2 weeks?	[ ]	[ ]
5. Has the patient been in close contact with someone with TB in the past year? (optional)	[ ]	[ ]
6. If done, does the patient have a Tuberculin Skin Test (TST) induration of >5 mm? (optional)	[ ]	[ ]

If 'YES' to Question 1, patient is a pulmonary TB suspect, regardless of answers to other questions, begin evaluation for TB.

If 'NO' to Question 1 but 'YES' to any other question, patient is a TB suspect. Begin evaluation for TB.

If 'NO' to all questions, patient is not a TB suspect. Repeat TB screening in 3-6 months time.

Source: Howard, A.A. and El-Sadr, W.M. (2010), 'Integration of tuberculosis and HIV services in sub-Saharan Africa: lessons learned', Clinical Infectious Diseases 50 (3): S238–S244. Available at: http://cid.oxfordjournals.org/content/50/Supplement_3/S238.full#sec-1

Tool 5.4:
Sample TB referral slips

If your national programme does not have a standard referral slip for you to use to send people with TB symptoms to a health facility for evaluation, you can use these samples to develop your own slip.

Sample from a Cambodia pharmacy project

Kingdom of Cambodia

"Nation, Religion, King"

Ministry of Health
National Center for Tuberculosis and Leprosy Control

Referral Slip

No .....

For private providers making referrals for clients with TB-like symptoms

PLEASE FILL IN ALL INFORMATION

Patient Name: ..... Age:..... Sex: Male ☐ Female ☐

Address of Patient: House #..... Street:..... Group:..... Village:.....

Commune..... District:..... Tel:.....

Date of referral:...../...../200.....

Referred from (Place Name) : ..... Code Number:.....

Hospital/Clinic ☐ Pharmacy/Depot ☐ Lab ☐ Factory/Enterprise ☐

To (Place name) :..... Public Service ☐ Private Service ☐

Symptoms ☐ Cough over 21days ☐ Chest pain ☐ Fever ☐ Cough with blood ☐

Others:.....

For: Smear exam

Please fill in the below information in the case that your client has received these services:

Use other drug besides TB drug: Yes ☐ No ☐ (Drug Name..... number of days used.....)

X-Ray: Yes ☐ No ☐ (Please tell you client takes it along)

Smear exam: Yes ☐ No ☐ (Please tell your client take the result of smear exam along)

If your clients have other documents please tell them to take it with them.

Tool 5.4:
Sample TB referral slips

Please tell your client that he/she has symptoms that might be TB, so he/she needs to go to health center or referral hospital for proper diagnosis (check smear). Please give this referral slip (Blue and Pink) to your client and ask your client to bring it along and give it to the health center or referral hospital staff.

For public provider to fill in:

Date of patient visit: ...../...../200.....

Smear result :	Lam 1	Lam 2	Lam 3
Smear exam 1			
Smear exam 2			

X-Ray No ☐ Yes ☐

Active TB ☐ TB suspect ☐ TB scar ☐ Other..... Clarify.....

Diagnosis: BK+ ☐ BK- ☐ EP ☐ No TB ☐

Case without TB : Refer back to Private service ☐ Do not refer back to private service ☐

Reasons:.....

Name of heath facility:..... Signature and Name:.....

- **Health service:** Public or private health service recognized by Ministry of Health in TB diagnosis.

  Note: This sample is used for public and private mix to implement of DOTS strategy.

Tool 5.4:
Sample TB referral slips

Sample referral slip from Tanzania

Ministry of Health and Social Welfare
National Tuberculosis and Leprosy Program
Engagement of Pharmacists and Traditional Healers in TB Diagnosis

PHARMACY/TRADITIONAL HEALER: PLEASE FILL IN ALL INFORMATION

Patient Name	Age
Referral Date	Sex ○ Male ○ Female
Referral From (Pharmacy/Traditional Healer Name): ID number:	Referral to (Dispensary/Health Center/Hospital Name): Town:
Symptoms ○ Cough > 2 weeks ○ Fever > 2 weeks ○ Weight Loss ○ Night sweats > 2 weeks ○ Chest pain ○ Hemoptysis	Notes: Please tell your client that she/he has TB symptoms and advise him/her to go to the designated dispensary, health center, or hospital for further diagnosis. Assure the person that TB diagnosis and treatment are available free of charge at the recommended facility. Please give the top copy of this referral slip to your client and ask your client to take it to the recommended DOTS facility.

DOTS DIAGNOSTIC FACILITY: PLEASE FILL IN ALL INFORMATION

Facility Name*	Diagnostic services provided ○ Smear test ○ X-ray ○ Clinical exam
Date receiving patient	Diagnosis ○ Smear positive TB ○ Smear negative/extrapulmonary TB
Signature	

*District TB/HIV Coordinator: Please note whether the facility name matches the referral; some clients may choose a DOTS center other than the one recommended by the pharmacist/traditional healer for convenience or privacy reasons.

