

TASC II TB South Africa Documentation of Best Practices



Joy Riggs-Perla
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List of Acronyms

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AIDS	Acquired Immunodeficiency Syndrome
DOH	Department of Health
DOTS	Directly Observed Treatment Short-course
DRAT	District Rapid Appraisal Tool
ETR	Electronic TB Register
HHDT	Human Health Development Trust
HIV	Human Immunodeficiency Virus
HST	Health Systems Trust
KZN	KwaZulu Natal
MDR TB	Multi Drug Resistance Tuberculosis
M&E	Monitoring and Evaluation
MSH	Management Sciences for Health
NDOH	National Department of Health
NGO	Non Governmental Organization
NHLS	National Health Laboratory Service
NTCP	National Tuberculosis Control Program
PEPFAR	President's Emergency Program for AIDS Relief
PMTCT	Prevention of Mother to Child Transmission
PPM	Public-Private Mix
QA	Quality Assurance
TA	Technical Assistance
TB	Tuberculosis
URC	University Research Co., LLC
USAID	United States Agency for International Development
VCT	Voluntary Counseling and Testing
XDR TB	Extremely Drug Resistant Tuberculosis

Executive Summary

In its fourth year of implementation, TASC II TB in South Africa is successfully applying tools and strategies for strengthening management of TB and TB-HIV programs that can be considered “best practices” because of the outcomes they are producing. The aim of this paper is to identify and describe some of those best practices, and to make observations about key lessons learned in project management which should be useful for the remainder of the current project as well as for any future activity.

Four major areas which are identified as best practices or emerging best practices are:

(1) **Decentralized Capacity Building** which includes involving provincial and district officials in problem analysis and planning, applying the District Rapid Appraisal Tool (DRAT) for supportive supervision, and the use of “collaboratives” for strengthening data accuracy, analysis and use to improve TB program management. These tools and approaches are clearly contributing to improved TB outcomes in the areas where they have been used.

(2) **TB-HIV Integration** by strengthening the system of cross-referrals and tracking patients between TB and HIV services at the facility level. Data collected on a monthly basis by the project are showing highly encouraging trends reflecting that increasing proportions of patients are receiving appropriate TB and HIV services due to referrals and tracking.

(3) **TB Laboratory Strengthening** by using a “TB Microscopy Supervisory Tool” to improve performance. This best practice is in its early stages of implementation and therefore there is no evidence yet of improvements in laboratory services but the excellent process used to develop the tool, and its ability to quantify improvements in lab services, warrant considering this a best practice if it proves itself during the next year.

(4) **Advocacy, Communications and Social Mobilization**, specifically the use of NGOs and social mobilization techniques to improve community understanding of and support for TB programs. While there is little quantitative evidence of its impact, managers and service providers uniformly report that social mobilization activities have resulted in reduced defaulter rates and increasing in case detection. Social mobilization strategies have been applied widely using strategies in the Behavior Change, Communication and Social Mobilization Guidelines developed by the project.

Finally, four areas are discussed for lessons learned in project management including the urgency of scaling up some of the best practices, the importance of remaining flexible and responsive to the National TB Control Program (NTCP) needs, the institutional arrangements for operations research and more efficient use of staff for data collection tasks.

I. Introduction

Background: The USAID-supported TASC II – TB Project in South Africa began in August 2004 and is scheduled to end in September 2008, with a one year extension currently under consideration. URC and its partners Health Systems Trust (HST) and Management Sciences for Health (MSH) are mandated to work with the National TB Control Program (NTCP) on activities related to improving the quality and availability of TB and TB-HIV services with a focus on strengthening program management capacity at the provincial, district, sub-district and facility levels. The project is funded at roughly \$18.6 million for the four year period. Approximately 46% of the project funding comes from the President’s Emergency Program for AIDS Relief (PEPFAR) sources principally for the TB-HIV activities.

By the end of the project, the following results are expected:

- Increase case detection rate to 70%
- Increase treatment success rate to 85%
- Improved capacity to plan and implement TB/DOTS at facility, district, provincial and national levels
- Increase early detection of Multi-Drug Resistant (MDR) TB
- Increased patient compliance and lower default rates

Soon after the project began, the TB-HIV (PEPFAR-funded) component was added on with the aim of strengthening the integration at the local level of the two programs given the high rates of co-infection in South Africa. Five provinces were chosen by the South African Government to participate in TASC II TB because they were felt to be in greatest need of additional support. The provinces were: KwaZulu Natal, Eastern Cape, Limpopo, Mpumalanga, and North West Province. TASC II TB works in selected districts of each province, and sometimes not in all sub-districts of each district.

