Final Evaluation of Pfizer Funded Projects on Non Communicable Diseases among Older People in Tanzania

Executive Summary

This report presents an end term evaluation for two Pfizer Pharmaceuticals funded projects namely: Supporting the Prevention and Control of Non-Communicable Diseases (NCDs) Among Older People and Extending Healthy Aging through the Life Course - Intergenerational Interventions in Tanzania. The evaluation also covers extension of the first phase of the NCD prevention and control project. While the first project covered three districts of Tanzania of Kibaha, Morongoro and Songea, the second project and the extension of the first project covered only Kibaha district. The projects which were implemented from March 2013 to March 2015 focused on supporting improved access to health care for older persons with particular emphasis to the prevention and control of Non Communicable Diseases (NCDs), intergenerational linkages for promoting healthy ageing through the life course approach and measuring healthy ageing. The project is implemented by HelpAge International in collaboration with three local partners namely Good Samaritan Social Services Trust (GSSST), Tanzania Mission for the Poor and Disabled (PADI) and Morogoro Elderly People's Organisation (MOREPEO). The overall goal of the project is to improve the prevention and control of NCDs among older persons in the three target districts. In conducting this evaluation, quantitative and qualitative methods were used. The evaluation identified the project as having been relevant and aligned to the national priorities, policies and strategies. Additionally, the project was identified as relevant to the needs of the target beneficiaries and the mission/vision of HelpAge International and the three implementing partners. The project implemented most of the planned activities as per the target and on time. Activities not achieved included the application of the Easy Care tool and development of and dissemination of the policy briefs. The activities and approaches implemented including use of volunteer peer educators and home based care providers, working with local partners, creating of community structures such as older persons monitoring groups among others were identified as being efficient and replicable. Project impacts at direct beneficiaries, at policy level and in creating an enabling environment for the provision of health care services to older persons were identified. The following is a summary of impacts reported at the various levels:-

Direct level

- Older people's participation in active ageing activities increased from 6 % to 74 %
- % of older persons with improved knowledge on NCDs increased from 28 % to 85 %
- % of older persons with excessive drinking reduced from 75 % to 56 %
- Positive attitude changes among health workers on uptake of health services

Policy level

- General prioritization of older person's health within the Ministry of Health and Social Welfare
- Increased budgetary allocation for older persons' health in the targeted district and municipal councils
- Increased policy discussions on older persons access to health care services at national, municipal, district and facility levels
- Ministry of Health and Social Welfare has strengthened their response to NCDs among older persons.

Creation of an enabling environment

- Infrastructural changes within the health facilities to facilitate provision of health services
- Positive health workers attitudes towards provision of health services to health workers
- Creation of a window in health facilities for the provision of health services to older persons
- Special days for provision of health services to older persons

It was noted that the interventions implemented were to most extent sustainable beyond the project period. Some of the measures put in place to ensure sustainability were identified as working with local partners, setting up community structures and engaging the district and municipal councils, empowerment of older persons and engaging the health facilities and creating attitude change among health workers. Emerging best practices which are also noted as having potential for sustaining the implemented interventions include establishment and working with older persons monitoring groups, integration of livelihood interventions into active ageing activities, partnership with schools and establishment of intergenerational groups. Based on these findings, the evaluation makes the following recommendations:-

- Strengthen advocacy for the provision of drugs to manage non communicable diseases among older persons
- Strengthen project management and Technical support to partners
- Simply the Easy Care tool for use by the HBC providers
- Standardize recruitment and training of home based care providers
- Develop and implement sustainable motivation scheme for community volunteers especially the HBC providers
- Provision of essential tools to the community based volunteers including IEC materials for peer educators and HBC kits for the HBC providers
- Strengthen transfer of knowledge from the HBC providers to the caregivers
- Conduct Behavior Change Communication (BCC) formative assessment on the NCD risk factors and develop a comprehensive strategy
- Strengthened integration of NCDS and other non communicable diseases especially HIV and AIDS
- Integration of data about NCDs and older persons in the national health information systems
- Development of an integrated older person's friendly model sites within the targeted sites
- Strengthen and scale up livelihood interventions as part of the project response

Acknowledgements

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Profuse thanks to all the respondents including representatives of district and municipal health councils visited, the health workers from targeted facilities and more importantly the direct beneficiaries including older persons in the three program areas, their caregivers and the young people participating in the intergenerational groups who provided information for this evaluation.

To all the people who played one role or another in making this evaluation a success, appreciations.

Abbreviations

AIDS	Acquired Immune Deficiency Syndrome
BCC	Behaviour Change Communication
HIV	Human Immune Deficiency Virus
HBC	Home Based Care
CEO	Chief Executive Officer
CHF	Community Health Fund
DHIS	District Health Information System
FGDs	Focus Group Discussions
GSSST	Good Samaritan Social Services Trust
IEC	Information Education and Communication
KII	Key Informant Interviews
NHIF	National Health Insurance Fund
NCDs	Non Communicable Diseases
MoHSW	Ministry of Health and Social Welfare
MOREPEO	Morogoro Elderly People Organization
OPMG	Older Persons Monitoring Groups
PADI	Tanzania Mission for the Poor and the Disabled
TB	Tuberculosis
TIKKA	Tiba Kwa Kadi
USD	United States Dollars
WHO	World Health Organisation

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1.0. Introduction

1.1. Project background

The World Health Organisation (WHO) estimates that Non Communicable Diseases (NCDs) such as cardiovascular diseases, cancers, diabetes and chronic respiratory diseases are estimated to cause 60% of all deaths globally with estimated increase by 17% over 10 years[1]. Several studies in Tanzania do indicate that although communicable diseases are still the major causes of morbidity and mortality, non communicable diseases are now contributing significantly to the disease burden and deaths in the country especially among older persons[2][3]. The Tanzania National Strategy for Non-Communicable Diseases (NCDs) of 2009–2015 identifies cardiovascular diseases, cervical and breast cancers, central diseases of the nervous systems, diabetes and chronic respiratory diseases among the NCDs with the greatest impact. The strategy further notes that despite the growing threat of NCDs, disproportionately high emphasis is placed on epidemics such as malaria, TB and HIV and AIDS and there is therefore a low level of awareness of the causes, symptoms, prevention and management of NCDs. Findings of a study by the Tanzania Healthcare and Career Awareness Program confirm this lack of awareness by older people and their caretakers, on prevention of NCDs, associated risk factors and their management.

Furthermore, the current approaches of providing health care for older people with NCDs are limited and often ineffective. This is due, in part, because of the lack of systematically collected disaggregated data on older people's heath, needs and outcomes. Additionally, although medicine represents a significant proportion of family or household expenditure often competing with other household needs, the availability of generic medicines for acute diseases in the public and private sector in low-income countries such as Tanzania, is very low (15% and 17.6% respectively), while the treatment gap of NCDs for some conditions such as epilepsy is over 75%[4]. Tanzania has a free health care policy for all older people 60 and above, but lack of accountability to government directives and the shortage of drugs in public health facilities forces older people to pay for drugs.

