TIMS

TB IN THE MINING SECTOR IN SOUTHERN AFRICA

Quarterly Report

01 October 2017 • 31 December 2017

TIMS Q8 Programme Report

WITS HEALTH CONSORTIUM

24 St Andrews Road, Parktown,
Johannesburg,
2193
+27112749200
tims@witshealth.co.za
www.timssa.co.za

UPDATE FROM OUR CHIEF OF PARTY

"Now this is not the end. It is not even the beginning of the end. But it is, perhaps, the end of the beginning." - *Winston Churchill*

The words of Winston Churchill rang true as the first two years of the TIMS grant drew to a close. Q8 marked the end of the beginning and the heralding in of the next chapter of the TIMS programme.

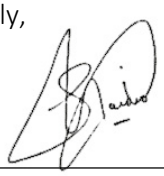
As we closed off work plans and assessed deliverables, we also reached some major milestones, from exceeding our increased screening target to installing a PACS system that is set to revolutionise the way medical documents such as X-Rays are viewed and shared in the region. You can read more about this exciting development in the OH&TB section of this report.

TIMS OH&TB unit also worked with the MBOD to bring medical professionals, from across the region, together for a much needed - Skills Training week. The M&E unit continued to work with the country NTP's to ensure that key population data from the countries were recorded and reported.

This report, as always, details the progress of all TIMS interventions in the quarter and we are pleased that by the end of Q8 all interventions were implemented, with some partner's delivering beyond expectation.

The first two years presented several challenges and lessons and established the groundwork to build a robust regional response to TB in the mining sector in Southern Africa. The implementation of the new grant will build on all the innovations and learnings we have gained. We thank all stakeholders for your support and assistance and we look forward to you continuing the TIMS journey with us, as we work to reduce the TB burden in the Southern African mining sector, by focusing on "finding the missing TB cases".

Sincerely,



Dr Julian Naidoo
Chief of Party – TIMS

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Q8 Grant Status

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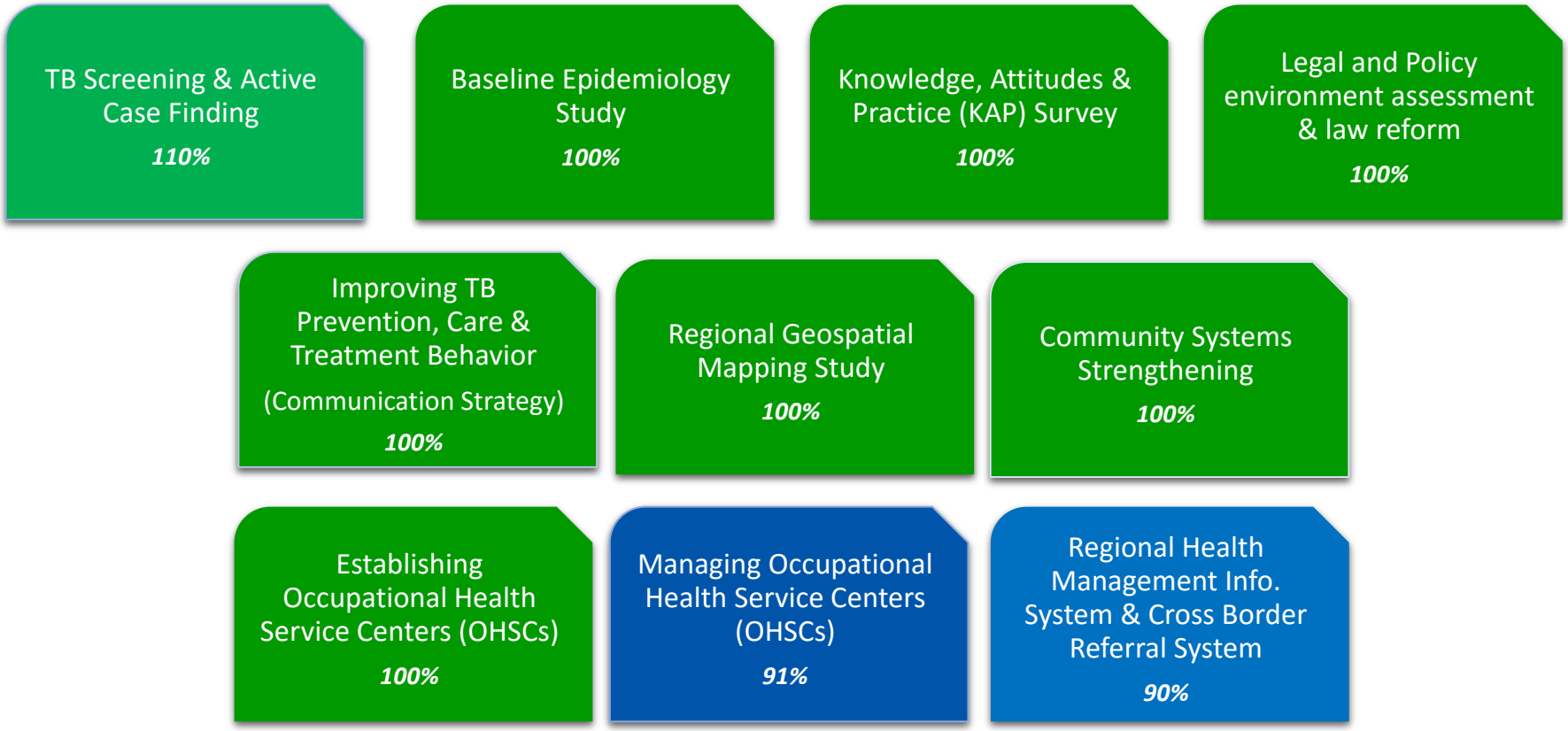
INTERVENTIONS



