VISION

TO BE A LEADER IN EMPOWERING COMMUNITIES TO BE HEALTHY AND FREE OF TB AND HIV

MISSION

TO EMPOWER AND CARE FOR COMMUNITIES BY SUPPORTING PRIMARY HEALTH CARE SERVICES TO:

• Prevent TB, HIV and other major diseases
• Improve diagnosis, treatment, care and adherence support for people infected and affected by TB, HIV and other major diseases
• Build the capacity of individuals and organisations to provide optimal comprehensive primary health care including TB and HIV services
• Participate in operational research, monitoring and evaluation to improve comprehensive primary health care

VFNT COVER - NOT JUST A TEST: HIV counselling and testing is linked to screening for TB, STIs and a range of other wellness services and includes supporting the client to form a plan to reduce risky behaviours. BACK COVER - HOME VISIT: Finding a client can mean a long walk in an unsafe area for community care workers. Photo: Global Fund and John Rae

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DRAWING THE CROWDS: A World AIDS Day event at Delft where 842 people were counselled and tested for HIV.
# MEMBERS

## EXECUTIVE COMMITTEE MEMBERS

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<td>Mr Lionel Janari</td>
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<td>Ms Stacie Stender</td>
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<td>Mr Greg Wesson</td>
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<td>Ms Yvonne Galvin</td>
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<td>Dr Andrew Young</td>
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## EX OFFICIO

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<td>Prof Harry Hausler</td>
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<td>Mr Carlos Orte</td>
<td>Chief Operating Officer</td>
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<td>Mrs Ria Grant</td>
<td>Senior Advisor</td>
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## MEMBERS

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<td>Dr Virginia Azevedo</td>
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<td>Mr Desmond Goliath</td>
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<td>Dr Frederick Marais</td>
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## HONORARY LIFE MEMBERS

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<td>Ms Johanna Honeyman</td>
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<td>Dr Michael Popkiss</td>
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THE SOCIAL WORK PROGRAMME SHOWS HOW SOCIAL SUPPORT CAN CONTRIBUTE TO HEALTH OUTCOMES

IN SOUTH AFRICA, HIV AND TUBERCULOSIS (TB) often occur in a context of poverty and its related social ills. Clients need to be diagnosed and initiated on treatment, but in addition to that many require care and psychosocial support to deal with the daily challenges of their disease and their circumstances.

TB/HIV Care in partnership with the Department of Social Development, have included three social workers and five social auxiliary workers in our programmes to address these needs. They are responsible for one-on-one psychosocial counselling sessions at the health facilities. Among the cases they deal with on a daily basis are issues of gender violence, child abuse, marital problems and drug and alcohol abuse. These issues all affect treatment adherence, TB treatment outcomes and the prevention of HIV and TB transmission.

In addition to the counselling and referral service, the social workers also implement and facilitate support groups and community awareness sessions on TB and HIV. They educate clients and conduct awareness sessions, as well as assisting with grant applications.

The following is an example of the cases they encounter and illustrates how social issues cannot be separated from health issues.

A 20 year old woman was referred to one of the social workers because she was defaulting on her ARV treatment. The social worker noticed bruises on her upper arms, a telltale sign of gender violence. The client disclosed that she lived in a house with seven adults and a number of cousins who are all dependent on their grandmother’s state pension of R1300. The client had wanted to get out of an abusive relationship with her partner but her grandmother insisted that she stay with him as he was providing some much-needed food to the household. Her situation had become unbearable and she saw no point in taking her antiretroviral treatment. After several counselling sessions and some groundwork by the social worker, the client was admitted to a shelter for women where she was enrolled in a hotel cleaning job creation programme. She was referred for psychiatric support for her depression and is back on treatment and coping with her life and her disease. During the year under review the three social workers saw 1898 cases one-on-one at 15 health facilities, and reached 1329 through outreach events.
TB/HIV CARE’S EASTERN CAPE TEAMS PROVE THAT MEDICAL MALE CIRCUMCISION CAN WORK ALONGSIDE TRADITIONAL CIRCUMCISION

ALTHOUGH MEDICAL MALE CIRCUMCISION (MMC) is a national campaign driven by the Department of Health there has been some resistance to the idea of offering MMC services in the Eastern Cape Province because of a perceived conflict with traditional circumcision. The experiences of TB/HIV Care’s Eastern Cape teams, however, demonstrate that MMC can work in areas where traditional initiation is also practiced.

Over the last year, there has been a remarkable increase in the number of males choosing medical male circumcision in the OR Tambo district. 1978 MMCs were conducted in the current reporting period compared to 129 in the previous one. Similarly, despite not performing any MMCs in the previous reporting period, Alfred Nzo provided MMC for 1308 men in the 2013/14 period.

This success is due to the effort the teams have put into engaging with communities and traditional leaders in the areas. After numerous meetings with the traditional house and other traditional authorities including local chiefs, the OR Tambo TB/HIV Care team was allowed to join a traditional circumcision forum in a supportive role.

In the June/July 2013 season, TB/HIV Care’s trained health professionals provided MMC in health facilities to some initiates prior to them entering initiation school. A TB/HIV Care community team leader (CTL) also discussed manhood and gender norms with the initiates. Thereafter, the clients continued the rest of the initiation process with their parents or guardians, but the CTL and professional nurse counsellor closely monitored the initiates by checking them daily. In this season more than 30 initiates graduated from this safe circumcision initiation school and none had a severe adverse event that warranted them being taken to hospital.

The Alfred Nzo team has also engaged with traditional leaders and communities to identify areas where the demand for MMC is high. MMCs were initially offered in two health facilities, but this number soon increased to six.
TB PHOTOVOICE RAISES SOCIAL ISSUES IN ZF MGCAWU

TB/HIV CARE HAS BEEN RUNNING TB PHOTOVOICE WORKSHOPS FOR FIVE YEARS, and 2013 saw the first workshop being held in the Northern Cape. TB Photovoice is an international initiative that gives community members whose lives have been affected by TB a public platform to tell their stories.

Over three days, participants who volunteered to be part of the process were trained by a facilitator to use a camera and were encouraged to think about issues in their community that they believe are relevant to respond to TB. Thereafter the participants took photographs of these issues and wrote brief stories about them. Many of the issues raised had to do with the way alcohol and substance abuse, poverty and unemployment impact on TB and HIV incidence in the area.

These photographs and stories were then displayed publicly at the Protea Hotel in Upington during a stakeholder’s meeting regarding the implementation of the re-engineering of primary health care services in ZF Mgcauwu district. Attendees who viewed the photographs were individuals and organisations well-placed to tackle some of the issues raised by Photovoice participants. They included officials from the Department of Education, the Department of Social Development, the Department of Health, community leaders and other NGOs.

MMC AT WELLNESS CENTRE IN THE WEST COAST

ONE OF THE CHALLENGES TO PROVIDING MEDICAL MALE CIRCUMCISION is sometimes space to perform the procedure. After consultation with the Department of Health, the West Coast TB/HIV Care team opened the TB/HIV Care Malmesbury Wellness Centre in July 2013. Here MMC is offered every day of the week and 2 Saturdays a month. MMC forms part of a package of HIV prevention and reproductive health services offered including HCT, TB and STI screening, condom distribution and contraception.

The site opened officially on 27th July 2013 amid much fanfare. Several important partners, such as the Mayor of Malmesbury, local general practitioners, the South African Police Service, the Traffic Department, other nongovernmental organisations and of course, the Department of Health, were invited to attend. 23 MMCs were performed on the day.

The site has a doctor, a professional nurse, two enrolled nurses and two MMC counsellors. As well as providing MMC services at the site, the team also supports the Central Karoo district and correctional facilities.
SOCIAL SUPPORT FOR CHILDREN AND FAMILIES IN BROOKLYN CHEST HOSPITAL

THIS YEAR A GRANT FROM THE NATIONAL LOTTERIES BOARD has enabled TB/HIV Care to implement a much-needed social support component to the existing care and treatment programme for children admitted with TB to the Brooklyn Chest Hospital.

Children admitted to this hospital with TB range from 0 to 13 years of age, but most are below the age of five. This is a critical period in the lives of children, and since these children may have to stay in the hospital for up to 18 months, this support programme provides the stimulation and care necessary for their development.

