



THANZI ("GOOD HEALTH")
(TB HEALTH ACTIVITIES IN ZAMBIA)

Second Annual Report under Tuberculosis Category to USAID CSHGP
Zambia - Eastern Province (Chipata, Lundazi, Petauke and Chadiza Districts)
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List of abbreviations and acronyms

ACS	Advocacy, Communication, and Social Mobilization
AED	Academy for Educational and Development
AIDS	Acquired Immune Deficiency Syndrome
ARI	Acute Respiratory Infection
ART	Antiretroviral Therapy
BCC	Behavior Change Communication
CBGP	Community Based Growth Promotion
CBO	Community-Based Organization
CBS	Community-Based Structures
CBTO	Community-Based Treatment Supporters
CDC	The Centers for Disease Control and Prevention
CDR	Case Detection Rate
CHAZ	Churches Health Association of Zambia
CIDA	Canadian International Development Agency
CARE	CARE International in Zambia
CNR	Case Notification Rate
COC	Chambers of Commerce
CONASA	Community-based Natural Resource Management and Sustainable Agriculture
CORE	Child Survival Collaborations and Resources Group
CSHGP	Child Survival and Health Grants Program
CSO	Central Statistical Office, Zambia
CSSA	Child Survival Sustainability Assessment
CSTS	Child Survival Technical Support
DACA	District AIDS Coordinating Advisor
DAFT	District AIDS Task Force
DFID	Department for International Development
DHO	District Health Office
DHMT	District Health Management Team
DIP	Detailed Implementation Plan
DOTS	Directly Observed Treatment Short course
EQA	External Quality Assurance
EP	Eastern Province
FBO	Faith Based Organization
FHI	Family Health International
FPP	Focal Point Person
GCPDO	Great Commission for People Development and Orphans
GDF	Global Drug Fund
GFATM	Global Funding to Fight AIDS, TB and Malaria
GRZ	Government of the Republic of Zambia
HBC	Home Based Care
HIPC	Highly Indebted Poor Countries
HIV	Human Immunodeficiency Virus
HQ	Head Quarters
HSR	Health Sector Reforms
HSSP	Health Systems Strengthening Program

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HW	Health Worker
ICMR	Integrated Child Mortality Reduction project
IEC	Information, Education, and Communication
IFAD	International Fund for Agricultural Development
IMCI	Integrated Management of Childhood Illnesses
INGO	International Non-Governmental Organization
ITAP	Integrated TB AIDS Project
KNCV	Royal Netherlands TB Association
LoP	Life of Project
MDR	Multi-drug Resistant
MoH	Ministry of Health
MTE	Midterm Evaluation
NAC	National AIDS Council
NGO	Non-Governmental Organization
NHC	Neighborhood Health Committees
NTLP	National Tuberculosis and Leprosy Program
NZP+	Network of Zambian People Living with HIV/AIDS
PACA	Provincial AIDS Coordinating Advisor
PATF	Provincial AIDS Task Force
PEPFAR	President's Emergency Plan for AIDS Relief
PHO	Provincial Health Office
PLWHA	People Living with HIV AIDS
PM	Project Manager
PMTCT	Prevention of Mother to Child Transmission
PVO	Private Voluntary Organization
PR	Principal Recipient
PRSP	Poverty Reduction Strategy Paper
QA	Quality Assurance
SCOPE- OVC	Strengthening Community Partnership for the Empowerment of Orphans and Vulnerable Children
SGBV	Sexual and Gender Based Violence project
SO	Strategic Objective
SS+	Sputum Smear Positive
STAMPP	Strengthening TB, AIDS, and Malaria Prevention Project
STD	Sexually Transmitted Disease
TB	Tuberculosis
TBLFPP	TB and Leprosy Focal Point Person
THPAZ	Traditional Health Practitioners Association of Zambia
TIPEC	Tuberculosis Integrated Project in Eastern and Central Provinces
TSR	Treatment Success Rate
TS	Treatment Supporters
UNDP	United Nation Development Program
USAID	United States Agency for International Development
VCT	Voluntary Counseling and Testing
WFP	World Food Program
WHO	World Health Organization
XDR - TB	Extremely Drug Resistant TB

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ZAMBART Zambia AIDS Related TB Organization
ZDHS Zambia Demographic Health Survey
ZESCO Zambia Electricity Supply Corporation

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Executive Summary

CARE's THANZI Project is now in its' second year of implementation. This report describes progress and achievements made toward activities according to the Detailed Implementation Plan (DIP) for the time period October 1, 2008 to September 30, 2009. The key implementing partners, the National Tuberculosis and Leprosy Program (NTLP) at the national, provincial, and district level, are working towards decreased mortality and morbidity due to tuberculosis and TB/HIV co-infection in four districts of Zambia's Eastern Province, Chadiza, Chipata, Lundazi and Petauke. The four districts were selected because they had the lowest Case Detection Rate (CDR) at 23% of estimated new smear positive cases and 30% of all new cases while the case notification was 55/100,000 and 155/100,000 respectively. However, the treatment success rate (TSR) is around 82% according to the cohort analysis at 8 months at baseline. The project objectives are:

1. To increase the CDR to 70% for newly detected sputum smear positive cases and increase CNR for new smear positive cases notified to 127/100,000
2. To increase the TSR to 85%; in line with the NTLP targets

To achieve project goals, the following three strategic objectives are to be carried out:

Objective 1: To intensify and expand systemic approaches to community-based control of TB through Directly Observed Therapy Short course (DOTS).

The project strengthened existing structures at zone and catchment levels in all 125 health centers and communities. Key activities included filling in leadership gaps at zone and catchment levels with community based TB focal persons (selected among treatment supporters) who oversee and coordinate all TB activities at the community level. The project continued to develop the capacity of service providers at the community level where a total of 348 treatment supporters and 38 Faith Based Organization (FBO) members were trained in TB DOTS and data management with 835 treatment supporters who received refresher trainings.

Objective 2: To strengthen the delivery capacity of the district and provincial TB program to address the impact of co-infection on TB.

Certified NTLP trainers trained 117 health workers in TB DOTS in order to improve service delivery and capacity to engage and support community-based TB control efforts. In addition, the project facilitated a sputum collection system created strategically situated health centers into sputum collection points. This increased accessibility and quickened the transport of sputum specimens to TB diagnostic facilities. The overall progress on sputum examined in the period marginally increased from 4,740 in Year 1 to 4,961 in Year 2. Two DHOs delayed the sputum collection point system and did not introduce results based incentives e.g. T-shirts/Chitenge like Chadiza and Petauke zones. THANZI, PHO and the two DHOs have adopted a plan to intensify TB cases detection in Chipata and Lundazi during the upcoming year.¹ In addition, the project re-activated TB/HIV coordinating bodies in all the four districts. TB/HIV coordinating bodies and initiatives such as STAMPP and ITAP increased collaboration between TB and HIV activities at all levels. This included mobile VCT, ART, referrals of TB patients to ART services, and referrals of HIV infected individuals for TB screening. The coverage on HIV infected individuals screenings for TB is very low because of a lack of available training materials for HIV and TB referrals and inadequate TB microscopy services. TB/HIV coordinating bodies and other stakeholders will strengthen this aspect to increase referrals.

Objective 3: To increase private sector participation.

Eighty company representatives were trained as treatment supporters from 32 companies registered with the Eastern Province Chamber of Commerce. The treatment supporters sensitized 823 fellow workers in the workplace in addition to 979 family members and nearby community members on TB. Company representatives made 1,466 referrals to health centers of which 146 were confirmed TB cases. Additionally, traditional healers were engaged in TB control in Chadiza District, a district with a low TB case detection rate, because health seeking behaviors among community members was strongly influenced by traditional healers. The district was divided into intervention and control sites with a total of 21 traditional healers from intervention sites trained in TB DOTS and record-keeping and 20 control sites trained

¹ At baseline, the CNR was 55/100,000. Although there was general reduction in the number of smear positive TB cases detected in Year 2 compared to Year 1 there were improvement in Chadiza (from 18/100,000 to 35/100,000) and Petauke (from 47/100,000 to 63/100,000). However, Chipata (85/100,000 to 66/100,000) and Lundazi (37/100,000 to 32/100,000) declined. This decline is attributed to low activation of the sputum collection point system and less support to treatment supporters, neighborhood health committee members and faith based organization members.

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in record-keeping only. The research was supported by the Chadiza District Health Office (CDHO), Provincial Health Office (PHO) and the Traditional Health Practitioners Association of Zambia (THPAZ). Modalities such as technical support, coordination, and monitoring were put in place to ensure research success. A progress report will be provided to all stakeholders with mid-term and final evaluations planned in the course of the project.

THANZI contributed to progress in achieving NTLP targets in the four selected districts (Chadiza, Chipata, Lundazi and Petauke of Eastern Province) as demonstrated in table below.

Table 1: Status of TB indicators in Year 2 compared to Year 1

Indicator	Year 1	Year 2
Number of Sputum smears examined	4,740	4,961
Number of Sputum smears tested positive	669	644
Case Detection Rate for new sputum positive TB	23%	22%
Case Notification Rate for new sputum positive TB cases	57/100,000	53/100,000
Cure Rate	72%	77%
Treatment Success Rate	76%	76%
Number of new smear positive cases notified TB	615	587
Number of new all forms of TB notified	1,575	1,578
Default Rate	5%	6%
Mortality Rate	12%	11%

Data source: Eastern Province NTLP annual report-2008/2009.

There was a drop in the CDR from Year 1 to Year 2 that follows a similar trend observed at the National level of a CDR of 62% in 2006 dropping to 58% in 2007, according to the Zambia Country TB profile report in 2007. The project will continue to assess the trend for the midterm evaluation. Chipata District has been sampled to investigate factors causing high default and mortality rates. The TB coordinating bodies at the provincial and district level will use results to address the situation.

THANZI cooperated with CARE's ITAP project on community sensitization with 47,055 community members benefitting from TB and AIDS and Counseling and Testing (CT). Key messages were on TB health seeking behavior and adherence to treatment. THANZI also trained the PHO, DHO, Society for Family Health (SFH), Health Communication Partnership (HCP), Network for Zambian People living with HIV (NZP+), former TB patients, treatment supporters, and CARE staff in Behavior Change Communication (BCC) and Sustainability Assessment.

A. Main Accomplishments

THANZI's key accomplishments in Year 2:

- a) Continued capacity development of staff in facilitation role and data management (including M&E).
- b) Conducted cohort survey and analysis of 40 health workers' skills in TB management
- c) Reactivated community participation in TB case identification through engagement of community based structures including 30 FBO, 125 Community AIDS Task Force (CATF) and 125 Neighborhood Health Committees (NHC).
- d) Trained 348 new treatment supporters to serve in deficit and hard to reach areas.
- e) Provided refresher trainings for 835 treatment supporters in TB and data management.
- f) Trained 117 health workers in TB and data management.
- g) Established 52 sputum collection points in health centers that were not diagnostic centers.

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- h) Supported 125 TB DOTS **corners** in all the 125 health facilities (cure rate increased from 72% in Year 1 to 77% in Year 2) and established effective monitoring system of follow-ups and referrals by linking TB patients to treatment supporters in their zones/neighborhood.
- i) Engaged National and Provincial TB/HIV coordinating body meetings where CARE's contribution to TB control was recognized.
- j) Continued to engage Eastern Province Chamber of Commerce (EPCC) in TB/HIV activities through the involvement of 32 member companies and 80 company representatives.
- k) Facilitated an evaluation of traditional healers' contributions in TB control in Chadiza District in collaboration with Chadiza District Health Office.

Through the engagement of partners such as PHO, DHO, CHAZ, SFH, THPAZ and EPCC, THANZI strengthened and consolidated monitoring systems at the community, health center, district and provincial levels for sustained TB/HIV control activities.

