Arkangelo Ali Association Implementation in collaboration with the National TB, Leprosy and Buruli Ulcer Program

Monitoring and Evaluation Plan for Tuberculosis Prevention and treatment in South Sudan 2015 - 2019

July 2015 edition

Introduction

This monitoring and evaluation plan has been prepared by Arkangelo Ali Association (AAA) as a normative guidance for its TB interventions implementation currently in fifteen counties within five states namely Western Bahr el Ghazal, Northern Bahr el Ghazal, Warrap, Lakes and Western Equatoria in South Sudan. The implementation in the AAA coverage area is based on its size and capacity, the current roles of AAA in community-based TB activities the South Sudan, the country's TB interventions strategic plan revised in 2014 for 2015-2019 period and on the principles of single national TB monitoring and evaluation system. This M&E plan is dynamic and will be revised regularly with every new funding awards and revisions of the implementation strategic plans by the South Sudan government. This M&E plan incorporates the core indicators to be reported to the NTLBP and the internal M&E system will monitor inputs and outputs and regularly review and evaluate the data that is recorded and collected. AAA does not have the capacity for conducting periodic evaluation of monitoring and evaluating outcomes and impact measurements for all the approaches and this is likely to be an NTLBP responsibility or a consultancy, but AAA will cooperate and/or collaborate in carrying this out.

The development of this Monitoring and Evaluation Plan for AAA was a highly participatory process that involved all the field and administrative staff and in consultation with the NTLBP leadership. All participants are acknowledged.

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Acronyms

AAA	Arkangelo Ali Association
CHD	County Health Department
DOT	Directly Observed Therapy
DOTS	Directly Observed Treatment Short Course
DQA	Data Quality Assurance
GFATM	Global Fund for AIDS, Tuberculosis and Malaria
GFATM	Global Fund to fight AIDS, Tuberculosis and Malaria
HFN	High False Negative
HFP	High False Positive
HMIS	Health Management Information Systems
M&E	Monitoring and Evaluation
NTLBP	National TB Leprosy and Buruli Ulcer Control Program
OPD	Outpatient Department
PHC	Primary Health Care
PHCC	Primary Health Care Center
PHCU	Primary Health Care Unit
RoSS	Republic of South Sudan
TB	Tuberculosis
TBIC	Tuberculosis Infection Control
TBMU	Tuberculosis Management Unit

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Preamble: Current system for TB surveillance, monitoring and evaluation in South Sudan and AAA proposed approach

The TB reporting system in South Sudan was established in 2008 and is operated in a vertical manner by the M&E Advisor attached to the NTLBP. It is not linked to the national HMIS that is managed by the Planning Department of the MOH. Data collection and reporting for TB at the facilities is primarily paper based. All tools that are used for recording patient level information and reporting on cases notified and outcomes of those placed on treatment are aligned to the WHO recording and reporting framework.

AAA reports all diagnosed TB patients and treatment outcomes to the NTLBP South Sudan according to the prescribed reporting channels and format. The organization has an M&E officer that reviews all reports from the TB management units (TBMUs) and transmits them to the NTLBP. At the county level there is a TB officer based at the main TBMU/health facility and is responsible for recording and reporting quarterly reports from all TBMUs/PHCCs that implement TB interventions and sends to the M&E officer at the AAA headquarters, bypassing county and state health authorities. Once validated, the copies are sent back with feedback to the TB Officers with copies to the State and CHD levels. These summaries are paper based on improvised Excel templates.

1.0. Background

South Sudan is not listed among the top 22 high burden countries in the world, Tuberculosis is considered as a serious public challenge in the country. In 2013, WHO estimated the incidence of the disease in South Sudan at 146/100,000 population and TB related mortality at 30/100,000 population.[1] Routine reported data available at the NTLBP level and from other implementing organizations shows increasing case notification rates which appears consistent with the increased establishment of new diagnostic and treatment facilities for TB.

There has been considerable growth for TB interventions and policy development in South Sudan. AAA has previously developed M&E plan as a set of indicators but without description of the intervention implementation. During 2009 – 2013 activities of the tuberculosis program was guided by the first National Strategic Plan (NSP) that was developed in 2008 for the country still at war with its colonial Sudan. After independence of South Sudan from the greater Sudan in 2011, a second strategic plan was developed to guide activities during 2012–2016. During implementation of the second strategic plan, there was a significant expansion in TB related services - the number of TB diagnostic facilities increased from 65 in 2012 to 87 (33 of them are AAA sites) in 2014 but the geographical and equitable distribution still remains a challenge. TB case notification increased from 4,414 (1,084 from AAA) in 2008 to 8,995 (2877from AAA sites) in 2014 and laboratory external quality assurance (EQA) activities were implemented in 17 out of 87 TB facilities; 13 of these being in AAA coverage area. These were mainly AAA sites that developed a memorandum of understanding with AMREF in Kenya to provide slide rechecking and TA. A few other sites conducted peer review of slides and were not consistently nor regularly done. Following a review of the NTLBP program performance in 2013, a new strategic plan for TB was developed for the period 2015-2019. This updated plan seeks to improve program performance and address the challenges faced during implementation of the previous plan. It also included the use of new interventions and technologies which were recently introduced globally and in South Sudan these were based on experiences and lessons learned from previous Global Fund implementations and other funding sources to AAA such as the Canadian International Development Agency (CIDA) to implement *"enhanced early and increased*

[1] WHO Global Tuberculosis report 2013

TB case detection and treatment with major focus on high risk population groups and congregate settings" also known as TB Reach. The objectives of this M&E plan for AAA will be to:

1. Increase the number of notified ALL TB cases in AAA sites from 2,877 in 2014 to at least 5754 in 2019, a 100% increase.
2. Increase the treatment success rate of bacteriologically confirmed TB cases in AAA sites from 90% in 2014 and maintain it to at least more than 90% by 2019.
3. Achieve 100% EQA participation among all TB diagnostic laboratories in AAA coverage by 2019.
4. Achieve 100% submission of specimen for DST and culture for all SS+ patients on CAT II in AAA sites by 2019.
5. Increase access to ARVs by TB/HIV co-infected patients in AAA sites from 32% in 2014 to 60% by 2019 through effective referral or co-location.

