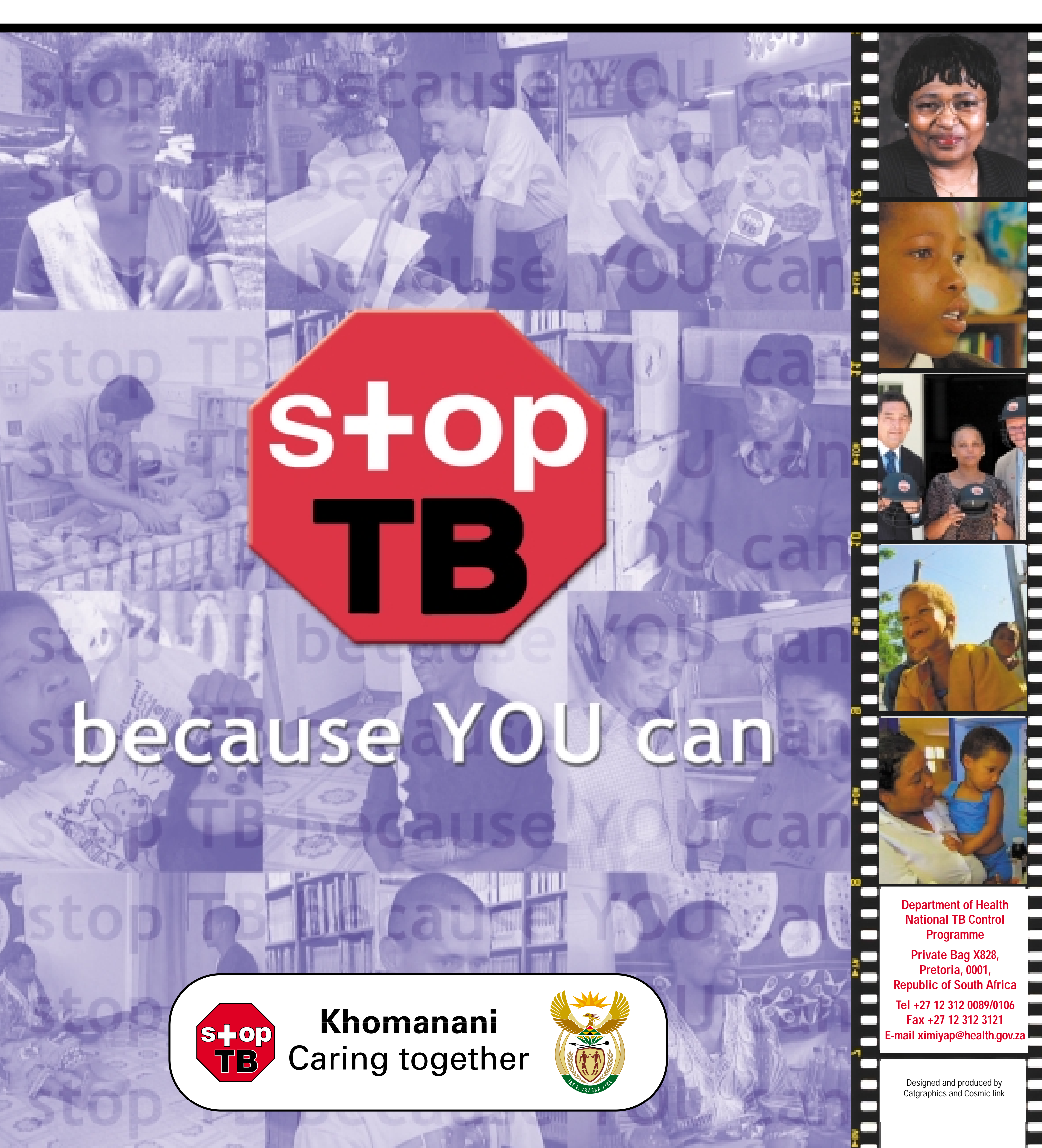
No 1 March 2003

TB Indaba

NEWSLETTER OF THE NATIONAL TB CONTROL PROGRAMME



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GUEST EDITORIAL FROM THE MINISTER OF HEALTH

Don't just read – *join* the Indaba

It is my pleasure to write the editorial column in the first TB Indaba and to explain the thinking behind this newsletter.

We are using the word "indaba" both in its modern and its more traditional meaning. On the one hand, we want to make sure that we inform you of developments in the National TB Control Programme. This should help keep us on course as we aim for our medium term goals. But equally importantly, we want to consult you. We want to hear your ideas and your experiences in tackling this enormous threat to our nation's health.

We believe that a newsletter is a way of talking to each other. TB Indaba should be a vehicle for profiling best practice. It should be a forum for lively debate. It should be a first contact point for new partners in the struggle against TB.

Above all – at the end of the day – it should leave us feeling that we are part of something bigger. Part of a body of South Africans from all walks of life who share this common vision of a healthier country. We hope that you will see, reflected in the pages of this publication, your own significance as you continue the battle against TB.

I would like to appeal to you to make TB Indaba your forum. If you know of an excellent initiative, tell the Managing Editor about it! If you are experiencing implementation problems, write and share them.

