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Community-based TB Management:
Best Practices and Lessons Learned from the South Africa Small Grants Program

JULY 2013

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Pictures taken by: Tebogo Kekana

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Acronyms

3I's	Intensified Case Finding (ICF), Isoniazid Preventive Therapy (IPT), and TB Infection Control (IC) for people living with HIV
ART	Antiretroviral therapy
CAG	Community Advisory Groups
CBO	Community-Based Organization
DoH	Department of Health
DOTS	Directly Observed Treatment Short course
DR-TB	Drug-resistant tuberculosis
HCT	HIV Counselling and Testing
ICF	Intensive Case Finding
IPT	Isoniazid Preventative Therapy
LO	Life Orientation
MDR-TB	Multi-Drug Resistant Tuberculosis
MEC	Member of the Executive Council
MOU	Memorandum of Understanding
NGO	Non-Governmental Organization
NPO	Non-Profit Organization
OVSA	OneVoice South Africa
PMTCT	Prevention of Mother-to-Child Transmission
SABC	South Africa Broadcasting Corporation
SACTWU	South African Clothing and Textile Workers Union
SAMRC	South African Medical Research Council
STI	Sexually Transmitted Infections
SWHP	SACTWU Worker Health Programme
TB	Tuberculosis
TCE	Total Control of the Epidemic
URC	University Research Co., LLC
USAID	United States Agency for International Development
WHO	World Health Organization
XDR-TB	Extensively Drug Resistant Tuberculosis

The Twin Epidemics: HIV and TB in South Africa

Carrying the Weight of the World

Tuberculosis (TB) is an ancient illness, as old an humanity itself. As a curable disease, TB should belong to the past, but it is still very much part of our modern world. Today, TB continues to kill nearly 2 million people worldwide every year and infect around nine million. Thriving in impoverished areas of Africa, Asia, and Europe, TB ranks as the second leading cause of death from an infectious disease worldwide, after HIV.

South Africa has not been spared from the clutches of the disease. With one out of every 100 South Africans infected with TB in 2011, the country has the third largest burden of TB globally. The incidence of TB has increased by 400 percent over the past 15 years,[1] fuelled in large part by the HIV epidemic, one of the worst in the world where close to two in 10 adults are living with HIV and AIDS.

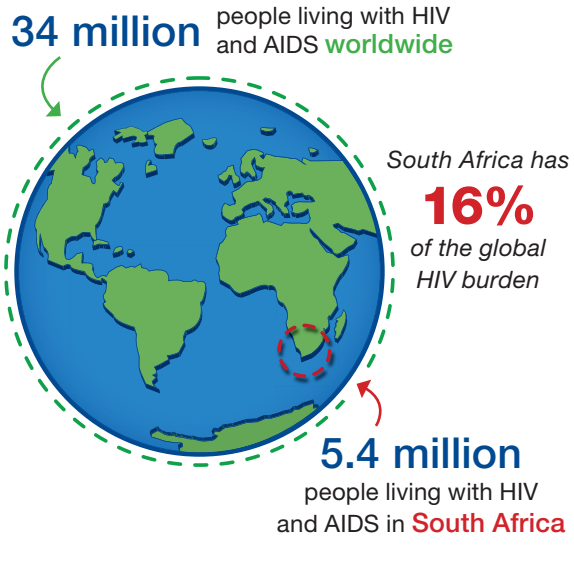
A Deadly Marriage

An easily transmitted airborne disease that strikes particularly those with weakened immune systems, TB has united with HIV in a deadly marriage. People living with HIV are up to 37 times more likely to develop TB than those without HIV.[2] TB is also a major cause of death among people living with HIV and AIDS.

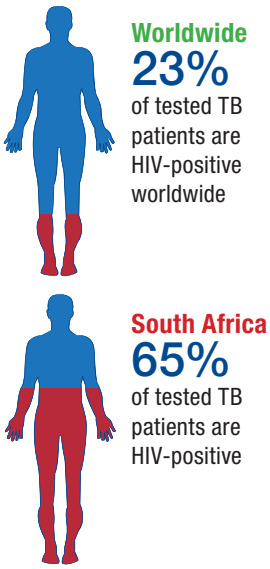
In 2011, 389,974 South Africans were diagnosed with TB, and 65% of tested TB patients were found to be HIV-positive, a rate much higher than the Africa region average of 25% and the global average of 24%.[3]

Snapshot: South Africa's TB and HIV Burden

People living with HIV and AIDS (2011)



TB Incidence (2011)



TB-HIV Co-infection (2011)

Source of data: UNAIDS. World AIDS Day report 2012; WHO. Global Tuberculosis Report 2012.

[1] National Strategic Plan on HIV, STIs and TB, 2012-2016, South Africa
[2] Towards a tuberculosis-free world, Advocacy Report, IFRC and Stop TB Partnerships, March 2011
[3] Global Tuberculosis Report 2012, WHO

Drug-resistant TB

Drug-resistant (DR) TB is also a growing concern in South Africa, especially in the context of HIV/TB co-infection. Despite an advanced public health system and far greater capacity for TB drug resistance surveillance than any other sub-Saharan country, the HIV epidemic has overwhelmed and disrupted the national TB control programme. This has led to increases in TB treatment failure and default and greater opportunities for drug-resistant TB to emerge and spread among HIV-infected and uninfected people.

In 2011, 17 per cent of the world's notified multidrug-resistant TB (MDR -TB) cases came from South Africa.[4] KwaZulu Natal, Eastern Cape and Western Cape provinces have emerged as the hotbeds of MDR-TB and extensively drug resistant TB (XDR-TB) infection in the country.

Action

The World Health Organization (WHO) has singled out 22-high burden countries that account for the vast majority of the world's TB cases. These countries are a particular focus of TB control efforts. South Africa is one of them.

For the past decade, a concerted effort to reform TB control in South Africa has resulted in changes in case-finding and treatment policies, standardization of recording and reporting systems, and monitoring of the performance of control programmes using pre-defined indicators; these changes were all made in line with the internationally recommended Directly Observed Treatment Short course (DOTS) strategy. The DOTS strategy has been expanded to all nine provinces, covering 183 health districts.

Comprehensive management of patients with MDR-TB became a national policy in 2000 in South Africa. More recently, the Department of Health (DoH) has begun decentralizing the management of drug-resistant TB to 'provincial centres of excellence' and satellite MDR-TB units, coupled with community-based treatment and care.

In 2004, WHO released a policy on TB and HIV collaborative activities aimed at reducing the joint burden of TB and HIV. South Africa adopted the policy and updated its guidelines on collaborative activities in 2012. The interventions in the policy include the 3I's (intensive case finding—ICF isoniazid preventative therapy—IPT, and infection control), HIV counseling and testing (HCT), prevention of opportunistic diseases and antiretroviral therapy (ART).

One of the goals of the current National Strategic Plan on HIV, Sexually Transmitted Illnesses (STIs) and TB (2012–2016) is to reduce the number of new TB infections and deaths from TB to half by 2016. Among the strategies to achieve are: ICF; TB infection control; workplace health policies on TB and HIV; provision of IPT; prevention of MDR-TB; and reduction of TB-related stigma. In addition, the strategic plan prioritizes testing and screening for HIV and TB, improved contract tracing, early diagnosis and rapid enrolment into treatment, and integration of HIV and TB care in the healthcare system.

Challenges

Despite efforts to strengthen TB control in South Africa, TB incidence and death rates have increased, MDR/XDR-TB is on the rise and treatment success for new smear positive TB cases is 79 %, less than the set target of 85%. Key challenges are:

- HIV and TB-related stigma
- Migration and massive growth in informal urban settlement, which leads to treatment failure and loss in follow-up
- Large number of treatment defaulters
- Poor infection control in hospitals and health clinics
- Not enough health workers in overcrowded health facilities
- Weak management capacity to deliver TB and HIV services effectively
- Weak community healthcare programmes
- Inadequate TB diagnostics, especially for advanced stages of HIV
- Lack of community understanding of TB, HIV and basic infection control

A dynamic and exceptionally strong collaboration between HIV and TB control programmes is required to avert large-scale HIV-associated epidemics of TB and DR-TB.

[4] Ibid.

USAID TB Small Grants Program

The TB Small Grants Program is part of the United States Agency for International Development (USAID) TB Program South Africa that supports the South African DoH to improve TB and HIV treatment and management in line with the goals of the National Strategic Plan for HIV, STIs and TB (2012–2016). The TB Program South Africa is a five-year program implemented by the University Research Co., LLC (URC). In South Africa, the USAID TB Program supports community organizations to increase demand for and availability of TB and TB/HIV services in partnership with the South African National TB Control Program, district health managers, and other local agencies. Our work also includes the integration of appropriate advocacy, communication and social mobilization that extend to community dialogues and use of mass media to help people recognize the symptoms of TB and HIV, test early, adhere to treatment and to take infection prevention and control measures.

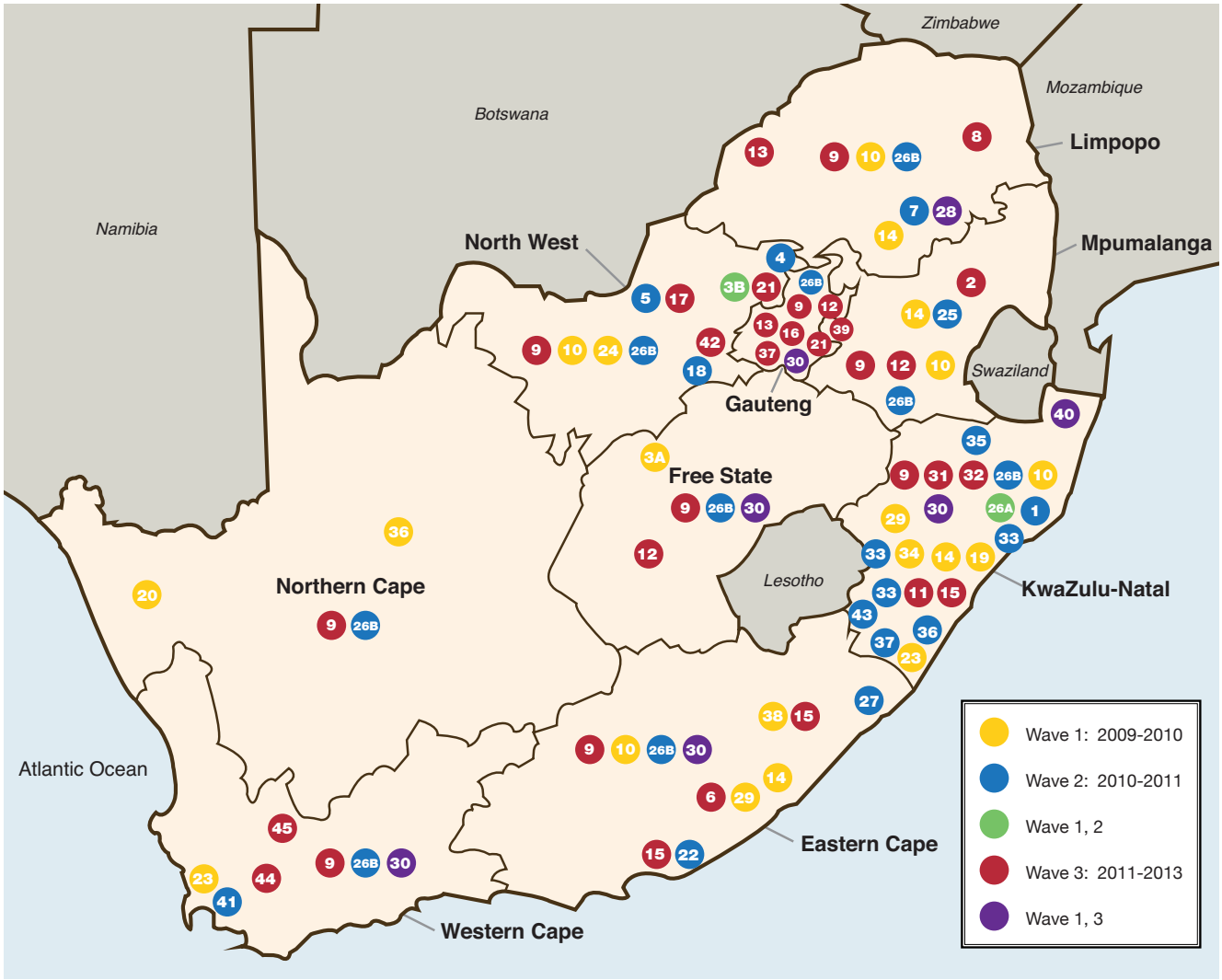
By April 2013, the TB Small Grants Program has provided funding to 41 non-profit organizations in all nine provinces of South Africa. Additional non-governmental organizations (NGOs) are in the process of still being funded. The NGOs carry out a range of technical activities that involve:

- Identifying TB suspects, and referring them for screening, diagnostics and treatment
- Tracing defaulters and contacts
- Creating community support to help patients stay on treatment
- Reducing stigma and encouraging people to seek testing and treatment early
- Strengthening advocacy, communication, and social mobilization in local communities on TB and HIV
- Strengthening services for TB/HIV co-infected people

From 2009 – 2011, the funded NGOs have:

- Reached over 950,000 people through TB and HIV communication and awareness raising activities (schools, churches, work places, door-to-door education) promoting TB and TB/HIV testing, raising awareness on TB and TB/HIV co-infection;
- Screened over 370,000 people for TB;
- Identified around 28,000 TB suspects;
- Offered HCT to 15,000 TB patients and
- Tested 8,000 TB patients for HIV

Grants are given to local community- and faith-based organizations, as well as larger NGOs with a proven track record or interest in the area of TB and HIV management. This report provides case studies of several of the NGOs that were funded from the beginning of the project in 2009 until the end of 2012.



Grantees

The USAID TB Program funding model is structured in periodic waves (see legend on Map).

1	AmakhumbuzaCommunity Development and Health Care Center
2	Arthur Seat Home Based Care
3A	Aurum Institute 3-I's
3B	Aurum Institute DCS
4	Baptist Body or Christ Ministry Orphan and HIV/AIDS Care
5	Bright Future HBC
6	Catholic Diocese of PE
7	Centre for Positive Care
8	Community Responsiveness Program
9	DENOSA
10	Desmond Tutu TB Centre (DTTC)
11	Eyaluth Development Unit
12	Footballers for Life
13	Get Down Productions
14	Humana People to People
15	Impangele Projects
16	International Labor Organization
17	Killer Disease Targeter
18	Mamosa Home Based Care
19	Medical Care Development International
20	Namakwa Development Foundation
21	Nkathalo Wellness Program
22	Octavovect Association
23	Operation Hunger
24	Perinatal HIV Research Unit
25	Phaphamani Home Based Care
26A	Philanjalo ICF
26B	Philanjalo (MDR)
27	Quakeni Empowerment Centre
28	Reach for Life HBC
29	SA Catholic Bishops Conference
30	SACTWU
31	SAMRC/GeneXpert
32	SAMRC/MDR
33	SAMRC/OVSA
34	Siyaphila Youth Support Services
35	Siyathuthuka Women's Group
36	Siyazama Youth Development Centre
37	Sustainable Livelihoods Foundation
38	TB HIV Care Association
39	Thabo Mwale TB Foundation
40	Tholulwazi Usivikele
41	Touching Nations
42	Tshepang Caregivers Project
43	Turn Table Trust
44	Wagon of Hope Foundation
45	Witzenberg Community Care

CASE STUDIES

KwaZulu Natal

Amakhumbuza Community Development and Healthcare Centre

Amakhumbuza at a glance

Established: 2005

Location: Matshana Village, uMhlathuze District, KwaZulu Natal province

Focus area: HIV counselling and testing, TB management and home-based care

Funding period: August 2011 – September 2012

Just over an hour's drive north of Durban lies the town of Empangeni in the heart of one of South Africa's main sugar producing areas. A short distance from the city centre passed sugar cane farms and along a road of bright red mud, is a turquoise coloured building that houses the Amakhumbuza Community Development and Health Care Centre. The centre is a hive of activity, its main office covered from floor to ceiling with hand-written work plans, quarterly progress reports, graduation pictures and the organization's vision and mission statement.

Amakhumbuza is a non-profit organization (NPO) based in Matshana village in uMhlathuze sub-district. It provides three core and integrated services: HIV counselling and testing (HCT), TB management and home-based care.[5] In fact, it is the only community-based organization (CBO) in the sub-district working in TB management.

David Cele registered Amakhumbuza in 2005. As a member of the nearby Lutheran Church, David had been involved in charity work through a church committee. This inspired him to expand his efforts and start addressing the intertwined HIV and TB epidemics that were killing many of his fellow villagers. "I felt that something was missing. I had to do something more and knew that I have the power to move beyond the boundaries of the Lutheran church community," said David.

The USAID TB Program South Africa provided support to Amakhumbuza to provide integrated HIV and TB services between August 2011 and July 2012. During the funding period, Amakhumbuza's community outreach

[5] The home-based care component of Amakhumbuza's service provision is not supported through funding from the USAID TB Program South Africa and will not be detailed in this case study.

Amakhumbuza's community outreach programme covered two wards of uMhlathuze sub-district with a population of more than 11,700 people, and for certain activities, the NGO serviced an even wider area of up to 50,000 people.

programme covered two wards of uMhlathuze sub-district with a population of more than 11,700 people, and for certain activities, the NGO serviced an even wider area of up to 50,000 people. The team at Amakhumbuza included a project manager (David Cele), a coordinator, secretary, treasurer, professional nurse, lay counsellors and community caregivers.

TB Management

Amakhumbuza provided a range of services in TB management: case finding, TB screening, sputum collection from suspects, tracing of contacts and defaulters, health education, DOT support by community caregivers, and HIV and TB awareness campaigns in schools, churches and community.

Case finding, TB screening and sputum collection were done in Amakhumbuza's health center and in the community through door-to-door campaigns, visits to farms and schools and through church-related community outreach. All HIV-positive clients were screened for TB and all TB clients were counselled to take an HIV test. Children were also screened and tested for TB. People who could not produce sputum were referred to Ngwelezana Community Health Centre or Ngwelezana District Hospital in Empangeni, 10 kilometres away from Amakhumbuza health centre. David Cele transported the sputum samples to the clinic and then collected the results three to four days later. Amakhumbuza provided a referral letter to clients with TB so that they could be initiated on treatment through the government public health system. HIV-positive clients were also encouraged to take IPT, a key intervention recommended by WHO to prevent and reduce active TB in communities affected by HIV and AIDS.

The organization also provided treatment adherence counselling and its 10 Community Care Givers implemented community DOT. All TB clients were registered on Amakhumbuza's TB register and could be followed-up easily. The caregiver-client relationship was one of trust and support. Both parties agreed on a time for the daily home visit and caregivers also educated family members on how to support the DOT process. Other strategies to support client's medical regimes included advising them to set their cellphone alarms as reminders to take their medication at the same time every day.

To minimise defaulting, Amakhumbuza worked closely with the DoH by having access to Ngwelezana Community Health Centre's list of defaulters, comparing it with its own TB register and then conducting follow-up home visits. Alcoholism is a major cause of treatment interruption in this area.

HIV Counselling and Testing

Amakhumbuza's lay counsellors provided pre- and post-HIV test counselling and the nurse conducted rapid HIV testing through daily home visits in the community, visits to surrounding farms and at the Amakhumbuza health clinic. The team covered on average five households every day.

For people who tested HIV-positive, the lay counsellors encouraged them to go to the organization's clinic where the nurse took their blood for CD4 count measurement and referred the patient to the Ngwelezana Community Health Centre for further management. David drove the

"We make sure that there are no gaps, that the results are not lost."

David Cele, Project Manager

blood samples to the clinic himself, which were then sent to the laboratory at Ngwelezana District Hospital. It took two weeks to get the results and David drove back to the clinic to pick up them. "We make sure that there are no gaps, that the results are not lost," said David proudly. The lay counsellors would follow up clients in their homes, provide them with the results and counsel them.

Another unique feature of their programme was that, through USAID TB Program South Africa funding, Amakhumbuza was able to employ a qualified nurse. This meant that the organization could bring integrated HIV and TB services closer and faster to the community while easing the workload at Ngwelezana Community Health Centre. A further innovation was the provision of ART literacy classes at home for bedridden patients, as well as in the NGO's health centre for those who were mobile. The classes help to improve understanding of, and promote adherence to HIV treatment.

Community Awareness Campaigns

Public demand for HCT and TB screening was created through awareness raising campaigns in congregate settings such as schools, churches and community meetings and/or through door-to-door campaigns. These events were also used to provide health education on HIV and TB. Amakhumbuza worked in partnership with ward counsellors and traditional and faith-based leaders to make sure that there was community buy-in and support.

Key Project Achievements

- 14,921 people were screened for TB through symptomatic screening process, and 1720 identified TB suspects were screened through sputum smear testing.
- 144 smear positive pulmonary cases of TB were detected.
- 2,077 teachers and students were reached through TB and HIV communication and awareness raising activities in schools.
- 15,123 people were reached through door-to-door education on TB and HIV.

KwaZulu Natal

Impangele Projects

Impangele Projects at a glance

Established: 2003

Location: Durban, KwaZulu Natal province

Focus area: Educational community radio programming and theatre

Project supported by USAID TB Program South Africa: Singayinqoba iTB radio and live dramas

Funding period: 2009 – 2012

"It's not so important what you say as how you say it," said Vela Xulu, managing director of Impangele Projects, an NGO based in Durban, KwaZulu Natal supported by the USAID TB Program South Africa. Impangele works with community radio and live drama in poor and remote areas in KwaZulu Natal and Eastern Cape provinces to lower stigma and unravel misconceptions around TB and HIV. Radio and community theatre are effective modes of communication in these areas where illiteracy rates are as high as 60 percent.

KwaZulu Natal and Eastern Cape are South Africa's hotspots for TB, as well as for TB and HIV co-infection. According to statistics released by the Electronic TB Register for the third quarter of 2012, the two provinces had the highest number of TB patients. Likewise, 1 in 2 TB patients in Eastern Cape and more than 7 in 10 in KwaZulu Natal were living with HIV and AIDS. Myths and misconceptions about TB abound, from the belief that witchcraft is responsible for causing the disease to not knowing that TB medication needs to be taken every day.

The Power of the Spoken Word

Community radio is a key feature of the South African broadcasting landscape. Today, there are more than 170 community radio stations throughout the country, broadcasting in local languages to 31 million South Africans.[6] Their scope and reach varies greatly, but they are able to target specific audiences with content that is local and relevant in a way that commercial and mass media broadcasters are unable to do. Impangele Projects (Impangele), with its long history in producing, broadcasting and disseminating educational radio dramas, uses community radio to make a difference in the fight against TB and HIV.

Vela Xulu, an award-winning writer from Durban, founded Impangele in 2003. Inspired by storytelling and the oral traditions of South Africa, Vela started writing radio soaps in high school. "With us Africans, we sit around fires

[6] Data from the South African Audience Research Foundation, RAMS 2012, June 2012.

with our elders or grannies telling us stories," said Vela. He continued to write during the height of Apartheid, and scooped an Artist's Award from the South African Broadcasting Corporation (SABC) for a 35-episode radio drama series on then-outlawed interracial marriages. In 2006, Vela met Canadian-born Warren G. Bessey, a production specialist who had produced more than 1,000 radio dramas, and they started working together.

