

# **PROJECT MONITORING, EVALUATION, AND LEARNING PLAN FOR TUBERCULOSIS PROJECTS TEMPLATE AND GUIDANCE**



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## Abbreviations

ADS	Automated Directive System
AOR	Agreement Officer's Representative
CLA	collaborating, learning, and adapting
COR	Contracting Officer's Representative
DMP	data management plan
IP	implementing partner
PIRS	performance indicator reference sheet
M&E	monitoring and evaluation
MEL	monitoring, evaluation, and learning
PBMEF	Performance-Based Monitoring and Evaluation Framework
QASP	Quality Assurance and Surveillance Plan
SIRS	standard indicator reference sheet
TB	tuberculosis
USAID	United States Agency for International Development

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## Introduction

The template that follows provides guidance for the development of a project monitoring, evaluation, and learning (MEL) plan for United States Agency for International Development (USAID) implementing partners (IP) working in the field of tuberculosis (TB).

USAID requires that, “Activities must have an approved Activity MEL plan in place before major implementation actions begin” (Automated Directive System [ADS] 201.3.4.10)<sup>1</sup>. This template is designed to assist IPs receiving TB funding with complying with this requirement in a standardized format for TB projects. While USAID has developed general guidance on how to prepare and maintain a MEL plan (see [How-To Note: Activity Monitoring Evaluation and Learning Plan](#)), the purpose of this document is to provide more detail specific to projects with TB activities.

The MEL plan focuses on measuring whether a project is achieving programmatic results and generating learning to inform the adaptation of activities based on evidence. It is intended to demonstrate the attribution and contribution from USAID’s investments in health programming. The MEL plan should be based on the planned activities and goals of the project and updated annually to reflect learning and adaptive changes proposed in the work plan. The revised MEL plan and the project's annual work plan should be submitted together.

Since MEL plans are used by IPs to guide their activities and by USAID to manage projects and track their TB investments, it is important that these plans clearly detail how the IP will monitor program implementation and performance over the life span of the award.

## Audience

The primary audience for this guidance is IPs who are awarded USAID TB funds and are required to develop a MEL plan. Additional users include USAID Contracting Officer’s Representatives/Agreement Officer’s Representatives (CORs/AORs), activity managers, and monitoring and evaluation (M&E) specialists.

## How to Use This Template

This template is offered as a tool to ensure that TB performance indicators from the [Performance Based Monitoring and Evaluation Framework \(PBMEF\)](#) are incorporated into any MEL plan and that the plan meets the requirement that all USAID IPs receiving TB funds collect TB-specific essential indicators from the PBMEF. The guidance and tables in this template can help IPs align their MEL plans with the PBMEF and demonstrate how the PBMEF’s essential indicators are being tracked by the project.

While MEL plans are required for most projects (with rare exceptions, and only when approved by the Mission Director), use of this template is not required, nor is there any agency-wide required MEL plan structure or format.

However, according to the [Program Cycle Operational Policy](#) (ADS Chapter 201), a MEL plan must

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<sup>1</sup> “Activity,” in reference to Activity MEL Plans in the ADS, refers to the USAID-funded project.

include two elements:

1. A **monitoring plan**, including any monitoring processes or information systems, and at least one relevant performance indicator for each Project Level outcome, with baseline values (or plans for collecting a baseline) and annual targets.
2. A **stakeholder feedback plan** (as appropriate).

The ADS recommends that the following are addressed in MEL plans:

- Expectations for collaboration between IPs and any external evaluators of the project planned by the mission or USAID/Washington.
- Any proposed internal evaluations.
- Plans for monitoring context and emerging risks that could affect the project's intended results.
- Learning activities, including plans for capturing knowledge at the close-out of the project.
- Estimated resources for the MEL plan that are in the IP's budget.
- Roles and responsibilities for all proposed MEL actions.

In addition to what is required and recommended in the ADS, MEL plans should also include other core components such as indicator reference sheets and a results framework. When users complete their MEL plan, they should verify the following components are included:

✓	Summary background information including the project's goals and objectives
✓	Theory of change and project's results framework
✓	Monitoring plan specifying the monitoring process or information systems
✓	Indicator matrix summary with the indicators, definitions, numerators, denominators, data sources, disaggregations, etc.
✓	A table that maps project activities and interventions to specific PBMEF indicators
✓	Indicator reference sheets
✓	Expectations for collaboration between IPs and any external evaluators of the project planned by the Mission or USAID/Washington
✓	Proposed internal evaluations
✓	Context monitoring
✓	Collaborating, learning, and adapting approach
✓	Stakeholder feedback plan
✓	Resources
✓	Roles and responsibilities

USAID Missions and other operating units that choose to provide a standard MEL plan template to their IPs for TB related activities may use this template, adapt it, devise a standard template of their own, or leave the decision of how to structure and format the MEL plan to their IPs. IPs should consult with

their COR/AOR about specific requirements or recommendations for their project’s MEL plan.

The italicized text in each section provides guidance and recommendations for what to include in that section, including example tables.

- **Part 1** is the MEL plan template with instructions for each section. Hyperlinks to resources on specific elements of a MEL plan are included for additional information and learning.
- **Part 2** is an example of a completed sample MEL plan.
- **Part 3** is a blank template for IPs to draft their own MEL plans.

## Incorporating USAID’s Global TB Strategy Results Framework in MEL Plans

According to [USAID’s Global TB Strategy \(2023-2030\)](#), USAID strives to work with partners worldwide to reach every person with TB, cure those in need of treatment, and prevent new infections and progression to active TB disease. USAID aims to achieve these goals by meeting the targets in the results framework below:

Measurements	Targets for USAID Priority Countries
<b>Impact</b>	<ul style="list-style-type: none"> <li>• Reduce TB incidence rate by 35% by 2030</li> <li>• Reduce TB mortality rate by 52% by 2030</li> </ul>
<b>Outcome</b>	<ul style="list-style-type: none"> <li>• 90% of incident TB cases diagnosed and initiated on treatment</li> <li>• 90% of incident DR-TB cases diagnosed and initiated on treatment</li> <li>• 90% treatment success rate for DS-TB and DR-TB</li> <li>• Provide TB preventive treatment to 30,000,000</li> </ul>
<b>Process</b>	<ul style="list-style-type: none"> <li>• All priority countries rapidly introduce new TB tools and approaches</li> <li>• All priority countries have strong TB national networks and USAID partnerships inclusive of affected communities</li> <li>• All priority countries include appropriate TB interventions in pandemic preparedness plans</li> <li>• All priority countries have implemented plans to address socio-economic determinants and health-related risk factors that impact the TB epidemic</li> </ul>

This strategy—and the accompanying targets in the results framework—should guide USAID-funded TB activities. Therefore, it is important that IPs are familiar with this strategy and can demonstrate in their MEL plans how their project is contributing to reaching USAID’s 90-90-90+ prevention strategic results.

The PBMEF essential list of indicators, comprised of the Core, Core Plus, National Level, and Project Level indicators, are aligned with the TB strategy and are key to USAID’s efforts to ensure effective accountability of investments in TB at global, regional, and country levels. Missions and IPs should track their overall contribution to collective efforts to end TB. The MEL plan is the appropriate place for IPs to demonstrate how their project and TB activities are contributing to the essential list of indicators. For the full list of essential indicators and more guidance on using the [Interim PBMEF Compendium of Indicators](#) to help inform indicator selection, see the forthcoming PBMEF Guide.

## Part 1: MEL Plan Template with Instructions

### I. OVERVIEW

#### 1.1 TITLE PAGE

*Include a title page to your MEL plan with the information and branding presented in the template below.*

# [PROJECT TITLE]

## Monitoring, Evaluation, & Learning Plan

**Approved Date:** [e.g., April 2024]

**Version:** [1]

**Contract/Agreement Number:** [Insert number]

**Project Start and End Dates:** [e.g., January 1, 2024 to December 31, 2028]

**AOR/COR/Activity Manager Name & Office:** [Insert name, office]

**Submitted by:** [Insert name, position; name of prime implementing partner]

**Implementing Partners:** [Insert names of partner organizations]

#### DISCLAIMER

The author's views expressed in this publication do not necessarily reflect the views of the United States Agency for International Development or the United States Government.





## 1.2 LIST OF ABBREVIATIONS

Include an abbreviations section here. Do not title this as “Acronyms” since every acronym is an abbreviation, but not every abbreviation is an acronym. (Acronyms are abbreviations that are sounded out as a word: e.g., NATO or AIDS.) Here are some tips for creating an abbreviations list:

- Don’t use abbreviations that appear fewer than three times in the document; spell them out instead.
- Spell out all abbreviations on first mention then only use the abbreviation going forward.
- Create the abbreviations list as you go along and present the abbreviations in alphabetical order.
- When explaining generic terms such as SOW, write the words in lowercase, not with initial caps: e.g., scope of work.
- Use initial caps for proper names only: e.g., World Health Organization (WHO).
- Do a cross-check of the abbreviations on the list with those in the text after completing your document.

## 1.3 TABLE OF CONTENTS

Include a table of contents for your MEL plan, with a list of tables and figures.

# II. INTRODUCTION

This section introduces the MEL plan and provides relevant summary background information. It should include the following:

- The project’s goals and/or objectives along with its geographic focus and intended population
- A brief description of current and previous years’ work plan activities
- A brief introduction to the MEL plan, including its purpose and intended use
- A description of the structure of the plan
- The time period covered by the plan
- How and when the MEL plan will be updated as a “living document” (and a brief comparison with previous years’ MEL plans, where applicable)

## 2.1 PROJECT’S THEORY OF CHANGE

A theory of change describes how an intervention, or set of interventions, are expected to bring about change. This is described in more detail in this USAID blog post, [What is this thing called “Theory of Change”?](#).

In this section, provide the project’s theory of change, intermediate results, and how it will contribute to USAID’s TB targets, as specified in [USAID’s Global TB Strategy \(2023-2030\)](#). Insert a graphic of the project’s theory of change. For more guidance, see USAID’s [Theory of Change Workbook: A Step-by-Step Process for Developing or Strengthening Theories of Change](#). An editable example is provided in Part 2 of this document. You may also see [Theories of Change Samples](#) in USAID’s Learning Lab.

## 2.2 RESULTS FRAMEWORK

The results framework flows from the theory of change. It is a visual display of the different levels or

*sequential results expected from the interventions. Include a summary description of the project's results or logic framework along with a graphical depiction of the framework. Activities, performance indicators, assumptions, and learning questions may be added to the framework where relevant to make the connection between them and the MEL tasks. For guidance on results frameworks, see [USAID's Technical Note: Developing Results Frameworks](#). An editable example is also provided in Annex 1.*

*The project's objective and each result level must incorporate Core and other essential list performance indicators relevant to the scope of work. This is the basis for monitoring progress toward reaching targets and assessing project impact. The indicators should measure the intended results of the activity and how these results will be achieved. IPs can also include appropriate non-indicator measures/learning questions that correspond to a given result where the indicators aren't sufficient for measuring the result.*

*IPs may also want to include a table showing how the project's planned activities or interventions will contribute to reaching the targets set using the PBMEF's essential list of indicators (Core, Core Plus, National Level, and Project Level). A results framework should also clearly demonstrate how a project is contributing to the 90-90-90+ prevention strategic results. (Missions need to ensure that the 10 core indicators and other PBMEF indicators, as appropriate, are incorporated at the TB portfolio level).*

**Table 1. Mapping activities and interventions to the PBMEF indicators**

PBMEF Indicators			How the project activity or intervention will contribute to the respective indicator
Indicator	Indicator Tier*	Category†	
			a. b.
			a. b.

\*Core, Core Plus, National Level, Project Level, or Extended

† Reach, Cure, Prevent, Innovate, or Sustain

## 2.3 CRITICAL ASSUMPTIONS

*In this section, explain relevant critical assumptions and assess the risks to the success of the project. A risk factor or the uncertainty of a "critical assumption" is something that lies beyond the control of an IP or USAID. For example, conflict may make implementation in certain areas too dangerous and would be a risk factor. Conversely, a stable administrative context with the expectation of quick importation and clearance of equipment is an assumption that one would expect to affect timely implementation of the project. For each risk factor, explain how the risks will be assessed and addressed. Your assumptions may appear in your results or logic framework. You might also include contextual indicators to measure critical assumptions.*

## III. MONITORING PLAN<sup>2</sup>

*This central element specifies the project's monitoring approach, including monitoring processes and systems. It also includes relevant performance indicators of activity outputs and outcomes, their baselines values (or plan for collecting baseline), and targets.*

<sup>2</sup> A monitoring plan is required in every project's MEL plan per ADS 201.3.4.10.