A structured programme, tailored to the pre-school, toddlers and infant age groups, covers areas such as music and movement, gross motor activities, creative art, educational and ‘free’ play. Some of the children have slight to severe physical and mental challenges as a result of TB meningitis. The stimulation which the activities offer these children, assists tremendously in promoting recovery.

All children from 7-13 years attend the hospital school and TB/HIV Care’s support programme offers them afterschool activities, including assistance with homework, and school holiday activities.

Because of the distances parents have to travel to visit their children in hospital, and the expense of transport, visits are often few and far between. It is important for the children to maintain contact with their parents and TB/HIV Care provides transport money to promote regular visiting.

The social worker provides a counseling service to parents and facilitates support groups at the hospital. It can be extremely difficult for a parent to adjust to a healthy child becoming disabled, sometimes severely, as a result of contracting TB meningitis. TB/HIV Care’s social worker can work with the doctors to assess the level of disability and apply for a care dependency grant through the South African Social Security Agency (SASSA).

As part of each child’s treatment plan, the social worker conducts home visits and assessments and refers families to relevant services to improve their circumstances, where this is necessary. This home assessment is also an opportunity to identify untreated adult TB cases and children under five years who need to access isoniazid preventive therapy so that they do not develop TB. The family is linked to a local community care worker to provide ongoing support to the family once the child is discharged from hospital.
STRENGTHENING TB/HIV HEALTH SYSTEMS ACROSS LOCAL AND INTERNATIONAL BORDERS

BECAUSE TB TREATMENT TAKES AT LEAST SIX MONTHS, and antiretroviral treatment is lifelong, there are a variety of factors that can interfere with a patient continuing to take their treatment as prescribed. One of these factors is migration. Many people work in a place that is far from their home. When they access treatment in a facility in one place, they may find it difficult to fetch medication if they move to another place. Sometimes patients may not know what treatment to ask for, they may not disclose that they have started treatment elsewhere or their new local health facility may just be too far away to access.

This year, TB/HIV care worked with a variety of partners to try to begin addressing these issues in an area bordering KwaZulu-Natal, the Eastern Cape and Lesotho. Initially, a series of meetings took place between the Alfred Nzo District in the Eastern Cape and the Harry Gwala District in KwaZulu-Natal as a high rate of people crossing between the districts to access health services and subsequently defaulting on their treatment or being lost to follow-up had been recorded. As a result the TB cure rates in the districts had been affected.

After several meetings, a team from TB/HIV Care undertook to trace 75 of the clients lost to follow up from the Harry Gwala District. Eventually, 36 of these clients were traced and it was discovered that the clients had moved to other neighbouring districts – including those of Ugu, OR Tambo and one in Lesotho.

The next cross border meeting therefore resolved to include these three districts in the meetings as well. The cross border meetings are now quarterly and are hosted by each district in turn. A contact person was identified for each district and sub-district managers and programme managers for each district attend. A template has been drawn up to enable all districts to formulate a single report, and a database of information and contact details is available for every district. Along with mentorship and health systems strengthening these efforts have contributed towards improving the TB cure rate in Harry Gwala.

The involvement of Lesotho in this process was assisted by an international workshop on nurse mentorship hosted by TB/HIV Care Association in November 2013. The workshop was the result of a grant awarded to TB/HIV Care as a winner of a Platinum Impumelelo Award. The National TB Programme Manager of Lesotho, Dr Llang Maama-Maime and Lesotho’s Qacha’s Nek District TB Co-ordinator, Bernard Thinyane Penane, as well as Swaziland’s Ministry of Health’s Lindiwe Dlamini and Siphiwe Ngwenya, Regional TB Co-ordinators of Hlohlo and Shiselweni, respectively, participated in site visits and discussions on the contributions of nurse mentorship to the improved TB cure rate in the Harry Gwala District.
The international study tour participants visit a local home to observe a community health worker conducting a home visit.
1. Harry Hausler, Chief Executive Officer
2. Carlos Orte, Chief Operating Officer
3. Jason Hinrichsen, Chief Financial Officer
4. Ria Grant, Senior Advisor
5. Raymond Chimaitira, HIV Prevention Programme Manager
6. Phebe Gribble, HIV/AIDS, STIs and TB Manager
7. Andrew Lambert, Key Populations Programme Manager
8. Zolani Barnes, Advocacy, Communication and Social Mobilisation Manager
9. Patricia Sterling, Training Manager
10. Juliet Schreiber, Human Resources Manager
## TB/HIV Care Areas of Operation

### Cape Town Metropole - Western Cape

**Total Staff:** 526

- **TB/HIV Prevention and Community-based Services**
  - Site Manager: 1
  - Nurse Mentors: 4
  - Medical Officer: 1
  - District Co-ordinators: 4
  - Professional Nurses: 9
  - HAST Area Co-ordinators: 11
  - Workplace Health Promotions Officer: 1
  - Educare Teacher: 1
  - Assistant Educare Teachers: 2
  - DR-TB Counsellors: 6
  - HAST Counsellors: 113
  - HAST Counsellor/Drivers: 4
  - TB Clerical Assistants: 30
  - TB Assistants: 37
  - Data Capturers: 2
  - Community Team Leader: 1
  - Area Treatment Supporters: 3
  - CCW Supervisors: 14
  - Home-based Carers: 16
  - Community Care Workers (CCW): 203
  - Community Health Workers: 9

### ZF Mgcawu District - Northern Cape

**Total Staff:** 12

- **TB/HIV Prevention**
  - Professional Nurse: 1
  - HAST Counsellors: 3
  - Community Team Leaders: 2
  - Data Capturers: 5
  - Driver: 1

- **TB/HIV Support in Correctional Services**
  - HAST Counsellors: 2

### Alfred Nzo District - Eastern Cape

**Total Staff:** 31

- **TB/HIV Prevention and Community-based Services**
  - Site Manager: 1
  - Clinical Associate: 2
  - Professional Nurses: 5
  - Enrolled Nurse: 1
  - Community Health Facilitators: 4
  - Community Team Leaders: 3
  - HAST Counsellors: 6
  - HAST Counsellor/Drivers: 2
  - Data Capturers: 6
  - Community Mobilisers: 2

### Umgungundlovu - KwaZulu-Natal

**Total Staff:** 11

- **TB/HIV Prevention in Sex Workers**
  - Professional Nurse: 1
  - Nurse Co-ordinator: 1
  - Peers: 1
  - Drivers: 2

### Harry Gwala - KwaZulu-Natal

**Total Staff:** 66

- **TB/HIV Prevention and Community-based Services**
  - Site Manager: 1
  - Nurse Mentors: 5
  - Professional Nurses: 7
  - M&E Co-ordinator: 1
  - M&E Officer: 1
  - Community Health Facilitators: 16
  - HAST Counsellors: 25
  - Data Capturer: 1
  - Drivers: 5
  - Community Mobilisers: 4

### Ethekwini Metropole - KwaZulu-Natal

**Total Staff:** 26

- **TB/HIV Prevention in Sex Workers**
  - Site Manager: 1
  - Professional Nurses: 3
  - M&E Co-ordinator: 1
  - Peers: 1
  - HAST Counsellors: 6

### Or Tambo District - Eastern Cape

**Total Staff:** 76

- **TB/HIV Prevention and Community-based Services**
  - Site Manager: 1
  - Medical Officer: 1
  - Clinical Associate: 1
  - Nurse Mentors: 4
  - Professional Nurses: 6
  - M&E Co-ordinator: 1
  - Community Team Leaders: 16
  - HAST Counsellors: 11
  - HAST Counsellor/Drivers: 3
  - Community Mobilisers: 7

### Nelson Mandela Bay Metropole - Eastern Cape

**Total Staff:** 43

- **TB/HIV Prevention in Sex Workers**
  - Key Populations Team Leader: 1
  - Professional Nurse: 1
  - HAST Counsellor: 1
  - Driver: 1

- **TB/HIV Support in Correctional Services**
  - Professional Nurse: 1
  - HAST Counsellors: 8
  - Data Capturer: 1

### Central Karoo - Northern Cape

**Total Staff:** 4

- **TB/HIV Prevention**
  - Medical Officer: 1
  - Professional Nurses: 5
  - HAST Counsellors: 4
  - Data Capturer: 1

- **TB/HIV Support in Correctional Services**
  - Professional Nurse: 1
  - Enrolled Nurses: 2
  - HAST Counsellors: 16
  - Data Capturer: 1

### Cape Winelands - Western Cape

**Total Staff:** 5

- **TB/HIV Support in Correctional Services**
  - HAST Counsellors: 5

### Eden - Western Cape

**Total Staff:** 4

- **TB/HIV Support in Correctional Services**
  - HAST Counsellors: 4
CHAIRMAN’S REPORT

OUR LAST FEW ANNUAL REPORTS HAVE DOCUMENTED TB/HIV CARE ASSOCIATION’S RAPID GROWTH. The organisation has expanded into new geographic regions, into new areas of expertise (TB in correctional services and primary health care), and is working with new target populations (sex workers and people who inject drugs). With all of this activity, it is easy to become lost in the hard work and the blur of reporting statistics.

