ARKANGELO ALI ASSOCIATION-AAA

SOUTH SUDAN

GLOBAL FUND TB ANNUAL REPORT 2018

Grant

TB NFM

SR Name

Arkangelo Ali Association -South Sudan

Report for implementation period:

01/01/2018 to 31/12/2018

Funds Available

Approved Budget (After Reprogramming Approval in December 2018)
US Dollars 702,220.00

Funds Disbursed
US Dollars 532,440.00

Funds Utilized
US Dollars 525,910.00

Project Areas

The project is operational in thirty five (35) counties, and located in ten(10) different newly established States in the Republic of South Sudan, namely:

Greater Northern Bahr el Ghazal State

1. **Aweil State**

- Aweil town (Aweil Centre County)
- Panthou (Aweil South County)
- Aroyo (Aweil Centre County)

2. **Aweil East State**

- Gordhim (Aweil East County)
- Akuem (Yargot County)
- Malualkon (Warguet County)
- Malualbaai (Malualbaai County)
- Wunyiik barracks (Wunlang County)

3. **Lol State**

- Nyamlell (Aweil West County)
- Gok Machar (Aweil North County)
- Marial Bai DTC(Aweil West County)
- Nyinbuoli DTC(Aweil West County)
- Chelkou DTC(Aweil West County)
- Wedweil DTC(Aweil West County)
- Udhum DTC(Aweil West County)
- Mayen Ulem(Aweil North County)

Greater Western Bahr el Ghazal state

1. Wau State
    - Wau Teaching hospital (Wau County)
    - Grinty (Wau county)
    - UDici(Jur RiverCounty)
    - Mapel(Jur River county)
    - Kuarjiena(Jur River county)

Greater Lakes State

1. **Eastern Lakes State**

- Bunagok (Awerial North County)
- Mingkam (Awerial South County)
- Adior (Adior County)
- Nyang (Nyang County)
- Yirol (Yirol West County
- Mapuordit (Ngop County)
- Aluak Aluak (Aluak Aluak County)
- WouWou (Ngop County)

2. **Gok State**
    - Agangrial (Cueibet County)
    - Cueibet (Cueibet County)
    - Western Lakes
    - Matangai (Rumbek Center County)
    - Wulu (Wulu County)
    - Cueicok (Western Barhnum County)
    - Aduel (Eastern Barhnum County)

Greater Western Equatoria State

1. **Gbudwe State**

- Tambura (Tambura County)
- Source Yubu (Source Yubu County)

- Mopoi (Mupoi County)
- Namutina (Nagero County)
- Nagero (Nagero County)

Greater Warrap State

- Gogrial State
- Kuacjok (Gogrial West County)
- Lounyaker(Gogrial East County)
- Liethnum (Gogrial East County)
- Gogrial (Aguok county)
- Alek (Aguok County)
- Akon (Awan Chan County)

1. **Tonj State**

- Marial Lou (Tonj North County)
- Tonj , (Tonj South County)
- Warrap (Tonj North County)

Contact persons

Mrs.Natalina Sala
AAA Director/Project Administratorr

Dr Callixte Minani
Project Manager (TB Coordinator)

ACKNOWLEDGEMENT

The TB care and prevention programme achievements have been realized because of the financial support and assistance from the Global Fund-GF, and implementation collaboration with the UNDP and the Ministry of Health –ROSS, specifically the National TB, Leprosy and Buruli Ulcers Control Program and Country Coordinating Mechanism-CCM.

Due to financial gap realized from the beginning of the grant, AAA also continued to seek financial aid from other well-wishers to help fill critical budget gaps that were essential towards the realization of the expected grant objectives, set targets and overall program results.

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	Country Coordinating Mechanism
CoS	Continuity of services
CTB DOTS	Community Based DOTS
DOTS	Directly Observed Therapy Short course
GF	Global Fund
HPF	Health pooled Funds
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
TBMU	TB Management Unit
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 2018 are 4382 (with 55% of bacteriologically 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.

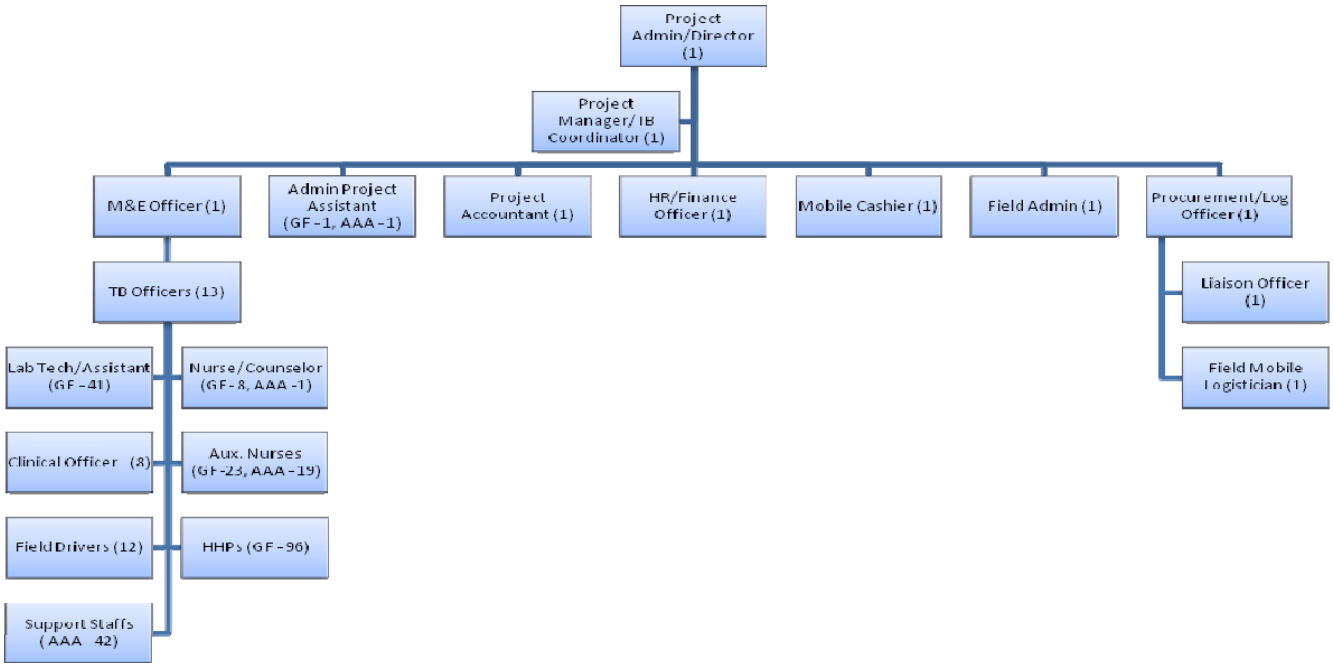
In 2018, AAA as a sub-recipient (SR) implemented the TB and TB HIV interventions with GFATM funding support under the leadership of the Principal Recipient (PR) United Nations Development Program (UNDP). AAA implemented TB prevention, care and treatment and AAA managed to report data from 38 functional diagnostic and treatment centres and these are either diagnostic sites or doubles as diagnostic and DOT centers and are spread across 35 counties in the 10 of the newly established States of South Sudan. This included expansion of TB/HIV services in the 6 new health facilities in addition to the 46 TB units which had been functional before the commencement of this TB Grant that started at the beginning of this year. The 6 TBHIV services were integrated in the following areas: 4 in Greater Western Bahr el Ghazal state - Wau State namely, Mapel DTC, Udici DTC, Grinty Military Barracks DTC and Kuajiena DTC; 1 in Greater Warrap State - Gogrial State namely Gogrial DTC and 1 in Tonj State Marial Lou (Tonj North County) namely Ngapagok DTC) despite budget constraints from the beginning of the grant. The 10 DTCs which had been handed over to the SMOH in different States, continued to offer follow-up services to the TB patients who had been diagnosed and initiated on treatment earlier. This follow up was made possible through the HHPs who traced and transported samples to different laboratories for control measures. All patients in the 2017 cohort were evaluated for their treatment outcomes and 93% was reported as a treatment success rate.