HEALTH FOCUS

Legislative Review & Dust Control Programme

Following the successful training of all country representatives on the dust control toolkit in Q7, Health Focus embarked on additional work to develop a scalable dust risk management tool. *This work is now complete and accessible on the TIMS website*.

The purpose of the risk assessment tool is to provide mine operators with a simple means to assess the risks of dust exposures in their mines. This assessment is the first step in designing a programme to mitigate dust exposure – examples of mitigation measures are contained in the dust control toolkit.

Legislative Review & Dust Control Programme

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

African Comprehensive HIV/AIDs Partnerships (ACHAP)

Community Systems Strengthening [1]

Having had a delayed start Q8 was a very productive quarter for the ACHAP.

Capacity Building workshop

A Capacity Building workshop was held in October 2017 at Dar es Salaam, Republic of Tanzania. The workshop was prompted by slow project implementation and low burn rates. All 20 CSO were represented.

Presentations detailing the challenges and solutions were made and CSOs then were given the opportunity to develop plans for accelerating implementation.

Mentorship through Supportive Supervision

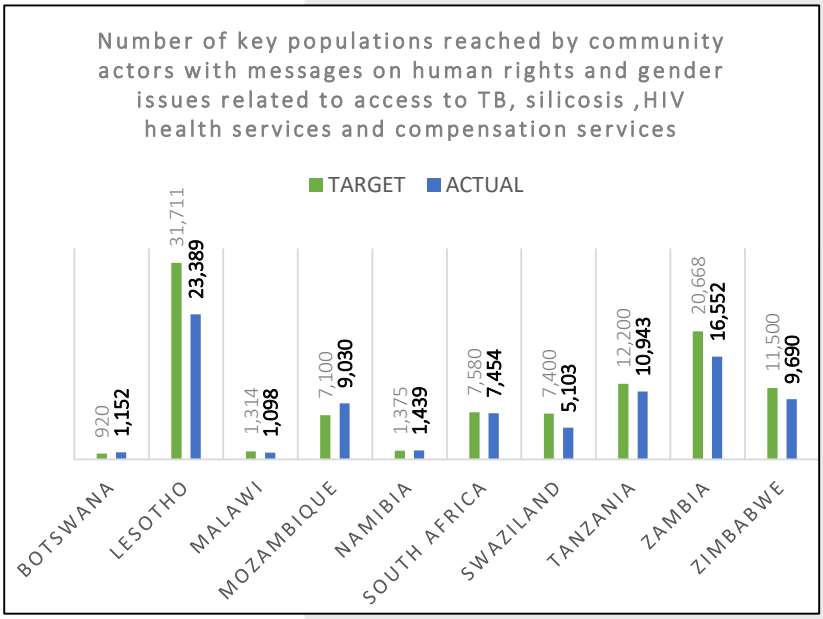
ACHAP provided mentoring and supportive supervision in November 2017 to 12 of the 20 CSOs which were lagging behind in project implementation. The monitoring visit focused on implementation of the accelerated work plan and budget developed following the October 2017 capacity building workshop.

Implement Advocacy and Sensitization Activities

EANNASO completed the Regional Advocacy Guidelines with implementation/mentoring plan in the Q7. The guidelines were presented in October during the capacity building workshop in Dar es Salaam, Tanzania and the schedule of in country visits developed. All ten countries were visited during October and November 2017 where CSOs were trained on advocacy and guided on development of country specific advocacy plans.

Routine Reporting

One of the key indicator for the CSS module is the number of people reached by community actors with messages on human rights and gender issues related to access to TB, Silicosis, HIV health services and compensation services. At the end of the quarter 85,850 (84%) of the targeted 101,768 were reached. Three countries surpassed their targets. Mozambique attained 127%, followed by Botswana with 125% and Namibia with 105 %. In Mozambique, especially, the community leaders embraced the project and led with the coordination of a lot of activities.



ACHAP

Partnerships for a healthy Africa

Community Systems Strengthening

To improve access to TB, Silicosis and HIV services by key populations through identification, capacitation and deployment of CSOs.

[1] This intervention had a very late start as a suitable SR was not identified in the first round of applications. ACHAP was contracted towards the end November 2016.

EOH-XDS

IT link, RHMIS & CBRS

XDS is responsible for the development of three IT systems:

Look Up Using Secure Link

IT link to Compensation Funds

Regional Health Management Information System (RHMIS)

Cross Border Referral System (CBRS)

IT Link

By Q7 an IT link was established between OHSCs and the South African Compensation Fund, which is the largest of the funds in the region. The first phase of this development entailed design, testing and piloting, the piloting was done in 3 facilities. I. Once this link to the South African Compensation fund is functioning smoothly, the system will be scaled up to involve other funds. This is to be done in the next phase of the grant.

