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TB CARE I

TB CARE I - Namibia

Year 2

Annual Report

October 1, 2011 – September 30, 2012

October 30, 2012

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List of Abbreviations

| | |
|--------------------|--|
| ACSM | Advocacy Communication and Social Mobilization |
| AIDS | Acquired immunodeficiency syndrome |
| APA | Annual Plan of Activities |
| ART | Anti-retroviral therapy |
| ARV | Anti-retroviral drugs |
| CCRC | Central Clinical Review Council |
| CBTBC | Community Based TB Care |
| CDC | United States Centers for Disease Control and Prevention |
| DR-TB | Drug-resistant TB |
| GFATM | Global Fund against AIDS, TB and Malaria |
| HIV | Human immunodeficiency virus |
| HSS | Health Systems Strengthening |
| IEC | Information, education, and communication |
| ICT | Information and communication technology |
| KNCV TB Foundation | Royal Netherlands TB Foundation |
| M&E | Monitoring and evaluation |
| MoHSS | Ministry of Health and Social Services |
| MoU | Memorandum of Understanding |
| MSH | Management Sciences for Health |
| NGO | Non-governmental organization |
| NSC | National Steering Committee (for TB) |
| NTP | National Tuberculosis and Leprosy Program |
| OGAC | Office of the Global AIDS Coordinator |
| OP | Condoms and other prevention |
| OR | Operational Research |
| OVC | Orphans and vulnerable children |
| PEPFAR | President's Emergency Plan for AIDS Relief |
| PLHIV | Person living with HIV |
| PMDT | Programmatic Management of Drug Resistant TB |
| PMTCT | Prevention of mother-to-child transmission |
| PMU | Programme Management Unit, TB CARE I, The Hague |
| SI | Strategic Information |
| SSF | Single Stream Funding (GFATM) |
| SOPs | Standard Operating procedure |
| TB | Tuberculosis |
| TB CAP | TB Control Assistance Programme |
| TB-IC | TB Infection Control |
| TB COMBI | Communication for Behavioural Impact for Tuberculosis |
| UNAM | University of Namibia |
| USAID | United States Agency for International Development |
| UVGI | Ultra-violet Germicidal Irradiation |
| VCT | Voluntary counseling and testing (for HIV) |

Executive Summary

The lead partner implementing TB CARE I (a USAID funding mechanism supporting TB control programs) in Namibia is KNCV TB Foundation. Other collaborating partners with a presence in Namibia include WHO and MSH, while The UNION, although not represented in the country provided international collaboration especially in the area of TB/HIV. A total of USD2.1 million was allocated to TB CARE 1 to fulfill its mandate in APA2.

APA2 followed successful implementation of APA1 with minimal new activities added. This strengthened TB CARE I's role in providing technical and financial support to TB control activities jointly planned with the NTLP according to the second-term NTLP Strategic Plan, 2010 - 2015.

Of the eight technical areas of in which TB CARE I is mandated to implement globally, Namibia focuses on six; Universal access, TB/HIV, PMDT, Infection Control, Health Systems Strengthening and Monitoring and Evaluation (M&E)/Operational Research (OR).

With TB CARE 1 support, Namibia achieved 85% treatment success rate for new smear positive TB cases for two years now, in TB/HIV, 90% of TB patients know their HIV status, and 31 out of 34 districts have community based TB care organizations supporting the MoHSS in CBTC services. TB CARE 1 continued to provide technical support to the NTLP throughout the year. By end of September 2012, TB CARE 1, Namibia had implemented over 90% of planned activities.