But there are a few sobering facts that should keep us focused. Except for Swaziland, South Africa’s TB incidence rate is the highest in the world at 1003 cases per 100,000 population. And TB is still South Africa’s leading cause of death. Despite all our efforts as a country, our TB control activities are not working nearly well enough.

Similarly, while there are positive trends in the latest figures on HIV released by the Human Sciences Research Council, a smaller proportion of people were using condoms or knew how HIV is transmitted in 2012 than did in 2008.

As an organisation working in the areas of TB and HIV, we cannot afford to rest on our laurels. We need to do better. We need to be smarter. Mostly importantly, we cannot work alone.

Fortunately, I do see TB/HIV Care doing just that. The organisation is evolving quickly. Our efforts are becoming more targeted at specific populations at risk. We are using evidence to drive and refine our programmes, and we are reinforcing what has always been our strong point - providing services within the community. Our work in comprehensive primary health care builds on this strength by taking health services right into households. Our new organisational vision recognizes that communities should be in the driving seat of their own health. Through various mechanisms such as community dialogues, ‘war room’ forums, community advisory boards and Photovoice projects we are engaging with communities and bringing this vision to life.

Once these efforts, and the excellent results we see in our reports start to translate into national effects, we can regard ourselves as beginning to succeed. Until then, we must continue to strive to do better, be smarter, and work together.

LIONEL JANARI
CHAIRMAN
Nailing Your Colours to the Wall: A local artist paints a mural promoting MMC onto the wall of staff member, Sammy Petersen's home.
“We cannot win the battle against AIDS if we do not also fight TB.” - Madiba
TB/HIV CARE ASSOCIATION (THCA) CONTINUES TO GROW IN THE SCOPE OF ITS WORK AND ITS GEOGRAPHIC COVERAGE. We are now working in partnership with government to prevent, find and treat TB and HIV and strengthen primary health care services in 13 districts in four provinces in South Africa. I thank all the management and staff of THCA for their dedication and achievements and the Executive Committee for their continuing guidance and support.

South Africa has made enormous progress in its antiretroviral treatment (ART) programme with an estimated 2.5 million people on ART, the largest ART programme in the world. This has contributed to decreased HIV incidence, HIV-related morbidity and mortality, as well as an increase in life expectancy. In his health budget vote speech on 23 July 2014, South Africa’s Minister of Health, Dr Aaron Motsoaledi, joined the call made by UNAIDS at the international AIDS conference in Melbourne for a 90-90-90 target to end AIDS by 2030 with 90% of people tested for HIV, 90% of HIV-infected people on treatment and 90% of those on treatment with suppressed viral loads.

It is estimated that 470,000 South Africans are infected with HIV every year, which amounts to more than 1200 new HIV infections per day. The latest Human Sciences Research Council (HSRC) national household survey 2012 showed that HIV incidence in 15-24 year old females is 2.5% per year, which is five times higher than males in the same age group. This shows that HIV prevention efforts need to intensify for young women as they are particularly vulnerable to HIV. The HSRC survey also showed that HIV risk behaviours have increased in South Africa from 2008 to 2012 with decreasing age of sexual debut for males, decreasing condom use at last sex for both genders, and increasing multiple sexual partnerships and age-disparate sexual relationships. At the same time that access to ART needs to be expanded, HIV prevention interventions need to increase, particularly among those most vulnerable to HIV infection.

THCA is at the forefront of HIV prevention efforts to help turn off the tap of new infections. Our combination HIV prevention activities include behavioural, biomedical and structural HIV prevention interventions. In the past five years, THCA-supported sites have tested more than 1.5 million people for HIV, 30% of whom have been tested through community outreach services. In the last year alone, THCA has provided individual and small group HIV prevention interventions to more than one million people. Medical male circumcision (MMC) has been shown to decrease the risk of HIV infection by 60% in men. We have begun to overcome sociocultural barriers and are providing MMC in the Eastern Cape in harmony with traditional practices. In all, THCA has circumcised 14,340 men in South Africa in the past year. Our structural HIV prevention efforts are working towards gender equity and the prevention of gender-based violence.

An analysis by the South African Centre for Epidemiological Modelling and Analysis (SACEMA) in 2010 estimated that, of new HIV infections in South Africa, 19.8% were among sex workers, their partners or their clients and 1.3% were among injection drug users or their partners. HIV prevention in these populations is therefore critically important for their health as well as for HIV prevention in the general population in South Africa. As a result, THCA has spearheaded peer-led mobile outreach services to bring respectful, client-centred services to these key populations. Our HIV prevention in sex workers services have been recognized as a best practice model by the Centers for Disease Control and Prevention (CDC) because they reach 80% of sex workers in identified sex work locations on a 3 monthly basis with HIV, TB and STI screening services and ensure that sex workers are linked to the clinical and social services that they need. In the past year, THCA has provided health screening to
2437 sex workers. THCA has also created community advisory boards (CAB) to help guide our project of harm reduction that will provide needle syringe distribution and opiate substitution treatment to people who inject drugs. A clarion call for key populations is ‘Nothing about us without us’. THCA’s programmes are anchored in this approach and are guided by monthly CAB meetings that reflect on whether their needs are being met adequately and appropriately.

Another key population that requires urgent attention is inmates in correctional services. Inmates are particularly vulnerable to both HIV and TB and require focused efforts on TB and HIV screening, linkage to care and retention in care. THCA has been fortunate to receive funding from the Global Fund Against AIDS, TB and Malaria through the National Department of Health (NDOH) and Right to Care (RTC) to prevent, find and treat TB and HIV in correctional facilities throughout the Western and Eastern Cape provinces as well as in two management areas in KwaZulu-Natal. THCA is helping to implement national guidelines on HIV, TB and STIs for correctional services that require that all inmates are screened on admission, biannually and on release. In the past year, THCA has tested 24 627 inmates for HIV and screened 36 427 inmates for TB, resulting in 450 inmates started on TB treatment.

THCA received continuation funding last year from the Stop TB Partnership for its TB REACH project in Harry Gwala district. The project aims to increase TB case finding through HIV counseling and testing, Xpert MTB/RIF (GeneXpert) implementation and household contact tracing. From April 2013 to March 2014, 4020 TB patients were diagnosed and started on TB treatment in Harry Gwala. As a result of district-wide GeneXpert implementation and the employment of community health facilitators who ensured that positive GeneXpert results were communicated to clinics and community health workers, the time from sputum collection to initiation of TB treatment decreased for both drug susceptible and drug-resistant TB. Through mentorship and continuous quality improvement, new smear-positive TB cure rates increased from 73% for patients registered in the first quarter of 2012 to 83% for patients registered in the first quarter of 2013. THCA and Harry Gwala district received a KwaZulu-Natal MEC for Health Service Excellence Award for the mentorship programme in February 2014.

THCA is a non-profit organization grounded in its values of professionalism, empowerment, appreciation and respect. We advocate for social justice and the promotion of health as a human right. I am able to advocate for these issues in my position as Deputy Chair of the NGO Sector and as a member of the Treatment, Care and Support Technical Task Team and the Programme Review Committee of the South African National AIDS Council (SANAC) as well as the Western Cape Provincial Council on AIDS. We recognize that our role is to support and extend the reach of government in partnership with other nongovernmental organisations and the private sector so that we achieve equitable access to essential services and create healthy communities. It is an honour for me to be part of an inspiring team of committed and caring individuals at THCA who strive to create a better future for all of us.