We have learned over the last few years that the methods of TB control are more complex than they sound. It takes skill, it takes particular resources and it takes support from many quarters to really record and sustain success. Communication is one of the critical ingredients of success that we often forget to include. But not this time!

TB Indaba is just one element of a broader Advocacy and Social Mobilisation Strategy that seeks to put communication and partnership high on the TB agenda. I urge you to read about it – on pages 6 and 7 – and put your heart into it. We all have a contribution to make on this front ... and we dare not fail.

Dr Manto Tshabalala-Msimang
Minister of Health

TB CONTROL: A SOUTH AFRICAN CHALLENGE

The Department of Health views turning the TB tide as a top priority for the next few years and will work consistently to achieve this – not just on World TB Day but on every day of the year.

According to WHO, it is estimated that South Africa ranks seventh on the list of 22 countries hit hardest by TB. In 2000, only 67% of TB cases were detected and of these only 54% were cured. Treatment interruption occurred in 12,7% of cases.

South Africa has to face three main challenges in the fight against TB:

- The late presentation of patients,
- The late detection of in TB cases,
- The failure for TB patients to finish their treatment.

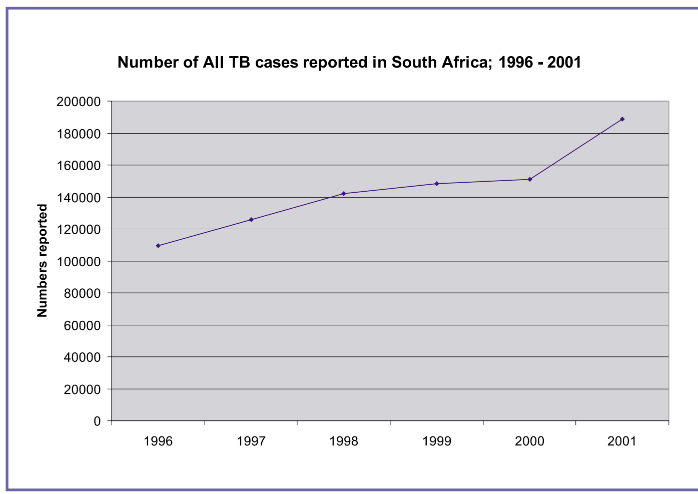
The growing HIV problem feeds directly into the spread of tuberculosis. Because of their lowered immunity, people with HIV are 30 times more likely than the general population to acquire TB. According to the South African Health Review, up to 40% of South African TB patients are co-infected with HIV.

The stigma that persists in relation to TB and HIV/AIDS leads to infected individuals hiding their illness for as long as possible. Late disclosure means that the infection is spread to others, while this could easily be prevented.

As early as 1999 Government merged its TB and AIDS units to address the dual epidemic in a coordinated way. Despite all efforts, we have not yet turned the tide against TB even though the infection is curable even in individuals who are HIV-positive.

An aspect of the problem is the development of multi-drug resistant tuberculosis (MDR-TB) which is complex and difficult to cure.

A recent study commissioned by the Department and done by the Medical Research Council showed that MDR-TB was strongly linked to failed or interrupted treatment. A total of 6,6% of individuals in this category had MDR-TB. Much lower levels of MDR-TB were found among patients undergoing their first TB treatment, indicating limited transmission at this stage.



South Africa's Minister of Health, Dr Manto Tshabalala-Msimang, was among the first signatories of the Amsterdam Declaration.

This commits high TB burden countries to meeting international targets. She made this commitment knowing that the goals would only be achieved if we empower the nation with an understanding of TB and if we make treatment easy to access.

TB MEDIUM TERM DEVELOPMENT PLAN

The TB Medium Term Development Plan is based on nine major strategies.

- Building political commitment in order to raise the profile of TB and to secure sufficient resources to achieve the international targets.
- Providing good access to laboratory testing as a precondition for early detection of TB.
- Ensuring an uninterrupted supply of quality drugs through reliable suppliers and distribution systems.
- Ensuring the technical soundness of Directly Observed Treatment, using standard short-course chemotherapy, and the availability of social support.
- Implementing regular recording and reporting systems in order to assess the treatment outcome of each TB patient.
- Building partnership between all levels of government; non-government and private sectors.
- Developing and implementing a policy on multi-drug resistant TB.
- Developing and implementing an Advocacy and Social Mobilisation Plan.
- Ensuring easy access to voluntary counselling and HIV-testing for all TB patients.

TB CONTROL: A SOUTH AFRICAN CHALLENGE

TOGETHER, WE WILL STOP TB. WE CAN DO IT!

ONE PLAN ... A CLEAR DIRECTION ... MANY PARTNERS

At the forefront of South Africa's response to TB is Dr Refiloe Matji, Director of the National TB Control Programme. Appointed by the Department of Health in 1996, Dr Matji (interviewed below) is known for plain talking and is not one to shy away from the truth. She acknowledges past deficiencies but feels confident that some of the more critical shortcomings are now being addressed.

Q: What challenges is South Africa facing with regard to the TB epidemic?