Report Objective and Methodology: At this juncture in project implementation, URC felt that there were “best practices” beginning to emerge based on several years of field experience. TASC II TB leadership decided to commission an analysis and documentation of those best practices and lessons learned not only because it may benefit the project during the remaining time left, but also serve as useful information for future work in this field. The purpose of this report was to identify project interventions that could be considered as “best practices” and to document them.

Consultations were held with TASC II TB staff, NCTP leadership and USAID to determine potential best practices. Subsequently, this consultant visited four of the five provinces to interview district and sub-district managers and supervisors, consult with facility staff, observe service delivery and consult with URC Provincial Coordinators.

Definition of “Best Practice”: In order to identify and agree on an activity that constitutes a best practice, the following definition was used. A best practice is “a

technique or methodology that, through experience or research, has proven to reliably lead to a desired result.” This definition implies an evidence-based approach, although not all of the evidence of success is necessarily quantitative. Preference, however, was given to those interventions for which data were available to demonstrate the impact or results achieved. The intervention must have been implemented long enough to determine that it had been successful. This report, therefore, does not describe all of the activities in the project because some have not been in use long enough to determine their level of success or because there was insufficient evidence that they had achieved the results intended. The purpose of the field visits was to gather as much information as possible about the impact or outcomes associated with the best practice

II. Brief Summary of Project Status

By the end of 2007, 382 facilities had been included in the project in 22 sub-districts, 11 districts in the five provinces. The TB-HIV (PEPFAR) activities are more intensive in 185 of those facilities, and data are collected directly from each facility for PEPFAR reporting purposes.

In each of the provinces, a substantial amount of work has been done to support improved management of the TB program including: improved data recording and reporting including cross referrals between TB and HIV services, data analysis and use, strengthening program supervision, staff training in areas such as TB-HIV and MDR TB, laboratory strengthening, improvements in case detection and defaulter tracking and a program aimed at advocacy, communication and social mobilization. Much of the work to improve the record keeping, data analysis and use and solving other facility level problems has been done through the use of “collaboratives” which are periodic meetings attended by staff from a group of facilities to analyze problems and carry out plans for corrective action. (see section IIIc) More recently, a new effort has also been launched to increase awareness and information in the work place about TB and TB-HIV services with a focus on large private sector employers.

At the national level, TASC II TB has worked closely with the National TB Control Program (NTCP) to provide technical support for the development of a number of policies and guidelines including: the Crisis Management Plan, the National TB Strategic Plan (2007-2011), TB Guidelines for Behaviour Change and Social Mobilization, MDR TB Guidelines, National TB Laboratory Indicators, Infection Control Guidelines for health facilities, recording and reporting tools for MDR TB and others. The project has also been active in helping disseminate these national guidelines and ensuring that provinces and districts benefit from their use. TASC II TB, with concurrence from USAID, has been flexible in responding to the needs of the national program including supporting work in MDR TB and especially XDR TB which became an urgent priority for the country in 2005.

Reporting on project progress and problems is done on a semi-annual basis. For the TB program, the data used for monitoring progress comes from the Electronic TB Register (ETR), usually directly from the district level to ensure the timely availability of the data.

While the ETR data still have problems, the project is working actively with local counterparts to improve the system. For the TB-HIV (PEPFAR) activities, a Facility Tool is used by project staff on a monthly basis to collect the data. Some of these data are required by the PEPFAR program and others are collected because they are important for internal program management and tracking. The data required by USAID are reported routinely on a semi-annual basis or as requested by USAID.

A mid term assessment of the project was carried out in December of 2006. While the project was demonstrating good progress, several issues were identified to improve implementation. These included focusing on fewer activities that have potential for direct contribution to achieving the four main project outcomes and scaling them up, dropping activities that have a less direct contribution or are unlikely to yield results (Public-Private Mix (PPM) as described in the original proposal, medical and nursing school curriculum reform), making final decisions on the frequency and methodology of data collection, having strategic consistency of activities across all five provinces, taking a more evidence-based approach to behavior change communication/media activities and modifying the plans for operations research. Some management improvements were also suggested. Many of the issues raised have subsequently been addressed.

