Annex 2

Handouts

2013

This document was produced for review by the United States Agency for International Development (USAID). It was prepared by PATH for USAID Tuberculosis Task Order 2015, Task Order 1, GHS-I-00-09-00006.

DAY 1

Overview of ACSM, Monitoring and Evaluation

Handout 1.1

Monitoring and Evaluation of Advocacy, Communication, and Social Mobilization (ACSM) Activities to Support TB Control

Workshop Agenda

Workshop Objectives:

- Build capacity for rigorous monitoring and evaluation (M&E) of ACSM activities.
- Assist participants to develop detailed M&E plans for ACSM activities.
- Familiarize participants with five basic categories of evaluation to support ACSM activities.
- Identify technical assistance resources to support improved M&E of ACSM.

DAY 1: Overview of ACSM, Monitoring and Evaluation

	Time	Session Title	Description
	8:30 - 9:00	Registration	
1	9:00 - 10:45	Introduction and Workshop Overview	Welcome, introductions, workshop objectives, agenda, materials, and logistics.
	10:45 - 11:00	**Coffee Break**	
2	11:00 - 12:00	Overview of ACSM	Role of ACSM in TB control. Review of ACSM components, their objectives, and target groups.
3	12:00 - 13:00	TB 101: TB Basics and Global Approaches	Review of essential TB prevention and care terms and strategies.
	13:00 - 14:00	**Lunch**	
4	14:00 - 15:00	Gap Analysis	ACSM gap analysis and linking ACSM activities to National Tuberculosis Program objectives.
5	15:00 - 15:45	Planning M&E to Tell Our ACSM Story	Developing ACSM plans and M&E plans together to demonstrate ACSM successes. Using M&E plans as a master strategy for M&E.
	15:45 - 16:00	**Coffee Break**	
6	16:00 - 17:45	Key Terms for M&E	Definitions of monitoring and evaluation and essential M&E terms.
7	17:45 - 18:00	Summary and Closing	Summary of key points from the day.

DAY 2: M&E Frameworks

	Time	Session Title	Description
1	9:00 - 9:30	Opening Session	Review key points from Day 1 and agenda for Day 2.
2	9:30 - 10:45	SMART Objectives	Writing effective ACSM objectives using the SMART criteria.
	10:45 - 11:00	**Coffee Break**	
3	11:00 - 13:00	Writing SMART Objectives	Participants create SMART objectives for their ACSM plans.
	13:00 - 14:00	**Lunch**	
4	14:00 - 15:45	Introduction to M&E Frameworks	Using frameworks to organize M&E components into a cohesive logic for objectives and activities.
	15:45 - 16:00	**Coffee Break**	
5	16:00 - 17:15	Frameworks, continued	Participants complete actual M&E frameworks.
6	17:15 - 17:30	Summary and Closing	Summary of key points from the day.

DAY 3: Routine Monitoring

	Time	Session Title	Description
1	9:00 - 9:30	Opening Session	Review key points from Day 2 and agenda for Day 3.
2	9:30 - 10:45	Indicators for ACSM	Defining qualitative and quantitative indicators and the criteria for effective indicators.
	10:45 - 11:00	**Coffee Break**	
3	11:00 - 12:00	Selecting Indicators	Participants select and define indicators for their M&E frameworks.
4	12:00 - 13:00	Uses for Data	Different ways data can be used by different stakeholders.
	13:00 - 14:00	**Lunch**	
5	14:00 - 15:45	Collecting High-Quality Data	Methods and tools for monitoring. Factors that impact data quality.
	15:45 - 16:00	**Coffee Break**	
6	16:00 - 17:15	Developing Monitoring Plans	Participants develop their monitoring plans.
7	17:15 - 17:30	Summary and Closing	Summary of key points from the day.

DAY 4: Introduction to Evaluation

	Time	Session Title	Description
1	9:00 - 9:30	Opening Session	Review key points from Day 3 and agenda for Day 4.
2	9:30 - 10:45	Introduction to Evaluation	Overview of the categories of evaluation.
	10:45 - 11:00	**Coffee Break**	
3	11:00 - 12:00	Evaluation Questions	What questions should we ask about our programs and why?
4	12:00 - 13:00	Evaluation Methods	Description, examples, benefits, and limitations of several evaluation methods.
	13:00 - 14:00	**Lunch**	
5	14:00 - 15:45	Selecting the Right Evaluation Method	How to select a good mix of evaluation methods for your ACSM plan.
	15:45 - 16:00	**Coffee Break**	
6	16:00 - 17:15	Plan Your Evaluation	Participants select evaluation methods for their ACSM objectives and activities.
7	17:15 - 17:30	Summary and Closing	Summary of key points from the day.

DAY 5: Putting It All Together

	Time	Session Title	Description
1	9:00 - 9:30	Opening Session	Review key points from Day 4 and agenda for Day 5.
2	9:30 - 10:45	Flextime	To be determined.
	10:45 - 11:00	**Coffee Break**	
3	11:00 - 13:00	Ask an Expert	Facilitate small group conversations about M&E and feedback on evaluation plans.
	13:00 - 14:00	**Lunch**	
4	14:00 - 15:00	Real-World Challenges of M&E	Practical challenges of conducting M&E and how to overcome them. Technical assistance resources.
5	15:00 - 15:45	What's My Story?	Defining the next steps of M&E back home.
	15:45 - 16:00	**Coffee Break**	
6	16:00 - 17:00	Final Evaluation and Workshop Closing	Summary of next steps. Final evaluation.

Handout 1.2

Pre-workshop ACSM M&E Quiz

ACSM: advocacy, communication, and social mobilization; **M&E:** monitoring and evaluation.

1.	Evaluation is a routine practice that helps ACSM managers understand whether or not activities are being implemented as planned.	True	False
2.	Outcome evaluation should always be done before process evaluation.	True	False
3.	The only important characteristics of high-quality data are accuracy, timeliness, and completeness.	True	False
4.	Gap analysis is a critical step in planning for M&E of ACSM activities.	True	False
5.	An M&E framework can help show how ACSM activities contribute to National Tuberculosis Program goals and objectives.	True	False
6.	Focus group discussions are a useful way to pre-test communication materials.	True	False
7.	An M&E plan includes a framework, indicators, and evaluation methods.	True	False
8.	An output is a long-term result of ACSM activities that should be analyzed over time.	True	False
9.	Knowledge, attitudes, and practices surveys are a very inexpensive, quick way to collect data needed to support ACSM programs.	True	False
10.	National Tuberculosis Program staff are always the best people to conduct evaluations of ACSM.	True	False

Your country: _____

Handout 1.3

Case Example

The National Tuberculosis Program (NTP) has a goal to reduce morbidity and mortality related to tuberculosis (TB). A key objective of the NTP is to raise its case detection rate from 42% to 60% by 2015. One problem in case detection is that urban residents are poorly educated about TB symptoms and where to go for care if they have TB-like symptoms (cough for 2+ weeks, chest pain, cough with blood, fever, night sweats). As a result, they consult local pharmacists to treat these symptoms rather than go to government health facilities.

Also, pharmacists have limited knowledge about TB and TB services and provide inappropriate treatments for prolonged cough. A local public health graduate student recently conducted a telephone survey of 70 pharmacists in three large cities to determine their knowledge of TB symptoms and their response to customers with prolonged cough (e.g., sell cough syrups, sell antibiotics, or refer them to a formal health facility for evaluation). Of the 70 interviewed, only one-third (23) of the pharmacists could list the most common symptoms of TB. Only six (9%) said they had referred a customer with prolonged cough for TB screening in the past six months and only eight (12%) knew where the nearest DOTS facility was located.