While you are explaining your project's monitoring approach, describe how the MEL plan will be implemented. Describe your data collection instruments, data management information system, and data quality assurance.

This is an appropriate place to include a table mapping the relationship between the project's intermediate results and indicators. If one of the listed indicators is found in the PBMEF, specify which category of PBMEF indicators it is (e.g., Core, Core Plus, National Level, Project Level, or Extended) and the reference number.

### 3.1 PERFORMANCE MONITORING

Describe the efforts to monitor the project's performance. This should include clear and precise descriptions of the types of performance monitoring data and other quantitative and qualitative information that will be collected and used by the activity, including data and information sources, flows, storage and management, and verification/quality assurance from the data collection points/units to submission. For more information on selecting appropriate data collection methods and ensuring high-quality data collection, see USAID's Monitoring Toolkit document, [Data Collection Methods and Tools for Performance Monitoring](#).

Using Annex I as a reference, include a summary table of the project's relevant performance indicators with the information shown in Table 2. For guidance on planning and selecting baseline data, see USAID's [Performance Indicator Baselines](#) document, and for guidance on selecting performance indicators, see USAID's resource collection for [Selecting Performance Indicators](#).

**Table 2. Indicator summary table**

PBMEF reference	Indicator	Definition with numerator & denominator	Indicator source	Data source	Frequency	Unit of measure	Disaggregations	PPR (Y/N)	Baseline		Targets					
									Date	Value	Yr1	Yr 2	Yr 3	Yr 4	Yr 5	Life of project

**Every project that is receiving USAID TB funds—even if it is a relatively small amount in an integrated project—must include PBMEF indicators to demonstrate their contribution to the TB indicators.** To justify TB funding, partners should consider the entire list of essential indicators and select all indicators that are relevant to monitoring planned TB activities; this should include as many Core indicators as possible. For assistance with using the Interim PBMEF Compendium of Indicators, selecting TB indicators, and deciding which indicators can help measure the contribution of activities toward desired TB outcomes and which would measure attribution, see the PBMEF Guide. For assistance on how to select performance indicators see USAID's [TIPS: Selecting Performance Indicators](#).

An indicator reference sheet is a tool used by IPs to define indicators and provide other indicator data collection information for the purpose of ensuring consistency in data collection. **As required by USAID, all performance indicators require a performance indicator reference sheet (PIRS),** as specified in [ADS, Chapter 201](#):

*“A PIRS is required for all performance indicators that are included in a PMP or Activity MEL Plan... The PIRS must be complete and sufficient within three months of the start of*

*the collection of indicator data. When possible, a PIRS should be complete prior to data collection to ensure the clear definition of indicators and its data collection methodology.”*

*The USAID template for a PIRS can be found in Part 3, Annex 12.1.*

*Indicators in the PBMEF Indicator Compendium are presented as “standard” indicators and are intended to be used as such. Per [ADS, Chapter 201](#):*

*“...standard indicators are pre-defined, and each standard indicator has an associated reference sheet. The standard foreign assistance indicator reference sheet does not include all the ADS required fields of information. When standard indicators are used, all required reference information must be completed in the PIRS.”*

*A [completed standard indicator reference sheet \(SIRS\)](#) is provided in Part 2 and a [blank template](#) is provided in Part 3, Annex 12.2. Both the PIRS and the SIRS templates include the following fields:*

- *Indicator name*
- *Definition*
- *Numerator*
- *Denominator*
- *Unit of measure*
- *Data type*
- *Possible disaggregations*

***The language for these common fields should match exactly in the PIRS and SIRS; numerator and denominator definitions should be included in the PIRS field “Precise definition.”***

*The PBMEF Guide provides guidance on how to develop a SIRS. Your MEL plan should include an annex with the SIRS for the performance indicators listed in your indicator summary table. Mission M&E staff can also be consulted for guidance on developing indicator reference sheets.*

*SIRS have already been developed for all PBMEF Core, Core Plus, National Level, and Project Level indicators and can be accessed in the PBMEF Compendium of Indicators. These SIRS should be utilized without modification in the interest of standardizing data collection across all projects tracking common outcomes. This is important as it allows for comparison and aggregation of data across projects and standard progress monitoring against global benchmarks and performance.*

*USAID requires that performance indicators must be disaggregated by sex when measuring person-level data (ADS 201.3.5.6 and ADS 205.3.6). ADS 201 recommends that indicator data be disaggregated by a geographical level that is feasible and useful for management purposes. Often this is to the first administrative level at a minimum. IPs should consider including other relevant indicator disaggregations to assist with data analysis, such as age. For more guidance on indicator disaggregations, see [ADS 201 Additional Help: Disaggregating Monitoring Indicators](#).*

*Note that an indicator summary table does not fulfill the requirement for having a completed PIRS. It also is not the same as an indicator-tracking table or an information system used for storing actual indicator data.*

***For the core indicators included in a project’s MEL plan, IPs should report on both National and Project Level data. This allows IPs to demonstrate the project’s contribution to National Level targets. National Level baselines and targets may be found in global reports.***

### 3.2 CONTEXT MONITORING<sup>3</sup>

Context or “situation monitoring” tracks the overall setting in which the project operates. It takes into consideration the conditions and external factors relevant to the implementation and performance of a strategy, a project, or activities.

Describe any efforts for monitoring risks or unexpected situations that may arise during the project cycle and possibly affect how the project will achieve results. Context-specific areas that IPs may want to address in their MEL plans may be related to poverty and equity considerations, the political situation in the intervention country/countries, environmental risks, or a public health crisis, for example.

For more guidance on context monitoring, see USAID’s [The 5Rs Framework in the Program Cycle](#) technical note.

## IV. DATA COLLECTION

This is where you will detail your data collection processes. Relevant details about types of data collection issues such as sampling, tool design, use of sub-contractors and project staff for data collection, etc. would go in this section.

1. Specify who will be generating the data (e.g., nurse, pharmacist, records clerk, community activist).
2. Specify how the data will be collected. Describe the data collection tool (e.g., health facility register), type of data to be collected, how the data will be captured (e.g., electronic database), and if it is primary or secondary data. See Table 3 for an example of how to present your data collection plan.
3. State how frequently the data will be collected. Please note that projects receiving USAID-TB funding must report annually on the relevant Core indicators at the National Level, in addition to the regular reporting at the Project Level.
4. Indicate who will be responsible for collating the data that’s been collected (e.g., MEL manager, technical specialist, others), managing the data, and producing which reports.

**Table 3. Data collection table**

Data generator	Data collection tool	Type of data collected	Data capture system	Data source	Frequency
Training facilitator	Training sign-in sheet	Name, sex, email, and affiliation of training participants	Paper-based	Primary	Every training
Facility nurse	Health facility TB register	Patient ID number, type of service rendered, treatment management & treatment outcomes	Electronic summary report	Primary	Monthly

### 4.1 DATA ANALYSIS

This section should include a basic description of how the collected data will be analyzed. At a minimum, the data should be compared to the targets identified in the indicator summary table. Likewise, data from the Core indicators included in a project’s MEL plan should be compared to National Level targets

<sup>3</sup> It is recommended that MEL plans include a section on context monitoring, per ADS 201.

to allow IPs to demonstrate the project's contribution to them. (National Level baselines and targets may be found in global reports.) If you will conduct cascade analyses, as explained in the PBMEF Guide, state that here along with other ways the data will be analyzed for programmatic M&E.

## V. DATA MANAGEMENT AND QUALITY ASSURANCE

All projects that require a MEL plan also require a data management plan (DMP [ADS Chapter 579]). The DMP guides the identification of anticipated data assets and outlines tasks needed to manage these assets across a full data lifecycle. The DMP may be developed and approved as a part of the MEL plan (i.e., included as this section of the MEL plan) or as a separate plan.

Explain how data will be managed at all stages. This includes data collection, quality assurance, repository, security, analysis, sharing, and use. If several organizations are jointly managing the project or involved in data collection, address how data will be consistently handled across partners to ensure a high quality of aggregated data. For more information about DMPs, see [ADS Chapter 579: USAID Development Data](#).

Describe the formats in which data will be stored and shared. This includes file types (e.g., Microsoft Word, Excel, paper copies), larger storage units (e.g., a private server, a cloud-based system, file cabinets), and processes for sharing knowledge internally and externally. Also explain how the data will be stored securely. Data security protocols for every project should meet a basic threshold of restricting access to key offices and workspaces, preventing unauthorized computer access, and safeguarding data during both storage and transfer. Personally identifiable information must be especially protected. For more information, see the USAID Monitoring Toolkit [Data Security Guidance](#).

Government contractors are required to submit a Quality Assurance and Surveillance Plan (QASP). It is used to ensure that the contractor is complying with the technical requirements in the contract relating to the quality of the services provided, the contract clauses about the inspection of services to be performed, and other quality controls incumbent on the contractor. A QASP is only required for contracts that use performance-based acquisition methods. These are contracts based on a Performance Work Statement or Statement of Objectives. For contracts that require both a MEL Plan and a QASP, the QASP may be developed and approved as part of this section of the MEL plan or as a separate plan. If you are looking for an example of a completed QASP, there are several examples online of QASPs for past USAID-funded projects such as [here](#) and [here](#).

## VI. M&E OF GENDER

According to [ADS Chapter 205: Integrating Gender Equality and Female Empowerment in USAID's Program Cycle](#), USAID has a requirement that holds IPs "responsible for complying with obligations under the contract or agreement to integrate gender in programming, which may include developing gender-sensitive indicators that measure specific gender-related goals for each project and/or activity, where relevant." Explain how your M&E activities can help determine whether your TB activities promote gender equity or may exacerbate gender inequalities. Describe how gender is being addressed under the project's intermediate results and associated strategic approaches. Specify if you will be tracking gender aspects by incorporating sex- and age-disaggregation in your data collection, analysis, and reporting. (This would be related to any indicators for person-level data.)

Describe, through the indicators you've selected and your expected results, where you are attempting to achieve certain outcomes related to specific gender groups. For instance, by wording an indicator



*“number of new female community activists” instead of “number of new community activists, by sex,” it highlights that the project is trying to engage more women in community activism.*

## VII. EVALUATION PLAN

*IPs are encouraged to consult USAID’s [ADS 201.3.6.5](#) to verify when an evaluation is required. In this section, describe the overall plan for evaluation through the life of the project. Per ADS 201, it is recommended that MEL plans include expectations for collaboration with any of the project’s external evaluations planned by the Mission or Washington and any proposed internal or external evaluations.*

*Internal evaluations are either commissioned by USAID in which the evaluation team leader is USAID staff or conducted or commissioned by an IP—or consortium of IP and evaluator—concerning their project.*

*An external evaluation is one in which USAID, not the IP, has commissioned a third party to implement an evaluation. External evaluations may include a USAID staff member, but the evaluation team leader must be from outside USAID. An evaluation with a team lead from USAID/Washington or an evaluation contracted through an IP subcontract is not an external evaluation.*

*For more information about internal and external evaluations and what purpose they serve, see USAID’s Evaluation Toolkit resource, [Choosing between a USAID External or Internal Evaluation](#).*

### 7.1 INTERNAL EVALUATION PLAN

*Provide information for each intended evaluation expected over the lifetime of the project. A sample template is shown below.*

**Table 4. Internal evaluation plan table**

<b>Evaluation Type</b>	
<b>Purpose and Expected Use</b>	
<b>Possible Evaluation Questions</b>	
<b>Estimated Budget</b>	
<b>Start Date</b>	
<b>End Date</b>	

### 7.2 PLANS FOR COLLABORATING WITH EXTERNAL EVALUATORS

*If USAID is planning to conduct an external evaluation of this project, describe how the project will collaborate with USAID’s external evaluation team.*

## VIII. COLLABORATING, LEARNING, AND ADAPTING (CLA) APPROACH<sup>4</sup>

*Include the project’s learning priorities and how the project will communicate its achievements and learning to project staff, USAID, local partners, and other stakeholders. In developing the CLA approach, identify and describe the following:*

<sup>4</sup> It is recommended that MEL plans include learning activities, including plans for knowledge capture at the project’s close out, per ADS 201.