Tool 5.4:
Sample TB referral slips

Sample referral slip from TB to HIV services, Tanzania

TB-HIV 03

Ministry of Health and Social Welfare
National TB/Leprosy Programme

TANZANIA TB-HIV REFERRAL / TRANSFER FORM

District: _____ District code: _____

Patient District TB ID number: _____

Patient name: _____ Age (yrs): _____ Sex (M/F): _____

Physical address of patient:If moving, future address: _____

Name and address of treatment supporter:_____

_____

Referred from: _____ (name of TB treatment clinic/ health facility)

Referred to: _____ (name of CTC/health facility, VCT, PMTCT)

Indication for referral: ☐a)For HIV care and treatment ☐b)Support services (spiritual or community) ☐ c)For VCT services ☐d)Others* (specify)

Date started treatment: __/____/ 20___

Type of treatment: RHZE/RH ☐
SRHZE/RHZE/RHE ☐
SRHZE/RHZE/RH_3E_3 ☐
RHZE/EH ☐

Other drugs patient is receiving including ART, CTX: _____

Remarks including side-effects and allergy: _____

Name of clinician: _____ Tel. No.: _____

Signature: _____

Date of referral: ___/____/ 20___ Official stamp: _____

**Medical, surgical, psychiatry, etc.*

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Tool 5.4:
Sample TB referral slips

This portion for use by CTC/health facility, VCT, PMTCT, Support Services and Others

Name of facility: _____

District: _____

Patient name: _____

Patient District TB ID number: _____

The above patient reported at this unit on: ____/__/ 20___

Patient HIV Care Registration No.: _____

Action taken: _____

Name of Clinician/Service Provider: _____

Signature: _____

Date of feedback: __/____/ 20___ Official stamp: _____

Remarks: _____

Return this part to referring/transferring facility as soon as patient has reported.

Source: Manual of the National Tuberculosis and Leprosy Program in Tanzania. Fifth edition (2006).

Tool 5.5: Monitoring template

Monitoring is the process of tracking your progress in completing the activities you set out to do. It is a routine process that is mostly concerned with whether you are reaching your expected interim results (outputs) within the timeframe you set for yourself. You want to develop your monitoring plan at the same time as you write your work plan. The monitoring plan will list what you are going to monitor, how often you will check, and where you will get the information to do the monitoring. It is really just an extension of your work plan table, but since it can be difficult to fit all of the information on one piece of paper, it is separated onto a different sheet. You refer to your objectives, activities, outputs and timeline from your work plan in this template, and add columns to help measure your progress and report on the status of your activity. An example is provided below (continued from our work plan example in Tool 5.2), followed by a blank template for you to use.

Example of project monitoring plan

	Expected interim result (from work plan)	Expected completion date (from work plan)	Monitoring indicator	How often monitored	Source of monitoring data	Status
CSO Objective 1.1	By December 2014, ensure all people diagnosed with TB in District Y receive information materials on TB treatment**,** and education sessions on the importance of treatment completion**,** at diagnosis and once per month while on treatment.					
Activity 1.1.1	200 brochures produced	March 2014	Number# of brochures produced	Monthly	Project records	

Tool 5.5:
Monitoring template

	Expected interim result (from work plan)	Expected completion date (from work plan)	Monitoring indicator	How often monitored	Source of monitoring data	Status
Activity 1.1.2	All (30) home-based care staff trained to provide TB education	April 2014	# of home-based care staff trained	Monthly through April 2014	Project records	
	Education and treatment support sessions conducted monthly for all people with TB in District Y	May 2014 and ongoing	# and % of people with TB receiving monthly educational sessions	Monthly	Project records	
CSO Objective 1.2	By December 2014, identify, recruit and train 15 community members who each provide treatment support to 10 people with TB in District Y.					
Activity 1.2.1	15 community members trained to be community DOT supporters	April 2014	# of community members trained as DOT supporters	Monthly through April 2014	Project records	
	Community DOT supporters are supervised on a weekly basis by health centre nurse	April 2014 and ongoing	# and % of DOT supporters who are supervised by the health centre nurse on a weekly basis	Monthly	Health centre nurse, clinic records	

Tool 5.5:
Monitoring template

	Expected interim result (from work plan)	Expected completion date (from work plan)	Monitoring indicator	How often monitored	Source of monitoring data	Status
CSO Objective 1.3	By December 2014, ensure that all clients with TB in District Y have access to DOT services in the clinic or in the community.					
Activity 1.3.1	1 focus group meeting conducted in District Y	February 2014	# of focus group meetings held	Monthly through February 2014	Project records	
Activity 1.3.2	1 meeting with District Y medical officer held	March 2014	# of meetings with District Y medical officer held	Monthly through March 2014	Project records	