This monitoring and evaluation plan outlines the approach that will be employed for monitoring and evaluation of TB interventions in AAA coverage area in South Sudan and is consistent with and complements the NTLBP developed National TB Strategic Plan TB 2015-2019. It provides a description of the system that will be employed during the next five years by AAA to: a) monitor implementation of the planned project activities, b) assess progress towards the annual targets and benchmarks, c) evaluate contribution of the organizations outputs towards the combined national targets, d) support data collection, analysis, use of data to guide evidenced-based decisions, and e) steps for sharing and using the data to promote learning. It also shows the key indicators that will be used to track progress along with expected annual targets each in Annex I.

2.0. AAA approach to TB interventions Monitoring and Evaluation

For the updated NSP 2015-2019, the NTLBP approaches M&E as a cross cutting issue which will provide high quality valid data in a timely manner to accurately monitor program achievements and strengthen monitoring and reporting within the health sector. AAA will fit into the proposed M&E structure for TB interventions. The M&E officer will be responsible for the collection, collation and reporting of the data for all AAA coverage area and the TB officers and the other technical staff will play a key role in ensuring compliance with data collection tools at TBMU and satellite laboratories and provide updates and feedback at the implementing partners' forums at the various levels. To strengthen the one national M&E system for TB, AAA will use the nationally approved standardized tools for recording patient level information and reporting of summary data. AAA will collaborate with the NTLBP to ensure that the monitoring and reporting requirements of the program are met while simultaneously participating in strengthening capacity for monitoring and evaluation at county and State levels of the local health care system in the organization's coverage area.

Decentralization and DOTS expansion

In keeping with the decentralized structure of the health care system in South Sudan and the revised TB strategic Plan 2015-19, AAA will not only collaborate with the NTLBP in policy development at the national level but will also focus on building capacity for collection, collation and use of data at facility, State and County levels. Reported data will be filed and available at all levels with adequate dissemination at various forums conducted. This approach will foster local ownership of the data and empower local staff to use the data to guide decisions regarding the services provided at that level. This decentralized approach to monitoring and evaluation will lead to the development of solutions that best fit the needs of each area. The AAA headquarters will maintain the current structure to ensure that all data generated at the local level are sent to the NTLBP and promote tracking of progress at the national level. The AAA will strengthen the feedback mechanism to promote greater involvement of partners and local governments at various levels that ultimately lead to a "bottom-up" approach to the building of capacity for monitoring and evaluation and greater sustainability of the system.

TB services integration and capacity development:

The AAA M&E system in collaboration with the NTLBP will continue to provide tailor-made M&E training to meet the unique needs of staff at each level of the system. These will include modular training within a group setting, one-on-one mentoring of staff during site visits, and exchange programs for cross-pollination and practical learning.

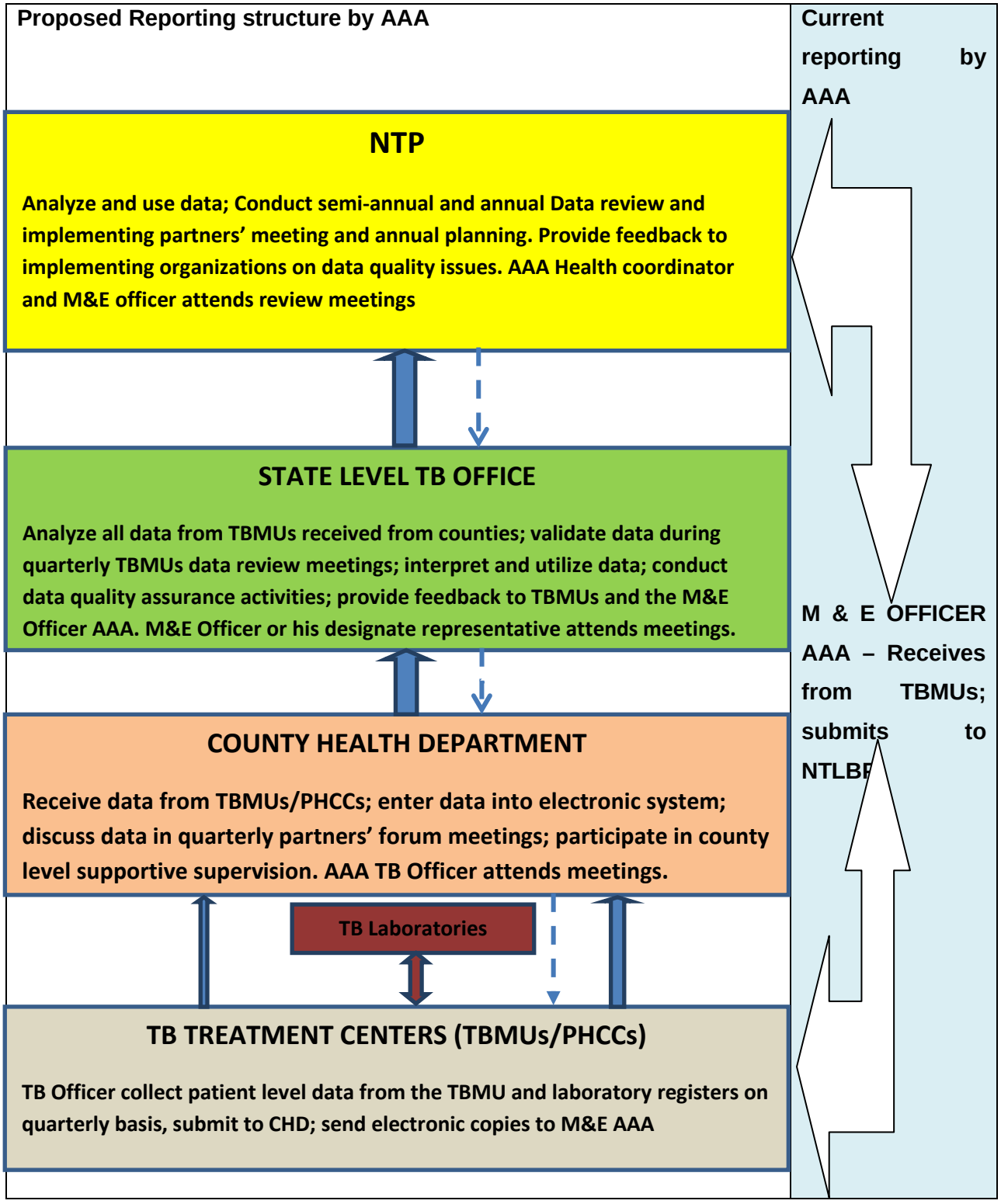
Currently there is inadequate of human resources both in numbers and capacity as well as a high rate of staff turnover in South Sudan. AAA will maintain a data base that describes the characteristics of persons who benefit from training through a standard sign-in sheet by persons who benefit as well as the training modules. These trainings will utilize the standard NTLBP approved training modules, available local resources within South Sudan and consultancies for high level trainings. See also capacity building plan notes in page …

