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Evaluation of ‘Reducing the burden of tuberculosis’ (2021-2025)

Final Report (tc)

Photo: Volunteers from TOKIUKI TB Club, Kinondoni, Tanzania

03905.2025

LHL International

Name of the project:	Reducing the burden of tuberculosis
Client Name:	LHL International (LHLI)
Time period:	January 2025 – April 2025

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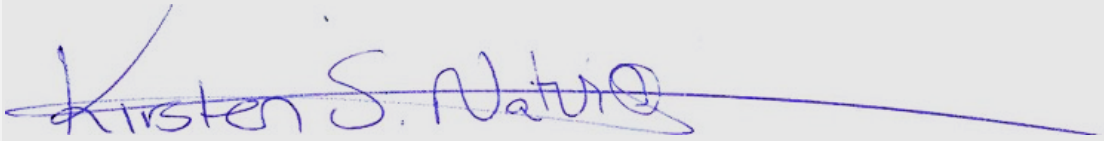
Acknowledgement

Scanteam would like to thank LHLI for giving us the trust in organising the evaluation as a "Participatory evaluation” in Malawi and Tanzania. Furthermore, we wish to express a heartfelt ‘Thank you!’ to Paradiso TB Patient Trust and MKUTA who took ownership and organised the participatory evaluation in Malawi and Tanzania, identifying evaluation team members and hosting the training and data-analysis.

This evaluation took place immediately after USAID closed their funding streams and offices, which created a historical financial shock in the health sectors in the four countries where the program under evaluation is carried out.

It is challenging to provide relevant recommendations in such times of uncertainty. It is therefore with large humbleness that we deliver this report.

On behalf of the evaluation team
Oslo, May 9th 2025



Kirsten S. Natvig / Scanteam

Abbreviations

AIDS	Acquired Immunodeficiency Syndrome
ARV	Antiretroviral (drugs)
BCG	Bacillus Calmette-Guérin (TB Vaccine)
CBO	Community-based organisation
CSO	Civil society organisation
DR-TB	Drug resistant tuberculosis
GDPR	General Data Protection Regulation
GF	Global Fund (to fight AIDS, tuberculosis and malaria)
HDP	Health Development Program (Sudan)
HIV	Human Immunodeficiency Virus
IBF	In But Free (Zambia)
IGA	Income generating activity
LHLI	LHL International – Tuberculosis Foundation (Norway)
MDR-TB	Multi-drug resistant tuberculosis
MoH	Ministry of Health
NGO	Non-Governmental Organisation
NTLEP	National Tuberculosis and Leprosy Elimination Program (Malawi)
NTLP	National Tuberculosis and Leprosy Program (Tanzania)
NTP	National Tuberculosis Program
PEPFAR	The United States President's Emergency Plan for AIDS Relief
SDG	Sustainable Development Goal
TB	Tuberculosis
TPT	Tuberculosis Prevention Treatment
UHC	Universal Health Coverage
USAID	Unites states of America's Agency for International Development
WHO	World Health Organisation

Executive summary

This evaluation has assessed Effectiveness, Relevance, Sustainability, and Cross-cutting issues of the LHLI-supported 'Reducing the Burden of tuberculosis'-program in Malawi, Tanzania, Sudan and Zambia.

In Malawi, Tanzania and Sudan, the partner organisations Paradiso, MKUTA, and Health Development Program are organisations consisting of TB survivors who operate at community level to bridge the gap between the communities and the health facilities. In Zambia, In But Free works for TB control and care in prisons. While all the four countries are highly challenged by tuberculosis, the program in Sudan is carried out amidst war and a devastating humanitarian crisis where in one and a half years more than 60,000 are estimated to have died[1] and some 30.4 million people are in need of assistance, hereunder health, food and other forms of humanitarian support[2].

The evaluation took place as USAID, a major donor to health and communicable diseases in all four countries, suddenly stopped its funding stream and closed down. This has increased the relative importance of LHLI and the 'Reducing the Burden of tuberculosis'-program over night.

With long-term, professional assistance from LHLI, the four implementing partners have developed from being small initiatives to have become influential organisations in the fight against tuberculosis in their respective countries. The evaluation found **that all four implementing partners play crucial roles in the national TB responses.** In Malawi, Paradiso stands as the sole TB patient organization, with a presence in almost every district. They actively participate in the Technical Working Group of the National Tuberculosis and Leprosy Elimination Program. MKUTA in Tanzania is widely acknowledged as a vital stakeholder in the national TB response, with volunteers spread across all regions. Their representatives hold positions in various working groups and committees under the National Tuberculosis and Leprosy Program, contributing to policies, guidelines, and research initiatives. In Sudan, the Health Development Program is a key player in the national TB response. They participate in national committees, collaborate with the Ministry of Health, and lead sub-TB committees. Their work encompasses training, advocacy, and community-based services. "In But Free" in Zambia has made significant strides in reducing TB-related deaths in correctional facilities. It has improved treatment success rates and bolstered healthcare systems within prisons.

The four implementing partners have shown **significant effectiveness** in awareness-raising and stigma reduction, TB prevention and care, improving access to health services for people

[1] November 2024; London School of Hygiene and Tropical Medicine's Sudan Research Group
[2]https://www.ungeneva.org/en/news-media/news/2025/02/103375/sudan-most-devastating-humanitarian-and-displacement-crisis-world?utm_source=perplexity (accessed 30 March 2025)

with presumed TB, increasing TB notifications and reducing TB-related deaths.

The interventions and strategies chosen by the four implementing partners appear to be **highly relevant** to reduce the burden of TB in the four countries. Actions taken are found to be effective and efficient. As long as tuberculosis exists, more of the same actions will be needed.

The implementing partners have identified at-risk key populations with high TB prevalence that the health systems do not have resources to reach. It seems plausible that the three partners working with outreach through volunteers have correctly identified all the key populations that need special attention. However, lack of funding, combined with lack of national and international prioritization of fighting tuberculosis, as well as the warfare in Sudan, prevent the implementing partners to reach every individual with presumed tuberculosis.

In terms of **sustainability,** aligning TB strategies with national TB policies ensures continuity despite political changes. In Malawi, Sudan and Tanzania, the TB volunteer networks have grown from small to large, and a reason for this has been the volunteerism upon which the networks are based. However, the same volunteerism is also found to be a weakness. While it allows the network to grow and expand, it also reduces the possibilities for each individual to be active long-term due to time consuming schedules, lack of compensation for the work, and exposure to TB and other communicable diseases without being protected or insured. The evaluation found that in all four countries, it appears likely that an **expansion to other diseases** or malaises beyond TB would increase funding opportunities, and thereby making the TB volunteer networks become more robust.

The four partner organisations have a strong **focus on inclusion, anti-discrimination, gender equality**, patient-friendly treatment, and dignity for all. There may be a potential to reach more men, both patients and volunteers.

Recommendations

From what this evaluation can fathom, the approaches, actions and activities carried out by the four implementing partners are relevant, effective and efficient, and should be continued or scaled up, to the degree that funding allows.

The evaluation was conducted as a participatory evaluation with internal stakeholders carrying out focus group interviews and generating recommendations in Malawi and Tanzania. For Sudan and Zambia, the evaluation included document review and one virtual interview per country. Data gathered from Sudan and Zambia has contributed to inform the evaluation, but not to such a detailed level that recommendations can be forwarded. The recommendations to Paradiso and MKUTA are directed at their overall work to fight tuberculosis, including and beyond the 'Reducing the burden of tuberculosis' program.

To LHLI

- LHLI is recommended to sit down with the four implementing partners and carefully scrutinize which activities and actions can only be carried out by the implementing partners, and which, if any, may be transferred or left to other actors.
- Support the four implementing partners to increase their fund-raising from the private sector, and, where feasible, from national, regional and/or local budgets.
- Continue to carry out advocacy to include post-TB follow-up in the NTPs.
- Look into opportunities to link the TB volunteer networks with ongoing research in the four countries for synergies and mutual benefit for all.

To Paradiso

- Carry out a gendered analysis of the target groups to identify a differentiated approach towards males and females. Introduce targeted interventions to encourage men to seek TB care. Also, find ways to recruit more men as TB volunteers.
- If funding allows, strengthen ongoing programs on *HIV/TB co-infection* and *Nutrition* and develop new programs on *Targeting men who have issues with alcohol and are smokers* and *Female sex workers.*
- Look into opportunities for collaboration with relevant actors for support and capacity building to volunteers.
- Broaden community outreach and TB awareness activities.
- Strengthen partnerships and relationships.

To MKUTA

- Identify ways to provide support enabling strategies of volunteers to enhance their effectiveness and sustainability.
- Solidify the TB Club network.
- Advocate for lower cost and higher quality health services.
- Link up with other existing services to enhance patients' wellbeing.
- Continue to reduce stigma by expanding use of social media.

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1 Background

1.1 Introduction

This Final Report for the evaluation of LHLI's program 'Reducing the burden of TB' is based on Scanteam's tender to LHLI and an Inception Report dated 22.01.2025, and LHLI and partners' reactions to this.

Scanteam has evaluated LHLI's Norad-funded program "Reducing the burden of TB" (2021-2025) in Malawi, Sudan, Tanzania and Zambia. It is a continuation of a program that started in 2015. The program cooperates with one implementing civil society partner in each country.[3] The implementing partners mainly consist of people affected by TB. They collaborate with local health services. The backbone of the program is awareness raising and referrals to treatment done by thousands of volunteers affected by TB. The program's objectives are:

0. The rights and needs of people affected by TB are met
1. CSOs for people affected by TB are considered as key stakeholders
2. People with TB are diagnosed
3. People affected by TB access care and support

The purposes of the evaluation are learning and documentation of effects of community systems in health. The results from the recommendations will inform the program in its next period.

The objective of the evaluation is to assess if the implementing partner in the program have become key stakeholders in the national TB response, focusing on the role of the implementing partner in service delivery across the cascade of care and contributions to health system strengthening, including reflections on the implementing partners' own progress.

The scope of the evaluation is the implementation period between 2021 and 2024 of the program: "Reducing the burden of TB", with fieldwork in Malawi and Tanzania, and with a focus on Effectiveness, Sustainability, Relevance, Human Rights and Gender Equality.

Scanteam proposed to carry out the evaluation as a Participatory Evaluation, and the two partners Paradiso in Malawi and MKUTA in Tanzania agreed to take full ownership in terms of identifying members of the evaluation team, making preparations, and taking care of the logistics.

2 Methodology

Scanteam has used four data gathering methods:
1) Document review

[3] In Tanzania, LHLI has two additional partners from the public health system that are not part of this evaluation.

2) Key informant interviews
3) Group interviews
4) Observation

There were two field visits, one to Malawi and one to Tanzania. Introductory meetings and interviews with key stakeholders were held by Scanteam in Lilongwe and Dar, thereafter the field work was participatory, see Box 1 below.

Box 1: Participatory evaluation

A participatory evaluation is based on the assumption that the involvement of the people implementing the program in the evaluation will help ensure that the evaluation addresses the appropriate issues. It is also assumed that participation will give them a sense of ownership over the evaluation results. The involvement should thus lead to use of evaluation results by program decision-makers and implementers. The participatory approach constitutes a learning experience for the program stakeholders who are involved. It can reinforce their skills in program evaluation and increase their understanding of their own program strategy, its strengths and weaknesses. The interactive evaluation process itself contributes to improved communication between program actors who are working at different levels of program implementation.

In the participatory approach, the role of the team members is:

- to share their experiences working with the program
- to participate in collecting additional information about program implementation
- to work in the evaluation team to analyse both the data collected and the experiences described
- to formulate findings, lessons learned and recommendations about the program strategy

The experience is that when people belonging to the local level of the implementing organisation participate in interviews of their own peers at community level, they are able to provide valuable contributions within observation of the community members' reactions and behaviour, and otherwise bring in depth of local insight for the data analysis.

It is assumed that the quality of the evaluation will be higher given that the results reflect both the subjective perspective of program implementers and the more objective perspective of an outside evaluator. The participatory evaluation methodology includes the identification of implementation problems, and emphasizes the development of lessons learned based both on the problematic and successful aspects of the program implementation process. From beginning to end the orientation of the evaluation methodology exercise addresses the question *"What can we learn from what we have already accomplished in order to improve the program in the future?"*.

The lessons which stakeholders develop tend to be based not only on the evaluation findings but also on their understanding of policy priorities, program context, resource availability, etc. Participation fosters ownership. It has been found that where program stakeholders have participated in this way in developing lessons, they not only have a clearer understanding of the evaluation results and of how they should be used, but also a greater commitment to putting the recommendations into practice.

2.1 Data gathering

1. Document Review:
Documents have included overall program proposal and annual reports, earlier reviews, assessments or evaluations, LHLI travel reports, implementing partners' proposals, plans and annual reports, and other relevant literature.

2. Key Informant interviews

- LHLI Oslo; 6 staff members, physical
- Health Development Program: 1 staff member, virtual
- In But Free: 3 staff members, virtual
- Paradiso TB Patient Trust, Lilongwe: 1 staff member, physical
- National TB program Malawi, Lilongwe: 2 staff members, physical
- Collaborating partners in Malawi, Lilongwe: 6 representatives, physical; 2 representatives, virtual
- MKUTA TB Patient Organization, Dar es Salaam: 4 staff members and 4 subsidiary staff members, physical
- National TB program Tanzania, Dar es Salaam: 2 representatives, physical/virtual
- Collaborating partners in Tanzania, Dar es Salaam: 3 representatives, physical/virtual

3. Participatory evaluation and focus groups interviews

Selection of the participatory evaluation teams

- In Malawi, the participatory evaluation team was composed of eight people divided into three teams. There were four Paradiso staff members and two volunteers from each of the two sites they visited.

- In Tanzania, the participatory evaluation team was composed of 12 members divided into four teams. There were three MKUTA staff members, three MUKIKUTE (MKUTA subsidiary) staff members and one volunteer, one TOKIUKI (TB Club) staff member and two volunteers, and two staff members of STEP (collaborating partner).

Selection of sites for focus-group interviews

- In Malawi, Paradiso selected the locations, and the participants involved in the evaluation. The consultant identified two external stakeholders to interview. Considering the limited time that was allocated to conduct the evaluation, Paradiso management decided that the two sites to be engaged should be easily accessible by road due to it being the rainy season in Malawi, and it would have been risky to go to hard-to-reach remote areas. Hence the selection of Kaigwazanga and Ngwenya which are accessible by tarmac roads.

- In Tanzania, the participatory evaluation was carried out in two different sites; Temeke in Dar es Salaam, and Kinondoni in Dar es Salaam. Dar es Salaam was chosen due to the time aspect. The choice of the two selected sites was guided by the fact that in Temeke, the oldest, the founder and the TB Club with the most experience, MUKIKUTE, operates. Kinondoni was

selected as TOKIUKI operates there, which is a younger and comparatively smaller and less experienced TB Club.

Interviews in selected communities/sites in Malawi and Tanzania

- In Malawi, three teams carried out three focus group interviews in two sites: Kaigwazanga and Ngwenya. In total, 66 stakeholders were interviewed: 19 volunteers (13F/6M); 20 community members (11F/9M); and 19 community leaders (4F/15M), and nine health workers (1F/8M).
- In Tanzania, there were four small teams carrying out focus group interviews in two sites; Temeke and Kinondoni in Dar es Salaam. In total 69 stakeholders were interviewed: 21 volunteers (14F/7M); 16 community members (8F/8M); 15 local leaders (8F/7M), and 17 local health workers (11F/6M).

Selection of informants

- In Malawi, various stakeholders that Paradiso directly collaborates with were selected.
  - These include the National TB and Leprosy Elimination Program, which granted Paradiso the mandate to operate in the country and to which it reports annually.
  - Paradiso also works with the Parliamentary TB Caucus in its advocacy efforts to lobby the government for increased resources in the fight against TB.
  - The Civil Society Advocacy Forum was engaged because Paradiso serves as the TB lead within this network, making their testimony crucial.
  - Orphans and vulnerable children who received educational support were also involved to share their experiences, attest to the assistance provided by Paradiso, and showcase their academic achievements from the project.
  - Volunteers, who are the custodians of all community TB projects implemented by Paradiso, were included as well.
  - Additionally, community leaders—who grant permission to Paradiso staff and volunteers to conduct TB activities within their jurisdictions—were engaged. Without their approval, activities cannot be implemented, as they enforce by-laws that empower them to accept, deny, or halt any activity in their areas if there is a breach of regulations or protocols.
  - Lastly, community members, as the direct beneficiaries of Paradiso's projects, were also consulted to determine their awareness of Paradiso and its initiatives.
- In Tanzania, community leaders around the TB Clubs as well as the citizens were selected through snowball sampling by the office bearers. Local health system members were identified through the two municipal authorities.

The participatory field work in Malawi and Tanzania took four days:

Day 1: A preparatory workshop with the evaluation team was held to finetune interview guides and prepare evaluation team members for the field visits.

Day 2 and 3: Visits to two selected communities: one day each. Group interviews and observation of community leadership; community volunteers; community citizens; local health services.

Day 4: Validation workshop with the evaluation team.

4. Observation

Evaluation team members observed the communities, the focus groups and the interviewees during the field visits. The evaluation team members belonging to the community played a key role in analysing and interpreting the observations made, given their insight. Observation was conducted by the evaluation teams in the selected sites/communities in Malawi and Tanzania.

