HIV counseling and testing is indicated for tuberculosis patients with symptoms and/or signs of HIV-related conditions and in tuberculosis patients having a history suggestive of high risk of HIV exposure.

Standard 13. All patients with tuberculosis and HIV infection should be evaluated to Determine if antiretroviral therapy is indicated during the course of treatment for tuberculosis. Appropriate arrangements for access to antiretroviral drugs should be made for patients who meet indications for treatment. Given the complexity of co-administration of anti tuberculosis treatment and antiretroviral therapy, consultation with a physician who is expert in this area is recommended before initiation of concurrent treatment for tuberculosis and HIV infection, regardless of which disease appeared first. However, initiation of treatment for tuberculosis should not be delayed. Patients with tuberculosis and HIV infection should also receive cotrimoxazole as prophylaxis for other infections.

Standard 14. An assessment of the likelihood of drug resistance, based on history of prior treatment, exposure to a possible source case having drug-resistant organisms, and the community prevalence of drug resistance, should be obtained for all patients. Patients who fail treatment and chronic cases should always be assessed for possible drug resistance. For patients in whom drug resistance is considered to be likely, culture and drug susceptibility testing for isoniazid, rifampicin, and ethambutol should be performed promptly.

Standard 15. Patients with tuberculosis caused by drug-resistant (especially Multiple Drug Resistant [MDR]) organisms should be treated with specialized regimens containing second-line anti tuberculosis drugs. At least four drugs to which the organisms are known or presumed to be susceptible should be used, and treatment should be given for at least 18 months. Patient centered measures are required to ensure adherence. Consultation with a provider experienced in treatment of patients with MDR tuberculosis should be obtained.

Standards for Public Health Responsibilities

Standard 16. All providers of care for patients with tuberculosis should ensure that Persons (especially children under 5 years of age and persons with HIV infection) who are in close contact with patients who have infectious tuberculosis are evaluated and managed in line with international recommendations. Children under 5 years of age and persons with HIV infection who have been in contact with an infectious case should be evaluated for both latent infection with *M. tuberculosis* and for active tuberculosis.

Standard 17. All providers must report both new and re-treatment tuberculosis cases and their treatment outcomes to local public health authorities, in conformance with applicable legal requirements and policies.

ANNEXURE C

SPECIFIC TARGETS AND INDICATORS

Main Indicators						
Indicator	Target	Numerator	Denominator	Routine Data elements	Data Source	Level(s) to be collected
Case detection rate	70%	Number of TB patients started treatment for a given reporting period	Number of estimated TB patients for the stated period	Number of TB patients started treatment	ETR.net	National
				Total number of estimated TB patients which includes undiagnosed active TB patients	Models based on Prevalence study and Vital statistics	
Treatment Success rate	> 85%	Total number of New sputum smear positive PTB patients started treatment in a given reporting period, that completed treatment, with or without proof of cure (A time period can be a specific quarter or year)	Total number of New sputum smear positive PTB patients started treatment in the stated reporting period	Total number of New sputum smear positive PTB patients that were Cured	Paper-based TB Registers and ETR.net	All Levels (Facility; Sub-district; District; Province and National)
				Total number of New sputum smear positive PTB patients that completed treatment without proof of Cure		
				Total number of New sputum smear positive PTB patients		
Cure rate	85%	Total number of New sputum smear positive PTB patients started treatment in a given reporting period that were Cured	Total number of New sputum smear positive PTB patients started treatment in the stated reporting period	Total number of New sputum smear positive PTB patients that were Cured	Paper-based TB Registers and ETR.net	All Levels (Facility; Sub-district; District; Province and National)
				Total number of New sputum smear positive PTB patients		
Subsidiary Indicators						
Indicator	Target	Numerator	Denominator	Routine Data elements	Data Source	Level(s) to be collected
Bacteriological coverage	100%	All 1Pulmonary TB patients started treatment in a given reporting period with bacteriological testing	All Pulmonary TB patients excluding children with no smear 0 - 7 years in the stated period	All Smear Positive Pulmonary TB patients	Paper-based TB Registers and ETR.net	All Levels (Facility; Sub-district; District; Province and National)
				All Smear Negative Pulmonary TB patients		
				All Pulmonary TB patients		
				Pulmonary TB patients with no smear 0 - 7 years		

