

2012

**[18 MONTHS PROGRESS REPORT
FOR THE R8 TB GRANT
OCTOBER 2010-MARCH 2012]**

PR-MINISTRY OF FINANCE AND DEVELOPMENT PLANNING

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ABBREVIATIONS

ACSM-	Advocacy Communication & Social Mobilisation
AIDS -	Acquired Immune Deficiency Syndrome
ART -	Antiretroviral Therapy
ARV-	Antiretroviral
CBO-	Community Based Organizations
CCM-	Country Coordinating Mechanism
CFCU-	Global Fund Coordinating Unit
CHAL-	Christian Health Association Of Lesotho
CHWs -	Community Health Worker
DSW-	Department of Social Welfare
DOTs-	Direct Observed Therapy-Short Course
GFATM -	Global Fund To Fight AIDS, TB and Malaria
GOVT-	Government
H.S.A-	Health Service Area
HCWs-	Health Care Workers
HIV-	Human Immunodeficiency Virus
HSS-	Health Systems Strengthening
HTC-	HIV Testing and Counseling
IEC-	Information, Education and Communication
LDHS-	Lesotho Demographic and Health Survey
MDR/TB-	Multi- Drug Resistance Tuberculosis
M&E-	Monitoring and Evaluation
MOFDP-	Ministry of Finance and Development Planning
MOHSW-	Ministry of Health and Social Welfare
PIH -	Partners In Health
PTB-	Pulmonary Tuberculosis
PR-	Principal Recipient
SRs-	Sub Recipients
STIs-	Sexually Transmitted Infections
TA-	Technical Assistance
TB-	Tuberculosis
TVD-	Department of Vocational & Technical Training
WHO-	World Health Organization

EXECUTIVE SUMMARY

This report reflects on progress made in the implementation of the Round8TB grant over the past 18month's i.e. from October 2010 to March 2012. The compilation of this report entailed a desk review of the progress reports and consultations with various implementers of the grant.

The reported constitutes four chapters, chapter one looks at the introduction, background information as well grant activities of the grant. Chapter two dwells on the programmatic performance of the grant. Financial performance of the grant is presented as chapter3. Challenges, recommendations and conclusion are discussed in chapter four of the report

At the end of 18 months of implementation, the main achievements of the grant were as follows:

- Improving and expanding drug sensitivity testing and the diagnostic capacity across the country with the procurement of MGIT 960 analysers for the National Reference Laboratory, and procurement of 5 iLED microscopes for district laboratories in high TB-burden regions (Maseru, Mafeteng and Leribe);
- Scaling up the national, community level MDR- TB programme to reach 700 ever enrolled adults and children with treatment and support. This was achieved through a partnership agreement between the MOHSW and Partners in Health. Most MDR TB patients were treated in their home community with the assistance of a full-time, one-on-one treatment supporter. MDR TB patients received food packages, psycho-social support, and, where required, temporary accommodation to ensure their adherence to the MDR TB treatment regimen;
- Construction of the three regional hospitals for the inpatient care of individuals with MDR- TB;
- Enhancing the knowledge and skills of health care workers MDR-TB through training.
- Awareness raising and TB screening amongst high-risk populations, in particular inmates in Correctional Institutes
- Improving adherence to infection control standards within hospitals through supportive supervision; and,
- Strengthening the management capacity of the NTP through the recruitment of critical human resources for the programme.

1 CHAPTER ONE: OVERVIEW AND BACKGROUND AND GRANT ACTIVITIES

1.1 OVERVIEW AND BACKGROUND

The main goal of the grant is to reduce the burden of MDR/XDR-TB by providing universal access to high quality diagnosis and patient-centered services in line with Global Plan to Stop TB targets. The grant contributes in the provision of quality MDR-TB diagnosis and treatment to all patients regardless of HIV status, age, gender, sexual orientation, or country of origin in both the civilian and penitentiary sectors.

Four(4) objectives identified under the grant are the following; a) pursue high quality DOTS expansion and enhancement through improved case detection, quality- assured bacteriology and treatment for basic TB, b) to address MDR/XDR-TB, TB/HIV and other challenges to making management and prevention of drug resistant TB a routine component of TB control, c) to empower people with TB and communities and provide continuum of patient-centered care through community-based systems and d) to enable and promote research on MDR/XDR-TB to develop national capacity for evidence generation that will inform national and international policy and practices.

Twelve(12) SDAs guide the implementation of interventions and these are; improving diagnosis for timely diagnosis and treatment of TB in general but specifically MDR/XDR-TB; patient support which entails provision of psychological support, food packages, transportation to help patients to overcome the barriers to care; procurement and supply management of second line drugs, monitoring and evaluation with impact measurement, management and supervision, training of health care workers on MDR/XDR-TB/HIV management, prevention, management and control of MDR/XDR-TB, address high risk groups, infection control to prevent transmission of TB in health care and congregate settings, Advocacy Communication and Social Mobilization, community TB care and operational research.

The main interventions of the grant are geared towards strengthening MDR/XDR-TB diagnosis and treatment follow up through establishment of second-line DST at the national TB reference laboratory, detecting and managing 2562 MDR-TB cases according to WHO/GLC protocols, increasing awareness of policy makers and general population on TB, HIV and MDR-TB through ACSM and building the national research capacity to implement programme-based operations research

1.2 GRANT ACTIVITIES

1.2.1 OBJECTIVE 1: PURSUE HIGH QUALITY DOTS EXPANSION AND ENHANCEMENT THROUGH IMPROVED CASE DETECTION, QUALITY- ASSURED BACTERIALOLOGY AND TREATMENT FOR BASIC

Interventions under this Objective were to be implemented under the following six service delivery areas: 1) Improving Diagnosis 2) Patient Support 3) Procurement & Supply Management 4) Monitoring & Evaluation 5) Management and Supervision 6) Human Resource Development

Activities to be carried out under SDA one included procurement of one MGIT analyzer for second line DST and second line DST. The second activity under this SDA entailed conducting laboratory QA supervisory visits to strengthen national QA system for AFB microscopy and culture services, Maintaining External QA (EQA) activities with Supra National Reference Laboratory (SNRL)- MRC South Africa, Transportation of sputum samples from districts laboratories to NRL for culture and DST. The third activity under this SDA entailed procurement of 5 LED microscopes for 5 high TB case load Hospitals as part of strengthening microscopy services

Under Patient Support activities to be carried out included provision of treatment adherence food packages to MDR/XDR-TB, temporary accommodation to MDR/XDR-TB patients, transport fare to needy MDR/XDR-TB patients and psychological support to MDR/XDR-TB patients.