"Vela and I have a combination of gifts that we have merged to do something good," said Warren. "Vela is a very gifted writer and when people listen to his radio dramas, they pull them into their minds. My gift is that I research an issue, find a solution and then Vela puts it into a communication format that is well received."

With funding from the USAID TB Program South Africa, Impangele produced three radio dramas on TB between 2009 and 2012. Each radio episode was 7–10 minutes long and was broadcast once a week. An entire radio programme ran for 40 episodes. The radio dramas were aired on 11 community radio stations in six districts in KwaZulu Natal, with a listening audience of about 1.2 million people.[7] In Eastern Cape, the programmes were heard by close to 800,000 people listening to seven community radio stations.

The stories centred around issues such as defaulting on TB treatment, and the importance of working with traditional health practitioners as DOT supporters. Listeners were able to call in after the programme, and their questions were answered by trained radio presenters or medical experts from the DoH and other invited guests. "We have a good relationship with the Department of Health, and their communication officers," said Vela. He was also fortunate to have a relationship with the traditional leadership in KwaZulu Natal and was able to get consent from the royal family to write about sensitive subjects. Also playing a key role in shaping the stories was USAID TB Program South Africa staff. Before the radio programmes went on air, Impangele sent storylines, scripts and recordings to the project headquarters in Pretoria for review and feedback.

Anecdotal evidence showed that the radio dramas were well received and strengthened the quality of community radio programming. "Community radio must be community-driven and address community issues," said Vela. "Many, however, do not have the capacity to produce local content and end up predominantly as music stations. Our radio dramas have been used to beef up their content, something they appreciate very much."

> *"With us Africans, we sit around fires with our elders or grannies telling us stories."*
>
> Vela Xulu, an award-winning writer from Durban

Ice Breakers

A complementary activity to the community radio programme was live dramas on TB and HIV. They provided easy-to-grasp information on issues such as TB and HIV co-infection, signs and symptoms of TB, infection control, stigma and adherence to treatment. These performances functioned as 'ice breakers' for URC community mobilization activities and also boosted community attentiveness to and receptiveness in absorbing key messages on TB and HIV. With funding from the USAID TB Program South Africa, Impangele organized five live dramas in community halls, taxi ranks, shopping centres and other areas where large numbers of people congregated in rural areas of KwaZulu Natal and Eastern Cape. The activities, which have reached

[7] Ibid.

"The airing of the drama has had a positive impact on the strengthening and widening the approach to TB in South Africa."

Ms. N.T. Sopiseka, Eastern Cape District Manager

5,500 people, were linked to related community events such as community dialogues, public TB screening campaigns and commemorations of World AIDS Day.

Measuring Impact

In 2011, Impangele partnered with Human Health Development Trust to conduct a field evaluation of the effectiveness of the community radio programme in four high TB prevalence/incidence urban and rural areas of KwaZulu Natal and Eastern Cape. The first Knowledge, Attitudes and Practices (KAP) assessment was done in January before the radio drama was played on air. This was followed by a series of radio dramas and a second KAP survey in June. The same individuals who were interviewed before the programme were followed up after the broadcast.

The results demonstrated that Impangele was able to a successfully improve understanding and knowledge of TB-related issues, a key step towards changing people's behaviour. During the second post-broadcast survey:

- 98% of interviewees did not feel embarrassed that they had TB, compared to the baseline survey of 61%.
- 97% of people no longer believed TB was passed through witchcraft compared to the baseline survey of 38%.
- 100% agreed that TB was transmitted through air, compared to 65% during the baseline survey.
- 98% of people agreed that drinking alcohol while taking TB medication was a problem, compared to 45% during the baseline.

Another key success of the program was significantly improved relationships between the DoH and community radio stations. "The airing of the drama has had a positive impact on strengthening and widening the approach to TB in South Africa," said Ms. N.T. Sopiseka, Eastern Cape District Manager. "The drama is addressing the challenges that we have in terms of TB management—late presentation of our clients in health facilities due to the stigma attached to TB and HIV."

KwaZulu Natal

South African Medical Research Council *and* One Voice South Africa

South African Medical Research Council at a glance

Established: 1969

Location: Headquarters in Cape Town, Western Cape with regional offices in Pretoria and Durban, an a office in Johannesburg

Focus area: Improvement of the health and quality of life of South Africans through research, development and technology transfer. Strategic areas include HIV and AIDS, TB, malaria, cancer public health search, nutrition, health promotion and traditional African medicine.

Project supported by USAID TB Program South Africa: A schools-based programme to increase awareness of TB/HIV and early case detection of TB

Funding period: August 2011 – November 2012

One Voice South Africa at a glance

Established: 2009

Location: Head office in Durban, KwaZulu Natal province

Focus area: Engaging young people on TB and HIV/AIDS through advocacy and education

Project supported by USAID TB Program South Africa: A schools-based programme to increase awareness of TB/HIV and early case detection of TB

Funding period: August 2011 – November 2012

Increasing case detection of TB, improving cure rates and implementing an integrated approach to TB and HIV management have become focus areas of the national TB programme in South Africa. One approach that could make an impact on increasing case detection of TB is to raise the awareness of TB and HIV at schools.

With this in mind, the USAID TB Program South Africa funded a partnership between the South African Medical Research Council (SAMRC) and OneVoice South Africa (OVSA) to increase the awareness of TB and HIV and to enhance early case detection of TB by involving high school learners in an integrated TB and HIV intervention.

"If we want to ensure that we are providing young people in South Africa with what they need, we can't see the HIV epidemic in isolation. All interventions have to look at an integrated approach," said Marlijn van Berne, the acting manager director for OVSA.

During the funding period, the joint SAMRC/OVSA project offered an intense educational TB and HIV programme over one year. The programme also included training and supporting teachers at the selected schools and community healthcare workers around the selected schools to screen for TB and refer suspects for testing and other services.

SAMRC and OVSA were responsible for different phases of the project. As OVSA predominately dealt with awareness and education, they decided jointly with SAMRC that it would be best if OVSA covered the first part of the project—working with learners to raise their levels of knowledge of TB and HIV. SAMRC would then take over

and work with teachers to see which learners needed testing and how they could access testing and treatment services. In addition, SAMRC set-up a community-based mechanism to involve communities surrounding schools in the project.

The Schools Programme

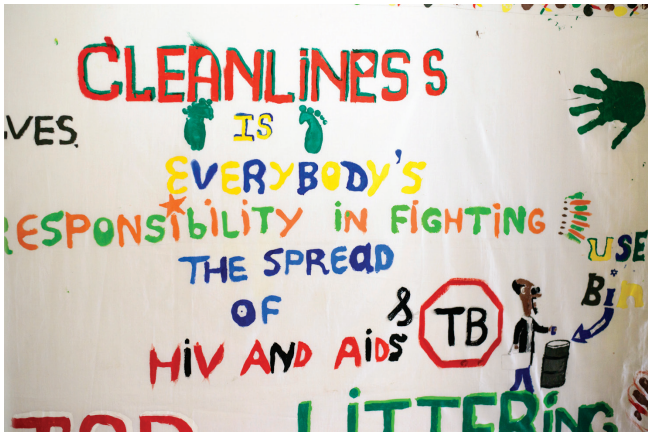
With funding from the USAID TB Program South Africa, the schools programme consisted of a series of 14 workshops in 15 schools in two townships and a rural site in KwaZulu Natal – eThekwini (KwaMashu and Umlazi townships) and Ilembe (Ndwedwe). The workshops were offered to Grade 8 learners, most of who were between the ages of 13 and 19. The choice of Grade 8 was based on a 'window of opportunity' to stop the transmission of TB and HIV. Marlijn explained: "The main aim is that we wanted to work with adolescents and we felt that Grade 8 was possibly just before sexual debut. And we felt that adolescents are on this journey from childhood to adulthood. That journey can be seen as a time of risk but we see it as a time of opportunity. That is a very good time to capture their attention."

> *"When we talk about TB in the classrooms, it's something new. You can find that some learners are infected with TB but they don't know it."*
>
> OVSA Facilitator

The TB and HIV programme was integrated into the compulsory high school Life Orientation (LO) curriculum. It complemented what was already being taught by providing a more in-depth look at some of the issues presented in the LO curriculum.

"In the initial stakeholder meetings where we introduced our programme, we emphasized that we are in support of LO not a replacement," said Marlijn. "Because these issues are so seriously affecting young people on the ground, the extra support element is necessary."

Stakeholder meetings were held twice a year with school representatives (principal, LO teachers, school governing body member and a Department of Education representative). School-specific 'mini' stakeholder meetings took place at the beginning of the year, and district-level major meetings happened at the end of the year. The



end-year meeting was a feedback session on progress made, challenges encountered and recommendations for future activities. OVSA also signed a memorandum of understanding (MOU) with the Department of Education and the participating schools. "The MOU is a very valuable tool," said Marlijn. It endorses our programme and gives us an entrance into schools."

A team of seven OVSA facilitators ran the school workshops. The facilitators were young people who had post-secondary education and experience of working with young people. They worked in schools from Monday to Thursday, covering four Grade 8 LO classes per day each. Fridays were spent on report writing and feeding information back to management. According to 30 year-old facilitator, Delisile Mdabe, "When we talk about TB in the classrooms, it's something new. You can find that some learners are infected with TB but they don't know it."

All OVSA staff members were trained in TB mainstreaming by Actwo Training, a company that also helps OVSA develop their training and learning material. The Facilitator Manual and Learner Notebook are reviewed annually by Actwo Training to make sure that they were in line with the LO curriculum, the national response to HIV and TB, and the experience of learners on the ground. OVSA staff also get refresher training every year.

As part of OVSA's monitoring activities, learners wrote three assessments a year on the TB and HIV programme and those results counted towards their overall LO mark for year. "Our programme is endorsed and recognized as being of a certain standard," said Marlijn. "Our outcomes are used for learners' overall outcomes." The assessments were also a tool to check if learners understood the concepts explored in the workshops and were able to

apply them in their daily lives. In addition to the learner assessments, provision was made for learners and teachers to feedback on the schools programme.

According to Marlijn, there were a number of challenges, including the uncertainty of funding. “We don’t want to be about just reaching numbers; we want to implement a quality programme. We would love to expand in each school, and we have taken on extra classes in schools. Our vision is to expand into the other grades but not outside of this province and not outside of these schools at this stage. Our resources are limited and the programme is very dependent on external funding.”

Linking Learners and Community Members with Health Services

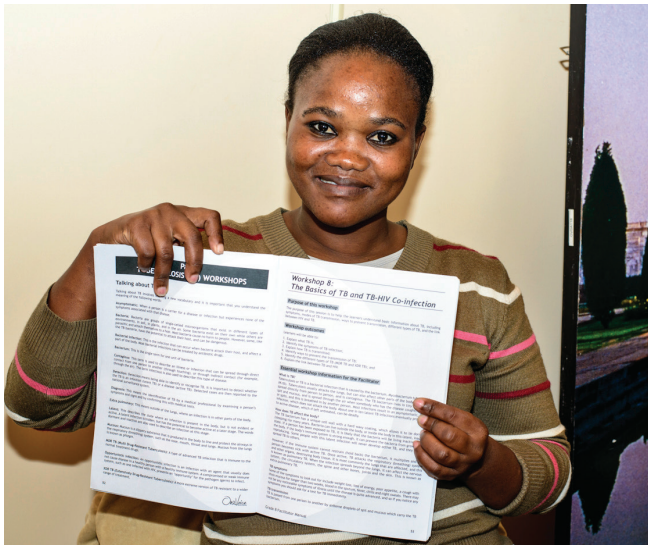
Once learners were empowered with knowledge and skills on TB and HIV, SAMRC stepped in and worked with teachers and community health workers around the participating schools to promote early TB detection. Teachers and community health workers were trained to detect TB suspects in classrooms and communities and

> *“It has been a very good programme, especially as it helps the learners to know more about HIV and TB.”*
>
> Teacher comment

refer them for testing at local health clinics. A key vehicle to establishing the link between schools/communities and the primary healthcare system was the community advisory groups (CAGs), which SAMRC helped to establish in Umlazi, KwaMashu and Ndwedwe.