This Grant Implementation was in collaboration with the Ministry of Health where the interventions follow the standard Ministry of Health guidelines and protocols with the National Tuberculosis, Leprosy and Buruli Ulcer (NTLBP) Program providing the Technical guidance and in close collaboration with the County Health Departments (CHD) and State level Ministries of Health in the former States where AAA implements).The projects targets a population estimated at 2,733,939 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 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 the current NFM TB Grant between AAA and the Principle Recipient (PR) United National Development Programme (UNDP) was signed by both parties on 02/03/2018 with a total budget of USD 1,597,320 for 3 years (2018-2020) for the purpose of utilization towards running the existing 46 TB units and then expand TB Treatment coverage by integrating TB/HIV services in 17 new health facilities by the end of 2020.

As the budget was very constraint and insufficient to implement the programme activities, achieve the project objectives and the set targets in line with the approved Performance Framework, there was continuous negotiation between AAA and the PR throughout the year. Finally, there was reprogramming in the course of the year where budgetary adjustments were made during TB reprogramming so as to create a new budget line for Operation Costs which had been left out in the original budget.

The Reprogramming proposal was approved towards the end of December 2018 and the 1st Amendment of the SR Agreement was signed on 21st December 2018. Through this process, AAA's budget for the 3 -year grant period was increased with USD 182,647 to total up to USD 1,779,967. The reprogramming only aided in bridging the 2018 gap of October, November and December (for payments to be done in January 2019); thus, AAA will embark on continuous fundraising to fill in the essential gaps of the next 2 years of the grant (2019 and 2020).

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:

- Increasing availability and access to TB DOTs services by integrating TB services in the existing health facilities, so that sputum examinations may be carried out.
- Complementing passive TB case finding through facility based services with active TB case finding through mobile outreach activities in key populations and incorporating TB care and prevention activities into the PHC system through collaboration with county and state health services in the PHCCs.
- Conducting the outreach activities to Key Populations like Military barracks, Prisons, cattle camps, nutrition centers, hard to reach villages, IDP and returnee settlement camps
- Conducting TB awareness and health education campaigns.
- Contributing to establishing referral lines of presumptive TB cases and sputum sample transfer, by conducting meetings with NTP and AMREF so as to establish a "Bodaboda transport" system.
- Ensuring a good TB-HIV collaboration at community, facility, county, payam and boma levels , by engaging the HHPs
- Supporting the TB-HIV co-infected cases while on treatment

- Early retrieval of persons lost to follow up, through the establishment of TB clubs and the involvement of TB ambassadors
- Conducting Door to Door health education and screening of contacts of smear positive TB patients and contacts of children under 5 years
- Behaviour Change Communication(BCC) in the community and mobilization to increase demand for TB-DOTS services
- Community TB-DOTs and promotion of treatment adherence through TB treatment supporters and TB clubs
- Systematic TB screening among PLHIV and patients admitted in wards.
- Strengthening community DOTS in the continuation phase and follow up using the HHPs
- Mentoring the Home Health Promoters to link the community with respective PHCCs and PHCUs for TB care.
- 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, whereby all orders are placed at the beginning of every quarter.
- Health education in the community and mobilization to increase awareness and create self-referral 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.
- TB sensitizations in congregate settings like prisons, military barracks, police cells, cattle camps, schools, churches and returnee/IDP camps.
- Continuing with the distribution of IEC materials to Health workers and HHPs together with imperatives like umbrellas, caps, mud boots, motorbikes and bicycles to ease reaching the communities during rainy seasons.
- 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.
- Supporting 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 an aim of planning for a targeted supportive supervision visits.

- 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. The NTP/UNDP installed GeneXpert machines in Wau, Aweil and Rumbek for molecular diagnosis of TB and detection of RR TB. In the whole year AAA continued to transport sputum samples from re-treatment cases in the peripheral health facilities to the

hub laboratories for Gene-xpert machine processing as active surveillance for MDR TB in South Sudan.