Activities to be carried out under Procurement and Supply Management incorporated: refurbishment of existing Central MDR/XDR-TB pharmacy to increase storage capacity of the second line anti-TB drugs, procurement of freezers for storage of PASER and Insulated Medicines bag.

Activities to be carried out under Monitoring and evaluation were geared towards strengthening routine MDR/XDR-TB surveillance by procurement of computers to strengthen routine MDR-TB surveillance and Maintaining international service and Technical Assistance (TA) agreement for ETR.Net

Main activities under Management and Supervision included; maintaining TA to NTP, recruitment of a laboratory Consultant (TA), 2 Medical Officers to strengthen NTP management capacity. 2 Medical Officers, 4 nurses, 4 nurse assistants for the central MDR/XDR-TB Hospital, 10 Community Nurses and 7 drivers. Quarterly Programme coordination and review meetings with technical partners and districts were also planned as well as participation in Cross-border collaboration meetings by the NTP. The fifth Activity under this SDA focussed on printing and disseminate MDR/XDR-TB and Community-TB Care (CBTC) guidelines. The sixth Activity under this SDA is to strengthen supervision at central and community level by conducting clinical supervisory support visit, Procure 7 vehicles to strengthen Central level supervision,

Under Human Resource Development the main activities incorporated training of two NRL laboratory on second line DST to improve diagnosis of MDR/XDR-TB, training of existing health workers on MDR/XDR-TB clinical management. training newly recruited MDR/XDR-TB Hospital Staff and TB Coordinators, TB Officers and Health facility staff on new TB Policy.

1.2.2 OBJECTIVE 2: TO ADDRESS MDR/XDR-TB, TB/HIV AND OTHER CHALLENGES

Three SDAs were identified to guide implementation under this objective; 1) Prevent, manage and control MDR/XDR-TB, 2) Address high risk groups and 3) Infection control

Main activities under the first SDA included procurement of second line drugs, undertaking serial laboratory monitoring tests on MDR/XDR-TB patients, expanding MDR/XDR-TB hospitalization capacity by Refurbishing MDR/XDR-TB ward at Bots'abelo and 3 TB wards in 3 District hospitals, procurement of back-up power generators for MDR/XDR-TB wards, furniture for the renovated MDR/XDR-TB wards as well basic equipment for TB clinics.

Main activities targeting high risk groups entailed; building consensus on addressing TB in high populations through Stakeholders consultations meetings, conducting mapping of MDR-TB among miners and ex-miners and screening of high risk groups (household contacts of MDR/XDR-TB cases, prisoners).

Under infection control main activities comprised of sensitization meetings on infection control, development of national infection control policy and guidelines through working group meetings, procurement and installation of ventilation system at Bots'abelo and the three regional sites, procuring and installing Ultraviolet Germicidal Irradiation (UVGI) lights in 18 District hospitals, provision respirators to health care workers and patients and sharps containers for use at community level.

1.2.3 OBJECTIVE 3: TO EMPOWER PEOPLE WITH TB AND COMMUNITIES

Two SDAs were identified to direct implementation of activities this objective and these are, 1) Advocacy, communication and social mobilization 2) Community TB care

Activities under the first SDA included development of appropriate TB advocacy and communication packages targeting MDR/XDR-TB, engagement of TA for IEC material development, conducting advocacy meetings with key stakeholders on TB/HIV.

Under Community TB care the key interventions identified included training of community treatment supporters for MDR/XDR-TB treatment and provision of incentives to the community treatment supporters.

1.2.4 OBJECTIVE 4: TO ENABLE AND PROMOTE RESEARCH ON MDR/XDR-TB

Operations research was the only SDA for objective four. Two activities were identified under these SDA namely; programme-based operations research and training of Programme staff on research methods.

2 CHAPTER TWO: PROGRAMMATIC PERFORMANCE

2.1 PROGRAMMATIC PERFORMANCE

The programmatic performance of the grant covers the period from October 2010 to March 2012. The overall rating on the programmatic performance of the grant is B1 which is defined as adequate. The current performance demonstrate a significant improvement compared to the previous rating of C which defined as unacceptable.

2.1.1 OBJECTIVE ONE: PURSUE HIGH QUALITY DOTS EXPANSION AND ENHANCEMENT THROUGH IMPROVED CASE DETECTION, QUALITY- ASSURED BACTERIALOLOGY AND TREATMENT FOR BASIC

2.1.1.1 IMPROVING DIAGNOSIS

The aim of this SDA is to increase access to timely quality diagnosis and treatment of TB in general and specifically MDR/XDR-TB. Two performance indicators are used to monitor performance under this SDA .

Service Delivery Area	Indicator description	Intended target by March 2012	Achieved results March 2012	Percentage achievement
Improving diagnosis	# of second line DST tests performed locally	864	0	0%
Improving diagnosis	% of laboratories showing adequate performance among those that received external quality assurance for smear microscopy	90%(15)	6(35%)	40%

Two MGIT 960 analyzers were procured however installation of these analyzers is still awaiting completion of the construction of the new Multipurpose National Laboratory, which has the TB National Reference Laboratory as an integral component. The Laboratory is expected to be functional by end of May 2012. The Laboratory will be accredited before it becomes operational. In addition the procurement of Reagents and consumable to do second line DST was on hold pending accreditation of the Laboratory as they have very short shelf lives. Therefore the second line DSTs have not yet been done locally hence performance on the affected indicator is 0%.

