External Evaluation Report

LHL/CHEP project "Strengthening Community Responses to TB and HIV/AIDS"

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ACRONYMS

ACSM	-	Advocacy, Communication and Social Mobilisation
AIDS	-	Acquired Immune-Deficiency Syndrome
CAT	-	Community Advocacy Team
CBO	-	Community-Based Organisation
CDR	-	Case Detection Rate
CBoH	-	Central Board of Health
CHAZ	-	Churches health Association of Zambia
CHEP	-	Copperbelt Health Education Project
CSO	-	Central Statistical Office
DATF	-	District HIV/AIDS Task Force
DCT	-	Diagnostic Counselling and Testing
DHMT	-	District Health Management Team
DOT		Directly Observed Treatment
DOTS	-	Daily Observed Short Course Therapy
E	-	Ethambutol
GF	-	Global Fund
GRZ	-	Government of the Republic of Zambia
IEC	-	Information, Education and Communication
H	-	Isoniazide
HIPC	-	Highly Indebted Poor Country
HIV	-	Human Immune Virus
HMIS	-	Health Management Information System
IUATLD		International Union Against Tuberculosis and Lung Disease
KAP	-	Knowledge Attitudes and Practices
LHL	-	Norwegian Heart and Lung Patients Organization.
LCMS	-	Living Conditions Monitoring Survey
M & E	-	Monitoring and Evaluation
MOH	-	Ministry of Health
NGO	-	Non-Governmental Organisation
NHC	-	Neighbourhood Health Committee
NORAD		Norwegian Cooperation for International Development
NTLP	-	National TB/ L Programme
PRSP	-	Poverty Reduction Strategy Paper
R	-	Rifampicin
SAP	-	Structural Adjustment Programme
SSA	-	Sub-Saharan Africa
TB	-	Tuberculosis
TPHAZ	-	Traditional Health Practitioners Association of Zambia
WHO	-	World Health Organisation
Z	-	Pyrazinamide
ZNAN	-	Zambia National HIV/AIDS Network
ZAMBART		Zambia AIDS Related Tuberculosis Project

EXECUTIVE SUMMARY

BACKGROUND

The Norwegian Heart and Lung Patient Organization (LHL) entered into a three years agreement (2004-2006) with CHEP to implement a program that would strengthen community response to TB and the co-infection of TB and HIV. The project was implemented in the context of high poverty levels and disease burden in the Copperbelt province, Zambia. Due to the overall decline in the economic performance, over the last 10 years or so, poverty levels have increased with over 70 percent of the population living on less than US$1 per day in 2005. In 2005, World Health Organisation (WHO) ranked Zambia among top 10 countries in the World with highest incidence of TB.

THE EVALUATION

LHL/CHEP commissioned two consultants to independently undertake the evaluation of LHL/CHEP Project *"Strengthening Community Responses to TB and HIV/AIDS".* The essence of the external evaluation was to have an independent review of the implementation of the project in order to assess achievements of the stated objectives, identify challenges so as to come up with appropriate recommendations.

The external evaluation was conducted in four districts on the Copperbelt: Kitwe; Chililabombwe; Masaiti; Lufwanyama. Data was collected through the review of key project documents, key informant interviews, Focus Group Discussions (FGDs) and unstructured observations.

FINDINGS

The project was successfully implemented following national and international standards and guidelines. Yearly technical support visits by LHL helped ensure that the project was on course. The evaluation found that the project has achieved its objectives and goals by implementing its planned activities in the four districts. Although TB case detection has not decreased in the four districts, the project has contributed to the improvement of treatment outcomes.

The project aimed at building capacity to control the dual TB and HIV epidemic. Capacity building was done in the form of training of community members as treatment supporters. The training was conducted in collaboration with DHMT and other stakeholders using national guidelines and curricula.

The Involvement of former TB patients as TB treatment supporters is recommendable and is inline with the national policy of community participation. However, the involvement of family members was low and the project needs to strengthen the role of family members in the provision of DOTS in order to lessen the burden of treatment supporters who have to travel long distance to supervise DOT daily. IEC was one of the core elements of CHEP TB project intervention even though CHEP did not develop a clear strategy to facilitate effective implementation.

MAIN RECOMMENDATIONS

- LHL/CHEP should maintain its strategy of strengthening community response on TB and HIV. The focus should continue to be on building capacity of community groups with attention to former TB patient groups and strengthening their institutional capacity.

- While CHEP has done tremendously well in building the capacity of treatment supporters on DOT, and in exceptional cases, the supporters can perform the role of a care giver, family members need to be mobilised and educated to ensure that they are involved in their relatives' treatment.

- Since (IEC) ACSM is the core intervention for CHEP TB project, there is need to develop an ACSM strategy with clear goals and targets for the implementation.

- LHL/CHEP should maintain database of TB patients notified and treated in the project areas whilst building the capacity of its staff in collection and analysis of the data and use the information in planning and monitoring of the project.

- Training of all the players including CBOs should be based on needs assessment for relevance and cost effectiveness. The needs assessments should be conducted at the end of each phase of the project circle in order to feed into the next set of strategies and planned activities.

- There should be proper documentation of all community-based activities and capacity for community-based information systems should also be built.

- LHL/CHEP should develop guidelines and manual for formulation and mentoring of CBOs. This should be based on well documented relevant experiences of the processes and outcomes.

- Best practices within the processes of establishing and mentoring of former TB patient and traditional healers CBOs should be well documented for replication and also for sharing with other organizations working with communities in TB and other diseases.

- The cooperation between the DHMTs and LHL/CHEP should be governed by formal arrangements that spell out roles and responsibilities. A Memoranda of Understanding (MoUs) should be developed and signed by both parties as a way of formalising the partnerships.

- Whilst the project has empowered communities with knowledge and skills and also assisted them to build enduring community structures, financial sustainability strategies must equally be built into the project at the design stage. With better insights gained over the last three years, CHEP/LHL needs to explore ways of gradually linking-up community based groups to micro-financing institutions for financial sustainability.

1. BACKGROUND

1.1 Introduction

Copperbelt Health Education Project (CHEP) and Norwegian Heart and Lung Patients Organization (LHL) commissioned two consultants to independently undertake the evaluation of LHL/CHEP Project *"Strengthening Community Responses to TB and HIV/AIDS"* at the end of three years of implementation from 2004 to 2006.

It is evident from the findings of this evaluation that a number of activities have been implemented and considerable achievements towards attaining the intervention objectives have been made. This report provides details of the evaluation of the *"Strengthening Community Responses to TB and HIV/AIDS"* Project. The report also describes HIV/AIDS/TB policy scenario and the project implementation within the policy guidelines and frameworks. Lessons learnt and the major challenges faced during the implementation are discussed followed by the recommendations of what needs to be done in order to improve future performance of CHEP's TB and HIV/AIDS programme.

1.2 National Development and Health Policy Implementation Environment

This section provides a brief overview of the general socio-economic context of Zambia's development, with a view to assess the enabling environment, or otherwise, for implementing TB and HIV/AIDS interventions. The poverty situation in Zambia is highlighted because of its contribution to TB and HIV/AIDS in particular and on the health of the population in general.

1.2.1 Macroeconomic Environment and Poverty

In the last 42 years, Zambia has moved from being one of the middle income countries in Sub-Saharan Africa (SSA), with US$1200 per capita at independence in 1964, to being one of the poorest with per capita income of less than US$200 in 2000 (CSO 2004). Zambia's human development index ranked at 165 out of 174 countries in 2004 reflecting a decline from 153rd position in 2000 (Human Development Report, 2006). The macroeconomic downward trend has been due to both internal and external factors – e.g. decline in terms of trade for copper, economic mismanagement, rapid implementation of Structural Adjustment Programme (SAP) measures since 1991 (CSO 1999). Consequently, Zambia came to be classified as a Highly Indebted Poor Country (HIPC). Even under this status, the country still had to make substantial foreign debt repayments, although the relief through HIPC have not really altered the adverse economic conditions affecting the majority of the people. The utilisation of the savings by the Government is still a matter of concern on the part of the general public, Non-Governmental Organisations (NGOs) and cooperating partners.

The HIPC conditions included a wage freeze. The wage freeze had a negative effect on the working conditions of key workers such as teachers and health staff. Historically, the Government has been the main employer of labour. The decline in formal sector employment has led to rapid growth in the

informal employment, which now employs over 70 percent of the Zambian labour force (CSO, 2004). This trend in employment structure is not conducive to rapid socio-economic development because of the fact that the informal sector, in which youths and women predominate, is characterised by low productivity and low incomes. Due to the overall decline in the economic performance, over the last 10 years or so, poverty levels have increased with over 70 percent of the population living on less than US$1 per day in 2005. Persons living in female-headed households are likely to be extremely poor than those living in male-headed households. For example, in 2004 it was found that food poverty was more prevalent in female-headed households (61%) than in male-headed households (52%) (CSO, 2004). Poverty is multi-dimensional and may be measured in a number of aspects including:

- high levels of malnutrition as reflected in the incidence of stunting in children (53% in 1995);
- poor health reflected in the spread of TB (425/100,000 population in 2000);
- high prevalence of HIV/AIDS (16% of the population was estimated to be HIV positive in 2000) (CSO 2002);
- low survival rates as reflected in high infant mortality rates (162/1000 in 2000 died before fifth birthday compared to 121/1000 in 1980); and
- decline in life expectancy from 42 years at independence in 1964 down to 37 years in 2000 (UNDP/HDR 2000).

1.2.2 Policy Response to Poverty and HIV/AIDS/TB

The most relevant general policies aimed at addressing poverty and the poor health status of the populations is the Poverty Reduction Strategy Paper (PRSP, 2001), the National Health Policy (2005), HIV/AIDS/TB Policy and the National HIV and AIDS Strategic Framework -2006-2010.

The *PRSP*, developed through a highly consultative process, represented Zambia's medium term overall policy framework for national planning and interventions for development and poverty reduction for the period 2002-2004, and would roll over every three years. It is the overarching national development policy on which sector policies are centred for sustainable development, and is, therefore, premised on broad coordination and harmonisation of various economic growth and other development interventions (PRSP 2001). The basic strategy for poverty reduction is rapid economic development and employment creation, which places emphasis on public institutional capacity building and the creation of a conducive environment for participation of other development actors (private sector, NGOs, CBOs, churches and the beneficiaries).

The *National Health Reform* (1992) and the *National Health Policy* (2005), stress access to and quality health services delivered *"as close to the family as possible"*. The health reforms aimed to increase efficiency of health services by:

- moving from centralised to decentralised planning systems;
- redistributing funds from tertiary to peripheral levels;
- introducing alternative funding mechanisms,

- provision of integrated services to the private sector and non-governmental organisation (National Health Reform 1992).

In order to foster the delivery of services at the family, village and community levels, the Neighbourhood Health Committees (NHCs) were formed to represent the populations covered by planned health facilities. At health centre level, health centre committees were formed to promote local community involvement in the catchment areas. At the district level, the District Health Management Teams (DHMTs) were responsible for the district and the Hospital Management Boards were responsible for the operation of district, general and central hospitals. At national level the CBoH functioned as the implementing agent of the Ministry of Health (MoH). This decentralised structure enabled decisions to be made locally according to the prevailing conditions. However, available data indicate that resource constraints negatively affected implementation of the health reforms. SAP measures included the introduction of medical fees, which reduced access to health care by the majority, most of whom fall in the poor category (National Health Reform 1992).

Needless to mention that in the 1980s Zambia had a very effective National TB and Leprosy Control Programme (NTLP). With the coming of the health reforms, the vertical approach to TB control was abandoned and instead an integrated approach was adopted. Unfortunately, the desired results were not achieved as the integrated approach led to very weak programmes on the prevention and control of TB (National AHIV/AIDS Policy 2005). Since the dissolution of the CBoH in 2005, the functions of health policy and programme implementation have reverted back to the Ministry of Health and the NTLP has since been restructured as shall be shown letter in this report.

The *National HIV/AIDS Policy (2005) and National HIV and AIDS Strategic Framework (2006-2010)*, define the country's response to the HIV/AIDS epidemic *"as a continuum of prevention (limiting the spread), mitigation (address impact), treatment and care (support those already infected with HIV"*.
The implementation of the policy and the strategic framework are coordinated by the National AIDS Council. The policy stresses the need for:

- a legal framework;
- appropriate national coordination and advocacy framework;
- treating HIV/AIDS/TB as a public health, social and economic problem; Information, Education and Communication for behavioural change;
- protection of human rights of the infected and affected.

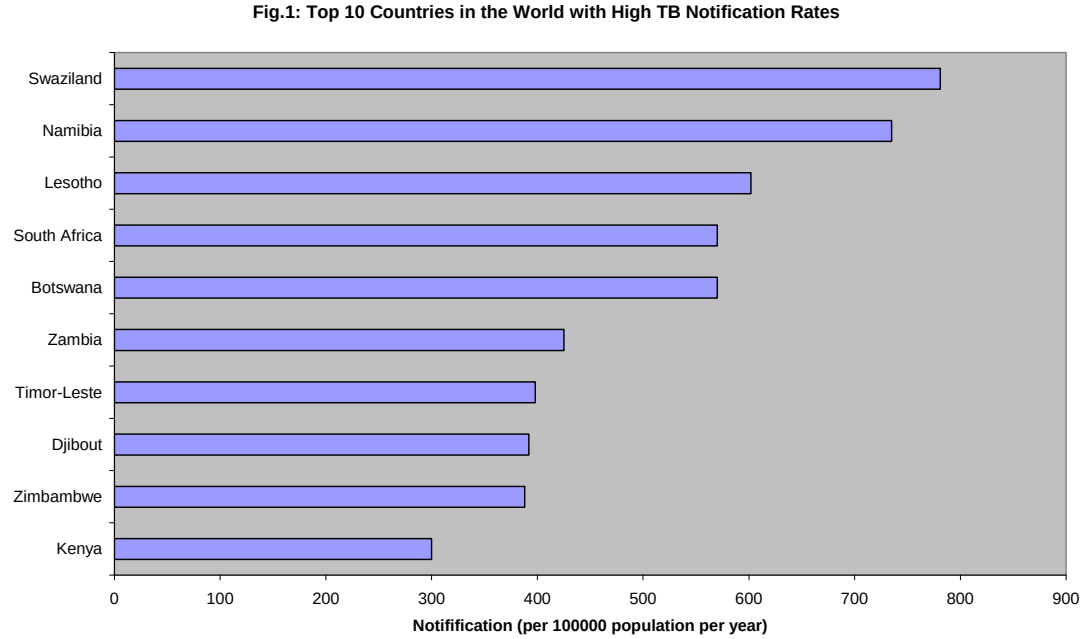
The above policies have a direct bearing on the successful implementation of HIV and TB programmes in the country. Policies that tackle both poverty and HIV/AIDS contribute immensely to reducing the incidence of TB. Similarly, the reduction in the incidence of TB contributes to improved health status of populations thereby creating opportunities for sustained economic development of the country.

