TB CTA
The Tuberculosis Coalition for Technical Assistance

USAID
FROM THE AMERICAN PEOPLE

TUBERCULOSIS CONTROL ASSISTANCE PROGRAM (TB CAP)

PROGRAM YEAR 2

Annual Progress Report II
October 1, 2006 – September 30, 2007

15 November, 2007

TB CAP Partners

- **American Thoracic Society (ATS)**
- **Centers for Disease Control (CDC)**
- **Family Health International (FHI)**
- **Japan Anti-Tuberculosis Association (JATA)**
- **KNCV Tuberculosis Foundation**
- **Management Sciences for Health (MSH)**
- **International Union Against Tuberculosis and Lung Disease (The Union)**
- **World Health Organization (WHO)**

Cover page: Facing Death, Eugeen van Mieghem (1875-1930) draws his dying muse. Contemporaries called the Antwerp-born Van Mieghem the 'artist of the people'. During his time at the Antwerp Academy, Van Mieghem met Augustine Pautre, the woman who was to become his wife. In December 1904 Augustine was diagnosed with tuberculosis, a disease that was still fatal at that time. She died in March 1905. Despite her physical decline, Van Mieghem continued to draw Augustine. His studies of her sunken face and her wasted body are the most impressive works he created. Rembrandt's poignant drawings and etchings of Saskia on her sickbed must have been an example and an inspiration to Van Mieghem.

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Executive Summary

Introduction
This is the second annual progress report of the Tuberculosis Control Assistance Program (TB CAP), carried out by the Tuberculosis Coalition for Technical Assistance (TBCTA) a coalition of the following eight organizations; KNCV Tuberculosis foundation (prime implementer), the American Thoracic Society (ATS), Centers for Disease Control and Prevention (CDC), Family Health International (FHI), The International Union Against Tuberculosis and Lung Disease (The Union), the Japanese Anti-Tuberculosis Association (JATA), Management Sciences for Health (MSH) and the World Health Organization (WHO). Close collaboration exists with the Stop TB Partnership, and with a number of other international and national collaborating agencies.

This report covers core, regional and country projects during the period October 1, 2006 till September 30, 2007.

Background
TB CAP is USAID's chief five year mechanism contributing to the global targets of TB control. The aim of it is to reach the following specific goals in the TB CAP countries with significant investment;

- 90% of public clinics implementing DOTS
- At least 70% case detection rate
- At least 85% treatment success rate and/or cure rate
- 75% of countries meeting MDR TB quality standards defined by TB CAP
- 100% of countries where nationwide TB and HIV programs effectively coordinated

TB CAP will achieve its objectives by focusing on five key components the so-called intermediate results (IRs):

- **IR 1:** Increased political commitment for DOTS (as a response to weak or wavering political commitment).

- **IR 2:** Strengthened and expanded DOTS programs (as a response to weak laboratory services, failure of drug supplies, inconsistent drug quality and inadequate drug policies, poor monitoring and evaluation (M&E)).

- **IR 3:** Increased public and private sector DOTS participation and collaboration (as a response to failure to engage private practitioners and other public providers in DOTS).

- **IR 4:** Increased and strengthened TB and HIV/AIDS coordinated activities (as a response to absence of effectively coordinated TB & HIV/AIDS programs and ineffective program coordination).

- **IR 5:** Improved human and institutional capacity (as a response to lack of qualified staff and lack of management skills at all levels).

Overview of the Year 1
<u>During the first year TB CAP's main achievements were:</u>

- The development of a **Financial Assessment and Budgeting Tool** for planning and budgeting at national and sub-national level.

- The field testing, finalization and distribution of **the International Standards of Tuberculosis Care** (ISTC) which is a major tool to involve the private sector into TB control and would increase the prevention of MDR and XDR TB worldwide.

- **A Country assessment tool** for NTPs to assess the complete picture of the magnitude and types of involvement of the private sector in TB control.

- **Expansion of the pool of consultants.** In total, 84 people were trained on MDR-TB, TB/HIV and PPP. Of these trainees, 41 of them have participated in related consultancies during the year.

- **Country support.** During the first year partners worked in Brazil, DR Congo, Mozambique, Namibia, Philippines, South Africa, South Sudan, Zambia and Kenya. Also, assessment visits

were conducted and workplans were prepared for Cambodia, Djibouti, Ghana, Indonesia and Malawi.

- For the first time, through USG/TB CAP funding, TBCTA partners have been approached to provide short-term **technical assistance to Global Fund granted TB projects** that are faltering in their implementation. Missions to Romania and Uzbekistan were successfully completed. Lesotho, Georgia, DR Congo and Vietnam missions were planned for next year.

During the first year TB CAP's main challenges were;

- Not being able to **address three TB CAP outputs** with specific projects, "Ensured political legal framework" (IR1), "Strengthened integration of DOTS services in general health services" and "Improved equitable access to quality TB care for vulnerable populations" (IR2) .

- A broader Human Resource Development (HRDR) approach needed to address the expected outputs from IR5, particularly that of **institutional capacity building**.

- Securing **PEPFAR funds** in other countries for TB/HIV collaborative activities.

- The emergence of **XDR TB** in the African setting to address, on top of the already existing challenge of MDR TB.

- **Preparing timely workplans** for the TB CAP countries.

Based on the achievements and challenges of Year 1 a work plan was prepared and implemented during the second year of TB CAP.

Main achievements of Year 2 are as follows;

- **TB CAP has started reaching the expected outcomes;**
  - In ten TB CAP countries the average **Case Detection Rate** (ss+) has reached to 54% (2006) and Treatment Success Rate (new ss+) has reached to 79% (2005 cohort).

  - Five of the ten selected TB CAP countries have met all three **quality standards** *(There is political will, surveillance (or survey) system is in place and at least one laboratory in the public sector performing culture & DST)* **of MDR TB**. These countries are; Cambodia, DR Congo, Mozambique, South Africa and Zambia.

  - Five of the ten selected TB CAP countries have met all four **quality standards** (*TB/HIV is reflected both in TB and HIV/AIDS strategic plans, Annual work plans available for TB/HIV both in TB and HIV/AIDS programs, Coordinating body is in place, Nationwide reporting system for TB/HIV is in place)* **of effective coordination of nationwide TB and HIV programs**. *These countries are; Cam*bodia, Malawi, Mozambique, Uganda and Zambia.

- **TB CAP has developed tools and guidelines for better TB control;**
  - **Handbook for Using the *ISTC*** was completed. A pilot study was conducted in Indonesia, India, Kenya, Mexico and Tanzania to review the use of the ISTC. Based on these site visits, the content for the Handbook was developed. TB CAP partners have also developed a flexible and locally adaptable series of **training modules for continuing education using the *ISTC*** as the focus. The modules will be field tested and finalized next year.

  - The **QUOTE tool** which is designed to measure and improve the quality of TB care and control is available. The tool will assist NTPs in sub Saharan African countries in regular supervisory activities. It will also help focusing in problem areas. There are plans to introduce the tool to additional countries beyond the field testing.

  - **Planning and budgeting tool** has been introduced to 15 African and four Asian countries. TB CAP, through the tool, assisted countries to prepare Medium Term Development Plans where these did not exist before, fine tune and revise existing work plans and medium term plans according to the Stop-TB Strategy and targets of the Global Plan to Stop TB. So far, Malawi and South Africa have fully used the tool to prepare their country work plans and budgets.

- **The Nurses TB Competencies Guide has been finalized.** Workshop "Guía de Competencias en Tuberculosis para Enfermería" was conducted in September, 2007 in Mexico City with participation of the nursing schools involved in the project from the 4 countries (Brazil, El Salvador, Mexico and Peru). The product was the ***Nurses TB Competencies Guide*** in Spanish and a Work Plan 2008-2012 for the implementation of this guide in the Americas.

- **E-portal for HRD** was developed and launched as a tool for continuous support of HRD focal points. This HRD e-portal structure makes possible of continuous learning and electronic follow up of HRD focal points in TB CAP countries.

- **A set of tools are at the final stages of development and will be widely available very soon. These tools are;**
  - X-ray supervisory checklists and accompanying guidelines;
  - TB Laboratory Standard Operating Procedures (SOPs);
  - Laboratory Management Information System (MIS).

- **Training courses and workshops were organized to improve HRD and strengthen NTPs;**
  - Similar to last year, TB CAP partners conducted a **Laboratory Consultant Training Course** to improve consulting capacity of laboratory experts. The training course was held in August 2007 in Cairo with 20 (12 female and 8 male) participants.

  - Annual **International MDR-TB Course of Mexico** took place in July 2007, with the attendance of 28 participants (14 men and 14 women) from 11 different countries.

  - A course on **Management of MDR and XDR TB in Africa Region** was organized in Johannesburg, South Africa in May, 2007**.** The purpose was to improve coordination between HIV and TB programs through strengthening and linking surveillance systems for HIV and MDR-TB. Forty-three participants from ten countries (Botswana, Kenya, Lesotho, Malawi, Namibia, South Africa, Swaziland, Uganda, Zambia, and Zimbabwe) attended the meeting.

  - The first multi-country, "**national PPM planning**" workshop was successfully organized in Cairo in February, 2007. NTP managers and their PPM focal persons from five African and six Eastern Mediterranean Region countries participated. All countries completed draft operational plans with budgets during the workshop.

- **Technical Assistance (TA) was provided both for GF proposal development and for supporting implementation;**
  - TB CAP supported Cambodia, Senegal, Malawi and Mozambique for **GF Round 7** proposal development**.** TB CAP is pleased to announce that Malawi, Mozambique and Senegal proposals have been approved. Cambodia proposal has been rated Category 3-4 (not approved) but is eligible to appeal.

  - TB CAP has completed providing short-term rapid **TA to selected GF countries** that are faltering in their implementation. As a result of these TA the NTPs in DR Congo, Georgia and Uzbekistan have M&E plans to better monitor the national programs while Primary Recipient in Uzbekistan has a financial system to better manage GF resources, monitor sub-recipients and timely and accurately report GF project expenditures. TA to Vietnam has helped NTP to improve provincial planning and supervision and also better monitor the national training activities.

- **Institutional capacity building has gained momentum;**
  - **Zaria Training Center in Nigeria** and **Gadjah Mada University in Indonesia** were selected as candidate institutions for institutional capacity building. TB CAP will assist those two institutes to become centers of excellence as **Regional Training Schools for TB Control.**

- **Country projects have produced notable results;**
  - **Cambodia;** a national facility survey and laboratory service inventory were conducted to assess the work load and distribution of staff, NGO support for community DOTS funded by organizations and the availability of HIV testing for TB patients. Results have helped NTP to identify nationwide shortage of lab consumables. The first draft of clinical

and management guideline of TB/HIV was completed. The IEC inventory was finalized and ISTC was translated into Khmer.

- **Djibouti;** A course on management of TB at health facilities was conducted for 28 clinic staff. Supervision guides and checklists were developed and two vehicles were purchased. The process of establishing HIV/TB collaborative activities in the country has been speed up with weekly meetings involving the two programs. An in-depth analysis of the causes of low case detection in Djibouti was carried out. An international laboratory specialist was recruited. Two courses were conducted for 44 laboratory technicians on the Quality Control Procedures.

- **DR Congo;** TB CAP has been supporting the training and supervision activities in South Kivu and Maniema provinces. Supervision visits and quarterly meetings with sub-districts and district coordinators were conducted in 52 health zones. In total, 91 nurses, 56 doctors, 70 lab workers were trained in NTP technical policies. Twenty-one supervision visits from national level to provinces were supported. In total, 47 staff was trained in VCT and 25 project coordinators were trained on TB/HIV collaboration activities. Rehabilitation of the NRL has been completed and the equipment purchased. Eleven lab technicians received training on fluorescence microscopy.

- **Indonesia;** TB CAP has considerable additional value for the NTP by creating supplementary local technical capacity being linked to specific external expertise. Progress was made on the implementation of ISTC and the establishment of ISTC task forces in four densely populated provinces. Recruitment of 18 local technical officers led to increased Hospital DOTS activities and boosting DOTS expansion in Jakarta, West, Central and East Java. District planning & budgeting tool was revised and staff trained for piloting. Strategic plan and work plan for TB in prisons finalized. Translation of the ISTC was finalized. First TB/HIV sero-prevalence survey in Jogjakarta finalized.

- **Kenya;** Under ISAC initiative, 26 unemployed health staff was contracted by the Kenyan Association for Prevention of Tuberculosis and Lung Diseases (KAPTLD), working for the NTP. Since January 2007, that staff is contracted by KNCV through TB CAP. This staff made a significant contribution to the development and implementation of national TB/HIV indicators that are collected through the revised recording and reporting system, making Kenya one of the few countries world-wide reporting these indicators.

- **Malawi;** TB CAP has adapted a model for the "continuum of integrated TB/HIV care" including decentralization (from the district to the Health Center) of TB diagnosis and case management. Community sensitization meetings were conducted with 600 community leaders. TB CAP in collaboration with NTP conducted a death audit check list to analyze the causes of deaths among TB patients. DOTS training provided to 35 health workers and 37 Implementation Managers. Forty-eight facilities and 237 facility health workers were oriented on active case finding. Sixteen sputum smear fixators were trained. Laboratory supplies and equipment were procured and distributed to the districts. Refurbishment of CRL was completed.

- **Mozambique;** Renovation of Beira Regional Laboratory is underway to decentralize M.TB culture. TB CAP purchased and distributed 25 binocular microscopes to support DOTS expansion. In addition, 250 slide storage boxes were distributed to selected laboratories. TB CAP developed the Strategic CB-DOTS plan and selected three NGOs as implementing agencies. TB CAP conducted four ToTs on CB-DOTS in selected districts. In total, 114 participants, including 69 health workers and 45 officials participated in the trainings. TB CAP conducted Provider Initiated Counselling and Testing (PICT) Workshops for 80 health workers. TB CAP revised and developed the following materials: TB/HIV treatment protocols, TB/HIV training guidelines and curricula for health workers and volunteers, IEC materials on TB, TB/HIV and counselling and testing for HIV to be used at TB health facilities, M&E tools (data collection forms, definition of indicators, etc) for CB DOTS.

- **Namibia;** TB CAP procured three vehicles for supervision visits. TB CAP supported the renovation of Walvis Bay district MDR-TB ward and also assisted the decentralization of the Walvis Bay district TB program from 1 clinic to 6 peripheral clinics providing DOT. TB CAP organized regular performance review meetings for 26 districts in 11 regions.

These are now going to be expanded into TB/HIV quarterly meetings that will include NGOs working in the regions. TB/HIV collaboration has been strengthened following the Management Organizational Strengthening Tool (MOST) training which brought together doctors, nurses, laboratory staff and health workers in the NGOs.

- **Nigeria;** Abt. Associates in collaboration with TB CAP facilitated a workshop targeting TB, HIV/AIDS and GF program managers and staff. The goal of this training was to improve knowledge and skills in management and leadership--covering basic program management techniques and method. A roll out planned was developed in collaboration with participants to be implemented by Zaria targeting State level managers.

- **South Sudan;** The five year Strategic Plan and TB Policy and Guidelines were officially adopted and disseminated. The National TB Policy and Guidelines were revised based on the new Stop TB Strategy. The recording and reporting system was updated. A course was conducted for 45 public and private health workers on DOTS and implementation of the South Sudan TB regimen, which is based on a six-month short course chemotherapy. A PPM task force was established following a workshop with prison authorities and stakeholders.

- **Uganda;** TB CAP has recruited a distinguished and well qualified team in Uganda. A course was conducted for 22 participants in management, leadership, finance and logistics. TB CAP has provided funding to NTLP for central level and district level supervision of 20 target districts. TB CAP assisted NTLP to revise TB Unit registers to improve recording and reporting and to improve data collection for TB/HIV and CB-DOTS. A TB/HIV Situation Analysis was also conducted in 26 districts.

- **Zambia;** TB CAP has made a remarkable achievement in improving the performance of TB microscopy in project provinces through training and technical support for EQA. The percent of laboratories performing TB microscopy with over 95% correct microscopy results has reached from 4% to 64% in Northwestern Province. TB CAP is fully renovating two general TB laboratories in the region. Six spirit lamps for smear preparation were distributed to health facilities. Three EQA and smear microscopy training courses were for provincial and district staff. TB CAP is supporting the revision of the National TB Manual which will help to strengthen timely detection and treatment of TB cases. A baseline assessment was completed to strengthen current TB and HIV activities. TB/HIV training manuals were produced. A total of 179 staff was trained in DCT. In total, 180 TB treatment supporters trained in HIV counselling.

Main challenges for future are as follows;

- **Addressing all expected outputs;** Under IR2 are the three outputs that have not been fully addressed yet.

- **HRD and institutional capacity building;** A broader approach is needed to address the expected outputs on HRD, particularly at country level.

- **Follow-up of TB CAP trained consultants;** Efforts should be made to ensure increased participation of trained consultants in different areas of TB Control.

- **TB/HIV;** TB CAP should ensure that all upcoming TB/HIV core and country projects are effectively coordinated and well managed.

- **XDR TB;** The Emergence of XDR TB in the African setting presents a greater challenge for TB CAP to address on top of the already existing challenge of MDR TB.

- **Laboratory Systems Strengthening;** TB CAP needs to develop the laboratory infrastructure especially for the East African Region.

- **Management of TB CAP Funds;** In two years time there has been a four fold increase in TB CAP's budget and with each additional country this budget keeps growing. TB CAP's challenge is to ensure that all the core, regional and country funds are absorbed and work plans are timely implemented.

1. Introduction

TBCTA partners are pleased to submit the second TB CAP Annual Progress Report covering the October 1, 2006 and September 30, 2007 period. The purpose of this report is to give an overview of TB CAP's second year activities, accomplishments and challenges.

The following sections provide information on TB CAP major accomplishments, as well as challenges experienced during the second program year. Annex 1 provides detailed information on each project.

2. Background

TB control relies on DOTS as the main public health approach. By the end 2004, 83% of the world's population from 200 countries lived in areas that had adopted DOTS. These countries reported 4.9 million new and relapse cases, among which 4.4 million were from DOTS areas. Based on WHO estimates, there were 8.9 million new incidence cases of TB (140 per 100,000), including 3.9 million new smear-positive cases. This is a case detection rate of only 53%. Although this is a strong upwards trend, it still falls short of the 70% case detection target. Of these estimated 3.9 million cases, approximately 36% were successfully treated under DOTS and of the ones that were actually registered for treatment (1.7 million), 82% successfully completed their treatment. In the same year (2004) an estimated 1.7 million persons died (27 per 100,000) from TB.

While global DOTS expansion has almost reached its 2005 objectives, there are major challenges that remain to be addressed. Access to early quality assured diagnostic and treatment services for TB and TB/HIV are still major challenges. Solutions include strengthening of health systems and specific TB control programs, as well as specific innovative approaches including strengthening Human Resource Development (in quality and quantity), community participation in TB control, collaboration within and among public and private sectors, appropriate diagnosis and treatment of MDR-TB, enhanced expansion of TB/HIV collaborative program activities. These improvements can only be achieved when sustained and adequate funding for NTP budgets is ensured.

TB CAP

Tuberculosis Coalition for Technical Assistance (TBCTA) is a coalition of the following eight organizations; KNCV Tuberculosis foundation (prime implementer), the American Thoracic Society (ATS), Centers for Disease Control and Prevention (CDC), Family Health International (FHI), The International Union Against Tuberculosis and Lung Disease (The Union), the Japanese Anti-Tuberculosis Association (JATA), Management Sciences for Health (MSH) and the World Health Organization (WHO).

The aim of TB CAP is to reach the following specific goals in the TB CAP countries with significant investment:

- 90% of public clinics implementing DOTS
- At least 70% case detection rate
- At least 85% treatment success rate and/or cure rate
- 75% of countries meeting MDR TB quality standards defined by TB CAP
- 100% of countries where nationwide TB and HIV programs effectively coordinated (defined by TB CAP)

TB CAP aims to achieve the goals above through five Intermediate Results (IR) mentioned below;

- IR 1: Increased political commitment for DOTS
- IR 2: Strengthened and expanded DOTS programs
- IR 3: Increased public and private sector DOTS participation and collaboration
- IR 4: Increased and strengthened TB and HIV/AIDS coordinated activities
- IR 5: Improved human and institutional capacity.

TB CAP's main strategy is to develop knowledge and expertise by building capacity, designing and adapting new tools, guidelines, methods and approaches using core funded projects and then gradually shifting and implanting this knowledge into TB CAP and other USAID priority country programs. TB CAP has focused on five key strategies:

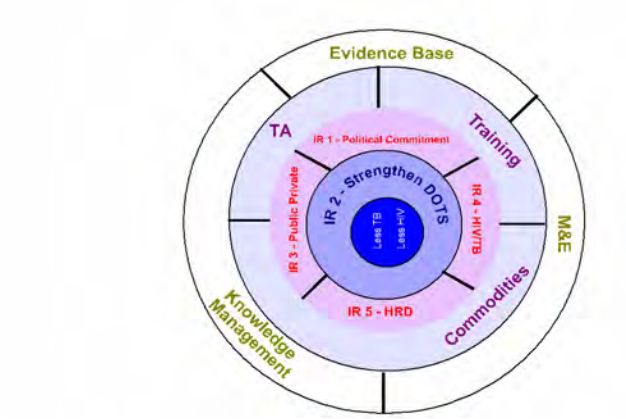
1. Address the needs and priorities of USAID missions and regional bureaus to scale up country programs by adapting TBCTA's successful model to individual needs.

2. Provide Global Leadership as a strategy for non-country specific funded activities.

3. Leverage resources to increase impact using TBCTA's reputation and global network and by expanding TB program partners.
4. Integrate TB control into country-level health strengthening programs.
5. Provide Global Leadership to all TB programs, encouraging them to include gender considerations and gender equity in their program planning and evaluation systems

The figure below illustrates TB CAP's vision towards achieving the goals and IRs.

Figure 1: TB CAP Conceptual Framework



The TBCTA first annual work plan was submitted to USAID in December, 2005. In May 2006, The Board of Directors, the PMU, and USAID held a meeting to develop the strategic approach and direction of projects for the next four years taking into consideration the Global Plan to Stop TB 2, the TB CAP technical proposal and the five IRs. During this meeting, the TB CAP strategic framework, expected outputs and performance indicators for each IR were also identified. Table 2 below illustrates the expected outputs.