Proposed Data collection and management:

Linkage to the national HMIS; paper and electronic system, promoting data use. Figure I below shows the flow of data from the facilities to the national level, the roles of staff at each level, and the proposed tools that will be employed by AAA in line with the National Program at each level.

AAA conforms to the National Tuberculosis Control Program reporting format and has in every basic management unit a Tuberculosis Basic Management Unit Register. All TB case finding record, laboratory activities and treatment outcomes data are entered in this register. On a quarterly basis, the TB Officer collects data and enters it into a quarterly report for treatment outcome and case finding. Currently this report bypasses the county and State levels and sent to the NTLBP due to inherent capacity gaps. AAA proposes to provide capacity building at the various levels in its coverage areas and have all the quarterly report is submitted to the County Medical Office which intern forwards the report to the State Ministry of Health and finally the Central Unit. Copies of the reports will then be submitted to the AAA headquarters that will provide routine supportive supervision to strengthen reporting systems. Feedback on data consistencies, quality and analysis should follow in the reverse manner.

Figure 1: Proposed and current reporting structure AAA



Notes on data quality assurance (DQA):

Review and evaluation are based on the information provided by monitoring. They are performed after implementation has continued for some time, often at the middle and the end of a funding or implementation period. As it would make no sense to try to measure everything that a program does, indicators are used. These are specific types of information that can be tested (validated) and relied upon to measure performance, progress and changes that can be linked to an activity.

Good data are essential for monitoring and evaluation. Activities and progress can be measured only if information is consistently and accurately recorded. Bad data will give an inaccurate picture of what is happening, for example when forms are not completed properly. This makes it difficult to know where good practice is happening and where action needs to be taken such as TA or change of plan to improve implementation. This will affect resource allocation as well as the management of the program.

A major requirement in ensuring that high quality data is captured and reported is controlling the quality of the data collection process at service delivery points through the use of standard tools for the collection, aggregation and reporting of all data. The should be complemented by a cadre of staff who are trained in using these tools coupled with rigorous follow up to assess compliance with the instructions. AAA will support dissemination of all NTLBP printed copies of relevant data recording and reporting tools to TB management facilities and track utilization of these to ensure adherence to guidelines and prevent stock-outs. While these will contain the relevant instructions as job aids or addendum, staff will be continuously trained and mentored in utilization. In addition, regular data quality assessments (DQA) will be undertaken during supervisory visits by AAA and the NTLBP at state and/or national levels either jointly or independently. AAA anticipates that a more regular internal DQA visits will be conducted by the M&E officer and a consultant to provide TA to the TB officers and the facility staff.

Data analysis, use and reporting:

The AAA will ensure strict adherence and understanding of data collected through TA and capacity building. AAA places high emphasis on the continued use of data to guide actions related to patient and program management and believes that data collection is only worthwhile if the data is used to guide decisions. AAA will provide continuous capacity building at TBMU and county level in its areas of operations to support data analysis and use to guide decisions related to TB at all levels.

AAA will provide quarterly performance monitoring reports to the NTLBP and its donors to track progress on implementation and achievements. These reports will show the quantifiable outputs of the project, using the appropriate and approved South Sudan NTLBP format, and provide reasons for any variation in its ability to meet established targets. As described above and in the proposed data flow table, AAA plans to attend all data validation and implementation sharing experiences at meetings or forums scheduled at all levels.

Operational research, experience sharing and promoting visibility of organizations and successes:

Operational research is a very useful capacity-building tool especially if the collected data is transformed into useful and correctly interpreted information. Implementing organizations that conduct operational research and/or routinely share implementation experiences and outcomes of various interventions including challenging tasks often learn new skills and the importance of collecting and documenting information. Operational research and data sharing can also make program activities better informed and help organizations to see how a program can become more effective. AAA will endeavor to document lessons learnt from successes and failures in all its implementations and share experiences in local, regional and international meetings and scientific conferences to guide the design of similar projects in the future. This is based on the premise that operational research can help to: assess the feasibility of new approaches identify how to improve health care and prevention.

