ARKANGELO ALI ASSOCIATION-AAA

SOUTH SUDAN

GLOBAL FUND TB ANNUAL REPORT 2016

Grant

TB NFM

SR Name

Arkangelo Ali Association

Report for implementation period:

01/01/2016 to 31/12/2016

Funds Allocated

TB NFM
US Dollars 926,742.27

Funds Utilized

TB NFM
US Dollars 896,395.36

Project Areas

The project is operational in former Fifteen (15) counties, supporting 39 TBMUs and located in five different former States in the Republic of South Sudan, namely:

Northern Bahr el Ghazal State

- Aweil town (Aweil Centre County)
- Gordhim (Aweil East County)
- Nyamlell (Aweil West County)
- Gok Machar(Aweil North county)
- Panthou(Aweil South county)

Western Bahr el Ghazal state

- Wau (Wau county)

Lakes State

- Bunagok (Awerial County
- Adior (Yirol East County)
- Yirol (Yirol West County
- Agangrial (Cueibet county)

Western Equatoria State

- Tambura (Tambura County)

Warrap State

- Kuacjok (Gogrial West County)
- Marial Lou(Tonj North County)
- Tonj , (Tonj South county)
- Lounyaker(Gogrial east county)

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ACKNOWLEDGEMENT

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Arkangelo Ali Association (AAA) would also like to extend sincere gratitude to individuals and agencies who have contributed towards the attainment of targets for the program. Special thanks go to the County Health Departments in all the AAA areas of operation, the Non-governmental organizations supporting Primary Health Care activities and the AAA dedicated members of staff who have been providing essential services to diagnose and initiate TB treatment promptly. Without their crucial support and commitment, many more lives could have been lost.

ACRONYMS

AAA	Arkangelo Ali Association
CBO	Community Based Organisation
CCM	
CoS	Continuity of services
CTB DOTS	Community Based DOTS
DOTS	Directly Observed Therapy Short course
GF	Global Fund
HHPs	Home health promoters
MDR-TB	Multi Drug Resistant Tuberculosis
M&E	Monitoring and Evaluation
NFM	New Funding Model
NTP	National TB Programme
PHC	Primary Health Care
PHCC	Primary Health Care Centre
RSS	Republic of South Sudan
TB	Tuberculosis
UNDP	United Nations Development Programme

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EXECUTIVE SUMMARY

The Global Fund TB NFM Grant focuses on maintaining the TBHIV services in the existing TB diagnostic and treatment centers by pursuing high quality DOTS expansion, addressing challenges related to multidrug-resistant TB (MDR TB) and strengthening the national management capacity by establishing a National TB care and prevention department in the Ministry of Health in the Republic of South Sudan. All these are aimed towards the reduction of mortality and morbidity caused by both diseases. This also remains a major focus of Arkangelo Ali Association (AAA) TB care and prevention Program. All interventions are based on the revised NSP 2015-19 that identified gaps and defined appropriate strategies and has already been operationalized operational. The programs follow the Global Fund performance based funding where specific indicators are used to monitor progress on quarterly basis. During the current reporting period, AAA met most of its set targets as shown in the table 1.4.

The strategies applied to meet the project goals include; on Job training of laboratory assistants, training of health workers in all Primary Health Care and strengthening of the PHCCs to be able to offer TB DOTs services so as to carry out sputum microscopy with an aim of increasing case finding and promptly initiating them on treatment with supervised DOTs. AAA provided TA to the TB officers and the CHD staff on supportive supervision and monitoring of programme activities, streamlining and strengthening the logistics management information systems (LMIS) and forecasting and quantifications including the drug ordering system, maintaining minimum-maximum (min-max) levels and inventory maintenance.

AAA has a team of dedicated staff for TB intervention programs with clear terms of reference and functions. The organizational structure is shown in the organogram below. All the TB cases registered for treatment in 2016 are 3693 (with 60% of bacteriological confirmed TB). AAA developed operational guidelines for Home Health Promoters and State TB coordinators to enable them have definite responsibilities and roles at their different levels of work.

