BLUE CROSS LESOTHO: THABA-BOSIU CENTRE

The Blue Cross Advocacy and Outpatient Treatment (BCAOT) Project 2015-2017

FINAL REPORT

Prepared By

Ms. 'Makuena Leboela-Kolobe

Mr. Maema Ramaema

Ms. Charlotte Moeketsi

Ms. Kananelo Makoetlane

December 2017

Document Approval

This is to certify that the Blue Cross Lesotho: Thaba-Bosiu Centre and 'Makuena Leboela-Kolobe accept this Evaluation Report.

Blue Cross: Thaba-Bosiu Centre

Signature _____ Date 13/02/2018

'Makuena Leboela-Kolobe

Signature _____ Date 13/02/2018

TABLE OF CONTENTS

ACKNOWLEDGMENTS

I would like to thank Blue Cross Norway and Blue Cross Lesotho: Thaba-Bosiu Centre for the opportunity afforded to me and my team to undertake this evaluation exercise. In particular the trust and support of Ms. Torill Pallesen, Ms. Eva Frydenborg and Messrs. Mokhuts'oane and Letsatsi,; who helped facilitate a smooth process of the evaluation. My gratitude also to the project team; the advocacy officers and mobile teams for all their coordination and guidance through supply of relevant information to track respondents.

Great appreciation goes to the Blue Cross youth, who dedicated their time to help collect quality data during fieldwork. And special thanks to all the other stakeholders; local chiefs and councillors, local policing forums and the police force, inmates, current patients, ex- patients and their families, who sacrificed their time to participate in the evaluation. The undeniable support of the SAAPA representative in Lesotho – Ms. Mphonyane Mofokeng – who provided invaluable information regarding the policy and the BCAOT project.

Greatest gratitude to my dedicated team – Mr. Maema Ramaema, Ms. Charlotte Moeketsi and Ms. Kananelo Makoetlane, for putting up with my endless demands. This evaluation report is evidence to their commendable expertise, their hunger for knowledge and dedication on issues of concern in Lesotho.

And to all who had a helping hand in seeing through the evaluation report as a success, words cannot express my gratitude. I can only hope the report presents the interpretation and analysis of your opinions and expectations with great deliverance and quality.

Ms. 'Makuena Leboela-Kolobe
Lead Consultant

ABBREVIATIONS AND ACRONYMS

ADAL	Anti-Drug Association Lesotho
APAL	Alcohol Policy Alliance Lesotho
BCAOT	Blue Cross Advocacy and Outpatient Treatment
BCL: TBC	Blue Cross Lesotho: Thaba-Bosiu Centre
BCN	Blue Cross Norway
CSO	Civil Society Organization
DALY	Disability Adjusted Life Years
GAPA	Global Alcohol Policy Alliance
LCS	Lesotho Correctional Services
MOH	Ministry of Health
MOU	Memorandum of Understanding
NGO	Non-Governmental Organization
NORAD	Norwegian Agency for Development Corporation
SAAPA	Southern African Alcohol Policy Alliance
SADC	Southern African Development Corporation
TOR	Terms of Reference
VHCW	Village Health Care Worker
WAAPA	Western African Alcohol Policy Alliance
WHO	World Health Organization

EXECUTIVE SUMMARY

This is an independent evaluation of the BCAOT Project covering 2015 - 2017. The purpose of this evaluation is to assess the achievements, the factors that facilitated or hindered achievements, and to compile lessons learned to inform future similar projects. The Project commenced in 2015 and it was fully funded by BCN through mobilizing resources from NORAD. The overall goal of this project is to prevent the harmful use of alcohol through alcohol policy and outpatient treatment: (a) to ensure Lesotho has an alcohol policy that is in line with WHO's recommendations to protect people from harmful use of alcohol, and are acting to implement the policy, (b) quality treatment for alcohol and substance abuse is available for, and used, by people in the rural areas of Lesotho.

The evaluation was undertaken by an independent consultant hired by BCL: TBC, with TOR to guide the process for four-to-seven weeks. The evaluation employed a combination of qualitative and quantitative methods to answer the questions related to the progress achieved, factors in project performance and relevance of the BCAOT Project. Data and information for the evaluation were derived from both secondary and primary sources. The evaluation team conducted a scan of grey and academic literature, manuals, project materials, documents and reports; including the budget and work plans, audit reports and other relevant documents. These documents formed basis for defining the subsequent thematic scope of the evaluation and critical areas of interest.

The review of Data and information from primary sources was obtained from key informants of both the Advocacy and Treatment teams, respectively comprising of the Advocacy officers, community policing forums, chiefs, members of the police, youth, members of BCL, CSOs, selected community councilors, mobile teams (Social Workers and Counselors), VHCWs, Self-Help Groups made of ex-clients, inmates at correctional services, family members of clients and current clients. Following field work, the completed questionnaires were collated, and data extracted and analyzed using relevant statistical techniques.

The greatest challenges faced by the review process were the unavailable baseline survey, the unresponsiveness of some respondents, tracing and tracking down self-help groups within limited time and unavailable VHCWs in some clinics. Nevertheless, through logistical arrangements organized by the project team, the evaluation team ensured work was carried out as defined in the TOR, and without compromising the quality and integrity of the report.

Findings and Conclusions

The analysis of the results identified challenges and strategies for future interventions. The findings determined the impact of the project on intended groups. Furthermore, A core set of criteria were applied in evaluating the project.

In evaluating the impact of the project on intended groups, the review of findings was as follows:

A staggering number of community leaders, local authorities and the youth know the content of the evidence-based alcohol policy; can document its violation and react upon it. And they have employed different strategies to advocate and implement relevant productive activities in their communities. As advocates of the policy, stakeholders complain though that due to lack of jobs and the unstable economy, they still face

reluctance from members of their communities who drink alcohol and use drugs as a means of stress-relief. Further reluctance, as claimed, comes from local bar owners who feel threatened by the advocacy of the policy. However, with stated challenges, respondents still maintain that the BCAOT project is very important in the lives of their communities, and they, therefore, wish for it to continue and spread throughout other communities.

In terms of outpatient treatment, the evaluation concludes that quality treatment for alcohol and substance abuse is available for, and used by people in the four identified districts of Lesotho. Inmates take a larger portion of those who have quit. Although this is highly commendable, the lack of relevant programs to integrate them into communities when released, and limited follow-up thereof, have contributed to non-realization of some results. Since none of the inmates have reported back after release from correctional services, the project's 50% target of inmates reporting back six months after release was never realized.

VHCWs play a vital role in motivating and encouraging potential clients to seek help. Majority claim to have basic knowledge of substance abuse and motivational counseling. Although they work with neither stipends nor manuals from the project, they highly regard the project and consider it to have a huge impact in people's lives. With all achievements and challenges by the project, the evaluation concludes that the harmful use of alcohol is reduced and treatment for substance abuse is available for people in Lesotho. Thus, there is a huge impact of the project on intended groups.

For overall evaluation of the project, the following criteria were identified:

Relevance

To determine the relevance of the project, the evaluation addressed two key issues; the extent to which BCAOT objectives were consistent with stakeholders' requirements and with country needs and global priorities, and the extent to which the outcomes addressed key issues, their underlying causes, and challenges. The evaluation concludes, therefore, that the project was in line with country needs. However, in terms of addressing the requirements of relevant stakeholders, the evaluation found gaps in the project's implementation.

With the treatment requirements of all patients, the BCAOT project was spot-on. And in terms of outcomes, the number of people trained and empowered by the project, and the impact on their lives, are clear indications that outcomes addressed key issues. However, due to inconsistencies observed with other stakeholders' requirements, and lack of baseline study thereof, it is difficult to conclude the objectives were in line with their requirements and aspirations.

However, BCN argued that as per donor's requirements, they view a baseline approach as establishing facts regarding starting point of indicators. Although, there are weaknesses as in the baseline indicators, the project team is adamant that a baseline survey was never required as part of the project, for several reasons. For instance, their argument stems from the fact that they could not measure the success of therapy by comparing the answers of clients in a baseline to what was delivered, but rather by the impact of therapy after treatment.

Design

It was clear through findings that the unavailable baseline survey led to limited indicators for the project to work on, and contributed highly to the project's role in not achieving some of the results. Furthermore, the project document did not have specific time bound and cost-based activities. The evaluation concludes, therefore, that the design had trivial bottlenecks that potentially hampered the project progress to a certain extent.

Effectiveness

Of all the issues addressed by the project, advocacy and awareness on the alcohol policy draft seemed to take top priority. The counselling sessions for alcohol and substance addiction were very effective and a great success thereof. Furthermore, networking with other civil society organizations played a huge role, although there is need to include NGOs in districts as well.

In conclusion, there were several factors, though, that contributed to the non-realization of some outcomes. Specifically, from the advocacy side, these were; the alcohol policy that has not yet been enacted, government's role in delaying the process, limited resources, other stakeholders' reluctance to take part in activities and to support the project, and limited academic research on the state of alcohol consumption and consequences in Lesotho. From the treatment side, factors included; the self-help concept that failed to take off, the delay in recruitment process, regular change of mobile teams, unemployment and lack of livelihood means, lack of treatment manuals and reintegration programs for inmates, relationships that were not nurtured and lack of incentives for VHCWs.

Efficiency

It was a challenge to identify if outputs were achieved with the lowest possible use of resources; funds, expertise, time and administrative costs. There were no financial reports, but rather statements, and this did not show expenditure on activities against the project income.

Impact, Coherence, Sustainability and Community Value Added

The project had a positive impact on all those who received counselling and trainings. The factors, though, that unintentionally hampered the smooth progress of the project and the prospect of sustainability were the limited follow-ups in treatment and trainings, the self-help concept that never took off, lack of training manuals for VHCWs, and the government's and SAAPA's partial commitment to seeing through the enactment of the policy. However, the evaluation found that some activities undertaken by the project had a potential to help the country achieve its policy objectives without internal contradiction or without contradiction with other countries' policies. And concludes, thereof, that the country's policy draft is coherent with other countries' policies and interventions

BCN – Value Added

BCN offered three one-week trainings on therapy to the mobile team. A BCN expert on addiction and family therapy was sent to Lesotho on three occasions to offer a week's trainings. The expert specifically trained staff from TBC and the mobile teams in

family therapy, outpatient treatment, prevention of drop-outs and other topics of relevance. The contribution was crucial and had a huge impact on the mobile team's performance. This explains why from the treatment side, the mobile team stated family therapy as the project's strength.

BCN further provided M&E system and anti- corruption trainings, and requested development of an anti-corruption policy from TBC. And all these efforts increased staff's capacity in these fields. The organization undertook monitoring visits to the project sites at least twice a year. These visits were important because they offered BCN and TBC an opportunity to discuss all aspects of the project during the project cycled.

Lessons Learnt

The evaluation identified valuable lessons learned, including both positive and negative lessons.

Project Development and Management

- There is no baseline survey to inform the design of the project accordingly. BCN took steps to ensure continuation of the most successful parts of the previous projects, partly merging the experiences into one comprehensive project. This limitation contributed immensely to non-realization of some results. A baseline survey would have put into consideration the requirements and aspirations of all stakeholders.
- Reporting tools for the Project were not sufficient. There were narrative reports of activities undertaken without financial reports. Overall, project monitoring tools/reports need to be aligned with the main project outcomes to help trace progress accordingly.
- Limited resources - some of the resources needed to facilitate the smooth running of the project, such as vehicles and office space, were acquired very late in the project cycle. And the recruitment of the project team, especially the project Manager, happened very late in the year. The delays hampered progress, especially where mobility was restrained and there was need for leadership from the manager.

Prevention and Advocacy

- The Lesotho Alcohol Policy draft is still at the phase at which it started in 2015; after ensuring it is in line with WHO's recommendations. This is mainly due to regular change in governments and respective officials. The delay and unresponsiveness of the government have affected SAAPA's commitment and determination of seeing the policy draft enacted in parliament.
- The advocacy officers do not have any vehicles to facilitate their work. Therefore, this implies that coverage of their advocacy has limitations. Moreover, although certificates were acknowledged and appreciated, they seemed not sufficient to convince stakeholders to keep volunteering.

Treatment and Rehabilitation

- Family therapy has been identified as one of the greatest strengths of the treatment section of the project, since it plays a vital role for complete rehabilitation. However, due to lack of relevant qualifications, the mobile team could not provide therapy to affected children. This implies that the children were directly neglected by the project and could not get needed therapy.
- The concept of self-help never kicked off since initial training sessions. There were no follow-ups and there was limited effort to sustain them.
- Out of the identified 12 clinics by the project, only 10 were suitable to facilitate the VHCWs concept. When this came to the fore during the project cycle, no replacement clinics were identified. The project team left the situation as was, and this affected the outcome as per VHCWs' requisite.
- It was expected that the project would have manuals to be used by VHCWs. However, these manuals were neither developed nor translated, and the omission was on top of VHCWs' grievances.
- Inmates in some correctional facilities, Maseru and Berea, had not been receiving therapy for months due to unstable relationships between the project team and LCS workers.

Recommendations

The recommendations are derived from the conclusions and lessons learned; followed by a discussion of their anticipated implications. The section consists of a list of proposals for action to be taken (short- and long-term) for follow-up, and suggestions for implementation.

Project Development and Management

In preparation for the next project, a baseline survey should be undertaken prior to project design to set base and to inform the design accordingly. In case of limited resources, at least vital phases such as stakeholders' participation to understand perceptions and expectations should be considered. This will, further, help identify other stakeholders that should have been consulted by the project, such as nurses and businessmen. And with consultation and participation, most stakeholders will feel they have ownership of the project, which will reflect in their commitment and determination.

Reporting tools for the project need to be sufficient and efficient. It must be made easy to track the progress of outputs implementation. Overall, project monitoring tools/reports should be aligned with the main project outcomes to help trace progress accordingly.

There should be an implementation of an M&E system for an ongoing tracking of project results. The M&E plan should include training provisions for staff on management of data as well as proper reporting of results. This will also be linked with the project undertaking a risk assessment process and subjecting their objectives and activities to a risk matrix development process that assesses the likelihood of a risk, the possible impact and mitigation strategy based on the results of risk profiling.

The recruitment of mobile teams should be revised. Having two individuals work in two districts stretches their limitations. At least there should be one mobile team per district. Although the team's work is complementary, there should be some independence that would allow one to work without limitations in the absence of the other.

The livelihood concept seems to be a challenge. This part of the project would be an answer to most challenges realized due to limited livelihood means, such as the self-help concept and inmates follow-up sessions. However, it was one of the concepts that was not viable and unsustainable in the previous projects, since it had high recourse inputs. If by any chance BCN cannot include the concept due to highlighted reasons, then the BCAOT team needs to work adeptly in partnering with local organizations in respective districts. The project should identify with other NGOs' and government's initiatives to see progress in their advocacy and work in general. Moreover, the project could consider replicating some of the approaches adopted by other African countries with similar cultural and economic values.

Prevention and Advocacy

Challenges faced through government's role call for an introduction of a top-down approach. For a more rapid response, the project needs to 'shake the tree from the top' and focus on educating and empowering the government to ensure officials understand the economic impact of having an alcohol legislation that is regionally and globally aligned.

A thorough analysis of the existing alcohol policy draft revealed the need for a revision. There are some sections in the draft that are left incomplete, with a note that says, 'to be revisited'. SAAPA should work together with advocacy officers to review the sections with rigor and amend as required; to have a thorough complete policy draft.

The draft, further, needs to involve groups such as church leaders, especially on issues surrounding Holy Communion. Church leaders can also encourage congregations, especially the youth, to join the blue cross movement, which is slowly fading due to low membership. And it needs to touch on the issue of local brews; which constitute majority of outlets in rural areas. It should also be specific on penalties and fees it proposes other statutes such as the Road Traffic Act and Liquor Licensing Act to adopt.

Treatment and Rehabilitation

From the outpatient treatment side, the team needs to learn to address grievances, risks and challenges immediately as they occur during the project cycle.

The mobile team needs to identify with government's current and proposed initiatives when dealing with clinics and correctional services. This will assist in developing coherent manuals and reintegration programs for VHCWs and released inmates respectively.

There is need to engage more qualified counsellors and social workers to include therapy for children. Since family therapy has been identified as one of the greatest strengths, it is vital to strengthen it in terms of expertise and capacity. Overall, despite a few challenges identified by the evaluation, the project has been a huge success in terms of the impact on intended groups.

1. INTRODUCTION

1.1. Background

The Thaba-Bosiu treatment and prevention centre was established in 1988 by the Blue Cross Lesotho (BCL), with assistance from Blue Cross Norway (BCN). As a global leader in the area of treatment, rehabilitation and prevention of alcohol and substance abuse, BCN partners with various organisations in developing countries. The Blue Cross Lesotho: Thaba-Bosiu Centre (BCL: TBC), as one of the partners, works towards prevention and in-patient treatment for people suffering from addiction to substances in the country.

Due to lack of neither public nor private therapy sessions for addicted people and their close ones in the early 90s, an establishment of such a nature was a dire necessity. Hence through BCN technical and financial support, BCL: TBC was empowered to introduce an alcohol and rehabilitation centre in September, 1991. Although BCL currently has full ownership of the Centre, it is however, fully financed through the Ministry of Health (MoH).