[1] WHO (2005) Preventing Chronic Diseases a Vital Investment. World Health Organisation, Geneva.
[2] AMMP (1997) Policy Implications of the Adult Morbidity and Mortality Project.
[3] WHO (2010) Global Status Report on Non Communicable Diseases. World Health Organisation, Geneva.
[4] HelpAge International NCD Concept Note to Pfizer Pharmaceuticals

In response to this, in partnership with the Ministry of Health and Social Welfare, Municipal and District Councils in Songea, Kibaha and Morogoro, HelpAge International in Tanzania started an NCD project focusing on older persons. Funded through Pfizer Pharmaceuticals, the program is implemented in collaboration with three local organizations: Good Samaritan Social Services Trust (GSSST) in Kibaha; Tanzania Mission for the Poor and Disabled (PADI) in Songea and Morogoro Elderly People's Organization (MOREPEO) in Morogoro. The overall goal of the project was to improve the prevention and control of non communicable diseases among older people in the three mentioned districts. To reach this goal, the project focused on 2 objectives of: (a) To promote healthy aging among older people, their caretakers, and health care workers in the three districts (b) to improve health care approaches to NCDs in older people and address the issue of accountability of public health services to government policy.

During the course of program implementation, two successive additional funds were secured from Pfizer Pharmaceuticals. The two "projects" ***Extending Healthy Aging through the Life Course - Intergenerational Interventions in Rural Tanzania*** **and an** ***Extension phase of the prevention and Control of NCDs among older people and Intergenerational Healthy Ageing*** were however implemented in Kibaha district only. ***Extending Healthy Aging through the Life Course - Intergenerational Interventions in Rural Tanzania*** **(2nd project)** was implemented between May 2014 and June 2015. The key focus of this second project was promoting Active Ageing Groups and developing synergy with youth led organizations to promote a life course approach to delay and prevent the onset of non communicable diseases among young people while mobilizing increased support for older people affected by NCDs.

The 3rd project, an extension phase of the prevention and control of NCDs and intergenerational interventions was implemented between November 2014 and March 2015. The extension phase sought to address gaps identified in the course of implementing the first and the second project. Given the short span of the last two projects, this evaluation focuses mainly on the first project but makes an observation on the value addition of the interventions added during the last two projects.

1.2. Evaluation Objectives

The overall purpose of the evaluation as per the Terms of Reference is to assess the impact of the Programme on the target population, identify successful approaches that have contributed to positive outcomes that can be highlighted as best practices and make recommendations for future NCD projects focusing on older persons. More specifically the evaluation aims at assessing:-

a. Relevance and quality of the programme design including project management and its influence on results
b. Overall efficiency of program approaches used
c. Overall effectiveness of programme implementation.
d. Overall impact of the programme on the target constituency,
e. The extent to which activities can be sustained beyond the funding period
   And based on the above draw out the key lessons and best practices of the programme and recommend appropriate ways of addressing NCDs among older people in Tanzania

2.0. Evaluation methods

This end of term evaluation utilized both quantitative and qualitative methods. Quantitative data collection methods involved extraction of data from project reports.

Data collection

The following data collection methods were used:-

Document review: Relevant documents were reviewed first to understand the context as well as to extract the project objectives. Key documents reviewed included: The Tanzania National Strategy for Non Communicable Diseases 2009-2015, the Health and Social Welfare Strategic Plan 2015-2020, the National Health Policy, project documents including the concept note, the annual reports, reports from community groups mainly the Older Persons Monitoring Groups (OPMGs) and facility based reports/data. The consultant further reviewed relevant websites including HelpAge International in Tanzania and WHO Tanzania websites.

The project monitoring matrix prepared by the implementing partners and reviewed by HelpAge International in Tanzania was used to extract progress on the achievement of the planned project indicators.

Key informant interviews: Using a pre-developed key informant interview guide, KII were conducted with HelpAge International staff (2), with the Ministry of Health and Social Welfare representatives at national level (1), with the implementing partners (3), with representatives from district and municipal councils (5) and with health workers at the targeted facilities (8). A total of 22 key informant respondents were reached.

Focus Group Discussions: Focus group discussions were held with active ageing groups (4 FGDs, 2 in each of the visited program areas -Kibaha and Morogoro), 2 intergenerational groups in Kibaha, home based care providers (2) and peer educators (2). A total of 82 key informant respondents were reached.

Visits to homebound older persons: A visit was conducted to 5 home bound older persons in each of the two sampled (Kibaha and Morogoro) program areas. Although the original design was to interview the home bound older persons, most of them we frail and sick and the plan changed to verification from the caregivers that the HBC providers were actually visiting the older persons. Verification was done with a total of 9 care givers of older persons. In addition to the verification on the visit by the HBC providers, the care givers were asked whether the HBC providers involved them in the provision of services to the older person and if this had in any way increased their knowledge and skills in the care of older persons.

Observations: Visits were made to 2 health facilities in Kibaha and in Morogoro. During these visits observations were done to verify if the project had undertaken any structural modifications in the targeted facilities to facilitate access to health services by older persons.

Data Analysis

Quantitative data was extracted from project reports to answer each of the quantitative indicators as specified in the project logical framework matrix. Qualitative data was grouped and manually analysed thematically as per the end term evaluation questions.

3.0. Key findings

3.1. Relevance and Quality of the Program design

The project relevance was assessed on three criteria of: Relevance to national priorities, relevance to the needs of the beneficiaries and finally relevance to the work of HelpAge International and the three implementing partners.

Relevance to the national priorities

This evaluation identified that the project is aligned to and responds to the national priorities as outlined in the national health sector strategic plan, the national strategy for NCDs and specific NCD strategies such as the National Cancer Strategy. The National NCD strategy which is the overall strategic document on prevention and management of NCDs identifies non communicable diseases as a priority for the United Republic of Tanzania. More specifically the strategy notes *"NCDs and conditions including injuries cause a significant and growing proportion of burden of disease in Tanzania accounting for between 15-28 % of all years lost. There is therefore need to address NCDS before the related morbidity, mortality and economic burden put a heavy toll on Tanzania and its population*[5]". The national health sector strategic plan recognizes NCDs and conditions such as: cancer, cardio-vascular diseases, nutritional disorders, diabetes mellitus, chronic respiratory diseases, renal disease, congenital abnormalities and injuries/trauma as growing priority area for the country[6].

The strategic framework identifies provision of preventive and curative services for NCDs as well as promotion of health lifestyles as priority areas for NCD response in the country. Interviews with national level focal point identified that NCDs are a high priority area within the Ministry of Health. As a demonstration of this prioritization, it was reported that the Ministry of Health and Social Welfare has established a department within the Ministry to deal with Non Communicable Diseases.

[5] *National Strategy for Non Communicable Diseases 2009-2015 page Xi*

[6] ***Health Sector Strategic Plan*** *III "Partnerships for Delivering the MDGs" July 2009 – June 2015 page*

Relevance to HelpAge International and Implementing Partners

Relevance of a project to the missions and visions of implementing organizations is important in promoting ownership and ensuring sustainability of project interventions. This evaluation identifies that the project activities were relevant to both HelpAge International and the implementing partners. Interviews with the Executive Director of PADI identified that the organization's mission as *"poverty reduction for the marginalized groups including older people"*. The organization reported that they were involved in the provision of health services to older persons including facilitating registration of older persons and their families in Community Health Fund (CHF). In the three implementing organizations, the project helped to both expand and scale up interventions both in terms of new focus areas (NCDs) and also geographically.

