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PROJECT FINAL EVALUATION REPORT

Improved access to TB services for underserved communities in Andhra Pradesh (TAP)

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Project Final Evaluation Report

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SUBMITTED TO

TB Alert

By

TRIOs Development Support (P) Ltd, New Delhi

14th February, 2015

TRIOs Development Support (P) Ltd
T 33, Manish Global Mall
Opp: Mount Carmel School
Sector: 22, Dwarka
New Delhi-110 075, INDIA
Landline & Fax: 91-11-456 94114
Email: trios@triosdev.org
Website: www.triosdev.org
CIN-U85100DL2010PTC199658

Support to sustainable development

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Dr Aravind Pulikkal PhD, MBA

Managing Director
TRIOs Development Support

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Abbreviations and Acronyms

ANM	Auxiliary Nurse Midwife
ASG	Adult Support Group
AWW	Anganwadi Worker
CBO	Community Based Organisation
CCG	Community Core Group
CSG	Children Support Group
CSO	Civil Society Organisation
FGD	Focus Group Discussion
GC	Grannies Clubs
DAP	District Action Plan
DMC	Designated Microscopic Centre
DOT	Directly Observed Treatment, Short Course
HF	Health Forum
HIV	Human Immunodeficiency Virus
Health &FW	Department of Health and Family Welfare
ICDS	Integrated Child Development Services
ICTC	Integrated Counselling and Testing Centre
IDI	In Depth Interviews
iNGO	Implementing NGO
IPC	Inter Personal Communication
KAP	Knowledge Attitude and Practices
LP	Lead Partner
MDR	Multi Drug Resistant Tuberculosis
MIS	Management Information System
NACO	National AIDS Control Organisation
NRHM	National Rural Health Mission
NGO	Non- Governmental Organisation
PMP	Private Medical Practitioner
PHC	Primary Health Centre
PHP	Private Health Practitioners
PIP	Program Implementation Plan
PLHIV	People Living with HIV
PPP	Public Private Partnership
RMP	Rural Medical Practitioner
RNTCP	Revised National Tuberculosis Programme
SHG	Self Help Groups
STO	State TB Officer
TB	Tuberculosis
TBAI	TB Alert India
VMM	Vasavya Mahila Mandali
WCD	Department of Women and Child Development

a) Basic Information

SECTION 1: BASIC INFORMATION		
1.1	**Organisation**	TB Alert, UK
1.2	**Address**	Community Base, 113 Queens Road, Brighton, BN1 3XG, UK
1.3	**Project partner(s)**	TB Alert India (TBAI) Vasavya Mahila Mandali (VMM) Mahila Mandali (MM) Serve Training Empower People's Society (STEPS) Children Leadership Development Association (CLDA) Coastal Network of Positive People (CNP+) Youth Club of Bejjipuram (YCB) Peace Educational And Rural Developments (PEACE)
1.4	**Project Title**	Improved access to TB services for underserved communities in Andhra Pradesh
1.5	**CSCF Number**	550
1.6	**Country**	India
1.7	**Location within Country**	Nellore, Prakasam, Krishna, East Godavari, Srikakulum and Visakhapatnam District
1.8	**Project Start & End Dates**	**Start:** 09/2011 **End:** 03/2015
1.9	**Reporting Period**	**From:** 04/2014 **To:** 09/2014
1.10	**Project Year**	Year 4
1.11	**Total project budget**	£ 484,219
1.12	**Total funding from DFID requested for project**	£ 482,361
1.13	**Financial contributions from other sources**	Total £1,857 Other contributions: £1,857 (VMM contribution)
1.14	**Date report produced**	16/01/2015
1.15	**Name and position of person(s) who compiled this report**	**Name:** Dr Aravind Pulikkal, Dr S.K. Mohanty, Dr R.K. Juyal **Position:** Technical Experts
		Name: Rajan Mahajan **Position:** Study Management and NGO Appraisal Expert
		Name: Dr. Keerti Jain Gupta **Position:** Quantitative Research Expert
		Name: Bhavna Nahata, Prakash Dutt **Position:** Qualitative Researcher
1.16	**Name and position of contact point for correspondence relating to this project**	**Name:** Rajan Mahajan, Senior Manager, TRIOs **Position:** Project Lead
1.17	**Email address(es) for correspondence**	**Email 1**: rajan@triosdev.org **Email 2**: trios@triosdev.org

b) Executive Summary

The Project “Improved access to TB services for underserved communities in Andhra Pradesh” was launched in September 2011. The coverage area under the project was 27 blocks spread across six districts of Andhra Pradesh namely, East Godavari Krishna, Nellore, Prakasham, Srikakulum and Vishakhapatnam. Duration of the Project was 42 months; however, the present end-line evaluation has been conducted after completion of 38th and 39th months of the Project. The total budget for the Project was £497,407 with total funding requested from DFID being £495,550 with contribution of VMM being £1,857. The aim of the Project was “To reduce levels of TB and TB/HIV co-infection, and increase access to effective health services, through sensitised and empowered communities and local advocacy’. The main outcomes/intended changes were (1) Increased awareness of TB and HIV and increased utilization of free government health services. (2) Establishing community structures in place that promote and support health rights, health seeking behaviour and a stigma-free health centre environment. (3) Improved TB diagnostic and treatment services. It was envisaged that people who are diagnosed with TB and HIV would be able to access free treatment in a self-stigma/ community-stigma free environment. The main target group included tribal and fishing communities, women and children, and those living in sparsely populated areas. On the basis of prevalence of HIV in the six intervention districts, it was estimated that the Project would reach a minimum of 1,405 HIV cases, 698 TB cases and 77 persons suffering from TB/HIV co-infection.

The implementation of planned interventions under the Project was carried out by VMM in partnership with six implementing NGOs (iNGOs), through a team of Outreach Workers, Volunteers and Community Groups who created awareness of TB/HIV and referred suspected and needy cases to nearby Government health facilities. The community groups included 7 Community Core Groups, 124 Adult Support Groups, 49 Children’s Support Groups, 7 Grannies Clubs, and 6 Health Forums. In all, 193 Groups were constituted with 3,214 (65% females and 35% males) members. The member of these community groups, especially ASG had the person who were either affected or infected with TB/HIV. Also, linkages were established with 680 Self Help Groups and a total 7,518 members of these SHGs were oriented on issues related to HIV, TB and Co- infection, so that they could include it in their agenda. In September 2014, comprehensive end-line evaluation of the project was commissioned by adopting quantitative as well as qualitative assessment techniques. This included desk review of project documents/ MIS, KAP survey covering 594 households, and patient satisfaction survey covering 270 patients availing services from DMCs or ICTCs. In Depth Interviews (IDIs) with 12 district level Government officials involved in TB and HIV programs, 27 AWWs, and 27 RMPs/PHPs were conducted. Besides 6-7 FGDs in each of the project districts were also conducted with members of various community groups formed under the project.

The evaluation revealed that the achievements in outcome and output indicators have met or exceeded the set targets and milestones, especially in respect to the number of people diagnosed with TB, HIV and co-infection. The milestones set for TB, HIV and Co-infection were 1405, 698 and 77 respectively whereas according to the project MIS till September 2014, total 2051, 652 and 135 cases were identified and put on treatment. This shows 46% and 75% extra coverage which could be attributed to the initiatives under the project such as sputum collection and transportation by

volunteers/adult support groups members, X-ray screening camps, group meetings of ASGs and referrals of cases for testing.

One of the main objectives of the project was to enhance knowledge of TB amongst community in project area. In the end-line evaluation it was found that the Project has made significant progress towards achieving the planned objectives and milestones. The Project has directly reached out to 1,65,839 (37%males and 63%females) people, that is around 12% of the total population of project area, through various awareness generation activities. This included Inter Personal Communication (IPC), community awareness meetings, cultural shows, observational days, mass awareness events as well as indirect mid media activities such as Radium paintings drawn on ships/ boats, and bus and auto panels, to widely spread the messages on TB and HIV. According to the baseline findings, 40% of the target population was aware that TB spreads from an infected person to any other person through cough. This proportion has increased to 75% at the time of end-line evaluation. According to baseline 45% of the population was aware of DOTS centres and the services offered there whereas in end line this awareness on this aspect increased to 93.6%.

Through systematic advocacy strategy Project, successfully influenced the government to adopt a policy for providing free double nutritional rations for children on DOTS and INH prophylaxis. The notification has been issued by Government of Andhra Pradesh to that effect and 111 (57 males and 54 females) children availed benefit of double nutrition under the project. Similarly, after issue of government orders for involvement of AWWs in awareness generation identification, referral to ensure treatment on tuberculosis, total 1649 AWWs and their supervisors were oriented by iNGOs in the project areas. It was mentioned that 231 AWWs have volunteered to provide DOTS services. However, during the discussion with district health officials it was felt that they were not completely aware about provision of double nutritional rations for children affected with TB. Thus, there is a need for inter-sector convergence between the health and WCD department to bridge this information gap.

The advocacy efforts of the Project to establish linkages between community structures and RNTCP schemes were at the proposal stage and government approval is still pending. Meanwhile, in January 2014, as an innovation 300 ASG members have been identified and trained to act as sputum collection and transportation agents, especially in remote areas where the testing facilities were not accessible. This innovation has been successful to enhance the access to TB testing facility, as till September 2014 sputum of 289 persons (173 males and 116 female) has been transported by these ASG members/ volunteers. By and large on financial front the working of the Project was smooth, barring some difficulties in the receipt of funds from TB Alert India during two quarters, as reflected in the financial and audit reports. However, this did not affect the Project achievements in any way.

Apart from being effective in realising the targets, in fact achieving more than that was planned, the human as well as financial resources were utilised effectively and efficiently. Advocacy on the part of the Project had brought good results in improving Government support and policy changes. The Project thus, has realised its basic aim as well as its objectives.

c) The Main Report

1. Results and Impact of the Project

The Project document mentions that, expected outcome to be “Increased access to effective TB and HIV services in line with MDG 6”. To measure this outcome, a set of three outputs were laid out at the beginning of project. The indicators and milestones in respect of each output were also stated in the log frame. These are discussed in the text later.

However, the values for achievements against milestones-3 for assessing impact proposed in log-frame would be available after finalization of Andhra Pradesh State RNTCP Report in 2015; therefore, it could not be included in this report.

It may be mentioned at the outset that VMM had strategy of inclusive efforts, instead of going it alone. This was evident in the vary design of the project, in which 6 iNGOs working at the base level working at the base level were co-opted in the implementation of the project.

This gave VMM a feel and connect with local population, there needs and aspirations. This coupled with orientation, training and technical support provided by VMM and TBAI shaped the fabric of the Project and made it more pragmatic in approach and effective in implementation.

Results of Project Outputs

During 36 months[1] of the project period, a total of 1,65,839 (37% males and 63% females) population was directly covered through IPC and group awareness raising activities including cultural shows, community awareness meetings, observational days such as World TB Day, World AIDS Day etc. Thus, out of a total 13,52,000 of population in the project area, 12 % were directly reached out through various IEC activities. The beneficiaries reached out indirectly through mass media activities and IEC material such as auto stickers, boat messages, charts displayed in various facilities, wall paintings etc. constituting external benefits, which were not amenable to estimates and therefore, does not figure in the coverage.

The Knowledge Attitude and Practice (KAP) and Patient Satisfaction Survey carried out during final evaluation indicates that Project has been successful in bringing about a significant increase in the awareness level of target population on issues related TB, HIV and co infection as discussed below

The baseline survey revealed that 52% respondents had heard of TB. This proportion increased to 92% during end-line evaluation. 40% of the target population was aware that TB spreads from an infected person to any other person through cough during baseline whereas 75% respondents were aware about it, during end-line. 93.6 % respondents were aware of DOTS centres and the services provided in it during end line whereas only 45% respondent knew about this during baseline. 99.6% respondents said that access to health care services is a health right during end-line as compared to 29% respondents during baseline. 33% respondents were aware about relationship between TB and HIV during base line. The proportion increased to

[1] The MIS data compiled till September 2014 has been analysed for this

56% during end-line. In the patient satisfaction survey conducted during end-line, it was found that 88% of respondents did not feel any self/community stigma while availing public health services. Majority (56%) of households covered under the sample survey, belonged to the marginalized, backward and remote community i.e. 33% of total households belonged to Schedule Caste (SC) and 23 % belonged to Schedule Tribes (ST).

It is worth noting that a large number of families continued to have high financial and economic burden due to health issues. According to the KAP survey 43% of total household covered had borrowed some kind of loan for health care purposes, or were in debt due to economic burden of diseases.

In all, 193 community groups having 3,214 (65% females and 35% males) members were constituted and oriented under the project as compared to 78 groups originally envisaged in the project. The community groups included 7 Community Core Groups (147 members), 124 Adult Support Groups (2,035 members), 49 Children's Support Groups (820 members), 7 Grannies Clubs (132 members), and 6 Health Forums (80 members). These community groups had enabled the project to gain access to more remote and unreached areas.

To enhance the coverage, 680 existing and active Self Help Groups (SHGs) were also linked up with the project and total 7,518 members of these SHGs were oriented under the project. Till September 2014, total 777 TB and 1014 HIV suspected cases were referred by these groups out of which 112 and 24 were found respectively positive.

503 PHPs were sensitised on TB and health rights during the project period as compared to 480 PHPs proposed in the log frame. Similarly 1,649 AWWs and their supervisors were also trained against 2000 planned to be oriented under the project.

As a result of systematic advocacy efforts under the project the State Government had issued orders to involve AWWs in creating awareness, identify and guide the TB cases in target population and ensure full course of treatment under DOTS. This contributed in provisioning of TB services in remote locations. As per the project MIS data (up to September 2014) total 231 AWWs were providing DOTS as part of their job in project area on voluntary basis.

After successful advocacy under the project State Government issued orders to provide double nutritional ration to children who were either infected with TB or recommended INH prophylaxis. Up to September 2014 total 111 (57 males and 54 females) children benefited under the scheme in project area. As a result of project advocacy these GOs were not restricted to only 6 project districts, but also extended to all other districts in the state. The GOs were also shared with Government of India so that other states may also adopt it. However based on the interviews with government health officials in all 6 districts, majority of them were not much familiar with this notification. This could be due to the reason that the notifications/ Memos were issues by Department of Women and Child Development and due to poor intersect or convergence between department it did not reach the official of Department of Health and Family Welfare.