2.2 Data analysis

Formulation of findings from data

After the focus-group interviews, the evaluation teams analysed the data and identified findings. Possible lessons learned and recommendations were noted down.

Answering the evaluation questions

When data from all focus group interviews were analysed, the evaluation teams worked in plenary to answer the evaluation questions with findings derived from the data from the interviews. Overall conclusions were made, and recommendations were put forward.

2.3 Ethical considerations

- ∨ The evaluation team obtained prior consent to all interviews. Paradiso and MKUTA were careful to only invite people who wanted to contribute in group interviews. An oral explanation of how data would be used was given ahead of every interview.
- ∨ Explicit consent was sought before taking photos.
- ∨ The interview guides only had open, non-leading questions during interviews.
- ∨ Scanteam adheres to ethical standards to be upheld, and addressed this during the Preparatory Workshops held in Malawi and Tanzania prior to field visits.
- ∨ Scanteam will delete all data gathered no later than three months after the finalization of the assignment, in accordance with General Data Protection Regulations.

2.4 Methodological limitations

In all evaluations of donor funded development assistance programs, there will be a positive bias, as stakeholders are often eager that the funding continues. In this case, the positive bias may have been stronger than one can normally expect, due to fear created by the sudden closure of the USAID. USAID has been a vital donor within health and TB control for many years, and stakeholders were concerned regarding what might happen in the future.

Time available is often a balance between what would have been optimal for data gathering, and what is possible within a given budget. In this case, as is often the case, there could have been more time for gathering more data to improve triangulation.

3 Country context and Partner organisations

3.1 Country context in Malawi

Malawi is among the high tuberculosis (TB) burden countries, with the disease remaining a major public health concern. According to the WHO, TB incidence was 119/100 000 in 2023, and people with a new or relapse case of TB who are living with HIV was 47%[4]. Multidrug-resistant TB (MDR-TB) is an emerging concern in Malawi. While the National Tuberculosis and Leprosy Elimination Program (NTLEP) has made progress in expanding TB services, challenges in detection, treatment adherence, and community awareness persist.

Many rural and remote communities in Malawi struggle to access TB diagnostic and treatment facilities. Long travel distances, poor road infrastructure, and a lack of healthcare facilities contribute to delays in TB diagnosis and treatment initiation. The high prevalence of HIV and AIDS in Malawi exacerbates the TB crisis, and TB-HIV co-infection is a significant challenge. Nonetheless, coordination between TB and HIV programs remains weak in some areas, leading to gaps in service delivery and patient management.[5]

There is a critical shortage of trained healthcare professionals, particularly in TB diagnostics and treatment. Many health facilities lack sufficient staff, affecting the quality and efficiency of TB services. Community health workers and volunteers play a crucial role, but they require additional training and support to enhance their effectiveness.[6]

Many TB patients face difficulties in adhering to the lengthy treatment regimen due to socio-economic factors, including poverty, malnutrition, and lack of social support. Additionally, periodic drug stockouts in health facilities disrupt treatment continuity, increasing the risk of drug-resistant TB.[7]

TB stigma remains a significant barrier to care-seeking behaviour in Malawi. Many individuals fear social exclusion and discrimination, leading to delays in diagnosis and treatment. This issue is particularly pronounced among marginalized groups, further limiting access to TB care.[8]

Malawi's TB control efforts rely heavily on donor funding, which poses sustainability challenges. Limited domestic investment in TB programs affects the expansion of diagnostic and treatment services, as well as the implementation of innovative community-based interventions.[9]

[4] https://www.who.int/teams/global-programme-on-tuberculosis-and-lung-health/data
[5] https://bmcpublichealth.biomedcentral.com/articles/10.1186/s12889-019-6577-8
[6] https://pmc.ncbi.nlm.nih.gov/articles/PMC11800521/
[7] Ibid.
[8] Ibid.
[9] Ibid.

In conclusion, TB remains a major public health challenge in Malawi, compounded by weak healthcare infrastructure, high HIV co-infection rates, socio-economic barriers and stigma. While progress has been made in improving TB detection and treatment, gaps in healthcare access, diagnostic capacity, and patient adherence continue to hinder TB control efforts. Addressing these challenges requires strengthening health systems, integrating TB and HIV services, increasing investment in TB programs, and enhancing community engagement to improve awareness and reduce stigma.

3.2 Implementing partner in Malawi: Paradiso

Paradiso is playing a pivotal role in TB prevention and care by engaging community-based volunteers, implementing early detection programs, supporting treatment adherence, reducing stigma, and influencing policy reforms. Paradiso has evolved significantly from being a community-based organization to a Non-Governmental Organization (NGO) addressing TB on a larger scale. Initially focused on community outreach, the NGO has expanded its work across 21 districts in the country. A key priority has been raising awareness about TB, ensuring that people understand the importance of early screening, diagnosis, and access to treatment. Beyond treatment, Paradiso has recognized the need for a continuum of care, addressing the challenges TB survivors face in the post-TB phase. As a pioneer in post-TB associated disability programs, Paradiso has successfully influenced policy, leading the government to adopt and integrate this initiative into healthcare facilities nationwide. Now operating at a national level, the organization is actively engaging multiple stakeholders to strengthen TB care and support systems across the country.

3.3 Country context in Tanzania

Tanzania continues to face a high burden of TB, which is compounded by significant challenges in its health system. According to the WHO Global Tuberculosis Report, the country remains among those with high TB incidence, with estimated rates around 183 cases per 100,000 population.[10] A considerable proportion of these cases goes undetected, and the situation is further complicated by a high prevalence of TB among individuals living with HIV, who are more vulnerable to progressing from latent to active disease. Additionally, while multidrug-resistant TB is not as widespread as in some other regions, emerging drug resistance poses a continuous threat that necessitates close monitoring and tailored treatment protocols.[11]

The health system in Tanzania faces a range of structural and operational challenges that hinder effective TB control. Many healthcare facilities, particularly those in rural areas, struggle with limited diagnostic capacity due to the inadequate availability of rapid testing technologies such as GeneXpert machines. This shortfall leads to delays in diagnosis and treatment initiation, ultimately affecting patient outcomes. The shortage of adequately trained healthcare workers,

[10]https://worldhealthorg.shinyapps.io/tb_profiles/?_inputs_&tab=%22tables%22&lan=%22EN%22&iso2=%22TZ%22&entity_type=%22country%22

[11] https://www.who.int/publications/i/item/9789240037021

along with an uneven distribution of those who are skilled in TB management, further exacerbates the problem. The integration of TB and HIV services, which is critical given the high co-infection rate, is often hampered by fragmented care pathways and insufficient coordination between different health programs.[12]

Moreover, broader systemic issues such as limited health infrastructure, sporadic supply chains for medications, and financial constraints play a significant role in impeding progress. Much of Tanzania's TB program relies on external funding, creating vulnerabilities when donor priorities shift or resources become constrained. Social determinants, including poverty, malnutrition, and persistent stigma surrounding TB, also contribute to delays in diagnosis and challenges in treatment adherence. Weak data management and surveillance systems further compound these difficulties by hindering the effective tracking of cases and allocation of resources for TB control.[13]

In response to these challenges, efforts are being made to strengthen the overall health system and improve TB control measures. Initiatives to expand the availability of rapid molecular diagnostics and bolster laboratory capacity are underway, especially in remote and underserved regions. Training programs aimed at increasing the number and skills of healthcare workers in TB detection and management are also being scaled up. Additionally, greater emphasis is being placed on integrating TB and HIV services to ensure that co-infected patients receive coordinated care, while community engagement programs are working to raise awareness and reduce the stigma associated with TB. These multi-faceted strategies, supported by international and national agencies, represent critical steps toward reducing the TB burden and improving health outcomes in Tanzania.[14]

In 2020, Tanzania moved from low to lower-middle income status. Still, 25% of the population is poor. Tanzania is in the line of countries who may reach SDG 3.3 and end TB by 2030, provided they succeed in maintaining the progress they have had over the recent years. The evaluation was carried out against the backdrop where USAID had just communicated a 90-day halt of payments and services. The health sector in Tanzania is highly funded by external donors, of which USAID has been an important player. The cut in the PEPFAR program that finances ARV-medicines for people living with HIV may also cause severe repercussions on TB.

The USAID closure has made the government in Tanzania to realise the vulnerabilities of the funding situation for their health system. The National Tuberculosis and Leprosy Program (NTPL) has identified a local manufacturer who will provide locally made sputum containers from June 2025, so Tanzania no longer needs to depend on procurement from the Global Fund for these.

[12] https://www.theglobalfund.org/en/portfolio/country/?loc=TZ.
[13] http://www.moh.go.tz/
[14] https://www.who.int/publications/i/item/9789240037021

3.4 Implementing partner in Tanzania: MKUTA

Around the year 2000, a doctor who was then deputy manager of the National Tuberculosis and Leprosy Program (NTLP), wanted to study the effect of peer follow up of treatment of HIV and TB. He undertook doctoral research with 10 former TB patients and 10 patients with HIV. LHLI was asked to fund the research, and so it all started. The results from the research were remarkable: more patients were identified, and a higher percentage completed their treatment. When the study was over, the patient organisation MUKIKUTE was established in Temeke in Dar es Salaam, where there was already an existing collaboration between the clinic and the NTLP. MUKIKUTE received support from LHLI from the start. In 2009, the national TB patient organisation MKUTA was formed, where MUKIKUTE and others are subsidiaries. The organisation has evolved from 20 volunteers in the year 2000 to 3,087 volunteers in 137 local TB Clubs in 2025. MKUTA is present in all 26 regions in the mainland, but not in all 188 districts. MKUTA is organized into 7 health zones, with one coordinator per zone.

In recent years, MKUTA has attracted new donors and runs a variety of projects. Unfortunately, several of these were directly or indirectly USAID-funded, which makes their future uncertain.

3.5 Country context in Sudan

Due to the war in Sudan some 30.4 million people are in need of assistance including health, food and other forms of humanitarian support[15]. According to WHO, there was an estimated incidence of 50 per 100.000 in 2023. TB notifications dropped down to 13 388 in 2023 (WHO) which is only 53% of the estimated incidence[16]. There are no WHO figures for years after 2023, but the ongoing crisis heightens concerns about disease transmission, drug resistance, and TB-related deaths. Additionally, TB is closely linked to HIV, malnutrition, and other underlying health conditions, further aggravating the public health crisis. The crisis has also severely impacted healthcare delivery. As of September 2024, over 100 attacks on healthcare facilities were reported since the onset of armed conflict in April 2023, leaving 80% of hospitals in conflict-affected areas unable to treat patients. Internally displaced populations and refugees, often living in overcrowded, unsanitary conditions with limited healthcare access, are particularly vulnerable to TB transmission. The instability also undermines the implementation of national TB control programs.

The healthcare system faces significant challenges, particularly in rural and conflict-affected areas. Access to TB services is limited due to long distances, inadequate transportation, and weak referral systems. Furthermore, the healthcare workforce is critically undersized, with a shortage of trained TB specialists, laboratory technicians, and community health workers. Many healthcare providers lack updated training in TB diagnosis, treatment, and patient management, which, combined with the lack of modern diagnostic tools and well-equipped laboratories, results in delayed diagnosis and increased transmission.

[15]https://www.ungeneva.org/en/news-media/news/2025/02/103375/sudan-most-devastating-humanitarian-and-displacement-crisis-world?utm_source=perplexity (accessed 30 March 2025)
[16]https://worldhealthorg.shinyapps.io/tb_profiles/?_inputs_&tab=%22tables%22&lan=%22EN%22&iso2=%22SD%22&entity_type=%22country%22

TB patients often struggle to complete their treatment due to long durations, medication side effects, and socio-economic hardships. Disrupted drug supplies and stockouts in health facilities exacerbate these challenges, contributing to higher rates of drug-resistant TB. Additionally, TB-related stigma remains prevalent, deterring individuals from seeking care, especially among women who face gender-specific barriers to accessing healthcare.

Sudan's TB control efforts heavily depend on external funding, as domestic investment in healthcare remains limited. Financial constraints hinder the expansion of TB services, procurement of diagnostic tools, and implementation of public health interventions.

3.6 Implementing partner in Sudan: Health Development Program

The Health Development Program (HDP) is a nationwide TB organization in Sudan with 30.500 volunteers, 380 sub-committees and 721 localities and remote areas committees. It focuses on raising TB awareness, screening, patient support, and training for health workers and volunteers. As the only civil society organization working on TB in Sudan, HDP plays a crucial role.

Although being in the midst of war, HDP has managed to keep up their activities, adapting to the situation in various ways. All HDP staff have remained safe, but the war has still had direct effects both personally and workwise. HDP offices were raided and looted by the rebel forces, with the loss of essential work tools like PCs and phones. HDP had to leave Khartoum, setting up new offices together with HAC (Humanitarian Aid Commission) and other organizations. HDP has used the war as an opportunity for organizational growth, setting up a vast number of new sub-committees and the number of volunteers increased by 7 500 during the 2023-2024 period of war. A lot of these being people who had to leave Khartoum and wanted to contribute in the locations they fled to. HDP has used this to become better involved with the local communities, especially in rural areas, by training more local volunteers to follow up TB patients and give health awareness information in their local language, to a degree that HDP in several places has taken on duties otherwise performed by the public health sector, like mobile clinics and transporting TB medicine to patients. LHLI´s flexibility in allowing HDP to adapt to patient needs has further strengthened the effectiveness of HDP's initiatives.

HDP has a federal office and coordinators. The organization maintains structured administrative and financial systems, including clear policies and a legal auditor conducting quarterly reviews. Plans and programs are developed at the local level and escalated through state and federal administration, ensuring efficient governance and recognized accountability.

3.7 Country context in Zambia

Zambia faces a significant TB burden, ranking 21st among the 30 high TB burden countries globally. In 2023, the WHO estimated an incidence of 59,000 TB cases, equating to 283 cases per

100,000 population.[17] Despite efforts to combat the disease, under-notification and underreporting remain substantial challenges. A national data quality assessment revealed that in 2018, 33% of TB cases were not notified at health facilities, and 11% of notified cases were not reported to national authorities, resulting in only 56% of all TB cases being officially reported.[18] The high prevalence of HIV and AIDS in Zambia exacerbates the TB crisis, as co-infection rates are significant. Multidrug-resistant TB also poses a growing threat, complicating treatment efforts and increasing the need for specialized healthcare interventions.

Many Zambians, particularly in rural and remote areas, face challenges accessing TB diagnostic and treatment facilities. Long distances to health centres, inadequate transportation, and insufficient healthcare infrastructure contribute to delays in diagnosis and treatment initiation. The high HIV prevalence in Zambia leads to significant TB-HIV co-infection rates. While efforts have been made to integrate TB and HIV services, gaps in coordination persist, resulting in missed opportunities for early diagnosis and comprehensive care.

There is a critical shortage of trained healthcare professionals, including TB specialists and laboratory technicians. This shortage affects the quality and efficiency of TB care, with many health facilities lacking sufficient staff to manage the patient load effectively. Despite investments in TB diagnostics, laboratory infrastructure remains inadequate in some regions. Limited access to rapid diagnostic tools, such as GeneXpert machines, leads to delays in TB detection. Challenges in transporting sputum samples from remote areas to diagnostic facilities further exacerbate these delays.

Ensuring that TB patients adhere to their full course of treatment is a persistent challenge. Socio-economic factors, lengthy treatment durations, and medication side effects contribute to non-adherence. Additionally, interruptions in TB drug supply chains can disrupt treatment continuity, increasing the risk of drug-resistant TB. Stigma and misinformation about TB are prevalent in many communities, discouraging individuals from seeking timely diagnosis and treatment. This stigma is often associated with social discrimination, particularly among people living with HIV, further hindering access to care.

Zambia's TB control efforts rely significantly on external funding, posing sustainability challenges. Limited domestic investment affects the expansion of services, procurement of diagnostic tools, and implementation of public health interventions. Tuberculosis continues to be a major public health issue in Zambia, compounded by high TB-HIV co-infection rates, limited healthcare access, and weak diagnostic and treatment systems. Addressing these challenges requires increased investment in TB programs, enhanced integration of TB and HIV services,

[17] WHO report 2024

[18] Lungu PS, Kabaso ME, Mihova R, Silumesii A, Chisenga T, Kasapo C, Mwaba I, Kerkhoff AD, Muyoyeta M, Chimzizi R, Malama K. Undernotification and underreporting of tuberculosis in Zambia: a national data quality assessment. BMC Health Serv Res. 2022 Aug 22;22(1):1074. doi: 10.1186/s12913-022-08431-2. PMID: 35996175; PMCID: PMC9396838.

expanded laboratory networks, and stronger community engagement to reduce stigma and improve healthcare-seeking behaviour.

3.8 Implementing partner in Zambia: In But Free (IBF)

In But Free was founded in 1995 as an outreach program at Copper Belt University, initially focused on understanding the epidemiology of HIV within prison communities. It operated under the Health Services Department, where its founders worked full-time. Over the years, the organization expanded its outreach efforts, responding to the growing demand for services. By 2005, it became evident that the initiative could no longer function effectively within the university structure, leading to its formal registration as a local NGO. At the time of its registration, In But Free had only one full-time staff member and operated from two small rooms. Since becoming an independent NGO, In But Free has gradually expanded its workforce, projects, and operational capacity. Today, the organization has ten full-time staff members, with eight of these being supported by LHLI programs and the remaining two funded through other donors.