HARRY HAUSLER
CHIEF EXECUTIVE OFFICER

WHAT’S YOUR GENDA AGENDA?: Some of the entries to the ‘What’s your Genda Agenda?’ campaign run in partnership with SABC 2’s youth television show ‘Hectic Nine-9’. Young people posted photos representing their gender challenges to Facebook, and the winner was featured on the ‘Hectic Nine-9’ show.
TEAM SPIRIT: Some of the Khayelitsha team demonstrate the energy that keeps the community engaged throughout a long outreach event.
IT’S NOW THREE YEARS SINCE I STARTED WRITING THIS ANNUAL REPORT and looking back at the transformation of the organization in this time gives me a lot of pleasure. My mandate is to ensure that the organization is fit to enable the best quality of service delivery and to ensure that it operates efficiently. With this in mind, during last year we have focused on strengthening the processes and systems that we started in the previous years. Our financial systems are now more robust than ever, and our human resources processes are becoming increasingly more refined.

We are well on the way to becoming the organisation that we want to be. At our strategic workshop last year we set the foundation and sketched the plans for taking our ideas further. A year has passed and I feel proud to start seeing the progress we are making. All this hard work is paying off.

We have been recognized by our funders and partners as an organization they want to work with and a good, solid partner that delivers. We have secured funding for another year from the Provincial Government of the Western Cape, PEPFAR continues to fund a lot of our work, and we have been selected as one of three organizations in the country to support the Department of Correctional Services with their TB and HIV prevention programs. Our work with key populations is regarded as a best practice model. We continue to be invited to be part of many different task teams, conferences and meetings at various different levels where we continue to advocate for improved services for all.

With all this work, many of us sometimes feel stretched and under pressure. Expanding our Employee Assistance Program has allowed us to reach each and every one of our service delivery staff and ensure that their voices are heard and their needs met in the best way possible. We are only as strong as our people, and that is reflected in our revised values of professionalism, empowerment, appreciation and respect. These values were selected by all our staff, and they really embody what the organization is about.

We have many challenges, but we will continue to work to resolve them. We will continue to strive to improve and streamline systems and processes to provide better and innovative services of good quality to all, whilst delivering value for money to our funders.

CARLOS ORTE
CHIEF OPERATING OFFICER
**SENIOR ADVISOR’ S REPORT**

**THIS YEAR HAS BEEN ANOTHER BUSY ONE,** with much of my work focused on international advocacy for TB and HIV.

I have been serving as the Lead Communications Focal Point with the Developing Country NGO Delegation to the Global Fund since September 2012 and have thoroughly enjoyed my time in this position. Before I joined the delegation, the Global Fund was something very far away in Geneva, which distributed grants for AIDS, TB and Malaria. It has been a wonderful experience being one of the many cogs in the wheel which turns one of the world’s largest financial instruments to fight these dreaded diseases.

As the Communications Focal Point, I have been responsible for organising the logistics for a retreat in Macedonia, a second one in Thailand and board meetings in Sri Lanka, Indonesia and Geneva. Moving people from around the world to a central position has its challenges and I am very grateful for the support I have had from Vivienne Evert, TB/HIV Care’s Travel and Logistics Co-ordinator. In February 2014, this communications role was converted to a full-time permanent position and I handed over the reins to Jomain McKenzie in Kingston, Jamaica.

My involvement with the Developing Country NGO Delegation has also allowed me to serve on civil society task teams and to attend training sessions on the new funding model of the Global Fund. In these forums, there is often an opportunity to promote TB/HIV Care’s work, and to share our experiences with civil society networks. In addition I am able to make regular contact with some of our funders.

Here at home I have also been representing the organisation. I was the co-coordinator of the ‘Financial Risk for NGOs in Community Management Forum’ workshop held in Cape Town, where representatives from many African countries shared their best practice models. I was also appointed to serve on the Board of the Brooklyn Chest Hospital in Cape Town for another 3 years and am the current chairperson.

Despite all my travelling during the year, I kept a finger on the pulse of TB/HIV Care’s operational workings by attending staff and executive committee meetings. It is a privilege to be in a position to see both the international context of policies and the way in which they affect our local implementation.

I am very proud of this 85 year old organisation which has essentially not deviated from the goals set in 1929, and which has become renowned for its work in tuberculosis and HIV across the globe. Within the organisation we are aware that the contribution of the community care worker walking the streets of Khayelitsha or Mitchells Plain or Du Noon, caring for her patients, is as great as our largest funder.

**RIA GRANT**

**SENIOR ADVISOR**
SERVICE FOR ALL: TB/HIV Care provides health services in the humblest and the grandest settings – in this case the South African parliament.
PROGRESS REPORT

TB/HIV CARE ASSOCIATION WORKS ON SEVERAL FRONTS TO PREVENT, FIND AND TREAT TB AND HIV. Our combination HIV prevention package offers a comprehensive package of interventions to the general populations at large, but particularly those between 15-49 years old. These include biomedical, behavioural and structural interventions. The work we are doing in supporting the national department of health’s re-engineering of primary health care similarly aims at improving access to health care for the general population by providing services within the community. In addition, TB/HIV Care’s strategy also targets populations most at risk and key to the onward transmission of diseases, and we have specialised programmes aimed at commercial sex workers, people who inject drugs and inmates and officials in correctional services.

1. COMBINATION HIV PREVENTION

BEHAVIOURAL HIV PREVENTION INTERVENTIONS

a) HIV counselling and testing linked to TB and STI

SINCE 2007, TB/HIV CARE ASSOCIATION HAS PROVIDED integrated TB/HIV/STI prevention and support services through its HIV counselling and testing (HCT) programme, including screening for TB and STIs. To conduct HCT, TB/HIV Care employs 21 community-based teams, each consisting of a professional nurse counsellor and three lay counsellors/community mobilisers, as well as lay counsellors based within health facilities.

HCT is an integral part of HIV prevention, and can be regarded as a behavioural intervention. Both community- and facility-based lay counsellors play an important role in communicating HIV prevention messages; including promoting condom use and mobilising males that are HIV negative to undertake medical male circumcision.

Each person who is tested is encouraged, through post-test counselling, to develop a risk-reduction plan based on their test result. HIV negative individuals can decide which behavioural methods of HIV prevention; including condom usage, reducing their number of sexual partners or delaying the onset of sexual debut, they are willing to adopt. HIV positive individuals can also plan with their counsellor how best to protect themselves and their partners through adopting different behaviours.

In year 2013/14 there has been a considerable increase in HCT compared to 2012/13 both in community-based HCT (9698 more tests or a 7% increase) and facility-based HCT (42,774 more tests or a 16% increase). (Figure 1)

The HCT programme’s package of care has evolved to provide HIV positive clients with point of care CD4 testing using the Pima™ machine. All HIV positive clients also receive World Health Organisation (WHO) clinical staging. Clients who are eligible for antiretroviral therapy (ART) are referred for ART initiation. Clients with STI symptoms are referred to a health facility of their choice, and the sputa of TB symptomatic clients are collected to be sent for laboratory testing.
MARCHING FOR HUMAN RIGHTS: TB/HIV Care joins a march to the International Conference on AIDS and STIs in Africa (ICASA) in Cape Town.
All of these interventions have potential preventive effects - for example, starting eligible patients on life-saving ART will also decrease their ability to transmit the virus and treating clients for a sexually-transmitted infection reduces their risk of acquiring HIV. However all of these interventions depend on the successful referral of clients to other services.

Since 2013, there has been a focus on strengthening the linkage of clients from our non-medical sites into healthcare facilities.

Between April 2013 and March 2014, the community-based HCT teams tested 147,102 people. Of the 2,378 people who tested positive for HIV, 83% were provided with a CD4 count. Of the 586 people tested who were eligible for ART, 86% were successfully referred to a facility and 69% were started on ART. (Figure 2)
Care for TB symptomatic individuals increased by 35% from the previous year. Of people with TB symptoms, 78% reached a health facility. Of these, all but two individuals had sputum collected. 96 people were diagnosed with TB, and 93 (97%) were started on TB treatment. (Figure 3)

1214 individuals with symptoms of a sexually-transmitted infection were found by the community-based HCT teams of whom 1032 (85%) were successfully referred to a health facility where they could receive treatment.

