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TB CHILD SURVIVAL AND HEALTH GRANTS PROGRAM EVALUATION

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ACRONYMS AND ABBREVIATIONS

ACSM	Advocacy, Communication, and Social Mobilization
ARV	Antiretroviral
CDC IAA	U.S. Centers for Disease Control Interagency Agreement
CDR	Case Detection Rate
CORE	CORE Group
CPT	Cotrimoxazole Preventive Therapy
CRS	Catholic Relief Services
CSTS	Child Survival Technical Support Project
CSTS+	Child Survival Technical Support Plus Project
DIP	Detailed Implementation Plan
DOT	Directly Observed Treatment
DOTS	Directly Observed Treatment, Short-course
DOW	Doctors of the World
FE	Final Evaluation
GFATM	Global Fund to Fight AIDS, Tuberculosis and Malaria
GH	Bureau for Global Health, USAID
GH Tech	Global Health Technical Assistance Project
HIDN	Office of Health, Infectious Diseases and Nutrition (USAID)
HQ	Headquarters
IMCI	Integrated Management of Childhood Illness
IOs	International Organizations
IPHO	Integrated Provincial Health Office
IPT	Isoniazid Preventive Therapy
IUATLD	International Union against Tuberculosis and Lung Disease
KAP	Knowledge, Attitudes, and Practice
KNCV	Royal Netherlands Tuberculosis Foundation
KPC	Knowledge, Practices and Coverage Survey
LOE	Level of Effort
MCDI	Medical Care Development Inc.
MDR TB	Multi-drug resistant tuberculosis
M&E	Monitoring and Evaluation

MSH	Management Sciences for Health
MTE	Mid-term Evaluation
NGO	Nongovernmental Organization
NTP	National TB Programme
PATH	Program for Appropriate Technology in Health
PCI	Project Concern International
PH	Project Hope
PHC	Primary Healthcare
PMU	Program Management Unit
POC	Point of Contact
PSI	Population Services International
PVO	Private Voluntary organization
RFA	Request for Applications
RPM Plus (MSH)	Rational Pharmaceutical Management Plus
SOTA	State of the Art
TA	Technical Assistance
TASC 2	Technical Assistance and Support Contract 2
TB	Tuberculosis
TB CAP	Tuberculosis Control Assistance Program
TB CSHGP	TB Child Survival and Health Grants Program
USAID	U.S. Agency for International Development
WHO	World Health Organization

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EXECUTIVE SUMMARY AND RECOMMENDATIONS

The objective of this U.S. Agency for International Development (USAID) TB Child Survival and Health Grants Program (TB CSHGP) Evaluation was to determine the performance of the TB CSHGP grants and provide recommendations to USAID for future direction. The team was convened by the Global Health Technical Assistance (GH Tech) Project and evaluated successes, constraints, failures, impact, and lessons learned. The findings were reported to USAID and to the grantees during group debriefings and resulted in recommendations to USAID for future project design and support.

The CSHGP TB grant category was created to address the gap in community-based TB programs, expand the partners actively involved in TB, and specifically build capacity in U.S.-based private voluntary organizations and nongovernmental organizations (PVOs/NGOs) with a background in community-oriented programming. Eight grants at US$1.5 million each of USAID plus NGO/PVO funding, were awarded over the past five years to seven NGOs/PVOs: Doctors of the World (DOW)/Population Services International (PSI); PATH, Medical Care Development Inc. (MCDI), Project Concern International (PCI), CARE, Catholic Relief Services (CRS) and Project Hope (PH). The grants were to implement projects in eight countries: Romania, Ukraine, South Africa, Mexico, Indonesia, Philippines, Malawi and Zambia.

The evaluation team reviewed the grants' project documents, interviewed headquarters (HQ) staff from all the projects, met with the USAID CSHGP and TB teams, and visited three sites in Mexico, Indonesia, and South Africa. The roles of two technical organizations, CORE and the Child Survival Technical Support Project (CSTS), and the quality of coordination with the USAID country missions were also included in the review. At field level, the team visited health facilities, microscopy laboratories, and communities; and interviewed NGO/PVO and public health system staff, TB patients and families, directly observed treatment (DOT) observers and supporters, community health volunteers, and community groups. Briefings and debriefings were held with staff of the National TB Programme (NTP) and the USAID country missions.

The main findings were:

- The CSHGP TB portfolio is, in general, technically sound and fills a need in TB control, complementing the national and international support to NTPs, strengthening the NTP delivery of public TB care, and developing community participation to increase case detection and treatment success. The evaluation team found quantitative (in Annex 6) and qualitative data demonstrating that the grantees' programs have made considerable progress against program indicators, as well as evidence of activities that have increased case detection, treatment success, knowledge, and behavioral changes in TB clients and their communities. Although projects were, in general, successful in increasing TB case detection and treatment success, their effectiveness and impact could be more fully documented.

- The CSHGP created a TB category to address the gap in community-based TB programming. The CSHGP made this commitment more than five years ago and continues to support expanding community-based TB programs as a priority. It has allowed PVOs to expand TB control activities with a focus on community detection and DOT coverage, promotion, and mobilization. These programs have increased detection in health posts and health centers and have increased TB treatment coverage in these facilities and in communities. They have also increased awareness and decreased stigma at the community level. CSHGP has gained enough experience from these five years of grantee programming to move forward. Differences in the countries' NTP capacity induced large variations in the scope of the PVOs' work and priorities of the projects,

from support to policy making and raising the level of government commitment to predominantly community-level detection, treatment, and mobilization efforts. Most projects had a strong component aimed at strengthening the delivery of TB services by public facilities, required to satisfy increased demand due to community mobilization.

- Barriers to change (obsolete practices, weak information systems, inappropriate norms and definitions) were underestimated and, in some projects, not addressed. Government ownership was slow to materialize, and commitments such as absorption or increase of staff and sharing of data were not always carried through. Some of the projects have been affected by sudden increases or decreases in NTP funding, owing to the often unpredictable availability or suspension of grants from Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM) as well as to irregular supplies of TB drugs in the public system.

- Diagnosis of infectious TB is in general good. The number of cases detected has increased in most project areas, although targets and pace of implementation vary widely. Community Advocacy, Communication, and Social Mobilization (ACSM) Working Groups to promote access to care for persons with TB symptoms are active in most projects; community knowledge of TB seems high. However, screening adults with cough among adults attending health facilities for other reasons—the most efficient method to detect suspects-—is usually not done. Data on the number of persons examined by the laboratory are available but are not being used as a rapid indicator of program impact on case detection.

- Patient adherence to treatment is promoted through several strategies, and the success rate—the only indicator specifically recommended—has increased in project areas. In some cases, the increase has been significant. For instance, in the Mexico project, while the baseline for treatment success was 58 percent, the third annual report reports 65 percent success in Tijuana and 95 percent in Mexicali, with an average of 80 percent. In the Philippines project, the baseline was 72 percent (2004); the target, 85 percent for 2009; and the reported success for 2006 reached 78 percent.

- There is often confusion between DOT (direct observation of drug intake by staff, community observers of family members) and self-administration plus patient support, which is often reported as DOT. There is poor or no recording of direct observation, required to evaluate the effectiveness of DOT versus general treatment support. Although several projects (particularly the most recent) include all treatment outcomes in the indicators, few projects manage, monitor, report, and analyze the information for action. Treatment outcome is a longer-term indicator; most projects are not using data on sputum conversion as a key early surrogate indicator for treatment success.

- In general, the monitoring and evaluation (M&E) systems resulted in a large amount of data collected and some complex instruments developed, but there should be more analysis at the facility level. The indicators are not always appropriate to small populations and short-term projects, and they are not monitored and reported regularly. The staff of the health facilities and PVO staff do not display the available data for key indicators in simple graphs to monitor and show achievements. The annual, mid-term, and final reports are bulky, and the key indicators of impact are not highlighted, even when they show project progress or success. Much of the reports concentrate on process and administrative achievements. Three of the projects include TB/HIV activities, but monitoring data are not yet available.

- Finding appropriate project field managers has proven difficult. Although the NGOs/PVOs have experience and skills in community work, a presence in the country,

links with the health authorities, and strong support from the HQ backups, TB represents a new challenge. There is a need for additional capacity building at the country level to strengthen the technical and managerial capacity of the NGOs/PVOs. This would provide them with the needed skills and allow them to gain further experience in planning and managing community-based TB interventions, using CORE, Tuberculosis Control Assistance Program (TB CAP), and other partner institutions. A more strategic approach is needed by CSHGP, its technical partners, and the PVOs to strengthen the TB program's management capacity at the country and field levels. The external experts who assist in the design and evaluation of TB CSHGP programs could further expand their role to strengthen the PVOs' TB management.

- NGOs/PVOs require more specific and simpler guidance to concentrate on the key interventions. The technical materials and resources internationally available are extensive, but often inappropriate for primary health care (PHC) and community activities in TB control. The most appropriate must be selected and, if necessary, simplified for use at community level and by NGOs/PVOs newly involved in TB control.

- The sustainability and feasibility of expanding and replicating the project experiences has not been adequately explored. Interaction between TB staff of the NGOs/PVOs has been limited, confined mostly to contact through the CORE working group, and field staff have little access to other projects' experience. In general, the projects have not sufficiently analyzed and reported their experience (for instance, through their web pages).

- In summary, the TB grants fill an important gap in community TB programs; performance has generally been technically sound, and the projects provide valuable lessons. Projects seem to have been effective in strengthening service delivery, while community participation appears to have been useful in increasing treatment compliance and, in some cases, in making programs more sustainable (for instance, when using unpaid trained volunteers). Case detection and treatment success have improved in most of the project areas, and some of the projects are already expanding or replicating in other sites.

- However, the TB CSHGP portfolio guidance lacks sufficient focus and direction for the reported objectives of rapidly involving more PVOs in TB control and promoting community-based TB activities. The development of the guidance, because it was based on the Child Survival program's broader and more complex emphases, has affected the management and technical focus of activities and the use of indicators for M&E. Clearer, more focused, and more streamlined technical guidance is required to direct TB CSHGP program development. A focus on data for key indicators and on recording and reporting DOT, along with a strong emphasis on the analysis of results, is needed.

- The experience from the eight projects is sufficient to provide recommendations, redirect the portfolio, and guide future projects. However, the number of projects funded per year and the level of funding are both insufficient to achieve rapid involvement of more NGOs/PVOs in TB control and to promote community-based TB activities at a global level, the two initial objectives of the TB category. The level of future funding available for PVO TB control interventions was not discussed with the team. However, the value of the program's contributions to date in developing TB control approaches, encouraging PVOs to undertake TB control programs and share their experiences, developing tools, and furnishing other support provided by the Core Group mechanism is considerable. These experiences and the NGOs' potential to continue the development of approaches, tools, and mechanisms, as well as the potential for NGO advocacy in advancing TB control, argues for continuing USAID funding. Even if limited, this funding should

support PVO TB control activities, especially at the community level, as part of the TB CSHGP portfolio and as part of the broader TB control portfolio.