- *Learning objective*
- *Strategic opportunities to “pause and reflect” and coordinate and collaborate with stakeholders*
- *Approaches for regular learning to address the identified learning objectives*
- *Plans for documenting the knowledge, learning from these opportunities, and disseminating findings*
- *Resources (financial and human resources as well as tools) needed to implement learning approaches*
- *Approaches to adapting or adjusting implementation and programming because of this learning*

*Include learning questions related to the results framework or knowledge gaps and your plans to address them. Describe plans for strategic collaboration with other projects or stakeholders, reflection opportunities, how you will use new knowledge and learning for adaptations, and plans for knowledge capture at closeout.*

*To learn more about CLA and access tools and resources to help you integrate CLA into your work, see USAID’s [CLA Toolkit](#).*

## **IX. STAKEHOLDER FEEDBACK PLAN<sup>5</sup>**

*In this section, determine whether collecting stakeholder feedback is appropriate for the project. If so, include the following:*

1. *Procedures for collecting feedback: Describe the project’s approach for collecting feedback from stakeholders of different interventions. If different interventions need different procedures, please be explicit about each of them.*
2. *Procedures for responding to feedback: Describe the procedures for responding to feedback from stakeholders.*
3. *Reporting to USAID: Describe the procedures for reporting feedback to USAID. This should include how and when a summary of the feedback information will be reported to USAID. This should also include how any actions taken in response to the beneficiary feedback will be reported to USAID (e.g., as a part of quarterly or annual reporting).*

*If a feedback plan is not appropriate for the project, provide a written explanation for why not.*

## **X. RESOURCES<sup>6</sup>**

*Specify the budget allocated to MEL activities by listing the tasks, estimated costs, and proportion of the budget for MEL.*

## **XI. ROLES, RESPONSIBILITIES, AND SCHEDULES<sup>7</sup>**

*Describe the general and individual roles and responsibilities of key IP staff for M&E and CLA tasks and*

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<sup>5</sup> MEL plans must include, as appropriate, a feedback plan per ADS 201.3.4.9.

<sup>6</sup> It is recommended that MEL plans include estimated resources for the MEL activities that are a part of the IP’s budget, per ADS 201.

<sup>7</sup> It is recommended that MEL plans include roles and responsibilities for all proposed MEL actions, per ADS 201.



*approaches. Identify which staff/position(s) has what type/level of responsibilities for MEL at different implementation levels and their competencies.*

### 11.1 SCHEDULE OF PROJECT MEL PLAN TASKS

*Provide a schedule of recurring tasks related to M&E, CLA, or other planned learning efforts during the project; how frequently the task will be performed; and the team or individuals who are responsible for them. Relevant details about types of data collection plans such as sampling, tool design, use of sub-contractors and project staff for data collection, etc. would go here. For this task, IPs often find gantt charts helpful.*

**Table 5. Schedule of recurring tasks**

Tasks	Y1	Y2	Y3	Y4	Y5

### 11.2 SCHEDULE OF MEL PLAN DELIVERABLES TO USAID

*List the various M&E, CLA, or other learning deliverables for the project (including ad hoc and recurring reports) that will be provided to USAID. If the project will conduct an internal evaluation, include the evaluation report here.*

**Table 6. Schedule of MEL plan deliverables to USAID**

Deliverable	Reporting Frequency	Description of Content

## XII. CHANGE LOG

*Since the MEL plan is a living document, it is meant to evolve to ensure that the project can effectively monitor progress toward achieving IRs and identify successes. Explain how the MEL plan will be updated to reflect changes in activities, indicators, or targets to reflect USAID priorities. The change log example below is useful for describing changes that are made to the MEL plan over time.*

**Table 7. Change log**

Date	MEL Plan Section	Summary of Change	Rationale for Change and Any Notes
<i>Effective date of change</i>	<i>Specify what element(s) in the MEL plan were changed</i>	<i>Summarize what was changed</i>	<i>Provide a reason for the change(s)</i>

## ANNEX I: INDICATOR SUMMARY TABLE

*Indicators reflect the intended goals and objectives of a program, allowing managers to measure distinct progress toward benchmarks and targets and identify where gaps in improvement exist. Indicators can be selected at various levels: input, process, output, outcome, and impact. For more information about these levels, see the PBMEF Guide.*

*A performance indicator is a specific measure of performance that an M&E system routinely tracks over time. They are the basis for observing progress and measuring actual results compared to expected results. Performance indicators must be included in your MEL plan.*

*IPs should carefully select as many indicators as necessary to ensure that progress toward expected results is sufficiently tracked, while also being cost-effective and efficient by eliminating redundant or unnecessary indicators. Project staff should select indicators in the following order:*

- 1) *The first priority should be identifying which relevant [PBMEF](#) indicators the project activities will report against.*
- 2) *Once the appropriate PBMEF indicators have been selected, consider existing indicators that have been standardized, vetted, and field-tested. Some sources for other high-quality TB performance indicators are as follows:*
  - [WHO TB data](#)
  - [Stop TB Partnership governance of TB reports](#)
  - [Global Fund TB indicators](#)
- 3) *The last priority would be developing custom (i.e., project-specific) indicators if the indicators needed do not exist in the above sources.*

*For more information about selecting performance indicators, see USAID's [Selecting Performance Indicators](#) tool.*

*Specific indicators for TB-related activities are shown in the Example Indicator Summary Table below. These indicators may be adapted to include other information based on what is most relevant to the needs of the project's IP or USAID Operating Unit. For another example of an indicator summary table, see USAID's [Performance Indicator Summary Table](#) template.*

*If further support is needed in selecting appropriate indicators, please refer to the PBMEF Guide. You may also reach out to your USAID Mission contact or USAID/Washington TB backstop.*

### **Instructions**

1. **Indicator:** State the name and unique identifier for the indicator that will measure the expected result listed in the next column.
2. **Desired Result Measured by Indicator:** State the result statement and the unique identifier for the expected result in the theory of change that the indicator intends to measure.
3. **Indicator Source:** State whether the indicator is from the PBMEF, another source (e.g., Global Fund, Stop TB Partnership), or is a custom indicator outside of the list of PBMEF indicators.
4. **Data Source:** State the source of the data or planned source of the data.
5. **Frequency:** State how often the data are reported to USAID.
6. **Unit of Measure:** State the unit of measure (e.g., number of cases, percent of contacts).

7. **Disaggregations:** State how the data will be potentially disaggregated (e.g., age, sex, subnational). If you are measuring person-level data, the indicator must be disaggregated by sex.
8. **Performance Plan and Report (PPR):** State “Y” if this indicator is included in the PPR or “N” if this indicator is not included in the PPR. (Note: The TB Core indicators are the required TB PPR indicators. It is therefore imperative that all Core indicators as described in the PBMEF handbook should be covered at the TB portfolio level at both the National and Project Level.)
9. **Baseline Date:** State the month and year (mm/yy) when the baseline data were collected. If a baseline is still planned, state the month and year when the baseline is planned to be collected.
10. **Baseline Value:** State the value of the indicator at “baseline,” i.e., before major implementation actions of the planned USAID-supported project. Enter “TBD” (to be determined) if the baseline has not yet been collected.
11. **Target Dates:** State the target dates, with an end-of-project value. Based on the selected indicators and project activities, these may be adjusted to align with the reporting frequency of the indicator, such as monthly, quarterly, yearly, or some other relevant milestone date.
12. **Target Value:** State the estimated value of the indicator expected on the target dates.

The performance indicator table should be updated by the IP M&E team as indicator information changes. This table should be provided to USAID as part of the quarterly and annual reports. The table should be organized in a way that clearly lists the indicators under the corresponding result from the activity’s logic model or results framework. USAID-required indicators should be clearly identified. The table should also include the following:

- Most recent indicator data available for the time period
- All required disaggregations
- Quarterly data and cumulative data
- Numerators and denominators for percentages (eventually, as reporting progresses past baseline)

**Table 8. Example of entries in an indicator summary table**

PBMEF reference	Indicator	Definition	Indicator source	Data source	Frequency	Disaggregations	PPR Y/N	Baseline		Targets					
								Date	Value	Year 1	Y2	Y3	Y4	Y5	Life of project
DS-TSR	DS-TB treatment success rate	<p>% of people with new and relapse DS-TB (bacteriologically confirmed or clinically diagnosed, pulmonary, or extrapulmonary) who were notified in a specified period that were cured or treatment completed, among the total people with new and relapse TB who were initiated on treatment during the same reporting period (excluding those moved to the RR-TB treatment cohort).</p> <p><u>Numerator:</u> # of people with new and relapse DS-TB (bacteriologically confirmed or clinically diagnosed, pulmonary or extrapulmonary), who were registered in a specified period that were cured or treatment completed.</p> <p><u>Denominator:</u> # of people with new and relapse DS-TB (bacteriologically confirmed or clinically diagnosed, pulmonary or extrapulmonary), who initiated treatment in the same period.</p>	PBMEF: Core	Health facility records	Annually	Age, sex, region	Y	2022	85%	85%	87%	88%	89%	90%	90%
									210	210	209	207	204	202	202
									247	247	240	235	229	224	224
TPT_PL HIV_E NROLL	Number of TPT initiations among PLHIV	Number of PLHIV who were started on TPT during the reporting period.	PBMEF: National Level	TB or HIV registers, TPT register, or electronic management systems	Annually	Age, sex, region	N	2022	25	30	40	60	75	95	300
TPT_C OMPL	TPT completions	Number of contacts or other eligible people who completed TPT during the reporting period.	PBMEF: Core Plus	TB or HIV registers, TPT register, or electronic management systems	Annually	Age (0–4, 5–14, 15+), sex, risk group (contacts, PLHIV)	N	2022	72	76	80	88	98	115	457

## PROJECT MEL PLAN TEMPLATE

TPT_C ON_EN ROLL	TPT initiations among contacts	Number of household contacts and other close contacts of people with bacteriologically confirmed, notified pulmonary TB who initiated TPT during the reporting period. This indicator is a subset of the core indicator "TPT initiations."	PBMEF: Core Plus	Health facility records	Annually	Age (0–4, 5– 14, 15+), sex, public vs private, region	N	2022	105	120	130	140	150	160	700
PLHIV_ TSR	Treatment success rate among PLHIV	% of PLHIV with new and relapse TB among PLHIV (bacteriologically confirmed or clinically diagnosed, pulmonary or extrapulmonary) who were notified in a specified period that were cured or treatment completed, among the total number of people with new and relapse TB (bacteriologically confirmed or clinically diagnosed, pulmonary or extrapulmonary) who were initiated on treatment during the same reporting period (excluding those moved to RR- TB treatment cohort).  <u>Numerator:</u> # of PLHIV with new and relapse TB who were registered in a specified period that were cured or treatment completed.  <u>Denominator:</u> # of PLHIV with new and relapse who initiated treatment in the same period	PBMEF: National Level	Health facility records	Annually	Age (<15, 15+), sex, region	N	2022	64%	65%	66%	67%	68%	70%	70%
									9.6	9.8	10	10.7	11	12	12
									15	15	15	16	16	17	17
N/A	ARV medicine stockouts	% of treatment sites that had a stock-out of one or more required antiretroviral medicines during a defined period  <u>Numerator:</u> # of health facilities dispensing ARV medicines that experienced a stock-out of one or more required ARV medicines during a defined period  <u>Denominator:</u> Total number of health facilities dispensing ARV medicines during the same period	UNAIDS indicator registry	Health facility records	Quarterly	Region, type of treatment site (public or private)	N	2022	12%	11%	10%	9%	7%	5%	5%
									14	13	12	10	8	6	6
									116	116	116	116	116	116	116
N/A	Number of	# of people reached by a	Custom	Project	Quarterly	Type of	N	2022	N/A	200	400	400	400	100	1500

PROJECT MEL PLAN TEMPLATE

	<i>individuals reached through outreach with information about TB testing services</i>	<i>community outreach worker (e.g., community health worker, nurse, project outreach staff) with information about TB and TB services. "Reached" refers to formal interactions, such as in-person sessions for the purpose of providing information on TB and availability of TB testing services</i>		<i>records</i>		<i>community outreach</i>									
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## Part 2: Sample MEL Plan

*This is a simplified example of a good MEL plan for a fictitious TB project (DETIZA) in a fake country (Zaccosa). IPs are encouraged to refer to this illustrative example when developing their own MEL plans.*

# Decreasing Tuberculosis in Zaccosa (DETIZA) Monitoring, Evaluation, & Learning Plan

**Approved Date:** November 2023

**Version:** 1

**Contract/Agreement Number:** 123456789

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**AOR/COR/Activity Manager Name & Office:** Mary Phili, USAID/Zaccosa

**Submitted by:** George Ukello, Chief of Party; Healthy Families & Healthy Country (HFHC)/ Zaccosa

**Implementing Partners:** HFHC/Zaccosa, Kalami International, The Southern African Development Group (SADG), and TB Care for Everyone (TCE)

### DISCLAIMER

The author's views expressed in this publication do not necessarily reflect the views of the United States Agency for International Development or the United States Government.



