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**TUBERCULOSIS
PROJECT
SOUTH AFRICA**

USAID TB Project South Africa

Annual Report (1 October 2010 to 30 September 2011)



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TABLE OF CONTENTS

LIST OF ACRONYMS	IV
1 EXECUTIVE SUMMMARY	1
2 INTRODUCTION	4
3 OVERALL PROJECT PERFORMANCE	5
3.1 Performance by Geographic Coverage	5
3.1.1 <i>URC-supported Districts</i>	
3.2 Performance by Intermediate Results	10
3.2.1 <i>IR1 Improved Quality of TB Services</i>	
3.2.2 <i>IR2 Increased Availability of TB Services</i>	
3.2.3 <i>IR3 Increased Demand for TB Services</i>	
3.2.4 <i>IR4 Improved Management Support Systems</i>	
3.2.5 <i>IR 5 Tested New Approaches for Expanding DOTS Coverage</i>	
4 CHALLENGES	34
4.1 Administrative	
4.2 Implementation	
5 COMMON AGENDA ITEMS	35
5.1 Project Administrative	
5.2 Coordination with Local and Other Stakeholders	
6 BEST PRACTICES / SUCCESS STORIES	36
6.1 Compelling individual-level success stories	
6.2 Documentation of better practices that can be replicated or taken to scale	
7 PLANS FOR NEXT QUARTER	40

Annex: USAID TB District Performance

List of Acronyms

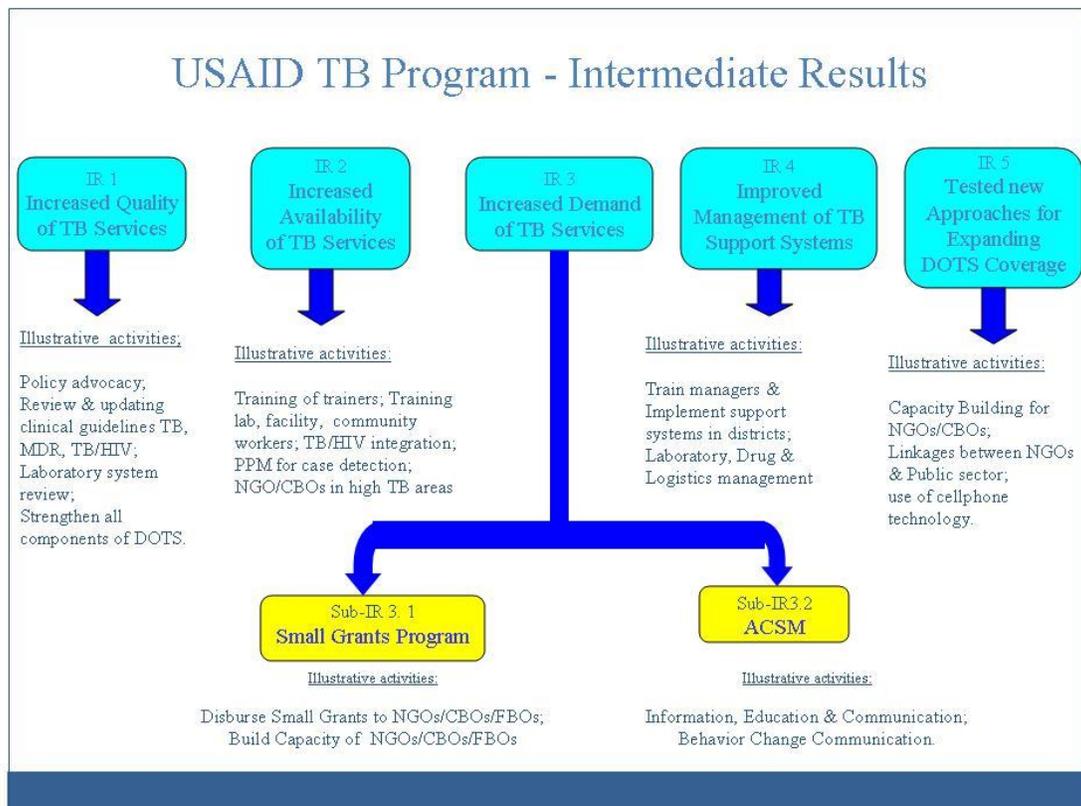
AIDS	Acquired Immunodeficiency Syndrome
ARV	Antiretroviral treatment
CBO	Community-Based Organization
CDC	Centre for Disease control
CHC	Community Health Centre
DOH	Department of Health
DOT	Directly Observed Treatment
DOTS	Directly Observed Treatment Short-course
DRAT	District Rapid Assessment Tool
DST	Drug Susceptibility Testing
EC	Eastern Cape Province
ETR	Electronic TB Register
FS	Free State Province
GP	Gauteng Province
HAST	HIV, AIDS, and Sexually Transmitted Infections and TB
HCT	HIV Counseling and Testing
HIV	Human Immunodeficiency Virus
HST	Health Systems Trust
IC	Infection Control
IPT	Isoniazid Preventive Therapy
IUATLD	International Union against Tuberculosis and Lung Disease
KZN	KwaZulu Natal Province
LP	Limpopo Province
LOP	Life of Project
MIS	Management Information System
MDR TB	Multi-drug Resistant Tuberculosis
MPU	Mpumalanga Province
NC	Northern Cape Province
NDOH	National Department of Health
NGO	Non Governmental Organization
NHLS	National Health Laboratory Service
NMBM	Nelson Mandela Bay Metro
NTCP	National Tuberculosis Control Program

NW	North West Province
PDOH	Provincial Department of Health
PEPFAR	President Emergency Plan for Aids Relief
PPM	Public-Private Mix
PTB	Pulmonary Tuberculosis
SAG	South African Government
SCR	Smear Conversion Rate
TB	Tuberculosis
3Is	Intensified case finding, Isoniazid preventive therapy and Infection control
URC	University Research Co., LLC
USAID	United States Agency for International Development
VCT	Voluntary Counseling and Testing
WC	Western Cape Province
WHO	World Health Organization
XDR TB	Extensive drug resistant TB

1. EXECUTIVE SUMMARY

The reporting period July ó September 2011 marks the end of the second year of the USAID TB project. Full implementation of Project activities is underway in all nine provinces. Marked improvements and strides in the initiated activities have been observed in the supported provinces, although at a slow pace in the Western Cape due to challenges with the recruitment of a Project provincial representative.

This report outlines the progress on activities implemented by the USAID TB Program South Africa and focuses on results and accomplishments, including challenges faced during the period July ó September of 2011 (FY2011). The report also attempts to draw comparisons between district TB data analysis for FY 10 and FY 11. The activities implemented were guided by the Strategic Objectives (SO) and the related Intermediate Results (IRs) as reflected in the figure below.



IR 1: Increased Quality of TB Services

The project continued to support the districts in improving quality of TB services through on site coaching and mentoring to assist the district in addressing the gaps identified. The project participated in various meetings at provincial, district and sub-district level across all nine provinces.

The performance results show that overall out of the 21 districts supported by the project in South Africa, close to 50% now have bacteriological coverage above the national target of 85%. One third of the districts supported have exhibited a decrease in cases of Smears Not

Done at Diagnosis stage. Almost half of the supported districts have reported cure rates that are above 70% and close to two thirds have treatment success rates that are above this mark.

IR 2: Increased availability of TB services

Capacity building:

The project was able to achieve and surpass the training target of 4000 for USAID with a total of 4869 HCWs trained in the period October 2010 to September 2011. Despite having exceeded the project's annual training target some training categories lagged behind, such as the TB/HIV clinical training, in part due to cancellations of the trainings.

There is a significant improvement in TB screening of HIV+ patients across all supported districts. TB screening among HIV infected clients remains high at 96% of the HIV positive clients screened for TB. The implementation and close monitoring of TB screening tool at facility level played a significant role regarding the improvement noted. IPT uptake has also improved in various supported districts and there was no INH stock-outs reported during this reporting period. CPT uptake for TB/HIV clients also indicated a significant improvement during this reporting period. What still remains a challenge is the ART uptake which is still <50% for all newly diagnosed TB/HIV patients eligible for ART. The project will work closely with the DoH to address this gap.

MDR-TB:

The project rolled out the MDR-TB community management workshop in Free State province and Ulundi, KwaZulu-Natal in which district managers, district TB coordinators and operational managers participated. Through this workshop, implementation plans were developed. The USAID TB Project and Philanjalo, a Grantee of the project, will jointly provide technical assistance and monitor the implementation of these plans.

Laboratory Diagnostics:

The project developed training materials on GeneXpert and Line probe assays. The materials were integrated into the NTCP's training agenda on new diagnostics including changes in the guidelines that came about as a result of implementing the GeneXpert. The facility Diagnostic Information Collection tool was introduced in North West during a DRAT round. This tool was utilized to document information on the types of TB tests the facility has access to; the laboratory that serves them and frequency of specimen courier; laboratory supplies and their procurement; TAT as well as communication channels between facility and laboratory. The objective of collecting this information is to identify practices and/or gaps in the systems that may affect the bacteriological diagnosis of TB in the facilities.

IR 3: Increased demand for TB services:

ACSM

The project was involved in community dialogues in various supported provinces where community organizations were gathered to discuss TB and TB/HIV issues affecting communities. As a result action plans were developed. School outreach programs continued during this reporting period through KICK TB campaigns.

Small Grants

The project assisted the Wave 1 grantees with the close out process which included the finalization of annual reports. 21 grantees have been awarded grants for Wave 2. Post award session for the 21 grantees will be conducted in the next quarter progress. 121 applicants were received for Wave 3 and short listing was done and review process is ongoing.

IR 4 Improved Management of TB Support Systems

The Project successfully conducted facility support supervision visits to districts in five provinces. In Kwazulu Natal ETR support was provided focusing on data quality management at facility level. For example, at UMkhanyakude, training and mentoring of data capturers resulted in clearance of the backlog. In Northwest province DRAT was jointly conducted with provincial and sub-district staff in Ventersdorp and Mafikeng. Improvement plans shall be developed together with sub-district and facility operational managers. In Gauteng district quarterly meetings were held and improvement plans developed jointly with the district.

In Free State province ETR.NET was conducted through on-the-job training of the newly recruited M&E officer in Fezile Dabi district. TB data clean up and validation exercise was conducted in Motheo and facilities were supported to develop improvement plans to manage registers and treatment cards. In Eastern Cape province, the Project supported and facilitated TB-HIV quarterly review meetings attended by various stakeholders. DRAT review was conducted in 10 facilities at Mnquma sub-district and follow up remedial interventions shall be conducted. Action plans have been developed for all five sub-districts.

Other planned activities for the program include data quality audits in selected districts and health facilities and training of HCW (together with the NDoH) on basic M& E and data quality management. A significant development will be the introduction of an electronic Access Database to minimize errors which are difficult to detect when using the current Excel Database.

IR 5 Tested New Approaches for Expanding DOTS Coverage

The project, in collaboration with the National Department of Health and GeoMed, developed an innovative home-based information system (mHealth). The system is used for remote data gathering, patient information and workforce management. It uses the Smartphone technology for contact tracing of MDR cases.

To-date forty-three teams are using the Smartphone technology to monitor households with TB smear positive cases. More than 6,000 households have been visited up to the current reporting period.

A priority activity in the next quarter is the review of the Smartphone to assess if the intervention is effective and efficient to be replicated in other program areas.

More focused research is planned on issues that affect district performance of the program. This includes investigating factors causing high mortality among TB patients in Free State Province, establishing reasons for late presentation of TB/HIV co-infected patients for health care and late ART initiation among TB/HIV co-infected patients

2. INTRODUCTION

The USAID TB Project is designed to support and expand current programmatic strategies by the NTCP for improving early case detection, improving access to laboratory diagnostics, ensure that patients comply with TB treatment regimens, provide appropriate and timely HIV care including ART treatment for eligible patients co-infected with HIV. Overall, the USAID TB Project continues to develop its multilevel support working closely with:

- a. The NTCP to build national support by mobilizing resources and creating a conducive environment for expansion of TB services. This includes TBHIV and developing strategic interventions that could rapidly address MDR/XDR TB threats;
- b. Provincial and district health departments to support the collaborative development of need based strategies to combat TB, TBHIV and DRTB, as well as communities to create appropriate social mobilization and service delivery models for rapid DOTS expansion in the country.

The expected results that the Project's technical and financial inputs are expected to produce include the following:

- Achieve case detection rate of 70 percent and a treatment success rate of 85 percent;
- Improved capacity to plan and implement TB DOTS at community, facility, district, municipality, provincial and national levels;
- Improved surveillance system resulting in early detection of TB cases, DRTB cases, co-infected patients eligible for ART as well as to prevent default and mortality
- Improved understanding and support among the general population regarding TB and TBHIV signs, symptoms, referral, and treatment.

