Welcome to the third edition of the TB CARE I newsletter which brings you a snapshot of TB CARE I work worldwide, with stories from the Dominican Republic, Cambodia, Mozambique, South Africa and Zambia.
From TB Patient to TB Treatment Supporter

Peter Bwalya Mwansa lives in Lubuto Centre (Ndola). He is married with three children.

When his brother and his brother’s wife both died from suspected HIV, Mwansa was left to look after their two children and he moved with them to a town called Mansa in Luapula province. There he began trading in clothes and dry fish in order to make a living.

It was at this time that Mwansa contracted TB, and he was frequently hospitalized in Mansa General Hospital. In 2002 a doctor advised him to get tested for HIV and when the results came back positive he turned to his friends for support, all of whom offered none and even ignored him.

Mwansa began his anti-retroviral (ARV) and TB treatment with a CD4 count of 90, and experienced the side effects of both the anti-TB and the ARV drugs, affecting his general well being. In addition, he received little support from both his family and that of his wife. In 2003, he moved to Ndola and got to know of an HIV/AIDS support group at Lubuto clinic which he joined in order to keep himself busy and to communicate with others who were HIV positive as well. The home based care providers made home visits two days a week. However, Mwansa felt stigmatized because the care givers wore uniforms which were visible to community members and caused some alarm.

Mwansa completed his TB treatment in 2005 and by this point his general health had improved significantly. He still had the challenge of not having a regular job, but thankfully his friends were willing help him with food and encouraged him to join the TB treatment support group.

Mwansa acknowledged that knowledge is power, especially after attending the District Health Management team (DHMT) training as a volunteer. He also said that the TB treatment helped him to stop coughing and regain some weight, he’s current weight is 60 Kg, up from the 37 Kg he weighed before he was treated. Mwansa also acknowledged the importance of being tested for HIV and how ones’ health improves with ARVs. He is also grateful to the Ministry of Health for the provision of free ARVs because they have saved his and many more lives. His health is still improving and friends and family have now all drawn closer to him again.

Mwansa now helps other community members as a community volunteer called a ‘TB treatment supporter’. TB treatment supporters provide facility and community level support to diagnosed TB patients who are initiating treatment or are already in care. Treatment supporters participate in the administration of anti-TB drugs through Directly Observed Treatment (DOT) during home visits to TB patients. Mwansa said that “People must be willing to get tested for HIV and to be screened for TB. After knowing my status I will live longer as my mind is free”. Mwansa is also thankful to the DHMT for the knowledge he has acquired through their training on HIV/AIDS and TB Infection Control.
TB infection control has been scaled up in Zambia from 2007 to date, but implementation is slow. This provided a platform for a focused approach to demonstrate safe work practices to reduce TB transmission among people living with HIV and health care workers (HCWs), by the TB CARE I program in partnership with the Ministry of Health in Ndola district, Copperbelt Province of Zambia, which has the second highest TB/HIV burden in the country. The one-year project provides a model to scale up TB Infection Control at district, facility and community levels.

A baseline assessment revealed low levels of infection control practices in the 15 selected health facilities: score 27%. After a three-days training on TB Infection Control work practices improved to 43% of the items listed on the CDC monitoring tool for clinical sites.

In order to reinforce compliance and further improve safe work practices, facilities agreed on Infection Prevention and Control procedures and practices and budget plans. Activities which need a budget have been endorsed by the District Medical Office and will be included in the next annual District Action Plan. Through quarterly supervisory visits, the district TB focal person together with TB CARE I project staff will provide advice on maintaining the new work practices and the step by step implementation of other work practices.

Focused integrated approach to the implementation of interventions to enhance TB Infection Control within the framework of existing district health systems and general Infection Prevention and Control policy, gives sustainable agreements on standard procedures and safe work practices which reduce TB transmission in health facilities.

Dickens Mutumbisha, 43 - Project Manager of the Ndola TB-IC Demonstration project

Dickens is a project planner and has been involved in the planning and implementation of various community based projects and programs from different sectors since 1996. In doing so he has assisted in the process of lifting these communities out of poverty. His first appointment was in government in 1996 as an Assistant Community Development Officer in charge of projects and programs, while working there he initiated a water and sanitation project through writing a project proposal to Peace Corps country office for training District officers in health and hygiene education. The training was conducted by Ministry of local Government and Housing and there after the district water and sanitation committee was formed and he was made the district coordinator. In 2002 the committee received funding and he coordinated the drilling and equipping of 588 bore holes with hand pumps, this project has contributed to the reduction in morbidity and mortality rate caused by water borne diseases and resulted in an improved quality of life.

