# TIMS

## TB in the Mining Sector in Southern Africa

# Quarterly Report

01-Oct-16

TO

31-Dec-16

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# UPDATE FROM THE CHIEF OF PARTY

A flurry of activity - that is the best way to describe the Q4 implementation of the TIMS grant. Q4 provided an opportunity to bring all selected implementing partners together for the first time to optimise coordination and to build the capacity of implementers. The coordination and capacity building workshop provided an ideal opportunity to unpack the complex nature and interdependencies of this grant, which I'm sure our implementing partners would agree was an eye-opener. It also provided a much-needed platform to reinforce the need to work together as a team to ensure full integration of intervention activities across different partners.

By then end of October, the first OHSC was constructed and ready for shipment to Lesotho. The PR and relevant stakeholders had to address several unforeseen challenges in the establishment and deployment of the first OHSC. The immense support from Lesotho and all engaged stakeholders assisted in navigating through and appropriately managing these challenges. We now have the first OHSC delivered, installed, inspected, staffed, and eagerly awaiting operation later this month! In total 6 OHSC have been established in this quarter.

Another significant milestone achieved in this quarter was the beginning of screening of the key populations. Again the regional nature of the grant presented some challenges and delays but by the beginning of November screening had started in 4 of the 10 countries. By December 2016 screening was operational in 7 countries with almost 40 000 people screened, the remaining 3 countries are set to start in Q5.

The PR is happy to report the by the end of Q4 the TIMS PMO was fully operational with all positions filled.

We look forward to building on the lessons learnt in Q4 as well as strengthening our partnerships with all stakeholders to successfully scale up the TIMS regional response from Q5 onwards.

Dr Julian Naidoo
Chief of Party – TIMS

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# PMO OPERATIONS

## i. Recruitments

The TIMS PMO is fully staffed as of the 01 November 2017. If you would like to find out more about members of this team please visit our website at www.timssa.co.za

## ii. Technical Progress

- Strengthening of National Monitoring & Evaluation Systems

One of the key mandates of the M&E Unit is to strengthen countries M&E systems to collect key population data by occupation. During this quarter, the M&E Team conducted a rapid assessment to determine which countries are currently collecting key population data by occupation. The assessment showed that while the majority of countries collect TB data they do not disaggregate by occupation. Some countries have the information in facility registers but it is not reported to the district. The M&E Team will work with countries to strengthen their M&E systems to enable them to collect and report on TB data by occupation. This will include manually modifying TB registers in collaboration with NTP managers or MOH to include occupation as a work around measure while a permanent solution is implemented.

In addition to conducting the rapid assessment, the M&E Team undertook a mission visit to Swaziland to finalise discussions on the development/ modification of tools to collect key population data. Swaziland had revised most of its TB data collection tools to capture key populations by occupation. However, some TB registers had not been revised to collect key population data by occupation. The NTCP agreed to revise the tools. Swaziland is expected to start collecting key population data by occupation by January 2017.

- Occupational Health & Tuberculosis

Occupational Health & Tuberculosis (OH & TB) issues within all TIMS projects were prioritised, using a risk assessment process. The service component, as it relates to the establishment and operationalization of the 11 Occupational Health Service Centres (OHSCs), was considered a high priority area and this is where the OH and TB unit concentrated most effort during the past quarter.

**Some highlights include:**

1. **OHSC Site visits (Lesotho)**

- A joint site visit (TIMS, SRs, NTP and Ministry/ Facility Manager) to the first TIMS OHSC being established at Mafeteng in Lesotho.
- A similar visit was made to the site proposed for the second Lesotho OHSC (in Maseru).
  - These two site visits flagged a number of issues which required further management involvement. OH and TB developed a "Lessons Learned Log" which also contains suggested solutions/mitigations and captures information relevant to the implementation of interventions. This has now been adopted by TIMS PMO and

all divisions are able to contribute to the organisation via SharePoint.

- Specifically, this activity has also informed the development of a specific "Site Selection Tool" which will be used to ensure that all site-specific risks are identified and taken into consideration before the establishment of each new site.

**2. OHSC Clinic**

- The OHSC floor plans were reviewed and new internal designs proposed and agreed by all parties for future OHSC.
- A simple "Services Guideline" was developed to ensure that service delivery is aligned with TIMS expectations.
- The OHSC Operations Manual was reviewed and approved.

OH and TB continue to liaise with the selected SR on equipment and other operational issues.

**2. Referral and Health Management Information System (RHMIS)**

- Inputs have been made into the Strengthening Referral Systems project and the IT Link, which are on track. In addition, discussions were held on the establishment of a cloud-based solution for X-ray storage and retrieval. It is expected that this would form the platform for a future RHMIS.
- A motivation was written and submitted to the RCM for the funding of the cloud-based solution, which will include a large server and Picture Archiving and Communication System (PACS). This will have wider benefits also for the South Africa compensation process impacting miners and ex-miners.

**3. Regional Geospatial Mapping study**

This is on track and progressing well.

**4. TB screening and active case finding**

Activities were slow to start but are now progressing according to TIMS expectations. After 6 weeks of screening just under 40 000 people were screened.

**5. Legislative Review**

Reports were reviewed and discussions held to confirm that expected deliverables are on track. The first draft of the 10 country report is expected in February. Efficiencies were proposed regarding upcoming regional workshops.

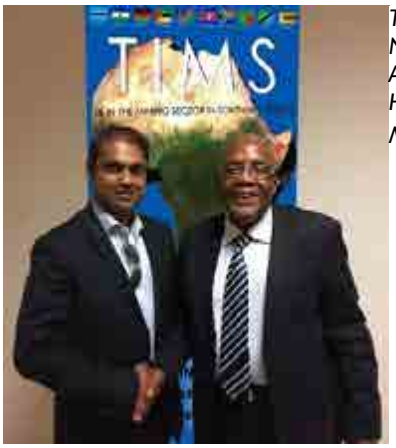
**6. Epidemiology Study**

The Baseline Epidemiology Study has submitted to the PR and is currently being reviewed internally. The study is also being reviewed externally, by an independent external reviewer.

The OH and TB Supervisory Plan has been revised and aligned with TIMS processes. The Plan will be regularly reviewed through continuous risk assessment of each TIMS project and will inform ongoing OH & TB activities.

## iii. Country Engagements

## a. Meeting with South African Minster of Health




*TIMS COP Dr Julian Naidoo with South Africa Minister of Health Dr Aaron Motsoaledi*

The senior management of the TIMS PMO continued their high-level county stakeholder engagements this month. The COP met with South African Minister of Health Dr Aaron Motsoaledi and provided him with a progress update on grant implementation and also discussed important issues such as the long-term sustainability of interventions. As the Chair of STOP TB, Minister Motsoaledi had some significant insights to share with the team. These included the need to ensure that prevention (upstream risks including dust control) is prioritised; the Regional Health Management Information System (RHMIS) is effective in ensuring a continuum of care, and the need for community systems strengthening.

The Minister was given a demonstration of the newly developed geospatial mapping software and highlighted the multiple applications in respect of tracking and tracing; use for other disease interventions, and to support the regional database being developed under the grant.

A key takeaway for the TIMS PMO was that we cannot treat our way out of the epidemic, but need to devise ways to prevent new TB infections. Preventative legislation and policy are key in this regard.

## b. SADC Joint Health Ministers Meeting

The Southern African Development Community (SADC) held a joint meeting of SADC Ministers of Health in the week of 7 – 11 November 2016 in Swaziland. The PR was invited to present an update of the grant at a dinner function on the evening of 9 November.

The PR was delighted to accept this invitation as the SADC Declaration of 2012 is ultimately what initiated the TIMS grant. This was an opportunity to provide feedback to the forum that was instrumental in creating the grant. Due the limited time available, the PR presentation focused on some key deliverables of the grant including:

- Establishment of OHSCs
- Development of the RHMIS
- Regional geospatial mapping
- Screening and active case finding.

The presentation was well received by the audience that included Ministers of Health as well as representatives of the private sector and development partners.

## c. Mozambique Country Coordinating Mechanism (CCM) meeting

The Country Coordinating Mechanism for Mozambique (CCM) is a key organisation through which coordination of grant activities is conducted. The CCM invited the PR to present an overview of the TIMS grant as well progress to date. The CCM meeting was held in Maputo on 29th November 2016 where the PR was represented by DrDr Riedawaan Pillay.