Dr Matji: South Africa is faced with many challenges when it comes to controlling the TB epidemic. Our people are dying of a curable disease despite numerous efforts to reduce the incidence of TB. In 1996 the National Tuberculosis Control Programme was established and it adopted the Directly Observed Treatment Strategy (DOTS) of the World Health Organisation. At that time various factors indicated that South Africa was in the grip of a serious TB epidemic. Despite the increase in financial resources for TB control, the number of cases notified remained high. The emergence of multi-drug resistant TB and the impact of HIV on TB also indicated that the epidemic was not under control. This led to government making all TB treatment free of charge for all patients.

Despite these positive interventions, TB still remains a threat to our people. It is important to understand why the number of cases is increasing so that we can find solutions. Although DOTS has been implemented in at least three-quarters of the country's health districts, we are still facing a number of challenges. One of them is the increase of HIV and AIDS, resulting in one of the highest co-infection rates in the world. We are facing a very serious problem of huge proportions.

Q: Why is it necessary to have a Medium Term Development Plan for TB?

Dr Matji: When this country signed the Amsterdam Declaration we committed ourselves to reaching the targets set out in that document. In order to achieve these targets we needed a detailed plan that would ensure we would expand control measures for TB and inspire increased political support. All of us who are involved in TB work needed to know: How are we going to achieve these targets with their defined deadlines?

The plan is also geared to giving TB patients a voice. Until now we have not put a human face to TB. It is an epidemic that we cannot ignore as it affects our society at many levels, socially and economically. It cries out for attention from many government departments – from housing and the environment to education and labour. We should therefore come together to create a strong foundation to deal with TB.

DR REFILOE MATJI

Q: What are the time frames for the Plan?

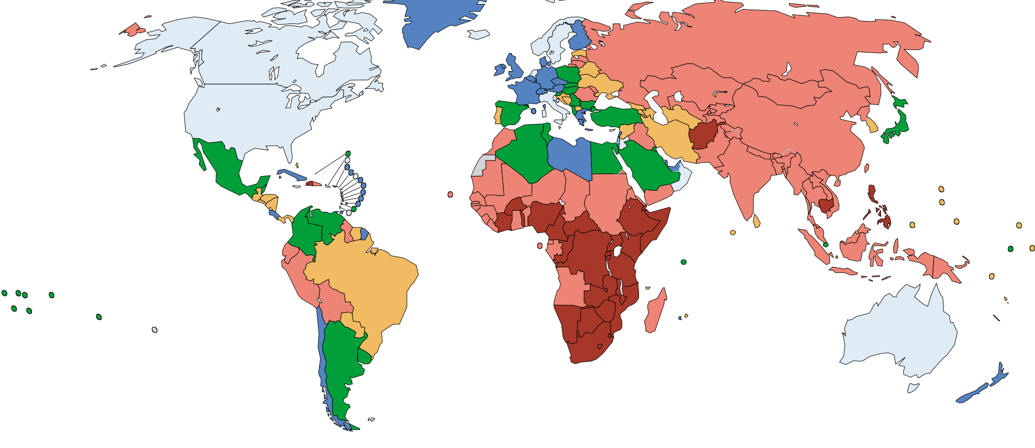
Dr Matji: The TB Medium Term Plan was launched in January 2002. It was the result of all principal stakeholders coming together to respond to the TB dilemma. The Plan binds government and its partners to reach its stated goals over a period of three years, from 2002 to 2005. This period will be crucial in terms of standardising strategies at all levels of government and building partnerships with private and civil society organisations. The Plan set a specific deadline to compel all key players to recognise that a sustained and focused commitment is needed.

Q: How does the Plan aim to raise the profile of TB, especially in the context of a high level of advocacy on HIV and AIDS?

Dr Matji: We're looking to politicians, heads of health and others in leadership positions to be more proactive about TB. It is time for the country to know that we are faced with a serious problem – but it is a problem we can successfully tackle. We can stop TB. We can provide free treatment and support for patients. All we need to do is to work together.

We intend to launch a massive advocacy and social mobilisation campaign because we believe this is a critical factor in reaching our targets. Our plea is for all organisations, spheres of government and business to join the fight to manage TB. We believe high mobilisation on AIDS is an asset rather than a handicap. We welcome initiatives by organisations already involved in the fight against HIV to combine their efforts to combat the effects of both epidemics.

GLOBAL PICTURE OF THE CHALLENGE TO STOP TB



RATE PER 100 000

- 0 – 9
- 10 – 24
- 25 – 49
- 50 – 99
- 100 – 300
- 3000 or more
- No Estimate

Tuberculosis is a curable disease yet it kills two-million people worldwide every year. The impact is devastating – but is almost ignored.

TB is usually defined as a disease of the poor. High infection rates are seen as the result of meagre living conditions and exploitative working conditions. There is a lot of truth in this stereotype, but the spread of HIV and AIDS has increased the risk of TB infection and made it a factor even in wealthy communities and nations.

One third of the world's population is infected with TB, according to the World Health Organisation (WHO). But eight out of 10 people with TB live in just 22 countries, the WHO believes. If these countries do not succeed in getting TB under control, the whole world could feel the consequences.

In March 2000 Ministers of Health from the 22 most affected countries met in Amsterdam to discuss how to tackle TB more effectively. They drew up and signed the Amsterdam Declaration for Accelerated Action against TB. This commits signatories to strive for:

- A cure rate of 85% of detected cases.
- A treatment interruption rate of 5% or less.
- A case detection rate of 70%.