Smear Conversion Rate **(at 2-months)**	75%	All New sputum smear Positive PTB patients started treatment in a given reporting period that converted by 2-months	All New sputum smear Positive PTB patients started treatment in the stated period	All New sputum smear Positive patients that converted by 2-months All New sputum smear Positive PTB patients started treatment	Paper-based TB Registers and ETR.net	All Levels (Facility; Sub-district; District; Province and National)
Smear Conversion Rate **(at 3-months)**	85%	All New sputum smear Positive PTB patients started treatment in a given reporting period that converted by 3-months	All New sputum smear Positive PTB patients started treatment in the stated period	All New sputum smear Positive PTB patients started treatment that converted by 3-months All New sputum smear Positive PTB patients	Paper-based TB Registers and ETR.net	All Levels (Facility; Sub-district; District; Province and National)
Defaulter rate	< 5%	All New sputum smear Positive PTB patients started treatment in a given reporting period that defaulted before end of treatment	All New sputum smear Positive PTB patients started treatment in the stated period	All New sputum smear Positive PTB patients that defaulted before end of treatment All New sputum smear Positive PTB patients started treatment All New sputum smear Positive PTB patients started treatment in the stated period	Paper-based TB Registers and ETR.net	All Levels (Facility; Sub-district; District; Province and National)
Turn Around Time (TAT) within 48 hours	80% of all facilities with TAT within 48hrs	Number of facilities with 80% of Smear results back from the laboratory, within 48hrs, in a given reporting period.	Number of facilities within the sub-district/district in the stated period	Number of specimens sent to the laboratory Number of smear results received back from the laboratory - within 48 hrs	TB Case Identification and Follow-up Register (Suspect Register)	Facility level
				Number of facilities with 80% of Smear results back from the laboratory, within 48hrs. Number of facilities within the sub-district/district	Sub-district / District Report	Sub-district / District level; Provincial and National levels

MDR-TB treatment starting rate	100%	Number of MDR-TB patients started treatment in a given reporting period	Number of MDR-TB patients registered in the stated period, excluding MDR-TB patients that died before starting treatment	Number of MDR-TB patients started treatment Number of MDR-TB patients registered, excluding MDR-TB patients that died before starting treatment	Drug Resistant-TB Register	MDR-Unit; Provincial and National levels
XDR-TB treatment starting rate	100%	Number of XDR-TB patients started treatment in a given reporting period	Number of XDR-TB patients registered in the stated period, excluding XDR-TB patients that died before started treatment	Number of XDR-TB patients started treatment Number of XDR-TB patients registered, excluding XDR-TB patients that died before started treatment	Drug Resistant-TB Register	MDR-Unit; Provincial and National levels
(V)CT rate for TB patients	100%	Number of TB patients (offered/accepted) counselling and testing for HIV in a given reporting period	Number of All TB patients in the stated period	Number of TB patients offered counselling and testing for HIV Number of All TB patients	Paper-based TB Registers and ETR.net	All Levels (Facility; Sub-district; District; Province and National)
CPT starting rate for TB/HIV co-infected patients	100%	Number of TB/HIV co-infected patients started CPT in a given reporting period	Total number of TB/HIV co-infected patients in the stated period	Number of TB/HIV co-infected patients started CPT Total number of TB/HIV co-infected patients	Paper-based TB Registers and ETR.net	All Levels (Facility; Sub-district; District; Province and National)
ART starting rate for TB/HIV co-infected patients qualifying for ART	100%	Number of TB/HIV co-infected patients qualifying for ART started on ART in a given reporting period	Number of TB/HIV co-infected patients with a CD4 count of $\leq$ 200 in a stated period	Number of TB/HIV co-infected patients qualifying for ART started on ART Number of TB/HIV co-infected patients with a CD4 count of $\leq$ 200	ART Registers, Paper-based TB Registers and ETR.net *(Data needs to be collected through TB HIV)*	All Levels (Facility; Sub-district; District; Province and National)
Prevalence rate		The total number of cases, new and old, in the population at a particular point in time.	The total population	The total number of cases, new and old, in the population at a particular point in time. The total population	National Survey	National

