TIMS Quarterly Report

Q1: JANUARY - MARCH 2018

WITS HEALTH CONSORTIUM

Complied by the TIMS Principle Recipient (PR)

MESSAGE FROM THE CHIEF OF PARTY

It is with great enthusiasm that the TIMS Principle Recipient (PR) invites you to join us as we continue to implement the next phase of the TIMS programme.

During phase 1 (*2016 to 2017*), all stakeholders rose to the challenge to aggressively address the historical challenge of TB in the mining sector. Phase 1 had ambitious targets and marked the development and foundation of the grant. Together with numerous stakeholders, in phase 1 we were successful in:

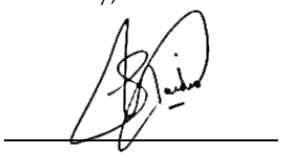
- establishing 10 OHSCs,
- screening over 350 000 people for TB,
- Completing 4 evidence generating studies,
- developing 4 screening models, and
- building 3 IT systems

The next three years of the grant has a new design with the aim of transitioning key interventions into country systems; as well as integrating, strengthening and deepening the existing interventions. A considerable amount of time in Q1 was dedicated to the fleshing out of the new grant design and operational planning. In this report, we provide more contextual insights into TIMS II. In this quarter, the PR also completed the Sub-Recipients (SR) selection process including SR evaluations; appointment of the two new sub-recipients; conducting capacity assessments and induction.

The next quarter will involve detailed planning by the SR's and the continued transitioning of programme knowledge from the PR to the SR with the aim of enabling the SR's to take over the operations of numerous interventions, such as the running of the OHSC's.

We look forward to you continuing this journey with us as we work to find missing TB cases in the key populations and ultimately reduce the TB burden among the Southern African mining community.