Some of the major highlights of APA2 include:

1. Improved universal access through maintained Political commitment to TB control
 - a. Successful Commemoration of World TB Day (WTBD) and TB weeks in Windhoek
 - b. Inauguration of an eighty (80) bed TB ward in Rundu hospital
 - c. Providing CB-DOTS supportive supervision to Erongo and Karas regions
 - d. Participating in a USAID Health Forward mission to Erongo region
2. TB IC control measures strengthened
 - a. Installation of Ultraviolet Germicidal Irradiation (UVGIs) in Oshakati and Rundu
 - b. All 34 districts hospitals had TBIC assessments in APA2
 - c. Supporting the TBIC focal person at HQ to attend a two-week training at Harvard University on Infection control
3. Improved funding opportunities for TB and HIV control through
 - a. The signing Global Fund Round 10/Single Stream Funds (SSF)
 - b. Approval of the TB/HIV OGAC proposal
4. PMDT strengthened
 - a. Successful conduct of the DR TB international training in June 2012
 - b. Two TA's on PMDT received in APA2
 - c. Regular CCRC meetings on second line medicines regimens for DR TB patients
5. Health systems strengthened through:
 - a. Revision and launch of the National Guidelines for the Management of Tuberculosis and Leprosy
 - b. Supporting several trainings for health care workers in conjunction with ITECH
 - c. Hosting several TA's from KNCV TB Foundation on HSS, HRH, PMDT and general programmatic issues
6. Operations research capacity strengthened and improved capacity to analyse data
 - a. Supporting the NTLP's participation in the UNION conference in Lille, where Namibia presented 7 abstracts display and presentation
 - b. Successful conduct of OR training for regional TB managers and national level staff with Drs. Ellen Mitchell and Juliana Cuervo-Rojas with a view to publish some work done by local researchers. Five research topics emanated from the OR training: 1. Factors associated with long Turnaround time for smear microscopy, 2. TB Diagnostic, treatment and reporting practices in private sector, 3. Impact of new guidelines on

- contact tracing, 4. An Ecological study on reasons for variations in TB case-notification rates across Namibia, 5. Factors associated with development of Leprosy in Namibia
- c. Development of Standard Operating Procedure (SOP's) for the conduct of zonal review meetings and supporting conduct of quarterly data review meetings throughout the country and revision of the quarterly reporting formats for community based TB care
 - d. Program management and data quality support visits to identified regions of Kavango and Khomas.

Introduction

TB CARE I Namibia is led by KNCV TB Foundation with collaboration from WHO and MSH in country to provide support the National TB and Leprosy programme (NTLP) in all aspects of TB control. Other coalition partners such as The UNION also collaborate with TB CARE I Namibia throughout the year. The total buy-in from USAID for APA2 was USD2.1 million. Most of the activities planned for Annual Plan of Activities (APA) 1 were continued in APA 2 with minimal changes. This allowed TB CARE I to play an important role in TB control during this period through strengthening ongoing activities jointly planned with the NTLP as per the second-term NTLP Strategic Plan, 2010 - 2015. There is buy-in from the local USAID mission in most of the planned activities and concurrence is sought on any activities implemented outside the plans.

The six technical areas of Universal access, TB/HIV, PMDT, Infection Control, Health systems Strengthening and Monitoring and Evaluation (M&E)/Operational Research (OR) dominated the efforts of TB CARE I during this quarter.

Due to unforeseen delays in disbursement of Global Fund 10 money, TB CARE I provided gap-filling financial support to three major local non-governmental organizations (NGOs) involved in community-based TB care (CBTBC), including CoHeNa, Penduka and Health Unlimited. Other CBTBC organisations supporting the NTLP include; Namibia Red Cross, Project Hope and Cestas.

TB CARE 1 operates in all 13 regions of Namibia through TA provided to the National TB and Leprosy Program. It also provides direct support to two regions of Erongo and Karas in the area of community based TB care services. During APA2, TB CARE 1 expanded direct support through CBTBC services to all the seven districts in the two regions. In broad terms, TB CARE I provided general technical advice in all aspects of TB control to the Ministry of Health and Social Services throughout the whole country. This was made possible by a team of committed public health specialists (3) and support finance (3) and support staff (2) in the country office.