The other advocacy efforts to establish linkages between community structures and RNTCP schemes could not achieve much success, despite of several discussions and follow ups by project team with concerned government officials. For example, the iNGOs have already submitted the proposals to "Establish Sputum Collection and Transportation Centres" under RNTCP to the Government but approvals are still pending. In January 2014, as an innovation, total 300 ASG members were identified and trained to act as sputum collection and transportation agents especially in remote areas where the testing facilities were not accessible. This innovation has been successful to enhance the access to TB testing facility and up to September 2014, sputum samples of 289 persons (173 males and 116 female) have been collected and transported by these ASG members/ volunteers to the nearest testing centres. It is worth noting that Government Health officials of all six districts recognize the efforts made by the Project and therefore they felicitated the iNGOs in their respective district during the 36 month of the project implementation. During interviews with government officials many of them came out with the important views and suggestions:

According to the officials of district Srikakulum, Vishakhapatnam, Krishna, stressed that *"There are many NGOs working on HIV/ AIDS related issues, but very few, who are working on awareness generation on issues related to Tuberculosis. The project (TAP) is contributing in achieving the objective of RNTCP in the district and thus activities undertaken under the project should be continued and extended to other underserved areas in the districts so as to create greater impact."*

The ratings assigned to each project outputs, based on performance against milestones are given below:

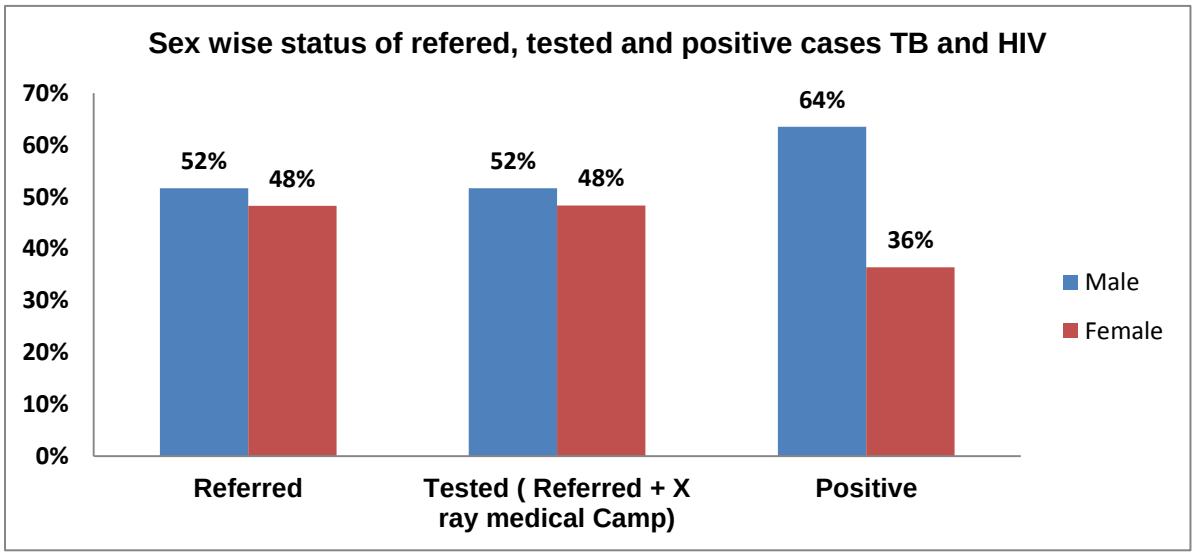
Output 1: "Local communities are aware of their health rights and have increased knowledge and awareness of TB and TB/HIV and availability of free government health services "moderately exceeded expectation, thus, scored as **A+**

Output 2: "Sustainable community structures that promote and support health rights and health seeking behaviour" substantially exceeded expectation and, thus, scored as **A++**

Output 3: "Access to TB diagnosis and treatment at state, district and local level are improved," met expectation, thus, scored as **A**

Project Outcome

All three sets of outputs contributed to achievement of the objectives of the project and desired outcome. During 36 months of project period, total 2051 new TB Cases, 652 new HIV cases and 135 new co-infection cases have been found positive and put on treatment. The achievement under this outcome indicator exceeded the targets/ milestones i.e. 1405 new TB cases, 698 new HIV cases and 77 new co-infection cases were diagnosed and put on treatment.



To achieve the above outcome, in 36 months of project period, total 28,440 suspected cases of TB, HIV and Co-infection were referred by the project staff and groups. Out of this total 27,522 person got tested and 2838 were found positive. The data of tested cases and positive cases also include the cases directly screened in the mobile X-ray camps. The sex-wise distribution of the referred, tested and positive diagnosed cased is given in above figure. It is evident from the figure that out of total cases detected TB or HIV positive, proportion of male was higher than the female.

The tables showing analysis in respect of outcome are attached as **Annexure VI.**

Key findings of analysis of MIS data on outcome indicator are given below;

- Dropout status of cases referred for sputum test
  - Out of total cases referred for sputum testing in project area in 36 months of project period, 9% dropped out. Overall dropout rate was 9 % in case of females and males.
  - Highest dropout of referred cases was in Nellore (19%) and lowest in Krishna (1%) districts.
- Dropout status of cases refereed for HIV testing
  - Out of total referred cases for HIV testing only 2% dropped out. Rate was same in case of female cases and male cases.
  - Among project district the drop out in cases refereed for HIV testing was nil in Krishna and highest 5% in Prakasham

Thus, it may be concluded that, by and large the dropout of referred cases was not very high; which is indication of the quality assurance at the message delivery and follow-up during referral process.

- Out of total project referred cases tested for tuberculosis, 13 % were found positive. This percentage was highest i.e. 15 % in East Godavari and Srikakulum and lowest in Vishakhapatnam districts.
- Out of total project referred cases tested for HIV, 5 % were found positive. This percentage was highest i.e. 10 % each in Nellore as well as Krishna and lowest i.e. 2% each in East Godavari and Vishakhapatnam districts.
- As per internal assessment done by project team for year 2013-14, out of total cases tested in 36 DMCs in the project area cases referred by the TAP team constituted 20%.

The feedback from patient satisfaction survey on utilization of public health services presented positive picture as shown in the table given below. Only in respect of toilets and waiting areas people desired better facilities.

Patient's perception about the health facility			
Factors	Satisfied		Not Satisfied
	Good	Average	
Cleanliness of the facility	85%	15%	0%
Condition of infrastructure	82%	18%	0%
Drinking water facility	82%	10%	8%
Cleanliness in toilets	75%	17%	8%
Waiting area/ room	66%	32%	2%
Privacy during the consultation / check up	83%	17%	0%
Diagnostic facilities	79%	21%	0%
Lab services	79%	20%	0%
Ease of getting a referral when required	76%	24%	1%
Overall Service Satisfaction	**70%**	**29%**	**1%**

During patient satisfaction survey 92% of patients said that they are cross referred for HIV testing whereas only 81% of the HIV patients said that they were referred for TB testing. Thus, more health personnel working with ICTCs need more sensitization on the issue.

Thus based on achievement against milestones in outcome indicators the project outcome significantly exceeded the expectation and scored as A++.

The detailed output / outcome scoring tables are given in ***section d***

2. Target Groups

Direct Beneficiaries

As per the details provided by VMM as well as review of latest log frame, the direct beneficiaries of the project included people suffering from tuberculosis, HIV or HIV-TB Co-infection in 27 blocks of 6 district of Andhra Pradesh. The project focused on tribal and fishing communities, women and children, people living with HIV and those living in sparsely populated areas in identified districts. In these areas literacy rates and awareness of TB, HIV and health rights was low and access to testing and treatment services was poor.

As per the milestone set under the project, a total of 2,580 direct beneficiaries were proposed to be covered during entire project period, which included 1405 people diagnosed with HIV, 698 people diagnosed with TB, and 77 people co-infected with TB and HIV.

During 36 months of implementation 27522 project referred cases were tested for HIV, TB, or Co-infection, out of which total 2838 persons were found positive. Out of positive cases 68 percent were male and 32 percent female.

Indirect Beneficiaries

As per the proposal a total of 1,352,000 people were proposed to be covered through awareness generation activities on TB, HIV sign and symptoms, prevention and treatment and free government health care services in the project area. This included the people planned to be contacted through IPC, group meetings/ orientation and mass media activities.

The Project adopted two pronged strategy to reach out to the target population as given below;

- Community level awareness through project staff and volunteers in the project area through IEC activities including IPC, Group meetings and mass media/ cultural activities
- IEC, referrals and follow up activities organized by community support groups formed under the project and existing SHGs linked under the project. These groups were trained by the partner iNGOs and to serve as channel to reach community at large.

During 36 months of the project period a total of 1,65,839 persons were directly contacted though IPC , group activities and cultural shows etc. which constituted 12% of total population in the project area. Besides this, large section of population was also reached out indirectly through various mass media activities and material.

Evidences and Process used for Final Evaluation: To measure the reach of the project to beneficiaries the evidence has been collected through following methods and processes as described below:

a. Desk Review of project proposal, log frame annual reports, reports of baseline study, and midline study and other relevant government report and project MIS
b. Consultations with TBAI, LP and iNGO staff
c. Quantitative Assessment
    - Knowledge Attitude and Practices (KAP) survey covering 594 sampled households covering all 27 blocks of 6 project districts
    - Patient Satisfaction Survey (PSS) covering 238 sampled patients availing services from DMCs or ICTCs in project area
    - Facility Survey in 27 DMCs/ICTCs (1 in each project block)
d. Qualitative Assessment
    - 6-7 FGDs with community support group members in each project district
    - IDIs with 12 District Nodal Officers for TB and HIV programs
    - IDIs with 27 AWWs and 27 RMPs covering all the project districts

Out of above the methods, KAP survey was undertaken to assess the changes in Knowledge Attitude and Practices of community after implementation of project in selected villages of 27 blocks of districts of Andhra Pradesh.

The results of the above surveys showed that there has been significant increase in the awareness levels of target population on issues related to TB and HIV. The details are discussed in previous section.

Unintended Consequences

- There has been a significant differential in the knowledge levels among the members of community groups. This could be attributed to the external reasons. As per the observation of the Research Experts during FGDs, group members who had exposure to other projects earlier or trained by iNGOs directly were better in communication and had in-depth knowledge as compared to those who's exposure was restricted orientation by ORWs. Thus they were deprived of expert inputs.
- Project envisaged that ASG formed under the project will refer TB/HIV/ Co-infection symptomatic cases for testing. It was interested to know that their willingness to come forward for sputum collection and transport it, was over-whelming and it emerged as a successful model.
- It was also noticed during FGDs that, though these groups were instrumental during the identification and formation of other community support groups, the members of these CCGs were the key motivators in the community. But at the present stage of project, majority of them could not convincingly spell out how they are different from other groups and what is their role as motivators. The reasons for the same could be 1). As key advocacy agents their tasks would have changed with the progression of project from one stage to other. 2) Inadequate training on their roles and responsibilities under TAP could be another reason

3. Risk

- Based on the review of the annual reports and consultation with the partners it may be concluded that the risks identified by the team during the project were pertinent and reasonable. Some of the key risks identified under the project were following:
  - Integration of TB may not be the priority of the SHGs.
  - Review meetings with government are not regular.
  - Government is not open to have new sputum collection centres.
  - Shortage of sputum cups, testing slides and other consumables at the testing facilities.
  - District TB department is not sharing the list of lost cases for follow up
  - Political disturbances in the project area due to division of Andhra Pradesh into two states. This disturbed the implementation of project activities.
  - Mobile testing centres for HIV are not carried out on a regular basis in the tribal areas.
- The project team had worked out the risk mitigation plan to address the risks and were able to manage majority of the risks successfully. Such as, to address the issues related to organizing review meetings with government, the lead partner and the iNGOs had setup dialogue with government and signed the MoUs on organizing review and advisory committee meetings in each Project districts.
- However, some of the external risks were "Government is not open to have new sputum collection centres" among others. Though the project team worked out the mitigation plan and undertaken activities to mitigate risk to greater extent. For example all iNGOs were felicitated by district government authorities for their efforts and contribution in addressing the issues related to TB. However it may take more time to visualise the benefits of setting up new sputum collection centres.

4. Value for Money (VfM)

Economy

- As per the key outcome indicator project planning to diagnose total 2180 positive cases infected with TB, HIV and Co-infection. However by 30th September 2014 it has already surpassed the target by diagnosing 2,838 cases and linked them on treatment. This could be achieved with in the approved budget lines due to various initiatives undertaken in project.
- Looking at the proactive involvement and success total 124 adult support groups were formed as against original target of 78 groups. This has led to greater achievement than the planned without committing any additional budget.
- Project had developed some economical and innovative approaches such as organizing X-ray screening camps in remote areas in Vishakhapatnam, with support of charitable organization namely "Ramakrishna Mission". Under these camps a total of 586 cases were screened in these camps out of which 74 were found positive. For these camps, Ramakrishna Mission partook some of the cost, i.e. vehicle maintenance, fuel and honorarium for the medical personnel whereas the project staff and community groups mobilized community for these camps.
- Centralized inverters (batteries) were procured and installed at iNGO's offices, to mitigate the impact of frequent and lengthy power cuts. This proved economical due to bulk purchase. All purchases above INR 10,000 were done based on comparative assessment of 3 quotations and approval by purchasing committee. Quotes were assessed against quality, durability, price and warranty.

Efficiency

- During the course of project the community based groups were formed having members from the local villages. After initial trainings they could create awareness among local community in more efficient manner due their familiarity of local issues, rapport with the community and moreover they belonged to those remote villages. In absence of this strategy to form and orient community in these remote areas, it would not have been possible to provide the resultant coverage by project ORWs alone.
- Besides forming the new community groups Project also identified already established and active 680 self-help groups and oriented their 7,518 members. This enabled the inclusion of project activities in their agenda and till September 2014, these groups have referred 1791 symptomatic cases out of which 136 were found positive. Thus, this led to efficiency as project did not commit any resources in forming and organizing these groups and yet could utilise them as vehicle to meet project objectives.

Effectiveness

- TAP has proved to be effective in bringing about anticipated changes. The awareness activities and capacity building programs have increased the knowledge levels of the community
- According to the KAP survey, knowledge about mode of spread of TB was 40% in baseline, which has increased to 70% in end line
- During baseline 29% understood that access to health care services is a health right where as this proportion has increased to 99.6% in end line
- Only 52 % people had heard about TB in baseline whereas in end line 92 % reported to have heard about TB

- 33 % of community in project area was aware about the correlation between HIV and TB during baseline, whereas in end line, 56% respondents were aware about it.

5. Sustainability

By and large Project has been successful in addressing sustainability issues. Increased community awareness and participation would help in promoting sustainability. However in some elements further support would be required for its sustenance. The output wise status is given below;

Output 1 "Local communities will be aware of their health rights and will have increased knowledge and awareness of TB and TB/HIV and available free government health services" could be sustained without any further funding support.

- The findings of the KAP survey conducted in end line reveals that there has been a significant increase in the knowledge level of community on TB, HIV and Co - infection among the community in comparison to the baseline.
- Total 1649 AWWs and their supervisors are sensitized under the program after government has issued notification for involving AWW as motivators for availing DOTS services by the community thus, mainstreamed in to the government system.

Output 2 "Sustainable community structures that promote and support health rights and health seeking behaviour";

- 680 existing active SHGs have been identified and their 7,518 members were oriented so that they could include activities to address HIV/TB and co- infection issues in their agenda. These groups can take forward the activities in long run and hence it is sustainable.
- 193 community support groups have been formed and their capacity has been built to create awareness in the community and doing referrals. These groups are the social capital created by the project as now they are recognized by the community and have enhanced capacities and hence can take forward the awareness building component of the project.
- During the interviews with government district nodal officials for TB as well as HIV program, some interesting suggestions/ views emerged on sustainability aspect. Some of the key suggestions/ views are as following:

  - District Srikakulum and East Godavari
    "The existing frontline workers such as ASHAs, AWWs should be made the coordinators of the field groups so that these groups may continue in long run. The project needs to be continued till such arrangements are done."
  - District Vishakhapatnam:
    "To sustain the Children School Groups (CSGs), identified schools teachers should be oriented and made the Co-ordinators of these groups".
  - District Prakasham and Krishna:
    "These community groups should be linked to NRHM under existing budgetary heads and provisions."