The main strength of the centre lies in the unparalled quality of its treatment services nationwide, and its unique therapy approach which incorporates the physical, psychological, social and spiritual dimensions. The services are offered through a three-month in-patient assessment. As such, through its Prevention and Treatment departments, the Centre has to date helped scores of people rediscover a life free of addiction.

Prevention and Advocacy

Through its work, BCN has evidently identified that by combining professional treatment services with prevention work and advocacy, partner organisations gain valuable experience and a strong voice in national alcohol policy making processes.

The Lesotho Alcohol Policy Draft

The national Alcohol Policy was developed in 2007. However, at the time, the policy was found not to be in line with recommendations put forward by the World Health Organization (WHO), and thus was never implemented. The policy neither embraced vital elements of public health nor included more recent outcomes and recommendations made by the WHO for effective alcohol policies. Therefore, since 2007, work has been ongoing to revise it.

The Lesotho MoH, relevant civil society organizations and other stakeholders have worked tirelessly to redesign a draft policy as a framework to provide a comprehensive guide for priority setting. Specifically, the framework offers guide in programme development and implementation of policies aimed at reducing the harmful use of alcohol through inter-sectoral coordination and the involvement of the community. And in view of this, BCN has increased efforts to contribute to the growth of civil society networks working on alcohol policy in Lesotho, and throughout the Southern African region. As such, it actively supports the networks/alliances to achieve national evidence-based alcohol policies in their countries. Two such networks are the Alcohol Policy Alliance Lesotho (APAL) and the Southern African Alcohol Policy Alliance (SAAPA).

Alcohol Policy Alliances in Africa

The national APAL was formed through an alliance of civil society organizations in 2013. The network performs its role as a watchdog for and supporter of evidence-based alcohol policies in the country. APAL is a subset organization of SAAPA; a network of Non-Governmental Organizations (NGOs) formed in November 2012 to advocate for evidence-based alcohol policies in Sub-Saharan African countries.

As an affiliation to the Global Alcohol Policy Alliance (GAPA), SAAPA is mainly a platform for southern African countries to collaborate on alcohol-related issues and to exchange experiences from policy to prevention work. Members further share research and strategy on alcohol policy development; respond to local challenges with appropriate policy interventions and identify common policies that can be lobbied for in all countries throughout the region.

With replication interests from other regions, 2017 saw another regional alcohol policy alliance become a reality; the Western African Alcohol Policy Alliance (WAAPA). The new alliance has members from six countries; Gambia, Sierra Leone, Liberia, Nigeria, Senegal and Ghana. In line with other Alliances, it is a coalition of civil society organizations and professionals with the goal of advocating, developing, implementing, enforcing and evaluating scientific based alcohol policies, monitoring and sharing information on alcohol issues among members, sub-regional collaborators and international partners.

Prevention and Treatment

From the treatment side of TBC; the aim of TBC still centers around curbing the harmful use of alcohol and drugs and offering rehabilitation. Although recently the Centre realized an exponential growth in clients willing to go for rehabilitation, the lack of infrastructure and human resource poses a great challenge. To address this problem, in previous years the Centre embarked on introducing and implementing various projects; the most recent one being the *Decentralization* project, which operated from 2010 to 2014.

TBC Decentralization Project

The project covered the northern region of the country, and was physically located at the Butha-Buthe district. The end of project evaluation evidently identified that more than 100 persons received therapy through this project. Furthermore, locals were empowered to create viable livelihood projects to replace the popular making of home-brew.

The entities included candle molding, vaseline-making with aloe, as well as poultry farming and tree planting. Youth groups were also initiated, with emphasis on sports, other leisure activities and participation in preventive substance abuse activities. Information and knowledge on substance abuse and possibilities for treatment were brought to local village councils, teachers, preachers, prisons and other relevant groups in the district.

The evaluation further claimed that the project assisted in widely increasing knowledge on the harms caused by alcohol and drugs. The district realised a decrease in alcohol consumption and there was positive feedback from those who received treatment. However, weaknesses were observed in the management structure of the

project; especially in the areas of capturing of data for monitoring purposes, and the need to increase local ownership of the project.

Therefore, partly as a continuation of the Decentralization project, in May 2015, the BCL: TBC signed an agreement with BCN to implement the 'Prevention of harmful use of alcohol through Advocacy for Alcohol Policy and Outpatient Treatment' project. The project is not a full continuation of the previous projects, but it builds on experiences gained and strictly ensures continuation only on the most successful parts.

1.2. The Blue Cross Advocacy and Outpatient Treatment (BCAOT) Project

With financial assistance from The Norwegian Agency for Development Cooperation (Norad), BCN entered into a new partnership with BCL: TBC. The project was introduced in 2015 to bring treatment and prevention to the rural people in four districts of Lesotho; Maseru, Berea, Leribe and Butha-Buthe. It contributed to the adoption and implementation of proven best and most cost efficient strategies to prevent the harmful effects of alcohol, as well as ensuring the availability of high quality treatment for persons suffering under substance abuse.

BCAOT project's main aim is to offer individual treatment, group therapy and family therapy. In cooperation with the prison authorities, inmates with substance abuse problems at the local prison are also offered treatment. The village healthcare workers (VHCW), who are already responsible for handing out tuberculosis medication, prenatal and afterbirth follow up and other basic health services, are offered training on motivational counselling. Through the approach they are likely able to recognize people with substance abuse issues, provide early intervention guidance and motivate them for further treatment.

1.2.1. Main objectives of the project[1]

The main objectives of the project, which translate as respective outcomes are as follows;

- To ensure an effective and evidence-based alcohol policy is passed and implemented in Lesotho
- To put in place cost-effective and easily accessible treatment services for persons suffering from substance addictions in the four districts.

'Prevention of harmful use of alcohol through Advocacy for Alcohol Policy and Outpatient Treatment'

Understanding of the Terms of Reference (TOR)[2]

The report, therefore, sets out the Evaluation team's understanding of the TOR for the evaluation of the BCAOT Project. It also serves to bring clarity to all the involved parties to ensure that the evaluation process and its output conformed to the expected results. The report attempts to create a level playing field to all parties; and to reconcile any differences in the definition of outputs and the deliverables, and jointly review the timeline for the

[1] Check Annexure 1 for a complete framework on results; providing specific outcomes and outputs

[2] Check Annexure 2 with TOR

process (including data collection, collation, analysis and report preparation) in terms of practicality and feasibility.

1.3. Purpose and Scope of the Evaluation

The purpose of the evaluation is to assess the extent to which the stated project's proposed objectives were achieved, and the impact of the implementation on achieving the expected outputs and outcomes of the project, as well as the envisaged sustainability of the interventions.

The evaluation assessed the implementation of the project's activities from the inception period in 2015 to the current period, with a coverage of the said four districts. The key stakeholders consulted were categorized into two departments; the Prevention and Advocacy team, and the Treatment and Rehabilitation team. The Advocacy team consists of the Advocacy officers, community policing forums, chiefs, members of the police, youth, members of Blue Cross Lesotho, Civil Society Organizations (CSO) and selected community councilors. The Treatment team, on the other hand, consists of the mobile teams (social workers and Counsellors), inmates, current patients, ex-clients and their family members.

2. EVALUATION APPROACH AND METHODOLOGY

2.1. Approach

Considering the scope of the evaluation, the approach taken by the evaluation team was characterised by: an appreciative enquiry approach, a theory of change lens to establish where the core contribution of the projects lay, and drawing on monitoring data. Guided by a review of best practice, the evaluation further established if/how the engagement was set to contribute to wider learning.

Evaluation Questions

The evaluation was guided by three overarching questions and ten specific ones below.

Overarching Evaluation Questions

1. Considering all activities of the project, what impact was achieved and were there any changes that were incidental (externalities) from project activities?

2. Assess the project efficiency in the use of resources allotted and project effectiveness in terms of implementation of activities (consistency, commitment, scheduling and implementing with specified quality and attention as well as monitoring project implementation and reporting effectively).

3. Based on feedback from the impact assessment as well as a review of modalities of implementation, make recommendations for future projects with focus on lessons learnt, sustainability, leveraged future

support from Blue Cross Norway, and immediate possible response mechanisms.

Specific Questions

- To what degree has the project achieved goals? Are there unplanned results?
- What kind of impact has the project had on the communities?
- Are there control measures introduced in the communities as a result of advocacy training to curb the harmful use of alcohol in accordance with the Alcohol Policy draft and the Liquor Licensing Act of 1998?
- What kind of impact has the treatment had on drinkers and their families, if any?
- What kind of impact has the motivational interviews had, if any?
- How effective is the implementation of the project, in terms of use of resources, use of funds and how it is organized?
- Can the project be organized or implemented differently and achieve similar results? What are the strongest points that should be prioritized for the future?
- What recommendations can be given for the next project period, 2018-2020?
- How can the project be advised to secure future sustainability?
- What strategies can be recommended to have tangible impact at both community and national level?
- What added-value has the Blue Cross Norway contributed besides funding, if any?

Evaluation Criteria

A core set of criteria and sub-questions was applied in assessing the results. The evaluation criteria included: *relevance, design, project impact, effectiveness, efficiency, sustainability, coherence and community value-added.* Each specific objective and key question required a specific methodology consisting of: evaluation objectives/overarching question, specific evaluation questions, performance indicators, data source, evaluation design, sampling plan, data collection instruments, and data analysis plan.

2.2. Data Collection Methods

The evaluation employed a combination of qualitative and quantitative methods to assess the project's performance and solicit lessons learned. Data and information for the evaluation were derived from both secondary and primary sources. The team conducted a scan of grey and academic literature, manuals, project materials, documents and reports; including the budget and work plans, audit reports and other relevant documents. These documents formed the basis for defining the subsequent thematic scope of the evaluation and critical areas of interest.

The review of Data and information from primary sources was obtained from key informants of both the Advocacy and Treatment teams, respectively comprising of the Advocacy officers, community policing forums, chiefs, members of the police, youth, members of Blue Cross Lesotho, Civil Society Organizations, selected community councilors, mobile teams (social workers and Counselors), VHCWs, inmates at correctional services, family members of ex-clients and current clients.

The evaluation carried out semi-structured in-depth key-informant interviews, focus group discussions, interview guides and participant observation. In-depth

interviews were optimal for collecting data on individuals' perspectives and experiences. The Focus groups were effective in eliciting data and in generating broad overviews/perceptions on the contribution of the project. The Interview guides were developed in a semi-structured style with open-ended questions to allow the evaluation team to follow-up where necessary with additional questions. Participant observation was also appropriate for collecting data on naturally occurring behaviours in their usual contexts.

Furthermore, with the help of Advocacy officers in respective districts, the evaluation team was able to identify ten BCL: TBC youths in each district and train them as fieldworkers. The youth underwent training on the following aspects of the assignment: objectives; identification of prospective respondents; assisting the team in obtaining written and informed consent from respondents, distribution, completion and collection of questionnaires; language translation (where necessary) and assistance to illiterate respondents during the completion of the questionnaires. This initiative helped address the high unemployment rate in Lesotho and further provided the trainees with relevant research skills.

2.3. Sampling Strategy: Design and Method

The evaluation used 'purposeful sampling approach' that led to a selection of a maximum variation framework. Selecting participants purposefully implied choosing those who could contribute towards the evaluation's purpose. Furthermore, purposive sampling of participants with wide-reaching information provided deeper understanding of the projects' challenges and successes.

In each district, semi-structured interviews were carried out with the project team, two VHCWs in each of the three clinics, at least two representatives of various community leaders (chiefs, Councilors and community watchdogs), police officers, current clients/patients, and ex-patients' family representatives. The SAAPA representative was, however, represented by one individual.

The evaluation hoped to assemble three focus group discussions in each district; specifically, when dealing with the youth, self-help groups and inmates at the correctional services. It was assumed these groups would provide the opportunity to investigate in detail the impact and effectiveness of the project implementation. And data from all conducted interviews was coupled with direct observations made by the evaluation team.

2.4. Data Analysis

Descriptive statistical analysis by means of frequency analysis was conducted after all completed questionnaires were captured into relevant data analysis software (NVivo). Furthermore, findings from these qualitative methods were triangulated based on the previous Decentralization project and its evaluation, policy reports and other relevant documents where available.

Quality assurance

The evaluation team managed to work for quality in the following ways:

- Held regular review meetings to discuss methodological issues and to agree on common approaches.
- Work samples were reviewed to identify inconsistencies.

- Draft reports were read by the BCL: TBC and the BCAOT project management for quality assurance.
- Records of all interviews and meetings were taken.

Together with the structured report documentation and use of databases to store data, these enabled verifications of source notes and material.

Ethical Considerations

Since human participants were involved, local ethics application in Lesotho was made to the Lesotho ethics Committee. And the following core principles of ethics were considered:

- Respect for persons – requires a commitment to ensuring the autonomy of participants, and, where autonomy may be diminished, to protect people from exploitation of their vulnerability. The dignity of all participants must be respected. Adherence to this principle ensures that people will not be used simply to achieve research objectives.
- Beneficence - requires a commitment to minimizing the risks associated with research, including psychological and social risks, and maximizing the benefits that accrue to research participants. Researchers must articulate specific ways this will be achieved.
- Justice - requires a commitment to ensuring a fair distribution of the risks and benefits resulting from research. Those who take on the burdens of research participation should share in the benefits of the knowledge gained. Or, to put it another way, the people who are expected to benefit from the knowledge should be the ones who are asked to participate.

3. TEAM COMPOSITION, WORK PLAN AND ORGANIZATION

The evaluation team comprised of a *Lead Consultant*, an *M&E Specialist*, two *Data Analysts* and *ten BCL: TBC youth* per district. The task was completed in 30 days. And Table 1 presents details of the proposed work plan that guided the evaluation process.

Table 1. Work Plan

Activity	No. of Days	Responsible Person	Timeframe in Weeks			
			1	2	3	4
Initial contact with key personnel at the BCL: TBC and the project unit	1	Lead Consultant				
Desk review, consultative meetings and inception report	5	Lead Consultant				
Various Questionnaire designs	2	Lead Consultant				
Data Collection	7	Evaluation Team and youth				

Data processing and Analysis	5	Data Analysts and M&E Specialist				
Drafting Report	5	Lead Consultant and the M&E Specialist				
Final report writing incorporating comments (final report)	5	Lead Consultant				
Total consulting days	**30**					

4. FINDINGS AND CONCLUSIONS

The chapter presents the findings and conclusions of the evaluation. It provides a critical assessment of performance (including factors affecting performance), and the results achieved, using the approved evaluation criteria. The findings are, therefore, analyzed according to the evidence derived from the information collected, and organized into two sections covering the following topics:

- Impact Assessment of the Project on Intended Groups
- Evaluation of the BCAOT Project

4.1. Response Rate

The evaluation team divided into four district leaders, with the mandate to facilitate and foresee smooth data collection in each district. The team held eight focus groups instead of the proposed twelve. The team had hoped to interview a group each of self-help support systems, inmates and the youths per district. Four groups of youths and four of inmates were interviewed without any challenges. However, it was observed during field work that the self-help concept initiated during the inception period never took off. The project team was able to provide a name for a former member of a self-help group in Maseru for consultation. As such, the evaluation failed to interview the four self-help groups as proposed. However, this observation did not impede on the progress of the evaluation, since evidence was collected from that one available individual.

Moreover, instead of interviewing VHCW in 12 clinics, three per district, the evaluation team was able to interview VHCW in eight clinics. Berea and Maseru did not keep to the mandate of three clinics per district. In Maseru only one clinic, Domiciliary, had VHCWs. The other two identified during inception period, Thamae clinic and Queen II Hospital, could not accommodate any VHCW due to their non-referral decree. In Berea only two clinics had VHCW. The current social worker explained that St. David's hospital was never approached because the former social worker had a target of 25 VHCW, and was able to cover that through the other two clinics in the district.

As per the evaluation's proposed methodology, the community leaders, local authorities and VHCW were interviewed by the youth. About 31 community leaders and

local authorities: four community leaders and four local authorities per district were interviewed. The youth encountered inevitable challenges in interviewing council members in villages. Since council seats are political, when governments change, some councilors get reshuffled. And because of change of governments in 2015 and 2017, some of the trained village councilors were no longer holding the positions. The Local Government elections were held just a few months before the evaluation was undertaken. As a result, all the councilors were all newly elected and the implication is that there was significant entrance of new councilors.

However, since BCL: TBC had offered trainings in these villages before, most were aware of its mission. Furthermore, the data collection tool was designed to accommodate this possibility, so most council members were more than willing to complete questionnaires. However, in some instances, respondents could not remember specific details of the project, since trainings were only offered once in 2015.

The team decided it would not be appropriate for the youth to interview the patients. As such, all patients including inmates and affected family members were interviewed by district leaders. This was for ethical considerations and to ensure protection of privacy.