Table 1: TB CAP expected outputs for each Intermediate Result

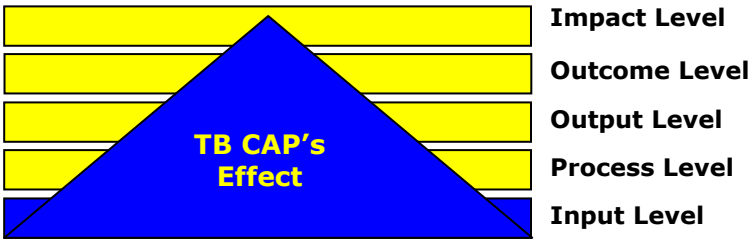
IR	Expected Outputs
1 Increased Political Commitment for DOTS	o Sustained appropriate level of government funding o Ensured political legal framework

2 Strengthened And Expanded DOTS programs	o Strengthened TB program leadership and management
	o Strengthened integration of DOTS services in general health services
	o Improved diagnostic capacity
	  o Strengthened culture and DST
	  o Strengthened sputum smear microscopy
	  o Improved quality of chest x-ray diagnosis
	o Improved prevention and management of MDR TB
	o Improved equitable access to quality TB care for vulnerable populations

3 Increased public and private sector DOTS participation and collaboration	o Increased NTP coordination and collaboration with public and private sectors
4 Increased and strengthened TB and HIV/AIDS coordinated activities	o Improved national policies and coordination between National TB and HIV programs o Improved access of HIV positive TB patients to HIV services o Improved access of persons living with HIV to TB services
5 Improved human and institutional capacity	o Improved competence of staff at different levels of the health system o Improved availability of staff of all categories involved in comprehensive TB control

In order to monitor and measure the overall success of the TB CAP an M&E framework has been developed. This framework helps to visually conceptualize the project inputs, processes, outputs as well as desired outcomes and impact of the TB CAP five year from now. The figure below illustrates the expected effect of TB CAP at different levels.

Figure 2: The effect of TB CAP at different levels



Based on the M&E Framework a five year Performance Monitoring Plan (PMP) has been developed. The five year PMP assumes that for each indicator a baseline will be collected in each country where there is a substantial investment. It has been decided that ***''selected indicators would be measured in at least countries where $300,000/year or more budget AND at least two years of investment.''***

While TB CAP's portfolio has reached to 18 countries, in Year 2 selected PMP indicators have been measured in only the 10 TB CAP countries which fit into the definition above. It should be noted that the data in the following tables are the most recent available in each country. Detailed data, including previous years can be found in Section 5 where each country is discussed separately.

Table 2: TB CAP's PMP Indicators

Expected Impact	
Less TB & Less HIV/AIDS associated TB mortality & morbidity	o TB incidence o HIV prevalence in adult incidence TB cases o Case fatality of HIV positive TB patients
Expected Outcome	
Strengthened and Expanded DOTS Programs	o Percent of public sector clinics implementing DOTS strategy o Case detection rate (all forms) o Case detection rate (ss+ cases) o Case notification rate (new ss+) o Treatment success rate and/or cure rate (new ss+) o Percent of countries meeting MDR TB quality standards defined by TB CAP o Percent of countries where nationwide TB and HIV programs effectively coordinated
IR 1: Increased Political Commitment for DOTS	
A sustained appropriate level of government funding Ensured political framework	o Number of countries that have been using the components of Advocacy Toolkit o Amount of government budget dedicated to NTP o Number of countries that formally adopted a national TB policy
IR 2: Strengthened and Expanded DOTS Programs	
Strengthened TB program leadership and management	o Number of countries where the NTP has identified priority challenges to be addressed within a defined time period according to a measurable action plan using MOST o Technology of assessing and improving leadership and management skills in the selected TB CAP institutions has been transferred
Strengthened integration of DOTS services in general health services	o Number of countries where NTPs have expanded case detection in other health programs and sectors
Improved diagnostic capacity o Strengthened culture and DST	o Number of countries providing TB culture and sensitivity services meeting international quality standards

o Strengthened sputum smear microscopy o Improved quality of chest x-ray diagnosis	o Number of countries that have implemented TB CAP's **"TB Laboratory Standard Operating Procedures (SOPs)"** o Average population per laboratory performing TB microscopy o Percent of laboratories performing TB microscopy with over 95% correct microscopy results o Number of countries that have implemented the **"X-ray Diagnosis Guidelines"**
Improved prevention and management of MDR TB	o Number of countries with policy on MDR TB o Number of countries conducting MDR TB surveys or having MDR TB surveillance systems
Improved equitable access to quality TB care for vulnerable populations	o Number of countries measuring socioeconomic status to document equitable access o Number of countries that have an official pro-poor policy
IR 3: Increased Public and Private DOTS Participation and Collaboration	
Increased NTP coordination and collaboration with public and private sectors	o Number of countries that have used the **"Situation Analysis Tool''** o Number of countries that implemented the **"ISTC"** o Number of countries that have developed and implemented a PPP strategy o Number of TB cases reported to NTP by non-MOH sector by each country
IR 4: Increased and strengthened TB and HIV/AIDS coordinated activities	
Improved national policies and coordination between National TB and HIV programs	o Number of countries that have implemented the revised recording and reporting system for TB/HIV o Number of countries with joint planning at national (and TB CAP areas) level for collaborative TB/HIV activities between NTP and NACP
Improved access of HIV positive TB patients to HIV services	o Percent of co-infected TB patients referred for HIV/AIDS care o Percent of all registered TB patients who are tested for HIV o Percent of co-infected TB patients on ART
Improved access of persons living with HIV to TB services	o Number of persons living with HIV receiving TB prophylactic therapy o Percent of all registered persons living with HIV who are screened for TB
IR 5: Improved human and institutional capacity	
Improved competence of staff at different levels of the health system Improved availability of staff of all categories involved in comprehensive TB control	o Number of countries where pre-service curricula have been upgraded/ revised to reflect the implementation of TB control activities based on the Stop TB Strategy o Number of NTPs that have an HRD MIS in place that collects and produces up-to-date information o Number of regional training courses conducted by regional institutions meeting international technical and educational quality standards o Percent of all TB CAP consultant trainees who have completed at least two consultancies (in the technical area that they have been trained) in the last 12 months o TFH provided leadership and quality technical assistance on HRD to both internal and external clients o Number of NTPs that have an HRD focal point in the NTP o Number of countries that have HRD plans prepared based on global HRD guidelines for comprehensive TB control o Percent of TB treatment facilities with at least one health care professional trained in TB case detection and treatment based on the DOTS strategy o Percent of key managerial NTP staff positions filled at national, intermediate and district levels per country according to the HRD plan o TB microscopy units with at least one laboratory technician trained in AFB microscopy o Number of people trained in DOTS

3. Project Overview

3.1 Core and Regional Projects

During the first year, TB CAP developed and implemented 28 core and regional projects. There are still four core and one regional ongoing project from Year 1. It is expected that all these four will be completed in early 2008. As of end of September 2007 the status of these projects are as follows;

Table 3: Status of Year 1 Projects as of end of September 2007

Type	Completed	Ongoing	Forwarded to Year 2	Cancelled	Total	Percent Completed
Core	17	4	1	2	24	71%
Regional	3	1	0	0	4	75%
Total	**20**	**5**	**1**	**2**	**28**	**71%**

In Year 2, TB CAP conducted 23 (20 core and 3 regionally funded) projects. While all regional projects were completed half of the Year 2 core projects are still ongoing. As of end of September 2007 the status of these projects are as follows;

Table 4: Status of Year 2 Projects as of end of September 2007

Type	Completed	Ongoing	Total	Percent Completed
Core	10	10	20	50%
Regional	3	0	3	100%
Total	**13**	**10**	**23**	**57%**

3.2 TB CAP Countries

The number of countries has reached from nine in Year 1 to 18 in Year 2.

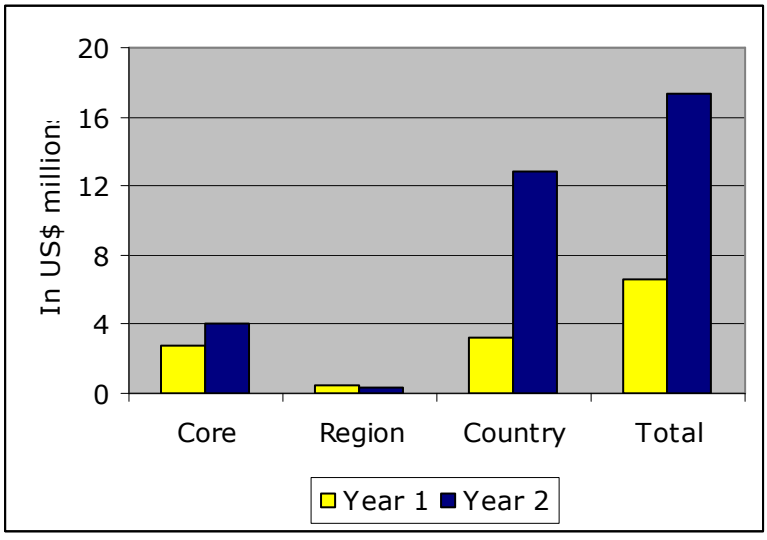
Table 5: TB CAP Countries as of end of September 2007

Latin America	Asia	Africa			
Brazil	Cambodia	Djibouti	DR Congo	Ghana	Kenya
Dominican Republic	Indonesia	Malawi	Mozambique	Namibia	Nigeria
Mexico	Philippines	South Africa	South Sudan	Uganda	Zambia

3.3 Budget

During the two years period total TB CAP budget has changed from $6.6 million in Year 1 to $17.3 million in Year 2. Figure below illustrates that the while increase in total core and regional budget is around 41%, there is a four fold increase in the country budget.

Figure 3: Change in the TB CAP Budget



4. Project Performance

4.1 Impact level

While TB CAP PMP identifies and regularly monitors several impact and outcome indicators it should be noted that it is hard to measure to what extend TB CAP interventions have attributed to desired changes. It gets more complex when there are larger international issues, national trends, rapid political, social and economic changes, existence or termination of other donor funded projects that may all have either limiting or enhancing influence on TB CAP interventions. TB CAP PMP identifies three impact level indicators. Table below summarizes the most recent country data for those three indicators;

Table 6: Impact Indicator Results in 10 TB CAP Countries (WHO 2007 Report)

	TB incidence (all forms) (WHO estimates) per 100,000 population		HIV prevalence in adult incident TB cases (%)		Case fatality of HIV positive TB patients (%)	
	2004	**2005**	**2004**	**2005**	**2004**	**2005**
TB CAP Average	**480**	**450**	**36**	**34**	**39**	**32**
Cambodia	510	506	13	6	14	6
DR Congo	366	356	21	17	21	17
Indonesia	245	239	0.9	0.8	1	1
Malawi	413	409	52	50	49	49
Mozambique	460	447	48	50	67	66
Namibia	717	697	61	56	41	35
Nigeria	290	283	27	19	27	19
South Africa	718	600	60	58	78	41
Uganda	402	369	19	30	22	32
Zambia	680	600	54	55	68	57

In 2005, among the ten TB CAP countries on average there has been a decline in all these three indicators. Namibia and South Africa continue to have the highest TB incidences and HIV prevalence in TB cases.

4.2 Outcome level

TB CAP PMP identifies seven outcome level indicators. These are;

- Percent of public sector clinics implementing DOTS strategy
- Case detection rate (all forms)
- Case detection rate (ss+ cases)
- Case notification rate (new ss+)
- Treatment success rate and/or cure rate (new ss+)
- Percent of countries meeting MDR TB quality standards defined by TB CAP
- Percent of countries where nationwide TB and HIV programs effectively coordinated

Public sector clinics implementing DOTS strategy;

Table 7: Percent of public clinics implementing DOTS strategy

	2005	**2006**	**2007**
TB CAP Average	**83%**	**86%**	**87%**
Cambodia	98%	100%	100%
DR Congo	100%	100%	100%
Indonesia	96%	96%	96%
Malawi	100%	100%	100%
Mozambique	45%	55%	71%
Namibia	100%	100%	100%
Nigeria	65%	65%	65%
South Africa	80%	94%	94%
Uganda	47%	47%	47%
Zambia	100%	100%	100%

There has been a slow but steady increase in the percent of public clinics implementing DOTS strategy in 10 TB CAP countries. While Cambodia, DR Congo, Malawi, Namibia and Zambia have reached 100%, Uganda remains below 50%.

Case Detection Rates;

Table 8: Case detection and notification rates (WHO 2007 Report)

	All new		New ss+		New Pulmonary Notification Rates
	2005	2006*	2005	2006*	2005
TB CAP Average	**53%**	**54%**	**61%**	**45%**	**124**
Cambodia	49%	52%	66%	65%	149
DR Congo	46%	48%	72%	72%	113
Indonesia	48%	60%	66%	76%	71
Malawi	46%	46%	39%	39%	66
Mozambique	36%	37%	49%	50%	90
Namibia	99%	No data	90%	No data	257
Nigeria	16%	No data	22%	30%	27
South Africa	85%	No data	108%	No data	265
Uganda	37%	47%	45%	50%	71
Zambia	68%	85%	52%	No data	127

* NTP estimates (due to missing data it is not possible to compare the two years)

Treatment Success Rates;

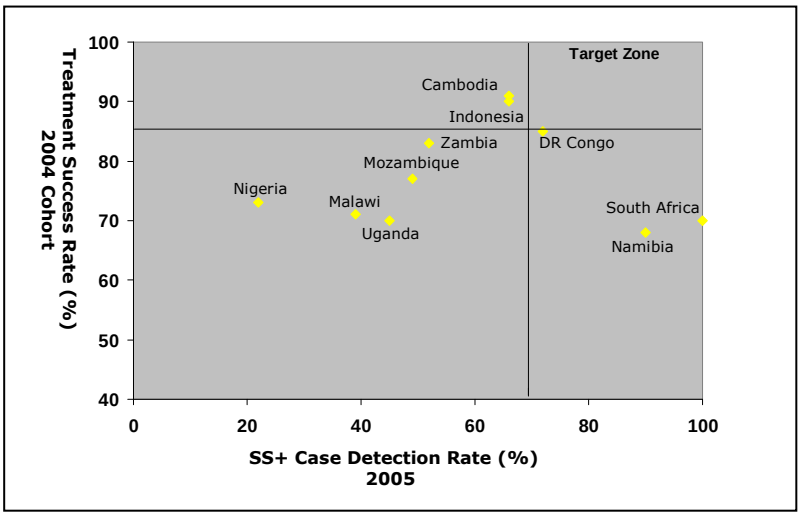
Table 9: Treatment success rate (new ss+) (WHO 2007 Report)

	2004 Cohort	2005 Cohort*
TB CAP Average	**78%**	**79%**
Cambodia	91%	93%
DR Congo	85%	85%
Indonesia	90%	91%
Malawi	71%	76%
Mozambique	77%	76%
Namibia	68%	75%
Nigeria	73%	75%
South Africa	70%	67%
Uganda	70%	73%
Zambia	83%	82%

* NTP estimates

According to 2006 estimates of new ss+ case detection rates and 2005 cohort estimates of treatment success rates Indonesia, Cambodia and DR Congo have come quite close to reaching both 70% case detection and 85% treatment success rates. The figure below illustrates the status of selected TB CAP countries toward reaching case detection and treatment success rate targets.

Figure 4: Progress toward the 70/85 Targets in 10 TB CAP Countries



Countries meeting MDR TB quality standards defined by TB CAP;
TB CAP has identified three MDR TB quality standards need to be met by selected countries. These are;

1. Political will
2. Surveillance (or survey) system is in place
3. At least one laboratory in the public sector performing culture & DST

The table below summarizes the results of this outcome indicator as of end of September 2007.

Table 10: TB CAP countries meeting MDR TB quality standards defined by TB CAP

Score (Max. 3.0)	2005	2006	2007	2007		
				Political will	Surveillance (or survey) system	Laboratory performing culture & DST
TB CAP Average	**1.6**	**2.0**	**2.4**	**0.9**	**0.5**	**1.0**
Cambodia	3	3	3	Yes	Yes	Yes
DR Congo	0	2	3	Yes	Yes	Yes
Indonesia	0	2	2	Yes	No	Yes
Malawi	2	2	2	Yes	No	Yes
Mozambique	1	1	3	Yes	Yes	Yes
Namibia	2	2	2	Yes	No	Yes
Nigeria	2	2	2	Yes	No	Yes
South Africa	2	2	3	Yes	Yes	Yes
Uganda	1	1	1	No	No	Yes
Zambia	3	3	3	Yes	Yes	Yes

As of end of Year 2, five of the ten selected TB CAP countries are meeting all three quality standards. While the political will and public sector laboratory performing culture and DST are in place in all ten countries, five countries (Indonesia, Malawi, Namibia, Nigeria and Uganda) are missing the surveillance systems.

Countries where nationwide TB and HIV programs effectively coordinated;
The final TB CAP outcome indicator is the measure of effectiveness of coordination between TB and HIV programs. TB CAP has identified four standards need to be met by selected countries. These are;

1. TB/HIV is reflected both in TB and HIV/AIDS strategic plans
2. Annual work plans available for TB/HIV both in TB and HIV/AIDS programs
3. Coordinating body is in place
4. Nationwide reporting system for TB/HIV is in place

The table below summarizes the results of this outcome indicator as of end of September 2007.

Table 11: TB CAP countries effectively coordinating nationwide TB and HIV programs

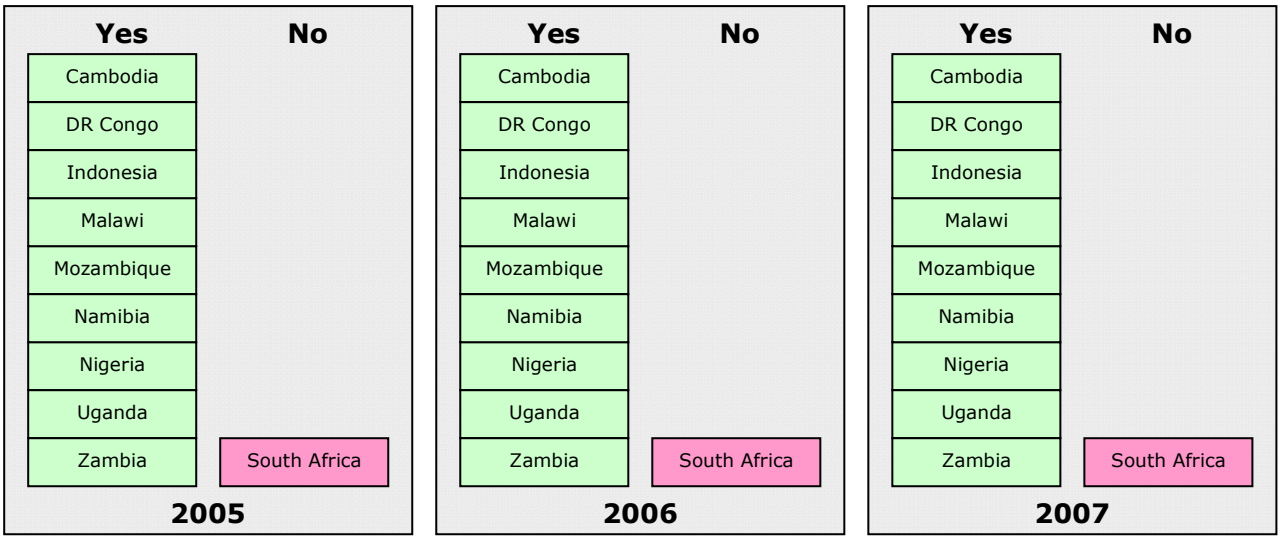
Score (Max. 4.0)	2005	2006	2007	2007			
				TB/HIV strategic plans	Annual work plans	Coordinating body	Reporting system
TB CAP Average	**2.0**	**2.3**	**3.0**	**0.8**	**0.6**	**0.8**	**0.8**
Cambodia	3	3	4	Yes	Yes	Yes	Yes
DR Congo	0	0	2	No	No	Yes	Yes
Indonesia	0	2	2	Yes	Yes	No	No
Malawi	2	2	4	Yes	Yes	Yes	Yes
Mozambique	4	4	4	Yes	Yes	Yes	Yes
Namibia	1	2	3	Yes	No	Yes	Yes
Nigeria	2	2	2	Yes	No	Yes	No
South Africa	0	0	1	No	No	No	Yes
Uganda	4	4	4	Yes	Yes	Yes	Yes
Zambia	4	4	4	Yes	Yes	Yes	Yes

In terms of effective coordination of nationwide TB and HIV programs five (Cambodia, Malawi, Mozambique, Uganda and Zambia) of the ten TB CAP countries have already reach all four expected results. The most challenging area is the availability of annual work plans for TB/HIV in both programs.

4.3 IR1: Increased political commitment for DOTS

TB CAP's strategic approach is to create an enabling policy environment for TB control. Under this IR, TB CAP aims to increase the number of countries where appropriate level of government funding is sustained and political legal frameworks ensured.

Figure 5: TB CAP countries that have formally adopted a national TB policy



A formally adopted National TB policy is the first essential step of TB control strategy. As seen from the figure on the left all nine TB CAP countries, except South Africa, have formally adopted a national TB policy through legislative or administrative measures.

TB CAP has invested in developing the budgeting and planning tool to be used at national and sub-national level within the framework of the Global Plan and the Stop TB Strategy. In Year 1, the tool was developed and field tested. In Year 2, the tool was introduced to 15 African (Angola, Cameroon, Central African Republic, Congo, DR Congo, Gabon, Kenya, Madagascar, Malawi, Nigeria, South Africa, Tanzania, Uganda, Zambia and Zimbabwe which was paid through other sources) and four Asian (Philippines, Cambodia, Mongolia and Laos) countries through two workshops and follow-up support was provided to Angola, DR Congo, Gabon, Kenya, Malawi, Nigeria, South Africa, Tanzania, Uganda and Zambia. The greatest progress to date has been in Zambia (comprehensive plan and budget for five years and Round 7 GF proposal) and Kenya (plan and budget for 2007-2011). TB CAP, through the tool, assists countries to prepare Medium Term Development Plans where these did not exist before, fine tune and revise existing work plans and medium term plans according to the Stop-TB Strategy and targets of the Global Plan to Stop TB. The next step is to implement the tool in all TB CAP countries using TB CAP country budgets. Table below summarizes the status of ten TB CAP countries in the use of the Tool. Since the tool has been finalized during the second year the indicator measurement is only applicable to 2007.