Over the past year the Project has followed SAG's key policies and recent changes. These key strategic policies include the following:

- Health Sector 10 Point Plan, in which point 7 specifically emphasizes accelerated implementation of the National HIV/AIDS Plan and the reduction of mortality due to TB;
- Decentralization of services to PHC and nurse initiated diagnosis, treatment, and monitoring of HIV infected patients, including management of TB/HIV co-infected patients; revised criteria for initiation of ART (for all patients with less than 350 CD4/ml, and all stage 4 patients irrespective of CD4 count);
- Revised National DRTB Control policy: amendment addressing decentralization of DRTB care and community based management of DRTB;

During this reporting period, (July- September, 2011), the Project implemented activities in 21 supported districts (**as reflected in the map on page 5**). The activities include health facility supervisory support visits, in-service and formal trainings, ACSM activities, focus on IPT implementation and closer support to specific Champion Facilities (CFs). The program has also seen the adaptation of the IPT registers in various supported provinces in the same period. This reporting period also marked the roll-out of MDR TB community management workshops in 2 provinces, these are KZN and Free State.

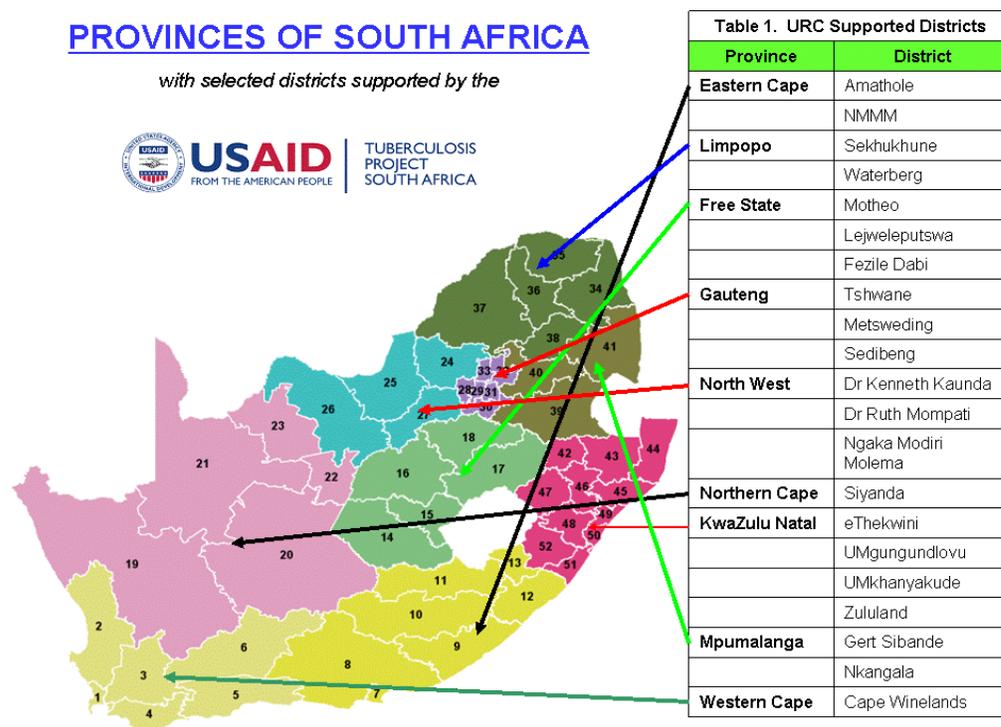
The *Champion Facilities*, which are selected facilities that receive more support and focused attention, have continued to perform well although a dip in performance has been noted for quarter 3 period in some provinces. The project has thus prioritized providing more technical support in verifying data reported, assessing M & E capacity which includes human resources and equipment for these specific districts.

3. OVERALL PROJECT PERFORMANCE

3.1 Performance by Geographic Coverage

Full project implementation activities continued in all nine provinces and twenty one districts although still minimal in Western Cape. This is due to challenges in recruiting a provincial coordinator due to appointed candidates declining the job offers. Two separate appointments were made at different times and both candidates declined.

Table 1: USAID TB allocated districts by province.



The project geographical coverage represents 40% (21/53) of all the districts in the country, translating to 1,188 health facilities.

In FY2011, the 21 supported districts reported 153, 088 TB cases, 132, 876 of which were PTB. As compared with adjusted numbers from FY2010, this represents a decrease of 14,717 total cases (- 8.8%) compared with 167, 805 in 2010 and a decrease of 12,133 PTB cases (- 8.4%), compared to 145,009 PTB cases in 2010 (see fig 1). This decreasing trend has been generally noted in the country.

Of the total TB cases, 48,859 were new smear positive cases (- 5,327 or 6 9.8%). Of note is that while the rate of pre-treatment no smears decreased by 15.9%, and the smear + PTB cases by 9.3%, the smear negative TB cases increased by 8.1%.

Also 45% of the new PTB cases are smear + (SS+); this represent a decrease as compared with the previous year. This could be due to an increase in the rate of SS-, the new PTB cases with no smear having comparatively decreased from 33.2% to 30.0%

The decrease of TB cases numbers is a worldwide finding which has been noted by the WHO in a recent publication, and as mentioned earlier this trend has also been noted in the entire country. The declining trend may be explained either by a decrease of the pool of contagious cases (SS+) coupled with an increased number of death in undiagnosed cases or late presentation of patients with HIV related TB as well as undiagnosed DRTB cases, (WHO news bulletin, September 2011).

Figure 1: TB cases by site of disease

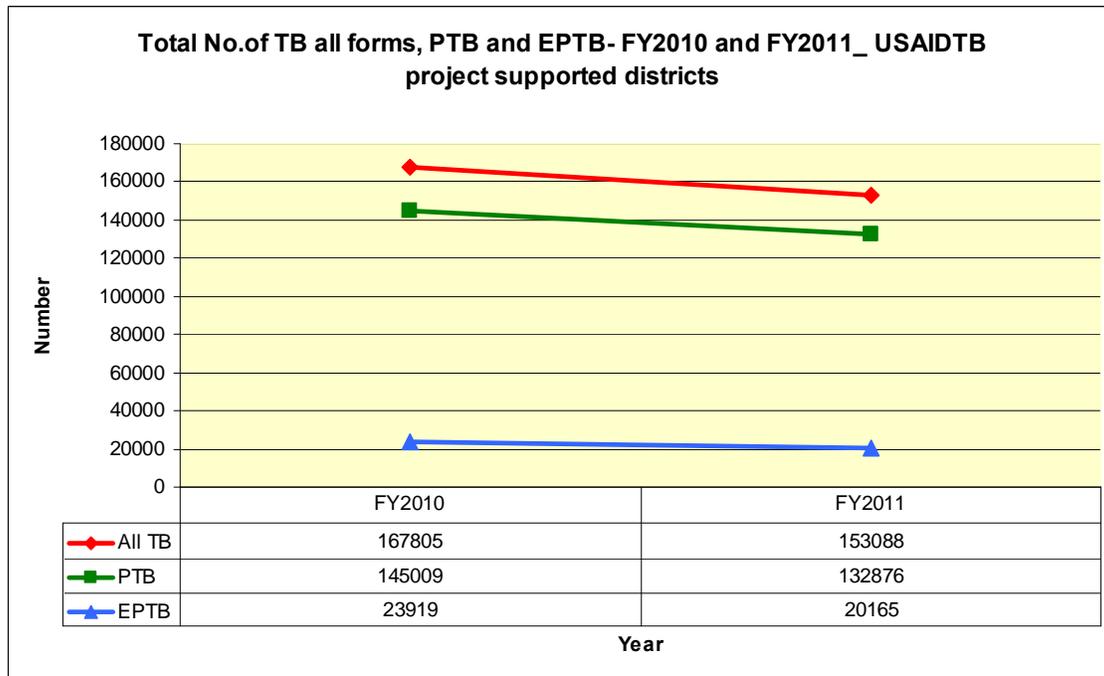


Figure 2: Smear conversion rate New SS+ PTB

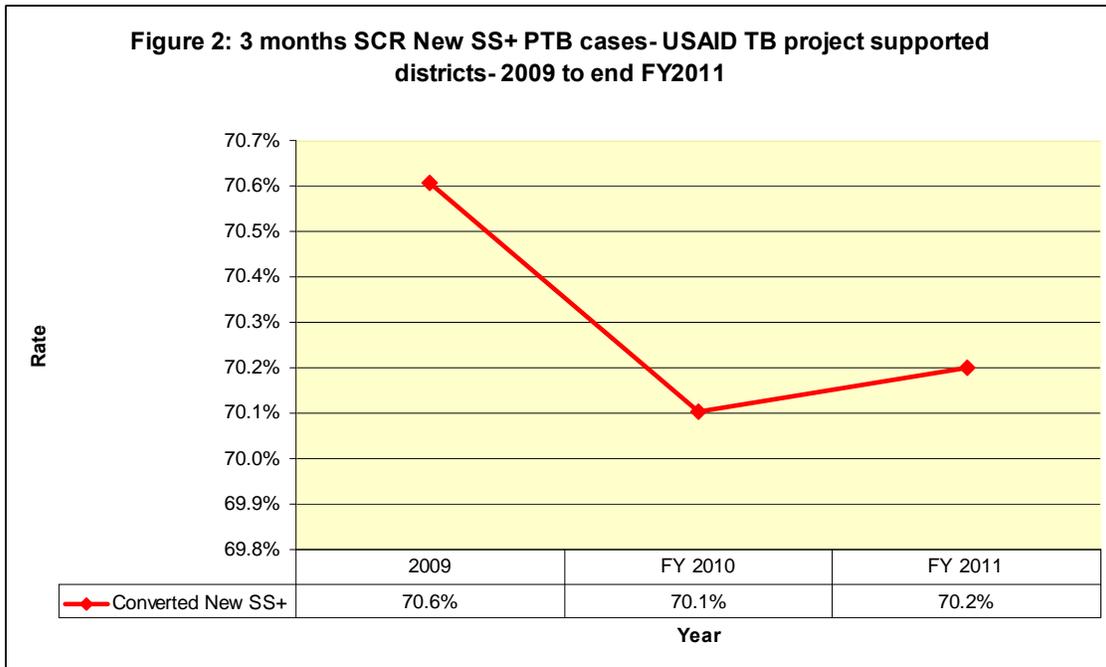
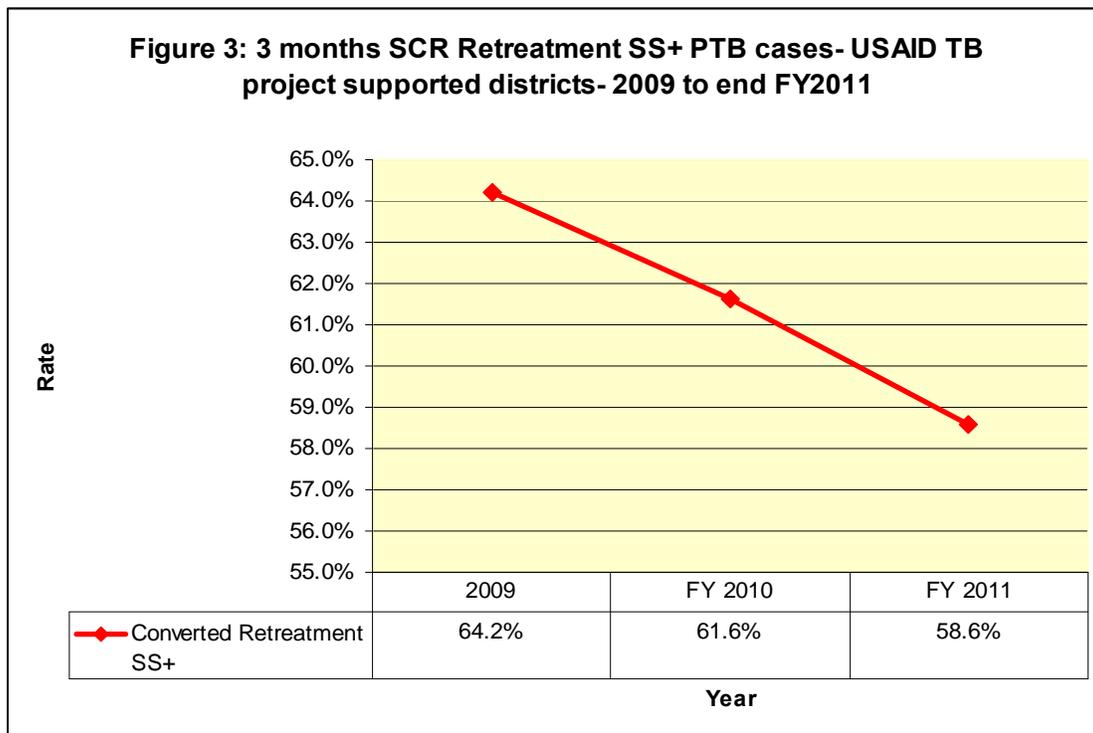


Figure 3: Smear conversion Retreatment SS+ PTB cases



The overall data (see fig. 3) indicate a decreasing pattern in the smear conversion rates of both new and retreatment SS+ PTB cases. This can be explained by the increasing rate of smear not done at 3 months. This finding will be investigated in FY2012 in supported

districts where this trend is observed. A protocol and a questionnaire have been developed to evaluate the possible reasons and contributory factors for smears not done at all levels of recording. This is from facility based paper trails, sub-district ETR and district ETR. The possible laboratory challenges will also be evaluated.

