Evaluation Summary

1. Outline of the Project		
Country: Republic of Zambia		Project title: Integrated HIV and AIDS Care Implementation Project at District Level
Issue/Sector: Healthcare and medical treatment		Cooperation scheme: Technical Cooperation Project
Division in charge: Zambia office		Total Cost (as of the evaluation): approximately 270 million yen
Period of cooperation	April 2006- March 2009	Partner Country's Implementing Organization: Ministry of Health
		Supporting Organization in Japan: International Medical Center of Japan (IMCJ)
		Other projects: the project for strengthening HIV/AIDS laboratory network services

1 − 1 Background of the Project

Zambia has been severely hit by the pandemic of HIV/AIDS with the adult HIV infection rate of 14.3 % in 2007 and the approximately 90,000 deaths due to AIDS per year. The Zambian government has introduced a free provision of Anti-retroviral treatment (ART) since August 2005 which leaded to increase of the number of ART centers (over 300 centers in 2007) and clients who can access to the ART (over 130,000 as of December 2007).

The project has been implemented in two target districts: Mumbwa and Chongwe Districts since April 1, 2006. It aims to expand the diagnostic system for early detection of HIV-positive persons, to improve the quality and accessibility of HIV care services and to strengthen the healthcare management system. At present, the project has been run by 3 long-term experts (Infectious Disease Control/Health Planning, HIV/AIDS care, Project Management/Monitoring) and other short-term experts.

1 − 2 Project Overview

(1) Overall Goal

Interventions to improve the HIV and AIDS care services for PLWHAs demonstrated at target districts are introduced in other districts.

(2) Project Purpose

HIV and AIDS care services are improved and accessible at target districts.

(3) Outputs

1) Access to HIV counselling and testing is improved.
2) Quality HIV care services are strengthened and scale-up.
3) DHMT's management capacities in HIV care services are enhanced.
4) Lessons learned by the Project are incorporated into national guideline on mobile ART services.

(4) Input (as of the evaluation)

Japanese side :

Long-term experts: 4 people Short-term experts: 7 people Trainees accepted: 4 people
Equipment: US$242,000 Local cost: 1,194,482,000 Kwacha

Zambian side :
Counterpart: 15 people Local cost: 179,922,000 Kwacha
Provision of offices and facilities, utilities, ARVs and HIV test kits, etc.

2 . Evaluation Team

Leader	Shiro NABEYA	Resident Representative, JICA Zambia Office
HIV Care	Tamotsu NAKASA	Director, 2nd Expert Service Division, Bureau of International Cooperation, International Medical Center of Japan
Evaluation Planning	Ippei MATSUHISA	Assistant Resident Representative, JICA Zambia Office
Evaluation Management	Satsuki KUNIKANE	Associate Expert, Infectious Disease Control Division, Health Human Resources and Infectious Disease Control Group, Human Development Department, JICA
Evaluation and Analysis	Akemi SERIZAWA	Social Development Specialist, Global Link Management, Inc.

Period of evaluation: September 16, 2008- October 9,2008

Study Type: Terminal Evaluation

3 . Results of Evaluation

3 − 1 Achievements

(1) Project Purpose

The Project is likely to achieve the Project Purpose by the end of the Project period.

The cumulative number of HIV positive cases detected by VCT/PMTCT (Indicator 1) in Chongwe District has already reached the target (4,193 people for 4,000 people) and that of Mumbwa is also likely to (5,887 people for 7,000 people), by the end of the Project period.

Though cumulative numbers of ART clients (Indicator 2) are currently 1,511 people for the target 2,300 people in Chongwe and 2,569 people for the target 3,500 people in Mumbwa, the number would reach the target by the end of the Project period in March 2009 taking into account the fact that the rate of increase has been accelerated recently.

The defaulter rate (Indicator 3) in Chongwe District is 3%: already below 10% and that in Mumbwa District is 13.3%: also likely to be less than 10% by the end of the Project period. Although the comparison between the two districts is not technically right as the definition of defaulter is not common among the Project members, lost and defaulter rate of mobile ART clients in the target districts collected in the operational research is lower than that of ART clients in Mumbwa district hospital, which proves the effectiveness of the approach taken by the Project.

