ザンビア国
HIV・エイズケアサービス強化プロジェクト
終了時評価調査報告書

平成 20 年 11 月
(2008 年)

独立行政法人国際協力機構
ザンビア事務所

ザン事
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序　　　　文

ザンビア共和国（以下、「ザ」国と記す）では、成人の HIV 感染率がいまだ 14.3%（2007 年）と深刻な問題となっています。

「ザ」国では、2003 年８月から HIV 感染者に対して抗レトロウィルス薬（Anti-retroviral : ARV）を使った治療（Anti-retroviral Treatment : ART）が開始されました。2005 年８月には、政府により ARV 薬の無料化が開始された結果、2007 年に入り ART センターの数は 300 か所を超え、2007 年 12 月には ART 患者数が 13 万人を突破しました。

しかし、地方及び農村部の保健施設では、医療従事者の不足や不十分なエイズ治療マネジメント体制など多くの問題を抱えているのが現状です。日本政府は「ザ」国の要請に基づき、早期に HIV 感染者を発見し、発見された HIV 感染者へ質の高いケアサービスを提供する体制の強化を目的として、2006 年４月１日から３年間の予定で協力を開始しました。

このたびプロジェクトの終了を約６か月後に控え、2008 年９月 16 日から 10 月９日にかけて終了時評価調査を実施しました。

ここに、本調査にご協力を賜りました関係各位に対しまして、深甚なる謝意を表しますとともに、ザンビア保健医療分野の協力に向けて今後も一層のご協力をお願い申し上げます。

平成 20 年 11 月

独立行政法人国際協力機構
ザンビア事務所長　鍋屋　史朗

調査対象位置図

Map No. 3731 Rev. 2 UNITED NATIONS
August 1998

Department of Public Information
Cartographic Section

略　語　表

AIDS	Acquired Immunodeficiency Syndrome	後天性免疫不全症候群（エイズ）
ART	Anti-retroviral Treatment	抗レトロウィルス薬療法
ARV	Anti-retroviral	抗レトロウィルス薬
CCM	Country Coordination Mechanism	国別調整メカニズム（世界エイズ・結核・マラリア対策基金の国内コーディネーション機能）
CDC	Centers for Disease Control and Prevention	米国疾病対策予防センター
CIDRZ	Center for Infectious Disease Research in Zambia	PEPFAR の資金援助によるプログラム
DATF	District AIDS Task Force	郡エイズタスクフォース
DCT	Diagnostic Counselling and Testing	診断的カウンセリング及び検査
DHMT	District Health Management Team	郡保健マネジメントチーム
DHS	Demographic Health Survey	人口動態保健調査
GFATM	Global Fund to Fight AIDS, Tuberculosis and Malaria	世界エイズ・結核・マラリア対策基金（通称「グローバルファンド」）
HIV	Human Immunodeficiency Virus	ヒト免疫不全ウイルス
JCC	Joint Coordinating Committee	合同調整委員会
NAC	National HIV/AIDS/STI/TB Council	国家 HIV／エイズ／性感染症／結核対策評議会
OI	Opportunistic Infection	日和見感染症
OR	Operational Research	オペレーショナルリサーチ
PDM	Project Design Matrix	プロジェクト・デザイン・マトリックス
PEPFAR	President's Emergency Plan for AIDS Relief	米国大統領エイズ救済緊急計画
PLWHA	People Living with HIV/AIDS	HIV/エイズとともに生きる人々
PMTCT	Prevention of Mother to Child Transmission	母子感染予防
RuHC	Rural Health Center	地方保健センター
UNAIDS	Joint United Nations Programme on HIV/AIDS	国連エイズ合同計画
USAID	United States Agency for International Development	米国国際援助庁
VCT	Voluntary Counseling and Testing	自発的カウンセリング及び検査
WHO	World Health Organization	世界保健機構
ZPCT	Zambia Prevention Care Treatment Partnership	PEPFAR の資金援助によるプログラム

評価調査結果要約表

１．案件の概要		
国名：ザンビア共和国		案件名：HIV・エイズケアサービス強化プロジェクト
分野：保健医療		援助形態：技術協力プロジェクト
主管部署：ザンビア事務所		協力金額（評価時点）：約 2.7 億円
協力期間	2006 年４月１日～ 2009 年３月 31 日	先方関係機関：保健省
		日本側協力機関：国立国際医療センター
		他の関連協力：HIV・エイズ検査ネットワーク強化プロジェクト等

１－１　協力の背景と概要

ザンビア共和国（以下、「ザ」国と記す）では、HIV/エイズの拡大が深刻な問題となっており、成人（15～49 歳）の HIV 感染率は 14.3％（2007 年）、HIV/エイズを起因とする疾病の死亡者数は、毎年約９万人と推計されている。このような状況のもと、「ザ」国では 2005 年８月に抗レトロウイルス（ARV）薬の無料化が開始された結果、2007 年に入り ART センターの数は 300 か所を超え、2007 年 12 月には ART 患者数が 13 万人を突破するなど、「ザ」国のエイズ治療は拡大の一途を辿っている。

本プロジェクトは、早期に感染者を発見するための診断体制の拡大、HIV 感染者への質の高いケアサービスの提供、治療のマネジメント体制の強化を支援することを目的とし、ルサカ州チョングウェ郡及び中央州ムンブワ郡において 2006 年４月１日から３年間の予定で実施している。現在は、長期専門家３名（感染症対策／保健計画、HIV/エイズケア、業務調整／モニタリング）及び必要に応じ派遣される短期専門家を中心として活動がなされている。

１－２　協力内容

（１）上位目標

活動対象郡で有効性が立証された HIV 感染者へのケアサービス改善のためのアプローチが他郡で導入される。

（２）プロジェクト目標

活動対象郡で HIV/エイズケアサービスの質が改善され、サービスの提供を受けることが容易になる。

（３）成果

１）HIV 感染の発見数増加と早期発見のために HIV カウンセリングと抗体検査へのアクセスが改善する。
２）HIV 感染者が自宅に近い場所で質の高い ART サービスが受けられるようになる。
３）HIV/エイズケアサービス強化に必要な郡保健マネジメントチーム（DHMT）の管理運営能力が向上する。
４）プロジェクトの教訓がモバイル ART サービスに関する国家ガイドラインに反映される。

（４）投入（評価時点）

日本側

長期専門家派遣　４名

短期専門家派遣　７名

機材供与　US$242,000

研修員受入れ　４名

ローカルコスト負担　Kwacha 1,194,482,000

ザンビア側

カウンターパート配置　15 名

ART サービスに必要な物品　土地・施設提供

プロジェクト事務所（保健省内）

ローカルコスト負担　Kwacha 179,922,000

２．評価調査団の概要

担当	氏名	所属
総括	鍋屋　史朗	JICA ザンビア事務所　所長
HIV/エイズケア	仲佐　保	国立国際医療センター国際医療協力局派遣協力第２課　課長
評価計画	松久　逸平	JICA ザンビア事務所　所員
評価管理	國金　さつき	JICA 人間開発部　感染症対策課　ジュニア専門員
評価分析	芹澤　明美	グローバル･リンク･マネージメント（株）

調査期間：2008 年９月 16 日～10 月９日　調査種類：終了時評価調査

３．評価結果の概要

３－１　実績の確認

（１）プロジェクト目標の達成状況

プロジェクト目標は、プロジェクト終了までに達成される見込みである。

「自発的カウンセリング及び検査（VCT）及び母子感染予防（PMTCT）で発見された HIV 陽性者数（累積）」（指標１）は、チョングウェ郡では 4,000 人の目標に対し、実績が 4,193 人と既に目標値に達している。ムンブワ郡でも 7,000 人の目標対し、実績が 5,887 人であることから、プロジェクト終了までに目標値に達する見込みである。

「抗レトロウイルス薬療法（ART）サービスを受けている人々の数」（指標２）は、両郡それぞれ 2,300 人、3,500 人の目標に対し、実績が 1,511 人、2,569 人と現時点では目標に達していないものの、プロジェクト終了時までに達すると思われる。

「開始後６か月以内に ART サービスを脱落した人の割合」（指標３）については、10%以下という目標に対してチョングウェ郡においては３%と既に目標を下回っており、ムンブワ郡でも現時点で 13.3%と、プロジェクト終了までには 10%未満になる可能性が高い。脱落の定義が共有されていないことからデータの比較はできないが、ムンブワ郡におけるオペレーショナル・リサーチのデータによると、モバイル ART 患者の脱落率は郡病院の ART 患者の脱落率よりも低かったので､モバイル ART サービスの有効性が実証されたといえる。

（２）成果の達成状況

１）成果１「HIV 感染の発見数増加と早期発見のために HIV カウンセリングと抗体検査へのアクセスが改善する」

「成果１」は、既にほとんど達成されている。VCT 実績（指標 1-5）や PMTCT 実績（指標 1-6）がプロジェクト終了までに目標値に到達する見込みであることから、HIV 関連サ

ービスの対象人口は予定通り拡大したといえる。結核クリニックで HIV 検査を受けた人の割合（指標 1-7）と妊産婦検診で HIV 検査を受けた人の割合（指標 1-8）は両郡ともほぼ目標を達成した。HIV カウンセリング・検査を実施している保健施設数（指標 1-1 から 1-4）はベースラインと比較すると大きく増加しているが、プロジェクト終了までに目標値には到達しない見込みである。各保健施設で最低１名はこれらのサービスに係る研修を受講済みであるものの、各施設の職員数が足りないことやスペースが狭いこと、必要な機材がないことから実施できていない施設がある。

２）成果２「HIV 感染者が自宅に近い場所で質の高い ART サービスが受けられるようになる」

成果２に関する指標の幾つかは目標値に到達していないものの、ベースラインに比較すると大きく増加していることから、成果２は達成されたと判断できる。

ART サービスを提供している保健施設の数（指標 2-1）は両郡で増加したが、目標値には到達しない見込みである。しかし、ART 患者の数（プロジェクト目標の指標 2-2）が大きく増え、目標値に達する見込みであることから、ART サービスへのアクセスは向上したといえる。施設数が目標値に達しないのは、モバイル ART サービスを新しい場所で開始して数を増やすよりも、既存のモバイル ART センターの質を高めることを優先した結果である。アドヒアランス・カウンセリングを提供している保健施設の数（指標 2-2）も目標値には達していないが、ART サービスを提供している施設はすべてアドヒアランス・カウンセリングを行っている。サービスの質を示す指標（2-3 から 2-6）は目標値に達している。しかし、データの信頼性に疑問が残る。モバイル ART サービスの質の高さを示す別の材料として、オペレーショナル・リサーチのデータによると、ムンブワ郡のモバイル ART 患者は、ムンブワ郡病院の ART 患者よりも脱落率が低かった。

３）成果３「HIV/エイズケアサービス強化に必要な郡保健マネジメントチーム（DHMT）の管理運営能力が向上する」

モバイル ART サービスの適切な運営管理に関する DHMT の能力は強化された。また、ART サービスを提供しているルーラルヘルスセンターの何か所かは ART 業務のかなりの部分を自立して行えるようになってきている。患者情報管理については、患者カルテがきちんと整理され管理されるようになったなど、両郡で改善してきている。

指標 3-1「プロジェクト経験を共有するための会議を開催する頻度」については、両郡とも 2008 年１月～９月末までの開催実績は２回となっており、目標である「四半期ごと」には達しないものの、増加傾向にある。

オペレーショナル・リサーチについては、データの分析は主に日本人専門家が行っているものの、DHMT もデータ管理の重要性についての認識を高めることができた。オペレーショナル・リサーチの結果は、DHMT 長が、2008 年後半に開催される国際会議と「ザ」国内での学会において発表することになっている。

４）成果４「プロジェクトの教訓がモバイル ART サービスに関する国家ガイドラインに反映される」

保健省と国家 HIV/エイズ/性感染症/結核対策評議会（NAC）が、2008 年末までに国家モバイル ART サービスガイドラインを策定する予定であるため、「成果４」はプロジェクト終了までに達成される見込みである。本ガイドライン策定のためのタスクフォース会議にはプロジェクトからも出席し、プロジェクトの経験がガイドラインに反映されるよう議論に参加した。保健省では 15 郡で新たにモバイル ART サービスを導入する予定でグローバルファンド（GFATM）の資金を獲得済みであり、これにも本プロジェクトの経験

を活用したいとしている。

プロジェクトの定例会議はほぼ毎月開催されている。2008 年に入り、保健省の ART 政策におけるキーパーソンの出席が増えて、その結果具体的な活動につながることが多くなった。2007 年末以降プロジェクトメンバー間のコミュニケーションの頻度が増加したこと、メンバーのプロジェクトに対する責任感・参加意欲が高まったこと、プロジェクトが目に見える結果を出していることで省内での存在感が高まったことが理由としてあげられる。

３－２　５項目評価結果

（１）妥当性

プロジェクトは、「ザ」国及びターゲットグループ（HIV/エイズとともに生きる人々、DHMT）のニーズに整合しており、また、「ザ」国の HIV/エイズ政策及び日本の政府開発援助政策とも整合しているので、妥当性が高い。

「ザ」国の成人 HIV 感染率（15～49 歳）は 14.3％（2007 年）と高く、国家 ART 拡大計画や国家 HIV/エイズ結核性感染症戦略計画を策定済みである。「ザ」国政府は 2005 年８月に ARV の無料化を開始した。本プロジェクトでは農村部で住民に近い場所で ART サービスを提供するというアプローチを採用しており、上記の国家政策・国際的戦略に沿っている。日本の開発援助政策も HIV/エイズを重要課題として取り扱っている。日本の対ザンビア国別援助計画（2002）では、HIV/エイズを含む感染症対策が重点分野となっている。また、本プロジェクトは JICA の HIV/エイズ対策事業の中で唯一「エイズ治療」を扱っているが、その背景には JICA の課題別指針「サブサハラアフリカにおける HIV/エイズ対策協力方針」において「ザ」国を「より包括的な対策に取り組む」重点国としていることが挙げられる。

（２）有効性

プロジェクト目標として掲げているとおり、事業対象地域の２郡の農村部で HIV/エイズケアサービスへのアクセスを改善しており、有効性が高いと認められる。

両郡で ART 患者の数が増えたことは、ART サービスへのアクセスが改善したことを示している。オペレーショナル・リサーチの結果は、モバイル ART サービス患者の脱落率が常設 ART センターの脱落率より低いことを示しており、これはモバイル ART サービスの質の高さを示すものである。モバイル ART サービスの患者に聞き取り調査を行ったところ、近くでサービスを受けられることで移動の時間が短縮されたことや、ARV の服用によって健康な生活が送れているということで、モバイル ART サービスに対する満足度が高かった。オペレーショナル・リサーチのデータによると、モバイル ART サービスがあることで、ART サービス利用に係る費用や時間が軽減されていることが示されている。

（３）効率性

本プロジェクトの効率性は高かったと判断できる。「ザ」国の HIV/エイズ対策事業において、本プロジェクトを含む日本の拠出額はドナー全体の１％以下にすぎないが、この小さな金額で「対象郡における ART サービスのアクセスと質の改善」を実現してきた。このことは他ドナーの類似プロジェクトと比較して本プロジェクトが高いコストパフォーマンスを有していることを示している。また、本プロジェクトが既存の保健省・DHMT のシステムとリソースを活用していることも、他ドナーの類似案件と比べて、より少ない投入で成