3.1.1 Treatment Outcomes for the 21 supported districts

The set Project targets for FY2011 were: 75% cure rate, 80% TSR and a lower than 5% defaulter rate. Although these targets were not achieved, the cure rate for new smear positive PTB cases improved to 65.7% compared to 61% achieved in 2010. The treatment success rate showed a slight improvement from 71.8% in 2010 to 73.7% in 2011 (see fig 4). Some of the reasons that contributed to the targets not being met include the high defaulter rates and high number of patients transferred out.

Figure 4: Cure rates, Treatment Success Rates (TSR) and defaulter rates for New SS+ cases

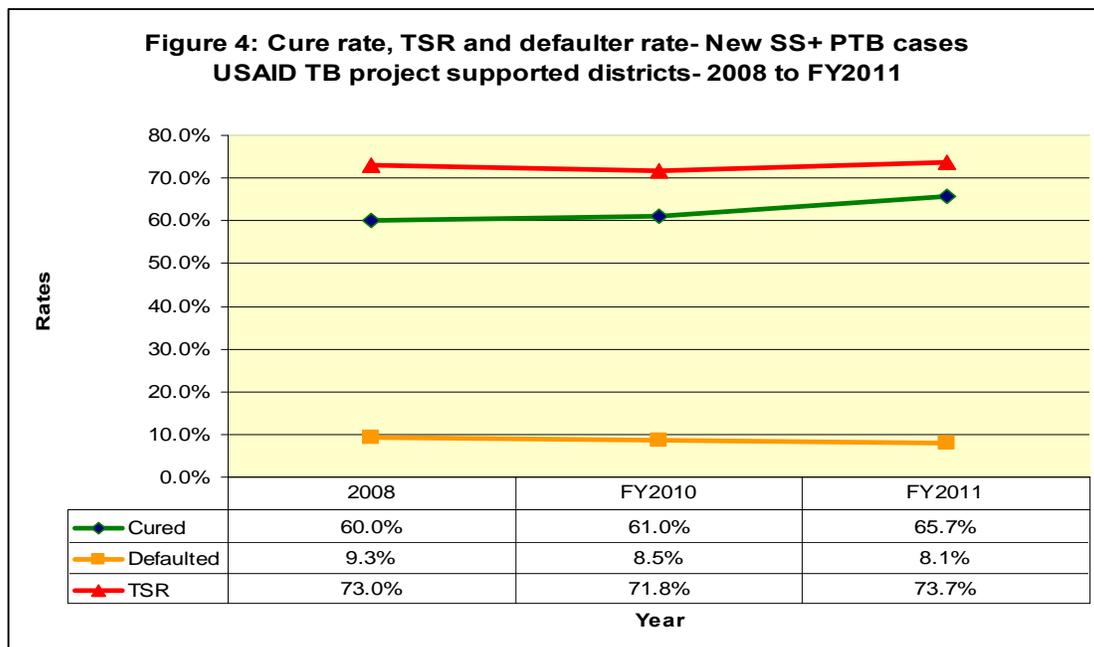
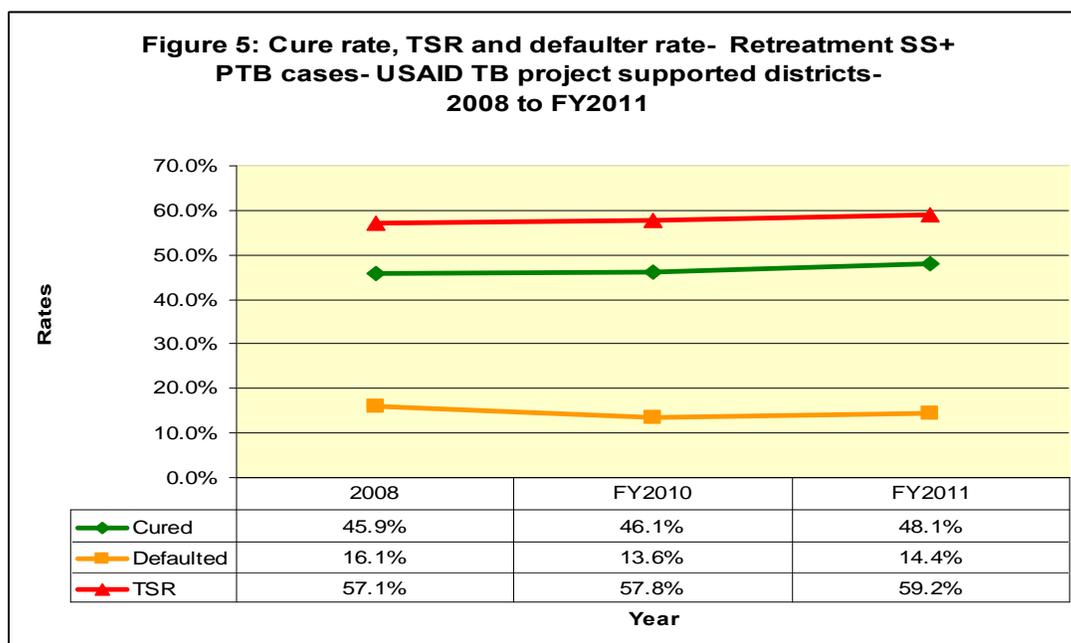


Figure 5: Cure rates, TSR and Defaulter rates for Retreatment SS+ PTB cases:



The treatment outcomes for Retreatment SS+ cases are a cause for concern with a poor cure rate of 48.1%, though a slight improvement from 46.1% in 2010. Similarly the TSR, at 59.2% though low but an improvement from 57.8% in 2010. The defaulter rate depicts a worrying upward trend at 14.4% compared to 13.6% in 2010; the defaulters are potential drug resistant TB patients. Due to the excessive defaulter rates and death rates; it is essential to assess the causes as it may be related either to poor TBHIV integration or to DRTB.

Table 2: USAID Project performance against targets

Indicator	Target (Oct 10-Sep-11)	Performance (Oct 2010 - Sep 2011)
Number of facilities		1188
Registered TB patients	65000	64863
% of all registered TB patients who are tested for HIV through USG-supported programs	85%	88% (57161)
Number of TB cases reported to NTP by USG-assisted non-MOH sector.	3000	3126
Number of improvements to laws, policies, regulations or guidelines related to improved access and use of health services drafted with USG support	1	2
Number of HCWs trained on Laboratory diagnosis of TB	50	19
Number of people trained in DOTS with USG funding	4000	4869

Performance by Project Supported Districts

The performance of the USAID TB project by the specific supported districts is contained in the detailed M & E data report in the **annex section of this report**.

3.2 Performance by Intermediate results

3.2.1 IR1- Improved quality of TB services:

3.2.1.1 Collaboration with Provincial DOH and other stakeholders

During the period July ó September 2011 the Project staff participated in a number of meetings with districts and other stakeholders. The objective was to discuss the progress in the TB and TBHIV programs implementation as well as review the activities that had been undertaken.

National level:

The Project participated in the national consultative meeting at national level in the drafting of the National Strategic Plan for 2012- 2016. The objective of the meeting was to finalize inputs from various quarters and Advisors.

The project also facilitated a joint USAID TB/NTCP meeting where progress made in the provinces was shared and various programmatic challenges and solutions discussed. Two working groups were established with the NTCP, one for training and the other for M & E. The training working group was involved in the recent adaptation of the National Guidelines to include the algorithms of the GeneXpert machines. The National Project staff and the NTCP staff jointly cascaded training in the new algorithms in all nine provinces.

Provincial:

In **Limpopo** province, URC project staff participated in district partnersø meetings in Waterberg where the USAID TB Project Provincial Coordinators and National Expansion Coordinator presented the MOU to the district management Team. The Project was also requested to specify its role in the PHC re-engineering process.

The Project participated in the Waterberg district TB quarterly meeting where the progress over the last quarter was reviewed. The district management Team presented the Health Plan for 2012/13. The Project, together with other partners, was requested to align plans with the district plans. The Project shall conduct joint planning of activities together with district and sub-district TB coordinators.

In the **Northern Cape**, the Project participated in the Provincial PEPFAR partners meeting where a progress report was presented to the TB provincial management Team. This opportunity was used to introduce the Project as a PEPFAR provincial partner and share proposed activities. The Project was requested to assist with MDR community management and Geo mapping of all TB cases in the province.

In **North West**, the Project participated in the district HAST working group meeting where a request was made to coordinate and arrange trainings through the regional training centre. The Project was also requested to disseminate the IPT registers and patient cards to the other 3 sub-districts in Ngaka Modiri Molema. The Project also participated in the provincial PEPFAR partners' realignment meeting where achievements and challenges of priority programs were discussed.

In the **Eastern Cape** the Project participated in the multi stakeholders meeting at provincial, district and sub-district level where the status of TB in the province was presented and discussed. Commissions were established to brainstorm challenges and develop action plans to address the challenges. The Project also participated in the Provincial PEPFAR Partners meeting where presentations were made on progress regarding re-alignment of Plans. The Project presented a plan of the activities and support that will be provided as a Provincial Partner. URC-USAID TB project will be the only program to provide technical support and guidance on TB in the province.

In **Gauteng** the project continued to disseminate guidelines on Infection control and IPT during trainings conducted in all 3 supported districts. Continuous monitoring on compliance with the guidelines was undertaken during the facility support visits. The Project participated in the Tshwane TB focal point meeting where progress on TB status was presented by the District management team. The project was requested to present the IPT register and Patient card and was also requested to assist in disseminating the register in all facilities.

In the **Free State**, Motheo the Project participated in the IPT task team meeting where an update on the IPT tools (IPT register and the TB screening tool) distributed by the Project was provided in (Motheo, Lejweleputswa and Xhariep districts).

The Project participated in various provincial strategic planning in the **Eastern Cape, North West and KwaZulu-Natal** in preparation for the implementation of the new National Strategic Plan.

The Project was represented in several meetings where the PEPFAR realignment strategy was discussed.

Districts and sub districts Meetings:

Several district review meetings were held where TB and TBHIV programmatic issues including challenges and interventions were discussed with District management.

In the Northern Cape Mnquma sub-district and Siyanda district TB review meetings were held, in Sedibeng district quarterly TB meetings were conducted. In Motheo district quarterly meetings were held in September. The project also made a presentation on the findings of the high smear not done investigation. In Waterberg a district quarterly TB review meeting was held on September 15th and a partners' meeting on August 8th. This is where roles of partners in the PHC reengineering was clarified.

In the Free State, Fezile Dabi district, a meeting was held in July to clarify the project's role and improve communication. In Mpumalanga a meeting was held in Nelspruit to introduce the IPT register. In Govan Mbeki sub-district a facility performance review feedback meeting was held. In Gert Sibande district a district Team was established to investigate the high level of pretreatment smears not done

In the North West NW province, Mahikeng district, a HAST meeting was held in July 22. The aim was to clarify the training procedures and roll out of IPT registers to the whole of Ngaka Modiri Molema district. In Ventersdorp a discussion on low microscopy uptake and challenges related to TBHIV, was held. In Taung, a HAST meeting was held to discuss the poorly performing indicators.

In Limpopo province, Warmbaths hospital, a TBHIV collaboration meeting was initiated because of low CD4 uptake by TB patients. In KwaZulu Natal, Zululand district, a meeting was held with the district management team to discuss community based DRTB management. In Gauteng province support was provided to 3 hospitals in Sedibeng in order to optimize the effective management and flow of the TB patients within the facilities.

3.2.2 Support for DOTS expansion:

The project facilitated the establishment of TB focal points within the supported districts. Activities were intensified during this reporting period. Several districts now have established TB focal points through assigned DOH personnel. In the EC, a TBFP was appointed and trained at Dora Nginza hospital. At Cecilia Makiwane, the person has been identified and training is underway.

In North West, 3 new TBFP have been identified for Mahikeng, Zeerust and Gelukspan hospitals and trained on recording and reporting. The TBFP in Ventersdorp was trained on the importance of sputum collection and Gateway clinic was allocated a TBFP in the reporting period.

In Limpopo, Waterberg district, the concept of TBFP was introduced in Mokopane hospital due to challenges in smear collection and recording. In Sekhukhune district, Philadelphia hospital, the already established TBFP has been mentored on the importance of performing culture and DST.