In 2007 Dickens joined the world of NGOs and coordinated the implementation of a community-based care project for orphans and vulnerable children (OVC), whose main aim was to improve the quality of life of over 4000 OVC through the implementation of the child status interventions including the economic strengthening of households keeping OVC. He formed 42 groups, which comprised of vulnerable primary caregivers supporting OVC, most of whom had only one meal per day, he mentored and coached them for three years from 2007 to 2010 on the importance of saving money no matter how little the amount was. Members of the group meet weekly, make deposits, get loans against their own savings, invest in individual businesses and payback with interest.

These groups are still active and every 8 months are able to save up to $6000, which they liquidate and then continue the process over and over again. The once vulnerable households are now economically empowered as they are now able to afford three meals per day and even sponsor the OVC in terms of paying school fees and other necessities. These groups are now a model in Zambia and NGOs, the government and other stakeholders visit these savings groups in order to learn from them. He feels there is also need to introduce this sort of model to the TB/HIV community volunteers and ex-TB patients as a way of improving their livelihoods.

Dickens has also provided technical support through on site mentoring and coaching to over 25 community based organizations in the Copperbelt, aimed at improving their capacities to manage projects. The NGOs and community based organizations were mentored in governance, monitoring and evaluation, strategic planning, proposal and business plan writing. These organizations have since managed to mobilize resources and are able to sustain themselves.
TB Treatment Supporters play a critical role in TB control activities, including the treatment, education and support of TB patients, their families and the wider community. They usually live in the communities in which they serve and they are the link between the patient and the health facility. Their roles vary, focusing primarily on support to ensure adherence to prescribed treatment through directly observed therapy (DOT). They also refer TB suspects for screening, trace contacts and defaulters, recognize side effects and provide basic counseling and provide health education to patients, family members and the wider community. They are often volunteers, and their commitment to serve their communities is extraordinary.

With a large network of national and reference laboratories staffed with highly qualified technicians, Zambia is a leader in TB diagnosis in the Africa region. A critical component of TB CARE I’s work with the National TB Control Program (NTP) is strengthening the technical capacity of laboratory staff. In March 2012, six staff attended a two-week training course at Makerere University in Kampala, Uganda. Two staff each from the National Reference Laboratory/Chest Diseases Laboratory, the Tropical Diseases Research Centre and TB CARE I attended the training.

The course objectives included a focus on newer laboratory technologies, such as the use of the automated diagnostic test, GeneXpert, and mastering the Hain Genotype® MTBDRplus Assay, a test used for the rapid screening of multi drug-resistant TB (MDR-TB).

The training sessions also covered:
- Good clinical laboratory practices
- Quality assurance system for TB cultures and specimen referral
- Drug susceptibility testing for first line drugs
- Direct detection of MDR-TB
- The operation and maintenance of diagnostic equipment.

The two TB CARE I laboratory support staff Robertson Chibumbya and Sunday Siwale both performed exceedingly well during the training, so much so that they were given scholarships by Makerere University to attend advanced training in molecular diagnostic techniques which is scheduled to take place this month.

The training in Uganda has resulted in a pool of national trainers who are able to develop the skills of laboratory staff throughout Zambia. In addition, capacity at the National Reference Laboratory has been strengthened, which means turnaround times for TB diagnosis will be reduced, and the accuracy of TB diagnosis (especially of MDR-TB) will be increased through the use of the GeneXpert and the application of the Hain GenoType® MTBDRplus Assay.

Training in New Diagnostic Techniques Strengthens Laboratory Services

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Training TB Treatment Supporters in Community-based TB Infection Control Practices

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With support from TB CARE I, a model TB infection control (TB IC) program is being implemented in Ndola District in the Copperbelt Province of Zambia. One of the components is to effectively train TB Treatment Supporters in key elements of community-based TB infection control, using a freely available tool, the Simplified Checklist for TB Infection Control.