As part of capacity building for the DST, two laboratory technologists have already undergone training at MRC Pretoria on the second line DST. The officers will be responsible for performing the tests when the laboratory is operational.



Caption: MGIT Analyzer

EQA helps to assure customers, such as physicians, patients, and health authorities, that the laboratory can produce reliable results. Individual laboratories can use EQA to identify problems in laboratory practices, allowing for appropriate corrective action. EQA participation helps to evaluate reliability of methods, materials, and equipment, and to evaluate and monitor training impact.

Efforts were made to strengthen the national quality assurance microscopy and culture services in the Laboratories through the EQA supervisory visits by The National Reference Laboratory to the 17 peripheral laboratories.

During the supervisory (support) visit, the supervisor performs what is called Random blinded rechecking (RBRC) and this is a process of rereading a sample of slides from a laboratory to assess whether that laboratory has an acceptable level of performance in smear reading.

By end of year one of the grant EQA supervisory visits were conducted for eight laboratories by the Laboratory Department within MOHSW. Three(3) facilities showed adequate performance from the eight(8) that received supervision. By end of 18 months period 16 laboratories were visited and 6 laboratories namely Maluti Hospital, Machabeng, Mafeteng, Mohales Hoek, Seboche St James, laboratories showed adequate performance. The inadequate performance of the other laboratories was mainly due to poor specimens that were collected and these has already been emphasized to the clinical staff especially TB Officers to improve efforts on ascertaining quality specimen collection.

Scoring Scheme for AFB smears during support supervision

Name of laboratory	Evaluat	Number of	Smear	SCORE %
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		ed (yes/no t)	smears evaluated	results	Smear Quality (WBC present on the smear ≥10)**	Smear Size 2cm (length x 1cm width)	Smear Thickness	Smear Staining	Smear Evenness	Average score % (Target = 80%)
1.	BEREA	Yes	9	9/9 (100%)	4/9 (44%)	7/9 (78%)	4/9 (44%)	8/9 (89%)	6/9 (67%)	70
2.	BUTHA BUTHE	yes	9	9/9 (100%)	5/9 (55%)	7/9 (78%)	7/9 (78%)	8/9 (89%)	6/9 (67%)	78
3.	MACHABENG	yes	8	8/8 (100%)	6/8 (75%)	8/8 (100%)	6/8 (75%)	8/8 (100%)	6/8 (88%)	90
4.	MAFETENG	yes	9	9/9 (100%)	7/9 (78%)	7/9 (78%)	6/9 (67%)	9/9 (100%)	6/9 (67%)	82
5.	LERIBE	yes	9	8/9 (89%)	5/9 (55%)	6/9 (67%)	8/9 (89%)	7/9 (78%)	6/9 (67%)	74
6.	MALUTI	yes	9	9/9 (100%)	9/9 (100%)	9/9 (100%)	9/9 (100%)	9/9 (100%)	9/9 (100%)	100
7.	MAMOHAU	no								
8.	MOHALES' HOEK	yes	8	8/8 (100%)	6/8 (75%)	8/8 (100%)	7/8 (88%)	8/8 (100%)	7/8 (88%)	92
9.	MOKHOTLON G	Yes	17	17/17 (100%)	9/17 (52%)	11/17 (64%)	12/17 (70%)	15/17 (88%)	13/17 (76%)	75
10.	QUTHING	yes	8	8/8 (100%)	6/8 (75%)	6/8 (75%)	6/8 (75%)	7/8 (88%)	5/8 (63%)	79
11.	PARAY	yes	9	9/9 (100%)	4/9 (44%)	8/9 (89%)	8/9 (89%)	9/9 (100%)	7/9 (78%)	77
12.	SCOTT	no								
13.	SEBOCHE	yes	8	8/8 (100%)	8/8 (100%)	8/8 (100%)	8/8 (100%)	8/8 (100%)	8/8 (100%)	100
14.	ST. JAMES	yes	100	100/100 (100%)	70/100 (70%)	74/100 (74%)	86/100 (86%)	100/100 (100%)	89/100 (89%)	87
15.	ST. JOSEPH'S	no								
16.	TEBELLONG	yes	8	8/8 (100%)	6/8 (75%)	5/8 (63%)	5/8 (63%)	5/8 (63%)	5/8 (63%)	71
17.	CENTRAL TB LAB	no								

Note:

- *****It should be noted that quality of specimen is dependent on the collection of specimen (which is outside laboratory control), yet it influences the preparation of smears and the results.***
- ***For laboratories that are highlighted in black, they were not visited***
- ***For St. James laboratory smears were read at Central TB and results confirmed telephonically.***

DHL has been contracted to transport sputum samples from the districts laboratories to the NRL for culture and Drug Susceptible Testing. It transports samples on a weekly basis from all district laboratories in the country to the National Reference Laboratory.

Furthermore five Light Emitting Diode microscopes were procured and distributed to high burdened districts namely Leribe (2), Mafeteng(1) and Maseru(2). These microscopes are meant to increase detection of infectious TB and reduce diagnostic delays and the expected outcomes includes sustenance TB case detection rate above 70%, improvement of treatment success rate to 85 % for newly detected smear positive cases and achieve at least 60% treatment success rate for MDR-TB cases.



Caption: LED Microscopes were procured to speed-up work in high burden hospitals.

2.1.1.2 PATIENT SUPPORT

The SDA endeavours to ensure that support is provided to all patients on MDR/XDR-TB treatment to encourage adherence to treatment. Performance under this SDA is assessed based on one indicator.