A local nongovernmental organization (NGO) is funded to work with the NTP to conduct a public awareness campaign and pilot efforts to engage private pharmacists in the capital, City X, to refer people with TB symptoms for TB screening at DOTS facilities. If the pilot shows good results, the NGO would like to approach its donor to expand the pharmacy intervention to ten large cities with high pharmacy density.

These are the planned activities:

1. Conduct a public awareness campaign:

Activity 1: Conduct a knowledge, attitudes, and practices survey to explore the general public's knowledge of TB symptoms and informational needs.

Activity 2: Develop and air a series of three radio commercials promoting awareness of TB symptoms and screening for symptoms at the DOTS facility.

Activity 3: Develop and produce a series of three subway advertisements promoting awareness of TB symptoms and screening for symptoms at the DOTS facility.

2. Involve pharmacies to refer people with TB-like symptoms for DOTS screening:

Activity 1: Train 50 pharmacists to recognize common TB symptoms and counsel customers with TB symptoms to be screened at the local DOTS facility.

Activity 2: Conduct monthly visits to participating pharmacies to track referrals and provide technical support.

Activity 3: Conduct monthly visits to participating DOTS facilities to track people with symptoms who came with pharmacy referrals and TB case detection.

3. Obtain expansion funding:

Activity 1: Develop a brief proposal describing the pilot results, expansion targets, and expected budget, and distribute to the donor and leaders at the NTP and Ministry of Health (MOH).

Activity 2: Conduct meetings with the NTP, MOH, and donor to present pilot results, review the proposal, and approve funding for the pharmacy intervention..

Handout 1.4

Results of ACSM

Approach	Key activities	What do we hope to achieve?	How will this contribute to case detection and treatment outcomes?	What is the ultimate goal?
Advocacy	• Lobbying meetings. • Petitions, letter campaigns. • Meetings with decision-makers and funders.	• TB is included on the political agenda. • Laws are improved/passed, new policies are approved, or existing policies are reinforced that promote innovative TB services. • Increased funding for TB programs. • Improved media coverage of TB.	• Politicians more willing to allocate funding and resources for TB control. • New policies and laws improve access to diagnosis and treatment. • National Tuberculosis Program has sufficient resources to update laboratories, conduct surveillance, and ensure adequate supply of drugs. • Media coverage of TB problems and possible solutions puts issues on the political and public agenda.	**Increased TB case detection** **Improved TB treatment outcomes** **Reduced mortality due to TB**
Communication	• Information, education, and communication activities such as posters, brochures, television spots. • Communication and counseling skills training for health workers. • Training for journalists to promote accurate and positive TB messages.	• Increased public awareness of TB. • Improved knowledge about TB symptoms, treatment, and services. • More compassionate attitudes of health workers and community members toward people with TB. • People seek care and maintain treatment. • Decreased stigma.	• People are more motivated to seek care when they are aware of TB symptoms and availability of treatment. • People are more willing to stay on treatment because they feel supported by providers and community members. • More positive TB messages in media change society's attitudes toward people with TB, reduce fear, and encourage people to seek care.	

Approach	Key activities	What do we hope to achieve?	How will this contribute to case detection and treatment outcomes?	What is the ultimate goal?
Social mobilization	• Recruiting current and former TB patients to participate in TB control (TB clubs, health educators, contact-tracing). • Community stakeholder meetings to help plan and implement TB control activities. • High-profile community events (e.g., World TB Day).	• Increased public support to stop TB and support TB patients. • Improved service delivery. • Engaged civil society to partner with government. • Empowered people affected by TB.	• Increases in demand for diagnosis and treatment services. • Increases in options for TB diagnosis and treatment. • Clients have access to more support services throughout the course of treatment. • Reinforcement of political commitment to sustain or increase resources to find, diagnose, and treat TB.	**Increased TB case detection** **Improved TB treatment outcomes** **Reduced mortality due to TB**

TB: tuberculosis.

Handout 1.5

Glossary of TB Terms

The Basics

Bacille Calmette-Guérin (BCG) – a vaccine for tuberculosis (TB) named after the French scientists who developed it, Calmette and Guérin. BCG is not effective in preventing TB in adults, but it can prevent severe forms of TB, such as TB meningitis, among infants and small children.

Contact – a person who has spent sufficient time with a person with active TB to be at risk of being infected.

Directly observed therapy (DOT) – the World Health Organization (WHO)-recommended way of helping clients take their medicine for TB that involves having a trained, supervised health care provider or volunteer observe clients taking their medication and recording the dosage on a standard form. Clients and health care workers meet every day or several times a week at a convenient place such as the TB clinic, the client's home, or at work. Clients take their TB medicine while the health care worker watches.

DOTS – the five-part WHO-recommended strategy for TB control that has been adopted by most countries. It consists of (1) political commitment and sustained financing for TB programs, (2) diagnosis with quality-assured smear microscopy, (3) DOT, (4) a reliable drug supply, and (5) standardized recording and reporting of case notification and treatment outcomes.

Incidence – the number of new and relapse TB cases per 100,000 population per year.

Mycobacterium tuberculosis – the bacteria that causes latent TB infection and active TB disease.

TB mortality – the number of deaths due to TB per 100,000 population per year.

Prevalence – the number of active TB cases (all forms) per 100,000 population at the middle of the year.

Sputum – phlegm coughed up from deep inside the lungs. Sputum is examined for TB bacteria using a smear. Part of the sputum can also be used for culture, drug susceptibility testing, and DNA-based tests.

Transmission – the way a disease is spread from one person to another. TB is spread through the air. When people with active pulmonary TB cough, sneeze, speak, or spit, they expel infectious droplets into the air around them. People with prolonged, frequent, or intense contact with a person with active TB are at particularly high risk of becoming infected. A person with active but untreated TB can infect 10–15 other people per year.

Types of TB

Active TB disease – an illness in which TB bacteria multiply and attack different parts of the body, causing symptoms such as cough, fever, weight loss, and night sweats. There are two forms of TB: *TB infection* **(latent TB)** and *TB disease* **(active TB)**. People with TB infection have no symptoms and cannot spread TB to others. People with active TB disease have symptoms and can sometimes spread TB to others. If active TB disease is in the lungs **(pulmonary TB)**, the symptoms may include a persistent cough, pain in the chest, and coughing up blood.

Latent TB infection – a condition in which TB bacteria are alive but inactive in the body. People with latent TB infection have no symptoms, do not feel sick, cannot spread TB to others, and usually have a positive skin test reaction. But they may develop active TB disease if their immune system is weakened and/or they do not receive treatment for latent TB infection.

Pulmonary TB – active TB disease that occurs in the lungs, usually producing a cough that lasts 2-3 weeks or longer. Most active TB disease is pulmonary.

Extrapulmonary TB – active TB disease in any part of the body other than the lungs, such as the kidney, spine, brain, or lymph nodes.

TB Diagnosis

Case detection rate – estimated percentage of all smear-positive cases that have been diagnosed and reported to the National Tuberculosis Program out of those existing in the community.

Chest x-ray – a picture of the inside of the chest. A chest x-ray is made by exposing a film to x-rays that pass through the chest. It is a helpful diagnostic tool when a person has symptoms of TB but the smear test is negative. It can be used to assess how much TB has damaged the lungs after TB is confirmed.

Culture – a laboratory test that grows TB bacteria in a tube or on a plate to see whether there are TB bacteria in a sputum specimen or other body fluids. TB bacteria grow very slowly, so it can take up to eight weeks to confirm a TB diagnosis using culture, depending on how the laboratory is growing the bacteria.

Person with presumptive TB – a person who presents with signs or symptoms that suggest TB infection (replacing the term “TB suspect”).

