USAID TB CARE II Project

Annual Report Year 2
Project Summary
October 1, 2011- Sept. 30, 2012

University Research Co., LLC

Funded by United States Agency for International Development
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1 Project Overview
The TB CARE II Project is a five-year cooperative agreement from the United States Agency for International Development (USAID) led by University Research Co., LLC (URC) designed to provide global leadership and assist National Tuberculosis Programs in high burden countries around the world to accelerate the implementation of programs for TB DOTS, TB/HIV and Programmatic Management of Drug Resistant TB (PMDT).

2 Malawi
The TB CARE II Malawi Project is a coordinated effort led by URC in collaboration with PIH and Project HOPE. The project aims to: (1) work with the government of Malawi to reach and sustain global and national targets for case detection and treatment success through DOTS expansion and strengthening; (2) scale up universal access to TB diagnosis and treatment, especially in women and vulnerable populations, utilizing community-based approaches; (3) improve TB/HIV integration at all levels, particularly at health facility level, and offer high quality DOTS through a wider range of service delivery outlets, especially for PLHIV; and (4) increase access to drug-resistant TB prevention and treatment through community-based approaches and improved diagnostic capacity for drug susceptible and drug resistant TB.

The project has received substantial support from and collaborated closely with the following organizations: USG and partners, the National Tuberculosis Programme (NTP), the Ministry of Health (MOH), and the district communities served by the program. TB CARE II has completed its second year, October 1, 2011 - September 30, 2012 of implementation. During the year under review, TB CARE II activities were based on national & local priorities relevant to TB described in NTP Strategic Plans 2007 – 2011 & 2012-2016 as harmonized with other MoH Health Development strategic plans and each target district’s District Implementation Plan (DIP).

TB CARE II Malawi implements activities in 6 target districts: Mulanje, Phalombe, Machinga, Mangochi, Neno and Ntcheu and the national level. At the district level, TB CARE II has focused on strengthening of management skills, technical & material support for partnerships, partners’ coordination; program implementation; joint supportive supervision, mentoring of staff as well as monitoring and evaluation. TB CARE II will build on the success accomplished in the six target districts in Year 2 to expand in Year 3 to additional districts with the implementation of a comprehensive package in all relevant health facilities. In
collaboration with the NTP, TB CARE II has selected the following additional target districts: Balaka, Chikhwawa, Zomba, Nsanje, Nkhotakota, Mzimba, and Lilongwe (see map).

**Key achievements:**

a) Completed recruitment and placement of all key technical and administrative staff.

b) Technical assistance for the development of the NTP 2012-2016 strategic plan

c) Technical assistance (STTA) for the development of a community-based MDR-TB operational guidelines conducted by Dr. Michael Rich and Deputy Director of TB CARE II Dr. KJ Seung

d) Provided technical assistance for the development of TB Prevalence survey protocol

e) Supported NTP weekly management meetings

f) Supported supervisory and monitoring visits by NTP logistics officers

g) Supported the development and printing of the revised national TB Control Manual and the operational guidelines for PMDT

h) Capacity building for MDR-TB management team for the proposed Centre of Excellence

i) Supported the procurement, installation and roll-out of GeneXpert in three districts of Neno, Machinga, Ntcheu and at the Central Reference Laboratory

j) Supported training on the use of GeneXpert technology for TB diagnosis & sponsorship of an international training of a Central Reference Laboratory technician on the managerial & technical aspects of GeneXpert at the Hague in Netherlands

k) Supported the training of 30 lab technicians on the use of GeneXpert

l) Supported capacity building of 1256 health care staff to improve TB diagnosis and correct treatment at the district level in six districts

m) Supported nation-wide distribution of SLDs to sites treating MDR-TB patients and monitoring of the usage of SLDs

n) Supported the establishment of 13 new TB registration and initiation centers in target districts

o) Supported the strengthening of community health systems through establishment of 64 additional community sputum collection points, building capacity of community volunteers (including procurement & distribution of enablers), and scaling up community education and mobilization through community campaigns. TB CARE II also supported the reactivation of 176 sputum collection points bringing the total of sputum collection points in the six target districts to 240.

