Welcome to the June 2013 edition of the TB CARE I newsletter which brings you a snapshot of TB CARE I work, with stories from Ghana, Nigeria, South Sudan, Kenya, the Dominican Republic and World TB Day.
A quick round up of the some of the events in which TB CARE I was involved for World TB Day (WTBD) 2013:

**Afghanistan:**
Working with the National TB Program (NTP) celebration events were held at 300 health facilities and communities in 13 USAID-supported provinces. TB text messages saying 'If you have had a cough with sputum for more than 2 weeks, please go to the nearest health facility for diagnosis and treatment' and 'Diagnosis and treatment of TB is free of charge in public health facilities countrywide', were sent to approximately 100,000 people. 145 high-performing health workers were publicly rewarded for their work.

**Cambodia:**
TB CARE I staff participated in March 24th events at the National Center for TB and Leprosy Program compound in Phnom Penh. NTP-funded activities included comedy performances, TB trivia for school students and inspirational speeches by national stakeholders including the NTP director and the Minister of Health.

**Ethiopia:**
WTBD was commemorated colorfully in Addis Ababa with a mass 2km walk from Sidest Killo Victory Monument to Addis Ababa convention center led by the Federal Police Marching Band. The Ethiopian HEAL TB team worked with the federal Ministry of Health to present six hours of television coverage of athletic events held on WTBD.

**Ghana:**
In Kumasi, the TB CARE I team held an exhibition which highlighted best practices for improving hospital-based TB case detection using standard operating procedures. The US Ambassador to Ghana also attended World TB Day in Accra.

**Indonesia:**
Working with the Global Fund to Fight AIDS, Tuberculosis and Malaria, and Indonesia’s NTP to organize a 5km race drawing over 10,000 runners, bikers, walkers and observers; Indonesia’s Minister of Social Welfare spoke at the event.

**Nigeria:**
The TB CARE I team in Nigeria participated in activities on the 22nd March in Abuja along with the Association for Reproductive and Family Health Nigeria, the World Health Organization (WHO), and KNCV Tuberculosis Foundation. The team also organized and funded a TV talk show on TB control.

**Mozambique:**
The TB CARE I team in Mozambique participated in WTBD on March 24th in Nampula province, along with Mozambique’s Ministry of Health and USAID. The Nampula Regional Reference Laboratory was inaugurated and TB awareness and educational presentations took place at primary and secondary schools, markets and churches from March 18th–24th.

**Namibia:**
Events began two weeks before with two road shows; with one team starting from Opuwo in the North western part of the country and another from Katima Mulilo in the far north eastern corner of the country. The team from the Opuwo travelled a total of 1350 km whilst the one from Katima Mulilo (in Caprivi region) covered almost 4500 km to arrive in Walvis Bay.

The road shows included marching through the main towns on the way, the distribution of pamphlets, posters, and music/dance, effectively engaging communities at every level.

In Walvis Bay there was a 10 km march led by the Navy Brass Band, soldiers and police as well as many community participants, health care workers, all of which wore bright yellow colored T-shirts emblazoned with the message 'I Want Zero TB Deaths" (see front cover) and handed out leaflets and TB information.

**South Sudan:**
The TB CARE I team celebrated WTBD on March 24th at the Nyakuron Cultural Center in Juba. Events included presentations, speeches, drama performances, a football tournament and promotion through the radio, TV, text messages, newspapers and churches. A song promoting TB prevention was translated into English & Juba Arabic and was broadcast on the local radio stations in Juba, potentially reaching millions of people.
TB control in Ghana is challenging: the detection of TB cases is low, and TB mortality rates are high. In many communities, such as the Lower Manya Krobo District, these challenges are compounded by the popular belief that TB is a spiritual disease. Many Ghanaians who contract TB seek healing in prayer camps (a traditional-spiritual house where people with various forms of physical and mental illness, stay temporarily for spiritual healing) and at shrines, rather than going to health facilities for testing and treatment. By the time such patients seek medical care, it often is too late to recover.

Lower Manya Krobo District has over 93,000 residents and a high incidence of TB: 209 cases per 100,000 people in 2011. The district is also home to many of the nation’s mushrooming prayer camps, where local healers provide daily services for residents who are ill. There are over 50 prayer camps in Lower Manya Krobo District, and only 18 health facilities.