In Motheo National hospital, although the TBFP started in January 2011, the concept of having a TBFP had to be explained to the entire staff due to some misunderstandings of the role. This will be closely monitored and followed up by the Project.

3.2.2 IR2- Increased availability of TB services

3.2.2.1 Capacity Building

National trainings

The joint NTCP/USAID TB (and later included ITECH) national training working group held several meetings during this reporting period. The aim was to finalize the new package of training materials for the NTCP guidelines. The meetings composed of NTCP, I-TECH and USAID TB project. The new adaptations were the algorithms for the GeneXpert machines and the section on TB diagnostic was incorporated in the existing basic TB and DRTB management training packages.

This was followed by the roll out of trainings in all nine provinces on the adapted and new sections in the guidelines including the GeneXpert algorithms.

A total of approximately 399 participants were trained across the 9 provinces. The breakdown of number of participants trained by province is given in table 3:

Table 3: Participants trained by province and date of training in September 2011

Province	Date of training	Estimated* No. of participants
Eastern Cape	14 September 2011	62
Free State	14 September 2011	47
Gauteng	05 September 2011	40
Kwazulu Natal	29 September 2011	66
Limpopo	27 September 2011	45
Mpumalanga	20 September 2011	47
Northern Cape	21 September 2011	30
Northwest	27 September 2011	37
Western Cape	25 September 2011	25

The project conducted joint final evaluations with a sub-partner (IUATLD) and NTCP between July and September. The evaluations were done in Chris Hani (Eastern Cape), eThekweni and uThungulu (KwaZulu Natal), Waterberg and Mopani (Limpopo). This evaluation was a follow up of the TB Programme management training conducted by the IUATLD.

Provincial trainings

A total of 2,347 various categories of health workers were trained in Q2/2011. The split by source of funding was 808 under USAID funds and 1,529 under PEPFAR funds. The gender breakdown was composed of 545 males and 1,772 females, reflecting the gender imbalance in the health care workers force.

Basic TB management training was held in Sedibeng, Metsweding, Tshwane, eThekweni, and Dr KK districts. TBHIV collaborative trainings had the largest number and were conducted in NMBM, Fezile Dabi, eThekweni (2), uMgungundlovu, Zululand (2), Nkangala, JS Moroka subdistrict, Siyanda, Dr KK, and Cape Winelands. Two sessions on TBHIV recording and reporting were held in Sekhukhune.

Three IC trainings were conducted in Tshwane, Metsweding, and Manguzi sub-district (IPT). IC trainings and risk assessments for clinical staff took place in Zululand, Waterberg (two of them), Nkangala, Gert Sibande and Thembisile .

CSIR conducted an IC workshop for the PPM initiative in NMBM where the project also participated. MDRTB trainings were conducted in Motheo (September 15th and 17th) and

Tshwane (July 28th and 29th, 2011). ACSM trainings took place in Amathole (Kick TB), Fezile Dabi (Kick TB), umGungundlovu, Platfontein (Siyanda), and Dr KK (Community dialogues). EC did not provide consistent trainings in this quarter as they already have very high training numbers from the previous quarters.

Table 4: Number trained by province: July – September, 2011

Training numbers for July – September 2011					
PROVINCE	Male	Female	PEPFAR	USAID	Grand Total
Eastern Cape	15	147	80	82	162
Free State	383	565	859	89	948
Gauteng	7	224	80	151	231
KwaZulu Natal	42	320	42	320	362
Limpopo	23	111	134	10	144
Mpumalanga	33	167	141	59	200
Northern Cape	6	56	25	47	72
North West	21	70	58	33	91
Western Cape	13	97	110	0	110
USAID TB Program	2	15	0	17	17
GRAND TOTAL	545	1,772	1,529	808	2,337

Overall USAID TB Training Targets for FY 2011

The USAID Project was able to meet the overall training targets for FY 2011. The total target for training was 9,000 split with 4,000 for USAID and 5,000 for PEPFAR. From October 2010 to date, the USAID TB project has trained a total of 11, 833 HCWs surpassing the target. The funding source is split with 4,869 having been trained with USAID funds and 1,529 with PEPFAR funds (**refer table 4**).

Table 5: Number trained per quarter by funding source: July – September, 2011

Total number trained per quarter				
Q1/FY2011	PEPFAR =	1323	USAID =	1346
Q2/FY2011	PEPFAR =	2343	USAID =	1366
Q3/FY2011	PEPFAR =	2769	USAID =	1349
Q4/FY2011	PEPFAR =	1529	USAID =	808
Totals		7964		4869
Targets		4000		5000

3.2.2.2 TBHIV Integration

Improve mechanism of TB/HIV collaboration

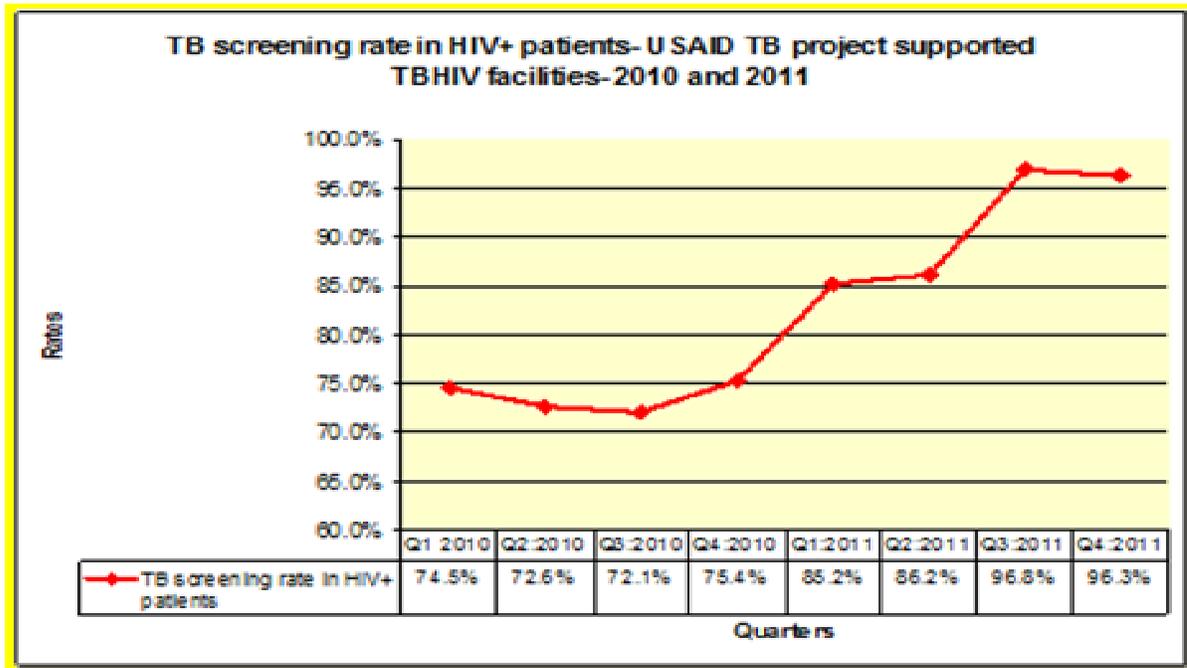
TB/HIV collaborative approach training was conducted for the first time in Western Cape. The collaborative trainings are now conducted quarterly in Free State, KwaZulu Natal, North West and Eastern Cape. In these workshops, district program coordinators, operational managers and operational nurses participate in monitoring implementation of TB/HIV programs.

Intensified Case Finding

A total of 114,906 clients were offered counseling and testing during Q4/2011 in 264 facilities. 109 815 (95.6%) of these were tested for HIV. Out of those who tested, 22,207 (20.2%) tested positive for HIV. TB screening among HIV infected clients remain high, with 96% of the HIV positive clients screened for TB.

Improvements have been observed in all the supported districts. The graphs below are examples of these improvements. Districts with high TB screening uptake among HIV infected clients of >98% include Dr Ruth Segomotsi Mompati district (99%), Dr Kenneth Kaunda (100%), Ethekewini (98%), Nkangala (99%), Gert Sibande (99%) and Zululand (100%). This is depicted in the graphs in figs 7 and 8.

Figure 6: TB Screening rate in HIV+ patients



The graph above indicates the improvements in TB screening among HIV positive patients in Project supported districts since Q1/2010 to Q4/2011.

