EVALUATION REPORT ON GLOBAL POVERTY ACTION IMPACT GRANT (GPAF-IMP-0004)

EARLY DETECTION OF TB IN SOUTH AFRICA

(Covering the Period 1 April 2012 to 31 December 2014)

of the programme of the

SOUTHERN AFRICAN CATHOLIC BISHOPS' CONFERENCE - AIDS OFFICE

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~ in collaboration with the School of Nursing at the University of the Free State

January 15, 2015

PREFACE

In conducting the evaluation of the Early Detection and TB project, the two authors have attempted to approach the process from the perspectives of all the stakeholders—those who provided leadership for the project activities, those who implemented activities on the ground, and those whose lives have been impacted by project activities. We wanted to present reliable data on the project outcomes, but we also wanted to tell the human stories—the stories of the project coordinators struggling to provide quality health care under challenging conditions, and the stories of the people who desperately needed that care.

To ensure that all these perspectives were represented, all voices heard, we interviewed project leaders, reviewed project documentation and statistics, received detailed written input from all project coordinators, and undertook field visits to ten of the nineteen implementing projects.

Coverage was achieved through email questionnaires and phone contact with all implementing site coordinators. In addition the evaluators made field visits to ten of the nineteen sites.

Dr Stark conducted seven of the site visits where she interviewed project coordinators, held meetings with the Community Health Workers, and individually met with a number of beneficiaries to listen to their stories and to learn how the project had impacted on their lives.

Dr Wilke and her field workers, following a protocol approved by the Research Ethics Committee of the University of the Free State, pursued a more structured, data-oriented approach to gain information about project achievements and challenges, to verify project statistics and to speak to the beneficiaries in their local language in a confidential setting without the presence of other project staff.

As the report will demonstrate, these two approaches produced consistent information, and, as a result, there is a certain amount of duplication. Nonetheless we decided to include it. We wanted all voices to be heard.

We wish to express our gratitude to all who patiently answered our questions and to all who opened their hearts and lives to us. It is our sincere hope that the information presented in this evaluation will contribute to the growing body of information about the value of low cost, simple innovations that can save lives and offer hope.

Respectfully submitted,

Marisa Wilke
Ruth Stark

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ACRONYMS AND ABBREVIATIONS

AIDS	Acquired Immune Deficiency Syndrome
ART	Antiretroviral Treatment
ARV	Antiretroviral Drugs
CATHCA	Catholic Healthcare Association
CHW	Community Health Worker
CRS	Catholic Relief Services
DFID	Department for International Development
DOH	Department of Health
DOTS	Directly Observed Treatment Short course
FPD	Foundation for Professional Development
Fr.	Father (Catholic Priest)
GPAF	Global Poverty Action Fund
HBC	Home Based Care
HIV	Human Immunodeficiency Virus
KWT	King Williams Town
KZN	Kwa/Zulu/Natal Province
M and E	Monitoring and Evaluation
MDG	Millennium Development Goal
MDR TB	Multi Drug Resistant Tuberculosis
NDOH	National Department of Health
NERCHA	National Emergency Response Council on HIV and AIDS
OVC	Orphans and Vulnerable Children
PEPFAR	President's Emergency Plan for AIDS Relief
SA	South Africa
SACBC	Southern African Catholic Bishops' Conference
Sr.	Religious Sister
TB	Tuberculosis
USA	United States of America
UFS	University of the Free State
XDR TB	Extremely Drug Resistant Tuberculosis

EXECUTIVE SUMMARY

This report represents the results of an external evaluation of the Early Detection of Tuberculosis (TB) project in South Africa financed by the United Kingdom's Department for International Development (DFID) through the Global Poverty Action Fund (GRAF-IMP-004) covering the period April 2012 through December 2014. This 36 month project (April 2012-March 2015) is implemented by the Southern African Catholic Bishops' Conference (SACBC) AIDS Office in the context of a dual TB/HIV epidemic that has gripped South Africa and has caused widespread disease and death. South Africa has the world's highest number of HIV-infected persons and the third highest number of active TB cases. This dual epidemic has impoverished countless families and left millions of orphans in its wake. The purpose was to assess the efficiency of project implementation and to evaluate the extent to which the door-to door TB screening by trained Community Health Workers (CHWs) using a simple questionnaire would be accepted by community members, would be effective in detecting clients with TB at an early stage, would result in appropriate referrals for further TB and HIV testing, treatment, and follow up services, and would have a positive impact on the quality of their lives.

METHODOLOGY:

Over a period of six months, (June through December 2014), the authors conducted an independent evaluation that included: interviews with AIDS Office staff; a desk review of all project-related documents; and questionnaires distributed to all project coordinators. They also traveled to a total of ten project sites where they reviewed project documentation and held further discussions with the coordinators as well as with CHWs and beneficiaries. In three of those project sites Dr Wilke and a team of field workers, in collaboration with the University of the Free State, studied the model of care represented by the Early Detection of TB project. This aspect of the evaluation was particularly significant in that the information from CHWs and from beneficiaries was gathered in the local languages and in confidence, without the presence of project staff who might possibly influence their responses. The field workers also made the effort to physically locate a randomized sample of beneficiaries whose names appeared on project lists in order to verify the statistics the implementing sites had reported to the SACBC AIDS Office.

FINDINGS:

Effectiveness:

- The screening of clients and their treatment exceeded the expectations and the milestones established at the beginning of the project.
- The project coordinators closely monitored the work of the CHWs. There was no evidence that the project statistics were falsified or inflated or that beneficiaries were pressured to answer the TB screening questions.
- The clients generally responded positively to the services offered through the project and reported that the CHWS treated them well.

- The project sites integrated TB/HIV screening with health education and other community support activities. Some actively addressed gender issues.
- The reluctance of local health officials to allow trained CHWs to do HIV testing independently (despite the fact that national government regulations permit this) has contributed to the relatively lower numbers of clients tested for HIV and accessing treatment.

Efficiency:

- The SACBC AIDS Office managed the grant efficiently and represents good value for money. Administrative costs were kept to a minimum. Expenditures at all levels were closely monitored. When changes in the exchange rate increased the availability of funds, the additional resources were used to increase the number of implementing sites and beneficiaries.
- The project operated from a network of established church service programmes that had earned the trust of the community and was able to begin implementation almost immediately.
- The utilization of CHWs proved once again to be a cost effective strategy.

Impact:

- Large numbers of individuals have been detected with TB, placed on treatment and given adherence support.
- Many individuals have received counseling and testing for HIV and those found co-infected placed on treatment.
- Beneficiaries overwhelmingly reported that the support they had received from the CHWs had improved (indeed even "saved") their lives.
- The South African health authorities have highly commended the implementing projects for their support to the local health services and for their impact on numbers of clients reached and TB and HIV cases detected and provided with adherence support.

Sustainability:

- It is expected that four of the current sites will continue to be supported by the South African National Department of Health (NDOH) when DFID funding ends. The remaining sites will not be able to sustain the full range of services but plan to fund raise for this purpose.
- None of the CHWs have confidence that they will be absorbed into the government health services.
- When the project ends, many CHWs say they will continue to use they skills they have developed and engage in volunteer work, but their activities will necessarily be limited due to lack of funds for transport and supplies.
- The implementing sites will continue to operate after the project ends and most say they will integrate the TB screening into the other support services they provide.
- Through the project many of the implementing sites have strengthened their relationship with the local health authorities. This continued mutually beneficial collaboration can be expected to continue.

- Through the project, the communities involved had gained critical information about the prevention and early signs of TB. This institutional knowledge represents an important contribution to sustaining awareness of the importance of early detection and treatment.

LESSONS LEARNED:

- Simple screening tools and straight forward monitoring systems that can be easily understood and utilized by CHWs increase the numbers of clients who can be reached and contribute to the sustainability of activities.
- The more support services provided by implementing projects, the larger the number of clients needing ongoing support, and the more challenging it is for CHWs to meet their targets for reaching out to new clients.
- Comparisons of performance between diverse implementing sites has not proven to be productive, as each provides a distinctive package of services in a unique operating environment and each faces its own sets of challenges.
- The level of stigma in communities and the form it takes varies significantly in the communities in which the implementing sites operate.
- Views about confidentiality and "private space" vary from one community to another and even between individual members of the same community. The range of health services it is possible to offer at the community level is highly dependent on the attitudes of the local authorities.

RECOMMENDATIONS:

- Priority for future and/or continued funding should be given to established well performing service programmes that are accepted by the community and that are able to integrate early TB detection and related activities into their general package of services.

- In the final months of the Early Detection of TB Project, all implementing site coordinators should be assisted to integrate their TB/HIV screening activities into their mainstream project activities.

- Implementing sites should be helped and encouraged to maintain and strengthen their collaboration and coordination with the South African Government health services at all levels.

I. INTRODUCTION

The purpose of this document is to present the results of the independent, external evaluation of the Early Detection of TB in South Africa funded through the Global Poverty Action Fund (GPAF) financed by the United Kingdom's Department for International Development (DFID) over a three year period of 1 April 2012 to 15 March 2015. The AIDS Office of the Southern African Catholic Bishops' Conference (SACBC) implemented the activities and Triple Line Consulting Ltd/Crown Agents served as the appointed GPAF Fund Manager.

The purpose of the evaluation was to establish the extent to which the project met its targets, improved the lives of the beneficiaries, and had the potential to reach its aim of impacting on the rates of TB and HIV in South Africa (SA) and its neighboring country, Swaziland, included in year 2 of the project.

1.1. CONTEXT

HIV increases the risk of developing TB by more than thirty fold. SA is the country with the largest number of HIV positive people in the world and has one of the world's highest prevalence rates of TB and TB/HIV co-infection. More than 200 people who are HIV-positive die from TB every day. Neighboring Swaziland is the country with the largest percentage of its population infected with HIV and has the highest estimated incidence of TB in the world. According to the USA Centers for Disease Control and Prevention, 80% of TB patients in Swaziland are co-infected with HIV. The impact of these devastating and life-threatening conditions on the economic and social well being of individuals, families, and communities (especially on the millions of orphans and other vulnerable children who are highly susceptible to TB) is well documented and is reflected in three related United Nations Millennial Development Goals (MDG) 6: Combat HIV/AIDS, Malaria and other diseases, the primary focus area; MDG 4: Reduce Child Mortality, the secondary focus; and MDG 1: Eradicate extreme poverty and hunger, the tertiary focus area.

Experts agree that early detection and treatment of HIV and TB is essential to the reduction of the mortality and morbidity caused by TB and HIV. Yet, despite government testing campaigns, the South African Human Sciences Research Council has raised concern that over 60% of the population still does not know their HIV status. Further, as Dr Christopher Dye, WHO Director for Health Information, recently reported to the 2014 Southern African TB Conference, only 60% of TB cases are ever detected and, of these, only half are cured.

Lack of early detection of TB increases the risk of disease transmission, leads to poor health outcomes and causes economic hardships. The devastating impact of these life-threatening conditions on the economic and social well being of individuals, families, and communities, particularly on the millions of orphans left bereft, is well documented, and the National Strategic Plan of the South African Department of Health has placed

accelerated case finding of TB as the highest level of priority. But the South African Department of Health (DOH) had not yet had the human resources required for conducting extensive TB screening, HIV testing, and treatment adherence monitoring, particularly in impoverished rural communities. Community structures to complement and support government programmes are required.

The lack of community structures that do not detect TB at an early stage and that do not monitor adherence on treatment has led to high defaulting rates and Multi Drug Resistant TB (MDR TB), an increasing problem in South Africa. Even more concerning, South Africa was the first country to report Extremely Drug Resistant TB (XDR TB). Drug Resistant TB takes a high toll on human life and causes an enormous burden on the economy as the cost of treatment can be 100 times greater than for drug-susceptible TB and 25 times the cost of treating providing first line ART.

The aim of the Early Detection of TB project is to detect and treat TB/HIV at an early stage and monitor adherence in order to reduce the transmission at the community level, to reduce the incidence of drug-resistant TB and to enable affected individuals to regain their health to the extent that they can re-engage in economic activity. This strategy can be expected to alleviate poverty and reduce the number of orphans.

1.2. PROJECT DESCRIPTION

This project addresses the need for early detection and treatment of TB and HIV in 19 highly affected poor, rural and marginalized communities by utilizing the extensive network of Home Based Care (HBC) structures supported by the AIDS Office of the SACBC, the administrative structure of the Catholic Church in South Africa and Swaziland. Community Health Workers (CHWs) in these programmes have access to all the homes in their areas and provide a variety of support services to clients in need. In this project, the implementing HBC programmes are supervised by either a medical doctor or a professional nurse. These professional health workers are responsible for providing regular in-service training and for ensuring that the clients receive quality care.

A table of projects sites, including their location, district, and TB/HIV statistics can be found in APPENDIX I.

During home visits to clients, CHWs interview all household residents with a simple questionnaire, asking 9 questions indicative of TB, questions like, Do you sweat at night? Have you been coughing for 2 weeks or more? Have you experienced loss of appetite? If any household member answers “yes” to one or more of the questions, the client and other household members are referred to a health care facility to be tested for TB with a sputum test and/or chest X-ray and are also tested for HIV (APPENDIX II.) Over the life of the project, government health regulations changed to allow CHWs to perform some of these diagnostic tests themselves. Now, where local health districts permit, some CHWs collect the sputum samples themselves in the home and, following training provided through the project, conduct HIV testing in the home as well.

If the client tests positive for TB, he or she is initiated on treatment at the local health facility. The CHW then monitors the patient to ensure that he or she adheres to treatment. Patients who test positive for HIV will be further tested to determine if they require antiretroviral drug (ARV) treatment.

1.3. PROJECT BUDGET

The budget for this 36 month project in GPB Sterling was 520,000 per annum of which DFID contributed 75% and the SA National Department of Health contributed 25% or 90,857.07. These funds covered the costs of staff, medical supplies, local transport for CHWs and clients, and some minimal administrative expenses, and the external evaluation. The budget also included funds for training the CHWs in topics related to TB and HIV screening, testing, treatment, and adherence support.

1.4. EVALUATION TEAM

The evaluation was conducted by Drs Ruth Stark and Marisa Wilke. Dr Stark, recently retired, has over 30 years experience in international health, including positions as WHO Country Representative in Papua New Guinea; and Senior Technical Advisor and Country Representative for Catholic Relief Services (CRS) in South Africa, Botswana, and Swaziland and CRS Senior Technical HIV/TB Advisor in South Africa. Dr Wilke has over eight years experience as the CRS Monitoring and Evaluation Manager of a large HIV care and treatment project funded by the United States President's Emergency Fund for AIDS Relief (PEPFAR). She currently serves on the Nursing Faculty of the University of the Free State (UFS) in Bloemfontein, South Africa, and she conducts research and serves as a consultant on models of community-based health care.

II. METHODOLOGY

Drs Stark and Wilke began the evaluation process by meeting with the AIDS Office GPAF-IMP-0004 project team as a group for an overall briefing on the objectives and implementation of the project. At this orientation meeting the overall plan for the evaluation was proposed: Dr Stark to conduct a desk review of relevant documents; to interview AIDS Office project staff; to design questionnaires; to conduct phone interviews as required, and to visit selected project sites to hold discussions with the project coordinators and CHWs and to meet with some of the beneficiaries.

Dr Wilke and her research team would travel to three diverse project sites to organise nominal group discussions with CHWs and structured interviews with beneficiaries. These would be conducted in the local languages. She and her team would also seek to verify project statistics by visiting a sample of beneficiary households. This evaluation was conducted in collaboration with the UFS with the formal approval of the University

Research Ethics Committee. The details of the research methodology are described in her full report (APPENDIX VIII).

2.1. INTERVIEWS WITH KEY SACBC AIDS OFFICE STAFF

Following this introductory meeting, Dr Stark conducted interviews with AIDS Office project staff to learn how the project was managed and implemented and how performance was monitored. Information was also gathered about how beneficiary statistics and financial expenditures were verified. Those interviewed included: Sr. Alison Munro, AIDS Office Director; Geraldine Hedley, Finance Manager; Johan Viljoen, Project Manager; and Lloyd Madzivadondo, Financial Compliance Officer.

2.2. DESK REVIEW

In order to evaluate the management of the grant, including the oversight of expenditures, Dr Stark undertook a review of key documents in the SACBC AIDS Office files. These included: the original GPAF-IMP-0004 project proposal including the log frame and budget; the annual project reports; the feedback reports from Triple Line Consulting, including the amended log frame; the annual financial reports; a random selection of minutes from AIDS Office staff and Management Committee Meetings; miscellaneous trip reports of the programme manager; and progress reports submitted to the SACBC Administrative Board and to the plenary session of the SACBC Bishops (2012-2014).

In addition, Dr Stark reviewed documentation of the DOH co-funding (1,400,000 ZAR), including the narrative and financial report submitted (March 2014).

Finally, the desk review included the beneficiary statistics reports submitted by the project sites and the project sites' monthly financial reports, including correspondence between the AIDS Office and the project sites that documented the follow-up action taken to clear queries, for example, when a receipt to support expenditure had not been submitted.

2.3. DATA COLLECTION

Project Coordinator Questionnaires were developed and field tested with project coordinators in two of the Tzaneen area sites, and the revised versions distributed to the coordinators at all project sites. When questionnaires had been completed and returned, Dr Stark discussed the content with each respondent, either in person during site visits or by phone. The purpose was to clarify the information submitted and/or to discuss any areas of concern. All 100% of the project coordinators responded to the questionnaires.

In addition, discussion guides were prepared to guide individual and/or groups meetings with the CHWs and beneficiaries. Questionnaires and discussion guides can be found in APPENDICES III, IV, and V.

2.4. SOUTH AFRICAN HEALTH OFFICIALS' SUPPORT OF PROJECT

To verify their collaboration with the government health authorities and to assess the value added to the public health sector, projects requested letters of support from district and provincial health departments as well as from some referral facilities. Sixteen responses were received. Five examples of the letters of support received can be found in APPENDIX VI.

2.5. ON-SITE EVALUATION ACTIVITIES

It would have been ideal to visit all project sites. But given that these sites are located throughout the rural areas of South Africa and Swaziland with large distances between and most reachable only by land, there was neither the time nor the resources to travel to all 19. Therefore it was decided to travel to locations where it was possible to gain an understanding of the diversity of sites and, in terms of logistics, where more than one project site could be reached on each field visit.

Dr Stark traveled to Tzaneen where the project coordinator manages three sites in the Limpopo Province; to Swaziland to visit sites in Siteki and Piggs Peak; to the mountainous region of Zululand to visit three project sites; and to the Tapologo project site in the Rustenburg area. Site visit reports can be found in APPENDIX VII.

At the eight sites visited, Dr Stark interviewed the project coordinator, some or all of the CHWs, and, where possible two or three beneficiaries. Given that many of the CHWs and beneficiaries are unable to express themselves in writing, these face-to-face discussions were enlightening. The field visits also make it possible to experience first hand the conditions under which the project staff and beneficiaries lived and worked.

There were, however, logistical limitations to this methodology. Firstly, the beneficiaries Dr Stark interviewed had been pre-selected by project staff, and it could be presumed that staff would select beneficiaries with whom they had a good relationship. Secondly, many the beneficiaries were not fluent in English and had to be interviewed through a translator, often a member of the staff. Thirdly, because of the long distances involved, only in Swaziland was it possible to interview beneficiaries in their homesteads; most had to be transported to the project offices. Finally, because of time and logistical considerations, it was not possible to interview all the CHWs at every site. Most were interviewed in a group where some, usually those with the best English skills, dominated the discussion.