RECOMMENDATIONS

- Clearly define the portfolio objectives and priorities—for instance, "Strengthening TB service delivery at PHC level and developing community models and interventions to improve population access to diagnosis of infectious TB cases and access of patients to treatment and to directly observed treatment."

- Revise and simplify the USAID TB CSHGP guidelines and procedures for project preparation and Detailed Implementation Plan (DIP), and focus them on TB and TB/HIV. TB guidance will need to evolve from complex, Child Survival–oriented guidance with extensive reporting and data collection requirements. The TB guidance from the Child Survival Technical Support Plus Project (CSTS+), with its multiple websites and references, many of which are appropriate for national-level programs, should be restructured to meet the needs for planning, managing, monitoring, and evaluating smaller community-oriented TB programs by PVOs. The guidance and a list of a few indicators appropriate for small and community-level projects should be developed and provided to PVOs. The guidance for TB programs should be modified further to be more specific and in-depth, based on the needs of TB interventions. This would help both the U.S. PVOs with years of experience with CS procedures and, in particular, new NGOs attempting to respond to USAID CS guidance on proposals, DIPs, and the like.

- Propose a limited set of appropriate, rapid TB monitoring indicators for analysis at facility and district level, and require regular reporting of progress.

- Revise the guidelines for medium-term and final evaluations, including simplifying and focusing reports on progress on indicators (in table form) so that the there can be an analysis of the strategy adopted, program implementation, and progress on indicators. Evaluations can also address strategy appropriateness in terms of its sustainability and its feasibility for replication to a larger population. At the mid-term, the effectiveness of the project strategy (to date) can be analyzed. In the final evaluation, the strategy's effectiveness can again be analyzed across the project's duration. The final evaluation is a more appropriate time to assess the potential for sustainability of the key interventions done during the project. The final evaluation should also provide the opportunity to assess the reliability of the interventions for adoption in a larger population base, and/or for adoption by communities, the government or other organizations.

- Develop and implement a strategic and practical approach to strengthen the technical and management capacity of the NGOs/PVOs' TB program managers and staff, especially at the country and field levels, to plan and manage community-based TB interventions. This capacity-building effort should further involve and focus PVO HQ staff, the CORE Group, TB CAP, CSTS+, and external consultants and should use various methods and materials to increase the capacity of PVO TB program managers. The mid-term and final reports should assess the progress of this approach.

- USAID should increase the number of projects supported per year and the amount of funding for each one (US$2–3 million in four to five years). USAID should be ready to go to scale and expand community TB programs as part of its larger TB, health, and TB/HIV/AIDS portfolio, given the tremendous needs. USAID should also consider mechanisms to support TB programs in special situations—for example, where NTPs are absent or inadequate. If funding is not expanded, the TB component of the CSHGP portfolio objectives should be maintained and refined, using more specific and limited objectives. Maintaining PVO TB control projects, especially with a focus on facility- and

community-level service delivery (even if limited in scope), would encourage continuation of PVO involvement in TB control and allow further progress on community-based TB control, treatment, and promotion. PVOs should continue to be mentored through CORE and other mechanisms. This would support them in developing their capacities and in mobilizing support from a variety of sources to further expand TB control activities. USAID should continue to advocate for the role of NGOs in TB control, especially in community-based TB programming.

I. OVERVIEW/BACKGROUND

OBJECTIVES AND PURPOSE OF THE EVALUATION

The primary objective of this evaluation is to determine the performance of grants under the U.S. Agency for International Development (USAID) Bureau for Global Health's TB Child Survival and Health Grants Program (CSHGP) and whether the grants are contributing to the overall USAID CSHGP program and TB Element objectives, as well as provide recommendations for the future direction of the category. The performance review will evaluate successes, constraints, failures, impact, and lessons learned. The team will look retrospectively and introspectively at the category as a whole and at the eight TB grants in order to evaluate the main objectives, as outlined in Section VI of the program scope of work. The results will be used to measure progress and results, gather successes and lessons learned, and inform USAID of recommendations for design of future efforts in this area.

HISTORY AND RATIONALE FOR THE EVALUATION

The CSHGP is housed in the Bureau for Global Health's Office of Health, Infectious Diseases and Nutrition (GH/HIDN). GH/HIDN strongly supports the role and contribution that PVOs/NGOs and their local partners play in improving the quality of life of some of the most disadvantaged populations in developing countries.

The purpose of the CSHGP is to contribute to sustained improvements in child survival and health outcomes by supporting the work of private voluntary organizations and nongovernmental organizations (PVOs/NGOs) and their in-country partners. This work is aimed at reducing infant, child, maternal, and infectious disease–related morbidity and mortality in developing countries. Sustained health improvements are achieved through building the capacity of communities and local organizations and improving countries' health systems and policies. In addition, the program seeks opportunities to scale up successful strategies to the national level and to contribute to global capacity and leadership in child survival and health through the dissemination of best practices. In order to reach vulnerable populations, grantees work in a variety of settings, from the district to the national level, and partner with local groups, including community-based organizations, local NGOs, and district and national health authorities.

Five years ago (2003), the CSHGP created a TB category to address the gap in community-based TB programs, expand the partners actively involved in TB, and, in particular, build capacity in U.S.-based PVOs/NGOs. This category focuses on PVOs and NGOs who have an established background in community-oriented programming. One to two $1,500,000 grants are awarded each year in the TB category. Grantees are selected based on their proposed response to the criteria specified in the request for applications (RFA).

This evaluation covers the portfolio of TB grants awarded through the CSHGP since the introduction of this category. The TB category includes the following grants:

- Ukraine: PATH (2003–2006)
- Romania: Doctors of the World (DOW)/Population Services International (PSI) (2003–2006)
- South Africa:* Medical Care Development Inc. (MCDI) (2004–2008)[1]
- Mexico:* Project Concern International (2004–2008)

[1] *Site visits were conducted in these countries during the evaluation

- Indonesia:* CARE (2005–2009)
- Philippines: Catholic Relief Services (CRS) (2005–2009)
- Malawi: Project Hope (2006–2011)
- Zambia: CARE (2007–2012)

The objectives for the TB programs within the CSHGP include fully supporting the World Health Organization's Stop TB Strategy as the approach for TB prevention and control. Each CSHGP TB project addresses at least one of the sub-elements of USAID's TB Element, which is in line with the Stop TB Strategy: Directly Observed Treatment, Short-course (DOTS) Expansion and Enhancement, TB/HIV, Multi-drug Resistant (MDR) TB, TB Care and Support, and Host Country Strategic Information Capacity. Grantees play a strategic role in TB program implementation with their comparative advantages and relevant experience. The grantees have expanded promotion of TB interventions and Directly Observed Treatment (DOT) support into urban and rural communities. A gap in community TB programming has been filled by the actions of CSGHP-funded NGOs who provide outreach TB education in communities, promote DOT, involve families and community members in DOT and in ensuring broader compliance of TB patients in areas where National Tuberculosis Programmes (NTPs) and ministry of health (MOH) TB programs cannot or do not expand outreach beyond the facility-based services. PVOs have helped to fill this gap with additional human resources, training, technical support, and financial resources, using their capacity to involve the community in identifying and, more importantly, providing follow-up of TB clients on TB treatment. Other important needs that PVOs fill include:

- Promoting and supporting community efforts to identify and facilitate examination of TB suspects at health centers and health posts and in the community.
- Giving training and support to health workers in identifying, diagnosing, and treating TB clients.
- Providing training, supportive supervision, and system strengthening for DOT volunteer observers/promoters.
- Providing referrals from the community and from private providers to increase client access to diagnosis and treatment and improve their compliance with treatment regimes.
- Developing outreach efforts to facilitate DOT, helping maintain records, and monitoring effectiveness.
- Assisting health posts and health centers in collecting, analyzing, and monitoring data/results on smear conversion, cure, and success rate of clients in the community**.**
- Conducting Stop TB days to sensitize communities and reduce the stigma that can deter clients from seeking treatment.
- Encouraging participation of community officials to support increased compliance with treatment regimes.
- Training and supporting private providers to identify, assess, and refer clients for treatment in the public sector.

In addition, grantees also provide their skills and experiences in TB training, supportive supervision, and program strengthening to partners, NTPs and MOHs. These CSHGP NGOs' TB interventions could be further analyzed and documented, and the results distributed, to enable full

understanding of the grantees' contributions to filling the gap in TB programming at the community level.

TECHNICAL ASSISTANCE (TA) SUPPORT TO CSHGP GRANTEES

There are two organizations that provide technical support to CSHGP grantees. The CORE Group is a network of 47 NGO members collectively working in over 180 countries. CORE's mission is to strengthen local capacity on a global scale to measurably improve the health and well-being of children and women in developing countries through collaborative NGO action and learning. NGOs participate in CORE's eight working groups in the areas of Integrated Management of Childhood Illness (IMCI), malaria, monitoring and evaluation (M&E), nutrition, safe motherhood and reproductive health, social and behavioral change, HIV/AIDS, and TB. USAID supports the CORE Group with special emphasis on the various working groups. The TB working group provides a lessons-sharing forum for the grantees as well as other CORE Group members interested in learning more about community-based TB programming.

In addition, the CSHGP provides resources to ORC/Macro International under the Child Survival Technical Support Plus Project (CSTS+). CSTS+ offers an array of services to CSHGP and its partners, including grantees, potential grantees, and new partners. This project's activities seek to enhance the abilities of grantees and their local partners to carry out effective, quality child and maternal health and infectious disease programs. CSTS+ gives technical support to its partners through a team with expertise in M&E, technical child survival and health interventions, organizational development, TB, family planning/reproductive health, and health management information systems.

MECHANISMS

All eight grants were awarded under the CSHGP as cooperative agreements. Other mechanisms within the broader USAID TB portfolio at the time of the evaluation include:

- Tuberculosis Control Assistance Program (TB CAP)
- World Health Organization (WHO) umbrella grant
- Centers for Diseases Control Interagency Agreement (CDC IAA)
- TB Country Support Task Order and the TB Task Order 2 – PATH under the Technical Assistance and Support Contract 2 (TASC 2) TB indefinite quantity contract
- Rational Pharmaceutical Management Plus (RPM Plus) – Management Sciences for Health (MSH)
- International Union Against Tuberculosis and Lung Disease (IUATLD) Cooperative Agreement
- Stop TB Partnership including the Global TB Drug Facility (GDF)

EVOLUTION OF THE CSHGP TB PORTFOLIO

Over the past five years, one to two awards have been given out annually under the CSHGP RFA for a total of eight awards at the time of the evaluation. Since the first year, a number of changes have taken place:

- Originally, TB grants were not included as a separate category within the RFA but were awarded through the general categories of the RFA (entry, mentoring, standard). In 2005, TB became a separate category within the RFA.