[1]Pulmonary TB (PTB) includes PTB with evidence of EPTB

[2]Defaulter = a patient that interrupted treatment for 2 consecutive months or more

Annexure D: Framework

	Interventions	Objectively verifiable indicators	Means of verification	Assumptions	Responsibility	07	08	09	10	11
Overall Objective	To reduce mortality, morbidity and transmission of Tuberculosis in the country	Reduction of TB incidence Reduction of TB prevalence Reduction in TB mortality rates	TB recording and reporting system SASTATS TB Prevalence Studies	Baseline for prevalence conducted in 2007	NDOH					
Specific Objectives	To increase TB case detection	Increase in case detection rate from 55 – 70% by 2011	Modelling based on Prevalence study and Vital statistics (SASTATS)	Trained staff empowered to use their new skills	NDOH PDOH NGOs Business sector	56	59	62	66	70
		80% of all facilities with a sputum result TAT of less than 48 hours by 2010	TB Case Identification and Follow-up Register TB laboratory reports Sub district reports. DHIS Paper-based TB Registers and ETR.net	Increased human resources at all levels Adequately funded district plans Accountability of District managers and facility managers Clear roles and responsibilities for staff at all levels Health information management system linked to the ETR Proper supervision of all levels	FPMS Mining industry DCS DME MHS	55	65	75	80	
	To reduce the TB defaulter rate	Reduction of the defaulter rate from 10% to below 5% by 2011	Paper-based TB Registers and ETR.net			8	7	6	5	4
	To increase the cure rates for new smear positive patients	Increase the smear conversion rate for new smear positive patients from 55% to more than 75% by 2011	Paper-based TB Registers and ETR.net SASTATS reports			60	65	70	75	80
		Increase in cure rates for new ss+ PTB from 56% to 85% by 2010				60	65	70	75	85

	To reduce the death rates as a result of TB	Reduction in death rates from 71 to 60 per 100 000 by 2011				71	68	65	62	60
	To ensure early detection and proper management of patients with MDR-TB	100% of all patients with confirmed MDR-TB started on treatment by 2007	Laboratory surveillance system Drug Resistant-TB Register			100	100	100	100	100
	To ensure early detection and proper management of patients with confirmed XDR-TB	100% of all patients with confirmed XDR-TB started on treatment by 2007	Laboratory surveillance system Drug Resistant-TB Register			100	100	100	100	100
	To improve access to HIV care for HIV infected TB patients	Increase the HIV testing rate among TB patients from 41% to 100% by 2011	Paper-based TB Registers and ETR.net DHIS			41	60	80	100	100

	Interventions	Objectively verifiable indicators	Means of verification	Assumptions	Responsibility	07	08	09	10	11
Programme Outputs	1. <u>Strengthened DOH human resource capacity to deliver TB treatment, care and support services</u>									
	1.1. Appointment of staff at national, province, district, sub-district and facility levels	Staff at all levels appointed by end 2008/9	National and Provincial organograms and reports		NDOH PDOH DCS MHS	30%	30%	40%		
	1.2. Conduct skills and knowledge audit among public and private sector health workers	Report available by end of 2007	Skills audit report Human resource development plan developed		Training institutions and NGOs Technical agencies Donor agencies Private sector	X				
	1.3. Conduct training of all health workers on clinical management of TB and drug Resistant TB	7 000 health workers trained by 2010	Provincial HRD progress reports			1750	3500	5250	7000	
	1.4. Conduct training of district managers, facility managers, PHC supervisors and sub and district TB coordinators on TB programme management	53 managers, 53 district coordinators, 3500 facility managers, 226 sub district coordinators and 1130 PHC supervisors trained on TB programme management by 2010	Provincial HRD progress reports			1241	2482	3723	4964	
	1.5. Conduct training of	53 district coordinators,	Provincial HRD			111	111	111		