In order to address some of these limitations, Dr Wilke organized three additional field visits to a sample of sites selected on the basis of *maximum variation sampling*, a type of purposive sampling utilized to ensure that the variation in project sites would be reflected in the results. The sites included the Joe Gwabi HBC group in Aliwal North; the Noyi

Bazi Clinic in Pomeroy; and the Kroonstad HBC group. Field workers fluent in Sesotho and isiZulu as well as English reviewed client records; visited beneficiaries in their homes to verify project statistics; and interviewed CHWs, beneficiaries, and other stakeholders in their home languages. In addition, Dr Wilke organized nominal group sessions with the CHWs. This nominal group technique is particularly effective in getting group consensus on topics of concern, particularly in situations where some participants are more vocal and/or more powerful than others and when differences of opinion emerge within the group. This technique has proven effective in previous studies conducted in rural South African communities. The full report of the methodology and findings can be found in APPENDIX VIII.

This utilisation of this combination of methodological strategies was intended to enable the evaluators to make a more complete and accurate assessment of the Early Detection of TB project.

III. FINDINGS

3.1. GRANT MANAGEMENT

The three-year Early Detection of TB project began in April 2012 under the leadership of the Director of the SACBC AIDS Office. A dedicated programme manager monitors project activities and performance and prepares statistical and narrative reports for submission to the donor. A finance officer with an administrative assistant and a compliance officer provide oversight of the budget expenditures.

The SACBC is audited on an annual basis. The results, disaggregated by donor, were submitted to DFID in support of the grant application. In addition, as required by DFID, a due diligence audit was conducted and several additional policies were put into place. The cost share of ZAR 400,000 was secured from the South African Department of Health (DOH) through a grant that will cover the expenses of four of the project sites through October 2014. The AIDS Office submits quarterly reports to the DOH with regards to those particular sites.

Initially the project team had selected eleven Church managed sites to implement the project. All had long been engaged in Home Based Care and other social and health-related community activities, and all were situated in districts highly affected by TB and HIV. These included the impoverished areas of Newcastle, Pomeroy, Wasbank, Aliwal North, Sterkspruit, Queenstown, Port Elizabeth, Kroonstad, Virginia, Viljoenskroon, and Keimoes. Each site budget covered the costs for a local project coordinator (generally a nurse); finance officer; monitoring and evaluation staff person: and ten CHWs. Because very few CHWs had formal qualifications in counseling, funds were allocated to fund government accredited courses in HIV Counseling and Testing (including screening for TB) and in HBC. In addition, funds were provided for transport costs and medical supplies.

Funds for project expenditures are dispensed in advance and on a monthly basis. Each month the sites submit their financial reports and supporting documentation for all expenditures, and these are closely reviewed by the compliance officer. Once the advance has been cleared, the next monthly tranche is released.

The AIDS Office conducts monthly management meetings where a committee comprised of designated leaders in the SACBC reviews all AIDS Office activities. In addition, staff of the AIDS Office meet weekly to update the Director and the team members on all activities. During these meetings the different project officers discuss their travel plans and look for ways they can combine trips and travel together. The DFID programme manager visits each site every three to four months, traveling long distances, usually by road, to remote rural communities. Where other AIDS Office project sites are located on the way to or within a short distance of the TB projects, this cooperation among staff saves travel costs and ensures increased value for money spent on a given site visit.

The members of the team working specifically on the Early Detection of TB project also meet together around particular requirements and issues. During these meetings, budgetary issues and site performance are reviewed and adjustments are made as required.

In 2013, the exchange rate between the South African Rand and the British pound Sterling changed from approximately 10:1 to nearly 18:1. Given the fact that the local funds available for the project had nearly doubled, the SACBC sought and received approval from the funder to add addition implementing sites. Again, the sites selected met the criteria of serving in poor communities in districts highly affected by TB and HIV. Over the life of the project, Escourt, Elandskop, Tapologo, and three sites surrounding or in Tzaneen became implementing sites. In addition, the donor gave approval to add two additional sites in Swaziland, a country almost completely surrounded by South Africa and having the highest rate of TB in the world, bringing the total number of sites to nineteen. Value for money was evidenced by the fact that, despite the increase in project sites and in beneficiaries served, no additional AIDS Office staff costs were incurred; the existing programme officer and finance officers continued to monitor the performance of all nineteen sites.

3.2. MILESTONES AND TARGETS IN LOG FRAME

- A review of the log frame shows that the project has consistently exceeded its milestones for screening clients with the questionnaire, thus increasing the opportunity that TB will be detected and treated at an early stage. Because of the lack of access to data from the health facilities, it is not possible at this point to demonstrate that the project has been effective in reducing the mortality rates for TB or for reducing the prevalence of drug resistant TB. Nonetheless, government health authorities believe this to be the case, as indicated in some of the letters of

support, including the letter in APPENDIX VI from the Uthukela District in Kwa Zulu Natal Province.

- Because of the successful project performance the milestones for some output indicators have had to be adjusted upward over the life of the project. The March 2015 target for Output Indicator 1.2, the number of people referred and tested for TB, has also had to be revised upward.

- When dealing with a large number of project sites in different communities, it has been a challenge to meet the exact milestones numbers for every output, particularly since these could only be considered projected estimates.

- There were far more challenges in reaching milestones for HIV testing than for TB screening because (1) Many districts did not allow CHWs to do HIV testing individually (despite the new regulations); (2) TB screening could be done in the home and in numerous other settings whereas the venue for HIV testing was more restrictive; (3) Beneficiaries often didn't follow up for recommended testing at the clinics because of fear and denial; distance to the clinics; and their negative view of the clinic staff and services.

- Beneficiaries were disaggregated by gender, leading to the surprising result that despite the challenges reported with regard to screening and treating males, some output milestones for males exceeded expectations.

- Despite the challenges, overall, the number of beneficiaries served far exceeded the numbers originally projected at the start of the project.

3.3. COORDINATOR QUESTIONNAIRE RESULTS

Every project coordinator completed and returned the questionnaire (APPENDIX III). In addition, coordinators were interviewed during site visits and/or over the phone. The following is a summary of the information based on their responses.

- All nineteen project sites are well established organizations associated with Catholic Church structures and all have a long history of community service. Fourteen implement extensive OVC programmes; ten provide comprehensive HBC. Other services provided by two of more sites include PHC, residential hospice care, peer education, job training, school health services, and antiretroviral treatment.

- Many project sites have additional sources of funding for their community service activities. Six receive funding from the Department of Health; five receive Department of Social Development funds; four receive PEPFAR OVC funds; and five receive funds from private businesses. Nine of the projects, however, report

that they will have no resources for the TB Detection and Treatment activities when the project comes to an end.

- The SACBC programme manager has allocated ten CHWs to most of the project sites. Based on need and performance, there have been some reallocations, resulting in 16 sites with 10 CHWs each, the others with 5 CHWs each.

- Through the Early Detection and Treatment of TB projects, the government accredited HIV counseling course (that includes TB screening) conducted by the Foundation for Professional Development (FPD) was provided for CHWs at all sites. In addition, twelve project sites offered the government accredited HBC course and two sites made the Level 2 (advanced) HBC course available to selected CHWs. In the case of the two Swaziland sites, additional training was offered through the National Emergency Response Council on HIV and AIDS (NERCHA).

- All sites offered in-service training on a regular basis for CHWs. Nine on a weekly basis; two on a bi-weekly basis; five on a monthly basis; and the others offered in-service every quarter. These in-service sessions are in addition to the one-on-one clinical supervision of individual CHWs in the course of their work. Two of the sites offer annual retreats for the CHWs that include training components.

- Most sites were able to meet their targets for screening with the TB questionnaire, but they faced a number of challenges when it came to ensuring necessary follow up testing, particularly for HIV, and follow-up monitoring and treatment for TB as well. In the rural communities, the lack of transport (and/or money for transport) and the large distances between homesteads and between client homes and health facilities make travel difficult for CHWs, especially in bad weather. Worse still is the situation where the CHWs travel a long distance to a client's home, only to find that the client is not there. In some communities many of the clients are seasonal and/or migrant workers who move from place to place without notice and become difficult to trace. The Tapologo project, for example, serves clients in a mining community, many of whom migrate back and forth between shacks near the mines and their home villages (and even home countries).

- In some projects the heavy workload was cited as a reason CHWs were not able to follow up as many clients as expected. If, for example, after visiting a homestead for TB screening purposes, the CHW discovers a bedridden patient in need of basic hygienic care, this would add to the day's workload. If, in addition, the client needed assistance to secure a disability grant, the burden on the CHW's time would be even greater. The seven project sites that provide comprehensive packages of home based services such as those cited above include: Noyi Bazi Clinic; Duduza Care Centre; Bisdom Vigsministerie; Caring Ministry; Tapologo HBC; Regina Mundi HBC; and Good Shepherd HBC.

Some projects cited safety concerns in the community and require that the CHWs go out to the community in pairs or small groups. The coordinator of the Caring Ministry project in Port Elizabeth reported that during episodes of gang violence in the area, it was difficult for CHWs to go out to visit clients at all. These safety concerns obviously affected the sites' ability to meet certain targets.

- The Coordinators use a variety of means to check the accuracy of statistics provided by the CHWs. They compare the screening forms with the weekly summary that the CHWs submit. These include the clients' identification numbers and house number or location. Seven of the coordinators do spot checks on a regular basis by phoning or visiting the clients in their homes or during health campaigns. Two of the coordinators accompany the CHWs on a rotating basis to visit all the clients who have tested positive. In Pomeroy the government clinic is located on the Noyi Bazi mission grounds, and the Coordinator has access to client records. Two of the projects actually recorded and monitored clients on the government TB Register and exchanged information with the local clinics. In three of the projects, the CHWs visit clients in pairs, primarily for safety but also as a check on accuracy.

- When asked if the pressure on CHWs to meet their target caused them to pressure community members to undergo the TB screening and HIV testing, the coordinators all gave answers such as, "No. Absolutely not!" and "Never." To quote the coordinator from the Tapologo site, "No, because the CHWs still need to maintain the respect of the community and pressurizing them will be a sure way of losing their trust."

- In twelve of the nineteen project sites, CHWs collect sputum specimens in the homes and these are accepted by the clinics. In several sites the clinic nurses require the CHWs to collect the specimens in their presence, either at the clinic itself or during a community campaign. These decisions appear to depend on the preference of the individual nurses. For instance, in the Caring Ministry HBC project in Port Elizabeth, the CHWs work with six clinics. One accepts the sputum specimens collected by the CHWs and five do not. Those five state that this is a quality control issue, since they have no way of knowing how long it had taken for the specimen to reach their facility.

- In only seven of the projects do the referring clinics accept HIV rapid test results conducted in the homes. Here again, clinics, districts and provinces currently differ in their acceptance of the national regulations that permit rapid testing in the homes. It is anticipated, however, that this eventually will change. For example, in the Port Elizabeth area NGOs have been specifically prohibited from implementing rapid HIV testing. But after a series of meetings with the district health authorities, the Care Ministry project has been approved to begin a pilot project to implement rapid HIV testing within the homes in early 2015. When, as expected, other districts permit home HIV rapid testing, the CHWs trained

through the project will be able to begin implementation without delay. Meanwhile, during health campaigns, CHWs in eight of the project sites are conducting HIV rapid testing in the government clinics and in community settings where professional nurses are present.

- When asked about their working relationship with government authorities, 100% of the project coordinators described it as excellent or good. The glowing support letters from government officials included in APPENDIX VI are evidence that the health districts place great value on the contribution of the Early Detection and Treatment of TB project. The project staff and the health authorities collaborate in many activities and, as the coordinator from the Mokgolobotha project in Tzaneen described it, "Our relationship is healthy, like a hand in glove."

  Clinic nurses refer clients to the CHWs for follow-up and, in turn, accept referrals from the CHWs, though some are said to complain that the CHWs are "overloading" the government clinics with the large number of patients they refer. Likewise, the coordinators from the sites in the Limpopo Province and Free State Province report that the government nurses sometimes overload the CHWs by requesting them to take on extra tasks, such as assisting in the clinics and filling in for absent workers. These tensions not withstanding, the coordinators characterize the relationship between clinic staff and CHWs as generally cooperative and productive.

  Project staff attend district health meetings, workshops and trainings; share their statistics; and participate in government health campaigns. Most clinics, in turn, provide sputum bottles and other supplies, including test kits. Government health authorities serve as board members in the iThembalethu project in Escourt, and the general manager of the Tapologo HBC project in Rustenburg serves on the district TB task force. Four projects receive funding from the Department of Health and several receive extensive support from the Department of Social Development.

- All nineteen coordinators report that the CHWs are generally well received in the community, and many commented that families approach them for help. One coordinator reported that "There are a large number of word of mouth referrals and requests to visit family or friends they know to be sick." One of the coordinators described their reception as "85% good." When the project started, many CHWs were already well known in the communities they served, but others needed to be introduced to the community. Some projects took the initiative to meet with the chief and/or to call a community meeting for this purpose.

  One coordinator expressed the general consensus by responding that, "For the most part, CHWs have been received extremely well as soon as clients feel it is better for the testing and assessment in households where they can't be identified and stigmatized." There are, however, small numbers of households who do not welcome the CHWs in their homes. Some small churches, particularly in rural

Swaziland, persuade their members to rely solely on prayer for healing, and some families want their members to source their care from traditional healers. In addition, as one coordinator stated, "Some clients do not wish to be visited in a regular pattern by identifiable caregivers because they are scared of the community exposure."

The issue of CHWs being "identifiable," though not addressed in the questionnaire, came up in discussions with CHWs during site visits. Some clients avoid CHWs because they fear they are "watchtowers." Other clients do not want to give their identification numbers to the CHWs because they fear a scam. In the deep rural areas, this is less of a concern because most CHWs live in the area in which they work and their role is well known. But in more urban areas and/or in areas where the distance covered by the CHWs is greater, some CHWs have felt the need to carry some form of identification. In the three projects in the diocese of Tzaneen, CHWs have been issued identifying name tags, but they carry these in their bags rather than wear them. In other projects, the CHWs have some type of uniforms, such as t-shirts. But these tend to be the projects that provide a whole package of HBC and the visit of the CHW is not necessarily associated with a stigmatizing condition. Though effective treatment for HIV and TB has served to decrease stigma, it remains a significant factor in certain communities.

When asked, some coordinators in the Zulu communities reported that clients often seemed to find it more acceptable to be tested for HIV and TB at group events, for example, in gazebos set up for health campaigns, where one by one, they receive counseling and testing in an area set up for privacy.

- The CHWs follow up on clients they refer to the clinic (and those the clinic refers to them) and monitor those placed on treatment on a regular schedule that varies by project, most commonly once weekly, three times weekly, or daily. Ten project coordinators report the monitoring schedule depends on the condition of the patient, daily if indicated, such as with DOTS. In the Sipithemba HBC project in Elandskop, for example, the project nurse categorizes the clients according to their condition and implements the monitoring schedule that has been established for that specific category.

- Many clients have difficulty in following up when referred to the clinics and in complying with their treatment regimen. Coordinators most often mention the following reasons: long distances; lack of availability or funds for transport; alcohol abuse; and long queues at the clinics, a particular problem for employed clients. The periodic stock out of certain drugs and the negative attitude of some of the clinic nurses are also commonly cited. The side effects of some of the medications, especially when patients lack adequate food, are another major reason why clients stop taking their medications, especially when they begin to feel better otherwise and think they can do without the drugs.

- Clearly, the provision of adherence counseling and treatment support are crucial aspects of the role of CHWs. In addition to patient screening, referral, adherence counseling, and routine monitoring, coordinators report that, when needed, CHWs send reminders about clinic visits; offer emotional support and encouragement; conduct support groups; accompany clients to the clinics; collect the clients' test results and medications from the clinics; provide general health education; identify PHC conditions among household members and help them access the required treatment; train family members to care for the chronically ill and bedridden; provide the clients funds for transport; provide nutrition support; and refer patients to social service agencies and hospice care, where available.

- The coordinators report that the provision of services to men is a particular challenge. Though the project sites have successfully screened large numbers of men, there is consensus among project staff that "Men are always a problem." This is particularly the case in reference to HIV. The topic of "sex is taboo" to them—to talk about anything related to sexual behavior is to "enter into their private space." Further, men think it is a sign of weakness to take medications. The projects in the Free State Province have held community campaigns targeted specifically at men, and they and a few other projects have recruited men to help them reach out to other men. Generally, however, any care-giving role of male CHWs would be limited because "culturally this is woman's work," and, as one coordinator explained, "A man will not be welcome in a woman's house."

- Teenagers are also mentioned as a challenging group to reach as they resist "coming forward" for screening and testing. The projects that engage with the schools and those involved with OVC programmes reach some of these young people; others are approached during door-to-door home visits and community campaigns.

- Because of gender inequalities, women in the community are particularly vulnerable to poverty and illness. As one coordinator described it, a woman can't seek employment because she has to stay home and care for her sick partner. Without a job, she cannot afford a proper diet. Her poverty and household exposure to infectious members of her family render her even more vulnerable to disease, particularly TB. All the projects do their best to support women clients on an individual basis. One project invites clients to weekly support groups to address gender issues and HIV and TB awareness. In addition, gender and other areas of human rights are integrated into the community health campaigns and other health education activities.

- When asked about what value the Early Detection and Treatment of TB project added to their communities, the coordinator in the Free State Province expressed what all the coordinators believe, that the project has literally been a "life saver." All agree that there is now an increased awareness in the community about TB. Because of the health education they have received, people know their state of health and seek help from the clinic rather than ignoring their symptoms. Now TB

is being detected and treated at an earlier stage. “People seek care when they see other people getting better” and have been made aware that if they adhere to their treatment they will recover quickly. The coordinators also noted that because of the home visits, other social and medical conditions are being identified and addressed as well, thus improving the overall welfare of the families.

The coordinator of the Caring Ministry in Port Elizabeth believes that “…community members have been empowered to look after themselves and others. Other coordinators said that the community members who received services from the CHWs feel that “people care about them” and that this reduces the burden on the families giving the clients a sense of dignity.” Through the project enhanced linkages have been formed between community NGOs, government departments, and the police, and people have been empowered to participate in community activities at different levels. One of the coordinators believes that project activities have encouraged people to respect one another, “irrespective of race, culture, faith, and gender.”

The priest who coordinates the Good Shepherd project in Siteki, Swaziland said, “It has changed our lives. When I first came here, I was burying twenty a year of documented TB/HIV patients; last year only six. People now have knowledge. They talk about TB and HIV over tea, in the buses, on health campaign days. Now they know they don’t have to die.”

- Finally, when asked about sustainability, about how they would carry on when funding for the project ended, only two of the coordinators said they “don’t know.” All the others planned to continue to some extent, offering what services they could, though they recognized that the lack of resources for CHW stipends, transport, supplies, and nutritional supplements would limit what they could accomplish.

  “We will continue to care for those who are sick but it will be difficult because the CHWs, though volunteers, depend on stipends to survive. We are also trying to access other funding because the Free State Department of Health has no money.” Many other projects mentioned plans to fundraise so they will be able to continue, some quite specific. For example, the Good Shepherd project plans to register as an NGO and then apply for available funds. The projects that receive government funds expect that funding to continue, but the other projects did not express confidence that the government would allocate them any resources or absorb the CHWs into government services.

  While they continue to look for additional funding, the projects with ongoing OVC, HBC, and health education activities will integrate TB screening and adherence support into those existing programmes.

The Coordinator from the Ntaba Maria Clinic in the Eastern Cape summed up the attitude of the coordinators when she stated: "Since we are working for the Church, we'll continue helping our people as part of our mission."