Though, Project has done efforts, to establish linkages between community groups and RNTCP schemes, by submitting proposals to the government. However they have not been approved yet. To sustain this innovation it is essential that either government should continue to support it after completion of this project or the LP and iNGO seek support from other donor agencies.

Output 3 "Access to TB diagnosis and treatment at state, district and local level are improved." funding would be required.

- As per the notification from state government AWWs had been involved in RNTCP. This has resulted in policy a definite initiative for main streaming. However still more efforts would be required to further increase the coverage of population and treatment of DOTS services through the help of AWWs.
- 61 ASG members are working as DOTS provider and getting incentive amount i.e. Rs 250 per TB patient cured in one of the government scheme. There is possibility that due to the active involvement of ASG members on TB related issues and their past experience; many more ASG member could be accorded DOT provider status by the government.
- As an innovation to enhance access to TB related services, in the year 4 total 300 ASG members and active volunteers were also trained to act as sputum collection and transportation agents, who receives honorarium for the same to meet the transportation cost etc. Innovation has shown encouraging results so far. The initiative was started in January 2014 and within span of 3 quarters i.e. till September 2014 these groups have transported 289 samples to the nearest testing centre out of which 37 were found positive.
- To sustain this innovation, project team is planning to document this innovation and share the case with government for linkages of these sputum collection agents with RNTCP. However after the close of project magnitude of sputum collection and transport might fall till Govt. take up this activity. Thus this would need the further funding support till these could be fully linked or main streamed in the government system.

6. Lesson learning on Approaches

a) Approaches to Empowerment and Advocacy

- Project emphasised that the name of iNGO referring the patients to DMC or ICTC should be recorded in the Register maintained at the government health institutions so that the information may be recorded in government MIS and a system of follow up of cases and data validation and documentation could be done. After repeated follow ups with government the system has been put in place now.
- The composition of community groups, especially ASG was found to be quite effective as it had the members who were either affected or infected or someone in their families were suffering from TB/HIV. This factor made them vibrant units; as they willingly joined hands for a larger cause and therefore were self- motivated, concerned and committed to take forward the project activities.

b) Equity and Gender Equality

- Women were one of the major target populations of project. Keeping this in view female members were given preference during formation of community support groups. This ensured greater participation of women folks in community in

awareness generation activities and events also resulted in referral of symptomatic women cases.
- The inclusion of women members in the community group had led to more and active involvement of women in community and resulted in more referrals, In 193 groups formed and 680 SHG linked up at community level Out of total 3,214 Community group members 2081 (65%) were female members

c) Capacity Building

- During FGDs with community support groups, it was observed that in majority of the groups the women members who were involved in other training program organized by the lead and partner NGOs, had more knowledge as well as leadership qualities.
- During implementation of project it was felt that it would be beneficial to have a dedicated group meeting specifically for the children support group members as opposed to inviting them to the annual meetings with other group members which were normally large. It was felt that they would benefit from learning more from their peers and also from more focused and child friendly/focussed activities.
- Capacity Building of community group members of Women Self Help Groups on health and health rights has enabled wider spread of awareness about the diseases. For example, the SHG leaders have taken the issue of TB and HIV to their blocks and district level associations.
- Local partners of the project have been trained on variety of areas including: advocacy, community mobilization and organising cultural shows. These trainings have capacitated the iNGOs to take active role in highlighting local level issues at bigger forums.

d) Monitoring

Over all approach:

- Based on the findings of baseline survey; a comprehensive log frame was prepared through consultative process and updated time to time to monitor the progress on outcome and output indicators.
- The monitoring system was developed on following aspect;
  - Program Implementation
  - Financial Management

Monitoring System

Three tier systems were developed for monitoring of both program as well as financial management as described below;

Tier-1: As for the ground level, the monitoring of day today activities was carried out by the staff of iNGO. The day wise activities were recorded in daily diary and registered were maintained for the meetings. The monthly compiled MIS data and reports were submitted by iNGO to lead partner. The monthly meetings of staff were also done to review the progress.

Tier-2: At this level the monthly data and reports were reviewed by the staff of lead partner and compiled monthly reports was shared by lead partner. The program staff of lead partner also made field monitoring visits to iNGOs on quarterly basis. After review and compilation the reports were sent to TB Alert India on quarterly and annual basis. Quarterly and annual review meetings, participatory community reviews and community sharing meetings were also organized to review the progress

Tier-3: TBAI and TBUK reviewed the quarterly and annual reports and submitted them to donor. Besides the TBAI and TBUK team also made quarterly and annual field monitoring and support visits to project area respectively.

Lessons learnt

The basic management information system was developed in beginning of the project and later based on the continued learnings over the time it was reviewed and improvised depending on the need. The preceding paragraph describes the overall monitoring frame developed and used under the project. Some of the key learning related to monitoring system is as follows;

- The data was recorded in six major programmatic registers which were interrelated and data could be cross checked and revalidated at iNGO level.
- For quick processing and analysis of data the Excel based MIS format were developed to be maintained at iNGO and lead partner level. The iNGO staff involved in MIS were also oriented on the excel format. This enabled the transfer and analysis of data in time effective manner.
- Based on feedback from project volunteers the referral slips were translated into Telugu, a vernacular language spoken in Andhra Pradesh. Volunteers have fed back that they find the translated slips easier to use as compared to the English versions. Accurately completed slips contributed, to more accurate record keeping and verification of the number of people reached. At each partner level an M&E register is used. VMM uses this to document their feedback on project visits and cross check referral slips with registers and the project workers daily diaries. This enables staff to verify information easily and efficiently and identify any issues they may need to address during their next field visit.
- For effective tracking of TB and HIV cases referred by the project referral slips were developed. These slips were in serial number and in triplicate copy so as to enable crossing checking between: testing facilities, NGOs and the person who did the referral. Initially it was printed in English but based on later on the feedback of community members it was translated and printed in Telugu language.
- Effective feedback mechanism was put in place (details given in separate section)
- The trainings of accounts and finance on accounting package Tally, revised FCRA guideline etc. strengthened the monitoring system.

As per the observation of evaluation team, the huge and complex data base some time creates confusion and leads to chances of errors thus, it is suggested to keep it simple and realistic with filters at various levels, so that it can be easily analysed for monitoring as well as further planning.

Baseline evaluation has given useful data on different aspects of evaluation however; these were in percentage form in terms of individual district level only, that does not allow data to be reworked in terms of overall state percentages and allow comparison with end line evaluation.

e) Innovation

Some of the key innovations undertaken in the project are as below;

- To enhance the access of testing facilities for TB cases, in January 2014, 300 ASG members/ volunteer were trained to act as sputum collection and transportation agents especially in remote areas where the testing facilities were not accessible. This innovation has shown good results, and till September 2014 these ASG

members collected and transported the sputum of 289 persons (173 males and 116 female) for testing.

- In Dumbariguda, one of the PHC of district Vishakhapatnam, the lab technician posted in government facility was on long leave for about 8-9 months; this resulted in difficulties to cater to the cases referred by Project for testing. To address this issue, one of the project volunteer, who was qualified lab technician; his services were provisionally deployed at the facility to take up testing work for 2 days per week. This was done in consultation with District TB officer. This had resulted in continued services to the referred cases.
- Some members from the fishermen community, who travel for many months at a stretch through sea route for business, were trained to act as the "On-Boat Motivator" to guide TB infected / on DOTS patients for regular intake of drugs so as to reduce the drop out cases.
- Paintings were drawn on ships/ boats to spread messages on TB and HIV. After advocating with fishermen cooperative society they agreed to paint the additional boats with TB/HIV related messages out of their own funds.
- Visual materials such as snakes and ladders game proved quite popular, particularly in communities having children in family and who had low literacy rates. It helped to attract people's attention and engaged them during awareness raising and community events.
- In fisherman community, the project linked the families having TB or HIV cases with its kitchen garden project so that they may get healthy and balanced diet. Outreach workers educated them about the benefits of green leafy vegetables and motivated them to grow low cost green vegetables at their backyards and also provided seeds and sapling. Their Body Mass Index (BMI) was regularly calculated and monitored
- Project had developed some economical and innovative approaches such as organizing X-ray screening camps in remote areas in Vishakhapatnam, with support of charitable organization namely "Ramakrishna Mission". Under these camps total 586 cases were screened out of which 74 were found positive. For these camps, Ramakrishna Mission partook some of the cost i.e. vehicle maintenance, fuel and honorarium for the medical personnel whereas the project staff and community groups mobilized community for these camps.

7. Project Accountability (Beneficiary feedback mechanism):

There was in built process in Project for collection of feedback from the beneficiaries as well as key stakeholders. Feedback sharing was done through following means and from activities:

- **Participatory Community Reviews (PCRs)** done with community and stakeholders using consultative processes and their feedback was collected and accordingly necessary steps were taken
- **Annual Review and Learning Meetings** were done one a year to give and take feedback on various aspects like project activities, processes, challenges and issues so that necessary actions could be taken to address the gaps.
- **Community Sharing Meetings** were organized for experience sharing among community groups. This also helped in cross group and district focused leanings so that best practices / strategies could be learned from groups from each other.

Besides above activities the Lead Partner staff also made quarterly visits to the project areas and captured suggestions and feedback from the target community, community support groups and stake holders. These were documented so that necessary actions could be taken in overall interest of project.

Project team also collected feedback twice as per the framework provided by DfID and shared back in initial three years of project. The feedback revolved around following key questions;

1) What areas / activities need improvement and what additional activities could be taken up to strengthen the services provided by TAP?
2) Is the information on TB/HIV/Co -Infection provided by TAP staff clear?
3) What are the needs of the community? Is TAP addressing the needs?
4) How are the services for TB at health centre? How could they be improved?
5) Any other innovative suggestion adding value to Project?

After review of the feedback from beneficiaries and stakeholders, the project team shared the responses with iNGOs during the periodic review meetings. The iNGOs staffs, in turn communicated the same to the beneficiaries during community group meetings and to beneficiaries during participatory community reviews. If suggestions could not be taken up then the reasons for the same were also explained.

Examples of how the Project changed course as a result of feedback from beneficiaries:

The examples of how project accommodated and was benefited by the feedback from the beneficiaries are as follows

- Majority of the IEC resource material like boat stickers, flute / picture boards and the resource directory, snake and ladder game etc. has been conceptualized and developed considering the feedback from the community.
- The key success stories and case studies were documented under the Project and shared with all the iNGOs, and stakeholders through newsletters.
- Based on the beneficiaries feedback collected by one iNGO, CLDA suggested that in addition to Adult Support Groups, another category of group should also be set up for young adults (between 18 and 26 years). Based on the suggestion the Young Adult Support Group was formed and was involved in Project from April 2012. The members of this group were selected from the active members of the Children Support Groups, who were major. Adults up to 26 years of age were also added to this group .The Young Adult Support group met on monthly basis to discuss TB and HIV issues in communities and their families and refer people for TB testing.
- Initially the case referral slips were in English therefore community was facing problem in understanding it. Later, based on the feedback of community and volunteers the slips were translated in to Telugu and reprinted.
- During PCRs it was felt it would be beneficial to hold beneficiary meetings specifically for the Children Support Groups and then a separate meeting for members of the other support groups. These meetings were in part aimed at providing support and training to these groups in addition to obtaining their feedback on challenges as well as areas of best practice in the field. This was welcome step and provided an opportunity for children, to provide feedback. They also got tailor made support in this forum.

8. Outcome and Output Scoring

During Final Evaluation the findings and values for each indicators for outcome and output planned in log frame has been recorded and outcome and output scoring have been arrived at using following scoring criteria;

Score	Description of Score
A++	Output/outcome substantially exceeded expectation
A+	Output/outcome moderately exceeded expectation
A	Output/outcome met expectation
B	Output/outcome moderately did not meet expectation
C	Output/outcome substantially did not meet expectation

The summary of scores for each outcome and output in the project is given in table below;

Outcome/Output	Indicators	Score
Outcome Increased access to effective TB and HIV services in line with MDG 6	Number of people diagnosed with TB, HIV and TB-HIV co-infection by the Project	A++
	Knowledge of TB amongst community in Project area	
Output 1 Local communities are aware of their health rights and have increased knowledge and awareness of TB and TB/HIV and availability of free government health services.	Knowledge of health rights and HIV amongst community in Project area	A+
	Number of PHPs and AWWs sensitised on TB and health rights.	
	Level of stigma and discrimination amongst community members towards people with HIV and TB	
Output 2 Sustainable community structures that promote and support health rights and health seeking behaviour.	Existing community structures integrate HIV and TB into their agenda.	A++
	Adult support groups endorsing and supporting the Project's health advocacy and community-based activities	
Output 3 Access to TB diagnosis and treatment at state, district and local level are improved.	RNTCP recognizes and supports community structures as sputum collection agents in intervention area.	A
	Provision of DOTS is included in the official job chart of AWW	
	Nutritional support provided for 12 months for children under 6 who are diagnosed with TB.	

9. Contribution to the CSCF Objectives

CSCF Objective	Example
1. Building capacity of Southern civil society to engage in local decision-making processes. *Can you find an example where the Project has helped marginalised groups to, for example, voice their concerns to local government departments in relation to their rights?*	Under the Project 193 community groups have been formed in Project area and their capacities have been built on issues related to TB, HIV and health rights. These groups have provided useful forum for advocacy for creating demand and provision of services for people suffering from TB / HIV or co infection. The members of these groups also worked to create awareness on TB and HIV in the community and referred the suspected cases for testing in nearest government facility. The mechanism for follow up of referred cases was also developed so as to rule out the dropouts. The problems and issues related to services were shared with concerned government officials in periodic Project Advisory Committee meetings so that these gaps were addressed. It is worth noting that at the beginning of the Project only 29% of households were aware that access to health care services is a health right and during end line KAP survey 99.6 % of HH were aware about it.
2. Building capacity of Southern civil society to engage in national decision-making. *Can you find an example where the Project has helped marginalised groups to, for example, voice their concerns to national government departments in relation to their rights (e.g. through the media or through a more direct engagement)?*	Yes, the government order issued by Department of Women and Child Development, Andhra Pradesh for provision of double nutrition for children affected with TB as well as involvement of AWW to identify, guide and create awareness among target group for identification and regular treatment of TB under RNTCP was also sent to RNTCP, Ministry of Health and Family Welfare, Government of India so that this may be used in other states also.
3. Global advocacy. *Has the Project capitalised on its experiences with marginalised groups to conduct advocacy at a global level (e.g. attended UN forums or participated in global campaigns to Project the concerns and views of marginalised groups)? Please provide an example.*	NA

CSCF Objective	Example
4. Innovative service delivery. *Have you identified examples of innovative service delivery pioneered by the Project? If so, please explain.*	TAP has established a sputum collection and transportation service, whereby trained volunteers collect the sputum samples and then it is transported to the testing centres. The aim is to increase early detection and also to reduce dropout between the initial point of referral and testing. This started at the beginning of Year 3 and till September 2014, 289 sputum samples had been collected and transported for TB testing. This service will be documented to feed into future TB programming in the region and to advocate for similar services under RNTCP
5. Service delivery in difficult environments. *If the Project is contributing to, or providing services, in a difficult environment, please explain. Provide a few bullet points to explain why the environment is challenging.*	Under the Project the Adult Support Groups and Community Groups have been formed and provided orientation of issues related to TB and HIV. The empowered group members not only provided support and motivation to take up treatment to the infected members in their own group but also built awareness among community and help in early detection and complete treatment. So far total 61 ASG members are the DOTS providers and providing their services in remote and areas having very difficult terrain. In 2014 some of the ASG members were trained to act as sputum collection agents. Till September 2014 they have collected and transported sputum of total 289 suspected cases out of which 72 have been detected positive Besides this the outreach camp approach has been adopted to provide services to community in very difficult and remote areas in district East Godavari, Vishakhapatnam and Nellore 586 persons have been screened in X-Ray Medical Camps. Out of these total 74 have been detected positive and put on the treatment. • The intervention area especially in Vishakhapatnam and East Godawari is hilly and population is also very scattered. The terrain is very difficult and remote • The nearest DMC (testing centres) in villages in above districts are more than 35 KM away • Some of the Project area in district Srikakulum bordering Orissa is Naxalite hit area.

