

Control and Prevention-Tuberculosis Summary Narrative

Burma, Thailand, and Yunnan, China
Family Health International (FHI 360)

FY2014 Semi-Annual Performance Report
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CAP-TB
CONTROL AND PREVENTION
OF TUBERCULOSIS

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Acronyms

APRO	Asia Pacific Regional Office
BTB	Bureau of Tuberculosis (Thailand)
CAP-TB	Control and Prevention of Tuberculosis (Greater Mekong Sub-region Multidrug Resistant Tuberculosis Prevention and Management Project)
DQA	Data Quality Assessment
DOT	Directly Observed Therapy
DST	Drug-susceptibility testing
FHI 360	Family Health International
FY	Fiscal year
GFATM	The Global Fund to Fight AIDS, Tuberculosis and Malaria
GMS	Greater Mekong Sub-region
GP	General Practitioner
IA	Implementing Agency
IEC	Information, education and communication
IR	Intermediate Result
IUATLD	International Union Against Tuberculosis and Lung Disease
MBCA	Myanmar Business Coalition on AIDS
MDR-TB	Multidrug resistant tuberculosis
MHAA	Myanmar Health Assistants Association
MMA	Myanmar Medical Association
MOU	Memorandum of Understanding
NCCM	National Catholic Commission on Migration
NTP	National TB Control Program
OCAT	Organizational Capacity Assessment Tool
PHO	Provincial Health Office
PGK	Pyi Gyi Khin
PMU	Program Management Unit
RDMA	Regional Development Mission Asia (USAID)
SLD	Second line drugs
TA	Technical assistance
TB	Tuberculosis
TCC	TB Clinical Center
USAID	United States Agency for International Development
WHO	World Health Organization
XDR	Extensively drug resistant
YATA	Yunnan Anti-Tuberculosis Association

Narrative I: Executive Summary

Control and Prevention-Tuberculosis (CAP-TB) is USAID RDMA's project on multi-drug resistant tuberculosis (MDR-TB) in the Greater Mekong Sub-region of Burma, Thailand, and Yunnan, China. The project's overall aim is to develop a model for cost-effective MDR-TB control that can be sustainably scaled up throughout Burma, China, and Thailand with potential for expansion in the Greater Mekong Sub-region.

The CAP-TB strategy is to provide patient-centered, community-driven support for MDR-TB elimination. Led by FHI 360, the prime cooperating agency, and its implementing agencies, CAP-TB carries out this strategy to meet the following objectives:

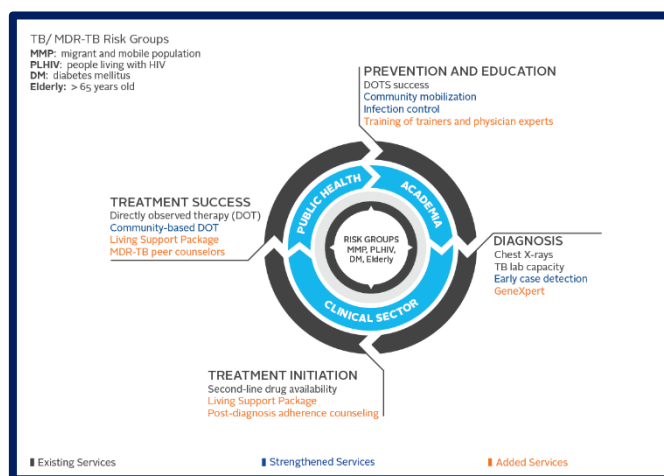
1. **To prevent disease transmission** through effective infection control. This is a critical element of MDR-TB control and prevention, particularly in settings where treatment is delayed due to shortage of second-line drug (SLD) or laboratory confirmation of molecular diagnosis is prolonged.
2. **To increase MDR-TB diagnosis** through training physicians, health care workers, and community workers on early referral for more effective identification of presumptive TB patients; educating at-risk populations and close contacts about TB/MDR-TB signs and symptoms.
3. **To maximize treatment success** through provision of a comprehensive "living support package" over 24 months of MDR-TB treatment. The package includes nutrition and transportation support; psychosocial care through patient support groups and TB/MDR-TB peer counsellors; and conducting home visits, phone calls, and engagement through social media platforms for TB patients. Specific components of the package are customized to each country, depending on the local needs.

Each of the above objectives is reflected in the intermediate results (IRs) of the FY14 SAPR's country narratives. The IRs are based upon the foundational building blocks for TB control, thus the activities and outputs for each country follow a consistent theme, while allowing for specific nuances at the local level. This is particularly relevant when designing strategies for MDR-TB control in countries as distinct as Burma, China, and Thailand, which have different levels of economic and social development while also sharing similarities—common factors include risk groups for MDR-TB, barriers in accessing care, and health system weaknesses that challenge diagnosis and treatment. Highlights from each country's SAPR include the following:

1. **Burma:** One of CAP-TB's strongest achievements is the comprehensive living support package for MDR-TB patients, which has been recognized by the NTP and the WHO as the model for MDR-TB treatment support. Given that 10,000 MDR-TB patients will be initiated on SLD in Burma over the next three years, it is imperative to identify a standard strategy for cost-effective support to maximize treatment outcomes and cure. The project's patient-centered, community-driven approach is implemented in the crowded urban areas of Rangoon, the rural communities in Mandalay, and the industrial zone in Monywa. Working in these three very different settings enables CAP-TB to develop a strategy that can be utilized in urban, rural, and industrial regions of the country, which is important for the project's scalability potential.
2. **China:** CAP-TB has developed innovative strategies for educating patients and health care providers that have potential for national impact: engaging MDR-TB peer counsellors to provide advice and support for patients; initiating patient support groups at the project's two main hospitals; and leveraging China's impressive social media momentum through CAP-TB's QQ group for TB patients. These strategies have attracted interest from the National China TB Bureau, Beijing Chest Hospital, and Peking Union Medical College, increasing the potential for CAP-TB China's initiatives to be sustainably scaled up throughout the country. The project's model for patient support has also decreased treatment default in Kunming's MDR-TB patients from 47% to less than 5%, an impressive decline that speaks to the success of CAP-TB's counseling and education strategy for patients and providers. These are the types of successes that will be followed over the next two years to track the project's impact on MDR-TB incidence and mortality.
3. **Thailand:** CAP-TB has focused on strengthening the TB system as a cohesive whole. Since the country of Thailand is capable of supporting TB control largely using its own resources, along with some GFATM support, CAP-TB has focused on strengthening capacity for critical thinking among TB health care workers to improve the quality of diagnosis and case management. This is done in

Rayong Province through monthly case conferences and patient cohort review and additionally strengthened by an innovative e-learning platform (QStream). The goal is to develop capacity at the provincial level in Rayong for complex MDR-TB case management and to build a system for routine monitoring of all MDR-TB patients through regular review of labs and culture data, treatment progress, and drug side effects. CAP-TB Thailand’s strategy also involves close engagement with the Bureau of TB (BTB) to strengthen connections with its network of provincial-level MDR-TB physicians. To do this, an online MDR-TB Experts Support desk was launched in FY14, which connects provincial-level physicians with regional and central-level MDR-TB experts. This helpdesk enables provincial physicians to have a systematic method to contact resources, while at the same time allowing the BTB to track the number and types of questions that arise from the provinces.

If CAP-TB’s key initiatives are to be integrated into health policy, a critical priority is to ensure that the project is sustainable and scalable. With the project in its third implementation year, collaboration from various arenas of the health system has made it increasingly clear that three sectors of the system need to be engaged if adoption of the project’s model will be successful: these are the public health, clinical, and academic sectors. MDR-TB is a communicable disease, thus the public health system—the National TB Program (NTP) in each country---will be responsible for MDR-TB guidelines and health policy development. However, since many patients often access the health system through private clinics rather than at the NTP, it is critical to strengthen the connection between the NTP with the clinical sector. Engagement by the NTP of private hospitals and general physicians using the “public-private mix” approach has been recognized as an international priority by the WHO. Lastly, the project’s focus on teaching and training of health care providers is most naturally suited to the academic arena. Because public health, academic and clinical institutions are under the authority of different departments within the Ministry of Health in any given country, it is important to identify key partners in each of these three arenas to strengthen their connections, with the goal to ensure sustainability and scale-up beyond the project’s lifetime.



The longer-term goal is to integrate the project’s model and its initiatives into the public health, clinical, and academic institutions in Burma, China, and Thailand, strengthening the health system for MDR-TB elimination.

Narrative II: Program performance/achievements and key challenges

1. **MDR-TB Prevention (IR1):** MDR-TB prevention consists of two main strategies: primary and secondary prevention. **Primary prevention** decreases the transmission of MDR-TB; this strategy focuses on early case detection and prompt initiation of treatment, with the goal to rapidly decrease patients’ infectivity and transmission to close contacts. **Secondary prevention** of MDR-TB decreases the generation of drug-resistant strains by improving treatment compliance and cure for drug-susceptible TB.

In all CAP-TB countries, infection control remains an important priority, emphasized for patients and families with a specific focus on the early phase of treatment when patients are most infectious. Infection control checks during home visits is routinely done on a monthly basis in Burma, something which has been highlighted as an urgent priority by the Myanmar NTP given the recent results of the country's Drug Resistance Survey, which showed an alarmingly high prevalence of MDR-TB among new TB cases in Rangoon (10%), which was twice the rate found in other parts of the country (5%). This suggests that the MDR-TB epidemic in the crowded urban settings may be due to different transmission dynamics, implying that different approaches for disease elimination may be necessary. Prompt initiation of SLD for MDR-TB patients in the Rangoon setting is one strategy to address the issue, as is effective infection control in the home and community---observing good cough hygiene (emphasized by the project's highly successful cough campaign in FY14 Q2), and maximizing ventilation and exposure to sunlight. Similar principles of cough hygiene and infection control are emphasized in China and Thailand for patients and their families and communities.