B. Activity Status:

Table 2: Project implementation activities, progress, and accomplishments

Objective 1: To intensify and expand sustainable community-based TB control structures in the context of TB/HIV		
Key Activities	Status of Activities	Comments
DIP log frame outline		
Output 1: Intensify Community Based Partnerships to implement TB Control activities		
1. Facilitate formation of support groups amongst PLWHA. LoP target: 125	Completed: To date, 125 new support groups formed with at least one per health facility. Total membership is 157 (95 females and 62 males). Key activities are support, community sensitization, stigma, and discrimination.	THANZI identified 24 existing groups that needed additional support and (due to its own budget limitations) linked them to other projects: ITAP, STAMPP, HCP, and World Vision.
2. Work with PLWHA groups for advocacy. LoP target: 125 PLWHA groups	Initiated: Two out of the four planned meetings were held to initiate linkages with NZP+.	THANZI worked with STAMPP and ITAP to link TB/HIV co-infected patients to NZP+ for support, counseling, testing and ARV adherence. Focus will be TB screening among HIV+ individuals in Year 3.
3. Identify schools and health posts active in TB/HIV activities. LoP target: 125	Completed: To date, at least one school and/or a health post has been identified in each of the 125 health facilities to promote BCC activities on TB control.	THANZI used schools and health facility to scale up BCC activities especially in hard-to-reach areas.
4. Facilitate NHC/FBO/PLWHA/Church and Women's Groups to hold meetings.	Ongoing: At least one meeting was held at each health facility quarterly.	More effort needed to strengthen activity because only 85 groups out of 125 regularly held quarterly meetings.
5. Share and learn best practices with FBO/PLWHA/ Church and Women's Groups. LoP target: 50	Ongoing: After training of 38 FBO members in TB DOTS and record keeping, THANZI together with PHO/DHO documented the contribution of FBO/PLWHA/Church and Women groups in TB/HIV activities.	The project would like to learn how these organizations have handled chronically ill clients as traditional institutions involved in care and support.
6. Advocate for linking of PLWHA to micro-finance institutions.	Initiated: 12 PLWHA groups across the four districts were sensitized through NZP+ on microfinance institutions that could assist with financial support to start income generating activities.	Follow-up action plan developed to identify micro-finance institutions with programs to assist PLWHA. CARE will facilitate linking of PLWHA to these micro-financing institutions to access loans to start IGAs.

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Output 2: Build capacity of volunteer health workers to generate community awareness and support TB patients and their families to fully participate in DOTS.		
1. Identify and train treatment supporters in TB DOTS and record keeping. LoP target: 400	Ongoing: To-date, 348 treatment supporters trained in TB DOTS and record keeping.	Provincial/District core trainers facilitated trainings using the latest TB manuals for treatment supporters.
2. Conduct TB DOTS refresher trainings including record keeping for treatment supporters. LoP target: 1,115	Ongoing: To-date, 835 treatment supporters received refresher training in TB DOTS and record keeping.	THANZI focused on filling skills gaps including up to date information on TB management and record keeping.
3. Identify and train church/ FBO/ Women's groups in TB DOTS for 5 days. LoP target: 50	Ongoing: To-date, 38 church/ FBO/ Women's groups were trained in TB DOTS and record keeping.	Provincial/District core trainers facilitated trainings using the latest TB manuals for treatment supporters.
Output 3: Use behavior change communications activities to increase the TB health-seeking practices of the community		
1. Conduct BCC workshop with partners, formulate strategy and adapt materials.	Completed. 19 representatives from different stakeholders were trained in BCC and a BCC strategy was developed.	BCC strategy document still in draft form
2. Identify four experts to discuss BCC for TB/HIV on local radio. LoP target: 5 shows	Completed: Four experts were identified that developed messages to be aired including implementation schedule.	
3. Air 5 TB DOTS radio programs in all districts. LoP target: 350,000	Not started.	Key messages developed by the four experts will be included in the final BCC strategy.
4. World TB/AIDS commemorations. LoP target: 25,000	Completed: To date, 47,055 people sensitized on TB/HIV key messages (Chipata 14,941, Chadiza 4,982, Lundazi 6,632 and Petauke 20,500).	ITAP and STAMPP supported this activity.

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Key Activities DIP log frame outline	Status of Activities	Comments
Objective 2: To strengthen the delivery capacity of the district and provincial TB programs.		
Output 1: Build capacity of district and provincial health workers to manage impact of co-infection on TB and build capacity of district health workers to manage DOTS-related activities.		
1. Carry out training needs assessment.	Completed: Cohort analysis of health workers' skills in TB management conducted.	Dissemination of results to PHO/DHO is planned after input from CARE US.
2. Train health workers in TB DOTS. LoP target: 160	Ongoing: To date, 117 health workers trained.	Standard NLTP training manuals used.
3. Review meeting on the establishment of sputum collection centers with PHO/DHO.	On-going: Progress report on sputum collection points system presented to the TB/HIV coordinating body for review.	52 sputum collections centers in the four districts were opened (Chipata - 7, Chadiza - 14, Lundazi - 7 and Petauke - 24).
4. Promote cross-checking of examined sputum smear slides for quality assurance (QA).	Ongoing: All four districts conducted QA visits to health center TB laboratories quarterly.	Results cross matched showed that 83% were the same while 17% were not. The results only differed in terms of number of bacilli identified in one field. For instance instead of 3+, 2+ or 1+, results showed less bacilli in one field. Follow up to health centers with slides had different results which were verified in the process of making stains and slides.
5. Develop TB DOTS support supervision guidelines and tools at health facility and district level.	Completed: The NTLTP developed guidelines which were subsequently adopted.	Consultative meeting of stakeholders reviewed guidelines. Currently, guidelines are being used by districts, provinces, and stakeholders during technical support visits to district facilities and health centers.
6. Refresher training for technical staff in TB microscopy. LoP target: 20	Initiated: PHO and THANZI agreed to share training costs.	PHO and CARE have planned to share costs. This will be done once funds are available from GRZ to PHO.
7. Help organize mobile VCT in community to increase uptake of VCT services. LoP target: 20 clinics reaching 5,500 TB suspects and patients	Ongoing: 20 health centers in all districts implemented a mobile VCT schedule.	GCPDO is providing VCT in Chipata district to support THANZI and ITAP. This will increase the number of TB patients tested for HIV and referrals for ART. See Annex 6 attached for mobile VCT schedules for four DHOs and number of clients reached.
8. Facilitate and develop procedures with PHO on sputum collection system from collection centers to TB microscopy points as a stop-gap measure to increase access to TB microscopy services. LoP target: 20 centers	Completed: PHO and DHO facilitated the establishment of 52 sputum collection centers in all districts (Chipata 7, Chadiza 14, Lundazi 7 and Petauke 24).	Two approaches promoted: <ul style="list-style-type: none"> • Sputum collection points strategically selected. Chipata and Lundazi district use this approach. • All health centers that are not TB diagnosis selected to be sputum collection points. Chadiza and Petauke implemented this approach.

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9. Strengthen district TB/HIV coordinating bodies.	Completed: All four districts have functional TB/HIV coordinating bodies.	Guidelines on composition, roles and responsibilities were framed and guide coordinating bodies. See Annex 7
10. Attend quarterly provincial TB/HIV coordination meetings. Attend national meetings twice a year.	Ongoing: The government bodies held only two meetings to date.	Terms of Reference, composition, roles and responsibilities of all stakeholders approved by the provincial TB/HIV coordinating body.
11. Attend quarterly provincial TB review meetings.	Ongoing: The government bodies called only two meetings to date.	THANZI agreed to provide supportive supervision in community health information systems for TB at health center level in response to request from DHO (Chipata, Lundazi, Chadiza and Lundazi).
12. Joint field visits with PHO (at least twice a year).	Ongoing: Two visits conducted by the PHO and CDC.	Recommendations from the visits discussed at TB/HIV provincial body for follow up and action.
13. Participate in developing the provincial strategic plan for TB DOTS (when opportunity arises).	Initiated: Planning cycle program from PHO received by CARE.	THANZI actively participated in the planning cycle launched in August, and exercise was completed.
14. Attend NTLP coordinating meetings twice a year at national level.	Ongoing: Two meetings held with CARE Zambia's Director of Health and HIV/AIDS in attendance on behalf of THANZI.	These meetings identified three key issues with national relevance: 1. intensifying infection control 2. TB case identification 3. Isoniazid prophylaxis. This is NTLP's focus. CARE offered support being key partner in TB/HIV control.
Output 2: Advocacy at the national level to influence best practices and identify issues for advocacy.		
1. Share lessons learned and identify best practices at NTLP review meetings.	Initiated: THANZI is compiling and verifying data on the engagement of treatment supporters in TB DOTS.	Documentation of the contribution treatment supporters have made in increasing TB case detection in Chadiza district, where CDR increased from 7% in Year 1 to 14% in Year 2.
2. Share lessons learned and identify best practices at provincial review meetings.	Initiated: THANZI is documenting TB case detection to assess the effectiveness of the sputum collection points system.	Assessment of the sputum collection point system contribution is planned for Year 3.
3. Facilitate stakeholder meeting to develop strategies to reach out to poor, vulnerable, and marginalized groups.	Initiated: One consultative meeting held with stakeholders PHO, DATF, all DHOs, and CHAZ.	Assessed issues limiting access to TB/HIV services and how to address issues. The agreed action points included the opening of mobile VCT services. See Annex 6.
4. Follow up stakeholder meeting on strategies to reach poor, vulnerable, and marginalized groups.	Initiated: Actions agreed upon during meeting: mobile CT and TB screening and expansion of sputum collection points in hard to reach areas.	Action plan developed to follow up with identified issues and how to assist project expansion to TB/HIV control activities to targeted beneficiaries.
5. Organize CSSA workshop.	Initiated: 25 partners identified to attend workshop.	19 (76%) attended the workshop. 24% invitees did not attend due to the restructuring in MOH.

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Key Activities DIP log frame outline	Status of Activities	Comments
Objective 3: To increase private participation in the TB program		
Output 1: Build capacity of traditional healers (TH) and private sector to adopt DOTS strategy for TB control		
1. Conduct needs assessment of TH.	Completed: Areas of focus were identified because there were no work records and low levels of participation in health center activities.	PHO/THPAZ and Chadiza District Health Management Team fully engaged in this process. Chadiza selected because of involvement of TH in TB Control program.
2. Train TH in TB DOTS in CHadiza pilot district. LoP target: 20 TH	Completed: 21 TH from intervention site trained in TB DOTS and record keeping, while 20 TH from control site trained in recording keeping only.	The NTLP Community based TB DOTS manual used in the training.
3. Follow-up meetings with trained TH in Chadiza.	Initiated: One follow-up visit conducted to both intervention and control sites.	The objective of the follow-up visit was to assess TH roles and use of data collection tools in both intervention and control sites.
4. Develop a referral system to health facilities with local companies and TH.	Completed: Referral system developed during the training of company representatives and TH.	THANZI will facilitate meetings with PH/DHO/THPAZ including EPCC to strengthen referral system through 80 trained company representatives involved in TB case detection.
5. Monitor referrals from TH to health facilities.	Ongoing: Monitoring tools developed and implemented.	Ongoing on-site mentoring of 41 TH on data collection. Assessment during follow up visits showed 20% able to record data correctly due to low literacy raters.
6. Supportive supervision of TH on quarterly basis.	Completed: Checklist developed and implemented.	See Annexes 8 and 9.
7. Adapt/develop TB DOTS monitoring tools for the workplace.	Completed: Private sector TB DOTS data tools developed and implemented.	Data collection tools implemented and scheduled for review in first quarter of Year 3. See Annex 10.
8. Identify local businesses willing to support TB/HIV collaborative activities. LoP target: 30	Completed: 32 companies identified.	32 responded and engaged exceeding target of 30 businesses.
9. Strengthen existing peer educator strategy in workplaces with TB DOTS training.	Ongoing: 32 companies engaged in the TB control program.	THANZI, in-conjunction with EPCC and PATF, will evaluate workplace policies of companies engaged in TB control to implement BCC strategy.
10. Identify and train business representatives to integrate TB/HIV workplace activities. LoP target: 100	Ongoing: 80 company representatives trained in TB DOTS and record keeping.	Will be completed by October 2009.
11. Identify 30 local businesses and solicit support for World TB and AIDS day.	Ongoing: 20 Local businesses engaged prior to commemoration of marked days. 20 provided transportation and refreshments.	Facilitated by PATF at provincial level and DATF at district level every year.

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Output 2: Collaborate with local businesses to improve outreach of TB activities into the community		
1. Identify 30 local companies to engage in TB/HIV co-infection activities.	Completed: 32 companies identified that participated in implementation of TB/HIV activities.	32 companies engaged exceeding target of 30 businesses.
2. Hold quarterly meetings with EPCC representatives.	Initiated: Planned meeting rescheduled in the first quarter of Year 2.	The EPCC fully involved in planning for supportive supervision visits to companies.

C. Impediments to progress

- Staffing at government primary health care facilities, especially laboratory technicians, in all target districts is poor.

Table 3: TB microscopy services mapping

Indicators	Baseline data	Current status
Laboratory technicians and TB microscopists	20	16
Health facilities without technical staff but with functional microscopes	20	24
Health facilities without TB laboratories facilities	40	44

- Inadequate functional TB laboratories. THANZI adopted two approaches to improve TB microscopy: (1) opening sputum collection points in all health centers in Chadiza and Petauke that are not TB diagnostic centers and (2) opening sputum collection points at strategically located health centers in Lundazi and Chipata. In addition, 40 microscopists will be trained with support from PHO and ITAP project. The first 20 trainees in TB microscopy will graduate in the second week of November 2009 with the second group trained in early January 2010.
- Inadequate screening of TB in HIV infected individuals in health facilities due to a lack of skills and on-site technical support to health workers. THANZI will strengthen NZP+, NHCs, and treatment supporters' involvement in the sensitization and referral of HIV individuals to the health centre for TB screening. THANZI's response is to advocate screening of TB for all PLWHA in all health facilities during the TB/HIV coordinating body meetings.