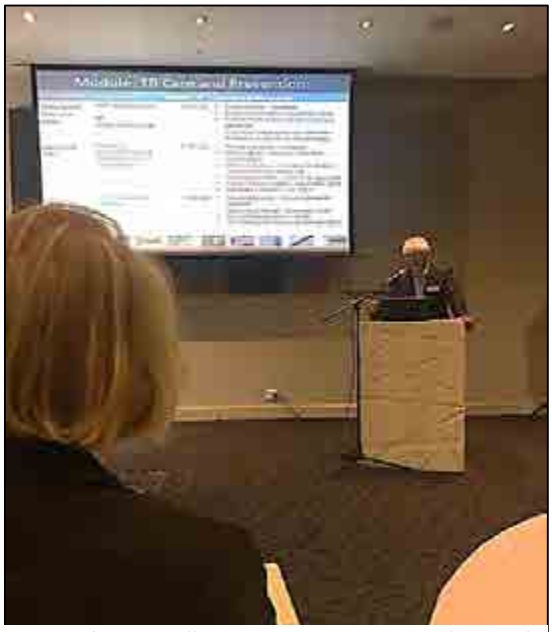
The PR presented an overview of the grant, grant status and areas for potential collaboration between the CCM and the PR. Following a robust discussion on the grant, the following issues emerged:

- Integration of the TIMS grant with other country grants – particularly those that are addressing similar issues. It was agreed that the CCM is an important player in that many of the grants are not sighted on other initiatives, whilst the CCM is.
- Mozambique is already implementing an mHealth technology. It would be important to link TIMS' service providers to this.
- Data flow was complicated and it may not be efficient to extract indicator data through NTP systems. It was suggested that TIMS should use its own data and report on this. But it was explained that after consultations with NTP managers, it was agreed that parallel systems should be discouraged to avoid information asymmetry. The PR agreed to review this.
- Country coordinator is a key focal person for the grant and should be utilised to coordinate TIMS activity in Mozambique
- TIMS grant should make sure that screening activity in overlapping areas such as Xai Xai is well managed to avoid duplication.

This was a very important engagement for the TIMS grant in Mozambique.

## d. Regional Coordinating Mechanism (RCM) Meeting

The TIMS Principal Recipient was invited to participate in the RCM orientation workshop and meetings from the 21st to 25th November 2016 in Johannesburg. The aim of the workshop is to orient participants on the oversight functions of the RCM, the roles of RCM, oversight committee and PR, and the tool to be used for oversight. Additionally, the PR presented to the RCM the grant implementation status to date highlighting milestones achieved and those yet to be met; challenges; lessons learnt; and future corrective solutions. It was a highly interactive meeting with productive and constructive exchanges between the PR, RCM and other stakeholders present such as the Local Fund Agent (LFA) and the Global Fund. Furthermore, the PR participated in the RCM Dashboard orientation during the same week



*Dr Riedawaan Pillay presenting a status update to the RCM, Johannesburg, South Africa.*

## e. Technical Working Groups (TWGs)

*Part of the PRs responsibility is to create or participate in technical coordination fora on TB in the 10 countries participating in the TIMS grant. To date, the PR has participated in two TWG in Tanzania and Mozambique with South Africa planned for early next year*

**Tanzania:**


*Participants of the Tanzanian TWG meeting*

The PR was invited to address the Technical Working Group (TWG) on TB in Tanzania on 17th November 2016.

The TWG, chaired by the International Organization for Migration (IOM) had its quarterly meeting in the town of Bagamoyo, about 60km north of Dar Es Salaam. The TWG consists of representatives from government, the private sector, NGOs and development partners. The PR was represented by Dr Julian Naidoo, Dr Riedawaan Pillay and Bright Chiranga.

The presentation made to the TWG highlighted the following areas:

a. Overview of the TIMS grant and the history of the grant to date
b. Summary of the grant modules and interventions
c. Current state of implementation
d. Areas for potential technical collaboration

The delegation from the PR was well received and participants engaged robustly following the presentation. Main points of discussion included:

- Long term sustainability of the grant
- Establishing the OHSC in Tanzania
- Ongoing cooperation between the PR and the TWG

It was agreed that TIMS will participate in future meetings and will explore ways to support the TWG with its quarterly meetings.

**Mozambique:**

*Participants of the TWG meeting in Maputo, Mozambique.*

On the 19th and 20th of December 2016, a TWG meeting was held in Maputo to ensure optimal coordination and planning of TIMS interventions in the country. Key implementers highlighted TIMS activities and technical aspects of delivery in Mozambique. There were two important outcomes of this TWG meeting:

I. Consolidated implementation plan of all planned activities was developed with due consideration to maximise efficiencies and synchronise similar activities between SRs;
II. Fast tracking of site selection and inspection to take place in January 2017

## f. Meeting with MOH – Namibia

On the 7th of November 2016, the Chief of Party, Dr Julian Naidoo visited Namibia for a high-level stakeholder engagement. The purpose of this focused stakeholder engagement was to brief the Minister of Health (Hon. Dr Bernard S. Haufiku), Permanent Secretary (Dr Andreas Mwoombola) and other senior management at the Namibian Department of Health on the progress of the TIMS grant and the need for sustainability of key interventions post the grant implementation period. Both the Minister of health and the Permanent Secretary of Health expressed commitment to ensuring the integration of services into country systems post the grant period and agreed to fast track the signing of the memorandum of understanding (MOU) and the next technical working group meeting in Namibia.

## iv. Memorandum of Understanding (MoU) Status

**Botswana**

The Government of Botswana has signed the MoUMOU and submitted to WHC, Will be signed off by WHC in January 2017.

**Lesotho**

The MoU with the Kingdom of Lesotho has been signed, first OHSC has been established.

**Mozambique**

The government of Mozambique has signed the MoUMOU which has been signed also by WHC.

**Namibia**

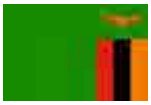
The Government of Namibia has received the draft MoUMOU. Feedback received that the MoUMOU is being reviewed by the Office of the Attorney General before being sent to the MoH for signature.

**Swaziland**

The MoU has been signed and the first OHSC has been delivered.

**Tanzania**

The Government of Tanzania has reviewed the MoUMOU and has submitted comments. These have been incorporated and the revised MoUMOU has been sent to Tanzania for signature.



**Zambia**

MoU signing for Zambia has to be renegotiated as the government, which the PR initially engaged have changed substantially following the 2016 Zambian National elections.

**Zimbabwe**

The government of Zimbabwe have agreed to the terms of the MoU. The signed MoU is expected in January 2017

# GRANT STATUS

## i. GRANT STATUS SUMMARY

| INTERVENTION | IMPLEMENTING PARTNER | STATUS |
|---|---|---|
| **Regional IT System** | *EOH XDS* | The IT link to compensation system has been developed. Testing with the Medical Bureau for Occupational Disease (MBOD) underway. To be piloted in February 2017. |
| **Strengthening the Referral System** | | Design specification documents ready. To be presented to the technical panel set up by the RCM in January 2017. |
| **Baseline Epidemiological (EPI) Study** | *PHRU* | Draft report submitted. Current under review by PMO, RCM and external reviewer. |
| **Regional Mapping** | *TomTom Consortium* | Draft report submitted. The system is almost completed. Will be reviewed by RCM (NTP managers). Ethical clearance in two countries is still outstanding. |
| **Knowledge, Attitudes and Practice (KAP) Study** | *Select Research* | Fieldwork concluded for eight countries. Ethical clearance for remaining two still a challenge. |
| **Communications Strategy** | *Meropa Communications* | Contracted and in the desktop review stage of their process. The communication strategy will be informed by the KAP study being undertaken by Select Research. |
| **Establishment of OHSCs** | *North Star Alliance /Enhancing Care Foundation* | Two OHSCs deployed in Lesotho<br>Four OHSCs ready for deployment in Mozambique and Swaziland<br>Five OHSCs under construction for the remaining countries. |
| **Operation of OHSCs** | *OGRA Foundation* | Mafeteng OHSC operational. Set up work for the Swaziland and Mozambique OHSC is underway. |
| **Implementation of TB Surveillance Models** | *IRD/ADPP* | Screening underway with good progress,<br>mHealth app ready by mid-February 2017.<br>Surveillance models ready by end June 2017. |
| **Community System Strengthening** | *ACHAP* | Contracted<br>Pre-work underway, CSO assessments in January 2017. |
| **Legal and policy environment assessment and law reform** | *Health Focus* | Draft 10 country report submitted.<br>Final report end February 2017.<br>Dust control training to commence in April 2017. |

*The table above provides a snapshot of where the grant is as of the 31st December 2016. Although there have been many challenges in this period, the grant is overall on track with all implementing partners contracted and having commenced work on their intervention. Below is a more detailed status account of the grant by implementing partner.*

## ii. GRANT STATUS: BY IMPLEMENTING PARTNERS

# EOH-XDS

**NTERVENTION**

**Strengthening the Referral System & Developing an IT Link to the Compensation Fund**

**OBJECTIVE**

XDS EOH is assessing the feasibility of establishing a regional database of mineworkers and ex-mineworkers and a centralized health information management system that will support cross-border referrals and enable access to interventions and support such as compensation through the following activities. XDS will review existing health information management systems that pertain to miners in the 10 countries of interest with regard to utility, compatibility, and accessibility.