Figure 7: HIV entry point data in support facilities

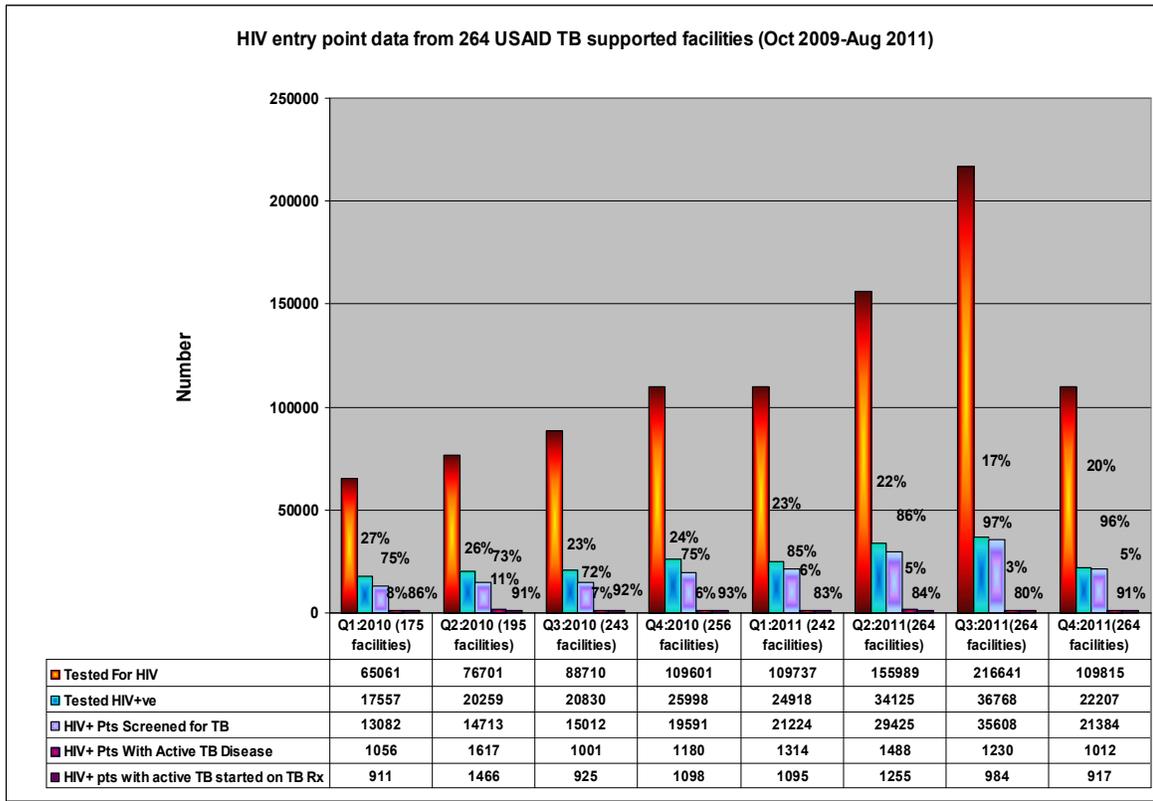


Figure 8: TB screening uptake among HIV patients

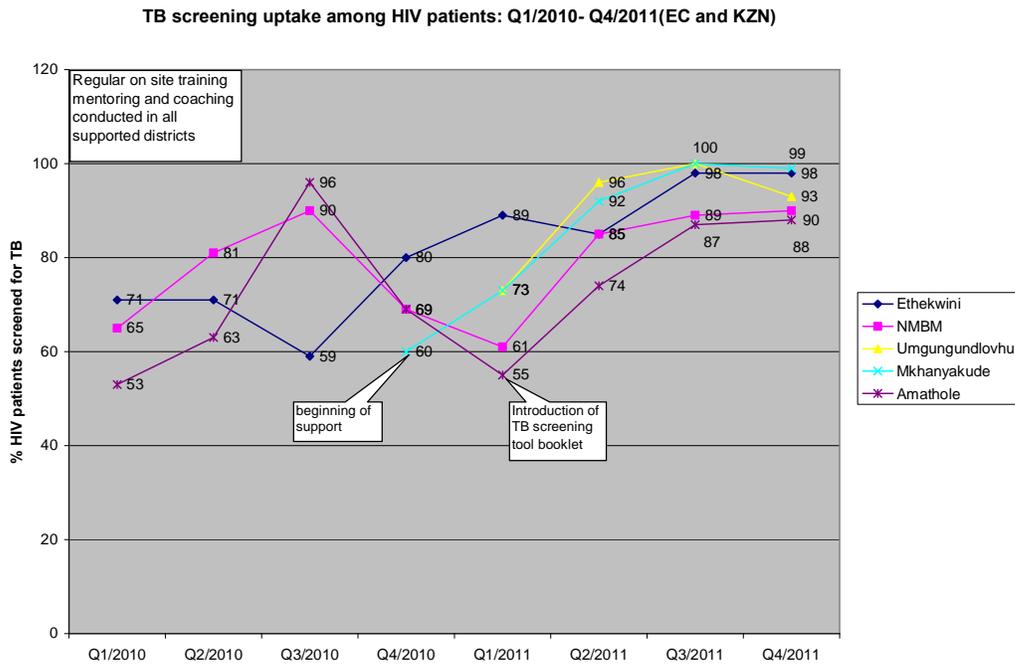


Figure 9: TB screening among HIV patients in NW, Gauteng and Mpumalanga

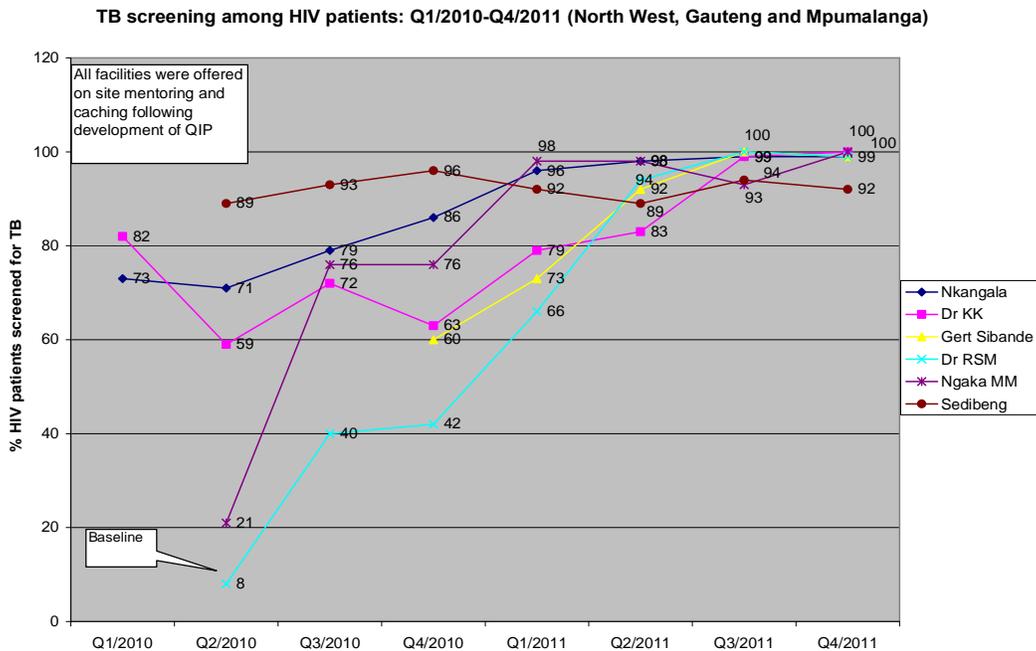


Fig 9 indicates the sustained improvements of TB screening in supported districts. The improvement is attributed to consistent support supervision, in service training and mentoring offered to facility staff by provincial coordinators.

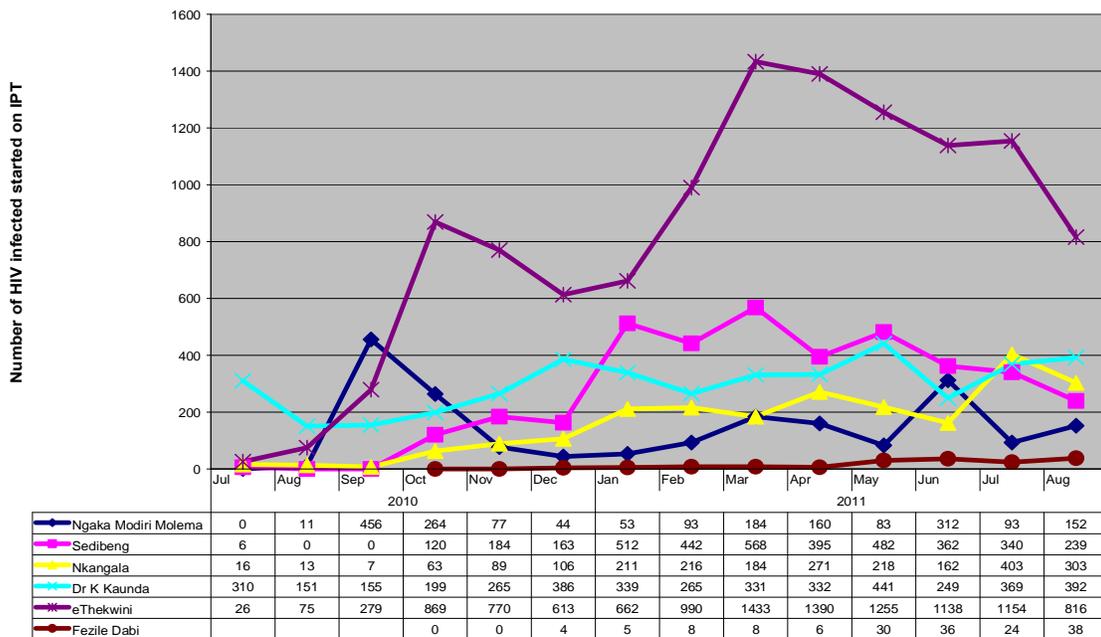
Six thousand two hundred and seventy (6,270) TB suspects were identified; 5,067 (80.8%) of which were investigated further for TB. Active TB was diagnosed in 1,012 clients who were investigated for TB, and 917 (91%) were started on TB treatment, achieving the set target of 90%.

IPT Implementation

IPT implementation continues to improve across the supported districts. During this quarter, an additional 6,980 HIV infected clients have been initiated on INH compared to 8,042 in Q3/2011. This accounts for 46.2% of the 15,114 (HIV infected clients screened for TB less 6,270 TB suspects) who were not TB suspects. The number is lower than in Q3/2011 because of the municipal strike in NMBM during July and August 2011, and lower numbers reported in KZN, as shown by the graph below. The total number of patients on IPT for FY 2011 is 24,302. The INH stock outs have been resolved; no INH stock outs were reported this quarter. The introduction of the IPT register as well as the patient card has resulted in improved recording for follow up patients on IPT in a number of districts as depicted in the figure below.

Figure 10: IPT uptake

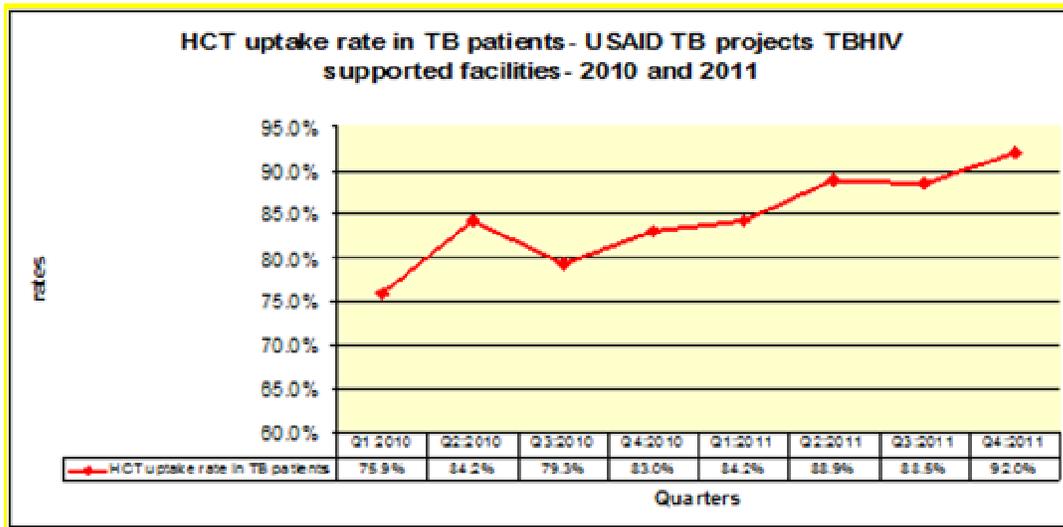
Figure 6: IPT Uptake: July 2010-Aug 2011



Decrease burden of HIV in TB patients

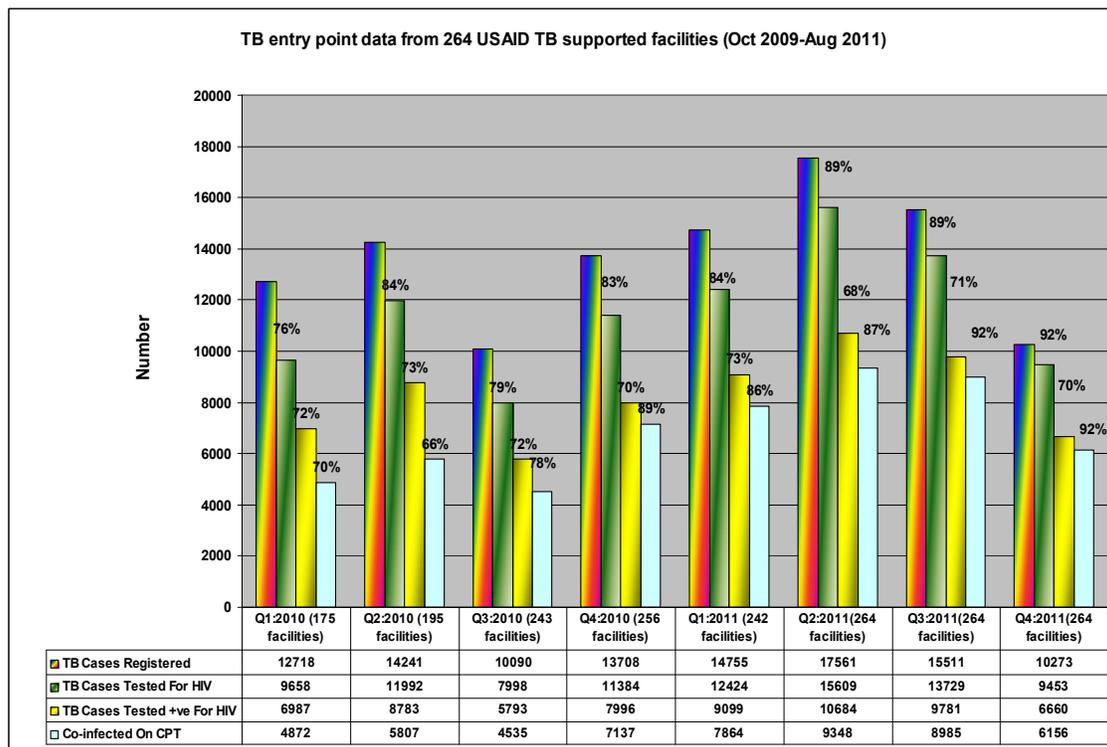
There had been an important improvement in TBHIV performance since the onset of the USAID TB project as shown in the 2 following graphs:

Figure 11: HCT uptake rate in TB patients



The graph above indicate the overall testing for HIV in TB patients in project supported districts from Q1/2010 to Q4/2011

Figure 12: TB entry point data in supported facilities



A total of 10,273 TB cases were registered in Q4/2011. 9,453 (92%) of the TB cases registered had a HIV test done, against a target of 90%. The TB/HIV co-infection rate remains high, averaging 72% for all districts. Of the 6,660 TB patients who are co-infected with HIV, 2121 (31.8%) were already on ART when diagnosed with TB. A further 1,409 (21.2%) patients were initiated on ART; bringing the number of co-infected patients on ART to 53%.

Out of the 4,539 co-infected clients who were not on ART, CD4 count was done in 3,018 (66.5%). CPT uptake among TB/HIV co-infected clients remain above the set target of 85%, with 92% of the co-infected patients on cotrimoxazole prophylaxis in Q4/2011. CPT uptake among TB/HIV co-infected clients remain above the set target of 85%, with 92% of the co-infected patients on cotrimoxazole prophylaxis in Q4/2011. This is an improvement compared to 86% reported in Q1/2011. CPT uptake remains above 90% in the following districts: Ethekwini (93%), NMBM (94%), Lejweleputswa (96%), Gert Sibande (95%), Nkangala (98%), Mkhanyakhude (98%), Sedibeng (100%), Zululand (95%) and Dr Kenneth Kaunda (94%). The graphs (figure 11 and 12) above depict some of the improvements mentioned above. The improvements noted on CPT uptake among co-infected clients are attributed to constant facility support supervision and mentoring offered to facility staff by provincial coordinators.