1.4 RESULTS

a. Programmatic TB Grant Year 1 (January-December 2018)

Indicator	Reporting Period	Target	Result	% Achievement
DOTS-1a: Number of notified cases of all forms of TB - bacteriologically confirmed plus clinically diagnosed, new and relapses	Jan- December	3648	4382	120%
DOTS-2a: 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 specified period	Jan-December	82%	3261/3523(93%)	113%
DOTS-3: 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	Jan-December	95%	57/67(85%)	89%
TB/HIV-1: Percentage of TB patients who had an HIV test result recorded in the TB register	Jan-December	85%	4209/4382(96%)	113%
TB/HIV-2: Percentage of HIV-positive registered TB patients given anti-retroviral therapy during TB treatment	Jan-December	85%	327/398(82%)	96%
MDR TB-1: Percentage of previously treated TB patients receiving DST (bacteriologically positive cases only)	Jan- December	95%	174/224(78%)	82%
MDR-TB 2 (M): Number of TB cases with Rifampicin-resistant (RR-TB) and/or MDR-TB notified	Jan-December	20	14	70%
MDR TB-3: Number of cases with drug resistant TB (RR-TB and/or MDR-TB) that began second-line treatment	Jan-December	20	5	25%

M&E-1: Percentage of HMIS or other routine reporting units submitting timely reports according to national guidelines	Jan-December	100%	48/48(100%)	100%
Number of TB diagnostic and Treatment Centres	Jan-December	48	48	100%

b. Status of Implementation of Approved workplan

Activity	Year Planned	Status of Implementation	Concise description of the status/results/achievements and challenges
Conduct quarterly outreach activity to Key populations	2018	Outreach Activities to Key populations carried out in 2018	Results -109 outreach activities conducted in key populations during the year. 9 TB units were engaged to carry out these outreach activities (Mariallou,Kuajok, Wau, Tonj, Matangai, Aweil, Gordhim Lanyaker and Nyamlell) and their yield is as below highlighted: -Number health educated during outreach activities :26,145 -Number of identified with TB S/s: 3985 -Number tested in the lab: 3046 -Number diagnosed/confirmed with TB and initiated on treatment : 370
TB contact screening with focus on smear positive cases	2018	The HHPs carried out the activity	Number of smear positive cases on whom Contact Investigation was conducted: 2763 • Number of people found at home: 6904 • Number of TB contacts screened: 6759 • Number of contacts identified with TB symptoms:818 • Number of sputum samples from symptomatic contacts tested in the lab:803 • Number of TB contacts confirmed with TB: 61
Intensify case detection	2018	Both active and passive approaches were employed	Results: Total of 4437 TB cases were diagnosed and initiated on TB treatment

		during the year	Strengths: Targeted outreaches always have high yield! HHPs were involved in the mobilisation and referrals of those people with presumptive TB to nearby TB units.
Supportive supervision visits	2018	Supportive supervision visits carried out	**Results:** 11 supportive supervision visits were carried out in the former Northern Lakes and Bahr Ghazal state TB units (Aduel,Cuiecok,Wulu,Matangai,Cueibet,Aweil, Nyamell and Gordhim). **Strengths** -The data in R&R tools in all TB units visited are always harmonised during the supportive visits. **Challenges** -Inadequacy of some TB drugs and reagents was noted during supervisory visits and the same situation was reported to NTP, who managed to replenish the stocks I n the course of the year.
Transporting DST samples to the hub labs of Aweil, Wau and Rumbek for Gene-Xpert process	2018	Sample transportation was carried out	**Results** -186 DST samples from retreatment patients were transported from the peripheral health facilities to the hub labs of Wau, Aweil and Rumbek and were processed by the Gene-Xpert machines. -14 RR TB cases were diagnosed -5 RR TB cases were initiated on SLD **Strengths** - The 2 additional installations of Xpert machines in Aweil and Rumbek have improved the performance of this indicator in the course of the year. - "Bodaboda sample transport" system that was facilitated by AMREF has helped to improve on the performance of this indicator. **Challenges** - Shipment of the RR samples from the

			hub laboratories to the PHL Juba for baseline investigations.

C. Financial (Income and Expenditure)

AAA GF/UNDP TB NFM Income & Expenditure reconciliation from 01/01/2018 to 06/11/2018

		Dr	Cr
Date	**Income**		
01/01/2018	Balance b/f (excluding $0.69 from closed Grant ended 31/12/17 see in bank reconciliation)		0.00
12/03/2018	Income from GF/UNDP TB NFM for 2 Disbursements (used for Full Q1/18 and Part of Q2/18)		266,220.00
09/07/2018	Income from GF/UNDP TB NFM for Q2 (Apr-June 18) Commitments and Part for starting the next period (Q3/2018)		133,110.00
29/10/2018	Income from GF/UNDP TB NFM **Received on 29/10/2018 for covering the Final Deficit of July, August, September 2018** (ex Q4/18)		133,110.00
	Total Income		**532,440.00**
	Expenditure		
Jan-Mar 2018	less expenditure Q1/2018 January, February March 2018	181,364.00	
Apr-16 May 2018	less expenditure Part of Q2/2018 April to 16 May 2018	72,945.00	
17 May to 30 May 2018	less expenditure Part of Q2/2018 17 May to 30 May 2018	11,656.00	
10 July 2018	less expenditure Part of Q2 (April, May, June 18) Commitments	98,868.00	

13-31 July 2018	less expenditure Part of Q3/2018 13 July to 31 July 2018 (1st Interim Report)	18,049.00
1-22 August 2018	less expenditure Part of Q3/2018 1 August to 22 August 2018 (2nd Interim Report)	15,766.00
For Period July/Aug/Sept 2018	less expenditure (ex Q4/18) Received on 29/10/2018 for covering the Final Deficit of July, August, September 2018	127,262.00

Total Expenditure	**525,910.00**
Balance as from 29/10/2018 to 06/11/2018 for continuation of Reprogrammed Period October to December 2018 with the other funds to be received in January 2019.	**6,530.00**

Balance as per bank reconciliation	**6,530.00**
balance as per project reconciliation	**6,530.00**
	-

Appendix on the Income & Expenditure reconciliation

From the beginning of the current GF TB Program grant of 2018-2020 - in January 2018, AAA was on continuous negotiations with the PR UNDP as the AAA Budget that was approved for implementing the TB Program for the 3 years (2018-2020) USD 1,597,320 with a quarterly disbursement of USD 133,110 was insufficient.