There were also questionnaires for current patients, ex-patients and their families. The initial plan was to interview two current patients, two ex-patients and two-family members per district. However, due to work commitments, two current patients, one from Leribe and the other from Berea, did not show up for their interviews. The two worked during awkward hours which could not allow for one-on-one sessions. Because of the sensitivity nature of the evaluation and ethical reasons, the evaluation team decided not to opt for telephone interviews. Instead, two more current patients were interviewed from the other districts.

The evaluation, further, designed specific data collection tools for the BCAOT project team. The project leader, advocacy officers and the mobile teams were interviewed on gaps observed during the desk review period.

Overall the evaluation was able to achieve a response rate that was representative to have allowed making inference to the population of interest. As such, the evaluation exceeded the response rate of 95% within review completion rate for all questionnaires. This, therefore, is a clear indication that irrespective of the identified limitations and challenges, the team was able to carry out the evaluation process with the best expertise for quality assurance.

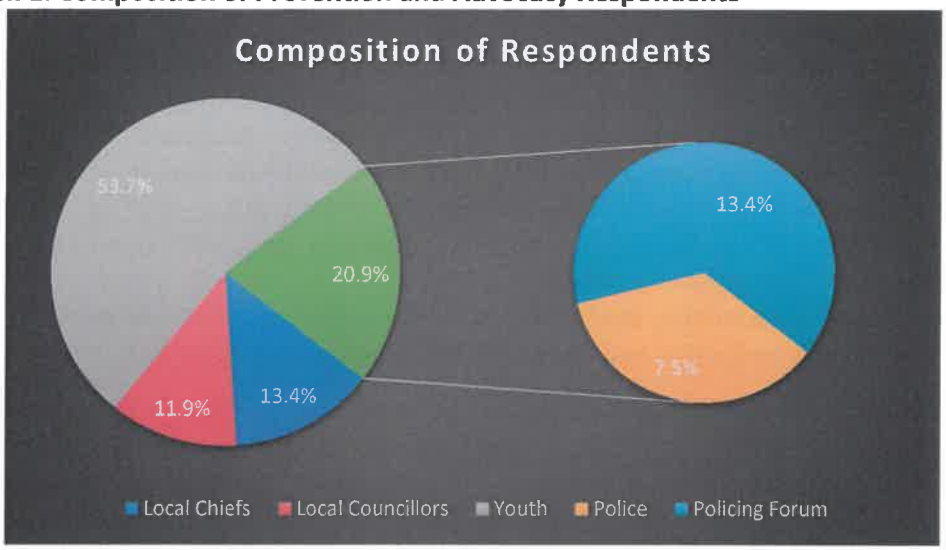
4.2. Impact Assessment on Intended Groups

Prevention and Advocacy

To assess the impact of the project in communities, the evaluation team investigated whether community leaders, local authorities and youth groups in Lesotho know the content of the alcohol legislation and can document its violation and react upon it. The evaluation interviewed a total of 31 community leaders and local authorities, and 36 members from BCL youth groups, aged between 18 and 35. Of the interviewed, 53.7%

were youth members, 25.4% community leaders (local chiefs and councilors) and 20.9% local authorities (police and community policing form).

Diagram 1: Composition of Prevention and Advocacy Respondents



About 94% of those interviewed had attended training sessions organized by BCL, and seemed to have significant knowledge on the Lesotho alcohol policy draft. They were further aware of the BCAOT project, and were knowledgeable on its specific objectives and role. For instance, they understood it as a tool encouraging advocacy on the alcohol policy, raising awareness, prevention and delivering outpatient treatment to people addicted to alcohol and drugs. The youth were particularly able to identify sections of the policy that addressed issues related to them as young people, such as the age limit and implications of advertisement rights. Only 6% of the respondents could not clearly remember the stipulated objectives of the project, although they knew it had to do with the fight against alcohol and drug abuse.

Upon training, they gained invaluable knowledge and were grateful to BCAOT's officers for their assistance and intervention. More importantly, the trainings are said to have united community leaders across villages; in the fight against alcohol and substance use. Local authorities noted that the training sessions enhanced their knowledge on the proposed laws relating to alcohol and drug abuse and were now in a better position to handle relevant cases and disputes.

"I am so proud of my certificate. It makes me unique and because of that, I have included it in my CV" interviewed

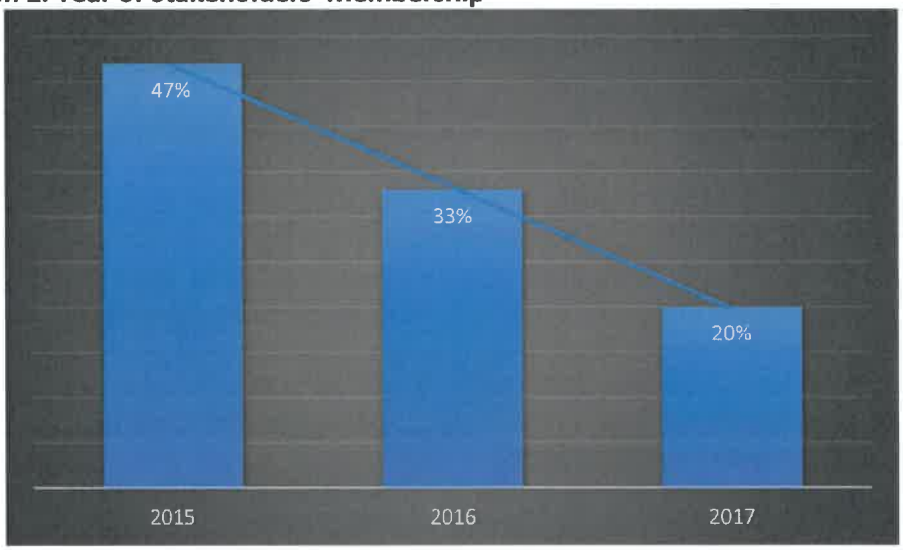
With acknowledgment and appreciation of the certificates received from the sessions, all leaders, except the 6% without training, indicated that they now feel qualified to impart training onto fellow members in respective communities. However, they iterated that they would need manuals and illustrative materials for

guidance. They feel with awarded certificates at hand, they get the credibility and confidence to engage in talks relating to alcohol and drug abuse. They see the certificates as evidence that they are BCL members, have been equipped with leadership skills and are, therefore, responsible members of their societies. The youth on the other hand use the certificates to apply for jobs and to tertiary institutions.

Although the respondents praised the dedication, patience and warmth of the trainers, they, however, complained that the training sessions were compact, brief, far-spaced, lacked illustrative materials, did not involve diverse groups and had no follow-up initiatives. They noted though that they still need the BCAOT project officers to offer refresher trainings on a regular basis, and play an advisory role as experts. They further suggested trainings could perhaps be on a quarterly basis and cover more areas, especially the urban part of the country.

Not all respondents started off with the project in 2015. As depicted in the diagram 2 below, only 47% had been with the project since 2015, 33% since 2016 and 20% joined in 2017.

Diagram 2. Year of Stakeholders' Membership



It is obvious, therefore, that majority started in 2015, although subsequent years experienced a significant linear decline in membership. In 2016 there was a 30% decline from the previous year's number, with a record 39% decrease in 2017. This indicates an undesirable performance from the project team; possibly instigated by limited resources to reach new places for increased coverage.

Through various strategies, about 92% claim to have taken active roles in their homes and communities advocating and supporting the policy. Community leaders and local authorities have engaged youth in community sports, counselling those affected, giving talks at schools, community meetings, and churches, working well with bar owners and zoning smoking areas at certain public places. They say they have taken to

supporting the policy by spreading the message at community meetings in the surrounding villages and schools.

Individuals in local policing forums have taken it upon themselves to check on the public drinking places for compliance, although they often face resistance and get verbally abused. Since these individuals are not employed nor paid for the work they do in communities, they rarely get the respect they deserve. They are ridiculed and called 'police without licenses,' and this negatively impacts on their confidence to carry out the job. They, however, acknowledge that they have relentless support of chiefs, councilors and local police.

Through word of mouth, leaders have spread awareness to neighboring villages that had not yet received trainings. They have indicated that they often receive invitations from other villages to hold public gatherings to impart knowledge on the project. The youth, on the other hand, have formed several groups and co-operations engaging in different activities. Some of the activities include sports teams, talent shows, income generating initiatives and choral music.

All these activities are just frontlines for the advocacy; since they use such platforms for advocacy. They, however, insisted that they need more than one encounter to finally get through to their targets. More often they need regular visits or consistent activities to finally convince their targets. As such, all respondents noted that with access to resources and remuneration for the work they do, they are certain that if the project ended they would be in a better position to carry through the work without regular guidance.

However, they explained that these strategies are often met with resistance and faced with challenges. Unemployment and poverty were stated as major constraints by almost all respondents. Without jobs, alcohol and drug users are said to be idle, bored and stressed out, hence spend days drinking alcohol and engaging in substance abuse.

Leaders are adamant, though, that there have been positive changes in their villages since some community members pay heed to their message. They claim to have realized a general reduction in alcohol consumption and alcohol and drug related crimes. Furthermore, some bars/taverns are said to be following stipulated opening and closing times.

However, there are still community members who feel leaders are interfering with their way of life and thus continue to brew alcohol, do not adhere to stipulated opening and closing times and sell to minors (under18s). And the greatest challenge that hinders progress is realized in cases where leaders themselves are involved in substance and alcohol abuse, and/or where they own such brewing places and public bars.

Bar owner are particularly reluctant to be involved with BCL, since they perceive the draft policy as a tool interfering with their livelihoods. To address this challenge, some villages have since introduced their own restrictions, although not legally binding. For instance, in one Butha-Buthe village, permission to brew traditional beer or open a public bar is first sought from local chiefs and councilors.

The police, on the other hand, claim poor legal support and lack of interest from colleagues as some of the challenges that impede the fight to advocate for the support measures to reduce substance and alcohol abuse. They decry limited time to dedicate to strategy and planning on prevention/reduction given the spectrum of their various duties. They feel restricted to extend the full arm of the law for motorists who drive drunk due to the shortage of breathalyzers for testing alcohol content in blood.

As advocates, youth face many challenges. They are called names for standing against harmful use of drugs and criticized for not being users. They are ridiculed by older people for thinking they can approach them and offer advice. This has to do with cultural values where youngsters are not freely allowed to talk to elders about such issues. And since the policy is not yet in action, it is difficult to have a fall back, as there is no specific law addressing some of the issues they advocate for. They also complained about limited documents and illustrative materials on the consequences of alcohol and drug abuse. Therefore, they cannot produce any evidence to explain for instance an exponential growth in car accidents caused by reckless driving when under influence. They also noted how most bar owners are community leaders and/or wealthy locals respected in communities; thus, making it difficult to stand against them, especially without any legal back-up of a legislation.

The respondents maintain, however, that the BCAOT project is important in the lives of their communities, and they wish for it to continue and spread throughout other communities. They advised that trainings should be conducted on regular basis so that the message is not lost in translation. In their opinion, the three years that it has been running has proved to be too short to bear fruits. They noted there is need to offer trainings at public gatherings, schools and churches, and felt the advocacy officers and SAAPA representatives are not able to cover all areas of need. They suggested BCL could start partnering with other NGOs like Kick for Life.

The youths suggested there would be far greater impact if they met with youths from other countries, especially SADC countries, to share with and learn from each other's experiences. They also felt they need to be trained beyond the scope of the project, specifically in leadership and conflict resolution skills to ensure the sustainability and well-functioning of the group. They suggested a few strategies that could be put in place to ease their role in the project. On top was the need to introduce various sports and entertainment activities to keep the youth busy, and to also illustrate how fun does not have to be linked to alcohol and drug abuse. They need to be empowered to be the facilitators of youth training sessions on advocacy. This is because the cohort tends to listen attentively and get motivated easily when trained or approached by their peers, rather than older people. They, further, suggested skills-training to improve their livelihoods, especially with the soaring unemployment rate in Lesotho.

Chiefs suggested livelihood projects could be introduced. Others pointed out that regular public meetings and workshops, especially at high schools are necessary to spread the message and offer training. They also suggested that organizations be formed in villages that will focus on policy advocacy. Should the project end, most of them feel empowered and equipped to carry out the work without regular guidance. They believe

that with the training they have received thus far, they can continue with the awareness, but would still need the BCAOT team for support and guidance.

The councilors suggested different approaches that could help in advocating for the policy. They advised that workshops, trainings, visits to schools and community meetings should be done continually. Radio programs in support of the policy should be developed to spread the message, especially to the areas where training has not been done. Some feel that introduction of projects that the youth can use to sustain themselves and keep busy would greatly help in combating the abuse of alcohol and substance abuse.

The police officers recommended that intensive measures should be taken with involvement of government officials to pass the draft policy into law and that BCAOT should recruit more advocacy officers who in turn should train as many people as possible. They believe that if the message is spread to the mass, that might just help in attracting relevant government ministries into action as far as the enacting of the policy is concerned. Substance and alcohol abuse prevalence is problematic to the force as it is in most cases the root of criminal offences. The officers work hand in hand advocating with other community leaders like teachers. However, others are of the views that fellow officers are not interested in their work and care more about their remuneration.

All respondents feel they are part of a life changing initiative in their respective communities. It is their hope that the alcohol policy draft could be passed into legislation as soon as possible. Overall, as individuals and in their respective groups, they portrayed a sense of pride and passion when discussing the impact of the project on the lives of their communities. They considered BCAOT to have been a success in its mission, thus rendering a positive impact.

Treatment and Rehabilitation

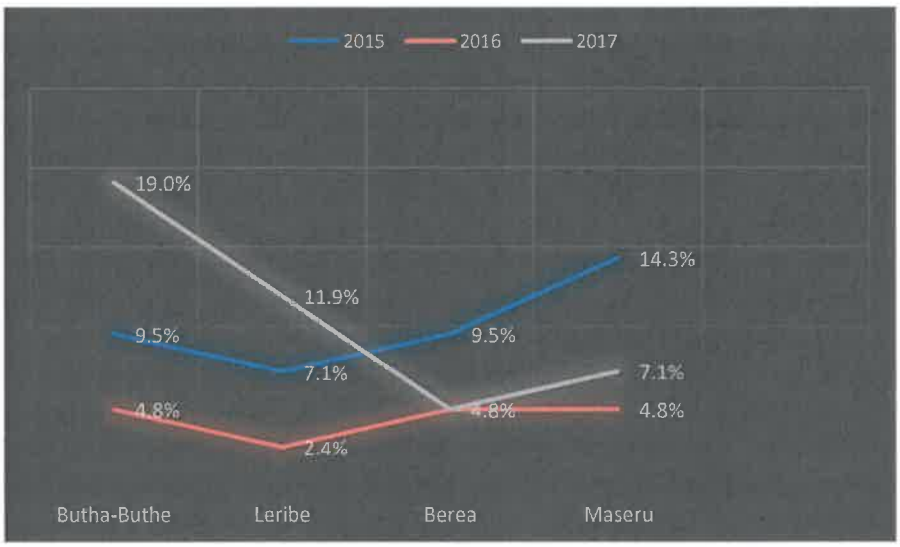
To assess the project impact on all categories of individuals offered therapy by the mobile teams, about 42 respondents were interviewed. To avoid having ineffective large groups, the inmates were interviewed as groups of five in each district, while current patients, ex-patients and their families were assessed individually. Overall 18 inmates, aged between 23 and 62, 16 current patients and ex-patients, aged between 18 and 45, and eight families of ex-patients were interviewed.

Of the interviewed, 94% were men, while women were represented by a trivial 6%. The poor representation of women seeking therapy could have several meanings. One could be the difference in shame and prejudice men and women face, from society, as alcohol and drugs users. Women are mothers and homemakers, therefore, expectations on how they ought to behave during everyday stresses are always high. The other could simply imply that as evidently proved by previous related projects in Lesotho, men constitute more users.

About 40% of respondents began therapy in 2015, 88% of which were inmates, and the remaining 12% shared by all other categories. None of the inmates reported to have started therapy in 2016; meaning the 17% was shared by current patients, ex-patients and families. The highest number, 43%, was realized in 2017 with inmates taking the smallest share of 17% and others sharing the 83%.

Diagram 3 shows the different years in membership as per district, and directly depicts the level of performance as indicated.

Diagram 3: Yearly Impact Per District



As illustrated, Butha-Buthe seems to be the one with greatest impact, while Berea takes the least, with no improvement in numbers between 2016 and 2017. The reason behind Butha-Buthe's performance could be the influence of the Decentralization project, which somehow laid the foundation for BCAOT. The year 2016 seems to be accompanied by worst performance. And this is mainly due to unavailability of the mobile team during that period. As explained earlier, the team that started off with the project was only available for a year, and the whole of 2016 the project was without a concrete team.

In assessing the quality and quantity of sessions offered, respondents were asked to comment on the spacing of sessions and on the quality of therapy offered. Almost all inmates claimed to have had one-on-one sessions with the counsellor, and group sessions with the social worker. However, the districts seem to have differing views in terms of the frequency of sessions. Butha-Buthe and Berea inmates see the counsellor and social worker (mobile team) once or twice a month, while Leribe and Maseru inmates, claim to have not seen them in seven and four months respectively. As such, inmates from the latter two districts were not satisfied with the spacing of the sessions. They suggested it would be best if they saw the mobile teams at least bi-monthly.