The focus of this intervention has shifted to increasing the capacity of the MBOD to receive electronic submissions. This is a key bottleneck in the system. Upgrades to the hardware, software and connectivity at the MBOD have commenced and should be ready early in the first quarter of 2018. This work is a spillover from Q8.

RHMIS

Piloting of this system will continue in January 2018 as 5 countries were not completed in December 2017 for a variety of reasons, such as availability of key personnel. Plans are underway to conclude this in Q1 of 2018. Following the pilots, the main deliverable for the next phase of the grant will be a broader scale-up of the system to 30 sites in each country. The scale-up will be preceded by a full review of lessons learnt and a determination of location for the additional sites.

CBRS

As with the RHMIS, the pilots in 3 countries will be completed in Q1 of 2018. The system will then be ready for scale-up in the new phase of the grant after lessons learnt and planning on additional sites is concluded. The key challenge for the next phase of the grant will be to integrate the scale up with the cross-border interventions to be conducted by the next phase SRs.

Regional Health Management Information System & Cross Border Referral System

Strengthening Referral Systems for continuity of TB care and treatment in the Mining Sector in Southern Africa

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.

MEROPA

Communications Strategy

In Q8 Meropa completed the development of the communications strategy as well as some of the accompanying communications materials.

The communication strategy was largely based on the findings of the KAP study which was only finalised in Q6 because of ethical clearance delays. Given this, Meropa had a contracted timeline to develop and test the communications strategy.

By the end of Q8 Meropa developed the following communications materials to be used in conjunction with the strategy:

	Format	Purpose
Multipurpose flipchart	14 illustrated charts on different topics, plus 14 pages of notes for presenters A3 in size	Interpersonal communication
Motivational videos: real-life stories of KP affected by TB and silicosis	Three individual videos Length: each has a 60-second version and a slightly longer version (about 90 seconds)	Public service announcement. Uploaded to websites, YouTube, etc.
Advocacy presentation on TB in the mining sector plus fact sheets	Fully designed PowerPoint presentation 22 slides	Tool for healthcare workers to use in advocating for leaders in other sectors to become involved in combatting TB in the mining sector
	Two-page A4 fact sheets on: TB in the mining sector in southern Africa Silicosis in the mining sector in southern Africa	As above Also for use in outreach to journalists
Guide to organizing health days in the community and workplace	Four-page A4 document (Plus a resource on activities for children, including a printable educational board game, 'The TB Challenge')	Tool to assist health workers and peer educators organise health days in communities and mine workplaces

The strategy along with the supporting materials were shared with the 10 country NTP's at the end of Q8 for their review. Implementation of the strategy will follow in the next phase of the grant.

Communications Strategy

Improving TB Prevention, Care & Treatment Behaviour

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.

NORTH STAR ALLIANCE CONSORTIUM *in collaboration with* Enhancing Care Foundation

Establishment of OHSC

All 11 OHSCs are built and equipped with 10 installed in-country and 10 operational. Below is a progress update:

SWAZILAND	1. Hlathikhulu 2. RFM	Operational Operational
LESOTHO	1. Mafeteng 2. Senkatana	Operational Operational
BOTSWANA	Molepolole	Operational
ZIMBABWE	Kadoma	Operational
MOZAMBIQUE	1. Manjakazi 2. Xai Xai	Operational Operational
TANZANIA	Kibong'oto	Operational
NAMIBIA	Swakopmund	Operational
ZAMBIA	Kitwe	Site selected 27 June 2017 delays with establishment due to in-country regulatory hurdles

Of the planned 11 OHSCs, 10 are now in country and operational. The delays due to the failure to receive a tax clearance certificate for Zambia still persist. To date, this matter has not been resolved and the Zambia OHSC remains in a warehouse awaiting delivery to Kitwe.

The focus of the PR, with regard to the established OHSC's, now shifts to improving the quality of service provided to the key populations. This will be achieved through a series of service quality assessment to be conducted on-site at the beginning of the next quarter.

North Star Alliance

Establishment of Occupational Health Service Centre - OHSC

Improving TB Prevention, Care & Treatment Behaviour

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

OGRA FOUNDATION

Operationalization of OHSC

There was an upsurge in the flow of patients attending the OHSCs. This was driven largely by the demand creation activities conducted by the OHSC programme and CSOs in the local districts.

10 were OHSC's operational in Q8.

OHSC Stats for :	Q8	Q7
Total seen (ex-miners, family and community	6473	2343
Ex-miners	5177	1896
Occupational lung disease diagnosed	2161	783
Occupational Lung Disease submitted to MBOD	2271	380
Compensated by the MBOD	62	0
TB diagnosed	224	48

The statistics above show an alarming rate of TB being diagnosed, in Q8 3.4% (Q7: 2%) of all clients seen at the OHSC had TB – such high TB rates are a concern as these clients were ostensibly well (undiagnosed) and in the community before being diagnosed with TB at the OHSCs. In addition, 187 of the 3 186 (5.8%) GeneXpert tests done were positive (3rd quarter: 3.6%).