Smear microscopy – a rapid screening test to see whether there are TB bacteria in a sputum specimen. A laboratory worker smears the sputum on a glass slide, applies a special stain (acid-fast stain), and then looks for any TB bacteria on the slide under a microscope. This test allows the health staff to receive a preliminary report within 24 hours.

Smear-negative TB (sputum smear negative, SS-) – a diagnosis of TB that means the person does not have infectious TB. The person’s smear test was negative in at least two samples, and no TB bacilli were visible on the slide under the microscope, but yet other diagnostic tests (e.g., chest x-ray) indicate TB, the person has symptoms, and the provider has decided to treat for TB. Smear-negative TB is common among people with TB/HIV co-infection and in children.

Smear-positive TB (sputum smear positive, SS+) – a diagnosis of TB that means that TB bacilli were visible on the slide under the microscope, so the person is possibly contagious. Smear-positive TB patients are often prioritized for interventions to avoid further transmission and because they are often very sick.

TB skin test (TST) – a test that is often used to detect latent TB infection. A liquid called tuberculin purified protein derivative (or PPD) is injected under the skin (intradermally) on the lower part of the arm in a standard dose. If the area around the injection site becomes red, it means the client probably has latent TB infection. This test is also known as a Mantoux test.

TB Treatment

Drugs used to treat TB – two broad categories of drugs are used to treat TB. "First-line" drugs are the most important drugs used to treat most cases of TB throughout the world, while "second-line" drugs are used to treat TB that has become resistant to the first-line drugs. All first-line anti-TB drug names have a standard three-letter and a single-letter abbreviation:

- ethambutol is EMB or E
- isoniazid is INH or H
- pyrazinamide is PZA or Z
- rifampicin is RMP or R
- streptomycin is STM or S

Isoniazid preventive therapy (IPT) – a strategy used to prevent active TB disease in people who have latent TB infection or people with HIV who are at high risk for becoming sick with TB but who do not have active TB disease. Isoniazid is also one of the four most common medicines used to treat active TB disease.

Treatment Outcomes

Cohort analysis – review of treatment results for a group of TB patients who started treatment during a specific period of time, usually a quarter. Each TB patient on treatment is part of a cohort. Cohorts are named by quarter/year. For example, the Q1 2012 cohort is the group of patients who started treatment between January and the end of March 2012 Cohorts are evaluated a full year after they start treatment. Quarterly cohort review is essential to the DOTS strategy for TB control.

Person lost to follow-up – a patient who starts TB treatment that is later interrupted for at least two consecutive months (replacing the term "defaulter").

Retreatment cases – total number of TB cases reported within a specific time period who have received prior treatment (can be relapse, treatment after failure, treatment after default). This is an important indicator of multidrug-resistant tuberculosis because a high number of retreatment cases could mean people have drug-resistant bacteria and their medicine is no longer effective.

Treatment success rate – the percentage of TB patients in a cohort who were cured or completed treatment. It is calculated by adding together the number of sputum smear-positive (SS+) patients in a cohort who have completed treatment PLUS the number of SS+ who have been cured, dividing by the total number of patients in the cohort, and multiplying the result by 100.

Definitions of TB treatment outcomes recommended by WHO:

Cured: Patient was initially smear positive and is now smear negative in the last month of treatment and on at least one previous occasion.

Completed treatment: Patient finished treatment but did not meet the criteria for cure or failure. This definition applies to pulmonary smear-positive and smear-negative patients and to patients with extrapulmonary disease.

Died: Patient died from any cause during treatment.

Failed: Patient was initially smear positive and remained smear positive at month 5 or later during treatment.

Defaulted: Treatment was interrupted for two or more consecutive months.

Not evaluated: Treatment outcome for the patient is not known.

TB/HIV

HIV-associated TB – TB disease in someone who is also infected with HIV.

HIV infection – infection with the human immunodeficiency virus, the virus that causes AIDS (Acquired Immunodeficiency Syndrome). A person with both latent TB infection and HIV infection is at high risk for active TB disease.

HIV prevalence among TB patients – percentage of all TB patients tested for HIV with HIV-positive test result. This is available for TB patients who actually get tested and is not an estimate of the overall prevalence of HIV among people with active TB in the population.

Three I's – strategies recommended to reduce the burden of TB among people living with HIV. Includes intensified case-finding, isoniazid preventive therapy (preventing latent TB from progressing to active disease), and infection control.

Uptake of HIV testing for TB patients – percentage of all TB patients counseled and tested for HIV and received their results.

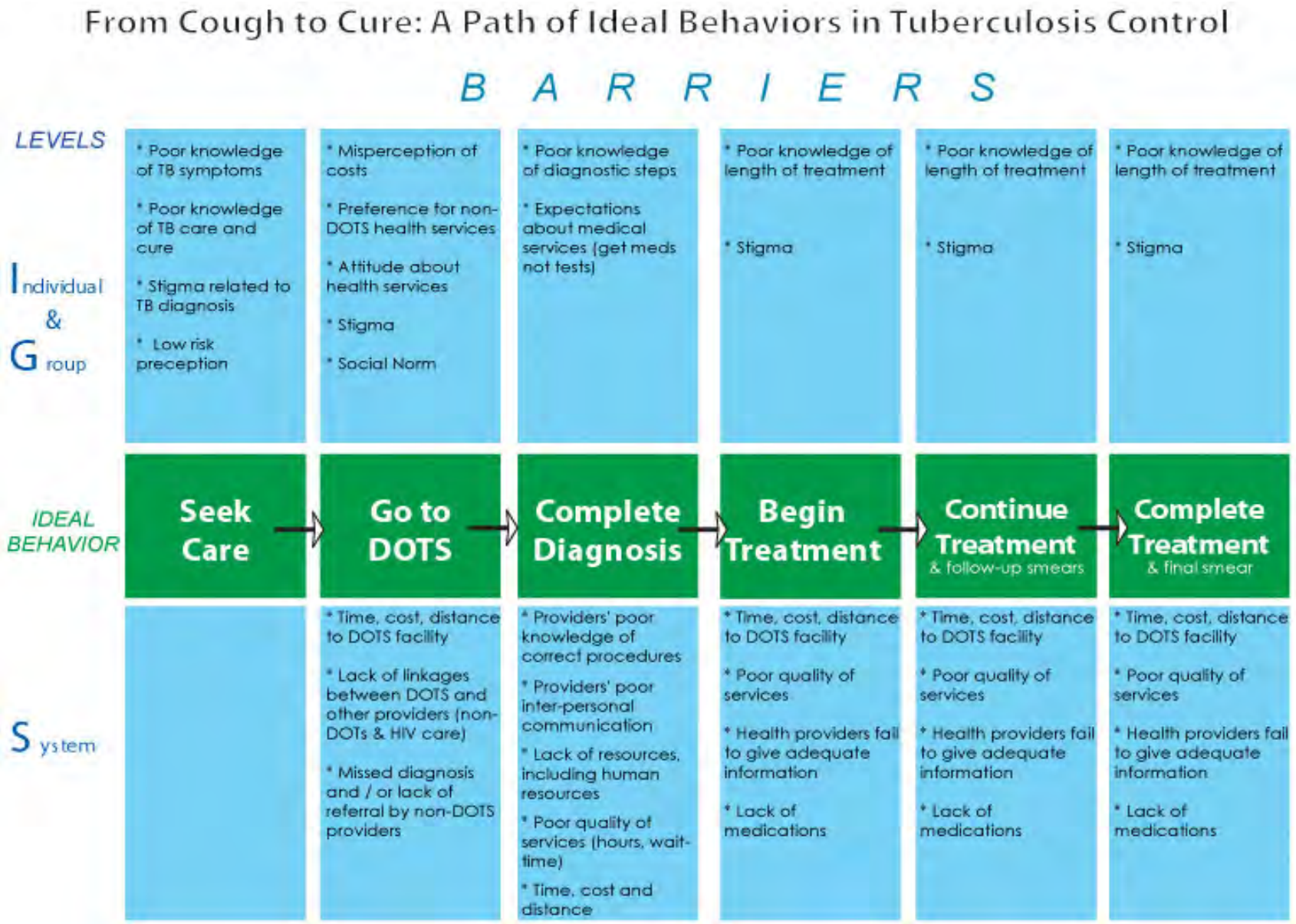
Drug Resistance

Drug-resistant bacteria – bacteria that can no longer be destroyed by a certain medicine because they have developed the ability to fight the medicine's effect.