3.0. Capacity building plan

Capacity-building aims to improve the ability of a person, group, organization or system to meet objectives or to perform better. For TB intervention activities, this means ensuring that all have the abilities, skills and resources to plan, implement and scale up their engagement. AAA will develop and review annually Capacity-building plan to include training, supervision, mentoring and adaptation of practices based on learning from experience or new evidence on what works. From our experience, this is likely to be needed in the following key areas:

- human resources: ensuring that sufficient people are involved, with the skills and abilities for technical, organizational, leadership and guidance tasks;
- financial resources: in collaboration with the NTLBP and other bilateral and multilateral donors, AAA will ensuring that sufficient funding is available to start up and sustain activities;
- material resources: in collaboration with the health system strengthening structures, AAA will ensuring that adequate infrastructure, information and commodities are available, e.g. tools are availed and places to work are maintained and renovated;
- systems development and strengthening: ensuring that systems are in place to support activities, including but not limited to; community support and care, TB referral, diagnosis and treatment and organizational systems; and
- knowledge-sharing: ensuring that data are collected, that good practices and lessons learnt are documented and shared in local, regional and international forums and conferences,

AAA understands clearly that capacity-building is an ongoing cycle. The AAA approach to capacity-building will depend on the national and local context. The capacity building plan will be part of AAA annual work plan meant to**:** strengthen systems and the organization, improve skills and performance of AAA staff and the county level in its operation area, and support scaling-up of activities when demand increases or in response to the South Sudan TB NSP as and when revised.

4.0. The M&E function in AAA: synergies with the NTLBP

The reporting of TB interventions in South Sudan is largely paper-based due to poor infrastructure and low funding levels. AAA will work collaboratively with the NTLBP and other stakeholders to introduce an electronic web based TB data collection system at TBMUs and at all reporting and data aggregation levels in South Sudan. In this implementation, AAA will ensure complementarity with the South Sudan HMIS.

All staff at the TBMUs, county and State Health Departments will be mentored on this initiative. AAA foresees adequate funding for this massive and costly adventure that is currently approved by WHO.

5.0. Concepts and definitions in the AAA M&E

AAA will base all its M&E activities on acknowledged conventional concepts and definitions. Monitoring and evaluation provides the mechanism for answering questions about the performance and effectiveness of any project or program. Monitoring and evaluation are aimed at measuring and collecting information on what is being done and what changes are happening over time in response to certain activities. M&E are important for a number of reasons:

• providing information on progress in implementation;

• assessing the quality and effectiveness of a program or activity; and

• reporting to the NTLBP, donors, and community representatives on what has been achieved, any barriers or blocks to implementation and lessons learnt.

These questions are usually answered through the use of a number of SMART indicators with corresponding targets which indicate the magnitude and direction of any change that may have occurred during program implementation. The selected indicators should be clear, easy to understand and SMART. They will help in tracking how the program is progressing with what it wants to achieve. AAA has tabulated the selected indicators in Annex 1 and included in Annex 2 the revised NSP 2015 – 2019 indicators and Annex 3 the NTLBP M&E framework for the NSP.

Monitoring

This is defined as the routine collection of data in order to determine if the project is on track, i.e. if activities are being implemented as planned, and to count the immediate outputs of specific interventions. Program monitoring can therefore serve to identify gaps/weaknesses in program implementation and involves the collection and use of routine HMIS and program data on the project's inputs, processes, and outputs.

- **Inputs** refer to the resources invested into the project, and may include for example, staff, money, time, buildings, commodities and supplies.

- **Processes** are the activities that are carried out by the project staff in order to achieve the stated objectives. Examples of processes for a TB control program may include activities such as the training of staff, provision of services such as TB education in schools, TB screening in congregate setting, quality assurance activities, development of guidelines and policies, and the printing of tools and forms for recording and reporting of information.

- **Outputs** are the immediate results or achievements that are seen as a result of services offered or the program processes. These generally fall into two broad categories namely, number of persons who accessed the services provided by the project of program and the number of persons trained. Examples of outputs are trained staff, community members reached with information materials, and persons who were screened for tuberculosis.

Evaluation

This is the systematic assessment of an ongoing or completed project to determine its effectiveness, identify factors that may have contributed to the achievement of results, and provide insights into possible actions that may be necessary to improve performance. Generally, evaluations are undertaken to improve performance on ongoing projects, assess their effect and impact, and inform decisions about future programs. Project evaluation can be either external or internal and generally involves the collection of data on the program's effectiveness or its outcomes and impact.

- **Outcomes** are the short or long-term results that have been achieved by the program. Outcomes may be changes knowledge, case notification rates in different states and counties; levels of access to TB related services, and outcomes of patients who received anti-tuberculosis treatment. In the context of TB control programs outcomes can be measured wither through the use of routine data or special surveys.

- **Impact** is often classified as a higher form of outcome and refers to changes at the population level. It refers to the superior goal of the overall national program. Impact seen at the population level may be due not only to interventions of any given project but may also be a reflection of changes that have been made though natural events as well as the

effects of other projects. It is usually the result of the sum of a number of different interventions.