Figure 13: CPT uptake among co-infected patients in EC and KZN

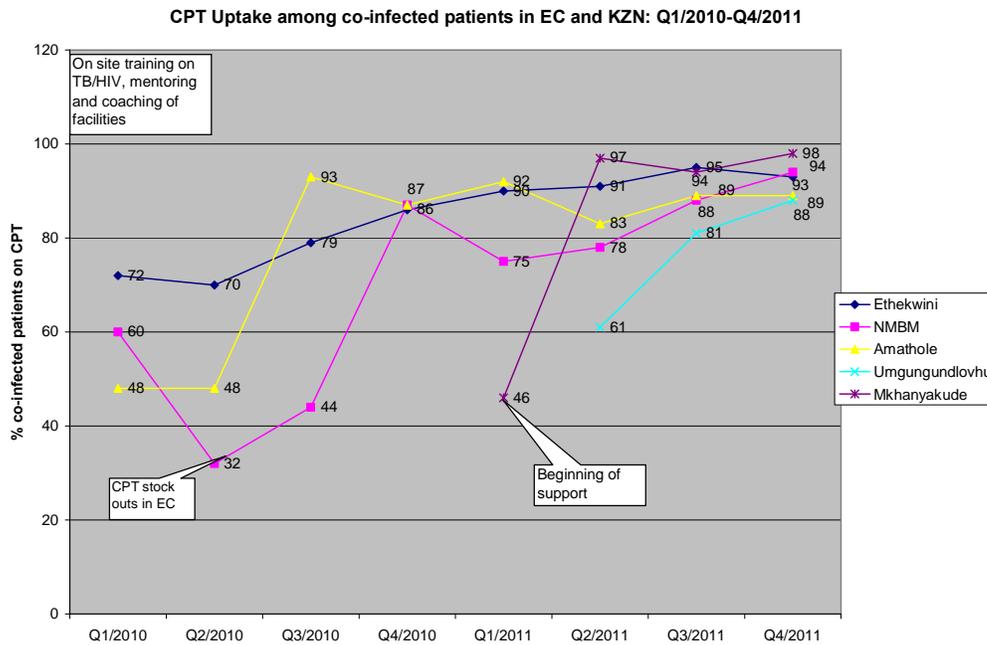
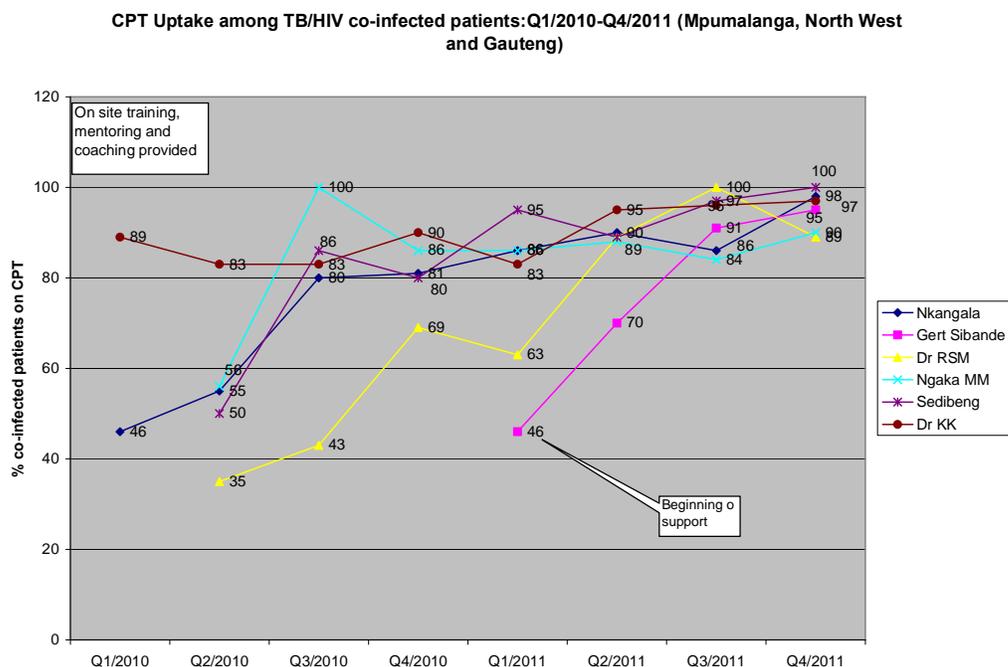


Figure 14: CPT uptake among TB/HIV co-infected patients



Infection Prevention and Control

Training has been provided to a total of 1,774 health care workers on infection control and infection control (IC) risk assessments since October 2010 (target 1,500). IC risk assessments and follow ups were conducted in 218 facilities, exceeding the target of 190. 219 facilities have IC plans in place, while 171 have a responsible person for IC in a facility. Among the facilities where follow up risk assessments were conducted in Matlosana (Dr Kenneth Kaunda district), all had the IC plans in place, but were found not to address respiratory protection, resulting in some facilities not having respirators available. All the 17 facilities however had a responsible person in place. In Mkhanyakhude and Umgungundlovu where initial risk assessments were conducted, training of staff on IC had never been done. In Nkonkobe sub district (Amathole district), although IC risk assessments had not been conducted previously in the 7 facilities, most of the administrative controls were in place. Five of the 7 had IC committee and IC plan, only 4 had a responsible person. All the 7 facilities had respirators available. Triaging is implemented in most of the facilities, despite the challenge of infrastructure.

3.2.2.3 Community MDR TB Management

The Project continued to work with the NTCP in the implementation of community management of Drug resistant TB. Implementation started in the previous reporting period. **the first** workshop was conducted in the Eastern Cape jointly with the provincial Department of Health and Philanjalo in Port Elizabeth on 27th June 2011.

The **second workshop** was held in Bloemfontein, Free State 15th September. Forty-seven participants from five districts (Fezile Dabi, Lejweleputswa, Motheo, Thabo Mofutsanyane and Xhariep) attended the training. All five districts managed to prepare a plan.

Mapping all TB cases was conducted for the Free State province. This is the first map produced for the province according to data provided by the Department of Health.

The **third workshop** was held in Ulundi, KwaZulu-Natal, on 28th September. Eighty participants attended. Vryheid Hospital will be provided with direct support from Philanjalo and the USAID T B project to assess the facility readiness and to have training done.

mHealth and geo mapping for improved community management of MDR TB

There is an overwhelming need to improve the management of TB in communities in South Africa. The Department of Health's move towards community-based management of TB is a positive development and needs to be supported with appropriate tools. At present, the weakest link is related to the current information system. The system has poor quality and outdated data that do not provide real time information that could meaningfully inform management decisions.

The USAID TB project, in collaboration with the National Department of Health and GeoMed, a private sector service provider, has developed an innovative home-based information system. A synergetic combination of Google[®] Earth and smart phone technology, the mHealth system is used for remote data gathering, patient information management and workforce management. It effectively brings healthcare directly to the community by enabling mobile health workers to link all the mapped households with home-base care services.

In the EC, the USAID TB provincial coordinators attended monthly meetings at MDRTB units and provided technical support in the recording and reporting meetings for DRTB. Coordinators also followed up on the of the district DRTB implementation plan for community based DRTB management developed in the previous quarter



USAID TB conducting MDR-TB community management workshop in the Free State

3.2.2.4 Diagnostic System's strengthening

Bacteriological Coverage and Smear Not Done (pre-treatment and follow-up)

In the last quarterly report (April to June 2011), the project reported a low bacteriological coverage and high number of smears not done (SND) in some of the USAID TB supported districts, including Gert Sibande, Motheo, Ramotshere Moiloa and Zululand. The project developed an intervention to address these challenges which was to investigate the possible causes in the affected districts, and this was implemented in the current reporting quarter.

Motheo district in Free State was selected as a pilot district for investigation into the causes of high smears not done and/or low bacteriological coverage. This investigation was limited to Mangaung sub-district, which has facilities receiving direct support on TB/HIV activities by Project staff. Facilities that contribute to this challenge in the sub-district were identified from the ETR data, using a low bacteriological coverage as an indicator of the problem.

Four facilities (Heidedal CHC, National District hospital, and Bloemspruit and Kagisanong clinics) were selected and visited for investigation. A review of the paper-based records (registers and patient cards) was done in association jointly with the facility staff. It was found that the main cause of SND was poor recording and lack of interest and/or understanding of the TB program by some facility staff. The findings were discussed with the relevant facility manager and TB focal persons and interventions were mapped out. Follow up visits to monitor progress will be conducted in January 2012.

Facility Diagnostic Information Collection (North West DRAT)

In response to challenges of poor performance of the TB program in Northwest, as identified by the province and the USAID TB project, the project conducted a District Rapid Appraisal of the TB program (DRAT) in Ventersdorp and Mafikeng in August, 2011. The DRAT was coupled with a basic collection of diagnostic information using the Facility Diagnostic Information Collection (FDIC) tool. This tool documents information on the types of TB tests the facility has access to; the laboratory that serves them and frequency of specimen courier; laboratory supplies and their procurement; TAT as well as communication channels between facility and laboratory. The objective of collecting this information is to identify practices and/or gaps in the systems that may affect the bacteriological diagnosis of TB in the facilities.

Twenty-two facilities in Mafikeng and 10 facilities in Ventersdorp, were assessed. In Mafikeng, all the facilities visited, with the exception of the two hospitals, were found to be collecting smears, and the TAT was generally good. However, the key challenge noted in all facilities, for both Mafikeng and Ventersdorp, was that there was no evidence of DST requests/results. When asked, facility staff indicated that they do not specify DST on the request form, despite indicating that they all have access to DST. The reason was that they were informed that the laboratory will automatically do DST on all positive cultures. This was confirmed by the provincial TB director during one of the facility visits. Another major challenge noted was poor recording or updating of results. This problem was much worse in Ventersdorp, where the facilities indicated that they do not have TB registers.

NTCP GeneXpert training and Guidelines Update

The project developed training materials on GeneXpert and Line probe assay. The materials were integrated into the NTCP's training agenda on the new diagnostics. Due to the delay in training of HCWs on the GeneXpert, the resulting challenges that were experienced in the districts where the technology has already been implemented, an urgent training schedule for all the 9 provinces was arranged for the month of September 2011. USAID TB project staff member's facilitated training for 7 of the 9 provincial trainings conducted (6 for the Laboratory Advisor). In provinces where the laboratory advisor could not attend, arrangements were made with NHLS to facilitate.

Incorporation of diagnostic training into the existing Basic TB and DR-TB training

An overview of TB diagnostics was also included in Basic TB and DR TB management trainings conducted in Gauteng between the months of July and September. This will continue as a way of reinforcing diagnostic information to as many HCWs as possible.

3.2.3 IR3- Increased demand of TB services

3.2.3.1 ACSM

Community dialogues

In **Northwest**, Dr Kenneth Kaunda District was assisted in conducting a dialogue session around TB/HIV in the Matlosana Sub District. This was attended primarily by traditional practitioners, community health care workers and a small religious sector contingent. A working group was established and an action plan formulated. The action plan is based on data presented by the district health office and discussions held on experiences. The working group will be monitoring the implementation of the plans and give feedback in future dialogue meetings.

In **Gauteng**, Sedibeng, a community dialogue was held where 89 people gathered at the Bophelong community hall in Sedibeng to take part in a community dialogue around TB/HIV issues in the district. This was a follow up dialogue meeting bringing together various health practitioners and the district health office. The aim was to consolidate plans and give progress report on the TB/HIV working group that was established. Additional action plans were developed and incorporated into the district plan.



A health care worker and traditional healers discuss issues of patient referrals during a community dialogue workshop in Sedibeng District Gauteng, Province.

School Outreach Campaign

In Free State the KICK TB Campaign was rolled out from 26th to 29th July reaching a total of 9,125 learners in eight schools focusing on TB and TB/HIV messages. Soccer balls with TB and TB/HIV messages were distributed to all learners.

In Northern Cape the KICK TB campaign was rolled out to eight schools across the province by the Provincial Health Department in partnership with USAID TB Project and Lily MDR partnership. A total of 3954 learners were reached with TB AND TB/HIV messages.

In Eastern Cape KICK TB Campaign was also rolled out and reached 4,500 school children with TB prevention messages. The schools in which the campaign was held are: Caesar Mlumbi Primary ó 97 learners; Sivuyisiwe Primary ó 185 learners; Msobomvu Primary ó 519 learners; Cookhouse Primary ó 462 learners; Van Der Merwe Primary ó 902 learners; St Boniface Primary ó 734 learners; Nonyaniso Primary ó 641 learners and Ellen Olivier Primary ó 960 learners.



Mrs Joyce Ramakau at a Kick TB school outreach event which was rolled out in Fezile Dabi and Lejweleputswa districts



Health Care Workers sharing TB information during the Kick TB campaign in Northern Cape



The Eastern Cape Provincial MEC for Health, Mr Sicelo Gqobana at a Kick TB Campaign launch.