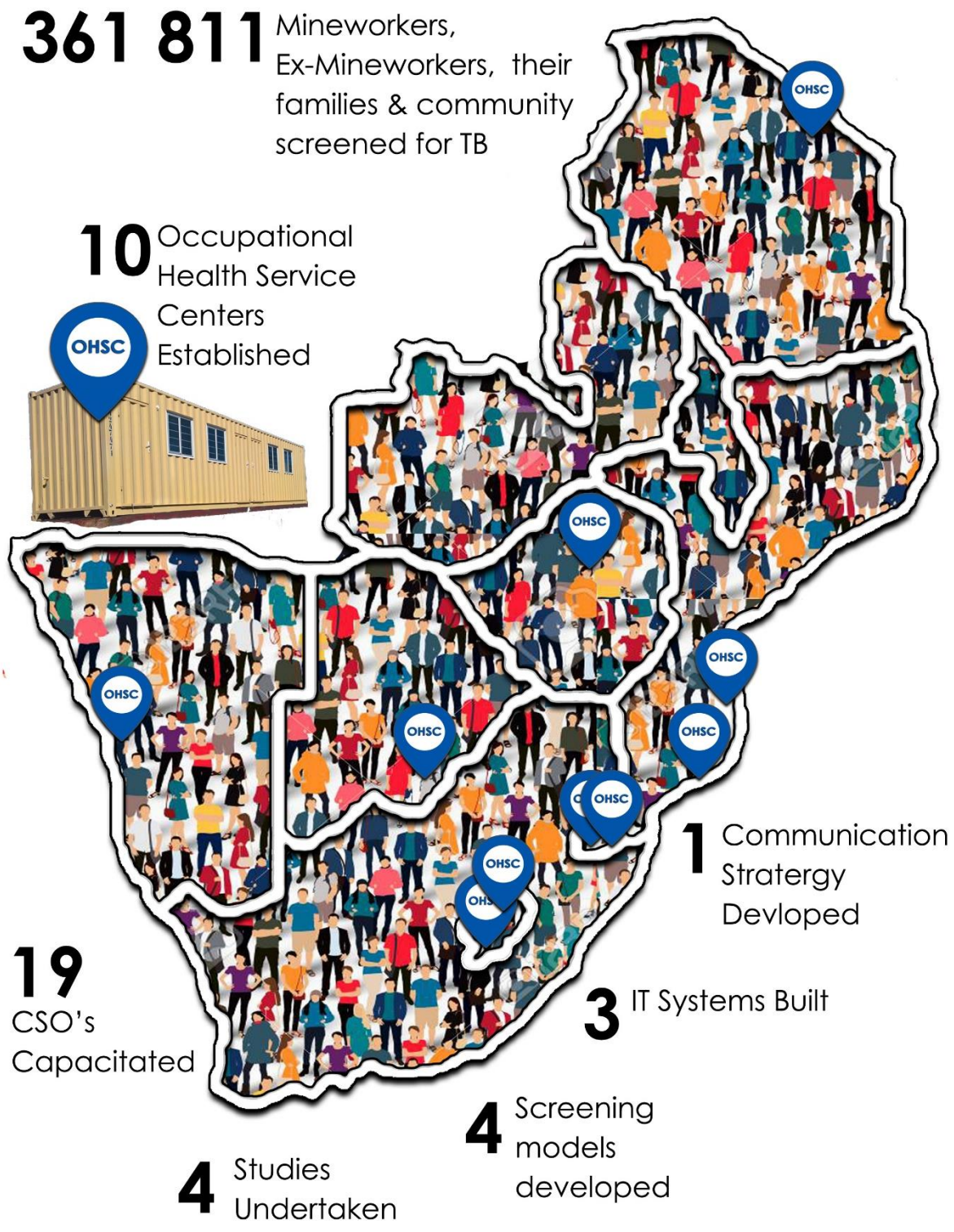
Sincerely,



Dr Julian Naidoo
TIMS – Chief of Party

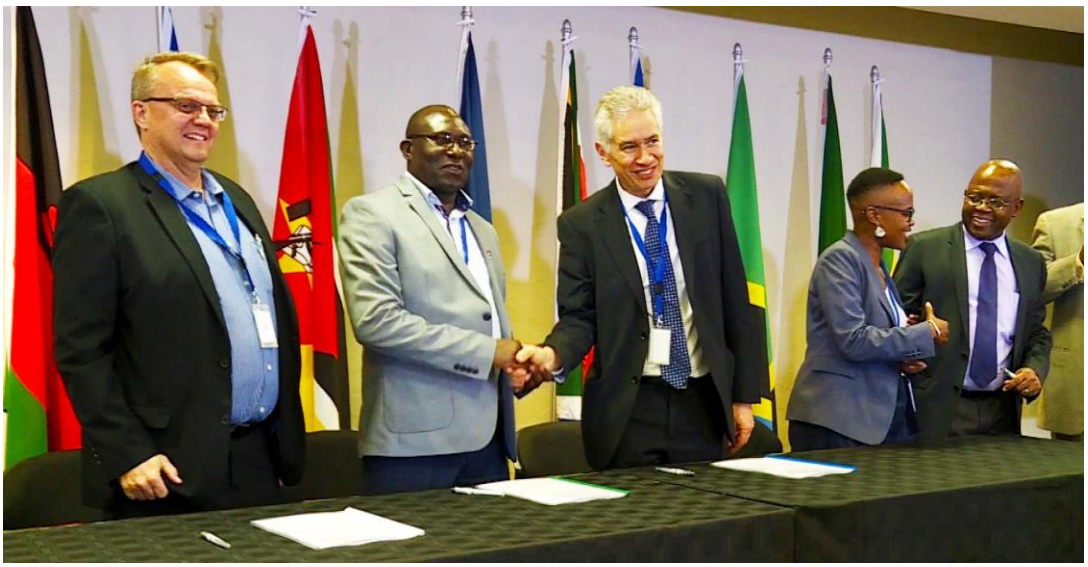
TIMS I

Hundreds of thousands of people were involved in making the first 2 years of the TIMS grant a success.
The infographic below depicts this incredible collective accomplishment.



TIMS II Grant Signing

The official signing of the second round of funding for the TIMS grant took place at the Southern Sun OR Tambo in Johannesburg, South Africa on the 13th March 2018.



TIMS Grant Signing pictured from the left: *Mr Alf Farrell (WHC); Mr Donald Tobaiwa (RCM), Mr Mark Eldon-Edington (Global Fund), Ms Lynette Mabote (RCM) and Mr Richard Matlhare (Botswana MoH)*

TIMS II Operational Planning Meeting

Hot on the heels of the official grant signing the PR and RCM held a 2-day TIMS II operational planning meeting on the 14th and 15th of March, in Johannesburg South Africa. The meeting was a high-level overview of the new grant structure, but the ultimate aim was to have stakeholders present at the meeting give their valuable input into the practical implementation of the grant. You can find out more about the information disseminated at this meeting here.

TIMS II SR/PR Operational Planning Workshop

Armed with the insights of the operational planning meeting, the PR together with the two SR's emerged themselves in an intensive 3-day workshop to flesh out detailed work plans and budgets. This workshop was held in Johannesburg from the 26th to the 28th March 2018. It was also an opportunity to orientate the new SR's on TIMS M&E and finance processes.

New Grant Design

The first quarter of phase two of TIMS focused on establishing a common framework by identifying the key areas of focus as the implementers of this grant. The areas identified were:

Building on the products of Phase I:	Deepen Capacity	Increase Collaboration	Transition to Government
•OHSC's •Models •Toolkits •IT Systems	•Community •Clinical •National Programmes	•Other projects •National projects •Professionals	•Sustainability

In phase I there were 10 Sub-Recipients and Service Providers that each carried out different interventions under the coordination and management of the PR. This design proved effective for the foundational phase of the grant.