p) Supported the procurement of 21 i-LED microscopes and 8 ParaLens attachments for the expansion of diagnostic networks

q) Supported training of lab technicians on the use of i-LED microscopes
r) STTA for the assessment of peripheral laboratory networks nation-wide supported by CLSI

s) Supported and performed joint supportive supervision and mentoring of MoH district laboratory technicians, lab assistants and HSAs on quality AFB microscopy in target districts.

t) Supported and performed joint mentorship of MoH district TB officers and assistant TB officers as well as health care workers in all target districts.

u) Supported the training of community volunteers for TB control activities at community level.

v) Conducted a situational analysis and evaluation of scale up plan for Community Sputum Collection Points with assistance from Dr. Francoise Nywagi Louis

w) Provided technical assistance to the TB and TB/HIV technical working groups

x) Supported planning for the national TB prevalence survey including assisting with procurement of TB Prevalence materials & commodities (tents, golf shirts for survey teams, tables etc.)

Success Stories:

**USAID TB CARE II PROJECT SAVES LIVES OF COMMUNITIES IN MANGOCHI: The experience of Catherine Pelani**

Access to health care services among rural, resource-poor people in low-income countries remains a major obstacle to TB control efforts. A critical factor is the need to improve access to diagnostic facilities, which in many rural areas double as TB treatment initiation and registration centres for TB patients. It is common for patients to travel over 50 kilometers to access TB treatment initiation services. Thanks to the USAID TBCARE II project, more than 31,558 people living near the Chilipa Health centre can now access TB diagnosis and treatment close to their communities.

One such person is 46 year-old Catherine Pelani, from Mphika village. She had this to say during a TB CARE II-organized a TB open day in Chilipa: “Ndikanafa ine kupanda anthuwa” – “I would be dead if it were not for TB CARE II.”

In 2010, Catherine was diagnosed with pulmonary TB at Chilipa Health Centre, which is located 3 kilometres away from her village. At that time Chilipa Health centre was only a microscopy centre, lacking the ability to start patients on TB treatment. As a result, Catherine had to go to Mangochi District hospital, which is more than 56 kilometres away from her home village to...
start TB treatment. After two months of intensive in-patient treatment, Catherine was discharged.

Unfortunately for Catherine, in early 2012 she fell ill again. A TB CARE II community volunteer Kabichi, a TB CARE II community volunteer, escorted Catherine to the Health Centre on a bicycle provided by the project. She continued to provide support throughout the treatment period and even transported sputum samples to the health centre for follow up testing. TB CARE II supports its community volunteers, like Judith, with bicycles, training in TB control, sputum transportation boxes, and other resources to help them help members of their community such as Catherine. These TB volunteers enjoy their work and take pride in helping their communities.

visited her and offered to take her sputum to Chilipa Health Centre for smear microscopy. The results from microscopy confirmed Catherine had a relapse of TB. Catherine recalled her trip to the district hospital, and worried about the time and resources it would take to again travel the long distance to Mangochi District hospital. However, thanks to TB CARE II, Catherine was able to start treatment the same day at Chilipa Health Centre, just a 20 minute bicycle ride from her home. She was cured six months later.

Judith

Catherine is grateful to TB CARE II and had this to say: “anthu amenewa agwira nthito ndipo sindakwanitse kuthokoza. Pano ndili bwino ngati wina aliyense mumudzimu” – “these volunteers are so invaluable I am now cured of TB and live like any other person in the village”.

Catherine encouraged her community to support the work of TB CARE II while advising those who suspect that they have TB to utilize TB services in their area.