(2) Outputs

1) Access to HIV counselling and testing is improved.

Output 1 was found almost achieved. The coverage of HIV-related services has been improved as the number of counselling and testing conducted in VCT (Indicator 5) and in PMTCT (1-6) is likely to meet the target by the end of the Project period. The target of percentage of HIV tested among TB clinic (Indicator 7) and in ANC clinic (1-8) has already been met in both districts. On

the other hand, the number of health facilities providing theses services is not likely to be achieved (Indicators 1-1 to 1-4). The reason for the slow expansion of health facilities providing VCT, PMTCT, DCT or finger-pricking HIV testing method is that, although at least one staff member from each health facility was trained in these technical areas, not all facilities have adequate human resources, space or equipment to provide these services.

2) Quality HIV care services are strengthened and scale-up.

The data indicates progress compared to the baseline, although some indicators have not reached the target to date. Therefore, it can be concluded that Output 2 has been achieved.

The number of health facilities providing ART services (Indicator2-1) has increased in both districts, however the target number is not likely to be achieved because the DHMTs have prioritized improvement of the quality of the existing mobile ART centres over the scaling up to other health facilities. Still, increase in number of ART clients (Project Purpose Indicator2) shows improved access to ART services.

While Indicator 2-2 (adherence counselling) has not reached the target, the data shows that all health facilities providing ART services do adherence counselling.

The indicators about the quality of the services (2 -3 to 2-6) have achieved the target, although reliability of the data is not necessarily confirmed. As evidence of good quality of mobile ART services, data collected in the operational research on lost and defaulter rate among mobile ART clients in Mumbwa District shows that it is lower than that of ART clients in the district hospital.

3) DHMT's management capacities in HIV care services are enhanced.

Management capacities of the DHMTs in sound implementation of mobile ART services have been strengthened. Some of the rural health centres providing ART services have already developed capacities to the level that the staff can perform larger part of the ART services. Information management including having client files sorted and kept in orderly manner has been improved in both districts.

Regarding Indicator 3-1, both districts held ART review meetings twice in 2008 from January to September, 2008. While it is not likely that it will meet the target (quarterly), it shows a progress as they did not have district meetings.

Operational research has enhanced awareness of the DHMTs on data management, although data analysis was mainly conducted by the Japanese experts. The results of the operational research are to be presented by the DHMT Directors at international conferences in Paris and Dakar, as well as in the National Health Research Conference, later in 2008.

4) Lessons learned by the Project are incorporated into national guideline on mobile ART services.

Output 4 is likely to be achieved as the MoH and NAC are aiming at the development of the said guidelines by the end of 2008. The Project members attended the NAC taskforce meeting on the national guideline development earlier this year so that the lessons learned from the Project could be incorporated in it. The MoH is willing to include good practices and lessons learned from the Project not only into the guidelines but also into newly initiated mobile ART services in 15 other districts that will be financed through the funding from the Clobal Fund to Fight Aids, Tuberculosis and Malaria (GFATM) (Round 4/Phase2) to the MoH.

The regular project meeting has held almost monthly. Since last year, improved attendance of key persons of the MoH headquarters facilitated quality discussions that lead to concrete actions. It indicates improved communication between the project members, their enhanced commitment to the Project and its increased presence derived from the visible outcomes produced so far.

3 － 2 Evaluation by Five Criteria

(1) Relevance

The Project is highly relevant to the needs of the Republic of Zambia and of the target groups (PLWHAs and the DHMTs of two target districts), and also in line with HIV/AIDS-related policies in Zambia and Japan's official development assistance policies.

Adult HIV prevalence rate of Zambia (15-49 years of age) was 14.3% in 2007 (Zambia Demographic and Health Survey 2007) and the government of Zambia introduced free ARVs in August 2005 in accordance with the National ART Scaling-up Plan and the National HIV/AIDS/TB/STI Strategic Plan (2002-2005,2006-2011). The approach of the Project to promote ART services closer to the communities in rural areas is consistent with these policies.