Relevant indicators (Annex III):

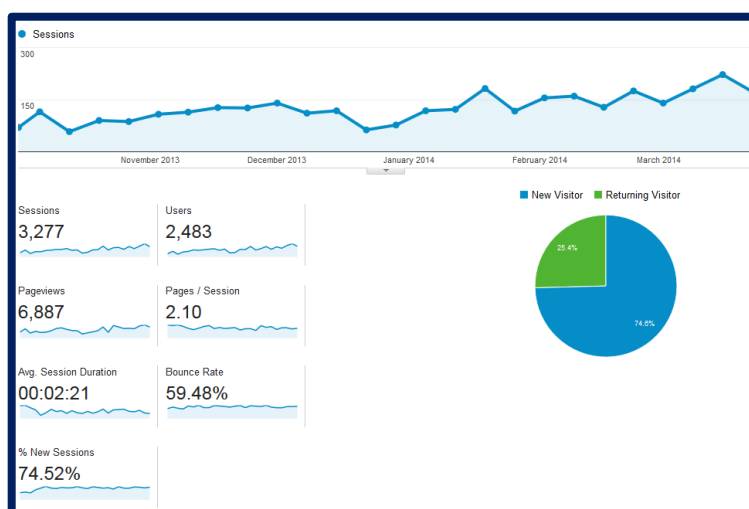
1. Infection Control: CAP-TB #6 and PMP #9 (CAP-TB #2).
 2. Ensuring DOT success for TB to prevent MDR-TB: CAP-TB #17 and PMP #9 (CAP-TB #2), CAP-TB #3 and #13
2. **MDR-TB Management (IR2)**: MDR-TB management is expensive, highly toxic to patients, and lengthy---lasting 20-24 months. All of these factors challenge treatment completion and cure. The project's goal is to increase MDR-TB case detection and improve MDR-TB treatment outcomes, as compared to current achievements for case detection and treatment success in each CAP-TB country.
- MDR-TB diagnosis using molecular methods (GeneXpert) decreases the wait time from weeks to hours, greatly increasing the potential for timely diagnosis and prompt initiation of SLD. Improving access and utilization of GeneXpert testing is also done by training physicians to better identify presumptive TB patients--- a key strategy to increase case detection. These data are monitored for CAP-TB Burma partners by measuring successful referrals of presumptive TB patients, rate of sputum testing, and rate of sputum positivity. Tracking these indicators and comparing sputum positivity rate for CAP-TB compared to the NTP will enable the project to identify successful screening strategies that can be utilized by the NTP and scaled up. Data are presented in the Burma SAPR country narrative.
 - Once patients are diagnosed and initiated on SLD, treatment compliance and cure is the goal, and the project has done this in each country through provision of the comprehensive "living support packages" that are customized to local needs. In Burma, monthly supply of nutrition is necessary given that food security and malnutrition are major issues, particularly among the urban and rural poor who are at risk for MDR-TB. In China and Thailand, providing monthly supply of nutrition is less urgent, while psychosocial support and counseling through home visits and regular follow-up are emphasized. In China, patient support groups, MDR-TB peer counselors, and social media TB groups have become a major project initiative with early success. Before the project's initiation, the rate of MDR-TB default in Yunnan Province was 47%, mostly due to intolerance of SLD and their side effects. Since initiation of the project's patient-centered support, the default rate has decreased to <5%, a marked improvement. As more patients who are supported by the project complete their 24 month treatment over the coming months, CAP-TB will continue to monitor default rate, treatment completion, and cure for comparison with national data.
 - Training to improve expertise in MDR-TB management is a priority to standardize care in all three CAP-TB countries---this is done for physicians, health care workers, and community supporters. On-site trainings by IUATLD experts on MDR-TB and TB/HIV are conducted in Kunming, with additional training via Skype to reinforce key concepts, improve retention, and increase adherence to clinical guidelines. In Burma, general practitioners are trained on MDR-TB to increase identification of potential MDR-TB patients with the goal to increase referrals and case detection by the TB network. In Thailand, CAP-TB has developed a training curriculum for

MDR-TB that is comprehensive, covering clinical concepts for TB, MDR-TB, and TB/HIV. Health care staff in the Thailand TB system are also trained to routinely track, monitor, and review MDR-TB cases to build skills on systematic cohort review with the goal to identify worrisome trends in patient outcomes as well as systems issues that can be addressed to improve the TB network.

Relevant indicators (Annex III):

1. Molecular diagnosis for MDR-TB: PMP #7 (CAP-TB #9), CAP-TB #17
2. Living Support Packages for MDR-TB patients: CAP-TB #17
3. Training to improve MDR-TB expertise: PMP #17 (CAP-TB #14); PMP #18 (CAP-TB #15); CAP-TB #16

3. **Strategic Information (IR3):** CAP-TB has a coordinated strategy to ensure that critical information is captured from the project’s activities and disseminated to a broad audience of clinicians, public health professionals, and academicians for maximum impact. The central hub in this strategic information strategy is the CAP-TB Knowledge Gateway (www.cap-tb.org). The graphs (right, below) show utilization of the gateway during the first six months of FY14. The data show the total number of sessions (3277) and unique users (2,483) who have accessed the web portal: 74.6% of the visitors are those who access the site for the first time, and 25.4% are returning visitors. The average session duration is 2:21 minutes, which indicates that the visitors stay on the web portal and visit more than two pages per session, a good indicator of their interest.



