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						

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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**

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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.

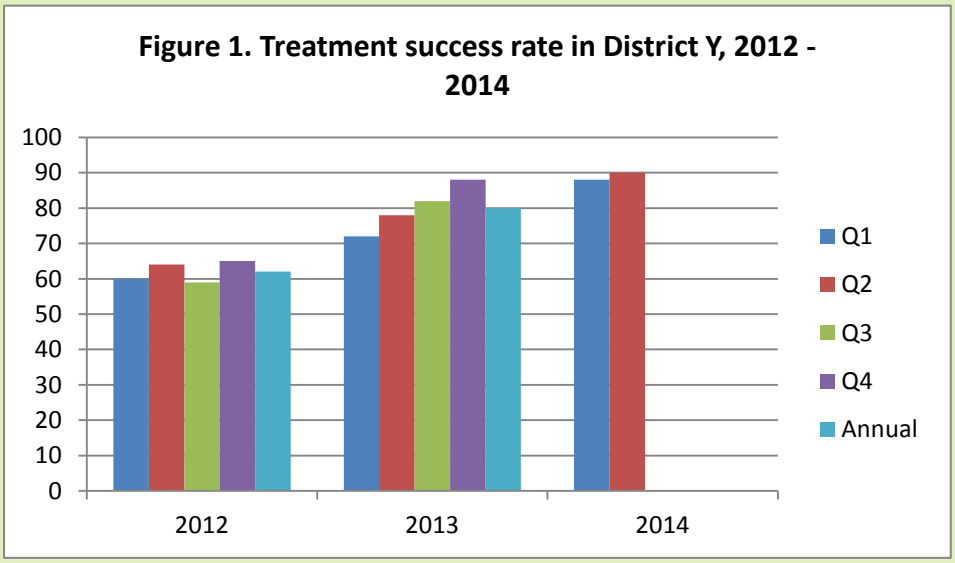
Health Action Partners conducted a community focus group to understand the challenges faced by people with TB in completing treatment, and to work with the community to develop suggestions for how services could be improved to increase TB treatment success.

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.

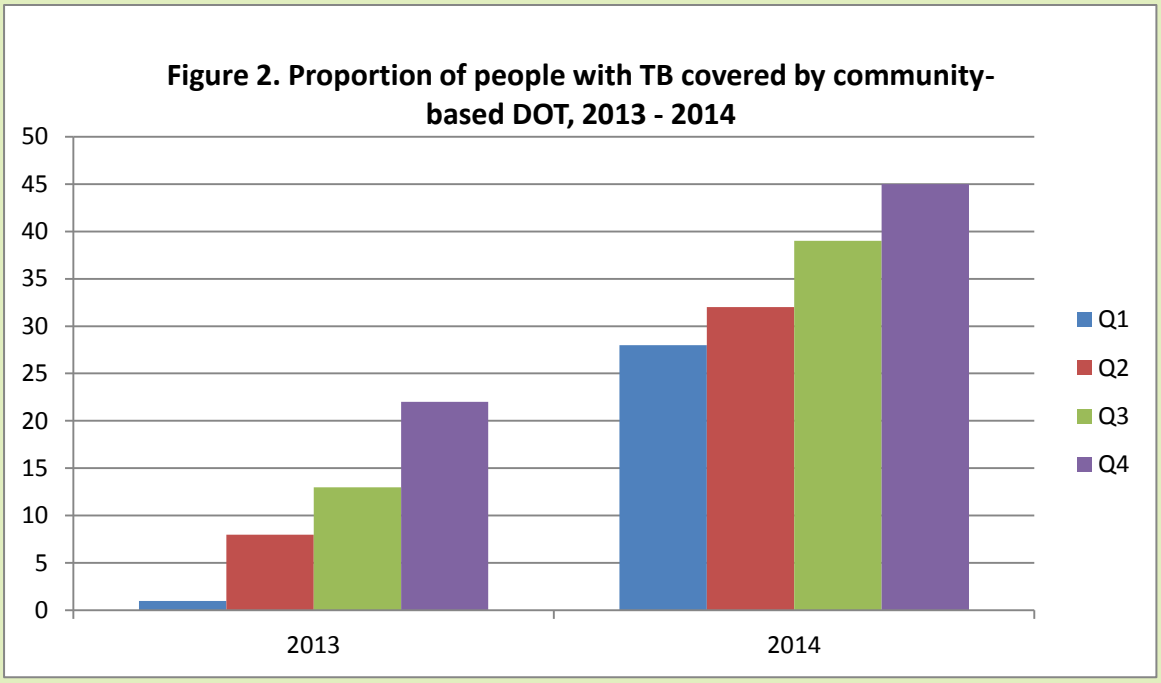
Results

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.