III. Best Practice # 1: TB Program - Decentralized Capacity Building

As mentioned earlier, a major area of focus for TASC II TB has been strengthening capacity for TB program management in the five target provinces. Several tools and approaches have been employed that have contributed to both achieving results and to building the capacity to sustain those results. Three of these areas are discussed below.

a. Provincial and District Level Involvement in Problem Analysis and Planning

In each of the districts where TASC II TB has been requested to work, the initial activity is a consultative process with local stakeholders to analyze their TB and TB-HIV program problems, and to come up with areas in which the project can provide support. These planning workshops have served to help achieve a common understanding of the problems and issues, clarify the kind of role URC can play in support of the programs, and reach consensus on a “work plan” to define what the project will do. It also serves to generate commitment and support for the effort from the onset. Project staff are convinced that these initial consultations are extremely important to ensure successful working relationships at the District level.

b. Improved Supportive Supervision – DRAT

Developing systems for supportive supervision for the TB and TB-HIV programs using existing and improved supervision check lists, has been an important activity since the onset of the work to build capacity. In the Eastern Cape, however, one of the Provincial Coordinators developed an alternate supervision tool called the District Rapid Appraisal Tool (DRAT). The tool was originally developed by DFID and the NTCP as a TB

Program monitoring tool at District level. Initial development of the tool preceded the TASC II TB project; however, under the project itself, it was tested and greatly expanded for use at facility level within the province.

The DRAT facility supervision tool assesses performance on 16 key indicators summarized on a score sheet which allows for an overall performance rating expressed in a percentage. The indicators include staffing, TB suspect rate, sputum turn-around-times, availability of DOTS supporters, cure rate, interruption rate and so on. (see Annex B) The basis for the scoring is explained to the facility staff and often based on the clinic records. DRAT is used on a quarterly basis by having a team of three or four supervisors and managers schedule clinic visits and apply the tool and score each clinic based on those visits. The clinics are all visited within a span of a week by several teams. The scoring sheet also shows the score received during the previous visit so staff can see how they are progressing (or falling back) and the particular indicators which are problematic.

Experience to date demonstrates that the DRAT is an excellent tool, both as an objective way of measuring TB program performance at the facility level but also as a teaching and mentoring tool to help staff understand the importance of recording keeping and addressing problem areas. Facility staff interviewed by this consultant were uniformly aware of their composite scores, could recite areas of weakness and areas where substantial progress had been made, as well as describe the corrective actions they had instituted or tried to address. Copies of the score sheets are retained at the facility. Trying to improve their scores was a strong motivating factor to address the problems



encountered. For the program supervisors and managers, the DRAT provides a way of quickly identifying clinics with performance problems and supporting them to address problems. National Health Laboratory Service (NHLS) staff have also been enlisted to participate in the DRAT visits which ensures that NHLS becomes aware of the laboratory-related issues (like sputum turn around times) and improves communication between the Department of Health and NHLS.

In the Eastern Cape, especially in Nelson Mandela Metro, the DRAT is well-institutionalized. The District managers set up the schedule of visits and invite the URC Provincial Coordinator to participate if she is available. They conduct the visits with or without URC staff. The Provincial Coordinator works with her counterparts to use the results from the DRAT rounds to make charts and graphs which show the progress and call attention to specific issues. Use of the DRAT in Nyandeni District is more recent and while several rounds have been conducted, it is not yet well-institutionalized. URC staff are proactive, however, to ensure that they are scheduled.

One interesting example from Nelson Mandela Metro District arose recently when managers realized that the sputum conversion rate for the DRAT was consistently higher than those recorded in the ETR. The discrepancy is related to the fact that DRAT allows for sputum conversions to be recorded even after the end of the second month of treatment whereas the ETR captures only those patients who do produce sputum by the end of the second month. Clearly, there was a problem with patients not coming in for their two-month sputum exam on time. This information prompted the URC Provincial Coordinator and the TB managers to urge the facilities to make a renewed effort to track and ensure that patients were coming back within the two month period as they knew that the ETR was the official NTCP system for tracking performance and it was important to achieve the targets for sputum conversion based on the national guidelines.

This raises another useful element of the DRAT. The ETR is the official recording and reporting system and therefore improving it and helping staff learn how to analyze and use the information is one of the highest priorities of work for the project. To date, however, there are still problems with the accuracy and timeliness of the ETR data. Because of this, the DRAT provides a more immediate and accurate way of tracking performance and addressing problems. But as illustrated above, it has been used to reinforce the importance of strengthening the ETR rather than replace it.

