ARKANGELO ALI ASSOCIATION-AAA

South Sudan

GLOBAL FUND TB ANNUAL REPORT 2014

Grant

TB R7-TFM YEAR1

SR Name

Arkangelo Ali Association

Funds Utilized

US Dollars 951,402.13

Project Areas

The project is operational in Fifteen (15) counties (supporting 33 TBMUs) located in Five different 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)

Contact persons

Mrs.Natalina Sala — Project administrator
Dr Callixte Minani — Project coordinator

ACKNOWLEDGEMENT

The TB control programme achievements have been realized because of the financial support and assistance from the Global fund-GF, UNDP and the Ministry of health –ROSS, specifically the National TB, Leprosy and Buruli Ulcers control program, without which nothing tangible could have been felt on ground.

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 different AAA areas of operation, the Non-governmental organizations supporting primary health care activities and the dedicated members of staff who have been providing essential services.
Without their crucial support and commitment many more lives could have been lost.

ACRONYMS

AAA	Arkangelo Ali Association
CCM	Comitato Collaborazione Medica
DOTS	Directly Observed Therapy Short course
CTB DOTS	Community Based DOTS
MDR-TB	Multi Drug Resistant Tuberculosis
M&E	Monitoring and Evaluation
NTP	National TB Programme
PHC	Primary Health Care
PHCC	Primary Health Care Centre
RSS	Republic of South Sudan
TB	Tuberculosis
TFM	Transitional Funding Mechanism
UNDP	United Nations Development Programme

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EXECUTIVE SUMMARY

The Global Fund TFM aim was **to ensure the continuity of essential diagnostic and treatment services for TB control in South Sudan, as it was during the just concluded TB R7. This** Grant focuses on maintaining the services in the existing TB diagnostic and treatment centers by pursuing high quality DOTS, addressing challenges related to multidrug-resistant TB (MDR TB) and strengthening the national management capacity by establishing a National TB control department in the Ministry of Health for Southern Sudan.

All these are aimed towards the reduction of mortality and morbidity caused by tuberculosis. This also remains a major focus of Arkangelo Ali Association (AAA) TB control Program.

AAA's is implementing the TB control program in Fifteen (15) Counties under this Transitional Funding mechanism grant. The Counties include; Aweil Center, Aweil East, Aweil West ,Aweil North , Aweil South in Northern Bahr el Ghazal State, Awerial, Cueibet ,Yirol East and Yirol West in Lakes State, Tambura in Western Equatoria State , Wau in Western Barh El Ghazal state, Gogrial East ,Gogrial West, Tonj South and Tonj North in Warrap State. The programs target a population in 2014 was estimated to be 1,979,599 as derived from the 2008 Sudan's national census result taking into account the 3% annual growth rate.

The strategies employed to meet the project goals include; on Job training of laboratory assistants, training of health workers, strengthening of the PHCCs like Aroyo in Aweil Central county, Akon and Alek in Gogrial West County, Liethnom in Gogrial East County and Mingkaman in Awerial County (serving IDPs from Jonglei State from 15th Dec 2013) so as to carry out sputum microscopy with an aim of increasing case finding, support supervision and monitoring of programme activities, streamlining the drug ordering system and inventory, increasing availability and accessibility of the TB DOTS services by complementing facility based services with mobile outreach activities and incorporating TB control activities into the PHC system and development of M&E guidelines and disseminating them to health facilities.

AAA has a team of dedicated staff for the Global Fund supported programs with clear terms of reference and functions. The organizational structure is shown in the organogram below.

The programs follow the Global Fund performance based funding where specific indicators are used to monitor progress on quarterly basis. During the current reporting year, AAA has managed to meet most of the targets as shown in the table below.

The TB case detection rate achievement for 2014 is 104% which is above the WHO target of 70% detection rate for all cases. This is attributed to active case finding through the door to door screening of the contacts of smear positive cases and screening of contacts of children on Tb treatment, active case finding in the congregate settings like prisons, cattle camps, returnee camp and military barracks, screening of the chronic coughers in the IPD/OPD in PHCC/Us and hospitals in our area of operation ,screening of all PLWHIV for TB symptoms and Tb mobilisers played an active role in the programme as they traced the treatment defaulters and brought them back unto treatment in the course of the year in most of the locations.

AAA has embarked on intensive CTB DOT 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 2.6% at the end of 2014.
The number of health facilities implementing TB control activities has extended its services to special groups such as jailed persons, cattle keepers, returnees and the military. Other activities like creating community awareness, 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.