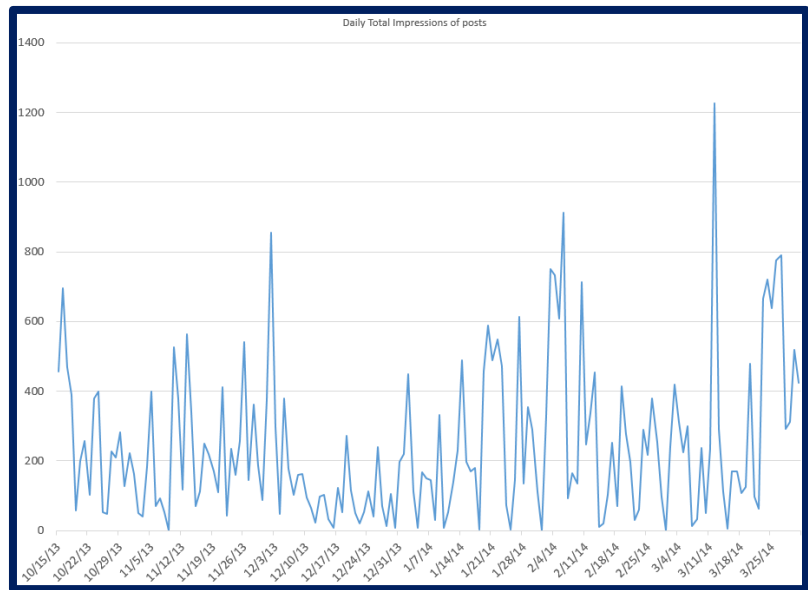
Country / Territory ?	Acquisition		
	Sessions ? ↓	% New Sessions ?	New Users ?
	3,277 % of Total: 100.00% (3,277)	74.58% Site Avg: 74.52% (0.08%)	2,444 % of Total: 100.08% (2,442)
1. Thailand	810 (24.72%)	58.40%	473 (19.35%)
2. United States	484 (14.77%)	76.65%	371 (15.18%)
3. Myanmar (Burma)	328 (10.01%)	53.66%	176 (7.20%)
4. China	234 (7.14%)	70.51%	165 (6.75%)
5. India	195 (5.95%)	87.69%	171 (7.00%)
6. United Kingdom	122 (3.72%)	87.70%	107 (4.38%)
7. Indonesia	76 (2.32%)	93.42%	71 (2.91%)
8. Philippines	59 (1.80%)	96.61%	57 (2.33%)
9. Canada	57 (1.74%)	70.18%	40 (1.64%)
10. South Africa	56 (1.71%)	89.29%	50 (2.05%)

The top 10 of the 129 countries represented among users of the Knowledge Gateway are shown in the table (left).

The CAP-TB focus countries of Burma, China, and Thailand in the Greater Mekong Sub-region are those generating the greatest traffic, along with visits from the United States.

Usage of the gateway is driven by social media syndication, using both international as well as China-specific social media apps. Full data for each CAP-TB country showing utilization by province and/or city in each country is provided in the Appendix I.

Social media. CAP-TB complements its strategic information strategy with an integrated social media platform centered on Facebook and Twitter. The social media sites disseminate resources, news, and latest developments in TB/MDR-TB: updates that are targeted at healthcare and TB stakeholders in the region and throughout the world. In many ways, the CAP-TB social media platform serves as the gateway to the project’s MDR-TB web portal—the Knowledge Gateway—as well as to other resources, with the goal of capturing the attention of the project’s audience and directing them to new publications and updates on MDR-TB. CAP-TB’s Facebook page has 521 “likes” to date, with the demographics showing an even split between men and women (Appendix I) predominantly in the 25-34 age range. The stories that CAP-TB posts to spread news, information, insights, and analysis about TB and related issues are viewed widely, and are often “re-shared” by followers, thus spreading virally and increasing their reach. The figure (above) displays CAP-TB’s “impressions” over time -- the number of times that the project’s stories are displayed around the world. When stories are popular and heavily re-shared, the numbers often rise to several hundred impressions per day. (<https://www.facebook.com/ControlAndPreventionOfTuberculosis>, https://twitter.com/CAP_TB)



Information tools. CAP-TB implements information applications tailored to the specific needs of certain key audiences. These applications currently include:

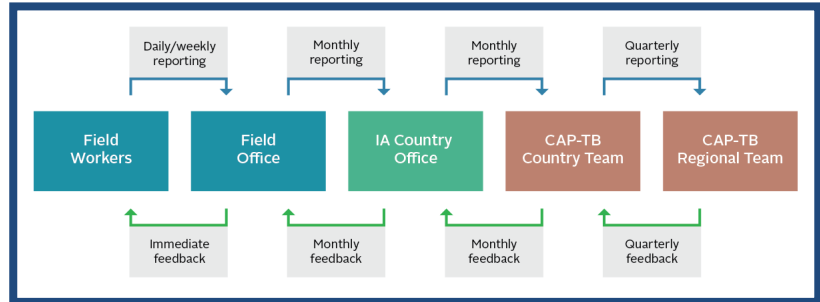
1. An online MDR-TB Experts Support Desk (or "ticketing") application designed to manage and track the questions and requests sent to the central-level MDR-TB experts in Thailand. This has been launched during FY14 with interest from both the provincial physicians who care for MDR-TB patients as well as from central-level MDR-TB experts who routinely field phone calls from the provinces. The goal is to strengthen Thailand’s Bureau of TB’s network of physicians throughout the country who care for MDR-TB patients, in order to improve and standardize the quality of care.
2. A mobile learning application that sends intermittent quiz questions via email or mobile phone to participants in CAP-TB training workshops (Rayong, Thailand). QStream is an e-learning platform that was developed to improve knowledge retention and guideline adherence among physicians at Harvard Medical School. CAP-TB has used this application to reinforce key concepts taught during the TB network’s monthly case conferences in Rayong; the project will also initiate QStream in China during Q3 FY14 in partnership with Beijing Chest Hospital and CAP-TB partner, the IUATLD.
3. An application for mobile data collection that allows community health workers to use smartphones to record and track data as they provide DOT to patients in Burma (CommCare). CAP-TB is training the country’s first community workers to support MDR-TB DOT: using CommCare will help to improve the capacity to train and track their performance with the overall goal to quickly and effectively scale up the community supporter-DOT model throughout the country.

Research: CAP-TB is conducting research in partnership with and led by Professor Richard Coker from the London School of Hygiene and Tropical Medicine. The focus of this research is on determining MDR-TB risk factors; barriers in accessing care; and analyzing the economic impact of MDR-TB on the health system. Analysis is currently under way for Yunnan data from the past nine years (2005 to present). Burma research will start with a case-control study assessing risk factors for MDR-TB, research that is particularly relevant and important given the recent findings from the country’s DRS, which showed the top risk factors for MDR-TB to be previous TB treatment, living in Rangoon, and co-infection with HIV.

Strategic Information indicators (Annex III): PMP #20 (CAP-TB #21); PMP #21 (CAP-TB #22)

4. **Monitoring and Evaluation**

(M&E): CAP-TB has used a regional support model for monitoring and evaluation (right). Data originate from the field, generated by outreach and community workers who conduct the activities. The IAs’ field offices or district/community-level offices collect these field-level data and submit them to their organizations’ central offices. The IAs then submit data to the CAP-TB country offices, where the project’s M&E Officer or Program Officers then check the data quality. The CAP-TB country offices monitor the data on a regular basis, reporting back to the IAs at least once monthly. Quarterly reports are submitted from the CAP-TB country offices to the CAP-TB regional team for review and input. The FHI 360 APRO team in Bangkok supports the project at the regional level, providing additional input on data collection, validation, and quality assurance. Twice yearly, the project submits data and progress reports to USAID RDMA. Training of the IAs is done through direct visits by the CAP-TB teams, at which time the project’s data collection forms are reviewed for completeness and accuracy.



M&E indicators (Annex III): PMP #20 (CAP-TB #21)

5. **Enabling environment for MDR-TB control and prevention (IR4):** Creating an “enabling environment” to support MDR-TB control and prevention is critical for strengthening the TB health system. CAP-TB’s strategy is to strengthen key linkages within the system, which is essential for long-term sustainability and scale-up of the project’s model, as discussed above in the **Executive Summary** (Page 3). Developing an enabling environment that promotes MDR-TB control and prevention includes engagement of the private sector through CAP-TB China’s partnership with Kunming No. 3 Hospital; training of general practitioners on the Programmatic Management of Drug-resistant TB in Burma; and engagement of the private hospital health workers in Rayong, Thailand through the monthly case conference and cohort review.

Private sector indicators (Annex III): PMP #24 (CAP-TB #26)

6. **Capacity building and technical assistance:** FHI 360’s Organizational Capacity Assessment Tool (OCAT) is used to assess capacity in the seven USAID Forward priorities: governance, administration, human resource, financial management, organizational (program) management, project performance management, and external communication. During FY14, the project has continued close engagement, partnership, and monitoring of the local implementing agencies (IA). A survey conducted at the start of FY14 showed the IAs’ impressions of the CAP-TB team in each of these seven USAID Forward priority areas (right).

	Myanmar	Thailand	China
CAP-TB / FHI 360 staff’s responsiveness in providing assistance and information	4.0	4.5	4.2
CAP-TB / FHI 360’s helpfulness in helping IAs to build capacity in:			
Knowledge on TB prevention	4.0	3.5	4.1
Knowledge on TB treatment	3.6	3.5	3.6
Monitoring and Evaluation (M&E)	4.1	4.5	4
Compliance with US Government regulations	3.2	3.5	3.4
Financial processes and management	3.9	3	3.8
Human resources (HR)	2.8	3.5	3.4
External communications	3.0	4	3.9
HIV and tuberculosis	3	3.5	3.1
CAP-TB / FHI 360’s capacity building compared to others	3.6	3.5	4.1

CAP-TB country teams in Burma, China, and Thailand also track their capacity building activities in each priority area to monitor progress; completion of tasks; and identify issues that need improvement. These data (Appendix II) will also inform the project’s capacity building profile that will be compiled and written up for each IA in the final year of implementation.