In the past five years, the organization has experienced remarkable growth, strengthening its internal systems and operational effectiveness. With support from LHLI, it has developed key organizational policies, including human resource manuals, financial policies, and communication materials, all of which have enhanced its capacity. The acquisition of two project vehicles has further improved logistical efficiency, allowing for better transportation of goods and services to beneficiaries. As a result, In But Free has grown into a well-structured and credible organization with an increased number of international partnerships.

4 Effectiveness

Under Effectiveness, the terms of reference ask how the implementing partners contribute to strengthening the TB prevention and care at local level, and how this contributes to health system strengthening.

The program 'Reducing the burden of tuberculosis' is implemented in four countries by TB survivor organisations in Malawi, Tanzania and Sudan who all have a national network of TB volunteers. In Zambia the program is implemented by a NGO working in prisons. The program manages to reduce the burden of TB in the four countries through awareness raising and stigma reduction, screening, and early diagnosis. The three TB survivor organisations reach out to the communities where the health system does not have resources to reach, and are as thus functioning as a bridge between the communities and the health services. The community volunteers identify persons presumed to have TB, refer them to diagnosis and follow them up closely during treatment. In Zambia, peers follow up their fellow prisoners. The 'Reducing the burden of tuberculosis' program succeeds in bringing TB control to areas and to key populations otherwise not reached. Also, the program lowers costs for the patients by facilitating easier access to diagnosis and treatment. Through collaborating with the TB volunteers in Malawi, Tanzania

and Sudan and the NGO serving patients in the prisons in Zambia, the health systems manage to identify more TB patients, lower transmission, treat more patients, reduce treatment default, and reduce TB deaths.

4.1 Malawi

4.1.1 Community-Based TB Screening and Early Diagnosis

In Malawi, one of the most significant contributions of Paradiso has been its community-based TB screening and early detection efforts, which is conducted through the mobilisation of TB survivors as volunteers.

> ***Paradiso's volunteers go door-to-door to screen and refer individuals for diagnosis, significantly increasing TB detection rates.***
>
> Representative from the First Lady's office

Paradiso's volunteers significantly contribute to the number of presumptive TB cases detected in health facilities.

> ***The indicators are doing really well – we track the contribution of their volunteers to the presumptive TB cases. More than 20% of the presumptive cases from each facility report are coming from Paradiso volunteers.***
>
> Partner organization representative

Paradiso has established TB Clubs composed of TB Survivors in health centres who are championing TB case findings, of which some collect sputum. With the Global Fund grant (GF GC7), Paradiso have adopted 174 community-based sputum collection points as a sub-recipient, expanding their reach with the volunteers. These collection points ensure that persons with presumed TB do not have to travel long distances to access testing, which increases case detection rates and treatment initiation. The introduction of sputum collection points allowed for more decentralized TB diagnostic services, making it easier for people in remote areas to provide samples without the logistical burden of traveling to distant health facilities.

4.1.2 Post-TB Care and Rehabilitation

Addressing Post-TB Associated Disability

Post-TB associated disability is a significant but often overlooked health challenge in Malawi. Paradiso has played a pioneering role in addressing this issue by introducing post-TB lung rehabilitation programs, developing assessment tools that the government did not have, and ensuring continued care for TB survivors. Paradiso's rehabilitation initiatives also address stigma and economic hardships faced by TB survivors, ensuring their reintegration into society.

Through advocacy and research, Paradiso successfully integrated post-TB care into Malawi's National TB Strategic Plan, ensuring sustainability and formal recognition within the healthcare system.

Despite these achievements, challenges remain in scaling up post-TB rehabilitation services due to funding limitations as well as the lack of formal recognition of TB survivors who work as volunteers.

> ***Paradiso initiated training for post-TB associated disabilities and the establishment of sites that are offering permanent rehabilitation programs for post-TB survivors.***
>
> NTLEP official

Community-Based Rehabilitation and Support

Paradiso has focused on rehabilitation at the community level, ensuring that TB survivors receive long-term care and psychosocial support. The TB survivor Clubs provide peer support and counselling, helping survivors cope with post-TB health challenges. Through structured rehabilitation support, Paradiso is helping former TB patients to reintegrate into society and prevent recurrence of TB.

4.1.3 Health system strengthening

Task Shifting and Volunteer Mobilization

Malawi's healthcare system faces severe human resource shortages, particularly in rural areas. Paradiso has mitigated this challenge by training and deploying community volunteers who are TB survivors, allowing task-shifting to support overburdened healthcare workers. The volunteers assist in contact tracing, health education and TB surveillance, reducing the workload on government healthcare workers.

> ***Health Surveillance Assistants are supposed to conduct health education and TB surveillance, but because they are overwhelmed, Paradiso stepped in to train lay volunteer.***
>
> NTLEP staff member

4.1.4 Improved access to and demand for primary care services

Paradiso plays a crucial role in enhancing access to and demand for primary care services in Malawi through innovative community engagement, policy advocacy, and health system strengthening.

Community-Based Healthcare Delivery

As noted above, Paradiso enhances access to primary healthcare by engaging TB survivors as community volunteers who actively participate in screening, treatment support, and awareness campaigns.

> ***Paradiso is the only organization working with community TB volunteers and the only one that began post-TB associated disability services.***
>
> Representative from NTLEP

This approach ensures that services reach underserved populations, particularly in rural areas. These volunteers act as a bridge between the community and healthcare facilities, providing education and psychosocial support to TB patients.

The involvement of volunteers in primary healthcare services has significantly improved early TB case detection. This demonstrates how Paradiso's grassroots engagement is increasing demand for primary care by identifying and referring patients who might otherwise not seek treatment.

Addressing Human Resource Shortages in Healthcare
A critical challenge in Malawi's healthcare system is the shortage of trained personnel. Paradiso helps mitigate this issue by leveraging trained community volunteers. These trained volunteers extend the reach of primary care services, particularly in areas where government healthcare workers are scarce.

Reducing Financial and Geographical Barriers
Many Malawians face financial and logistical challenges in accessing healthcare. Paradiso alleviates this burden by bringing services closer to the people. Their community sputum collection points and door-to-door screenings minimize the need for long-distance travel.

> ***Paradiso's initiatives have helped reduce costs for people by providing local screening services and follow-up care.***
>
> Medical doctor

Paradiso's initiatives, including community-based healthcare delivery, task-shifting to volunteers, and decentralized TB diagnostics, significantly cut financial and logistical burdens for patients. This model not only improves access to care but also strengthens the overall healthcare system by making it more sustainable and cost-efficient. Nevertheless, mobility challenges for volunteers have been identified as a barrier to effective service delivery, and several volunteers suggested that it would help effectiveness if they were given more bicycles.

Tackling Stigma and Raising Awareness
Paradiso actively combats stigma associated with TB and other health conditions, encouraging more people to seek care. Paradiso has been proactive in decreasing TB cases by engaging survivors in door-to-door awareness campaigns and early detection efforts. This model not only improves access but also increases demand by making healthcare more acceptable and accessible within communities.

4.2 Tanzania

4.2.1 TB prevention and care at the community level

Increased general awareness and reduced stigma
In Tanzania, the volunteers have successfully reduced TB-related stigma at both family- and community level, including self-stigma, by increasing general awareness and displaying

misconceptions about TB in the communities. Because of the awareness-raising in the communities, community members identify potential patients and call the TB volunteers for them to come and screen and arrange for diagnosis. The TB volunteers have become ambassadors of change for people to believe that TB is treatable and curable. Medical staff in the health facilities in a district in Dar es Salaam with high TB-prevalence informed that due to early detection by TB volunteers, TB-related deaths have gone down.

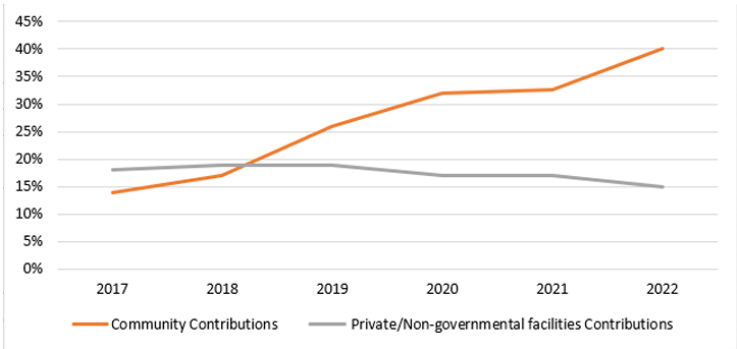
The pillar of MKUTA's work is that their volunteers are former TB patients with first-hand experience of having TB.

External stakeholder

The TB volunteers are the bridge between the community and the health facilities. Several informants underlined that, due to fear and lack of knowledge, few people with presumptive TB would go to the health facilities without the facilitation of the volunteers.

In the sites visited by the evaluation, the work of the TB Clubs was well recognised, highly valued and largely supported by the local leadership. The local leadership shared that they found that the citizens to a large degree had overcome fear and stigma and were no longer hiding their illness.

Increased notification from the community level



After MKUTA came into being as a national umbrella organisation for TB Clubs with TB volunteers all over the country, notifications from the community have gone up from 14% in 2017 to 41% in 2022. While MKUTA is not the only CSO working on TB in Tanzania, informants from the National Tuberculosis and Leprosy Program (NTLP) confirmed that the noticeable increase in notifications from the community is largely due to the existence of MKUTA, see graph from NTLP 2022 above.

National reports show that where MKUTA is present, notification is higher, and more people complete the treatment than in areas where MKUTA is not present.

The TB Clubs and their volunteers are recognised by the local governments. They carry out various health campaigns where they provide TB education to the public, and screen potential patients presumptive of TB. In one of the sites visited by the evaluation, the citizens shared that the TB Club's traditional dances were particularly popular. The TB Clubs undertake door-to-door campaigns, provide awareness and knowledge, and screen households of people presumed to have TB. They do the screening using a questionnaire with 5 symptoms-related questions. If the

answer is "yes" to one of the five questions, the person is asked to present a sputum sample for diagnosis.

There was a noticeable difference between the sites visited by the evaluation, where outreach and notification and patient follow-up were higher and stronger where the TB volunteers were given transport allowance as opposed to where they were not given such allowance, showing that enabling the volunteers, matters.

Many patients presumptive of TB must take X-rays to be diagnosed, i.e. people living with HIV, children and others. X-ray is not free in Tanzania, except for the mobile vans, thus volunteers sometimes fail to assist people who require X-ray to receive a diagnosis and enter treatment.

Patient-friendly treatment

There is a lack of knowledge about TB among health workers. They often don't ask the right questions when people come to the health facilities. Many health workers are found to be unfriendly, which is a barrier for patients. MKUTA is using the training manual and the e-learning course on inclusive health communication that is developed by LHLI. MKUTA trains the TB Club volunteers and the health facility workers alike, in inclusive health communication. This has lowered peoples fear of coming to the health facilities. Also, the MKUTA TB Club volunteers are trained in community health care, infection prevention and control, and mental health issues, all of which enable the volunteers to provide patient-friendly screening and identification, reduce stigma, and enhance awareness of TB in the communities.

I was surprised to see how much family members lean on the TB volunteers when they have a TB patient in their family.

Evaluator

Ensuring successful fulfilment of treatment

In the first two months that is the intensive phase of the treatment, patients receive two weeks' supply of TB medicines. In the four next months of continued treatment, patients receive medicines for one month at a time. Many patients have family members who can assist them in remembering to take their medication. TB volunteers follow up patients who live alone or otherwise have high levels of challenges. Health workers informed that the close follow-up of the patients provided by the TB volunteers have significantly reduced the number of patients who discontinue their TB treatment.

Poor adherence is the largest threat to TB control. Volunteers help make sure that patients complete treatment.

Health worker

Former TB patients shared how the TB volunteers had helped them by providing home-based services, such as bringing them medicines. They also shared how the TB volunteers had sensitized the surrounding households to create awareness and reduce stigma.

The TB Club helped me to follow my treatment. Without them I would not have been treated due to my fear of visiting the hospital.

Former drug user

4.2.2 Health system strengthening

Strengthened capacity at local health services

Health workers interviewed during the evaluation in Tanzania informed that the TB Clubs and their volunteers helped to reduce staff shortage at health facilities. According to health workers, there is a 40% gap of health facility staff that is currently being "plugged" by the TB volunteers. Health workers appreciated the community awareness work done by the TB Clubs, as this increased people's ability to inform the health system whenever someone has symptoms. The increased awareness of TB in communities enabled by the TB Clubs has helped patients to be detected earlier. The TB Clubs function as a link between community and the health facilities.

Some TB volunteers informed that they go to the clinic in the morning, thereby strengthening the workforce of the health facilities. By screening and referring to TB clinics, they help reduce hospital congestion and long queues.

Without the volunteers, the whole TB system would collapse

Health worker

In general, there is low awareness of TB in Tanzania, even among health workers and people working in pharmacies. The public education carried out by the TB Clubs has helped to make people aware of the TB symptoms, TB services and where these can be accessed. When the volunteers screen people for TB, patients presumptive of TB are referred to special TB clinics. This reduces the potential spread of TB in ordinary health facilities.

Health workers informed that due to the TB Clubs and their volunteers, the recurrent reporting system has been improved and the health facilities have become able to reach the notification target they are supposed to.

Reduced transmission

TB Clubs improve the health outcomes in their communities by accelerating identification of TB patients, thereby curbing transmission. The TB volunteers observe treatment of high-risk patients. They trace patients who are lost to follow up, and bring them back to treatment, thereby avoiding development of drug-resistant TB and TB-deaths.

Citizens expressed that without the TB Clubs, there would be fewer patients who would receive diagnosis and treatment, health facilities would be overcrowded as TB infections would increase, high risk groups would struggle to access health services due to stigma and fear, and more people would die.

Health workers informed that the TB volunteers make a large contribution in contact tracing, thereby identifying others with TB and also facilitating the uptake of Tuberculosis Prevention Treatment (TPT), a health service that has started to be given to children under 14. Health workers informed that the way the TB Clubs work has been replicated to other diseases, like Covid-19, where community screening was also done. In addition, TB volunteers informed that they refer patients for other diseases, such as HIV, high blood pressure and hepatitis. Furthermore, TB volunteers working with high-risk groups, also work with other malaises such as gender-based violence, where they refer victims to legal assistance.

4.2.3 Improved access to and demand for primary care services

Identification of patients presumptive of TB among key populations

Drug use masks TB symptoms, which complicates identification. Due to the volunteers being good at screening, they can identify patients with presumed TB among drug users and refer them to testing and treatment. Drug users' lifestyle, and their fear of being recognised as illegal drug users, put a lot of demands on the volunteers to succeed in making the drug users with TB be diagnosed and take their treatment. MKUTA detects side-effects in patients and helps the patients to receive medical attention.

Several TB patients, i.e. people living with HIV, and children, are hard to diagnose with sputum tests, and should be X-rayed. X-ray costs money for people who come the hospitals. However, it is free from the governmental mobile TB vans. The TB Clubs acquire the public TB van as often as they can and run it in areas where there are high rates of TB and people who need X-ray in order to get diagnosed and start treatment.

> ***My child had a prolonged health issue, one day I met the TB volunteers, I approached them and they assisted me to get my child X-rayed and he was found to have TB.***
>
> Community member

Geographic coverage

MKUTA has TB Clubs in all the 26 regions in mainland Tanzania, but they do not cover all districts and councils within each region. MKUTA has statistics that show that where MKUTA is present, community-based notifications are higher, the percentage of successful treatments is higher, and the number of TB- related deaths are lower, than in areas without the presence of the TB Clubs.

Reduced cost for patients

Patients must present themselves at the health facility at least once, for the initiation of the treatment. If they cannot afford to travel, the volunteers can help them save money by fetching medicine for them and bringing it to their homes. Some members of at-risk populations, i.e.

female drug users in Temeke in Dar es Salaam, are given nutritional support and opportunities for income generating activities.

4.3 Sudan

4.3.1 TB prevention and care at the community level

In Sudan, HDP has made significant progress in TB, with strong support of LHLI as a main donor. HDP is playing a significant role in strengthening TB prevention and care at the local level through a range of targeted initiatives. The role of the HDP has increased during the time of war, as the health services have become less effective, and some places not functional at all.

Training healthcare workers and volunteers

One of the key contributions is the training programs for healthcare workers and volunteers. These initiatives help to increase knowledge about TB, address misconceptions, and reduce stigma. By equipping healthcare personnel with the necessary skills, HDP ensures that early detection and treatment adherence are promoted, leading to better health outcomes.

Raising community awareness

HDP also utilizes health education and community awareness activities in public spaces such as markets and gathering places. These sessions are conducted in local dialects and often use drama performances as a tool to convey health messages effectively. Such culturally sensitive approaches increase public engagement and make critical TB-related information more accessible to diverse populations.

Former TB patients are also actively involved in HDP's initiatives, serving as advocates and community mobilizers. The organization engages youth, university students, and traditional healers in TB control efforts, broadening its outreach. Targeted awareness campaigns provide health education materials to high-risk groups, including displaced individuals, prisoners, mining workers, and HIV patients, ensuring that prevention and treatment measures reach those who need them most. Lastly, sports and cultural activities, along with training programs for HDP partners, community leaders, and local administrators, further strengthen TB prevention efforts.