Tool 5.5: Monitoring template

Project monitoring plan

	Expected interim result (from work plan)	Expected completion date (from work plan)	Monitoring indicator	How often monitored	Source of monitoring data	Status
CSO objective 1.1						
Activity 1						
Activity 2						
CSO objective 1.2						
Activity 1						
CSO objective 2.1						
Activity 1						
Activity 2						
Activity 3						

Tool 5.6:
Evaluation template

Evaluation is a process of assessing the final results (outcomes and impact) of your activities. It is usually done once at the end of your project or on an annual basis. It allows you to see whether the activities you completed had the desired effect. If so, then you know you are doing the right thing. If not, you can use the evaluation information to adjust what you are doing to make your work more effective. Evaluation is a process that is time-consuming and can be quite expensive, depending on what you are trying to measure. For that reason, you may choose to evaluate only certain key outcomes of your work, rather than trying to evaluate the outcome or impact of every single activity. We will discuss this below in our example.

It is important to plan your evaluation at the beginning of your project. This is because you need to measure where you start (the baseline) if you want to compare where you end up, and whether the situation has improved, stayed the same or become worse as a result of your interventions. Develop your evaluation plan at the same time as you write the work plan and monitoring plan. The example below continues our example from the Tool 5.2 work plan and the Tool 5.5 monitoring template. After that, there is a blank template for you to use.

Example discussion:

Below we have put together a table to evaluate our activities that support the NTP's first objective, to increase treatment success in all districts of the country to 90% by 2015. We developed three CSO objectives to contribute to this target in District Y, where treatment success is currently low at 62%. What we are trying to achieve with our CSO activities is to help raise treatment success from 62% to 90% by 2015, in collaboration with all the other efforts the NTP and partners are making. So, the ultimate measure of our success will be whether we reach the 90% treatment success target in District Y. That is the most important outcome for us to evaluate. We can also evaluate the effects of each of our activities, but we may not have enough time and money to do so, and it may not be necessary. In this case, we might choose to evaluate only one or a few of the key outcomes we expected to achieve. What we choose to evaluate will depend on how easy or difficult the evaluation will be, how much it will cost in time and money, and how substantially each individual activity contributes to our overall target. In the example below, we have listed how each evaluation would be done, and then we have highlighted the evaluations we intend to do as the highest priority.

Tool 5.6:
Evaluation template

Example of a project evaluation plan

NTP objective 1: By 2015, increase treatment success to 90% in all districts of the country.
CSO target: By 2015, increase treatment success to 90% in District Y.
Baseline value: 62% (2012)
Method of measurement: Review of NTP reports for District Y.

CSO objective	Expected final results (outcome and/or impact)	Baseline value (before activity started)	Method of measurement	Evaluation (this column is completed in the future: examples are provided here)
By December 2014, ensure all people diagnosed with TB in District Y receive information materials on TB treatment, and education sessions on the importance of treatment completion, at diagnosis and once per month while on treatment.	100% of people diagnosed with TB in District Y receive and understand educational information. All people diagnosed with TB in District Y have a good understanding of TB and can explain the importance of completing a full course of treatment.	No printed information is available, and education is limited to a 10-minute provider-initiated session at the time of diagnosis, with no reinforcement. Only 65% of people with TB interviewed could accurately describe the length of treatment and the importance of taking a full course of medication.	Visits to health centres to check for availability of printed material. Review of project documentation and observations of education sessions. Standard questionnaires administered in one-to-one interviews with people being treated for TB to measure change in knowledge from baseline.	
By December 2014, identify, recruit and train 15 community members who each provide treatment support to 10 people with TB in District Y.	150 people with TB in District Y have access to community-based DOT.	Community-based DOT is not available to any clients in District Y.	Review of project and health centre records to quantify number of people being covered by community-based DOT and their treatment outcomes.	In quarters 1 and 2 of 2014, 16 trained community members provided DOT support to 150 people with TB. Of these, 94% completed treatment successfully.

Tool 5.6:
Evaluation template

CSO objective	Expected final results (outcome and/or impact)	Baseline value (before activity started)	Method of measurement	Evaluation (this column is completed in the future: examples are provided here)
By December 2014, ensure that all clients with TB in District Y have access to DOT services in the clinic or in the community.	Specific barriers posed by current clinic hours are understood and documented. The community's ideas on improvements are documented for discussion. A community representative to join the meeting with the medical officer is chosen.	Only informal evidence is available to suggest that clinic hours are a barrier to treatment completion.	Review of project documents to confirm that community concerns have been recorded and shared.	
	Clinic hours are changed to allow more people to access services and decrease the number of people lost to follow-up (default).	Clinic provides DOT from only from 8–10.30am Monday to Friday. Only 114 people with TB accessed DOT services there in 2012, or 50% of the cases notified. Default rate for 2012 was 7%.	Review of opening hours of clinic. Review of clinic records to quantify how many people are accessing DOT at the clinic (number and proportion). Review of NTP reports for District Y to compare default rates before and after CSO interventions.	In 2014, the clinic expanded hours to provide DOT at the regular 8–10.30am hours, for one hour in late afternoons from 5–6pm, and on Saturdays from 8–10am. In the first two quarters of 2014, 210 people accessed DOT at the clinic, representing 58% of cases notified. Default rates decreased from 7% in 2012 to 4% by 2014.
	District Y medical officer agrees to a formal partnership with CSOs to provide community-based DOT to people who cannot come to the clinic for DOT, increasing access to services for all people with TB.	No clients receive community-based DOT.	Review of clinic and project records to quantify how many people with TB are provided with community-based DOT.	(This is important, but is already quantified above in the evaluation of community-based DOT.)