There are many people who still cannot access TB health care services closer to their homes. TB CARE II is working to improve access to TB diagnosis facilities and access to TB treatment. TB CARE II is helping to launch new TB initiation and registration centres by training health care workers, providing start up materials, and conducting mentoring support visits to the new centres. TB CARE II also supports TB diagnostics and facilitates community linkages to health care services through a network of community volunteers. Chilipa Health Centre is one of 13 new TB initiation and registration sites that TB CARE II opened in 2012. Through this model, TB CARE II has been able to reach out to many communities. In the past year, a total 3051 TB cases were detected and patients notified in the six targeted districts of Neno, Ntcheu, Machinga, Mangochi, Mulanje and Phalombe.
USAID/TB CARE II PROJECT WORKS WITH NTP TO IMPROVE TB PATIENT CARE AND TREATMENT

TB CARE II District Coordinator Patrick Gomani adjusts a mask on tuberculosis patient Zefa Charles to prevent transmission of the disease during an ambulance ride.

The National TB Control Program (NTP) in Malawi faces a number of challenges, including low case detection rates, high levels of HIV co-infection, and the presence of multi-drug resistant tuberculosis (MDR-TB). Effective TB control requires an integrated response to all of these challenges. The story of Zefa Charles illustrates how all of these factors come into play and how the NTP, through its partnership with the USAID TB CARE II Project, is working to address these challenges to improve TB patient care.

Zefa lives more than two hours away from the district hospital and 20 kilometers from the nearest health center. She lives at the end of a road that quickly degrades into little more than a muddy footpath. Her home is a small mud-walled hut that she shares with her grandmother, sisters, and children.

Over a year ago, Zefa tested positive for HIV at the health center. Her CD4 count — an indicator of immune system strength — was too high to begin antiretroviral therapy, and the tuberculosis bacteria in her lungs went unrecognized, presenting a constant risk of infecting her family. Sick and failing to get better, she spent many days traveling to the health center, only to receive bactrim, an antibiotic to prevent opportunistic infections.
“Bactrim, bactrim, bactrim,” she said, “until the day I was diagnosed with tuberculosis.” She received first-line drugs, but did not get any better; tests confirmed she had MDR-TB, a deadly manifestation that does not respond to first-line treatments.

MDR-TB made an already difficult life much more challenging. “I don’t have food. I have no money. My children have no notebooks for school. The only food I eat is what these children have found,” she explained. Gaunt with sunken eyes, it was clear how significant a toll the difficult access to health services and lack of appropriate treatment options had taken on her.

However, Zefa was able to get the care she needed, thanks to USAID/TB CARE II and its partners. The NTP supplied the rare second-line drugs to treat Zefa, while a room was specifically outfitted at Neno District Hospital so she could benefit from the close oversight of clinicians.

“I’m feeling better because I will finally find the right treatment there,” she said, as she prepared for the long journey back to Neno to be admitted.

After six weeks of treatment and monitoring, Zefa was finally getting better and looking forward to returning home to finish her treatment, finally on her way to being free of TB.

Through its continuing efforts, the TB CARE II project is working to ensure that all patients, even challenging cases like Zefa, are able to access the care and treatment they need to live TB free.

**TB CARE II-SUPPORTED SPUTUM SMEAR FIXATION SITE IMPROVES COMMUNITY ACCESS TO TB DIAGNOSIS**

Not long ago, it took four or more weeks for patients with suspected TB to get the results of their sputum smear microscopy tests.

Now, thanks to the efforts of the USAID-funded TB CARE II project, the Kapeni health centre in the Ntcheu district of Malawi is reducing turnaround time, lowering cost, and increasing community access to TB diagnosis through the introduction of a sputum smear fixation site at the health centre.

Kapeni health centre has a catchment population of 10,842. Prior to the establishment of the sputum smear fixation site, members of this community with suspected TB had to travel to the Ntcheu district hospital laboratory, located 16 km from the Kapeni health centre over a road that is bumpy, dusty, and difficult to travel. Due to high transport costs, many patients chose not to make the journey at all. Those who did often experienced high costs, poor turnaround time, and lost test results. In both circumstances, many suspected cases of TB went untested and undiagnosed.
Things began to improve in January of 2012, when Kapeni health centre was assessed by TB CARE II and earmarked for the establishment of a sputum smear fixation site. At this site, patients provide their sputum samples which are then fixed onto slides and prepared for transport by TB CARE II-trained health workers. These samples are then transported to the district hospital microscopy site for testing. This reduces the time and cost to the patient, which has led to an increase in the number of community members coming forward to give sputum samples.

