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Tuberculosis Control Assistance Program (TBCAP)

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Improving Coordination and Information Sharing amongst PEPFAR-supported Partners

By TB CAP/The Union, Uganda Team

The Tuberculosis Control Assistance Program (TB CAP) is providing TB technical assistance to PEPFAR partners. In an effort to improve coordination and the sharing of information among partners, TB CAP organizes and supports quarterly coordination meetings. The first meeting was held on 3 September 3 2009 and the second meeting on 11 December 112009. The meetings provide an opportunity for Ministry of Health officers from the AIDS and TB control programmes to share with the partners what the ministry would like them to improve or support, and to provide updates on new information or revised materials or guidelines. PEPFAR partners supporting TB/HIV activities, as well as USAID and CDC officers, are represented in the coordination meetings

During the meetings, the representative of the MoH programmes shared information on the performance of national TB/HIV collaborative and TB control activities. It was noted that despite the multiple in-country partners who are supporting TB and TB/HIV activities, the NTLP had not yet achieved the WHO and national targets for TB control, namely a case detection rate of 70 percent and a treatment success rate (TSR) of 85 percent. Nationally in 2008, the CDR was 56.7%, and the TSR was 74.5%. The number of patients on DOTS is unacceptably low. In addition, the number of TB patients tested for HIV was relatively low (58%), and those who were co-infected with HIV and were receiving Cotrimoxazole Preventive Therapy was still sub-optimal (59%). Intensified TB case finding among PLHIV and implementation of TB infection control measures in HIV clinics and other HIV congregate settings was still inadequate as well. The poor performance was partly attributed to the failure of partners to use existing MoH data collection tools, as they tended to support separate management information systems that were parallel from the MoH.

Partners were informed that failure to use existing MoH registers and tools leads

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Greetings!

Happy New Year!

We are pleased to bring you the 1st Issue in the year 2010.

In this issue, we highlight the support provided to partners through TB CAP and the recommendations agreed upon by all PEPFAR partners to improve the harmonization of the support provided to districts and the Ministry of Health.

We wish to thank all the partners that have contributed articles to this newsletter. As a reminder partners supporting and or implementing TB/HIV activities are invited to share their stories through this newsletter. Please direct all articles, comments and questions to bnabaggala@theunion.org.

Thank you for taking the time to read this newsletter.

DR. ANNA NAKANWAGI – MUKWAYA
Chief of Party
TB CAP

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to under-reporting of implementation of TB and TB/HIV service delivery nationally. They were informed about the need to harmonize their data management systems with those of the MoH throughout the country so as to capture and report data on TB and TB/HIV activities and stop the use of parallel systems for reporting data.

The MoH also shared that most of the PEPFAR partners providing TB and TB/HIV support were not coordinated at the district level or at the health facilities where they operate. The failure of partners to coordinate their activities had led to a duplication of services and poor use of resources that would have otherwise been used to help improve national performance.

It was noted that a coordinated response was needed by all stakeholders especially in regard to joint planning, implementation, monitoring and sharing of information between HIV and TB programmes at all levels of service delivery. Different approaches to improve partner coordination were recommended; they included mapping out the partners in different districts and facilities and supporting coordination meetings among partners at district and facility levels.

Partners were further informed that it was critical for them to align and support TB and TB/HIV activities within the framework of the Uganda National Health Plan, the Health Sector Strategic Plan, the NTLP policy guidelines and strategic plan. It was recommended that partners' support should focus on:

- building and strengthening capacity of all public and private health providers involved in TB care and TB/HIV collaborative services using existing MoH training materials and guidelines;
- integrated TB/HIV support supervision that involved regional supervisors from the MoH and partners within the districts that they operated in;
- supporting communities to provide care for TB and co-infected patients to adhere to treatment;
- infrastructural support, especially with regard to equipping and improving laboratory capacity and supporting external quality assurance (EQA) activities;
- support for the printing, distribution and use of tools and IEC materials;
- support for the process of finalizing the development of the national TB guidelines and TB infection control policy;
- garnering support for MDR-TB.