Mobile clinics

HDP has introduced mobile clinics (financed by the Global Fund) to reach vulnerable and hard-to-reach communities, particularly in mining areas, ensuring better healthcare access. The mobile clinics serve the most vulnerable populations, including displaced persons, refugees, prisoners, and individuals living in remote areas. These mobile units provide screening, diagnosis, and treatment services in areas where TB care is otherwise inaccessible. By bringing healthcare directly to at-risk communities, HDP enhances early detection rates and ensures that individuals receive timely medical attention, reducing the spread of TB.

Additionally, HDP focuses on educating the public to normalize TB as an ordinary disease and reduce stigma.

Advocacy

Advocacy and support campaigns target community leaders and decision-makers, pushing for urgent policy interventions to combat TB. By influencing stakeholders at different levels, HDP fosters stronger political and financial commitment to TB control efforts. These advocacy efforts also extend to educational activities in primary and secondary schools, ensuring that younger generations are aware of TB prevention and treatment.

Tracing absentees

To improve treatment adherence, HDP has implemented default and absentee tracing programs and home visits by volunteers. This initiative helps reconnect patients with healthcare workers, motivating them to continue their treatment while also reducing self, family, and societal stigma. Additionally, food and nutrition support are provided to all MDR patients and some other TB patients, ensuring that they receive adequate nourishment to enhance their recovery.

4.3.2 Health system strengthening

HDP has made a marked impact on health outcomes within the communities it serves. By facilitating early diagnosis and ensuring adherence to TB treatment protocols, the organization has significantly improved recovery rates and reduced the overall burden of TB. They use a comprehensive approach—which combines medical interventions with psychosocial support, nutritional assistance, and community education. The involvement of recovered patients as advocates helps build community trust and reinforces the message that effective treatment is achievable, thereby sustaining improved health outcomes over time.

HDP is instrumental in bridging the gaps in health service access for some of the most marginalized and underserved groups. The organization actively targets populations that face significant barriers to care, such as rural residents, refugees, prisoners, and nomadic communities, by deploying mobile clinics and establishing localized outreach initiatives. This strategic focus on equity ensures that financial, geographic, and social barriers are minimized, enabling a broader segment of the population to receive essential TB services.

HDP emphasizes patient-centred care by adopting a holistic approach that goes beyond mere clinical treatment. The organization delivers personalized care through regular home visits, individualized follow-up, and the provision of psychosocial and nutritional support. This focus on the patient's overall well-being, coupled with sensitivity to cultural and gender-specific issues, ensures that care is not only effective but also respectful and responsive to individual needs. HDP's integration of recovered patients into its advocacy work further reinforces a patient-centred model, as it builds trust and encourages a community-wide understanding of the importance of comprehensive TB care.

4.3.3 Improved access to and demand for primary health care services

Extensive outreach

Through the deployment of mobile clinics and the establishment of community-based screening programs, HDP has successfully reached areas that are traditionally underserved by the formal health system. Its extensive network of trained volunteers and local coordinators ensures that even remote villages and marginalized communities are included in its outreach efforts. By partnering with local health centres and adapting services to meet the specific needs of various populations, HDP has effectively expanded access to primary care, ensuring that essential TB prevention and treatment services are available to a wide demographic. Additionally, children under five years old are referred to have the BCG vaccination.

Increased access and reduced costs for patients

HDP plays a pivotal role in reducing both the direct and indirect costs associated with TB care. Direct cost savings are achieved through the provision of free or subsidized diagnostic services, mobile clinic visits, and home-based care, which minimize the need for travel and reduce out-of-pocket expenses. Indirect cost reductions are realized by supporting patients with food, financial assistance and psychosocial support, especially those from marginalised communities, which help to mitigate the economic impact of lost work time and prolonged illness. By streamlining access to comprehensive TB care and alleviating financial burdens, HDP ensures that the economic barriers to effective treatment are significantly lowered, particularly for vulnerable populations.

4.4 Zambia

4.4.1 TB prevention and care at the community level

Reduction of TB related deaths in prisons

In Zambia, the work is concentrated to prisons. One of the most significant achievements of the program has been the drastic reduction in TB-related deaths within correctional facilities. At Mukobeko Maximum Correction Facility, with a population of about 2,500 inmates, TB-related deaths averaged forty per year before the collaboration with LHLI. During the intervention, fatalities declined to four in 2019, one in 2020, two in 2021, and finally zero from 2022 to 2024. Similarly, at Kamfinsa Correction Facility, the largest correctional facility in the country with nearly 4,000 inmates, TB-related deaths, which once exceeded 60 per year, have now been reduced to just two annually. This decline highlights the program's success in controlling TB mortality among incarcerated populations.

Improved TB treatment success

In addition to reducing mortality, the program has significantly improved TB treatment success rates by promoting early diagnosis and timely access to treatment. Increased awareness has led to earlier detection, preventing complications and reducing transmission. By ensuring that patients seek medical care sooner, the program has helped contain TB outbreaks and enhanced recovery rates among inmates. Trained inmates and correctional officers now play a critical role in identifying individuals at risk, linking them to medical care, and supporting adherence to treatment, thereby improving overall health outcomes within correctional settings. The program

has also strengthened TB screening procedures within correctional facilities, ensuring early detection both at the point of entry and during incarceration.

Peer-led health support

A key factor in this success has been the establishment of a peer-led health support system, where trained inmates actively participate in health surveillance, awareness, and treatment adherence. This model has reduced the burden on healthcare professionals. Weekly health awareness sessions led by trained inmates reinforce TB education among the incarcerated population. Customized information materials, including posters and brochures, further support these awareness efforts. Also, infection prevention and control committees have been established to oversee surveillance efforts and maintain TB control measures, ensuring that infection prevention protocols are effectively implemented.

4.4.2 Health System Strengthening

Effective screening and early detection

IBF has played a critical role in strengthening the health system by enhancing TB screening and treatment processes within correctional facilities and integrating these efforts into the broader healthcare system. The development and implementation of effective screening tools have contributed to the early detection of TB cases, allowing for timely intervention and treatment. Additionally, IBF has improved sample transportation to laboratory facilities, ensuring that diagnoses are made efficiently, which facilitates quicker treatment initiation and better health outcomes.

Integrated service delivery

A major component of IBF's health system strengthening strategy is its integrated service delivery approach, which ensures that TB programs incorporate additional services such as nutrition support, HIV screening, and capacity building for both officers and inmates. This holistic model not only improves TB outcomes but also enhances overall healthcare within correctional settings. Officers trained within the Zambia Correctional Service can transfer to other departments, such as the Ministry of Health, bringing their acquired skills with them and further strengthening the national healthcare workforce. In cases where services are not directly provided within correctional facilities, referrals are made to other service providers to ensure continuity of care.

Overall reduction of TB transmission

Beyond correctional facilities, IBF's impact extends to the broader healthcare system by contributing to the reduction of TB transmission in communities. Strengthening TB prevention and treatment in prisons directly benefits public health by curbing the spread of the disease both inside and outside prison walls. Through its efforts in training inmates and officers to identify and manage TB cases effectively, IBF ensures that patients receive timely treatment, preventing complications and the development of drug-resistant TB. By integrating TB control measures within broader health system strengthening efforts, IBF is making significant contributions to the sustainability and effectiveness of TB management in Zambia.

5 Relevance

Under relevance, the terms of reference asked for gaps in the health services that are filled by the implementing partners, and populations that would not access health services without the support of the implementing partners. The 'Reducing the burden of tuberculosis' program is found to address important health service gaps in the four countries, where outreach to underserved areas is key. Through this outreach, the program assists the health service in the four countries to diagnose and treat people who would otherwise not have been identified. Furthermore, the program targets underserved, key populations. In Zambia, the program has targeted the prison population, significantly bringing down TB related deaths. Also, in the other three countries, the TB volunteers target prisoners, miners, drug users, nomads, fisherfolks among others. In Sudan, the war has made millions to flee, and a large part of the population that is now reached by the program are people who are internally displaced.

5.1 Malawi

5.1.1 Addressing health service gaps

In Malawi, as also mentioned under Effectiveness, Paradiso has played a crucial role in filling health service gaps in Malawi through community-based interventions, policy advocacy, and health system strengthening. Paradiso's use of community volunteers helps to bridge the health service gap by increasing community awareness, providing psychosocial support, and facilitating early case detection. These volunteers act as crucial links between healthcare facilities and communities, supporting screening, treatment adherence, and awareness campaigns. By engaging these volunteers, Paradiso has not only increased community engagement but also alleviated the workload of healthcare workers in areas with severe human resource shortages. In addition to its grassroots efforts, Paradiso has been instrumental in policy advocacy, particularly in integrating post-TB care into Malawi's National TB Strategic Plan. This integration ensures the sustainability of post-TB rehabilitation services and formal recognition within the healthcare system. Furthermore, poverty and food insecurity make TB treatment adherence challenging. Paradiso provides nutritional support to drug-resistant TB patients to ensure they can take their medication properly. When patients receive food supplies, treatment dropout rates are reduced.

5.1.2 Reaching underserved populations

Certain populations in Malawi face a higher burden of TB due to their living and working conditions. Paradiso has taken a targeted approach to reach these groups:

Populations affected by TB and HIV and AIDS: Paradiso primarily focuses on serving underserved and vulnerable populations affected by TB and HIV and AIDS.

Prisoners: TB is prevalent in overcrowded prisons, where limited healthcare access exacerbates infection risks. Paradiso has implemented TB screening and treatment programs in Zomba Prison.

> ***Paradiso's work in prisons is critical because of the high prevalence of HIV and TB in these environments.***
>
> NGO representative

Rural Communities: Many rural populations lack access to hospitals due to distance and poor infrastructure. As noted above, Paradiso's community sputum collection points have reduced the need for long-distance travel, allowing easier diagnosis.

Remaining underserved groups
While Paradiso has expanded its reach significantly, certain groups remain underserved and require more tailored interventions. These are:

Men as a High-Risk Group for TB: Data shows that more men than women contract TB, yet more women than men are identified as TB patients. This suggests that men could be targeted to a larger extent, both for testing and for becoming volunteers. TB rates are higher amongst men who have issues with alcohol and smoking.

Orphans and Vulnerable Children: Children orphaned due to TB or HIV often lack proper healthcare, education, and social support.

People in Extremely Remote Areas: While Paradiso has sputum collection points in some rural locations, many villages remain too far from health centres.

5.2 Tanzania

5.2.1 Addressing health service gaps

Community awareness and stigma-reduction
In Tanzania, the community awareness raising is an important gap-filling exercise, as very few people in Tanzania have knowledge about tuberculosis and its symptoms. Furthermore, reducing stigma helps people overcome fear, and subsequently dare to access health services.

Bringing patients presumptive of TB to health facilities
Health facilities in Tanzania are highly understaffed. They do not do outreach activities. Given the very high level of unawareness of TB among both the general population, and also among health workers, identifying patients presumptive of TB through screening and bringing them for diagnosis to health facilities is an important way for MKUTA to fill a health service gap. Many of these patients would never have gone to the health facilities, due to lack of awareness, fear and stigma.

Outreach! The most important thing MKUTA does to strengthen the health system is that they reach out to where the patients are!

External stakeholder

Contact tracing
TB volunteers in Tanzania do contact tracing of family members and close contacts of persons diagnosed with TB, an activity the health facilities do not have resources to undertake.

Patient follow-up
The volunteers follow up the TB patients in a way the health facilities do not have resources to do. i.e. bring medicines to their homes and provide psychosocial support.

Making sure there is adequate equipment and treatment in place
TB volunteers advocate for those in need. They advocate for services needed for the patients and for equipment to be present at the various sites and facilities, thereby improving the quality of the treatment.

MKUTA, with financial aid from USAID, is rolling out the use of a community-led monitoring application, 'OneImpact', where patients and volunteers can provide feedback on the services they receive. This system is valued by the authorities as it gives them direct feedback upon which they continuously improve services.

5.2.2 Reaching underserved populations

There are many key populations who are at risk of getting TB in Tanzania that for several reasons, hereunder unawareness and stigma, would not access health services on their own. TB is primarily a poverty-related illness contracted by people who may be ill nourished or otherwise have a low immune system, such as people living with HIV.

MKUTA has reported that they reach the following key populations: Miners, people who use drugs, people who cross borders, fisherfolks, Maasai people/nomads, prisoners, factory workers, children, female sex workers, truck drivers, people with multi-drug resistance, and people with post-TB disabilities.

While informants were sure that MKUTA has mapped all the at-risk and key populations that need attention, lack of funds prevents that they reach out and identify all individuals belonging to the identified risk groups.

People who use drugs: One key population at risk that MKUTA is specifically addressing, is people who use drugs. As drug use is illegal, drug users have a fear of presenting themselves to health facilities. They fear stigma, both social stigma and self-stigma. Most drug users are male. Female drug-users are fewer, but even more stigmatized and even harder to find. Drug-use can mask symptoms of TB, making it complicated to identify. MKUTA's subsidiaries in Dar es Salaam

visited by this evaluation were found to provide harm reduction measures to drug users, facilitating their diagnosis, TB treatment, treatment of other diseases as well as helping them to leave heroin-use by linking them to methadone treatment. Female drug-users were given access to nutrition and income-generation in one of the sites visited by the evaluation.

Sex workers: Another at-risk group, although smaller in size, is female sex-workers, who face high social stigma from the community as well as self-stigma. They are generally poor.

Unhealthy alcohol use: Stakeholders mentioned that another at-risk group are people with alcohol use disorders, who often spend time in congested bars. Volunteers informed that these are difficult to follow up due to recurrent interruption of treatment.

Fisherfolk: Some fishing communities, where fisherfolk live in temporary makeshift houses close to one another far away from home, are found to have very high TB prevalence. Some informants believed that there may be more individuals to be identified within this key population than what is being done today.

Miners: Tanzania has gold and tanzanite, and many mines. While occupational health and safety in mines is regulated by law, the mine sector is full of informal artisanal mines where people enter and work without protection. Miners often develop silicosis. Due to the silicosis, the dense working conditions, and the dense living quarters, miners often acquire TB. They are hard to reach as they live a nomadic life. Targeted work towards the overall sector appears to be needed.

5.3 Sudan

5.3.1 Addressing health service gaps

In Sudn, HDP fills a number of critical health service gaps, particularly in the realm of TB prevention and care. In regions where the formal health system struggles to reach remote and marginalized populations, HDP provides essential services such as active screening, diagnostic support, and treatment adherence monitoring. The organization's efforts ensure that communities, which might otherwise be left without timely TB care, receive comprehensive services, from health education to mobile clinic support, that are vital for early detection and effective treatment. Without HDP's intervention, these services would be significantly less accessible, leading to higher rates of undetected TB and poorer overall community health outcomes.

5.3.2 Reaching underserved populations

The organization pioneered the introduction of the GeneXpert system in prisons and mining regions, improving TB diagnosis. Several populations would likely remain underserved in the absence of HDP's support. These include individuals living in remote rural areas, refugees, internally displaced persons, prisoners, and nomadic communities, groups that frequently face geographical, economic, and legal barriers to accessing conventional health services.

Additionally, gender-specific and culturally marginalized groups, particularly women and girls, often encounter social stigma and discrimination that further limit their access to care.

5.4 Zambia

5.4.1 Addressing health service gaps

In Zambia, inmates in correctional facilities would face significant barriers in accessing TB-related healthcare services without IBF's intervention. One of the most vulnerable populations in Zambia is incarcerated individuals, who experience unique challenges in healthcare access due to institutional constraints, overcrowding, and a lack of resources dedicated to TB care. The absence of screening programs, diagnostic tools, and treatment support within prisons means that without IBF, many inmates would remain undiagnosed and untreated, leading to prolonged illness and increased transmission within the confined prison environment. Furthermore, there would have been more transmission between the prisons and the general public, because inmates interact with officers and officers interact with the general public. Also, when inmates get released, they can transmit to the general public if they are not treated.

Without IBF's provision of high-energy supplements, fresh produce from community gardens, and nutrition counselling, many TB patients would experience prolonged illness and an increased risk of relapse. Without IBF's provision of basic diagnostic enablers such as specimen containers and biohazard bags, inmates would experience delayed diagnoses, leading to increased disease transmission. Without the follow-up by peers, TB patients would struggle to complete their treatment regimens, increasing the likelihood of drug-resistant TB strains emerging.

6 Sustainability

Under Sustainability, the terms of reference ask for barriers and opportunities for the implementing partners to work with health services delivery long-terms, and if there is potential for increasing scope of services. While TB is curable, it proves to be a hard disease to eliminate. The previous chapters on Effectiveness and Relevance show how the four implementing partners in the 'Reducing the burden of tuberculosis' program has developed highly relevant and effective strategies to increase the level of TB notifications in the four countries. This evaluation has not come across any futile strategies or approaches. On the contrary: to eliminate TB, it appears that more of everything that is already being done is needed. Here, lack of funding is the one large constraint. At the same time, the war in Sudan and the closure of USAID put enormous strains on the fight against tuberculosis in the four countries, and increase the relative importance of the 'Reducing the burden of tuberculosis' program.