During a visit to the Kapeni health centre in May 2012, the TB CARE II project team was introduced to Mr. Kapeni, a community health leader and secretary to the village health committee. Mr. Kapeni was addressing community members, stressing the importance of their role in supporting active TB case finding through the use of the sputum smear fixation site.

Recalling how things had been before the site was established, Mr. Kapeni said:

“\textit{I am happy an intermediate service has been brought closer to the facility and the community. I am also happy that now sputum samples are being smeared and only fixed sputum specimens are sent to the district for examination. Unlike before when we were required to travel by ourselves to the district for the sputum smear fixation and microscopy. Sometimes we were being forced to visit private CHAM hospitals for the same service of which now we are able to get it freely.}”

Community members thanked TB CARE II for bringing services closer to them and motivating them to play a more active role in the detection, management, and control of TB within their community.

\textit{Secretary to the Village Health Committee Mr Kapeni praises the collaboration between the Malawi government and the USAID/TB CARE II Project.}
3 Bangladesh
The TB CARE II project has been designed in consultation with USAID/Bangladesh and NTP to contribute to achieving Bangladesh national objectives for preventing and controlling TB and to help GOB achieve its Millennium Development Goals (MDGs) for TB. The specific objectives of the project include the following:

- Improve universal access to TB diagnosis and treatment;
- Work with GOB to reach and sustain the global targets of > 80% case detection and > 90% cure rates under DOTS;
- Providing high quality DOTS through all levels including those of private providers;
- Improve programmatic management of MDR TB and increase access to MDR TB prevention and treatment through community-based approaches;
- Strengthening diagnostic capacity for drug susceptible and drug resistant TB;
- Health systems strengthening with an Upazila-based approach as accepted in GHI Bangladesh strategy.

The project targets the whole country for increasing access to diagnosis and treatment of all forms of TB. The project provides technical assistance to the NTP and NGO partners to strengthen their capacity to improve and expand the management of TB and MDR TB programs.

The Bangladesh TB program has already achieved its global targets for case detection and treatment success rates. Emphasis is now on universal access to TB care for all TB patients in the community and high risk groups, expanding facilities and their capacity for diagnosis and treatment of MDR TB services, and strengthening health systems to improve national capacity to provide high quality TB services in a sustainable manner.

Aligned with National TB Control Programme strategic objectives and USAID/Dhaka strategic framework, the TB CARE II partnership’s activities complement the Global Fund and Government of Bangladesh efforts to strengthen all the components of Stop TB Strategy with a major emphasis on universal and early access to TB services, Programmatic Management of Drug Resistant TB (PMDT), and health systems strengthening. The TB CARE II Bangladesh project results framework has been developed to contribute to achieving Mission IR 3.2 Increased Use of Integrated Essential Family Planning, Health (including TB) and Nutrition Services and IR 3.3 Strengthened Health Systems and Governance.

The TB CARE II Bangladesh project has completed its second year and has successfully implemented almost all the activities planned for this period. The project has assisted the NTP to develop TB control and prevention plan for all the 64 districts. Significant progress has been made in several areas including strengthening DOT for increased detection and management of all types of TB, management of childhood TB, expanding national capacity for diagnosis of MDR TB using state-of-the art technologies such as GeneXpert, and community based programmatic management of MDR TB (cPMDT), strengthening laboratory services and systems, and increasing private sector participation in the TB control program.
Increase Access to Quality TB services

As per Year 2 work plan, the project implemented several activities to increase access to TB and MDR TB services. Given the project focus on increasing detection of TB amongst children, developing the National Guideline and Operational Manual for the Management of Childhood Tuberculosis was a priority for designing and organizing training on detection and management of childhood TB. A major achievement of the project was to facilitate the adoption of policy decisions geared at improving the immediate scale up of IPT based on revised criteria adopted in the national guidelines.