CHAPTER 1: INTRODUCTION

1. 1 BACKGROUND

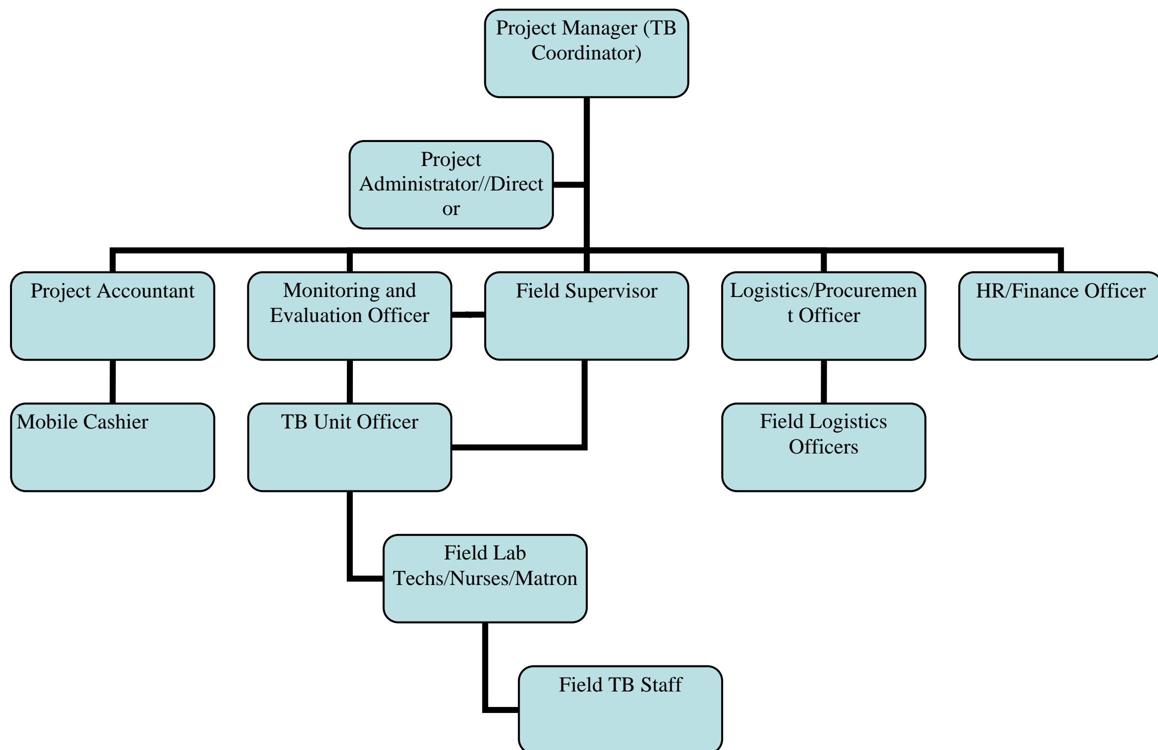
Arkangelo Ali Association (AAA) started as an indigenous South Sudanese Non Governmental Organization (NGO) founded in November 2006 and registered under Relief and Rehabilitation Commission and the Ministry of Legal Affairs and Constitutional Development. AAA was upgraded to International NGO on 27th January 2012 by the chief Registrar, Ministry of Justice following successful TB program collaboration and implementation in South Sudan (SSD). Internationally, AAA is a founder member of the Bakhita Consortium along with 7 other Italian organizations, Kenyan and South Sudanese NGOs/Associations that works for the development of South Sudan. The mission of AAA is to uplift dignity of disadvantaged people through provision of social services with respect of transparency, quality, equity, availability and accessibility with a vision of a community that believes in respect for human dignity. AAA has a Regional office in Nairobi, Kenya under the umbrella of Verona Fathers (Comboni Missionaries Kenya Province) and a country Office in Juba, South Sudan.

In 2016 AAA implemented TB prevention, care and treatment in 13 health facilities(TBMUs) and 26 satellite laboratories that are either diagnostic sites or doubles as diagnostic and DOT centres and are spread across 15 counties and five out of the ten States of South Sudan. The projects targets a population estimated at 2,577,000 according to the projected 2008 census results factoring in a growth rate of 3% per annum.

The Global Fund NFM aims to maintain the existing TB diagnostic and treatment centers by pursuing high quality DOTS expansion and enhancement, addressing challenges related to multidrug-resistant TB and strengthening the national management capacity by establishing a national TB care and prevention department in the Ministry of Health of South Sudan. All these are aimed towards the reduction of mortality and morbidity caused by TB.

The implementation of the TB care and prevention interventions is carried out at various levels within the AAA organizational structure, right from the headquarters to the health facilities as shown in the organogram below.

AAA Organization Structure for TB care and prevention Program



1. 2: OVERALL PROJECT GOAL AND SPECIAL GRANT AGREEMENT

The overall goal for this Global Fund supported TB project is to reduce mortality and morbidity caused by TB disease and the prevention of multidrug-resistant TB (MDR-TB) by Expanding and Enhancing Quality TB Prevention, Care and Control in South Sudan. However, TB TFM/NFM Grant mainly focus on the diagnosis of TB through microscopy that results in smear positive cases, offering standardized treatment to all diagnosed TB patients, giving patients support and strengthening the patients charter by educating

them on rights and responsibilities following TB diagnosis and the full TB treatment duration, strengthening drug management as part of logistics management information system, improving monitoring and evaluation through capacity building and technical assistance as a comprehensive package of human resource development, prevention and controlling Multi-Drug resistant TB (MDR)-TB and strengthening the national TB care and prevention department in the Ministry of Health. The First Global Fund Grant Agreement signed for NFM TB Grant between AAA and UNDP was signed with the United National Development Programme (UNDP) on 09/09/2015. Thereafter, a Second Amendment No.1 of the First Signed Global Fund Grant Agreement was signed on 11/04/2016. The overall NFM Grant will be implemented between 01st July 2015 to 31st December 2017.

1.3: STRATEGIES AND IMPLEMENTATION DURING THE REPORTING PERIOD

The TB NFM Grant had a specific focus which required development of specific strategies to meet its overall goal. The strategies employed by AAA in collaboration with the PR (UNDP) and the NTP during the reporting period so as to maintain the services and achieve desired results include:

- Training of the health workers and Home Health promoters on TB management, care and screening of TB among PLHIV.
- Training of TB Officers and Health workers in TBMUs by a Consultant on TB so as to be as ToTs for for capacity building the low cadres in their respective health facilities.
- Joint Supportive supervision and monitoring of programme activities by AAA TB coordinator, M&E officer, the NTP and the PR for on-site training and data management and validations.
- Streamlining the drug ordering system and inventory to strengthen the LMIS.
- Health education in the community and mobilization to increase awareness and create self-agency and demand for TB-DOTS services. This included school health, mass media, community theatre and utilizing HHPs to educate the community in administrators' meetings, markets, local community courts and other organized gatherings.
- Increasing availability and access to TB DOTs services by complementing passive TB case finding through facility based services with active TB case finding through mobile outreach activities and incorporating TB care and prevention activities into the PHC system through collaboration with county and state health services in the PHCCs.