D. Technical assistance

- The Eastern Province project team received technical support from the ACD-Programs and the Health and HIV/AIDS Sector Director from headquarters. Support included budgeting and updates on TB/HIV interventions.
- The technical backstop based in USA, Dr. Khrist Roy provided technical guidelines on project implementation and assisted in the design of evaluation tools used in the assessment of TH's participation in TB DOTS. In addition, Dr. Roy provided guidance on project implementation during Year 2.
- The project also received technical support from Deepak Paudel, a Public Health Consultant from Nepal during a training of CARE staff (THANZI and other CARE Project staff) in BCC and CSSA skills.

E. Substantial changes: *No substantial changes.*

F. Sustainability

A CSSA workshop for partners is planned for September 2009. During this workshop, a Sustainability Framework and plan will be developed for implementation in Year 3. THANZI together with its partners has already initiated sustainable activities such as strengthening community organization structures, involving the private sector, opening sputum collection points, and promoting key messages of TB/HIV co-infection prevention, care and support through the BCC strategy.

G. Specific Information: *No specific information.*

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H. Monitoring Indicators & Benchmarks

1. Table 4: THANZI TB DOTS commitments compared to National and WHO targets

	Populations	Notification Rate new ss+/100,000	Case Detection rate (all new cases, %)	Case Detection rate (new ss+ cases, %)	Treatment success rate	DOTS Geographic Coverage
THANZI Project Commitment	1,045,684	127/100,000	70%	70%	85%	100%
National targets (reported in 2007)	11,922,000	112/100,000	74%	58%	85%	100%
WHO targets			80%	70%	85%	100%

Data source: WHO Global Health Atlas-2008 Country profile-2007

2. THANZI conducted a cohort analysis of health worker skills in TB and data management at health facility and district level. Results will be shared separately as soon upon review and validation by MoH officials at provincial and district level.
3. As indicated in the approved DIP for THANZI, a survey on Doer and Non-Doer on two selected behaviors was conducted. The chosen behaviors are TB patients taking a HIV test (20 Doers-TB patients that took HIV test and 20 Non-Doers did not) and health workers routinely ask for cough in all adults 15 years and above who seek medical services from the health centre or OPD. 20 Doers- health workers routinely asked for cough in all adults 15 years and above who seek medical services from the health centre or OPD and 20 Non Doers who did not). The findings are included in Annex 5.

I. Management Systems

1. Financial management system and budgeting

Salaries and Benefits: The planned national and international staff is paid by THANZI in line with the approved budget.

Travel: THANZI did not undertake any international travel during the period under review. However, planned local travel within the project area to support project activities and project staff was undertaken.

Supplies and Equipment: Funds were spent on the following project activities and equipments:

- Training supplies
- Stationary and office supplies
- Project workshops and meetings
- Two motorcycles and one motor vehicle for project

Contractual: THANZI obtained TA for the CSSA and BCC workshop for Training of trainers (TOT) from Deepak Paudel, a Public Health Consultant from Nepal. The objective of this consultancy was to build the capacity of project staff in CSSA and BCC as well as to train them on how to train others in BCC and CSSA.

Other: As planned, resources were spent on fuel, vehicle repairs and maintenance, and office utilities. All these expenditures were in accordance to the approved and allocated budgets.

Burn Rates: The project burn rates are in line with plans with execution of nearly all key activities and procurement (delayed from year one due to the need to seek a waiver) of the project vehicle during the period under review.

Budget for Activities Projected for Year Three: It is expected that in Year Three, US\$49,613 will be spent on field activities. See Annex 2.

2. Human Resources: THANZI continued to receive technical support from the CARE USA team based in Atlanta and CARE International Zambia Country Office. Technical support was mainly in the areas of administration, financial management, and project management. From the CARE Zambia Country Office, support was in the areas of day to day program management as well as provision of administrative and financial oversight for the project. The support provided by both Project Technical Advisor and CARE Zambia Country office greatly helped ensure timely implementation project activities. The Technical Advisor also played an active role in identifying the consultant for the CSSA and BCC for the project. In addition, TA actively participated in the Training of Trainers workshop on CSSA and BCC for Project Team members.

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The TB Program Manager has continued to effectively execute the affairs of the project and provide technical oversight on program issues to team members on a daily basis. In addition to the TB Program Manager, other staff for the project include: Clinical Training/Monitoring and Evaluation Coordinator (1), Development Coordinator (Field Officers) (4), and Finance and Administrative Officer (2) and a Driver. In order to ensure that the project staff stays apprised of current trends in programming, THANZI holds quarterly review meetings where technical guidelines and updates are shared with team members. These meetings are usually held in collaboration with the Ministry of Health.

3. *Communication Systems and Team Development:* During the period under review, the TB Program Manager attended M&E training and the Clinical Training/M&E Coordinator attended M&E refresher training. CARE Zambia has upgraded the internet communications infrastructure in the Eastern Province to ensure access for all staff. With this in place, staff utilizes technical websites such as www.tbvrc.org and www.childsurvival.com to download relevant and up-to-date material.

J. Local Partner Organization Collaboration and Capacity Building

THANZI maintains a positive relationship with all participating partners and ensures communication and collaboration at all times. The main partners include the MoH/NLTP at National, Provincial, District, and Health center levels, CDC, CHAZ, THPAZ, Center for Infectious Disease and Research of Zambia (CIDRZ), HCP, NZP+ and the EPCC. In particular, THANZI enhanced the capacity of local partners in areas such as BCC and CSSA. Additionally, partners were trained in TB DOTS and data management. Collaboration with partners has been through conducting trainings for both health workers and the community; sensitization of the community on TB-HIV; conducting joint supportive supervision to health centers and the community; and joint planning. Trainings have resulted in effective collaboration and coordination between THANZI and its partners. In addition, THANZI has engaged partners in project review meetings to discuss project performance and review project activities. THANZI has been working closely with MoH in all activities since the MoH is the custodian of health service provision in Zambia. The role of the MoH is provision of technical staff, drugs, microscopy services in health institutions, and technical expertise during trainings and field visits. During the period under review, THANZI worked with partners in capacity building activities such as BCC and CSSA trainings to strengthen collaboration and effective activity implementation. Apart from engaging outside partners, THANZI worked with other CARE projects such as STAMPP, ITAP and SCOPE-OVC to strengthen synergies and leverage resources to maximize benefits for targeted beneficiaries.

Government Coordination and Collaboration

THANZI has actively engaged the MoH and partners in all activities. At district level, CARE's District Coordinators continue to play a key role in facilitating the TB-HIV coordination body meetings held in collaboration with the DHO. The meetings facilitate coordination among all involved in TB-HIV activities at district level. In addition, the meetings result in leveraging additional resources from all partners including THANZI and harmonizing activities at district level thus avoiding duplication of efforts.

At Provincial level, THANZI was represented both the Provincial TB-HIV Coordination body and Provincial TB Review meetings. The meetings have greatly improved coordination among key partners involved in TB-HIV in the province. During quarterly meetings, the provincial TB situation is reviewed and strategies to address identified gaps are developed. THANZI, in collaboration with partners conducted quarterly supportive supervision visits to all 125 sites. In addition, THANZI engaged partners in activities such as trainings and quarterly review meetings.

At National Level, THANZI is represented at the NLTP Review and National TB-HIV Coordination meetings.

K. Mission Collaboration

During the period under review, THANZI retained Dr. George Sinyangwe, the designate in-country CTO, informed of developments. However, a face-to-face meeting was not possible because of conflicting schedules and distance between THANZI's operational area, Eastern Province, and the USAID office in Lusaka. Where necessary, the Lusaka-based Health and HIV/AIDS Director for CARE Zambia will meet with the CTO. Finally, THANZI plans to invite the mission to participate in the MTE, scheduled for May 2010.

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ANNEXES

Annex 1: M&E Table

Goal: To decrease morbidity caused by tuberculosis, in the context of HIV co-infection selected districts of Zambia's Eastern Province

Objectives	Impact Indicators	Baseline	Progress of indicator	Target (EOP)	Verification of data	Frequency	Explanation or Reference
1) To increase the CDR to 70% for newly detected sputum smear positive cases.	1.1 Increase # or % of New Pulmonary Smear Positive CDR to 70%.	23%	CDR for New smear positive coverage is 23%	2 nd Year target 48%	NTLP district annual reports	Annual	The actual TB SS+ cases reduced slightly from 615 to 587. Total TB cases slightly increased from 1,563 to 1,587. This trend was observed at National level. Ref: WHO Global Report 2008; WHO Anti Tuberculosis Drug Resistance in the World Report, 2008.
2) To increase the TSR to 85% according to the NTLP target.	1.2 Increase # or % New Smear Positive Cases notified to 127/100,000	55/100,000	CNR coverage of New Smear positive increased to 53/100,000	2 nd year target 119/100,000	NTLP district annual reports		
	1.3 Increase # or % All new TB cases notified to 425/100,000	155/100,000	CNR coverage of All new TB cases reduced to 145/100,000	2 nd year target- 155/100,000			
3) To reduce mortality rate by 50%.	1.4 Reduce # or % TB patients dying from any cause during treatment (Mortality Rate) by 50%	10%	MR reduced to 11% in Year 2 compared to 12% in Year 1, a decline of 1%	Less than 5%	NTLP district annual reports	Annual	The mortality rate had a down trend in Year 2 compared to Year 1.

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Strategic Objectives	Performance Indicators	Baseline	Progress of indicator	Target	Verification of data	Frequency	Explanation or Reference
S.O.1: To intensify and expand sustainable community based TB control structures in the context of TB/HIV.	1.1 At least 125 (100%) NHC committees strengthened and disseminating TB and TB/HIV information.	8%	64 (51%) of 125 NHC committees active	100%	NHC reports	Annually	Strengthened skills of NHC members in BCC
	1.2 At least 25% (13) out of 50 designated community structures/ FBOs/Women groups disseminating TB and TB/HIV information.	10%	10 (20%) out of 50 FBO/Women groups disseminated information on TB/HIV	25%	FBOs/Women/ DHO quarterly reports on IEC		FBOs/Women groups engaged in the BCC plan.
	1.3 Increase number of TB suspects referred by treatment supporters to the health centre.	No data	2,105 TB suspects referred for sputum examination	Compared with previous year	Community based quarterly reports	Annually	Data collected after training and refresher training in record keeping in Year 2. Comparison will be done in Year 3.
S.O.2 To strengthen the capacity of district and provincial TB program to implement DOTS and address the impact of co-infection.	2.1 Proportion of new smear positive cases cured.	72%	77% (396) New Smear positive patients were cured out of 512	85%	NTLP district reports	Annual	NTLP target for Cure Rate (85%)
	2.2 Proportion of All TB patients that defaulted.	5.3%	6% TB patients defaulted above the NTLP target of less than 5%	Less than 5%	NTLP district annual reports	Annual	Follow up and defaulter tracing to be strengthened.
	2.3 Increase from 53% to 80% number of new TB patients tested for HIV.	53%	Increased to 71% (1,132) out of 1,587 all new TB cases tested for HIV. Non CARE supported districts in the province, Nyimba (67%) and Chama (45%)	80%	NTLP district annual reports	Annual	A good performance above the NTLP target of 37% due to increased TB/HIV integration activities.

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Strategic Objectives	Performance Indicators	Baseline	Progress of indicator	Target	Verification of data	Frequency	Explanation or Reference
	2.4 Increase number or % of all TB patients who tested HIV+ and referred for ART services.	37% (275/748)	Increased to 54% (616) of 1,132 tested HIV+ and 49% (299) were put on ART	80%	DOTS TB and HIV program, PEPFAR records	Annual	Smart care data software developed by MOH being fine tuned for methodology to include data on TB.
	2.5 Increase # of sputum smears done in the year from 4,740 to 70,000.	4,767	Increased to 9,631 cumulative	70,000	NTLP reports	Annual	Coverage increased from 4,740 in Year 1 to 4,961 in Year 2.
	2.6 Proportion of TB suspects tested who were sputum smear positive in the year.	17%	13% (638/4,891) suspects found smear positive	Expected result <15%	NTLP district annual reports	Annual	Coverage within the range. Continue strengthening quality control system.
	2.7 Proportion of smear positive TB cases notified should be at least 70% of total number of all TB cases reported in period of review.	32%	37% (587) smear positive cases diagnosed out of 1,587 all TB cases	70%	NTLP district annual reports	Annual	More effort needed to increase coverage to meet the NTLP target. Refer to revised work plan.
	2.8 100% of smear slides sent by facilities to the district main TB lab for quality control in the year.	No data	515 (83%) slides crossed matched had same results out of 617 during QA ²	100%	Laboratory reports on QA monitoring	Annual	QA visits will be strengthened in all districts and orientation of TB microscopy is planned in Year 3.