CAGs were committees or task forces made up of key role players from the community who commit themselves to early TB detection and ensuring the welfare of their communities. CAG members were trained on TB and HIV, as well as on organizational management, and SAMRC helped them to register as non-profit organizations so that they could fundraise on their own and become sustainable. CAGs were involved in a range of activities, from TB screening campaigns and awareness days to helping orphaned learners access food parcels.

Another innovation was the creation of ‘mini-CAGs’ at school level. Composed of representatives from the school



boards, learners, teachers, the main CAG, local councillors and the Department of Health, mini-CAGs were responsible for taking care of the health of the school and the surrounding community. The members were also trained on TB screening, referral and follow-up. Like the bigger CAGs, the mini-CAGs will also ensure that once SAMRC leaves, the important work done so far will continue.

Key Project Achievements

- 15 schools and a total of 2,486 learners were reached with TB and HIV education.
- 350 teachers and 81 community health workers were trained to identify and refer TB suspects.
- 84% of teachers and learners had measured improvements in attitudes, beliefs and knowledge of TB and TB and HIV co-infection.
- 576 people with presumptive TB were identified and referred for diagnosis; 126 were smear positive—16 of these were learners and 110 community members.
- 100% of smear positive pulmonary TB cases were provided with treatment.

According to written responses from teacher feedback forms, a teacher commented: “It has been a very good program; especially as it helps the learners to know more about HIV and TB. It has also helped the LO teachers”. Another teacher pointed out that the impact was felt beyond the schools: “The information on TB gained by learners is communicated even at community level.”

KwaZulu Natal

Philanjalo

Philanjalo at a glance

Established: 1998

Location: Tugela Ferry, Msinga sub-district, KwaZulu Natal province

Focus area: Integrated management of HIV and TB in remote rural areas

Projects supported by USAID TB Program South Africa:

1. Intensified case finding in congregate settings
2. MDR-TB community management national rollout

Funding period: June 2010 – April 2013

In 2006 the medical community in South Africa was confronted with one of its worst fears, the emergence of a virulent strain of drug resistant TB—XDR TB (extensively drug resistant TB)—that quickly led to the death of almost every person it infected. Most alarmingly, the outbreak of XDR-TB emerged in Tugela Ferry. A small rural town in Msinga sub-district in central KwaZulu Natal province, the epicentre of the HIV epidemic. As the news made headlines across the world, Tugela Ferry became ground zero for the lethal convergence of HIV and XDR–TB, and subsequently, for intense efforts to better manage HIV and TB co-infection.

Msinga is inhabited by around 180,000 rural Zulu people, most of who follow a traditional way of life. A large proportion of households are led by women. Services are poor—70% of people have no access to clean water or electricity—and the majority of people are unemployed. A third of pregnant women attending antenatal care are living with HIV and AIDS.

In such an under-developed context, the prospects for those with HIV and TB are bleak. A significant factor in the high levels of HIV and TB illness in Msinga is that people delay in getting treated. Men in particular only seek medical attention when they become very sick. By then their chances of survival are slim. In such an environment, it is crucial to introduce people into care quickly, with HIV and TB patients receiving care where possible in the community.

Integrated TB and HIV Care in Remote Rural Areas

Philanjalo, a local NGO based at Tugela Ferry, was established in 1998 to mitigate the impact of HIV and AIDS in this remote and poor area. They provided home-based care, voluntary counselling and testing and the management of opportunistic infections in the years before the launch of the South African national antiretroviral programme. This was done in partnership with the DoH to provide a continuum of care for patients from hospital to home.

Prior to the XDR–TB epidemic, in 2002 and 2003, Philanjalo and its partners first demonstrated that TB and HIV care could be integrated with successful outcomes in rural and low-resource areas. Following the epidemic, the programme became a demonstration site for integrated care and treatment for MDR/XDR TB and HIV co-infection.

"It is important to find people early on in the disease so that when they are still walking around looking healthy, they can be diagnosed and put on treatment and care quickly."

Mdu Mntambo, project manager for ICF at Philanjalo.

Intensive Case Findings

The USAID TB Program South Africa provided funding to Philanjalo to pursue ICF and voluntary HCT in congregate settings. The specific aims were to: identify people with HIV, TB and MDR/XDR TB at community level; improve access to clinical care for HIV- and TB-positive patients by facilitating entry into the healthcare system and helping remove transport cost barriers; and integrating HIV and TB services at clinical care and community levels.

"It is important to find people early on in the disease so that when they are still walking around looking healthy, they can be diagnosed and put on treatment and care quickly," said Mdu Mntambo, project manager for ICF at Philanjalo.

This integrated approach to TB and HIV was delivered as an outreach service in Msinga, including pension pay points, taxi ranks, special municipal events, prisons and schools. A branded mobile clinic, manned by a team of health and field workers, including a professional nurse, was parked at or near the location or event.

"We use posters, megaphones and we mingle with crowds to talk about HV and TB and point them to the van," said Mdu. "During municipal events, we get 5 to 10 minutes on the podium to introduce our services."

Interested members of the public came to the van for a health education session where they were given information on both TB and HIV. A screening questionnaire was completed, which asked questions on symptoms of TB and HIV. The client was then counselled before and after the rapid HIV test and/or sputum collection. If the person was found to be HIV-positive, blood was drawn for a CD4 count test. The sputum samples were sent to the district hospital, Church of Scotland Hospital in Tugela Ferry, for smear and culture testing. Because of the high rates of XDR TB in the sub-district, Msinga has a special agreement with the DoH to conduct smear, culture and drug susceptibility testing on all submitted sputum samples from TB suspects.

Philanjalo kept a record of all client information, including test results. If the client needed to be referred to a government health clinic or hospital, the mobile health team provided him/her with a referral letter. Philanjalo tracked the client for six months, with weekly phone calls or home visits. In cases where they could not get hold of the client, Philanjalo did a home visit and made sure that the client had been for medical treatment. Philanjalo also worked closely with the DoH's TB DOTS office to ensure that TB patients received support in adhering to their treatment. Philanjalo also provided money for transport to the health clinic or hospital for the first two to three visits in situations where a client could not afford the cost.

Working with Other Partners

Philanjalo's access to the population in Msinga, its ability to cover such a remote area and the success it had in linking services was enhanced by its partnership with the DoH, the office of the Member of the Executive Council (MEC) and local government. One example of this was that at the beginning of the year, Philanjalo was sent a schedule of municipal events so that it could prepare its ICF activities accordingly. Philanjalo was also a respected and trusted service provider in the community, a reputation gained through its long-standing network of more than 60 home-based care workers.

"We work with diverse stakeholders, which makes referral easy," said Mdu. "When we screen clients for TB and HIV, we find for example, that someone is very poor and struggling, and we then refer them to relevant services through our partnership with local government."

The district health office requested Philanjalo to expand its ICF activities beyond Msinga and the organization began training and mentoring other NGOs to carry out the work. There were, nonetheless, several challenges.

"Awareness of TB is still not good. You sometimes identify a TB client but they don't go for treatment. You have to nudge them," said Mdu. "But that can be a challenge as we work in areas with very poor roads and infrastructure."

Key Project Achievements for ICF

With financial and technical support from the USAID TB Program, Philanjalo was able to achieve the following results for ICF:

- Philanjalo held 166 community-based screening events during the complete project period.
- An estimated 13,000 people received health education on TB and HIV at various sites in Msinga.
- A total of 2,226 people were screened for TB.
- TB symptoms were reported in 352 clients. Among these, 213 were able to produce and submit sputum for TB culture and/or smear testing. Among these 213 presumptive TB suspects, two were smear positive and 13 were culture positive pulmonary TB cases. They were all put on treatment. Of the 13 culture positive, two turned out to be MDR-TB and one XDR-TB. Ten of these 13 culture positive TB patients were also tested for HIV and three were diagnosed with HIV.

By having 'next steps' services (sputum collection, HCT and drawing of blood for CD4 count testing) on-site, Philanjalo was able to increase access to TB and HIV services in Msinga. This meant that clients did not have to spend precious resources on transport to the clinic, eliminating a key cost barrier to access. The organization's integrated HIV and TB case finding, coupled with the bundling of 'next steps' services was what made their approach unique.

Success Story

Holistic help for a distressed man

A 38-year-old man heard about Philanjalo's work during a community event and came to their offices for help. He had been losing weight over the past six months and was suffering from diarrhoea, swollen lymph glands and a loss of sensation in his hands and feet. Philanjalo staff screened him for TB but he could not produce sputum. He was taken to the COSH ARV clinic where they ruled out a diagnosis of TB. He was, however, identified as HIV positive. Philanjalo made sure that he attended ARV literacy sessions at the clinic and he was then started on ART.

The man was not only in poor physical health, he did not have an income and was very distressed. He had lost his parents and a stroke had paralysed the left side of his body. As a result, he could not find a job but needed to look after his two children and their mother. Philanjalo's social worker counselled him, provided him with a food parcel and referred him to the South African Social Security Agency for additional food vouchers and an application for a social grant. His grant was approved and he began received a monthly disability grant. The man returned to the Philanjalo offices to thank everyone and it was clear he felt much better and that his health was beginning to improve.

Community-based Management of MDR–TB and HIV

With support from various partners, Philanjalo and the DoH established one of Africa's first community-based management programmes for patients who are co-infected with MDR-TB and HIV. The goal is to improve treatment outcomes for MDR-TB and limit the generation and transmission of XDR-TB. This model, developed in uMzinyathi district in 2007 as part of an operational research project, was shown to help patients complete their treatment successfully and reduce the burden on

overcrowded hospitals. It involved establishing mobile injection teams comprised of nurses who conducted daily home visits to give second-line TB drugs by injection to their patients and observe doses of oral TB medications and ARVs. Philanjalo also designed an innovative treatment literacy education curriculum for patients and their family members to teach them the importance of medication adherence and how to prevent MDR-TB and HIV. Home visits provided close monitoring for any treatment-related adverse effects or disease progression.

From March 2011 to April 2013, the USAID TB Program South Africa provided funding to Philanjalo to start the process of scaling-up the MDR-TB decentralized model in eight provinces (Eastern Cape, Free State, Gauteng, KwaZulu Natal, Limpopo, Mpumalanga, Northern Cape and North West). This was done in line with the national policy on de-institutionalized management of MDR–TB.

Philanjalo also designed an innovative treatment literacy education curriculum for patients and their family members to teach them the importance of medication adherence and how to prevent MDR–TB and HIV.

Philanjalo provided targeted support to the 14 districts to assess their capacity to rollout the community-based MDR-TB management programme. This involved conducting situational analyses of all sites by looking at what resources, infrastructure and TB services were in place and what could be done to improve them. A total of 19 situation analyses were completed, with findings varying from site to site. For example, in Piet Retief Hospital in Mpumalanga, the facility was very active in TB care but the buildings that housed the HIV and TB units needed urgent renovation and much better infection control. Progress in the Nelson Mandela Bay Metro was slow and the guidelines for MDR community-based management had not yet been printed. There were also no focal TB nurses, vehicles or injection teams in place. There were, however, common challenges across all sites, including: inadequate infection control, referral systems and trained health workers. Recommendations were made to address these stumbling blocks.

A final activity involved improving the expertise of nurses, TB assistants and other health workers to carry out community-based management of MDR-TB. Philanjalo developed training material and tools and helped to train 617 health workers.