Tool 5.6:
Evaluation template

Project evaluation template

NTP objective: **CSO target:** **Baseline value:** **Method of measurement:**				
CSO objective	**Expected final results (outcome and/or impact)**	**Baseline value (before activity started)**	**Method of measurement**	**Evaluation of results**

Tool 5.7:
Sample results reporting forms

Reporting the results of your work back to the community you serve, your partners, the NTP and your donors is a very important part of making your work a success. How you tell the story of your work will depend on your audience and what information is most important to them. You may report back using many different forms: a written document, a community meeting, a PowerPoint presentation, a radio or TV interview, or an article in a newspaper or a scientific journal. Regardless of how you do it, focus on communicating the results of your work rather than the process. This is where many organisations have trouble communicating effectively: they tell the story of what they did, but not why it is important. Below, you will find a written example you can use as a model for reporting your own results, employing the activities we have used throughout the workbook.

Reporting results to the community

Tips for reporting to the community:

- Use non-technical language.
- Keep it short.
- Summarise who was involved, what you did and what the results were.
- Use personal examples to bring the story to life.
- Use photos and pictures.

SAMPLE ARTICLE

Community organisations band together with the health department and citizens in District Y to tackle tuberculosis

Tuberculosis (TB) is an illness that affects more than 700 people annually in District Y, causing suffering for many families and leading to the death of about 65 people per year. Our community has faced challenges in dealing with TB because people under treatment have to go to the health clinic to receive daily medication, and it was only open for a few hours in the morning to provide this service. “When I was having treatment for TB at the clinic, it was hard for me to take my medicines every day,” said Samuel Lee. “I had to be late for work if I wanted to go to the clinic. It was a hard choice between getting well and earning wages.” As a result, only 62% of the people who became ill with TB each year completed the TB treatment. Those who did not complete treatment risked dying, having their TB become resistant to TB medications, or transmitting TB to other members of their households. The national TB programme’s target is to make sure that at least 90% of people with TB complete treatment. “In District Y, we were far behind this goal,” commented Dr K. Abuja, District Y medical officer. “We were happy when the community came forward to help us tackle this problem.”

In 2013, four community organisations launched an initiative together with the community and the District Y health clinic to help support people with TB throughout the six months of their treatment, so that they could be cured and go back to healthy, productive lives. The Positive Living Group, Hand in Hand for Health, Health Action Partners and the Community Health Coalition worked closely with the District Y health clinic and volunteer community members to make it easier for community members to access TB treatment. First, they

worked with the clinic to expand opening hours for treatment. Now the clinic opens its doors for people with TB to get their medications Monday to Friday from 8–10.30am and from 5–6pm, and on Saturdays from 8–10am. “Being able to receive my medications after work each day helped me stay on my treatment,” said Rosemary Mbwala, who recently completed her treatment. In 2014, a total of 210 people with TB were able to receive their medications at the clinic because of the new expanded hours.

Thanks to the TB project, District Y’s health clinic now has extended hours to serve people with TB

In addition, the four groups recruited community members to provide TB treatment outside the clinic, in community member’s homes. By the end of 2014, they had trained 16 community treatment supporters who helped more than 150 people with TB. Of the people they helped, 92% completed their treatment and are back to living normal lives. As Dorothy Bikindu, a community treatment supporter said, “I feel good being able to give something back to my community. The people we help are our friends and neighbours, and now I have had a small part to play in keeping my community healthy.” People who have suffered from TB are equally happy with the programme. “It was very far for me to walk to the clinic each day,” said Moses Makame. “I am grateful to my treatment supporter, Joseph, who brought my medicines to me each day. Now I am feeling better and am glad I could finish my treatment.”

The community organisations and the health clinic are committed to working together and continuing this programme to support people with TB in District Y. Hand in Hand for Health project director Michael Nzimwa said, “This collaboration has shown the successes that the community and the health clinic can have when they work together. Our success means that people with TB are getting cured and becoming healthy again. That is our ultimate reward.”