The key focus for the next quarter will be to commence with the process of transitioning the management of the OHSCs to national governments. This will be a collaborative process between NTPs, the PR and the new SRs whom will be appointed in Q1 and Q2 of 2018.

OGRA Foundation

Giving Hope, Saving Lives

Operationalization of OHSCs

Managing the Occupational Health Service Centres (OHSCs)

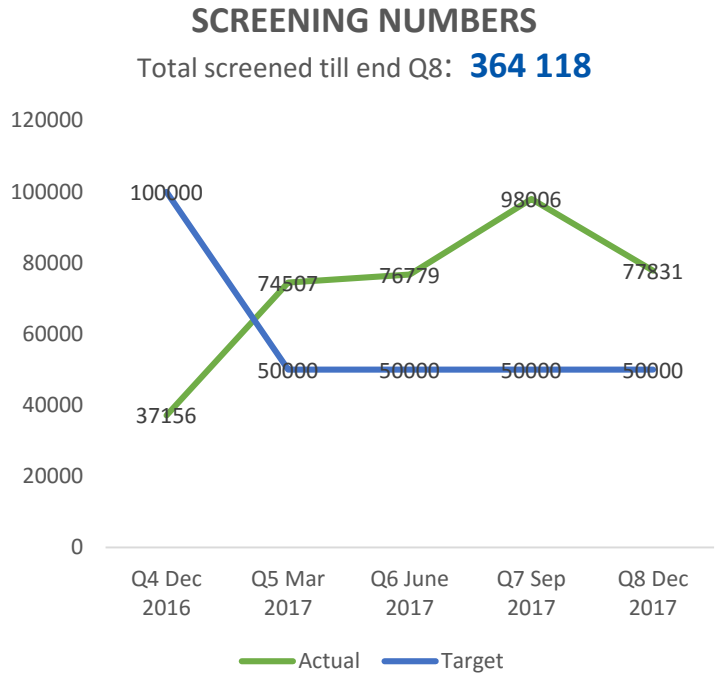
Oversee and manage occupational health services in 11 Occupational Health Service Centres (OHSCs) in 8 Southern African countries – Botswana, Lesotho, Namibia, Mozambique, Swaziland, Tanzania, Zambia and Zimbabwe.

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.

ADPP & IRD

TB Screening and Active Case Finding

In Q8, ADPP, IRD and the OHSCs collectively screened 77, 831 individuals of whom 23% were found to be presumptive of TB. Access to diagnostic services was facilitated for 68% of the presumptive clients, which resulted in a diagnosis of 592 TB cases and a yield of 0.9 %. With the screening that was done over the quarter, all countries except Zimbabwe exceeded their allocated country targets for a number of persons screened. Zimbabwe had a very late start to screening and had been allocated an additional 9 500 persons, increasing their target to 65 500, of which they managed 64, 332.



Breakdown of Screening Numbers for Q8:

- 77, 831 screened
- 17, 777 presumptive (22.8%)
- 12, 055 tested for TB (68%)
- 592 diagnosed with TB (0.9%)
- 534 started on treatment (90.2%)

Of the total 364 118 clients screened, 1 511 TB cases were diagnosed with TB, resulting in an overall yield of 0.42%. It had been noted during Q6 that yields were low (0.21%), the main reason being that on average only 37% of those considered to be presumptive on screening (in Q4 and Q5) had properly investigated and followed up. A concerted effort was made by TIMS OH & TB and M&E to manage these poor yields – these efforts have delivered results, as evidenced by a marked improvement in overall yield rates.

TB Screening & Active Case Finding

TB case detection

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.

Retrospective Sputum Collection

ADPP and IRD focused significant energies on ensuring that they addressed the backlog of presumptive clients who had not accessed diagnostic services from previous quarters. This was done in addition to the ongoing screening target for the quarter and in some cases required the recruitment of additional staff in order to focus on follow up of presumptive clients. SRs were notified of the need to ensure that a minimum 60% of presumptive client's accessed diagnostic services. Where clients could not produce spot sputum, next day follow up was done and if necessary transport provided to ensure the clients visited health facilities where they would be assisted to produce sputa. Efforts to increase access to diagnostics also included procurement of consumables needed for specimen collection or testing; agreements with laboratory staff to work longer hours; in some cases intervention by NTP managers to ensure labs accepted and tested specimens submitted by the SRs. These efforts culminated in overall improved access to diagnostic services. In Q8 ADPP and IRD facilitated access to diagnostic services for 62% of all presumptive clients, with country performance ranging from 33% - 97% , a marked improvement from about 28% in the first few months of the grant.

Piloting of Screening Models

IRD piloted the four screening models developed to enhance active case finding in specified contexts. The models were piloted in the following countries

- Cross-border migration: South Africa, Lesotho, Swaziland and Mozambique
- Internal migration: Zimbabwe
- Public-Private Partnerships (PPP): Namibia
- Artisanal and Small Scale Mining (ASM): Tanzania

Piloting of the PPP and ASM models concluded at the close of November 2017, the cross-border and internal migration models were extended to conclude in January 2018 in order to allow for anticipated peak migration between December and January. Pilot reports detailing results of each model will be available in mid February 2018.