Three-day skills-focused workshops took place in Ndola and participants were selected on the basis of their involvement in local catchment areas. The aim was to strengthen competencies in TB IC administrative, environmental and personal protection controls – with an emphasis on effective use of the locally field-tested Simplified Checklist for TB Infection Control. A total of 116 community health workers affiliated with 12 clinics participated. The training team included two trainers from FHI 360 and two local facilitators. A highly participatory, problem-solving approach was used, including case studies which focused on household and community scenarios.

Participants improved scores on post-training tests by a mean of 9.1% and indicated both verbally and on workshop evaluations that their self-confidence in implementing TB IC activities had increased. Furthermore, facilitators observed that participants were able to apply the concepts and practices in practical exercises that clearly demonstrated new skills. It is anticipated that trainings of this type, and broader use of tools such as the Simplified Checklist, will strengthen the understanding and broaden the implementation of TB-related infection control principles across the country.
Every year about 100,000 (mostly) men from the surrounding countries (Lesotho, Mozambique and Swaziland) are recruited to work in South African mines, doing the hard physical underground work in the mine shafts. In addition to these legally employed miners, a large number of illegal miners are moving to South Africa on a yearly basis.

The incidence of TB is very high among the groups of current as well as ex-mine workers. In addition the prevalence of HIV is very high as is the occurrence of silicosis in the same population. There are many problems related to diagnosis of TB, treatment of TB and the follow-up of miners. The miners move constantly between South Africa and their home countries and as such, are difficult keep track of whilst they are on treatment. The group of ex-miners is very large (there are however, no reliable estimates on the actual total number of ex-miners) and they remain at high risk of developing TB, AIDS and silicosis disease after returning to their home country. There is a need to focus on active TB case finding combined with services related to HIV, silicosis and compensation for loss of earnings.

On August 18th 2012 the Heads of State from the countries of the Southern African Development Community (SADC) signed an important Declaration on TB in the Mining Sector. In order to use the political goodwill following the signing of the declaration, the USAID Regional HIV/AIDS Program (RHAP) Office in Pretoria requested that TB CARE I develops a Regional Project on TB in the mines and KNCV Tuberculosis Foundation (lead partner of the TB CARE I coalition) was appointed the lead technical partner.

The aim of the project is to improve the coordination and collaboration between different governments and partners in the field of TB in the mines. The project is coordinated by Dr. Emmy van Grinten (pictured above) who has worked in TB Control since 1999. After having lived and worked in Nigeria for the past 13 years (where she was the TB CARE I country director), she and her family moved to South Africa at the beginning of August.

At this moment the project covers South Africa, Lesotho, Mozambique and Swaziland, with the final scope of the project still being finalized. The focus will however be on the coordination between the different partners on the ground and in addition, technical assistance will be supplied for the following interventions:

- Development of a regional action plan
- Development of specific indicators and an M&E framework for TB in the mines,
- Introduction of the patients’ charter for TB Care
- Development of a regional (electronic) patient tracking system
- Active TB case finding among mining communities.
Under TB CAP (the forerunner to TB CARE I) a Patient Centered Approach package was developed which included a strategy and five tools (QUOTE TB Light, Tool to Estimate Patient Costs, TB/HIV Literacy tool, Patient’s Charter and the Practical Guide to Improve Quality Patient Care) designed to help NTPs and their local partners become more patient centered.

In years one and two of TB CARE I, implementation of the package is being piloted in five countries: Cambodia, Indonesia, Mozambique, Nigeria and Zambia. Each country established teams consisting of 6 persons including representatives from the NTP, researchers and CSO/NGOs. Last year the teams attended regional workshops to introduce them to the package, the tools and to receive some training for implementation. During the workshops each country team chose two or three tools to be implemented and developed work plans including a research component to measure the underlying assumptions of patient centeredness and implementation of the package - what worked, what did not work and why. This year each country has started implementation.

Cambodia chose two tools to implement, of which one is QUOTE TB Light. In the picture above you can see focus group discussions with patients being held using the pictogram cards included in the package, to measure the importance of the nine quality dimensions, and one picture of an interview with a patient to measure the performance of a health facility. The results of these exercises can be used to specifically indicate which elements of TB services offered at a health facility need to be improved based on the patient’s perspective.