### Q4 STATUS

✓ **Phase 1 of the project was completed.**

- Feasibility and Research was done for all ten countries, i.e. all country site visits have been completed and reports have been submitted to TIMS PMO
- The IT link to compensation funds system has been developed and is currently in User Acceptance Testing.
- The prototypes of the Cross-Border Referral System (CBRS) and the Regional Health Management Information System (RHMIS) have been developed.
- XDS provided weekly and monthly reports during phase 1 of the project.
- Overall the objectives detailed in the project plan for phase 1 have been achieved.

### DELIVERABLES

XDS completed site visits to all the ten countries involved in the project. During the visits, we met National TB.

- Programme Managers, Ministry of Health officials, Technical personnel and health development partners.
- XDS visited clinics in both rural and urban settings to get a better understanding of the operational climate.
- The IT link system was designed and developed and tested (internal).
- The CBRS and RHMIS prototypes were designed and developed. Final design documentation will be released to TIMS PMO in January 2017 for tech review.

### LESSONS LEARNT

**Planning**

Some of the country visits could have been planned better. A lot of the issues experienced could have been avoided.

Some of the issues encountered included (but not limited to)

- Some countries required business visas for the site visits.
- All Health Ministries required letters of permission. This is time-consuming and must be signed by the relevant authorities.
- All relevant documents, as well as appointments, must be sourced and confirmed prior to the visit.

**Education**

A bigger effort needs to be made to educate our stakeholders on the TIMS project. Many of the stakeholders met had either no understanding or limited understanding of the project. Perhaps more Project awareness needs to be done prior to visits.

Some of the issues encountered included (but not limited to):

- Stakeholders not having an understanding of the SP/SR's mandate on the project.
- SP's and SR's not having an understanding of the protocols and climate in the country being visited.
- Confirmed availability of the officials we seek to have an audience with.

**Communication**

Communication can always be improved upon, communicating and confirming with the right people would have certainly helped

Some of the issues encountered included (but not limited to):

- Sometimes speaking to the wrong people and sometimes not speaking to the right people.
- Coordination between the Country Coordinators, partners and the Ministry of Health personnel.
- Sometimes scheduled appointments were not kept.
- Confirmed itinerary for the site visits.

## MAJOR CHALLENGES

Legal agreements regarding data sharing and confidentiality must be in place.

- Data hosting legal agreements by SADC. While we have an agreement in principle with SADC we do not have the legal documents.

## COMING UP IN Q5

**Phase 2 - Part 1**

- Submit system design documents to the Global Fund of the RHMIS.
- Development of the CBRS.
- Finalisation of the data agreements.
- Internal testing of the CBRS.
- User Acceptance Testing of the CBRS.
- Country visits (part of the CBRS release).
- Future RHMIS agreements.

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# TOMTOM CONSORTIUM

INTERVENTION

Regional Mapping Study of Key Populations & Health Services for the Mining Sector in Southern Africa

**OBJECTIVE**

Conduct a regional mapping study. The mapping study is being conducted in a two-phase approach, phase-one is the desktop mapping of mines, population settlement areas and health facilities, data preparation and interpretation exercise. In phase-two communities and hotspots identified during Phase 1 of the project, will be visited by field teams to verify the data.

## Q4 STATUS

*Fieldwork status per country*

**Tanzania, Malawi, Mozambique, Lesotho and Namibia**

- Data collection completed.
- Fieldwork completed.
- Final datasets transferred to Riskscape for analysis.

**Zambia**

- Fieldwork completed.
- Review of data has been done by Africascope.
- Queries on the data have been sent to ExpoAfrica for their input.

**Botswana**

- Health facility data received.
- Extracted clinic and health post data in hotspot areas.
- Data with coordinates and maps to be sent to Expo Botswana tomorrow.
- Fieldwork to be completed in approximately in Q5.

**Swaziland**

- Fieldwork not yet started in Swaziland because of significant delays in getting ethical clearance.
- Data from Service Accessibility Mapping (SAM) will be integrated with health facilities in hotspots for further analysis by Riskscape.
- Financial reconciliation to close off Swaziland still to be done.

**Zimbabwe**

- Health Facility Census data for Zimbabwe is not a census but a sample and therefore cannot be used to do any further detailed analysis.

*GIS Analysis Status*

Geographic Information System (GIS) analysis and algorithmic models developed and tested for each country. Awaiting final data from fieldwork before finalising each country.

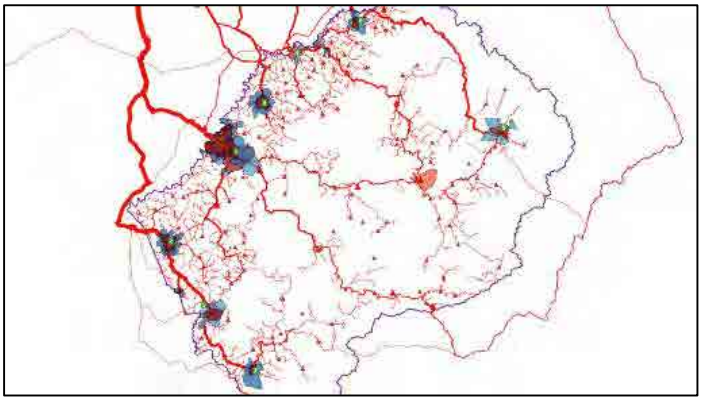
## DELIVERABLES

**FIELDWORK:** TomTom has collected all available geospatial, report and attribute data they could on mines, health facilities, hotspots and population for the countries. They have fully completed fieldwork in five countries. Fieldwork in Zambia is complete but data validation needs to be done. Fieldwork in Botswana will be completed in approximately two weeks. Fieldwork in Swaziland will not be done because of systematic delays in getting ethical clearance. Data from the SAM data will be integrated with the health facilities identified in the hotspots to allow further analysis to be done.

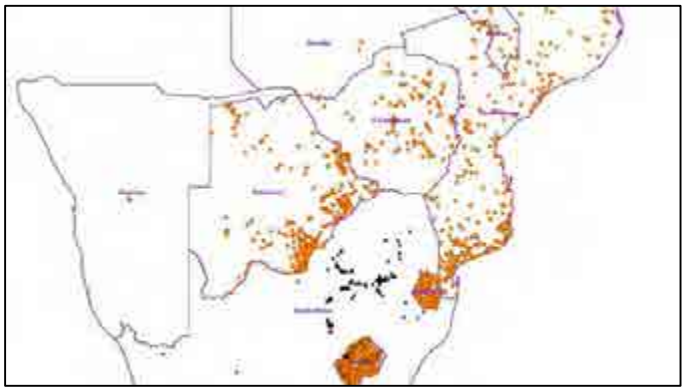
**GIS ANALYSIS:** We have developed, tested and implemented the GIS and algorithmic models in those countries where we have received feedback from fieldwork process. Identified and documented the HOTSPOTS for these countries.

## LESSONS LEARNT

At the start of the project, the risk of delays as a consequence of requiring ethical clearance was identified. The significant delay in getting ethical clearance and the requirement of still completing the project within the stipulated timelines was and are a major problem. The fieldwork portion of the project was an extremely complex because of the very different circumstances relating to TB and the mining sector in each country. Unwillingness from especially the mining sector to share information related to TB in the workforce.



*Demonstrates patterns of migration to South Africa and major roads used*



*Concentration of key populations in relation to nearby towns/cities*

*Polygons showing distribution of key populations*

# PHRU

INTERVENTION

## Baseline Epidemiology Study on Tuberculosis, MDR-TB, Silicosis and HIV amongst Miners and Ex-Miners in Southern Africa.

**Objective**

The baseline epidemiological assessment will be to collect and assimilate, and analyse available secondary data describing the current TB, MDR TB, HIV and silicosis epidemics in miners both regionally and in the listed ten (Mozambique, Lesotho, Swaziland, South Africa, Botswana, Zambia, Zimbabwe, Namibia, Malawi and Tanzania) Southern African countries.

### Q4 STATUS

Data collection and analysis are completed in all ten countries. Key informants interviews have been completed in five of the 10 countries, and a total of 84 participants have enrolled in the study.

### DELIVERABLE

A draft report on the study has been submitted to TIMS PMO for review.

### LESSONS LEARNT

- The assumptions regarding the availability of secondary data is flawed for the following reasons:
    - There is very little published data on TB, HIV and Silicosis in mine workers in most of the participating countries.
    - There is more data available on TB and HIV literature for the general population.
    - Some countries do not consider silicosis as an occupational disease.

### MAJOR CHALLENGES

- Ethics Approval in some of the countries has been a major challenge.
- There has also been a high refusal rate among key informants for participation in the study.

### COMING UP IN Q5

- Complete interviews in the five outstanding countries.
- Capture and analyse the data.
- Finalise the Epidemiology Study.