- Renovations of some structures like TB wards,labs so as to create more cross window ventilations for infection control, patient kitchens and in-patient toilets etc in the existing TBMUs.
- TB sensitizations in congregate settings like prisons, military barracks, police cells, cattle camps, schools, churches and returnee/IDP camps.
- Utilizing HHPs for door to door education and screening of contacts of smear positive TB patients and contacts of children under 5 years on TB treatment.
- TB screening among PLHIV in HIV care sites during medicines refill and psycho-social support group meetings.
- Community TB-DOTs and promotion of treatment adherence through TB treatment supporters and TB club meetings. Monthly feedback meetings were conducted for TB education to patients, continuous counseling and experience sharing aimed at promoting treatment adherence. Collaboration with WFP provided food supplements and rations that were distributed during these feedback meetings and medicines refill.
- Continued creation awareness of TB through dramatization by theatre performances by artistic groups.
- Engagement of Mass Media (Radio FM stations) to create awareness in the community as regards TB and availability of services.
- Continued distribution of IEC materials to HWs and HHPs together with imperatives like umbrellas, mud boots and bicycles to ease reaching the communities during rainy seasons.
- Early retrieval of persons interrupting TB treatment and those lost to follow up, through the establishment of TB clubs and the involvement of TB ambassadors as well as the HHPs. The list of treatment interrupters was generated and distributed for tracing during the feedback meeting. AAA developed a TB agenda (Diary for tracing contacts of SS+/children under 5 years on TB treatment and TB patients interrupting treatment) for both TB officers and the HHPs. The tracing outcomes were updated in the TBMU registers during feedback meetings.
- TB screening among patients admitted in wards and safe referral of sputum to laboratory for microscopy and relaying of results back to patients for treatment initiation within 48 hours.
- Support for the EQA sampling and transportation from the peripheral laboratories to the Central Reference Laboratory (CRL) in Juba and provision of feedback by the focal laboratory staff in the Central Reference laboratory to peripheral laboratories' staff with the sole aim of high quality and reliable TB diagnosis.

The new WHO post-2015 global TB strategy, endorsed in May 2014 by the World Health Assembly (WHA), includes the target of a 95% reduction in TB mortality by 2035 worldwide (compared with 2015 levels) and a 90% reduction in TB incidence (compared with 2015 levels). These reductions will require novel tools for TB control allowing quicker and better diagnosis, treatment and prevention, with simultaneous efforts to optimize the use of existing technologies for TB prevention, diagnosis and treatment

globally. In this regard AAA continued to provide mentorship on use of algorithms to diagnose clinical TB, utilization of TB screening tools and prompt referral for diagnosis and treatment initiation and promotion of adherence. Due to the limited utilization of GeneXpert machine only available in Juba for molecular diagnosis of TB, AAA continued to provide support of peripheral laboratories and clinicians to submit specimen from classified patients of retreatment cases and HIV positive-TB co-infected patients for DST and culture as active surveillance for MDR TB in South Sudan

1. 4 RESULTS

a. Programmatic TB NFM Year 2

Indicator	Reporting Period	Target	Result	% Achievement
	Please include reporting period for indicators which are cumulative annually			
Number of notified cases of bacteriologically confirmed TB, new and relapses	January-December	1760	2211	126%
Number of notified cases of all forms of TB- bacteriologically confirmed plus clinically diagnosed, new and relapses	January-December	3142	3693	118%
Percentage of TB cases , all forms, bacteriologically confirmed plus clinically diagnosed, successfully treated(cured plus treatment completed)among all new TB cases registered for treatment during a	January - December	82%	2977/3292(90%)	110%

specified period				
Percentage of bacteriologically confirmed TB cases successfully treated (cured plus completed treatment) the bacteriologically confirmed TB cases registered during a specified period	January - December	82%	1566/1766(89%)	109%
Percentage of laboratories showing adequate performance in external quality assurance for smear microscopy among the total number of laboratories that undertake smear microscopy during the reporting period.	January - December	95%	75/75(100%)	EQA concordance of 97%
Percentage of TB patients who had an HIV test results recorded in the TB register	January-December	80%	3286/3693(89%)	111%
Percentage of HIV positive registered TB patients given ART during TB treatment	*January - December*	*70%*	*149/267 (56%)*	*80%*
Percentage of HIV positive patients who were screened for TB in HIV care or treatment settings	*January - December*	*50%*	*0*	*0*
Percentage of previously treated TB patients	*January - December*	*50%*	*99/187(53%)*	*106%*

receiving DST(bacteriologically positive only)				
Number of cases with drug resistant TB(RR-TB and /or MDR-TB)that began second line treatment	*January - December*	*0*	*0*	*0*
Percentage of HMIS or routine reporting units submitting timely reports according to National guidelines	*January - December*	*100%*	*39/39*100 (100%)*	*100%*

b. Financial-(Budget expenditure per activity)
NFM
Program Expenditure

	Amount in USD	%	Reason for variance
Opening balance in 1st January 2016	35,184.89		The balance b/f from 2015 for continuation of program activities
Approved budget from 1st January 2016 to 31st December 2016	892,285.57		
Actual disbursement 1st January	891,557.38		Disbursement/funds received for

2016 to 31st December 2016			implementing 1st January 2016 to 31st Dec 2016
Total expenditure 1st January 2016 to 31st December 2016	(896,395.36)		
Remaining balance end of 31st December 2016	**30,346.91**		The balance open to be carried forward to Q7 2017 (1st January to March 2017)