Furthermore, it was recommended that partners support the AIDS and TB control programmes by encouraging districts to recruit more health staff especially in sites with high patient loads, so as to improve the quality of services.

At the end of these meetings, it was agreed that:

- Partners adopt and start using MoH data collection tools and report to MoH according to schedules. In cases where partners did not find this feasible, they were to consult with the MoH. To date, most partners have adopted the MoH data collection and reporting tools.
- TB CAP supports the mapping of PEPFAR partners involved in TB/HIV services to determine location and supported activities in the various sites in the districts. TB CAP has so far supported the development of a database for all TB/HIV partners, and this has been shared with MoH and partners for their input and feedback.
- Partners be involved in integrated TB/HIV supervision with the MoH teams in the different regions in the country, partners be oriented on the MoH tools for integrated TB/HIV supervision. So far, four of the nine zones have been supervised by MoH and partners.
- TB CAP conduct a needs assessment for the remaining CDC and USAID partners that have not been assessed, so as to determine the specific needs for each partner.
- Partners write up best practices within their sites, so that they can be shared in the next coordination meetings.
- MoH TB zonal and HIV regional officers send regular feedback to all partners about performance in their supported districts/sites to enable partners focus their support and interventions based on needs.
- The routine technical support supervision implemented by partners to continue and use the bi-annual integrated supervision as an opportunity for learning and sharing of experiences, from partner's activities and to inform MoH about progress and compliance from partners.
- Partners to prioritize and promote the implementation of TB infection control and intensified TB case finding (ICF), in their sites as it is a priority gap for HIV programmes.
- TB CAP to facilitate partners to obtain access to the soft copies of the MoH newly revised pre-ART, ART registers, and HIV and TB care cards, as well as the reporting formats. The partners who lacked these tools have received them.

Dr. Hudson Balidawa from the AIDS Control Program during 1st partners' coordination meeting (3rd Sep, 09)

NTLP Program Manager, Dr. Adatu Francis (far right) addressing partners during 2nd coordination meeting (11th Dec, 09)

The Need to Accelerate TB Infection Control Measures in Health Facilities in Uganda

By National Professional Officer TB/HIV, WHO

One person dies of tuberculosis (TB) every 18 seconds worldwide and it is estimated that 2 billion people are infected with TB. Even more worrying is the observation that there is also an increasing association between HIV and multidrug-resistant (MDR) TB and extensively drug-resistant (XDR) TB.

Transmission of TB is associated with inhaling TB germs from an infectious source (usually a person with TB of the lungs or larynx). The risk of TB transmission increases in places where there is close proximity to an infectious source who is sputum smear positive; poor ventilation and prolonged exposure. Research has shown that health facilities, households and congregate settings are associated with higher incidence of TB than in a general population. In these places there is usually overcrowding and associated prolonged exposure to the TB germ. This calls for urgent action to institute TB infection control measures in these settings. The World Health Organization (WHO) produced guidelines for TB infection control in 1999and 2006. In 2009, a policy was developed to guide countries on how to set up interventions for controlling TB transmission.

Uganda is one of the 22 high TB burden countries which have been implementing the Direct Observed Treatment Short-course (DOTS) strategy to control TB. MDR-TB cases in the country are said to be increasing, although the actual magnitude of this problem is still unknown.

Although there are efforts to control general infection transmission in health facilities, not much emphasis has been placed on TB infection control, and therefore not much has been done. But with support from partners, the Ministry of Health is in the process of adopting the WHO TB infection control guidelines. The National TB/Leprosy Programme and the AIDS Control Programme are taking the lead. Partners involved in the process of adopting the guidelines include:

- Makerere- Mbarara Joint HIV/AIDS Programme (MJAP)
- Regional Centre for Quality of Health Care in Africa (RCQHC)
- Uganda Prisons
- Traditional Healers and Health Practitioners Against HIV/AIDS (THETA)
- Tuberculosis Control Assistance Programme (TB CAP)/ The Union
- Uganda Peoples Defence Force (UPDF)
- WHO Country Office Uganda

So far, a draft version of the new TB infection control guidelines document is in place.