3.4. RESULTS OF DISCUSSIONS WITH CHWs

During her site visits Dr Stark received input from a total of 58 CHWs from eight projects, six in South Africa—Tapologo HBC, Duduza Care Centre, Mokgolobotha HBC, Mothupa HBC, iThembalethu HBC, and Siphithemba HBC; and the two in Swaziland—Good Shepherd and Regina Mundi. Given the limited time constraints and given that most CHWs were most comfortable expressing themselves verbally, the source of most of the input below comes from group discussions.

The CHWs were overwhelmingly females in their forties and fifties with prior experience as community caregivers. Through the project, all had received government accredited HIV counseling courses (that included TB); most had been trained in HBC and/or had attended numerous other courses related to their work; and all received ongoing in-service training arranged by their project coordinators.

The writer found no discrepancies between the information received from the Project Coordinators and that received by the CHWs. On some discussion points, however, the CHWs elaborated in more detail, and this is the information reported in this section.

- Some CHWs conducted house-to-house screening area by area as assigned by their coordinators; others in more rural settings (Swaziland, for example) were assigned to visit the households in the geographic area where they lived. Some (Tapologo, for example), because of their heavy workload of patients needing frequent monitoring and support, screened clients who lived in areas close to the homes of existing patients.

- Some CHWs reported challenges in reaching their targets, particularly those CHWs that worked in projects that provided a comprehensive package of HBC services to the clients they served, projects such as Good Shepherd, Tapologo, and iThembalethu.

- All CHWs vehemently denied that they ever pressured clients to be screened.

- All CHWs provided the following services: screened clients for TB using the standard questionnaire; provided health education about TB and HIV; assisted those who tested positive to access further testing and needed clinical services; provided adherence counseling and other logistic and emotional support for those placed on treatment; counseled patients on HIV and encouraged them to be tested.

- All CHWs helped clients with sputum collection and with HIV testing, some in the clients' homes. Others, because of the policies of the particular province,

district, or clinic, referred clients to the nearest health facility and/or provided these services in the presence of the local nurses in the clinics and during health campaigns.

- CHWs report that the clients' main challenges in accessing and adhering to testing and treatment include:

    - Lack of available transport and/or lack funds for transport to the clinic, especially when the clinic is a long distance away;
    - Lack of food;
    - The side effects of the drugs, especially when taken on an empty stomach;
    - Stigma, worse in some communities than others;
    - Clients not wanting to go to clinics because of negative attitude of nurses and perceived lack of confidentiality;
    - Some clients believe that they have been bewitched and prefer treatment from the traditional healers, the sangomas.

- Clients that were particularly challenging to serve were reported to be:
    - Men, because they do not like to "talk about their lives" and be tested and because, once on treatment, "they drink and forget about their drugs."
    - Teenagers and young adults, because they "feel shame in front of their friends.

- CHWs did what they could to assist clients in need. They provided food parcels, nutritional supplements, and transport money, using resources available through the project as well as resources provided by the parish and other donors. In cases of desperate need, some CHWs even shared their own food with clients.

- When needed, CHWs accompanied clients to the clinics; queued for the clients at the clinics; and/or collected medicine from clinics and delivered it to the clients' homes.

- When requested, CHWs supported local health authorities by participating in government health campaigns and by contributing to school health initiatives. CHWs in some programmes even reported assisting the government nurses with their clinic duties.

- CHWs, particularly those working in sites that provide comprehensive HBC, provide other support services in the households they serve: CHWs give hygienic care to clients; teach family members how to care for and encourage their ill relatives; mentor child-headed households; care for the elderly; and assist households to access needed social services.

- CHWs report that their clients welcome the services they offer and that, as the word spreads, other community members generally welcome them into their homes.

- In the group discussions, however, CHWs mentioned a number of challenges they face in providing service to the communities:

    - The long distances between households and between households and clinics. Just to reach these areas, even by bus, takes considerable time. One commented that one of the areas they visited was three bus rides away.
    - Where there is no transport, the CHW has to walk—a sometimes insurmountable challenge in inclement weather.
    - Sometimes CHWs travel long distances only to find that the client is not there and/or has moved.
    - One CHW said that it was difficult to get the test results from government mobile clinics—a challenge for client follow up.
    - Other CHWs reported that there was a slow response from government social service agencies to client referrals.
    - In some communities, small churches oppose the work of the CHWs, believing that prayer is all that is required.

- CHWs describe their relationships with the government clinics as generally "good," despite the challenges, including the fact that the clinic nurses sometimes say that the CHWs give them "too much work," i.e. too many referrals.

- When asked about the value the Early Detection and Treatment Project added to the community, the CHWs mentioned their perceptions of:

    - The increased awareness in the community of TB and HIV:
    - The increased practical knowledge about prevention, e.g. opening the windows in buses;
    - The increased access to testing and treatment;
    - The decreased stigma;
    - The decreased mortality—people they are helping "come back to life;"
    - The many affected members of the community who now know that "someone cares."

- When the CHWs were asked what the project had meant to them personally, they said that through the project they had:
    - Learned how to solve problems;
    - An increased knowledge of TB and HIV;
    - A better understanding of holistic care:
    - Gained increased confidence:
    - Become role models in the community;
    - Satisfaction of knowing they are contributing to government health initiatives and programmes;
    - Learned many things, "by mingling in the community," that help them in their own lives.

- When ask about the future, when project funding is no longer available, only one CHW thought she might be absorbed by government. Most said they would continue to volunteer with the church programmes, but would not be able to provide the same level of services to the communities. Because there would be less (or no) funds for transport or for food parcels, they would be unable to reach those in the outlying areas and would be unable to assist with the nutritional needs, so important to adherence and recovery. And though it would be difficult for them to survive without a stipend, many said they would continue and do what they can.

3.5. KEY RESULTS FROM MODEL OF CARE STUDY

Results from the Model of Care Study (APPENDIX VIII) conducted by Dr Wilke were consistent with the finding reported above. They did, however, ask some questions not included in the questionnaires and discussions and addressed certain issues in a more rigorous and structured way. Key among these findings are the following:

Services provided according to community health workers (Table 4, Appendix VIII)

Project	Select beneficiaries	Services delivered
Aliwal	Door to door, in area	Greet patient, ask about wellbeing, ensure confidentiality, refer to clinic, check on clinic cared and treatment, check if there is someone to take care of the patient when we are not there
Kroonstad	Door to door & anyone	Screen for TB, teach them about TB and HIV, refer to clinic, monitor adherence, give support, assist bedridden patients
Pomeroy	In own area & OVC homes	TB screening. Education on TB symptoms, hygiene, general health, ventilation. Refer to clinic, accompany to hospital, take food parcels, make sure they take their treatment

Nominal groups with CHWs: Top 3 priorities in the provision of care to beneficiaries (Table 5 APPENDIX VIII)

Priority	Aliwal	Kroonstad	Pomeroy
1	**Confidentiality** - Don't talk about pt. treatment/ illness/ problems - Keep pt. records private - CCW must be faithful to pt. - CCW must be trustworthy	**We need** - Identity to be known in this community (name badge, uniform, etc.) - Equipment (masks, gloves, soap, linen savers, etc.) - Organisation's stamp on documents - Immunisations against infections - Administration documents (leave forms etc.)	**Confidentiality** - Don't discuss pt. problems - Secret between CCW and pt. - To avoid being discriminated - Pt. might not be ready to accept condition
2	**Training** - CCW must be trained to do work - CCW must have correct information to avoid misinforming pt.	**TB Education** - TB symptoms - Explain different types of TB - Sputum bottles - Eat healthily, malnutrition - HIV education - Mode of transmission	**Love** - Love your job - Love your pt. - Be happy - Show openness with pt.
3	**Cleanliness** - CCW must be clean - CCW must teach about cleanliness	**Support** - Support pt. - Support family members too (important to pt.) - Management also to support CCWs - Link & work with clinic - Be there to collect treatment for pt. - Give hope to pt. - Team building among co-workers	**What is TB** - Symptoms of TB - Know that it is curable - It is contagious - It kills - Know how long it takes to cure it - To treat it - How it is contracted

In structured interviews with a randomized sample of 239 beneficiaries in households representing a total of 1,202 members, the data available in ANNEX VI confirm that the majority of the beneficiaries are living under difficult circumstances with limited resources and are heavily dependent on state grants and pensions.

The beneficiaries reported that the programme had an overwhelmingly positive effect on their life. They are satisfied with the services of the CHWs and most have followed up and reported to the health facilities the CHWs had referred them to.

Effect of programme on life of beneficiaries (Table 14 ANNEX VIII)

	Aliwal	Kroonstad	Pomeroy
Effect on life	Positive = 76.4% None = 23.6%	Positive = 81.9% None = 18.1%	Positive = 91.3% None = 8.7%
Why positive effect (main)	Support given = 14.5% Helped, now better= 13.6% Information given = 13.6% OVC support = 12.7%	Support given = 37.3% Helped, now better= 10.8% Referred = 10.8% Adherence support = 10.8%	Adherence support = 23.9% Improve quality of life = 23.9% Helped, now better= 15.2%
Satisfied with services	*Information given re.* TB symptoms = 78.0% TB diagnosis = 67.0% HIV = 79.0% HIV testing = 76.3% Taking medication = 66.3% Referral to clinic = 71.9%	*Information given re.* TB symptoms = 86.7% TB diagnosis = 83.3% HIV = 88.0% HIV testing = 86.3% Taking medication = 79.7% Referral to clinic = 73.5%	*Information given re.* TB symptoms = 63.0% TB diagnosis = 63.0% HIV = 85.0% HIV testing = 80.4% Taking medication = 87.0% Referral to clinic = 91.3%
Had complaints	Complained = 6.4%	Complained = 11 (13.3%)	Complained = 10.9%
Complained about	General health system issues = 5.5% Need info re. other diseases = 0.9%	CHWs not helpful = 6 (7.2%) CHWs do not provide treatment = 1 CHWs do not do best = 1	CHWs not helpful = 4.4% Poor assistance = 4.4% Need info re. other diseases = 2.2%
What if programme were not there	*We would:* have died = 19.1% not have access = 20.9%	*We would:* not have access = 36.1% have died = 21.7%	*We would:* have died = 28.7% not have access = 23.9% have gone to hospital = 4.4%

When asked what would have happened if the programme were not offered in their community beneficiaries felt they would have died, or that they would not have had easy access to health services/ information.

IV. CONCLUSIONS

4.1. RELEVANCE

The objectives of the Early Detection and Treatment of TB project are consistent with the needs of South Africa and its people and with global health priorities and of DFID's commitment to take action to address global poverty.

- South Africa has one of the world's highest prevalence of TB and TB/HIV co-infection.
- TB control is one of the most urgent international health priorities as reflected in the *STOP TB* strategy of the World Health Organization which focuses on early detection and treatment support and is related to MDG 6: Combat HIV/AIDS, Malaria and other diseases
- Because children are particularly at risk for TB, this project also addresses MDG 4: The Reduction of Child Mortality.

- Given the well documented fact that poor health has a profoundly negative impact on the economic status of individuals, families and communities, this project is relevant to the objectives of the DFID Poverty Action Fund and to MDG 1: The Eradication of Extreme Poverty and Hunger.

- The project was particularly relevant to the needs of beneficiaries who live in poor rural communities and who face numerous challenges in accessing health services.

- Many projects addressed gender inequalities.

4.2. EFFECTIVENESS

This project was effective in utilizing trained CHWs to screen individuals living in impoverished, high prevalence communities for TB with a simple questionnaire and for helping them access needed diagnostic and treatment services.

- The screening of clients and their treatment far exceeded the expected results as reflected in the project milestones.

- The HIV counseling and testing of community members far exceeded the planned numbers of patients and household members.

- Large numbers of patients co-infected with TB and HIV have received life-saving treatment.

- In the process of providing TB/HIV screening and adherence support, CHWs provided numerous support services which contributed to the social and economic well being of the households they served.

- Beneficiaries responded positively to the door-to-door and related forms of community TB/HIV screening and to the support services provided by CHWs.

- Some implementing projects actively address gender issues through community forums and group meetings. All recognize the challenges in addressing the health needs of men and teenagers, and all recognize the vulnerability of women and strive to support them.

- The work of the CHWs is closely monitored. There is no evidence that CHWs pressure clients to accept screening or falsify statistics.

4.3. EFFICIENCY

This project was efficiently implemented and represented good value for money.

- The project operated from a network of service programmes long established in the community and able to begin implementation almost immediately.

- The utilization of CHWs in the provision of many basic health and social services has long been proven to be a cost effective development strategy and represents value for money.

- Many of the CHWs of the project lived in the areas they served and had prior experience in providing support services to those in need. The training offered through the project built upon these skills.

- The grant was managed so as to keep administrative expenses to a minimum, employing no more staff than absolutely required and prioritizing the allocation of funds to the points of community service. When the change in exchange rates increased the availability of funds, more project sites were added and far more households served.

4.4. IMPACT

The impact of this project has been considerable. Large numbers of individuals have been screened and detected with TB at an early stage, placed on treatment and given adherence support. In addition, many have received counseling and testing for HIV and those found to be co-infected identified and treated.

- The early detection of TB and the provision of treatment adherence support are cornerstones of the World Health Organization *STOP TB* Strategy and the assumption is that this will impact on the TB mortality rates and reduce the rates of drug resistant TB. At this stage, data is not available to demonstrate that this project has reduced the prevalence and mortality of TB in South Africa, but it can be presumed that this is the case.

- This project has provided important support for the government health services, and has been well regarded and much appreciated by the local district health authorities and facilities.

- The beneficiaries have reported, with expressions of gratitude, that through the project they have received logistic as well as emotional support for accessing and adhering to treatment, and that this support has saved their lives. In addition, though not directly included in project activities, beneficiaries in need have received home nursing care when required; food

packets; and assistance to access social services, including grants, old age pensions, and support for the vulnerable children in their households.

4.5. SUSTAINABILITY

It is expected that the NDOH will provide ongoing support for four of the current project sites. These include the Duduza Care Centre, the Noyi Bazi Clinic, Kroonstad HBC, and the Care Ministry, Port Elizabeth. The remaining sites will not be able to sustain the full range of services to beneficiaries but these long standing church services programmes will continue to provide TB screening and adherence support, albeit to a lesser extent.

- Most of these church service HBC programmes will integrate the TB screening questionnaire, HIV counseling and testing and adherence support into their ongoing HBC activities.

- Many of the implementing sites are actively fundraising to enable them to continue to offer services such as food packets and transport funds.

- None of the CHWs have confidence that they will be absorbed into the government health services.

- Many CHWs have a long history of volunteering in the community and indicated their intention to continue project activities, either as volunteers or as CHWs attached to other HBC projects. However, the lack of funds for transport and supplies will limit their reach into the deep rural areas as well as the support they can give clients.

- The skills the CHWs received in the government accredited training courses in TB and HIV offered through the project will expand the services they will be able to provide to the communities they serve.

- The positive, collaborative relationship with government health authorities and facilities which has developed through this project bodes well for future resources, particularly for those implementing sites where government officials participate on their boards.

- Through the door to door TB screening visits and community health campaigns, the community members have an increased knowledge of the symptoms of TB and an increased understanding of the nature and availability of TB and HIV treatment. The institutionalization of this knowledge will make it more likely that symptomatic clients will seek appropriate treatment.

V. LESSONS LEARNED

- Simple tools, such as the TB screening questionnaire, and simple, straight forward monitoring systems that can be quickly and easily understood and utilized at the community level increase the success of the project and contribute to its sustainability.

- The more support services the implementing partner offers to beneficiaries, the more challenging it may be to meet large numerical targets. For this reason, the performance of implementing organizations cannot be compared with one another simply on the basis of, for example, numbers screened, without taking into account the total package of services offered to clients.

- The level of stigma present in these diverse communities varies significantly, in terms of intensity and in the way it manifests itself: there is no one formula for addressing it. Consultation with key informants in the community prior to the initiation of activities is essential.

- Patient confidentiality is a complex issue and perceptions of confidentiality vary from community to community and from individual to individual. In some communities, for example, clients may be more comfortable being tested for HIV in their homes; in other communities they may prefer being counseled in a group setting such as in a tent during a campaign and afterwards being called by the health worker to a private space for testing.

- The range of services CHWs can provide in a given community depends as much on the attitude of the local health workers as it does on the training CHWs have received or the health regulations in force at the time. Thus, it is essential that the implementing partners, from the beginning, make every effort to establish productive relationships with the local government nurses as well as with the district health authorities.

VI. RECOMMENDATIONS

- Preference for continuing and/or additional funding should be given to existing, well performing service programmes that offer a variety of health and social support services to impoverished communities and that are able to integrate TB screening into existing services.

- In the final months of the current Early Detection of TB project, all project site coordinators should be counseled and assisted to mainstream the TB screening

tool, HIV testing and relevant follow-up services into their general programme of activities.

- Project sites should give priority to maintaining and strengthening their coordination with the SA government health services at all levels.

VII. APPENDICES

APPENDIX I

Project Name	Town	District/ Province	Incidence of TB (2012-13) Per 100,000	HIV prevalence (%) among antenatal clients at first visit (2011)
Zanethemba HBC	Newcastle	Amajuba/ KZN	662	**35.3**
Noyi Bazi Clinic	Pomeroy	Umzinyathi/ KZN	818	**24.6**
Duduza Care Centre	Wasbank	uThukela/ KZN	660	**33.4**
Masabelane HBC	Sterkspruit	Joe Gwabi/EC	776	**29.9**
Joe Qwabi HBC	Aliwal North	Joe Qwabi/EC	776	**29.9**
Ntaba Maria Clinic	Queenstown	Amathole/EC	591	**28.4**
Bisdom Vigsministerie	Keimoes	Siyanda/NC	843	**19.1**
Kroonstad HBC	Kroonstad	Fezile Dabi/FS	620	**35.6**
Virginia HBC	Virginia	Lejweleputswa/FS	839	**34.2**
Viljoenskroon HBC	Viljoenskroon	Fezile Dabi/FS	620	**35.6**
Care Ministry Port Elizabeth HBC	Port Elizabeth	Nelson Mandela Bay Metropolitan District/EC	949	**28.3**
Mokgolobotha HBC	Tzaneen	Mopani/ Limpopo	407	**25.2**
Mothupa HBC	Mothupa	Mopani/ Limpopo	407	**25.2**
St Joseph's Clinic	Sibasa	Vhembe/ Limpopo	324	**14.6**
Tapologo HBC	Rustenburg	Bojanala Platinum District Municipality/North west	599	**33.9**
iThembalethu HBC	Escourt	uThukela/ KZN	660	**33.4**
Sipithemba HBC	**Elandskop**	**Msunduzi, uMundgundlovu KZN**	**880**	**38.9**

Source: *District Health Barometer 2012-2013*, Health Systems Trust, South Africa. http://www.hst.org.za

APPENDIX II

SOUTHERN AFRICAN CATHOLIC BISHOPS CONFERENCE
Health Screening Tool

Date: .....
Name of client: ..... age: .....
sex:.....
Village/Location/Township: .....
House No:.....
Caregivers Name:.....

		YES	NO
1.	Have you been coughing for 2 weeks or more?		
2.	Have you recently coughed out blood in the sputum?		
3.	Have you experienced loss of appetite?		
4.	Have you lost weight of more than 3kg in the last past 4 weeks?		
5.	Have you been sweating unusually at night?		
6.	Have you been recurrent fevers/chills lasting more than 3 days ?		
7.	Have you experienced tiredness/lassitude?		
8.	Have you experienced chest pains/fast breathing or difficulty in breathing?		
9.	Have you got swellings in the neck, armpits or elsewhere?		