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 TB mobilisers 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 TB mobilisers 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.

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 recently 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 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 2014 AAA implemented TB prevention, care and treatment in 13 health facilities (TBMUs) and 20 satellite laboratories that are either diagnostic sites or doubles as diagnostic and DOT centres and are spread across 15 counties and Five States out of the ten of South Sudan (Lakes, Western Equatoria, Northern Bahr-el-Ghazal, Warrap and Western Bahr-el-Ghazal States). The 15 counties of implementation are: Lakes State (*Yirol East, Yirol West, Awerial and Cueibet*), Western Equatoria State (*Tambura*), Western Bahr-el-Ghazal (*Wau)*, Warrap (*Tonj North, Gogrial East, Gogrial West and Tonj South*) and Northern Bahr-el-Ghazal States (*Aweil Centre, Aweil East, Aweil West, Aweil South and Aweil North*).

In the course of 2014, due to war situation, AAA expanded TB programme to Mingkaman in order to serve the Internally Displaced people (IDP) who had settled along the River Nile across Bor town.

Moreover 4 diagnostic and treatment centres were established and strengthened. These are Aroyo PHCC (Aweil centre), Alek and Akon PHCCs (Gogrial West) Liethnom PHCC (Gogrial East). AAA also managed to strengthen the already functioning diagnostic and treatment centres (Mapourdit, Gok Machar, Marialbaai and Panthou). This sort of expansion increased the case finding from the 2341 all forms of TB notified in 2013 to 2877 cases in 2014.

Apart from increasing the case finding, the following are noted as well:

- Access to TB services closer to the patients in the community
- Patients are likely to adhere to the treatment – continue their economic activities of daily living (EADL)
- Traveling/feeding/accommodation costs for the patient is reduced for both patients and hospital administration
- Reduced death due to TB in the community

Tuberculosis is one of the leading causes of morbidity and mortality in South Sudan. The estimated incidence of new smear positive pulmonary TB (PTB) patients and all TB forms is 79 per 100,000 and 140 per 100,000 accordingly. South Sudan has noticed an increasing notification rate of new smear positive PTB cases from 22 per 100,000 in 2008 to 31 per 100,000 in 2011 and from 50 per 100 000 in 2008 to 84 per 100 000 in 2011 for all TB forms, while maintaining a treatment success rate around 80%. The burden of smear positive cases in South Sudan is estimated to be 10,270 new sputum smear positive TB cases and 18,200 cases of all forms of tuberculosis (including sputum smear negative and pulmonary cases). The male to female ratio of reported new smear positive PTB cases in 2012 was 1.5 males to 1 female (M:F=1.5:1). This has been the general trend over the last 5 years. The most affected age group is 25-44 years (54%), with a peak within the group 25-34 age. HIV prevalence is estimated at 2.6% in the general population based on the 2012 ANC surveillance report and 13-15% among TB patients[1]. From routine data, AAA has increased notification rate of new smear positives from 46 per 100,000 in 2008 to 92 per 100,000 in 2011 and from 53 to 70 per 100,000 of all forms of TB and a treatment success rate of 87% through Global Fund implementation.

The projects targets a population estimated at 1,979,599 according to the projected 2008 census results factoring in a growth rate of 3% per annum.