## Abbreviations

AOR	Agreement Officer Representative
CB-DOT	community-based direct observed (TB) treatment
CCR	Consultation for Children-at-Risk
CHW	community health worker
CLA	collaborating, learning, and adapting
DETIZA	Decreasing Tuberculosis in Zaccosa
DR	drug-resistant
DS	drug-sensitive
FAST	finding actively, separate, and treat
GOZ	Government of Zaccosa
HCW	healthcare worker
HFHC	Healthy Families and Healthy Country
IP	implementing partner
IR	intermediate result
LTFU	lost-to-follow-up
LPA	line probe assay
MDR	multi drug-resistant
M&E	monitoring and evaluation
MEL	monitoring, evaluation, and learning
MIS	management information system
NTP	National TB Program
PBMEF	Performance-Based Monitoring and Evaluation Framework
PPM	public-private mix
RR	rifampicin-resistant
STR	short-term regimen
TA	technical assistance
TB	tuberculosis
TPT	tuberculosis preventive treatment
USAID	United States Agency for International Development
WHO	World Health Organization
XDR	extensively drug-resistant



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# Introduction

## PROJECT OVERVIEW

The Decreasing Tuberculosis in Zaccosa (DETIZA) project is supporting the Government of Zaccosa's (GOZ) efforts to reduce the burden of tuberculosis (TB). DETIZA was developed in consultation with Zaccosa's National TB Program (NTP) and key country stakeholders. The project is implementing interventions at multiple levels in line with the strategies laid down in the country's National Strategic Plan (2020 to 2030). The planned activities are aligned with existing operational plans and guidelines from the NTP and Ministry of Health.

The project is being implemented in the primary hotspots for TB notification in Zaccosa: Cosaville, Western, and Central Provinces.

DETIZA is expected to contribute to USAID/Zaccosa's Development Objective 2: "Increased Capacity of Zaccosa's Government, Citizens, and Private Sector to Improve Health Outcomes and Meet Critical Needs of Vulnerable Populations", as laid out in the USAID/Zaccosa Country Development Cooperation Strategy. In particular, it will contribute to intermediate result (IR) 3.1: "Utilization of quality health, water, and sanitation services and prevention practices increased."

## MONITORING, EVALUATION, AND LEARNING (MEL) PLAN OVERVIEW

The purpose of this MEL Plan is to describe how Healthy Families and Healthy Country (HFHC) will monitor, evaluate, and learn from collected data to manage DETIZA. This plan presents both indicators from the Performance-Based Monitoring and Evaluation Framework (PBMEF) and other indicators, the data needed to assess achievement of each of the core expected results of the project, and evaluation and other learning data required to understand key elements of the project's theory of change. It also describes the processes HFHC will use to implement MEL throughout the life of the project to inform effective adaptive management required to achieve the desired results.

This MEL plan has been organized around the key learning objectives identified by core activity stakeholders. It has the following objectives:

- Enable the project to monitor and evaluate progress on the pathway to achieving DETIZA's IRs and the overall project objective.
- Allow for monitoring of work being implemented in accordance with approved work plans.
- Enable the project to learn from its implementation and make midcourse adjustments to improve the effectiveness of its activities.
- Provide USAID with adequate information for project management and planning.

The MEL plan is a living document that may be updated throughout the project's implementation to reflect accomplishments funded under DETIZA and changes in USAID's priorities. DETIZA will work closely with the USAID Agreement Officer Representative (AOR) to review and update this MEL plan regularly and will use the plan as the foundation for monitoring and reporting to USAID.

## PROJECT GOAL AND OBJECTIVES

The overall goal of DETIZA is to reduce the burden of TB and drug-resistant (DR)-TB in the country. The objectives of the project are as follows:

1. Local TB service delivery platforms strengthened to increase TB case detection and notification.
2. Quality of patient-centered care improved for optimal TB diagnosis and treatment.
3. Public-private mix (PPM) approach introduced and scaled up.

4. Critical evidence generated to inform continuous learning and performance improvements.
5. Partners and resources leveraged at district, provincial, and national levels to amplify impact and achieve sustainability.

### PROJECT INTERMEDIATE RESULTS

The project has defined four intermediate results (IRs) with sub-IRs, as follows:

**IR 1: Improved Active Case Detection**

IR 1.1: Increased Community-Based Screening, Referral, and Linkage to Care

IR: 1.2: Improved TB Diagnosis Network

**IR 2: Improved Quality of Care for TB and DR-TB Cases**

IR 2.1: Improved Capacity of Health Care Workers to Provide TB Services

IR 2.2: Increased Used of Integrated Patient-Centered Treatment Models

IR 2.3: Expanded Interventions to Engage the Private Sector

**IR 3: Improved Surveillance Platform and Programmatic Response to TB and DR-TB**

IR 3.1: Increased Access to High-Quality DR-TB Surveillance and Program Data

IR 3.2: Improved Use of Surveillance Data to Inform Programmatic Response to TB and DR-TB

**IR 4: Improved Capacity of Local Entities to Implement the TB National Strategic Plan**

IR 4.1: Strengthened Technical Capacity of Entities to Deliver Services

IR 4.2: Improved Organizational Management, Governance, and Leadership Capacity of Local Entities

### THEORY OF CHANGE

TB is one of the major causes of morbidity in Zaccosa and one of the country's top 10 causes of mortality (USAID/Zaccosa TB Roadmap, 2021). According to the Global TB Report 2021, Zaccosa is listed in each of the three global groups of high burden countries, i.e., for TB, TB/HIV and multidrug-resistant (MDR)/rifampicin-resistant (RR)-TB. With an estimated burden of 335 TB cases per 100,000 in 2020, the World Health Organization (WHO) ranked Zaccosa 19th among the 30 high-burden TB countries.

Key challenges for the NTP in implementing their TB strategy at the community and facility level include:

- A case detection gap with low diagnosis and notification of TB to the NTP
- Treatment success rate likely lower than what is reported to the NTP
- Low diagnosis of DR-TB and drug-sensitive (DS)-TB
- High lost-to-follow up (LTFU) and TB-related mortality, especially among DR-TB and co-infected TB/HIV patients, due to difficulties accessing diagnostics and completing treatment
- Suboptimal diagnostic networks and treatment support for patients with DR-TB, resulting in poor treatment success rates
- Poor access to health facilities for diagnosis and treatment
- Limited involvement of civil society organizations and the private sector in the TB response

DETIZA's theory of change to address TB is centered on cross-sectoral change to address root causes and critical barriers to eliminating TB by creating a sustainable ecosystem of strengths and opportunities. Evidence-driven solutions within USAID's TB technical areas (reach, cure, prevent, and sustain) will lead to resilient and vibrant communities free of TB. This project will build on the existing strengths of the NTP to accomplish lasting change through proven approaches to stop spreading the disease, including activities to interrupt TB transmission in communities, scaling up preventive interventions, increasing TB case finding and notifications, and ensuring all people with TB complete treatment. These interventions will be underpinned by a strengthened and more resilient health system to address the main drivers of the TB epidemic in the country.

If TB case notification, curative and preventive treatment initiation, and completion rates increase,

accompanied by systems strengthening to sustainably increase the quality of TB service delivery, then the project will contribute to achieving the national targets, reducing the burden of TB in Zaccosa, and maintaining the quality of TB service delivery at all levels.

To support the NTP to increase TB notifications, treatment success, and TB preventive treatment (TPT) initiation and completion, DETIZA will strengthen collaboration and coordination with the NTP and key partners at all levels to find missing people with TB both at health facilities and in the community. DETIZA will implement approaches like house-to-house visits, contact screening, monthly cough days/mobile clinics (at the community level with participation of healthcare workers and activists), and the FAST (finding actively, separate, and treat) approach at the health facilities, to be implemented by the health facilities' auxiliary staff, DETIZA case manager, and selected trained activists. DETIZA will support the TB diagnostic networks through targeted technical assistance (TA) to improve especially bacteriologically confirmed-TB and DR-TB diagnoses. DETIZA will continue to support TB screening in high-risk groups, particularly the prison population. Figure 1 illustrates DETIZA's theory of change.