However, with the need to transition specific interventions to countries and strengthen and deepen existing interventions it was necessary to have a more integrated approach to grant implementation.

The new design fosters improved implementation coordination; efficiencies and integration.

The design comprises of a clustered approach where two SR's manage all interventions. Each SR will be responsible for 5 countries.
Cluster 1: South Africa, Lesotho, Mozambique, Swaziland and Namibia.
Cluster 2: Zimbabwe, Tanzania, Malawi, Zambia and Botswana.

Each SR along with the PR and RCM will be responsible for the implementation of the different modules of the grant. There are 4 modules in this new grant design, below is a snapshot of the modules of phase II and the entity responsible for implementation:

Click on the icon to read more about the intervention

MODULE 1 **TB Care & Prevention**	MODULE 2 **Health Information and M&E**	MODULE 3 **Community Response & Systems**	MODULE 4 **Programme Management**
Active Case Finding SR	Health Information SP	Institutional Capacity Building SR	Policy, Governance & Advocacy RCM
Engaging Care Providers SR	M&E PR	Social Mobilization SR	Planning & Coordination RCM/PR
Human Rights & Gender Barriers SR		Community-led Advocacy SR	Grant Management PR
		Community-based Monitoring SR	

Module 1: TB Care & Prevention

TB care and prevention is rooted in the WHO End TB strategy that is endorsed by all governments. It outlines a shift from 'controlling' TB globally to ending TB as a public health problem by 2035, with 'integrated, patient centred care and prevention' as a central pillar. This module is subdivided into three interventions that are detailed below.

Active Case Finding

Finding the missing cases by targeting high-risk groups

Demonstration of Screening Models developed in Phase 1

The TB case finding models will be implemented for two years to demonstrate, refine and document lessons. This activity is designed to create buy-in, build capacity and mentor NTP personnel. This will precede adoption and transitioning of the models to country plans. The ultimate goal is for countries to adopt the models for TB case finding among the targeted KPs and incorporate the models into national systems and planning.

Index based contact tracing

A shift will be made from generalized to targeted TB case detection through index case based contact tracing involving index cases of mineworkers and ex-mineworkers identified from mining houses and NTP databases. In the ASM context, index cases will be identified through Active Case Finding. Community Health Workers will conduct targeted contact tracing of each index case. Civil society organisations, including those led by key populations, will conduct contact tracing within and across borders and the Cross-Border Referral System (CBRS) will be utilised to identify receiving health facilities.

Strengthening referral and diagnostic capacity

This funding request will support training on good quality sputum collection, sputum transportation using appropriate specimen storage and transport to minimise patient loss. Sputum transportation will involve the full transport chain i.e. from the community to clinic and from clinic to laboratories.

Engaging All Care Providers

Developing centres of excellence that deliver quality services

The 11 Occupational Health Service Centres (OHSCs) set up under the current Grant provide TB screening and diagnosis services, HIV testing, silicosis screening and diagnosis; and linking ex-mineworkers to compensation funds. Since these centres are located at health facilities, they refer clients for treatment when needed. Through linking OHSCs to compensation funds, TIMS has started unlocking compensation for ex-mineworkers, who qualify for compensation for occupation lung diseases.

Transitioning management of OHSCs to governments

A transition plan detailing steps to be taken to transition the OHSCs to host governments will be developed to ensure services are not compromised or interrupted. This funding request will support the staggered implementation of the transition as guided by each country's status of preparedness. Human resources will be transitioned by end of year 1 and other operating costs transitioned by end of year 2. The aim is to have completed the transition process by the end of year two and use year three for mentoring.

Management of OHSCs

The grant will support continued operations of the OHCS to ensure efficient service delivery until transition. The management effort will be directed at improving the quality of service to create centres of excellence in Occupational Health. KP-led organisations and other CSOs will be engaged under the Community Response and Systems (CRS) module to generate demand for services provided at these centres. Local forums will be established at each OHSC to consult stakeholders and advise OHSC management on broader issues affecting mineworkers and ex-mineworkers.

Capacity building for occupational health practitioners

This grant will support updating of skills and knowledge of current personnel and establish a

regional expert technical panel to facilitate knowledge exchange. This proposed structure will collaborate with other technical formations in the region, such as The Southern African Tuberculosis and Health Systems Support (SATBHSS) Community of Practice.

Strengthening linkages with Compensation Funds

OHSCs linkage to compensation funds will be operationalized at all OHSCs that see clients that have claims against the South African Compensation Fund. Other compensation funds in the region will be mapped out so that the claims process is fully understood. This will set the stage for the potential electronic submissions to these funds as well.