Julieta was only 16 years old but she looked much older than her age. Having suffered from poor health for months, her once well-built body had withered away. Believing that a bad spell had been cast on Julieta, her family had tried all the traditional healers and medicines, but she continued to lose weight, getting paler each day. One day, Dinga, a trained Community Based DOTS field officer working with ADPP passed by her house during his routine community activities. He managed with a lot of difficulty to talk with Julieta, but she was unable to talk for more than a minute without her violent cough interrupting. With all the symptoms which she was exhibiting and had experienced, Dinga suspected that Julieta had TB. He lost no time in explaining to the family what he suspected and told them that he was going to collect her sputum in order to send it to the nearest health facility for TB laboratory diagnosis.

Three days later, Dinga returned with Julieta’s results and told her she was smear sputum positive and she was taken to the health facility to begin her treatment where at the time of admission she weighed only 21 kg. Soon after she started her treatment Julieta was also counseled about doing an HIV test which she decided to do and fortunately it came back negative. Dinga advised Julieta’s family to stop treating her with other medications and stick with the TB drug regimen.

Two months after her intensive phase treatment, Julieta went back to the health facility for her control services and amazingly she managed to increase her weight by 10 kg, nearly a 50% weight gain. She could also walk again and talk properly once more. Julieta says that before Dinga intervened she and her family were convinced a spell had been cast on her and that she was going to die at an early age, without even finishing school.

Julieta is grateful each day as she gets better and better and she is committed to adhering to the treatment regimen as directed, until she is completely cured.
Screening Returnees for TB

The NTP in Cambodia is implementing a new strategy which focuses on active case finding among the high-risk group of returned irregular migrants (IMs). IMs (people who illegally enter another country, or whose visa has expired, and lack the legal status to remain in a transit or host country) are subsequently returned to their country of origin. IMs with prolonged detention histories abroad are at increased risk of having contracted TB and of developing active TB. The new strategy aims to identify active TB disease early, in order to contain the risk of TB transmission and to help cure the patients.

With funding from TB CARE I, the WHO and the International Organization for Migration (IOM), a pilot project on the two main borders of Cambodia with Thailand and Viet Nam was launched in July 2011, with the primary criterion for screening being a detention history of more than one month in either country.

100,000 Cambodian IMs are deported from Thailand to Cambodia annually and pass through the Poipet Immigration Center (PIC). Up to 15% of them have spent more than one month in Thai detention centers which are overcrowded, have poor sanitation and limited access to healthcare. The health indicators of the IMs returning to Cambodia from Thailand are very poor, with 14 percent showing the signs and symptoms of TB. Migrants which have been interviewed describe cells in detention centers as “so overcrowded that there was no room to lie down and sleep” and that holding cells often contain over 100 detainees. At the Cambodia-Viet Nam border, the number of returned IMs is much less: only 607 returnees in 2011 and migrants are detained in much better conditions.

The pilot project established procedures for the systematic screening of IMs at the PIC and Poipet Referral Hospital (PRH) at the Thai-Cambodian border. 13 radiology and laboratory staff at the hospital were trained and equipped to actively screen and test up to 30 IMs per day for pulmonary TB, using symptom screening and chest X-rays as screening tools, and fluorescence microscopy as a diagnostic tool. At the Cambodia-Viet Nam border, the project worked with the local village chiefs and community health workers to implement a campaign, which included tracking returned migrants who had been detained in the detention centers for more than one month and inviting them to be taken to the nearest referral hospital in Chipou for TB screening.

Under an interagency collaboration between the NTP, WHO, IOM, and the provincial health and immigration authorities, the immigration officers - who are the first points of contact for migrants returning at the Thai-Cambodian border in Poipet - document and refer IMs who have been detained for more than one month, to the PRH for screening. The radiology and general health personnel at the hospital perform chest X-rays and symptom screening. Data from the new screening procedure shows that 14.4% of the migrants are either symptomatic, or have abnormal chest X-rays consistent with TB, or both. A different approach was used for active case finding at the Cambodia-Viet Nam border because of the lower number of returned IMs: local government health staff screened IMs with detention history of over one month. Once identified, they were transported to the Chipou Referral Hospital (CRH) where the government radiologist and lab technicians conducted diagnostic tests.

From October 2011 to January 2012, the pilot project screened a total of 629 IMs on the Thai-Cambodian border, and the Viet Nam-Cambodian border. Of these, 33 (5.2%) were diagnosed with TB using fluorescence microscopy. The result suggests that the TB prevalence rate among returnees may be at least seven to eight times higher than that in the general population.