果を創出した要因となっている。

（４）インパクト

上位目標「活動対象郡で有効性が立証されたHIV感染者へのケアサービス改善のためのアプローチが他郡で導入される」は、達成される可能性が高い。本プロジェクトで開発したモバイルARTサービスのモデルが「ザ」国の国家モバイルARTガイドラインに反映される予定であり、また、保健省がGFATMの資金を使って他郡で開始するモバイルARTサービスにも本プロジェクトのモデルが活用される見込みが高い。

その他の正のインパクトとして、モバイルARTサービスは、ARTへのアクセスに関して女性をより裨益したことがわかる。ムンブワ郡のART患者をみると、郡病院よりもモバイルARTセンターで女性患者の比率が高い。自宅により近いところでサービスが受けられるようになったことで、女性患者の掘り起こしにつながった。

プロジェクトメンバーは、保健省内でプロジェクトの結果を積極的に発信してきた。ARTサービスの認定ガイドラインが現在見直されているが、この中でプロジェクトの経験を反映し、より多くのルーラルヘルスセンターがARTサービスを提供できるように認定条件を変更する動きがある。

負のインパクトとして、プロジェクトの成果としてART患者が急激に増えたことで、もともと人材不足に悩んでいる保健施設が対応できる限界を超える可能性が出てきていることが挙げられる。この結果、サービスの質が低下する恐れがある。

（５）自立発展性

政策的な自立発展性は高い。「ザ」国でHIV/エイズケアを推進する政策は今後も維持されると思われる。農村部でARTサービスへのアクセスを改善する必要性も十分認識されている。現実的に、HIV/エイズ対策事業はドナーからの資金なくしては実施不可能であるが、HIV/エイズが国際的な課題である以上、ドナーからの援助は今後も継続する可能性が高い。

技術的な自立発展性に関しては、DHMTと保健施設のARTサービスを提供する能力は向上したが、サービスの質を維持し、さらに改善していくためには日本人専門家が今後も技術支援を続けていくことが望ましい。ART患者の数が急激に増えているなかで、保健人材が不足していることは大きな課題である。プロジェクトでは、レイ・カウンセラーやアドヒアランス・サポーターとして住民の参加を促進し、効果を上げているが、金銭的な報酬が払われないなかで住民ボランティアのやる気を維持することは難しい。

組織的な自立発展性は高い。郡保健管理チームの本プロジェクトに関するオーナーシップは高く、これは毎年の郡保健行動計画の中で本プロジェクトについての予算が確保されていることにも示される。本プロジェクトが開発したモバイルARTサービスのモデルは保健省・DHMTの既存のシステムの中で動いており、彼らの日常業務となっていることからも、プロジェクト終了後も継続される可能性が高い。

３－３　効果発現に貢献した要因

（１）計画内容に関すること

・2005年８月に「ザ」国でARVの無料化が始まったことは本プロジェクトにとって追い風になった。
・プロジェクトでは、農村部において、自宅により近いところでARTサービスが受けられるようにする形で、ARTサービスの拡大をめざしている。

・HIV/エイズケアサービスの拡大にあたり、本プロジェクトは既存のシステムを活用しており、これは自立発展性の確保の観点から有効である。
・プロジェクトは DHMT の能力向上を活動の中心においている。これは自立発展性を確保しドナーへの依存度を減らすために有効である。

（２）実施プロセスに関すること
・「ザ」国の HIV/エイズケアサービスの変化に対応するため、プロジェクトは適宜計画を変更してきた。当初の計画では常設 ART センターをルーラルヘルスセンター内に設置する予定であったが、2006 年に策定された ART サービス認定ガイドラインの示す ART センター認定基準が厳しいことから、計画を変更し、モバイル ART サービスを導入することにした。
・DHMT と保健施設の能力強化のため、日本人専門家が現場をこまめに訪れて技術支援を行っている。
・本プロジェクトは、JICA の「HIV・エイズ及び結核対策支援プログラム」内の他の事業とも協力し、効果を高めている。
・プロジェクトが目に見える成果を上げ、それが保健省内に発信されたことで、本プロジェクトの保健省内における存在感が高まった。
・「ザ」国政府は HIV/エイズ対策のためにドナーからの資金を確保することに成功している。保健省では、GFATM 資金を使って、15 郡にモバイル ART サービスを導入する計画であり、そこに本プロジェクトの経験を活用することにしている。

３－４　問題点及び問題を惹起した要因
（１）計画内容に関すること
・プロジェクトの形成段階で、関係者との協議が十分でなく、「ザ」国及び対象郡における HIV/エイズケアの状況が十分把握されなかったために、プロジェクトの当初計画の中には適切とはいえない活動が含まれていた。
・プロジェクトの討議議事録（R/D）にカウンターパートとして記載されている人々の中には、業務上関係が薄いためにプロジェクトにかかわっていない人もいる。カウンターパートの選定の際、彼らに期待する役割についての議論が不足していたと思われる。

（２）実施プロセスに関すること
・プロジェクト１年目に、日本人専門家が揃うのが遅れたことと、「ザ」国の ART ガイドラインの策定が遅れたために、プロジェクト活動に多少の遅れが生じた。
・日本人専門家と保健省本省とのコミュニケーションが十分でなく、プロジェクトが保健省内で軽視される傾向があった。カウンターパートは、他の業務との兼ね合いで本プロジェクトの活動を後回しにする傾向もあった。2008 年に入り、プロジェクトが目に見える成果を出し、また関係者間のコミュニケーションが改善したことで、プロジェクトへの認識が高まり状態が改善した。
・チョングウェ郡において、他ドナー事業との関係で患者情報管理に問題が生じ、日本人専門家とチョングウェ郡保健管理チームとの関係が損なわれた。コミュニケーションが十分でなかったことが根本的な原因であった。この問題のため、2008 年２月までチョングウェ郡では幾つかのプロジェクト活動が中断した。その後、日本人専門家とチョングウェ郡保健管理チームの対話を増やし、目標を共有したことで協働の意識が生まれ、状

況は改善した。

３－５　結　論

プロジェクト目標及び各アウトプットは達成され、上位目標もプロジェクト終了後早晩達成される見込みである。５項目評価についてもおおむね高い評価である。

本評価結果を受けて、本プロジェクトは今後以下の提言内容を履行しつつ、計画通りプロジェクト期間内に終了させることが適当である。

３－６　提　言

（１）プロジェクト終了までの提言事項

１）モバイル ART サービス実施のためのガイドライン作成に注力すること。

２）ART サービス実施施設の継続的な増加。ただし、拡充にあたってもサービスの質は維持すること。

３）HIV/エイズプログラム関連のデータ管理の拡充を進めること。

４）保健省によるモバイル ART サービス拡大政策の推進に対し、プロジェクト側も知識・経験の提供など積極的に関与していくこと。

（２）プロジェクト終了後に関する提言事項

１）ART サービスを、その質を維持しつつ拡充していくために、保健省は DHMT、地方保健センター（RuHC）への予算的・技術的支援を行いつつ、活動モニタリングを継続していくこと。

２）保健省はガイドラインに基づきモバイル ART サービスの拡大を推進していくこと。

３）保健省は DHMT を通じて HIV/エイズへの取り組みの主流化を進めること。

３－７　教　訓

（１）ART サービスを支援するプロジェクトは治療に終わりがないというサービスの性質上、継続的なサービス実施体制を構築していくには十分な期間をもって実施される必要がある。本プロジェクトは３年間に達成し得ることに絞って目標を設定し達成したが、より正確に ART サービスの内容を評価し持続的な体制を構築するには３年間という期間は十分ではなかった。

（２）HIV/エイズ対策は緊急的課題と捉えられることもあるが、ART サービスを含む各種 HIV/エイズ対策事業は既存リソースの活用を図るなど、活動の持続性も考慮することが重要である。

（３）アフリカにおける HIV/エイズ対策のように政策・制度の変化や技術的進歩が著しい分野においては、それらの変化・進歩に伴って活動を迅速かつ柔軟に軌道修正していく必要が生じることもある。

（４）治療拠点の地方分散化は、HIV/エイズ治療の継続性確保の観点からも必要である。その点において本プロジェクトで導入したモバイル ART サービスという手法は、特に活用できるリソースが極めて限られた状況下において有効な手法であるといえる。

Evaluation Summary

<table>
<tr><td colspan="3">１． Outline of the Project</td></tr>
<tr><td colspan="2">Country: Republic of Zambia</td><td>Project title： Integrated HIV and AIDS Care Implementation Project at District Level</td></tr>
<tr><td colspan="2">Issue/Sector: Healthcare and medical treatment</td><td>Cooperation scheme: Technical Cooperation Project</td></tr>
<tr><td colspan="2">Division in charge: Zambia office</td><td>Total Cost (as of the evaluation)： approximately 270 million yen</td></tr>
<tr><td rowspan="3">Period of cooperation</td><td rowspan="3">April 2006- March 2009</td><td>Partner Country’s Implementing Organization: Ministry of Health</td></tr>
<tr><td>Supporting Organization in Japan: International Medical Center of Japan (IMCJ)</td></tr>
<tr><td>Other projects: the project for strengthening HIV/AIDS laboratory network services</td></tr>
</table>

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 l0% 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 HlV-related services has been improved as the number of counselling and testing conducted in VCT (Indicator 5) and in PMTCT (l-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-l to l-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-l) 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.

第１章　団長所感

本プロジェクト終了時評価調査を通じ、ザンビア保健省既存のリソースを強化しつつ活用した本プロジェクトのモバイル抗レトロウィルス薬療法（Anti-retroviral Treatment: ART）サービスは、効率的かつ持続可能な方法で質の高い HIV/エイズケアサービスを提供できるという事実を証明できた。これは本プロジェクトのみならず「ザ」国の保健セクターにおける財産であり、日本のHIV/エイズ対策支援において貴重な足跡を遺すことができたといえる。この財産をさらに進化させつつ普及していくためにも、引き続き「ザ」国でのエイズケア支援を行うことが望まれる。

なお、「ザ」国の HIV/エイズケア分野においては他ドナーが多数参画していること、保健省は有効性が確認された本プロジェクトのモバイル ART サービスの経験を国家ガイドライン策定に活かし、他地域への拡大を希望していることから、現行プロジェクト終了後速やかに後継案件を開始することが、日本／JICA の存在を示すうえでも重要である。

付　属　資　料

1．ミニッツ及び合同評価調査報告書

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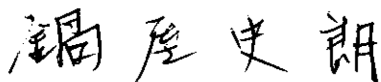
MINUTES OF MEETINGS
BETWEEN
THE JAPANESE TERMINAL EVALUATION TEAM
AND
THE AUTHORITIES CONCERNED OF
THE GOVERNMENT OF THE REPUBLIC OF ZAMBIA
ON THE JAPANESE TECHNICAL COOPERATION FOR
THE PROJECT
FOR
THE INTEGRATED HIV AND AIDS CARE IMPLEMENTATION PROJECT AT DISTRICT LEVEL

The Japanese Terminal Evaluation Team (hereinafter referred to as "the Team") was organized by the Japan International Cooperation Agency (hereinafter referred to as "JICA"), from 16 September to 9 October, 2008. The purpose of the Team was to confirm the achievements made during the three year's cooperation period, and to undertake the terminal evaluation of the Integrated HIV/Aids Care Implementation Project at District Level (hereinafter referred to as "the Project").

During the stated period, both the Team and the authorities concerned of the Republic of Zambia (hereinafter referred to as "both sides") had a series of discussions and exchanged views on the Project. Both sides jointly monitored the activities and evaluated the achievements.

As a result of the discussions, both sides agreed upon the matters referred to in the Joint Evaluation Report documents attached hereto.

Lusaka, 8 October, 2008



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Joint Terminal Evaluation Report

on

Japanese Technical Cooperation Project

for

Integrated HIV and AIDS Care Implementation Project at District Level

8 October 2008

Ministry of Health, Republic of Zambia
Japan International Cooperation Agency, Japan

ABBREVIATIONS

AIDS	Acquired Immuno Deficiency Syndrome
ANC	Antenatal Care
ART	Anti-Retroviral Treatment
ARV	Anti-retroviral
CDC	Centers for Disease Control and Prevention
CIDRZ	Center for Infectious Disease Research in Zambia
DHMT	District Health Management Team
DCT	Diagnostic counselling and testing
DOTS	Directly Observed Treatment Short Course
GFATM	Global Fund to Fight Aids, Tuberculosis and Malaria
HIV	Human Immunodeficiency Virus
JCC	Joint Coordination Committee
JICA	Japan International Cooperation Agency
NAC	National HIV/AIDS/TB/STI Council
OI	Opportunistic infection
OR	Operational research
PEPFAR	President's Emergency Plan for AIDS Relief
PDM	Project Design Matrix
PLWHA	People living with HIV/AIDS
PMTCT	Prevention of Mother-To-Child Transmission
PO	Plan of Operation
RD	Record of Discussions
RuHC	Rural Health Centre
STI	Sexually Transmitted Infections
TB	Tuberculosis
VCT	Voluntary Counselling and Testing
WHO	World Health Organization
ZPCT	Zambia Prevention, Care and Treatment Partnership

DEFINITIONS

Mobile ART team	A team consists of a doctor/clinical officer, a counsellor, a lab technologist, a pharmacist, etc. dispatched from an ART centre (usually District Hospital, Mission Hospital or Referral Health Centre of the District) depending on the needs of a RuHC

(16)

Mobile ART services	The ART services provided at the RuHC only on the specific dates (usually every two weeks) with the technical support of the mobile ART Team
Mobile ART centre	Health facility where ART services are provided through the mobile ART services.

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1. Introduction

1.1 Background and Summary 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, though it is slightly decreasing compared with that of 15.6 % in 2002. The socio-economic development of the country has been hindered by the ravages of the disease through the loss of human resources in all sectors. The Zambian government has made significant effort to expand care services to People Living With HIV/AIDS (PLWHAs), including introduction and free provision of Anti-Retroviral Treatment (ART), with increasing levels of support from external funding agencies.

Given the urgent need to ensure the access to care services for PLWHAs, the government has been eager to develop approaches to expand the services through strengthening the existing public healthcare system. It expressed the intention to expand HIV testing and treatment facilities to all 72 districts and as close to the household as possible in the Fifth National Development Plan for 2006-2010.

In response to the above, the Ministry of Health requested the Technical Cooperation Project to the Government of Japan, and then the Project "Integrated HIV and AIDS Care Implementation Project at District Level" was commenced in April 2006. The Project aims to improve the accessibility and quality of HIV care services in two target districts though strengthening the existing public healthcare system. Project activities are to identify HIV-positive persons and provide PLWHAs with appropriate care service, including ART, at district and community levels.

1.2 Joint Evaluation Team

This evaluation was jointly conducted by both Zambian and Japanese sides, in accordance with the JICA Guideline for Project Evaluation (2004).