One thing that has been found to enhance sustainability in the four countries, has been to advocate for content in the national TB policies, and to align the implementing partners own strategies with these. Strategic alignment ensures continuity, despite political changes.

The four implementing partners have shown sustainability in their ability to grow steadily from small initiatives into to larger organisations with important impact. In Malawi, Tanzania and Sudan the backbone of the implementing partners is their network of TB survivors. An important value added of TB volunteers is the credibility and confidence that is generated by the fact that they themselves are survivors from TB. In addition to that, comes the geographical presence they represent. On the one hand, that they are volunteers enable more people in numbers than would have been possible if they had been paid workers. On the other hand, the evaluation has shown that the volunteerism itself is also an important barrier towards sustainability. Lack of compensation makes it hard for people to be volunteers over time. It would not be sustainable for the implementing partners to put their volunteers on wages. Instead, different opportunities were discussed on how the implementing partners can attempt to link the volunteers to district councils or other local government initiatives in order to give the volunteers both a compensation and recognition. One way of securing local public support may be to slightly expand beyond TB to also include other similar diseases.

6.1 Malawi

6.1.1 Barriers for long-term engagement of TB volunteers

In Malawi, community-based health service delivery relies significantly on volunteers to bridge the gap between the formal healthcare system and underserved populations. Paradiso volunteers play a crucial role in TB prevention, treatment adherence, and health promotion. However, their long-term engagement faces multiple barriers and opportunities that determine their sustainability and effectiveness. Despite their contributions, a major barrier remains the lack of formal recognition and financial incentives for volunteers. Addressing this issue through better incentives and formal integration into the health system could further enhance access to care.

> ***Volunteers are not on salary or pension, leading to high attrition rates.***
>
> Medical doctor

Lack of Financial Incentives and Compensation

One of the primary challenges faced by volunteers is the lack of financial compensation. Many TB volunteers work without any allowance, leading to high attrition rates. Lack of financial support discourages long-term commitment, as volunteers often leave to seek paid employment.

Additionally, some health workers wrongly assume that volunteers receive money for their services. One volunteer expressed frustration, saying, "*Health workers refuse to sign the papers because they think we have received money*". This misconception affects morale and relationships with healthcare staff.

Lack of Transportation and Mobility Challenges

Many volunteers face difficulties in reaching distant villages due to transportation constraints. Without bicycles for every volunteer or other transport means, volunteers struggle to conduct

home visits, community screenings, and awareness campaigns effectively. While every TB Club has bicycles, lack of transport for each volunteer reduces the possibility to scale up outreach services, particularly in remote or hard-to-reach areas.

> ***The volunteers face challenges that include long-distance travel, as people travel long distances but lack sufficient transportation.***
>
> Village chief

Insufficient Training and Capacity Building
Volunteers often lack adequate training, limiting their ability to perform more complex health-related tasks. A health worker at Bwaila noted that volunteers need "*refresher courses and training twice a year*". Without continuous training, volunteers struggle to keep up with evolving health protocols and policies.

Stigma and Community Resistance
Despite their efforts, some volunteers face resistance from community members due to stigma, cultural beliefs, or misinformation. TB-related stigma, in particular, makes it challenging for volunteers to convince patients to seek treatment.

Furthermore, some community members still hold harmful beliefs about TB. Overcoming these misconceptions requires sustained awareness efforts and strong community engagement.

> ***Some beliefs say that TB is a type of curse, but volunteers help educate people about tuberculosis.***
>
> Community member

Psychological and Emotional Burden
Many volunteers face emotional stress due to the nature of their work. They often assist critically ill patients, support orphans, and handle distressing cases. The inability to provide tangible support to patients in need can lead to emotional burnout.

6.1.2 Opportunities for long-term engagement of TB volunteers

Strong Community Trust and Support
Despite the challenges, volunteers are highly trusted by their communities. This trust allows volunteers to deliver messages effectively and facilitate referrals to healthcare facilities.

Community members also recognize the important role that volunteers play in improving health-seeking behaviour.

People are rushing to the hospital to receive TB treatment quickly because of the messages they hear from the volunteers.

Community member

Bridging the Gap Between Health Facilities and Communities

Volunteers serve as a crucial link between communities and healthcare facilities. By referring patients, supporting treatment adherence, and disseminating health information, volunteers strengthen healthcare systems.

The gap that existed between the village people and the hospital has reduced because of the volunteers.

Health worker

Furthermore, health workers appreciate their contributions. Their presence of the volunteers ensures that patients complete their treatment regimens, improving health outcomes.

Potential for Skills Development and Career Growth

Engaging in volunteer work provides opportunities for personal and professional growth. Many volunteers expressed interest in expanding their skills. By formalizing training and certification programs, Paradiso can help volunteers transition into paid healthcare roles.

Additionally, some volunteers have initiated income-generating activities to sustain themselves. These initiatives provide financial stability while maintaining their engagement in health service delivery.

We have started working together on income-generating activities and have plans to engage in farming to ensure we have food to support TB patients.

TB volunteer

Expansion of Volunteer-Led Programs

There is significant potential to expand volunteer programs beyond TB services. A health worker at Bwaila suggested "*Volunteers should be supported by providing them with skills or increasing their knowledge so that they can handle Community Sputum Collection Point activities*".

Furthermore, a chief in Mchinji recommended integrating volunteers into development programs. He stated, "*Giving them the opportunity to provide guidance to someone suffering from TB and including their names in village development benefits so they can also benefit*". This highlights the possibility of embedding volunteerism into local governance and community development initiatives.

Potential for Policy Advocacy and Systemic Change
Volunteers have already influenced health policies at the community level. One interviewee noted, "*Volunteers continue to deliver messages to all community groups".* Their grassroots efforts have played a role in shifting attitudes toward TB prevention and treatment.

Additionally, some volunteers are advocating for better recognition and integration into formal health systems. A participant emphasized, "*Volunteers should receive adequate training on how to manage their own well-being while helping patients*". This suggests that formalizing volunteer roles through policy changes could improve long-term engagement.

6.1.3 Potential for scaling up scope of services

Paradiso has demonstrated significant impact in TB care, community-based health services, and policy advocacy in Malawi. Given its existing initiatives and community trust, there is substantial potential to scale up its services in multiple areas, including expanding geographical reach, integrating additional health services, strengthening volunteer incentives, and influencing policy reforms. Below is an analysis of the key opportunities for scaling up Paradiso's work.

Expanding Geographical Coverage: Paradiso has successfully implemented TB care programs in specific districts, but its reach remains limited due to resource constraints. According to NTLEP officials, "*Scaling up post-TB associated disability services to all facilities across the country is necessary, as it is currently only available in 13 out of over 500 facilities*". Expanding to rural and underserved areas would enhance access to TB screening, rehabilitation services, and community education.
Opportunity: Increase the number of trained volunteers to cover more districts.
Challenge: Limited funding for volunteer training and expansion.

Integrating Additional Health Services: Paradiso currently focuses primarily on TB. In addition they support MDR TB patients with nutritional support, HIV/AIDS, nutrition, and mental health. There is a potential to further expand these services. According to a medical doctor, "*There is potential for Paradiso to integrate HIV self-testing into their TB screening programs, extending their normal approach*". This would allow for more comprehensive care, addressing co-infections and broader public health needs.
Opportunity: Increase nutrition support, particularly for drug-resistant TB patients, as many lack proper food security.
Challenge: Requires additional funding and partnerships to support nutritional and HIV care initiatives.

Strengthening Volunteer and Community Health Worker Programs: One of Paradiso's greatest strengths is its use of trained TB survivors as volunteers. However, there are barriers to long-term retention, including lack of incentives and formal recognition.
Opportunity: Advocate for formal integration of volunteers into the government health system, securing stipends and incentives.
Challenge: Government recognition is still lacking, and funding remains a barrier.

Expanding Advocacy and High-Level Policy Engagement: Paradiso has already made significant progress in advocacy and policy influence, including securing the First Lady of Malawi as a TB Ambassador. However, there is potential to further scale up advocacy efforts, especially in gender-sensitive TB programming.
Opportunity: Develop targeted TB interventions for men, who are less likely to seek healthcare but have higher TB prevalence.
Challenge: Need for research-backed gender-transformative approaches to engage male populations effectively.

6.2 Tanzania

6.2.1 Barriers for long-term engagement of TB volunteers

When barriers were discussed, informants pointed at the volunteerism itself.

Lack of income for volunteers: One obvious barrier for the volunteers is their lack of income. Volunteers can perhaps work for one year, or two or three, but due to lack of salary or compensation, they would eventually need to turn to something else to sustain their lives. To mitigate this, MKUTA has set up a loan- and credit-scheme for the TB Clubs and volunteers. So far 40 of the 3,078 volunteers have become members. While the income-generating activities for these volunteers are helpful, informants doubted that it would generate enough to sustain the lives of the volunteers. Unless the volunteers can receive some sort of compensation, the MKUTA set-up may remain vulnerable as MKUTA will constantly have to train and engage new volunteers to replace those that leave.

Lack of funds for outreach: Shortage of funds to reach remote patients, or patients far from the volunteer's workstation, is a barrier, as only a few of the volunteers in Tanzania receive transport allowance. Furthermore, citizens and community leaders suggested that the volunteers be given gum boots and umbrellas to be able to move around during the rainy season. Volunteers also informed that they need cooler boxes for sputum containers and tablets for reporting.

Lack of health insurance: TB volunteers informed that they had a high risk of contracting TB and other related illnesses given their own health history and the work they undertake. They were not given adequate protection equipment such as gloves and face masks. Since they are not employed, they do not have health insurance, which is a barrier for some to become, or continue to be, long-term volunteers. Recently, Tanzania decided that all residents must have a health insurance, and there are plans to establish a Community Health Insurance Fund for people without formal employment. Linking volunteers to this fund may be an opportunity once it becomes established.[19]

[19] https://www.wtwco.com/en-bm/insights/2024/02/tanzania-all-residents-must-be-covered-by-health-insurance

6.2.2 Opportunities for long-term engagement of TB volunteers

There were in particular two contextual changes that informants discussed around when being asked about opportunities: how to meet the closure of USAID; and how to meet the government's new system of community health workers at village level.

Collaboration and sandwiching with Community Health Workers: TB volunteers have identified more TB cases over the last decade than was originally thought. The success by having people working on health issues in the communities have inspired the Tanzanian health system to establish a new education, where a public course is established for people to officially become "community health worker". The government's plan is to roll out a system where there shall be two community health workers employed in each village. This can be both an opportunity and a threat to the unpaid, community TB volunteers. The two systems of community health volunteers and community health workers may operate in parallel or may find a way to collaborate as an integrated village health package where workers and volunteers have specific roles that complement one another. Stakeholders belonging to the NTLP believed there was a golden opportunity to look at the MKUTA volunteers as part of the integrated community health service delivery chain, collaborating strategically with the public community health workers that the government will be posting in all villages. There could be a sandwich approach, a package, where tracing, treatment and education is integrated. These issues have not yet been discussed. One obvious dilemma is the fact that the community health workers have an education and will have a salary, while the community health volunteers work for free.

Capacity building on income generating activities: With regard to opportunities, volunteers in Tanzania believed there was an opportunity for MKUTA to provide capacity building on Income Generating Activities to enable volunteers to run small businesses to earn income that can sustain them. They also saw an opportunity in establishing Village Community Banks and credit and loaning schemes among the volunteers that could allow members to borrow money for their personal activities.

Training: Volunteers saw an opportunity for more education and training, e.g. inclusive health communication, TB care, operating TB related apps, like 'OneImpact', and more. While MKUTA is using several apps, the government was mentioning that there are other apps and digital platforms they would have liked to see being used by the TB volunteers.

Linking volunteers to local structures: Health workers said that the experience of the TB volunteers would allow them to serve in health committees at local levels e.g. as health representatives in ward committees.

Expanding the scope: TB volunteers and other stakeholders alike were of the opinion that there is room for more integration and collaboration between the TB volunteers and other actors providing services to other groups, such as HIV, malaria, leprosy, and non-communicable diseases, reproductive maternal health, and more. Several informants also believed that MKUTA should expand beyond TB, for instance to epidemics, as MKUTA showed during Covid-19 that

they have a perfect set-up for working with pandemic preparedness. Others mentioned malnutrition as an area of intervention.

Private sector: The government is working on a Multisectoral Accountability Framework for TB where all ministries and all sectors shall come together to identify how all can contribute to end TB, hereunder the private sector. MKUTA sees a potential in entering into strategic collaboration with the mining sector. Furthermore, it was suggested to collaborate with private clinics to enable these to screen patients for TB.

6.2.3 Potential for scaling up scope of services

While the TB volunteers are commended for doing a tremendous job, there is still a need for more of the same. Informants suggested that much of what is done, could be done more. To be able to scale up, MKUTA would need increased funding, as well as an increased number of strategic partnerships with other actors.

Door-to-door campaigns: Door-to-door campaigns in targeted areas have proven to be effective, and may be expanded.

Prevention: The government plans to roll out provision of Tuberculosis Prevention Treatment (TPT) to minors under 14, miners, people injecting drugs, and prisoners, starting this year. Volunteers should play a large role in reaching these groups. The intake of preventative medication, at least for some groups, may require observation.

Increase screening: To ensure that everyone with TB is identified, screening must increase, and for this the existing community volunteer system can be used. MKUTA has tested a system in four regions where TB volunteers screen everyone coming to a health facility before they are sent to medical staff. This has increased the identification of TB patients. There is a potential to scale up this activity to more facilities.

Increased use of mobile vans for X-rays: The government is procuring more mobile vans, there should be 12 more coming in 2025 and the aim is to have one mobile van per region. The vans are important for the TB volunteers. Vans provide free X-ray, while patients with presumed TB must pay for X-rays other places. Using the vans therefore both lowers costs for the patients and speed up the time for diagnosis. Making sure these vans come to areas where key populations and at-risk community members live, is important.

Lung rehabilitation: The work with lung rehabilitation could be expanded and worked on more systematically according to some stakeholders. It was suggested that the TB Clubs collaborate with other services that may provide transport for patients to and from clinics, alternatively provide means for patients to follow training at home via video links.

Increase research: To create synergies for scholars, researcher, and communities alike, one informant suggested that MKUTA enters into agreements with universities and research

institutions and link master students, PhD candidates and researchers to the community work. Researchers would enhance their understanding of the situation in the communities, and the TB Club and their volunteers could collaborate on data gathering, reporting and monitoring for research.

Children: Some stakeholders suggested that the TB Clubs should increase their interventions at schools and with children.

Invest in screening drug users: Drug use masks the TB symptoms, which means drug users can have transmitted the disease to many others before they are identified. Further investment in screening this group is needed.

6.3 Sudan

6.3.1 Opportunities and Barriers for long-term engagement of TB volunteers

In Sudan, volunteers play an essential role in raising awareness through health campaigns, educating the public about disease prevention, and promoting healthy lifestyles. They assist in community screening, and ensure timely medical intervention. Given that the war has incapacitated large parts of the health system, there is a need for more of everything HDP is already doing.

Limited financial support presents a major obstacle. Many volunteers work without financial incentives, making it difficult to sustain their involvement, particularly for those who rely on personal funds to cover expenses such as transportation, food, or necessary supplies. This financial strain can lead to volunteer burnout or decreased participation over time. Moreover, access to remote areas poses a logistical challenge, as geographic and infrastructural barriers make it difficult for volunteers to reach certain communities. Poor road conditions, lack of transportation, or the distance of rural locations can hinder service delivery, limiting the support available to those who need it most.

These barriers collectively highlight the need for better training programs, financial assistance, and improved infrastructure to support volunteers in their essential work.

6.3.2 Potential for scaling up scope of services

One potential is to expand community outreach and awareness. Strengthening public education campaigns on TB prevention and treatment ensures that communities are well-informed, leading to early diagnosis and improved treatment adherence. Moreover, increasing access to TB screening services, particularly in remote and underserved areas, can significantly enhance early detection rates. Implementing mobile clinics and outreach programs will further support this effort by bringing healthcare services directly to those in need.

Another potential might be integrating TB screening with other healthcare services. By making TB screening available alongside routine health services, HDP might improve accessibility and

encourage more people to seek early diagnosis. Additionally, ensuring that TB treatment is free or affordable will help eliminate financial barriers, ensuring that no patient is left behind.

6.4 Zambia

6.4.1 Opportunities and barriers for long-term engagement of TB volunteers

In Zambia, the engagement of volunteers in IBF presents both significant opportunities and notable barriers. On the positive side, past experiences show that volunteers who receive training while participating in IBF programs often acquire valuable skills that enable them to secure employment upon release. Many of these individuals transition into roles such as psychosocial counsellors or TB treatment supporters within organizations operating in similar fields. This suggests that IBF provides a viable pathway for reintegration into the workforce, particularly in health-related roles. Additionally, the need for health service delivery, especially in addressing TB and other communicable diseases, creates a demand for skilled volunteers, further enhancing the opportunities for sustained involvement.

However, there are substantial barriers that hinder the long-term integration of volunteers in health service delivery. One of the primary challenges is an advocacy issue related to employment restrictions for former prisoners in government sectors. This has been a very controversial issue. Despite possessing relevant skills and experience, these individuals often face systemic barriers to employment, particularly when their past convictions are unrelated to their professional capabilities. This restriction reflects broader societal stigma, where former inmates are often perceived as risks to the community, despite their rehabilitation. Additionally, family resistance further complicates reintegration efforts, as some prisoners may have strained relationships with their families, making acceptance and support difficult post-release. Addressing these barriers requires robust advocacy to shift public and institutional perceptions, ensuring that ex-inmates are recognized for their skills and potential contributions rather than their past offenses.