Relevance to the needs of the target beneficiaries

This evaluation identified that the project interventions addressed the needs of the target beneficiaries as identified during design phase consultative meetings with the target beneficiaries. Although there was lack of data to provide evidence to this, those interviewed reported that the project was relevant to older persons given the burden of NCDs among this population and that there were no specific programs or interventions focusing on NCDs among older persons in the three targeted regions. Additionally it was identified that older people unlike the rest of the population faced unique challenges including poverty, difficulties in transportation and structural barriers that hindered their access to health services.

Although the interventions implemented were to a large extent relevant to the needs of older persons, interviews with the target beneficiaries identified that some of their priority needs such as livelihoods were not addressed by the first project. A focus group discussion with older persons identified that while the target beneficiaries appreciated the active ageing group activities; there was need to strongly integrate this with livelihood and income generating activities. Making this observation, one of the FGD discussant posed:

> *"Wazee wako na njaa unataka wavute kamba?*[7]"

[7] Interview with FGD discussants in Kibaha. Translated as " older persons are hungry and you ask them to do rope puling"

Going forward, those interviewed reported that the project was still relevant and should be extended. Those interviewed noted that there was need to train more health workers on NCDs and older persons, continue with advocacy for NCDs response among older persons at all levels to ensure sustainability, develop clear exit strategy, and scale up additional interventions implemented in Kibaha to the other regions as well as document and disseminate emerging best practices to all stakeholders. It is noted that Project extension will further help implement activities related to the application of the *Easy Health Care Tool* in country which have to a large extent not been implemented as described in the effectiveness section of this evaluation report.

Involvement of stakeholders and target beneficiaries in the program design, implementation and evaluation is critical for ensuring program sustainability. This evaluation identified that to a greater extent the stakeholders were involved at the various cycles of the project. Making this observation a key informant respondent with the Ministry of Health noted:

> *"When they design their programs, they always involve us, we are the ones on the driver's seat"….*

Although the involvement of the stakeholders was reported as stated above, this evaluation identified that there was inadequate involvement of the implementing partners and more importantly the project beneficiaries. In terms of design, this evaluation identified that the project interventions were well aligned to the national strategy for NCD response which identifies key program areas as being: promotive, preventive, care and treatment and rehabilitation services.

3.2. Project Efficiency and Implementation approaches

The project utilized a number of innovative implementation approaches in delivering project interventions. To a large extent, this evaluation identified that most of the implementation approaches were efficient. The description below outlines the various implementation approaches utilized, their efficiency and some of the gaps observed.

Focusing more on health promotion and preventive activities than treatment services: This evaluation identified that the project interventions focused more on promotive and preventive interventions rather than treatment interventions such as procurement of drugs which is more costly and not sustainable. This is in line with the national NCD strategy that advocates for more focus on promotive and preventive interventions.

Working with local implementing partners: In implementing the project, HelpAge International in Tanzania worked with local implementing partners already operating in the three program areas of Morogoro (MOREPEO), Kibaha (GSST) and Songea (PADI). This approach is seen as being more cost effective since the project did not require to establish project offices and to recruit new staff for implementing project interventions. Interviews with implementing partners identified that while some were initially implementing health programs and with special targeting to older persons, the Pfizer funded program had increased their scope and capacity in programming on prevention and management of NCDs among older persons. This strengthened capacity of the local implementing partners in programming on prevention and management NCD among older persons is expected to ensure that the organizations can sustain interventions beyond the project period.

Health workers capacity building approaches: This evaluation identified that the project attempted to use a trainer of trainers approach in rolling out training of health workers on NCDs. It was however reported that this hindered by the delay in the approval of health workers training curriculum for training health workers on NCDs and provision of health services to older persons. Health workers reached through this training reported increased skills and change in attitudes as described in the effectiveness and the impact section of this evaluation. To increase efficiency, the project will need to pretest and roll out the already existing NCD training manual for health workers.

Home Based Care approach for homebound older persons: Towards ensuring project efficiency, the project recruited trained and utilized community volunteers to provide home based care services to home bound older persons. To reduce on training time, the project planned to recruit already trained home based care providers. This evaluation identified that although this worked in Songea, all the interviewed home based care providers in Kibaha and Morogoro requested for more training to ensure they can effectively deliver services to older persons. Additionally, the project envisioned to have home based care providers transfer skills to caregivers of homebound older persons. It was noted that this transfer of knowledge from HBC providers to care givers did not work well and most of the HBC providers concentrated more on the older persons and not transfer of knowledge to the care givers. Health workers interviewed further reported that they did not have adequate facilitation in terms of transport and allowances to provide supportive supervision to the trained volunteer home based care providers**.**

Peer Education as a strategy: Like the HBC providers approach, use of volunteer peer educators approach to reach older persons with information on prevention and management of NCDs is seen as both efficient and effective strategy. Interviews with respondents identified that Peer Educators are more likely to influence behavior change among fellow older persons.

Use of the school approach: This evaluation identified an attempt by one of the implementing partners, PADI, in using schools as settings for creating awareness on prevention and management of NCDs. This is seen as efficient since the approach promotes both healthy ageing through the life course approach as well as using the children to reach older people in their homes and in their communities. Although this evaluation did not find any reports to confirm that children reached older people with information on NCDs this is seen as efficient strategy for reaching many older people. This can be strengthened by providing more technical assistance, allocating targets of number of older people to be reached by the trained pupils, monitoring whether older people are being reached and providing pamphlets which the trained students can share with the older persons they reach out to.

Provision of services to older persons through integrated outreaches: This evaluation identified that in Kibaha District, the project utilized community based outreaches to reach older persons with information and treatment services for NCDs. This approach was identified as being efficient as it reached many older persons with required health services.

3.3. Project Effectiveness

This section of the evaluation reviews whether the activities were implemented as planned. Given the short duration of the project, achievements of the project objectives are discussed under the impact section of this evaluation report. From the review of the project documents and interview with project staff, most of the planned activities were implemented on time and all the targets met. The table below discusses the key activities per each of the project result areas. Most of the activities under result area 2.2 on "*Easy Care tool updated and customised to meet local needs and context*" were not implemented as this is still being reviewed for customization and use in the country.

Table 1: Summary of project Achievements

Result	Output	Planned Activities	Achievements
Result 1.1: Older people and their families are able to practice healthy life styles to prevent and manage NCDs	Quarterly community meetings on NCD awareness	18 Meetings, 12 year 1 and 6 year 2	30 meetings reaching 8386 participants, 1998 were older persons (1091 female, 907 male)
	Mobilizing and training of HBC providers, PE and other community volunteers to champion active ageing within the community.	3 trainings all in year 1	120 HBC Providers and PE trained. These have reached 1,141 OP (682 Female, 459 male)
	Production of publications with healthy life style messages including dietary practices	420 posters and 200 and leaflet	1,000 IEC materials in total produced, 1,000 OP reached,
Result 1.2: Local health facilities and older people's organizations have improved capacity to promote early diagnosis, prevention and management of NCDS among older people	Support to the formation of active ageing groups in four wards	600 members of the active age groups	832 OP (454 female, 378 male) members of active ageing clubs
	Training of health workers in early diagnosis and treatment of NCDs in 2 districts (3 days)	3 trainings all in year 1	228 health staff (87 female, 141 male) trained.
	District level peer review forums to review the new geriatrics training manual	2 peer review forums	District peer review forum held to review the new geriatrics training manual involved 60 (F35, M 25) health staff.
Result 2.1: Increased accountability and responsiveness by local authorities and health care workers to older people's health rights and	Formation/training of OPMG (data collection and analysis)	12 OPMGs established	12 OPMGs (4 in each district) with a total of 80 older persons established.
	Training of district health workers on data disaggregation	3 trainings all in year 1	A total of 63(29Fe) health workers from 26 health facilities trained
	District Joint meetings of OPMG with council officials on data and health	6 sessions, 4 in year one	6 Joint meetings conducted. A total of 96 participants including 45 local council leaders, and 51