1.3 TB/HIV/AIDS Situation and National Response

1.3.1 Tuberculosis in Zambia

Zambia is among the countries with high TB case notifications in the World. WHO has ranked Zambia in 2005, as the 6th leading country in the world with high incidence rate (Global TB report, 2007). Figure one presents WHO ranking of countries in the world with high case notification rates

Figure 1: WHO ranking of countries in the world with high case notification rates



Source: Global TB report, 2007

1.3.2 The National Tuberculosis and Leprosy Programme (NTLP)

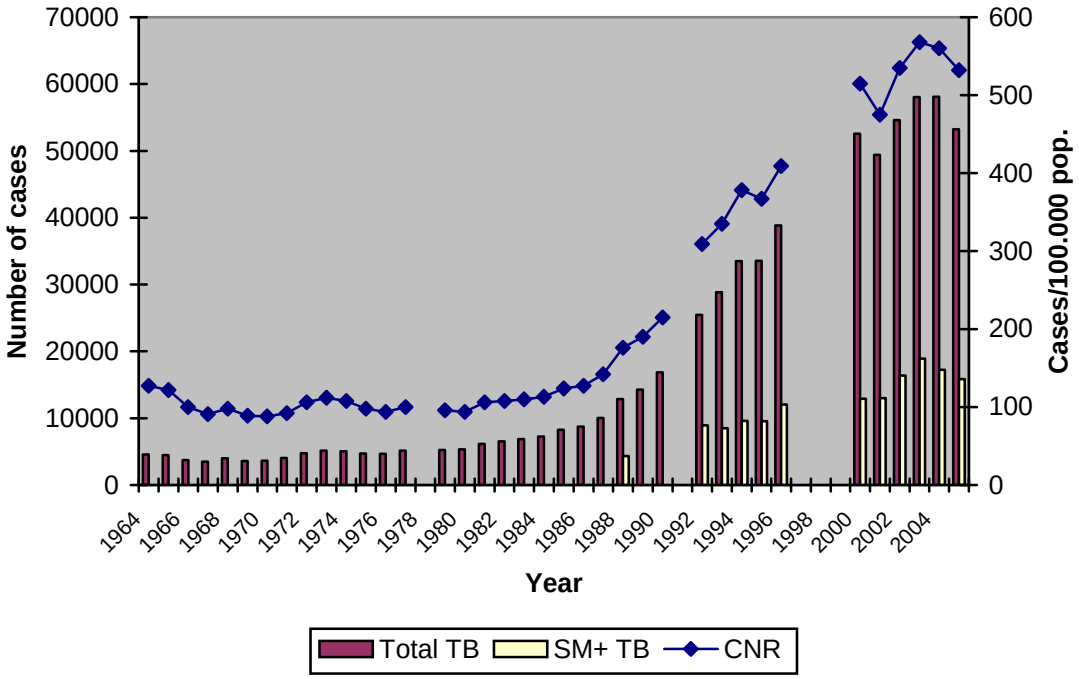
The National Tuberculosis program was established in 1964 and operated as a vertical program until 1993 when the health reforms were implemented. During the health reforms, the TB program was combined with the AIDS and STI programs to form the National AIDS/STD/TB/Leprosy programs. In 1997, with the implementation of the decentralized health system, the vertical TB program was fully integrated within the district health structure and the specific TB posts at Provincial and District levels were abolished. With the realization that the new structural arrangement had resulted in a lack of focus for TB control at all levels which led to almost collapse of the program, there was reorganisation of the programme in the year 2000. In its current structure the TB and Leprosy control program consists of the National, Provincial, District and health facility level structures. At the central level, the TB unit in the Directorate of Public Health and Research is headed by TB/Leprosy specialist who is called the National TB/Leprosy Program Manager. At the provisional level, the TB/Leprosy focal person works with the Infectious Diseases Control Specialist to coordinate TB control activities. At the District level, the TB focal person is responsible for coordinating TB control activities working in conjunction with the Clinical Care Specialist and Manager for Planning and Development. The TB focal person coordinates all the

stakeholders in the district, including the public and private sectors, NGOs and CBOs, ensuring the integration of TB and HIV/AIDS control activities. At the health facility level, tuberculosis care has been fully integrated in the service delivery points in line with the principles of primary health care. The programme core activities of diagnosing TB and treatment are performed by the health workers. Health centres and clinics serve as the primary entry to health care.

The NTLP adopted WHO advocated DOT strategy in 1995 and implemented it gradually to cover the entire country. TB treatment is provided free to the patients in all Government and NGO health facilities. The treatment regimen comprises of 2RHZE/6EH for all new adult cases and 2RHZ/4RH for new children cases. The new 4 drug fixed dose combination was introduced in the country in 2005.

The NTLP has reported nearly a fourfold increase of TB notification rates from an average of 101 per 100,000 in 1982 to 425 per 100,000 in 2005. The current Case Detection Rate (CDR) for all forms of TB is 65 percent and 55 percent for smear positive and smear negative, respectively. The main reasons for the rapid increase of TB cases are due to HIV/AIDS and poverty (National HIV/AIDS Policy 2005). Zambia is highly affected by the HIV/AIDS epidemic with 16 percent of the adult population living with HIV. The HIV infection is the major known individual risk factor for development of TB. Case notifications have increased steadily with the advance of HIV infection. A study conducted in Lusaka showed that about 70% of all TB are co-infected with HIV. In 2005, a total of 49,576 were notified. Among them were 14,857 new smears positive patients, 24,327 smear negative PTB patients, 8,587 EPTB patients and 1,805 patients that were diagnosed with any form of recurrent TB. Figure two shows the notifications and CDR of TB in Zambia for the period 1964-2005.

Figure 2: Notifications and CDR of TB in Zambia, 1964-2005



1.3.3 TB situation on Copperbelt province

TB is unevenly distributed in Zambia with highest TB burden in major urban areas. In 2005, Copperbelt province notified 13,321 TB cases which is about 27 percent of all TB cases in Zambia (Copperbelt TB office,2007). The Copperbelt province has case notification rates of 799 cases per 100,000 populations which is above the national average of 425 cases per 100,000 populations. Copperbelt province is also reporting good treatment outcomes. The treatment success in 2004 was 84 percent and default rate was 2 percent which compares well with that from the national level of 83 percent and 2 percent, respectively.

As in HIV/AIDS, majority of the TB patients are young people in their productive age group. The Copperbelt province, just like any other province has gone through a series of reforms over the past decade aimed at decentralization of resources and services. The health reforms decentralised almost all aspects of the health care systems to provincial and district levels. One of the benefits of decentralization was the emphasis on the importance of community participation in order to scale up quality delivery of DOTS. Community participation was reflected in the recruitment of community volunteers who contribute in sensitizing the community on TB. Patient support groups have emerged in all the districts to raise their concern on issues of access to diagnosis, treatment and care.

However, poverty levels in various communities have continued to pose challenges to patients' completing treatment. Like most provinces, Copperbelt province is faced with a critical shortage of human and financial resources over stretching the TB prevention and control program.

2. COPPERBELT HEALTH EDUCATION PROJECT (CHEP)

2.1 The Organisation

CHEP was founded in 1988 as one of the service delivery components of the Rotary Club of Kitwe North. It was registered with the Registrar of Companies as a Company Limited by Guarantee. In spite of being registered as a company, CHEP is a not-for-profit Non-Governmental Organisation. Its services are targeted at the community as a whole and have particular emphasis on equity and equality of all populations and individuals. CHEP has a wide geographic coverage within the Copperbelt and thus contributes significantly to the prevention of HIV/AIDS, TB and other preventable diseases through collaborate with other NGOs and CBO, most of which it has helped to initiate and strengthen through technical support. With special focus on vulnerable groups such as Children and Women, CHEP ensured community involvement in issues that affect them.

2.1.1 Mission Statement

CHEP Collaborates with all sectors of the community to help develop knowledge, values and life skills that enable creativity, responsibility and healthy Life-Styles.

2.1.2 The Goal

To contribute to the prevention of further spread of HIV/AIDS and to the mitigation of its impact on individuals and communities on the Copperbelt province of Zambia and Create opportunities for shared learning at national and regional level.

2.1.3 Specific Objectives

1) To facilitate an expanded community response to HIV/AIDS and poverty alleviation through the provision of IEC strategies and Technical Support.

2) To strengthen Copperbelt Health Education Project's management and quality service delivery to partners.

2.1.4 Organisational Structure

In order to implement programmes that are people centred, the organisation has an elaborate and well-structured organo-gram as explained here below:

- Board of Directors
- The Directorate
  - Executive Director
  - Programmes Manager
  - Training and Research Centre Manager
  - Finance Manager
  - Programme Coordinators
  - Technical support Officers
  - Support Staff

- Departments and Projects
  - Gender and Advocacy Programme (CHANGES 2, Starfish)
  - HIV/AIDS Policy Programme (LHL, ZNAN TB)
  - Community Support Programme (Irish Aid, Cecily, Egmont)
  - Community Based Care for Orphans (CBCO) programme
  - Community Involvement in Primary Education (CIPE, HIVOS)
  - Monitoring and Evaluation Programme (ZNAN Global/Bilateral)
  - Volunteer Management Programme (VMP)

The operations of CHEP are guided by a comprehensive organizational strategic plan that provides a framework for both implementation as well as donor buy-in. Because of many partners and donors, CHEP is progressing towards a holistic approach in the fight against HIV/AIDS and TB. Institutional development within the framework of continuity and sustainability has taken place. For example, research infrastructure including a resource centre and internet facilities are being developed to be part of the sustainability strategy.

2.2 CHEP/LHL Project

2.2.1 *"Strengthening Community Responses to TB and HIV/AIDS"*

LHL (Norwegian Heart and Lung Patients Organisation) and CHEP entered into a 3 year agreement (2004-2006) to implement a program that would strengthen community response to TB and the co-infection of TB and HIV. This agreement was motivated by the fact that TB has become one of the leading causes of morbidity and mortality among the most productive age group of 19 to 49 years, and is the leading cause of death among HIV positive people. The project combined CHEP's vast experience in HIV/AIDS programming, community knowledge and involvement and social mobilization with LHL's extensive experience and competence in TB programming and implementation.

The project interventions have taken place in four districts, namely Chililabombwe, Kitwe, Masaiti and Lufwanyama (2 urban and 2 rural districts).

2.2.2 Project Justification

- Increase community awareness about what to do when they suffer from TB and the relationship between TB and HIV.
- Reduce high stigma levels believed to be perpetrated and reinforced by some health workers because of poor interpersonal communication with patients;
- Reduce high stigma levels among neighbours and family members and fears of being labelled HIV positive;
- Improve community and individual health and treatment seeking behaviours;
- Increase the numbers of TB supporters in order to cover all the TB patients scattered in different localities to ensure that TB patients receive the care and support needed for adherence and treatment completion;
- Contribute to strengthening community responses to TB epidemic and work within the TB strategic framework of the MoH.

2.2.3 Project aim

To strengthen the community's own responses to the dual epidemic of tuberculosis and HIV/AIDS.

2.2.3 Intervention Objectives

- By December 2006, CHEP and LHL will have facilitated an expanded response to improved prevention, care and support for TB and HIV/AIDS through community-based efforts using IEC strategies covering 30% of the targeted catchments areas on the Copperbelt Province of Zambia.

- By December 2006, CHEP will have been enabled to develop its institutional quality service delivery capacity and enhanced its technical

knowledge and skills in mainstreaming, managing and sustaining efforts aimed at confronting the duo epidemic of TB and HIV/AIDS

2.3 External Evaluation of the CHEP/LHL project

LHL/CHEP commissioned two consultants to independently undertake the evaluation of LHL/CHEP Project *"Strengthening Community Responses to TB and HIV/AIDS"* during the months of April 2007. The essence of the external evaluation was to have an independent review of the implementation of the project in order to assess achievements of the stated objectives, identify challenges so as to come up with appropriate recommendations for the future.

2.3.1 Objectives of the Evaluation

1. To assess to what extent the objectives of the project have been reached
2. To assess to what extent the planned activities have been carried out
3. To assess the impact of the interventions carried out in the 4 districts during the 3 years period

2.3.2 OECD/DAC Evaluation Criteria

The evaluation followed the OECD/DAC evaluation criteria, as outlined below:

- **Efficiency**
  A measure of how economically resources/inputs (funds, expertise, time, etc.) are converted to outputs in the TB/HIV project
- **Effectiveness**
  The extent to which the implemented programme's purpose was achieved, or is expected to be achieved.
- **Impact**
  Positive and negative, primary and secondary, long-term effects produced by a development programme, directly or indirectly, intended or unintended.
- **Relevance**

  The extent to which the objectives of a programme are consistent with beneficiaries' requirements, country needs, global priorities and partners' and donors' priorities.
- **Sustainability**

  The continuation of benefits from a programme after major development assistance has been completed. It is the probability of continued long-term benefits.

2.3.3 General evaluation tasks

1. To assess the efficiency (have we done the things right), and the effectiveness (have we done the right things) of the project (as a whole, not only for parts of it)

    - Cooperation and partnering with communities and CBOs;
    - Integrated HIV and TB activities;

- Monitoring and experience sharing;
- Partnering with government and other NGOs involved in TB control.

2. To assess the relevance of the interventions (of how it is done and with whom).
3. To assess the sustainability of collaborative TB/HIV community interventions and to identify the factors that might be in the way of sustainability, or put it at risk.
4 Assess the intended and not expected impacts. Evidence for achieved impacts should be sought, and indicators might be identified that point to impacts to be expected in the future (For more details on objectives and specific task of the evaluation, see the Terms of Reference attached as **Annex 2**).

This review is a follow up and builds on two previous assessments undertaken in 2002 and 2006 which focused on other aspects of CHEP activities and operations, particularly on HIV/AIDS programme and CHEP management. Broadly, the assessments found out that CHEP had implemented the programme and activities in line with the agreed objectives and outputs and the weaknesses that the organization faces are typical in any organization that is this stage of development (Mulenga S, 2002, Nkandu P, 2006). The current review will complement the findings and recommendations of the previous reviews particularly on CHEP/LHL TB/HIV interventions.

3.0 METHODOLOGY

3.1 Sites

The external evaluation was conducted in April 2007 in four districts on the Copperbelt as follows:

- Kitwe
- Chililabombwe
- Masaiti
- Lufwanyama

3.2 Data collection techniques

The data was collected through the review of key project documents, key informant interviews, Focus Group Discussions (FGDs) and unstructured observations. Therefore, the data collection tools were individual interview schedules and FGDs guides. The interviews and FGDs guides contained pre-devised topic guides to steer discussion. Data collection was mainly by note taking.

3.3 Evaluation participants and selection

The evaluation participants that took part in the interviews and discussions were:

- CHEP staff;
- District Directors of Health or their representatives;
- TB Focal Point Persons and other health care providers;
- DOTS Corner Nurse;
- Treatment supporters (former TB patient groups, community volunteers, traditional healers);
- Community Leader (2 Pastors, 1 DATF Chairperson, Chairman General of NHC, THPAZ Provincial Representative);
- LHL-Consultant.

The participants were purposively selected in order to include all those who were knowledgeable about the activities of the project (A list of participants is attached as **Annex 3**). In Chililabombwe, focus group discussions with health care providers and traditional healers were held.

At the end of the fieldwork, a meeting for all the stakeholders was held during which preliminary findings from the field were presented. The meeting served both as a forum for presenting the preliminary findings as well as for data validation through feedback from the stakeholders.

3.4 Data Analysis

The notes the interviews and discussions were typed up after interviews and using a common framework, a content analysis of interview notes was used. Secondary information sources, such as quarterly and annual reports were reviewed, used and cited, where appropriate.