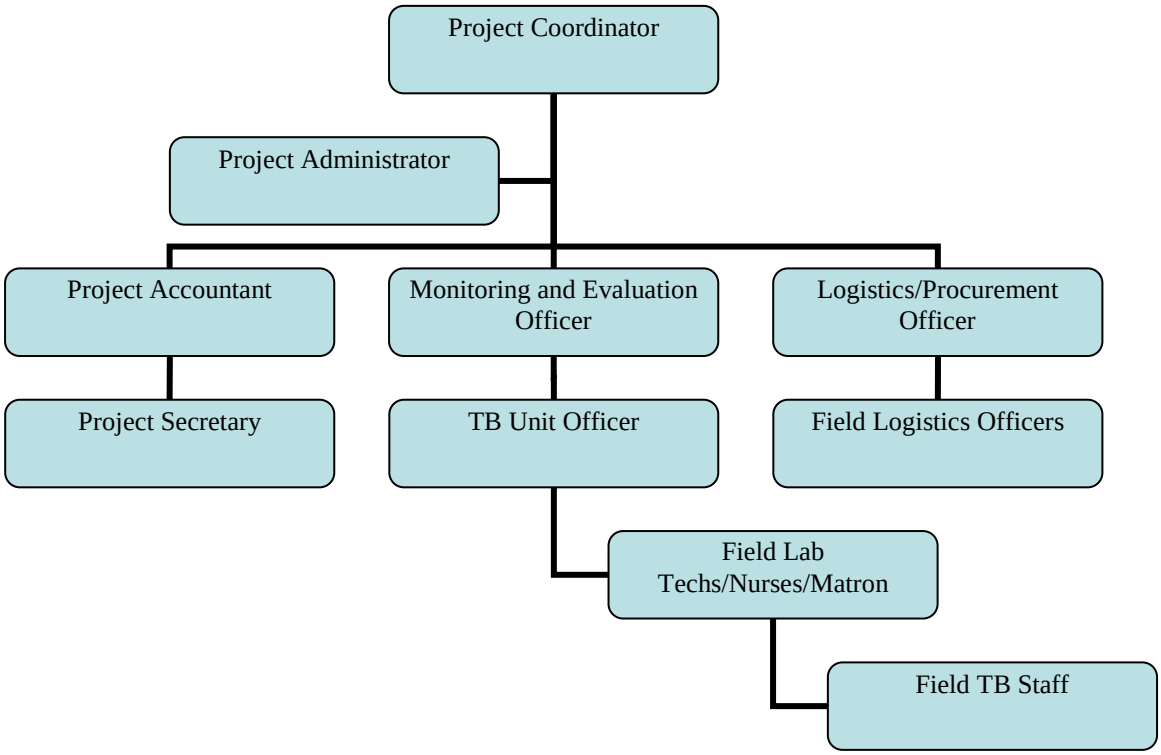
The Global Fund TFM aims to maintain the existing TB diagnostic and treatment centers by pursuing high quality DOTS expansion and enhancement, addressing challenges related to multidrug-resistant TB and strengthening the national management capacity by establishing a national TB control department in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

In order to meet the objectives of TFM Grant, 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, intensified health education in the community, establishment of Internal quality control systems and sending out of sputum smear slides for EQA, engaging a consultant to provide technical support to the field staffs and increasing support supervision.

The implementation of the TB control programme is carried out at various levels within the organization, right from the headquarters to the health facilities.

The organization Structure for TB control is as shown in the organogram below.

AAA Organization Structure for TB Control Program



1. 2: OVERALL PROJECT GOAL AND SPECIAL GRANT AGREEMENT

The overall goal for TB project is to reduce mortality and morbidity caused by TB and the prevention of multidrug-resistant TB (MDR-TB). However TB TFM Grant focuses on maintaining the diagnosis of patients through microscopy targeting all smear positive cases, offering standardized treatment, giving patients support and patients charter, strengthening drug management as part of Health Systems Strengthening (HSS), improving monitoring and evaluation through human resource development and technical assistance, prevention and controlling Multi-Drug resistant TB (MDR)-TB and strengthening the national TB control department in the Ministry of Health. The TB TFM Grant was signed with the United National Development Programme (UNDP) at the end of 2013 and implementation of the activities started in January 2014. The grant number is **SSD-708-G11-T**

1.3: STRATEGIES

The TB TFM Grant had a specific focus which required development of specific strategies required to meet the overall goal of the grant. The strategies employed so as to maintain the services include:

- Support supervision and monitoring of programme activities
- Streamlining the drug ordering system and inventory
- Health education in the community and mobilization to increase demand for TB-DOTS services
- Increasing availability and accessibility of the TB DOTS services by complementing facility based services with mobile outreach activities and incorporating TB control activities into the PHC system
- TB sensitization in congregate settings like prisons, military barracks, police cells, cattle camps, schools, churches and returnee camps.
- Door to Door education and screening of contacts of smear positive TB patients and contacts of children under 5 years.
- TB screening among PLHIV
- Community TB-DOTs and promotion of treatment adherence through TB treatment supporters and TB clubs
- Early retrieval of persons lost to follow up, through the establishment of TB clubs and the involvement of TB ambassadors
- TB screening among patients admitted in wards
- Ensure EQA is done at the Juba Reference laboratory.