Program areas	Amount allocated in USD	Amount expended in USD	%	Reasons for variance
Section1:Programme Management				
1.1 Salaries-Programme Management	196,800.00	217,516.00	110.53%	See NB on next page explaining the variance
Planning and Administration				
1.3 Planning and Administration (Ind Costs)	145,699.08	148,342.68	101.81%	
Overhead	62,255.68	62,255.68	100%	
Section 2: TB Care and Treatment				
2.1 Salaries-TB Care and Treatment	443,400.00	424,151.00	95.66%	See NB on next page explaining the variance
2.2 Training on TB Care and Treatment	44,130.81	44,130.00	100%	

NB: The negative variance under Cost Category Section 1 Programme Management related to HR is due to the wrong Budget Allocation by the PR at the beginning of the Program for both Cost Categories Section 1 Programme Management (HR) and Section 2 TB Care and Prevention (HR).
(The PR is aware of this which was never rectified including during the Signed Second Amendment)
This negative variance came about afte0r the introduction of the New Reporting Format in Quarter 2/2016 (April, May, June 2016) by the PR, then was removed in the Quarter 3/2016 (July, August, September 2016) by the PR (otherwise in the old Reporting Format up to March 2016 was not appear).
This variance under Cost Category Section 1 Programme Management (HR) is absorbed under Cost Category Section 2 TB Care and Prevention (HR).

Important is (as per result during the discussion with the PR and SR (AAA) at the Meeting in Nairobi end of September 2016) at the END of the Program in December 2017, the overall HR Section will be Zero between the Two Categories.

c. Procurement and supply Management

In the year 2016 there was no provision allocated in the budget for procurement of Assets. Therefore no purchases were done.

Supply Management for purchase of Diesel, Petrol and Spares Parts for the Vehicles used in the TB program: The Project Manager (TB Coordinator) has the authority to analyze and approve work plans from different TB Unit so as to authorize together with the Project Administrator/Director the procurement of fuel and spare part as well as to check the Logbooks and confirm if the usage is in tandem with the activity.

CHAPTER 2: CURRENT PROJECT MANAGEMENT ARRANGEMENT

Project Management

The Global Fund TB NFM Grant is managed by a Project Manager (TB Coordinator). He has the overall responsibilities for all programme activities and support of the field staff. The Project Manager (TB Coordinator) is responsible for monitoring of the programme activities to ensure that they are in line with the set work plan, prioritizing the activities for the field staff so as to achieve the set targets, he is responsible for recruitment and retention of staff, capacity building, ensuring that the programme needs are met which may include; timely supply of drugs, availing the right equipment and offering technical assistance whenever a need arises. The Coordinator oversees the procurement of items and equipment as required and is also responsible for forging alliances with other agencies involved in health care delivery in the areas of integration of TB services in the PHCC system. The Project Manager (TB Coordinator) is the focal contact person for the programme and is the link between the donor agency, the Ministry of Health, NTP and the programme.

The Project Manager (TB Coordinator) ensures proper management of drug supplied as all the field TB officers prepare the drug orders using a standardized format which is submitted to the Project Manager (TB Coordinator) for verification and review. The Project Manager (TB Coordinator) then submits the orders to the NTP, makes follow-up to ensure the drugs are delivered and contacts the field staff regarding delivery and quantities. The inventories from the field, consumption records etc are also submitted

to the Project Manager (TB Coordinator). To ensure smooth operation, there is a National Programme Officer based at the Country office in Juba, the Programme Officer is responsible for all the follow up of programme issues in Juba through the Ministry of Health, NTP, UNDP and other partners.

AAA has a Project Administrator/Director responsible for all the funds of the project. The Project Administrator/Director in collaboration with the Project Manager (TB Coordinator) ensures that the funds are utilized as per the work plan to meet the set targets. Approval of the expenditures is done in consultation with the Project Manager (TB Coordinator), Project Administrator/Director. The Project Accountant with the Project Administrator/Director keeps all the financial records and there is periodic audit which is carried out annually. The Regional TB Officers are responsible for all the activity funds disbursed and there is a comprehensive accountability system in place which involves at least two National staff to verify all the expenditures in conjunction with the Field Supervisor. AAA operates a bank account specifically for the TB grant as a way of increasing transparency in the utilization of the funds.

The AAA M&E officer in conjunctions with the Project Manager (TB Coordinator) are responsible for all the data collection and reporting activities, monitoring of the programme activities to ensure that it is in accordance with the set work plan, prioritizing the activities as required, capacity building on M&E, verification, collation and analysis of data and submission of the quarterly reports. The TB unit officer also performs various M&E activities such as data verification, ensuring that all staff understands the data collection tools, compiling data from the facilities and also offers some training to facility lower cadre staff on data collection and verification.

Finance Management

The Project Administrator/Director as the Head of the Finance/Procurement in consultation with the Project Manager (TB Coordinator) is charged with the analysis of all the field requests before the approval and release of the funds for implementation of program activities in the field. All financial records are maintained by the Project Administrator/Director in conjunction with the other Finance Department staff who are charged with proper follow up of grant funds and preparation of financial reports. The AAA Field Supervisor is in charge of monitoring that funds were used in line with what they were approved for during his field visits to all the TB Units where he verifies the expenditures. The Project Manager (TB Coordinator) together with the M&E officer also assists in verifying that approved activities were actually implemented.