4.0 MAIN FINDINGS

4.1 TB Project Implementation

Zambia adopted the DOTS strategy for TB control in 1995. However, DOTS was only implemented in health facility levels. Due to the high patient to staff ratio in the health services and the need to involve communities in TB care, the MoH endorsed integrated community based DOTS approach to strengthen TB control in district hospitals and health centres. Recently, WHO through the Stop TB partnership has expanded the TB global control strategy in order to dramatically reduce the global TB burden by 2015 in line with the millennium development goals and the Stop TB partnership targets. The strategy has six components, namely:

- Pursue high-quality DOTS expansion and enhancement;
- Address TB/HIV, MDR-TB and other challenges;
- Contribute to health system strengthening;
- Engage all care providers;
- Empower people with TB, and communities;
- Enable and promote research.

The Stop TB strategy has also been adopted by the MoH in Zambia.

LHL/CHEP TB project aimed at strengthening community responses to the dual epidemic of tuberculosis and HIV/AIDS. Specifically, the project aimed at improving prevention, care and support for TB and HIV through community based efforts and improving institutional capacity of CHEP to deliver quality TB and HIV/AIDS. The main areas of intervention for the project included:

- Capacity building of TB Treatment supporters groups to provide DOTS;
- Community mobilisation and sensitisation through ACSM;
- Capacity building of CHEP staff;
- Sharing of experiences and lesson learnt among stakeholders;
- Mobilising and involving former TB patients.

CHEP implemented the above interventions in close collaboration with the provincial health office, the DHMTs, communities and other stakeholders. There was high political commitment from the Government with good cooperation from DHMTs. Close working relationships between CHEP and TB focal point persons for TB in each district and the fact that CHEP was invited to participate in district TB quarterly meetings. In certain instances, CHEP facilitated some of the meetings. The meetings were important for exchanging experiences, coordination and planning of the activities to avoid overlaps and duplication. CHEP implemented the activities following national TB and HIV/AIDS policy and guidelines. The guidelines used for training treatment supporters were developed by the ministry of health in collaboration with other partners. In the trainings, CHEP used facilitators both from public services

and other partners. In total, 424 treatment supporters were trained by CHEP during the last three years of project implementation.

Treatment supporters are involved in the provision of DOT. CHEP supports mainly former TB patient groups although other volunteer groups also have been supported by CHEP. Treatment supporters are responsible for daily observation of TB treatment during the Intensive Phase. During the continuation phase, patients take self medication at home since the medication (EH) does not need DOT. Patients are given a seven day supply to be taken under the direct observation of the treatment supporter. Treatment supporters also come to the health centres to assist the DOT corner nurse with administration of medication to the patients. The involvement of treatment supporters in the provision of DOT has significantly helped in alleviating acute human resource shortage at the health centres. The majority of TB patients in the CHEP TB sites who are in the intensive phase are receiving DOTS under the observation of treatment supporters. For example, at Kawamwa health centre in Kitwe among 56 patients found in the register, 41 (73%) were observed by treatment supporters and in Kakoso health centre in Chililabombwe all 9 TB patients were under the observation of treatment supporters. The involvement of treatment supporters has also helped the patients who no longer have to walk long distances to the health facilities.

Zambia was among the countries which piloted the implementation of collaborative TB/HIV activities under the Protest project supported by WHO. The need to scale-up these activities has been outlined in the national HIV/AIDS/TB policy and some collaborative TB/HIV activities have started to be implemented in the sites visited. Some health workers have been trained on Diagnostic Counselling and Testing (DCT) in Kitwe, Masaiti, Lufwanyama and Chililalombwe. The new reporting and recording forms which include TB/HIV variables have been distributed to the health facilities. Discussions with district directors in the field have shown little understanding of the collaborative TB/HIV policy due to the inadequate dissemination of the policy in the country. As a result collaborative TB/HIV/AIDS activities are taking place on a very small scale. There is a need to disseminate and avail the national policy on collaborative TB/HIV/AIDS. CHEP can lobby to Government for training of health workers in DCT and where necessary supplement Government efforts whilst taking full responsibility to support the training of more community lay counsellors.

CHEP has implemented TB and HIV control activities in close collaboration with all care providers. In Chililabombwe, CHEP is working with traditional healers who have been trained as TB treatment supporters. The traditional healers are also involved in community sensitisation, identification of and referring TB suspects to health facilities. In Konkola, CHEP is working with a mining company to formulate HIV policy and integrated TB activities in the workplace. CHEP is also acting as a bridge between the traditional healers, private sector and DHMT. This is a practical example of Public-Private Partnership which is inline with national and global TB strategy

Recommendations

- LHL/CHEP should maintain its strategy of strengthening community response on TB and HIV. The focus should continue to be on building capacity of community groups with attention to former TB patient groups and strengthening their institutional capacity.

- Given the achievements and lesson learnt in the implementation of the TB project, CHEP/LHL should expand and scale-up these interventions within the districts and beyond.

- CHEP needs to document what worked well and why, the processes and the outcomes (Lessons Learnt booklets) to provide evidence.

- CHEP should use its comparative advantage in community aspects of HIV/AIDS to encourage and promote collaborative TB/HIV activities in partnership with DHMTs.

4.2 Advocacy, Communication and Social Mobilisation (ACSM)

The National HIV/AIDS/STI/TB policy clearly outlined the role of Advocacy, Communication and Social Mobilisation in the fight against TB and HIV/AIDS. The policy promotes stronger and more strategic partnerships between the government and other stakeholders such as NGOs, CBOs and the private sector in the fight against HIV/AIDS/STI/TB

Community mobilisation, sensitisation, advocacy and lobbying were the key strategy in the implementation of LHL/CHEP TB project. This activity was implemented either through CBOs or by CHEP in collaboration with DHMTs.

CHEP developed a number of information, education and communication (IEC) materials such as leaflets, brochures and calendars in order to increase community's knowledge on TB. The materials were said to be developed using participatory method where by health workers, treatment supporters and other key stakeholders were involved in the development and pre-testing of the materials. Between 2004 and 2006, a total of 6500 calendars and 5000 brochures were developed and distributed. The brochures were in both English and Bemba languages. The IEC materials were developed based on the baseline data that was collected at the beginning of the project. The baseline survey was conducted to provide a situational analysis before the implementation of the project. A KAP survey conducted before the introduction of the IEC material would have provided a more useful input into the development of the IEC materials. Post-exposure assessments to determine the effectiveness of the materials were not conducted.

CHEP also used radio and television programmes to educate the communities on TB. Radio programmes were broadcasted on Zambia National Broadcasting Corporation (ZNBC). The main focus in the programmes was on patient empowerment and discussion on the challenges that TB patients face while on treatment. The program has dramatized and discussed stigma and discrimination faced by the TB patients. In the three

year period CHEP has broadcast a total of 65 series of programmes. One of the most significant elements of the radio programmes was the participation of former and current TB patients who were invited by CHEP to come and talk about their situation and experiences.

CHEP has also participated in commemoration of World TB day in all four implementing districts. The participation of CHEP in these activities has been through provision of funds to DHMT, distribution of IEC materials and supporting treatment supporters and other community based organisations to conduct community sensitisation. CHEP printed a total of 450 T-shirts with World TB day themes in the last three years which were distributed during the commemorations. Apart from participating in World TB days, CHEP also assisted treatment support groups and community based organisations to conduct sensitisation meetings in the community. Former TB patients used these occasions to give their testimony on how they lived with TB and got cured. Most of the treatment support groups visited during the evaluation had set a day in the week for community sensitisation.

CHEP also conducted a five days workshop in 2006 on advocacy for former TB patients as part of its IEC strategy. A total of 23 treatment supporters from Shimukunami in Lufwanyama and Kawama in Kitwe were trained in advocacy skills. The focus of the training was to educate former TB patients to advocate on the issues that affect them so that community leaders and policy makers put TB higher on their agenda. Community Advocacy Teams (CAT) were initiated to advocate for TB drugs in the health facilities.

Recommendations

- LHL/CHEP should conduct KAP studies before and after implementation of IEC strategy in intervention districts to determine knowledge levels and impact of IEC strategy

- Since (IEC) ACSM is the core intervention for CHEP TB project, there is need to develop an ACSM strategy with clear goals and targets for the implementation.

- CHEP should build capacity of its staff and stakeholders in IEC development process, including training on communication skills

- CHEP should develop more IEC materials including posters and distribute to all its stakeholders. CHEP can seek technical assistance in development of IEC materials

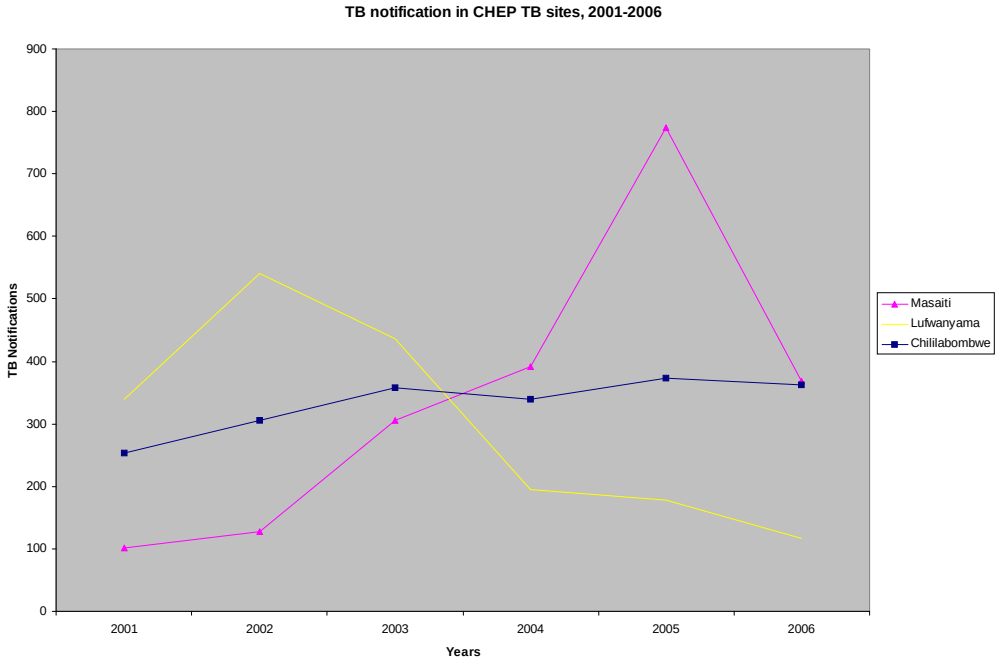
4.3 Case Finding and Treatment Outcomes

4.3.1 Case finding

CHEP TB project aims at complementing Government's efforts in the control of TB. One of the key objectives of the Zambia TB programme is to detect about 70 percent of infectious TB cases. In 2005, WHO estimated that only 68

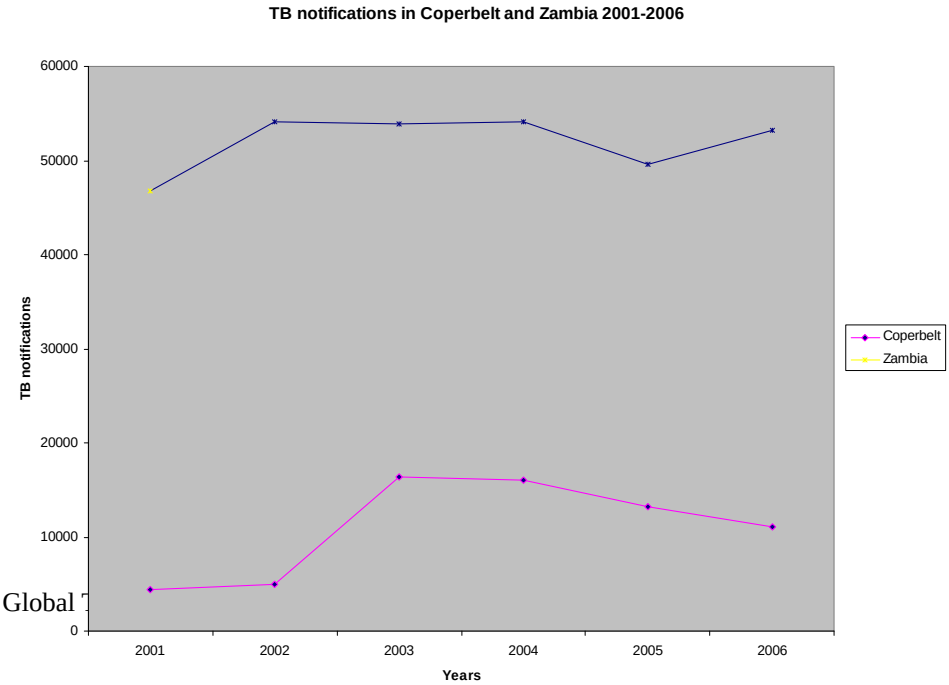
percent of infectious TB cases in Zambia were detected (WHO report, 2007). Figure 3, Shows the trend of TB cases notification in CHEP TB project sites.

Figure 3: TB case notification in CHEP TB districts, 2001-2006



Source: Copperbelt TB province office. Data for Kitwe not included

Figure 4: TB notifications in Copperbelt and Zambia 2001-2006



Source: Global T

The analysis shows that the number of incident TB cases has either been stabilising or declining. The same trend has been observed in the Copperbelt province and Zambia in general (Figure 4). For example between the year 2003 and 2006, the proportion of TB cases notified on the Copperbelt declined by 32 percent from 16,328 to 11,020. The main question is why there

is a decline in TB cases despite massive IEC campaigns and involvement of other partners such as CHEP in TB control in project districts in the last three years?

Different possible explanations for the decline in case notifications could be discussed:

- The observed decline in TB cases is true. That means that the incidence of tuberculosis is really going down. This seems unlikely given that WHO estimates that only 68 percent of the patients are detected. Furthermore, the high HIV prevalence in the projects districts and its impact on TB makes this explanation unlikely.

- Increased stigma to TB because of the link to HIV. The strong recommendation for HIV testing (DCT) may have deterred TB suspects from coming for diagnosis. The issues of stigma to TB and its link to HIV/AIDS need a deeper analysis. Diagnostic counselling and testing is recommended to all TB patients in Zambia, although the policy document on DCT has not yet been officially approved and distributed to the districts. Data from WHO/NTLP shows that only 2 percent (1082 patients) were tested for HIV in 2005 in Zambia. During this evaluation, it was found that DCT was not performed in all health facilities in the four project districts. Few health workers were trained on DCT but in Kakoso health centre in Chililabombwe it was reported that about 80 percent of TB patients accept DCT. Given that DCT is not wide spread practice in project sites and only few patients are offered DCT , it is unlikely that DCT may contribute to the decline of TB.

- Decline in TB cases because of the availability of Anti Retroviral drugs (ARVs). This explanation needs to be supported by the number of people on ARV. According to WHO, only 418 TB patients were on ARV by 2005 (Global TB report, 2007)

- Health seeking behaviour and access to a health facility when have TB needs to be further explored. Although CHEP has been collaborating with traditional healers and private sector, FGD with TB patients showed that there were significant delays in reporting to the health facility and also diagnosis for TB took too long to be completed.