Universal Access

Technical Outcomes

| Expected Outcomes | Outcome Indicators | Indicator Definition | Baseline (Year or timeframe) | Target | Result | Comments | |
|-------------------|--|---|--|-------------------|-------------|------------------|---|
| | | | | Y2 | Y2 | | |
| 1.1 | Increased demand for and use of high quality TB services and improve the satisfaction with TB services provided (Population/Patient centered Approach) | 1.1.1 Updated information available on the quality of services from a patients' perspective | Indicator Value: Yes/No | No, 2009 | Yes, 2014 | Annual | No data on this Because there is no source for this data: no survey has been conducted to inform us on this. |
| 1.2 | Increased quality of TB services delivered among all care providers (Supply) | 1.2.4 CB-DOTS program is implemented | Indicator Value: Score (0-3) based on definition. | 2, 2009 | 3, 2014 | 3, 2012 | CB-DOTS expanded to remaining districts. TB CARE I now provides direct CB-DOTS supports all seven districts in the two regions |
| | | 1.2.5 Capacity building of health care workers | Description: Number of field promoters (health care workers) trained on any area of TB control using TB CARE 1 funds Indicator value: Number Level: National and Regional (TB CARE 1 geographical area) Source of funds: TB CARE I project/USAID Frequency: Quarterly/Annually | 75%, 47/63 (2011) | 100% (2014) | 100% 63/63, 2012 | An annual retreat for all field promoters supported through TB CAREI funding was held in Windhoek during this fiscal year. A total of 63 (7 male and 56 females) participants attended. Training on TB guidelines |

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|--|--|---|---|-----------|--------------------|-----------------------|--|
| | | | Means of Verification: Training reports Disaggregation: by gender and type of training | | | | and networking were the main outcomes of this retreat. |
| | | 1.2.6 Direct salary/stipend support for health care workers supported health workers in the region at the beginning of the TB CARE I project | Description: The proportion of USAID salary/stipend supported health workers who should remain in-country beyond USAID support that are known to have been absorbed by Namibian stakeholders. Indicator value: Percentage Level: National Source of funds: TB CARE I project/USAID Frequency: Annual Means of verification: Employment contracts Numerator: Number of USAID salary/stipend supported health workers absorbed by Namibian stakeholders at the end of each year. Denominator: Total number of USAID salary/stipend | 47 (2011) | 100% (63/63), 2014 | 0% (0 out of 63) 2012 | All 63 field promoters were paid their stipends from Oct 2011 to September 2012. It is anticipated that these cadres will be absorbed into the MoHSS in due course |

Key Achievements

During the second quarter of APA2, a successful innovative initiative of commemorating world TB day through what is called a flash-mob (*see picture, page 21*).

TB CARE I expanded to cover all seven districts in the two regions. Until 2010, only four out of the seven districts in the two regions had field promoters supported through TB CARE 1. Expanding to cover all seven is a good result in providing universal access to community based TB care services. It is also important to note that presence of field promoters improves universal access in the sense that these cadres ensure contacts are traced and investigated for TB.

Challenges and Next Steps

Suboptimal funding for some CB-DOTS organizations relying on Global Funding resulted in near-total disruption of services. TB CAREI stepped in with gap-filling funding to these organizations.

Infection Control

Technical Outcomes

| Expected Outcomes | Outcome Indicators | Indicator Definition | Baseline (Year or timeframe) | Target | Result | Comments | |
|-------------------|--|---|--|-----------|----------|----------|---|
| | | | | Y2 | Y2 | | |
| 3.2 | Scaled-up implementation of TB-IC strategies | 3.2.2 Facilities implementing TB IC measures with TB CARE support | The number of facilities where TB CARE I supported the implementation of TB IC measures. | 17 (2009) | 34, 2014 | 34, 2011 | TB-IC implemented throughout the country. All 34 district hospitals of Namibia have been assessed and have been found to be compliant with infection control practices (at least each has a functional TB-IC policy/plan in place). |

Key Achievements

TB CARE I also supported the National TB-IC focal person at NTLP to attend training on TB-IC at Harvard University. Visits of the TBIC focal person to all 34 districts was facilitated through TB CAREI funding. Installation of UVGIs in two regional referral centers of Rundu and Oshakati also happened this year with support from TB CARE1 funding. During the second quarter of APA2, the Minister of Health and Social Services inaugurated a new 80-bed TB ward in Kavango region. This will serve as a specialized unit managing difficult cases of TB in the region which has a huge burden of TB and MDR TB. Although direct financial support for the construction was from the state, TB CARE I provided technical support during the design and construction of this unit.