Strengthening linkages with other services

The OHSC will be used as a hub to access other services outside the scope of the grant. These include accessing treatment and social security for other medical conditions such as hearing loss, disabilities and also linking to provident funds. Support for additional services will be sought from mining companies, the SATBHSS project, national governments and compensation funds. This approach will strengthen the sustainability of these centres

Removing Human Rights Barriers

Raising awareness and advocating for change

Awareness-raising for ASMs and communities

This intervention will improve ASM awareness of and access to a minimum package of OH services, which will cover TB/HIV and silicosis. The intervention involves training regional trainers to train CSOs to implement activities that create awareness of OH services. Innovative outreach initiatives will be piloted in 3 countries with high ASM populations; mobilising ASM communities and establishing a database of ASM persons reached.

Capacity building for the utilization of the basic Occupational Health and Safety Package

Standardized protocols will be developed to define a minimum OH package that could be applied to ASM populations. The target audience will consist of key implementers such as civil society organizations (CSOs), inspectorate staff, ASM mineworkers and ex-mineworkers and ASM community leaders. This intervention will enable countries to allocate resources and develop the capacity to provide a minimum level of services which can be built on over time.

Advocacy for Policy and Legislative Reforms

Policy and legislative reform initiative are supported by the SATBHSS project. This funding request will produce policy briefs to inform policy change resulting from studies funded under the current Grant and other initiatives.

Module 2: Health Information and M&E

Good, reliable data drives quality health planning

Roll out the CBRS to strengthen continuity of care

This funding request will support a demonstration of the CBRS system in mining and labour-sending areas according to the geospatial mapping. 30 facilities per country will participate in the demonstration. The process will involve installing the CRBS in the given facilities; training of users of the system; monitoring the use of the system and documenting lessons learnt, and support integration of CBRS into national systems.

RHMIS rollout

The funding request will support the rollout of the RHMIS (developed in phase I) through:

1) Installation and linking of the RHMIS system with the national HMIS and training users;
2) Analysis of data and reporting to platforms at regional and national level (RCM, PIC, high-level policy meetings, SADC ministerial meetings, national TWGs, sector meetings etc.); and
3) Support SADC to maintain the system to ensure sustainability beyond the grant.

Development and dissemination of strategic information

The surveys conducted under the TIMS grant and data to be collected through the RHMIS will be utilized to develop strategic information products for different stakeholders. Implementation will involve dissemination of information products;

development of country-specific plans following dissemination; bi-annual M&E technical working groups meetings to review best practices, annual program performance reviews developing a system for ASM and community response data.

Updating and maintenance of the geospatial mapping

This intervention will involve:

1) Production of spatial analysis highlighting hotspot areas for each country to support advocacy and planning; and
2) Updating of the geospatial mapping with data sets such as mining information, population census data, compensation data, and health facilities information among others.

Monitoring & Evaluation

As part of grant M&E activities, the regional M&E technical working group will be established to address bottlenecks in data collection and reporting in the course of the program.

Module 3: Community Response and Systems

Empowered communities to build stronger health systems

The institutional capacity building, planning and leadership development

Ex-mineworkers associations and trade unions will be mobilised too, in addition to existing CSOs, expand services to key populations, especially those in hotspots identified through the geospatial mapping as well as artisanal mines. The KP organisation will be a catalyst in advocating directly to mining houses (especially large mines), chambers of mines and the public sector to ensure proper conduct needed for continued prevention, treatment and care services.

Social mobilization, building community linkages, collaboration and coordination

CSO's shall be capacitated to provide outreach services and link ASM to social protection programmes to mitigate catastrophic costs that may arise from diseases and injury. This includes:

- Selected artisanal and/or small-scale miners will be supported and linked to health services in the public and private sectors and NGOs.
- Tried and tested service delivery models for artisanal and small-scale miners will be developed for use nationally and regionally.
- All communication materials, including the communication strategy, dust control toolkit and IEC materials, developed under the current grant will be rolled out through CSOs, regional organisations and various community groups.

Community-led advocacy

1) The CSO's toolkit will be strengthened and leveraged for use by other entities such as workplace peer educators/village development committees/ treatment supporters, and regional CSOs such as SAT and ARASA.
2) Identify existing regional structures to serve as Grievance Mechanism that monitors violations of human rights and where necessary, intervene (examples; SADC, NEPAD, ARASA, Regional Associations of Ex-mineworkers)

Community-based monitoring

This will involve establishing or strengthening mechanisms that allow for information/data about migrant TB infected persons to reach CSOs and NTPs for prevention, treatment, care and support.