	district, sub district coordinators and information officers on TB data management	53 information officers and 226 sub district coordinators trained on TB data management by 2009	progress reports							
	1.6. Conduct training on TB data collection tools and data management for health care workers and data capturers	3500 health workers and 3500 data capturers trained on TB data collection tools and data management by 2009	Provincial HRD progress reports			1750	3500	5250	7000	
	1.7. Conduct training on infection control for health care workers, infection control officers and facility managers	3500 health care workers, 3500 infection control officers and 3500 facility managers trained on infection control by 2009	Provincial HRD progress reports			3500	3500	3500		
	1.8. Conduct training on social mobilisation for advocacy, health promotion and communication officers	30 Advocacy, health promotion and communication officers from national and provincial levels trained on social mobilisation for advocacy by 2008	National HRD progress reports				30			
	1.9. Conduct training of community care givers on adherence counselling and support for TB patients	25 000 community care givers trained on adherence counselling and support for TB patients by 2010	Provincial HRD progress reports			6250	6250	6250	6250	
	1.10. Conduct training of for laboratory	429 laboratory assistants, medical	NHLS Reports		NHLS	214	215			

	assistants, medical technicians and technologists on TB laboratory work	technicians and technologists trained on TB laboratory work by 2008								
	1.11. Conduct training of health workers and pharmacy assistants on TB drug stock management	3500 health workers and pharmacy assistants trained on TB drug stock management by 2009	Provincial quarterly progress reports		NDOH	1750	1750			
	2. <u>Equitable access to quality TB diagnostic, treatment and care services</u>									
	2.1. Establish three new culture laboratories in Limpopo, Mpumalanga and KwaZulu-Natal	3 culture facilities operational in Limpopo, Mpumalanga and KwaZulu-Natal by 2008	NHLS Reports		NHLS NDOH Technical agencies Donor agencies	3				
	2.2. Establishment of a functional National TB Reference Laboratory	NTRL operational by 2008	NHLS Reports				1			
	2.3. Develop and implement a laboratory blind checking quality assurance system for microscopy services	Quality assurance system for all peripheral microscopy services operational by 2008	NHLS Reports				X	X	X	X
	2.4. Ensure adequate supply of TB drugs in all facilities	0% TB drug stock outs in all facilities by 2007	Provincial/ district quarterly progress reports Clinic stock cards		PDOH	0%	0%	0%	0%	

	2.5. Establish an efficient referral and recall system for TB patients in all facilities	100% of clinics with an operational referral and recall system	Provincial/ District quarterly progress reports Supervision reports		PDOH DMT	30%	60%	100%		
	2.6. Ensure provision of patient centred TB care in all facilities	100% of clinics implementing a fast tracking system for TB patients	Provincial/ District quarterly progress reports Facility TB Registers, ETR reports		DMT	40%	80%	100%		
	2.7. Construct or upgrade facilities to accommodate patients with Drug Resistant TB	Increase bed capacity for MDR-TB from 2514 to 3364 by 2011 Increase bed capacity for XDR-TB patients from 946 to 1301 by 2011	Provincial/ District quarterly progress reports Supervision reports		NDOH PDOH DMT	2514	2727	2940	3153	3364
	2.8. Improve infection control measures in all health facilities	100% of hospitals with proper ventilation systems for infection control by 2010	Provincial reports Facility infection control reports Supervision reports		NDOH PDOH DMT	25%	50%	75%	100%	
		100% of clinics implementing administrative controls to prevent spread of infection by 2009	District and Provincial reports Supervision reports			30%	60%	100%		
	2.9. Review and document existing models of community TB care	CTBC models implemented in all 53 districts by 2010	Document on good practise in Community TB care		NDOH PDOH	15	30	45	53	