In other districts, inmates differed in their preferences on sessions' spacing. Some preferred weekly sessions, while others were still comfortable with monthly sessions. This deviation in the need to see the mobile team is brought about by the different problems they have and the quality of the sessions they seem to be getting. Overall, inmates iterated they would be happy to see more commitment and follow-up sessions from the mobile teams.

For current patients, the number of therapy sessions is higher in the beginning, but decrease with time. For instance, when patients begin therapy, they progressively have one-on-one sessions with the counsellor at least twice a week, then once a week and thereafter monthly. The ex-patients, however, receive therapy monthly, while affected family members get to see the mobile team once or twice a year. Although they

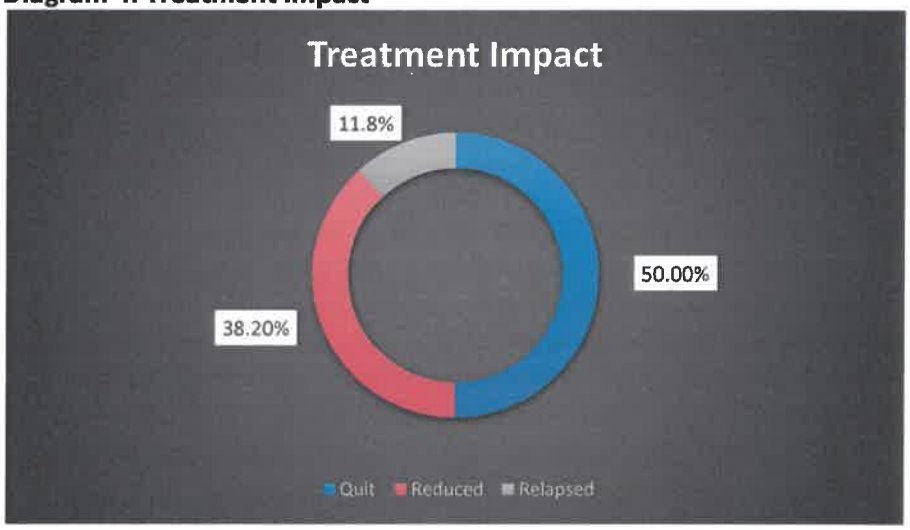
still also get one-on-one sessions, they mostly see the mobile teams in group sessions. It is important to note that the mobile team only attends to adults in affected families, since they are not qualified to provide therapy to children.

Most respondents were adamant that the therapy sessions offered by the mobile teams had a huge impact on their lives in general, as they were helped beyond their addictions. Current patients and ex-patients were able to see progress, while family members felt more equipped to help patients. However, about 10% of inmates seemed to be uncomfortable with their counsellor. They mainly complained of her age, not necessarily her approach to work.

Although majority of inmates do seem to trust the mobile teams and think highly of their work, they still complained about the fact that when they get used to a counsellor she leaves and a new one gets introduced by the project. This seemed to cause disruption in terms of building trust and consistency in therapy, and it also affected inmates' progress to rehabilitation.

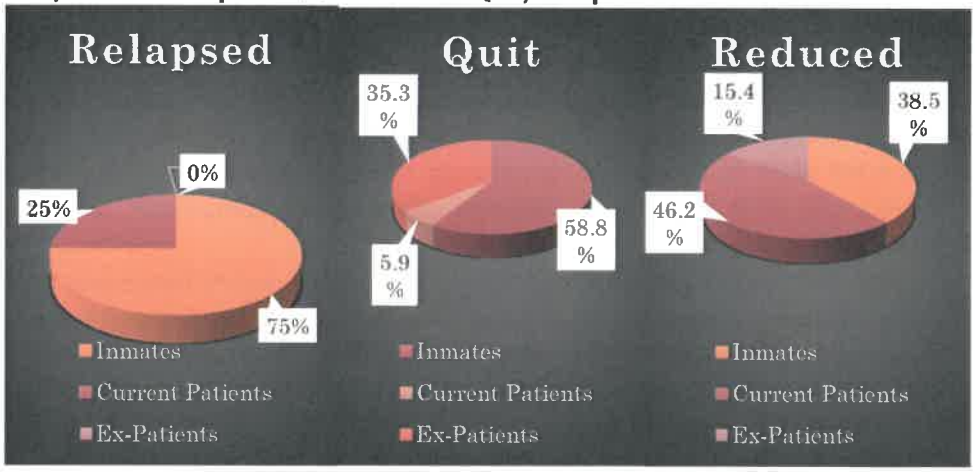
However, they all maintain that the sessions help them with issues beyond alcohol and drug abuse. Since they have started therapy, inmates feel more responsible and their depression has subsided. They feel part of their success in the program is brought about by the low impact of peer pressure, and the fact that they have ample time to independently think things through while in correctional services.

Diagram 4: Treatment Impact



As diagram 4 illustrates, 50% of respondents claim to have quit entirely, with 38.2% getting better, while 11.8% relapse every now and then. The 50% mark is, therefore, in line with the expected project output of 50% on all those who claim to have quit. As diagrams 5, 6 and 7 depict, the inmates take a larger share of those who have quit, but who also relapse often.

Diagrams 5, 6 and 7: Respondents who have Quit, Relapsed and Reduced



Current patients seem to have reduced usage more than other patients, but also take a larger share of those who relapse. What seemed laudable is the fact that none of the ex-patients seem to have relapsed. This, therefore, says a lot about the quality of therapy offered.

The main reason behind the relapsing inmates is that they have recently just been introduced to therapy, therefore, when they are stressed out, they easily get tempted to smoke tobacco. Most indicated that part of their relapse is caused by depression. The tobacco they all seemed to be hooked to is a pipe tobacco brand called Best Blend (BB). Apparently, the brand is very affordable, comes in big packages and is easily accessible from the inside.

Inmates claim the stress is caused by the isolation, the fact that friends and family do not come for visits, and knowing that they never got an opportunity to sincerely apologize to their victims. This creates a range of emotions that have a negative impact such as confusion, regret and disappointment among many others. As such, majority felt the mobile team could help them if on top of seeing their families they could further offer therapy to correctional officers and their victims to make them understand their situation. Inmates placed a lot of weight on the benefit of the opportunity to sit with their victims. Forgiveness from these victims is highly valued by the inmates and is a prerequisite to closure and ultimately a positive change in the inmates' lives.

As per the challenges faced by each group, a similar trend was observed for current and ex-patients. Most complained of getting severe cravings when angry, stressed, bored or even when in proximity to users. They reiterated that what further pulls them back were the withdrawal symptoms, the negative influence of old friends who are still users and existing family conflicts in their homes.

Family members, on the other hand, explained that although they have been counselled by mobile teams, they do at times lose their temper and often get discouraged when patients relapse. There was one case of an 18-year-old who resorted to using drugs after losing his mother in a terrible accident. His guardian explained how she found it

challenging to disciple him and be firm at the same time, since she mostly had to sympathize with his situation.

When discussing different strategies that the project could employ to best help them, some inmates suggested an introduction of physical therapy that includes relevant exercise routines. Others said they need to be empowered on how to face the world outside and overcome the stigma on their release. Majority seemed worried of the acceptance they would get and if their communities would believe in their rehabilitation. They noted it would help if on their release they could be part of the BCAOT project; working as ex-patients to empower and educate other people.

This they noted would open more job opportunities for them, especially if they received certificates of recognition as ambassadors. Inmates in all districts asked for pamphlets and books on treatment and rehabilitation. They noted that such books will empower them and work as a reminder of the treatment steps they need to take for complete rehabilitation. They stressed out how most information concentrates on the physical and psychological impact of drugs, and rarely on the financial impact. They felt such should be done through proper approach and education.

They suggested on release, they could be assisted to start small scale projects to maintain their livelihoods, especially with the criminal records they now had to their names. They also touched on the issue of project coverage; how it would be best if there are mobile teams in all districts, especially because all interviewed inmates wanted to keep contact with the mobile teams even after their release from prison, and they came from districts not covered by BCAOT.

VHCWs

To further assess the impact of the project, the evaluation team investigated if VHCWs have basic knowledge of substance abuse and motivational counseling. About 17 VHCWs were interviewed; 18% representative of men, while the rest of the districts were manned by 82% of females. Majority of VHCWs, about 94%, were trained in motivational counselling in 2015, except for the 6% that has not yet received training in alcohol and substance abuse, and motivational training.

All VHCWs were adamant that they can offer motivational counselling. Regarding follow-up on trainings, Leribe is the only district in which there was follow-up. VHCWs in the other three districts claim there has never been any follow-up to the trainings offered.

The number of people they offer counselling to differ drastically with a range of 7 to 60 per quarter. On a weekly basis, the range is between 1 and 5 people. In terms of the referral procedure employed, most said they first begin by talking to their clients and raising awareness on the harm that could be brought about by alcohol & substance abuse and then refer them to the mobile group. They claim to do follow ups to ensure that their patients have indeed met up with the mobile team, and were getting treatment.

However, their main challenge is that the mobile team is changed from time to time, and this negatively affects their work relations. Majority work is undertaken without manuals or guidelines from the BCAOT project. The VHCWs are adamant that if provided with materials, this would instil a sense of confidence in their work and that people would believe that they work for BCL: TBC. Since VHCWs work without identification cards, people become sceptical of their work.

Some users hurl insults at them and even want incentives to be motivated to quit. In terms of the impact on workload because of motivational counselling, some have created support groups to help each other. Majority expressed that they would like to be helped with incentives, airtime and transport, to reach clients who live far, instead of using personal funds in such instances. They suggested frequent trainings from the BCAOT team and motivational counselling in the villages, at schools and churches would have more impact.

Although there were challenges faced by the treatment and rehabilitation team, the project still had a significant impact on intended groups. However, more needs to be done for better coverage, effectiveness and to ensure sustainability.

4.3. Evaluation of the BCAOT Project

A core set of criteria was applied in assessing the results of the evaluation. The analysis of results, as stipulated below, identify challenges and strategies for future interventions.

Relevance

The evaluation identified the extent to which BCAOT's objectives were consistent with stakeholders' requirements and with country needs and global priorities, and the extent to which the outcomes addressed key issues, their underlying causes, and challenges. At this point it was important to reflect on the project's main objectives; being that an effective and evidence-based alcohol policy is passed and implemented, and to put in place cost-effective and easily accessible treatment services for persons suffering from substance addictions.

Country needs and global priorities

The harmful use of alcohol represents the fifth largest risk factor for disability adjusted life-years (DALYs) globally. It is also the number one risk factor for DALYs in Southern Sub-Saharan Africa and the third highest risk factor for DALYs in Lesotho[3]. The WHO globally, as well as regionally, clearly states that increased effort is needed to reduce the harmful use of alcohol through the development and implementation of comprehensive and evidence-based policies and availability of treatment for addiction. The BCAOT project thus contributes to the adoption and implementation of the proven best and most cost-efficient strategies to prevent the harmful effects of alcohol, as well as ensuring the availability of high quality treatment for persons suffering under substance abuse.

The Lesotho Alcohol Policy, developed in 2007, was at the time found not to be in line with recommendations put forward by the World Health Organization (WHO), and thus was never implemented. The policy neither embraced vital elements of public health nor included more recent outcomes and recommendations made by the WHO for

[3] Global Status Report on Alcohol and Health 2014, WHO, Geneva, http://www.who.int/substanceabuse/publications/globalreport/profiles/lso.pdf?ua=1

effective alcohol policies. Therefore, it was vital that the country worked on having an alcohol policy in line with WHO's recommendations, and acts to implement it.

As elaborated in the introduction section, BCL: TBC is currently the only specialist centre in the country that works towards prevention and in-patient treatment for people suffering from addiction to substances. The services are offered through a three-month *in-patient* assessment. As such, there is evident lack of neither public nor private therapy sessions for addicted people and affected family members. The rehabilitation centre is currently understaffed, lacks facilities and financial support to accommodate all potential clients. Therefore, to help people rediscover a life free of addiction, a project such as BCAOT was a dire necessity. And it is through the stated observations that the evaluation establishes the relevance of such a project in Lesotho.

Stakeholders' Requirements and Aspirations

In terms of the requirements of all those offered therapy and rehabilitation treatment; current patients, ex-patients, inmates and affected family members, the BCAOT project was spot-on. It is difficult, however, to say if the objectives were in line with the remaining stakeholders' requirements and aspirations. There was no prior communication with stakeholders on what they required from the project, and what expectations and aspirations they had. This is mainly because there was no baseline survey to bring all these to the fore.

The baseline survey would have identified all stakeholders' requirements and aspiration. It is important to note that, this would have been in line with the identified aspects of the evaluation process, and would have simplified the analysis in terms of comparisons with the baseline findings. To ensure 'relevance' in projects, it is important to take note of all stakeholders' needs, as this helps identify and outline stakeholders' needs. The baseline study would have identified the needs of all patients and stakeholders, them being an important component of the project.

The previous projects used as baseline were, however, able to equip the project with less than 50% of indicators needed to address requirements and aspirations. And with regards to the identified indicators, the project dealt with them exquisitely. The project team was able to train and empower VHCWs, the youth, community leaders and local authorities in all areas of importance; including equipping them with strategies to spread the message in the communities. As such, in terms of training, the BCAOT advocacy and treatment departments were also spot on.

However, due to lack of information and partial transparency on issues of importance to the identified groups, the project encountered inevitable challenges along the cycle. And this relies heavily on the recommendations that would have been made by the baseline survey, had it been carried out prior to inception.

However, BCN argued that as per donor's requirements, they view a baseline approach as establishing facts regarding starting point of indicators. Although, there are weaknesses as in the baseline indicators, the project team is adamant that a baseline survey was never required as part of the project, for several reasons. For instance, their argument stems from the fact that they could not measure the success of therapy by comparing the answers of clients in a baseline to what was delivered, but rather by the impact of therapy after treatment.

Project's Outcomes

To address relevance in terms of the project's outcomes, the evaluation examined if the outcomes addressed key issues, their underlying causes, and challenges. It further tried to understand if new issues and causes, and challenges that arose during the project cycle were adequately addressed.

Considering the number of people trained and treated through the project, the important aspects they were being trained on and the impact of the therapy offered, it is logical to conclude that the outcomes addressed key issues as identified by previous projects.

However, as noted earlier, the omission of other stakeholders' requirements and aspirations implies that there were key issues that the study failed to address. To be specific, VHCWs and self-help group members should have been interviewed to understand their role, challenges and expectations from the project. It would have, therefore, been revealed that the self-help concept was a challenge to sustain and relations between VHCWs, nurses and the BCAOT mobile teams needed to be addressed before inception.

Immediately when VHCWs and self-help ideologies were identified as the weakest links to the project's success, then to strengthen their capacity and to empower them required a thorough hindsight review in addressing the source of the problem. This should have been the core issue to consider. The 'omission', therefore, manifested into a huge challenge during the project cycle, which was never dealt with adeptly.

Design

There is no specific baseline study to inform the evaluation. Building on experience gained, BCN took steps to ensure continuation of the most successful parts of the previous projects, partly merging the experiences into one comprehensive project, whilst incorporating the proven effective methodology used in the *training program on evidence-based alcohol policies*. A baseline study would have explicitly identified accurate levels of harmful use of alcohol and drugs in Lesotho. This would have provided the project with specific indicators and helped the evaluation to assess if the project was in line with country needs.

The project document was prepared by BCN, with the help of BCL: TBC. The latter, though, is strictly the implementing partner and is responsible for the daily running of the project. The Centre was engaged to provide information in developing a local situational and needs assessment. And the board and staff members gave key input to the formulation of the project's objectives and content.

It is commendable that the project document had very clear goals and outputs. However, it does not state precisely the development processes that preceded the implementation process, and does not have specific time bound and cost-based activities. As such it is a challenge to know if relevant stakeholders such as community leaders, local authorities, VHCWs, prison management, the youth and patients, including the project management team (treatment mobile teams and advocacy officers), were involved in its development. And since activities were only shown as achieved on monthly and quarterly reports, it was impossible to assess whether the achieved activities were planned to be undertaken during the specified period.

There were also some discrepancies between the reporting format and the project document. The reports did not trace achieved activities from the log-frame. They were reported rather from the objectives. The periodic project reports were also not methodically recorded, and had inconsistencies that could not be linked to the main project document. The outcomes and respective outputs in the main project document were not in line with activities undertaken. This made it difficult to track whether the activities undertaken were explicitly relevant to what the project intended to achieve.

Although, given the project's timeframe and resources, the expected outcomes were realistic and clear, it was not clear how risks and assumptions would be addressed in the project design. Therefore, when challenges rose during the cycle, the project failed to achieve some outcomes.

Effectiveness

To determine the effectiveness of the project, the evaluation tried to find ways in which special emphasis was placed on; self-help groups', VHCWs', youths', community leaders' and local authorities' capacities, advocacy and awareness on the alcohol policy draft, outpatient treatment and networking with other CSO locally and regionally. To assess thorough effectiveness of the project, the evaluation, further, analyzed factors that contributed to the realization or non-realization of the outcomes.