Grace Tsawe owns a prayer camp in this district. She usually sees over 100 patients on her main clinic day. Until recently, Grace did not recognize the need to refer her patients to health facilities because she believed that TB could only be cured through prayer. In December 2011, Grace developed a persistent cough and began to rapidly lose weight. Although she prayed fervently, Grace’s symptoms persisted. Eventually, she decided to visit Atua Government Hospital. The doctors tested her and, finding her infected with TB, initiated treatment.

TB CARE I in Ghana, led by Management Sciences for Health (MSH) in partnership with the KNCV Tuberculosis Foundation and the World Health Organization, has been working to increase TB case detection in the Lower Manya Krobo District since early 2012. As part of this process, the project facilitated a workshop on improving TB case detection for over 120 of the district’s health care workers. In addition to training staff on TB screening, diagnosis, and treatment, TB CARE I also taught them to encourage prayer camp owners to screen their patients for TB and refer them to health facilities if they are in need of testing and treatment.

One of the project’s trainees, Victoria, is a TB Coordinator at Atua Government Hospital. After Grace began TB treatment, Victoria encouraged her to give her prayer camp clients the same opportunity for testing and treatment. Having experienced a full recovery, Grace was easily persuaded. Victoria taught her how to identify TB symptoms and conduct a timely referral to the hospital. Grace is pleased to see how TB screening and treatment have helped to improve her patients’ health. “I now know that TB is not a spiritual disease and, when it is promptly tested and treated, TB is indeed curable. TB treatment has saved my life and I am ready to proudly give my testimony to my counterparts across the country,” she said.

Grace is now encouraging her fellow prayer camp owners to refer patients who they suspect of having TB to the hospital. She has also requested support from the hospital to hold a workshop for other prayer camp owners so that they can be trained in TB case detection activities. TB CARE I and the Atua Hospital managers are working with Grace to organize this training. Last year TB CARE I arranged for Grace to give her testimony to a gathering of over 200 health professionals and local residents in Koforidua Region. The project is now developing a documentary film about Grace’s life that will be broadcast on radio and TV stations across the country.

Since 2012, TB CARE I has supported TB case detection activities at the three main hospitals in Lower Manya Krobo District. In just 12 months, these efforts have allowed the district’s health workers to screen nearly 140,000 people for TB. In total, 298 of those screened were diagnosed with TB and initiated on treatment. This represents an additional 119 TB cases detected as compared to the number of cases detected in 2011. The project is conducting similar training and support in four districts in Ghana’s Eastern region. The TB CARE I team is documenting best practices and lessons learned from these activities and disseminating them to health care workers in all 10 regions of the country.
TIBU: Use of innovative technology to improve Kenya’s TB Program

Weak program management is a key issue faced by most National TB programs. Kenya has embarked on a revolutionary journey to improve the management of its TB program with an innovative web based solution integrated with mobile technology - the first of its kind to be implemented in Africa. TIBU, meaning “to treat” in Swahili, was developed and launched in November 2012 with support from TB CARE I.

TIBU is a unique system developed for use by the Division of Leprosy, Tuberculosis and Lung Disease (DLTLD) in Kenya to specifically address challenges in data management and ensure tracking and monitoring of all TB patient data throughout the country. TIBU is based on a two pronged approach that enables the TB program to easily access data for informed decisions at all levels. It is strengthening and improving recording and reporting with real time data from the facility level up to the central unit, as well as provision of feedback. TIBU is also strengthening and improving governance and accountability through utilization of mobile money transfer to make payments for supervision and provide MDR-TB patient support.

How does TIBU work?
In practical terms, TIBU is used in the field to perform regular monitoring activities like supervision and EQA. Data is collected electronically with tablets and uploaded into the central database of the DLTLD. The data is immediately available for analysis and TIBU can generate cohort reports on case finding, treatment success, MDR incidence and mapping of specific TB issues. In addition, TIBU can be used for logistics planning of commodities and MDR patient support. To enable integration, TIBU is also linked with the national District Health Information System for TB data sharing at the Ministerial level.

The payment system comes into action once supervision or EQA activities are completed. TIBU indicates a need for payment to be made via mobile money transfer using M-pesa to a TB or Lab Coordinator for any costs incurred during supervision or EQA activities.