Table 1-1 – 1-7: Program level monitoring results: *Please reference “CAP-TB Data Collection” Excel sheet and Annex III, pp. 9-15(below)*

Annex I: Method to estimate total number of individuals reached and adjustment factor to calculate for potential overlap among different partners and other USG

No estimations were made in Burma or Thailand data; all data reported represent actual numbers recorded and reported.

In China, estimations were made for large-group activities reported for PMP #9 (CAP-TB #2). Estimations were performed as follows for large community events (e.g., WTBD): all volunteers were instructed to keep count of the number of participants with whom they interacted and conducted surveys. At the end of the event, the number of volunteers was multiplied by the average number of participants. For community events, an average head count was conducted at the beginning, middle, and end of the event, and the average of the three counts was used to give the total participants in the event.

The project regularly assessed potential overlap with other donors and other USG-funded activities, thus there is no adjustment factor for overlap since none occurred to our knowledge. Project programming in all three countries was done in close alignment with the government TB control programs, other donors, and partners in order to ensure that the strategy and implementation plans were coordinated and complementary.

Annex II: Processes carried out to ensure data quality: *Please reference Monitoring and Evaluation Narrative II, Section D (above) as well as each country’s narrative report.*

Annex III: Summary of accomplishments against the work plan and targets: *Please see following pages 9-15 for country results and progress against work-plan and targets.*

Summary of accomplishments against the work plan and targets.

Burma						
PMP	CAP-TB	Indicator description	FY 14 Target	Achievement		Explanation
				#	%	
8	1	Number of TB patients newly registered for DOTs through USAID supported sites	278	119	43%	<u>MBCA</u> (83 out of 200) 42% as NTP enrolled only 83 TB DOTs as of March. <u>MMA</u> (36 out of 78) 46% as case selection to conduct DOTs was jointly done with Township Medical Officer and NTP.
9	2	Number of individuals reached with TB prevention and treatment messages, through outreach and small group activities	22,910	11,097	48%	<u>MBCA</u> (5,972 out of 4,780) 125% <u>MHAA</u> (2,937 out of 4,200) 70% <u>MMA</u> (193 out of 290) 67% <u>PGK</u> (1,995 out of 3,050) 65% Target set for FY14 includes repeated individual contacts. During FY13 APR, CAP-TB decided to report only new individual contact which would represent number of individuals. So, a meeting with IAs conducted on 26 th February and discussed about target revision. As an output, newly set targets were reported to CAP TB project on 17 th March. In this FY14 SAPR, number represents individual counts but achievement percentages were calculated based on previously set targets.
	3	Number of individuals referred to TB- and MDR –TB related services	770	413	54%	<u>MBCA</u> (106 out of 180) 59% <u>MHAA</u> (88 out of 120) 73% <u>MMA</u> (80 out of 110) 73% <u>PGK</u> (139 out of 360) 39%
	4	Number of IEC materials distributed through outreach and clinical interventions	58,250	38,058	65%	<u>MBCA</u> (9,587 out of 15,100) 64% <u>MHAA</u> (13,032 out of 22,000) 59% <u>MMA</u> (6,194 out of 12,000) 52%. One PMDT training was shifted to Q3 FY14, so distributed number will be reported during Q3. <u>PGK</u> (9,245 out of 9,150) 101%
	6	Percentage of households with MDR-TB patients meeting quality infection control standards	100%	98%	NA	CAP-TB selected 10 top questions from the IC checklist directly related to infection control, in line with National TB Programme. Numbers of households receiving 7 of 10 points were defined as “meeting infection control standards”. 533 households of MDR TB patients passed the standards out of total 542 households. (6 monthly indicator)
15	8	Number of laboratories provided with TA for the rollout of new diagnostics	2	NA		
7	9	Number of MDR-TB cases diagnosed	360	211	59%	Currently 33% positivity among tested 647 presumptive MDR TB cases. Previously targeted 180 were calculated by 18% positivity among 1,000 provided cartridges (half of total 2,000). But positivity was higher than expected.