Module 4: Programme Management

Contributing to a Regional TB Strategy

Policy, governance and advocacy

Both the Global Fund and World Bank-supported initiatives will collaborate in strengthening the policy and governance mechanisms for the regional TB response. Activities to be undertaken are as follows:

Strengthen leadership and coordination:

1) Placing a focal person at SADC Secretariat to serve as a liaison between GF and WB initiatives and SADC with co-funding by both programs;

2) Development of a regional TB strategy and operational plan co-funded by GF and WB initiatives;
3) supporting inclusion and participation of mining sector stakeholders in the national TB TWGs (as mining, labour, chamber of mines and mining companies and key populations); and
4) Convene an annual partnership forum to review program progress and identify common priorities.

Policy Advocacy:

1) RCM engaging with SADC secretariat and SADC chairs of ministers of health to ensure TB in the mines is anchored in SADC processes;
2) disseminate policy briefs and other strategic information to be produced under the HIS module to SADC health, mining, labour and finance sectors meetings;
3) Convene a high-level policy meeting bringing together relevant ministries, all other sectors and experts to sustain country commitment and provide strategic direction to the TB initiative.

Public-private partnerships:

1) Consultations with Chambers of Mines to disseminate evidence on TB and other occupational lung diseases and develop a plan of action for private sector participation on this initiative.
2) Supporting chambers of mines in all 10 Countries to develop a private sector plan of action and monitoring framework based on lessons learnt from countries such as South Africa Chamber of Mines. Through this approach, mining companies will be sensitized and supported to develop or strengthen gender-sensitive policies and practices and support TB, TB/HIV and other services proposed under module 1.

Planning and coordination

This intervention will sustain and strengthen the grant coordination mechanism in place. This will involve supporting the activities of the Regional Coordinating Mechanism to ensure effective harmonization, oversight and accountability of the grant.

a. Coordination: The RCM will be supported to strengthen linkages with CCMs and other regional initiatives. This will involve holding annual meetings with CCMs and participation of RCM and NTP managers' representatives in the SATBHSS project Regional Advisory Committee meetings to coordinate this program with the country and regional initiatives.
b. Oversight of the Global Fund grant: This is a key role of the RCM. The funding request will support meetings of RCM and its committees, regular review of implementation, country oversight visits, membership renewal and orientation, capacity building and knowledge exchange with other initiatives regionally and globally, and ensuring the RCM meets GF eligibility requirements.

Grant management

Under the current grant, the Global Fund regional program implementation arrangements were established. These arrangements include a program management unit established by the Principal Recipient, Sub-recipients tasked with implementation and liaison with focal persons with national programs. This intervention has been prioritized to ensure proper planning, coordination, monitoring and evaluation, funds disbursement and accountability and reporting on implementation of the program according to Global Fund requirements. The intervention also takes into account the need to have a lean grant but efficient grant management structure.

Activities to be supported include:

a. Reviewing the current grant management structure to make it lean and fit for purpose
b. Building the capacity of PRs, Sub Recipients and Sub-Sub Recipients
c. Providing required resources and capacities for the Program Management Office at the PR and SRs in terms of physical and human resources, planning, monitoring and evaluation, procurement and financial management and communication among others.

Selection of New Sub-Recipients

The most critical activity that the PR engaged in Q1 was the selection of the new sub-recipients (SR) for phase II. The funding opportunity announcement for TIMS Phase II closed on 22nd January 2018 and it generated a huge interest leading to a high number of responses tendered. The selection process commenced towards the end of Q8, with the setting up of a technical selection and evaluation panel with membership consisting of technical experts with diverse capabilities from the PR, CDC, WHO, MBOD and NTP Managers from Zimbabwe and South Africa. Having duly constituted the Selection and Evaluation Panel, and clearing each member of any conflict of interest, a meeting was convened on 12 February 2018 where qualifying bidders as per the pre-selection criteria were evaluated and recommended for endorsement to the RCM. The recommended SRs were subjected to organizational capacity assessments by the PR which followed a stylised and dynamic approach focusing on assessing critical organizational development components that include but are not limited to Leadership and Governance, Human Resources Management, Financial Management, Programme Management, Planning, Monitoring & Evaluation. The purpose of the organizational capacity assessments was to determine the readiness of the recommended organizations to receive, manage and report fully on Global Fund grants.

Subsequently, an RCM meeting was set up to discuss among other things, selection and endorsement of SRs. After three independent evaluations and presentations by the PR Selection and Evaluation Panel, the NTP Managers and RCM Oversight Committee, the RCM representatives overwhelmingly endorsed the recommended SRs, Enhancing Care Foundation (ECF) and ACHAP. Consequently, the two organizations were then formally pronounced as the winning bidders for implementing in TIMS interventions in Cluster 1 and 2 respectively.