# SELECT RESEARCH

INTERVENTION

Knowledge, Attitudes and Practice (KAP) Survey to Inform an Information, Education and Communication (IEC) Strategy for the Mining Sector in Southern Africa

**Objective**

To provide a detailed understanding of the Knowledge, Attitudes and Practices (KAP) in terms of TB prevention, care and treatment adherence support among key populations in the mining sector in the 10 participating countries Botswana, Lesotho, Namibia, Malawi, Mozambique, Tanzania, South Africa, Swaziland, Zambia, and Zimbabwe.

## Q4 STATUS

The KAP Survey is now in the data collection stage after a series of Interviewer Training Sessions across all 10 countries. Those countries for which data collection has been completed have progressed to data cleaning in preparation for tabulation while other countries are finalising data collection. The table below indicates the detailed status:

| COUNTRY | TOTAL SAMPLE | COMPLETED | OUTSTANDING | COMMENTS |
|---|---|---|---|---|
| Malawi | 970 | 951 | 19 | In progress |
| Mozambique | 1,400 | 805 | 595 | In progress |
| Tanzania | 2,300 | 2,252 | 48 | In Progress |
| South Africa | 2,500 | - | 2,500 | Starting 16/01/2017 |
| Zimbabwe | 1,200 | - | 1,200 | Starting 24/01/2017 |
| Lesotho | 200 | 200 | - | Completed |
| Namibia | 210 | 210 | - | Completed |
| Botswana | 210 | - | 210 | Starting 17/01/2017 |
| Swaziland | 110 | - | 110 | Start date moved, Notification of Local Authorities in progress. |
| Zambia | 1,400 | 1,400 | - | Completed |

*KAP Survey Status*

## DELIVERABLES

1. **Questionnaire approvals**: These were duly approved by TIMS PMO and shared with other partners for their input

2. **Ethics clearances**: All countries except Swaziland have received their ethics clearances. In Swaziland, all the documents have been provided and clearance is expected in January 2017.

3. **Training in all the countries on data collection:** All countries carried the data collection training sessions and Select Research and TIMS PMO was able to attend some of the training sessions. All countries that trained in 2016 and were not able to collect data are required to have refresher training courses to make sure that the interviewers are up to scratch on the instruments.

4. The questionnaires were successfully uploaded into ***Survey-To-Go*** the online data collection tool being utilised.

## LESSONS LEARNT

A few of lessons have been learnt thus far, key among them are the following:

- Changes/modifications of the survey instrument need to be carefully coordinated to ensure uniformity across all countries to avoid going back and forth.
- The festive month of December should be avoided, where possible, for fieldwork scheduling.
- Prior notification of Authorities in sampled areas is a prerequisite to avoid delays in data collection.
- The rainy season slows down the rate of data collection and, where possible, should be avoided.

### COMING UP IN Q5

The following activities are pencilled in immediately after data collection:

- Finalise data collection in the remaining countries.
- Data validation and cleaning.
- Data processing and analysis.
- Report writing.
- Submit Final Report.
- Present Report to TIMS PMO.

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# MEROPA COMMUNICATIONS

INTERVENTION

Improving TB Prevention, Care & Treatment Behavior
(Communication Strategy)

**Objective**

Development of relevant and responsive communication strategy targeting key populations in the mining sector in Southern Africa. They will also be developing and testing materials, conducting communication capacity building and supporting the integration of the communication strategy into national TB programmes.

### Q4 STATUS

Meropa Communications was contracted at the end of Q4 and are in the desktop review stage of this intervention.

### COMING UP IN Q5

The Meropa team have compiled the initial batch of materials regarding their communication strategy mandate. These documents relate to the research phase of the project and follow the methodology contained in the initial proposal, which includes:

- Outline for the proposed literature review.
- The key informant interviews guide/questionnaire and sampling framework.
- A questionnaire for country coordinators. In their liaison with country coordinators to date, most had expressed willingness to help with this endeavour.

In terms of the process, Meropa anticipates that the literature review will be completed first. Upon receiving PR feedback and approval, the key informant interviews and the country coordinators questionnaire will begin in parallel, to maximise time.

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# OGRA FOUNDATION

INTERVENTION

**Managing the Occupational Health Service Centers (OHSCs)**

**Objective**

Oversee and manage occupational health services in 11 Occupational Health Service Centres (OHSCs) in 8 Southern African countries – Botswana, Lesotho, Namibia, Mozambique, Swaziland, Tanzania, Zambia and Zimbabwe.
To provide a range of services at a single point to improve continuity of care and to access compensation for occupationally lung diseases including TB

## Q4 STATUS

During the reporting quarter, OGRA Foundation finalised contractual issues with the TIMS PMO, which culminated in the signing of the Project agreement on the 7th October 2016. This was followed by completion and submission of the Inception Report and the OHSC Operations Manual to the TIMS PMO. The Operations Manual details how the OHSC will operate on a day to day basis. Both the Operations Manual and the Inception report have been reviewed by the TIMS PMO with the Operations Manual being approved while the Inception Report is in the final stages of approval. OGRA Foundation also conducted site inception meetings in Lesotho (*pictured below*). This led to the evaluation of the OHSC sites and troubleshooting most of the anticipated issues in preparation for the operation. OGRA Foundation also conducted recruitment of the OHSC staff in Lesotho through a collaborative process that involved the National TB Program, the local hospital in Mafeteng and the TIMS Country Coordinator. The following positions were filled for the first OHSC in Mafeteng, Lesotho:

1. OHSC Nurse Manager
2. Occupational Medicine Practitioner
3. One Enrolled/ Registered Nurse
4. Radiographer
5. Social Worker
6. IT/Data Officer
7. Administrative Clerk
8. One General Assistant

*The inspecting the OHSC in Mafeteng, Lesotho*

Using the same opportunity in the field during the same period, OGRA was also able to finalise and procure security services for the already established OHSC in Lesotho and initiated the process of engaging other service providers including insurance providers.

A joint site visit was conducted for the first OHSC in Mafeteng, which involved the TIMS PMO, North Star Alliance, Enhancing Care Foundation and OGRA Foundation.

In the same quarter, OGRA Foundation conducted site inception meetings in Swaziland where the two proposed sites were visited. This was followed by attending a multi-stakeholder introduction meeting in Mozambique. Recruitment also commenced in Swaziland.

## LESSONS LEARNT

- The need for closer collaboration of all the stakeholders including the TIMS PMO, the Sub-Recipients, the host health facility and the relevant government ministries and departments was a clear lesson.

- There is need to engage all the stakeholders from the planning stage including site selection.
- There is a need for close coordination and communication between the North Star Alliance and OGRA Foundation to prevent any project delays.

## MAJOR CHALLENGES

The interdependent nature of this intervention means that OGRA is heavily reliant on North Star Alliance to fulfil their mandate to establish the OHSC's that OGRA will be operating. This independence has presented a major challenge for OGRA who are ready to deliver. [1]

## COMING UP IN Q5

In the coming quarter, OGRA Foundation plans to train staff that were recruited in Lesotho and to commence operations in the first site in Mafeteng. The training and commissioning of operations are scheduled to take place during the month of January 2017. The training will be undertaken by OGRA Foundation program experts in collaboration with the NTP.

The project will also finalise recruitment of staff in Swaziland and commence operations of the first Swaziland site in Hlatikulu in January 2017. This will be done concurrently with site identification and inception meetings in Mozambique.

OGRA Foundation will work hand in hand with North Star Alliance, the PR and other respective parties to receive a total of six OHSC facilities that are scheduled to be ready within the coming quarter (Q5), prior discussions indicate that these are likely to be two sites each in Lesotho, Swaziland and Mozambique.

Once the handing over process is completed OGRA Foundation plans to officially commission six OHSC within quQ5and begin operations. During the same coming period, OGRA plans to advertise, recruit and contract staffs to work in the additional five OHSC that will be up and running within thin the stated period.

OGRA Foundation also plans to continually engage with the Compensation Manager in South Africa, Swaziland, Lesotho and Mozambique as well as NTCP managers, TIM's coordinator and stakeholders (Swaziland, Lesotho, Mozambique) to enhance working synergy and quality delivery of the services/network to the target groups.

They will also attend Steering Committee meetings to address any blockages which may hamper service delivery to the patient with a clear understanding of how to be more effective.

OGRA Foundation plans to conduct supervisory and support visits to the OHSC in liaison with the NTP managers in the respective countries.

For effective and quality delivery of the services to the patient, OGRA plans to conduct training of all OHSC personnel.

This will be followed by outreach and awareness activities of OHSCs through links with other Sub-recipients geared towards raising awareness as well as creating the demand for the services at the OHSC.

OGRA plans to organise review meetings at the OHSC levels, conduct mentorship sessions to the teams on the ground as well as conducting data quality audits at the sites in a bid to enhance the quality of services offered at the OHSC.

[1] For more on the challenges faced see the North Star Alliance/ECF status update on page 26.