Service Delivery Area	Indicator description	Intended target by March 2012	Achieved results by March 2012	Percentage achievement
Patient Support	# of MDR-TB patients receiving treatment adherence food packages	384	208	54%

The MDR-TB/XDR –TB treatment being a long therapy is normally plagued with many side effects which affect treatment adherence of many patients. Poverty and malnutrition are factors that make treatment more difficult to patients and families. Under the grant all patients receiving MDR –TB drugs receive food packages, transportation, temporary accommodation for those who travel long distance to the facilities and psychosocial support. The package of food consists of mealie meal(25 kg), Salt(5kg), sugar(5kg),Full cream milk (500mg), Cooking oil(2L), peas and beans (2kg) and mabele flour(10)kg. The food packages are aimed at ensuring that all patients adhere to treatment as required.

MDR-TB patients are provided with food packages and transport assistance when they come for their monthly check up visits to the hospitals until they have completed treatment. Temporary accommodation nearer to a public facility is provided to patients travelling long distances to the health facilities.

By end of the reporting period 208 patients received treatment adherence food packages. The target was to reach 384 MDR-TB patients. The number of patients enrolled on 2nd line drugs are less than the projected number of 384 hence why fewer patients were given treatment adherence food packages.



Caption: Above are food package distributed to patients with MDR

Based on previous experience, 25% of registered MDR/XDR-TB cases are severely malnourished and require special enhanced food package. 53 MDR-TB patients were severely malnourished and were provided with food packages for the severely malnourished patients.

In addition temporary accommodation and transport reimbursement is provided for patients travelling long distances to the health facilities. By the end of March 2012, 231 patients were given transport fees and these are patients who come on monthly for follow up and routine check-up. Transportation fare is provided to needy patients to enable them come for follow up at the hospital. The assistance is critical in ensuring that patients are able to attend follow up sessions continuously and consistently. Sixteen (16) of these patients were provided with accommodation due travelling long distance between home and the public facility.

Prior to Phase 1, PIH had been supporting the salary of a psycho-social support counselor since 2007. However, as the grant became effective the support that PIH had secured for the counselor got depleted and the services were stopped. Within the grant,

only transportation costs were included with the assumption that the salary support would continue therefore this intervention was not carried out.

2.1.1.3 PROCUREMENT AND SUPPLY MANAGEMENT

The purpose of the SDA is to ensure un-interrupted supply of quality assured drugs and supplies for effective MDR/XDR-TB management. Planned activities under this SDA included refurbishment of existing central MDR/XDR-TB pharmacy, procurement of freezers for storage of PAS, procurement of insulated medicines bag. One indicator was used to measure performance under the SDA

Service Delivery Area	Indicator description	Intended target by March	Achieved results March 2012	Percentage achievement
Procurement and supply management (second line drugs)	# and % of units reporting no stock out of 2nd line anti-TB treatment drugs on the last day of the quarter	0%	0%	100%

During the report period there were no stock outs of 2nd line anti-TB treatment drugs, all new patients were initiated on treatment and those currently on treatment had an uninterrupted supply of medicines. This is essential in curbing possibilities of resistance of the second line drugs.

The central MDR/XDR-TB pharmacy was refurbished to increase storage capacity. This has enabled proper storage of drugs and supplies and will accommodate for future demand. Medicines bags were not procured this reporting period as there was still sufficient supply in stock that was procured by PIH prior to phase I implementation.



Caption: refurbished pharmacy



Caption: Interior of the refurbished pharmacy

Three freezers were procured during the reporting period. These freezers are to be used to store PAS one of the second line drugs which is sensitive to warm temperatures. The freezers are meant for the three regional MDR wards which are currently under construction.

2.1.1.4 MONITORING AND EVALUATION

The activities to be carried out under this SDA are: Procurement of computers for MDR/XDR-TB routine surveillance, print MDR/XDR-TB recording and reporting formats and International Service and TA agreement for Electronic TB Registration system (ETR.net).

Six desk top computers and six printers were procured. Two computers and two printers are to be use at The National TB Programme for data management. The other computers and printers will be distributed to the three regional MDR wards for records keeping and data management. Procurement process to print 20 000 MDR-TB patients' treatment cards and 1 MDR register is still underway.

Electronic TB Register.net is electronic software which is used to record data and report data for TB patients. This software is installed on computers in the public hospitals and DHMTS'. The TB Officers enter data and TB Coordinators view and run reports for their respective districts. A service Provider was identified and engaged to provide technical assistance, training and maintenance of ETR.net.

2.1.1.5 MANAGEMENT AND SUPERVISION

The main aim of the SDA is to ensure quality of TB/HV care including MDR/XDR-TB *through improving health workers knowledge, efficiency and motivation through routine supervision*

Service Delivery Area	Indicator description	Intended target by March 2012	Achieved results March 2012	Percentage achievement
Management and supervision	Number of supervisory visits conducted out of planned for the period	48	24	50%

During the reporting period 24 supervisory visits were conducted out of the 48 planned and this represented 50% of the target. Partners In Health (PIH) is doing programmatic management of the MDR/XD-TB Programme on behalf of the Ministry Of Health and Social Welfare. PIH was contracted as a Sub- Sub Recipient to the GFTAM R8 TB Grant. PIH officers carry out support supervisory visits to the districts on a weekly basis for clinical management of the patients and continued capacity building to the district clinical staff and treatment supporters. The supervision team comprises of medical officers and nurse assistant.

Two vehicles were procured under this grant with the aim supporting PIH to carry out the supervisory visits. The third vehicle was procured for the National TB Programme to be used to for quarterly supervisory visits to the districts.



A TB Advisor was engaged to strengthen NTP'S technical and managerial capacity, support to the GFATM grant processes, oversee the MDR-TB programme, support TB laboratories activities, participate in resource mobilization for the programme, support to NTP policy, strategy and M&E system. An additional Programme officer was engaged to oversee the effective implementation and coordination of all

components of the Global Fund R6 and R8 TB activities

The Laboratory Consultant was engaged. The main duties of the consultant are to build capacity for sputum microscopy, Exercise surveillance of primary and acquired tuberculosis drug resistance and participate in operational research and drug resistance surveillance. A TB/HIV Medical Officer was engaged to be the focal point for TB/HIV at central level. Five Drivers were also engaged to transport officers for supervisory visits to the hospital.