Tool 5.7:
Sample results reporting forms

Tips for reporting to partners, NTP, and donors:

- Use technically correct language.
- Briefly summarise who was involved, what you did and the timeframe.
- Divide your report into sections and title each one.
- Concentrate on results and include numbers.
- Clearly link your results to national TB control objectives and targets.
- Use graphs and tables to illustrate the important changes that resulted from your work.
- Include a description of any challenges and lessons learnt or best practices.
- Discuss what you plan to do in the next time period.
- Provide a financial summary as needed.

SAMPLE REPORT

Report on District Y TB project, January–December 2014

Background
The national TB control programme has set an objective to increase TB treatment success to 90% in all districts of the country by 2015. In 2012, treatment success in District Y was only 62%, far below the national target. The Positive Living Group, Hand in Hand for Health, Health Action Partners and the Community Health Coalition discovered through focus group discussions with community members that limited health clinic hours posed a significant barrier to treatment completion, and community-based directly observed treatment (DOT) was not available in the district. In addition, a Knowledge, Attitude, and Practice study revealed that only 65% of people with TB were aware of the duration of TB treatment and could explain the importance of taking a full course of treatment.

In collaboration with the community and the local health clinic, the four community organisations worked to improve treatment success results in the district by increasing knowledge, improving access to DOT, and providing community-based treatment support. The project was launched in 2013. This report summarises work and results from 2014.

Summary of activities
In collaboration with the local health clinic and using volunteers from the community, we provided ongoing education to people with TB on the importance of a full course of treatment; extended the clinic hours to accommodate community access needs; and used trained community volunteers to offer community-based DOT for those who could not reach the clinic during opening hours.

The Positive Living Group produced and distributed 350 copies of an educational brochure for people diagnosed with TB, and continued to reinforce the importance of treatment completion for 350 people on treatment in 2014 by conducting monthly education sessions during home visits and at the health clinic during DOT hours.

Hand in Hand for Health recruited, trained and helped supervise 16 community volunteers who provided community-based DOT to 150 people with TB throughout their course of treatment.

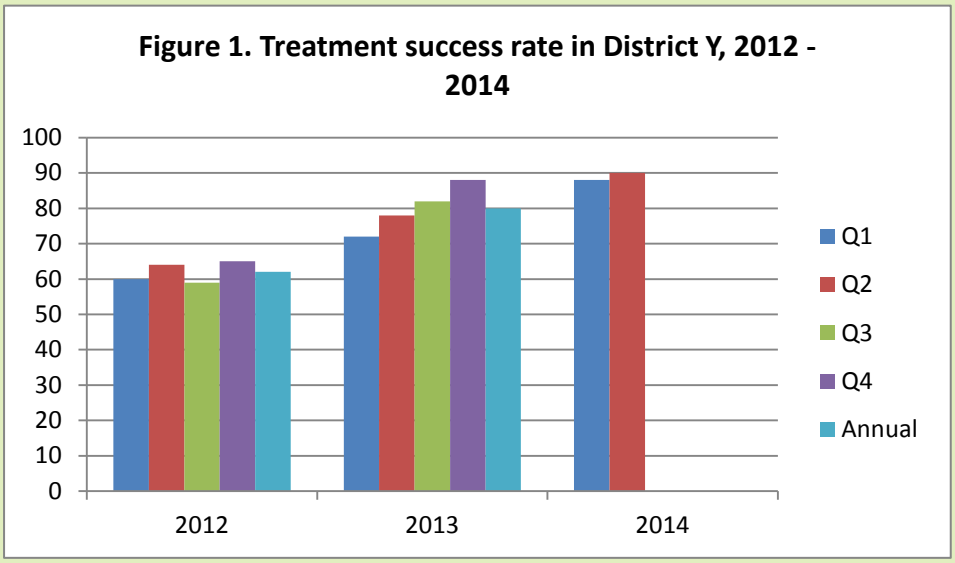
Health Action Partners conducted a community focus group to understand the challenges faced by people with TB in completing treatment, and to work with the community to develop suggestions for how services could be improved to increase TB treatment success.

The Community Health Coalition, representing the above groups as well as a number of other community stakeholders, presented the results of the focus group discussions to the District Y medical officer and health clinic staff. They worked together to develop a feasible plan for extending clinic opening hours and to develop a MOU between the health clinic and the four community groups to provide community-based DOT to people who could not attend the clinic.