Training on Revised Screening Tools

Field officers/screeners were trained on the use of the revised TIMS screening tools in all countries that had approved the use of revised tools. In response to feedback from NTP managers, the TIMS screening tool was revised in Q7 to make the TB symptoms listed on the tools country specific. The revision also addressed a challenge identified early in grant implementation where field teams, contrary to instructions, did not apply national TB protocols to identify presumptive clients but rather used the generic and much longer list of symptoms on the tool. This resulted in too many false presumptives. All but two of the TIMS implementation countries signed off on use of the revised screening tools, Zambia and South Africa being the exceptions.

TIMS Screening Mobile App

The TIMS screening app was further developed to include an offline version, as challenges had been encountered with data upload when not connected to a network. Piloting of the app was rolled out to all countries. The period of use varied across countries, minimal screening was done after screening targets were met as SRs redirected field teams to do everything possible to ensure presumptive clients accessed diagnostic services. For the period of the pilot, paper tools were used concurrently with the app to facilitate comparison of the accuracy of data upload. Paper tools will continue to be used alongside the app until such time that data reviews show numbers reflected in Open MRS accurately reflect the numbers on the paper tools.

Challenges Encountered in Q8

- **Overburdened diagnostic facilities** as the number of samples submitted for testing by TIMS implementing partners were in most cases too many for public health facilities to handle.
- **Difficulty in tracking presumptive clients** identified in earlier quarters and who had not yet accessed diagnostic services. Some people were no longer reachable on telephone numbers provided, had moved from the area where they were screened, refused to provide sputum when traced or were no longer presumptive when follow up was done.
- **Screening app was not sufficiently piloted** as countries stopped screening new clients to focus on a retrospective presumptive follow-up when they reached their screening targets.
- **Piloting of screening models done over a very short time period** which limited the ability to rigorously test proposed concepts

TOMTOM CONSORTIUM

Regional Mapping Study

TomTom completed the regional mapping study in Q6. However secondary data was used in Zimbabwe because of challenges faced on the ground. TomTom worked to resolve this in Q8.

A mapping software training session was planned for all NTP manages in Q8 but due to scheduling clashes, the training had to be postponed.

View study here.

TOMTOM

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

TB case detection

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. The need to update and refresh data, especially for health care facilities, communities and hotspots identified during Phase I of the project is important.

PHRU

Baseline Epidemiology Study

The EPI study was completed in Q6.

View study here.

PHRU
IMPROVING LIFE THROUGH RESEARCH

Baseline Epidemiology Study

On Tuberculosis, Mdr-Tb, Silicosis and HIV amongst Miners & Ex-Miners in Southern Africa

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.

SELECT RESEARCH

Knowledge, Attitudes and Practice (KAP) Survey

The KAP study was completed in Q6.

View study here.

Knowledge, Attitudes & Practice (KAP) Survey

To inform an information, education and communication (IEC) strategy for the mining sector in southern Africa

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.

Programme Management Office

i. General

Occupational Health Training

Some of the occupational health training attendees

The OH and TB unit of TIMS and the Medical Bureau for Occupational Disease (MBOD) held an occupational health training program for doctors working in the TIMS OHSCs and in the MBOD's One Stop Centres. The training took place in Johannesburg from the 20th to the 24th November 2017. Other doctors from within the SADC region also attended, bringing the total number of doctors coming on all or some of the course days, to 34.

The topics covered during the 5-day program included:

- Occupational health principles and scope of practice;
- Occupational Lung Diseases – diagnosis and management;
- Diagnostic tools – radiology,
- ILO radiographs and classification;
- Diagnostic tools – spirometry and audiometry; and pathology (post-mortem examination of heart and lungs for compensation consideration).

Of special interest at the course was the demonstration of the **new** TIMS Picture Archiving and Communications Systems (PACS).

Find out more about the training here.

Occupational health course in progress

Q6 Dashboard Review Meeting

The M&E Unit hosted the Q6 dashboard review meeting with all SRs and some SPs on 30 October 2017 at Southern Sun, South Africa that contributed data to the RCM dashboard. The dashboard review meeting also served as a platform to discuss grant implementation

challenges, mitigation measures and allowed for SRs to discuss means to collaborate and create synergies. As this was the last dashboard review meeting to be hosted for the first phase of the TIMS grant, the meeting used this opportunity to share lessons learnt that could inform programming for the next phase. Some key lesson shared include: need for comprehensive assessment of diagnostic capacity prior to start of screening activities in a district; need to take services to small-scale miners as they may not have time to go to a health facility; need to harmonise TIMS reporting with NTP and to provide support to NTP to enable them track key populations. It was also recognised that the RCM was not sufficiently utilised to unlock challenges encountered at country level. Comments made on data were incorporated in the dashboard, the final dashboard was presented to the RCM in November 2017.

ii. Technical Progress

Occupational Health and TB Unit

OH and TB has been involved in the following areas during the 4th quarter of 2017:

Occupational Medical Task Group (OMTG) - improving OHSC service delivery

The OMTG was formed in August 2017 and comprised doctors from TIMS OH and TB, OGRA and Boitekanelo Occupational Health Services (Gaborone). Members of the OMTG made regular visits to the OHSCs in order to identify problems and assist in training.