Cluster 1:

Enhancing Care Foundation (ECF)

South Africa

Lesotho

Mozambique

Swaziland

Namibia

Cluster 2:

ACHAP

Zimbabwe

Tanzania

Malawi

Zambia

Botswana

PR OPERATIONS

Grant Management

M&E

During Q1 of TIMS phase II, the M&E unit undertook a number of activities that were predominantly focused on phase I closeout activities and planning of phase II.

Q8 Data Verification

In February 2018, the unit conducted data verification for Q8 for nine of the ten TIMS implementation countries. The exception was Mozambique as previous data quality assessments found minimal data quality issues. No significant new data quality challenges were identified through the verification visits conducted, it was however noted that there were still large numbers of presumptive clients who had not accessed diagnostic services despite there being a strong drive to ensure diagnostic access in Q8. Overall, access to diagnostic services for presumptive clients across all countries was at 65% in Q8, an improvement from 58% in Q7.

Collection of Outstanding Coverage Indicator Data for PU Reporting

A significant amount of time was spent by the M&E Unit collecting outstanding coverage indicator data from countries. This activity was conducted alongside the Q8 data verification. Most countries had submitted coverage indicator data up to Q3, the countries visits in Q1 of 2018 were to collect outstanding Q8 data, Mozambique was the exception as the full data January – December 2017 had already been submitted. NTP M&E staff and district TB coordinators were instrumental in conducting facility visits, they coordinated and led facility visits. The 2018 PU report was thus compiled with data collected as of the end of February 2018.

Performance Framework (PF) Finalisation

In November 2017, the RCM initiated communication with NTP managers to obtain confirmation of districts with artisanal and small-scale mining (ASM) which could be considered as TIMS implementation districts in the next phase of the grant. The M&E Unit followed up with countries that had yet to respond to the RCM request. Responses from outstanding countries were obtained in March 2018, however a review of proposed districts found that some countries had more than seven possible implementation districts, one country had nine possible districts. Given available resources, the grant cannot be implemented effectively if spread out across too many districts. Thus, NTP managers were requested to prioritise implementation districts based on:

1) The concentration of ASM populations and
2) TB disease burden.

Upon receipt of this information, the M&E unit will then finalise the PF as baselined ad targets will be informed by data relating to the selected implementation districts.

SR Orientation to TIMS M&E Requirements

The M&E unit participated in the operational planning meeting in Johannesburg from 26 to 28 March 2018 for SRs selected to lead activities in the next phase of the grant. As part of the meeting, M&E activities planned for the full grant period were presented for inclusion in SR plans and budgets. A full day was then spent with M&E leads from each SR to have in-depth discussions of the tools to be used, data quality assurance measures that should be in place and reporting requirements. A detailed M&E training will be conducted for SRs and SSRs before the close of Q2.

Meeting with Global Fund Country Team

During Q1, the M&E unit met with the Global Fund Country Team and LFA on 16 March 2018 to discuss among other things the finalization of phase 2 PF and M&E management action plans. The meeting resolved that the PF should be finalized as soon as missing data from South Africa was accessed. At the time of the meeting, South

Africa was the only country yet to confirm ASM districts and provide data on key indicators that was critical to finalizing the PF. South Africa has since confirmed prioritised implementation districts and provided data to facilitate baseline and target establishment. However, the M&E Unit was unable to finalise the PF as the process to obtain feedback from other NTP managers on which ASM districts to prioritise for implementation is still underway, this is expected to be completed before the end of April. Regarding other management action plans, the meeting acknowledged that everything was on course to meet all the listed M&E management actions.

Technical Assistance Terms of Reference

One of the outcomes of with the meeting with the country team on 19 March 2018, was the need for the M&E Unit to identify areas where technical assistance would help strengthen the ability for Unit to carry out its functions. A technical assistance plan was developed and submitted to the Country Team for review.

Occupational Health and TB Unit

Managing the Occupational Health Service Centres (OHSC)

The end of the first phase of the TIMS grant saw a close out of all interventions and a conclusion of contracts with all sub-recipients (SR). However, operations at the OHSC's still needed to continue necessitating that the PR oversee management of the OHSC's as an interim measure while new SR's were being selected and contracted in Q1.

There were a number of immediate issues that the PR had to address including poor consumable logistics and an absence of petty cash systems, both of which have impacted OHSC operations during the past quarter. For example, the Marien Ngoubi and Mandlakazi OHSCs are highly dependent on generators as a source of electricity. The absence of petty cash resulted in there being no diesel for the OHSC generators for long periods of time – no electrical power meant that no x-rays or GeneXpert tests could be done, sometimes for an entire week. Over the past quarter, the PR has managed to stabilise the consumable logistics and petty cash situation such that the OHSCs should be able to operate optimally.