Burma						
PMP	CAP-TB	Indicator description	FY 14 Target	Achievement		Explanation
				#	%	
16	12	Number of USAID-supported facilities with strengthened MDR-TB referral system	2	2	100%	1 MBCA clinic and 1 Lower Myanmar TB center which CAP TB supported Gene-Xpert machine (6 monthly indicator)
	13	Percentage of successful referrals	75%	90%	NA	Among 413 referred cases, 372 accessed to diagnosis and treatment services <u>MBCA</u> (102 had access out of 106) 96% <u>MHAA</u> (66 had access out of 88) 75% <u>MMA</u> (72 had access out of 80) 90% <u>PGK</u> (132 had access out of 139) 95%
17	14	Number of individuals trained in TB-case-finding activities	121	59	50%	One ORW training and three TB Champion trainings were conducted by MBCA during reporting period. ORW refresher training was postponed to Q3.
18	15	Number of individuals trained in programmatic management of MDR-TB	140	21	15%	Unexpected program implementation delays and host government delays: 1 PMDT training and two PMDT TOT have been postponed to Quarter 3 of FY14. One PMDT training sessions was conducted during Q2 FY14.
	16	Number of individuals trained	14	0	0%	The follow up activity for Organizational Capacity Development will be conducted during Q3
	17	Number of individuals received package of TB/MDR-TB service through USAID supported sites	655	560	86%	The achievement reported here represent 18 coverage townships, as of March 2014
19	18	Number of local organizations provided with TA for strengthening community-based approaches for PMDT	4	4	100%	4 implementing agencies
	19	Percentage of MDR-TB cases on MDR-TB treatment regimen with negative culture by six months	>80%	100%	NA	173 MDR TB cases started treatment during April (start month of CAP TB support) to August 2013. 36 patients had completed month 6 th sputum culture and all resulted 'Negative'.
	20	Percentage of MDR-TB cases on MDR-TB treatment regimen who died by six months	≤12.5%	4%	NA	297 MDR TB cases started treatment during April (start month of CAP TB support) to end of March. 12 patients had expired.

Burma						
PMP	CAP-TB	Indicator description	FY 14 Target	Achievement		Explanation
				#	%	
20	21	Number of individuals trained on the collection, use, and analysis of data and strategic information for the management of the TB program	23	7	30%	25 th -27 th M&E and DQA training was conducted by MHAA with technical assistance from external consultant and FHI 360. M&E session at ORW refresher training will be conducted during Q3 FY14. Which is a delay from the initial timing of the training, thus the underachievement in the target.
21	22	Number of operational research studies supported with USAID funds	1	1	100%	LSHTM, in collaboration with FHI 360, NTP and University of Public Health, is conducting three inter-linked projects on incentives, gender, and economic modeling to predict effective TB/MDR-TB control and prevention. This activity is in progress.
24	26	Number of private-sector partners working with NTP with USAID support	254	258	102%	Among 4 Implementing agencies, MMA and MHAA are existing partners with National TB Program, with Public Private Mix DOTs and community outreach TB care. Their capacity in TB care was enhanced on PMDT through CAP TB related activities. MBCA and PGK are new partners to National TB Program and their capacity in PMDT was initiated and strengthened through CAP TB related advocacy meetings and trainings. 233 GPs are trained during previous year and 21 new GPs in FY14 at PMDT trainings and strengthened their capacity in MDR TB management by strengthening their relationship with NTP by updating their knowledge on MDR TB management and current practices of NTP, case finding and contact tracing. They are existing partners of NTP since they already worked with MMA for Public Private Mix DOTs.

China							
PMP	CAP-TB	Indicator description	Target FY14	Achievement		%	Explanation
				YATA	KM No.3 Hospital		
9	2	Number of individuals reached with TB prevention and treatment messages, through outreach and small group activities	3640	1543	311	50%	<p>Small group:</p> <ol style="list-style-type: none"> 93 (XSCDC 45 men, 48 women) attended in the small group activities in FU Hai community 135 (TCC 89 men, 46 women) + 251 (No.3 hospital 139 men, 112 women) TB/MDR-TB patients who received one-on-one counseling; or attended small group activities; 115 (XSCDC 80 men, 35 women) TB/MDR-TB patients who received adherence education support through home visit, face-to-face counselling and/or phone calls; <p>Large group:</p> <ol style="list-style-type: none"> 500 persons (YATA 320 men, 180 women); reached in community event on Dec.27,2013;

China							
PMP	CAP-TB	Indicator description	Target FY14	Achievement		%	Explanation
				YATA	KM No.3 Hospital		
							2. 700 (YATA 400 men, 300 women) and 60 (No.3 hospital 36 men, 24 women) persons reached by 2014 World TB Day Event;
	3	Number of individuals referred to TB- and MDR –TB related services	800	749	20	96%	1. Number of TB suspects referred to TB services - 187 persons in Fuhai and 558 persons in TCC –The 558 reported from TCC includes the people referred from prefectures, other hospitals in Kunming, and the people referred from XS district. The target is overachieved due to 1) increased number on the MDR-TB suspects from prefectures; 2) increased number from out-patient referrals. 2. Numbers of TB/MDR-TB patients successfully referred from Kunming No.3 Hospital and TCC to XS district for community-based DOTS – 4 from TCC (YATA) and 20 from No.3 Hospital;
13	5	Number of facilities with quality infection control standards with USAID support	5	3	1	80%	XSCDC, TCC, Fu hai community health centre/stations, and Kunming No.3 Hospital;
	6	Percentage of households with MDR-TB patients meeting quality infection control standards	100%	100%			3 MDR TB patients have been visited at home and had all met quality infection control standards;
7	9	Number of MDR-TB cases diagnosed	56	26		46%	26 MDR TB patients reported by YATA/Yunnan CDC. 6 MDR-TB patients reported by Kunming No.3 hospital in the narrative part of the report
10	11	Number of new MDR-TB diagnosed patients initiated on treatment	40	16		40%	16 new MDR-TB patients initiated on treatment (Source: YATA/Yunnan CDC). Underachievement is due to the following reasons, for the 10 patients who have not started treatment: 4 refused entry into the GF program, they prefer to have Chinese Medicine treatment; 2 still use the first line drug (doctor’s judgment); 1 because of kidney failure; 1 for poor adherence; 2 are very poor and cannot afford the costs for hospitalization, transportation, and nutrition.
16	12	Number of USAID-supported facilities with strengthened MDR-TB referral system	26	26		100%	USAID-supported facilities includes community health centers/stations for DM/TB screening (10), Fu Hai community health center/stations (13), TCC, Kunming No.3 hospital, and Xi Shan CDC.
	13	Percentage of successful referrals	100%	82%	100%		1. The percentage of successful referrals for DM/TB screening - 77% (198/258) 2. 20 TB/MDR-TB patients in Kunming No.3 Hospital, who are also XS citizens, all successfully referred to XSCDC for community follow up service – 100% (20/20)