Insert your review notes here for future revisions

Annex 1: AAA Implementation indicators

The following indicators and outcomes have been set based on the revised South Sudan National Strategic Plan (NSP) 2015 - 2019

Table 1: High priority AAA indicators

Activity	Indicator	Frequency	Quarter of the year	Target	Milestone by Year 2015-19					Responsible person	Source of funds	Means of verification/ data source
					15	16	17	18	19			
1. Capacity building to AAA and CHD staff												
1.1 Training of Home Health Promoters and/or TB Mobilizers	Number of HHP to be trained	Once a year	Q 3 Q4		X					TB officers	GFATM TB Reach MoH	Training reports
1.2 Sensitization community leaders and community theatre groups	Number community leaders/theatre sensitized	Once a year	Q 1- Q 4		x	x	x	x	x	TB Officers	GFATM TB Reach MoH	Sensitization report Signed attendance
1.3 Sensitization of HHP on TB screening and community TB	Number HHP/TB Mobilizers sensitized	Once a year	Q 1 – Q 2		x	x	x	x	x	TB Officers	GFATM TB Reach MoH	Sensitization report Signed attendance
1.4 Sensitization of HTC/VCT counselors and TB screening and community TB	Number HTC/VCT counselors sensitized	Alternate years	Q 1 – Q 2			x		x		TB Officers	GFATM TB Reach	Sensitization report Signed

											MoH	attendance
1.5 Refresher AFB microscopy for laboratory staff	Number of Lab Tec/Ass refreshed	Half yearly	Q 3		x	x	x	x	x	RoSS Regional Lab Tech	GFATM TB Reach MoH	Training reports Signed attendance
1.6 Training of TB Officers and TBMU staff on Community TB and ENGAGE TB implementation	Number of staff trained	Alternate years	Q 2 – Q 3			x		x		AAA Health Coordinator	GFATM TB Reach MoH	Training reports Signed attendance
1.7 Training of TB Officers and TBMU staff on TB HIV	Number of staff trained	Alternate years	Q 1 Q 4		x		x		x	AAA Health Coordinator	GFATM TB Reach MoH	Training reports Signed attendance
1.8 Training of TB Officers and TBMU staff on Infection Prevention Control	Number of staff trained	Alternate years	Q 1 Q 4			x		x		AAA Health Coordinator	GFATM TB Reach MoH	Training reports Signed attendance
1.9 Training and orientation of CHD staff on Integration and M&E skills to support TBMUs	Number of CHD staff trained	Annual	Q 4		X		x		x	AAA Health Coordinator	GFATM TB Reach MoH	Training reports Signed attendance
1.10 Develop scientific paper for dissemination in 45th International Lung Health Conference	Number of conferences attended with	Annual	Q 4		x	x	x	x	x	AAA Health Coordinator	GFATM TB Reach	Paper presented, Conference

	presentations										MoH	booklet
2. Out Reaches												
2.1 Conduct TB out reaches to underserved populations	Number of out reaches conducted	Monthly	Q1 – Q4		x	x	x	x	x	TB officers,	GFATM TB Reach MoH	Out reaches reports TB Outreach registers
2.2 Conduct laboratory quality assurance (EQA) visits to TBMUs	Number of quality assurance visits carried out	Quarterly	Q1 - Q4		x	x	x	x	x	M&E Officer	GFATM TB Reach MoH	Supervision report
2.3 Supportive M&E visits to TBMUs	Number of M&E visits done	Quarterly	Q1 – Q4		x	x	x	x	x	M&E Officer	GFATM TB Reach MoH	M&E supervision reports
2.4 Conduct Door to Door TB screening of contacts of TB patients	Number of people screened	Daily	Q 1 – Q 4		x	x	x	x	x	TB Officers	GFATM TB Reach MoH	Quarterly reports, TB contact screening register
2.5 Conduct out reaches to hard-to-reach areas and congregate settings	Number of out reaches carried out	Quarterly	Q 1 – Q 4		x	x	x	x	x	TB Officers	GFATM TB Reach MoH	Quarterly reports
2.6 Conduct feedback meetings and TB education to TB Ambassadors,	Number of feedback meetings	Monthly	Q 1 – Q 4		x	x	x	x	x	TB Officers	GFATM	Quarterly

TB Clubs	carried out										TB Reach MoH	reports
2.7 Conduct TB education in schools	Number of schools TB education done	Quarterly	Q 1 – Q 4		x	x	x	x	x	TB Officers	GFATM TB Reach MoH	Schools TB education report
3. Procurement to facilitate TB mobilization and health promotion and expansion of DOT coverage												
3.1 Purchase of Motorbikes	Number of motorbikes	Once a year	Q 3 - Q4		x					Procurement Officer	GFATM TB Reach MoH	LPO, invoice, payment receipts
3.2 Procurement of bicycles to facilitate TB mobilizers community activities	Number of bicycles purchased	Once a year	Q 3 - Q4		x		x		x	Procurement Officer	GFATM TB Reach MoH	LPO, invoice, payment receipts
3.3 Purchase of IPAD and smart phones to facilitate timely reporting	Number of IPAD and Smart phones purchased	Once a year	Q 2 - Q3		x		x			Procurement Officer, TB officer, TB Coordinator, Finance Officer	GFATM TB Reach MoH	LPO, invoice, payment receipts
3.4 Purchase of branded bags, umbrella, T-shirts to promote visibility and	Number of assorted items (branded bags,	Annual	Q 1		x	x	x	x	x	Procurement Officer, TB officer, TB	GFATM	LPO,