The project provided grants to NGO implementing partners through a competitive process to support ACSM, expand the network of public-private mix, improve knowledge and awareness about TB, in-service training of different cadres of service providers, pre-service training of intern medical doctors, and increase timely utilization of TB services by vulnerable populations. The project’s grant program is also geared at assisting local NGO partners to sustainably build the capacity to manage local TB projects by focusing on building technical and managerial capacities.

TB CARE II with its sub-partner BRAC contributed to a significant increase in the identification of TB suspects as well as detection of smear positive, smear negative and extra pulmonary cases during the reporting period. During this year, the project support contributed to notification of 23,220 smear positive, 4,855 smear negative and 4,898 EPTB cases. The project was able to reach 64 schools and approximately 35,000 students with educative messages on TB. Starting implementation of the planned activities targeted to vulnerable population living in the tea gardens is a significant project achievement.

The project supported initiatives to expand public-private mix through developing functional linkages with graduate and non-graduate private practitioners (PPs) to increase suspect referrals. This effort resulted in the orientation of 1,039 graduate PPs and 2,377 non-graduate PPs and developing a formal partnership with them. These PPs have referred more than 43,000 suspected TB cases in the current year.

Strengthening lab capacity

Developing national capacity for increasing access to diagnosis of TB and MDR TB was a major focus in this year. The project has installed two GeneXpert MTB RIF machines at the National TB Reference Laboratories (NTRL), Dhaka, and Regional Reference Laboratories (RTRL), Chittagong. The project also provide on-going support to integrate the operations and management of this new technology with the existing government laboratory facilities contributing to significant increase in detection of RIF resistant TB. Since introduction of this technology in May 2012, the project support has enabled NTP to test 915 samples out of which 243 were found to be resistant to RIF. It is anticipated that the introduction of this new technology will significantly enhance the national capacity for faster diagnosis of an increased number of suspected MDR-TB cases.

The project also supported training of 28 laboratory technicians on GeneXpert for diagnosis of MTB/RIF. The training of 26 lab technicians on LED and 238 on AFB microscopy in the current year is going to have a tangible impact on the quality of smear microscopy in the coming months. The table below shows the performance of lab services provided through the NTRL and
RTRL for the period from October 2011 to September 2012. In FY 12, out of 915 suspects tested by Xpert, 677 cases were found positive including 243 MTB RIF resistant.

Table 1: Laboratory Performance of NTRL and RTRL

<table>
<thead>
<tr>
<th>Type of Service</th>
<th>Lab Service Data</th>
<th>Quarter 1</th>
<th>Quarter 2</th>
<th>Quarter 3</th>
<th>Quarter 4</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>NTRL</td>
<td>RTRL</td>
<td>NTRL</td>
<td>RTRL</td>
<td>NTRL</td>
</tr>
<tr>
<td>Routine Microscopy</td>
<td></td>
<td>14,694</td>
<td>-</td>
<td>18,354</td>
<td>-</td>
<td>15,887</td>
</tr>
<tr>
<td>Routine TB Culture</td>
<td></td>
<td>816</td>
<td>96</td>
<td>825</td>
<td>91</td>
<td>1,032</td>
</tr>
<tr>
<td>Number of DST</td>
<td></td>
<td>480</td>
<td>66</td>
<td>260</td>
<td>54</td>
<td>180</td>
</tr>
<tr>
<td>Total suspect tested by Xpert</td>
<td></td>
<td>-</td>
<td>-</td>
<td>11</td>
<td>-</td>
<td>286</td>
</tr>
<tr>
<td>Total MTB tested</td>
<td></td>
<td>-</td>
<td>-</td>
<td>7</td>
<td>-</td>
<td>196</td>
</tr>
<tr>
<td>Total MTB/RIF detected</td>
<td></td>
<td>-</td>
<td>-</td>
<td>3</td>
<td>-</td>
<td>98</td>
</tr>
</tbody>
</table>

**Management of MDR TB patients**

The project made significant progress in implementing the cPMDT activities during this year. Under this approach, the period of hospital based treatment has reduced from 6-8 months to maximum 2 months. The early release of patients from hospital has helped initiate treatment for increased number of patients immediately after their diagnosis. The project has formed and trained 30 Outpatient MDR TB Teams in the 3 cPMDT pilot districts on clinical care and 51 MDR TB DOTS providers for providing on-going management of MDR TB patients.