For the HR Management the Projects Manager (TB Coordinator) with the help of the Regional/National TB Officers is responsible for recruitment and retention of the Staff. Jobs vacancies are advertised locally, the TB Officers have the mandate to select

applicants for interview as well as interview the staff and share all the documents with the Project Manager (TB Coordinator) and Project Administrator/Director who approves.
TB officers are obligated to evaluate the staffs at the end of every contract period before their contracts are renewed by the Project Manager (TB Coordinator).
Each staff is required to sign the attendance sheet on daily basis; the Home Health Promoters sign the attendance sheet on monthly basis when they are submitting their monthly reports. The documents are shared with the Project Manager (TB Coordinator) and Project Administrator/Director for approval of the payment.
TB Officers are also required to submit the Salary Requisition as per their requirement.
The HR Officer prepares the payrolls which are approved by the Project Manager (TB Coordinator) and Project Administrator/Director.

a) Trainings Management

In the current grant, Training budget was approved by GF and the First trainings started in July 2016. The Trainings are managed as follows:

- The Project Manager (TB Coordinator) informs the Trainings Facilitators on the Trainings to be done within the year. He gets suggestions from them on the No. of attendants that may benefit in each training and why in order to factor in these while working on the Training Schedule. During this process, the STBCs and CHDs) who are representatives of the MOH in the county level) are also involved as they are informed of the Trainings to be conducted hence they support in the selection of the participants. In some cases, at the inception phase of the Trainings, an External ToT is hired to capacitate the TB Officers and other senior HWs in the TBMUs in order to empower them train low cadres.
- The Project Manager (TB Coordinator) sends to the Technical team in the PR (UNDP) office the breakdown of the budget intended to be utilized within the year. The allocations of amounts to be spent per Training are within the approved budget.
- Alongside the budget breakdown, the Project Manager (TB Coordinator) also sends the Training schedules. This document includes the Type of Training to be conducted, The TBMUs that will conduct the Trainings, The period of Training (not fixed as change in dates may occur during the preparation), The No. of participants to attend the Trainings and the per diem each attendant will get.
    - -Per Diem decision depends on the number of participants to be trained following the need of each TBMU. There is no official training cost per participant from PR/NTP because there are different kinds of trainings with different approved budgets. However, the rates established for paying out in each training are always within the range of AAA per diem policy.
- After presenting the documents highlighted in 1 & 2 above, The Project Manager (TB Coordinator) prepares the Requisitions for the Location's where Trainings are to take place. The Requisition is accompanied by the Training Schedule

(which has the Type of Training to be conducted, the period of Training, The No. of participants to attend the Trainings and the per diem each attendant) and the Instructions of how the Trainings should be done and documented. The Instructions are dispatched earlier to the Facilitators for preparations.

- The Project Manager (TB Coordinator) presents the documents in No.4 to the Project Administrator/Director for approval and authorization of the funds to conduct the Trainings.
- There's follow up of how the Trainings are being conducted by the Facilitators. This includes ensuring involvement of the STBCs and CHDs in selection of the attendants to be trained. The STBCs and CHDs are also involved in the payments as they co-sign the attendance lists and payment sheets for authentication.
- Once the Trainings are completed, the support documents are sent to the Project Manager (TB Coordinator) and the Project Administrator/Director who together with the Technical and selected finance team analyze and verify.
- The reports are also sent upon completion of each training. They are sent to The Project Manager (TB Coordinator) and M&E Officer for review.
- The Original copies of the documents are retained in the H/O.
- The replicas of all the documents in No.9 are presented to The LFA through the PR (UNDP) Office.

CHAPTER 3: SUCCESSES AND ACHIEVEMENTS

The TB project has managed to carry out the planned activities within the time frame and budget limits provided. The project's successes were as a result of having clear terms of reference of the staff, proper delegation of the duties from the head office to the field staff, having specific staff responsible for certain activities and continuous mentoring of the national staff on programme management. The project hierarchy is also well established as per the organogram shown on page 9 and interlinked with other departments such as procurement and logistics.

In order to meet the objectives of NFM Grants, AAA embarked on intensive CTB DOTs activities to ensure improvement on case detection and defaulters tracing. DOTs supporters were further trained on ways of curbing the rate of defaulters. The efforts have started bearing fruits as AAA reported a defaulter rate of 3% at the end of 2015.
The number of health facilities implementing TB care and prevention activities has extended its services to special groups such as jailed persons, cattle keepers, returnees and the military. Other various strategies were employed .These include; training of staff on diagnosis, case holding, treatment and management of TB patients, improving on the drug management through updating of inventories/stock cards, renovations of

structures like labs, wards, kitchen and toilets to help service TB, intensified health education in the community, establishment of Internal quality control systems and sending out of sputum smear slides for EQA, engaging a TB consultant to provide technical assistance to the field staffs and increasing support supervision, creating community awareness, conducting TB club meetings and integrated feedback meetings, theatre/dramatized performances on TB, Continued awareness on TB, Control and Treatment through Radio airing programs health education meetings and sensitization of community opinion leaders to solicit their support and distribution of IEC materials were successfully undertaken as support activities geared towards improvement of case detection and treatment outcomes.

The project has specific indicators to measure its success, these indicators are used to ensure that project stays on track and program activities are prioritized.

During the TB NFM Grant the following key successes were also realized:

Deliverable	**Target**	**Achievements (%)**
Number of Health education beneficiaries	0	374,832
Number of persons with presumptive TB examined for TB in the lab	0	12,607
Number of TB patients diagnosed in the lab	1260	2287/1260(182%)
Number of TB patients tested for HIV	2954	3286/3693*100(111%)
Number of co-infected TB patients provided with CPT	240	149/240*100(62%)
Sputum conversion rate:	95%	1843/1998*100(92%)
Number of supportive supervisions and mentorships conducted to the TBMUs	51	51/39*100(131%)

The Kwajok HIV room was rehabilitated and furnished in order to improve TB/HIV collaboration at Kwajok hospital.