<Zambian side>

Name	Designation	Position, Organization
Dr. Gardner Syakantu	Evaluation Planning	Deputy Director of Clinical Care and Diagnostic Services, Ministry of Health

<Japanese side>

Name	Designation	Position, Organisation
Mr. Shiro Nabeya	Leader	Resident Representative, JICA Zambia Office
Dr. Tamotsu Nakasa	HIV Care	Director, 2nd Expert Service Division, Bureau of International Cooperation, International Medical Center of Japan
Mr. Ippei Matsuhisa	Evaluation Planning	Assistant Resident Representative, JICA Zambia Office
Ms. Satsuki Kunikane	Evaluation Management	Associate Expert, Infectious Disease Control Division, Health Human Resources and Infectious Disease Control Group, Human Development Department, JICA
Ms. Akemi Serizawa	Evaluation Analysis	Social Development Specialist, Global Link Management, Inc.

1.3 Method of Evaluation

The objective of the terminal evaluation is to determine the achievement of the Project as regards the Project Purpose, Outputs, and other emerging issues and to map out its direction in the remaining Project period as well as towards the achievement of the Overall Goal after the Project period ends sustaining the Project's outcomes. The specific objectives of the evaluation were as follows:

1) To determine the progress of the project (Input, Activities, Outputs, Project Purpose and Overall Goal) based on the Project Design Matrix (PDM) version 2, adopted on 11th December 2007 during the mid-term evaluation (Annex 2).
2) To evaluate the achievement level of the Project using the five criteria of evaluation (Relevance, Effectiveness, Efficiency, Impact, and Sustainability).
3) To identify contributing and hindering factors through analysis of collected information.
4) To make recommendations in order to improve implementation of the Project for the remaining period and achievement of the Overall Goal.

The five criteria of evaluation are defined as follows[1]:

a) Relevance

The extent to which the objectives of a development intervention are consistent with beneficiaries' requirements, country needs, global priorities and cooperating partners' policies.

[1] Development Assistance Committee (DAC), OECD. "Glossary of Key Terms in Evaluation and Results Based Management." www.oecd.org

b) Effectiveness

The extent to which the development intervention's objectives were achieved, or are expected to be achieved, taking into account their relative importance.

c) Efficiency

A measure of how economically resources/inputs (funds, expertise, time, etc.) are converted to results.

d) Impact

Positive and negative, primary and secondary long-term effects produced by a development intervention, directly or indirectly, intended or unintended.

e) Sustainability

The continuation of benefits from a development intervention after major development assistance has been completed. The probability of continued long-term benefits. The resilience to risk of the net benefit flows over time.

Data collection methods used by the evaluation team were as follows:

- Review of project documents such as the Record of Discussions, PDM, progress reports and minutes of meetings in order to examine the progress and achievements of the Project.
- Review of data collected by the District Health Management Teams.
- Questionnaire survey of key Zambian and Japanese project members to confirm the findings from the document review and obtain their insights about the achievements and challenges of the Project and issues in the implementation process;
- Key informant interviews to draw out their opinions on the issues above,

  Interviewees: Zambian and Japanese project members, staff members of Ministry of Health headquarters, DHMTs and health facilities providing ART services, ART clients and Cooperating Partners;
- Direct observation of some rural health centres providing ART services in the target districts.

2. Achievements and implementation process

2.1 Inputs

2.1.1 Inputs from the Zambian side

1) Zambian members assigned to the Project
Fifteen (15) staff members of the Ministry of Health (MoH), the District Health Management Teams (DHMTs) of Chongwe and Mumbwa Districts and the National HIV/AIDS/STI/TB Council (NAC) have been assigned to the Project. The list is shown in Annex 3-5.

2) Provision of the project office and equipment
An office space for the Project was provided in the Ministry of Health together with utilities. Necessary commodities for provision of ART/VCT at district level were made available through the national health logistics system. Vehicles of the DHMTs are utilised for mobile ART services.

3) Operational expenses
Operational expenses for the Project from the Zambian side amounted to ZMK179,922,000 (Chongwe: ZMK65,881,000; Mumbwa ZMK114,039,000) as of the end of August 2008, which is approximately USD51,000 (US$1.00=Kwacha 3,525). It included fuel for the vehicles utilised for the mobile ART services and expenses of training such as transportation cost and allowance for the trainees. The details are shown in Annex 3-6.

2.1.2 Inputs from the Japanese side

1) Experts
Four long-term experts have been assigned to the Project. Their job titles are Project Coordinator/Community Participation, Infectious Diseases Control/Health Planning, HIV/AIDS care and Project Coordinator/Monitoring. To date, seven short-term experts in total were dispatched in the technical areas of HIV/AIDS Care, Operational Research, TB/HIV Control, HIV/AIDS Management, Information Education and Communication, and PMTCT. Total working days spent by the short-term experts were for a total of 7.2 person/month (= 216 days).

2) Counterpart training

To date four Zambian project members participated in overseas training courses: two in Japan and two in Thailand. The details are described in Annex 3-2.

3) Provision of equipment

The cost of equipment directly provided by Japan to the Project amounted to approximately USD242,000 as of September 2008. The details of the equipment are described in Annex 3-3.

3) Operational expenses

The operational expenses for the Project borne by the Japanese side since the beginning of the Project to September 2008 is Kwacha 1,194,482,000 (USD 339,000; US$1.00=Kwacha 3,525). The details are shown in Annex 3-4.

2.2 Activities

The terminal evaluation team reviewed the progress of the Activities and Outputs vis-à-vis the Project Design Matrix (PDM) version 2, and confirmed that the project Activities were carried out as planned in general.

Achievement of Activities under Output 1: "Access to HIV counselling and testing is improved."

Trainings were conducted for health workers and non-health workers in the skills related to ART services.

Achievement of Activities under Output 1

	Activities	Achievements
1-1	To identify and provide training for lay counsellors	• 20 non-health workers (10 from each district) participated in psycho-social counselling training at Chainama College. (2-4/2007) • 5 community members from Mumbwa District participated in lay-counsellor training at Chainama College. (2/2008) • 19 community members in Mumbwa District were trained as lay-counsellors in PMTCT at Kara counselling. (3/2008)
1-2	To train more professional counsellors	• 20 health workers (10 from each district) participated in psycho-social counselling training at Chainama College.(1-3/2007)

1-3	To promote Diagnostic Counselling and Testing (DCT), Prevention of Mother to Child Transmission (PMTCT) in health facilities such as TB, STI and Antenatal clinic	DCT: • 20 health workers (10 from each district) participated in DCT training at Chainama College. (2-3/2007) • 10 health workers from Mumbwa District participated in DCT training at Chainama College. (7-8/2007) • DCT was introduced at the health facilities (Chongwe 26, Mumbwa 14). PMTCT: • The short-term expert in PMTCT conducted a survey in the two districts and formulated recommendations for improvement of PMTCT at district level. (2-3/2008)
1-4	To introduce the Finger Pricking HIV testing in health centres	• Training on the finger-pricking method and its Training of Trainers were conducted by the Virology Laboratory, University Teaching Hospital (UTH). 22 participated (20 health workers who attended the psycho-social counselling training and 2 scientists). (2/2007) • Training on the finger-pricking method was conducted by Chainama College. 20 non-health workers (who attended the psycho-social counselling training) participated. (2/2007) • The External Quality Assurance (EQA) manual for finger-pricking was developed by the Project (5/2007). • The finger-pricking method was introduced with pilot-based EQA system in the ART services after the training conducted by the Project. • The results of finger-pricking test conducted by the lay counsellors were re-examined by UTH for EQA and needs for stronger quality control was confirmed (7/2008).

Achievement of the Activities under Output 2: "Quality HIV care services are strengthened and scaled-up."

Ten rural health centres in the two districts provide mobile ART services with the support of the Project as of September 2008 in addition to four static ART centres. Activities to improve the quality of the mobile ART services have been conducted in the areas such as client information management through supervisory visits, training sessions and regular meetings. The ART client

files are now kept and managed by each mobile ART centre also in Chongwe District since early 2008 as per the recommendation from the Mid-term evaluation instead of bringing those files to the Chongwe Referral Health Centre for the purpose of data entry for the CIDRZ-supported programme. The ART client files of Chongwe Referral Health Centre are also to be reorganised.

Achievement of the Activities under Output 2

	Activities	Achievements
2-1	To provide mobile ART services	• Mobile ART services started (2/2007). Ten rural health centres (Chongwe 4; Mumbwa 6) provide mobile ART services (once every two weeks) as of September 2008 in addition to the static ART centres. • The management of the mobile ART services has been improved: fixed schedule, use of appointment books and register books, and management of client files.
2-2	To conduct training for the health facility staff on HIV/OIs	• 16 health workers (8 from each district) participated in ARVs and OIs management training at Chainama College. (11-12/2006) • 23 health workers (Chongwe 10, Mumbwa 13) participated in ART/OIs management training at Chainama College (2, 6/2008).
2-3	Conduct training for community members such as adherence counsellors in HIV/AIDS services	• 20 community members in Mumbwa District participated in facility-based adherence supporter training. (6/2007) • 19 community members from Mumbwa District participated in PMTCT lay-counsellor training conducted by Kara counselling. (3/2008) (same as 1-1) • 99 community members from the two districts participated in adherence counselling training sessions financed by the UNICEF fund. (7-8/2008)
2-4	To conduct regular supervisory visit to health facility by DHMTs	• Supervisory visits of the mobile ART centres were conducted by the DHMTs and the JICA experts in both districts.
2-5	To strengthen the health system at health facility level such as diagnostic capacity, transport, infrastructure, etc.	Mumbwa District Hospital : • The JICA experts provided technical support on utilisation and maintenance of the CD4 count machine. A stabiliser for the CD4 count machine was provided. • A room for the ART services was

		constructed, the waiting space was renovated, and equipment and re-agents were provided.(8/2007-) • A chemistry analyser was provided. • Facilities for ART services are being constructed in Mwenbezhi and Nampundwe Rural Health Centres. Some equipment is to be purchased. Chongwe Referral Health Centre: • A CD4 count machine was provided. (3/2008) • A chemistry analyser is being procured. • The short-term expert in Information, Education and Communication developed IEC materials (posters for the health facilities and leaflets for clients) (9-11/2007). They were finalised and the leaflets were translated in local languages and distributed to rural health centres (3/2008).
2-6	To conduct training in TB and other OIs management for PLWHAs	• A TB/HIV workshop was conducted. 12 health workers and DHMT staff members (6 from each district) and staff of the Ministry of Health and WHO participated. (2/2007)

Achievement of the Activities under Output 3: "DHMT's management capacities in HIV care services are enhanced."

Activities to strengthen management capacity of the DHMTs were carried out with technical support provided by the Japanese experts. As stated in the preceding section, information management at mobile ART centres has been improved in Chongwe District since early 2008.

Achievement of the Activities under Output 3

	Activities	Achievements
3-1	To conduct trainings for DHMT staff to improve necessary management skills for strengthening HIV care services	• A baseline workshop of the Project was held inviting the DHMTs of the two districts. 12 (6 from each district) participated. (5/2006) • Project implementation action plan workshops were held for the two districts. 12 (6 from each district) participated. (6/2006) • A project implementation joint workshop was held. 27 (15 from

		Chongwe and 12 from Mumbwa) participated. (7/2006) • Situation analysis of the two districts was conducted (8-10/2006) • Selected national guidelines were disseminated in the regular meetings of the Project. • The short-term expert in HIV/AIDS care provided technical support on data management of ART services (7-8/2008). • Technical support on mobile ART service management is provided to both DHMTs as a regular activity of the Project.
3-2	To conduct quarterly meetings	• Chongwe District: ART review meetings were held twice: June and September 2008. • Mumbwa District: ART review meetings were held three times: October 2007, April and July 2008.
3-3	To conduct Operational Research	• A preliminary report of the operational research on TB/HIV in Mumbwa District was presented by the Project in the IUATLD conference in Cape Town. (11/2007) • The short-term expert in OR developed a draft protocol (12/2007). It will be approved by the MoH. • Operational Research is being conducted on the following topics and data are being analysed: ➢ Quality of mobile ART services. ➢ Improvement of TB/HIV care services at mobile ART centres. ➢ Cost-benefit analysis on mobile ART clients. ➢ Factors associated with ART adherence. ➢ Quality of HIV testing (finger pricking conducted by lay counsellors) • The results are to be presented in international conferences in Paris and Dakar, as well as in a national conference (later in 2008).

Achievement of the Activities under Output 4: "Lessons learned by the Project are incorporated into national guideline on mobile ART services."

The Project holds monthly Project meetings since September 2006. The Project conducted a dissemination workshop and participated in a task force meeting to develop national guidelines for mobile ART services so that the experiences of the Project can be incorporated in national policies.

Achievement of the Activities under Output 4

	Activities	Achievements
4-1	To conduct monthly meetings at national level	• Monthly project meetings are held since September 2006.
4-2	To compile the lessons learned, and conduct workshop to disseminate the lessons learned for their incorporation in national guidelines	• The lessons learned from the Project were compiled (2/2008) • A dissemination workshop was conducted (5/2008). • The Project shares with the MoH its experiences in mobile ART services for application in other districts.
4-3	To participate in the working group for development of national guideline on mobile ART services	• The project members participated in the task force meeting at NAC to develop guidelines of mobile ART services and made a presentation on the Mumbwa experience (2/2008).

2.3 Outputs

The Project has made considerable progress towards achievement of the Project's Outputs. Most of the indicators of Output 1 and 2 regarding improvement of access and quality of HIV care services have been achieved. Output 3 regarding DHMT's management capacity in HIV care services has been achieved. Output 4 aiming at incorporation of lessons learned from the Project into the national mobile ART guidelines is likely to be achieved by the end of the Project period.

Achievement of Output 1: "Access to HIV counselling and testing is improved."

Output 1 was measured as shown in the table below and was found almost achieved. The coverage of HIV-related services has been improved as the number of counselling and testing conducted in VCT (Indicator 1-5) 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 1-7) and in ANC clinic (1-8) has already been met in both districts, although the number of health facilities providing these 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 resource, space or equipment to provide these services. Another reason is that coverage of services is not necessarily captured by the data. For example, a rural health centre which does not provide VCT in the region where a NGO provides such services is not counted in Indicator 1-1despite the fact that the population has access to VCT. It must be noted that the definitions of "providing PMTCT" (indicator 1-2) and "providing DCT" (indicator 1-3) are not shared between the Project members, therefore it is not technically adequate to compare the data from the two districts. Regarding finger-pricking method (indicator 1-4), the Project recognises the need to strengthen its quality assurance as the result of the re-examination at the UTH was not at a satisfactory level as stated in the section of Activity 1-4.