IF "YES" TO ONE OR MORE OF THE QUESTIONS, SUSPECT TB, REFER TO THE CLINIC FOR FURTHER INVESTIGATION e.g. SPUTUM COLLECTION

Referred to clinic for further investigation	TB Education	Repeat screening in 6 months time

		Yes	No
10	Have you ever been treated for tuberculosis? When were you treated for tuberculosis? (month and year)		
11	Was TB treatment completed?		
12	Have you been in contact with someone diagnosed with TB in the past year? E.g. same household or at work?		

IF "NO" TO ALL QUESTIONS PATIENT IS NOT A TB SUSPECT- REPEAT THE SCREENING IN 6 MONTHS' TIME.

APPENDIX III

Project Coordinator Questionnaire

Name of Project/Facility_____

Location_____District_____

Name_____ Contact Details_____

Date of Phone Interview_____ Date of Visit_____

1. Other services provided at project site_____

_____

2. Other sources of funding for site_____

_____

3. Month/year TB project began_____Number of Community Health Workers_____

4. Have the community health workers met their targets for screening clients for TB?____ Please briefly describe any challenges and constraints?

_____

Does the pressure on community health workers to meet the targets cause health workers to pressure the community members to undergo the TB screening and HIV testing?____

_____

How do you check to see that the statistics from the community health workers are accurate?_____

_____

5. Training courses Community Health Workers received? Please list month and year.

FPD government accredited training in HIV counseling?_____

Government accredited training in home based care?_____

Other? _____

6. What in-service training is offered to Community Health Workers? How often?

_____

7. Do Community Health Workers take sputum samples in clients' homes?_____

If yes, do the clinics accept these? _____

If no, please explain_____

_____

8. Do Community Health Workers do HIV rapid tests in clients' homes?_____
If no, please explain why not_____

_____

If yes, do the clinics accept the results?_____

9. Do Community Health Workers monitor patients on treatment?_____

If yes, how often?_____

10. What are the challenges in monitoring patients on TB treatment and ART?

_____

11. Do Community Health Workers identify and address other health conditions in the households they visit?_____Please explain_____

_____

12. How would you describe your working relationships with the government clinics?_____

13. Have you had contact with the District or Province in connection with this TB project?_____ If yes, please describe_____

14. How have the Community Health Workers been received in the community? Please describe and explain any challenges encountered?_____

_____

15. How do Community health workers follow up on referrals?_____

_____

16. Are there any challenges in the referral process?____If yes, please explain_____
_____

17. What problems do community members have in taking/adhering to treatment, for example, lack of food, long distances to the clinic, etc_____
_____

18. What kind of support do Community Health Workers provide support for patients put on treatment?_____
_____

19. What do you think the project has meant to the community?_____
_____

20. Are there social conditions or inequalities (for example between men and women) in the community that make it difficult to serve certain individuals or groups?_____ If yes, please explain how you are addressing this?
_____

21. What value has the project added to individuals and households?_____
_____

22. When the project funding ends, how do you see yourselves operating in the community. What activities will it be possible to sustain?_____
_____

23. Have you received the support you require from the AIDS Office?_____

Thank you for your participation. Is there anything you would like to add?_____

_____

_____

_____

APPENDIX IV

Community Health Worker Discussion Guide

Project/Facility_____Location_____
Name_____
Date of Interview_____
Approximate Age_____ Gender_____

Discussion questions:

How much work experience do you have in the HIV/TB field?

Please describe what you do as a Community Health Worker?

What training courses have you had in TB and HIV?

What in-service training and mentoring do you receive from the project staff?

Have you been able to meet your targets for screening clients for TB? If not, please describe the challenges.

Do you ever need to pressure clients to be screened in order to meet your targets?

How do you select the homes you will visit?

How do community members respond to your visits?

What do you typically do on a home visit?

Do you take sputum samples if required in clients' homes? If yes, do the clinics accept these? If not, please explain

Do you do HIV rapid tests in clients' homes? If no, please explain why not.

If yes, are community members willing for you to do the rapid test? If no, please explain.

Do the clinics accept the result?

Do you do pre and post HIV test counseling?

Do you monitor patients on TB treatment?____On ARV's?____If yes, how often?

Do you address other health conditions in the households you visit?__ If yes, please explain.

Please describe when and how you refer to the local clinic.

How do you follow up referrals?

Are there any challenges in the referral process or in working with clinic staff?

What problems do community members have in taking/adhering to treatment?

Please name any major frustrations or problems you have experienced in your work and describe what you did about them.

What do you think the project has meant to the community.

Are there any particular groups in the community that are more difficult to get started on treatment and to monitor, for example, men or women, or marginalized groups in the community?

When the project funding ends this year, what activities will it be possible to sustain?

What has this project meant to you in your life?

When the project ends, what are the opportunities for other employment?

With the increased skills you have gained, do you think you will be able to get another job?

Thank you for your participation. Is there anything you would like to add?

APPENDIX V

Individual Beneficiary Interview Guide

Name of Project/Facility_____Location_____
Beneficiary Name_____
Date of Interview_____ Consent Signed?_____
Approximate Age_____ Gender_____ Religion?_____

Discussion questions:

Are you currently employed? What is the main source of your household income?

How has ill health in your family affected the household income and well being?

How did you come into contact with the project?

What services have you received from the project staff?

How satisfied are you with the services you have received?

How have you been treated by the CHWs? What attitude have they shown toward you?

What is your opinion of the value of lay health workers in the community?

Have the services you have received improved your life?__Please explain

Do you have any problems taking or adhering to treatment?

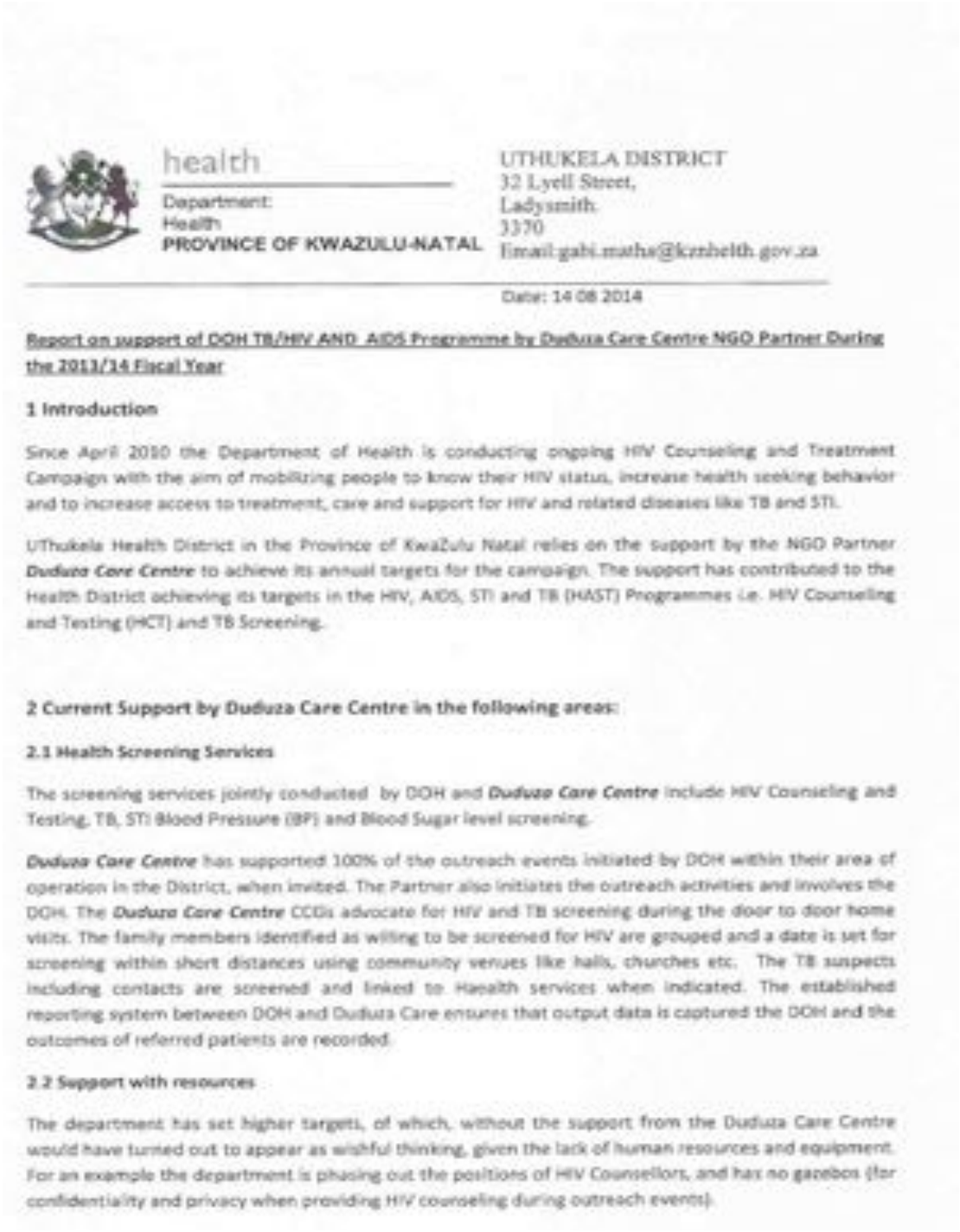
Has the project helped the community? Please explain.

Have you experienced less stigma as a result of home testing and treatment?

~ Thank you. Anything else you would like to add?

APPENDIX VI

SAMPLES OF LETTERS OF SUPPORT FROM GOVERNMENT HEALTH AUTHORITIES



health

Department:
Health
PROVINCE OF KWAZULU-NATAL

UTHUKELA DISTRICT
32 Lyell Street,
Ladysmith.
3370
Email:gabi.mathe@kznhelth.gov.za

Date: 14 08 2014

Report on support of DOH TB/HIV AND AIDS Programme by Duduza Care Centre NGO Partner During the 2013/14 Fiscal Year

1 Introduction

Since April 2010 the Department of Health is conducting ongoing HIV Counseling and Treatment Campaign with the aim of mobilizing people to know their HIV status, increase health seeking behavior and to increase access to treatment, care and support for HIV and related diseases like TB and STI.

UThukela Health District in the Province of KwaZulu Natal relies on the support by the NGO Partner ***Duduza Care Centre*** to achieve its annual targets for the campaign. The support has contributed to the Health District achieving its targets in the HIV, AIDS, STI and TB (HAST) Programmes i.e. HIV Counseling and Testing (HCT) and TB Screening.

2 Current Support by Duduza Care Centre in the following areas:

2.1 Health Screening Services

The screening services jointly conducted by DOH and ***Duduza Care Centre*** include HIV Counseling and Testing, TB, STI Blood Pressure (BP) and Blood Sugar level screening.

Duduza Care Centre has supported 100% of the outreach events initiated by DOH within their area of operation in the District, when invited. The Partner also initiates the outreach activities and involves the DOH. The ***Duduza Care Centre*** CCGs advocate for HIV and TB screening during the door to door home visits. The family members identified as willing to be screened for HIV are grouped and a date is set for screening within short distances using community venues like halls, churches etc. The TB suspects including contacts are screened and linked to Hapalth services when indicated. The established reporting system between DOH and Duduza Care ensures that output data is captured the DOH and the outcomes of referred patients are recorded.

2.2 Support with resources

The department has set higher targets, of which, without the support from the Duduza Care Centre would have turned out to appear as wishful thinking, given the lack of human resources and equipment. For an example the department is phasing out the positions of HIV Counsellors, and has no gazebos (for confidentiality and privacy when providing HIV counseling during outreach events).

Duduza Care Centre supported with (2) Enrolled nurses, ten (10) HAST Counsellors and CCGs who are always the first to arrive at the outreach sites to erect gazebos and start rendering screening services. The support is much appreciated.

2.3 Directly Observed Treatment

Duduza Care Centre also provides DOT support to community members diagnosed with TB which ensures adherence and better treatment outcomes for the TB infected clients.

2.4 Duduza Care Centre Hospice

Palliative Care rendered by the Hospice staff is of great support to the families of the terminally ill patients and to the patients themselves. This often brings emotional and economical relief to the family of the patient, who has to deal with a burden of caring for their dying loved ones within poverty as a context. Patients that are discharged from hospitals or referred by Department of Social Development terminally ill with AIDS or cancer spend their last days in dignity under care of Hospice staff. This on the side of the Department of Health reduces congestion and cost at the local hospital.

2.5 Care of Orphans and Vulnerable Children

AIDS deaths in South Africa have left another societal challenge, whereby the number of Orphans and Vulnerable Children (OVCs) is forever escalating. More often the OVCs no matter how young they maybe are left on their own to fend for themselves, because of stigma and the fact that they are usually more than two per family of a deceased, and no relative is prepared to support more children than she already has home. The AIDS Orphans and Vulnerable Children are either living in child headed families or with grandparents who are dependent on old age grants or are without any income. So often these children are even more vulnerable to poverty, any forms of abuse, emotional trauma, prejudice and discrimination and even to HIV; TB; AIDS and STIs.

The ***Duduza Care Centre*** provides Nutritional support and psychosocial support for the OVCs to prevent school drop outs. The soup kitchens have been built using cheap building material nearby schools to support OVCs with meals during school days. And trained youth volunteers provide counseling, education and play sessions for OVCs.

2.5.1 Support with nutrition and learning

The ***Care Centre*** has 4 soup kitchens where the children get a cooked meal daily and are assisted with their homework. Besides the intended outputs these activities contribute to a longer stay at school by some children who otherwise would have dropped out earlier.

2.5.2 Psychosocial support

The trauma counseling sessions help children to cope better with the negative experiences. Orphan shelters that ***Duduza Care Centre*** builds for the orphans improves their lives as the shelters protect

these destitute children from extremes of weather and reduce the incidence of the respiratory disorders which are common.

2.5.3 Advocacy for the orphans who get dismissed from schools

Due to unpaid school fees or for other reasons related to chronic poverty the orphans are often dismissed from schools, ***Duduza Care Centre*** has advocated for a number of the children to be reaccepted at schools. The Diocese provides school uniforms or track suits and blankets for the children

3 Impact of Duduza Care Centre

For the year 2013/14 the Health District achieved 102% in HCT and TB case finding has improved since the 100% of HIV counseled and tested clients were also screened for TB. TB cure and adherence rate has also improved, with the support from the tracing for treatment defaulters capacity that the ***Duduza Care Centre*** has supported the district with.

4 The working relationship

The DOH empowers the Duduza Care Centre HAST Counsellors through exposure to Departmental inservice trainings and mentorship on HIV Testing and Counseling on quarterly basis and when necessary.

Compiled by:

G M Mathis

District HAST Coordinator

N I Maphalala

District Deputy Director Clinical Programmes

M T Zulu

District Manager, Acting Regional Manager :Region 3

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District HAST Coordinator

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District Deputy Director Clinical Programmes

M T Zulu

District Manager, Acting Regional Manager :Region 3

Province of the
EASTERN CAPE
HEALTH

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Nelson Mandela Bay Health
District
Private Bag X 28000
Greenacres
Port Elizabeth
6057
REPUBLIC OF SOUTH AFRICA

Enquiries: Mrs. N. van der Bergh
Telephone: 041 391 4130
Facsimile: 041 391 4060
E-mail:

Our Reference: Care Ministry
Your Reference
Date: 24 Jul 2014

To whom it may concern

The Care Ministry is well known to the management of the Nelson Mandela Bay Health District (NMBHD) and we are proud of our partnership with the said organisation.

The organisation has actively engaged with the Department of Health (DOH), as well as numerous role players within NMBHD, in order to position themselves as a supportive stakeholder within the development of the Revitalisation of Primary Health Care (RPHC) initiative.

They provide a holistic service to the community of NMBHD and incorporate a number of different projects such as early detection of TB, HIV support services, OVC support and intervention as well as broader Home Based Care (HBC).

Early detection of TB is one of the main pillars of the National Department of Health (NDOH) and as NMBHD, we value the support from our community based organisations to reach our goals. Our partnership with the Care Ministry helps to extend the range of our services through their strong connections with the broader community and the local clinics in NMBHD.

As a result of the Care Ministry's "*Early Detection of TB*" screening project, 388 clients have been initiated onto TB treatment as a direct result of the caregiver's interventions. Of these 97 have since completed TB treatment, with the support of the Care Ministry caregivers, and have been successfully cured of TB. A total of 4334 clients have been screened for TB symptoms since the launch of this TB screening project. On a monthly basis approximately 70 clients receive direct TB treatment support from the Care Ministry caregivers with a further 80 clients receiving ARV treatment support.

We therefore request that DFID consider extending their funding to the Care Ministry, through the SACBC AIDS Office, in order that these valuable services may continue within our communities.

Thank you for your consideration

Mrs. N. van der Bergh
HAST MANAGER
NELSON MANDELA BAY HEALTH DISTRICT

GOOD SHEPHERD
MISSION HOSPITAL

P.O. Box 2, Siteki
Swaziland, Southern Africa
Tel: 343 4133 / 4, 343 4487
Fax: 343 4003, 343 4064

31 July 2014

CARITAS
Swaziland

Re: Letter of Support for the Treatment Support programme

Good shepherd mission Hospital has been working in collaboration with CARITAS Swaziland in proving treatment support to TB patients in the Lubombo region. This program has greatly enhanced early detection of TB which is one of the chief targets of government policy. Over the years this initiative has been ensuring identification of presumptive TB cases and properly diagnosis as well as retention into care and treatment to improve treatment outcomes.

The program is implemented with assistance from treatment supporter called Basili. This is a cadre of community volunteers who provide care and support to TB patients in the communities through adherence support i.e. literally seeing the patient while taking their treatment at home, TB screening in the community, supervision of family treatment supporters, counseling and information sharing on HIV and TB related issues and also encouraging patients to use the available health services in their community.

We look forward to continued collaboration with CARITAS to achieving the MDG target for TB by 2015.

Nhombiluthi Ndzinisa
Community Health MAtron

DEPARTMENT OF HEALTH
LEFAPHA LA BOITEKANELO
ISEBE LEZEMPILO
DEPARTEMENT VAN GESONDHEID

PRIVATE BAG X5900
UPINGTON
8800
TEL. 054 – 337 0600
FAX. 054 – 332 2662

Enquiries: Mr. K Boithomo
Date: 07/08/2014
Reference:

To: SOUTHERN AFRICAN CATHOLIC BISHOPS CONFERENCE
SACBC

The Department of Health ZF Mgcawu herewith give recognition of effective and efficient service delivery from Diocese Aids Ministry.
The Diocese Ministries helps the DOH to improve quality of health services since they act as the foot soldiers for the Department.

With the severe staff shortages it plays an integral part in reaching the department's goals and objectives especially in the following areas:
1. Antenatal and postnatal services
2. Immunization of children
3. Screening households for TB
4. HIV counselling and testing
5. Tracing of treatment defaulters especially TB & ART
6. Rendering of Palliative Care at home
7. Reproductive Health and choices available
8. Health promotion campaigns e.g. HCT, TB, PMTCT, MMC, healthy lifestyle etc.
9. Nutritional screening and Vit. A supplementation

Reporting from the NGO is always on time and they also attend planned meetings. The important role that this NGO plays especially in the Khai Garib sub district can never be over emphasized.

As the ZF Mgcawu District Department of Health we hope for, and rely on a long and healthy partnership.

Yours in Health

Mr. NG Mashego
District Director Health: ZF Mgcawu

We are committed to achieving our vision through a decentralized, accountable, accessible and constantly improving health care system within available resources. Our caring, multi-skilled, effective personnel will use evidence-based, informative health care and maturing partnerships for the benefit of our clients and patients.