² Results cross matched showed that 83% were the same while 17% were not. The results only differed in terms of number of bacilli identified in one field. For instance instead of 3+, or 2+ or 1+, results showed less bacilli in one field. Follow up to health centres that had slides that had different results was made for verification of the process of making the stains and slides.

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	2.9 At least 2 joint supervisory visits conducted by TBLFPP per district annually.	Nil	2 out of 2 joint supportive supervisory visits conducted	2/year	Supportive supervisory visit reports	Annual	Recommendations from field visits discussed during Provincial TB/HIV coordination meeting.
S.O.3 To increase private participation in TB program.	3.1 At least 100% (30) local companies participate in DOTS activities.	No data	(Above 100%) 32 of targeted 30 actively participated in TB DOTS	100%	Private sector community based reports	Annually	More companies engaged than the target.
	3.2 At least 75% (22) of 30 local business support TB/HIV activities.	10%	40% (12) of targeted 30 local business support TB/HIV activities	75%	Private sector community based reports and DATF		Local businesses supported World TB or AIDS days
	3.3 At least 100% (20) TH actively refer suspected TB patients to health centre and disseminate TB/HIV information.	No data	41 TH in both intervention and control sites trained.	100%	TH TB registers		Data collection tools developed and implemented by TH.

Strategic Objectives	Output performance Indicators	Baseline	Progress of indicator	Target	Verification of data	Frequency	Explanation or Reference
1. Sustainable community based partnerships to implement TB control activities							
S.O.1.1 Intensify community based partnerships to implement TB control activities.	1.1.1 At least 75% (37) of 50 Church groups/FBO/ Women Organizations actively involved in TB/HIV activities.	10%	30 (60%) of 50 actively involved in TB DOTS	75%	FBOs/Women/DHO quarterly reports on IEC	Annually	FBOs/Women groups engaged in BCC plan.
	1.1.2 At least 100% attend community based TB/HIV coordinating committee meeting held each month at each health facility.	No data	79 (63%) of 125 held meetings	2 x 125 committees	Minutes	Biannually	The challenge to form 125 TB/HIV coordinating bodies is the need for resources at community level. To date, only 79 out 125 have been formed.

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S.O.1.2 Train and support treatment observers.	1.2.1 Train 80 % (400) of 500 untrained treatment supporters in DOTS.	No data	348 (87%) treatment supporters trained in TB DOTS	80%	Community based TB DOTS training directory	During training	The project is on course in training new treatment supporters.
	1.2.2 100% support to the 1,115 (old and new) treatment supporters.	No data	835 old and 348 new treatment supporters supported	100%	Support supervision reports	Biannually	Support supervision checklist for treatment supporters developed and implemented.
S.O.1.3 Use BCC activities to increase TB seeking practices in the community.	1.3.1 Increase % or # of TB suspects referred by community members to the health facility for sputum examination.	No data	2,105 TB suspects referred to the health facility	Compared to the previous year (no data was available)	Community based TB registers, TB cards, quarterly reports	Biannually / annually	Comparison of treatment supporters' contribution in TB case detection will be reviewed quarterly and annually.
	1.3.2 Collect and adapt BCC tools available in the Country.	No data	BCC strategy developed during the stakeholders training in BCC	1	BCC monitoring reports	Annually	BCC strategy document still being finalized and expected to be ready the third week of October 2009.
	1.3.3 At least 90% (1,003) of 1,115 treatment supporters effectively using BCC tools to create awareness on TB and DOTS.	30%	BCC tools developed	90%	BCC monitoring reports	Annually	

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2. District and Provincial TB program capacity building and coordination to implement DOTS and address the impact of co-infection on TB							
S.O.2.1 Build capacity of district and provincial health workers to manage impact of co-infection on TB.	2.1.1 Train 100% (8) District TB/HIV focal persons in TB DOTS programming.	50%	All 100% (8) District TB focal point persons trained in TB DOTS	100%	TB DOTS training Directory	During training	District TB/HIV focal point persons provide technical support to Districts.
	2.1.2 Train 50% (150) of 300 (Nurses/Clinical Officers/Doctors) in TB DOTS.	18%	73% (117) of 150 health workers trained in TB DOTS	50%			NLTP TB DOTS manuals used in the training. These make extensive reference to TB and HIV/AIDS.
	2.1.3 Open 20 sputum collection centers.	No data	52 sputum collection points opened	20 sputum collection points	PHO/DHO meetings		DHO/Project reviewed sputum collection system and agreed to explore 2 strategies.
	2.1.4 At least 100% (125) TB DOTS focal point persons report cohort analysis correctly and on time	No data	To be done at least with first after MTE	100%	NLTP reports	Annually	Cohort Analysis Skills of health study completed and draft report concluded.
	2.1.5 100% support supervision visits and follow ups to 125 health facilities quarterly.	Nil	At 105 (84%) health centres received technical supervision of 125.	100%	Support supervision reports	Annually	Integrated support supervision with other partners and projects like ITAP.
S.O.2.2 Spearhead the activation of TB collaborative bodies at provincial and district level by encouraging agencies working on TB and HIV.	2.2.1 100% attendance in all TB Partnership meetings at District, Provincial, National level.	Nil	Attended four meetings	2/year	Minutes	During meetings	Increased TB/HIV collaboration improved TB/HIV coordination.
	2.2.2 100% held biannual TB review meetings by key stakeholders (NLTP, THANZI Project/DHO/MOH.	No data	Attended three meetings	4/year (100%)	Minutes/reports	During meetings	

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S.O.2.3 Advocacy at national level to influence best practices and disseminate lessons learned.	2.3.1 One THANZI presentation at national, province, and district level after each evaluation.	No data	To be done possibly after MTE or FE		TB Monitoring reports Progress reports		Cohort Analysis Skills of health study completed and draft report concluded. Operation Research on TH contribution in TB control is being done in Chadiza
3. Private participation in the TB control program							
S.O.3.1 Build capacity of TH to adopt DOTS strategy for TB treatment.	3.1 Identify 20 TH to actively participate in TB DOTS.	NA	20 TH identified in the intervention site and 20 in the control site. Note: OR is only being done in Chadiza district.	100%	TH training directory	During training	21 TH from the intervention site identified and trained in TB DOTS and record keeping while 20 trained in record keeping only.
	3.2 Train 100% (20) TH in TB DOTS.		21 TH from intervention site identified and trained in TB DOTS and record keeping while 20 trained in record keeping only.	100%	Traditional healers training directory	During training	As referred in DIP, OR has been instituted in Chadiza district to assess the contribution TH in TB control. Intervention and control sites were selected.
S.O.3.2 Collaborate with local businesses to improve outreach of TB activities into the community.	3.2.1 Identify 30% (30) of 100 local businesses registered by Chamber of Commerce and partner with PHO/DHO/project to improve TB outreach services.	No data	32 of the targeted 30 companies identified and participated.	30%	Private sector community based reports and DATF	Annually	Private sector TB DOTS structure developed with full participation of the EPCC. Private sector contributed to an increase in identification of all forms of TB cases from 1,575 in Year 1 to 1,587 in Year 2. ³
	3.4 Orient at least 100 company representatives in TB DOTS.	24%	80 (80%) of 100 were trained in TB DOTS	100 trained		During training	

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Annex 2: Workplan for Year Three October 2009/2010

S/NO	Major Activity	YEAR 3: 2009/10				Responsible staff	Budget
		Q1 O-D	Q2 J-M	Q3 A-J	Q4 J-S		
SO1: To intensify & expand sustainable community based TB Control structures in the context of TB/HIV							
Advocacy and Coordination							
1.1	<i>National/Provincial level</i>						
1.1.2	Attend NTLP coordinating meetings twice a year at national level		x		x	Project Manager	-
1.1.3	Attend NTLP review meetings semi-annually at national level		x		x	Project Manager	-
1.1.4	Attend Province Program TB/HIV Quarterly Review meeting	x	x	x	x	Project Management Coordinator	676
1.1.5	Facilitate meetings with DHOs to strengthen sputum collection system as a stop gap to increase access to TB microscopy	x	x	x	x	Project Management Coordinator	-
1.1.6	Advocate for linking of PLWHA to micro-finance institutions and build on the pilot experiences of IGA		x			Project Management Coordinator	-
1.1.7	Share lessons learned and identify best practices at NTLP review meetings	x				Project Manager	-
1.1.8	Share lessons learned and identify best practices at provincial review meetings	x				Project Management Coordinator	-
1.1.9	Facilitate a stakeholders meeting to develop strategies to reach out to the poor, vulnerable, and marginalized groups	x	x			Project Management Coordinator	540.50
1.1.10	Facilitate a follow up meeting with stakeholders on strategies to reach out to the poor, vulnerable, and marginalized groups		x			Project Management Coordinator	540.50
1.1.12	Follow up of CSSA implementation plan		x		x		-

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1.2	<i>District level</i>						
1.2.1	Facilitate a stakeholders meeting to develop strategies to reach out to the poor, vulnerable, and marginalized groups		x			District Development Coordinator	-
1.2.2	Facilitate a follow up meeting with stakeholders on strategies to reach out to the poor, vulnerable, and marginalized groups		x			District Development Coordinator	-
1.2.3	Link PLWHA support groups to NZP+ district office. Targeted: 16	x	x			District Development Coordinator	-
1.2.4	Study DOTS TB data for gender equity in diagnostic, managerial and treatment outcomes	x	x			M&E Coordinator	1,200.00
1.2.5	FGD with Women Groups on TB and gender equity	x	x			M&E Coordinator	-
1.2.6	Advocate for gender equity in DOTS TB control			x		PMC/District Development Coordinator	-
1.3	<i>Health/Community level</i>						
1.3.3	Facilitate formation of support groups amongst PLWHA. Targeted: 125	x	x			District Development Coordinator	-
1.3.4	Work with PLWHA groups for advocacy. Targeted: 125	x	x			District Development Coordinator	-
1.3.5	Identify schools and health posts active in TB/HIV activities. Targeted: 125	x				District Development Coordinator	-
1.3.6	Facilitate NHCs/FBOs/PLWHA/Church and Women Groups quarterly meetings.	x	x	x	x	District Development Coordinator	2,162.00
1.3.7	Share and learn best practices with FBOs/PLWHA / Church and Women Groups Targeted: 50		x	x	x	District Development Coordinator	-
1.3.8	Advocate for linking of PLWH to micro-finance institutions	x	x			District Development Coordinator	-
1.3.9	Strengthen the existing referral system from TS/TH to HF and from HF to TS/TH in Chipata.	x	x			District Development Coordinator	-

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1.4	Capacity Building: Community Level						
1.4.1	Community level						
1.4.1.1	Identify and train 52 treatment supporters in TB DOTS including recording keeping in 125 HF(5)days	x	x			District Development Coordinator	5,000.00
1.4.1.2	Conduct TB DOTS refresher training including record keeping for 555 treatment supporters in TB DOTS for 2 days.	x	x			District Development Coordinator	1,622.00
1.4.1.3	Identify and train 10 churches/FBOs/Women groups in TB DOTS including record keeping for 5 days.	x				District Development Coordinator	2,000.00
1.5	BCC Strategy						
1.5.1	Provincial level						
1.5.1.1	Identify 4 experts to discuss BCC on TB/HIV on radio	x				Project Management Coordinator	-
1.5.1.2	Develop BCC key messages for radio program	x				Project Management Coordinator	-
1.5.1.3	Facilitate IEC distribution from NTLP to the project.	x	x			Project Management Coordinator	-
1.5.1.4	Participate in World TB and AIDS Day commemoration	x	x			Project Management Coordinator	-
1.5.2	District level						
1.5.2.1	Identify experts to discuss BCC on TB/HIV on radio	x				District Development Coordinator	-
1.5.2.2	Air 5 series of TB DOTS programs in all 3 strategic districts with radio stations. Targeted: 1,045,684 people	x	x			District Development Coordinator	1,027.00
1.5.2.3	Distribution of IEC materials to 125 HFs	x	x			District Development Coordinator	-
1.5.2.4	Conduct Radio 5 quiz on TB DOTS	x	x			District Development Coordinator	-
1.5.2.5	Participate in World TB and AIDS Day commemoration	x	x			District Development Coordinator	1,000.00
1.5.3	Health/community level						
1.5.3.1	Conduct BCC activities such as distribution of IEC materials and drama performances	x	x			District Development Coordinator	-
1.5.3.2	Drama performances 12 sessions/year/ HF in all the 125 HF on BCC. Targeted: 1, 045,684	x	x	x	x	District Development Coordinator	500