After two years of programme support, districts were in different stages of decentralization but progress was seen throughout the country. More than 2,000 MDR-TB patients were being followed in the community during injection and continuation phases, with uThungulu and Zululand districts in KwaZulu Natal recording the largest number of clients followed and injection team members trained.

The kind of comprehensive community-based MDR-TB management programme that Philanjalo has achieved in Msinga; however, takes a long time to build. According to Dr. Raymond Chimatira, project manager, “To really be able to rollout the programme we have in Msinga, it would take a few years. At the moment, there aren’t enough resources in many sites. The biggest challenge is dedicated staff to go out every day and look after MDR-TB patients.” Raymond felt that for long-term sustainability of the programme, there needed to be continuous engagement of provincial and district managers so that adequate resources were allocated to activities in high-burden districts.

Key Project Achievements for MDR

- Philanjalo facilitated 14 provincial and 22 district advocacy and capacity-building workshops on comprehensive community-based MDR–TB management by mid–April 2013.
- Around 539 provincial, district and sub-district managers and other participants benefited from the training. At the end of each workshop, each district or sub-district had developed a draft community MDR-TB plan.
- Trained 634 healthcare workers to provide comprehensive community-based MDR-TB services.

Eastern Cape

Octavovect Association

Octavovect Association at a glance

Established: 2005

Location: Nelson Mandela Bay Metro, Eastern Cape

Focus area: Improving access and continuum of care of quality TB and HIV services (with a focus on DOT support, default tracing and contact management); health worker capacity building; and nutrition (food gardens)

Project supported by USAID TB Program South Africa: Training, prevention, care, support and awareness programmes

Funding period: November 2011 – November 2012

"I felt that after I retired in 2001, I must do something for the community, plough back to the community."

Nonkosi Ndalasi, Octavovect Association founder and manager

Octavovect Association founder and manager Nonkosi Ndalasi defies her age. At 71, she goes about her day with the energy and passion of a much younger person. One gets the impression that nothing will stop this former nurse whose life-long calling has been to be of service to others. "I felt that after I retired in 2001, I must do something for the community, plough back to the community," said Nonkosi.

After working in East London with children who had defaulted on ART, Nonkosi started Octavovect in 2005 to address TB and HIV in three sub-districts (A, B and C) of Nelson Mandela Bay Metropolitan municipality in Port Elizabeth, the economic powerhouse of the Eastern Cape Province. Nelson Mandela Bay Metro faces a number of challenges, including an extremely high TB defaulter rate of around 30 percent in some of the facilities; a primary healthcare system overwhelmed by high patient caseloads; lack of capacity in clinics to conduct defaulter and contact tracing; weak case identification; and mobile populations that are difficult to follow-up such as contract workers in industrial areas and fishermen employed in the fishing industry.

"Defaulter and contact tracing are major gaps in the metro," said Thandeka Dayimani, the URC coordinator for Eastern Cape Province.

A Holistic Approach

With funding from the USAID TB Program South Africa, Octavovect partnered with 18 primary healthcare facilities in the three sub-districts and supported their TB clinics by providing DOT support, as well as defaulter and contact tracing. The financial support also allowed the organization

"When I ask Octavovect to help a clinic attend to its records, I find that the gaps are gone the following day."

Thandeka Dayimani, URC coordinator for Eastern Cape Province

to recruit 50 DOT supporters, three data capturers and three coordinators. Nonkosi stressed, however, that their approach extended beyond a specific mandate. "If you come to a house, you don't just inquire about TB. We also look around and we see if children have gone for their vaccinations. If there is a person with a mental disability, we also refer. Our approach is holistic."

She also emphasized that households needed to become self-reliant and generate their own income to support diagnosis and treatment. "Anyone can have TB. If we see that this house is poor, we encourage people to have a garden in their own back yard so that they can eat from their garden. They can also sell vegetables so that can get money to take a taxi to go to the clinic. People often say: "I didn't go to the clinic because I didn't have money."

Going the Extra Mile

Octavovect DOT supporters were identified through the local health clinics where they usually worked as volunteers. Once recruited by Octavovect, they were trained on integrated management of TB and HIV, including prevention of MDR–TB, sputum collection, treatment adherence and nutrition, and received a stipend. According to Nonkosi, her DOT supporters often went beyond their job description: "They often use their own money to buy food for their clients and help bath them. Our DOT supporters are so committed."

There were many reasons why someone decided to become a DOT supporter but having direct experience of the problem was a major motivator. Nosipho Cholani, the DOT supporter for sub-district B, was a volunteer at the health clinic in Soweto-on-Sea township before she joined Octavovect. "I also got sick with TB," said Nosipho. "I attended the clinic and after I was cured, I wanted to help other people understand how good the treatment is."

Strength in Record Keeping

A unique aspect of Octavovect's work was their data collection tools, which they developed themselves. A TB defaulter register recorded all aspects of a client's treatment history, whether they were relocated to another clinic, lost to follow up, died or went to prison. It also recorded the type of TB they had (normal, XDR, MDR, co-infection) and whether they were on ARVs. The contact register included information on the names of all contacts, relationship to index case, age, gender, number of TB symptoms, sputum collected and method of diagnosis. The daily patient treatment register was also thorough in its data collection, with information on diagnosis, treatment start dates, sputum results, list of drugs and presence of a home vegetable garden.

Octavovect's expertise in meticulous record keeping was being used to fill in gaps at the clinic level. In primary health facilities with poor record keeping, Octavovect often assisted by updating registers and relieving overburdened nurses. "When I ask Octavovect to help a clinic attend to its records, I find that the gaps are gone the following day," said URC's Thandeka.

Talking with Communities

Community dialogues, or imbizo, were used by Octavovect, in partnership with the DoH, to raise awareness of TB and HIV, conduct mass screenings for TB and encourage community members to use TB and HIV services.

Octavovect DOT supporters also carried out door-to-door TB awareness campaigns, as well as in areas where people were at higher risk of infection due to overcrowding and poor infection control such as schools, churches, taxi ranks and taverns.

At an *imbizo* in November 2012, a community hall in Soweto-on-Sea was packed with men, women, children and babies from the community. Windows and doors were open. Octavovect DOT supporters walked around registering people's name and contact details, handing out pamphlets and leading songs on TB. The local clinic had set up a table with sputum collection bottles and Department of Health brochures on TB and HIV. People were encouraged to produce sputum in a private area behind the community hall and hand them in. Sixty-five year-old Khulile Nofemele had come to the imbizo to share her story about being cured from TB: "I just finished my treatment in October and I feel good," she said. "I encourage everyone to do it; it makes you healthy and strong again."

"There were a lot of defaulters at Soweto-on-Sea clinic," said Nonkosi. "We need to talk to the community and explain how dangerous it is to stay with a person that is defaulting on treatment. It helps to put a bit of pressure on relatives, friends and neighbours to urge a defaulter to go back to the clinic."

Key Project Achievements

- 11,516 individuals were screened for TB using symptomatic screening and 1,892 people were identified with presumptive TB.
- 1,892 people with presumptive TB were referred to the clinic for TB testing and of those 261 were found to be smear positive.
- 433 patients and their families were counselled on TB, with the aim of reducing stigma and increasing family support for patients.
- Octavovect DOT supporters visited a total of 426 clients on a daily basis; 58 percent had TB and HIV co-infection.
- Contacts of 2174 index patients were followed up during the reporting period; 63 children diagnosed with TB had been infected by exposure to their parents with active TB disease.
- 8341 contacts were followed up and screened: 94 adults and 63 children tested positive for TB and were started on treatment. They were also offered HIV counselling and testing at the local clinic.
- 5,266 people were reached with TB health education through *imbizo,*

Success Story

Yogurt and Tablets

DOT supporter Nosipho Cholani recounts a story of a young child she helped in 2012:

It was September, I was doing door-to-door, I went into a house with three kids between 5 and 9 years. A five year-old boy was sleeping on the couch and the other two were watching TV. You could see the one sleeping was sick. I asked about their mother but they didn't know where she was. I asked the neighbour where she was. The neighbour said, "Oh, they are drinking, you'll never find them here." I took my phone and called the ambulance.

The grandmother then came back and I found out that the mother was in Cape Town. The grandmother's the one who is drinking. She agreed to have her grandchild taken to the clinic. I then went to the hospital to check what is going on. I found out the boy had TB and it was MDR. I went back to the house and found out that they had not yet taken the boy to the clinic for treatment though they had a referral letter from the hospital. I said, "Ok, let's go now." We went to the clinic and the child started on treatment.

Every morning I go to that house to make sure that the child is getting his pills and then the nurses from the clinic come to give the injection at home. The boy doesn't want to be given the tablets by anyone else but me. When I go there I must have yogurt and juice. I put the pills in the yogurt and just with one spoon, he takes his tablets. I then give him something to drink. He's coming all right now. He can run and play. When he sees me near the house, he comes out and runs to me.

Western Cape

South African Clothing and Textile Workers Union Worker Health Programme

SACTWU Worker Health Programme at a glance

Established: 1998

Location: In five provinces – Western Cape, KwaZulu Natal, Eastern Cape, Gauteng and Free State

Focus area: TB and HIV management in the workplace

Project supported by USAID TB Program South Africa: TB prevention and infection control

Funding period: April 2010 – May 2013

Formed in 1989, SACTWU is the largest union in the clothing, textile and leather industry in South Africa. Apart from representing their members in a number of areas including wage negotiations, SACTWU also runs the one of the biggest integrated HIV and TB worker health programmes on the continent.

Vuyiswa Moshani, or 'Sister V' as she's affectionately known in the Cape Town HIV and TB clinic of the South African Clothing and Textile Workers Union (SACTWU) is the kind of nurse that everyone would love to have. Her bright turquoise dress is complemented with a multi-coloured wooden beaded necklace and matching turquoise earrings—a far cry from the nurses' uniforms that many people find intimidating. Her colleague, lay counsellor Edward 'Eddy' Moeng, is equally approachable with his long braided hair and broad smile. "We are trying to have a welcoming approach for our clients by softening the overall look and reception," said Bhotwe Phakati, the national clinical manager.

Formed in 1989, SACTWU is the largest union in the clothing, textile and leather industry in South Africa. Apart from representing their members in a number of areas including wage negotiations, SACTWU also runs the one of the biggest integrated HIV and TB worker health programmes on the continent.

The SACTWU Worker Health Programme (SWHP) began in 1998 as an HIV and AIDS education project and expanded to provide a full continuum of care, from screening and testing to treatment and support. With funding from the USAID TB Program South Africa since 2011, the program was able to scale up its TB services across all its clinics in Western Cape, KwaZulu Natal, Eastern Cape, Gauteng and Free State. The program employed trainers, lay counselors, doctors, nurses and home-based carers. Using mobile

teams, it provided factory workers with access to health education and primary healthcare services. School children in surrounding communities are also targeted with health awareness on TB and HIV.

In 2012, SWHP won a gold award for social innovation from the Impumelelo Social Innovation Centre, an organization that champions home-grown solutions towards local challenges.

An Unique Workplace Health Centre

The clinic in Salt River, the industrial heart of Cape Town, is a particularly good example of what can be achieved through close collaboration with local health authorities. The partnership with the Western Cape City Health TB Department has given SHWP the authority to initiate TB treatment, a privilege no other organization has outside the Department of Health in the Western Cape Province.

'In the labour sector, there is nobody doing our kind of work," said Nikki Soboil, executive director for SHWP. "There are other NGOs who do workplace TB but it's not the kind of follow through or continuum of care that we provide, which I think is quite unique."

Educating the Whole Workforce

During the funding period, critical step in helping workers and management become aware of dangers of TB and the services offered by the clinic was health education, TB screening and implementation of simple infection control measures in factories and offices. Factory floors are often congested and poorly ventilated, an environment that is high risk for TB transmission.