# IRD and ADPP

INTERVENTON

TB Screening and Active Case Finding

**Objective**

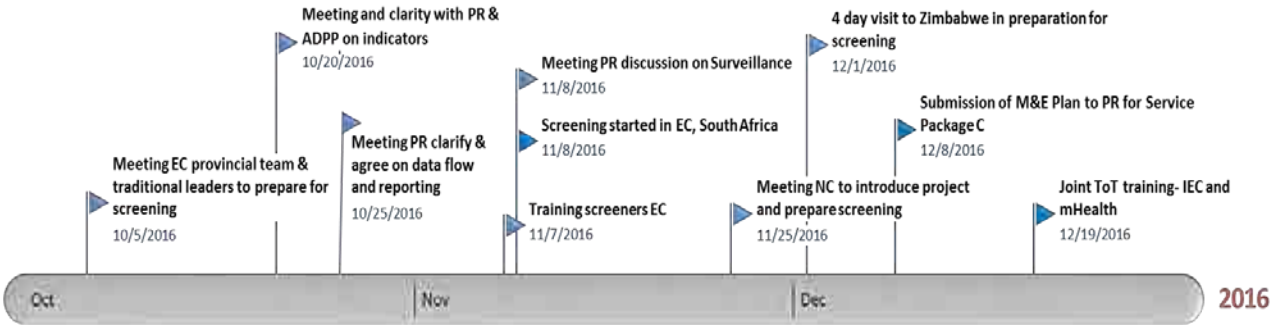
Increase TB case finding and linkage to care among the key populations in the mining sector in Southern Africa. Key tasks under this service package has been divided between the two SRs, however there are obvious points of collaboration and interdependencies.

### Screening Numbers

| Country | Target (over grant period) | Actual as at 31st December 2016 |
|---|---|---|
| Botswana | 22 000 | 4 039 |
| Lesotho* | 25 000 | 0 |
| Malawi | 15 000 | 2 868 |
| Mozambique | 35 000 | 9 868 |
| Namibia | 19 000 | 1 314 |
| South Africa | 30 000 | 14 144 |
| Swaziland* | 15 000 | 0 |
| Tanzania | 30 000 | 415 |
| Zambia | 53 000 | 6 790 |
| Zimbabwe* | 56 000 | 0 |

** Screening has not yet started. Expected to start Q5*

## IRD




### Q4 STATUS

The timeline below plots key milestones that have been completed during the fourth quarter of 2016. This period also included ongoing tasks such as: drafting of cross-border surveillance model, development of screening model, screening guide and standard operating procedure, creation of patient IDs for project countries, printing of QR Codes, finalisation of the codebook (which is based on the screening tool and is required for development of TIMS APP), and drafting of user- guide for the TIMS APP.

### DELIVERABLES

The screening started in the Eastern Cape (EC) – a total of 9 735 people screened as at 31st December 2016.

- ✓ The project introduced in Northern Cape (NC).
- ✓ The project was introduced in Zimbabwe and NGO's appointed.
- ✓ M&E Plan submitted to the PR.
- ✓ IEC joint training with ADPP in December 2017.
- ✓ mHealth introductory training.
- ✓ Surveillance model: Cross-border draft.

### LESSONS LEARNT

- The importance of buy-in from the Ministry through introductions to strengthen project implementation.
- Screening tool experience in EC and ADPP countries - Screening criteria not standardised resulting in different definition what is considered a 'presumptive' case.
- NC against sputum collected on the spot – illustrating that screening approach even differs within the same country.
- Providing resources for the Ministry, e.g. cartridges for gene expert machines and sputum bottles.
- DQA highlighted the need for refresher training which included specific scenarios to help screeners practice completing the form.
- Also, printing of a screening booklet in triplicate was useful so that a copy of the completed tool is left at the facility.

### MAJOR CHALLENGES

- To ensure that the patient medical records remain within the country, each country must have their own Server. Unfortunately not all the countries have been budgeted to have their own servers. PR to assist in getting more servers or engaging countries and SADC on a possible solution.
- Some of challenges related to screening: Shortages of laboratory forms and specimen bottles, high screener turnover, distances within villages travelled by health screeners, weather conditions (slowing down screening), taxi violence affecting Hub Agent's ability to do follow-up/support visits, and failure to disclose patients who are already on TB treatment and other chronic conditions.

## COMING UP IN Q5

1. Start screening in Zimbabwe
2. Start screening in Northern Cape
3. Continue screening in EC
4. Mobile Health Application launch
5. Surveillance models

*Screeners working in the Eastern Cape, South Africa*

# ADPP

## Q4 STATUS UPDATE

ADPP started Active Case Finding (ACF) activities in November with 2 countries and by December had begun ACF in six countries, namely Botswana, Malawi, Mozambique, Namibia, Zambia and Tanzania.

The project is on track and achieved 76% of the revised targets for Q4 of 2016 which is 38% of the overall screening target for ADPP.

TB screening activities started gradually in two countries Botswana and Mozambique, and progressed to four more countries for a period of 6-9 weeks (Malawi, Zambia, Namibia, Mozambique, Botswana and Tanzania) and it allowed ADPP and implementing partners to focus on understanding, making adjustments in approaches to improve programme quality issues.

The number of people screened is lower than initially envisaged in the revised targets agreed with the PR in November. However, it is important to understand that field officers are still familiarising themselves with tools and will increase the rate of work as they become more proficient.

## DELIVERABLES

The table below provides an overview of the deliverables in each of the countries during Q4:

| Country | Status |
|---|---|
| **Botswana** | 1 967 KPs have been screened (1 012 male; 955 female) across the three sentinel sites of Francistown, Selibe-Phikwe and Palapye. 146 presumptive cases identified, 1 TB case confirmed (but results from the majority of presumptive cases is still unknown) Challenges in the provision of sputum mugs for the three sentinel sites have been solved. |
| **Lesotho** | Project staff recruitment started in December and will be finalised in January 2017. Training of key staff commenced in December and training of field officers will be conducted in January 2017. TB screening will be starting in Q5 |
| **Malawi** | 2 787 KPs have been screened (1 063 male; 1 724 female) across the three sentinel sites of Neno, Phalompe and Chiradzulu. 388 presumptive cases identified and two TB cases confirmed (but results from the majority of referred cases is still unknown) |
| **Mozambique** | 6 788 KPs have been screened (2 960 male; 3 828 female) in the sentinel site of Xai Xai. 328 presumptive cases referred and seven TB cases confirmed (but results from the majority of referred cases is still unknown) A new project manager has been appointed and to take up her position in early January. |
| **Namibia** | Training of field staff took place between 28th Nov and 2nd Dec. Screening activities scheduled began on 12th Dec 2016. 1 314 KPs have been screened (654 male; 660 female). 78 presumptive cases have been referred but the outcome of referrals was still unknown at the time of compilation of this report. |
| **Swaziland** | Project staff recruitment started in December and will be finalised in January 2017. Training of one key staff was done in December and training of field officers will be conducted in January 2017 TB screening will be starting in Q5 |
| **Tanzania** | 415 KPs (309 male; 106 female) were screened in Merarani and Kahama sentinel sites. 127 presumptive cases were referred for TB testing and 6 were found positive and started on treatment. |
| **Zambia** | 6 790 KPs have been screened across the sentinel sites of Kitwe, Chingola, Solwezi and Chililambombwe. 210 presumptive cases have been referred but the majority have not been tested due to lack of cooperation with health |

## CHALLENGES

The following challenges have been identified by the project:

- **Over-reporting of presumptive cases:** The current SOPs for the screening tool result in an over-reporting of presumptive cases due to the strict referral guidelines used by this intervention.(i.e.. people who screen positive for a single criterion are referred. This is not aligned with some national guidelines and is resulting in reluctance to cooperate from some health facilities and loss of credibility of implementing partners' field staff amongst local communities. Issues with the screening tool have been documented by ADPP and shared with the PR and IRD in December.
- **Provision of medical supplies:** In the initial budgeting phases, ADPP did not allocate funding to TB testing supplies (primarily sputum mugs) as these are to be provided by the NTP and the Ministry of Health through the health facilities. However, the programme has frequently been struggling to obtain supplies for all the sentinel sites. This has resulted in an inability to collect sputum samples at the doorstep during the initial months. The Project has identified budget lines for supplies that can cover some of these costs. This will have to be taken into account for the budget realignment and further advocacy by the PR with MoH by engaging at the highest level at the national headquarters, specifically with decision makers in all eight countries is required to ensure supplies are provided and that TIMS project can receive approval from the PR to have a limited buffer stock to cover deficits when there are stock-outs at health facilities located in TIMS sentinel sites.
- **Low case detection rate:** Despite large numbers of KPs screened, the overall number of confirmed TB cases remains low. This is due to a combination of factors such as over-reporting of presumptive cases due to the screening tool's SOPs.
- **Reluctance from KPs referred for testing to attend health facilities:** This is due to low prioritisation of health, working commitments and long working hours and shifts that miners face.
- **Unavailability of Kiswahili TB screening tool for Tanzania** has made it hard for the Field officers to advance in doing field work as they are currently using English version of the screening tool which is not user-friendly for them.
- **The unknown outcome of referrals for people found with TB-like symptoms** due to time constraints and prioritisation of screening targets, which have not allowed field officers to follow up appropriately with presumptive cases.
- **Lack of cooperation from the lab technicians** who are refusing to test collected sputum samples brought in by DAPP Zambia unless financial incentives are provided.
- **Reduced work days in December:** The festive season during the month of December has slowed down the programme's progress due to limited availability to meet with stakeholders, reduced number of working days and internal displacement of mineworkers back and forth from their workplace/home which made it difficult to identify and screen them.
- **Provision of IEC:** Inability to carry out mass awareness and screening campaigns due to the delay in the provision of IEC materials.
- **Disbursement of funds:** Disbursement of funds from the PR to ADPP at the end of December was delayed. This has prevented ADPP from carrying out technical assistance and DQA visits at the end of December/beginning of January to implementing partners.