Despite its usefulness, the DRAT has only been expanded for use throughout Eastern Cape province. URC staff report that District and Provincial buy-in for using this tool is essential and not all have been universally sold on the idea. Nevertheless, progress is being made. KwaZulu Natal province has now expressed a willingness to pilot its use and Limpopo province is also interested. In one sub-district in Mpumalanga, the first round of DRAT was conducted but subsequent rounds were suspended due to transportation problems. There appears to be interest to continue.

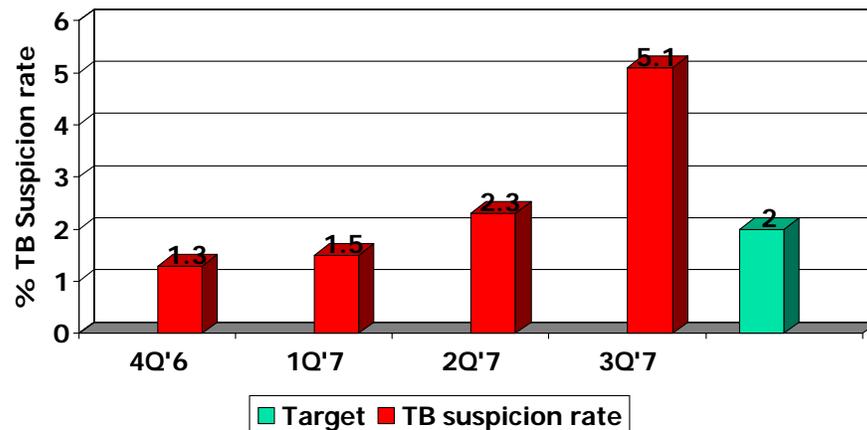
URC should be highly proactive during the remainder of the project to support the use of the DRAT as widely as possible within the 5 provinces for two reasons. (1) Most importantly, it is a supervision tool that has proven itself to be effective based on the evidence of improved program performance, and (2) the DRAT also provides URC with stronger quantitative evidence of the impact of its work to help strengthen the TB program. While evidence of improved program performance should also be demonstrated with the ETR, data problems to date prevent the emergence of a clear, consistent picture of progress. The DRAT is an excellent example of an evidence-supported “best practice” and it deserves to be scaled up.

c. Collaboratives and the ETR: Strengthening Data Accuracy, Analysis and Use

As mentioned earlier, TASC II TB staff have devoted much time and effort to supporting districts, sub-districts and facilities to strengthen the collection, analysis and use of ETR data. One of the ‘best practices’ identified for doing so is the “collaborative” approach.

Essentially, periodic meetings (quarterly or in some cases, once every two months), are arranged for clinic staff to gather with their ETR data to analyze progress, discuss problems and develop plans for addressing those problems. This approach has been used fairly widely in the five provinces where URC is working, although the degree to which it is conducted regularly by district or sub-district managers as part of their normal work, is variable. In Nelson Mandela Metro, collaborative meetings are called every two months with facility staff from sub-districts to discuss both ETR data and the DRAT scores. Well performing facilities are requested to present and share information on how they achieved success in selected areas. As a result of identifying problems with defaulter rates, tracer teams have been introduced to track down patients who do not show up as scheduled. Patient records have been organized in the TB units to help staff identify defaulters and mobilize either DOTS supporters or tracer teams to find them. Vehicles are made available for the purpose. Quarterly door-to-door campaigns have also been organized to improve case finding and increase community awareness about the importance of compliance with treatment. As a result of these efforts, the District, for instance, reported that suspect rates in 2007 have increased from 1.3% to 5.1% and treatment interruption rates decreased in 2006 from 16 to 11%. Clearly in some areas, these efforts are paying off in measurable improvements.

NMBM Suspect Rate



In Ilembe district of KZN, the use of collaborative meetings began in the last quarter of 2006, and has been conducted twice a year in each sub-district. The URC Provincial Coordinator reported that they are not completely institutionalized as she often must take the initiative to help the District schedule the meetings. A very supportive and active DOH District Manager in Ilembe has contributed greatly to what is considered a high performance in the TB program in this province.