The strategies that have been employed to strengthen the referral system are: the standardization of a referral toolkit which includes a referral letter, a referral card, a list of TB/HIV Care staff contacts in health facilities, a tracking tool and a referral register, the verification of the client’s contact number while they are still within the counselling setting, the expansion of the counselling session for those who test positive with additional time spent on the risk reduction plan and the provision of the professional nurse’s contact number, and the forging of links between the community-based HCT team and the local health facility prior to an outreach event.

b) Sexual and other behavioural risk HIV prevention interventions

During the reporting period, TB/HIV Care continued implementing behavioural interventions to minimise sexual risk or to increase protective behaviours targeting the general population and the youth. The interventions addressed social norms, including reducing intergenerational and transactional sex, multiple and concurrent sexual partners, condom promotion, condom skills training and distribution, delaying sexual debut, promoting medical male circumcisions (MMC), promoting and providing HCT including partner testing and disclosure, and referrals for post exposure prophylaxis (PEP) and prevention of mother to child transmission of HIV (PMTCT) services. 1 945 924 female and 8 285 117 male condoms were distributed.

The target group is clients aged 15 to 49 years and includes mobile workers (seasonal farm workers, migrant miners, truck drivers), prisoners, young girls in or out of school in peri-urban areas and HIV-negative men for MMC. The interventions continued to evolve in an iterative process in response to the clients’ needs and lessons learned. Individual and small group interventions were delivered in a variety of settings including workplaces, schools and tertiary education institutions, health care facilities, home visits and through mobile teams.
The sexual and other behavioural risk HIV prevention interventions reached 1 088 267 individuals. (Figure 4)

The interventions also reached 30 235 offenders inside correctional facilities and 1 485 other vulnerable populations, including sex workers, military populations, migrant farm workers, and truck drivers.

A specialised subset of this programme is the workplace programme which focuses on bringing health services, including sexual and behavioural risk reduction interventions, to employees at their place of work. Lower-income employees may not be able to afford health insurance or the time off work to attend public health facilities. An on-site health service is therefore an effective way to reach this group. Through information sessions, the workplace co-ordinator discusses TB/HIV/STI prevention, post-exposure prophylaxis, emergency contraception, condom demonstrations, chronic diseases of lifestyle and male medical circumcision. Employees can receive support for TB treatment at work, and the workplace co-ordinator addresses any fears and concerns around TB in the workplace by providing education about the disease. 206 304 individuals were reached by the workplace programme this year. (Figure 5)
c) Positive health, dignity and prevention (PHDP) interventions

HIV PREVENTION EFFORTS HAVE PRIMARILY FOCUSED ON HIV-NEGATIVE INDIVIDUALS; however, a recent paradigm shift has focused greater attention on prevention among persons living with HIV (PLWH). Changes in the risk behaviours of HIV-infected individuals are likely to have larger effects on the transmission of HIV than comparable changes in the risk behaviours of HIV-negative individuals.

Helping people living with HIV adopt safer behaviours is an important component of the THCA comprehensive HIV prevention approach. The package of interventions provided includes the following set of services and messages: HCT for sex partners and family members, counseling and support for serodiscordant couples, support for disclosure to sex partners and family members; assessment of sexual and reproductive health/family planning needs including promotion of safer sex (consistent condom use, reduction in number of sexual partners and concurrent partners), STI screening and treatment; adherence counseling for clients on antiretroviral therapy (ART), retention in care with 6 monthly CD4 counts for clients not yet eligible for ART and treatment for opportunistic infections (including TB). These prevention efforts with PLWH aim to protect the health of infected individuals and to prevent the transmission of HIV to sex partners and infants born to HIV-infected mothers.

During the reporting period 77,663 individuals were reached with stand-alone PHDP interventions, including newly tested HIV positive individuals and known persons living with HIV (PLHIV). The numbers reached represent a 28% increase from the previous year during which 60,641 individuals were reached.

The NDOH provided training to 10 THCA professional nurses on PHDP as well as training of trainers to three managers and five professional nurses on syndromic management of STIs this year.

d) Community dialogues

THCA USES COMMUNITY DIALOGUES to offer local stakeholders the opportunity to discuss health issues specific to their community and to create solutions that will work locally.

A community dialogue was held in Kakamas in the Northern Cape on the 31st October 2013. The event was attended by members of the community, the DOH, church groups, Lovelife and Lifeline. The issues identified as affecting the community included teenage pregnancy, alcohol and substance abuse, poor parenting skills, inadequate housing, and inadequate service delivery by the South African Police Service and the Department of Social Development (DSD). The community then formulated a plan to address these issues.

In OR Tambo and the Umgungundlovu districts, TB/HIV Care partnered with the Community Media Trust to conduct several community dialogues within schools. The aim of these dialogues was to address the issue of teenage pregnancy. Stakeholders who participated included the local primary health care facilities, DSD, parents, local municipalities, school educators and school governing body representatives. The most common challenge learners identified as contributing to teenage pregnancy was the attitude of local clinic staff. Learners reported that they find it extremely difficult to visit the neighbouring clinics to access sexual and reproductive health (SRH) services due to the highly negative behavior shown towards them by health workers. Parents and teachers also shared the same concern stating that even if the learners have been referred to the local clinic, they hardly ever receive the full package of SRH services they have been referred for. Stakeholders agreed that having SRH services offered at the school would offer an interim solution.
Medical male circumcision (MMC) as part of its biomedical interventions to prevent HIV, TB/HIV care started a medical male circumcision (MMC) programme in October 2012. During the reporting period, THCA provided MMC services in 60 sites in ten districts: Buffalo City Municipality, Alfred Nzo, Cacadu, Nelson Mandela Bay Municipality and OR Tambo (Eastern Cape); Harry Gwala (KwaZulu-Natal); and City of Cape Town, Central Karoo, Eden, and West Coast (Western Cape). THCA has set up three fixed sites in East London, Port Elizabeth and Malmesbury, while the rest of the MMC services are provided by roving teams in collaboration with the DOH as outreach services in DOH facilities.

During the reporting period 14,360 males were circumcised as part of the HIV prevention programme. This represents a significant increase from the 2,258 males circumcised during the first six months of the programme (1 October 2012 to 31 March 2013). There is also seasonal fluctuation, with most males preferring to be circumcised during the cooler winter months. (Figure 6). Number of men circumcised by district. (Figure 7).

Clinical mentorship to provide ART through nurse initiated & managed ART

On effective ART can be greatly reduced to an undetectable level. In this situation, the risk of transmission of HIV is markedly reduced and ART can be regarded as a form of HIV prevention. However, as the number of clients requiring ART increases, health facilities come under increased pressure to meet the growing demand for the supply, initiation and management of ART. Nurse initiated and managed ART (NIMART) enables patients to be started on ART.
without the presence of a doctor. Through experienced nurse mentors, TB/HIV Care within the Cape Metro has mentored and enabled many nurses to provide NIMART in the Khayelitsha and Southern sub-district. During the 2013-2014 financial year 12 nurses (10 from Khayelitsha and 2 from Southern sub-districts) were trained and mentored on the NIMART programme by TB/HIV Care's nurse mentors. This up-skilling of nurses has helped more clients to access ART at more facilities. As a result, this year 1611 new clients were initiated on ART by THCA mentored nurses.

STRUCTURAL HIV PREVENTION INTERVENTIONS ADDRESSING GENDER EQUITY AND MASCULINITY NORMS

A STUDY PUBLISHED BY THE MEDICAL RESEARCH COUNCIL (MRC) suggests that women with violent or controlling partners are at greater risk of HIV infection, with 12% of HIV cases among women associated with more than one case of violence from an intimate partner. Dealing with gender-based violence and gender norms that increase vulnerability to HIV is therefore considered an important part of HIV prevention. TB/HIV Care has implemented two programmes to address this issue; Stepping Stones and the Zazi campaign.