Technical Oversight of OHSC Operations

OH & TB provided technical oversight to all the OHSC's in Q8. Read more on page 9.

Occupational Health Training

The OH and TB unit together with the MBOD held an occupational health training session in November 2017. Read more here.

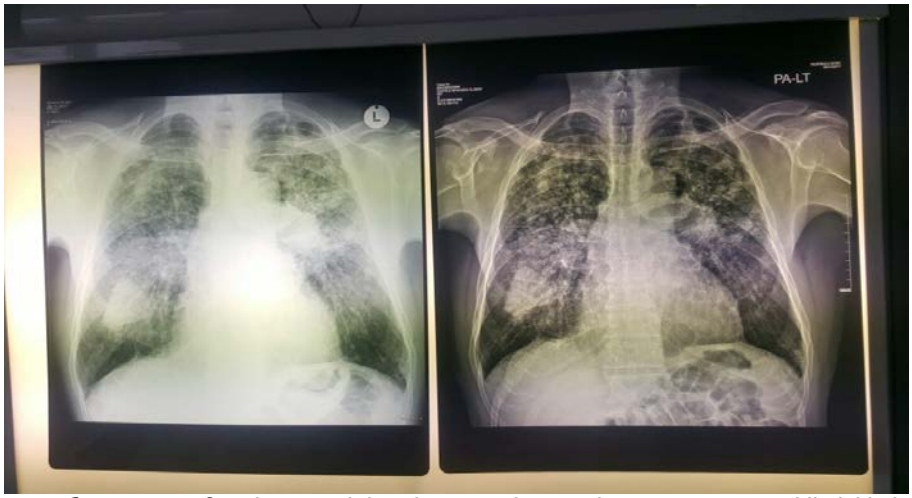
Occupational Lung Disease Compensation

During the past quarter, TIMS OH and TB continued to have meetings with the South African Occupational Disease in Mines and Works Act (ODMA) compensation commissioner and staff, in an effort to expedite TIMS OHSC claims. *As of the end of December 2017, there had been 1 250 Benefit Medical Examinations (BME) files sent to the Medical Bureau for Occupational Diseases (MBOD) from the TIMS OHSC. 350 of these have been processed at the MBOD* and sent on to the MBOD Certification Committee (CC), results of which include:

- 80 diagnosed with 1st or 2nd-degree Occupational Lung Disease (OLD) – compensation now being processed;
- 107 not compensable;
- 82 have OLD TB or the same level of disease as before;
- The remaining 81 are still to be seen or have been deferred by the CC for further information.

During the 4th quarter of 2017, a further 2 161 *(3rd quarter: 584)* OLD cases were diagnosed at the OHSCs. Unfortunately, as a consequence of OGRA not being able to supply sufficient consumables to the OHSC (such as X-ray film and GeneXpert cartridges), only 80 *(3rd quarter: 380)* BME files were considered complete enough for submission to the MBOD. As of January 2018, the TIMS PR has taken over interim management of the OHSCs and complete submissions to the MBOD are being prioritised.

TIMS cloud-based Picture Archiving and Communication System (PACS)



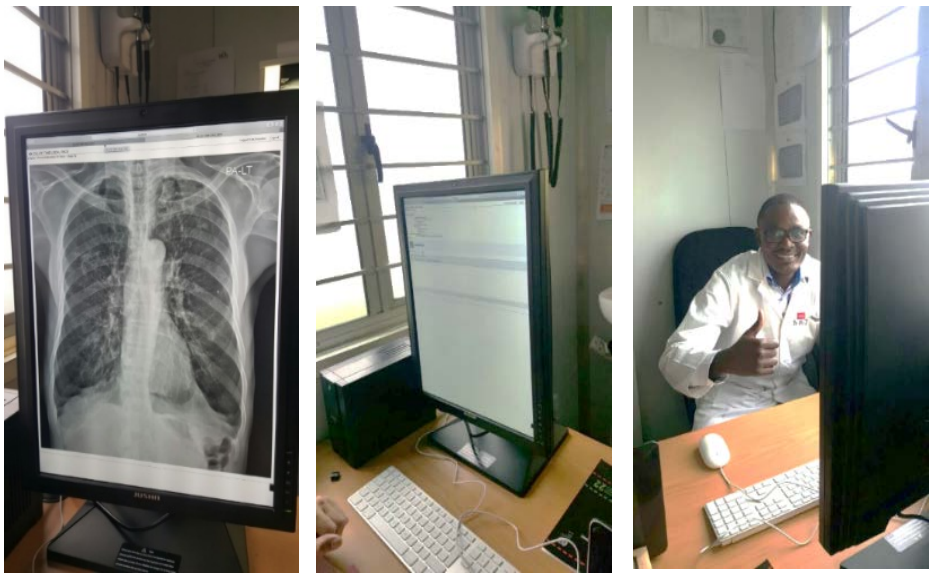
Comparison of analogue and digital image taken on the same patient at Hlathikhulu OHSC – the digital image (on the right, from PACS) is significantly clearer

One of the most exciting projects that the OH and TB unit has been involved with this quarter was the rollout of the TIMS PACS system.