In both Mpumalanga and Limpopo provinces, facility staff who had participated in collaboratives had prepared, by hand, charts and graphs of TB program performance in



their facilities for display on the clinic wall. Most facilities do not have computers and most staff, unless they are participating in collaborative meetings, do not have the time to do data analysis. In both provinces, managers reported that they have undertaken ETR data audits to identify recording problems using patient records and the TB registers at the clinics.

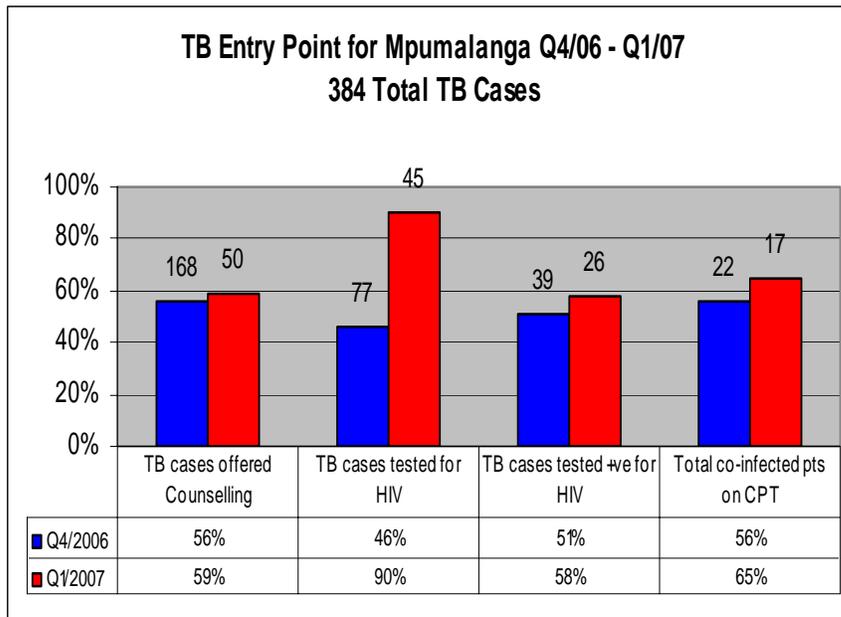
While the ability to analyze and use the ETR data has undoubtedly improved since the beginning of TASC II TB, it is difficult to assess whether the accuracy and timeliness of the ETR data have improved. There continue to be problems at the facility level such as when nurses assigned to the TB unit are transferred and staff untrained in TB recording and reporting take over. Well-kept TB registers can fall apart overnight from problems related to staff turn over. Likewise, there are many facilities whose record keeping is very complete and yet there may be problems related to personnel responsible for data entry not being available or computers out of order which result in months of good facility level data not being entered into the system. There continue to be problems with temporary, contractual data entry staff and high rates of inaccurate data entry. These overall problems underscore the importance of continuing to examine the ETR data and encourage facilities and districts to get credit for their good work by ensuring that these recording problems are solved. Visiting facilities makes it clear that the actual practice in managing TB patients is better than is evident from looking at the data.

IV. Best Practice # 2: TB-HIV Integration

TASC II TB has also a major, and highly important, component for improving the integration of the TB and HIV programs. Work at the national and provincial level has included providing technical assistance to revise the TB registers and also to help staff at the facility level in VCT units to capture cross-referrals to TB. In 2006, the project modified the three- page URC Facility Tool, originally designed to collect data on both the TB and the TB-HIV (PEPFAR) program. Currently, the data for TB-HIV has been reduced to 21 indicators that are required by PEPFAR or because they are needed for program management and tracking purposes. The data are collected by the Provincial Coordinators once a month from 185 facilities with large case loads in the five provinces. The data come directly from the registers at the facility level to ensure accuracy. The choice of high volume facilities is aimed at achieving the numerical targets important for PEPFAR. But project staff themselves have added indicators that track the increase in proportion of TB patients at facilities who receive HIV testing and counseling as well as vice versa to ensure that there is an increase in referrals.

Although the Facility Tool is not a Department of Health required form, project staff are also trying to involve facility staff and district managers in the process to increase awareness of the importance of TB-HIV cross referral issues. In some cases, provinces require managers to collect similar information on the PHC reporting form used for the DHIS. Provincial Coordinators and the URC Pretoria office also periodically analyze the data to assess whether progress is being made. Having this extra data collection system has been highly beneficial as the project is able to track progress with confidence.