Achievement of Output 1

Verifiable indicators	Achievement	
	Chongwe	**Mumbwa**
1-1. Number of health facilities providing VCT service	Target: 29 10 (2006 Q1) 26 (2008 Q3)	Target: 29 17 (2006 Q1) 23 (2008 Q3)
1-2. Number of health facilities providing PMTCT service	Target: 29 2 (2006 Q1) 18 (2008 Q3)	Target: 29 12 (2006 Q1) 19 (2008 Q3)
1-3. Number of health facilities providing DCT service	Target: 29 0 (2006 Q1) 26 (2008 Q3)	Target: 29 0 (2006 Q1) 20 (2008 Q3)
1-4. Number of health facilities applying Finger Pricking HIV testing method	Target: 29 0 (2006 Q1) 10 (2008 Q3)	Target: 29 0 (2006 Q1) 13 (2008 Q3)
1-5. Annual number of counselling and testing in VCT	Target: 3,500 694 (2005) 3,005 (2008, as of August)	Target: 4,000 1,171 (2005) 2,300 (2008, as of Q2)
1-6. Annual number of counselling and testing in PMTCT	Target: 4,000 167 (2005) 2,917 (2008, as of Q2)	Target: 5,000 2,659 (2006 Q1) 2,900 (2008, as of Q2)
1-7. Percentage of HIV tested among TB clinic	Target: 80% 0% (2006 Q1) 81% (2008 Q1), 71% (Q2)	Target: 80% 20% (2006 Q1) 77% (2008 Q1), 73% (Q2)
1-8. Percentage of HIV tested among ANC clinic	Target: 80% 100% (2006 Q1) 97% (2008 Q1), 100% (Q2)	Target: 80% 9% (2006 Q1) 85% (2008 Q1), 47% (Q2)

Achievement of Output 2: "Quality HIV care services are strengthened and scaled-up."

It can be concluded that Output 2, "quality HIV care services are strengthened and scaled up", has been achieved. The data indicates progress compared to the baseline, although some

indicators have not reached the target to date.

The number of health facilities providing ART services (indicator 2-1) has increased in both districts. The target number is not likely to be achieved because the DHMTs have prioritised 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 Indicator 2) shows improved access to ART services. If the mobile ART services are implemented at 10 rural health centres in a district every two weeks, the mobile teams have to visit the rural health centres every day, which is beyond the current capacity of the DHMTs. The Japanese experts have suggested the DHMTs several measures to expand services without compromising quality of the services. One is that rural health centres set another ART day between the scheduled visits of the mobile team so that stable clients can be attended by the staff of the rural health centres. Another is that staff of other rural health centres near mobile ART centres joins and assists the mobile team on mobile ART days. The Project has already trained some staff members of such rural health centres for this purpose. These ideas have been discussed between the DHMTs and the Japanese experts, but are yet to be implemented. While Indicator 2-2 (adherence counselling) has not reached the target, the data shows that all health facilities providing ART services do adherence counselling. Community members participate in provision of ART services as counsellors and adherence supporters, which is effective in the environment that human resource constraints are always a challenge.

The indicators about the quality of the services (2-3 to 2-6) have achieved the target, although reliability of these 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 as discussed in the section of Project Purpose.

Achievement of Output 2

Verifiable indicators	Achievement	
	Chongwe	**Mumbwa**
2-1. Number of health facilities providing ART services	Target: 10 plus 4 outreach sites (2006 Q1): 2 static ART centres (Chongwe Referral Health Centre and Mpanshya Mission Hospital) (2008 Q3): 6 static and mobile centres, plus 4	Target: 10 (2006 Q1): 1 static ART centre (Mumbwa District Hospital) (2008 Q3): 8 static and mobile centres =

	outreach sites = 2 static ART centres (Chongwe Referral Health Centre and Mpanshya Mission Hospital), 4 mobile ART centres (Kasisi, Chinyunyu, Lwimba, Chalimbana) and 4 outreach sites under Mpanshya Mission Hospital	2 static ART centres (Mumbwa District Hospital and Nangoma Mission Hospital), 6 mobile ART centres (Lungobe, Nampundwe, Mwembezhi, Kaindu, Nalubanda and Mpusu Health Post as an outreach site of Kaindu)
2-2. Number of health facilities which provide adherence counselling	Target: 20 2 (2006 Q1) 10 (2008 Q3)	Target: 20 0 (2006 Q1) 7 (2008 Q3)
2-3. Percentage of patients on ART who are screened by CD4 count testing for eligibility	Target: 80% 100% (2008 Q2)	Target: 80% 89% (2008 Q2)
2-4. TB Treatment Success (TB Cure) rate	Target: 85% 86% (2005 Q1) 85% (2007 Q2)	Target: 85% 70% (2006 Q3) 74% (2007 Q2)
2-5. Percentage of HIV positive patients who undertook CD4 test	Target: 80% 100% (2008 Q2)	Target: 80% 100% (2008 Q2)
2-6. Percentage of TB patients who are eligible and started ART	Target: 80% 100% (2008 Q2)	Target: 80% 100% (2008 Q2)

Achievement of Output 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. All rural health centres providing ART services continue working together with the mobile team dispatched by the DHMTs, and some of these rural health centres have already developed capacities to the level that the staff can perform larger part of the ART services. Information management has been improved in both districts. Most mobile ART centres have had clients files sorted and kept in orderly manner. In Chongwe District, the ART client files are now kept at each rural health centre instead of being kept at the Chongwe Referral Health Centre for the purpose of data entry for the CIDRZ-supported Programme.

Regarding Indicator 3-1, both districts held ART review meetings twice in 2008 so far. While it is not likely that it will meet the target (quarterly), it shows a progress as they did not have district meetings until October 2007.

Operational research (Indicator 3-2) is conducted as a tool to prove the effectiveness of the

project approach (mobile ART services in rural areas). It 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.

Achievement of Output 3

Verifiable indicators	Achievement	
	Chongwe	**Mumbwa**
3-1. Frequency of experience sharing meetings (see Activities 3-2)	Target: Quarterly • ART review meetings in Chongwe were held twice (June and September 2008).	Target: Quarterly • ART review meetings in Mumbwa were held three times (October 2007, April and July 2008).
3-2. ORs conducted and shared at central level	Target: "Yes" (same as Activity 3-3) • A preliminary report of the operational research on TB/HIV based on data in Mumbwa District was presented by the Project in the IUATLD conference in Cape Town. (11/2007) • The short-term expert in OR developed a draft protocol (12/2007). It will be approved in the the MoH. • ORs are being conducted on the following topics and data are being analysed: ➢ Quality of mobile ART services. ➢ Improvement of TB/HIV care services at mobile ART centres. ➢ Cost-benefit analysis on mobile ART clients. ➢ Factors associated with ART adherence. ➢ Quality of HIV testing (finger pricking). • The results are to be presented in international conferences in Paris and Dakar as well as in a national conference (later in 2008).	

Achievement of Output 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 Global Fund to Fight Aids, Tuberculosis and Malaria (GFATM) (Round 4/Phase 2) to the MoH.

The regular project meetings are held almost monthly. Since last year, improved attendance of key persons of the MoH headquarters, ARV coordinator and TB specialist in particular, 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.

Achievement of Output 4

Verifiable indicators	Achievement
4-1. Lessons learned by the Project are incorporated into national guideline on mobile ART services	Target: "Yes" • The project members participated in the NAC taskforce meeting to develop national guideline of mobile ART services (2/2008). • The MoH has consulted the Project to learn about its mobile ART service model to be replicated in other districts. (2008)
4-2. Number of monthly regular meetings	Target: 12 • Monthly project meetings are held since September 2006. 8 meetings were held in 2008 (as of September). • Meetings led to quality discussions and actions.

2.4 Project Purpose and Overall Goal

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, and that of Mumbwa is also likely to, by the end of the Project period if cases are continuously detected at the similar pace. Cumulative numbers of ART clients (Indicator 2) are currently 71% of the target in Chongwe and 73% 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. It should be noted at the same time that the rapid increase of ART clients would exceed the services delivery capacities of health facilities in the near future where human resource constraints are always a challenge.

The defaulter rate (Indicator 2) in Chongwe District is already below 10% and that in Mumbwa District is also likely to be less than 10% by the end of the Project period, although the reliability of the data is not confirmed and comparison between the two districts is not technically right as the definition of defaulter is not common among the Project members. However, 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.

Overall Goal is expected to be achieved in the near future. The ART service model developed by the Project will be incorporated in newly-initiated mobile ART services in other districts. The MoH has consulted the Project to learn from its experiences.

Achievement of Project Purpose: "HIV and AIDS care services are improved and accessible at target districts."

Verifiable Indicators	Achievement	
	Chongwe	**Mumbwa**
1. Cumulative number of HIV positive case detected by VCT/PMTCT	Target: 4,000 481 (2006 Q1 only) 2,616 (2007 Q3) 4,193 (2008 Q2)	Target: 7,000 942 (2006 Q1) 3,473 (2007 Q3) 5,887 (2008 Q2)
2. Cumulative number of ART clients	Target: 2,300 235 (2006 Q1) 1,268 (2007 Q3) 1,634 (2008 Q2)	Target: 3,500 324 (2006 Q1) 1,529 (2007 Q3) 2,566 (2008 Q2)
3. Percentage of defaulters within 6 months among ART clients	Target: Less than 10% 3% (2007 Q4)	Target: Less than 10% 13.3% (2007 Q4)
Data from the operational research on mobile ART services (conducted in 2008)		
Lost and defaulter cases within 6 months	9.7% in mobile ART centres	10.3% in mobile ART centres (District Hospital: 21.6%)

Achievement of Overall goal: "Interventions to improve the HIV and AIDS care services for PLWHAs demonstrated at target districts are introduced in other districts."

Verifiable indicators	Achievement
Number and contents of interventions introduced in other districts	The MoH is planning replication of the mobile ART service model of the Project in 15 other districts using funding from the GFATM.

2.5 Implementation process

Chongwe and Mumbwa DHMTs being intervention sites of the Project are responsible for managing of HIV/AIDS care services at the district level, and the Project aims at their capacity building which is the prerequisite to achieve other outcomes. The Project has been implemented through hardwork on the ground by the DHMTs and selected health facilities with continuous technical support provided by the Japanese experts. The DHMTs take initiatives in the Project

implementation with strong commitment, which is also indicated by the sufficient resources mobilised for the Project by the DHMTs. The DHMTs are making efforts to coordinate different Cooperating Partners in line with the needs of the districts.

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 regular ART centres in the rural health centres as a response to the Accreditation Guidelines of ART services finalised in 2006. On the other hand, the Project members felt that the Project period (three years) was too short as an ART project as it takes several years to evaluate long-term results of ART services.

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, the Project Manager is advocating incorporation of lessons learned from the Project into the guidelines so that the conditions for accreditation of ART centres can be revised and that more rural health centres can provide ART services.

There was misunderstanding between Chongwe DHMT and the Japanese experts largely due to insufficient communication on the information management issue derived from the presence of other Cooperating Partner (CIDRZ). The relationship improved in 2008 as communication became more effective and both parties have been working together with commitment towards the achievement of the Project goals. Information management in mobile ART centres in Chongwe District has been improved.

The Project has generated more visible outcomes and improved communication. The vertical programmes of the MoH are now able to collaborate with each other as most of them are members of the Project committee which is held monthly. Regular attendance by members of vertical programmes to the monthly meetings of the Project would even add more value to the Project.

3. Evaluation by Five Criteria

3.1 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). HIV/AIDS is recognised as one of the priority areas in national development in Zambia. Having secured funding for ARVs from the GFATM and other Cooperating Partners, 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). This ART programme of Zambia is also in line with the World Health Organization/UNAIDS initiative to put 3 million people in developing countries on ART by the end of 2005 (the 3 by 5 initiative) and the following Universal Access Initiatives, as well as with the stop TB strategy of WHO. 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 prioritise HIV/AIDS response. Such policies include Japan's ODA charter, the concept of Human Security that Japan advocates in the international community, and JICA's thematic Strategy in Response to HIV/AIDS. Improving health of people, including HIV/AIDS, is one of the priority areas of Japan's country assistance policy in Zambia (2002). JICA's country assistance plan also places emphasis on HIV/AIDS response by implementing a programme on "HIV/AIDS and TB responses" that includes this Project as a component. This Project is the first technical cooperation project of JICA in the world to assist provision of ART services while other HIV/AIDS related projects focus on the prevention aspects.

The strengths of the Project are found in its approach that aims at capacity building of the Zambian counterparts through provision of continuous technical support in the field and that the Project operates within the existing system and using existing resources.

3.2 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).

As stated in the section of Project Purpose, accessibility to 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 centres 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 centres compared to the situation that the mobile ART service was absent.

Three out of four Important Assumptions (IAs) that are set to link the Outputs and the Project Purpose have been met: ARV drugs have been available (IA1), the political, economic and social situations have not worsened (IA3), and number of new infection has not increased rapidly (IA4). As for Important Assumption 2, while other partners have been cooperative with the DHMTs and the DHMTs take initiatives to align partners in line with the needs of the DHMTs, competing demands have been experienced between partners such as the case of JICA and CIDRZ on data management in Chongwe District last year, which resulted in postponement of some activities of the JICA project. DHMT used to take the client files away from the mobile ART centres for the purpose of data entry for the CIDRZ-supported programme, against which the JICA experts advised that the files must always be available at the mobile ART centres. Both parties discussed in 2008 and agreed to have files kept at the mobile ART centres. It is observed that there are some other Cooperating Partners operating in the area of HIV/AIDS care in the districts, not fully in line with the MoH/DHMT plans and programmes. It could be a potential threat to the Project as well as to Zambia's ART programmes.

3.3 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.

The input from the Japanese side experienced some delay in the first year of the Project. The

team of the three long-term experts was finally established about ten months after the Project started, which delayed commencement of the Project activities. Also, the Project needed to modify some Activities in the first PDM because they were found irrelevant in the actual situations.

Regarding Important Assumptions (IAs) to link the Inputs/Activities and the Outputs, one out of two IAs has been met: medical technology regarding HIV/AIDS service has not significantly changed (IA2). As for human resources (IA1), while no serious level of turnover has been experienced, there is always a challenge to meet the demand from rapidly increasing ART clients. The Project has promoted participation of community people as lay counsellors and adherence supporters to cover the shortage of health workers, which is in line with the task shifting approach promoted in the health sector global/nationwide. Very active participation of community members is observed in some mobile ART centres, an example of which is Mwembezhi Rural Health Centre in Mumbwa District where PLWHA groups provide ART clients with health education, assistance such as weighing clients on ART days, and adherence support. However, relying on voluntary workers has a limitation as they might lose their motivation for working free of charge, particularly when other Cooperating Partners pay allowances. Health centres reported that some volunteers have stopped participating in provision of HIV/AIDS services for this reason.

3.4 Impact

As discussed in the section of the Overall Goal above, the model of mobile ART services developed by the Project is likely to be integrated into the national mobile ART guidelines. 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 is 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, the Project Manager is advocating incorporation of lessons learned from the Project into the

guidelines so that the conditions for accreditation of ART centres can be revised and that more rural health centres can provide ART services.

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 hence the quality of service could be compromised. As a result of this challenge, the Project decided to train more adherence counsellors and ART providers.

The Important Assumption (IA) to link the Project Purpose and the Overall Goal has been met: HIV/AIDS policies of the government have not been changed significantly.

3.5 Sustainability

Prospects of sustaining the outcomes of the Project are positive. Since HIV/AIDS is a priority issue in Zambia, 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 recognised. The NAC and the MoH are developing the national guidelines on mobile ART services, and the MoH is going to introduce mobile ART services in 15 districts using funding from the GFATM, to which the lessons from the Project would be incorporated. 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.

3.6 Contributing and hindering factors

3.6.1 Contributing factors

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 emphasises capacity building of the staff members of the DHMTs and the health facilities to ensure sustainability and avoid dependency on support from cooperating partners.