The concerted project effort has resulted in enrolment of 53 MDR TB patients under cPMDT in the 5 months since initiation of this intervention. The early release of these patients from hospital has helped initiate treatment for diagnosed patients who were on the waiting list. A strong monitoring and supervision system has been set up requiring national, divisional, district and upazila level participation to ensure that the patients receive clinical care and support in a timely manner and that they adhere to treatment for successful outcome. The table provides a district-wise snapshot of the patients receiving treatment under cPMDT.

Table 2: Distribution of DR TB patients on cPMDT by district

<table>
<thead>
<tr>
<th>Name of district</th>
<th>the number of patients May-June 2012</th>
<th>No. of patients July-September 2012</th>
<th>Total number of patients</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chittagong</td>
<td>22</td>
<td>18</td>
<td>40</td>
</tr>
<tr>
<td>Narayanganj</td>
<td>5</td>
<td>3</td>
<td>8</td>
</tr>
<tr>
<td>Gazipur</td>
<td>2</td>
<td>3</td>
<td>5</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>29</strong></td>
<td><strong>24</strong></td>
<td><strong>53</strong></td>
</tr>
</tbody>
</table>

**Increased Compliance with TB and MDR-TB Treatment**
The project has been supporting a program at NIDCH to provide regular counseling services to the MDR TB patients in order to improve patient compliance with treatment regimen. During the project period, the project supported staff conducted 704 sessions of individual counseling and 60 sessions of group counseling for 298 patients who were receiving in-patient MDR TB services at NIDCH.

Success story:
The launching of the Community-based Programmatic Management of MDR-TB in Bangladesh

The TB CARE II project in collaboration with the National TB Control Programme (NTP) of the Ministry of Health and Family Welfare (MOHFW) of the Government of Bangladesh organized a launching ceremony for the Community-based Programmatic Management of Multi Drug Resistant TB (MDR TB) in Bangladesh, on September 11, 2012. The TB CARE II project is funded by the U.S. Agency for International Development, the premier development agency of the U.S. Government. The objective of this project is to strengthen the NTP to achieve the national goal for prevention and control of TB with focus on timely diagnosis and management of MDR TB cases with a community-based approach. The project is implemented by University Research Co., LLC and its local and international partners.

With financial support from USAID, Bangladesh, the TB CARE II project has introduced Xpert MTB/RIF test which is a molecular based technology that can detect active TB and rifampicin resistant TB which is a predictor of MDR TB. The machine provides accurate results in less than two hours, and can be placed in frontline facilities increasing access to MDR TB services. The use of this technology enables the patients to start treatment on the same day instead of waiting for two to three months that is needed to perform drug sensitivity test and culture which are commonly done for diagnosis of MDR TB cases. The project has already installed two GeneXpert machines at the National TB Reference Laboratory, Dhaka, and Regional TB Reference Laboratory, Chittagong. The project is going to install ten additional GeneXpert machines at different places of the country within a short time. Installation of these machines is expected to significantly increase the detection of suspected MDR TB cases in Bangladesh and also with the diagnosis of Smear Negative TB.

The TB CARE II project is also supporting NTP to implement the community-based programmatic management of MDR-TB. WHO estimates that approximately 5,000 new MDR TB cases emerge every year in Bangladesh. The treatment duration for MDR TB is at least 24 months. Currently, patients need to stay in hospital for the intensive phase of treatment for six to eight months. Because of the limited in-patient facility for treatment of MDR TB, many patients have to wait for a long time before they can start treatment. Under the community-based approach, MDR-TB patients will be discharged from hospital after about two months and will be shifted to their homes where they will complete the treatment. The project has formed and trained Upazila-based Outpatient MDR TB Clinical Team which is responsible for management of the patients. This initiative has been started in Narayanganj, Gazipur and Chittagong districts on a pilot basis in last May 2012. The project has successfully enrolled 40 MDR TB patients in the community based treatment program in the first two months since the initiative has started.