Japan's development assistance policies also prioritize HIV/AIDS response. Improving health of people including HIV/AIDS, is one of the priority areas of Japan's country assistance policy in Zambia (2002). This Project is the first technical cooperation project of JICA in the world to assist provision of ART services, based on the recognition of Zambia as one of prioritized countries in JICA's guidelines on Response to HIV/AIDS in Sub-Saharan Africa'.

(2) Effectiveness

The Project has been found effective as it has improved the accessibility of HIV/AIDS care services in rural areas in the target districts (Project Purpose).

Accessibility of ART services has been improved and the number of ART clients has increased in both districts. The data from the operational research shows low defaulter rate in the mobile ART centers indicating good quality of the mobile ART services. According to the mobile ART clients interviewed by the terminal evaluation team, they are happy about the ART services as they do not have to travel long distance for the treatment and that they can live healthier lives. According to data from the operational research, less time and cost are incurred by patients to visit mobile ART centers compared to the situation that the mobile ART service was absent.

(3) Efficiency

The Project has been efficient. The achievement of the Project has been remarkable considering the small size of the input. The contribution of Japan to HIV/AIDS response in Zambia, including this Project and others, is less than one percent in financial terms compared to that of other international and national partners. The Project operates within the existing system of the MoH and the DHMTs and utilises existing resources, which has contributed to efficiency as well as sustainability.

(4) Impact

Overall Goal 'interventions to improve the HIV and AIDS care services for PLWHAs demonstrated at target districts are introduced in other districts.' can be achieved. The model of

mobile ART services developed by the Project is likely to be integrated into the national mobile ART guidelines. Furthermore, the model will also be replicated in other districts, as being planned by the MoH using funding from the GFATM.

The data collected in the health facilities show that the mobile ART services promoted gender equality in access to ART services. Services closer to the community and shorter travel have benefited more women than men, which supported by the fact that the share of women among ART clients in the mobile ART centres in Mumbwa District is larger than that of Mumbwa District Hospital.

The outcomes of the Project have been advocated by the Project members within the MoH. During the ongoing process of revision of the Accreditation Guidelines of ART services, incorporation of lessons learned from the Project into the guidelines is advocated so that the conditions for accreditation of ART centers can be revised and that more rural health centers can provide ART services.

As a negative impact, the Project has experienced rapid increase of number of ART clients exceeding the capacity of the health facilities which do not have enough number of health care providers. Therefore, the quality of service could be compromised.

（5）Sustainability

Political sustainability is high. The government is likely to maintain its policies to promote HIV/AIDS care in the future. Needs of increased access to ART services particularly in rural areas are recognized. Programmes for HIV/AIDS responses cannot be implemented without resources from Cooperating Partners, ART in particular, but the support from the cooperating partners is likely to continue as long as HIV/AIDS remains to be a global issue.

In terms of technical capacity, the DHMTs and health facilities have improved their capacities in provision of ART services, although continuous technical support from the JICA experts would be desired in order to sustain and continue improving the availability and quality of services, along with the evolution of ART services in future. Human resource constraint is a challenge as it has become more difficult to respond to the needs of ever increasing number of ART clients. The Project has trained community people as lay counsellors and adherence supporters, which is effective but at the same time has limitations in maintaining their commitment due to inadequate monetary incentives.

Institutional capacity to sustain the Project outcomes has been developed. The DHMTs demonstrate strong ownership of the Project, which is supported by the fact that the budget for the Project is clearly indicated in the District Health Action Plan. The Project developed a mobile ART service model in the existing system of the MoH/DHMT and the mobile ART services are already made part of their routine work..

3－3　Contributing factors

（1）In the planning stage:

- Introduction of free ARVs by the government in August 2005 created enabling environment for scaling-up of ART.
- The Project aims at expansion of ART services in rural areas so that they can be available to more people closer to their home.

・The Project utilises the existing resources to expand HIV/AIDS care services, which is a good strategy to ensure sustainability.
・The Project emphasise capacity building of the staff members of the DHMTs and the health facilities to ensure sustainability and avoid dependency on support from cooperating partners.