The new system will enable cloud storage of Chest X-rays (CXR) and other medical information from all 11 OHSCs. Compensation authorities, medical service providers and others, may be given permission to access CXR and other clinical data from the TIMS PACS. This will markedly improve medical information sharing, improve treatment and expedite compensation claims.

Each OHSC will receive an Apple mini-PACS and high-resolution monitor (3 Megapixel). The OHSC doctor will have quick access to CXRs (current and past) and be able to read these at the required standard of resolution. The MBOD will also receive 2 Apple mini-PACS and 2 high-resolution monitors, so that CXRs taken at TIMS OHSCs may be read in digital format (DICOM) by the MBOD radiologist and the Certification Committee.

The PACS has been installed at the 2 Swaziland OHSCs (Hlathikhulu and RFM Manzini) and at the 2 OHSCs in Mozambique (Marien Ngoubi and Mandlakazi). Installation of the PACS at the 2 Lesotho OHSCs will be done in January with full rollout to all OHSC and the MBOD completed by the first week of February



High resolution monitor (as part of PACS installation) at Hlathikhulu OHSC

Monitoring and Evaluation Unit

The M&E unit has been involved in the following areas during the 4th quarter of 2017:

Support visits to health facilities

A key focus for the M&E Unit in Q8 was to ensure data flow from implementation districts to ensure coverage indicator data were available for PUDR reporting. To this end support visit were conducted with assistance from NTP M&E or District TB Coordinators. Coverage indicator data were collected from most countries for the period January 2016 up to the time of the M&E site visits. Follow up is required to ensure missing data is available ahead of PUDR reporting. A summary of activities and results by country are provided in the table below:

Country	Data Availability	Follow on Activity
Botswana	Coverage indicator data up to September 2017, collected and submitted	NTP Support needed to facilitate collection of data for period October – December 2017
Lesotho	Coverage indicator data up to November 2017, collected and submitted for most health facilities	NTP Support needed to facilitate collection of data for October - December 2017 and for facilities not covered in first data collection
Malawi	Coverage indicator data up to November 2017, collected	NTP Support needed to facilitate collection of data for December 2017
Mozambique	Coverage indicator data up to December 2017, collected and submitted	None required
Namibia	Coverage indicator data up to September 2017, collected and submitted	NTP Support needed to facilitate collection of data for period October – December 2017
South Africa	Coverage indicator data collected for high volume facilities in Northern Cape Data collection in Eastern Cape outstanding, use of high-risk stickers for registers not adopted due to on-going migration electronic patient management	NTP Support needed to facilitate collection of data for period January – December 2017
Swaziland	Coverage indicator data up to September 2017, collected and submitted	NTP Support needed to facilitate collection of data for period October – December 2017
Tanzania	Coverage indicator data up to November 2017, collected and submitted	NTP Support needed to encourage submission of data for December 2017
Zambia	Coverage indicator data up collected and submitted for 2 districts	NTP Support needed to facilitate collection of data from remaining 2 districts
Zimbabwe	Coverage indicator data up to September 2017, collected and submitted	NTP Support needed to facilitate collection of data for period October – December 2017

Verification of Q7 data

TIMS M&E Unit verified a 30% sample of screening data submitted from each country. Verification results show that reporting accuracy has greatly improved as country data were in most cases reported accurately or with an acceptable 5% margin of error. The verification activities also included follow up on data management improvement plans that had been suggested to SRs at the time of the Q6 RDQAs. Most Q6 RDQA suggested improvements had been implemented, the results of which were reflected in the improved reporting accuracy and data management processes. However, follow up of presumptive cases remains a challenge despite this being

one of the key recommendations in Q6 RDQAs. Several reasons were cited for failure to address this recommendation, the biggest challenge identified was the limited diagnostic capacity at testing centres to cope with high volumes of sputum samples submitted by the SRs. This was at time compounded by slow lab turnaround times and inability to track or contact clients previously identified as being presumptive when follow up for sputum collection was done.

Development of Performance Framework for the next phase of the grant.

The M&E Unit contributed to the development of the funding request for the next phase of the TIMS grant, mostly through development of the performance framework (PF) and ensuring that all required M&E activities were included in the funding request documents. As part of the PF development process, mapping data were utilised to identify districts which potentially had artisanal and small-scale mining (ASM), these districts were proposed as possibly implementation districts for the next phase of the grant. Epidemiological data was then used to determine baselines for proposed implementation districts. NTP managers were requested to confirm if the proposed districts do indeed have ASM activity and if not, to propose alternative districts. NTP managers were also requested to provide up to date data on TB case notification for the districts proposed as implementation areas for the next round of the grant. Upon confirmation of ASM districts and receipt of baseline data, the M&E Unit will finalise the grant performance framework.