- Underreporting of TB cases. CHEP does not maintain database for TB cases notified and for treatment outcomes in the districts they operate nor are detailed analyses of the information obtained from the districts done. Given the reforms and changes in the NTLP in the past, the issue of quality and completeness of the data needs more emphasis. CHEP in collaboration with DHMT should establish TB database and improve quality and analysis of the data

- Fewer TB diagnostic facilities and lower quality of smear microscopy? According to Copperbelt TB provincial office, the province has 41 diagnostic facilities but not all diagnostic facilities are functioning because

of shortage of personal. Interviews with health workers and patients during the evaluation showed that this was the main problem. Some districts such as Chililabombwe have only two functioning diagnostic centres. To what extent does this problem contribute to the low case detection in project areas? This needs to be established.

4.3.2 Treatment outcomes

The treatment outcomes in the four project sites have significantly improved over the last three years. The cure rates have increased by an average of 11 percent between 2003 and 2005. The improvement of treatment outcomes has mainly been due to the decline in default rate in all four project sites. The default rate has declined by an overall average of 2.5 percent between 2003 and 2005. This is a good achievement. Many health workers interviewed during the evaluation attributed the improvement in treatment outcomes to the involvement of treatment supporters in DOT and defaulter tracing. DHMTs in the project areas have recognised the contribution of CHEP in the improvement of treatment outcomes. The main contribution of CHEP in improvement of treatment outcomes appears to be through the involvement of treatment supporters in DOT. In many health facilities visited majority of patients were taking DOT under the supervision of treatment supporters. At Kawama health centre in Kitwe, about 73 percent of the patients were taking DOT under treatment supporters and at Kakoso health centre in Chililabombwe, all TB patients were taking DOT under treatment supporter option. The treatment supporters who were trained by CHEP were found to be more motivated because most of them are former TB patients. Cured former TB patients were also involved in defaulter tracing. They served as living testimony to the patients who are still on treatment that TB is indeed curable. A closer examination of the treatment outcomes shows that the failure rate has not changed much since the project started and stands at an overall average of 2.3 percent. Patients who fail from first-line anti TB treatment need to be actively monitored because they might be a potential source of MDR. CHEP needs to monitor the quality of home based DOT in order to safeguard the success gained by the project and reduce the threat of developing MDR

Table 1: Treatment outcomes 2003 to 2005.

District	Year	Cure Rate	Treatment Completion Rate	Failure Rate	Mortality Rate	Defaulter Rate	Transfer Rate
Lufwanyama							
	2003	58%	23%	2.5%	10%	4%	0%
	2005	74%	7.1%	4.8	9.5%	0%	4.8%
Kitwe							
	2003	77.5%	5.2%	1.9%	3.8%	6.6%	4.6%
	2005	82%	7%	2%	4.4%	1.8%	4.5%
Chililabombwe							
	2003	69%	1%		13%	2%	10%
	2005	78.2%	2.2%	0.7%	11.3%	1.5%	6%
Masaiti							
	2003	64%	2%	2.5%	10.1%	3%	8%
	2005	78%	8.4%	0%	5.9%	2.4%	6%

Source; District TB consolidated Annual reports.

Recommendations

- The reasons for stable/decline in TB notifications in CHEP TB project areas need to be established. Prevalence studies would provide more comprehensive information but they are technically difficult to conduct and require a lot of resources. Therefore, CHEP in collaboration with DHMT can conduct health seeking behaviour to determine delays, stigma and their role in the decline in TB case findings.

- CHEP should maintain database of TB patients notified and treated in the project areas and build capacity of its staff in data collection and analysis of the data. This information is useful in planning and monitoring of the project.

- CHEP needs to monitor the quality of home based DOT in order to safeguard the success gained by the project and reduce the threat of developing MDR

4.4 Capacity Building and enhancement

Training has been one of the core capacity building activities of CHEP/LHL project. In all the districts visited by the evaluators, training of community members and CBOs as well as health care providers was conducted. The main community members and CBO groups trained include former TB patients, community volunteers, and traditional healers. The role of CHEP in training was that of funding, logistical and technical support and follow-up after training. The broad areas of focus for training of community treatment supporters were:

- TB management and control;
- Advocacy and lobby;
- TB/HIV/AIDS Counselling;
- TB/HIV/AIDS relationship;
- Data Management;
- Social Mapping;
- Financial Administration and Management for CBOs;
- Patient empowerment.

One of the key findings of the baseline survey conducted at the beginning of the project in 2004 was the need to train and equip community members with appropriate skills to be able to provide adequate care and support to TB patients (Baseline Survey, 2004). Following this and in consultation with the DHMT, a decision to train community members as treatment supporters within their communities in all the four districts was made. In 2004, five workshops were held in which 199 community members were trained in treatment support skills. Each workshop lasted for five days. The participants were selected by DHMTs through TB Focal Point Persons and other community stakeholders such as the NHCs. They were selected based on their availability and anticipated levels of commitment to TB treatment and control.

Table 2: The number of treatment supporters and health workers trained per district from 2004-2006.

Training Conducted	**2004**				**2005**				**2006**			
	L	M	K	C	L	M	K	C	LK	M	K	C
Community DOTS.	69	40	40	50	20	20	20	20	20	0	0	20
Advocacy skills.	0	0	0	0	0	0	0	0	0	10	39	10
Basic Counselling.	0	0	0	0	0	0	0	0	0	0	0	0
Refresher course.	0	0	0	0	0	0	0	0	0	21	0	23
Health workers.	0	0	0	0	5	5	5	5	0	0	0	0
Total	**199**				**100**				**143**			

Key:
L: Lufwanyama
LK: Lusaka Heals TB Project.
M: Masaiti.
K: Kitwe.
C: Chililabombwe.

Over the project period, a total of 442 people have been trained by the project. Table 2 shows the number of treatment supporters and health workers trained per district during the project period (2004 to 2006). Former TB patients and traditional healers were part of the target groups that were trained as treatment supporters. 71 treatment supporters were trained through funding from GFATM out of which 21 were traditional healers.

The TB treatment supporters were also trained in advocacy skill to enhance their knowledge in advocacy methods and how to identify issues to advocate on in their respective communities.

As shown in the above table, In all the four districts, CHEP invited the focal point persons and DOTS corner nurses to participate in a five days training workshop on IEC materials development using participatory approaches.

The treatment supporters who were interviewed during the evaluation indicated that they appreciated the training and that they felt empowered by the knowledge and skills they acquired. They also felt that, after the training, they were able to confront community sensitisation on matters of TB and HIV/AIDS with great confidence. They further stated that, of more importance during sensitisation was their ability to tackle issues of stigma since they had become more knowledgeable about the difference between HIV/AIDS and TB.

There were, however, challenges regarding the training during the entire LHL/CHEP project phase. It was noted that most of the training was done without any training needs assessment neither were pre and post training evaluations done. Training needs assessments are important for designing

specific training modules and manuals based on individual and groups training requirements.

Recommendation

- Training of all the players including CBOs should be based on needs assessment for relevance and cost effectiveness. The needs assessments should be conducted at the end of each phase of the project circle in order to feed into the next set of strategies and planned activities.

- There is need in future to constantly remind and instil a sense of accurately recording events and maintaining the numbers as this is good for accountability and the evaluation of the project.

4.5 Supervision, mentorship and technical support

CHEP provided support to DHMTs, CBOs and the communities. The technical support for CBOs was in the form of development of constitutions and registration, training facilitation, development of IEC materials, supervision and mentoring. Over the last three years, CHEP facilitated formal registration of 12 CBOs. CHEP also conducted constant supervision of CBOs and treatment supporters and follow-ups to the health centres to monitor the implementation of TB activities. The supervision was carried out through visits to project sites to assess activity implementation as well as to provide support and mentorship. There is a detailed Activity Monitoring Report Form that was filled in by the project coordinators for supervision and monitoring purposes. Supervision and monitoring schedules were developed and each field visit and the actual activities conducted are recorded. These schedules were shared with the partners especially the health centre staff and CBOs.

For example, in 2004, CHEP carried out field support visits in order to provide continued support to TB and HIV/AIDS prevention activities implemented by collaborating partners and other health care providers. Eight field support visits to all project sites to share experiences and learn from partners what was going on in the project were conducted. In 2006, a total of 20 technical support visits were carried out in order to keep in contact with treatment support groups in the project sites. Treatment supporters were provided with information on how they could strengthen their organizational structures in order to improve on the delivery of patient related services.

However, the challenge for supervision and mentoring was the recording and storage of the reports and the subsequent sharing of the reports with the stakeholders particularly those at community levels. Whilst the CBOs do report their monthly activities to CHEP, the keeping and the reporting format and details are not adequate and consistent enough. For example, in some areas that were visited by the evaluators, community groups did not have proper forms for recording their activities. In some cases exercise books were being used for recording and keeping vital project activity information. This needs to improve.

In order to effectively implement TB related activities, CHEP has been receiving technical support from LHL and most of the staff in the project have received various trainings within and outside Zambia. However, the technical support to strengthen CHEP and its implementing partners did not adequately benefited DHMT staff who are key in the treatment of TB. In future, LHL/CHEP should consider including DHMT staff based at health centres in capacity building initiatives that will expose them to new developments in TB control. Only one staff from Chililabombwe DHMT was given an opportunity to attend a workshop in Namibia during the period under review. Similar exchange programmes involving health centre staff will need to be systematically planned and conducted in the future.

Recommendations

- Preparation and submission of detailed monthly and quarterly progress reports should be made mandatory for all CBOs.

- There should be proper documentation of all community-based activities and capacity for community-based information systems should also be built.

- CHEP needs to develop a systematic way of sharing their monthly reports with the major stakeholders particularly community treatment supporters so that they can have a bigger picture of the project beyond their own involvement.

- Since LHL/CHEP is not mandated to train DHMT staff, it would benefit the project if some of the staff could be provided with technical support on a regular basis to enhance their skills. CHEP would do this by extending some of the training opportunities available from LHL to the DHMT staff.

4.6 Community involvement in TB/HIV/AIDS

One of the main tenets of the health sector reforms in Zambia is community participation and involvement. The National HIV/AIDS/STI/TB policy also stresses the need for community involvement in the fight against HIV/TB as highlighted in two of the objectives:

a) Encourage and support the family and community as the basic social unit of society in the protection and fight against HIV/AIDS/STI/TB;
b) Promote stronger and more strategic partnerships with stakeholders such as NGOs, CBOs and the private sector in the fight against HIV/AIDS/STI/TB.

DOTS and its expansion- a five point TB control strategy that includes directly observed short-course treatment, is the current focus of the Stop TB partnership (Bissell 2004). Community involvement is key in the overall management of the DOTS. The mobilisation and training of community treatment supporters is one of the strategies that are more likely to improve

adherence and guarantee successful completion of treatment by most TB patients.

In line with the above, LHL/CHEP has involved various community members and structures in the implementation of TB and HIV/AIDS interventions. Community members are mobilised, recruited and trained to implement the interventions on voluntary bases. Even though the community members do not receive direct payment for the work they do, this evaluation revealed that they are highly motivated through a number of incentives that include:

- Training opportunities;
- Recognition through belonging to organised community groups;
- Transport and lunch allowances during major health events such as World TB day;
- Per diems during training;
- Equipment and materials for use during their daily work (bicycles, bags, T-shirts, chitenge material and identity cards).

Whilst the LHL/CHEP project has trained and adequately equipped former TB patients and community volunteers with knowledge and skills to supervise treatment, it appears that family involvement has not been emphasised sufficiently enough. Consequently, instead of the community treatment supporters involving and supervising the families, they are actually supervising DOTS. This proves to be hard and time consuming for most treatment supporters as they are expected to visit each patient most of the time to ensure that they take their medication. For example, during the evaluation, in the rural sites, the treatment supporters complained of long distances from one patient to the other as they feel that they should visit every patient on a daily basis. It is therefore necessary for the project to redefine the *modus operandi* and emphasise greater involvement of the family members, not withstanding the fact that there are isolated cases of family neglect due to a number of social factors including stigma. Furthermore, some TB treatment supporters did not seem to understand their role viz-a-vis home based care giver. Whilst in exceptional cases, the supporters can perform the role of a care giver, but in situations where the family members have been adequately mobilised and educated on care giving they should take more responsibility whist the treatment supporter concentrates on supervisory roles. The added advantage of this is that the few treatment supporters will be able to cater for many patients. In the areas where home-based care groups are available, there is a need to harmonise their work with that of TB treatment supporters to avoid duplication. The lack of clarity in the role definition between treatment supporters and HBC groups seems to be consistent with the observation that most of the treatment supporters were women and probably found it easier to get involved in domestic chores.

The main community structures supported by CHEP to implement TB related community activities were:

- CBOs consisting of former TB patients
- Voluntary TB Treatment Supporters

- Traditional Healers
- Neighbourhood Health Committee

In 2004, after training workshops, several technical support visits to the trained treatment supporters were undertaken by CHEP. Through the visits, a need to provide treatment supporters with transport and means of identification was identified. It became clearer that in rural districts of Lufwanyama and Masaiti the distances between villages on the one hand and between the villages and the clinics on the other were considerably long for treatment supporters to cover on foot as they provided their services. During one of the visit to CHEP by LHL official, consultations to reallocate part of the budget to purchase the bicycles and identification materials for treatment supporters were made. In November 2004, 72 bicycles, Chitenge materials, T-shirts, and identity cards were purchased. Table two shows the number of bicycles bought for each district.

Table 3: The number of bicycles provided to each of the four districts

District	Number Provided
Chililabombwe	11
Kitwe	10
Lufwanyama	12
Masaiti	39

The interventions by CHEP have contributed to the empowerment of TB patients and the community. The communities have been empowered with knowledge and improved awareness of TB and HIV/AIDS issues. A major challenge to community and patient empowerment, however, is lack of food supplements for TB patients. Food scarcity is posing a challenge to many patients as they find it hard to take drugs on empty stomachs especially during the intensive phase of treatment.

Recommendation

- LHL/CHEP needs to work closely with other organizations that provide food supplements and also to lobby other organizations such as the WF programme for food supplements to TB patients.

- While CHEP has done tremendously well in building the capacity of treatment supporters on DOT, and in exceptional cases, the supporters can perform the role of a care giver, family members need to be mobilised and educated to ensure that they are involved in their relatives' treatment.

- Treatment supporters should work hand in hand with home-based care groups in order to avoid duplication and ensure optimisation of available resources and time.

4.7 Community-Based Organizations (CBOs)

CHEP facilitated the initiation of various former TB treatment support groups which have been formally registered as CBOs. These groups were mobilised and initiated by CHEP in collaboration with health centres and the community through the neighbourhood committees. The role of former TB treatment supporters include:

- Supervision of DOTS;
- Community sensitisation about TB and HIV/AIDS;
- Contact tracing;
- Advocacy and lobbying for TB

During the period under review, CHEP facilitated the formation and formal registration of 12 CBOs and these were:

- Kawama former TB patients support group based in Kitwe.
- Mishikishi former TB patients support group in Masaiti district.
- THPAZ HIV/AIDS/TB Task Force in Chililabombwe.
- Shimukunami former TB patients support group in Lufwanyama.
- Reigners in Life in Chililabombwe.
- Umunwe TB support in Kitwe.
- Lufwanyama Health Initiative in Lufwanyama.
- Tusangalale Home based Care in Masaiti.
- Tubombele pamo TB support Group in Kitwe.
- Community Health foundation in Lufwanyama.
- Yasat TB support Program in Kitwe.
- Shilo Community Health Project.