The signatories set themselves a deadline of 2005.

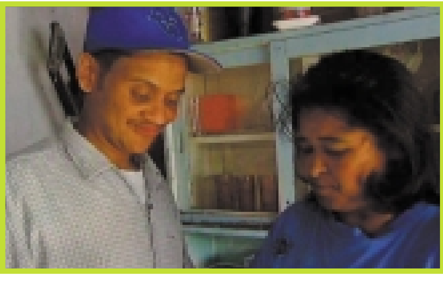
In November 2000, representatives from the 22 countries met again – this time in Cairo – to talk about how they would reach their common targets. They pledged to build partnerships and drew up a global DOTS Expansion Plan.

In October 2001, the 22 high burden nations recommitted themselves to the Amsterdam goals by signing the Washington Commitment.

Despite all these efforts, the world is far from reaching the global targets. Presently, only 30% of infectious TB cases are detected globally. Worldwide, about 5,000 children, women and men continue to die every day from this treatable illness. And they will continue to die without a substantial global effort to support the programmes in the 22 most affected countries.

- For more information see www.stoptb.org – the website of the Stop TB Partnership.

TOUGH LOVE FROM DOTS SUPPORTER



Willem Bergman has TB for the second time. He was not cured the first time because he did not complete his treatment. Like many others, as soon as he felt healthy he stopped taking his medicine.

Now his TB has returned and it's back to square one with treatment. But this time he has an additional weapon against TB: DOTS supporter Denise Botha. Willem does not take his daily medicine at home. Instead he visits Denise, who gives him his tablets and watches as he takes them. These visits will continue for six months, until Willem has completed his treatment. Denise keeps records of his visits and reports to the nearby clinic.

Another of Denise's patients is Clarence Lackay who lives too far from the clinic get his daily medication there. Denise volunteered as a DOTS supporter because she realised the clinic was overburdened with patients. She is caring but strict and gets her daughter to track down any patient who fails to turn up for medicine. She is like a mother, sister, friend and nurse to all her patients.

ADVOCACY AND SOCIAL MOBILISATION PLAN:

HARNESSING LEADERSHIP AND BUILDING PEOPLES' POWER

Health workers in TB control programmes have long understood that an informed public is the foundation of their success. There have been various efforts to communicate. But these have not been big enough, sustained enough and loud enough to wake the nation to the danger of TB.

The new Advocacy and Social Mobilisation Plan is ambitious. Not only does it aim to ensure that every man, woman and school going child knows the basics about TB. It is also a call to action, a call to influential figures to put their power in the service of TB, a call to ordinary citizens to help build the support systems that will guarantee success in treatment.

By building commitment from above and participation from the ground, Advocacy and Social Mobilisation can impact on developing better facilities for people to access testing and treatment. This includes the support of DOTS volunteers.

At a general level, the Plan aims to ensure that everybody knows the symptoms of TB, understands that it is curable and appreciates why treatment compliance is so important. High awareness and acceptance of these three "messages" helps the TB Programme attain its goals of:

- Better and earlier case finding.
- Higher cure rates.
- Lower treatment interruption rates.

The communication strategy recognises that failure to get tested and failure to complete treatment are often caused by factors outside the patient's control. Overcoming the obstacles to treatment and cure therefore demands a change in the behaviour of other people in the infected person's environment.

An aware colleague at work can be the saving of others who don't know the symptoms of TB.

The Advocacy and Social Mobilisation Plan for 2003 to 2005 aims to co-ordinate a comprehensive communication campaign. It will comprise much more than a few isolated events and it will be built around partnerships at all levels of society

THE CHALLENGES

- To boost the profile of TB.
- To achieve year-round visibility.
- To secure political buy-in.
- To create clear messages on TB and HIV.

THE PROCESS

- To kick-start the Plan the National TB Control Programme met health and communication co-ordinators from each province to understand the challenges facing them. Participants discussed relevant strategies to mobilise their communities and create partnerships.
- The first of these workshops took place in September 2002. It brought together representatives from national and provincial government in the fields of TB control, health promotion and communication plus a small number of experts in these fields. They shared examples of best practice in community mobilisation – borrowing from some related fields – and explored how to engage the support of NGOs, private sector organisations and community leaders. They also examined ways to successfully communicate with TB patients and their families.
- In October, the TB Programme embarked on a road show, taking a team to each province, to assist them to finalise their advocacy and social mobilisation plans for the next three years. This gave the national office a much clearer picture of the challenges ahead. And it gave provinces a chance to examine their strengths and weaknesses and formulate plans to overcome their weaknesses.
- In December, the National Advocacy and Social Mobilisation Plan was presented to the Health Minmec that is, to a meeting of the Minister of Health with all provincial MECs for Health. There was an open discussion about the difficulties that were likely to be experienced in the course of implementing the Plan. The Health Minmec took on board the challenges and endorsed the Plan. It also decided that the Plan should be publicly launched on World TB Day, 24 March 2003.