Extensively drug-resistant tuberculosis (XDR-TB) – active MDR-TB disease caused by bacteria that are also resistant to the most effective second-line drugs for treating MDR-TB.

Multidrug-resistant tuberculosis (MDR-TB) – active TB disease caused by bacteria that are resistant to rifampicin and isoniazid, the two most powerful first-line drugs.

Handout 1.6


From Cough to Cure: A Path of Ideal Behaviors in Tuberculosis Control
B A R R I E R S
LEVELS
Individual & Group
System
IDEAL BEHAVIOR
* Poor knowledge of TB symptoms
* Poor knowledge of TB care and cure
* Stigma related to TB diagnosis
* Low risk preception
* Misperception of costs
* Preference for non-DOTS health services
* Attitude about health services
* Stigma
* Social Norm
* Poor knowledge of diagnostic steps
* Expectations about medical services (get meds not tests)
* Poor knowledge of length of treatment
* Stigma
* Poor knowledge of length of treatment
* Stigma
* Poor knowledge of length of treatment
* Stigma
Seek Care
Go to DOTS
Complete Diagnosis
Begin Treatment
Continue Treatment & follow-up smears
Complete Treatment & final smear
* Time, cost, distance to DOTS facility
* Lack of linkages between DOTS and other providers (non-DOTs & HIV care)
* Missed diagnosis and / or lack of referral by non-DOTS providers
* Providers' poor knowledge of correct procedures
* Providers' poor inter-personal communication
* Lack of resources, including human resources
* Poor quality of services (hours, wait-time)
* Time, cost and distance
* Time, cost, distance to DOTS facility
* Poor quality of services
* Health providers fail to give adequate information
* Lack of medications
* Time, cost, distance to DOTS facility
* Poor quality of services
* Health providers fail to give adequate information
* Lack of medications
* Time, cost, distance to DOTS facility
* Poor quality of services
* Health providers fail to give adequate information
* Lack of medications

Handout 1.7

Typical ACSM Action Plan

National Tuberculosis Program (NTP) goal _____

ACSM Activities	Outputs	Organization	Lead Staff	Timeline											
				1	2	3	4	5	6	7	8	9	10	11	12
NTP Objective 1															
ACSM Objective 1.1															
ACSM Objective 1.2															
NTP Objective 2															
ACSM Objective 2.1															
ACSM Objective 2.2															

Handout 1.8

Monitoring & Evaluation Checklist

PHASE 1: PLANNING

ACSM: advocacy, communication, and social mobilization; **M&E:** monitoring and evaluation; **NTP:** National Tuberculosis Program; **TB:** tuberculosis.

STEP 1: Conduct an ACSM needs assessment.	
	Perform Cough to Cure gap analysis to identify TB control challenges and barriers.
	Determine which gaps can be addressed with ACSM interventions.
	Prioritize ACSM interventions based on needs and resources.

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

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

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

PHASE 2: IMPLEMENTATION

STEP 1: Conduct routine monitoring.	
	Collect data on indicators according to the M&E plan.
	Analyze data to determine which activities are below, at, or exceeding the target, based on your analysis of outputs and outcomes.
	Document any problems or challenges in implementation.
	Implement the data quality assurance strategy.
	Develop and disseminate monitoring reports according to the M&E plan timeline.

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

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

Handout 1.9

M&E Plan Outline

This is a sample of how you might organize a monitoring and evaluation (M&E) plan to submit to donors, National Tuberculosis Program (NTP) managers, organizational leaders, or other important stakeholders. M&E plans can look very different but often include a combination of brief narrative summaries and charts.

PART 1: PROGRAM OVERVIEW

Briefly describe your advocacy, communication, and social mobilization (ACSM) project and/or organization. Include your program partner, important stakeholders, and how your project is funded.

PART 2: NTP GOALS, OBJECTIVES, AND KEY TUBERCULOSIS (TB) PREVENTION AND CARE CHALLENGES

Outline the NTP goals and objectives that your ACSM objectives will help support. Describe the key TB prevention and care challenges faced in reaching these particular NTP objectives.

NTP goals:

NTP objectives:

TB control challenges and barriers:

PART 3: ACSM OBJECTIVES AND ACTIVITIES

*List your **SMART** ACSM objectives and related activities. This could be presented as an outline or a chart. Link each ACSM objective to an NTP objective. (SMART: Specific, Measurable, Attainable, Relevant, Time-bound.)*

OBJECTIVE 1:

ACTIVITIES:

PART 4: MONITORING and EVALUATION MATRIX

Provide a chart that shows your plan and schedule to collect and report monitoring data and how you will evaluate your objectives (and at what stage of the project).

NTP GOAL				
NTP Objective				
ACSM Objective				
Expected Outcomes • **Indicators**				
ACSM Activity	**Outputs/Indicators**	**Data Source**	**Frequency**	**Reporting Responsibility**
Evaluation Summary				
Evaluation Type: **Purpose:** **Method:** **When:**				

PART 5: DATA USE and DATA QUALITY

Summarize how different data will be shared and how the data will be used by your organization. How will your organization review and ultimately use these data? How will you ensure the quality of your data? Include the organizations with which you will share results, when, and in what formats or methods.

DAY 2

M&E Frameworks

Handout 2.1

TB Control Objectives and ACSM Objectives

TB Control Objective	ACSM Objective	ACSM Activities
Secure stable funding for the National TB Program (NTP) as a line item in the Ministry of Health annual budget by 2015. Challenge: Lack of funding for NTP. Barrier: Politicians do not view TB control as a priority.	By mid-2014, ensure that TB is declared a national health priority.	• Develop print materials (spokesperson talking points, letters, and press briefs). • Conduct press conferences that spotlight the TB situation in the country. • Meet with different stakeholders to sign petition to government. • Conduct seminars and briefing meetings with policymakers and political leaders.
Improve case detection from 50% to 70% by 2014. 1. Challenge: Low screening rates among urban poor with high TB prevalence. Barrier: Lack of knowledge on TB and TB services among urban poor. 2. Challenge: Low TB screening referrals from primary health providers. Barrier: Lack of knowledge about TB problem and DOTS among primary health care providers.	1. By the end of 2013, raise awareness of TB symptoms and free screening services among the urban poor in five provinces.	• Conduct formative research to determine knowledge gaps, best messages, and forms. • Develop information, education, and communication materials on TB for urban poor and distribute during outreach visits in slums.
	2. By mid-2013, improve TB knowledge of primary health care providers in 20 medical facilities of five provinces.	• Conduct DOTS trainings for primary health care providers.

TB Control Objective	ACSM Objective	ACSM Activities
Increase treatment success rate from 75% to 85% by 2015. *<u>Challenge</u>: Poor treatment adherence among TB patients.* *<u>Barriers</u>:* • *Health workers in Provinces A and B are not communicating effectively with patients about TB treatment.* • *In Provinces C and D, TB patients need treatment support in the community.*	1. Increase awareness about consequences of not adhering to treatment among TB patients in Provinces A and B by 50% by the end of 2013.	• Develop brochures and distribute at health care facilities and via treatment supporters. • Train treatment supporters on adherence and interpersonal communication skills.
	2. Increase patient satisfaction with TB counseling by 30% in ten hospitals of Provinces A and B by the end of 2013.	• Conduct interpersonal communication and counseling training for health workers. • Develop job aids for health workers.
	3. In Provinces C and D, involve family and community volunteers to supervise treatment of TB patients in order to ensure treatment completion.	• Hold community or interest group meetings. • Conduct trainings for community volunteers and family members.