CHEP provides support to CBOs through setting up of management structures, training and formulation of plan of operations. In addition to this process of mentoring former TB patient groups from Post TB clubs, CHEP provides funding to the registered CBOs to enable them effectively implement TB related activities. The CBOs can also access funding from other sources such as the Global Fund through the Zambia National AIDS Network (ZNAN) of which CHEP is one of the leading agencies on the Copperbelt. So far non of the CBOs have accessed funding from anywhere.

All the members of the CBOs interviewed during the evaluation expressed satisfaction over the support they got from CHEP in terms of mobilising them into formal groups, facilitating their registration and provision of technical support and mentorship. CHEP found it easier to deal with organised groups than individuals. All the former TB patient support groups have about 20 members with executive committees. Members have regular meetings where key decisions are made.

Former TB patients are actively involved in TB work and the majority of them expressed similar a reason for becoming treatment supporters. Asked during the interviews why they decided to be treatment supporters, one of the responses is summarised as:

"We saw that when we were sick we were helped by other human beings. That is mainly why we thought we should help others. After getting better, we realised that life was precious so we came together as former TB patients and decided we should help others in our community"

The above quotation shows that former TB patients are more sympathetic to TB patients, having experienced the disease themselves. The care they provided is motivated by an earnest need to save a life. Therefore, the process of supporting the formation of the former TB patient groups is a very innovative move that has great potential in the control of TB among the community members. The process needs to be carefully documented so as to serve as a repository for future reference and for replication to other similar settings. There are also best practices and vital lessons that can be drawn from the process of supporting and involving former TB patients in the treatment, care and support of TB patients including HIV/AIDS patients.

It was clear that, despite the need to help those affected by TB, treatment supporters faced some challenges that included:

- Abandonment of work at home to attend to patients;
- Walking long distances to follow patients (Noting that some of the former TB patients will never be as strong as they used to be);
- Inadequate equipment like bicycles, gloves, rain coats or umbrellas;
- Hunger among the patients they supported due to inadequate food;
- Shortage of laboratory staff for speedy diagnosis of TB;
- They equally did not have enough to eat at they homes.

Recommendations

- LHL/CHEP should develop guidelines and manual for formulation and mentoring of CBOs. This should be based on well documented relevant experiences of the processes and outcomes.

- Best practices within the processes of establishing and mentoring of former TB patient CBOs, should be well documented for replication and also for sharing with other organizations working with communities in TB and other diseases.

4.8 Community Volunteers

A number of community volunteer groups under the auspices of the DHMTs are operating in the four districts visited. The community volunteers are working alongside former TB patients in their respective communities. Some of the community volunteer groups have been supported by CHEP, even though they are also mentored by DHMTs. Like the former TB patients, the community volunteers are selected by the health centre staff through the NHCs. Some of the groups have former TB patients but none of the community volunteer groups were registered as CBOs at the time of the evaluation. Discussions with community volunteers indicated that, whilst the volunteers appreciated the support they got from CHEP, they felt that the former TB groups were receiving more attention. They lamented at that the

little financial and material support that was coming from the DHMTs was too little to enable them fully exploit their potential. They also observed that, due to low levels of motivation, attrition rates among community volunteers were higher than those of former TB patient support groups. Therefore, one of the challenges was that of motivating the community volunteers as one DOTS corner Nurse observed:

> *"The challenge is how to motivate the treatment supporters even though they are volunteers but we are unable to provide-so they are de-motivated. They volunteered because they expected something"*

However, it should be noted that it was not within the mandate of CHEP/LHL to fully support the community volunteer groups but to supplement contributions from DHMTs. In the spirit of collaboration with DHMT, CHEP rendered support to community volunteers through training and it is necessary that the DHMT also make some budgetary provision for supporting the volunteers in the interest of TB control and the benefit of patients.

Recommendations

- Since TB needs to be fought from all fronts, community volunteers are a crucial force that needs equal attention and support. The MoH through DHMTs needs to fully support community volunteers who are augmenting the efforts of former TB patients.

- Communities' situations and expectations need to be understood. Clear guidelines should be developed and communicated during implementation to communities on what incentives would be applicable for different activities and groups. This will also strengthen their ownership of the process.

4.9 Traditional Healers

Traditional Health Practitioners Association of Zambia (THPAZ) was formed in 1978 for the purpose of uniting all the traditional healers in the country. The unity among the healers would facilitate the collaboration between government and the traditional healer fraternity at the national level on the one hand and between healers and the biomedical health workers at the district and community levels. THPAZ has grown over the years to be the largest healers association in Zambia and its membership is estimated to be over 40,000 traditional healers drawn from all the parts of Zambia. Hitherto, THPAZ has been serving as a pivotal link between the healers and the Ministry of Health especially where sensitisation of healers about HIV/AIDS is concerned.

During the period under review, CHEP has worked with THPAZ in Chililabombwe in collaboration with the DHMT and has supported a group of traditional healers called Chililabombwe THPAZ HIV/AIDS/TB Task Force. The group was formed in 2000 and has a current membership of 20 healers. The traditional healers are serving as TB treatment supporters for Kakoso catchment area in Chililabombwe. The traditional healers in Chililabombwe

were mentored to develop a constitution for the District Traditional healers task force which was fully registered in 2005

FGDs with the healers indicated that they had gone through the required training and some of the topics they covered during their training were:

- Biomedical perspective of TB;
- Administration of DOTS;
- HIV/AIDS and its relationship with TB.

Further, the FGDs also indicated that these healers are highly motivated and greatly appreciate the collaboration they have with CHEP and the DHMT including the health centre staff.

The healers said that they were motivated by a number of things including:

- Training,
- Materials such as T-shirts, bags and Chitenje
- Allowances.

The evaluation found that, like all the TB treatment supporters, the healers were also involved in assisting with providing TB treatment related services at the health facilities such as packing of drugs and weighing patients. This was perceived as vital service considering the low numbers of staff at Kakoso health centres.

The healers pointed out that they were very keen to contribute to the fight against TB and since they were the first contact with patients in the community they were now referring all TB suspects to the health centre as one healer said during FGDs:

> *"We are motivated by CHEP and that is why we do not delay the patients. At the clinic, we pack drugs for patients, weigh them and we follow the patients at home to ensure that they take the medicine"*

> *"The community perceives us well because in the past TB patients used to die in our homes but now people think we are more concerned with saving lives. In the past people used to think we are witches but now they know we are not"*

Asked why they opted to be treatment supporters instead of concentrating on their profession as healers, they responded:

> *"We traditional healers felt we should collaborate with health workers so that we learn about TB so that if a patient comes and we see that the signs look like TB then we can refer to the hospital. We discovered that we have no medicine for TB"*

The Government of Zambia has, in many occasions in the past, issued policy statements encouraging collaboration between the formal and the traditional health care systems in order to ensure a consolidated fight against the rising incidences of diseases such as TB and HIV/AIDS. The LHL/CHEP project

provides a good illustration of the operationalisation and implementation of Government policy on collaboration. This collaboration between the NGO sector, the formal and the traditional health systems needs to be encouraged and promoted throughout the country.

This evaluation found that, although the involvement of traditional healers was an innovative move aimed at harnessing and utilising existing community resources, comprehensive and accurate documentation of the process and the outcomes was lacking. In order to effectively assess and document the impact of the traditional healers' involvement in TB, there is a need to carry out operations research as a component of the overall project. CHEP has conducted an operational research on involving traditional healers in TB control. The research aimed at determining the role of traditional healers as resource people in TB control. The findings from this research were presented an international TB conference in Paris, 2006. However, a pre and post intervention design could considerably inform the project about the impact of the healers' involvement.

Recommendations

- Detailed documentation of lesson learnt and best practices should be undertaken in order to inform future collaboration between the NGOs, formal and traditional health systems

- Operational Research to monitor trends in health seeking behaviour of communities including delays should form a key component of project implementation. There is also need for baseline and endpoint (before and after the involvement of healers) surveys to determine the contribution of traditional healers in community awareness for improved case finding.

- Best practices within the processes of mentoring traditional healers should be well documented for replication and also for sharing with other organizations, nationally, regionally and beyond.

4.10 Sub-granting and nesting

CHEP is a lead agency for Zambia National AIDS Network (ZNAN) and disburses sub-grants to other NGOs and CBOs on the Copperbelt. For most CBOs, CHEP builds financial capacity through training and "nesting"- a process where funds are allocated to a CBO for use in community activities. The funds are not directly transferred to the CBOs' bank accounts but are kept by CHEP and drawn by the CBOs when and if needed based on the approved budget. Sub-granting to CBOs follows a very clear procedure and potential CBO must have the following in order to qualify for a grant:

- Registration Certificate from the Registrar of Societies;
- An active Executive Committee for a collective and transparent decision-making;
- Bank Account
- A clear and concise work-plan

During the period under review, a number of CBOs received funding from CHEP/LHL for TB activities. The following are the organizations that were sub granted funds:

Kitwe District

- Kawama former TB patient support group based in Kitwe.
- Twafwane Home based Care.
- Third World Images.
- Bechap theatre group.

Masaiti District.

- Mishikishi former TB patient treatment support group in Masaiti.
- Tweshe Integrated Association.
- Kaloko Trust.

Chililabombwe District.

- District Traditional health Practitioners of Zambia branch in Chililabombwe.
- Reighners in Life.
- Kakoso Youth Project.
- Cindi Chililabombwe.

Lufwanyama.

- Shimukunami former TB patient support Group.
- Lufwanyama Health Initiative.
- Harvest Foundation.
- Luweda.

In all the CBOs visited during the evaluation, CHEP was the only NGO that was funding TB related activities. In 2004 CHEP sub granted a total sum of US$29,918 to CBOs involved in community mobilization and sensitization. In 2005 a total of US$25,738 was sub granted to CBOs in the respective districts.

In 2006, CHEP disbursed a uniform amount of US$20,039 to the following CBOs:

- Kawama former TB patient support group based in Kitwe.
- Mishikishi former TB patient support group in Masaiti.
- District Traditional health Practitioners of Zambia branch in Chililabombwe.
- Shimukunami former TB patient support group in Lufwanyama.

The funds were earmarked for use on specific activities and purchase of requisites. These funds were disbursed directly to the CBOs following CHEP/LHL financial procedures and regulations. Although the interviews with the recipients indicated that the funds sub-granted went a long way in boosting TB related activities, the disbursement of a uniform amount did not take into account the differential needs of the CBOs. They suggested that CHEP should workout a proper fund allocation criteria based on the needs of each CBO as supported by the budgets they present.

Indeed, the CBOs are at different levels of development and their structures vary and this was evidenced by the manner in which the financial expenditure of the funds was recorded. The CBOs seemed to entirely depend on CHEP despite several other funding opportunities which they were not aware of. One of the mentoring responsibilities should include orienting the CBOs to the various funding opportunities in order to lessen dependence on CHEP and to ensure sustainability.

Through the Global Fund, CHEP is also sub-granting to support groups of people living with HIV/AIDS/TB in which creative programmes such as farming, food supplementation to chronically ill patients and income generating activities are being implemented to lift the burden of food shortages. So far 10 groups supporting approximately 500 PLWHAs have benefited from the grants. This scheme is not available to TB patients. CHEP should lobby other organizations such as the WF programme for food supplements to TB patients.

Recommendations

- Allocation of financial resources should be based a comprehensive assessment to determine the capacity to implement the interventions and on the absorptive potential of each CBOs.

- In order to ensure sustainability of the TB interventions, CHEP should assist the CBOs identify microfinance institution and build their capacity to write and submit viable project and/or business proposals.

4.11 Partnership, Cooperation and Coordination

Partnership implies equal participation at all levels of the project leading to cooperation in carrying out the various tasks. CHEP is working in partnership with DHMTs and DATFs at the district level and CBOs at the community level. CHEP is also working with other TB/HIV stakeholders in all the intervention districts. DHMT and DATF members who were interviewed during the evaluation said that they were pleased with the cooperation and partnership with CHEP. Although CHEP works very closely with DHMT and other partners, there is no written contractual relationship. The cooperation and partnerships are informal but based on a mutual understanding that in order to effectively combat TB and HIV/AIDS the Government institutions need to partner with NGOs at all levels of public health service delivery. However, it is essential that such an understanding should always be governed by formal arrangements that spell out specific roles and responsibilities including financial and material obligations. This could be done through Memoranda of Understanding (MoUs) executed by both parties. However, it was noted that LHL and CHEP have been discussing with MOH over the MOU with the NTP and with DHMT's.

The partnership between CHEP and LHL was found to be useful and complementary. LHL brings a wealth of knowledge and experience in TB and International TB control strategy and exposure while CHEP has vast

experience in HIV/AIDS and community based projects. CHEP regards LHL not only as a donor but also a technical partner. CHEP appreciate biannual visits provided by LHL and international exposure on TB related issues facilitated by LHL. On the other hand, LHL is impressed by CHEP's community activities and its local knowledge of the health problems on the Copperbelt. Both organisations have shown willingness to continue and expand the scope of their collaborations in the future. Discussions with staff from CHEP and LHL revealed that there is frequent communications between CHEP and LHL beyond the formal communications stipulated in the MOU. On the other hand CHEP is rapidly expanding its activities and also its donor base. There is a need for both organisations to discuss and agree on what is expected from each other.

Coordination is a key function of management and it must be viewed within the overall collaboration between CHEP and its implementing partners. With several players involved in TB activities, coordination and harmonisation mechanisms are essential. To do this CHEP convenes quarterly meetings, workshops, arranges for community to community visits and sharing of experiences among partners. DHMT is the main Government organ charged with the responsibility of ensuring that there is coordination of all health related activities in the district. To ensure harmonisation, CHEP attends the DHMT quarterly meetings where they present their action plans, activities and progress made on various projects. The quarterly meetings provide a regular feedback of CHEP activities to the district to ensure that they are updated and also for their support and ownership of the district project.

Another mechanism for coordination of HIV/AIDS/TB interventions is the District HIV/AIDS Task Force (DATF). DATFs were created by Government to coordinate and harmonise HIV/AIDS/TB related interventions in the districts. Kitwe DATF has a membership of 15 people drawn from a cross section of sectors and communities and CHEP is the current chair for the Kitwe DATF.

On the other hand, CHEP coordinates the overall activities of CBOs and other community structures and ensures that they have input into CHEP work plans through a number of mechanisms such quarterly sharing meetings. During quarterly meetings, the CBOs report their activities and through this CHEP ensures that all the interventions they support are harmonised.

The consultative meetings CHEP normally convenes in other Copperbelt districts, Kabwe and Lusaka serve to strengthen networking among institutions involved in HIV and TB interventions. Some of CHEP's partners are Ndola Catholic Diocese, Zambian Nurses Association, CHAZ, ZAMBART and NTP. CHEP/LHL project holds regular briefing sessions with the Norwegian Embassy.

Recommendation

- The cooperation between the DHMTs and CHEP should be governed by formal arrangements that spell out roles and responsibilities. A Memoranda of Understanding (MoUs) should be

developed and signed by both parties as a way of formalising the partnerships.