10. Capacity Building

Capacity building was carried out in different phases of the Project broadly at two level i.e. Capacity building of Project staff and capacity building of community groups and stakeholders. These training/ orientations were organized by lead partner as well as the INGOs and their staff.

Capacity Building of Project Staff:
The details of trainings organized by lead partner for the capacity building of Project staff are as given below;

- Workshop on "Cultural Awareness and Development" organized by VMM (Participants: 35 staff members of INGOs)
- Training on "TB, HIV and advocacy techniques" organized by VMM (Participants: 93 INGO personnel)
- Trainings of Volunteers on Project activities organized by INGOs (Participants: 91 volunteers trained)
- Training on MIS and financial documentation organized by VMM (Participants: 24 personnel of INGOs involved in accounts and finance)
- Trainings on Community Mobilisation organized by VMM (Participants: 50 personnel of INGOs)

Capacity Building of Community Groups and Stake Holders:
The details of trainings/ orientation provided to community groups and stakeholders are as follows

- 1649 AWWs and their supervisors were sensitized under the Project on issues related to TB/HIV and issues of GOs on double nutrition ration and involvement of AWWs in provision of DOTS
- 503 PHPs were sensitized under the Project on issues related to TB/HIV
- 193 community groups formed with 3214 members under the Project. They were oriented by the Project team on the Project activities and issues related to HIV and TB.
- Total 7518 members of 680 women Self Help Groups (SHGs) were linked up and oriented on the issues related to TB and HIV.

In the IDIs conducted with the 28 PHPs and 28 AWWs in the Project area, 25 RMPs were aware of the Project especially the local INGOs and 23 AWW received the orientation on TB / HIV. As per the MIS data of the Project 61 ASG members and 231 AWWs are involved in RNTCP as DOTS provider as volunteers

11. Gender Mainstreaming

- In order to build capacity of women the project involved more women in various community groups, women constituted 65% (2081) of all the members in 193 groups. In addition, 7518 women of 680 SHGs were also roped in.
- Out of 75% respondents who were aware of signs and symptoms of TB 58% were females and 42% males. 88% of the total female respondents knew that TB is curable. Similarly 64% have heard about ICTC centres. Higher knowledge among female respondents reflects that project focussed more on women in the project area.

12. Challenges and Enablers

- Challenge faced in initial phase of Project implementation was high attrition of ORWs mainly due to the issues related to long distance travel on foot in project villages which were situated in hilly and difficult terrain. To address this team identified local staff as ORWs having own two wheelers, which solves the issue of accessibility and to further support this, Project related travel support to ORWs was raised from INR 750 to INR 1200 per month as discussed with the donor.
- Attitude of government is slow in allotting schemes which are still pending and prolonging. The project team of LP and iNGO have resubmitted the proposal on setting up sputum collection and transportation centre and following it up with Government. It may take some time due to government procedures.
  It may however, be mentioned that in respect of advocacy the support from TBAI found to be a bit wanting. Perhaps, TBAI could have effectively topped up endeavours made by project to get state and national government on board, which could have a lasting effect for the sustainability of project and benefits.
- State division and change in the government officers has created challenge in taking up the advocacy initiatives effectively.
- There was some difficulty in the receipt of funds from TB Alert in two quarters as reflected in the financial and audit reports. This has been noticed in respect of first quarter of and third quarter of second year. Moreover, the proportion of funds distributed to iNGO out of the total received, fluctuated between 53% to 77% over the quarters, as shown in the Annexure VI. In order to ensure proper fund flow for project activities, TB Alert had given advance equal to one month expenditure from the corpus till the funds were received from DFID. This ensured smooth implementation of program.
- Retaining the motivation of community group members without any honorarium and bring them out of those expectations was a challenge. This may be addressed in later projects.

13. Recommendations

1. The community structures created under the project, especially Adult Support Groups have been trained and empowered to work on TB and HIV issues under the project and a social capital created under the project. To sustain the project activities these groups needs to be further strengthened. The Lead and iNGOs (as a consortium or individually) should develop comprehensive plans and proposal for economic empowerment of these groups through building their capacities and linking them with existing schemes on entrepreneurship, vocational skills development and other economic empowerment. This would not only help the group members in addressing the critical challenge faced by them at this stage, i.e. higher education of their children, additional nutritional support and care to their family member infected with TB/HIV etc. but also provide them resources to carry forward their awareness generation activities, referral and follow up work for people affected with TB/ HIV.
2. In children groups, all the children to be encouraged to motivate the other children in the junior classes to form such groups. Some children in the existing children groups should also be specifically trained on further orienting the junior children group members. This will help in continuation of the initiative when the present children group students leave the school. A mechanism should also be developed to keep the current children group students in touch with the new

children groups even after leaving the school. These children may later be co-arched in the future projects.

3. For addressing sustainability and mainstreaming, the project should specifically plan for the phase out activities in project proposal itself.
4. Project should identify and orient the leaders/ champions among the community and stakeholders who could take forward the activities in future as leaders, after completion of project.
5. In addition to the advocacy efforts of TB Alert under the project in past, TBAI can plan to organizing learning and sharing workshop, involving the key stake holders of the state and districts to share human case studies, success stories and lessons learned under the project, so that it further contributes to advocacy with state and central authorities towards relevant policy changes and program actions. It could be more effective if TBAI may engage an independent agency / consultant for above documentation.
6. The financial sustainability and mainstreaming of project activities with existing systems is very important. In such projects the implementing agencies can conduct a scoping study to explore all possible viable options and opportunities for sustainability and main streaming. For example one of the components in the NRHM PIP/DAPs is innovations and NGO/PPP initiative. Under this, the district / state government can propose the need based and local specific intervention and budget lines for those. The agencies may advocate and put forth their case strongly to the district administration when the PIP preparation process is on. They may also hire some short term technical expert to facilitate such initiatives.in this respect TBAI, TBUK may provide necessary funding and support.
7. The Project has the data base of all the project villages and their distances from the nearest DMC. The systematic documentation of this data through digital maps or other presentable form could serve as an effective tool for advocacy with the government to address the problem of access.
8. IEC material developed under the project is quite innovative. It is target group specific and generates interest. Project can formally collect quick field responses from beneficiaries through small video films and share the selected tools with state and district level officials of Department of Health and FW as well as Department of WCD to advocate for replication and use of this material on a large scale. The funds under IEC components in NRHM - PIP could be used for this.
9. As suggested by the project staff and workers, valedictory functions at the end of project should be organized in all project districts so that the progress and achievements of project can be showcased and TB/HIV related issues could then go higher in the priorities of Government officials, workers, stakeholders and community.
10. More focussed work/ intervention on reducing stigma and discrimination on TB and HIV in community is still needed. In order to combat this aspect in future, this type of project should also include Behaviour Change Communication component instead of restricting to create awareness about the diseases and services available. BCC component would have been more effective in changing their practises for seeking health care services without any reservations fears and misconceptions.

d) Outcome and Output Scoring

Although the project duration was 42 months, however, the present evaluation was done after 38th and 39th months of project period. Consequently, the status of final achievements may be higher than described below. Also some of the government data will be available later, which will capture the actual achievements.

OUTCOME 1

A.0.1	**Outcome:** Increase access to effective TB and HIV services in line with MDG 6						
A.0.2	**Outcome Score:** (A++)						
A.0.3	**Performance against each outcome indicator**						
	Outcome Indicator 1. Number of people diagnosed with TB, HIV and TB-HIV co-infection by the Project **Milestone 3: March 2015 : TB New: 1405, HIV new: 698, Co-infection: 77** Till September 30th, 2014 the cumulative total reached was: TB New Cases: 2051, HIV new: 652, Co-infection: 135, however based on past trends the cumulative figure expected to be achieved by March 2015 works out to be TB New Cases: 2363, HIV New Cases: 764, Co infection:194 **Outcome Indicator 2. Knowledge of TB amongst community in Project area** **Milestone 2: 60% are aware of DOTS centres and the services offered at DOTS centres and 55% of the target population is aware that TB spreads from an infected person to any other person through cough.** Till September 30th, 2014, 93.6 % are aware of DOTS centres and the services offered there & that 89% of the target population is aware that TB spreads from an infected person to any other person through cough.						
A.0.4	**Evidences**						
	Disaggregated number of citizens benefitting from this outcome;						
	Adult Male	Adult Female	Child Male	Child Female	Total	Brief description	Change/improvement
	1719	892	72	81	2764	This is the number of people tested positive for TB, HIV during the Project period.	All of those found to have TB have been put on treatment. All of those with HIV were provided with ART. 111 children affected with TB are receiving additional nutritional support.
	46	27	0	1	74	This is the number of people tested positive for TB, HIV during various X-ray	Three iNGOs organized X-ray medical camps in 3 districts (Nellore, East Godavari and Vishakhapatnam) in which 586 people were tested. Out of

						medical camps organized by iNGOs.	these 573 were adults (312 males and 261 females) and 11 (5 males and 8 females) children were tested.
	48023	82720	12,954	22142	165839	This is the number of people reached through awareness raising activities such as observational days, mass events, cultural shows and awareness meetings. This is the number of people reached in Project period.	The impact of these activities was supported by end-line evaluation where 75% people were aware that TB spreads from an infected person to any other person through cough. 93.6% were aware of DOTS centres and the services offered there.
A.05	**Feedback from FGDs** As part of end-line evaluation during the FGDs, the group members mentioned that personal contact of Project staff promotes referral as well as continuity of treatment. They were also appreciative about the effectiveness of IEC material prepared under the Project as well as posters, hangings and paintings for boats and autos. Members felt that referral sheets, follow up cards, minutes books were helpful in monitoring and tracking of the target population.						
A.1.1	**Local communities will be aware of their health rights and will have increased knowledge and awareness of TB and TB/HIV and available free government health services.**						
A.1.2	**Output score** A+						
A.1.3	**Output Indicator 1.1. Knowledge of health rights and HIV amongst community in Project area** **Milestone 2: 44% understand that access to health care services is a health right** The end-line evaluation shows that 99.6% understand that access to health care services is a health right						

	Output Indicator 1.2. Number of PHPs and AWWs sensitised on TB and health rights **Milestone 2: 480 PHPs and 2000 AWWs / supervisors.** 503 PHPs were sensitised on TB and health rights during the Project period. Similarly 1649 AWW and their supervisors were also trained. 231 AWWs have volunteered to provide DOTS as part of their job. They were trained during their regular monthly meetings. The government order has already been issued for the provision of additional nutrition for eligible children with TB. **Output Indicator 1.3. Level of stigma and discrimination amongst community members towards people with HIV and TB** **Milestone2: 55% of target population are not afraid to share a meal with person who has TB** At the time of baseline this indicator was 27% and later increased to 39% during mid-line. Now according to the end-line evaluation conducted in September 2014; 45% of target population are not afraid to share a meal with person who has TB.
A.1.4	**Evidences**
	In respect of output indicator, 1.1 and 1.3 People's knowledge was measured during end-line evaluation, which was conducted in September 2014. It was based on sample survey covering 578 households in the 6 districts. Information was gathered using structured interviews and focus group discussions. Regarding 1.2, Number of AWWs and PHPs trained - This is the number of people who have been engaged with and trained by TAP. Information has been derived from the meeting minutes and attendance lists.

OUTPUT 2	
A.2.1	**Sustainable community structures that promote and support health rights and health seeking behaviour.**
A.2.2	**Output score** *:A++*
A.2.3	**Output 2.1 Existing community structures integrate HIV and TB into their agenda.** **Milestone 3: 300 groups (4500 SHG women members)** Since the Project began, 680 Self Help Groups with 7,518 female members have been provided with knowledge on HIV and TB, and have included in their agenda to discuss during their monthly meetings. During the Project period 193 groups were constituted having 3,214 members. They were given training by the Project team. **Output 2.2 Adult support groups endorsing and supporting the Project's health advocacy and community-based activities** **Milestone :78 Groups** 124 cumulative Number of ASGs formed124 and 2035 members were oriented. Out of which 78 ASG groups having 1192 members are very much active and doing awareness and referral related activities under the Project.

OUTPUT 2	
A.2.4	**Evidences**
	Linkages were established with the existing SHGs by orienting SHGs about the objectives of the Project and activities organized and attending regular meetings of SHGs by the staff. However, ASGs were established by the Project and necessary training was given. Consequently, their involvement is more interactive. Through the review of Project MIS it was found that the Project was able to observe organization of ASG meetings regularly, in fact 2545 meetings were held during the Project period against 2270 meetings envisaged.

OUTPUT 3	
A.3.1	**Access to TB diagnosis and treatment at state, district and local level are improved**.
A.3.2	**Output 3 score** (A)
A.3.3	**Progress against milestone for output indicators**
	Output 3.1 RNTCP recognizes and supports community structures as sputum collection agents in intervention area. **Milestone 3: March 2015 - STO office recognizes community structures as agents for sputum collection** The Project partners have identified and trained the ASG members to act as sputum collection agents in their area. In some of the Project districts the training sessions were also conducted by district health department officials. Despite of the continued advocacy by the LP as well as iNGO there is no formal scheme or notification by the government which indicates mechanism to recognize, or support, the community structures as sputum collection agents. However the sputum collection details are recorded in the "referred by" column in the registers kept at the government testing centres in Project area. The sputum collection and transportation work was commenced in January 2014 and up till September 2014 sputum for 289 cases has been collected and transported by ASG members for testing. Out of the total sample tested; 72 cases were found positive. The LP and iNGOs are in dialogue and pursuing with Department of Health Services to provide the status of DoT providers to all ASG members and also provide the financial support for sputum collection and transportation. As an alternative, the iNGOs have also mooted their proposals to government under RNTCP scheme for NGOs for setting up sputum collection centre but those proposals are all stuck in government processing. **Output 3.2 Provision of DOTS is included in the official job chart of AWW.** **Milestone 3: March 2015 - Provision of DOTS is included in the official job chart of AWW.** Based on the advocacy efforts made under the Project the Government of Andhra Pradesh (GoAP) issued an order which approved Anganwadi workers involvement in TB work (memo number 7452/J1/2012 - 19th March 2013). After issue of government order for involvement of AWWs in DOTS, total 1649 AWWs and their supervisors were oriented by iNGOs in the Project area. 231

OUTPUT 3

AWWs have volunteered to provide DOTS in the Project area.