The Key Features of TIBU:
- Electronic registers: i.e. TB facility, Commodities
- One time data entry at source using mobile tablet
- Data transfer in real time to central unit
- Seamless integration with DHIS2 (National Health Information System)
- Ability to generate real time reports at any level
- Automation of referral forms leading to identification & tracking of suspects
- Identification of duplicate patient entries
- Funds transfer to NTP staff and MDR-TB patients using M-Pesa

It is through the vision of USAID Kenya and leadership of DLTLD this venture was made possible. USAID-Kenya is the sole supporter and motivating force behind the development of TIBU. DLTLD is in the driving seat of TIBU’s development. They provide the input for the system; knowledge of how TB is managed in Kenya and the needs from the field. DLTLD also is training staff from the central unit to district level and managing most of the help desk functions regarding technical issues of the system.

TIBU was developed through a unique partnership led by the DLTLD and USAID Kenya with TB CARE I and three Kenya companies - Safaricom, Iridium Interactive and Tangazoletu. This partnership of five separate entities has been successful in pulling their expertise together to develop a system that is simplifying health delivery services and providing an equitable platform for tackling TB.
The state-of-the-art treatment center for multidrug-resistant tuberculosis (MDR-TB) was commissioned on November 1, 2012 at the Infectious Disease Hospital (IDH) in Kano State by the Executive Governor, Engr. (Dr.) Rabi’u Musa Kwankwaso. The inauguration of this facility marks a major milestone in Nigeria’s effort to provide MDR-TB treatment in accordance with established global standards. It is the first MDR-TB treatment center in the Northwestern region of Nigeria, serving Kano State and adjoining States in the region. It has the capacity to absorb TB patients from other treatment centers outside the region, as needed. The availability of this facility expands the country’s capacity to provide essential treatment to MDR-TB patients.

TB CARE I is working with the Government of Nigeria to strengthen the National TB and Leprosy Control program (NTBLCP). The NTBLCP is implemented in 36 states of the Federation including the Federal Capital City of Abuja. TB CARE I is working in 26 out of the 36 states, including Abuja. The project’s work in Programmatic Management of Drug Resistant TB includes upgrading existing facilities to expand capacity for treating MDR-TB patients.

The project supported the renovation of an existing structure at the 52-year old Infectious Disease Hospital and the procurement of infection control materials. TB CARE I also provided training for facility staff on the management of MDR-TB and infection control, and funded the development of job aids, treatment guidelines, and standard operating procedures. The Kano State government supported the facility by supplying beds, and other equipment and supplies, including an X-ray machine. The treatment center has three wards — for men, women, and children — as well as two common rooms for the clinical team, an administrative block, and fully equipped recreation and prayer areas. Eight MDR-TB patients are currently being treated at the facility.

TB is a major public health problem in Nigeria. The country is ranked tenth among the 22 high TB burden countries that contribute 80% of the global TB burden. Resistance to TB drugs is an important threat to TB control. The World Health Organization estimates that more than 425,000 MDR-TB cases occur every year. Global prevalence may be as high as one million cases. Nigeria is estimated to have 2,700 MDR-TB cases occurring annually, of which 2.2% are new cases, and 9.4% are retreatment cases. Of these cases, 118 are currently being treated at MDR-TB facilities around the country: 62 cases at the MDR-TB treatment center of University College Hospital, Ibadan; eight at the IDH in Calabar; 40 at the Mainland Hospital in Lagos; and the current eight cases at the upgraded treatment center at IDH, Kano.
During the 4th Conference of The Union Asia/Pacific Region from April 10-13th, 2013 in Hanoi, Viet Nam, TB CARE I held a symposium to discuss some of the program’s achievements so far in Viet Nam, Cambodia and Indonesia.

The role of Xpert MTB/RIF in support of PMDT scale-up in the three countries was presented with all three reporting different barriers to scale-up, but the result has been a shortening in diagnosis time, an increase in the number of patients diagnosed and starting on Category IV treatment and a reduction in the need for culture and DST.

The presentation on the management of childhood TB in Viet Nam showed how there was an immediate and sustained increase in the reporting of TB among children in a pilot area which used contact tracing and a good reporting system.

Finally the introduction of e-TB manager in support of scale-up of PMDT in Viet Nam demonstrated the advantages for management of second line drug supplies.