The Akon laboratory was constructed for improving sputum microscopy services in the area.

The patient's toilets and kitchen were built for Wau TB department to improve hygiene in the hospital

On the 28th 30th November 2016MoH-UNDP did a joint monitoring and evaluation of TB programs for Wau. The general programme performance was satisfactory apart from the challenge of delayed supplies (TB drugs and lab reagents) from NTP.

On the 12th 15 the December CCM Members visited Wau and Kwajok TBMUs for having an insight of the TB program activities being implemented by in by AAA. The team was impressed by the TB activities being implemented by AAA. The local authorities and the

patients who were around by the time of visiting also confirmed that AAA was helping them a lot in terms of services delivery.

"On the 19th to 20th December, the CCM had a mission in Rumbek, Lakes state. AAA was invited as the leading agency in TB service implementation. The aim of the visit to Rumbek was to sensitize the former Lakes state SMOH officials that AAA was to integrate TB HIV services in 6 new health facilities in the former Greater Lakes state, using the proposed NTP shifted funds "

-21 Laboratory staff mentored/refresher trained on sputum microscopy.
397 (341 males and 56 females) health workers trained on TB/HIV
79Integrated feedback back meetings conducted where all the HHPs and health workers met and discussed challenges they faced and also get lists of names of TB patients from the TBMU registers who might have required immediate follow-ups.
- 80 TB club/ambassador meetings were conducted to ensure early retrieval of treatment interrupters which led to adherence hence improved treatment success rates among all patients registered.
- 389HHPs were involved in the TB sensitization and door to door screening of contacts of smear positive patients and children under 5 years on treatment
- 173 quality assurance visits were made to the health facilities in the periphery so as to mentor the health facility staff on how to deliver quality services to the community Records were always verified and updated accordingly
-12 community theatre performances conducted.
- 490 assorted IEC materials with basic facts on TB distributed in the community.
- 17 outreaches/mobile labs conducted in remote and hard to reach areas
- 122 HHPs involved in the TB contact investigations
-1747 homesteads visited by HHPs for contact investigations
- 8091 people found at home during contact investigations
- 7576 TB contacts screened during contact investigations
- 741 TB contacts found with TB symptoms
- 637 sputum samples from symptomatic TB contacts tested in the laboratories
- 91 TB contacts confirmed with TB
- 87 TB contacts with confirmed TB initiated on treatment.

Due to some shortage of lab reagents that occurred in some locations, AAA managed to step in by purchasing and distributing lab reagents for those TB units that had dire needs.
AAA provided as well a fridge to Wau TB department for storing DST samples from surrounding TBMUs while waiting for transportation to Juba CNL.

In order to strengthen TB activities and improve on the quality of the services rendered; supervision activities for mentorship and on-site training were carried out by the M&E officer, the Project Manager (TB Coordinator) and a TB Consultant to ensure alignment

to the South Sudan NSP and programmatic and treatment guidelines. All the TB centres were supervised during the year. The supervisory activities included on-job training, assessment of the project activities, follow-up of the recommendations from the previous visits and discussions on the practical ways of meeting the set targets and also strategies to accelerate implementation during the dry seasons prior to the prolonged rainy seasons. These supervisory visit activities were carried out using an approved checklist. During the visits, on job trainings are conducted with emphasis on proper data collection that encompasses complete and accurate recording in the various TBMU registers, compiling quarterly data, verification of the data and the filing of all support documents required.

A filing system was introduced in all the TB centers that ensure all the programmatic and financial reports are inter-linked to ensure that the budget is utilized as planned and create a clear account of the expenditures.

In conclusion the programme staff made a lot of efforts to achieve the set targets in the year ending. Based on this experience, it is important to hire and train more HHPs in the programme as they have proved that during the long rain season they are at hand to conduct door to door giving health education, screening of TB suspects and then transporting sputum samples to the unit for microscopy.

The involvement of the HHPs in the programme has been having a positive impact on the overall programme performance as patients lost to follow up were traced back and re initiated on treatment. There is a need to allocate a budget line for the expansion of TB services into the hard to reach areas. Regular trainings should be offered to all programme staff on TB care and management, which will keep them abreast with the challenging TB world as they strive to offer quality services to the community

Success Stories

TOPIC: I CAN NOW SMILE

What is your name?

My name is Abuk Rual Rual . I live in Mawut village, Mawut Payam . I don't know my age because I never went to school. I am married with 7 children.

When did the TB disease start?

My son, I started coughing in 2015 but I never bothered to seek treatment because since childhood I have never been injected.

What happened later?

The cough continued, my elder son took me to Kuajok Nursing Home where I was treated with slight improvement. Later, i consulted one of the famous Spear Master's who treated me for 2 months, with no improvement. My husband sold 2 cows and all the money was spent without recovery. My condition worsened, i lost weight, fever and coughing blood.

Then ? *One of the village Dr's came and asked me about my problem, I narrated my sickness and before I could finish my history he immediately gave me a white plastic cup to cough sputum into it.*

Later very early in the morning the very young man woke me up and requested for another sample this time 2 sputum samples were collected from me , after 2 days I was told to report to Luonyaker TB hospital for treatment .I wanted to refuse since many earlier Doctors had failed to treat my disease.

On arrival to the Hospital I was told that I had TB disease. I could not believe because I knew TB was inborn and no one in our family has ever been treated for TB before.

I was treated very well with tablets which changed the color of my urine. If I was not warned about the color change, I would have stopped treatment because I passed real blood which I got used to later!

Were you charged money during the period of treatment?