Handout 2.2

Developing SMART Objectives

DOTS: global strategy for tuberculosis control; **SMART:** Specific, Measurable, Attainable, Relevant, Time-bound; **TB:** tuberculosis.

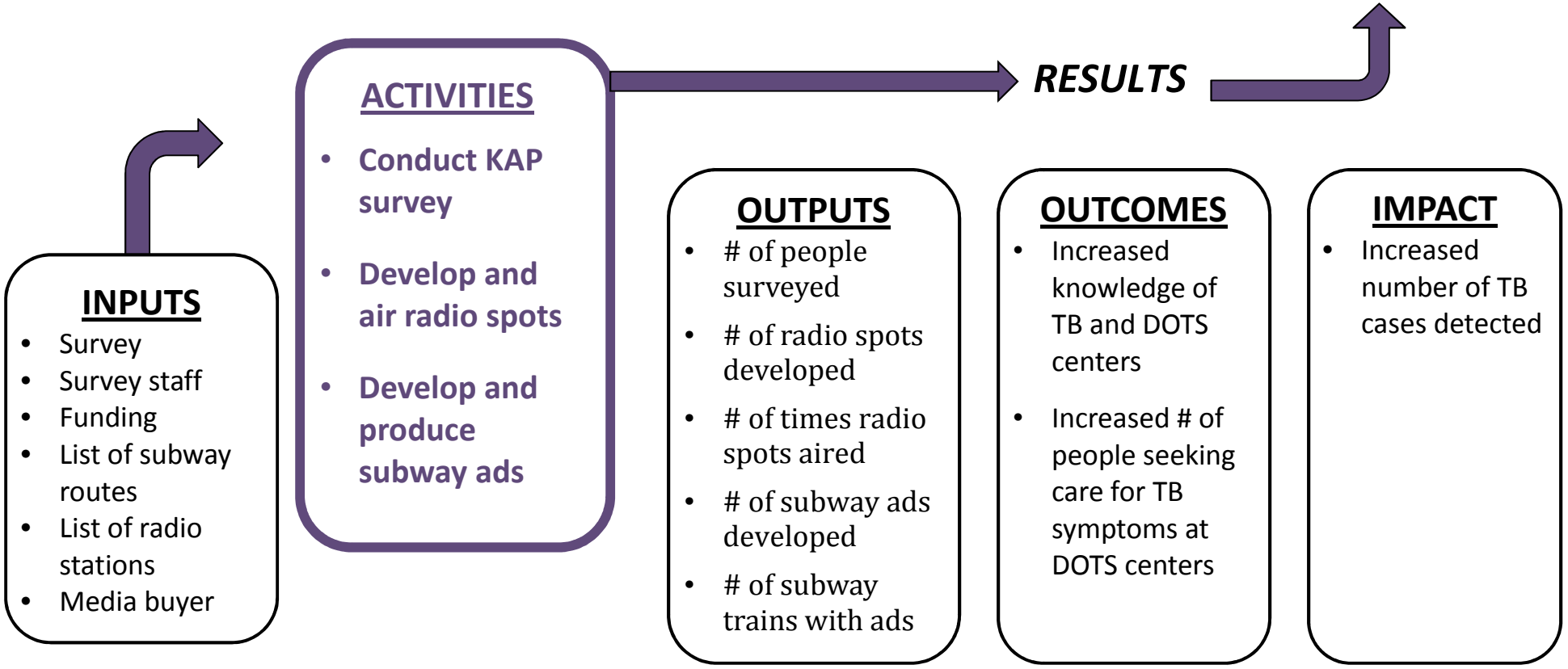
Issue	People in the capital, City X, are poorly educated about TB symptoms and where to go for care of symptoms. (Communication).				
Parts	**Verb**	**What?**	**Who?**	**From __ To __ or By ___**	**Time Frame**
	Raise / Increase	Knowledge / Number seeking care for TB symptoms	People in City X	By 30%	December 2013
Objective	**Raise the knowledge of TB symptoms and TB services to increase the number of people in City X seeking care for TB symptoms at DOTS centers by 30% by December 2013.**				

Issue	Urban pharmacists do not refer customers with prolonged cough for DOTS screening. (Social mobilization).				
Parts	**Verb**	**What?**	**Who?**	**From __ To __ or By ___**	**Time Frame**
Objective					

Handout 2.3

M&E Framework Example

NTP Goal:	**Reduce morbidity and mortality related to TB.**
NTP Objective:	**Increase case detection rate from 42% to 60% by 2015.**
ACSM Objective:	**Raise knowledge of TB symptoms and TB services to increase the number of people in City X seeking care for TB symptoms at DOTS centers by 30% by December 2013.**



Handout 2.4

M&E Framework Template

NTP Goal:				
NTP Objective:				
ACSM Objective:				
Activities	**Inputs**	**Outputs**	**Outcomes**	**Impact**

DAY 3

Routine Monitoring

Handout 3.1

Common ACSM Indicators

Advocacy Activity	Output Indicators (versus Target)	Outcome Indicators
Create an advocacy network of key stakeholders to increase local and national political commitment to TB in Country X.	• # of individuals and/or organizations participating in the TB advocacy network. • # of advocacy network meetings per year.	• Annual work plan developed and disseminated to members (improved coordination). • % increase in districts with an advocacy representative (increased coverage). • Multi-sectoral involvement exists at the national level for TB control (increased political commitment).
Lobby district government officials to increase funding for TB diagnosis and treatment centers.	• # of district officials sensitized on the importance of appropriate TB diagnosis and treatment. • # of district council meetings organized. • # of advocates attending the meetings.	• Level of funding for TB diagnosis and treatment services (increased funding). • % increase in budget allocated for ACSM activities to raise public awareness of TB screening (increased funding).
Lobby Ministry of Health (MOH) officials to scale up community-based treatment for TB.	• # of policymakers receiving reports and results of the community-based treatment pilot. • # of MOH officials attending the lobbying meetings.	• # of policymakers willing to sign support letter to the Minister of Health (increased political commitment). • Adoption of desired policy change (reduced barriers to TB screening and treatment).

Communication Activity	Output Indicators (versus Target)	Outcome Indicators
Train DOTS nurses in interpersonal communication and counseling (IPCC) skills.	• Training curriculum developed and approved by focus group of DOTS nurses. • # of IPCC training workshops conducted. • # of DOTS nurses trained in IPCC skills.	• Higher scores on empathy survey given after training compared to pre-training survey (improved attitudes toward TB clients). • % increase in client satisfaction (reduced stigma).

Communication Activity	Output Indicators (versus Target)	Outcome Indicators
Work with local theater groups to incorporate TB messages into performances.	• TB messages developed. • # of street theater performances conducted with TB messages/content. • # of people attending street theater performances with TB content.	• # of people presenting for diagnosis at nearby DOTS centers after street theater performances (increased demand for screening). • % of audience members who can identify chronic cough as a sign of TB (increased knowledge).
Develop and print patient brochures and posters on treatment adherence strategies.	• # of brochures printed. • # of brochures distributed.	• % of clients who can recall at least two key strategy messages during exit interviews in clinics with brochures and posters versus clinics without those materials (increased knowledge).