	for scaling up									
	2.10 Review existing models for delivery of TB and HIV services at PHC level and document for scaling up	100% of PHC facilities implementing the model for integrated TB and HIV care by 2010	District and provincial reports		NDOH PDOH	20%	40%	70%	100%	
	2.11 Provide food supplements to all TB patients	100% of TB patients started on treatment getting food supplements	Supervision reports District and provincial reports		PDOH	100%	100%	100%	100%	100%
	2.12 Provide food parcels to all qualifying TB patients	100% of qualifying TB patients provided with food parcels			PDOH DSD	30%	80%	100%	100%	100%
	3. <u>Change in attitudes and behavior attained through advocacy, communication and social mobilization</u>									
	3.1 Develop and distribute ACSM guidelines	Guidelines distributed to all sub districts and districts by 2007	Provincial reports National ACSM reports		NDOH Technical agencies Donor agencies	X				
	3.2 Conduct press conferences on TB to disseminate information on progress with TB control	Four press conferences conducted per year	Media reports		NDOH	4	4	4	4	4
	3.3 Conduct mass media campaigns	Four bursts of mass media campaigns conducted per year	Reports on exposure or reach National ACSM reports		NDOH PDOH Technical agencies Donor agencies	4	4	4	4	4

	3.4 Conduct training on TB for journalists	One training work shop for journalists conducted per year	Workshop report and attendance list		NDOH PDOH	1	1	1	1	1
	3.5 Develop and disseminate IEC materials on advocacy	Adequate supplies of materials available at district, sub-district, provincial and national levels	Supervision reports Provincial and district reports		NDOH PDOH	X	X	X	X	X
	3.6 Conduct community "Imbizos" on TB	36 Imbizos held per year in all provinces	National, Provincial and district reports		NDOH PDOH DMT	36	36	36	36	36
	3.7 Conduct door to door campaigns and TB Blitz campaigns	90 campaigns conducted in each province per year	Provincial and district reports		NDOH PDOH DMT	90	90	90	90	90
	3.8 Mobilize political commitment for TB	90 community meetings held in each province per year	District and provincial reports		NDOH PDOH DMT	90	90	90	90	90
	3.9 Establish ACSM Steering committees at national and provincial levels	1 national and nine provincial ACSM steering committees established and functional by 2007	Minutes of the meetings held		NDOH PDOH DMT		2	2	2	2
	3.10 Conduct KAP studies in selected districts	KAP studies conducted in at least 20 districts from all nine provinces by 2008	Reports on KAP studies		NDOH PDOH Technical agencies Donor agencies		20		20	
	3.11 Develop best practice guidelines on ACSM based on provincial	100% of districts and sub-districts with best practise guidelines	Provincial and district reports		NDOH PDOH Technical agencies		100%			

	experiences				Donor agencies Stakeholders					
	3.12 Establish a monitoring and evaluation framework for the ACSM plan	100% districts reporting on indicators for ACSM	Provincial and district reports KAP study reports		NDOH PDOH Technical agencies Donor agencies		100%			
	3.13 Develop and disseminate business tool kits on TB	TB toolkits distributed to business sector	Reports from business sector Provincial and district reports		NDOH PDOH Technical agencies Donor agencies Stakeholders					
	4. <u>Enhanced partnerships with key stakeholders in TB Control</u>									
	4.1 Conduct a situation analysis of TB control in the mines, private sector, SANDF and Correctional Services	Reports with recommendations available by 2008	Report on situation analyses		NDOH PDOH DCS COM MHS Private sector partners		100%			
	4.2 Develop a comprehensive plan to strengthen the TB programme in the mines, private sector, SANDF and Correctional Services	Plan developed and implemented by 2008	TB Improvement Plan Progress reports				100%			
	4.3 Develop a memorandum of	Memorandum of understanding signed by	Memorandum of Understanding				X			