The challenges to improving cross referrals, and ensuring that patients get a complete set of both TB and HIV/AIDS services as needed, are substantial. TB unit staff in facilities are generally aware of the high rates of co-infection and do urge patients to get tested for HIV, as VCT services are normally available at the same facility. There are no reliable data on the proportion of TB patients that refuse HIV testing or who choose to be tested at another location. They do maintain records of those who report having been counseled and tested, and the results of those tests. In the VCT units in some provinces, the VCT



registers do not require that TB referrals are recorded. VCT counselors reported that often patients, upon learning that they are HIV+, are emotionally unable to deal with the need for also receiving a TB test. Some patients report not being able to produce sputum. In some provinces, the VCT registers have been

modified to include the TB test results and patients are being tracked.

Analyzing the trends shows strong achievements. However, the data must be interpreted with care because since the beginning of the data collection effort, new facilities have been added and therefore the denominator consists of new and old facilities, making comparisons among quarters difficult. In Mpumalanga, however, the facilities providing data have remained the same over time (see chart above) and it gives an example of an increase in referrals, even over the period of one quarter. TASC II TB staff have agreed to segregate the reporting forms from the sub-set of facilities that have been tracked since the beginning in order to develop an accurate picture of progress. In the facilities visited while collecting information for this paper, most facilities were showing improvements. The TASC II TB Projects strategy for increasing cross referrals between the two

programs can also clearly be considered a best practice. This should be well-documented in the final analysis for the project, using the data generated from the Facility Tool.

V. Best Practice # 3: TB Laboratory Strengthening

TASC II TB has been quite delayed in activities related to strengthening laboratory services and has not been able to pursue the plan in the original proposal for introducing a laboratory quality assurance system for NHLS. Until recently (October 2007), lab services in just one province (KZN) were still under the management of the Department of Health rather than the NHLS. MSH as the TASC II TB partner responsible for lab technical inputs, guided a series of lab ‘diagnostic’ activities aimed at identifying some of the problems associated with lab support for the TB program. In early 2007, an MSH consultant was able to conduct a “performance improvement” workshop with lab managers in KZN using a highly interactive, participatory approach to encourage NHLS staff themselves to identify problems and determine the steps needed for corrective action. Participation included the national NHLS TB manager and provincial NHLS decisions makers. This resulted in a decision to develop a system for improving the supervision of TB lab services in the decentralized laboratory network in KZN. An excellent supervisory tool called the “TB Microscopy Supervisory Tool” was developed with guidance from MSH and is now being tested with six hospitals and six clinic labs. It includes all of the key elements to ensure high quality operations including, equipment, safety, supplies, transport, administration, management information, continuous quality improvement and so on. Very importantly, it also includes a ‘client satisfaction’ feedback form to solicit comments from the client clinics which send sputum samples. Findings are summarized in a scoring sheet which facilitates tracking of progress. In March a follow-up workshop is planned to analyze whether any modifications are needed in the tool and to make plans for expanding its use within the province.

Managers reported that deficiencies found using this tool will be addressed in the annual Business Plans that are part of the NHLS planning process. The technical advice and input from TASC II TB will then be institutionalized within the NHLS system. While there are no data yet to verify that this tool will result in improved lab performance, the participatory process used to develop the tools, and the leadership now being taken by the NHLS staff to further develop and expand its use, is certainly highly encouraging.

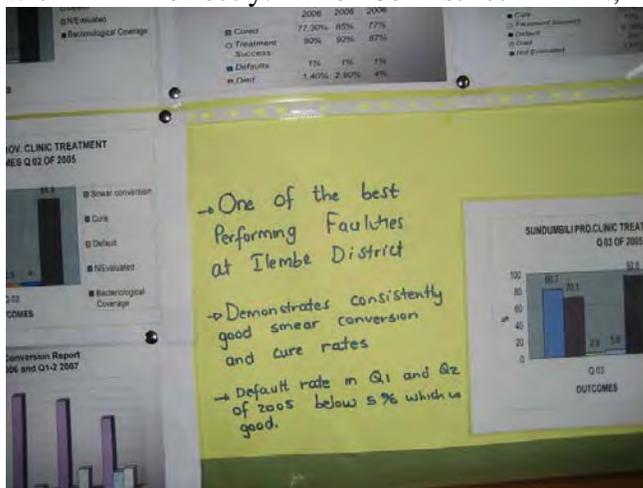
With the good progress that is soon to be made in KZN, the challenge for TASC II TB is to determine how this innovation can be expanded to other provinces. A meeting is planned for April to gather key NHLS staff from the other four provinces and the national level to report on work in KZN and determine whether it can be applied elsewhere. Staff do hope that by demonstrating the benefits to KZN, other provinces will be willing to undergo a similar planning process. It seems important that any plan development is preceded by a ‘diagnostic’ step to reveal the problems in a particular area. In some areas, the lab services are highly centralized in well-developed laboratories serving clinics in urban or semi urban environments where efficient transportation is ensured. In more rural settings where a centralized system is impossible, the development of a network of smaller, less well-endowed labs has created quality assurance problems that need