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, which can be attributed to improved communication between the Japanese members and the MoH. There is a growing interest within the MoH in good practices and lessons learned from the Project for integration in the national mobile ART guidelines.
- The government of Zambia successfully mobilises resources for HIV/AIDS response from Cooperating Partners. With the funding from the GFATM (Round 4), the MoH is planning to introduce mobile ART services in other 15 districts, to which the experiences of the Project will be incorporated.

3.6.2 Hindering factors

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 and indicators 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 are involved in the Project.

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 CIDRZ. In large part it was due to insufficient communication. It led to the postponement of some project activities in Chongwe until February 2008 and it was felt by the Chongwe members that the treatment was not fair. The situation has improved since then as they have more discussions and work together towards the goals shared by both parties.

4. Conclusions

The Project has successfully implemented all planned activities despite the number of difficulties and hindering factors. And the Project is expected to achieve its Outputs by the end of the period of technical cooperation. The effectiveness of the mobile ART services model developed by the Project has been verified for the future duplication in other districts.

This terminal evaluation has found that the prospect of achieving the Project Purpose is very likely, given the continuous effort are made by the Project and its stakeholders for the rest of the project period. The Project is, therefore, expected to be completed successfully.

However, the mobile ART services model developed by the Project should be continuously monitored and evaluated, in order to evolve with the changing circumstances, including the rapid increases of the number of ART clients.

5. Recommendations

5.1. Measures recommended to be taken before the end of the Project are as follows:

1) The Project should continue to make efforts to reactivate the Task Force for developing the mobile ART guidelines and work closely with the people in charge of it at NAC and the MoH.
2) Reference to Output 2, in increasing the number of health facilities providing ART services, DHMTs are expected to make continuous efforts towards achieving the Project target. However, the opening of new mobile services outlets shall be facilitated while the qualities of services are ensured.
3) The Project should continue improving data management of HIV/AIDS programmes.
4) Responding to the resent initiative of the MoH to introduce mobile ART services to 15 districts with the funds from the GFATM, the Project should proactively commit itself to contribute in the planning and implementation for the MoH with the experiences and lessons learned to date.

5.2. Measures recommended to be taken after the completion of the Project are as follows:

1) In order to sustain the quality of ART services while scaling them up, in respect of increased workload for health care workers, the following measures are recommended:
   - The MoH should continue ensuring budgetary and technical support to DHMTs and RuHCs to assure the quality of mobile ART services in rural areas.

- The MoH should continuously monitor and evaluate the mobile ART services model developed by the Project, in order to evolve with the changing circumstances, including rapid increase in number of ART clients and progress in treatment technologies.

2) The MoH should promote the expansion of quality mobile ART services to rural areas in accordance with the guidelines.
3) The MoH should streamline HIV/AIDS programmes through DHMTs.

6. 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 responses in Africa, projects may need to modify planned inputs and activities in flexible and timely manners. An example of this Project was an introduction of mobile ART services as activities though it was not included in the original plan/PDM.
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 decentralisation of treatment, especially in resource-limited settings.
5) As there are many Cooperating Partners in the field of HIV/AIDS, especially in Sub-Sahara Africa, the leadership and ownership of the programme by the host country which can be strengthened through capacity development is imperative.

Annex 1

Project Design Matrix (PDM)

Project Name: Integrated HIV and AIDS Care Implementation Project at District Level
Target Groups: ❶ PLWHAs (Estimated 29,000 persons [*1]) ❷ DHMTs at district level (About 300 professional staff)
Target Area: Chongwe and Mumbwa Districts

Project Period: April 2006- March 2009 (3years)
Date: March, 2006
PDM Version_1

Narrative Summary	Objectively Verifiable Indicators [*2]	Means of Verification	Important Assumptions
Overall Goal Interventions to improve the HIV and AIDS care services for PLWHAs demonstrated at target districts are introduced in other districts	Number and contents of interventions introduced in other districts	1 Record of Ministry of Health and National HIV/AIDS/STI/TB Council	
Project Purpose HIV and AIDS care services [*3] are improved and accessible at target districts	1 Number of death of PLWHAs while on care/ Total number of enrolled PLWHAs 2 Population coverage by HIV and AIDS care services in the targets districts 3 Case detection rate of HIV positive (Number of HIV+ detected / Estimated sero plevalence of HIV+)	1 Record of district hospitals and health centers 2 Record of district hospitals and health centers 3 Record of district hospitals and health centers	1 HIV/AIDS policy of the Government of Zambia, including free provision of ARV drugs, does not change significantly
Outputs 1 Access to HIV counseling and testing is improved in order to detect HIV infection more and earlier	1-1 Number of people counseled and tested 1-2 Persentage of HIV tested among TB ,STI ,ANC clinic 1-3 Proportion of clinical stage 1 & 2 (WHO criteria) among all the HIV detected 1-4 Percentage of referred PLWHAs among all the HIV detected	1-1 Record of health centers 1-2 Record of district hospitals/ referral health centers 1-3 Record of district hospitals/ referral health centers 1-4 Record of district hospitals and health centers	1 Necessary amount of ARV drugs is available at target districts 2 Concerned non-governmental organizations, including mission hospitals, at districts are cooperative to HIV/AIDS related activities of DHMT 3 The political, economic, and social situation is not severely worsened than at the commencing time of the Project 4 Number of new infection is not increased rapidly
2 District hospitals and referral health centers are strengthened to provide appropriate care services to PLWHAs	2-1 Number of PLWHAs received ART eligibility screening 2-2 Number of PLWHAs screened with CD4 count	2-1 Record of district hospitals/ referral health centers 2-2 Record of district hospitals/ referral health centers	
3 Standard ART services are decentralized and scaled-up	3-1 Number of health centers with ART program 3-2 Number of ART patients 3-3 Adherence rate of ART is over 95% 3-4 Case mortarity rate of ART patients 3-5 Percentage of health centers having community participation 3-6 Number of ART patients under DOT	3-1 Record of health centers 3-2 Record of health centers 3-3 Record of health centers 3-4 Record of health centers 3-5 Record of health centers 3-6 Record of health centers	
4 Quality of TB and TB/HIV services are improved	4-1 TB Cure (Treatment success) rate 4-2 Number of sputum examination 4-3 Number of case detection of TB 4-4 Percentage of TB patient receiving HIV counseling and testing 4-5 Percentage of PLWHAs receiving TB screening	4-1 District Health Office 4-2 District Health Office 4-3 District Health Office 4-4 District Health Office 4-5 District Health Office	
5 Necessary management capacities of DHMTs to strengthen HIV and AIDS care services are enhanced	5-1 Degree of capacity building	5-1 Checklist developed by the Project	
6 Innovative approaches to improve the HIV/AIDS situation are identified through OR	6-1 Number of OR conducted and reported	6-1 Project Report	
7 Networking with concerned organizations is strengthened at central level	7-1 Degree of Networking	7-1 Checklist developed by the Project	

Narrative Summary	Objectively Verifiable Indicators [2]	Means of Verification	Important Assumptions
Activities	Inputs		
1-1 To identify and provide training for lay counselors [4] 1-2 To conduct exchange visits for lay counselors 1-3 To train more professional counselors 1-4 To conduct quarterly review meetings for counselors 1-5 To conduct orientation courses on Counseling and Testing at community level 1-6 To promote Recommended/ Routine Counseling and Testing in health facilities such as TB,STI and Antenetal clinic 1-7 To introduce the Finger Pricking HIV testing in health centers 1-8 To ensure to refer the HIV detected to the district hospitals/referral health centers 2-1 To install and provide guidance for maintenance for necessary medical equipment, such as x-ray machine, CD4 Counter, and others, at district health centers/ referral hospitals 2-2 To conduct training for staff of the district hospitals/ referral health centers on HIV/ART management, including prevention and care for opportunistic infections 3-1 To conduct training for community people, such as treatment supporters, care givers, community health workers, and traditional birth attendants 3-2 To conduct training for clinical staff of health centers on HIV/ART management, including prevention and care for opportunistic infections 3-3 To conduct training for staff of the health centers on commodity management 3-4 To conduct regular supporting supervising visit to health centers and lay counselors by DHMTs 3-5 To introduce ART/DOT for necessary PLWHAs 4-1 To conduct training/ sensitization in TB/HIV co-infection management for clinical staff 4-2 To conduct follow-up of defaulters for both TB and HIV treatment 4-3 To strengthen DOT strategy for both TB and HIV 4-4 To upgrade sputum smear examnation of laboratory capacity and quality by quality assurance	Japanese Side 1 Dispatch of experts (1) Long-term Expert (3 person) Health Administration/Infectious Disease Control, HIV/AIDS Care, Coordinator/Community Participation (2) Short-term Expert TB/HIV Control, TB/HIV Laboratory, Laboratory quality Asureance , Logistics, Health Management, Advocacy/IEC, OR and others 2 Provision of equipment CD 4 Counters, HIV test kits, x-ray machine, Other laboratory equipments, Vehicles, Office equipment, Audio/visual equipment, Computers, and others 3 Training of counterparts in Japan and third country (ies) About 1-3 persons/ year 4 Dispatch of study team when necessary 5 Allocation of operational costs for the Project	Zambian Side 1 Assignment of counterpart personnel at central and district level 2 Provision of land, spaces, and other necessary facilities at central and district level 3 Allocation of operational costs for the Project	1 Frequent transfer of trained personnel at district level does not occur 2 Medical technology regarding HIV and AIDS services does not significantly change

Narrative Summary	Objectively Verifiable Indicators [*2]	Means of Verification	Important Assumptions
5-1 To ensure that national guidelines for HIV and AIDS care are available and followed by DHMTs			
5-2 To improve communication, referral, and transportation systems among health facilities			
5-3 To conduct training for DHMT staff to improve necessary management skills for strengthening HIV and AIDS care services, such as performance assessment, monitoring and evaluation, District Integrated Logistic Assessment Tool, and technical support			
5-4 To develop HIV/ART/TB planning system			
5-5 To conduct experience sharing meetings between pilot districts			
6-1 To conduct baseline, follow-up, and end-line surveys for OR			
6-2 To plan and implement OR in collaboration with concerned organizations			**Pre-conditions**
6-3 To monitor and evaluate the progress and findings of OR			1 Project concept, and roles and responsibilities of project stakeholders are shared and clearly understood among them
7-1 To conduct Taskforce Meeting quarterly			
7-2 To conduct periodical sharing workshop bi-annually			

*1 Estimated Adult Positive Population in 2005 includes only the population from which the Zambia Demographic Health Survey derived the prevalence rate - men (15-59) and women (15-49)

*2 Indicators must be quantified within a month after the commencement of the Project

*3 HIV and AIDS services include counseling (including prevention and social support), testing for ART eligibility by CD4 counting/immunology/ bio-chemistry/ x-ray, and prevention and care of opportunistic infections for both ART eligible and non-eligible PLWHAs, and ART services for ART eligible PLWHAs

*4 Lay counselors are defined as community people, such as community workers and volunteers, who don't have professional medical background

Abbreviation:
ART: Anti-Retroviral Treatment, ARV: Anti-Retroviral, DHMT: District Health Management Team (including District Health Offices, District Hospitals, and Health Centers), DOT: Directly Observed Treatment, OR: Operational Research, PLWHA: Person Living With HIV/AIDS

PDM(Project Design Matrix)

Project Name: Integrated HIV and AIDS Care Implementation Project at District Level
Target Groups: ❶ PLWHAs (Estimated 29,000 persons) ❷ DHMTs at district level (About 300 professional staff)
Target Area: Chongwe and Mumbwa Districts

Project Period: April 2006- March 2009 (3years)
Date: 11 December,
Version_2

Narrative Summary	Objectively Verifiable Indicators	Chongwe	Mumbwa	Means of Verification	Important
Overall Goal Interventions to improve the HIV and AIDS care services for PLWHAs demonstrated at target districts are introduced in other districts.	Number and contents of interventions introduced in other districts	N/A	N/A	1 Record of Ministry of Health and National HIV/AIDS/STI/TB Council	
Project Purpose HIV and AIDS care services are improved and accessible at target districts.	1 Cumulative number of HIV positive case detected by VCT/PMTCT	4,000	7,000	1 VCT/PMTCT Register	1 HIV/AIDS policy of the Government of Zambia, including free provision of ARV drugs, does not change significantly
	2 Cumulative number of ART clients	2,300	3,500	2 ART Register	
	3 Percentage of defaulters within 6 months among ART clients	Less than 10%	Less than 10%	3 ART Register	
Outputs 1 Access to HIV counseling and testing is improved.	1-1 Number of health facilities providing VCT service	29	29	1-1 Record of DHMT	1 Necessary amount of ARV drugs is available at target districts
	1-2 Number of health facilities providing PMTCT service	29	29	1-2 Record of DHMT	
	1-3 Number of health facilities providing DCT service	29	29	1-3 Record of DHMT	
	1-4 Number of health facilities applying Finger Pricking HIV testing method	29	29	1-4 Record of DHMT	
	1-5 Annual number of HIV counselling and testing in VCT	3,500	4,000	1-5 VCT/PMTCT registration	2 Concerned non-governmental organizations, including mission hospitals, at districts are cooperative to HIV/AIDS related activities of DHMT
	1-6 Annual number of HIV counselling and testing in PMTCT	4,000	5,000	1-6 VCT/PMTCT registration	
	1-7 Percentage of HIV tested among TB clinic	80%	80%	1-7 TB Register / PMCT register	
	1-8 Percentage of HIV tested among ANC clinic	80%	80%	1-8 TB Register / PMCT register	
2 Quality HIV care services are strengthened and scaled-up.	2-1 Number of health facilities providing ART services	10 plus 4 outreach sites	10	2-1 Record of DHMT	
	2-2 Number of health facilities which provide adherence counseling	20	20	2-2 Record of DHMT	3 The political, economic, and social situation is not severely worsened than at the commencing time of the Project
	2-3 Percentage of patients on ART who are screened by CD4 count testing for eligibility	80%	80%	2-3 ART register	
	2-4 TB Treatment Success(TB Cure) rate	85%	85%	2-5 TB Register	
	2-5 Percentage of HIV positive TB patients who undertook CD4 test	80%	80%	2-6 Operational Research data and others	
	2-6 Percentage of TB patients who are eligible and started ART	80%	80%	2-7 Operational Research data and	
3 DHMT's management capacities in HIV care services are enhanced.	3-1 Frequency of experience sharing meetings	Quarterly	Quarterly	3-1 Record of DHMT	4 Number of new infection is not increased rapidly
	3-2 ORs conducted and shared at central level	yes	yes	3-2 Record of DHMT	
4 Lessons learned by the Project are incorporated into national guideline on mobile ART services.	4-1 Lessons learned by the Project are reflected in the national guideline on mobile ART services.	yes	yes	4-1 National guideline on mobile ART services	
	4-2 Number of monthly regular meetings	12	12	4-2 Minutes of the meetings	