1. 4 RESULTS

a. Programmatic

Indicator	Target	Achievement	Variance	Reasons for deviation
Number of bacteriologically confirmed TB patients including relapses notified to the National Health Authority(NTP)	1617	1542	95%	The long rains that led to flooding, made some villages inaccessible for activities that had been planned there to be called off; also insecurity in some of our areas of operation slowed down some activity implementation!
Number of all forms of TB patients notified to NTP	4990	2877	58%	The reasons as cited above
Number and percentage of labs showing adequate performance in external quality assurance for smear microscopy among the total number of lab that undertakes EQA during the reporting period.	33/33(100%)	29/38(76%)	76%	Some slides from different locations could not be selected for Juba double-checking as the locations were inaccessible due to the floods.
Number and percentage of new smear positive TB cases registered under DOTS who smear convert at 2 or 3 months of treatment out if all new smear positive cases registered under DOTS	95%	1289/1366(94%)	94%	Some patients relocated before conversion
Number and percentage of bacteriologically confirmed TB patients including relapses successfully treated (cured plus completed treatment)among new sputum smear positive registered during a specified period	82%	1284/1420(90%)	90%	Some patients could not be traced back to treatment due to insecurity in their areas which forced them to relocate to other unknown safer areas!.
Number and percentage of TBMUs submitting complete and timely reports according to National Guidelines	33/33(100%	38/38(100%	100%	All TB units submitted complete and timely reports in the course of the year!
Number and percentage of	90%	1284/1420(90%)	90%	Some patients could

bacteriologically confirmed TB patients including relapses successfully treated among new sputum smear positive TB patients managed or supervised by the community based treatment supporter at any time during treatment				not be traced back to treatment due to insecurity in their areas which forced them to relocate to other unknown safer areas!
Number and proportion of samples from TB retreatment cases subjected to culture and DST	79/99(80%)	68/118(58%)	58%	Transporting sputum samples for culture and DST remained a challenge as the timing is very critical, as some locations could not avail sputum samples within the required time of 24hours!
Number and proportion of TB patients with known HIV status	3493/4990(70%)	2188/2877(76%)	76%	Inadequate supply of HIV test kits contributed to this low uptake and other patients decided to opt out!
Number and percentage of TB/HIV co-infected patients initiated on CPT among the total number of TB/HIV patients registered	477/524(91%)	173/180(96%)	96%	All TB-HIV co-infected patients were educated on the importance of CPT uptake but 7 patients opted out.
Number and proportion of HIV positive registered TB patients given ART during treatment	262/524(50%)	58/180(32%)	32%	The TBHIV co-infected patients could not access the ART services that are offered only in a few selected key Hospitals across the country! Patients were referred but the distance was prohibitive!
Number of community health workers trained to support DOTS	848	848	100%	Training funds were released on time to the SR and then field sites
Number of supervisions/ mentorships conducted to the TBMU per quarter	33	54	164%	Some TB units were supervised more than once in a given quarter in course of the year

b. Financial-(Budget expenditure per activity)

Program Expenditure

	Amount in USD	%	Reason for variance
Opening balance in January 2013	0.94		The balance b/f was left to keep the bank account open for continuation
Budget for 2014	951,402.00		
Actual disbursement during 2014	951,402.00		Disbursement/funds received for the activities of 2014.
Total expenditure in 2014	(951,402.13)		
Remaining balance end of 2014	**0.81**		The balance is for keeping the bank account open for continuation

Program areas	**Amount allocated**	**Amount expended in USD**	**%**	**Reasons for variance**
Human Resource	590,040.00	590,040.00	100.00%	
Technical assistance		0		
Training	21,190.00	21,190.00	100.00%	
Health products and Health equipment		0.00		
Medicines and pharmaceutical products		0.00		
Procurement and supply Management	5,200.00	5,200.00	100.00%	
Infrastructure and Other Equipment	0.00	0.00		
Monitoring and Evaluation	149,288.00	149,287.50	100.00%	
Living support to Clients/Target Population				
Planning and administration	122,116.00	122,116.63	100.00%	
Overheads	63,568.00	63,568.00	100.00%	
Other				

c. Procurement and supply management

In the year 2014 there was a provision allocated in the budget to replace bicycles for the TB mobilisers, which had been bought under TB R2.This was timely as it facilitated the movement of the Tb mobilisers when tracing treatment defaulters and creating awareness in the community. Apart from the bicycles and all the other assets in use are those that were provided during the closed Round 2 program and they were physically verified in the course of this year.

