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TB CARE I

TB CARE I - Nigeria

Year 3

Annual Report

October 1, 2012 –September 30, 2013

November 1, 2013

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List of Abbreviations

ACSM	Advocacy, Communication and Social Mobilization
AFB	Acid Fast Bacilli
APA	Annual Plan of Activities Year
CHW	Community Health Worker
CTBC	Community TB Care
DOTS	Directly Observed Therapy short course
DQA	Data Quality Assessment
FHI	Family Health International
Global Fund	Global Fund to Fight AIDS, TB, and Malaria
HIV	Human Immunodeficiency Virus
HSS	Health Systems Strengthening
IC	Infection Control
ICF	Intensified Case Finding
IHVN	Institute of Human Virology of Nigeria
KNCV	KNCV Tuberculosis Foundation
LED	Light-Emitting Diode
LGA	Local Government Area
LTWG	Laboratory Technical Working Group
MDR-TB	Multidrug-Resistant TB
M&E	Monitoring and Evaluation
FMOH	Federal Ministry of Health
MSH	Management Sciences for Health
NCE	No Cost Extension
NGO	Non-Governmental Organization
NRL	National Reference Laboratory
NTBLCP	National TB and leprosy Control Program
OR	Operational Research
PCA	Patient Centered Approaches
PMDT	Programmatic Management of Drug-Resistant TB
PPM	Public-Private Mix
SLD	Second-Line Drug
SOP	Standard Operating Procedure
SRL	Supra-National Reference Laboratory
TA	Technical Assistance
TB	Tuberculosis

Executive Summary

TBCARE I provided technical assistance to the National TB and Leprosy Control Programme (NTBLCP) in year 3 through its partners including Family Health International (FHI 360), KNCV Tuberculosis Foundation, Management Sciences for Health (MSH) and World Health Organization (WHO). Working in partnership with the International Federation of Anti-Leprosy Organizations (ILEP) organizations in country, TB CARE I provided support to the NTBLCP control efforts in the following technical areas- Universal access to TB diagnosis, treatment and care, Scaling up programmatic management of drug resistant tuberculosis (PMDT), Health System Strengthening (HSS) and M & E and surveillance system of the NTBLCP. The total buy-in for the implementation of planned activities was USD 5,748,000 from 1 January to 30 September 2013. Though the implementation period was short, TB CARE 1 recorded demonstrable achievements at the end of year 3.

Universal Access

The PCA strategy was implemented in 18 facilities using 3 key tools including Quote TB Light, Patient Charter for TB control and the Tool to Estimate Patient cost. The target of 90% was achieved in the number of facilities where cost to patients was implemented. For the implementation of Patient Charter for TB control at the designated facilities, 198 (M101; 97) GHWs were trained. This resulted in 75% increase over the defined target of 72 persons due to the step down training conducted following the ToT workshop conducted at TB CARE 1 office in Abuja on the Use of Tuberculosis Patient charter. In like manner, 55 additional communities were established for CTBC activities thus surpassing the target by 28%.

Laboratory Strengthening

TB CARE I supported Laboratory TB expansion to 51 new sites with the provision of microscopes in the military and paramilitary health facilities during the year. One hundred (100%) percent of the planned number (70) of microscopes procured were received and of these 73% have been distributed.

Programmatic Management of Drug-Resistant Tuberculosis (PMDT)

Increased support for Xpert MTB/Rif implementation resulted in the achievement of 157% over the target of the number of total sputa tested (3500). This great achievement was due to increased access of PLHIV for TB screening as well as the support of cartridges provided to Agbami Partners sites. However the DR-TB enrolment data reported for two quarters is only 37.5% of the target which might likely improve when comprehensive data for the year is made available.

Health System Strengthening (HSS)

TB CARE I supported central coordination of the NTBLCP activities through PPM, Laboratory Technical Working (LTWG) Group, TB/HIV Technical Working Group coordination mechanisms. Ninety three (93%) of the planned supervisory visits (375) were conducted to the health facilities, though security remains a challenge in some of the states.

Monitoring and Evaluation, Surveillance and Operational Research (OR)

Data Quality Assessments were conducted in six states to verify the quality of data reported and afterwards strengthen any area of weakness in data collection and management. The result of the DQA indicated sub-optimal data management at the Local Government and facility levels. TB CARE I will support the national level and states in strengthening the M & E system through integration of routine DQA into state and LGA supervision.