4.12 Ownership and sustainability

Ownership of the project and its activities means that CHEP and all its implementing partners can claim rights and control based on legal documentation, social understanding and obligation. CBOs and communities have to realise that ownership of the project means commitment to protect and to ensure its sustainability and continuity. CHEP's institutional capacities and those of the DHMTs are continuously being built through joint reviews, conferences, and involvement of DHMT's as co-facilitators with CHEP staff in the trainings. CHEP staff have shared skills and information from its interactions with LHL partners and have also shared the Union conferences with TB focal point persons from all districts. For example, in 2005, a provincial TB conference was held at which all TB officers attended. CHEP is increasingly involved in national TB planning meetings including participation in proposal writing for Global Fund aapplications. CHEP's institutional structures, assets and human resource will contribute as well to this sustainability question. Further, the evaluation found that the feeling of ownership of the project by different partners varied considerably. For example, at community level, whilst there appeared to be a high sense and feeling of emotional ownership, it was difficult to comprehend how this could be sustained in the absence of “effective ownership” (doing those things that legally/legitimise control and sustainability). The continuation of project outputs beyond LHL/CHEP timeframe or duration, ownership and management of intervention outputs by target communities was hard to envisage. Some CBOs members said that they had began putting certain strategies in place to ensure that the interventions will be sustainable for the future, but the strategies were still unclear.

Recommendation

- Whilst the project has empowered communities with knowledge and skills and also assisted them to build enduring community structures, financial sustainability strategies must equally be built into the project at the design stage. With better insights gained over the last three years, CHEP/LHL needs to explore ways of gradually linking-up community based groups to micro-financing institutions for financial sustainability.

4.13 Personnel, Administration and Financial Management

4.13.1 Human Resources

CHEP has a human resource policy and strategy. The policy is premised on equal employment opportunity to all eligible Zambian without any discrimination based on gender, religion or HIV status. There are 35 members of staff employed on a permanent basis whilst 7 are employed on a temporary basis. The perception is that CHEP has adequate staff to implement its overall activities. There are two core staff on the CHEP/LHL project involved in TB activities.

There is no doubt that CHEP is expanding as a result of need arising from both donor confidence and public health imperatives. However, it needs to expand its human resource establishment in order to cope with the increasing call to provide more services to communities on the Copperbelt. This will have to be based on a comprehensive human resources plan with clear targets and projections. One big challenge for human resources management is the fact that there is no specific person responsible for human resources within CHEP.

Factors that undermine efforts in building capacities at partner institutions have been identified as including: high turnover of health staff in health institutions; under-staffing at health centres; over reliance on volunteers. Whilst CHEP has been undertaking capacity building initiatives within its staff members, similar efforts have not been made at partner institutions, especially at district level. Mortality among former TB patients has contributed to the attrition of community-based treatment supporters in some districts.

4.13.2 Administration

Administrative unit within CHEP falls under the office of the Executive Assistant. The Senior Coordinator also performs administrative functions.
Some of the administrative functions such as procurement, inventories and vehicle log books are jointly performed by the executive assistance and the senior Coordinator. These staff members report to the Programmes Manager. CHEP is in the process of engaging a full time Administrative Manager. This will improve administrative functions and ensure that the procedures and controls are fully adhered to.

4.13.3 Financial management

CHEP is a multi-donor funded organization with a fully fledged Finance department. The main responsibilities of the finance department are:

- Ensure that all the funds entrusted to CHEP are safe;
- Interpret the various budgets for different projects;
- Ensure that expenditures are in line with budgets;
- Preparation and disbursement of funds based on approved requests;
- Prepare financial reports according to formats required by each donor.

There are five members of staff in the finance department and each donor-funded project has a focal person charged with day to day accounting of the project. Although there is a general CHEP account, each of the major projects including CHEP/LHL project maintain separate accounts. The CHEP/LHL project account was opened in 2004. During the project period a total of US$412,800 (equivalent of K1,676,355,940:00) was received by CHEP for financing various project activities as indicated in table four below.

Table 4: The breakdown of annual receipts from LHL

Year	Amount (US$)
2004	92,500
2005	150,300

2006	170,000
Total	**412,800**

Annual work plans were prepared and funds requested biannually from Norway. The financial system and procedures within CHEP are transparent and have adequate internal checks and balances to ensure the safety of funds. For example, the requests for funds are generated by the implementing officer usually at the level of technical support staff and project coordinators. The requests are based on the work plans containing the actual activities to be undertaken and for which the funds are being sought. The Programmes Manager approves the requests which are then forwarded to the finance department for processing according to the standard financial procedures. The Executive Director authorises all payments after they have been prepared and internally audited.

Based on the above, CHEP has a very transparent system of financial accounting. The scrutiny of the CHEP/LHL financial expenditures and transactions shows a very high level of accountability. Over the period under review, CHEP was able to utilise all the moneys requested and disbursed, an indication of an adequate absorptive capacity.

4.14 Monitoring and Evaluation (M&E)

CHEP has the responsibility of monitoring and evaluation of all its activities in order to ensure attainment of project goals and objectives. The monitoring and evaluation is done using CHEP's own procedures for M&E. With regard to monitoring of the TB interventions, CHEP executed this role effectively through regular visits to the districts and project sites. However, it was observed that the involvement of DHMTs and other partner institutions in monitoring visits to CBOs was non-existent due to a number of factors including inadequate capacity. Overall, the M&E unit within CHEP is rather weak and needs strengthen. This is evidenced by the lack of a substantive person fully responsible for M&E functions in the organisation. CHEP needs to strengthen its M&E unit through the appointment of a substantive M&E specialist who will be responsible for, *inter alia,* development and execution of a comprehensive organisational M&E plan.

Recommendations

- CHEP should recruit a full time Monitoring and Evaluation Officer with appropriate skills in order to strengthen the overall institutional capacity for M&E to ensure that project activities are constantly in line with goals and objectives as enshrined in the M&E plan or the project log-frames.

5. SUMMARY OF OECD/DAC EVALUATION CRITERIA

Based on the presentation of the findings, the table below presents a summary of the OECD/DAC evaluations criteria as outlined in the Terms of Reference for the evaluation. Comments are provided for each of the OECD/DAC criteria.

Criteria	Comments
Efficiency	Most of the project inputs (funds, technical assistance/expertise, time) were effectively utilised for the achievement of the project goal.
Effectiveness	LHL/CHEP implemented the project as per the plan and the main objectives of the project were achieved.
Impact	The assessment of the impact of the project was beyond the scope of this evaluation. However, the stakeholders interviewed perceived the project to have made a significant impact on the communities.
Relevance	LHL/CHEP project was timely and extremely relevant and it addressed a real need.
Sustainability	Although the beneficiary communities and treatment supporters had gained considerable levels of knowledge, the continuation of project interventions beyond LHL/CHEP funding in target communities was hard to establish and the reported future strategies to ensure financial sustainability were unclear.

6 DISCUSSIONS

Overall, the project has been successfully implemented following national and international standards. The policies and strategies used by CHEP are acceptable and sound and the iimplementation was carried out based on annual plans and almost all activities in the 2004-2006 strategic plans were implemented. The project was flexible, thus allowing for activities that were not already planned for to be implemented. For example, the reallocation of funds to buy 72 bicycles in the year 2004 was evidence of flexibility in financial management. Despite successful implementation of the project, there is a need to improve the documentation of best practices and what worked well in order to document the experiences and achievements but also to scale-up the interventions to other districts. The expansion of the activities within the four districts and scale-up to remaining 6 districts within the Copperbelt in the next 3 years is important in order for the project to have a wider impact and to optimise on the presence of CHEP on the Copperbelt.

During the evaluation, most directors of health requested CHEP to expand their interventions beyond their impact zones within the districts. Given the achievements and experience accumulated in the implementation of the project in 4 districts in 2004-2006, the evaluators were of the opinion that CHEP has the experience and capacity to scale-up in the remaining 6 districts in the next three years. The expansion can be carried-out in phased manner whilst simultaneously strengthening CHEPs capacity to carry out the scaling-up.

Twice yearly supervisory visits by LHL helped ensure the programme was on course, however, in 2005 and 2006 there was only one annual visit because the LHL technical advisor for Zambia was on duty assignment for WHO. Twice yearly supervision visits need to be maintained and strengthen with technical support in other areas such as TB data collection, interpreting and monitoring, competency building etc. While tremendous work has been done to train treatment supporters, training of CHEP staff in key TB/HIV needs to be improved. It was impressive to find that CHEP technical officer has been trained in monitoring and evaluation, even though the staff in the TB unit needed further training in TB and TB/HIV issues such as TB data analysis and interpretation. Sending one of CHEP staff in advanced TB course such as IUATLD/WHO course in Arusha, Tanzania would greatly improve their capacity to provide technical support not only to CBOs but also to health staff. Improving the capacity of health staff and indeed contributing towards health system strengthening is one among the new components of Stop TB strategy. The focus of the CHEP TB project in 2004-2006 was on the building capacity of treatment supporters and CHEP staff. However, with chronic shortage of staff in health sector, CHEP should also focus on building the capacity of health staff as part of its TB strategy. This will not only contribute to health system strengthening but also help to motivate the few health staff in public services and improve their performance and ultimately improve TB control efforts

The Involvement of former TB patients as TB treatment supporters is recommendable and is inline with national policies (National HIV/AIDS Policy 2005) and Stop TB strategy of empowering people with TB, and communities. Former TB patients have been found to be motivated and effective in provision of DOTS (Wandwalo et al, 2004). Former TB patients are also a living testimony that TB is indeed cured and might help to reduce defaulting and improve confidence in TB treatment and therefore increase TB case detection. However, CHEP needs also to strengthen the role of family members in the provision of DOTS. Family members can also be involved in provision of DOTS and lessen the burden of treatment supporters who have to travel long distance to supervise DOTS daily. The role of treatment supporters can therefore focus on more of support and supervision of the family and DOTS in the community and sensitisation. This preposition should not be interpreted as excluding treatment supporters in DOTS for patients at home but rather expand their role of family and patients support. Since DOTS is regarded as the core activity of treatment supporters this can be limited to a few patients and allow the family to be more involved

CHEP TB project also aimed at building capacity to control the dual TB and HIV epidemic. One of the strategies on capacity building was training of providers on TB and HIV. CHEP has conducted these trainings in collaboration with DHMT and other stakeholders. During the period of 2004 to 2006 a total of 299 treatment supporters were trained on various aspects of TB and HIV control and prevention. The trainings were conducted using national guidelines and curriculum. The trainings have been instrumental in improving knowledge and skills of TB care providers. The overall knowledge of the treatment supporters on different aspects of TB was quite high. During the evaluation, many would explain the transmission and causes of TB in a fairly technical level and many knew the relationship between TB and HIV. Although during the review we did not interview the general public on their knowledge on TB, discussions with community leaders also showed high levels of knowledge on TB. It be can be concluded that, the trainings and sensitisations campaigns conducted by CHEP had some effects on raising awareness on TB in the project sites, however, this needs to be validated by a Knowledge, Attitude and Practice (KAP) study. The importance of conducting KAP studies before and after the implementation of IEC strategy cannot be overemphasised. KAP studies help to ascertain knowledge levels and identify common misconceptions which exist. KAP studies will also help identify the best channels for dissemination of IEC messages.

IEC was the core element of CHEP TB project intervention and was implemented following annual and three year plan. However, there was no overall IEC strategy with clear targets and indicators. The overall IEC strategy will give a clear vision of what CHEP wants to achieve and how to measure the achievements. This will also ensure that all the components of IEC strategy are implemented. For example the communication component in the IEC strategy was not implemented. Interviews with treatment supporters as well as health workers revealed that most of them lack basic communication skills which are vital in their daily work and also health education to patients and community.

CHEP has over 15 years experience on HIVAIDS health education with billboards and posters in all districts in Copperbelt. However, only one billboard was seen which also addresses TB in the four districts visited and no posters were found with TB messages in the health facilities. The number of brochures produced in the last three years (5000) need to be increased given the number of patients and targeted population in order to have intended impact in the intervention districts.

Although CHEP has done an impressive work on production of IEC materials, the review team identified lack of basic skills in development of IEC materials. For example, the brochure which were produced in English and bemba were developed without following basic IEC development procedures and skills such as needs assessment, language use etc. CHEP would benefit by acquiring basic IEC development skills from LHL experts and other partner countries such as Tanzania and Namibia.

Most of the findings of this evaluation are consistent with other evaluations conducted within CHEP over the last four years or so that have made similar observations with regards to the successful and effective implementation of planned interventions. The evaluations have also made recommendation for improvement that are in line with what is being recommended in this report. For example, the QInter Search Evaluation report for the period 2003 to 2006 made similar observations with regard to the transparent nature of CHEP's financial system. The report equally made recommendations on the need to strengthen the monitoring and evaluation capacity of CHEP by engaging a full time M & E manager; and to develop operational manuals for use by CBOs and replication (Quinter Search 2006).

7. CONCLUSION, LESSONS LEARNT AND RECOMMENDATIONS

7.1 Conclusion

LHL/CHEP project *"Strengthening Community Responses to TB and HIV/AIDS"* is a very vital project that has contributed immensely to the fight against TB and HIV/AIDS on the Copperbelt. The evaluation also found that CHEP has achieved its objectives and goals by implementing its planned activities in the four districts. Discussions with DHMTs in the four districts have revealed that CHEP has implemented its activities even beyond the 30 percent of the targeted catchments area stipulated in the project document. Over the last three years, the project has mobilised, organised and empowered community members with knowledge and skills that have enabled them to be effective TB service providers. This evaluation has found that through the leadership of the DHMTs and DATFs, CHEP has partnered very well with other NGOs and the communities to support the effort of the Government in the fight against TB and HIV/AIDS in the four district of Kitwe, Lufwanyama, Masaiti and Chililabombwe. However, it must be recognised that the fight against TB and HIV/AIDS is not an easy task. Although TB case detection has not increased in the four districts, the project has contributed to the improvement of treatment outcomes. CHEP's contribution has mainly been the involvement of treatment supporters in the provision of DOT and default tracing. The proportion of the patients who failed from treatment remained the same at 2.3 percent and this needs to be actively monitored. Although there has been some level of collaborative TB/HIV/AIDS activities such as diagnostic counseling and testing (DCT) for TB patients, a need to avail and widely disseminate the national policy on collaborative TB/HIV/AIDS still exists. The local health centers have been a key factor in the success of the project despite the numerous difficulties they face such as staff shortages. CHEP can lobby to Government for training of health workers and where necessary supplement Government efforts whilst taking full responsibility to continue supporting the training of more community treatment supporters.

7.2 Lessons Learnt

- Understanding of what communities are, what they can do, and that they can work along side bio-medical workers is essential. After all, TB lives in the community. Trained community treatment supporters

can have multiple roles that include helping health staff with other duties beyond TB DOTS.

- There is great strength in bringing various players with different HIV/AIDS/TB perspectives to work together, learn from each other and synergise their competencies and expertise. For example, it has always been assumed that traditional healers are important community resource, but history has very few instances where they have been drawn from the informal to the formal health care systems. This project provides one of those instances.

- For the spirit of voluntarism to be sustained, it is important that there is adequate dialogue with the community at needs assessment, planning and implementation stages to assess the forms of incentives that the community can sustain. Voluntarism at community level should be considered in relation to broader influencing factors and within the local context of expectations, as well as the practices of other NGOs.