A) STEPPING STONES

STEPPING STONES IS AN INTERNATIONAL PROGRAMME that aims to improve communication between sexual partners and to examine gender norms. It is one of the few programmes addressing gender norms at an individual level to have been scientifically evaluated. A study published by the British Medical Journal found that Stepping Stones reduced the risk factors for HIV transmission; those who participated in the programme were 33% less likely to acquire genital herpes than those who did not, and the proportion of men reporting perpetrating intimate partner violence and problem drinking was reduced.

Some of the benefits reported are increased knowledge around issues such as HIV, contraception, MMC, condom use and basic human rights. Behaviour changes have been observed in the areas of better listening and negotiation skills regarding sexual issues, and the ability of parents to talk with their children about issues around HIV and gender.

In mid-2013 Stepping Stones was introduced into several of the schools in the district and has received support from the local department of education.

b) The Zazi Campaign

THE ZAZI INITIATIVE is a partnership between the South African National AIDS Council (SANAC), DOH, DSD and civil society. The programme focuses on sexual and reproductive health and HIV prevention for women and girls. Two THCA staff were trained as master trainers on this programme, and have since held four facilitator courses, reaching 78 staff in the Cape Metro, West Coast and OR Tambo districts. These 78 staff members are now able to implement Zazi in their communities and have already held several workshops for local groups. In one case, the interest in the programme from boys in the community was so great that the facilitator formed a boys group as well.
2. TARGETING KEY POPULATIONS
SEX WORKER HIV PREVENTION PROJECT

IT IS ESTIMATED THAT 20% OF NEW HIV INFECTIONS IN SOUTH AFRICA are in sex workers, their partners or their clients. It is therefore critically important to implement HIV prevention interventions for sex workers to protect them from HIV as well as to effectively prevent HIV transmission throughout the country. TB/HIV Care, in collaboration with the Departments of Health (DoH), and partners in the provinces in which they work in the Western Cape, Eastern Cape, and Kwa-Zulu Natal, are finding ways to do just this. TB/HIV Care’s comprehensive sex worker peer-linked mobile HIV prevention and wellness project for sex workers provides an enhanced package of HIV prevention, health, wellness and human rights services to sex workers where they work. This is achieved by fusing TB/HIV Care’s mobile HIV/AIDS/STI/TB (HAST) screening and linkage-to-care model with working with the DoH to improve pathways into local clinics and other support structures.

The success of TB/HIV Care’s model has led to its expansion into other parts of South Africa. The sex work mobile wellness clinics can now be seen operating and providing sex worker and sex work industry friendly services in the Cape Town Metro in the Western Cape, the eThekwini and uMgungundlovu Municipalities in KwaZulu-Natal, and the Nelson Mandela Bay Municipality and OR Tambo district in the Eastern Cape.

This past year has seen an increase in the number of sex workers who have accessed services and been linked to care and support. Last year, from April 2012 to March 2013, TB/HIV Care provided 2437 health screens to sex workers. This year, from April 2013 to March 2014 that number increased by 30% to 3164. Overall successful linkage to HIV care rates for HIV positive sex workers across all our sex work sites also increased between the same periods from 31% (236/746) to 38% (309/804). Our ability to provide point of care CD4 tests to HIV positive individuals assists with linking HIV positive individuals eligible to begin ART (CD4<350) with care. The percentage rose between the same period from 43% (97/224) to 49% (138/280). Our coverage model to reach all identified sex work locations with full health screening every three-five months, allows us to then try and reconnect with those that needed to be linked to treatment, care and support when they come back for another health screen. Our new linkage to care peer navigation system model has been partly responsible for this increase and is being employed in all of our sex work HIV prevention sites. This system consists of using the same peer mobilisers who provide accompanied (escorted) support to sex workers to receive HIV/ TB/STI and other psycho social screenings at the THCA mobile health unit to assist those sex workers that are in need of onward referrals to clinics for further care and support.

Our clinic and law enforcement sensitivity trainings aim to decrease stigma and discrimination and, together with continual key population community engagement, risk reduction meetings and support groups, will contribute to improved health seeking behaviours.
PEOPLE WHO INJECT DRUGS (PWID) HARM REDUCTION PROJECT

PEOPLE WHO INJECT DRUGS (PWID) IN SOUTH AFRICA are at high risk for HIV due to unsafe injecting and risky sexual practices. The World Health Organisation, United Nations Office on Drugs and Crime (UNODC) and UNAIDS have recommended a comprehensive package of services for PWID. TB/HIV Care Association and OUT LGBT Well-being (OUT) supported by CDC, PEPFAR and UNODC will implement a demonstration project providing a package of services to PWID in Cape Town, Durban, and Pretoria. This project aims to develop best practice models and recommendations for HIV prevention in PWID for the South African context.

Services will be provided through mobile outreach services (supported by fixed service centres both in Durban and Cape Town). Extensive engagement with relevant stakeholders and community members has been happening since the start of programme and will continue throughout.

Services will include an HIV, TB, STI, drug use and wellness screening, behavior change interventions, HIV prevention and harm reduction commodities, hygiene packs, medication assisted treatment (MAT), support groups and referrals to appropriate services.

Drop in centres will be available in Durban and Cape Town to provide ‘safe spaces’ for clients to access services and undergo the MAT selection process. Outreach services will access clients in the community. This programme will have a comprehensive monitoring and evaluation element so that lessons can be learned for wider implementation.

TB/HIV SERVICES FOR INMATES AND OFFICIALS IN CORRECTIONAL SERVICES SETTINGS PROGRAMME

a) HIV Counselling and Testing Linked to Screening and Testing for TB in Correctional Services

THROUGHOUT THE WORLD, prison populations have higher rates of TB and HIV than the general population. Because of the overcrowding and poor ventilation often found in prison settings, prisons have even been termed ‘amplifiers’ of the TB epidemic. Inmates and officials within correctional services can therefore be regarded as one of the populations most at risk of TB and HIV and key to stopping the onward transmission of disease.

TB/HIV Care has been supporting TB and HIV health services in correctional facilities in the Western Cape since 2008. This year, TB/HIV Care continued providing the HCT and TB/STI screening in correctional facilities in the Western Cape (Allandale, Brandvlei, Drakenstein, Malmesbury, Pollsmoor and Southern Cape Management Areas) and the on-site GeneXpert diagnosis in Pollsmoor management area that had been offered the previous year. The National Department of Correctional Services (DCS) provided TB/HIV Care with ‘national quality assurance’ for all six DCS regions. In addition, these services including TB testing by means of GeneXpert were extended to the St Albans and Mthatha management areas in January 2014.

Within the areas where the standard HCT package was offered over the course of the year, 24 627 inmates accepted HIV counselling and testing. Of those 1342 (5,5%) tested HIV positive of whom 1265 (94%) were referred for CD4 testing, but only 781 (62%) had blood drawn for the CD4 count, and only 651 (83%) of those received their CD4 count test result.
Systems need to be strengthened to ensure that HIV-positive inmates have blood drawn for CD4 tests and obtain CD4 results. To try and close this gap in care, enrolled nurses with phlebotomy skills were employed. They are overseen by professional nurses and have to ensure that bloods are drawn for the CD4 count on the day the inmate is diagnosed as HIV-positive. (Figure 8)

Within Pollsmoor, Mthatha and St Albans management areas TB sputa samples are tested by GeneXpert, either by an on-site machine or at the National Health Laboratory Service (NHL5).

36 427 inmates were screened for TB by GeneXpert in these areas. These include routine screening of all new admissions and mass biannual screening of incarcerated inmates for TB, that may not include HCT. Of the inmates screened, 6997 (19%) had TB symptoms and 6324 (90%) had GeneXpert tests, from which 6217 (98%) results were obtained. Of these, 465 (7.5%) inmates were found to have TB of whom 15 (3.2%) inmates had TB resistant to rifampicin. Of the inmates diagnosed with TB, 450 (97%) were initiated on TB treatment and the others were released.

The TB services need support in closing the gaps between sputum specimens being collected, sent to the laboratory, obtaining results and initiating treatment. Follow up on test results and initiating treatment for those who test positive is critical. Data capturers will ensure that the results are communicated and filed in the inmates’ records.