APPENDIX VII

SITE VISIT SUMMARIES

Piggs Peak, Hhohho District, Swaziland, 23 July 2014

The Regina Mundi Mission is located in a poor rural community in Piggs Peak. The project coordinator is Fr Mandla Makama, the parish priest. Fr Mandla has a degree in Biology and a great concern for the health and welfare of the people of the community.

He works with 15 community health workers (CHWs), women from 40 to 60 years of age, not all of whom are Catholic. The women provide home based care, orphan care, mentoring of child headed households and care for the elderly. They also distribute second hand clothing to the needy. The funds for these services come from the parish.

TRAINING: Since August 2013, these CHW's have used the TB screening tool to detect TB and the risk of HIV, as well as other health conditions, such as diabetes. Trainers from the government National Emergency Response Council on HIV and AIDS (NERCHA) traveled to Piggs Peak to train them in basic primary health care. For their training in TB/HIV detection, they traveled to Lydenberg, South Africa for the government accredited training provided by the Foundation for Professional Development (FPD).

Fr Mandla supplements the formal training with weekly meetings with the CHWs. At the time of our visit, there was a cholera outbreak in the district, and the subject of the in-service training was prevention of diarrhea by frequent hand washing, treatment of water; oral rehydration therapy; and the signs and symptoms that indicate a need for medical referral.

I had the opportunity to meet with the CHWs as a group and then to travel with three of them to visit two of the beneficiaries. Though the CHWs live in the areas that they serve, most of the homesteads scattered through the rough mountainous regions can only be reached in four wheel drive vehicles (which they do not have) or by foot and the distances between the homesteads are considerable. The difficulty in reaching all the homesteads was cited as one of their main challenges.

TARGETS: Nonetheless, the CHWs have exceeded their targets and insist that very few people object to answering the screening question. But there is still some stigma attached to TB and HIV, and a few people do not want to talk about their health. In his in-service training sessions, Fr Mandla puts great emphasis on developing good patient relations and effective communication skills. In the few cases where the patient expresses reluctance, the CHWs report that they respect the patients' wishes and do not pressure them. Rather, they return at a later date, by which time almost all the clients are comfortable answering the TB screening questions.

Fr Mandla verifies the accuracy of the statistics by doing random checks on the patients. He also encourages the CHWs to visit clients in groups of two to three.

COMMUNITY RESPONSE: When the CHWs first began their TB screening, some community members thought they were Jehovah's Witnesses and thought the papers they carried in their bags (the TB screening tools) were copies of the *Watchtower*. But Father Mandla introduced them to the chiefs and the community members soon came to understand their role and welcomed them into their homes. Now community members actively seek their help.

BENEFICIARY INTERVIEWS #1 We drove deep into the hills and walked through the brush until we came to a homestead and found an elderly man, Mr M., sitting on a chair outside his rundown dwelling. With a short gray beard and in tattered clothes, he warmly smiled at the approach of the CHWs but was unable to stand up to greet us. His right arm and leg were limp, as a result of a stroke. Mr M happily gave his consent to our visit and told us that all his children had died with HIV and that he was left to care for two grandchildren and one great grandchild, a five year old that sat next to him on the ground. While he had been hospitalized with the stroke, cows had eaten up everything he had planted in the adjacent field. His only source of income was the small income one of the grandsons earned washing cars along the side of the road. Mr M. had a persistent cough and the CHWs had collected his sputum, but the results had come back negative. The CHWs, who visited him regularly, said they were going to collect a second sample. Mr M said the CHWs were kind and friendly and gave him pills for his pain and Jik (Clorox) for cleaning. He said it was good to have people in the community (lay workers) provide these health services.

#2 The second patient we visited was a woman in her mid-fifties lying on a blanket and propped up next to her dwelling. The CHWs had been assisting her but she had resisted all efforts to seek more medical treatment for a suppurating lesion of her foot. She consented to speak with me and showed me the massive swelling in her left leg that extended all the way up her thigh. Then she removed the gauze covering her foot and ankle and revealed a massive growth with black fluid filled nodules that could have been caused by a number of life-threatening conditions. The CHWs believed that her she was being treated by a traditional healer but suggested that her daughter in Manzini town take her to the main referral hospital. She agreed and the government public health nurse supervisor was informed and arranged for a government professional nurse to follow up and ensure her referral, transport and treatment. The good relationship with the CHWs and the collaboration with the government health officials were evident throughout and bode well for a positive outcome.

RELATIONSHIP WITH GOVERNMENT HEALTH SYSTEM: CHWs receive sputum bottles from the clinic and take the sputum samples in the patients' homes. They have an excellent working relationship and reciprocal referral system with the government clinic and referral hospital and receive the results without difficulty. The CHWs follow up the patients in their homes and help them comply with their treatment. HIV is rife in the

community and many community members are on ARVs. All patients who are referred for TB symptoms are tested at the local government clinic.

The Public Health Supervisor for the District called in at the mission during my visit. She reported that she and the Senior District Officer both collaborate closely with the health and development activities of the Regina Mundi Parish and are grateful for the support they provide to the community.

CHALLENGES: The most often mentioned challenges were the distances the CHWs had to travel and the destitution, much of it HIV-related, of the beneficiaries. The poverty is so devastating that the CHWs often use part of their personal stipends to provide food for the people they serve.

Another challenge relates to compliance with treatment. The pastors in some churches insist that, with the laying on of hands, Jesus has healed the suffering person, and tell the patients to stop their treatment. This is so frequent that the Cabrini Sisters, missionary nurses in Swaziland, have started a program of education for pastors in collaboration with the Swaziland Church Forum.

Another concern is that men are said to view the taking of medication as a sign of weakness. This compounded with excessive alcohol use can marginalize them and interfere with a successful treatment outcome. Fr Mandla believes that gays and lesbians are also marginalized, but it is probable that most have not disclosed their orientation. The project tries to address this by communicating a nonjudgmental attitude of openness to all, whatever their circumstances, and through a programme of community education.

One strategy for community education are the mission "health days" where a cow is slaughtered and a capacity crowd is given information on the social as well as medical aspects of healthy living.

VALUE ADDED TO THE COMMUNITY: Father Mandla says that "the project has changed our lives. When I came here I was burying 20 parish members a year with documented cases of TB/HIV. Last year, I buried only six. People now have knowledge of TB. They talk about it over tea, in the buses, on health days. Now they know they don't have to die.

When asked what they thought the project had meant to the community, the health workers agreed that the knowledge base in the community had increased, that people now have greater access to health services, and that "they know that someone cares."

SUSTAINABILITY: When the project ends, the CHWs say that they will continue to support the current beneficiaries and others in need of help because it gives them great satisfaction. But without their stipend they won't be able to provide any material support and won't have the funds to travel any further than they can walk.

Because of the economic situation in the country, it is unlikely, though not impossible, that they will be absorbed by government, at least not in the immediate future. Fr Mandla is working to get NGO status for his community development program so they can explore other funding opportunities.

Meanwhile, the sustainability of the Early Detection of TB Program will reside in the institutional knowledge that the community has gained over the three years and the continuing commitment of the parish and CHWs.

Duduza Care Centre at Maria Ratschitz Mission, Wasbank, uThukela District, KZN Province, August 11, 2014

The Duduza Care Centre is located deep in the heart of the Zululand mountains on the mission run by the Franciscan Nardini Sisters. Housed on the spacious grounds are an inpatient hospice, the sisters'convent, food gardens, classrooms, and dormitories. The professional nurse, Ms Hlengiwe Mkhize, and the mission Administrator, Mr Z. Kunene, provide day-to-day management of project activities under the overall supervision of the Coordinator, Sister Collette Mthimkulu. Because of logistic issues, it was not possible to interview beneficiaries on this visit, but the nursing manager, administrator and three CHWs gave input.

The mission cares for residential hospice patients, provides a full range of home based care services, and provides support for OVCs. The Early Detection of TB project began in March of 2012 with 10 CHWs.

TRAINING: The CHWs have been trained in the FPD government accredited course in HIV counseling as well as in the government accredited home based care course. Once a week they come together for in-service training, submit their forms for review, and review their clients with the professional nurse. The nurse and the CHWs also attend trainings offered by the Department of Health.

TARGETS: The CHWs are able to meet their targets for TB screening. When indicated, they collect sputum specimens in the home and deliver them to the clinic for onward forwarding to the laboratory. The Department of Health, however, does not allow HIV testing to be done in the homes. Interestingly, the project staff have found that clients are more willing to be tested during campaigns, where a gazebo is set up and the clinic nurses and CHWs do the counseling and testing on an individual basis. CHWs monitor the treatment of patients, sometimes on a daily basis.

The nurse checks the statistics for accuracy when she reviews the forms and does spot checks on patients in their homes. In addition, she visits all bedridden patients herself.

COMMUNITY RESPONSE: The CHWs are well accepted in the community and report that community members "are happy and request us to do more visits."

RELATIONSHIP WITH THE GOVERNMENT HEALTH SYSTEM: The coordinator describes the relationship with the Department of Health as excellent. The government provides sputum bottles, HIV test kits, and other medical supplies. The clinic nurses refer patients who test positive to the CHWs.

In a written three page letter, senior officials of the Department of Health said, "The Department has set higher targets, of which, without the support from the Duduza Care Centre would have turned out to appear as wishful thinking, given the lack of human resources and equipment." The officials gave the Early Detection of TB project credit for the fact that the District reached 102% of their target in HIV testing and the fact that 100% of HIV tested clients were also screened for TB. In addition, "TB cure and adherence rate has also improved, with the support from the tracing for treatment defaulters that the Duduza Care Centre has supported the district with." The letter expressed gratitude that the Centre has supported 100% of the Department's outreach events and has included the Department in outreach activities which the Centre initiated.

CHALLENGES: Despite the good relationship with the government health services, some of the nurses at the clinics reportedly complain that the CHWs are referring too many patients to them and giving them "too much work." As in other parts of the country, nurses are in short supply and often consider themselves overworked and underpaid.

The most challenging clients are said to be the teenagers, female as well as male, who are reluctant to be screened and tested. Stigma and fear seem to be the operative factors.

Poverty in the area and long distances between homesteads and to the clinics also pose challenges to treatment and adherence.

VALUE ADDED TO THE COMMUNITY: As noted by the health officials, people now have more information about TB and HIV, know that treatment is available and effective, and have the practical assistance they need to learn their status, to access the medications, and to adhere to their treatment.

SUSTAINABILITY: The CHWs and the nurse report that the training they have received and the experience they have gained has given them increased skills and increased confidence in working with the community. This will help them in any future activities they engage in. From the perspective of the Department of Health, strong ties have been forged with this long established mission, and it is expected that these ties will ensure a continued, albeit more limited, partnership going into the future.

Ithembalethu Home Based Care, Escourt, Tugela Distict, KZN Province, 12 August 2014

The Ithembalethu Project is implemented by the Augustinian Catholic Sisters in collaboration with the Department of Health and the Department of Social Development in the Tugela District where extremely resistant TB was first diagnosed. During this site

visit I met with the Coordinator, with two beneficiaries individually and with 10 CHWs as a group.

The Early Detection of TB project began in 2008. The coordinator, Sr. Maureen Aaron, is an experienced professional nurse. The CHWs are all women whose ages range from the mid-twenties to the early fifties. One is HIV positive. Three are fully qualified lay counselors.

Other services offered through this programme include palliative home based care services for the sick and disabled, distribution of food parcels, and provision of practical care and support for OVCs.

TRAINING: The CHWs have benefitted from extensive training in formal courses offered through government accredited providers in HBC, HIV counseling, nutrition, and palliative care. In addition, Sr Maureen provides in-service education programmes twice a month and has taught the CHWs to provide basic nursing treatments and general home nursing care. She also helps motivated CHWs further their formal education. For instance, she is assisting one of the young women train to be a school teacher.

TARGETS: The CHWs screen and refer a healthy number of beneficiaries but do not always meet the target of 100 a month. In this mountainous region where they need to travel great distances, harsh weather conditions can be a deterrent. For safety, they must travel in twos and this also makes it difficult to reach targets because the pair need to reach out to twice as many homesteads than they would otherwise. In addition, because of their close partnership with government, the coordinator and CHWs are required to attend many government meetings, all of which are valuable but take up time.

To ensure the accuracy of the statistics, Sr Maureen reviews the screening forms with the M and E officer and performs spot checks on the clients. In addition, she personally accompanies CHWs to visit all HIV positive clients, all very ill TB patients, all sick children, and all noncompliant patients. During the biweekly meetings, the CHWs report on the follow up care and support they have provided to individual clients in need.

Except during mass testing and screening campaigns, the CHWs do not generally collect the sputum specimens or test for HIV in the homes. Rather, because of their close collaborative relationship with the clinic nurses, they refer or accompany the clients to the clinic. They even queue for them in the long lines of patients awaiting treatment. For their part, the clinic nurses regularly refer clients to the CHWs for follow up and monitoring.

COMMUNITY RESPONSE: In general, the response of the black community, the vast majority, is positive. CHWs go out to the community wearing uniforms—black pants and white shirts with an iron-on emblem of the church project, but that makes no reference to HIV or TB. They say that the "people trust the church and the uniform helps us get respect in the community." For some, however, the uniform they wear and the papers they carry make clients mistake the CHWs for Jehovah's Witnesses.

"Coloured" people, however, are said to be more economically advantaged and less receptive, even to the one CHW who is herself a member of that community. One CHW said, "Sophisticated and coloured community members say 'we all know that,' and don't want us to visit."

BENEFICIARY INTERVIEWS: Two beneficiaries were interviewed individually at the Ithembalethu Outreach Centre.

Beneficiary #1 was a 58 year old female who attends a small independent church. Her family of 8 includes children and grandchildren. None are working. The entire family lives on three child grants (300 ZAR per grant x 3 = 900 ZAR). The CHWs screened her and referred her to the clinic where she was diagnosed with TB and tested positive for HIV. Now she reports that the CHWs follow up her treatment with home visits and help her with food parcels when the family runs out of food. Though she emphasizes that "what I really need is a job," she appreciates the work of the CHWs. "They treat me very well," she said. When asked if it was a good idea to have lay workers providing these diagnostic and treatment services, she responded, "Yes, they work so hard and help us so much."

Beneficiary #2 was a 46 year old female who attends the Zionist Church. She lives with her 2 children and 3 grandchildren. No one in the family is working. Their only income is from child grants. She had already known that she was HIV+ when the CHW visited her home. But when the CHW asked her the questions on the screening tool, she learned that she might have TB and was referred to the clinic where she was eventually diagnosed and placed on TB treatment. The CHWs continue to visit her and bring her food parcels on occasion. When asked about the CHS's attitude, she responded that "they encourage me to take my pills and treat me very well. If I have a question, I ask and they tell me." When asked, she said that lay health workers like her CHW are a big asset to the community.

RELATIONSHIP WITH GOVERNMENT HEALTH SYSTEM: Ithembalethu has a particularly effective partnership with the Department of Health and the Department of Social Development and receives funding from both entities. Significantly, three members of the Ithembalethu Board are officials from those departments and the chairperson is a Department of Health nursing officer.

CHALLENGES: As in so many rural communities, poverty and sheer hunger pose major challenges to health and to compliance with treatment. Patients cannot take their medications if they lack food and often complain of side effects. The CHWs provide emergency food parcels and refer clients to the social workers, but the response of the overloaded social workers is often long in coming.

Some patients fail to go to the clinic because they are too ill; others because they don't trust the nurses to keep confidentiality. Stigma, though decreasing, "will always be with us," according to Sr. Maureen. She and the CHWs find that men are particularly affected by stigma, especially in relation to HIV. "Men are always a problem because sex is taboo

to them. If you talk about anything to do with sex, "men think you are entering into their private space." And, the CHWs went on to explain, "men don't like to talk about their lives. When asked if having a male CHW would help, the CHWs thought it might. But Sr. Maureen disagreed, explaining that, "culturally this is women's work." Further, "a man would not be welcome in a woman's house."

The CHWs said that young adults also posed a challenge with regard to screening, testing and treatment because "they feel shame in front of their friends.

Surprisingly, many community members appeared to be more comfortable coming for HIV testing in a group setting—in a community hall, in the care giver's house, or even "under a tree—" rather than in the home. Another surprising outcome was that many CHWs reported the lack of acknowledgement and appreciation from clinic nurses as a major source of frustration, despite their close collaboration.

VALUE ADDED TO THE COMMUNITY: The CHWs report that the project has meant a lot to the people they visit. In many cases clients tell them that "I didn't know this (cough, etc) could be TB." Through their work, the knowledge about TB and HIV in the wider community seems to have increased.

The project has also had an impact on their own lives. The group agreed that it has been a "learning experience" in that they have learned how to "solve problems. "You can't drink and then tell others not to," said one CHW. "You have to change your own life so you can be a role model."

Many of the more advantaged community members have pitched in to contribute financially to the project and to volunteer as well. Sr Maureen displayed photos of community members helping organize events for OVCs and other such activities. Private businessmen have contributed maize meal, and large chain stores have provided toys and equipment. The parishes provide blankets and clothes during the winter.

SUSTAINABILITY: Some of the CHWs said they would continue to volunteer when the project ends, though they would have fewer resources to help their clients. Some CHWs thought that the training they received would make it possible for them to get a proper job. Most are counting on Sr. Maureen to continue fundraising in the community. It is expected that the Department of Social Development and the Department of Health, strong supporters of Ithembalethu, will continue to provide resources.

Noyi Bazi TB Project, Pomeroy, Umnzinyathi District, KZN Province, August 14, 2014

Pomeroy is an impoverished community in the mountainous region of the country that has been racked with TB and HIV. The Augustinian Sisters have long provided the only primary health care services available in the area. Located next to the convent on church grounds, this clinic, subsidized by the government, provides comprehensive medical

services and houses a TB/HIV section where the TB coordinator supervises the work of the CHWs.

The government is now building its own clinic and plans to take over the services and absorb the staff. The Augustinian clinic will be converted to serve the 500 OVCs they support as well as to house the Sisters' other community activities—peer education, nutrition schemes, sewing projects, computer lessons, income generating projects, and the establishment of a library. Funding for these activities comes from private donors, from the Department of Health, and from the SACBC.

The Early Detection of TB project began in 2012 with 10 female CHWs. Sr Madeleine Rouille coordinates the project and all TB/HIV activities are closely supervised and monitored by the government TB nurse coordinator in the TB facility attached to the mission clinic, Sr. Chiliza.

On this visit, I interviewed the project coordinator, the clinic nurses, and the TB nurse coordinator. I saw several CHWs and beneficiaries at the TB centre who were involved in treatment activities but it was not appropriate at the time to conduct individual interviews with them.

TRAINING: In 2008 the CHWs completed the government accredited training in home based care. Some have progressed to Home Based Care, Level 2. In 2012 they completed the FPD government accredited training in HIV counseling, and after Sr Madeleine's persistent follow up, received their certificates.

In-service training is offered twice monthly. Once a month the content of the training focuses specifically on information and concerns related to the TB project. For the second monthly session, the CHWs in the project join the other volunteer home based care givers for a day of training on more general health topics and on topics related to social issues, including gender based violence. Efforts are made to empower the CHWs with regard to their rightful roles as women in the family and the community.

CHWs in the TB project gain additional one-on-one training with the TB coordinator on a rotating basis. On these days they help with patient records, follow-up referrals, and assist with general patient services.