Success Story

What if I hadn't come to Eddy?

Thirty-two year-old single mother Patty Edwards completed her TB treatment at the SHWP clinic in 2011. She is a credit controller at a textile factory and this was her second bout of TB. About four years after she was cured from her first TB infection, she started coughing again. "After my sputum test came back negative, I continued being so sick," said Patty. "I went to Eddy and he said I should do a culture test. That's when I met Sister V and all the nice ladies here." The culture test came back positive and the SWHP clinic started on her treatment. "The service here was excellent. The second time around you need to be injected daily and I'm afraid of needles. They helped me through that and then I got used to needles."

Patty is also grateful to the counselling provided by the SHWP clinic. "What if I hadn't come to Eddy? I would have been sick, for how long? The first time, I was sick for over a year before somebody could actually tell me: you have TB. I went to doctors, I went to the day hospital. They treated me for asthma. It was so bad that I couldn't walk properly because of the breathing."

The trainers and lay counselors went to the factories every day and held sessions with workers in canteens during their lunch break. Group TB screening was also held during these talks and suspects were referred to the SHWP clinic for sputum collection and further support. Factory managers benefitted from specific training aimed at them. Newly appointed shop stewards were also provided with formal three-day training on TB, HIV and AIDS at the union's offices. In addition, SWHP trainers offered awareness talks at schools located in communities where workers reside.

Infection control measures included simple actions such as opening windows and blinds, using cough officers to monitor workers who were sick, and making use of scrap material to cover mouths while coughing.

Success Story

Sister V's Comforting Touch

Thirty-four year-old Thozama Manya, a machinist at Pals Clothing, works long hours bent over a sewing machine. When she was diagnosed with TB, she was scared. ""I wasn't sure what must I do. I thought I was going to die. I was losing weight and I didn't eat." When she met Sister V at the SHWP clinic, she immediately relaxed. "Sister V said, Thozama, you won't die. When you get treatment, you're going to be all right. Sister gave me treatment, every day I come to the clinic for my tablets."

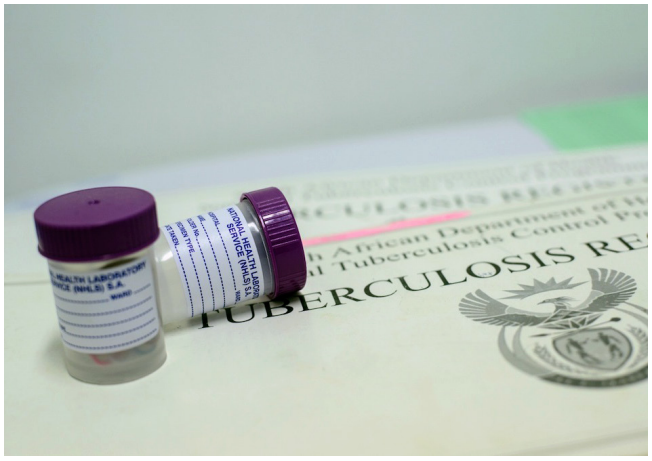
"There has been a lack of awareness amongst the management themselves about TB," said Soboil. "This programme has enabled us to educate the entire workforce, including management, and introduce basic infection and prevention skills… we have had a very positive response."

Health education was conducted in such a way that everyone, regardless of their educational level, could understand complex medical conditions such as HIV and TB. Fluent in five South African languages, layout counsellor Moeng explained: "When I started talking about immune system, I have to break it down. I tell them it is the army of the human body. And CD4 is working as a general of the army…if you use all the big words, people won't hear what you are trying to say and they won't come to you."

From Health Education to Treatment

Eddy also conducted talks on TB in the reception area of the clinic in Salt River. If a person suspected that he or she has TB, the clinic was able to do spot-on sputum collection in a specially designated sputum room with has an air extractor. The sputum sample was couriered to the lab and when the results come back, the patient was seen by the clinic's part-time doctor. Once diagnosed, the worker was booked off work for the initial two weeks of treatment when they were still infectious.

Treatment was started either by the SHWP clinic or the patient was referred and admitted to a government health



facility. Sister V liaised with the health centres to follow up on the client. The clinic had a TB register where all the relevant information on each client was recorded. Community caregivers conducted contact tracing and home visits, ensuring that defaulting was kept to a minimum. "We are treating a small number of people right now but we have a 100 percent conversion rate at 2 or 3 months and a 100% cure rate," said Sister V.

Key Project Achievements

Between June 2010 and February 2013, SWHP was able to achieve the following results across all five focus provinces:

- 103,260 workers received TB education and awareness training.
- 902 shop stewards benefitted from formal TB and infection control training.
- 51,773 learners were able to gain knowledge of TB and how to prevent the disease.
- In 426 factories, infection prevention and control plans were implemented.
- More than 80,000 workers were screened for TB (including those receiving HCT).
- More than 850 workers with TB symptoms were tested; 50 tested TB positive.
- 33 TB-positive workers were successfully referred to a Department of Health facility to start treatment; 17 workers were initiated on treatment through SWHP's TB treatment site in Salt River, Cape Town.
- SWHP achieved a 100 per cent treatment success rate.

Western Cape

Touching Nations

Touching Nations at a glance

Established: 2005

Location: Elsie's River, Cape Town

Focus area: HIV counseling and testing, community DOT and home-based care

Project supported by USAID TB Program South Africa: Provision of maximum access to HIV/AIDS and TB health care services/VCT

Funding period: December 2011 – February 2013

In the poor and gangster-ridden communities of Elsie's River township in Cape Town, a local NGO is working against all odds to make a difference in the lives of those infected with TB and HIV.

Touching Nations was formed in 2005 by two pastors from the Logos Assemblies of God church. Today, their program includes 62 HIV counselors based at different government health clinics, 35 community workers that provide DOT to TB clients and 14 home-based carers who support clients living with the HIV and AIDS. At head office, five administrative and managerial staff, including TB coordinators and program managers, ensure the smooth running of all activities. "Our core function is HIV and TB," said Winifred Le Fleur, programme manager. The DoH is their main funder, especially for their HIV services, while the USAID TB Program South Africa supports their community DOT program.

Empowering Communities

At the heart of their TB services lies a cadre of community-based DOT supporters, who are trusted and well-known members of the community. During the USAID TB Program South Africa funding period, they provided DOT support to around 15 clients a day in their own homes or the homes of the clients. Trained in DOTS, infection control and community mobilization, the community workers received support from Touching Nations' TB coordinators who did regular home visits to check if everything was ok.

Being a community worker helped to empower individuals and encourage them to become leaders in their own community, a skill that they could apply to other areas. "Before they became DOT supporters, they were unemployed. Some of them don't have high school education," said Rene Rushin, TB coordinator. "So what we do is try to raise their self-esteem by making them leaders. We also send them on the training. Two of our former DOT supporters are now working as HIV counsellors [a promotion as it requires a higher level of skill]."

Touching Nations had a close working relationship with local government clinics. Their 35 community DOT supporters serviced six clinics, which referred TB patients to them. The clinics also liaised with the DOT supporters

> *"Our outreach activities are very successful because a lot of people don't want to go to the clinic and have that long wait."*
>
> Felicity Horn, TB coordinator

to inform them of a new client and provide their contact details.

"Our DOT supporter knows the patient is coming," said Winifred. "If that patient doesn't come to her, she will go and look for him or her. We also work the other way around where the clinic will refer patients to Touching Nations or with our outreach programme, we will also refer sick people that we find to the clinic."

Bring Services Directly to People

During the funding period, Touching Nations also ran around four awareness campaigns every month. Their 'sputum blitzes', conducted by the TB coordinators and community DOT workers, were particularly popular because they brought TB education, screening and testing services to people's doorsteps. "Our outreach activities are very successful because a lot of people don't want to go to the clinic and have that long wait. Now they come to us and we do the test for them, which goes much quicker for them," said Felicity Horn, TB coordinator. Once the sputum samples were collected, Touching Nations dropped them off at the clinic where they were sent to the lab for testing. When the results came back, the clinic sent their TB assistants to locate the patients and start them on treatment.

Support Groups

Another much-needed service offered by the Touching Nations DOT workers was support groups. "We have an open support group. It's for clients and their families, as well as people living with HIV and AIDS," said Winifred. "We also recently welcomed MDR and XDR-TB patients." Support groups took place in libraries or in the health clinic waiting rooms and were led by the DOT supporter or TB coordinator. They worked around the availability of the clients, taking place anywhere between once a week to twice a month. The support groups were centred around talks on prevention, identification and treatment of TB but

also covered other issues brought up by clients, such as how to register for a social grant. Touching Nations invited guest speakers such as a government social worker to explain to the group how to access government services.

Key Project Achievements:

- 40 community health workers and other staff were trained on TB and HIV.
- 15 health education sessions were held at community meetings, community-based organizations, schools, youth centres and factories.
- 7,821 people were reached with advocacy messages on TB and HIV.
- 7,850 people were screened for TB using symptomatic screening.
- 1,584 TB suspects were identified and all were referred to a clinic for TB testing through sputum smear.
- 645 TB cases were referred to Touching Nations for DOT support.
- 662 new smear positive TB cases were registered under the Touching Nations DOT programme; 554 were smear negative at the end of the initial phase of treatment (2–3 months). Sixty-one successfully completed treatment and 63 were cured.
- 941 TB patients were counselled on adherence to treatment.
- 81 TB patients who defaulted treatment were traced.

Success Story

I love what I do… I don't like sitting around

Fifty-three year-old Jacqueline Peters, or 'Aunty Jacky' as she is known, has been a community DOT supporter for Touching Nations since 2009. She has been living in Epping Forest, an impoverished community in Elsie's River for 35 years. Her journey to becoming a DOT supporter was one where tragedy was transformed into positive change. "My brother was infected with TB and I didn't know. He died but not from TB," said Jacky. "I went to a college for computer training and one of the girls there encouraged me to become a community worker because I love kids. I foster children. I went to Sister Scott at my local clinic and I got my two-week training in DOT."

Aunty Jacky provides DOT support to around 30 people a month in the neighbourhood. Many of her clients were young children between the ages of two and three; most had been infected by family members. The clients come to her house in the morning to take their medication, or if they work, they drop by in the afternoon. "I don't say no, you can't come. I accept them because they must drink their pills," she said with emphasis. "It's for their health and my sake so that other people don't get infected."

Twenty-seven year-old Clinton Bostik is one of her current clients. "He's one of my best patients. He likes to drink his pills," said Jacky. Clinton exemplifies what happens to a lot of young people in the community. He dropped out of school at Grade 7, never had formal employment and collects scrap metal to sell for a pittance. A nurse at the local clinic referred him to Jacky: "Sister called me and told me there is a patient. I got the address and went to look for him. I then went to the clinic to fetch his pills and he then comes to my home to take them."

Despite the poverty and crime in the community, Jacky is passionate about what she does. "I love to work, I like to go to my clients' houses and see how they are. I don't like sitting around. There was one lady who had MDR. She was sitting in the house and didn't want to go out because she was afraid that people would think she's the one infecting them. I started going to her house and getting her to come out for fresh air. Now she walks up and down, up and down the street."

Aunty Jacky is proud of the success she has had. "All of my clients have been cured of TB. Nobody died. My MDR clients are up and about."

Aunty Jacky is proud of the success she has had. "All of my clients have been cured of TB. Nobody died." Her two MDR-TB patients she had also completed their treatment. "My MDR clients are up and about. They still go every month to give their sputum but they are fine."