- **Budget constraints**, particularly in the transport budget lines particularly for the eight TIMS country projects, have made start-up of activities and regular monitoring of activities difficult. Alternative solutions within existing budget lines have been put in place but this needs to be taken into account for the budget realignment which we would benefit from having as early as possible in Q5 (January to March 2017).

**Budget Utilisation - Summary of challenges realised:**

- Difficulties in the procurement of major items such as motorcycles due to inflation and depreciation of currencies as is the case of Malawi.
- Delay in the procurement of T-shirts in Mozambique, Botswana and Namibia during the month of December as initially planned because of suppliers closing down until the New Year.
- Delay in the implementation of costly activities such as meetings with stakeholders or large sensitisation meetings due to the lack of available IEC materials.
- In order to improve burn-rates and expenditure forecasts, ADPP's PMU will work over the coming month with the implementation partners for the development of fine-tuned forecasts and the revision of work-plans for the next quarter to ensure a close alignment of forecasts and expenditure. More accurate spending will also be facilitated once the budget realignment is carried out with the PR over the next months and ADPP's PMU Financial Manager has, through on-site visits, compiled specific budget modifications that will be requested as part of the realignment.

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# ACHAP

INTERVENTION

Community Systems Strengthening

**Objective**

To improve access to TB, Silicosis and HIV services by key populations.

## Q4 STATUS

The contract between the Principal Recipient (WITS Health Consortium) and ACHAP was signed on 1st December 2016; however, ACHAP did a lot of work before this in order to make optimal use of limited time.

ACHAP has initiated the contracting process for delivery of the training toolkit, development of the community-based program, and support in-country NGOs in developing their advocacy and sensitization strategies with East African Network of National AIDS Service Organizations (EANNASO). The contract is expected to be signed by end of January.

- **CSO Identification and Capacity Assessment**

ACHAP intensified the process of identifying CSOs that are working on TB in the mines or related areas in each of the ten (10) project countries. The table below outlines CSOs that have been identified in each country as well as

dates on which the assessments are scheduled.

Three teams, each consisting of a Finance expert, M&E expert and Grants Management expert will conduct the assessment using a standardised capacity assessment tool (CAT). It is expected that contracts with the targeted 20 CSOs will be signed by end of February 2017.

- **Staff Recruitment**

Advertising of project positions was done in November and December 2016. Shortlisting of candidates is currently on-going and interviews are scheduled for the third week of January 2017. It is hoped that most, if not all staff will report for duty at the beginning of March.

- **Review Recommendations from Related Projects**

Terms of Reference (TORs) for this exercise have been finalised and ACHAP is currently sourcing a Consultant to conduct the review of identified literature. The review is expected to be completed by end of February 2017.

| No | Country | Organization | Expected Date of Assessment |
|---|---|---|---|
| 1 | **Botswana** | Botswana Network on Ethics Law and HIV/AIDS (BONELA) | 3rd February 2017 |
| 2 | | Botswana Labour Migrants Association (BoLAMA) | 6th February 2017 |
| 4 | **Lesotho** | Lesotho National AIDS Service Organization (LENASO) | 30th January 2017 |
| 5 | | Migrant Workers Association | 31st January 2017 |
| 6 | | Phelisanang Bophelong | 1st February 2017 |
| 7 | **Malawi** | Malawi National AIDS Service Organization (MANASO) | 6th February 2017 |
| 8 | | Project Hope Malawi | 7th February 2017 |
| 9 | | Action Aid Malawi | 8th February 2017 |
| 10 | | Paradiso Community TB Organisation | 9th February 2017 |
| 11 | **Mozambique** | UNIDOS | 18th January 2017 |
| 12 | | Movimento Nacional de Luta Contra TB | 19th January 2017 |
| 13 | | AMIMO | 20th January 2017 |
| 14 | **Namibia** | Namibia National AIDS Service Organization (NANASO) | 23rd January 2017 |
| 15 | | DAPP | 24th January 2017 |
| 16 | **South Africa** | NACOSA | 30th January 2017 |
| 17 | | TEBA Development | 1st February 2017 |
| 18 | | TB-HIV Care Association | 2nd February 2017 |
| 19 | **Swaziland** | Swaziland Migrant Mineworkers Association (SWAMMIWA) | 23rd January 2017 |
| 20 | | SAfAIDS | 24th January 2017 |
| 21 | **Tanzania** | Tanzania Council for Social Development (TACOSODE) | 1st February 2017 |
| 22 | | Tanzania AIDS Forum | 2nd February 2017 |
| 23 | **Zambia** | CITAM+ | 23rd January 2017 |
| 24 | | ZATULET | 24th January 2017 |
| 25 | **Zimbabwe** | Jointed Hands | 27th January 2017 |
| 26 | | Bekezela Home-based Care | 28th January 2017 |

# HEALTH FOCUS

INTERVENTION

**Prevention of TB in the Mines (Legislative Review)**

**Objective**

To prevent TB in the mining sector by reducing occupational risk for all mineworkers across the 10 countries participating in the TIMS programme.

**Desk Review**
- Macro economic situation
- Role of mining sector in economy
- OH Legislation
- Mine health and safety legislation

**Report submitted November 2016**

**In-country consultations**
- Validation of desk review findings
- Insitutional frameworks
- Key challenges identified in the 10 countries

**Last mission February 2017**

**10 Country Report**
- Comprehensive analysis of policy and legal framework for Occupational risk protection, particularly dust control in the mining sector.
- Organisation management and funding framework
- Status of occupational risk protection in mining sector

**Recomendations report February 2017**

**Toolkit Development**
- Compliation of available material in mining
- Definition of tookit elements
- Content development
- Country adaptation

**Production March 2017**

**Roll-Out of Toolkit Training**
- Identification of dates and participant organisations in the 10 countries

**End July 2017**

**Final Conference**

## Q4 UPDATE

Health Focus has finalised ten desktop reviews on the macroeconomic situation in TIMS countries, their mining sectors and their occupational health and mine safety legislation and policy environment. A respective 10-country report was submitted to TIMS. The report serves as a preparatory document for in-country consultations and thorough assessments of the occupational health and mine safety systems and institutional frameworks (with particular emphasis on dust control). While in-country consultations in Mozambique, Lesotho, Swaziland, Botswana, Tanzania, South Africa and Zambia have been completed successfully during the past quarter, the in-country studies in Malawi, Zimbabwe and Namibia will follow over the course of the next six weeks (until mid-February**.** Health Focus has finalised all desk reviews (see above). Implementation status of country missions is on track and according to the agreed work-plan. Consolidation of in-country study findings is in the making with comprehensive 10 country reports following this quarter (to be presented to TIMS on the 6th March 2017).

Contents for the dust control toolkit has been defined and is developed at the time being. Contents are to be presented to TIMS on the 6th of March.

## LESSONS LEARNT/ FINDINGS

Contrary to most other SRs the core entry point for our intervention are not the Ministries of Health, but the Ministries of Mines and Labour and their respective Inspectorates.

Findings from country studies so far indicate that apart from South Africa, individual dust exposure of mineworkers is not measured. The

Mine Safety Inspectorates are understaffed and underequipped to enforce the existing mine safety regulations. Only large, mostly multinational Mining Corporations apply international occupational health and hygiene standards.

Knowledge of tuberculosis and silicosis among mine workers is very poor and in many cases not understood or clouded in myths (like drinking of milk will cure "miner's lung" disease).

Mine safety standards, in the artisanal mining sector, especially are very poor (protection from falling into excavations, poor or no ventilation in of shafts and stopes, no second outlets, no ground control or support installed etc.).

### COMING UP IN Q5

Within the next quarter of the TIMS grant, the final dust-control toolkits will be developed based on the findings from the country missions and discussed with the TIMS PMO before production.