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CHAPTER 2: CURRENT PROJECT MANAGEMENT ARRANGEMENT

Project Management

The Global Fund TB TFM Grant just as it was during TB Round 7 is managed by a Project Coordinator. He has the overall responsibilities for all programme activities and support of the field staff. The Project 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 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 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 Coordinator for verification and review. The Project 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 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 responsible for all the funds of the project. The Project Administrator in collaboration with the Project Coordinator and the Project Accountant ensure 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 Coordinator, Project Administrator and Project Accountant. The Project Accountant keeps all the financial records and there is periodic auditing which is carried out annually. The field TB Officers is responsible for all the activity funds disbursed and there is a comprehensive accountability system in place which involves at least two field staff to verify all the expenditures. AAA operates a bank account specifically for the TB grant as a way of increasing transparency in the utilization of the funds.

The M&E officer in conjunctions with the Project 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 on data collection and verification.

Finance Management

The Project Administrator as the Head of the Finance/Procurement in consultation with the project 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 Accountant and project administrator who are charged with proper follow up of grant funds and preparation of financial reports. To be able to monitor that funds were used in line with what they were approved for, the staff in the finance team visit all the programs to verify the expenditures. The Project Coordinator together with the M&E officer also assists in verifying that approved activities were actually implemented.

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 successes include 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 above and interlinked with other departments such as procurement and logistics.

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 year 2014, the following key successes were attained:

- Capacity building
  - Lab staff mentored,,,,,,,,9
  - TB mobilisers sensitized,,,,,,,,,,,,,,,,,,,45
  - Community opinion leaders sensitized,,,,,,,90
- Number of mobile laboratory activities conducted ------ 414
- Number of TB suspects screened in the laboratory------- 16,354
- Case detection rate ----------2877/2772*100(104%)
- Number of health education beneficiaries--- 198,730
- Number of IEC materials distributed-------- 3109
- Number of bicycles purchased and distributed…..25

In order to strengthen TB activities and improve on the quality of the services rendered; supervision activities were carried out by the M&E officer and the Project Coordinator. 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. 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 collection of data from the registers, proper recording, compiling quarterly data, verification of the data and the 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.

Success Stories

TB Screening in Aweil Prison: 20th /October/2014:
Documenter: Namuli Annet
Aweil TB Officer

Aweil Central Prison is a state prison which is always over congested as it was built to cater for 150 inmates but currently accommodating over 500 inmates. TB screening in the prison is done on a quarterly basis and TB patients identified are put on treatment under DOTs by TB mobilizer and prison health workers.
AAA good collaboration with prison administration has facilitated TB screening initiative which is helping in the control of TB in the prison

Photo: Thiep Thiep Yel-Inmate Administrator & Aweil Hospital TB Nurse screening prison staff for TB

Lessons Learned

1. Health promotion through mass media and other communication channels that increased awareness, created demand and promoted healthy behaviour change leading to early seeking of diagnosis for TB and adherence to TB treatment. The action utilized radio programs (Radio Bakhita -Juba, Nhomlau FM and Weelbei FM-Gordhim, Voice of Hope Radio-Wau, Radio Good News- Rumbek; Don Bosco Radio-Tonj, Radio Anisa-Yambio) and community theatres. For massive, Repetitive, intense and persistent (M-RIP) TB messaging and meaningful behavior change, these approaches will need to be continued and additionally school health clubs and drama will be introduced.

2. Door-to-door education and screening of contacts of smear positive TB patients and contacts of children under 5 years on TB treatment.

3. Outreach activities and mobile microscopy increased access to service in high-risk and congregate settings i.e. IDPs, cattle camps, fisher folk community, prisons and army camps/barracks.

5. Community engagement for early retrieval of persons interrupting TB treatment by TB mobilizers, 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 90% treatment success.

CHAPTER 4: CHALLENGES and BOTTLENECKS

There were no big challenges in the project management as the system structures are well established 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.
However, some of the challenges encountered at the implementation stage included:

- Insecurity which slowed down the implementation of activities especially the outreach activities in remote villages which had to be re-planned.

- Stigma is still high among health workers and general community. AAA has embarked on intensification of TB sensitization in the community, so as to correct the misconception.

- Heavy rains and floods making the roads impassable .This mainly affected the outreach and community mobilization activities. These activities had to be re-planned and carried out during the dry seasons with resounding success.
- Inadequate supply of HIV test kits ,TBMUs share whatever they have in stock

- Untimely supply of anti TB drugs and lab reagents. AAA TB units were encouraged to share the drugs and reagents amongst themselves. Adult formulations were divided up for children.