- Since 2005, the information in the TB section of the RFA has gradually become more focused and descriptive.
- The level of effort (LOE) for TB/HIV has evolved from being ≤ 30 percent attributed to HIV to being 100 percent attributed to TB with an HIV component.

In addition, guidance to the PVOs has become clearer. Changes over the years include working within the context of or in coordination with the host country's NTP, given the variations in the needs of each country and the technical expertise required; how other actors are addressing the other components of DOTS; comparative advantage and relevant experience; and a focus on underperforming areas or areas where other International Organizations (IOs) are not working.

See Annex 1b for a matrix depicting the evolution of the RFA.

Early in the process, some NGOs provided technical support and direct intervention at the national level—for example, when national TB programs were weak or nonexistent. USAID's guidance has allowed PVOs to respond at the national level to countries' NTP needs. However, CSHGP has gradually focused more on strong community-based TB interventions and mobilization to strengthen community TB programs—and has provided more TB funding to grantees to carry them out. This support makes good use of the comparative advantage of some PVOs in the community and especially supports interventions at the community level, where WHO, USAID, and other international organizations have identified a particular need.

In the future evolution of support to CSHGP TB programs, if the CSHGP TB program solicits applications with a strong focus on community TB programming, its funds should support community-based TB interventions such as those discussed above. On the other hand, if the CSHGP TB RFA solicits a broader set of TB program interventions, this would allow NGOs to support a wider range of efforts, such as NTPs. Generally, CSHGP has been the avenue for support to NGO community-based programming. And while it is true that PVOs have the flexibility to use their comparative advantage and to address national TB program needs if desired, the TB CSHGP should be more focused on community-level TB control. The report provides recommendations to USAID CSHGP on this issue.

PROCESS FOR REVIEW OF KEY DOCUMENTS

Support for the reviews of the TB PVO applications, DIPs, and reports are provided thanks to the cooperation of several teams working together. The table below lists the teams and organizations involved in the reviews.

TABLE 1. REVIEW TEAMS AND ORGANIZATIONS

Applications Technical Panel Review	DIP Reviews	Annual Reports, Mid-Terms, and Final Evaluations
CSHGP team **TB team** **Country team** **Mission** **CSTS** (do not score or participate in final decision) **External reviewers** (do not score or participate in final decision)	**CSHGP team** **TB team** **Mission** **CSTS** **CAs**	**CSHGP team** **TB team** **Mission** **CSTS**

A table of critical events in the entire process of RFA development, announcement, and review, along with the steps of award management, is presented in table form in Annex 1a, RFA Timeline.

TABLE 2. FUNDING OF CSHGP GRANTS (IN US DOLLARS)						
	Country	**Award Year**	**USAID Funding**	**Project Match**	**Subgrants**	**Grant Years**
PATH	**Ukraine**	2003	1,500,000	500,000		3
DOW/PSI	**Romania**	2003	1,700,000	438,000		3
MCDI	**South Africa**	2004	1,500,000	375,000	80,000, various partners	4
PCI	**Mexico (GH 50 percent)**	2004	1,500,000	532,000		4
CARE	**Indonesia**	2005	1,500,000	500,000		4
CRS	**Philippines**	2005	1,500,000	477,000	124,470 Integrated Provincial Health Offices (IPHOs)	4
Project Hope	**Malawi**	2006	1,500,000	509,000		5
CARE	**Zambia**	2007	1,500,000	526,000		5

MANAGEMENT STRUCTURE TO SUPPORT CSHGP TB GRANTS

- The CSHGP TB grants are managed by the CSHGP team within GH/HIDN.
- Jill Boezwinkle serves as the Cognizant Technical Officer and TB backstop within the CSHGP team.
- Technical guidance is provided by the TB team within GH/HIDN, with Cheri Vincent as the Point of Contact for the CSHGP TB grants.

One member of the TB team is assigned to serve as the technical backstop for each award. This decision may be based on previous experience and knowledge of the country. This person reviews the DIP and annual reports and provides comments/feedback.

II. METHODOLOGY

The TB evaluation team used a variety of methods to obtain input from USAID, PVOs, CORE, CSTS, national counterparts, and others. The following methods were used:

- Two-day team planning meeting
- Document review (see Annex 2)
- Meeting with USAID Global Health CSHGP team (for a list of all meeting participants and those interviewed, see Annex 3.)
- Meeting with USAID Global Health TB team
- Development of interview guides
- Interviews via conference call with all PVO headquarters staff
- Interviews via conference call with CORE
- Meeting with CSTS TB contact
- Site visits to Mexico, Indonesia, and South Africa (see Annex 5 for schedule and list of those interviewed)
- Interviews with PVO field staff in country
- Interviews/debrief in country with USAID mission and NTP
- Interviews in country with health clinic staff, district and provincial level health staff, laboratory staff, patients, DOT observers, DOT supporters, community health volunteers, other community groups, and others
- Data analysis: review and analysis of indicators, strategies, methodologies and program (strategies)
- Team analysis: team discussions to analyze data and field observations and draw conclusions. Discussed lessons learned and prepared a summary of the country visits. Debriefed with project staff, USAID, and NTPs. Provided conclusions and recommendations during site visits as appropriate.
- Debriefings with USAID and PVO HQ staff
- Email interviews with USAID missions not visited

III. TECHNICAL SOUNDNESS OF THE CSHGP TB PORTFOLIO

The following discussion of the technical aspects of the portfolio and of examples of project implementation is based on the following premises:

- The main objective of TB CSHGP was to support NGOs/PVOs in improving TB treatment outcomes and increasing detection of infectious cases in countries implementing the DOTS strategy.
- The program's main strategy was to strengthen public TB service delivery and to develop and test methods of increasing community support to facilitate access to diagnosis and TB treatment.
- A project supported by TB CSHGP could include a variety of interventions, depending on country needs and the status of and collaboration with the respective NTP (see Table 3).

This analysis of findings follows the five elements of the DOTS strategy; community and private sector mobilization activities; and interventions in TB/HIV.

Note: a detailed analysis of each PVO's TB programs was done by the evaluation team and is presented in spreadsheets. These spreadsheets present the key project data, project status, USAID monitoring, and evaluation team comments and are included as Annex 6.

The following table provides a summary of project duration, coverage and main objectives.

TABLE 3. PROJECT DURATION, COVERAGE, AND MAIN STRATEGIC OBJECTIVES

Project/ Country	Years	Population /Area Covered	Estimated TB Incidence *	Other	Main Strategic Objectives
PATH Ukraine	3	> 7.4 million In Kiev city, Donetska oblast and another oblast	6,000 TB/yr 500,000 HIV		Increase capacity and political support for DOTS, including legislative basis and preparation of oblasts Improve quality of diagnosis and quality of microscopy Develop and introduce recording and reporting system and M&E Reduce diagnostic delay; increase case detection and adherence to treatment; improve provider practices, referrals, TB/HIV care
DOW Romania	3	National, including 2.5 million Roma	31,000 total per year		Original: strengthen NTP, community outreach, vulnerable populations (Roma, ex-prisoners) Revised: Develop health education strategy, NTP capacity for education; strengthen skills of providers to improve outcome; increase TB knowledge in Roma populations Increase treatment adherence with incentives

TABLE 3. PROJECT DURATION, COVERAGE, AND MAIN STRATEGIC OBJECTIVES					
Project/ Country	Years	Population /Area Covered	Estimated TB Incidence *	Other	Main Strategic Objectives
MCDI South Africa	4	181,000 subdistrict Ndwedwe of Ilembe in KZN	9,000 total TB 25,000 HIV	TB/ HIV	Increase laboratory capacity Increase capacity for TB treatment, prevent TB in HIV+, provide CPT and IPT; increase access to voluntary counseling and testing Increase district capacity for NTCP and the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM) Increase capacity of MCDI for TB control Operational research: trace defaulters, reasons, evaluate family DOT provision, evaluate "opt-out" for HIV testing
PCI Mexico	4	2.5 million 2 districts (Tijuana and Mexicali) in Baja California	800 TB		Influence national strategy and develop community model Improve treatment outcomes and provider practices Develop strategy for high-risk groups (persons living with AIDS, intravenous drug users) Increase DOT supporters; increase political commitment DOTS in medical schools
CARE Indonesia	4	6.2 million 4 districts in Banten Province	47,000 total 20,000 smear-positive		Increase public capacity for TB service delivery Increase Case Detection Rate (CDR) Increase in private provider participation Increase sustainable community structures
CRS Philippines	4	475,000 adults 28 municipal. Magindanao Province	5,152 Smear-positive		Increase CDR; increase treatment cure/success and participation of local government Increase quality and number of microscopy labs Networking with private providers
Project Hope Malawi	5	850,000 2 districts Mulange/ Palombe	15,000 total 7,500 Smear-positive	TB/HIV	Improve treatment outcomes Increase CDR Increase capacity for microscopy (add 10 laboratories, staff 7 more) Decentralize HIV care Identify TB/HIV, provide Cotrimoxazole Preventive Therapy (CPT) and Antiretrovirals (ARV)

TABLE 3. PROJECT DURATION, COVERAGE, AND MAIN STRATEGIC OBJECTIVES					
Project/ Country	Years	Population /Area Covered	Estimated TB Incidence *	Other	Main Strategic Objectives
CARE Zambia	5	1.05 million 22,581 TB 4 districts in East Province: Chipata, Chadiz, Petuake, Lundazi		TB / HIV	Project document in preparation
* Estimates presented by the applicant in the DIP (TB case incidence estimates for the area)					

INTRODUCTION

The technical soundness section addresses key issues in the TB portfolio. These include political commitment and sustainability, diagnosis and case detection, treatment, community-specific activities, the use of private practitioners, HIV/AIDS and TB, and M&E.

Annex 6 of this report provides an extensive analysis of the performance of each grantee, with quantitative data supporting their documentation of their TB programs. In CSHGP grantee interviews and reports, they informed the team about TB training, support and promotion activities that have increased the number of suspects tested, who have been put on treatment, and who completed treatment. For example, in South Africa dozens of DOT community workers and DOT facilitators interviewed have been trained and continue working in their communities and health facilities to orient and counsel TB clients and follow them after initiating treatment. Training of staff and volunteer health workers in Indonesia resulted in expanded community-level follow-up of TB clients with increased compliance. In Mexicali, PVO-paid DOT observers not only directly observed clients taking their TB drugs but also represented the needs of TB clients to health staff; moreover, they established and maintained broader TB programs in their respective health centers, including outreach into the communities. In Ukraine, the PVO has been contracted to provide follow-on activities. In Mexico, expansion to some 12 states now receives USAID Mexico's support. CARE has been awarded a grant for an additional program, recently started in Zambia.

POLITICAL COMMITMENT AND SUSTAINABILITY

The extent of involvement of CSHGP grantees in policy development varies. According to the guidance from CSHGP, a precondition for PVO community mobilization in support of TB is the capacity of the public system to satisfy demand and provide appropriate care according to the DOTS strategy and recommended norms and standards. Because national NTP capacity and adherence to international recommendations was not consistent from one country to the next, the CSHGP-supported projects varied widely in the focus of their projects, from contributing to national policy to strengthening public TB services and community development. In Mexico (Tijuana) the emphasis was on using community members to support patients, while in Ukraine it was on achieving political commitment and developing norms and instruments at the national level, while supporting implementation at the state level.