To my surprise I was not charged money until i completed treatment yesterday. Am very grateful to the village Doctor because he used to visit my home to encourage me to swallow drugs as per Dr's instructions .My sputum was examined 2 times and to day I have come for the last examination . On top of treatment we were supplied with free food rations which improved my health .My family members supported me a lot to swallow drugs on daily basis.

Are you happy with the TB treatment?

Am very happy that's why you see me smiling.

Lessons Learned

1. Health promotion through mass media and other communication channels that increased

awareness, created demand and promoted healthy behavior change leading to early seeking of diagnosis for TB and adherence to TB treatment. The action utilized radio Nhomlau FM and Werber FM-Gordhim.

2. Community engagement for early retrieval of persons interrupting TB treatment by HHP, TB club and TB ambassadors for patient follow ups and monthly feed-back meetings and enhancement of community DOT through treatment support promoted adherence to achieve 91% treatment success.
3. ENGAGE TB to other partners has made the program to be known for better TB integration into the community level.

CHAPTER 4: CHALLENGES and BOTTLENECKS

There were no major challenges in the project management as the system structures are well established and functional at Arkangelo Ali Association (AAA).

A comprehensive plan with the budget and targets are done during proposal development stage, with strict timelines to be followed. These are reviewed on a quarterly basis and underperforming activities that require strengthening are identified and way forward developed.

However, some of the challenges encountered at the implementation stage included:

1. Limited integration of TB into the PHC system which is the overall pillar for health service delivery in South Sudan. 35% of the counties in South Sudan lack TB services, only 31% TBMUs coverage.
2. Inadequate implementation of TB prevention, treatment and care services in high risk/hard to reach populations:
3. Recurrent conflicts lead to displacements and IDP situations that lead to limited access.
4. Prisoners and military services' protocol to access services is prohibitive.
5. Poverty/malnutrition: 4.8 million people (about 100,000 children, have severe acute malnutrition) face severe food shortage worsening TB spread, delayed diagnosis and poor adherence.
6. Inadequate implementation of TB and HIV services: Weak TB and HIV referral linkages, screening and reporting of presumptive TB is sub-optimal.
7. Weak community health systems: The HHPs is envisaged in the country's NSP and Boma Health initiative but insufficiently utilized for referral and door-to-door TB screening/tracing.
8. Poor Infrastructure, stigma and cultural practices leading to delayed diagnosis – Patients trek long distances or seek traditional treatment due to infrastructure destruction by floods, poor roads access, or inter-ethnic/clan conflicts.
9. Human Resource and diagnostic capacity challenge of staff and/or services.
10. Untimely supply of anti TB drugs and lab reagents

Way Forward

- Engage TB to be intensified to other partners to be able to suspect TB, screen and refer for diagnosis and treatment.
- More mentorship/field supervisory visits to be made so as to bench train all health workers about TB care and management.
- Continuous coordination with UNDP, NTP, State TB Coordinators and other partners.
- HHPs to be involved in the programme more actively as they play an important role of reaching TB patients for drug refills, sputum collection and transportation and referral of people with presumptive TB to the Tb unit for microscopy during rainy season when most of the villages are cut off due to flooding.

Chapter 5: BEST PRACTICES

The Project Manager (TB Coordinator) focused on improving communication with various locations as a way of ensuring that the programme activities were implemented according to the set work plan. Devising practical methods of meeting the needs of the programme such as transferring of experienced staff to locations where there are weaknesses and on-job mentorship of the national staff on programme management. The work plans were disseminated to all the locations with clear targets to be met in every quarter .There exists a strong link between the finance, logistics and program departments to ensure that all the activities are carried out according to the budget and work plan. There are both regional and national staffs working in these programs. Regional expatriate staffs had specific management duties and are deputized by the National staff.
The implementation of the programme activities followed strictly the set work plan and involved all the staff. Information sharing among the field staff and the Headquarters was excellent, despite the existing challenges. The implementation process involved advance planning of various activities at the field level, making requisitions for funds and supplies in advance analysis/approval by the project administrator and project manager and finally carrying out the activity and reporting.
Monitoring of these activities is carried out at various levels, the job descriptions of some of the staffs were revised to include monitoring and evaluation functions. Despite the added responsibility, their main activities remained supervision, data collection, verification, quality assurance of the procedures such as laboratory performance and clinical evaluation. A guideline for M&E was developed and a standardized checklist is available for supervision. The guideline and the checklist are both used in monitoring of these activities. The M&E officer provided regular feedback after the supervisory visits, always ensured that the tools for data collection were provided to all sites and performed on-job mentorship and trainings as required. The lessons learnt during the

monitoring exercise are always used to improve the programme performance. There is efficient data storage and archiving system. The system ensures availability and easy access of both aggregated and disaggregated data. Bi – annual supervision is done by the M&E officer and the project manager. Other best practice should be the door-to-door screening and referral of specimen and timely treatment initiation. We devolved finance management to the locations with budgeting and practical interventions being determined by the location staff. Transparency is ensured by cross-checking and countersigning by two persons the expenditure. An orientation workshop hosted by PR (UNDP), was well educative to the SR. Quarterly reviews by the PR (UNDP) also played an important role in the increasing of knowledge and guidance to the management staff in various areas that need improvement.

Chapter 6: RECOMMENDATIONS

- NTP to come up with away of conducting more trainings for the TB programme staff, so as to keep themselves abreast with the latest facts about TB care and management .
- Supply systems should be strengthened to avoid TB units running short of TB drugs and lab reagents
- The Ministry of Health should avail policy Guidelines as regards TB service integration in the Primary Health care across the country.
- Global Fund/UNDP should be releasing the activities funds timely so that activities may be accelerated during dry season.
- NTP to distribute the newly approved reporting and recording tools to all the TBMUs.