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1.5.3.3	World TB and AIDS Day commemoration. Targeted: 350,000	x	x			District Development Coordinator	581
1.5.3.4	Facilitate sharing of experiences of TB disease cured and PLWHA during World TB/AIDS Day commemoration.	x	x			District Development Coordinator	
2.1	Provincial level						
2.1.1	Participate at the provincial level PHO/NLTP meetings and program review meetings	x	x	x	x	Project Management Coordinator	-
2.1.2	Joint field visits with PHO (at least twice a year)		x		x	Project Management Coordinator	1,200.00
2.1.3	Participate in Province Strategic Plan for DOTS/TB (as and when opportunity dictates)				x	Project Management Coordinator	-
2.1.4	Facilitate meetings at PHO to monitor sputum collection system from collection centers to TB microscopy points as a stop gap to increase access to TB microscopy	x	x	x	x	Project Management Coordinator	-
2.2	District level						
2.2.1	Participate at the district level NTP review meetings	x	x	x	x	District Development Coordinator	5,086.00
2.2.2	Joint field visit with DHO (at least twice a year)		x		x	District Development Coordinator	1,200.00
2.2.3	Participate in district Strategic Plan for DOTS/TB (as and when opportunity dictates)				x	District Development Coordinator	-
2.2.4	Establish sputum collection points in strategic sites and monitor the system	x	x	x	x	District Development Coordinator	-
2.2.5	Review meeting on the establishment of sputum collection centers with PHO/DHO	x		x		District Development Coordinator	-
2.2.6	Promote cross checking of examined sputum smear slides for quality assurance	x	x	x	x	District Development Coordinator	-
2.3	Health centre level						
2.3.1	Train 43 health workers in TB DOTS including recording and reporting of data aimed at TB and HIV integration at HF level	x	x			District Development Coordinator	6,757.00
2.3.2	Conduct refresher training for 140 health workers in TB DOTS including recording and reporting of data		x	x		District Development Coordinator	5,405.00
2.3.3	Conduct quarterly review meetings and supervision CBOs/FBO	x	x	x	x	District Development Coordinator	1,000.00

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2.3.4	Health centre and community based TB/HIV coordinating committee quarterly meetings (activity to review, compile, and analyze TB data)	x	x	x	X	District Development Coordinator	3,243.00
2.3.5	Refresher training for 20 technical staff in TB microscopy including recording and reporting of data	x	x			District Development Coordinator	1,470.00
2.3.6	Monitor referrals of TB suspects from TS/TH to the health facilities	x	x	x	x	District Development Coordinator	-
2.3.7	Joint review meeting on TB microscopy services with DHO (at least twice a year)	x		x		District Development Coordinator	-
2.3.8	Help coordination committee for HIV/TB to organize TB/HIV clinical meetings biannually	x		x		District Development Coordinator	3,243.00
2.3.9	Help organize 20 mobile VCTs in the community to increase uptake of VCT services to 5,500 TB patients through complimentary project, ITAP	x	x	x	x	District Development Coordinator	-
3.1	Provincial level						
3.1.1	Facilitate quarterly meetings with private companies involved in the TB program	x	x	x	x		1,011.00
3.2	District level						
3.2.1	Strengthen the existing peer educator strategy in workplaces with training in TB DOTS.	x				District Development Coordinator	-
3.2.2	Identify and train 20 business representatives in TB DOTS to integrate TB/HIV workplace activities	x				District Development Coordinator	1,400.00
3.2.3	Support supervision of trained company representative (treatment supporters) quarterly	x	x	x	x	District Development Coordinator	1,000.00
3.2.4	Identify local businesses and solicit support for World TB and AIDS day commemoration	x	x			District Development Coordinator	-
3.2.5	Monitor referrals from TH to health facilities	x	x	x	x	District Dev Coordinator	-
3.2.6	Support supervision of Traditional Healers quarterly		x			District Development Coordinator	749

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1	Monitoring Plan						
1.1	Provide quarterly M&E support to districts	x				M&E Coordinator	-
1.2	Conduct cohort survey of health workers skills in TB management follow up			x	x	M&E Coordinator	-
1.3	Submit quarterly reports at district level	x	x	x	x	District Development Coordinator	-
1.4	Carry out gender and equality survey among TB patients in four districts	x	x			M&E Coordinator	-
1.5	Submit biannual reports at provincial level	x		x		Project Management Coordinator	-
2	HMIS						
2.1	Collect data from HMIS for documentation of annual reports.	x				M&E Coordinator	-
3	Evaluations						
3.1	Preparation for mid-term survey	x				Project Management Coordinator	-
Total Budget for Activities							49,613.00

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Annex 3: Social Behavior Change Strategy for New Partners

THANZI completed a BCC workshop with stakeholders in May 2009. A BEHAVE Framework was developed with support from the MOH and stakeholders such as Society For Family Health, HCP, DHO, NZP+ , Radio Breeze, former TB patients and treatment supporters. The BCC strategy document is still being developed and expected to be completed by the third week of October 2009. During the workshop the participants developed the BCC strategy that included identification of key behaviors, Doer and Non Doer, analysis and formulation of the BEHAVE Framework to be included in the overall BCC strategy.

The key behaviors identified were:

- TB patients who are aware of TB/HIV co-infection (or else who were advised to take an HIV test) do not take HIV test
- Health workers who do not routinely ask for cough in adults 15 years and above who seek medical attention at the health centre and OPD.

The first behavior: TB patients who are aware of TB/HIV co-infection (or else who were advised to take an HIV test) that did not take HIV test. A total of 40 TB patients were interviewed: 20 Doers (TB patients that tested for HIV) and 20 Non Doers (TB patients that have not taken HIV test). The tool below was used to investigate the barriers to behaviors among TB patients that are aware of TB/HIV co-infection (or those who were advised to take an HIV test) that did not take HIV test.

1. What do you see as advantages or good things that would happen if you went for HIV test?
2. What do you see as the disadvantages or bad things that would happen if you went for HIV test?
3. What would make it easier for you to go for HIV test?
4. What would make it more difficult for you to go for HIV test?
5. Who would approve or support you if you went for HIV test?
6. Who would disapprove or object if you went for HIV?
7. Which of these individuals or groups in either of the two of the two questions above is **most important** to you?

The key barriers identified were:

- Fear to be stigmatized when seen testing for HIV.
- Fear to test for HIV because TB is associated with HIV.
- Disclosure of HIV status to partners was a challenge.
- Fear testing HIV positive when past sexual history was risky

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Table 5: Doer and Non Doer Analysis of Results

Doer and Non Doer Analysis: TB patients who are aware of TB/HIV co-infection do not take HIV test

<i>Research findings</i>	<i>% Doers</i>	<i>% Non-doers</i>	<i>Implications</i>	<i>Program focus?</i>		
				<i>Y</i>	<i>N</i>	<i>?</i>
Advantage: prolongs life if put on ARV	85%	83%	same		✓	
Disadvantage: Fear of being stigmatized and discriminated	38%	55%	different likely to be important	✓		
Easier: if sure of being negative	54%	65%	different likely not to be important		✓	
Difficult: Fears of being positive if sexual activities have been risky	18%	46%	difference; try to reach partners			✓
Approve: Spouse	36%	58%	different likely to be important	✓		
Disapprove: No one	6%	34%	difference; try to reach partners			✓
Most Important: Wife and husband	64%	30%	different likely to be important	✓		

The second behavior: health workers who do not routinely ask for cough in adults 15 years and above who seek medical attention at the health centre and OPD. A total of 40 health workers were interviewed. 20 Doers were health workers that routinely ask for cough in all adults 15 years and above who seek medical attention at the health centre or OPD. The hypothesis was that health workers from Chadiza and Chipata districts were grouped together as Doers because of increased number of slides of TB suspects examined in Year 2 compared to Year 1. While 20 Non doers were health workers from Petauke and Lundazi that recorded reduced number of slides examined in Year 2 compared to Year 1⁴ Petauke. The tool below investigated the barriers to the behavior among health workers who do not routinely ask for cough in adults 15 years and above who seek medical attention at the health centre and OPD.

1. What do you see as **advantages** or good things that would happen if you asked cough for more than two weeks in all adults 15 years old and above that seek medical attention at the health facility?
2. What do you see as the **disadvantages** or bad things that would happen if you asked for cough for more than two weeks in all adults 15 years old and above that seek medical attention at the health facility?
3. What makes it **easier** for you to ask for cough for more than two weeks in all adults 15 years old and above that seek medical attention at the health facility?
4. What makes it **more difficult** for you to ask for cough for more than two weeks in all adults 15 years old and above that seek medical attention at the health facility?
5. Who would **approve** or support you if you asked for cough for more than two weeks in all adults 15 years old and above that seek medical attention at the health facility?
6. Who would **disapprove** or object if you asked for cough for more than two weeks in all adults 15 years old and above that seek medical attention at the health facility?
7. Which of these individuals or groups in either of the two of the two questions above is **most important** to you?

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The key barriers identified were:

- Not knowing the importance of asking for cough
- Fear to stigmatize patients because TB is associated with HIV.
- Work over load to ask for cough in patients who had not complained of cough.
- Asking for cough in adults 15 years was wasting time because there are a lot of patients waiting to be attended to.

Table 6: Doer and Non Doer Analysis: Health Workers who do not routinely ask for a cough among OPD patients above 15 years

<i>Research findings</i>	<i>% Doers</i>	<i>% Non-doers</i>	<i>Implications</i>	<i>Program focus?</i>		
				<i>Y</i>	<i>N</i>	<i>?</i>
Advantage: Saves patients	78%	80%	same			✓
Disadvantage: More people will be infected with TB because there will be a lot of undetected TB in community.	38%	55%	different likely to be important	✓		
Easier: More staff	54%	65%	different likely not to be important		✓	
Difficult: Work overload	24%	56%	difference; try to reach partners			✓
Approve: DHOs	36%	58%	different likely to be important	✓		
Disapprove: Patients feel stigmatized when asked for cough when they did not present complains not related to cough.	12%	40%	difference			✓
Most Important: DHOs	60%	42%	different likely to be important	✓		

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In order to promote positive behaviors among the selected groups on the two identified behaviors, the project together with stakeholders developed the BEHAVE Framework and the Monitoring Plan below.

Table 7: BEHAVE Framework

Priority Group	Behavior	Key Factors	Activities
<p>TB patients aware of TB/HIV co-infection (or else advised to take an HIV test) do not take HIV test.</p> <p>Supporting groups: family members, treatment members, health workers.</p>	<p>TB patient take HIV test</p>	<ul style="list-style-type: none"> • Address fear of stigma among TB patients • Address fear to test for TB even if TB associated with HIV • Address fear of disclosure of HIV status to partners • Reducing fear of testing HIV positive with past risky sexual history • Increasing knowledge of the risks of co-infection • Increasing knowledge of the benefits of TB patients to know HIV status 	<ul style="list-style-type: none"> • Anti-stigma campaigns sensitization among TB patients and community members • Promotion of HIV testing among TB patients to reduce fears and amplify the importance of taking HIV test • Facilitate counseling and testing of TB patients in the company of their partners and disclosure of HIV status. • Development and dissemination of IEC messages that dispel fear of being HIV positive if past sexual history was risky • Facilitation of radio program spots for current and former TB patients who have taken HIV test to give testimonies on the benefits of HIV testing • Conducting drama performances on the benefits of taking HIV test by TB patients. • Educating TB patients/suspects on the basic factors about TB/HIV co-infection
<p>Indicators</p> <ul style="list-style-type: none"> • Priority group: 100% of TB suspects and TB patients 	<ul style="list-style-type: none"> • Proportion of TB suspects that took HIV test • Proportion of TB patients that took HIV test 	<ul style="list-style-type: none"> • Number of TB patients/suspects that took the HIV test • % or Number of TB patients and suspects tested that disclosed their HIV status to partners • % or Number of TB patients and suspects that encouraged other TB patients and suspects to get HIV test 	

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<ul style="list-style-type: none"> Supporting group: All active treatment supporters, family members, health workers and TB patients that have taken HIV test 	<ul style="list-style-type: none"> Motivate TB suspects and patients take HIV test 	<ul style="list-style-type: none"> Encouraging TB patients and suspects who have taken HIV test to freely discuss the importance of taking HIV test. Assuring TB patients and suspects that knowing their HIV status helps medical service providers to provide correct treatment and helps them recovery quickly. Addressing in-adequate knowledge on the dangers of co-infection. Assuring TB patients confidentially of taking HIV test. Integration of HIV testing in all TB patients and suspects 	
<p>Indicators</p>			<ul style="list-style-type: none"> Proportion of treatment supporters that counseled TB patients on HIV testing. Proportion of health workers that counsel TB patients on HIV testing. Proportion of TB patients that counsel fellow TB patients (that have not taken HIV test) on HIV testing. Proportion of family members that counsel TB patients on HIV testing.