6.4.2 Potential for scaling up scope of services

There is significant potential to expand the scope of services that IBF provides. Given that the communities served by IBF face high rates of TB alongside other intersecting challenges, an integrated service delivery approach could significantly improve health outcomes. The current health services primarily focus on TB treatment, yet many of the patients also experience additional health issues, such as mental health challenges or disabilities, which must be addressed concurrently for effective treatment. Integrating mental health and disability services into IBF's existing framework as cross-cutting issues would ensure more holistic care, improving treatment adherence and overall well-being. Furthermore, IBF has a strategic plan that identifies nine thematic areas for potential service expansion. This includes extending health services beyond correctional facilities to include vulnerable populations in mining areas and refugee camps, where TB and other respiratory infections are prevalent. Given that IBF operates in the heart of a mining belt, expanding TB programs to these settings appears to be a logical next step.

7 Human rights and gender equality

The 'Reducing the burden of tuberculosis' program has human rights, inclusion, anti-discrimination and gender equality at its core. The program is implemented in countries where many sorts of discrimination find place, against women, against poor people, against sick people and more. Such discrimination may be found all over the society, including in the health services. Ensuring equal and friendly access to TB care for all, regardless of background, is at the very heart of the program.

Human rights is a basic pillar, the right to health, the right to dignity, finding vulnerable people and giving them equal access to treatment and medical follow-up is fulfilling their rights. This is exactly what the TB survivor organisations are good at!

LHLI staff member

6.5 Malawi

6.5.1 Promoting inclusive and rights-based approaches

In Malawi, a core element of Paradiso's work is ensuring that all people have access to TB care regardless of their social or economic status.

Addressing Structural Barriers to Healthcare: Many marginalized groups, including older people, orphans, and rural communities, face difficulties accessing TB care. Paradiso bridges this gap by ensuring that these populations are not left behind. A guardian of an orphan child highlighted, *"Paradiso used to provide funding for the child that I take care of to go to school"* This ensured that vulnerable children were not only receiving healthcare but also accessing education.

Integrating Human Rights into Policy and Programming: Paradiso embeds human rights and gender equity in their TB toolkits. This highlights their commitment to making health services rights-based rather than charity-based.

6.5.2 Addressing gender-related barriers in TB access

Paradiso actively considers gender dimensions in its programming, ensuring that both men and women are included in TB screening and treatment efforts. In Malawi, men are disproportionately affected by TB compared to women.[20] Informants to this evaluation recommended that Paradiso, alongside with other actors in Malawi, identify ways to specifically reach out to men. Furthermore, attempts should be made to recruit more men as volunteers.

[20] https://bmjopen.bmj.com/content/bmjopen/11/6/e044944.full.pdf

6.6 Tanzania

6.6.1 Promoting inclusive and rights-based approaches

In Tanzania, MKUTA has a focus on reducing stigma, and reaching key, at-risk populations and providing patient-friendly treatment in an inclusive and a non-discriminatory way.

MKUTA is a hope organisation created by patients themselves!

MKUTA staff member

TB Club volunteers have carried out education on TB-related gender issues and human rights, e.g. through banners, flyers, cultural troupes, and participating in government health campaigns. They have a digital approach, e.g. by registering TB related challenges through the 'OneImpact'-app. This application provides a voice to otherwise marginalised populations and groups of patients, either by directly using the app, or by communicating through the volunteers. 'OneImpact' is being used in 12 regions in Tanzania so far (43% of mainland Tanzania). Through this tool, 48,000 people have been engaged; patients, volunteers, and health workers. Through the 'OneImpact'-system, MKUTA can report challenges directly to the affected health facility, district or region.

MKUTA TB volunteers also carry out door-to-door campaigns, informing about people's rights. By reaching out to hard to reach and key marginalized populations, and providing access to friendly TB services to these groups, MKUTA works towards inclusion and against discrimination.

MKUTA helps Tanzania to un-medicalize the TB response, as TB is no longer only a medical issue but has become a social issue.

MKUTA staff member

6.6.2 Addressing gender-related barriers in TB access

Men and women are found to think differently of themselves and each other when contracting TB. The 'OneImpact'-app helps MKUTA to generate gender-based statistics on stigma and barriers faced by different groups of men and women. According to MKUTA themselves, they have become one of the leading organisations in the country addressing "Community rights and gender". The TB Club volunteers provide spousal support of TB patients where they reach out to spouses of TB patients for education and screening. In one of the sites that was visited by the evaluation, the TB Club has established a clinic on Saturdays to especially reach women who are often too busy during the week to seek health services. The same TB Club also offers a safe space for women using drugs and female sex workers where they can come, receive psycho-social support, eat nutritious food, wash and relax.

The TB Clubs use the international Women's Day; the International TB Day; and the 16 days in November; to talk about TB and gender-based violence

6.7 Sudan

6.7.1 Promoting inclusive and rights-based approaches

In Sudan, HDP engages community leaders and use locally appropriate communication methods, to create an environment in which all individuals, regardless of gender or social status, can access high-quality TB services. HDP ensures that marginalized groups, including the poorest patients and those who lost their jobs due to TB infection, receive income-generating activities and emergency support. Such interventions provide financial relief to affected individuals, enabling them to continue their treatment without socioeconomic hardship.

6.7.2 Addressing gender-related barriers in TB access

HDP actively promotes gender equity by ensuring balanced representation in its volunteer teams and by providing comprehensive training on gender sensitivity and cultural competence. Its outreach strategies are designed to address the specific needs of both men and women, with targeted communication that respects local customs and addresses gender-based barriers to care. Although HDP has made significant progress in incorporating human rights and gender-sensitive practices, there remains room for improvement. Enhancements in legal support mechanisms and more comprehensive integration of gender policies into every level of program planning could further reinforce these efforts. Moreover, establishing more systematic ways to capture community feedback and engage marginalized groups in decision-making processes would help address any residual biases and ensure that all vulnerable populations are fully represented. Strengthening these aspects would not only improve program delivery but also contribute to a more equitable and rights-based approach to healthcare.

6.8 Zambia

6.8.1 Promoting inclusive and rights-based approaches

In Zambia, IBF is committed to fostering inclusivity and gender sensitivity in its initiatives, particularly within the correctional system. The organization implements strategies to address the unique needs of all inmates. One of the key ways IBF promotes inclusivity is through its gender policy, which serves as a guiding framework for daily operations, ensuring that gender issues are systematically considered. Additionally, IBF demonstrates its commitment at an organizational level by ensuring that leadership positions reflect gender balance, with two out of three senior management roles occupied by female staff. At the program level, the organization further emphasizes inclusivity by having over 50% of Zambia Correctional Service health coordinators as female, which enhances the effective coordination of health-related activities.

Furthermore, IBF actively promotes gender inclusivity among inmates by encouraging female inmates to participate as volunteers in various correctional facilities. This effort extends across both female-only and mixed-gender facilities, ensuring that women have equal opportunities to engage in meaningful activities. Recognizing the specific health needs of female inmates, IBF provides gender-responsive healthcare services, including reproductive care, counselling, and access to sanitary products. The organization has also introduced skills training programs, such

as tailoring reusable sanitary pads, which not only addresses immediate hygiene needs but also empowers female inmates with sustainable skills.

Beyond these direct interventions, IBF acknowledges the need for continuous improvements in its human rights and gender-sensitive approaches, particularly through policy advocacy and systematic change. By further collaborating with governmental bodies and other stakeholders, IBF seeks to influence national policies related to healthcare and human rights within correctional facilities. Additionally, the organization wishes to hold regular staff training on human rights and gender sensitivity, fostering a culture of respect and inclusiveness within correctional institutions. These efforts collectively reinforce IBF's commitment to a rights-based and inclusive approach that improves the well-being of individuals in the correctional system.

8 Contributions to the national TB response

Paradiso in Malawi, MKUTA in Tanzania, HDP in Sudan and In But Free in Zambia each play vital roles in the national TB responses. They advocate for enhanced prioritization of TB control in their countries, and they have significantly influenced the national TB strategies.

8.1 Malawi

Recognised community actor

In Malawi, Paradiso has played a critical role in the national TB response through a multifaceted approach that includes community engagement, early detection initiatives, post-TB care, and policy advocacy. Although not formally listed as a stakeholder in key government documents, Paradiso is recognized as a key actor in the fight against TB by informants that participated in this evaluation. A core element of its contribution has been the mobilization of TB survivors as community volunteers, who conduct door-to-door screenings, provide treatment support, and help increase case detection rates. This approach has significantly improved early TB diagnosis and access to treatment.

Policy Influence and National TB Strategy Integration

Paradiso has also been instrumental in advocating for the integration of post-TB care into Malawi's National TB Strategic Plan, introducing rehabilitation services for TB survivors to address long-term health complications. Paradiso's influence extends to policy advocacy, having secured Global Fund resources through World Vision, worked with the Parliamentary TB Caucus to push for increased TB funding, and played a key role in engaging the First Lady of Malawi as a TB ambassador. Overall, Paradiso's efforts have significantly strengthened TB prevention, treatment, and policy frameworks in Malawi, making it a key contributor to the national TB response.

> ***Paradiso played a role in policy development, including the integration of post-TB care into Malawi's national TB strategy.***
>
> Partner organization representative

8.2 Tanzania

A recognised community arm of the national TB control system

In Tanzania, stakeholders confirmed that MKUTA is a key stakeholder in the national TB response. MKUTA is the only organization that represents TB survivors in the country. MKUTA has a national geographic coverage with volunteer TB survivors who support TB interventions including active case finding contact tracing, treatment support and community led monitoring interventions. MKUTA supports local TB volunteers through capacity building in TB care and prevention and other related issues, as well as income generating activities (IGA). A vivid example is in Temeke district where MKUTA contributed 34% of all the TB notifications in 2024. MKUTA is aligned with and implements the national TB strategy. The TB Clubs operate in close collaboration with and under the supervision of, the governmental TB coordinator and together with the DOT nurses in each health facility. Reports made by the TB Clubs are directly recorded in the governmental system. The Clubs work within the system and are a part of the system.

MKUTA and their subsidiaries are important stakeholders in the national TB program, contributing in technical working groups, strategy and policy reviews, and in TB national campaigns, such as World TB Day and Annual TB Conference. At the time of undertaking this evaluation, MKUTA was actively taking part in the establishment of the National Social Protection plan that will come into action in 2025 and should reduce patients' costs.

Research and development

With funding from LHLI/Norad, MKUTA collaborated with researchers at Kibong'oto infectious disease hospital 2020-2022. The research found a high number of treated TB patients with severe lung impairment after being declared cured from TB. They developed an exercise program for lung rehabilitation to be done at home or in local clinics that yield very good results. The research also identified a high number of treated TB patients with recurrent TB. This has made MKUTA advocate for a systemic follow-up of treated TB patients by the health systems, and a new guideline is being drafted and will become operational.

8.3 Sudan

In Sudan, HDP is the only national organization in Sudan that carries out training of volunteers to monitor TB patients and conduct home visits. They also provide health awareness and education programs to all communities across the various states of Sudan. The war has led to more cooperation and joint efforts among civil society organizations, and the Sudan Humanitarian Aid Commission (HAC) in Sudan. HDP is the chair of both the civil society organizations (CSO) in Sudan Forum and SCOVA (Sudanese council of voluntary agencies). HDP's media coverage has grown during the war, from a baseline of eight to a total of 313 for the period 2021-2024 including television, social media and print media.

HDP significantly contributes to Sudan's national TB response by providing essential screening and diagnostic services, which improves patient outcomes and strengthens Sudan's overall

public health system. HDP has participated in the updates of six policies in total, hereunder one on patients' rights; and another on TB and gender. They have also contributed to a guideline for TB patients.

HDP ensures strong coordination with the Sudanese Ministry of Health and the National TB Control Program, ensuring that HDP's efforts align with the national TB control strategy, making interventions more effective and integrated. At both federal and state levels, HDP engages with health authorities to support policy implementation and strengthen the country's TB response framework. This strategic coordination enhances resource utilization, policy execution, and healthcare accessibility for TB patients across Sudan.

HDP also remains actively involved in national health discussions by participating in policy-making meetings and strategic planning sessions focused on combating TB. This involvement allows the organization to contribute valuable insights from field experiences, advocate for patient-centred policies, and align its initiatives with broader national health goals. By staying engaged in national health discussions, HDP helps shape Sudan's TB control policies, ensuring they remain effective, inclusive, and sustainable.

8.4 Zambia

In Zambia, IBF has become a key stakeholder in Zambia's national TB response. Its efforts in reducing TB mortality, increasing early detection, ensuring treatment adherence, and advocating for policy reforms have significantly contributed to TB control in correctional facilities. With its continued expansion, international partnerships, and commitment to strengthening healthcare systems, IBF remains instrumental in addressing TB in Zambia.

Beyond improving healthcare delivery, the program has played a vital role in shaping policy and advocating for enhanced inmate healthcare services. Its efforts have led to policy changes that acknowledge the necessity of dignified healthcare for inmates. A major contribution has been the development of symptom screening tools, now integrated into national TB programs. These tools, along with infection prevention measures, have standardized TB surveillance and response efforts across the prison system, ensuring a coordinated and sustainable approach to TB control.

IBF participates in the National TB Technique Working Groups. They are also members of the Prison Health Advisory Committee, which is a national committee that takes care of the inmates in the country.

9 Conclusions and recommendations

1.1 Conclusions

The 'Reducing the burden of tuberculosis' program is implemented in four countries. In Malawi, Tanzania and Sudan, the implementing organisations Paradiso, MKUTA, and Health Development Program consist of TB survivors who operate at community level to help raise awareness about and reduce stigma around TB in order to identify as many patients presumptive of TB as possible and bring them to the health facilities for treatment. In Zambia, In But Free works for TB control TB in prisons.

The evaluation took place as USAID, a major donor to health and communicable diseases in all the four countries in the program, suddenly stopped its funding stream and closed. Furthermore, the program in Sudan is being implemented amidst a devastating humanitarian crisis where in one and a half year more than 60,000 are estimated to have died[21], 11 million are internally displaced, 50% of the population face acute food insecurity and 1.5 million are on the edge of famine.[22]

All four implementing organisations **contribute significantly to the national TB response** in their countries. Paradiso is the only TB patient organisation in Malawi, and they are present in nearly all districts in the country. Paradiso is a member of the Technical Working Group of the National Tuberculosis and Leprosy Elimination Program. In Tanzania, MKUTA is widely recognised as a crucial stakeholder in the national TB response, having TB volunteers in all regions of the country. Several MKUTA representatives hold positions in working groups and committees under the National Tuberculosis and Leprosy Program, where they are actively contributing to policies, guidelines and new research. Health and Development Program in Sudan is a key stakeholder in the national TB response, and participates in national committees, collaborates with the Ministry of Health, and leads sub-TB committees. They provide training, advocacy, and community-based services. In Zambia, In But Free has significantly reduced TB-related deaths in correctional facilities. It has improved treatment success rates and strengthened healthcare systems in prisons.

The four implementing organisations have shown **significant effectiveness** in enhancing TB prevention and care, strengthening health services at local level, increasing TB notifications, and reducing TB-related deaths. By carrying out awareness raising, the implementing organisations have managed to reduce stigma, thereby motivating people to be screened and diagnosed and referred to treatment. The outreach activities in Malawi, Tanzania and Sudan to geographically remote areas as well as to marginalised key populations, and the important interventions in prisons in Zambia have significantly increased TB notifications, brought people to treatment who otherwise would never have become diagnosed, and through that enabled patients to be cured. Overall, this has reduced both transmission, development of multi-resistant bacteria, and eventually TB-related deaths in the four countries.

[21] November 2024; London School of Hygiene and Tropical Medicine's Sudan Research Group
[22] https://www.nrc.no/news/2024/november/sudan-world-ignores-countdown-to-famine

In **Malawi**, Paradiso has contributed to an improvement of early detection and treatment outcomes by mobilizing TB survivors. This has increased detection of TB patients and reduced logistical barriers for remote communities. Integrating post-TB care into the national strategy has strengthened the health system.

In **Tanzania**, the MKUTA TB Clubs have raised public awareness, reduced stigma, and surpassed their notification goals. Volunteers conducted screenings and ensured patient follow-up, which in turn has increased adherence to treatment and reduced development of drug-resistant TB. The TB Clubs function as a bridge between communities and health facilities, that are understaffed and unable to carrying out outreach activities.

In **Sudan**, Health Development Program's mobile clinics and culturally sensitive outreach has led to earlier diagnosis and improved treatment adherence. Their community engagement efforts have dispelled myths, reduced stigma, and enhanced coordination with formal health institutions. This approach has expanded access to primary care services, particularly for marginalized populations.

In **Zambia**, In But Free's initiatives in correctional facilities have improved early detection and treatment adherence through capacity building and training. Weekly health awareness sessions have reduced stigma, and systematic TB screening has ensured consistent care for vulnerable populations. The organization's expansion and strategic partnerships have reinforced the health system and secured additional funding.