Table 12: TB CAP Countries using the components of the *Planning and Budgeting Tool in 2007*

	Score (Max. 3.0)
TB CAP	**1.3**
Cambodia	1
DR Congo	1
Indonesia	2
Malawi	3
Mozambique	0
Namibia	0
Nigeria	1
South Africa	1
Uganda	1
Zambia	3

The scoring is based on the following levels;

0 = Country has <u>not</u> been introduced to the **"Toolkit"**

1 = Country has been introduced to the **"Toolkit"** and there are plans for using it

2 = One component of the **"Toolkit"** was used in the last 12 months

3 = More than one component of the **"Toolkit"** was used in the last 12 months

So far, among 10 TB CAP countries Zambia, Malawi and South Africa have used the tool to prepare their country work plans and budgets.

4.4 IR 2: Strengthened and expanded DOTS programs

TB CAP considers the nationwide expanded DOTS strategy as the strategic approach to improve access to timely and quality assured diagnosis and treatment. TB CAP has identified five output areas that together lead to strengthened and expanded DOTS programs. These are;

1. Strengthened TB program leadership and management

2. Strengthened integration of DOTS services in general health services

3. Improved diagnostic capacity
    a. Strengthened culture and DST
    b. Strengthened sputum smear microscopy
    c. Improved quality of chest x-ray diagnosis

4. Improved prevention and management of MDR TB

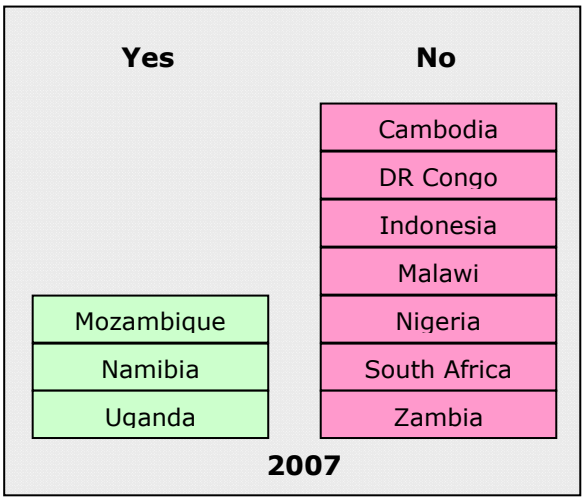
5. Improved equitable access to quality TB care for vulnerable populations

Year 1 projects focused on #1, #3 and #4. During Year 2 TB CAP continued investing in earlier and increased detection of TB cases through quality radiology and has also developed a comprehensive laboratory Standard Operating Procedures (SOPs).

4.4.1 Strengthened TB program leadership and management;

TB CAP partners have developed and tested two tools for better program management. These are MOST or TB and QUOTE. TB CAP's key indicator result for strengthening TB program leadership and management as end of Year 2 is illustrated below. Since the tool has been finalized during the second year the indicator measurement is only applicable to 2007.

Figure 6: TB CAP Countries where the NTP has identified priority challenges to be addressed within a defined time period according to a measurable action plan using MOST



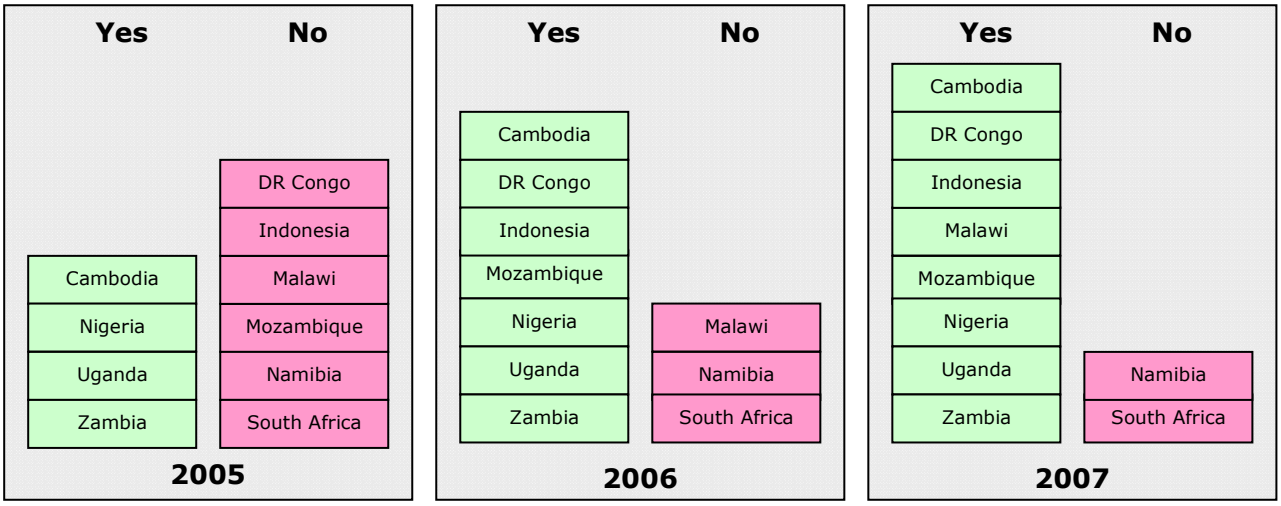
MOST for TB: In Year 1, TB CAP partners adapted the MOST (Management Organizational Sustainability Tool) for TB for use in African settings. MOST is a new approach for improving the management of TB programs to achieve results meeting health needs.

TB CAP partners conducted a three-day MOST TB workshop in Uganda in 2006 attended by 17 participants from 5 countries. The purpose was to adapt the tool for use in Africa. All five countries believe that conducting MOST for TB would be of value for their NTPs. Mozambique, Namibia and Uganda have used MOST to identify priority challenges. The tool will be finalized during Year 3.

4.4.2 Strengthened integration of DOTS services in general health services

The figure below illustrates that seven of the 10 selected TB CAP countries have already expanded case detection in other health programs and sectors.

Figure 7: TB CAP Countries where NTPs have expanded case detection in other health programs and sectors



In order to further improve integration of case detection into other programs and sectors, TB CAP has developed and implemented a Year 2 project to update the "**TB Handbook**" which was written eight years ago. While many elements of the first Handbook are still relevant today, there are many important aspects of TB control that are not included, including TB/HIV, MDR-TB, TB and poverty, health system strengthening, public-private mix, advocacy, communications and social mobilization, community TB care, and operational research. The book would provide information to national TB control program managers and staff on effective integration of DOTS in general health services in the country. As of writing this report the final draft was ready, and editing and layout have started. Both the hard copy and the electronic version of the revised TB Handbook will be widely available in the next few months.

4.4.3 Improved diagnostic capacity

TB CAP's key laboratory indicator results for Year two are provided in the two tables below.

Table 13: Average population per laboratory performing TB microscopy

	2005	2006	2007
TB CAP Average	**80,993**	**76,147**	**85,932**
Cambodia	70,400	70,400	75,000
DR Congo	No data	44,500	42,500
Indonesia	75,000	75,000	No data
Malawi	No data	No data	135,627
Mozambique	93,103	94,581	96,153
Namibia	65,500	61,750	59,735
Nigeria	170,000	170,000	170,000
South Africa	No data	No data	No data
Uganda	34,196	34,196	35,309
Zambia	58,750	58,750	73,135*

* This is the figure only for TB CAP's North Western province.

Table above indicates that average population served by laboratories performing TB microscopy has not improved since 2005.

Table 14: Percent of laboratories performing TB microscopy with over 95% correct microscopy results

	2005	2006	2007
TB CAP Average	**43%**	**45%**	**62%**
Cambodia	77%	75%	No data
DR Congo	No data	60%	60%
Indonesia	No data	No data	No data
Malawi	No data	No data	No data
Mozambique	50%	60%	62%
Namibia	No data	No data	No data
Nigeria	No data	No data	No data
South Africa	No data	No data	No data
Uganda	No data	26%	No data
Zambia	4%	4%	64%

Although, the table above indicates an improving trend since 2005, seven countries in 2007, five countries in 2006 and seven countries in 2005 did not provide data to make a meaningful observation. It should be mentioned that through TB CAP, Zambia has made a remarkable achievement in improving the performance of TB microscopy in project provinces through training and technical support for EQA. The details of this achievement can be found on page 60 under Zambia section.

Table below summarizes the performance of TB CAP countries in providing TB culture and sensitivity services meeting international standards. Since 2005 there has been a gradual improvement in the DR Congo, Indonesia and Malawi while South Africa and Zambia have already met the desired performance level.

Table 15: TB CAP countries providing TB culture and sensitivity services meeting international quality standards

Score (Max. 4.0)	2005	2006	2007	2007
TB CAP	**1.9**	**2.5**	**2.6**	The scoring is based on the following levels; **0 =** No culture **1 =** A national TB laboratory policy on culture and DST **2 =** A national reference laboratory with culture and DST service **3 =** A functional network of TB culture and DST service (with national quality assurance system) **4 =** Provides TB culture and sensitivity services meeting international quality standards
Cambodia	3	3	3	
DR Congo	0	2	2	
Indonesia	0	1	2	
Malawi	0	3	3	
Mozambique	2	2	2	
Namibia	2	2	2	
Nigeria	2	2	2	
South Africa	4	4	4	
Uganda	2	2	2	
Zambia	4	4	4	

In Year 2, TB CAP continued investing in projects to improve diagnostic capacity. One project focused on a guide to improve quality of radiology for better diagnosis of smear negative TB cases. TB CAP partners developed **X-ray supervisory checklists** and accompanying guidelines and field tested in few countries including Cambodia and Pakistan. The field test were conducted to ensure that the checklists are applicable in the resource-limited settings and useful in assessing the quality of chest X-rays. The checklists and the guidelines are at the final stages of development and will be available soon. TB CAP has also been developing comprehensive **TB Laboratory Standard Operating Procedures (SOPs).** This document is comprehensive enough to cover all aspects of TB laboratory including culture and DST. Plans for field testing of the SOPs are being made and the product will be finalized following the field testing.

Since both these products are still not available the two PMP indicators (***Implemented "TB Laboratory Standard Operating Procedures (SOPs)"*** and ***Implemented the "X-ray Diagnosis Guidelines"***) are not applicable this year.

To improve TB laboratory performance TB CAP partners have been developing **Laboratory Management Information System (MIS)**. The system uses Excel (supply and rechecking analysis spreadsheets) and EpiInfo (culture/DST database). The whole package will be ready after field testing.

An annual **laboratory managers meeting** was also organized to further improve laboratory services through increased collaboration and TA in East Africa. A meeting of nine Eastern African target countries was held in Geneva in January 2007. During the meeting, four candidates were discussed as Regional Supranational Reference Laboratories (SRL) and Kenya, Tanzania and Uganda were chosen as National Reference Laboratories. TB CAP consultants then conducted assessment visits to those and analyses are underway to select and support the development of SRLs in East Africa. Please also refer to Section 4.4.5 (page 24) for additional TB CAP work in East Africa.

4.4.4 Improved prevention and management of MDR TB

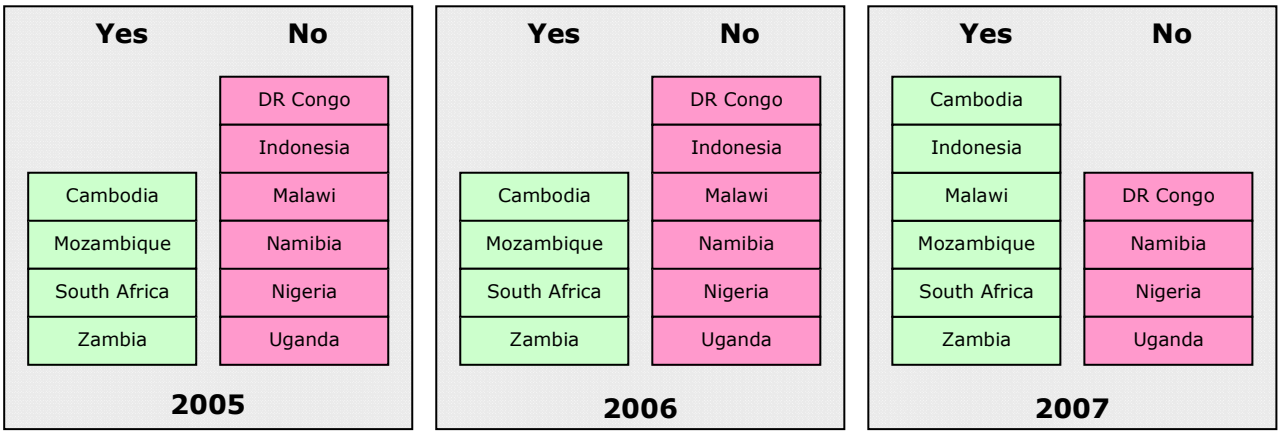
TB CAP PMP defines two indicators on MDR TB. The first one is the availability and quality of a national policy on MDR TB while the second one focuses on the availability of MDR TB surveys. Table below provides the results. National MDR Policy documents of Indonesia, Malawi and Mozambique have met all three standards mentioned in the Table 16 below.

Table 16: Status of National MDR TB Policy

Score (Max. 3.0)	2005	2006	2007	2007		
				Written and officially approved	Mentions that a surveillance or survey system be implemented	Mentions the establishment of at least one laboratory performing culture & DST
TB CAP	**1.2**	**1.5**	**1.9**	**0.=,5**	**0.6**	**0.8**
Cambodia	2	2	2	No	Yes	Yes
DR Congo	0	2	2	Yes	No	Yes
Indonesia	1	2	3	Yes	Yes	Yes
Malawi	2	2	3	Yes	Yes	Yes
Mozambique	3	3	3	Yes	Yes	Yes
Namibia	1	1	1	No	No	Yes
Nigeria	0	0	0	No	No	No
South Africa	3	3	3	Yes	Yes	Yes
Uganda	0	0	0	No	No	No
Zambia	0	0	2	No	Yes	Yes

In 2005 and 2006 only four countries (Cambodia, Mozambique, South Africa and Zambia) were conducting MDR TB surveys or having MDR TB surveillance systems two more countries (Indonesia and Malawi) joined those in 2007 (Figure 8)

Figure 8: TB CAP Countries conducting MDR TB surveys or having MDR TB surveillance systems



TB CAP partners have been conducting courses for specialized health care providers to be trained in the clinical and operational management of complex MDR TB patients. This year the **International MDR-TB Course of Mexico** took place in July 2007, with the attendance of 28 participants (14 men and 14 women) from 11 different countries. TB CAP partners are planning to conduct similar international courses every year transferring the methodology to local trainers from the selected

Latin American countries. It is expected that in 2010, staff of National Institute of Respiratory Diseases (INER, Instituto Nacional de Enfermedades Respiratorias) of Mexico City and also facilitators from other Latin American countries will be able to conduct the entire course.
Another training course in Year 2 was on **Management of MDR and XDR TB in Africa Region.** The purpose was to improve coordination between HIV and TB programs through strengthening and linking surveillance systems for HIV and MDR-TB. The regional course was organized in Johannesburg, South Africa in May, 2007. Ten countries (Botswana, Kenya, Lesotho, Malawi, Namibia, South Africa, Swaziland, Uganda, Zambia, and Zimbabwe) for a total of 43 participants were invited and all of them were able to attend the meeting. The participants were either staff of the NTP or laboratory experts or senior clinicians in charge of patients with DR-TB, or WHO NPOs. Overall, the course was very well received by the participants. The sessions on clinical management and IC raised lots of interest and discussion showing the need of organizing dedicated training activities on these two topics. At the end of the course each delegation developed a plan for concrete next steps to address MDR and XDR-TB surveillance, diagnosis, and treatment in their own country.

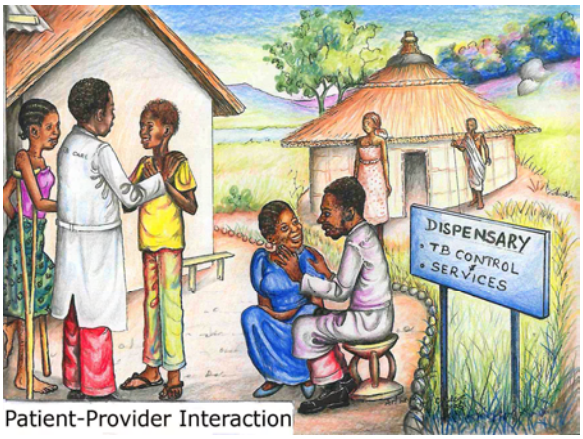
4.4.5 Improved management of IC and XDR-TB

In the absence of adequate political commitment and measures to implement the Stop-TB Strategy in an effective manner, and the urgent measures to address the already existing problem of MDR- and XDR-TB, efforts for control of TB in the region will slide more "out of control", resulting in increasing numbers of incurable patients, ongoing transmission and spread of infection, and increased mortality. There is thus an urgent need to address the shortcomings in detection and management of drug resistant TB and IC measures in sub-Saharan Africa.

After global consultation, TB CAP partners selected two strategic components; laboratory strengthening and IC and developed a project to have an impact on the prevention and management of MDR- and XDR-TB in the Sub-Saharan region by investment in laboratory system strengthening and TB IC. This project will update TB IC policies and practices implemented in regional countries and will also create one additional SRL in East Africa. Major project activities have just started as of writing of this annual report. Please also refer to Section 4.4.3 (page 22) for additional TB CAP work in East Africa including annual laboratory managers meeting and establishement of two regional SLRs.

4.4.6 Improved equitable access to quality TB care for vulnerable populations

Although TB CAP has identified this as one of the output areas so far there is only one project that indirectly addressing the improved access to quality TB care. **QUOTE** (**Q**uality **o**f care as seen **t**hrough the **e**yes of the TB patient) tool has been developed to measure and improve the quality of TB services from the patients' point of view. It measures services by combining preferences and importance of certain aspects of health services. In the previous TBCTA project, the tool was already developed. However, the tool was not yet been tested in the field for validation and psychometric characteristics. For that purpose, a regionally funded project was developed which field tested and finalized the tool. The tool and the guidelines are available now. The tool will assist NTPs in sub Saharan African countries in regular supervisory activities. It will also help focusing in problem areas. Picture cards denoting the nine important concepts of TB care are designed, field-tested and produced. A series of dissemination workshops are planned for Kenya, Malawi and Uganda.



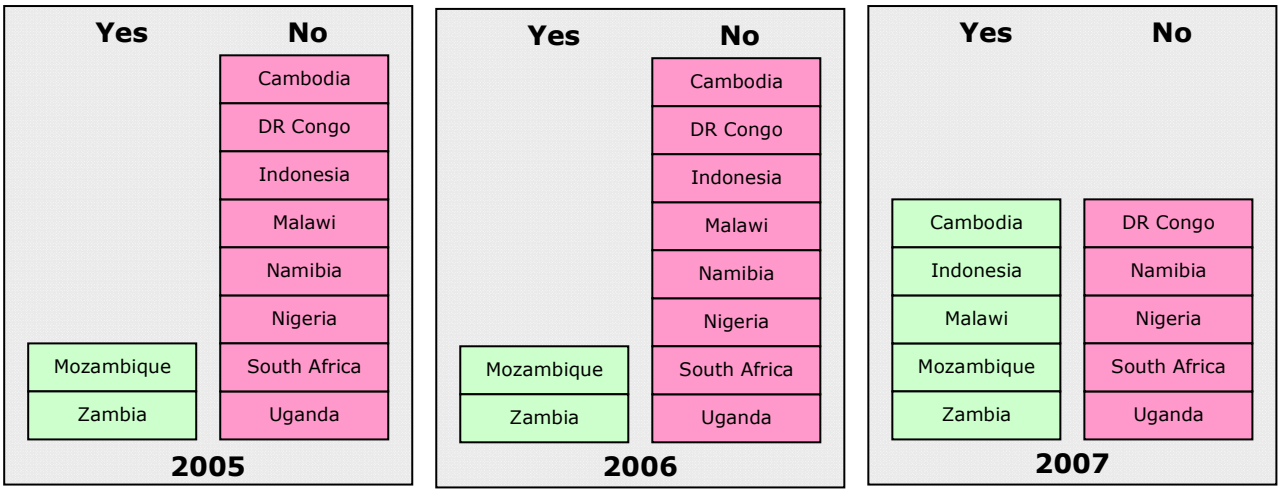
Patient-Provider Interaction

TB CAP PMP has two indicators to measure improved access to quality TB care. Those are;

- TB CAP Countries measuring socioeconomic status to document equitable access
- TB Countries that have an official pro-poor policy

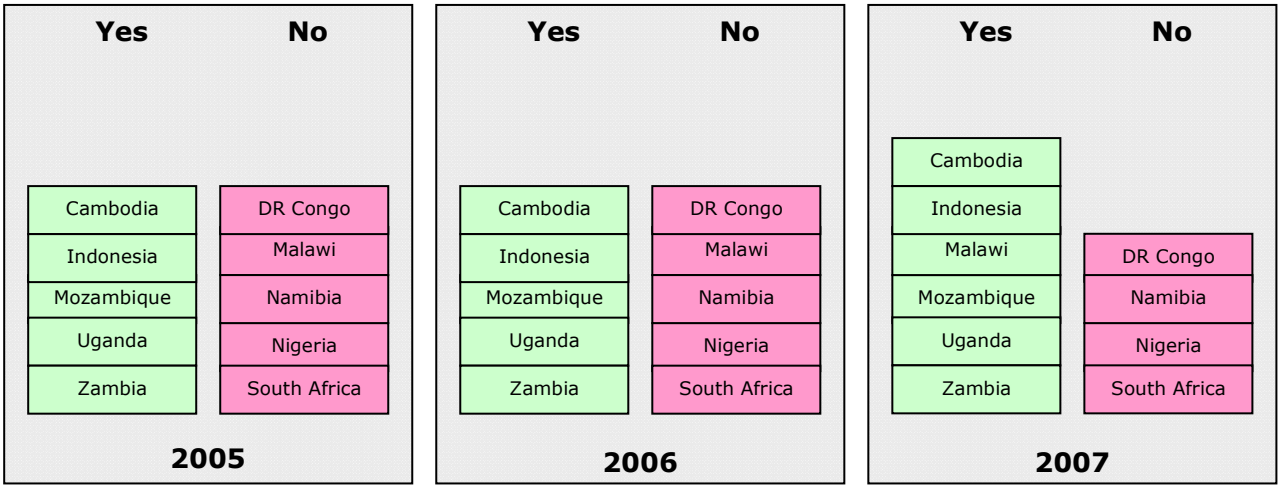
The following two tables provide information on those two indicators;

Figure 9: TB CAP Countries measuring socioeconomic status to document equitable access



Although TB CAP has not directly supported any activities there has been an improvement in 2007. Cambodia, Indonesia and Malawi joined Mozambique and Zambia that measure socioeconomic status to document equitable access.