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Priority Group	Behavior	Key Factors	Activities
Health Workers who do not routinely ask for a cough among OPD patients above 15 years of age	Health workers routinely ask for a cough among OPD patients above 15 years of age	<ul style="list-style-type: none"> • Address fear of stigmatizing patients among health workers because asking for cough in patients is very important • Increase on-spot technical support to health workers on screening of TB at the OPD/health center • Increase staff level in health facilities overwhelmed by staff shortages • Increase knowledge levels among health workers on risks of contracting TB themselves if TB suspects are identified and treated • Increase awareness on use of TB screening flow charts 	<ul style="list-style-type: none"> • Facilitation of psycho-counseling training of health workers to enable them under their role in TB control • Provision of on site technical support to health workers on screening of TB patients • Facilitation of staff inventory and strengthen health centers overwhelmed by staff shortages • Creation of awareness among health workers about risks involved if TB suspects not identified early • Provision of updates on TB management to health workers
Indicator Priority group: Trained health workers 100% trained health managing OPD	Proportion of health workers who routinely ask for cough among OPD patients above 15 years	<ul style="list-style-type: none"> • % or Number of health workers oriented in TB management • % or Number of health workers received psycho-social counseling • % or Number of health workers oriented on TB guidelines and National TB policy • % of health centers with copies of latest TB guidelines and policy 	
Supporting group District Health office	Motivate health workers to routinely ask for a cough among OPD patients above 15 years	<ul style="list-style-type: none"> • Increase on spot technical support to health workers on clinical skills (asking of cough in patients) • Increase staffing levels in centers with critical shortage of staff • Increase use of simpler and user friendly TB screening flow charts 	<ul style="list-style-type: none"> • Provision of on spot technical support to health workers on clinical skills (asking of cough in patients). • Provision of back up staff in health centers with critical shortage of staff. • Provision of simpler and user friendly TB screening flow charts
Indicator 100% District Health office		<ul style="list-style-type: none"> • % or Number of health centers strengthened with staff to alleviate the shortage • % or Number of on spot technical support visits conducted in the year. • % or Number of health workers provided with technical support. 	

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Table 8: Monitoring table

Priority Group	Awareness	Knowledge	Attitudes/skills	Trial	Behavioral maintenance
TB patients who are aware of TB/HIV co-infection (or else who were advised to take an HIV test) do not take HIV test	To take HIV test	<ul style="list-style-type: none"> Basic facts of TB/HIV co-infection Benefits of being tested for HIV Sites where to get the service. 	<ul style="list-style-type: none"> Take steps to get tested Take the HIV test 	40 TB patients that have not taken HIV test on trial. Ref: TB district registers	40 TB patients that have taken HIV test and taken CD4 count every 3 months. Ref: TB district registers
	Importance of taking HIV test	<ul style="list-style-type: none"> TB patients have a responsibility to take HIV test. 	Fear to know HIV status for fear to have marital problems (divorced)		
		<ul style="list-style-type: none"> Start ARV early if tested positive and prolong life 	Positive feeling of being HIV positive		
		<ul style="list-style-type: none"> Benefits of knowing their HIV status 	Ready to know HIV status.		
Health Workers who do not routinely ask for a cough among OPD patients above 15 years	Health workers routinely ask for cough in all adults 15 years and above who seek medical attention at the health centre of OPD	<ul style="list-style-type: none"> Knowledge on TB management Gangers of not asking cough in patients Un-diagnosed TB could affect them as well 	Health workers take it as their responsibility to screen for TB.	Non-Doer health workers identified to be on trial were from health centers that recorded low TB cases; Muzeyi, Lumezi, Nsadzu, Tafelasoni, Vizenge Petauke Hospital, Minga hospital and Lundazi Hospital	Doer health workers from health centers with good TB case detection rate; Kapata, Mkumbuzi Petauke Urban, Mwasemaphangwe, Chipata Chest clinic and Nyanje Hospital
		<ul style="list-style-type: none"> Knowledge on the key symptoms of TB Knowledge of the procedures for TB screening 	<ul style="list-style-type: none"> Use of TB screening protocols by health Ready to learn 		

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Annex 4: Papers or Presentations about Project

No paper presented.

Annex 5: Results Highlight

Innovative idea

The project in consultation with PHO and the four districts revised sputum collection points system to address the problem of low TB CDR in the four districts: Chadiza, Chipata, Lundazi and Petauke in the Eastern Province with 23% new smear positive cases at baseline. The opening of 20 selected sputum collection points in strategic sites in the four districts had a number of challenges such as long distances, slow transport of sputum samples to the diagnosis centers, and delay to get results from TB microscopy centers. The initial approach sputum samples collected from TB suspects to the nearby health centre were transported to the collection point and thereafter to the diagnosis centre. This delayed transportation to the TB microscopy for examination because sputum samples were only transported when there were at least 2-5 samples. It was not communicated back to the TB suspects from the health centre on time because results were sent to the collection point. However, through consultative meetings with all the four DHOs, districts adopted different strategies. Chipata and Lundazi adopted an approach where sputum collection points were strategically selected; 7 in Chipata out of 38 health centers while in Lundazi 7 were selected out of 22 health centers without TB diagnosis services. Chadiza and Petauke adopted an approach where all health centers that were not TB diagnosis became sputum collection points. In Chadiza, 14 of 16 health centers were turned into sputum collection points while in Petauke 24 out of 30⁵.

To effectively support the sputum collection point system at community level which is the key area of intervention, PHO, DHO, and CARE trained 348 treatment supporters and refreshed 835 in sputum collection and recording keeping. In addition, the project leveraged resources like bicycles from SCOPE and ITAP. The two projects implemented by CARE are being used by treatment supporters to transport sputum samples from TB suspects or health centers directly to TB microscopy centers.

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Figure 1



One of the treatment supporters receiving a bicycle leveraged from SCOPE in Mchini, Chipata district for TB/HIV activities.

Figure 2



Bicycles leveraged from ITAP at the Regional office in Chipata before they were distributed to the districts for re-distribution to treatment supporters and other community based agents for use in TB/HIV activities.

This motivated treatment supporters and made their work easier to intensity TB case identification in the community. Furthermore, individual DHOs introduced performance based incentives where treatment supporters that recorded at least more than 10 sputum samples examined qualified for a token of appreciation such as a T- shirt. The private sector was also involved in the transportation of sputum samples from the collection points to the TB microscopy centers. Updates on the progress of sputum collection discussed in TB/HIV coordinating bodies meetings reviewed the strategy with PHO, DHO, CDC and partners from the private sectors.

This innovation has benefitted community members through provision of TB microscopy closer to them and also facilitated early case detection. So far, 2,105 TB suspects were referred to health facilities for TB screening and sputum examination by treatment supporters with 412 TB suspects testing smear positive. A result based assessment on this strategy will be conducted to compare the performance of the strategy taken by Chipata and Lundazi with that one taken by Chadiza and Petauke. There is a monitoring system (data collection system) put in place. See Annex 11 and 12.

Expected results through this innovation

The project is expected to achieve increased case detection of all new forms of TB cases notified in all the four districts.

Table 9: Targeted and Actual Cases Notified

All Districts	Year 1	Year 2	Year 3	Year 4	Year 5
Targeted: All new TB cases to be detected	3,410	4,096	4,666	5,109	5,301
Actual: New all forms of TB cases notified (cumulative)	1,575	3,162	X	X	X

Data source NTLP-Eastern Province Health Office

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Expected beneficiaries

Table 10: Expected Beneficiaries

Districts	Direct beneficiaries (community members)	Direct beneficiaries(treatment supporters)
Chipata	42,9250	480
Chadiza	98,082	96
Lundazi	275,483	185
Petauke	276,598	354
Totals	1,079,414	1,115

The community members have benefited through the provision of IEC, BCC activities on TB/HIV prevention, care and support, counseling, early referral to the health facility, and provision of care and support by the trained 835 old and 348 new treatment supporters. In addition, through community based meetings the community participated in problem identification and solving. This promoted community participation in TB control and contributes to the sustainability of the program.

Expected Results

The project has taken up the successes recorded in the two districts (Chadiza and Petauke) as lessons learnt. The table below demonstrates the comparison between TB data in Year 1 and Year 2 after the implementation of this practice.

Table11: Expected results under this innovation

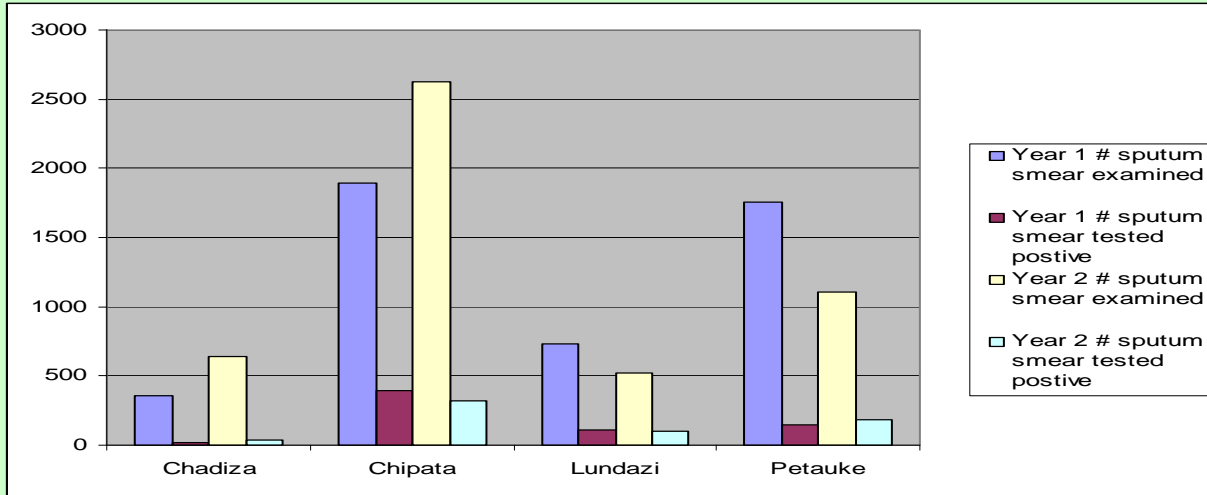
Districts	Estimated Population	Expected OPD attendance (15 years and above)	Estimated TB suspects among adults who seek medical attention	Actual TB suspects who had sputum smears examined	Target of sputum smears under innovation	Actual coverage of sputum smear examined (TB suspects referred) through Innovation	Actual coverage of sputum smear examined that tested Smear positive through the Innovation
Chadiza	98,082	24,349	2,434	640	730	567(78%)	37
Chipata	429,250	106,562	10,656	2,693	3,197	893(28%)	281
Lundazi	275,483	68,389	6,838	522	2,051	229(11%)	8
Petauke	276,598	68,666	6,866	1,106	2,060	416(20%)	86
Totals	1,079,414	267,966	26,794	4,961	8,038	2105(26%)	412

Through this innovation, 2,105 sputum smears were examined in addition to 2,856 that gave a total of 4,961 sputum smears examined in the period under review. THANZI targeted 30% (8,038) of 26,794 of the expected TB suspects 15 years and above to be referred and have their sputum smears examined. Chadiza districts performed exceptionally well at 77% of the targeted sputum smears (TB suspects) identified and referred for sputum smear examination. The other three districts (Chipata, Lundazi and Petauke) performed below 30% therefore, lessons have to be drawn from Chadiza to see what measures activated the impetus of treatment supporters, health centre staff and DHO to attain this achievement.

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The successes are recorded in the two districts (Chadiza and Petauke) as lessons learned. The table below demonstrates the comparison between TB data in Year 1 and Year 2 after the implementation of practice.

Figure 3 Sputum Smears Examined



Data source NTLP-Eastern Province Health Office

In the graph, Chadiza and Chipata districts recorded increased number of sputum smears examined in Year 2 compared to Year 1. Lundazi and Petauke recorded a downward trend. Chadiza and Petauke recorded increased number of sputum smears that tested positive while Chipata and Lundazi recorded a downward trend. The reasons were that the two DHOs started the sputum collection point system late and did not introduce results based incentives e.g. T-shirts. The project through TB/HIV coordinating bodies at the Province and the two DHOs (Chipata and Lundazi) will follow up to address the situation.

MOBILE VCT SCHEDULES FOR THE FOUR DISTRICTS				
Districts	Number of health facilities (outreach sites)	Frequency	Key activities	Partners/Project supporting the activity
Chadiza	15	Quarterly	VCT	ITAP
Chipata	5	Weekly	VCT/ART	STAMPP/ITAP
Lundazi	14	Monthly	VCT	ITAP
Petauke	8	Monthly	VCT	ITAP

THANZI project will use this opportunity to strengthen TB/HIV activities in sites where mobile services were provided through the trained treatment supporters and health workers.