	understanding on delivery of TB services with these sectors	2008								
	4.4 Ensure monitoring and evaluation of TB control in these sectors	All sectors reporting on indicators quarterly by 2008	Minutes of meetings held Stakeholder progress reports				100%			
	4.5 Explore models for engagement of the private medical practitioners in TB control activities and pilot them	Models for engagement of private medical practitioners piloted in 5 districts by 2008	Report on the pilot study		NDOH PDOH Professional organisations IPAs Research institutions		X			
	4.6 Develop a best practise guide on engagement of private medical practitioners for scale up	Best practise document disseminated to all provinces and districts by 2008	Best practise document		NDOH PDOH Professional organisations IPAs Research institutions		X			
	4.7 Engage training institutions or organizations in inclusion of TB in curricula and developing short courses on TB as part of the continued medical education programme	TB included in curricula in medical and nursing colleges by 2008	Minutes of meetings Training curricula		NDOH Heads of training institutions		X			

	4.8 Develop guidelines for engagement of NGOs in TB control.	Guidelines for engagement of NGOs in TB control distributed by 2008	Guidelines for engagement of NGOs in TB control		NDOH PDOH Technical agencies NGOs		X			
	4.9 Conduct joint monitoring and evaluation of all sectors engaged in TB control activities	One meeting in a quarter held with the sectors to review progress	Minutes of meetings held Progress reports		NDOH PDOH All stakeholders		4	4	4	4
	4.10 Mobilise other relevant government departments to address TB in their plans	All 11 identified government departments with plans to address TB by 2008	Minutes of meetings held Departmental plans Progress reports		NDOH PDOH		4	4	4	4
	4.11 Engage research and academic institutions in conducting research on TB	Database of all research conducted in the country established by 2008	Research Database Minutes of meetings held		NDOH PDOH		X	X	X	X
		Research priorities published annually					X	X	X	X
	5. <u>Supervision, monitoring and evaluation of the TB programme strengthened at all levels</u>									
	5.1 Conduct quarterly supervisory visits to national to the provinces	36 supervisory visits conducted to all provinces per year	National reports		NDOH PDOH	36	36	36	36	36
	5.2 Conduct monthly supervisory visits from province to the	636 visits conducted to districts in all provinces per year	Provincial reports		DMT Technical agencies Donor agencies	636	636	636	636	636

	Districts									
	5.3 Conduct monthly supervisory visits from district to sub-District	2712 visits conducted to sub districts in all provinces per year	District reports			2712	2712	2712	2712	2712
	5.4 Conduct monthly supervisory visits from sub-district to facilities	42 000 visits to all facilities in all provinces per year	Sub district reports			42000	42000	42000	42000	42000
	5.5 Conduct quarterly meetings with provinces at national level to monitor progress	Four meetings held per year	Minutes of meetings held Progress reports			4	4	4	4	4
	5.5 Conduct quarterly meetings at provincial level with district and sub districts to monitor progress	36 meetings held per year	Minutes of meetings held Progress reports			36	36	36	36	36
	5.6 Conduct monthly meetings with facility managers to monitor progress	108 meetings held per year	Minutes of meetings held Progress reports			108	108	108	108	108
	5.7 Conduct an annual national reviews of the TB programme	One review conducted per year	Review report				1	1	1	1
	5.8 Conduct external reviews of the TB programme	One review conducted bi-annually	Review report				1		1	

Annexure E: Human Resource requirements at all levels

National

The main function of the national unit is to provide support and technical guidance to the provinces on the following key activities:

- Countrywide implementation of the DOTS strategy
- Training of provincial and district TB coordinators on all elements of the DOTS strategy
- Establish and update the national technical policies and guidelines on TB case detection and treatment for health facilities and laboratories.
- Conduct quarterly supervisory visits and advise on planning, monitoring and evaluation of TB control activities.
- Develop and update training materials on case management, programme monitoring and supervision for TB and Drug Resistant TB
- Collaborate with the pharmaceutical and laboratory services to ensure programme needs are met.
- Ensuring an efficient recording and reporting system for monitoring TB and DR TB patients and programme performance.
- Strengthening collaboration between TB and HIV and AIDS programmes to ensure better management of co- infected patients.
- Enhance and support communication, coordination and collaboration between all stakeholders in tuberculosis control.
- Support implementation of the Advocacy and social mobilization plan.
- Promote, coordinate and support operational and epidemiological research activities

Recommended staffing:

TB Cluster Manager (1)
Directorate: DOTS implementation – supervision, training, Treatment support and adherence (9)
Directorate: Monitoring and evaluation (5)
Directorate: Advocacy, Communication and Social mobilisation (5)
Clinical advisor for Drug Resistant TB (1)

Province

The key functions at provincial level are to:

- Collaborate with district management teams in planning TB activities so that the provincial work plan is the sum of the district work plans.
- Plan training and conduct supervisory/support visits including laboratory and pharmacy personnel who perform activities related to TB control.
- Facilitate procurement of TB dugs and advise on rational distribution and accountable drug management ensuring uninterrupted supply of drugs throughout the province.
- Supervise record keeping of the TB case registers and laboratory registers.
- Review quarterly reports provided by the districts for accuracy and completeness and provide feedback to the district officers.
- Collaborate with staff working in the HIV and AIDS programme to ensure better management of patients.

- Collaborate with other agencies and NGO's as well as private doctors, who provide care for TB patients.
- Coordinate the advocacy and social mobilization activities.
- Coordination of DR-TB management in the province.
- Surveillance of DR-TB patients and reporting on outcomes
- Conducting training for health care workers on DR-TB management.
- Ensuring proper follow up and referral of DR-TB patients

In order to conduct these core activities a full time TB coordinator has to be appointed and because of the large size of the provinces there is a need for support.
Recommended staffing:

Provincial TB manager – director level (1)
Clinical advisor Drug resistant TB, TB and HIV (1)
Reporting and recording – TB and DR-TB (2)
Advocacy Communication and Social Mobilization (1)
Supervision, Training and district support (2)
Inpatient care and Infection control (1)

Sub district and District

The district and sub-district is the implementation level and the key functions at this level are to:

- Coordinate training activities at district level
- Develop an efficient referral system of patients to ensure continuity of care for TB patients
- Ensure sufficient drug supply at all facilities
- Coordinate laboratory services and communication with laboratories
- Coordinate and establish community based DOT programmes
- Conduct support visits to health facilities including NGO's, laboratories and pharmacies
- Collate and validate facility data and submit quarterly reports on case finding, case holding and treatment outcomes
- Ensure adequate supplies of diagnostics and drugs at all times
- Ensure functional integration of TB and HIV activities at facility level
- Plan and conduct social awareness, health promotion and educational campaigns.
- Adapt, develop and distribute relevant IEC (information, education and communication) material in local language.
- Collaborate with all stakeholders in the district.

For efficient provision of these core activities and the large size of the districts, sub district TB coordinator is needed who will work closely with the primary health care supervisor, HIV and AIDS, laboratory services coordinator, district pharmacist, health promotion and the health information units. Supportive staff for the coordinator for data entry is also necessary.
Recommended staffing:

TB coordinator (1)
Data capturer (1)

Functions of the District Coordinator

- Responsible for smooth implementation of the NTCP and for achieving the programme objectives in the district.
- Planning and coordinating TB control activities in the district.
- Maintaining and distributing supplies (drugs, forms, TB stationary) and equipment.
- Organizing training of all medical staff of the peripheral health institutions.
- Supervising and supporting the facilities with the help of the primary health care supervisors. The facilities should be visited monthly for supervision.
- Compiling and analysing quarterly reports and administrative data on programme implementation in respect of the district, and sending the quarterly reports to the province.
- Organize health education campaigns and establish linkages with private practitioners, non-governmental organizations and community leaders.
- Ensure maintenance of appropriate budgets and monitor quarterly expenditure.
- Ensure proper referral and follow up of MDR-TB patients.