The guidelines highlight a combination of measures aimed at minimizing TB transmission. The interventions, categorized into three levels, are based on early and rapid diagnosis and proper management of TB patients.

Some of the guidelines at different levels include:

Organisational (managerial) activities

- Identify and strengthen coordinating bodies and develop a comprehensive facility plan for implementation
- Rethink the use of available spaces and consider renovation of existing facilities or construction of new ones to optimise implementation controls
- Conduct on-site surveillance of TB among health workers and assess the health facility for risk of transmission of TB
- Address advocacy, communication and social mobilisation (ACSM) for health workers, patients and health facility visitors
- Monitor and evaluate the set of TB infection control measures in the TB infection control plan
- Enable and conduct operational research

Administrative controls

- Develop strategies to promptly identify potentially infectious cases (triage), separate them, control the spread of pathogens (cough etiquette) and minimise time in health care settings
- Provide a package of prevention and care interventions for health workers, including HIV prevention, antiretroviral therapy, Isoniazid preventive therapy (IPT) for HIV-positive health workers

Environmental controls

- Use ventilation systems (natural ventilation and mechanical ventilation)
- Use ultraviolet germicidal irradiation (UVGI) fixtures, at least when adequate ventilation cannot be achieved

At personal level

- Use particulate respirators

TB CAP Supports the Scale-up of PEPFAR Implementing Partners' TB/HIV training

By The Union Uganda / TBCAP team

A needs assessment was carried out by TB CAP from February to April 2009, and the main objectives were

- To understand what partners were doing in regard to TB and TB/HIV activities
- To assess partner performance in TB and TB/HIV activities
- To identify partner needs/gaps in TB and TB/HIV activities
- To establish a baseline before technical assistance

One of the key findings of this needs assessment was that most health workers in partner-supported districts and implementing sites had not been trained on TB/HIV collaboration and TB infection control services. Training had not taken place primarily because technical staff in the partner organizations had not been trained as trainers for TB/HIV co-management, including TB infection control. This meant that they had to wait for the few Ministry of Health (MoH) trainers to support them during their trainings.

In light of the above, TB CAP collaborated with MoH's TB and AIDS Control Programmes to embark on the training of trainers (ToT) in the partner organizations. Two ToT workshops were held, and a total of 52 participants were trained from the following partner organizations; Joint Clinical Research Centre (JCRC), AIDS Information Centre-(AIC), Inter-religious council Uganda (IRCU), Northern Uganda Malaria, TB and AIDS project (NUMAT), Mildmay Uganda, Strengthening Tuberculosis and AIDS Response (STAR)-East project, STAR East Central, The AIDS Support Organization (TASO), Health Care Improvement-(HCI), Research Triangle International (RTI), Mbuya Reach-Out, Mulago-Mbarara University Joint AIDS Programme (MJAP) AIDS Relief, and Health Initiatives for Private Sector (HIPS).

The goal was for each partner to establish a team of trainers that would cascade the training of health workers in their supported health facilities. The trainees were selected primarily because they were technical officers involved in supervision and training activities within the different organizations. The CDC teach-back methodology was used because it allows participants to gain hands-on training skills and get constructive feedback from both their peers and the faculty. The standardized and recommended MoH training materials for the TB/HIV co-management course were used.

Team of trainees, faculty and MoH officials who participated in the 1st ToT for partners

Following the ToT, participants from each partner organization drew up a training action plan to guide them in scaling-up the training of health workers throughout their supported districts/facilities. In addition to training other health workers, this was seen as an opportunity to put into practice the training skills gained from the ToT. Between July and September 2009, TB

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TB CAP Supports the Scale-up....

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CAP conducted follow-up support visits to some of the trainees from all the partner organizations. The main objectives of the follow-up visits is to assess the training skills of trainees as they facilitate the trainings; boost morale of trainees; and provide support on technical issues related to TB.