Output 3.3 Nutritional support provided for 12 months for children under 6 who are diagnosed with TB.

Milestone 3: March 2015 - Policy change at WCD department

As a result of systematic and planned advocacy efforts with government the notification for provision of free double nutritional rations for children on DOTS and INA has been issued by Government of Andhra Pradesh vide. memo number 7452/J1/2012 - 19th October 2012.

In order to realize the milestones under this indicator the Project team prepared a Position Paper on the issue through consultative process in July 2012 and presented it to Department of Women and Child Development Government of A.P. After meetings with state government officials over two months, finally the GO was issued on October 2012. After issue of GO the LP and iNGOs disseminated the information to the concerned government functionaries in intervention areas.

Till September 2014 a total 111 children have received the benefit under double nutrition scheme in Project intervention blocks. This includes 57 boys and 54 girls. As per findings of KAP survey conducted during end-line, 53% households were aware of the provision of double nutrition scheme in Anganwadi Centres.

A.3.4 **Disaggregated number of citizens reached by this output**

Adult Male	Adult Female	Child Male	Child Female	Total	Brief description	Change/improvement
0	0	57	54	111	Children under 6 years using double nutrition	111 children now receive double nutritional support for 25 days which include Rice, Dal - 465 gms, Oil - 295gms and eggs. They are provided with this twice a week
28	1621	-	-	1640	Anganwadi workers and their supervisors oriented on double nutrition and inclusion of AWW in RNTCP	Now total 261 AWW are DOTS providers in Project area

A.3.5 **Evidence that supports the progress described.**

- Evidence includes the government orders/letters issued in the context
- End line KAP Survey
- Process documentation for advocacy (Newsletter)

A.3.6 **Impact weighting - 40%**

Consolidated Beneficiary Table (Till September2014)						
	Consolidated Beneficiary Table	Gender and Age Disaggregation				
Number of people	**Overall Total**	**Adult Male** (18 years +)	**Adult Female** (18 years +)	**Child Male** (under 18 years)	**Child Female** (under 18 years)
Observational days	31,408	7,582	15,240	4,058	4,528
Mass events	17,449	5,112	8,054	1,870	2,413
Cultural shows	11,970	3,629	6,335	864	1,142
Awareness meetings	105,012	31,700	53,091	6,162	14,059
Sub-total	**165,839**	**48,023**	**82,720**	**12,954**	**22,142**
Children received nutritional support	111	-	-	57	54
Member of SHGs oriented	7,518	-	7,518	-	-
Member of community support groups formed and oriented	3,214	819	1,575	314	506
PHPs trained	503	463	40	-	-
Anganwadi Workers and their supervisors	1,649	28	1,621	-	-
Number of people tested positive - TB and HIV	2,838	1,701	956	96	85
Consolidated total number of beneficiaries reached since Project began	1,81672	51,034	94430	13,421	22,787

Beneficiaries include: Fisher folk, tribal communities, agricultural labourers, students, urban slum workers, truckers, villagers, children, grandparents of those affected by TB and private and government health workers.

The above numbers for the Project are broken down as follows:

- 165,839 were reached through awareness raising activities (observational days – 31,408, mass events – 17,449, cultural shows – 11,970, awareness meetings – 105,012). Numbers reached for the granny clubs, health forum and children support groups are included in those reached via the awareness meetings.
- 111 children received nutritional support.
- 7518 Self Help Group members received training on TB and health rights and regular support through the Project.
- 3214 Community Group members received training on TB and health rights and regular support through the Project.
- 503 Private Medical Practitioners (PMP) have been trained on TB to enable them to make referrals.
- 1,649 Anganwadi Workers (AWWs) and 17 of their supervisors have been trained.

Annexure I. Evaluation Terms of Reference

TAP – Project Final Evaluation
September 2014

Project Background

Improved access to TB services for underserved communities in Andhra Pradesh (TAP) began in September 2011. It is due to end on 31st March 2015 and as a result TB Alert is hiring an external consultant to assess the impact of the project. TAP is funded by DFID through the Civil Society Challenge Fund (CSCF). The CSCF is a grant mechanism for ensuring DFID reaches poor and marginalized groups (e.g. disabled, children, women, people living with HIV/AIDS, indigenous people, ethnic minorities) through supporting a more empowered and cohesive civil society (made up of NGOs, religious and community organizations, professional associations and others).

TAP is implemented in six districts of Andhra Pradesh, India. The project areas include underserved mountainous areas where myths regarding TB and HIV are prevalent and access to services is poor. Poor access coupled with lack of active case finding means that early identification and testing remains a challenge and it is essential that information and opportunities for testing are provided to mitigate this situation. The project's intended impact, outcomes and outputs are:

- **Impact:** To contribute to poverty reduction through reduced TB and HIV related deaths among people in Andhra Pradesh.
- **Outcome:** Increased access to effective TB and HIV services in line with MDG 6.
- **Output 1:** Local communities will be aware of their health rights and will have increased knowledge and awareness of TB and TB/HIV and available free government health services.
- **Output 2:** Sustainable community structures that promote and support health rights and health seeking behaviour.
- **Output 3:** Access to TB diagnosis and treatment at state, district and local level are improved.

These are achieved through:

- **Awareness Generation:** Awareness activities with simple and clear messages about TB / HIV symptoms, treatment and prevention, using traditional and popular methods.
- **Forming and Strengthening Community Structures:** Training and support of Community Groups. These groups act as information resource centers, make referrals and act as pressure groups.
- **Advocacy:** TAP advocates the needs of communities at the district and state level, including door step TB testing and for supplementary nutrition through the national food programme.
- **Improving service delivery and access:** This includes piloting community testing projects, referrals, training of AWWs and traditional health practitioners.

Some of the major achievements of the project over past three years include:

- 86,586 community members have been provided information on HIV, and TB
- Around, 11,318 people with TB like symptoms were referred for testing by project. About 10,236 people referred reached for testing and 1591 people were diagnosed with TB and linked to TB. Similarly among 12,219 people referred for HIV testing near about 11,459 have reached for testing and 544 are diagnosed with HIV

- 302 women self-help groups, 480 private health practitioners, 124 Community Groups were trained to facilitate prevention, diagnosis & treatment of TB and HIV
- The Women and Child Welfare Department of Andhra Pradesh released a government order to provide free additional nutrition to children with TB and HIV and families affected by TB and HIV.

Partners

The project is managed by TB Alert, UK. TB Alert India, based in Hyderabad, undertake in-country management, co-ordination and financial and programmatic monitoring. Vasavya Mahila Mandali (VMM) is the lead partner, in Vijayawada, Andhra Pradesh. They manage the implementing partners, provide technical support to the partners and undertake financial and programmatic monitoring. The Implementing Partners are: Mahila Mandali (MM), Prakasam district, Serve Training Empower People's Society (STEPS), Nellore District, Children Leadership Development Association (CLDA), Krishna district, Coastal Network of Positive People (CNP+), East Godavari District, Youth Club of Bejjipuram (YCB), Srikakulam district and Peace Educational and Rural Developments (PEACE),Visakhapatnam.

Final Evaluation

A baseline study was undertaken in 2012 in each of the sites and a Midline evaluation was undertaken in 2013. As we are nearing the end of the project, we are now seeking to hire an experienced independent evaluator(s) of firms to undertake the final evaluation to assess its impact.

Aim

The aim of the Final Evaluation is to:

- Identify the contributions and impact (intended and unintended impact) of the project with respect to the project purpose, outcomes and outputs and in comparison with the baseline findings.
- Assess the efficacy and lessons learned of the approaches used during the project (on community empowerment; equity; gender; capacity building; monitoring and innovation) and make recommendations.
- Identify lessons learned, successes and challenges.
- Assess whether the project represented value for money (economy, efficiency and effectiveness) in its efforts to deliver results.
- Make recommendations

Scope of work

- Desk review, including a review of key project documents.
- Develop participatory assessment tools to measure the impact of the project and its success in achieving the outcomes and outputs.
- Co-ordinate with TB AIert India / VMM the submission of the assessment tools to the relevant authorities for approval.
- Undertake a pre-test of the tools.
- Analyze the information collected.
- Write and submit an Evaluation Report.
- Carry out an initial briefing session and a final de-briefing session with TB Alert India and VMM.

Expected outcomes / deliverables

- Final participatory assessment tools.
- Final evaluation report, using the CSCF template and evaluation guidelines.

Location

The evaluation is to take place in the TAP project sites in Andhra Pradesh, India. These are:

- Prakasam, Nellore, Krishna, East Godavari, Vishakhapatnam, and Srikakulam.

Methodology

- The evaluation shall capture both quantitative and qualitative information through a range of methods, using participatory and structured methods.
- Methods include one to one interviews including a Knowledge Awareness and Practice survey (KAP), meetings, focus group discussions and observation techniques with project beneficiaries, target groups, project personnel and volunteers and other stakeholders/partners. In detail it will include the following:
  - Desk review of documents including the project proposal and logframe, annual donor reports, monitoring data and relevant government strategies.
  - Interviews with Project staff and volunteers and Rural Medical Practitioners (RMPs).
  - KAP survey with target community about TB, HIV and Health Rights – Sample size to be decided
  - Focus Group Discussions with 6 Community Core Groups, 21 Adult Support Groups, and 12 Children support groups, 12 Self Help Groups.
  - Patient satisfaction survey with people who have used the local health services
  - Meetings with government officials

The data collected should be disaggregated by age and gender.

Timeframe

- The evaluation is to take place from September 2014 and January 2015, with the submission of the draft report by 22nd December 2014 and the final report by the 19th January 2015.

Qualification and Experience required

The Final Evaluation needs to be carried out by an independent consultant / consulting firm to obtain un-biased findings as per the donor's requirements. The consultant / consultancy firm should have the following:

- A public health background/degree with experience on TB and HIV.
- Extensive and proven experience of leading and undertaking baseline and final evaluations, including experience of health projects.
- Extensive experience of developing and using both qualitative and quantitative evaluation methods including participatory methodologies.
- Skills in analyzing and synthesizing complex information.
- Sound English writing skills as evidenced by published or circulated documents (examples should be provided in the EoI). Preferably knowledge of the local language (Telugu).
- A demonstrated ability to communicate and build strong relationships with stakeholders including the communities, government representatives and NGO staff and volunteers.

Communication/Co-ordination

- The **TB Alert** contact person is – for submitting draft and final evaluation reports, progress updates, contractual issues and payment:
- Kate Beavis – Programme Officer: kate.beavis@tbalert.org
  - Tel: +44 (0)1273 234030.

  Alternative TB Alert contact person is:
  - Sameer Sah - International Programme Director: sameer.sah@ tbalert.org
- On the ground communication regarding: submitting draft and final evaluation reports, conducting the two de-brief meetings, regular progress updates, scheduling field visits, arranging transport and gaining any necessary approvals for the evaluation. The first point of contact is **TB Alert India** copying in **VMM** into communications:
  - **TB Alert India -** Vikas Panibatla: vikas@tbalertindia.org
  - Tel:+91-40-27843499 Mobile: +91- 07702202399/+91- 9848287045
  - Plot. No. 25&26, White House, Ishaq Colony, Secundrabad, Telangana, India
  - **VMM –** Dr. Keerthi: vasavyamm@gmail.com
  - Telephone:+91 866 2470966, 9032669997

TB Alert India will carry out regular field visits during the evaluation field work phase. Payment requests will be processed after recommendation of TB Alert India.

The consultants will also notify both TB Alert and TB Alert India and in advance, if they envisage any potential changes to the implementation and timeframe of the work.

Likewise, TB Alert and TB Alert India will keep the consultant up to date and informed on any issues which may affect the implementation of the evaluation.

Documents to be supplied by TB Alert

Donor guidelines

1. DFID Final Evaluation Guidelines – please read as this includes the structure/headings and formatting requirements required for the report
2. DFID Project Competition Report template – with data disaggregation requirements
3. DFID Value for Money guidelines
4. Bond Value for money – what it means for NGOs

Project Information

5. Original Project Proposal and TAP Project Organogram
6. Latest version of the Logframe
7. Latest version of the budget
8. Baseline study report – 2012
9. Midline study report - 2013
10. Annual Project Reports and Tripleline/DFID responses to Annual Reports – Year 1, 2 and 3
11. TAP Newsletters – 2012 & 2013
12. List of TAP NGOs with addresses/contact details

Annexure II. Evaluation Schedule

Time line -"Final Evaluation TAP"																				
S.No	**Week**	1	2	3	4	5	6	7	8	9	10	11	12	**13**	14	15	16	17	18	19	20
	Month	Sep	Sep	Sep-Oct	Oct	Oct	Oct	Oct-Nov	Nov	Nov	Nov	Nov	Dec	Dec	Dec	Dec	Dec-Jan	Jan	Jan	Jan	Jan-Feb
1	Inception meeting & Partner meet	X	X																		
2	Desk review	X	X																		
3	Review of study tools		X	X	X	X															
4	Translation and Pre-test						X	X													
5	Comments from TBA							X	X												
6	Finalization of tools							X	X												
7	Hiring and training of field team									X											
8	Data collection-Quantitative									X	X	X									
9	Data collection-Qualitative									X	X	X									
10	Data Processing and Analysis									X	X		X	X	X						
11	Preparation and Submission of draft report															X	X	X	X		
12	Comments/ Suggestion from TBA																		X	X	
13	Submission of final report for dissemination																				X

Annexure III. People Met

1. Sameer Sah (International Programme Director)
2. Mr. Vikas Panibatla (CEO TB Alert India)
3. Dr B. Keerthi, (Technical Advisor) and Program team -Lead Partner VMM
4. Staff of iNGOs -STEPS, MMC, CLDA, CND+, PEACE,YCB
5. In- Depth Interviews**:**

District	Designation	Name
Prakasham	ADMHO	T. Ranaga Rao (Program Officer)
Prakasham	DTCO	Dr. P. Ramesh
Nellore	ADMHO	Dr. Ramadevi
Nellore	DTCO	Dr.K.Srinivasa Rao
East Godavari	DTCO	Dr. Prasanna Kumar
East Godavari	ADMHO	Refused to Meet
Vishakhapatnam	ADMHO	Dr. R. Ramesh
Vishakhapatnam	DTCO	Dr. N. Vasundhara
Srikakulum	DTCO	Dr.G. Ratnakumari (Joint Charge)
Srikakulum	ADMHO	
Krishna	ADMHO	Dr. T.V.S.N. Sastry
Krishna	DPO	Mr. Kiran