Functions of the Data clerk

- The data clerk is responsible for entry of the data collected from the facilities into district electronic TB register, collation, validation and analysis of the data.
- Compilation of facility and district reports for facility and district management and the province.
- Assist in the compilation of annual TB reports reflecting progress based on the established performance indicators.
- Follow up on inconsistent and incomplete data and ensure timeous reporting.
- Assist with on site training of health care workers on reporting and recording.

Facility

At facility level there should be a person responsible for the coordination of the programme. Activities particularly in facilities with case load less than 200 patients. The responsibilities should be that of ensuring proper referral and follow up of patients, record keeping, infection control and DOT monitoring. In facilities with higher case loads there should be dedicated staff to manage TB in each facility, the suggested norm is 1:200 with a split of 2/3 Professional nurse and 1/3 Enrolled nurse/ Enrolled nursing assistant. Notwithstanding this, all staff at facility level needs to be trained in TB to ensure integration and a comprehensive primary health care approach. The facility manager remains accountable for the TB programme at facility level.

Functions of Facility coordinator

- Responsible for the quality of DOT and achievement of Programme objectives in the facility (clinic or hospital).
- Responsible for case-detection and organizing direct observation of treatment in the catchment area.
- To maintain the TB Register, incorporating required information in respect of all cases diagnosed in the facility.

- To prepare quarterly reports on case detection, sputum conversion and treatment outcome for facility management.
- To maintain a map of the area detailing all other health facilities in the area, and of government organizations and NGOs/ CBOs, which carry out TB activities, including contact details of these organizations. This should also show location of the TB patients.
- To ensure (by checking the Suspect register, Treatment Cards, comparing the TB Register and the Laboratory Register, patient cards with the treatment supporters for retrieval of defaulters) that patients are correctly classified; appropriate treatment given and taken; microscopy tests carried out and treatment outcome indicated appropriately at the time of discharge. Any discrepancies found should be addressed immediately.
- To ensure implementation of the suspect register.
- To maintain a regular supply of drugs and other logistics and to ensure their uninterrupted availability.
- To arrange and facilitate the referral of patients to other facilities and follow up.
- Provide appropriate display of health education materials and conduct group health education activities.
- Ensure initial visit to the home of the patient prior to starting treatment and follow-up visits for retrieval of defaulters.
- Maintain the Treatment Cards, ensure that follow-up smear examinations are carried out as per guidelines.
- Ensure that contacts are suitably examined.
- Coordinate with the laboratory to ensure that sputum is received and examined on time.
- Ensure proper follow up and referral of MDR-TB patients.

Trained lay people can assist with the clerical workload of TB control programme to relieve the nurses to do clinical work i.e. data clerks & TB assistants employed through the Expanded Public Works Programme (EPWP) or an NGO. The suggested norms for data clerks or capturers are 1:400 and for TB assistants is 1:300.

Functions of the Community Health Worker

- Verify address of all new patients and educate patients and their families on the plan of treatment.
- Ensure regularity of DOT and administer DOT five times a week throughout the treatment period.
- Arrange time and place for DOTS, according to the patient's convenience.
- Ensure that follow-up smear examinations of sputum are carried out as per the stipulated schedule.
- Maintain the Treatment Card and record information.
- Ensure that the Patient Card is given to the health care worker for entry in the Clinic/ Hospital Card and TB Register.
- Take steps for immediate retrieval of defaulters. It should be no later than the day after the default.
- Assist with contact tracing.