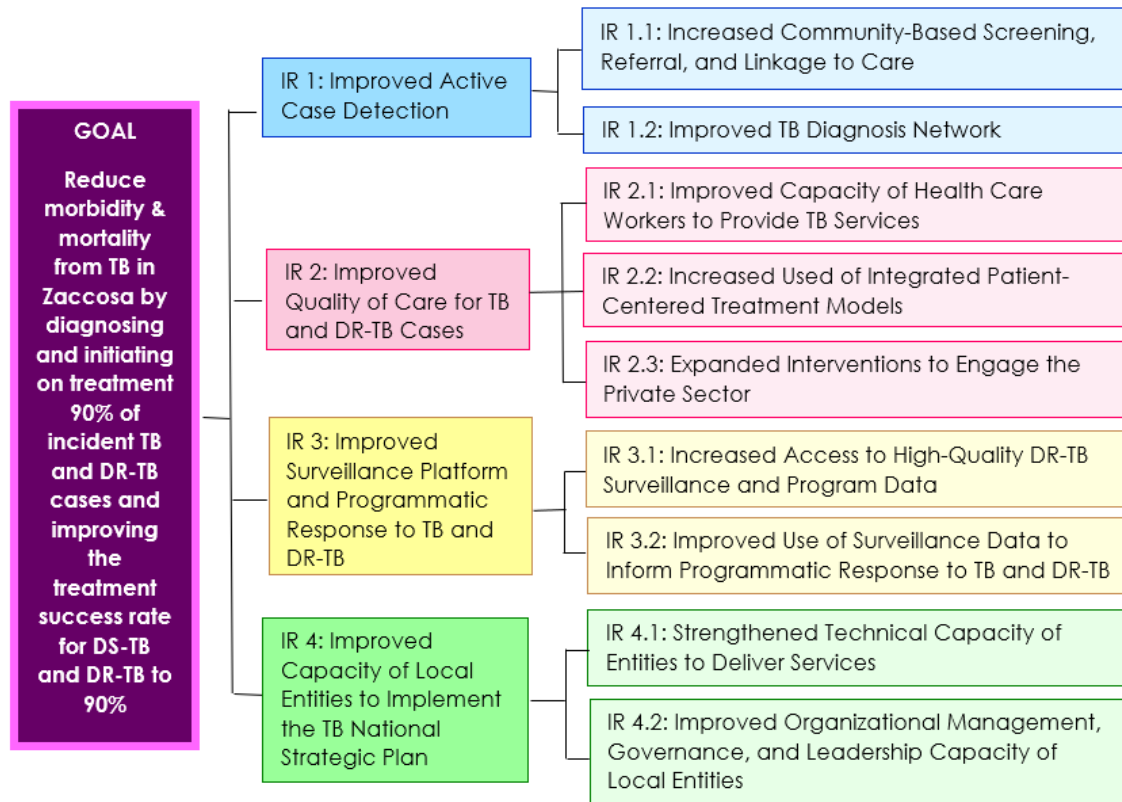
**Figure 1. DETIZA theory of change**

SITUATION				
Challenges	<ul style="list-style-type: none"><li>• High TB, TB/HIV, and DR-TB burden</li><li>• Many TB cases missed</li><li>• Lower treatment success rate than reported</li><li>• Poor culture of sharing and using data for decision making</li><li>• Limited engagement of the private sector</li><li>• Zaccosa's health sector is widely underfunded</li></ul>		Opportunities	<ul style="list-style-type: none"><li>• Improvements in treatment success</li><li>• 97% of new TB cases tested for RR (2019)</li><li>• TPT implementation has been successfully scaled up with broader eligibility criteria</li><li>• Donors like USAID and Global Fund have a strong presence in Zaccosa</li></ul>
USAID TB TARGETS		INTERVENTIONS		
Rapidly introduce new TB tools and approaches		<ul style="list-style-type: none"><li>• Conduct house-to-house visits and community outreach</li><li>• Implement the FAST approach in facilities</li><li>• Improve the sputum production and transport system</li><li>• Design training modules and conduct a training of training on capacity strengthening for TB healthcare workers</li></ul>	ILLUSTRATIVE INDICATORS <ul style="list-style-type: none"><li>• Human resources available</li><li>• Updated strategies and policies available</li><li>• # of trainings conducted</li><li>• # of people reached with community outreach</li><li>• # of community awareness events held</li><li>• Capacity needs assessment created</li><li>• Research protocol developed</li></ul>	
Have strong TB national networks and USAID partnerships inclusive of affected communities		<ul style="list-style-type: none"><li>• Establish collaborative structures to work with key stakeholders to improve data collection, reporting, analysis, dissemination, &amp; use</li><li>• Engage private sector providers to enhance the PPM for TB</li><li>• Conduct a capacity needs assessment of local TB entities</li><li>• Conduct monthly data district meetings with area TB stakeholders</li></ul>		
Include appropriate TB interventions in pandemic preparedness plans		<ul style="list-style-type: none"><li>• Improve Zaccosa's TB surveillance system by scaling up the active drug safety monitoring system for DR-TB</li><li>• Develop data quality standards, to be used as an example for improving Zaccosa's other health data</li><li>• Strengthen data use for decision making at all levels</li></ul>		
Implement plans to address socio-economic determinants and health-related risk factors that impact the TB epidemic		<ul style="list-style-type: none"><li>• Document and disseminate good practices</li><li>• Conduct operational research on the socioeconomic determinants of TB in Zaccosa</li><li>• Conduct awareness-raising and demand-creation activities, particularly among high-risk groups</li><li>• Conduct TB screenings in high-risk groups, such as prisoners</li><li>• Design and implement a patient-centered TB care package</li></ul>		
OUTPUTS				
<ul style="list-style-type: none"><li>• More awareness of TB and the availability of TB services</li><li>• Improved TB diagnoses</li><li>• Reduced lost-to-follow-up (LTFU)</li><li>• Improved FAST at health facilities</li><li>• TB surveillance strengthened with the active drug safety monitoring system</li><li>• More private sector healthcare workers providing TB services</li><li>• Improved data use for decision making at all levels</li><li>• Information gaps in TB and DR-TB diagnosis and treatment filled</li><li>• Increased capacity among local entities</li><li>• Cadre of master trainers trained</li></ul>			ILLUSTRATIVE INDICATORS <ul style="list-style-type: none"><li>• # of master trainers trained</li><li>• #/% of healthcare workers from private sector trained</li><li>• # of clients LTFU</li></ul>	
OUTCOMES				
Short-term			ILLUSTRATIVE INDICATORS <ul style="list-style-type: none"><li>• % of contacts screened for TB</li><li>• # of TB and DR-TB patients notified</li><li>• DR-TB treatment initiations</li><li>• DS-TB treatment success rate</li><li>• DS-TB treatment outcomes</li><li>• DR-TB treatment outcomes</li></ul>	
90% of incident TB and 90% of DR-TB cases diagnosed and initiated on treatment		<ul style="list-style-type: none"><li>• Improved health seeking behavior</li><li>• Improved active case finding</li><li>• Increased number of incident TB patients on treatment</li><li>• Increased number of incident DR-TB patients on treatment</li></ul>		
Medium-term				
		<ul style="list-style-type: none"><li>• Improved provider skills on TB and DR-TB management</li><li>• Strengthened community systems for TB elimination</li><li>• Improved case management of TB and DR-TB patients</li><li>• Improved capacity of local organizations to provide TB services</li></ul>		
Long-term				
90% treatment success rate for DS-TB and DR-TB		<ul style="list-style-type: none"><li>• No patients facing catastrophic costs due to TB</li><li>• Improved treatment success for DS- and DR-TB</li><li>• Increased engagement of the private sector in TB services</li></ul>		
IMPACT				
Reduced morbidity and mortality from TB in Zaccosa by diagnosing and initiating on treatment 90% of incident TB and DR-TB cases and improving the treatment success rate for DS-TB and DR-TB to 90%			ILLUSTRATIVE INDICATOR TB death rate	

## RESULTS FRAMEWORK

The results framework presents the linkages between the project goal and objectives through its four IRs and sub-IRs due to project implementation represented through IRs. The project performance will ultimately be measured based on these objectives and results. The output, outcome, and impact levels indicators that relate to each IR are presented in the performance monitoring framework below.

**Figure 2. DETIZA results framework**



**Table 1. DETIZA's contribution to the PBMEF indicators**

Indicator	Indicator Category	How DETIZA will contribute to the respective PBMEF indicators
TB detection rate	Core	<ul style="list-style-type: none"> <li>a. Implement active case finding activities through house-to-house visits, contact screening visits, monthly cough days, and mobile clinics at the community level</li> <li>b. Implement FAST strategy through trained cough officers and case managers at the health facilities</li> <li>c. Intensify clinical mentoring and provide TA to healthcare workers (HCWs) to strengthen TB screening at all entry points within health facilities</li> <li>d. Implement active case finding activities targeting group risks, especially prisoners</li> </ul>
# of contacts with presumptive TB	National Level	<ul style="list-style-type: none"> <li>a. Provide referral to health facilities for all people with presumptive TB identified during active case finding activities: house-to-house visits, contact screening visits, monthly cough days, and mobile clinics at the community level</li> </ul>
# of people screened for TB	Project Level	<ul style="list-style-type: none"> <li>a. Implement active case finding approaches house-to-house visits, contact screening visits, monthly cough days and mobile clinics at the community level</li> </ul>
% bacteriologically confirmed	Core	<ul style="list-style-type: none"> <li>a. Collaborate with the NTP to ensure that samples are efficiently transported to the right labs</li> <li>b. Provide LED microscopes to strengthen lab network and increase access to lab TB testing where needed taking into consideration that GeneXpert machines and modules are working deficiently</li> <li>c. Support the GeneXpert network through technical and logistical support</li> </ul>
Childhood TB notifications	Core	<ul style="list-style-type: none"> <li>a. Implement systematic contact screening for TB index cases in all project districts</li> <li>b. Provide clinical mentoring to mother and child health nurses and other HCWs to improve quality of screening and improve TB diagnosis among children</li> <li>c. Provide support to the NTP to scale up the use of stool analysis for TB diagnosis in children</li> </ul>
RR/MDR-TB notifications	Core	<ul style="list-style-type: none"> <li>a. Provide clinical mentoring, on-the-job-training, and formal trainings to clinicians to improve TB and DR-TB diagnosis</li> <li>b. Coordinate transport of samples from peripheral to central labs to access sophisticated tests for DR and extensively drug-resistant (XDR) early diagnosis</li> <li>c. Strengthen follow-up of TB patients on treatment focusing especially on those LTFU</li> </ul>
DS-TB Treatment Success Rate	Core	<ul style="list-style-type: none"> <li>a. Provide community-based direct observed (TB) treatment (CB-DOTS) for treatment adherence improvement</li> <li>b. Intensify samples referral for sputum smear control exams</li> </ul>
DR- TB treatment initiations	Core Plus	<ul style="list-style-type: none"> <li>a. Provide DOTS Plus for treatment adherence</li> <li>b. Provide psychosocial support to DR-TB patients to improve clinical monthly follow up at health facilities</li> <li>c. Support and track follow-up exams for DR-TB patients (GeneXpert, culture, and line probe assay [LPA])</li> </ul>
# of people with adverse reactions to DR-TB treatment	Core Plus	<ul style="list-style-type: none"> <li>a. Provide psychosocial support to DR-TB patients to increase clinical monthly follow-up at health facilities to improve correct intake of drugs</li> <li>b. Intensify samples referral for sputum smear control exams, support and track follow up exams for DR-TB patients (GeneXpert, culture, &amp; LPA)</li> </ul>
% of contacts screened for TB	Core	<ul style="list-style-type: none"> <li>c. In close coordination with health facilities, allocate TB index cases to community health workers (CHWs) for systematic contact screening</li> <li>d. Promote mobile clinics and monthly cough days with contacts screening included</li> </ul>
TPT initiations	Core	<ul style="list-style-type: none"> <li>a. In close coordination with health facilities, conduct community visits for TPT initiation and follow up and provide TPT drugs to CHWs for contacts of TB patients under CB-DOTS</li> <li>b. Conduct community visits for TPT initiation and follow-up</li> <li>c. Improve link between NTP and consultation for children-at-risk (CCR)</li> <li>d. Provide TPT drugs to CHWs for contacts of TB patients under CB-DOTS</li> </ul>
TB/HIV		<ul style="list-style-type: none"> <li>a. Intensify clinical mentoring and provide TA to HCWs to strengthen TB screening at all entry points within health facilities, including HIV clinics</li> </ul>
Private Sector		<ul style="list-style-type: none"> <li>a. Engage private sector providers to enhance the PPM for TB</li> </ul>
HCW Screening		No DETIZA activities
Sustainability		No DETIZA activities

## CRITICAL ASSUMPTIONS

We assume we will have political support from the Government of Zaccosa and continued Global Fund resources throughout implementation. We assume the COVID-19 pandemic will have ended so full implementation may occur. We also assume that the involvement of communities and the private sector will not be suppressed. However, due to global warming and more extreme weather incidents recently, along with the national elections slated for 2024, we assume we will need to account for the possibility of a major natural disaster and/or political unrest in Zaccosa diverting resources from TB interventions.

## Monitoring Plan

### MONITORING APPROACH

DETIZA will implement and monitor four active search approaches for increased TB and DR-TB screening, diagnosis, and treatment in the communities and at the health facilities. The key approaches are as follows:

**House-to-house visits:** With this approach, each activist will develop and implement a plan to visit/reach households within their areas of activities with TB education, screening, and referral to health facilities of those with presumptive TB using dedicated community project tools (e.g., activist community register, referral form, contact screening form, and TB patient community treatment form).

Home visits will be a way for DETIZA activists to continuously provide treatment and adherence support to TB patients and their families. At these visits, the activists will interact with the patient and family by providing counselling for treatment adherence. During these visits, the activist will monitor the patient's drug adherence using the community treatment form.

**Contact screening:** DETIZA activists conduct systematic contact screening of TB index cases (both TB patients from CB-DOTS and the health facilities) at the household level using the community contact screening form. The activist will conduct at least five follow up visits to ensure that all presumptive contacts are identified, refer to health facilities for diagnosis and treatment, ensure eligible contacts less than 15 years are on TPT, and attend monthly TB control meetings.

**FAST:** DETIZA is supporting TB screening activities, conducted by trained cough officers (auxiliary staff at the health facilities) in the waiting areas at the health facilities to identify and immediately refer people with presumptive TB to the TB sector for diagnosis and treatment. These cough officers will use the health facilities' FAST register to record FAST data.

**Monthly cough day mobile clinics:** To increase access to health services, DETIZA will conduct monthly cough days in the community in conjunction with the health facilities in areas that are pre-identified as hot spots or are a priority due to their distance from the health facilities. DETIZA will gather data on the people seen at the mobile clinics.

### PERFORMANCE MONITORING

#### TRACKING AGAINST THE PBMEF INDICATORS

DETIZA will be implementing several activities that correspond to the PBMEF indicators (Table 1). Table 2 presents an indicator summary table for reporting against the core PBMEF indicators.

A summary of all performance indicators that the project will report to USAID can be found in Annex 1 in the Performance Indicator Reference Sheet, with detailed indicator definitions and data collection methods for all indicators.