Annex 1

AAA -TB UNITS -39

STATE	**COUNTY**	**TB UNITS**	**Remarks**	**Action taken for no performing TB units**	**Way forward**
NORTHERN BAHR EL GHAZAL	Aweil centre	Aweil state hospital TB unit			
		Aroyo Diagnostic and treatment Centre	Poorly performing of PHCC due to low motivation of staffs under MoH supported by HPF	Informing CHD and STC	- Continuous mentorship of the centre staffs - CHD and STBC to involve MoH
	Aweil East	Gordhim TB unit			
		Akuem Diagnostic and treatment Centre	Poorly performing of PHCC due to low motivation of staffs	Informing CHD and STC	- Continuous mentorship of the centre staffs - CHD and STBC to involve

			under MoH supported by HPF		MoH
		Malual Baai Diagnostic and treatment Centre	Poorly performing of PHCC due to low motivation of staffs under MoH supported by HPF	Informing CHD and STC	- Continuous mentorship of the centre staffs - CHD and STBC to involve MoH
		Malualkon Diagnostic and treatment Centre	Poorly performing of PHCC due to low motivation of staffs under MoH supported by HPF	Informing CHD and STC	- Continuous mentorship of the centre staffs - CHD and STBC to involve MoH
		Omdurman Diagnostic and treatment Centre	Lab no functioning	Lab staff not yet recruited by the CHD	Discussing with the CHD and STBC if the Unit can be replaced with a busy

				and hence all TB suspects are referred to Gordhim. CHD and STBC still working on that without success	PHCC
		Wunyik Diagnostic and Treatment Centre	Very low case finding		Continuous mentorship of the centre staff
		Panthou Diagnostic and Treatment Centre	Very low case finding		Continuous mentorship of the centre staff
	Aweil West	Nyamlell TB unit			
		Chelkou Diagnostic and Treatment Centre	Very low case finding		Continuous mentorship of the centre staff
		Gok Machar Diagnostic and Treatment Centre	Very low		Continuous

			case finding		mentorship of the centre staff
		Marial Baai Diagnostic and Treatment Centre	Very low case finding		Continuous mentorship of the centre staff
		Udhum Diagnostic and Treatment Centre	Very low case finding		Continuous mentorship of the centre staff
		Wedwil Diagnostic and Treatment Centre	Lab temporally closed due to Lab personnel who disconnect his contract	Informing CHD and STBC for looking another one	Advertisement done but nobody showed up Rotating Lab staffs of Nyamlell for doing TB microscopy at Wedwil
		Nyinbouli Diagnostic and Treatment Centre	Very low case finding		Continuous mentorship of the centre staff
		Mayen Ulem Diagnostic and Treatment Centre	Very low case finding		Continuous mentorship of the centre staff

WESTERN BAHR EL GHAZAL	Wau	Wau TB unit			
LAKES	Yirol West	Yirol TB Unit			
		Mapourdit TB unit			
		Ateriu Diagnostic and Treatment Centre		Closed due to intertribal insecurity and patients prefer to go to Mapuordit due to poorly managed peripheral health Centers	Nyang PHCC in Yirol East was found to be suitable to replace this unit and provide microscopy services instead of Atirieu PHCC for the time being
		Wou Wou Diagnostic and Treatment Centre			
	Yirol East	Adior TB unit	Very low case finding		Continuous mentorship of the centre staff
	Awerial	Bunagok TB unit	Very		Continuou

			low case finding		s mentorship of the centre staff
	Awerial	Mingkaman Diagnostic and Treatment Centre	High defaulter rate	Involved STBC	Opening Bor TBMU as soon as possible to limit cross river TB patients
	Cuiebet	Agangrial TB unit			
WESTERN EQUATORIA	Tambura	Tambura TB unit			
		Mupoi Diagnostic and Treatment Centre	Very low case finding	Discussed with CHD and STBC about insecurity affecting the program	Continuous mentorship of the centre staff if the security allows
		Source Yubu Diagnostic and Treatment Centre	Very low case finding	Discussed with CHD and STBC about insecurity affecting the progr	Continuous mentorship of the centre staff if the security allows

				am	
		Nagero Diagnostic and Treatment Centre	Very low case finding	Discussed with CHD and STBC about insecurity affecting the program	Continuous mentorship of the centre staff if the security allows
		Namutina Diagnostic and Treatment Centre	Very low case finding	Discussed with CHD and STBC about insecurity affecting the program	Continuous mentorship of the centre staff if security allows
WARRAP	Gogrial West	Kuacjok TB unit			
	Gogrial West	Alek Diagnostic and Treatment Centre			Continuous mentorship of the centre staff
	Gogrial west	Akon Diagnostic and Treatment Centre			Continuous mentorship of the centre

					staff
	Gogrial East	Luanyaker TB unit			
	Gogrial East	Liethnom Diagnostic and Treatment Centre			Continuous mentorship of the centre staff
	Tonj North	Marial Lou TB unit			
	Tonj North	Warrap			Continuous mentorship of the centre staff
	Tonj South	Tonj TB Unit			

Annex 2: Some photos that were taken when TB activities were being carried out in 2016

1.

A treatment supporter helping her grandmother take the TB drugs (DOTS)

2.

Health education to the patient and her treatment supporter before a patient is initiated on TB treatment

3.

An HHP passing TB messages to the WFP food beneficiaries in Mingkaman IDP camp

4.
A health education session in Mingkaman IDP camp, Awerial county