The budget negotiations/revisions which AAA engaged the PR UNDP for consideration entailed the following:

1. **Increasing of the number of TB Officers from 6 as approved by the PR to 13** for the entire grant implementation (in order to have one for each of the main 13 TBMUs and to foresee the attached DTCs). Note that AAA's areas of operation are sparsely distributed in 10 different states– not forgetting the logistical challenges of moving from one area to another. In AAA negotiations, the unit cost remained USD 782 as that of the PR UNDP budget. The only difference was the proposed number of TB Officers.

2. **Increasing of the number of Lab Technicians and Assistants from 25 as approved by the PR to 46** for the entire grant implementation to service the main TBMUs and attached DTCs as it is impossible to have 25 Lab Technicians and Assistants serve in the current HFs for AAA which are sparsely distributed in 10 different states– not forgetting the logistical challenges of moving from one area to another. Without Laboratory staffs, there will be no TB services in the Health Facilities. The WHO and NTP recommendation is that for a Health Facility to be referred to as a Diagnostic and Treatment Centre, it must have a functional TB microscopy Laboratory. These laboratory staffs are key in the diagnosis and follow up of TB patients. The negotiation factored in that if the number of lab staff is reduced as per the first approved budget by the PR, then it would mean that the number of TB units would be closed as they would not be functional without AFB microscopy. In AAA negotiations, the unit cost remained USD 131 as that of the PR UNDP budget. The only difference was the proposed number of Lab Techs/Assistants.

3. **Provision of Operational costs:** These costs are linked to service delivery and grant implementation. Given the large coverage of AAA's area of operation, it is impossible to implement without these costs. These costs were provided in the previous SR budgets and even in the GF TB NFM Grant which ended on 31/12/17 but not incorporated in the current budget.
   These include costs related to maintenance of cars - putting into consideration our vehicles are very old, maintenance of motorbikes, fuel for outreaches, picking up of drugs and laboratory reagents from airport and airstrips drop off points to HFs, field monitoring and supervision (including flights and travel permits), maintenance and repairs of TB facilities and equipment among others. In AAA negotiations, a minimum of USD 16,000 per quarter was being requested for operating in all the current 46 HFs.

4. **Costs of Envisaged expansion with 17 more TB Sites:** as per approved Performance Framework as the first approved budget was not even enough to maintain the current 46 HFs.

In summary, factoring in all the above 4 gaps from 2018-2020, AAA required a minimum additional of USD 400,000*.

Due to the gaps that AAA addressed in the course of Year 1 (2018) - in order to achieve the expected results (i.e. maintaining the required number of Lab Staff, TB Officers and Operational Costs); AAA had a full gap for Q4/18 of USD 169,780 as we had utilized all the approved Year 1 budget for implementation of Q1/18 to Q3/18. Fortunately, a possibility for budget reprogramming was forecasted by the PR and a proposal presented to the Global Fund and the CCM.

Reprogramming:
From the forecasted Budget to be reprogrammed, AAA's allocation was an additional USD 182,647 for the 3 years to the initial approved USD 1,597,320. This was to increase AAA's budget to

USD 1,779,967. AAA presented a reprogramming proposal working out within this increased amount to fill in the minimum requirement of USD 169,780 for closing out Q4/18 October to December 2018 gap. This left out a balance of only USD 16,467 to be reprogrammed in Years 2 and 3 (2019 and 2020) respectively. In this balance of USD 16,647 for 2019 and 2020; AAA allocated it towards Operational Costs for the next 8 quarters from Jan 2018 at USD 2,058 per quarter.

Outcome of the Reprogramming:

1. As shared above, the reprogramming' was only significant in 2018 as it only addressed the year's gap. However, it did not address the 2019 and 2020 budget gap for AAA at all apart from provision of USD 2,058 per quarter for Operational Costs.

2. The number of the TB Officers has not changed from the initial approved number. Therefore, we will still have 6 TB officers instead of 13 TB Officers. Gap remains 7 TB Officers for 2019-2020 but AAA envisages continuing negotiations with the PR to see way forward through some approvals within the reprogrammed budget.

3. The number of the Lab Technicians/Assistants has not changed from the initial approved number. Therefore, we will still have 25 Lab staff instead of 46 TB Officers. Gap remains 21 Lab Staff for 2019-2020.

4. The minimum required Operational Costs per Quarter is USD 16,000. From the reprogramming, only USD 2,058 was spared which means AAA still has a gap of USD 14,000 worth of needful Operational Costs per Quarter.

5. Envisaged expansion: This gap has existed from the beginning of the grant as costs associated were not incorporated in the initial approved budget. The cognizant expansion gap for 2019-2020 still stands but AAA envisages continuing negotiations with the PR to see way forward through some approvals within the reprogrammed budget.

Current Situation:

As highlighted earlier, even though the reprogramming addressed the 2018 gap where payments are to be made in January 2019, it did not address the 2019 and 2020 gap (where the quarterly disbursement from GF grant will be USD 134,718).

As the budget is still constraint, it threatens to interfere with the grant objectives and failure to achieve targets. Nonetheless, AAA is continuously fundraising from well wishers in order to meet these gaps but it is very difficult for donors to support the Global Fund TB program as they feel this is the mandate of the Global Fund to support the TB program fully.

3rd Participation:

AAA through its third participation to the programme implementation in support of the Global Fund gap had some very essential activities covered critical in aiding achieve the set targets in the course of the year as it would be impossible to attain as expected with only the funds approved under GF. For October to December 2018, the TB programme was maintained and achieved through 3rd participation and sacrifice of all staff who worked and remained in the program

without salaries as we waited for the approval of the reprogramming which was done towards end of December 2018 for funds to be disbursed in January 2019.

Below are the summarized tables highlighting AAA 3rd participation in the course of the year 2018.