While NGOs/PVOs dedicated significant efforts to getting commitment from NTPs, some projects underestimated the resistance they would encounter—resistance to change and to accepting NGOs/PVOs as full partners. They also found it difficult to accurately evaluate the consistency of national norms and definitions with WHO recommendations. In Romania and Ukraine, the Soviet-era system of specialized TB care (hospitalization, TB specialists, case detection in the general population with X-rays and tuberculin tests) is deeply entrenched, and the grant period proved insufficient to modify it and at the same time achieve measurable implementation results. The project in Romania identified the problems but did not address them in its objectives or activities; the project in Ukraine addressed them but underestimated the time needed to achieve changes. In Mexico, there is resistance to sharing data and jointly analyzing the information for action, as well as to absorbing project staff as agreed.

Commitment to DOTS was also often problematic. In Indonesia, South Africa and, to a lesser extent, Mexico (where national guidelines specify DOT), advice and counseling to patients by "DOTS supporters" is often interpreted, registered, and reported as DOT. Direct observation of drug intake may or may not be done by family members, but there is inadequate registration and differentiation between DOT and self-administration plus support, and TB drugs are frequently provided to the patients (for two to four weeks) and not to the DOT observer. The system appears to give reasonably good results in Indonesia, where there seems to be strong social pressure on the patients to take treatment and little TB stigma; on the other hand, it does not seem effective in South Africa, where TB is linked with HIV and there is a high level of fear (even project staff are reluctant to speak to TB patients about the disease). In all sites visited, the effectiveness of DOT versus "treatment or DOTS support" is not adequately documented, and DOT is not strictly promoted and facilitated in the projects. DOT (direct observation of intake) should be strictly recorded, although provision of drugs to the patient for self-administration for a limited number of days is also acceptable if duly recorded.

The increase of public resources (funding and staff) is an indicator of government commitment. Such commitment strongly depends on the NTP's participation in project preparation, monitoring, and evaluation. Even when the district and provincial government commit to support a project, strategies to ensure compliance are required. These may include having the project increase staff through the public system (although paid by the project) from the start, and having the USAID mission give regular political support. For example, the commitment to absorb project staff and functions in the Mexico project has not materialized, and the grantee has no access to program data at the peripheral level. As the NTP and PCI have agreed to expand the project to 12 additional Mexican states with USAID mission support, these issues need urgent attention.

Another source of considerable difficulty is rapid changes in external funding, such as the granting, and then suspension, of GFATM grants. Such instability may create serious risks for the NTP's regular functions and project success. This was the case in Romania, where the NTP capacity was overwhelmed and the project had to be almost completely reprogrammed, and in

Indonesia, where GFATM funding allowed the government to co-opt some activities planned by the project, while the subsequent suspension of funding left the activities undone.

Sustainability of interventions after the grant finishes, and the possibility of expanding or replicating successful experiences, are to a large extent determined by their feasibility and cost. Thus improvement of TB care by public facilities through staff training, development of easy methods for private providers to refer cases, and the mobilization and training of community volunteers have the potential to be more sustainable than increasing project efforts mostly through the addition of paid PVO project staff. This is particularly true if a project's "volunteers" are costly, have limited training, and have not been accepted as a cadre by the public health system. An example of the first type of project is the PCI model in Mexicali, where auxiliary nursing staff based in health facilities go into the community to follow patients and support DOT providers; they also provide some broader/PHC services in the health facilities when not busy with DOT/TB control. This model has the potential to be absorbed into the public system, where it can continue to provide TB control activities. The CARE model in Indonesia is based on volunteers who perform out of a sense of community, personal, and group interests and are supported by facilitators/supervisors. CARE, too, was assessed by the team to be relatively easy to replicate. On the other hand, in Tijuana, the paid, trained community "volunteers," many of whom had been on PCI's staff for more than 10 years, would be difficult for the MOH to absorb due to their costs and limited formal education. This therefore limited the long-term sustainability of the model for use by the government in its expansion of TB coverage.

Although NGO/PVO projects should not be responsible for procurement and distribution of TB drugs, the success of treatment and attracting patients to diagnosis by the public system depends strongly on regular availability of good-quality TB drugs in PHC outpatient facilities. Thus the irregularity of drug supply (streptomycin and ethambutol) in the project areas in Mexico is a serious cause for concern. The same is true in Indonesia, where there has been a lack of drug stocks for new patients and a possibility of stock-out with the interruption of GFATM funding. These issues were reported to the authorities but have not yet been corrected. It seems that the USAID missions in the respective countries should take the lead in mobilizing the partner organizations (WHO, KNCV, TB CAP) in support of the NTP to solve the problem.

DIAGNOSIS AND CASE DETECTION

Project activities of the various grantees include support to training staff in methods for detection of TB suspects and diagnosis of infectious (pulmonary smear positive) TB cases; training and supervision of recording and reporting; and getting out information to the community and special groups on the importance of cough as a symptom of possible TB. Some projects also include support and expansion of the laboratory network and operational research. In general it was observed that diagnostic activities are carried out well—within the limits of local capacity and resources—and use referral when necessary. Training of staff seems adequate. The information is provided to the community through different mechanisms, and generally links TB with cough of long duration. The PVO projects' use of community groups and patient groups seems particularly effective and sustainable. Local NGOs established as not-for-profit entities seemed to be only rarely involved in TB control in the areas where the grantees worked, and it is doubtful that they would be sustainable if created. However, existing NGOs and other community organizations (clubs, etc.) could be motivated to incorporate TB into their activities and usually are sustainable on their own resources.

Knowledge, attitudes, and practice (KAP) studies are used to provide baseline data and measure changes after interventions. However, it is difficult to attribute changes to any particular intervention, as several activities are generally being done concurrently by the project and other partners. The project objective should be not so much to increase knowledge as to accelerate the detection and treatment of infectious cases. Knowledge of TB was reported in some KAPs and

seemed in other communities to be fairly extensive; therefore, changes in the population's practices regarding TB and project actions to facilitate access (and provider action, when the persons visit a health facility, health provider, or community volunteer) are more important than changes in general knowledge regarding TB.

To increase the number of persons with TB who are tested and treated for TB, one of the most significant interventions is to ask adult patients in general outpatient departments, who are there to be seen for other conditions, if they have a cough. A significant problem detected in the projects visited was the lack of screening for cough among adults attending health facilities (PHC and outpatient services of hospitals) for other reasons than respiratory symptoms. There were no messages about cough in the general waiting areas that would encourage adult patients to self-identify for cough. ("If you have a cough, let us know"). Program staff and volunteers were generally not aware of this missed opportunity, and training of health center staff reportedly did not include asking adult patients to self-identify. TB volunteers and staff interviewed regarding health promotion concerning cough stated that their health education messages stressed the link between cough and TB. Given that the KAPs identified the population's fear that a cough meant TB, training needs to be changed to promote self-identification of cough by outpatients—but delinked from an immediate relationship with a TB diagnosis. Delinking this relationship will reduce the fear of TB and its role as a barrier to self-identification and to screening. This is a missed opportunity that can and should be addressed in all TB programs. PVOs should stress this opportunity in its training and support to staff in all health facilities.

Regarding laboratory capacity and accuracy of microscopy, it was found that in general there was too little supervision of laboratory staff within the health facilities. Such supervision is necessary in order to complement initial training and to identify errors in recording, as well as deviations from the national guidelines. The PVO staff's support of laboratory staff did not generally identify this issue or provide technical support to increase their capacity. The supervision of laboratory workers by MOH staff also did not fully address this issue. In the public health facilities, there was also insufficient staff, in the laboratories and in clinics and district TB offices. In addition, staff members had limited capacity to interpret their data for action, and no analysis and presentation of their achievements (such as graphs and charts of increased case detection, treatment successes, etc.), that would inform staff and visitors of the status of and progress in TB control in their facility or in the district. In general, the PVOs did not include in their training, or stress during their support visits, the analysis, use and presentation of basic data on TB control as part of their projects. The broad and complex guidance on M&E did not address this issue (see below in the discussion of M&E).

TREATMENT

As mentioned above, a problem noted in the CSHGP projects visited was that DOT was poorly understood, both in objectives and process. Often patient registration/records of DOT do not differentiate between observation of intake (DOT) and the supplying of TB drugs to the patient with a recommendation to pass them to a provider or observer. Community DOT providers and supporters are often not selected by the patient: some PVOs trained DOT observers more as long-term community volunteer resources not linked to the TB patients. Unpaid volunteers are often temporary; paid community members are in general not sustainable. The WHO-recommended strategy—with DOT preferably done in existing health facilities, and if not possible by volunteers chosen by and with the patient and trained ad-hoc for that patient only—was not seen by the evaluation team. In sites visited by the team, the various methods used (considered DOT by the PVO) were not differentiated from DOT, were not sufficiently described, or were not compared for their effectiveness. Research shows that adherence through directly observing the patient taking the drugs (DOT) greatly increases compliance while decreasing dropouts and development of drug resistance. The CSHGP projects' very limited actual DOT use is of great concern. It is also of concern that some projects are assumed to be and are reporting to be carrying out DOT

without sufficient recorded evidence. Technical guidance to grantees/projects to stress the importance of proper implementation of DOT is not adequate. The guidance that is provided is often taken from resources that are too complex. The WHO publications on TB and the Compendium of Indicators and other reference materials are found to be too voluminous and complex to serve as guidance to the CSHGP NGOs. These larger guidance documents have not yet been reviewed and a selection made that would provide clear, simplified, useful guidance documents for use by the NGOs.

The main advantage of NGOs/PVOs is their capacity to work with the community to extend and make accessible TB treatment to patients, in particular to facilitate and ensure DOT. TB treatment, particularly treatment of new patients and first re-treatment, has a long history, is standardized, and is commonly accepted globally. The innovations that PVOs can make in TB control lie in developing methods to ensure that the treatment is taken regularly, for the appropriate duration, with the minimum interference with the clients' normal life, and with low cost to the patients. The grantees' programs have a great potential to structure these innovations, to analyze their use, and to document and share them. These methods are usually society-specific, and different ones may be appropriate to each country, but some can be useful models for adoption in other countries. In any case, these models of innovations must be tested and documented regarding feasibility, effectiveness and cost, so the NTP and other institutions can consider expanding their use to achieve epidemiological impact.

The team's observation of three PVO TB projects, and analysis of the documentation available for others, indicated improvement in treatment outcomes in the areas covered, though not fully attributable to the projects. However, in many cases these improvements were inadequately recognized and reported by project staff. The results were often not documented, and although baselines and target indicators were established, progress on key indicators was not clearly presented among the main achievements in the mid-term evaluations (MTEs) or annual reports. One exception is that all projects' reports included the mandated USAID indicator on treatment success.