- Difficult to monitor and supervise staffs who do not have contract/agreement with you (ref of GOSS staffs involved in TB program who receive top ups from AAA).

- Difficult to retain staffs as they ran away for green pasture

Quality Assurance visit

Way Forward

- Health education to be intensified so as to correct misconception about TB disease.
- AAA to strive and engage other partners in working in the same area(TB Engage)
- 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

Chapter 5: BEST PRACTICES

The project 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 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 office 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 programme coordinator.

Chapter 6: RECOMMENDATIONS

- NTP to come up with away of having 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

Annex 1

AAA -TB UNITS -38 (5 newly established)

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	Newly established		
	Aweil East	Gordhim TB unit			
		Akuem Diagnostic and treatment Centre	Not reported any patient	Lab staff is not yet replaced and hence all TB suspects are referred to Gordhim. CHD and STBC acted on that without success	Discuss with CHD and STBC if the Unit can be replace d
		Malual Baai Diagnostic and treatment Centre	Not reported any patient	Lab staffs are not willing to do sputum microscopy and hence all TB suspects are referred to Gordhim. CHD and STBC acted on that without success	Discuss with CHD and STBC if the Unit can be replace d
		Malualkon Diagnostic and treatment Centre	Not reported	Lab staffs are not	Discuss with

			any patient	willing to do sputum microscopy and hence all TB suspects are referred to Gordhim. CHD and STBC acted on that without success	CHD and STBC if the Unit can be replace d
		Omdurman Diagnostic and treatment Centre	Not reported any patient	Lab staff not yet replaced and hence all TB suspects are referred to Gordhim. CHD and STBC acted on that without success	Discuss with CHD and STBC if the Unit can be replace d
		Wunyik Diagnostic and Treatment Centre			
		Panthou Diagnostic and Treatment Centre			
	Aweil West	Nyamlel TB unit			
		Chelkou Diagnostic and Treatment Centre			
		Gok Machar Diagnostic and Treatment Centre			
		MarialBaai Diagnostic and Treatment Centre	Newly established		
		Udhum Diagnostic and Treatment Centre			
		Wedwil Diagnostic and Treatment Centre			
		Nyinbouli Diagnostic and Treatment Centre	Not reported any patient		Discuss with CHD and STBC if the Unit can be replace d
		Mayen Ulem			

		Diagnostic and Treatment Centre			
WESTERN BAHR EL GHAZAL	Wau	Wau TB unit			
LAKES	Yirol West	Yirol TB Unit			
		Mapuordit TB unit			
		Ateriu Diagnostic and Treatment Centre	Not reported any patient	Closed due to insecurity and patients prefer to go to Mapuordit due to poorly managed periphery health Centers	Discuss with CHD and STBC if the Unit can be replaced
		Wou Wou Diagnostic and Treatment Centre	Not reported any patient	Patients prefer to go to Mapuordit Hospital due to poorly managed periphery health Centers	Discuss with CHD and STBC if the Unit can be replaced
	Yirol East	Adior TB unit			
	Awerial	Bunagok TB unit			
	Awerial	Mingkaman Diagnostic and Treatment Centre			
	Cuiebet	Agangrial TB unit			
WESTERN EQUATORIA	Tambura	Tambura TB unit			
		Mupoi Diagnostic and Treatment Centre			
		Source Yubu Diagnostic and Treatment Centre			
		Nagero Diagnostic and Treatment Centre			
		Namutina Diagnostic and Treatment Centre	Not reported any patient		Discuss with CHD and STBC if the Unit

					can be replaced
WARRAP					
	Gogrial West	Kuacjok TB unit			
	Gogrial West	Alek Diagnostic and Treatment Centre	Newly established		
	Gogrial west	Akon Diagnostic and Treatment Centre	Newly established		
	Gogrial East	Lounyaker TB unit			
	Gogrial East	Liethnom Diagnostic and Treatment Centre	Newly established		
	Tonj North	Marial Lou TB unit			
	Tonj south	Tonj TB Unit			

Annex 2
Some of the photos of the TB program activities carried out in 2014

Selection of slides of EQA

CHW ready for TB mobilization

Child, mother, father admitted due to TB

early morning Sputum collection

AAA was invited to present "Challenges and Opportunity of building TB Control Program in South Sudan after more than 20 years of war"