Introduction

Nigeria ranks 10th among the 22 high TB burden countries that account for 80% of the Global TB burden (WHO Global TB report 2011). The current TB Case Detection Rate (CDR) is 43%, an improvement from CDR of 40% recorded in 2010; the treatment success rate currently stood at 84% (NTBLCP Report 2011), this is slightly below the 85% national target. The burden of TB in the country is complicated by the high National HIV prevalence of 4.1% and the emergence of drug resistant TB.

TB CARE I was established under the USAID Cooperative Agreement to build and expand on the tuberculosis support of the National TB and Control Program (NTBLCP) through the TB CARE I. The project is currently being implemented by four coalition partners in country which include KNCV Tuberculosis Foundation (KNCV), the coordinating partner, Family Health International (FHI 360), Management Sciences for Health (MSH) and World Health Organization (WHO). This implementing mechanism commenced on 1 October, 2010 and will end on 30 September 2014.

The support provided by the coalition partners in country are targeted at addressing the gaps identified by NTBLCP and partners in the implementation of the 2011 – 2015 National TB strategic plan. TBCARE I with APA 1, 2 and 3 has supported the NTBLCP in 4 key technical areas which include the following:

Universal access to TB diagnosis,

Laboratory Services

Scaling up programmatic management of drug resistant tuberculosis

Contribute to health system strengthening

Strengthening the M & E and surveillance system of the NTBLCP

Core Indicators

TB CARE I has seven core indicators that the program as a whole is working to improve across all countries. Table 1 summarizes the core indicator results across the life of the project for TB CARE I Nigeria. Results for 2013 will be reported on next year.

Table 1: TB CARE I core indicator results for Nigeria

Indicators	2010 (Baseline)	2011 (Year 1)	2012 (Year 2)
C1. Number of cases notified (all forms)	90,447	93,050	97,853
C2. Number of cases notified (new confirmed)	81,454	84,263	90,305
C3. Case Detection Rate (all forms)	20%	43%	50%
C4. Number (and percent) of TB cases among HCWs	NA	NA	NA
C5. Treatment Success Rate of confirmed cases	84%	84%	86%
C6. Number of MDR cases diagnosed			
C7. Number of MDR cases put on treatment			142*

Data for indicator C6 is not available from the NTP. Data for C7 is also not available as efforts is being made to have a comprehensive review from the 9 treatment sites. *Obtained from e-TB manager.

Summary of Project Indicators and Results

Table 2: TB CARE I-Nigeria Year 3 indicators and results

Expected Outcomes	Outcome Indicators	Indicator Definition	Baseline or Y2 (timeframe)	Target	Result	Comments	
				Y3	Y3		
Universal Access							
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 Number of facilities where quality of services is measured	NTP should measure the patient perception of the quality of services available/accessible and the appropriate health seeking behavior related to TB. Available tools for this purpose are TB CAP's QUOTE TB and QUOTE TB Light tools. However, any other tools could be used to measure it. Count the number of facilities where quality of services from a patient's perspective was measured using QUOTE or any other tool in the last 12 months	12 (2012, Year 2)	40	13	Only 32.5% of the target was met. This activity involves surveys and FGD with TB patients and this can only be done periodically.
		1.1.2 Number of facilities where cost to patients is measured	NTP should measure the cost to patients for TB diagnosis, treatment and/or care. One available tool for this purpose is TB CAP's Tool to Estimate Patients'	6	20	18	90% of the target was achieved.

			Cost. However, any other tools could be used to measure it. Count the number of facilities where cost to patients was measured using any tool in the last 12 months.				
		1.1.3 TB personnel trained on the Patients' Charter	The Patients' Charter for Tuberculosis Care (The Charter) outlines the rights and responsibilities of people with tuberculosis. The Charter outlines 15 rights: Care (3), Dignity (2), Information (5), Choice (3) and Confidence (2). This WHO indicator measures whether TB personnel have been trained on the use of the Patient's Charter in the last year.	6	72	198 (M101; F97)	The strategy was modified to include step-down trainings in more states.
1.2	Increased quality of TB services delivered among all care providers (Supply)	1.2.1 Private providers collaborating with the NTP	Number of private providers collaborating with the NTP (i.e. reporting TB case information to the NTP). This is a WHO indicator.	685	1133	Data for 2013 not yet available	Data for 2012 is still 685 from NTP. Figure for 2013 is yet to be out. However TB CARE I has supported the NTP to expand PPM services to 140 facilities in 10 states (Lagos, Kebbi, Nasarawa, Ogun, Abia, Akwalbom, Niger, Yobe, Kano and Bornu)