health messaging	umbrella, T-shirts)		Q 3							Coordinator, Finance Officer	TB Reach MoH	invoice, payment receipts
3.5 Develop and revise health promotion materials for radio and other communications channels materials	Number of radio spots and messages developed	Once a year	Q 1		x	x	x	x	x	AAA Health coordinator	GFATM TB Reach MoH	Quarterly reports, LPOs, VCD recorded materials and prints
3.6 Conduct radio programs through live talk shows and dramatized ads to promote behavior change	Number of talk shows and dramatized series aired	Yearly	Q1		x	x	x	x	x	AAA Health Coordinator	GFATM TB Reach MoH	Media reports, invoices, payment receipts
3.7 Support activities for commemoration of World TB Day	Number of counties supported for WTBD activities	Yearly	Q 1		x	x	x	x	x	AAA Health Coordinator	GFATM TB Reach MoH	Activity reports
3.8 Expand coverage for DOT to existing PHCs	Number of TBMUs initiated among existing PHCCs in coverage area	Annual	Q 1 – Q 4		x	x	x	x	x	AAA Health coordinator	GFATM TB Reach MoH	NTLBP quarterly/ Annual reports
3.9 Support to ensure functionality of expanded TBMUs	Number of New TBMUs with minor renovations and refurbishments	Annual	Q 1 – Q 4		x	x	x	x	x	AAA Health Coordinator	GFATM TB Reach	NTLBP quarterly/ Annual

	conducted										MoH	reports
3.10 Submit Sputum samples from among retreatment patients for DST	Number of sputum samples submitted for DST and culture among bac+ confirmed retreatment patients registered in the quarter	Annual	Q 1 – Q 4		x	x	x	x	x	Lab Tech	GFATM TB Reach MoH	NTLBP quarterly/ Annual reports
3.11 Increase the number of notified TB cases in coverage area from 2877 in 2014 to at least 5754 in 2019	Number of TB cases ALL forms notified to the National authority (NTLBP) in the quarter	Annual	Q 1 – Q 4		x	x	x	x	x	TB Officers	GFATM TB Reach MoH	NTLBP quarterly/ Annual reports
3.12 To sustain the treatment success rate of bacteriologically confirmed TB cases above 90% each year up to 2019	Percentage of SS+/bac+ (N+ and R+) patients successfully treated among registered TB patients in quarter	Annual	Q 1 – Q 4		x	x	x	x	x	TB Officers	GFATM TB Reach MoH	NTLBP quarterly/ Annual reports
3.13 To achieve and sustain treatment success rate of 85% among ALL TB cases	Percentage of TB patients ALL types successfully treated among registered ALL types TB patients in quarter	Annual	Q 1 – Q 4		x	x	x	x	x	TB Officers	GFATM TB Reach MoH	NTLBP quarterly/ Annual reports

4. Staff Establishment												
4.1 Laboratory and Health Workers to support short term implementation (Mobile TB officers on relieving duties, CHD staff for incentives and consultants)	Number of staffs recruited	continuous	Q 1 – Q 4		x	x	x	x	x	Director AAA		Interview form, recommendation from CHD and in charge of PHCC
OTHER AAA SUPPORTING PROGRAMS												
Leprosy Control Program												
1. Capacity building												
1.1 training of Leprosy volunteers/assistants on Leprosy prevention and treatment interventions	Number of staff trained	Alternate years	Q 1 – Q 4		x		x		x	AAA Health Coordinator	GLRA	Training report Signed attendance list
1.2 Supportive supervision and mentorship to Leprosy assistants	Number of supervisions conducted	Quarterly	Q 1 – Q 4		x	x	x	x	x	AAA Health Coordinator	GLRA	Supervision reports
1.3 Training of Leprosy assistants on Occupational therapy and activities of daily living	Number of leprosy assistants trained	Annual	Q 1 – Q 4		x	x	x	x	x	AAA Health Coordinator	GLRA	Training reports Signed Attendance list
2. Primary health care and Surgical Interventions												

2.1 Routine and emergency reconstruction/rehabilitation of deformities for Persons Affected with Leprosy (PALs)	Number of PAL benefitted from surgical	Half yearly	Q 1 Q 4		x	x	x	x	x	AAA Health Coordinator	GLRA Friends of AAA	Activity report
2.2 Elective surgery to correct deformities and facilitate activities of daily living (ADL)	Number of patients screened and benefitted from surgical mission	Half yearly	Q 1 Q 4		x	x	x	x	x	AAA Health Coordinator	GLRA Friends of AAA	Surgical team activity report
3. Out reaches for active case search and mop up towards elimination of leprosy												
Leprosy screening in remote areas and contacts of newly diagnosed and active leprosy disease.	Number of out reaches carried out	Monthly	Q 1 – Q 4		x	x	x	x	x	Leprosy Assistant	GLRA Friends of AAA	Out reaches reports
Prevention and health promotions activities in Primary health care												
Health education	Number of people health educated on basics for leprosy prevention	Daily	Q 1 – Q 4		x	x	x	x	x	Leprosy assistant	MoH Friends of AAA	Health education diary
Distribution of ITNs to pregnant and lactating mothers	Number of ITNs distributed to pregnant and lactating mothers	weekly	Q 1 – Q 4		x	x	x	x	x	Officer i/c PHCC/U	MoH Friends of AAA	Distribution report
Provision of Mebendazole to	Number of children de-	Daily	Q 1 – Q 4		x	x	x	x	x	Officer i/c	MoH	Monthly epidemiologic

children	wormed									PHCC/U	Friends of AAA	al report
Curative services for PHCC/Us												
Provision of diagnostic and treatment services to outpatient and in-patients at PHCC/U	Number of people treated	Daily	Q 1 – Q 4		x	x	x	x	x	PHCC i/c	MoH Friends of AAA	Epidemiological report
Provision of high energy food for malnourished children	Number of malnourished children benefitting from nutrition program	Daily	Q 1 – Q 4		x	x	x	x	x	Nutritionist	MoH Friends of AAA	Nutrition activity report
Immunization of children under 5 years	Number of children receiving immunization	Monthly	Q 1 – Q 4		x	x	x	x	x	EPI officer	MoH Friends of AAA	EPI report
Provision of ANC to all pregnant mothers	Number of pregnant mothers attending ANC	Monthly	Q 1 – Q 4		x	x	x	x	x	Midwife, nurses	MoH Friends of AAA	ANC report
Rehabilitation/construction of	Number of building rehabilitated/const	Annual	Q 1		x	x	x	x	x	Finance	MoH	Building