Result	Output	Planned Activities	Achievements
entitlements	issues		OPMGs members
	National stakeholders workshop to share good practices	2 meetings at the national level	Not accomplished to be conducted after the evaluation
	Joint mid-year review sessions on progress, challenges and way forward (in Morogoro 2 days)	2 meetings	1 meeting held 24 participants (F7 and M17)
	Policy briefing papers based on good practices community and local government actions addressing NCDs	500 policy briefing papers	Not accomplished

In Kibaha, additional activities including integrated outreaches targeting older persons, facilitating intergenerational group meetings and establishment of livelihood/ income generating activities were implemented.

3.4. Project Impact

This section of the report outlines e changes observed from the project activities. Based on the short time period for the project, the impact assessment focuses on the outcome level of the project results chain. As per the Terms of Reference, the project impact is discussed under three levels of direct impact (impact on project beneficiaries), policy level impact and creation of an enabling environment (impact at facility and at health workers levels).

Direct Impact

The project direct impact reviews the results achieved by the interventions as per the project outcome level indicators. The section further documents the reported and observable project impacts on the target beneficiaries based on interviews with the various respondents as well as observations made during visits to health facilities. Review of project reports and interviews with beneficiaries as well as the key informant respondents identified that the project had made significant impact on all the indicators focusing on the direct beneficiaries. Under result area 1.1-older people and their families are able to practice healthy lifestyles to prevent and manage NCDs, review of project reports identified increase in % of older persons practicing healthy ageing activities, improved understanding on NCDs by older persons and caregivers and change in practices related to NCD risk factors such as excessive alcohol consumption and smoking. Overall, the % of older persons participating in healthy ageing activities increased from 6 % to 74 % representing an improvement of 68 %. This change was highest in Songea (80 %) and lowest in Kibaha (64%) as shown in figure 1 below.

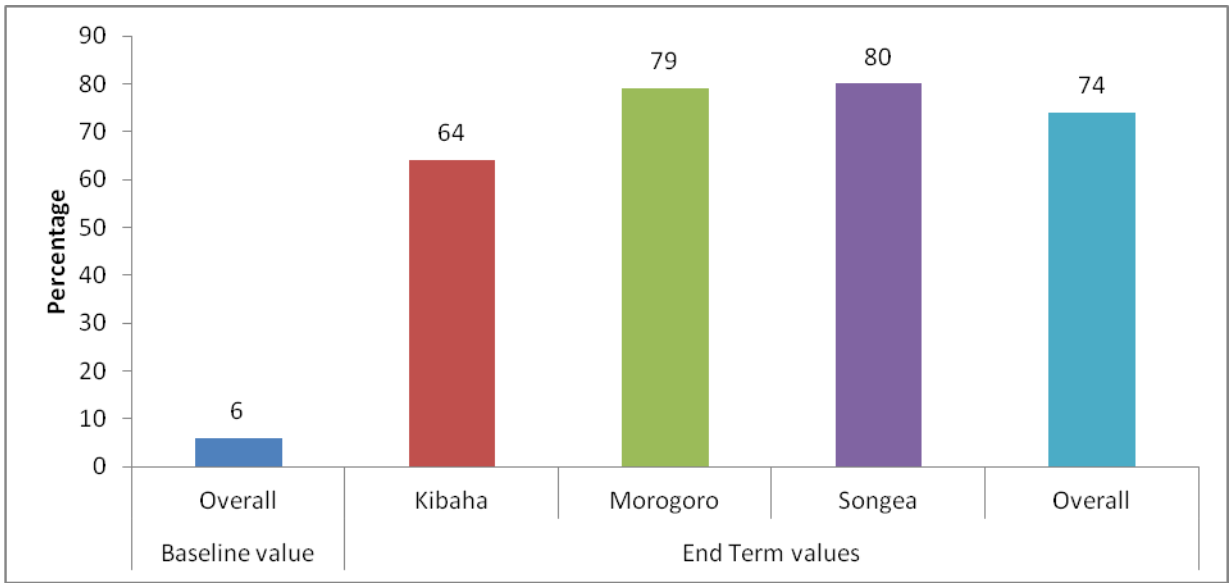

Figure 1: % of older persons taking part in healthy ageing activities

Through home visits by the home based care providers trained by the project, review of project documents identified that there was increased understanding by older people and care givers on the causes, symptoms, prevention and management of NCDs from 28 % to 85 %. This however contradicts reports from key informant interviews with care givers visited and the home based care providers that there was no structured process of knowledge transfer from the HBC provider to the caregivers.

This difference could be explained by lack of disaggregation of the data collected by the older persons monitoring groups into responses by older persons and responses by the care givers. Figure 2 below shows this improvement in knowledge.

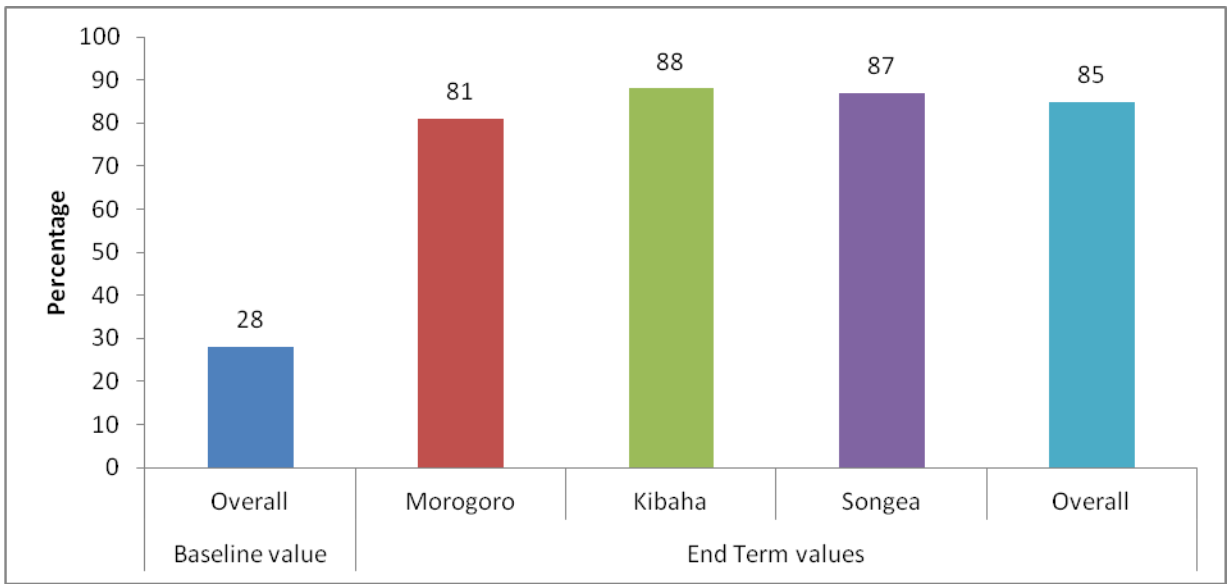

Figure 2: % of older persons and their caregivers with improved knowledge on NCDs

The evaluation further identified that through project interventions including participation in older person's group meetings and health education, older people changed behaviors that predispose them to non communicable diseases. Behavior changes reported included quitting smoking as well reduction in alcohol consumption based on data provided by the older persons monitoring groups in all the three project implementation sites of Morogoro, Kibaha and Songea. On overall, out of 282 older persons who were smoking in all sites, 194 (69 %) quit smoking representing a 6 % reduction from 75 % at baseline. Of those older persons who were excessively drinking, there was an overall reduction of 19 % from the 75 % baseline at the initiation of the project. Figure 3 below shows this change.