(2) In the implementation stage:
・The Project responded to the rapidly evolving situation around HIV/AIDS care services in Zambia and modified the Project plan accordingly. For example, the Project started supporting the mobile ART services in rural areas instead of having static ART centres in the rural health centres as a response to the Accreditation Guidelines of ART services drafted in 2006.
・The Japanese experts visit the DHMTs and the health facilities frequently for their capacity building in ART services management and implementation.
・The Project is working in close collaboration with other components of JICA's HIV response programme to bear broader impact of the Project activities.
・The Project is getting better recognition in the MoH as the outcomes of the Project have been advocated and became visible.
・The government of Zambia successfully mobilises resources for HIV/AIDS response from Cooperating Partners. With the funding from the GFATM, the MoH is planning to introduce mobile ART services in other15 districts, to which the experiences of the Project will be incorporated.

3－4 Hindering factors
(1) In the planning stage:
・In the formulation stage of the Project, it would have been necessary to have more detailed analysis of the situation of the HIV/AIDS care in Zambia and the target districts through more rigorous discussions with the counterparts-to-be. It could have avoided having some irrelevant activities in the PDM version 1.
・More discussions would have been necessary for the selection of the counterpart members and their expected roles in the Project. Not all members listed in the Record of Discussions are aware of their roles in the Project and involved in the Project.

(2) In the implementation stage:
・Some Project activities were affected due to delayed formation of the Japanese Project team and suspension of national guidelines of Zambia.
・Communication surrounding the Project at the MoH central level was not optimal, which have sidelined the Project in the MoH. Zambian counterparts were not always able to prioritise the Project meetings due to competing demands. The situation has improved this year as the communication among members became more effective and the outcomes of the Project became visible.
・There was misunderstanding between the Chongwe DHMT and the Japanese experts, which was on the data management issue derived from the presence of other cooperating partner. In large part it was due to insufficient communication. It let to the postponement of some project activities in Chongwe until February 2008. The situation has improved since then as they have more discussions and work together towards the goals shared by both parties.

3 − 5 Conclusions

The Project has successfully implemented all planned activities and is expected to achieve its Outputs. Overall Goal is also likely to be achieved soon after the end of the Project. Good results are found in the evaluation by five criteria.

The Project is, therefore, expected to be completed successfully within the Project period following the recommendations below.

3 − 6 Recommendations

（1） Measures recommended to be taken before the end of the Project :

1) To make efforts to reactivate the Task Force for developing the mobile ART guidelines and work closely with the people in charge of it.

2） To make continuous efforts towards increasing the number of health facilities providing ART services ensuring the qualities of services.

3） To continue improving data management of HIV/AIDS programmes.

4） To proactively contribute in the planning and implementation for the MoH with the experiences and lessons leaned to date, responding to the resent plan of the introduction of mobile ART services by the MoH.

（2） Measures recommended to be taken by the MoH after the completion of the Project:

1） To continue ensuring budgetary and technical support to DHMTs and RuHCs, and monitoring and evaluating the mobile ART services in order to assure the quality of services while scaling them up.

2） To promote the expansion of quality mobile ART services in accordance with the guidelines.

3） To streamline HIV/AIDS programmes through DHMTs.

3 − 7 Lessons learned

（1） Considering the nature of ART services, any project that supports ART services shall be planned for adequate duration of time, as the duration given to this Project (three years) was not adequate. Properly evaluating the long term results and impacts of ART services requires adequate implementation period.

（2）Even though HIV/AIDS responses are sometimes considered as an emergency relief, it is important to ensure sustainability of various HIV-related services including ART, utilising existing resources as much as possible.

（3） In the rapidly evolving context of HIV/AIDS response in Africa, projects may need to modify planned inputs and activities in flexible and timely manners.

（4） Decentralisation of treatment to the rural health centre level is deemed necessary for the improved continuity of HIV/AIDS care and treatment. The mobile ART services model developed by the Project is found as one of effective methods in decentralization of treatment, especially in resource-limited settings.