Social Mobilization Activity	Output Indicators (versus Target)	Outcome Indicators
Involve community health workers to collect sputum of people with TB symptoms during home visits.	• # of community health workers trained on sputum collection. • # of homes visited by the community health workers. • # of sputum samples collected by the community health workers.	• % of smear-positive TB cases identified by community health workers (increased case detection).
Sensitize religious leaders in District X on the challenges of TB-related stigma.	• # of materials developed. • # of sensitization meetings held. • # of religious leaders sensitized on TB and TB stigma.	• # of speeches given by religious leaders with positive messages about TB (improved attitudes). • Estimated # of people at religious gatherings where TB stigma is discussed. • % of district population expressing accepting attitudes toward TB suspects, patients, and survivors (reduced stigma).

Social Mobilization Activity	Output Indicators (versus Target)	Outcome Indicators
Involve former TB patients to become treatment educators and monitors.	• # of former TB patients trained. • # of educational group sessions held. • # of current TB patients attending education sessions.	• % of patients surveyed who express commitment to completing treatment (improved attitudes). • % of patients completing treatment (increased treatment completion).

Handout 3.2

Indicator Description Examples

Indicator description: Percentage of people who know two TB symptoms and what the DOTS center is.		
Complete definition	**Data source**	**How will we calculate?**
Percentage of subway riders who can accurately name two TB symptoms and can recall that the DOTS center is a place to get screened for TB.	Exit interviews at subway stations before and during the campaign.	• Number of people who can identify two symptoms of TB and DOTS center correctly. • Number of people who complete a survey.

PRACTICE EXAMPLE:

Indicator description:		
Complete definition	**Data source**	**How will we calculate?**

Handout 3.3

Indicator Worksheet

Valid	Does it tell us what we really want to know or could it measure something else?
Reliable	Is the description clear? Will everyone interpret and calculate this the same way?
Activity Specific	Does this tell us *only* about our activity? Could any other factor influence this indicator?
Feasible	Can we realistically collect and analyze this? Do we have a workable data source and enough money and people to collect it?
Comparable	Do the results mean the same thing in different geographic areas at different times?

Indicator description:		
Complete definition	**Data source**	**How will we calculate?**
Indicator description:		
Complete definition	**Data source**	**How will we calculate?**
Indicator description:		
Complete definition	**Data source**	**How will we calculate?**

Handout 3.4

Data Use Plan

Data	Share with whom?	When/How often?	Which format?	How to use these data
Example: Results of subway surveys	NTP, donor	NTP: monthly Donor: quarterly	Brief narrative summary with tables in report	Compare to baseline survey data. Assess effectiveness of ad campaign and what to change. Request more funds.
	Staff, graphic designer of ads	Monthly	Discussion at staff meeting (invite designer)	Inform staff and get ideas to improve campaign. Shape design or placement of future ads.

Handout 3.5

Tools to Collect Monitoring Data

	Activities	Tools to Collect Monitoring Data
ADVOCACY	Lobbying meetings	
	Petitions/Letter campaigns	
	Sensitization meetings with media managers	
	Press conferences	
	Creation of networks	
COMMUNICATION	Interpersonal communication and counseling trainings	
	Television/Radio spots	
	Patient brochures	
	Theater/Drama events	
	Telephone TB hotline	
	TB website	

	Activities	Tools to Collect Monitoring Data
SOCIAL MOBILIZATION	World TB Day events	
	Community meetings	
	TB patient clubs	
	Involvement of family as treatment supporters	
	Partnership activities	

Handout 3.6

Elements of Data Quality

Validity	Data measure what they are intended to measure.
Reliability	Everyone defines and measures the data the same way and uses the same methods to collect the data—all the time.
Completeness	Data include all of the values you need to calculate indicators. No variables are missing.
Precision	Data have sufficient detail. Units of measurement are very clear. This can be difficult with qualitative indicators. Increase precision with: • Complete indicator descriptions with specific data sources. • Instructions on how to collect data, calculate values, and analyze results.
Timeliness	Data are up to date (current). Information is available on time. Monitoring and evaluation processes ensure that reports are submitted by a specific deadline.
Integrity	Data are true. The values are safe from deliberate bias and have not been changed for political or personal reasons.

Adapted from: http://www.cpc.unc.edu/measure presentation by Win Brown, USAID/South Africa, School of Health Systems and Public Health. Monitoring and Evaluation of HIV/AIDS Programs: Data Quality; March 2, 2011.

Handout 3.7

Data Quality Plan Example

Case example: Training pharmacists and monitoring their DOTS referrals

How can we ensure:	Strategy	Resources
Validity?	Make sure that staff agree on which indicators to use. Document the reasons why we selected specific indicators.	Reports from staff meetings to agree on how to measure success of advocacy efforts.
Reliability?	Train all trainers, referral monitors, and program managers on indicator definitions and data sources.	Indicator descriptions and exercises to use during the training.
Completeness?	Check each training and referral report to ensure all required data were reported. Contact trainers and referral monitors to request missing data and emphasize the importance of complete reports.	Example of complete reports to share with trainers and referral monitors.
Precision?	Create a definition of “referral” and include in trainings. Ask M&E officer to review pre-/post-tests to ensure questions are clear and effectively assess knowledge.	Definitions, surveys.
Timeliness?	Remind trainers and referral monitors about deadlines. Work with them to address reasons for reporting delays.	Agreed timeline for submitting reports.
Integrity?	Ensure that all pharmacists listed as completing training have completed the attendance form and pre-/post-tests. Randomly select and interview three pharmacists per month to ensure they remember TB symptoms and can recall their referrals.	M&E plan, including data quality assurance strategy, is shared with all trained pharmacists and staff so expectations about integrity are clear.

Handout 3.8

Monitoring Plan

Example

ACSM Activity	Outputs/Indicators	Data Source, Frequency	Quality Assurance	Reporting (to whom, when)	Reporting Responsibility

ACSM Activity	Outputs/Indicators	Data Source, Frequency	Quality Assurance	Reporting (to whom, when)	Reporting Responsibility

DAY 4

Evaluation

Handout 4.1

Evaluation Questions Worksheet

ACTIVITY:			
Baseline	**Formative**	**Process**	**Outcome**

ACTIVITY:			
Baseline	**Formative**	**Process**	**Outcome**

ACTIVITY:			
Baseline	**Formative**	**Process**	**Outcome**

Handout 4.2

Guide to Effective Focus Group Discussions

Steps to Develop a Focus Group Discussion Guide

1. Assemble the project team, the moderator, and key research or program management personnel.

2. Discuss what kinds of decisions/actions will be taken based on the focus group findings.

3. Agree on the specific objectives and information needs of the research.

4. The team leader should brief the other researchers about prior research findings, important issues, hypotheses, and opinions that exist.

5. Determine what background information is needed from respondents in order to evaluate their comments during the group.

6. Prepare a list of topic areas which move from general, unthreatening issues to specific topics of interest.

7. Prepare a list of questions for each major topic area.

8. Prepare probing questions to use if the important information does not emerge spontaneously.

9. Prepare transition approaches to help move to a new topic or introduce stimulus materials.

10. Prepare a different discussion guide on the same topic for each different target population being studied.

11. Review the guide and eliminate any non-essential topic areas, “dead-end” questions, or quantitative-type questions. Estimate how much time each topic will need based on its priority and complexity.

12. Sleep on it and review the guide again with “fresh eyes” before a final agreement.

Principles of Question Design

How you state questions can make a big difference in the responses you receive. When developing your discussion guide, check the questions against the following principles of question design. You can also use this list to evaluate the flow of the discussion:

- **Use open-ended questions to solicit longer, more thoughtful responses.**
  Example: “What have you heard about tuberculosis?”