Capacities of Self-Help Groups, Community Leaders, Local Authorities, the Youth, and VHCWs

The concept of self-help showed signs of failure from the start, and thus, needed deliberate consideration. Although members for the groups were trained, it became a challenge to maintain regular meetings without common interest beyond the identified goal of rehabilitation. Most members had to relocate in search of livelihood means in other districts, meaning groups could not be sustained.

The training of community leaders, local authorities and the youth was well accepted by majority of respondents and they reflected on its importance and the caliber of the facilitators. This part of the training was a success and what had a huge impact was the awarding of certificates at the end of the training. Therefore, the said groups are quite capable as trained advocates.

Although motivational counselling for VHCWs was ideal, the evaluation found that there was need for further consideration on existing relationships between the VHCWs and the nurses as immediate supervisors. Furthermore, manuals proposed in the project document were neither developed nor implemented, and this had a negative impact on VHCWs' capacity to perform well.

Advocacy and Awareness on Alcohol Policy Draft

Since BCL has increased its organizational capacity and members are knowledgeable on the policy, this implies that the project team was also effective in mobilizing others to support the alcohol policy draft. More NGOs have come on board, and the trained stakeholders in respective districts have been able to advocate beyond identified boundaries.

Some villages that were neither included in trainings nor offered any support are now on par in terms of knowledge and interest with those who did. Word has spread fast, and the process has united community leaders and local authorities; as they work in

harmony to achieve the common interest of reducing harmful use of alcohol and drugs in their communities.

Outpatient Treatment

Quality treatment for alcohol and substance addiction is now available beyond the BCL: TBC, and it is more accessible to people in rural areas of the country. The mobile teams have been effective in offering counselling sessions to those in need. However, the main challenge has been follow-up sessions after treatment, since most patients relocate to search for jobs.

The project has been effective in changing inmates' perspective on life in general. As per their claim, they have been able to receive counselling beyond their addiction problems. However, follow-up sessions after release were never realized, and this explains why none have reported back after release. Moreover, there are no developed programs introduced for integrating them into communities, and this also counteracts on the effectiveness of the therapy treatment they received while in correctional services.

Networking with Other Civil Society Organization Locally and Regionally.

The Anti-Drug Association Lesotho (ADAL) is one other organization working on substance abuse. The NGO works with prevention and they are strongly involved with policy work. BCL and ADAL form the core of SAAPA. Their ongoing cooperation is very important in the effort to create a strong and nation-wide campaign. There are other organizations that have joined the alliance, like Kick for Life and Phela. These NGOs see harmful use of alcohol as a threat towards achieving their objectives, for example fighting HIV transmission where alcohol is a main structural driver. Currently there are eight NGOs forming SAAPA Lesotho.

Furthermore, during the project cycle, the project team attended several workshops in the SADC region; advocacy training, conflict sensitivity and counselling ethics amongst others. This in its own opened doors for networking. However, it is important to note that such networking is also important for other stakeholders such as the youth; to share ideas and to learn from others, taking into consideration the geographical and cultural factors.

Factors that Contributed to the Realization or Non-Realization of the Outcomes

The Lesotho Alcohol Policy Draft

Although the advocacy officers and SAAPA representatives followed proper channels to ensure the alcohol policy draft gets to parliament, the country still has no alcohol legislation. SAAPA travelled through all districts to document a video in support of the existing alcohol policy. The organization further sought petition from all stakeholders, which they are yet to present to the MoH. Despite all efforts, the draft policy has not yet been enacted in Parliament.

The project proposal and inception year, 2015, was already a critical phase for the alcohol legislation to be implemented in Lesotho. In 2015 there was political instability in the country, which led to a change in governments. And in less than 24 months, the country called for another emergency election. The unstable political state, frequent change of governments and officials stifled all progress made and achieved. Therefore, to push for the new alcohol policy to be passed in the Parliament seemed an impossible task.

In as much as the existing draft policy is in line with WHO's recommendations, the process to enact it is still at the beginning stages.

The enactment and implementation of the policy is most likely to happen in years to come. Since the policy is still at the MoH's legal office desk for review, this means it is yet to pass several stages before it gets to cabinet, and then parliament. The delay and frustrations caused by change in governments have demotivated SAAPA members and some project personnel; since some seem to have lost interest and are not as committed as before.

Even where little progress is made, there is still lack of political will from government. Officials fail to weigh social ills caused by alcohol consumption against revenue collected from the alcohol industry. Public interest at heart is unrealized in most aspects. For instance, the government is reluctant to remove ginger beer from the grocery store shelves, and efforts to convince officials in this regard have come to a halt.

Limited funds have also played a part in hindering success of the project. There are limited resources to enable trainings. As such, there is no continuous communication between the project office and all stakeholders, largely due to lack of funds on the side of the project. This explains why there has not been a follow-up in most cases after the initial training sessions. As a result, the project's prospects of sustainability in this regard has been hugely affected.

Some stakeholders expect sustained payment, such as the youth, and thus lose interest when they discover that such is not forthcoming. Most of the trained groups thought they would be provided with incentives to carry through the advocacy work. Some show reluctance and become negative towards the draft policy. For instance, some law-enforcers fail to make confiscations on leads provided by the project, only because they get offered free beer as incentives. Reluctant members of the communities fail to relate or link the social ills with the use of alcohol. There is general lack of interest by some on issues pertaining to alcohol abuse. Alcohol and drugs have become socialized so much that some people do not see any harm drinking or using them. Limited academic research hampers advocate officers' and all trained stakeholders' abilities to validate assertions and claims when giving presentations. As such, there is lack of research studies and findings to track the statistics and claims made of alcohol induced incidents and illnesses in Lesotho.

The Outpatient Treatment

As indicated before, the self-help concept is a huge challenge in the country, since it is difficult to sustain such a group. Transport and lack of livelihoods are cited as a huge challenge for most participants. Lack of livelihood means drives most patients to relapse; due to the stress and pressures of life. Since the project lacks a factor in livelihoods, which is one aspect that worked well in previous projects, the bottom-up approach advocated for is limited in effectiveness.

The mobile team's progress has mostly been hit by the inconsistency and inadequate handover of responsibilities. Three of the mobile team members hired in 2015 were only available for a year. In 2016 the districts suffered a great deal due to the decline in counselling sessions.

The current personnel were hired in 2017. This implies, therefore, that patients were left without therapy for a long time, and when that part of the project resumed,

they were introduced to new counsellors and social workers. This did not sit well with most clients, especially some inmates who complained about the change. The change was also not accepted by most VHCWs, who explained how it affected their work.

> "I am due for release in 5 days and I feel that I still have some outstanding issues and consultations with the counsellor." An interviewed inmate in Maseru

This imprints on the importance of building and maintaining relationships throughout the project cycle. To be specific, nurses feel burdened as immediate supervisors of VHCWs, as they are the ones loaded with the everyday responsibility of managing them. It is claimed they often influence VHCWs not to take part in activities organized by the mobile team. Furthermore, lack of developed manuals and stipend or other incentives for VHCWs have also negatively affected the performance of VHCWs. Most complain that the project does not offer them anything in return for the work they do.

There is no program for reintroducing inmates into their villages. The mobile teams at times work with the rehabilitation unit at the LCS, and go to communities and the victims of the clients. As such, none of the inmates treated have reported back after release. Moreover, not much is done to help ex-prisoners kick-start their lives after release, and this is one of the greatest weaknesses of the project. Results are impossible to monitor since there is no program in place. The mobile team claims that once released, most inmates focus on getting jobs, and thus relocate to South Africa, therefore, hindering any opportunity for follow-up therapy.

The inmates in Maseru claim to have not seen the mobile team in seven months. The responsible mobile team claims it is challenging to work within the LCS's structure. For instance, the team is asked to call two days before seeing inmates. However, even after making calls they still do not get access to inmates. At times they are told they jeopardize the security of the Centre, and would be denied access to inmates.

Working in four districts is a challenge for two mobile teams. They are neither able to balance in-between duties districts nor to reach all those in need. And due to restricted mobility (only one vehicle per team) and limited financial resources, the teams are unable to extend their services to cover other districts of the country.

Family therapy has been stated as the greatest strength of the project, as it plays a vital role in sustainability. However, the team has not been able to help children from affected families. This is mainly because they are not equipped and skilled enough to offer counselling to children, as therapy is only offered to adults. This has become a huge hindrance since children are the ones most negatively affected by alcohol and drug-use in families.

Efficiency

Under efficiency, the evaluation tried to determine if the outputs were achieved with the lowest possible use of resources; funds, expertise, time and administrative costs. All these could easily be determined through an analysis of the proposed budget; outlining all budget line items, their unit of measure, quantities and costs, against the

actual amounts spent. The budget should also segregate funds per outcome and identify the amount to be spent per activity.

In terms of budgetary control, the budget allocation was sound. Most of the costs encountered were directly related to the project. The evaluation could, however, not identify a specific standard segregation of the budget, thus hampering a strong analysis of resource allocation.

In terms of actual spending, the project did not deviate much from the budget. For most activities, implementation was delayed and probably done towards the end of the year. The retained earnings at the end of both year 1 and year 2 signal that money was not used as intended. And this was partly due to the delay in hiring and engaging some project personnel, and the late purchases of some resources such as vehicles.

The initial financial analysis carried out during the inception period of the evaluation identified that the project received an unqualified opinion from the auditors, which implies that it adhered to the set standards, laws and regulations. There were financial reports that showed expenditure against the project income. Upon the request of financial reports, the consultant was furnished with the financial statements. All these did not clearly show the amount spent per activity. On that basis, it was not possible to measure whether resources were efficiently utilized for specific activities.

Impact

The project had a positive impact on both the prevention and treatment sides. There is an advocacy officer per district. These officers raise awareness on issues surrounding alcohol and the alcohol policy; by organizing education and advocacy activities on all possible platforms in and outside the identified districts. They train different groups on alcohol policy advocacy and assist them to develop plans and activities to implement thereafter. They, further, teach communities on the contents of the policy and attend public gatherings and pay planned visits to schools and churches.

As such, community leaders and local authorities now have knowledge on evidence-based alcohol policy and act to implement such in their community. The youth are knowledgeable on the content of the policy draft and can document its violation and react upon it. And most importantly, SAAPA in Lesotho is a strong alliance and capable of advocating for the enactment and implementation of alcohol policy nationally.

The project, further, consists of two mobile treatment teams operating in the four districts. The social workers provide health education at health facilities, public gatherings and correctional services, conduct family therapy sessions and supervise VHCWs and train them on motivational counselling. As such, VHCWs have basic knowledge of substance abuse and motivational counselling. The counsellors help clients with drug abuse and alcohol problems through counselling. The offered therapy is meant to help them face everyday challenges that trigger their use. As a result, out-patient treatment for individuals and inmates in respective districts has been established

Sustainability

The project thus far has been tailored to sustain results after the end of the project period. The assumption is that when all stakeholders had received thorough training and proper follow-up, most of the activities will be sustained with limited funds. However,

there have been limitations in terms of the said follow-ups, thus affecting the project's chances to sustain itself.

The country's alcohol policy draft has not yet gone through all the stages such that it is accepted as a final policy that can be used. The reason for this change is that a policy will never be enacted into a law but rather a bill, since it needs to be approved by the relevant ministry and then parliament. And due to changes of governments within a short space of time, the implementation of the draft is at its preliminary stage, assumed to be at the MoH's legal office desk for their review. It also takes time to build rapport, as such, the project team and SAAPA need to begin the process from scratch every time new government officials take over. As a result, to this day the Policy draft has still not been to cabinet as per requisite, and government officials keep reneging on their promises.

However, to ensure sustainability in this aspect, a partnership of all CSOs with interest would be invaluable. The synergies as well with other NGOs from the identified districts will help spread the message, increase coverage and realize sustainable impact.

Although, SAAPA in Lesotho is powerful and capable of advocating for the policy, there is need to change approach when dealing with the government structure. Currently a lot of emphasis is placed on bottom-up approach; the idea being that the advocates need to have a buy-in of the populace. However, with the challenges of frequent unplanned government changes, the approach needs to incorporate a top-down approach. This will in turn ensure sustainability from different angles.

The impact of prevention training and the outpatient treatment also plays a vital role towards sustainability. The VHCWs and self-help concepts; chosen due to evidence that such activities reach numerous people with limited funds, have been the most hit with challenges in Lesotho. The expectation was that after motivational counselling, VHCWs can continue their activities with less follow-up, especially with manuals developed. However, these manuals were neither developed nor translated, thus hampering progress.

The treatment program as well was to be implemented in close cooperation with the relevant government structures. However, this concept omitted a vital group in charge of supervising the VHCWs; the nurses at identified clinics. Participation from this group prior to project inception would have played a vital role to ensure project sustainability.

Coherence

The evaluation determined the extent to which activities undertaken would allow the country to achieve its policy objectives without internal contradiction or without contradiction with other countries' policies. The comparative analysis in Table 2 confirms that the current Lesotho policy draft is coherent with other countries' policies and interventions[4]. Therefore, the trainings and advocacy were relevant, and their direction (i.e. focus and approach) was in line with activities in other African countries.

[4] http://www.who.int/substance_abuse/publications/global_alcohol_report/msb_gsr_2014_2.pdf?ua=1

Table 2: Alcohol Policies and Interventions in Africa

policies and interventions	Lesotho	Botswana	South Africa	Senegal	Benin	Mali
Written national policy/ National action plan	Yes (draft)/ =	Yes (2010/—) / No	Yes (1999/2007) / Yes	No / —	No / —	No / —
Tax/levy on beer/wine/spirits	Yes / Yes / Yes	Yes / Yes / Yes	Yes / Yes / Yes	Yes / Yes / No	Yes / Yes / Yes	No / No / No
National legal minimum age for off-premises sales of alcohol beverage (beer/wine/spirit	18 / 18 / 18	18 / 18 / 18	18 / 18 / 18	18 / 18 / 18	No / No / No	No / No / No
National legal minimum age for on-premise sales of alcoholic beverages (beer / wine / spirits)	18 / 18 / 18	18 / 18 / 18	18 / 18 / 18	18 / 18 / 18	No / No / No	No / No / No
Restrictions for on-/off-premise sales of alcoholic beverages: Hours, days / places, density/special events/petrol stations	Yes, Yes/ Yes, Yes, Yes/ No/ Yes	Yes, Yes / Yes, No Yes/Yes/Yes	Yes, No / Yes, No No/Yes/No	Yes, No / Yes, Yes Yes/No/No	Yes, No / No, No No/No/No	No, No / No, No No/No/No
National maximum legal blood alcohol concentration (BAC) when driving a vehicle (general / young / professional), in %	0.08 / 0.08 / 0.08	0.08 / 0.08 / 0.08	0.05 / 0.05 / 0.05	Zero tolerance	0.05 / 0.05 / 0.05	0.03 / 0.03 / 0.03
Legally binding regulations on alcohol advertising / product placement	No / No	No / No	No / No	Yes / No	No / No	No / No
Legally binding regulations on alcohol sponsorship / sales promotion	No / No	Yes / No	No / No	Yes / Yes	No / No	No / No
Legally required health warning labels on	No / No	No/No	No / Yes	No / No	No / No	No / No

policies and interventions	Lesotho	Botswana	South Africa	Senegal	Benin	Mali
alcohol advertisements / containers						
National government support for community action	Yes	Yes	No	No	Yes	Yes
National monitoring system(s)	No	Yes	Yes	No	No	No

Value-Added

BCN

BCN offered three one-week trainings on therapy to the mobile team. A BCN expert on addiction and family therapy was sent to Lesotho on three occasions to offer a week's trainings. The expert specifically trained staff from TBC and the mobile teams in family therapy, outpatient treatment, prevention of drop-outs and other topics of relevance. The contribution was crucial and had a huge impact on the mobile team's performance. This explains why from the treatment side, the mobile team stated family therapy as the project's strength.

BCN further provided M&E system and anti- corruption trainings, and requested development of an anti-corruption policy from TBC. And all these efforts increased staff's capacity in these fields. The organization undertook monitoring visits to the project sites at least twice a year. These visits were important because they offered BCN and TBC an opportunity to discuss all aspects of the project during the project cycled.

Community

It was important for the evaluation to determine the extent to which the project added benefit to what would have resulted from interventions in the same context. It is evident that the BCAOT project has decentralized BCL: TBC's services to meet the nation half-way. The project has raised awareness on the contents of the alcohol policy, has helped people in their own communities and has given them an opportunity to heal in their places of origin. Through the Project, communities are equipped with relevant information to make informed and conscious decisions on using alcohol. And majority of stakeholders are empowered in their respective lines of duty.

The stakeholders have expressed gratitude on the knowledge acquired through the prevention training sessions offered by BCAOT. Anecdotally, communities are experiencing decreased crime related activities induced through alcohol and drug abuse. Through support of patients who abuse alcohol and drugs, dignity is restored in families and societies.

Alcohol is very much linked with gender inequality, and in many respects, contribute greatly when left unregulated. More men than women are addicted to alcohol, therefore, the harm they do to others when drunk; physical abuse instigated by domestic

violence for instance, is significant. On the contrary, women who drink alcohol are faced with more negative effects than men due to an often-smaller body size, physical vulnerability and often social stigma and exclusion.