A Case of TB in an Irregular Migrant

One TB case detected was a young man, aged 22, who had worked in Thailand for only a few months before being arrested and locked up in the immigration detention center. After two months of detention in an over-crowded cell, the Thai authorities deported him to the Poipet border by truck, along with other Cambodian detainees. Upon arriving at the Immigration Center on the Cambodian side, the TB CARE I project screened him based on his long detention history, and referred him to the PRH for symptom screening and a chest X-ray. Staff at the hospital noted he was exhibiting the classic symptoms of TB, and a chest X-ray was taken which showed extensive TB. The laboratory staff then confirmed the diagnosis of TB using fluorescence microscopy on the same day.

The project subsequently referred the young man for Directly Observed Treatment at his local health center in Nimitt district of Banteay Meanchey province. With his permission, the IOM informed his family about his condition. His father and brother, who had not seen him since he went to Thailand, were very glad to see him. Now, one month after he was diagnosed with TB, his medical condition has improved dramatically. He is currently employed as an agricultural laborer and he visits the health center in his neighborhood regularly for his medication, and is determined to complete his six months of treatment.

He has promised not to leave again until his treatment is completed and he is cured of the disease.
“Invisibles” TB - The Naked truth

TB Patients let their (photo) voice be heard by policy makers and the general public.

Since World AIDS Day 2011, an impressive collection of pictures taken by TB patients has been exhibited at several key places in Santo Domingo, with the purpose of showing the human face behind TB and the need to take action against the disease.

The exhibition began at the Ministry of Culture during the week around World AIDS Day, before it transferred to the Ministry of Health, where it was inaugurated by the Dominican Republic Minister and Sub-Minister of Health. Both ministers stressed the importance of this initiative and the relevance of it travelling around the country so as to have an impact on a wider public and local policy makers as well. In February 2012, during a visit of a USAID delegation, the exposition was also displayed at the Chamber of Deputies, an important location for policy making at country level.

The tool developed to achieve this result is called Photovoices and it has been developed by TB CARE I. It is a useful instrument for TB advocacy, stigma reduction and patient empowerment. Photovoices uses photography to help people to identify, represent and manifest their needs related to TB. It employs the principles of documentary photography to capture experiences from the perspective of the most vulnerable. The photography gives them a chance to recognize their strengths, priorities and worries related to life and to the disease, giving a voice to those who normally are not heard. It also promotes the generation of knowledge and a critical dialogue around the most important issues related to TB through discussions about the pictures.

The products of Photovoices will also be used for the development of audiovisual material to improve patient adherence and encourage people to seek help early when experiencing TB symptoms. A slideshow of the photos can be viewed at http://www.tbcare1.org/voices/
Electronic Recording and Reporting for TB Care and Control

This guide provides practical advice for countries planning to introduce electronic recording and reporting systems, or to enhance existing systems. It is intended for people likely to be involved in the design and implementation of electronic recording and reporting systems for TB care and control such as NTP Managers, Procurement Officers, Legal Officers, Project Managers, Software Developers, Health Information System Managers, Consultants and Technical Agencies. To download the publication click here.

TB IC at Community Level - Training Handbook

This handbook is designed to facilitate the understanding and use of the Simplified Checklist for TB Infection Control, with a particular emphasis on settings where TB, HIV and TB with HIV are prevalent. To download the publication click here.

Guidelines to Measure the Prevalence of Active TB Disease Among Health Care Workers (HCWs)

Although guidelines for population-based TB disease prevalence surveys exist (WHO Tuberculosis Prevalence Surveys: a handbook), these cannot readily be used for measuring the prevalence of TB disease among HCWs, specific adaptations are needed. This guide is intended to provide that guidance for the specific setting of HCWs. This guide is designed to be used in combination with the WHO TB Prevalence Surveys: A Handbook. To download the publication click here.

TB CARE I Year 2 Quarter 3 Full Report

The full report covering TB CARE I’s third quarter year 2 results. To download the publication click here.

World TB Day 2012 Summary

A summary of the events and activities TB CARE I was involved in for World TB Day 2012. To download the publication click here.

TB CARE I @ The Union Conference 2012

We are holding a workshop named ‘Linking Outcomes to Finances’ at this year’s Union Conference in Kuala Lumpur, Malaysia. If you would like to find out more, please download the flyer below and hopefully we’ll see you there or at our booth in the conference center. To download the flyer click here.

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