- Institutional and human capacity at local and community levels is key to the successful implementation of a project. Before the CHEP/LHL project there were low levels of:
    - Community involvement;
    - Community understanding of TB;
    - community outreach activities;
    - Treatment outcomes.

- The LHL/CHEP project has taught that impact assessment can be done at two levels; Level 1- identifying direct outputs e.g. Number of treatment supporters trained, number of CBOs formed, etc. Level 2- the effects of the direct outputs e.g. the number of people they reach with information and the number of TB suspects referred for services to local health facilities.

- “Experience is the best teacher” when real experiences of a disease like TB are reflected upon, internalised and used to teach and support other victims, the effects and results are more positive. The idea of using former TB patients as treatment supporters is a novel one.

- Support by the community members and local leadership in matters of health is critical for the successful implementation of the project.

- CHEP has undergone a successful transition from a concentration on information dissemination, *per se*, through different structures including community voluntary groups including the youths **to** mobilisation of target groups such as former and current TB patients into effective community structures for combating TB and HIV/AIDS.

7.3 Recommendations

TB project implementation

- LHL/CHEP should maintain its strategy of strengthening community response on TB and HIV. The focus should continue to be on building capacity of community groups with attention to former TB patient groups and strengthening their institutional capacity.

- Given the achievements and lesson learnt in the implementation of the TB project, LHL/CHEP should expand and scale-up these interventions within the districts and beyond.

- While CHEP has done tremendously well in building capacity of treatment supporters on DOTS, the role of family members needs to be strengthened to ensure that they are involved in their relatives' treatment.

- CHEP needs to document what worked well and why, the processes and the outcomes (Lessons Learnt booklets) to provide evidence

- CHEP should use its comparative advantage in community aspects of HIV/AIDS to encourage and promote collaborative TB/HIV activities in partnership with DHMTs.

Advocacy, communication and social mobilisation

- LHL/CHEP should conduct KAP studies before and after implementation of IEC strategy in intervention districts to determine knowledge levels and impact of the IEC strategy

- Since (IEC) ACSM is the core intervention for CHEP TB project, there is need to develop an ACSM strategy with clear goals and targets for the implementation.

- LHL/CHEP should build capacity of its staff and stakeholders in IEC development process, including training on communication skills.

- LHL/CHEP should develop more IEC materials including posters and distribute to all its stakeholders. CHEP can seek technical assistance in development of IEC materials.

Case detection and Treatment outcomes

- The reasons for stable/decline in TB notifications in CHEP TB project areas need to be established. Prevalence studies would provide more comprehensive information but they are technically difficult to conduct and require a lot of resources. Therefore, CHEP in collaboration with DHMT can conduct health seeking behaviour studies to determine delays, stigma and their role in the decline in TB case findings.

- LHL/CHEP should maintain database of TB patients notified and treated in the project areas whilst building the capacity of its staff in collection and analysis of the data and use the information in planning and monitoring of the project.

- LHL/CHEP needs to monitor the quality of home based DOT in order to safeguard the success gained by the project and reduce the threat of developing MDR

Capacity Building

- Training of all the players including CBOs should be based on needs assessment for relevance and cost effectiveness. The needs assessments should be conducted at the end of each phase of the project circle in order to feed into the next set of strategies and planned activities.

- There is need in future to constantly remind and instil a sense of accurately recording events and maintaining the numbers as this is good for accountability and the evaluation of the project.

Supervision and mentorship

- Preparation and submission of detailed monthly and quarterly progress reports should be made mandatory for all CBOs.

- There should be proper documentation of all community-based activities and capacity for community-based information systems should also be built.

- LHL/CHEP needs to develop a systematic way of sharing their monthly reports with the major stakeholders particularly community treatment supporters so that they can have a bigger picture of the project beyond their own involvement.

- Since LHL/CHEP is not mandated to train DHMT staff, it would benefit the project if some of the staff could be provided with technical support on a regular basis to enhance their skills. CHEP would do this by extending some of the training opportunities available from LHL to the DHMT staff.

Community Involvement

- While CHEP has done tremendously well in building the capacity of treatment supporters on DOT, and in exceptional cases, the supporters can perform the role of a care giver, family members need to be mobilised and educated to ensure that they are involved in their relatives' treatment.

- Treatment supporters should work hand in hand with home-based care groups in order to avoid duplication and ensure optimisation of available resources and time.

- LHL/CHEP should develop guidelines and manual for formulation and mentoring of CBOs. This should be based on well documented relevant experiences of the processes and outcomes.

- Best practices within the processes of establishing and mentoring of former TB patient CBOs, should be well documented for replication and also for sharing with other organizations working with communities in TB and other diseases.

- Since TB needs to be fought from all fronts, community volunteers are a crucial force that needs equal attention and support. The MoH through DHMTs needs to fully support community volunteers who are augmenting the efforts of former TB patients.

- Communities' situations and expectations need to be understood. Clear guidelines should be developed and communicated during implementation to communities on what incentives would be applicable for different activities and groups. This will also strengthen their ownership of the process.

- Detailed documentation of lesson learnt and best practices should be undertaken in order to inform future collaboration between the NGOs, formal and traditional health systems

- Operational Research to monitor trends in health seeking behaviour of communities including delays in treatment seeking should form a key component of project implementation. There is also need for baseline and endpoint (before and after the involvement of healers) surveys to determine the contribution of traditional healers to community awareness for improved case finding.

- Best practices within the processes of mentoring traditional healers should be well documented for replication and also for sharing with other organizations, nationally, regionally and beyond.

- CHEP/LHL needs to work closely with other organizations that provide food supplements and also to lobby other organizations such as the WF programme for food supplements to TB patients.

Sub-granting

- Allocation of financial resources should be based a comprehensive assessment to determine the capacity to implement the interventions and on the absorptive potential of each CBOs.

- In order to ensure sustainability of the TB interventions, LHL/CHEP should assist the CBOs identify microfinance institution and build their capacity to write and submit viable project and/or business proposals.

Partnership, Sustainability and Monitoring and evaluation

- The cooperation between the DHMTs and LHL/CHEP should be governed by formal arrangements that spell out roles and responsibilities. A Memoranda of Understanding (MoUs) should be developed and signed by both parties as a way of formalising the partnerships.

- Whilst the project has empowered communities with knowledge and skills and also assisted them to build enduring community structures, financial sustainability strategies must equally be built into the project at the design stage. With better insights gained over the last three years, CHEP/LHL needs to explore ways of gradually linking-up community based groups to micro-financing institutions for financial sustainability.

- CHEP should recruit a full time Monitoring and Evaluation Officer with appropriate skills in order to strengthen the overall institutional capacity for M&E and to ensure that project activities are constantly in line with goals and objectives as enshrined in the project log-frames.

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9. ANNEXES

ANNEX 1: Working Definitions of Concepts used in this Evaluation Report

Access and control: Access means the opportunity to make use of a resource instrumental to production of goods and services (e.g. employable skills, finances, equipment, vehicles, decision making power, leadership), but without having control to decide on outputs or exploitation methods. Control means the authority to decide about the use and output of resources.

Benefits (gains accrued): These include things that contribute towards improvement in quality of life (basic human needs) – e.g. information, education, knowledge, health care, water and sanitation, etc).

Decision-making: A complex process, which includes other dimensions of power – e.g. '**influence'** (formal or informal pressure that is successful in imposing an individual's point of view); **'authority'** (legitimate power which derives from socio-cultural and legal norms of society; **'power'** (the ability to make one's interests count even when others resist).

Empowerment: The recognition from within an individual of capabilities and capacities to exercise influence, power, and leadership in some or all social relations; and then going out and acting on that recognition. Empowerment is self-generated, it cannot be given – e.g. all that a gender-transformative policy or program can do is to provide women with the enabling resources, which will allow them to take greater control of their own lives.

Effectiveness analysis: Involves examination and assessment of performance in implementing a program/project. A program is likely to have a positive impact if the management structures and systems are effective. Examination of management systems helps to show clearly how well the program has been able to meet its stated objectives by focusing on the direct outputs of the program.

Evaluation: A systematic appraisal and assessment of a project/program or process at a given point in time (past, present, future), which includes making value judgements (stating relevance of a program) in a given context.

Review: Examines processes and outputs of a program/project, identifying both facilitating and constraining factors to program/project implementation. It makes recommendations on situations/aspects that need action for more effective implementation. A review facilitates adjustments to implementation methodology.

Impact assessment: Establishing with certainty whether or not a program/project is producing intended effect (i.e. if it achieves some change towards desired direction). Assessing impact means ability to clearly show that the changes observed are the function of the program/project, and whether or not the changes were intended and cannot be explained in other

ways. Impact assessment includes quantitative impact assessment (direct outputs, numbers, activities) and qualitative impact assessment (effects or changes influenced by the direct outputs).

Gender: Identifies social differences (reflected in activities, roles, forms of behaviour, responsibilities) between men and women. Gender is a socially constructed relational category that carries with it expectations and responsibilities that are not biologically determined.

Monitoring: Refers to on-going internal activity to determine appropriateness of program/project implementation methodology with a view to making adjustments as necessary. Monitoring may be done in various ways – e.g. needs assessment, baseline studies, reports, meetings etc.

Poverty reduction: Increasing incomes, reducing vulnerability, improving household food security, and sustainable use of natural and other resources.

Management: Refers to planning and budgeting processes, financial reporting and programmatic reporting, implementation of activities, monitoring and evaluation, capacity building (institutional and human resource levels), technical support (providing required expertise as necessary), communication between and among different levels of a programme, administration (joint contribution to the budget, personnel recruitment and deployment).

Coordination: Refers to the definition of functions, roles and responsibilities of various players (e.g. DHMTs, Health Centres, NGO, CHEP project staff and communities)

Partnership: Refers to shared values, equal participation at all levels of the programme, equal decision-making power, trust between and among partners, transparency in the management of resources (finances, material things, human resources, time), cooperation in carrying out the various tasks and joint ownership of a programme in all the aspects.

Ownership: Means that an institution, individual, or group can claim rights and control over something based on legal document or cultural norms. In the case of a development programme by an institution or group, ownership would be defined in a legal document. Having ownership of a programme means commitment to protect and ensure its sustainability and continuity.

Sustainability: Refers to continuation of programme outputs beyond its timeframe or duration, ownership and management of a programme or programme outputs by target beneficiaries, and potential of a programme for its replication to other areas. Assessing sustainability of a programme involves examination of strategies put in place to ensure that the programme will be sustained for the future.

Innovativeness (best practices): The ability to address new challenges in the field in programme implementation through identification and adoption of appropriate and practical strategies that are applicable to intended target

groups. Innovativeness entails acknowledging the realities and the situation on the ground, being flexible and adaptive to the situation. This results into best practices arising out of the recognition of and meeting development needs as prioritized by the beneficiaries.

Self-reliance: Refers to an institution or individual's ability to be independent/autonomous from external dependency. This means that they are in total control of their circumstances/situation. For example in the context of the CHEP, self-reliance is interpreted to mean CBOs and communities undertaking planning and implementation of TB interventions with little donor support.

ANNEX 2 Terms of Reference for the external Evaluation

Copperbelt Health Education Project &
Norwegian Heart & Lung Patient Organization

Terms of Reference

External evaluation of the CHEP/LHL project

"Strengthening Community Responses to TB and HIV/AIDS"

Contact persons:
Mr Alick Nyirenda
CHEP – Copperbelt Health Education Project

Mr Ted Torfoss
LHL - Norwegian Heart & Lung Patient Organisation

March 2007

1.0 Background

The duo epidemic of TB and HIV/AIDS has reached disaster proportion such that it is tearing apart the social fabric of families and communities and overstretching health and social services to serious levels. The notification rate of Tuberculosis in Zambia increased from 100 per 100.000 in 1984 to 580 per 100.000 population in 2004, and 58070 TB patients were recorded. The increase of TB cases since the late 1980s is largely due to the concurrent HIV epidemic which is further compounded by poverty, lack of knowledge and stigma, among other factors. It is estimated that 70% of TB patients are co infected with HIV.

One of the great challenges in TB control is to provide real access to diagnostics and treatment (increase case finding) and make sure patients are treated correct and are able to complete the whole treatment period (increase treatment outcome). The Zambian National Tuberculosis and Leprosy Programme (ZNTLP) is following the WHO DOTS-strategy. Still it has shown that both in Zambia and internationally this is not enough to control TB. In order to accelerate progress according to the new Global Plan to fight TB (2006-2015) and the New Stop TB strategy presented by WHO and the Stop TB Partnership in 2006, additional focus need to be on empowering and involving people with TB and communities, involve private sector, address TB and HIV challenges, contribute to health system strengthening, engage all care providers and enable and promote research.
The government and NGOs/faith based organizations have responded to this to a certain extent in the implementation of TB prevention and control but a lot needs to be done.

2.0 The CHEP/LHL project

CHEP - Copperbelt Health Education Project entered into partnership with LHL - The Norwegian Heart and Lung Patient Organization with a 3 year agreement (2004-2006) to implement a program that would strengthen community responses to TB and the co-infection of TB/HIV. This agreement was motivated by the fact that TB has become one of the leading causes of morbidity and mortality among the most productive age group of 19 to 49 years, and is the leading cause of death among HIV+. Project intention was to combine CHEP's vast experience in HIV/AIDS programming, community knowledge and involvement and social mobilization with LHLs extensive experience and competence in TB programming and challenges.

The project interventions have taken place in four districts, namely Chililabombwe, Kitwe, Masaiti and Lufwanyama (2 urban and 2 rural districts). Initially, the intention was to cover all 10 districts in 3 years, but it was decided early within the first year that we were not able to cover more than 4 district in the 3 years period.

Current TB situation in the Copperbelt province.
Tuberculosis is one of the top ten causes of morbidity and mortality in Zambia. The TB notification rate in 2004 was 580 per 100,000 persons and in 2005 it was estimated to be at 530 per 100,000 persons. Copper belt province accounts for 27.6% of the national TB burden after Lusaka province. In Zambia 70 % of the TB patients are also infected with HIV which is estimated at 16%.Majority of the TB patients are young people in their productive age group. All the four districts documented an increase in the cure rates as compared to the time when the baseline was conducted in 2004.
The Copperbelt province just like any other province has gone through a series of reforms over the past decade aimed at decentralization of resources and services. The reforms decentralised almost all aspects of the health care systems to provincial and district level. One of the benefits of decentralization was the emphasis on importance of community participation in order to scale up quality delivery of DOTS. Copperbelt province is faced with a critical shortage of human and financial resources over stretching the TB prevention and control program. Community volunteers contribute in sensitizing the community on TB. Patient support groups have emerged in all the districts to raise their concern on issues of access to diagnosis, treatment and care. Poverty levels in various communities have continued to pose challenges to complete treatment.

Before implementation of the TB project we noted during the base line survey that although the level of understanding on TB was high, community members were not aware on what to do when they suffer from TB and the relationship between TB and HIV. Stigma was perpetrated and reinforced by health workers because of poor interpersonal communication with patients who come to the health centre for the first time. Stigma by neighbours and close family members contributed to patients postponing

seeking care due to fear of finding out their HIV status. We noted that although the district health boards trained TB supporters they were not enough to cover all the TB patients scattered in different localities. We noted the need to increase the number of supporters in order to ensure that TB patients receive the care and support needed to be able to complete treatment and be cured. CHEP's long experience in community work in HIV/AIDS prevention provided us with a link to partner with the district health boards without taking over their responsibility, but contribute in strengthening the community responses to TB epidemic and work within the TB strategic framework of the ministry of health.