TARGETS: Sr. Madeleine believes that the targets are too high for this area. CHWs have to walk long distances in this mountainous area and cannot always reach as many as they would like. In addition, they provide a whole range of health and social services for those they do care for, including chronic illnesses and elderly care. They also address malnutrition and emotional disorders. All this takes considerable time.

Accurate records are kept, and statistics are carefully reviewed for completeness and accuracy. Those who screen positive for TB are referred to the TB coordinator who collects the sputum, and sends it to the hospital laboratory. All clients who receive services on mission grounds are counseled and offered HIV tests. If the patient is unable

to go to the TB facility on mission grounds, the CHW collects the sputum in the home. When the results come back from the hospital, the government TB coordinator notifies the CHW who contacts the patient and helps them come in for treatment and then follows them up in their homes. Some are visited every day. The TB facility uses the government register and reports all statistics to the government.

COMMUNITY RESPONSE: The Augustinian Sisters have been in Pomeroy for many years. The PHC clinic is full every day and the CHWs are known in the community and generally received well. The CHWs wear identifying t-shirts with a badge so that staff in referral health services will recognize them attend to them quickly when they accompany clients to these facilities.

RELATIONSHIP WITH GOVERNMENT HEALTH SERVICES: The clinical services offered by the Augustinian Sisters *are* the government primary care services. They have strong communication and a mutual referral system with outlying clinics and the hospital, and a collaborative relationship with the district and provincial authorities.

CHALLENGES: Patients move from place to place and it is sometimes difficult to follow up and ensure treatment compliance. Also stigma is still high in this area, and the lack of privacy in the home makes it challenging to care for clients who wish to hide their status from other family members. When their status is known, some family members and traditional leaders pressure clients to go to the sangomas (traditional healers) for treatment, rather than to the clinic. The long distances and lack of transport in the area is a challenge for both CHWs and clients. Many impoverished clients don't want to take their medications when they lack sufficient food. They say that "the pills are too big" and the side effects intolerable. Men, in particular, tend to be more resistant to HIV testing and reluctant to reveal their status.

IMPACT ON THE COMMUNITY: There is an increased awareness in the community of the symptoms of TB, of the fact that both TB and HIV are treatable, and of the fact that treatment is available. When community members see their neighbors improving with treatment, they are encouraged to learn their own status as well. The health workers believe this awareness of the availability and effectiveness of treatment has decreased, though not eliminated, the stigma associated with these health conditions. In addition, people feel they are cared for and treated with dignity.

SUSTAINABILITY: Because the TB project has been so integrated into the government health system, it will have a positive impact on the clinical services available to this community even after the project ends. In addition, many of the CHWs (as well as the current volunteer caregivers) will continue to provide screening and treatment support to the people of Pomeroy. Unfortunately, without the funding support for transport, food parcels, etc it will not be possible to provide the same level of services to the number of clients they now serve.

Tapologo Home Based Care, Rustenburg, Bojanala Platinum District, Northwest Province, September 16, 2014

The Tapologo project site is located on the grounds of the Diocese of Rustenburg in a community surrounded by platinum mines. Gathered around the mines are desperately poor informal communities of South African citizens and immigrants—documented and undocumented—who have been attracted to the economic opportunities potentially available in a mining community. Many of the settlements around the mine lack electricity and water and sanitation services.

This area is the site of the 2012 Marikana miners' strike that lasted for 6 months and which led to the deaths of the deaths of 44 strikers and police and which exacerbated the poverty in the area resulting in an increase in the already high levels of child malnutrition. Because of the violent nature of the strike, many patients on HIV and/or TB were too fearful to venture out to collect their medications.

Tapologo provides comprehensive HBC, an antiretroviral treatment clinic that has been funded through PEPFAR, a large OVC program and a residential hospice. The Early Detection and Treatment of TB program began in November 2013 with 5 CHWs.

During the visit I met with the coordinator, Meacala van Tonder, with three of the CHWS and interviewed two of the beneficiaries. I also had the opportunity to meet with the Bishop of the area, Bishop Kevin Dowling.

TRAINING: The CHWs are women in their forties and fifties who have between seven and eleven years community health experience. All have been trained in the government accredited HIV Counseling programme and training in TB and HBC. In addition, they attend monthly in-service sessions organized by or through Tapologo.

TARGETS: Each beneficiary they encounter has multiple needs that need to be addressed, and the CHWs find it difficult to meet their target numbers. The coordinator is committed to helping them organize their work and reach the required beneficiary numbers, but recognizes the need to be flexible in applying the performance targets. The CHWs do HIV rapid testing in the home, but refer those requiring sputum testing.

Tapologo has a decade of experience in monitoring PEPFAR patients and the Monitoring and Evaluation Officer applies this diligence when she captures and verifies the data submitted by the CHWs. The nurse also conducts periodic spot checks on the beneficiaries reported.

COMMUNITY RESPONSE: For the most part CHWs have been received extremely well received in this migrant community, though the some still "hide away," reluctant to have their patient status and identification numbers (if indeed they have them) recorded. Most, however, live in desperate circumstances and are grateful to have health services provided in their homes.

BENEFICIARY INTERVIEW #1: The first client interviewed is a 34 year old woman who lives with her aunt and two teenage children. Government child grants are the only source of support for the family. She had been feeling weak and ill for some time and, when she saw a CHW visiting her neighbor, she approached the CHW and asked for help. The CHW screened her, tested her for HIV and helped her collect a sputum specimen to deliver to the Tapologo clinic. She tested positive for HIV but negative for TB. After further testing, she was placed on antiretroviral treatment. Now the CHWs continue to monitor her on treatment. She says they come and "count my pills, talk to me about my health and about condom use" and is more than thankful for their care and compassion." During the school holidays, she plans to have her teenaged children screened as well. She reports that the "availability" of the CHWs has made a big change in her life and in the lives of others in the community.

BENEFICIARY INTERVIEW #2: The second beneficiary interviewed was a 57 year old man who lives with his girlfriend and their five children. He has been unable to find a job and the family survives on the government child grants. He became very ill with cough, weakness, and night sweats and went to the Tapologo clinic where he was tested and found to be HIV negative but severely ill with TB and placed on treatment. His whole family was then screened and tested and the two year old was found to be infected and placed on Isoniazid to prevent the progression to active TB. The CHWs monitor his treatment regularly and give the family information about healthy living and TB, HIV. This beneficiary particularly appreciates that fact that his CHW comes to his home. "She sees what is going on in the house and shows me things," he said. She has taught him how to garden and to grow some vegetables for the family—a big help since, at his age and with his health, he is unlikely to be able to secure employment. When asked how he feels he has been treated by the CHWs, he responds, "They are always good to me all the time. I was dying and they helped me."

RELATIONSHIP WITH GOVERNMENT HEALTH SYSTEM: Tapologo has a long relationship with the district health services and the hospital as a PEPFAR antiretroviral treatment site. Now that PEPFAR funding is winding down, there is a proposed government agreement that Tapologo will continue to initiate people on treatment on behalf of the health services and that the government will supply the necessary drugs. In relation to TB, the General Manager of Tapologo is an active member of the Rustenburg Health Forum and an active member of the TB task force. He regularly attends meeting with the District and Sub-District Department of Health Managers and from these platforms is able to discuss issues and to negotiate the expansion and effectiveness of the partnership between Tapologo and the government in the provision of TB detection and treatment.

CHALLENGES: The CHWs face many challenges in providing services to the members of this community. Many of the impoverished migrants suddenly pick up and leave for their home villages and/or countries without notifying their care givers and/or clinic facilities. They depart without a supply of medications or a referral to another treatment source and are simply lost to follow-up. Those residents and immigrants who remain in the mining areas, come from many different countries and cultures, and lack the social

cohesion and supports found in more stable communities. Under these circumstances, the role of the CHW becomes even more critical to their health and general well being. Stigma in the Rustenburg area is a particular challenge for those who are ill and for those who screen and treat HIV and TB. One CHW said, that "when some community members see me, they think HIV." Partners are often afraid to disclose to one another and often skip their medications when the other partner is in the home. This became a particular issue when the male mine workers were on strike and spent more time in the home. Tapologo invites clients to weekly support meetings to address these and other issues related to gender inequalities and to provide education about TB, HIV, and other health conditions.

As in other project sites, men are particularly challenging to reach and are described as "difficult." When they agree to be screened, they say things like, "Why do you ask me so many questions," and "How can a woman ask me about…?" But the CHWs say that with patient persistence, "at the end of the day," they win most of them over.

Again, as in all project sites, many clients lack the food required to sustain health and promote recovery. Nutritional food supplements and food parcels are provided to the extent that resources permit.

VALUED ADDED TO THE COMMUNITY: Through the project, community members now have access to social support, health information, and clinical services that can prevent the spread of TB and HIV in the communities, detect and treat it when present, and prevent the spread of disease to family members, and restore the health of persons affected so that there will be at least the possibility that they will in future be able to earn a living.

SUSTAINABILITY: The Tapologo site has sustained its operations for over a decade. It actively fund raises and has secured resources from local businesses, international organizations, private donors, and the government. When funds for the Early Detection and Treatment of TB Project are no longer available, the Tapologo will integrated these activities into their basic HBC, health education, and treatment support.

Good Shepherd, Siteki, Lubombo District, Swaziland 22 July 2014

The Good Shepherd Project is administered from Caritas, Swaziland in association with the Good Shepherd Hospital and parish in the rural Lubombo District in the mountainous east of Swaziland. Lubombo has long been known for its high prevalence of TB and low treatment rates. At the time of the visit, the area was experiencing a serious outbreak of diarrhoea caused by what Swazi health authorities described as cholera or a "cholera-like" organism.

The administrative coordinator works from the Caritas center in Manzini. On-site day-to-day community service coordination in Siteki is supervised by a senior Community Health Worker (CHW), Ms Magagula.

The Good Shepherd parish has 24 volunteer CHWs, middle aged women who provide a wide range of home based care services. Since August 2013, thirteen of these CHWs have worked on the Early Detection of TB program. One of the women is a former community council member.

During the site visit I met with the administrative coordinator in Manzini and traveled to Siteki to meet with 12 of the 13 CHWs as a group and then accompanied one of the care givers to meet two of the beneficiaries at their homesteads.

TRAINING: The clinical staff of Good Shepherd Hospital provide a structured program of monthly training programs for the CHWs related to TB detection, referral and treatment, HIVcounseling and testing, and basic home care. The CHWs also participate in the HIV campaigns conducted by the hospital.

TARGETS: CHWs reported no difficulty in reaching their TB screening targets. CHWs are assigned to geographic areas in the vicinity of their own homesteads and go door to door on a regular basis. The local coordinator, Ms Makababula reviews the screening forms and checks the reported statistics for accuracy. If she has questions or concerns, she can verify the CHW reports by following up directly with the clients or by consulting the hospital register.

COMMUNITY RESPONSE: The CHWs report that at the beginning they experienced some resistance when they tried to help patients get the necessary treatment, primarily from Jehovah's witnesses and members of other small churches. But over time, that resistance has lessened. The clients themselves welcomed the CHW visits and asked them to return.

Significantly, at the specific invitation of the government Regional Education Officer, CHWs provide health education services in the schools as well.

BENEFICIARY INTERVIEW #1 The CHW led us to a homestead where we found a 26 year old male seated on the ground. He lived with his five cousins from ages 6 to 18. All the parents had died because of HIV. He told how he had been coughing for several weeks when the CHW came to visit him. After screening him using the TB questionnaire, she organized the collection of his sputum and he tested positive. He was then taken to the clinic and started on treatment. Now she comes to visit him on a regular basis and provides him with nutritional supplements. Because of his illness, he cannot work. The only income in the family comes from the work of the 18 year old cousin. He is taking his medication exactly as prescribed so he will regain his strength and be able to work. When asked about the CHW, he smiled warmly at her and said, "She's my friend, someone I can talk to."

BENEFICIARY INTERVIEW #2 The CHW accompanied us to a second homestead where we found a thin young man sitting on the porch of his dwelling beside his 8 year old daughter. The father impressed us all as hopelessly depressed and the child that sat motionless next to him stared straight ahead, expressionless. The father told us that his

wife had died in 2009 and that his brother had also died of HIV. The man was the sole support of his daughter, his 18 year old son and his deceased brother's two children. He has had difficulty finding work in the area and goes to Manzini to do "piece jobs" when he can get them to send funds back to the family, leaving the 18 year old to look after the younger children.

While he was in Manzini, the 18 year old went to the house of the CHW who is known in the area and told her, "My little sister is sick." The CHW went to the home, screened the child, gave her nutritional supplements, and contacted the father. The father then fetched the child, took her to the Raleigh Memorial Hospital in Manzini, where they collected her sputum. A week later the father picked up the results and learned that she had active TB. He secured a referral letter for the hospital in Siteki, and brought her back to the care of the CHW who arranged for her treatment. The CHW screened all the other household members (all negative) and now follows up with this child every single day to give her the medication as well as much needed motherly care. The strong bond between the CHW and this family was almost palpable.

RELATIONSHIP WITH GOVERNMENT HEALTH SYSTEM: As the sole hospital in the Lubombo district, the Good Shepherd Catholic Hospital works in close partnership with the Swazi Government and oversees 16 rural clinics in the district. The CHWs are registered with the hospital and issued with sputum collection bottles. In cases where the client has difficulty with transport, the registered CHWs can accompany the clients or can deliver the sputum specimens themselves and collect the results. Where necessary (some homesteads are over 20 km from the nearest health facility), arrangements can be made for sputum samples to be collected by a transport officer on a motorbike. In cases where the CHWs collect the results, the professional health workers instruct them on how to advise and/or care for the client.

The government has certain CHWs as well and these receive a very small stipend. But these CHWs focus their work primarily on the "cleanliness" of the home and surrounding environs and refer clients who need care to the Good Shepherd CHWs.

CHALLENGES: Many rural dwellers have little or no income and live scattered throughout the mountainous region. Lack of food and the long distances (and limited transport available) involved were most often cited as the greatest barriers to the early detection and treatment of TB and HIV. Many of the CHWs share their own personal resources with their most desperately poor clients.

Other challenges relate to local beliefs and practices. Some believe that their sick relatives have been bewitched and that TB treatment will not help. In some cases local pastors insist that only prayer is needed. Elders in some families refuse to allow the ill client to take the prescribed treatment.

The treatment of men in the communities can also pose a challenge. Some at first resist any form of screening. But when, after counseling, they agree to be screened, are found to test positive and subsequently put on treatment, some forget to take their medications,

especially those who take alcohol. The CHWs address this with counseling and frequent follow-up visits, including daily DOTS visits if required.

VALUE ADDED TO THE COMMUNITY: The individuals interviewed all agree that this project has increased the knowledge of the community about TB and HIV. One evidence of this is that now people discuss TB and take preventive measures, like opening the windows on the buses. As a result, stigma has been reduced. People know the symptoms and more frequently seek treatment on their own.

Of course, the CHWs are also an integral part of the community, and they reported great satisfaction by helping community members "get back to life." They say that "by mingling" they have "learned many things" from the people they serve. For instance, they see how their clients deal with "bad situations," and learn from them. This helps them in their own lives.

SUSTAINABILITY: The CHWs say they will continue to do what they can for the community with the project ends, but that it will be difficult to deliver services, as they will have no bus fare to reach those far away and no funds for nutritional supplements. This concerns them because "the further the distance from the hospital, the more the need." Because of the economic situation in the country, there is only a slim chance that these CHWs will be absorbed into the government services.

Siphithemba Caregivers, Elandskop, Msunduzi District, KZN Province, August 13, 2014.

Located in a per-urban slum on the periphery of Pietermaritzburg, the Siphithemba Project is part of a mission of the Holy Family Sisters and provides a whole range of services: home based care; awareness campaigns; memory boxes with families; HIV counseling and testing in the homes; health education; peer education; school health programmes; and care and support for OVCs. In addition to the support from the AIDS Office of the SACBC, funding is provided by private donors, proceeds from jumble sales, and other such activities.

The Early Detection of TB project began in August 2013. Holy Cross Sister Priscilla Masuku, an experienced nurse, serves as coordinator of 10 CHWs, four of whom are not Catholic. There are also volunteers who assist with some of the support activities, including one male.

During the site visit, I met individually with Sr Masuku; held a group discussion with the ten CHWs and the lay professional nurse (referred to as the facilitator) who directly assists them; and met individually with two beneficiaries.

TRAINING: In addition to the government accredited training in HIV counseling (FPD) and in home based care, the CHWs have benefitted in a wide range of formal training courses on topics including leadership, financial management, peer education, and an

advanced (level 2) course in Home Based Care. In addition, the CHWs receive in-service training monthly and attend trainings organized by the local clinics. The Holy Family Sisters address gender issues in these training, including gender based violence.

TARGETS: The CHWs report that they are able to meet their TB screening targets without putting pressure on their clients. Though not all welcome them in their homes, and those that do are not all are willing to test for HIV.

CHWs collect sputum specimens in the clients' homes and three of the CHWs counsel and test for HIV on home visits. They often accompany patients to the clinic and/or collect their medicines from the clinic nurses and deliver it to the homes of those who are too sick to make the trip. The CHWs also assist with other health problems they identify in the homes.

The nurse facilitator and the nurse coordinator go on home visits with the CHWs on a rotating basis. This helps ensure the accuracy of the statistics, the continued learning of the CHWs, and the quality of service provided. The M&E officer goes over the statistics on a weekly basis with the health workers and gives the final report to the Coordinator for verification.

COMMUNITY RESPONSE: The nurse coordinator, the lay nurse facilitator and the CHWs have, in general, found that most community members are open to them and welcome them into their homes. There are some clients, however, who are suspicious of the CHWS, believing them to be "watchtowers." This may be due to the fact that they do their home visits in twos for safety reasons. A few community members fear that the CHWs are involved in some sort of scam. Most community members, however, are grateful for the support they receive.

BENEFICIARY INTERVIEWS: Two beneficiaries were interviewed individually at the Holy Family Centre.

Beneficiary #1 is a 54 year old Methodist woman who lives with her 3 adult children. The part-time and casual jobs of these young people are the only source of income for the family. They have tried to grow some food, but lack a fence to keep out the livestock which gobble up most of the crop before it is ripe for harvest.

When she became very ill, a relative helped her go to the clinic where she was tested and found to be HIV+. Her sputum tested negative for TB, but she was very weak. One of the CHWs who lived in her area learned of her plight and came to her house to assist her. The CHW cleaned her house, accompanied her to her clinic appointments and helped her to comply with her treatment. She describes her CHW as "kind" and says she is "happy and grateful" to have such lay health workers in the community.

Beneficiary #2 is a 38 year old female who looks much older. She is a Jehovah's Witness who lives in a large extended family that survives on two old age grants and two child grants. She said she "trusted" the CHW in her area and asked her to accompany her to the

clinic when she was losing weight. She tested positive for both HIV and TB, and the CHW helped her collect her medicines and comply with her treatment. The CHW also gave her needed palliative care services.

"She rubs me when my body feels sore," she reported. "She is the one person I can share my feelings and my problems with. I can go to her for advice or for whatever help I need."

She believes it is good to have lay health workers in the community. The clinics are a long distance away and are packed. Patients have go early and come home late. Sometimes they are not even seen and are told to come back. Lay health workers who collect the medicine for the patients and who visit the homes make an invaluable contribution to the clients' recovery and general welfare.

RELATIONSHIP WITH THE GOVERNMENT HEALTH SYSTEM: Though some nurses are more cooperative than others and some clinics provide better care than others, on the whole the relationship is positive. The government clinics distribute sputum bottles and HIV test kits to the CHWs and accept their test results. The clinics make referrals to the CHWs and accept the CHW referrals.