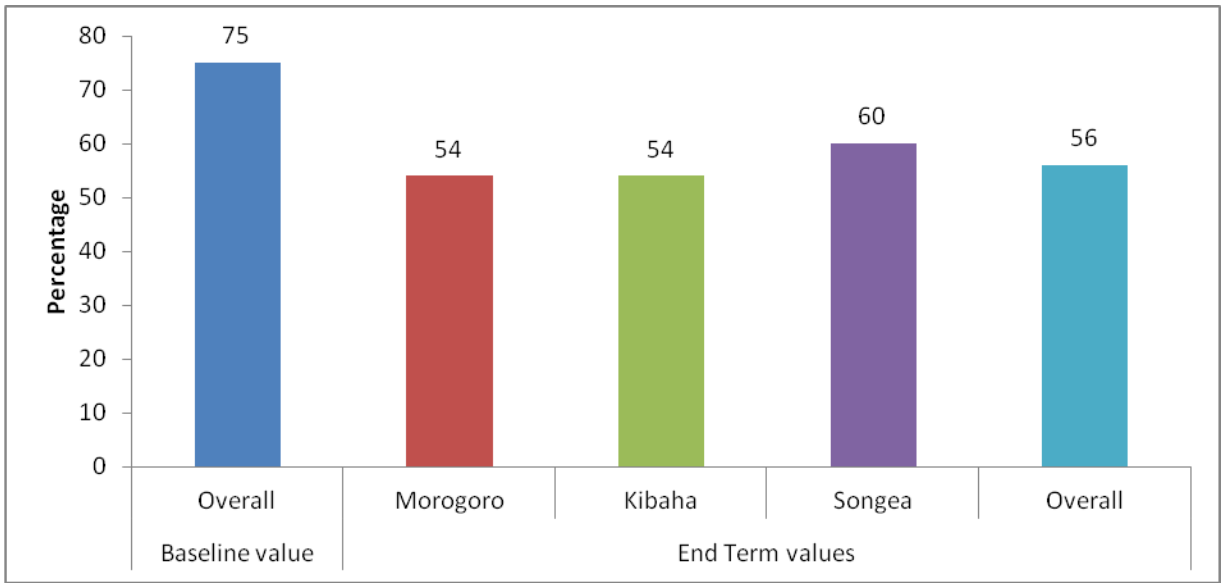

Figure 3: % of older persons who reduced drinking

Qualitative data from FGDs and KII with older persons, health workers and staff from implementing partner organizations identified increased awareness and positive changes in health seeking behavior among older people for prevention, management and treatment of NCDs. Some of the changes reported included increased awareness on rights to health services by older persons, increased attendance to health facilities for checkups and early diagnosis of NCDs and for treatment services. The increased attendance of the health facilities by the older persons was reported to be as a result of better services at health facilities and improved reception by the health workers. The following extracts from interview notes support this finding.

> *"Older people now know their rights; they come with newspaper cuttings on policy directives on provision of services to older persons*[8]*"*
>
> *Being old is not a disease, older people used to stay at home because they believed that what they are experiencing is part of old age, this has now changed*[9]*"*
>
> *"Although we have not conducted any impact evaluation as yet, we think the project has changed the lives of older persons, when you visit older people in the targeted areas, they look happy*[10]*"*

[8] Key informant interview with Incharge Morogoro regional referral hospital
[9] Key informant interview with Health worker at Mlandizi Health Centre, Kibaha
[10] Key informant interview with national older person's focal point person at the Ministry of Health and Social Welfare.

"Many older persons now know they do not have to be sick to visit a health facility… many are now visiting health facilities just for checkup[11]*"*

"others had high blood pressure and they did not know, through our programs we refer them to health facilities[12]*"*

"Attitude has changed… before the project, eating refined food was seen as great.. lakini sasa eating ugali ambayo haijakombolewa imekuwa sawa sana[13]*"*

"We did not have older persons coming to the facilities, attendance to health facilities has now increased…[14]*"*

An indirect impact of the project intervention on healthy ageing group meetings was reported as increasing socialization, togetherness and reducing loneliness among older persons. These meetings are noted as helpful in promoting older persons psychosocial health.

Project Impact at policy level

Through capacity building and advocacy interventions inbuilt in this project, this evaluation identified policy level impacts at national, district/councils and at health facility levels. At national level the Ministry of Health and Social Welfare, has strengthened their response to NCDs among older persons. Key Informant interviews identified that a desk for older persons has been established at the MoHSW and advocacy for older persons institutionalized. Making this observation a national level key informant respondent observed:

"within the Ministry, I included a paragraph in this year's budget speech by the Minister on the need to fund interventions for older persons, it will be read, I hope it remains in the speech and that it will not be deleted" [15]

[11] Key informant interview with health workers at Saba Saba Health Centre in Morogoro
[12] Key informant interview with health workers at Saba Saba Health Centre in Morogoro
[13] Key informant interview with CEO PADI. Swahili translated as "eating unrefined maize meal is now the accepted thing"
[14] Key informant interview with district lab coordinator; Kibaha district health office
[15] Key informant interview with national older person's focal point person at the Ministry of Health and Social Welfare.

Additionally, through national level project advocacy, it was reported that the revised health and social welfare strategy had included more budgets for NCD related health promotion activities. At the council and district level, it was reported that implementing partners and older persons monitoring groups advocacy, all the councils have increased their budgets for supporting older persons health activities including procurement of drugs for treatment of non communicable diseases and supporting older persons enrollment into CHF. Overall, the councils in the target districts have increased the health budgets allocation for older persons by US$56,092 against a baseline for CHF which was 13,063 representing an increase of over 329% increase. The bulk of this increase was from Songea at US$ 47,502 (85 %) as shown in figure 4 below.