Figure 10: TB CAP Countries that have an official pro-poor policy



In 2007 the number of TB CAP countries that have an official pro-poor policy increased from five to six. DR Congo, Namibia, Nigeria and South Africa still do not have such a policy.

4.5 IR 3: Increased public and private sector DOTS participation and collaboration

TB CAP aims to increase NTP coordination and collaboration with public and private sectors. The strategic approach of TB CAP is to work in close collaboration with The Stop TB Partnership's global PPM DOTS sub group. This collaboration provides an overall global strategic framework for public and private participation (PPP) activities and help to develop generic tools and guidance to assist TB CAP countries as well as other countries.

TB CAP Year 1 and 2 projects have complemented and significantly advanced the global efforts for increased public and private participation and collaboration in DOTS implementation. During Year 2 **Handbook for Using the *ISTC*** (International Standards of Tuberculosis Care) was completed. The Standards are intended to facilitate the effective engagement of all care providers in the delivery of high-quality care for all TB patients increasing the likelihood of controlling TB and preventing the development of MDR and XDR TB worldwide. The Lancet's Volume 6 November 2006 issue published the *ISTC* and also an editorial in the context of XDR-TB. The ISTC has been translated into English, French and Russian, Indonesian, Vietnamese, Chinese and Khmer. In Year 2, a pilot was conducted in Indonesia, India, Kenya, Mexico and Tanzania to compile relevant experiences regarding the utilization of the ISTC and the Handbook for using the ISTC was developed. TB CAP partners have also developed a flexible and locally adaptable series of **training modules for continuing education using the *ISTC*** as the focus. The modules will be field tested and finalized next year.

This year a **Professional Society Workshop** was held during the ATS International Conference. The purpose was to organize a network of medical professional societies. Participants found this to be an extra benefit of the conference and an extreme value added for their participation. The majority of the participants attended sessions at the ATS meeting each day including the sessions on TB. Table below provides the result of TB CAP PMP indicator on ISTC implementation.

Table 17: Status of ISTC implementation in TB CAP Countries

Score (Max. 3.0)	2005	2006	2007	The scoring is based on the following levels;
TB CAP	**0.0**	**0.1**	**0.9**	**0 =** Country has not adopted the "ISTC" and there are no plans for the implementation
Cambodia	0	0	1	
DR Congo	0	0	2	**1 =** Country has adopted the "ISTC" and there are plans for implementation but the implementation has not started
Indonesia	0	1	2	
Malawi	0	0	1	
Mozambique	0	0	0	**2 =** "ISTC" have been partially implemented in several institutions/regions
Namibia	0	0	1	
Nigeria	0	0	1	
South Africa	0	0	0	**3 =** "ISTC" have been fully implemented and used at the national level
Uganda	0	0	1	
Zambia	0	0	0	

The number of TB CAP countries that adopted the ISTC has increased from one (Indonesia) in 2006 to seven (Cambodia, DR Congo, Indonesia, Malawi, Namibia, Nigeria and Uganda) in 2007. However, still no country has fully implemented the ISTC at the national level.

A **situation analysis tool and guidelines for Hospital DOTS involvement** is under development. This document describes general strategies and tools for hospital linkage.

The first multi-country, "**national PPM planning**" workshop was successfully organized in Cairo in February, 2007. NTP managers and their PPM focal persons from five TB CAP countries (Malawi, Namibia, Nigeria, Uganda and Zambia) and six other countries from the WHO Eastern Mediterranean Region participated. All countries completed draft operational plans with budgets during the workshop. Seven countries finalized and submitted their operational plans to WHO after the workshop. Assistance is being provided to countries to enhance, mobilize resources for and implement PPM operational plans. The following table summarizes TB CAP's PMP indicator for PPP implementation.

Table 18: Status of PPP Implementation Strategy in TB CAP Countries

Score (Max. 4.0)	2005	2006	2007
TB CAP	**0.9**	**1.5**	**2.0**
Cambodia	1	1	2
DR Congo	0	2	3
Indonesia	1	3	4
Malawi	2	2	3
Mozambique	1	2	2
Namibia	0	0	0
Nigeria	2	2	2
South Africa	0	0	0
Uganda	2	2	2
Zambia	0	1	2

The scoring is based on the following levels;

0 = The country has not done anything on PPP

1= The country has piloted at least one PPP intervention

2 = The country has developed a PPP strategy

3 = The country has started implementation of the strategy

4 = The county has started countrywide implementation of PPP

As seen from the table above TB CAP countries have gained momentum in PPP implementation. Indonesia has started countrywide implementation while Namibia and South Africa has not done anything on PPP.

4.6 IR 4: Increased and strengthened TB and HIV/AIDS coordinated activities

Since its launch TB CAP has been developing and implementing projects to improve national policies and coordination between National TB and HIV programs and improve access to HIV and TB services for HIV positive TB patients and persons living with HIV. TB CAP's main strategy is to work with governments and partners to improve the policy environment for coordinated TB and HIV/AIDS activities. Projects under TB CAP have been developed and implemented to ensure the scaling-up of TB/HIV activities. The main accomplishments of the second year are as follows;

TB CAP partners have revised the **TB in Prison Guidelines** including the TB/HIV chapter. The members of the writing committee reached consensus on new diagnostic algorithm of TB in prisons and finalized the status paper of TB in prisons in Europe. The writing committee was also involved in updating International TB handbook. While this helped with having prison guidelines which were in line with the latest international guidelines, the final product is expected in early 2008.

TB/HIV literacy package and curriculum project has been developing guidelines for community-based groups on TB/HIV literacy. A content outline and resource guide were finalized, and a survey was drafted and shared with community support groups to gather input on audience needs and proposed toolkit relevance.

Develop guidance on TB/HIV activities outside the public sector project, which is still in progress, supports the development of a continuum of care on TB/HIV within and between public and private sector, and support an integrated approach on TB/HIV.

Strengthen the national capacity of the TB and HIV programs in G-CAP Region project has provided TA to Guatemala for integration and designed the Guatemala TB Strategic Plan. The TB/HIV training package has been translated. TA to Nicaragua has been provided for writing the TB and HIV/AIDS components of the GF proposal. Sub-regional protocols for clinical management of TB/HIV patients and guidelines at country level have been completed. The TB/HIV training package has been translated into Spanish.

The following two tables provide the data for IR4 PMP indicators.

Table 19: Status of the implementation of the revised recording and reporting system for TB/HIV in TB CAP Countries

Score (Max. 3.0)	2005	2006	2007
TB CAP	**0.9**	**1.7**	**1.9**
Cambodia	1	2	2
DR Congo	0	2	2
Indonesia	0	1	1
Malawi	1	2	2
Mozambique	0	0	1
Namibia	1	3	3
Nigeria	1	1	1
South Africa	2	2	2
Uganda	2	2	2
Zambia	1	2	3

The scoring is based on the following levels;

0 = Country has not adopted the **system** and there are no plans for the implementation

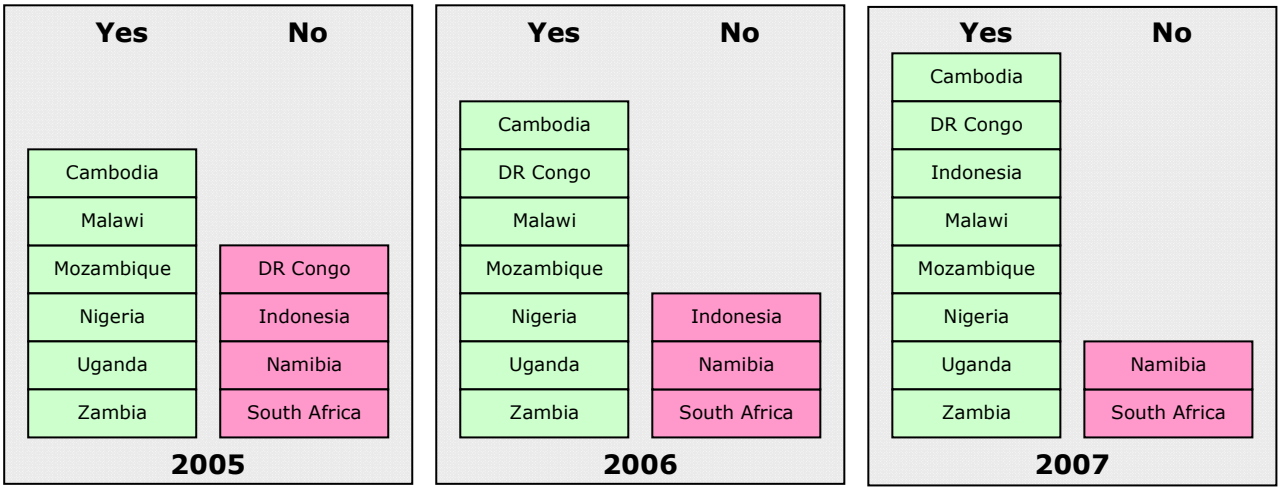
1 = Country has adopted the **system** but the implementation has not started

2 = The **system** has been partially implemented in selected regions/institutions

3 = The **system** has been fully implemented and operational countrywide

So far, only two TB CAP countries (Namibia and Zambia) have fully implemented the revised recording and reporting system.

Figure 11: Joint planning at national level for collaborative TB/HIV activities between NTP and NACP



The table above indicates that only Namibia and South Africa still do not have joint planning at the national level for collaborative TB/HIV activities.

TB CAP PMP has four additional indicators for i*ncreased and strengthened TB and HIV/AIDS coordinated activities.* These are;

- Percent of co-infected TB patients referred for HIV/AIDS care
- Percent of all registered TB patients who are tested for HIV
- Percent of co-infected TB patients on ART
- Number of persons living with HIV receiving TB prophylactic therapy
- Percent of all registered persons living with HIV who are screened for TB

Since, only few TB CAP countries were able to regularly collect and report those indicators, the results will not be presented in this report. However, there are concerted efforts in Year 3 to get this information for next year's report.

4.7 IR 5: Improved human and institutional capacity

The expected output for TB CAP IR5 is ***improved staff at different levels of the health system and improved availability of staff of all categories involved in comprehensive TB control***.. It means that there is a sufficient number of all staff categories involved in comprehensive TB control (clinical and managerial) at all levels of the health system with the needed support systems to motivate them.

To achieve these, TB CAP focuses on improving Human Resource Capacity and improving institutional capacity and training institutions. TB CAP considers HRD plans an essential component of a country's NTP medium-term development plan.

In Year 2 TB CAP designed and implemented several important projects summarized below;

E-portal for HRD was developed and launched as a tool for continuous support of HRD focal points. As of end of this project year there are 39 member countries. The most active members are; Cambodia, Ethiopia, Ghana, Kenya, Lesotho, Malawi, Philippines, South-Africa, Tanzania, Thailand, Vietnam, Zambia and members of the IR5 working group. This HRD e-portal structure makes possible of continuous learning and electronic follow up of HRD focal points in TB CAP countries. The project will continue in Year 3.

This year **Institutional Capacity Building** project has gained momentum. A Request for Application (RFA) was developed and published on the website of TBCTA and sent to the identified Institutes in May 2007. In total 5 institutes applied from English speaking Africa and 3 from Asia. The review committee scored the applications and selected **Zaria Training Center in Nigeria** and **Gadjah Mada University in Indonesia** as candidate institutions. No applications were received and no other potential names of institutes were identified from the Francophone African country institutions. Introductory visits to Indonesia and Nigeria are planned in October and November 2007, respectively. The objectives of these visits are to come to a mutual agreement on steps needed to develop the two institutes selected into a centre of excellence as **Regional Training Schools for TB Control** and to develop a plan of action for the project period.

In year 2, the **first HRD/TB platform meeting** conducted in May 2007 in The Netherlands. In total, there were 31 participants, from the following 15 countries: (Afghanistan, Cambodia, DR Congo, Ghana, Indonesia, Lesotho, Malawi, Namibia, Nigeria, Pakistan, Philippines, Tanzania, Thailand, Vietnam and Zambia). Not only TB CAP priority countries were invited but also countries that attended previous HRD workshops organized by TBCTA & TB CAP.

> ***"...this platform meeting is very useful for everyone who works hard for TB control because knowing challenges is one thing and dealing with these problems is another thing and much more difficult, we need each other and hope to be bigger and stronger"***
> a meeting participant

This was the first meeting of its kind to bring HRD focal points together from Asia and Africa to share experiences and lessons learned. The most important outcome of the meeting was creating a platform for further exchange on HRD challenges and solutions and getting a clear picture how TB CAP can better support HRD activities at country level as well as move the global agenda in this area. All participants are connected to the E-portal and this will stimulate further exchange and support to each other.

The Nurses TB Competencies Guide has been finalized. Workshop "Guía de Competencias en Tuberculosis para Enfermería" was conducted on 2-5 September, 2007 in Mexico City with participation of the nursing schools involved in the project from the 4 countries (Brazil, El Salvador, Mexico and Peru). The product was the ***Nurses TB Competencies Guide*** (in Spanish) and a Work Plan 2008-2012 for the implementation of this guide in the Americas. The success of this project is due to the good participation of the involved universities and their representatives.

This year TB CAP remained involved in the activities of the CORE group of US based PVOs. TB CAP members attended the best practices and lessons learned on community based TB workshop conducted in February, 2007 in the US and they shared their experiences with the international audience.

The following tables provide results of IR5 PMP indicators;

Table 20: Status of HRD plans prepared based on global HRD guidelines for comprehensive TB control in TB CAP countries

Score (Max. 3.0)	2005	2006	2007
TB CAP	**1.0**	**1.2**	**1.5**
Cambodia	0	0	1
DR Congo	2	2	2
Indonesia	2	2	3
Malawi	2	2	2
Mozambique	0	1	1
Namibia	0	0	0
Nigeria	2	2	2
South Africa	2	2	2
Uganda	0	0	0
Zambia	0	1	2

The scoring is based on the following levels;

0 = NTP has not prepared an HRD plan

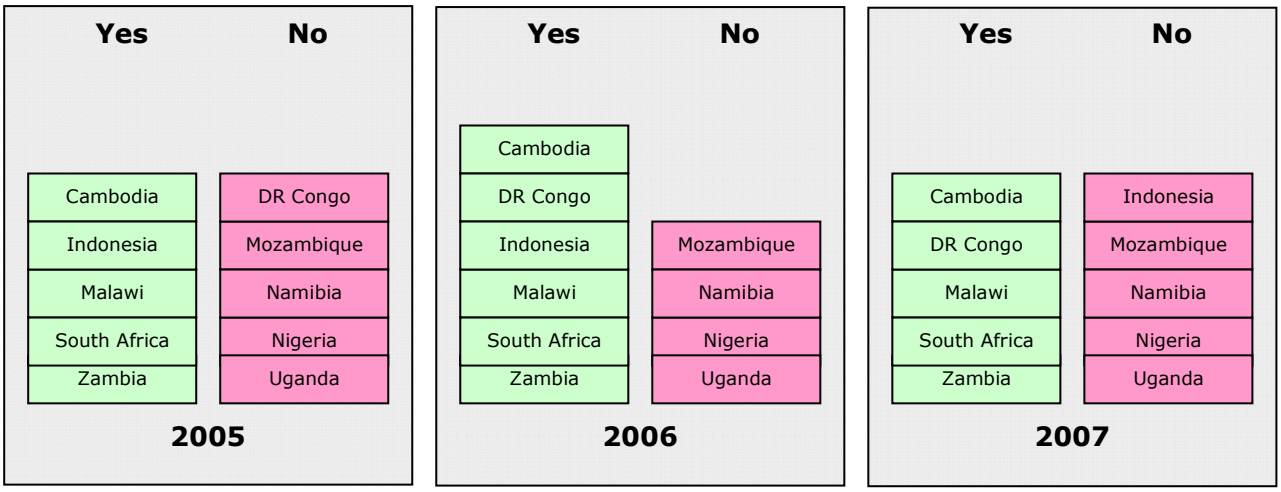
1 = NTP has initiated the process of preparing the HRD plan

2 = NTP has developed a somewhat complete HRD plan

3 = NTP has developed a comprehensive HRD plan and officially incorporated into the country strategic plan

Only Indonesia has developed a comprehensive HRD plan while Namibia and Uganda have not prepared an HRD plan yet.

Figure 12: TB CAP Countries where NTP has an HRD focal point



Based on the table above still 50% of the TB CAP countries NTPs do not have an HRD focal point.

Table 21: TB CAP countries where pre-service curricula have been upgraded/revised to reflect the implementation of TB control activities based on the Stop TB Strategy

	2005	2006	2007
Cambodia	No	No	No
DR Congo	No	Yes	Yes
Indonesia	Ongoing	Ongoing	Ongoing
Malawi	No	No	Yes
Mozambique	Yes	Yes	Yes
Namibia	No	No	No
Nigeria	Yes	Yes	Yes
South Africa	No	Ongoing	Ongoing
Uganda	No	No	No
Zambia	Ongoing	Ongoing	On-going

As of 2007, four TB CAP countries (DR Congo, Malawi, Mozambique and Nigeria) have revised pre-service curricula based on the Stop TB strategy while there are ongoing efforts to complete the revision in Indonesia, South Africa and Zambia.

Figure 13: TB CAP Countries where NTP has an HRD MIS in place that collects and produces up-to-date information

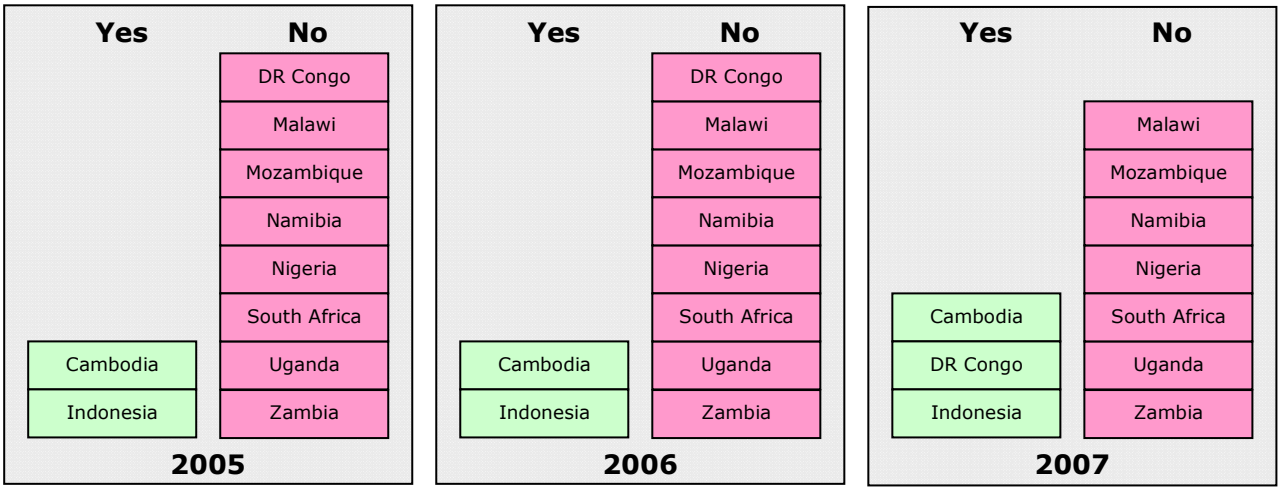


Table above indicates that in 2007 only three of the TB CAP countries have an HRD MIS in place. This makes it difficult to monitor the PMP indicators below about the staff availability in TB CAP countries;

- Percent of facilities with staff trained in TB case detection and treatment
- Percent of key managerial NTP staff positions filled according to the HRD plan
- Percent of TB microscopy units with at least one laboratory technician trained in AFB microscopy

TB CAP will focus on improving the availability and quality of HRD data in countries where there is a substantial investment. TB CAP will also gather more information on the features of existing HRD MIS, the use of information collected in those countries so that tailored TA could provided in the coming years.

4.8 Expanding the pool of international TB consultants

Expanding the pool of consultants is one of TB CAP's key strategies. Since 2005, TB CAP has conducted four international consultancy training courses. These are;

1. PPM DOTS Course for Consultants - WHO Headquarters, Geneva, 27-31 March 2006
2. TB/HIV Course for Consultants - Sondalo, Italy, June 8-15, 2006
3. Laboratory Course for Consultants - Cairo, Egypt, June 25-29, 2006
4. Laboratory Course for Consultants – Cairo, Egypt, June 5-10, 2007

The distribution of participants is summarized below;

Table 22: TB CAP Consultancy Courses Conducted

Type of Course	PPM (Mar 2006)	TB/HIV (Jun 2006)	Laboratory (Jun 2006)	Laboratory (August 2007)	Total
Number of consultant trainees	**19**	**22**	**14**	**20**	**75**
Female	4	7	6	12	29
Male	15	15	8	8	46

Similar to last year, TB CAP partners conducted a **Laboratory Consultant Training Course** to improve consulting capacity of laboratory experts. The training course was held in August 2007 in Cairo with 20 (12 female and 8 male) participants. Participants from this year's training course, as well as those from last years course are now part of the TBTEAM (**TB TE**chnical **A**ssistance **M**echanism of the Stop TB Partnership). TBTEAM aims to strengthen TA to countries through the coordination of existing technical mechanisms. It maintains a database of TA missions to countries that enables partners to better coordinate efforts, and manage requests for assistance from countries.

PPM Consultants trained in Year 1 were assigned as mentors to several countries to assist the PPM National Situation Assessments (NSA) using the TB CAP tool. Seven of the eight countries supported by TB CAP successfully conducted NSA.

TB CAP maintains contact with the trained consultants. Specifically, TB CAP partners would like to know whether newly trained consultants have been using the newly acquired skills, conducting consultancies and whether they need additional support. A database has been developed and one of the key TB CAP indicators for this purpose is; *"Percent of all TB CAP consultant trainees who have completed at least two consultancies in the last 12 months"* In September 2007, after one year following the courses all trainees of the first three courses were sent an electronic questionnaire. The purpose was to ensure trainees' connectedness with the international TB community while updating TB CAP's consultancy database for future collaboration and assess the impact of training efforts. The results are summarized below;

Table 23: Type of TB CAP Consultancy Courses and Responses to TB CAP Survey

Type of Course	PPM (Mar 2006)	TB/HIV (Jun 2006)	Laboratory (Jun 2006)	Total
Total number of consultants trained	19	22	14	**55**
Total responded to mail survey	5	13	8	**26**
Response Rate	26%	59%	57%	**47%**

As seen above the lowest response rate was among PPM trainees while over half of the Laboratory and TB/HIV consultant trainees have responded.