Another difficulty is that information is not sufficiently used to motivate staff. Only in one facility of one of the projects visited was the progress of achievements shown on the facility's wall chart, although it was presented in a format not easy for staff, patients, or visitors to interpret. The team noted that the electronic processing of data by either TB projects or by facilities or districts may be detrimental to on-site analysis and monitoring. Electronic processing of data often leads staff to suppose that their job is only the reporting of data to those higher in the project or in the MOH, and that they therefore did not need to analyze their own results.

COMMUNITY-SPECIFIC ACTIVITIES

The comparative advantage of NGOs/PVOs is that they have expertise and usually are already involved in community development in the project sites. Most of the TB project grantees actually had child survival projects in the area or in an area adjacent to the TB project area chosen. This experience can be used to complement public system TB control programs by facilitating the community's access to diagnosis and by facilitating patients' compliance with treatment. Community involvement is usually a weak area in TB control programs, partially because facility-based staff has limited freedom and resources to leave the facility and follow patients into their domicile or workplace. Since one of the key objectives of the CSHGP project was to develop and test models for future expansion, NGOs/PVOs can develop and test methods to strengthen case detection and treatment through community activities. These models could include mobilization (and if necessary creation) of TB support groups; commitment to action by local authorities, faith-based and other organizations to support TB activities; and training, supporting, and overseeing volunteers for DOT, patient support, and retrieval of noncompliant patients.

PVOs' community-level TB activities are often labor–intensive. While they improve coverage in small populations, their impact on national and global TB burden is somewhat more limited. The main advantage of these CSHGP projects is the development of strategies and models appropriate to specific socioeconomic environments that could be adopted and expanded by the public system (as in Mexico and possibly Indonesia) or in projects with additional external resources (as in Ukraine). In Indonesia, the high level of participation by community volunteers and their contributions to the increase in TB testing and indirect/community pressure methods to assure compliance has promise for adoption and expansion and should be analyzed and documented. Project Hope's very early strategy of broad collaboration with other partners in Malawi should be assessed early for effectiveness in increasing community-level TB control. In addition, PVOs should take care to use the lessons learned and trained staff when expanding to larger projects (the experience in Mexicali could be used more to significantly expand TB control in PCI's new project in 12 states in Mexico). New models and their costs should be carefully developed and monitored so that activities are sustainable with available resources or limited additional input.

Private Practitioners

Involvement of private practitioners (formal and informal for-profit health providers) is a particular kind of community involvement. This is a special opportunity for CSHGP grantees to identify and involve private providers. In general, over half of the initial health care contacts of the population are with private sector practitioners. Some of these patients have TB, and private providers are often poorly prepared for TB management. For most diseases, the provider's role is to diagnose and prescribe, and the patient is responsible for procuring and complying with treatment. Private providers normally do not report on patient diagnosis and treatment outcome, and they have neither the responsibility nor the capacity to follow up with patients that do not return. Thus many of the patients that go to private providers are inadequately counseled and treated, do not continue with the medications, and therefore default and develop drug resistance.

Tuberculosis is not a frequent diagnosis in most private general practice, so it has a low priority for private for-profit providers. Private providers react negatively to any intervention that takes their time (long training, complex recording and reporting) or results in loss of income (loss of patients). Thus, the most practical interventions that PVOs can use to orient private providers are very brief information on national norms for diagnosis and treatment regimens; offering free access to TB sputum microscopy; and offering free drugs and follow-up for TB patients referred to the public system (instead of to a private pharmacy to purchase drugs). Positive strategies to be used by CSHGP PVOs in dealing with private providers can be the guarantee of fair attention and regular drug supplies for the patient, return of information on the referred patient to the practitioner, and return of the patient (if accepted) for treatment of other illnesses and for possible controls.

The simplest way for NGOs/PVOs to measure if the project is reaching and effectively working with private practitioners is to monitor the number and proportion of referrals received from private providers—with the goal of increasing this number. The burden of recording and reporting (the provider's name and address in the patient card, a tick in the TB patient register) should be with the MOH/public system. The CSHGP projects in the Philippines and Indonesia have included work with private physicians; no progress report is yet available to assess any increase in referrals.

Another potential resource under the "private providers" category is the use of traditional healers and traditional midwives, mainly for referral of TB suspects to the public system (South Africa). These traditional healers and traditional midwifes could also act as DOT observers for patients that live nearby; these options have not yet been adequately explored by the PVO projects.

HIV/AIDS AND TB

Several projects' activities include developing strategies for TB/HIV or persons living with AIDS (Mexico, Ukraine) or supporting specific TB/HIV management and care activities in more recent projects (South Africa, Malawi, and Zambia). This component is particularly important to reduce TB deaths during treatment (which can reach as high as 19 percent, as in Malawi), improve treatment success, and reduce stigma for TB and TB/HIV. The interventions that can be used are well defined in international reference materials. Despite the significant toll of TB on patients with HIV/AIDS, no concrete results are yet available from the CSHGP projects. There was no real information from MCDI on this intervention in South Africa, and the Project Hope project in Malawi is just beginning. It is also early in the process for CARE Zambia, but it should be included in the DIP (recently developed), which was not yet available to the evaluation team.

Major differences in the approaches used by TB programs, as compared to programs for HIV/AIDS, significantly affect the TB/HIV/AIDS programs. First, TB services are usually integrated into general health facilities, while HIV/AIDS is still concentrated in few specialized centers with more difficult access. Patients must go back and forth with loss of time and wages, and often there is poor coordination between TB and HIV/AIDS health providers. Second, there are very marked differences between TB control methods and those used for HIV/AIDS treatment. TB control gives high priority to ensuring drug intake (through DOT) and to using fixed-dose, low-cost drug combinations to prevent drug resistance, while HIV/AIDS provides separate drugs of much more expensive regimens directly to the patient, trusting that drugs will be taken (self-administered by the client) correctly.

MONITORING AND EVALUATION (M&E)

The CSHGP projects included among their strategic objectives the giving of technical assistance (TA) and support to develop quality reporting and recording systems, analyze the data gained in this way, and use the information for program decisions. The only key indicator formally required by USAID was the success rate (treatment outcome for new smear-positive patients, the cure plus treatment completion). The success rate is a useful indicator and responds directly to small-area program and project interventions, but the results are available only one year after the patients have started treatment, so it is available too late for monitoring and to implement program changes and corrective actions. Several projects included the case detection rate (CDR) in their reporting. The CDR is useful at the national and global level, but is not appropriate for projects in limited areas or populations because there are no estimates for the denominator and the real incidence may vary significantly within the same country.

The team's review noted that in the technical reference materials, grantees were referred to the TB Compendium of Indicators and to specific websites, without particular guidance regarding the priority indicators that could be reliably used for projects and small project areas. Given the limited guidance, the selection of indicators varied widely among projects, particularly in the first years of the portfolio. More recent projects (Philippines, Indonesia, and Malawi) have included baseline data on selected indicators. If the future focus of the program is mainly on community interventions plus support to the peripheral service delivery system, CSHGP can substantially improve the set of indicators and guide PVOs in their use to monitor program progress. It is not necessary (or possible) to attribute all the results to the project, but it should be possible to monitor and improve the results (in terms of case detection and success rates), if they are the projects' objectives and targets. Data in project areas can be compared those of other areas and to past trends. The team recognizes that there has been considerable discussion about the focus of the TB CSHGP and that it has varied over time.

If the criteria for the RFA focus on service delivery, key indicators that best serve to monitor progress and to adjust project interventions are the number of TB suspects examined by microscopy, the number of pulmonary smear-positive TB cases detected, and the success rate. A

rapid predictor of the success rate is the proportion of smear-positive cases that show negative microscopy at two or three months (sputum conversion rate). Other indicators can be added depending on the interventions.

PVOs are required to provide baseline data and to measure it at intervals for progress. Determination of baseline data for impact of the project was sometimes inadequate (Romania), Few CSHGP projects monitored and reported clearly and systematically on the indicators chosen and the trends in time. Their annual reports are in general very extensive in text, but the data on changes in key indicators and on impact achieved are not stated, not clear, or very difficult to find (some are buried deep in the annexes of the reports, as in the case of South Africa). The MTE and comments to the annual reports noted the problem of monitoring key indicators of progress. In several cases (Mexico, Indonesia, and South Africa), the recommendation was for the PVOs to reduce their objectives and to focus their efforts. South Africa did improve its reporting in Year 3 after the MTE recommendations, and Indonesia showed progress between the last report and the team visit. A major problem in Mexico is that the public system does not share data for the project areas, so monitoring depends on data collected by the project, without official co-participation.

It is evident that better guidance on indicators is very important and is required for future projects. This guidance should focus on a few key indicators that can be monitored quarterly by every PVO during the life of the project and that are part of the NTP information system; with additional indicators for specific objectives of the project if necessary. A list of indicators with these characteristics is suggested in Annex 10.

The information on the few selected indicators should be analyzed by PVO and MOH facility and district staff. PVOs should provide TA, training, and support to staff in interpreting their own data and in developing simple graphs to show the results of their work.[2] PVO project staff should be trained first on the basic elements, with guidance from PVO HQ backstops, and transmit the practices to program staff so a simple, effective M&E system, focused on a small number of key indicators, is sustainable after project completion.

The CSHGP Project's annual, MTE, and final reports should be substantially simplified and the indicators should be presented systematically in table format (baseline, target, achieved by the time of the report), according to clear criteria (impact, intermediate impact, process). The Results Framework should be used and presented as a cover summary to focus PVOs, USAID, and CSTS on the key set of established indicators and the project actions and progress achieved. This use of the Results Framework or a similar tool would increase project planning and management focus on key items, reduce an unnecessarily heavy reporting burden, and allow future monitoring of a larger number of projects by CSHGP. Impact, process, and administrative indicators such as number and type of persons trained and changes in KAP can also be included in the Results Framework table.

OPERATIONAL RESEARCH

Operational research should be fast, be inexpensive in cost and staff time, and respond to immediate needs of the project. Studies will be generally part of routine operations, so protocols can be less strict and simpler than in pure research. However, a good description of objectives, methodology, findings, and interpretation is required. Examples of useful studies are:

- The proportion of adults attending health facilities for any reason who have a cough of more than two weeks' duration.

[2] WHO, ALA/ATS, KNCV, Tuberculosis Foundation, US/CDC. Management of tuberculosis. Modules for health facility staff: H. Monitor TB case detection and treatment. WHO/CDS/TB/2003.314h

- Effectiveness of full DOT, partial DOT (some doses observed and some self-administered), and client self-administered treatment with family or other support.
- Effectiveness of family DOT.
- Impact of the involvement of private practitioners in referring TB cases for treatment.

It was noted than the proposed operations research in PVO projects generally was of limited practical application and was rarely completed.