Annex 7

Membership of TB-HIV Coordinating Bodies

1. Provincial TB-HIV Coordination Body Membership

Member Organizations

- Ministry of Health- Provincial Health Office- Eastern Province
- CARE International Zambia – ITAP/THANZI
- CIRDZ
- CHAZ
- THPAZ
- NZP+
- Public Private Partnership – Motala Surgery
- National AIDS Council – Provincial Health Office
- CDC

2. Chipata District

- Ministry of Health- Chipata DHO
- CARE International Zambia-Chipata Office
- Zambia Tuberculosis and Leprosy Trust (ZATULET)
- Great Commission for People Development and Orphan (GCPDO)
- Network of Zambian People Living with HIV(NZP+)
- National AIDS Council- Chipata District Office
- Churches Health Association of Zambia (CHAZ)
- Comprehensive HIV /AIDS Management Programme (CHAMP)

3. Chadiza

Member Organizations

- Ministry of Health - Chadiza DHO
- CARE International Zambia - Chadiza Office
- Expanded Church Response
- Health Communication Partnership
- Community Representative

4. Lundazi

Member Organizations

- Ministry of Health-Lundazi DHO
- CARE International Zambia-Lundazi Office
- Thandizani
- National AIDS Council
- Lundazi District Council
- Ministry of Education
- Catholic Dioceses
- Churches of Central Africa Presbyterian
- Tikondane Home Based Care
- Dunavant Cotton Company
- Africare

5. Petauke

Member Organizations

- Ministry of Health-Petauke DHO
- CARE International Zambia-Petauke
- World Vision Zambia
- Africare
- Salvation Army
- National AIDS Council
- Youth Parliamentarian
- Representatives of 2 Faith Based Organizations
- Representative of the Business Community
- Representative of 2 Community Radio Stations

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Annex 8

Roles and responsibilities (Terms of Reference of TB/HIV Coordinating Body)

Provincial TB/HIV Coordinating body

1. To foster and coordinate the establishment of District TB/HIV coordinating bodies.
2. To disseminate National Policy Guidelines and monitoring tools for TB/HIV collaborative activities to District bodies.
3. Provide technical expertise for the implementation of TB/HIV activities at District level of care.
4. To foster and coordinate the implementation of TB/HIV activities within the Province.
5. To monitor and evaluate the implementation of collaborative TB/HIV activities within the Province.
6. To facilitate the development and dissemination of IEC materials on collaborative TB/HIV activities at District.
7. To support relevant TB/HIV Operational research at District level with guidance from National TB/HIV Coordinating body.
8. To be proactive in liaising with partners for implementation of TB/HIV activities within the Province
9. To compile and submit reports on TB/HIV related activities to the Ministry of Health.

District TB/HIV Coordinating Body

1. To foster and coordinate the establishment of Health facility TB/HIV coordinating bodies
2. To disseminate National Policy guidelines and monitoring tools for TB/HIV collaborative activities to health centre bodies.
3. To build capacity among health staff and stakeholders and provide technical support for the implementation of such guidelines at health facility level.
4. To foster and coordinate implementation of TB/HIV activities at health centre level.
5. To monitor and evaluate the implementation of collaborative TB/HIV activities at Health centre level.
6. To facilitate the dissemination of IEC material on collaborative TB-HIV activities at the health facilities in line with national guidelines.
7. To promote relevant TB/HIV Operational Research at health facility level with guidance from Provincial TB/HIV coordinating body.
8. To coordinate activities and provide a forum for sharing of experiences among partners implementing TB/HIV activities at Health centre levels.
9. To compile and submit reports on TB/HIV related activities to Provincial coordinating body.

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Annex 9

Technical supportive Supervision Checklist for the Private Sector participation in TB/HIV control

This tool is only for use by CARE International Zambia-THANZI TB DOTS Project to assess the contribution of Private Sector in TB/HIV control as agreed in the Memorandum of Understanding between Eastern Chamber of Commerce and the affiliated companies

Name of the company:			District:	
TB/HIV Company Focal:				
Other staff trained in TB/HIV:				
Date of the visit:			Comments	
A	Company commitment			
A.1	Is the workplace policy on TB/HIV in place	Yes	NO	
A.2	List at least three key activities in the policy	Yes	NO	
A.3	Is there Yearly work-plan to support TB/HIV activities?	Yes	NO	
A.4	Which activities were implemented in the last three months?			
A.5	How frequently is the Yearly work-plan revised? (indicate number-for instance per quarter)			

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A.6	Is there a plan for the next three months?	Yes	NO		
A.7	List the support their received from the health facility (health facility within the catchment area)				
B	Company representatives trained in TB management contribution in TB/HIV	Last quarter	Current quarter	Comments	
B.1	Community mobilization				
B.1.1	Is there a work-plan on TB/HIV activities				
B.1.2	Number of sensitization meetings held with workers on TB/HIV				
B.1.3	Key messages in the sensitization meeting/s (list the key messages per meeting held)				
B.1.4	Number of workers sensitized on TB/HIV by gender.	F	M	F	M
B.1.5	Number of community members or employees' family members sensitized on TB/HIV.	F	M	F	M
B.1.7	Number of TB suspects (community members or employees' family members) referred TB screening.				
B.2	TB cases identification and referral				
B.2.1	Number of TB suspects (fellow workers) referred to the health centre by company trained treatment supporters.	F	M	F	M
B.2.2	Number of TB suspects (community members and family members) referred to the health centre by company trained treatment supporters.	F	M	F	M
B.2.3	Number of TB suspects (fellow workers and community members) referred that tested smear positive by company trained treatment supporters.	F	M	F	M

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B.2.4	Number of TB contacts referred to the health centre by company trained treatment supporters.	F	M	F	M
B.2.5	Number of Clients(fellow and community members) referred for HIV counseling and testing by company trained treatment supporters	F	M	F	M
B.2.6	Number of TB patients referred for HIV counseling and testing by company trained treatment supporters.	F	M	F	M
B. 2.7	Number of HIV+ referred for TB screening	F	M	F	M
C.	Recording and Reporting				
C.1	Examine completeness and correctness of the TB suspects registers. Checklist all TB suspects of trained treatment supporters. Make comments				
C.2	Check if the referred TB suspects had cough for more than two weeks in the TB suspect register.-Make comments				
C.3	Is there a quarterly report compiled?	Last quarter	Current quarter		
D.	What were the key challenges?				
D.1	How were the challenges resolved?				
E	Observations/Comments				

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Annex 10.

Technical support supervision checklist for TH involved in TB DOTS.

Instructions:

This checklist shall only be used by a team of THANZI project staff, Chadiza District Health Office, Eastern Province Health Office, THAPZ and any Institution/s invited to participate in this Evaluation of TH contribution in TB DOTS.

List of Team members:

- 1.
- 2
- 3
- 4.

Name of Traditional Healer: Assessor:..... Date of Follow up:..... Address/Zone.....

A	Assess the level of support received from health centres and other partners in the Operational research.
A2	What support did you receive from the health centre?
A3	What support did you receive from other community based agents such as treatment supporters, FBOs, CATF and NHCs?
C	Assess the understanding and use of data collection tools such as Traditional healer's registers and reporting forms.
C1	Assess the filling of TH register
	All columns filled in correctly; make comments

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	Column 1, 2, 3,4,5,6 filled in correctly.
C2	Assess the number of referrals: 0, 1-4 and 5 and above
C3	Assess the date of first contact.
C4	Assess the date client was referred to the health centre
C5	Was there any feedback recorded in the register?
C6	Was the feedback correctly indicated? Make comments
D	Assess their experiences from the time the traditional healer was trained in recording keeping
D1	What experiences has the traditional healer had from the time s/he was trained under THANZI project?
D2	What changes has s/he observed in his/her practice after training in TB DOTS and record keeping under THANZI project?
D3	What are the challenges

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	How have you tried to resolve them?
E	Observations/Comments

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ANNEX 11 COMMUNITY TB SUSPECT REGISTER

FORM 1

NAME OF TREATMENT SUPPORT

TYPE OF CBO

HEALTH CENTRE

NAME OF ZONE

A	B	C	D	E	F	G	H	I	J
No	Date TB suspect/contact seen	Name of Suspect	Sex	Age	Signs and Symptoms	Address	Date Result received	Status of sputum Results	Remarks

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ANNEX 12 COMMUNITY TREATMENT SUPPORTERS REPORTING

FORM 2

HEALTH CENTRE

PERIOD

NAME OF TREATMENT SUPPORTER

DATE

Indicators	October		November		December		Totals		Grand Totals
	F	M	F	M	F	M	F	M	
Number of new TB suspects referred this month									
Number of referred TB suspects with smear Positive results this month									
Number of new TB patients admitted in the DOTS program this month									
Number of reported deaths in this month due to TB									
Number of contacts referred for TB testing this month									
Number of referred contacts with Smear Positive results this month									
Number of TB patients referred for counseling and Testing this month									
Comments									

The Community Treatment Supporters Report is used by treatment supporters to report on project key indicators to show contribution in TB/HIV control. The report is used to monitor the progress of the Innovation to increase CDR.

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Annex 13: Highlights on Private Sector Participation in TB/HIV control

Thanzi TB DOTS project explored the opportunity to help companies increase participation in the prevention, diagnosis and treatment of TB/HIV co-infection in the workplaces through engaging the EPCC to proactively participate in these TB/HIV control interventions. These measures will in turn help alleviate the burden and cost associated with absenteeism, disrupted workflow, and reduced productive. Furthermore, companies can off-set the marginal cost of partnering with local stakeholders with huge benefits through greater efficiency in the workplace and good will in the community.

To achieve this objective:

- The project signed a memorandum of standing (MoU) with EPCC. Of the 32 companies targeted, 30 have been actively involved and supportive of TB/HIV activities in the Province.
- Eighty company representatives trained in TB/HIV control as treatment supporters.
- Quarterly supportive visits conducted with the 32 companies to strengthen TB/HIV activities and review company work-plans. See checklist in Annex 9.
- Held one consultative meeting with individual DATFs(Chadiza, Chipata, Lundazi and Petauke) and stakeholders to identify how the local business community could contribute and participate in International Commemoration Days for TB, AIDS and VCT including traditional ceremonies. So far 12 companies have participated and contributed in terms of transportation and financial contributions.
- Facilitated TB/HIV activities. See table below.

No.	Details	Number of People Reached
1.	Number of Workers sensitized on TB/HIV at work place	823
2.	Number of Families(of workers) sensitized on TB-HIV	979
3.	Number of Community members sensitized on TB-HIV from nearby communities	13,260
4.	Number of Referrals to Health centers	1,466
5.	Number of Confirmed with TB	146

Future Plans:

- Facilitate quarterly review meetings with private companies involved in TB DOTS.
- Facilitate document private sector contributions towards World TB, AIDS and VCT.
- Facilitate documentation and monitor progress of private sector contribution towards CDR, Cure Rate and Treatment Success Rate (TSR) including VCT.

CSHGP Project Data Form (Sub Form 1 of 7)

Project: **CARE Zambia (2007 - 2012) TB Control**

General Project Information:

Cooperative Agreement Number:	GHS-A-00-07-00024
CARE Headquarters Technical Backstop:	Khrist Roy
Field Program Manager:	Bryan Ng'ambi
Midterm Evaluator:	
Final Evaluator:	
Headquarter Financial Contact:	
Project Grant Cycle #:	23
Project Start Date:	10/1/2007
Project End Date:	9/30/2012

USAID Mission Contact Person:	William Kanweka
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Project Field Contact Information:

Field Program Manager

Name: **Bryan Ng'ambi**

Title:

Email:

Address1:

Address2:

City:

State:

Zip Code:

Country:

Telephone:

Fax:

Alternate Field Contact

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First Name:

Last Name:

Title:

Email:

Address1:

Address2:

City:

State:

Zip Code:

Country:

Telephone:

Fax:

Project Web Site:

Grant Funding Information:

USAID Funding: (US \$)

PVO

Match: (US

\$)


Project Description:

"TB Health Activities in Zambia" or THANZI, meaning Good Health in the Chew a language, will implement this project working closely with the following key partners: Zambia's National Tuberculosis and Leprosy Program (NTLP); Churches Health Association of Zambia (CHAZ); Traditional Health Practitioners Association of Zambia (THAPAZ); Chambers of Commerce (CoC) (EP); prisons and various CBOs and NGOs working in HIV. This project will attempt to reach 22,581 TB patients over five years. The goal of this project is to support the NTLP's Directly Observed Treatment Short Course (DOTS) program to decrease morbidity and mortality caused by TB and TB/HIV co-infection in EP.

Project Location:

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Four districts of Eastern Province (EP): Chipata, Chadiz, Petuake, and Lundazi.



CSHGP Project Data Sheet (Sub Form 2 of 7)

Project: **CARE - Zambia (2007 - 2012) - TB Control Project**

Partner Name:	Partner Type:	USAID \$ Allocated:	Delete:
<input type="text"/>	<input type="text"/>	<input type="text"/>	

CSHGP Project Data Form (Sub Form 3 of 7)

Project: **CARE Zambia (2007 - 2012) TB Control**

Project Location/ Subareas:

Does this project collect, monitor and report on Rapid CATCH data for different *geographic* project subareas ?

If this is true, click **Yes** and enter each distinct subarea name:
If this is false, click **No**.