Challenges and Next Steps

It is generally difficult to influence building projects once they are begun since the Ministry of Health and Social services are not responsible for infrastructure; TB CARE I played a facilitator role in ensuring that there is communication between the NTLP and the directorate of Policy and Planning which is responsible for infrastructure in the ministry. Continued engagements are planned to ensure that there is smooth collaboration at all stages of planning and implementing construction work.

Programmatic Management of Drug Resistant TB (PMDT)

Technical Outcomes

| Expected Outcomes | | Outcome Indicators | Indicator Definition | Baseline (Year or timeframe) | Target Y2 | Result Y2 | Comments |
|-------------------|-----------------------------------|--|--|--------------------------------|-----------|------------------|--|
| 4.1 | Improved treatment success of MDR | 4.1.2 MDR TB patients who are still on treatment and have a sputum culture conversion 6 months after starting MDR-TB treatment | Indicator Value: Percent Numerator: Number of MDR TB patients in a cohort who are still on treatment and had culture conversion latest at month 6 (having had 2 negative sputum cultures taken one month apart and remained culture negative since) Denominator: Total number of MDR patients who started treatment in the cohort. | 52% (143/275) (2009) | 65% | 66% (105/158) | These figures are for period January to September 2011. Oct-Dec 2011 results were being analyzed during the zonal review meetings currently from 8-12 October 2012 |

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| | | 4.1.3 MDR TB patients who are still on treatment and have a sputum culture conversion 11 months after starting MDR-TB treatment | Indicator Value: Percent Numerator: Number of MDR TB patients in a cohort who are still on treatment and had culture conversion latest at month 11 (having had 2 negative sputum cultures taken one month apart and remained culture negative since) Denominator: Total number of MDR patients who started treatment in the cohort | 58% (160/275), 2009 | 70% (2014) | No data on this | No data on this |
| | | 4.1.4. MDR TB patients who have completed the full course of MDR TB treatment regimen and have a negative sputum culture | Indicator Value: Percentage Numerator: Number of MDR TB patients in a cohort who completed a course of MDR treatment and who fit the WHO criteria for cure or | 46% (93/201), 2008 | 70% (2014) | 115/275 (42%) annual | The 2009 cohort is reported here. A very high mortality among DR TB patients was reported throughout the years. |

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| | | | completed treatment Denominator: Total number of MDR patients who started treatment in the cohort | | | | |
|--|--|--|---|--|--|--|--|

Key Achievements

TB CARE I, in collaboration with The UNION supported the conduct of another international course on Clinical management of DR TB for doctors; a total of 19 (11 male and 8 female) participants attended this course. Almost all weekly planned CCRC meetings to deliberate on second line treatment regimens for DR TB patients were held with coordination and financial and technical support from TB CARE I. This improved treatment outcomes and ensured there were no undue delays in commencement of second-line TB medicines where indicated. It also strengthened collaboration between clinicians and central TB unit.

Procurement and delivery of tents bought with TB CARE I support was done in Tsumkwe for the Ambulatory care project for DR TB patients in this constituency.

Challenges and Next Steps

NO major challenges.

Next steps:

1. Continued use of the CCRC as a platform for improved collaboration with regional and district staff in the management of DR TB
2. Use of the eTB manager in case management of patients on second line TB medicines
3. Use of the gene Xpert to diagnose TB and DR TB will enable more Rif susceptible and Rif resistant TB patients to be commenced on treatment without much delay.