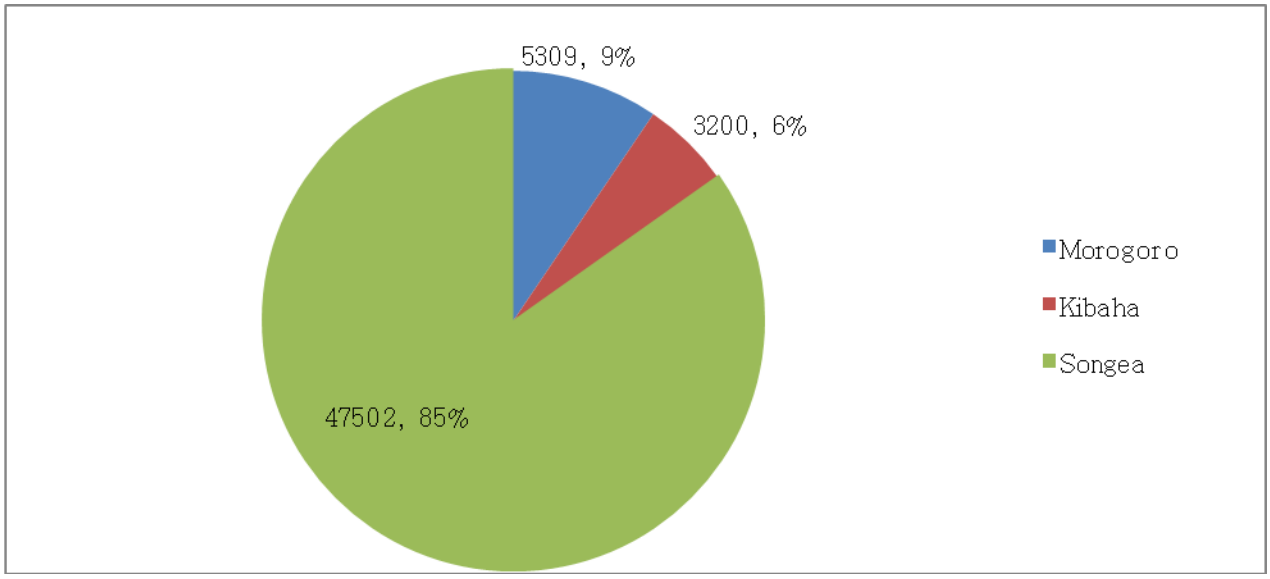

Figure 4: Budget allocation in USD for Older Persons Health by council (2014)

Although Tanzania has a policy for free treatment of older persons 60 years and above, it was reported that this policy was rarely applied in most facilities or implemented selectively targeting only "*vulnerable*" older persons. Through advocacy by older persons monitoring groups, this has been changed and treatment for all older persons in the targeted facilities is provided for free. As a result of this project, a curriculum for pre-service training of nurses on managing NCDs among older persons has been developed. This is expected to impact on the capacity of health workers to provide quality services to older people.

Older person's window at facility

Creation of an enabling environment

The Pfizer supported NCD project has contributed to the creation of an enabling environment for the provision of health services to older people by improving the skills and changing the attitudes of health workers as well as through system and infrastructural changes at health facility level. This evaluation identified that the health workers training implemented through this project had resulted in positive changes in their (health workers) attitudes towards the provision of services to older persons. Interviews with health workers as well as with older persons identified their prioritization and reduced discrimination in service delivery as per the following quotes.

> *"Hata na sisi ni wazee watarajiwa, uzee haukwepeki*[16]*"*
>
> *"Kwa nini wazee wateseka na hata sisi tunaelekea uko?*[17]*"*
>
> *"Before we used to think all the patients are the same, after the training we realize that older persons are more vulnerable and should be given priority*[18]*"*
>
> *"We have trained health workers and now they have positive attitude towards health workers….wazee wanasema wakienda hospitali wanapokewa vizuri, zamani walikuwa wakiambiwa hakuna dawa nenda ukanunue*[19]*"*

[16] Interview with facility based health workers, Morogoro translated as " even us are older persons in waiting, no one can run away from old age"

[17] Interview with regional medical officer; Morogoro Regional Referral Hospital translated as " why should older persons be subject to suffering even us are going to become old"

[18] Key informant interview with a health worker who participated in the training.

"Older persons are now not complaining…..they are satisfied with our services[20]*"*

The evaluation identified notable changes in the supported facilities. In all the facilities a clearly marked window for the provision of services to older persons has been created as a result of the project advocacy. Other infrastructural changes in the targeted facilities have been creation of a specific room to and sitting place for older persons. In Morogoro Regional Referral Hospital for instance, older persons share room and services provided for the National Hospital Health Insurance (NHIF) and privately insured clients.

"There is a difference between facilities supported by the project and those not supported, if you go to the supported facilities and dispensaries you will find a window and room specifically for serving older persons .., this has increased uptake of facility services by older persons… if older persons know they will spend less time in the facility, they will come to the facility…[21]*"*

Additionally, the recognition of the older persons structures established through the project by policy and decision makers at district and municipal council level is identified as a key project impact. In Morogoro for instance, the OPMGs were able to meet with the Municipal Council to advocate for services for older persons at the health facilities.

3.5. Project Sustainability

Review of the project's sustainability focused on whether the project had established structures and systems to ensure sustainability of the project interventions beyond the Pfizer funded project period. Additionally, the assessment also sought to understand whether the project had set up any exit strategy to ensure sustainability. In general terms, this evaluation identifies that some interventions will be sustained albeit not at the same scale while others will not be sustained at all. The evaluator did not identify any structured and written program exit strategy and the respondents were basically unaware about the end of the project period.

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[19] Key informant interview with a district health official Kibaha translated as *" when older persons go to hospital they are reporting that they are received well, before they used to be told there are no drugs"*

[20] Key informant interview with health care providerin Morogoro Regional Referral Hospital

[21] Key Informant Interview with health service provider in Morogoro Regional Referral Hospital. .

Interviews with the respondents seemed to suggest that community level interventions are more likely to be sustained than the facility based interventions. This situation is mainly attributed to the community structures that have been established through the program. The main challenge to sustainability of the facility based interventions was reported as being due to lack of drugs for treatment of common non communicable diseases affecting older persons. Key informants interviewed at district health office and at the health facilities reported that there are usually no drugs specifically for older persons and as a result it will be difficult to sustain effective treatment and care services to older persons with NCDs. It was further reported that there was an opportunity to utilise the facility cost sharing fund to buy some drugs for older persons. In Morogoro sites where the implementing partner had adequately involved the local councils and the health facilities, the evaluation identified higher chances of sustaining the program interventions. The following extracts present respondent views on the sustainability of the interventions:

> "*you will find some facilities have supplies while others do not have … I think the issues is leadership and governance- the older persons program may also need to target leadership and governance issues as part of the program intervention areas… the Government provides funds and where the health facility in charge is committed, they have and will continue procuring drugs to address NCDs among older persons*"[22].