**Table 2. Indicator summary table for reporting against the PBMEF indicators**

PBMEF Core Indicators	PBMEF Reference	Indicator	Numerator	Denominator	PBMEF	Type of Indicator	Frequency Reporting	Data Sources	Unit of Data Measurement	Base-line	Project Results to Date (Years 1 and 2)	End of Project Target by 2024
TB Detection Rate	DT-RT	# of people reached with TB information	Estimated # of people reached with TB information	N/A	No	Output	Monthly	DETIZA community register	Number	N/A	1,069,035	4,041,930
	DT_SC RN	# of people screened for TB	# of people in the defined risk group category who were screened for TB	N/A	Yes	Output	Monthly	DETIZA community register	Percent	N/A	85%	90%
	DT_PRES	# of people with presumptive TB identified	# of people with presumptive TB identified during the reporting period	N/A	No	Output	Monthly	DETIZA community register	Percent	N/A	19%	15%
		% of people referred to health facilities	# of people referred to a health facility after being screened for TB	# of people screened for TB in community	No	Output	Monthly	DETIZA community register; DETIZA referral form	Percent	N/A	88%	90%
		% of people referred and reaching health facilities	# of people referred to a health facility for TB services who presented at the health facility	# of people screened for TB in community	No	Output	Monthly	DETIZA referral form; lab register	Percent	N/A	93%	90%
	DT_TST	# of people with presumptive TB tested for TB	# of people with presumptive TB tested for TB during the reporting period	N/A	Yes	Output	Monthly	DETIZA referral form; lab register	Percent	N/A	93%	90%
		# of people with TB diagnosed through community efforts	# of all forms of people with TB diagnosed through community efforts	N/A	No	Outcome	Monthly	Lab and NTP registers	Number	N/A	28,556	63,350
Child-hood TB Notifications	PEDS_NOTIF	# of pediatric TB (all forms) notified in project districts	# of all forms of pediatric (0-14 yrs) TB cases notified in project districts	N/A	No	Outcome	Monthly	Lab and NTP registers	Number	N/A	12%	12%

Percent Bacteriologically Confirmed	BAC_CON	% of people with TB (bacteriologic al) detected through community efforts	# of people with new and relapse bacteriologically confirmed pulmonary TB detected through community efforts alone	# of people with notified new and relapse pulmonary TB during detected	No	Outcome	Monthly	Lab and NTP registers	Percent	N/A	16%	55%
RR/MDR-TB Notifications		% of new TB cases tested for MDR/RR-TB	# of new TB cases tested for MDR/RR-TB	# of new TB patients during the reporting period	No	Output	Monthly	Lab and NTP registers	Percent	N/A		
	DT-RT	TB case notifications	# of new and relapse TB cases and cases with unknown previous TB treatment history (all forms) notified	N/A	Yes	Outcome	Monthly	Lab and NTP registers	Number	N/A		
	MED_NOTIF	DR-TB notifications	#of laboratory-confirmed DR-TB cases notified in the project areas	N/A	Yes	Outcome	Monthly	Lab and NTP registers	Number	440	799	1131
Percent of Contacts Screened for TB	DT_CI_INIT	% of eligible index cases with contact investigations conducted	# of eligible index cases receiving contact investigation	# of index cases eligible for contact investigation	Yes	Output	Monthly	NTP registers; contact screening forms	Percent	N/A	91%	90%
		Estimated average # of household contacts identified per one notified new and relapse bacteriologically confirmed pulmonary TB case	Estimated average # of household contacts identified per one notified new and relapse bacteriologically confirmed pulmonary TB case	N/A	Yes	Outcome	Monthly	DETIZA community register	Number	N/A	82686	N/A
	CON_SCRN	% of identified contacts investigated	# of contacts investigated	# of contacts identified	Yes	Outcome	Monthly	DETIZA community register	Number	N/A	79%	90%
	DT_CON_DX	# of contacts detected with TB disease	# of TB cases identified (both bacteriologically and clinically) among evaluated contacts	N/A	Yes	Outcome	Monthly	Lab and NTP registers	Number	N/A	5%	5%

DR- TB Treatmen t Success Rate		% of DR-TB cases initiating treatment	# of DR-TB patients enrolled in TB care who were started on TB treatment	# of DR-TB patients enrolled in TB care	No	Output	Monthly	NTP register	Number	N/A	100%	100%
	TX_DR _SUPP ORT	% of DS-TB patients who receive TB care package	# of TB patients (all forms) who received any social or economic benefits during the first month of treatment	# of TB cases (new and relapse), all forms, notified	Yes	Output	Monthly	DETIZA community register	Percent	N/A	58%	95%
	DR_TS R	% of DR-TB treatment success rate	# of DR-TB cases who were cured or treatment completed	# of DR-TB cases who were enrolled on appropriate treatment	Yes	Outcom e	Annually	NTP register	Percent	52%	49%	80%
		% of DS-TB receiving DOTS	# of DS-TB cases receiving DOTS	# of DS-TB patients enrolled in DOTS	Yes	Outcom e	Annually	NTP register	Percent		92%	95%
TPT Initiations		# of TB contacts less than 15 years eligible for TPT	# of household contacts of people with confirmed TB who are age 14 or younger who are ruled out for TB and eligible for TPT		no	Output	Monthly	DETIZA community register /PNCT 10	Number	N/A	25,732	
	TPT_C ON_0 4	# of contacts TB less than 5 years starting TPT	# of children household contacts (age <5 years) of bacteriologically confirmed pulmonary new and relapse TB cases notified who started on TPT	N/A	Yes	Output	Quarterly	NTP register; CCR register	Percent	N/A	10%	90%
		% of contacts less than 5 years completing TPT	# of children (<5 years) household contacts that began TPT and completed the therapy	# of children (<5 years) household contacts of bacteriologically confirmed pulmonary new and relapse TB cases notified who were started on TPT	Yes	Outcome	Quarterly	NTP register; CCR register	Percent	N/A	16%	90%

## CONTEXT MONITORING

In the past few years, Zaccosa has experienced unprecedented rainfall and flooding, making some major roads impassable. This is an identified risk that may hinder DETIZA's activities and the ability to gather data. If certain project areas become inaccessible, the project will need to rely more on electronic data collection and virtual supportive supervision.

Based on the national elections slated for 2024 and possible political unrest, DETIZA will plan its monitoring and evaluation (M&E) activities accordingly.

## Data Collection

DETIZA will collect data from project activists and the NTP on a monthly and quarterly basis for all Core PBMEF indicators being implemented by the project. The National Level data for the Core indicators will be collected annually. This will be used for quantitative and qualitative quarterly and annual reporting to USAID and the NTP. Monthly presentations of activity progress will be conducted at the provincial level. While DETIZA has developed project-specific community data collection tools to be used by activists and district area leaders, the project will also use NTP registers to collect health facility data to report on facility-based indicators, like notification rate and treatment success for TB and DR-TB. Table 3 lists the project data collection tools and sources of data while Table 4 shows the periods of data collection with method of data collection and responsible staff.

**Table 3. Data collection tools and sources**

Data generator	Data collection tool	Type of data collected	Data capture system	Data source	Frequency
Community activists	Activist community activity register book	Individuals reached through community awareness activities, symptomatically screened, presumptive referred by CHWs to health facilities, and contact screening	Paper	Primary	Quarterly
CHWs	Community referral forms	People with presumptive TB referred from CHWs to a health facility		Primary	Monthly
CHWs	Community TB treatment forms	CB-DOTS for follow up of patient treatment in the community		Secondary	Monthly
CHWs	Community contact investigation form	Index case contacts registered, screened, and followed up		Secondary	Monthly
Facility health workers	FAST register at health facilities	Cough officer tool to register data on people referred and diagnosed		Primary	Monthly
Facility health workers	Health facility TB register	Notifications of TB, patients initiated on treatment, treatment management and treatment outcomes	Electronic summary reports	Primary	Monthly
Facility health workers	Health facility DR-TB register	Notifications of DR and XDR-TB patients initiated on treatment, treatment management, and treatment outcomes at 12 & 24 months.			Monthly

**Table 4. Data collection periods with method of data collection and staff responsible**

Data collection period	Method of collection	Type of data collected using this method	Source Documents	Responsible Staff
Monthly	District meeting with area leaders, NTP supervisors, and project activists for compiling, verifying, validating, and analyzing data	Compilation of the project's performance indicators against targets from primary data sources from DETIZA activists and health facilities.	Activists' community activity register; TB, DR-TB, MDR-TB, and XDR-TB registers; and CCR register	DETIZA district area leader and NTP district supervisor
Weekly	Weekly data revision meeting in health facilities to review and correct project data	Project data to closely monitor progress on TB and DR-TB detection and treatment initiations, index contact investigation, contact screening, TPT initiation, and LTFU on second line treatment	HCWs, activists' community activity register, TB and DR-TB registers, and CCR register	Health facility TB focal point, DETIZA activists

Standardized templates have been developed to facilitate data analysis and investigate trends. Data will be analyzed at every level of reporting with emphasis on use of data for decision making and planning.

## Data Management and Quality Assurance

### DATA STORAGE AND SECURITY

Paper-based tools like activity registers, referral forms, and contact investigation forms will be used daily by activists to register and collect data. These and their monthly reports, referral forms, and contact information will be stored at the health facilities.

Project M&E staff and implementing partners (IPs) with access to individual data must sign a data confidentiality agreement. At the end of each project year, physical data collection tools will be stored at the project's provincial offices under the responsibility of the provincial M&E officers. Soft copies of data sets will be maintained on password-protected computers. Any electronic database will be accessible to staff members based on data use needs and geographic location. All staff and activists are instructed on data confidentiality and have signed a non-disclosure confidentiality agreement.

The project management information system (MIS) is password protected allowing for secure access. While several members of the project team will have access to view monitoring data, which will not contain any personally identifiable information, data managers and the M&E advisor will have access to edit that data; this will help to ensure data quality and prevent falsification. Once data has been entered electronically, paper data will be stored for audit purposes in locked file cabinets within the project's head office until six months after the project end date. Data stored on hard drives will be password protected, with only the M&E advisor and other senior members of the project team having access.

### DATA USE

DETIZA's MIS will generate data outputs (reports, success stories, lessons learned, abstracts, etc.) that will be used internally for performance monitoring and decision making. The project activists use a standardized reporting template to produce monthly activity reports from their community registers and contact screening forms (primary sources of data). These reports will be used by the activists themselves to self-evaluate their performance during the reporting month against targets assigned, assessment of the quality of their data recording and reporting, and learning lessons for improving the next reporting period.

With GOZ and USAID's input, and drawing on content emerging from the collaborating, learning, and

adapting (CLA) approach, the project will develop a series of engaging knowledge products that document best practices, lessons learned, and innovative approaches. These will be disseminated through multiple channels, including online and in international conferences, forums with stakeholders, and donors. This documentation and dissemination will help to ensure that the project's impact will be known throughout Zaccosa and beyond its borders.

## DATA QUALITY

DETIZA has put in place data quality measures to ensure data quality standards (accuracy, reliability, precision, completeness, and timeliness) using standardized data recording and reporting tools, as well as regular integrated TA and supervision visits and mentoring visits conducted at multiple levels (district, province, and project management).

## M&E of Gender

DETIZA has an interest in monitoring gender equity to ensure optimal demand for and analysis of both routine and nonroutine TB data for decision making and appropriate use of such information for performance management, and to inform the interventions and policies of the GOZ, NTP, USAID, and other stakeholders.

Activities that support achievements against person-centered indicators will include practices that address the United Nations Sustainable Development Goals 5 and 3, Target 3.3, WHO recommendations, and USAID priorities. The documentation of results against these indicators will include specifics about gender integration in data management, analysis, and use practices. When possible, our data systems will retain disaggregation by sex for improved analytics and decision making by population. These data will be tracked by the project MIS.

DETIZA will also conduct a gender assessment in year 2 to understand gender barriers in the provinces and the country.

## Evaluation Plan

Evaluation activities will be integrated into the annual work plans, and they will consider the data that will be collected by other projects. The team foresees these evaluations:

1. Baseline assessment
2. Midterm evaluation (to be conducted in year 3) by external consultants contracted by USAID
3. Outcome evaluation (conducted in year 5) to measure key impact indicators and assess the effectiveness of project interventions
4. Annual pause and reflect session (to be conducted midterm of year 3)

**Table 5. The purpose, key questions, methodology, and timeline for project evaluations**

Type	Annual Pause and Reflect Session	Baseline Assessment and Midterm Evaluation	Final Outcome Evaluation
<b>Purpose</b>	To track project progress performance and identify areas for improvement and/or apply lessons learned where necessary	Conducted at baseline and mid-way through the project, to focus on the progress made in project implementation against the program objectives	To assess the extent to which project long-term outcomes, targets, and goal were achieved
<b>Key Evaluation Questions</b>	How has the project performed in terms of reaching targets?	What is the status of key NTP outcome indicators in project provinces and districts?	Did the project achieve its targets and goal?

Type	Annual Pause and Reflect Session	Baseline Assessment and Midterm Evaluation	Final Outcome Evaluation
	Where does performance need strengthening? What best practices have been identified and can be copied? What are the main gender gaps in TB diagnosis and treatment, and have the gaps been closing? What are the new opportunities for improved TB case detection and management that the project can take advantage of? What lessons learned need to feed into implementation the following year?	What is the capacity among the NTP and other stakeholders? What has been the magnitude of change in these indicators from the baseline? What are the main gender gaps in TB diagnosis and treatment, and have those gaps been closing? What key feedback do stakeholders have for guiding (baseline) or improving performance (midterm)? Is the project aligned with its theory of change (midterm)?	What worked well and what did not work well? What are the main gender gaps in TB diagnosis and treatment, and did they reduce? What external contextual factors had an impact on project performance, and did the project adequately take these factors into account? Did the partners fulfill their roles adequately? What are the programmatic or policy recommendations for the future?
<b>Evaluation Methods</b>	Secondary data analysis (project results), key informant interviews with NTP, provincial, district and site level stakeholders, data quality assurance findings	Secondary data analysis (surveys and surveillance, NTP patient-level data and project results [midterm only]) and interviews with NTP, provincial, district and site-level stakeholders	Secondary data analysis (surveys and surveillance, NTP patient-level data and project results, key informant interviews with NTP, provincial, district and site level stakeholders)
<b>Planned Start Date</b>	Year 2, Q1	Year 1 & 3, Q2	Year 5, Q2
<b>Estimated End Date</b>	Year 5, Q1	Year 3, Q3	Year 5, Q4

USAID will be highly involved in each internal evaluation activity, including development of the terms of reference, reviewing an evaluation statement of work, methods/tools, and draft reports.