attention. TASC II TB staff need to be strategic in selecting areas for expansion to those districts where lab support issues are constraining program performance and where NHLS is willing to partner with the project on improvements.

VI. Best Practice # 4: Advocacy, Communication and Social Mobilization

TASC II TB is supporting a number of activities in advocacy, communication and social mobilization that are likely to have significant program impact over time. It is difficult at this juncture to substantiate this impact given the nature of the interventions. Some of the most promising are described below.

NGO activities – URC has engaged organizations such as Human Health Development Trust (HHDT) in KZN province which began as an HIV/AIDS-oriented NGO but subsequently became engaged in TB work. HHDT, as an explicit part of its mandate, has worked with a number of smaller NGOs to mentor and train them to provide support at the community level for the TB and HIV programs. As evidence of their success, HHDT reports that several of these smaller NGOs have gone on to qualify for direct funding from other donors. The DOH and the Department of Social Welfare have also worked with HHDT directly. In Ilembe District in KZN, HHDT-supported NGOs worked



closely with the facilities targeted by TASC II TB to mobilize DOTS supporters who engaged in various community mobilization activities in support of TB. The clinic staff visited all believed that the NGOs' involvement had directly contributed to lowering defaulter rates and ensuring better patient compliance. They have been particularly effective dealing with culturally-sensitive approaches to improving community understanding of TB and the need for early diagnosis and treatment.

Traditional healers are involved as DOTS Supporters. HHDT is also working with prison populations as well as seasonal sugar workers on the TB program. URC's grant to HHDT to work in Ilembe expired in September 2007; discussions are underway about further work with HHDT in a new site.

One note of concern in Ilembe District is a problem with maintaining DOTS Supporters are who are no longer receiving stipends. When the district did not pay stipends, HHDT, working with local NGOs found a way to continue paying stipends until September of 2007. Since then, while the Department of Health has the funds to pay the stipends, they have not agreed with the Province on a mechanism to pay the volunteers. When the DOTS Supporter became less active, Sundumbili Clinic, for example reported that defaulter rates began to increase. They have attempted to use tracer teams to find the

defaulting patients but it is clearly not working as well as the previous use of DOTS supporters.

Other Social Mobilization: Each of the five provinces has been provided technical support for communications and social mobilization work by TASC II TB. At the national level, guidelines were developed called “Behavior Change, Communication and Social Mobilization – Tuberculosis Guidelines”, a simple but high-quality document aimed at guiding work in this area. Other activities range from door-to-door information campaigns, imbizos (traditional community gatherings), and training for ward counselors and traditional leaders. TB managers in locations where these activities have been conducted are convinced that they have been essential for educating the population about TB and eliciting support for tracing defaulters and so on. More recently, TASC II TB launched a ‘workplace’ initiative involving large commercial firms. Information pamphlets on TB and TB-HIV were produced and round table discussions held to increase awareness and support for TB treatment for workers.

At this juncture, there is not much quantitative evidence of the impact of the advocacy, communication and social mobilization work although strong conviction among facility staff and managers that it is both essential and paying off in terms of improving program outcomes.

VII. Lessons Learned:

The purpose of this section in the report is to provide some observations about programmatic and management issues in the project at this juncture. These observations may be useful for making changes during the next 18 months and for future work in this area.

- a. **Expansion of Best Practices:** If TASC II TB does have another 18 months of time to implement activities, it is critically important to move proactively and aggressively to expand the interventions that have been identified as ‘best practices’ in order to broaden the impact of the project in the five provinces. The use of the DRAT supervision tool is a good example. The use of DRAT is clearly producing measurable improvements in the program. Project provinces beyond Eastern Cape are now expressing interest in using it. Even non-TASC II TB provinces such as Gauteng are now using the tool successfully. Project staff should make implementing the DRAT a high priority activity. The more opportunity district managers have to use the tool, the more institutionalized it will become. As illustrated by the Nelson Mandela Metro experience, the DRAT also serves to strengthen the ETR by calling attention to the specific areas of weak performance, including record keeping. The NTCP and the project have much to gain by assisting the provinces apply this tool as widely as possible.