IV. SOUNDNESS OF THE MANAGEMENT OF THE TB CSHGP PORTFOLIO

Strong, capable management is crucial to project success, and the team assessed the essential functions most related to success in the management of the TB CSHGP programs. These include recruitment, planning, monitoring progress, supervision, identifying and using technical and management resources, and building relationships. Giving attention to the relatively small cadre of managers of TB programs—building their technical and managerial capacities—could be of great benefit. The following is an assessment of the current major management functions and what various TB grantees did to meet the challenges. In the final part of this section, several recommendations are made for strengthening management and overall institutional capacity of the grantees.

RECRUITMENT

To provide solid management and direction to their TB programs, a couple of the PVOs drew on experienced and long-standing staff with some 20 and 6 years of experience respectively (Tijuana and Mexicali). These managers had experience, infrastructure, and systems at their disposal for managing the TB program. Other PVOs identified and brought in new staff under their existing country directors to manage new TB programs. Still other PVOs were encouraged by missions to hire managers to direct TB programs who had strong technical skills but did not necessarily have the perspective and management skills required for directing a program (Indonesia). A number of PVOs chose staff internally, moving staff from projects whose funding has finished to TB programs. Still others, with strong networks, identify TB managers or TB technical experts who are working with other agencies and recruit them to work with the CSHGP projects.

PLANNING THE CSHGP PROGRAM

CSHGP managers generally received strong technical support from their PVO HQ to plan/design their CSHGP program as part of the proposal process. This gave managers an opportunity to strengthen the technical and management planning of their program and to be involved from the beginning in assuring the appropriateness of the planning based on local needs. Managers are also involved in the DIP, which offers them another opportunity to plan their CSHGP program in more depth. PVOs usually bring in HQ or outside TA to develop the DIP and to strengthen the planning capacity of CSHGP program managers. In cases where there has been a change of managers of a PVO's CSHGP program, there has not been sufficient support and a clear process to provide additional TA, documents, and orientation rapidly to the new managers to enable them to rapidly assume their role.

MONITORING OF PROGRESS

CSHGP program managers generally had difficulty in monitoring and reporting on the progress of their programs. Monitoring and reporting was expansive and covered a number of areas, generating pages of reports. Monitoring of progress consisted mainly in collecting administrative and general narrative information on activities. For example, in Tijuana, the paid community workers came in to "report" weekly on activities and apparently also to assure administrative compliance, while the data they provided was reportedly analyzed annually. Managers usually neither monitored key indicators/results nor used those results to manage and make changes based on the data. This situation may have been driven by the complex monitoring and reporting system of the CSHGP programs themselves. Managers and the M&E staff did not generally take the initiative to identify and select a small number of indicators as priorities to use to manage, direct, and monitor their programs. Perhaps they thought that the indicators were mandated by CSHGP and could not be changed. CSHGP requires only periodic reporting and analysis by the PVOs and the PVOs did that reporting to meet the established schedule. Managers often oversaw

the collection of a great deal of data but generally did not direct or guide CSHGP program M&E activities to analyze the data for program management and technical decisions. There was little evidence depicted in charts, graphs, and other visuals that show the program's monitoring of progress that would provide information to guide management decisions. Such graphics were not prominent in the PVOs' program documents, in charts and graphs on the walls of the PVO's CSHGP program offices, or at the MOH TB service delivery sights. The evaluation team assessed that managers were generally not using data as a key element in the management of their programs.

SUPERVISION

Managers were recognized clearly as the supervisors of local staff who were providing DOT support, training, and mobilization of communities. Local staff was eager for the structure, training, and supportive supervision that managers could provide. Some staff, such as in Mexico, was stable and of relatively high capacity and therefore could provide quality services with limited supervisory guidance from managers. Results were, however, different in the two sites in Mexico and it was not clear how much this was a function of the differences in management and staff. The CSHGP project in South Africa had only two local staff, but the program's supervision/support extended to DOT supporters, community health workers, lab and TB clinic staff, and TB voluntary facilitators. In Indonesia, the change in managers in the third year provided an opportunity for the program to progress more rapidly. In the first two years, the local staff (paid PVO TB promoters) did a number of activities that helped themselves as a group, with limited management support, to organize and manage their activities and to interchange lessons learned. Due to time constraints, the team was not able to assess the extent to which the managers in the eight TB projects had developed planning and training sessions to involve staff in analyzing their activities and results and developing lessons learned to improve their projects. Again, a TB CSHGP and PVO management focus on fewer indicators, with a streamlined M&E approach and making use of these data, would strengthen PVO management for results.

IDENTIFICATION AND USE OF TECHNICAL AND MANAGEMENT RESOURCES

Managers could assist local staff by identifying and providing them with staff training materials, manuals, protocols, job aids, and many other resources. There is a wealth of resources available from USAID, WHO, UNAIDS, CORE, CSTS, and other sources, although the managers may need to review these and adapt them for project use. The PVO managers can request resources from many sources—their HQ, CORE, CSTS and others—to provide additional material to strengthen their program. In general, materials to support training, or job aids to support the quality of work of DOT supporters, lab or clinic staff, were not in evidence. Mexicali project staff did present their training and supervision manuals and other resources, and there were maps and graphics in the key district clinic. Indonesia stated that they had provided some information to their staff, and South Africa did have some evidence of protocols for staff in clinics.

BUILDING RELATIONSHIPS WITH PARTNERS

Managers are often the face of the CSHGP projects with partners. PVOs in some countries had strong relationships with local MOH clinic staff that was built over the period of the project (despite difficulties, such as the case of data sensitivity in Mexico). Other PVOs had concerns about sharing information and coordinating with other organizations (Indonesia). In general, the USAID missions were supportive and urged PVOs to collaborate with government and private sector TB organizations. The USAID Mission in South Africa discussed the linking of MCDI with other TB and HIV/AIDS organizations. The USAID mission in Indonesia involved the NTP in the briefings and encouraged CARE to coordinate with the KNCV and others. USAID Malawi reported that Project Hope has been included in the health partners group and attends monthly meetings to share experiences and information with other health partners. Project Hope has also

been linked with USAID/M TB partner Tuberculosis Control Assistance Program (TB CAP) for collaboration on TB issues. Project Hope attends quarterly meetings of TB CAP with its TB partners and other stakeholders. USAID encourages them to continue to work closely with the NTP. The PVO/NGOs have generally worked with the NTPs and MOHs as technical partners, providing support, information, and systems strengthening. Depending on the project, this assistance has been at the national, regional, and/or local levels. Generally, there are few private sector partners. In Ukraine and Romania, the almost exclusive role of the government and the near-absence of private organizations involved in TB control made it particularly difficult to involve the private sector. In Indonesia, some local mayors and other officials and informal community groups were involved and supported TB outreach in communities. The new Project Hope program in Malawi is participating in networks of organizations, and this should lead to the building of local organizational TB capacity.

- In summary, strong capable management is crucial to project success. Some PVO TB managers have been trained in the essentials of TB efforts, others have learned on the job. Management changes are frequent in international programs, including PVOs managing CSHGP programs.

- The evaluation team recommends a modified CSTS capacity development assessment to identify managers' capacities and needs in terms of their technical and management skills. The PVOs, with support from the CORE Group, TB CAP, and others, should implement a realistic capacity development plan to strengthen and maintain TB managers (once trained). Sections of the report discuss pushing out the capacity development in planning, monitoring, and evaluating to the PVOs' country and field level to strengthen CSHGP TB program managers and staff.

- Significant effort by CSTS+, CORE and others should also be made to select, simplify, and widely distribute the resource material that currently is being recommended for use. TA advisors to mentor and strengthen TB managers and staff could be expanded beyond the ones currently used to write proposals and DIPS. HQ staff time for TA to strengthen CSHGP program managers should be assessed and expanded as needed to strengthen the current cadre of managers and staff. This would allow future planning for the inevitable future needs for expanded programs and plan for additional CSHGP program managers for the expanded role of PVOs in CSHGP program expansion, whether funded by CSHGP, Global Fund, or other sources.

- Streamlining guidelines and clarifying CSHGP program indicators would benefit CSHGP TB program managers. Clarifying the focus of the TB grants would also help guide managers. CSHGP should mandate the development of a more limited number of key appropriate indicators and more focused reporting so that CSHGP, PVO HQ, CSTS+, CORE, and CSHGP TB program managers implement a common and essential monitoring approach for management decisions. CSHGP TB program managers will also need to be trained further in M&E, in the analysis and use of data for decision making, and in the dissemination of data and training of local MOH staff in its use for making program decisions.

V. STRATEGIC DIRECTION AND MANAGEMENT OF THE CSHGP TB PORTFOLIO

USAID: OVERSIGHT AND MANAGEMENT ROLE

USAID, through the CSHGP, provides the vision, guidance, and direction to the PVOs to expand CSHGP programs. This vision, guidance and strategic direction have developed since 2002, and USAID has provided more detailed and specific guidance especially since 2005. The TB Team provides support to CSHGP's preparation of guidance, offers technical input on each PVO proposal review, gives frequent guidance to support the RFA, workshops, DIP criteria and reviews of PVO DIPS, and provides input into the content of the Mini-university and in the selection of midterm and final evaluation team leaders, as well as in the review and comment on the MTEs (see Annex 1a: Chronology of Critical Events). To address community-based CSHGP program needs worldwide and to establish models for broader expansion of community-based CSHGP programs, USAID funded one or two grants per year for the past five years at a funding level of $1.5 million each. This low number of partners and level of funding has limited both the expansion of TB control coverage and the development of models focused on community-based TB control.

The CSHGP approach to oversight and management of the TB grants was generally aligned with the approach long used for the overall Child Survival (CS) grants. For example, the team found that 80–90 percent of the TB grants' guidance/requirements were aligned with the CS RFA guidance. Because of the number and extensive requirements for information in the assessments, proposals, DIPs, MTEs, annual reports, and other reporting requirements, TB CSHGP program reporting is labor-intensive and involves both the CSHGP and TB teams. As mentioned earlier, the guidance for CS programs is extensive and complex, and was found not to be specific to the needs of CSHGP programs.

The RFAs refer to cooperative agreements between USAID and U.S. PVOs to expand community-based TB coverage and develop models for future major expansion of CSHGP programs. The current oversight of cooperative agreements allows CSHGP and the TB team to have significant interaction with PVOs in the development and implementation of their CSHGP programs. In addition to CSHGP and the TB team, the USAID missions provide guidance, coordination of the PVO with other TB projects, and support in addressing policy issues with national CSHGP programs and Ministries of Health. One USAID mission related that they had almost "co-developed" the PVO's new project. Much of USAID's interaction provides technical guidance, support, encouragement of collaboration among PVOs, and policy support with national governments. At least two of the missions (Ukraine and Mexico) have committed funding to sustain or expand coverage of the projects. It is not known if there has been a recent review of USAID's oversight role, to judge its sustainability, especially in light of projected needs for major future expansion of community-based TB projects. It is not clear that USAID will be able to manage a greatly expanded number of grants—and larger ones—while maintaining this level of involvement. Annex 6 provides a chart of key characteristics by year and review comments by the team.