		1.2.5 Childhood TB approach implemented	Score based on the following: 0 = Childhood TB is not mentioned in the NTP Strategic Plan 1 = Childhood TB is mentioned in the strategic plan, but no activities are implemented on childhood TB 2 = Childhood TB activities are being piloted or are implemented in select sites 3 = Childhood TB is an integral part of the NTP strategic plan and regular activities.	NA	NA	2	
		1.2.x Number of communities providing CB DOTS	Number of communities providing CB DOTS in TB CARE I supported areas	168	198	253	Data is cumulative. FHI has 125 and KNCV 128
Laboratories							
2.1	Ensured capacity, availability and quality of laboratory testing to support the diagnosis and monitoring of TB patients	2.1.1 A national strategic plan developed and implemented for providing the TB laboratory services needed for patient diagnosis and monitoring, and to support the NTP	Score based on the following: 0 = Laboratory strategic plan is not available 1 = Laboratory strategic plan is ready but no annual implementation plan or budget available for the current year 2 = Laboratory	0	1	0	

			annual implementation plan and budget is available for the current year 3 = NTP annual report for the current year includes a section demonstrating progress with the implementation of the laboratory strategic plan.				
		2.1.x Number of PPM labs providing AFB services	Total number of PP labs supported by TB CARE I supplied with microscopes	60	70	51	However 51 of the 70 microscopes (73%) have been distributed through the ILEP partners as follows (GLRA 22, TLMN 22 and NLR 7). There are 19 outstanding microscopes yet to be distributed.
Programmatic Management of Drug-Resistant TB (PMDT)							
4.1	Improved treatment success of MDR TB	4.1.4 A functioning National PMDT coordinating body	National PMDT coordinating body has been established is recognized by the MoH and is functioning. Indicate Yes/No	NA	NA	Yes	
		4.1.x Number of DR TB suspects tested by GeneXpert	This indicator measures the number of patients diagnosed using GeneXpert (disaggregated by risk group and RIF-resistance).	2,009	3,500	8997	The total sputa tested is also inclusive of the 5 Agbami sites where TB CARE I supports with cartridges distribution. MTB+ cases is 2613 and Rif resistance cases for the same period among total sputa tested is 515

		4.1.x Number of confirmed DR TB cases enrolled on treatment	Number/proportion of confirmed DR TB cases enrolled on treatment	94	400	150	Data reported here is for Jan-June 2013. Awaiting July-Sept data
Health System Strengthening							
6.2	TB control components (drug supply and management, laboratories, community care, HRD and M&E) form an integral part of national plans, strategies and service delivery	6.2.1 TB CARE-supported supervisory visits conducted	TB CARE supports supervisory activities in several countries. This indicator measures TB CARE's support of NTP's supervisory activities by comparing the number of planned visits in the TB CARE workplan (denominator) to what is actually conducted (numerator).		375	348	Data reported here is from Oct 2012-september 2013. The data here is comprised of Gene Xpertsupervision, mentoring visits on e-tb manager and other related visits (ICD etc)
Monitoring, Evaluation & Surveillance							
7.2	Improved capacity of NTPs to analyze and use quality data for the management of the TB program	7.2.1 Data quality measured by NTP	Any aspect of data quality has been measured in the last year (internal consistency, timeliness, completeness, accuracy, etc.) at national, intermediate/regional or peripheral levels. If yes, list the dimensions being measured.	NA	NA	Yes	The NTP was supported by TB CARE I to conduct DQA in 6 states (Rivers, Anambra, Taraba, Niger sokoto and Lagos) states from August 5-14th 2013. The finalized report is available
		7.2.2 NTP provides regular feedback from central to	NTP prepares and disseminates regular, written and comparative	NA	NA	Yes	

		intermediate level	feedback from central to intermediate levels based on analysis of national surveillance and programmatic data. Comparative feedback is when results from various areas are displayed and compared with each other to provide context for good/poor results. Intermediate levels are any level between the health facility/peripheral level and national level (i.e. regional, district or zonal level).				
7.3	Improved capacity of NTPs to perform operations research	7.3.1 OR studies completed	TB CARE-supported OR studies completed in the last 12 months.	0	4	0	TB CARE I is supporting the conduct of 2 out of the 4 OR studies billed to take place. Two of the study teams have commenced data collection from the field. The other two are working to finalize their protocols

Universal Access

Within the Nigeria TB CARE 1 partners, FHI 360, KNCV and WHO provided technical assistance in this technical area. Some of interventions were implemented in the following program areas-Patient Centered Approach (PCA) strategy, community TB Care, Childhood TB and Public-Private Mix DOTS in the private sector including military as well as the paramilitary health institutions.