Table 24: Consultancies completed by TB CAP Trainees

Consultancies	PPM (Mar 2006)	TB/HIV (Jun 2006)	Laboratory (Jun 2006)	Total
Total responded to mail survey	5	13	8	**26**
Number of respondents who completed at least one consultancy in the last 12 months	3	6	1	**10**
Number of respondents who completed at least two consultancies in the last 12 months	3	3	2	**8**
Percent of respondents who have done at least two consultancies in the last 12 months	60%	23%	25%	**31%**
Total number of consultancies done by respondents	11	14	10	**35**
Average number of consultancy per respondent	2,2	1,1	1,3	**1,3**

The table above indicates that 31% of all respondents have completed at least two consultancy missions in the last 12 months.

PPM consultants did 11 visits while TB/HIV consultants and Laboratory consultants did 14 and 10 visits, respectively. In total, respondents did 35 visits to 24 countries mainly in Asia and sub-Saharan Africa. The trainees were also asked about their willingness and availability for future consultancy missions. The responses are summarized below;

Table 25: Availability of TB CAP Trainees for future consultancies

Availability	**PPM** (Mar 2006)	**TB/HIV** (Jun 2006)	**Laboratory** (Jun 2006)	**Total**
Total responded to mail survey	5	13	8	**26**
Total respondents available for future consultancies	4	11	7	**22**
Percent available per respondent	80%	92%	88%	**85%**

The results above indicate that 85% of all trainees who responded to the survey were also available for future missions. It could also be possible that mainly the trainees who were willing to join consultancy missions have responded to the survey.

The above results show a major challenge in improving the capacity of consultants for specific areas of TA. A more in depth analysis is needed to find out the cause for the low responses to the survey and the low utilization of trained consultants.

4.9 Support to Global Fund (GF) projects

TB CAP supported countries for GF Round 7 proposal development: TB CAP supported **Cambodia**, **Senegal**, **Malawi** and **Mozambique** for the preparation and submission of GF Round 7 proposals for TB grants. PMU worked in close collaboration with WHO to identify the countries, contact consultants and set the appropriate dates for missions. All planned missions were completed on schedule and all four countries submitted TB proposals to the GF.

On November 12th, The Board of the GF announced the approval of $1.1 Billion in new grants. Malawi, Mozambique and Senegal proposals have been approved. Cambodia proposal has been rated Category 3-4 (not approved) but is eligible to appeal.

It should be noted that TB CAP is more successful than GF Round 6. While 43% of proposals supported by TB CAP were approved for funding in Round 6, this has increased to 75% in Round 7.

TB CAP has provided TA to selected GF countries. The U.S. Government has provided short-term, rapid assistance to GF grantees that are faltering in their implementation. The TA is to focus on alleviating the specific bottlenecks causing the under-performance. TB CAP was selected as one of the mechanisms to provide TA for this purpose. To date, TB CAP has provided TA to Georgia, DR Congo, Lesotho, Romania, Uzbekistan and Vietnam. All missions were successfully completed. In ***Georgia***, TA was provided to both National TB and HIV programs to develop a joint TB/HIV collaborative strategy and TB/HIV M&E Plan. In ***DR Congo***, TA was provided to improve financial management, procurement planning and M&E in order to assist NTP as the future primary recipient of the grant. n ***Lesotho***, TA was provided to NTP for implementing new reporting and recording system and district level TB registers. In ***Uzbekistan***, TA was provided to GF Primary Recipient to develop a National M&E Framework for TB program and also to better manage finances and in ***Vietnam***, to improve planning, supervision and financial management.

DR Congo, Georgia and Uzbekistan have now M&E plans to better monitor the national programs while Primary Recipient in Uzbekistan has a financial system to better manage GF resources, monitor sub-recipients and timely and accurately report GF project expenditures. TA to Vietnam has helped NTP to improve provincial planning and supervision and also better monitor the national training activities.

5. TB CAP Country Projects

At the end of Year 1 Tb CAP had work plans with nine countries. During Year 2 nine more countries were added and the country portfolio of TB CAP has reached to 18 countries. The table below summarizes all TB CAP Countries as of end of September 2007.

The table below provides an overview of TB CAP countries as of end of September 2007.

Table 26: Overview of TB CAP Country Projects

Countries	Leading Partner	Approved Budget (US$)		
		Year 1	Year 2	Total
Brazil	The Union	170.000	170.000	340.000
Cambodia	JATA		1.360.399	1.360.399
Djibouti	WHO		225.000	225.000
Dominican Republic	KNCV		200.000	200.000
DR Congo	The Union	800.000	200.000	1.000.000
Ghana	MSH	160.001		160.001
Indonesia	KNCV		3.220.000	3.220.000
Kenya	KNCV	55.000	180.000	235.000
Malawi	MSH		1.441.858	1.441.858
Mexico	The Union		486.640	486.640
Mozambique	FHI	141.424	1.556.174	1.697.598
Namibia	KNCV	580.000	948.000	1.528.000
Nigeria	WHO		104.841	104.841
Philippines	KNCV	169.000		169.000
South Africa	KNCV		750.000	750.000
South Sudan	WHO	150.000		150.000
Uganda	The Union		1.000.000	1.000.000
Zambia	FHI	993.144	914.000	1.907.144
		3.218.569	**12.756.912**	**15.975.481**

It should be noted that while the number of countries have reached from nine to 18, the total budget has increased four-fold in two years. In the next chapter detailed information is provided for the ten major country projects.

5.1 Major TB CAP Countries

Cambodia

Background Information

Cambodia has made substantial progress since 1993 in socio-economic recovery. However, there are gaps in living conditions between cities and areas. One third of the population lives under the poverty line. Long lasting conflict and poverty have been offered as explanations for the high TB burden. In late 1980s a prevalence rate of 455 ss(+) cases per 100,000 population was recorded. NTP Cambodia was rehabilitated in 1994 with strong support from WHO, introducing DOTS through public hospitals which were equipped with TB units, TB beds, microscopes and staff. Both treatment and detection rates have been improving since then. However, poor accessibility has been an issue.

TB CAP in Cambodia is playing an essential role for the NTP to achieve the MDG in TB control. The NTP has achieved much in the last decade, and the GF is becoming the major funding source of the NTP. TB CAP provides a significant contribution to facilitate TB/HIV collaborative activities through the work of the ground level collaborating partners. A defining characteristic of TB CAP Cambodia is TA provided to the NTP through strong partnerships. The partners that have rich experience in project management in Cambodia and other partners with renowned expertise in specific areas of TA are also strengths of TB CAP Cambodia. **TB CAP Partner JATA** has been working as Coordinating Partner and runs the office housed in the NTP, providing TA in various areas through stationed JATA staff, local staff and short term experts from JATA headquarters in Tokyo. **FHI** works mainly for TB/HIV and IEC. **WHO** provides TA to the NTP on advocacy, policy development, strategic planning, resource mobilization, M&E, IEC, TB/HIV, PPM and MDR-TB. **MSH** provides TA on drug management. The project was officially approved and launched in February, 2007.

1. Key Data	**2004**	**2005**	**2006**
Total Population (millions)	13	14	n/a
TB incidence (WHO estimates) per 100.000 population	510	506	n/a
HIV sero-prevalence among TB patients (%)	13	6	n/a
Case fatality of HIV positive TB patients (estimated %)	14	6	n/a

2. Outcome Indicators	**2005**	**2006**	**2007**
Percent of public clinics implementing DOTS strategy	98	100	100
Case detection rate (all cases)	49	52	
Case detection rate (SS+ cases)	66	65	
Treatment success rate (new ss+)	91*	93**	
Meets MDR TB quality standards defined by TB CAP (max. 3)	**3**	**3**	**3**
• Political will	Yes	Yes	Yes
• Surveillance (or survey) system is in place	Yes	Yes	Yes
• At least one laboratory in the public sector performing culture & DST	Yes	Yes	Yes
Nationwide TB and HIV programs effectively coordinated (max. 4)	**3**	**3**	**4**
• TB/HIV is reflected both in TB and HIV/AIDS strategic plans	Yes	Yes	Yes
• Annual work plans available for TB/HIV both in TB and HIV/AIDS programs	Yes	Yes	Yes
• Coordinating body is in place	Yes	Yes	Yes
• Nationwide reporting system for TB/HIV is in place	No	No	Yes

* 2004 Cohort ** 2005 Cohort (NTP estimates)

3. Financial Overview (US$)						
Period	**Funds**		**Expenditures**			**Level of Spending**
	Obligated	**Budget**	**Declared**	**Accrued**	**Total**	
Year 2	$1,300,000	$1,360,399	473,793	158,193	631,986	46%

4. TB CAP Project Highlights 2006-2007

Strengthened TB program leadership and management
TB CAP designed and conducted a national facility survey to assess the work load and distribution of staff, NGO support for community DOTS funded by organizations other than USAID, GF and JICA and the availability of HIV testing for TB patients.

Improved diagnostic capacity
A national laboratory service inventory was conducted and an electronic database is under construction. Preliminary analysis has helped NTP to identify nationwide shortage of lab consumables. It was realized that there were no (or minimum amount of) slides, reagents kits and sputum containers in the Central Medical Store, same situation at the ODs Pharmacies. Several of the highest TB burden provinces were also out of stock at peripheral level. TB CAP has prepared an emergency procurement plan to cover the needs for 2007 with TB CAP funds. Laboratory diagnostic kits procurement through GDF was completed.

TB CAP has supported CENAT to finalize the National Strategic Plan for Laboratory, in conjunction with JATA and CDC. DST for National Drug Resistance Survey at CENAT was started in September. Pilot scheme was implemented in 5 provinces (Battambang, Pursat, Kg Cham, Kg Som and Prey Veng). Five more provinces will be involved in this scheme to improve sputum smear quality.

Training of the provincial TB lab supervisors as cross checkers. This training was organized by CENAT, fully supported by TB CAP, in the context of decentralization of the EQA activities to

Increased and strengthened TB and HIV/AIDS coordinated activities
The development of the TB/HIV Clinical Guidelines has helped to strengthen the TB/HIV Technical Working Group.

The SOPs for implementing TB/HIV Activities in Cambodia is under development with the support of Clinton Foundation. As soon as a final draft of the SOP will be available, a national TB/HIV meeting will be convened. In Feb 2008, WHO will convene a Regional TB/HIV in Phnom Penh, aimed at discussing the revised "TB/HIV Regional Framework". TBCAP partners involved in TB/HIV activities will be invited to participate in this Regional Meeting to share field experiences and lessons learned.

TB CAP has developed a work plan to compare two different options for referral TB patients. Two options have been identified; transportation support for the TB patients or blood drawn at the HC level in selected settings.

TB CAP has hired a consultant to provide TA to CENAT on improvement of the clinical management of TB/HIV and development of clinical guideline. In collaboration with NTP and other partners, the first draft of clinical and management guideline of TB/HIV was completed.

Strengthened and Expanded DOTS program
In collaboration with NTP, TB CAP advisor and PATH, the IEC inventory has been finalized. NTP will review and endorse the book, which will be translated into Khmer and printed. A dissemination workshop will also be held. TB CAP has also assisted the translation of ISTC into Khmer.

DR Congo

Background Information

DRC is one of the 22 high-burden countries targeted by Stop-TB Partnership for achieving the targets of 70% case-detection rate and 85% treatment success rate. Given the vast size of the country and the extremely difficult infrastructural conditions DR Congo, as one of the poorest countries in the world, has already achieved these targets. In spite of almost achieving the global targets for TB control, NTP is faced with large challenges and is still very vulnerable because of its extreme dependency on external funding. The growing TB/HIV epidemic and the presence of well documented patients with MDR-TB pose a serious threat to the achievements of NTP. Due to the vastness of the country and the weak national health system coordination and supervision in various areas of the country is weak. This also poses a threat to the reliability of the drugs supply system which is almost entirely dependent on aerial transportation.

The new fragile states policy of USAID has led TB CAP focus on two geographic areas (South-Kivu and Maniema) due to poor program outcomes and absence of any other partner or donor for the TB activities. The TB CAP project is well placed to provide this support because of the long-standing relation of The Union with the NTLP in introducing DOTS in many parts of DRC. The Union is also working in the province of Kivu trough its TB/HIV program financed by the European Commission. This program has started in 2004 and will end in December 2008. It gives The Union, hence TB CAP, a good knowledge of the situation in Kivu especially and helps regarding procurements, logistics and travels and safety procedures. No other projects or programs operate in the same geographic area, which is located in the Eastern part of the country, seriously afflicted by conflict and insecurity.

1. Key Data	**2004**	**2005**	**2006***
Total Population (millions)	56	58	60
TB incidence (WHO estimates) per 100.000 population	366	356	356
HIV sero-prevalence among TB patients (%)	21	17	17
Case fatality of HIV positive TB patients (estimated) (%)	21	17	25

* NTP estimates

2. Outcome Indicators	**2005**	**2006**	**2007**
Percent of public clinics implementing DOTS strategy	100	100	100
Case detection rate (all cases)	46	48	n/a
Case detection rate (SS+ cases)	72	72	n/a
Treatment success rate (new ss+)	85*	85**	n/a
Meets MDR TB quality standards defined by TB CAP (max. 3)	**0**	**2**	**3**
• Political will	No	Yes	Yes
• Surveillance (or survey) system is in place	No	No	Yes
• At least one laboratory in the public sector performing culture & DST	No	Yes	Yes
Nationwide TB and HIV programs effectively coordinated (max. 4)	**0**	**0**	**2**
• TB/HIV is reflected both in TB and HIV/AIDS strategic plans	No	No	No
• Annual work plans available for TB/HIV both in TB and HIV/AIDS programs	No	No	No
• Coordinating body is in place	No	No	Yes
• Nationwide reporting system for TB/HIV is in place	No	No	Yes

* 2004 Cohort ** 2005 Cohort (NTP estimates)

3. Financial Overview (US$)						
Period	**Funds**		**Expenditures**			**Level of Spending**
	Obligated	**Budget**	**Declared**	**Accrued**	**Total**	
Year 1	1,000,000	800,000	903,161	68,663	971,824	97%
Year 2		200,000				

4. TB CAP Project Highlights 2006-2007

In order to increase the case-detection rate from 67% to 70% and the treatment success rate from 78 – 85% in South Kivu and Maniema provinces TB CAP has been supporting the following training and supervision activities in those two provinces;

- Every quarter one-day meetings with sub-districts and three-day meetings with district coordinators have been conducted in 52 health zones.

- Internet connections have been established in two provinces. This has been helping a lot in coordination and communication of training needs, lab reagents needs, reporting needs, supervision planning, etc.

- In total, 91 nurses, 56 doctors, 70 lab workers were trained in NTP technical policies.

- Supervision visits to 52 health zones in two provinces by district TB coordinator and health workers have been supported. Four motorcycles for supervision visits were locally purchased for two provinces. The road conditions in Maniema province are very bad. This makes very difficult to conduct all the supervisions that are necessary. The war has started again in Kivu province, which of course increases the risk of social workers to travel within the region to attend trainings and quarterly meetings.

At the national level TB CAP is also supporting the NTP for better management. TB CAP has supported 21 supervision visits from national level to provinces in the last 12 months. In total, 47 staff has been trained in VCT and 25 project coordinators have been trained on TB/HIV collaboration activities.

Building rehabilitation of the National Reference Laboratory has been completed and the equipment has been purchased. Eleven lab technicians have received training on fluorescence microscopy. The guide book 'Quality Control" has been updated and is ready for printing. Internet connection for National Laboratory has been established.

TB CAP will fund a Medical Doctor based at the NTP to monitor the activities and support the NTP in various aspects of TB Control. ToR has been agreed on and will be published in local newspapers. FHI and Damien Foundation were involved in the process of recruitment. USAID mission has agreed that the remaining funds from Year 2 could be used until September 2008 for this purpose.

Indonesia

Background Information

Despite major progress in DOTS expansion over the last few years, the Republic of Indonesia still ranks third on the list of TB 'high burden' countries in the world. Its incidence is estimated to be around 540,000 new cases per year. Yearly there are around 240,000 new smear positive cases. The estimated prevalence of TB is around 600,000 smear positive cases and yearly around 100,000 people die of the disease. Indonesia has made rapid progress towards reaching the global targets; case detection rates have steadily increased to from 21% in 2002 to 67% in 2005, while the treatment success rate has remained steadily above the national target of 85%. The quality of DOTS implementation through the Puskesmas (Health Center) network was the cornerstone for further progress towards these targets. The significant increase of external financial resources has challenged the capacity of the NTP and its partners in their efforts to expand the program. Central and provincial program management units are facing an increasing workload due to the expansion of activities. Current challenges to DOTS expansion in Indonesia can be summarized as; equitable access for the un-reached, difference in area-specific TB burden, case management in hospitals, clinics and private practices, emergence of MDR-TB and TB/HIV and the need for public-private partnership. There is still a need to expand and improve access to effective TB treatment and quality care through a variety of channels (public sector providers, private sector and NGO providers, HIV and other programs) while maintaining program quality. Two related issues of extreme importance, TB in the context of HIV infection and MDR-TB, require new or different approaches in addition to DOTS. The purpose of TB CAP is to strengthen local technical and management capacity through external TA, with the objective to improve access and quality of the TB services provided by government as well as non-government health providers. TB CAP partner **KNCV** has been leading the project while collaborating closely with the NTP, international and local partners and external donors, in particular USAID. It will continue the successful work started under TBCTA. **FHI**, **MSH** and **WHO** have been supporting the program as collaborating partners.

1. Key Data	**2004**	**2005**	**2006***
Total Population (millions)	224	227	230
TB incidence (WHO estimates) per 100.000 population	245	239	239
HIV sero-prevalence among TB patients	0.9%	0.8%	2%
Case fatality of HIV positive TB patients (estimated)	1%	1%	n/a

* NTP estimates

2. Outcome Indicators	**2005**	**2006**	**2007**
Percent of public clinics implementing DOTS strategy (Country total)	96	96	96
Percent of public clinics implementing DOTS strategy (TB CAP areas)	100	96	96
Case detection rate (all cases) (Country total)	48	60	
Case detection rate (all cases) (TB CAP areas)	51	63	
Case detection rate (SS+ cases) (Country total)	66	76	
Case detection rate (SS+ cases) (TB CAP areas)	56	70	
Treatment success rate (new ss+) (Country total)	90*	91**	
Treatment success rate (new ss+) (TB CAP areas)	87*	91**	
Meets MDR TB quality standards defined by TB CAP (max. 3)	**0**	**2**	**2**
• Political will	No	Yes	Yes
• Surveillance (or survey) system is in place	No	No	No
• At least one laboratory in the public sector performing culture & DST	No	Yes	Yes
Nationwide TB and HIV programs effectively coordinated (max. 4)	**0**	**2**	**2**
• TB/HIV is reflected both in TB and HIV/AIDS strategic plans	No	Yes	Yes
• Annual work plans available for TB/HIV both in TB and HIV/AIDS programs	No	Yes	Yes
• Coordinating body is in place	No	No	No
• Nationwide reporting system for TB/HIV is in place	No	No	No

* 2004 cohort ** 2005 Cohort (NTP estimates)

3. Financial Overview (US$)						
Period	**Funds**		**Expenditures**			**Level of Spending**
	Obligated	**Budget**	**Declared**	**Accrued**	**Total**	
Year 2	2,970,000	3,220,000	1,476,677	664,952	2,141,629	67%

4. TB CAP Project Highlights 2006-2007

TB CAP has considerable additional value for the NTP by creating supplementary local technical capacity being linked to specific external expertise.

Considerable progress has been made regarding implementation of ISTC and the establishment of ISTC task forces in four densely populated provinces in Indonesia. Involvement of professional societies in the ISTC activities has added another driving force to DOTS expansion and PPM. These Taskforces will boost PPM expansion and involvement of hospitals in the NTP (HDL). Strong involvement of professional societies seems very promising.

Major accomplishment of TB CAP is the creation of supplementary local technical capacity in various fields, being linked to specific external expertise. Recruitment of 18 new local technical officers has had the most positive impact on accomplishments. The addition of this young professional staff leads to increased Hospital DOTS activities in teaching - and VCT hospitals and boosting DOTS expansion to 10 clusters of districts in Jakarta, West, Central and East Java. Posting of a senior technical officer at the Central KNCV office in Jakarta is relieving the workload of the RO considerably. Recent posting of a Senior Technical Officer in Surabaya will expectedly boost activities in the Eastern parts of Indonesia, and HDL activities in East Java. The increased number of technical staff working all over the country deserves a sound human resource management approach to ensure optimal functioning of the workforce assisting the NTP. The continuous local TA provided through TB CAP , boosted by intermittent external TA has a positive impact on the activities at health facility level, both in the hospital sector as well as in the remote areas of Papua. Situational analysis has been made in both areas which form the basis of the work plans for DOTS expansion in the provinces and districts.

The major challenge was dealing with the impact of GF suspension. This had major implications for implementation of TB CAP activities because most TA activities are depending on operational inputs /work plan supported by GF. The TB CAP work plan/budget needed to be adjusted on a regular base to cope with the GF funding restrictions. This has caused serious delay in implementation of a wide range of activities related to all Intermediate Results. Moreover involvement of RO to support PR and CCM in addressing the conditions for lifting GF restrictions absorbed considerable time and energy of the RO. This had major impact on the already high workload of the RO office, which continued to be understaffed.

Recurrent adjustments of work plan and budget revisions were necessary to cope with the GF funding stop. The purpose is to assure that crucial activities will not be disrupted.

Specific accomplishments in main result areas are as follows;

Increased political commitment; District planning & budgeting tool has been revised for piloting. Staff in 8 districts (5 provinces) has been trained in using the revised tool. Piloting has been completed in 3 rounds.

Strengthened & expanded DOTS

- **Underserved areas/vulnerable groups;** Visits to provinces are taking place and TA has been provided. Three new Technical Officers have been recruited, trained and positioned in IJB and Papua. Currently assessments are being conducted.

- **Improving the quality of DOTS;** A laboratory focal point has been appointed and now coordinating laboratory working group and DRS survey. One new Laboratory Officer recruited and trained.

- **Engaging other providers (PPM);** Technical Officer to provide support to NGOs has been recruited and has started implementing work plan in collaboration with NTP. PPTI assessment conducted, report presented to PPTI and stakeholders, work plan currently in development. Strategic planning workshop with PPTI was conducted in November 2006.