health provision service area	ruction		Q 4							Manager	Friends of AAA	report
Provision of Emergency Obstetric services (EmONC).	Number of pregnant mothers benefitted from Caesarian section	Daily	Q 1 – Q 4		x	x	x	x	x	Obstetrician	MoH Friends of AAA	Quarterly Maternal & reproductive health reports
Capacity building												
On job training for health staff on PHC and EmONC	Number of staff benefitted on job training	Monthly	Q 1 – Q 4							Obstetrician	MoH Friends of AAA	Training and Mentorship report, Signed attendance list
Training of health staff on current practices on anaesthesiology	Number of staff attending short course training in local or regional institutes	Annual	Q 4 – Q 1		x		x		x	AAA Health coordinator	MoH Friends of AAA	Training report, Copies of certificate of attendance

Annex 2: High priority NTLBP Strategic Plan indicators

The following indicators for South Sudan TB program implementations were selected from the NSP in a consultative process.

Objective	Outcome Indicator	Baseline and year	Milestones by Year				
			2015	2016	2017	2018	2019
1. To increase the number of notified TB cases to at least 24,000 in 2019.	Case notification rate of all forms of TB per 100,000 population - bacteriologically confirmed plus clinically diagnosed, new and relapse cases (disaggregated by age <15, 15+, sex and HIV status)	78 (2012)	105	112	119	123	141
2. To increase the treatment success rate of bacteriologically confirmed TB cases from 72% in 2012 to at least 85% by 2019.	Treatment success rate - bacteriologically confirmed new TB cases (disaggregated by age <15, 15+ and sex)	72.2% (2012)	80.0%	82.0%	85.0%	85.0%	85.0%
3. To achieve a treatment success rate of at least 75% among enrolled Multi Drug Resistant TB (MDR-TB) patients by 2019.	Notification of RR-TB and/or MDR-TB cases- Percentage of notified cases of bacteriologically confirmed, drug resistant RR-TB and/or MDR-TB as a proportion of the estimated number of RR-TB and/or MDR-TB cases among notified TB cases who are put on second line treatment	0% (2014)	5%	9%	15%	20%	25%
4. To reduce death rate during TB treatment in TB/HIV co-infected patients from 11% to less than 5% by 2017.	Death rate in TB/HIV patients on TB treatment	11% (2012	9%	7%	5%	5%	5%
5. To strengthen overall NTLBP program	Program targets achieved						

management capacity to achieve at least 80% of program targets by 2019.		No (2014)	Yes	Yes	Yes	Yes	Yes

Insert your review notes here for future revisions

Annex 3: The NTLBP Monitoring and evaluation framework for the NSP in South Sudan

	Indicators	Definition	Baseline/ Year	Target	Data Source	Frequency	Responsible	Frequency of Reporting
Goal: To contribute towards the reduction of TB prevalence from 257/100,000 (WHO estimate 2012) to 180/100,000 (30%) by 2030								
Objective 1: To increase the number of notified TB cases to at least 24,000 in 2019.								
	Case notification rate							
1.1.	Number and proportion of labs with 100% concordance at EQA	Numerator: Number of labs with 100% concordance Denominator: Total number of labs participating in EQA	19 (98%) 2014	200 (100%)	EQA reports	Quarterly	Program officers	Quarterly
1.2.	Number and proportion of private hospitals and clinics providing TB diagnostics	Numerator: Number of private hospitals and clinics providing periodic reports Denominator: Number of private hospitals and clinics validated for TB activities	100%	0%	Quarterly reports	Quarterly	Program officers	Quarterly
1.3.	Number and proportion of presumptive TB cases referred for diagnosis from high-risk and hard-to-reach populations	Numerator: Number of presumptive TB cases referred for diagnosis from high-risk and hard-to-reach populations Denominator: All presumptive TB cases	n/a	34,472 (10%)	Quarterly reports	Quarterly	Program officers	Quarterly
1.4.	Number and proportion of children enrolled on TB treatment	Numerator: Number of children enrolled on TB treatment Denominator: Number of all forms of TB	24%	10%	Quarterly reports	Quarterly	Program officer	Quarterly
1.5	Number of new TB patients (all forms) referred by community health workers or community volunteers to health facility for diagnosis and notified in BMU in notification period	Numerator: Number of all forms of TB referred by CHWs or community mobilizers Denominator: Number of all forms of TB notified			Quarterly reports	Quarterly	Program officer	Quarterly
1.6.	Number of health facilities with integrated TB	Numerator: Number of health facilities with integrated TB	N/A	200	Annual report	Annually	NTLBP	Annually

	Indicators	Definition	Baseline/ Year	Target	Data Source	Frequency	Responsible	Frequency of Reporting
	activities	services Denominator: All health facilities		(100%)			manager	
Objective 2: To increase treatment success rate of bacteriologically confirmed TB cases from 72% in 2012 to at least 85% by 2017								
2	Treatment success rate (TSR)	Numerator: Number of all new TB patients who are cured or who have completed treatment Denominator: Number of new patients enrolled on treatment	72.2%	85%	Annual report	Annually	NTLBP manager	Annually
2.1.	Number and proportion of health facilities providing quality anti-TB treatment	Numerator: Number of health facilities providing quality TB treatment Denominator: Total number of health facilities providing TB services	100	200 (100%)	Annual Report	Annually	NTLBP manager	Annually
2.2.	Number of TBMU visited where anti-TB drugs are present out of total number of BMU visited	Numerator: Number of TBMU where anti-TB drugs are present Denominator: Total number of TBMU visited	100%	100%	Quarterly reports	Quarterly	Program officer	Quarterly
2.3.	Number and proportion of new TB patients (all forms) under supervision of community TB mobilizers who successfully complete TB treatment	Numerator: Number of new TB patients under supervision who were successfully treated Denominator: Total patients on treatment under supervision of mobilizers	N/A	90%	Quarterly reports	Quarterly	Program officer	Quarterly
Objective 3: To achieve a treatment success rate of at least 75% among enrolled MDR-TB patients by 2019								
3.	MDR-TB TSR	Numerator: Number of MDR-TB patients cured or who have completed treatment Denominator: Total number of	N/A	75%	Quarterly reports	Quarterly	Program Officer	Quarterly