## OPERATIONS RESEARCH

**Gender assessment:** The project will conduct a gender assessment in year 2 to understand gender barriers in the provinces and the country. The results of the assessment will be available in year 3 and will be used to train local entities and to provide feedback to the NTP for use in its guiding materials for community activities.

**TB patient satisfaction survey:** In year 3, the project, in collaboration with the NTP, will conduct a patient satisfaction survey with current and former TB patients to inform the TB program for programmatic decision making and policy changes, as needed.

**Short-term regimen (STR) cohort study:** In year 3, DETIZA will support the NTP's study on STR to evaluate the implementation of STR oral treatment of DR-TB within programmatic conditions in Zaccosa. DETIZA will support this study by providing logistics and technical support to study sites. This is a longitudinal cohort study of MDR/RR DR-TB patients receiving the totally STR oral treatment regimen. DETIZA clinicians will also do follow up and treatment management with patients in the study.

## CLA Approach

Quarterly narrative reports and data analysis presentation to USAID will provide the opportunity to discuss the impact of learning on the program, updates in key assumptions, and the underlying development hypotheses. Continuous feedback will be provided on data analysis, data quality, and improvement in capacity training.

The project will foster a culture of learning and sharing of experiences among all staff, from field

activists to the Chief of Party. Experience sharing will be included in weekly team meetings, including brainstorming to devise new approaches and solutions to challenges encountered in the field. Lessons learned, challenges faced, and adaptations made will be laid out in brief monthly reports. Multiple WhatsApp groups have been created at different levels within the project to encourage staff to share experiences and to solve problems in real time. Every month, the M&E Advisor will prepare questions for discussion in this group and facilitate creative problem solving. Regular learning forums and opportunities for learning will be established, including the following:

**Site-level learning:** On a weekly basis, activists and health facility staff will meet to review activities already conducted and plan activities for the coming week. The focus will be on identifying barriers to reaching targets and identifying missed opportunities for improved TB diagnosis and patient care. Site-level action plans will serve as documentation for quality improvement efforts at this level and will be monitored in terms of completing action items and any further implications for program management.

**District-level learning:** Monthly district-level data review meetings will validate data and compile monthly reports. These meetings will be expanded to include a focus on project performance at the district level, aligning project data to NTP data, analyzing barriers to achieving targets, and identifying and addressing cross-cutting barriers to improved TB diagnosis and patient care.

**Provincial-level learning:** Project performance will be shared and discussed in monthly meetings with provincial area leaders to evaluate each district's performance against indicators. Monthly activity progress meetings will be held with USAID, the NTP, and the project management team to present progress; leverage resources with the NTP; and identify and address barriers to improve TB diagnosis, management, and patient care.

**Project-management level:** Overall performance will be reviewed during monthly meetings based on project targets. Findings from district- and provincial-level learning forums will be reviewed during these meetings, particularly in districts and provinces falling behind on targets. These meetings will incorporate a broader range of data, rather than just routine monitoring data.

**Annual pause and reflect exercises:** The project's staff, NTP, USAID, and local partners will come together once a year for a pause and reflect session in one selected province. These day-long exercises will integrate internal project learning with broader perspectives on changes to the context and operating environment of the province, including any shifts in GOZ and/or USAID priorities. One key feature will be obtaining structured feedback from the GOZ on how well the project is responding to their needs and what changes need to be made to make the TB service platform well-functioning and strong, and to ensure that future scale-up is feasible.

Continuous learning and adapting are at the core of the project, enabling the team to improve existing work, to test and learn from new approaches, adapt as needed, and rapidly integrate mid-course corrections into implementation. The learning that results from the project will enable the consortium to create an evidence-based model to reduce the burden of TB and related morbidity/mortality. Periodic integration of data reviews and reflection exercises will be conducted during regular team meetings at the district, provincial, and project management levels.

## Stakeholder Feedback Plan

DETIZA will conduct monthly meetings at the district, provincial, and central levels to review progress and solicit feedback from project clients:

1. District-level meetings (prior to submission of activist report) where activists and health facilities' TB focal points will discuss and review project activity progress.



2. Provincial-level meetings where all project area leaders will participate to present each district report. Discussion and analysis will be conducted using prepared charts and tables to evaluate districts performance against target. It is also a learning opportunity as best practices for the month will be shared.
3. DETIZA's central level team will present the project's progress to the NTP, other IPs, USAID, and TB technical working group.

The results of the TB patient satisfaction survey conducted in year 3 will be summarized and shared with the participating health facilities, along with the NTP and TB technical working group.

See Table 8, Schedule of MEL Deliverables to USAID, for how DETIZA will report to USAID and what information will be included.

## Resources

DETIZA's M&E Officer is responsible for the MEL activities outlined in this document. This individual will be provided with sufficient information and communication technology equipment and resources, including, but not limited to, laptops and access to appropriate software and hardware to support their work. The proprietary MIS has been developed to enable efficient and accurate tracking of project progress and results, and programming staff dedicated to work on enhancements and improvements to the MIS and other internal communication resources will be available to ensure that the MIS and internal communication platforms adequately support the work of the M&E Officer.

The M&E Officer has access to standard operating procedures, MEL tools and resources, and training materials developed for other USAID-funded projects managed by HFHC to use as resources for their work under DETIZA. Additionally, the M&E Officer will have access to USAID-developed M&E resources.

## Roles, Responsibilities, and Schedules

Within the consortium, HFHC is responsible for all routine monitoring and reporting work, including reporting to USAID and the NTP. The table below outlines roles and responsibilities of staff involved in monitoring, tracking, and reporting on project activities.

**Table 6. M&E roles and responsibilities**

Team Member with M&E Responsibility	No.	M&E Roles and Responsibilities
Chief of Party	1	Provide strategic leadership to the project. The Chief of Party will be a key user of the data and learning generated through the MEL system and a 'champion' of data-based decision making as well as of the CLA process.
Senior Technical Advisor	1	Review major project outputs prior to their submission to USAID or sharing outside the consortium, ensure that there is a culture of data use throughout the technical team, create opportunities to integrate data and learning throughout implementation, coordinate learning activities with other USAID-funded activities, and work with the MEL Advisor to broadly disseminate project lessons learned and best practices.
MEL Advisor	1	Has final responsibility for all MEL activities, managing the monitoring of data collection, tracking indicators, and reporting to USAID and other stakeholders. They will review project data and support refresher trainings to project staff on MEL tools and processes. With technical support from HFHC, they will oversee implementation of the project's learning agenda, all periodic CLA activities, and the creation and dissemination of knowledge products.
Data Manager	2	Manage data collection schedules, data storage and data generation. Track report submission status and provide preliminary feedback on noticeable quality issues. Implement data quality assessment.

M&E Officer	4	Ensure reports are submitted and provide preliminary feedback on noticeable quality issues. Ensure that project data are aligned with NTP data. Conduct data verification. Provide weekly/monthly feedback on progress against project targets.
Districts Area Leaders	50	Report on data based on the activists' workflow and patients' results by aggregating the information from health facilities/activist activity results from community awareness and lessons learned. The Area Leaders will report to their province project leader.
Data Entry Clerks	50	Verify project data against primary sources, align community data with NTP health facility data and ensure that all project electronic information is verified, quality assured and entered completely on timely bases into the project MIS.
Project Activists	1000	Implement project activities directly, use data recording tools to register and report.

## SCHEDULE OF PROJECT MEL PLAN TASKS

The following table lists key MEL tasks and in what year they will be completed.

**Table 7. Schedule of project MEL plan tasks**

Tasks	FY 1	FY2	FY3	FY4	FY5
Baseline evaluation	X				
Develop and provide training on data collection tool	X				
Gender assessment		X			
Collect data	X	X	X	X	X
Conduct data quality assessment trips in provinces	X	X	X	X	X
Midterm evaluation (internal)			X		
Final evaluation (external)					X
Case study		X			
TB patient satisfaction survey				X	
STR cohort study			X		
Pause and reflect events	X	X	X	X	X
Submit annual report to USAID, including information from stakeholder feedback	X	X	X	X	X
MEL plan review and update	X	X	X	X	X

## SCHEDULE OF PROJECT MEL PLAN DELIVERABLES TO USAID

Reporting schedules have been defined by the donor and the project will report accordingly. The compilation of reports will include all the technical areas (laboratory, clinical, and community). Table 8 below provides details on the frequency of monitoring reports to the project management and donor.

**Table 8. Schedule of MEL deliverables to USAID**

Deliverable	Reporting Frequency	Description of Content
Monthly progress update presentation	Monthly	Using charts and tables, the project provinces will prepare and present on monthly project progress against targets. Summarize provincial key achievement for the month, challenges and ways forward to overcome them.
Quarterly project progress report	Quarterly	Include narratives of quarterly achievements, progress against the work plan, and agreed-upon performance indicators demonstrating trends in charts. The quarterly reports will also include beneficiary feedback and what actions were taken as a result of the feedback.
Annual project progress report	Annually	Summary of project achievements across core and field activities and progress toward results, implementation, and management issues, for a period of one year
Final report	90 days after the end of the award	Summarize the accomplishments of the agreement, methods used, and recommendations regarding unfinished work and/or program continuation as well as key learnings from the total implementation experience.

Project provinces prepare and present a monthly progress report to USAID during USAID and DETIZA monthly meetings. The project also conducts monthly meetings with the NTP's central and provincial

levels to present to discuss project contributions toward the NTP’s key indicators. This is an opportunity for USAID and the NTP to provide feedback and make recommendations to address challenges and improve performance.

## Change Log

Updates to the MEL plan will be documented in a change log. Each version of the plan will be archived with the date. These steps will ensure that changes over time can be used for project learning. The log will be provided to the DETIZA AOR for review and approval, as required by the cooperative agreement.

**Table 9. DETIZA MEL plan change log**

Date	MEL Plan Section	Summary of Change	Rationale for Change and Any Notes
Dec. 2021	Monitoring Plan; Performance Monitoring; Table 2	The indicators were revised in the indicator summary table for reporting against PBMEF indicators, along with accompanying targets.	Due to the evolution of the technical work that has been funded, the DETIZA team and USAID/Zaccosa management team determined that a revision to the project indicators and targets were necessary.

## Annex 1: Indicator Reference Sheet

<b>Indicator name and number</b>	TB Detection Rate (Treatment Coverage) (DT_RT)
<b>Definition</b>	<p>Percent of people with new and relapse TB and with unknown previous TB treatment history (all forms) who were notified during the reporting period, out of the estimated number of people with incident TB for that year.</p> <p>Note: This indicator is also referred to as "Treatment Coverage Rate"; the name is updated to TB detection rate here to emphasize that treatment coverage is not represented in this data.</p> <p>Calculation: (Numerator/Denominator) x 100</p>
<b>Numerator</b>	Number of people with new and relapse TB (and with unknown previous TB treatment history), all forms (bacteriologically confirmed plus clinically diagnosed, pulmonary plus extra pulmonary) who were notified during the reporting period.
<b>Denominator</b>	Estimated incidence of TB (all forms) in the same reporting period.
<b>Category</b>	REACH
<b>Indicator type</b>	Core outcome
<b>PBMEF Level</b>	Core
<b>Unit of measure</b>	Percent of estimated TB
<b>Data type</b>	Percentage
<b>Disaggregate by</b>	Age (<15, 15+), sex, notification source (e.g., non-NTP facilities, prisons, public/private facilities, prisons, community referral)
<b>Reporting level</b>	All Core PBMEF indicators should be reported at the national level. Data may be collected at the subnational level for more granular monitoring.
<b>Reporting frequency</b>	This indicator should be reported on a semi-annual basis, at a minimum. More frequent monitoring on a quarterly or monthly basis is recommended. Performance plans and reports for this indicator are based on calendar year periodicity to reflect national level attainment and align with the USAID congressional reporting requirements.
<b>Data source(s)</b>	<p>The numerator is reported from national TB program (NTP) official records. Quarterly report on TB case registration in the basic management unit.</p> <p>This indicator is related to incident TB cases; therefore, the following category of patients should not be included in the data reported:</p> <ol style="list-style-type: none"> <li>1) Treatment after failure patients (previously been treated for TB and whose treatment failed at the end of their most recent course of treatment)</li> <li>2) Treatment after loss to follow-up patients (previously been treated for TB and were declared lost to follow-up at the end of their most recent course of treatment)</li> <li>3) Other previously treated patients</li> </ol> <p>Care should be taken to properly address common issues in reporting such as patients transferring in and out of facilities. National reporting guidelines should be followed to ensure all people with TB are reported and not double counted.</p>