THE PLAN

- The main objective of the plan is to mount **sustained and highly visible campaigns that will unite all South Africans in the fight against TB.** The messages communicated will support the aims of the Amsterdam Declaration.
- The Plan envisages a much greater use of **mass communication methods** and a greater investment of resources and creative capacity to achieve this. TB will be on the air waves, its logo will occupy TV screens and it should suddenly appear where people least expect it – for example, on taxis, in shopping trolleys, on service accounts and the middle of your favourite soap opera!
- The Plan also focuses on putting more effort into **direct dialogue with communities** through events, door-to-door campaigns and participation in the programmes of community organisations. This is what is meant by social mobilisation.
- Another aspect of social mobilisation is **bringing in partners at all levels – national, provincial, town and community.** Partners can play a role in expanding communication and social mobilisation. Or they can play a role in other aspects of TB control – providing clinics, serving as DOTS networks.
- Central to the success of the National TB Control Programme is the **reduction of the stigma** that is associated with TB. In the minds of many people TB still means a long, slow death in a dark, sad hospital. Nothing could be further from the truth! And the best proof of this are the thousands of TB patients who have been successfully cured.
- The Plan seeks to turn as many cured patients as possible into **TB ambassadors.** And this aspect of the Plan goes into action in March 2003, around World TB Day.
- The Plan also aims to **use the established influence of leaders in many fields – political leaders,** religious leaders, cultural figures – in our national effort to stamp out TB. Almost all leaders are good communicators. Some are truly great communicators – so all we need to do is ensure that they know the essential issues in TB control. They will do the rest!
- As the Plan unfolds, there will be constant **evaluation and research** to check if we are on track and if we are having the impact that is desperately needed to: Stop TB before 2005.

MDR-TB CAN BE PASSED ON

Jaco Joseph is 12 years old and has lost both his mother and grandmother to TB. He is a patient at Brooklyn Chest Hospital in Cape Town where he must stay until he is cured of the multi-drug resistant TB (MDR-TB) that his mother transmitted to him.

Jaco is a brave and responsible boy. When he became ill he made sure that his three-year-old brother was tested for TB. Luckily his mother had not infected the younger boy.

Young as he is, Jaco understands that failure to complete TB treatment can be fatal. He also understands how untreated TB puts others at risk. “My mother should have taken her tablets. It is through her that I am sick.”

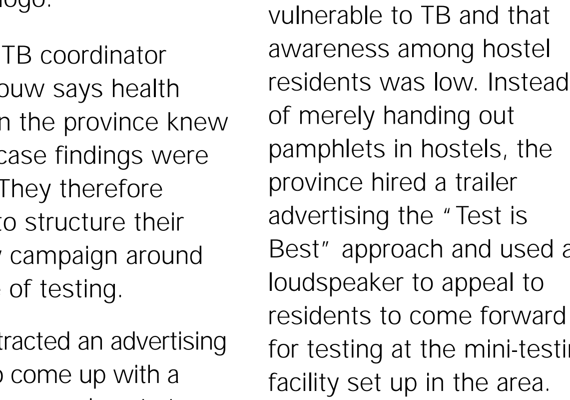
It is a harsh reality for a child to face, but Jaco puts his experience to good use by encouraging other young people at Brooklyn Hospital to stick to their treatment.

BEST PRACTICE – GAUTENG

INSTANT TESTING AT HEART OF CAMPAIGN

Gauteng Health Department has developed a successful advocacy strategy that rests on the dual approach of awareness plus instant testing.

To convince communities that testing is free and readily available, Gauteng health workers leave their clinics behind and set up temporary testing sites in the community. As they spread information about TB symptoms, testing and treatment, they are able to direct concerned individuals to the testing facility, which is easily identified by the "Test is Best" logo.



Gauteng TB coordinator Rianna Louw says health officials in the province knew their TB case findings were too low. They therefore decided to structure their advocacy campaign around the issue of testing.

"We contracted an advertising agency to come up with a logo and a campaign strategy that is easy to use and creates awareness," explains Dr Louw.

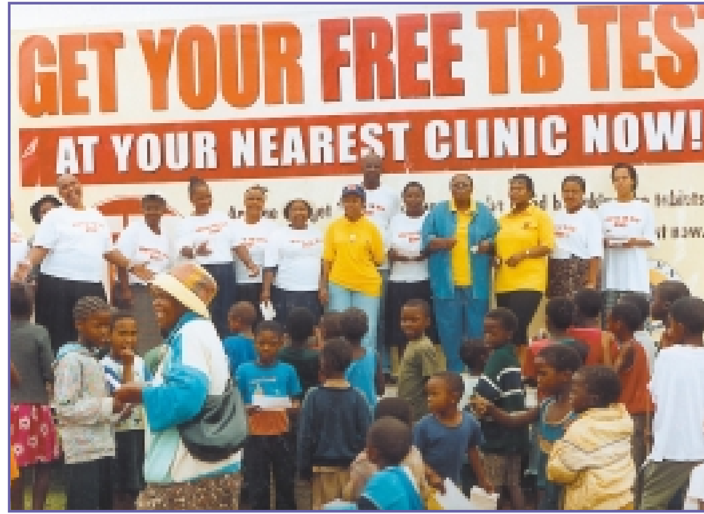
The "Test is Best" campaign focuses on areas the province regards as TB "hotspots", where there is a high incidence of TB and unsatisfactory interruption rates. "Each year we identify five hotspot areas which we target," says Dr Louw. She adds that they do not simply go into communities without consulting leaders and local health workers. "We want the message to be effective and local leaders and workers know what they need and what campaigns can work."