China							
PMP	CAP-TB	Indicator description	Target FY14	Achievement		%	Explanation
				YATA	KM No.3 Hospital		
17	14	Number of individuals trained in TB-case-finding activities	130	20		15%	MDR-TB case finding training (YATA) on Jan.9, 2014 - 20 persons; The reason for underachievement is that this target mainly measures private sector training. In the reporting period, Xi Shan CDC worked with the Xi Shan Drug Administration bureau and Xi Shan Society of Private Medical Practitioners: training will be conducted in Q3 and Q4, thus delaying achievement of the target. In addition, large group training on for TB health care providers by Kunming No.3 Hospital is not reported here: 278 participants (77 men and 201 women)
18	15	Number of individuals trained in programmatic management of MDR-TB	140	42	16	41%	1. Training on TB diagnosis and first-line treatment by Dr. Chiang, the Union - 20 (YATA); 16 (Kunming No.3 Hospital); 2. Training on TB/HIV conducted Dr. Ignacio, the Union (22) Dr. Chiang's second mission will be conducted in August, at which time additional individuals will be trained. The reason for the underachievement is due to the timing of his second mission.
	16	Number of individuals trained	100	56	13	69%	1.Number of persons received TB counselor training: 30 (YATA); 13 (Kunming No.3 Hospital); 2.Training for TB staffs in Fuhai community center: 26 persons
19	18	Number of local organizations provided with TA for strengthening community-based approaches for PMDT	6	5	1	100%	YATA/Yunnan CDC, Kunming CDC, Xi Shan CDC, TCC, Fuhai Community Health Center, and Kunming No.3 hospital;
20	21	Number of individuals trained on the collection, use, and analysis of data and strategic information for the management of the TB program	60	28	4	53%	1. Project launch and M&E training in Oct 2013; 10(YATA), 4 (Kunming No. 3hospital) 2. Working group meeting for leaders from Fu Hai community health centers: 18 persons
21	22	Number of operational research studies supported with USAID funds	3	1		33%	DM/TB bi-directional screening study; London School will start to work on the research activities in Q3 (May 2014)
22	23	Number of studies published or conference presentations given as a result of USAID support for research programs	1	0	0		

China							
PMP	CAP-TB	Indicator description	Target FY14	Achievement		%	Explanation
				YATA	KM No.3 Hospital		
24	26	Number of private-sector partners working with the national TB control program with USAID support	100	82		82%	Number of private sector partners in Fu Hai RD.

Thailand						
PMP	CAP-TB	Indicator description	Target	Achievement		Explanation
				#	%	
9	2	Number of individuals reached with TB prevention and treatment message in USAID-supported project areas	1500	1203	80%	The reported numbers included people reached through small group activities and World TB Day events.
	3	Number of individuals referred to TB- and MDR –TB related services	500	382	76%	
15	8	Number of laboratories provided with technical assistance for the roll-out of new diagnostics	1	7	700%	Training on good clinical laboratory practices was organized for laboratory personnel from seven provincial and community hospitals in Rayong Province. While there is one main laboratory at Rayong Provincial Hospital that serves the province, CAP-TB included all relevant hospitals in the training to maximize resources.
7	9	Number of MDR-TB cases diagnosed during the reporting period (both by conventional and molecular)	35	2	5.7%	There was a five-month gap (between November 2013-April 2014) while the cartridges were being procured. # of patients diagnosed with conventional method is still pending, but the result will be higher than what is shown here. The target was based on FY13 achievements, and the underachievement is due to delays in GeneXpert cartridge procurement.
	13	Percentage of successful referrals	80%	73%		Calculated as # of cases received services at the four hospitals divided by total cases referred to and amongst the four hospitals reported for October 2013 – March 2014, FY14.
18	15	Number of individuals receiving training in programmatic management of MDR-TB	50	53	106%	29 are medical personnel while the remaining 24 are public health personnel, staff from local administrative organizations and VHV's
	16	Number of individuals trained	80	94	117.5%	The target was estimated based on 20 VHV's and health care providers in each area. The higher number of individuals trained resulted from more representatives from lower-level health facilities attended the intensive DOT training than expected.