Activities	Inputs: Japanese Side	Inputs: Zambian Side	Important
1-1 To identify and provide training for lay counselors 1-2 To train more professional counselors 1-3 To promote Diagnostic Counselling and Testing (DCT), Prevention of Mother to Child Transmission(PMTCT) in health facilities such as TB,STI and Antenatal clinic 1-4 To introduce the Finger Pricking HIV testing in health centres 2-1 To provide mobile ART services 2-2 To conduct training for the health facility staff on HIV/OIs management 2-3 To conduct training for community members such as adherence counselors in HIV/AIDS services 2-4 To conduct regular supervisory visit to health facility by DHMTs 2-5 To strengthen the health system at health facility level such as diagnostic capacity, transport, infrastructure, etc. 2-6 To conduct training in TB and other OIs management for PLWHAs 3-1 To conduct trainings for DHMT staff to improve necessary management skills for strengthening HIV care services 3-2 To conduct quarterly meetings 3-3 To conduct Operational Research 4-1 To conduct monthly meetings at national level 4-2 To compile the lessons learned, and conduct workshop to disseminate the lessons learned for their incorporation in national guidelines 4-3 To participate in the working group for development of national guideline on mobile ART services	1 Dispatch of experts (1) Long-term Expert (3 person) Health Administration/Infectious Disease Control, HIV/AIDS Care, Coordinator/Community Participation (2) Short-term Expert HIV/AIDS Care, OR, TB/HIV, IEC and others 2 Provision of equipment Necessary Laboratory Equipment, Necessary Office Equipment, Vehicles and others 3 Training of counterparts in Japan and third country (ies) About 1-3 persons/ year 4 Dispatch of study team when necessary 5 Allocation of operational costs for the Project	1 Assignment of counterpart personnel at central and district level 2 Provision of land, spaces, and other necessary facilities at central and district level 3 Allocation of operational costs for the Project	1 Frequent transfer of trained personnel at district level does not occur 2 Medical technology regarding HIV and AIDS services does not significantly change

*ARTIS trainings by DHMTs included

INPUTS OF EXPERTS

Long-term Experts

1st of September, 2008

	Job Title	Name	Period
1	Project Coordinator/Community Participation	Katsunori SHIRAI (Mr)	20 Mar 2006 - 19 Mar 2008
2	Infectious Diseases Control/Health Planning	Tadao HAYAKAWA (Dr)	13 June 2006 - 13 April 2009
3	HIV/AIDS Care	Ikuma NOZAKI (Dr)	19 January 2007 - 02 April 2009
4	Project Coordinator/Monitoring	Kyo YOSHIDA (Mr)	03 March 2008 - 15 April 2009

Short-term Experts

	Job Title	Name	Period
1	HIV/AIDS Care	Kazuhiro KAKIMOTO (Dr)	29 May -14 July 2006
2	Operational Research	Norio YAMADA (Dr)	18 November -02 December 2006
3	TB/HIV Control	Ikushi ONOZAKI (Dr)	18 February -01 March 2007
4	HIV/AIDS Management	Yutaka ISHIDA (Dr)	03 - 31 March 2007
5	Information Education Communication	Kazuaki SUMIDA (Mr)	24 September - 23 November 2007
6	PMTCT	Takanori Hirayama (Dr)	28 February -25 March 2008
7	HIV/AIDS Care	Hideki MIYAMOTO (Dr)	08 July - 02 August 2008
8	Operational Research	Norio YAMADA (Dr)	01 October - 12 October 2008

INPUTS: OVERSEAS TRAINING

1st of September, 2008

Japan

	Duration	Name	Position	Name of the Course	Training Institute	Contents of the Course
1	28 October -16 November 2007	James SIMPUNGWE (Dr)	Director, Directorate of Clinical Care and Diagnostic Services, Ministry of Health	Group Training (CODE:J-06-00741) "Seminar for Health Policy Development" and Individual Counterpart Training	National Institute of Public Health, International Medical Center of Japan (IMCJ), Japan Foundation for AIDS Prevention (JFAP), Research Institute of Tuberculosis (RIT)	Group Training "Seminar for Health Policy Development", Visitation to IMCJ, JFAP and RIT Discussion of Joint Study in Zambia, TV Meeting (RIT, IMCJ ⇔JICA Zambia)
2	11 -31 May 2008	Christopher DUBE (Dr)	Mumbwa District Director of Health	HIV/AIDS Care/Community Health (Individual Counterpart Training)	International Medical Center of Japan (IMCJ), Ministry of Health, Labor and Welfare, Disease control section, Medical council of Tokyo, Taitou Health Center, Saku Health Center, Nagano Prefecture Health Office, Research Institute of Tuberculosis (RIT)	Situation of HIV/AIDS and HIV testing in Japan, Role of health center in urban setting, Community Health, Health system, Way of health service in rural area of Japan, Role of community health in rural setting in Japan, General information for community health in Nagano Prefecture, TB control in Japan, Latest treatment of HIV in Japan

Thailand

	Duration	Name	Position	Name of the Course	Training Institute	Contents of the Course
1	13 -30 July 2006	Lawrence PHIRI (Dr)	ART Manager, Mumbwa District	Training of trainers on HIV/AIDS Care and ART Management	HIV/AIDS Regional Coordination Center, Asean Institute for Health Development,Mahidol University	ART Management Course (Training of Trainers)
2		Charles KAHIRA (Mr)	Manager of Planning & Development, Chongwe District			

South Africa

	Duration	Name	Position	Name of the Course	Training Institute	Contents of the Course
1	7 -13 November 2007	Charles MSISKA (Dr)	Chongwe District Director of Health	38th Union World Conference on Lung Health	N/A	"Confronting the challenges of HIV and MDR in TB prevention and care" Poster Session (Title: Improvement of TB-HIV service at rural health centers by mobile ART clinic)
2		Christopher DUBE (Dr)	Mumbwa District Director of Health			
3		Nangana KAYAMA (Mr)	TB/HIV Focal Person of Mumbwa District Health Management Team			

Paris

	Duration	Name	Position	Name of the Course	Training Institute	Contents of the Course
1	16-20 October 2008	Charles MSISKA (Dr)	Chongwe District Director of Health	39th Union World Conference on Lung Health	N/A	"Global threats to lung health: the importance of health system responses" Poster Session (Title: Assessment of improvement of TB/HIV care service in districts where the mobile Anti-Retroviral Treatment (ART) service has been introduced.)
2		Christopher DUBE (Dr)	Mumbwa District Director of Health			

Senegal

	Duration	Name	Position	Name of the Course	Training Institute	Contents of the Course
1	3-7 December 2008	Charles MSISKA (Dr)	Chongwe District Director of Health	International Conference on HIV and STIs in Africa (ICASA)	N/A	Poster Session (Title:)
2		Christopher DUBE (Dr)	Mumbwa District Director of Health			

INPUTS: DOMESTIC TRAINING

1st of September, 2008

No	Title of Training	Training Period	Number of Trainees		Implementing Agency	Funding
			Chongwe	Mumbwa		
1	ARVs and OIs Management		5	–	CIDRZ	CIDRZ
2	PMTCT		22	–	CIDRZ	CIDRZ
3	ARVs and OIs Management		10	–	CIDRZ	CIDRZ
4	ARVs and OIs Management	27 Nov – 8 Dec 2006	8	8	Chainana College	JICA
5	Psychosocial Counseling Course	29 Jan – 23 Mar 2007	10	10	Chainana College	JICA
6	Finger Pricking (TOT) Course	06 Feb – 09 Feb 2007	10	12	Virology Laboratory, UTH	JICA
7	Psychosocial Counseling Course	12 Feb – 05 Apr 2007	10	10	Chainana College	JICA
8	Finger Pricking Course	19 Feb – 23 Feb 2007	10	10	Chainana College	JICA
9	Diagnostic Counselling & Testing	26 Feb – 02 Mar 2007	10	10	Dr. Kasoma (Provincial Health Office, Southern)/ Mr. Muvuma (DHMT, Chongwe)/ Ms. Lucy Zulu (MOH)/ Mr. Graham Samungobe (DHMT, Lusaka)	JICA
10	Facility Based Adherence Supporter	18 Jun – 22 Jun 2007	–	20	Kara Counselling	JICA
11	Diagnostic Counselling & Testing	30 Jul – 03 Aug 2007	–	10	Mr. Saul Banda (Ndola Central Hospital)/ Ms. Inambao Nalishebo (UTH)/ Mr. Dominic Phiri (DHMT, Monze)	JICA
12	PMTCT (phase 1)	19 Nov – 02 Dec 2007	–	18	–	Global Fund
13	PMTCT (phase 2)	03 Dec – 17 Dec 2007	–	21	–	Global Fund
14	Diagnostic Couselling & Testing	26 Dec – 29 Dec 2007	–	11	–	Global Fund
15	ARV and OIs Management	11 Feb – 22 Feb 2008	–	10	Chainama College	JICA
16	Psychosocial Counselling	18 Feb – 22 Feb 2008	–	5	Chainama College	JICA
17	Community Lay Counsellors in PMTCT	03 Mar – 07 Mar 2008	–	19	Kara Counselling	JICA
18	ARV and OIs Management	09 Jun – 20 Jun 2008	10	3	Chainama College	UNICEF
19	Community-based Adherence Counselling	14 Jul – 18 Jul 2008	24	24	Kara Counselling	UNICEF
20	Community-based Adherence Counselling	27 Jul – 02 Aug 2008	26	25	Kara Counselling	UNICEF
		TOTAL	155	226		

ANNEX3-3

INPUTS: Equipment

1st of September, 2008

No.	Acquisition DD/MM/YY	Item (Type, Model)	QTY	Currency	Unit Price	Total Price	Allocation	Frequency of Use	Condition	Item of expense	Remarks
1	15/11/2005	Personal Computer (Laptop, Toshiba/Satelite A 60)	1	Kwacha	8,000,000	8,000,000	MOH Office	A	A	Carry-in	
2	22/03/2006	Vehicle (Ford EVELEST/ 2500cc Turbo Diesel) Reg No. ABF6436	1	USD	24,000	24,000	MOH Office	A	A	Carry-in	
3	22/03/2006	Laser Printer (CANON, Laser Shot LBP5200)	1	Kwacha	5,500,000	5,500,000	MOH Office	A	A	Carry-in	
4	22/03/2006	Copy Machine (CANON, iR2020)	1	Kwacha	19,042,553	19,042,553	MOH Office	A	A	Carry-in	
5	07/07/2006	Vehicle (Ford EVELEST/ 2500cc Turbo Diesel) Reg No. ABG6853	1	USD	26,000	26,000	MOH Office	A	A	Provision	
6	01/09/2006	Personal Computer (Laptop, Toshiba/A105-S4004)	1	USD	2,663	2,663	MOH Office	A	A	Provision	
7	01/09/2006	Data Projector (Sony VPL-ES3 with Screen)	1	USD	2,708	2,708	MOH Office	A	A	Provision	
8	12/01/2007	Desk-Top Computer (HP DX 2200 MicroTower, HP7540 CRT Monitor)	2	Kwacha	4,595,319	9,190,638	MOH Office	A	A	Provision	
9	12/01/2007	UPS (MGE NOVA 600 AVR)	2	Kwacha	410,212	820,424	MOH Office	A	A	Provision	
10	29/01/2007	Vehicle (TOYOTA LandCruiser)	2	Kwacha	163,124,800	326,249,600	Chongwe DHMT	A	A	Provision	
							Mumbwa DHMT	A	A		
11	22/05/2007	CD4 counter (Becton Dickinson)	1	Rand	270,100	270,100	Chongwe DHMT	B	A	Provision	
12	21/02/2008	Heamatology Analyzer (Poch 100i)	1	USD	9,760	9,760	Mumbwa DHMT	A	A	Provision	
13	21/02/2008	Bio-Chemistry Analyzer (Cobas C -111)	1	USD	22,890	22,890	Mumbwa DHMT	B	A	Provision	
14	18/03/2008	Reagents for Heamatology Analyzer (Sysmex)	1000	USD	3,087	3,087	Mumbwa DHMT	-	-	Provision	Consumables
15	18/03/2008	Reagents for Bio-Chemistry Analyzer (Roche)	2000	USD	13,413	13,413	Mumbwa DHMT	-	-	Provision	Consumables

Frequency of Use:
- A/ Almost every day use
- B/ Weekly basis use
- C/ Concentrated use for certain times (In case of C, explain the reason in the remarks)
- D/ 3-11 times per year (In case of D, explain the reason in the remarks)
- E/ Not in use at present (In case of E, explain the reason in the remarks)

USD	104,521		
Kwacha	200,672,884	→USD	59,021
Rand	270,100	→USD	36,842

USD TOTA 200,384 →yen 21,240,683

Condition :
A/ Good condition and well maintained B/ Good condition C/ Needs to be repaired D/ Malfunction (Needs to be replaced)

INPUTS: LOCAL ACTIVITY FEE BY JAPANESE SIDE

1st of October, 2008

Item	FY-2006 (Apr 2006-Mar 2007)	FY-2007 (Apr 2007-Mar 2008)	FY-2008 (Apr 2008-Sep 2008)	Total
Construction	2,503,000	1,509,250	0	4,012,250
Maintenance of Equipment	17,660,200	10,085,280	8,087,166	35,832,646
Equipment and Materials	20,772,078	32,826,819	1,482,724	55,081,621
Consumables	54,862,650	141,020,708	41,949,540	237,832,898
Traveling Expense	106,603,548	80,960,030	26,735,700	214,299,278
Communication and Transportation	22,401,888	44,807,277	14,462,000	81,671,165
Material Printing	4,222,900	9,350,482	5,110,395	18,683,777
Office Rent	10,215,300	36,255,800	19,401,000	65,872,100
Training and Workshop	97,234,000	44,250,000	17,733,969	159,217,969
Allowance	58,872,580	120,779,970	60,268,190	239,920,740
Meeting Expence	13,682,362	15,242,000	4,378,000	33,302,362
Others	17,716,363	19,972,770	11,066,028	48,755,161
Total in KWACHA	426,746,869	557,060,386	210,674,712	1,194,481,967
YEN Equivalent	14,215,684	16,521,069	6,703,669	37,440,422

INPUTS: Counterpart Personnel

1st of September, 2008

	Position	Job Title	Counterpart Name	Assigned Period as Project Counterpart
1	Project Director	Permanet Secretary, Ministry of Health	Dr. Simon Miti	April 2006 to up to now
2	Deputy Project Director	Director, Directorate of Planning and Development, Ministry oh Health	Mr. Davis Chimfwembe	April 2006 to up to now
3	Project Manager	Director, Directorate of Clinical Care and Diagnostic Services, Ministry of Health	Dr. Veleti Mtonga	April 2006 to May 2006
4			Dr. James Simpungwe	May 2006 to up to now
5	Others	ARV Coordinator, Ministry of Health	Dr. Albert Mwango	April 2006 to up to now
6		TB Specialist, Ministry of Health	Dr. Nathan Kapata	April 2006 to up to now
7		Laboratory Specialist, Ministry of Health	Ms. Fales Mwamba	April 2006 to up to now
8		PMTCT Specialist, Ministry of Health	Dr. Max Bweupe	April 2006 to up to now
9		Chongwe District Director of Health	Dr. Charles Msiska	April 2006 to up to now
10		Mumbwa District Director of Health	Dr. Christopher Dube	April 2006 to up to now
11		Director, Provincial Health Office, Lusaka	Dr. Mary. Zulu	April 2006 to March 2008
			Dr. Taskson Lambart	March 2008 to up to now
12		Director, Provincial Health Office, Central	Dr. Dickson Suya	April 2006 to up to now
13		Paediatric ART Program Officer	Dr Mutinta Nalubamba Phiri	April 2008 to up to now
14		Director-General, National HIV/AIDS/STI/TB Council	Dr. Ben Chirwa	April 2006 to up to now