The project also has a positive effect on the environment in identified local communities. Respondents claimed that there was less littering and vandalism. Furthermore, the amount of research confirming the connection between harmful use of alcohol and HIV/AIDS is significant and growing. Alcohol is a leading driver causing new cases of infection as persons with an addiction problem are more likely to contract HIV. Alcohol consumers are at 77% higher risk of being HIV positive than non-drinkers[5]. Thus, through its focus on the prevention of harmful alcohol use, the project contributes to limit new cases of HIV infections and enable infected persons to take care of their overall health and treatment schedule.

5. CONCLUSIONS

The section discusses achievements; extent of activities' impact and challenges. As illustrated below, the conclusions are addressed as per the report's findings category. The conclusions include a discussion of the reasons for successes and failures, especially the constraining and enabling factors.

Evaluation of the BCAOT Project

Relevance

To determine the relevance of the project, the evaluation addressed two key issues; the extent to which BCAOT objectives were consistent with stakeholders' requirements and with country needs and global priorities, and the extent to which the outcomes addressed key issues, their underlying causes, and challenges. The evaluation concludes, therefore, that the project was in line with country needs. However, in terms of addressing the requirements of relevant stakeholders, the evaluation found gaps in the project's implementation.

With the treatment requirements of all patients, the BCAOT project was spot-on. However, due to inconsistencies observed with other stakeholders' requirements, and lack of baseline study thereof, it is difficult to conclude the objectives were in line with their requirements and aspirations. This is also because there was no prior communication with the stakeholders on their requirements and expectations.

In terms of outcomes, the number of people trained and empowered by the project, and the impact on their lives, are clear indications that outcomes addressed key issues. However, the omission of other important stakeholders such as nurses implied that there were key issues that the study failed to address. The VHCWs and Self-Help concepts did not work as anticipated. More should have been done to strengthen their capacity and to empower them when failure seemed inevitable. This would have clearly revealed the main source of the problem, which could have been adeptly dealt with during the project cycle.

Design

[5] Baulinas, D and J. Rehm (2009), Alcohol consumption and risk of incident human immunodeficiency virus infection: a meta-analysis, International Journal of Public Health, Issue 3, 2010, pp 159-166

It was clear through findings that the unavailable baseline survey led to limited indicators for the project to work on, and contributed highly to the project's role in not achieving some of the results. Although specific goals and outputs were set, there was ambiguity in terms of set targets. Furthermore, the project document did not have specific time bound and cost-based activities. The evaluation concludes, therefore, that the design had bottlenecks that potentially hampered the project progress to a certain extent.

Effectiveness

Of all the issues addressed by the project, advocacy and awareness on the alcohol policy draft seemed to take top priority. The counselling sessions for alcohol and substance addiction were very effective and a great success thereof. Furthermore, networking with other civil society organizations played a huge role, although there is need to include NGOs in districts as well.

In conclusion, there were several factors, though, that contributed to the non-realization of some outcomes. Specifically, from the advocacy side, these were; the alcohol policy that has not yet been enacted, government's role in delaying the process, limited resources, other stakeholders' reluctance to take part in activities and to support the project, and limited academic research on the state of alcohol consumption and consequences in Lesotho. From the treatment side, factors included; the self-help concept that failed to take off, the delay in recruitment process, regular change of mobile teams, unemployment and lack of livelihood means, lack of treatment manuals and reintegration programs for inmates, relationships that were not nurtured and lack of incentives for VHCWs.

Efficiency

It was a challenge to identify if outputs were achieved with the lowest possible use of resources; funds, expertise, time and administrative costs. There were no financial reports, but rather statements, and this did not show expenditure on activities against the project income. Therefore, one concludes that the Project had weak programmatic and financial reporting systems.

Impact, Coherence, Sustainability and Community Value Added

The project had a positive impact on all those who received counselling and trainings. The factors, though, that unintentionally hampered the smooth progress of the project and the prospect of sustainability were the limited follow-ups in treatment and trainings, the self-help concept that never took off, lack of training manuals for VHCWs, and the government's and SAAPA's partial commitment to seeing through the enactment of the policy. However, the evaluation found that some activities undertaken by the project had a potential to help the country achieve its policy objectives without internal contradiction or without contradiction with other countries' policies. And concludes, thereof, that the country's policy draft is coherent with other countries' policies and interventions

Impact Assessment of the Project on Intended Groups

A staggering 94% of community leaders, local authorities and the youth know the content of the evidence-based alcohol policy draft; can document its violation and react

upon it. And about 92% have employed different strategies to advocate and implement relevant productive activities in their communities. As advocates of the policy, stakeholders complain though that due to lack of jobs and the unstable economy, they still face reluctance from members of their communities who drink alcohol and use drugs as a means of stress-relief.

Further reluctance, as claimed, comes from local bar owners who feel threatened by the advocacy of the policy. However, with stated challenges, respondents still maintain that the BCAOT project is very important in the lives of their communities, and they, therefore, wish for it to continue and spread throughout other communities.

In terms of outpatient treatment, the evaluation concludes that quality treatment for alcohol and substance abuse is available for, and used by people in the four identified districts of Lesotho. About 50% of all interviewed patients claim to have entirely quit using alcohol and drugs, with 38.2% getting better, while 11.8% relapse every now and then. This is inline, therefore, with the project's expected output of 50% of patients claiming to have quit.

Inmates take a larger portion, about 58.8%, of those who have quit. Although this is highly commendable, the lack of relevant programs to integrate them into communities when released, and limited follow-up thereof, have contributed to non-realization of some results. Since none of the inmates have reported back after release from correctional services, the project's 50% target of inmates reporting back six months after release was never realized.

VHCWs play a vital role in motivating and encouraging potential clients to seek help. More than 90% claim to have basic knowledge of substance abuse and motivational counseling. Although they work with neither provision of stipends from the project nor manuals, they highly regard the project and consider it to have a huge impact in people's lives.

With all achievements and challenges faced by the project, the evaluation concludes that the harmful use of alcohol is reduced and treatment for substance abuse is available for people in the four identified districts of Lesotho. Thus, there is a huge impact of the project on intended groups. Although there were loopholes, the BCAOT project was a success in term of impact on intended groups.

6. LESSONS LEARNT

This Section focus on lessons learned with a basis on the evaluation findings and drawing from the evaluation team's overall experience. In other contexts; valuable lessons learned are identified, including both positive and negative lessons.

Project Development and Management

- There is no baseline survey to inform the design of the project accordingly. BCN took steps to ensure continuation of the most successful parts of the previous projects, partly merging the experiences into one comprehensive project, whilst incorporating the proven effective methodology used in the *training program on evidence-based alcohol policies*. This limitation contributed immensely to non-realization of some results. A baseline survey would have put into consideration

the requirements and aspirations of all stakeholders. And this would have put to the fore the importance of improving existing relations before project inception.

- Reporting tools for the Project need to be sufficient. There were narrative reports of activities undertaken without financial reports. Overall, project monitoring tools/reports should be aligned with the main project outcomes to help trace progress accordingly.
- The project was not able to retain the mobile team that started with the project in 2015. The initial team took only a year, and for months there were none employed. The current teams were recruited in 2017, and this had a negative impact on the relationships already built by the previous counsellors and social workers. Taking into consideration the sensitivity of the work they do, this change had a huge impact on non-realization of expected results.
- Limited resources - some of the resources needed to facilitate the smooth running of the project, such as vehicles and office space, were acquired very late in the project cycle. This delay hampered progress, especially where mobility was restrained.
- Most stakeholders, including the project team, did not feel like they had full ownership of the project. This is because BCN and BCL did not involve and consult all with stake before project inception; to get opinions, perceptions and aspirations. Most stakeholders mainly felt like implementing actors or mere volunteers. This partly explains the lack of commitment from some of them, and the need for incentives to play their part.
- The livelihood projects part of the Decentralization project was not part of the successes continued through the BCAOT project. The continuation would have played a vital role in assisting the project team to realize some of the expected results. A lot of challenges faced by the project, including the self-help concept, would have been eased by available livelihood projects. The released inmates as well, would benefit greatly in such projects.

Prevention and Advocacy

- The Lesotho Alcohol Policy draft is still at the phase at which it started in 2015; after ensuring it is in line with WHO's recommendations. This is mainly due to regular change in governments and respective officials. The delay and unresponsiveness of the government have affected SAAPA's commitment and determination of seeing the policy draft enacted in parliament. This implies that the energy with which activities were carried out with during the inception period is slowly fading.
- The advocacy officers do not have any vehicles to facilitate their work. Therefore, this implies that coverage of their advocacy has limitations. Although certificates were acknowledged and appreciated, they seemed not sufficient to convince stakeholders to keep volunteering. Most stakeholders demanded incentives to

stay motivated to do their work. However, due to limited funds, the demanded incentives were not available, and this somehow affected project results.

Treatment and Rehabilitation

- The concept of self-help never kicked off since initial training sessions. There were no follow-ups and there was limited effort to sustain them. When the project team realized there were challenges regarding the self-help's sustainability, no action was taken to mitigate the challenge.
- Out of the identified 12 clinics by the project, only 10 were suitable to facilitate the VHCWs concept. When this came to the fore during the project cycle, no replacement clinics were identified. The project team left the situation as was, and this affected the outcome as per VHCWs' requisite. Moreover, out of the 10 clinics, some were not included by the project team due to challenges that could have easily been addressed without any hassle.
- It was expected that the project would have manuals to be used by VHCWs. However, these manuals were neither developed nor translated, and the omission was on top of VHCWs' grievances.
- Inmates in some correctional facilities, Maseru and Berea, had not been receiving therapy for months due to unstable relationships between the project team and LCS workers. There were stringent requirements from the LCS, and the team showed lack of patience in pushing through for the results under the circumstances.
- The project team did not develop any programs to help integrate the inmates back into society after release. Last contact with inmates is while in correctional services, since no follow-ups take place. As a result, none of the inmates have reported back after release. This means that the project cannot claim sustainability in terms of treatment in this regard.
- Family therapy has been identified as one of the greatest strengths of the treatment section of the project, since it plays a vital role for complete rehabilitation. However, due to lack of relevant qualifications, the mobile team could not provide therapy to affected children. This implies that these children were neglected by the project and could not get needed therapy. This on its own has future implications that could impact negatively on society.

7. RECOMMENDATIONS

The recommendations are derived from the conclusions and lessons learned; followed by a discussion of their anticipated implications. The section consists of a list of proposals for action to be taken (short- and long-term) for follow-up, suggestions for implementation.

Project Development and Management

In preparation for the next project, a baseline survey should be undertaken prior to project design to set base and to inform the design accordingly. In case of limited

resources, at least vital phases such as those involving stakeholders' participation in investigating opinions, perceptions and expectations should be considered. This will, further, help identify other stakeholders that should have been consulted by the project, such as nurses and businessmen. And with consultation and participation, most stakeholders will feel they have ownership of the project, which will reflect in their commitment and determination.

Reporting tools for the project need to be sufficient and efficient. It must be easy able to track the progress of outputs implementation. The reporting on activities need not be narrative in nature without financial reports. Overall, project monitoring tools/reports should be aligned with the main project outcomes to help trace progress accordingly.

There should be an implementation of an M&E system for an ongoing tracking of project results. The M&E plan should include training provisions for staff on management of data as well as proper reporting of results. This will also be linked with the project undertaking a risk assessment process and subjecting their objectives and activities to a risk matrix development process that assesses the likelihood of a risk, the possible impact and mitigation strategy based on the results of risk profiling.

The recruitment of mobile teams should be revised. Having two individuals work in two districts stretches their limitations. At least there should be one mobile team per district. Although the team's work is complementary, there should be some independence that would allow one to work without limitations in the absence of the other. There is need for an enquiry into the remuneration packages offered by similar projects in the country. This will ensure that packages offered by BCAOT's are on par with those offered by other projects; with sufficient and competitive benefits to retain staff for the duration of the project.

The livelihood concept seems to be a challenge. This part of the project would be an answer to most challenges realized due to limited livelihood means, such as the self-help concept and inmates follow-up sessions. However, it was one of the concepts that was not viable and unsustainable in the previous projects, since it had high recourse inputs. If by any chance BCN cannot include the concept due to highlighted reasons, then the BCAOT team needs to work adeptly in partnering with local organizations in respective districts. The project should identify with other NGOs' and government's initiatives to see progress in their advocacy and work in general. Moreover, the project could consider replicating some of the approaches adopted by other African countries with similar cultural and economic values.

Prevention and Advocacy

Challenges faced through government's role call for an introduction of a top-down approach. For a more rapid response, the project needs to 'shake the tree from the top' and focus on educating and empowering the government to ensure officials understand the economic impact of having an alcohol legislation that is regionally and globally aligned.

A thorough analysis of the existing alcohol policy draft revealed the need for a revision. There are some sections in the draft that are left incomplete, with a note that

says, 'to be revisited'. SAAPA should work together with advocacy officers to review the sections with rigor and amend as required; to have a thorough complete policy draft. For instance, the issue of the 500m clause in the section of the draft that discusses eligible places to sell alcoholic beverages is not clear on what will happen to places that already exist within stated perimeters.

The draft, further, needs to involve groups such as church leaders, especially on issues surrounding Holy Communion. Church leaders can also encourage congregations, especially the youth, to join the blue cross movement, which is slowly fading due to low membership. And it needs to touch on the issue of local brews; which constitute majority of outlets in rural areas. It should also be specific on penalties and fees it proposes other statues such as the road traffic act and liquor licensing act to adopt.

Outpatient Treatment

From the outpatient treatment side, the team needs to learn to address grievances, risks and challenges immediately as they occur during the project cycle. For instance, two more clinics should have been identified to replace the ones not suitable to accommodate VHCWs. This also implies that more needs to be done in working on relations with BCN, nurses, correctional service employees and with all other stakeholders involved.

The mobile team needs to identify with government's current and proposed initiatives when dealing with clinics and correctional services. This will assist in developing coherent manuals and reintegration programs for VHCWs and released inmates respectively. VHCWs should, further, be offered incentives such as affordable mobile phones, airtime and monthly transport fees to ease communication with and transportation to potential clients. This will in turn yield positive results since they would feel acknowledged and accepted as part of the project.

There is need to engage more counsellors and social workers to include those with the skill-set to undertake therapy for children. Since family therapy has been identified as one of the greatest strengths, it is vital to strengthen it in terms of expertise and capacity.

Overall, despite a few challenges identified by the evaluation, the project has been a huge success in terms of the impact on intended groups. For better coverage, as the evaluation team, we would like to take the opportunity to advise BCN and the project management team to broaden the expertise and scope of the project to include at least two more districts with increment in clinics. As much as the project introduces invaluable change in people's lives, it is important to remember that change affects people's perceptions and values, thus it is a notion that needs long-term commitment. For BCN and BCL: TBC to observe change that can be sustainable, the project needs to be extended at least for two-to-three more years. Not only will the nation prosper in different aspects, but the two organizations will for years be remembered and honored as agents of change in Lesotho. The evaluation pleads with higher academic institutions in Lesotho to take part and bridge the gap in limited research on issues concerning alcohol and drug use, and calls upon statisticians to track and trace data on alcohol induced incidents and illnesses in Lesotho. It is the responsibility of all with stake to see the use of alcohol and drugs decline in Lesotho, therefore, as a nation we all need to make significant moves.