6. Focus Group Discussions

District	Block	Village	Location	Name of the group	Category
Prakasham	Vetapalem	Vetapalem	Sarvodaya colony	Prakasham	ASG
	Chinaganjam	Ramachandra Nagar	Kothapalem		ASG
	Chinaganjam	Ramachandranagara	Ramachandra Nagar	Chandamama	CSG
	Nagulappudapadu	AmmanaBrolu	ST colony	Mahatma Gandhi	ASG
	Chinaganjam	Ramachandra Nagar	Member's House	Thirupathamma	SHG
Srikakulam	Srikakulam Rural	Kundavani Peta	Angaanwadi	Polamma	ASG
	Gara	Sri Kurmam	Panchayat Presidents house		CCG
	Gara	Kalingapatnam	VFVR Colony	Srirama	ASG
	Sri Kakukulam Rural	Kalingapatnam	High School	Gandhi	CSG
	Etcherla	Bandaravarla	High School	Saraswathi	CSG

District	Block	Village	Location	Name of the group	Category
	Etcherla	BudagatlaPalem	Member's house	SwayamShakthi	ASG
	Ranasthali	Kostha	Member's House	Lakshmi Durga	SHG
East Godavari	Rampachodavaram	Chilakamamidi	Nutrition Centre		ASG
	Raja vommangi	UrlakulaPaadu	Member's house	Vennala	SHG
	Devi Patnam	Indukuru	Forest Office		CCG
	Mallavaram	MallavaraMamilli	Member's House	Sairam	ASG
	Gangavaram	K.Gangavaram	Member's House		CSG
	Devi Patnam	M.Ravi Lanka	Member's House	Apple	CSG
	Gangavaram	P.GangaVaram	Member's House	Sri Devi	SHG
Nellore	Venkatagiri	Kampalem	Member's House	Bapuji	ASG
	Venkatagiri	Paravolu	Member's House	Venkateshwara	ASG
	Venkatagiri	Jangalapalli	Harijana Wada	Padmavathi	SHG
	Venkatagiri	Vattivedu	ZPH School	Shiva	CSG
	Venkatagiri	Petluru	ZPH School	Vivekananda	CSG
	Venkatagiri	Venkatagiri town	leaders house	Thirupathamma	SHG
Vishakaha Patnam	Hukum Peta	Podali	CHW house	Alluri Seetharama Raja	ASG
	Hukum Peta	Guda	Member's House	Mother Theresa	ASG
	Araku Valley	BandapaniValasa	Chilagam Panchayat	Anusha Group	ASG
	PedaBayalu	Kullubha	Member's House	Bhagat Singh	ASG
	Paderu	GuttulaPuttu	GTWA School		CSG
	HukumPeata	Addu Munda	Sanyasamma Palem		CCG
	HukumPeata	Hukumpeata	GTWA School		CSG
Krishna	Vijaywada urban	VMM office	VMM office	Community Core Group	CCG
	Vijaywada Rural		House of one member	Pragati	ASG

District	Block	Village	Location	Name of the group	Category
	Vijaywada Rural	Nunna	House of one member		SHG
	Kankipadu	Punadipadu	House of one member	Srirama	ASG
	Vijaywada urban	Vijaywada urban	School	Apple	CSG
	Ibrahim Pattnam		School		CSG
	Ibrahim Pattnam	Jupudi	House of one member		ASG

Annexure IV. Documents Consulted

- Project Proposal
- Log Frame
- Baseline Report
- MIS for the project period
- Annual Progress Reports -Year 1, Year 2 and Year 3
- Audited Financial Statements
- IEC Material used under the project including News Letters
- IEC material and message recommended by Central TB Division by Government of India
- RNTCP/ APSACS Reports for Andhra Pradesh and project districts 2011 to 2014
- Government Notifications / Memos issued related to project

Annexure V. Statistical Data on the Baseline and End line

List of tables and figures

1. Financial Data

Table1.1: Funds received and funds disbursed as per audit reports

Quarter Starting	Funds Received	Funds Disbursed	% of funds disbursed *vis a vis* Funds recieved
2011 Spt. /Oct.	28,61,423	17,30,110	60.46 %
2012 January	25,91,374	13,59,968	52.48%
2012 Apr.	13,00,033	7,16,727	55.13%
2012 July	30,09,833	21,61,656	71.82%
2012 October	18,49,500	14,54,067	78.62%
2013 January	26,05,150	18,09,433	69.46%
2013 Apr	21,83,164	16,68,342	76.42%
2013 July	25,27,169	15,64,691	61.91%
2013 October	19,94,364	15,80,176	79.23%
2014 Jan	26,25,324	17,53,282	66.78%
2014 Apr	23,31,331	17,90,060	76.78%
2014 July	24,03,314	17,57,136	73.11%
Total	3,02,76,343	2,09,25,824	69.12%

Figure1.1:Trends in receipt of funds and disbursement

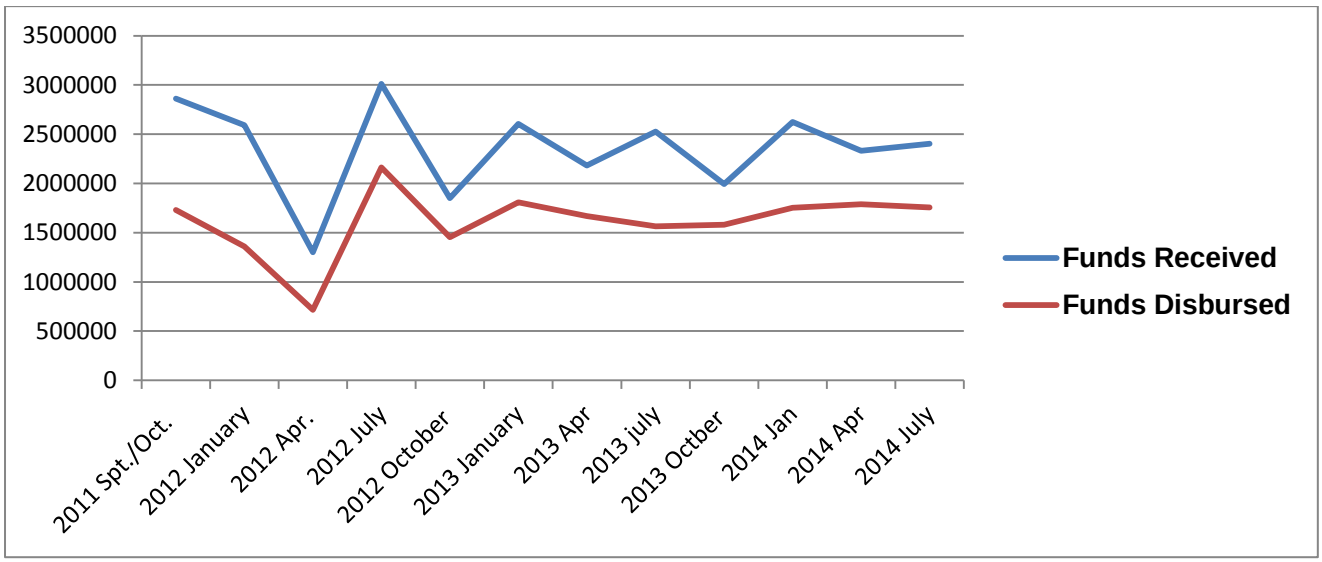
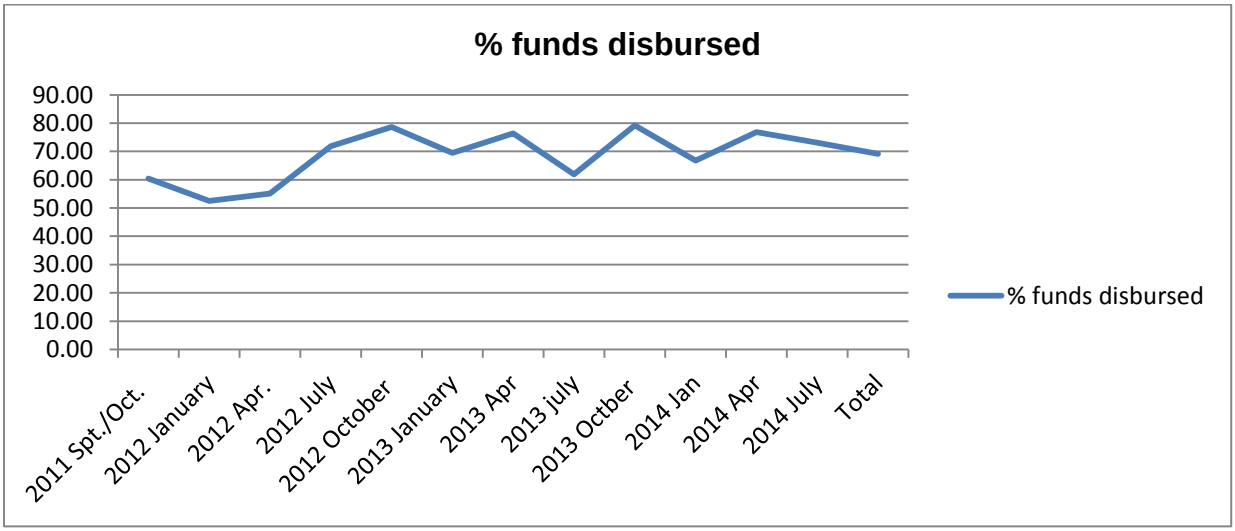


Figure1.2: Trends in the proportion of recipt disbursed to iNGOs



2. KAP Data

Figure2.1: Percent distribution of respondents according to the caste- Endline

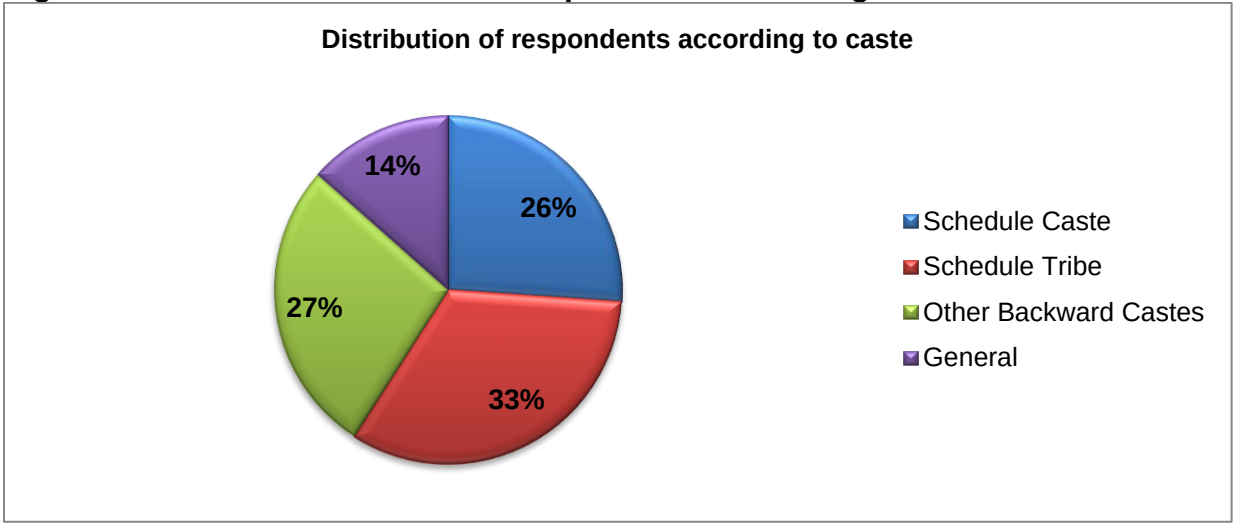


Figure2.2: Percent distribution of respondents according to the Debt status- Endline

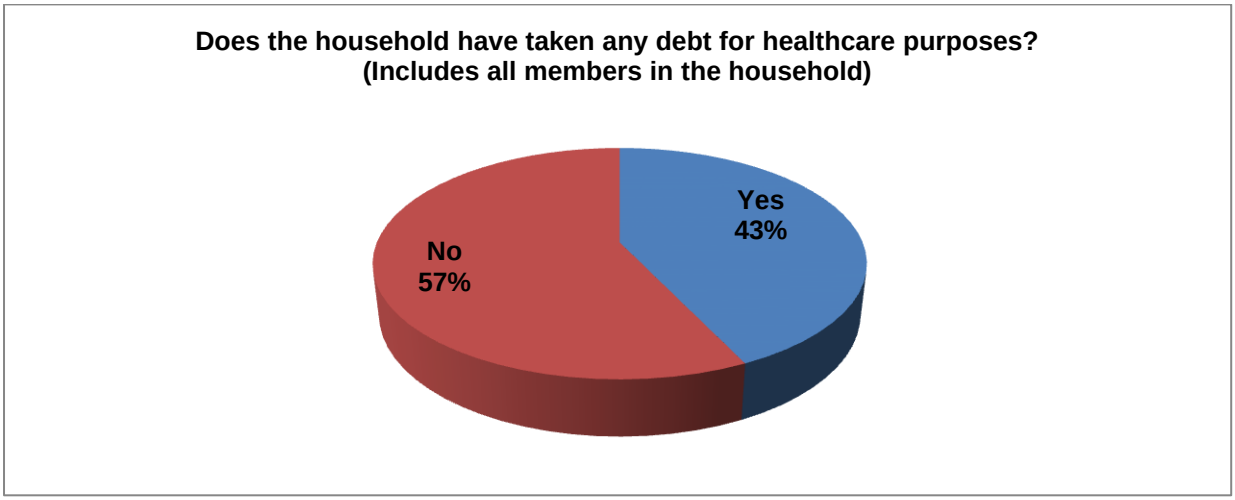


Table2.1: District wise percentage distribution of respondents according to their awareness about TB *vis. a vis.* baseline

District	Baseline			Endline	
	Awareness about TB				
	Yes	No	DK	Yes	No
East Godavari	33%	6%	61%	81%	19%
Krishna	67%	26%	7%	93%	7%
Nellore	75%	13%	13%	98%	2%
Prakasam	54%	5%	41%	99%	1%
Srikakulum	83%	6%	11%	93%	7%
Visakhapatnam	28%	16%	56%	100%	0%
Total	52%	12%	36%	92%	8%

Table2.2: District wise percentage distribution of respondents according to the source of knowledge about TB- Endline