Professional staff recruitment for PPTI has been completed. TA provided to five NGOs (PERDAKI, PPNI, PELKESI, WVI and NU). One technical officer appointed and trained.

- **Strengthen diagnosis & treatment of MDR-TB;** TA delivered by IMVS sub-contractor for planning, monitoring and on-the-job training. TA provided to develop work plan for dissemination of ISTC. National MDR expert group has been established, DOTS plus outline presented to National expert committee. MDR guidelines distributed. MGIT960 installed in Microbiology UI. First cultures revived for DST in Surabaya. Unabridged version of the ISTC was finalized and amended by IDI and a plan for dissemination developed. National IDI Task Force was established. TA for culture, DST and EQ has been delivered by IMVS, recommendations are being followed up.

- **TB in prisons;** Strategic plan for TB in prisons finalized and work plan developed. National Technical Officer has been recruited and trained.

Increased Public-Private & Public-Public Mix; Provinces for PPM have been selected: East, Central, West Java, DKI Jakarta, North Sumatra and South Sulawesi. Situation analysis tool (feasibility assessment) revised. Publication of the abridged ISTC in IDI journal is in progress. Translation of the full version has been finalized and amended by IDI.

Two senior staff has been recruited and is in place in provinces. Ten technical officers have been recruited, trained and posted in 5 provinces (DKI, West Java, Central Java, East Java and South Sulawesi) as DOTS coordinators in priority hospitals. In May 2007 a training course was carried out for technical officers. Specific HDL training was combined with the same course.

Expanded TB/HIV activities; First TB/HIV Sero-prevalence in Jogjakarta finalized. Survey protocol and toolkit has been developed.

Improved Human & Institutional Capacity; Two National Technical Officers have been recruited. They started implementing their work plans in December 2006. Two Technical Officers for drug management have been recruited. Recruitment for the prisons has started. Three National Technical Officers for TB/HIV have been assigned by FHI. TB Operational Research proposals have been reviewed and improved. Advanced Course for DOTS Acceleration carried out from February-April 2007. 17 senior staff successfully trained.

Malawi

Background Information

Malawi is one of the poorest countries in the Africa region, where poverty is still widespread and inequities in the distribution of income are the most profound on the African continent. Approximately 14% of the population lives in urban or peri-urban areas. Almost 50% of the population is under the age of 15 years. The literacy rate is low - 56% in adults in 1995 with 72% in men and 42% in women. Despite these challenges, the Malawi NTP is well known for its achievements in TB control. Malawi was one of the first countries where the DOTS strategy was successfully piloted in the early eighties. The NTP is regarded as one of the well functioning DOTS programs in the African region. Nevertheless, the Malawi NTP faces important challenges. The high rates of TB and HIV/AIDS pose an unprecedented burden on the public health system. There is a six-fold increase in reported TB cases since 1983. The mortality rate among TB patients remains high. TB and HIV care and treatment is still not well coordinated and patients must often seek diagnosis and treatment for each illness in different facilities, increasing the burden of access to care of co-infected individuals and their families. Malawi has a critical shortage of human resources for health. This has created a lack of capacity to delivery health services, especially in rural areas where primary health care is severely compromised. The laboratory services are overwhelmed. In light of the reported X-DR TB strains in South Africa and their lethal impact in a high HIV prevalence setting, it is more urgent than ever that Malawi develop the capacity to implement a sound MDR-treatment program.

The TB CAP provides a unique opportunity for the NTP to access a broad, comprehensive range of internationally recognized TA that supports the new global Stop TB Strategy through its membership. MSH, KNCV, FHI, and WHO are currently working in Malawi. USAID has selected MSH to coordinate the TB CAP in Malawi. In addition, MSH works with other partners, such as REACH Trust and the Liverpool School of Tropical Medicine and coordinates its activities with Project Hope.

1. Key Data	**2004**	**2005**	**2006***
Total Population (millions)	13,0	12,7	13,1
TB incidence (WHO estimates) per 100.000 population	413	409	n/a
HIV sero-prevalence among TB patients (%)	52	50	70
Case fatality of HIV positive TB patients (estimated) (%)	49	49	n/a

* NTP estimates

2. Outcome Indicators	**2005**	**2006**	**2007**
Percent of public clinics implementing DOTS strategy (Country total)	100	100	100
Percent of public clinics implementing DOTS strategy (TB CAP areas)	100	100	100
Case detection rate (all cases) (Country total)	46	46	46
Case detection rate (all cases) (TB CAP areas)	n/a	22	29
Case detection rate (SS+ cases) (Country total)	39	39	39
Case detection rate (SS+ cases) (TB CAP areas)	n/a	20	27
Treatment success rate (new ss+) (Country total)	71*	76**	n/a
Treatment success rate (new ss+) (TB CAP areas)	n/a	73**	n/a
Meets MDR TB quality standards defined by TB CAP (max. 3)	**2**	**2**	**2**
• Political will	Yes	Yes	Yes
• Surveillance (or survey) system is in place	No	No	No
• At least one laboratory in the public sector performing culture & DST	Yes	Yes	Yes
Nationwide TB and HIV programs effectively coordinated (max. 4)	**2**	**2**	**4**
• TB/HIV is reflected both in TB and HIV/AIDS strategic plans	Yes	Yes	Yes
• Annual work plans available for TB/HIV both in TB and HIV/AIDS programs	Yes	Yes	Yes
• Coordinating body is in place	No	No	Yes
• Nationwide reporting system for TB/HIV is in place	No	No	Yes

* 2004 cohort ** 2005 cohort (NTP estimates)

3. Financial Overview (US$)						
Period	**Funds**		**Expenditures**			**Level of Spending**
	Obligated	**Budget**	**Declared**	**Accrued**	**Total**	
Year 1+2	1,441,858	1,441,858	583,241	269,892	853,133	59%

4. TB CAP Project Highlights 2006-2007

Model for Continuum of integrated care for TB/HIV defined and implemented; TB CAP has stated the project implementation with a baseline data collection on current status, strengths and weaknesses and barriers to accessing TB and HIV care at the community level including the referral systems in demonstration areas. Results have been disseminated to NTP and districts. The results were well appreciated by NTP and were viewed as a true reflection of the situation on the ground.

TB CAP has developed a model for the ***"continuum of integrated TB/HIV care"*** including decentralization (from the district to the Health Center) of TB diagnosis and case management. A series of meetings have been organized with the MOH, NTP and the Zonal Health Management Team in the selected zone to identify the districts, health centers and communities for intervention of the model of care. Community sensitization meetings have been conducted with 600 community leaders for both Zomba and Mangochi. The model is still being tested and discussed at the district level.

"I personally have suffered from TB, I was diagnosed, put on treatment and I am fine now. I would like to urge more people to go to the health facility to be diagnosed and get treated. Most of the deaths taking place are due to not getting the right treatment timely."
A TB patient's testimony during community sensitization meetings

TB CAP has also introduced the concept of ***X-TB patients***. These are individuals who have previously suffered from TB and deliver health talks at health centers and during other community gatherings. They are usually well known in the community and provide a good example of someone who had TB before and has been cured. These individuals normally give testimony of their experience as a TB Patient and discuss signs and symptoms of TB, how they were diagnosed, their experience with the long TB treatment and what had motivated them to continue the treatment. They give advice to other community members about TB diagnosis, treatment and outcome. X-TB patients' contributions during community sensitization meetings had a positive impact on the audience.

TB CAP in collaboration with NTP conducted a death audit. This is similar to maternal death audit which the main emphasis of the exercise is to identify the underlying causes of death and analyze these causes to prevent further deaths and further improve quality of care. A TB team which includes a TB Clinical Officer, TB Nurse, District TB Officer and care provider meets on a monthly/quarterly basis to review the TB death cases. A checklist has been used to analyze the causes of deaths among TB patients especially those who die in a hospital. The districts of Mangochi and Zomba have started using this death audit check list.

Several trainings have been held to build the capacity of health workers including training of 35 health workers in DOTS and training of 37 Implementation Managers for both Zomba and Mangochi. 48 facilities have been oriented on active case finding from the targeted facilities for both Zomba and Mangochi. Orientation of 237 catchment facility health workers has been conducted on active case finding.

"We need a forum at the district level for discussing TB issues because the only forums available now are for HIV/AIDS".
A health center staff during district quarterly review meeting in Mangochi.

The first district quarterly meeting has been conducted for both Mangochi and Zomba districts. The main objectives of the meetings were to review the quarterly performance and plans, discuss the reporting format, discuss TB death audit and agree on who to involve in the subsequent meetings. The general feeling is that this should be a forum to share both TB and HIV/AIDS activities in the district. This would involve all the stakeholders working in the district for TB/HIV needs to be involved, the District AIDS Coordinator from the District Assembly and meetings to be chaired by District health Officer. The districts have selected 8 data elements to be closely monitored and presented on quarterly basis at facility level with support from the cluster supervisors.

A draft methodology has been developed for workload assessment of zonal and district, of TB officers to determine the feasibility of expanding their supervisory responsibilities to include the supervision of ART services.

Improved diagnostic capacity; Recruitment of Laboratory Coordinator contributed a lot to the laboratory activities in the two districts of Zomba and Mangochi. District hospital and health centre needs and laboratory workload assessment has been conducted in selected project districts. Baseline data have been collected on laboratory equipment. Current microscopy centers and VCT sites in selected districts have been mapped. In collaboration with NTP and DHO 20 microscopic and 69 fixation centers have been identified in both Mangochi and Zomba Districts. Initial assessment of the current laboratory services was carried out in collaboration with the District Health Management Teams of Mangochi and Zomba. The main problems identified were inadequate access of services, general shortage of trained laboratory workers, and shortage of supplies like slides and lancets and inadequate quality of care. Mapping of microscopy facilities for both Zomba and Mangochi have been done and laboratories which require refurbishment have been identified. Training of 16 sputum smear fixators for health facilities not conducting sputum microscopy has been conducted.

> ***"This is the only project which has laid a good foundation, making sure we are oriented on the project activities and we give in our inputs. I wish all other NGOs could be taking such type of approach"*** DHM member Zomba and Mangochi

Procurement of laboratory supplies and equipment has been done and materials have been delivered to the districts. Furniture requirements have been identified for each facility and furniture has been procured, but not yet delivered to the districts.

One day orientation training has been conducted for drivers and administrative staff on importance of handling transportation of slides and sputum specimens. A total of 47 participants participated in this orientation. A framework has been developed on the process to and be followed during this transportation process which should be dully signed by responsible officers.

Strengthened Central TB Reference Laboratory; Refurbishment of CRL has been completed and the following staff has been appointed; Clinical Officer at NTP(REACH) to co-ordinate MDR survey and the nested DOTS-Plus pilot, Laboratory assistant and data entry clerk.

MDR survey has started but still at the earl implementation stage. Two desk top computers have been procured to be used for MDR survey.

Improved public-private partnerships to provide quality TB and HIV services; WHO mission of 2 PPM experts have conducted assessment with NTP and stakeholders. Based on the assessment staff has attended workshop in Cairo to develop an implementation plan. A stakeholders meeting has been organized with Private sector representatives. NTP has oriented the DHMTs on PPM and has defined their roles and responsibilities. Action plans have been developed at Zonal level to implement PPM activities.

> ***"We are very happy that there is now an NGO which can address TB issues because for a long time, it has been only HIV/AIDS being addressed by several NGOs and CBOs,"*** DHMT member Mangochi.

Timely support for district activities rendered by TB CAP central office in terms of procurement and decentralization of funds to district level has enabled the district to implement activities in a timely manner. This was backed up by flexibility in the handling of issues by TB CAP officials from both at District and Central level.

Mozambique

Background Information

Mozambique is one of 22 countries identified with a high burden of TB. The country participated in the piloting of what was later dubbed the DOTS strategy, starting in the early eighties. The Government of Mozambique has made a concerted effort to address some of the challenges facing the TB control program, namely to increase the case-detection rate, estimated by WHO (2005 Report) at 33% and 45% (all and new ss+ cases) and availability of drugs.

Since 2005, TB medicines have been procured and the 6-months regimen using adult formulation FDCs in blister-cell packs has been introduced. The country benefits support through the GF with funds reducing since mid-2005. Other donors for HIV/AIDS include World Bank (MAP), Clinton Foundation, USAID and a long list of smaller NGOs from Europe and USA.

For several years, technical TB support has been provided by the WHO-Afro for a DOTS expansion initiative. The Union has also provided support to the NTP through technical review and monitoring missions over the past 20 years.

Funding from USAID through the **TB CAP** supports the MOH´s strategy to expand and broaden current TB programs at the national level in order to increase access to DOTS and strengthen linkages with HIV activities and improve the capacity of national reference laboratories. TB CAP partner **FHI** coordinates the project in collaboration with **MSH** and **CDC**.

1. Key Data	**2004**	**2005**	**2006***
Total Population (millions)	19	19	20
TB incidence (WHO estimates) per 100.000 population	460	447	470
HIV sero-prevalence among TB patients	48	50	50
Case fatality of HIV positive TB patients (estimated)	67	66	n/a

* NTP estimates

2. Outcome Indicators	**2005**	**2006**	**2007**
Percent of public clinics implementing DOTS strategy (Country total)	45	55	71
Percent of public clinics implementing DOTS strategy (TB CAP areas)	46	56	64
Case detection rate (all cases) (Country total)	36	37	40
Case detection rate (all cases) (TB CAP areas)	31	35	37
Case detection rate (SS+ cases) (Country total)	49	50	55
Case detection rate (SS+ cases) (TB CAP areas)	46	48	50
Treatment success rate (new ss+) (Country total)	77*	76**	n/a
Treatment success rate (new ss+) (TB CAP areas)	73*	75**	n/a
Meets MDR TB quality standards defined by TB CAP (max. 3)	**1**	**1**	**3**
• Political will	Yes	Yes	Yes
• Surveillance (or survey) system is in place	No	No	Yes
• At least one laboratory in the public sector performing culture & DST	No	No	Yes
Nationwide TB and HIV programs effectively coordinated (max. 4)	**4**	**4**	**4**
• TB/HIV is reflected both in TB and HIV/AIDS strategic plans	Yes	Yes	Yes
• Annual work plans available for TB/HIV both in TB and HIV/AIDS programs	Yes	Yes	Yes
• Coordinating body is in place	Yes	Yes	Yes
• Nationwide reporting system for TB/HIV is in place	Yes	Yes	Yes

* 2004 cohort ** 2005 cohort (NTP estimates)

3. Financial Overview (US$)						
Period	**Funds**		**Expenditures**			**Level of Spending**
	Obligated	**Budget**	**Declared**	**Accrued**	**Total**	
Year 1+2	1,697,598	1,697,598	1,222,626	137,037	1,359,663	80%

4. TB CAP Project Highlights 2006-2007

TB CAP has been managing a very successful project in Mozambique. NTP has appointed the TB CAP Project Director as its leading counterpart at the national level. In less than a year, the Minister of Health has approved the TB IC approach for Mozambique, one of the main areas for TB CAP technical support under TB/HIV collaborative activities. This is an important step that will facilitate the development of the National TB IC Strategy and its dissemination which had been on hold due to lack of political commitment.

Improved access to TB quality assured laboratory diagnosis; Renovation of Beira Regional Laboratory is underway to decentralize M.TB culture. This initiative is the outcome of an intense involvement of a comprehensive team of technical professionals including Medical and Engineering staff and Laboratory Equipment and Procurement experts who achieved a consensus on a harmonious concept that will allow the Beira Laboratory to perform TB culture. TB CAP has issued a public announcement to request bids for the renovation of the Beira laboratory and also submitted a list of laboratory equipment approved by the MoH to USAID for procurement approval. TB CAP is stepping up its efforts in-country to mobilize alternate funding sources to support the renovation of the Beira laboratory.

Mozambique National Reference Laboratory

TB CAP has purchased and distributed 25 binocular microscopes to support DOTS expansion. Microscopes will facilitate access to smear sputum diagnosis. In addition, 250 slide storage boxes were distributed to these selected laboratories to ensure adequate storage, protection and transportation of slides for quality control.

Improved DOTS Coverage; The MOH has requested the development of a National Strategic Plan that would embrace different partners using a unique approach in order to compare accomplishments in different geographic areas. In addition, the CB-DOTS Strategic Plan was intended to serve as a point of reference for M&E purposes. TB CAP has developed the Strategic CB-DOTS plan based on the recommendations of the WHO and taking into consideration the Mozambican context. This Strategic Plan meets the TB CAP objectives and activities and will undergo a technical review and will be submitted to the MOH for approval in the next quarter.

Since CB DOTS activities are being implemented for the first time in Mozambique, TB CAP has received several requests for technical support from Provincial Health authorities as well as other partners and stakeholders. The introduction and successful implementation of CB DOTS will cement TB CAP as a technical leader in this area in Mozambique.

In order to expand CB DOTS activities to four additional districts, TB CAP has selected three NGOs as implementing agencies for CB DOTS. TB CAP has provided technical and program guidance in developing their work plans and budgets. TB CAP successfully conducted four simultaneous ToTs on CB-DOTS in Nhamatanda, Dondo, Mocuba and Milange Districts in order to prepare the selected NGOs for CB DOTS implementation. In total, 114 participants, including 69 health workers and 45 officials actively participated in the trainings. The ToT curriculum was revised and improved based on the experience of the previous ToT training and the agenda covered various basic topics related to TB and HIV/AIDS, such as diagnosis and treatment, as well as the role and responsibilities of each actor in implementing CB DOTS. This ToT provided an opportunity to develop a comprehensive training plan for the volunteers from each of the selected districts.

TB/HIV collaborative activities expanded and monitored in HIV/AIDS and DOTS services; As part of the strategy to broaden support for TB/HIV collaborative activities, TB CAP has partnered with the MOH in its TB application to the GF Round 7 Call for Proposals as a sub-recipient. If successful, resources received from the GF will be used to implement TB/HIV collaborative activities

in Zambezia and Niassa Provinces that would complement and further strengthen the TB CAP program. In addition, FHI has begun to integrate TB case detection into its existing PMTCT, counselling and testing and home-based care programs.

While developing the National CB DOTS Strategy, it was strongly felt that HIV/AIDS issues needed to be integrated due to the strong linkages between the two diseases. As a result, the TOT covered HIV/AIDS and TB/HIV as a topic in the CB DOTS training curricula. The outcomes of the CB DOTS pilot in Gaza indicate that although the volunteers were trained mainly to find TB suspects, almost 25% of patients referred for TB were found to be HIV positive and not TB positive. Through this experience, we have learned that while it is important to emphasize community training and sensitization for TB, concurrent efforts must also be made to address HIV issues in order to increase case detection of both TB and HIV patients and to improve referral systems between both programs to provide efficient HIV and TB care and treatment.

TB CAP has conducted Provider Initiated Counselling and Testing (PICT) Workshops; Provincial Supervisors and clinical staff have been trained to provide Counselling and Testing for HIV to all TB patients. A total of 80 health workers from Zambézia, Gaza and Sofala Provinces have been trained. These Provinces are ready to scale up TB/HIV activities as well as to expand DOTS and begin CB DOTS with the support from TB CAP.

TB CAP has developed leaflets on TB/HIV for TB patients, PLWHA, TB Provincial Supervisors and other health workers, including counsellors, have been disseminated by the MoH. The final version of the leaflets incorporated new illustrations and revised text to improve the quality of these materials and to better reach different target groups.

The above flyer for patients, *"Why should I get tested for HIV?,"* explains that TB and HIV should be treated together.

TB CAP revised and developed the following materials:
- TB/HIV treatment protocols,
- TB/HIV training guidelines and curricula for health workers and volunteers,
- IEC materials on TB, TB/HIV and counselling and testing for HIV to be used at TB health facilities,
- M&E tools (data collection forms, definition of indicators, etc) for CB DOTS.

All above mentioned materials have been approved by the MOH and will be essential instruments for the overall implementation of the National CB DOTS strategy.

Namibia

Background Information

Namibia covers an area of 824,000 square km, in South West Africa, bordered by the Atlantic Ocean to the west, Botswana and Zimbabwe in the east, South Africa in the South and Angola and Zambia in the North. The country is made up of 13 administrative regions. At independence in 1991, life expectancy at birth was estimated at 60 years; however, this has declined to 47 years as a consequence of the HIV/AIDS pandemic. TB, HIV/AIDS and Malaria are the major communicable diseases. The NTP was established in 1991 and adopted DOTS strategy for TB control from inception. Implementation started soon afterwards with one region gradually covering the entire country in 1995. Namibia continues to report one of the severest TB epidemics in the world, ranking second to Swaziland in the Global TB report 2006. In 2005, 15,984 TB cases were notified. Only 16% of notified patients were reported tested for HIV, of which 58% were HIV sero-positive. By the mid year report 2006, this percentage has increased to 24%. In 2005 (2004 cohort), 70% of new sputum smear pulmonary TB cases were treated successfully. In the mid year report of 2006, (cohort 2005) treatment success rate has increased to 74%. Fixed-Dose Combination tablets for management of TB cases were introduced in the entire country in April, 2006. This has reduced the pill burden for patients especially those on concomitant HAART.

KNCV, through TB CAP provided Namibia with part-time TA since 2002. From April 2005, KNCV provides for both a full time resident TB/HIV technical advisor and part-time external consultant funded by PEPFAR through TB CAP. USAID support in year one of TB CAP was used in part to strengthen the management capacity at all levels through trainings, district TB review meetings, decentralization of DOT in Erongo region, renovation of MDR-TB ward etc.

1. Key Data	**2004**	**2005**	**2006**
Total Population (millions)	2	2	2
TB incidence (WHO estimates) per 100.000 population	717	697	n/a
HIV sero-prevalence among TB patients (%)	61	56	n/a
Case fatality of HIV positive TB patients (estimated) (%)	41	35	n/a

2. Outcome Indicators	**2005**	**2006**	**2007**
Percent of public clinics implementing DOTS strategy (Country total)	100	100	100
Case detection rate (all cases) (Country total)	99	n/a	n/a
Case detection rate (SS+ cases) (Country total)	90	n/a	n/a
Treatment success rate (new ss+) (Country total)	68*	75**	n/a
Meets MDR TB quality standards defined by TB CAP (max. 3)	**2**	**2**	**2**
• Political will	Yes	Yes	Yes
• Surveillance (or survey) system is in place	No	No	No
• At least one laboratory in the public sector performing culture & DST	Yes	Yes	Yes
Nationwide TB and HIV programs effectively coordinated (max. 4)	**1**	**2**	**3**
• TB/HIV is reflected both in TB and HIV/AIDS strategic plans	Yes	Yes	Yes
• Annual work plans available for TB/HIV both in TB and HIV/AIDS programs	No	No	No
• Coordinating body is in place	No	No	Yes
• Nationwide reporting system for TB/HIV is in place	No	Yes	Yes

* 2004 cohort ** 2005 cohort (NTP estimates)

3. Financial Overview (US$)						
Period	**Funds**		**Expenditures**			**Level of Spending**
	Obligated	**Budget**	**Declared**	**Accrued**	**Total**	
Year 1	1,646,000	580,000	976,275	272,975	1,249,300	82%
Year 2		948,000				

4. TB CAP Project Highlights 2006-2007

Strengthened and expanded DOTS;
TB CAP has procured three vehicles and delivered to the NTP. The vehicles have helped to improve supervision visits.