1). January to June 2018 Semester:

Essential HR Gaps identified and supported through AAA private fund raising to aid in service delivery during:

No.	Name of location(TBMU + Attached DTCs)	Amount USD
1	Wau	300
2	Kuajok	720
3	Luanyaker	720
4	Tonj	492
5	Marial Lou	560
6	Aweil	1,200
7	Gordhim	7,533
8	Nyamlell	657
9	Agangrial	1,134
10	Yirol	1,122
11	Bunagok/Mingkaman DTC	456
12	Tambura	615
13	Rumbek (New sites)	450

14	H/O Technical Support Officer	1,500
	Total 3rd Participation for HR	**17,459**

Gaps supported in Other Interventions

No	TBMU + Attached DTCs	Description of the Intervention	Amount USD
1	Gordhim	Repair of ward roof after storm mishap	2,500
2	Nyamlell	Repair of ward ceiling that had been eaten by up termites	525
3	Tonj	Repair of hospital Fence, that had fallen apart due to heavy storm	150
4	Marial Lou	Repair of old Ex-Malaria car that is being used for the supporting TB programme in the location	3,000
5	Wau, KK,LK,TJ,MR	Procurement of TB Treatment cards in Wau and distribution of the same to Wau , Kuajok, Luanyaker and Marial Lou	333
6	Adior	Ward roof repair that had been blown away by heavy wind	1,500
7	New Sites (Grinity, Udic, Kuajina, Mapel)	Procurement and distribution of Lab supplies to the new sites to enable start up before the NTP/UNDP supply provision; cost related the opening of the new TB sites eg diesel, DSA for the officials involved in the ensuring the sites are opened and functional	1,200

8	Rumbek (New sites)	Internal transport of program supplies provided by UNDP/NTP to MT, YL and Mingkaman stations/distribution hubs	1,100
9	Wau	Offloading of program supplies provided by UNDP/NTP from Wau airport and downloading at hospital including + AC Refill & glass for Lab	150
10	Wau for Aweil	Road transport of Diesel from Wau (where purchased in Dalbit) to Aweil	339
11	Aweil	Participation for hospital drainage maintenance	100
	Total 3rd Participation - Others		**10,897**

Total AAA 3rd Participation in the January to June 2018 Semester was USD 28,356

2) July to December 2018 Semester

July to September 2018 period:

Essential HR Gaps identified and supported through AAA private fund raising to aid in service delivery.

No.	TBMU + Attached DTCs	Area of Intervention	Amount in USD
1	All 38 HFs	Gap in essential HR supporting service delivery of GF TB Program July, Aug, Sept 2018	16,343
2	All 38 HFs	Costs associated with M&E for mission in Juba from July, Aug & Sept for matters pertains GF UNDP TB Program	600
3	Aweil, Nyamlell, Gordhim	Road transport of diesel for TB Programs in Aweil, NY & GD from Wau to Aweil in Aug 2018	150
4	Cueicok	Repair of motorbike used for TB program	140
5	All 38 HFs	1,963.5 litres of Petrol (@$3 per litre) for use by TB motorbikes in implementation of TB program outreaches and running other programmatic	5,890

		errands related to TB from Jan up to Sept 2018	
6	Tonj	Repair of TB wards	950
7	Wau	Repair of AAA car supporting TB program	1,000
8	All 38 HFs	Penalty by RoSS Ministry of Finance for late remittance of PIT of HR supporting service delivery of GF TB Program	2,000
9	All 38 HFs	Security of the Country office for overall TB Program Coordination and Liaison - for 2018	3,600
	Total 3rd Participation to TB program Q3.18		**30,673**

October to December 2018 period:

A) 3rd Participation towards Module 1 (HR for servicing the GF TB Program)

No.	Area of Intervention	Amount in USD
1	Salaries and arrears of 3 TB Officers not covered under Reprogramming.	12,900
2	Costs associated with TB Officers (of all AAA TBMUs) like Feeding, Visas and Registrations.	3,097
3	Support of some Essential HR supporting Service Delivery of GF TB Program + Support Staff (Cooks, Cleaners and Guards) and VCs (all AAA TBMUs)	15,399
4	Costs associated with AAA M&E Officer for mission in NBeG Nyamlell TBMU for GF UNDP TB Program	450
	Total 3rd Participation towards Module 1 (HR Costs)	**31,846**

+

B) 3rd Participation towards Module 4 (Operational Costs for servicing the GF TB Program)

No.	Area of Intervention	Amount in USD
1	General Running costs for All AAA TBMUs/Sites	1,255
2	Rehabilitation of Nyamlell TB Unit fence	250
3	Emergency Diesel for use in implementation of TB program for Supervisions and running other programmatic errands related to AAA TB programs in Great Lakes, WBeG, NBeG and Warrap States.	1,500
4	Repair of Luanyaker car supporting TB program	100
5	Costs for Internal and External Transport to and from various TB Program sites	5,800
	Total 3rd Participation towards Module 4 (Operational Costs)	**8,905**

Total 3rd Participation/AAA Fundraising under Reprogramming period of October, November and December 2018 towards support of GF TB Program gap is USD 40,751.

Total AAA 3rd Participation in the July to December 2018 Semester was USD 71,424.

Total AAA 3rd Participation to the GF TB Program gap in 2018 was USD 99,780

C. Procurement and supply management

The management of items supplies/purchased was well tended in accordance to AAA's operations manual as well as in the standards expected and communicated by PR UNDP in workshops and Reviews in the previous implementing years.
Within the year, there was only minor purchase of Diesel and Spare Parts for the Motor Vehicles used in the different TBMUs as there was no Operational costs provided under Global Fund budget. The rest of the procurement of other essentials including rehabilitation of various structures related to TB program was supported through AAA's 3rd participation.

Additionally, through own resources, in some scenarios, AAA was able to provide Laboratory Materials (like Lab reagents etc) and Drugs for second disease related to the TB Patients and delivered to various AAA TBMUs through 3rd participation transport budget.

In the usual procedures where procurement is involved, the Project Manager (TB Coordinator) is the mandated person to analyse the procurement requisitions/work plans presented by the TB Officers from different TBMUs. Upon analysis and approval, he liaises with the Project Administrator/Director who in accordance with the Budget approves the procurement of the required requested items.
In terms of fuel purchases, approval is after checking the Logbooks to confirm if the usage is in tandem with the activities and distances covered.
In cases where transport is involved incase of sufficient grants, selection of the transport is usually reached through scrutiny of various Quotations from different companies for bid selection.

ASSETS

There was no provision of assets to AAA through GF/UNDP in 2018. However, AAA has maintained the records of all the assets provided in the previous grant of 2017 in the AAA Asset Form and in the UNDP Register. Focal persons are also in place as custodians of these assets.