Due to severe under budgeting funds for; recruitment of Medical officer for Central MDR/XDR TB Hospital, the four Nurses and four Nurse Assistants have been

reprogrammed to bridge the gap for refurbishment of the three regional MDR/TB wards.

Three meetings were held in Mafeteng, Leribe and Berea during the reporting period. The three districts were identified as hot spots districts in terms of reduced notification rates and poor treatment outcomes, the rationale to hold these meetings was to discuss the reasons behind the poor performance and to draw action plans in order to thrash out these problems.

The fourth meeting was with all GFATM TB implementing partners, the main objective of the meeting was to discuss implementation and find ways to trash bottle necks that might impact on the implementation of the grant. The fifth meeting was with all TB technical partners. The main objective of the meeting was to strengthen partnership and discuss any updates within the National TB Programme. The sixth meeting was with Private Practitioners, the main objectives of the meeting were to discuss ways to improve the poor treatment outcomes and TB medicines management in their facilities.

There was provision of funding under this grant to support one officer to travel to South Africa to participate in a cross border collaborative meeting with NTP South Africa however NTP Lesotho did not receive any invitation for such a meeting during the reporting period. However the MOHSW has requested to instead hold a meeting of this nature in country.

There was also provision of funds to develop Community- TB care guidelines from GFATM R2 TB however the guidelines were not developed, funding under this grant was for updating and printing the guidelines but since they were not developed this activities could not be carried out. The funds were reprogrammed to support review of the National TB Strategic Plan.

2.1.1.6 HUMAN RESOURCES DEVELOPMENT

The SDA strives to ensure the availability of competent and motivated programme staff to effectively delivery quality TB/HIV services including MDR/XDR-TB. One indicator was identified to monitor implementation of activities under this SDA.

Service Delivery Area	Indicator description	Intended target by March 2012	Achieved results March 2012	Percentage achievement
Human Resources	# of health care workers trained on	30	38	127%

Development	MDR/XDR-TB/HIV management			
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Mokhotlong district held training for 38 health care workers. The training focused on MDR/XDR TB Management, TB/HIV Management, Intensified Case Finding, Isoniazid Preventive Therapy and Infection Control.

The trainings of TB Coordinators, TB Officers, Health Facility Staff on new NTP policy and training on infection control for Hospital Management Teams (HMTs) as planned due to capacity challenges within the MOHSW. During the implementation period ICAP was identified as a technical partner to conduct these trainings on behalf of the MOHSW, these trainings will be conducted before end of phase I

2.1.2 OBJECTIVE 2: TO ADDRESS MDR/XDR-TB, TB/HIV AND OTHER CHALLENGES

2.1.2.1 MDR-TB: PREVENT, MANAGE AND CONTROL MDR/XDR-TB

The specific objective of the SDA is to prevent deaths from TB/HIV co-infection and interrupt transmission of drug resistant forms of TB. One indicator was identified to guide implementation of activities under this SDA

Service Delivery Area	Indicator description	Intended target by March 2012	Achieved results March 2012	Percentage achievement
MDR-TB	# and % of laboratory confirmed MDR-TB patients enrolled in 2nd line anti-TB treatment	384	81	21%

Regular laboratory monitoring tests are performed on all enrolled MDR/XDR-TB patients. These tests include full blood count (FBC, Electrolytes especially potassium (K+), Urea and serum Creatinine, Liver function tests (LFTs) and Thyroid function tests). This is to ensure early detection of the most frequent side effects (hypokalemia, jaundice, anemia, gastro-intestinal disorders, psychosis, hypothyroidism and hyponatraemia) to institute early and appropriate actions. Based on the experience gained from the DOTS plus project implementation, 100% of the patients experienced

two or more side effects requiring intensive management. During the reporting periodtests were made.

The new Multipurpose Laboratory in Lesotho which will perform both culture and DST is still under construction. Following the completion of the facility, two MGIT 60 analyzers will be installed to do DST locally. It is envisaged that performance thereafter improves on this indicator. The targets were done based on the assumption that the new laboratory will be operational by 2011. Equipment to be installed at the new laboratory is already procured and staff to operate the equipment has already been trained.

Construction of the three regional MDR wards is still underway. The wards are being constructed at Leribe Hospital, Mokhotlong Hospital and Mophale's Hoek Hospital. The wards are being constructed at these hospitals due to the fact that a significant proportion of the MDR-TB cases currently enrolled are coming from their catchment areas. Three isolation wards are being constructed in Mokhotlong hospital, two isolation wards are being constructed in Mophale's Hoek hospital and four isolation wards are being constructed in Leribe hospital. The Bill OF Quantities (BOQ) prepared by the Estate Management Unit of the Ministry of Health and Social Welfare showed the cost of refurbishment of MDR/XDR-TB ward at Bot'sabelo Referral Hospital to be over the budgeted amount. The Ministry Of Health and Social Welfare is in the process of requested and approved to reprogramme some funds from the GFATM R8 TB to bridge the gap to refurbish the hospital and was approved. The MOHSW is in the process of awarding tenders and works will begin thereafter.

Procurement of Second Line Anti TB medicines has been done and the MOHSW is awaiting delivery of the consignment. The quantification for the secondline Anti-TB medicines was done for all patients who were on treatment as well as new patients to be enrolled until end of phase I. Quantification was done such that all the patients in phase I will be catered for the entire duration of treatment. The delay in procurement was due to the insufficient budget for the 2nd line Drugs. A request was made to TGF to reallocate funds from some activities within the grant to bridge the gap. Procurement process commenced as soon as the request was approved.