OHSC Statistics: 1st Quarter 2018:

OHSC Statistics for the 1st Quarter of 2019	TIMS I Q7	TIMS I Q8	TIMS II Q1
Total clients seen (miners, ex-miners, family and community)	2343	6473	**5380**
Miners and ex-miners seen (subset of total)	1896	5177	**3929**
Occupational lung disease diagnosed by OHSCs	783	2161	**1402**
Occupational lung disease submitted to MBOD	380	2271	**811**
Certified as compensable by the MBOD (1st or 2nd degree)	0	62	**126**
TB cases diagnosed	48	224	**292**
TB yield (TB cases diagnosed/total clients seen*100)	2.05%	3.46%	**5.43%**

There continues to be a high rate of TB diagnosed at the OHSCs, with the TB yield rate increasing from 2.05% to 5.43% over the past 3 quarters. 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.

The highest TB yield rates are amongst artisanal and small-scale miners in Tanzania (49 TB cases

amongst 275 clients seen = 18%) and Zimbabwe (120 TB cases amongst 795 clients seen = 15%). The TB yields for Lesotho and Swaziland OHSCs are much lower (2.2% and 1.2% respectively). The 2 Mozambique OHSCs are a concern in that the yields are quite different: Mandlakazi saw 439 clients and diagnosed 50 cases of TB (11.4%), whilst Marien Ngoubi saw 1 358 clients and diagnosed 18 cases of TB (1.3%); most likely a consequence of logistic issues experienced during the quarter.

As mentioned above, the PR has been responsible for running the OHSCs during Q1. During Q2, this function will be taken over by the newly appointed SRs.

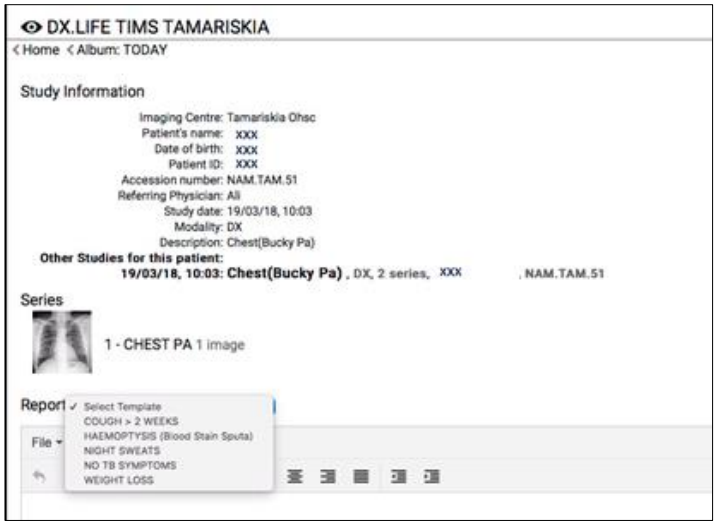
Picture Archiving and Communications System (PACS)

The PACS system has now been rolled out to all 10 operating OHSCs: The digital x-ray acquisition station in each OHSC x-ray container has been connected by LAN to the OHSCs doctor's consulting room, where an Apple mini-PACS and the high-resolution monitor has been installed. All images and reports are now stored at the OHSC and on the DX Life TIMS Cloud. Four screens have been developed for the PACS:

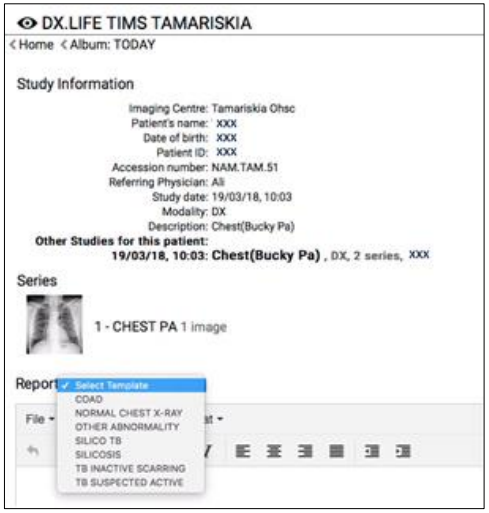
1) The first is a screen filled in by the radiographer, which includes name and identification numbers and the results of the TB symptom questionnaire;
2) the second screen consists of dropdown lists and a free text field for the OHSC doctor;
3) the third screen is used by the MBOD specialist radiologist for reading, including ILO diagnosis;
4) The fourth screen has been specially designed to contain the content of the MBOD Certification Panel findings.