> *"it will be difficult to sustain some interventions… we do not have enough drugs for treating NCDs among older persons…. However we have some little money from the cost sharing account, we can do something small but that is not enough*[23]"

> "*The project is sustainable; it has been appreciated that it is the responsibility of the council to provide age friendly health services. They have already started implementing interventions; at the national level within the Ministry of Health there is a permanent desk responsible for issues around older person's health. It will be sustainable because at national level a curriculum has been developed for training health workers….this will ensure the interventions are sustained*[24]"

[22] Key Informant respondent in Murogoro site
[23] Key informant respondent Saba Saba Health Centre.
[24] Key informant interview respondent at Morogoro

This evaluation identified that the project has put in place measures/actions to ensure sustainability of the interventions beyond the project period. Some of the measures put in place to ensure sustainability of the project include:

a. **Involvement of the local councils and targeted facilities in the project implementation**: Although this could be improved, it was noted that the project had involved the local councils and the targeted facilities in the implementation of the project and hence created ownership of the interventions. This evaluation identified that to some extent the project has involved and advocated with the local councils for the inclusion of the project interventions in the council's action plans. Inclusion of these activities in the council action plans means allocation of budgets and their implementation even beyond the project period. Based on key informant interviews at facility, district and municipal councils, out of the two sites visited, it was observed that there was more ownership of the project at health facility and district/municipal council level in Morogoro than in Kibaha sites. Director of the Municipal council of Morogoro reported being aware of the project while the health workers at the regional hospital had already designed a strategy to enroll older persons in the community health fund model.

b. **Establishment of community advocacy groups including older persons clubs, associations and OPMGs**: As part of creating community structures for sustainability, the project in all the 3 targeted regions created older people's associations, clubs and older persons monitoring groups at the lowest level of the community. The project built the capacity of the various groups by engaging them in different activities such as monitoring the provision of health services to older persons. As explained in other sections of this report, the groups demonstrated increased capacity through their engagement with the municipal councils to advocate for the rights of older persons. Some of the groups have established cooperatives which have been registered. These will ensure sustainability of the interventions beyond the project period.

c. **Training of peer educators and home based care providers:** The trained peer educators and home based care providers in all the targeted sites are expected to ensure sustainability of the project interventions.

d. **Working with local implementing partners**: Working with local implementing partners is seen as key strategy for ensuring sustainability beyond the project period.

e. **Community Health Fund and Tiba Kwa Kadi (TIKKA)**: In some regions, older persons have been recruited into community health fund in rural areas and in Tikka, the equivalent for peri-urban areasand provided with identity cards to enable them to access services. This is seen as an effective strategy for ensuring provision of treatment services to older persons.

An older persons TIKKA card in

f. **Integration of livelihood interventions such as income generating activities**: Integration of livelihood interventions including income generating activities with other interventions was identified in Kibaha site. Additionally, active ageing groups in Morogoro engaged in income generating activities including soap and mat making. This evaluation identifies this as key strategy both for promoting sustainability as well as for motivating the community volunteers.

Mat making Income Generating

Despite those measures, this evaluation identified a gap in the design and the implementation of the program that could comprise sustainability of the implemented interventions. Review of project documents and interviews with key informants including those from implementing partners and the Ministry of Health officials identified that the project did not develop a clear exit strategy. The strategy should have covered an agreement with the local facilities and councils on handover of the project interventions as well as strengthening community structures to ensure integration. This exit strategy should have been in built within the overall project design.

4.0. Challenges and emerging practices

4.1. Challenges

The overall project challenges reported included:-

a. Inadequate drugs and other supplies in the targeted facilities for treatment and management of NCDs among older person

b. Inadequate health service providers and attrition of those trained. It was reported that in most facilities there were high health staff shortages which impacts on the provision of services to older persons. With frequent transfers, some of the health workers who had been trained in Kibaha had been transferred to other areas.

c. Lack of specialists in older person's health in the country. It was reported that in the country and even in the targeted program areas, there is an acute shortage of older people's health specialists.

d. Health data does not make a mention of older persons. It was reported the national health information tools do not capture data on older persons. Although all the targeted facilities had created a register for collection of older person's data at facility level, this was yet to be reflected in the national health information systems.

e. Lack of approved curriculum for training health workers as ToTs and also community volunteers on Home Based Care for NCDs.

f. Lack of motivation for home based care providers and Peer Educators. This evaluation identified that lack of motivation for volunteer home based providers as a key challenge to the provision of services to home bound older persons.

4.2. Emerging Best Practices

This section of the evaluation report highlights some best practices identified through this evaluation that could be documented, disseminated and scaled up. The following is a description of some of the emerging best practices.

Recruitment of Older Persons into the Community Health Fund: This evaluation identified that in some sites the older persons had been recruited into the community health fund where they are provided with an affordable insurance service to enable their access to health services together with their families. In Morogoro for instance, the regional hospital reported that some older persons had been enrolled into the urban and peri urban equivalent of CHF referred to as Tiba Kwa Kadi or simply TIKA. This is identified as a good practice that can be documented and scaled up to other areas.

The community Health Fund[1]

The community health fund was started in Tanzania in 1996 as a pilot scheme and has now been scaled up to most municipal councils including in the three NCD project target areas. The objective of the scheme is to address financial barriers to accessing basic health care services to populations in the rural areas. It is based on the concept of risk sharing whereby members pay a small contribution on a regular basis to offset the risk of needing to pay a much larger amount in health care user fees if they fall sick. According to the Community Health Fund Act of 2001 the objectives of the CHF are: (i) to mobilize financial resources from the community for provision of health care services to its members; (ii) to provide quality and affordable health care services through sustainable financial mechanism; and (iii) to improve health care services management in the communities through decentralization by empowering the communities in making decisions and by contributing on matters affecting their health. An equivalent for urban and peri- urban areas is referred to a *Tiba Kwa Kadi*, or TIKA.

Intergenerational Group approach: Although this approach was introduced late in the project implementation, interviews with the project intergenerational groups in Kibaha identified that this as innovative strategy. It was reported that the approach was effective in promoting sharing of ideas among young and the older persons. The following extracts from those interviewed confirm this observation:

> *"Addressing healthy living from early age is of great importance*[25]*" "When mixed youth and older people… the young people were very happy, to mix with older persons… this has build good relationships… the older persons have become more active*[26]*"*

Intergenerational Group

[25] NCD national Strategy Page 3
[26] Discussant from Kibaha Intergenerational Group

"Kuwa na vijana ni bora zaidi, watuchangamcha, wakivuta kamba tunaanguka[27]*"*

Working with Older Persons Monitoring Groups: Working with OPMGs is identified as an innovative strategy for involving the older persons in the advocacy of their own rights. This evaluation identified that the OPMGs were very successful in carrying out monitoring activities on the provision of health services and advocating at both facility and district/municipal council levels for actions to remove barriers that hinder access to health services by older persons.

School Health Approach: Related to the intergenerational approach, this evaluation identified that the school approach to NCDs programming had been used in Songea program area. This concept seeks to implement the WHO life course approach in programming for NCDs response as well as using school children to transfer knowledge from the schools to older persons in their families and communities.

Operations research: This evaluation identified that Morogoro Regional Hospital had instated cost analysis research to understand how much it would cost the hospital to provide services to older persons. It was reported that the hospital enrolled the older persons to be provided services together with patients covered through NHIF and other private insurance schemes. Findings from this operations research could be used as both a planning and advocacy tool for service provision for older persons.

5.0. Conclusions and Recommendations

5.1. Conclusions

On overall, this evaluation identifies the project as having been successful in instutionalising response to NCDs among older persons at national and facility levels. The project has created the necessary structures at community levels for facilitating the implementation of promotive, prevention, rehabilitative and care interventions for addressing NCDs among older persons. Given the short project duration, the project will require more time to strengthen the structures established, develop necessary implementation tools and document emerging best practices. Involvement of the target beneficiaries at design stage and development of a clear exist strategy are identified as having been weak.