	Indicators	Definition	Baseline/ Year	Target	Data Source	Frequency	Responsible	Frequency of Reporting
		MDR-TB patients						
3.1.	Number and proportion of laboratory-confirmed cases of MDR-TB identified among new cases and re-treatment cases	Numerator: Number of confirmed MDR-TB patients Denominator: Total number of new and re-treatment cases tested for MDR-TB	15/235 (6.4%)	457/5131 (8.9%)	Quarterly reports	Quarterly	Program Officer	Quarterly
3.2.	Number and proportion of DR-TB cases put on treatment among the notified cases	Numerator: Number of DR-TB patients enrolled on treatment Denominator: Total number of confirmed DR-TB patients	n/a	320 (70%)	Quarterly reports	Quarterly	Program Officer	Quarterly
3.3.	Number of MDR-TB patients who are provided with support throughout the treatment period	Numerator: Number of MDR-TB provided with support Denominator: Total number of MDR-TB patients	N/A	457 (100%)	Quarterly reports	Quarterly	Program Officer	Quarterly
Objective 4: To reduce death rate during treatment among TB/HIV co-infected patients from 11% to less than 5% by 2017								
4.	Death rate among TB/HIV patients	Numerator: Number of TB-HIV co-infected patients who die during treatment Denominator: Total number of TB-HIV co-infected patients during the cohort period	11%	Less than 5%	Quarterly reports	Quarterly	Program Officer	Quarterly
4.1.	Number and proportion of functional TB/HIV coordination bodies at national, state, and county levels	Numerator: Number of functional TB/HIV coordination bodies Denominator: Total number of TB/HIV coordinating bodies formed	1	90 (100%)	Meeting minutes	Quarterly	Program Officer	Quarterly
4.2.	Number of PLHIV who were screened for TB in HIV care or treatment settings	Numerator: Number of PLHIV who were screened for TB	N/A	22,750 (100%)	Pre-ART and ART registers Screening	Quarterly	HIV program	Quarterly

	Indicators	Definition	Baseline/ Year	Target	Data Source	Frequency	Responsible	Frequency of Reporting
		Denominator: Total number of PLHIV			tool			
4.3.	Number and proportion of TB and HIV sites with operational infection control plans in place	Numerator: Number of health facilities implementing TB infection control plan Denominator: Total number of health facilities with TB infection control plan	N/A	200 (100%)	Supervisory reports	Quarterly	Program officer	Quarterly
4.4.	All (100%) of HIV positive TB patients will be enrolled on ART by 2019	Numerator: Number of HIV positive TB patients enrolled on ART Denominator: Total number of HIV positive TB patients	N/A	100%	TBMU registers Quarterly reports	Quarterly	Program officers	Quarterly
Objective 5: To strengthen overall NTLBP program management capacity to achieve at least 80% of program targets								
5.	Program targets achieved	Yes/No	No	Yes	Annual reports	Annually	NTLBP Program manager	Annually
5.1.	Availability of core NTLBP policy documents, manuals, and periodic reports	Yes/No	No	Yes	Annual reports	Annually	NTLBP Program manager	Annually
5.2.	Number and proportion of key NTLBP staff positions filled as in organogram (12 central, ten state, 79 county, and five CRL)	Numerator: Number of key NTLBP positions filled by national staff Denominator: Total number of key NTLBP position as described in NTLBP human resources development plan	18	106	Annual reports	Annually	NTLBP Program manager	Annually
5.3.	NTLBP budget allocated for operations to implement DOTs as required by annual plan	Numerator: Total amount of funds allocated for DOTS in	N/A	80%	Annual reports	Annually	NTLBP Program	Annually

	Indicators	Definition	Baseline/ Year	Target	Data Source	Frequency	Responsible	Frequency of Reporting
		previous years NTLBP budget Denominator: Total amount of funds budgeted for DOTs in previous year as in annual plan					manager	
5.4.	Number of supervisory visits performed during specified period out of planned supervisory visits using supervisory check list	Numerator: Number of supervisory visits performed during specified time Denominator: Total number of planned supervisory visits during specified period of time		100%	Supervisory reports	Quarterly	Program officers	Quarterly
5.5.	Number and proportion of health facilities that submit case finding and treatment outcome reports to the NTLBP quarterly	Numerator: Number of health facilities submitting timely reports Denominator: Total number of health facilities providing TB services	75%	100%	Quarterly reports	Quarterly	Program officers	Quarterly
5.6.	Proportion of funding from government for annual plan of activities out of total budget required for full implementation of annual plan of activities	Numerator: Total annual government allocation for TB implementation Denominator: Total implementation amount as in annual plan	5%	15%	Annual report	Annually	NTLBP manager	Annually
5.7.	Number of stock-out days of first line drugs in a given period at all levels	Numerator: Total number of stock out days for all FLDs x100 Denominator: 365 x Number of FLDs	N/A	0%	Storage facility individual drug stock cards	Quarterly	Program officer	Quarterly