TB/HIV

Technical Outcomes

| Expected Outcomes | | Outcome Indicators | Indicator Definition | Baseline (Year or timeframe) | Target | Result | Comments |
|-------------------|--|---|--|----------------------------------|----------------------------|-----------------------------------|--|
| | | | | | Y2 | Y2 | |
| 5.1 | Strengthened prevention of TB/HIV co-infection | 5.1.2 Districts that are providing HIV prevention message at TB services | Indicator Value: Per cent Numerator: Number of randomly-selected districts, providing DOTS, which have a trained staff on HIV counseling. Denominator: Total number of districts providing DOTS | 50% (17/34), 2009 | 95% (32/34)? (2014) | 100% (34/34)? | All 34 districts in Namibia participated in training health care workers on TB guidelines which incorporate TB/HIV efforts |
| 5.2 | Improved diagnosis of TB/HIV co-infection | 5.2.2 TB patients with known HIV status | Indicator Value: Per cent Numerator: Total number of all TB patients registered over a given time period who were tested for HIV (after giving consent) during their TB treatment Denominator: Total number of TB patients registered over the same given time period. | 74% (9849/13332), 2008 | 90%, 2014 | 84%, (10042/11924) 2011 | Namibia has been doing very well in ensuring that all TB patients are offered an HIV test and subsequent HIV care if indicated. The figures reported here are for January to Dec 2011. |
| 5.3 | Improved treatment of TB/HIV co-infection | 5.3.1 Registered HIV infected TB patients receiving ART during TB treatment | Indicator Value: Per cent Numerator: All HIV-positive TB patients, registered over a given time period, who receive ART (are started on or continue | 35% (1995/5676), 2009 | 90% (2014) | 54% (2700/4990) (2011) | More still needs to be done to increase the coverage. |

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|--|--|--|---|--|--|--|--|
| | | | previously initiated ART) Denominator: All HIV-positive TB patients registered over the same given time period. | | | | |
|--|--|--|---|--|--|--|--|

Key Achievements

Provider-initiated HIV testing and counseling has become standard practice in Namibia as evidenced by the 84% and close to 100% coverage in HIV testing rate and provision of CPT respectively.

Challenges and Next Steps

Although the ART guidelines have been reviewed to include immediate commencement of the dually infected on ART, slow implementation has been mainly because of the backlogs in patients eligible for ART and staggered implementation of new guidelines

Health System Strengthening (HSS)

Technical Outcomes

| Expected Outcomes | | Outcome Indicators | Indicator Definition | Baseline (Year or timeframe) | Target Y2 | Result Y2 | Comments |
|-------------------|--|---|--|------------------------------|------------------|------------|--|
| 6.1 | Ensure that TB control is embedded as a priority within the national health strategies and plans, with commensurate domestic financing and supported by the engagement of partners | 6.1.1 TB care and control strategic plan embedded within national health strategies, including quantifiable indicators and budget allocations | Indicator Value: Yes/No | Yes, 2010 | Yes, 2015 | Yes, 2011 | Existence of Second Medium Strategic plan for TB and Leprosy is evidence that TB is a priority health problem. |
| | | 6.1.4 Local KNCV and NTLP staff provided continuous education to upgrade skills and knowledge | Indicator Value: Number Level: National and regional Source: KNCV quarterly report Means of Verification: Numerator: Number of staff attending local and international trainings/conferences/workshops Denominator: Total number of NTLP staff | No baseline (2009) | No target (2009) | 5/7 (2011) | All planned international trainings for local staff were held with support from TB CARE I. Other trainings which were not planned but were deemed important were also supported such as the WHO STOP TB workshops on strategic planning and global fund M and E systems strengthening. |

Key Achievements

TB CARE I supported the successful conduct of a Team Building exercise in which the NTLP staff, KNCV staff and other support staff from the Directorate of Special programs participated in (see pictures). This was a very important activity whose benefits will be improved cooperation and enhanced collaboration among these key stakeholders in Tb control in Namibia.