Procurement of needles/ syringes and water for injection is in process. The newly refurbished MDR/XDR TB wards will be furnished with ward furnisher and basic equipment to be used in these wards. The four centers to be renovated will require some basic equipment and supplies which includes: examination screens, patient beds, examination couch, emergency alarms. The centers will also be furnished with patient beds, examination screens, examination couches, drugs cabinet, equipment cabinet, nurses tables, high back chairs, ordinary chairs, patient trolleys, drugs trolleys, notice boards and filling cabinets. To ensure un-interrupted power supply to the 4 MDR/XDR-TB management centers especially as regards the ventilation systems,

backup generators will be procured and distributed to the centers. The procurement process of basic equipment, furniture and backup generators for these wards is already underway. The wards will be furnished and equipment will be installed when the wards are completed in before end of phase I.

Basic equipment (29 weighing scales, 29 thermometers and 29 BP apparatus) were procured and distributed to the 17 hospitals within the TB clinics for basic TB and MDR/XDR-TB management.

2.1.2.2 ADDRESS High risk group

The SDA aims to increase access to high quality MDR/XDR-TB prevention and care services to high risk groups such as migrant workers and prisoners. Two indicators were used to monitor performance under the SDA.

Service Delivery Area	Indicator description	Intended target by March 2012	Achieved results March 2012	Percentage achievement
High risk groups	% of prisoners screened for Tuberculosis	50%	27.7%	55.3%
High risk groups	# of contacts of smear positive miners and ex-miners screened for TB	288	0	0%

Prisoners constitute high risk groups since they are in congregate settings. The Lesotho Correctional Service has thirteen (13) health centers within its institutions. Prisoners are already been screened for TB within the LCS health facilities. There were 688 prisoners screened for TB as at end of March 2012 within the Correctional Institutions in all the districts of Lesotho.

Ex-miners and their families also constitute high risk populations and during the reporting period 288 contacts of miners and ex-miners were to be screened for TB. During the reporting period there were no recorded contacts of smear positive miners and ex miners screened for TB

Conducting contact tracing and screening of MDR/XDR-TB cases is an ongoing process that MDR Programme carries out when a patient is diagnosed with MDR-TB.

As part of accelerating implementation of activities under the SDA, ICAP is to be contracted as a Sub-Sub Recipient to the GF R8 TB Grant. The activities to be carried out by ICAP are; undertaking stakeholders consultation meetings on high risk groups (Prisons, Workplace, detention units), Conduct mapping of MDR/XDR-TB in miners

and ex-miners. Procurement stationery for mapping, undertaking field visits for mapping activity and holding a dissemination workshop. There was a delay in final approval of the contact and these activities will be reported on in the next reporting period.

2.1.2.3 INFECTION CONTROL

The SDA aims to prevent transmission of TB in health care and congregate setting. The infection control requirements are high due to the high burden of both TB and HIV. Performance under the SDA is monitored through one indicator.

Service Delivery Area	Indicator description	Intended target by March 2012	Achieved results March 2012	Percentage achievement
Infection Control	% Of health facilities with functional infection control procedures for TB transmission according to National Policy	50%	100%	150%

All the 18 (100%) hospitals had functional infection control procedures for TB according to the National Policy. Despite the good performance on the indicator some activities under the SDA were not implemented by the end of year one of the grant. These included group meetings to develop national infection control guidelines, contracting of consultant for development of infection control policy and printing of the infection control guidelines.

As part of accelerating implementation of activities under the SDA, ICAP is to be contracted as a Sub-Sub Recipient to the GF R8 TB Grant to carry out these activities. There was a delay in final approval of the contact and these activities will be reported on in the next reporting period.

Standard sets of Ventilation system (8) with HEPA filtration will be procured installed in the extension of the Bots'abelo hospital as well as the three regional centers and this will be done during works. All staff (doctors, nurses, ancillary staff, CHWs, etc.) will be given N95 or N100 respirators to protect them from infection at work.¹⁰ Ultraviolet Germicidal Irradiation (UVGI) lights were procured and distributed to Berea, Botha

Bothe, Mafeteng, Qacha'snek, Maluti, Mamohau, Seboche, Paray Scott and St Joseph's Hospitals to be installed in the TB clinics.

1100 waste sharp disposal containers were procured and distributed to Botshabelo MDR/XDR-TB Programme and TB central Laboratory. These waste sharp disposal containers are used at community level, at the MDR/XDR TB Clinic and Central TB Laboratory to minimize the risk of infection.

2.1.3 OBJECTIVE 3: TO EMPOWER PEOPLE WITH TB AND COMMUNITIES

2.1.3.1 ACSM (ADVOCACY COMMUNICATION AND SOCIAL MOBILIZATION)

The main purpose of the SDA is to engage society and community at large in TB control and provide treatment nearer to the patient's home. One performance indicator was identified to guide implementation of activities.

Service Delivery Area	Indicator description	Intended target by March 2012	Achieved results March 2012	Percentage achievement
ACSM	Number of advocacy meetings held out of the planned	2	2	100%

Two Meetings were held through Health Education Division for Correctional Services personnel. The objective of these meetings is to discuss infection control in congregate setting like prisons, MDR/XDR TB and TBHIV management

A Consultant to support Health Education Division in designing IEC messages for MDR/XDR-TB/HIV was engaged. Two working group meeting were held for development of the MDR/XDR-TB Advocacy packages. The main aim of the meeting was to review the advocacy packages developed by the consultant. Messages about TB, MDR-TB, XDR-TB and TB/HIV were developed, in both Sesotho and English language, and printed as posters, pamphlets, flyers, pens and highlighters, rulers and stickers. All this material will be distributed to communities

2.1.3.2 COMMUNITY TB CARE

The SDA endeavors to promote patient centered continuum of care at the community level. Provision of treatment support at the community level is critical and community health workers form the cornerstone of the community based MDR/XDR-TB treatment programme. Two performance indicators are utilized to monitor performance under the SDA

Service Delivery Area	Indicator description	Intended target by March 2012	Achieved results March 2012	Percentage achievement
Community TB care	# of treatment supporters trained on MDR/XDR-TB/HIV care	1600	137	9%
Community TB care	# of community treatment supporters receiving incentives	384	216	56%

Training of treatment supporters is an important part of the MDR/XDR-TB programme. The community treatment supporters are equipped with skills to provide adherence support to MDR/XDR-TB patients while on treatment. The training also includes basic treatment of MDR-TB, the early identification of potentially life-threatening adverse events and the treatment of common adverse events. Because of the high rate of HIV co-infection among patients with MDR-TB, the treatment supporters also receive training in the delivery of HIV care and the identification of other illnesses.