To date, 167 health workers have been trained in TB/HIV co-management and TB infection control in the partner-supported districts and at operation sites. .
The trainees have had remarkable experiences during the trainings they have conducted and have future plans to continue scaling-up training.

Participants and facilitators during the 2nd ToT for partner organizations

Representative from (L-R) ACP, NTLP and the Chief of Party TBCAP awarding certificates to trainees

ToT Trainees Talk About Their Experiences Conducting Training

Ms. Kyomugisha Sarah

Sarah facilitating in a training supported by AIC in Wakiso district

Sarah facilitating in a training for health workers in Kawempe Division , Kampala

Dr. Mary facilitating during the training

A section of participants during Mary's sessions

Following the training, Ms. Sarah Kyomugisha became involved in conducting two workshops on TB/HIV co-management during which she and her team trained over 40 health workers in Wakiso and Kawempe. She says she was tense and worried when she was about to begin training others for the first time. But she soon found that her fears were unwarranted. She shares her experience below:

"The training went on well, and all the trainers turned up which was good. I always had with me my slides which were well organized. I also made sure that I was early enough for each day's presentation".
"The trainees were very happy with the training and wished to have other similar sessions. The training was successful because the lowest score in the pre-test was 10% compared to the lowest score in the post- test of 60% which was well above average, and showed that knowledge had been imparted".

She has now gained valuable experience in conducting the TB/HIV trainings and cannot wait for the next opportunity.

Dr. Mary Abwola Olwedo

Following the ToT supported by TB CAP, JCRC conducted training for health workers from their supported satellite and regional sites in the eastern region. The training faculty comprised all four members from JCRC who had undergone the ToT. Mary is JCRC'S Manager for the Mbale Regional Centre of Excellence. She remarked that the ToT imparted knowledge and skills that prepared her for the trainings that she later facilitated in her region. She conducted training in Eastern Uganda, and she shares her experience below:

"I was well prepared to conduct the training exercise, since I knew the training materials well and was organised and relaxed", said Dr Abwola. "I was audible enough to all and used different kinds of questions both open-ended and probing. During my sessions, I felt in control of the class which consisted of my peers and colleagues. I was able to employ techniques I learnt during the ToT to involve my class as I encouraged participants to make contributions and also kept time".

Experience from NUMAT: Scaling-up TB/HIV training in the Northern Region of Uganda

TB CAP in collaboration with NTLP supported the Northern Uganda Malaria AIDS and TB-NUMAT programme to join other partners for a ToT in TB/HIV co- management and TB infection control. The session trained eight trainers from NUMAT-supported districts. These included five districts health workers and three NUMAT technical officers. Since attending the ToT, to date, the trained district health workers with support from NUMAT and TB CAP have trained 118 health workers from the districts of Gulu, Amuru, Dokolo and Amolatar in TB/HIV co-management and TB infection control. This was possible because, with eight trainers, it was feasible to conduct concurrent trainings. The trainings will continue until all NUMAT-supported districts are covered.

However, challenges still occur:

- Limited human resources at the district level: This has led to the district trainers carrying more than one responsibility and making them unavailable to conduct any training.
- High staff turnover: Because of relatively poor living conditions in the north, there is a high turn over of staff, including the trainers. This reduces the training capacity in the zone.

Participants in a role play, during the TB/HIV training for health workers in Amolatar and Dokolo district

Dr. Erisa (NUMAT) a trainee from the ToT, conducting a session during training of health workers

Strengthening DOT for TB/HIV patients: The experience of a Clinic Support Agent from Mengo Home Care

By Mpamulungi Ruth; Mengo Bakuli-Kampala City; namulema@yahoo.com

A client whom I will only refer to as BR is dually infected with HIV and tuberculosis (TB). He was first diagnosed with HIV in April 2009; and later developed pulmonary TB while seeking care from Mengo Hospital. As a Clinic Support Agent (CSA), I have been trained about TB and TB/HIV and the need to follow-up TB patients in the community to ensure that patients are taking TB medication under directly observed therapy (DOT). In addition it is the role of the CSA to support patients who are co-infected to adhere to the prescribed TB and ARV drug regimens.