The CHEP/LHL programme is meant to be an innovative intervention and additional input, developed in close cooperation with the local health facilities and in consultation with the national programme. The project is not a replacement for the ZNTLP, neither is it an independent activity, but an additional intervention to improve access and quality of service for suspects seeking TB diagnosis and treatment, and to create more awareness, knowledge and information about TB and HIV/AIDS in the target communities on the Copperbelt. Successful interventions and good practices are meant to be transferred to other districts and to be useful inputs for the NTLPs planning and delivery of services.

2.1 Aims, objectives and interventions

Aims

To strengthen the community's own responses to the dual epidemic of tuberculosis and HIV/AIDS.

Intervention Objectives

a) **By December 2006, CHEP and LHL will have facilitated an expanded response to improved prevention, care and support for TB and HIV/AIDS through community-based efforts using IEC strategies covering 30% of the targeted catchments areas on the Copperbelt Province of Zambia.**

b) **By December 2006, CHEP will have been enabled to develop its institutional quality service delivery capacity and enhanced its technical knowledge and skills in mainstreaming, managing and sustaining efforts aimed at confronting the duo epidemic of TB and HIV/AIDS**

Timetable

The first year of the project focussed on :

1. Baseline study in 4 districts
2. Strengthening CHEP staff and partners knowledge about TB
3. Community mobilisation
4. Advocacy and networking

For the second and third year the development of the project depended on experience and knowledge from activities carried out. Monitoring of the project has been carried out with quarterly meetings for Zambian stakeholders, and LHL followed up as a co-partner with bi-annual visits. An external evaluation was planned to be carried out in the second half of the third year.

Planned main interventions

- Community mobilization through drama and sensitisation outreach (sub-grants to CBOs, capacity building on TB, facilitating establishment of TB patient groups, community to community sharing, technical assistance, etc.)
- IEC activities; messages development, radio programmes, production of material, etc.
- Training of volunteers as treatment supporters
- Mainstreaming TB in HIV/AIDS activities
- Advocacy and lobbying
- Operational research activities
- Building TB and TB/HIV capacity among CHEP-staff
- Experience sharing through meetings, seminars, etc. at different levels

2.2 Future Plans

With knowledge and experiences from this 3 year project period, a new 3 year agreement will be signed between CHEP and LHL. Intention for the new 3 year period is to initiate interventions in one new district every year based on best practices for the first project period, and further develop these in the 4 districts already involved.

3.0 External Evaluation of the CHEP/LHL project:

An external evaluation was planned at the end of the 3 year project, but had to be postponed to the first half of 2007.
The importance of the evaluation is to have an independent review which will look at the achievements and challenges and come up with recommendation on the way forward.

3.1 Aims and Objectives of the Evaluation

This proposed evaluation shall follow the OECD/DAC evaluation criteria, as outlined below:

- **Efficiency**
  A measure of how economically resources/inputs (funds, expertise, time, etc.) are converted to outputs in the TB/HIV project
- **Effectiveness**
  The extent to which the implemented programme's purpose was achieved, or is expected to be achieved.
- **Impact**
  Positive and negative, primary and secondary, long-term effects produced by a development programme, directly or indirectly, intended or unintended.
- **Relevance**

  The extent to which the objectives of a programme are consistent with beneficiaries' requirements, country needs, global priorities and partners' and donors' priorities.
- **Sustainability**

  The continuation of benefits from a programme after major development assistance has been completed. The probability of continued long-term benefits.

Main objectives of the evaluation will be to:

4. To assess to what extent the objectives of the project have been reached
5. To assess to what extent the planned activities have been carried out
6. To assess the impact of the interventions carried out in the 4 districts during the 3 years period

General evaluation tasks

4. To assess the efficiency (have we done the things right), and the effectiveness (have we done the right things) of the project (as a whole, not only for parts of it)
   a. Cooperation and partnering with communities and CBOs (Community based organizations
   b. Integrated HIV and TB activities,
   c. Monitoring and experience sharing
   d. Partnering with government and other NGOs involved in TB control
5. To assess the relevance of the interventions (of how it is done and with whom).
6. To assess the sustainability of collaborative TB/HIV community interventions and to identify the factors that might be in the way of sustainability, or put it at risk.
7. Assess the intended and not expected impacts. Evidence for achieved impacts should be sought, and indicators might be identified that point to impacts to be expected in the future.

Specific evaluation issues and questions[1]

[1] The review team should come up with key questions which will elicit information to respond to these objectives within the timeframe of the review. Some of the highlighted questions here are listed as guidance but may not all be inclusive.

1) Assess if the impact of the project has contributed to increased case-finding and improved treatment outcome
2) What are the changes in the communities when it comes to TB and HIV/AIDS knowledge, awareness, stigma and behaviour?
3) Assess the impact of involving former TB patients in different TB activities (treatment supporters, information spread, community engagement, outreach, etc.)
4) Assess the impact of the different IEC activities
5) Assess the training of the treatment supporters and how they are followed up.
6) Assess the use of voluntary treatment supporters in the TB programme
7) Assess the technical support and training provided by CHEP to the different CBOs
8) Assess the use of sub-grants in the project
9) What are the comparative strengths and challenges in using traditional healers as treatment supporters in DOT?
10) Assess the integrated TB and HIV activities and how can the results and outcomes of this be attributed to this project?
11) What are strengths and weaknesses of the different project components?
12) Assess the project organisation and management, including decision-making processes, human resources, relationship with key stakeholders at district, regional and national level, project administrative system, operational researches and the monitoring and evaluation processes.
13) Assess the use of funds (budgets, disbursement of funding, expenditures consistent with the budget, external audits) – and to see if reports have been sent in time, and how they are responded to. This is about a properly kept and transparent system, rather than the question of correct accounting, which should be assessed by a certified auditor.
14) Identify which project components are important for the long-term vision to improve the quality of life of the beneficiaries, and discuss these aspects, especially in relation to involving the former TB patients and People living with AIDS.
15) How has the project empowered patients, former TB patients, health workers, healers and other beneficiaries in the Copperbelt specific areas and beyond?
16) How can the results of the project be scaled-up in other parts of the Copperbelt and beyond?
17) Assess aspects of ownership.
18) Assess strengths and weaknesses in the partnership among CHEP/LHL and, relevant government departments, other NGO's and community groups.
19) Assess how the CHEP/LHL project is coordinated with other similar initiatives working with TB and HIV/AIDS, especially initiatives funded by the GFATM through CHAZ, ZNAN and MOH.

3.2 Methodology and Data collection

a) Evaluation method

Focus on the implementation mechanisms and project management, through discussions with project staff and stakeholders at different level, especially the different target groups of the project. Meet project staff and partners to understand their roles and responsibilities with the project, how the components work, the strength and difficulties, and any synergies between components. The approach is to play a facilitation role in allowing people to examine the project as objectively as possible and to enable them to suggest ways of strengthening the project. Hence, the presentation of findings is usually a very rewarding experience for all those involved and provides a further platform for debate and ownership of the recommendations emerging from the evaluation.

The consultants should decide in dialog with CHEP staff on who should be contacted for appointments.

b) Data collection.

The team will go through relevant documentation provided by CHEP and LHL (indicated behind each document), which will include:

- CHEP Annual(overall) reports(2004-2006) - CHEP
- Baseline study carried out in the 4 districts - CHEP
- National TB/HIV policy guideline - CHEP
- National TB Strategic plans - CHEP
- National TB annual reports – CHEP

- Masters Thesis: Medical Pluralism in Zambia, the health seeking dilemmas of People Living with HIV/AIDS, Alick Nyirenda, 2005(University of Oslo) - CHEP
- Copperbelt Province Statistics on TB, 2004-2006 - CHEP
- CHEP Proposals to LHL 2004-2006 - LHL
- Annual plans and budgets (2004, 2005 and 2006) - LHL
- CHEP Proposal to LHL (2007-2009) - LHL
- Financial bi-annual reports and audited accounts(2004-2005) – CHEP/LHL
- District TB consolidated annual reports(2004-2006) - CHEP
- Travel project reports, (2004-2005) by LHL – LHL
- Reports of TB conferences, meetings and research papers presented (2004-2006) - CHEP
- Study the overall draft strategic plans for CHEP(2007-2009) - CHEP
- Study the overall External evaluation reports (for periods 2002-2006) – CHEP
- Agreement CHEP/LHL 2004-2006 – LHL
- Agreement CHEP/LHL 2007-2009 - LHL

3.3 Evaluation Output

The product of the review will be a concise, focussed report responding to the objectives of the evaluation and outlining key findings and recommendations for the formulation of the next Strategic Plan 2007 – 2009 to inform future implementation by CHEP, LHL and their community and government partners

Based on the evaluation findings and future plans, recommendations should be formulated that are understandable and realistic:

- Recommend action that will enhance project replication and/or expansion
- Identify opportunities and recommend operational research and the human and economic resources needed for implementation.
- Make recommendations that will in general strengthen the project in the future

4.0 Time frame

The consultant will report simultaneously to the CHEP board of directors, through the Executive Director of CHEP, and to the International consultant at LHL working with the Zambian partnership. The evaluation is planned to take place from 13 to 25 April 2007. The task should take no longer than 21 days. Preparatory works will be done in March/April 2007, undertaken by CHEP. All relevant documentation in hard copy or soft copies will be sent to the consultants by mid March 2007. While together in Zambia the team will prepare a debriefing with key findings and recommendations to be presented to CHEP and LHL; and cooperating partners

The team-leader will prepare the **first draft** to be submitted to CHEP and LHL by May 4th 2007. The draft will also be sent to the co-operating partners for comments. Comments should be presented to the review team by May 11th 2007.
The final report will be submitted to CHEP and LHL by May 18, 2007 in an electronic format.

5.0 Remuneration

Mode of payment to the team will be divided in two disbursements. The first disbursement will be transferred to the respective accounts on 01 April 2007, or as soon as the contracts are signed, and the second by the delivery of final report.

6.0 Members of the team

The evaluation team consists of two persons. Both have been recommended and appointed jointly by LHL and CHEP. The qualifications and experiences of the team are broad and will complement each other well.

Dr Philimon Ndubani, UNZA, Zambia – Team Leader pndubani@yahoo.co.uk

Dr. Eliud Wandwalo NTLP Tanzania ewandwalo@hotmail.com

7.0 Property Rights

LHL and CHEP has the proprietary right to the final report. LHL and CHEP plead the right to give comment on the report. The final report will be presented electronically.

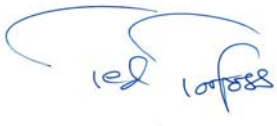
8. Workplan

The team will communicate by e-mail and agree on the division of activities.

Activities for the team	**Days required**	**Dates**
Prepare and read documents	1	March 2007
Document review of reports	2	March 2007
Arrival at CHEP, Kitwe, Zambia		Thursday April 12
Scoping Meeting with CHEP TB team to conduct a SWOT analysis, gain a good understanding of the project and observe processes & dynamics	1	Friday April 13
Methodology plan, developing interview questionnaires	1	Saturday April 14
Review of training materials & methods, minutes of project meetings, administrative files, M&E documents	1	Sunday April 15
Key Informant Interviews with partners and recipients of the project . Interviews with health authorities at district level, NTLP at different levels, TB coordinators, health workers, volunteers, CBOs, former TB patients and patients on treatment.	8	Monday April 16 to Monday April 23
Meeting with CHEP staff for clarification, etc. Analyses and preparation for debriefing	1	Tuesday April 24
Presentation and discussion of key finding and recommendations to staff & partners	1	Wednesday April 25
Departure		Thursday April 26
Analysis and write-up – deadline 04.05.2007	4	April/May 2007
Feedback and comments from CHEP, LHL and Partners – Deadline 11.05.2007		May 2007
Incorporation of corrections from the CHEP, LHL and project partners	1	May 2007
Submission of final report to CHEP and LHL	**21**	**Friday May 18 2007**

Oslo …16th March 2007…….. Dar es Salaam ……

Kitwe ……. Lusaka ……

Ted Torfoss	Alick Nyirenda	Philimon Ndubani	Eliud Wandwalo
			
Project manager LHL	Director CHEP	Consultant (team-leader)	Consultant

ANNEX 3: LIST OF PERSONS INTERVIEWED

Kitwe		
Name/Group	**Organisation**	**Role/Position**
Mr. Alick Nyirenda	CHEP	Executive Director
Mr. A. Cheemba	CHEP	Programmes Manager
Mr. Isaac Mumba	CHEP	Project Coordinator
Mr. Lotiie Mwale	CHEP	Technical Support Officer
Ms. Nsombo Chunda	CHEP	Acting Financial Manager
Mr. P. Muzyamba	CHEP	Programme Coordinator
Mr. Eric Mulenga	CHEP	LHL/CHEP Project Accountant
Mr. Westone M. Bowa	CHEP	Senior Coordinator
Ms. E. Kunda Lumba	CHEP	Gender and Advocacy Coordinator
Dr. M. L. Sichimba	DHMT	Manager, Planning and Dev.
Ms. Nachizya Chabala	Buchi Health Centre	Nurse In-Charge
Ms. Miyanda Kaonde	Buchi health centre	DOTS Corner Nurse
Former TB patients Group	Kawama	
TB Patient Group	Kawama	
Mr. Raphael Mulembi	Community Representative	Ward Secretary
Dr. Mulenga	PHO	Provincial TB Manager
Lufwanyama		
Dr. Kamalamba	DHMT	Health Director
Mr. Sondashi Ngosa	DHMT	TB Focal Point Person
Mr. Martin Kashila	Shimukunami Health Centre	Clinical Officer In-Charge
TB Patient Group	Shimukunami	
Community Volunteer Group	Shimukunami	
Former TB Patient Group	Shimukunami	
Mr. Wilfred Chihande	NHC/Community Leader	Chairperson
Masaiti		
Mr. Bernard Maswana	DHMT	Health Director
Mr. Stephen Nakasamu	DATF	Chairperson
Mr. Tendai Chihota	Former TB Patient Group	Chairperson
Mildred Kauseni	Former TB Patients Group	Administrative Secretary
Binwell Kankobwe	Former TB Patients Group	Executive Committee Member
Mr. Josiah Simfukwe	Mishihkishi Health Centre	Officer In-Charge
Ms. Robina Kalolo	Mishikishi	TB Patient
Ronald Lyandisha	Mishikishi	TB Patient
Chililabombwe		
Ms. Kampamba	DHMT	TB Focal Point Person
Ms. Mutambo	Kakoso Health Centre	DOTS Nurse
Ms. Jane Choongo	Kakoso Health centre	Nurse
Group of Health Care Providers	Kakoso Health centre	
Traditional Healer Group	Kakoso	
Stephen Mutale	THPAZ	Provincial Chairperson
Ms. Catherine Bwalya	Lubengele Health Centre	Treatment Supporter
Mr. Peter Bwalya	Lubengele Health Centre	Treatment Supporter
Pastor Albert Kafulila	CMML	Religious Leader
Management Staff	Konkola Ex-Miners Ltd	
LHL Representative		
Mr. Ted Torfoss	LHL	Deputy Manager International Co-operation