The PCA Strategy

As a follow on to implementation of PCA strategy in APA 2, TB CARE I expanded the scope of the implementation to 6 additional states namely Borno, Kebbi, Ekiti, Niger, Akwalbom and Abia States. Three key tools of the PCA strategy were adopted for implementation in Nigeria namely: Patient Charter for Tuberculosis Care, Quote TB Light and the Costing tool. A total of 198 (M-101; F-97) health care staff were trained in these selected states on Patient Charter from 83 health facilities to discuss the charter as part of treatment education. With further support of TB CARE I, 13 facilities in 6 states commenced implementation of the Quote TB Light. Based on the issues identified in the respective states, the state teams were encouraged to develop action plans to address them. So also the costing tool survey was implemented in 18 facilities in 3 states. The average cost to the patient from the survey showed that \$52.02 was spent on each visit to the DOTS clinic to obtain DOTS services of one form or the other. Fifteen thousand copies of The Patient Charter were printed and 2100 copies were distributed to the implementing states after the training. With all these interventions, the report from PCA End Line survey has shown that 94% of the patients sampled agreed to improved quality of TB care by DOTS service providers. Based on the implementation of the PCA approaches in the states, TB CARE I would be presenting 2 posters in November at the forth coming Union Conference in Paris.

PPM DOTS

TB CARE I provided technical assistance for the integration of tuberculosis care services within the general health care services including the private sector, the military and paramilitary health services particularly, the Nigerian prisons. TB CARE I supported the review of the health screening tool of the prisons which now has TB components incorporated into it ensuring that every prison inmate is screened for TB. Thirty-five (M-27; F-8) GHWs were trained from 20 facilities within the paramilitary health services for the diagnosis of AFB. Additionally 248 (M-139; F-109) GHWs including medical officers were trained from 10 more states including Lagos, Abia, Akwalbom, Ogun, Nasarawa, Kano, Borno, Yobe, Niger and Kebbi. All these new facilities have been linked to the National TB programme. As a result of expansion of DOTS services to additional health facilities there has been more than a 2-fold increase in reported all forms of TB cases of 6282 in Q 1 & 2, 2013 over the 2807 reported in the same quarters of 2012 from the PPM sites.

Childhood TB

With increasing focus on the management of childhood TB, and the need to prevent death among children, TB CARE I in collaboration with the NTP and Pediatric Association organized a stakeholder's meeting for the control of Childhood TB in Nigeria from the 28-31 May 2013. The participants for this meeting were drawn from Academia, FMoH (including the NTP, NASCAP, and Family Health), National AIDS Control Agency (NACA), GLRA and WHO. Through partnership with the pediatricians, National AIDS Control Agency (NACA), NASCP, Family Health Department of FMoH and ILEP partners, TB CARE I through WHO supported the NTP to develop a roadmap for the implementation of Childhood TB in Nigeria. The National TB Program Desk guide for diagnosis and management of childhood TB in Nigeria was developed and 5000 copies were printed and distributed to the tertiary and Federal Medical Centers in the country. This has provided guidance to the diagnosis and management of childhood TB among clinicians in the tertiary health institutions.

Community TB Care

The country has recently moved from a 8-month regimen to the 6-month rifampicin containing regimen thus underscoring the increased need to monitor TB patient intake of drugs by the health care personnel, family and community volunteers. TB CARE I continued to provide support to on-going community TB Care activities in 253 established communities in the previous years. The capacity of 692 (343M; 349F) facility as well as community volunteers personnel was built to implement CTBC activities and another 337 (191M; F146) persons on monitoring and recording/documentation. At the end of Year 3, 13,379 (M7286; F6093) TB suspects were referred by community volunteers from which a total of 1384 TB cases were detected. In addition, 1776 (955M; 821F) TB patients received treatment and care from the community volunteers.

During year 3, TB CARE I also supported active TB case finding efforts in Oyo, Edo, Niger and Katsina states with the aim of improving TB case detection. One hundred and seventy-two new TB patients were notified through the introduction of innovative strategies such as door to door screening, identification and screening of contacts of index TB patients.

