Partnership for DOTS expansion in Post-conflict Situations: - Experience from South Sudan

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- Independence on 9th July 2011
- Population (2011) - 9,025,925
- Cultural diversity – 650 languages
About 300km of tarmac road
- More than 90% live on < $1/day
- High maternal mortality rates (2,054/100,000 live births) and mortality rate among children < 5 years (135/1,000 live births).
National TB Program (NTP) History (1)

• During the most recent civil war TB services were largely implemented by faith-based organizations.

• WHO was the coordinating body for TB services before 2005.

• The NTP was founded within the MoH in 2006 after a Comprehensive Peace Agreement (CPA) was reached in 2005.
NTP History (2)

- NTP has administrative structures at central, state and county levels (24 staff at central and state levels)

- TB services at service delivery points are integrated into the general health system.

- Key implementing partners include Arkangelo Ali Association (AAA), Catholic Diocese of Torit (CDoT), Doctors with Africa (CUAMM) and the MoH.

- The USAID-funded TBCAP and TB CARE programs have helped NTP to develop key documents for coordination of TB control in the country.
TB Situation (WHO Global Report/ NTP)

2011 Global TB Report:
- Incidence rate = 146 (121–174) /100,000
- Notification (new + relapse) = 7,217
- Notification rate = 70/100,000
- Case Detection = 48%

- Percentage of TB patients with known HIV status = 47%
- HIV positive TB patients = 13%
- TB/HIV prevalence survey showed 14.7% TB/HIV co-infection
TB Management Strategies in Rural S. Sudan

- In about 60% of the country, intensive phase (2 months) is health facility Directly Observed Therapy (DOT),
- Continuation phase (4 months), DOT is by use of family and community supporters- role played by partners.

Disaggregated treatment outcome by use of community mobilizes
TB Management Strategies in urban S. Sudan

• In about 40% of the country, ambulatory DOT for patients during intensive phase and continuation phase, expect for very sick. Treatment re-fill on weekly/ bi-weekly basis,

Disaggregated analysis of TB Treatment Outcomes in Juba 2008 – 2011 (an example of urban centre)

• High defaulter rates (10 – 42%)

• Not all TB patients supervised

• Urban dynamics
Partnership for TB Control

- Facilities with supervised treatment for entire treatment duration are mainly implemented by NGOs.
- Ambulatory treatment is mainly a practice of urban and government implemented facilities.

**Distribution of Health Facilities with TB Services**

- **Government**: 26%
- **Faith based organizations**: 9%
- **Local NGOs**: 2%
- **NGOs**: 63%
Partner Roles and Responsibilities

• Government
  - Central level: policy formulation, resource mobilization, coordination of TB control activities
  - State/county level: coordination of TB control activities
  - M&E and supervision
  - Facility level: implementation of TB activities

• None Governmental Organizations (NGOs):
  - International, local and Faith Based organizations,
  - Implement TB and TB/HIV activities
  - Reporting to the state and central level
  - Monitoring and supervision
Challenges (1)

Security
- Conflicts as communities compete for limited pastures
- Staff close or desert health facilities
- Health seeking is hampered with in affected areas,
- Delivery of TB supplies and drugs is a challenge,

Limited government funding / high donor dependency
- Austerity measures diminishes government funds for NTP,
- Affects co-financing, a key requirement for e.g. Global Fund,

Influx of displaced population after independence (July 2011)
- Returnees strain health services
- No TB services in refugee settings
Challenges (2)

Influx of displaced population


The administrative units and their names shown on this map do not imply acceptance or recognition by the Government of South Sudan. This map aims only to support the work of the Humanitarian Community. Not yet in final destination or final destination undetermined. Not included in the overall figures.
Challenges (3)

Gaps in Partner Coordination
• Gap in coordination of TB services at county level
• Reporting through the required channel not strictly adhered to,
• Some partners preferring to used drugs from sources other than through NTP,

Insufficient clinical practices
• Policies, guidelines, and tools exist but dissemination and training at all level remains a challenge

Inadequate human resources at all level of health care delivery
• Unity State ratio of doctors to patients = 1 : 195,267
• Central Equatoria State has best ratio = 1 : 11,377
• Only 10% of staff in health care are qualified
Challenges (4)
Sparse and hard-to-reach populations
Challenges (5)
Poor road networks

NTP vehicle for supervision
Challenges (6)
Debilitated health facilities

- 25% (1,147) of functional health facilities require reconstruction
- Just 7% (78) integration of TB activities into PHC and the general health system

A health facility requiring renovation

PHCU

TB patients with members of the family at a treatment facility requiring renovation
Lessons Learnt/ (1)

• Partnership with local and international organizations is vital for improving access to quality TB diagnosis, although still a challenge for S. Sudan (48% case detection).

• Partnerships are also important for improving outcomes through innovations like use of community mobilizes (Treatment success rates of over 90%),

• Strong NTP leadership is important to sustain the program (through its roles e.g. resource mobilization),

• Despite challenges, NTP has reported an increase in TB case notification and good outcomes in the rural areas.
Lessons Learnt/way forward (2)

Lack of infrastructure does not mean No TB treatment

Poor road network does not mean Drug/supplies stock out is acceptable

Innovative approaches can be used to provide basic services as a way to overcome challenges e.g. treatment and health education in the open.
Lessons learnt/Way forward (3)

Identification and engagement of key stakeholders is key

Team work makes the dream work!
Contact information

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THANK YOU