Capacity Building in ACSM

The Project conducted a ACSM training with Provincial ACSM directorate in KwaZulu-Natal where 28 people were trained in “ACSM, Strategic Information and M&E”. The target group included ACSM practitioners from all districts and NGOs funded to conduct ACSM. The outcome of the training was to ensure that the participants will be able to implement provincial ACSM workplan for 2012.

Other ACSM Activities:

- Door to door campaigns for ICF were conducted in Matlosana
- Defaulter tracing in Emalahleni sub district (which was a success with a 86% return rate)
- TBHIV campaign was conducted in Gauteng, Emfuleni subdistrict, with door to door and health education
- TBHIV awareness campaign was conducted in Klipspruit (Sekhukhune) reaching 3,800 - people; 5 people were diagnosed with HIV (out of 208 tests) and 38 TB suspects were identified and 0 TB case confirmed

TB/HIV campaign 13-16 September 2011

Bringing services to the community of Evaton West Area at Emfuleni Sedibeng District



3.2.3.2 Small Grants

During the reporting period the small grants planned activities focused more on facilitating close-out processes for Wave 1 grantees, projects start up for Wave 2 grantees and review of applications for Wave 3 grants.

The Small Grants team provided technical support to all Wave I grantees to ensure that the close-out process is completed appropriately. A further 5 grantees contracts ended between July to September 2011. To date, 11 out of 13 Grantees contracts have ended and they are in process of submitting final reports.

Closeout documents have been sent to all grantees that have completed their projects and final reports have been received and are under review. Final invoices will only be paid once grantees have satisfied the requirements for close-out process.

Table 6: Current status on close out processes for Wave 1 Grantees*

Name of organization	Start Date	End Date	Current Status and progress
1.SACTWU	1 May 2010	30 June 2011. (Closed)	Close-out reports submitted and reviewed. Final invoice have been paid. Follow-on application has been recommended, the grantee is in the process of finalizing work plan and performance indicators for approval.
2. MCDI	1 April 2010	31 July 2011 (Closed)	Close-out reports submitted and reviewed. Final invoice have been paid. Follow-on application was not recommended. Regret letter will be sent to the organization
3. Philanjalo (Intensified Case Finding project)	1 April 2010	31 May 2011 (Closed)	Close-out reports submitted and reviewed. Final invoice have been paid and project has been closed. Follow-on application has been approved. The grantee will start implementation on the 1 st of October 2011
4. TB HIV Care	1 April 2010	31 August 2011	Close-out notification has been sent to the grantee, reviewed. Final invoice has not been paid due to the grantee delaying in submission of signed modification letters. Follow-on application was not recommended. Regret letter sent to the organization.
5. Aurum Institute (FS : 3Is project)	1 July 2010	31 October 2011	The project will be finalized by end of October 2011. Close-out notification letter has been sent. Final reports are expected by end of November 2011.
6.Aurum Institute (NW : DCS Project)	1 July 2010	30 September 2011	Project ended 30 th September 2011. Close-out notification letter has been sent.
7. SACBC	1 May 2010	31 May 2011 (Closed)	The final reports for close-out have been submitted and reviewed. Final invoice has been paid and the project has been closed. A follow-on application has been recommended. The organization is finalizing work plan and performance indicators for final approval.
8.Siyaphila Youth Development	1 April 2010	31 July 2011	The project ended in July 2011. Final reports have been submitted and are still under review. Follow-on application was not recommended
9.Operation Hunger	1 April 2010	30 September 2011	The project closed on the 30 September 2011. Notification letter has been sent. Final reports are expected by end of October 2011. Follow-on application was not recommended.
10.Namakwa Development Foundation	1 June 2010	31 May 2011	Contract ended in May 2011, the grantee is struggling to finalize the close-out report due to lack of capacity. The Small Grants team together with URC Provincial Coordinator is working with

			the grantees to finalize reports.
11. DTTC	1 April 2010	31 December 2011	The study was extended and will end by 31 December 2011 due to implementation delays in Mpumalanga and Kwazulu-Natal provinces. The project is doing well and has managed to visit the last province that was outstanding. The final report will be due by end of January 2012.
12. Reach for Life	1 May 2010	31st May 2011	Contract ended, final reports have been received and are under review. A follow-on application has been recommended, the organization is working on finalizing the work plan and performance indicators for final approval.
13. Humana People to People	1 May 2010	30th June 2011	The project ended on the 30 th June 2011. Final reports have been received and are still under review. Follow-on application is still under review.

* This table excludes the two national projects (Philanjalo Community MDR and Impangele)

Wave 2

A total of 21 NGOs have been awarded grants including follow on of some Wave 1 grantees. Only 3 out of 21 have thus far started with implementation of their activities in their respective areas of work. Delays in finalizing work plans and performance indicators have delayed the start up processes, and the remaining grantees will start implementation in the next reporting quarter.

Wave 3

A total of 121 applications have been received covering all nine provinces, with a total of 148 projects. There were some organizations applied to implement projects in more than one province. Short listing process was started and qualifying applications have been forwarded to different reviewers. To date only 4 review meetings 55 applications have been reviewed so far. All recommended applicants will be provided with an opportunity to work on recommendations of the reviewers before being submitted to HQ for further review.

3.2.3.3 Public- Private Mix/ Partnerships (PPM)

In KZN, the project trained and mentored staff in the Sugar Bay Industry which led to TB screening, sputum collection, adherence support to TB patients, and contact tracing in the employees' households

The Project started PPM activities in NMBM with general practitioners and with traditional healers in KwaZulu-Natal and both activities are on going. The concept of PPM with traditional healers in KwaZulu-Natal was used by North West for bench marking. A meeting was organized with the North West traditional healers where referral forms were shared. In the FS, the project is awaiting its introduction by the province to the mines to be able to initiate a PPM model in the area

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3.2.4 Improved Management of TB Support Systems

Support Supervision

During this reporting quarter the project participated in facility support supervision across all supported districts except in Cape Winelands where there is still no provincial coordinator. The support visits are conducted on a monthly basis to address TB and TB/HIV program activities.

In Kwazulu Natal, ETR Support is provided at least once a week in supported districts. Issues of data capturing, data quality and timely reporting by the facilities are addressed and monitored during these visits. Monitoring of performance of individual facilities and direct support to those not doing well was conducted. At UMkhanyakude training and coaching of new data capturers as well as mentoring of new TB Coordinator was carried out. Assistance in capturing data was provided and backlog from Q3/2010 has been cleared.

In North West DRAT was conducted in Ventersdorp sub-district and Mahikeng sub district. This was a joint activity with provincial, sub district and Project staff. Gaps in TB data were identified and improvement plans would be developed jointly with the sub-district, facility and operational managers. The DRAT exercise revealed challenges in TB/HIV collaboration activities, IC implementation and low suspect rate in the sub districts.

In Gauteng district quarterly meetings were held in Sedibeng where progress, achievements and challenges were presented. Improvement plans were developed jointly with the district to address gaps identified.

In Free State, the project conducted ETR.NET support through on the job training of the newly recruited M&E officer in Fezile Dabi district. The officer was trained on data entry, generating reports and conducting data checks. The project also conducted a TB data clean up and validation exercise in Motheo district. The objective of the exercise was to review and audit the facility TB case identification registers, TB registers and treatment cards from facilities in the two districts as well as assist facilities to develop improvement plans for improving recording of information in the registers and treatment cards.

In Eastern Cape, the project supported and facilitated the Amathole district TB-HIV quarterly review meetings. TB coordinators, HIV managers, quality assurance managers, clinic supervisors, information managers, health promotion managers (from the five sub-districts of Amathole), facility operational managers (Mnquma sub-district) the hospital manager for Thafalofefe district hospital at Mnquma as well as other NGO partners supporting the district, (namely AMREF and Donald Woods Foundation) attended.

DRAT review was conducted in 10 facilities at Mnquma sub-district as part of district TB-HIV quarterly review support intervention. Feedback on the DRAT review findings was provided revealing a drastic reporting of TB screening, 100% treatment uptake in TB confirmed patients, but an increased retreatment rate and a huge challenge with contact tracing. The identified gaps and proposed interventions were shared with the facility managers of the relevant clinics that were reviewed in order to follow up on remedial interventions.

All the five sub-districts of Amathole developed action plans to address the identified challenges in the review and these were submitted to the district TB manager as well as the provincial TB M & E manager for follow up.

In Limpopo, project staff initiated TB/HIV peer review meetings on performance indicators jointly with facility and sub district staff.

In Mpumalanga, Nkangala the project provided support to the quarterly DOT report focusing on understanding of indicators, data collation and data analysis.

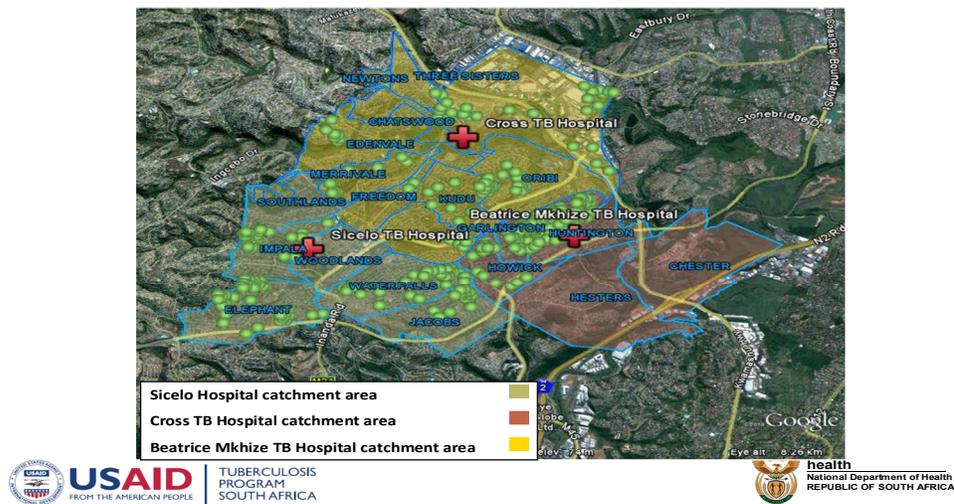
3.2.5 Tested New Approaches for Expanding DOTS Coverage

The project, in collaboration with the National Department of Health and GeoMed, a private sector service provider, has developed an innovative home-based information system. This is a synergetic combination of Google Earth and smart phone technology. The mHealth system is used for remote data gathering, patient information and workforce management. It effectively brings healthcare directly to the community by enabling mobile health workers to link all the mapped households with home-base care services.

The activities of the contact tracing teams are ongoing in EThekweni. The table below summarizes the completed activities.

Table 1: Intensified case finding coverage report in Q4/2011

TEAMS AND HOUSEHOLDS					
Total no. of teams	No. of households visited	No. of index cases found		No. of contacts found	
53	5,986	4,328		4,933	
TB					
Category	No. of persons screened	No. of suspects found	No. of sputum collections	Children started on IPT	Started on TB treatment
Children 0-4	364	133	14	0	48
Persons >=5	2,286	852	277	11	133



The Geomapping of DRTB cases has been completed in EC, Gauteng and Free State where the highest numbers of MDR TB were found in Lejweleputswa (mines and migrant workers). This exercise will be continued in the next quarter in Limpopo, Northern Cape and North West.

4. CHALLENGES

4.1 Administrative challenges solutions

Problems identified in the last quarter still Outstanding

There are still delays in implementation of activities in Western Cape as a provincial coordinator is still to be appointed. The last appointed candidate declined the offer.

Resolution - The Cape Wineland District requested URC-HR to re-advertise the post in their local news paper, website and other media which was for and interviews are scheduled for October.

The Finance manager assisting with Grants resigned in the last quarter, the post was re advertised. Interviews for the Grants manager and for the Technical director were conducted and submissions of appointed candidates were forwarded to USAID for approval.

4.2 Implementation challenges and problem resolution

High No Smears at Pre-treatment

High number of smears not done at initial diagnosis was reported in several Project supported districts over the past quarters. Some examples are Hospitals and NonMOH sites in North West and UMkhanyakude. EThekwini had a rate of 22%, Zululand had a rate 45%, Amathole in EC, Motheo had a rate of 25% and Gauteng 25%. In Limpopo the high smears not done pre treatment still remains high in Waterberg district (25%). The project through the Diagnostic Advisor and national expansion Coordinator in Free State conducted a study in one of the 4 supported facilities to address the issue of high no smears done at pre treatment.

Preliminary results indicate recording gaps, however a full report will be provided in the next reporting period.

Long TAT

Due to industrial action by NHLS staff some facilities were starting to report long turn around times high might be more evident in the next reporting quarter.