Key Results

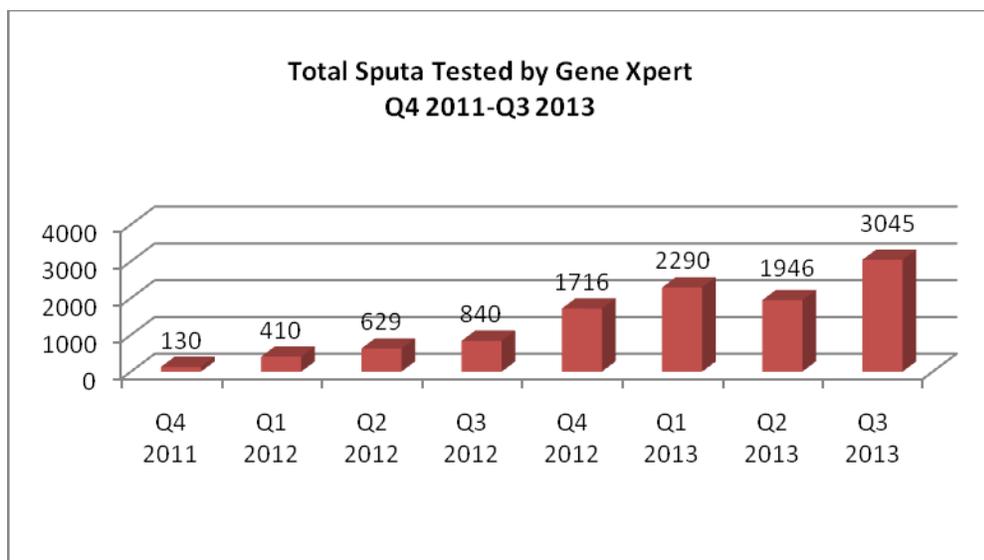
Utilization of 3 key tools for assessing the quality of TB care demonstrated improvement in quality of TB services provided in the states where assessments were conducted. There was slight increase in the number of health facilities where Quote TB light was implemented over 2012 baseline result though the target for 2013 was not met. The costing tool was implemented in 18 facilities in 3 states representing 90% achievement of the target for the number of sites where costing tool was implemented. Furthermore there was a 75% increase in the number of persons trained over the target of 72 persons because there was a change in the strategy where a training of trainer's workshop was organized followed by a step down training in the six states on Tuberculosis patient charter.

Moreover the result in respect of the target for establishment of communities for the implementation of CTBC activities was also surpassed by 28% at the end of the year.

Laboratories

TB CARE I through WHO provided support for the routine supervision and monitoring of laboratory activities of the national and zonal reference laboratories which include Jos University Teaching hospital, Amino Kano University Teaching Hospital, Zankli Medical Centre, University College Hospital, Ibadan, University of Port Harcourt Teaching hospital and Lawrence Henshaw Memorial Hospital, Calabar. Key findings of the lab assessment conducted include among others, an average turnaround time (TAT) for sputum AFB microscopy examination of 48-72 hours, completion of infrastructural development for Xpert MTB/RIF, culture services as well as PCR suites and adequate human resources trained for culture and DST service provision in all these labs.

Fig 1



Additionally 8 GeneXpert machines were procured and installed to support further scale-up of Xpert MTB/Rif implementation in the country bringing the total to 23. Additional 6 sites are routinely supported with Xpert cartridges by TB CAREI. Fig above suggests a gradual increase in the total number of sputa tested by Gene Xpert over there year with substantial increment in Year 3. Through this new initiative a total of 8,997 sputa were tested during the last year, resulting in 8640 successfully conducted tests.

Compared to the last year, there is a significant increase in the number of detected new presumptive TB cases as well as RIF resistant TB cases with Xpert MTB/RIF. In APA3, 515 sputa tested were MTB + with RIF resistant. Of these, 500 were presumptive MDR-TB cases

and 15 were new presumptive TB cases. In addition, 19% (283) of new presumptive TB cases tested positive for TB. (Fig. 2)