	<p>The denominator is available from the current World Health Organization (WHO) Global TB Report for the 30 TB high-burden countries and on the WHO country profile for all countries published on the WHO website. It is an estimation calculated annually based on a mathematical model.</p> <p>This is a standard WHO indicator. Referring to the WHO database, the variable for the numerator is <i>c_newinc</i>, and the variable for the denominator is <i>e_inc_num</i>.</p>
<b>Importance</b>	<p>Case-finding is a fundamental principle of effective TB programming. However, one-third of the people who are estimated to fall ill with TB each year are not reached with proper screening, detection, and treatment, or are under-reported. The inability to find and treat the “missing” cases hampers efforts to make further progress in TB care. This indicator measures country-level progress in finding and diagnosing people with TB. Globally, the TB detection rate was 61% in 2021, down from 71% in 2019. The COVID-19 pandemic reversed gains made in access to TB diagnosis and treatment, and progress achieved in the years up to 2019 has slowed, stalled, or reversed, and global TB targets are off track. The most obvious and immediate impact was a large global drop in the reported number of people newly diagnosed with TB, from a peak of 7.1 million in 2019; this fell to 5.8 million in 2020 (–18%), back to the level last seen in 2012. In 2021, there was a partial recovery, to 6.4 million (the level of 2016–2017). Overall, there is a large gap between the estimated number of incident cases and the number of new cases reported due to a combination of under-reporting of detected cases and under diagnosis.</p> <p>Country national strategic plans for TB set annual targets for the number of TB notifications. This target will vary by country, but each country should be trying to achieve the End TB Strategy and United Nations High-Level Meeting target of 90% more case detection by 2025 to close the gap between estimated incidence and actual notifications. The USAID TB strategy (2023–2030) also sets the same target that 90% of incident TB cases are diagnosed and initiated on treatment and specifies that at least 75% of individuals with TB should be tested with molecular WHO-recommended rapid diagnostic tests in each USAID priority country. A high detection rate means more TB patients will be put on treatment and cured, thereby breaking the transmission by undiagnosed infectious TB patients, leading to less TB disease and death in the population.</p> <p>TB case detection is also used as a planning tool for the NTP. For example, forecasting TB notifications needed to meet detection targets will help with securing sufficient procurement of TB diagnostic platforms and supplies and ensure that they are available to all in need of TB diagnosis.</p>

## Data use and visualization

Reaching all individuals with TB with quality diagnostic services is an important goal for national and global policy makers. The numerator, total number of new and relapse TB case notifications, can be analyzed as a trend over time on its own. However, it is more powerful when compared to the estimated TB incidence to determine the magnitude of the gap between the number of TB cases expected and the TB cases detected.

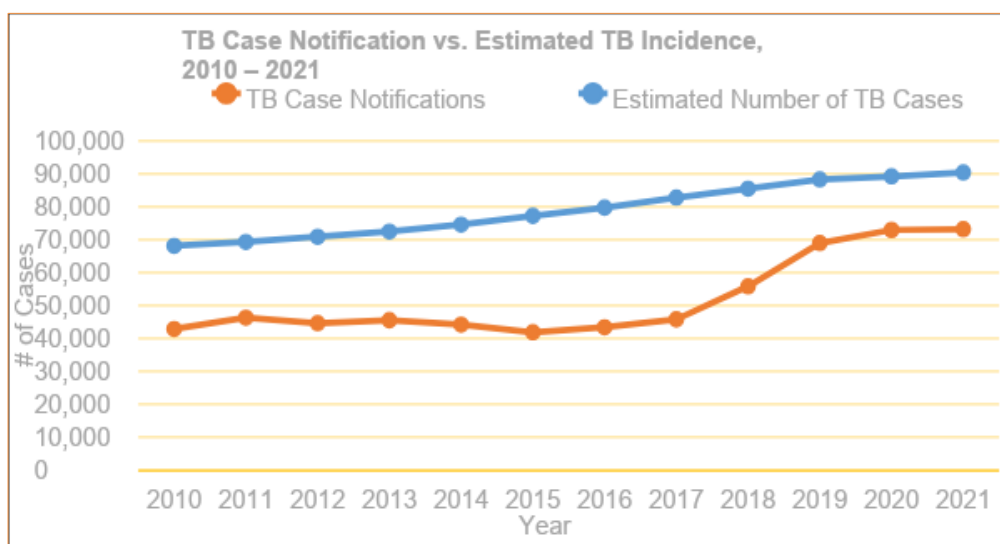
Trends in TB case detection can be used to monitor progress toward achieving national targets to eliminate TB, assess access to WHO-recommended diagnostics, and identify weaknesses in recording and reporting systems.

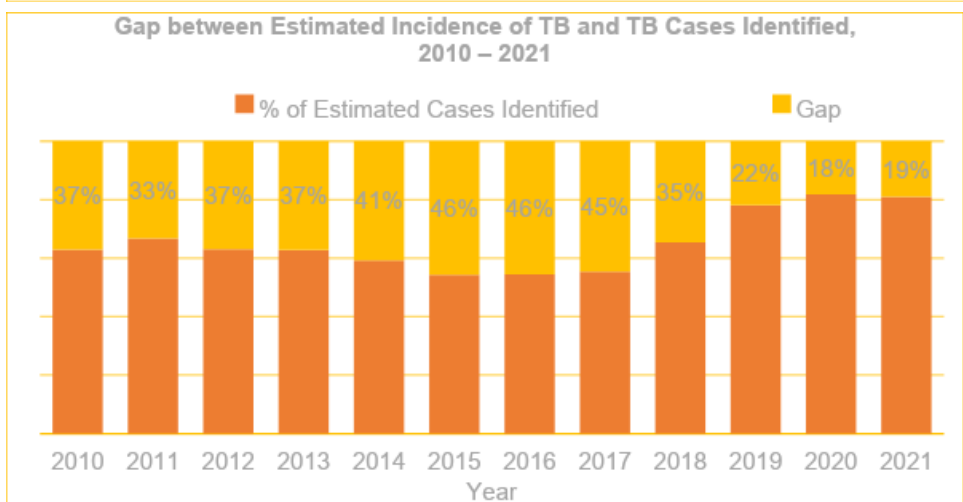
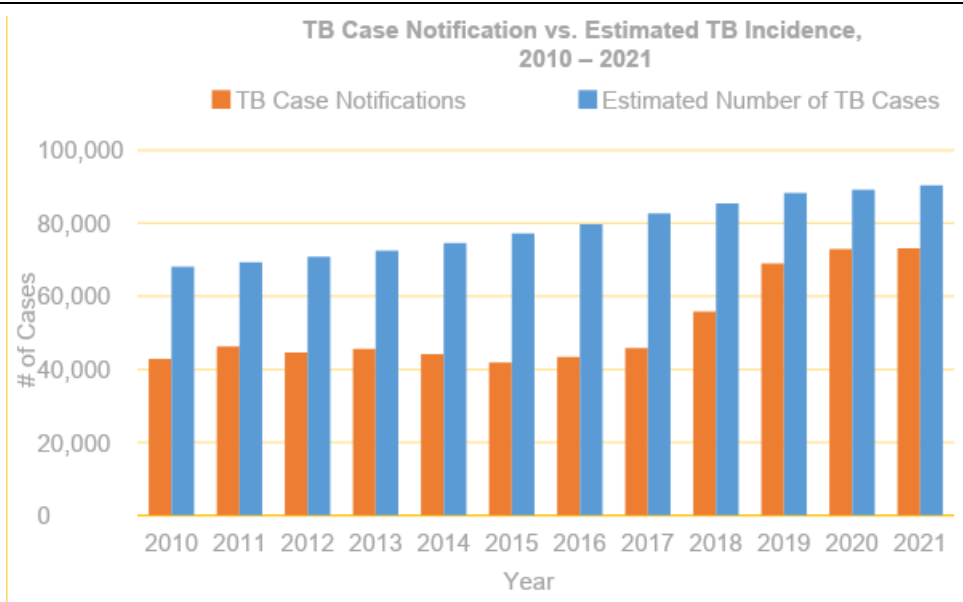
Marked changes in the trend should be reviewed in conjunction with any specific events that may have occurred (e.g., increase/decrease in active case finding, establishment of new diagnostic facilities, expanding TB services through private sector or natural disasters that disrupt TB services) and the impact of other disease outbreaks, like COVID-19.

This indicator, in conjunction with other indicators, especially bacteriologically confirmed cases and treatment success rate, will provide a picture of the cascade of TB care in the country which will help stakeholders to understand the extent to which the TB program is "losing" TB cases along the care pathway. This indicator is limited to the national level only because the denominator is a national level estimate, however, the numerator can be collected at subnational levels.

Below are examples (for illustrative purposes only) one can use when presenting this indicator. These charts provide important information but will provide more insight if viewed along with additional contextual information, including age, sex, and key program activities.

### Examples of data visualizations:





## Part 3: Blank MEL Plan Template

# [PROJECT TITLE] Monitoring, Evaluation, & Learning Plan

**Approved Date:**

**Version:**

**Contract/Agreement Number:**

**Project Start and End Dates:**

**AOR/COR/Activity Manager Name & Office:**

**Submitted by:**

**Implementing Partner(s):**

### **DISCLAIMER**

The author's views expressed in this publication do not necessarily reflect the views of the United States Agency for International Development or the United States Government.





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PBMEF Indicators			How the project activities or interventions will contribute to the respective indicator
Indicator	Indicator Tier*	Category†	
			a. b.
			a. b. c.

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[illegible]

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Purpose and Expected Use	
Possible Evaluation Questions	
Estimated Budget	
Start Date	
End Date	

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Tasks	Y1	Y2	Y3	Y4	Y5

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#### Schedule of Activity MEL Plan Deliverables to USAID

Deliverable	Reporting Frequency	Description of Content

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Date	MEL Plan Section	Summary of Change	Rationale for Change and Any Notes

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### XII.1 PERFORMANCE INDICATOR REFERENCE SHEET (PIRS)

USAID Performance Indicator Reference Sheet	
<b>Name of indicator:</b>	
<b>Name of result measured (DO, IR, sub-IR, Project Purpose, Activity-level Outcome, etc.):</b>	
<b>Is this a Performance Plan and Report (PPR) indicator?</b> No_____ Yes _____ for reporting year(s) _____	
<b>If yes, link to the foreign assistance framework:</b>	
DESCRIPTION	
<b>Precise definition(s):</b>	
<b>Unit of measure:</b>	
<b>Data type:</b>	
<b>Disaggregated by:</b>	
<b>Rationale for indicator</b> <i>(optional)</i> :	
PLAN FOR DATA COLLECTION	
<b>Data source:</b>	
<b>Method of data collection and construction:</b>	
<b>Reporting frequency:</b>	
<b>Individual(s) responsible at USAID:</b>	
TARGETS AND BASELINE	
<b>Baseline timeframe:</b>	
<b>Rationale for targets</b> <i>(optional)</i> :	
DATA QUALITY ISSUES	
<b>Dates of previous data quality assessments and name(s) of reviewer(s):</b>	
<b>Date of future data quality assessment</b> <i>(optional)</i> :	
<b>Known data limitations:</b>	
CHANGES TO INDICATOR	
<b>Changes to indicator:</b>	
<b>Other notes</b> <i>(optional)</i> :	
THIS SHEET WAS LAST UPDATED ON:	

## XII.2 STANDARD INDICATOR REFERENCE SHEET

<b>Indicator name and number</b>	
<b>Definition</b>	
<b>Numerator</b>	
<b>Denominator</b>	
<b>Category</b>	<i>(reach, cure, prevent, sustain, or innovate)</i>
<b>Indicator type</b>	<i>(output, outcome, impact)</i>
<b>PBMEF level</b>	<i>(core, core plus, national, or project)</i>
<b>Unit of measure</b>	<i>(ex. percent of cases, number of people)</i>
<b>Data type</b>	<i>(ex. percentage)</i>
<b>Potential disaggregation(s)</b>	<i>(ex. age, sex, public or private facility)</i>
<b>Reporting level</b>	<i>(recommendation based on indicator and indicator level)</i>
<b>Reporting frequency</b>	<i>(recommendation based on indicator and indicator level)</i>
<b>Data source(s)</b>	<i>(data source plus WHO indicator equivalent, if applicable)</i>
<b>Importance</b>	<i>(narrative)</i>
<b>Data use and visualization</b>	<i>(narrative plus visuals such as tables or charts)</i>