USAID's oversight and management was discussed with grantees for their input. The PVOs related some issues that affect them in their efforts to do community-based TB control. Some of the key desired changes mentioned by the CSHGP grantees include:

- Shortening the lag time between proposal submission and award.
- More clarity on requirements, and a stronger focus in the RFA on TB control.
- More rapid, more consistent, and stronger feedback from USAID to the PVOs.

- More consistency in guidance for TB control, with this guidance provided as a cohesive system.
- Clearer and more user-friendly technical reference materials and CSTS+ web site information.

A more complete list of PVO comments is included as Annex 7.

CSTS+ AND CORE ROLES IN CAPACITY BUILDING

CSTS+ and the CORE Group provide technical support to TB CSHGP grants.

CSTS+

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

In 2002, CSTS+ was charged with providing TA (after the proposal is approved) and support to the TB portfolio as a relatively small part of its overall support to some 60–80 CS grants. CSTS+ reported that it participates in the Applications Technical Review Panel, in the DIP reviews, and in the review of the annual reports as well as the mid-term and final evaluations. CSTS+ has a limited staff component devoted to TB (20 percent full-time equivalent) and has contracted TA from technical specialists to provide additional guidance and support to the PVOs. Technical reference materials are abundant and comprehensive but, reportedly, still not focused on community-level TB control. CSTS+ maintains a website for posting CSHGP TB documents. CSTS+ commented that the Compendium of Indicators provides little guidance to PVOs on community-level indicators. Some efforts have been made to extract several appropriate indicators for PVOs to use to guide their CSHGP programs. CSTS+ reflected on several inputs that would help PVOs strengthen their CSHGP programs: increased TA, clear technical guidelines, an increase in human resources dedicated to TB efforts, and increased sharing of lessons learned and best practices. Additional funding and support could be provided for basic operations research to analyze and document best practices. Since limited funding is being provided, CSTS+ has recognized that many of the PVOs are hesitant to commit to hiring staff for expanding into CSHGP programs. They also recognize that USAID has been hesitant to provide more funding because of their concern that they have not gotten sufficient benefit from the funding provided to date to PVOs for their CSHGP programs.

The CORE Group

The CORE Group is a network organization of 47 NGO members collectively working in more than 180 countries. CORE's mission is to strengthen local capacity on a global scale to measurably improve the health and well-being of children and women in developing countries through collaborative NGO action and learning. NGOs participate in CORE's eight working groups in the areas of IMCI, malaria, M&E, nutrition, safe motherhood and reproductive health, social and behavioral change, HIV/AIDS, and tuberculosis. USAID supports the CORE Group and, in particular, the various working groups. The TB working group provides a lessons-sharing forum for the grantees as well as for other CORE Group members interested in learning more about community-based TB programming.

The CORE Group has funding and a mandate from TB CSHGP to provide coordination and support to PVO TB efforts. It has one staff person who provides support to TB efforts including the TB Working Group. CORE informed the team that the TB Working Group needs to expand: several NGOs/PVOs (CRS, CARE) are heavily involved in this area, but a full 25 members are already enrolled in the TB Working Group. Other areas of CORE support include development and sharing of lessons-learned case studies of community-level TB/HIV interventions, and support to the STOP TB Initiative. The CORE TB support is reportedly provided through frequent contact with PVOs; CORE has also been involved in training and in development of the Knowledge, Practices, and Coverage Survey (KPC) Rapid Catch indicators for TB, and has established a resource center and website to share information among PVOs and between the PVOs and the broader TB community. CORE TB support collaborates with CSTS+ on State of the Art (SOTA) and Mini-university sessions. Time constraints did not allow the team to review the content of the Mini-university sessions. CORE also coordinates the "Illuminate" sessions—a virtual sharing by PVOs, especially their HQ staff. They reportedly provide some support to the publication of documents as well.

CORE expressed the need for more awareness of the role of PVOs in community-level TB interventions, increased support to PVOs for expansion of TB control at the community level, and capacity building in TB technical and management areas for PVOs. They stated that there were increased opportunities for training in TB areas and for the standardization of indicators, adding that although good in quality, there could be an increase in the number of qualified TB evaluators. CORE reiterated the value of PVOs in decreasing stigma, mobilizing communities for DOT, and increasing the involvement of truck drivers and other mobile populations in TB control efforts.

USAID's strategic direction and management of the CSHGP portfolio, and the capacity building provided by CSTS+ and CORE, take place during reviews of PVO applications, DIPS and their annual reports, mid–terms, and final evaluations. The following table provides a snapshot of the review process for CSHGP TB applicants and grantees and the teams and organizations involved in these reviews.

TABLE 4. REVIEW PROCESS FOR CSHGP APPLICANTS AND GRANTEES

Applications Technical Panel Review	DIP Reviews	Annual Reports, Mid-Terms, Final Evaluations
CSHGP team **TB team** **Country team** **Mission** ***CSTS+*** (does not score or participate in final decision) ***External Reviewers*** (do not score or participate in final decision)	**CSHGP team** **TB team** **Mission** **CSTS** **CAs**	**CSHGP team** **TB team** **Mission** **CSTS**

VI. COORDINATION AND LINKAGES

BETWEEN THE CSH TB GRANTS PORTFOLIO AND USAID'S LARGER TB PORTFOLIO

At the USAID portfolio level, the potential interaction between the CSHGP grants portfolio and the other TB mechanisms does not seem to be put to sufficient use at this time. There is too little sharing in both directions, from the larger technical mechanisms/organizations to the PVOs, and from the PVOs implementing community-based programming to the larger mechanisms. USAID could make use of the larger technical mechanisms, which could be providing technical input on the grants. At the same time, the PVO grants could be used to sell the idea of investing in community-based TB control to the larger mechanisms, something that has not yet happened.

Some linkage exists, because they are all members of the larger Stop TB initiative: there is the potential to make more use of joint efforts in the community and providing appropriate technical inputs. The WHO and the IUATLD do not seem to be very aware of the CSHGP TB portfolio. Due to time constraints, KNCV/Program Management Unit (PMU) was not interviewed; however, they reportedly are working with some of the PVOs. TB CAP's involvement with the individual CSHGP grantees varies greatly. One of the PVOs indicated that they felt a strong encouragement from USAID to work with TB CAP, while others did not mention working closely with TB CAP.

Other linkages that benefit both the CSHGP TB grantees and the larger TB mechanisms includes the fact that USAID, through the CORE Group, supports the travel and per diem for one member of the CORE TB Working Group to participate on the ACSM country-level subgroup. In addition, USAID supports one person's travel and per diem to the Union conference each year. In addition, many of the grantees have presented at Union and other TB or HIV meetings.

BETWEEN CSH TB GRANTS AND HOST COUNTRY TB PROGRAM

Links with the NTP should be started much earlier in the process of project development. The NTPs should be notified about the intent to develop a proposal and should be more involved in the preparation of the proposal and DIP, and later in monitoring, preparation for sustainability, and use of lessons gained. Sustainability can be seen as sustainability of the project or as adoption of the strategies developed, if shown effective.

Some of the projects have strengthened their links with the NTPs and made good progress in improving how the NTP views community-based TB control efforts. The team and MCDI staff were invited when the Regional TB Manager in KwaZulu Natal presented on the importance of TB control to staff of the South African Ministry of Agriculture. The CARE project and USAID invited the new NTP Director in Indonesia to the team's debriefing: they expressed interest in the methods the community DOT promoters were using and their effectiveness in increasing success rates. CRS discussed strong linkages with the regional and local levels in joint planning and implementation of the TB control programs. Links with the MOH at the appropriate level seem to be strong. All the CSHGP TB projects are working in close partnership with the public health system. However, in several project areas, difficulties were noted in getting the public health system to take over the responsibility for sustaining the community TB control activities after project completion.

BETWEEN CSHGP TB AND OTHER PARTNERS IN COMMUNITY-BASED TB ACTIVITIES

There have been some linkages with a wider range of organizations doing community-based organization/mobilization work, but selling the idea of community support for TB control to local

NGOs, PVOs, and private donors or institutions involved in TB control efforts has not been actively pursued. There seem to be few efforts to involve other community groups, such as industry and commerce associations, the Rotary, or the Lions Clubs. One possible reason for the limited activity is that strengthening the public sector TB service delivery has often been needed to ensure access to and quality of TB care before increasing patient demand through community mobilization.

Sharing best practices through tools, and sharing project experiences through the CORE Group (TB Working Group), project websites, and other venues, can be further developed. For instance, the PCI website could be greatly strengthened to include the description and the valuable experiences of their project.

ROLE OF CSHGP TB GLOBAL EFFORT TO EXPAND COMMUNITY-BASED TB

The intention is to mobilize NGOs and PVOs that are not currently involved in TB. Some of these organizations have significant experience in community organization/mobilization and health work, and others do not, but they are interested in improving the people's health. Sharing the experience of these grants may be useful. There seems to be a lot of cross-learning within the PVOs to other projects they are working on (both TB and non-TB).

IMPACT OF CSH TB GRANTS ON COMMUNITY-BASED TB PROGRAMMING AT THE GLOBAL LEVEL

The impact of the grants at the global level seems very small so far. One project (Zambia) has not yet started, and Romania had to change its plans and address mainly training, so only six projects with widely different objectives and strategies have provided experiences and lessons learned in five years. The projects have provided substantial experience on how to work with communities and how to complement and strengthen the public sector TB programs. They provided fewer experiences on how to make use of the lessons learned to expand population coverage for epidemiological impact.

The commitment to TB programs is defined in the CSHGP portfolio: the CSHGP and the broader USAID TB Portfolio should multiply the number of community-level TB control projects and increase financial support to each project. This commitment opens the field to other PVOs through better guidance and simplification of models in order to increase impact. PVO grantees contribute value to USAID's development of approaches to TB control and to delivery of services. Both in the CSHGP portfolio and in its larger TB portfolio, USAID will need to expand NGO community-based TB programs to a larger scale to meet its own objectives. If funding is limited, USAID should keep supporting PVO interventions in TB control to sustain interest among PVOs in TB control programs, to continue the development of tools and methods, and promote the exchange of information among NGOs and with the broader TB community. This would promote continued development of the capacity of NGOs in TB control and prepare them to obtain funding from other sources to expand services.

So far, the success rate of the TB programs funded by the CSHGP has been good, given the limited resources. Case detection and treatment success has improved, as is proved wherever there are data. Two projects expanded (Ukraine and Mexico) with additional mission funding; one NGO (CARE) was approved for a second country program in Zambia. The team judged that given that there have been so few projects, broad project design, and limited M&E focus, this is fairly good progress. The experiences gained in these programs will reveal other lessons when they are fully analyzed by PVO managers and can be used by TB CSHGP to strengthen and expand into a wider range of countries and organizations.