TB CAP has supported the renovation of Walvis Bay district MDR-TB ward and also assisted the decentralization of the Walvis Bay district TB program from 1 clinic to 6 peripheral clinics providing DOT.

District review meetings as a tool to improve performance; TB CAP has organized regular district review meetings for 26 districts in 11 regions attended. During those quarterly TB review meetings performance of the previous quarter has been reviewed and data from the districts compiled and analyzed. A digital video conference aimed at standardizing the conduct and content of the review meetings was conducted and has helped guide the conduct of the meetings. The conference has also set standards and content for the review meetings. It is anticipated that every region will now routinely have the quarterly meetings. These are now going to be expanded into TB/HIV quarterly meetings that will include NGOs working in the regions to participate. TA has also been provided to district health workers during those review meetings. The quality of presentations being made has improved drastically and is now standard and comparable across districts and regions.

The annual TB data were compiled before the end of February 2007 - an achievement attributable to the review meetings held in the regions. The 2006 TB report indicates that the epidemic has levelled off and has started declining (CNR 765), treatment success rate increased from 70% in 2004 to 75% in 2005, and TB patients tested for HIV increased from 16% in 2005 to 30% in 2006.

MOST for improved program management; TB/HIV collaboration has been strengthened after national, regional MOHSS staff and staff from NGOs involved with TB and HIV participated in the Management Organizational Strengthening Tool (MOST) training. (35 participants from government and NGOs and parastatals involved in TB and HIV were trained). The HIV/TB MOST workshop was very successful and it brought together doctors, nurses, laboratory staff and other health workers in the NGOs together to analyze TB/HIV collaborative activities. It opened the eyes of the National level to some problems they thought did not exist and helped strengthen TB/HIV collaborative activities through gap identification and proposed solutions including who should carry out the next steps to cover the gaps identified.

Strengthened and expanded TB and HIV/AIDS coordinated activities; National quarterly TB data, including Erongo is being submitted timely and TB/HIV collaborative activities have improved. The HIV testing among TB cases has risen to 47% in the first two quarters. As for Erongo the proportion tested for HIV is 64% compared to 24% in 2006; HIV positive among the tested is 57% compared to 69% for 2006: and for Walvis bay in particular the percentage of TB patients tested for HIV is 76% compared to 14% in 2006; and HIV positivity among the tested is 56% compared to 70% in 2006. The percentage of TB patients with a known HIV status has increased from the previously reported 44% to 48%. HIV positivity among TB patients is reported as 67% among the 48% tested.

Nigeria

Background Information

The National Tuberculosis and Leprosy Control Program (NTBLCP) of Nigeria was established in 1989. TB is a serious public health problem in Nigeria with an estimated prevalence of 684,000 cases. This data places Nigeria as the highest TB disease burden country in Africa and 4th among 22 high TB burden countries in the World. Nigeria adopted the WHO recommended DOTS strategy in 1994. By 2002, 21 of the 36 states and 350 of the 774 Local Government Areas (LGA) in the country were implementing DOTS with support of the ILEP organizations (Damien foundation, GLRA, NLR) and some bilateral donors (DFID, CIDA). USAID support for the expansion and strengthening of TB control program started in 2003 through the TBCTA, mainly in the field of general TA and HRD. WHO/Nigeria was selected as the coordinating partner to provide program support and TA to the NTBLCP. KNCV provided TA on HRD. USAID and CIDA jointly supported the expansion of DOTS services to 17 states in the North that had no services prior to 2002. From FY 2005, the Global HIV/AIDS Initiative in Nigeria (GHAIN), an in-country project of FHI has also received funds from USAID to support the implementation of the Stop TB strategy in Nigeria. In total, the USAID support has been $ 7.8 million since 2003.

As a result of these resources, DOTS expansion further increased. In 2006, DOTS services were available in all 36 states and Federal Capital Territory (FCT) and 548 of 774 LGAs had at least one facility providing DOTS services. The national case detection rate increased from 16.1% at end of 2002 to 27% at end of 2005. At the end of 2005, the case detection rate in the 17 Northern states supported by USAID was 54% or approximately twice the national average. After 14 years of DOTS implementation, Nigeria has only achieved a case detection rate of 27% and treatment success rate of 79% at the National level.

In January, 2007 an evaluation was carried out to assess impact of USAID support for the TB control program in Nigeria and to recommend strategies to maximize the effectiveness and impact of USAID TB funds. Based on the results and recommendations of the evaluation, USAID Nigeria obligated funding to **TB CAP** with the primary objective of offering TA to the NTBLCP. **WHO** was chosen as Coordinating Partner with **FHI**, **KNCV** and **MSH** as collaborating partners. The TB CAP work started in May 2007.

1. Key Data	**2004**	**2005**	**2006**
Total Population (millions)		131	n/a
TB incidence (WHO estimates) per 100.000 population	290	283	n/a
HIV sero-prevalence among TB patients (%)	27	19	n/a
Case fatality of HIV positive TB patients (estimated %))	27	19	n/a

2. Outcome Indicators	**2005**	**2006**	**2007**
Percent of public clinics implementing DOTS strategy	65	65	65
Case detection rate (all cases)	16	n/a	n/a
Case detection rate (SS+ cases)	22	30	n/a
Treatment success rate (new ss+)	73*	75**	n/a
Meets MDR TB quality standards defined by TB CAP (max. 3)	**2**	**2**	**2**
• Political will	Yes	Yes	Yes
• Surveillance (or survey) system is in place	No	No	No
• At least one laboratory in the public sector performing culture & DST	Yes	Yes	Yes
Nationwide TB and HIV programs effectively coordinated (max. 4)	**2**	**2**	**2**
• TB/HIV is reflected both in TB and HIV/AIDS strategic plans	Yes	Yes	Yes
• Annual work plans available for TB/HIV both in TB and HIV/AIDS programs	No	No	No
• Coordinating body is in place	Yes	Yes	Yes
• Nationwide reporting system for TB/HIV is in place	No	No	No

* 2004 cohort ** 2005 cohort (NTP estimates)

3. Financial Overview (US$)						
Period	**Funds**		**Expenditures**			**Level of Spending**
	Obligated	**Budget**	**Declared**	**Accrued**	**Total**	
Year 2		104,841	61,464	0	61,464	59%

4. TB CAP Project Highlights 2006-2007

Strengthened TB program leadership and management:
Abt. Associates in collaboration with TB CAP facilitated a workshop targeting TB, HIV/AIDS and GF program managers and staff in September, 2007. The goal of this training was to improve knowledge and skills in management and leadership--covering basic program management techniques and method. A roll out planned was developed in collaboration with participants to be implemented by Zaria targeting State level managers.

Strengthened MDR-TB Control in Nigeria:
In July, 2007, TB CAP conducted a situation analysis to identify the laboratory and diagnostic capacity, and needs on the ground. Based on observations and recommendations the following steps have been taken;

- **Meeting International Safety Standards:**
  A general layout based on the WHO standard requirements for a TB containment laboratory is adopted and will be used for all the six zone laboratories.

  First steps to renovate and refurbish are being taken in four of the zone laboratories with completion plans in October.

  A consultant from the NRL in Cape Town, SA will assist with the installation the negative pressure system at NIMR in October 2007. A consultant from CDC will assist Zaria also in October.

- **Increasing staff at National and Zone Laboratories:**
  Since there have been plans to deploy more personnel to the labs WHO sent a questionnaire to the zone labs to document the personnel on ground, their qualifications and expertise, and all the relevant TB training programs they have had if any. Based on the results 37 State laboratory focal persons have been trained through GF at NIMR on Laboratory Quality Control and Assurance.

  Updated WHO modules for training on various aspects of microscopy, culture, DST, Quality Assurance, safety procedures, good laboratory practices and IC were provided. The modules will be adapted to meet country specific needs and use them to conduct several in-county training programs of staff from the various laboratories.

  The SOPs provided by the TB CAP consultant are adapted by the laboratory team at NIMR for national use.

- **Development of National Working Documents:**
  WHO provided the international guidelines on Quality Assurance and IC. These guidelines were adapted for the Nigerian context.

- **Linkage between the NRL and a Supranational Laboratory Abroad:**
  Although not supported by TB CAP, it is important to mention that the NRL in Cape Town, South Africa has agreed to serve as the SRL to both National and Zone Reference Laboratories.

South Africa

Background Information

South Africa is plagued by one of the most serious TB and HIV epidemics worldwide, causing the trends of TB to rise in the past 15 years. As a middle income country SA has introduced the 6 month regimen using single dose formulations, already since the middle eighties, in the absence of a well functioning TB control program. This has resulted in the emergence of MDR-TB and XDR-TB. Lately a serious outbreak of XDR-TB has been reported in Kwazulu Natal, where of 50 XDR-TB cases, all of whom HIV positive, 48 died quite soon after the start of their TB treatment. The wide variation between the federal provinces (states) in socio-economic and health system development poses a great challenge for the National Department of Health (NDoH). Quality of DOTS is variable and access to TB care as well. The NDoH does not command technical policies and practice and TB funding in the provinces, as these are independent Ministries of Health, in which TB is competing for priority with other health and political priorities, resulting in also a wide variation of funding and staffing levels. The political administrative nature the federal state of South Africa, the strong private sector, the devastating HIV/AIDS epidemic, and the most variable quality of provincial health systems create a difficult and complex environment for successful TB control, resulting in a poor performance in treatment outcomes and the emergence of MDR- and XDR-TB. To reverse this trend NDoH needs in particular TA to address the different challenges and constraints, in strategic development and planning and HRD, and areas that have up to now received little attention.

TB CAP partners, and particularly **KNCV**, have a track record of working with the NDoH on strategic development, which has been very useful in the past 5 years. The skills mix available in **TB CAP** provides for a flexible approach tailored to the needs of the NDoH and Provincial DoHs.

1. Key Data	**2004**	**2005**	**2006***
Total Population (millions)	43	44	45
TB incidence (WHO estimates) per 100.000 population	718	600	600
HIV sero-prevalence among TB patients (%)	60	58	65
Case fatality of HIV positive TB patients (estimated %))	78	41	n/a

* NTP estimates

2. Outcome Indicators	**2005**	**2006**	**2007**
Percent of public clinics implementing DOTS strategy	80	94	94
Case detection rate (all cases)	85	n/a	n/a
Case detection rate (SS+ cases)	108	n/a	n/a
Treatment success rate (new ss+)	70*	67**	n/a
Meets MDR TB quality standards defined by TB CAP (max. 3)	**2**	**2**	**3**
• Political will	Yes	Yes	Yes
• Surveillance (or survey) system is in place	No	No	Yes
• At least one laboratory in the public sector performing culture & DST	Yes	Yes	Yes
Nationwide TB and HIV programs effectively coordinated (max. 4)	**0**	**0**	**1**
• TB/HIV is reflected both in TB and HIV/AIDS strategic plans	No	No	No
• Annual work plans available for TB/HIV both in TB and HIV/AIDS programs	No	No	No
• Coordinating body is in place	No	No	No
• Nationwide reporting system for TB/HIV is in place	No	No	Yes

* 2004 cohort ** 2005 cohort (NTP estimates)

3. Financial Overview (US$)						
Period	**Funds**		**Expenditures**			**Level of Spending**
	Obligated	**Budget**	**Declared**	**Accrued**	**Total**	
Year 1+2	750,000	750,000	146,539	36,000	182,539	24%

4. TB CAP Project Highlights 2006-2007

The work plan combining Year 1 and 2 was approved on May 18th, 2007. KNCV has appointed a country coordinator. Activities started on July 1st, 2007. Following the initial visit, country coordinator conducted a short follow up mission to follow up on a new work plan for 2007/8.

TB CAP has decided to revisit the current approved work plan and will determine what activities need re-programming because they have become redundant. A revised work plan and budget will be developed for the remaining funds of year 1 and 2, and the new obligation for year 3.

Uganda

Background Information

Uganda is one of the 22 high-burden TB countries and also one of the sub-Saharan African countries which is enduring the impact of the dual TB/HIV epidemic. Uganda achieved 100% DOTS coverage in the late 1990s and adopted CB-TB care as a national strategy in 2002. This national TB control policy includes community sensitization and mobilization, as well as offering every TB patient DOT by a community volunteer. The country has increased the number of diagnostic centers for sputum-smear microscopy and treatment centers for TB. Despite these efforts, the NTLP has been unable to ensure that all the components of the DOTS strategy and CB-DOTS are operating at optimum throughout the country due to lack of financial support and dedicated and competent personnel. There has also been a lack of funding to support national supervision, communications to improve community awareness and political and financial commitment from the district health management committees. The challenges faced by the NTLP have resulted in case detection rates below the internationally recognized 70% target. Similarly, Uganda has only achieved a 68% treatment success, again below the target of 85% driven down by a high default rate of 16%. The TB/HIV dual epidemic has seriously affected Uganda, and is the main explanation for the doubling of case-notifications between 1991 and 2004.

The goal of **TB CAP**, which started in 2007, is to decrease the burden of TB among PLWA and the burden of HIV among notified TB patients by: strengthening TB control activities, providing diagnostic HIV counselling and testing to TB patients and increasing active TB case finding at HIV service points. This project draws on the expertise and strong country knowledge of **The Union** which has been selected as the implementing partner and other TB CAP partners, such as **WHO** and **CDC**.

1. Key Data	**2004**	**2005**	**2006***
Total Population (millions)	28	28	29
TB incidence (WHO estimates) per 100.000 population	402	369	n/a
HIV sero-prevalence among TB patients (%)	19	30	n/a
Case fatality of HIV positive TB patients (estimated %))	22	32	n/a

* NTP estimates

2. Outcome Indicators	**2005**	**2006**	**2007**
Percent of public clinics implementing DOTS strategy (Country total)	47	47	47
Percent of public clinics implementing DOTS strategy (TB CAP Areas)			6
Case detection rate (all cases)	37	47	n/a
Case detection rate (all cases) (TB CAP Areas – 11 Districts)	n/a	39	n/a
Case detection rate (SS+ cases)	45	50	n/a
Case detection rate (SS+ cases) (TB CAP Areas – 11 Districts)	n/a	43	n/a
Treatment success rate (new ss+)	70*	73*	n/a
Meets MDR TB quality standards defined by TB CAP (max. 3)	**1**	**1**	**1**
• Political will	No	No	No
• Surveillance (or survey) system is in place	No	No	No
• At least one laboratory in the public sector performing culture & DST	Yes	Yes	Yes
Nationwide TB and HIV programs effectively coordinated (max. 4)	**4**	**4**	**4**
• TB/HIV is reflected both in TB and HIV/AIDS strategic plans	Yes	Yes	Yes
• Annual work plans available for TB/HIV both in TB and HIV/AIDS programs	Yes	Yes	Yes
• Coordinating body is in place	Yes	Yes	Yes
• Nationwide reporting system for TB/HIV is in place	Yes	Yes	Yes

* 2004 cohort ** 2005 cohort (NTP estimates)

3. Financial Overview (US$)						
Period	**Funds**		**Expenditures**			**Level of Spending**
	Obligated	**Budget**	**Declared**	**Accrued**	**Total**	
Year 2	750,000	1,000,000	455,022	67,337	522,359	52%

4. TB CAP Project Highlights 2006-2007

TB CAP has recruited a distinguished and well qualified team in Uganda. Their combined expertise and passion will be the key to the advancement of TB CAP in Uganda; and their positive impact has already been felt within the short time that they have been working on the project.

The USAID Uganda Mission obligated an additional $1.35 million in additional PEPFAR funds to this project. The Union has developed a revised technical proposal narrative, implementation plan, logical framework and budget to accommodate the increased budget and targets.

A Memorandum of Understanding (MOU) was signed with the MOH which recognizes and supports planned TB CAP activities in Uganda.

Megan Elliott and Jennifer Baluka (M&E Manager) with District staff in Opit IDP camp in Gulu District

A training course on management, leadership, finance and logistics was conducted for 22 participants (14 males and 8 females) from NTP and districts.

A well organized drug store at Opit Health Center in Gulu District

TB CAP has provided funding to NTLP for central level and district level supervision of 20 TB CAP target districts.

TB CAP assisted NTLP to revise TB Unit registers to improve recording and reporting and to improve data collection for TB/HIV and CB-DOTS.

A TB/HIV Situation Analysis was also implemented in 26 districts. Results from situation analysis are expected in October 2007.

MOH Uganda is expecting a large consignment of HIV rapid test kits; however, the Mission has suggested that this funding be reserved in case of stock-outs. The Mission has indicated that it would prefer SCMS, the PEPFAR procurement mechanism, be used to procure test kits.

Zambia

Background Information

Zambia has an area of 752,614 square km and borders seven other African countries. It is one of the poorest countries in the world with 78% of the population living below the poverty line. Public expenditure on health amounted to 8% of the total domestic budget in 2005. Zambia has gone through a series of health system reforms over the past decade. The main focus has been on integration and decentralization of resources and services. During this same period, HIV prevalence rates increased dramatically. The prevalence in the 16-49 year age group is currently 16.5% according to the Zambia Demographic Health Survey 2002. Currently, major issues facing the health care system are the critical shortage of financial and human resources as well as HIV/AIDS overstretching the capacity of the entire system. TB, HIV/AIDS and Malaria are the major communicable diseases leading to serious public health problems in the country. TB is one of the top ten causes of morbidity and mortality.

TB CAP supports Central, Copperbelt, Luapula, Northern and North Western provinces and assists MOH achieve a 70% or greater case detection rate and successfully teat 85% of the cases in selected provinces. TB CAP also builds on the TB/HIV collaborative activities in these provinces to increase numbers of TB patients tested for HIV and accessing HIV care and of HIV patients diagnosed with TB. TB CAP Zambia was established in 2006 at FHI offices and is the representative for the consortium of partners in Zambia. FHI, the coordinating partner, is responsible for the execution, management, coordination, monitoring the technical quality of the implementation and performance of TB CAP. TB CAP implementing partners have specialized technical staff that address the program's specific needs with regards to laboratory services (**JATA**), collaborative TB/HIV activities (**FHI**), enhanced and strengthened quality DOTS (**WHO**). With this collaboration as a consortium TB CAP covers all of the five components of the DOTS strategy.

1. Key Data	**2004**	**2005**	**2006**
Total Population (millions)	11	12	12
TB incidence (WHO estimates) per 100.000 population	680	600	n/a
HIV sero-prevalence among TB patients (%)	54	55	n/a
Case fatality of HIV positive TB patients (estimated %)	68	57	n/a

2. Outcome Indicators	**2005**	**2006**	**2007**
Percent of public clinics implementing DOTS strategy (Country total)	100	100	100
Percent of public clinics implementing DOTS strategy (TB CAP areas)	100	100	100
Case detection rate (all cases) (Country total)	68	85	68
Case detection rate (all cases) (TB CAP areas)	32	46	48
Case detection rate (SS+ cases) (Country total)	52	30	27
Case detection rate (SS+ cases) (TB CAP areas)	37	39	n/a
Treatment success rate (new ss+) (Country total)	83*	82**	n/a
Treatment success rate (new ss+) (TB CAP areas)	79*	79**	n/a
Meets MDR TB quality standards defined by TB CAP (max. 3)	**3**	**3**	**3**
• Political will	Yes	Yes	Yes
• Surveillance (or survey) system is in place	Yes	Yes	Yes
• At least one laboratory in the public sector performing culture & DST	Yes	Yes	Yes
Nationwide TB and HIV programs effectively coordinated (max. 4)	**4**	**4**	**4**
• TB/HIV is reflected both in TB and HIV/AIDS strategic plans	Yes	Yes	Yes
• Annual work plans available for TB/HIV both in TB and HIV/AIDS programs	Yes	Yes	Yes
• Coordinating body is in place	Yes	Yes	Yes
• Nationwide reporting system for TB/HIV is in place	Yes	Yes	Yes

* 2004 cohort ** 2005 cohort (NTP estimates)

3. Financial Overview

Period	Funds		Expenditures			Level of Spending
	Obligated	Budget	Declared	Accrued	Total	
Year 1	1,914,000	993,144	1,240,379	133,057	1,373,436	72%
Year 2		914,000				

4. TB CAP Project Highlights 2006-2007

TB CAP has successfully completed Year 2 of project implementation in Luapula, Copperbelt and North Western provinces. The good collaboration among the TB CAP partnership, the guidance by the Ministry of Health and the USAID mission and the open communication with the provincial staff have enabled this accomplishment.

A full-time Project Director and part-time finance, admin and program staff have been providing support. Two full-time laboratory staff is also implementing TB CAP activities. TB CAP will also hire 15 microscopists for program support.

In order to strengthen laboratory services and system, TB CAP is fully renovating two general TB laboratories in the region. Also six spirit lamps for sputum smear preparation were procured and distributed to health facilities. Three EQA and smear microscopy training courses have been conducted for provincial and district staff. All these efforts have helped TB CAP to make a remarkable achievement in improving the performance of TB microscopy. In 2007, following the TB CAP funded EQA component of panel testing of laboratory staff, the percent of laboratories performing TB microscopy with over 95% correct microscopy results has reached from 4% to 64% in Northwestern Province.

Mansa General Hospital Director Dr. Bwalya receiving the fluorescent microscope procured by TB CAP.

Also TB CAP has initiated the scale up of EQA activities in the provinces to the level of District TB diagnostic centers in North Western and Luapula provinces.

TB CAP is supporting the revision of the National TB Manual which will help to strengthen timely detection and treatment of TB cases.

A baseline assessment has been completed to strengthen current TB and HIV activities.