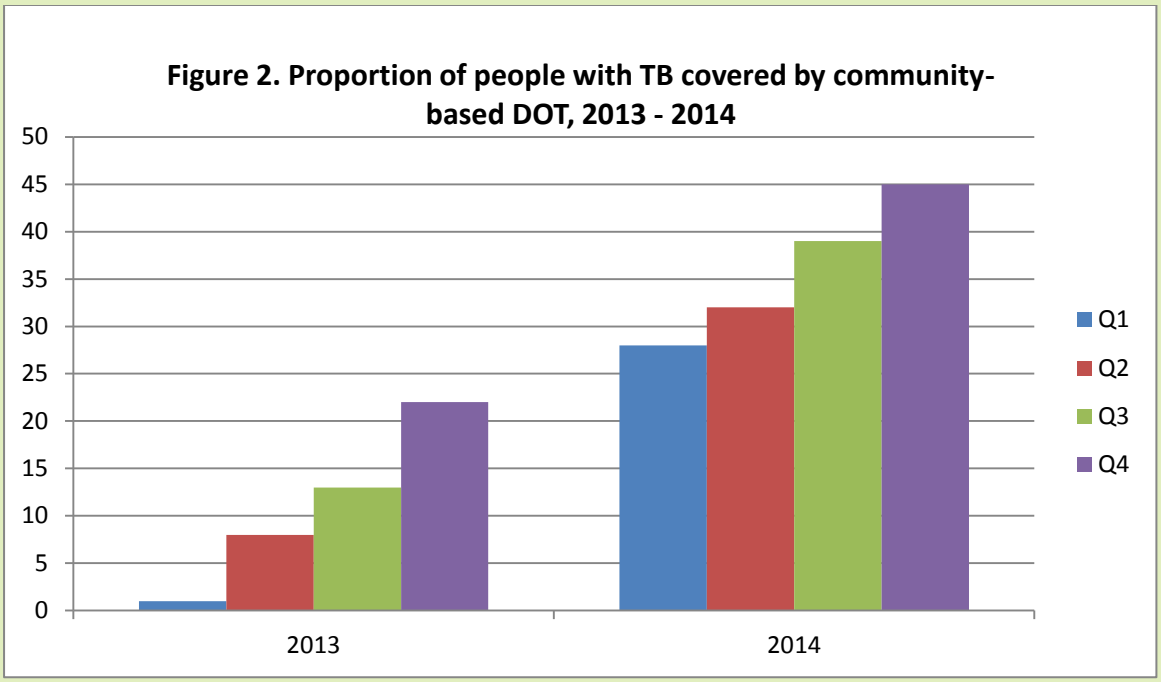
Results

Treatment success for quarterly cohorts is provided in Figure 1. Since the beginning of the project in 2013, treatment success has increased steadily and, as of the second quarter in 2014, has reached the national target of 90% under NTP objective 1. Treatment outcome data for the last two quarters are not yet available.

Figure 1. Treatment success rate in District Y, 2012 - 2014



As a result of the project, District Y now has 16 trained community TB treatment supporters. In the first two quarters of 2014, they provided support to 150 people with TB, covering approximately 42% of the people diagnosed with TB during that period. Of these, 141 people or 94% successfully completed treatment. This is even higher than the second quarter cohort average for the district as a whole, at 90%. Community-based treatment support has contributed significantly to the increase in treatment success in District Y. Demand for community-based services continues to increase and we have plans to conduct training for an additional 15 volunteers next year. The increasing DOT coverage provided by community volunteers is illustrated in Figure 2.



In addition, the health clinic has supported an increasing number of people by extending its hours of service. Approximately 30% of people receiving DOT at the clinic in the first two quarters of 2014 did so during the extended hours periods. As a result, an additional 70 people were able to access care at the clinic and 88% of them completed treatment.

Challenges and lessons learnt

The biggest challenge to the project has been retaining trained volunteers. Once trained, they are often eligible for health worker positions with larger internationally funded projects. In the first half of the project, six of the volunteers who had been trained moved, got jobs or otherwise dropped out of the project, and new volunteers had to be recruited. An incentive scheme, stipend payments and community recognition activities are being used to try to address this problem.

At the outset, the extended clinic hours did not result in significant numbers of additional clients accessing services because the change was not well advertised. After the first two quarters of 2013, when results for this intervention were weak, information about extended clinic hours was incorporated into the educational sessions conducted by Positive Living Group, and after that, results improved markedly. They will continue to incorporate these messages and to add the revised clinic hours to new printings of educational materials.

A positive lesson learnt is that the collaboration between community groups and the health clinic can function well when roles are clearly divided, expectations are clear, and communication is frequent through standardised channels. In District Y, community volunteers have a weekly hour-long meeting with the clinic nurse supervisor to review DOT issues and progress. Representatives from all four community groups attend the monthly TB meeting held by the district medical officer to report on activities and discuss any problems. Project progress is reported back to community leaders on a quarterly basis, and we hold an open community meeting annually to present results and listen to community feedback.

Conclusion
Based on the results so far, the interventions being carried out under this project are good value for money. For an initial investment of $50,000, we have been able to increase treatment success from 62% to reach the national target of 90% in District Y. We have set up systems for community-based DOT that are sustainable and can cover a significant proportion of people needing treatment support. Our model can be easily replicated in other districts of the country where performance is below the national target.

Next steps
The community organisations involved in this project will seek ongoing funding for project activities from the national TB control programme and from an international funding source. We plan to train an additional 15 community treatment supporters; expand support in District Y to cover 55% of the people diagnosed with TB; and provide training-of-trainer services to other organisations in low-performing districts so they can replicate this model.