CHAPTER 2: CURRENT PROJECT MANAGEMENT ARRANGEMENT

Project Management

The Global Fund TB NFM Grant is managed by the Project Manager (TB Coordinator). He is the overall overseer of all Program activities. This is made possible through the support of the field staff under leadership of the TB Officers.

The Project Manager (TB Coordinator) is responsible for monitoring the Program activities and to ensure that they are in line with the approved work plan so as to achieve the set targets. This is with the support of the M&E Officer.

The Project Manager (TB Coordinator) is also involved in the decisions pertains the recruitment, retention and capacity building of staff.

He also ensures that the Program needs are met which may include; timely supply of drugs, availing the right equipment and offering technical assistance whenever a need arises.

He also oversees the procurement of items 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 Program and is the link between the donor agency, the Ministry of Health, NTP and the Program.

The Project Manager (TB Coordinator) ensures proper management of drug supplied as all the field TB Officers prepares 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 officers regarding delivery and quantities.

The inventories from the field, consumption records etc are also submitted to the Project Manager (TB Coordinator) for reviews.
To ensure smooth operation, there is a National Program Officer based at the Country office in Juba, the Program Officer is responsible for all the follow up of Program issues in Juba through the Ministry of Health, NTP, UNDP and other partners.

AAA has a Project Administrator/Director who is responsible in managing all the Program funds. 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 expected end-deliverables.
Approval of the expenditures is done in consultation with the Project Manager (TB Coordinator) and the Project Administrator/Director.
The 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.

The AAA M&E officer in conjunction with the Project Manager (TB Coordinator) are responsible for all the data collection and reporting activities, monitoring of the Program activities to ensure that it is in accordance with the set work plan, prioritizing the activities as required, capacity building, verification, collation and analysis of data and submission of the quarterly reports.

The TB officers 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 trainings and sensitizations on data collection and verification to lower cadres.

Finance Management

The Project Administrator/Director is under the leadership of Finance management.
As the Head of the Finance/Procurement, she works in close consultation with the Project Manager (TB Coordinator). The two parties are 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.

The 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 Administrator.

During the implementation, the AAA Field Administrator is in charge of monitoring that funds are 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 through the approved funds.

The Project Accountant with the Project Administrator/Director keeps all the financial records and there is Quarterly review of expenditure by PR. Also, an Annual audit is conducted after every financial year.

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.

AAA operates a bank account specifically for the TB grant as a way of increasing transparency in the utilization of the funds.

The Project Administrator/Director together with the Project Manager (TB Coordinator) also oversees the Human Resource involved in the implementation of the Program. In summary, see what is and was entailed under Human Resource within the year:

a) Human Resources:

AAA had an average of 250 National staffs involved in the TBHIV implementation in year 2018. These staff worked in various AAA TB Units situated in across 35 counties and 10 of the newly established States of South Sudan as stipulated under subtitle **"Project areas".**

In HR Management, the Program Manager (TB Coordinator) with the help of the TB Officers are responsible for recruitment and retention of the Staff. Jobs vacancies are advertised locally and the TB Officers and SMoH through the CHDs have the mandate to select applicants for interviews, conduct interviews and thereafter share the outcome and all the applicants' documents with the Project Manager (TB Coordinator) and Project Administrator/Director for approval.

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.

Approval of salaries is bound on the TB Officers submission of Salary Requisitions to the Project Administrator/Director for analysis.
Thereafter, the HR Officer prepares the payrolls which are approved by the Project Manager (TB Coordinator) and Project Administrator/Director.

As noted under "**Appendix on the Income & Expenditure reconciliation";** in 2018, AAA experienced budget constraints from the beginning of the Global Fund TB grant and it was of paramount importance to seek funds from 3rd participants to fill in gaps essential to aid in the achievement of expected results by maintaining some critical Human resource that were not considered in the approved budget by PR UNDP. These included Support staff like (Cleaners for the Laboratories and TB wards, Cooks who prepare food for the intensive care TB patients to aid in treatment adherence and Guards who safeguard the storage facilities where drugs, microscopes etc are stored). Through 3rd participation, AAA was also able to recruit service delivery staff for the 6 new sites established and functioning in 2018. These are (One Lab staff and one Clinical Officer for each new site). Because of these resources from well wishers, AAA was able to maintain all these staff in service of the TB program and the same recruitment, management and reporting procedures applied for the staff funded under Global fund grant were also applied in these staff supported under 3rd participation.

Challenging experiences that faced the HR management during the year
Due to the accountability of human resource under Global Fund grant and the 3rd participation well wishers in support of the TB Program, there is involvement of a lot of paperwork and additional workload in the HR management.

Further, there was the introduction of the system of decentralization of Personal Income Taxes payment whereby the new system requires the payment taxes for all locally employed staffs at the State Ministry of Finance and submit copies of the payments made to the Central Ministry of Finance office for tracking which is cumbersome and very involving. Additionally, with the continuous financial challenges in the fiscal year 2018, AAA incurred numerous penalties by Ministry of Finance – Juba due to late remittance of PIT.

Ongoing traits to improve on quality of work delivered by HR (former) and (newly recruits in new established Sites):

Capacity Building

AAA TB Officers and the M&E Officer carried out on site mentorship of the programme staff in the course of the year. The focus was on bench training of TB Management and referral of presumptive TB cases to the nearby TB units. The M&E related costs including field site visits were catered for under 3rd participation.

b) Outreach Activities Management

In 2018, funds for conducting quarterly outreaches to Key Populations were approved.
All the Outreach activities were/are managed as follows:

- All outreaches are conducted are in line with the approved budget to cover the Performance Framework sent by the PR at the beginning of the grant.
- The Project Manager (TB Coordinator) shares with the TB Officers the projected number of Outreaches to be conducted within the Quarter. He receives suggestions from them on way forward (depending on ground needs and why) in order to factor in these while working on the outreaches Schedules.
- After this engagement with the Facilitators on ground at the beginning of each Quarter, the Project Manager (TB Coordinator) requests the outreaches WorkPlan proposal. This document includes the areas planned to be conducted the outreaches and the estimated diesel or petrol for to be used, the period of the outreaches including advance mobilization (not fixed as change in dates may occur during the preparation), the No. of participants to attend the outreaches and the DSAs. Usually, AAA gives at rate of USD 10 per person per outreach.
- After receipt of the outreach WorkPlans from field, The Project Manager (TB Coordinator) analyzes and with the support of the selected technical/finance team prepares the Requisitions for the Location's where outreaches are to take place. The Requisition is supported/ accompanied by the Instructions to the Facilitators for management and accountability of the outreach funds.
- The Project Manager (TB Coordinator) presents the above documents to the Project Administrator/Director for approval and authorization of the funds to conduct the Outreaches.