Free State and North-West Province

The Aurum Institute

The Aurum Institute at a glance

Established: 1998

Location: Head office in Johannesburg, Gauteng with satellite offices in Pretoria, Johannesburg and surrounding townships, and North West, Free State and Eastern Cape provinces

Focus area: TB and HIV prevention, treatment and care through specialist research and health systems strengthening and management

Projects supported by USAID TB Program South Africa:

1. Implementation of the 3 I's strategy at primary care clinics in Matjhabeng sub-district of Lejweleputswa district in the Free State province;
2. Addressing TB/HIV through community mobilization in the Department of Correctional Facilities

Funding period: July 2010 – September 2012

"We in Aurum have seen TB as one of our strengths. A lot of the research we do is on TB."

Dr. Salome Charalambous, Project Director

The Aurum Institute is a public-benefit organization working primarily on TB and HIV. Through their team of dedicated scientists and professionals, the organization:

- Provides support and advice to public and private sector healthcare programmes;
- Conducts research that influences and transforms public health policy;
- Develops evidence-based treatment and health management systems to meet the needs of different stakeholders involved in TB and HIV.

Between April 2010 and September 2011, the USAID TB Program South Africa provided funding to the Aurum Institute to implement the 3 I's strategy in primary healthcare clinics in the Matjhabeng sub-district of Lejweleputswa district in Free State province. This was done in close collaboration with the provincial Department of Health and NGOs working in the area.

Research has shown that IPT, one of the 3I's, reduces the risk of TB disease in HIV-positive patients who had not been treated for TB before by 40% for up to four years. IPT also diminishes the re-occurrence of TB by 50–80 % in subsequent years.

The organization was deemed to be well placed to implement a projected aimed at increasing TB and HIV collaborative activities. It had extensive experience in ICT, partnering with the public health sector and implementing of the 3I's. "We in Aurum have seen TB as one of our strengths," said Dr. Salome Charalambous, Project Director. "A lot of the research we do is on TB."

Delivering the 3I's

Matjhabeng sub-district, the site of the 3I's project, had a population of more than 467,000. More than 30% of pregnant women attending antenatal care were living with HIV and one in 75 people became infected with TB in 2008. The high prevalence of HIV as well as the high incidence of

TB in the district made it an ideal site to implement TB and HIV collaborative activities. Lejweleputswa district has five sub-districts with Matjhabeng sub-district reported by the provincial Department of Health as the most affected by TB and HIV.

The target population for the project consisted of HIV-positive people attending primary care clinics in the sub-district. At the time of project implementation, there were 27 public health clinics in the sub-district and the Aurum Institute focused on five of these facilities. The project had four objectives for the sub-district:

- Increase awareness and acceptance of TB screening, testing and treatment among community members, patients and health workers.
- Strengthen the capacity of clinics to diagnose, treat record and report TB cases, and provide pre-ART care.
- Demonstrate the feasibility of implementing the 3 I's strategy in primary healthcare clinics.
- Monitor and evaluate the implementing of the project and provide provider-initiated TB screening through routine collection of data.

A first step was to determine the state of TB and HIV services in the sub-district. "We did a baseline assessment of clinics to see what the sub-district was doing and what could be improved," said Dr. Charalambous. Findings of the assessment were shared with stakeholders in the sub-district and used for planning project implementation.

The project team was led by a medical doctor, which facilitated access to key informants and partners. Many of Aurum's staff were from the area and spoke the language, another element to Aurum's ability to open doors and ensure that the project rolled out smoothly.

Project activities were comprehensive. To improve knowledge of TB services, the Aurum Institute helped design, print and distribute educational material on TB and HIV, and supported health education in clinics and awareness campaigns in the community.

To show that it was possible to implement the 3I's at the clinic level, the Aurum Institute helped to develop TB screening forms, trained staff on the DoH screening tool and empowered the project coordinator and clinic managers to monitor the implementation of TB screening among HIV-positive clients. Training was also provided on the DoH's guidelines on IPT, stock management systems were put in place and implementation of IPT was monitored. The project was also able to recruit two experienced professional nurses who were vital to the implementation of the project.

The Aurum Institute designed educational material on TB and HIV, and supported health education in clinics and the community.

The Aurum Institute believes in implementing good quality programmes with measurable outcomes. A database was developed for the project, clinic staff were trained in monthly clinic reporting and data from clinics was entered on a monthly basis.

Key Project Achievements

- **Bringing partners on board:** Through the USAID TB Program South Africa, the Aurum Institute had the opportunity to meet with programme directors at provincial and district levels, where the project was presented to them and buy-in was secured.
- **Health education:** During the project period, all five Aurum-supported clinics had sufficient educational materials on TB and HIV and daily health education was integrated into the clinics' processes. In collaboration with the DoH and other NGOs within the area, three community events were held where members of the community were sensitized on TB and HIV. The partnership with other stakeholders also meant that people could access multiple services in one go, including screening for sexually transmitted illnesses and condom distribution. The involvement of the local clinics also made it easier for clients to be linked to care as the need arose.
- **IPT:** All five clinics had adopted the use of the DoH TB screening tool, using the four cardinal symptoms of TB (coughing for two weeks, weight loss, fever and night sweats). Trained 25 nurses from the five clinics were trained on-site on IPT, ICT and infection control. The two professional nurses employed as part of this project provided regular monitoring and mentoring of TB screening and IPT.

- **Infection control:** TB infection control assessments were conducted in all five clinics with a follow up assessment after six months. All facilities appointed a TB infection control focal person and developed an infection control plan for their facilities.
- **Recording:** A database that collects information from the clinics was developed and systems were put in place to ensure that relevant information was recorded and reported from each clinic. Facility-based staff members were trained on relevant indicators as part of training on ICF and IPT. Clinics were also able to produce aggregate data on a monthly basis. Between July 2010 and October 2011, 629 HIV-positive patients were screened for TB and placed on IPT: 120 completed their IPT treatment by September 2011. Another 2,175 patients with HIV were screened for TB and 261 were put on TB treatment. Of those, 113 completed their TB treatment by September 2011.

Good Prison Health is Good Public Health

Accurate TB and HIV statistics within the South African correctional environment are a challenge to obtain.[8] In the majority of countries across the world, HIV infection rates are much higher amongst inmates than the general population. This situation is often exacerbated by high rates of TB and other illnesses such as hepatitis C. Given that South Africa is one of the world's highest HIV and TB burden countries; there is little doubt that the management of TB and HIV in correctional facilities is more important today than ever.

Inmates have the right to health and their health is directly linked to that of their families, husbands, wives and partners. Offenders come from the community and the vast majority return to the same community. Diseases contracted in prison or made worse by conditions of confinement became issues of public health when people are released. By protecting and treating inmates, broader communities are also protected.

It is in this context that the USAID TB Program South Africa funded the Aurum Institute to implement integrated TB and HIV services in four correctional centres in Bojanala district, and three in Dr. Kenneth Kaunda district, North West province. The objectives of this intervention were to:

> *"Before we started with project activities, we did a baseline and discovered that nurses were not aware of TB infection control."*
>
> Joyce Lethoba, project manager

- Improve TB screening of all new prisoners;
- Develop understanding of TB among health workers in prison clinics and offenders;
- Improve HIV testing in the prison setting, including patients diagnosed with TB;
- Improve TB screening in all HIV-infected patients;
- Implement IPT for the eligible HIV-positive offenders;
- Strengthen infection control in correctional facilities, including isolation of newly-diagnosed infectious patients;
- Improve follow-up for TB and HIV-infected offenders once they were released from prison to ensure successful continuity of care in community health services;
- Strengthen the follow-up of TB-infected contacts for referral to community health services.

Healthcare in South Africa correctional services ranges from primary healthcare clinics in small centres to provincial correctional hospitals for serious cases. The four correctional facilities covered by the project each had a small clinic staffed by professional nurses.

One of the first things that the Aurum Institute did was to assess the know-how and practices of prison health workers. "Before we started with project activities, we did a baseline and discovered that nurses were not aware of TB infection control," said Joyce Lethoba, project manager. Not only that, but offenders were not screened for TB on admission to their cells; sputum collection was done in cells; the prisons did not have isolation sleeping cells for those newly diagnosed with TB; and the facilities were not implementing the IPT policy. These assessment findings were shared with prison management, who were actively involved in finding and implementing solutions.

[8] The Department of Correctional Services no longer publishes HIV statistics in its annual report.

Project activities were then tailored around filling in the gaps. They included capacity building of health workers and inmates, improving TB screening, strengthening infection control systems, implementing protocol-driven IPT for TB in HIV-positive patients and putting in place a stronger discharge and referral system for offenders.

Key project achievements

- **Capacity building:** During the project period, 18 professional nurses from all four facilities were trained on TB and HIV integration activities and 75 offenders were trained as peer educators. They were able to arrange talks with fellow inmates, hold support groups, refer peers for TB screening and HIV testing and participate in implementing infection control measures.
- **Infection control:** Infection control was stepped up in all seven prisons and TB infection control plans were drafted and shared with all relevant people. Ten nurses were trained in infection control and all centres started screening offenders when they were first admitted and before they mingled with others. Sputum collection was moved to an open courtyard and the prison health clinic began separating and screening suspects in their waiting rooms (and gave them face masks). Clinic staff were also provided with N95 respirator masks, which were more effective in filtering out bacteria than ordinary surgical masks. All centres identified isolation sleeping cells and new TB cases were isolated for the first two weeks of TB treatment.

  UV lights were installed in all centres—in the consulting rooms, isolation cells and TB communal cells. An innovation was the agreement to unweld windows without compromising security by placing a bullet-proof wire mesh behind the window. This meant that windows could be opened to improve ventilation.
- **IPT:** Prior to Aurum's intervention, prison health facilities were not implementing IPT and did not have the necessary medication. Aurum was able to successfully request for isoniazid to be provided and all seven centres now receive the drug from the Department of Correctional Service's pharmacy in Pretoria. As of October 2012, 970 HIV-positive offenders were screened for TB, 611 were eligible for IPT, and 303 were started on IPT .
- **Referral system:** When offenders were released, they should know where to go to continue their treatment that was initiated in prison. As a result of Aurum's support, a referral system was put in place were none had existed before. The released prisoners were provided with a referral letter and a relationship was established with health authorities in the sub-districts from where an offender was from to make sure the person did not fall through the gaps.
- **Partnerships:** Because of the need to work with multiple partners, stakeholder engagement was an important area of investment for Aurum and considerable time was spent on it. The project was first introduced to management from the correctional services and then follow-up meetings were held to inform them of progress and options for the way forward. Staff from USAID TB Program South Africa also conducted a site visit and met with the Department of Correctional Services in Rustenburg.

  A key achievement was linking the services of the two key departments. Aurum facilitated meetings between the DoH and Department of Correction Services in Rustenburg to set-up a working relationship for contact tracing and follow-up of released prisons. The sub-district agreed to trace and follow up offenders and their families. Both parties also agreed to modify the existing TB transfer letter to enable mutual coverage of IPT referrals. "Even if we as Aurum move out of the prisons, that relationship is there and the work can continue," said Joyce.
- **Reporting:** A further highlight was the creation of standardized recording systems. Aurum helped clinic staff establish registers, purchased computer equipment and set up an electronic database.

Additional project achievements included:

- 51 new smear positive pulmonary TB cases were found.
- 119 HIV-positive offenders were started on ART.
- 65 TB patients received HCT, and 22 tested HIV positive.

Mpumalanga

Humana People to People

Humana People to People at a glance

Established: 1995

Location: In five provinces across South Africa – Eastern Cape, Gauteng, KwaZulu Natal, Limpopo and Mpumalanga

Focus area: Community-based TB and HIV prevention and management

Project supported by USAID TB Program South Africa: Strengthening TB services in the Total Control of the Epidemic (TCE) program

Funding period: April 2010 – July 2011

The first thing you notice when walking into the offices of Humana People to People in Ehlanzeni, one of the three districts of Mpumalanga province, is the military style of uniform of its staff. Dressed in red polo shirts, black pants and red berets with titles such as 'division commander' and 'special forces', they are ready for battle. Except here the war is against an insidious threat: HIV and TB. "We use a military corps system because we see ourselves as soldiers fighting the epidemics," said Memory Makwembere, division commander.