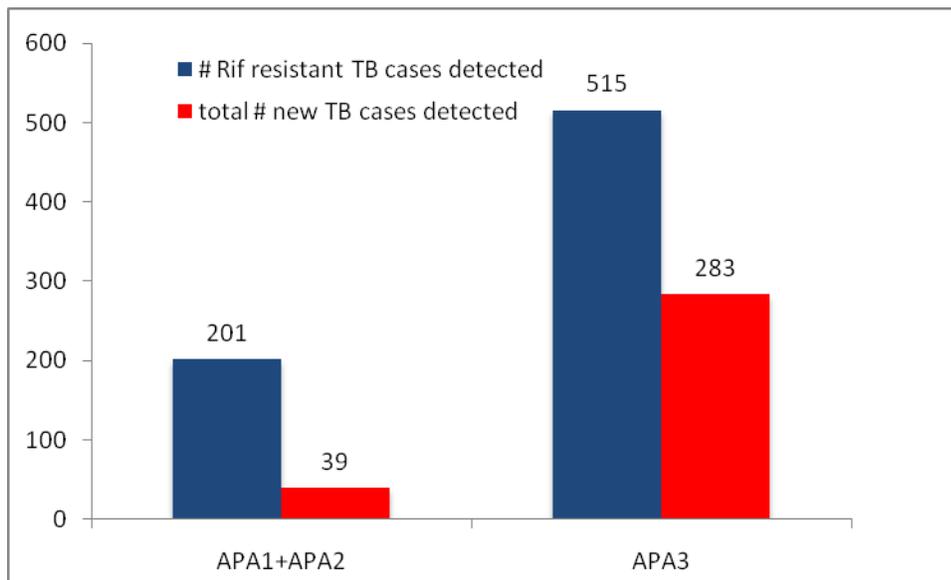


Fig. 2: Total number of new TB cases as well as RIF resistant TB cases detected in APA1+APA2 compared to APA3.

While the prime focus for using Xpert MTB/RIF in Nigeria has been the detection of RIF resistant TB, the eligibility criteria have been extended and Xpert is increasingly used for detecting TB in new presumptive TB cases, specifically PLHIV. The proportion of tests conducted for presumptive new TB compared to the previous year increased from 11.4% in APA2 to 18.2% in APA3 (Tab. 2). This reflects the progress of extending and scaling up the Xpert testing eligibility criteria in Nigeria, which will continue also in the next year.

Table 2: Proportion of Xpert tests conducted for presumptive MDR TB and presumptive new TB

	Presumptive MDR TB	Presumptive new TB
Proportion of test / all successful tests conducted -end of APA2	88.6%	11.4%
Proportion of test / all successful tests conducted - end of APA3	81.8%	18.2%

TB CARE I supported microscopy expansion in the private health facilities including the military health facilities through the procurement and distribution of 70 microscopes (50Light and 20 iLed microscopes). Supervision conducted to the sites revealed challenges in the implementation of the new technology consisting of completeness of report, error rates, electricity and commodity management. However TB CARE 1 would continue to support the various sites to address all the identified issues and challenges.

Key Results

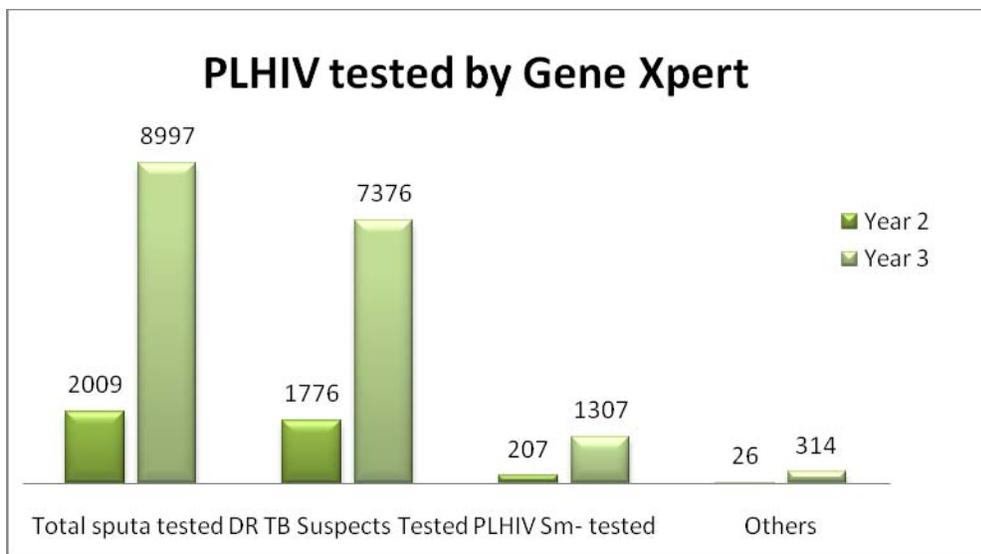
TB CARE I supported the NTBLCP efforts at development of the National Laboratory Strategic Plan in year 2. Though the process has reached 80% completion, it was temporarily suspended until development of the new National TB Strategic Plan for the national programme has been completed. TB CARE 1 will support the finalization of the document in year 4.