Section 6

Use this section of the workbook together with the corresponding Action in the Guide, *Action 6: Fund your activities*

Tool 6.1: Existing and potential donors

Tool 6.2: Fundraising plan and timeline

Tool 6.3: Fundraising application checklist

Tool 6.1:
Existing and potential donors

This tool will help you do two things: 1) identify your TB funding needs clearly, and 2) list your existing sources of funding and identify other sources that might be approached to fund your TB work. Remember to think about non-traditional sources of funds as well as the usual donors.

Funding needs

Use the activities you have developed in your work plan (Tool 5.2) to help you clearly define what you need funding to do.

Types of funding needed	☐ Salaries
	☐ Organisational development
	☐ Administrative/operating expenses
	☐ Equipment and supplies (office machinery, vehicles, stationery, etc.)
	☐ Medications (TB and HIV drugs)
	☐ Project activities
	  ○ advocacy/lobbying
	  ○ training/education
	  ○ service delivery (including community care, DOT, TB screening, etc.)
	☐ Travel/international conferences
	☐ Other
	  _____

Main project activities/anticipated results	1. 2. 3.
Populations served	☐ General public ☐ Women ☐ Children ☐ Minority groups ☐ People living with HIV ☐ Diabetics ☐ People who use drugs ☐ Migrant laborers ☐ Refugees/displaced persons ☐ Prisoners ☐ Miners ☐ Health care providers ☐ Students

Tool 6.1:
Existing and potential donors

Geographic areas covered	Region: Country: Local area(s):
Scale of funding needed	☐ <$10,000 ☐ $10,000 – 99,999 ☐ $100,000 – 999,999 ☐ >1,000,000

Existing funding sources

Use the template below to list your existing funding sources or any other support you receive, such as equipment, supplies or volunteer time. Include funding you use to operate any office you may have or other administrative costs, as well as your activity costs.

Current annual budget:				
Funding source	Amount	Time period	Activities funded	Comments

Tool 6.1:
Existing and potential donors

Potential sources of additional funding for TB activities

Use this template to generate ideas about other potential funding sources for your TB work. Use the techniques described in the Guide under Action 6 to help you create the list.

What other sources fund TB work in your area right now or might do so in the near future?

Category	List of specific entities	Comments
Community groups		
Wealthy individuals		
Local government		
Private companies		
Large national non-governmental organisations (NGOs)		
International NGOs		
Global Fund (list principal and sub-recipient groups)		
Bilateral donors USAID, DFID, AusAID, JICA, or others		
Private foundations		
Other		

Tool 6.1:
Existing and potential donors

Priority potential funding sources for TB activities

Now you can use the template below to prioritise which of the funding sources you have identified will be most likely to support the project you are proposing. List all of your current and potential funding sources in column 1. For each potential funding source, put a tick in columns 2 through to 6 where you can answer "yes" to the statement in the heading. Use the funding needs template you filled in at the beginning of this tool to help with this process. You may also have to do some research on that funding source to find the answers. Once you have finished with this task, identify the sources for which you have ticked all boxes. Those are your highest priority funding sources because your needs most closely match their interests, and your request for funding will have the best chance of being approved. For those sources, put a tick in column 7. These are the funding sources you will focus on in creating your funding plan in Tool 6.2.

1. Potential funding source	2. Will support the type of funding needed	3. Supports the kinds of activities and results the project will produce	4. Is interested in the populations the project will serve	5. Supports projects in the geographic region we will cover	6. Provides funding at the scale we require for this project	7. High priority funding source to approach

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Tool 6.2:
Fundraising plan and timeline

Now that you have generated a list of priority funding sources, use this tool to help you plan your fundraising strategy for TB. Be realistic about what you can handle in terms of writing proposals and managing grants. Many smaller organisations can handle one or two grant applications per year, but find it challenging to write multiple applications and manage multiple grants at the same time. It is better to write fewer applications and be successful than to try to do too many and not have enough time to do a good job with them. As stated in the guide, it is important to develop ongoing relationships with your potential funders so that your applications have a greater chance of success. Assign one person to be in charge of managing your relationship with a potential or current funder, communicate your successes to them regularly, and always thank them for their interest in your work. At the bottom of this tool, you will find a template to help you track your relationships with donors.

Funding application plan

Organisation: _____ Funding year: _____

Potential funding source	Contact information and website	Potential level of funding	Activities to be funded	Partners on application	Funding application deadline date	Lead staff person responsible for application

Tool 6.2:
Fundraising plan and timeline

Other fundraising

In addition to funding applications, we will raise money through the following activities:

Category	Description	Anticipated funds raised	Timing	Person responsible
☐ Income generating activities				
☐ Membership dues				
☐ Community contributions				
☐ Other				

Fundraising assessment

Now assess whether your fundraising efforts listed in the tables above will allow your organisation to do the activities you planned. If not, think about how you will address that problem, either by finding additional sources of funding to support your work or by cutting activities.