MUMBWA DISTRICT HEALTH MANAGEMENT
SCHEDULE OF ACCUMULATED EXPENDITURE ON ART PROGRAMME
FROM OCT 2007 TO JULY 2008

NAME OF ART CENTRE	NO OF VISITS	RATE	NO OF STAFF	TOTAL
ALLOWANCES				
LUNGOBE	20	50,000.00	5	5,000,000.00
NAMPUNDWE	20	50,000.00	5	5,000,000.00
MWEMBEZHI	20	50,000.00	5	5,000,000.00
KAINDU	20	50,000.00	5	5,000,000.00
Motor Vehicle Service		275,000.00	1	275,000.00
Motor Vehicle Service		275,000.00	1	275,000.00
Motor Vehicle Service		275,000.00	1	275,000.00
Motor Vehicle Service		275,000.00	1	275,000.00
Total				**21,100,000.00**
FUEL				
LUNGOBE	20	6777	50	6,777,000.00
NAMPUNDWE	20	6777	80	10,843,200.00
MWEMBEZHI	20	6777	70	9,487,800.00
KAINDU	20	6777	70	9,487,800.00
Motor Vehicle Service	1	6777	80	542,160.00
Motor Vehicle Service	1	6777	80	542,160.00
Motor Vehicle Service	1	6777	80	542,160.00
Motor Vehicle Service	1	6777	80	542,160.00
Total				**38,764,440.00**
MOTOR VEHICLE SERVICE				
Motor Vehicle Service-Toyota Zambia				3,507,945.00
Motor Vehicle Service-Mauro's				2,244,250.00
Motor Vehicle Service-Mauro's				2,325,325.00
Motor Vehicle Service-Mauro's				2,120,132.00
Tyres/Tubes				4,600,000.00
Total				**14,797,652.00**
Grand Total				**74,662,092.00**

ANNEX3-6

CHONGWE DHO
EXPENDITURE REPORT FOR ART PROGRAMME
FROM OCTOBER 2007 TO AUGUST 2008

ITEM	AMOUNT/TRIP	AMOUNT
SERVICING of Vehicle	-	3,978,186
Vehicle Maintenance	-	12,370,233
Meal Allowance	From October 2007 to December 2007 @20,000	2,950,000
	From January 2008 to August 2008 @50,000	12,000,000
Fuel	-	11,719,400
Insurance	-	7,000,000
	TOTAL AMOUNT	50,017,819

(12)

Annex 3-7

Lands and Facilities by Zambian Side

1 Project Office in the Building of MoH
2 Furnitures in the Project Office
3 Laboratories, medical equipments, and vehcles in Chongwe and Mumbwa

Chongwe District

Annex 4

	Indicators	Baseline (Q1 2006)	M. E. (Q3 2007)	As of Q4 2007	As of Q1 2008	As of Q2 2008	As of Q3 2008	Target
Project Purpose: HIV and AIDS care services are improved and accessible at target								
1	Cumulative number of HIV positive case detected by VCT/PMTCT	481	2,616	3,114	3,704	4,193		4,000
2	Cumulative number of ART clients	235	1,268	1,395	1,511	1,634		2,300
3	Percentage of defaulters within 6 months among ART clients (Quorterly)	(Clients 2005) Unknown	(Clients Q1 2007) 3%	(Clients Q2 2007) 4%	(Clients Q3 2007) 2%	(Clients Q4 2007) 3%		<10%
Outputs 1: Access to HIV counselling and testing is improved								
1-1	Number of health facilities providing VCT service	10	20	20	20	20	26	29
1-2	Number of health facilities providing PMTCT service	2	18	18	18	18	18	29
1-3	Number of health facilities providing DCT service	0	26	26	26	26	26	29
1-4	Number of health facilities applying Finger Pricking HIV testing method	0	10	10	10	10	10	29
1-5	Annual number of HIV counselling and testing in VCT	(2006 Q1) /694	(2007) /2762	(2007)	(2008)	(Aug 2008) 3005		3,500
1-6	Annual number of HIV counselling and testing in PMTCT	(2005) /167	(2007) 2734/2246	(2007) 2678	(2008) 2869	(2008) 2917		4,000
1-7	Percentage of HIV tested among TB clinic	(Q1 2006) 0%	(Q3 2007) 40%	(Q4 2007) 72%	(Q1 2008) 81%	(Q2 20087) 71%		80%
1-8	Percentage of HIV tested among ANC clinic	(Q1 2006) 100%	(Q3 2007) 79%	(Q4 2007) 100%	(Q1 2008) 97%	(Q2 20087) 100%		80%
Outputs 2: Quality HIV care services are strengthened and scaled-up								
2-1	Number of health facilities providing ART services	2	6+4	6+4	6+4	6+4	6+4	10+4
2-2	Number of health facilities which provide adherence counselling	2	10	10	10	10	10	20
2-3	Percentage of patients on ART who are screened by CD4 count testing for eligibility	(Q1 2005) Unknown	(Q3 2007) 100%	(Q4 2007) 100%	(Q1 2008) 100%	(Q2 2008) 100%		80%
2-4	TB Treatment Success(TB Cure) rate(Quorterly)	(Q1 2005) 86%	(Q3 2006) 79%	(Q4 2006) 85%	(Q1 2007) 88%	(Q2 2007) 85%		85%
2-5	Percentage of HIV positive TB patients who undertook CD4 test	(Q1 2006) Unknown	(Q3 2007) 100%	(Q4 2007) 100%	(Q1 2008) 100%	(Q2 2008) 100%		80%
2-6	Percentage of TB patients who are eligible and started ART	(Q3 2007) Unknown	(Q3 2007) 100%	(Q4 2007) 100%	(Q1 2008) 100%	(Q2 2008) 100%		80%
Outputs 3: DHMT's management capacities in HIV care services are enhanced.								
3-1	Frequency of experience sharing meetings	—	(Q3 2007) —	(Q4 2007) —	(Q1 2008) —	(Q2 2008) 12-Jun-08	(Q3 2008) 05-Sep-08	Quarterly
3-2	ORs conducted and shared at central level	—	Shortterm Exp	IUATLD		Dissemination Workshop		yes
Outputs 4: Lessons learned by the Project are incorporated into national guideline on mobile ART services.								
4-1	Lessons learned by the Project are reflected in the national guideline on mobile ART services.				Guideline TF			yes
4-2	Number of monthly regular meetings	—	(Q3 2007) 3 /Qtr	(Q4 2007) 2 /Qtr	(Q1 2008) 3 /Qtr	(Q2 2008) 3 /Qtr	2/Qtr	12/year

Mumbwa District

* Data from Mumbwa DH and mobile ART sites only

Annex 4

	Indicators	Baseline (Q1 2006) ~	M. E. (Q3 2007)	As of Q4 2007	As of Q1 2008	As of Q2 2008	As of Q3 2008	Target
Project Purpose: HIV and AIDS care services are improved and accessible at target								
1	Cumulative number of HIV positive case detected by VCT/PMTCT	942	3,473	4,582 (+1109)	5,221 (+639)	5,887 (+666)		7,000
2	Cumulative number of ART clients	324	1,529	1,846 (+317)	2,404 (+558)	2,569 (+165)		3,500
3	Percentage of defaulters within 6 months among ART clients (Quorterly)	(Clients 2005) 19.1%	(Clients Q1 2007) 21.3% *	(Clients Q2 2007) 20.1% *	(Clients Q3 2007) 17.9% *	(Clients Q4 2007) 13.3% *		<10%
Outputs 1: Access to HIV counselling and testing is improved								
1-1	Number of health facilities providing VCT service	17	23	23	23	23	23	29
1-2	Number of health facilities providing PMTCT service	12	12	19	19	19	19	29
1-3	Number of health facilities providing DCT service	0	9	14	14	14	20	29
1-4	Number of health facilities applying Finger Pricking HIV testing method	0	?	5	5	6	13	29
1-5	Annual number of HIV counselling and testing in VCT	(2005) 1171/1171	(2007) 3355/3355	(2007) 4689/4689	(2008) 1129/1129	(2008) 2300/2295		4,000
1-6	Annual number of HIV counselling and testing in PMTCT	(2005) 2659/294	(2007) 4229/2708	(2007) 6090/4152	(2008) 1155/979	(2008) 2900/1803		5,000
1-7	Percentage of HIV tested among TB clinic	(Q1 2006) 20%	(Q3 2007) 47%	(Q4 2007) 49%	(Q1 2008) 77%	(Q2 20087) 73%		80%
1-8	Percentage of HIV tested among ANC clinic	(Q1 2006) 9%	(Q3 2007) 49.6%	(Q4 2007) 77.5%	(Q1 2008) 84.8%	(Q2 20087) 47.2%		80%
Outputs 2: Quality HIV care services are strengthened and scaled-up								
2-1	Number of health facilities providing ART services	1	6	6	6	6	8	10
2-2	Number of health facilities which provide adherence counselling	0	6	6	6	6	7	20
2-3	Percentage of patients on ART who are screened by CD4 count testing for eligibility	(Q1 2006) 0%	(Q3 2007) 86.4% *	(Q4 2007) 85.2% *	(Q1 2008) 71.4% *	(Q2 2008) 88.7% *		80%
2-4	TB Treatment Success(TB Cure) rate(Quorterly)	(Q3 2006) 70%	(Q3 2006) 76%	(Q4 2006) 75%	(Q1 2007) 73%	(Q2 2007) 74%		85%
2-5	Percentage of HIV positive TB patients who undertook CD4 test	(Q1 2006) Unknown	(Q3 2007) —	(Q4 2007) 100%	(Q1 2008) 100%	(Q2 2008) 100%		80%
2-6	Percentage of TB patients who are eligible and started ART	(Q1 2006) Unknown	(Q3 2007) —	(Q4 2007) —	(Q1 2008) 100%	(Q2 2008) 100%		80%
Outputs 3: DHMT's management capacities in HIV care services are enhanced.								
3-1	Frequency of experience sharing meetings	—	(Q3 2007) —	(Q4 2007) 17-Oct-07	(Q1 2008) —	(Q2 2008) 15-Apr-08	(Q3 2008) 15-Jul-08	Quarterly
3-2	ORs conducted and shared at central level	—	Shortterm Exp	IUATLD	Quesstionnaire Survey	Dissemination Workshop		yes
Outputs 4: Lessons learned by the Project are incorporated into national guideline on mobile ART services.								
4-1	Lessons learned by the Project are reflected in the national guideline on mobile ART services.				Guideline TF			yes
4-2	Number of monthly regular meetings	—	(Q3 2007) 3 /Qtr	(Q4 2007) 2 /Qtr	(Q1 2008) 3 /Qtr	(Q2 2008) 3 /Qtr	2/Qtr	12/year

２．調査日程表

TERMINAL EVALUATION STUDY OF THE PROJECT ON "INTEGRATED HIV/AIDS CARE IMPLEMENTATION PROJECT AT DISTRICT LEVEL" TENTATIVE SCHEDULE

Date	Time	Schedule	Venue	Meeting with
16/Sep/08 (Tue)	12:50	Consultant's arrival at Lusaka		
	14:00	Check-in to the hotel		
	15:00	Discussion in JICA Zambia Office	JICA	JICA Zambia Staff Project Experts
17/Sep/08 (Wed)	08:30	Courtesy call on MoH	MoH	Dr. Simpungwe
	09:00	Interview with CP of MOH (1)	MoH	Ms. Fales
	10:00	Meeting with Zambian Evaluation Team Member	MoH	Dr. Syakantu
	11:00	Briefing from and Interview with the project experts	Project Office	Project Experts
	14:00	Interview with the project experts	Project Office	Project Experts
18/Sep/08 (Thu)	**AM**	**- MOH, HQ -**		
	09:00	Interview with CP of MOH (2)	MoH	Dr. Phiri
	09:30	Interview with CP of MOH (3)	MoH	Dr. Mwango
	10:00	Interview with CP of MOH (4)	MoH	Dr. Simpungwe
	PM	**-Field visit to Chongwe-**		
	13:30	Leave Lusaka for Chongwe		
	14:00	Interview with CP of Chongwe DHMT 1	DHO	Dr. Msiska
	～	Interview with CP of Chongwe DHMT 2	DHO	Dr. Chibeza
	～	Interview with CP of Chongwe DHMT 3	DHO	Mr. Muvuma
	～	Observation of ReHC	ReHC	
19/Sep/08 (Fri)		**-Field visit to Mumbwa-**		
	08:00	Leave Lusaka for Mumbwa		
	10:00	Interview with CP of Mumbwa DHMT 1	DHO	Dr. Dube
	～	Interview with CP of Mumbwa DHMT 2	DHO	Mr. Mukololo
	～	Interview with CP of Mumbwa DHMT 3	DHO	Mr. Kayama
	～	Interview with Ns in charge, Mumbwa DH ART Center	DH ART Cent	Mrs. Phiri
	～	Interview with PLHIV, Mumbwa DH	DH ART Cent	PLHIV
	～	Observation of District Hospital		
20/Sep/08 (Sat)		Organize the collected information		
21/Sep/08 (Sun)		Organize the collected information and draft the achievement grid Elaborate the draft achievement grid		
22/Sep/08 (Mon)		Interview with CP of MOH		Dr. Kango
		Additional study for the achievement grid (if necessary)		
		Elaborate the draft process grid		
23/Sep/08 (Tue)		**-Field visit to Chinyunyu, Chongwe-**		
	09:00	Leave Lusaka for Chinyunyu RuHC		
	10:00	Interview with CO in charge, Chinyunyu RuHC	RuHC	Mrs. Banda
	～	Interview with PLHIV, Chinyunyu RuHC	RuHC	PLHIV
	14:30	Regular meeting	MOH	CPs, Experts
24/Sep/08 (Wed)	08:30	Interview with CP of MOH		Dr. Kapata
		-Field visit to Mwembezhi, Mumbwa-		
	09:00	Leave Lusaka for Mwembezhi RuHC		
	10:00	Interview with CO in charge, Mwembezhi RuHC	RuHC	Mr. Karekwe
	～	Interview with Support group, Mwembezhi RuHC	RuHC	Support Group
		Additional study for the achievement grid (if necessary)		
		Elaborate the draft process grid		
25/Sep/08 (Thu)		Organize the collected information about five-criteria		
		Necessary study about five-criteria		
		Elaborate the five-criteria grid		