Humana People to People is a NPO actively involved in reducing the stem of HIV and TB through a program known as Total Control of the Epidemic (TCE). TCE was first implemented in 2000 in Zimbabwe and it now being implemented in 10 countries, including South Africa. Between April 2010 and July 2011, the USAID TB Program South Africa supported the TCE program to integrate HIV and TB services in Ehlanzeni and two other districts: Amathole district in Eastern Cape and iLembe district in KwaZulu Natal.

Founded on the ethos that "only the people can liberate themselves from HIV and TB," TCE was a unique and systematic approach to empowering communities to manage the twin epidemics. Its basis was a dialogue on HIV and TB between a TCE field officer, who was a trained peer educator recruited from the community, and residents in a community. The program's aim was ambitious but feasible given the dedication field officers exhibited: to reach every single person in a TCE operational area of 100,000 people over the three-year period.

"We are looking for people who have passion for their work. This is one of the key criteria for recruiting field officers," said Memory's colleague, deputy corps commander Mohammed Matovu.

Equipped with a map, a household register, an individual assessment tool, these foot soldiers walked through the community, talking, listening, answering questions and facilitating decisions about safe sexual behaviour, helping recruit other volunteers, training peer educators and encouraging people to use sexual and reproductive health, child and maternal health, and TB services.

"When we go into the community, we assume that there is zero control of HIV and TB. By the end of three years, we expect it to be 100 percent."

Deputy Corps Commander Mohammed Matovu

"When we go into the community, we assume that there is zero control of HIV and TB. By the end of three years, we expect it to be 100 percent," add Mohammed.

The success of the TCE program was based on the following three key elements.

Door-to-door campaigns: Over the three-year lifespan of a TCE programme, a field officer was mandated to visit 2,000 people and to mobilize them towards 'TCE compliance.' This meant that each every member of a family knew their HIV status and was screened for TB. They also needed to demonstrate an in-depth understanding of HIV and TB and commit to preventing the transmission of the two diseases. TCE compliance in terms of TB meant that a person with TB had completed his or her treatment successfully. Field officers assisted individuals in making personal risk reduction plans that lead to TCE compliance.

Community mobilization for TB screening and HCT, ART and prevention of mother-to-child transmission (PMTCT): TCE conducted community mobilization for TB screening and HCT at designated sites in collaboration with local health authorities or other NGOs, as well as encouraging mobile testing actions at TCE sites. Once people were referred for examination/treatment services, field officers kept regular contact with both the service providers and the patients throughout the program duration.

Supplementary interventions tailored to specific needs: These were carried out by community volunteers called 'passionates' who worked with field officers to promote prevention, reduce stigma and provide care for TB clients and people living with HIV and AIDS. The 'TRIO' system was one such intervention and was supported by the USAID TB Program South Africa.

The TRIO system was facilitated by the field officer who asked a TB and/or ART client to identify two other people (close friends or family members) to support them with their respective medical regimes. These passionates were trained on how to promote treatment adherence, prevent defaulting and promote open dialogue around TB and HIV in order to reduce stigma and discrimination.

Collaborating with Other Partners

Humana's work was further supported by the close working relationship with the DoH's local clinic in the area. Clinic nurses provided field officers with a list of defaulters for follow-up while defaulters were identified through Humana's door-to-door campaigns and were assisted to return to treatment.

Humana was part of a wide network of partners working in the area. "We don't work in isolation, we work with many stakeholders," said division commander, Memory. Before engaging with a community in an area, Humana met with local leaders and municipal authorities to introduce their approach and secure buy-in.

Field officers were recruited and trained by Humana, as well as by medical staff from the DoH. TB nurses from local clinics trained field officers in TB screening and referrals for testing and other services, and Humana liaised with health centres to strengthen tracing and prevention of defaulting. A clinic placed a box with referral slips in its reception

"It has improved health services in our areas as we are able to reach patients at home. Previously we had a lot of defaulters, but the default rate has gone down."

Sister Freda, from Block B Clinic in Tonga

area, which field officers emptied on a weekly basis. Field officers also had access to clinic staff and regularly talked to nurses. "It's a very good partnership," said Sister Freda, from Block B Clinic in Tonga, a 10-minute drive from Humana's offices. "It has improved health services in our areas as we are able to reach patients at home. Previously we had a lot of defaulters, but the default rate has gone down."

The organization collaborated with other NGOs in an area to ensure that there was no duplication of effort and that interventions were reinforced for the good of the community. "We supplement and complement existing programmes," said deputy corps commander, Mohammed. "We exchange notes with other NGOs on what areas are under-served and what additional help our clients need."

Key Project Achievements

During the period funded by the USAID TB Program South Africa, Humana People to People was able to show the considerable progress and impact they had made in providing combined HIV and TB services to communities in the three targeted districts of Ehlanzeni, Amathole and iLembe.

- More than 670,000 people benefited from health education and information on HIV and TB.
- Close to 240,000 individuals were screened for TB.
- More than 4,000 community members in the three districts were referred for TB diagnosis.
- Nearly 900 defaulters were identified, tracked and referred back for treatment.
- Close to 2,000 TRIO support groups were formed.

Humana learnt a number of lessons during implementation. A key lesson was the importance of working collectively with stakeholders. Humana actively participated in local coordination meetings on HIV and AIDS, TB and STIs and workshops held by local DoH structures. Such fora provided an opportunity to share experience, ideas and strategies to strengthen integrated HIV and TB services.

The TCE programme also made a mark on the tracing of both TB and HIV treatment defaulters. Health authorities in the districts were especially impressed by the TRIO system and the ability of passionates to break through stigma and discrimination.

Humana also noted the overwhelming response of communities in the targeted districts for TB screening once they became aware of that TB can be easily cured but could threaten lives if not treated in time.

Lessons Learnt

The USAID TB Program South Africa together with our partner NGOs has helped strengthen and improve communities' health systems. We created appropriate advocacy, communication and social mobilization strategies to increase awareness about TB. Likewise, we developed innovative service delivery models that include public private mix models for the rapid expansion of DOTS for the control of TB. Our key achievements from 2009 – 2013 include:

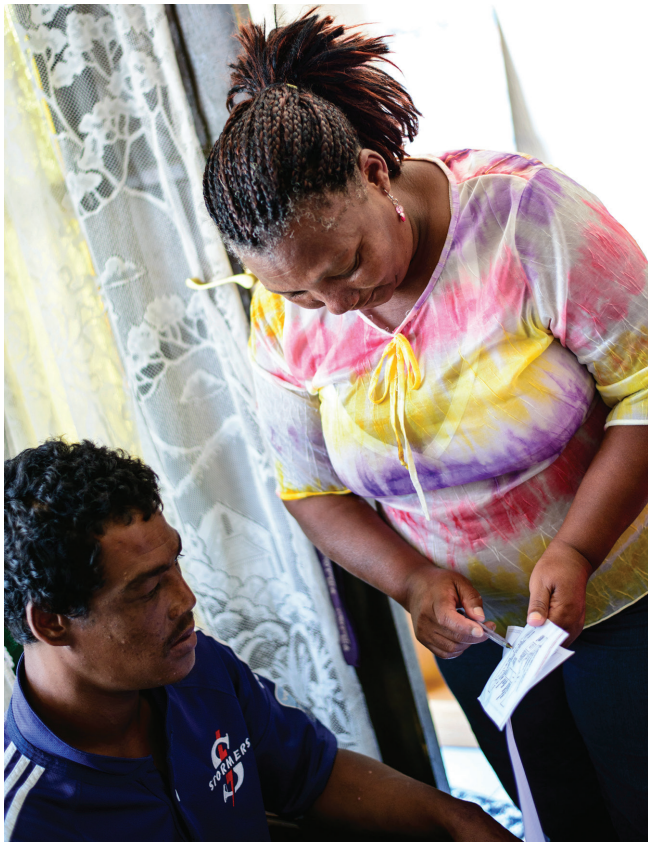
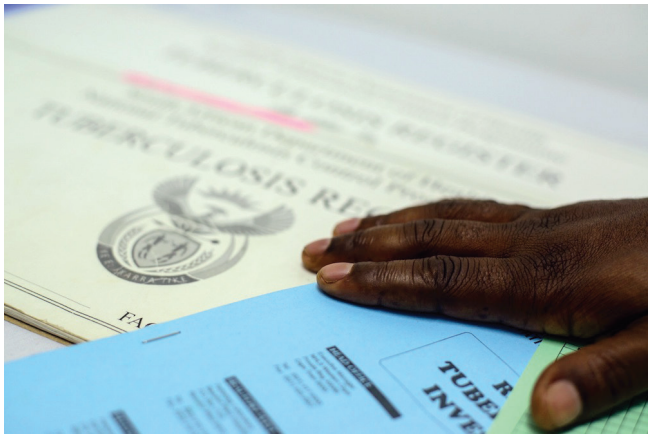
- 702,145 people were reached with key messages through health education, awareness campaigns and community dialogues.
- Through the mass media campaign 'We Beat TB', 72% of South Africans were reached through popular TV and radio adverts and dramas, and the dissemination of TB material to a wider audience.
- 267,260 people were screened for TB across the country.
- 8,107 people were identified as TB suspects.
- 1,067 people were confirmed with TB.

Partnering with NGOs and community-based organizations also helped us learn a number of key lessons. These lessons include:

- An important observation was that grantees with solid working relationships with DoH structures and clinics made good progress in case findings, DOT support, defaulter and contract tracing and referrals. NGOs often helped to relieve the burden off under-resourced and under-staffed primary health facilities, filled in record keeping gaps when necessary, built capacity of health workers and acted as a key link between communities and healthcare services.
- NGOs such as Philanjalo were able to demonstrate the feasibility of implementing integrated TB and HIV management in remote, rural and poor settings. However, their model requires time and sustained support and resources to replicate in other locations.

- Well-established grantees were also key to success. Grantees providing a continuum of care for TB and HIV such as SACTWU had long-standing programmes that provided a solid foundation (infrastructure, staff and systems) for the scale-up of integrated TB and HIV services.
- Thinking 'out of the box' helped a number of organizations to deliver TB and HIV services effectively. Several organizations took innovative approaches to TB and HIV management such as the TRIO system implemented by Humana and integrated HIV and TB services in prisons supported by the Aurum Institute.
- The importance of record keeping was also a major lesson learnt. Keeping TB registers and other recording tools up-to-date is critical to saving lives and the proper management of the TB control programme. Organizations such as Octavovect and the Aurum Institute were key in helping to develop health worker capacity in this area.

Grantees with solid working relationships with DoH structures and clinics were able to make good progress in case findings, DOT support, defaulter and contract tracing and referrals.

- Building the technical skills of personnel, several grantees such as Amakhumbuza, Octavovect and Touching Nations demonstrated impressive personal commitment and dedication to their work. These organizations often went out of their way to ensure that the communities they served received the best possible support.
- Working with schools proved to be an effective strategy in reaching vulnerable communities with information and services. SAMRC/OVSA illustrated how to help improve the health of adolescents and their families by engaging school children and communities surrounding schools involved in early TB detection. This also empowered them to become agents of change.
- Finally, tackling stigma and encouraging people to get tested for TB and HIV can be achieved successfully through storytelling and community theatre. Impangele demonstrated this with their community radio and live drama programme.

These findings continue to shape our support to the National TB Program to reduce TB-related stigma and help increase awareness and understanding of TB and HIV risks, especially among under-served or hard-to-reach populations.