VIII. CONCLUSIONS

- The CSHGP TB portfolio is in general technically sound and fills a need in TB control, complementing current national and international support to NTPs, strengthening the NTPs' public TB care delivery, and developing community participation to increase case detection and treatment success. The projects were, in general, successful in increasing TB case detection and treatment success, but did not focus their activities and analysis on the essential elements and indicators, and the effectiveness and impact of interventions were often not fully documented.

- There is a wide variety of interventions among projects, from policy support and development of the information system in Ukraine to community mobilization in Mexico. Apparently the guidance and direction from USAID on giving priority to community-based TB activities was insufficiently clear. The situation diagnosis, particularly in the early projects, did not recognize or address the resistance to changing obsolete practices, accepting NGOs/PVOs as useful partners, and identifying national deviations from the internationally recommended norms and definitions. Government commitment was not always obtained or did not result in the agreed-on strengthening of the public TB system.

- Strengthening of delivery of TB care by health facilities with support of the NGOs/PVOs seems effective. The development of community supporters/providers has proven effective in providing information and support to TB clients in the community. In Indonesia, where community mores support active use of volunteer brigades for health and other social services, the TB volunteers, although not paid, are recognized by government officials and by health clinic staff for their work. Indonesia's CDR rose from 66 percent at baseline to 71 percent at midterm, while treatment success rose from 85 percent to 95.8 percent at mid-term. The CRS program in the Philippines reported increased CDR from 69 percent to 84 percent in two years, with a reported cure rate that increased from 72 percent in 2004 to 78 percent in 2006, due to community-based TB control efforts linked with MOH facility services.

- There is often a misunderstanding of DOT by the PVOs and the MOHs. In addition, there has not been adequate analysis by the PVOs, NTPs or MOHs of the various methods being used and their efficacy. There is a need to analyze the various methods currently being used, comparing "strict" DOT provision with other methods currently being used by PVOs and MOHs, i.e. (1) promotion of client self-administration of TB drugs; (2) provision of TB drugs to patients while urging them to find a support system for compliance with a daily TB drug dose; (3) training of general community volunteers who are later linked with TB patients; (4) encouragement of family members to "support" (not necessarily directly observe) TB patients in taking their drugs. It is difficult for the PVOs and MOHs to increase treatment compliance using the various methods, given that they have not analyzed and documented the methods' effectiveness. Both PVOs and NTPs were surprised when they were told that the evaluation team had seen all the different methods above and thought that clients were actually being directly observed to take their TB drugs. Although PVO and other community approaches support TB patient compliance with drug treatment, these approaches do not give priority to facilitating, implementing, and monitoring direct observation of drug intake (DOT) as recommended in the International Standards of Care.

- Guidance for program management, technical focus, and monitoring has been generally been insufficient. Data on the key indicator recommended by USAID to guide program direction (treatment success) are available too late in the life of the project to allow corrective action. The case detection rate (CDR), a key indicator used by several PVO projects, is not appropriate to monitoring TB in small areas and populations. There has been little guidance to assist PVOs in selecting appropriate indicators from among the multiple alternatives available in the Compendium of Indicators and other TB technical reference materials. Recording and reporting systems, in the five years of the CSHGP, have been improved, but health facility and PVO staff have not been trained in the interpretation of their data, close to the source of collection**,** to use for decision making. Often they report data "up" and generally are not aware of the trends and achievements of their programs. There were only limited examples of displays of data that could inform and guide program decisions by staff.

- Weaknesses in the NTPs constitute serious risks to project and overall TB program success—in particular, irregularity of drug supplies, observed in two of the three countries visited, and insufficient direct supervision of microscopy laboratories. The GFATM grant support and grant suspension has caused changes in national plans and affected some CSHGP projects. Coordination with other partners and the support of the USAID mission could help the NTP to overcome these problems.

- The annual reports, MTE, and final evaluation documents are too long and not focused enough to guide program management and technical decisions and to effectively monitor selected targets and indicators. The choice of expert evaluators selected by the PVOs could lead to inconsistent criteria and could result in bias.

- The projects have increased the capacity of the NGOs/PVOs involved, developed staff capacity, and mobilized the community in the project sites, and some have resulted in expansion (Ukraine and Mexico) or replication of experience in another country (CARE). Given the limited funding and the constraints and short duration of the initial projects, this can be considered an important achievement. Improved guidance on development and analysis of the strategies used and modest amounts of operational research, plus wider exchange and dissemination of experiences with assistance from CORE, can facilitate involvement of other NGOs/PVOs in community-based TB and sharing of lessons learned.

- The current small number of projects per year and the limited funding do not allow rapid expansion of the network of U.S. NGOs/PVOs involved in TB nor to fully promote use of the lessons learned by other NGOs/PVOs and by NTPs at a global level. Yet these were the objectives of the portfolio. The accumulated experience of the CSHGP grants to date has been analyzed by the team and found to be sufficient to guide USAID in redirecting the portfolio. This redirection would increase access to grants and strengthen implementation and monitoring. The pace should be greatly accelerated to achieve a substantial growth of effective community-based TB programs. If funding is limited, USAID should continue to develop and support NGOs in TB control, especially supporting community-based TB control. This would encourage continued development of tools and methods for TB control, promote interchange among NGOs, and build NGO capacity. USAID's advocacy role in TB control will also support NGOs in seeking funding from other sources.

- Technical partners such as CSTS+ have provided general guidance and encouraged collaboration that supported PVO TB programs. PVOs would benefit from TB guidance and TB technical materials more focused in scope and more directed to small programs at the community level. Technical partners such as the CORE Group have also provided guidance and encouraged collaboration. There is a need to expand the number of PVOs that actively collaborate in the TB Working Groups to lessen the burden on a few active PVO members and to expand active collaboration among the PVOs engaged in TB efforts. TB CAP and other technical partners can be engaged more actively to technically support PVO TB efforts and to include TB PVO programs in their collaboration mechanisms.

IX. RECOMMENDATIONS

- Clearly define the TB CSHGP portfolio objectives and priorities. The original objectives—to address the gap in community-based TB programs, expand the partners actively involved in TB control efforts, and specifically build capacity in U.S.-based NGOs/PVOs—should be maintained and clarified to give a focus to the portfolio. More explicit guidance should be provided to facilitate involvement of new NGOs/PVOs. For instance, there should be a clear focus on strengthening TB service delivery at PHC level and in developing community models and interventions to improve the population's access to diagnosis of infectious TB cases and the access of patients to treatment and to DOT. More detailed suggestions can be found in Annex 8, "Role for USAID-Supported NGOs/PVOs in TB Control," and in Annex 9 "Key Elements of TB Control."

- Revise and simplify the guidelines and procedures for project preparation and DIP, and focus them on TB and TB/HIV, to allow PVOs experienced in child survival and not in TB, as well as new NGOs/PVOs, to respond. Ensure that the initial PVO situational assessment includes possible constraints and pitfalls, and that available recommendations to the NTP from the Stop TB partners (WHO, IUATLD, KNCV, etc.) are taken into account in the program designs and proposals.

- Identify, propose, and encourage the use of appropriate, rapid TB monitoring indicators for analysis at the facility and district levels, and require regular analysis and reporting of progress. A list of the most appropriate indicators is attached in Annex 10, "Recommended Operational Indicators." The three more important, which are highlighted in the text, are: (1) number of persons examined by sputum microscopy for diagnosis, (2) the number of smear-positive and total TB cases reported, and (3) the sputum conversion rate in new smear-positive patients as an early predictor of treatment success. Other indicators may be added, depending on the project's objectives. A list of selected indicators used or discussed by the PVO projects is included as Annex 11. Key indicators include: (1) the treatment outcome in cohorts of new smear-positive patients is a late but important measure of program and project quality; (2) "success" measures compliance with treatment; and (3) "cure" measures the capacity to monitor evolution of the disease and treatment efficacy.

- Revise and streamline the guidelines for mid-term and final evaluations, including simplifying and focusing reports on progress of indicators (in table form) and analysis of the strategy adopted, sustainability, and feasibility of replication. Data should only be collected if they will be analyzed and used. In particular, data and collection instruments beyond what is already used by the NTP should be simple and limited to activities not normally covered by the NTP (for instance, organization of community groups).

- Strengthen the technical and managerial capacity of the NGOs/PVOs to plan and manage community-based TB interventions, using CORE, TB CAP, and other TB technical partner institutions. Staff in health facilities and supervisors should also be trained in the use of the most important indicators so they can understand and process their own data and monitor progress. To achieve this, NGO/PVO staff should be supported and trained. Guidance can be provided by CORE and the partner organizations to HQ staff, but summary technical and operational guidance should be actively provided to the PVO peripheral staff in the field.

- Further disseminate the experience of the portfolio projects through accessible media, and encourage and support the projects to carry out critical analysis of their findings and

discuss them openly with other NGOs/PVOs and with USAID. The CORE workshop on lessons learned was a useful example, but the activity should be more frequent and accessible to field staff. A good model would be short presentations and discussion in groups, plus simultaneous transmission such as Illuminate sessions, plus selected items on a webpage, plus email discussion as in the Stop TB forum.

- Support the NGOs/PVOs' linkages with other sources of funding that can be used directly by the NGOs/PVOs or indirectly by the government or other institutions (such as GFATM or PEPFAR funding) to expand, replicate, or adapt the experiences of the USAID-supported projects in community-based TB control.

- Consider different mechanisms than the CSHGP grant portfolio (which should be primarily focused on community-level TB activities) to support TB programs in special situations—those without NTP or with inadequate NTP—where community mobilization is not the focus of the proposed intervention. USAID is already supporting NTPs through some other technical programs/agencies. Special cases (mainly in Eastern Europe and Africa) could be better served by direct support, tailored to the specific situations and provided to a NGO/PVO or other agencies that have another focus to its programs. This includes countries with major resistance to implementing DOTS policies, those with poorly developed NTPs, and those where war or political unrest has broken regular health service delivery, including TB.

- Increase the number of projects supported per year and the amount of funding for each one (US$2–3 million in four to five years). The experience of the last five years and the findings and recommendations of the current review should be sufficient to improve project design and support. At the present rate, the impact desired to increase U.S.-based NGO/PVO involvement in TB and to promote community-based TB control will be minimal. A larger number of projects are necessary to achieve a critical mass of experience that will be convincing to the global community, particularly regarding sustainability, feasibility of replication, and adoption of the methods by the NTPs. The current amount is small and calls into question the wisdom of PVOs' investing resources in competing for a grant in the new field of TB, given that it requires retraining or new staff and a different approach than the traditional Child Survival projects. An increase in funds, clear technical direction and streamlining, and focusing of PVO TB efforts in CSHGP assumes that USAID has committed to providing leadership in the international community for community-based TB programming. If the funding is more limited, USAID should still continue to fund NGOs in TB control. With limited funds, the objectives should be more focused. Encouraging interchange among NGOs, providing support through CORE and other mechanisms, and providing training would help NGOs continue to provide TB control interventions.

- Recommended next steps to redirect the portfolio are included in Annex 12.

For more information, please visit
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