[27] Discussant from Kibaha Intergenerational Group. Translation: "Being with young people is better, they make us excited and more active, when they pull the rope we fall"

5.2. Recommendations

Based on the study findings, emerging best practices and gaps identified, this evaluation makes the following recommendations:-

Advocacy for the provision of drugs to manage non communicable diseases among older persons

This evaluation identified lack of drugs for NCDs among older persons as the biggest challenge to sustaining interventions around treatment and care for older persons with NCDs. This evaluation recommends that HelpAge International in Tanzania and the implementing partners strengthen advocacy at the national, council/district and at facility level to ensure the provision of budgets for procurement of drugs for treatment and management of NCDs among older persons. At national level, a focus for advocacy could be advocating for inclusion of selected drugs for management of NCDs among older persons in the national essential medicines list.

Strengthen project management and Technical support to partners

Partners interviewed reported need for more technical supportive supervision by HelpAge International in Tanzania. Interviews with project staff and review of project documents did not identify a structured process of managing the program and providing technical support to the implementing partners. This evaluation recommends that such projects in future form Project Advisory Committee at the national and at the regional levels. It is further recommended that HelpAge International in Tanzania should structure and ensure regular supportive supervision and monitoring visits to partners. This technical committee should involve all the relevant stakeholders most importantly council heads and representatives from the Ministry of Health. This committee should have clear terms of reference and should meet frequently to offer support to the partners in the implementation of the project.

Simply the Easy Care tool for use by the HBC providers

This evaluation identified that the Easy Care Tool is a useful tool for completing holistic assessments of older people. This evaluation identified that the tool as currently designed is only for use by trained health workers. Health workers complained that the tool is too long and with the high shortage of health workers, it is challenging for the assessment to be conducted. It is identified that the tool can be reviewed, made simpler and used for home based care providers who can summarise the notes for use by the facility based health care workers during their visit to the health facilities.

Standardize recruitment and training of home based care providers

This evaluation identified that the selection of the Home Based Care providers was not standardized. While interviews with the project staff at HelpAge International reported that the Home Based Care providers trained were a mix of older persons and young people and those that were already providing home based care services before the start of the project, this was not observed as the case in both Kibaha and Morogoro. All the HBC providers interviewed in the two project sites were aged above 60 years and all reported that they needed additional training to be able to adequately provide services to older persons. None of those interviewed reported that they had worked before as HBC providers. However, telephone interview with the CEO in PADI identified that HBC providers in Songea were both a mix of old and young people and also had previously undergone training in HBC. It is recommended that the program standardizes the identification and the training of the HBC providers. In all the two sites visited, the HBC providers had been trained only for 3 days. It was reported that the Ministry of Health would only recognize HBC who have been trained for 21 days. This evaluation recommends that for the HBC providers who have been trained before on HBC there will be need to train them as well as provide refresher trainings for all the trained HBC providers.

Strengthen transfer of knowledge from the HBC providers to the caregivers

Interviews with care givers of homebound older persons identified that although HBC provider visited the households, the transfer of knowledge from HBC providers to care givers was not structured. It is recommended that the project in collaboration with the Ministry of Health develops an instruction manual for home based care providers to guide transfer of knowledge to the care givers during the home visits. Additionally the HBC providers should be provided with a Home Based Kit for diagnosis and management of NCDs.

Conduct BCC formative assessment on the NCD risk factors and develop a comprehensive strategy

The national NCD strategy calls for a strengthened campaign against substance abuse. To systematically address this, there is need to conduct a detailed BCC formative assessment in the target areas on substance abuse upon which the country could develop a detailed BCC strategy targeting both those in old age as well as the young people. The BCC strategy would address the risk factors to NCDs including diet, physical inactivity, smoking as well as alcohol abuse.

Strengthened integration of NCDS and communicable diseases especially HIV and AIDS

Studies have demonstrated close linkages and opportunities for integrating NCDs with communicable diseases especially HIV and AIDS. Although this evaluation identified some attempt by the project in linking HIV and AIDS interventions with NCDs, it is recommended that the project systematizes and strengthens this integration.

As part of the integration process, it is recommended that the project identify the common communicable diseases that affect older people in the target regions and define opportunities through which these could be integrated NCD program interventions. Home Based Care providers could for instance be trained and provided with materials for provision of messages on prevention of the communicable diseases during their visits to home bound older persons.

Integration of data about NCDs and older persons in the national health information systems
With support from the project, targeted facilities were able to institutionalize data collection, recording and reporting of NCDs among older persons. This was however done in separate registers. This evaluation recommends strengthening of advocacy for integration of data on older persons and NCDs in the already existing national health information systems such as District Health Information Systems (DHIS) 2 to ensure sustainability and buy in from health workers.

Development of an integrated older person's friendly model sites within the targeted sites
Interviews with older persons and other stakeholders identified the need to start a model "*active ageing centre*" which could serve as a model for older people friendly centre. This centre could in addition to be used for active ageing activities could also provide self diagnosis services where health workers could conduct simple self diagnostic tests such as blood sugar and tests on their sugar levels. This centre could also be open to the public at a fee and can serve as an income generating activity for older persons. To ensure cost effectiveness, "gym" equipment could be made from locally available materials.

Strengthen and scale up livelihood interventions as part of the project response
Interviews with older persons identified integration of livelihood interventions with interventions on active ageing as being motivating to older persons, helping address the financial barriers that hinder older person's access to health services as well as providing the required nutrition to older persons. This evaluation recommends strengthening of the livelihood interventions in the sites where these are being implemented and scale up to other sites.

6.0. Annexes

6.1. Key informant Respondents

Name	Organisation	Designation
1. Dr. Edwin Patrick Mung'ong'o	Ministry of Health and Social Welfare	Coordinator Health Services to Older People
2. Ms Amleset Tewodros	HelpAge International	Country Director
3. Mr. leonard Ndamgomba	HelpAge International	Program Coordinator
4. Agnes Lazaro	GSST	Chairperson
5. Elisha Sibale	GSST[28]	Chief Executive Officer
6. Mr. Iskaaka Musingwa	PADI	Chief Executive Officer
7. Dr. Suma Kabunje	Saba Saba Health Centre Morogoro	CTC Incharge
8. Dr. Said Mbwana	Saba Saba Health Centre	Incharge Saba Saba H/C
9. Dr. Hellen Mwayoya	Saba Saba Health Centre	Health Worker
10. Dr. Caroline Sakaya	Saba Saba Health Centre	Health Worker
11. Mr. Samson Msemwembo	MOROPEO	Executive Director
12. Dr. Rita Lyamuya	Morogoro Regional Refferal Hospital	Incharge
13. Ms Mary Hyva	Mlandizi Health Centre	Nurse
14. Ms. Siyawezi Mwiche	Mlandizi Health Centre	Medical Attendant
15. Dr. Magadelene Maggy	Mlandizi Health Centre	Ophthalmologist
16. Ms Betty Kolila	Mwendapole Dispensary	Nurse
17. Ms. Augustina Pantaleo	Mwendapole Dispensary	Nurse
18. Dr. Mukhisu Issa	Mwendapole Dispensary	Facility Doctor
19. Dr. Bagiswa	Morogoro Regional Refferal Hospital	Dermatologist and older persons focal point person
20. Naswike Mwaihiga	Kibaha District Office	District Laboratory Coordinator

[28] Good Samaritan Social Services Trust