CHALLENGES: As in the other impoverished, rural, mountainous areas of this province, distance between clinics is a barrier to early treatment because people often do not have the money for transport and miss clinic appoints. People lack the food required to mitigate some of the side effects of the medication. Under these circumstances, people need constant encouragement to continue with their treatment, especially when the families do not provide the required support and DOTS supervision.

The poor attitude of many of the nurses is a fact well known and often discussed in South Africa. This makes the patients reluctant to visit the clinic. For this reason, it is often necessary for the CHW to accompany and support their clients.

VALUE ADDED TO THE COMMUNITY: The project has impacted on the community as a whole in two major ways. Firstly, more people are aware about the symptoms of TB and know it is treatable. Secondly, as more people receive TB and HIV care and treatment, stigma has decreased.

SUSTAINABILITY: The Holy Family Sisters have a volunteer programme and, when the project comes to an end, they anticipate that many of the current CHWs will continue to provide services on a volunteer basis. Unfortunately, however, there will be less resources to help with food parcels, transport for CHWs and clients, etc, though the Sisters will fund raise and do the best they can to continue their support for those in need.

APPENDIX VIII

Models of care for a community-based early detection and treatment of TB programme

Tuberculosis (TB) is a major international health problem and second to the human immunodeficiency virus (HIV), the leading cause of death worldwide (WHO, 2013: 1). South Africa has a high burden of both diseases. South Africa is rated as the country with the highest number of HIV infected persons and the third highest number of active TB cases in the world (SANAC, 2012: 13). The World Health Organization (2013: 11, 52) estimated that 461,000 new TB cases are reported each year and the country has a total number of 6, 4 million persons infected with HIV (Simbayi, Shisana, Rehle, Onoya, Jooste, Zunga, Labadarios & Zuma, 2014: xxiv). The co-infection of these two diseases is catastrophic as TB remains the leading cause of death among people with HIV (UNAIDS 2013: 60).

Care for TB and HIV were integrated in South Africa to increase the effective care for co-infected individuals (South African National AIDS Council, 2012: 20). Despite an initial slow start the country scaled up antitertroviral therapy (ART) between 2004 and 2014. By 2014, more than 2 million HIV infected persons in South Africa had been initiated on ART. Taking ART has clear health gains for the HIV infected person and subsequent increase in life expectancy (Simbayi, et al., 2014: xxvii; UNAIDS, 2013: 48). The treatment of HIV in co-infected persons has however not been as effective in reducing mortality in South Africa as hoped. Mortality in co-infected persons has decreased by less than 25% (UNAIDS 2013: 60, 62). Merely providing ART is thus not enough to reduce mortality significantly.

The Joint United Nations Programme on HIV/AIDS (UNAIDS) has called for **enhanced reach**, **timeliness** and **effectiveness** of **tuberculosis screening and treatment programmes** for people living with HIV (UNAIDS, 2013: 66). Door-to-door home-based testing is highly acceptable and can increase the reach of HIV testing and access to TB care (Khumalo, 2014: online; Sekandi, *et al*., 2011: online).

The study aimed to document aspects of the SACBC door-to-door TB screening programme. The SACBC has coordinated the "Early Detection and Treatment of TB Programme" since 2012. The programme is implemented over 36 months and has an annual budget of £900 000, funded by the UK based Department of International Development (DFID). The project is implemented at 17 projects in South Africa and 2 projects in Swaziland. Trained Community care workers (CCW) provide door-to-door TB and HIV screening.

Methodology

Three projects were selected (sampled) to be studied (Bryman, 2012: 12). The projects were chosen in collaboration with the project manager based at SACBC to ensure as wide a variation as possible. **Maximum variation** sampling, a type of purposive sampling, was utilised to ensure that there is a good deal of variety in the resulting sample so that the cases differ from each other in terms of key characteristics relevant to the research questions (Bryman, 2012: 418-419).

Table 1 South African projects

Project name	Location	District	Province
1. Ntaba Maria Clinic	Queenstown	Amathole	Eastern Cape
2. Joe Gwabi HBC	**Aliwal North**	**Joe Gwabi**	**Eastern Cape**
3. Masabalane HBC	Sterkspruit	Joe Gwabi	Eastern Cape
4. Care Ministery HBC	Port Elizabeth	Nelson Mandela Bay	Eastern Cape
5. Kroonstad HBC	**Kroonstad**	**Fezile Dabi**	**Free State**
6. Viljoenskroon HBC	Viljoenskroon	Fezile Dabi	Free State
7. Virginia HBC	Virginia	Lejweleputswa	Free State
8. Zanethemba HBC	Newcastle	Amajuba	KwaZulu-Natal
9. Sipithemba HBC	Elandskop	Msunduzi	KwaZulu-Natal
10. Noyi Bazi Clinic	**Pomeroy**	**uMzinyathi**	**KwaZulu-Natal**
11. iThembalethu	Escourt	uThukela	KwaZulu-Natal
12. Duduza Care Centre	Wasbank	uThukela	KwaZulu-Natal
13. Mothupa HBC	Mothupa	Mopani	Limpopo
14. Mokgolobotha HBC	Tzaneen	Mopani	Limpopo
15. St Joseph's Clinic	Sibasa	Vhembe	Limpopo
16. Tapologo HBC	Rustenburg	Bojanala Platinum	North West
17. Bisdom Vigsministerie	Keimoes	Siyanda	Northern Cape

The Joe Gwabi home-based care (HBC) group (only DFID funding – refers to a public clinic), the Kroonstad HBC group (DFID and other funding – refers to public clinic) and the Noyi Bazi Clinic (DFID funding and refers to own clinic) were selected.

Data were collected through various techniques: structured- and semi-structured interviews as well as nominal groups.

Table 2 Data collection and analysis

	Population & Sampling	Data collection	Data analysis
Structured interviews	**Beneficiaries** (Community members visited by CHWs) at the three sampled cases ~ Random sampling ~ Assisted by Department of Biostatistics	Trained fieldworker(s)	Department of Biostatistics, UFS

Semi-structured interviews	**Staff and Project Managers** ~ Project managers (at 3 sites and SACBC) ~ All office staff at three sampled cases	Researcher	Researcher from the School of Nursing and co-analyser
Nominal group technique	**Community Care Workers** ~ All CHWs at three sampled cases ~ What are the most significant lessons you have learned from working in this project?	Researcher or experienced facilitator	Consensus by groups. Consolidation of group data by researchers

Hereby a brief report of the findings.

Community care workers

The three sites' CHWs were asked to participate in nominal groups (reported on later). Table 1 reflects some of the demographic information of the CHWs.

Table 3 Community care worker information

Project	Nr	Age			Gender	Time working as a CCW		
		minimum	Average	maximum		minimum	Average	maximum
Aliwal	9	27	43	56	9F	4	6	10
Kroonstad	10	25	30	40	8F, 2M	2	2.5	3
Pomeroy	10	35	43	60	10F	6	7	11

Aliwal: There are two sites in Aliwal itself. The community care workers (CHWs) were all female, had an average age of 43 and all the CHWs worked in the programme before the onset of the DFID programme (minimum 4 years working in the project). The CHWs are also involved in the Orphan and Vulnerable Children (OVC) programme. The programmes also have a registered nurse on staff and provide HIV testing at the sites and in the community on special occasions. The DFID CHWs and the local South African Government (SAG) funded CHWs work in close collaboration.
Kroonstad: The DFID funded activities are implemented around Kroonstad. The office in Kroonstad also coordinates OVC and home-based care (HBC) programmes in several other Free State towns. Ten CHWs are implementing the programme; all but two of the CHWs are female. All the CHWs reported working as CHWs for an average of two and a half years, but not longer than three years. The majority of the CHWs therefore worked with the programme for a similar time period to that of the DFID programme. The CHWs were also younger than at the other sites investigated (average age 30, with the youngest member 25 years old). The programme coordinator is a trained nurse and the CHWs provide HIV testing on special occasions.

Pomeroy: The site have several projects in the Pomeroy area ranging from a formal Primary Healthcare (PHC) clinic, OVC and HBC programmes. Ten CHWs are funded through the DFID programme to do early TB detection with 20 CHWs funded through

the local government (SAG) with additional volunteers who implement the same programme in different areas around Pomeroy. The DFID funded CHWs are older than those at the other sites (average age of 43 and maximum age of 60). All the CHWs have worked at least 6 years in the communities they live. They also implemented the OVC and or HBC programmes in the area. The programme is coordinated from the Noyi Bazi Clinic (a Catholic managed PHC clinic, supported by the SAG). The CHWs work very closely with the nurse in the TB department of the clinic. The DFID funded CHWs works in the TB department of the Noyi Bazi twice a month.
Table 2 reflects the CHWs answers on where beneficiaries are recruited and the services they provide.

Table 4 Services provided according to community care workers

Project	Select beneficiaries	Services delivered
Aliwal	Door to door, in area	Great patient, ask about wellbeing, ensure confidentiality, refer to clinic, check on clinic cared and treatment, check if there is someone to take care of the patient when we are not there
Kroonstad	Door to door & anyone	Screen for TB, teach them about TB and HIV, refer to clinic, monitor adherence, give support, assist bedridden patients
Pomeroy	In own area & OVC homes	TB screening. Education on TB symptoms, hygiene, general health, ventilation. Refer to clinic, accompany to hospital, take food parcels, make sure they take their treatment

The CHWs in Aliwal verbalised a more personalised approach with focus on greeting the patient, ensuring confidentiality and also making sure the patients are taken care of when they are not there.
The CHWs in Kroonstad explained TB related activities while the Pomeroy CHWs also included general OVC and HBC related activities in addition to the TB related activities.
When asked what lessons they have learned from implementing the DFID programme – the CHWs felt that the following were most important when implementing a community-based TB detection programme.

Nominal group interviews

Nominal Groups are a structured method for small group discussions with the aim of reaching consensus (Botma et al., 2010: 251; Potter, Gordon and Hamer, 2004: 126).
The technique is very effective in generating a large quantity of creative new ideas. It is designed to allow every member of the group to express their ideas and put them in some order that is shared by the group (Cohen, Manion and Morrison, 2007: 309).
CHWs at both Aliwal and Pomeroy felt that maintaining confidentiality of patient (pt.) information is crucial. CHWs at all three the projects mentioned correct TB information. CHWs at Kroonstad focused on their own needs in both the first and third topic. Table 5 reflects the three topics voted as most important by the CHWs.

Table 5 Nominal groups with CHWs: Top 3 priorities

Priority	Aliwal	Kroonstad	Pomeroy
1	**Confidentiality** 🗝 Don't talk about pt. treatment/ illness/ problems 🗝 Keep pt. records private 🗝 CCW must be faithful to pt. 🗝 CCW must be trustworthy	**We need** 🗝 Identity to be known in this community (name badge, uniform, etc.) 🗝 Equipment (masks, gloves, soap, linen savers, etc.) 🗝 Organisation's stamp on documents 🗝 Immunisations against infections 🗝 Administration documents (leave forms etc.)	**Confidentiality** 🗝 Don't discuss pt. problems 🗝 Secret between CCW and pt. 🗝 To avoid being discriminated 🗝 Pt. might not be ready to accept condition
2	**Training** 🗝 CCW must be trained to do work 🗝 CCW must have correct information to avoid misinforming pt.	**TB Education** 🗝 TB symptoms 🗝 Explain different types of TB 🗝 Sputum bottles 🗝 Eat healthily, malnutrition 🗝 HIV education 🗝 Mode of transmission	**Love** 🗝 Love your job 🗝 Love your pt. 🗝 Be happy 🗝 Show openness with pt.
3	**Cleanliness** 🗝 CCW must be clean 🗝 CCW must teach about cleanliness	**Support** 🗝 Support pt. 🗝 Support family members too (important to pt.) 🗝 Management also to support CHWs 🗝 Link & work with clinic 🗝 Be there to collect treatment for pt. 🗝 Give hope to pt. 🗝 Team building among co-workers	**What is TB** 🗝 Symptoms of TB 🗝 Know that it is curable 🗝 It is contagious 🗝 It kills 🗝 Know how long it takes to cure it 🗝 To treat it 🗝 How it is contracted

Structured interviews were held with randomly selected beneficiaries.

Structured interviews

Table 6 Structured interviews with beneficiaries

	Aliwal	Kroonstad	Pomeroy
Persons reported	901 (Oct 2014)	1289 (Oct 2014)	116 (Sep 2014)
Sample based on	Oct 2014 statistics	Oct 2014 statistics	List provided by CHWs
Houses reached	704	778	*106
Sample size	324	350	53
Interviewed	110	83	47
Declined	94	195	3
Unable to interview	120	72	3
Town is in	Semi-rural area	Peri-urban area	Deep rural area
Fieldwork done	8 – 12 December	1 – 5 December	24 – 28 November

The Monitoring and Evaluation (M&E) system reports persons screened and does not make provision for the number of households these persons come from. As the interviews were going to be based at the homes of beneficiaries (where door-to-door screening takes

place) the beneficiaries had to be sampled by house as to prevent that in a random sample a household was selected more than once.
In order to generate a list of households the researcher visited the sites in early November and used the last complete month's beneficiary data (September or October 2014) to compile a list of beneficiaries reached. From the addresses recorded on the CHWs reports households reached were identified.
The statistician at the department of biostatistics at the University of University provided the researcher with a list of randomised numbers (without replacement) to draw a sample.

The main challenge during the data collection was:

Aliwal – The schools closed prior to the data collection and several families were no longer in Aliwal as it is a common practice to visit relatives in more rural communities during the December holidays (Members in 120 households were not at home, the majority of the homes could however be allocated. In cases where CHWs screened persons at public events, such as funerals, it was indicated if the person was from another area or town). Interviews were voluntary and 94 (29.01%) of the households randomly selected declined to be interviewed.

Kroonstad – The CHWs were not working in the community as long as CHWS at other sites and the community was far more urban than the other sites. Some of the CHWs were unable to locate the address recorded on the reports and in other cases if the address could be located the inhabitants of the house denied ever being screened by the CHWs. The CHWs in question explained that persons are screened at public events and in public transport and that the address reported were incorrectly provided by the beneficiaries. This could not be confirmed. The problem seemed prominent with three of the ten CHWs in about two-thirds of their beneficiaries. The fact that they report that door-to-door screening is being done could not be confirmed. The CHWs explained that there is a big focus on supporting patients diagnosed with TB to adhere to treatment.

Pomeroy – The CHWs were well known by the community and has had a history of providing a range of services. The challenge was that 80% of the persons screened were screened at the Noyi Bazi Clinic and not from door-to-door screening. The site was forthcoming with this information early on and the houses sampled for interviews were thus the houses the CHWs do visit (indicated by * in Table 6. The area is very rural and covers vast mountainous areas. Traveling from household to household is difficult and houses not always accessible by motor vehicle. The model here was thus different where the majority of screening done was not in the community. The DFID CHWs were able to counsel and support persons who came for TB related care at the Noyi Bazi Clinic, often referred by these other TB detection teams, some of them supported by the SAG.

Table 7 Structured interviews: Household members

	Aliwal	Kroonstad	Pomeroy
# of Interviews	110	83	46
Person interviewed	71.8% direct beneficiary, 28.2% a family member	78.3% direct beneficiary, 21.7% a family member	69.8% direct beneficiary, 30.2% a family member
Gender of person interviewed	20.9% male, 79.1% female	20.5% male, 79.5% female	30.4% male, 69.6% female
Language spoken	Sesotho = 44.5% isiXhosa = 55.5%	Sesotho = 96.4%	isiZulu = 100%
# of household members	553	359	290
Age of household members (years)	Minimum = 0 Average = 27 Maximum = 89	Minimum = 1 Average = 27 Maximum = 92	Minimum = 0 Average = 25 Maximum = 94
Number of persons that were (all, ever)	Screened for TB = 381 Diagnosed with TB = 48 Treated for TB = 40 Treated for HIV = 60	Screened for TB = 254 Diagnosed with TB = 28 Treated for TB = 31 Treated for HIV = 33	Screened for TB = 182 Diagnosed with TB = 25 Treated for TB = 24 Treated for HIV = 43

More than 70% of the dwellings inhabited by the household members were formal and used doors and windows for ventilation. The more rural the area the bigger the families and the fewer number of rooms they lived in.

Table 8 Dwellings

	Aliwal	Kroonstad	Pomeroy
Number of persons	Minimum = 1 Average = 5 Maximum = 17	Minimum = 1 Average = 4 Maximum = 15	Minimum = 1 Average = 6 Maximum = 20
Type of dwelling	Formal = 73.6% Informal = 25.4.%	Formal = 74.7% Informal = 25.3%	Formal = 78.3% Informal = 21.7%
Ventilation available	Door = 100% Window = 84.5% Other = none	Door = 100% Window = 85.5% Other = none	Door = 91.3% Window = 71.7% Other = none
Number of rooms	Minimum = 1 Average = 3 Maximum = 10	Minimum = 1 Average = 3.5 Maximum = 8	Minimum = 1 Average = 3 Maximum = 8
Cleanliness	53.6% = Fair to bad	32.5% = Fair to bad	37.0% = Fair to bad

Most household members in Aliwal and Kroonstad had accessed to piped-water, flushed toilets and electricity for cooking and lighting. Household members in Pomeroy had far less access to these services, which is a challenge when ensuring environmental health to all.

Table 9 Sanitation and services

	Aliwal	Kroonstad	Pomeroy
Water	100% piped water	97.6% piped water	67.4% piped water
Where	34.5% in dwelling 45.5% inside yard 12.7% communal	45.8% in dwelling 53.0% inside yard	2.2% in dwelling 21.7% inside yard 76.1% communal
Toilet	Flushed toilets: 62.7% inside dwelling 13.6% inside yard 0.6% off site	Flushed toilets: 38.6% inside dwelling 59.0% inside yard	Pit latrine toilets: 52.2% inside yard 23.9% off site Bucket toilets = 23.9%

Cooking	72.7% = electricity 23.6% = paraffin 0.4% = wood	90.4% = electricity 0.1% = paraffin	2.2% = electricity 8.7% = paraffin 76.1% = wood 6.5% = gas/coal
Heating	20.0% = electricity 60.0% = paraffin 13.6% = wood	39.8% = electricity 27.7% = paraffin 21.7% = other	65.0% = wood 13.0% = coal 4.3% = animal dung
Lighting	73.6% = electricity 10.0% = paraffin 16.4% = candles	95.2% = electricity	2.2% = electricity/ paraffin 6.5% = solar 87.0% = candles

Deaths in the last twelve months were relatively low and mainly due to natural causes in individuals between 44 and 50 years of age.

Table 10 Recent deaths among household members

	Aliwal	Kroonstad	Pomeroy
Number of homes	16	10	15
Number of persons	17	10	13
Age (years)	Minimum = 1 Average = 50 Maximum = 87	Minimum = 21 Average = 46 Maximum = 70	Minimum = 0 Average = 44 Maximum = 89
Gender	Male = 6, Female = 11	Male = 2, Female = 8	Male = 9, Female = 6
Cause	Natural causes = 15 Other = 2	Natural causes = 9 Accidental = 1	Natural causes = 12 Accidental = 2 Other = 1

Households are heavily dependent on state grants and pensions (the more rural the more dependant) and therefore also had higher numbers of adults that cut the size of a meal or skipped a meal due to a lack of food. Children in Aliwal seem to cut meal size and skip meals more frequently than at the other two projects. Not having access to food does not always prohibit the intake of medication, but it does decrease the general health status of the household members.