- **After a participant response, ask a probing question to help you understand the answer or to get more information.**

Example: "You said *X*. Tell me, what makes you feel that way?"

- **Use closed-ended questions when you want a brief and exact reply.** (Try not to use too many closed-ended questions).

  Example: "How many children do you have?"

- **Avoid leading questions that impose assumptions or bias the responses.**

  Example: "Have you heard that tuberculosis treatment is provided free of charge?" or "Most smart people in this community know tuberculosis symptoms, don't they?"

- **Avoid questions that can be misinterpreted.**

  Example: "How many times did you see the doctor last year?" could have different meanings. "Doctor" could mean a regular physician, traditional healer, or a specialist. "Last year" could mean the previous calendar year or the past 12 months.

- **Avoid asking too many "why" questions**, which can make respondents feel defensive.

  Example: "Why didn't you go to the health center?" should be restated as "What keeps you from going to the health center?"

- **Do not ask two questions at one time.** Respondents may get confused and not answer both questions. Separate responses are also easier for the notetaker to record.

  Example: "What is your opinion about service in this facility?" rather than "What do you think about the service in this facility, and why?"

- **Avoid supplying response alternatives.**

  Example: "Why did you come to this clinic—because it's known as a high-quality facility or because it's near your home?"

How to Be an Effective Focus Group Discussion Leader

1. **Have confidence.**
   Do not be afraid to make a mistake. Participants probably will not know if you make one and will just follow your lead. You have the discussion guide if you get off track. Every group may not be perfect. You will always learn from mistakes and get better with practice!

2. **Encourage participation.**
   Facilitators tend to relate more actively to those seated in front of them so that there is direct eye contact. Remember to include those next to you in the discussion. If the group were a clock, be sure you get a response from every "hour," but not only in that order.

3. **Be personable.**
   Spend enough time introducing people at the beginning of the focus group discussion. Be sure to share something personal about yourself if it is appropriate. Make the group comfortable from the start to avoid problems later.

4. **Keep the group on the topic.**
   People will sometimes wander off the topic. When that happens, you can:

- Hold up your hands and say, "Wait—how does that relate to _____?"
- Say, "Interesting point. But how about _____?"
- Say, "That's a side issue. Let's get back to _____."

5. **Finish "early."**
   Sometimes it is a good idea to pretend the discussion will end soon by saying, "Oh, our time is running out." This may encourage participants to speak up. If you are recording the discussion, keep the tape recorder going even as the session breaks up.

6. **Link ideas.**
   Link ideas to get group consensus. Assume you hear these comments in a focus group discussion on oral rehydration solution: "I don't give my girl anything to drink if she has diarrhea," "Breast milk makes sick children sicker," and "My mother always said never give water to an ill child." A linking comment would be, "It seems that many of you feel that liquids are dangerous for children with diarrhea. Is that correct?" Then note how they react to your summary.

7. **Self-evaluate.**
   After the focus group discussion is over, reflect on both the good and the not-so-good moments. Ask the notetaker how s/he might have handled the group. Facilitators become more skilled as they discuss and think about their experiences.

A good moderator tries to[1]: and tries NOT to:

• Show flexibility.	• Dictate the course of discussion.
• Show sensitivity.	• Lose control over the conversation.
• Have a sense of humor.	• Judge comments or be an "expert."
• Link ideas together.	• Inform or educate *during* the group.
• Encourage participation from everyone.	• Lead a question and answer session.

Problems That May Arise During Focus Group Discussions

1. **Shy participants.**
   Encourage shy respondents to speak by calling on them by name and asking:
   - "What do you think, Abdul?"
   - "Has that ever happened to you, Natalia?"
   - "What do you do, Maria, when _____ happens?"

2. **Participants who dominate.**
   - Point out politely that others need to be heard.
   - Redirect conversation to someone sitting opposite the domineering participant.
   - Avoid eye contact.
   - Interrupt the speaker in mid-phrase or when s/he draws a breath.
   - Intervene by saying, "You present a complex problem (or an interesting perspective). Can we talk about it after the session? I'd like to hear how others feel about this."

[1] Family Health International (FHI). *Qualitative Research Methods: A Data Collector's Field Guide*. Research Triangle Park, NC: FHI; 2005. Available at: http://www.fhi360.org/en/RH/Pubs/booksReports/QRM_datacoll.htm.

3. **Participants who ask you questions.**
   You do not have to comment on everything that everyone says. Allow some silence and see what happens. If someone asks for your ideas or views, respond by asking:
   - "I'd like to hear what others think."
   - "Why do you feel that way?"
   - "What would you do?"

   Set aside time after the session to give participants the information they need.

4. **Erroneous statements.**
   Participants may say something you know is incorrect. Do not correct them, but explore why they feel the way they do. These phrases may be helpful:
   - "What makes you feel that way?"
   - "That's an interesting point—can anybody support that comment?"
   - "Thoughtful point—do others agree or disagree?"

   Wait until the session is over to correct any misinformation.

5. **Ambiguous statements.**
   Try rephrasing the response or probing to draw out hidden meaning. For example, if a participant says, "Most mothers breastfeed their babies regularly," you can probe by asking, "And how often is that?" "How about yourself, how often do you feed your baby?"

6. **Disagreement in the group.**
   - Affirm that disagreement is healthy and continue the discussion.
   - Intervene by saying:
     "Luis and Abdul seem to disagree. How do others feel about this issue?"
     "You have highlighted an important issue for us," and summarize the issue.
     "We are free to have own attitudes and feelings about this and don't need to agree with each other. It's great to have so many different views!"
   - Ask the group if they feel comfortable to move on, even though the issue dividing them is not yet resolved.

Moderating Techniques[2]

Here are some "tricks of the trade" to get deeper responses or to help people uncover and express what they are feeling. A skilled moderator will use a combination of these techniques as the situation requires.

Technique	Example
Top-of-mind associations	What is the first thing that comes to mind when I say "tuberculosis"?
Constructing images	Who is the person who has tuberculosis symptoms? What does s/he look like? Where does s/he live? Describe this place.
Querying the meaning of the obvious	What does "soft" mean to you? What do you mean by "homemade"?
Image-matching	Here are pictures of ten different situations and people. Which go with this one and which do not? Why?

[2] Academy for Educational Development (AED). *Handbook for Excellence in Focus Group Research.* Washington, DC: AED; 1990. Available at: http://www.globalhealthcommunication.org/tools/60.

Technique	Example
"Man from moon" routine	I am from the moon and I have never heard of DOTS. Describe it to me…why it is important…convince me.
Chain of questions	Why do you buy X? Why is that important? Why does that make a difference to you? Would it ever not be important? Etc.
Pointing out contradictions	You said earlier that it is very important to complete the full course of treatment. Now you're saying that tuberculosis drugs have many side effects, and you would stop taking them when you feel better. How do you explain that?
Sentence completion and extensions	The ideal doctor is one that…. The best thing about this new program is…. It makes me feel….
Role-playing	Okay, now you are the elder of this village—what would you do? Or, I am the mayor of this city. Talk to me, tell me what you want.

The real trick is to know when to use which of the above techniques and how to enlist respondents to play along with the game. Later, the challenge is to try and make sense out of what they tell you.

In-Depth Probing

A probe is a question that tries to get more information or clarification from a participant. Some examples include:

- Can you tell me more about that?
- What about that?
- What do you mean when you say…?
- What makes you feel that way?
- What happened then?
- Can you give an example of X?

Some strategies to probe include:

- Remaining silent—allow the respondent to amplify what s/he said.
- Using the mirror technique—restating what the respondent has just said.
- Repeating the respondent's words as a question—"It's good?"
- Confronting the respondent to clarify a position. "I'm a little confused. Earlier you said X, now you're saying Y."
- Using "key word" probes such as the following:

Respondent Statement	Moderator Probe
"It's good."	"What about it is good?"
"I like the size."	"What is it about the size?"
"It would be convenient."	"In what way would it be convenient?"
"It works."	"How can you tell that it works?"