The specific indicator for this activity is the number of Community treatment supporters trained on MDR/XDR-TB/HIV care. The low performance on the indicator is attributed to under-reporting of trainings that were conducted and overall delayed implementation of the trainings.



Caption: Community treatment supporters at Botsabelo central MDR and on the left treatment supporters receive training facilitated by PIH.

Treatment supporters are also given a remuneration of M500 per month to cover transport cost when they accompany patients for monthly check up visits. By March 2012, 216 community treatment supporters were receiving incentives and this constituted 56% of the intended target. The low performance is attributed to the low number of patients currently on MDR-TB treatment.

Stationery for patient treatment monitoring was not procured because it was still in adequate stock. The stationery will be procured in the next reporting period.

2.1.4 OBJECTIVE 4: TO ENABLE AND PROMOTE RESEARCH ON MDR/XDR-TB

2.1.4.1 OPERATIONAL RESEARCH

The SDA focuses on creating a system for guiding programme performance through collection of reliable and accurate data on TB management in Lesotho. One indicator is used to monitor implementation of activities under this SDA

Service Delivery Area	Indicator description	Intended target by March 2012	Achieved results March 2012	Percentage achievement
Operational research	# of operational research studies completed and results disseminated through a national or GlobalTB M&E	2	0	0%

One of the strategic objectives of the national TB plan is to create a system for guiding programme performance through the collection of reliable and accurate data on TB management in Lesotho. The Ministry of Health and Social Welfare in collaboration with The HSS firm conducted a training of programme staff on research methods on the January 2012. The training is intended to equip central NTP staff with skills to conceptualize research priorities including development and implementation of research proposals.

The MOHSW has not conducted an operational research with funds from the grant however during phase I NTP Manager participated as a co-investigator in one operations research on **“Integration of active Case Finding for TB (ACF) and Isoniazid Preventive Therapy (IPT) WITH Prevention of mother to Child Transmission of HIV Services (PMTCT) in Lesotho”**. This was a tripartite approach relationship with EGPAF; implementing partner and NGO in HIV Care for, John Hopkins University and NTP. Direct benefit to NTP is facilitation of IPT roll out in Lesotho. The second Operations research conducted in TB Clinic in Maseru to evaluate the role of culture as a diagnostic entry point for all TB suspects and the TB/HIV Medical Officer co-investigated within one collaboration Medical doctor from Wales.

Further Operations research is envisaged to address factors leading to non-evaluation of patients and protocol is being finalized, it is hoped that this will improve the treatment outcomes when factors leading to non-evaluation of patients are established and appropriate remedial actions will be implemented.

The second planned Operations research is in partnership with ICAP, NGO and implementing partner in TB, Columbia University and NTP on how to improve ART enrollment of HIV co-infected TB patients. The NTP manager will be co-investigator in this study if protocol is approved by the Research and Ethics Committee (REC).

3 Chapter 4: Round 8 TB FINANCIAL PERFORMANCE

The implementation of the grant started in October 2010. The grant focuses on TB intervention in the country. An amount of US\$ 3,824,288.76 was disbursed by the Global Fund during the period under review. Of that amount US\$ 2,394,289 was disbursed to the PR, and US\$ 1,429,999.37 was paid to GDF for procurement of 2nd line anti-TB drugs. The total expenditure to date represents 41% of the Budget for the period under review.

The Budget and Expenditure analysis for the eighteen months in US\$ by category is as in the table indicated below:

Category	Budget	Expenditure	Variance	% Variance
Human Resources	1,160,150.00	176,535.55	983,614.45	84%
Technical Assistance	231,587.00	0.00	231,587.00	100%
Training	245,864.00	66,248.25	179,615.75	73%
Health Products and Health Equipment	357,135.00	135,322.18	221,812.82	62%
Medicines and Pharmaceutical Products	690,824.00	1,429,999.37	-739,175.37	-107%
Procurement and Supply Management	128,878.00	25,236.38	103,641.62	80%
Infrastructure and other equipment	1,623,626.00	245,852.19	1,377,773.81	85%
Communication materials	19,215.00	0.00	19,215.00	100%
Monitoring and evaluation	413,859.00	62,081.57	35,177.43	8%
Living support to clients/Target population	983,150.00	282,501.78	700,648.22	71%
Planning and administration	157,998.00	11,251.07	146,746.93	93%
Overheads	93,900.00	81,145.23	12,754.77	14%
Total	6,106,186.00	2,516,173.57	3,590,012.43	59%

Budget and Expenditure Analysis by category

With regard to HR the low expenditure was attributed to few staff recruited under the grant. The other factor is the delay in the refurbishment of the three regional wards as result of underbudgeting on renovations and by the time the PR obtained approval to utilise savings from year had already ended. Delays were experienced on the engagement of the TA due to procurement process. However all the activities to be conducted have accrued and expenditure will be reflected beyond the cutoff date of the report.

The expenditure on Health products is 38% and this because procurement of drugs for second line DST, ILED microscopists could not be procured due to delays in the completion of the new National Reference Laboratory and regional Laboratory. The new NRL will first have to undergo the accreditation phase before it becomes operational.

Only 15% of the budget under infrastructure and other equipment has been used. This is because equipment and furniture to be procured for the regional hospitals is still on hold pending the completion of the renovation currently on going.