Table 11 Economic indicators

	Aliwal	Kroonstad	Pomeroy
Sources of income (top 3)	State grants = 60.9% Salaries = 28.2% Wages = 14.5%	State grants = 69.9% Salaries = 25.3% Wages = 12.0%	State grants = 78.3% Sales = 43.5% Wages = 10.9%
Adult cut meal size	60.9% cut meal size	47.0% cut meal size	78.3% cut meal size
Adult skip a meal	56.4% skip a meal	31.3% skip a meal	63.0% skip a meal
Child cut meal size	46.4% cut meal size	21.7% cut meal size	32.6% cut meal size
Child skip a meal	43.6% skip a meal	15.7% skip a meal	21.7% skip a meal

Persons do not only cut meal size or skipped meals, but they also do not follow a balanced diet consisting of calcium rich food (diary) and fruit. Only around four in ten households (39.1% – 43.6%) were producing vegetables (veg) themselves. Reasons for not producing vegetables can be addressed by providing relevant garden education/instruction.

Table 12 Food security

	Aliwal	Kroonstad	Pomeroy
Frequently eats	Carbohydrates = 99.1% Protein = 80.0% Diary = 60.9% Vegetables = 90.0 % Fruit = 13.6%	Carbohydrates = 100.0% Protein = 71.1% Diary = 62.7% Vegetables = 86.7 % Fruit = 22.9%	Carbohydrates = 97.8% Protein = 69.6% Diary = 15.2% Vegetables = 89.1 % Fruit = 4.3%
Garden, produce veg.	43.6%	41.0%	39.1%
Main reasons not having garden	Limited space = 21.8% No interest = 9.1% Lack of soil/ water = 9.1 %	Limited space = 19.3% No interest = 7.2% Animals destroy =8.4 % No seeds = 8.4%	Lack of water = 17.4 % Animals destroy = 30.4% Need seeds = 8.7%

Beneficiaries mostly accessed state funded PHC clinics.

Table 13 Access to healthcare

	Aliwal	Kroonstad	Pomeroy
Services used	PHC = 91.8% Private doctor = 4.5% Hospital = 2.7%	PHC = 91.6% Private doctor = 30.1% Hospital = 4.8%	PHC = 100% Hospital = 10.9%
Transport	Walk = 82.7% Public transport = 8.2% Private transport = 8.2%	Walk = 84.3% Public transport = 13.3%	Walk = 54.3% Public transport = 45.7%
Persons tested for HIV	343	269	145
Persons that want to test for HIV	300	155	155
Person in house recently (1 year) diagnosed with	Diabetes = 7.3% Diarrhoea = 6.4% HIV = 40.0% Hypertension = 50.0% Mental health = 2.7% Pneumonia = none TB =30%	Diabetes = 13.3% Diarrhoea = 9.6% HIV = 26.5% Hypertension = 53.0% Mental health = 4.8% Pneumonia = none TB =22.9%	Diabetes = 17.4% Diarrhoea = 21.7% HIV = 58.7% Hypertension = 39.1% Mental health = 2.2% Pneumonia = none TB =28.7%

Due to vast distances in the rural areas Pomeroy beneficiaries are more reliant on public transport.

CHWs in Kroonstad were not as well known by the community prior to the project as at the other two projects. This might be due to the shorter time associated with community work and the younger ages of the CHWs (Table 3). The majority of beneficiaries were comfortable with the CHWs visiting them at home. Nearly half of the beneficiaries were visited at least weekly.

Services the beneficiaries felt were lacking are not necessarily part of the DFID "package of care". There is however a call for food parcels (in line with prior food security information). Some beneficiaries at Aliwal and Kroonstad were requesting information on other diseases and not only TB and HIV. Pomeroy beneficiaries asked for transport to the clinic (in line with the transport to clinics) and help with food gardens (in line with lower access to food producing gardens).

Table 14 Regarding the community care workers

	Aliwal	Kroonstad	Pomeroy
Known before DFID programme	Known before = 67.3%	Known before = 43.7%	Known before = 80.4%
Comfortable with CCW visiting	Yes = 90.0%	Yes = 89.2%	Yes = 93.5%
Reasons for being comfortable (main)	Assistance given = 23.6% Attitude of CCW = 20.9% Familiar with CCW = 20.0%	Encourage us = 22.9% Helpful = 20.5% Assistance given = 18.1%	Helpful = 37.0% Assistance given = 21.7% Happy with CCW = 13.0%
How often visit	Fortnight = 23.6% Weekly = 22.7% Infrequent = 17.3%	Fortnight = 41.0% Weekly = 13.3% Infrequent = 21.7%	Fortnight = 21.7% Weekly = 19.6% Monthly = 23.9%
Services provided (main) to at least one person in home	Screen for TB = 84.5% Screen for HIV = 80.0% Refer for testing = 75.5% Adherence = 29.1%	Screen for TB = 89.2% Screen for HIV = 71.1% Refer for testing = 73.5% Adherence = 45.8%	Screen for TB = 67.4% Screen for HIV = 54.3% Refer for testing = 76.1% Adherence = 80.4%
What else should be done	Food parcels = 41.8% Nothing else = 30.0% Info on other diseases = 8.2%	Food parcels = 30.1% Nothing else = 41.0% Info on other diseases = 8.4%	Food parcels = 47.8% Transport to clinic = 17.4% Help with food garden = 15.2%
Could not indicate symptoms of TB	Only 12.7% did not know any of the TB symptoms	Only 2.4% did not know any of the TB symptoms	Only 15.2% did not know any of the TB symptoms

Referrals to healthcare facilities were highly successful, as all beneficiaries that reported they (or another household member) were referred, reported that they went to the institution referred too.

Table 15 Referrals

	Aliwal	Kroonstad	Pomeroy
Number referred	82	58	44
Where	Clinic = 81 (98.8%) Hospital = 1 (1.2%)	Clinic = 58 (100%)	Clinic = 42 (91.3%) Hospital = 1 (2.2%) Social worker = 2.2%
Went	Yes = 100%	Yes = 100%	Yes = 100%

The beneficiaries reported that the programme had an overwhelming positive effect on their lives. Their experiences were positive due to the support they received, the fact that they got help and are now healthier. Beneficiaries were also satisfied with the services provided. Very few complaints were documented.

Table 16 Effect on life

	Aliwal	Kroonstad	Pomeroy
Effect on life	Positive = 76.4% None = 23.6%	Positive = 81.9% None = 18.1%	Positive = 91.3% None = 8.7%
Why positive effect (main)	Support given = 14.5% Helped, now better= 13.6% Information given = 13.6% OVC support = 12.7%	Support given = 37.3% Helped, now better= 10.8% Referred = 10.8% Adherence support = 10.8%	Adherence support = 23.9% Improve quality of life = 23.9% Helped, now better= 15.2%

Satisfied with services	*Information given re.* TB symptoms = 78.0% TB diagnosis = 67.0% HIV = 79.0% HIV testing = 76.3% Taking medication = 66.3% Referral to clinic = 71.9%	*Information given re.* TB symptoms = 86.7% TB diagnosis = 83.3% HIV = 88.0% HIV testing = 86.3% Taking medication = 79.7% Referral to clinic = 73.5%	*Information given re.* TB symptoms = 63.0% TB diagnosis = 63.0% HIV = 85.0% HIV testing = 80.4% Taking medication = 87.0% Referral to clinic = 91.3%
Had complaints	Complained = 6.4%	Complained = 11 (13.3%)	Complained = 10.9%
Complained about	General health system issues = 5.5% Need info re. other diseases = 0.9%	CHWs not helpful = 6 (7.2%) CHWs do not provide treatment = 1 CHWs do not do best = 1	CHWs not helpful = 4.4% Poor assistance = 4.4% Need info re. other diseases = 2.2%
What if programme were not there	*We would:* have died = 19.1% not have access = 20.9%	*We would:* not have access = 36.1% have died = 21.7%	*We would:* have died = 28.7% not have access = 23.9% have gone to hospital = 4.4%

When asked what would have happened if the programme were not offered in their community beneficiaries felt they would have died, or that they would not have had easy access to health services/ information.

The DFID funded, TB early detection programme was set within the South African context with high TB and HIV prevalence rates (Simbayi, et al., 2014: xxiv; SANAC, 2012: 13). The programme answeres the Joint United Nations Programme on HIV/AIDS' (UNAIDS) call for **enhanced reach**, **timeliness** and **effectiveness** of **tuberculosis screening and treatment** (UNAIDS, 2013: 66). The way in which the call is answered was described.

Conclusions

Three of the DFID funded "TB Early detection programme" were evaluated. Community-based work is done by community care workers (CHWs).

Table 17 Summary: Community care workers

	Aliwal	Kroonstad	Pomeroy
Number of CHWs	9	10	10
Median age	43	30	43
Median time working as CCW	6	2.5	7
Topics seen as important in implementing the programme	Confidentiality Training for CHWs Cleanliness	CCW needs TB education Support needed	Confidentiality Love What is TB?
Recruit benificiaries	Door-to-door, in area	Door-to-door, anyone	OVC homes, TB clinic

CHWs all emphasised that although TB screening is important and that there are targets to reached for persons screened, a lot of their focus is on the patients diagnosed with TB and to ensure that they complete their treatment.

Structured interviews were held with beneficiaries based on benificiary reports by the CHWs. It is clear that not only one person per household benefited from the services.

Table 18 Household members reached

	Aliwal	Kroonstad	Pomeroy
# of Interviews	110	83	46
# of household members	553	359	290
Number of persons that were (all, ever)	Screened for TB = 381 Diagnosed with TB = 48 Treated for TB = 40 Treated for HIV = 60	Screened for TB = 254 Diagnosed with TB = 28 Treated for TB = 31 Treated for HIV = 33	Screened for TB = 182 Diagnosed with TB = 25 Treated for TB = 24 Treated for HIV = 43

Household members in deep rural Pomeroy had less access to sanitation, water and electricity.

Table 19 Sanitation and services

	Aliwal	Kroonstad	Pomeroy
Area	Semi-rural area	Peri-urban area	Deep rural area
Cleanliness	53.6% = Fair to bad	32.5% = Fair to bad	37.0% = Fair to bad
Access to water	100% piped water	97.6% piped water	67.4% piped water
Main type of toilets available	Flushed toilets	Flushed toilets	Pit latrine toilets Bucket toilets
Access to electricity for	72.7% = cooking 20.0% = heating 73.6% = lighting	90.4% = cooking 39.8% = heating 95.2% = lighting	2.2% = cooking None = heating 2.2% = lighting

The number of deaths per household during the last 12 months was also higher among Pomeroy beneficiaries – possibly linked to a combination to poorer access to services and environmental cleanliness in the homes. .

Table 20 Recent deaths among household members

	Aliwal	Kroonstad	Pomeroy
Number of interviews	110	83	46
Number of deaths	17 (15.5%)	10 (12.0%)	13 (28.3%)
Age (years)	Minimum = 1 Average = 50 Maximum = 87	Minimum = 21 Average = 46 Maximum = 70	Minimum = 0 Average = 44 Maximum = 89
Gender	Male = 6, Female = 11	Male = 2, Female = 8	Male = 9, Female = 6
Cause	Natural causes = 15 Other = 2	Natural causes = 9 Accidental = 1	Natural causes = 12 Accidental = 2 Other = 1

Households are heavily dependent on state grants and pensions (the more rural the more dependent) and therefore also had higher numbers of adults that cut the size of a meal or skipped a meal due to a lack of food.

Table 21 Economic indicators

	Aliwal	Kroonstad	Pomeroy
Sources of income (top 3)	State grants = 60.9% Salaries = 28.2%	State grants = 69.9% Salaries = 25.3%	State grants = 78.3% Sales = 43.5%

	Wages = 14.5%	Wages = 12.0%	Wages = 10.9%
Adult cut meal size	60.9% cut meal size	47.0% cut meal size	78.3% cut meal size
Adult skip a meal	56.4% skip a meal	31.3% skip a meal	63.0% skip a meal
Child cut meal size	46.4% cut meal size	21.7% cut meal size	32.6% cut meal size
Child skip a meal	43.6% skip a meal	15.7% skip a meal	21.7% skip a meal

Consumption of diary and fruit were low (especially at Pomeroy). Reasons for not having a food garden could be addressed by education and local innovation to increase food security.

Table 22 Food security

	Aliwal	Kroonstad	Pomeroy
Frequently eats	Carbohydrates = 99.1% Protein = 80.0% Diary = 60.9% Vegetables = 90.0 % Fruit = 13.6%	Carbohydrates = 100.0% Protein = 71.1% Diary = 62.7% Vegetables = 86.7 % Fruit = 22.9%	Carbohydrates = 97.8% Protein = 69.6% Diary = 15.2% Vegetables = 89.1 % Fruit = 4.3%
Garden, produce veg.	43.6%	41.0%	39.1%
Main reasons not having garden	Limited space = 21.8% No interest = 9.1% Lack of soil/ water = 9.1 %	Limited space = 19.3% No interest = 7.2% Animals destroy =8.4 % No seeds = 8.4%	Lack of water = 17.4 % Animals destroy = 30.4% Need seeds = 8.7%

Beneficiaries mostly accessed state funded PHC clinics. Due to vast distances Pomeroy patients have to make use of transport as nearly half could not walk to the closest PHC clinic.

Table 23 Access to healthcare

	Aliwal	Kroonstad	Pomeroy
Services used	PHC = 91.8%	PHC = 91.6%	PHC = 100%
Transport	Walk = 82.7% Public transport = 8.2%	Walk = 84.3% Public transport = 13.3%	Walk = 54.3% Public transport = 45.7%
Persons tested for HIV	343	269	145
Persons that want to test for HIV	300	155	155
Person in house recently (1 year) diagnosed with	Diabetes = 7.3% Diarrhoea = 6.4% HIV = 40.0% Hypertension = 50.0% Mental health = 2.7% Pneumonia = none TB =30%	Diabetes = 13.3% Diarrhoea = 9.6% HIV = 26.5% Hypertension = 53.0% Mental health = 4.8% Pneumonia = none TB =22.9%	Diabetes = 17.4% Diarrhoea = 21.7% HIV = 58.7% Hypertension = 39.1% Mental health = 2.2% Pneumonia = none TB =28.7%

High numbers of persons have been tested for HIV, yet several hundred household members feel they need to be tested (or re-tested) for HIV. Health education about Hypertension could be beneficial as around half of the houses had a person living with the chronic condition. The absence of cases of pneumonia might be due to the household members not being able to distinguish between different types of chest infections. Door-to-door home-based testing is highly acceptable and can increase the reach of HIV testing and access to TB care (Khumalo, 2014: online; Sekandi, *et al*., 2011: online).

This was confirmed in the study. Members from most of the households could indicate some (if not all) of the most important symptoms of TB – indicating high levels of awareness.

Table 24 Regarding the community care workers

	Aliwal	Kroonstad	Pomeroy
Comfortable with CCW visiting	Yes = 90.0%	Yes = 89.2%	Yes = 93.5%
Reasons for being comfortable (main)	Assistance given = 23.6% Attitude of CCW = 20.9% Familiar with CCW = 20.0%	Encourage us = 22.9% Helpful = 20.5% Assistance given = 18.1%	Helpful = 37.0% Assistance given = 21.7% Happy with CCW = 13.0%
Services provided (main) to at least one person in home	Screen for TB = 84.5% Screen for HIV = 80.0% Refer for testing = 75.5% Adherence = 29.1%	Screen for TB = 89.2% Screen for HIV = 71.1% Refer for testing = 73.5% Adherence = 45.8%	Screen for TB = 67.4% Screen for HIV = 54.3% Refer for testing = 76.1% Adherence = 80.4%
Could not indicate symptoms of TB	Only 12.7% did not know any of the TB symptoms	Only 2.4% did not know any of the TB symptoms	Only 15.2% did not know any of the TB symptoms

Referrals to healthcare facilities were highly successful, as all beneficiaries that reported they (or another household member) were referred, reported that they went to the institution referred too.

Table 25 Referrals

	Aliwal	Kroonstad	Pomeroy
Number referred	82	58	44
Where	Clinic = 81 (98.8%) Hospital = 1 (1.2%)	Clinic = 58 (100%)	Clinic = 42 (91.3%) Hospital = 1 (2.2%) Social worker = 2.2%
Went	Yes = 100%	Yes = 100%	Yes = 100%

The beneficiaries reported that the programme had an overwhelming positive effect on their lives and were mostly satisfied with services provided. Very few complaints were reported and respondents felt that if the programme were not available they might have died and would have had less access to healthcare.

Table 26 Effect on life

	Aliwal	Kroonstad	Pomeroy
Effect on life	Positive = 76.4%	Positive = 81.9%	Positive = 91.3%
Satisfied with services	*Information given re.* TB symptoms = 78.0% TB diagnosis = 67.0% HIV = 79.0% HIV testing = 76.3% Taking medication = 66.3% Referral to clinic = 71.9%	*Information given re.* TB symptoms = 86.7% TB diagnosis = 83.3% HIV = 88.0% HIV testing = 86.3% Taking medication = 79.7% Referral to clinic = 73.5%	*Information given re.* TB symptoms = 63.0% TB diagnosis = 63.0% HIV = 85.0% HIV testing = 80.4% Taking medication = 87.0% Referral to clinic = 91.3%
Had complaints	Complained = 6.4%	Complained = 11 (13.3%)	Complained = 10.9%
What if programme were not there	*We would:* have died = 19.1% not have access = 20.9%	*We would:* not have access = 36.1% have died = 21.7%	*We would:* have died = 28.7% not have access = 23.9% have gone to hospital = 4.4%

The programme therefore (at the three selected projects) had mostly a positive effect on the beneficiaries that were reached and enhanced access to TB and HIV related health services. These services are important in South Africa, but crucial in rural areas where **access to** basic services, healthcare, proper shelter and balanced diets are even lower.

APPENDIX IX

LIST OF DOCUMENTS CONSULTED

GRAF: Impact Grant project: Early Detection and Treatment of TB:

Concept Note
Proposal
Annual Progress Report 2013 and 2014
Triple Line Consulting Progress Feedback Letter
Project Budget

SACBC AIDS Office:

Financial statement of project expenditures
Examples of monthly financial statements and supporting documents from sites
Examples of communication with sites for documentation of expenditures
Examples of Minutes of AIDS Office Staff Meetings, 2013, 2014
Examples of AIDS Office project trip reports
AIDS Office Annual Report, 2012
AIDS Office Reports to the SACBC Administrative Board, 2013, 2014
Minutes of AIDS Office Management Committee Meeting 2012
Letters to notify project site coordinators of forthcoming external evaluation
Quarterly statistics

South African Health Authorities documentation of support for project:

Letter of Recommendation from Umzinyathi District Health Office
Letter of Support from Uthukela District Department of Health
Letter of Appreciation from Vhembe District Department of Health
Letter of Appreciation from the Letaba Provincial Hosptial, Tzaneen
Letter of Support from the Motupa Clinic, Tzaneen
Letter of Support and request for further funding from Boitumelo Hospital
Letter of Support from the Free State Province Department of Health
Letter of Support from the Good Shepherd Mission Hospital, Swaziland
Letter of Support from the ZF Mgcawu District Department of Health
Letter of Support from the Nelson Mandela Bay Health District
Letter of Support from the Escourt District Hospital
Acknowledgement of funds from National Department of Health for TB project
National Department of Health Annual Project Report, October 2012-2013
National Department of Health quarterly project reports

Documentation at project sites visited

Early Detection of TB Screening Tools
Monthly statistics forms

Documentation of South Africa TB and HIV Burden

District Health Barometer 2012-2013, Health Systems Trust, South Africa. http://www.hst.org.za

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APPENDIX X

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