Furthermore, the final and comprehensive 10 country reports will be shared. These reports will contain validated information on occupational health and mine safety legislation and systems in place, gaps and challenges with regards to policy and legislation and its enforcement as well as articulated recommendations.

# North Star Alliance (NSA) & Enhancing Care Foundation (ECF)

INTERVENTION

**Establishing Occupational Health Service Centers (OHSC's)**

**Objective**

Scale up responsive occupational health services for the mining sector in 8 of the 10 countries participating in the TIMS programme

### Q4 STATUS

Enhancing Care Foundation (ECF) has provided technical support and assistance to the inception meetings and coordination of in-country communications for the scale up of Occupational Health Service Centres' (OHSCs) in the respective countries. North Star Alliance has participated in all inception meetings and strategic planning, whilst also implementing the scale-up plans for the OHSCs in preparation for handover to OGRA. This partnership has worked well with ECF providing a clinical and technical backbone to the site works and OHSC scale-up plans that have been achieved with each country. Regular meetings are held with the respective teams, and both organisations are represented during in-country meetings.

To date, we have held in-country inception meetings with five out of eight TIMS countries (i.e., Botswana, Lesotho, Mozambique, Swaziland and Zimbabwe), with only Tanzania, Namibia and Zambia outstanding. Follow-up meetings with stakeholders and site visits have been held in three of eight TIMS countries (i.e., in Botswana, Lesotho and Swaziland) with Mozambique and Zimbabwe in progress. We have installed one OHSC in-country and handed over in principle to OGRA (OHSC 1 Mafeteng Lesotho), the second OHSC is on site & final site works is in progress (OHSC 2 Hlatikhulu Swaziland). Two other sites have been identified (total of four). Maseru Lesotho quotes for site work underway and whereas Botswana has no site work in progress due to MOU not yet signed as at the 31st of December

2016. Site visits are being planned for Mozambique in January. Cluster 1(OHSC 1- 6) have all been produced.

## DELIVERABLES

1. Assessment of existing OHSCs: this has been completed and is being reviewed by the PR. The lessons learnt and recommendations from this exercise have been used as a basis for the infrastructural development and engagement with in-country TB Control Programmes (TCP) with regards to integration recommendations.
2. Engagement with NTCP: successful planning meetings have been held with NTCP of Swaziland, Lesotho, Mozambique and Botswana.
3. Site identification: four (out of 11) sites identified (Mafeteng Lesotho, Hlatikhulu Swaziland, Maseru, Molepolole Botswana) but only three of the sites with MOUs signed, work in progress on these three sites (see Erection of clinics below)
4. Design and construction of clinics: Cluster 1 (OHSC1 - 6) sites containers constructed and ready for implementation, Cluster 2 (OHSC7-11) containers construction started.
5. Procurement of equipment: All furniture and medical equipment being procured site by site by agreed list. Potential changes to spirometer & generator still in progress.
6. Erection of clinic/s: two sites have containers on site - OHSC 1 Mafeteng Lesotho handed over in principle to OGRA with some site works still in progress (roofing, removal of medical room, ramp adjustment & hand basins), OHSC 2 Hlatikhulu Swaziland containers on site and final site works to be completed. For one site (OHSC 3 - Maseru Swaziland), site location has been approved & initial site works to be commissioned.

## LESSONS LEARNT

During this inception phase, the North Star and ECF team have gathered important lessons that relate to the following:

**Country Specifications and Sensitivity:** It should be noted that while the TIMS project has offered a scalable, 'one size fits all' solution to establishing the OHSCs aligned with the specifications of the World Health Organization (WHO), all countries have their own regulatory procedures and health and safety standards to roll out the OHSCs. This can include specific clearances for the radiological equipment; diagnostic equipment; audio-booths and provision of ablutions, infection control, etc. In addition, some countries would have preferred establishing their facilities within existing institutions. Thus, there is a need to be cognizant and sensitive to country-specific requirements and also allow time to meet these specifications. This also applies to identifying subcontractors for site preparation and build, as well as tax clearance certificate requirements (which need to be done by country and have certain specific time frames and requirements); the country coordinator should be well briefed as to their roles and responsibilities in this regard.

## MAJOR CHALLENGES

The following have posed challenges to delivering on pace and within proposed timeframes:

**MoUs**: One of the major challenges to initiating discussions and maintaining momentum to establish the OHSCs is the lack of an approved MoU between the NTP and TIMS PMO. While there may be great willingness to move forward with site identification and scale-up, the North Star-ECF team is limited in corresponding in countries where the MoU process is not yet finalised. So far only three countries have signed MoUs (Lesotho, Swaziland & Mozambique).

**Communication and Availability of Senior Level Officials**: Due to the high level of coordination required for this project, it is of note that often senior officials are difficult to reach or meet with during protracted periods of time. Without delegation of these activities to a second-in-command or to the Country

Coordinator, such inception meetings and site visits can take longer than expected to plan and attend. Email correspondence is often slow. To date, only five countries have had initial country meetings and only four sites have been identified in three countries.

**Site selection delays:** Since only four sites (of the 11) have been identified to date due to delayed MoU signing and delayed country meetings and although time pressure is necessary to select further sites, it is imperative that when selecting the sites, accessibility should be a key decision making factor as this directly impacts cost and time to get sites sets up.

Site work contractor logistics: When the first meeting between Ministry of Health officials and North Star Alliance/ECF takes place, the official channels and protocols and government departments that deal with building and associated permits etc. should provide a list of the best available legitimate contractors. While site works occur the hospital at site keeps the keys, this can limit the access the contractor has to site. Post-delivery of the container, keys to gain access to containers may also not always be available.

**Regulatory hurdles:** Country coordinators are needed to drive the tax clearance certificate process within each country; so far we have experienced delays in obtaining this certificate in both Lesotho and Swaziland, which impacts transport.

Transport logistics: Delays in receiving tax clearance certificates, transporter inefficiencies as well as sites with accessibility issues have made the transport element very challenging so far. We are working towards correcting this going forward.

Handover logistics: Containers can be on site and although some site works may still need to be completed (e.g. roofing, signage, window screens), the handover can take place and the clinic can be opened while the work is completed (with written acknowledgement between North Star Alliance and OGRA as to the outstanding elements).

Continuous changes: Changes have been made to both the containers and equipment lists long after signed off versions had been agreed. These have had both timing and cost implications.

Administrative hurdles: Additional requests for sites and changes to containers have had cost implications as mentioned, the budget sign off in this regard has not been timeously managed.

## COMING UP IN Q5

The following areas are a high priority to establish OHSCs in the next quarter:

- **LESOTHO**: Lesotho Site 1 Mafeteng OHSC handed over in principle to OGRA in Dec 2016, final site works to be completed (roofing, signage etc.). Site 2 Maseru OHSC contractor to be identified and site works commissioned, so containers which are ready can be set up at the site and expedited.
- **SWAZILAND**: Swaziland Site 1 Hlatikhulu finalisation of site works and handover to OGRA. The next priority is to identify Site 2 for scale-up.
- **MOZAMBIQUE**: A follow-up meeting in Mozambique to identify placement for Sites 1 and 2 is urgently needed, and a top priority for the next quarter.
- **BOTSWANA:** We plan to establish the Botswana Site upon final approval from Botswana government in the next quarter, pending finalisation of MoU.
- **ZIMBABWE**: We plan to retrieve confirmation of the Site for Zimbabwe and begin site works in next quarter, pending finalisation of MoU.
- **TANZANIA AND NAMIBIA**: Inception meetings to be held in next quarter for stakeholder engagement, pending finalisation of MoU.
- **ZAMBIA:** Inception meeting to be held in Zambia pending finalisation of MoU and appropriate contact within NTP and for country coordination.