Seventy microscopes (100%) were procured and distributed to strengthen TB laboratory services in the private health facilities. Furthermore under the laboratory technical area, expansion of GeneXpert efforts yielded 57% increase over the year 3 target. The increment is partially attributed to the sites of Agbami partners which TB CARE I is supporting with the supply of cartridges.

Programmatic Management of Drug Resistant TB (PMDT)

TB CARE I provided support to the Damien Foundation of Belgium (DFB) for the support of 50 confirmed DR-TB patients on treatment and care. This support covers the provision of feeding, ancillary medications, baseline and other investigations during treatment, sputum transport and the provision of hearing aid devices. During year 3, seven (7) patients were provided with hearing aid devices. As a result of this support many more patients have accepted admission in the treatment facilities, a decision which was difficult to make by the patients. TB CARE I conducted trainings for the clinic staff of high HIV burden facilities on the diagnosis of TB and DR-TB among the PLHIV using a simple algorithm. Three hundred (M=130; F=170) GHCWs were trained. Following this training the number and quality of Xpert MTB/Rif data reported from these sites has improved.

Fig 3



TB CARE I supported continuing medical education of doctors and nurses from the MDR-TB treatment centers in Kano, Cross River and Lagos states to effectively manage diagnosed DR-TB patients. Twenty-five participants (10M, 15F) were trained. Experiences were shared among the participants on the management of DR-TB patients and this has contributed to improved quality of services provided at these centers.

The utilization of e-TB manager in the management of DR-TB data and reporting was further supported in year 3 with the procurement of 8 additional computers and installation of the M & E tool in the new treatment centers. Though challenges still exist with regards to uploading of patient information into the system and tracking patients for timely assigning of admission options, TB CARE I provided supportive supervision and mentoring of the e-TB manager focal points of the treatment centers. TB CARE I would support the expansion of e-TB Manager system to 2 new DR-TB centers by the end of 2013.

The confirmed DR-TB patients enrolled for treatment from January - June 2013 was reported as 150 resulting in 60% increase in DR-TB cases enrolled in the first half of 2013

as against 94 cases enrolled in the previous year. The target of 400 might likely not be reached even though the results of July -September 2013 are still being awaited as the report will be only for one quarter.

Key Results

Great achievement of 157% was recorded for the target of the number of sputum tested as a result of the support for GeneXpert implementation. This was made possible by the facilitating the access of PLHIV for TB screening. Half year data of DR-TB enrolment on treatment for 2013 indicates only 37.5% of the target has been achieved. This achievement would likely improve when comprehensive data for the year is made available.

Health System Strengthening (HSS)

Under HSS, TB CARE I provided technical assistance for the coordination of the various components of the national TB control programme through the established coordinating mechanisms including PPM, DR-TB, TB/HIV, CTBC and ACSM. TB CARE I supported the National PPM coordination meetings during the year where issues concerning reward system for provision of PPM DOTS services, strengthening effective linkages, supervision and monitoring of state PPM DOTS activities were discussed and ways of addressing them identified. TB CARE I also supported the strengthening of ten facilities implementing SOPS intervention for increased detection of TB cases in the facilities. Supportive supervision and mentoring was provided to the sites and this resulted in 20% increase in the detection of TB cases over the previous year.

Key Results

Ninety three (93%) of the target (375) for supervisory visits to the health facilities was achieved. This will have been met but for the security challenges in some of the states.

Monitoring & Evaluation, Surveillance and OR

TB CARE I supported the operational research (OR) agenda of the NTBLCP with three teams having submitted proposal for ethical approval out of which two have received the approval. The studies are aimed at assessing the factors responsible for the differential performance among the CVs supported by the various funding partners and their contribution to case finding. While the second study is aimed at assessing the effectiveness of an intervention to increase TB screening and referral behavior of local Quranic school pupils in Kano, North-Western Nigeria. The work plan and budget with clear timelines was developed and approved and field work has commenced.

Data Quality Assessment (DQA) in the NTBLCP is another aspect of this technical area supported by TB CARE I in year 3. The assessment conducted in 6 states including Rivers, Anambra, Taraba, Niger Sokoto and Lagos states indicated that though a good and functional M & E system was in place in all the states visited the quality in terms of accuracy and completeness was lacking.