THCA has helped to establish continuum of care meetings in the management areas that it supports. These meeting occur on a monthly basis and include representatives from DCS, DOH, the National Health Laboratory Service (NHL5) and THCA. The meetings review the treatment cascade for HIV and TB to identify gaps in obtaining laboratory results and initiation of treatment. The meetings also coordinate household contact tracing in homes of recently admitted inmates who have been diagnosed with TB and track recently released inmates on TB treatment or ART to ensure that they continue their treatment in the community. (Figure 9)
b) Kick TB/HIV programme to educate on TB and HIV

The OBJECTIVE OF THE KICK TB/HIV PROGRAMME is to create TB and HIV awareness by fusing soccer and social mobilization to create an engaging platform through which appropriate TB and HIV messages can be conveyed to inmates.

The TB/HIV Care advocacy, communications, and social mobilisation (ACSM) team started the Kick TB/HIV programme roadshow in correctional facilities on 4 March 2014.

Each Kick TB/HIV activation includes an impromptu dance competition, an interactive question and answer session where inmates are given the opportunity to engage with information on TB and HIV, and a kicking activity where a ball branded with signs and symptoms of TB is kicked into a goalpost. These activities involve inmates in the learning experience which ideally promotes better retention and internalization of the information given.

TB/HIV Care counsellors are present at some of the activations or offer HCT services the following day.

The ACSM team completed 30 activation activities in Pollsmoor, Malmesbury, St Albans and Goodwood Correctional Facilities. 5373 inmates were reached with TB and HIV information within a single month. As a result of the activations, 366 inmates tested for HIV and screened for TB, eight inmates were found to be HIV positive and 134 were found to have TB symptoms and were successfully referred for sputum collection.

c) Peer education on TB/HIV for inmates

PEER EDUCATOR TRAINING was provided to 14 staff and prisoners in the female prison at Pollsmoor, focusing on TB, HIV and ART. Information on TB or HIV that comes from a peer may be more easily understood by inmates than education from health workers so peer education can reinforce education provided by nurses and counselors.
3. SUPPORTING THE RE-ENGINEERING OF PRIMARY HEALTH CARE TO REDUCE MATERNAL AND CHILDHOOD MORTALITY

WARD-BASED OUTREACH TEAMS

THE HCT PROGRAMME IN KWAZULU-NATAL, Eastern Cape and Northern Cape provinces has evolved into ward-based outreach teams (WBOT) providing a comprehensive package of care within wards in collaboration with other government departments. This model is part of the strategy of the re-engineering of primary health care envisaged by the NDOH.

The service has now become more than a screening service and is instead a wellness service. The HCT programme’s extended wellness package consists of blood pressure checks, glucose checks, body mass index measurements, providing pregnancy testing, contraception, emergency contraception and post exposure prophylaxis.

The purpose of the ward-based outreach teams is to proactively offer services to hard-to-reach individuals by covering all households within a certain geographic area instead of waiting for individuals to access services at their local clinics.

FAMILY HEALTH TEAMS ASSIST WITH COMMUNITY-BASED CHILD REGISTRATION AND MALNUTRITION ASSESSMENT

AT THE REQUEST OF THE HARRY GWALA DISTRICT MANAGEMENT, TB/HIV Care began to transition its HCT teams into family health teams (the name for ward based outreach teams in KwaZulu-Natal) at the end of 2012. TB/HIV Care, with the assistance of funding from Edzimkulu, arranged for the new family health teams to be trained on community integrated management of child illnesses (CIMCI).

A district task team met with the subdistrict multisectoral teams to select the six pilot sites where the teams would operate. At the local ‘war room’ meetings of community stakeholders and government departments, the family health teams were introduced and their proposed activities were demonstrated through the use of role-play.

After the war room had chosen the areas best suited to provide services, children under five in the area were registered by the family health teams so that their progress could be followed.

A web-based tracking tool from Edzimkulu showed evidence of increased numbers of children under five with HIV found and linked to care, decreased infant mortality, and increased exclusive breast-feeding. The rate of childhood malnutrition in each area was also tracked.

4. TB REACH

INCREASING TB CASE FINDING & DECREASING TIME TO TREATMENT

TB/HIV CARE ASSOCIATION RECEIVED A TB REACH GRANT from the Stop TB Partnership to increase TB case finding and treatment in Harry Gwala district in KZN through TB screening and sputum collection by mobile HCT teams and community health workers (CHWs), and the implementation of GeneXpert testing.
When a TB case is diagnosed, the patient receives counseling from a community health facilitator (CHF) who links the patient with a CHW. The CHW visits their house to offer HCT and screen their contacts for TB. CHWs collect sputum from symptomatic contacts and refer children less than five years for initiation on isoniazid preventive therapy. All TB tests are performed by a GeneXpert instrument, that allows diagnosis of drug susceptible and rifampicin resistant TB in two hours. This programme was made possible through a collaboration between THCA, DOH and the National Health Laboratory Service (NHLS). CHFs played an important role in linking facilities and communities; informing facilities and CHWs of positive results so that clients are recalled to start TB treatment. TB/HIV care’s nurse mentor and CHFs act as a safety net, ensuring that all clients diagnosed with TB are started on treatment. One of the most exciting results of this programme was that from the period April-June 2011 to January-March 2013, the time to treatment for drug-susceptible TB cases decreased from 9.2 days to four days and, for rifampicin-resistant TB, decreased from 4.5 months to less than one week.

Through TB REACH, THCA also supported the national initiative for decentralization of drug-resistant (DRTB) TB treatment. THCA trained the local TB hospital to initiate patients on DRTB treatment, validate their diagnosis and provide outpatient treatment to smear-negative patients by outreach injection teams. Instead of having to transport patients 150 km to King George V Hospital, DRTB patients were hospitalized in their home district until they were no longer infectious and then discharged to recover in their own homes.

This year, the initiative has resulted in the diagnosis of 4020 new TB patients. Since the beginning of the project in 2008, the TB cure rate in the Harry Gwala district has risen from 44% to 83% for 2013.

CONTINUOUS QUALITY IMPROVEMENT TO DECREASE MATERNAL MORTALITY FROM TB

TUBERCULOSIS HAS EMERGED AS A MAJOR CONTRIBUTOR to maternal mortality in high prevalence HIV settings. The Harry Gwala district of KwaZulu-Natal has an antenatal HIV prevalence rate of 35%. Early case finding and treatment of HIV and HIV/TB co-infected women in antenatal care is therefore essential to preventing maternal deaths.

Through the Stop TB partnership’s TB REACH funding, TB/HIV Care began operational research on the contribution of continuous quality improvement (CQI) methods to increase TB screening and integrate TB, HIV and antenatal services.

Quality improvements methods included setting aims, mapping care processes, identifying gaps in care, root cause analysis of barriers to implementation, selecting change ideas to address the barriers, and the use of the ‘plan, do, study, act’ model.

Quality improvement cohort tools were developed and were used to audit the data in the registers to ensure that all clinic patients received the standard of care outlined in the guidelines. This was done at an individual patient level so that where gaps in care were identified, patients could be recalled. The cohort tool evaluated the performance of the PmTcT program at a clinic level and this was discussed at monthly multidisciplinary team meetings. Where changes were needed, an improvement plan was developed.

Monthly application of the cohort tool improved the completeness and accuracy of the antenatal care registers - providing valid data for assessing performance.
The intervention achieved significant improvements across multiple care processes in the HIV/TB management of pregnant women. CQI resulted in an increase in TB screening of pregnant women and isoniazid preventive therapy for HIV-positive pregnant women who were asymptomatic for TB. However, excellent reliability (>95%) of ART initiation was achieved only in the sustainability period when nurse initiated management of ART (NIMART) was introduced through a policy change.

5. ADVOCACY, COMMUNICATION AND SOCIAL MOBILISATION

INTERNATIONAL AND LOCAL ADVOCACY EFFORTS

TB/HIV CARE USES ADVOCACY to ensure that decision-makers remain strongly committed to TB and HIV issues. Advocacy initiatives took place at international level through the work of the Senior Advisor on the Global Fund’s Developing Country NGO Delegation and of the CEO on the Global Coalition of TB Activists, and at national level through the CEO’s work on the South African National AIDS Council’s (SANAC) Civil Society Forum and Programme Review Committee.