- Using the third-person technique. "You seem to feel strongly about this. How do you think others might feel about it?"

Tips for the Notetaker

The notetaker and facilitator work together before, during, and after the focus group discussion to obtain and record as much useful information as possible. Here are some tips on how to be a good notetaker.

Before the session:

With the facilitator:

- Review the guidelines prepared for the focus group discussion.
- Discuss what kind of information you are looking for, what you need to write.
- Agree on abbreviations.
- Agree on cues for: get more information, move on, have something repeated, etc.
- Have enough supplies (lined writing pad, 2-3 pens).
- Write the date, facilitator's name, your name, and the focus group discussion location and topic at the top of several pages.
- Make a seating chart, numbering each seat (fill in the names during the session).
- Decide on your format: wide left/right margin, dashes, bullets, underlining, indentations.

During the session:

- Sit where you can see everybody's face and communicate with the facilitator.
- Have the facilitator introduce you.
- Number pages as you go.
- Fill in the seating chart.
- Speak up if you miss something, but do not become a facilitator.
- Do not rely on the tape recorder. Get as much information as you can on paper.

How should I take notes?

- Record important information, not every single word.
- Try to record who says what.
- Record non-verbal communication (surprise, [dis]agreement, confusion, disgust, etc.).
- Summarize (without changing meaning).
- Abbreviate wherever possible.
- Use quotation marks to show repetition.
- Organize with bullets, indentations, etc.

Handout 4.3

More Qualitative Methods

Method Description	Uses/Benefits	Cautions
RAPID ASSESSMENT		
• Use multiple methods to gather diverse information in a short period of time. • Look at results from different methods and identify common themes.	When you need more than one data source or information from several groups of people to help understand an issue, but you do not have a lot of time or resources.	Try to validate your conclusions from one method by using another method. If there are similarities, you are on the right track. When you find differences, look for additional sources of information.
Example: Analysis of recent newspaper articles, a few in-depth interviews with new TB patients, and a mystery client interview exercise at two clinics are used to identify different sources of stigma related to TB.		
DIRECT OBSERVATION		
• Observer is present during facility operations and uses a checklist to record information on daily activities. • Identifies strengths or weaknesses of a clinic/program or facility-level barriers to care.	When you need to quickly identify quality of care issues that may impact patient satisfaction. Can also be used to advocate for more resources (e.g., observer notices that several clinics have chronic stockouts of key supplies or are very understaffed).	Often produces biased results. If clinic staff know that the observer is present (often hard to hide), they may be on their best behavior and conduct the clinic differently than when they are not being observed.
Example: Observer watches patient flow for one day and notes long waiting time, lack of educational materials in the waiting area, chronic stockouts, etc.		
CASE STUDY		
• Examine multiple sources of data to determine and provide a very rich, detailed description of a specific project, activity, event, or facility to identify strengths, weaknesses, what works well, or what does not.	When you want to identify lessons learned and best practices for implementation, especially at the community or district level where lessons can be applied in a similar context. Can show how ACSM was or could be used to improve the activity.	Difficult to generalize findings to a larger population or different setting and to show cause and effect. Information is retrospective and subject to memory bias.
Example: The results/lessons learned of a pilot community DOTS program are examined through staff interviews, analysis of registration and treatment outcome data, and patient focus group discussions.		

Handout 4.4

Evaluation Example

ACSM Objective:	Mobilize at least 20% of private pharmacies in City X by December 2013 to refer people with TB-like symptoms for screening at DOTS facilities.
ACSM Activity:	Train 50 pharmacists to recognize common TB symptoms and counsel customers with TB symptoms to be screened at the City X DOTS center.

Evaluation Question	Evaluation Category/Method	When or How Often	Sampling	Resources Needed	Plan for the Results
What successes and challenges do pharmacists experience in making referrals?	Process evaluation. Interviews with pharmacists.	Trainers will visit each pharmacist within one month of training to discuss successes and challenges and collect referral records.	Every trained pharmacist.	Standard checklist of interview questions. List of pharmacists and addresses.	Submit report (activity numbers and narrative summary of successes and challenges) each month to the project manager, NTP, and donor. Develop and distribute a "Tips for TB Referrals" information sheet for pharmacists that addresses their most common challenges and lists helpful tips and reminders.
Was our project successful in increasing the number of screenings at the City X DOTS center?	Outcome evaluation. Analysis of NTP data and program data.	Project manager reviews pharmacy referral records and DOTS center registration cards every month. Summary after six months.	All trained pharmacists and all patients at City X DOTS center.	Pharmacist referral record. Patient registration records.	After six months, conduct a meeting with NTP managers and the donor to review evaluation data, and recommend ending, continuing, or expanding the project. Advocate for expansion funding. Prepare and distribute a summary report to inform all trained pharmacists.

Handout 4.5

Evaluation Template

ACSM Objective:					
ACSM Activity:					
Evaluation Question	**Evaluation Category/Method**	**When or How Often**	**Sampling**	**Resources Needed**	**Plan for the Results**
ACSM Objective:					
ACSM Activity:					
Evaluation Question	**Evaluation Category/Method**	**When or How Often**	**Sampling**	**Resources Needed**	**Plan for the Results**

DAY 5

Putting It All Together

Handout 5.1

Post-workshop ACSM M&E Quiz

ACSM: advocacy, communication, and social mobilization; **M&E:** monitoring and evaluation.

1.	Evaluation is a routine practice that helps ACSM managers understand whether or not activities are being implemented as planned.	True	False
2.	Outcome evaluation should always be done before process evaluation.	True	False
3.	The only important characteristics of high-quality data are accuracy, timeliness, and completeness.	True	False
4.	Gap analysis is a critical step in planning for M&E of ACSM activities.	True	False
5.	An M&E framework can help show how ACSM activities contribute to National Tuberculosis Program goals and objectives.	True	False
6.	Focus group discussions are a useful way to pre-test communication materials.	True	False
7.	An M&E plan includes a framework, indicators, and evaluation methods.	True	False
8.	An output is a long-term result of ACSM activities that should be analyzed over time.	True	False
9.	Knowledge, attitudes, and practices surveys are a very inexpensive, quick way to collect data needed to support ACSM programs.	True	False
10.	National Tuberculosis Program staff are always the best people to conduct evaluations of ACSM.	True	False

Your country: _____

Handout 5.2

Final Evaluation

1. **What did you like most about the training?**

2. **What was your greatest area of learning from this training?**

3. **In what area did your skills improve the most?**

4. **Please indicate how strongly you agree or disagree with the following statements:**

	Strongly agree	Agree	Neutral	Disagree	Strongly disagree
From what I learned at the workshop, I feel more able to monitor my ACSM activities.					
From what I learned at the workshop, I feel more able to evaluate my ACSM activities.					
I will use frameworks at home to help think strategically about M&E in my organization.					
During this workshop, I strengthened my ACSM objectives to be more SMART.					
The small group work helped me understand how to develop an M&E plan appropriate for my own ACSM projects.					
I can name at least four components of an M&E plan.					
I have the skills to implement the M&E plan I prepared.					

5. **The biggest challenge I will face in implementing my M&E plan is:**

6. **The following teaching methods were most useful in helping me learn (select top 3):**

___ Facilitator presentations
___ Case examples
___ Peer feedback
___ Group work/exercises
___ Table Coaches during group work
___ Facilitated discussions among participants

7. **What feedback do you have about the styles or methods of facilitation?**

8. **What could we change to improve this training?**

9. **What other comments do you have?**