The interventions and strategies chosen by the four implementing partners appear to be **highly relevant** to reduce the burden of TB in the four countries. The partners have identified at-risk key populations with high TB prevalence that the health system does not have resources to reach on their own. While the four partners have identified highly effective and efficient approaches to reach the key populations, they all suffer from a general lack of funding that prevents them from reaching every person with presumed TB. In **Malawi**, they have successfully focused on underserved populations like prisoners, miners, and rural communities. There are challenges to reach orphans and remote populations. In **Tanzania**, they work with key at-risk populations like drug users, artisanal miners, Maasai/nomads, and remote fisherfolk communities. While MKUTA is believed to have an accurate analysis of which key populations they must reach to curb TB, there is not enough funding to reach all the individuals belonging to the identified at-risk groups. In **Sudan**, they have focused on reaching underserved areas and marginalised populations. In **Zambia**, In But Free focuses on one key population: inmates in prisons.

While the networks of TB volunteers have expanded in an impressive manner in terms of both numbers and geographic presence in Malawi, Tanzania and Sudan, the **long-term engagement of the TB volunteers** appears **threatened** due to lack of compensation for their work, time consuming schedule, and exposure to TB and other communicable diseases without being protected or insured. Also, there is a lack of enabling equipment like transport allowance for

outreach, gum boots and umbrellas for working in the rainy season, cooler boxers to transport sputum containers in the heat, and tablets to do efficient reporting to the health system. In all four countries, an **expansion to other diseases** or malaises beyond TB appears likely to enhance resilience, increase funding opportunities and increase the likelihood of recognition that seems to be needed for the volunteers to be able to receive some form of compensation.

Human rights, inclusion, anti-discrimination, gender equality, patient-friendly treatment, and dignity compose the backbone of the program. In Malawi, males are presumed to compose 57 percent of the people diagnosed with TB; while they only represent 40 percent of the identified patients. Paradiso focuses on removing structural barriers for marginalized groups and emphasizes gender equity in TB toolkits. There appears to be a potential for engaging more men. MKUTA in Tanzania mainstreams community rights and gender equity, using an application that allows patients to report their patient experiences. MKUTA subsidiaries work with women's rights and combat gender-based violence. HDP in Sudan promotes gender equity through balanced volunteer teams and culturally sensitive training. They tailor outreach to meet unique needs but recognize the need for stronger legal support and community feedback mechanisms. IBF in Zambia implements a gender-sensitive framework in correctional settings, offering tailored healthcare services and promoting female leadership. They address gender-specific barriers through education and targeted services.

1.2 Recommendations

All actions and approached chosen by the program come across as relevant, effective and efficient. Since tuberculosis is still around us, more of everything that is already being done, seems to be needed. The USAID closure has created further shortage of funding for an already underfunded fight against a deadly disease. This new situation has increased the relative importance of LHLI and the 'Reducing the burden of tuberculosis' program, which again poses an even stronger pressure than earlier for strict prioritizations.

The evaluation was carried out with field visits in Malawi and Tanzania, where the participatory evaluation teams formulated recommendations. The recommendations to Paradiso and MKUTA are recommendations to them and their TB work, included and beyond the 'Reducing the burden of tuberculosis' program. These recommendations may be supported financially by LHLI, or by other suitable funding sources and strategic partners. In Sudan and Zambia, the evaluation included a document review and one virtual interview per country. Due to this difference in engagement, country-specific recommendations are only forwarded to Malawi and Tanzania.

1.2.1 Recommendations to LHLI

1. Given the new global funding situation, LHLI is recommended to sit down with the four implementing partners and carefully scrutinize which activities and actions can only be carried out by the implementing partners, and which, if any, may be transferred or left to other actors.

2. Support the four implementing partners to increase their fund-raising from the private sector, and, where feasible, from national, regional and/or local budgets.

3. Continue advocacy to include post-TB follow-up in the NTPs.

4. Look into opportunities to link the TB volunteer networks with ongoing research in the four countries for synergies and mutual benefit for all.

1.2.2 Recommendations to Paradiso

1. Carry out a gendered analysis of the target groups to identify a differentiated approach towards males and females. Introduce targeted interventions to encourage men to seek TB care. Also, find ways to recruit men as TB volunteers.

2. If funding allows, strengthen ongoing programs on *HIV/TB co-infection* and *Nutrition* and develop new programs on *Targeting men who have issues with alcohol and are smokers* and *Female sex workers.*

3. Look into opportunities for collaboration with relevant actors for support and capacity building of volunteers:
   - Regular Meetings and Collaboration: Volunteers are encouraged to meet frequently and work closely with health workers, TB Clubs, and community chiefs. This fosters coordination and ensures everyone is updated with current health information.
   - Training and Skill Development: There is a strong emphasis on continuous, structured training for volunteers and health workers. This includes training on TB symptom recognition, effective communication, counselling, and even managing their own well-being.
   - Provision of Tools and Incentives: Ideally, all volunteers should be equipped with necessary resources—such as protective equipment (masks, gloves), bicycles, referral letters, and food during work—to enhance their efficiency. Additionally, support through transport allowances and performance-based incentives is recommended.

6. Broaden Community Outreach and TB Awareness activities:
   - Diversify Communication Methods: Widen outreach, including the use of social media, radio broadcasts, printed materials, and interactive methods like drama, storytelling, and testimonies from TB survivors.
   - Strengthen TB Clubs: Maintain and expand TB Clubs for early symptom recognition to ensure that TB messages are well disseminated across communities, especially in rural or underserved areas.
   - Strengthen engagement with Community Leaders: Actively involve local chiefs, traditional healers, and community influencers to build trust and ensure that TB awareness messages are accepted and acted upon.

5. Strengthen Partnerships and Relationships:

- Sustain Good Relationships between the volunteers, TB Clubs, hospitals, and community leaders.
- Promote Collaborative Health Initiatives: Advocate so health workers support volunteers during their outreach, guiding them on updated health practices and ensuring that messages remain accurate and impactful.
- Gather Community Feedback: Regular feedback from the community should be gathered to refine strategies and address any challenges faced by volunteers.
- Expand Outreach: There is a call to create more TB Clubs and recruit additional volunteers to increase the program's outreach, ensuring that even the most at-risk populations are reached.
- Provide Economic and Social Support: Look for opportunities to deliver support beyond health-related initiatives, to programs such as school fee support for orphans, and assisting patients with food to help them adhere to their treatment.

1.2.3 Recommendations to MKUTA

1. Identify ways to provide support to enabling strategies of volunteers to enhance their effectiveness and sustainability.
   - For TB volunteers to be effective, they need transport allowance, protection and enabling equipment like gloves, masks, rain boots, umbrellas, back packs, cooler boxes for sputum containers, tablets for reporting. Look into possibilities of funding this through private funding.
   - Identify a system for recognition of the performance of the volunteers.
   - For volunteers to last, they should have a health insurance. Seek to link volunteers to the new Community Health Insurance Funds that will become established.
   - For volunteers to last, they need some kind of compensation. Seek support for TB Clubs and their volunteers over district council budgets.
   - Negotiate with the government to finance training and refreshment training of TB volunteers.
   - Negotiate with MoH/NTLP on how Community Health Workers and Community TB volunteers can collaborate and complement one another in a non-competitive way where also community volunteers receive sufficient recognition and/or compensation.

2. Solidify the TB Club network:
   - There is room to create further synergies and cross-fertilization between the different MKUTA subsidiaries and TB Clubs, and MKUTA should look into whether this could be achieved through stronger coordination.

3. Advocate for lower cost and higher quality health services:
   - MKUTA should lobby for TB X-rays to be free, particularly for key populations.
   - Look into opportunities to work more research-based.

4. Link up with other existing services:

- Find ways of providing nutrition to TB patients who belong to key populations.
- Train traditional healers in TB screening and link them up to TB Clubs/TB volunteers.
- Look into opportunities to develop or link up with safe spaces for people who use drugs and other hard-to-reach key populations.

5. Continue to educate and reduce stigma by expanding the use of social media

Annex A: Terms of reference

EVALUATION: REDUCING THE BURDEN OF TUBERCULOSIS

1 BACKGROUND

Worldwide, tuberculosis (TB) is the leading cause of death from an infectious disease. More than 10 million people develop TB every year, of which close to a third remain undiagnosed and untreated[23]. There are multiple reasons for this, many that go beyond the purely biological. TB affects the poorest and most marginalized populations hardest, and women and men have different barriers to care[24]. This is why, to tackle the complex and dynamic nature of the TB epidemic, sturdy primary health care[25] is needed. Research suggests that strengthening health systems and investing in tuberculosis care and control, are complementary and mutually reinforcing[26] [27]

LHLI's program *Reducing the burden of TB* (2021-2025), funded by Norad, is approaching its last year of implementation under the current grant. The program takes place in four countries: Malawi, Sudan, Tanzania and Zambia. Malawi, Tanzania and Zambia have a fairly high incidence of TB (119, 183 and 283:100 000 respectively[1]), and Sudan is a country in conflict and with a failing health system. The program has been ongoing since 2015 and is implemented in close partnership with local organizations, and/or the public health system. In general, the organizations are community-led and consist of people affected by TB.

The program has a right based- approach[28]; (Overall outcome: The rights and needs of people affected by TB are met), with a focus on community systems strengthening (CSS), i.e. developing strong civil society organizations (CSO) of people affected by TB, with the ability to deliver

[23] WHO Global TB report 2024
[24] Yang, Wei-Teng, et al. "Barriers and delays in tuberculosis diagnosis and treatment services: does gender matter?" Tuberculosis research and treatment 2014.1 (2014): 461935.
[25] https://www.who.int/health-topics/primary-health-care#tab=tab_1
[26] Health-system strengthening and tuberculosis control, Atun, Rifat et al. The Lancet, Volume 375, Issue 9732, 2169 – 2178, 2010
[27] *Contributing to health system strengthening guiding principles for national tuberculosis programs. WHO/HTM/TB/2008.400.*World Health Organization, Geneva, 2008
[28] Citro B, Lyon E, Mankad M, Pandey KR, Gianella C. Developing a Human Rights-Based Approach to Tuberculosis. Health Hum Rights. 2016 Jun;18(1):1-8. PMID: 27780995; PMCID: PMC5070676.

services at community level, and advocate at both local and national level. This is both a goal in its own right (lower outcome 1: CSOs for people affected by TB are considered as key stakeholders), but also a means to improve access to diagnosis (lower outcome 2: People with TB are diagnosed) and treatment and care (lower outcome 3: People affected by TB access care and support).

Key activities under outcome 2 and 3, such as screening for TB, raising awareness at community level, referring people with symptoms and supporting people on treatment, are done by thousands of volunteers of people affected by TB. This is the backbone of the program. These volunteers go out to remote areas that are far from health facilities, and they work closely with stigmatized and vulnerable populations such as prisoners, people who use drugs, nomads, refugees and people working in the mines. So far in this grant period, from 2021-2023, more than 1,2 million people with vulnerabilities have been reached by the CSOs in our program.

CSOs are recognized as key stakeholders in reaching SDG 3.3[29] and 3.8[30], and are acknowledged as such in the Political Declaration of the HLM on the Fight Against Tuberculosis[31]. When empowered, CSOs have the potential of improving access to health and health education, preventing disease and diagnostic delay, and reducing health disparities. Robust CSOs and well-functioning community health systems can play a major role in tuberculosis control programs - and consequently in the overall health systems-, by covering the different gaps at every step of the cascade of care[32] specific to each context. The cascade of care includes access to testing, diagnosis, linkage to care, treatment completion, and recurrence free survival.

Tuberculosis is an indicator of social marginalization and inequity[33]. Due to health inequalities, the burden of TB falls heavily on people living in poverty, and as TB incidence drops within countries, it concentrates on vulnerable and neglected populations[34]. Communities and health systems need to work in tandem to address the gaps.

[29] By 2030, end the epidemics of AIDS, tuberculosis, malaria and neglected tropical diseases and combat hepatitis, water-borne diseases and other communicable diseases.
[30] Achieve universal health coverage, including financial risk protection, access to quality essential health-care services and access to safe, effective, quality and affordable essential medicines and vaccines for all.
[31] UN Political declaration of the High-Level Meeting on the fight against tuberculosis, United Nations, New York, NY, 2023
[32] R Subbaraman, T Jhaveri, RR. Nathavitharana. Closing gaps in the tuberculosis care cascade: an action-oriented research agenda, J Clin Tuberc Other Mycobact Dis, 19 (2020), Article 100144.
[33] Anete Trajman, The social drivers of tuberculosis, reconfirmed. The Lancet Infectious Diseases, Volume 24, Issue 1, 5 – 6, 2024.
[34] European Centre for Disease Prevention and Control. Guidance on tuberculosis control in vulnerable and hard-to-reach populations. Stockholm: ECDC; 2016.

Program partners:

Paradiso TB Patient Trust is an organization of people affected by tuberculosis. It was founded in 2003 by Mara Banda and is situated in Lilongwe. Today they work in six regions and have more than 3000 members. Paradiso do a great job to find people with symptoms of tuberculosis in their community and care for the sick, including orphans. They are important champions for people with tuberculosis associated disabilities in Malawi and are the first to implement community-based lung rehabilitation in Malawi.

MKUTA TB Patient Organization has developed from a small tuberculosis patient organization in Dar Es Salaam to become a nationwide organization with more than 3000 members. They play a key role in tuberculosis in Tanzania, screening around a million people a year and reaching out to vulnerable populations such as drug users and miners. MKUTA are important advocates for people affected by tuberculosis and influence policy development in the country.

Health Development Program is a large organization in Sudan, with more than 27 000 members across all 18 states. HDP works to support people affected by tuberculosis and HIV, and they play an important role in creating awareness and reducing stigma, for example through street theatre. HDP also focus on the rights of women, refugees, and people with disabilities. Due to conflict and coups in Sudan HDPs work is very challenging, but they continue to play a key role in ensuring the right to health in the country.

In But Free is a small rights-based organization that has worked in Zambian prisons since 1995. Today, they are present in 13 correctional facilities across 3 provinces in the country. By empowering prison inmates as peers, they ensure tuberculosis screening and HIV voluntary testing for everyone in the prison and provides nutritional support and care to the sick. They also focus on mental health for the inmates. In But Free is a key national stakeholder for the right to health for people that are incarcerated and for people living in refugee camps and congregate settings.

2. PURPOSE AND USE

This evaluation will mainly be used for learning purposes, and to document the effect of community systems in health. The findings and recommendations will inform the planning for the next grant period 2026-2030.

3. OBJECTIVES AND EVALUATION QUESTIONS

It is well recognized that active involvement of communities and people affected by TB are essential in achieving universal access to quality TB services[35]. LHL International invest significantly in the organisational development of, and long-term partnerships with, organisations of people affected by TB. The aim is that they become key stakeholders who actively join the fight against the disease and contribute to strengthening TB services at primary health care level.

The overall objective of the evaluation is therefore to assess if the CSOs in the programs have become key stakeholders in the national TB response.

[35] UNHLM Declaration, Global plan to end TB

Although advocacy and being watchdogs are intrinsic parts of the work of CSOs, this evaluation will mainly be limited to the assessment of the role of the CSOs in service delivery across the TB cascade of care, and contributions to health system strengthening. This should also include brief reflections about the CSOs progressions from when the organizations were founded.

Evaluation questions:

1. How are the CSOs contributing to strengthening TB prevention and care at local level?
    - Are there health services gaps that are currently being filled by CSOs? I.e. what TB services would not be delivered without the support of CSOs?
    - Are there populations that would not access health services without the support of CSOs? If yes, which populations and for what reason? (please consider gender, marginalized groups, people who experience legal barriers and/ or live in distant areas)
    - What are the barriers and opportunities for volunteers in CSOs to work with health service delivery long -term? And is there any potential for increasing the scope of services?
    - How are the CSOs work on TB prevention and care contributing to health system strengthening?

2. Are there other indirect, positive or negative, consequences, of CSO's contribution to health service delivery?
    - What are the intended or unintended consequences for CSOs?
    - What are the intended or unintended consequences for the health system?

The evaluation will refer to the OECD criteria for evaluations, with specific focus on relevance, effectiveness and sustainability, considering also aspects of human rights and gender equality.

4. SCOPE

The evaluation period is from this current grant period 2021- 2024, and includes Malawi, Sudan, Tanzania and Zambia.
In depth assessments will be of the work with MKUTA in Tanzania https://mkuta.or.tz/about/ and Paradiso in Malawi https://paradisomw.org/ as these are organisations of people affected by TB. Due to security, it might not be possible to travel to HDP in Sudan.

5. APPROACH AND METHODOLOGY

Appropriate methodology and data collection must be applied to answer the evaluation questions. More than one source of information (triangulation) and the inclusion of both quantitative and qualitative data is required.
An overview of the chosen methodology should be described in the tender submission. This may include:

- Combination of desk study for an overview of the whole portfolio, field visits to Malawi and Tanzania, key informant interviews and group interviews.
- Participatory approach that includes volunteers/ people affected by TB, health workers, project staff and national TB programs

Implementing partners and LHL International will participate as facilitators for the consultants and as sources of information. Methodological challenges and potential limitations in findings and conclusions must be described in the report.

6.QUALITY STANDARDS

OECD/DAC Quality Standards for Development Evaluations serve as the reference point for the evaluation, and all findings and conclusions must be backed by reference to evidence (source) and their representativeness.