I obtained BR's address from the TB officer at Mengo Hospital. This information was clearly documented and mapped in the address tracking form. I got in touch with him by telephone to request permission to pay him a home-visit, which he willingly granted.

I set out to visit BR in the slummy area of Bakuli, where many houses are congested in one area. This made it rather difficult to locate the house. However, we eventually met, and I introduced myself as a CSA from Mengo Hospital. During my visit, I informed BR that the purpose of the visit was to provide psychosocial support, as well as follow-up on his adherence to TB and ARV drugs. As we talked I learned that BR had informed his family about his TB condition, but he had not yet disclosed his HIV status to his wife or any family member. BR did not have a treatment supporter.

Through continuous counseling, BR eventually disclosed his HIV status to his wife, who agreed to act as his treatment supporter for both his TB medication as well as the ARVs for HIV treatment. His wife was encouraged to take an HIV test, and she was found to be HIV negative. BR's wife was educated about the importance of supporting her husband to take his treatment daily, which included those for TB, Septrin for prevention and ARVs. She was also informed about the importance of filling in the patient TB card whenever he took his TB medication. They were also offered counseling about HIV prevention for discondants.

Because BR was still in his initial phase of TB treatment, I visited him two times a month to ensure that he was taking his drugs properly and at the right time.

After a series of counseling visits and with support from the family members, BR's wife is now supporting him well. He has shown some improvement, especially since starting TB treatment and ARV. His CD4 count has risen from 17 cells to 84 cells in (over) 6 months. His sputum test results at two months were negative.

BR, who was bedridden for two months, is now working. Meanwhile, the rest of the family members have been assessed for TB and his wife's brother was found to be sputum positive for TB. This man has been enrolled for TB treatment, undergone HIV serology testing, and received his HIV test results.

I have encouraged the family and the household and provided health education regarding TB infection control, especially the importance of having good cough etiquette and proper ventilation.

We would like to thank USAID through The Union/ TB CAP for supporting the TB-DOT activities and IRCU for supporting the HIV prevention and care services.

A team of CSAs visiting a TB patient (sitting on chair) with The Union/TB CAP team

The Union and IRCU team meeting with Mengo Home-based care team (includes nurses, CSAs, and doctor)

MJAP Supports TB Diagnosis and Treatment Monitoring in Districts

By PRO - MJAP

Over 50 light microscopes have been given to more than 48 regional, district and lower-level laboratories in Jinja, Masaka, Soroti, Hoima, Fort Portal. This is in support of the MoH National Tuberculosis and Leprosy Programme (NTLP) strategy for the areas in which the Mulago Mbarara Teaching Hospitals Joint AIDS Programme (MJAP) regional referral hospitals programme operates.

Since 2004, MJAP has been a supporting health facility to implement TB/HIV integrated services with funding from the US President's Emergency Plan for AIDS Relief (PEPFAR) through the Centre for Disease Prevention and Control (CDC). MJAP is one of the key players in HIV/AIDS treatment and care programmes in Uganda, providing HIV care to more than 40,000 patients.

In 2006, MJAP started a programme to expand TB/HIV integrated services in Uganda. These integrated services are currently offered in Mulago national referral hospital, as well as in Mbarara, Masaka, Jinja, Hoima, and Mbale regional referral hospitals. In these facilities, patients with HIV are routinely assessed for TB, while those with TB are routinely offered HIV counseling and testing. Those found with TB/HIV co-infection are provided with TB/HIV co-management and care in specialized TB/HIV clinics.