The health department was advised that hostels were vulnerable to TB and that awareness among hostel residents was low. Instead of merely handing out pamphlets in hostels, the province hired a trailer advertising the "Test is Best" approach and used a loudspeaker to appeal to residents to come forward for testing at the mini-testing facility set up in the area.

Sputum samples were taken there and then. Every person tested was advised to collect the results at the nearest clinic. As a backup strategy the physical address and contact details of each individual were recorded.

Shebeens have been targeted for attention in some of the hotspots. In such cases health workers do not use a trailer and loudhailer, but they take a more personal approach. They go into the shebeens and talk to patrons about TB and about the conditions for successful treatment. "We say to them that we know they are drinking and we explain to them how alcohol affects TB treatment. But we make it clear that we will still treat them," says Dr Louw.

The major lesson that Gauteng has learnt is that communities know what kind of support they need. The major success the province has scored is providing proof that the TB service lives up to the promises made. In addition, says Dr Louw, the campaign has a strong visual impact and the sight of people openly testing for TB begins to reduce the stigma that this illness still carries.



THAT COUGH COULD BE TB - GET TESTED!

Attie de Lange is a regular guy who works in a video shop in Pretoria. Usually strong and well, he was troubled by a change in his health. "I started coughing, would break out in a sweat and began to lose weight," he says.

Attie did the sensible thing and consulted his doctor. He was diagnosed incorrectly three times before his doctor finally sent him for a TB test. The test turned out positive. "As soon as I was diagnosed, I informed my colleagues about what symptoms to expect in case I had spread the disease," he says. He did not want to perpetuate the stigma of TB by keeping his condition secret. Attie was not ashamed of having contracted TB.

He stuck to his treatment for six months and was rewarded with a complete cure.

BEST PRACTICE – KWAZULU-NATAL

AWARENESS ON WHEELS

Standing in downtown Durban, taxis whiz past you and pick up passengers. What catches your eye – even at high speed – is the brightly coloured TB adverts decorating the taxis. It is hard to ignore these messages that emphasise that TB is curable

For six months of each year 50 taxis are transformed to vehicles for TB advocacy. Passengers and pedestrians are bombarded with information about the symptoms of TB, how to get tested and what treatment is all about.

"If we look at the profile of TB patients, most listen to radio and most also use public transport. So we decided to focus our campaign on a mobile population," explains Bruce Margot, head of Communicable Disease Control in the KZN Health Department.

The strategy is in line with the Advocacy and Social Mobilisation Plan that insists we should target the population as a whole – not only those directly affected by TB. Every South African should know that TB is curable, treatment is free and it can be stopped if we act together

Mr Margot says that the campaign has not been formally evaluated, but the value of increased exposure of the public to TB information is self evident. The campaign is planned to ensure that some of the adverts appear on long distance taxis that travel to remote areas. "My feeling is that you cannot get better coverage for your money," comments Mr Margot. He adds that once the development of the messages and the adverts is done, it is easy to extend the campaign to more cities and districts.

However, like all advertising the taxi campaign costs. Mr Margot admits that it is difficult to balance the funding requirements of a major advocacy campaign with the demands for investing in the logistics of the TB control programme.

BEST PRACTICE – FREE STATE

WORKERS HEALTH = COMPANY HEALTH

To tackle the high incidence of TB among its workers, Harmony Mine keeps cough registers at the mineshafts of its Free State operations. This ensures that early detection occurs and there is a decrease in the spread of TB.

Controlling TB among miners is a factor in the productivity of most mining companies. The mines tend to experience high TB rates because of the confined working conditions underground and the fact that miners live in the same hostels. When any mineworker has TB that goes undetected, there is plenty of opportunity for it to spread among the workforce.

"If a miner has a cough he is sent to the dressing station where a sputum test is done," says Elemene le Roux, occupational health administrator at the Harmony Hospital. Dressing stations are mini-clinics and they are conveniently situated at shaft sites.

In the past, the miner would have been sent to hospital where he would wait for his test result. Now the sputum sample is sent to the hospital for testing. "If the test comes back positive, we inform the nurse at the dressing station to begin TB treatment immediately," says Ms le Roux. The practice is that the miner does not go down the shaft for a short period until he is no longer infectious.

The nurses at the dressing stations are also the DOTS supporters. They keep a TB register where they enter the daily treatment. All mineworkers with TB also sign a treatment contract. "This explains why they should continue and complete treatment," says Ms le Roux. It remains the miner's responsibility to visit the dressing station daily for medication. If he does not attend, the lapse is reported to the manager.

Ms le Roux says that interruption rates are reduced because of the convenient location of the dressing stations. Treatment does not interfere with the infected individual's work schedule.

The mine hospital has trained 150 peer educators among mineworkers who are able to teach their co-workers about HIV and AIDS, TB and alcohol abuse. "I never sit back and say we have done enough," reflects Ms le Roux.

DON'T ISOLATE - OFFER YOUR HELP!