From where did you get the knowledge about TB?															
Districts	TV/ Radio/ Newspaper			Government health Staff (Doctor/ANM/ AWW)			Wall paintings / hoarding/Boat paintings/ auto-bus Panels			Awareness meeting organized any NGOs /Cultural events			Interpersonal communication		
	Total	Male	Female	Total	Male	Female	Total	Male	Female	Total	Male	Female	Total	Male	Female
East Godavari	25%	23%	26%	78%	83%	75%	3%	4%	3%	29%	37%	24%	50%	52%	49%
Krishna	67%	56%	70%	70%	72%	69%	24%	28%	22%	46%	36%	49%	52%	56%	51%
Nellore	61%	65%	58%	82%	65%	96%	25%	40%	13%	82%	70%	92%	86%	90%	83%
Prakasam	52%	47%	56%	92%	95%	90%	1%	0%	2%	87%	92%	83%	97%	100%	94%
Srikakulum	33%	50%	25%	86%	92%	84%	4%	8%	2%	23%	17%	25%	33%	50%	25%
Vishakhapatnam	51%	56%	46%	86%	85%	87%	1%	2%	0%	97%	98%	96%	98%	100%	96%
Total	46%	47%	46%	82%	84%	81%	8%	9%	7%	58%	63%	55%	68%	77%	62%

Table2.3: State wise percentage distribution of respondents according to their awareness about TB and HIV co-relation *vis. a vis.* baseline

	Baseline			Endline		
	Relationship between TB and HIV			Awareness about person suffering from HIV has greater risk of getting infected with TB?		
	Yes	No	DK	Yes	No	DK
Total	33%	54%	13 %	56%	12%	32%

Table2.4: District wise percentage distribution of respondents according to the awareness about signs and symptoms of TB-Endline

According to you what are the signs and symptoms if a person is suffering from TB?												
District	Persistent cough for 2 weeks			Coughing with blood			Fever and night sweats			Constant Tiredness / fatigue & loss of weight		
	Total	Male	Female	Total	Male	Female	Total	Male	Female	Total	Male	Female
East Godavari	78 %	75 %	81 %	28 %	35 %	24 %	12 %	12 %	13 %	72 %	77 %	68 %
Krishna	53 %	68 %	49 %	59 %	52 %	62 %	65 %	72 %	63 %	69 %	68 %	69 %
Nellore	95 %	95 %	96 %	50 %	45 %	54 %	75 %	65 %	83 %	61 %	85 %	42 %
Prakasam	97 %	97 %	96 %	78 %	68 %	85 %	43 %	42 %	44 %	57 %	66 %	50 %
Srikakulum	75 %	77 %	74 %	49 %	62 %	44 %	12 %	8%	14 %	63 %	50 %	68 %
Vishakhapatnam	97 %	96 %	98 %	59 %	62 %	57 %	57 %	62 %	53 %	10 0%	10 0%	92 %
Total	81 %	86 %	78 %	53 %	54 %	52 %	41 %	41 %	41 %	72 %	79 %	68 %

Table2.5: District wise percentage distribution of respondents according to the awareness about TB curability *vis. a vis.* baseline

District	Baseline			End line		
	TB is completely Curable					
	Agree	Neutral	Disagree	Yes	No	Don't know
East Godavari	87%	11%	2%	81%	2%	17%
Krishna	79%	4%	16%	83%	4%	13%
Nellore	97%	3%	0%	91%	7%	2%
Prakasam	65%	33%	2%	97%	1%	2%
Srikakulum	71%	21%	9%	89%	4%	7%
Vishakhapatnam	64%	21%	11%	98%	0%	2%
Total	Not available			89%	2%	9%

Table2.6: District wise percentage distribution of respondents according to the awareness about DOTS *vis. a vis.* baseline

District	Baseline	Endline
	Awareness about DOTs	
East Godavari	14%	90%
Krishna	37%	94%
Nellore	35%	93%
Prakasam	14%	97%
Srikakulum	48%	89%
Vishakhapatnam	18%	98%
Total	Not available	93%

Table2.7: District wise percentage distribution of respondent's according to the DOTS service provider in their area- Endline

District	AWW			ANM			ASHA			Any Other		
	Total	Male	Female	Total	Male	Female	Total	Male	Female	Total	Male	Female
East Godavari	32 %	27 %	36 %	42 %	42 %	43 %	57 %	62 %	53 %	10 %	10 %	12 %
Krishna	56 %	63 %	54 %	28 %	33 %	26 %	55 %	54 %	56 %	3 %	4 %	3 %
Nellore	98 %	100 %	95 %	18 %	5%	29 %	60 %	58 %	62 %	0 %	0 %	0 %
Prakasam	98 %	97 %	98 %	41 %	22 %	57 %	60 %	61 %	59 %	0 %	0 %	0 %
Srikakulum	37 %	36 %	37 %	38 %	44 %	35 %	64 %	60 %	67 %	8 %	4 %	10 %
Vishakhapatnam	97 %	100 %	94 %	30 %	33 %	26 %	48 %	41 %	56 %	3 %	0 %	6 %
Total	65 %	68 %	62 %	35 %	33 %	36 %	57 %	55 %	58 %	4 %	3 %	5 %

Table2.8: District wise percentage distribution of respondents according to the awareness about DMC and ICTC - Endline

Awareness about DMC and ICTC		
District	Aware about DMC	Aware about ICTC
East Godavari	70%	34%
Krishna	70%	67%
Nellore	89%	82%
Prakasam	93%	84%
Srikakulum	70%	64%
Vishakhapatnam	95%	93%
Total	80%	66%

Figure2.3: State wise % of respondents aware about special nutritional support provided at anganwadi center for children under 6 who are diagnosed with TB (in %)

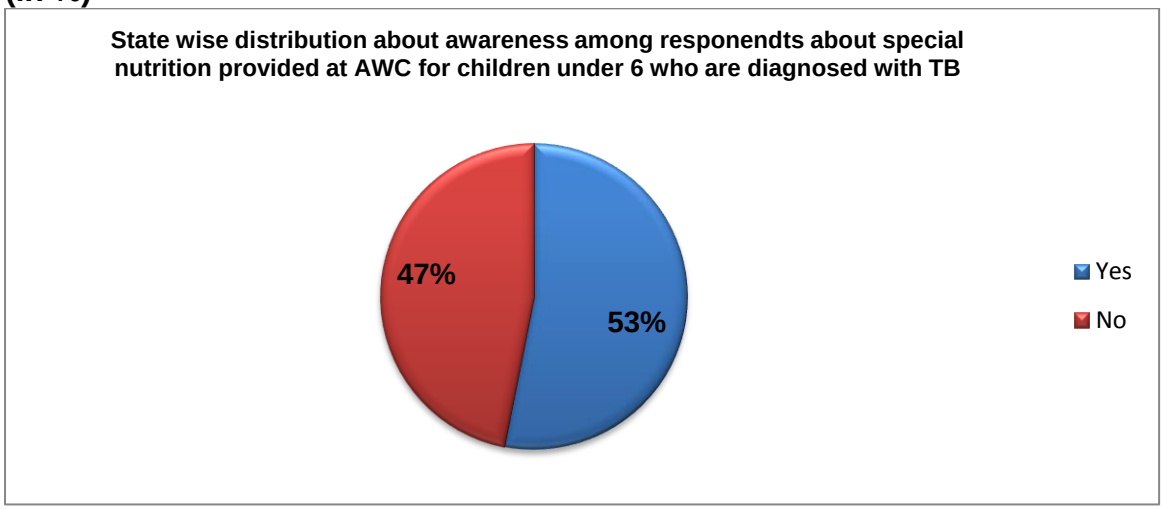


Table2.9: District wise % of respondents according to the awareness about special nutritional support provided at AWCs for children under 6 who are diagnosed with TB (in %)- Endline

% of people aware about special nutritional support provided at anganwadi centre for children under 6 who are diagnosed with TB (in %)	
District	**Total**
East Godavari	43%
Krishna	47%
Nellore	60%
Prakasam	65%
Srikakulum	43%
Vishakhapatnam	71%
Total	53%

Table2.10: District wise % of respondents according to the utilization of special nutritional support provided at anganwadi center for children under 6 who are diagnosed with TB (in %)- Endline

Have you availed this service for children in your family	
District	**Yes**
East Godavari	20%
Krishna	50%
Nellore	36%
Prakasam	12%
Srikakulum	15%
Vishakhapatnam	13%
Total	22%

Figure2.4: State wise % of respondents about utilization of special nutritional support provided at anganwadi center for children under 6 who are diagnosed with TB (in %)

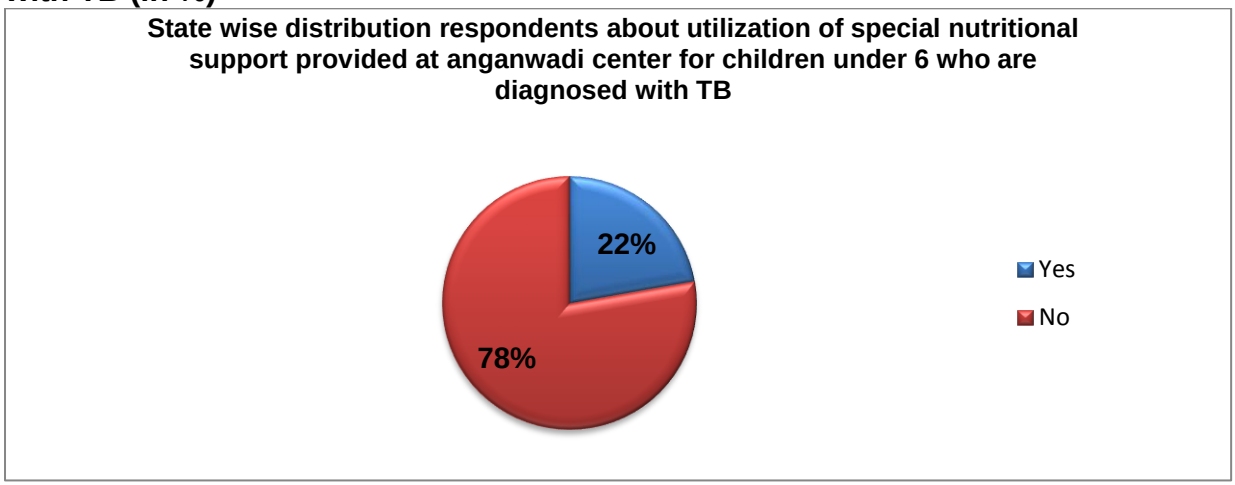


Table2.11: District wise percentage distribution of respondents according to the perception on sharing meals with TB infected person *vis. a vis.* baseline

District	Baseline			End line		
	Fear of sharing meal with a person having TB			Will never share meal with a person having TB		
	Agree	Neutral	Disagree	Agree	Neutral	Disagree
East Godavari	54%	15%	30%	78%	12%	10%
Krishna	63%	13%	24%	33%	14%	54%
Nellore	70%	7%	23%	45%	0%	55%
Prakasam	28%	37%	35%	43%	2%	55%
Srikakulum	55%	14%	32%	80%	16%	5%
Vishakhapatnam	54%	21%	21%	42%	3%	55%
Total	Not available			56%	9%	36%

Table2.12: District wise percentage distribution of respondents perception according to their willingness to work with TB infected person *vis. a vis.* baseline

District	Baseline		Endline		
	Willing to work with TB infected person		If one of your co-workers is infected with TB will you still work with him?		
	Yes	No	Yes	No	Don't know
East Godavari	57%	43%	56%	25%	19%
Krishna	57%	43%	78%	17%	5%
Nellore	83%	18%	100%	0%	0%
Prakasam	64%	35%	95%	1%	3%
Srikakulum	36%	64%	64%	31%	6%
Vishakhapatnam	33%	53%	96%	3%	1%
Total	Not available		78%	15%	7%

Table2.13: District wise percentage distribution of respondent's perception according to their willingness to work with PLHIV *vis. a vis.* baseline

District	You work with a PLHIV in your workplace			If one of your co-workers is infected with HIV will you still work with him?		
	Agree	Neutral	Disagree	Yes	No	Don't know
East Godavari	52%	15%	33%	70%	6%	23%
Krishna	60%	21%	19%	93%	5%	3%
Nellore	77%	13%	10%	100%	0%	0%
Prakasam	74%	14%	12%	95%	1%	3%
Srikakulum	36%	41%	23%	83%	8%	9%
Vishakhapatnam	57%	14%	29%	98%	1%	1%
Total	Not available			87%	4%	9%

Table2.14: District wise percentage distribution of respondents according to the awareness about health rights *vis a vis* baseline

Do you think access to health services is a right?				
	Baseline	Endline		
District	Total- Yes	Total-Yes	Male	Female
East Godavari	89%	99%	100%	98%
Krishna	45%	100%	100%	100%
Nellore	98%	100%	100%	100%
Prakasam	75%	100%	100%	100%
Srikakulum	85%	99%	100%	98%
Vishakhapatnam	69%	100%	100%	100%
Total	Not available	99.6%	100%	99.4%

Table2.15: District wise percentage distribution of respondents according to the awareness about TAP project- Endline

Have you heard of TAP project?			
District	Total-Yes	Male-Yes	Female-Yes
East Godavari	24%	47%	53%
Krishna	50%	22%	78%
Nellore	80%	49%	51%
Prakasam	88%	44%	56%
Srikakulum	41%	39%	61%
Vishakhapatnam	87%	51%	49%
Total	56%	43%	57%

Table2.16: District wise percentage distribution of respondents according to the participation in TAP IEC activities- Endline

Have you ever participated in any of the TAP IEC activities?			
District	Total-Yes	Male-Yes	Female-Yes
East Godavari	63%	55%	45%
Krishna	74%	18%	82%
Nellore	82%	43%	57%
Prakasam	80%	49%	51%
Srikakulum	73%	44%	56%
Vishakhapatnam	74%	51%	49%
Total	75%	44%	56%

Table2.17: District wise percentage distribution according to the respondents has come across any ORW /Volunteer of TAP- Endline

Did you come across any ORW /Volunteer of TAP?						
	Yes			No		
	Total	Male	Female	Total	Male	Female
East Godavari	41%	46%	37%	59%	54%	63%
Krishna	52%	41%	55%	48%	59%	45%
Nellore	80%	85%	75%	20%	15%	25%
Prakasam	90%	92%	88%	10%	8%	12%
Srikakulum	66%	65%	66%	34%	35%	34%
Vishakhapatnam	92%	93%	91%	8%	7%	9%
Total	66%	70%	64%	34%	30%	36%

Table2.18: District wise percentage distribution of respondents according to the awareness about X-ray camps conducted in their area- Endline

Any X-ray camps are conducted in your area?		
Districts	Yes	No
East Godavari	15%	85%
Krishna	24%	76%
Nellore	23%	77%
Prakasam	28%	72%
Srikakulum	13%	88%
Vishakhapatnam	8%	92%
Total	18%	82%

Table2.19: District wise percentage distribution of respondents according to the awareness about doctor /facility doing X-rays at reduced prices in their area- Endline

Do you know any doctor /facility in your area doing X-rays at reduced prices?		
Districts	Yes	No
East Godavari	14%	86%
Krishna	17%	83%
Nellore	14%	86%
Prakasam	24%	76%
Srikakulum	11%	89%
Vishakhapatnam	5%	95%
Total	14%	86%

Table2.20: District wise percentage distribution of respondents according to the awareness about the members who are collecting and transporting sputum- Endline

Do you know about the members who are collecting and transporting sputum		
Districts	**Yes**	**No**
East Godavari	35%	65%
Krishna	65%	35%
Nellore	75%	25%
Prakasam	88%	13%
Srikakulum	45%	55%
Vishakhapatnam	87%	13%
Total	62%	38%