ANNEXES

I. Results Framework

Project Goal	Project Results level	Indicators	Baseline	Targets
Harmful use of alcohol is reduced and treatment for substance abuse is available for people in Lesotho.	**<u>Outcome 1.</u> Lesotho has an alcohol policy in line with WHO's recommendations to protect people from harmful use of alcohol and are taking action to implement the policy**	Policy document passed in parliament (binary response)	No	Yes
		Alcohol levy legislation passed in parliament (binary response)	No	Yes
		Excise tax on beer/wine/spirits	15%	18%
		National minimum age of alcohol consumption, for on-premise and off-premise sales	18	21
		National maximum legal blood concentration (BAC) when driving a vehicle	0.1	0.03
		Legally binding regulations on alcohol advertising/product placement (binary response)	No	Yes
		Operation of a National surveillance monitoring system collecting data for basic indicators related to alcoholic consumption and all related issues	No	Yes
	Output 1: Blue Cross Lesotho has increased their organizational capacity and members have knowledge of evidence-based alcohol policy and are able to mobilize others to support the alcohol legislation members	Number (count) of Blue Cross members of both genders trained in evidence based and cost-effective alcohol policy work and advocacy.	78	150
		Development and adoption of an action plan for mobilization, support and implementation of a new alcohol policy in Lesotho (binary response variable)	No	Yes
		Number (count) of advocacy activities per	0	10

Project Goal	Project Results level	Indicators	Baseline	Targets
		year to mobilize support for a good alcohol policy		
	Output 2: Community leaders and local authorities (including community policing forums) in the districts of Maseru, Berea, Leribe and Butha Buthe have knowledge on evidence based alcohol policy and act to implement such in their community	Number of community leader groups in each of the 4 districts who are able to describe at least 3 cost effective ways to reduce harm of alcohol in their communities	-	10
	Output 3: Youth Groups in Lesotho know the content of the alcohol legislation and can document violation of it and react upon this violation	Number (count) of youth groups trained on evidence based alcohol policy and advocacy per year	-	10
		Youth groups carry out at least three activities to advocate for evidence based and effective measures to reduce harms of alcohol in their area	0	10
	Output 4: The alcohol policy alliance in Lesotho is a strong alliance and capable of advocating the implementation of new alcohol legislation nationally	Number (count) of active civil society organizations who are active members of the alcohol policy network	2	5
		Number of people mobilized in support of the National Alcohol policy and take part in at least one concrete activity	0	1,500
Harmful use of alcohol is reduced and treatment for substance abuse is available for people in Lesotho.	**<u>Outcome 2.</u> Quality treatment for alcohol and substance addiction is available, and used by people in rural areas in Lesotho**	Number (count) of people from Berea, Leribe, Butha Buthe and Maseru receiving treatment for substance abuse	-	600
		Percentage of Treated individuals who report to have either quit or reduced drinking of alcohol	-	60

Project Goal	Project Results level	Indicators	Baseline	Targets
	Output 1: Blue Cross Lesotho and Thaba Bosiu Centre are running self-help groups in 4 districts	Number of self-help groups established and operational.	2	20
		Number of people trained as self-help group leaders	2	40
		Percentage of Self-help members who report either a reduction in alcohol or having quit the use of an addictive substance	-	50%
	Output 2: Village health care workers in Lesotho have basic knowledge of substance abuse and motivational counseling	Number of village health care workers trained in motivational counseling and substance abuse	49	149
		Number of people who benefit from motivational counseling by trained village health care workers	1080	6000
		Number of people referred to mobile clinics or TBC by village health care workers	0	1000
		A manual developed by TBC and used by village health care workers in Lesotho (binary response)	No	Yes
	Output 3: Two mobile treatment teams are run by TBC and offer treatment in the 4 districts	Two mobile treatment teams offer outpatient in cooperation with 12 village health clinics	No	Yes
		Number of consultations for substance addiction by the mobile treatment teams	0	132
		Number of people reached with mobile treatment services per year	0	120

Project Goal	Project Results level	Indicators	Baseline	Targets
		Percentage of mobile treatment beneficiaries who report either a reduction in alcohol or having quit the use of an addictive substance	0	50%
	Output 4: Substance abuse treatment for inmates in 4 prisons in the districts of Butha Buthe, Leribe, Berea and Maseru in Lesotho are established	Number of inmates who receive therapy for substance abuse each year.	30	65
		Percentage of inmates who report either a reduction in alcohol or having quit the use of an addictive substance	49%	35%

II. Terms of Reference (TOR)

Introduction

Blue Cross Lesotho runs a rehabilitation Centre at Thaba-Bosiu as a project aiming to curb the harmful use of alcohol and drugs. This Centre was originally supported by Blue Cross Norway until the Government of Lesotho took over. The Centre has two main departments to achieve this goal. These are the Prevention and Treatment Departments. The Centre has been in operation for 25 years. There has been a growing trend in the number of clients willing to go for rehabilitation but the infrastructural and human resource capacity is never sufficient to accommodate all the potential clients. In order to address this problem, Blue Cross Norway has supported the Blue Cross Advocacy and Outpatient Treatment Project which operates in selected areas in the four districts of Maseru, Berea, Leribe and Butha-Buthe. The project started running in 2015 and is now applying for an exit period, which will allow TBC to secure results and sustainability for the project. The Centre is therefore looking for the services of a consultant to undertake project evaluation of the Blue Cross Advocacy and Outpatient Treatment Project.

Project Background

The project aims to push for the implementation of National Alcohol Policy in order to reduce the harmful use of alcohol in the country. In order for the public to have a say in the policy document which is still in a draft form, different groups of the community are being trained in alcohol policy advocacy. They are highlighted on the contents of the draft policy and encouraged to make advocacy plans to take action in their respective communities to make a difference. These groups are, the community policing forums, chiefs, members of the police, youth, members of Blue Cross Lesotho, Civil Society Organizations and elected community councilors.

On the treatment side the project has a mobile team which comprises of the Social Worker and Counselor. The project has two such teams which work in the two districts each (Maseru-Berea Team and Leribe-Butha-Buthe Team). The teams are responsible for training Village Health Workers on Motivational Counseling. This is meant to empower them with skills to encourage people already addicted to alcohol and

other drugs to come for our free counseling. The Social Workers are also responsible for the coordination and formation of Self Help Groups which are formed out of ex-Clients to share experiences and advise one another on how to overcome challenges and triggers on their recovery journey. The teams are also responsible for family therapy/ home visits in order to include family members in the recovery of the clients. The Counselor offers individual and group counseling sessions for the clients.

Expected outcome from the evaluation:

- Assess the project's results. To what degree has the project achieved goals? Are there unplanned results?
-What are the reasons if goals are or are not achieved?
-What kind of impact has the project had on the communities, if any?
-Are there control measures introduced in the communities as a result of advocacy training to curb the harmful use of alcohol in accordance with the Alcohol Policy draft and the Liquor Licensing Act of 1998?
-What kind of impact has the treatment had on drinkers and their families, if any?
-What kind of impact has the motivational interviews had, if any?
- How effective is the implementation of the project, in terms of use of resources, use of funds and how it is organized?
-Can the project be organized or implemented differently and achieve similar results? What are the strongest points that should be prioritized for the future?
- What recommendations can be given for the next project period, 2018-2020?
- How can the project be advised to secure future sustainability?
- Recommend strategies to have tangible impact at both community and national level.
- What added value has Blue Cross Norway contributed besides funding, if any?

Methods:

- Conduct field visits to assess the impact of the project at community level. Interview trained groups and village leaders.
- Consultation with the trained Village Health Care Workers.
- Interview ex-clients and current clients, and family members to determine the difference in behavior change and perception of alcohol and drugs.
  Assess project documents and reports
- Interview or focus groups with project staff and Blue Cross members.

Qualifications and Experience

- Appropriate tertiary qualification (preferably Postgraduate in Project Management, Health Sciences or Economics) with 10 year experience in project evaluation or similar role
- Proven track record in project evaluation
- Ability to undertake inspections and monitoring
- Knowledge of the proposed national Alcohol Policy
- Experience working with NGOs
- Knowledge of Lesotho's Health sector.
- No personal bindings to Thaba Bosiu Center, the project, staff or other stakeholders.

Skills and Competences

- Excellent stakeholder analysis in project management
- Conscientious understanding of policy issues
- Thorough knowledge of Lesotho's political situation and the possible effect on policy issues
- Excellent report writing skills

- Fluent in both Sesotho and English languages
- Proven knowledge to analyze project progress
- Approve ethical standards of evaluations and Digni's ethical guidelines (attached).
- Conduct the evaluation openly and independent. Share openly the findings, include all stakeholders and beneficiaries in a respectful way, also giving them a chance to adjust impressions before finalizing the evaluation report.

Reporting:
The findings of the evaluations should be presented in a report of which the project management and donor can give its comments. A final report should then be finalized and presented in a meeting with project staff, and other stakeholders can be invited. Thaba-Bosiu Center will be responsible for disseminating findings to beneficiaries and other stakeholders, like the government.

Duration

The successful consultant is expected to start on 1st November 2017 and submit the evaluation report on or before 21st December 2017.

III. List of Documents Reviewed

Baulinas, D and J. Rehm (2009), Alcohol consumption and risk of incident human immunodeficiency virus infection: a meta-analysis, International Journal of Public Health, Issue 3, 2010, pp 159-166

Global Status Report on Alcohol and Health 2014, WHO, Geneva, http://www.who.int/substanceabuse/publications/globalreport/profiles/lso.pdf?ua=1http://

Parry, C and J. Rehm (2013), *Alcohol Grows as a risk factor for death and disability in 2010 GBD Study*, The Globe. Issue 1, 2013, pp 3-4

Rossow, I. and T. Clausen 2013, The Colectivity of drinking cultures: is the theory applicable to African settings?, Addiction, Vol 108(9), pp. 1612-7

Websites

www.blakors.no/this-is-blue-cross-norway

www.who.int

www.sadc.int

www.healthdata.org

https://www.norad.no/en/front

https://www.facebook.com/BlueCrossThabaBosiuCentre

Other reviewed Documents

The report briefly reviewed key strategic documents – including the project proposal, project budget, audit reports and financial statements, workplans, training and workshop documents, policy documents and quarterly reports.

IV. Specimen schedule for data collection

EVALUATION OF THE BLUE CROSS ADVOCACY AND OUTPATIENT TREATMENT (BCAOT) PROJECT: 2015 - 2017

Data Collection Tool for PROJECT MANAGER (BCAOT)

This is an independent evaluation of the BCAOT project. This evaluation at end of project cycle is designed to assess the achievement of the results, the factors that facilitated/hindered achievement, and to compile lessons learned. You are kindly requested to answer all applicable questions in this schedule and, if possible, provide any additional information that will facilitate this important exercise. Thank you for your support.

A. Background information

1. Name.....
2. Position.....
3. Year of employment.....

B. Organizational Plan

1. Briefly explain your role in the project

.....
.....
.....
.....
.....
.....

2. How many people do you have in your team? Name them

.....
.....
.....
.....
.....
.....
.....

3. Do you feel they each understand their roles and responsibilities clearly? Explain

.....
.....
.....
.....
.....
.....
.....

4. Which government ministries/departments and civil society groups do you work with?

.....
.....
.....
.....
.....
.....

5. In your own words, please explain the relationship with the different stakeholders

.....
.....
.....
.....
.....
.....
.....
.....
.....

C. **The BCAOT Project**

1. Were you and your team part of the planning process of the Project?

.....
.....
.....
.....
.....
.....

2. Where does your team fit in within the project cycle?

.....
.....
.....
.....
.....

3. What activities have you achieved so far (under the BCAOT Project)?

.....
.....
.....
.....
.....
.....
.....
.....
.....

4. What frameworks have been proposed or adopted with the help of the project?

.....
.....
.....
.....

.....
.....
.....

5. What challenges have you faced so far as Project Manager?

.....
.....
.....
.....
.....
.....
.....
.....
.....

6. In your own opinion, how successful were the activities carried out by BCAOT?

.....
.....
.....
.....
.....
.....
.....

7. What do you think BCAOT project could have done better since the inception period?

.....
.....
.....
.....
.....
.....
.....
.....
.....
.....

8. Comment on efficiency of resource utilization under the BCAOT project in general

.....
.....
.....
.....
.....
.....

9. What would you say are the project's:

Strengths:

.....
.....
.....
.....
.....
.....
.....

Weaknesses:

.....
.....
.....
.....
.....
.....

10. Any other comments:

.....
.....
.....

Thank you

EVALUATION OF THE BLUE CROSS ADVOCACY AND OUTPATIENT TREATMENT (BCAOT) PROJECT: 2015 - 2017

Data Collection Tool for ADVOCACY OFFICERS

This is an independent evaluation of the BCAOT project. This evaluation at end of project cycle is designed to assess the achievement of the results, the factors that facilitated/hindered achievement, and to compile lessons learned. You are kindly requested to answer all applicable questions in this schedule and, if possible, provide any additional information that will facilitate this important exercise. Thank you for your support.

A. Background information

1. District.....
2. Name.....
3. Work Title .....
4. Year of employment.....

B. Advocacy and National Alcohol Policy (Draft)

1. Briefly explain your role in the project

.....
.....
.....

.....
.....

2. Who do you train and work with? Name all with stake

.....
.....
.....
.....
.....
.....

3. How can you rate your relationship with each stakeholder? 1: worst – 10: Best

.....
.....
.....
.....
.....
.....
.....

4. What are the reasons behind the worst relationships you have?

.....
.....
.....
.....
.....

5. Currently what materials have been adapted in your line of duty?

.....
.....
.....

5. At what Phase of implementation is the draft of the Policy?

.....
.....
.....

7. Which government ministries/departments do you work with?

.....
.....
.....

8. In your own word, please explain the relationship with government

.....
.....
.....
.....
.....

.....
.....

9. What do you think is the stumbling block in the policy's progression to legislation?

.....
.....
.....
.....
.....

10. What measures could be put in place to counterattack the challenges?

.....
.....
.....
.....
.....

11. How do you mobilize the nation to support the policy and take part in the organized activities?

.....
.....
.....
.....

12. Which media channels do you use to advocate?

.....
.....
.....
.....
.....
.....

13. How many people have you reached so far? And what was the initial target?

.....
.....
.....
.....
.....
.....

14. What challenges have you faced in advocating for and implementing the Policy?

.....
.....
.....
.....
.....
.....
.....
.....

.....
...

15. Are you happy with the draft Policy, or do you feel there are gaps that still need to be bridged?

.....
.....
.....
.....
.....
.....

16. What challenges do you face in your line of work?

.....
.....
.....
.....
.....
.....

17. What can you say about the whole project?
    Strengths:

    .....
    .....
    .....
    .....
    .....
    .....

    Weaknesses:

    .....
    .....
    .....
    .....
    .....

18. Any other comments:

    .....
    .....
    .....
    .....
    .....

19. Please attach or list any publications, reports or documents produced by your Alliance which you consider relevant to this evaluation:

    .....
    .....

Thank you!

EVALUATION OF THE BLUE CROSS ADVOCACY AND OUTPATIENT TREATMENT (BCAOT) PROJECT: 2015 - 2017

Data Collection Tool for MOBILE TEAM

This is an independent evaluation of the BCAOT project. This evaluation at end of project cycle is designed to assess the achievement of the results, the factors that facilitated/hindered achievement, and to compile lessons learned. You are kindly requested to answer all applicable questions in this schedule and, if possible, provide any additional information that will facilitate this important exercise. Thank you for your support.

A. Background information

1. Districts covered.....
2. Name.....
3. Work Title .....
4. Year of employment.....

B. Treatment and Rehabilitation

1. Briefly explain your role in the project

.....
.....
.....
.....
.....

2. Who do you work with in offering treatment for substance addictions? Name all with stake

.....
.....
.....
.....
.....

3. How can you rate your relationship with each stakeholder? 1: worst – 10: Best

.....
.....
.....
.....
.....
.....

4. What are the reasons behind the worst relationship you have?

.....
.....
.....

.....
.....

5. At least how many consultations do you offer

   weekly?.....Monthly?.....

6. Of the consultations, how many are referred by

   VHCW?.....Without referral?.....

7. Of the treated patients, how many reported to have:
   Quit?.....improved?.....relapsed?
   .....

8. What do you think are the reasons for a relapse?
   .....
   .....
   .....
   .....
   .....

9. Do we have treatment manuals?
   Yes? ..... No? .....

10. When were the manuals produced?
    .....

11. The manuals are written in which language?
    .....

12. Do we have a program for reintegrating inmates into their villages? Please explain

.....
.....
.....
.....

13. If yes, how do we monitor the results?

.....
.....
.....
.....

14. How many inmates have reported back to you after their release?
    .....
    a) If yes, how many have quit, improved or relapsed?
    b) .....
       .....
       .....
    c) In no, what are the reasons?
       .....
       .....
       .....
       .....
       .....

15. How many self-help groups have you established?
    .....

And how many of those are still functioning?

.....

16. What challenges do you face in your line of work?

.....

.....

.....

.....

.....

17. What can you say about the whole project?

Strengths:

.....

.....

.....

.....

.....

Weaknesses:

.....

.....

.....

18. Any other comments:

.....

.....

.....

.....

.....

19. Please attach or list any publications, reports or documents produced by your Alliance which you consider relevant to this evaluation:

.....

.....

Thank you!

EVALUATION OF THE BLUE CROSS ADVOCACY AND OUTPATIENT TREATMENT (BCAOT) PROJECT: 2015 - 2017

Data Collection Tool for VILLAGE HEALTH CARE WORKERS (VHCW)

This is an independent evaluation of the BCAOT project. This evaluation at end of project cycle is designed to assess the achievement of the results, the factors that facilitated/hindered achievement, and to compile lessons learned. You are kindly requested to answer all applicable questions in this schedule and, if possible, provide any additional information that will facilitate this important exercise. Thank you for your support.

A. Background information

1. District.....
2. Clinic .....

3. Name of Respondent.....
4. Female ..... Male .....
5. How long have you been a VHCW? .....

B. Knowledge on Substance Abuse and Motivational Counselling

1. How often do you get visits from the BCAOT Social Worker?

.....
.....

2. Did you get any training in substance abuse and motivational counselling? Yes..... No.....When?.....

3. After your training, was there a follow-up after six months?

Yes.....No.....Don't remember?.....

4. After the trainings you received, are you confident to offer motivational counselling to patients? Yes.....No.....

5. At least how many people do you offer motivational counselling to:

Week.....Monthly? .....Quarterly? .....

6. In that period, how many do you refer to the BCAOT mobile team or to the Thaba-Bosiu Centre?.....
7. Briefly explain the referral procedure

   .....
   .....

   .....
   .....