- There's follow up of how the outreaches are being conducted by the Facilitators. This includes ensuring involvement of the STBCs and CHDs also In the DSA payments as they co-sign the attendance lists and payment sheets for authentication if at will.
- Once the Outreaches 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 outreach. 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 and copies in the field locations where outreaches are conducted.

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. HHPs and health workers from public, private and health facilities in the congregates settings were trained on TB management and presumptive case referral linkages to the nearest TB units for diagnosis and initiation of treatment. The efforts have started bearing fruits as all TB patients registered in the 2017 cohort were evaluated and indicated a low rate of 3% for Lost to follow up was recorded, which is within the recommended WHO standard.

The number of health facilities including the new ones 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, creating community awareness, conducting TB club meetings and integrated feedback meetings, Continued awareness creation 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 year 1, the following key successes were also noted:

Deliverables	Achievements
Number of Outreach activities in key populations	109
Number of TB cases confirmed with TB during outreaches	370
Number of Health education beneficiaries including those in outreach sites	369,397
Number of persons with presumptive TB examined for TB in the lab	18,029
Number of Patients with presumptive TB with positive bacteriological examination results	2556
Number of TB patients tested for HIV	4211
Number of co-infected TB patients	398
Number of co-infected TB patients initiated on ART	327
Number of co-infected TB patients provided with CPT	389
Percentage of new smear positive patients whose smears converted at either 2 or 3 months	2039/2206(92%)
Number of supportive supervisions and mentorships conducted to the TBMU staff	11

- AAA received 6 New LED microscopes from NTP through the support of UNDP as away of boosting TB case detections in high burden locations.
- 8 Laptop(*LENOVO,Thinkpad*) Computers donated by NTP to AAA through the support of UNDP for improving eTBr in NYamlell, Wau, Aweil, Gordhim,Kuajok, Luanyaker,Tonj TBMUs and one for the M&E office for the installation of the overall eTBr so as to monitor the performance of the TB programme activities.
- 6 new health facilities were integrated with TB services(Udici PHCC, Mapel PHCC, Gogrial PHCC, *Kuajina PHCC, Grinty military Barracks and Ngapagok PHCC*) after a joint Health facility assessment for suitability had had been carried out by the SMOH, CCM, MOH and AAA
- 51 HHP monthly feedback meetings were carried out.
- 30 Integrated feedback 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.
- 72 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.
- 3 EQA meetings were conducted where staff from the peripheral health facilities meets at the main TBMUs and then go through all the tools and update them accordingly.

- 104 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.
- 416 assorted IEC materials with basic facts on TB distributed in the community.

Contact investigations

In the course of the year, HHPs were actively engaged in the programme activities whereby they were involved in the creation of TB awareness, tracing the lost to follow up and TB contact health education and screening. Below cited are the outcomes of the Contact investigations:

- 8 HHPs involved in TB contact investigations
- 1615 homesteads visited by HHPs for contact investigations
- 6904 people found at home during contact investigations
- 6759 TB contacts screened during contact investigations
- 818 TB contacts found with TB symptoms
- 803 sputum samples from symptomatic TB contacts tested in the laboratories
- 61 TB contacts confirmed with TB
- 61 TB contacts with confirmed TB initiated on treatment.

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 centers 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 were 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 allocate more outreach activity funds to all TB sites as the easiest way of reaching the key populations where more TB cases can be detected.

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 separate budget line for the expansion of TB services into the existing health facilities.

Success Story

Nyaliet Magak benefits from the free TB treatment

"I am grateful for the organizations which brought the TB hospital to MarialLou which is within the community's reach; as I can now smile again like all other parents. I come from Magok which is about 20km from this hospital but I could bring my daughter here in time here for treatment as I had to seek the consent of my husband who used to believed that our child had been bewitched by a hater, my daughter Nyaliet is 1 year of age and is a 5th born in my family and was unable to sit by herself at that age of 1 year. I had tried different traditional herbs before I came here to seek medical attention. When I arrived here my daughter Nyaliet was reviewed and screened for TB during the Infant and Young Child Feeding clinic at the second visit and there was no improvement and was being treated for Pneumonia unresponsive to antibiotics and multiple lymphadenitis of the groin and cervical glands. Nyaliet was then started on Tuberculosis treatment on 19/09/2018. My daughter was also tested for Malaria as her body was always hot and the results was positive for malaria and she was pale (her Hemoglobin was 3g/dl).
*The diktori managed all the conditions simultaneously as my daughter was given blood (transfused) and started on Malaria treatment as well as Tuberculosis drugs***.**

Nyaliet enjoying the company of other children

My daughter Nyaliet can now crawl, stand and tries to take a few steps without support and is able to play around with the other children. I am very happy as a mother of the child who was almost dying. I am very grateful for the efforts done to revive the life of my daughter who was almost gone and I would never ignore the hospital as their work is like "GOD's".
The above are the words from Nyaliet's mother." Tuberculosis is curable and treatment is also free of charge and thank you to all the programs involved in saving the lives in our community and for my child."

What a supper smile for Nyaliet during her free time with the mother and enjoying energy biscuit

Lessons Learned

1. Conducting Outreach activities to the key populations like military, prisons and communities in hard to reach areas have a higher TB yield.

2. Engagement of the HHPs for patient follow ups and conducting monthly TB club feed-back meetings promoted adherence to achieve 93% treatment success.
3. Supportive supervision visits to all the TB units for mentorship, couching and re-strategizing the activities with the field programme staff always helps in enhancing programme performance.