Ethical standards must be upheld. All consultants hired by LHL International must sign a Code of Conduct.

6.1 Data protection and ownership

Statement regarding ownership and confidentiality

When undertaking the study all information and documentation are considered to be confidential and the property of LHL International. All documents should be returned to LHL International, or deleted, once the study is completed. The consultant shall be discrete about any information they may receive or encounter during the evaluation.

Statement on privacy rights and data protection

Matters to consider:

- whether there is need to interview anyone who is not employed or engaged in a volunteer role in the project. If this is key to the evaluation – evaluators prepare information on privacy and data protection which is easy to understand – written or orally.
- Interviewees do not have to be identified by name in the report, but consultants need to keep their contact information. The interviewees should only be interviewed voluntarily, with prior consent given.
- If children are involved, prior consent should be acquired from their guardian(s).
- The same guidelines apply to the use of pictures.
- Partner organisation may (or may not) assist or facilitate in this process

7.MANAGEMENT OF THE REVIEW/EVALUATION

- Preferably a multi-disciplined and gender balanced team with expertise within tuberculosis, community systems, health system strengthening and international development projects.

- Proficiency in English and preferably one or more local languages
- Team leader; Preferably at least 5 years' experience as a consultant

8.TIME FRAME AND SCHEDULE

- The evaluation time frame is between January 2025 and March 2025.
- An inception report should be submitted within 14 days after signing the contract.
- Draft report to be submitted by 20th March, and final report by April 1st. LHL International will provide input within 8 days of received report.

9. DELIVERABLES / REPORTING

The report should have clear key findings and recommendations, including a 2 pages executive summary.

A presentation should be made and shared in a digital meeting and a joint dissemination meeting in one of the project countries.

10. BUDGET

We estimate approximately 30 days for this assignment. This includes desk review, preparing evaluation tools, data collection- including travel to/in-country travel, report writing and result dissemination. The budget and work plan in the tender should clearly justify what considerations that have been made.
The budget should cover all expenses, such as travels, visas, insurances, local transport, fees. The consultant(s) should already have available any equipment necessary to carry out the assignment.

11. TENDER PROCESS AND RULES

- Deadline for submission of bid: 30.12. 2024
- Submissions shall include:
  - A 1-page cover letter with brief description of previous relevant experience.
  - Proposal of max 5 pages describing suggested methodology and workplan/milestones.
  - Detailed budget in NOK or USD or EUR.
  - Contact details for at least 3 references from previous relevant assignments.
  - CVs of consultants.
- Shortlisting ready by 6.01.2025
- Any questions should be emailed to Director Mona Drage (mona@lhli.no).

11.1 Award criteria

The following criteria will be used considering the tenders.

- A good understanding of the assignment (40%)
- Relevant experience from previous assignments or within this field of expertise (40%)
- Price and ability to conduct a quality evaluation within the set budget frame (20%)

Clarification about Health System Strengthening

LHLI and partners have provided definition and explanation to the evaluation question put forward in the Terms of Reference: "How are the CSOs work on TB prevention and care contributing to health system strengthening?"

LHLI provided the below explanation:
Health system strengthening is necessary to achieve universal health coverage.
So if we look at the Universal health coverage dimension of 1) population coverage, 2) service availability and 3) financial protection, the questions arise:

How do the CSOs:
-improve access to primary care services (geographic and population coverage)
-increase demand for primary health services (through community outreach, information work, anti-stigma work), add services (also out-reach- treatment support, advocacy, supporting the health work force so they can attend to other things/more patients)
-reduce costs (direct and in-direct) for people

LHLI has also asked that the below three questions are reflected on:
How do the CSOs in their communities contribute to:
-Improve health outcomes
-Equitable access to health services.
-Ensure high-quality, patient-centered care.

MKUTA provided an operationalisation of Health System Strengthening, and suggest that the evaluation be used to showcase MKUTA's contributions to:

- How MKUTA address the human resource shortages.
- How MKUTA provide service delivery (dealing directly with patients; engaging sample transportation, referrals, treatment support, strong focus on reaching key vulnerable population)
- Being a bridge between the health system and the community.
- Advocacy at different level, from community up to global level.
- Capacity building for community volunteers, health professionals and others
- Monitoring of health systems
- Promote community-rights and gender for the people in the community and health system.

Annex B: Evaluation Questions

Effectiveness:
E1: Are there direct or indirect, positive or negative, consequences, of CSO's contribution to health service delivery?
E2: What has been the CSOs' progressions from when the organizations were founded
E3: What are the intended or unintended consequences for CSOs?
E4: What are the intended or unintended consequences for the health system?
E5: How are the CSOs contributing to strengthening TB prevention and care at local level?
E6: To what extent do the CSOs contribute to improve health outcomes in their communities?
E7: To what extent do the CSOs contribute to equitable access to health services in their communities?
E8: To what extent do the CSOs contribute to ensure high-quality, patient-centred care in their communities?
E9: How do the CSOs improve access to primary care services (geographic and population coverage)
E10: How do the CSOs increase demand for primary health services (through community outreach, information work, anti-stigma work), add services (also outreach-treatment support, advocacy, supporting the health work force so they can attend to other things/more patients)
E11: How do the CSOs reduce costs (direct and indirect) for people
Sustainability:
S1: What are the barriers and opportunities for volunteers in CSOs to work with health service delivery long-term? And is there any potential for increasing the scope of services?
Relevance:
R1: Are there health services gaps that are currently being filled by CSOs? I.e. what TB services would not be delivered without the support of CSOs?
R2: Are there populations that would not access health services without the support of CSOs? If yes, which populations and for what reason? (please consider gender, marginalized groups, people who experience legal barriers and/ or live in distant areas)
Crosscutting issues:
C1: Human rights
C2: Gender equality
Impact:
I: Have the CSOs in the programs become key stakeholders in the national TB response in their countries?
Recommendations

Annex C: Interview Guides

1. LHLI – for four different countries / partners

Time: In Oslo, February 4th at 12:30 – 15:30

(The tag in brackets indicates to which Evaluation Question/s the interview question belongs)

1. (E1) What about the Reducing the burden of TB/LHLI program has made you most satisfied?

2. (E1) How have the partner organisations contributed to the national TB response in their countries? To what extent have they become key stakeholders to the national TB response? (PROBE in what way…?)

3. (E2) How have the partner organisations evolved since their founding, and over the last five years?

4. (E5, E6, E7, E8) What key initiatives have the partner organisations undertaken to enhance Tuberculosis (TB) prevention and care at the local level? What impact have these initiatives had on community awareness, early detection, and access to treatment?

5. (E3) What significant changes are there in the partner organisations as a result of the LHLI program? Have there been any unintended changes – positive or negative?

6. (E4) What significant changes are there in the health systems in the program countries as a result of the LHLI program? Have there been any unintended changes – positive or negative?

7. (E9, E10, E11) How has the partner organisations' TB work helped strengthen the broader health system in the four countries? Can you share examples? (PROBE: access to primary care services? Increased demand for primary health services? Community outreach/information work/anti-stigma work/advocacy? Reduced costs for people? Address human resource shortages? Capacity building?)

8. (S1) Are you aware of any opportunities or barriers that exist for volunteers to engage in long term health service delivery?

9. (S1) Do you see any potential for increasing the scope of services for the partner organisations?

10. (R1) What are the key health service gaps, in tuberculosis prevention and care, that the partner organisations are addressing? Can you provide examples of specific services or initiatives that would not be available if the partners were not involved?

11. (R2) Which barriers exist for specific populations to access health services without the involvement of the partner organisations in the four countries? (PROBE: Who are these

people? How do the barriers wok? What does the partner organization do to overcome the barriers) Please provide examples

12. (C1, C2) How do the partner organisations work to ensure inclusivity and gender sensitivity in its work? Are there areas for improvement in human rights and gender approaches?

13. (Rec) What recommendations do you have for improving the overall program for the future?

2. Partner organisations

Virtual interview with In But Free and Health Development Program between February 3rd and February 7th

Interview with MKUTA and Paradiso in Dar es Salaam and Lilongwe on February 10th

(The tag in brackets indicates to which Evaluation Question/s the interview question belongs)

1. (E1) What about the Reducing the burden of TB/LHLI program has made you most satisfied?

2. (E1) How has your organisation contributed to the national TB response? To what extent has your organisation become a key stakeholder to the national TB response? (PROBE in what way…?)

3. (E2) How has your organisation evolved since its founding, and over the last five years?

4. (E5, E6, E7, E8) What key initiatives has your organisation undertaken to enhance Tuberculosis (TB) prevention and care at the local level? What impact have these initiatives had on community awareness, early detection, and access to treatment?

5. (E3) What significant changes are there within your own organisations as a result of the LHLI program? Have there been any unintended changes – positive or negative?

6. (E4) What significant changes have occurred in the health systems as a result of the LHLI program? Have there been any unintended changes – positive or negative?

7. (E9, E10, E11) How has your organisation's TB work helped strengthen the broader health system? Can you share examples? (PROBE: access to primary care services? Increased demand for primary health services? Community outreach/information work/anti-stigma work/advocacy? Reduced costs for people? Address human resource shortages? Capacity building?)

8. (S1) Are there opportunities and barriers that exist for volunteers to engage in long term health service delivery?

9. (S1) Do you see any potential for increasing the scope of services of your organisation?

10. (R1) What are the key health service gaps, in tuberculosis prevention and care, that your organization is addressing? Can you provide examples of specific services or initiatives that would not be available if CSOs were not involved?

11. (R2) Which barriers exist for specific populations to access health services without the involvement of your organization? (PROBE: Who are these people? How do the barriers wok? What does your organization do to overcome the barriers) Please provide examples

12. (C1, C2) How does your organisation ensure inclusivity and gender sensitivity in its work? Are there areas for improvement in human rights and gender approaches?

13. (Rec) What recommendations do you have for improving your organisation´s work or the overall program for the future? (with the current cut-back from US, and possible cut-back in Norway from 2027 – how do you foresee to prioritize in the future?)

3. National TB Program stakeholders in Tanzania and Malawi

Physical interviews in Dar es Salaam and Lilongwe on February 10th

(The tag in brackets indicates to which Evaluation Question/s the interview question belongs)

1. (E1) What is the most remarkable about the TB work undertaken by MKUTA/Paradiso?

2. (E1) How does MKUTA/Paradiso contribute towards the national TB response? To what extent would you say that MKUTA/Paradiso is a key stakeholder to the national TB response? (PROBE in what way…?)

3. (E5, E6, E7, E8) Are you aware of any impacts of the TB work of the MKUTA/Paradiso Clubs at community level? (PROBE: community awareness, early detection, and access to treatment?)

4. (E4) Are there any changes at the health systems level as a result of the TB work of MKUTA/Paradiso?

5. (E9, E10, E11) To what extent has How has MKUTA/Paradiso contributed to strengthen the broader health system? Can you share examples? (PROBE: access to primary care services? Increased demand for primary health services? Community outreach/information work/anti-stigma work/advocacy? Reduced costs for people? Address human resource shortages? Capacity building?)

6. (S1) Are you aware of existing opportunities and barriers for volunteers to engage in long term health service delivery?

7. (S1) Do you think there is potential for increasing the scope of services of MKUTA/Paradiso?

8. (R1) What are the key health service gaps, in tuberculosis prevention and care, that MKUTA/Paradiso is addressing? Are you aware if there are specific services or initiatives that would not be available if MKUTA/Paradiso was not involved?

9. (R2) Which barriers exist for specific populations to access health services without the involvement of MKUTA/Paradiso? (PROBE: Who are these people? How do the barriers wok? What are the barriers overcome?) Please provide examples

10. (C1, C2) Are you aware if MKUTA/Paradiso ensures inclusivity and gender sensitivity in its work? Are you aware if there are areas for improvement in human rights and gender approaches?

11. (Rec) What recommendations do you have for improving MKUTA/Paradiso's work in the future?

4. Community TB volunteers, field visits Tanzania and Malawi

Physical interviews February 12 and 13th

Interview guides may be amended by evaluation team during Preparatory workshops on February 11th

(The tag in brackets indicates to which Evaluation Question/s the interview question belongs)

1. (E1) What about being a volunteer has made you most proud?

2. (E5) What are the changes you have seen in your community as a result of the work the TB Club is doing? (PROBE: Awareness, treatment, access to care, reduced costs)

3. (E3) Has the work led to changes within the Club? Please explain how.

4. (E4) Has the work led to changes within the local health system? Please explain how.

5. (E6, E7, E8) How has your organisation's TB work helped the local health system? Can you share examples? (PROBE: Increased access to primary care services? Increased demand for primary health services? Community outreach/information work/anti-stigma work/advocacy? Reduced costs for people? Address human resource shortages? Capacity building?)

6. (S1) What are the opportunities for volunteers to work with the health system? What are the barriers for volunteers to work with the health system?

7. (S1) Do you see any potential for increasing the scope of services of your organisation?

8. (R1) What are the gaps in the existing tuberculosis prevention and care that your Club is addressing? Can you provide examples of specific services or initiatives that would not be available if your Club was not involved?

9. (R2) Which barriers exist for specific populations to access health services without the involvement of your Club? (PROBE: Who are these people? How do the barriers wok? What does your organization do to overcome the barriers) Please provide examples

10. (C1, C2) How does your Club work to include all types of people? Could more be done to be even more inclusive, and make sure there is no discrimination against anyone?

11. (Rec) What recommendations do you have for the good work to become even better?

5. Community citizens, field visits Tanzania and Malawi

Physical interviews February 12 and 13th

Interview guide may be amended by evaluation team during Preparatory workshops on February 11th

(The tag in brackets indicates to which Evaluation Question/s the interview question belongs)

1. (E5) What is your experience with the TB Club?

2. (E5) What would you say are the most important changes in the community that have come as a result of the work of the TB Club?

3. (E1) How do you as citizens support the TB Club?

4. (E6) What would have been the situation if the TB Club had not existed?

5. (R2) Do you know if there are any barriers for specific populations to access health services without the involvement of the TB Club? (PROBE: Who are these people? How do the barriers work? What does the TB Club do to overcome the barriers) Please provide examples

6. (C1, C2) Does the TB Club work with all kinds of people (gender, age, ethnicity, sickness, social status…) Can you think of more they could do to ensure that all people are equally included in their work?

7. (Rec) Do you have any recommendations for the TB Club for the future?

6. Community leadership, field visits Tanzania and Malawi

Physical interviews February 12 and 13th

Interview guide may be amended by evaluation team during Preparatory workshops on February 11th

(The tag in brackets indicates to which Evaluation Question/s the interview question belongs)

1. (E1) What are the most significant changes that you have noticed in the community as a result of the work of the local TB Club?

2. (E5, E6, E7, E8) How would you say that the TB Club is strengthening TB prevention at community level?

3. (S1) Do you know any opportunities for the TB Club to work more with the health system? Are you aware if there are any barriers for the volunteers to work with the health system

4. (R1) What do you think are the most important health system gaps in the tuberculosis prevention and care that the TB Clubs are addressing? What do you think would have been the situation if the TB Club had not been present? (PROBE: awareness, access to services, access to treatment)

5. (R2) Which barriers exist for specific populations to access health services without the involvement of the TB Club? (PROBE: Who are these people? How do the barriers wok? What does your organization do to overcome the barriers) Please provide examples

6. (C1, C2) How does the TB Club work to include all kinds of people and ensure there is no discrimination?

7. (R1) What opportunities can you provide for the TB Club in your area?

8. (Rec) Do you have any recommendations for further improving the work of the TB Club?

7. Local health services, field visits Tanzania and Malawi

Physical interviews February 12 and 13th

Interview guide may be amended by evaluation team during Preparatory workshops on February 11th

(The tag in brackets indicates to which Evaluation Question/s the interview question belongs

1. (E1) What are the most positive aspects with the work of the TB Club?

2. (E5, E6, E7, E8) What are the most significant changes in the TB prevention and care at community level due to the work of the TB Club?

3. (E5) How will you say that the TB Club contributes to strengthening TB prevention and care at local level? (PROBE: access to health services, outreach, treatment, address human resource shortages, service delivery, awareness raising, capacity building)

4. (E4) Are there any changes at the local health system as a result of the work of the TB Club?

5. (E9, E10, E11) To what extent would you say that the work of the TB Club is contributing to strengthening the broader health system? Can you share examples? (PROBE: access to primary care services? Increased demand for primary health services? Community outreach/information work/anti-stigma work/advocacy? Reduced costs for people? Address human resource shortages? Capacity building?

6. (S1) Are you aware of existing opportunities and barriers for volunteers to engage in long term health service delivery?

7. (S1) Do you think there is potential for increasing the scope of services of the TB Clubs?

8. (R1) What are the key health service gaps, in tuberculosis prevention and care, that the TB Clubs are addressing? Are you aware if there are specific services or initiatives that would not be available if the TB Clubs were not involved?

9. (R2) Which barriers exist for specific populations to access health services without the involvement of the TB Clubs? (PROBE: Who are these people? How do the barriers wok? What are the barriers overcome?) Please provide examples

10. (C1, C2) Are you aware how the TB Club works for inclusion of all and anti-discrimination? Are you aware if more work could be done to include all kinds of people?

11. (Rec) Do you have any recommendations you would like to give to the TB Club?