8. Do you carry any follow-ups to ensure the patient indeed went for the referral? Please explain

   .....
   .....
   .....
   .....

9. Do you have manuals from the Blue Cross: TBC that you use as guidance to help people with substance abuse?
   Yes?.....No? .....
10. Are the manuals helpful or do you think more could have been done?

    .....
    .....
    .....
    .....
    .....
    .....

11. What are the greatest challenges you face each day?

    .....
    .....
    .....

.....
.....

12. Is there any impact on your workload with regards to an addition of motivational counselling?

.....
.....
.....
.....
.....

13. Any other comments

.....
.....
.....
.....

Thank you!

EVALUATION OF THE BLUE CROSS ADVOCACY AND OUTPATIENT TREATMENT (BCAOT) PROJECT: 2015 - 2017

Data Collection Tool for COMMUNITY LEADERS and LOCAL AUTHORITIES

This is an independent evaluation of the BCAOT project. This evaluation at end of project cycle is designed to assess the achievement of the results, the factors that facilitated/hindered achievement, and to compile lessons learned. You are kindly requested to answer all applicable questions in this schedule and, if possible, provide any additional information that will facilitate this important exercise. Thank you for your support.

A. Background information

1. District.....
2. Village/Police Station.....
3. Do you know about the BCAOT Project? Yes?.....No? .....
4. In your own words, what is the project about?

.....
.....
.....
.....
.....
.....

B. Information on the Quality of Trainings Offered

1. Have you been trained by BCL: TBC?

2015?.....2016?.....2017?.....

2. At least in a year, how many trainings have you been to?
.....

3. What were the trainings about?

.....

.....
.....
.....
.....
.....

4.Who offered the trainings?

.....

5. Name three things or more you liked about the trainings?

a) .....

b) .....

c) .....

.....

6. Name three things or more you disliked/ felt uncomfortable with, regarding the trainings

a)

.....
.....

b)

.....
.....

c)

.....
.....

.....
.....

7. Do you feel empowered to facilitate the trainings on your own (training other people)?.....
8. If not, what are the reasons behind?
.....
.....
.....
.....
.....
.....
.....
9. Have you been awarded a certificate by BCL: TBC?
.....
.....
.....

.....
.....

10. What is the significance of the certificate/ what does it mean to you?.....
.....
.....
.....
.....

C. Knowledge and Advocacy on the National Alcohol Policy (Draft)

1. Have you seen the Lesotho Alcohol Policy draft?
.....
2. What exactly is the role of this policy/ what does it do?
.....
.....
.....
.....
3. As advocates of the policy, how do you see yourselves playing your role (How do you fit in?
.....
.....
.....
.....
.....
4. What actions have you taken so far in your communities to support the Policy?
.....
.....
.....
.....
.....
5. What challenges do you face as Leaders/Authorities in advocating for the support measures to reduce substance abuse and alcohol addiction in your communities?
a)
.....
.....
b)
.....
.....
c).....
.....
.....
.....
.....

6. What strategies do you think would be best in advocating for the Policy?

.....
.....
.....
.....

.....
.....

7. Do you feel you say the mission of advocating with other leaders/ do you work towards the same goal?

.....
.....
.....
.....
.....
.....

8. Do you think your communities understand your message?

Yes? Why do you say so?

.....
.....
.....
.....

No? Why do you say so?

.....
.....
.....

9. If this project ends, do you feel you are empowered and equipped enough to carry through the work without regular guidance?

Yes?.....
.....
.....
No?.....
.....
.....

10. Comment Freely on the BCAOT Project

.....
.....
.....

Thank you

EVALUATION OF THE BLUE CROSS ADVOCACY AND OUTPATIENT TREATMENT (BCAOT) PROJECT: 2015 - 2017

Data Collection Tool for SELF-HELP GROUPS

This is an independent evaluation of the BCAOT project. This evaluation at end of project cycle is designed to assess the achievement of the results, the factors that facilitated/hindered achievement, and to compile lessons learned. You are kindly requested to answer all applicable

questions in this schedule and, if possible, provide any additional information that will facilitate this important exercise. Thank you for your support.

A. Background information

1. District.....
2. Village .....
3. Name of Group .....
4. The Group was started in which year? .....
5. Number of Individuals in Group.....Male?.....Female?.....
6. Age Range of Group Members.....
7. How often do you meet? Weekly?..... Monthly? .....Yearly? .....
8. How many are certified self-help group leaders? .....

B. Counselling and Rehabilitation

1. How often do you get visits from the BCAOT mobile team?

.....

2. Do you have one-to-one sessions or group sessions?

.....

3. At least how many sessions do you have:

Weekly?.....Monthly?.....Yearly?.....

4. Are you happy with the spacing of the sessions?

Yes? Why?

.....
.....
.....

No? Why?

.....
.....
.....

5. Do you trust your counsellor and her abilities to guide you?

Yes? Why?

.....
.....
.....

No? Why?

.....
.....
.....

6. Do you feel the sessions are helping you? If not, why?

.....
.....
.....
.....
.....

7. At least how many of you have: quit? .....reduced? ..... relapsed?.....
8. What do you find as most challenging in this journey of treatment and rehabilitation?

.....
.....
.....
.....
.....
.....

9. What do you find as most challenging in keeping the group alive?

.....
.....
.....
.....
.....
.....
.....
.....
.....

10. What strategies do you think could be employed to best help you stay clean?

.....
.....
.....
.....
.....
.....
.....
.....
.....

11. Do you feel this self-help group is helping you? Yes?

In what way?

.....
.....
.....
.....
.....
.....

No? Why?

.....
.....

.....
.....

12. Any other comments?

.....
.....
.....
.....
.....
.....
.....

Thank you!

EVALUATION OF THE BLUE CROSS ADVOCACY AND OUTPATIENT TREATMENT (BCAOT) PROJECT: 2015 - 2017

Data Collection Tool for INMATES (CORRECTIONAL SERVICES)

This is an independent evaluation of the BCAOT project. This evaluation at end of project cycle is designed to assess the achievement of the results, the factors that facilitated/hindered achievement, and to compile lessons learned. You are kindly requested to answer all applicable questions in this schedule and, if possible, provide any additional information that will facilitate this important exercise. Thank you for your support.

A. Background information

1. District.....
2. Number of Individuals in Group.....Male?.....Female?.....
3. Age Range of Group Members.....

B. Counselling and Rehabilitation

1. How many have received counselling therapy since:

2015?.....2016?.....2017?.....

2. Do you have one-to-one sessions or group sessions?

.....

3. At least how many sessions do you have:

Weekly?.....Monthly?.....Yearly?.....

4. Are you happy with the spacing of the sessions?

Yes? Why? .....

No? Why? .....

5. Do you trust your counsellor and her abilities to guide you?

Yes? Why?

.....
.....
.....

No? Why?

.....
.....
.....

6. Do you feel the sessions are helping you? If not, why?

.....
.....
.....
.....

7. At least how many of you have: quit? .....reduced? ..... relapsed?.....
8. What do you find most challenging in this journey of treatment and rehabilitation?

.....
.....
.....
.....
.....
.....

9. Do you feel empowered to face your communities when released, without the temptation to relapse?

.....
.....
.....
.....

10. What strategies do you think could be employed to best help you with the addictions?

.....
.....
.....
.....
.....

11. Any Comments?

.....
.....
.....

Thank you!

EVALUATION OF THE BLUE CROSS ADVOCACY AND OUTPATIENT TREATMENT (BCAOT) PROJECT: 2015 - 2017

Data Collection Tool for APAL and SAAPA REPRESENTATIVES

This is an independent evaluation of the BCAOT project. This evaluation at end of project cycle is designed to assess the achievement of the results, the factors that facilitated/hindered achievement, and to compile lessons learned. You are kindly requested to answer all applicable questions in this schedule and, if possible, provide any additional information that will facilitate this important exercise. Thank you for your support.

A. Background information

1. Name and address of the Alliance

.....
.....
.....

2. Name of Official completing questionnaire

.....

3. Rank or Position

.....

4. The mission of the Alliance

.....
.....
.....
.....
.....

5. Please explain the organizational structure of the Alliance

.....
.....
.....
.....
.....
.....
.....

6. How many Civil Society Organizations form your alliance? Name a few

.....
.....
.....
.....
.....

.....
.....

7. What are the recognized achievements of the Alliance thus far?

.....
.....
.....
.....
.....
.....
.....

B. Advocating and Implementing the National Alcohol Policy (Draft)

1. At what Phase of implementation is the draft of the Policy?

.....
.....
.....

2. What are the Alliance's interventions in ensuring awareness of the Policy?

.....
.....
.....
.....
.....
.....
.....

3. Which government ministries/departments do you work with?

.....
.....
.....
.....

4. In your own word, please explain the relationship with government

.....
.....
.....
.....
.....
.....

5. What do you think is the stumbling block in the policy's progression to legislation?

.....
.....
.....
.....

6. What measures could be put in place to counterattack the challenges?

.....
.....
.....
.....
.....
.....

7. Which sections of the Nation do you work with? (e.g. Youth, tertiary institutions, communities)

.....
.....
.....
.....
.....
.....
.....

8. How do you mobilize the nation to support the policy and take part in the organized activities?

.....
.....
.....
.....
.....
.....
.....

9. How many people have you reached so far? And what was the initial target?

.....
.....
.....
.....

10. What challenges have you faced in advocating for and implementing the Policy?

.....
.....
.....
.....
.....
.....
.....
.....
.....
.....

11. Are you happy with the draft Policy, or do you feel there are gaps that still need to be bridged?

.....
.....

.....
.....
.....
.....

12. Please attach or list any publications, reports or documents produced by your Alliance which you consider relevant to this evaluation:

.....
.....
.....
.....
.....
.....
.....

Thank You

EVALUATION OF THE BLUE CROSS ADVOCACY AND OUTPATIENT TREATMENT (BCAOT) PROJECT: 2015 - 2017

Data Collection Tool for CURRENT PATIENTS

This is an independent evaluation of the BCAOT project. This evaluation at end of project cycle is designed to assess the achievement of the results, the factors that facilitated/hindered achievement, and to compile lessons learned. You are kindly requested to answer all applicable questions in this schedule and, if possible, provide any additional information that will facilitate this important exercise. Thank you for your support.

A. Background information

1. District.....
2. Male?.....Female?.....
3. Age Range of Group Members.....

B. Counselling and Rehabilitation

1. You have been receiving counselling therapy since:

2015?.....2016?.....2017?.....

2. How did you learn about the mobile team? Referral? Please explain

.....
.....
.....

3. Do you have one-to-one sessions or group sessions?

.....
.....

4. At least how many sessions do you have:

Weekly?.....Monthly?.....Yearly?.....

5. Are you happy with the spacing of the sessions?

Yes? Why? .....

No? Why? .....

6. Do you trust your counsellor and her abilities to guide you?

Yes? Why?

.....
.....
.....

No? Why?

.....
.....
.....

7. Do you feel the sessions are helping you? If not, why?

.....
.....
.....
.....

8. Since attending therapy sessions, have you:
   quit? .....reduced? ..... relapsed?.....
9. What do you find most challenging in this journey of treatment and rehabilitation?.....
   .....
   .....
   .....
   .....
   .....
   .....
10. Do you feel there is prejudice or stigma attached to going for treatment? Explain

.....
.....
.....
.....

11. Do you have you family's support? Community support?

.....
.....

12. Any Comments?

.....

.....

Thank you!

EVALUATION OF THE BLUE CROSS ADVOCACY AND OUTPATIENT TREATMENT (BCAOT) PROJECT: 2015 - 2017

Data Collection Tool for FAMILIES of EX-CLIENTS

This is an independent evaluation of the BCAOT project. This evaluation at end of project cycle is designed to assess the achievement of the results, the factors that facilitated/hindered achievement, and to compile lessons learned. You are kindly requested to answer all applicable questions in this schedule and, if possible, provide any additional information that will facilitate this important exercise. Thank you for your support.

A. Background information

1. District.....
2. Male?.....Female?.....
3. Relation to the patient.....

B. Counselling and Rehabilitation

1. You have been receiving counselling therapy since:

2015?.....2016?.....2017?.....

2. Do you have one-to-one sessions or group sessions?

.....

3. At least how many sessions do you have:

Weekly?.....Monthly?.....Yearly?.....

4. Are you happy with the spacing of the sessions?

Yes? Why? .....

No? Why? .....

5. Do you trust your counsellor and her abilities to guide your family member?

Yes? Why?

.....

.....

No? Why?

.....

.....

6. Do you feel the sessions are helping you and the patient? If not, why?

.....
.....
.....
.....

7. Has your family member: quit? .....reduced? ..... relapsed?.....
8. What do you find most challenging in supporting him/her?

.....
.....
.....
.....
.....
.....

9. Do you feel the community/village is also empowered to support the patient?

.....
.....
.....
.....
.....

10. What strategies do you think could be employed to best help you and the patient?

.....
.....
.....
.....
.....
.....

11. Any Comments?

.....
.....
.....
.....
.....

Thank you!

Blue Cross Norway's comment to the evaluation of The Blue Cross Advocacy and Outpatient Treatment (BCAOT) Project.

Blue Cross Norway is grateful for the effort and thorough work made by the evaluation team. The report gives valuable insight to the operations by our partner Blue Cross Lesotho, Thaba Bosiu Center. The evaluation report will be an invaluable guidance towards the second phase of the project from 2018.

Blue Cross Norway have read the report and would like to add the following comments:

We are grateful that the report shows that the impact on the lives of clients is extremely good. This is the "reason for being" for Blue Cross all over the world, and a main purpose of the project.

We are also very grateful to hear that local communities, community leaders and others trained in the alcohol policy and prevention have the knowledge and have taken action to follow up prevention measures in their local communities, and that several of them find this is making an impact on their community.

Comments to the challenges identified:

Main challenges pointed out in the report is connected to project implementation, monitoring and evaluation of the project.
The evaluation team repeatedly comes back to the lack of a baseline study as a necessity for the project design, establishment of indicators and evaluation. From Blue Cross Norway's side this project is built on the previous decentralization project. Mentioned project did an extensive feasibility study before starting three years earlier and given very limited recourses we did not chose to do a new large study after only three years. However, needs- and context analysis were done. Also, baselines are defined in different ways. In our perspective we requested a baseline as establishment of the starting point of chosen indicators. We therefore disagree to some of the foundation given by the evaluation team in this regard. In our opinion there are definitely challenges and weaknesses in the project, but we question whether a baseline -study in the regard the evaluation team is asking for is what would make the largest impact on the project results or design. That said, we do see that some of the stakeholders might not have been given enough opportunity to participate in the design or to give their input to expectations from the project, and this should be improved in the next phase.

Blue Cross Norway does also recognize the challenge of high quality M&E from the project, and area we have given great emphasis in our support to the partner. An unfortunate factor of high turnover in staff have increased the challenge of the project providing good enough data for monitoring. We are happy that our partner has been able to recruit staff with the ability to provide quality treatment, and training for policy. These qualifications have been prioritized above qualifications in project monitoring, a continuous challenge, but still a choice to which we agree. The lack of capacity in project management will continue to be addressed and improved.

Blå Kors Norge
Storgata 38
0182 Oslo

Telefon: (+47) 22 03 27 40
Telefaks: (+47) 22 03 27 41
e-post: post@blakors.no

Bankgiro: 3201.52.74165
Org. Nr. 962.323.855 Mva
www.blakors.no

We are grateful that Blue Cross Norway's contributions are appreciated. The family treatment trainings were well received and implemented. We do also see family treatment and support to parents as the very best way to provide treatment and support to children affected by adult's addiction problems. Our view in this differs from the one of the evaluator, but is built on extensive knowledge of the treatment sector.

We recognize the need for more follow up of clients, those who have been to prisons, and others, as well as a general need for income generating activities. This has mainly been due to a lack of resource, and therefore a conscious prioritization of what Blue Cross does best. As we do not expect more financial recourses into the project, we think this is best solved through searching cooperation with other organizations and public bodies with different competences and priorities.

The revision of the alcohol policy of Lesotho has provided a huge challenge for the project, particularly due to the unstable political situation in Lesotho, which changed a lot from the time the project was planned. The partner has therefore chosen an approach with a lot of mobilizing on public opinion and local communities. This has been very important to be able to keep some attention to the issue. We agree with the evaluation team that there is a need to increase effort to advocate also at a high- level of national policy making. No matter what main approach is taken, the fact that civil society in Lesotho is taking upon themselves the role of keeping attention to the need of a new policy is very important. If they are not, the policy in not likely to be revised, and the current policy, which was made with huge influence from the alcohol industry will continue as the legal framework in Lesotho.

This project is now entering into a final three – years exit phase. We will use the learnings from the evaluation to the best of our ability to support our partner to improve and to ensure sustainability of results and core activities for best for people and society of Lesotho.

Eva Frydenborg

Program manager, Blue Cross Norway

Blå Kors Norge
Storgata 38
0182 Oslo

Telefon: (+47) 22 03 27 40
Telefaks: (+47) 22 03 27 41
e-post: post@blakors.no

Bankgiro: 3201.52.74165
Org. Nr. 962.323.855 Mva
www.blakors.no