A. Total potential funds raised (if all efforts are successful):	
B. Total needed for all activities planned:	
C. Funding gap or surplus: (A - B)	
D. If there is a funding gap, we will:	☐ Identify additional sources of funding ☐ Cut activities
D1. If seeking additional funding, we will apply to:	
D2. If cutting activities, we will cut the following:	

Once you have identified deadlines and people responsible for managing each fundraising effort, use a calendar to map out what activities will need to happen in the months leading up to the application deadlines so that a successful proposal can be put together. Monitor fundraising activities every month to make sure you are on track.

Tool 6.2:
Fundraising plan and timeline

Donor relationship maintenance

For every funder your organisation currently works with and every funder you would like to approach in the future, assign someone in your group to be responsible for communicating with them on a regular basis. For existing donors, write down when your reports are due to them and make sure they are submitted on time. In addition, you may want to communicate with them at other times in between reports. Set a schedule for doing so. Make sure you invite them to events you are holding so they can see the fruits of their investments, and send them copies of any news articles that cover your activities, documents you produce, or other items that result from their funding of your work.

Existing donors

Donor organisation	Donor contact person and contact information	Due dates of reports	Frequency of communication in between reports	Person responsible	Status

Potential donors

Donor organisation	Donor contact person and contact information	Frequency of contact	Person responsible	Status

Tool 6.3:
Fundraising application checklist

Use this tool to track your progress in preparing funding applications to make sure they are complete and submitted on time. Good luck with your application!

Application information

Funding source	
Contact information	
Deadline date and time for application	
Address/email for delivery of the application	
Format in which it must be delivered (hard copies, electronic)	
Number of copies (if hard copies needed)	
Font and font size for application (if specified)	
Maximum number of pages (if specified)	
List of required attachments	
List of required organisational documents	
Maximum budget request allowed	
Budget format required (if specified)	

Tool 6.3:
Fundraising application checklist

Proposal team information

Write down the names of the main people responsible for making sure the application is written, documents are prepared, budget is prepared, and everything is submitted on time. You should consider making specific assignments for writing each part of the application, including the covering letter, and setting specific due dates for each part to give you enough time to put it all together at the end and edit it.

Person in charge of preparing and submitting the application	
Support staff for application	
Person in charge of preparing budget	
Support staff for budget preparation	

Tool 6.3:
Fundraising application checklist

Specific application assignments

If you are lucky enough to have a team of people to help you with the application, assign them specific tasks and record those here. Check on progress on a daily or weekly basis, depending on how long you have before the deadline. You can include the written sections, the budget and any needed attachments in this template.

Application section	Person responsible	Due date	Status

Tool 6.3:
Fundraising application checklist

Partners involved in the application

Use this template to track your partners in the funding application and what you need to receive from them for the application. Assign one person in your group to make sure partners know what is required and that follow-up is done. Make sure your deadlines to them allow you time to put the entire application together. Their deadlines for getting things to you should be a few days before the submission date.

Partner organisation	Contact person Phone Email Mailing address	Person in our organisation responsible for working with this partner	Partner role in project	Documents/items needed from partner for application	Due date	Status

International HIV/AIDS Alliance (International secretariat) Preece House 91-101 Davigdor Road Hove, BN3 1RE UK

Telephone: +44(0)1273 718900 Fax: +44(0)1273 718901 mail@aidsalliance.org Registered charity number: 1038860

PATH (Headquarters), PO Box 900922, Seattle, WA 98109 USA
Telephone: +1(206)285 3500 Fax: +1(206)285 6619 info@path.org

Established in 1993, the **International HIV/AIDS Alliance** (the Alliance) is a global alliance of nationally-based organisations working to support community action on AIDS in developing countries. To date we have provided support to organisations from more than 40 developing countries for over 3,000 projects, reaching some of the poorest and most vulnerable communities with HIV prevention, care and support, and improved access to HIV treatment.

The Alliance's national members help local community groups and other NGOs to take action on HIV, and are supported by technical expertise, policy work, knowledge sharing and fundraising carried out across the Alliance. In addition, the Alliance has extensive regional programmes, representative offices in the USA and Brussels, and works on a range of international activities such as support for South-South cooperation, operations research, training and good practice programme development, as well as policy analysis and advocacy.

www.aidsalliance.org

PATH is an international nonprofit organization that transforms global health through innovation. We take an entrepreneurial approach to developing and delivering high-impact, low-cost solutions, from lifesaving vaccines and devices to collaborative programs with communities. Through our work in more than 70 countries, PATH and our partners empower people to achieve their full potential.
Headquartered in Seattle, Washington, PATH operates offices in 39 cities in 22 countries. PATH currently works in the areas of health technologies, maternal and child health, reproductive health, vaccines and immunization, and emerging and epidemic diseases.

For more information, please visit www.path.org.