- b. **Flexibility and Responsiveness to NTCP Needs:** One of the reasons that TASC II TB has been successful to date is its ability, and USAID's willingness, to remain flexible and responsive to the changing needs of the National TB Control Program. For example, in the original proposal, there was not much emphasis on MDR-TB and no mention of XDR. However, as these problems became more pronounced, the project, with USAID's support, was able to provide technical assistance to the NTCP to develop new training programs and guidelines for MDR-TB, including infection control guidelines which are aimed at providing guidance to clinic staff to reduce risk of transmission for themselves and other patients. Another example is that the original proposal contained more activities related to PPM and working with private doctors and clinics which would have put the project out in front of NTCP policy in this area. Instead the project has worked to introduce TB awareness in larger commercial firms and larger employers. These activities fit well within the strategic framework of the project but emerged from the needs and conditions in the country. That kind of flexibility and responsiveness to the NTCP will continue to be important during the remainder of the project as well as being an important feature in any follow-on program.
- c. **Role of Operations Research:** The institutional set up with URC and HST for conducting the operations research in the project has never worked as originally envisioned for several reasons. (1) Having some of the project staff who are HST employees sitting and working in the TASC II TB offices and being supervised on a daily basis by URC has been dysfunctional, especially since HST is headquartered in Durban. (2) The protracted process of obtaining ethical reviews and approvals from the Department of Health resulted in difficulties for undertaking any real intervention research. (3) There have been communication problems and differing expectations about how research topics were to be set, with URC expecting more initiative from HST and HST wanting the research to be program-driven and therefore proposed by URC. (4) HST has not been able to devote the kind of time and staff resources to managing the TASC II TB work as had been expected at the beginning, given their other obligations. In spite of these difficulties, some of the descriptive research (e.g. profile of XDR patients) has been very useful for the project and the NTCP. At this stage in the project, it is important for URC and HST to agree on a limited number of studies that can be conducted within the time left. Ideally, this should include work during the final six months on documenting the impact of the various project interventions to provide the analytic basis for a final evaluation. In any future project of this nature, a better model may be for the prime institution to hire and supervise all key staff directly and to sub-contract, as needed, with a variety of research institutions for specific research studies.

- d. Data Collection:** One of the recommendations of the midterm assessment was to use short term or part time staff to undertake data collection and recording activities that are necessary but do not necessarily need to be carried out directly by the Provincial Coordinators. To date, the Provincial Coordinators are still spending large amounts of time filling out the Facility Tool TB-HIV data collection forms once a month. They definitely do need to oversee that data collection and to use the information to coach and build the capacity of their counterparts but actually sitting at the registers filling out the forms is not a good use of their time, and could be done by someone whom they supervise.

VIII. Summary and Conclusions

This report summarizes some of the key ‘best practices’ supported by the TASC II-TB Project in its contribution to the National TB Control Program. As part of decentralized capacity building, the first two interventions described, the DRAT supportive supervision tool and the use of “Collaboratives” to strengthen local data recording, analysis and use, are clearly showing strong and unequivocal evidence of success. All that remains is to scale them up as rapidly as possible. The area of strengthening TB laboratory services is a best practice in its early stages. The methodology and tools are excellent, and once applied beyond the pilot phase, should also provide a good tool to support improvements in this very important and essential aspect of the TB program in each province. The fourth area, advocacy, communications and social mobilization, has been widely used and is believed to be contributing to improved TB program performance, although quantitative evidence is not available to the same degree as the other best practices.

This report also includes some lessons learned in program management; most especially (1) the importance of remaining flexible and responsive to the national TB control program and (2) the need to accelerate expansion of the best practices and optimize the use of staff time for this purpose. Research work in any future project should be organized on an as-needed basis, selecting those research institutions best suited to carry out the work.

In conclusion, USAID, through the TASC II TB Project, is clearly contributing in important ways to the National TB Control Program with the introduction and expansion of best practices aimed at building capacity to manage TB and TB-HIV programs at the facility, sub-district, districts levels and provincial levels. Hopefully a final project evaluation can capture the full extent of that contribution before the end of the project.