South Sudan Country Director Interviewed on VoA

The director of TB CARE I in South Sudan Dr. Stephen Macharia was interviewed on Voice of America, In the broadcast, he discusses the TB epidemic in South Sudan, TB CARE I project achievements, and the way forward for improving funding for TB services and multi-drug resistant TB (MDR-TB) control in fragile states, such as South Sudan. You can hear the interview by going to the TB CARE I Vimeo page: http://vimeo.com/tbcare1

Post Graduate Course @ Union Conference Paris, 2013

TB CARE I will be holding a post-graduate course entitled ‘Data for Decision Making and the Use of Data for Continuous Improvement’ at this year’s Union Conference in Paris on Thursday 31st October 2013 from 9:00 to 17:00. This course will provide participants with tools to use both technical and financial data for programmatic decision-making.

During this interactive session, participants will examine how data can be used and interpreted for making informed decisions. Participants will recognize the importance of quality data, explore ways to maximize data use, comparative data and performance feedback, and learn tips for prioritizing programmatic activities and resource allocation based on data. If you are going to be at the conference and would like to participate, sign-up will be available in June via the conference website, see link below.

Jeroen van Gorkom Elected Vice Chair of Union HIV Section

Jeroen van Gorkom the Deputy-Director of Technical Services for TB CARE I has been elected to the position of Vice Chair of the HIV Section at The Union.
After South Sudan gained independence from Sudan in 2011, disagreements over oil-sharing between the two nations caused fighting and high inflation in certain regions. Desperate for security, over 110,000 Sudanese refugees escaped to South Sudan and now reside in camps in Maban County.

These refugees, and the county’s 40,000 residents, are served by Bounj Hospital, the only TB diagnostic and treatment center in the district. This hospital is currently treating 75 patients for TB, 56 of whom are refugees.

TB CARE I South Sudan project is helping to build the hospital staff’s capacity in TB treatment and infection control (IC), despite the challenges the health workers face. Led by Management Sciences of Health in partnership with the National TB Program (NTP), the TB CARE I project team has trained over 200 health workers in TB diagnosis and treatment.

TB CARE I also teaches the health workers how to educate their patients about TB IC and provides the trainees with regular supportive supervision and mentorship.

Bakhari correctly diagnoses and treats Santo for TB. The TB program manager at Bounj Hospital, Bakhari Adam, is working hard to ensure that all TB patients initiate treatment and receive the correct medication at the correct times:

“I don’t have a room to use as TB clinic and so I am working from... the hospital’s kitchen. Working under these conditions is very difficult. My patients are in the tents... Sometimes the relatives have to share the tents with the patient, which is not good for infection control.”

Santo is one of the refugees currently being treated by the newly trained staff. Two weeks ago, Bakhari diagnosed Santo with TB after discovering that he had been diagnosed inaccurately and treated for malaria.

Santo said he is happy that, after just 14 days of treatment, he is feeling strong again. Bakhari has also been teaching Santo about TB prevention and treatment. These lessons have inspired Santo to carefully follow his treatment regimen and to promote TB prevention and testing among his peers.

"If I find anybody with cough I will tell him or her to come to the hospital," Santo said.

Coordinating TB control throughout South Sudan
The TB CARE I project helps the NTP to coordinate TB control efforts in all 10 of South Sudan’s states. Together, these partners have scaled-up TB interventions identified in the NTP strategic plan and implemented a series of innovative TB prevention and treatment approaches.

TB CARE I’s activities have helped to improve treatment outcomes throughout the nation. In 2008, 6,525 patients were diagnosed with TB in South Sudan and, by 2011, this number had increased to 7,599 identified TB cases. TB CARE I also helped the NTP increase the number of TB diagnostic and treatment centers from 44 in 2008 to 65 in 2012.

Santo reflected on South Sudan’s progress in TB in light of his own recovery. His message to fellow refugees and the South Sudanese shows both his urgency and hope:

“Before you become very ill, come to the hospital early so that you can be diagnosed, treated and healed!”

"Before you become very ill, come to the hospital early so that you can be diagnosed, treated and healed!”
At the end of April 2013 the TB CARE I project closed out in the Dominican Republic, leaving a lasting impact on a diverse country.

**Stop TB Strategy**

While the incidence of all forms of TB in the Dominican Republic has been estimated to be among the highest in the Americas much progress has been achieved since the implementation of DOTS in 1999. MDR-TB remains of the greatest challenges for the Dominican Republic, which in the mid-1990s was classified as one of the world’s hot spots for MDR-TB.

In 2008 an evaluation mission revealed the underlying problems with the TB program. Specifically low TB case detection rates, a high incidence of TB/HIV and MDR-TB in the highest populated poor urban areas, combined with a low commitment to TB by general and health authorities, no involvement of civil society and finally the full Stop TB Strategy (STBS) was not being implemented.