26/Sep/08 (Fri)		Meeting in JICA Office about the Joint Evaluation Report	JICA	
		Meeting with Zambian Evaluation Team Member	MOH	Dr. Syakantu
27/Sep/08 (Sat)		Draft the Joint Evaluation Report		
28/Sep/08 (Sun)		Draft the Joint Evaluation Report		
29/Sep/08 (Mon)	12:50	JICA mission member arrive at Lusaka (SA062)		
	14:00	Check-in to the hotel		
	15:00	Courtesy call on MoH	MOH	Dr. Simpungwe
	16:00	Courtesy call on the Embassy of Japan	EOJ	Ambasader
	17:00	Discussion in JICA Zambia Office	JICA	Mr. S. Nabeya Mr. I. Matsuhisa Ms. M. Seko Project Experts
30/Sep/08 (Tue)		**-Field visit to Chongwe-**		
	08:00	Leave Lusaka for Kasisi, Chongwe RuHC (Mobile ART)		
	10:00	Interview with Ns in charge, Kasisi RuHC, Chongwe	RuHC	Mr. Kapyata
	~	Interview with PLHIV, Kasisi RuHC, Chongwe	RuHC	PLHIV
	~	Visit Chongwe DHO (Disucussion with DHMT members)	DHO	Dr. Msiska
	~	Visit ReHC (ART center, Labo, Pharmacy)		
1/Oct/08 (Wed)		**-Field visit to Mumbwa-**		
	08:00	Leave Lusaka for Nampundwe RuHC (Mobile ART)		
	~	Interview with Ns in charge, Nampundwe RuHC	RuHC	Mrs. Edith
	~	Interview with PLHIV, Nampundwe RuHC	RuHC	PLHIV
	~	Visit DHO (Disucussion with DHMT members)		
	~	Visit DH (ART centre, Labo, TB corner)		
2/Oct/08 (Thu)		Discussion between the project and the evaluation team		
		Visit other donors (CIDRZ, ZPCT) to discuss a future plan		
		Visit other donors (CIDRZ, ZPCT) to discuss a future plan		
3/Oct/08 (Fri)		Visit NAC to discuss the achievement of the project and Mobile guideline	NAC	Dr. Maxwell
		Discussion with the experts (including the reccomendation and lesson learned)		
		Visit other donors (UNICEF) to discuss the program		
4/Oct/08 (Sat)		Finalize the Joint Evaluation Report	JICA office	Mr. S. Nabeya Mr. I. Matsuhisa Ms. M. Seko Project Experts
5/Oct/08 (Sun)		Drafting the Minutes of Meeting	JICA office	
4/Oct/09 (Sat)	14:00	M/M discussion		Dr. Simpungwe Dr. Msiska Dr. Dube Dr. Syakantu
7/Oct/08 (Tue)	09:00	M/M discussion (Occasional date)		
8/Oct/08 (Wed)		Joint Coordination Committee Meeting - Progress report (Dr. Simpungwe ?) - Evaluation report (Ms. Serizawa ?) - Disucussion	MOH	Dr. Miti Dr. Simpungwe Dr. Syakantu Dr. Msiska Dr. Dube Other C/P
		Sign the M/M		Dr. Miti
		Report to EoJ	EOJ	
9/Oct/08 (Thu)	7:20	Leave Lusaka (SA067)		

３．主要面談者リスト（官団員）

9 月 29 日（月）保健省（MoH）次官表敬訪問

氏名	所属
Dr. Simon K. Miti	Permanent Secretary, MoH
Dr. James Shimpungwe	Director, Clinical Care and Diagnostics Services, MoH

日本大使館表敬訪問

氏名	所属
鈴木　人司	二等書記官

9 月 30 日（火）Chongwe 郡調査

氏名	所属
Dr. Charles Msiska	Director, Chongwe DHMT
Mr. Henry Kapyata	Nurse, Kasisi RuHC
Mr. Samba Muvuma	TB/HIV Forcal Person, Chongwe DHMT 他に患者、レイカウンセラー等

10 月 1 日（水）Mumbwa 郡調査

氏名	所属
Dr. Christopher Dube	Director, Mumbwa DHMT
Mrs. Edith Sosela	Nurse, Nampumdwe RuHC
Mr. Nangana Kayama	TB/HIV Forcal Person, Mumbwa DHMT 他に患者、ヘルススタッフ等

10 月 2 日（木）ドナー動向調査

氏名	所属
Dr. P. Randy Kolstad	Population. Health and Nutrition Director, USAID （他に Ms. Chihotala、Mr. Sinyangwa）
Dr. Isaac Zulu	Chief of Clinical Research, CDC 他に Ms. Masheke, Ms. Mwinga
Ms. Catherine Thompson	Country Director, FHI - ZPCT 他に Dr. Kwasi Torpey
Dr. Stewart Reid	Medical Director, CIDRZ 他 8 名
Ms. Lotta Sylwander	Representative, UNICEF 他 Dr. Mwale, Mr. Kucita 等 5 名

10 月 3 日（金）NAC 訪問

氏名	所属
Dr. Geoffrey Chishimba	Director General, NAC

10 月 8 日（水）JCC

氏名	所属
Dr. Simon Miti	Permanent Secretary
Dr. James Simpungwe	Director, Clinical Care and Diagnostic Services
Ms. Fales Mwamba	Laboratory Specialist, Ministry of Health
Dr. Charles Msiska	Director of Chongwe DHMT
Mr. Samba Muvuma	TB/HIV Focal Person, Chongwe DHMT
Dr. Faith Chibeza	ART Coordinator, Chongwe DHMT
Dr. Christopher Dube	Director of Mumbwa DHMT
Dr. Albert Mwango	ARV Coordinator, Ministry of Health（別会場で協議）

4．JCC 調査結果報告資料

Integrated HIV/AIDS Care Implementation Project at District Level

Terminal Evaluation Findings

8 October 2008

Terminal evaluation team

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Achievement of the Project

- **Output 1: "Access to HIV counselling and testing is improved."**

	Chongwe	Mumbwa
1-1. Number of health facilities providing VCT service	Target: 29 10 (2006 Q1) 26 (2008 Q3)	Target: 29 17 (2006 Q1) 23 (2008 Q3)
1-2. Number of health facilities providing PMTCT service	Target: 29 2 (2006 Q1) 18 (2008 Q3)	Target: 29 12 (2006 Q1) 19 (2008 Q3)
1-3. Number of health facilities providing DCT service	Target: 29 0 (2006 Q1) 26 (2008 Q3)	Target: 29 0 (2006 Q1) 20 (2008 Q3)
1-4. Number of health facilities applying Finger Pricking HIV testing method	Target: 29 0 (2006 Q1) 10 (2008 Q3)	Target: 29 0 (2006 Q1) 13 (2008 Q3)

2

Output 1: "Access to HIV counselling and testing is improved."

	Chongwe	Mumbwa
1-5. Annual number of counselling and testing in VCT	Target: 3,500 694 (2005) 3,005 (2008, as of August)	Target: 4,000 1,171 (2005) 2,300 (2008, as of Q2)
1-6. Annual number of counselling and testing in PMTCT	Target: 4,000 167 (2005) 2,917 (2008, as of Q2)	Target: 5,000 2,659 (2006 Q1) 2,900 (2008, as of Q2)
1-7. Percentage of HIV tested among TB clinic	Target: 80% 0% (2006 Q1) 81% (2008 Q1), 71% (Q2)	Target: 80% 20% (2006 Q1) 77% (2008 Q1), 73% (Q2)
1-8. Percentage of HIV tested among ANC clinic	Target: 80% 100% (2006 Q1) 97% (2008 Q1), 100% (Q2)	Target: 80% 9% (2006 Q1) 85% (2008 Q1), 47% (Q2)

3

Output 2: "Quality HIV care services are strengthened and scaled-up."

	Chongwe	Mumbwa
2-1. Number of health facilities providing ART services	Target: 10 plus 4 outreach sites (2006 Q1): 2 static ART centres (2008 Q3): 6 plus 4 = 2 static and 4 mobile centres, plus 4 outreach sites	Target: 10 (2006 Q1): 1 static ART centre (2008 Q3): 8 = 2 static and 6 mobile centres
2-2. Number of health facilities which provide adherence counselling	Target: 20 2 (2006 Q1) 10 (2008 Q3)	Target: 20 0 (2006 Q1) 7 (2008 Q3)

4

Output 2: "Quality HIV care services are strengthened and scaled-up."

	Chongwe	Mumbwa
2-3. Percentage of patients on ART who are screened by CD4 count testing for eligibility	Target: 80% 100% (2008 Q2)	Target: 80% 89% (2008 Q2)
2-4. TB Treatment Success (TB Cure) rate	Target: 85% 86% (2005 Q1) 85% (2007 Q2)	Target: 85% 70% (2006 Q3) 74% (2007 Q2)
2-5. Percentage of HIV positive patients who undertook CD4 test	Target: 80% 100% (2008 Q2)	Target: 80% 100% (2008 Q2)
2-6. Percentage of TB patients who are eligible and started ART	Target: 80% 100% (2008 Q2)	Target: 80% 100% (2008 Q2)

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Output 3: "DHMT's management capacities in HIV care services are enhanced.

	Chongwe	Mumbwa
3-1. Frequency of experience sharing meetings	Target: Quarterly ART review meetings in Chongwe were held twice (June and Sept 2008).	Target: Quarterly ART review meetings in Mumbwa were held three times (Oct 2007, April and July 2008).
3-2. ORs conducted and shared at central level	Target: "Yes" A preliminary report of and OR on TB/HIV was presented by the Project in the IUATLD conference in Cape Town. (11/2007) Protocol was developed and will be approved in the MoH. ORs are being conducted and data are being analysed. Results will be presented in conferences (2008).	

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Output 3: "DHMT's management capacities in HIV care services are enhanced.

- Capacity of the DHMTs and health facilities in implementation of mobile ART services, including data management, has been strengthened.

7

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

4-1. Lessons learned by the Project are incorporated into national guideline on mobile ART services	**Target: "Yes"** **The project members participated in the NAC taskforce meeting to develop national guideline of mobile ART services (2/2008).** **The MoH has consulted the Project to learn about its mobile ART service model to be replicated in other districts. (2008)**
4-2. Number of monthly regular meetings	Target: 12 Monthly project meetings are held since September 2006. 8 meetings were held in 2008 (as of September). Meetings led to quality discussions and actions.

8

Project Purpose: "HIV and AIDS care services are improved and accessible at target districts."

1) Accessibility

	Chongwe	Mumbwa
1. Cumulative number of HIV positive case detected by VCT/PMTCT	Target: 4,000 481 (2006 Q1 only) 2,616 (2007 Q3) 4,193 (2008 Q2)	Target: 7,000 942 (2006 Q1) 3,473 (2007 Q3) 5,887 (2008 Q2)
2. Cumulative number of ART clients	Target: 2,300 235 (2006 Q1) 1,268 (2007 Q3) 1,634 (2008 Q2)	Target: 3,500 324 (2006 Q1) 1,529 (2007 Q3) 2,566 (2008 Q2)

9

Project Purpose - continued

- 2) Quality

	Chongwe	Mumbwa
3. Percentage of defaulters within 6 months among ART clients	Target: Less than 10% 3% (2007 Q4)	Target: Less than 10% 13.3% (2007 Q4)
Lost and defaulter cases within 6 months (Operational research)	9.7% in mobile ART centres	10.3% in mobile ART centres (21.6% in District Hospital)

10

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

Number and contents of interventions introduced in other districts	The MoH is planning replication of the mobile ART service model developed by the Project in 15 other districts using funding from the Global Fund.

11

Evaluation by Five criteria

- Relevance
- Effectiveness
- Efficiency
- Impact
- Sustainability

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1. Relevance

National priority

- HIV prevalence rate: 14.3% (15-49 years of age, 2007)
- National HIV/AIDS/TB/STI Strategic Plan
- Free ART services
- Needs of improved access to HIV/AIDS care services closer to the communities

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Relevance - continued

Japan's assistance policy

- HIV/AIDS response is a priority area
- Capacity development

Approach of the Project

- Use of existing systems and resources

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2. Effectiveness

Quality and accessibility to HIV/AIDS care services in rural areas has been improved. (Project Purpose)

1) Accessibility

	Chongwe	Mumbwa
1. Cumulative number of HIV positive case detected by VCT/PMTCT	Target: 4,000 481 (2006 Q1 only) 2,616 (2007 Q3) 4,193 (2008 Q2)	Target: 7,000 942 (2006 Q1) 3,473 (2007 Q3) 5,887 (2008 Q2)
2. Cumulative number of ART clients	Target: 2,300 235 (2006 Q1) 1,268 (2007 Q3) 1,634 (2008 Q2)	Target: 3,500 324 (2006 Q1) 1,529 (2007 Q3) 2,566 (2008 Q2)

15

Effectiveness - continued

- 2) Quality

	Chongwe	Mumbwa
3. Percentage of defaulters within 6 months among ART clients	Target: Less than 10% 3% (2007 Q4)	Target: Less than 10% 13.3% (2007 Q4)
Lost and defaulter cases within 6 months (Operational research)	9.7% in mobile ART centres	10.3% in mobile ART centres (21.6% in District Hospital)

- Mobile ART clients are satisfied with the services.
- Less cost and time for travel.

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3. Efficiency

- Use of existing systems and resources
- Small size of input
- Participation of community people

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Efficiency - continued

- Delay of input/activities in the first year
- Modification of activities (→ mobile ART services)
- Limitation of depending on volunteers

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4. Impact

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

Number and contents of interventions introduced in other districts	The MoH is planning replication of the mobile ART service model developed by the Project in 15 other districts using funding from the Global Fund.

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Impact - continued

- Impact on women: Improved access to ART services.
- Possibility of revision of the Accreditation Guidelines.
- Rapid increase of ART clients: a challenge in human resource constraints

20

5. Sustainability

- Policies to support HIV/AIDS care including ART services are likely to be maintained.
- Technical capacities of DHMTs/health centres have been improved. Continuous effort to sustain/improve the services is required.
- Human resource constraints.

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Sustainability - continued

Institutional sustainability

- Ownership, commitment and budgetary arrangement by the DHMTs
- Use of existing systems and resources

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Conclusions

- The Project is highly likely to achieve the Outputs and Project Purpose by the end of the Project period.
- The mobile ART service model: effective to improve accessibility to and quality of services in rural areas → to be replicated in other districts.
- Continuous monitoring and evaluation of the model is required.

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Recommendations

Measures to be taken by the Project during the Project period:

- To make efforts to reactivate the Task Force for developing the mobile ART guidelines, working closely with NAC and the MoH.
- The DHMTs to make continuous efforts towards achieving the Project target regarding the number of health facilities providing ART services. Quality of the services should be ensured.

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Recommendations - continued

- To continue improving data management of HIV/AIDS programmes.
- To proactively commit itself to contribute in the planning and implementation of newly-initiated mobile ART services in other districts for the MoH with the experiences and lessons learned.

25

Recommendations - continued

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

- 1) In order to sustain the quality of ART services while scaling them up:
  - To continue ensuring budgetary and technical support to DHMTs and RuHCs to assure the quality of mobile ART services in rural areas.
  - To monitor and evaluate continuously the mobile ART services model developed by the Project.

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Recommendations - continued

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

- 2) To promote the expansion of quality mobile ART services to rural areas in accordance with the guidelines.
- 3) To streamline HIV/AIDS programmes through DHMTs.

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Lessons learned

- Adequate duration of time of ART-supporting projects for monitoring and evaluation of results and impacts.
- Use of existing resources to ensure sustainability.
- Flexibility in project planning and implementation in rapidly changing situation of HIV/AIDS responses in Africa.
- Decentralisation of HIV/AIDS care treatment to rural health centre level for continuity of services.
- Enhancement of leadership and ownership of the programme by the host country through capacity development.

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Thank you!

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