If Anastasia Jafta had known she had TB she could have been treated and avoided infecting her little girl, Benechia. But Anastasia did not recognise the symptoms of TB. Nor did she know that she could get free treatment from the clinic. She also did not realise that three-year-old Benechia had TB meningitis.

Benechia could not alert her mother to the headaches and exhaustion she was experiencing. So it was only when the child refused to eat and became lame that her mother rushed her to hospital.Benechia survived but she will never fully recover. She will always have learning and behavioural difficulties and muscle spasms.

Anastasia coped with her child's illness and her own in isolation. She was incorrectly told to stay away from work as she could spread TB to fellow workers. Nobody informed her that once she began treatment others close to her were no longer at risk of infection.

BEST PRACTICE – WESTERN CAPE

EMPOWERING COMMUNITY ORGANISATIONS

Empowerment of community organisations to implement and monitor DOTS is critical to the success of the Medium Term Development Plan.

It is these organisations that are close to the frontline of the struggle against TB and HIV. They watch family members, neighbours and friends struggle with these conditions. It is this closeness that gives them the power to advocate for a total offensive to cure TB, even in the face of the HIV epidemic.

The Central Karoo AIDS Action Group in the Western Cape is a sterling example of an AIDS organisation that has made a real impact on TB. It has adopted a comprehensive approach, and incorporates DOTS and TB awareness into its programmes.

The Networking AIDS Community of South Africa (Nacosa) supports organisations like the Central Karoo Group, assisting them to access donor funds, manage the money they receive and network with partners in various sectors. It also helps them develop their own capacity through training.

Nacosa director Luanne Hatane says it is important to provide training for organisations because it makes their work sustainable and spreads the national burden of fighting TB and HIV. "Most of these non-governmental organisations face problems related to securing funds. Often they have no capacity to draw up a business plan or put together a budget."

Western Cape Nacosa fills this vacuum by providing community-based organisations opportunities to build their skills. It mentors organisations over a period of two years, until they are trained and able to work independently in all important areas, including the management of finances. "Sustainability cannot be achieved in the TB control programme if these people are expected to work under difficult conditions," says Ms Hatane. She also believes that compensation of volunteers is a sound investment. "Without them we do not stand a chance of defeating the dual burden of TB and HIV."

THE WESTE

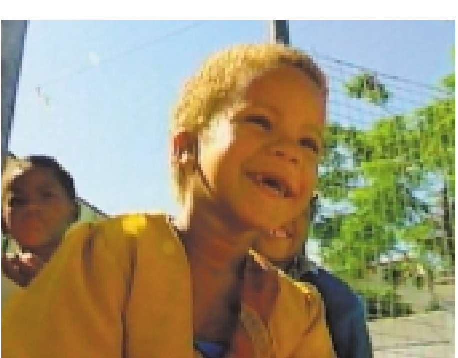
At the invitation of TB Indaba, the Western Cape Department of Health provided its perspective on the reasons for substantial progress in the province in the fight against TB.

The Western Cape has one of the highest incidence rates of tuberculosis in the world. Recognising the enormity of the situation, the Western Cape Department of Health, in 1996, declared TB a health emergency in the province.

It also adopted and implemented the internationally recognised DOTS strategy as the route to fight, control and eradicate TB in the province.

TB incidence continues to rise year on year due to the unfolding HIV epidemic. Despite the high incidence, and the continuing increase in incidence due to the HIV epidemic, the Western Cape has attained a reasonable measure of success in its efforts to reduce and control TB.

SAVED BY FREE DRUGS AND MOTHER'S CARE



Carol Snyman was frantic when she found her little girl had TB meningitis. Simply finding food and shelter was a daily struggle. Paying for treatment was out of the question – but she knew that Fredelien could suffer permanent harm without treatment. Her fears were calmed as soon as she got to the clinic and heard that government provides free TB treatment for all. However, she also learned that she would carry the responsibility for ensuring Fredelien took the medication every day for six months. It wasn't as easy as it sounded. Fredelien couldn't swallow the handful of tablets. The medication had to be forced down a pipe inserted in her nose. Only the thought of what could happen if she stopped treatment ñ brain damage or multi-drug resistant TB – kept Carol on track. Fredelien took the full course and today is a healthy child.

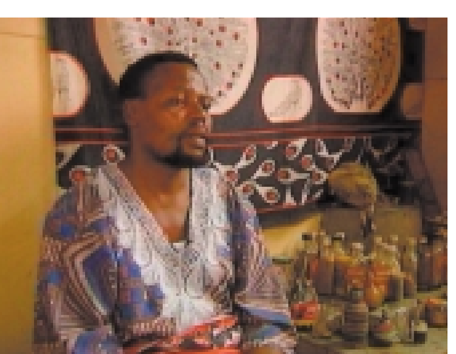
RN CAPE'S CHECKLIST FOR SUCCESS

The Western Cape Department of Health is proud of this success, but clearly acknowledges that there is still a long way to go. This will require massive efforts in terms of manpower, resources for many years to come.