Key Results

DQA showed sub-optimal data management at the Local Government and facility levels. This might be due, among other factors, to poor quality and ineffective supervision at these levels. However feedback from national to the states is provided on a quarterly basis during the zonal review meetings and from the states to the LGAs and facilities during the states quarterly review meetings.

Success Story

Implementing a Patient-Centered Approach in Nigeria

"Now I feel I am accepted by society."

Tuberculosis (TB) is a public health concern in Nigeria with the nation ranking tenth among the twenty-two high-burden TB countries. Promoting patients' rights is a core principle of the World Health Organization's STOP TB strategy. TB control efforts in Nigeria include engaging patients and the community and making their voices heard. Specific activities to empower patients have focused on providing them with knowledge of their basic rights, yet awareness among TB patients and in the larger community remains limited. To bridge this gap, the USAID-funded TB CARE I project piloted the use of the World Care Council's Patients' Charter for Tuberculosis Care in 12 facilities in Ogun and Osun states in 2012. Developed in tandem with other efforts to promote a "patient-centered" approach; the Charter outlines the rights and responsibilities of people with TB. Patients' rights include the right to high-quality care, the right to be treated with respect and dignity, the right to information, and the right to job security.

Activities conducted for the pilot project included a one-day orientation for DOTS clinic staff from the 12 participating centers to introduce them to patient-centered approaches. To ensure that TB patients, irrespective of their socio-economic status, know and understand their rights, TB CARE I facilitated the translation of the Patients' Charter into the three main Nigerian languages: Yoruba, Hausa, and Igbo. 15,000 copies of the Charter were printed and distributed to the health centers and healthcare personnel received training on how to explain the Patients' Charter to TB patients. During group counseling at the health care facilities, patients are counseled about their rights and responsibilities as TB patients, as described in the Charter, and are provided with copies to take home.

The story of Mrs. Chidi* demonstrates the benefits of the Patients' Charter:

Life could not have been better for Mrs. Chidi, a 39 year old certified Grade 2 school teacher and mother of five, until her experience with TB:

"I started coughing last year and thought it was an ordinary cough. I told my husband, who said there was no need to go to the hospital and my relatives advised me to take some medications. We went to see a pharmacist who prescribed antibiotics for a month, but suggested that if the cough persisted, I should see a doctor. Initially, when I started using the drugs, the sputum was thick but later it changed so I thought I was better.

*Not her real name.



TB CARE I Senior M&E Advisor in an interview session with MrsChidi at the Sabo Health Centre, Osogbo. Picture taken by Stephanie Gande, TB CARE I M&E Assistant

Then in January 2013 I felt like I was having malaria symptoms, but they were continuous, so I thought that during the school holiday I would go to the health facility. A church member referred me to the Sabo Health Centre because she had been treated there. When I went to the hospital, I was tested for TB and started on treatment. I had to tell the school headmistress, to get her permission to go to the health center to get my medicines before going to school each day. At first she agreed, but then after a week she told me that she had consulted a family doctor who advised that I stay away for three months without pay and have another TB test before I would be allowed to resume teaching. When she said this to me, I thought I was being dismissed from the school.

I was weeping in my classroom, but not in front of the headmistress. I was really hurt because I am diligent and very hard working. The headmistress asked me to leave, not to come to school the next week. She told the other staff that I had gone for training to get a National Certificate in Education, so when my colleagues saw me, they said I did not even say goodbye to them. I told the ones I was close to that I was sick, but I did not mention TB. My colleagues were very supportive and did not discriminate against me. At first, when the headmistress asked me to leave, I separated myself from my friends. I didn't go out, I just isolated myself at home.

One of the fundamental rights of TB patients, as detailed in the Charter, is the right to job security. Having been empowered by the Charter, I went to the Sabo Health Centre and told Mr. Usman, the Local Government TB and Leprosy supervisor, what had happened. He went with me to the school and educated the headmistress about TB. I was reinstated at the school, but taught there for only one week as I was not in the right frame of mind. I decided that it would be better for me to leave because I felt betrayed. With my husband's encouragement, I looked for work elsewhere and I am now teaching in another school. The job that I have now makes me feel that I am accepted by society. The USAID-funded TB CARE I project could not have come at a better time in pioneering patient-centered approaches in the country and helping Nigerian TB patients know and demand their rights."