Challenges Encountered

A significant challenge encountered by the M&E Unit was the rigidity of country data management systems to adopt the use of the temporal measure suggested aiding tracking of key populations in national TB data management systems. The tracking system proposed entails the use of high-risk group stickers affixed to TB registers and in some cases TB treatment cards. The stickers assign codes to the key population groups TIMS aims to reach: 1 = mine worker; 2 = ex-mine worker; 3 family member of current mine workers; 4 = family member of the ex-mine worker; 5 = community member. Some countries have included additional categories such as prisoner/ prison staff; health care worker, index patient contact etc. on the stickers depending on their needs. Healthcare workers placed stickers in TB registers and write down the relevant risk group code against each patient entered in the register. Though stickers are being placed in registers and at times on patient cards, the relevant risk group codes are not consistently indicated. The main challenge, however, has been with non-submission of TB reports disaggregated by risk group, even in countries where registers have been permanently modified to include miners and ex-miners. This necessitated support visits to health facilities carried out by the M&E Unit in Q8. Assistance from NTP managers to encourage health facilities to submit TB reports disaggregated by key population categories will help mitigate this. However, a long-term solution is to revise TB registers and reporting tools such that key population categories are included in the occupations documented in TB registers and in reports submitted to the NTP.

FINANCE

High-level overview of the TIMS Grant

Reporting period	Q1	Q2	Q3	Q4	Q5	Q6	Q7	Q8
Budget (in USD)	773 686	640 468	3 349 801	5 289 607	4 323 551	7 371 064	4 695 319	3 555 531
Disbursements by GF (in $)	1 167 380	1 402 617	3 304 363	4 683 047	2 256 488	5 125 186	5 136 510	6 923 506
Cumulative budget	773 686	1 414 154	4 763 955	10 053 562	14 377 113	21 748 177	26 443 496	29 999 097
Cumulative disbursements	1 167 380	2 569 997	5 874 360	10 557 407	12 813 895	17 939 081	23 075 591	29 999 097

Overall Burn Rate Q8: 127%

Overview of Quarter 8 and Total of the TIMS Grant

Entity	Budget – Q8	Disbursement – Q8	Expenditure - Q8	Burn-Rate – Q8	Budget - Total	Disbursement - Total	Expenditure - Total	Burn-Rate - Total	Notes
NORTHSTAR	48 365	111 337	284 180	255%	1 870 355	1 939 605	1 939 605	100%	1
OGRA	923 580	916 295	916 295	100%	3 948 498	2 116 858	2 116 858	100%	2
ADPP	701 333	709 377	995 850	140%	3 701 905	3 526 822	3 395 008	96%	3
IRD	332 135	624 365	572 491	92%	2 359 310	2 359 310	2 202 159	93%	4
ACHAP	172 273	198 325	737 362	372%	2 309 999	2 309 999	2 249 846	97%	5
HEALTH FOCUS	0	53 724	75 412	140%	570 472	570 472	570 472	100%	6
Wits Health (PR)	521 120	927 222	927 222	100%	7 553 863	6 558 965	6 558 965	100%	7
Sub - Partners	646 441	1 012 426	1 012 426	100%	7 684 696	7 134 126	7 134 126	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).
- Burn rates are calculated by dividing Expenditure by Disbursement
- All sub-partners have been grouped due to the sensitivity of their pricing.
- These are not the final audited figures and does not include any closeout costs

Notes:

1. For NSA, there were a number of activities added in Q7/Q8 for them to complete on the OHSC's. We are therefore seeing a higher burn-rate on NSA and a full utilisation of the Budget.

2. The difference between budget and expenditure is due to the delay in getting the OHSC's operational. This has had an impact on salary spend and the delays have essentially created savings. However, the remainder of the spend is in line with budget.

3. ADPP is responsible for the screen in in eight of the ten countries. In Q8 we saw ADPP finish their screening activities and use their cash on hand, hence the higher expenditure than disbursements.

4. IRD is responsible for the screening in the remaining two countries. In Q8 we saw IRD finish their screening activities, however, some activities are subject to a slippage extension and the result is cash on hand at the end of Q8.

5. ACHAP disbursed the last funds to the CSO's (originally budgeted in earlier quarters.) there was a higher than budgeted expenditure.

6. Health Focus has maintained a very healthy burn rate and has spent well against their budgeted expenditure, final funds were used up in Q8.

7. The policy of WHC regarding the Disbursements is that the funding is kept centrally and used when needed, no additional disbursements are made to the Project Management Office. As you can see from the budget, the Q8 spend was above the budgeted spend, this is due to a number of catch-ups and delayed expenditure that has now been expended. Some of the variances between actual and budget are also the PR's commitment to be good stewards 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 Q8 there was a larger variance between actual expenditure and budgeted expenditure. The variance is due to timing differences between budget and actual payment.

TIMS

Tuberculosis in the Mining Sector in Southern Africa

TIMS PMO Office Details

24 Saint Andrews Road,
Parktown,
Johannesburg,
South Africa.

Email: tims@witshealth.co.za
Website: www.timssa.co.za
Telephone: +27 11 274 9400