Expenditure on living support was low due to low number of MDR/XDR-TB patients on treatment than the projected number from the budget forecasted. As a result of that, there is less number of food packages procured and transport allowance provided to patients than budgeted. In addition the number of community treatment supporters engaged was also lower

than the projected number as per the budget. This is because the number of treatment supporters is dependent of the number of patients currently with the ratio of one to one.

Analysis of expenditure by service delivery areaS in US\$

Service Delivery Area	Budget	Expenditure	Variance	% Variance
Improving diagnosis	221,085.00	139,871.07	81,213.93	37%
Standardized treatment, patient support and patient charter	411,682.00	80,804.03	330,877.97	80%
Procurement and supply management	41,541.00	32,033.30	9,507.70	23%
M&E	76,860.00	9,721.27	67,138.73	87%
Management and supervision	1,557,881.00	367,413.99	1,190,467.01	76%
Human resource	133,768.00	65,041.33	68,726.67	51%
MDR-TB	1,776,322.00	1,524,216.76	252,105.24	14%
High risk groups	51,850.00	0.00	51,850.00	100%
Infection control	767,602.00	14,800.46	752,801.54	98%
ACSM (Advocacy, communication and social mobilization	49,380.00	1,206.92	48,173.08	98%
Communication TB care	537,396.00	154,351.38	383,044.62	71%
Programme-based operational research	11,583.00	2,895.55	8,687.45	75%
Supportive environment: program management and administration	469,236.00	123,817.51	345,418.49	74%
Total	6,106,186.00	2,516,173.57	359,012.43	59%

Budget and expenditure Analysis by SDA

Expenditure on improving Diagnosis was 37% and this has been attributed to the procurement of drugs for second DST and consumables. The procurement will take place when the NRL is operational. This is likely to happen at the start of phase II since the NRL is yet to undergo the accreditation process before it can be operational

The expenditure under the management and supervision is 24% of the budget due to low expenditure on human resources and low expenditure on twice weekly supervisory visits to the districts by the central team.

On community TB care expenditure was 29% and this attributed to low number of community treatment support compared to the projected number per the phase 1 budget. The other contributing factor is the low level of achievement on the planned number of trainings.

Expenditure is 86% of the budget for the MDR-TB and this is because budget allocated for drugs has been expended and delivery is expected before the end of phase.

The budget for address high risk groups was not yet spent by the cutoff date of the report. However ICAP the technical partner to the NTP has been identified as the SSR which will accelerate implementation. Implementation had already started and expenditure will be incurred before end of Phase 1.

The expenditure under infection control is 2% of the budget. procurement, instalation and maintenance of the mechanical ventilation system for the four isolation wards has not been done pending completion of renovation of the isolation wards.

2% of the budget has been spent for the ACSM since the because engagement of the consultant to support the Health Education Division to design IEC materials for the MDR/XDR-TB/HIV and printing and dessemination of the patient charter has not yet been done.

The table below shows analysis of expenditure by implementing entity in US\$.

Implementing Entity	Budget	Expenditure	Variance
Ministry of Health and Social Welfare	1,610,838.00	2,076,777.44	-465,939.44
Partners in Health	4,495,347.00	438,370.12	4,056,976.88
MOFDP/GFCU	0.00	1,026.01	-1,026.01
Total	6,106,185.00	2,516,173.57	3,590,011.43

The reason for the high expenditure under MOHSW is also attributable to the US\$ 1,429,999.37 paid for the 2nd line anti-TB drugs paid directly from the Global Fund. An amount of US\$202,756.61 was disbursed to the Ministry of Health and Social Welfare for implementation of the activities. The MOHSW delayed implementation of activities as the funds were disbursed in July 2011. An amount of US\$457,388.66 was disbursed to PIH during the period under review, with the first disbursement made in September 2011.

4 Chapter 4: Challenges, Recommendations and Conclusion

4.1 CHALLENGES

The main challenge to this grant was delayed implementation of activities and these negatively affected the programmatic and financial performance of the grant. Specific challenges were articulated below

- Challenges pertaining to recruitment of medical doctors, nurses and nurse assistant's and funding for these positions was reprogrammed to supplement funds for construction of three regional MDR TB wards where it found that there was under budgeting.
- This grant was aimed at scaling up MDR/XDR, TB, TBHIV services however the number of patients enrolled on MDR-TB treatment is fewer than initially projected and this resulted low expenditure on the activity.
- The number of MDR TB patients to benefit from the grant support was lower than anticipated. This was largely due to delays in improving case identification and laboratory diagnostic capacity.
- The implementation of some activities was linked to completion of other activities not within the grant workplan. When the completion of these other activities was delayed, those within the grant workplan could not proceed. For example, the MOHSW had received support from Partners in Health (PIH) to construct a DR TB laboratory attached to the Botsabelo MDR TB treatment facility in Maseru. Construction of the laboratory encountered significant delays to the extent that, by the end of March 2012, it was not yet functional. This meant that none of the resources included within the grant to support the operation of the new laboratory could be used.
- The number of MDR TB patients to benefit from the grant support was lower than anticipated. This was largely due to delays in improving case identification and laboratory diagnostic capacity.

4.2 RECOMMENDATIONS

In future it is recommended that the NTP should focus more on managing the implementing the activities by the SRRs rather than doing the implementation. The other important lesson is that frequent meetings between the PR, SR and SRRs are vital to address implemetation challenges. In future it is highly recommended that such meetings be consistently held since they provide a platfrom for diagnosis of challenges and remedial actions.

4.3 CONCLUSION

The phase 1 of the Round 8 TB grant started in October 2011, performance was not very impressive in the first two periods as it was rated C under TGF rating. However in period 3 a

significant improvement was realised as the grant obtained B1. This performance demonstrates that the grant has the potential to improve further within the remaining period of Phase. The grant has tremendously contributed in the national response towards the achievement of the MDG and Global Plan to TB targets. National efforts for scaling up the provision of MDR-TB services in the country have gained momentum as a result of the contribution from the grant. It is vitally important that the interventions under the grant maintained. There is however more to be done on the R8 TB grant to improve performance.