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. Shipment of the RR TB samples from the hubs to the PHL Juba for baseline investigations.
2. Untimely supply of anti TB drugs and reagents to the TB units.
3. Financial constraints which led to the reprogramming in October as the funds that had been allocated approved for AAA were not adequate to implement and achieve the set targets.
4. Harsh economic situation in the country that has led to the devaluation of the currency has made the staff run away from their work in search of greener pastures.
5. Flooding in the 1st and 2nd quarters hampered the implementation of the programme activities as the roads were impassable and the villages inaccessible.
6. Inadequate implementation of TB and HIV services: Weak TB and HIV referral linkages, screening and reporting of presumptive TB is sub-optimal.
7. Nutritional support not catered for in the Global Fund budget and yet it contributes to treatment adherence that leads to high treatment success rates.
8. Insecurity in some of the catchment areas eg in the former Lakes state where the Catholic priest was shot dead in his house at night. This led to tension in the community and this situation led to planned activities not being implemented on time.
9. High staff turnover in the diagnostic and treatment centers as some of them resign to seek for better remunerations.
10. Challenges of economic crisis in the country whereby the newly established States are more demanding for their survival.

Way Forward

- More funds should be allocated for outreach activities to the key populations as that are an activity that can have a high yield.
- Operationalization of the decentralization of the medical commodities to the State Medical Warehouses eg in Wau for Greater Bahr el Ghazal region will help in alleviating the chronic delays in the supplies(TB drugs and lab reagents)
- The MOH to ensure that the Health Policy guidelines that recommend for the TB integration in all PHCCs is well understood and practiced at the lower levels(County and State), as this will help when it comes to new partners integrating TB in the existing health facilities.

- 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 PRACTICE

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.

CHAPTER 6: RECOMMENDATIONS

- MDR TB drugs should always be packaged and then supplied to the State in time so as to avoid delays in initiating the diagnosed RR TB cases on SLD.
- TB drugs and reagent supplies should be decentralized, as this will solve the delays and untimely supplies.
- The childhood TB focal point in the MOH should ensure that the Childhood TB Policy guidelines are printed out and well disseminated to all levels.
- NTP to provide IEC materials
- UNDP to be releasing funds for implementation on time

Annex 1: TBMU/DTCs

AAA -TB UNITS -52

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 under MoH supported by HPF	Informing CHD and STC	-Continuous mentorship of the centre staffs - CHD and STBC to involve MoH
		MalualBaai Diagnostic and treatment Centre	Poorly performing of PHCC as the lab staff is demandin	Informing CHD and STBC	-Continuous mentorship of the centre staffs - CHD and STBC to involve MoH for services

			g for a top before he works on AFB microscopy		
		Malualkon Diagnostic and treatment Centre	Low case finding	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 and hence all TB suspects are referred to Gordhim. CHD and STBC still working on that without success	Discussing with the CHD and STBC if the Unit can be replaced with a busy 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 case finding		Continuous 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			
		Nyinbouli Diagnostic and Treatment Centre	Very low case finding		Continuous mentorship of the centre staff
		Mayen Ulem Diagnostic and Treatment Centre			
WESTERN BAHR EL GHAZAL	Wau	Wau Teaching Hosp TB unit			
	Wau	Grinty military Diagnostic and Treatment centre			Newly established in 2018
	Jur River	Mapel Diagnostic and Treatment centre			Newly established in 2018
		Udici Diagnostic and Treatment centre			Newly established in 2018
		Kuarjiena Daignostic and Treatment centre			Newly established in 2018
LAKES	Yirol West	Yirol TB Unit			
		Mapourdit TB unit			
		Aterieu Diagnostic and Treatment Centre		Closed due to intertribal insecurity and patients prefer to go to Mapuordit due to poorly managed peripheral health Centers	Due to tribal clashes the community relocated, thus it was not viable to continue the services until the situation is stable…..the CHD and SMOH are aware.
	Rumbek East	Aduel Diagnostic and Treatment Centre	Low case finding	Lab staff reluctantly working on AFB microscopy due to low incentives	CHD and STBC are aware of the situation are following it up

				from HPF	
	Rumbek East	Cueicok Diagnostic and Treatment Centre	Low case finding	Lab staff reluctantly working on AFB microscopy due to low incentives from HPF	CHD and STBC are aware of the situation are following it up
	Wulu	Wulu Diagnostic and Treatment Centre	Low case finding	Lab staff reluctantly working on AFB microscopy due to low incentives from HPF	CHD and STBC are aware of the situation are following it up
	Yirol West	Wou Wou Diagnostic and Treatment Centre			
	Yirol East	Adior TB unit	Very low case finding		Continuous mentorship of the centre staff
		Nyang diagnostic and treatment centre	Low case finding		Continuous mentorship of staff
	Awerial	Bunagok TB unit	Very low case finding		Continuous mentorship of the centre staff
	Awerial	Mingkaman Diagnostic and Treatment Centre	High defaulter rate	Involved the CHD and the STBC from both States(Jonglei and Lakes)	Opening Bor TBMU as soon as possible to limit cross river TB patients
	Cuiebet	Cueibet hospital TB unit			
		Agangrial TB unit			
WESTERN EQUATORIA	Tambura	Tambura TB unit			
		Mupoi Diagnostic and Treatment Centre	Very low case finding	Discussed with CHD and STBC about	Continuous mentorship of the centre staff if

				insecurity affecting the program	the security allows
		Source Yubu 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
		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	The unit is insecure.Continuous mentorship of the centre staff if security allows
WARRAP					
	Gogrial West	Kuacjok TB unit			
		Alek Diagnostic and Treatment Centre			Continuous mentorship of the centre staff
		Gogrial Diagnsotic and Treatment centre			
		Akon Diagnostic and Treatment Centre			Continuous mentorship of the centre staff
	Gogrial East	Luanyaker TB unit			
		Liethnom Diagnostic and Treatment Centre			Continuous mentorship of the centre staff
	Tonj North	Marial Lou TB unit			
		Ngapagok Diagnostic and treatment centre			Newly established in 2018
		Warrap diagnostic and treatment centre			Continuous mentorship of the centre staff

	Tonj South	Tonj Bosco TB Unit			

Annex 2: Some photos that were taken in 2018 when TB activities were being carried out.

Patients in Aweil queuing up for WFP food rations

Sensitizing the medical seekers at the OPD on TB ….Santino Lual sensiting school children on TB disease

One of the TB patients addressing fellow TB club members meeting

Addressing TB club members on treatment adherence before their drug refill