High Defaulter Rates

In NMBM, the supported champion facilities have a high defaulter Rate, similarly champion facilities in North West, (Pudumong, Tigane, Botshabelo) are high. The Project will explore the reasons for high defaulter rates and will conduct a root cause analysis in order to make its recommendations.

TB/HIV Collaboration

HIV care for TB/HIV co-infected patients remains a challenge. CD4 count is taken from only 60% of patients not on ART instead of all. The process of appointing doctors to improve ART access has been affected by the PEPFAR realignment process. The Project has now been assigned as a provincial PEPFAR partner with limited access to facility level activities.

The unavailability of staff in Limpopo which was supported from the National office resulted in implementation of some activities lagging behind. Two Coordinators have since been appointed to support the 2 districts.

Management and Information Systems

The late submission of TB forms for ETR information capturing in Ramotshere Moiloa, NW reported in the last quarter has still not been resolved. A CDC officer has just recently been appointed. The district management team has made a commitment to monitor and give feedback on the progress. In Free State, provincial coordinators were denied access to facility patient records and this was reported to the district.

Training

Although the project exceeded the annual training target by approximately 2000, the requests received from the districts were for similar category of trainings resulting in some categories lagging behind as per scheduled trainings in the work plan.

PEPFAR Realignment Strategy

5. COMMON AGENDA ITEMS

5.1 Project Administration

The USAID TB Project staff submitted eight Abstracts for presentations at the IUATLD conference, seven Abstracts were accepted for Poster presentation in Lille in October 2011.

5.2 Coordination with Local and Other Stakeholders

1. The Project has been in negotiating with two institutions for training assistance: the International Council of Nurses (ICN), through a local chapter DENOSA. DENOSA was requested to provide TB management training for student nurses specific Nursing colleges prior to graduating from. A proposal was received which is currently under review and evaluation. It is in the process of partnering with the ICN) through their local affiliate, the Democratic Nursing Organization of South Africa (DENOSA) and the University of Stellenbosch.
2. Stellenbosch University was requested to provide training on infection prevention and control to health care workers and community care workers, including conducting if risk assessments in district hospitals over a two year period. A proposal was reviewed, comments forwarded and awaits the adaptations

6. BEST PRACTICES/SUCCESS STORIES

Miracles of facelift on documentation in accelerating TB screening among HIV Positive patients: Scaling up the uptake of IPT among eligible HIV positive patients.

Background

The USAID TB Project is currently supporting TBHIV programs in Amathole and Nelson Mandela Bay Metro Districts. The URC-USAID TB project identified a gap in Recording of IPT activities (IPT register) as well as activities related to screening of HIV Positive patients for TB (TB screening tool)

The unfavorable consequences of this gap at facility level implied that:

- i. There was no register for documenting eligible HIV positive patients that Have been put on IPT
- ii. There was no register for documenting HIV positive patients that have been screened for TB

Unavailability of these registers at facility level meant that:

- 1) Patients initiated on IPT were not recorded and there was no monitoring tool for patients on IPT
- 2) Patients that are screened for TB were not documented anywhere and similarly there was no appropriate tool in place to record this intervention

The USAID TB project developed an IPT register and IPT card for recording and monitoring patients on IPT. The project reproduced and printed the TB screening tool into a carbonated booklet version. The above tools were then presented to project supported district management teams for comments and further input. The Eastern Cape provincial TB-HIV and TB Monitoring and Evaluation manager was part of this consultation process over and above the supported district teams. All the tools which include the IPT register, patient IPT card as well as the TB screening tools were unanimously accepted. Initially for immediate distribution into the TB-HIV facilities in the project supported districts of Amathole and Nelson Mandela Bay Metropolitan Municipality. Later they were distributed to non project supported facilities within the districts and beyond.

The tools were disseminated to the 34 TB-HIV facilities in Amathole district and 17 TBHIV facilities in NMBM. The TB-HIV provincial coordinators assisted by the facility based project coordinators were responsible for the distribution process. The sub-district counterparts were part and parcel of this process which also encompassed onsite orientation and mentoring of facility staff on using these tools.

Results:

- 1) All the project supported TB-HIV facilities in both project supported districts are using both IPT and TB screening the tools
- 2) For the first time, there is now a correct source document clearly reflecting patients that are on IPT, enabling monitoring of these patients (routine screening for TB and INH side effects in every visit) as well as the outcome of IPT intervention.
- 3) All patients on IPT carry an IPT card that clearly shows their progress on IPT and which serves as a valuable IPT management and follow up tool
- 4) Every facility has a TB screening tool in which all HIV positive patients that have been screened for TB are documented including TB suspects that have been referred for further clinical work up (for example, sputum examination)
- 5) TB screening tools also serve as a useful source document for HIV positive clients who have been screened for TB and found to be TB clinically fit, with negative TB symptom screen and thus referred for IPT.

Follow-on Results:

There is increased IPT uptake in the TB-HIV facilities where the IPT tools are being implemented.

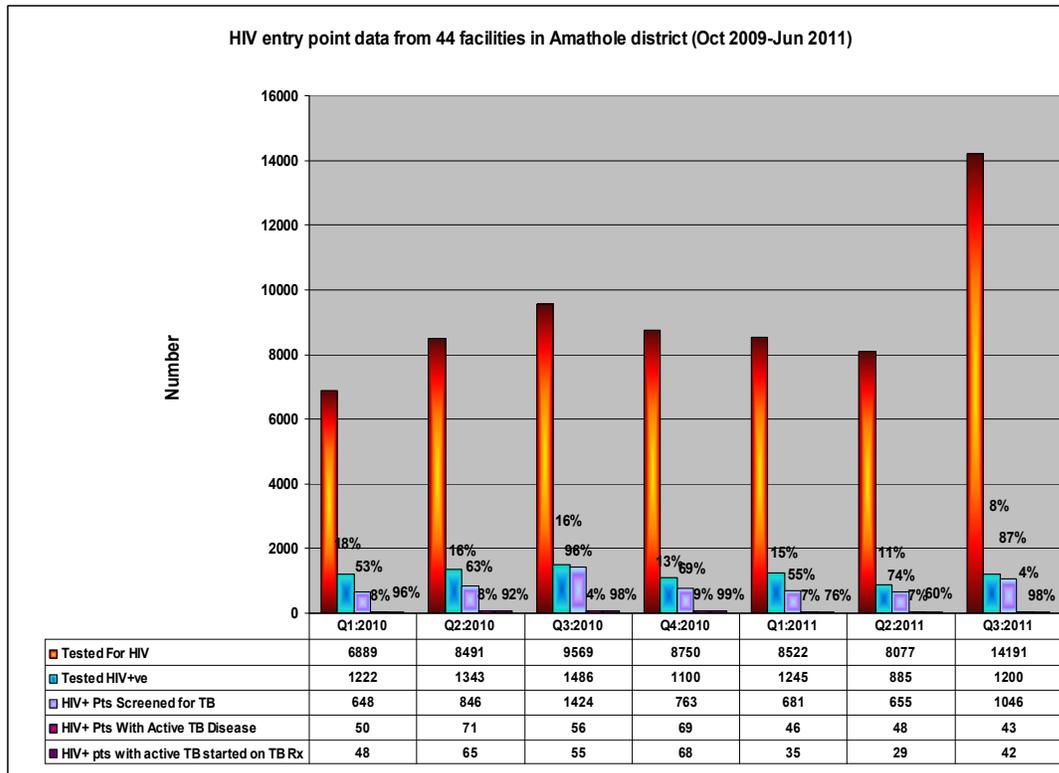
There is an increase in the number or proportion of HIV positive patients that have been screened for TB in the TB-HIV facilities implementing the tool (**refer to TB-HIV data below**)

The supported sub-districts have requested the project to roll out these tools to the non project supported facilities

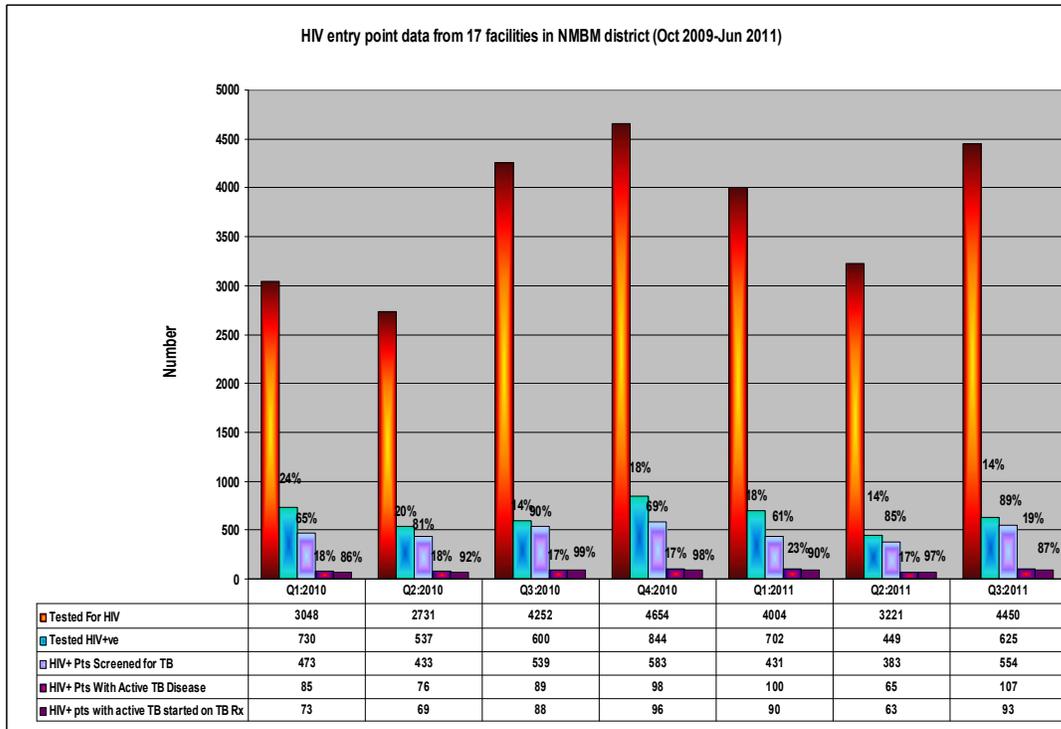
Chris Hani district, which is not supported by the project, has also requested to adopt the IPT tools for roll out in the district. Africare, a Chris Hani district designated PEPFAR partner, offered to assist in rolling out the tool.

The Nelson Mandela Bay Metropolitan Municipality Pharmaceutical Committee has adopted the project IPT register for its own use in recording monitoring of IPT implementation in the district.

The TB-HIV provincial coordinator intends to rollout the tool throughout the province for recording and monitoring of IPT interventions, however, standardization of tools through PEPFAR re-alignment process may require further engagement around the planned rollout.



In Amathole district, TB screening among HIV positive patients increased from 54, 7% in Q1 2011 to 74% in Q2 2011 and subsequently to 87% in Q3 2011. This was the same period when the TB tools were being disseminated and institutionalized, thereby demonstrating the impact of a successful rollout and implementation of the TB screening tool at facility level.



At NMBM, TB screening among HIV positive patients progressed from 61, 3% in Q1 2011 to 85% in Q2 2011 and 88,6% in Q3 2011. This also demonstrated the impact of the TB screening tool at facility level.

Conclusion

The USAID TB Project, working closely with DoH and other interfacing partners within the province, has made significant progress in developing practical program implementation tools. The USAID TB Program in Eastern Cape has an objective of advancing the ECDoH agenda and maintains good relations with the Department of Health. However the level of effort of the program does not always match the districts and province expected results. There is therefore need to partner with other institutions in developing needs based plans and co-implement activities.

7. Planned activities for next quarter

Key activities for the next quarter (October- December 2011):

- Participate in Provincial meetings with TB directorate in Free State, Eastern Cape and North West. The purpose of the meetings is to re establish the relationship with the above mentioned provinces.
- Introduce the project in respective provinces where we are designated as provincial PEPFAR partners.
- Participate in the preparation of the upcoming World AIDS DAY with the National and provincial department of health.
- Conduct DRAT feedback conducted in Mahikeng and Ventersdorp to the District Management team in North West. Strengthen support supervision visits jointly with the Ventersdorp sub-district coordinator.
- Strengthen TB Focal points in Ngaka Modiri Molema and Dr Kenneth Kaunda districts in North West and continue with establishing TB focal points.
- Conduct Data clean verification and validation exercises in Fezile Dabi, Motheo and Lejweleputswa districts.
- Conduct MDR-TB community management workshop in Limpopo, North West and Mpumalanga and Complete Geo-mapping of MDR TB patients in the remaining provinces
- Complete wave 3 review process and conduct post award workshops
- Conduct community dialogues in Motheo, Umkhanyakude, Sekhukhune, and Umgungundlovu districts.
- Finalize preparations Commence with the implementation of the 3Is campaign
- Conduct Data Quality Assessments in poor performing districts.