# FINANCE

**High-level overview of Year 1 of the TIMS Grant**

| Reporting period | Q1 | Q2 | Q3 | Q4 |
|---|---|---|---|---|
| Budget | 1 167 380.23 | 3 266 753.20 | 4 862 207.65 | 5 041 859.28 |
| Disbursements by GF | 356 707.00 | 2 213 290.00 | 3 304 363.00 | 4 683 047.00 |
| Cumulative budget | 1 167 380.23 | 4 434 133.43 | 9 296 341.08 | 14 338 200.35 |
| Cumulative disbursements | 356 707.00 | 2 569 997.00 | 5 874 360.00 | 10 557 407.00 |

**Overview of Quarter 4 and Year 1 of the TIMS Grant**

| Entity | Budget Q4 | Disbursement Q4 | Expenditure Q4 | Burn-Rate Q4 | Budget Y1 | Disbursement Y1 | Expenditure Y1 | Burn-Rate Y1 | Notes |
|---|---|---|---|---|---|---|---|---|---|
| **NORTHSTAR** | 298 608 | 547 907 | 414 990 | 76% | 661 464 | 716 400 | 518 702 | 72% | 1 |
| **OGRA** | 370 042 | 246 694 | 230 974 | 93% | 535 402 | 246 694 | 230 974 | 93% | 2 |
| **ADPP** | 621 657 | 455 001 | 391 635 | 86% | 1 506 712 | 804 941 | 705 898 | 88% | 3 |
| **IRD** | 491 525 | 491 525 | 269 865 | 55% | 895 092 | 970 881 | 349 513 | 36% | 4 |
| **ACHAP** | 162 472 | 345 638 | 72 921 | 21% | 162 472 | 345 638 | 72 921 | 21% | 5 |
| **HEALTH FOCUS** | 126 750 | 90 815 | 120 455 | 133% | 312 480 | 204 294 | 202 599 | 99% | 6 |
| | | | | | | | | | |
| **Wits Health (PR)** | 692 847 | 520 266 | 520 266 | 100% | 2 725 450 | 1 452 541 | 1 452 541 | 100% | 7 |
| | | | | | | | | | |
| **Sub- Partners** | 1 651 082 | 1 412 699 | 1 412 699 | 100% | 4 834 139 | 3 982 648 | 3 982 648 | 100% | 8 |

## Key Assumptions

- All amounts are in US Dollars.
- For consistency in reporting a conversion rate of 13.1 to the US Dollar has been used to convert all amounts to US Dollars (the rate is the agreed to rate in the TIMS contract with Global Fund).
- All burn rates are calculated by dividing Expenditure by Disbursement
- All sub-partners have been grouped together due to the sensitivity of their pricing.
- The variance between the Year 1 budget from the Global Fund and the Year 1 budget in the reporting is due to a difference in allocation of costs between Year 1 and Year 2, the movement of the Health management Information System Budget to Year 2 and savings made.

## Notes

1. The North Star Alliance disbursement is higher for Q4 and Year 1 due to the additional requirements on the Occupational Health Service Centres (OHSC's). A number of requirements were not budgeted for and these were only identified after the budgeting process. A budget realignment process will be completed in Q5, there were certain savings that were made in Year 1 and some of those savings will be reallocated to the OHSC's to ensure that all centres are to the same standard.

2. OGRA's contract was finalised in Q4 and the first disbursement was only made to them in Q4 as well. The delay in finalising the contract and the delay in having all 6 OHSC's fully operational. However, the burn rate has still been reasonable. What appears to be a shortfall in funding is due to a timing issue on the disbursements. The necessary disbursement was made to OGRA for Year 2 only in Q5 and as such does not reflect on this report.

3. ADPP is responsible for the screen in in eight of the 10 countries and even with a delayed start as seen by the variance between the overall Year 1 budget and the expenditure for Year 1 however, in Q4 we see this gap closing significantly as the screening activities kick in and there is significant spend against the budget. With the exception of Lesotho and Swaziland, screening is occurring in all remaining countries.

4. IRD is responsible for the screening in the remaining 2 countries and while the burn rate for Year 1 looks poor, this is due to a large disbursement that was made to IRD just before the end of the quarter. However as seen from Q4 burn rate the burn rate is reasonable. The burn rate will also improve once full screening starts in Zimbabwe in Year 2.

5. ACHAP has a very low burn rate due to them being contracted late in Q4. The delay means that they were not able to start when required. The variance between the Q4 budget and the higher disbursement is due to the advance that was provided to ACHAP on start up. The ACHAP burn rate will significantly increase in Year 2.

6. Health Focus has maintained a very healthy burn rate and will be receiving a disbursement in Q5 to cover Q5 expenditure. The above 100% burn rate for Q4 was due to Health focus receiving funding in Q3 and only using the funding in Q4.

7. The policy of WHC with regard to the Disbursements is that the funding is

kept centrally and used when needed, no space disbursements are made to the Project Management Office. As you can see from the budget the Q4 spend was near the budgeted amount. The Year 1 expenditure was a bit behind budget, however, in year 2 some of this expenditure will be caught up. Some of the variances between actual and budget are also the PR's commitment to being a good steward of the Global Fund money and ensure that the PR is as efficient as possible.

8. The Sub-Partner budget has been consolidated into one line item. This is done to protect pricing information from the Sub-Partners. During Q4 the actual expenditure was very close to the actual expenditure. The variance is due to timing and contractual issues. The timing difference is due to contractual requirements only making payment once the work is 100% complete. While most of the SR work for Year 1 is complete there were a few outstanding matters and this meant that not all payments were made by the end of Year 1. All these payments should be made early in Year 2.

# PROJECT SPECIFIC VALUE-ADDS

## i. Project Management Training

The TIMS PMO along with some of its implementing partners went through a robust 2-day project management training workshop. The facilitator was involved in developing the detailed project plan for the TIMS grant and therefore brought unique insight to the training. This made the session decidedly focused for all the participants.

Based on Project Management Body of Knowledge (PMBOK) the training encompassed foundational project management tools and knowledge. It was also an opportunity for relationship building as the team completed various practical exercises directly linked to the grant. This meant that the team present was able to identify and workshop solution for actual challenges being experienced as the grant gains momentum.

*TIMS Project Management Training attained by TIMS PMO and SR's, Johannesburg, South Africa.*

## ii. TIMS Dashboard

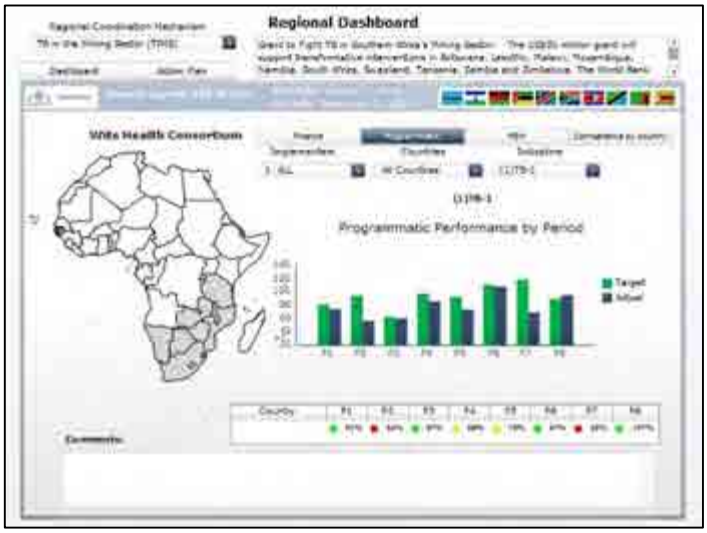
In March 2016 the TIMS PMO was faced with a decision to use of whether or not to use the Grants Management System (GMS) dashboard as a reporting tool. The team was initially reluctant given the short period of the grant and the time that would be needed to generate a working dashboard. But on the other hand, the complex regional nature of the grant meant that a dashboard reporting tool would make management of indicators simpler. After some deliberation, the team decided the pros outweighed the cons.

TIMS M&E Specialist, Dr John Mkandawire spearheaded efforts to apply for Technical Support from the US Government. The request was approved and GMS was assigned to the TIMS Grant to configure the GMS Dashboard to the TIMS Grant requirements. GMS Team lead by Rita Motlana conducted their first visit to develop the TIMS Dashboard. Other team members were Zach Zeh Akiy, Eduardo Samayoa Acevedo, and David Masengu

Once the initial dashboard was developed the GMS team had their second session with the TIMS PMO to test the system. They went back and implemented the changes. The final Dashboard session in October was an opportunity to bring all sub-recipients to Johannesburg for hands-on 2-day training on the TIMS Dashboard. Training included basic data capturing and how to generate datasheets among other things. The outcome of the 2-day training was the generation of the first Q3 Tims Dashboard with real data.

Q4 TIMS Dashboard will be populated with real data and will mark the first time the TIMS Dashboard will be shared with all the SRs and the RCM who are responsible for the oversight of the TIMS Grant.

*An example of the TIMS PR dashboard and the RCM regional dashboard. The TIMS PMO will be producing both these dashboards.*

## iii. M&E NTP Managers Meeting

The M&E Unit convened the M&E Consultative Meeting for NTP Managers. The purpose of the meeting was to provide a platform for engaging NTP Managers to input in the development of harmonised data systems that will enable the TIMS Grant to collect key population data by occupation. One of the outcomes of this meeting was that NTP managers agreed to work with the M&E Unit to strengthen their M&E systems to enable TIMS to collect key population data by occupation.

The meeting also provided an opportunity for the NTP managers to input on the TIMS screening tool as well as to identify areas of support from the TIMS to enable them to collect and report on TB data by occupation.




*Regional NTP Managers, the TIMS PMO and Country Coordinators, Local Funding Agent, and The World Bank were present at this meeting, Parktown, Johannesburg.*

# TIMS

Tuberculosis in the Mining Sector in Southern Africa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