The requirements were to improve case finding, technical capacity at frontline level (to implement the full STBS) and to involve both the community and other partners.

To meet these challenges, TB CARE I (and the previous TBCAP program) set about training frontline staff in all components of the STBS, supervision was improved and a new supervision tool was designed and introduced, which included all the STBS components.

**Stop TB Committees**

Through TB CARE I/TB CAP an extensive network of Stop TB Committees was set up to educate everyone from health workers, to prisoners and the general public on TB. In total 71 committees were established which reached out to the wider public through a myriad of activities such as backyard chats, schools, mural painting, lottery shops and beauty salons. Pamphlets and posters were produced and spots were aired on local TV and radio.

As a result of these interventions, Area IV in Santo Domingo saw a sizeable increase in the detection of smear positive TB cases, along with a doubling of the positivity rate (the ratio of Smear Positive TB Cases/Suspects screened).

**Photovoice**

‘Voices’ and images of TB or indeed any other disease allow the people affected by the disease to document and reflect on their experience, promote critical dialogue and knowledge through group discussions and the use of photographs, and importantly reach the people who set policies and make decisions, to help create positive change.

In Photovoice, patients, ex-patients, their family members and TB staff attended sessions which encouraged open dialogue and explored their relation to the topic being discussed. The idea being not to train the person, but rather to gradually reveal the ‘observer’ in them, to change their perspective and ultimately for them to show in pictures what they see, from the point of view of language, body and emotion. Each participant was also given a mini course in basic photography and photojournalism, with each having the use of a camera to take moving and revealing images about their experiences with TB.

Photovoice gives TB a human face and as a result key people such as decision makers, civil society organizations and health personnel are moved to improve the services to people affected by the disease. It also is a driver behind stigma reduction and discrimination whilst at the same time creating new spaces for communication about TB and empowering patients, and strengthening their self-esteem through the process of coaching and the production of the photos and their final exhibition.

The Photovoice slideshow can be viewed here:
http://www.tbcare1.org/voices/

The project has produced several videos in Spanish two of which can be viewed here with English subtitles:
http://vimeo.com/62604633
http://vimeo.com/62613981
Lessons from Loss

This tool is designed to collect information on factors leading to mortality among TB patients in order to help health professionals, planners, managers working in TB programs, and TB advocates to save TB patients’ lives by improving care seeking and the quality of care. The tool offers step by step guidance on how to pinpoint where the problems lie and to build consensus toward feasible solutions.

To download the publication click here.

Assessing TB Under-reporting Through Inventory Studies

The main purpose of this guide is to describe and explain how to design, implement and analyze an inventory study to measure TB under-reporting.

To download the publication click here.

Building the Capacity of Civil Society Organizations in TB Control

An approach to develop the capacity of civil society organizations in TB Control has been developed and pilot tested in 3 countries, this package includes the approach, the training materials, the monitoring and evaluation framework, and the results.

To download the publication click here (Zipped Package).

Recommendations for investigating contacts of persons with infectious TB in low- and middle-income countries

These recommendations are designed to assist national and local public health TB control programs in low- and middle-income countries to develop and implement case finding among people exposed to infectious cases of TB.

To download the publication click here.

Guide to Measuring the Incidence of TB disease in Healthcare Workers

The guide addresses issues such as stigma and work discrimination, and also provides practical recommendations on how to establish an effective monitoring system. This document is the result of years of operational research as well as debates and discussions organized by the WHO and TB CARE partners.

To download the publication click here.

TB CARE I Quarterly Report - January - March 2013

As of March 2013, TB CARE I reached the halfway point for the program’s five year implementation period (2010-2015). This report provides a technical and financial update on progress made between January-March 2013 for TB CARE I core, regional and country projects.

To download the publication click here.

Contact Details

E-mail pmu@tbcare1.org
Phone +31-70-7508447
Website www.tbcare1.org
Twitter @tbcare1

The Global Health Bureau, Office of Health, Infectious Disease and Nutrition (HIDN), US Agency for International Development, financially supports this newsletter through TB CARE I under the terms of Agreement No. AID-OAA-A-10-00020. This newsletter is made possible by the generous support of the American people through the United States Agency for International Development (USAID). The contents are the responsibility of TB CARE I and do not necessarily reflect the views of USAID or the United States Government.