BEHAVIOUR CHANGE COMMUNICATION

BEHAVIOUR CHANGE COMMUNICATION is one of the core aspects of TB/HIV Care’s services and spans all programme areas. To reinforce the messages of counselling and group sessions, information and educational communication material such as pamphlets and flyers are provided to clients. An MMC guide focusing on the care of the circumcision wound was developed to assist men who have undergone circumcision.

TB/HIV Care develops online campaigns to complement its other activities. To commemorate youth month, TB/HIV Care partnered with SABC 2’s popular youth television show, Hectic Nine-9 to create a social media campaign to engage young people. The campaign asked young people to take photographs expressing their ‘genda agenda’; how they experience gender as either empowering or restrictive, and to load these onto a Facebook page. Since gender inequality is regarded as a key driver of the HIV epidemic, the objective of this campaign was to identify gender issues that young people feel are important.

Gender and communication again featured in an online 16 days of activism campaign. The campaign proposed ‘16 days of everyday activism’ and gave participants a daily idea (via tweet, Facebook and the website) of a simple act of everyday activism they could perform for that day. The campaign encouraged participants to look at the resources available in their own communities, and within themselves, to help prevent gender-based violence and violence against children.

SOCIAL MOBILISATION FOR MMC AND WORLD TB DAY

ONE OF THE RESPONSIBILITIES THAT ACSM IS TASKED WITH is to increase the demand for medical male circumcision (MMC). As described in the highlights section, TB/HIV Care engaged traditional leaders through extensive meetings and workshops to explore ways to integrate traditional circumcision with MMC through meetings and workshops. The Pondoland queen and her princess invited TB/HIV Care to meet to discuss traditional circumcision and MMC.

Every year TB/HIV Care supports and hosts TB-related events in commemoration of World TB Day, 24 March. This year TB/HIV Care supported and hosted 35 events across the various districts in which the organisation operates. These events included community...
events where HCT services were offered, a high profile event in the Eastern Cape with the Eastern Cape’s MEC for Health, and Kick TB/HIV activations in correctional facilities.

In total 4760 people were tested for HIV, 5274 were screened for TB and 4704 were screened for STIs. 58 people tested HIV positive and 722 people were found to have TB symptoms. During these events, 20 282 people were reached through behavioural change interventions, 114 620 condoms were distributed and a total of 340 males were recruited for MMC.

6. TRAINING

THE TB/HIV CARE TRAINING UNIT provides services to both internal staff as well as to partners in the health sector. Training is an important part of ensuring quality health services. It provides staff with additional, necessary skills as well as updates on clinical developments in the field of TB, HIV, and primary health care.

In 2013, TB/HIV Care Association was contracted by the Western Cape Department of Health (DOH) to provide a ten-day TB/ART adherence support training course for community care workers (CCWs) in the Cape Town Metro District. Over the course of the year, 336 CCWs were trained in 12 ten day courses, representing 120 days of training for this project alone. In the Harry Gwala district, TB/HIV Care in collaboration with the DOH, trained 35 master trainers, including nurse mentors, professional nurses and community health facilitators on community based services (CBS) monitoring and evaluation. In turn, CHFs have trained 615 community care givers on CBS monitoring and evaluation.

As part of the continuous quality improvement (CQI) project, TB/HIV Care trained 35 staff at seven health facilities in the Ingwe sub district in KwaZulu-Natal, on CQI and the use of tools which integrate TB, HIV and antenatal care. This consisted of two learning sessions followed by on-site mentorship. TB/HIV Care has also contracted ACTS SA to conduct provider initiated counselling and testing (PICT) training to 100 professional nurses in Harry Gwala district.

In Ethekwini and Cape Town, professional nurses and lay counsellors were trained in key populations sensitization training. The training, which sensitizes health workers to the health needs of sex workers and other key populations, also addresses stigma, attitudes, and HIV prevention. In the past year, THCA has conducted sensitization training at 11 health facilities reaching 118 staff within eThekwini. Many of these facilities are those that sex workers are linked to for treatment and are now considered as “key populations - friendly” clinics.

In order to provide MMC services, clinical staff have been trained by the Centre for HIV/AIDS Prevention Studies (CHAPS). CHAPS has provided training for 4 medical officers, 21 professional nurses and 2 clinical associates.

MMC awareness training enables TB/HIV Care counsellors and mobilisers to provide information on MMC to men and their partners, and to mobilise males to take up this service. During the year 251 staff were trained on HIV prevention and MMC awareness.

The ART/TB initiation counselling model, including PMTCT, is a programme which was piloted by Medicine Sans Frontieres (MSF) in Khayelitsha due to ART guideline changes which allow patients to be started on ART more quickly and assists them to develop a meaningful adherence plan. Training focuses on the counselling model and its tools and is followed up with on-site mentoring. THCA are now providing this training, and 13 staff (counsellors, coordinators and professional nurses) have been trained.
## Financial Report

**TB HIV Care Association - Annual Financial Statements for the Year Ended 31 March 2014**

### Statement of Financial Position

<table>
<thead>
<tr>
<th>Assets</th>
<th>2014</th>
<th>2013</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Current Assets</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Trade and other receivables</td>
<td>1 663 642</td>
<td>1 677 577</td>
</tr>
<tr>
<td>Cash and cash equivalents</td>
<td>5 733 226</td>
<td>2 665 462</td>
</tr>
<tr>
<td><strong>Total Assets</strong></td>
<td>7 396 868</td>
<td>4 341 039</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Equity and Liabilities</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Equity</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Accumulated surplus</td>
<td>4 132 692</td>
<td>3 591 866</td>
</tr>
<tr>
<td><strong>Liabilities</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Current Liabilities</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Trade and other payables</td>
<td>704 804</td>
<td>749 173</td>
</tr>
<tr>
<td>Deferred income</td>
<td>2 559 372</td>
<td>-</td>
</tr>
<tr>
<td><strong>Total Equity and Liabilities</strong></td>
<td>7 396 868</td>
<td>4 341 039</td>
</tr>
</tbody>
</table>

### Statement of Comprehensive Income

<table>
<thead>
<tr>
<th>Figures in Rand</th>
<th>2014</th>
<th>2013</th>
</tr>
</thead>
<tbody>
<tr>
<td>Revenue</td>
<td>115 712 022</td>
<td>115 567 284</td>
</tr>
<tr>
<td>Operating expenses</td>
<td>(115 224 867)</td>
<td>(115 441 617)</td>
</tr>
<tr>
<td>Operating surplus</td>
<td>487 155</td>
<td>125 667</td>
</tr>
<tr>
<td>Investment revenue</td>
<td>53 754</td>
<td>15 963</td>
</tr>
<tr>
<td>Finance costs</td>
<td>(83)</td>
<td>(1)</td>
</tr>
<tr>
<td>Surplus for the year</td>
<td>540 826</td>
<td>141 629</td>
</tr>
</tbody>
</table>
TREATMENT ADHERENCE: A community care worker (CCW) explains a treatment regimen to a client. CCWs are able to devote the time to this that a busy nurse or doctor may not have.

Photo: Global Fund and John Rae
APPROACHABLE: Friendliness and respect are key to conducting successful outreach work in the community. A smile can do a lot of the work in mobilizing people to have an HIV test.
ACKNOWLEDGEMENTS

THE MANAGEMENT AND STAFF OF TB/HIV CARE ASSOCIATION WISH TO RECORD OUR THANKS TO THE FOLLOWING FOR THE SUPPORT RECEIVED DURING THE YEAR:

- ABSA Trust
- AIDS Healthcare Foundation
- Alan and Gill Gray charitable trust
- BIMAF
- Cape Cookies
- Centers for Disease Control and Prevention (CDC)
- C & E Harding Charitable Trust
- Community Chest of the Western Cape
- E Pilliner Trust
- HIVOS
- Hope4health
- IVOIS Pty Ltd
- Jet Lee Will Trust
- Leigh Rynhoud
- NACOSA
- National Lottery

- Prac-Pak CC
- Presidents Emergency Plan for AIDS Relief (PEPFAR)
- Price Waterhouse Coopers
- OWA Cape
- Right to Care
- Sendor industries
- Stiching
- Swift Silliker
- TB REACH, Stop TB Partnership
- The Department of Social Development
- The Global Fund
- The National Department of Health
- The Western Cape Department of Health
- Transfer Press Spinning
- University of the Western Cape
- Waste-Mart