Yes No

CSHGP Project Data Form (Sub Form 4 of 7)

Project: **CARE Zambia (2007 - 2012) TB Control**

Strategies:	
<p><i>The following 3 boxes list different kinds of general strategies, assessment tools and BCC strategies that could be implemented during the life of this CSHGP project.</i></p> <p><i>Please check those boxes that are planned for this project.</i></p>	
General Strategies:	
Microenterprise <input type="checkbox"/>	Social Marketing <input type="checkbox"/>
Private Sector Involvement <input checked="" type="checkbox"/>	Advocacy on Health Policy <input checked="" type="checkbox"/>
Strengthen Decentralized Health System <input checked="" type="checkbox"/>	Information System Technologies <input type="checkbox"/>
Use Sustainability Framework (CSSA) <input type="checkbox"/>	
M&E Assessment Strategies:	
KPC survey <input checked="" type="checkbox"/>	Health Facility Assessment <input checked="" type="checkbox"/>
Organizational Capacity Assessment with Local partners <input type="checkbox"/>	Organizational Capacity Assessment for your own PVO <input type="checkbox"/>
Participatory Rapid Appraisal <input type="checkbox"/>	Participatory Learning in Action <input type="checkbox"/>
Lot Quality Assurance Sampling <input checked="" type="checkbox"/>	Appreciative Inquiry-based strategy <input type="checkbox"/>
Community-based Monitoring Techniques <input type="checkbox"/>	Participatory Evaluation Techniques (for mid-term or final evaluation) <input checked="" type="checkbox"/>
Use of Pocket PCs or Palm PDA Devices <input type="checkbox"/>	TB Cohort Analysis <input checked="" type="checkbox"/>
Behavior Change & Communication (BCC) Strategies:	
Social Marketing <input type="checkbox"/>	Mass Media <input checked="" type="checkbox"/>
Interpersonal Communication <input checked="" type="checkbox"/>	Peer Communication <input checked="" type="checkbox"/>
Support Groups <input checked="" type="checkbox"/>	Use of BEHAVE Framework <input checked="" type="checkbox"/>
Capacity Building:	
<p><i>Please check the box next to each capacity building area or group that is targeted for institutional strengthening during the life of this CSHGP project:</i></p>	

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PVO	Non-Govt Partners	Private Sector	Govt	Community
US HQ (General) <input checked="" type="checkbox"/>	PVOs/NGOs (Int'l./US) <input type="checkbox"/>	Pharmacists or Drug Vendors <input type="checkbox"/>	National MOH <input checked="" type="checkbox"/>	Health CBOs <input checked="" type="checkbox"/>
US HQ (CS Unit) <input type="checkbox"/>	Local NGO <input checked="" type="checkbox"/>	Business <input checked="" type="checkbox"/>	Dist. Health System <input checked="" type="checkbox"/>	Other CBOs <input type="checkbox"/>
Field Office HQ <input checked="" type="checkbox"/>	Networked Group <input checked="" type="checkbox"/>	Traditional Healers <input checked="" type="checkbox"/>	Health Facility <input checked="" type="checkbox"/>	CHWs <input checked="" type="checkbox"/>
CS Project Team <input checked="" type="checkbox"/>	Multilateral <input type="checkbox"/>	Private Providers <input type="checkbox"/>	Staff <input checked="" type="checkbox"/>	FBOs <input checked="" type="checkbox"/>
			Other National Ministry <input type="checkbox"/>	

Project Interventions & Components:

Enter a percentage representing the amount of funds your project is targeting towards each intervention. If you are not implementing a particular intervention then leave the box blank. On the same line as the intervention percentage, check the boxes indicating whether or not this intervention is part of an overall IMCI strategy and also check the kinds of training (CHW or HF) envisioned for this particular intervention. For each intervention implemented, check the specific intervention components that are planned.

Immunizations <input type="text"/> %	IMCI Integration <input checked="" type="checkbox"/>	CHW Training <input checked="" type="checkbox"/>	HF Training <input checked="" type="checkbox"/>
Polio <input type="checkbox"/>	Classic 6 Vaccines <input type="checkbox"/>	Vitamin A <input type="checkbox"/>	Surveillance <input type="checkbox"/>
Cold Chain Strengthening <input type="checkbox"/>	New Vaccines <input type="checkbox"/>	Injection Safety <input type="checkbox"/>	Mobilization <input type="checkbox"/>
Measles Campaigns <input type="checkbox"/>	Community Registers <input type="checkbox"/>		
Nutrition <input type="text"/> %	IMCI Integration <input checked="" type="checkbox"/>	CHW Training <input checked="" type="checkbox"/>	HF Training <input checked="" type="checkbox"/>
ENA <input type="checkbox"/>	Gardens <input type="checkbox"/>	Comp. Feed. from 6 mos. <input type="checkbox"/>	Hearth <input type="checkbox"/>
Cont. BF up to 24 mos. <input type="checkbox"/>	Growth Monitoring <input type="checkbox"/>	Maternal Nutrition <input type="checkbox"/>	
Vitamin A <input type="text"/> %	IMCI Integration <input checked="" type="checkbox"/>	CHW Training <input checked="" type="checkbox"/>	HF Training <input checked="" type="checkbox"/>
Supplementation <input type="checkbox"/>	Post Partum <input type="checkbox"/>	Integrated with EPI <input type="checkbox"/>	Gardens <input type="checkbox"/>

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Micronutrients <input type="checkbox"/> %		CHW Training <input checked="" type="checkbox"/>	HF Training <input checked="" type="checkbox"/>
Iodized Salt <input type="checkbox"/>	Iron Folate in Pregnancy <input type="checkbox"/>	Zinc (Preventive) <input type="checkbox"/>	Food Fortification <input type="checkbox"/>
Pneumonia Case Management <input type="checkbox"/> %	IMCI Integration <input checked="" type="checkbox"/>	CHW Training <input checked="" type="checkbox"/>	HF Training <input checked="" type="checkbox"/>
Pneum. Case Mngmnt. <input type="checkbox"/>	Case Mngmnt. Counseling <input type="checkbox"/>	Access to Providers Antibiotics <input type="checkbox"/>	Recognition of Pneumonia Danger Signs <input type="checkbox"/>
Zinc <input type="checkbox"/>	Community based treatment with antibiotics <input type="checkbox"/>		
Control of Diarrheal Diseases <input type="checkbox"/> %	IMCI Integration <input checked="" type="checkbox"/>	CHW Training <input checked="" type="checkbox"/>	HF Training <input checked="" type="checkbox"/>
Water/Sanitation <input type="checkbox"/>	Hand Washing <input type="checkbox"/>	ORS/Home Fluids <input type="checkbox"/>	Feeding/Breastfeeding <input type="checkbox"/>
Care Seeking <input type="checkbox"/>	Case Mngmnt./Counseling <input type="checkbox"/>	POU Treatment of water <input type="checkbox"/>	Zinc <input type="checkbox"/>
Malaria <input type="checkbox"/> %	IMCI Integration <input checked="" type="checkbox"/>	CHW Training <input checked="" type="checkbox"/>	HF Training <input checked="" type="checkbox"/>
Training in Malaria CM <input type="checkbox"/>	Adequate Supply of Malarial Drug <input type="checkbox"/>	Access to providers and drugs <input type="checkbox"/>	Antenatal Prevention Treatment <input type="checkbox"/>
ITN (Bednets) <input type="checkbox"/>	ITN (Curtains and Other) <input type="checkbox"/>	Care Seeking, Recog., Compliance <input type="checkbox"/>	IPT <input type="checkbox"/>
Community Treatment of Malaria <input type="checkbox"/>	ACT <input type="checkbox"/>	Drug Resistance <input type="checkbox"/>	Environmental Control <input type="checkbox"/>
Maternal & Newborn Care <input type="checkbox"/> %	IMCI Integration <input checked="" type="checkbox"/>	CHW Training <input checked="" type="checkbox"/>	HF Training <input checked="" type="checkbox"/>
Emerg. Obstet. Care <input type="checkbox"/>	Neonatal Tetanus <input type="checkbox"/>	Recog. of Danger signs <input type="checkbox"/>	Newborn Care <input type="checkbox"/>

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Post partum Care <input type="checkbox"/>	Delay 1st preg Child Spacing <input type="checkbox"/>	Integr. with Iron & Folate <input type="checkbox"/>	Normal Delivery Care <input type="checkbox"/>
Birth Plans <input type="checkbox"/>	STI Treat. with Antenat. Visit <input type="checkbox"/>	Home Based LSS <input type="checkbox"/>	Control of post-partum bleeding <input type="checkbox"/>
PMTCT of HIV <input type="checkbox"/>	Emergency Transport <input type="checkbox"/>		
Child Spacing <input type="checkbox"/> %	IMCI Integration <input checked="" type="checkbox"/>	CHW Training <input checked="" type="checkbox"/>	HF Training <input checked="" type="checkbox"/>
Child Spacing Promotion <input type="checkbox"/>	Pre/Post Natal Serv. Integration <input type="checkbox"/>		
Breastfeeding <input type="checkbox"/> %	IMCI Integration <input checked="" type="checkbox"/>	CHW Training <input checked="" type="checkbox"/>	HF Training <input checked="" type="checkbox"/>
Promote Excl. BF to 6 Months <input type="checkbox"/>	Intro. or promotion of LAM <input type="checkbox"/>	Support baby friendly hospital <input type="checkbox"/>	PMTCT of HIV <input type="checkbox"/>
Peer support <input type="checkbox"/>			
HIV/AIDS <input type="checkbox"/> %		CHW Training <input checked="" type="checkbox"/>	HF Training <input checked="" type="checkbox"/>
OVC <input type="checkbox"/>	Treatment of STIs <input type="checkbox"/>	Behavior Change Strategy <input type="checkbox"/>	Access/Use of Condoms <input type="checkbox"/>
STI Treat. with Antenat. Visit <input type="checkbox"/>	ABC <input type="checkbox"/>	PMTCT <input type="checkbox"/>	Nutrition <input type="checkbox"/>
Home based care <input type="checkbox"/>	PLWHA <input type="checkbox"/>	ARVs <input type="checkbox"/>	HIV Testing <input type="checkbox"/>
Family Planning <input type="checkbox"/> %	IMCI Integration <input checked="" type="checkbox"/>	CHW Training <input checked="" type="checkbox"/>	HF Training <input checked="" type="checkbox"/>
Knowledge/Interest <input type="checkbox"/>	FP Logistics <input type="checkbox"/>	Community-Based Distribtuion <input type="checkbox"/>	Social Marketing <input type="checkbox"/>
Male Reproductive Health <input type="checkbox"/>	Youth FP Promotion <input type="checkbox"/>	Quality Care <input type="checkbox"/>	Human Capacity Development <input type="checkbox"/>
FP/HIV integration <input type="checkbox"/>	Maternal/Neonatal Integration <input type="checkbox"/>	Cost Recovery Schemes <input type="checkbox"/>	Community Involvement <input type="checkbox"/>

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Access to Methods <input type="checkbox"/>	Policy <input type="checkbox"/>		
Tuberculosis <input type="text" value="100"/> %	IMCI Integration <input checked="" type="checkbox"/>	CHW Training <input checked="" type="checkbox"/>	HF Training <input checked="" type="checkbox"/>
Facility based treatment/DOT <input checked="" type="checkbox"/>	Microscopy <input checked="" type="checkbox"/>	Monitoring/Supervision Surveillance <input checked="" type="checkbox"/>	Community IEC <input checked="" type="checkbox"/>
Drug management <input type="checkbox"/>	Advocacy/Policy <input type="checkbox"/>	Linkages with HIV services <input checked="" type="checkbox"/>	Community based care/DOT <input checked="" type="checkbox"/>
Pediatric TB <input type="checkbox"/>			

CSHGP Project Data Sheet (Sub Form 5 of 7)

Project: **CARE Zambia (2007 - 2012) TB Control**

<i>Target Beneficiaries:</i>	
Number of Suspected TB Cases:	<input type="text" value="22,581"/>
Population of Target Area:	<input type="text" value="1,050,000"/>

CSHGP Project Data Form (Sub Form 6 of 7)

Project: **CARE Zambia (2007 - 2012) TB Control**

<i>Rapid CATCH Data:</i>			
<p>Under the 'Sample Type' column please select either 30 cluster or LQAS to define the type of sample used for this particular survey. This information will be used in estimating the confidence interval for each indicator.</p> <p>If data has already been entered for a particular phase, the date of first entry will appear under the 'Date' column and an 'X' will appear under the 'Entered' column.</p> <p>Click on the Red link (under the 'Stage' column) to view/access/update Rapid Catch data for that phase of the project.</p>			
Date	Stage	Sample Type	Entered
30-Oct-08	DIP	<input checked="" type="checkbox"/> 30 Cluster <input type="checkbox"/> LQAS	X

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	Mid Term	 30 Cluster  LOAS	
	Final Evaluation	 30 Cluster  LOAS	