These 4 screens are fixed to an individual chest x-ray and are available to OHSC staff and others, who may be granted access. This means that the OHSC doctor may check back on chest x-rays and see the radiologist's and Certification Panel opinion – greatly assisting teaching and quality control. Also, the OHSC staff are able to see the Certification Panel findings and initiate the compensation process. Examples of the screens are shown below:

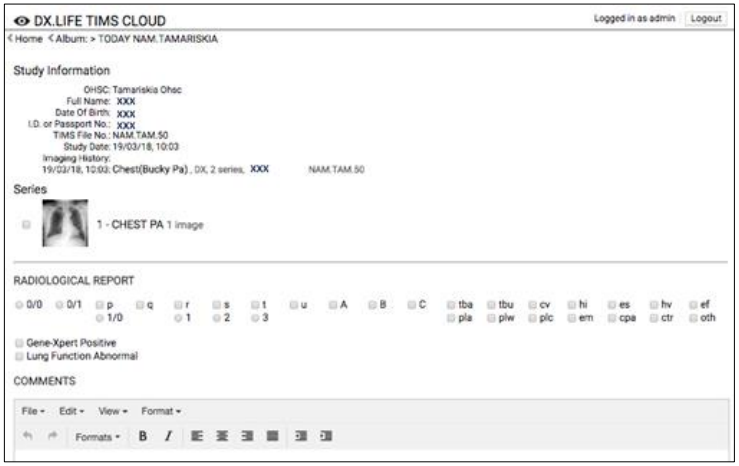
Screen 1 - Radiographer



Screen 2 – OHSC doctor



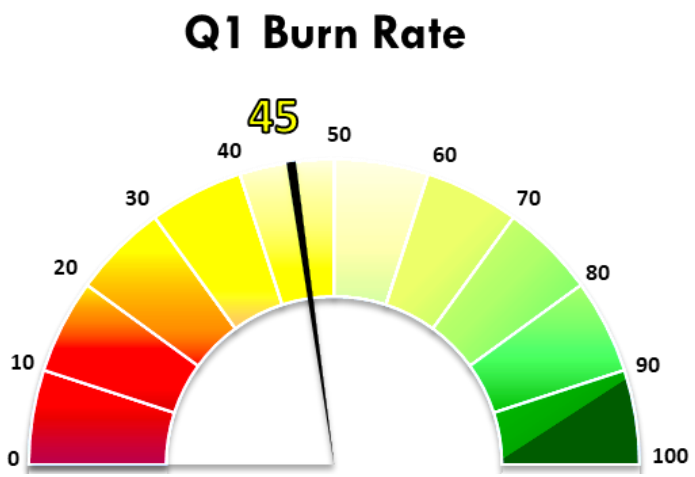
Screen 3 – MBOD radiologist

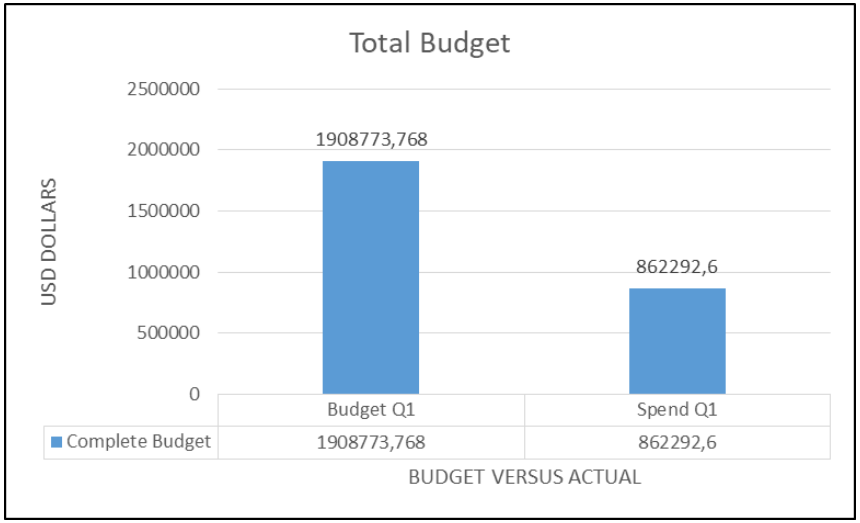


Screen 4 – Certification panel

Finance

Q1 Budget Analysis - Total Budget





Budget Variances	The reason for the low Burn Rate is due to two large budget items being included in Quarter 1 that will need to be moved to Quarter 3. The items were the procurement of Mobile Vans at $600,000 and the procurement of Cross-Border Reporting system Computers at $300,000. **If you take these items out of the budgeted amount, the total burn-rate is at 92%.** Which is significantly better.
Additional notes	Overall, the only operations in Quarter 1 were the Occupational Health Service Centres which delivered on the required mandate. The only challenge remains the Zambia Centre that is still not operational, this has caused a budget lag at this stage. Overall the expenditure is tracking very well against the budget.

TIMS

TUBERCULOSIS IN THE MINING SECTOR IN SOUTHERN AFRICA

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