Visit to The Hague by the CRO and finance manager; attending a WHO sponsored workshop (in Harare) by the CMO and M and E officer on grant implementation, two training sessions for the DR TB clinical coordinator in Kenya, support training on Infection control for the TB IC focal person were some of the major achievements in strengthening capacity of NTLP central level staff. TB CARE1 also supported three NTLP staff and one KNCV staff to attend the UNION conference in Lille during the first quarter of APA2. All these are efforts at building the technical capacity of Namibians.

Challenges and Next Steps

Inadequate funding for international training/international conference attendance continues to be a challenge as this is important to build capacity at national level. Putting more funding on international trainings for central level staff will improve capacity building at this level.

Monitoring & Evaluation, Surveillance and OR

Technical Outcomes

| Expected Outcomes | Outcome Indicators | Indicator Definition | Baseline (Year or timeframe) | Target | Result | Comments |
|--|---|---|------------------------------|-------------|-------------|---|
| | | | | Y2 | Y2 | |
| 7.2 Improved capacity of NTPs to analyse and use quality data for management of the TB program | 7.2.1 National M&E plan is up-to-date | Indicator Value: Yes/No | No (2009) | Yes (2014) | Yes (2011) | In 2010, an M and E plan was developed alongside the NSP 2010-2015 |
| | 7.2.2 NTP provides regular feedback from central to lower levels | Indicator Value: Percent per quarter Numerator: Number of quarterly feedback reports prepared and disseminated disaggregated by three levels. Denominator: Total number of recipient units/facilities at each level | ? 2009 | 100% (2014) | 100% (2011) | Individual program officers provide feedback to regions following targeted supervision |
| | 7.2.3 A data quality audit at central level has been conducted within the last 6 months | Indicator Value: Yes/No | Yes | Yes | Yes | Planned data quality audits are not happening at the moment but regular zonal review meetings are being conducted and these provide a rich source of data quality improvement. All 20 zonal data review meetings were held as |

| | | | | | | | |
|-----|---|---|---|----------|----------|----------|---|
| | | | | | | | planned. Support from National level to support |
| 7.3 | Improved capacity of NTPs to perform operational research | 7.3.1 OR studies completed and results incorporated into national policy/guidelines | Indicator Value: Number (of OR studies and instances reported separately) | 0 (2009) | 2 (2014) | 0 (2012) | An OR course was conducted in September 2012 |

Key Achievements

All planned 20 zonal review meetings were held; the country's 13 regions were divided into five zones, and each zone conducts a quarterly review meeting during which data cleaning and use are the main outcomes. This has improved data quality over the years, as evidenced by fewer errors noted during the review meetings.

Under APA2, a two-week OR course in Namibia using technical and financial support from TB CARE I. This was successfully held in Swakopmund and a total of 20 (17 females and 3 males) participants and five teams emerged which will work towards developing research protocols and eventually conduct research and publish papers, hopefully by mid2014.

Challenges and Next Steps

The NTLP has not had a substantive M and E officer at national level. This resulted in lack of consistency in the reporting writing after program officers support regions or districts. Although reports are generated and shared at national level, concern remains on whether same reports are shared with regions and districts as well.

Lack of capacity to publish research work was identified as a gap and the OR training became very handy and it is hoped that this will generate interest in conducting and publishing research work.

Quarterly data review meetings will be continued APA3 to ensure consistency and improved data quality.

A substantive M and E officer at central level will be recruited under Global Fund Round10/SSF. This will strengthen data quality as well as improved program management through use of data for decision making.

Photos



NTLP and KNCV staff during Team building activities



More team building exercises



Some participants at the OR course organized and funded through TB CARE I

World TB day commemorated in style in 2012: "Flush Mob". Loud TB music and dancing in the middle of the city attracted a lot of spectators as TB messages were spread in Windhoek.



Team-work; everyone taking part in a teambuilding activity



Collective responsibility: All smiles even after failing a team building activity.....