The reasons for the provinces success are many and varied but can

BE ATTRIBUTED TO THE FOLLOWING:

- Identifying all new infectious cases and curing them at the first attempt.
- Seeing cure as a major TB prevention tool.
- Recognising and admitting the enormity of the TB epidemic in the province.
- Declaring the TB epidemic a health emergency.
- Making TB the Number 1 Health Priority Programme within the Department of Health.
- Introducing and strictly implementing all elements of the internationally recognised DOTS strategy.
- Decentralising the microscopy (smear) service.
- Introducing a courier service to ensure rapid transfer of sputum specimens from clinics to laboratory.
- Supplying and installing fax machines in all treatment points to expedite the return of laboratory results. The goal is to have results available at treatment points for the majority of specimens within 48 hours.
- Introducing a strict recording, reporting, monitoring and evaluation process for managing TB control at all levels. Recording and reporting were considerably simplified and computerised without compromising indicators or the quality of data.
- Strengthening the management of TB at all levels, culminating in provision of funds for the critical posts of full-time district TB co-ordinators.
- Providing continuous feed back – with commentary – to all levels of management, including treatment points or clinics. Feed back with commentary gives morale a boost and encourages a feeling of belonging and participation at all levels. This is particularly true at treatment points where staff are empowered to use data generated by them to identify and solve problems – and subsequently manage their programme better to the benefit of TB clients.
- Using community treatment supporters.
- Targeting treatment interruption rates, with the subsequent reduction of treatment interruption from 20% to 13% in 2001.
- Ensuring an uninterrupted supply of quality TB medication including the introduction of a four-drug combination tablet.
- Maintaining low levels of multi-drug resistant TB.
- Developing a medium term development plan for TB and beginning its implementation.
- Publishing provincial policies on TB control.
- Undertaking regular provincial support visits to regions and districts.
- Active participation by top management in TB control with widespread political commitment from Minister through to Standing Committees on Health.
- Recognising that control of TB is a long-term process, and that the province must commit itself to providing the necessary resources for as long as is necessary.
- The availability of dedicated, loyal and hardworking teams at all levels.



HIV NO BARRIER TO TB CURE

Nyangezizwe Mpila is a traditional healer in Mpumalanga who became a DOTS supporter to save the lives of his patients. He believes it is important for traditional healers and clinic-based health workers to work together, to give patients the same messages and to avoid confusing patients. Nyangezizwe has successfully supported individuals who have HIV and TB. He says counselling is especially important in such cases to help the patient believe in the possibility of a cure. When this confidence is established, patients will follow the treatment for the full six months.

CONTACTS USEFUL LINKS

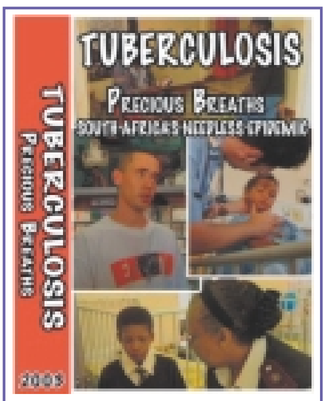
PRECIOUS BREATHS SOUTH AFRICA'S NEEDLESS EPIDEMIC

Today in Africa, only Ethiopia and Nigeria have higher incidences of tuberculosis than South Africa. Yet, this is a completely curable disease.

In **PRECIOUS BREATHS**, we journey first to Cape Town to Tygerberg Children's hospital where children have been admitted to hospital with one of the most dangerous forms of TB – TB meningitis. Doctors in the developed world may see perhaps one case of TB meningitis in their lifetime.

PRECIOUS BREATHS explores the spread of TB from adults to children. Grown-ups get pulmonary-TB and spread it when they cough. The TB germ destroys the lungs and harms other vital organs. It's incredibly dangerous to children, even those immunized at birth.

We introduce you to adults who never knew they were infected, and made their own children sick.



We speak to former TB patients who completed their drug courses. Today they're cured.

If one patient's TB remains untreated, they will infect up to 15 other people a year.

The message is clear: These are needless deaths, because TB can be cured completely.

A series of five Public Service Announcement was also produced in six languages and are available on request at the National TB Control Programme. Email: ximiyap@health.gov.za

All the patient's stories that are featured in this Newsletter are taken from a TV documentary that was produced for World TB Day.

If you need more information on TB please contact your nearest TB control unit:

Kwazulu Natal	033 395 2016
Limpopo Province	015 295 7055
Mpumalanga Province	013 766 3317
North West Province	018 387 3000
Eastern Cape Province	040 609 3111
Northern Cape Province	053 830 2000
Western Cape Province	021 483 5417
Gauteng Province	011 355 3540
Free State Province	051 405 5703

National TB Control Programme
012 312 0089

CRICKET INITIATIVE

Chairman of the ICC World Cup Cricket 2003, Dr Ali Bacher, Dr Refiloe Matji from the National TB Control Programme and Mr Michael Luhan of the Stop TB Partnership gives his thumbs up to the launch of "Hit TB for a 6" Initiative, March 2003

CLOSING CRACKS IN THE HEALTH SYSTEM

Fanie Simelane is undergoing his third course of treatment for TB and his DOTS supporter is a traditional healer. Previously he has failed to complete treatment. The reason for this was that he was getting one kind of advice from clinic health workers and hearing something completely different from traditional healers. Who should he believe?

This time he can be assured that the message on TB treatment will be the same, no matter who gives it. Clinic personnel and traditional healers have adopted a common approach to TB and traditional healers have been trained as DOTS supporters.