Table2.21: District percentage distribution of respondents according to the awareness who has ever received any benefit from these groups- Endline

Have you ever received any benefit from these groups?		
Districts	**Yes**	**No**
East Godavari	35%	65%
Krishna	65%	35%
Nellore	75%	25%
Prakasam	88%	13%
Srikakulum	45%	55%
Vishakhapatnam	87%	13%
Total	62%	38%

3. MIS data

Table 3.1 : District wise distribution of patient referred , and dropout percentage vis a vis patient referred for sputum testing

TAP project reach from Sept 11 to Sept 2014 (Sputum testing)									
District	Referred			Tested			Drop out %		
	Male	Female	Total	Male	Female	Total	Male	Female	Total
Nellore	795	391	1186	659	300	959	17%	23%	19%
Prakasam	837	624	1461	764	556	1320	9%	11%	10%
Krishna	1456	966	2422	1445	941	2386	1%	3%	1%
East Godavari	2427	1719	4146	2146	1502	3648	12%	13%	12%
Visakhapatnam	1795	1208	3003	1645	1084	2729	8%	10%	9%
Srikakulum	1086	909	1995	1069	892	1961	2%	2%	2%
Total	8396	5817	14213	7728	5275	13003	8%	9%	9%

Figure 3.1: Depicting number of patient referred, tested and found Positive in Sputum testing

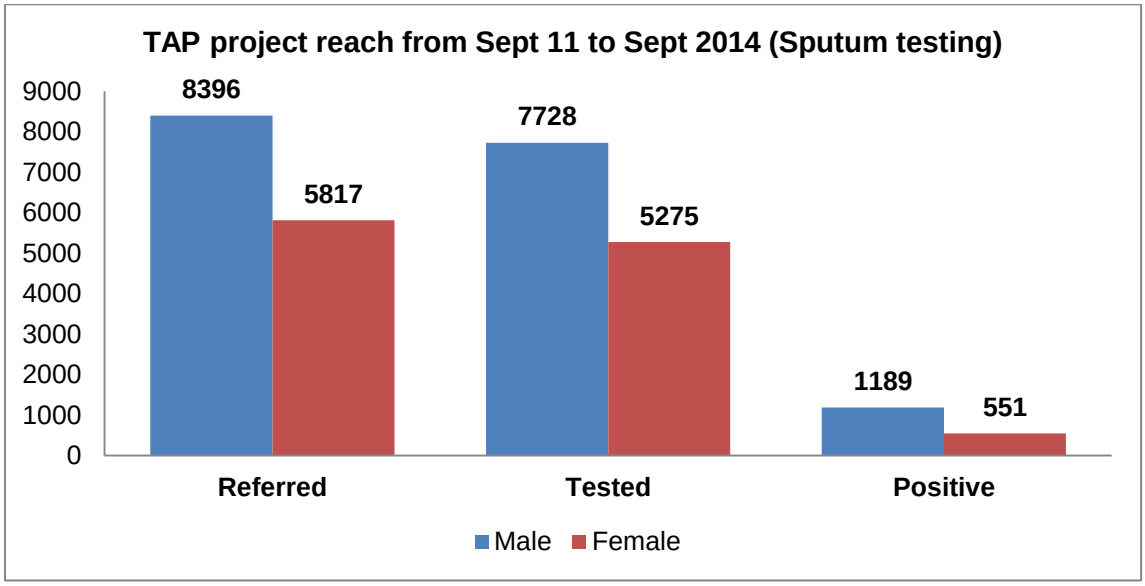


Table 3.2: District wise distribution of patient referred, and dropout percentage vis a vis patient referred for HIV testing

TAP project reach from Sept 11 to Sept 2014 (HIV testing)									
District	Referred			Tested			Drop out %		
	Male	Female	Total	Male	Female	Total	Male	Female	Total
Nellore	349	206	555	344	201	545	1%	2%	2%
Prakasam	536	889	1425	508	849	1357	5%	4%	5%
Krishna	1291	1682	2973	1289	1681	2970	0%	0%	0%
East Godavari	2542	3223	5765	2456	3127	5583	3%	3%	3%
Visakhapatnam	384	520	904	379	502	881	1%	3%	3%
Srikakulum	1208	1403	2611	1197	1400	2597	1%	0%	1%
Total	6310	7923	14233	6173	7760	13933	2%	2%	2%

Figure 3.2: Depicting number of patient referred, tested and found Positive for HIV testing

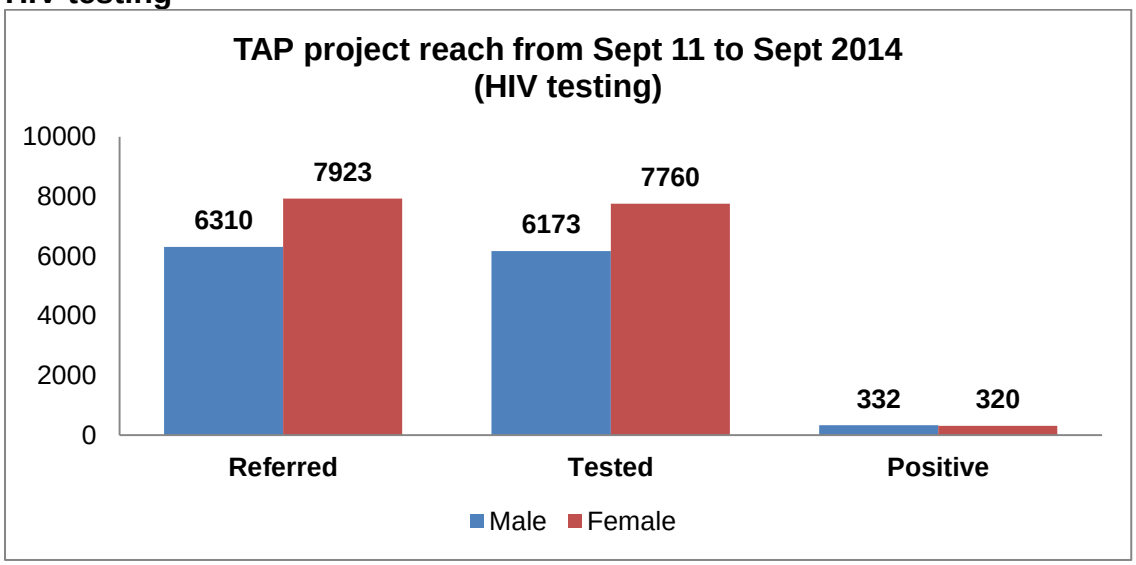


Table 3.3: District wise distribution of patient tested, and postive percentage vis a vis total patient tested for Sputum testing

TAP project reach from Sept 11 to Sept 2014 (Sputum testing)									
District	Tested			Positive			Positive %		
	Male	Female	Total	Male	Female	Total	Male	Female	Total
Nellore	659	300	959	105	34	139	16%	11%	14%
Prakasam	764	556	1320	131	39	170	17%	7%	13%
Krishna	1445	941	2386	223	87	310	15%	9%	13%
East Godavari	2146	1502	3648	370	194	564	17%	13%	15%
Visakhapatnam	1645	1084	2729	171	83	254	10%	8%	9%
Srikakulum	1069	892	1961	189	114	303	18%	13%	15%
Total	7728	5275	13003	1189	551	1740	15%	10%	13%

Table 3.4: District wise distribution of patient tested , and postive percentage vis a vis total patient tested for HIV testing

TAP project reach from Sept 11 to Sept 2014 (HIV testing)									
District	Tested			Positive			Positive %		
	Male	Female	Total	Male	Female	Total	Male	Female	Total
Nellore	344	201	545	32	23	55	9%	11%	10%
Prakasam	508	849	1357	44	36	80	9%	4%	6%
Krishna	1289	1681	2970	149	149	298	12%	9%	10%
East Godavari	2456	3127	5583	49	50	99	2%	2%	2%
Visakhapatnam	379	502	881	8	11	19	2%	2%	2%
Srikakulum	1197	1400	2597	50	51	101	4%	4%	4%
Total	6173	7760	13933	332	320	652	5%	4%	5%

4. Patient Satisfaction Survey Data (at DMC and ICTC centers)

Table4.1: State wise distribution of patient perception under various heads- Endline

Patient's perception about the facility			
	Good	Average	Poor
Cleanliness of the facility	85%	15%	0%
Condition of infrastructure	82%	18%	0%
Drinking water facility	82%	10%	8%
Cleanliness in toilets	75%	17%	8%
Waiting area/ room	66%	32%	2%
Privacy during the consultation / check-up	83%	17%	0%
Diagnostic facilities	78%	21%	0%
Lab services	79%	20%	0%
Ease of getting a referral when required	76%	24%	0%
Overall Service Satisfaction	70%	29%	1%

Table4.2: District wise distribution of patient perception on stigma / discrimination in health care settings *vis. a vis.* baseline

District	Baseline			Endline	
	Stigma in health care setting				
	Agree	Neutral	Disagree	Yes	No
East Godavari	57%	15%	28%	19%	81%
Krishna	61%	10%	24%	17%	83%
Nellore	64%	30%	8%	4%	96%
Prakasam	31%	53%	16%	15%	85%
Srikakulum	24%	20%	56%	5%	95%
Vishakhapatnam	24%	18%	34%	2%	98%
Total	Not available			12%	88%

Table4.3: District wise distribution of patient according to the status of being referred to VCT after TB testing and vice versa- Endline

Do the provider referred you to VCT(HIV testing) after TB testing		
District	Yes	No
East Godavari,	99%	1%
Krishna,	74%	26%
Nellore	95%	5%
Prakasam,	98%	3%
Srikakulum	95%	5%
Vishakhapatnam	90%	10%
Total	92%	8%

Do the provider referred you to TB testing after HIV testing		
District	Yes	No
East Godavari,	91%	9%
Krishna,	69%	31%
Nellore	95%	5%
Prakasam,	94%	6%
Srikakulum	89%	11%
Vishakhapatnam	55%	45%
Total	81%	19%

Annexure VI. Evaluators Profile

Snapshots of the Evaluation Team
Rajan Mahajan- MBA (Management systems and NGO appraisals) **Senior Consultant** Rajan has over 16 years of experience in health sector with expertise in NRHM and health planning, capacity development, program implementation, surveys and studies and monitoring. He has worked for various assignments and projects funded by International governments and development partners such as USAID, EU, GFATM, UNICEF, WHO, WB, and UNDP at various level. He has also represented MHIMC and shared fact sheet on situation analysis of Tuberculosis in U.P. in regional program launch workshop on Project- Akshya under GFATM- (The Global Fund to Fight AIDS, Tuberculosis & Malaria) round -9 in Dehradun (2010). He has previously served as the Executive Director of the Himachal Pradesh Voluntary Health Association of India and has led the Evidence based technical assistance project on strengthening New born care component in five districts of Uttar Pradesh under USAID supported Vistaar project.
Dr. Keerti Jain Gupta- BDS, MBA (Health system Research and Health Management) **Research Expert** Dr Keerti has expertise in project monitoring and evaluations, research and documentation. She was involved in data analysis and documentation of report for Baseline study on child labor issues for Plan India in A.P. and Karnataka and Evaluation of Red Ribbon Clubs program for Chandigarh State AIDS Control Program. She has conducted study on “Determinants that influence decision making power of women in health issue at house hold level” and “study on male partner involvement in ante natal care in Rajasthan” for UNICEF and has conducted training and provided handholding support to front line workers- e-ASHA.
Aravind Pulikkal- PhD, MBA (Health Policy, Planning and Management) **Senior Consultant** Aravind, a health system expert has over 26 years of working experience with national and international agencies and UN organizations and Government. He has been a Lead Consultant for several State Governments for planning Reproductive and Child Health Programs and the National Rural Health Mission (NRHM). At TRIOs, apart from managing the organization, he has led several assignments that include Principal Investigator for several State and National level research and evaluations, state wide capacity development programs, setting up and managing state level technical resource centers and program management and support units and decentralized program and project planning for various health and related development programs for Central and State Governments, UNFPA, UNICEF, World Bank, Clinton Foundation, Micronutrient Initiative, etc.
Dr. Rajni Kant Juyal- PhD, M.Sc. (Health Economics and Financing) **Senior Consultant** An expert in health economics with 35 years of experience in national and international organizations at various positions such as Expert Planning, PPP and Information System in World Bank Assisted Project; European Commission State Partnership Program with Chhattisgarh Government - GIS International Services; Sr. research positions with NIHFW, New Delhi; Advisor (Health Economics) to Government of Mauritius; Faculty IIHMR, Rajasthan. As Health Economist he has contributed to the National Plan, Development of Medium-term Action Plan for the Health Sector Reform which covered the entire health and hospital sector of Mauritius and schemes like health insurance, PPP, etc.

Snapshots of the Evaluation Team
Dr S K Mohanty- MD, DPH (Public Health) **Senior Consultant** Dr Mohanty is a medical professional with more than 36 years of experience that includes management of primary, secondary and tertiary health care services, and working with Government of India, state governments, local bodies, NGOs, autonomous social research organizations, Bilateral and UN agencies. He has worked with international governments and authorities/ development partners such as USAID, EU, GFATM, UNICEF, WHO, WB, ECHO and UNDP at various levels. He was the Country Director/ Country Health Director of Merlin in Afghanistan supporting international efforts in post war health sector rehabilitation. He was part of the Technical Advisory Committee (WHO/Merlin/UNICEF/ GoM)) to support Global Fund Malaria Projects in Myanmar. He has been a technical consultant to LFA of GFATM for PR assessment in round 9.
Bhavna Nahata - B Pharma, MBA (Health system Research and Health Management) **Research Expert** Ms Bhavna has experience of developing process documents for National and International level NGOs in relation to evaluation of infant and maternal death audits and for health, nutrition and water and sanitation projects. She has monitored and coordinated “Behavioural Change Communication Strategy for Enhancing the Demand of Zinc and ORS in the Management of Childhood Diarrhoea in Bihar” project Bihar, She has conducted an impact analysis of Mobile Health Units, functional in urban slums of South District of Delhi by using comparative approach between intervention and non-intervention clusters.

OUR VISION
IS THE CONTROL AND ULTIMATE ELIMINATION OF TB

OUR MISSION
IS TO INCREASE ACCESS TO EFFECTIVE TREATMENT FOR ALL

TB Alert is the UK's national tuberculosis charity. Our projects are in the UK, India and Africa, and we also work with international partners to tackle TB as a global issue.

Our activities focus on three main areas:

- Raising public and professional awareness about TB and providing support to patients during their treatment
- Bringing together statutory health services, voluntary organisations and people affected by TB to plan and deliver better TB services
- Developing policy and advocating for the resources to improve the care of patients and the prevention and control of TB

This work all supports our organisational mission of increasing access to effective treatment for all people affected by TB.

TB ALERT THE UK'S NATIONAL TUBERCULOSIS CHARITY

TB Alert
Community Base
113 Queens Road
Brighton, BN1 3XG

01273 234029
contact@tbalert.org

www.tbalert.org
www.thetruthabouttb.org
www.tbalertindia.org

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