DCT training participants in North western province with TB CAP staff Catherine Mumba and Francs Mkbo

TB CAP has been providing TA to strengthen routine HIV testing of TB patients TB/HIV training manuals have been produced. In year two a total of 179 staff was trained in DCT from Luapula, North Western, Copperbelt, Northern and Central Provinces.

In total, 180 TB treatment supporters trained in HIV counselling in the Copperbelt, Luapula and North Western provinces.

5.2 Other TB CAP fieldwork

Brazil

TB CAP hired a full-time resident consultant (Denise Garrett) to assist Brazil's NTP in reaching the goals outlined in the new TB strategy. During Year 1 the consultant assisted Brazilian NTP to implement Drug Resistance and HIV Prevalence Surveys in 3 additional Brazilian states. The consultant continued routine work in the last 12 months and the project has ended with the consultant's departure in August 2007.

Djibouti

A training course on management of TB at health facilities was conducted for 28 clinic staff. Following the course which participants have prepared action plans for 2007. In order to reinforce supervision guides and checklists have been developed, two vehicles have been purchased so that the visits are conducted on a regular basis by the central team. A survey on diagnosis and treatment delay was also scheduled. The process of establishing HIV/TB collaborative activities in the country has been speed up with weekly meetings involving the two programs being held regularly to finalize the TB/HIV strategic framework. In the meantime, VCT activities in TB patients have been reinvigorated in Djibouti city. Based on the WHO checklist a thorough and in depth analysis of the causes of low case detection in Djibouti was carried out. In order to set up a quality-based laboratory network the project has recruited an international laboratory specialist, purchased and distributed microscopes for ten clinics both in Djibouti city and in five districts. Two training courses were conducted for a total of 44 laboratory technicians on the Quality Control Procedures recommended by WHO.

Dominican Republic

The project was approved on May 1st, 2007. The project has been providing technical assistance to the Dominican Republic NTP for the quality implementation of the Stop TB Strategy, prioritizing the implementation of the basic DOTS components, MDR-TB, public private partnership and the management of TB/HIV co-infection in the country. An external review by TBCAP partners (KNCV, WHO/PAHO, Union and MSH-RPM+) took place in May 2007. The mission concluded that the program is in a transition phase. A lot has been achieved such as coverage (80%), case detection rate new smear positive patients (74%) and treatment success rate (85%). An EQA system has been implemented and the last quarter of 2007 FDC's will have been introduced in half of the country. TB patients are being tested for HIV in increasing percentages and IPT is being provided. MDR treatment has started, the two social mobilization projects are now being coordinated and activities in prisons are taking shape. Frequency of supervision visits has been increased. However, there are still a number of issues that create major challenges to the program such as the laboratory network (the Central Reference Laboratory is still not functional), the TB/HIV coordination, expansion of MDR treatment and a new Health Sector Reform Process. In June 2007, TB CAP (through MSH and KNCV) provided technical assistance for the preparation of the proposal to the GF Round 7. The proposal was approved. WHO/PAHO has been conducting follow-up visits for the MDR program. The expansion has been realized. In October 2007, the creation of the TB/HIV Coordination Committee was officially ratified.

Ghana

A comprehensive review report has been finalized and edited which has provided important recommendations for TB CAP work plan which was approved in June 2007. The TB CAP provides a unique opportunity for NTP to access a comprehensive range of internationally recognized TA that supports the new global Stop TB Strategy through its membership. TB CAP partner **MSH** has been leading the project with **KNCV** as the collaborating partner. The recruitment of a full-time TB Technical Advisor is ongoing and will be finalized soon. A study-tour and workshop was conducted to Zambia for 4 Staff from the Ghana NTP and Department of Pharmacy. The purpose was to enhance the capacity and skills of staff to undertake planning and implementation of the introduction of the new TB treatment regimen (FDC) nationwide. Following the study tour the team decided to document and report the lessons learnt to all stakeholders. In the coming months the roll-out strategy and implementation plan will be developed. It is expected that the distribution of FDCs to service outlets will soon start.

Kenya

Through USAID support, **KNCV** was able to strengthen human capacity at the provincial and district levels in Kenya. Under ISAC initiative, 26 (6 provincial, 19 district and 1 PPP officer) unemployed health staff was contracted by the Kenyan Association for Prevention of Tuberculosis and Lung Diseases which has been working for the NTP. PATH contracted 10 more staff under the same conditions. Since January 2007, this staff is contracted by KNCV through TB CAP which made a significant contribution to the development and implementation of national TB/HIV indicators that are collected through the revised recording and reporting system, making Kenya one of the few countries world-wide reporting these indicators. All ISAC staff, which received their last ISAC salaries in October, has been offered a transition to the "Capacity Project", a local USAID funded human resource strengthening AIDS project. PATH, USAID, KAPTLD and TB CAP have agreed that the salaries for 34 staff members for November and December will be provided by TB CAP. Capacity will take over as soon as administrative issues have been solved.

Mexico

TB CAP work plan has recently been approved and the work has just started. The project's main three activities are each likely to contribute to the overall success of TB control in Mexico. The adaptation and implementation of the ISTC should lead to both increased identification of TB cases, as well as improved management of these cases. The provision of training in management of drug-resistant TB, including the training of future facilitators should enhance the capacity to manage drug-resistant as part of routine program activities. This increased capacity is in line with the Stop TB Strategy's emphasis on addressing challenges such as MDR-TB. Similarly, the project's efforts to enhance collaboration with private health care providers directly address the Strategy's aims to engage all care providers in TB control efforts.

Philippines

During the Year 1 TB CAP completed the Phil-TIPS program evaluation and a detailed evaluation report was submitted to USAID. KNCV has been identified as the coordinating partner for the follow-up of the project. Assessment of the Enabling Environment for PPM DOTS Expansion was carried out in May 2007. TB CAP will plan a follow on visit during next project year.

South Sudan

Since the start of the TB CAP project, the five year Strategic Plan and TB Policy and Guidelines developed in 2004 have been officially adopted and disseminated. The NTP has been strengthened with the appointment of a National TB Coordinator. The recording and reporting system was also updated to include TB/HIV collaborative activities. An assessment of the former Garrison towns of Malakal, Juba and Wau resulted in a training course on DOTS and implementation of the Southern Sudan TB regimen, which is based on six month short course chemotherapy instead of the eight month regimen. Forty-five public and private health workers participated in the training.

Participants of Training workshop in Wau during group discussion

Furthermore, construction of the quality assurance laboratory has reached new momentum. A PPM task force was established following a workshop with prison authorities and stakeholders. Based on the results of the workshop the South Sudan PPM guidelines will be finalized.

6. Financial Status

As of November 15th, 2007, the levels of spending were 69% for Year 1 Core, 54% for Year 2 Core, 80% for Regional, 57% for Countries and 100% for GF TA (Table 27). Detailed financial status of each project can be found on Tables 29-33.

Table 27: Summary financial status as of November 15th, 2007

Year 1	Approved Budget	Expenditures			Level of Spending
		Declared	Accrued	Total	
Core Projects	$1,425,813	$1,028,029	$41,964	$1,069,993	75%
Management	$1,764,308	$1,283,516	$23,560	$1,307,076	74%
Management SWAP Indonesia	-$250,000				
Management SWAP Mozambique	-$80,000				
ACF	-$389,300	-$389,300	$0	-$389,300	100%
Total Management	**$1,045,008**	**$894,216**	$23,560	**$917,776**	**88%**
Total Core	**$2,470,821**	**$1,922,245**	**$65,524**	**$1.987,769**	**80%**
Year 2	**Approved Budget**	**Expenditures**			**Level of Spending**
		Declared	**Accrued**	**Total**	
Core Projects	$2,890,047	$1,245,670	$650,202	$1,895,872	66%
Management	$2,415,728	$2,157,120	$221,007	$2,378,127	98%
ACF	-$1,261,762	-$1,261,762	$0	-$1,261,762	100%
Total Management	**$1,153,966**	**$895,358**	**$221,007**	**$1,116,365**	**97%**
Total Core	**$4,044,013**	**$2,141,028**	**$871,209**	**$3,012,237**	**74%**
Regional	**Approved Budget**	**Expenditures**			**Level of Spending**
		Declared	**Accrued**	**Total**	
Year 1	$536,783	$411,372	$33,741	$445,113	83%
Year 2	$435,777	$346,336	$0	$346,336	79%
Total	**$972.560**	**$757,708**	**$33,741**	**$791,449**	**81%**
Countries	**Approved Budget**	**Expenditures**			**Level of Spending**
		Declared	**Accrued**	**Total**	
Total	**$15,975,481**	**$8,661,063**	**$1,910,325**	**$10,571,388**	**66%**
Global Fund TA	**Approved Budget**	**Expenditures**			**Level of Spending**
		Declared	**Accrued**	**Total**	
Total	**$713,049**	**$343,444**	**$369,605**	**$713,049**	**100%**

Cost Share

The cooperative agreement mentions that a minimum of 17.8% need to be cost shared over the course of the project. We received a cost share totalling $9,888,158 in Year 1 and $8,062,004 in Year 2 (See table below), which corresponds with a cost share of 75% of the total approved budget for two years.

Table 28: Cost Share Year 1 and 2 of TB CAP as of November 15th, 2007

Partner	Year 1	Year 2	Total
JATA	$2,381,514		$2,381,514
KNCV	-	$8,045,940	$8,045,940
MSH	-	-	-
ATS	$6,518	$16,064	$22,582
The Union	$5,247,092	-	$5,247,092
WHO	$2,253,034	-	$2,253,034
FHI	-	-	-
Total	**$9,888,158**	**$8,062,004**	**$17,950,162**
Total Approved Budget			**$24,078,899**
Percentage Cost share			**75%**

7. Challenges for future

Addressing all expected outputs
"Ensured political legal framework" under IR1, "Strengthened integration of DOTS services in general health services" and "Improved equitable access to quality TB care for vulnerable populations" under IR2 are the three outputs that have not been fully addressed yet. This poses a considerable challenge for the last three years of TB CAP.''

HRD and institutional capacity building
HRD remains a challenge for TB CAP. A broader approach is needed to address the expected outputs on HRD, particularly at country level. In Year 2, TB CAP addressed this challenge by establishing the IR5/HRD Working Group and also by selecting the two regional institutes for capacity building.

Another challenge for HRD is to support countries in developing HRD strategic plans based on the handbook developed by WHO and CDC and part of the core projects for IR5. The handbook is expected to be ready in December 2007 and a draft copy already available.

Finally the challenge is to develop a strategy to link the HRD/TB platform meeting to the working groups of the Stop TB Partnership to make the platform a sustainable structure in initiatives to strengthen health systems after TB CAP.

Follow-up of TB CAP trained consultants
The recently conducted survey among the TB CAP consultant trainees showed that efforts should be made to ensure increased participation of those in different areas of TB Control in the future.

TB/HIV
Leveraging resources for TB/HIV is also a challenge for TB CAP. Securing PEPFAR funds in other countries for TB/HIV collaborative activities remain a continuing challenge. In Year 2, TB CAP started gaining momentum in receiving funds from PEPFAR. In addition to more funds for Namibia TB CAP were asked to prepare Country Operation Plans for Malawi, Nigeria and Uganda. TB CAP also started preparing a core project using PEPFAR funds. TB CAP's main challenge now is to ensure that all these and upcoming TB/HIV core and country projects are effectively coordinated and well managed. TB CAP recently announced a full-time TB/HIV coordinator position based in The Hague to meet that challenge.

XDR TB
The Emergence of XDR TB in the African setting presents a greater challenge for TB CAP to address on top of the already existing challenge of MDR TB. In Year 2, TB CAP responded to that challenge by preparing and implementing a comprehensive core funded project of $500k. An additional $250k core project funded by PEPFAR is under development. However, the growing MDR and XDR problem will remain as a challenge for TB CAP.

Laboratory Systems Strengthening
In Year 3 and beyond one important challenge for TB CAP is to develop the laboratory infrastructure especially for the East African Region. There are already one regional and one PEPFAR funded projects are underway to develop at least one SRL in the region.

Management of TB CAP Funds
In two years time there has been a four fold increase in TB CAP's budget and with each additional country this budget keeps growing. TB CAP's challenge is to ensure that all the core, regional and country funds are absorbed and work plans are timely implemented. TB CAP PMU will closely monitor the project implementation and ensure a high burn rate of budget.

Table 29: Status of Year 1 Projects as of November 15, 2007

APA1 Projects		Leading Partner	Level of Completion (%)											Approved Budget	Expenditures			Level of Spending
IR Code	Project Title		0	10	20	30	40	50	60	70	80	90	100		Declared	Accrued	Total	
C1.01	Developing Financial Assessment and Budgeting Tool	WHO												127.440	115.840		115.840	91%
C2.01	Improved diagnostic capacity	MSH												85.431	67.336		67.336	79%
C2.02	Improved health systems mapping and organization	MSH												12.929	5.395		5.395	42%
C2.03	Promotion of rational use of TB diagnostic process	JATA												64.432	24.685	15.876	40.561	63%
C2.04	Improved TB program management – MOST	MSH												90.923	90.923		90.923	100%
C3.01	Preparing a strategic coordination plan for developing PPP in USAID priority countries	WHO												18.295	14.457	1.160	15.617	85%
C3.02	Developing tools for situational analysis	WHO												39.550	39.550		39.550	100%
C3.03	Promotion of PPP through sharing of PPP experiences among TB CAP and other countries	WHO												122.364	122.364		122.364	100%
C3.04	Dissemination and implementation of *ISTC*	ATS												16.000	16.000		16.000	100%
C4.01	Lessons learned for scaling up	FHI												81.259	21.111	13.328	34.439	42%
C4.02	Validation of revised recording and reporting system	WHO												75.025	27.032		27.032	36%
C4.03	Accurate and faster diagnosis of sputum-negative EPTB patients for TB/HIV	WHO												60.010	40.680		40.680	68%
C4.04	Assessment of role and potential of community based TB/HIV care in scaling-up	FHI												98.760	5.025		5.025	5%
C5.01	Task Force on HRD	PMU												114.242	66.708		66.708	58%
C5.02	Development of a guide on "How to develop an HRD plan for comprehensive TB control"	WHO												15.255	15.255		15.255	100%
C5.03	Support to CORE workshop in India for US PVOs	PMU												7.658	7.658		7.658	100%
C5.05	Institutional capacity building	PMU	Forwarded to APA 2															
C5.06	Regional workshop for HRD focal points	KNCV	Project has been cancelled															
C5.07	Training course for TB/HIV consultants and support for field experience	WHO												99.994	83.365		83.365	83%
C5.08	Training PPP consultants	WHO												86.965	75.365	11.600	86.965	100%
C5.09	Field experience for laboratory consultant trainees	WHO												29.663	29.663		29.663	100%
C5.10	International MDR-TB Course Mexico	The Union												48.622	48.622		48.622	100%
C5.12	Generic advanced course on supervision of TB management at sub-national level	WHO	Project has been cancelled											20.001				
	Support to GF Round 6 proposal development	WHO												60.995	60.995		60.995	100%
	Shortfall Brazil/Core savings APA1	The Union												50.000	50.000		50.000	100%
														Subtotal IR Projects	**1.425.813**	**1.028.029**	**41.964**	**1.069.993**	**75%**
	Management	All												1.764.308	1.283.516	23.560	1.307.076	74%
	Management SWAP Indonesia	PMU												-250.000				
	Management SWAP Mozambique	PMU												-80.000				
	Management ACF	PMU												-389.300	-389.300		-389.300	100%
														Total Management	**1.045.008**	**894.216**	**23.560**	**917.776**	88%
														Grand Total Core	**2.470.821**	**1.922.245**	**65.524**	**1.987.769**	**80%**

Table 30: Status of Year 2 Projects as of November 15, 2007

APA2 Projects		Leading Partner	Level of Completion (%)											Approved Budget	Expenditures			Level of Spending
IR Code	Project Title		0	10	20	30	40	50	60	70	80	90	100		Declared	Accrued	Total	
C1.01	Planning and Budgeting Tool	WHO												204.881	186.985	17.896	204.881	100%
C2.01	Quality Diagnosis and role of X-ray	JATA												94.088	4.140	41.149	45.289	48%
C2.02	Revision of the "TB Handbook"	WHO												64.410	46.664	17.746	64.410	100%
C2.03	Field testing of laboratory SOPs	WHO												81.812			0	0%
C2.04	Development of MIS tools for TB laboratories	The Union												62.190	40.414	4.785	45.199	73%
C3.01	Dissemination and implementation of the ISTC	ATS												223.546	218.490		218.490	98%
C3.02	Hospital DOTS Involvement	KNCV												145.240	77.941		77.941	54%
C3.03	Use of ISTC for Training	ATS												139.521	139.521		139.521	100%
C3.04	PPP planning workshop	WHO												146.103	144.723		144.723	99%
C4.01	TB/HIV Control in Prisons	KNCV												98.408	21.109	5.400	26.509	27%
C4.02	TB/HIV literacy package and curriculum	FHI												128.252	784	5.734	6.518	5%
C4.03	Develop guidance on TB/HIV activities outside the public sector	WHO												277.425	42.231	3.900	46.131	17%
C5.01	E-learning portal HRD focal points	KNCV												59.247	11.816	18.061	29.877	50%
C5.02	MDR-TB International Course Mexico	The Union												55.040	33.122	8.285	41.407	75%
C5.03	Institutional Capacity Building	PMU												119.026	20.284	42.353	62.637	53%
C5.04	Laboratory consultant training course	WHO												99.709	78.459		78.459	79%
C5.05	Strengthening and supporting HRD	PMU												197.632	103.794	2.011	105.805	54%
C5.06	Develop EQA training materials	The Union												145.364	49.646	37.079	86.725	60%
C5.07	Workshop for CORE "Community TB"	PMU												10.017		1.100	1.100	11%
XDR.01	XDR	PMU												500.000	1.733	430.381	432.114	86%
	Support to GFATM round 7 proposal	WHO												38.136	23.814	14.322	38.136	100%
														Subtotal IR Projects	**2.890.047**	**1.245.670**	**650.202**	**1.895.872**	**66%**
	Management	PMU												2.415.728	2.157.120	221.007	2.378.127	98%
	Management ACF	PMU												-1.261.762	-1.261.762		-1.261.762	100%
														Total Management	**1.153.966**	**895.358**	**221.007**	**1.116.365**	97%
														Grand Total Core	**4.044.013**	**2.141.028**	**871.209**	**3.012.237**	**74%**

Table 31: Status of Regional Projects as of November 15, 2007

APA1 & 2 Regions		Leading Partner	Level of Completion (%)											Approved Budget	Expenditures			Level of Spending
IR Code	Project Title		0	10	20	30	40	50	60	70	80	90	100		Declared	Accrued	Total	
R1.01	Africa QUOTE TB instrument development, Phase 2	KNCV												119.582	98.582	21.000	119.582	100%
R1.02	Africa TB CAP Assessment in Djibouti and one follow-up visit: HRD focal point	WHO												20.418	16.882	2.541	19.423	95%
R2.01	LAC TB nursing curriculum translation and adaptation to LAC countries	WHO												96.783	92.426		92.426	95%
R3.01	G-CAP TB/HIV collaborative activities in El Salvador, Guatemala, Nicaragua & Panama	PMU												300.000	203.482	10.200	213.682	71%
														Total Region APA 1	**536.783**	**411.372**	**33.741**	**445.113**	**83%**
R1.01	Workshop for HRD focal persons Africa Region	KNCV												137.835	136.403		136.403	99%
R1.02	Annual laboratory managers meeting in East Africa	The Union												164.256	96.445		96.445	59%
R1.03	Training Couse on Managment of MDR and XDR TB in the African Region	WHO												133.686	113.488		113.488	85%
														Total Region APA 2	**435.777**	**346.336**	**0**	**346.336**	**79%**
														Grand total regions	**972.560**	**757.708**	**33.741**	**791.449**	**81%**

Table 32: Status of Global Fund Projects as of November 15, 2007

Global Fund Name	Leading Partner	Level of Completion (%)											Approved Budget	Expenditures			Level of Spending
		0	10	20	30	40	50	60	70	80	90	100		Declared	Accrued	Total	
Romania	MSH												22.588	15.908	6.680	22.588	100%
Lesotho	KNCV												98.000	54.807	43.193	98.000	100%
Uzbekistan	MSH												150.000	22.622	127.378	150.000	100%
GF Training	PMU												7.461	2.131	5.330	7.461	100%
Georgia	KNCV												111.000	82.616	28.384	111.000	100%
DR Congo	FHI												111.000	11.100	99.900	111.000	100%
Vietnam	KNCV												213.000	154.260	58.740	213.000	100%
												Grand Total	**$713.049**	**$343.444**	**$369.605**	**$713.049**	**100%**

Table 33: Status of Country Projects as of November 15, 2007

Missions	Leading Partner	Approved Budget			Expenditures			Level of Spending
Name		Year 1	Year 2	Total	Declared	Accrued	Total	
Brazil	The Union	170.000	170.000	340.000	274.739	65.261	340.000	100%
Cambodia	JATA		1.360.399	1.360.399	473.793	158.193	631.986	46%
Djibouti	WHO		225.000	225.000	215.000		215.000	96%
Dominican Republic	KNCV		200.000	200.000	90.836	12.000	102.836	51%
DR Congo	The Union	800.000	200.000	1.000.000	903.161	68.663	971.824	97%
Ghana	MSH	160.001		160.001	153.648		153.648	96%
Indonesia	KNCV		3.220.000	3.220.000	1.476.677	664.952	2.141.629	67%
Kenya	KNCV	55.000	180.000	235.000	208.081	0	208.081	89%
Malawi	MSH		1.441.858	1.441.858	583.241	269.892	853.133	59%
Mexico	The Union		486.640	486.640	19.069	23.258	42.327	9%
Mozambique	FHI	141.424	1.556.174	1.697.598	1.222.626	137.037	1.359.663	80%
Namibia	KNCV	580.000	948.000	1.528.000	976.325	272.975	1.249.300	82%
Nigeria	WHO		104.841	104.841	61.464		61.464	59%
Philippines	KNCV	169.000		169.000	73.967	1.700	75.667	45%
South Africa	KNCV		750.000	750.000	146.539	36.000	182.539	24%
South Sudan	WHO	150.000		150.000	86.496		86.496	58%
Uganda	The Union		1.000.000	1.000.000	455.022	67.337	522.359	52%
Zambia	FHI	993.144	914.000	1.907.144	1.240.379	133.057	1.373.436	72%
		3.218.569	**12.756.912**	**15.975.481**	**8.661.063**	**1.910.325**	**10.571.388**	**66%**