Professor Dr. A.H.M. Ruhul Huq, honorable Minister, Ministry of Health and Family Welfare (MOHFW), attended the launching ceremony as the Chief Guest. He thanked USAID and the
U.S. Government for their support to improve health conditions of the people of Bangladesh. USAID Mission Director Mr. Richard Greene attended the event as a Special Guest. In his speech, he highlighted the project activities supported by USAID. He also handed over a GeneXpert machine to the Health Minister to mark the occasion.

The event was attended by Mr. Humayun Kabir, Senior Secretary, MOHFW; Dr. Thushara Fernando, WHO Representative to Bangladesh; and Ms. Barbara N. Turner, President of the University Research Co., LLC. Senior officials from the MOHFW including Line Director and Program Managers of National TB Control Program, and representatives from different implementing and development partners also participated in the event. The launching event was chaired by Professor Dr. Khondhaker Md. Shefyet Ullah, Director General Health Services.
4 Core Activities
During its second year, TB CARE II continued to develop a broad framework of core-supported activities, building on lessons from Year 1 and implementing an innovative array of activities that included a blend of field work, analysis, online and distance learning, conferences, and development of much needed tools and materials. The activities successfully blended the array of talents and skills brought by the consortium members and included inputs from stakeholders at the country level as well partners within the TB CARE I team. The transition between Year 1 and Year 2 activities occurred for different activities at different points during the year, and some constraints were experienced as a result of delayed communications, approvals, or simply longer-than-anticipated work requirements. Nevertheless, activity across the board was steady, and most issues were able to be resolved on a case-by-case basis. By the end of the year, almost all year 1 and most year 2 activities were complete.

Key achievements:
1. The final report from the TB Patients Delay study was completed and published on the TB CARE II website.
2. The findings of the assessment in Zimbabwe targeting the factors behind increased early initiation of ART for TB/HIV patients were drafted and circulated among activity partners, including the Union. A second assessment visit was planned and conducted in South Africa, reaching two provinces where significant increases in ART for TB/HIV patients have been achieved.
3. The MASS Design Group conducted two case finding/data collection trips to Peru and Georgia. The sites visited will be evaluated for inclusion in the online Case Book.
4. All 10 participants sponsored by TB CARE II were successful in arriving for the course: Building Design and Engineering Approaches to Airborne Infection Control which started on July 30, 2012. The participants are from: Ethiopia, Uganda, Zambia (2), Rwanda, Cameroon, South Africa, Kenya, Lesotho, and Namibia.
5. The facilitator’s guide and participant manual for the training guide on MDR TB/HIV were review and finalized.
6. The online Introductory Training Course on MDR-TB Clinical Management took place between 10 - 26 July the aim of which was to provide practitioners working in high TB-burden contexts, with basic clinical knowledge on how to initiate and treat MDR-TB patients, as well as to provide an opportunity for participants to communicate directly with leading TB experts. It was a six webinar course on 1) Drug-resistant tuberculosis – a historical overview; 2) Basics of transmission control in an era of MDR-TB; 3) Amplification and development of drug-resistance; 4) Second-line medications for MDR-TB treatment and new drugs in the pipeline; 5) Designing an MDR-TB treatment regimen; and 6) Management of side-effects during MDR-TB treatment. The average number of people who signed up for the webinars was 396 and the average number of people who participated was 99. The software package has a limit of 100 participants. On average 51% of participants came from Asia, 30% from Africa, 12% from North, Central and South America and 7% from Europe. All archived webinars are available at https://drtbnetwork.org/webinars.
The PMSG in collaboration with BEA also undertook to redesign the project’s website to create a new, more user-friendly design and increase accessibility of the project's resource library and to direct more users to the site. The website is now located at the address www.tbcare2.org. The team continued to work with all partners to maintain fresh and relevant content for the site.