TB is a leading cause of death in Uganda especially for people living with HIV/AIDS, yet in many of them, the diagnosis of TB is not made in time, resulting in unnecessary deaths from this curable condition. The primary method of diagnosing TB is by using a light microscope to examine the sputum of patients with symptoms of TB. However, in many of the peripheral health units-serving the rural communities, these microscopes are either not functional because of their poor mechanical condition or not available at all. Therefore patients do not get diagnosed in time for TB treatment, and this increases their chances of being killed by the disease.
In addition, most rural health centers do not have sufficient laboratory staff, so MJAP is supporting districts to train microscopists as laboratory staff. These staff will subsequently be deployed to the peripheral units so that the microscopes that have been provided can be fully utilized. This will increase access to TB diagnosis, treatment monitoring and other laboratory services in these communities.
In a related development, all hospitals implementing TB/HIV integrated services received bio-safety hoods to protect laboratory staff from acquiring TB as they process the TB slides for diagnosis and treatment monitoring.

Dr. Simon TB/HIV Coordinator (MJAP) during handover of Microscopes to district officials in Masaka.

A laboratory technician working on samples in the bio-safety cabinet hood in a regional hospital.

Strengthening Laboratory Capacity of the Nsambya Home Care TB Programme

By Mayanja Simon, Assistant Coordinator (simonmayanja@yahoo.com)

Interior of old laboratory for Nsambya Home-Care

Exterior of old laboratory (inset, lab personnel giving results to patient through window) located in patient waiting area

Nsambya Home Care HIV programme has been in existence since 1987. It started as a mobile HIV unit that was intended to relieve congestion in the medical wards at St. Francis, Nsambya Hospital. Due to the increasing number of HIV clients, it was later upgraded to a fully-fledged department offering comprehensive HIV care and treatment services.

In 2004, the Nsambya Home Care programme was boosted further with support from AIDS Relief, a PEPFAR-funded programme through a grant from CDC to Catholic Relief Services to start providing the life-saving ARV drugs. Close to 4,000 patients are currently active on ART while there are also approximately 7,500 in general HIV care. Through this new support, Nsambya Home Care was able to receive more HAART, equipment and infrastructural support, which included a new building block that housed office space for staff working in the home-based care unit and clinic space.

A TB clinic was also started at the new home-care complex specifically to address the new TB cases that were being identified from the HIV care and

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treatment clinics. However, although TB patients were receiving treatment from Nsambya Home Care, they had to be referred to the main hospital for sputum analysis for purposes of diagnosis.
Visiting the main hospital meant that patients had to incur costs for sputum tests as they were charged for fees. In response to this challenge, Nsambya Home Care decided to convert a small room to act as a mini-laboratory for sputum analysis for the HIV patients, so that TB suspects and patients would access TB diagnosis at no cost. This laboratory also served as an HIV testing site.

In 2005-2006, the TB clinic from Nsambya Hospital was transferred to the home-care programme. This meant that all TB patients and suspects were now to be managed under the Nsambya Home Care TB clinic. This came along with a lot of challenges in terms of limited space, overcrowding and issues of infection control.

In 2008, the National TB and Leprosy Programme Manager visited the unit and recommended that the team consider setting up a larger TB laboratory to cater to the high patient load and shift the position of the laboratory to a place that reduced TB infection transmission. Through discussions with the NTLP and TB CAP, an agreement was reached to support Nsambya Home Care with a well furnished laboratory that would be located and attached to the new TB clinic building. In 2009, TB CAP supported the renovation of this new more spacious laboratory.

Through this support, the TB suspects whether HIV positive or not are now able to access free TB diagnostic services in a comfortable and convenient area. Because the new laboratory has adequate space, biochemical tests, CD4 and viral loads are now carried out in this new laboratory, so that HIV patients do not have to visit the hospital to access them. TB infection control measures are now better instituted in the home-care complex since coughing patients are separated and sent to the TB laboratory immediately for early diagnosis. Over 70 new TB patients are identified and receive care per month from this new unit.

Exterior of Newly renovated laboratory of Nsambya home care

Inside of the new Newly renovated laboratory in Nsambya Home Care.

Upcoming EVENTS

1	Stop TB partnership meeting, 21st January 2010.
2	World Leprosy day, 31st January 2010.
3	NCC meeting, 18th February 2010.
4	World TB day, 24th March 2010. Slogan: “On the move against Tuberculosis Innovation to accelerate action” (http://www.stoptb.org)

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